Managed Care Subsystem User Manual

Kentucky MMIS Project

Cabinet for Health and Family Services
Department for Medicaid Services

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1 Introduction

This user manual is designed to cover the information necessary to perform the tasks of the Managed Care functional area.

This manual covers the following areas:

- Subsystem Overview,
- Getting Started,
- Procedures,
- Panels,
- Reports,
- Letters;
- Glossary of Terms:
- interChange Navigational Overview;
- Managed Care How To Guide;
- How to Use Audit Functionality; and
- How to Use Help Functions.

1.1 User Manual Audience

This manual is designed to serve the needs of the following staff:

- System and Functional Area Users; and,
- System Testers.

1.2 Table of Contents Help Function

The Table of Contents (TOC), in the PDF document, contains a user-friendly point and click capability. When the user moves the mouse over a section name in the TOC, the pointer changes from a hand to a pointing finger. When the user clicks, while it is a pointing finger, it takes them to that section."

2 Managed Care Overview

The Managed Care function is designed to assure member access to necessary medical care, while at the same time controlling medical assistance program costs. The Commonwealth uses the Passport Managed Care Organization (MCO) for members in the Louisville area, and a Primary Care Case Management (PCCM) business model called KenPAC (Kentucky Patient Access Care) for the rest of the Commonwealth. Payment of Non-Emergency Medical Transportation (NEMT) capitations is part of the Managed Care subsystem, as is the payment of lock-in fees to medical providers.

KenPAC sites receive an administrative fee for providing Primary Care Provider (PCP) services to members, and the members medical services are covered on a fee-for-service basis. Passport receives a capitation payment, while its members claims are paid by Passport. Encounter records of the medical services are submitted by Passport for analysis, reporting, and other purposes. In addition, most members receive pharmacy and certain other wrap-around services including NEMT.

The Managed Care has the following main areas:

- Member enrollment and eligibility in Managed Care plans;
- Provider enrollment for Primary Medical Providers (PMPs);
- Capitation Payment information; and,
- Enrollment Roster information.

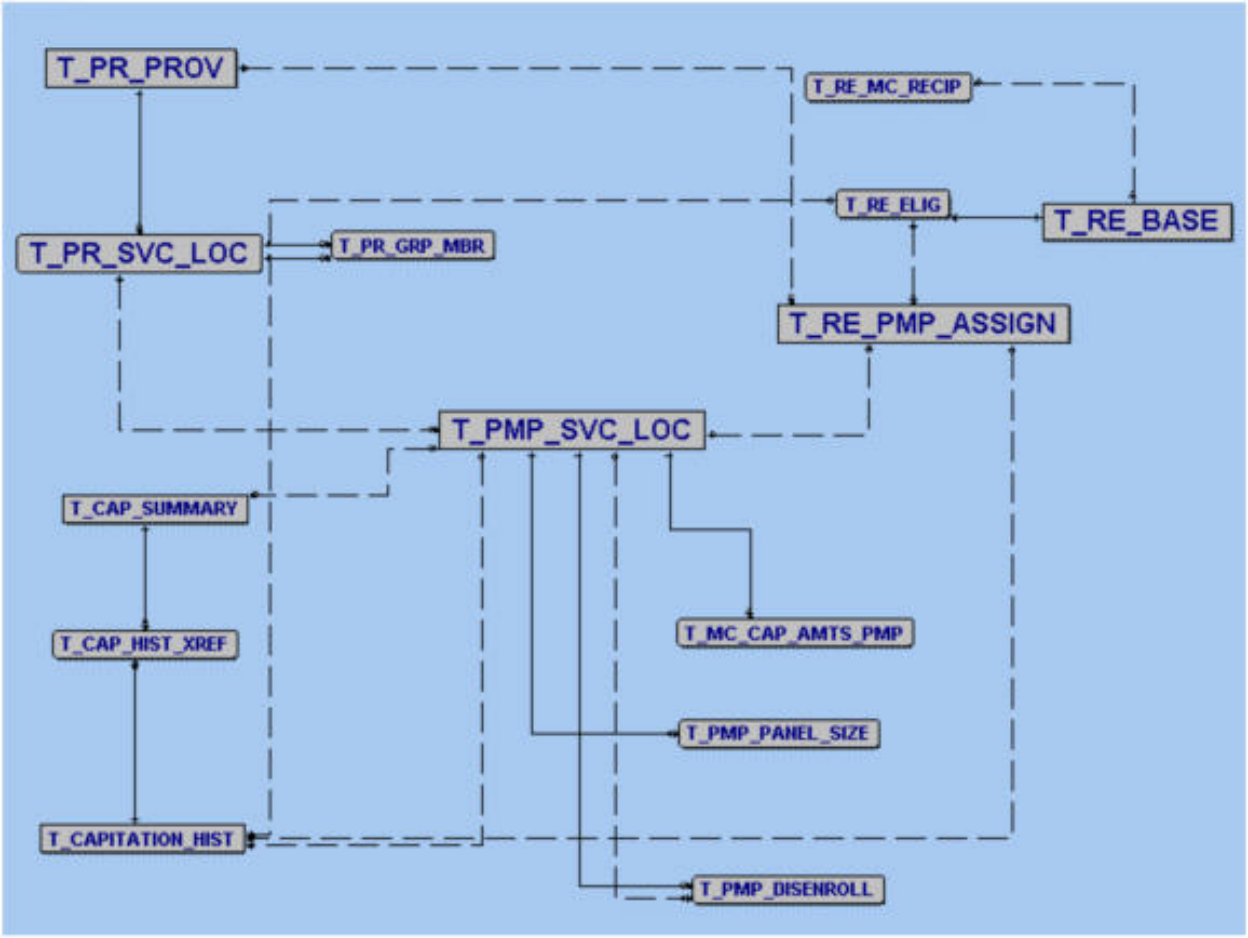
2.1 Data Model

This section explains the Managed Care data model illustrated below.

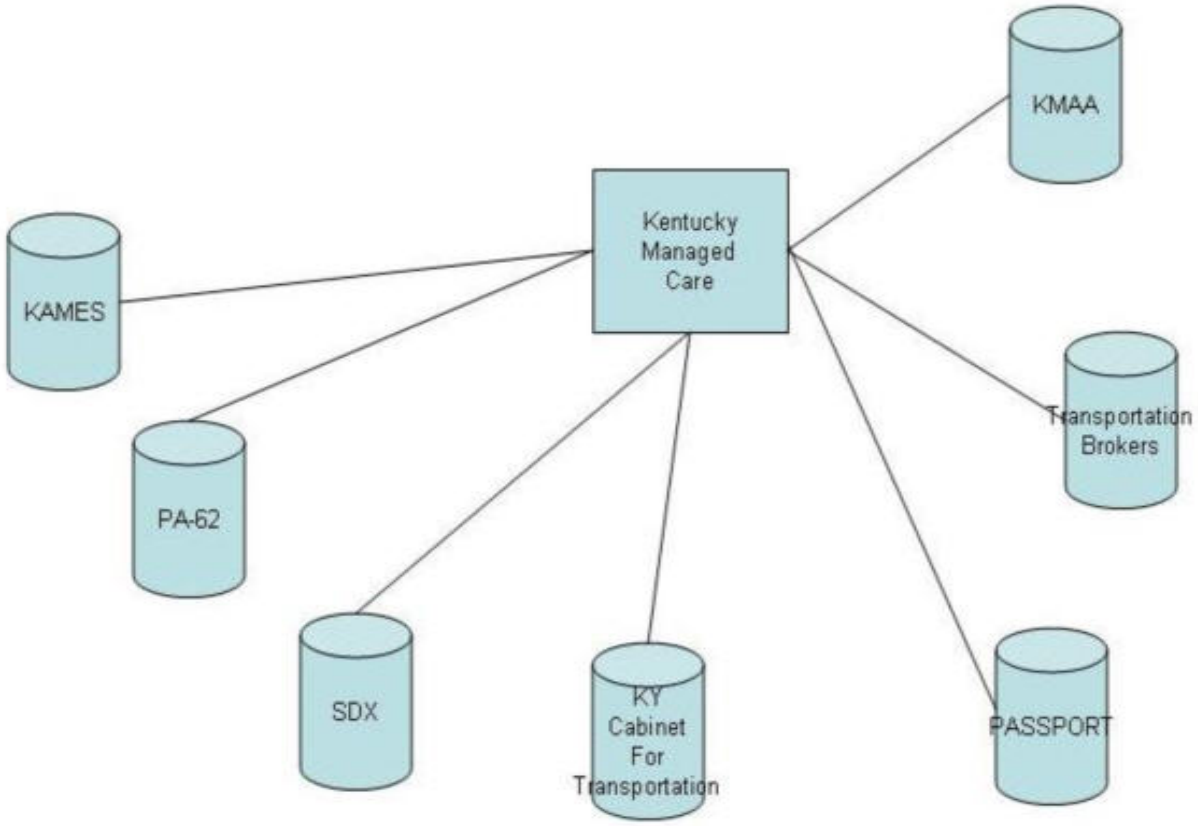
2.1.1 Data Model Diagram

The following content is an example of the type of information that appears in the finished documents. Each field on the diagram is defined.

2.1.1.1 Managed Care Data Model



2.2 External System Interfaces



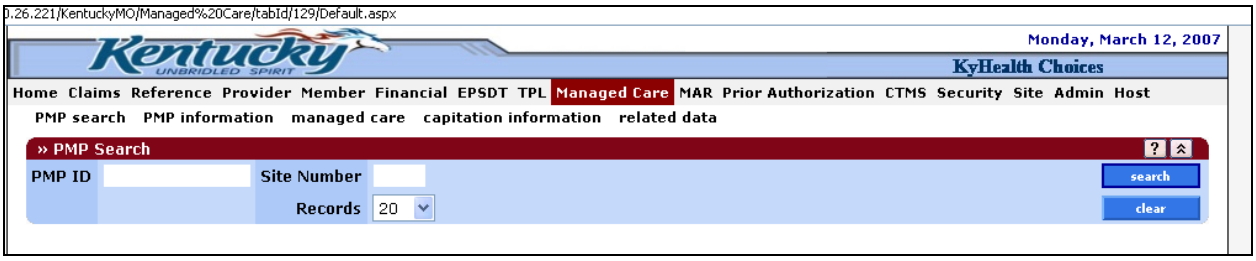
3 Getting Started

3.1 System Access

A user with access to the Managed Care system can access Managed Care in interChange. If you do not have access and require access please contact your Manager.

3.2 Accessing the Managed Care Subsystem

To access the Managed Care subsystem in interChange MMIS, click on the interChange icon which takes you to the home page and then click on Managed Care.



3.2.1.1 Managed Menu Selections

Field	Description
Search	Allows user to search for information using Managed Care Provider's ID or Site Number.
PMP Information	Allows user to search for information using Managed Care Provider's ID or Site Number, also displays PMP information.
Managed Care	Allows user to search Case PMP Assignment History or PMP Autoassignment Distribution.
Capitation Information	Allows user to search for information about capitations.
Related Data	Allows user to access code tables, cross-reference information and other searches.

4 Pages and Panels

The Pages/Panels section is set up to display first the Page, and then all associated Panels. If a panel is accessible through more than one page, it displays multiple times in the document.

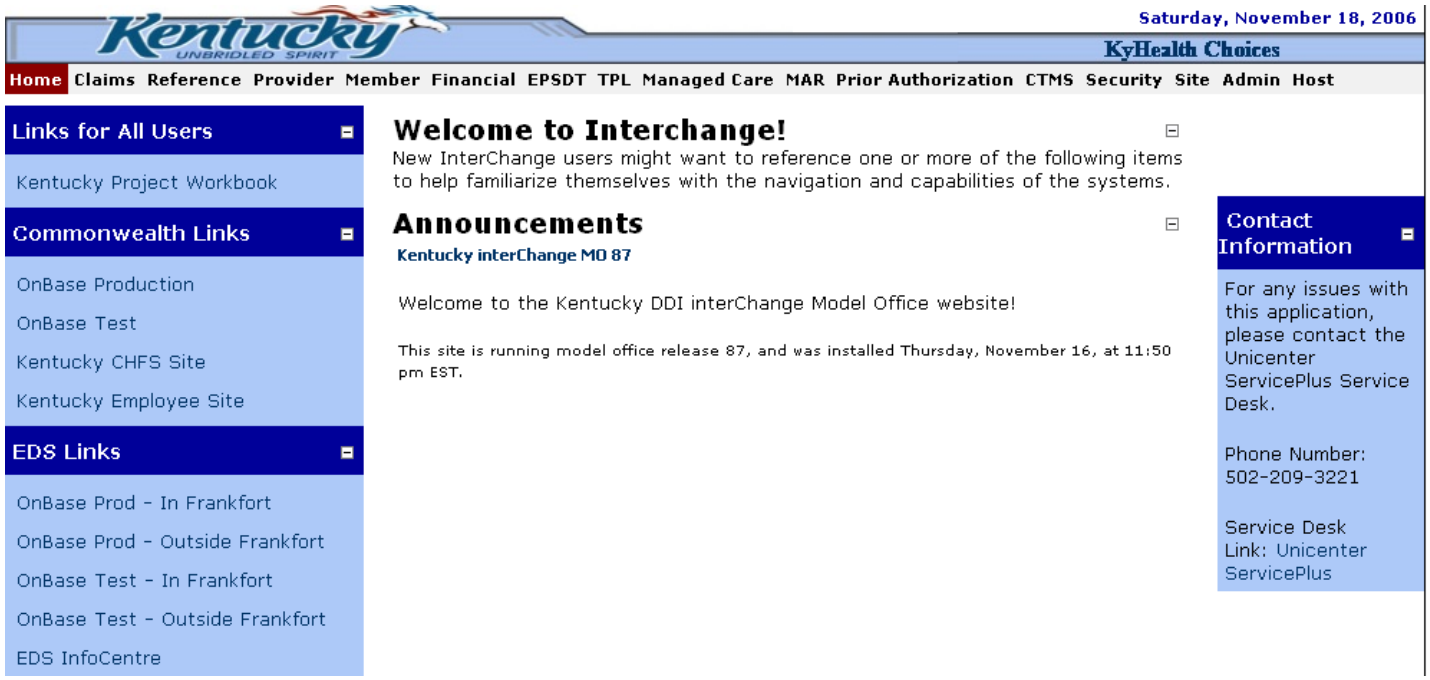
Each of the interChange (iCE) panels contain a button on the panel title bar showing a question mark, that provides the user with a hyperlink to the corresponding PWB documentation for the panel that the user has displayed. Information contained in the PWB includes a sample layout and list of the fields with descriptions.

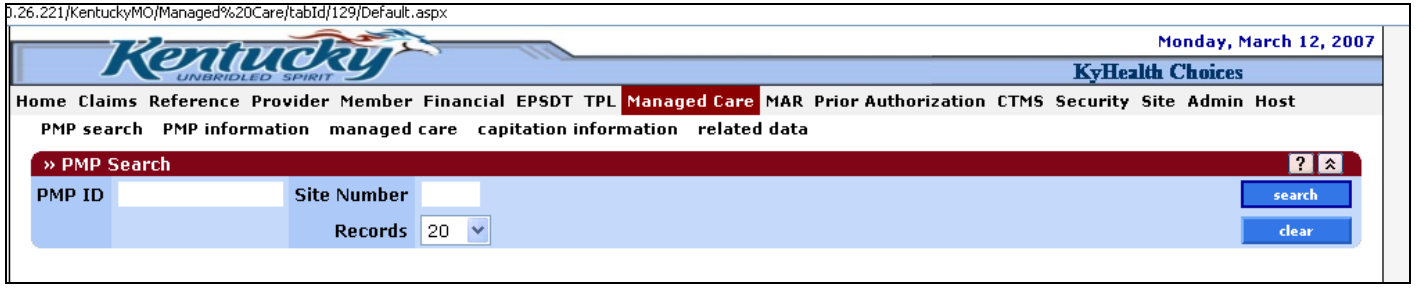
As appropriate, each field with a small arrow next to the drop down list box allows the user to select or view all values that the field can contain. The majority of the values are also defined in the related data panel for the system area being displayed.

Some information in this section is represented in table format. In order to fit information on the page, some data field information may wrap to the next line.

Note to users:
Each panel is numbered, with corresponding field information. The valid values are listed in the New KY MMIS Code Value Book.

4.1 Managed Care Menu





4.1.1 Managed Care Key Menu Field Descriptions

Field	Description
Search	Allows user to search for information using Managed Care Provider's ID or Site Number.

Field	Description
PMP Information	Allows user to search for information using Managed Care Provider's ID or Site Number, also displays PMP information.
Managed Care	Allows user to search Case PMP Assignment History or PMP Autoassignment Distribution.
Capitation Information	Allows user to search for information about capitations.
Related Data	Allows user to access code tables, cross-reference information and other searches.

4.2 PAGE: Managed Care Capitation Information Page

4.2.1 Description

This page displays the Managed Care Capitation Information Maintenance panels.

Navigation Path: [Managed Care - Capitation Information]

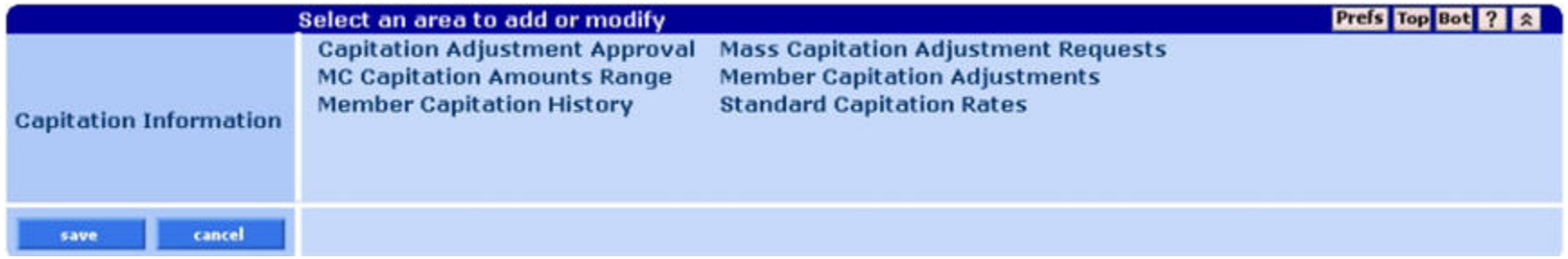
4.2.2 Technical Name

MC.CapitationAdjustmentMaintenancePage

4.2.3 Web Page Name

Capitation Information

4.2.4 Managed Care Capitation Information Page Layout



In order to access the Managed Care Capitation Information page, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select Capitation Information from the Managed Care menu.

STEP 3: Managed Care Capitation Information page will be displayed.

4.2.5 PANEL: Member Capitation Adjustments

4.2.5.1 Description

The Member Capitation Adjustments panel allows the user to search for assignments for a specific member, and then create capitation adjustments for the selected assignment.

Navigation Path: [Managed Care - Capitation Information] - [Member Capitation Adjustments]

Table: T_CAPITATION_ADJ

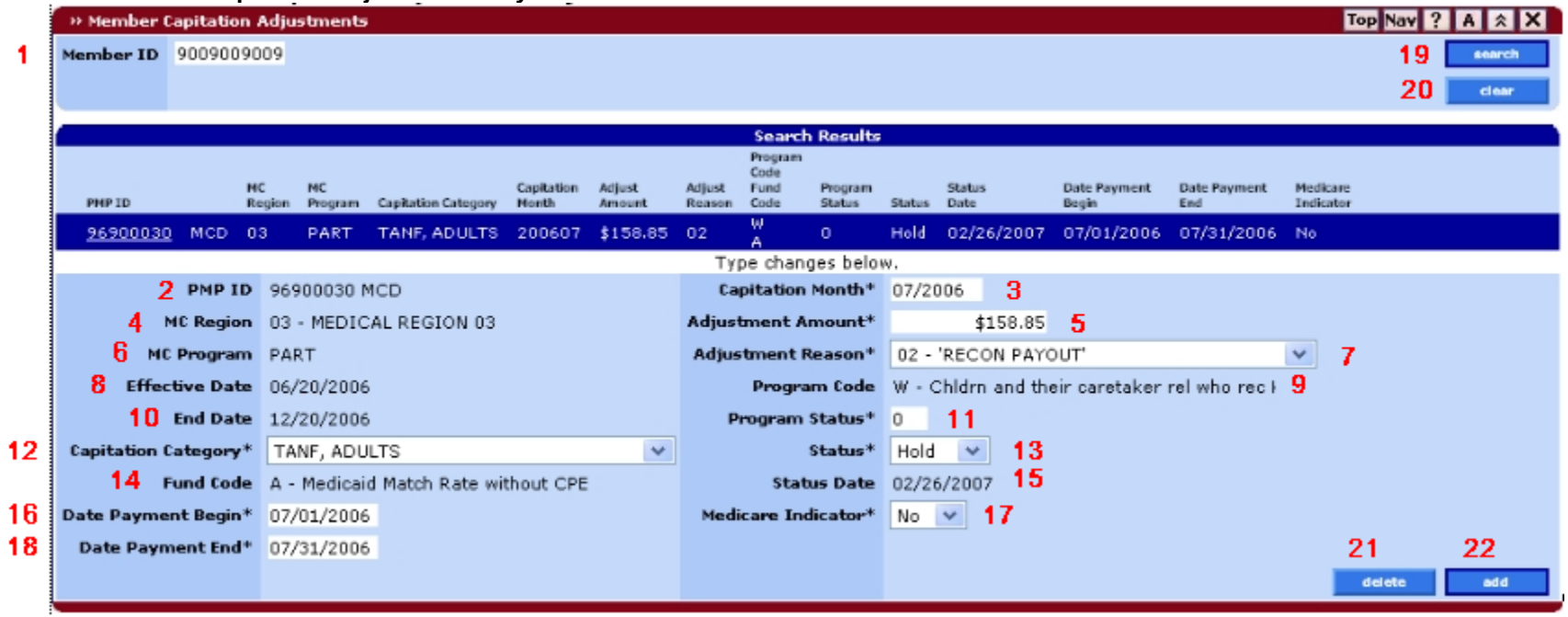
4.2.5.2 Technical Name

MC.RecipCapAdjustPanel.ascx (member)

4.2.5.3 Panel Name

Member Capitation Adjustments

4.2.5.4 Member Capitation Adjustments Layout



In order to access the Capitation Adjustments panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select Capitation Information from the Managed Care menu.

STEP 3: Select Capitation Adjustments link.

STEP 4: Capitation Adjustments panel will be displayed.

STEP 5: Use the “add” button to modify the record

4.2.5.5 Extra Features

This panel has no extra features.

4.2.5.6 Field Descriptions

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
1	Member ID	Member's identification number.	12	Character	T_RE_BASE	ID_MEDICAID
2	PMP ID	This is the primary medical provider (PMP) ID. In the datalist this field is divided into two fields, which are PMP ID (length 10) and PMP Provider Type.	10	Character	T_PMP_IDENTIFIER	SAK_PROV _LOC
3	Capitation Month	This is the month that the capitation adjustment is being made for. Format MM/YYYY.	6	Date (MM/CCYY)	T_CAPITATION_ADJ	DTE_CAPITATION
4	MC Region	This is the identification of the managed care region. In the datalist the MC region is the code (length five) and in the datapanel the field is the code (length five) " - " and description (length 32).	40	Character	T_MC_REGION	CDE_MC_REGION + DSC_MC_REGION

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
5	Adjustment Amount	The amount of money that was paid or recouped to an external entity. The amount could be negative if it was a recoupment. Format is 9999999.99.	9	Number	T_CAPITATION_ADJ	AMT_CAP_PAID
6	MC Program	This is the identification of the managed care program.	5	Character	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
7	Adjustment Reason	This is the code of the reason the capitation is being done. In the datalist the adjust reason is the code (length two) and in the datapanel the adjustment reason is the code (length two) " - " and description (length 35).	0	Drop Down List Box	T_CAPITATION_ADJ	CDE_CAP_REASON
8	Effective Date	The begin date the member capitation will be used for auditing.	8	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
9	Program Code	Identifies the type of program for which a member is eligible. In the datalist the program code is the code (length two) and in the datapanel the program code is the code (length one) " - " and description (length 36).	40	Character	T_CDE_AID	CDE_AID_CATEGORY/ DSC_AID_CATEGO
10	End Date	The date the member capitation will no longer be used for auditing.	8	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_END
11	Program Status	The status of the program code.	1	Character	T_CAPITATION_ADJ_STATE	PROGRAMSTATUSCODE

Field No	Field	Description	Length	Data Type	DB Table	DB Attributes
12	Capitation Category	This is the category of the capitation.	0	Drop Down List Box	T_MC_RATE_CELL	SAK_RATE_CELL
13	Status	This code indicates the status of the adjustment if it has been processed or if it still pending. Valid values are A=Active and H =Hold.	0	Drop Down List Box	T_CAPITATION_ADJ	CDE_STATUS
14	Fund Code	This is the fund code that is used in financial reporting to correctly categorize funds. In the datalist the fund code is the code (length three) and in the datapanel the fund code is the code (length three) " - " and description (length 34).	40	Character	T_FIN_FUND_CODE	DSC_FUND
15	Status Date	Date the adjustment was added to this entity as pending or the date the status was changed to processed.	8	Date (MM/DD/CCYY)	T_CAPITATION_ADJ	DTE_STATUS
16	Date Payment Begin	The date of "Date Payment Begin" from date of service when a capitation is pro-rated.	8	Date (MM/DD/CCYY)	T_CAPITATION_ADJ	FROMDOS
17	Medicare Indicator	The indicator of the Medicare or non-Medicare.	1	Character	T_CAPITATION_ADJ	INDMEDICARE
18	Date Payment End	The date of "Date Payment End" when a capitation is pro-rated.	8	Date (MM/DD/CCYY)	T_CAPITATION_ADJ	TODOS

4.2.5.7 Button Descriptions

Button No.	Button	Description
19	Search	Search for a Member ID.
20	Clear	Clear the search fields.
21	Delete	Delete a Member Capitation Adjustment.
22	Add	Add a Member Capitation Adjustment.

4.2.5.8 Field Edits

Field No.	Field	Field Type	Error Code	Error Message	To Correct
1	Member ID	Field	1	Member ID is required.	Member ID is required for the search.
2	PMP ID	Field	1	A required RE PMP Assign is required.	In order to add a member capitation adjustment record you must select a PMP assignment from the "Assignments Available" list. Once this is selected then this error will be resolved.
2	PMP ID	Field	2	A valid RE Base is required.	In order to add a member capitation adjustment record you must select a PMP assignment from the "Assignments Available" list. Once this is selected then this error will be resolved.
2	PMP ID	Field	3	A valid PMP ID is required.	In order to add a member capitation adjustment record you must select a PMP assignment from the "Assignments Available" list. Once this is selected then this error will be resolved.
3	Capitation Month	Field	1	Capitation Date month must be between 01 and 12.	Insert a month between 01/XXXX and 12/XXXX.
3	Capitation Month	Field	2	Capitation Month must be greater than or equal to 196001.	Insert a month between 01/XXXX and 12/XXXX.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
4	MC Region	Field	1	A valid MC Region is required.	In order to add a member capitation adjustments record you must select a PMP assignment from the "Assignments Available" list. Once this is selected then this error will be resolved.
5	Adjustment Amount	Field	2	Adjustment Amount is a Recoupment and must be less than 0.	Insert a value less than zero in the adjustment amount field when the reason is for recoupment.
5	Adjustment Amount	Field	3	Adjustment Amount is a Payment and must be greater than 0.	Insert a value less than zero in the adjustment amount field when the reason is for recoupment.
5	Adjustment Amount	Field	4	Adjustment Amount can not equal 0.	Insert a value less than zero in the adjustment amount field when the reason is for recoupment.
5	Adjustment Amount	Field	5	Adjustment Amount is a Recoupment and is more than Total Cap Paid.	Insert a value less than zero in the adjustment amount field when the reason is for recoupment.
6	MC Program	Field	1	A valid MC Region is required.	In order to add a Member Capitation Adjustments record you must select a PMP Assignment from the "Assignments Available" list. Once this is selected then this error will be resolved.
7	Adjustment Reason	Field	1	A valid Adjustment Reason is required.	Select an adjustment reason from the drop down list.
7	Adjustment Reason	Field	6	Adjustment Reason is for a Full Recoupment, but this is NOT a Full Recoup.	Select an adjustment reason from the drop down list.
7	Adjustment Reason	Field	7	Adjustment Reason is for a Death Recoupment, but this is NOT a Full Recoup.	Select an adjustment reason from the drop down list.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
7	Adjustment Reason	Field	8	Adjustment Reason is for a Death Recoupment, but the Member is still Alive.	Select an adjustment reason from the drop down list.
7	Adjustment Reason	Field	9	Adjustment Reason is for a Delivery Payment, but the Member is Male.	Select an adjustment reason from the drop down list.
7	Adjustment Reason	Field	10	Adjustment Reason is for a Delivery Recoupment, but there was No Delivery Payment.	Select an adjustment reason from the drop down list.
9	Program Code	Field	1	A valid Program Code is required.	In order to add a member capitation adjustment record you must select a PMP assignment from the "Assignments Available" list. Once this is selected then this error will be resolved.
12	Capitation Category	Field	1	A valid Capitation Category is required.	Select a capitation category from the drop down list.
13	Status	Field	1	Status is required.	Select a status from the drop down list.
15	Status Date	Field	1	Status Date is required.	Enter a valid date in MM/DD/CCYY format.
114	Fund Code	Field	1	A valid Fund code is required.	In order to add a member capitation adjustment record you must select a PMP assignment from the "Assignments Available" list. Once this is selected then this error will be resolved.

4.2.6 PANEL: Capitation Adjustment Approval

4.2.6.1 Description

Use the Capitation Adjustment Approval panel to view all capitation adjustments that have not yet been processed and change their status in mass. Possible status selections are `Active' and `Hold'.

The top portion of the panel is where the criteria are entered to find records in the datalist. Select the status from the Status drop-down list ('Active', and 'Hold') to update multiple adjustments. For example, to set every record with a capitation month of '04/2005' to a status of 'Hold', enter '04/2005', change the status to 'Hold', and click 'Update'. This will update the datalist. Click Save to record/save the status change.

Navigation Path: [Managed Care - Capitation Information] - [Capitation Adjustment Approval]

Table: T_CAPITATION_ADJ

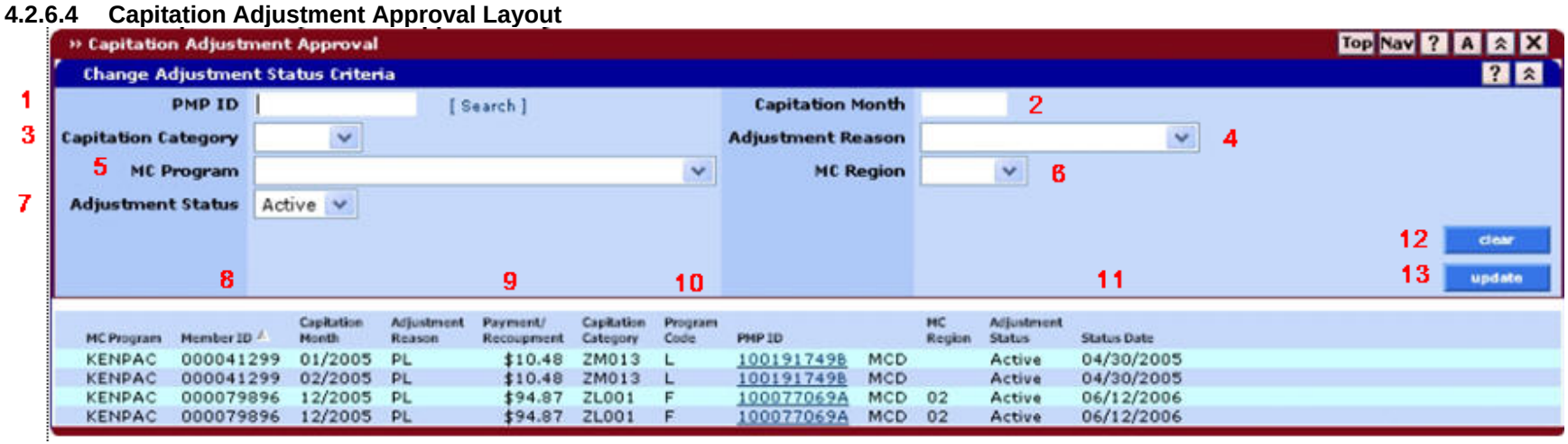
4.2.6.2 Technical Name

MC.CapitationAdjustmentListPanel.ascx

4.2.6.3 Panel Name

Capitation Adjustment Approval

4.2.6.4 Capitation Adjustment Approval Layout



In order to access Capitation Adjustment Approval Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Capitation Information” from the Managed Care menu.

STEP 3: Click the Capitation Adjustment Approval link.

STEP 4: Capitation Adjustment Approval panels will be displayed.

4.2.6.5 Extra Features

This panel has no extra features.

4.2.6.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PMP ID	Provider ID	Field	Character	10	T_PR_IDENTIFIER	ID_PROVIDER
2	Capitation Month	This is the month that the capitation adjustment is being made - in format MM/CCYY.	Field	Date (MM/CCYY)	6	T_CAPITATION_ADJ	DTE_CAPITATION
3	Capitation Category	This is the category of the capitation.	Field	Drop Down List Box	5	T_MC_RATE_CELL	CDE_RATE_CELL
4	Adjustment Reason	This is the code of the reason the adjustment is being made.	Field	Drop Down List Box	2	T_CAP_REASON	CDE_CAP_REASON
5	MC Program	This is the identification of the managed care program.	Field	Drop Down List Box	0	T_PUB_HLTH_PGM	SAK_PUB_HLTH
6	MC Region	This is the identification of the managed care region.	Field	Drop Down List Box	0	T_MC_REGION	CDE_MC_REGION
7	Adjustment	This is the status of the	Field	Drop Down	5	T_CAPITATION_	CDE_STATUS

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
	Status	adjustment.		List Box		ADJ	
8	Member ID	Member's identification number.	Field	Character	12	T_RE_BASE	ID_MEDICAID
9	Payment/Recoupment	The amount of money that was paid or recouped to an external entity. The amount could be negative if it was a recoupment. Format 99999999.99.	Field	Number	10	T_CAPITATION_ADJ	AMT_CAP_PAID
10	Program Code	Identifies the type of program for which a member is eligible.	Field	Character	2	T_CDE_AID	CDE_AID_CATEGORY
11	Status Date	Date the adjustment was added to this entity as pending (hold) or the date the status was changed to processed (active).	Field	Date (MM/DD/CCYY)	8	T_CAPITATION_ADJ	DTE_STATUS

4.2.6.7 Button Descriptions

Button No.	Button	Description
12	Clear	This button clears the "Change Adjustment Status Criteria" fields.
13	Update	This button updates the status for the records that match the data entered in the "Change Adjustment Status Criteria" fields.

4.2.6.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Capitation Month	Field	1	Invalid date. Format is MM/CCYY.	Verify data entry. Enter a valid date in MM/CCYY format.

4.2.7 PANEL: Mass Capitation Adjustment Requests

4.2.7.1 Description

The Mass Capitation Adjustment Requests panel allows the user to request that mass capitation adjustments be made for capitation payments that have already been processed and are in capitation history. It is generally utilized when capitation rates need to be retroactively changed. The requests created by this panel are then processed through a batch cycle that actually creates the adjustments and updates the request with summary information.

Navigation Path: [Managed Care - Capitation Information] - [Mass Capitation Adjustment Requests]

Table: T_CAP_MASS_ADJ_RST

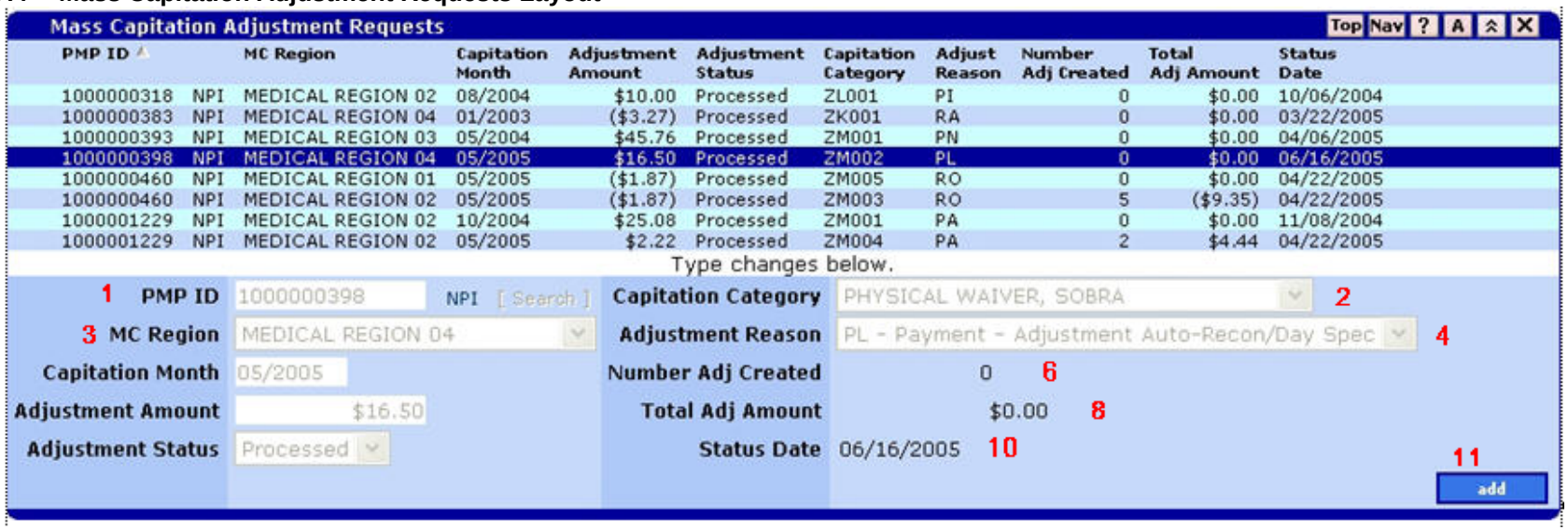
4.2.7.2 Technical Name

MC.CapMassAdjustmentRstPanel.ascx

4.2.7.3 Panel Name

Mass Capitation Adjustment Requests

4.2.7.4 Mass Capitation Adjustment Requests Layout



In order to access Mass Capitation Adjustment Requests Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: "Capitation Information" from the Managed Care menu.

STEP 3: Click the Mass Capitation Adjustment Requests link.

STEP 4: Mass Capitation Adjustment Requests panels will be displayed.

STEP 5: Use the "add" button to modify the record.

4.2.7.5 Extra Features

This panel has no extra features.

4.2.7.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PMP ID/Svc Loc	This is the primary medical provider (PMP) ID and service location. In the datalist this field is divided into two fields, which are PMP ID (length nine) and PMP Svc Loc (length one).	Field	Character	10	T_PMP_SVC_LOC	SAK_PROV + CDE_SERVICE_LOC
2	Capitation Category	This is the category of the capitation.	Field	Drop Down List Box	0	T_MC_RATE_CELL	SAK_RATE_CELL
3	MC Region	This is the code that identifies a region (or managed care coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, or the entire state.	Field	Drop Down List Box	0	T_MC_REGION	CDE_MC_REGION
4	Adjustment Reason	This is the code of the reason the adjustment is being made. Format is code - description.	Field	Drop Down List Box	0	T_CAP_REASON	CDE_CAP_REASON

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Capitation Month	This is the month of the capitation.	Field	Date (MM/CCYY)	6	T_CAP_MASS_ADJ_RST	DTE_CAPITATION
6	Number Adj Created	The number of transactions created when the rate increase was processed.	Field	Number	9	T_CAP_MASS_ADJ_RST	NUM_CAP_COUNT
7	Adjustment Amount	The amount to increase or decrease the payment. Format 99999999.99.	Field	Number	10	T_CAP_MASS_ADJ_RST	AMT_CAP_PAID
8	Total Adj Amount	This is the total amount paid or recouped on a rate change or correction adjustment once it has been processed. Format 999999999.99.	Field	Number	11	T_CAP_MASS_ADJ_RST	AMT_TOT_CAP_ADJ
9	Adjustment Status	This is to indicate the status of the request. (A) Active, (H) Hold, (P) Processed.	Field	Drop Down List Box	0	T_CAP_MASS_ADJ_RST	CDE_STATUS
10	Status Date	This is the date that the current status was done.	Field	Date (MM/DD/CCYY)	8	T_CAP_MASS_ADJ_RST	T_CAP_MASS_ADJ_RST

4.2.7.7 Button Descriptions

Button No.	Button	Description
11	Add	Add a Mass Capitation Adjustment Requests.

4.2.7.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	PMP ID/Svc Loc	Field	1	A valid PMP ID/Svc Loc is required.	Enter a valid PMP ID/service location or click [search] to select a value.

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Capitation Category	Field	1	A valid Capitation Category is required.	Select a valid capitation category from the drop down list.
2	Capitation Category	Field	7	Capitation Category inactive on capitation month.	Select a valid capitation category from the drop down list.
3	MC Region	Field	1	A valid MC Region is required.	Select an MC region for the drop down list.
4	Adjustment Reason	Field	1	A valid Adjustment Reason is required.	Select an adjustment reason from the drop down list.
4	Adjustment Reason	Field	2	Recoupment for Death is not valid for Rate Adjustment.	Select an adjustment reason from the drop down list.
5	Capitation Month	Field	1	Capitation Date month must be between 01 and 12.	Insert a month between 01/XXXX and 12/XXXX.
7	Adjustment Amount	Field	3	Adjustment Amount can not equal zero.	Insert a non-zero value in this field under one exception: If the adjustment reason is full recoupment, you cannot insert a zero.
7	Adjustment Amount	Field	4	Recoupment Amount must be zero on a Full Recoup. The System will compute the Full Recoupment.	Insert a non-zero value in this field under one exception: If the adjustment reason is full recoupment, you cannot insert a zero.
7	Adjustment Amount	Field	5	Recoupment Amount must be less than zero.	Insert a non-zero value in this field under one exception: If the adjustment reason is full recoupment, you cannot insert a zero.

Field No	Field	Field Type	Error Code	Error Message	To Correct
7	Adjustment Amount	Field	6	Adjustment Amount must be greater than zero.	Insert a non-zero value in this field under one exception: If the adjustment reason is full recoupment, you cannot insert a zero.
9	Adjustment Status	Field	1	Adjustment Status is required.	Select a valid adjustment status from the drop down list.

4.2.8 PANEL: Member Capitated Lock-In Assignment History

4.2.8.1 Description

The Member PMP Lockin panel serves as a cross-reference between a member and any managed care providers that the member should be assigned to. It allows the user to maintain existing lock-ins and to create new ones.

Navigation Path: [Member Management - Information] - [Capitated Lock-in Assignment History]

Table: T_RE_PMP_ASSIGN

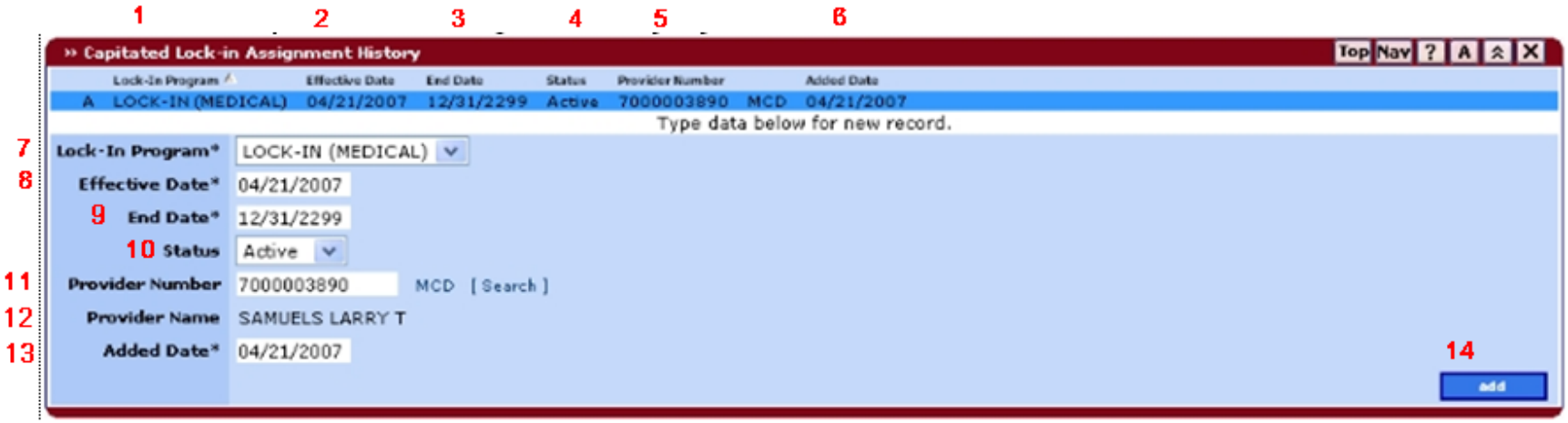
4.2.8.2 Technical Name

MC.LockInAssignmentHistoryPanel.ascx

4.2.8.3 Panel Name

Member Capitated Lock-In Assignment History

4.2.8.4 Member Capitated Lock-In Assignment History Layout



4.2.8.5 Extra Features

This panel has no extra features.

4.2.8.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Lock-In Program (List)	The lock-in assignment plan/program that the member is tied in to.	Listview	Drop Down List Box	0	T_PUB_HLTH_PGM	DSC_PGM_HEALTH
2	Effective Date (List)	The date that the lock-in assignment became effective.	Listview	Date (CCYYMMDD)	0	T_PUB_HLTH_PGM	DTE_EFFECTIVE
3	End Date (List)	The date that the Lock-In assignment ends.	Listview	Date (CCYYMMDD)	0	T_PUB_HLTH_PGM	DTE_END
4	Status (List)	Indicates the status of the assignment (Active or History).	Listview	Drop Down List Box	0	T_RE_PMP_ASSIGN	CDE_STATUS1
5	Provider ID (List)	The provider that the member is locked in to.	Listview	Number	15	T_PMP_SVC_LOC	SAK_PROV
7	Lock-In Program (Panel)	The lock-in assignment plan/program that the member is tied in to.	Field	Drop Down List Box	0	T_PUB_HLTH_PGM	DSC_PGM_HEALTH
8	Effective Date (Panel)	The date that the lock-in assignment became effective.	Field	Date (CCYYMMDD)	0	T_PUB_HLTH_PGM	DTE_EFFECTIVE
9	End Date (Panel)	The date that the lock-in assignment ends.	Field	Date (CCYYMMDD)	0	T_PUB_HLTH_PGM	DTE_END
10	Status (Panel)	Indicates the status of the assignment (Active or History).	Field	Drop Down List Box	0	T_RE_PMP_ASSIGN	CDE_STATUS1

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
11	Provider ID (Panel)	The provider that the member is locked in to.	Field	Character	15	T_PMP_SVC_LOC	SAK_PROV
12	Provider Name (Panel)	The name of the provider that the member is locked in to.	Field	Character	50	T_PUB_HLTH_PGM	NAM
13	Added Date	The date that the PMP assignment was created/inserted.	Field	Date (CCYYMMDD)	8	T_RE_PMP_ASSIG	DTE_ADDED

4.2.8.7 Button Descriptions

Button No.	Button	Description
14	Add	Add button.

4.2.8.8 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.2.9 PANEL: Member Capitation History

4.2.9.1 Description

The Member Capitation History panel lists all of the capitation transactions ever made for the specified member.

Navigation Path: [Managed Care - Capitation Information] - [Member Capitation History]

Table: T_CAPITATION_HIST

This panel is an inquiry panel. No audit button is needed.

4.2.9.2 Technical Name

MC.RecipientCapitationHistoryPanel.ascx

4.2.9.3 Panel Name

Member Capitation History

4.2.9.4 Member Capitation HistoryLayout

In order to access Member Capitation History Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Capitation Information” from the Managed Care menu.

STEP 3: Click the Member Capitation History link.

STEP 4: Enter Member ID in the Member Capitation History panel. Click the search button and the member information will be displayed.

STEP 5: Member Capitation History panel will be displayed for member identified.

STEP 6: Use the “search” or “clear” buttons to modify the search.

4.2.9.5 Extra Features

This panel has no extra features.

4.2.9.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Member ID	Member's identification number.	Field	Character	12	T_RE_BASE	ID_MEDICAID
2	Capitation Month	This is the month that the capitation payment covers.	Field	Date (MM/CCYY)	6	T_CAPITATION_HIST	DTE_CAPITATION
3	PMP ID	This is the Primary Medical Provider (PMP) ID.	Field	Character	10	T_PR_PROV	ID_PROVIDER
4	MC Region	This is the identification of the Managed Care region.	Field	Character	5	T_CAPITATION_HIST	CDE_MC_REGION
5	Effective Date	The date the capitation was effective.	Field	Date (MM/DD/CCYY)	8	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
6	End Date	The date the capitation was ended (terminated).	Field	Date (MM/DD/CCYY)	8	T_RE_PMP_ASSIGN	DTE_END
7	Capitation Month	This is the month that the capitation payment covers.	Field	Date (MM/CCYY)	6	T_CAPITATION_HIST	DTE_CAPITATION

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
8	Capitation Txn Date	This is the date that the capitation payment was made. If the payment is being made for a retro month the date is still the current month, that is:, payment in April of February admin fee, this date would have the April payment date.	Field	Date (MM/DD/CCYY)	8	T_CAPITATION_HIST	DTE_CAPITATION
9	Capitation Amount	The amount of money (check or EFT) we will pay to an external entity for capitation. Format 9999999.99.	Field	Number	9	T_CAPITATION_HIST	AMT_CAP_PAID
10	Capitation Reason	This is the code of the reason the capitation is being done.	Field	Character	2	T_CAPITATION_HIST	CDE_CAP_REASON
11	Capitation Category	This code reflects the category (type) of capitation being paid.	Field	Character	5	T_MC_RATE_CELL	CDE_RATE_CELL
12	Program Code	Identifies the type of program code for which a member is eligible.	Field	Character	2	T_CDE_AID	CDE_AID_CATEGORY
13	Date Payment Begin	The date of Date Payment Begin from Date of Service when a capitation is pro-rated.	Field	Date (MM/DD/CCYY)	8	T_CAPITATION_HIST	DTE_FROM_DOS
14	Date Payment End	The date of Date Payment End Date of Service when a capitation is pro-rated.	Field	Date (MM/DD/CCYY)	8	T_CAPITATION_HIST	DTE_TO_DOS
15	Medicare Indicator	The indicator of the Medicare flag	Field	Character	1	T_CAPITATION_HIST	IND_MEDICARE
16	Program Status	The status of the Program.	Field	Character	1	T_CAPITATION_HIST_STATE	PGM_STATUS

4.2.9.7 Button Descriptions

Button No.	Button	Description
17	Search	Search for Member ID and Capitation Month.
18	Clear	Clear the search fields.
19	Financial Details	Shows the financial details for the Member Capitation History.

4.2.9.8 Field Edits

Field No.	Field	Field Type	Error Code	Error Message	To Correct
7	Capitation Month	Field	1	Invalid date. Format is MM/CCYY.	Enter a valid capitation month in MM/CCYY format.

4.2.10 PANEL: Standard Capitation Rates

4.2.10.1 Description

The Standard Capitation Rates panel allows the user to maintain the default capitation rates. These rates are utilized for the specified capitation category when a PMP does not have their own (override) rate defined in the Capitation Rate Override panel.

Navigation Path: [Managed Care - Capitation Information] - [Standard Capitation Rates]

Table: T_MC_RATE_CELL, T_MC_CAP_AMTS (Capitation Amounts), T_MC_CAP_AMTS_RANGE

4.2.10.2 Technical Name

MC.McRateCellAmtsXrefPanel.ascx

4.2.10.3 Panel Name

Standard Capitation Rates

4.2.10.4 Standard Capitation Rates Layout

In order to access Standard Capitation Rates Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: "Capitation Information" from the Managed Care menu.

STEP 3: Click the Standard Capitation Rates link.

STEP 4: Standard Capitation Rates panel will be displayed.

STEP 5: Use the "add" or "delete" buttons to modify the record.

4.2.10.5 Extra Features

This panel has no extra features.

4.2.10.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Capitation Category	The capitation category code represents the various groups of demographics for managed care members.	Field	Character	5	T_MC_RATE_CELL	CDE_RATE_CELL
2	Description	Describes the managed care rate cell.	Field	Character	35	T_MC_RATE_CELL	DSC_CAP_CATEGORY
4	End Date	This is the date that the capitation category expired and is no longer effective.	Field	Date (MM/DD/CCYY)	8	T_MC_RATE_CELL	DTE_END
5	MC Region (Capitation Amounts)	This is the region that the capitation rate is effective in.	Field	Character	50		CDE_MC_REGION, DSC_MC_REGION
6	Effective Date	This is the date that the capitation category became effective.	Field	Date (MM/DD/CCYY)	8	T_MC_RATE_CELL	DTE_EFFECTIVE

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	Effective Date (Capitation Amounts)	Effective date for the payment record.	Field	Date (MM/DD/CCYY)	8	T_MC_CAP_AMTS	DTE_EFFECTIVE
7	Capitation Amount (Capitation Amounts)	Amount of the capitation payment. Format is 9999999.99. The capitation amount needs to edit to make sure that rates entered fall within the minimum and maximum range for capitation rates on the T_MC_CAP_AMTS_RANGE table.	Field	Number	9	T_MC_CAP_AMTS	AMT_CAPITATION
8	End Date (Capitation Amounts)	End date of the payment record.	Field	Date (MM/DD/CCYY)	8	T_MC_CAP_AMTS	DTE_END

4.2.10.7 Button Descriptions

Button No.	Button	Description
9	Delete	Delete a Standard Capitation rate.
10	Add	Add a Standard Capitation rate.

4.2.10.8 Field Edits

Field No.	Field	Field Type	Error Code	Error Message	To Correct
6	Effective Date (Capitation Amounts)	Field	1	Effective date is required.	Insert the effective date, which must be less than the end date.
6	Effective Date (Capitation Amounts)	Field	2	Invalid date. Format is MM/DD/CCYY.	Insert the effective date, which must be less than the end date.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
6	Effective Date (Capitation Amounts)	Field	3	Effective date must be less than or equal to end date.	Insert the effective date, which must be less than the end date.
6	Effective Date (Capitation Amounts)	Field	4	Effective date must be equal to first day of the month.	Insert the effective date, which must be less than the end date.
7	Capitation Amount (Capitation Amounts)	Field	1	The capitation amount being added is not a valid capitation amount range.	Enter a valid capitation amount from 0 to max 9,999,999.99.
7	Capitation Amount (Capitation Amounts)	Field	2	Capitation amount must be less than or equal to 9999999.99.	Enter a valid capitation amount range.
7	Capitation Amount (Capitation Amounts)	Field	91067	Capitation amount must be greater than zero.	Enter a capitation amount.
8	End Date (Capitation Amounts)	Field	1	End date is required.	Insert the end date, which must be greater than the effective date.
8	End Date (Capitation Amounts)	Field	2	Invalid date. Format is MM/DD/CCYY.	Insert the end date, which must be greater than the effective date.
8	End Date (Capitation Amounts)	Field	3	Date segments can not overlap.	Insert the end date, which must be greater than the effective date.
8	End Date (Capitation Amounts)	Field	4	End date must be equal to last day of the month.	Insert the end date, which must be greater than the effective date.
8	End Date (Capitation Amounts)	Field	5	Date segment can not overlap.	Insert the end date, which must be greater than the effective date.

4.2.11 PANEL: MC Capitation Amounts Range

4.2.11.1 Description

This panel maintains the minimum and maximum capitation rate limits as set by the actuaries. CMS requires that the Commonwealth negotiate rates within the range. The ranges in this table are used in edits on the standard capitation rate panel and the override capitation rate panel.

Navigation Path: [Managed Care - Capitation Information] - [MC Capitation Amounts Range]

Table: T_MC_CAP_AMTS_RANGE

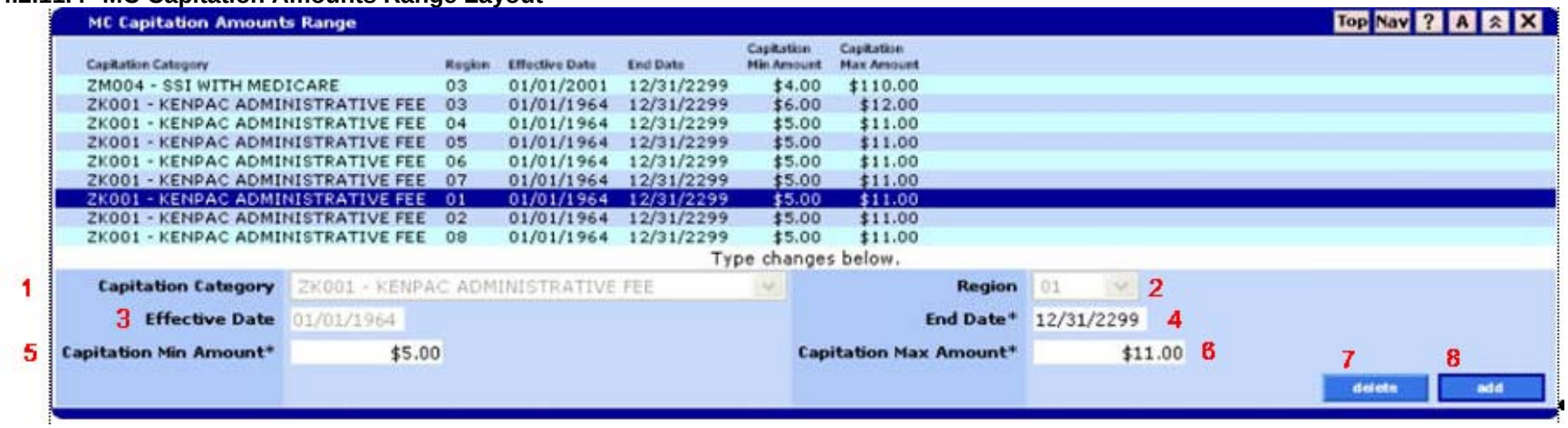
4.2.11.2 Technical Name

MC.McCapAmtsRange.ascx

4.2.11.3 Panel Name

Capitation Amount Range

4.2.11.4 MC Capitation Amounts Range Layout



In order to access MC Capitation Amounts Range Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Capitation Information” from the Managed Care menu.

STEP 3: Select MC Capitation Amounts Range link.

STEP 4: MC Capitation Amounts Range panel will be displayed.

STEP 5: Use the “add” button to modify the record.

4.2.11.5 Extra Features

This panel has no extra features.

4.2.11.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Capitation Category	Capitation payment category.	Field	Character	5	T_MC_RATE_CELL	CDE_RATE_CELL
2	Region	Region applicable to the capitation category and rate ranges.	Field	Character	5	T_MC_REGION	CDE_MC_REGION
3	Effective Date	Effective date for this rate range.	Field	Date (MM/DD/CCYY)	10	T_MC_CAP_AMTS_RANGE	DTE_EFFECTIVE
4	End Date	End date for this rate range.	Field	Date (MM/DD/CCYY)	10	T_MC_CAP_AMTS_RANGE	DTE_END
5	Capitation Min Amount	Minimum allowable payment amount.	Field	Number	9	T_MC_CAP_AMTS_RANGE	AMT_CAPITATION_MIN
6	Capitation Max Amount	Maximum allowable payment amount.	Field	Number	9	T_MC_CAP_AMTS_RANGE	AMT_CAPITATION_MAX

4.2.11.7 Button Description

Button No.	Button	Description
7	Delete	Delete a Capitation Amounts Range.
8	Add	Add a Capitation Amounts Range.

4.2.11.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
4	End Date	Field	1	End date must be greater than or equal to 1/1/1900.	Verify data entry. Update the end date.
4	End Date	Field	100	The capitation amount range being added overlaps with another capitation amount range in the list.	Verify data entry. The date range should not overlap.
5	Capitation Min Amount	Field	3	Minimum capitation amount must be greater than zero.	Verify data entry. The amount must be greater than zero.
5	Effective Date	Field	100	The capitation amount range being added overlaps with another capitation amount range in the list.	Verify data entry. The date range should not overlap.
6	Capitation Max Amount	Field	4	Maximum capitation amount must be greater than zero.	Verify data entry. The amount must be greater than zero.
6	Capitation Max Amount	Field	5	Capitation max amount must be greater than or equal to capitation min amount.	Verify data entry.

4.3 PAGE: Managed Care Maintenance Page

4.3.1 Description

This page displays the Managed Care Maintenance data panels.

Navigation Path: [Managed Care - Managed Care]

4.3.2 Technical Name

MC.ManagedCareMaintenancePage

4.3.3 Web Page Name

Managed Care

4.3.4 Managed Care Maintenance Page Layout

In order to access Managed Care Maintenance Page use the following steps:

STEP 1: Select Managed Care.

STEP 2: Select “Managed Care” from the Managed Care menu.

STEP 3: Managed Care Maintenance page will be displayed.

Note: The Save and Cancel buttons are only used in conjunction with other panels.

4.3.5 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Case PMP Assignment History	Opens the Case PMP Assignment History Panel	Hyperlink	N/A	N/A	N/A	N/A

4.3.6 Button Descriptions

Button No.	Button	Description
3	Save	Clicking the Save button saves the data.
4	Cancel	Clicking the Cancel button cancels the action.

4.3.7 PANEL: Case PMP Assignment History

4.3.7.1 Description

The Case PMP Assignment History panel displays the PMP assignment history for all members of the specified case and allows the user to create new assignments and end-date previously existing ones.

Navigation Path: [Managed Care - Managed Care] - [Case PMP Assignment History]

Table: T_RE_CASE (Search), T_RE_PMP_ASSIGN (Selected Member PMP Assignment History)

4.3.7.2 Technical Name

MC.CaseRePmpAssignPanel.ascx

4.3.7.3 Panel Name

Case PMP Assignment History

For readability the layout displays on the next page.

4.3.7.4 Case PMP Assignment History Layout

» Case PMP Assignment History

Top Nav ? A

1 Case Number a006254 Case Name TRUSTY, JANET 2 24 search 25 clear

3 4 5 6 7 Search Results

Member ID	Name	Gender	Date of Birth	Death Date
000002398	TRUSTY, JANET	Female	05/01/2003	

-Selected Member PMP Assignment History-

8 9 10 11 12 13 14 15 16 17

MC Program	Effective Date	End Date	Status	PMP ID	Group Member ID	Site Number	MC Region	MC County	Added Date
NON-EMERGENCY MEDICAL TRANSPORATION	10/01/2004	05/31/2006	Active	200308009A	MCD	0000		Grant	10/06/2004

Type changes below. 8 18

MC Program NON-EMERGENCY MEDICAL TRANSPORATION 9
Effective Date 10/01/2004 10
End Date 05/31/2006 11
Status Active 12
PMP ID 2003[illegible]09A MCD [Search] 14
Site Number 0000 15
MC Region 16
MC County Grant 17
Added Date 10/06/2004

Start Reason 19
Stop Reason 99 - OPEN ENDED ENROLLMENT 20
Assignment Source 13
Group Member ID 21 [Search]
Group Member Source 22
Provider Name TRAVIS FAMILY HEALTH CENTER 23
Focus GENERAL PEDIATRICIAN

26 add

In order to access Case PMP Assignment History Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select "Managed Care" from the menu.

STEP 3: Select the Case PMP Assignment History link.

STEP 4: Enter Case number in the Case PMP Assignment History panel. Click the search button and the case information will be displayed.

STEP 5: Case PMP Assignment History panel will be displayed for member identified. Use the "add" button to create new assignments.

STEP 6: In order to save the record, the user must select the "save" button in the Managed Care panel.

4.3.7.5 Extra Features

This panel has no extra features.

4.3.7.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Case Name	Identifies the name of the member that is the case head.	Field	Character	35	T_RE_CASE	NAM_LAST+NAM_FIRST
2	Case Number	Uniquely identifies a Medicaid case - grouping of members	Field	Number	10	T_RE_CASE	NUM_CASE
3	Member ID	Member's identification number.	Field	Character	12	T_RE_BASE	ID_MEDICAID
4	Name	The case member's name. Format last name (length 15), ", ", and first name (length 13).	Field	Character	30	T_RE_BASE	NAM_LAST+NAM_FIRST
5	Gender	The case member's gender.	Field	Character	18	T_RE_BASE	CDE_SEX
6	Date Birth	The case member's date of birth.	Field	Date (MM/DD/CCYY)	8	T_RE_BASE	DTE_BIRTH
7	Date Death	The case member's date of death.	Field	Date (MM/DD/CCYY)	8	T_RE_BASE	DTE_DEATH
8	MC Program	This is the identification of the managed care program.	Field	Drop Down List Box	0	T_PUB_HLTH_PGM	SAK_PUB_HLTH
9	Effective Date	Date that the PMP assignment became effective	Field	Date (MM/DD/CCYY)	8	T_RE_PMP_ASSIGN	DTE_EFFECTIVE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
10	End Date	Date that the PMP assignment is no longer effective	Field	Date (MM/DD/CCYY)	8	T_RE_PMP_ASSIGN	DTE_END
11	Status	Indicates the status of the aid category eligibility (Active or History)	Field	Drop Down List Box	0	T_RE_PMP_ASSIGN	CDE_STATUS1
12	PMP ID	This is the primary medical provider (PMP) ID. In the datalist this field is divided into two fields, which are PMP ID (length 10) and PMP Type.	Field	Character	10	T_RE_PMP_ASSIGN	SAK_PMP_SER_LOC
13	Group Member ID	Identifies the group member the PMP ID is associated with. In the datalist this field is divided into two fields, which are Group Member ID (length109) and Group Member PMP Type.	Field	Character	10	T_PR_SVC_LOC	SAK_PROV+CDE_SERVICE_LOC
14	Site Number	The KenPAC site number. Only present for KenPAC providers. Blank for other managed care programs.	Field	Character	4	T_PMP_SVC_LOC_STATE	SITE_NUMBER
15	MC Region	This is a description or name of the managed care region.	Field	Character	40	T_MC_REGION	CDE_MC_REGION + DSC_MC_REGION

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
16	MC County	This is a description or name of the managed care county.	Field	Character	12	T_COUNTY	DSC_COUNTY
17	Added Date	Date that the PMP assignment was created/inserted.	Field	Date (MM/DD/CCYY)	8	T_RE_PMP_ASSIGN	DTE_ADDED
18	Start Reason	Describes why the member was assigned to this provider.	Field	Drop Down List Box	0	T_RE_PMP_ASSIGN	CDE_RSN_MC_START
19	Stop Reason	Describes why the member was no longer assigned to this provider.	Field	Drop Down List Box	0	T_RE_PMP_ASSIGN	CDE_RSN_MC_STOP
20	Assignment Source	This identifies how the PMP assignment record was assigned to this member.	Field	Character	40	T_MC_ENTITY	DSC_MC_ENTITY
21	Group Member Source	Indicates the source of the group member.	Field	Character	40	T_PR_GRP_MBR	CDE_SVC_LOC_MBR
22	Provider Name	This provider individual name (format last name, first name, middle initial) or the business name.	Field	Character	50	T_PR_NAM	NAME
23	Focus	The PMP focus. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: general practitioner, internist, and pediatrician.	Field	Character	30	T_MC_PMP_FOCUS	DSC_PMP_FOCUS

4.3.7.7 Button Description

Button No.	Button	Description
24	Clear	Clears fields of data.
25	Search	Searches for record using Case ID criteria.
26	Add	Creates a new record

4.3.7.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
8	MC Program	Field	1	A valid MC program is required.	Select an MC program from the drop down list.
8	MC Program	Field	10146	Member has an invalid living arrangement for the MC program.	Select an MC program from the drop down list.
8	MC Program	Field	10162	Member has no prerequisite program eligibility that spans assignment.	Select an MC program from the drop down list.
8	MC Program	Field	10163	Member is enrolled in a mutually-exclusive program.	Select an MC program from the drop down list.
8	MC Program	Field	10164	Member has invalid aid category eligibility.	Select an MC program from the drop down list.
10	Effective Date	Field	4156	Member is deceased as of effective dte.	Verify data entry. The member can not be deceased on the effective date.
10	Effective Date	Field	8012	Effective date must be less than or equal to end date.	Verify data entry. The member can not be deceased on the effective date.
10	Effective Date	Field	10058	Effective date not within PMP start and end date.	Verify data entry. The member can not be deceased on the effective date.

Field No	Field	Field Type	Error Code	Error Message	To Correct
10	Effective Date	Field	10144	Warning: Effective date is prior to today.	Verify data entry. The member can not be deceased on the effective date.
10	Effective Date	Field	91001	Invalid date. Format is mm/dd/yyyy.	Verify data entry. The member can not be deceased on the effective date.
11	End Date	Field	4159	Stop reason requires end date.	Select a valid stop reason or remove the end date.
11	End Date	Field	10052	The end date may not be increased.	Select a valid stop reason or remove the end date.
11	End Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Select a valid stop reason or remove the end date.
11	End Date	Field	91030	Date segment can not overlap.	Select a valid stop reason or remove the end date.
14	PMP ID	Field	1	There is no provider in the system with that ID.	Verify data entry. PMP ID and provider type must be a valid provider in the application.
14	PMP ID	Field	2	PMP provider ID not found.	Verify data entry. PMP ID and provider type must be a valid provider in the application.
14	PMP ID	Field	3	MC Program is needed to validate the PMP ID.	Verify data entry. PMP ID and provider type must be a valid provider in the application.
14	PMP ID	Field	4	No PMP ID found given effective date.	Verify data entry. PMP ID and provider type must be a valid provider in the application.
14	PMP ID	Field	5	A valid PMP ID is required.	Verify data entry. PMP ID and provider type must be a valid provider in the application.
14	PMP ID	Field	10073	PMP ID is not in this MC Program.	Verify data entry. PMP ID and provider type must be a valid provider in the application.

Field No	Field	Field Type	Error Code	Error Message	To Correct
14	PMP ID	Field	10172	Member locked out from provider type location.	Verify data entry. PMP ID and provider type must be a valid provider in the application.
16	MC Region	Field	4163	Member not in provider region.	Verify the data entered. If the member and PMP aren't in the same region, then the member shouldn't be assigned to the PMP. The only option is to select a PMP that is enrolled in the same region as the member.
18	Start Reason	Field	1	A valid start reason is required.	Select a start reason from the drop down list.
19	Stop Reason	Field	4023	End date requires stop reason.	Select appropriate stop reason from stop reason drop down list box.
21	Group Member ID	Field	1	Group member ID not found.	Verify data entry. The group member ID must be a valid provider ID in the application.
21	Group Member ID	Field	2	Group member ID not in the PMP ID group.	Verify data entry. The group member ID must be a valid provider ID in the application.
21	Group Member ID	Field	3	A valid PMP ID must be entered before you can search for the group member ID.	Verify data entry. The group member ID must be a valid provider ID in the application.

4.4 PAGE: Managed Care PMP Information Page

4.4.1 Description

This page displays the Managed Care PMP Information panels.

Navigation Path: [Managed Care - PMP Information]

4.4.2 Technical Name

MC.PmpInformationPage

4.4.3 Web Page Name

PMP Information

For readability the layout displays on the next page.

4.4.4 Managed Care PMP Information Page Layout

Next Search By: PMP ID | Site Number | search | clear

PMP Information

PMP ID	1000000007 NPI	Effective Date	01/03/2000
Site Number	0151	End Date	12/31/2299
Provider Name	COUNTRY MEDICAL CLINIC	MC Program	KENPAC

PMP Maintenance — Select an area to add or modify — Prefs Top Bot ? ⌃

PMP

Region Enrollment Maintenance | Capitation Rate Override | KenPAC PCP
PMP Capitation History

save | cancel | new

PMP — Top Nav ? A ⌃ ✕

PMP ID	1000000007 NPI [Search]	Site Enrollment	420
Site Number*	0151	Site Quota	420
Provider Name	COUNTRY MEDICAL CLINIC	Site Status*	Not Active
MC Program*	KENPAC	KCHIP III	No
Special Conditions*	No	Age Restriction*	No age restrictions
Obstetrics*	No	Focus*	Family Practitioner (Mgd Care)
Families*	No	24 Hour Phone*	8005551212 8002
All Women*	No	Effective Date*	01/03/2000
Output Media*	Paper	End Date*	12/31/2299
Exceed Allowed*	No	Number of Dr.*	1
Number of PA*	3	Number of ARNP*	2
Number of Midwife*	4	Site Name*	BEAM CLINIC 1
City*	CLERMONT	Address 1*	100 HAPPY HOLLOW RD
State*	KY	Address 2	
Zip*	40110 0000		

4.4.5 PANEL: PMP Mini Search

4.4.5.1 Description

The PMP Mini Search panel allows the user to search for managed care providers (PMPs) using limited criteria.

Navigation Path: [Managed Care - PMP Search] - [(select row from search results)]

Table: T_PMP_SVC_LOC

4.4.5.2 Technical Name

MC.PMPMiniSearchPanel.ascx

4.4.5.3 Panel Name

PMP Mini Search

4.4.5.4 PMP Mini SearchLayout

4.4.5.5 Extra Features

This panel has no extra features.

4.4.5.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PMP ID	The PMP Identifier to search for.	Field	Character	10	T_PMP_SVC_LOC	ID_PROVIDER
2	Site Number	The KenPAC site number. Only present for KenPAC providers. Blank for other managed care programs.	Field	Character	4	T_PMP_SVC_LOC_STATE	SITE_NUMBER

4.4.5.7 Button Description

Button No.	Button	Description
4	Clear	Clear the search information.
3	Search	Search for a PMP.

4.4.5.8 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.4.6 PANEL: PMP Maintenance

4.4.6.1 Description

The PMP Maintenance panel allows inquiries or updates to a provider's PMP (managed care provider) information for a specific service location.

Navigation Path: [Managed Care - PMP Search] - [(select row from search results)]

Table: N/A

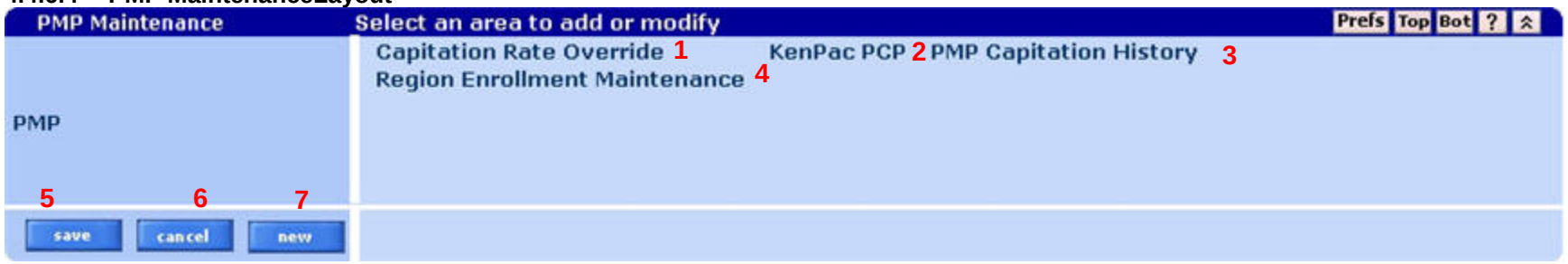
4.4.6.2 Technical Name

MC.PMPInformation.ascx (Maintenance)

4.4.6.3 Panel Name

PMP Maintenance

4.4.6.4 PMP MaintenanceLayout



In order to access PMP Maintenance Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: “PMP Information” from the Managed Care menu.

STEP 3: PMP Maintenance will be displayed.

Note: The Save and Cancel buttons are only used in conjunction with other panels.

4.4.6.5 Extra Features

This panel has no extra features.

4.4.6.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Capitation Rate Override	Hyperlink to PMP Capitation Rate Override panel	Hyperlink	N/A	0	N/A	N/A
2	KenPAC Site PCP	Hyperlink to KenPAC Site PCP panel	Hyperlink	N/A	0	N/A	N/A
3	PMP History Capitation	Hyperlink to PMP History Capitation	Hyperlink	N/A	0	N/A	N/A
4	Region Enrollment Maintenance	Hyperlink to Region Enrollment Maintenance	Hyperlink	N/A	0	N/A	N/A

4.4.6.7 Button Description

Button No.	Button	Description
5	Save	Save the PMP panels.
6	Cancel	Cancel the changes on the PMP panels.
7	New	Clicking the New button will clear all of the PMP panels for a new record.

4.4.6.8 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.4.7 PANEL: Capitation Rate Override

4.4.7.1 Description

The Capitation Rate Override panel allows the user to override the standard capitation rates for a specific PMP. Unless an override rate is entered, the rate specified in the Standard Capitation Rates panel will be utilized for the given capitation category.

Navigation Path: [Managed Care - PMP Search] - [(select row from search results)] - [Capitation Rate Override]

Table: T_MC_CAP_AMTS_PMP, T_MC_CAP_AMTS_RANGE

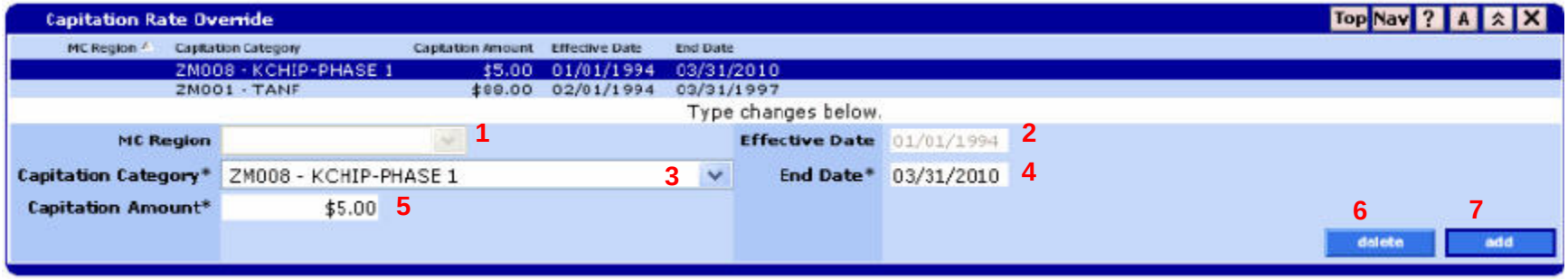
4.4.7.2 Technical Name

MC.McCapAmtsPmpPanel.ascx

4.4.7.3 Panel Name

Capitation Rate Override

4.4.7.4 Capitation Rate Override Layout



In order to access Capitation Rate Override Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “PMP Information” from the Managed Care menu.

STEP 3: Navigating to the PMP Maintenance panel, select Capitation Rate Override link.

STEP 4: Capitation Rate Override will be displayed.

4.4.7.5 Extra Features

This panel has no extra features.

4.4.7.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MC Region	This is the identification of the managed care region.	Field	Drop Down List Box	0	T_MC_REGION	CDE_MC_REGION
2	Effective Date	Effective date of the payment record. The date can not overlap.	Field	Date (MM/DD/CCYY)	8	T_MC_CAP_AMTS_PMP	DTE_EFFECTIVE
3	Capitation Category	This is the category of the capitation. Format Code - Description.	Field	Drop Down List Box	0	T_MC_RATE_CELL	SAK_RATE_CELL
4	End Date	End date of the payment record. The date can not overlap.	Field	Date (MM/DD/CCYY)	8	T_MC_CAP_AMTS_PMP	DTE_END
5	Capitation Amount	Amount of the capitation payment. Format 9999999.99. The capitation amount needs to edit to make sure that rates entered fall within the minimum and maximum range for capitation rates on the T_MC_CAP_AMTS_RANGE table.	Field	Number	9	T_MC_CAP_AMTS_PMP	AMT_CAPITATION

4.4.7.7 Button Description

Button No.	Button	Description
6	Delete	Delete a capitation rate override.
7	Add	Add a capitation rate override.

4.4.7.8 Field Edits

Field No.	Field	Field Type	Error Code	Error Message	To Correct
1	MC Region	Field	91006	A valid MC Region is required.	Select valid option from MC region list.
2	Effective Date	Field	1	Effective date must be equal to first day of the month.	Effective date must be in the form MM/DD/CCYY where DD = 01.
2	Effective Date	Field	8012	Effective date must be less than or equal to end date.	Effective date must be in the form MM/DD/CCYY where DD = 01.
2	Effective Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Effective date must be in the form MM/DD/CCYY where DD = 01.
2	Effective Date	Field	91030	Date segments can not overlap.	Effective date must be in the form MM/DD/CCYY where DD = 01.
3	Capitation Category	Field	91006	A valid Capitation Category is required.	Select valid option from Capitation Category list
4	End Date	Field	2	End date must be equal to last day of the month.	End date must be in the form MM/DD/CCYY where DD is the last day of the month, ex: Jan has 31 days, 01/31/2099.
4	End Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	End date must be in the form MM/DD/CCYY where DD is the last day of the month, ex: Jan has 31 days, 01/31/2099.
4	End Date	Field	91030	Date segments can not overlap.	End date must be in the form MM/DD/CCYY where DD is the last day of the month, ex: Jan has 31 days, 01/31/2099.
5	Capitation Amount	Field	3	Capitation amount must be greater than zero.	Verify input. Capitation amount must be greater than 0.
5	Capitation Amount	Field	4	Capitation amount stays with the inclusive rate range.	Verify input. Capitation amount must be within minimum rate and maximum rate range.

4.4.8 PANEL: PMP Capitation History

4.4.8.1 Description

The PMP Capitation History panel lists all of the capitation transactions ever made to the specified PMP.

Navigation Path: [Managed Care - PMP Search] - [(select row from search results)] - [PMP Capitation History]

Table: T_CAPITATION_HIST

This panel is an inquiry panel. The table is updated in a batch process.

4.4.8.2 Technical Name

MC.McPmpCapitationTxnPanel.ascx

4.4.8.3 Panel Name

PMP Capitation History

4.4.8.4 PMP Capitation History Layout

In order to access PMP Capitation History Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “PMP Information” from the Managed Care menu.

STEP 3: Navigating to the PMP Maintenance panel, select PMP Capitation History link.

STEP 4: PMP Capitation History will be displayed.

4.4.8.5 Extra Features

This panel has no extra features.

4.4.8.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Member ID	Member's identification number.	Field	Character	12	T_RE_BASE	ID_MEDICAID
2	Capitation Category	This is the category of the capitation. The drop down is code and description, in the datalist it is just the description.	Field	Drop Down List Box	0	T_MC_RATE_CELL	DSC_CAP_CATEGORY
3	Cap Txn Date	This is the date that the capitation payment was made.	Field	Date (MM/DD/CCYY)	8	T_CAPITATION_HIST	DTE_CAP_TXN
4	Capitation Txn Date	This is the date that the capitation payment was made.	Field	Date (MM/DD/CCYY)	8	T_CAPITATION_HIST	DTE_CAP_TXN
4	Name	This provider individual name (format last name, first name, middle initial) or the business name.	Field	Character	50	T_RE_BASE	NAM_LAST+NAM_FIRST+NAM_MID_INIT
5	Gender	Gender of member.	Field	Character	12	T_RE_BASE	CDE_SEX

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	Cap Date	This is the month that the capitation payment covers.	Field	Date (MM/CCYY)	6	T_CAPITATION_HIST	DTE_CAPITATION
7	Cap Amount	The amount of money (check or EFT) we will pay to an external entity for capitation.	Field	Number	9	T_CAPITATION_HIST	AMT_CAP_PAID
8	Cap Reason	This is the code of the reason the capitation is being done.	Field	Character	2	T_CAP_REASON	CDE_CAP_REASON

4.4.8.7 Button Description

Button No.	Button	Description
9	Search	The Search button will return the search results.
10	Clear	The Clear button will clear the search fields.

4.4.8.8 Field Edits

	Field	Field Type	Error Code	Error Message	To Correct
1	Member ID	Field	1		“This member ID xxxxxxxxxx is linked to yyyyyyyyyy”
1	Member ID	Field	2		Please enter member ID, capitation category or capitation transaction date.
3	Capitation Txn Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify data entry. The date must be in MM/DD/CCYY format.

4.4.9 PANEL: Region Enrollment Maintenance

4.4.9.1 Description

The Region Enrollment Maintenance panel allows the user to enroll the selected managed care provider (PMP) into one or more geographical regions of the state.

Navigation Path: [Managed Care - PMP Search] - [(select row from search results)] - [Region Enrollment Maintenance]

Table: T_MC_PMP_ENRL_RGN

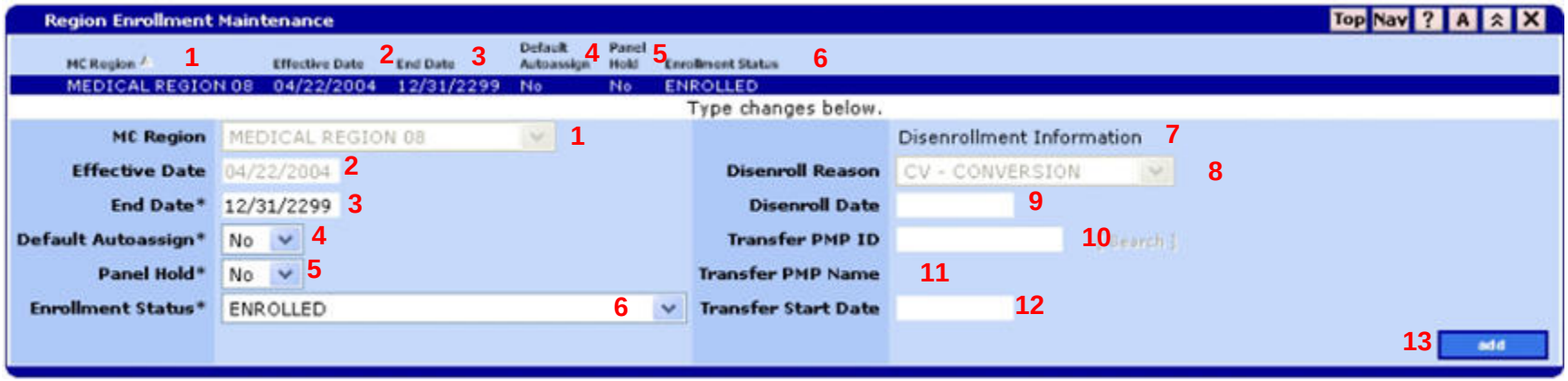
4.4.9.2 Technical Name

MC.McPmpEnrlRgnPanel.ascx

4.4.9.3 Panel Name

Region Enrollment Maintenance

4.4.9.4 Region Enrollment MaintenanceLayout



In order to access Region Enrollment Maintenance Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “PMP Information” from the Managed Care menu.

STEP 3: Navigating to the PMP Maintenance panel, select Region Enrollment Maintenance link.

STEP 4: Region Enrollment Maintenance will be displayed.

STEP 5: Use the “add” button to create a new record.

4.4.9.5 Extra Features

This panel has no extra features.

4.4.9.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MC Region	This is the identification of the managed care region.	Field	Drop Down List Box	0		CDE_MC_REGIN
2	Effective Date	This is the effective date of the managed care region.	Field	Date (MM/DD/CCYY)	8	T_MC_PMP_ENRL_RGN	DTE_EFFECTIVE
3	End Date	This is the end date of the managed care region.	Field	Date (MM/DD/CCYY)	8	T_MC_PMP_ENRL_RGN	DTE_END
4	Default Autoassign	This controls if the PMP service location allows autoassignments. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_MC_PMP_ENRL_RGN	IND_AUTOASSIGN
5	Panel Hold	This column specifies that the provider is not accepting new members. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_MC_PMP_ENRL_RGN	IND_PANEL_HOLD
6	Enrollment Status	Contains the enrollment status description.	Field	Drop Down List Box	0		CDE_ENROLL_STATUS
7	Disenrollment Information	This label defines the "Disenrollment Information" section on the panel.	Label	N/A	0	N/A	N/A

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
8	Disenroll Reason	Contains the PMP enrollment reason description. Format is code (length two), " - ", and description (length 50).	Field	Drop Down List Box	0		CDE_ENROLL_RSN
9	Disenrollment Date	The date that the PMP has elected to disenroll from the specified region.	Field	Date (MM/DD/CCYY)	8	T_MC_PMP_ENRL_RGN	DTE_DISENROLL
10	Transfer PMP ID	Identifies the transfer provider enrollment tracking ID and service location. This field is the Transfer PMP ID (length nine) and the service location (length one).	Field	Character	10	T_MC_PMP_ENRL_RGN	SAK_PMP_SER_LOC
11	Transfer PMP Name	Transfer PMP provider individual name (format last name, first name, middle initial) or the business name.	Field	Character	50	T_PMP_SVC_LOC	PROV_NAME
12	Transfer Start Date	The start date of the transfer.	Field	Date (MM/DD/CCYY)	8	T_MC_PMP_ENRL_RGN	DTE_START_XFER

4.4.9.7 Button Description

Button No.	Button	Description
13	Add	Add region enrollment record.

4.4.9.8 Field Edits

Field No.	Field	Field Type	Error Code	Error Message	To Correct
1	MC Region	Field	1	Valid MC region is required.	Select an MC region from the drop down list.
2	Effective Date	Field	1	Effective date is required.	Enter a valid effective date in MM/DD/CCYY format.
2	Effective Date	Field	4122	Effective date must be the first day of the month.	Enter a valid effective date in MM/DD/CCYY format.
2	Effective Date	Field	8012	Effective date must be less than or equal to End Date.	Enter a valid effective date in MM/DD/CCYY format.
2	Effective Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Enter a valid effective date in MM/DD/CCYY format.
3	End Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify data entry. The date must be in MM/DD/CCYY format.
3	End Date	Field	91030	Date segments can not overlap.	Verify data entry. The date must be in MM/DD/CCYY format.
3	End Date	Field	91135	End date must be the last day of the month.	Verify data entry. The date must be in MM/DD/CCYY format.
6	Enrollment Status	Field	1	Valid enrollment status is required.	Select an enrollment status from the drop down list.
6	Enrollment Status	Field	10070	Enrollment status may only change to enrolled.	Select an enrollment status from the drop down list.
6	Enrollment Status	Field	10071	Enrollment status may only change to mass disenrollment approval pending.	Select an enrollment status from the drop down list.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
6	Enrollment Status	Field	10072	Enrollment status may only change to enrolled or mass disenrollment approved.	Select an enrollment status from the drop down list.
6	Enrollment Status	Field	10073	Enrollment status may only change to enrolled or mass disenrollment approval pending.	Select an enrollment status from the drop down list.
6	Enrollment Status	Field	10079	Enrollment status may not change.	Select an enrollment status from the drop down list.
8	Disenroll Reason	Field	10002	Disenroll reason is required.	Select a valid disenroll reason from the disenroll reason drop down menu.
9	Disenrollment & Assign End Date	Field	10232	Disenrollment and assign end date must fall between enrolled dates.	Verify input. Disenrollment and assign date must be >= effective date and <= end date.
10	Transfer PMP ID	Field	10075	Transfer PMP ID is required, because transfer start date was entered	Verify input. Enter a valid PMP ID or remove the transfer start date.
10	Transfer PMP ID	Field	10076	Transfer PMP ID cannot be the same as the disenrolling PMP	Verify input. Enter a valid PMP ID or remove the transfer start date.
10	Transfer PMP ID	Field	10080	Transfer PMP ID must be enrolled in a MC region on the transfer start date.	Verify input. Enter a valid PMP ID or remove the transfer start date.
10	Transfer PMP ID	Field	10081	Transfer PMP ID must be enrolled in the same PMP managed care program as the disenrolling PMP.	Verify input. Enter a valid PMP ID or remove the transfer start date.
12	Transfer Start Date	Field	10074	Transfer start date is required, because transfer PMP ID was entered.	Verify input. Either remove the PMP ID or enter a valid transfer start date.

Field No.	Field	Field Type	Error Code	Error Message	To Correct
12	Transfer Start Date	Field	10077	Transfer start date must fall between enrolled dates.	Verify input. Enter a valid transfer start date between region effective and end dates.
12	Transfer Start Date	Field	10078	Transfer start date must be after the disenrollment and assign end date.	Verify input. Enter a valid transfer start date.
12	Transfer Start Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify Input. Either remove the PMP ID or enter a valid transfer start date.

4.4.10 PANEL: PMP

4.4.10.1 Description

The PMP panel displays information about the selected managed care provider (PMP). In Kentucky there are four types of PMPs. A PMP can be a Managed Care Organization like Passport. Transportation brokers are PMPs. KenPAC sites are PMPs, and finally lock-in physicians are PMPs. The PMP is the entity that is paid a fee or capitation for the members that are "enrolled" with the PMP.

Navigation Path: [Managed Care - PMP Search] - [(select row from search results)]

Table: T_PMP_SVC_LOC

4.4.10.2 Technical Name

MC.PmpServiceLocationPanel.ascx

4.4.10.3 Panel Name

PMP

4.4.10.4 PMPLayout

In order to access PMP Panel, use the following steps:

STEP1: Select Managed Care panel.

STEP 2: Select “PMP Information” from the Managed Care menu.

STEP 3: PMP will be displayed.

4.4.10.5 Extra Features

This panel has no extra features.

4.4.10.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PMP ID	The PMP identification number. This field is PMPID (length 10).	Field	Character	10	T_PR_SVC_LOC	SAK_PROV + CDE_SERVICE_LOC
2	Site Enrollment	This is the number of members currently assigned to the PMP location.	Field	Number	9	T_PMP_SVC_LOC	NUM_ACT_PANEL
3	Site Number	The KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.	Field	Character	4	T_PMP_SVC_LOC_STATE	SITE_NUMBER
4	Site Quota	This is the number of members assigned to the PMP location that are effective AFTER the current date.	Field	Number	9	T_PMP_SVC_LOC	NUM_FUTURE_PANEL
5	Provider Name	This provider individual name (format last name, first name, middle initial) or the business name.	Field	Character	50	T_PR_NAM	NAME

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	Site Status	This column controls the KenPAC site status. Valid values are "Active" or "Unknown" or "Not Active Status".	Field	Alphanumeric	1	T_PMP_SVC_LOC_STATE	CDE_SITE_STATUS
7	MC Program	This is the identification of the managed care program.	Field	Drop Down List Box	0	T_PUB_HLTH_PGM	SAK_PUB_HLTH
8	KCHIP III	Indicates the provider is willing to accept members with KCHIP III eligibility. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_PMP_SVC_LOC	KCHIP_III (TO BE CREATED)
9	Special Conditions	Indicates whether the PMP offers special services at this location for special patient conditions. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_PMP_SVC_LOC	IND_SPEC_COND
10	Age Restriction	The age restrictions a primary medical provider (PMP) can select for a given PMP location.	Field	Drop Down List Box	0	T_AGE_RESTRICT	CDE_AGE_RESTR
11	Obstetrics	Indicates whether a PMP provides obstetric services in their practice. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_PMP_SVC_LOC	IND_OBSTETRICS

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
12	Focus	Contains list of valid focuses that a PMP can have. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: general practitioner, internist, and pediatrician.	Field	Drop Down List Box	0	T_MC_PMP_FOCUS	SAK_PMP_FOCUS
13	Families	Indicates whether a PMP accepts entire families in their practice. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_PMP_SVC_LOC	IND_FMLY_PRAC
14	24 Hour Phone	The 24-hour availability phone number for the provider in the format area code + prefix + suffix. This field is divided into two fields, which are 24-Hour Phone (length 10) and Extension (length four).	Field	Character	14	T_PMP_SVC_LOC	NUM_PHO_24_HOUR + NUM_PHO_EXT
15	All Women	Indicates whether the provider only accepts women as managed care members. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_PMP_SVC_LOC	IND_WOMEN_ONLY
16	Effective Date	This is the effective date for PMP for this managed care program. Used to signify the start of a span or period of participation in the managed care program.	Field	Date (MM/DD/CCYY)	8	T_PMP_SVC_LOC	DTE_EFFECTIVE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
17	Output Media	Type of media used for output. Valid values are "Electronic" and "Paper".	Field	Drop Down List Box	0	T_PMP_SVC_LOC	CDE_FILE_FORMAT
18	End Date	This is the end date for PMP for this managed care program. Used to signify the end of a span or period of participation in the managed care program.	Field	Date (MM/DD/CCYY)	8	T_PMP_SVC_LOC	DTE_END
19	Exceed Allowed	Indicates whether a PCP will or will not accept members of the same family when the PCP's allowed is reached.	Field	Drop Down List Box	0	T_PMP_SVC_LOC	IND_ALLOW_EXCEED (TOBE CREATED)
20	Number of Dr.	Used to determine if a provider has met the quota on new members. Dr. counts the same as a physician. Used for Dr. practitioner providers.	Field	Number	9	T_PMP_SVC_LOC	NUM_PHYS
21	Number of PA	Used to determine if a provider has met the quota on new members. PA counts the same as a physician. Used for PA practitioner providers.	Field	Number	9	T_PMP_SVC_LOC	NUM_PHYS_ASST

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
22	Number of ARNP	Used to determine if a provider has met the quota on new members. ARNP count the same as a physician. Used for ARNP practitioner providers.	Field	Number	9	T_PMP_SVC_LOC	NUM_ARNP
23	Number of Midwife	Used to determine if a provider has met the quota on new members. Midwife counts the same as a physician. Used for midwife practitioner providers.	Field	Number	9	T_PMP_SVC_LOC	NUM_MIDWIFE (TOBE CREATED)
24	Site Name	This is the site name for the physical location of the site.	Field	Character	50	T_PMP_SVC_LOC_STATE	SITE_NAME
25	City	This is the city for the physical location of the site.	Field	Alphanumeric	30	T_PMP_SVC_LOC_STATE	ADR_SITE_CITY
26	Address 1	This is the street address for the physical location of the site.	Field	Alphanumeric	30	T_PMP_SVC_LOC_STATE	ADR_SITE_STRT1
27	State	This is the state for the physical location of the site.	Field	Alphanumeric	2	T_PMP_SVC_LOC_STATE	ADR_STATE
28	Address 2	This is the second street address for the physical location of the site.	Field	Alphanumeric	30	T_PMP_SVC_LOC_STATE	ADR_SITE_STRT2
29	Zip	This is the first five digits of the zip code plus the four-digit suffix for the physical location of the site.	Field	Number	9	T_PMP_SVC_LOC_STATE	ADR_SITE_ZIP, ADR_SITE_ZIP_4

4.4.10.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	PMP ID	Field	1	A valid provider number is required.	Enter a valid provider number/service location or click [search] and select one.
1	PMP ID	Field	101	An entry must exist on the Region Enrollment Maintenance panel.	Enter a valid provider number/service location or click [search] and select one.
4	MC Program	Field	1	A valid MC program is required.	Select a valid MC program from the drop down list.
9	Output Media	Field	1	Output media is required.	Select an output media from the drop down list.
20	Age Restriction	Field	1	A valid age restriction is required.	Select an age restriction from the drop down list.
21	Focus	Field	1	A valid focus is required.	Select a focus from the drop down list.
22	24 Hour Phone	Field	1	24-hour phone is required.	Enter a valid 24-hour phone.
23	Effective Date	Field	1	Effective date is required.	Enter a valid effective date.
23	Effective Date	Field	103	The PMP has overlapping dates for the managed care program.	Enter a valid effective date.
23	Effective Date	Field	4122	Effective date must be the first day of the month.	Enter a valid effective date.
23	Effective Date	Field	8012	Effective date must be less than or equal to end date.	Enter a valid effective date.

Field No	Field	Field Type	Error Code	Error Message	To Correct
23	Effective Date	Field	10063	Date range is not within the provider's Medicaid eligibility.	Enter a valid effective date.
23	Effective Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Enter a valid effective date.
24	End Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify data entry. The date must be in MM/DD/CCYY format.

4.4.11 PANEL: KenPAC Site PCP

4.4.11.1 Description

Providers associated with a KenPAC site are displayed on this panel.

Navigation Path: [Managed Care - PMP Search] - [(select row from search results)] - [KenPAC Site PCP]

Table: T_MC_KENPAC_PCP

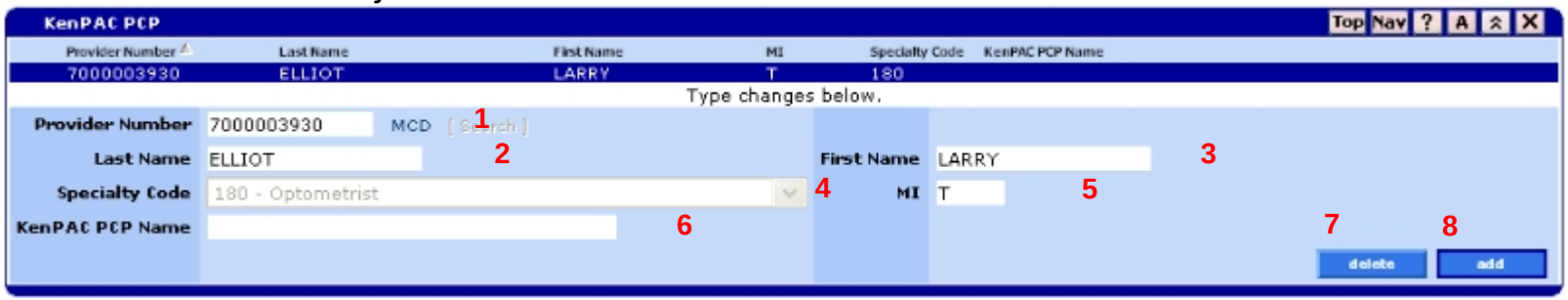
4.4.11.2 Technical Name

MC.KenPACPCP.ascx

4.4.11.3 Panel Name

KenPAC PCP

4.4.11.4 KenPAC Site PCP Layout



In order to access KenPAC PCP Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “PMP Information” from the Managed Care menu.

STEP 3: Navigating to the PMP Maintenance panel, select KenPAC PCP link.

STEP 4: KenPAC PCP will be displayed.

STEP 5: Use the “add” button to modify the record.

4.4.11.5 Extra Features

This panel has no extra features.

4.4.11.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Provider Number	This is the primary medical provider (PMP) ID field.	Field	Character	10	T_PR_SVC_LOC	SAK_PROV + CDE_SERVICE_LOC
2	PCP Last Name	The last name of the KenPAC site PCP.	Field	Character	20	T_MC_KENPAC_PCP	LNAME
3	PCP First Name	The first name of the KenPAC site PCP.	Field	Character	19	T_MC_KENPAC_PCP	FNAME
4	Specialty Code	The specialty code of the KenPAC site PCP.	Field	Character	3	T_MC_KENPAC_PCP	SPEC_CD
5	PCP MI	The middle initial of the KenPAC site PCP.	Field	Character	1	T_MC_KENPAC_PCP	MI
6	KenPac PCP Name	Either PCP name is enterable or provider number is selected from the provider search link. If KenPAC PCP name is entered, and the other fields are left blank.	Field	Character	40	T_MC_KENPAC_PCP	NAM_PCP

4.4.11.7 Button Description

Button No.	Button	Description
7	Delete	Delete a record.
8	Add	Add region enrollment record.

4.4.11.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Provider Number	Field	1	There is no Provider in the system with that ID.	Verify data entry. PMP ID must be a valid provider in the application.

4.4.12 PANEL: PMP Information

4.4.12.1 Description

The PMP Information panel displays information about the selected managed care provider (PMP).

Navigation Path: [Managed Care - PMP Search] - [(select row from search results)]

Table: T_PMP_SVC_LOC

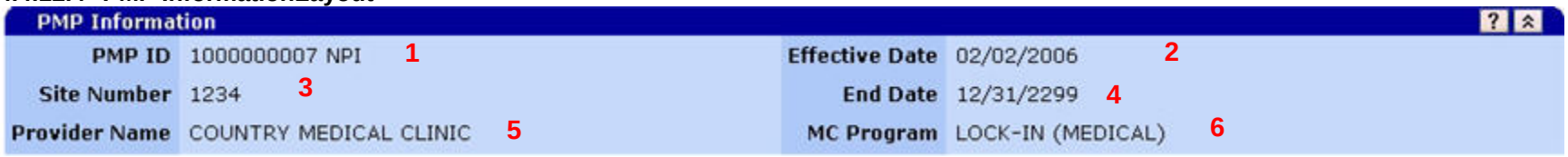
4.4.12.2 Technical Name

MC.PMPInformation.ascx

4.4.12.3 Panel Name

PMP Information

4.4.12.4 PMP InformationLayout



In order to access PMP Mini Search Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “PMP Information” from the Managed Care menu.

STEP 3: PMP Information will be displayed.

4.4.12.5 Extra Features

This panel has no extra features.

4.4.12.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PMP ID	The unique PMP identification number as listed in the Provider subsystem. The number can be any of the following: Provider Medicaid ID, NPI number, or InterChange Provider Identifier number (known in the Managed Care subsystem as Base PMP ID)	Field	Character	10	T_PR_SVC_LOC	SAK_PROV+CDE_SERVICE_LOC
2	Effective Date	This is the effective date for PMP for this managed care program. Used to signify the start of a span or period of participation in the managed care program.	Field	Date (MM/DD/CCYY)	8	T_PMP_SVC_LOC	DTE_EFFECTIVE
3	Site Number	The KenPAC site number. Only present for KenPAC providers. Blank for other managed care programs.	Field	Character	4	T_PR_SVC_LOC_STATE	NUM_SITE
4	End Date	This is the end date for PMP for this managed care program. Used to signify the end of a span or period of participation in the managed care program.	Field	Date (MM/DD/CCYY)	8	T_PMP_SVC_LOC	DTE_END
5	Provider Name	This provider individual name (format last name, first name, middle initial) or the business name.	Field	Character	50	T_PR_NAM	NAME
6	MC Program	This is the identification of the managed care program.	Field	Character	50	T_PUB_HLTH_PGM	DSC_PGM_HEALTH

4.4.12.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.5 PAGE: Managed Care PMP Search Page

4.5.1 Description

This page displays the Managed Care PMP Search panel.

Navigation Path: [Managed Care - PMP Search]

4.5.2 Technical Name

MC.PmpSearchPage

4.5.3 Web Page Name

PMP Search

4.5.4 Managed Care PMP Search Page Layout

Search Results

National PMP ID	Medicaid PMP ID	Base PMP ID	Site Number	Name	MC Program	Effective Date	End Date
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	AAAA	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	1234	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	111Q	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0011	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299
1000000007	100000009A	100000009	0000	COUNTRY MEDICAL CLINIC	LOCK-IN (MEDICAL)	01/01/2001	12/31/2299

1 2 3 4 5 6 7 8 9 10 ... Next >

4.5.5 PANEL: PMP Search

4.5.5.1 Description

The PMP Search panel allows the user to enter criteria for searching through the managed care providers (PMPs).

Navigation Path: [Managed Care - PMP Search]

Table: T_PMP_SVC_LOC

4.5.5.2 Technical Name

MC.PMPSearchPanel.ascx

4.5.5.3 Panel Name

PMP Search

4.5.5.4 PMP SearchLayout

In order to access Managed Care PMP Search Page use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “PMP Search” from the Managed Care menu.

STEP 3: Managed Care PMP Search Panel will be displayed.

4.5.5.5 Extra Features

This panel has no extra features.

4.5.5.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	PMP ID	The PMP ID to search for.	Field	Character	10	T_PMP_SVC_LOC	SAK_PROV_LOC

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	Site Number	The KenPAC site number to search for.	Field	Character	4	T_PMP_SVC_LOC_STATE	SITE_NUMBER

4.5.5.7 Button Description

Button No.	Button	Description
3	Search	Search for a PMP.
4	Clear	Clear the search information.

4.5.5.8 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.5.6 PANEL: PMP Search Results

4.5.6.1 Description

The PMP Search Results panel displays the results of the user's search for managed care providers (PMPs) based on the entered criteria.

Navigation Path: [Managed Care - PMP Search] - [(click the search button)]

Table: T_PMP_SVC_LOC

4.5.6.2 Technical Name

MC.PMPSearchPanel.ascx (search results)

4.5.6.3 Panel Name

Search Results

4.5.6.4 PMP Search ResultsLayout

» Search Results

1 National PMP ID	2 Medicaid PMP ID	3 Base PMP ID	4 Site Number	5 Name	6 MC Program	7 Effective Date	8 End Date
	99999999	999999999	0771	ALBAREE HLTH SVC LLC	KENPAC	11/01/2005	11/16/2006
	99999999	999999999	0000	PRIMARY CARE CTR OF EASTERN KY HINDMAN	LOCK-IN (MEDICAL)	08/01/2007	12/31/2299
9999999999	99999999	999999999	0761	FAMILY HEALTH CARE CLINIC PSC	KENPAC	04/04/2006	12/31/2299
9999999999	99999999	999999999	0000	MADISON FAMILY CLINIC	LOCK-IN (MEDICAL)	12/01/2006	12/31/2299
9999999999	99999999	999999999	0301	MOHAMMED J SAYED MD PLLC	KENPAC	06/01/2004	12/31/2299
9999999999	99999999	999999999	0591	PEDIATRIC PARTNERS OF NO KY PSC	KENPAC	11/15/2005	12/31/2299
	99999999	999999999	0651	JAMES B NOBLE RHC	KENPAC	12/01/2005	05/25/2006
9999999999	99999999	999999999	0361	ALL FAMILY HEALTH CARE	KENPAC	04/01/2005	12/31/2299
9999999999	99999999	999999999	0000	MOUNTAIN FAMILY PRACTICE	LOCK-IN (MEDICAL)	04/01/2007	12/31/2299
9999999999	99999999	999999999	0000	EAST KY HEALTH SERVICES	LOCK-IN (MEDICAL)	03/01/1999	12/31/2299
9999999999	99999999	999999999	8033	MOUNTAIN PEOPLES HLTH CTR INC	KENPAC	04/25/1997	12/31/2299
9999999999	99999999	999999999	5011	CHILDRENS HOSP MED CTR	KENPAC	08/01/1986	12/31/2299
9999999999	99999999	999999999	5013	UNIVERSITY INTERNAL MED	KENPAC	04/02/1997	10/31/1999
	99999999	999999999	0023	CMNWLTH HLTH CORP IN	KENPAC	09/01/2001	10/31/2002
9999999999	99999999	999999999	0361	CONSOLIDATED HEALTH SYSTEMS	KENPAC	07/01/2001	12/31/2299
9999999999	99999999	999999999	0594	ALLIANCE PRIMARY CARE	KENPAC	10/11/2006	12/31/2299
9999999999	99999999	999999999	0000	JENKINS FAMILY CARE CTR	LOCK-IN (MEDICAL)	12/01/2006	12/31/2299
	99999999	999999999	0471	XAVIER HEALTHCARE PLLC	KENPAC	08/21/1997	12/31/2299
9999999999	99999999	999999999	0000	JACKSON PRIMETIME MEDICAL SERVICE	LOCK-IN (MEDICAL)	04/01/1999	12/31/2299
	99999999	999999999	0000	FAMILY CARE ASSOCIATES	LOCK-IN (MEDICAL)	02/12/2001	12/31/2299

1 2 3 4 5 6 7 8 9 10 ... Next >

4.5.6.5 Extra Features

This panel has no extra features.

4.5.6.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	National PMP ID	The National PMP identification number.	Field	Character	10	T_PR_IDENTIFIER	ID_PROVIDER
2	Medicaid PMP ID	The Medicaid PMP identification number.	Field	Character	10	T_PR_IDENTIFIER	ID_PROVIDER
3	Base PMP ID	The base PMP identification number.	Field	Character	10	T_PR_IDENTIFIER	ID_PROVIDER
4	Site Number	The KenPAC site number. Only present for KenPAC providers. Blank for other managed care programs.	Field	Character	4	T_PMP_SVC_LOC_STATE	SITE_NUMBER
5	Name	This provider individual name (format last name, first name, middle initial) or the business name.	Field	Character	50	T_PR_NAME	NAME
6	MC Program	This is the identification of the managed care program.	Field	Character	50	T_PUB_HLTH_PGM	DSC_PGM_HEALTH
7	Effective Date	Effective date managed care program is active.	Field	Date (MM/DD/CCYY)	8	T_PMP_SVC_LOC	DTE_EFFECTIVE
8	End Date	Date managed care program terminates.	Field	Date (MM/DD/CCYY)	8	T_PMP_SVC_LOC	DTE_END

4.5.6.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6 PAGE: Managed Care Related Data Page

4.6.1 Description

This page displays the related data for Managed Care containing Codes, Other, and Xref sections.

Navigation Path: [Managed Care - Related Data]

4.6.2 Technical Name

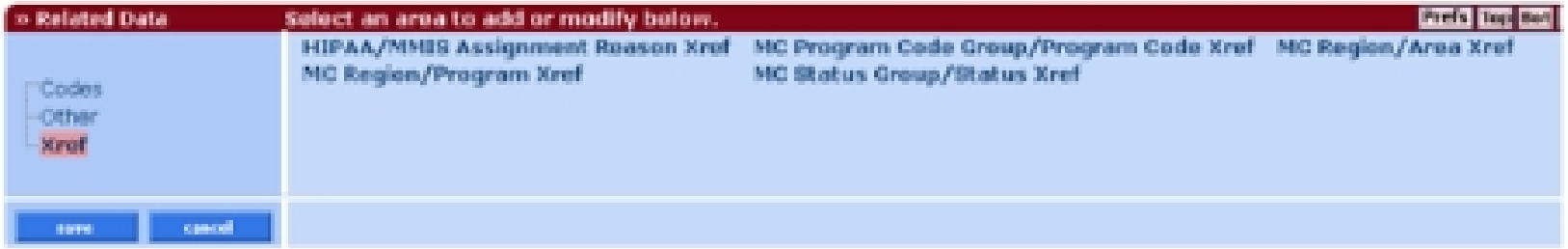
MC.RelatedDataPage

4.6.3 Web Page Name

Related Data

For readability the layout displays on the next page.

4.6.4 Managed Care Related Data Page Layout



In order to access Related Page use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Related Data Page will be displayed.

4.6.5 PANEL: Codes-Capitation Reason

4.6.5.1 Description

The Capitation Reason panel allows the user to maintain the reason codes/descriptions of capitation payments and adjustments.

Navigation Path: [Managed Care - Related Data] - [Codes] - [Capitation Reason]

Table: T_CAP_REASON

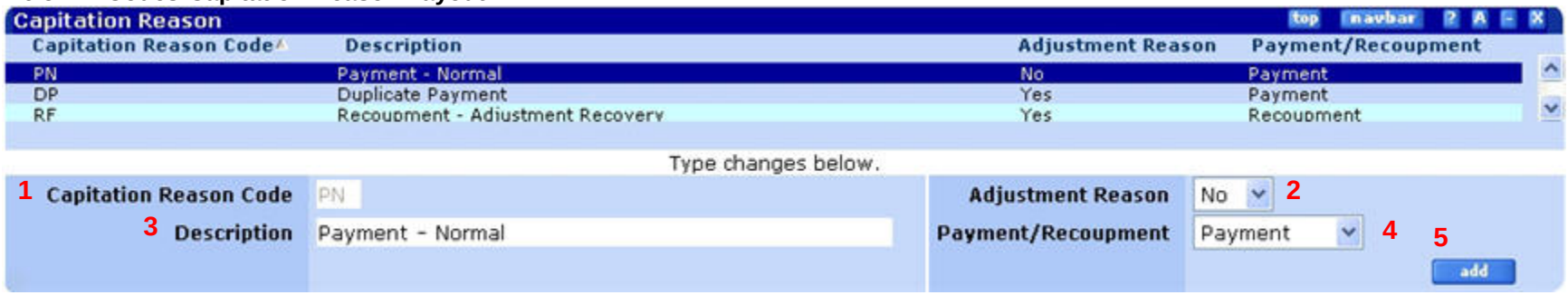
4.6.5.2 Technical Name

MC.CapReasonPanel.ascx

4.6.5.3 Panel Name

Capitation Reason

4.6.5.4 Codes-Capitation Reason Layout



In order to access Capitation Reason Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select "Related Data" from the Managed Care menu.

STEP 3: Navigate to the Related Data panel.

STEP 4: Select Capitation Reason link.

STEP 5: Capitation Reason panel will be displayed.

STEP 6: Use the "add" button to modify the record.

4.6.5.5 Extra Features

This panel has no extra features.

4.6.5.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Capitation Reason Code	This is the code of the reason the capitation is being done.	Field	Character	2	T_CAP_REASON	CDE_CAP_REASON
2	Adjustment Reason	This value indicates whether this reason code can be used for an adjustment or not. Valid values are "Yes" and "No".	Field	Drop Down List Box	1	T_CAP_REASON	IND_CAP_ADJ
3	Description	This is the description of the adjustment reason code.	Field	Character	50	T_CAP_REASON	DSC_50
4	Payment/Recoupment	This specifies if the reason is for payments or recoupments. Valid values are "Payment" and "Recoupment".	Field	Drop Down List Box	1	T_CAP_REASON	CDE_PAY_RECOUP

4.6.5.7 Button Description

Button No.	Button	Description
5	Add	Add a capitation reason.

4.6.5.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Capitation Reason Code	Field	1	Capitation Reason Code is required.	Enter a valid reason code.
1	Capitation Reason Code	Field	2	A duplicate record cannot be saved.	Enter non duplicate Reason code.
3	Description	Field	1	Description is required.	Enter a description.

Field No	Field	Field Type	Error Code	Error Message	To Correct
4	Payment/Recoupment	Field	1	Payment/Recoupment is required.	Select a payment/recoupment from the drop down list.

4.6.6 PANEL: Other-Capitation Categories Demographics

4.6.6.1 Description

The Capitation Categories/Demographics panel allows the user to view the pre-defined capitation categories and the demographics that make up each one. Demographics are broken down into program code group, program status group, age, gender, Medicare, and special conditions. The panel also displays the individual program codes that exist within each program code group, and the individual program statuses that exist within each program status group

Navigation Path: [Managed Care - Related Data] - [Other] - [Capitation Categories/Demographics]

Table: T_MC_RATE_CELL, T_MC_CAP_DEMOGRAPH (demographics), T_MC_AID_GRP_XREF (program code)

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

4.6.6.2 Technical Name

MC.McRateCellPanel.ascx

4.6.6.3 Panel Name

Capitation Categories/Demographics

For readability the layout displays on the next page.

4.6.6.4 Other-Capitation Categories Demographics Layout

Capitation Categories/Demographics Top Nav ? A X

1 Capitation Category	2 Description	3 Effective Date	4 End Date	5 Pro-Rate	Auto-Adjust	6 Primary Payment 7
ZK001	KENPAC ADMINISTRATIVE FEE	01/01/1964	12/31/2299	No	Yes	Yes
ZL001	MEDICAL LOCK-IN ADMINISTRATIVE FEE	01/01/1964	12/31/2299	No	Yes	Yes
ZM001	TANF	01/01/1964	08/31/2003	No	Yes	Yes
ZM002	SOBRA	01/01/1964	08/31/2003	No	Yes	Yes
ZM003	FOSTER CARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM004	SSI WITH MEDICARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM005	SSI WITHOUT MEDICARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM006	KCHIP-PHASE 2	01/01/1964	12/31/2299	No	Yes	Yes
ZM007	KCHIP-PHASE 3	01/01/1964	12/31/2299	No	Yes	Yes
ZM008	KCHIP-PHASE 1	01/01/1964	12/31/2299	No	Yes	Yes

1 2 Next >

--Demographics Breakdown-- The demographic breakdown below is for the capitation category selected above.

8 MC Program Code Group	9 MC Status Code Group	10 Min Age	11 Max Age	12 Medicare Indicator	13 Gender	14 Special Condition Override	15 Effective Date	16 End Date
A, AP, B, BP, D, DP, F, FP, H, HP, G, GP, J, K, M	ALL	0	999	Yes	Male		01/01/1964	12/31/2399
A, AP, B, BP, D, DP, F, FP, H, HP, G, GP, J, K, M	ALL	0	999	Yes	Female		01/01/1964	12/31/2399

--Program Code/Description-- The program code/description below is for the demographic breakdown selected above.

17 Program Code / Description	18 Effective Date	19 End Date
A / Aged indiv 65 and over who rec SSI	01/01/1964	12/31/2399
AP / Aged indiv 65 and over who rec SSI	01/01/1964	12/31/2399
B / Blind indiv who rec SSI	01/01/1964	12/31/2399
BP / Blind indiv who rec SSI	01/01/1964	12/31/2399
D / Disabled indiv who rec SSI	01/01/1964	12/31/2399
DP / Dis indiv who rec SSI and State Suppl	01/01/1964	12/31/2399
F / Aged indiv 65 and over who lost SSI benefits	01/01/1964	12/31/2399
FP / Aged indiv 65 and over who rec State Suppl	01/01/1964	12/31/2399
G / Blind indiv who lost SSI benefits	01/01/1964	12/31/2399
GP / Blind indiv who rec State Suppl	01/01/1964	12/31/2399

1 2 Next >

--Status Code/Description-- The status code/description below is for the demographic breakdown selected above.

20 Status Code / Description	21 Effective Date	22 End Date
	01/01/1964	12/31/2399
	01/01/1964	12/31/2399
	01/01/1964	12/31/2399
	01/01/1964	12/31/2399
	01/01/1964	12/31/2399
	01/01/1964	12/31/2399
	01/01/1964	12/31/2399
00 / 00	01/01/1964	12/31/2399
01 / 01	01/01/1964	12/31/2399
02 / 02	01/01/1964	12/31/2399

1 2 3 4 Next >

In order to access Capitation Categories/Demographics Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select Other, Capitation Categories/Demographics link.

STEP 4: Capitation Categories/Demographics will be displayed.

4.6.6.5 Extra Features

This panel has no extra features.

4.6.6.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Capitation Category	The capitation category code represents the various groups of demographics for managed care members.	Field	Character	5	T_MC_RATE_CELL	CDE_RATE_CELL
2	Description	Describes the managed care capitation category.	Field	Character	35	T_MC_RATE_CELL	DSC_CAP_CATEGORY
3	Effective Date	This is the date that the capitation category became effective.	Field	Date (MM/DD/CCYY)	8	T_MC_RATE_CELL	DTE_EFFECTIVE
4	End Date	This is the date that the capitation category expired and is no longer effective.	Field	Date (MM/DD/CCYY)	8	T_MC_RATE_CELL	DTE_END

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
5	Pro-Rate	This specifies if the capitation category should be pro-rated on a daily basis, or if it applies to an entire month only. Valid values are "No" and "Yes".	Field	Character	3	T_MC_RATE_CELL	IND_PRORATE
6	Auto-Adjust	This column indicates if the capitation category should be included when the system is determining the total amount paid for a member during a given month. Valid values are "No" and "Yes".	Field	Character	3	T_MC_RATE_CELL	IND_AUTO_ADJ
7	Primary Payment	Indicates if the capitation category is a payment for the member's primary care (the standard monthly payment). Valid values are "No" and "Yes".	Field	Character	3	T_MC_RATE_CELL	IND_PRIME_PYMT
8	MC Program Code Group (demographics)	The program code group for the demographic.	Field	Character	75	T_PUB_HLTH_PGM	DSC_PGM_HEALTH
9	MC Status Code Group (demographics)	The status code group for the demographic.	Field	Character	75	T_PUB_HLTH_PGM	DSC_PGM_HEALTH
10	Min Age (demographics)	The minimum age for the demographic. Format is 999.	Field	Number	3	T_MC_CAP_DEMOGRAPH	MIN_AGE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
11	Max Age (demographics)	The maximum age for the demographic. Format is 999.	Field	Number	3	T_MC_CAP_DEMOGRAPH	MAX_AGE
12	Medicare Indicator (demographics)	This is the indicator for Medicare. Valid values are Y (Yes), N (No), B (Both).	Field	Drop Down List Box	5	T_MC_CAP_DEMOGRAPH	IND_MEDICARE
13	Gender (demographics)	The gender for the demographics.	Field	Character	18	T_MC_CAP_DEMOGRAPH	CDE_SEX
14	Special Condition Override (demographics)	The special condition override for the demographic.	Field	Character	100	T_MC_SPEC_COND	SAK_SPEC_COND
15	Effective Date (demographics)	The effective date for the demographic.	Field	Date (MM/DD/CCYY)	8	T_MC_CAP_DEMOGRAPH	DTE_EFFECTIVE
16	End Date (demographics)	The end date for the demographic.	Field	Date (MM/DD/CCYY)	8	T_MC_CAP_DEMOGRAPH	DTE_END
17	Program Code/ Description (program code)	This is the program code and description that are part of the program code group. Format code/ description.	Field	Character	55	T_MC_AID_GRP	CDE_MC_AID_GRP +DSC_MC_AID_GROUP
18	Effective Date (program code)	This is the effective date for the program code.	Field	Date (MM/DD/CCYY)	8	T_MC_AID_GRP	DTE_EFFECTIVE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
19	End Date (program code)	This is the end date for the program code.	Field	Date (MM/DD/CCYY)	8	T_MC_AID_GRP	DTE_END
20	Status Code Code/Description (Status Code)	This is the status code and description that are part of the status code group. Format code/description.	Field	Character	55	T_MC_PGM_STAT_GRP	CDE_MC_PGM_STAT_GRP+DSC_MC_PGM_S
21	Effective Date (status code)	This is the effective date for the status code.	Field	Date (MM/DD/CCYY)	8	T_MC_PGM_STAT_GRP	DTE_EFFECTIVE
22	End Date (status code)	This is the end date for the status code.	Field	Date (MM/DD/CCYY)	8	T_MC_PGM_STAT_GRP	DTE_END

4.6.6.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.7 PANEL: Xref-MC Region Area Xref

4.6.7.1 Description

The MC Region Area Xref panel serves as a cross-reference between the managed care regions and the areas (specific counties, zip codes, etc.) that comprise them.

Navigation Path: [Managed Care - Related Data] - [Xref] - [MC Region/Area Xref]

Table: T_MC_AREA_RGN_XREF, T_MC_REGION (Region),T_MC_AREA_RGN_XREF (Area)

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

4.6.7.2 Technical Name

MC.McRegionPanel.ascx

4.6.7.3 Panel Name

MC Region/Area Xref

4.6.7.4 Xref-MC Region Area Xref Layout

In order to access MC Region/Area Xref Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select Xref, MC Region/Area Xref link.

STEP 4: MC Region/Area Xref will be displayed.

4.6.7.5 Extra Features

This panel has no extra features.

4.6.7.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MC Region	This is the code that identifies a region (or managed care coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, or the entire state.	Field	Character	5	T_MC_REGION	CDE_MC_REGION
2	Description	This is a description or name of the managed care region.	Field	Character	50	T_MC_REGION	DSC_MC_REGION
3	Region Type	This field defines the type of the region. Values are C=Capitation, E=Enrollment.	Field	Character	10	T_MC_REGION	CDE_REGION_TYPE
4	Ranking	This field specifies how regions rank when they overlap. This is primarily for regions created for capitation rate overrides. See PWB for additional information.	Field	Number	4	T_MC_REGION	NUM_REGION_RANK
5	Area Type (Region)	This is the area for the region.	Field	Character	15	T_MC_AREA_RGN_XREF	CDE_AREA_TYPE
6	Area Code (Region)	This is the area code for the region	Field	Character	5	T_MC_AREA_RGN_XREF	CDE_AREA
7	Effective Date (Region)	Effective date for the region.	Field	Date (MM/DD/CCYY)	8	T_MC_AREA_RGN_XREF	DTE_EFFECTIVE

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
8	End Date (Region)	End date for the region.	Field	Date (MM/DD/CCYY)	8	T_MC_AREA_RGN_XREF	DTE_END

4.6.7.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.8 PANEL: Codes-PMP Focus

4.6.8.1 Description

The PMP Focus panel allows the user to maintain the different focus codes and descriptions that a managed care provider can select. Focuses are implementation-specific, but examples include general practitioner, pediatrician, OB/GYN, and HMO/MCO.

Navigation Path: [Managed Care - Related Data] - [Codes] - [PMP Focus]

Table: T_MC_PMP_FOCUS

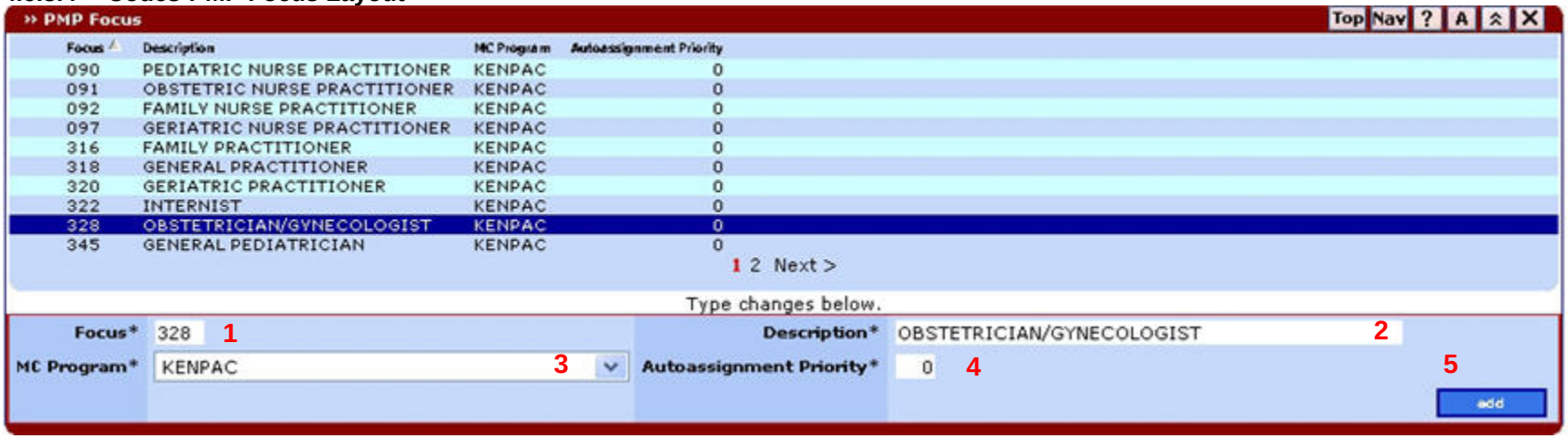
4.6.8.2 Technical Name

MC.McPmpFocusPanel.ascx

4.6.8.3 Panel Name

PMP Focus

4.6.8.4 Codes-PMP Focus Layout



In order to access PMP Focus Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select PMP Focus link.

STEP 4: PMP Focus will be displayed.

4.6.8.5 Extra Features

This panel has no extra features.

4.6.8.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Focus	Unique code that identifies the focus.	Field	Character	3	T_MC_PMP_FOCUS	CDE_PMP_FOCUS
2	Description	Description of the focus.	Field	Character	100	T_MC_PMP_FOCUS	DSC_PMP_FOCUS
3	MC Program	The managed care program for this PMP focus.	Field	Drop Down List Box	0	T_PUB_HLTH_PGM	SAK_PUB_HLTH
4	Autoassignment Priority	This is the MMIS-specific priority order for the focuses to receive and the order that they should be processed (1 = highest priority, 2 = next, and so on. ...). Format is 99.	Field	Number	2	T_MC_PMP_FOCUS	NUM_PRIORITY

4.6.8.7 Button Description

Button No.	Button	Description
5	Add	Add a PMP focus.

4.6.8.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Focus	Field	1	Focus is required.	Enter a code for the focus.
2	Description	Field	1	Description is required.	Enter a description.

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	MC Program	Field	1	A valid MC program is required.	Select an MC program from the drop down list.

4.6.9 PANEL: Codes-PMP Enrollment Reason

4.6.9.1 Description

The PMP Enrollment Reason panel allows the user to maintain the various reason codes/descriptions that a managed care provider may select when disenrolling from a program.

Navigation Path: [Managed Care - Related Data] - [Codes] - [PMP Enrollment Reason]

Table: T_MC_ENROLL_RSN

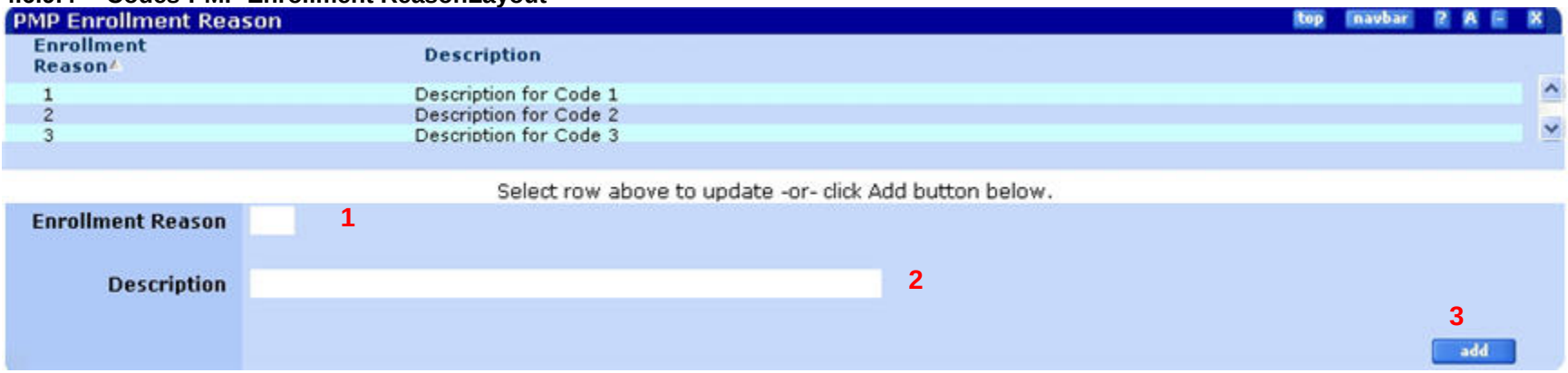
4.6.9.2 Technical Name

MC.McEnrollRsnPanel.ascx

4.6.9.3 Panel Name

PMP Enrollment Reason

4.6.9.4 Codes-PMP Enrollment ReasonLayout



In order to access PMP Enrollment Reason Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select PMP Enrollment Reason link.

STEP 4: PMP Enrollment Reason will be displayed.

4.6.9.5 Extra Features

This panel has no extra features.

4.6.9.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Enrollment Reason	Identifies the enrollment reason.	Field	Character	2	T_MC_ENROLL_RSN	CDE_ENROLL_RSN
2	Description	This is the description of the enrollment reason code.	Field	Character	50	T_MC_ENROLL_RSN	DSC_ENROLL_RSN

4.6.9.7 Button Description

Button No.	Button	Description
3	Add	Add a PMP enrollment reason.

4.6.9.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Enrollment Reason	Field	1	Enrollment Reason is required.	Enter an enrollment reason.
1	Enrollment Reason	Field	2	A duplicate record cannot be saved.	Enter a unique enrollment reason.
2	Description	Field	1	Description is required.	Enter a description.

4.6.10 PANEL: Xref-HIPAA MMIS Language Xref

4.6.10.1 Description

The HIPAA MMIS Language Xref panel serves as a cross-reference of the MMIS language codes/descriptions and the corresponding HIPAA codes/descriptions.

Navigation Path: [Managed Care - Related Data] - [Xref] - [HIPAA/MMIS Language Xref]

Table: T_HIPAA_LANG_XREF

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

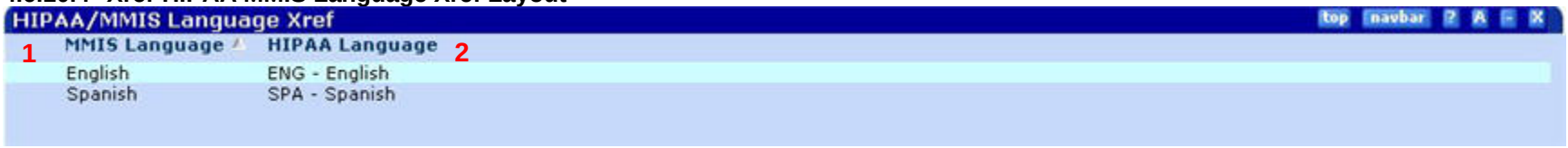
4.6.10.2 Technical Name

MC.HipaaLanguageXrefPanel.ascx

4.6.10.3 Panel Name

HIPAA/MMIS Language Xref

4.6.10.4 Xref-HIPAA MMIS Language Xref Layout



4.6.10.5 Extra Features

This panel has no extra features.

4.6.10.6 Field Descriptions

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MMIS Language	This is MMIS description for a specific language.	Field	Character	12	T_HIPAA_LANG_XREF	CDE_LANG_MMIS

Field No.	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	HIPAA Language	This includes the language codes for HIPAA (three character), " - ", and the HIPAA description for a specific language (50 characters).	Field	Character	55		CDE_LANG_HIPAA + DSC_LANG_HIPAA

4.6.10.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.11 PANEL: Xref-MC Status Group Status Code Xref

4.6.11.1 Description

The MC Status Code Group Status Code Xref panel serves as a cross-reference between the managed care status code groups and the individual status codes that comprise them.

Navigation Path: [Managed Care - Related Data] - [Xref] - [MC Status Code Group/Status Code Xref]

Table: T_MC_PGM_STATUS_GRP, T_MC_PGM_STATUS_GRP_XREF

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

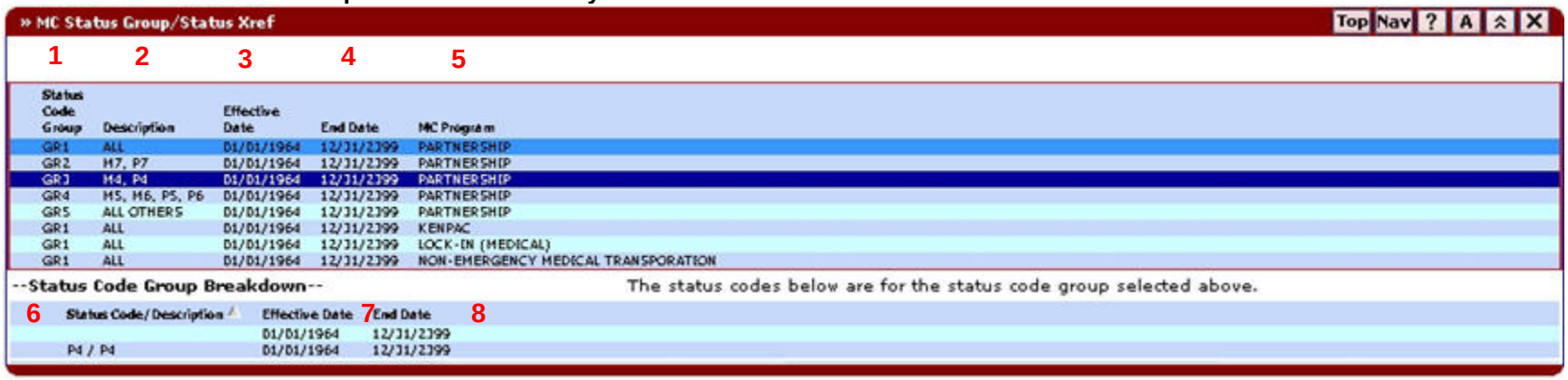
4.6.11.2 Technical Name

MC.McStatusGroupPanel.ascx

4.6.11.3 Panel Name

MC Status Group Status Code Xref

4.6.11.4 Xref-MC Status Group Status Code XrefLayout



In order to access MC Status Group/Status Code Xref Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select Xref, MC Status Group/Status Code Xref link.

STEP 4: MC Status Group/Status Code Xref will be displayed.

4.6.11.5 Extra Features

This panel has no extra features.

4.6.11.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	StatusCode Group	Code of the status code/group.	Field	Character	3	T_MC_PGM_STATUS_GRP	CDE_MC_PGM_STAT_GRP
2	Description	Description of the status code/group.	Field	Character	75	T_MC_PGM_STATUS_GRP	DSC_MC_PGM_STAT_GRP
3	Effective Date (StatusCode Group)	Effective date for the status code.	Field	Date (MM/DD/CCYY)	8	T_MC_PGM_STATUS_GRP_XREF	DTE_EFFECTIVE
4	End Date (StatusCode Group)	End date for the status code.	Field	Date (MM/DD/CCYY)	8	T_MC_PGM_STATUS_GRP_XREF	DTE_END
5	MC Program	This is the identification of the managed care program.	Field	Character	50	T_PUB_HLTH_PGM	DSC_PGM_HEALTH

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	StatusCode/ Description (StatusCode Group)	Identifies the type of status code for which a member is eligible. Format Code (length two), "/", and description (length 50).	Field	Character	53	T_CDE_STAT	CDE_STAT_GRP/ DSC_STAT_GRP
7	Effective Date	The date that the group record becomes effective.	Field	Date (MM/DD/CCYY)	8	T_MC_PGM_STATUS_GRP	DTE_EFFECTIVE
8	End Date	The date that the group record ends.	Field	Date (MM/DD/CCYY)	8	T_MC_PGM_STATUS_GRP	DTE_END

4.6.11.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.12 PANEL: Codes-MMIS KenPAC Autoassign Enroll Criteria

4.6.12.1 Description

The Managed Care MMIS KenPAC Autoassign Enroll Criteria panel allows the user to maintain program code and program status to turn on or off auto-assignment in interChange. Members who have eligibility program code and status codes that match the table entries will be brought into the autoassignment program for assignment to a KenPAC site. This is not used for the other programs of Partnership, Lock-In, and NEMT.

Navigation Path: [Managed Care - Related Data] - [Codes] - [MMIS KenPAC Autoassign Enroll Criteria]

Table: T_MC_ENROLLMENT_XREF

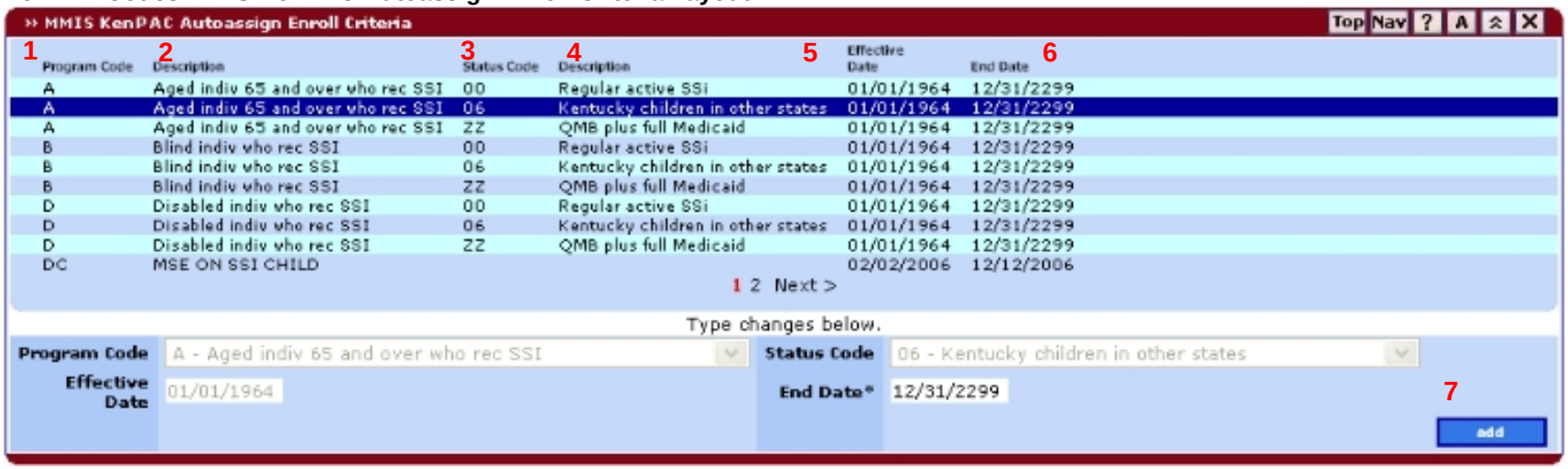
4.6.12.2 Technical Name

MC.MMIS KenPAC Autoassign Enroll Criteria.ascx

4.6.12.3 Panel Name

MMIS KenPAC Autoassign Enroll Criteria

4.6.12.4 Codes-MMIS KenPAC Autoassign Enroll Criteria Layout



In order to access MC MMIS Enrollment Criteria Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select MC MMIS Enrollment Criteria link.

STEP 4: MC MMIS Enrollment Criteria will be displayed.

STEP 5: Use the “add” button to modify the record.

4.6.12.5 Extra Features

This panel has no extra features.

4.6.12.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Program Code	Identifies the type of program code for which a member is eligible to turn on or off auto-assignment. Format code.	Field	Character	2	T_MC_AID_GRP	CDE_MC_AID_GRP
2	Program Code Description	Identifies the type of program code description for which a member is eligible to turn on or off auto-assignment. Format description.	Field	Character	50	T_MC_AID_GRP	DSC_MC_AID_GROUP
3	Status Code	The program status code	Field	Character	2	T_MC_CDE_AID_ENROLL	CDE_PGM_STATUS
4	Status Code Description	Description of the program status code	Field	Character	50	T_RE_PGM_STATUS_CODE	DSC_PGM_STATUS
5	Effective Date	This is the date that the autoassignment became effective.	Field	Date (MM/DD/CCYY)	8	T_MC_ENROLLMENT_XREF	DTE_EFFECTIVE

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
6	End Date	This is the date that the autoassignment expired and is no longer effective.	Field	Date (MM/DD/CCYY)	8	T_MC_ENROLLMENT_XREF	DTE_END

4.6.12.7 Button Descriptions

Button No.	Button	Description
7	Add	Add a standard MMIS enrollment criteria.

4.6.12.8 Field Edits

Field No.	Field	Field Type	Error Code	Error Message	To Correct
1	Program Code	Field	1000	The Program Code/Status Code being added overlaps with another Program Code/Status Code in the list.	Enter data that does not overlap.

4.6.13 PANEL: Codes-MC Special Condition

4.6.13.1 Description

The MC Special Condition panel allows the user to maintain the managed care special condition codes/descriptions. Special conditions are implementation-specific, but examples may include pregnancy, and voluntary managed care enrollment.

Navigation Path: [Managed Care - Related Data] - [Codes] - [MC Special Condition]

Table: T_MC_SPEC_COND

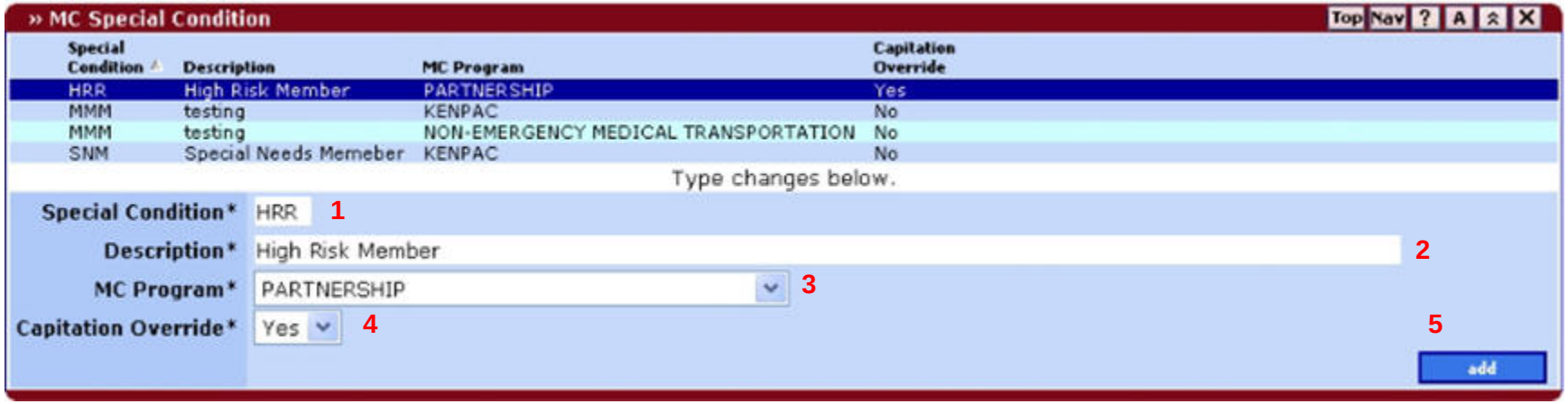
4.6.13.2 Technical Name

MC.McSpecialtyConditionPanel.ascx

4.6.13.3 Panel Name

MC Special Condition

4.6.13.4 Codes-MC Special Condition Layout



In order to access MC Special Condition Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select Related Data" from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select MC Special Condition link.

STEP 4: MC Special Condition will be displayed.

4.6.13.5 Extra Features

This panel has no extra features.

4.6.13.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Special Condition	Code representing the special condition. The special condition can be duplicated with unique SAK key value.	Field	Character	3	T_MC_SPEC_COND	CDE_SPEC_COND
2	Description	Description of the special condition.	Field	Character	100	T_MC_SPEC_COND	DSC_SPEC_COND
3	MC Program	This is the identification of the managed care program.	Field	Drop Down List Box	0	T_PUB_HLTH_PGM	SAK_PUB_HLTH
4	Capitation Override	If the special condition overrides the 'normal' calculation of a member's capitation category using demographics. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_MC_SPEC_COND	IND_CAP_OVERRIDE

4.6.13.7 Button Descriptions

Button No.	Button	Description
5	Add	Add an MC special condition.

4.6.13.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Special Condition	Field	1	Special condition is required.	Enter a special condition.
2	Description	Field	1	Description is required.	Enter a description.

Field No	Field	Field Type	Error Code	Error Message	To Correct
3	MC Program	Field	1	A valid MC program is required.	Select an MC program from the drop down list.

4.6.14 PANEL: Codes-MC Area Type

4.6.14.1 Description

The MC Area Type panel allows the user to view the managed care area type definitions that comprise the regions. Examples of area types include zip, county and state.

Navigation Path: [Managed Care - Related Data] - [Codes] - [MC Area Type]

Table: T_MC_AREA_TYPE

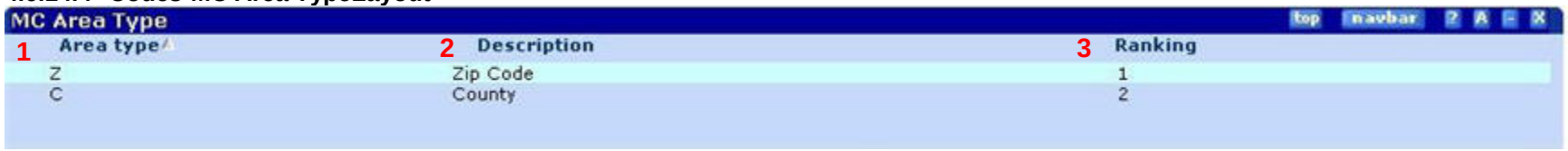
4.6.14.2 Technical Name

MC.McAreaTypePanel.ascx

4.6.14.3 Panel Name

MC Area Type

4.6.14.4 Codes-MC Area TypeLayout



In order to access MC Area Type Panel use the following steps*:*

STEP 1: Select Managed Care panel.

STEP 2: “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select MC Area Type link.

STEP 4: MC Area Type will be displayed.

4.6.14.5 Extra Features

Global_ERL.doc http://uspldssc003.edsdomdssc.dssc.eds.com/UImockupProd/WebProject/htdocs/ERL/Global_ERL.doc

4.6.14.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Area Type	Identifies the type of the MC area	Field	Character	1	T_MC_AREA_TYPE	CDE_AREA_TYPE
2	Description	Identifies the description of the MC area type	Field	Character	15	T_MC_AREA_TYPE	DSC_AREA_TYPE
3	Ranking	Identifies the ranking of the MC area type	Field	Number	4	T_MC_AREA_TYPE	NUM_AREA_RANK

4.6.14.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.15 PANEL: Xref-HIPAA MMIS Race Xref

4.6.15.1 Description

The HIPAA MMIS Race Xref panel serves as a cross-reference of the MMIS race codes/descriptions and the corresponding HIPAA codes/descriptions.

Navigation Path: [Managed Care - Related Data] - [Xref] - [HIPAA/MMIS Race Xref]

Table: T_HIPAA_RACE_XREF

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

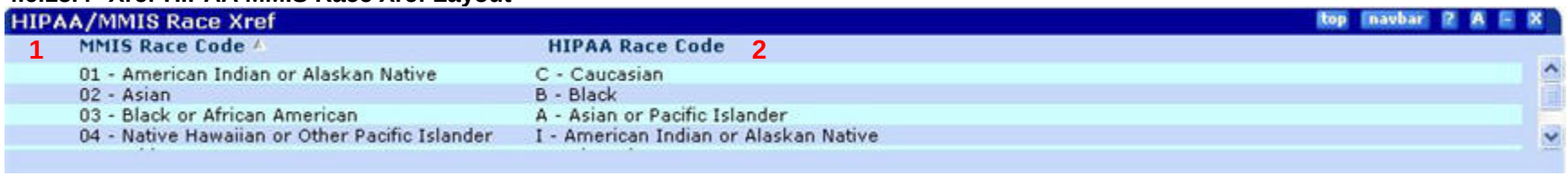
4.6.15.2 Technical Name

MC.HipaaRaceXrefPanel.ascx

4.6.15.3 Panel Name

HIPAA/MMIS Race Xref

4.6.15.4 Xref-HIPAA MMIS Race Xref Layout



4.6.15.5 Extra Features

This panel has no extra features.

4.6.15.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
2	HIPAA Race Code	This is the HIPAA-specific race code (three characters)" - ", and the HIPAA-specific race code description (50 characters).	Field	Character	56		CDE_RACE_HIPAA + DSC_RACE_HIPAA

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MMIS Race Code	This is the MMIS-specific race code (two characters), " - ", and the MMIS-specific race code description(100 characters).	Field	Character	105		CDE_RACE

4.6.15.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.16 PANEL: Xref-MC Program Code Group Program Code Xref

4.6.16.1 Description

The MC Program Code Group Program Code Xref panel serves as a cross-reference between the managed care program code groups and the individual program codes that they are composed of. Aid category will be changing to program code in the title of this panel.

Navigation Path: [Managed Care - Related Data] - [Xref] - [MC Program Code Group/Program Code Xref]

Table: T_MC_AID_GRP, T_MC_AID_GRP_XREF (Program Code)

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

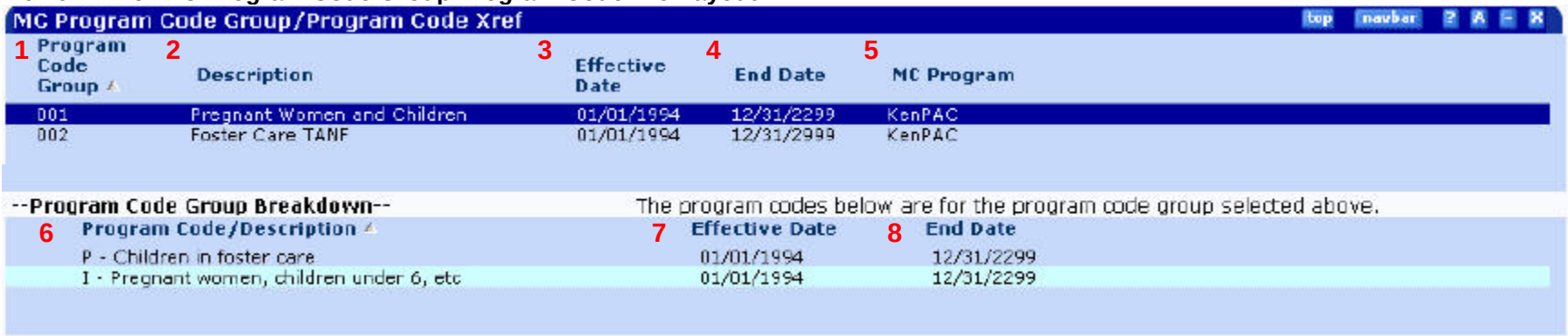
4.6.16.2 Technical Name

MC.McAidGrpXrefPanel.ascx

4.6.16.3 Panel Name

MC Program Code Group Program Code Xref

4.6.16.4 Xref-MC Program Code Group Program Code XrefLayout



In order to access MC Program Code Group/Program Code Xref Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select Member “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select Xref, MC Program Code Group/Program Code Xref link.

STEP 4: MC Program Code Group/Program Code Xref will be displayed.

4.6.16.5 Extra Features

This panel has no extra features.

4.6.16.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Program Code Group	Code of the program code/group.	Field	Character	3		CDE_MC_AID_GRP
2	Description	Description of the program code/group.	Field	Character	75		DSC_MC_AID_GROUP
3	Effective Date	The date that the group record becomes effective.	Field	Date (MM/DD/CCYY)	8		DTE_EFFECTIVE
4	End Date	The date that the group record ends.	Field	Date (MM/DD/CCYY)	8		DTE_END
5	MC Program	This is the identification of the managed care program.	Field	Character	50		DSC_PGM_HEALTH
6	Program Code/Description (Program Code Group)	Identifies the type of program code for which a member is eligible. Format Code (length two), "/", and description (length 50).	Field	Character	53		CDE_AID_CATEGORY/ DSC_AID_CATEGO
7	Effective Date (Program Code Group)	Effective date for the program code.	Field	Date (MM/DD/CCYY)	8		DTE_EFFECTIVE
8	End Date (Program Code Group)	End date for the program code.	Field	Date (MM/DD/CCYY)	8		DTE_END

4.6.16.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.17 PANEL: Related Data

4.6.17.1 Description

The Managed Care Related Data panel is the access point for the Managed Care Codes, Other, and Xref panels.

Navigation Path: [Managed Care - Related Data]

Table: N/A

4.6.17.2 Technical Name

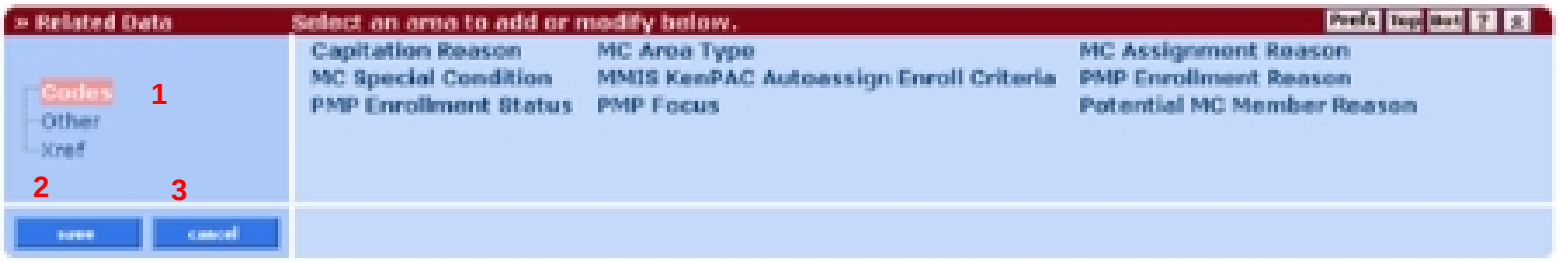
MC.RelatedData.ascx

4.6.17.3 Panel Name

Related Data

For readability the layout displays on the next page.

4.6.17.4 Related DataLayout



In order to access the Related Data Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Related Data will be displayed.

4.6.17.5 Extra Features

This panel has no extra features.

4.6.17.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type
1	Codes	Link for Related Data Codes panels.	Hyperlink	N/A
4	Other	Link for Related Data Other panels.	Hyperlink	N/A
7	Xref	Link for Related Data Xref panels.	Hyperlink	N/A

4.6.17.7 Button Descriptions

Button No.	Button	Description
2	Save	Save changes.
3	Cancel	Cancel changes.
5	Save	Save changes.
6	Cancel	Cancel changes.
8	Save	Save changes.
9	Cancel	Cancel changes.

4.6.17.8 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.18 PANEL: Xref-MC Region Program Xref

4.6.18.1 Description

The MC Region Program Xref panel serves as a cross-reference between the managed care regions and the programs/benefit plans that are valid for them.

Navigation Path: [Managed Care - Related Data] - [Xref] - [MC Region/Program Xref]

Table: T_MC_PGM_RGN_XREF

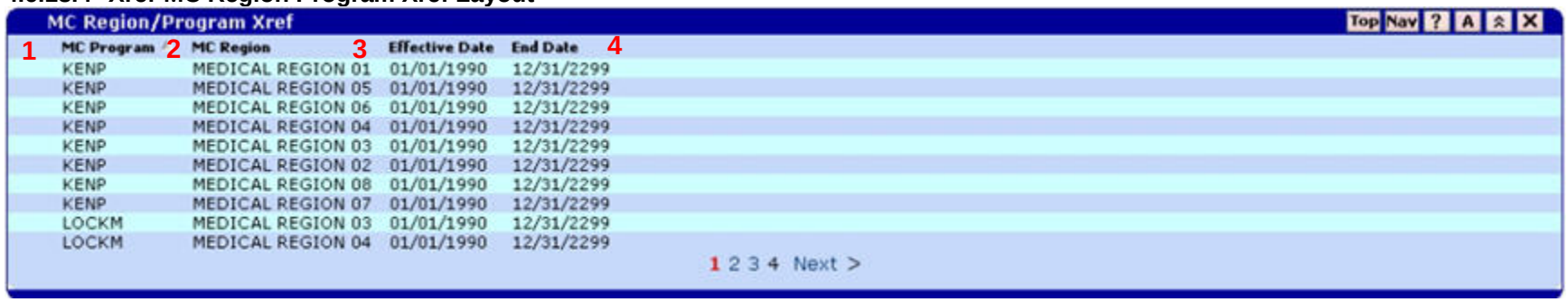
4.6.18.2 Technical Name

MC.McPgmRgnXrefPanel.ascx

4.6.18.3 Panel Name

MC Region/Program Xref

4.6.18.4 Xref-MC Region Program Xref Layout



MC Region/Program Xref

1 MC Program	2 MC Region	3 Effective Date	4 End Date
KENP	MEDICAL REGION 01	01/01/1990	12/31/2299
KENP	MEDICAL REGION 05	01/01/1990	12/31/2299
KENP	MEDICAL REGION 06	01/01/1990	12/31/2299
KENP	MEDICAL REGION 04	01/01/1990	12/31/2299
KENP	MEDICAL REGION 03	01/01/1990	12/31/2299
KENP	MEDICAL REGION 02	01/01/1990	12/31/2299
KENP	MEDICAL REGION 08	01/01/1990	12/31/2299
KENP	MEDICAL REGION 07	01/01/1990	12/31/2299
LOCKM	MEDICAL REGION 03	01/01/1990	12/31/2299
LOCKM	MEDICAL REGION 04	01/01/1990	12/31/2299

1 2 3 4 Next >

In order to access MC Region/Program Xref Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select Xref, MC Region/Program Xref link.

STEP 4: MC Region/Program Xref will be displayed.

4.6.18.5 Extra Features

This panel has no extra features.

4.6.18.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MC Program	Valid managed care program/benefit plan.	Field	Character	5		CDE_PGM_HEALTH
2	MC Region	Contains the regions within the state. Different regions can be created for different managed care programs.	Field	Character	50		DSC_MC_REGION
3	Effective Date	The date that the program/region combination became valid.	Field	Date (MM/DD/CCYY)	8	T_MC_PGM_RGN_XREF	DTE_EFFECTIVE
4	End Date	The date that the program/region combination is no longer valid.	Field	Date (MM/DD/CCYY)	8	T_MC_PGM_RGN_XREF	DTE_END

4.6.18.7 Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

4.6.19 PANEL: Codes-Potential MC Member Reason

4.6.19.1 Description

The Potential MC Member Reason panel allows the user to maintain the reason codes/descriptions of a member who has been added to the table of potential managed care members. This record also controls the number of days that the system will wait before defaulting the member into a PMP assignment. Potential managed care members are all people who come through the Member Data Management interface. Managed care programs use various rules to determine which members are assigned to managed care in the interChange system, and which are not assigned by interChange because KAMES and PA-62 are responsible for their enrollment.

Navigation Path: [Managed Care - Related Data] - [Codes] - [Potential MC Member Reason]

Table: T_RE_MC_REASON

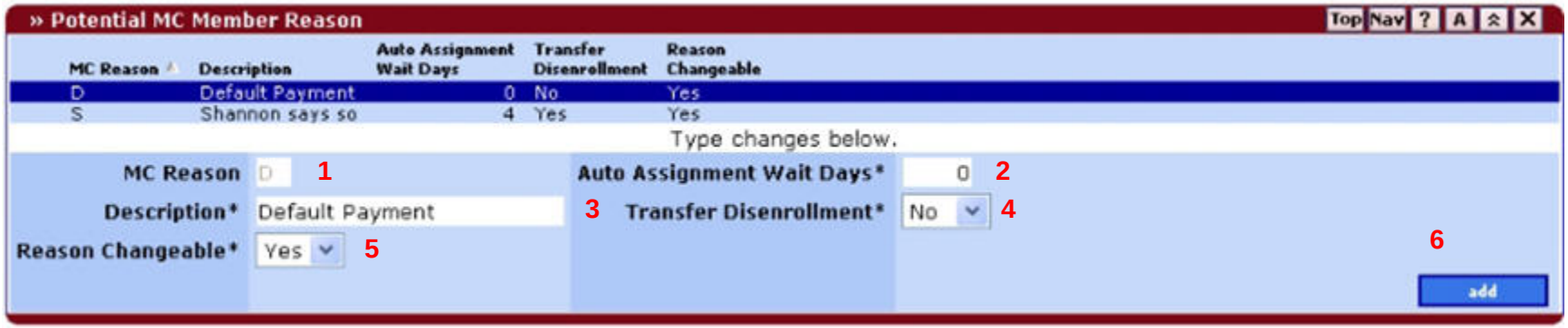
4.6.19.2 Technical Name

MC.ReMcReasonPanel.ascx

4.6.19.3 Panel Name

Potential MC Member Reason

4.6.19.4 Codes-Potential MC Member Reason Layout



In order to access Potential MC Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select Codes link.

STEP 4: Potential MC will be displayed.

4.6.19.5 Extra Features

This panel has no extra features.

4.6.19.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MC Reason	The reason code for potential managed care members used to autoassign or keep members from autoassignment.	Field	Character	1	T_RE_MC_REASON	CDE_REASON_MC
2	Auto Assignment Wait Days	The number of days a particular reason code should wait before members who have it are autoassigned. Format is 999.	Field	Number	3	T_RE_MC_REASON	AA_WAIT_DAYS
3	Description	The description of the managed care reason codes used to indicate when a member will automatically go into autoassignment and when the member will be excluded.	Field	Character	25	T_RE_MC_REASON	DSC_REASON_MC
4	Transfer Disenrollment	This field indicates transfer disenrollments from the disenrollment process. Valid values are "No" and "Yes".	Field	Drop Down List Box	0	T_RE_MC_REASON	IND_TRANSFER
5	Reason Changeable	The reason changeable with Yes or No value. Default value is No.	Field	Drop Down List Box	0		

4.6.19.7 Button Descriptions

Button No.	Button	Description
6	Add	Add a potential MC member reason.

4.6.19.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	MC Reason	Field	1	MC Reason is required.	Enter an MC reason.
1	MC Reason	Field	2	A duplicate record can not be saved.	Enter unique MC reason.
3	Description	Field	1	Description is required.	Enter a description.

4.6.20 PANEL: Xref-HIPAA MMIS Assignment Reason Xref

4.6.20.1 Description

The HIPAA MMIS Assignment Reason Xref panel serves as a cross-reference of the MMIS assignment start/stop reason codes/descriptions and the corresponding HIPAA codes/descriptions.

Navigation Path: [Managed Care - Related Data] - [Xref] - [HIPAA/MMIS Assignment Reason Xref]

Table: T_HIPAA_ASGN_XREF

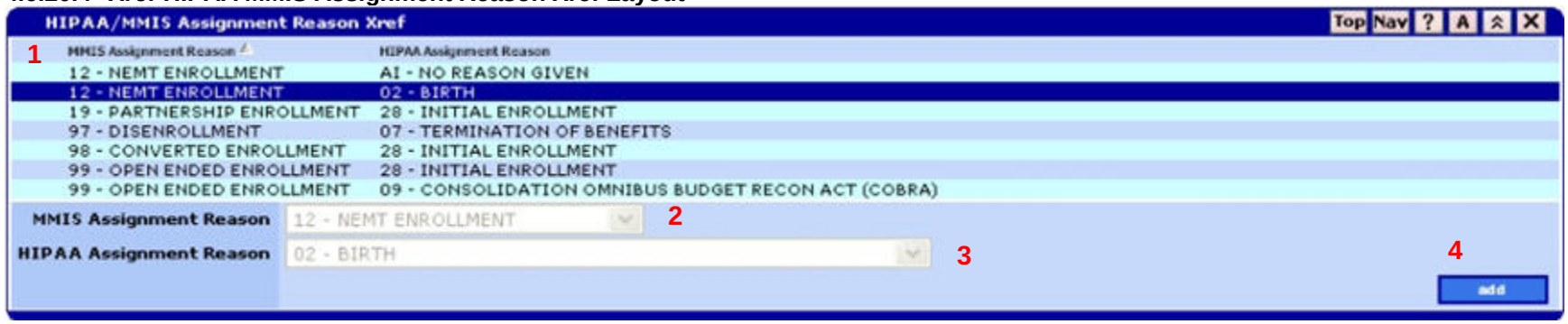
4.6.20.2 Technical Name

MC.HipaaAsgnXrefPanel.ascx

4.6.20.3 Panel Name

HIPAA/MMIS Assignment Reason Xref

4.6.20.4 Xref-HIPAA MMIS Assignment Reason Xref Layout



In order to access HIPAA/MMIS Assignment Reason Xref Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select Xref, HIPAA/MMIS Assignment Reason Xref link.

STEP 4: HIPAA/MMIS Assignment Reason Xref will be displayed.

4.6.20.5 Extra Features

This panel has no extra features. Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	MMIS Assignment Reason/HIPAA Assignment Reason	Add the duplicate HIPAA/MMIS assignment reason values. The "A duplicate record cannot be saved' message will be displayed.	Field	N/A	0	N/A	N/A
2	MMIS Assignment Reason	Contains the PMP assignment reason codes and descriptions used to begin and end a member's assignment to a PMP. Format is code (length two), " - ", and description (length 100).	Field	Drop Down List Box	50		CDE_RSN_MC_ASSIGN + DSC_RSN_MC_A
3	HIPAA Assignment Reason	This displays the managed care eligibility reason codes for HIPAA. Format is code (length two), " - ", and description (length 50).	Field	Drop Down List Box	50		CDE_RSN_HIPAA + DSC_RSN_HIPAA

4.6.20.6 Button Descriptions

Button No.	Button	Description
4	Add	Add a HIPAA/MMIS Assignment Reason Xref.

4.6.20.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	MMIS Assignment Reason	Field	1	A valid MMIS Assignment Reason is required.	Select an MMIS assignment reason from the drop down list.
3	HIPAA Assignment Reason	Field	1	A valid HIPAA Assignment Reason is required.	Select a HIPAA assignment reason from the drop down list.

4.6.21 PANEL: Codes-PMP Enrollment Status

4.6.21.1 Description

The PMP Enrollment Status panel allows the user to maintain the statuses that a managed care provider may have during the course of their enrollment.

Navigation Path: [Managed Care - Related Data] - [Codes] - [PMP Enrollment Status]

Table: T_MC_ENROLL_STATUS

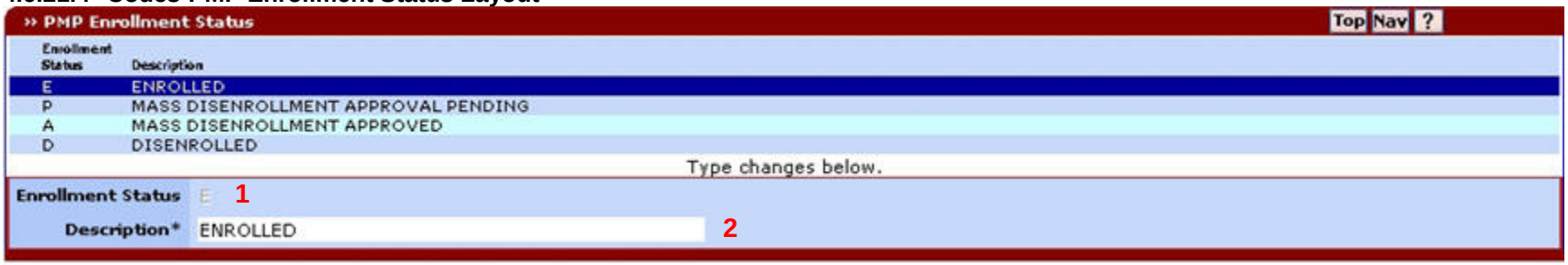
4.6.21.2 Technical Name

MC.McEnrollStatusPanel.ascx

4.6.21.3 Panel Name

PMP Enrollment Status

4.6.21.4 Codes-PMP Enrollment Status Layout



In order to access PMP Enrollment Status Panel use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select PMP Enrollment Status link.

STEP 4: PMP Enrollment Status will be displayed.

4.6.21.5 Extra Features

This panel has no extra features.

4.6.21.6 Field Descriptions

Field No	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Enrollment Status	This is the enrollment status code. It is read only.	Field	Character	1	T_MC_ENROLL_STATUS	CDE_ENROLL_STATUS
2	Description	This is the description of the enrollment status code.	Field	Character	50	T_MC_ENROLL_STATUS	DSC_ENROLL_STATUS

4.6.21.7 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
2	Description	Field	1	Description is required.	Enter a description.

4.6.22 PANEL: Codes-MC Assignment Reason

4.6.22.1 Description

The MC Assignment Reason panel allows the user to maintain the start and stop reason codes/descriptions for managed care assignments.

Navigation Path: [Managed Care - Related Data] - [Codes] - [MC Assignment Reason]

Table: T_RE_PMP_REASON

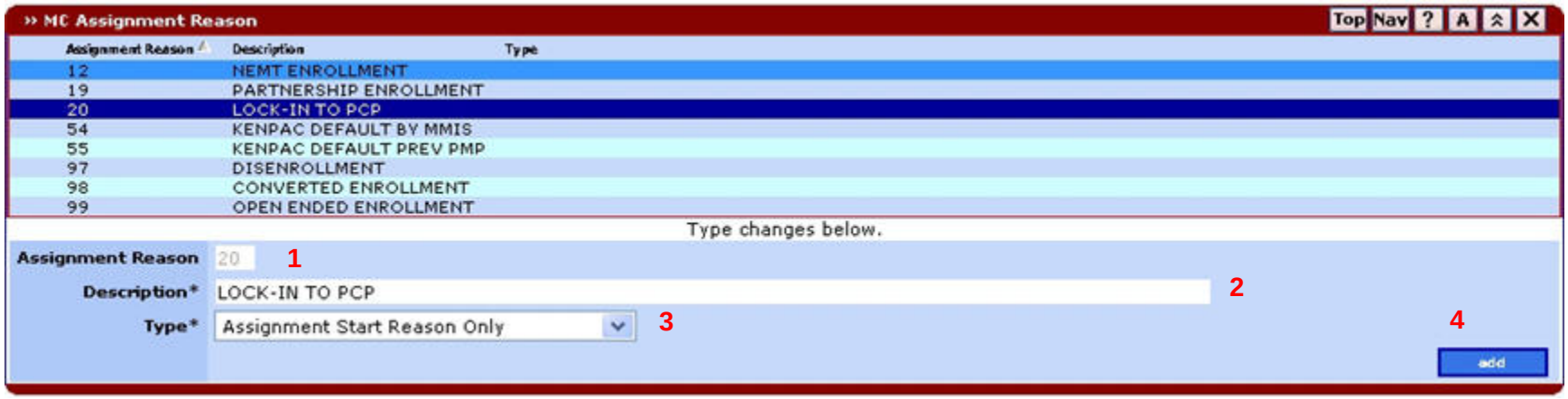
4.6.22.2 Technical Name

MC.RePmpReasonPanel.ascx

4.6.22.3 Panel Name

MC Assignment Reason

4.6.22.4 Codes-MC Assignment Reason Layout



In order to access MC Assignment Reason Panel, use the following steps:

STEP 1: Select Managed Care panel.

STEP 2: Select “Related Data” from the Managed Care menu.

STEP 3: Navigating to the Related Data panel, select MC Assignment Reason link.

STEP 4: MC Assignment Reason will be displayed.

4.6.22.5 Extra Features

This panel has no extra features.

4.6.22.6 Field Descriptions

	Field	Description	Field Type	Data Type	Length	DB Table	DB Attributes
1	Assignment Reason	This indicates the reason a member was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a member's relationship with a PMP was terminated; for example, death or an approved change.	Field	Character	2	T_RE_PMP_REASON	CDE_RSN_MC_ASSIGN
2	Description	The description of the reason a member was assigned to a PMP, or the member's reason for disenrollment from a PMP.	Field	Character	100	T_RE_PMP_REASON	DSC_RSN_MC_ASSIGN
3	Type	This indicates if a reason code may be used as only a start reason, as only a stop reason, or both a start and stop reason. Valid values are "Assignment Start Reason Only", "Assignment Stop Reason Only", and "Utilized for both Start and Stop Reasons".	Field	Drop Down List Box	0	T_RE_PMP_REASON	CDE_RSN_PMP_ASSIGN

4.6.22.7 Button Descriptions

Button No.	Button	Description
4	Add	Add an MC Assignment Reason.

4.6.22.8 Field Edits

Field No	Field	Field Type	Error Code	Error Message	To Correct
1	Assignment Reason	Field	1	Assignment reason is required.	Enter an assignment reason.
2	Description	Field	1	Description is required.	Enter a description.
3	Type	Field	1	Type is required.	Select a type from the drop down list.

5 Reports

This manual contains a sample page for each report for this system with a short description. The last character of the report name indicates the frequency of the report.

A = ANNUAL

D = DAILY

M = MONTHLY

Q = QUARTERLY

R = ON REQUEST

W = WEEKLY

O = ON REQUEST

The following section provides a description and sample layout for each Report associated to the Managed Care subsystem.

Some information in this section is represented in table format. In order to fit information on the page, some data field information may wrap to the next line.

Purpose of Managed Care Reports

The purpose of all Managed Care reports is to provide material for analysis when assessing the impact of the program and needs that should be addressed.

5.1.1 MGD-0008-M -- Primary Medical Providers

This report lists all primary care providers sorted by Member ID, Group ID, PMP ID, and Program.

5.1.1.1 Technical Name

MGD-0008-M

5.1.1.2 Sort Order

Member ID, Group ID, PMP ID, and Program

5.1.1.3 Primary Medical Providers Layout

```
Report  : MGD-0008-M                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/YY/CCYY
Process : MGDJM430                 MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   99:99:99
Location: MGD0008M                        Primary Medical Providers                                   Page:        999

Member ID    Member Name            Group ID                                          PMP ID      Site                 Program
                                    Group Name                                        PMP Name

xxxxxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
                                    xxxxxxxxxx                                        xxxxxxxxxx  xxxx                 xxxxx
                                    xxxxxxxxxxxxxxxxxxxx
```

5.1.1.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Group ID	ID number + service location of group provider	10	Character	T_PR_PROV	ID_PROVIDER
Group Name	Name of group provider	50	Character	T_PR_NAM	NAME
Member ID	Provider ID	10	Character	T_PR_PROV	ID_PROVIDER
Member Name	Name of member provider	50	Character	T_PR_NAM	NAME
PMP ID	Provider ID	10	Character	T_PR_PROV	ID_PROVIDER
PMP Name	Name of PMP	50	Character	T_PR_NAM	NAME
Program	Managed care program (MCO, PCCM, or NEMT)	5	Character	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
Site	The KenPAC site number, only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER

5.1.1.5 Associated Programs

Program	Description
srgjqfsz.sh	srgjqfsz
otsortd	Sort - UNIX
waapsplt.c	waapsplt
mgd0008m	Managed Care Primary Medical Providers
copy2routedir	Copy Reports to Router

5.1.2 MGD-0065-M -- Member Breakdown by Capitation Category

This report lists the breakdown of enrolled members for each PMP with the number of enrollees in each capitation category.

5.1.2.1 Technical Name

MGD-0065-M

5.1.2.2 Sort Order

Member ID, Capitation Date

5.1.2.3 Member Breakdown by Capitation Category Layout

```
Report  : MGD-0065-M                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJM460                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   99:99:99
Location: MGD0150M                 Member Breakdown by Capitation Category                    Page:        999
                                          Effective Date: MM/DD/CCYY


PMP ID: XXXXXXXXXX   Site: XXXX
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                              Capitation Worksheet

Capitation   Caption Category Desc                Continuing      New            Terminated      Total Current
Category                                         Enrollees       Enrollees      Enrollees       Enrollees
Code

XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999
XXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999          999999         999999          999999

Totals                                            999999999       999999999      999999999       999999999


                                              End Of Report
```

5.1.2.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address 1	First part of PMP street address	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address 2	Second part of PMP street address	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Capitation Category Code	Member's capitation payment classification	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL
Capitation Category Description	Member's capitation category description	35	Character	T_MC_RATE_CELL	DSC_CAP_CATEGORY
City, State, Zip	PMP city, state and zip plus 4	30	Character	T_PR_ADR	ADR_MAIL_CITY, STATE, ZIP, ZIP_4
Continuing Enrollees	Total - Continuing enrollees	6	Number	N/A	CALCULATED
Effective Date	Date report was run	10	Date (MM/DD/CCYY)	N/A	CALCULATED
New Enrollees	Total - New enrollees	6	Number	N/A	CALCULATED
PMP ID	PMP ID number	10	Character	T_PR_PROV	ID_PROVIDER
PMP Name	Name of PMP	30	Character	T_PR_NAM	NAME
Site	The KenPAC site number, only for KenPAC providers, blank for other managed care providers.	5	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER

Field	Description	Length	Data Type	DB Table	DB Attributes
Terminated Enrollees	Total - Terminated enrollees (members whose eligibility has ended; thus the PMP is no longer responsible for them)	6	Number	N/A	CALCULATED
Total Current Enrollees	Total - Current enrollees	6	Number	N/A	CALCULATED
Totals	Total - Total (accumulated totals of each)	9	Number	N/A	CALCULATED

5.1.2.5 Associated Programs

Program	Description
otsortd	Sort - UNIX
mgd0150m	Member Breakdown By Capitation Category
mgd0150m	Member Breakdown By Capitation Category

5.1.3 MGD-0110-M -- Managed Care Enrollment Numbers

This report includes monthly enrollment subtotals by managed care program for the current contract year. In addition, grand totals are reported for managed care MCO, managed care PCCM, and NEMT.

5.1.3.1 Technical Name

MGD-0110-M

5.1.3.2 Sort Order

Managed Care Area

For readability, this layout appears on the following two pages.

5.1.3.3 Managed Care Enrollment Numbers Layout

```
Report  : MGD-0110-M                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/YY/CCYY
Process : MGDJM910                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   99:99:99
Location: MGD0110M                     Managed Care Enrollment Numbers                        Page:        999

                          MMM-YY   MMM-YY   MMM-YY   MMM-YY   MMM-YY   MMM-YY   MMM-YY   MMM-YY   MMM-YY   MMM-YY   MMM-YY   MMM-YY
CENTRAL

XXXXXXXXXXXXXXXXXXXX
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXXXXXXXXXXXXXXXXXXX
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
AREA TOTAL
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

NORTHEASTERN

XXXXXXXXXXXXXXXXXXXX
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXXXXXXXXXXXXXXXXXXX
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
AREA TOTAL
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

SOUTHWESTERN

XXXXXXXXXXXXXXXXXXXX
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
XXXXXXXXXXXXXXXXXXXX
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999
AREA TOTAL
                          9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999    9,999

Managed Care MCO
Total                    99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999
```

```
Managed Care PMP

URBAN

Northeastern
                    99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

Central
                    99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

Southweatern
                    99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

URBAN TOTAL
                    99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

RURAL
                    99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

INVALID ZIP/COUNTY
                    99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

PMP Total
                    99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999


Managed Care
Total               99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

Non Emergency Medical Transportation
Total               99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999   99,999

                                    End Of Report
```

5.1.3.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Area Total	Managed care MCO grand totals by month and by state region	8	Number	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
INVALID ZIP/COUNTY	Denotes bad data for PMP or managed care MCO	20	Character	N/A	CALCULATED
MCO Name	Denotes the name of the MCO	15	Character	N/A	CALCULATED
Managed Care ASO Total	Managed care MCO grand total by month	8	Number	N/A	CALCULATED
Managed Care MCO Total	Managed care MCO grand totals by month	8	Number	N/A	CALCULATED
Managed Care PMP Total	Managed care PMP grand totals by month	8	Number	N/A	CALCULATED
Managed Care Total	Managed care grand total for by month	8	Number	N/A	CALCULATED
Month/Year	Managed care MCO/managed care PMP totals by month	6	Character	N/A	CALCULATED
NEMT Total	NET grand total by month	8	Number	N/A	CALCULATED
RURAL	Denotes RURAL region for PMP or managed care MCO	20	Character	N/A	CALCULATED
Region Name	Denotes the name of the Commonwealth region	20	Character	N/A	CALCULATED
URBAN	Denotes urban region for PMP or managed care MCO	20	Character	N/A	CALCULATED
URBAN TOTAL	Managed care PMP or managed care MCO urban region total	20	Number	N/A	CALCULATED

5.1.3.5 Associated Programs

Program	Description
mgd0110m	Managed Care Enrollment Numbers

5.1.4 MGD-0400-D -- PRO-Online Waiver Managed Care Overlap Report

This report displays members with online waiver with managed care overlap.

5.1.4.1 Technical Name

MGD-0400-D

5.1.4.2 Sort Order

Member ID

5.1.4.3 PRO-Online Waiver Managed Care Overlap Report Layout

```
Report  : MGD-0400-D                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : MGDJD600                  MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time: 99:99:99
Location: MGD0400D                PRO-ONLINE WAIVER/MANAGED CARE OVERLAP REPORT                       Page: 9999

MEMBER      LAST     FIRST    WAIVER     WVR BEG   WVR END     TXN        PMP      SITE   MC BEG    MC END     TXN
  ID        NAME     NAME   INDICATOR     DATE      DATE      DATE        ID               DATE      DATE      DATE
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY
999999999   XXX      XXXXXX      X       MMDDCCYY  MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX  MMDDCCYY  MMDDCCYY  MMDDCCYY

                                   ***   END OF REPORT   ***

                                  ***   NO DATA THIS RUN   ***
```

5.1.4.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
FIRST NAME	The member's first name	6	Character	T_RE_BASE	NAM_FIRST
LAST NAME	The member's last name	3	Character	T_RE_BASE	NAM_LAST

Field	Description	Length	Data Type	DB Table	DB Attributes
MC BEG DATE	Member enrollment effective date.	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
MC END DATE	Member enrollment end date.	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_END
MEMBER ID	The member's Medicaid ID.	10	Character	T_RE_BASE	ID_MEDICAID
PMP ID	The ID number of the PMP.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
SITE	The KenPAC site number, only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
TXN DATE	Last waiver transaction update date.	10	Date (MMDDCCYY)	T_RE_ASSIGN_PLAN	DTE_LAST_CHANGE
TXN DATE	Last managed care transaction update date.	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_CHANGED
WAIVER INDICATOR	Indicates that the member has waiver coverage.	1	Character	N/A	N/A
WVR BEG DATE	Waiver effective date.	10	Date (MMDDCCYY)	T_RE_ASSIGN_PLAN	DTE_EFFECTIVE
WVR END DATE	Waiver end date.	10	Date (MMDDCCYY)	T_RE_ASSIGN_PLAN	DTE_END

5.1.4.5 Associated Programs

Program	Description
mgd0400d	PRO-Online Waiver Managed Care Overlap Program

5.1.5 MGD-0410-D -- Managed Care LTC Overlap Report

The MGD-0410 report displays members enrolled in managed care with LTC overlap.

5.1.5.1 Technical Name

MGD-0410-D

5.1.5.2 Sort Order

Member ID

5.1.5.3 Managed Care LTC Overlap Report Layout

```
Report  : MGD-0410-D                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : MGDJD600                 MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: 99:99:99
Location: MGD0410D                     MANAGED CARE / LTC OVERLAP                                     Page: 9999

                                                        --- KAMES TXN ---  ------------- MMIS DATABASE TABLES -----------
TRANSACTION COUNTY   MEMBER   LAST        FIRST     PROGRAM   MC BEG   MC END   LTC BEG  LTC END    MC BEG   MC END    TXN
   DATE      CODE      ID     NAME        NAME       CODE      DATE     DATE      DATE     DATE      DATE     DATE     DATE
 MM/DD/CCYY  XXX   9999999999 XXXXX      XXXXXXXX   XXXXX   MMDDCCYY MMDDCCYY  MMDDCCYY MMDDCCYY  MMDDCCYY MMDDCCYY MMDDCCYY

                                   ***   END OF REPORT   ***

                                  ***   NO DATA THIS RUN   ***
```

5.1.5.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
COUNTY CODE	County code	3	Character	T_RE_BASE	CDE_COUNTY
FIRST NAME	The member's first name	8	Character	T_RE_BASE	NAM_FIRST
LAST NAME	The member's last name	5	Character	T_RE_BASE	NAM_LAST
LTC BEG DATE	Long term care effective date in interChange.	10	Date (MMDDCCYY)	T_RE_ASSIGN_PLAN	DTE_EFFECTIVE
LTC END DATE	Long term care end date in interChange.	10	Date (MMDDCCYY)	T_RE_ASSIGN_PLAN	DTE_END

Field	Description	Length	Data Type	DB Table	DB Attributes
MC BEG DATE	This is member's enrollment effective date passed in the KAMES file.	10	Date (MMDDCCYY)	T_RE_PS2_LOG	DSC_COMPLETE_TXN
MC BEG DATE	This is member's enrollment effective date in interChange.	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
MC END DATE	This is member's enrollment end date in interChange.	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_END
MC END DATE	This is member's enrollment end date passed in the KAMES file.	10	Date (MMDDCCYY)	T_RE_PS2_LOG	DSC_COMPLETE_TXN
MEMBER ID	The member's Medicaid ID	10	Character	T_RE_BASE	ID_MEDICAID
PROGRAM CODE	Program code under which member is listed	5	Character	T_PUB_HLTH_PGM	CDE_PGM_HEALTH
TRANSACTION DATE	Date the transaction occurred.	10	Date (MMDDCCYY)	N/A	CALCULATED
TXN DATE	Last managed care transaction update date	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_CHANGED

5.1.5.5 Associated Programs

Program	Description
mgd0410d	Managed Care LTC Overlap Program

5.1.6 MGD-0420-D -- Managed Care Waiver Overlap Report

This report displays managed care members with waiver overlap.

5.1.6.1 Technical Name

MGD-0420-D

5.1.6.2 Sort Order

Member ID

5.1.6.3 Managed Care Waiver Overlap Report Layout

```
Report  : MGD-0420-D                    COMMONWEALTH OF KENTUCKY                                    Run Date: MM/DD/CCYY
Process : MGDJD600                  MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time: 99:99:99
Location: MGD0420D                  MANAGED CARE / WAIVER OVERLAP                                       Page: 9999

                                                        --- KAMES TXN ---  ------------- MMIS DATABASE TABLES -----------

TRANSACTION COUNTY   MEMBER  LAST          FIRST     PROGRAM   MC BEG   MC END   WVR BEG  WVR END    MC BEG   MC END    TXN
   DATE      CODE      ID    NAME          NAME       CODE      DATE     DATE      DATE     DATE      DATE     DATE     DATE
 MM/DD/CCYY  XXX   999999999 XXXXX        XXXXXXXX     X   MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY

                                      ***   END OF REPORT   ***

                                     ***   NO DATA THIS RUN   ***
```

5.1.6.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
COUNTY CODE	County code	3	Character	T_RE_BASE	CDE_COUNTY
FIRST NAME	The member's first name	8	Character	T_RE_BASE	NAM_FIRST
LAST NAME	The member's last name	5	Character	T_RE_BASE	NAM_LAST
MC BEG DATE	This is member's enrollment effective date in interChange.	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE

Field	Description	Length	Data Type	DB Table	DB Attributes
MC BEG DATE	This is member's enrollment effective date passed in the KAMES file.	10	Date (MM/DD/CCYY)	N/A	N/A
MC END DATE	This is member's enrollment end date passed in the KAMES file.	10	Date (MM/DD/CCYY)	N/A	N/A
MC END DATE	This is member's enrollment end date in interChange	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_END
MEMBER ID	The member's Medicaid ID	12	Character	T_RE_BASE	ID_MEDICAID
PROGRAM CODE	Program code under which member is listed	1	Character	T_PUB_HLTH_PGM	DSC_PGM_HEALTH
TRANSACTION DATE	Date the transaction was made	10	Date (MM/DD/CCYY)	N/A	CALCULATED
TXN DATE	Last managed care transaction update date	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_CHANGED
WVR BEG DATE	Waiver effective date	10	Date (MM/DD/CCYY)	N/A	N/A
WVR END DATE	Waiver end date	10	Date (MM/DD/CCYY)	N/A	N/A

5.1.6.5 Associated Programs

Program	Description
mgd0420d	Managed Care Waiver Overlap Program

5.1.7 MGD-0430-D -- KAMES LTC Managed Care Overlap Report

This report displays KAMES LTC with managed care overlap.

5.1.7.1 Technical Name

MGD-0430-D

5.1.7.2 Sort Order

Member ID

5.1.7.3 KAMES LTC Managed Care Overlap Report Layout

```
Report   : MGD-0430-D                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process  : MGDJD600                  MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time: 99:99:99
Location: MGD0430D                      KAMES LTC / MANAGED CARE OVERLAP                              Page: 9999

                                                 -------- KAMES TXN --------       ---- MMIS DATABASE TABLES ----
TRANSACTION     MEMBER    LAST    FIRST   STATUS   ADMIT    DISCHARGE    PMP      SITE    MC BEG    MC END    TXN
   DATE           ID      NAME    NAME     CODE    DATE       DATE        ID               DATE      DATE     DATE

MM/DD/CCYY  XXXXXXXXXXXX XXXXXX   XXXX      XX    MMDDCCYY  MMDDCCYY  XXXXXXXXXX  XXXX   MMDDCCYY  MMDDCCYY  MMDDCCYY

                                                  ***   END OF REPORT   ***

                                                 ***   NO DATA THIS RUN   ***
```

5.1.7.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ADMIT DATE	The date member is admitted	10	Date (MMDDCCYY)	T_RE_LOC_DATES	DTE_ADMIT
DISCHARGE DATE	The date member is discharged	10	Date (MMDDCCYY)	T_RE_LOC_DATES	DTE_TERM
FIRST NAME	The member's first name	4	Character	T_RE_BASE	NAM_FIRST
LAST NAME	The member's last name	6	Character	T_RE_BASE	NAM_LAST
MC BEG DATE	This is the member enrollment effective date	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE

Field	Description	Length	Data Type	DB Table	DB Attributes
MC END DATE	This is the member enrollment end date.	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_END
MEMBER ID	The member's Medicaid ID	12	Character	T_RE_BASE	ID_MEDICAID
PMP ID	The ID number of PMP + PMP's service location	10	Character	T_PR_PROV	ID_PROVIDER
SITE	The KenPAC site number; only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
STATUS CODE	The program status code	2	Character	T_RE_AID_ELIG	CDE_PGM_STATUS
TRANSACTION DATE	Date the transaction is made	10	Date (MM/DD/CCYY)	N/A	CALCULATED
TXN DATE	Last managed care transaction update date	10	Date (MMDDCCYY)	T_RE_PMP_ASSIGN	DTE_CHANGED

5.1.7.5 Associated Programs

Program	Description
mgd0430d	KAMES LTC Managed Care Overlap Program

5.1.8 MGD-0550-M -- KenPAC Enrollment Errors Report

This monthly report lists any KenPAC member that has an enrollment error. This report is produced after the KenPAC 1st issuance file is received.

5.1.8.1 Technical Name

MGD-0550-M

5.1.8.1 Sort Order

Case SAK

5.1.8.2 KenPAC Enrollment Errors Report Layout

```
Report  : MGD-0550-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : MGDJM655                MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   99:99:99
Location: MGDKENUP                         KENPAC ENROLLMENT ERRORS                 Page:          999


                                     PROVIDER    SITE  DATE      DATE
MEMBER ID  MEMBER NAME                 ID        CODE  EFFECTIVE END      ERROR REASON

XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                End Of Report
```

5.1.8.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Date Effective	Effective date	8	Number	T_PMP_SVC_LOC	DTE_EFFECTIVE
Date End	End date	8	Number	T_PMP_SVC_LOC	DTE_END

Field	Description	Length	Data Type	DB Table	DB Attributes
Error Reason	Enrollment error reason. The error reason is obtained from the mgd_ken_enrl_updt program	50	Character	N/A	N/A
Member ID	Member's Medicaid ID	10	Character	T_RE_BASE	ID_MEDICAID
Member Name	Member's Name	36	Character	T_RE_BASE	NAM_LAST+NAM_FIRST +NAM_MID_INIT
Provider ID	Provider's ID	10	Character	T_PR_PROV	ID_PROVIDER
Site Number	KenPAC site code	4	Character	T_PMP_SVC_LOC _STATE	NUM_SITE

5.1.8.4 Associated Programs

Program	Description
No associated Programs found.	

5.1.9 MGD-0551-M -- KenPAC Enrollment Errors Report-2

This monthly report lists any KenPAC member that has an enrollment error. This report is produced after the KenPAC 2nd issuance file is received.

5.1.9.1 Technical Name

MGD-0551-M

5.1.9.2 Sort Order

Case SAK

5.1.9.3 KenPAC Enrollment Errors Report-2 Layout

```
Report  : MGD-0551-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : MGDJM660                MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   99:99:99
Location: MGDKENUP                       KENPAC ENROLLMENT ERRORS                   Page:          999


                                     PROVIDER    SITE  DATE      DATE
MEMBER ID  MEMBER NAME                 ID        CODE  EFFECTIVE END      ERROR REASON

XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXX    XXXX  CCYYMMDD  CCYYMMDD XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                   End Of Report
```

5.1.9.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Date Effective	Effective date	8	Number	T_PMP_SVC_LOC	DTE_EFFECTIVE

Field	Description	Length	Data Type	DB Table	DB Attributes
Date End	End date	8	Number	T_PMP_SVC_LOC	DTE_END
Error Reason	The Error Reason	50	Character		
Member ID	Member's Medicaid ID	10	Character	T_RE_BASE	ID_MEDICAID
Member Name	Member's Name	36	Character	T_RE_BASE	NAM_LAST+NAM_FIRST+NAM_MID_INIT
Provider ID	Provider's ID	10	Character	T_PR_PROV	ID_PROVIDER
Site Number	KenPAC site code	4	Character	T_PMP_SVC_LOC_STATE	NUM_SITE

5.1.9.5 Associated Programs

Program	Description
No associated Programs found.	

5.1.10 MGD-0555-D -- Partnership Enrollment Errors

Partnership Enrollment Errors Report. This report is produced daily.

5.1.10.1 Technical Name

MGD-0555-D

5.1.10.2 Sort Order

Member ID

For readability, the report displays on the next page.

5.1.10.3 Partnership Enrollment Errors Layout

```
Report  : MGD-0555-D                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : MGDJM670                MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time: 99:99:99
Location: MGDPARTN                 Partnership Enrollment Errors Report             Page: 9999

                                                        DATE       DATE
MEMBER ID      MEMBER NAME                     REGION   EFFECTIVE  END      ERROR REASON

XXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXX      CCYYMMDD   CCYYMMDD XXXXXXXXXXXXXXXXXXXX
```

Field	Description	Length	Data Type	DB Table	DB Attributes
Date End	Date End	0	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_END
Error Reason	Error Reason	40	Character	None	none
MEDICAID_ID	Member ID	20	Character	T_RE_HIST_LOG	ID_MEDICAID
Member Name	Member Name	500	Character	T_RE_HIST_LOG	DSC_COMPLETE_TXN
Region	region	2	Character	T_MC_PMPENRL_RGN	CDE_MC_REGION

5.1.10.5 Associated Programs

Program	Description
No associated Programs found.	

5.1.11 MGD-0560-M -- Member Managed Care Segment Closures

This report displays member managed care segment closures.

5.1.11.1 Technical Name

MGD-0560-M

5.1.11.2 Sort Order

Member ID

5.1.11.3 Member Managed Care Segment Closures Layout

```
Report  : MGD-0560-M                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : MGDJM640                  MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time: 99:99:99
Location: MGD0560M                   MEMBER MANAGED CARE SEGMENT CLOSURES                             Page: 9999

        -------------------------MEMBER ELIGIBILITY DATA-------------------------        -------MANCARE SEGMENTS CLOSED-------
MEMBER ID    LASTNAME      FIRSTNAME  CASE NO.     ELIG BEG    ELIG END    ST PROG CNTY    PMP ID     HMO BEG     HMO END
9999999999   XXXXXXXXXX    XXXXXXX    9999999999   MM/DD/CCYY  MM/DD/CCYY  XX  XX  XXX   9999999999  MM/DD/CCYY  MM/DD/CCYY
9999999999   XXXXXXXXXX    XXXXXXX    9999999999   MM/DD/CCYY  MM/DD/CCYY  XX  XX  XXX   9999999999  MM/DD/CCYY  MM/DD/CCYY
9999999999   XXXXXXXXXX    XXXXXXX    9999999999   MM/DD/CCYY  MM/DD/CCYY  XX  XX  XXX   9999999999  MM/DD/CCYY  MM/DD/CCYY
9999999999   XXXXXXXXXX    XXXXXXX    9999999999   MM/DD/CCYY  MM/DD/CCYY  XX  XX  XXX   9999999999  MM/DD/CCYY  MM/DD/CCYY
9999999999   XXXXXXXXXX    XXXXXXX    9999999999   MM/DD/CCYY  MM/DD/CCYY  XX  XX  XXX   9999999999  MM/DD/CCYY  MM/DD/CCYY
9999999999   XXXXXXXXXX    XXXXXXX    9999999999   MM/DD/CCYY  MM/DD/CCYY  XX  XX  XXX   9999999999  MM/DD/CCYY  MM/DD/CCYY

                 TOTAL SEGMENT CLOSURES:          9,999

                 TOTAL MEMBERS WITH CLOSURES:     9,999


                                        End Of Report
```

5.1.11.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CASE NO.	Number used to identify a group of members that are grouped together	10	Character	T_RE_CASE	NUM_CASE
CNTY	County code	3	Character	T_COUNTY	CDE_COUNTY
ELIG BEG	The date that the member becomes eligible for Medicaid program.	10	Date (MM/DD/CCYY)	T_RE_ELIG	DTE_EFFECTIVE

Field	Description	Length	Data Type	DB Table	DB Attributes
ELIG END	The date that the member is no longer eligible for Medicaid program.	10	Date (MM/DD/CCYY)	T_RE_ELIG	DTE_END
FIRSTNAME	Member's first name	7	Character	T_RE_BASE	NAM_FIRST
HMO BEG	Date the assignment became effective	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
HMO END	Date the assignment is no longer effective	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_END
LASTNAME	Member's last name	10	Character	T_RE_BASE	NAM_LAST
MEMBER ID	The member's Medicaid ID number	10	Character	T_RE_BASE	ID_MEDICAID
PMP ID	PMP identification number	10	Character	T_PR_PROV	ID_PROVIDER
PROG	Program code	2	Character	T_CDE_AID	CDE_AID_CATEGORY
ST	Program status	2	Character	T_RE_PGM_STATUS _CODE	CDE_PGM_STATUS
TOTAL MEMBERS WITH CLOSURES	Total number of members with closure	5	Number	N/A	CALCULATED
TOTAL SEGMENT CLOSURES	Total number of segments that have been closed	5	Number	N/A	CALCULATED

5.1.11.5 Associated Programs

Program	Description
mgd0620m	MC vs. KenPAC and Lockin Overlap

5.1.12 MGD-0570-D -- Daily Managed Care Enrollment Extract Count

This report lists Managed Care enrollment data.

5.1.12.1 Technical Name

MGD-0570-D

5.1.12.2 Sort Order

Member ID

5.1.12.3 Daily Managed Care Enrollment Extract Count Layout

```
Report  : MGD-0570-D                          COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJD570                      MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   HH:MM:SS
Location: MGDDSDTH                         MANAGED CARE DEATH DISENROLLMENT                         Page:    999,999
```

Medicaid ID	Member Name	Date Of Death	Program	PMP ID	Enroll Effective	Enroll End
0000012345	AMES, AMY	03/21/2001	14	67891234	01/01/1998	03/31/2001
0000023456	STOW, STAN	05/04/2005	17	56789012	04/01/2005	05/31/2005
0000098765	DOE, DORA	07/01/2003	17	50001234	07/01/2003	07/31/2003
7300012345	SMITH, JOHN	01/06/1999	17	60000078	01/01/1999	01/31/1999
7300023456	BROWN, BARB	09/26/1999	17	50006789	01/01/1999	09/30/1999
7300034567	STEVENS, STEVEN	01/17/1997	15	90012345	12/01/1996	01/31/1997
7300123456	ROE, RHONDA	01/21/1996	15	23456789	05/01/1995	01/31/1996
7300234567	JONES, JOE	10/09/2000	17	65432109	03/01/1999	10/31/2000
7301234567	FLASH, JACK	07/15/1996	15	43210987	04/01/1996	07/31/1996
7302345678	GREEN, GRETA	02/28/2001	17	30000021	02/24/2001	02/28/2001
7323232323	BLACK, BOB	04/06/1997	15	98765432	04/01/1997	04/30/1997
7343456789	SIMPSON, MARGE	09/28/1998	14	12345678	01/01/1998	09/30/1998
7345678901	WHITE, BOB	05/05/1996	15	78901234	11/01/1995	05/31/1996
7378901234	TAYLOR, TYLER	05/02/1997	15	23456789	04/01/1997	05/31/1997
7456789012	WOODS, TY	11/23/1999	17	67890123	04/01/1999	11/30/1999

```
Total Processed Members:    99999

                          ** End Of Report **
```

5.1.12.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Date of Death	Death Date	10	Char	T_RE_BASE	DTE_DEATH
Disenrollment Date	Disenrollment Date	10	Char	T_RE_PMP_ASSIGN	DTE_END
Enrollment Date	Enrollment Date	10	Char	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
Member ID	Member ID	10	Char	T_RE_BASE	ID_MEDICAID
Member Name	Member Name	25	Char	T_RE_BASE	NAME_LAST, NAME_FIRST
Program Code	Program Code	2	Char	T_PUB_HLTH_PGM	SAK_PUB_HLTH
Provider	Provider ID	8	Char	T_PR_IDENTIFIER	ID_PROVIDER

5.1.12.5 Associated Programs

Program	DESCRIPTION
mgd_dsnrl_death	Death Disenrollment
elgpcdme	KMAA Case & Disease Management Update Error Report
copy2routedir	Copy Reports to Router
mgd0570d	Daily Managed Care Enrollment Extract Count

5.1.13 MGD-0580-D -- Daily Managed Care Extract Count

This report gives the results of the managed care partnership enrollment update processing. If a record is sent by the Commonwealth and the program cannot find the person in the system, then an error message is displayed with the person's ID and name. The program also reports counts of the number of reads, updates, closures, etc.

This program does not access the database, but uses an extract file created by the partnership enrollment program. All errors reported were found in the partnership enrollment program.

5.1.13.1 Technical Name

MGD-0580-D

5.1.13.2 Sort Order

N/A – Totals Only

5.1.13.3 Daily Managed Care Extract Count Layout

```
Report   : MGD-0580-D                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process  : MGDJD580                  MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time: 99:99:99
Location: MGD0580D                      DAILY MANAGED CARE EXTRACT COUNT                       Page: 9999


MEDICAID ID AND NAME OF MEMBERS NOT FOUND:

            XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

            XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

            XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


NUMBER OF TRANSACTIONS READ: 999,999

NUMBER OF TRANSACTIONS UPDATED: 999,999

NUMBER OF TRANSACTIONS INSERTED: 999,999

NUMBER OF MEMBERS DISENROLLED FROM PARTNERSHIP: 999,999


                                End Of Report
```

5.1.13.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
MEDICAID ID AND NAME OF MEMBERS NOT FOUND	Free-form text containing the ID and name of a person who could not be found in the system.	60	Character	N/A	Calculated
NUMBER OF MEMBERS DISENROLLED FROM PARTNERSHIP	Free-form text containing the number of people disenrolled from partnership.	60	Character	N/A	Calculated
NUMBER OF TRANSACTIONS INSERTED	Free-form text containing the number of records inserted.	60	Character	N/A	Calculated
NUMBER OF TRANSACTIONS READ	Free-form text containing the number of records read.	60	Character	N/A	Calculated
NUMBER OF TRANSACTIONS UPDATED	Free-form text containing the number of records updated.	60	Character	N/A	Calculated

5.1.13.5 Associated Programs

Program	Description
mgd0580d	Daily Managed Care Extract Count

5.1.14 MGD-0600-M -- Managed Care vs. LTC Information Report

This report displays members enrolled in managed care who are also enrolled in long-term care. This report supports Kentucky's business policy in that the partnership MCO pays the first 31 days of long-term care for its enrollees, and then the person is disenrolled from the MCO.

5.1.14.1 Technical Name

MGD-0600-M

5.1.14.2 Sort Order

Member ID

5.1.14.3 Managed Care vs. LTC Information Report Layout

```
Report  : MGD-0600-M                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/YY/CCYY
Process : MGDxxxxx                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   99:99:99
Location: MGD0600M                           MANAGED CARE VS LTC INFORMATION                            Page:          999
                                              REPORT COVERS MONTH MARCH

          MEMBER ID  FNAME   LNAME     MC PMP ID   MC BEGIN   MC END     IND  MC SENT     MC ADD     MC TXN     SRCE
          9999999999 XXXXX   XXXXXXXX  9999999999  CCYY/MM/DD CCYY/MM/DD  P   CCYY/MM/DD  CCYY/MM/DD CCYY/MM/DD   D

          LTC PMP ID   LTC BEG    LTC END    LTC TXN    LTC ADD    SRCE PA INST STAT MC MONTHS
          9999999999   CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD   0   1     M3        38


                                          ***   END OF REPORT   ***

                                         ***   NO DATA THIS RUN   ***
```

5.1.14.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
FNAME	Member's first name	5	Character	T_RE_BASE	NAM_FIRST
IND	Unknown	1	Character	TBD	TBD
INST STAT	Initial status	2	Character	TBD	TBD
LNAME	Member's last name	8	Character	T_RE_BASE	NAM_LAST

Field	Description	Length	Data Type	DB Table	DB Attributes
LTC ADD	Long term care addition date	10	Date (CCYY/MM/DD)	TBD	TBD
LTC BEG	Long term care begin date	10	Date (CCYY/MM/DD)	T_RE_LOC	DTE_EFFECTIVE
LTC END	Long term care end date	10	Date (CCYY/MM/DD)	T_RE_LOC	DTE_END
LTC PMP ID	Long term care provider's number + service location code	10	Character	T_PR_PROV	ID_PROVIDER
LTC TXN	Last long term care transaction update date	10	Date (CCYY/MM/DD)	T_RE_LOC	DTE_LAST_CHANGE
MC ADD	Managed care addition date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_ADDED
MC BEGIN	Managed care begin date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
MC END	Managed care end date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_END
MC MONTHS	Months of service of managed care	2	Character	N/A	CALCULATED
MC PMP ID	Managed care provider's number + service location code	10	Character	T_PR_PROV	ID_PROVIDER
MC SENT	Managed care sent date	10	Date (CCYY/MM/DD)	TBD	TBD
MC TXN	Last managed care transaction update date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_CHANGED
MEMBER ID	Member's Medicaid ID	10	Character	T_RE_BASE	ID_MEDICAID
PA	PA long term care	1	Character	TBD	TBD
SRCE	Source of managed care	1	Character	TBD	TBD
SRCE	Source of long term care	1	Character	TBD	TBD

5.1.14.5 Associated Programs

Program	Description
MGD-0600-M	Managed Care vs. LTC Information Report

5.1.15 MGD-0610-M -- Managed Care vs. Waiver Information Report

This report displays members in managed care with waiver overlap for the partnership (MCO).

5.1.15.1 Technical Name

MGD-0610-M

5.1.15.2 Sort Order

Member ID

5.1.15.3 Managed Care vs. Waiver Information Report Layout

```
Report  : MGD-0610-M                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/YY/CCYY
Process : MGDxxxxx                         MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   99:99:99
Location: MGD0610M                            MANAGED CARE VS WAIVER INFORMATION                        Page:          999
                                                REPORT COVERS MONTH MARCH

          MEMBER ID  FNAME   LNAME     MC PMP ID  MC BEGIN   MC END     IND  MC SENT    MC ADD     MC TXN     SRCE
          9999999999 XXXXX   XXXXXXXX  9999999999 CCYY/MM/DD CCYY/MM/DD  P   CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD   D

          WAV PMP ID   WAV BEG    WAV END    WAV TXN    WAV ADD    SRCE ELIG CODE SPEC IND PAY NOPAY MC MONTHS
          9999999999   CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD   0      B                 N          7


                                                 ***   END OF REPORT   ***

                                                ***   NO DATA THIS RUN   ***
```

5.1.15.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ELIG CODE	Eligibility code for waiver	1	Character	TBD	TBD
FNAME	Member's first name	5	Character	T_RE_BASE	NAM_FIRST
IND	Indication of type of managed care service	1	Character	T_RE_PMP_ASSIGN	IND_PRIMARY
LNAME	Member's last name	8	Character	T_RE_BASE	NAM_LAST
MC ADD	Managed care addition date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_ADDED

Field	Description	Length	Data Type	DB Table	DB Attributes
MC BEGIN	Managed care begin date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
MC END	Managed care end date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_END
MC MONTHS	Months of managed care	1	Character	N/A	CALCULATED
MC PMP ID	Provider ID	10	Character	T_PR_PROV	ID_PROVIDER
MC SENT	Managed care sent date	10	Date (CCYY/MM/DD)	TBD	TBD
MC TXN	Last managed care transaction update date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_CHANGED
MEMBER ID	Member's Medicaid ID	10	Character	T_RE_BASE	ID_MEDICAID
PAY NOPAY	Pay or No Pay option	1	Character	TBD	TBD
SPEC IND	Specific indication of waiver	1	Character	TBD	TBD
SRCE	Source for managed care	1	Character	TBD	TBD
SRCE	Source waiver	1	Character	TBD	TBD
WAV ADD	Waiver addition date	10	Date (CCYY/MM/DD)	TBD	TBD
WAV BEG	Waiver begin date	10	Date (CCYY/MM/DD)	T_RE_LOC	DTE_EFFECTIVE
WAV END	Waiver end date	10	Date (CCYY/MM/DD)	T_RE_LOC	DTE_END
WAV PMP ID	Waiver provider number + service location code	10	Character	T_PR_PROV	ID_PROVIDER
WAV TXN	Last waiver transaction update date	10	Date (CCYY/MM/DD)	T_RE_LOC	DTE_LAST_CHANGED

5.1.15.5 Associated Programs

Program	Description
MGD-0610-M	Managed Care vs. Waiver Information Report

5.1.16 MGD-0620-M -- Managed Care vs. KenPAC Information Report

This report displays members in managed care with KenPAC overlap for the partnership (MCO).

5.1.16.1 Technical Name

MGD-0620-M

5.1.16.2 Sort Order

Member ID

5.1.16.3 Managed Care vs. KenPAC Information Report Layout

```
Report  : MGD-0620-M                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/YY/CCYY
Process : MGDJM620                         MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   99:99:99
Location: MGD0620M                           MANAGED CARE VS KENPAC INFORMATION                         Page:          999
                                                REPORT COVERS MONTH XXXXX

          MEMBER ID     FNAME  LNAME        MC PMP ID      MC BEGIN     MC END      IND  MC ADD      MC TXN
          999999999999 XXXXX  XXXXXXXX  999999999999999 CCYY/MM/DD  CCYY/MM/DD    P   CCYY/MM/DD CCYY/MM/DD

          KEN PMP ID        KEN BEG    KEN END    KEN TXN    KEN ADD   SITECODE MC MONTHS
          999999999999999 CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD    XXXX      8

                                          ***   END OF REPORT   ***



                                        ***   NO DATA THIS RUN   ***
```

5.1.16.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
FNAME	Member's first name.	5	Character	T_RE_BASE	NAM_FIRST
IND	Indication of type of service of managed care	1	Character	T_RE_PMP_ASSIGN	IND_PRIMARY
KEN ADD	KenPAC addition date.	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_ADDED
KEN BEG	KenPAC begin date.	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE

Field	Description	Length	Data Type	DB Table	DB Attributes
KEN END	KenPAC end date.	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_END
KEN PMP ID	KenPAC provider's number.	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
KEN TXN	Last KenPAC transaction update date.	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_CHANGED
LNAME	Member's last name.	8	Character	T_RE_BASE	NAM_LAST
MC ADD	Managed care addition date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_ADDED
MC BEGIN	Managed care begins date.	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
MC END	Managed care end date.	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_END
MC MONTHS	Months of managed care.	2	Number (Integer)		CALCULATED
MC PMP ID	Managed care provider's number.	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
MC SENT	Managed care sent date	10	Date (CCYY/MM/DD)	TBD	TBD
MC TXN	Last managed care transaction updated date.	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_CHANGED
MEMBER ID	Member’s Medicaid ID.	12	Character	T_RE_BASE	ID_MEDICAID
SITECODE	Site where KenPAC service is provided.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
SRCE	Source of KenPAC	1	Character	TBD	TBD
SRCE	Source of managed care	1	Character	TBD	TBD

5.1.16.5 Associated Programs

Program	Description
MGD-0620-M	Managed Care vs. KenPAC Information Report

5.1.17 MGD-0630-M -- Managed Care vs. Lockin Information Report

This report displays members in managed care with lock-in overlap for the partnership (MCO).

5.1.17.1 Technical Name

MGD-0630-M

5.1.17.2 Sort Order

Member SAK

5.1.17.3 Managed Care vs. Lockin Information Report Layout

```
Report  : MGD-0630-M                          COMMONWEALTH OF KENTUCKY                                  Run Date: MM/YY/CCYY
Process : MGDJM620                         MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   99:99:99
Location: MGD0630M                           MANAGED CARE VS LOCKIN INFORMATION                         Page:          999
                                                REPORT COVERS MONTH XXXXX

        MEMBER ID     FNAME  LNAME       MC PMP ID       MC BEGIN   MC END      IND   MC ADD      MC TXN
        999999999999 XXXXX  XXXXXXXX  999999999999999 CCYY/MM/DD CCYY/MM/DD   X   CCYY/MM/DD CCYY/MM/DD

        LOC PMP ID        LOC BEG    LOC END    LOC TXN    LOC ADD  LOCKINTYPE MC MONTHS
        999999999999999 CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD CCYY/MM/DD      X       99

                                          ***   END OF REPORT   ***

                                         ***   NO DATA THIS RUN   ***
```

5.1.17.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
FNAME	Member's first name	5	Character	T_RE_BASE	NAM_FIRST
IND	Indication of type of managed care	1	Character	T_RE_PMP_ASSIGN	IND_PRIMARY
LNAME	Member's last name	8	Character	T_RE_BASE	NAM_LAST
LOC ADD	Lock-in addition date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_ADDED
LOC BEG	Lock-in begin date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
LOC END	Lock-in end date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_END

Field	Description	Length	Data Type	DB Table	DB Attributes
LOC PMP ID	PMP identification number.	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
LOC TXN	Last lock-in transaction updated date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_CHANGED
LOCKINTYPE	Type of lock-in	1	Character	TBD	TBD
MC ADD	Managed care addition date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_ADDED
MC BEGIN	Managed care begin date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
MC END	Managed care end date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_END
MC MONTHS	Months of managed care	2	Number (Integer)	N/A	CALCULATED
MC PMP ID	PMP identification number.	15	Character	T_PR_IDENTIFIER	ID_PROVIDER
MC SENT	Managed care sent date	10	Date (CCYY/MM/DD)	TBD	TBD
MC TXN	Last managed care transaction updated date	10	Date (CCYY/MM/DD)	T_RE_PMP_ASSIGN	DTE_CHANGED
MEMBER ID	Member's Medicaid ID	12	Character	T_RE_BASE	ID_MEDICAID
SRCE	Source Lock-in	1	Character	TBD	TBD
SRCE	Source managed care	1	Character	TBD	TBD

5.1.17.5 Associated Programs

Program	Description
MGD-0630-M	Managed Care vs. Lockin Information Report

5.1.18 MGD-0640-M -- Member Not Eligible Has KenPAC Report

This report displays members who are enrolled in KenPAC who do not have the eligibility that entitles them to be enrolled in KenPAC.

5.1.18.1 Technical Name

MGD-0640-M

5.1.18.2 Sort Order

Member ID

5.1.18.3 Member Not Eligible Has KenPAC Report Layout

```
Report  : MGD-0640-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/YYYY
Process : MGDJM650                 MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:   99:99:99
Location: MGD0640M                  Member Not Eligible - Has KenPAC               Page:          999

MEMBER ID     MEMBER NAME                      ERROR REASON
XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                End Of Report
```

5.1.18.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ERROR REASON	Error reason	38	Character	N/A	N/A
MEMBER ID	Member's Medicaid ID	9	Character	T_RE_BASE	ID_MEDICAID
MEMBER NAME	Ineligible member's name	29	Character	T_RE_BASE	NAM_LAST+NAM_FIRST+NAM_MID_INIT

5.1.18.5 Associated Programs

Program	Description
MGD-0640-M	Member Not Eligible Has KenPAC Report

5.1.19 MGD-0675-D -- Pregnant Enrollment Women Summary Report

This is a daily report that summarizes all the online Presumptive Eligibility applications completed for pregnant women. The report indicates what Managed Care medical region the member lives in and if the medical region is a partnership region, gives a message of whether the member was enrolled in the Partnership program.

5.1.19.1 Technical Name

MGD-0675-D

5.1.19.2 Sort Order

Member ID

5.1.19.3 Pregnant Enrollment Women Summary Report Layout

```
Report  : MGD-0675-D                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : MGDJD670                MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   99:99:99
Location: MGDPREGN               Pregnant Women Enrollment Summary Report               Page:      99999


                                                   Date       Date
 Member ID     Member Name                 Region  Effective  End        Description/Error Reason

 xxxxxxxxxx    xxxxxxxx, xxxxxxxx          xx      CCYYMMDD   CCYYMMDD   PE Enrollment was
added

 xxxxxxxxxx    xxxxxxx, xxxxxxx            xx      CCYYMMDD   CCYYMMDD   PE member is not in Region 03


                                      End Of Report
```

5.1.19.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Date Effective	Effective Date	8	Number	T_PMP_SVC_LOC	DTE_EFFECTIVE
Date End	End Date	8	Number	T_PMP_SVC_LOC	DTE_END
Description/Error Reason	Indicates if member's PE enrollment was added as segment to Partnership or not. Gives a reason if not added to Partnership. This is obtained from mgd_pe_enrl program	50	Character	N/A	N/A
Member ID	Member's Medicaid ID	10	Character	T_RE-BASE	ID_MEDICAID
Member Name	Member's Name	36	Character	T_RE-BASE	NAM_LAST+NAM_FIRST+NAM_MID_INIT
Region	Managed Care Medical Region	5	Character	T_MC_PGM_RGN_XREF	CDE_MC_REGION

5.1.19.5 Associated Programs

Program	Description
No associated Programs found.	

5.1.20 MGD-0700-W -- All Active KenPAC Providers Report

This report displays all active KenPAC providers.

5.1.20.1 Technical Name

MGD-0700-W

5.1.20.2 Sort Order

Provider SAK

5.1.20.3 All Active KenPAC Providers Report Layout

```
Report   : MGD-0700-W                          COMMONWEALTH OF KENTUCKY                                    Run Date: MM/DD/CCYY
Process  : MGDJW700                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: MGD0700W                             ALL ACTIVE KENPAC PROVIDERS                                Page:        999

 PROVIDER   PROVIDER       PROVIDER   PROV        ACT   SITE    SITE       CNTY   CNTY     SITE           SITE        SITE  SITE
 NUMBER     NAME           SPECIALITY ENROL QUOTA SITES NUMB    NAME       CODE   NAME     SPECIALITY     PHONE       ENROL QUOTA
 XXXXXXXXXX XXXXXXXXXXXXXX XX XXXXXXX XXXXX XXXXX XXX   XXXX XXXXXXXXXXXX  XXX XXXXXXXXXXX XX XXXXXXXXX XXX/XXX/XXXX  XXXXX XXXXX
 XXXXXXXXXX XXXXXXXXXXXXXX XX XXXXXXX XXXXX XXXXX XXX   XXXX XXXXXXXXXXXX  XXX XXXXXXXXXXX XX XXXXXXXXX XXX/XXX/XXXX  XXXXX XXXXX
 XXXXXXXXXX XXXXXXXXXXXXXX XX XXXXXXX XXXXX XXXXX XXX   XXXX XXXXXXXXXXXX  XXX XXXXXXXXXXX XX XXXXXXXXX XXX/XXX/XXXX  XXXXX XXXXX
 XXXXXXXXXX XXXXXXXXXXXXXX XX XXXXXXX XXXXX XXXXX XXX   XXXX XXXXXXXXXXXX  XXX XXXXXXXXXXX XX XXXXXXXXX XXX/XXX/XXXX  XXXXX XXXXX
 XXXXXXXXXX XXXXXXXXXXXXXX XX XXXXXXX XXXXX XXXXX XXX   XXXX XXXXXXXXXXXX  XXX XXXXXXXXXXX XX XXXXXXXXX XXX/XXX/XXXX  XXXXX XXXXX
 XXXXXXXXXX XXXXXXXXXXXXXX XX XXXXXXX XXXXX XXXXX XXX   XXXX XXXXXXXXXXXX  XXX XXXXXXXXXXX XX XXXXXXXXX XXX/XXX/XXXX  XXXXX XXXXX
 XXXXXXXXXX XXXXXXXXXXXXXX XX XXXXXXX XXXXX XXXXX XXX   XXXX XXXXXXXXXXXX  XXX XXXXXXXXXXX XX XXXXXXXXX XXX/XXX/XXXX  XXXXX XXXXX

                                                   End Of Report
```

5.1.20.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ACT SITES	Total number of KenPAC sites for the provider	3	Number	N/A	CALCULATED
CNTY CODE	County code	3	Character	T_PMP_SVC_LOC_STATE	NUM_SITE (first 3 Character)
CNTY NAME	Name of the county	11	Character	T_COUNTY	DSC_COUNTY

Field	Description	Length	Data Type	DB Table	DB Attributes
PROV ENROL	Total number of members currently assigned to the provider across all sites	5	Number	T_PMP_SVC_LOC	NUM_ACT_PANEL
PROVIDER NAME	The provider's name	14	Character	T_PR_NAM	NAME
PROVIDER NUMBER	Provider ID	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
PROVIDER SPECIALITY	Code and description of the provider's specialty	10	Character	T_PR_SPEC_CDE	CDE_PROV_SPEC, DSC_PROV_SPEC
QUOTA	Total number of members assigned to the provider across all sites during the upcoming enrollment period	5	Number	T_PMP_SVC_LOC	NUM_FUTURE_PANEL
SITE ENROL	Number of members currently assigned to the KenPAC site	5	Number	T_PMP_SVC_LOC	NUM_ACT_PANEL
SITE NAME	Name of the KenPAC site	12	Character	T_PMP_SVC_LOC_STATE	NAM_SITE
SITE NUMB	KenPAC site number	4	Character	T_PMP_SVC_LOC_STATE	NUM_SITE
SITE PHONE	Phone number	12	Character	T_PMP_SVC_LOC	NUM_PHO_24_HOUR
SITE QUOTA	Number of members assigned to the site during the upcoming enrollment period	5	Number	T_PMP_SVC_LOC	NUM_FUTURE_PANEL
SITE SPECIALITY	Code and description of the KenPAC PMP focus	12	Character	T_MC_PMP_FOCUS	CDE_PMP_FOCUS, DSC_PMP_FOCUS

5.1.20.5 Associated Programs

Program	Description
No associated Programs found.	

5.1.21 MGD-0750-W -- All Active KenPAC Clinics Report

This report displays all active KenPAC clinics.

5.1.21.1 Technical Name

MGD-0750-W

5.1.21.2 Sort Order

Provider Group Number

5.1.21.3 All Active KenPAC Clinics Report Layout

```
Report  : MGD-0750-W                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJW750                  MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   99:99:99
Location: MGD0750W                        ALL ACTIVE KENPAC CLINICS                       Page:        999

 PROVIDER      PROVIDER       SITE   INVIVIDUAL   INVIVIDUAL    IND   IND   PROVIDER     PROVIDER       CNTY   CNTY
 GROUP NUMB    NAME           NUMB   LAST NAME    FIRST NAME   INIT   TITLE NUMBER       SPECIALITY     CODE   NAME
 XXXXXXXXXX  XXXXXXXXXXXXXX   XXXX   XXXXXXXXXX   XXXXXXXXXX     X    XXXX  XXXXXXXXX    XX  XXXXXXXX   XXX    XXXXXXXXXX
 XXXXXXXXXX  XXXXXXXXXXXXXX   XXXX   XXXXXXXXXX   XXXXXXXXXX     X    XXXX  XXXXXXXXX    XX  XXXXXXXX   XXX    XXXXXXXXXX
 XXXXXXXXXX  XXXXXXXXXXXXXX   XXXX   XXXXXXXXXX   XXXXXXXXXX     X    XXXX  XXXXXXXXX    XX  XXXXXXXX   XXX    XXXXXXXXXX
 XXXXXXXXXX  XXXXXXXXXXXXXX   XXXX   XXXXXXXXXX   XXXXXXXXXX     X    XXXX  XXXXXXXXX    XX  XXXXXXXX   XXX    XXXXXXXXXX
 XXXXXXXXXX  XXXXXXXXXXXXXX   XXXX   XXXXXXXXXX   XXXXXXXXXX     X    XXXX  XXXXXXXXX    XX  XXXXXXXX   XXX    XXXXXXXXXX
 XXXXXXXXXX  XXXXXXXXXXXXXX   XXXX   XXXXXXXXXX   XXXXXXXXXX     X    XXXX  XXXXXXXXX    XX  XXXXXXXX   XXX    XXXXXXXXXX

                                        End Of Report
```

5.1.21.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
COUNTY CODE	County code	3	Character	T_PMP_SVC_LOC_STATE	NUM_SITE (first 3 Character)
COUNTY NAME	County name	10	Character	T_COUNTY	DSC_COUNTY
IND INIT	Site PMP's middle initial	1	Character	T_PR_NAM	NAME

Field	Description	Length	Data Type	DB Table	DB Attributes
IND TITLE	Site PMP's title	4	Character	T_PR_NAM	NAM_TITLE
INDIVIDUAL FIRST NAME	Site PMP's first name	10	Character	T_PR_NAM	NAME
INDIVIDUAL LAST NAME	Site PMP's last name	10	Character	T_PR_NAM	NAME
PROVIDER GROUP NUMBER	Provider ID for the group	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
PROVIDER NAME	Provider's name	14	Character	T_PR_NAM	NAME
PROVIDER NUMBER	Provider ID	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
PROVIDER SPECIALITY	PMP's focus	12	Character	T_MC_PMP_FOCUS	CDE_PMP_FOCUS, DSC_PMP_FOCUS
SITE NUMBER	KenPAC site number	4	Character	T_PMP_SVC_LOC_STATE	NUM_SITE

5.1.21.5 Associated Programs

Program	Description
No associated Programs found.	

5.1.22 AMGD-0760-M -- Enrollment Report per Month for Medicaid Population

This report generates the information for the total members in Medicaid, Passport and FFS. The report includes the total number of children and total children in foster care.

5.1.22.1 Technical Name

MGD-0760-M

5.1.22.2 Sort Order

N/A - Totals Only

For readability, this layout appears on the following two pages.

5.1.22.3 Enrollment Report per Month for Medicaid Population Layout

```
Report  : MGD-0760-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/YY/CCYY
Process : MGDJM760                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   99:99:99
Location: MGD0760M               ENROLLMENT REPORT PER MONTH FOR MEDICAID POPULATION     Page:       999
                                 FOSTER CARE CHILDREN WITH PROGRAM CODES P, S, OR X

                                   STATEWIDE POPULATION            XXXXXXXXX
                                   ALL MEMBERS                       9999
                                   TOTAL POPULATION
                                   ENROLLED STATEWIDE               999999
                                   TOTAL CHILDREN
                                   ENROLLED STATEWIDE               999999
                                   TOTAL FOSTER CARE CHILDREN
                                   ENROLLED STATEWIDE               999999
                                   TOTAL NEWLY ENROLLED
                                   FOSTER CARE CHILDREN
                                   ENROLLED STATEWIDE               999999
Report  : MGD-0760-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/YY/CCYY
Process : MGDJM760                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   99:99:99
Location: MGD0760M               ENROLLMENT REPORT PER MONTH FOR MEDICAID POPULATION     Page:       999
                                 FOSTER CARE CHILDREN WITH PROGRAM CODES P, S, OR X

                                   POPULATION-FFS                  XXXXXXXXX
                                   (EXCLUDING PASS)                  9999
                                   TOTAL POPULATION
                                   ENROLLED IN MEDICAID - FFS       999999
                                   TOTAL CHILDREN
                                   ENROLLED IN MEDICAID - FFS       999999
                                   TOTAL FOSTER CARE CHILDREN
                                   ENROLLED IN MEDICAID - FFS       999999
                                   TOTAL NEWLY ENROLLED - FFS
                                   FOSTER CARE CHILDREN
                                   ENROLLED IN MEDICAID             999999
```

```
Report  : MGD-0760-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/YY/CCYY
Process : MGDJM760                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   99:99:99
Location: MGD0760M            ENROLLMENT REPORT PER MONTH FOR MEDICAID POPULATION       Page:       999
                              FOSTER CARE CHILDREN WITH PROGRAM CODES P, S, OR X

                                PASS POPULATION                 XXXXXXXXX
                                (EXCLUDING FFS)                   9999
                                TOTAL POPULATION
                                ENROLLED IN PASS                 999999
                                TOTAL CHILDREN
                                ENROLLED IN PASS                 999999
                                TOTAL FOSTER CARE CHILDREN
                                ENROLLED IN PASS                 999999
                                TOTAL NEWLY ENROLLED
                                FOSTER CARE CHILDREN
                                ENROLLED IN PASS                 999999

                                     ***End Of Report***
```

5.1.22.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
PASS POPULATION (EXCLUDING FFS)	Name of the month and year.	9	Character	N/A	N/A
POPULATION FFS (EXCLUDING PASS)	Name of the month and year.	9	Character	N/A	N/A
STATEWIDE POPULATION ALL MEMBERS	Name of the month and year	9	Character	N/A	N/A
TOTAL CHILDREN ENROLLED IN MEDICAID - FFS	Total number of children not enrolled in Passport and eligible in Medicaid.	6	Number	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL CHILDREN ENROLLED IN PASS	Total number of children enrolled in Passport.	6	Number	N/A	CALCULATED
TOTAL CHILDREN ENROLLED STATEWIDE	Total number of children eligible statewide for Medicaid (Passport + FFS).	6	Number	N/A	CALCULATED
TOTAL FOSTER CARE CHILDREN ENROLLED IN MEDICAID - FFS	Total number of foster care children not enrolled in Passport.	6	Number	N/A	CALCULATED
TOTAL FOSTER CARE CHILDREN ENROLLED IN PASS	Total number of foster care children enrolled in Passport.	6	Number	N/A	CALCULATED
TOTAL FOSTER CARE CHILDREN ENROLLED STATEWIDE	Total number of foster care children eligible in Medicaid.	6	Number	N/A	CALCULATED
TOTAL NEWLY ENROLLED - FFS FOSTER CARE CHILDREN ENROLLED IN MEDICAID	Total number of newly enrolled foster care children not enrolled in Passport.	6	Number	N/A	CALCULATED
TOTAL NEWLY ENROLLED FOSTER CARE CHILDREN ENROLLED IN PASS	Total number of newly enrolled foster care children in Passport.	6	Number	N/A	CALCULATED
TOTAL NEWLY ENROLLED FOSTER CARE CHILDREN ENROLLED STATEWIDE	Total number of newly enrolled foster care children eligible in Medicaid.	6	Number	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL POPULATION ENROLLED IN MEDICAID - FFS	Total number of members not enrolled in Passport and eligible in Medicaid.	6	Number	N/A	CALCULATED
TOTAL POPULATION ENROLLED IN PASS	Total number of members enrolled in Passport.	6	Number	N/A	CALCULATED
TOTAL POPULATION ENROLLED STATEWIDE	Total number of members eligible in Medicaid (Passport + FFS).	6	Number	N/A	CALCULATED

5.1.22.5 Associated Programs

Program	Description
No associated Programs found.	

5.1.23 MGD-P060-D -- Enrollment Roster Errors

This report lists all of the members that had errors on the daily enrollment rosters. Daily rosters are only applicable to the Partnership program.

5.1.23.1 Technical Name

MGD-P060-D

5.1.23.2 Sort Order

Member ID

5.1.23.3 Enrollment Roster Errors Layout

```
Report  : MGD-0060-D                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJD800                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   99:99:99
Location: MGD0060D                     Enrollment Roster Errors Report                        Page:        999

PMP ID/       Site  Member ID     Member Name                          Program   Assignment    Error Reason
Location                                                                         Date

999999999  X  XXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999  X  XXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999  X  XXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999  X  XXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999  X  XXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999  X  XXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999  X  XXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                        End Of Report
```

5.1.23.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Assignment Date	The PMP assignment date. This field is populated from assignment_date field in mgd41504.dat file.	10	Date (MM/DD/CCYY)	N/A	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
Error Reason	The reason why a member was denied managed care enrollment. This field is populated from error_reason field in mgd41504.dat file.	35	Character	N/A	N/A
Location	PMP service location. This field is populated from pmp_svc_loc field in mgd41504.dat file.	1	Character	N/A	N/A
Member ID	Member identification number. This field is populated from member_ident_number field in mgd41504.dat file.	12	Character	N/A	N/A
Member Name	Member's name. This field is populated from member_last_name, member_first_name, member_mid_initial fields in mgd41504.dat file.	31	Character	N/A	N/A
PMP ID	PMP identification number. This field is populated from pmp_ident_number field in mgd41504.dat file.	9	Character	N/A	N/A
Program	The name of the health program. This field is populated from prog_hlth field in mgd41504.dat file.	5	Character	N/A	N/A
Site	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers. This field is populated from site_number field in mgd41504.dat file.	4	Character	N/A	N/A

5.1.23.5 Associated Programs

Program	Description
otsortd	Sort - UNIX
mgd_rstr	Managed Care Roster Program
otsortd	Sort - UNIX

Program	Description
otsortd	Sort - UNIX
mgd0060d	Enrollment Roster Error Report
otsortd	Sort - UNIX
mgd0060d	Enrollment Roster Error Report
copy2routedir	Copy Reports to Router

5.1.24 MGD-X002-M -- Capitation Payment Listing

This report provides a detailed listing of all members for whom the PMP is receiving a capitation payment. The report is run during each of the capitation cycles. Four versions of this report are produced, one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.24.1 Technical Name

MGD-X002-M

5.1.24.2 Sort Order

PMP Site, Member Name, Member ID

5.1.24.3 Capitation Payment Listing Layout

```
Report  : MGD-X002-M                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : MGDJM410                 MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   99:99:99
Location: MGD0002M                      CAPITATION PAYMENT LISTING                                    Page:        999
                                   DATE RANGE:  MM/DD/CCYY  -  MM/DD/CCYY

PMP ID: XXXXXXXXXX  Site: XXXX                                                   Payment Issue Date: MM/DD/CCYY
PMP Name: XXXXXXXXX
```

5.1.24.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ADJUSTMENT AMOUNT	Adjustment amount for this member	14	Decimal	T_CAPITATION_ADJ	AMT_CAP_PAID
AMOUNT PAID	Capitation payment made to the PMP for the member	9	Decimal	T_MC_CAP_AMTS	AMT_CAPITATION
Address1	First part of PMP street address	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address2	Second part of PMP street address	30	Character	T_PR_ADR	ADR_MAIL_STRT2
CASE NUM	Member's case number	10	Number	T_RE_CASE	NUM_CASE
City	PMP city address	20	Character	T_PR_ADR	ADR_MAIL_CITY
DATE RANGE	The report time period	23	Date (MM/DD/CCYY)	N/A	CALCULATED
EFF DATE	This is the member assignment date	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
END DATE	This is the date member assignment will end	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_END
MEMBER ID	Member's Medicaid ID number	12	Character	T_RE_BASE	ID_MEDICAID
MEMBER NAME	Member last name, first name, middle name initial	31	Character	T_RE_BASE	NAM_LAST, FIRST, MID_INIT
PMP ID	The PMP identification number	10	Character	T_PR_PROV	ID_PROVIDER
PMP Name	The name of the PMP who receives cap payments	50	Character	T_PR_NAM	NAME
Payment Issue Date	Check issue date	10	Date (MM/DD/CCYY)	T_CHECK	DTE_ISSUE

Field	Description	Length	Data Type	DB Table	DB Attributes
Payment No	Check number	9	Number	T_CHECK	NUM_CHECK
Site	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
State	PMP's state address	2	Character	T_PR_ADR	ADR_MAIL_STATE
Total Amount	Total amount paid to the PMP	10	Decimal	T_CHECK	TOTAL_AMT_PAID
ZIP	PMP's ZIP address	9	Character	T_PR_ADR	ADR_MAIL_ZIP+ADR_MAIL_ZIP_4

5.1.24.5 Associated Programs

Program	Description
mgd0002m	Capitation Payment Listing for Managed Care
copy2routedir	Copy Reports to Router

5.1.25 MGD-X040-M -- Capitation Payment Reconciliation

This report lists all adjustments created as a result of the automated adjustment process (recon). The report is run during each of the capitation cycles. Four versions of this report are produced: one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.25.1 Technical Name

MGD-X040-M

5.1.25.2 Sort Order

PMP, Member ID

5.1.25.3 Capitation Payment Reconciliation Layout

```
Report  : MGD-X040-M                          COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/YYYY
Process : MGDJM720                         MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:   99:99:99
Location: MGD0040M                          Capitation Payment Reconciliation                   Page:          999
                                            Date Range: YYYY/MM/DD - YYYY/MM/DD

PMP ID:  XXXXXXXXXX  Site: XXXX
PMP Name:  XXXXXXXXXXXXXXXXXXXX
Address1:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address2:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State Zip:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Member ID                      Age Gender  Eff Date    Cap Date      New Cat   New Rsn    New Amt Paid
Member Last Name, FI MI                    End Date    Old Txn Date  Old Cat   Old Rsn    Old Amt Paid

XXXXXXXXXXXX                   999   X     YYYY/MM/DD  YYYY/MM/DD    XXXXX     XX         99999999.99
XXXXXXXXXXXXXXX,  X, X                     YYYY/MM/DD                                     99999999.99
XXXXXXXXXXXX                   999   X     YYYY/MM/DD  YYYY/MM/DD    XXXXX     XX         99999999.99
XXXXXXXXXXXXXXX,  X, X                     YYYY/MM/DD                                     99999999.99
XXXXXXXXXXXX                   999   X     YYYY/MM/DD  YYYY/MM/DD    XXXXX     XX         99999999.99
XXXXXXXXXXXXXXX,  X, X                     YYYY/MM/DD                                     99999999.99
XXXXXXXXXXXX                   999   X     YYYY/MM/DD  YYYY/MM/DD    XXXXX     XX         99999999.99
XXXXXXXXXXXXXXX,  X, X                     YYYY/MM/DD                                     99999999.99

P M P    S U M M A R Y
----------------------

Total Number Payments:       9999       Total Payment Amount:    $99999999.99
Total Number Recoupments:    9999       Total Recouped Amount:   $99999999.99
                                                                ------------
                                        TOTAL AMOUNT PAID:       $99999999.99

                                                End Of Report
```

5.1.25.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address1	First part of PMP street address	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address2	Second part of PMP street address	30	Character	T_PR_ADR	ADR_MAIL_STRT2

Field	Description	Length	Data Type	DB Table	DB Attributes
Age	Member age. This field is populated from pmp_id field in mgdjm720.srt file.	3	Number (Integer)	N/A	N/A
Cap Date	The capitation payment date that the adjustment is being made for. This field is populated from pmp_id field in mgdjm720.srt file.	10	Date (CCYY/MM/DD)	N/A	N/A
City, State, Zip	PMP state, city and zip code address	30	Character	T_PR_ADR	ADR_MAIL_CITY, STATE, ZIP, ZIP_4
Date Range	The time period for the capitation payment reconciliation	23	Date (CCYY/MM/DD)	N/A	CALCULATED
Eff Date	PMP assignment date. This field is populated from pmp_id field in mgdjm720.srt file.	10	Date (CCYY/MM/DD)	N/A	N/A
End Date	The date that member PMP assignment ended. This field is populated from pmp_id field in mgdjm720.srt file.	10	Date (CCYY/MM/DD)	N/A	N/A
FI	First initial of member's name. This field is populated from pmp_id field in mgdjm720.srt file.	1	Character	N/A	N/A
Gender	Member gender. This field is populated from pmp_id field in mgdjm720.srt file.	1	Character	N/A	N/A
MI	Middle initial of member's name. This field is populated from pmp_id field in mgdjm720.srt file.	1	Character	N/A	N/A
Member ID	Member's Medicaid ID number. This field is populated from pmp_id field in mgdjm720.srt file.	12	Character	N/A	N/A
Member Last Name	Member last name. This field is populated from pmp_id field in mgdjm720.srt file.	15	Character	N/A	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
New Amt Paid	The new amount paid to the PMP. This field is populated from pmp_id field in mgdjm720.srt file.	11	Decimal	N/A	N/A
New Cat	The new capitation category. This field is populated from pmp_id field in mgdjm720.srt file.	5	Character	N/A	N/A
New Rsn	The reason for reconciliation. This field is populated from pmp_id field in mgdjm720.srt file.	2	Character	N/A	N/A
Old Amt Paid	The amount that was deducted due to reconciliation. This field is populated from pmp_id field in mgdjm720.srt file.	11	Decimal	N/A	N/A
Old Cat	The old capitation category. This field is populated from pmp_id field in mgdjm720.srt file.	5	Character	N/A	N/A
Old Rsn	Normal payment reason. This field is populated from pmp_id field in mgdjm720.srt file.	2	Character	N/A	N/A
Old Txn Date	The month in which the previous (original) capitation transaction was generated. This field is populated from pmp_id field in mgdjm720.srt file.	10	Date (CCYY/MM/DD)	N/A	N/A
PMP ID	PMP identification number.	10	Character	T_PR_IDENTIFIER	ID_PROVIDER
PMP Name	The name of the PMP that the member has selected	20	Character	T_PR_NAM	NAME
Site	The KenPAC site number, only present for KenPAC providers, blank for other managed care providers. This field is populated from num_site field in mgdjm720.srt file.	4	Character	N/A	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL AMOUNT PAID	Total amount paid to the PMP	11	Decimal	N/A	CALCULATED
Total Number Payments	The total number of payments made to the PMP	5	Number (Integer)	N/A	CALCULATED
Total Number Recoupments	The total number of recoupments	5	Number	N/A	CALCULATED
Total Payment Amount	Total amount due to the PMP	11	Decimal	N/A	CALCULATED
Total Recouped Amount	The total amount recouped from the PMP	11	Decimal	N/A	CALCULATED

5.1.25.5 Associated Programs

Program	Description
mgd0040m	Capitation Reconciliation Report.
copy2routedir	Copy Reports to Router

5.1.26 MGD-X050-M -- Managed Care Networks

This report lists all managed care providers along with any MCO and group associations that they may have. Three versions of this report are produced, one for KenPAC, one for partnership (e.g., Passport), and one for Non-Emergency Medical Transportation.

5.1.26.1 Technical Name

MGD-X050-M

5.1.26.2 Sort Order

PMP (referred to “Member ID” on report)

For readability, this layout appears on the next page.

5.1.26.3 Managed Care Networks Layout

```
Report  : MGD-X050-M                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJM800                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   99:99:99
Location: MGD0050M                          MANAGED CARE NETWORKS                             Page:        999

PMP ID:   XXXXXXXXXX  Site: XXXX
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Group ID     Group Name                                  Member ID    Member Name

XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 End Of Report
```

5.1.26.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Group ID	ID number + service location of group	10	Character	T_PR_PROV	ID_PROVIDER
Group Name	Name of group	40	Character	T_PR_NAM	NAME
Member ID	ID number + service location of member provider	10	Character	T_PR_PROV	ID_PROVIDER
Member Name	Name of member provider	41	Character	T_PR_NAM	NAME
PMP ID	ID number + service location of PMP	10	Character	T_PR_PROV	ID_PROVIDER
PMP Name	Name of PMP	40	Character	T_PR_NAM	NAME
Program	Name of the program	50	Character	T_PUB_HLTH_PGM	DSC_PGM_HEALTH
Site	The KenPAC site number, only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER

5.1.26.5 Associated Programs

Program	Description
mgd0050m	Managed Care Networks Report
copy2routedir	Copy Reports to Router
copy2routedir	Copy Reports to Router

5.1.27 MGD-X055-M -- Monthly PMP Enrollment Roster

This report lists PMP enrollment information by member. The report is broken out by New, Continuing, and Terminated members. A legend is provided at the end of the report listing race, language and stop reason codes.

This report is produced in three different versions, for KenPAC, Lock-In, and NEMT.

5.1.27.1 Technical Name

MGD-X055-M

5.1.27.2 Sort Order

Provider ID, Member ID

For readability, this layout appears on the following two pages.

5.1.27.3 Monthly PMP Enrollment Roster Layout

```
Report  : MGD-X055-M                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : MGDJM500                 MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   99:99:99
Location: MGD0055M                      MONTHLY PMP ENROLLMENT ROSTER                                 Page:        999
                                        EFFECTIVE DATE:  MM/DD/CCYY


PMP ID:  XXXXXXXX X  SITE: XXXX
PMP NAME:   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 2:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY, STATE  ZIP:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                NEW ENROLLEES

MEMBER ID /SSN          STREET ADDRESS 1            GND DATE OF    ASSIGNMNT  RACE COUNTY/  PHONE NO  HNDCAP START DATE        CAP
LAST NAME, FIRST, MI    STREET ADDRESS 2                BIRTH /    EFFDATE/   LANG OFFICE               IND   STOP  EPSDT       CAT
                        CITY, STATE  ZIP                DEATH      ENDDATE    IND  IND                         RSN   EXAM

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                            CONTINUING ENROLLEES

MEMBER ID /SSN          STREET ADDRESS 1            GND DATE OF    ASSIGNMNT  RACE COUNTY/  PHONE NO  HNDCAP START DATE        CAP
LAST NAME, FIRST, MI    STREET ADDRESS 2                BIRTH /    EFFDATE/   LANG OFFICE               IND   STOP  EPSDT       CAT
                        CITY, STATE  ZIP                DEATH      ENDDATE    IND  IND                         RSN   EXAM

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

```
                                        TERMINATED ENROLLEES

MEMBER ID /SSN          STREET ADDRESS 1             GND DATE OF    ASSIGNMNT  RACE COUNTY/  PHONE NO  HNDCAP START DATE        CAP
LAST NAME, FIRST, MI    STREET ADDRESS 2                 BIRTH /    EFFDATE/   LANG OFFICE               IND   STOP  EPSDT       CAT
                        CITY, STATE  ZIP                 DEATH      ENDDATE    IND  IND                         RSN   EXAM

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX  X MM/DD/CCYY MM/DD/CCYY 99   XXX    (999)999-9999 X    XX   MM/DD/CCYY  XXXXX
XXXXXXXX, XXXXXXX, X    XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY MM/DD/CCYY XXX  X
                        XXXXXXXXXXXXXXXXXXXXXXXXXXXX

<PAGE BREAK>

Report  : MGD-X055-M                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : MGDJM500                 MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   99:99:99
Location: MGD0055M                      MONTHLY PMP ENROLLMENT ROSTER                                 Page:        999
                                        EFFECTIVE DATE:  MM/DD/CCYY


Code Legend:

     Language

     XX  XXXXXXX  XXXXXXXXXXXXXXXXX
     XX  XXXXXXX  XXXXXXXXXXXXXXXXX

     Race

     XX  XXXXXXX  XXXXXXXXXXXXXXXXX
     XX  XXXXXXX  XXXXXXXXXXXXXXXXX

     Stop Reason

     XX  XXXXXXX  XXXXXXXXXXXXXXXXX
     XX  XXXXXXX  XXXXXXXXXXXXXXXXX


                                        End Of Report
```

5.1.27.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
ADDRESS 1	First part of PMP street address	30	Character	T_PR_ADR	ADR_MAIL_STRT1
ADDRESS 2	Second part of PMP street address	30	Character	T_PR_ADR	ADR_MAIL_STRT2
ASSIGNMENT EFF DATE	Effective date with PMP	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
ASSIGNMENT END DATE	End date with PMP	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_END
CAP CAT	Member's capitation payment classification	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL
CITY	Member city	20	Character	T_RE_BASE	ADR_CITY
CITY, STATE ZIP	PMP city, state and zip plus 4	30	Character		CALCULATED
COUNTY IND	County identification number	3	Character	T_RE_BASE	CDE_COUNTY
DATE EPSDT EXAM	Date of member's last EPSDT exam	10	Date (MM/DD/CCYY)	T_RE_EPS_HIST_EXT	DTE_FIRST_SVC
DATE OF BIRTH	Member date of birth	10	Date (MM/DD/CCYY)	T_RE_BASE	DTE_BIRTH
DATE OF DEATH	Member's date of death	10	Date (MM/DD/CCYY)	T_RE_BASE	DTE_DEATH
EFFECTIVE DATE	Date report was run	10	Date (MM/DD/CCYY)		CALCULATED
FIRST NAME	Member's first name	7	Character	T_RE_BASE	NAM_FIRST
GND	Gender of member	1	Character	T_RE_BASE	CDE_SEX

Field	Description	Length	Data Type	DB Table	DB Attributes
HHDCAP IND	Handicap indicator	1	Character	T_RE_BASE	IND_SPEC_HLTH
LANG IND	Member's language	2	Character	T_RE_BASE	CDE_LANGUAGE
LAST NAME	Member's last name	8	Character	T_RE_BASE	NAM_LAST
MEMBER ID	Member ID number	12	Character	T_RE_BASE	ID_MEDICAID
MIDDLE INITIAL	Member's middle initial	1	Character	T_RE_BASE	NAM_MID_INIT
OFFICE IND	County office member lives nearer to.	1	Character	T_RE_BASE	CDE_OFFICE
PHONE NO	Member's telephone number	10	Character	T_RE_BASE	NUM_PHONE
PMP ID	PMP ID Number + service location of PMP	10	Character	T_PR_PROV	ID_PROVIDER
PMP NAME	PMP's name	50	Character	T_PR_NAM	NAME
RACE IND	Member's race	2	Character	T_RE_BASE	CDE_RACE
SITE	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
SSN	Social Security number	9	Number	T_RE_BASE	NUM_SSN
START RSN	Member eligibility start reason	2	Character	T_RE_PMP_ASSIGN	CDE_RSN_MC_START
STATE	Member state	2	Character	T_RE_BASE	ADR_STATE
STOP RSN	Member eligibility termination reason	2	Character	T_RE_PMP_ASSIGN	CDE_RSN_MC_STOP

Field	Description	Length	Data Type	DB Table	DB Attributes
STREET ADDRESS 1	Member street address	29	Character	T_RE_BASE	ADR_STREET_1
STREET ADDRESS 2	Member street address 2	30	Character	T_RE_BASE	ADR_STREET_2
ZIP	Member zip plus 4	9	Number	T_RE_BASE	ADR_ZIP_CODE+ADR_ZIP_CODE_4

5.1.27.5 Associated Programs

Program	Description
mgd0055m	HIPAA 834 Details Paper Report
copy2routedir	Copy Reports to Router

5.1.28 MGD-X060-M -- Monthly Enrollment Roster Errors

This report lists all of the members who had errors on the monthly enrollment rosters. Four versions of this report are produced, one for KenPAC, one for partnership (e.g., Passport), one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.28.1 Technical Name

MGD-X060-M

5.1.28.2 Sort Order

PMP ID, Member ID

5.1.28.3 Monthly Enrollment Roster Errors Layout

```
Report  : MGD-X060-M                    COMMONWEALTH OF KENTUCKY                                Run Date: MM/DD/CCYY
Process : MGDJM920                 MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   99:99:99
Location: MGD0060M                 MONTHLY ENROLLMENT ROSTER ERRORS REPORT                          Page:       999

PMP ID        Site  Member ID      Member Name                          Program   Assignment    Error Reason
                                                                                   Date

999999999     XXXX  999999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999     XXXX  999999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999     XXXX  999999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999     XXXX  999999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999     XXXX  999999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999     XXXX  999999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999     XXXX  999999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999     XXXX  999999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXX     MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 End Of Report
```

5.1.28.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Assignment Date	The PMP assignment date. This field is populated from assignment_date field in mgd41504.dat file.	10	Date (MM/DD/CCYY)	N/A	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
Error Reason	The reason why a member was denied managed care enrollment. This field is populated from error_reason field in mgd41504.dat file.	38	Character	N/A	N/A
Member ID	Member identification number. This field is populated from member_ident_number field in mgd41504.dat file.	12	Character	N/A	N/A
Member Name	Member's name. This field is populated from member_last_name, member_first_name, member_mid_initial fields in mgd41504.dat file.	31	Character	N/A	N/A
PMP ID	PMP identification number. This field is populated from pmp_ident_number field in mgd41504.dat file.	10	Character	N/A	N/A
Program	The name of the health program. This field is populated from prog_hlth field in mgd41504.dat file.	5	Character	N/A	N/A
Site	The KenPAC site number, only present for KenPAC providers. The field will display 0000 for all other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER

5.1.28.5 Associated Programs

Program	Description
otsortd	Sort - UNIX
mgd_rstr	Managed Care Roster Program
mgd0060d	Enrollment Roster Error Report
otsortd	Sort - UNIX

Program	Description
mgd0060d	Enrollment Roster Error Report
copy2routedir	Copy Reports to Router

5.1.29 MGD-X060-W -- Weekly Managed Care Enrolled But Not Eligible

This report lists members who are enrolled in managed care, but are no longer eligible. The report is sorted by PMP ID and member ID. It also prints a total disenrolled summary for providers and another one for the Commonwealth. Two versions of this report are produced, one for KenPAC and one for Partnership.

5.1.29.1 Technical Name

MGD-X060-W

5.1.29.2 Sort Order

PMP ID, Member ID

5.1.29.3 Weekly Managed Care Enrolled But Not Eligible Layout

```
Report   : MGD-X060-W                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process  : MGDJW060                  MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   99:99:99
Location: MGD0060W                 WEEKLY MANAGED CARE ENROLLED BUT NOT ELIGIBLE                       Page:        999


PMP ID: XXXXXXXXXX  Site: XXXX
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Member ID      Member Name                          Program    Eff Date       Prev           New
                                                    Code                      End Date       End Date

999999999999   XXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X    XXXXX      MM/DD/CCYY     MM/DD/CCYY     MM/DD/CCYY
999999999999   XXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X    XXXXX      MM/DD/CCYY     MM/DD/CCYY     MM/DD/CCYY
999999999999   XXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X    XXXXX      MM/DD/CCYY     MM/DD/CCYY     MM/DD/CCYY
999999999999   XXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X    XXXXX      MM/DD/CCYY     MM/DD/CCYY     MM/DD/CCYY


<PAGE BREAK>
```

```
Report  : MGD-X060-W                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : MGDJW060                  MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:   99:99:99
Location: MGD0060W                Weekly Managed Care Enrolled But Not Eligible         Page:       999
                                              Provider Summary

PMP ID: XXXXXXXXXX  Site: XXXX
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Reason Code          Reason Description         Total

    999              XXXXX XXXXXXXXXXXXX         9999999999
    999              XXXXX XXXXXXXXXXXXX         9999999999
    999              XXXXX XXXXXXXXXXXXX         9999999999
    999              XXXXX XXXXXXXXXXXXX         9999999999


Total Disenrolled  9999999999

<PAGE BREAK>

Report  : MGD-X060-W                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : MGDJW060                  MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:   99:99:99
Location: MGD0060W                Weekly Managed Care Enrolled But Not Eligible         Page:       999
                                              Statewide Summary


Reason Code          Reason Description         Total Disenrolled

    999              XXXXX XXXXXXXXXXXXX         9999999999
    999              XXXXX XXXXXXXXXXXXX         9999999999
    999              XXXXX XXXXXXXXXXXXX         9999999999
    999              XXXXX XXXXXXXXXXXXX         9999999999

Total Disenrolled For State: 9999999999

                                          **END OF REPORT**
```

5.1.29.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Address 1	Provider address 1	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address 2	Provider address 2	30	Character	T_PR_ADR	ADR_MAIL_STRT2
City, State, Zip	Provider city, state and zip code address	30	Character	T_PR_ADR	ADR_MAIL_CITY,STATE, ZIP,ZIP_4
Eff Date	Member assignment effective date. This field is populated from dte_eff field in mgw06001.srt file.	10	Date (MM/DD/CCYY)	N/A	N/A
Member ID	Member identification number. This field is populated from member_id field in mgw06001.srt file.	12	Character	N/A	N/A
Member Name	Member last name, first name and middle initial. This field is populated from member_name field in mgw06001.srt file.	30	Character	N/A	N/A
New End Date	The date member is disenrolled from managed care. This field is populated from dte_end field in mgw06001.srt file.	10	Date (MM/DD/CCYY)	N/A	N/A
PMP ID	PMP identification number. This field is populated from prov_id field in mgw06001.srt file.	10	Character	N/A	N/A
PMP Name	Name of primary medical provider.	50	Character	T_PR_NAM	NAME
Prev End Date	Member assignment end date. This field is populated from prev_dte_end field in mgw06001.srt file.	10	Date (MM/DD/CCYY)	N/A	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
Program Code	The health program member is assigned to. This field is populated from cde_pgm_hlth field in mgw06001.srt file.	5	Character	N/A	N/A
Reason Code	The reason code for member disenrollment. This field is populated from rsn_cde field in mgw06001.srt file.	3	Number	N/A	N/A
Reason Description	The actual reason why the member is disenrolled. This field is populated from rsn_desc field in mgw06001.srt file.	18	Character	N/A	N/A
Site	The KenPAC site number, only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
Total	Total member disenrolled for the reason code for the provider.	10	Number	N/A	CALCULATED
Total Disenrolled	Total number of members disenrolled for all the reason codes for the provider.	10	Number	N/A	CALCULATED
Total Disenrolled For State	Total number of members disenrolled for the state.	10	Number	N/A	CALCULATED

5.1.29.5 Associated Programs

Program	Description
No associated Programs found.	

5.1.30 MGD-X080-M -- Capitation Errors

This report lists all errors that were encountered where the capitation generation programs are unable to generate the capitation payment. Examples include ineligible members or rates not being on file. Four versions of this report are produced - one for KenPAC, one for partnership (e.g., Passport), one for Lock-in, and one for Non-Emergency Medical Transportation. This error report is also used for the daily online-entered adjustments, mass rate adjustments, recon, and monthly prospective capitation generation, and will be differentiated by report heading or ID.

5.1.30.1 Technical Name

MGD-X080-M

5.1.30.2 Sort Order

PMP ID, Member ID

5.1.30.3 Capitation Errors Layout

```
Report  : MGD-X080-M                          COMMONWEALTH OF KENTUCKY                                    Run Date: MM/YY/CCYY
Process : MGDJM106                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            Run Time:   99:99:99
Location: MGD0080M                            CAPITATION ERRORS REPORT                                        Page:        999

PMP ID          Site  Member ID                        Cap       Assignment Date/  Pgm Cde/   Med  Error Reason
                      Member Name                      Category  Cap Month         Pgm Status Ind

999999999999999 XXXX  999999999999                     XXXXX     MM/DD/YYYY          XX/       X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           MM/DD/YYYY          XX
999999999999999 XXXX  999999999999                     XXXXX     MM/DD/YYYY          XX/       X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           MM/DD/YYYY          XX
999999999999999 XXXX  999999999999                     XXXXX     MM/DD/YYYY          XX/       X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           MM/DD/YYYY          XX
999999999999999 XXXX  999999999999                     XXXXX     MM/DD/YYYY          XX/       X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           MM/DD/YYYY          XX
999999999999999 XXXX  999999999999                     XXXXX     MM/DD/YYYY          XX/       X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           MM/DD/YYYY          XX
999999999999999 XXXX  999999999999                     XXXXX     MM/DD/YYYY          XX/       X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           MM/DD/YYYY          XX
999999999999999 XXXX  999999999999                     XXXXX     MM/DD/YYYY          XX/       X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           MM/DD/YYYY          XX
999999999999999 XXXX  999999999999                     XXXXX     MM/DD/YYYY          XX/       X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           MM/DD/YYYY          XX

                                          End Of Report
```

5.1.30.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Assignment Date	Member assignment date. This field is populated from assignment_date field in mgdjm106.srt file.	10	Date (MM/DD/CCYY)	N/A	N/A
Cap Category	Member capitation category. This field is populated from cap_category field in mgdjm106.srt file.	5	Character	N/A	N/A
Cap Month	Capitation month. This field is populated from dte_capitation field in mgdjm106.srt file.	10	Date (MM/DD/CCYY)	N/A	N/A
Error Reason	Capitation error reason. This field is populated from error_reason field in mgdjm106.srt file.	38	Character	N/A	N/A
Med Ind	Member's Medicare indicator. This field is populated from medicare_ind field in mgdjm106.srt file.	1	Character	N/A	N/A
Member ID	Member's Medicaid ID number. This field is populated from member_id field in mgdjm106.srt file.	12	Character	N/A	N/A
Member Name	Member name (last, first, MI). This field is populated from member_nam field in mgdjm106.srt file.	32	Character	N/A	N/A
PMP ID	PMP identification number. This field is populated from pmp_id field in mgdjm106.srt file.	15	Character	N/A	N/A
Pgm Cde	Member's program code. This field is populated from cde_aid_category field in mgdjm106.srt file.	2	Character	N/A	N/A
Pgm Status	This is the status of the category. This is populated from cde_status field in mgdjm106.srt file.	2	Character	N/A	N/A

Field	Description	Length	Data Type	DB Table	DB Attributes
Site	The KenPAC site number, only present for KenPAC providers, blank for managed care providers. This field is populated from num_site field of mgdjm106.srt file.	4	Character	N/A	N/A

5.1.30.5 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
mgd0080m	Capitation Error Report

5.1.31 MGD-X100-M -- Capitation Payment Listing Summary by Provider

This report summarizes all capitation transactions by provider for a capitation payment cycle. Capitation payments created during the cycle, whether prospective payments, adjustments to previous payments, or retro payments, are included in the report. The report is run during each of the capitation cycles. Four versions of this report are produced, one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.31.1 Technical Name

MGD-X100-M

5.1.31.2 Sort Order

PMP ID

For readability, this layout appears on the next page.

5.1.31.3 Capitation Payment Listing Summary by Provider Layout

```
Report  : MGD-X100-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/YY/CCYY
Process : MGDJM790                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   99:99:99
Location: MGD0140M                 Capitation Payment Summary By Provider               Page:        999
                                     Date Range  MM/DD/YYYY - MM/DD/YYYY

PMP ID: XXX XXXXXXXXXXXXXX  Site: XXXX
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXX, XX  XXXXX-XXXX

                                        Capitation Worksheet

Capitation Category                    Cont      Adjust     Total      Gross       Total       Total       Total
                                       Enroll    Enroll     Enroll     Amount      Adjust      Recouped    Amt
                                       Months    Months     Months     Paid        Amount      Amt         Paid

XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99
XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99
XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99
XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99
XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99
XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99
XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99
XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99
XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 99,999    99,999     99,999     999999.99   99,9999.99  99,9999.99  99,9999.99

TOTALS                                 999,999   999,999    999,999    9999999999.99 9999999999.99 9999999999.99 9999999999.99

                                                 End Of Report
```

5.1.31.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(Provider ID Type)	Provider ID type	3	Character	T_PR_IDENTIFIER	CDE_PROV_ID_TYPE

Field	Description	Length	Data Type	DB Table	DB Attributes
Address 1	Provider address 1	30	Character	T_PR_ADR	ADR_MAIL_STRT1
Address 2	Provider address 2	30	Character	T_PR_ADR	ADR_MAIL_STRT2
Adjust Enroll Months	Member adjusted enrollee months	5	Number		CALCULATED
Capitation Category	Member capitation category description	35	Character	T_MC_RATE_CELL	DSC_CAP_CATEGORY
Capitation Category Code	Member capitation category code	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL
City	Provider's city	15	Character	T_PR_ADR	ADR_MAIL_CITY+ADR_ MAIL_STATE+ADR
Cont Enroll Months	Member continuing enrollee months	5	Number	N/A	CALCULATED
Date Range	The report time period for which the program is being run	23	Date (MM/DD/CCYY)	N/A	CALCULATED
Gross Amount Paid	Gross amount paid	9	Number	N/A	CALCULATED
PMP ID	PMP identification number	9	Character	T_PR_PROV	ID_PROVIDER
PMP Name	Name of primary medical provider	50	Character	T_PR_NAM	NAME
Site	The KenPAC site number - present only for KenPAC providers, zero for managed care providers.	4	Character	T_PMP_SVC_LOC_ STATE	SITE_NUMBER
State	Provider's state	2	Character	T_PR_ADR	ADR_MAIL_STATE

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTALS	Total of total enrollee months column	6	Number	N/A	CALCULATED
TOTALS	Total of gross amount paid column	12	Number	N/A	CALCULATED
TOTALS	Total of total adjust amount column	12	Number	N/A	CALCULATED
TOTALS	Total of adjusted enrollee months column	6	Number	N/A	CALCULATED
TOTALS	Total of total amount paid column	13	Number	N/A	CALCULATED
TOTALS	Total of total recouped amount column	12	Number	N/A	CALCULATED
TOTALS	Total of continuing enrollee months column	6	Number	N/A	CALCULATED
Total Adjust Amount	Total adjusted amount	10	Number	N/A	CALCULATED
Total Amt Paid	Total amount paid - the sum of the gross amount and the adjusted amount.	10	Number	N/A	CALCULATED
Total Enroll Months	Member total enrollee months	5	Number	N/A	CALCULATED
Total Recouped Amt	Total recouped amount	10	Number	N/A	CALCULATED
Zip Code	Provider's zip code	10	Character	T_PR_ADR	ADR_MAIL_ZIP+ADR_MAIL_ZIP_4

5.1.31.5 Associated Programs

Program	Description
mgd0140m	Capitation Payment Listing Summary by Provider
copy2routedir	Copy Reports to Router

5.1.32 MGD-X300-M -- Capitation Summary by Fund Code

This report provides a summary of capitation details by fund code. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.32.1 Technical Name

MGD-X300-M

5.1.32.2 Sort Order

N/A – Totals Only

5.1.32.3 Capitation Summary by Fund Code Layout

```
Report  : MGD-X300-M                    COMMONWEALTH OF KENTUCKY                                  Run Date: MM/DD/CCYY
Process : MGDJM300                  MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   99:99:99
Location: MGD0300M                      Capitation Summary by Fund Code                               Page:        999

                                                        Cap Category      Cap Category    Fund Code        Fund Code
Fund Code       Capitation Category                        Count             Amount          Count            Amount
---------       ---------------------------             ------------    ---------------  -----------      ---------
XXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         999,999,999     999,999,999.99   999,999,999   999,999,999.99
XXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         999,999,999     999,999,999.99   999,999,999   999,999,999.99
XXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         999,999,999     999,999,999.99   999,999,999   999,999,999.99
XXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         999,999,999     999,999,999.99   999,999,999   999,999,999.99

                                                                                         ============  ===============
                Total for Fund ...  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                999,999,999   999,999,999.99
                                                                                         ============  ===============
                                Grand Total for All Funds                                  999,999,999   999,999,999.99
```

5.1.32.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Cap Category Amount	Total capitation payments for the capitation category	14	Decimal	N/A	CALCULATED
Cap Category Count	Count of capitation transactions	11	Number	N/A	CALCULATED
Capitation Category	Description of the capitation category	35	Character	T_MC_RATE_CELL	DSC_CAP_CATEGORY
Capitation Category Code	Capitation payment category code	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL
Fund Code	Shows the fund code of the capitation transaction	4	Character	T_FIN_FUND_CODE	CDE_FUND_CODE
Fund Code Amount	Total amount of capitation for fund code	14	Decimal	N/A	CALCULATED
Fund Code Count	Total capitation count for fund code	11	Number	N/A	CALCULATED
Fund Code Description	Fund code description	30	Character	T_FIN_FUND_CODE	DSC_FUND
Grand Total for All Funds	Grand total of all capitations for all funds	14	Decimal	N/A	CALCULATED
Total for Fund	Total count of all categories for all funds	12	Number	N/A	CALCULATED

5.1.32.5 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
mgd0300m	Capitation Summary by Fund Code Report Program

5.1.33 MGD-X301-M -- Capitation Summary by Capitation Category

This report provides a summary of capitation details by capitation category. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.33.1 Technical Name

MGD-X301-M

5.1.33.2 Sort Order

N/A - Totals Only

5.1.33.3 Capitation Summary by Capitation Category Layout

```
Report  : MGD-0301-M                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJM301                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   99:99:99
Location: MGD0301M                Capitation Summary by Capitation Category                   Page:        999

                                                        Cap Category        Cap Category
Cap Category     Capitation Category                       Count               Amount
                                                        ------------      ---------------
   XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999,999,999       999,999,999.99
   XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999,999,999       999,999,999.99
   XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999,999,999       999,999,999.99
   XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999,999,999       999,999,999.99
   XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999,999,999       999,999,999.99
   XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999,999,999       999,999,999.99
   XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999,999,999       999,999,999.99
                                                        ============      ===============
           Grand Total for All Categories               999,999,999       999,999,999.99


                                   End Of Report
```

5.1.33.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Cap Category	Capitation payment category code	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL

Field	Description	Length	Data Type	DB Table	DB Attributes
Cap Category Amount	Total capitation category payments.	14	Decimal	N/A	CALCULATED
Cap Category Count	Count of capitation category transactions	11	Number	N/A	CALCULATED
Capitation Category	Description of the capitation category	30	Character	T_MC_RATE_CELL	DSC_CAP_CATEGORY
Grand Total Cap Category Amount	Grand total capitation category payments	14	Decimal	N/A	CALCULATED
Grand Total Cap Category Count	Grand total count of capitation category transactions for the fund	11	Number	N/A	CALCULATED

5.1.33.5 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
mgd0301m	Capitation Summary by Capitation Category

5.1.34 MGD-X302-M -- Capitation Summary by Program

This report provides a summary of capitation details by program. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.34.1 Technical Name

MGD-X302-M

5.1.34.2 Sort Order

N/A - Totals Only

5.1.34.3 Capitation Summary by Program Layout

```
Report  : MGD-X302-M                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJM302                 MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   99:99:99
Location: MGD0302M                      Capitation Summary by Program                         Page:        999

                                                                     Program            Program
Program Code     Program Description                                  Count              Amount
------------     ---------------------------------------------------  ------------       ---------------
   XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999        999,999,999.99

                                                                     ============       ===============
            Grand Total for All Programs                              999,999,999        999,999,999.99

                                          End Of Report
```

5.1.34.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Grand Total For All Programs Amount	Grand total program amount	14	Decimal	N/A	CALCULATED
Grand Total For All Programs Count	Grand total program count	11	Number	N/A	CALCULATED
Program Amount	Amount of capitation for the program	14	Decimal	N/A	CALCULATED
Program Code	Program code for the capitation transactions	5	Character	T_PUB_HLTH_PGM	CDE_PGM_HEALTH

Field	Description	Length	Data Type	DB Table	DB Attributes
Program Count	Count of capitation for the program	11	Number	N/A	CALCULATED
Program Description	Program description	50	Character	T_PUB_HLTH_PGM	DSC_PGM_HEALTH

5.1.34.5 Associated Programs

Program	Description
copy2routedir	Copy Reports to Router
mgdp3002	Capitation Summary by Program Report

5.1.35 MGD-X440-M -- Current and Retro Cap Counts

This report is a count summary, by provider, of capitations and management fees for current and retroactive payment. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.35.1 Technical Name

MGD-X440-M

5.1.35.2 Sort Order

PMP ID, Site No.

5.1.35.3 Current and Retro Cap Counts Layout

```
Report   : MGD-X440-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process  : MGDJM620X                 MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time: 99:99:99
Location: MGD0440M                       CURRENT AND RETRO CAP COUNTS                    Page: 9999

                PMP          SITE      CURRENT       RETRO          TOTAL
                ID                     MONTH        MONTHS       CAPITATIONS
            -----------      ----    ----------   ----------    -----------
            XXXXXXXXX X      XXXX     999,999      999,999      99,999,999
            XXXXXXXXX X      XXXX     999,999      999,999      99,999,999
            XXXXXXXXX X      XXXX     999,999      999,999      99,999,999
            XXXXXXXXX X      XXXX     999,999      999,999      99,999,999
            XXXXXXXXX X      XXXX     999,999      999,999      99,999,999
            XXXXXXXXX X      XXXX     999,999      999,999      99,999,999

            TOTALS                    999,999      999,999      99,999,999

                                                End Of Report
```

5.1.35.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(Service Location)	The PMP's service location code	1	Character	T_PMP_SVC_LOC	CDE_SVC_LOC
CURRENT MONTH	Capitation counts for the current month	7	Number	N/A	CALCULATED
PMP ID	PMP identification number	9	Character	T_PR_PROV	ID_PROVIDER

Field	Description	Length	Data Type	DB Table	DB Attributes
RETRO MONTHS	Capitation counts for retro months	7	Number	N/A	CALCULATED
SITE	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
TOTAL CAPITATIONS	Sum of current and retro months counts	10	Number	N/A	CALCULATED
TOTALS	Grand total of retro months counts	7	Number	N/A	CALCULATED
TOTALS	Grand total of total capitations	10	Number	N/A	CALCULATED
TOTALS	Grand total of current month counts	7	Number	N/A	CALCULATED

5.1.35.5 Associated Programs

Program	Description
mgd0440m	Current and Retro Cap Counts

5.1.36 MGD-X450-M -- Cap Recon Payments Not On History

This report lists all recon adjustment capitations that were created and will be processed for payment. The capitations are for payments that were missed during the original capitation month. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.36.1 Technical Name

MGD-X450-M

5.1.36.2 Sort Order

Member ID

5.1.36.3 Cap Recon Payments Not On History Layout

```
Report   : MGD-X450-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process  : MGDJM730X                 MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time: 99:99:99
Location: MGD0450M                      CAP RECON PAYMENTS NOT ON HISTORY                Page: 9999

                    MEMBER ID        PMP ID      SITE   CAP MONTH   CAP CAT     PAID AMOUNT
                    ------------   -------------  ----   ---------  ---------  --------------
                    XXXXXXXXXXXX    XXXXXXXXXX    XXXX    MM/CCYY    XXXXX     999,999,999.99
                    XXXXXXXXXXXX    XXXXXXXXXX    XXXX    MM/CCYY    XXXXX     999,999,999.99
                    XXXXXXXXXXXX    XXXXXXXXXX    XXXX    MM/CCYY    XXXXX     999,999,999.99
                    XXXXXXXXXXXX    XXXXXXXXXX    XXXX    MM/CCYY    XXXXX     999,999,999.99
                    XXXXXXXXXXXX    XXXXXXXXXX    XXXX    MM/CCYY    XXXXX     999,999,999.99
                    XXXXXXXXXXXX    XXXXXXXXXX    XXXX    MM/CCYY    XXXXX     999,999,999.99
                    XXXXXXXXXXXX    XXXXXXXXXX    XXXX    MM/CCYY    XXXXX     999,999,999.99
                    XXXXXXXXXXXX    XXXXXXXXXX    XXXX    MM/CCYY    XXXXX     999,999,999.99

                TOTAL RECORDS: 999,999,999        AMOUNT:   999,999,999.99

                              End Of Report
```

5.1.36.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
AMOUNT	Total amount of capitation payments	14	Number	N/A	CALCULATED
CAP CAT	The capitation payment category code	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL

Field	Description	Length	Data Type	DB Table	DB Attributes
CAP MONTH	This is the month that the capitation adjustment is being made for	7	Number	T_CAPITATION_ADJ	DTE_CAPITATION
MEMBER ID	Member identification number	12	Character	T_RE_BASE	ID_MEDICAID
PAID AMOUNT	The amount of money that was paid	14	Number	T_CAPITATION_ADJ	AMT_CAP_PAID
PMP ID	PMP identification number	10	Character	T_PR_PROV	ID_PROVIDER
SITE	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
TOTAL RECORDS	Total number of capitation payments	11	Number	N/A	CALCULATED

5.1.36.5 Associated Programs

Program	Description
mgd0450m	Cap Recon Payments Not On History Report

5.1.37 MGD-X460-M -- Cap Recon Adjustments To Existing Caps

This report lists all recon adjustment capitations that were adjusted or recouped and will be processed for payment. The capitations are for payments that were in history for the original capitation month, which have been repriced or recouped. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.37.1 Technical Name

MGD-X460-M

5.1.37.2 Sort Order

Member ID

5.1.37.3 Cap Recon Adjustments To Existing Caps Layout

```
Report  : MGD-X460-M                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJM730X                MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time: 99:99:99
Location: MGD0460M                 CAP RECON ADJUSTMENTS TO EXISTING CAPS                     Page: 9999

MEMBER ID      PMP ID        SITE   CAP MONTH   CAP CAT     PAID AMOUNT          TYPE
------------   ----------    ----   ---------   --------    --------------    -----------
XXXXXXXXXXXX   XXXXXXXXXX    XXXX    MM/CCYY     XXXXX      999,999,999.99-   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXX    XXXX    MM/CCYY     XXXXX      999,999,999.99-   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXX    XXXX    MM/CCYY     XXXXX      999,999,999.99-   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXX    XXXX    MM/CCYY     XXXXX      999,999,999.99-   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXX    XXXX    MM/CCYY     XXXXX      999,999,999.99-   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXX    XXXX    MM/CCYY     XXXXX      999,999,999.99-   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXX    XXXX    MM/CCYY     XXXXX      999,999,999.99-   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXX    XXXX    MM/CCYY     XXXXX      999,999,999.99-   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                    TOTAL CREDIT      RECORDS: 999,999,999       AMOUNT:   999,999,999.99-
                    TOTAL DEBIT       RECORDS: 999,999,999       AMOUNT:   999,999,999.99-
                    TOTAL CREDIT ONLY RECORDS: 999,999,999       AMOUNT:   999,999,999.99-

                                        End Of Report
```

5.1.37.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CAP CAT	The capitation payment category code	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL
CAP MONTH	This is the month that the capitation adjustment is being made for	7	Date (MM/CCYY)	T_CAPITATION_ADJ	DTE_CAPITATIO N

Field	Description	Length	Data Type	DB Table	DB Attributes
MEMBER ID	Member identification number	12	Character	T_RE_BASE	ID_MEDICAID
PAID AMOUNT	The amount of money that was paid or recouped to an external entity. The amount could be negative if it was a recoupment.	14	Number	T_CAPITATION_ADJ	AMT_CAP_PAID
PMP NUMBER	PMP identification number	10	Character	T_PR_PROV	ID_PROVIDER
SITE	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
TOTAL CREDIT ONLY RECORDS	Count of credit only records listed on report	11	Number	N/A	CALCULATED
TOTAL CREDIT ONLY RECORDS AMOUNT	Sum of credit only records listed on report	14	Number	N/A	CALCULATED
TOTAL CREDIT RECORDS	Count of credit records listed on report	11	Number	N/A	CALCULATED
TOTAL CREDIT RECORDS AMOUNT	Sum of credit records listed on report	14	Number	N/A	CALCULATED
TOTAL DEBIT RECORDS	Count of debit records listed on report	11	Number	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
TOTAL DEBIT RECORDS AMOUNT	Sum of debit records listed on report	14	Number	N/A	CALCULATED
TYPE	The description on the adjustment reason code	50	Character	T_CAP_REASON	DSC_50

5.1.37.5 Associated Programs

Program	Description
No associated Programs found.	

5.1.38 MGD-X480-M -- Capitation Payment Summary - PMP

This report lists capitation payment cycle summary totals by PMP. Amounts are reported by capitation category code, with subtotals by PMP and grand totals for the report. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.38.1 Technical Name

MGD-X480-M

5.1.38.2 Sort Order

PMP ID, Site No.

5.1.38.3 Capitation Payment Summary - PMP Layout

```
Report  : MGD-0480-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : MGDJM480                 MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time: 99:99:99
Location: MGD0480M                    CAPITATION PAYMENT SUMMARY - PMP                 Page: 9999

  PMP ID       SITE   CAP CATEGORY   CAP ERRORS       CAP PAID       PAID AMOUNT
-----------    ----   ------------   -----------      -----------    --------------
XXXXXXXXX X    XXXX      XXXXX       999,999,999      999,999,999    999,999,999.99
                         XXXXX       999,999,999      999,999,999    999,999,999.99
PMP TOTAL:                           999,999,999      999,999,999    999,999,999.99

XXXXXXXXX X    XXXX      XXXXX       999,999,999      999,999,999    999,999,999.99
                         XXXXX       999,999,999      999,999,999    999,999,999.99
PMP TOTAL:                           999,999,999      999,999,999    999,999,999.99

GRAND TOTAL:                         999,999,999      999,999,999    999,999,999.99

                                        End Of Report
```

5.1.38.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(PMP Service Location)	The PMP's service location code.	1	Character	T_PMP_SVC_LOC	CDE_SVC_LOC
CAP CATEGORY	Code associated with a capitation category.	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL

Field	Description	Length	Data Type	DB Table	DB Attributes
CAP ERRORS	Number of capitations that were attempted but had errors.	9	Number (Integer)	N/A	CALCULATED
CAP PAID	Number of capitations that were paid.	9	Number (Integer)	N/A	CALCULATED
GRAND TOTAL	Sum of capitation payment amounts for all PMPs.	11	Number (Decimal)	N/A	CALCULATED
GRAND TOTAL	Number of paid capitations for all PMPs.	9	Number (Integer)	N/A	CALCULATED
GRAND TOTAL	Number of capitations with errors for all PMPs.	9	Number (Integer)	N/A	CALCULATED
PAID AMOUNT	Sum of capitation payment amounts for paid capitations.	11	Number (Decimal)	N/A	CALCULATED
PMP ID	The ID number of the PMP.	9	Character	T_PR_PROV	ID_PROVIDER
PMP TOTAL	Sum of capitation payment amounts for this PMP.	11	Number (Decimal)	N/A	CALCULATED
PMP TOTAL	Number of capitations with errors for this PMP.	9	Number (Integer)	N/A	CALCULATED
PMP TOTAL	Number of paid capitations for this PMP.	9	Number (Decimal)	N/A	CALCULATED
SITE	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER

5.1.38.5 Associated Programs

Program	Description
mgd0480m	Capitation Payment Summary - PMP

5.1.39 MGD-X490-M -- Capitation Payment Detail - PMP

This report lists capitation payment cycle summary totals by PMP. Amounts are reported by capitation month and capitation category code, with subtotals by capitation month. The report is run during each of the capitation cycles.

5.1.39.1 Technical Name

MGD-X490-M

5.1.39.2 Sort Order

Cap Month, PMP ID, Site No.

5.1.39.3 Capitation Payment Detail - PMP Layout

```
Report  : MGD-X490-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process : MGDJM600X                 MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time: 99:99:99
Location: MGD0490M                      CAPITATION PAYMENT DETAIL - PMP                 Page: 9999

  PMP ID         SITE    CAP MONTH    CAP CATEGORY     CAP ERRORS     CAP PAID       PAID AMOUNT
-----------      ----    ---------    ------------    ------------   -----------    --------------
XXXXXXXXX X      XXXX    MM/CCYY        XXXXX         999,999,999    999,999,999    999,999,999.99
                                        XXXXX         999,999,999    999,999,999    999,999,999.99
MONTHLY TOTALS:                                       999,999,999    999,999,999    999,999,999.99

XXXXXXXXX X      XXXX    MM/CCYY        XXXXX         999,999,999    999,999,999    999,999,999.99
                                        XXXXX         999,999,999    999,999,999    999,999,999.99
MONTHLY TOTALS:                                       999,999,999    999,999,999    999,999,999.99

                                                     End Of Report
```

5.1.39.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
(PMP Service Location)	The PMP's service location code.	1	Character	T_PMP_SVC_LOC	CDE_SVC_LOC
CAP CATEGORY	Code associated with a capitation category.	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL
CAP ERRORS	Number of capitations that were attempted but had errors.	9	Number (Integer)	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
CAP MONTH	Capitation payment month.	7	Date (MM/CCYY)	N/A	CALCULATED
CAP PAID	Number of capitations that were paid.	9	Number (Integer)	N/A	CALCULATED
MONTHLY TOTALS	Number of capitation errors for the month.	9	Number (Integer)	N/A	CALCULATED
MONTHLY TOTALS	Number of paid capitations for the month.	9	Number (Integer)	N/A	CALCULATED
MONTHLY TOTALS	Amount of paid capitations for the month.	11	Number (Decimal)	N/A	CALCULATED
PAID AMOUNT	Sum of capitation payment amounts for paid capitations.	11	Number (Decimal)	N/A	CALCULATED
PMP ID	The ID number of the PMP.	9	Character	T_PR_PROV	ID_PROVIDER
SITE	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER

5.1.39.5 Associated Programs

Program	Description
mgd0490m	Capitation Payment Detail - PMP

5.1.40 MGD-X500-M -- Cap Payment Listing

This report lists all capitations processed for the month for each program provider. Total counts for paid and errored capitations are calculated and printed on the report along with the total paid amount. The report is run during each of the capitation cycles. Four versions of this report will be produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.40.1 Technical Name

MGD-X500-M

5.1.40.2 Sort Order

PMP, Site, Member ID

5.1.40.3 Cap Payment Listing Layout

```
Report  : MGD-X500-M                    COMMONWEALTH OF KENTUCKY                          Run Date: MM/DD/CCYY
Process : MGDJM610                MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time: 99:99:99
Location: MGD0500M                          CAP PAYMENT LISTING                               Page: 9999

PMP Identification Number: XXXXXXXXXX
Site: XXXX

MEMBER ID          MEMBER NAME                          EFF DATE     END DATE     CAPITATION        AMOUNT
                                                                                   CATEGORY          PAID
XXXXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY     XXXXX       99999999.99
XXXXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY     XXXXX       99999999.99
XXXXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY     XXXXX       99999999.99

TOTAL PAID CAPITATIONS: 999,999,999   TOTAL ERROR CAPITATIONS: 999,999   TOTAL PAYMENT AMOUNT: 999,999,999.99

PMP Identification Number: XXXXXXXXXX
Site: XXXX

MEMBER ID          MEMBER NAME                          EFF DATE     END DATE     CAPITATION        AMOUNT
                                                                                   CATEGORY          PAID
XXXXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY     XXXXX       99999999.99
XXXXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY     XXXXX       99999999.99
XXXXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY     XXXXX       99999999.99

TOTAL PAID CAPITATIONS: 999,999,999   TOTAL ERROR CAPITATIONS: 999,999   TOTAL PAYMENT AMOUNT: 999,999,999.99

                                              End Of Report
```

5.1.40.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
AMOUNT PAID	Capitation amount paid for the member PMP	11	Decimal	T_CAPITATION_HIST	AMT_CAP_PAID
CAPITATION CATEGORY	Capitation payment category code	5	Character	T_MC_RATE_CELL	CDE_RATE_CELL
EFF DATE	Effective date with PMP	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_EFFECTIVE
END DATE	End date with PMP	10	Date (MM/DD/CCYY)	T_RE_PMP_ASSIGN	DTE_END
MEMBER ID	Member's Medicaid ID number	12	Character	T_RE_BASE	ID_MEDICAID
MEMBER NAME	Name of the member	32	Character	T_RE_BASE	NAM_LAST+NAM_FIRST +NAM_MID_INIT
PMP ID	PMP identification number	10	Character	T_PR_PROV	ID_PROVIDER
SITE	The KenPAC site number - only present for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER
TOTAL ERROR CAPITATIONS	Total number of capitation errors for the PMP	7	Number	N/A	CALCULATED
TOTAL PAID CAPITATIONS	Total number of capitations for the PMP	11	Number	N/A	CALCULATED
TOTAL PAYMENT AMOUNT	Total amount paid to the PMP	14	Decimal	N/A	CALCULATED

5.1.40.5 Associated Programs

Program	Description
mgd0500m	Cap Payment Listing

5.1.41 MGD-X510-M -- Capitation Fee Payment Summary Analysis Provider Type

This report lists, by provider, summary totals for number capitations paid, and amount paid with subtotals by provider and report totals. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.41.1 Technical Name

MGD-X510-M

5.1.41.2 Sort Order

PMP ID, Site No., Cap Month

5.1.41.3 Capitation Fee Payment Summary Analysis Provider Type Layout

```
Report   : MGD-X510-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process  : MGDJM610                 MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time: 99:99:99
Location: MGD0510M            CAPITATION FEE PAYMENT SUMMARY ANALYSIS - PROVIDER TYPE     Page: 9999

                        PMP TYPE         SITE   CAP MONTH      CAP PAID       PAID AMOUNT
                        -------------    ----   ---------     -----------    --------------
                        XXXXXXXXXXXXX    XXXX    MM/CCYY      999,999,999    999,999,999.99

                                                MM/CCYY      999,999,999    999,999,999.99

                                                MM/CCYY      999,999,999    999,999,999.99

                        PMP TYPE TOTALS:                     999,999,999    999,999,999.99

                        XXXXXXXXXXXXX    XXXX    MM/CCYY      999,999,999    999,999,999.99

                                                MM/CCYY      999,999,999    999,999,999.99

                        PMP TYPE TOTALS:                     999,999,999    999,999,999.99

                        GRAND TOTALS:                        999,999,999    999,999,999.99

                                          End Of Report
```

5.1.41.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CAP MONTH	Capitation month	7	Date (MM/CCYY)	T_CAPITATION_HIST	DTE_CAPITATION
CAP PAID	Number of capitations for the month	11	Number	N/A	CALCULATED
GRAND TOTAL CAP PAID	Total number of capitations for all months and all provider types	11	Number	N/A	CALCULATED
GRAND TOTAL PAID AMOUNT	Total amount paid for all months and all provider types	14	Decimal	N/A	CALCULATED
PAID AMOUNT	Amount paid for the month	14	Decimal	N/A	CALCULATED
PMP TYPE	Description of PMP focus	13	Character	T_MC_PMP_FOCUS	DSC_PMP_FOCUS
PMP TYPE TOTALS CAP PAID	Total number of capitations from all months for the provider type	11	Number	N/A	CALCULATED
PMP TYPE TOTALS PAID AMOUNT	Total amount paid for all months for the provider type	14	Decimal	N/A	CALCULATED
SITE	The KenPAC site number - only for KenPAC providers, blank for other managed care providers.	4	Character	T_PMP_SVC_LOC_STATE	SITE_NUMBER

5.1.41.5 Associated Programs

Program	Description
mgd0510m	Capitation Fee Payment Summary Analysis Provider Type

5.1.42 MGD-X520-M -- Capitation Fee Payment Summary Analysis Month

This report details capitation and administrative fee summary totals by capitation month. The report is run during each of the capitation cycles. Four versions of this report are produced - one for KenPAC, one for Partnership, one for Lock-In, and one for Non-Emergency Medical Transportation.

5.1.42.1 Technical Name

MGD-X520-M

5.1.42.2 Sort Order

Cap Month (descending order)

5.1.42.3 Capitation Fee Payment Summary Analysis Month Layout

```
Report   : MGD-X520-M                    COMMONWEALTH OF KENTUCKY                    Run Date: MM/DD/CCYY
Process  : MGDJM610                 MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time: 99:99:99
Location: MGD0520M              CAPITATION FEE PAYMENT SUMMARY ANALYSIS - MONTH          Page: 9999

                          CAP MONTH        CAP PAID       PAID AMOUNT
                          ---------       -----------    --------------
                          MM/CCYY         999,999,999    999,999,999.99

                          MM/CCYY         999,999,999    999,999,999.99

                          MM/CCYY         999,999,999    999,999,999.99

                          MM/CCYY         999,999,999    999,999,999.99

                GRAND TOTALS:             999,999,999    999,999,999.99

                                          End Of Report
```

5.1.42.4 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
CAP MONTH	Capitation month	7	Date (MM/CCYY)	T_CAPITATION_HIST	DTE_CAPITATION
CAP PAID	Number of capitations paid for the month	11	Number	N/A	CALCULATED

Field	Description	Length	Data Type	DB Table	DB Attributes
GRAND TOTALS CAP PAID	Total number of capitations from all months	11	Number	N/A	CALCULATED
GRAND TOTALS PAID AMOUNT	Total amount paid across all months	14	Number (Decimal)	N/A	CALCULATED
PAID AMOUNT	Amount paid for the month	14	Number (Decimal)	N/A	CALCULATED

5.1.42.5 Associated Programs

Program	Description
mgd0520m	Capitation Fee Payment Summary Analysis Month

6 Letters

6.1.1 MGD-9001-M -- PCP Default Letter

Letter to inform the member that a PCP has been chosen for them.

6.1.1.1 Technical Name

MGD-9001-M

6.1.1.2 Layout

Letter Date
Case Number

Member Name
Member Address
Member City, State, Zip

KenPAC Notice – We Have Picked a Primary Care Provider (PCP) For You

We asked you to pick a KenPAC primary care provider (PCP). You did not pick a PCP. Here is the PCP we picked for you:

KenPAC PCP	Phone
Site Name *Site Address* *Site City, State, Zip*	*Site Phone*

Call the PCP when you need medical care, unless it is an emergency. Take your medical card to all appointments. If you do not, you may have to pay for your care.

You may change your PCP in the next 90 days without a reason. You can also change your PCP when you renew your benefits. If you have a reason to change your PCP at any other time, call your worker.

Need help? Have questions? Please contact Member Services at (877) 298-6108.

If you want legal help, call your lawyer. You may be able to get free legal help from your local legal aid office at (866) 452-9243.

6.1.1.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Case Number	Uniquely identifies a Medicaid case.	12	Character	T_RE_CASE	NUM_CASE
Letter Date	Date the letter was created.	18	Date (MM/DD/CCYY)		
Member Address	The mailing address of the member.	30	Character	T_RE_BASE	ADR_STREET1
Member City, State, Zip	Member city state and zip, 2 digit state and 9 digit zip.	29	Character	T_RE_BASE	ADR_CITY, ADR_STATE, ADR_ZIP_CO
Member Name	The name of the member.	50	Character	T_RE_BASE	NAM_LAST, NAM_FIRST, NAME_MID_IN

Field	Description	Length	Data Type	DB Table	DB Attributes
Site Address	The KenPAC site address.	30	Character	T_PMP_SVC_LOC_STATE	ADR_SITE_STRT1
Site City, State, Zip	Site city state and zip, 2 digit state and 9 digit zip.	28	Character	T_PMP_SVC_LOC_STATE	ADR_SITE_CITY, ADR_SITE_ST,ZIP
Site Name	The name of the KenPAC site.	50	Character	T_PMP_SVC_LOC_STATE	NAM_SITE
Site Phone	The phone number of the KenPAC site.	10	Character	T_PMP_SVC_LOC	NUM_PHO_24_HOUR

6.1.1.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.2 MGD-9002-M -- Member Moved Letter

Letter to inform the member that they must choose a new PCP since the member has moved from one county to another.

6.1.2.1 Technical Name

MGD-9002-M

6.1.2.2 Layout

Letter Date
Case Number

Member Name
Member Address
Member City, State, Zip

KenPAC Notice – You Moved, Pick a New Primary Care Provider (PCP)

You need to pick a new KenPAC primary care provider (PCP). You have moved to a county not covered by the PCP you have now. You have 10 days to pick a new PCP.

If you do not pick a PCP within 10 days, we will pick one for you. If no PCP is available, you will get a regular medical card.

Who can be a PCP?

- A family doctor, pediatrician, generalist, internist, or OB/GYN;
- A nurse practitioner; or
- A physician assistant who works in a primary care center or rural health center.

To pick a PCP, please contact member services at 877-298-6108.

6.1.2.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Case Number	Uniquely identifies a Medicaid case.	12	Character	T_RE_CASE	NUM_CASE
Letter Date	Date the letter was created.	18	Date (MM/DD/CCYY)		
Member Address	The mailing address of the member.	30	Character	T_RE_BASE	ADR_STREET1
Member City, State, Zip	Member city state and zip, 2 digit state and 9 digit zip.	29	Character	T_RE_BASE	ADR_CITY, ADR_STATE, ADR_ZIP_CO
Member Name	The name of the member.	50	Character	T_RE_BASE	NAM_LAST, NAM_FIRST, NAME_MID_IN

6.1.2.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.3 MGD-9003-M -- LI Removal (MBR) Letter

Letter to inform member that he/she is no longer enrolled in the Lock-in program.

6.1.3.1 Technical Name

MGD-9003-M

6.1.3.2 Layout

Date

Member Name
Address
City, State, Zip

Dear Member,

Your Lock-in medical services/claims over the past year have been reviewed. Your assigned primary care physician (PCP) and the Department for Medicaid Services Chief Medical Director have determined that **you no longer need to be enrolled in the Lock-In Program**.

Because you have experienced some problems with overuse or misutilization of medical services in the past, we will review your claims every six months for the next year. It is important that you continue to use your primary care physician (PCP) for your medical needs and/or referrals to other medical providers. Should a pattern of abuse or inappropriate use of the Kentucky Medicaid Program occur, you will again be considered for the Lock-In program.

Examples of inappropriate utilization of Kentucky Medicaid Services may include but are not limited to: inappropriate or excessive doctor visits, drug utilization, hospital admissions and/or emergency room services. In the event of an emergency, members are not limited by the program from seeking appropriate and necessary medical care.

We appreciate your compliance. With your assistance, the ultimate goal of the Kentucky Medicaid Program will be realized: To supply all citizens of Kentucky the appropriate and necessary medical care they cannot afford themselves.

If you have any questions, please contact Member Services at (877) 298-6108.

Sincerely,
Lock-In Case Manager

Electronic Data Systems * P.O. Box 5350 * Frankfort, KY 40601

LL6

6.1.3.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Letter Date	Date the letter was created.	18	Date (MM/DD/CCYY)		
Member Address	The mailing address of the member.	30	Character	T_RE_BASE	ADR_STREET1
Member City, State, Zip	Member city state and zip, 2 digit state and 9 digit zip.	29	Character	T_RE_BASE	ADR_CITY, ADR_STATE, ADR_ZIP_CO
Member Name	The name of the member.	50	Character	T_RE_BASE	NAM_LAST, NAM_FIRST, NAME_MID_IN

6.1.3.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.4 MGD-9004-M -- LI PCP Assignment Letter

Letter informing a member that they have been assigned to a medical Lock-In provider.

6.1.4.1 Technical Name

MGD-9004-M

6.1.4.2 Layout

Date

Member Name
Address
City, State, Zip

Dear Member, MAID#########

The Department for Medicaid Services has enrolled you into the Lock-in Program and assigned you the following Primary Care Physician (PCP) and Pharmacy. These providers **must** be used when medical care or prescriptions are required. Your Medicaid card should be presented to your PCP or pharmacy each time medical care is requested.

Physician (PCP) *******

Pharmacy **You are locked in to this location, you may not have your prescriptions filled by other ****Pharmacy Chain name.**

Pharmacy Name
Pharmacy address
City, State, Zip

If you have any questions regarding the Lock-In program you may contact Member Services at (877) 209-6108.

Sincerely,

Lock-In Case Manager

Electronic Data Systems *P.O. Box 5350* Frankfort, KY 40601

LL3

6.1.4.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Letter Date	Date the letter was created.	18	Date (MM/DD/CCYY)		
MAID#	Uniquely identifies a Medicaid case.	12	Character	T_RE_CASE	NUM_CASE
Member City, State, Zip	Member city state and zip, 2 digit state and 9 digit zip.	29	Character	T_RE_BASE	ADR_CITY, ADR_STATE, ADR_ZIP_CO
Member Name	The name of the member.	50	Character	T_RE_BASE	NAM_LAST, NAM_FIRST, NAME_MID_IN

Field	Description	Length	Data Type	DB Table	DB Attributes
Member Street Address	The mailing address of the member.	30	Character	T_RE_BASE	ADR_STREET1

6.1.4.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.5 MGD-9103-M -- Choose a PCP Letter

Letter to inform a member that they must choose a PCP.

6.1.5.1 Technical Name

MGD-9103-M

6.1.5.2 Layout

Letter Date
Case Number

Member Name
Member Address
Member City, State, Zip

KenPAC Notice – It's Time to Pick a Primary Care Provider (PCP)

You are now in the KenPAC program. In KenPAC, you must have a primary care provider (PCP) to manage your medical care. You have 10 days to pick a PCP.

If you do not pick a PCP within 10 days, we will pick one for you. If no PCP is available, you will get a regular medical card.

Who can be a PCP?

- A family doctor, pediatrician, generalist, internist, or OB/GYN;
- A nurse practitioner; or
- A physician assistant who works in a primary care center or rural health center.

You can pick a PCP in the county where you live or a KenPAC county next to it.

To pick a PCP, please contact Member Services at (877) 298-6108.

6.1.5.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Case Number	Uniquely identifies a Medicaid case.	12	Character	T_RE_CASE	NUM_CASE
Letter Date	Date the letter was created.	18	Date (MM/DD/CCYY)		
Member Address	The mailing address of the member.	30	Character	T_RE_BASE	ADR_STREET1
Member City, State, Zip	Member city state and zip, two digit state and nine digit zip.	29	Character	T_RE_BASE	ADR_CITY, ADR_STATE, ADR_ZIP_CO
Member Name	The name of the member.	50	Character	T_RE_BASE	NAM_LAST, NAM_FIRST, NAME_MID_IN

6.1.5.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.6 MGD-9104-M -- PCP No Longer Participating Letter

This letter informs the member that their PCP is no longer available to provide medical services and directs the member to choose a new PCP.

6.1.6.1 Technical Name

MGD-9104-M

6.1.6.2 Layout

Letter Date
Case Number

Member Name
Member Address
Member City, State, Zip

KenPAC Notice – It's Time to Pick a New Primary Care Provider (PCP)

Your KenPAC primary care provider (PCP) will no longer provide medical care for:

Member Name

You have 10 days to pick a new PCP.

If you do not pick a PCP within 10 days, we will pick one for you. If no PCP is available, you will get a regular medical card.

Who can be a PCP?

- A family doctor, pediatrician, generalist, internist, or OB/GYN;
- A nurse practitioner; or
- A physician assistant who works in a primary care center or rural health center.

You can pick a PCP in the county where you live or a KenPAC county next to it.

To pick a PCP, please contact Member Services at (877) 298-6108.

6.1.6.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Case Number	Uniquely identifies a Medicaid case - grouping of members.	12	Character	T_RE_CASE	NUM_CASE
Letter Date	Date the letter was created.	18	Date (MM/DD/CCYY)		
Member Address	The mailing address of the member.	30	Character	T_RE_BASE	ADR_STREET1

Field	Description	Length	Data Type	DB Table	DB Attributes
Member City, State, Zip	Member city state and zip, two digit state and nine digit zip.	29	Character	T_RE_BASE	ADR_CITY, ADR_STATE, ADR_ZIP_CO
Member Name 1	The Name of the Member.	50	Character	T_RE_BASE	NAM_LAST, NAM_FIRST, NAME_MID_IN
Member Name 2	KenPAC primary care provider (PCP) will no longer provide medical care for this Name of the Member.	50	Character	T_RE_BASE	NAM_LAST, NAM_FIRST, NAME_MID_IN

6.1.6.4 Associated Programs

Program	Description
No associated Programs found.	

6.1.7 MGD-9105-M -- Disenrolled Still Eligible Letter

The letter informs member that they have been disenrolled from KenPAC but they are still eligible for Medicaid.

6.1.7.1 Technical Name

MGD-9105-M

6.1.7.2 Layout

Letter Date
Case Number

Member Name
Member Address
Member City, State, Zip

KenPAC Notice

You no longer need to have a KenPAC primary care provider (PCP). You will get a regular blue medical card instead of a KenPAC card. You still have the same medical coverage.

Need help? Have questions? Please contact member services at 877-298-6108.

If you want legal help, call your lawyer. You may be able to get free legal help from your local legal aid office at 800-928-4556.

6.1.7.3 Field Descriptions

Field	Description	Length	Data Type	DB Table	DB Attributes
Case Number	Uniquely identifies a Medicaid case.	12	Character	T_RE_CASE	NUM_CASE
Letter Date	Date the letter was created.	18	Date (MM/DD/CCYY)		
Member Address	The mailing address of the member.	30	Character	T_RE_BASE	ADR_STREET 1
Member City, State, Zip	Member city state and zip, two digit state and nine digit zip.	29	Character	T_RE_BASE	ADR_CITY, ADR_STATE, ADR_ZIP_CO
Member Name	The name of the member.	50	Character	T_RE_BASE	NAM_LAST, NAM_FIRST, NAME_MID_IN

6.1.7.4 Associated Programs

Program	Description
No associated Programs found.	

7 Glossary of Terms and Acronyms

7.1 Terms and Acronyms

270/271 **Eligibility/Benefit Inquiry/Response – The Eligibility and Benefit transactions are designed so that inquiry submitters (information receivers) can determine: a) whether an information source organization (e.g., payer, employer, HMO) has a particular subscriber or dependent on file, and b) the health care eligibility and/or benefit information about that subscriber and/or dependent(s). The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use. The information source organization may provide information about other organizations that may have third party liability for coordination of benefits. These are x-12 transactions mandated by HIPAA regulations.**

276/277 Claim Status Request/Claim Status Response – The 276 and 277 transaction sets are intended to meet specific needs of the health care industry. The 276 is used to request the current status of a specified claim(s). The 277 transaction set can be used as the following: a) a solicited response to a health care claim status request (276), b) a notification about health care claim(s) status, including front end acknowledgments, or c) a request for additional information about a health care claim(s). The 276 is used only in conjunction with the 277 Health Care Claim Status Response. These are x-12 transactions mandated by HIPAA regulations.

277 Unsolicited Claim Status – The Unsolicited Claim Status (277) transaction set can be used to transmit an unsolicited notification about a health care claim status. This is an x-12 transaction mandated by HIPAA regulations.

820 Premium Payment – The 820 can be used by premium remitters to report premium payment remittance information, as well as premium payment to a premium receiver. The premium remitter can be: a) an employer-operated internal department or an outside agency which performs payroll processing on behalf of an employer, b) a government agency paying health care premiums, or c) an employer paying group premiums. The premium receiver can be either an insurance company, a government agency, or a health care organization. The 820 can be sent from the premium remitter to the premium receiver either directly, through a VAN, or through a financial institution using an ACH (Automated Clearing House) Network to facilitate both the remittance and dollars movement. This is an x-12 transaction mandated by HIPAA regulations.

834 Enrollment/Maintenance – The 834 is used to transfer enrollment information from the sponsor, the party that ultimately pays for the coverage, benefit, or policy to a payer, the party that pays claims and/or administers the insurance coverage, benefit, or product. This is an x-12 transaction mandated by HIPAA regulations.

835 Payment Advice – The 835 contains information about the payee, the payer, the amount, and any identifying information of the payment. In addition, the 835 can authorize a payee to have a DFI (Depository Financial Institutions) take funds from the payer's account and transfer those funds to the payee's account. This is an x-12 transaction mandated by HIPAA regulations.

837 Dental/Professional/ Institutional Claim – The Claims/Encounters (837) is intended to originate with the health care provider or the health care provider's designated agent. The 837 provides all necessary information to allow the destination payer to at least begin to adjudicate the claim. The 837 coordinates with a variety of other transactions including, but not limited to, the following: Claim Status (277), Remittance Advice (835), and Functional Acknowledgment (997). This is an x-12 transaction mandated by HIPAA regulations

997 Functional Acknowledgement – The Functional Acknowledgement is generated by the receiver of an 837 and is used to notify the sender that the acknowledged transaction has been: a) accepted, b) rejected, c) accepted with errors, or d) partially accepted. This is an x-12 transaction mandated by HIPAA regulations.

7.1.1 A

ABANDONED CALL	**A call is considered abandoned if the caller is connected to the system but hangs up before being connected with an agent or informational announcement. Also known as a lost call.**
ABR	Automatic Backup and Recovery
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	A lump sum payment made upon the loss of life of an insured as a direct cause of an accident or upon the accidental loss of a limb or sight of an insured.
ACCOMMODATION	A hospital room with one or more beds.
ACCOMMODATION CHARGE	A Charge billed on inpatient hospital claims for bed, board, and nursing care (revenue codes 100-219).
ACCOUNTS RECEIVABLES (AR, A/R)	Money owed to the State by a provider, beneficiary, insurance company, drug manufacturer, etc.
ACCRETION	A process that occurs when a beneficiary is eligible for coverage under both Medicaid and Medicare. Medicaid pays the beneficiary's Medicare premium, thus buying into the Medicare Program.
ACG	Ambulatory Care Grouper
ACTUAL CHARGE	A Charge made by a physician or other supplier of medical services and used in the determination of reasonable Charges.
AD HOC REQUEST	A request to provide non-production support. This support may be in the form of one-time updates to production files or the creation of specific one-time or as needed output reports.

ADA	Americans with Disabilities Act
ADC	Adult Day Care
ADJUDICATE (CLAIM)	The adjudication process occurs during claims processing to determine the disposition of a claim (paid or denied). A claim passes through all the edit and audit criteria until it is determined whether all program requirements have been met and whether the claim is to be paid or denied.
ADJUSTMENT (ADJ)	A change made to a previously processed claim that is not in denied status by correcting underpayments, overpayments, or history. Adjustments also include capitation correction of a payment or credit to capitation. The provider, contractor, or State can submit adjustments.
ADJUDICATION CYCLE	This cycle refers to the daily, or daily/weekly claims processing cycles that are known as the system processing of claims to the point where a decision has been made to pay, deny, or suspend the claim.
ADJUSTED CLAIM	A previously paid claim that has undergone data modification. The need to adjust a claim may result from data entry errors, billing errors, file updates, or program logic modifications. (See Adjustment.)
ADJUSTMENT PROCESSING	A batch process that sends a file of adjustment request records to the Financial Subsystem for incorporation into the claims processing cycle.
ADJUSTMENT REASON CODES (PRIMARY AND SECONDARY)	The adjustment reason codes specify why the initial adjustment took place, whereas the secondary adjustment reason indicates the second adjustment occurrence on a claim. These codes are also known as the primary reason and the secondary adjustment reason.
ADMISSION	The first day on which a patient is furnished inpatient hospital or extended care services by a qualified provider.
ADR	Address

Advanced Registered Nurse Practitioner (ARNP)	A registered nurse with specialized training in advanced nursing skills.
AG	Attorney General
AGGREGATE	A collection of data at the summary level.
AHA	American Hospital Association
AID CATEGORY	Program category under which a member can be eligible for Medicaid.
Aid to Families with Dependent Children (AFDC)	A welfare program funded by federal and State dollars that provides cash and Medicaid benefits to families with at least one child where one or both parents are absent, deceased, or incapacitated.
AIDS	Acquired Immune-Deficiency Syndrome
ALLOWABLE AMOUNT	The maximum dollar amount assigned for a particular procedure based on various pricing mechanisms. Medicaid reimburses hospitals for certain, but not all costs. Excluded costs include non-covered services, luxury accommodations, and unnecessary and unreasonable costs.
ALLOWED AMOUNT	The amount billed for a medical service or the amount determined payable by the State, whichever is the lesser figure.
ALPHANUMERIC	The use of alphabetic letters mixed with numbers and special Characters as in name, address, city, and state.
ALS	Advanced Life Support
AMERICAN DENTAL ASSOCIATION (ADA)	The national professional association for dentists.

AMERICAN MEDICAL ASSOCIATION (AMA)	The national professional association of physicians. This organization publishes the highly utilized CPT-4 books.
AMERICAN NATIONAL STANDARDS INSTITUTE (ANSI)	In computer programming, ANSI most often denotes the standard versions of C, FORTRAN, COBOL, or other programming languages. ANSI-standard escape sequences control computer screens; whereas ANSI extended Character set used in Microsoft's Windows products includes all of the ASCII Characters.
AMERICAN STANDARD CODE FOR INFORMATION INTERCHANGE (ASCII)	The most popular coding method used by small computers for converting letters, numbers, punctuation and control codes into digital form. Once defined, ASCII Characters can be recognized and understood by other computers and by communications devices. ASCII represents Characters, numbers, punctuation marks or signals in seven on-off bits. Capital "C", for example, is 1000011, while "3" is 0110011. This compatible coding allows all PCs to talk to each other, if they use a compatible modem or null modem cable and transmit and receive at the same speed (Imaging).
ANCILLARY CHARGE	A Charge used only in institutional claims for any item except hospital and doctor fees (examples include drug, laboratory, and x-ray Charges).
ARCHIVE	A copy of data on disks, CD-ROM, magnetic tape, etc., for long-term storage and later possible access. Archived files are often compressed to save storage space (Imaging).
AS OF DATE	Based on parameters entered, the date of the cycle run.
ASC	Ambulatory Surgical Center
ASSIGNED CLAIM	A claim for which the provider of service has agreed to accept the program allowed Charge as payment in full without recourse to the patient, except for coinsurance or deductible amounts.

ASSIGNMENT When a provider accepts the maximum allowable Charge offered for a given procedure under the Medicare Program, it is said that this person accepts assignment. The provider has waived the right to bill the beneficiary for the difference between what Medicare pays and what the provider usually Charges for a fee. The term assignment is not related to the administration of the Medicaid Program except that some Medicaid agencies treat crossover claims differently depending upon whether or not the provider accepts assignment.

ATTACHMENT Attachments may accompany claims to provide additional claim-related information for which no field is specified on the corresponding claim form, or when the specified field is not adequate to submit the required information.

AUDIT Limitations applied to specific procedures, diagnoses or other data elements after editing and validation of the claim to ensure conformity and consistency of claim payment.

AUTHENTICATION A query method that ensues that both the sender and receiver of an electronic message are valid and are authorized to transmit and receive messages.

AUTO ASSIGNMENT An automated process used to make 'intelligent' Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord.

AUTOMATED VOICE RESPONSE SYSTEM (AVRS) This is the machine and the application that enable users to access KY Medicaid information by using a touch-tone telephone.

AUTOMATIC RECOUPMENT Automatic recoupment occurs when an A/R with a credit balance has recoupments applied to it by adjustments or new-day claims. Money is recouped only through the payment process, which is automatic, and cannot be posted online with a refund.

7.1.2 B

BACKUP	**Duplicate copy of data placed in a separate, safe place - electronic storage, on a tape, on a disk, in a vault - to guard against total loss in the event the original data somehow become inaccessible. Generally for short-term safety. Contrast with archive, which is a filed-away record of data meant to be maintained a long time, in the event of future reference. (Imaging)**
BALANCED BUDGET ACT OF 1997 (BBA)	Federal legislation enacted in 1997 that gave beneficiaries certain rights related to Managed Care enrollment and disenrollment. Most significant changes in the Medicaid/Medicare Program since their inception. Provides for state option to use Managed Care. Provides that an MMIS must be compatible with Medicare claims processing and must, after January 1, 1999, transmit data in a format consistent with the Medicaid Statistical Information System (MSIS).
BATCH	A set of claims.
BENEFICIARY DATA EXCHANGE SYSTEM (BENDEX)	An interface system between the Commonwealth of Kentucky and Social Security Administration that provides Social Security beneficiary information. Information includes eligibility for benefits as well as Medicare Part A and Part B entitlement and eligibility information.
BENEFIT PERIOD	The period of time a health plan will pay for covered benefits.
BENEFIT PLAN	A group of covered services (benefits) that are granted to a beneficiary who is deemed eligible for the program the benefit plan represents.
BENEFITS	A schedule of health care service coverage that an eligible KY Medicaid member receives for the treatment of illness, injury, or other conditions allowed under the State Plan.
BILLED AMOUNT	The billed amount is the dollar figure submitted by a provider for medical services rendered.

BILLING PROVIDER The provider who will receive payment (if a group/clinic number is present, it would be the "Billing Provider"

BIN Bank Identification Number

BITMAP Representation of Characters or graphics by individual pixels, or points of light, dark or color, arranged in row (horizontal) and column (vertical) order. Each pixel is represented by either one bit (simple black and white) or up to 32 bits (fancy high definition color). (Imaging)

BLS Basic Life Support

BUNDLED CHARGES Charges that are combined together or represent a flat rate such as in capitated reimbursed where there would be a specified fee for a service. In an example of a surgery procedure, the bundled Charges would include supplies, surgery Charges, anesthesia Charges, recovery, etc. In contrast, unbundled Charges would be separate Charges for each entity.

BUY-IN Procedure whereby states pay a monthly premium to the Social Security Administration on behalf of Medicaid beneficiaries, enrolling them in Medicare Title XVIII Part A, Part B and/or Part D program.

BUY-IN DATA MAINTENANCE Medicaid beneficiaries who are entitled to receive Medicare benefits may have Medicare premiums paid by the State. This is known as Medicare buy-in. Automated data exchanges between HP Enterprise Services and the Centers for Medicare and Medicaid Services (CMS), are conducted monthly to identify, update, resolve differences, and monitor new and ongoing Medicare buy-in cases. The State is responsible for initiating Medicare buy-in for eligible members. Because Medicare is usually primary to the State, payment of Medicare premiums, coinsurance, and deductibles costs the State less than paying the entire cost of medical care for a beneficiary. In addition, the State receives Federal Financial Participation (FFP) for premiums paid on behalf of members eligible as Qualified Medicare Beneficiaries (QMB), Qualified Disabled Working Individual (QWSI), Specified Low Income Medicare Beneficiaries (SLMB), and Cash Assistance beneficiaries (Supplemental Security Income (SSI) and cash assistance from Temporary Assistance for Families (TAF).

BYTE Common unit of computer storage. A byte is eight bits of information, one of which may be a parity bit. Generally, eight bits equals one Character. Also called 'octet'. (Imaging)

7.1.3 C

CACHE	**(Pronounced "cash") Small portion of high-speed memory used for temporary storage of frequently used data. Reduces the time it would take to access that data, since it no longer has to be retrieved from the disk. (Imaging)**
CAPITATION	A specified amount paid periodically to a health care provider for a group of specified health care services regardless of quantity rendered. A fee is paid per person. Capitation fees are paid for each enrollee, regardless of whether an enrollee actually received a service. The use of capitation separated the payment process from the claims submission process. Encounter claims are submitted for historical data, not for payment. Also known as capitation payment or rate.
CAPITATION RATE	The payment of a fixed dollar amount, per person, for the provision of a defined set of health services to a defined population for a specified period of time (e.g. one month). Capitation is a fixed revenue system that pays the same amount each month no matter how many or how few services are actually provided.
CARRIER	A carrier refers to a private insurance company.
CASE	A file opened at the DCBS office when an individual applies for government assistance.
CASE MANAGEMENT/MANAGER	Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost-effective manner.
CASE MIX INDEX	A numeric score with a specific range that identifies the relative resources used by a particular group of residents and represents the average resource consumption across a population or sample.
CASE NUMBER	The number assigned to each Medicaid case opened by DCBS.

CASH CONTROL NUMBER (CCN)	This is the unique number assigned to a Cash Receipt.
CATEGORICALLY NEEDY	Individuals certified by the state welfare agency as being low income and thus being eligible for Medicaid benefits. A person is categorically needy and may receive assistance if that person's income and resources do not exceed the categorically needy maximums and they fit into one of six categories: Age 65, Blind, Disabled, Families with dependent children (TANF), Pregnant, Incapacitated. A person must still meet various other criteria (categorical relationship, citizenship etc.) before receiving Medicaid payments from the Commonwealth of Kentucky. This applies to all cases. Individuals whose income and resources are in excess of the maximums but still cannot pay their medical expenses are considered medically needy. However, to receive aid, the client must still fall into one of the six) categories.
CATEGORY OF SERVICE (CAT OF SRVC, COS)	The type of service that a provider renders. An indication of the general classification of the procedures performed. Examples include: inpatient hospital, outpatient hospital, skilled nursing facility, hospice, prescribed drugs, physician care, dental care, transportation, family planning services, therapy services, and crossover.
CCN	Cash Control Number
CDC	Centers for Disease Control
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	The agency within the U.S. Department of Health and Human Services responsible for administering Title XIX and Title XXI of the Social Security Act. With the help of Health Resources and Services Admin, CMS also runs the Child Health Insurance program.
CENTRAL PROCESSING UNITY (CPU)	The computing part of the computer. Also called the processor, it is made up of the control unit and ALU.

CERTIFICATION A review by the U.S. Department of Health and Human Services/CMS of an operational MMIS, in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system and the ensuing certification resulted from a favorable review.

CERTIFICATION DATE An effective date specified in a written approval notice from CMS to the State when 75 percent federal financial participation (FFP) is authorized for the administrative costs of an MMIS.

CHANGE ORDER (CO) The documentation of a modification to the transfer system. A change order is not a modification of a requirement; it is the modification of the base system to meet an existing requirement.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) A classification given to children who require special health services. The classification comes through the Title V program.

CIVILIAN HEALTH AND MEDICAL PROGRAMS OF THE UNIFORMED SERVICES (CHAMPUS) The medical benefit program for military personnel or retirees and their dependents who exercise their option to obtain civilian medical treatment. CHAMPUS can be considered as a possible source for third-party coverage.

CLAIM The form required for providers to bill their services. Each claim is formatted into three levels of information: Header, Detail, and Trailer or Footer.

CLAIM ADJUSTMENT A claim adjustment is a modification to some part of the data of a previously paid claim. All adjustments will maintain an audit trail to deny adjustments to a previously adjusted claim. A message is displayed stating that the claim has already been adjusted or denied. (See Adjusted Claim)

CLAIM HISTORY All claims processed in the MMIS are kept available in the system and are referred to as being “in history.” The Kentucky MMIS adjustment process has access to 60 months of claims data plus a lifetime file.

CLAIM TYPE	Claim types indicate the classification of claims by origin or type of service provided to a beneficiary. In the MMIS, this is a user-defined data element that refers to the kind of service being billed. For example, common claim types are dental, pharmacy, transportation, nursing, EPSDT, physician, inpatient, etc. Outside of the MMIS, the term often refers to the invoice type, i.e., HCFA-1500, UB-92, etc. The invoice type could be the claim type in an MMIS, but because more than one type of service can be billed on an invoice, the term "claim type" is usually defined in more detail.
CLAIMS PROCESSING ASSESSMENT SYSTEM (CPAS)	A State-administered Medicaid quality-control program that serves as a management tool for examining and evaluating the accuracy of claims processing and payments.
CLERK ID	A code assigned to personnel involved with processing records in the MMIS claims processing system.
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)	A certification process done by CMS to ensure the proficiency of medical laboratories.
COINSURANCE **(also CO-INSURANCE)**	The dollar amount or percentage of the cost of medical care that a patient pays. The coinsurance or a percentage amount that will be paid by KY Medicaid if the beneficiary is eligible for Medicaid.
COMMON BUSINESS-ORIENTED LANGUAGE (COBOL)	A third generation computer language developed by the Federal Government and adopted by computer manufacturers in the 1960s. It is the most utilized language on mainframe business computers
COMMON GATEWAY INTERFACE (CGI)	One of the most common ways to add programs or scripting languages that execute on the server to your Web-based applications.
COMMON PROCEDURAL TERMINOLOGY (CPT)	A unique structure scheme for all medical procedures approved by the American Medical Association.

COMMUNITY MENTAL HEALTH CENTER (CMHC) A center that provides many services necessary for treatment of mental health conditions. Services include diagnostic evaluations, psychological testing, therapy (family, group, and individual), and medication checks.

COMPACT DISK (CD) A standard medium for storage of digital data in machine-readable form, accessible with a laser-based reader. CDs are 4-3/4 in diameter. CDs are faster and more accurate than magnetic tape for data storage: Faster, because even though data is generally written on a CD contiguously within each track, the tracks themselves are directly accessible. This means the tracks can be accessed and played back in any order. More accurate, because data is recorded directly into binary code; whereas magnetic tape requires data to be translated into analog form. In addition, extraneous noise (tape hiss) associated with magnetic tape is absent from CDs.

COMPACT DISK-READ ONLY MEMORY (CD-ROM) A data storage system using CDs as the medium. CD-ROMs hold more than 600 megabytes of data.

COMPUTER OUTPUT TO LASER DISK (COLD) A system that provides the ability to take output from a report program that often runs on a mainframe computer and makes the information useful without the use of paper.

CONSOLIDATION OF BENEFITS IN RETIREMENT ACT (COBRA) Cobra is a law that makes an employer let an employee remain covered under the employer's group health plan for a period of time after: the death of your spouse, losing your job, work hours reduction, or getting a divorce. The employee may have to pay both their share and the employer's share of the premium.

CONTACT TRACKING NUMBER (CTN) A unique number assigned in CTMS.

CONTRACTOR Successful bidder under an RFP or ITB. A person or organization from which the State contracts for products or service.

CONTRACT START DATE The date the Contract for Services requested by an RFP becomes effective.

CONTROLLED DRUGS / SCHEDULED DRUGS	Drugs that have a high potential for abuse. These are drugs classified as narcotics. There are five schedules, with Schedule I drugs being the most dangerous.
CONVERSION FACTOR	The factor used to convert units of service; applicable to drug claims being processed in Drug Rebate.
COORDINATION OF BENEFITS (COB)	When Medicaid and other primary insurance companies coordinate their benefits to ensure that beneficiaries/providers do not receive duplicate payments for a service.
COPAY/COPAYMENT **(also CO-PAY)**	A Charge the beneficiary is responsible for paying on selected procedures or services. It is the patient's responsibility to pay some fixed portion of the cost of the medical service received, while the insurer pays the remainder.
CONTACT TRACKING MAINTENANCE SYSTEM (CTMS)	This ancillary application provides a means of access and storage for all information associated with a customer service contact. All contact information is associated with an assigned CTN. This information includes contact type, demographic information, questions, resolutions, and contact reasons. HP Enterprise Services and DMS staff enter information for each contact through online windows. Search windows allow users to sort and access contacts based on a variety of criteria. Reports are available based on open dates, status, clerk IDs and department.
COS	Category of Service
COST AVOIDANCE	A claim may be denied when coverage exists and there is no indication that the carrier has been billed (cost avoided).
COST SHARING	Provisions of an insurance policy requiring the covered individual to pay some portion of covered medical expenses. Premium amounts are not included in cost sharing. Deductibles (a set amount paid before payment of benefits occurs), co-payments (a fixed amount paid for each service), and coinsurance (payment of a set portion of the cost per service), are forms of cost sharing.

COVERAGE CODE A system of letters or numbers assigned to the type of coverage provided by the third party carrier policy.

CLAIM CREDIT A financial transaction that reverses a previously paid claim to zero amount. A credit is entered in the MMIS just like a claim. A provider can request a credit if he has been paid for a service he did not perform. The State agency can also request a credit. It is one type of adjustment. Also known as Credit-Only Adjustment.

CRNA Certified Registered Nurse Anesthetist

CROSSOVER CLAIM If a beneficiary is eligible for both Medicare and Medicaid, the Medicare claim is automatically sent to Medicaid after the Medicare carrier processes it. The claim, in effect, crosses over from one system to the other via tapes or disks. It is important to know that Medicaid is considered the payer of last resort. Therefore, claims must always be sent to Medicare first when a beneficiary is eligible for both programs.

CROSS WALK A table used to relate one code to another code

CURRENT PROCEDURAL TERMINOLOGY, FOURTH EDITION (CPT-4) Contains procedure codes that are used by medical practitioners in billing for services rendered to Medicaid beneficiaries. The book is published by the American Medical Association. The CPT codes are also included as the Level One codes in the HCPCS list of codes.

CURSOR A highlighted mark on the screen that shows where the next Character you enter will appear.

CUSTOMARY CHARGE A dollar amount that represents the median Charge for a given service by an individual physician or supplier.

CUSTOMER INFORMATION CONTROL SYSTEM (CICS)

An IBM software system that provides the on-line user interface to MMIS data. This is the “front” end of the mainframe-based MMIS online system. CICS was originally developed to provide transaction processing for IBM mainframes. It controls the interaction between applications and users and lets programmers develop screen displays without detailed knowledge of the terminals used. It provides terminal routing, password security, transaction logging for error recovery and activity journals for performance analysis. CICS commands are written along with and into the source code of the applications, typically COBOL.

CUTBACK

A reduction in quantity or rate.

7.1.4 D

DATA ELEMENT DICTIONARY (DED)	**Describes the fields (data elements) within a database.**
DATA ENTRY	Entering data into the computer, which includes keyboard entry, scanning and voice recognition. When transactions are entered after the fact (batch data entry), they are just stacks of source documents to the keyboard operator. Deciphering poor handwriting from a source document is a judgment call that is often error prone.
DATA WAREHOUSE	The architecture that serves as the secondary storage area for a collection of data, both at a detailed and aggregated level. The EIS/DSS Data Warehouse is a collection of ORACLE tables that contain the data extracted from flat files generated from the Kentucky MMIS on a monthly basis.
DATABASE (DB)	Data that has been organized and structured in a disciplined fashion, so that access to information of interest is as quick as possible. Database management programs form the foundation for most document storage indexing systems. (Imaging)
DATABASE ADMINISTRATOR (DBA)	The person responsible for maintaining the database system: managing data, designing database objects, database performance and data recovery and integrity at a physical level. This person is not an applications programmer.
DATABASE TABLE	A collection of similar records in a database.
DATE OF SERVICE (DOS)	The date of service on a claim; the date the beneficiary received medical service.
DC	Doctor of Chiropractic
DD	Developmentally Disabled

DDE	Direct Data Entry
DDI	Design, development, and implementation.
DDS	Doctor of Dentistry
DECISION SUPPORT SYSTEM (DSS)	The Decision Support System (DSS) function provides access to the MMIS data and various external data sources. The data is stored in an Oracle RDBMS and is accessed through the Business Objects application. A computer program application that analyzes and presents business data in a form that assists users in making business decisions more easily. It is an informational ad-hoc reporting application, not an operational one. A DSS may present information graphically and may include an expert system or artificial intelligence.
DECOMPRESS	To reverse the procedure conducted by compression software, and thereby return compressed data to its original size and condition. (Imaging)
DEDUCTIBLE	The out-of-pocket expense a beneficiary must pay before other third party will begin payment for covered medical expenses, usually based on a calendar year. This amount, or a percentage thereof, is paid by Medicaid for beneficiaries also eligible for Medicaid.
DEFAULT	An automated process used to make random Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord or were not assigned through auto assignment.
DEFENSE ENROLLMENT AND ELIGIBILITY REPORTING SYSTEM (DEERS)	A system that contains eligibility information on CHAMPUS, the insurance company for military dependents.
DELIMITER	A special Character used to separate fields of data. The three used in an EDI file are the segment delimiter, the element delimiter, and the sub-element delimiter.

DENIED CLAIM Claim for services not paid by KY Medicaid, including services provided to an ineligible member, services provided by an ineligible provider, or services not billed in the correct manner.

DENY Claim denial.

DETAIL (DTL) A term that refers to the actual health care service provided to a member, billed on a claim form as the only service or possibly as one of several services provided. This is frequently called a line item or detail line.

DETAILED SYSTEM DESIGN (DSD) Document created by the Fiscal Agent as a detailed guide to developing a new system or subsystem.

DIAGNOSIS CODE (DIAG, DX) The medical classification of a disease or condition according to ICD-9-CM or HCPCS.

A numeric code that identifies the patient's condition as determined by the provider of the performed service.

DIAGNOSIS-RELATED GROUP (DRG) DRGs are the basis for one type of hospital reimbursement. A hospital specific fee is calculated for each diagnosis group for each hospital. Factors of age, sex, length of stay data, and historical costs for each hospital are taken into consideration in calculating the reimbursement amount. Usually, mental institutions and pediatric hospitals are excluded from DRG reimbursement due to the abnormal length of stay experienced by most patients.

DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS, THIRD EDITION, REVISED (DSM III) A publication of the American Psychiatric Association establishing a coding system for mental diagnoses.

DISABILITY A physical or mental condition that makes an insured incapable of performing one or more duties of his occupation or any occupation.

DISABILITY BENEFIT	A payment that arises because of the total and/or permanent disability of an insured; a provision added to a policy that provides for a waiver of premium in case of total and permanent disability.
DISABILITY DETERMINATION SERVICES (DDS)	A division of SRS that contracts with the Social Security Administration to determine the disability status of Social Security Disability applicants.
DISABILITY INCOME INSURANCE	A form of health insurance that provides periodic payments when the insured is unable to work as a result of illness, disease, or injury.
DISASTER RECOVERY (DR)	Facilities, plans, tests, etc. for the recovery of the MMIS from a total loss.
DISENROLLMENT	Removal of assignment or from the Managed Care program.
DISPOSITION	The actual status of a claim. The result of processing a claim is the assignment of a status or disposition. The disposition of a claim is determined by the Exception Control File.
DISPROPORTIONATE SHARE HOSPITAL (DSH)	Qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income persons.
DO	Doctor of Osteopathy
DOB	Date of Birth
DOCTOR	Specifically, any person with a doctoral degree. In common usage, a synonym for physician; a person with a doctor of medicine degree.
DOCUMENT	Structured file sent to a trading partner. In ASC X12 usage, a document is synonymous with a transaction set.

DOCUMENT IMAGES	A computerized representation of a picture or graphic. (Imaging)
DOCUMENT RETRIEVAL	The ability to search for, select and display a document or its facsimile from storage. (Imaging)
DOD	Date of Death
DOING BUSINESS AS (DBA)	Refers to a type of Provider Name and Address.
DOT	Department of Transportation
DP	Data Processing
DPM	Doctor of Podiatric Medicine
DRILLDOWN	Applies additional criteria to an existing subset of data displayed on the DSS.
DROP DOWN DATAWINDOW (DDDW)	This is a tabular presentation of data that is used as a drop-down list on a window.
DRUG	Any substance or its components recognized in one of the official drug compendia for use in the diagnosis, cure, mitigation, treatment or prevention of disease, or intended to affect the structure or function of the body.
DRUG FORMULARY	A listing of drugs covered by a state Medicaid Program, which includes the drug code, description, strength and manufacturer.

DRUG REBATE SYSTEM (DR, DRS)	Federal regulations provide for drug manufacturers, with whom CMS has a formal agreement and whose drug products are covered by Medicaid, to give financial rebates to Medicaid based upon the volume of the manufacturer's products dispensed by Medicaid. The Kentucky Drug Rebate Subsystem maintains the information to carry out the federal mandates related to drug rebate processing.
DUPLICATE PAYMENT	A payment to a provider for services provided to a beneficiary resulting from the processing of a duplicate or near-duplicate claim by the contractor.
DURABLE MEDICAL EQUIPMENT (DME)	Equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, such as crutches, wheelchairs, and walkers.
DX	Diagnosis Code, Diagnosis.

7.1.5 E

E&M	**Evaluation and Management**
E-DOS	Ending Date of Service
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)	As described in Title XIX of the Social Security Act.
EDIT	As applied to MMIS, an edit is a set of parameters against which a claim transaction is "edited." These edits can stop payment and/or generate reports. The verification and validation of claims data for detection of errors or potential error situations. Logic placed in the MMIS programming to cause claims that have specific errors to be placed in a suspend or deny mode due to not having successfully passed these edits.
EDP	Electronic Data Processing
EFT	Electronic Fund Transfer
ELECTRONIC BENEFITS TRANSFER (EBT)	EBT capabilities allow the State to issue food stamps and benefit checks electronically by utilizing the plastic Beneficiary ID Cards. Conforms to the ANSI Uniform Health Care ID Card Standards.
ELECTRONIC CLAIMS SUBMISSION (ECS)	See EDI.

ELECTONIC DATA INTERCHANGE (EDI)	Standard format for exchanging business data. The standard is ANSI x12, which was developed by the data interchange standards association (DISA). ANSI x12 is either closely coordinated with or is being merged with an international standard, EDIFACT. Standards for EDI include: ANSI for claims, eligibility, enrollment, EBT, and remittance. CCIT for others. NCPDP for pharmacy, HEDIS for managed care.
ELECTONIC DATA SYSTEMS (HP Enterprise Services)	The Fiscal Agent for the Commonwealth of Kentucky.
ELECTRONIC FUNDS TRANSFER (EFT)	An electronic deposit system for provider remittance amounts, and the process of authorizing a computer system to transfer funds between accounts.
ELECTRONIC MEDIA CLAIMS (EMC)	Claims that are electronically transmitted to the MMIS through media such as telephone lines, diskettes, or tapes. This term is no longer used.
ELECTRONIC REMITTANCE ADVICE (ERA)	Generally, RAs are submitted to the provider using the same media that the provider uses when submitting a claim. If the claim is submitted using a particular standard format, the RA is returned in the same format. See RA, NCPDP.
ELIG	Eligibility
ELIGIBLE PROVIDER	An institute, facility, agency, person, partnership, corporation, or association as enrolled and approved by the State that accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules.

ENCOUNTER A record of a medically related service rendered to a beneficiary who is enrolled in a participating health plan (HMO) or in a PCCM plan during date of service. It includes (but is not limited to) all services for which the plan incurred any financial responsibility. Encounters are priced at the Medicaid value of a similar claim, but the reimbursement amount is zero (see STOP-LOSS). If a service is not covered under the HMO/PCCM plan, the claim will be billed by the provider as a FFS claim. Encounters are sometimes referred to as Shadow Claims as no money is paid out.

ER Emergency Room

ESC Error Status Code

EXCEPTION The phrase "posts an exception" is commonly used when discussing claims processing to indicate there is data on the claim that fails an edit; therefore, an exception is posted to the claim.

EXCEPTION CODE This code indicates that there is data on a claim that has caused the claim to fail an edit. An exception is then posted to the claim in question. Depending on the disposition of the edit on the Claim Edit Disposition Listing, the claim may pay, even with edits posted to it. An exception code can have different dispositions dependent upon media type.

EXPENDITURES (EXP) The issuance of checks, disbursement of cash, or electronic transfer of funds as reported by the State.

EXPLANATION OF BENEFITS (EOB) A notice issued to a provider that explains in detail the payment or nonpayment of a specific claim processed. Also a three-digit code that prints on the remittance advice to explain why a claim was either denied or suspended.

EXTENSIBLE MARKUP LANGUAGE (XML) Universal format for structured documents and data on the Web.

7.1.6 F

FAIR HEARING (FH)	**A formal meeting where a Hearings Officer listens to all the facts and then makes a decision based on the law.**
FAMILY PLANNING (FP)	A medically approved treatment, counseling, drugs, supplies, or devices that are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	Number assigned to a business entity for tax purposes. This number might be of value in identifying all the businesses owned by a corporation.
FEDERAL INSURANCE CONTRIBUTIONS ACT (FICA)	Social Security taxes deducted by the employer.
FEDERAL POVERTY LEVEL (FPL)	The poverty threshold is a statistical measure used to indicate the level of cash income needed by a family to purchase a “minimally adequate” market basket of goods and services. The threshold is adjusted for family size and updated every February for inflation. It is a nationwide standard of poverty.
FEDERAL REGISTER (FR)	The Federal Register is the official daily publication for Rules, Proposed Rules, and Notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents.
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A federally funded agency that provides medical services on a sliding fee schedule to the general public.
FEE FOR SERVICE (FFS)	The payment method by which KY Medicaid reimburses providers on a service-by-service basis.

FEE SCHEDULE A listing of acceptable Charges or established allowances, normally representative of either standard or maximum Charges, for the listed medical or dental procedures.

FIELD An on-screen area used for entering specific information, such as a name or extension number, within the telephone system. A field prompt identifies the type of information that belongs in each field.

FILE MAINTENANCE The periodic updating of master files. For example, adding or deleting employees and customers, making address changes and changing product prices. It does not refer to daily transaction processing and batch processing.

FILE TRANSFER PROTOCOL/PROGRAM (FTP) A method of transferring files between heterogeneous computing platforms. Since most large scale computing systems interface between mainframes, mini, PC's, and the Internet, a method is needed to transfer data between these different platforms. (See TCP/IP)

FIREWALL Security protection for a Web site (see proxy server), LAN, and Intranet. May check incoming and outgoing messages.

FISCAL AGENT (FA) The contractor retained by the State for operation of the MMIS and for the performance of claims processing and other related Medicaid functions in KY Medicaid.

FISCAL INTERMEDIARY (FI) Similar to a fiscal agent. A corporation is designated to have complete responsibility for a government health program, including all data processing functions, program administration, professional relations, and clerical staffing for claims processing.

FISCAL YEAR (FY) Any twelve-month period for which manual accounts are retained. The fiscal year may, but need not, correspond to the calendar year. The federal Fiscal Year starts October 1 and ends September 30 of the following year. States usually operate on July 1 through June 30 of the following year.

FLAT FILE	A database consisting of one table. It is a stand-alone data file that does not have any predefined linkages or pointers to locations of data in other files. This is the type of file used in a relational database; however, the term is often used to refer to a type of file that has no relational capability, which is exactly the opposite.
FOOD AND DRUG ADMINISTRATION (FEDERAL DRUG AGENCY, FDA)	A federal agency responsible for the monitoring and regulation of foods and drugs distributed in the United States.
FORMULARY	A listing of drugs and the regulations that govern payment.
FPA	Family Planning Agency
FROM DATE OF SERVICE (FDOS)	Date used in the claim.
FRAUD AND ABUSE (F&A)	Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by KMAP. This is not the same as fraud.
FTE	Full-Time Equivalent
FULL TEXT SEARCH	The ability to search text files for occurrences of certain words, digits, sentences, or patterns of Characters. Generally, a scanned document cannot be full text searched. To do that, the document would have to be retyped or scanned with an OCR to create a text file. (Imaging)
FUNCTIONAL ACKNOWLEDGEMENT	An EDI message that is sent in response to the receipt of an EDI message or packet of messages to notify the sender of the original message that it was received. It acknowledges only the receipt of the message or message packet, and does not imply agreement with or understanding of its content.

7.1.7 G

GARNISHMENT	**A court-ordered attachment, or withholding, of a provider's earnings to pay a debt.**
GATEWAY	The interconnection between public or private networks that allow the transmission of documents in X12 format across multiple networks. Also called interconnect.
GB	Gigabyte
GENERAL PRACTITIONER	A doctor of medicine who generally performs a wide range of medical services as opposed to one who specializes only in certain areas of practice.
GENERIC	A term used in reference to drugs that meet the following criteria: 1) The product is available from more than one source. 2) The Average Wholesale Price of the product is significantly lower than the non-generic. 3) The product is not under patent.
GENERIC CODE NUMBER (GCN)	The standard generic code for drugs.
GLOBAL POSITIONING SOFTWARE (GPS)	This software is incorporated into the MMIS interChange allowing default and auto assignment of beneficiaries to providers. It utilizes longitude and latitude for assignment purposes.
GRAPHICAL USER INTERFACE (GUI)	A "windows" based computer interface that allows for consistency of this application with other applications used by the operators. The device drivers associated with these GUIs optimize the painting of snippets and the rendering of fonts to take full advantage of the high-performance graphic cards installed in PCs. (Imaging)

GRAY SCALE The spectrum, or range, of shades of black an image has. Scanners and terminals gray scales are determined by the number of gray shades, or steps, they can recognize and reproduce. A scanner that can only see a gray scale of 16 will not produce as accurate an image as one that distinguishes a gray scale of 256. (Imaging)

GROUP PRACTICE A medical practice where more than one provider render and bill for services under a single provider number.

GSD General System Design

7.1.8 H

HARD DISK	**A storage device that uses a magnetic recording material. Generally, hard disks are fixed inside a PC, but there are removable cartridge versions. Hard disks store anywhere from five to hundreds of megabytes. (Imaging)**
HCFA-1500	CMS-approved uniform claim form that is required for most professional providers to bill for most non-institutional services. The form is mandated for use in billing both Medicare and Medicaid programs for medically related services.
HEADER (HDR)	This term refers to data on a claim that is not line item specific, but applies to the entire claim. An example of header information would be the provider's name, address and SSN.
HEALTH AND HUMAN SERVICES (HHS)	The executive department of the federal government responsible for social and economic security, educational opportunity, national health and child welfare. Specifically, the department is responsible for Medicaid and Medicare Programs. Formerly DHEW.
HEALTH CARE FINANCING ADMINISTRATION (HCFA)	See CMS.
HEALTH INSURANCE	A contract under which a company guarantees payment for specified loss by disease or accidental bodily injury normally by covering a portion of the associated medical costs.

HEALTH INSURANCE PORTABILITY AND ACCOUTABILITY ACT OF 1996 (HIPAA)	A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191. Accountability Act of 1996.
HIPAA	Health Insurance Portability and Accountability Act of 1996
HEALTH INSURANCE PREMIUM PAYMENT SYSTEM (HIPP)	A program where Medicaid-eligible beneficiaries may receive insurance premium assistance using Medicaid funds when it is determined cost-effective to purchase group health insurance.
HEALTH MAINTENANCE ORGANIZATION (HMO)	A prepaid cost-effective health plan that provides a range of preventative and maintenance services in return for a fixed monthly premium that entitles the enrollees to a predetermined set of basic and supplemental services. A health care providing organization, which Charges a flat fee per month (Capitation) per person, enrolled. The services provided are defined by contract and generally are comprehensive. HMO enrollment is an alternative form of health care delivery that is offered to Medicaid beneficiaries.
HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)	Used to measure a plan's performance. Utilized in Quality Assurance for Managed Care. HEDIS and HEDIS and Compliance Audit are registered trademarks of the National Committee for Quality Assurance (NCQA). NCQA encourages and promotes the use of performance measures that comprise HEDIS. HEDIS Compliance Audit is a rigorous process for evaluating the accuracy and validity of plan-reported performance results.
HEALTH PLAN EMPLOYER DATA AND INFORMATION SET STANDARD (HEDIS STANDARD)	A Federal standard for Electronic Data Interchange (EDI) for Medicaid Managed Care programs.

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

A uniform health care procedural coding system approved by CMS. It describes the physician and non-physician patient services covered by the Medicaid and Medicare programs. It is used primarily to report reimbursable services provided to patients.

There are three types of HCPCS codes.

Level 1 includes the CPT-4 codes.

Level 2 includes the alphanumeric codes A through V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by the CPT-4 coding.

Level 3 includes the alphanumeric codes W through Z, which are assigned for use by the state agencies.

HOME AND COMMUNITY BASED SERVICES (HCBS)

Home and Community Based services are for persons with mental retardation or other developmental disabilities are made possible through Medicaid waivers. These services are intended as an alternative to institutional services. Each waiver offers services for a specific group: Head Injury, Technology Assistance, Physical Disability, Frail and Elderly, Developmental Disabilities, and Children with Severe Emotional Disturbance.

HOME HEALTH AGENCY (HHA)

An agency that provides home health care services such as home health aide visits, LPN and RN visits, and therapy services.

HOSPICE

A program that provides an integrated program of appropriate hospital and home care for the terminally ill patient. A hospice is a public agency or private organization that provides services for terminally ill people. It is usually affiliated with a hospital. Hospice care may be home care, inpatient care, or respite care. Respite care is inpatient care provided for the beneficiary to give the family temporary relief from the strain of caring for a loved one at home.

HOSPITAL

A health care institution whose primary function is to provide inpatient services for a variety of surgical and non-surgical medical conditions. Hospitals are classified by length of stay, teaching or non-teaching, major type of services, and by control.

HOSPITAL INSURANCE PROGRAM (PART A)	The compulsory portion of Medicare that automatically enrolls all persons 65 years of age or older, entitled to railroad retirement and eligible for disability for over two years, and insured workers and their dependents requiring dialysis or kidney transplants.
HOST	Computer in which an application or database resides or to which a user is connected. Sometimes used generically as synonym for computer. (Imaging)
HYPERTEXT MARKUP LANGUAGE (HTML)	Programming language used to develop and maintain web pages on the Internet.
HYPERTEXT TRANSFER PROTOL (HTTP)	The underlying protocol used by the World Wide Web. HTTP defines how messages are formatted and transmitted, and what actions Web servers and browsers should take in response to various commands.
HYPERTEXT TRANSFER PROTOCOL SECURE (HTTPS)	Protocol to provide encrypted transmission of data between Web browsers and Web servers.

7.1.9 I

ICD-10-CM	**International Classification of Diseases, Tenth Revision**
ICF/MR	Intermediate Care Facility/Mental Retardation
ICN	Each claim is imprinted with an ICN in a sequential numbering order, beginning with the initial ICN keyed in the system by the scanner operator. The ICN is printed across the top of the claim and is also written out to the OCR output record. The imaging system captures the ICN for indexing of the claim images and compiles a file containing all ICNs used to automatically update the control range of valid ICNs within the MMIS.
ICON	The basis of a graphical user interface, an icon is a picture or drawing of a device or program that is activated, usually with a mouse, to access the device or run the program.
IMAGE	The computerized representation of a picture or graphic. (Imaging)
IMAGING	A method of electronically capturing a representation of a form, whether it is a claim or other piece of correspondence, to allow rapid retrieval and processing of the source document copy.
IMAGING SYSTEM	Collection of units that work together to capture and recreate images. At its simplest, it has an acquisition device (scanner, camera), an image processor and an imaging device (printer, microfilm, computer). (Imaging)
INCOME MAINTENANCE (IM)	A division within the Commission of Income Maintenance/Employment Preparation Services of SRS. The division is responsible for administration and oversight of programs relating to eligibility for Public Assistance programs, including AFDC, Medicaid, and food stamps.

INFORMATION TECHNOLOGY (IT) A broad term referring to the entire field – computers, communications, Internet, imaging, etc.

INPATIENT (IN, INP, IP) A patient who has been admitted, at least overnight, to a health care facility. A patient who is literally in residence or in bed in the facility.

INQUIRY MODE An window mode where the user is viewing data as the result of an inquiry rather than having accessed the specific window in order to add, change or delete data from certain financial records and/or claims. Inquiry Mode allows flow between the various parts of the system but does not allow changes to the data being viewed.

INSURANCE Health insurance.

INTEGRATED TEST FACILITY (ITF) Copy of MMIS production system used for testing changes and enhancements to the MMIS.

INTENSIVE CARE UNIT (ICU) The level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.

INTERACTIVE Back-and-forth dialog between the user and a computer.

INTERMEDIARY A public or private insurance organization under contract with the government to handle claims from hospitals, skilled nursing facilities and home health agencies (Part A Medicare).

INTERMEDIATE CARE FACILITY (ICF) Any facility that provides room, board, and all routine services and supplies.

INTERMEDIATE CARE FACILITY FOR MENTAL RETARDATION (ICF/MR) Facilities that have met state licensure standards and that provide habilitation-related care and services, prescribed by a physician, in conjunction with active treatment programming for beneficiaries who are mentally retarded and who have related health and physical conditions.

INTERNAL CONTROL NUMBER (ICN)	A unique 13-digit identification number assigned to every KMAP claim in order to distinguish it from all other claims received by the system. The ICN consists of: 2-byte Region, which represents claim media and claim type; a 5-byte Date of Receipt, which consists of the YY – year and JJJ – Julian; and a 6-byte Sequence number.
INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)	A classification and coding structure of diseases used by the health care community to describe patients' conditions and illness, and to facilitate the collection of statistical and historical data.
INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION (ICD-9-CM)	A three-volume coding manual that contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.
INTERNATIONAL STANDARDS ORGANIZATION (ISO)	An international organization, working with the United Nations that maintains the standards for all applications of technology and mechanics for global industry.
INTERNET CONTROL MESSAGE PROTOCOL (ICMP)	Extension to IP supporting packets containing error and control information. For example. The PING command uses ICMP to test an Internet connection. (See IP, TCP/IP.)
INTERNET PROTOCOL (IP)	Works like the postal system. There is no direct connection – just the packet address to send messages to, and the address for returned messages.
INTERNET SERVICE PROVIDER (ISP)	Commercial provider of Internet services; e.g., AOL, Sprynet, Flashnet, etc. To use the Internet a user must have a commercial ISP that maintains a computer system through which the user accesses the Internet.
IP	Inpatient

7.1.10 J

JCAHO	**Joint Commission On The Accreditation Of Health Care Organizations**
JCODE	A five-digit procedure code that begins with the letter J.
JOB CONTROL LANGUAGE (JCL)	A language designed to express statements in a computer job that are used to identify the job or describe its requirements to an operating system.
JOINT APPLICATION DESIGN (JAD)	The process where the system user and designer meet together to define the application. Generally, requirements are reviewed, validated, and clarified.
JULIAN DATE	The representation of month and day by a consecutive number starting with January 1. For example, February 1 is Julian 032. Dates are converted into Julian dates for calculation.

7.1.11 K

KEY	**Keys are indexed columns in tables, often used to join tables. Keys uniquely identify each record, or row, in a table. Examples would be Cust-ID or Provider Number.** **A word, number or phrase associated with a document to aid in its retrieval from storage. Sometimes called descriptors. There are often many keys used together to fully locate a document; together they are called an index. Also called a retrieval key. (Imaging)**
KILOBYTE	One thousand bytes. To a computer, its actually 1,024. So, 16 kbytes, or 16K, is actually 16,384 bytes; 64K is 65,536 bytes, etc. (Imaging)

7.1.12 L

LASER DISC	**An optical disc with the same technology as a Compact Disc, except laser discs are 12 inches in diameter. (Imaging)**
LENGTH OF STAY/SERVICE (LOS)	A designation generally correlated to the patient's diagnosis that refers to the number of days that a patient is confined to an inpatient facility.
LIFETIME RESERVE DAYS	A nonrenewable sixty-day period of additional hospital days awarded to Medicare beneficiaries.
LINE ITEM	A term used in reference to a level of detail on a claim. Line item details are services billed using a procedure code, a quantity, and a date of service for a specific fee. Claims may have multiple line items or detail lines.
LKN	Lock-In
LMB	Low-Income Medicare Beneficiary
LOC	Level of Care

LOCAL AREA NETWORK (LAN)

A communications network that serves users within a confined geographical area. It is made up of servers, workstations, a network operating system and a communications link.

Servers are high-speed machines that hold programs and data shared by all network users. The workstations, or clients, are the users' personal computers, which perform stand-alone processing and access the network servers as required.

The controlling software in a LAN is the network operating system, such as NetWare, UNIX, and Appletalk, which resides in the server. A component part of the software resides in each client and allows the application to read and write data from the server as if it were on the local machine.

The message transfer is managed by a transport protocol such IPX, SPX, and TCP/IP. The physical transmission of data is performed by the access method (Ethernet, Token Ring, etc.), which is implemented in the network adapters that plug into the machines. The actual communications path is the cable (twisted pair, coax, optical fiber) that interconnects each network adapter.

LOCAL CODES

A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III Codes, but also applies to state-assigned Institutional Revenue Codes, Condition Codes, Occurrence Codes, Value Codes, etc.

LOCAL OFFICE

The DCBS office in an individual county. Local county offices are grouped into a management area for administrative efficiency.

LOCK-IN

The punitive restriction of a Medicaid beneficiary to a particular provider for a period of time as determined by the State.

LONG TERM CARE (LTC)

Beneficiary care that includes room, board, and all routine services and supplies. The LTC program includes the SNF, ICF and ICF/MR services.

LPN

Licensed Practical Nurse

7.1.13 M

MAGNETIC DISK AND TAPE	**The primary computer storage media. The choice depends on accessing requirements. Disk is direct access; tape is sequential access. Locating a program or data on disk can take a fraction of a second. On tape, it can take seconds or minutes.**
MAGNETIC RESONANCE IMAGING (MRI)	A noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.
MAINFRAME	A large, powerful computer, often serving several connected terminals.
MANAGED CARE (MC)	Comprehensive health care integrating clinic/admin for cost effective care (HMO). Managed Care includes Capitated HMO, PCCM, and Fee-For-Service managed care.
MANAGED CARE ORGANIZATION (MCO)	An organization paid to provide services to a select group of beneficiaries assigned to them for a given time period.
MANAGEMENT ADMINISTRATIVE REPORTING SUBSYSTEM (MAR, MARS)	The MMIS subsystem that produces the management data required for financial, benefit, provider and beneficiary reporting.
MANUAL CHECKS	Checks written outside the automated check writing cycle.
MAPPING	The act of determining what pieces of information in the company's database should be placed into each data element of an EDI message or transaction set, or in reverse, what data elements of an EDI message or transaction set should be placed into the company's database.

MASS ADJUSTMENTS

The systematic adjustment of more than one claim at the same time for the same reason. Multiple adjustments entered at one time. Mass adjustments are requested on line and they are particularly useful when it is necessary to reprocess hundreds or thousands of claims. Mass adjustment requests are submitted for a specific population of claims. In other words, claims that have something in common. They may be all of the drug claims processed after a certain date; they may be a subset of claims for a specific provider, or they may be all of the claims processed for a specific beneficiary. The criterion for claims selection is highly variable.

MB

Megabyte

MEDICAID (MCD)

The joint federal and state medical assistance program that is described in Title XIX of the Social Security Act, designed to provide health benefits assistance to medically needy young persons (less than 21 years of age) and to the aged (more than 65 years of age). A health insurance program for the poor which is jointly funded by the state and federal governments. Also, referred to as Title XIX of the Social Security Act. The Medicaid Program is administered by the states under the management of the Centers for Medicare and Medicaid (CMS).

Federal/State partnership of medical assistance for low income (title XIX, SS act) persons. There are 33 million people eligible. Includes ABD, low-income with children, low-income pregnant, and people with very high medical bills. In order to receive medical assistance a client must qualify into one of six categories: age 65, Blind, disabled, families with dependent children (TANF), pregnant, incapacitated (= categorically needy).

MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS)

Reporting required by CMS in standard formats. MSIS reports are required by each state and combined by CMS.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS, MMIS INTERCHANGE)

Computer application that makes up the Medical Assistance Program system. A system composed of at least six subsystems for the general design of Title XIX systems as defined, outlined, and documented by the Department of Health and Human Services. All states with Medicaid Programs are required to have an MMIS. The MMIS processes medical claims and produces reports which track expenditures by aid category, claim type, category of service, or some other parameter.

MEDICAL NECESSITY (MN) A documented decision by a medical practitioner that a therapy, treatment, drug, item, or service prescribed or provided is essential to treat or diagnose a specific physical or psychiatric condition.

MEDICALLY NEEDY (MN) Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.

Beneficiary who has a catastrophic illness and cannot pay the incurred costs. (See "CATEGORICAL NEEDY"). Must still fall into one of the six categories.

MEDICAL REVIEW (MR) Analysis of Medicaid claims to ensure that the service was necessary and appropriate.

MEDICARE The federal medical assistance program that is described in Title XVIII of the Social Security Act for people 65 years of age or older, for persons eligible for Social Security disability payments, and for certain workers of their dependents who require kidney dialysis or transplantation. A health insurance program for individuals over 65 years of age, as well as certain disabled persons. Medicare is 100 percent federally funded. The Medicare Program is administered by the Health Care Financing Administration (HCFA). Applications for Medicare benefits are processed by the Social Security Administration. Medicare has two distinct plans: Part A is hospital insurance covering inpatient, hospice, home health, and skilled nursing facility care; and Part B is medical insurance covering physicians' services, outpatient care, diagnostic tests, durable medical equipment, and ambulance services. Refer to Title XVIII.

MEDICARE PART A Part A of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for hospital and hospital-related services. The formal designation is "Hospital Insurance Benefits for the Aged".

MEDICARE PART B Part B of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for physician's services. The formal designation is "Supplementary Medical Insurance Benefits for the Aged".

MEDIGAP In relation to Medicare, this private health insurance pays most of the health care service Charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by many commercial health insurance companies.

MEGABYTE Approximately one million bytes. Precisely, 1,024 kilobytes or 1,048,576 bytes. (Imaging)

MENTAL RETARDATION (MR) Significantly sub-average intellectual functioning, evidenced by an IQ rating of 70 or below on any standardized measure of intelligence, concurrently existing deficits in adaptive behavior as listed in the Other Development Disability definition.

MICROMEDIA For the purpose of this document, micromedia refers to microfilm, microfiche, or the ability to access online those documents residing on the State's imaging database.

MSIS Medicaid Statistical Information System

MSW Master of Social Work

MTD Month to Date

MULTIMEDIA Combining more than one media for the dissemination of information, i.e., using text, audio, graphics, animation and full-motion video all together. Requires enormous amounts of bandwidth and processing power. (Imaging)

7.1.14 N

NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)	**An ANSI-accredited council developed to review and define national standards for the billing of prescription drug services for reimbursement by private insurance as well as state and federal agencies. Some of the standard formats are included in the HIPAA mandates.** **Provides standards for data interchange and standards for processing pharmacy services in the health care industry. The NCPDP Telecommunications Standard defines the record layout for interactive prescription drug claim transactions between providers and adjudicators. Version 5 of this standard is currently in draft form.**
NATIONAL DATA CORPORATION/NATIONAL DRUG CODE (NDC)	Provider of communication software/hardware for pharmacies. (See ENVOY.) or A generally accepted system for drug identification that is the primary drug ID used. (1) A standard coding scheme of eleven digits that assigns a unique numeric code to all drugs on the market. (The first five digits indicate the drug manufacturer; the next four digits specify the particular drug and the last two digits refer to the package size.) (2) A 10-Character code assigned to all prescription drug products by the labeler/distributor of the product under FDA regulation. Each NDC is composed of three sub-codes, which can assume different configurations. The NDC codes are impractical to use for data processing applications such as sorting, searching, etc., because of the variable structure of the sub-codes. The National Drug Data File (NDDF) Code therefore is always eleven digits in length and each of its sub-codes always contains the same number of Characters (5-4-2). This is achieved by inserting a leading zero in one of the three sub-codes in the NDC.
NATIONAL PROVIDER FILE (NPF)	A national repository of provider identification data to support assignment of a national provider identifier.
NATIONAL PROVIDER IDENTIFIER (NPI)	A national system of provider identification that is used nationally by all providers starting in 1997.

NATIONAL STANDARD FORMAT (NSF)	The NSF was designed to standardize and increase the submission of electronic claims and coordination of benefits exchange. The NSF is used to electronically submit health care claims and encounter information from providers of health care services to payers. It is also used to exchange health care claims and payment information between payers with different payment responsibility.
NH	Nursing Home
NON-COVERED SERVICES (NC)	The service does not meet the requirements of a Medicaid benefit category, or the service is excluded from coverage or is not reasonable and necessary.
NON EMERGENT MEDICAL TRANSPORTATION (NEMT)	Non-commercial medical transportation provided to beneficiaries in private vehicles, including their own.
NURSE PRACTITIONER (NP)	A registered nurse who has advanced training in a specialized nursing field such as geriatrics or pediatrics.

NURSING FACILITY (NF)

Any facility that provides room, board, and all routine services and supplies. All NFs are required to be licensed by the secretary of the state Department of Health.

An institution or a distinct part of an institution which is primarily engaged in providing to residents: nursing care and related services, rehabilitation services or health related care, and services (above the level of room and board) which can be made available only in an institutional facility. The facility must have in effect a transfer agreement with one or more hospitals and must meet Medicaid participation requirements.

Any place or facility operating for not less than twenty-four (24) hours in any day and caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24-hour-a-day, licensed, nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care.

7.1.15 O

OCC	**Occurrence Codes (Inpatient claims)**
OCCUPATIONAL THERAPY (OT)	The use of life related activities to restore and evaluate motor skills so that disabled persons may attain health, social, or economic independence.
OCR DATA RECOGNITION (OCR)	Images passed to the OCR subsystem are fed to the recognition engines one claim at a time. The recognition engines interpret each Character or mark sense field based on the form definition used. All recognized data is placed in an ASCII data file. (Imaging)
OD	Doctor of Optometry
OIG	Office of Inspector General
OMNIBUS BUDGET RECONCILIATION ACT (OBRA)	See PASARR. OBRA-90 establishes the Drug Rebate program.
OMNIBUS BUDGET AND RECONCILIATION ACT OF 1990 (OBRA-90)	Establishes the Drug Rebate program.
ONBASE	OnBase processes the print output of application programs, extracts index fields from the data, stores the index information in a relational database, and stores one or more copies of the data in the system so that the user can archive newly created and frequently accessed reports or images on high speed, disk storage volumes and automatically migrate them to other types of storage volumes as they age.

ONLINE The use of a computer terminal to display computer data interactively.

Available for immediate use. If your data is on disk attached to your computer, the data is online. If it is on a disk in your desk drawer, it is offline.

A peripheral device (terminal, printer, etc.) that is turned on and connected to the computer is said to be online. However, a printer can be taken offline by simply pressing the ONLINE or SEL button. It is still attached and connected, but is internally cut off from receiving data from the computer. Pressing the ONLINE or SEL button will turn it back on-line.

Systems are designed as either online or batch. Online means terminals are connected to a central computer, and batch means entering batches of transactions on a second or third shift. Other terms, such as real-time and transaction processing evolved from online processing.

OPERATING SYSTEM (OS) The master control program that runs the computer. It is the first program loaded when the computer is turned on, and its main part, called the kernel, resides in memory at all times. It may be developed by the vendor of the computer it's running in or by a third party. It is an important component of the computer system, because it sets the standards for the application programs that run in it. All programs must "talk to" the operating system. See API, JCL.

ORACLE The Corporation that provides the ORACLE software which is the major Relational Database software for minicomputers and PCs.

OTHER INSURANCE (OI) A term used to describe primary insurance payers. Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.

OUTPATIENT (OPT) A patient who is receiving care at a hospital or other health facility without being admitted. Outpatient normally does not include patients receiving services from a facility that does not also give inpatient care.

OUTPATIENT CARE Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.

OVER THE COUNTER (OTC) A drug classification used to describe pharmaceuticals that do not require a prescription.

7.1.16 P

PA	**Physician's Assistant** **Prior Authorization**
PAID CLAIM	A claim that has been processed through the adjudication and payment cycles. In the MMIS, the term “paid” refers to a claim with a payment status of either “paid” or “denied”. A paid claim can result in the provider being reimbursed for some dollar amount or a zero paid amount.
PARAMETER	Any value passed to a program by the user or by another program in order to customize the program for a particular purpose. A parameter may be anything; for example, a file name, a coordinate, a range of values, a money amount or a code of some kind. Parameters may be required as in parameter-driven software or they may be optional. Parameters are often entered as a series of values following the program name when the program is loaded.
PASSWORD	Confidential code used in conjunction with the User ID to gain access to a system.
PATIENT	A person receiving treatment or care from a physician or other health professional.
PATIENT LIABILITY (PAT LIAB)	A beneficiary's monetary obligation to a nursing facility that is determined by his or her income level.
PAY AND CHASE	Under certain circumstances, the claims are initially paid by the Claims processing system and then the claims must accumulate to a pre-determined threshold prior to payment by the third party insurance. In this situation, a claim is paid, despite coverage, and the carrier is billed (pay and chase).

PAYER OF LAST RESORT	The insurance program that pays after all of a patient's other insurance programs have paid for a service. Medicaid is usually the payer of last resort.
PAYMENT CYCLE	The processing of adjudicated claims to a paid or denied status. Users determine the frequency of running payment cycles. Most state agencies pay providers weekly.
PAY-TO PROVIDER	The provider who will receive payment (if a group/clinic number is present, it would be the "Pay-to Provider"
PAYOUT (PAY)	Non-claim specific payment to a provider or other entity (i.e.: insurance company).
PDD	Procedure, Drug, Diagnosis
PE	Presumptive Eligibility
PEER	A person or committee in the same profession as the provider whose claim is being reviewed.
PEER REVIEW	An activity performed by a group or groups of practitioners or other providers to review the medical practices of their peers for conformance to generally accepted standards.
PEER REVIEW ORGANIZATION (PRO)	A quality assurance or peer review program that reviews Medicare, Medicaid and Maternal and Child Health program claims. Mandated by the federal government to review the necessity and appropriateness of admissions to hospitals and continued stay in hospitals. PROs have the authority to deny payment or recoup payment for services that are deemed unnecessary.
PER DIEM	A daily rate usually associated with payment to an institution such as a hospital or a skilled nursing facility assigned to institutional providers.

PERSONAL COMPUTER (PC) Although the term "PC" is sometimes used to refer to any kind of personal computer, PC refers to computers that conform to the PC standard originally developed by IBM. PCs are used as stand-alone personal computers or as workstations and file servers in a LAN (local area network). They are predominantly used as single-user systems under DOS; however, they are occasionally used as a central computer in a multi-user environment under UNIX and other operating systems.

PERSONAL IDENTIFICATION NUMBER (PIN) A number used to provide a password into the system for security purposes.

PF KEY The function keys at the top of a computer keyboard which serve as commands (for example, F1, F2, F3, etc.).

PHARMACIST A professional qualified by education and authorized by law to prepare, preserve, compound, dispense and give appropriate instruction in the use of drugs.

PHARMACY BENEFIT MANAGEMENT (PBM) Pharmacy Benefit Management (PBM) applies managed care principles to prescription drug programs, with the goal of optimal and cost-effective drug prescribing and use. PBM functions include (1) claims processing and adjudication, (2) data management, reporting, and trending (3) formulary management and clinical review services, (4) prospective Drug Utilization Review (ProDUR), and (5) drug rebate management.

PHARMACY POINT-OF-SERVICE (RX-POS, POS) The Pharmacy POS system enables Medicaid providers to submit electronic pharmacy claims in an on-line, real-time environment. The electronic claim submission will verify beneficiary eligibility; including other health insurance coverage, and monitor Medicaid drug policies. Claims will also be screened against beneficiary medical and prescription history within the Medicaid system. Once these processes are complete, the provider will receive an electronic response indicating payment or denial within seconds of submitting the electronic claim. Also referred to Point of Sale.

PHD Psychologist

PHYSICAL THERAPY (PT)	Rehabilitation concerned with the restoration of function and prevention of disability following disease, injury, or loss of a body part.
PHYSICIAN (PHY, PHYS)	A professional qualified by education and authorized by law to practice medicine.
PHYSICIANS DESK REFERENCE (PDR)	PDR is considered the standard prescription drug reference.
POS	Place Of Service The location at which a service was rendered, such as office, home, emergency room, etc.
POS	Point Of Sale
PLAN OF CARE	A document completed following the determination of long-term care eligibility and the individual elects home and community based services instead of nursing facility services. This document must include: the services to be provided, the frequency of each service, who will provide each service, and the cost of each service.
PM	Project Manager
PMP	Primary Medical Provider
POD	Podiatrist
POVERTY LEVEL	The poverty threshold is a statistical measure used to indicate the level of cash income needed by a family to purchase a “minimally adequate” market basket of goods and services. The threshold is adjusted for family size and updated every February for inflation. It is a nationwide standard of poverty.
POWERBUILDER	The coding language used to build the STARS application.

PPO	Preferred Provider Organization
PRE-CERTIFICATION (PRE-CERT)	Serves as an entry and approval process PA requests. It interfaces with the PA subsystem to provide automated update to the PA files.
PREMIUM	The periodic payment (e.g. monthly, quarterly) made to an insurance company to keep an insurance policy in force.
PRICING INDICATOR CODE (PIC)	An indicator that determines the reimbursement restrictions for drug and procedure codes.
PRIMARY CARE	Basic level of health care rendered by general practitioners.
PRIMARY CARE PROVIDER (PCP)	A professional, which could be a physician, ARNP, health department, or clinic, who manages a beneficiary's health care needs.
PRIMARY CARE SERVICES	Those services provided by a duly licensed medical practitioner who has contracted with SRS to initiate or approve specified medical services for participating Medicaid beneficiaries.
PRIMARY MEDICAL PROVIDER	An individual provider or organization assigned to a beneficiary with the responsibility of providing the majority of a beneficiary's medical services.
PRIOR AUTHORIZATION (PA)	Authorization granted by SRS staff, or its designated representative, to a provider to render specified services to a designated beneficiary. Acknowledgement, given before payment may occur, that certain specified services meet an established criterion. Acquiring permission before performing a service. Prior authorization is a condition for payment for many services reimbursed by Medicaid.
PROCEDURE (PROC)	A numeric or alphanumeric code used to describe the specific service rendered to a patient by a provider.

PROCEDURE, DRUG, AND DIAGNOSIS FILE (PDDF FILE) A file within the Reference Subsystem that contains records on all billable codes. The file also contains information on provider restrictions, beneficiary eligibility, and service limitations.

PROCESSED CLAIM A claim that has been adjudicated, properly paid or denied, and the remittance has been sent.

PROFESSIONAL COMPONENT (PC) Charges associated with a physician's expert reading of and interpreting some x-ray, lab, and diagnostic procedures.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO) A quality assurance or peer review program that reviews Medicare, Medicaid and Maternal and Child Health program claims.

PROJECT WORKBOOK (PWB) HP Enterprise Services proprietary WEB application that serves as a repository of HP Enterprise Services interChange information. The Project Workbook contains administrative, application, and project information.

PROMPT To request input from the user by displaying a message on the computer screen or by playing an audio message on the telephone.

PROTOCOL In information technology, it is a set of rules describing the contents of an electronic communication. To communicate, both the sender and receiver must adhere to the protocol. See TCP/IP, HTTP, and FTP.

PROVIDER An eligible institution, facility, agency, managed care organization, administrative service organization, person, partnership, corporation, or association as enrolled and approved by the State which accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules.

PROVIDER CATEGORY OF SERVICE A code that indicates on a claim the type of service given by the provider in question. This code indicates the specific categories of service a provider may bill for.

PROVIDER SPECIALITY (PS)	A code that specifies the type of service a provider renders.
PROVIDER TYPE	A general code that indicates the type of service a provider can perform.
PROXY SERVER	A firewall security for a web site. A server that acts as an intermediary between a workstation user and the Internet and is associated with the gateway server that separates the enterprise network from outside intrusion.
PSY	Psychologist
PSYCHIATRIC HOSPITAL	An institution that is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons.
PURGE	Refers to moving data from the master files to the archive files. For example, beneficiary eligibility records may be purged if there is no activity within a three-year period.

7.1.17 Q

QA	**Quality Assurance**
QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI)	A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Certain formerly disabled persons who lost Medicare benefits because of their return to work are allowed to purchase Medicare Part A coverage. The State Medicaid Program must pay the Part A premium for those individuals entitled to enroll in Part A if their income does not exceed twice the SSI limit and they are not otherwise eligible for Medicaid benefits.
QUALIFIED MEDICARE BENEFICIARY (QMB)	A State program that pays for a beneficiary's Medicare premiums, coinsurance, and deductible amounts within limits.
QUALIFIED WORKING DISABLED (QWD)	See QDWI. A special program authorized by the Social Security Administration that allows certain individuals to work and still collect their disability payments for a period of time. SRS allows these individuals to remain on Medicaid while in QWD status.
QUARTER	Calendar quarter unless otherwise specified.
QUEUE DIRECTORY	A directory on a hard drive into which batch requests to unit storage are placed. (Imaging)

7.1.18 R

RA	**Remittance Advice**
RAILROAD RETIREMENT BOARD (RRB)	A separate insurance program that covers some aged people who would otherwise be covered by Medicare.
RANDOM ACCESS	An accessing process that finds any record in a database quickly by using two logical reads; the first read being the accessing of the index pointing to that data, the second read accessing the actual record or data. This process is the opposite of sequential accessing.
RANDOM ACCESS MEMORY (RAM)	The primary memory in a computer. Memory that can be overwritten with new information. The random access part of its name comes from the fact that all information in RAM can be located -- no matter where it is -- in an equal amount of time. This means that access to and from RAM memory is extraordinarily fast. By contrast, other storage media -- like magnetic tape -- require searching for the information, and therefore take longer. (Imaging)
RD	Registered Dietitian
REALTIME SYSTEM	A computer system that responds to input signals fast enough to keep an operation moving at its required speed.
RECORD	A set of related fields used to enter and store information in the telephone system. A table is a set of records.
RECOUPMENT (REC)	Money withheld from a provider's payment due to overpayment of claims during adjudication cycles. Recoupments may be established ion line by accessing the Accounts Receivable Set Up window. They may be set up as a percentage or as a set amount to be recouped. An Accounts Receivable record is established for each recoupment type a provider might have.

REFERENCE DATA MAINTENANCE SUBSYSTEM The Reference Data Maintenance subsystem maintains a consolidated source of reference information that is accessed by the MMIS during performance of claims and adjustment processing functions, prior authorization functions, and Third Party Liability (TPL) processing. The Reference Data Maintenance function also supports MMIS reporting functions.

REFERRING PROVIDER Provider who gives referral (such as the KenPAC provider)

REFORMAT To change the record layout of a file or database.

To initialize a disk over again.

REGULATION A federal or state agency legal statement of general or specific applicability designed to implement or interpret law.

REHABILITATION THERAPIES Services designed to improve the skills and adjustment of the head injured individual, integrating prevocational, educational, and independent living goals, in order to return, or maintain the individual at their most optimum level of functioning at the least restrictive level of care. Services include occupational therapy, physical therapy, speech-language therapy, cognitive therapy, behavioral therapies, and drug and alcohol abuse counseling.

REJECTED CLAIM A claim that contains errors such as missing data, incorrect claim form, or missing provider signature and is returned to the responsible provider without being adjudicated.

RELATIONAL DATABASE A database or collection of data organized into related tables comprised of rows and columns. The tables define relationships between the records.

RELATIVE VALUE SCALE A type of fee schedule which uses unit values (multiplied times a dollar conversion factor) to price procedures, instead of using a flat fee. The methodology establishes value relationships between procedures. For example, a limited office visit might be valued at five units and an extended office visit (which is more complex) at 8 units. RVS based fee schedules have the advantage of being easier to revise because it is not necessary to change the units, only the conversion factors. These are carried as system parameters in the MMIS.

RELEASE The release is associated with a specific version of a product being made available to the client. Also known as system release or version.

REMITTANCE ADVICE (RA) The statement mailed to a provider detailing Charges pending, paid, denied.

REMITTANCE ADV A document sent to providers to explain the payment status of claims. The statement mailed to the provider detailing the outcome of the claims processed in the most recent payment cycle. The claims are listed by claim type and then disposition, i.e., paid, denied, suspense, and History only. RAs are generated in the financial system in accordance with the providers' RA media type indicator. Only those providers sending the majority of their claims electronically will be allowed a choice of media. All providers will be allowed only one type of media for RAs.

REMOTE ACCESS SERVICES (RAS) A feature built into Windows NT that enables users to log into an NT-based LAN using a modem, X.25 connection or WAN link. RAS works with several major network protocols, including TCP/IP, IPX, and Netbeui.

RENDERING PROVIDER Provider who actual provides the service (for example, an individual physician)

REQUEST FOR PROPOSAL (RFP) The bidding mechanism used to purchase goods and services.

RESOLUTION Usually used in context as claims resolution, pending resolution, or suspense resolution. It refers to the process of working or correcting errors on a claim, forcing edits, updating or modifying inaccurate data such as a provider number or category of service, or any other activity necessary to complete the adjudication of the claim.

Measure of imager output capability, usually expressed in dots per inch (DPI).

Measure of halftone quality, usually expressed in lines per inch (LPI). (Imaging)

RETRIEVE To call up data that has been stored in a computer system. When a user queries a database, the data is retrieved into the computer first and then transmitted to the screen.

RETURN TO PROVIDER (RTP) Request for additional information from the provider in the form of a letter.

REVENUE CODES The three-digit accounting codes used on hospital claims to designate the service which generated the income, e.g., room and board = 110, laboratory pathology = 300, and physical therapy = 420. Revenue codes are used in billing both inpatient and outpatient services. These codes are essential to the hospital cost reporting process.

RN Registered Nurse

RN BSN Registered Nurse with Bachelor of Science Degree in Nursing

ROUTE TABLE A database table that specifies resources, such as agent groups or trunks, for which calls can be routed to within the telephone system.

RULES BASED PROCESS Rules Based Processing, or Table Driven System, or Parameter Based Processing are terms that refer to systems that store data element variables in user-alterable tables rather than storing them inside a fixed computer program.

RUN DATE	The date a report was generated.
RURAL HEALTH CLINIC (RHC)	A federally funded rural agency that provides medical services on a sliding fee schedule to the general public.
RVS	Relative Value Scale
RX	Prescription

7.1.19 S

SAK	**System Assigned Key**
SCALING	Process of uniformly changing the size of Characters or graphics. (Imaging)
SCAN	To convert human-readable images into bitmapped or ASCII machine-readable code. (Imaging)
SCAN RATE	Number, measured in times per second, a scanner samples an image. (Imaging)
SCANNER	A device that reads text, images and bar codes. Text and bar code scanners recognize printed fonts and bar codes and convert them into a digital code. Graphics scanners convert a printed image into a video image without recognizing the actual content of the text or pictures.
SCHOOL-BASED SERVICES	Medicaid reimbursable services provided to Medicaid eligible children in local education agencies (LEAs) by enrolled providers.
SCL	Supports for Community Living
SCU	Storage Control Unit
SKILLED NURSING FACILITY (SNF)	Any facility that provides room, board, and all routine services and supplies. A nursing home facility requiring qualified professional personnel to remain on site twenty-four hours a day.
SOBRA	Sixth Omnibus Budget Reconciliation Act

SOCIAL SECURITY ADMINISTRATION (SSA) Branch of the Department of Health and Human Services which administers the Medicare and Medicaid Programs.

SOCIAL SECURITY INCOME (SSI) A program of income support administered by the Social Security Administration that replaces the previously stated administered programs for low-income aged, blind and disabled individuals. Federal dollars paid to aged, blind, or disabled individuals to help pay their living expenses.

SOCIAL SECURITY NUMBER (SSN) An account number issued and used by the SSA to identify an individual on whose earnings SSA benefits are being paid. It is a Social Security account number followed by a three-digit suffix designating the type of beneficiary.

SOCIAL SERVICES (SS) Services that seek to improve the quality of life for individuals and families (i.e., public assistance, medical assistance, food stamps, etc.).

SPECIALIST A physician, dentist, or other health professional who works primarily in a certain field of medicine, related to specific services, certain categories of patients or types of diseases.

SPECIALTY The specialized area of practice of a provider, such as general practice, surgery, endocrinology, pathology.

SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLMB) Medicare beneficiaries who would meet the QMB requirements, except for having income in excess of the QMB limit but less than 110 percent of the federal poverty level in 1994 and less than 120 percent of the federal poverty level in 1995. The state Medicaid Program must pay the Medicare Part B premium for these individuals.

SPENDDOWN (SPN) A type of Medicaid insurance deductible. The dollar amount of medical bills the beneficiary is responsible for taking care of before Medicaid can help the beneficiary pay his or her medical bills. Spenddown is the difference between the beneficiary's income and the Medicaid income limit. A qualifying county nurse may assign this dollar amount to a beneficiary (based on the beneficiary's income, etc.), which must be spent on medical needs prior to Medicaid benefits being available.

A process whereby an otherwise Medicaid-eligible person, but for excess income, may become eligible through obligation of the excess amount of incurred medical expenses. A requirement that certain beneficiaries, in order to be eligible for Medicaid, must spend money on their medical bills to offset their excess income. This is a requirement for the Medically Needy category of eligible beneficiaries. In cases of short-term spenddown, the spenddown amount is defined as being the amount that should be used for a beneficiary's provided services prior to Medicaid being involved.

SQL SERVER RDMS from Microsoft that is similar to Oracle.

SSDI Social Security Disability Income

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) A program providing medical benefits for beneficiaries under the age of 19 who are between 150 and 200 percent of poverty. Also referred to as Title XX. In Kentucky, this is referred to as K-CHIP.

STD Sexually Transmitted Diseases

STOP-LOSS Portion of a claim that exceeds the Stop-Loss cap. Provides protection for a managed care provider (as agreed to in the HCA/HMO contract) from catastrophic expenses (losses). For example, if the HMO refers a beneficiary to a specialist whose fee ends up to be greater than the Stop-Loss amount and the HCA/HMO contract provides for Stop-Loss, then the excess will be paid at a percentage factor (70% or 90%) contained on the Plan File for this Plan and Service Class. PCP/CM claims are paid at 100% when the cap is reached.

STRUCTURED QUERY LANGUAGE (SQL) The programming language used to access data in relational databases.

SUBCONTRACTOR	The entity contracting with the prime Contractor to perform services.
SUBJECT MATTER EXPERT (SME)	A person who is an expert for a particular subject matter and becomes the contact for information in that area.
SURVEILLANCE AND UTILIZATION REVIEW (SUR)	The processes and procedures by which the quality, quantity, appropriateness, cost of care, and services provided are evaluated against established standards.
SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS)	A subsystem within the KMMIS that reports on benefit usage, profiles beneficiaries and providers, and reports on anomalies in payment or services.
SUSPENDED	When a claim is being processed, it is considered a “suspended” claim. The claim has neither paid nor denied.
SUSPENDED ADJUSTMENT	An adjustment that cannot pay or deny until data is corrected.
SUSPENDED CLAIM	A claim that cannot pay or deny until data is supplied or corrected. Claims which could not be processed during an initial or previous submission cycle.
SUSPENSE FILE LIST	A list containing all ICNs that should remain in cache is provided by the mainframe and transferred to the PC imaging network. (Imaging)
SYSTEM	This term refers to all of the subsystems within the MMIS collectively.
SYSTEM GENERATED	Information not input from another source (e.g., a data file, data transmission or keyed by the user). Examples are date, time, calculated numbers, etc.

7.1.20 T

T-1 CONNECTION	**A high-speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.**
TAGGED IMAGE FILE FORMAT (TIFF)	A bit map file format for describing and storing color and gray scale images. (Imaging)
TB	Tuberculosis
TCN	Transaction Control Number
TDOS	To Date of Service - Date used in the claim.
TECHNICAL COMPONENT (TC)	The technician's services used in some x-ray, lab, and diagnostic procedures.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	Replaces AFDC rules. Must use old AFDC eligibility standards for Medicaid, so a person may be eligible for Medicaid but not TANF whereas before if a person was eligible for AFDC he/she was automatically eligible for Medicaid. A welfare program funded by federal and state dollars that provides cash and Medicaid benefits to families with at least one child where one or both parents are absent, deceased, or incapacitated.
TEXT-STRING SEARCHES	When a text-string search is performed, each page returns whether the specific text-string value was found. A page is searched for specific text string based on the columns in which that text string appears. (Imaging)

THERAPEUTIC CLASS

Drugs are categorized according to their beneficial effects or their ingredients. First DataBank offers three different therapeutic classifications systems. Therapeutic class is used as a selection criterion to group together claims for different drugs that have the same effect, e.g., central nervous system depressants.

THIRD PARTY LIABILILTY (TPL)

A system that provides cost containment of the Medicaid program through the identification of services for which other insurance should be the primary payer. This includes, but is not limited to, private health insurance, any applicable Medicare coverage, worker's compensation, and accident-related liability insurance.

Implies that another insurance company has primary responsibility to pay for the service - not the patient or Medicaid. A term referring to a situation in which a submitted claim is the result of an accident or injury where another individual or organization may be at fault and responsible for payment, or in which an individual has health insurance resources other than Medicaid or Medicare.

TITLE I (1)

The Old Age Assistance program (OAA) that was replaced by the Supplemental Security Income program (SSI).

TITLE IV (4)

The Aid to Families with Dependent Children program (AFDC).

TITLE IV-E

Title IV-E of the Social Security Act provides federal funds for the purposes of providing maintenance cost of care for eligible children in foster care, administration of the foster care program and training of workers and foster parents. Title IV-E Adoption subsidy is also available for eligible children placed for adoption with special needs and provides support for maintenance cost of care.

TITLE X (10)

The Aid to the Blind program (AB) that was replaced by the Supplemental Security Income program (SSI).

TITLE XIV (14)

The Permanently and Totally Disabled program (PTD) that was replaced by the Supplemental Security Income Program (SSI).

TITLE XVI (16)

The Supplemental Security Income program (SSI). Grants to states for ABD—Supplemental Security Income for ABD – SS Act.

TITLE XVIII (18) ABD Health Insurance Program as part of SS Act. The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B) of the Social Security Act. See Medicare.

TITLE XIX (T19) Medicaid law as part of the Social Security Act (Medicaid). Federal law authorizing federal payments to states that have elected to provide Medicaid services to residents. See Medicaid.

TITLE XXI (T21) Child Health Insurance Program as part of SS Act. A program providing medical benefits for beneficiaries under the age of 19 who are between 150 and 200 percent of poverty. Also referred to as SCHIP. Refer to HealthWave.

TOC Table of Contents

TOC Type of Coverage

TOOLBAR Icons that work as short cuts to many system functions are located on the top or side of the screen within a toolbar.

TRANSACTION PROCESSING Processing transactions as they are received by the computer. Also called online or real-time systems, transaction processing means that master files are updated as soon as transactions are entered at terminals or received over communications lines.

TRANSACTION SET A block of information in EDI, making up a business transaction or part of a business transaction.

TRANSACTION SET STANDARDS The system of syntax, data elements, segments, and transaction sets (messages) with which EDI will be conducted.

TRANSLATOR A program used to convert information from flat file to EDI format or from EDI format to flat file.

TRANSMISSION CONTROL PROTOCOL/INTERNET PROTOCOL (TCP/IP) A set of protocols developed to allow cooperating computers to share resources across a network. This methodology is used to communicate on the Internet and the Wide Area Network. Also used to transfer data between a web site (Internet or Intranet) and other computing platforms. The IP portion refers to the addressing scheme used to address the Internet Network, hence the IP address for a packet. And while the IP does not establish a direct link (just to/from address), the TCP enables two computers to have a connection and exchange streams of data. See IP, ICMP.

TREATMENT Any type of medical care and services recognized under state law to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

TRUNK A telephone line used to make and/or receive calls within the telephone system.

TYPE OF SERVICES (TOS) A code indicating a general category of service, such as medical, surgical, consultation, laboratory or x-ray. A broad classification of services used in conjunction with a procedure code to uniquely define a service.

7.1.21 U

UAT	**User Acceptance Testing**
UB-92	A standard claim form used to bill hospitals, home-health, and LTC services. (HCFA) Uniform Billing Form for all hospital services used by all payers (HCFA 1450) – Universal Billing form that was revised in 1992. Previously it was UB-16, then UB-82. This form is in use nationally for billing hospital-based services. In some states, it is also used for billing home health, rural health, hospice, and nursing home services.
UNIX	A computer operating system used primarily in mini computers. The IBM 390 mainframe platform provides this OS as a sub-operating system to OS 390.
UPIN	Universal Provider Identification Number
USER	A data processing system customer.
USER ID	The code unique to an individual which allows the user to sign-on to the computer system and defines the user's security status.
USUAL AND CUSTOMARY CHARGE (UCC ,U&C)	Those Charges most commonly billed for a service by each provider. The price the provider Charges his patients for a given service.
USUAL AND CUSTOMARY RATE (UCR)	A method of calculating a reasonable Charge based on profiles generated from historical billed Charges.
UTILIZATION MANAGEMENT (UM)	A unit of the fiscal agent that promotes cost-effective, quality health care through research, thorough reviews, and networks with agencies and committees.

UTILIZATION REVIEW (UR/UTLIZATION REV)	Methods and procedures related to the utilization of covered care and services necessary to safeguard against unnecessary or inappropriate use of care and services.

7.1.22 V

VACCINE FOR CHILDREN (VFC)	**A federally funded program that provides immunization serum for qualified children.**
VALUE-ADDED NETWORK (VAN)	A vendor of EDI data communications and translation services. (Switched network provider).
VDT	Video Display Terminal (Screen)
VENDOR	An institution, agency, organization, or an individual practitioner who provides health care services.
VIRTUAL PRIVATE NETWORK (VPN)	Internet software for the client desktop. This allows two users to communicate via the Internet and for security purposes; it is a closed network between the two sites. Along with this technique is "tunneling" which allows data to be sent through a private tunnel rather than over the Internet connection.
VIRTUAL STORAGE ACCESS METHOD (VSAM)	An IBM access method for storing data, widely used in IBM mainframes.

7.1.23 W

WAIVER	**A CMS-approved process that allows states to customize specific rules and regulations to their medical assistance programs to provide more cost-effective services.**
WAN	Wide Area Network. See LAN.
WARRANT	An order for payment/reimbursement. After adjudication, a claim is marked for payment or denial. For the ones marked for payment, a warrant is issued for State finance to issue a check.
WARRANT NUMBER	The actual check number issued for claims payments to providers.
WARRANT TYPE	The type of warrant that is issued to Medicaid providers, be it a value of E (electronic funds transfer) or P (paper).
WIC	Women, Infants, and Children
WINDOWS	A graphics-based windows environment from Microsoft that integrates with and interacts with DOS. It provides a desktop environment similar to the Macintosh, in which applications are displayed in re-sizable, movable windows on screen.
WITHHOLD	An amount which SRS instructs the Fiscal Agent to withhold from the monthly capitation of an HMO.
WORKERS' COMPENSATION	A type of third party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which the employer's insurance company may be obligated under the Workers' Compensation Act.

WORKSTATION A single-user microcomputer or terminal, usually one that is dedicated to a single type of task (graphics, CAD, scientific applications, etc.). (Imaging)

7.1.24 X

X12	**An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are X12 standards.**
X.25	A CCITT protocol that defines a standard way of arranging data in packets to be shipped over transmission lines. (Standard for packet switched networks). See CCITT.
X.400	A CCITT mail and messaging standard.
X.500	A CCITT directory services standard.
XA	Extended Architecture
XOVER	Cross Over
XREF	Cross-Reference

7.1.25 Y

YEARLY ENROLLMENT	**Managed Care re-enrollment opportunity that includes formal education on enrollment for all beneficiaries annually after the actual county conversion.**
YTD	Year to Date

8 Appendix A – interChange Navigational Overview

8.1 System Navigation Introduction

8.1.1 Introduction

The new Kentucky Medicaid Management Information System (MMIS), currently based upon an HP Enterprise Services proprietary system called interChange, is designed according to a set of development standards. This document is designed to introduce users to standard system navigation features within interChange.

8.1.2 Screen Display Features

The interChange system is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

8.1.2.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log in to interChange.	The Home page opens.
2	In the Web browser menu bar, click View.	The View menu options appear.
3	Highlight Text Size, and then click Smaller.	The default Text Size is set to medium; however, after the user selects smaller, the system objects appear smaller.

8.2 System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing, or more importantly documenting, aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms which are described within this document:

- Page;
- Page Header;
- Page Footer;
- Sub Menu;
- Main Menu bar;
- Panel;
- Advanced Search;
- Mini Search panel;
- Hot Link;
- Information panel;
- Navigation panel;
- Task List panel;
- Title Bar Icons;
- Related Data; and,
- Personal Settings.

8.2.1 Home Page Layout

Figure 1 interChange Home Page

Menu Selection	Description
Home	Home Page, includes links to other applications
Claims	Link to Claims subsystem
Reference	Link to Reference subsystem
Provider	Link to Provider subsystem
Member	Link to Member subsystem
Financial	Link to Financial subsystem
EPSDT	Link to EPSDT subsystem
TPL	Link to TPL subsystem
Managed Care	Link to Managed Care subsystem
MAR	Link to MAR subsystem

Menu Selection	Description
Prior Authorization	Link to Prior Authorization subsystem
CTMS	Link to CTMS subsystem
Security	Link to Security settings
Site	Link to activate or modify personal settings
Admin	Link to log in as administrator and set up site settings
Host	Link to log in as host and set up host settings

8.2.2 Page Layout

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels. The bottom of the page contains the Page Footer with the HP Enterprise Services copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that opens an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.

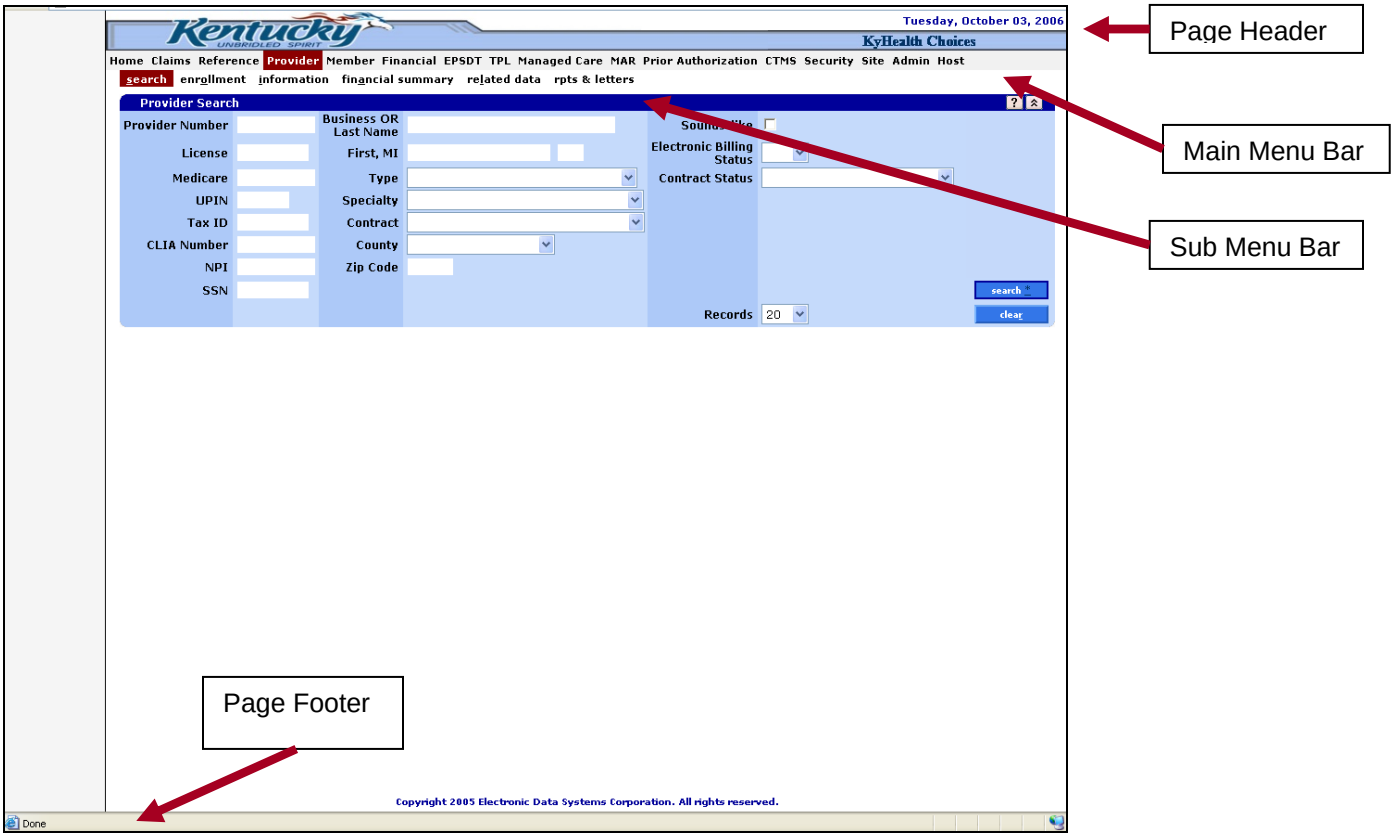


Figure 2 Provider Search Page

In general, when navigating a page, the vertical scroll bar should be the only scroll bar needed to view panels stacked in a vertical manner.

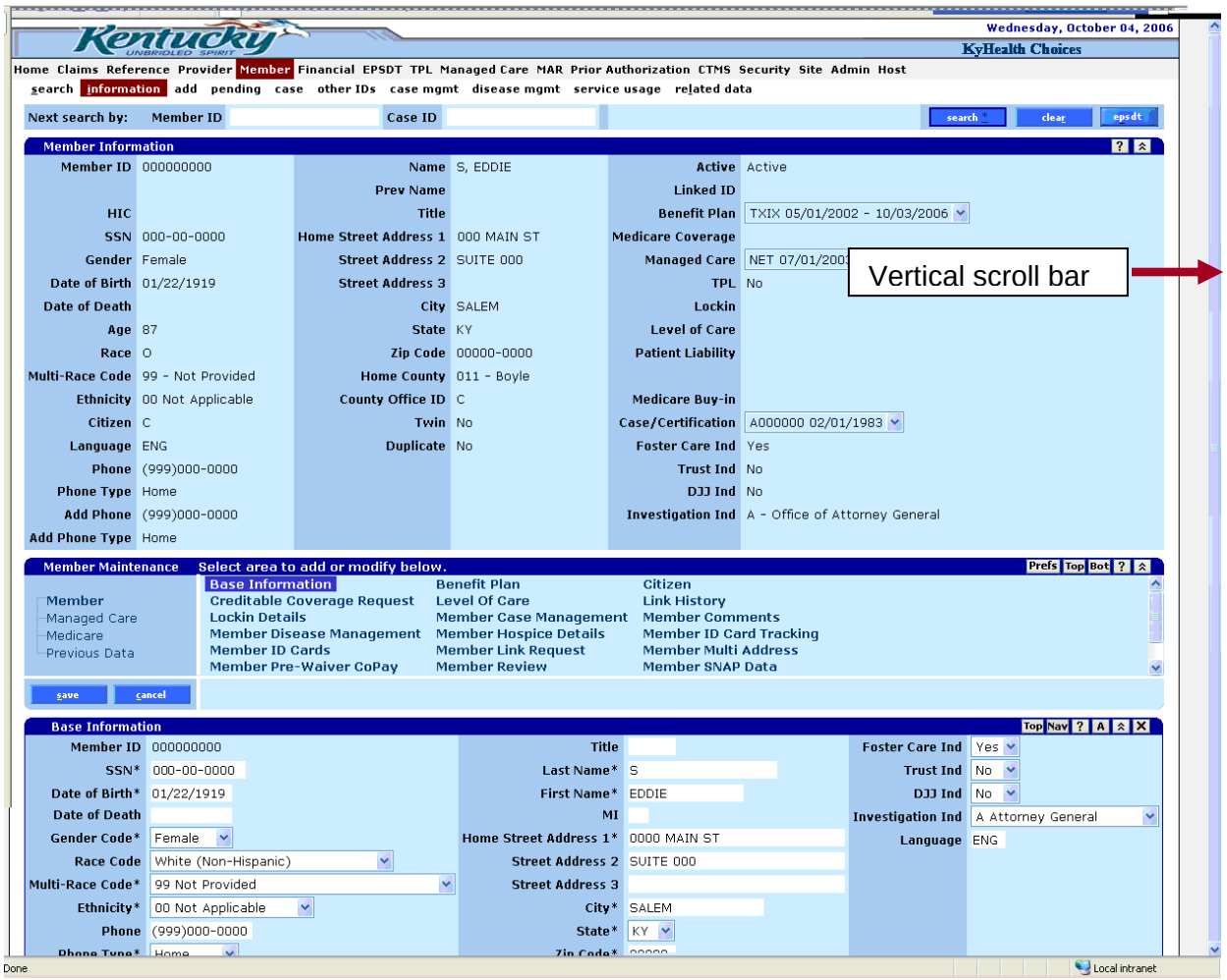


Figure 3 Member Information Page

If a user attempts to add, update, or delete information within the page, then prior to navigating away from the page, the system prompts the user with a pop-up modal window message. When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.

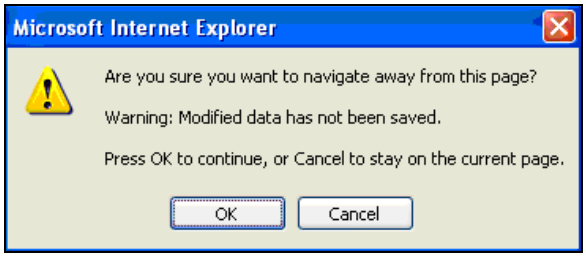


Figure 4 System Message

8.2.3 Search Options

There are several search options available within interChange.

8.2.3.1 Search Panels

The system contains more than one type of search panel: Search and Advanced Search.

Some subsystems such as the Provider Data Maintenance subsystem contain a search panel without an advanced search button included on the panel.

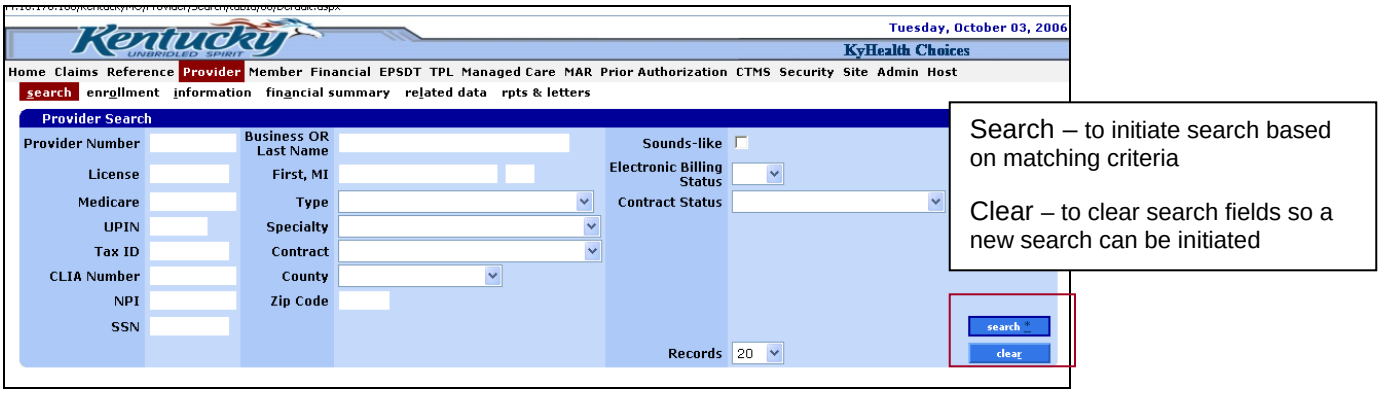


Figure 5 Provider Search Panel

Some subsystems such as the Claims subsystem contain a search panel with an advanced search button included for displaying an additional, advanced search panel.

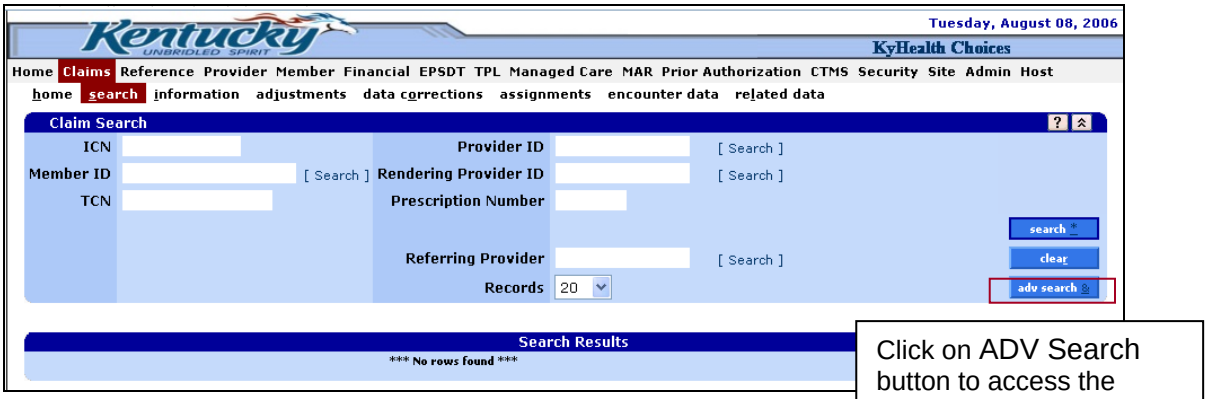
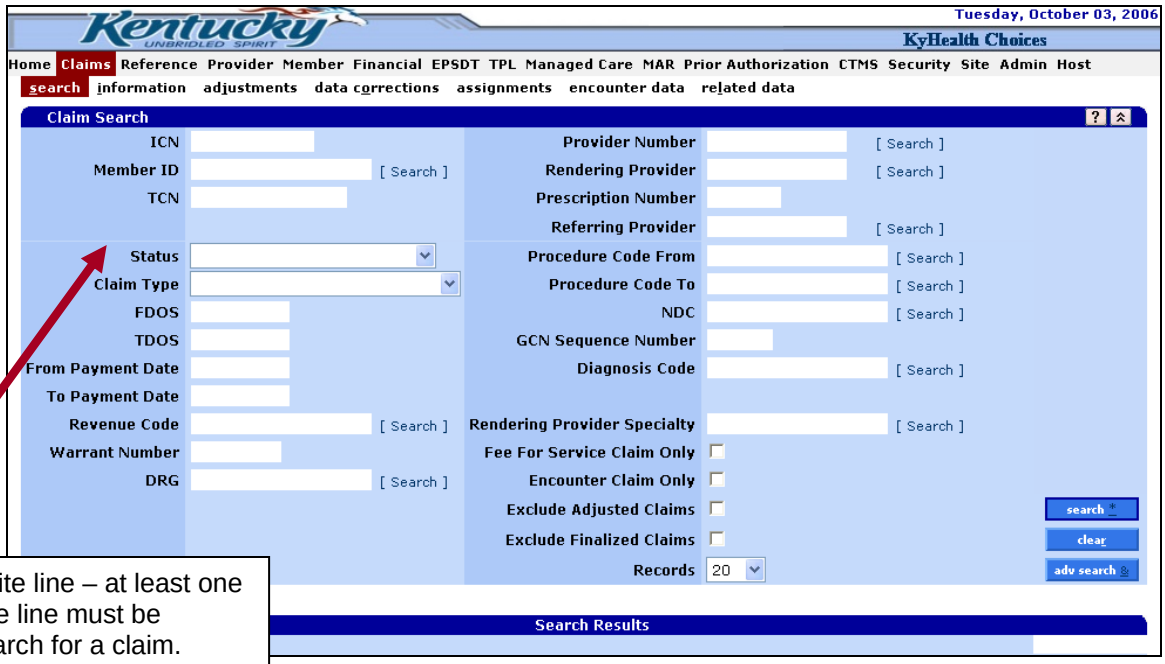
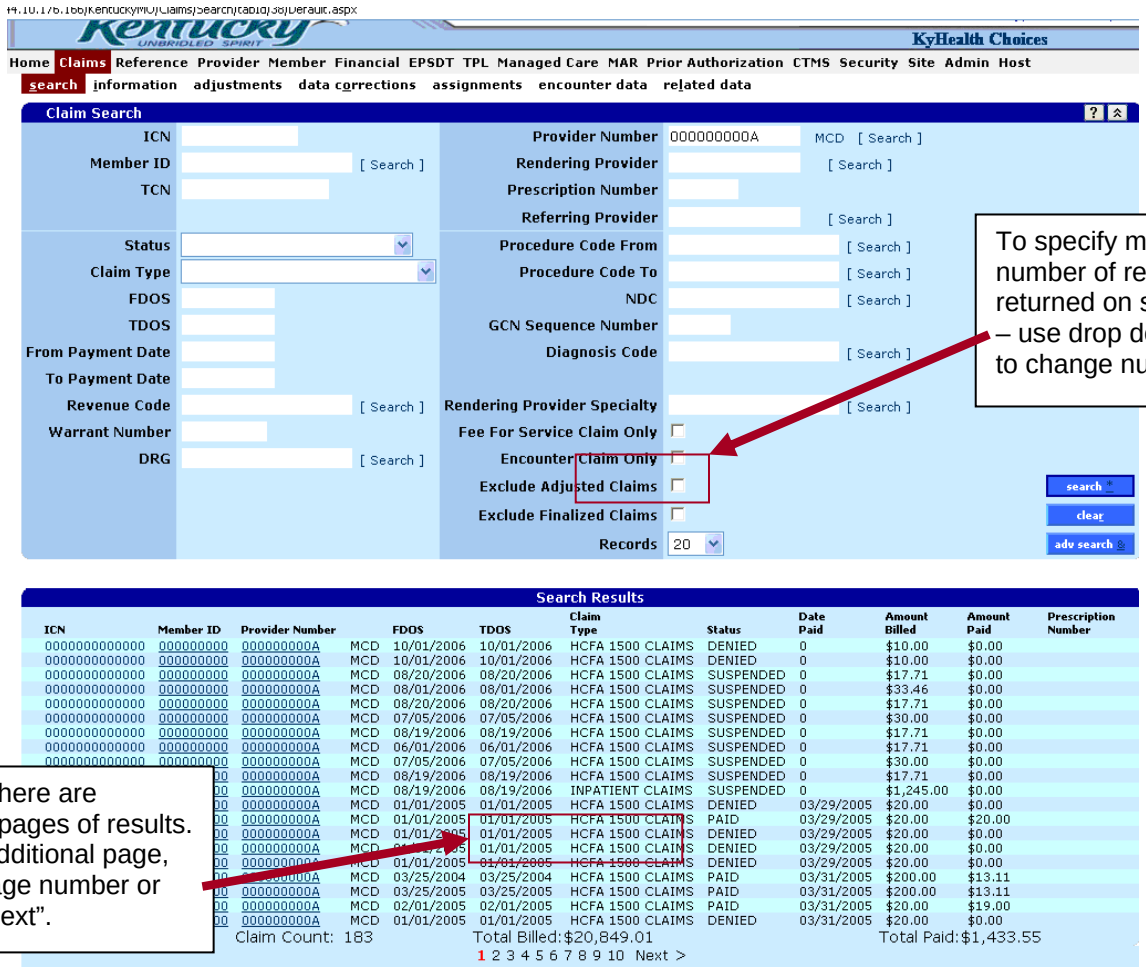


Figure 6 Claim Search Panel



Notice the white line – at least one field above the line must be entered to search for a claim. Fields below the line are optional.

Figure 7 Advanced Claim Search Panel



To specify maximum number of records to be returned on single page – use drop down menu to change number

Indicates there are additional pages of results. To go to additional page, click on page number or click on "Next".

Figure 8 Claim Search Results Panel

The search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.

In Figure 9, the search results are sorted in ascending order by Member ID.

Search Results

ICN	Member ID	Provider Number		FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number
0000000000000	000000000	000000000A	MCD	05/15/2005	05/15/2005	HCFA 1500 CLAIMS	PAID	05/26/2005	$100.00	$3.11	
0000000000000	000000000	000000000A	MCD	05/20/2005	05/20/2005	HCFA 1500 CLAIMS	PAID	06/28/2005	$100.00	$3.11	
0000000000000	000000000	000000000A	MCD	05/25/2005	05/25/2005	HCFA 1500 CLAIMS	DENIED	06/30/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	06/25/2005	06/25/2005	HCFA 1500 CLAIMS	DENIED	06/30/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	06/25/2005	06/25/2005	HCFA 1500 CLAIMS	DENIED	06/30/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	05/21/2005	05/21/2005	HCFA 1500 CLAIMS	DENIED	06/30/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	06/01/2005	06/01/2005	HCFA 1500 CLAIMS	PAID	07/14/2005	$100.00	$3.11	
0000000000000	000000000	000000000A	MCD	04/20/2005	04/20/2005	HCFA 1500 CLAIMS	PAID	07/14/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/01/2005	01/01/2005	HCFA 1500 CLAIMS	PAID	07/14/2005	$20.00	$10.00	
0000000000000	000000000	000000000A	MCD	06/20/2005	06/20/2005	HCFA 1500 CLAIMS	PAID	07/14/2005	$100.00	$3.11	
0000000000000	000000000	000000000A	MCD	0	01/01/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/06/2006	01/06/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	0	01/01/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	0	01/03/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	05/21/2005	05/21/2005	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/05/2006	01/05/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/04/2006	01/04/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/02/2006	01/02/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	0	01/01/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	0	01/01/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	

Claim Count: 183 Total Billed:$20,849.01 Total Paid:$1,433.55

1 2 3 4 5 6 7 8 9 10 Next >

Figure 9 Search Results Page Sorted by Member ID

8.2.3.2 Selecting a Search Result Row

If the user clicks once on a search result row, the associated information panel opens. In Figure 10, the user clicks the second row of the Claim Search Results panel and the Paid HCFA 1500 Claim for the associated ICN displays.

Search Results

ICN	Member ID	Provider Number		FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid	Prescription Number
0000000000000	000000000	000000000A	MCD	05/15/2005	05/15/2005	HCFA 1500 CLAIMS	PAID	05/26/2005	$100.00	$3.11	
0000000000000	000000000	000000000A	MCD	05/20/2005	05/20/2005	HCFA 1500 CLAIMS	PAID	06/28/2005	$100.00	$3.11	
0000000000000	000000000	000000000A	MCD	05/25/2005	05/25/2005	HCFA 1500 CLAIMS	DENIED	06/30/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	06/25/2005	06/25/2005	HCFA 1500 CLAIMS	DENIED	06/30/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	06/25/2005	06/25/2005	HCFA 1500 CLAIMS	DENIED	06/30/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	05/21/2005	05/21/2005	HCFA 1500 CLAIMS	DENIED	06/30/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	06/01/2005	06/01/2005	HCFA 1500 CLAIMS	PAID	07/14/2005	$100.00	$3.11	
0000000000000	000000000	000000000A	MCD	04/20/2005	04/20/2005	HCFA 1500 CLAIMS	PAID	07/14/2005	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/01/2005	01/01/2005	HCFA 1500 CLAIMS	PAID	07/14/2005	$20.00	$10.00	
0000000000000	000000000	000000000A	MCD	06/20/2005	06/20/2005	HCFA 1500 CLAIMS	PAID	07/14/2005	$100.00	$3.11	
0000000000000	000000000	000000000A	MCD	0	01/01/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/06/2006	01/06/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	0	01/01/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	0	01/03/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	05/21/2005	05/21/2005	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/05/2006	01/05/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/04/2006	01/04/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	01/02/2006	01/02/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	0	01/01/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	
0000000000000	000000000	000000000A	MCD	0	01/01/2006	HCFA 1500 CLAIMS	DENIED	05/02/2006	$100.00	$0.00	

Claim Count: 183 Total Billed:$20,849.01 Total Paid:$1,433.55

1 2 3 4 5 6 7 8 9 10 Next >

Figure 10 Selecting a Search Result Row

8.2.3.3 Hot Links

Within certain Search panels, the user can also click hot links to see additional information. If the fields in a column are underlined, there is a hot link available. As Figure 11 demonstrates, if the user clicks the Member ID hot link, then the Member Information panel opens for that claim Internal Control Number (ICN) search result.

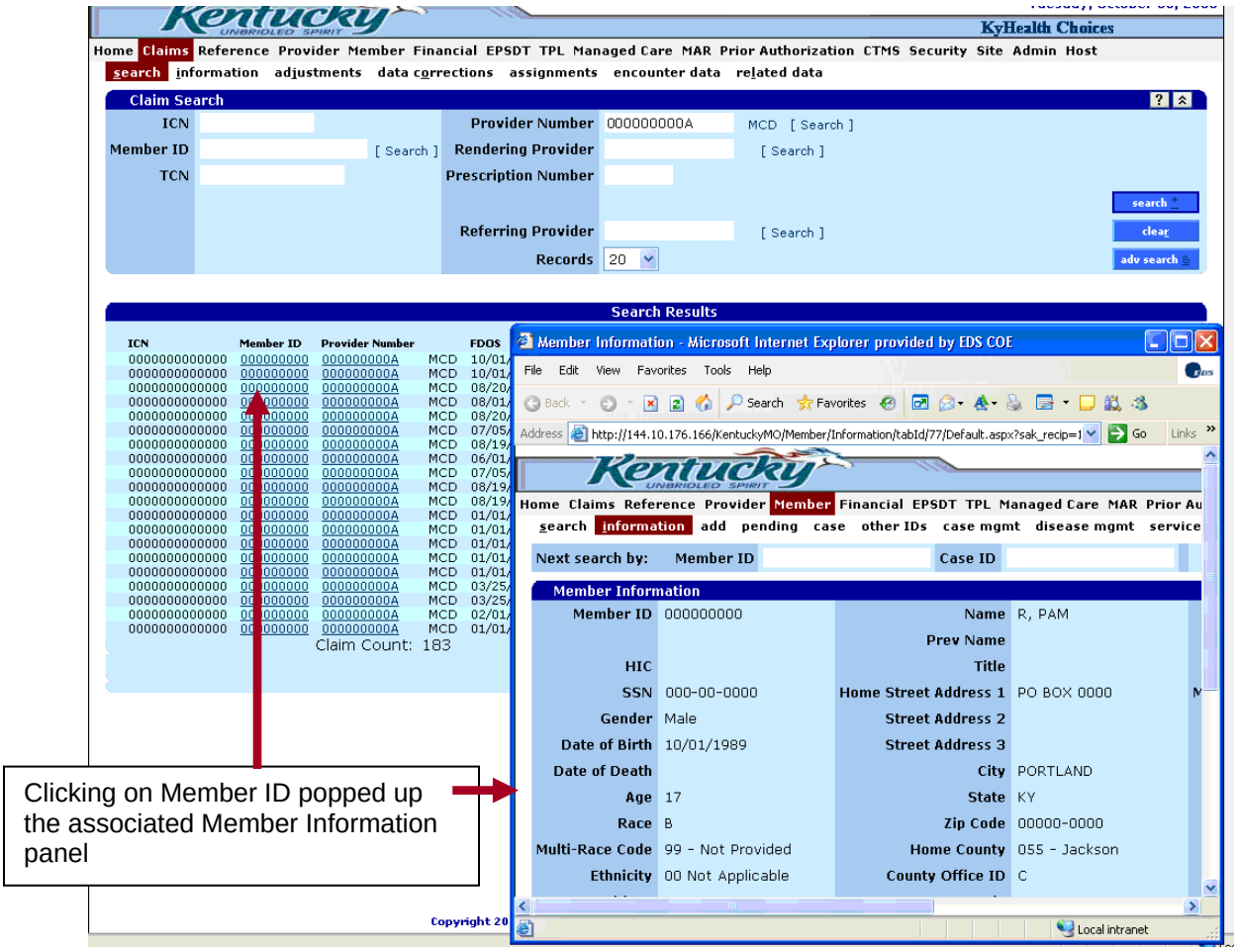


Figure 11 Member Information Pop Up

8.2.3.4 Mini Search

After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

Mini Search panels contain one or two primary search fields related to the business process.

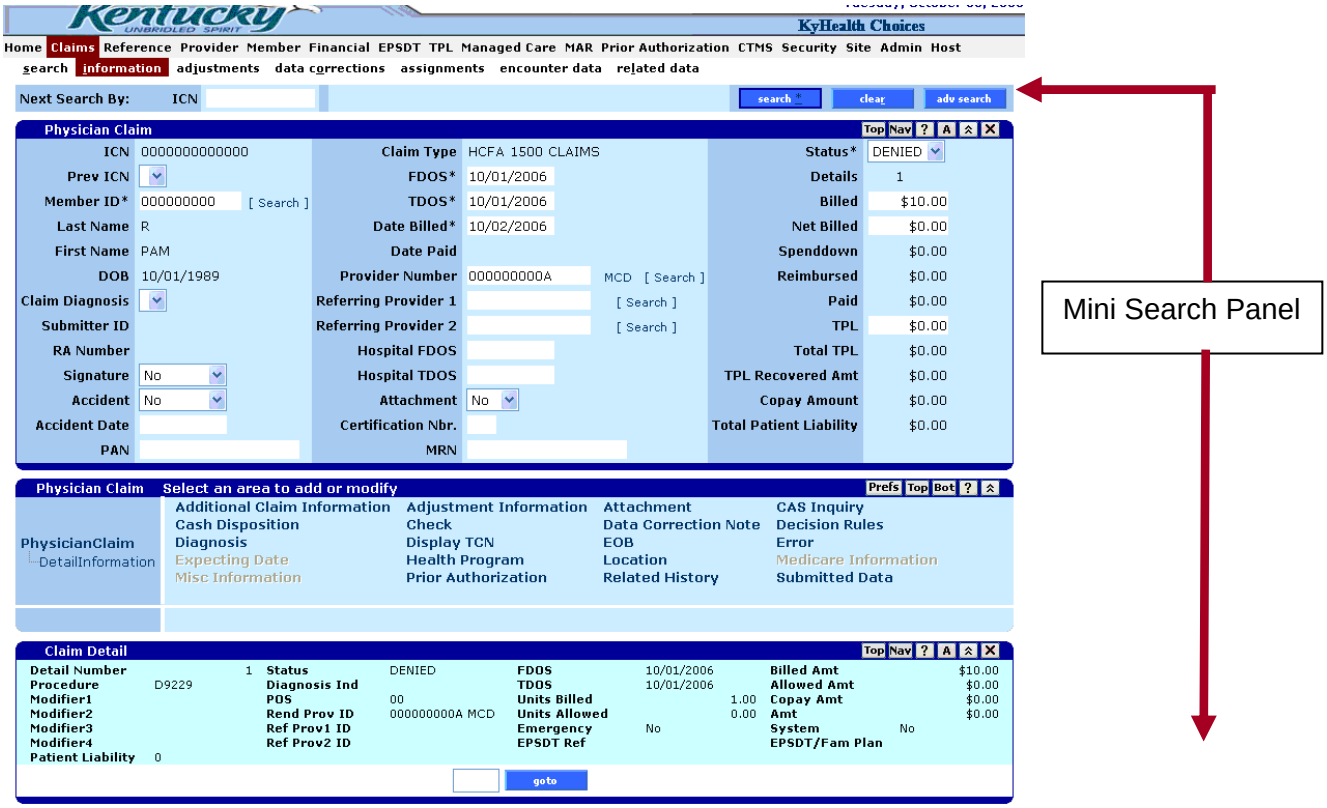


Figure 12 Claim Mini Search Panel

8.2.3.5 Pop Up Search

A Pop Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accesses the search panel that is associated with that particular field.

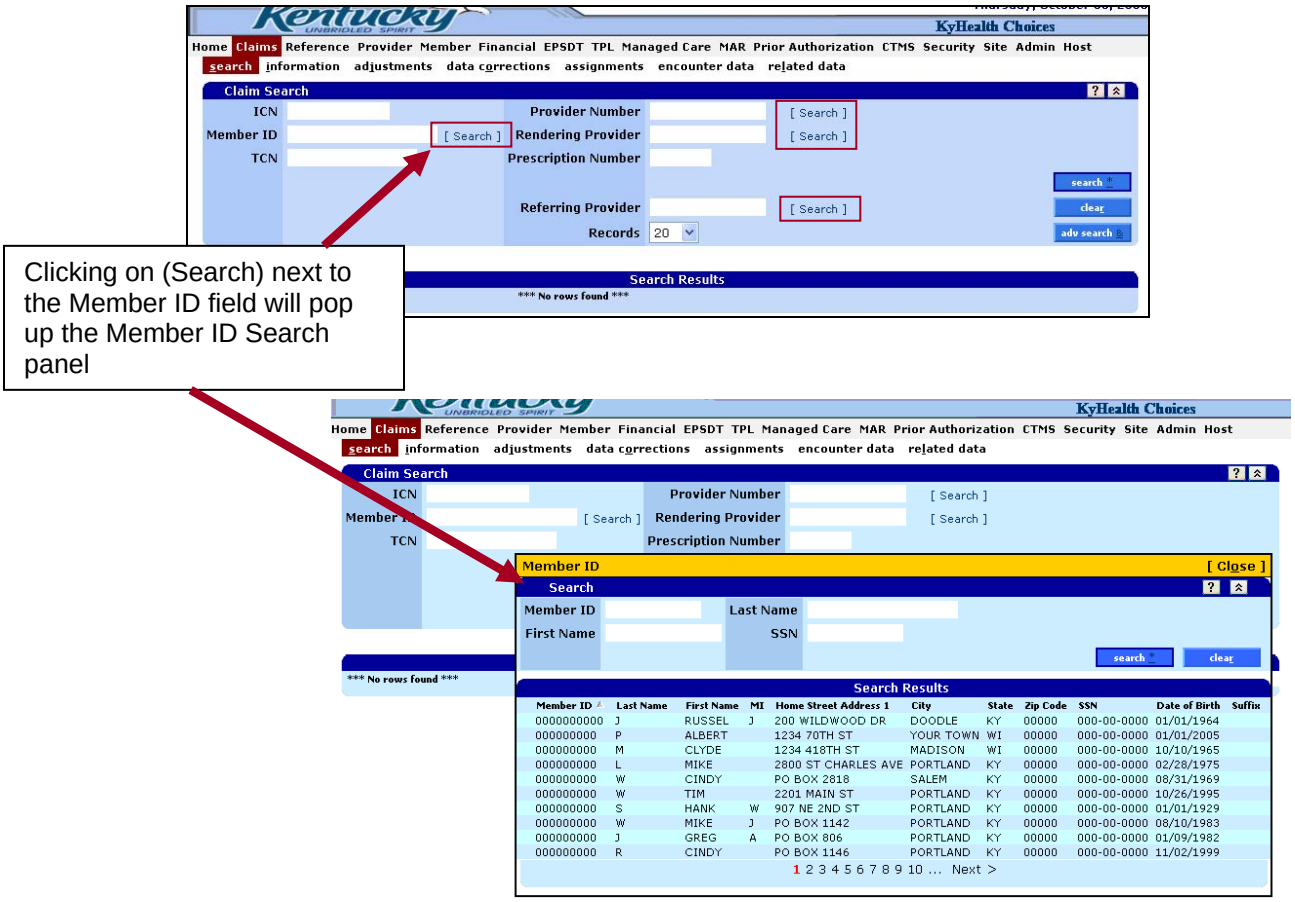


Figure 13 Claim Search Page

8.2.4 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

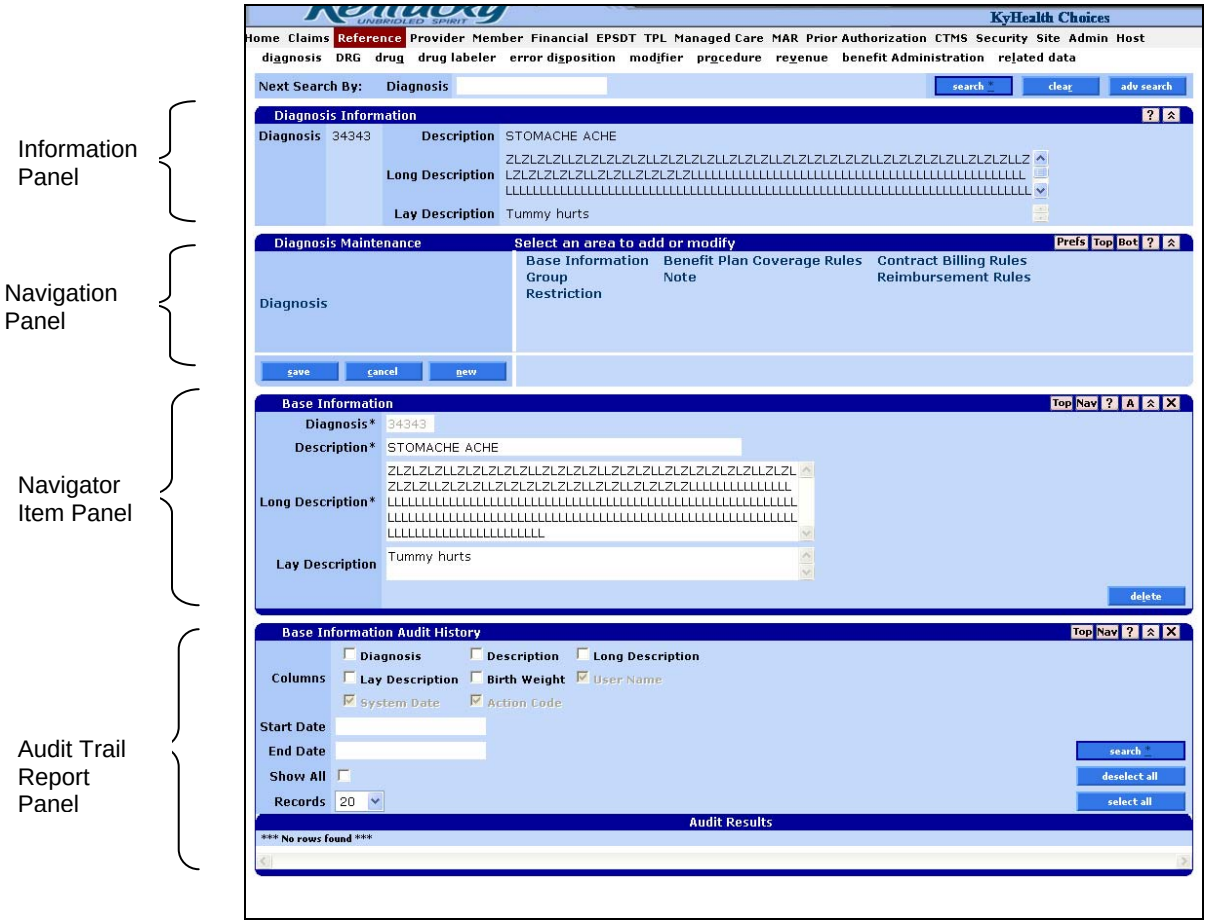
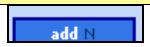
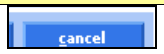
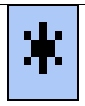


Figure 14 Diagnosis Code Base Information and Audit Panel

8.2.4.1 Panel Types and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Button/Icon	Description
Add Button 	Allows the user to insert a new data record on a panel. Click “Add” to open a record with blank fields. Fill in the applicable information. Click the “Save” button located on the Navigation panel to save the new record.
Delete Button	Allows the user to delete a selected data record on a panel. Click on the record that needs deletion, which will highlight the record. Click on “Delete”. Click the “Save” button located on the Navigation panel to save the deletion.

Button/Icon	Description
Cancel Button 	Cancels all unsaved changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	If a new record is added to a panel, clicking “Save” will save the new record. If changes are made to an existing record on a panel, clicking “Save” will save the changes. If validation errors occur, an error message displays in the Task List panel. Can be found on the Navigation panel.
Asterisk 	Displayed next to a required field. Fields indicated with an asterisk are required to contain data.
Preferences Button	Displays a checkmark box next to each Navigator Item link. By checking the box, the link automatically opens whenever the user browses the page. To hide the boxes, click on the button a second time. Can be found only on the Navigation panel.
Top Button	Allows user to jump to the top of the page.
Bottom Button	Allows user to jump to the bottom of the page.
Help Button	Opens a window that displays the panel help page.
Maximize Button	Expands a panel to display all of its content.
Minimize Button	Collapses a panel.
Navigation Button	To jump to the Navigation panel.
Audit History Button	Opens the Audit History Panel for a specific panel.
X Button	Closes a panel.
Green Information Button	Opens information file for the associated field.

Among the panel types are the following:

- Navigation panel;
- Task List panel;
- Navigator Item Panel; and,
- Audit panel.

8.2.4.2 Navigation Panel

A navigation panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Navigator Group Link, the associated Navigator Item panels are displayed. Changes to Navigator Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Navigator panel.

The navigation panel is used to navigate within a page, never to leave the page.

Figure 15 demonstrates Navigator Group Links (Provider and Service Location) and the associated Navigator Item links. By clicking on an Item Link (such as Comment), the associated panel opens.

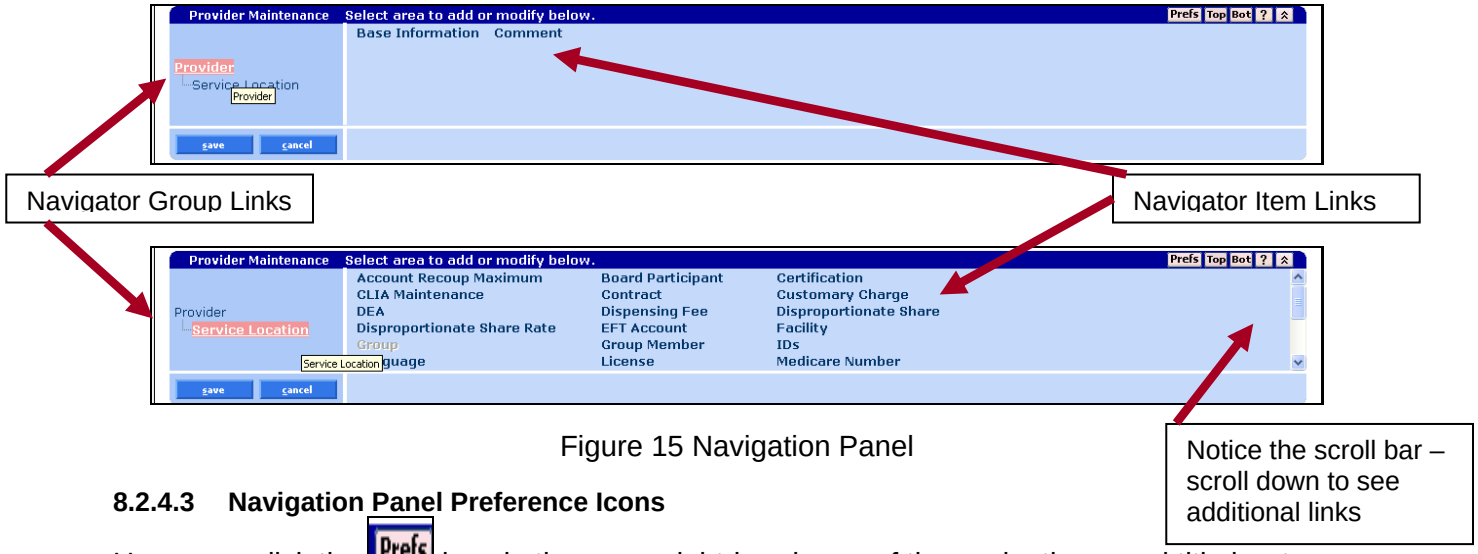


Figure 15 Navigation Panel

8.2.4.3 Navigation Panel Preference Icons

Users can click the icon in the upper right-hand area of the navigation panel title bar to pre-set which panels automatically opens each time the user accesses that particular navigation page.

When the user clicks a link in the right-hand side of the navigation panel, the associated panel displays beneath the navigation panel.

In Figure 16, the Provider Maintenance navigation panel is open. If the user checks the Certification and Customary Charge check boxes, then the associated panels automatically displays directly beneath the navigation panel each time the user accesses this page.

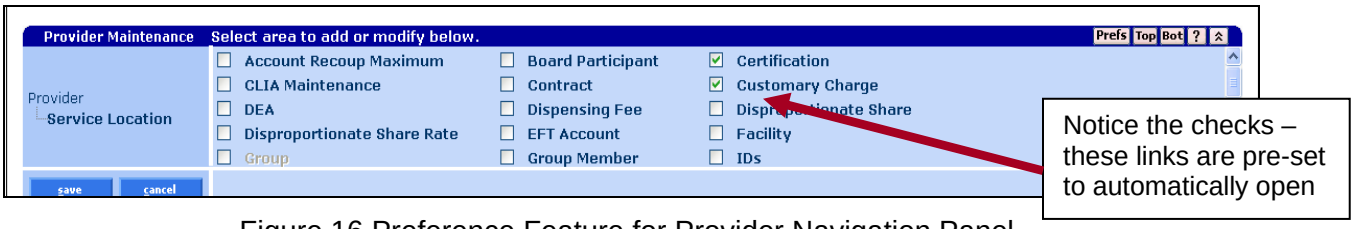


Figure 16 Preference Feature for Provider Navigation Panel

The opening of multiple panels results in the display of the panels vertically down the page.

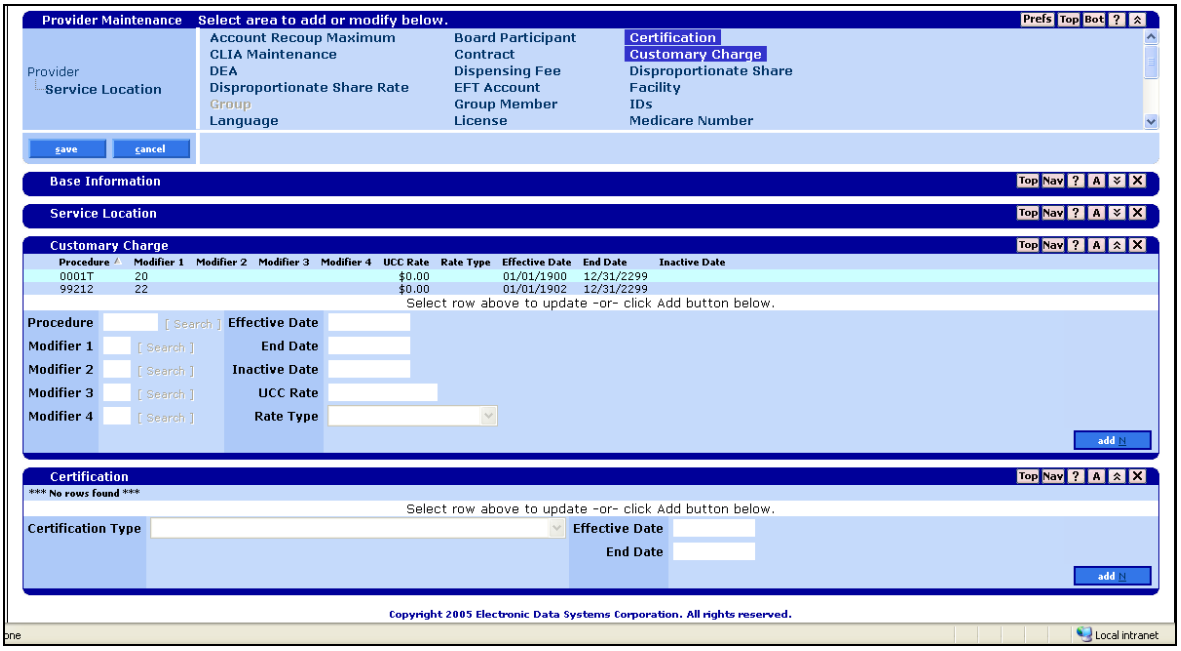


Figure 17 User Preference Panel Display

8.2.4.4 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.

Detail panels are locked open and navigation away from the page is not permitted until changes are saved or cancelled.

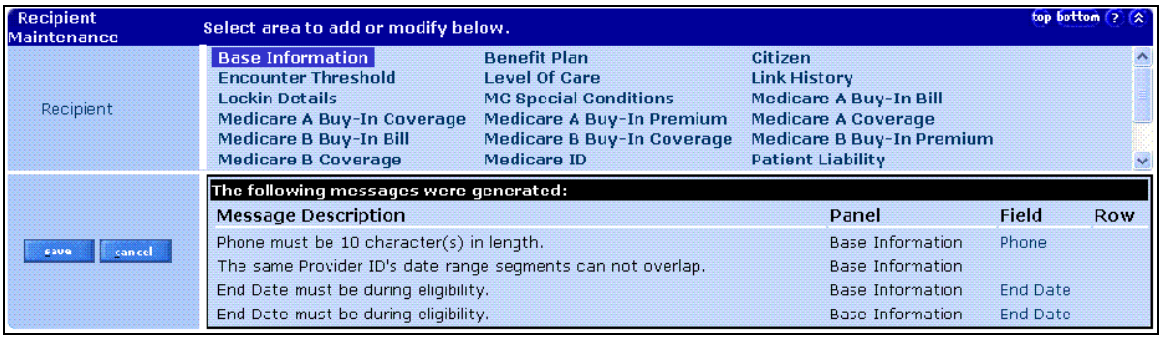


Figure 18 Task List Panel

The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

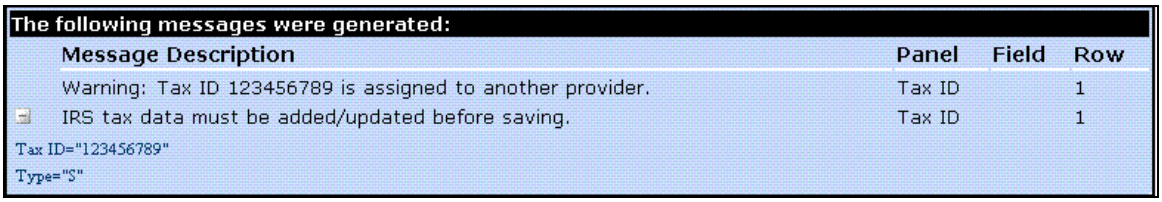


Figure 19 Warning Message

The task list can also be used to display messages that require a response. The user answers the question by completing an action within the message area, then click on the Continue link at the center bottom of the Task List panel to indicate the answer is ready for processing.

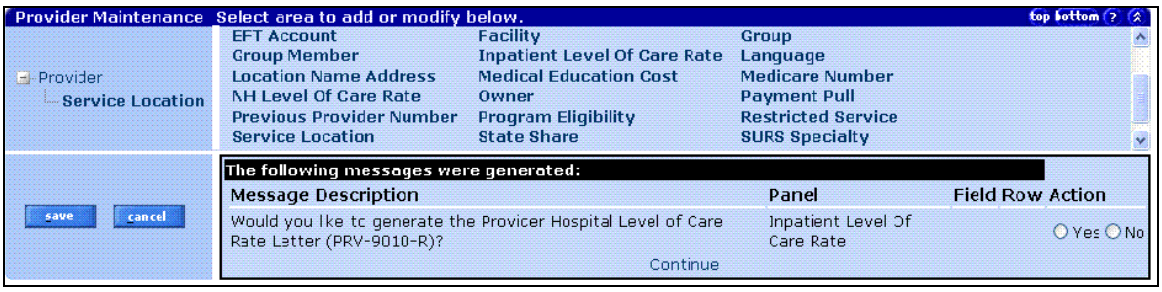


Figure 20 Response Message

The user answers the question posed by the message and then the user clicks the Continue link to indicate the answer is ready for processing.

8.2.4.5 Navigator Item Panel

A Navigator Item panel is opened by clicking a link on a Navigation panel. Navigator Items allow detail data to be viewed and updated. Usually a Navigator Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.

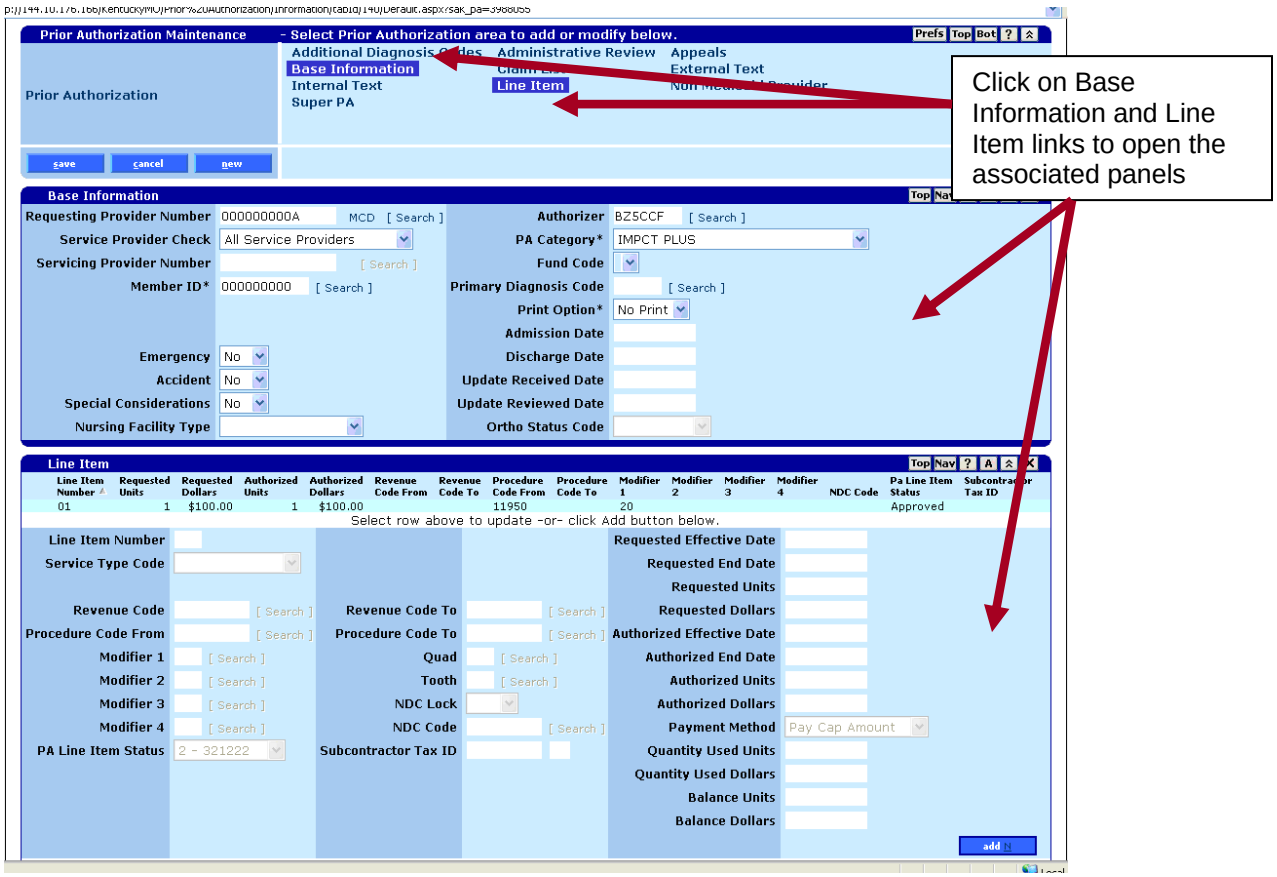


Figure 21 Base Information and Line Item Panels

By clicking on a data record, the fields below auto-populates. This allows the user to view detailed information about the data record, or, modify or delete the data record.

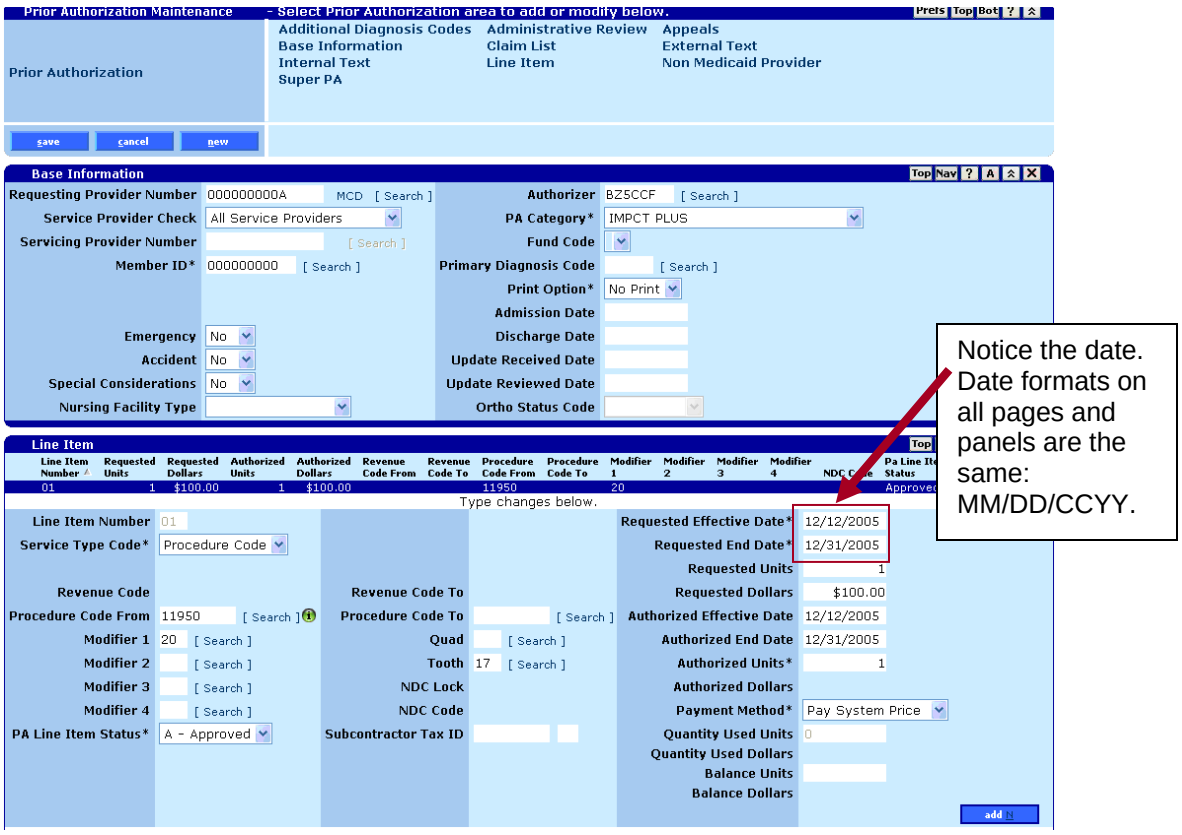


Figure 22 Row Selection in Navigator Item Panel

8.2.4.6 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an auditable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.

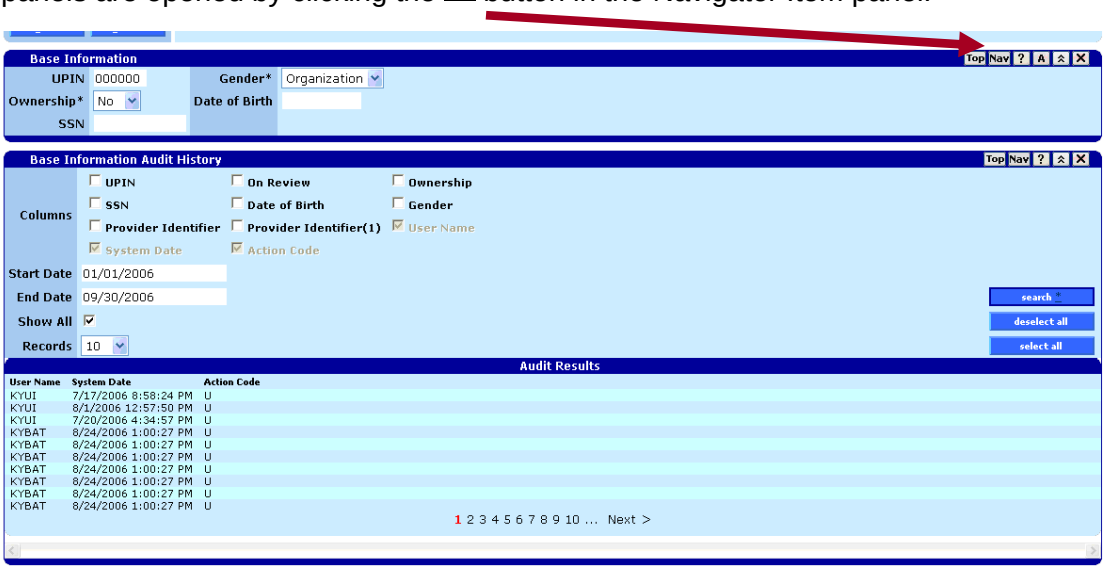


Figure 23 Audit History Panel

Field Name	Field Description
Columns	A check box for each editable field on the main panel displays. Allows the user to display select fields only.
Start Date	User can optionally limit Audit Results to matches where the system date of the change is equal to or greater than this date.
End Date	User can optionally limit Audit Results to matches where the system date of the change is equal to or less than this date.
Show All	If not checked, the audit result displays changes to only the single data row selected in the main panel. If checked, the audit results reports changes to all data rows contained in the list of the main panel.
Records	Number of records to display per page in the Audit Results.
Search	Displays Audit Results based on search criteria entered on the panel.
Deselect All	Removes all column checkboxes.
Select All	Checks all column checkboxes.
System Date	The date of the change.
Action Code	The type of change performed (delete, insert, update).

8.2.5 Related Data

Each subsystem, with the exception of MAR, contains Related Data. Related Data is a Sub Menu that contains codes, cross-reference tables, and other information for each associated subsystem.

8.2.5.1 Related Data Codes Page

The Related Data Codes page allows the user to access the various code tables not otherwise defined within the associated subsystem area.

The following subsystems contain a Related Data Codes page: Reference, Provider, Member, Financial, TPL, Managed Care, and Prior Authorization. Listed below are examples of "Codes" that can be found in Related Data.

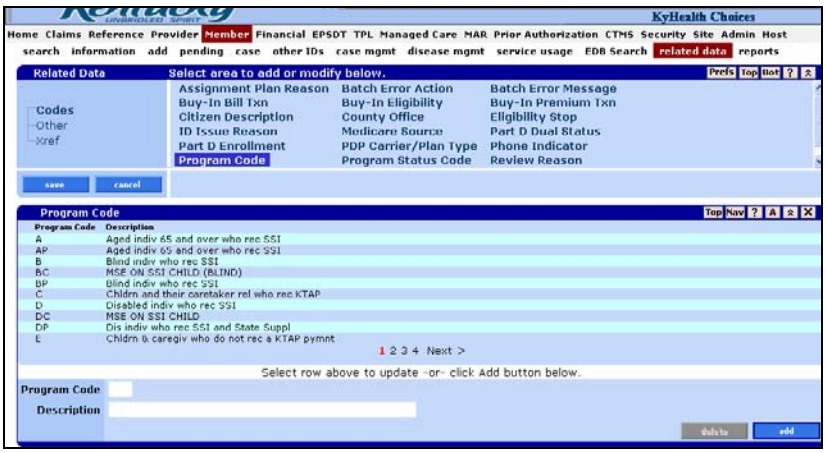


Figure 24 Program Codes (located in Member)

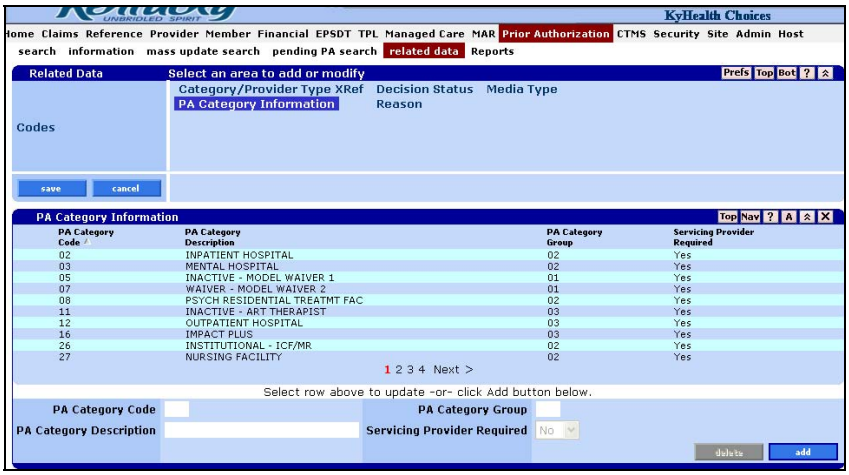


Figure 25 PA Category Information (located in Prior Authorization)

8.2.5.2 Related Data Other Page

The Related Data Other page allows the user to access the various miscellaneous data maintained within the associated subsystem area.

The following subsystems contain a Related Data Other page: Claims, Reference, Provider, Member, Financial, EPSDT, TPL, and Managed Care. Listed below are examples of "Other" panels that can be found in Related Data:

Click on "Other" to access these links.

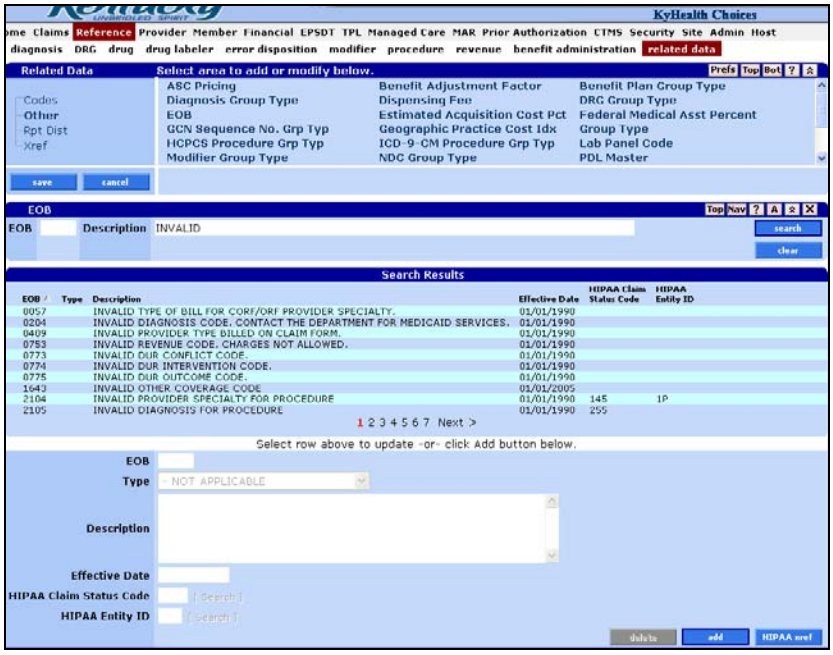


Figure 26 EOB (located in Reference)

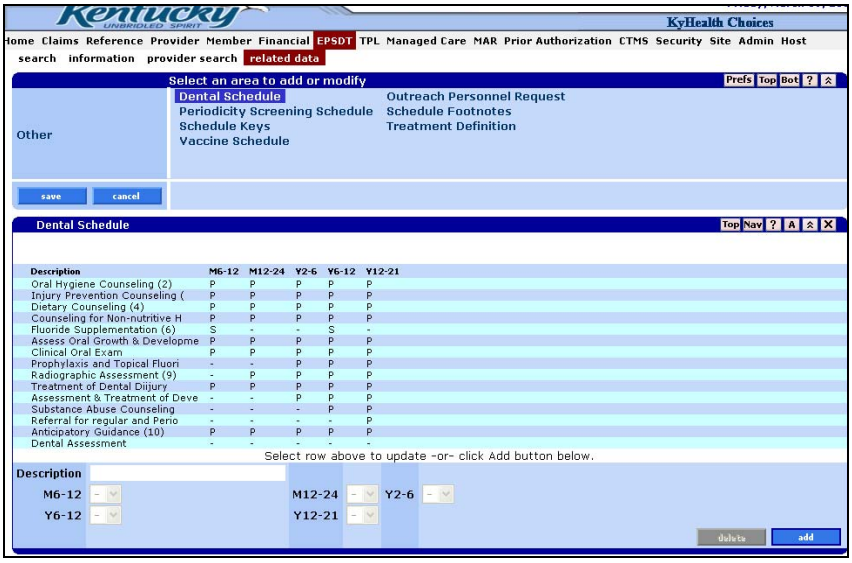


Figure 27 Dental Schedule (located in EPSDT)

8.2.5.3 Related Data Cross-Reference (Xref) Page

The Related Data Xref page allows the user to access the various cross-reference data tables maintained within the associated subsystem area.

The following subsystems contain a Related Data Xref page: Reference, Member, TPL, and Managed Care. Listed below are examples of "Xref" panels that can be found in Related Data:

Click on "Xref" to access these links.

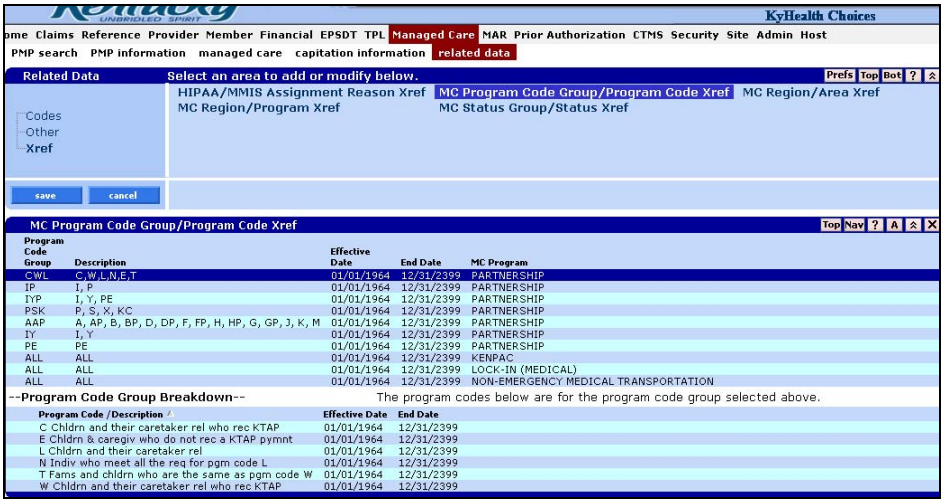


Figure 28 MC Program Code Group/Program Code Xref

(located in Managed Care)

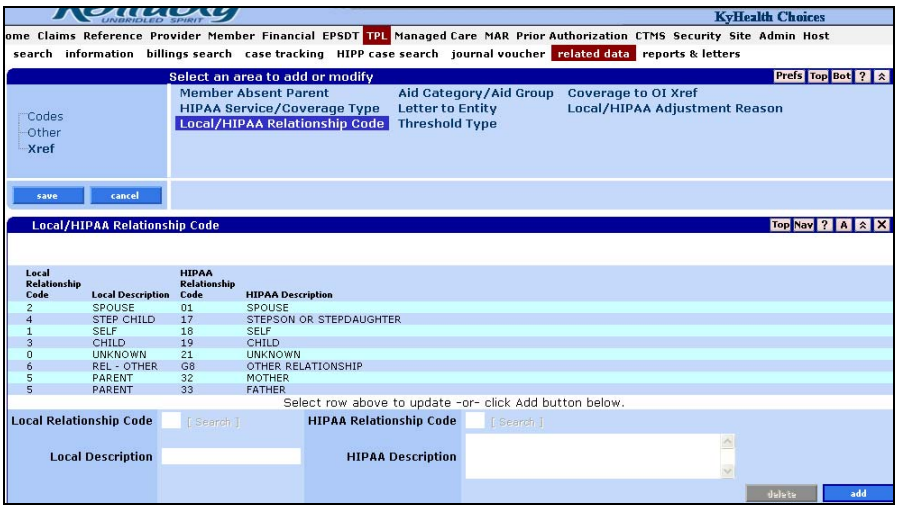


Figure 29 Local/HIPAA Relationship Code (located in TPL)

8.2.5.4 Related Data Report Distribution Page

The Reference subsystem contains a Related Data Report Distribution page. Listed below is an example of a Report Distribution panel:

Click on "Rpt Dist" to access these links.

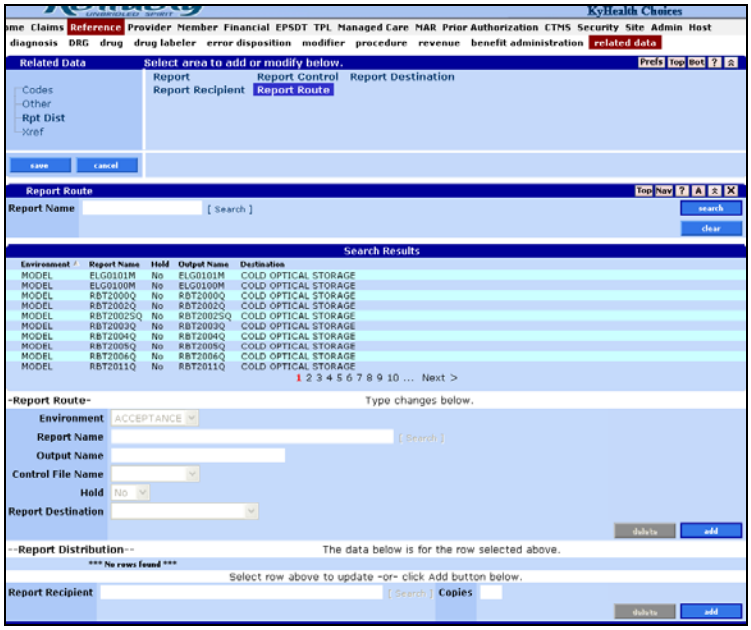


Figure 30 Report Route (located in Reference)

8.2.5.5 Related Data Payee Page

The Financial subsystem contains a Related Data Payee page. This page contains the link for one panel – EFT Account.

Click on "Payee" to access the EFT Account link.

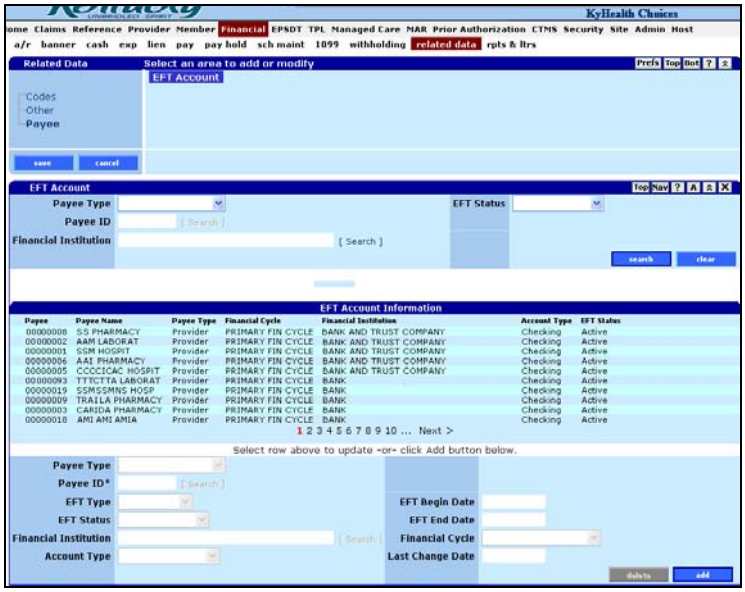
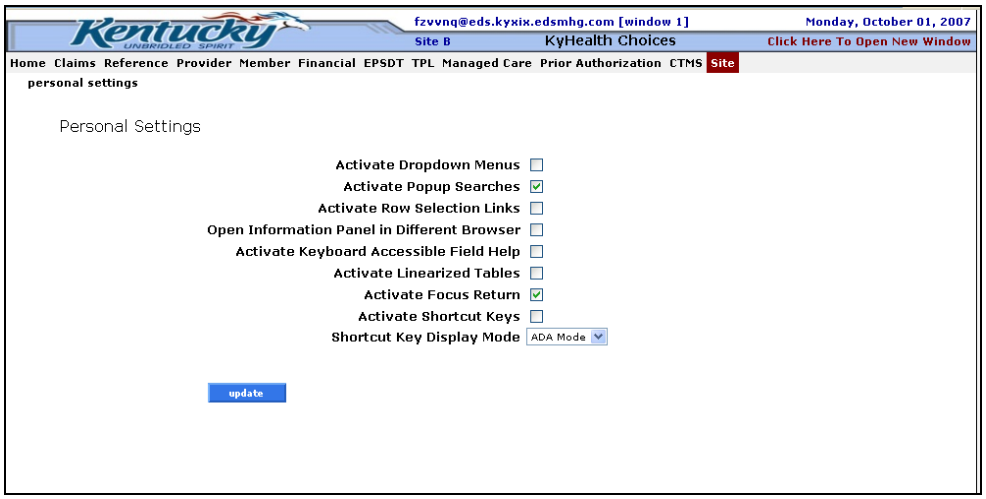


Figure 31 EFT Account (located in Financial)

8.2.6 Personal Settings

The Site subsystem allows the user to activate or modify personal settings. Click on the Site link and the following page will be displayed:



Field	Description
Activate Dropdown Menus	If enables, a drop down menu will display when scroll the mouse over the subsystem menu. If disabled, a drop down menu will not display.
Activate Popup Searches	If enabled, popup searches will be accessible by clicking the “[Search]” link next to some fields. If disabled, popup searches will not be available.
Activate Row Selection Links	If enabled, a link will be added at the beginning of each row in a list. To select a row, the user will click on the link. If disabled, there will not be a link and the user will click on the row itself to select a row.
Open Information Panel in Different Browser	If enabled, when a record is selected from search results, a different browser window will open, displaying the record selected. If disabled, a different browser window will not open. The selected record will be displayed in the same browser window as the search result panel.

Field	Description
Activate Keyboard Accessible Field Help	If enabled, the help feature for a field will be accessible by pressing ENTER on the keyboard. If disabled, the help feature will be accessible by clicking on the field name with the mouse.
Activate Linearized Tables	If enabled, the fields on a page and panel will be displayed in one column. If disabled, the fields on a page and panel will be displayed in two or more columns.
Activate Focus Return	If enabled, the cursor placement will be handled automatically, which will eliminate the need for the user to scroll and click on fields after a page navigation or refresh. If disabled, the cursor will not automatically return to the last field.
Activate Shortcut Keys	If activated, the system will enable shortcut keys and display shortcut key indicators on buttons and menu links. If disabled, the user will navigate the system by clicking on menu links and buttons with the mouse.
Shortcut Key Display Mode	The mode in which the shortcut key is displayed: ADA Mode or Underlined.
Update	Updates changes to the Personal Settings fields.
Last Update	Indicates date and time of most recent update to personal settings.

To activate a personal setting, click to insert a check mark in the associated box, and then click the “Update” button.

To disable a personal setting, click to remove the check mark in the associated box and click the “Update” button.

The following personal setting functions are demonstrated in the next sections: Popup Searches, Row Selection Links, Linearized Tables, and Shortcut Keys.

8.2.6.1 Pop Up Searches

If the user activates the pop up searches function, the [Search] link located next to certain fields will become accessible.

If the pop up search function is not enabled, the [Search] link will not be displayed, as shown in Figure 32.

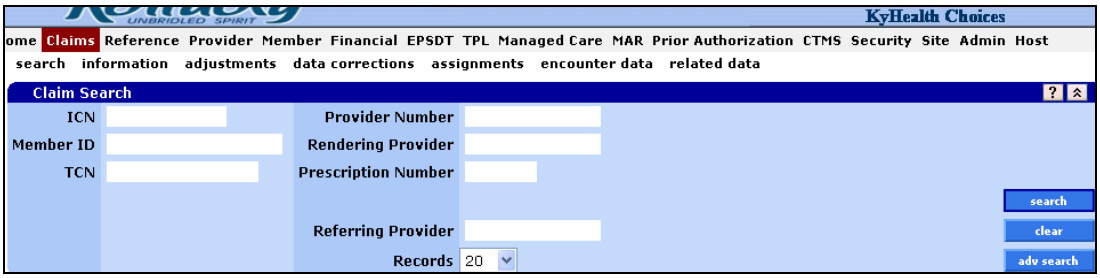


Figure 32 Claims Search Page without Pop Up Searches

To activate the pop up searches, click on the Site link, check “Activate Popup Searches”, and click the “Update” button.

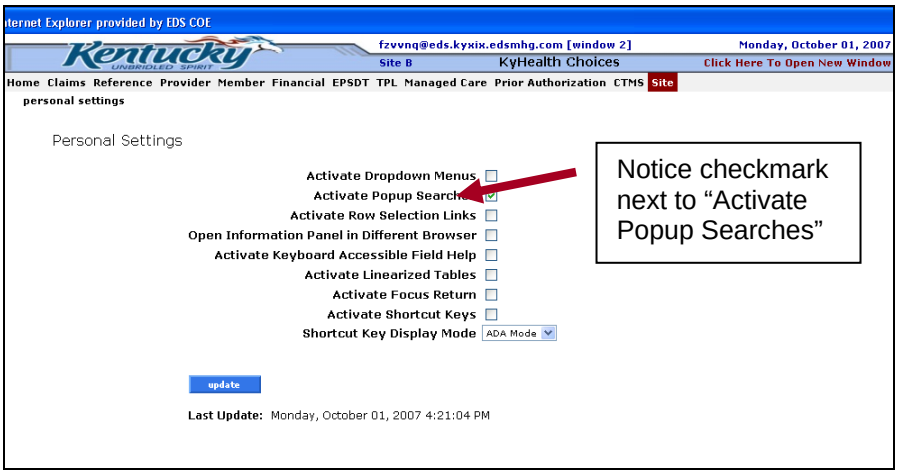


Figure 33 Personal Settings Page – Activate Popup Searches

The pop up search links are now accessible.

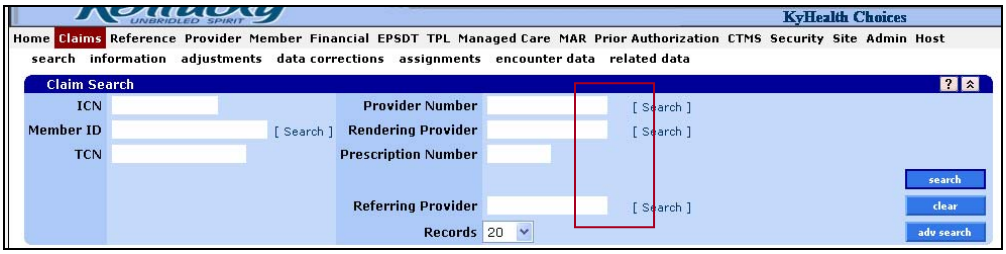


Figure 34 Claims Search Page with Pop Up Searches

8.2.6.2 Row Selection Links

The “Activate Row Selection Links” field determines how a user will select a row of records.

To activate the row selection links, click on the Site link, check “Activate Row Selection Links”, and click the blue “Update” button.

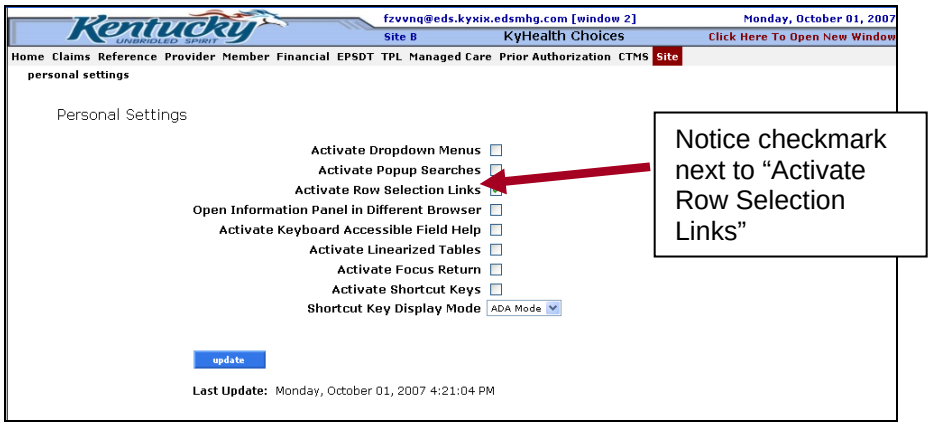


Figure 35 Personal Settings Page – Activate Row Selection Links

When activated, the user will select a row by clicking on the link next to the row.

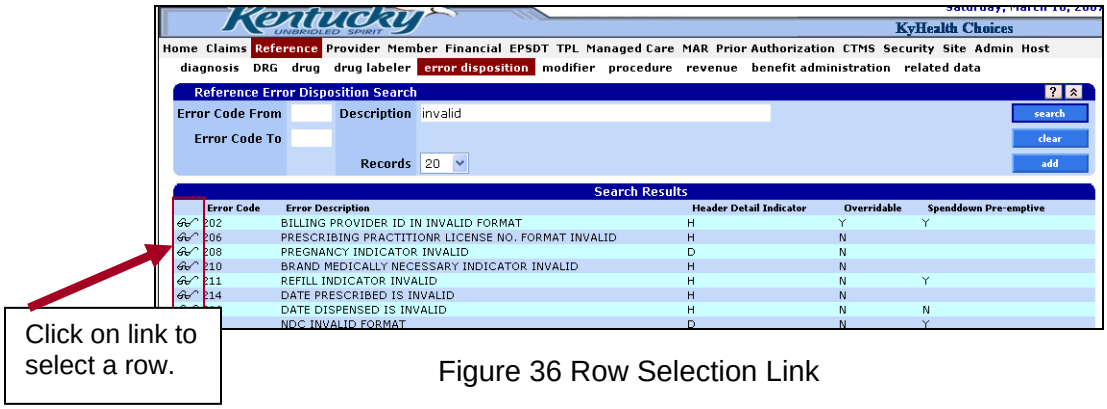


Figure 36 Row Selection Link

If the Row Selection Links is disabled, the link next to the row will not be available. The user will select a row by clicking once anywhere within the row itself (except on a Hot Link, as discussed in a previous section).

8.2.6.3 Linearized Tables

The "Activate Linearized Tables" function determines how fields are displayed on a pages and panels.

To activate the linearized table function, click on the Site link, check "Activate Linearized Tables", and click the blue "Update" button.

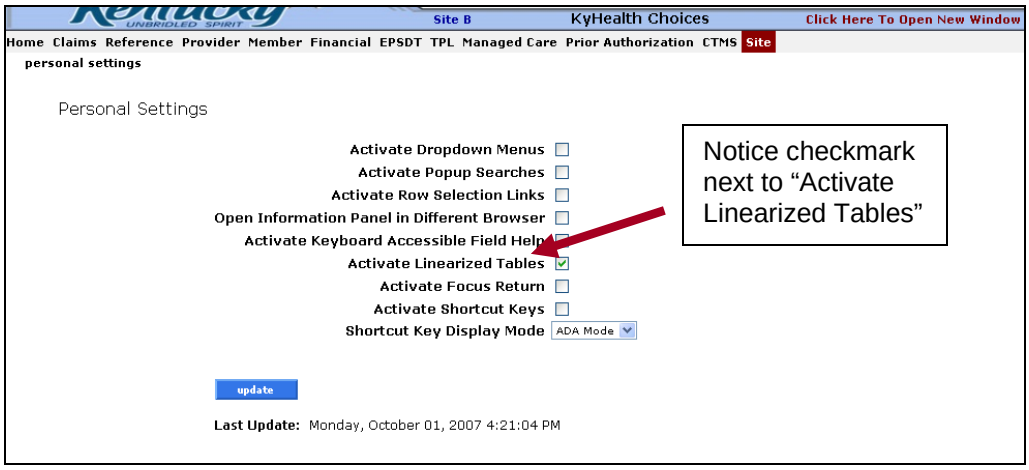


Figure 37 Personal Settings Page – Activate Linearized Tables

When activated, the linearized table function will display the fields in one column on a page and panel.

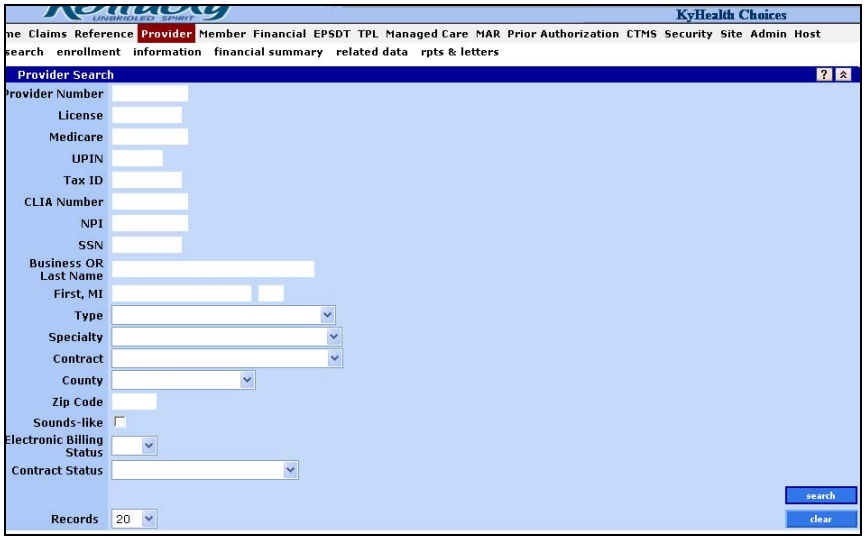


Figure 38 Provider Search Panel with a Linearized Table

If the linearized table function is disabled, the fields will be displayed in two or more columns.

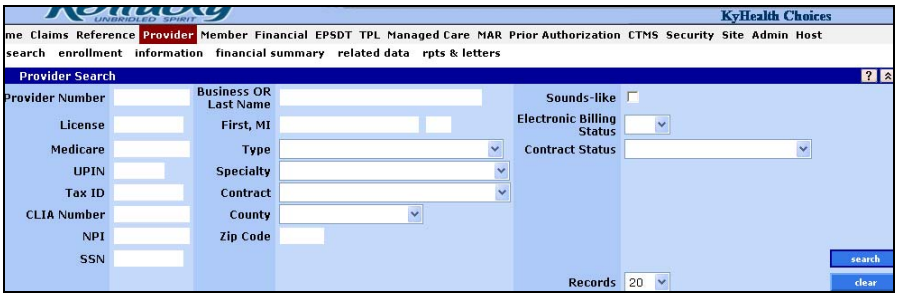


Figure 39 Provider Search Panel without a Linearized Table

8.2.6.4 Shortcut Keys

If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + focus key) to quickly open the associated page.

To active the shortcut key, click on the Site link, check “Activate Shortcut Keys”, and select the Shortcut Key Display Mode (either “Underline” or “ADA Mode”). Click the blue “Update” button.

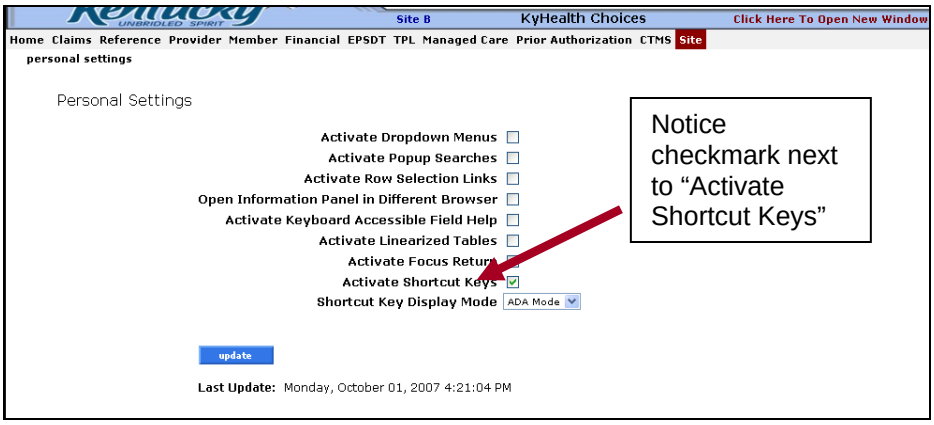


Figure 40 Personal Settings Page – Shortcut Key Activated

To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name.

If the “Underline” display mode is selected, the shortcut key will be displayed within the sub menu name. Within the name, the letter that has a horizontal bar above and below it is the shortcut key letter.

Figure 41 demonstrates how the user can use the shortcut keys to quickly navigate from the Claims Search panel to the Data Corrections panel by using the following shortcut key combination: (Ctrl + Alt + O) since the letter “O” is found within the horizontal bars on the Sub Menu adjustment link.

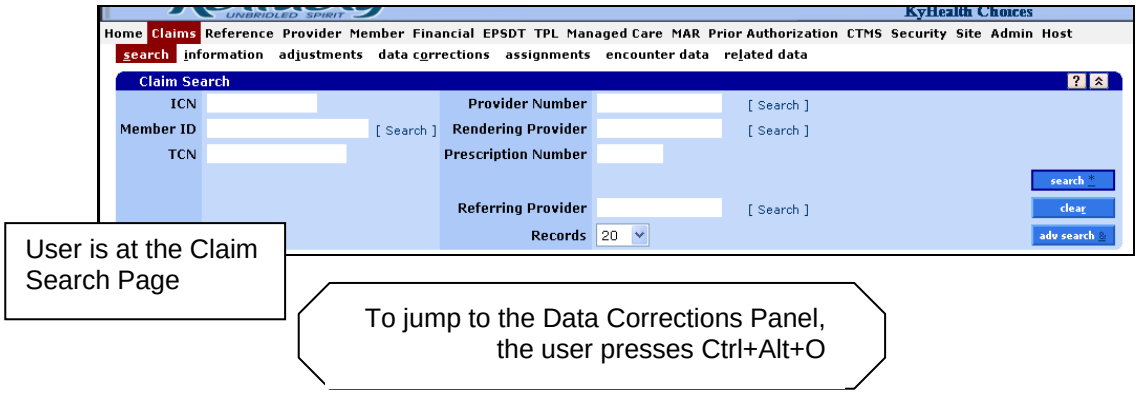


Figure 41 Shortcut Key – Jump from Search Page to Data Corrections Page

If the “ADA Mode” is selected as the display mode, the shortcut key will be displayed to the right of the sub menu name in brackets [ ].

Figure 42 Shortcut Keys in ADA Display Mode

8.2.6.5 Drop Down Menus

If the user activates the drop down menu function, a drop down menu will display when the mouse is scrolled over the subsystem menus. Each submenu within the subsystem will display.

If the drop down function is not enabled, then the menu is displayed horizontally across the page.

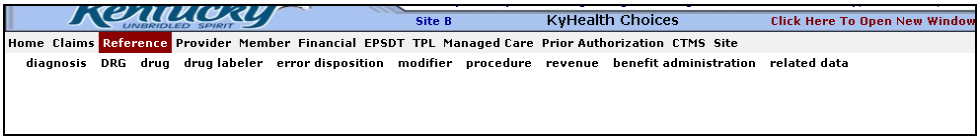


Figure 43 Subsystem Menu Without the Drop Down Menu Function

To active the shortcut key, click on the Site link, check “Activate Dropdown Menus”. Click the blue “Update” button.

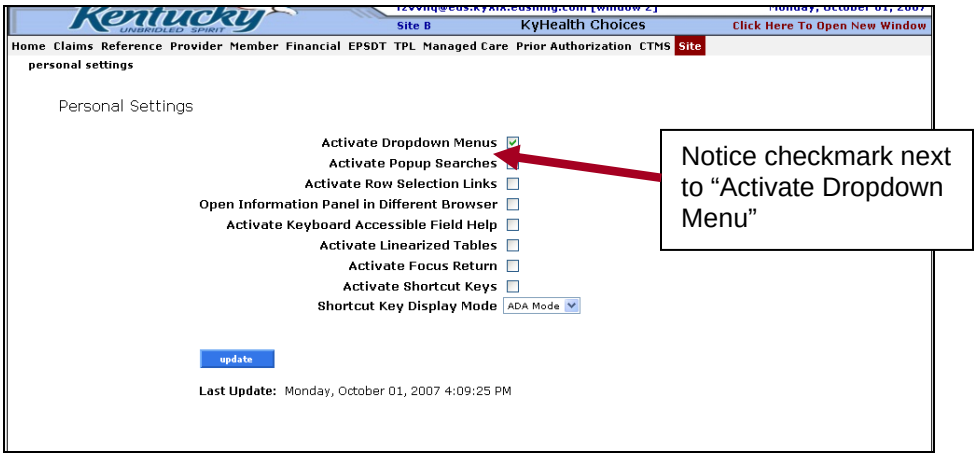


Figure 44 Personal Settings Page – Dropdown Menu Activated

If the dropdown menu is activated, the submenu will be displayed in the dropdown menu when the mouse is scrolled over the subsystem menu.

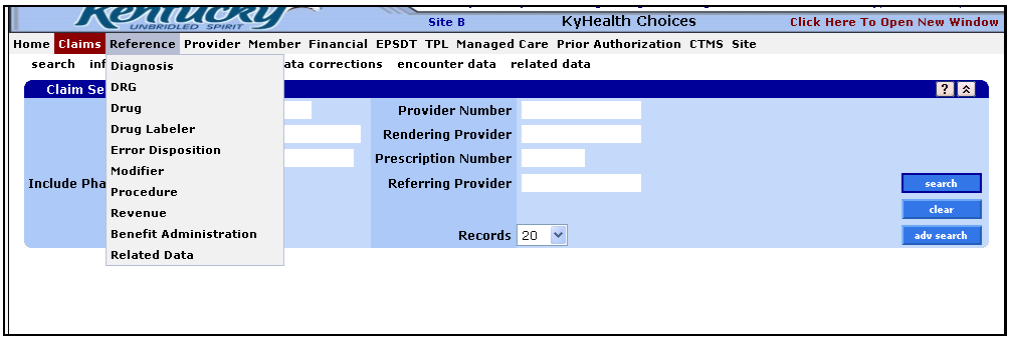


Figure 45 Dropdown Menu Displayed

8.2.6.6 Opening the Information Panel in a Different Browser Window

If the user activates the different browser window function, the user can select a search result from the search panel, and the selected record will open in a different browser window. Then the user will have two different browser windows open.

If the user does not activate this function, then only one browser window will be open. When a record is selected from the search results panel, the record will display in the same browser window as the search panel.

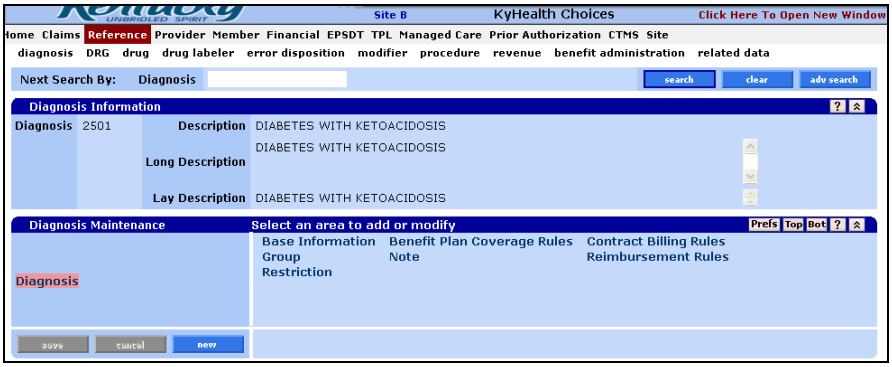


Figure 46 Diagnosis Information Panel (One Browser Window)

To active the shortcut key, click on the Site link, check “Open Information Panel in Different Window”. Click the blue “Update” button.

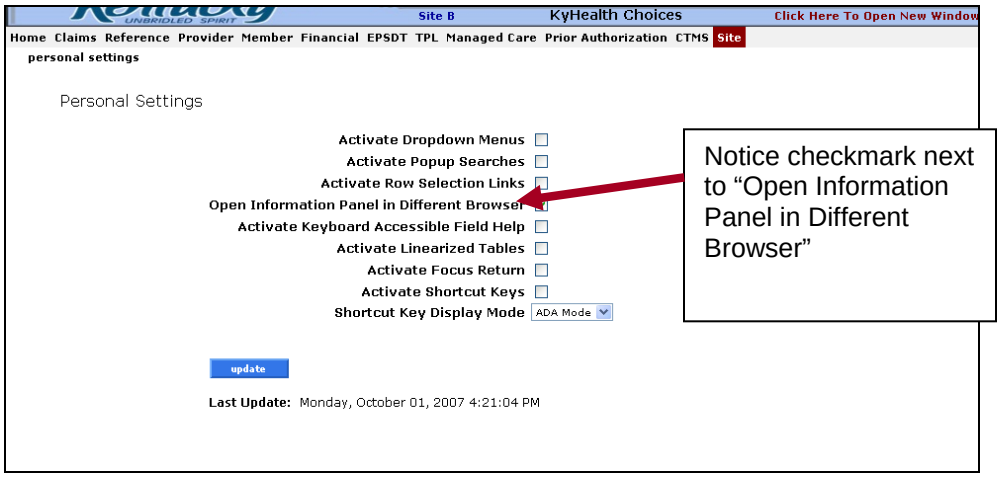


Figure 47 Personal Settings Page – Different Browser Function Activated

If the different browser function is activated, two browser windows will display. One window displayed the search results panel and the other window will display the record.

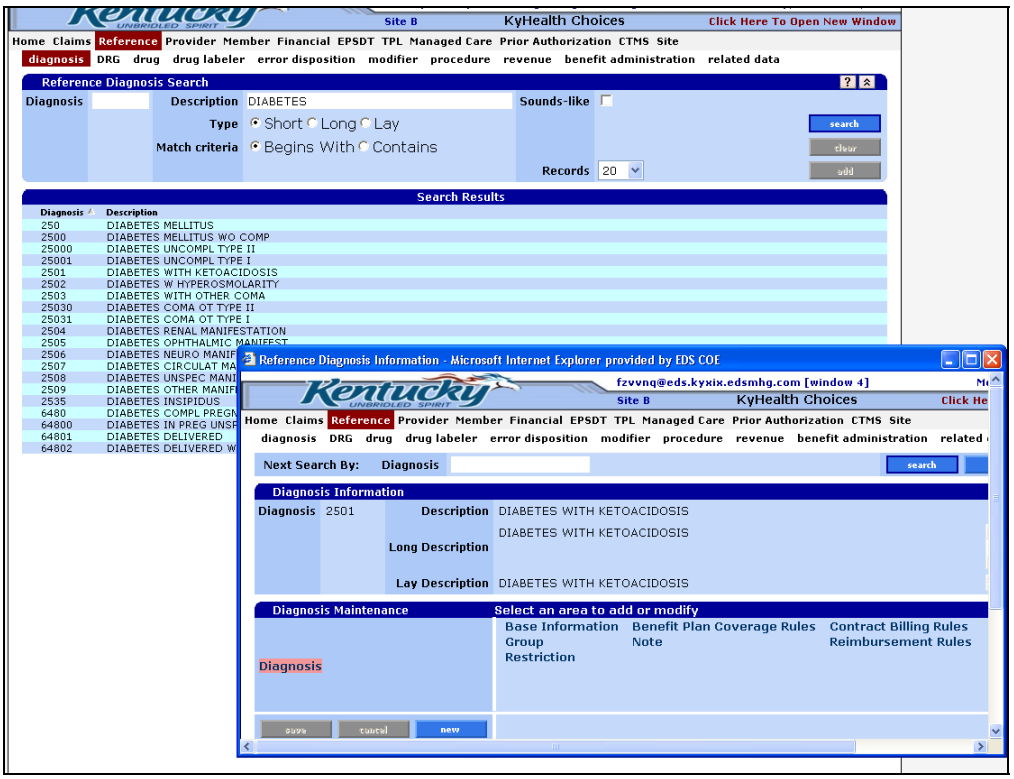


Figure 48 Two Browser Windows Displayed

Diagnosis Search Panel and Diagnosis Information Panel

9 Appendix B – Managed Care How to Guide

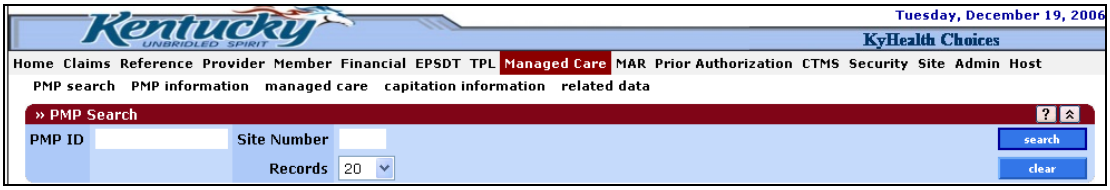
9.1 PMP Search

9.1.1 Searching for a Primary Managed Care Provider

STEP 1. Access interChange.

STEP 2. Select “Managed Care” from the main menu.

The PMP Search Panel will open.



PMP Search Panel

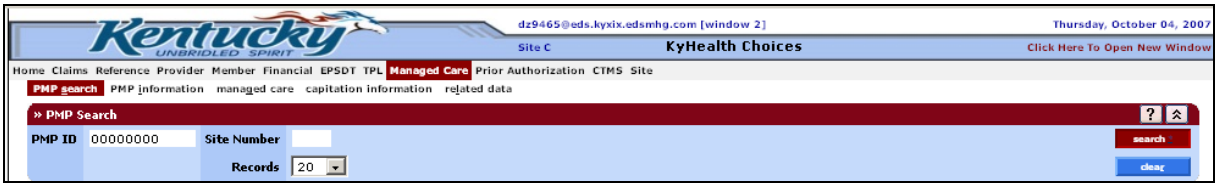
9.1.1.1 Managed Care/ PMP Search Panel Field Descriptions

Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Records	Option to limit number of entries displayed per page.

9.1.1.2 Managed Care/ PMP Search Panel Button Descriptions

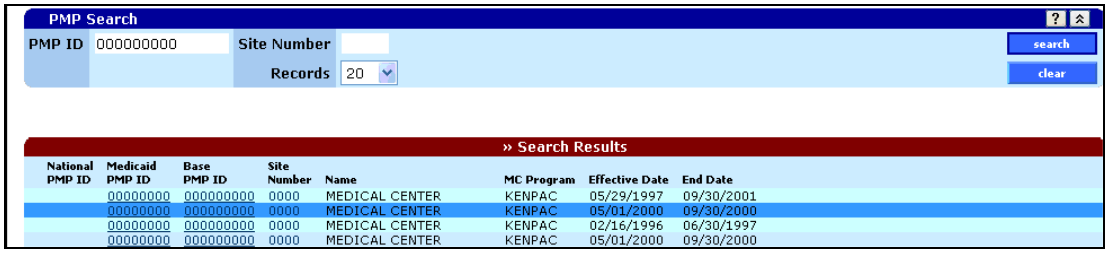
Field	Description
Search	Initiate search based upon selected criteria.
Clear	Clears fields so that a new search may be conducted.

STEP 3. Enter the Provider ID in the PMP ID field, or enter the Provider Site Number in the Site Number field.



STEP 4. Click the “Search” button.

STEP 5. If a search returns multiple providers, select the specific provider by clicking on the row once.



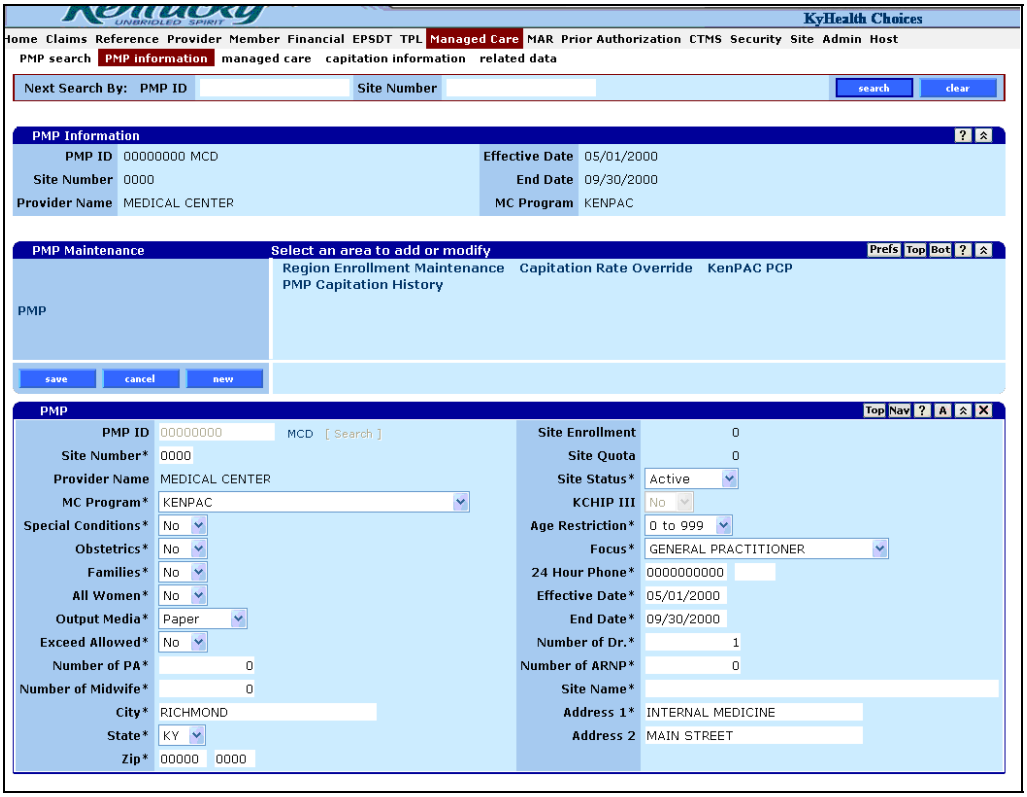
PMP Search Results Panel

9.1.1.3 Managed Care/ PMP Search Results Panel Field Descriptions

Field	Description
Natl PMP ID	The National PMP identification number.
Medicaid PMP ID	The KY Medicaid PMP identification number.
Base PMP ID	The Base PMP identification number.

Field	Description
Site Number	The KenPAC site number. Only present for KenPAC providers. Zeros for other Managed Care programs.
Name	This provider individual name (format Last Name, First Name Middle Initial) or the business name.
MC Program	This is the identification of the Managed Care program.
Effective Date	Effective date Managed Care program is active.
End Date	Date Managed Care program terminates.

The following panels will open: PMP Information, PMP Maintenance, and PMP.



PMP Information and Maintenance Panels

9.1.1.4 Managed Care/ PMP Information Panel Field Descriptions

Field	Description
PMP ID	Unique PMP identification number. This field contains provider ID (length 10) and provider type.

Field	Description
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Provider Name	Provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
MC Program	Identification of Managed Care program.

9.1.1.5 Managed Care/ PMP Maintenance Panel Field Descriptions

Field	Description
Region Enrollment Maintenance	Opens the Region Enrollment Maintenance panel.
PMP Capitation History	Opens the PMP Capitation History panel.
Capitation Rate Override	Opens the Capitation Rate Override panel.
KenPAC PCP	Opens the KenPAC PCP panel.

9.1.1.6 Managed Care/ PMP Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancels changes made to panel(s).
New	Activates panel so that a new record may be added.

9.1.1.7 Managed Care/ PMP Panel Field Descriptions

Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for managed care programs.
Provider Name	Provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
MC Program	Identification of managed care program. This is identification of managed care program.
Special Conditions	Indicates whether PMP offers special services at location for special patient conditions. Valid values are "No" and "Yes".
Obstetrics	Indicates whether a PMP provides obstetric services in their practice. Valid values are "No" and "Yes".
Families	Indicates whether a PMP accepts entire families in their practice. Valid values are "No" and "Yes".
All Women	Indicates whether provider only accepts women as managed care members. Valid values are "No" and "Yes".
Output Media	Type of media used for output. Valid values are "Electronic" and "Paper".

Field	Description
Exceed Allowed	Indicates whether a PMP does or does not accept members of the same family when the PMP has reached the maximum number of members allowed.
Number of PA	Used to determine if a provider has met quota on new members. PA counts same as a physician. Used for PA practitioner providers.
Number of Midwife	Used to determine if a provider has met quota on new members. Midwife counts the same as a physician. Used for midwife practitioner providers.
City	City for physical location of site.
State	State for physical location of site.
Zip	First five digits of zip code for physical location of site, including four-digit suffix.
Site Enrollment	Number of members currently assigned to PMP location.
Site Quota	Maximum number of members that can be assigned to a PMP location.
Site Status	Controls KenPAC site status. Valid values are “Active” or “Unknown” or “Not Active Status”.
KCHIP III	Indicates provider is willing to accept members with KCHIP III eligibility. Valid values are "No" and "Yes".
Age Restriction	Age restrictions a PMP can select for a given PMP location.
Focus	Contains list of valid focuses that a PMP can have. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: general practitioner, internist and pediatrician.
24 Hour Phone	24-hour availability phone number for provider in format area code + prefix + suffix. This field is divided into two fields, which are 24-Hour Phone (length 10) and Extension (length four).
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
Number of Dr	Used to determine if a provider has met quota on new members. Dr. counts the same as a physician. Used for Dr. practitioner providers.
Number of ARNP	Used to determine if a provider has met quota on new members. ARNP count same as a physician. Used for ARNP practitioner providers.
Site Name	Site name for physical location of site.
Address 1	First line of street address for physical location of site.

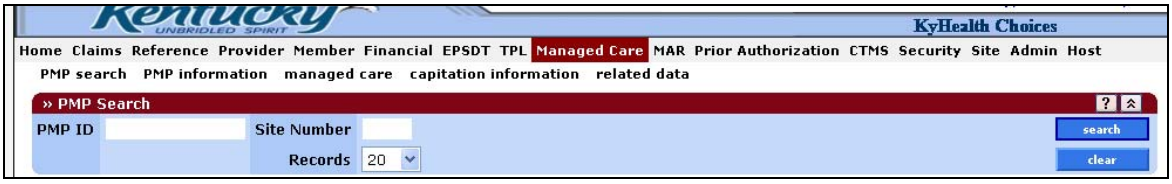
Field	Description
Address 2	Second line of street address for physical location of site.

9.1.2 Searching for a KenPAC Primary Care Provider

STEP 1. Access interChange.

STEP 2. Select “Managed Care” from the main menu.

The PMP Search panel will open.



PMP Search Panel

9.1.2.1 Managed Care/ PMP Search Panel Field Descriptions

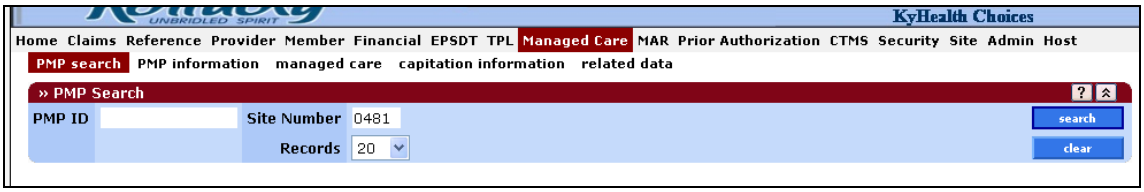
Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Records	Option to limit number of entries displayed per page.

9.1.2.2 Managed Care/ PMP Search Panel Button Descriptions

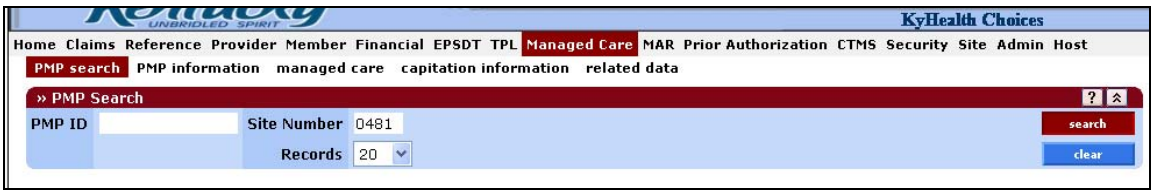
Field	Description
Search	Initiate search based upon selected criteria.
Clear	Clears fields so that a new search may be conducted.

STEP 3. Enter the Provider ID in the PMP ID field, or enter the Provider Site Number in the Site Number field.

NOTE: Only KenPAC providers have a site number.

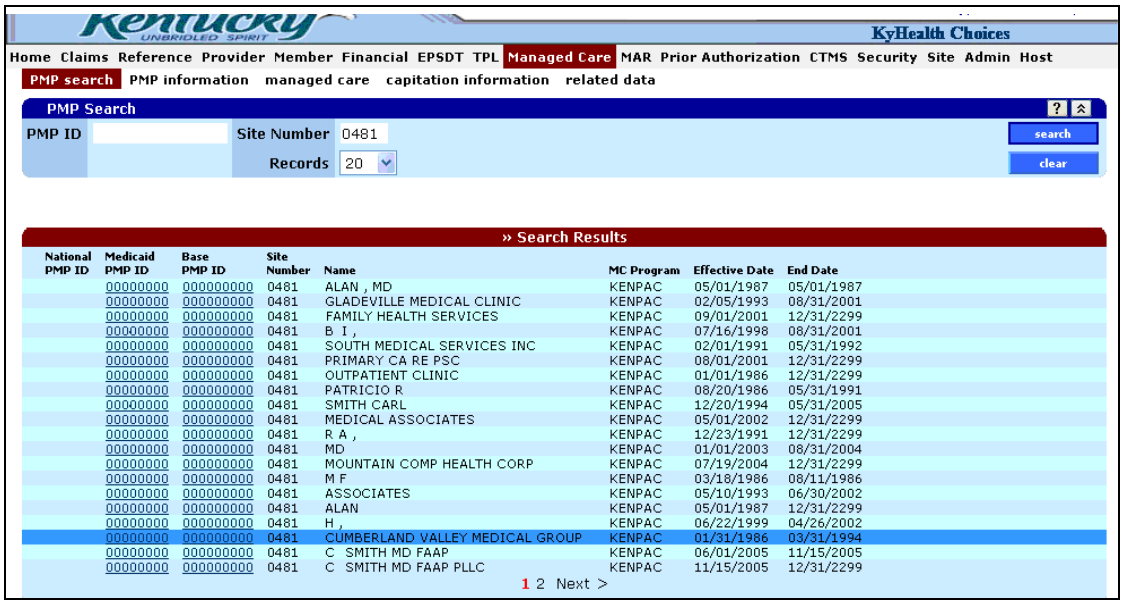


STEP 4. Click the “Search” button.



STEP 5. If a search returns multiple providers, select the specific provider by clicking on the row once.

NOTE: The MC Program column will indicate if the provider is a KenPAC Primary Care Provider.



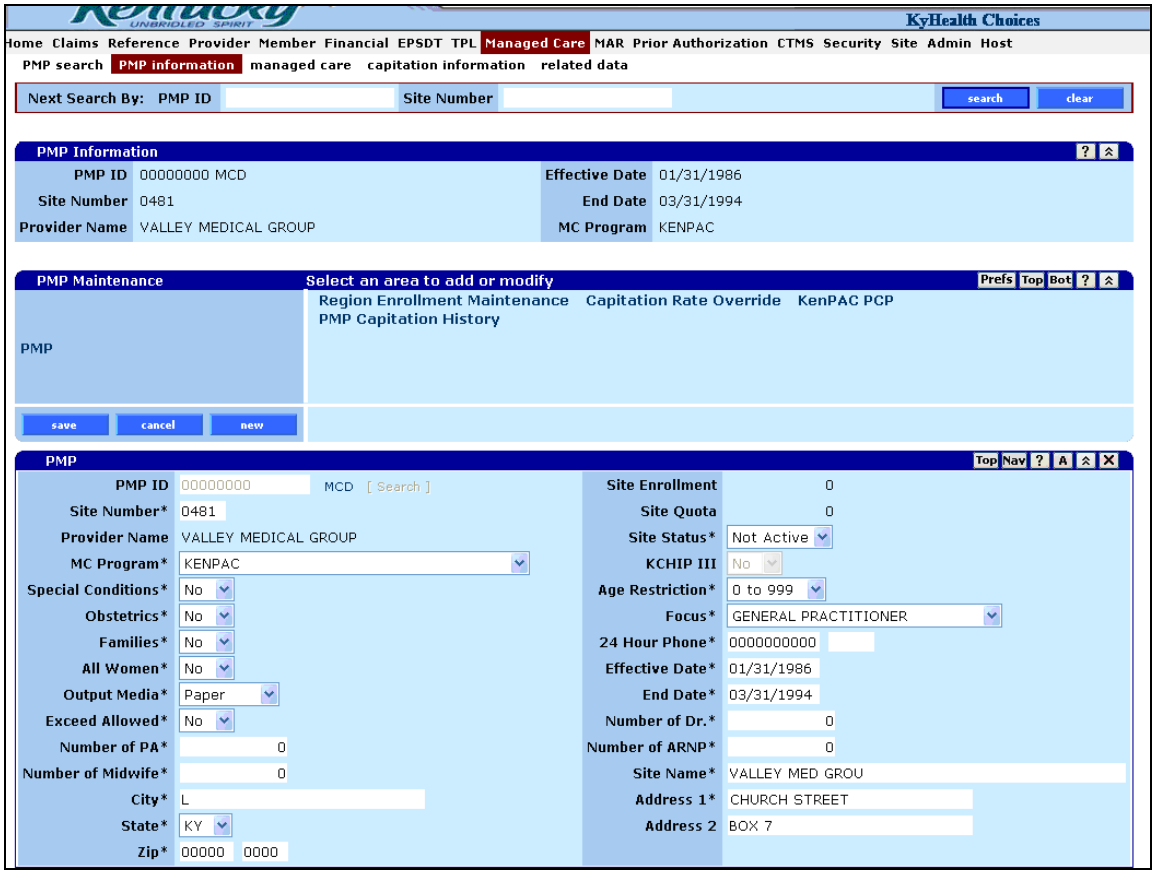
National PMP ID	Medicaid PMP ID	Base PMP ID	Site Number	Name	MC Program	Effective Date	End Date
	00000000	000000000	0481	ALAN , MD	KENPAC	05/01/1987	05/01/1987
	00000000	000000000	0481	GLADEVILLE MEDICAL CLINIC	KENPAC	02/05/1993	08/31/2001
	00000000	000000000	0481	FAMILY HEALTH SERVICES	KENPAC	09/01/2001	12/31/2299
	00000000	000000000	0481	B I ,	KENPAC	07/16/1998	08/31/2001
	00000000	000000000	0481	SOUTH MEDICAL SERVICES INC	KENPAC	02/01/1991	05/31/1992
	00000000	000000000	0481	PRIMARY CA RE PSC	KENPAC	08/01/2001	12/31/2299
	00000000	000000000	0481	OUTPATIENT CLINIC	KENPAC	01/01/1986	12/31/2299
	00000000	000000000	0481	PATRICIO R	KENPAC	08/20/1986	05/31/1991
	00000000	000000000	0481	SMITH CARL	KENPAC	12/20/1994	05/31/2005
	00000000	000000000	0481	MEDICAL ASSOCIATES	KENPAC	05/01/2002	12/31/2299
	00000000	000000000	0481	R A ,	KENPAC	12/23/1991	12/31/2299
	00000000	000000000	0481	MD	KENPAC	01/01/2003	08/31/2004
	00000000	000000000	0481	MOUNTAIN COMP HEALTH CORP	KENPAC	07/19/2004	12/31/2299
	00000000	000000000	0481	M F	KENPAC	03/18/1986	08/11/1986
	00000000	000000000	0481	ASSOCIATES	KENPAC	05/10/1993	06/30/2002
	00000000	000000000	0481	ALAN	KENPAC	05/01/1987	12/31/2299
	00000000	000000000	0481	H ,	KENPAC	06/22/1999	04/26/2002
	00000000	000000000	0481	CUMBERLAND VALLEY MEDICAL GROUP	KENPAC	01/31/1986	03/31/1994
	00000000	000000000	0481	C SMITH MD FAAP	KENPAC	06/01/2005	11/15/2005
	00000000	000000000	0481	C SMITH MD FAAP PLLC	KENPAC	11/15/2005	12/31/2299

PMP Search Results Panel

9.1.2.3 Managed Care/ PMP Search Results Panel Field Descriptions

Field	Description
Natl PMP ID	The National PMP identification number.
Medicaid PMP ID	The KY Medicaid PMP identification number.
Base PMP ID	The Base PMP identification number.
Site Number	The KenPAC site number. Only present for KenPAC providers. Zeros for other Managed Care programs.
Name	This provider individual name (format Last Name, First Name Middle Initial) or the business name.
MC Program	This is the identification of the Managed Care program.
Effective Date	Effective date Managed Care program is active.
End Date	Date Managed Care program terminates.

The following panels will open: PMP Information, PMP Maintenance and PMP.



PMP Information and Maintenance Panels

9.1.2.4 Managed Care/ PMP Information Panel Field Descriptions

Field	Description
PMP ID	Unique PMP identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Provider Name	Provider individual name (format: "Last Name, First Name Middle Initial") or business name.
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
MC Program	Identification of Managed Care program.

9.1.2.5 Managed Care/ PMP Maintenance Panel Field Descriptions

Field	Description
Region Enrollment Maintenance	Opens the Region Enrollment Maintenance panel.
PMP Capitation History	Opens the PMP Capitation History panel.
Capitation Rate Override	Opens the Capitation Rate Override panel.
KenPAC PCP	Opens the KenPAC PCP panel.

9.1.2.6 Managed Care/ PMP Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancels changes made to panel(s).
New	Activates panel so that a new record may be added.

9.1.2.7 Managed Care/ PMP Panel Field Descriptions

Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for managed care programs.

Field	Description
Provider Name	Provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
MC Program	Identification of managed care program. This is identification of managed care program.
Special Conditions	Indicates whether PMP offers special services at location for special patient conditions. Valid values are "No" and "Yes".
Obstetrics	Indicates whether a PMP provides obstetric services in their practice. Valid values are "No" and "Yes".
Families	Indicates whether a PMP accepts entire families in their practice. Valid values are "No" and "Yes".
All Women	Indicates whether provider only accepts women as managed care members. Valid values are "No" and "Yes".
Output Media	Type of media used for output. Valid values are "Electronic" and "Paper".
Exceed Allowed	Indicates whether a PMP does or does not accept members of the same family when the PMP has reached the maximum number of members allowed.
Number of PA	Used to determine if a provider has met quota on new members. PA counts same as a physician. Used for PA practitioner providers.
Number of Midwife	Used to determine if a provider has met quota on new members. Midwife counts the same as a physician. Used for midwife practitioner providers.
City	City for physical location of site.
State	State for physical location of site.
Zip	First five digits of zip code for physical location of site, including four-digit suffix.
Site Enrollment	Number of members currently assigned to PMP location.
Site Quota	Maximum number of members that can be assigned to a PMP location.
Site Status	Controls KenPAC site status. Valid values are “Active” or “Unknown” or “Not Active Status”.
KCHIP III	Indicates provider is willing to accept members with KCHIP III eligibility. Valid values are "No" and "Yes".
Age Restriction	Age restrictions a PMP can select for a given PMP location.
Focus	Contains list of valid focuses that a PMP can have. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: general practitioner, internist and pediatrician.

Field	Description
24 Hour Phone	24-hour availability phone number for provider in format area code + prefix + suffix. This field is divided into two fields, which are 24-Hour Phone (length 10) and Extension (length four).
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
Number of Dr	Used to determine if a provider has met quota on new members. Dr. counts the same as a physician. Used for Dr. practitioner providers.
Number of ARNP	Used to determine if a provider has met quota on new members. ARNP count same as a physician. Used for ARNP practitioner providers.
Site Name	Site name for physical location of site.
Address 1	First line of street address for physical location of site.
Address 2	Second line of street address for physical location of site.

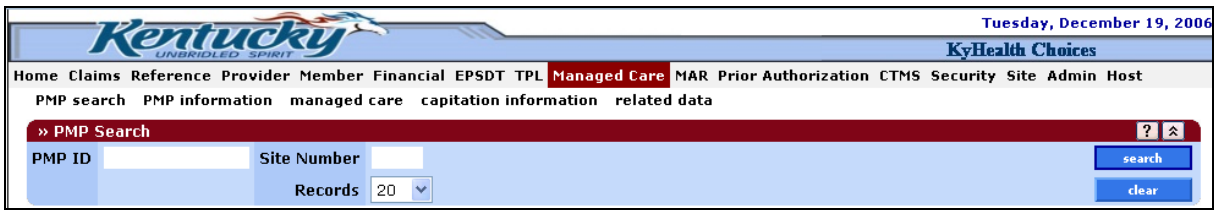
9.2 PMP Information

9.2.1 Determining a Provider's Managed Care Program

STEP 1. Access interChange.

STEP 2. Select "Managed Care" from the main menu.

The PMP Search Panel will open.



PMP Search Panel

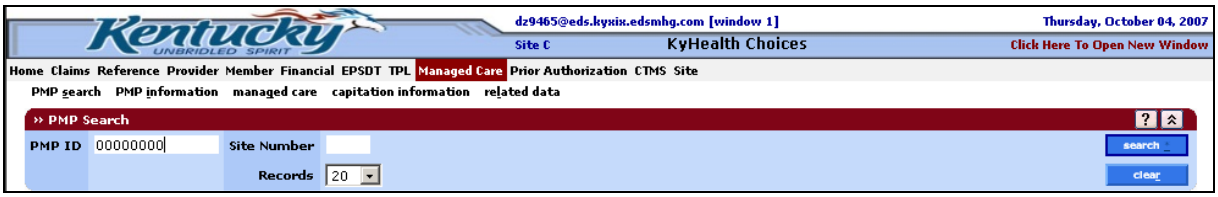
9.2.1.1 Managed Care/ PMP Search Panel Field Descriptions

Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Records	Option to limit number of entries displayed per page.

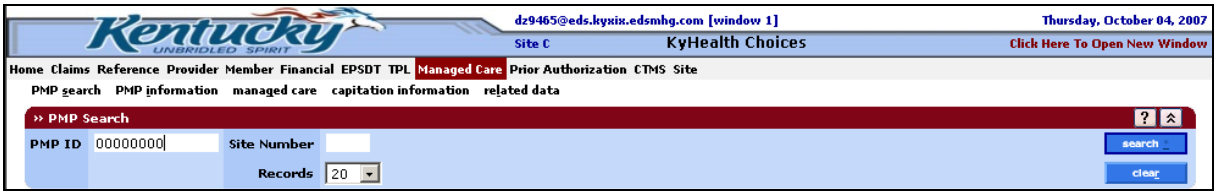
9.2.1.2 Managed Care/ PMP Search Panel Button Descriptions

Field	Description
Search	Initiate search based upon selected criteria.
Clear	Clears fields so that a new search may be conducted.

STEP 3. Enter the Provider ID in the PMP ID field, or enter the Provider Site Number in the Site Number field.

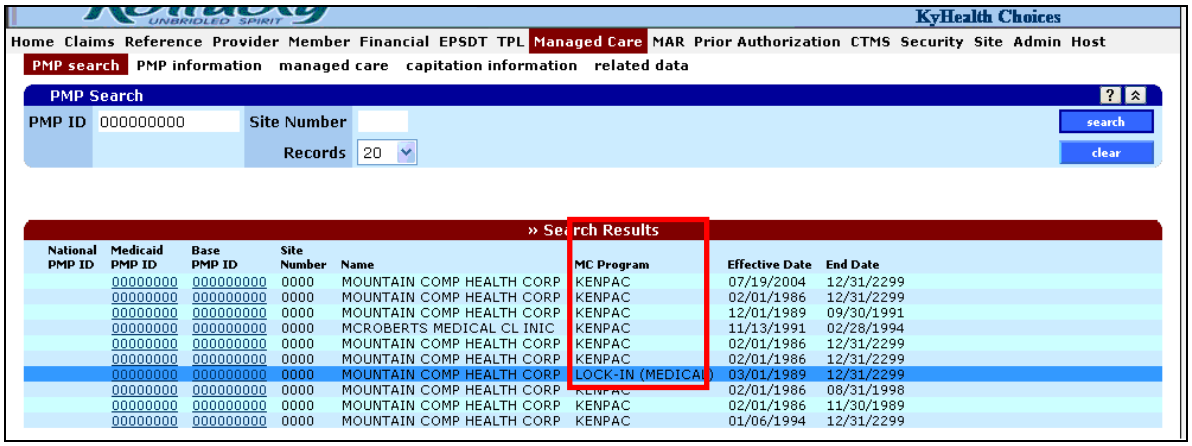


STEP 4. Click the "Search" button.



STEP 5. If a search returns multiple providers, select the specific provider by clicking on the row once.

NOTE: The MC Program column will indicate the provider's Managed Care Program.



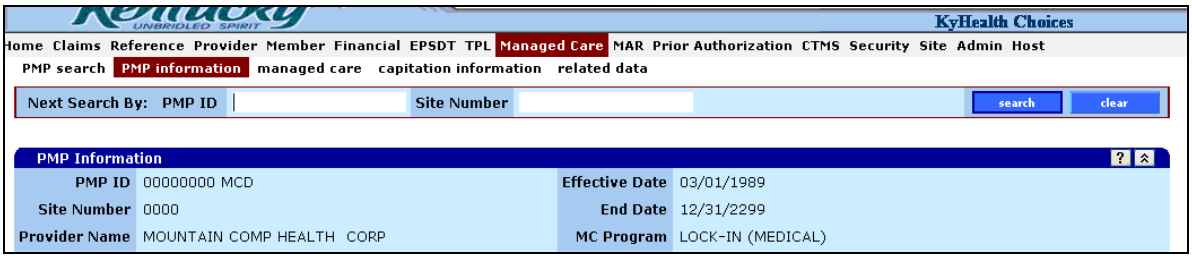
PMP Search Results Panel

9.2.1.3 Managed Care/ PMP Search Results Panel Field Descriptions

Field	Description
Natl PMP ID	The National PMP identification number.
Medicaid PMP ID	The KY Medicaid PMP identification number.
Base PMP ID	The Base PMP identification number.
Site Number	The KenPAC site number. Only present for KenPAC providers. Zeros for other Managed Care programs.

Field	Description
Name	This provider individual name (format Last Name, First Name Middle Initial) or the business name.
MC Program	This is the identification of the Managed Care program.
Effective Date	Effective date Managed Care program is active.
End Date	Date Managed Care program terminates.

The PMP Information panel will open.

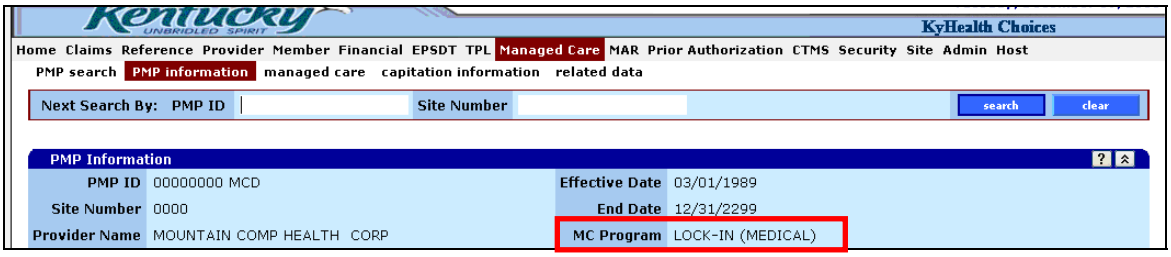


PMP Information Panel

9.2.1.4 Managed Care/ PMP Information Panel Field Descriptions

Field	Description
PMP ID	Unique PMP identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Provider Name	Provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
MC Program	Identification of Managed Care program.

STEP 6. The “MC Program” field will indicate the provider’s Managed Care Program.



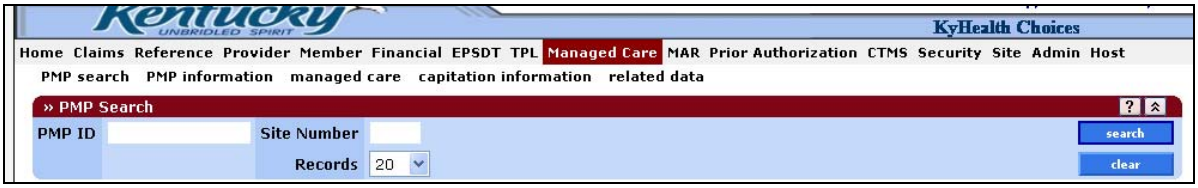
PMP Information Panel

9.2.2 How to Find a Phone Number/Address for a Primary Managed Care Provider

STEP 1. Access interChange.

STEP 2. Select “Managed Care” from the main menu.

STEP 3. The PMP Search Panel will open.



PMP Search Panel

9.2.2.1 Managed Care/ PMP Search Panel Field Descriptions

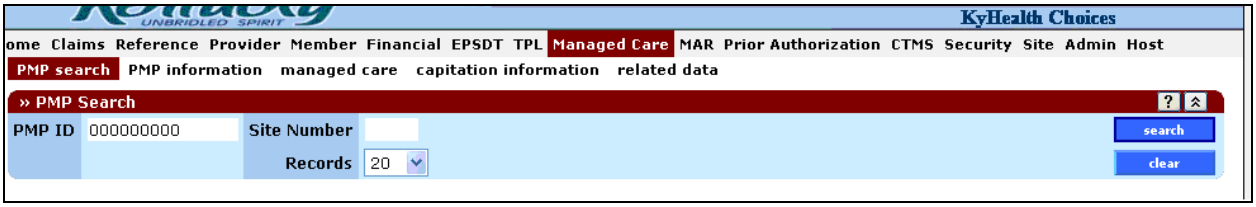
Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Records	Option to limit number of entries displayed per page.

9.2.2.2 Managed Care/ PMP Search Panel Button Descriptions

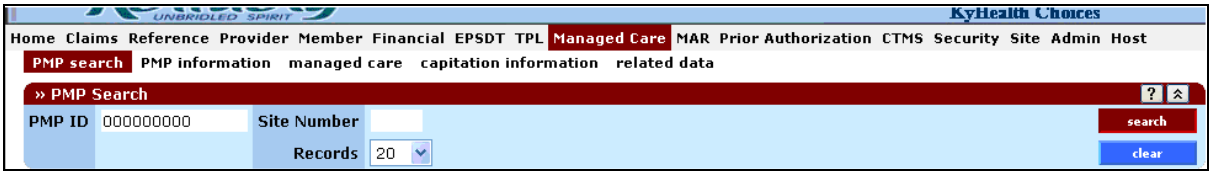
Field	Description

Field	Description
Search	Initiate search based upon selected criteria.
Clear	Clears fields so that a new search may be conducted.

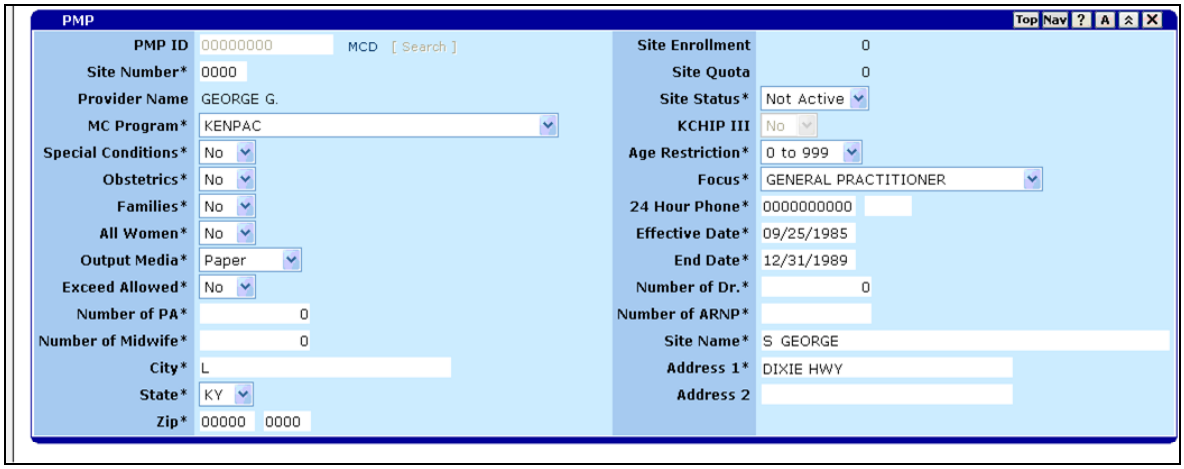
STEP 3. Enter the Provider ID in the PMP ID field, or enter the Provider Site Number in the Site Number field.



STEP 4. Click the "Search" button.



The PMP panel will open.



PMP Panel

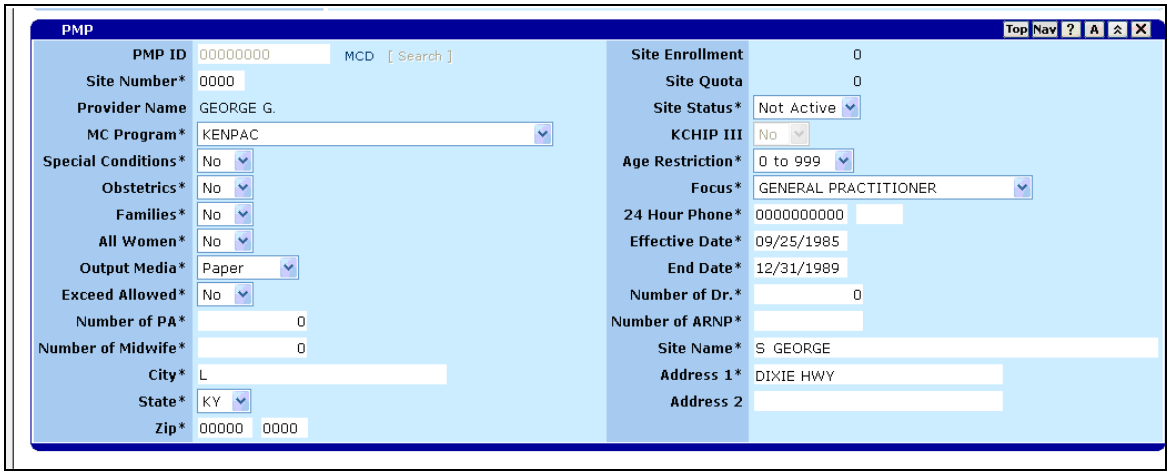
9.2.2.3 Managed Care/ PMP Panel Field Descriptions

Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.

Field	Description
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for managed care programs.
Provider Name	Provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
MC Program	Identification of managed care program. This is identification of managed care program.
Special Conditions	Indicates whether PMP offers special services at location for special patient conditions. Valid values are "No" and "Yes".
Obstetrics	Indicates whether a PMP provides obstetric services in their practice. Valid values are "No" and "Yes".
Families	Indicates whether a PMP accepts entire families in their practice. Valid values are "No" and "Yes".
All Women	Indicates whether provider only accepts women as managed care members. Valid values are "No" and "Yes".
Output Media	Type of media used for output. Valid values are "Electronic" and "Paper".
Exceed Allowed	Indicates when a PMP’s allowed quota is reached.
Number of PA	Used to determine if a provider has met quota on new members. PA counts same as a physician. Used for PA practitioner providers.
Number of Midwife	Used to determine if a provider has met quota on new members. Midwife counts the same as a physician. Used for midwife practitioner providers.
City	City for physical location of site.
State	State for physical location of site.
Zip	First five digits of zip code for physical location of site, including four-digit suffix.
Site Enrollment	Number of members currently assigned to PMP location.
Site Quota	Maximum number of members that can be assigned to a PMP location.
Site Status	Controls KenPAC site status. Valid values are “Active” or “Unknown” or “Not Active Status”.
KCHIP III	Indicates provider is willing to accept members with KCHIP III eligibility. Valid values are "No" and "Yes".
Age Restriction	Age restrictions a PMP can select for a given PMP location.
Focus	Contains list of valid focuses that a PMP can have. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: general practitioner, internist and pediatrician.

Field	Description
24 Hour Phone	24-hour availability phone number for provider in format area code + prefix + suffix. This field is divided into two fields, which are 24-Hour Phone (length 10) and Extension (length four).
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
Number of Dr	Used to determine if a provider has met quota on new members. Dr. counts the same as a physician. Used for Dr. practitioner providers.
Number of ARNP	Used to determine if a provider has met quota on new members. ARNP count same as a physician. Used for ARNP practitioner providers.
Site Name	Site name for physical location of site.
Address 1	First line of street address for physical location of site.
Address 2	Second line of street address for physical location of site.

STEP 5. The provider's phone number and address are available in the PMP Panel.



PMP Panel

9.3 Capitation Information

9.3.1 How to Find The Capitation Rate

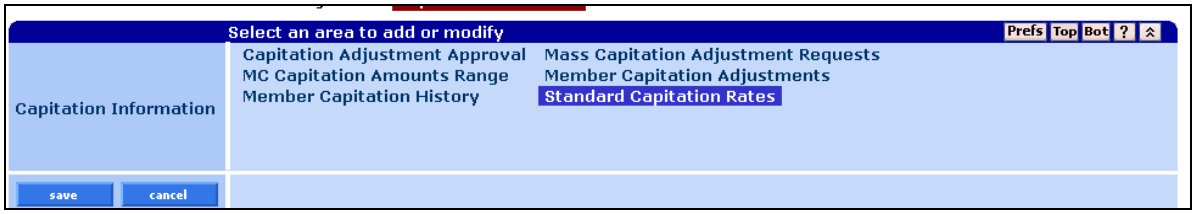
STEP 1. Access interChange.

STEP 2. Select "Managed Care" from the main menu.

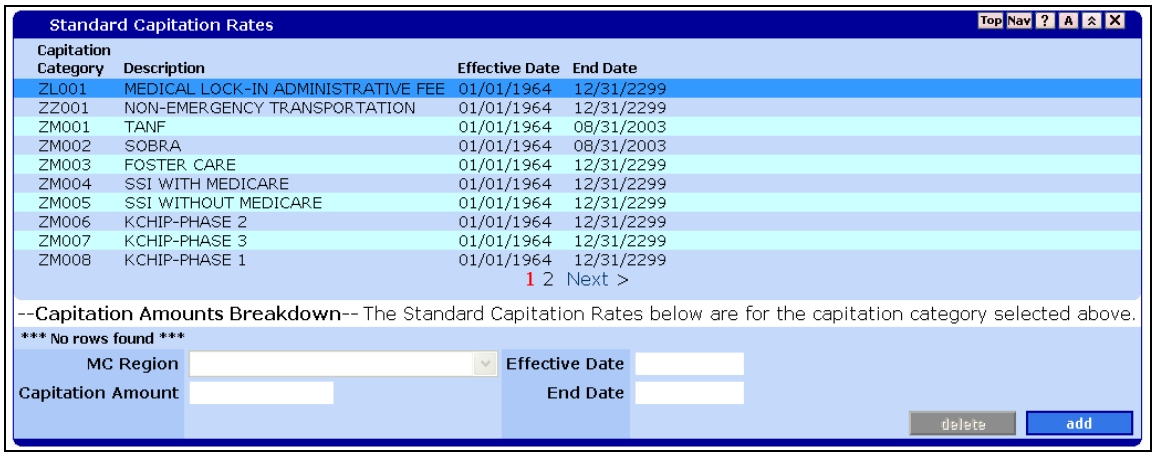
STEP 3. Select "Capitation Information" in the Managed Care sub-menu. This will open the Capitation Information Navigation Menu.

Managed Care / Capitation Information Navigation Menu

STEP 4. Select the "Standard Capitation Rates" link in the navigation menu.



STEP 5. Select a capitation category by clicking the row one time.



Standard Capitation Rates Panel

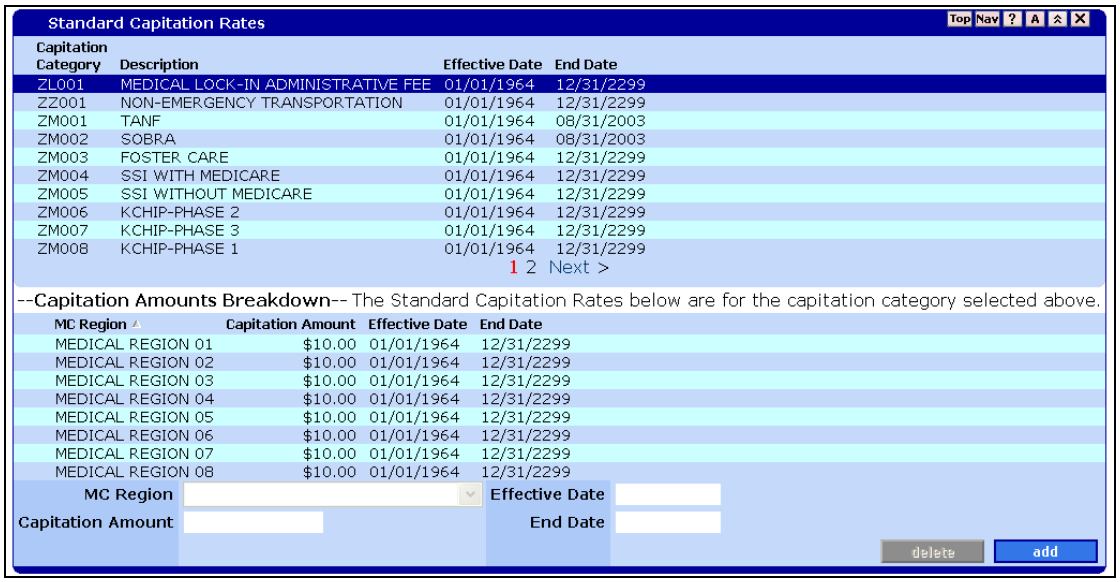
9.3.1.1 Managed Care/Capitation Info/Standard Capitation Rates Panel Field Descriptions

Field	Description
Capitation Category	The capitation category code represents the various groups of demographics for Managed Care members.
Description	Describes the managed care rate cell.
MC Region	Code that identifies a region (or managed care coverage area) of state. A region is made up of different geographical areas such as zip codes, counties or the entire state.
Capitation Amount	Amount of capitation payment.
Effective Date	Date that capitation category became effective.
End Date	Date that capitation category expired and is no longer effective.

9.3.1.2 Managed Care/Capitation Info/Standard Capitation Rates Panel Button Descriptions

Button	Description
Add	Add a new record.
Delete	Delete an existing record.

The capitation category information will auto-populate in the fields below. The capitation rate is available to view.



Standard Capitation Rates

Capitation Category	Description	Effective Date	End Date
ZL001	MEDICAL LOCK-IN ADMINISTRATIVE FEE	01/01/1964	12/31/2299
ZZ001	NON-EMERGENCY TRANSPORTATION	01/01/1964	12/31/2299
ZM001	TANF	01/01/1964	08/31/2003
ZM002	SOBRA	01/01/1964	08/31/2003
ZM003	FOSTER CARE	01/01/1964	12/31/2299
ZM004	SSI WITH MEDICARE	01/01/1964	12/31/2299
ZM005	SSI WITHOUT MEDICARE	01/01/1964	12/31/2299
ZM006	KCHIP-PHASE 2	01/01/1964	12/31/2299
ZM007	KCHIP-PHASE 3	01/01/1964	12/31/2299
ZM008	KCHIP-PHASE 1	01/01/1964	12/31/2299

1 2 Next >

--Capitation Amounts Breakdown-- The Standard Capitation Rates below are for the capitation category selected above.

MC Region	Capitation Amount	Effective Date	End Date
MEDICAL REGION 01	$10.00	01/01/1964	12/31/2299
MEDICAL REGION 02	$10.00	01/01/1964	12/31/2299
MEDICAL REGION 03	$10.00	01/01/1964	12/31/2299
MEDICAL REGION 04	$10.00	01/01/1964	12/31/2299
MEDICAL REGION 05	$10.00	01/01/1964	12/31/2299
MEDICAL REGION 06	$10.00	01/01/1964	12/31/2299
MEDICAL REGION 07	$10.00	01/01/1964	12/31/2299
MEDICAL REGION 08	$10.00	01/01/1964	12/31/2299

MC Region Effective Date
Capitation Amount End Date
delete add

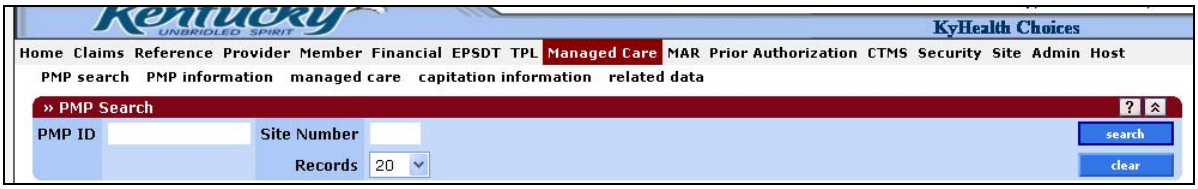
9.4 Viewing Capitation History

9.4.1 Viewing a Provider's Capitation History

STEP 1. Access interChange.

STEP 2. Select "Managed Care" from the main menu.

STEP 3. The PMP Search panel will open.



PMP Search Panel

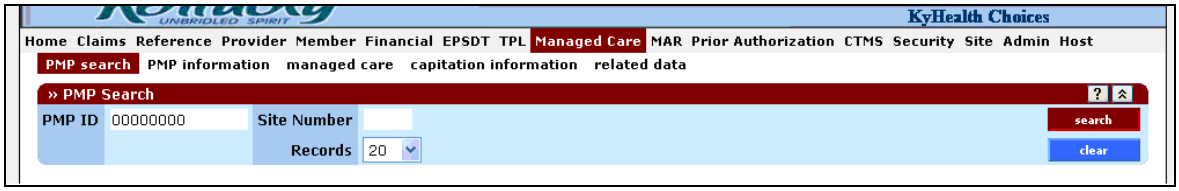
9.4.1.1 Managed Care/ PMP Search Panel Field Descriptions

Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Records	Option to limit number of entries displayed per page.

9.4.1.2 Managed Care/ PMP Search Panel Button Descriptions

Field	Description
Search	Initiate search based upon selected criteria.
Clear	Clears fields so that a new search may be conducted.

STEP 4. Enter the Provider ID in the PMP ID field, or enter the Provider Site Number in the Site Number field. Click the “Search” button.



The following panels will open: PMP Information and PMP Maintenance.

PMP Information and Maintenance Panels

9.4.1.3 Managed Care/ PMP Information Panel Field Descriptions

Field	Description
PMP ID	Unique PMP identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Provider Name	Provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
MC Program	Identification of Managed Care program.

9.4.1.4 Managed Care/ PMP Maintenance Panel Field Descriptions

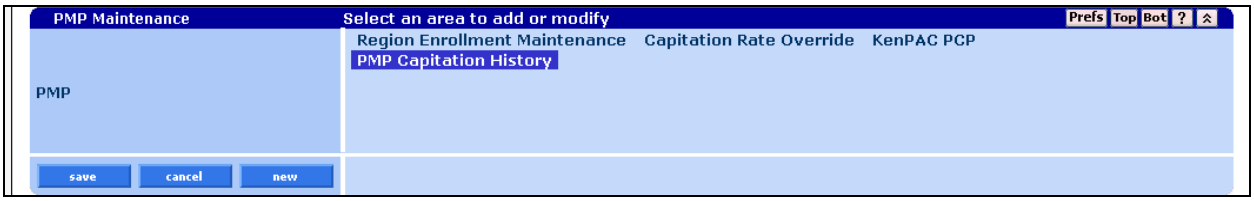
Field	Description

Field	Description
Region Enrollment Maintenance	Opens the Region Enrollment Maintenance panel.
PMP Capitation History	Opens the PMP Capitation History panel.
Capitation Rate Override	Opens the Capitation Rate Override panel.
KenPAC PCP	Opens the KenPAC PCP panel.

9.4.1.5 Managed Care/ PMP Maintenance Panel Button Descriptions

Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancels changes made to panel(s).
New	Activates panel so that a new record may be added.

STEP 5. Access the PMP Maintenance Panel. Select the “PMP Capitation History” link.



PMP Maintenance Panel

STEP 6. This will open the PMP Capitation History Panel. Select a Capitation Category. Click the “Search” button.

PMP Capitation History Panel

9.4.1.6 Managed Care/ PMP Information/PMP Capitation History Panel Field Descriptions

Field	Description
Capitation Category	Category of capitation. Drop down box is code and description.
Capitation Txn Date	Date that capitation payment was made.
Member ID	Member Medicaid ID.

9.4.1.7 Managed Care/ PMP Information/PMP Capitation History Panel Button Descriptions

Button	Description
Search	Initiates search based upon selected criteria.
Clear	Clears search fields so a new search may be conducted.

The Search Results will provide a listing of all capitation transactions made to the provider under a specific capitation category.

PMP Capitation History Search Results Panel

9.4.1.8 Managed Care/ PMP Info/PMP Capitation History Search Results Panel Field Descriptions

Field	Description
Member ID	Member's identification number.
Name	The member's name.
Gender	The member's gender.
Capitation Category	The description of the capitation category.
Cap Date	The month that the capitation payment covers.
Cap Txn Date	The date that the capitation payment was made.

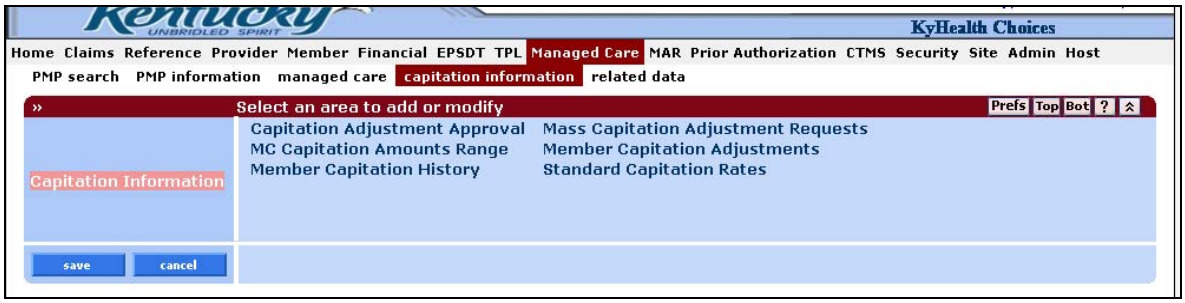
Field	Description
Cap Amount	The amount of money (check or EFT) we will pay to an external entity for capitation.
Cap Reason	Reason code of why the capitation is being done.

9.4.2 Viewing a Member's Capitation History

STEP 1. Access interChange.

STEP 2. Select "Managed Care" from the main menu.

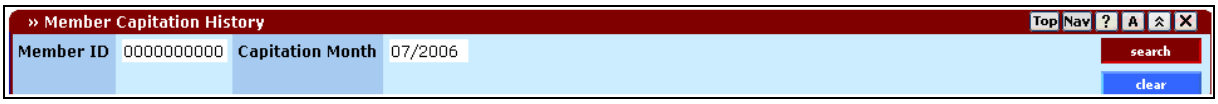
STEP 3. Select "Capitation Information" in the Managed Care sub-menu. This will open the Capitation Information Navigation Menu.



Managed Care / Capitation Information Navigation Menu

STEP 4. Select the "Member Capitation History" link in the navigation menu.

STEP 5. This will open the Member Capitation History Panel. Enter the search criteria and click the "Search" button.



Member Capitation History Panel

9.4.2.1 Managed Care/Capitation Info/Member Capitation History Panel Field Descriptions

Field	Description
Member ID	The member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Capitation Month	Month of capitation payout.

9.4.2.2 Managed Care/Capitation Info/Member Capitation History Panel Button Descriptions

Button	Description
Search	Initiates search based upon selected criteria.
Clear	Clears search fields so that a new search may be conducted.

A listing of all capitation transaction for that member is available for viewing.

Member Capitation History Search Results Panel

9.4.2.3 Managed Care/Capitation Info/Member Capitation History Search Results Panel Field Descriptions

Field	Description
PMP ID	The is the Primary Medical Provider (PMP) ID.
MC Region	This is the identification of the Managed Care region.
Effective Date	The date the capitation was effective.
End Date	The date the capitation was ended (terminated).
Capitation Month	The month that the capitation payment covers.
Capitation Txn Date	The date that the capitation payment was made. If the payment is being made for a retro month the date is still the current month, that is:, payment in April of February admin fee, this date would have the April payment date.
Capitation Amount	The amount of money (check or EFT) we will pay to an external entity for capitation.
Capitation Reason	The reason code of why the capitation is being done.

Field	Description
Capitation Category	The category of the capitation.
Program Code	Identifies the type of program code for which a member is eligible.
Date Payment Begin	The date of Date Payment Begin from Date of Service when a capitation is pro-rated.
Date Payment End	The date of Date Payment End Date of Service when a capitation is pro-rated.
Medicare Indicator	The indicator of the Medicare flag.
Program Status	The status code that is connected to the member's program code.

9.5 Viewing Capitation Demographics

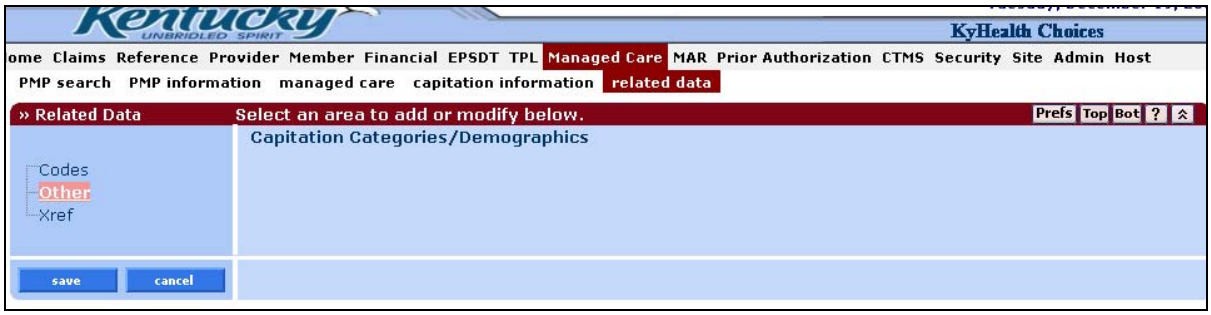
STEP 1. Access interChange.

STEP 2. Select “Managed Care” from the main menu.

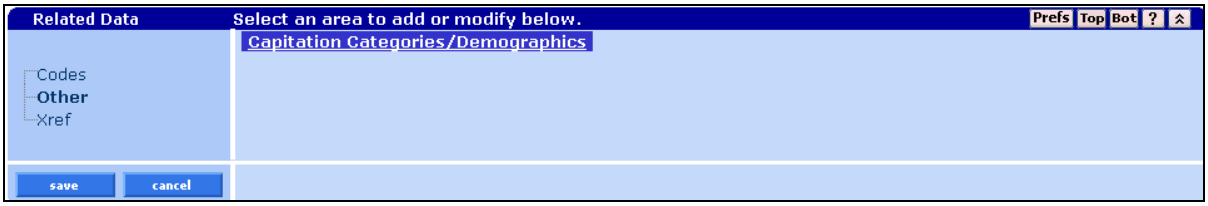
STEP 3. Select “Related Data” in the Managed Care sub-menu. This will open the Related Data Navigation Menu.

Managed Care / Related Data Navigation Menu

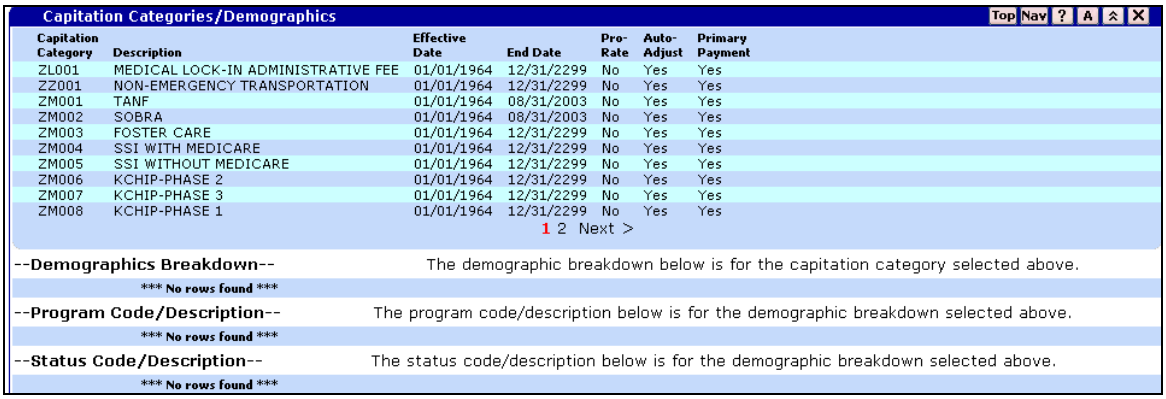
STEP 4. On the left side of the Related Data Navigation Menu, click the “Other” link.



STEP 5. Select the “Capitation Categories/Demographics” link in the navigation menu.



The Capitation Categories / Demographics panel will open.



Capitation Categories/Demographics

Capitation Category	Description	Effective Date	End Date	Pro-Rate	Auto-Adjust	Primary Payment
ZL001	MEDICAL LOCK-IN ADMINISTRATIVE FEE	01/01/1964	12/31/2299	No	Yes	Yes
ZZ001	NON-EMERGENCY TRANSPORTATION	01/01/1964	12/31/2299	No	Yes	Yes
ZM001	TANF	01/01/1964	08/31/2003	No	Yes	Yes
ZM002	SOBRA	01/01/1964	08/31/2003	No	Yes	Yes
ZM003	FOSTER CARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM004	SSI WITH MEDICARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM005	SSI WITHOUT MEDICARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM006	KCHIP-PHASE 2	01/01/1964	12/31/2299	No	Yes	Yes
ZM007	KCHIP-PHASE 3	01/01/1964	12/31/2299	No	Yes	Yes
ZM008	KCHIP-PHASE 1	01/01/1964	12/31/2299	No	Yes	Yes

1 2 Next >

--Demographics Breakdown-- The demographic breakdown below is for the capitation category selected above.

*** No rows found ***

--Program Code/Description-- The program code/description below is for the demographic breakdown selected above.

*** No rows found ***

--Status Code/Description-- The status code/description below is for the demographic breakdown selected above.

*** No rows found ***

Capitation Categories / Demographics Panel

9.5.1 Managed Care/Related Data/Capitation Categories/Demographics Panel Field Descriptions

Field	Description
Capitation Category	Capitation category code represents various groups of demographics for managed care members.
Description	Describes managed care capitation category.
Effective Date	Date that capitation category became effective.
End Date	Date that capitation category expired and is no longer effective.
Pro-Rate	Specifies if capitation category should be pro-rated on a daily basis, or if it applies to an entire month only. Valid values are "No" and "Yes".
Auto-Adjust	Indicates if capitation category should be included when system is determining total amount paid for a member during a given month. Valid values are "No" and "Yes".
Primary Payment	Indicates if capitation category is a payment for member's primary care (standard monthly payment). Valid values are "No" and "Yes".

STEP 6. Select a Capitation Category by clicking on the record one time.

» Capitation Categories/Demographics

Capitation Category	Description	Effective Date	End Date	Pro-Rate	Auto-Adjust	Primary Payment
ZL001	MEDICAL LOCK-IN ADMINISTRATIVE FEE	01/01/1964	12/31/2299	No	Yes	Yes
ZZ001	NON-EMERGENCY TRANSPORTATION	01/01/1964	12/31/2299	No	Yes	Yes
ZM001	TANF	01/01/1964	08/31/2003	No	Yes	Yes
ZM002	SOBRA	01/01/1964	08/31/2003	No	Yes	Yes
ZM003	FOSTER CARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM004	SSI WITH MEDICARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM005	SSI WITHOUT MEDICARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM006	KCHIP-PHASE 2	01/01/1964	12/31/2299	No	Yes	Yes
ZM007	KCHIP-PHASE 3	01/01/1964	12/31/2299	No	Yes	Yes
ZM008	KCHIP-PHASE 1	01/01/1964	12/31/2299	No	Yes	Yes

1 2 Next >

--Demographics Breakdown-- The demographic breakdown below is for the capitation category selected above.

*** No rows found ***

--Program Code/Description-- The program code/description below is for the demographic breakdown selected above.

*** No rows found ***

--Status Code/Description-- The status code/description below is for the demographic breakdown selected above.

*** No rows found ***

This will auto-populate the category information in the “Demographics Breakdown” section.

Capitation Categories/Demographics

Capitation Category	Description	Effective Date	End Date	Pro-Rate	Auto-Adjust	Primary Payment
ZL001	MEDICAL LOCK-IN ADMINISTRATIVE FEE	01/01/1964	12/31/2299	No	Yes	Yes
ZZ001	NON-EMERGENCY TRANSPORTATION	01/01/1964	12/31/2299	No	Yes	Yes
ZM001	TANF	01/01/1964	08/31/2003	No	Yes	Yes
ZM002	SOBRA	01/01/1964	08/31/2003	No	Yes	Yes
ZM003	FOSTER CARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM004	SSI WITH MEDICARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM005	SSI WITHOUT MEDICARE	01/01/1964	12/31/2299	No	Yes	Yes
ZM006	KCHIP-PHASE 2	01/01/1964	12/31/2299	No	Yes	Yes
ZM007	KCHIP-PHASE 3	01/01/1964	12/31/2299	No	Yes	Yes
ZM008	KCHIP-PHASE 1	01/01/1964	12/31/2299	No	Yes	Yes

1 2 Next >

--Demographics Breakdown-- The demographic breakdown below is for the capitation category selected above.

MC Program Code Group	MC Status Code Group	Min Age	Max Age	Medicare Indicator	Gender	Special Condition Override	Effective Date	End Date
ALL	ALL	0	999		Male		01/01/1964	12/31/2399
ALL	ALL	0	999		Female		01/01/1964	12/31/2399

--Program Code/Description-- The program code/description below is for the demographic breakdown selected above.

*** No rows found ***

--Status Code/Description-- The status code/description below is for the demographic breakdown selected above.

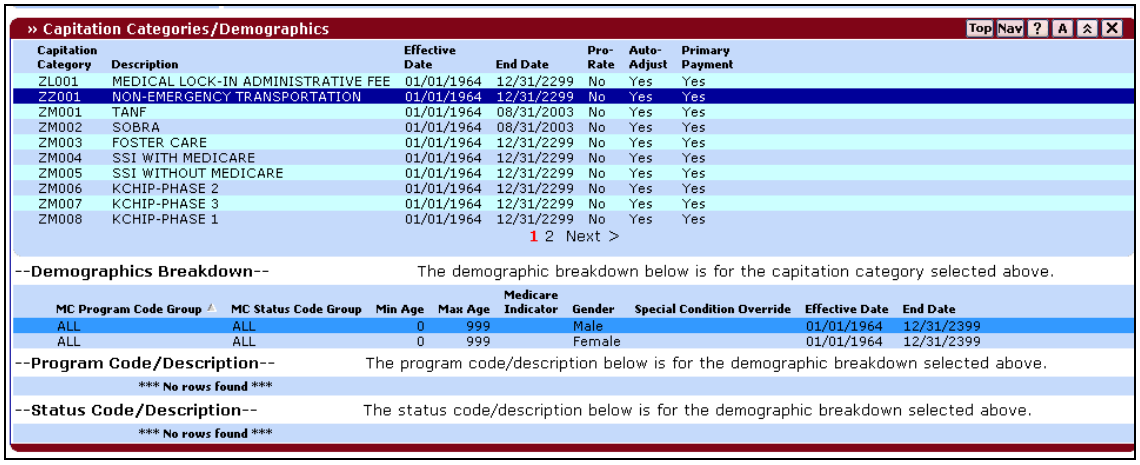
*** No rows found ***

9.5.2 Managed Care/Related Data/Capitation Categories/Demographics Panel Field Descriptions

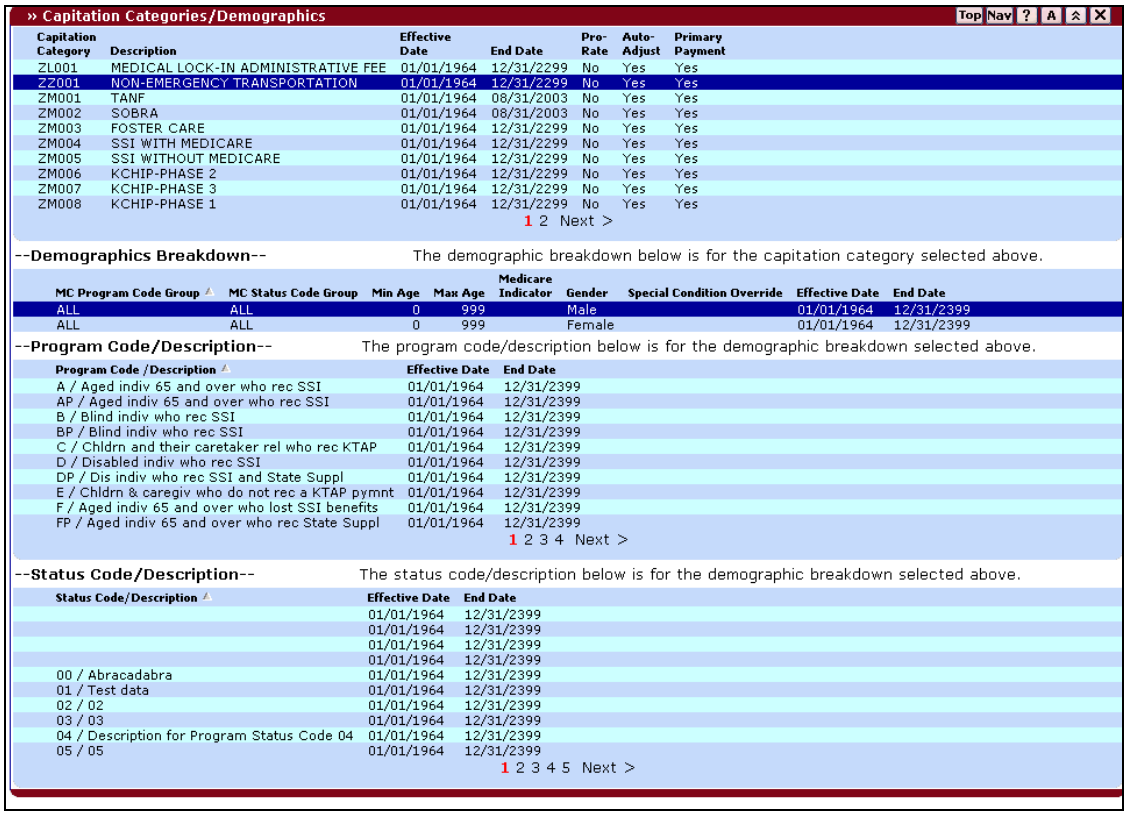
FIELD	DESCRIPTION
	DEMOGRAPHICS BREAKDOWN
MC Program Code group	Program code group for demographic.
MC Status Code Group	Status code group for demographic.
Min Age	Minimum age for demographic.
Medicare Indicator	This is the indicator for the Medicare. Valid values are Y(yes), N (No), B (Both).
Max Age	Maximum age for demographic.
Medicare Indicator	Indicator for Medicare. Valid values are Y (yes), N (No), B (Both).
Gender	Gender for demographics.
Special Condition Override	Special condition override for demographic.
Effective Date	Effective date for demographic.

FIELD	DESCRIPTION
End Date	End date for the demographic.

STEP 7. Select an “MC (Managed Care) Program Code Group” by clicking on the record one time.



The record information will auto-populate in the “Program Code/Description” and “Status Code/Description” sections.



9.5.3 Managed Care/Related Data/Capitation Categories/Demographics Panel Field Descriptions

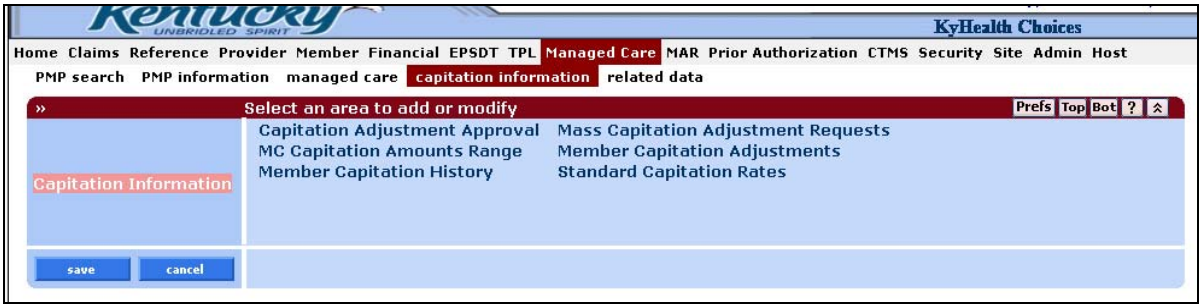
FIELD	DESCRIPTION
PROGRAM CODE / DESCRIPTION	
Program Code/Description	Program code and description that is part of program code group. Format code/description.
Effective Date	Effective date for program code.
End Date	End date for program code.
STATUS CODE / DESCRIPTION	
Status Code/Description	Status code and description that is part of status code group.
Effective Date	Effective date for status code.
End Date	End date for status code.

9.6 Searching for a Mass Capitation Adjustment

STEP 1. Access interChange.

STEP 2. Select “Managed Care” from the main menu.

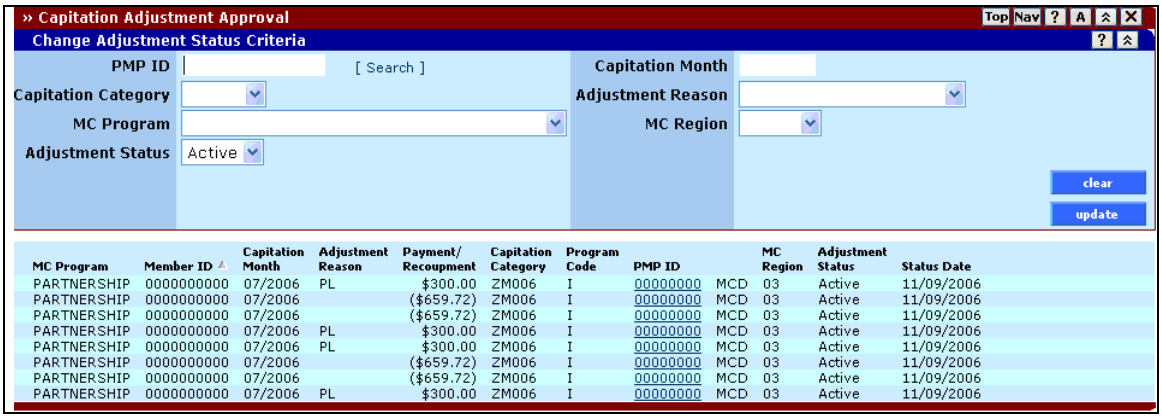
STEP 3. Select “Capitation Information” in the Managed Care sub-menu. This will open the Capitation Information Navigation Menu.



Managed Care / Capitation Information Navigation Menu

STEP 4. Select the “Capitation Adjustment Approval” link in the navigation menu.

This will open the Capitation Adjustment Approval panel. All capitation adjustments that have not yet been processed are available to view.



MC Program	Member ID	Capitation Month	Adjustment Reason	Payment/ Recoupment	Capitation Category	Program Code	PMP ID		MC Region	Adjustment Status	Status Date
PARTNERSHIP	0000000000	07/2006	PL	$300.00	ZM006	I	00000000	MCD	03	Active	11/09/2006
PARTNERSHIP	0000000000	07/2006		($659.72)	ZM006	I	00000000	MCD	03	Active	11/09/2006
PARTNERSHIP	0000000000	07/2006		($659.72)	ZM006	I	00000000	MCD	03	Active	11/09/2006
PARTNERSHIP	0000000000	07/2006	PL	$300.00	ZM006	I	00000000	MCD	03	Active	11/09/2006
PARTNERSHIP	0000000000	07/2006	PL	$300.00	ZM006	I	00000000	MCD	03	Active	11/09/2006
PARTNERSHIP	0000000000	07/2006		($659.72)	ZM006	I	00000000	MCD	03	Active	11/09/2006
PARTNERSHIP	0000000000	07/2006		($659.72)	ZM006	I	00000000	MCD	03	Active	11/09/2006
PARTNERSHIP	0000000000	07/2006	PL	$300.00	ZM006	I	00000000	MCD	03	Active	11/09/2006

Capitation Adjustment Approval Panel

9.6.1 Managed Care/Capitation Info/Capitation Adj. Approval Panel Field Descriptions

Field	Description
PMP ID	Unique PMP identification number. This field contains provider ID (length 10) and provider type.
Capitation Category	This is the category of the capitation. Valid Values are: Zk001 ZL001 ZM001 ZM002 ZM003 ZZ001 ZM004 ZM005 ZM006 ZM007 ZM008 ZM009 ZM010 ZM011 ZM012 ZM013
MC Program	Identification of managed care program.
Adjustment Status	Current status of the adjustment in the KY MMIS. Valid Values are: Active or Hold
Capitation Month	Month that capitation adjustment is being made for in format MM/YYYY.
Adjustment Reason	Code of reason capitation is being done.
MC Region	Identification of managed care region.
MC Program	The identification of the Managed Care program.
Member ID	The member's 10-digit *KY Medicaid* ID number. Field is numeric only.
Capitation Month	The month that the capitation adjustment is being made
Adjustment Reason	The reason code for why the capitation is being done.
Payment / Recoupment	The amount of money that was paid or recouped to an external entity. The amount could be negative if it was a recoupment.
Capitation Category	The category of the capitation.
Program Code	Identifies the type of program for which a member is eligible.

Field	Description
PMP ID	The Primary Medical Provider (PMP) ID.
MC Region	The identification of the Managed Care region.
Adjustment Status	Current status of the adjustment in the KY MMIS. Valid values are: Active or Hold.
Status Date	Date the adjustment was added to this entity as pending (hold) or the date the status was changed to processed (active).

9.7 How to Add/Update Information

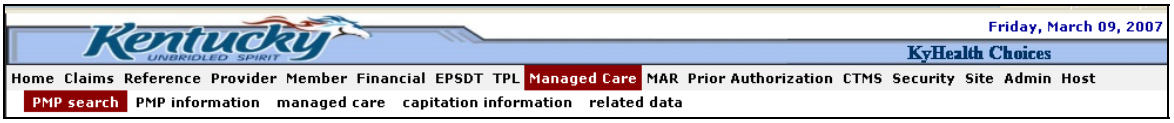
9.7.1 How to Update Managed Care Primary Medicaid Provider Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

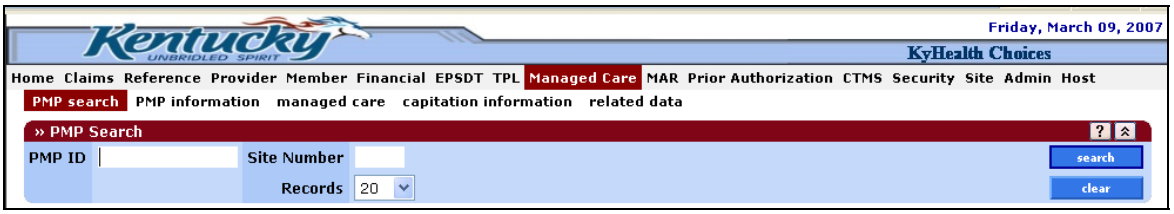
InterChange Home Page

STEP 3 Select PMP Search from the Managed Care Submenu by clicking on it one time.



The PMP Search panel will open.

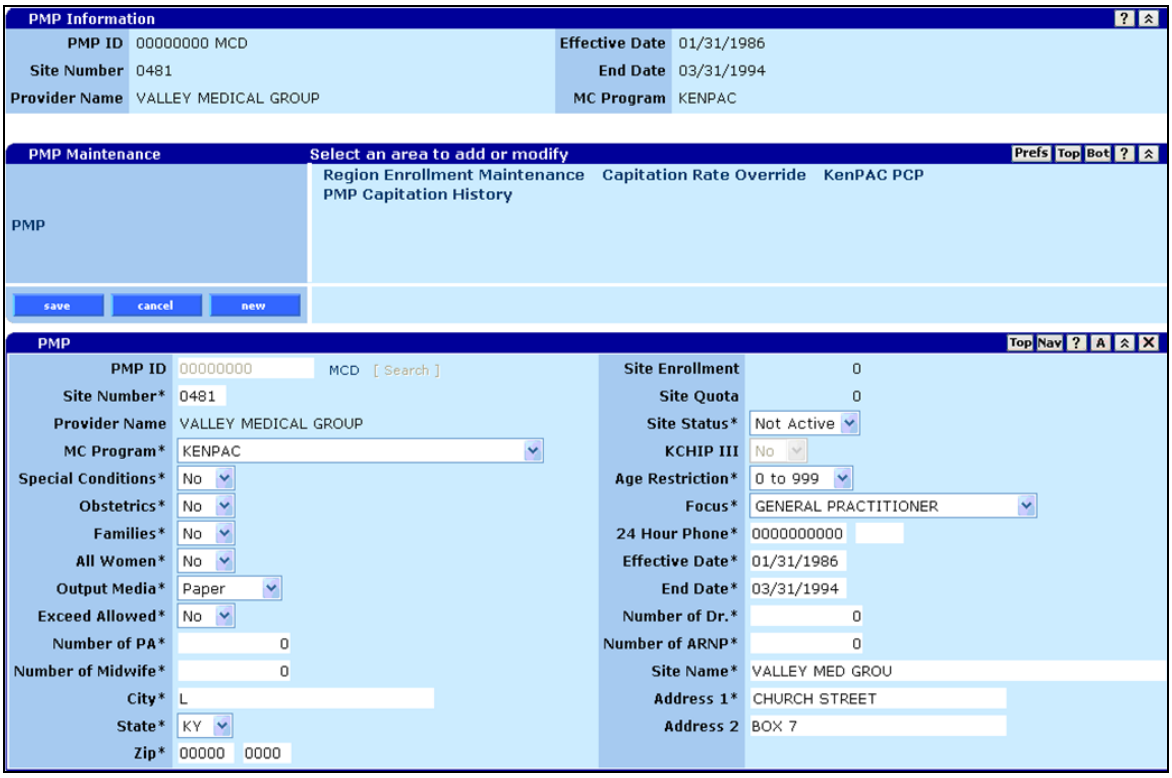
STEP 4 Enter search criteria and click on the blue “Search” button.



PMP Search Panel

The PMP Information, Maintenance and Base Information panels will open. Changes can be made in the file by updating information in the PMP panel.

STEP 5 Update information in the panel.



PMP Information, Maintenance and Base Information Panels

9.7.1.1 Managed Care/ PMP Information Panel Field Descriptions

Field	Description
PMP ID	Unique PMP identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for other managed care programs.
Provider Name	Provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
MC Program	Identification of Managed Care program.

9.7.1.2 Managed Care/ PMP Maintenance Panel Field Descriptions

Field	Description
Region Enrollment Maintenance	Opens the Region Enrollment Maintenance panel.
PMP Capitation History	Opens the PMP Capitation History panel.

Field	Description
Capitation Rate Override	Opens the Capitation Rate Override panel.
KenPAC PCP	Opens the KenPAC PCP panel.

9.7.1.3 Managed Care/ PMP Maintenance Panel Button Descriptions

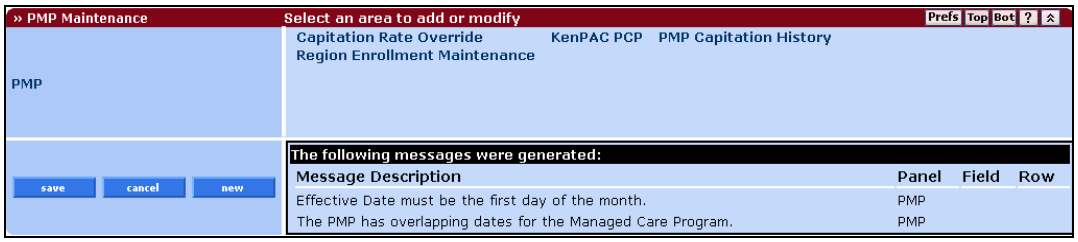
Button	Description
Save	Saves changes made to panel(s).
Cancel	Cancels changes made to panel(s).
New	Activates panel so that a new record may be added.

9.7.1.4 Managed Care/ PMP Panel Field Descriptions

Field	Description
PMP ID	Unique primary medical provider (PMP) identification number. This field contains provider ID (length 10) and provider type.
Site Number	KenPAC site number. Only present for KenPAC providers. Zeros for managed care programs.
Provider Name	Provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
MC Program	Identification of managed care program. This is identification of managed care program.
Special Conditions	Indicates whether PMP offers special services at location for special patient conditions. Valid values are "No" and "Yes".
Obstetrics	Indicates whether a PMP provides obstetric services in their practice. Valid values are "No" and "Yes".
Families	Indicates whether a PMP accepts entire families in their practice. Valid values are "No" and "Yes".
All Women	Indicates whether provider only accepts women as managed care members. Valid values are "No" and "Yes".
Output Media	Type of media used for output. Valid values are "Electronic" and "Paper".
Exceed Allowed	Indicates when PCP’s allowed quota is reached.
Number of PA	Used to determine if a provider has met quota on new members. PA counts same as a physician. Used for PA practitioner providers.
Number of Midwife	Used to determine if a provider has met quota on new members. Midwife counts the same as a physician. Used for midwife practitioner providers.
City	City for physical location of site.
State	State for physical location of site.

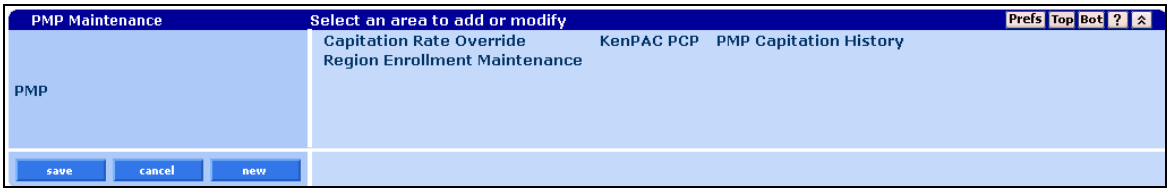
Field	Description
Zip	First five digits of zip code for physical location of site, including four-digit suffix.
Site Enrollment	Number of members currently assigned to PMP location.
Site Quota	Maximum number of members that can be assigned to a PMP location.
Site Status	Controls KenPAC site status. Valid values are “Active” or “Unknown” or “Not Active Status”.
KCHIP III	Indicates provider is willing to accept members with KCHIP III eligibility. Valid values are "No" and "Yes".
Age Restriction	Age restrictions a PMP can select for a given PMP location.
Focus	Contains list of valid focuses that a PMP can have. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: general practitioner, internist and pediatrician.
24 Hour Phone	24-hour availability phone number for provider in format area code + prefix + suffix. This field is divided into two fields, which are 24-Hour Phone (length 10) and Extension (length four).
Effective Date	Effective date for PMP for managed care program. Used to signify start of a span or period of participation in managed care program.
End Date	End date for PMP for managed care program. Used to signify end of a span or period of participation in managed care program.
Number of Dr	Used to determine if a provider has met quota on new members. Dr. counts the same as a physician. Used for Dr. practitioner providers.
Number of ARNP	Used to determine if a provider has met quota on new members. ARNP count same as a physician. Used for ARNP practitioner providers.
Site Name	Site name for physical location of site.
Address 1	First line of street address for physical location of site.
Address 2	Second line of street address for physical location of site.

STEP 3 Click on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error. This Message Description shows two errors to correct.



STEP 4 Correct errors and save. Message Description will show “Save was Successful” after a successful save.

STEP 5 To Add a new file click once on the “New’ button in the PMP Maintenance panel.



Most of the fields will empty in the PMP panel.

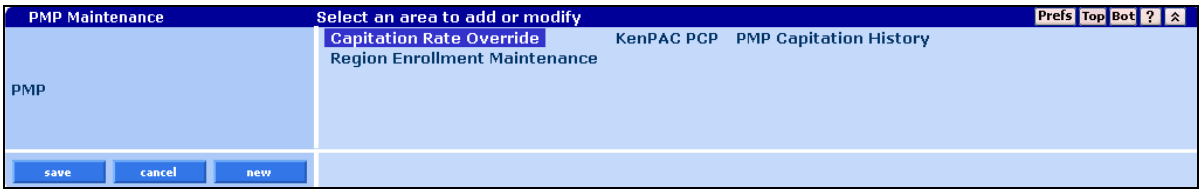
STEP 6 Enter the new file information into the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

9.8 How to Add/Update Capitation Rate Override Information

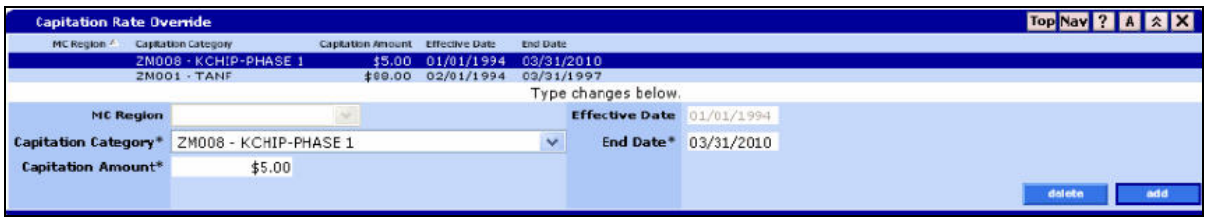
STEP 1 Access a managed care PMP file.

STEP 2 Select Capitation Rate Override link from PMP Maintenance panel by clicking on it one time.



The Capitation Rate Override panel will open.

STEP 3 Click the "Add" button to activate the fields in the panel. Now the information can be updated.



Capitation Rate Override Panel

9.8.1 Managed Care/ Capitation Rate Override Panel Field Descriptions

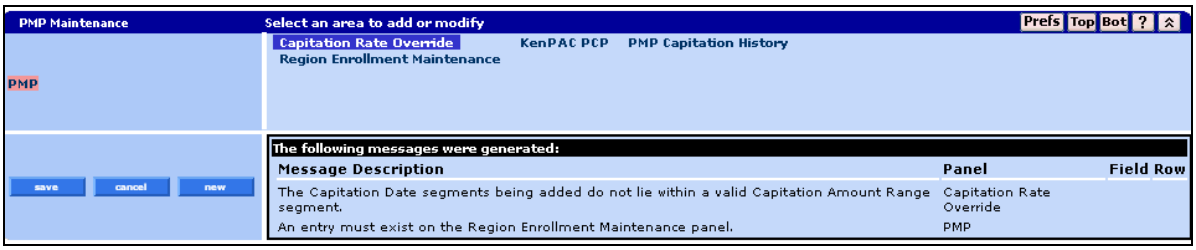
Field	Description
MC Region	Identification of managed care region.
Capitation Category	Category of capitation. Format: Code - Description.
Capitation Amount	Amount of capitation payment.
Effective Date	Effective date of payment record.
End Date	End date of payment record.

9.8.2 Managed Care/ Capitation Rate Override Panel Button Descriptions

Button	Description
Add	To add a new record to the panel.

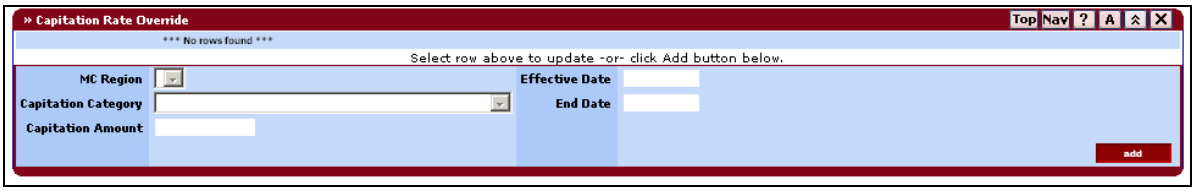
STEP 4 Update information.

STEP 5 Save updated information by going to the Maintenance panel and clicking on the blue "Save" button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error. The Message Description box shows two errors to correct.

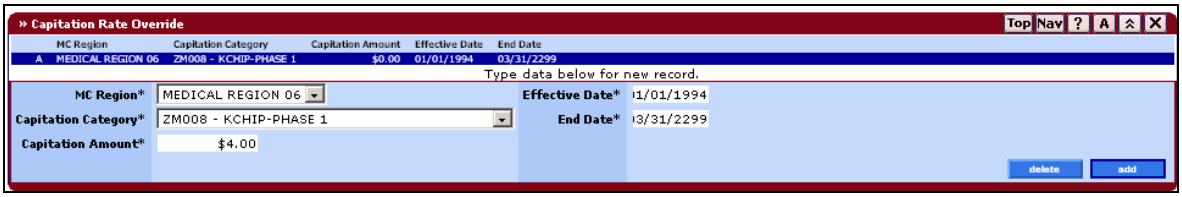


STEP 6 Correct errors and save. Message Description will show "Save was Successful" after a successful save

STEP 7 <u>To Add a new file</u> click on the "Add" button.



STEP 8 Enter new file information into fields.

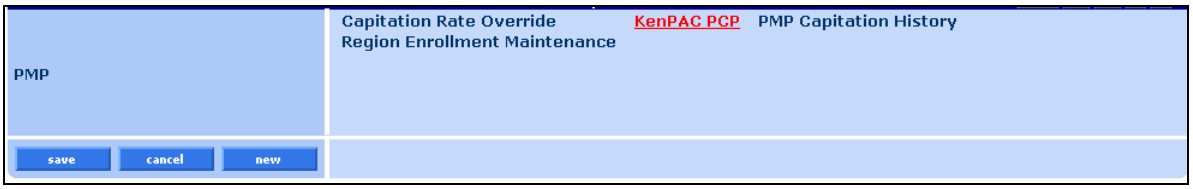


STEP 9 Save updated information by going to the Maintenance panel and clicking on the blue "Save" button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

9.9 How to Update/Add KenPAC PCP Information

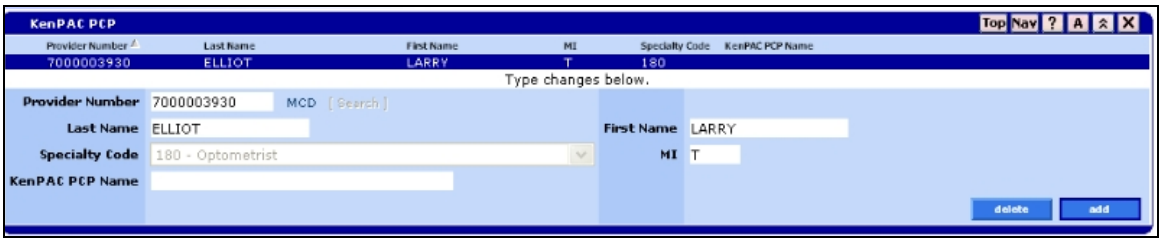
STEP 1 Access a managed care PMP file.

STEP 2 Select KenPAC PCP link from PMP Maintenance panel by clicking on it one time.



The KenPAC PCP panel will open.

STEP 3 Select the blue result row by clicking one time on it to populate the information into the fields so it can be updated. If there is no row just click on the "Add" button.



KenPAC PCP Panel

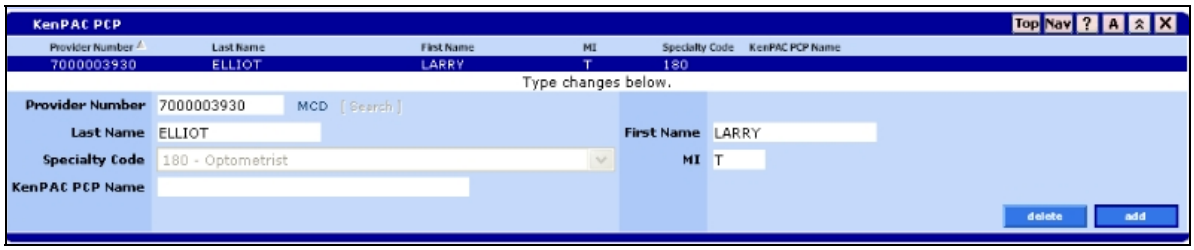
9.9.1 Managed Care/ KenPAC PCP Panel Field Descriptions

Field	Description
Provider Number	Primary medical provider (PMP) ID (length 10) field.
Specialty Code	Specialty code of KenPAC Site PCP.
KenPAC PCP Name	Name of the KenPAC PCP provider.
Last Name	First name of KenPAC Site PCP.
First Name	Last name of KenPAC Site PCP.
MI	Middle initial of KenPAC Site PCP.

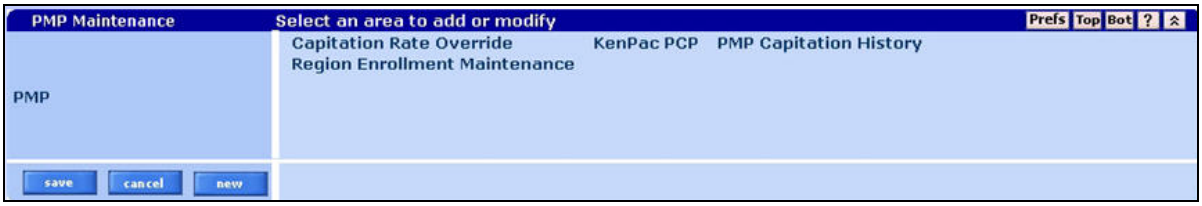
9.9.2 Managed Care/ KenPAC PCP Panel Button Descriptions

Button	Description
Delete	To delete an existing record from the panel.
Add	To add a new record to the panel.

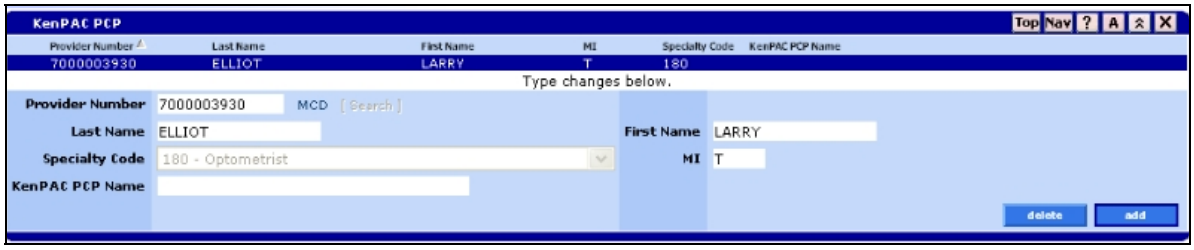
STEP 4 Update the information in the fields.



STEP 5 Save updated information by going to the Maintenance panel and clicking on the blue "Save" button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.



STEP 6 <u>To Add a new file</u> click on the "Add" button.



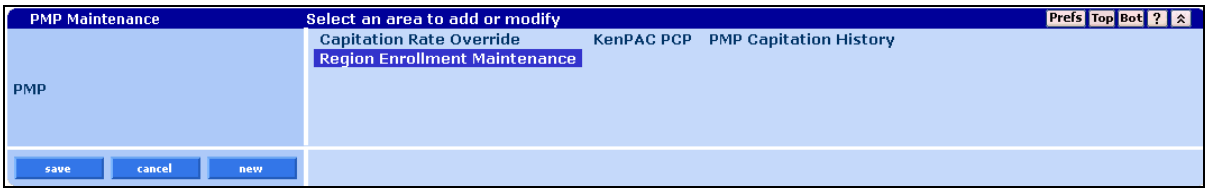
STEP 7 Enter new file information into fields.

STEP 8 Save updated information by going to the Maintenance panel and clicking on the blue "Save" button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

9.10 How to Update Region Enrollment Maintenance

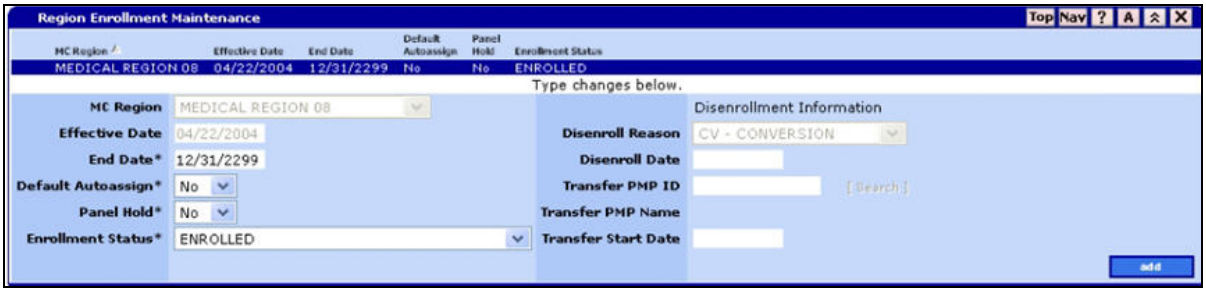
STEP 1 Access a managed care PMP file.

STEP 2 Select the Region Enrollment Maintenance link in the PMP Maintenance panel by clicking on it one time.



The Region Enrollment Maintenance panel will open.

STEP 3 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Region Enrollment Maintenance

9.10.1 Managed Care/ Region Enrollment Maintenance Panel Field Descriptions

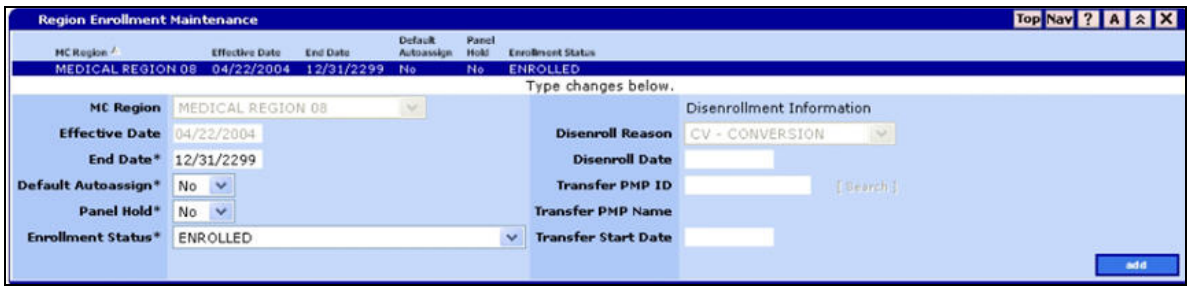
Field	Description
MC Region	Identification of managed care region.
Effective Date	Effective date of managed care region.
End Date	End date of managed care region.
Default Auto assign	Controls if PMP service location allows auto-assignments. Valid values are “No” and “Yes”.
Panel Hold	Specifies that provider is not accepting new members. Valid values are “No” and “Yes”.
Enrollment Status	Contains enrollment status description.
Disenrolll Reason	Contains PMP enrollment reason description. Format is code (length two),” – “, and description (length 50).
Disenroll Date	Date that PMP has elected to disenroll from specified region.
Transfer PMP ID	Identifies transfer provider enrollment tracking ID and service location. This field is Transfer PMP ID (length nine) and service location (length one).

Field	Description
Transfer PMP Name	Transfer PMP provider individual name (format: “Last Name, First Name Middle Initial”) or business name.
Transfer Start Date	Start date of transfer.

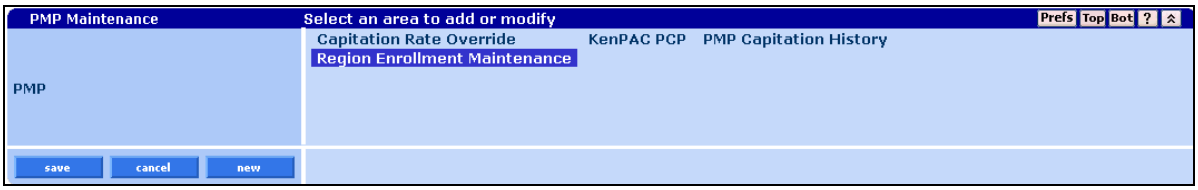
9.10.2 Managed Care/ Region Enrollment Maintenance Panel Button Descriptions

Button	Description
Add	To add a new record to the panel.

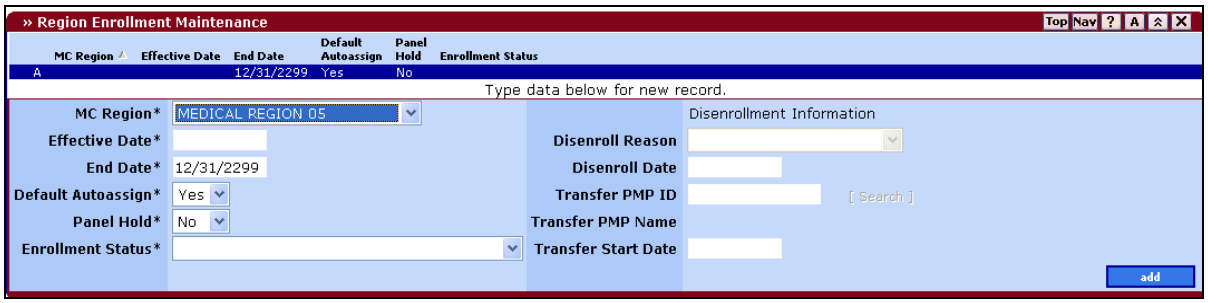
STEP 4 Update information in the fields.



STEP 5 Save the information by clicking one time on the blue “Save” button.



STEP 6 <u>To Add a new file</u> click on the “Add” button.



STEP 7 Enter new file information into fields.

STEP 8 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

How to Update Case PMP Assignment Distribution Information

STEP 1. Access InterChange.

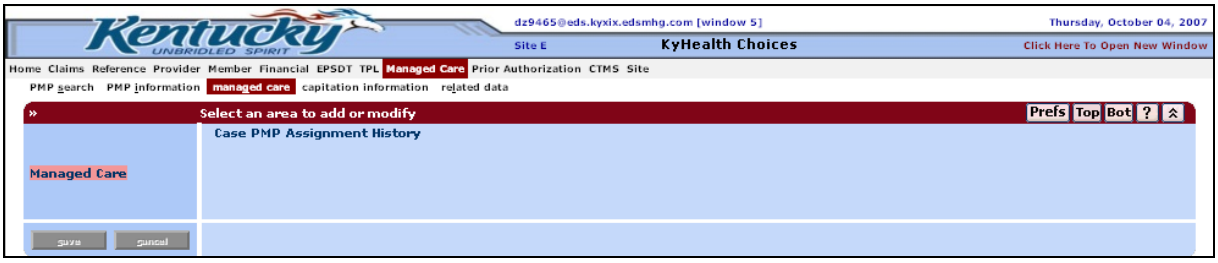
STEP 2. Select “Managed Care” from the main menu.

InterChange Home Page

STEP 3 Select Managed Care from the Managed Care submenu by clicking on it one time.

The Managed Care panel will open.

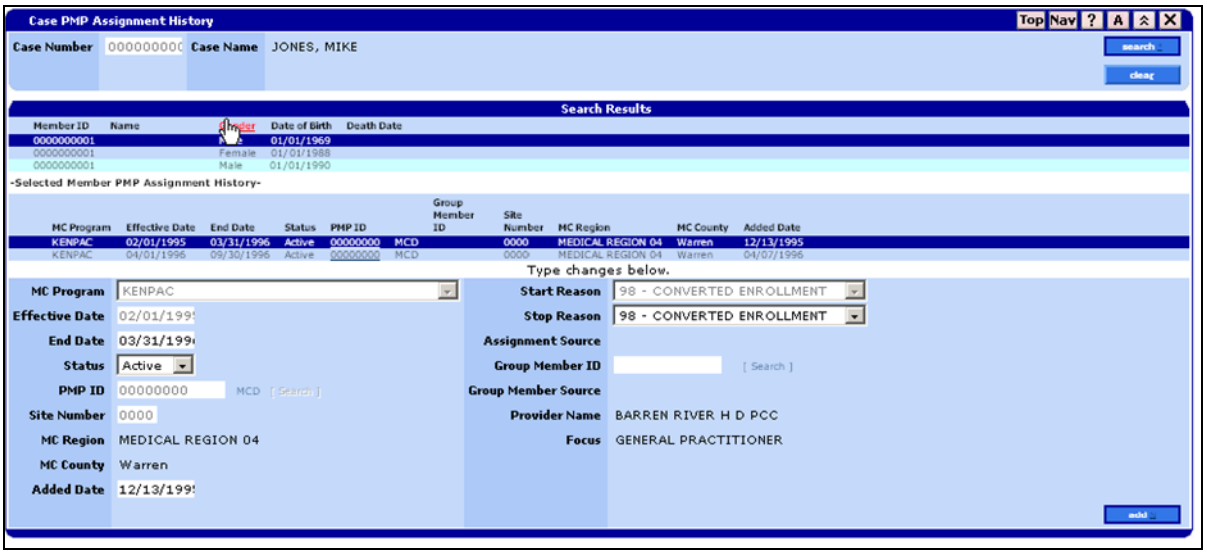
STEP 4 Select the Case PMP Assignment History link from the Maintenance panel by clicking on it one time.



The Case PMP Assignment History panel will open.

There are ten rows of results and there are page numbers under the tenth row. “Next” allows the user to move page by page through the results.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Case PMP Assignment History Panel

9.10.3 Managed Care/ Case PMP Assignment History Panel Field Descriptions

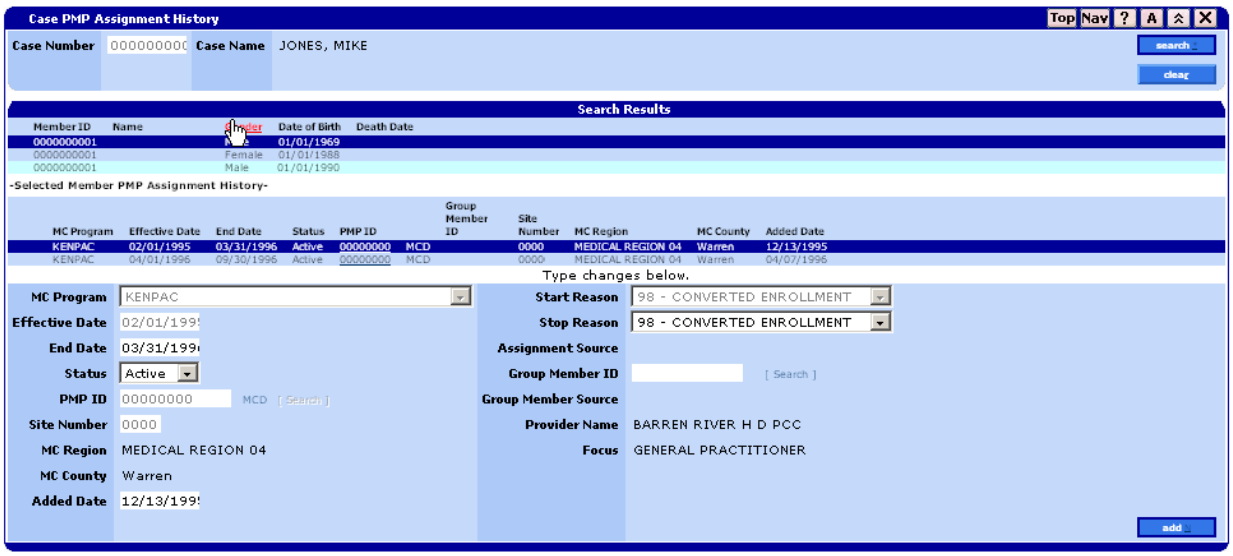
Field	Description
Case Number	Uniquely identifies a *KY Medicaid* case - grouping of members.
Case Name	Identifies name of member that is case head.
Member ID	The case member's 10-digit *KY Medicaid* ID number.
Name	The case member's name. Format last name (length 15), and first Name (length 13).
Gender	The case member's gender.
Date of Birth	The case member's date of birth.
Death Date	The case member's date of death.
MC Program	This is the identification of the Managed Care program.
Effective Date	Date that the PMP assignment became effective.
End Date	Date that the PMP assignment is no longer effective.
Status	Indicates the status of the aid category eligibility (Active or History).
PMP ID	This is the Primary Medical Provider (PMP) ID.
Group Member ID	Identifies providers in Passport only.
Site Number	The KenPAC site number. Only present for KenPAC providers. Zero for other Managed Care programs.
MC Region	A description or name of the Managed Care region.

Field	Description
MC County	The description or name of the Managed Care County.
Added Date	Date the PMP assignment was created/inserted.
Start Reason	Describes why the member was assigned to this provider.
Stop Reason	Describes why the member was no longer assigned to this provider.
Assignment Source	This identifies how the PMP Assignment record was assigned to this member.
Group Member ID	Identifies the Group Member with whom the PMP ID is associated.
Group Member Source	Indicates the source of the Group Member.
Provider Name	This provider individual name (format Last Name, First Name Middle initial) or the business name.
Focus	The PMP focus. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: General Practitioner, Internist, and Pediatrician.

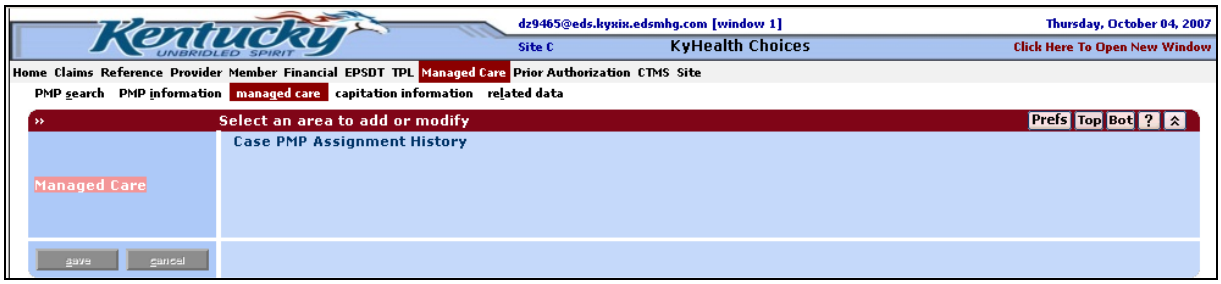
9.10.4 Managed Care/ History Panel Button Descriptions

Button	Description
Search	Searches the KY MMIS for all information matching the information in the search criteria.
Clear	Clears all information form the search criteria fields.

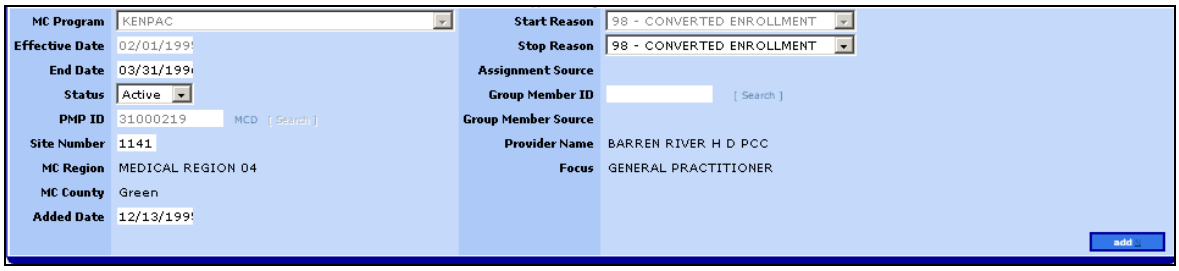
STEP 6 Update information now that it has populated into the fields.



STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.



STEP 8 <u>To Add a new file</u> click on the “Add” button.



STEP 9 Enter new file information into fields.

STEP 10 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

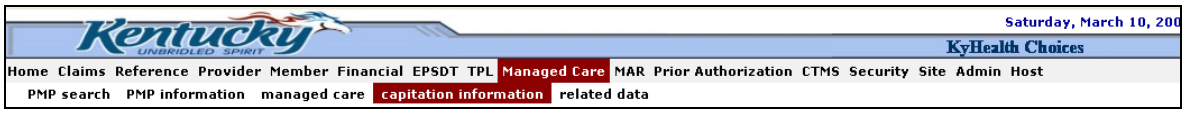
9.11 How to Update/Add Capitation Adjustment Approval Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

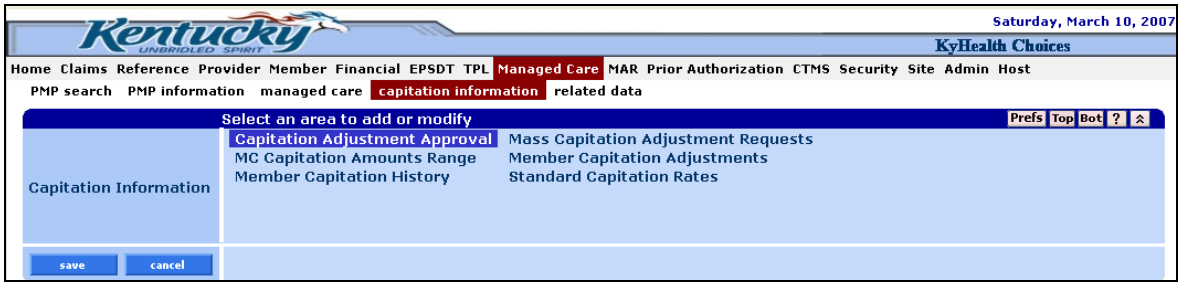
InterChange Home Page

STEP 3 Select Capitation Information from the Managed Care submenu by clicking on it one time.



The Capitation Information panel will open.

STEP 4 Select Capitation Adjustment Approval link by clicking on it one time.



Capitation Information Panel

The Capitation Adjustment Approval panel will open.

STEP 5 Select the row you wish to update.

STEP 6 Update the information.

STEP 7 Click the “Update” button. NOTE: The “Save” button is not used for this function at all.

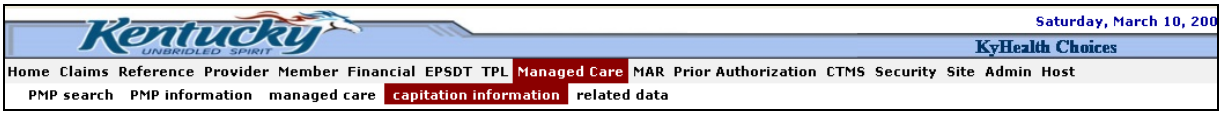
9.12 How to Update/Add Standard Capitation Rates Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

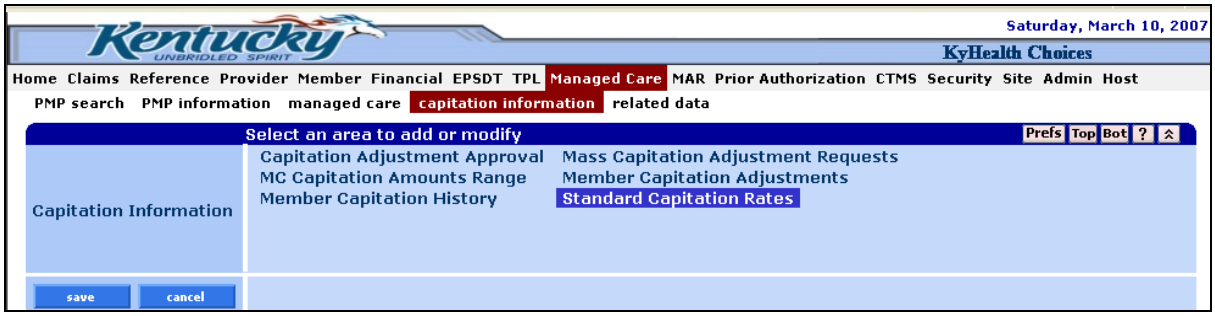
InterChange Home Page

STEP 3 Select Capitation Information from the Managed Care submenu by clicking on it one time.



The Capitation Information panel will open.

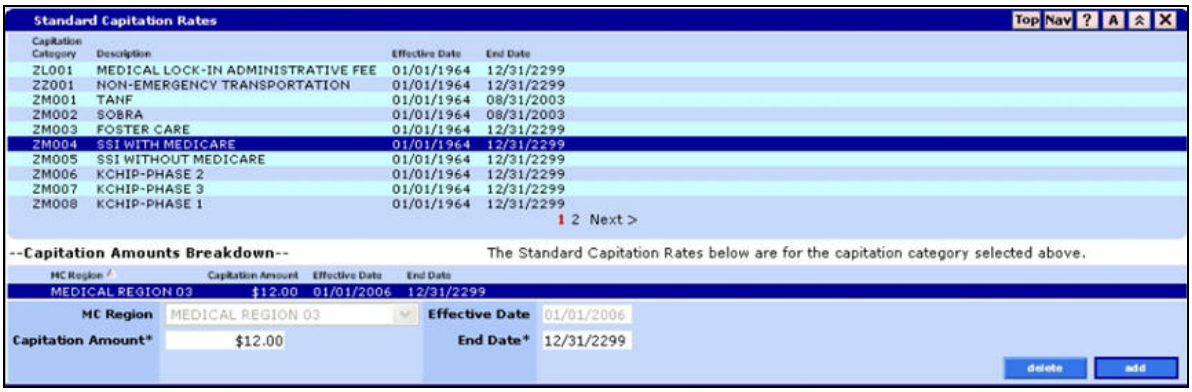
STEP 4 Select Standard Capitation Rates by clicking on it one time.



The Standard Capitation Rates panel will open.

There are ten rows of results and there are page numbers under the tenth row. “Next” allows the user to move page by page through the results.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Standard Capitation Rates Panel

9.12.1 Managed Care/ Standard Capitation Rates Panel Field Descriptions

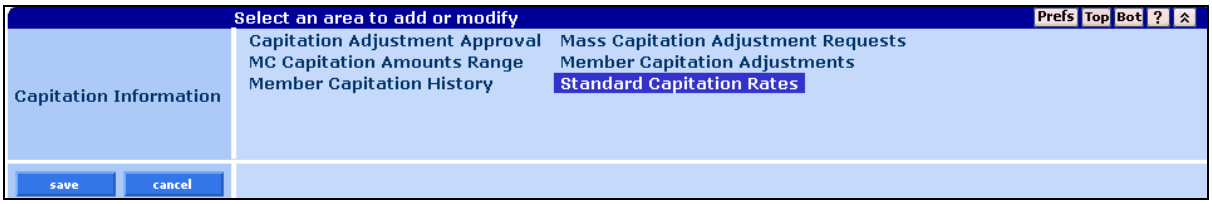
Field	Description
MC Region	Code that identifies a region (or managed care coverage area) of state. A region is made up of different geographical areas such as zip codes, counties or the entire state.
Capitation Amount	Amount of capitation payment.
Effective Date	Date that capitation category became effective.
End Date	Date that capitation category expired and is no longer effective.

9.12.2 Managed Care/ Standard Capitation Rates Panel Button Descriptions

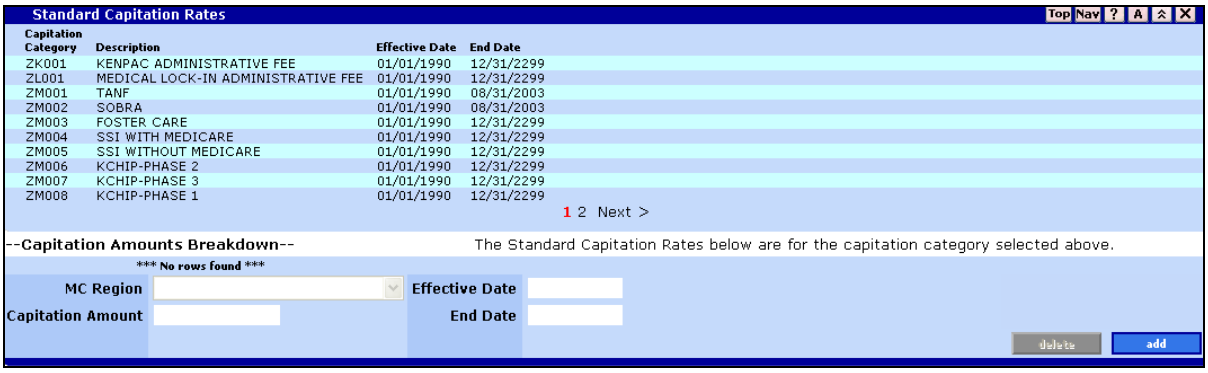
Button	Description
delete	To delete an existing record from the panel.
add	To add a new record to the panel.

STEP 6 Update information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.



STEP 8 <u>To Add a new file</u> click on the “Add” button.



STEP 9 Enter new file information into fields.

STEP 10 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

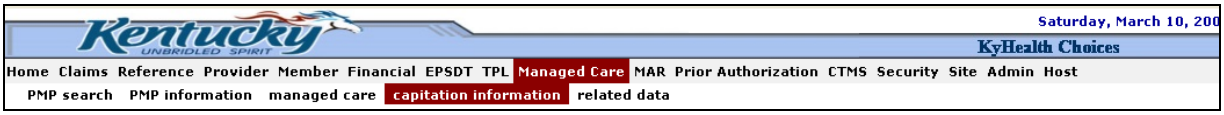
9.13 How to Update/Add Mass Capitation Adjustment Requests Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

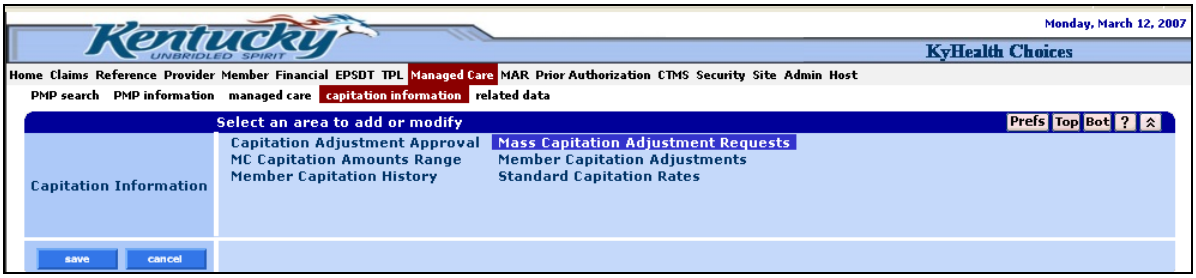
InterChange Home Page

STEP 3 Select Capitation Information from the Managed Care submenu by clicking on it one time.



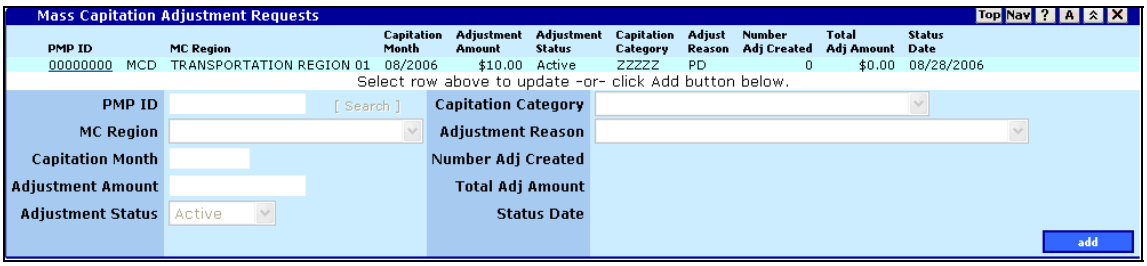
The Capitation Information panel will open.

STEP 4 Select Mass Capitation Adjustment Requests link by clicking on it one time.



The Mass Capitation Adjustment Requests panel will open.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Mass Capitation Adjustment Requests Panel

9.13.1 Managed Care/ Mass Capitation Adjustment Requests Panel Field Descriptions

Field	Description
PMP ID	Unique PMP identification number. This field contains provider ID (length10) and provider type.
MC Region	Code that identifies a region (or managed care coverage area) of state. A region is made up of different geographical areas such as zip codes, counties or the entire state.
Capitation Month	Month of capitation.
Adjustment Amount	Amount to increase or decrease payment.
Adjustment Status	Indicates status of request. (A) Active, (H) Hold, (P) Processed.
Capitation Category	Category of capitation.
Adjustment Reason	Code of reason capitation is being done.
Number Adj Created	Number of Txn's created when rate increase was processed.
Total Adj Amount	Total amount paid or recouped on a rate change or correction adjustment once it has been processed.
Status Date	Date that current status was done.

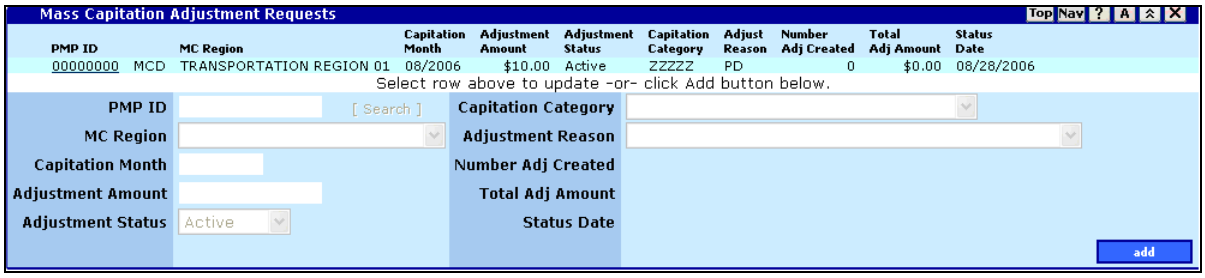
9.13.2 Managed Care/ Mass Capitation Adjustment Requests Panel Button Descriptions

Button	Description
Add	To add a new record to the panel.

STEP 6 Update the information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

STEP 8 <u>To Add a new file</u> click on the “Add” button.



STEP 9 Enter new file information into fields.

STEP 10 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

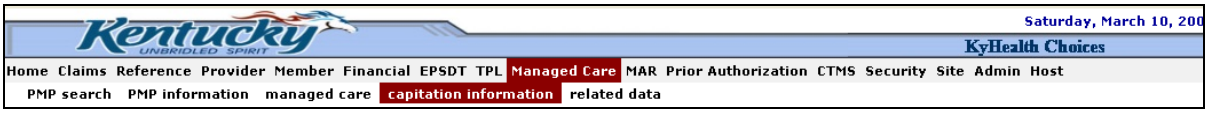
9.14 How to Update/Add Managed Care Capitation Amounts Range Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

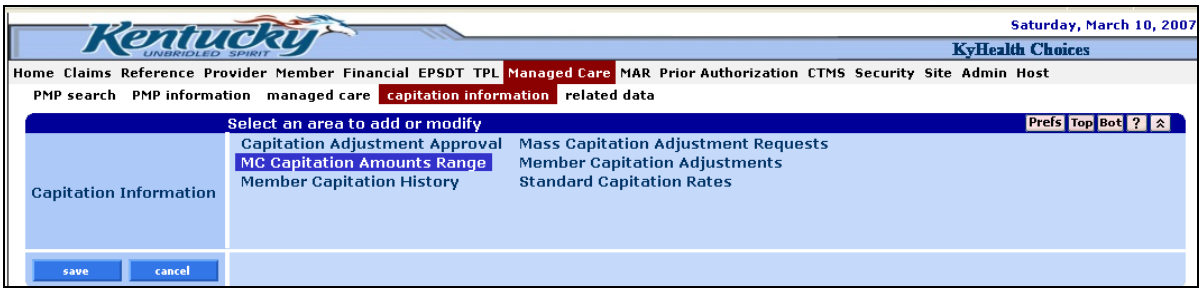
InterChange Home Page

STEP 3 Select Capitation Information from the Managed Care submenu by clicking on it one time.



The Capitation Information panel will open.

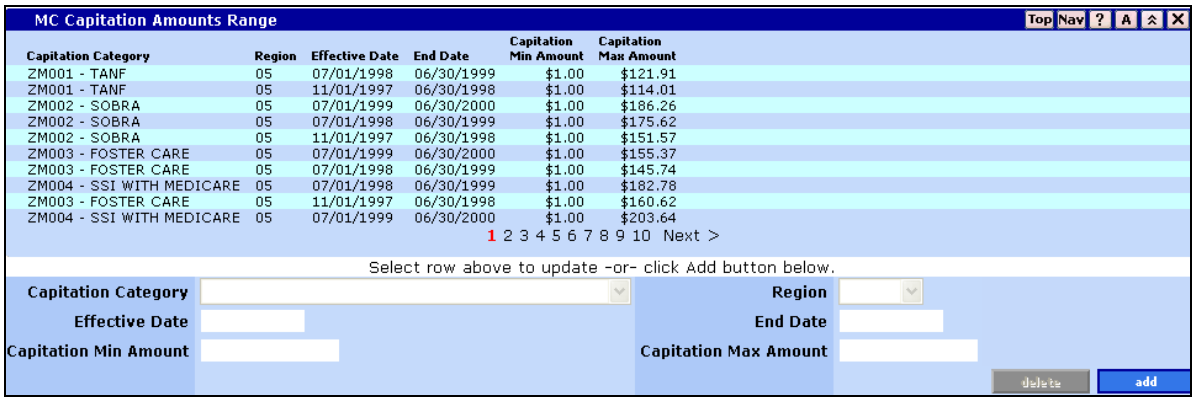
STEP 4 Select Capitation Amounts Range link by clicking on it one time.



The Capitation Amounts Range panel will open.

There are ten rows of results and there are page numbers under the tenth row. “Next” allows the user to move page by page through the results.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Managed Care Capitation Amounts Range Panel

9.14.1 Managed Care/ Mass Capitation Amounts Range Panel Field Descriptions

Field	Description
Capitation Category	Capitation payment category.
Effective Date	Effective date for this rate range.
Capitation Min. Amount	Minimum allowable payment amount.
Region	Region applicable to the capitation category and rate ranges.
End Date	End date for this rate range.
Capitation Max Amount	Maximum allowable payment amount.

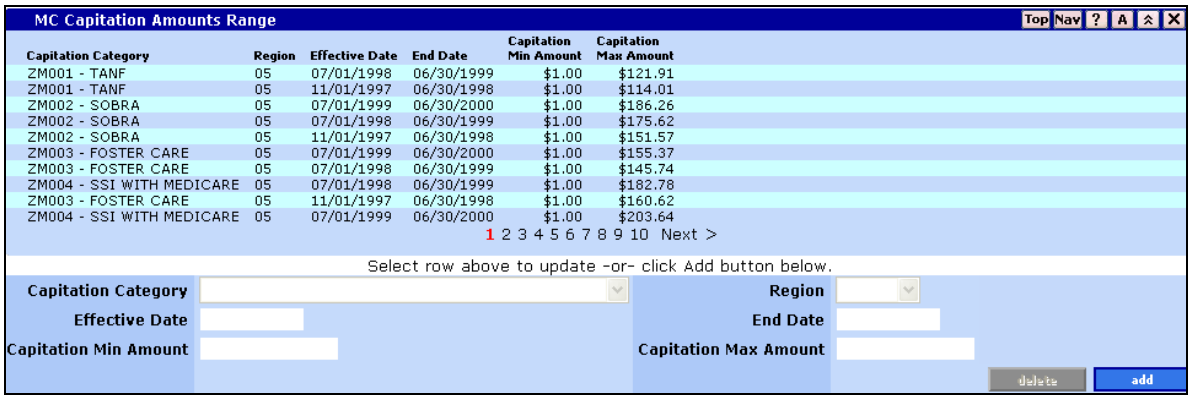
9.14.2 Managed Care/ Mass Capitation Amounts Range Panel Button Descriptions

Button	Description
Add	To add a new record to the panel.
Delete	To delete an existing record from the panel.

STEP 6 Update information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

STEP 8 <u>To Add a new file</u> click on the “Add” button.



STEP 9 Enter new file information into fields.

STEP 10 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

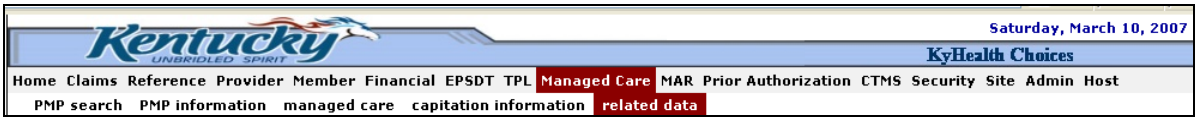
9.15 How to Update/Add Capitation Reason Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

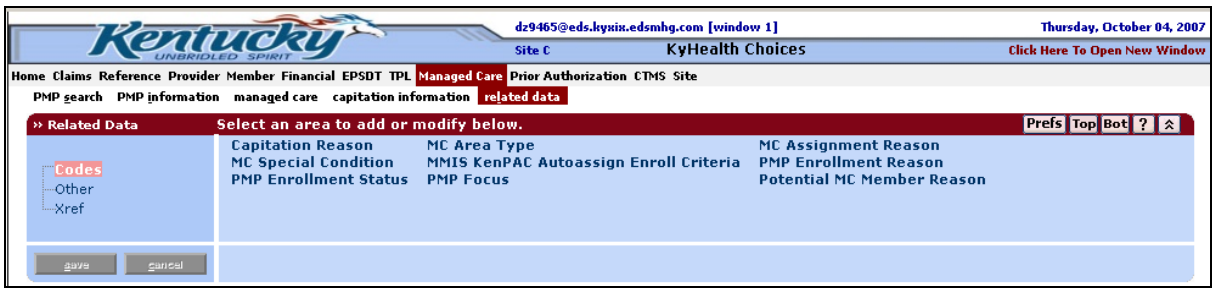
InterChange Home Page

STEP 3 Select Related Data from the Managed Care subsystem by clicking on it one time.



The Related Data Panel will open.

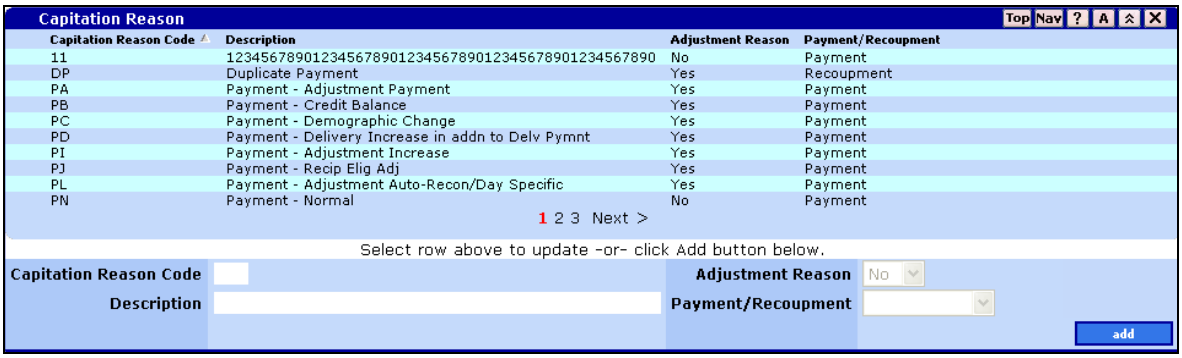
STEP 4 Select Capitation Reason by clicking on the link one time.



Related Data Panel

The Capitation Reason panel will open.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Capitation Reason Panel

9.15.1 Managed Care/ Related Data/ Codes/ Capitation Reason Panel Field Descriptions

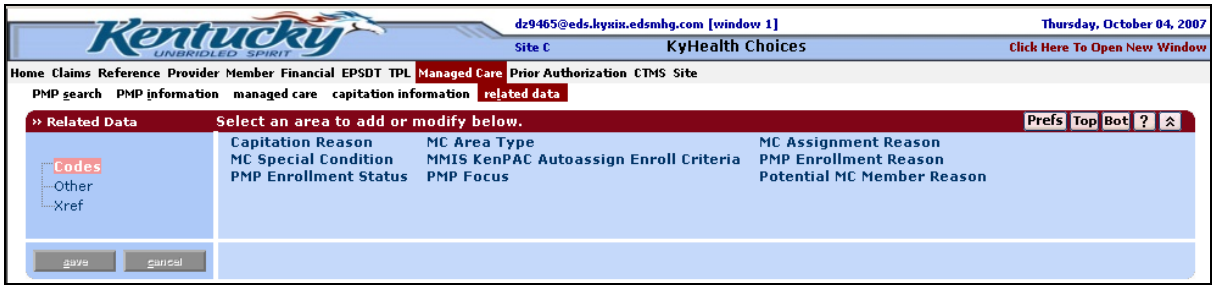
Field	Description
Capitation Reason Code	Code of reason capitation is being done.
Description	Description on adjustment reason code.
Adjustment Reason	Indicates whether reason code can be used for an adjustment or not. Valid values are "Yes" and "No".
Payment/Recoupment	Specifies if reason is for payments or recoupment. Valid values are "Payment" and "Recoupment".

9.15.2 Managed Care/ Related Data/ Codes/ Capitation Reason Panel Button Descriptions

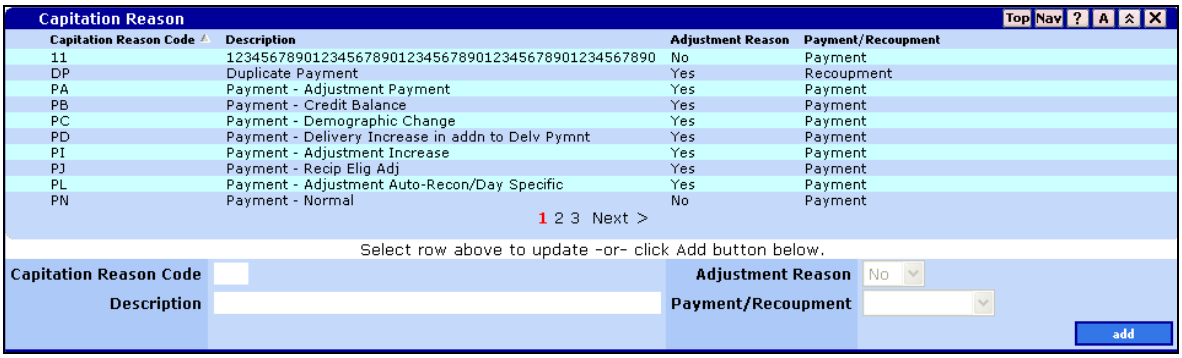
Button	Description
add	To add a new record to the panel.

STEP 6 Update information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.



STEP 7 <u>To Add a new file</u> click on the “Add” button.



STEP 8 Enter new file information into fields.

STEP 9 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

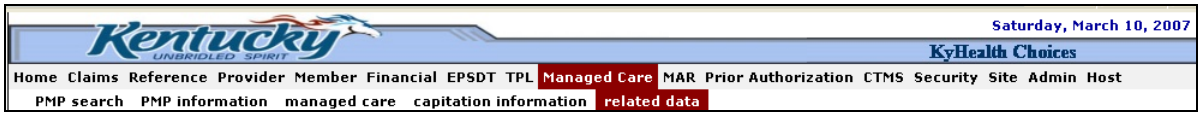
9.16 How to Update/Add MMIS KenPAC Auto-Assign Enrollment Criteria

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

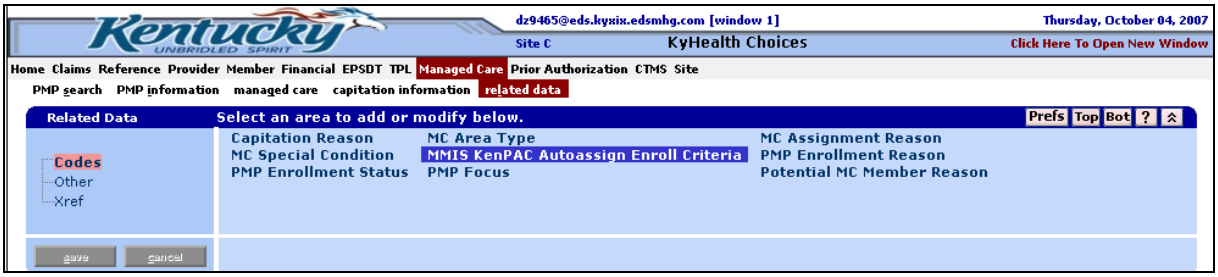
InterChange Home Page

STEP 3 Select Related Data from the Managed Care subsystem by clicking on it one time.



The Related Data Panel will open.

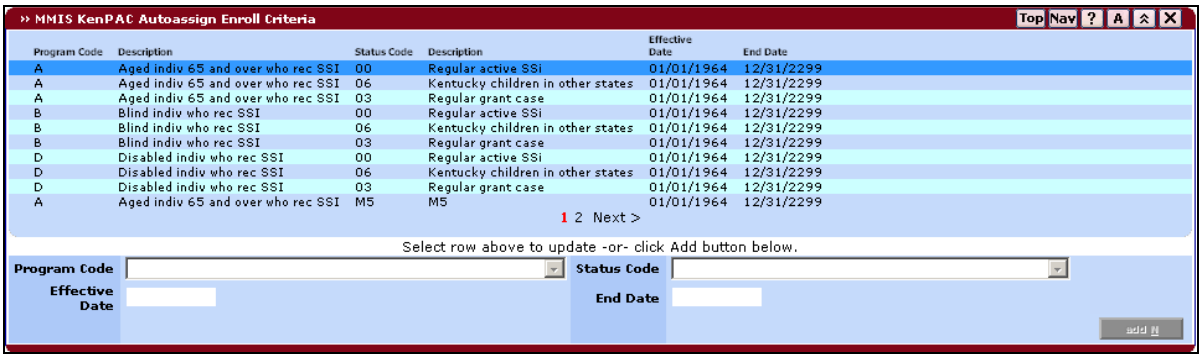
STEP 4 Select MMIS KenPAC Auto-assign Enroll Criteria by clicking one time on the link.



Related Data Panel

The MMIS KenPAC Auto-assign Enroll Criteria panel will open.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



MMIS KenPAC Auto-Assign Enroll Criteria Panel

9.16.1 Managed Care/ Related Data/ Codes/ MMIS KenPAC Auto-assign Enroll Criteria Panel Field Descriptions

Field	Description
Program Code	Identifies type of program code for which a member is eligible to turn on or off auto-assignment.
Effective Date	Date that auto-assignment became effective.
Status code	Identifies type of status code for which a member is eligible to turn on or off auto-assignment.
End Date	Date that auto-assignment expired and is no longer effective.

9.16.2 Managed Care/ Related Data/ Codes/ MMIS KenPAC Auto-assign Enroll Criteria Panel Button Descriptions

Button	Description
add	To add a new record to the panel.

STEP 6 Update information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

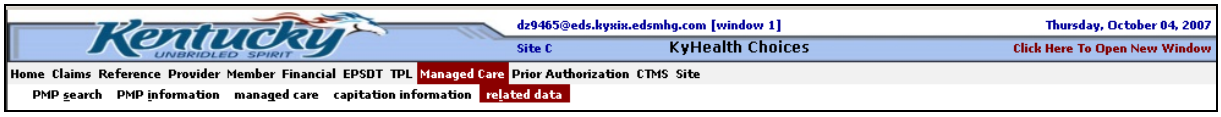
9.17 How to Update/Add Capitation Reason Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

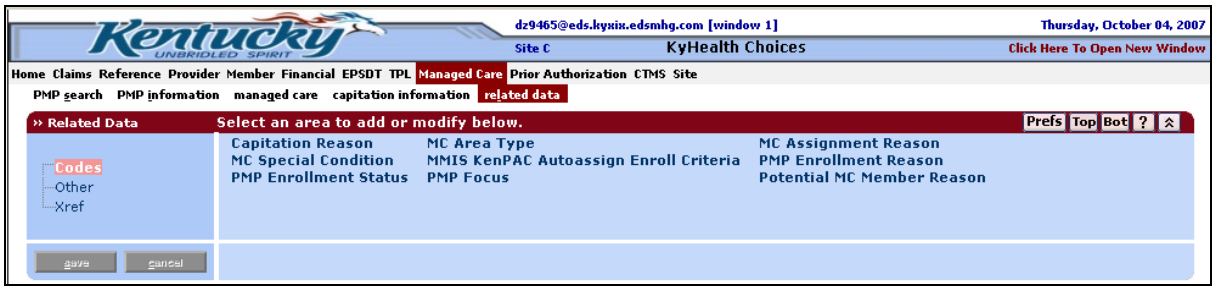
InterChange Home Page

STEP 3 Select Related Data from the Managed Care subsystem by clicking on it one time.



The Related Data Panel will open.

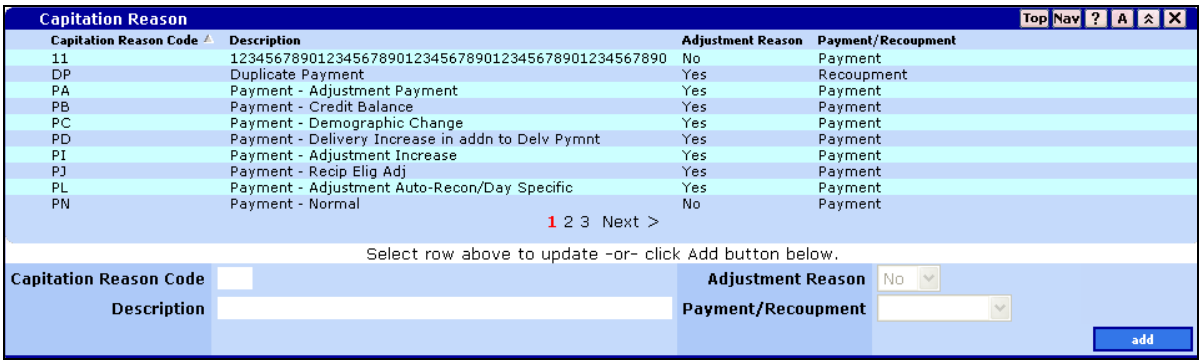
STEP 4 Select PMP Enrollment Status link by clicking on it one time.



Related Data Panel

The PMP Enrollment Status panel will open.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Capitation Reason Panel

9.17.1 Managed Care/ Related Data/ Codes/ PMP Enrollment Status Panel

Field	Description
Enrollment Status	Enrollment status code; it is read only.
Description	Description of enrollment status code.

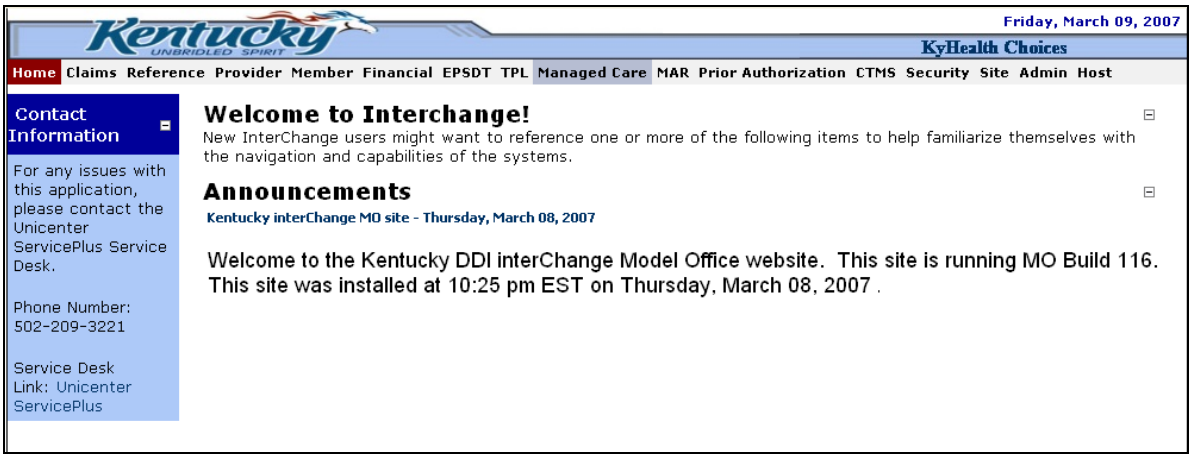
STEP 6 Update information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

9.18 How to Update/Add Managed Care Area Type Information

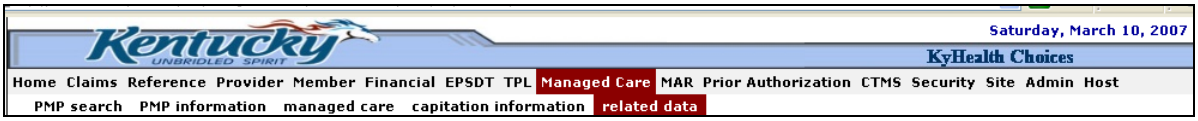
STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.



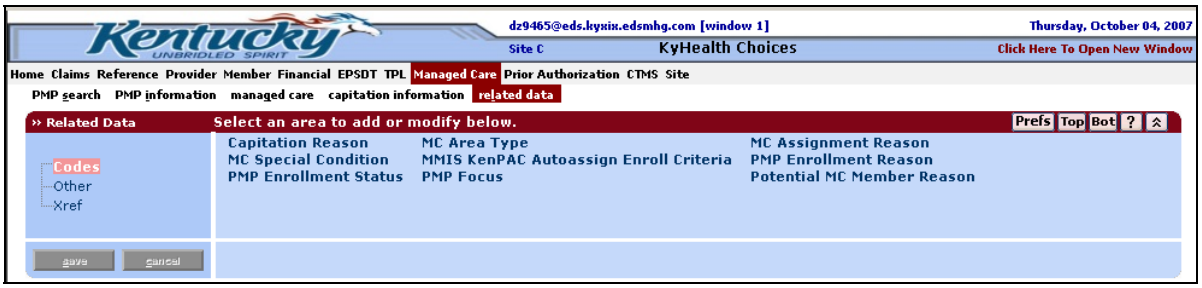
InterChange Home Page

STEP 3 Select Related Data from the Managed Care subsystem by clicking on it one time.



The Related Data Panel will open.

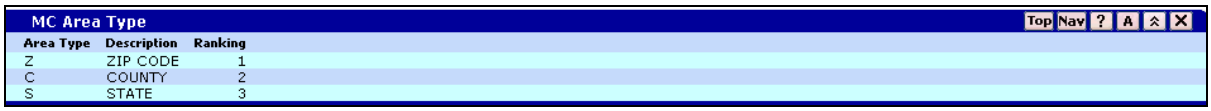
STEP 4 Select MC Area Type link by clicking on it one time.



Related Data Panel

The MC Area Type panel will open.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Area Type	Description	Ranking
Z	ZIP CODE	1
C	COUNTY	2
S	STATE	3

Managed Care Area Type Panel

9.18.1 Managed Care/ Related Data/ Codes/ MC Area Type Panel Field Descriptions

Field	Description
Area Type	Identifies type of MC area.
Description	Identifies description of MC area type.
Ranking	Identifies ranking of MC area type.

STEP 6 Update information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

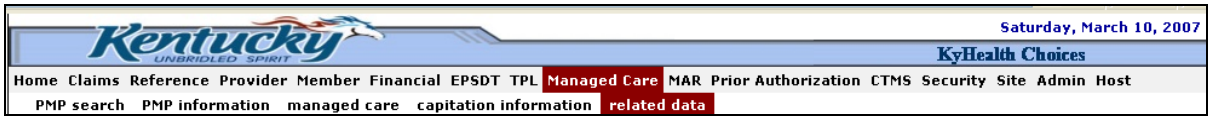
9.19 How to Update/Add Managed Care Special Condition Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

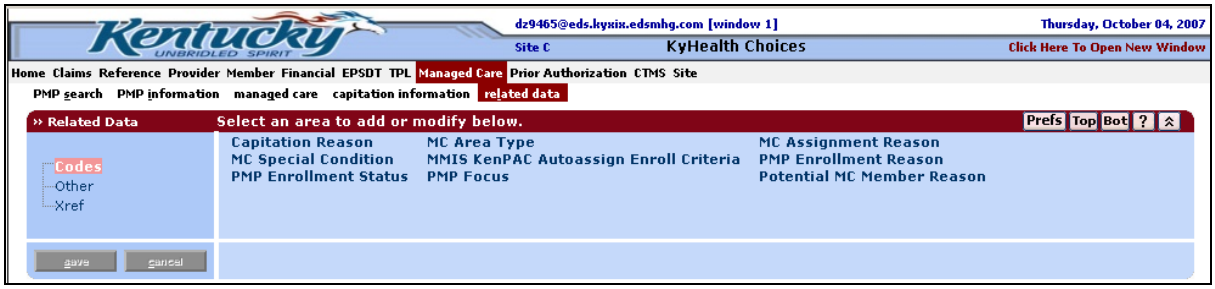
InterChange Home Page

STEP 3 Select Related Data from the Managed Care subsystem by clicking on it one time.



The Related Data Panel will open.

STEP 4 Select MC Special Condition link by clicking on it one time.

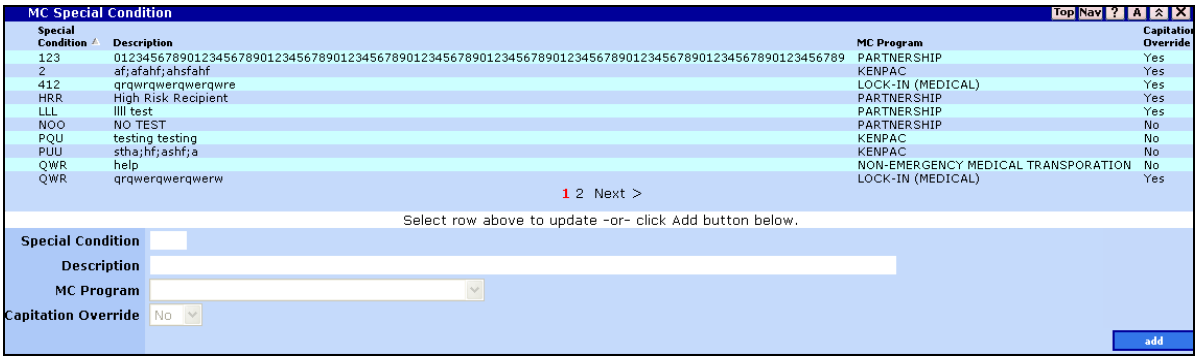


Related Data Panel

The MC Special Condition panel will open.

There are ten rows of results and there are page numbers under the tenth row. “Next” allows the user to move page by page through the results.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Managed Care Special Condition Panel

9.19.1 Managed Care/ Related Data/ Codes/ MC Special Condition Panel Field Descriptions

Field	Description
Special Condition	Code representing special condition.
Description	Description of special condition.
MC Program	Identification of managed care program.
Capitation Override	If special condition overrides 'normal' calculation of a member's capitation category using demographics. Valid values are "No" and "Yes".

9.19.2 Managed Care/ Related Data/ Codes/ MC Special Condition Panel Button Descriptions

Button	Description
Add	To add a new record to the panel.

STEP 6 Update information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue "Save" button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

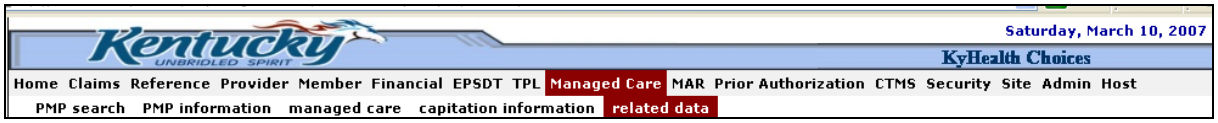
9.20 How to Update/Add PMP Focus Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

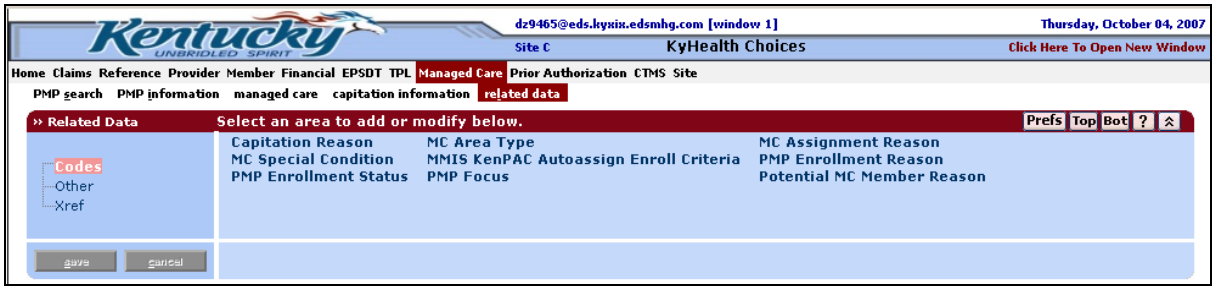
InterChange Home Page

STEP 3 Select Related Data from the Managed Care subsystem by clicking on it one time.



The Related Data Panel will open.

STEP 4 Select PMP Focus link by clicking on it one time.

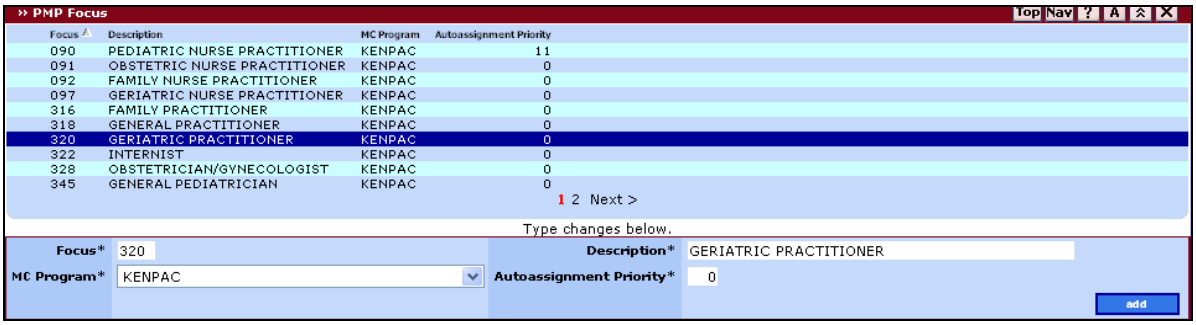


Related Data Panel

The PMP Focus panel will open.

There are ten rows of results and there are page numbers under the tenth row. “Next” allows the user to move page by page through the results.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



PMP Focus Panel

9.20.1 Managed Care/ Related Data/ Codes/ PMP Focus Panel Field Descriptions

Field	Description
Focus	Unique code identifies focus.
MC Program	Managed care program for PMP focus.
Description	Description of focus.
Auto assignment Priority	KY MMIS specific priority order for focuses to receive and order that should be processed (1 = highest priority, 2 = next and so on).

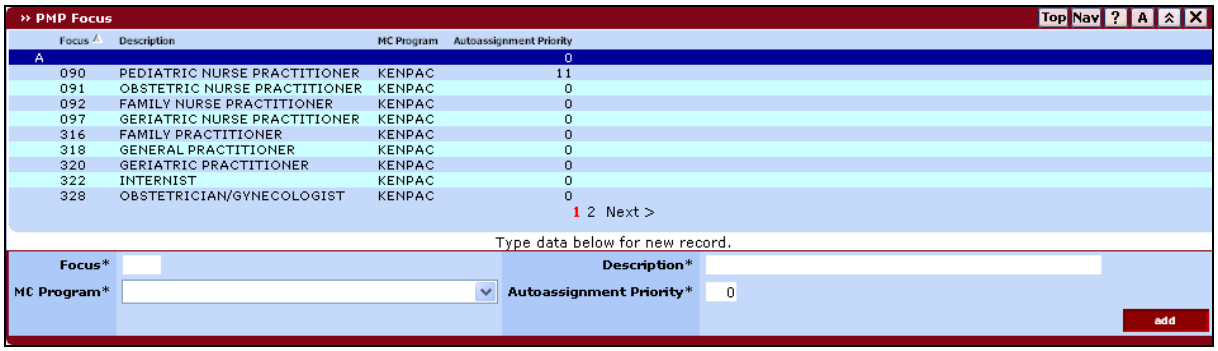
9.20.2 Managed Care/ Related Data/ Codes/ PMP Focus Panel Button Descriptions

Button	Description
Add	To add a new record to the panel.

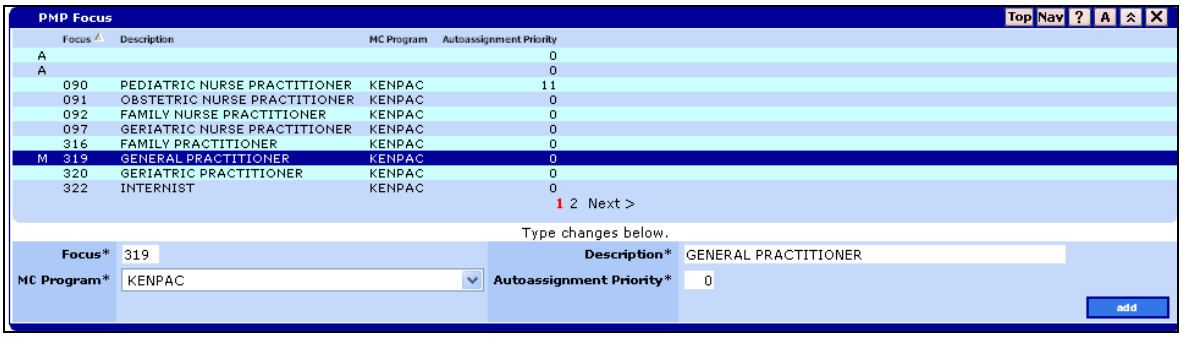
STEP 6 Update information in the fields.

STEP 7 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.

STEP 8 <u>To Add a new file</u> click on the “Add” button.



STEP 9 Enter new file information into fields.



STEP 10 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel.

Changed information shows in the result row above the fields and has an “M” in front of it indicating it was a “Manual” change.

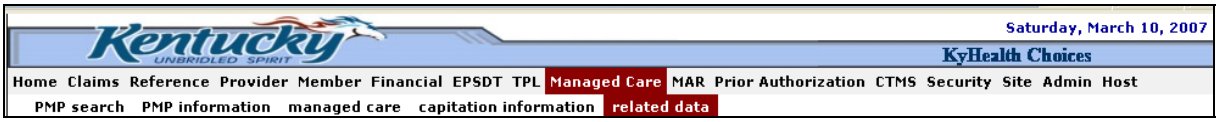
9.21 How to Update/Add Managed Care Assignment Reason Information

STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.

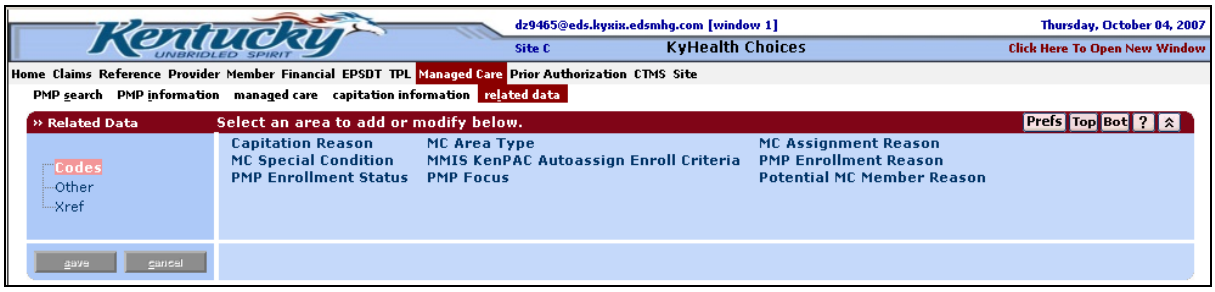
InterChange Home Page

STEP 3 Select Related Data from the Managed Care subsystem by clicking on it one time.



The Related Data Panel will open.

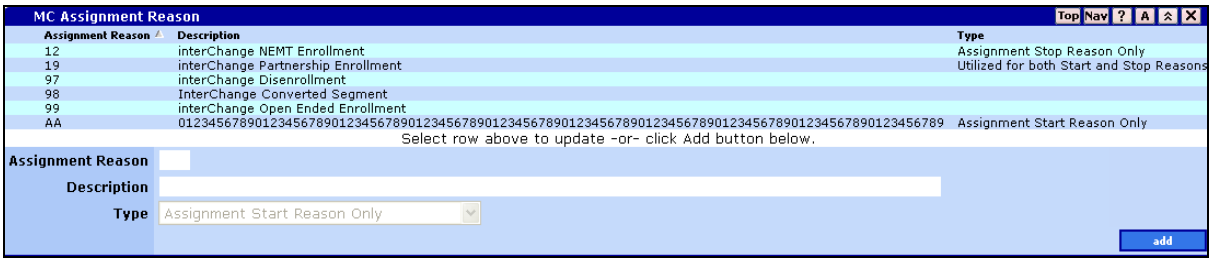
STEP 4 Select MC Assignment Reason link by clicking on it one time.



Related Data Panel

The MC Assignment Reason panel will open.

STEP 5 Select a row to update by clicking on it one time. The information will populate into the fields of the panel.



Managed Care Assignment Reason Panel

9.21.1 Managed Care/ Related Data/ Codes/ MC Assignment Reason Panel Field Descriptions

Field	Description
Assignment Reason	Indicates reason a member was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes reasons a member's relationship with a PMP was terminated; for example, death or an approved change.
Description	Description of reason a member was assigned to a PMP or member's reason for disenrollment from a PMP.
Type	Indicates if a reason code may be used as only a start reason; as only a stop reason; or both a start and stop reason. Valid values "S" = Assignment Start Reason Only; "T" = Assignment Stop Reason Only; and "B" = Utilized for both Start and Stop Reasons.

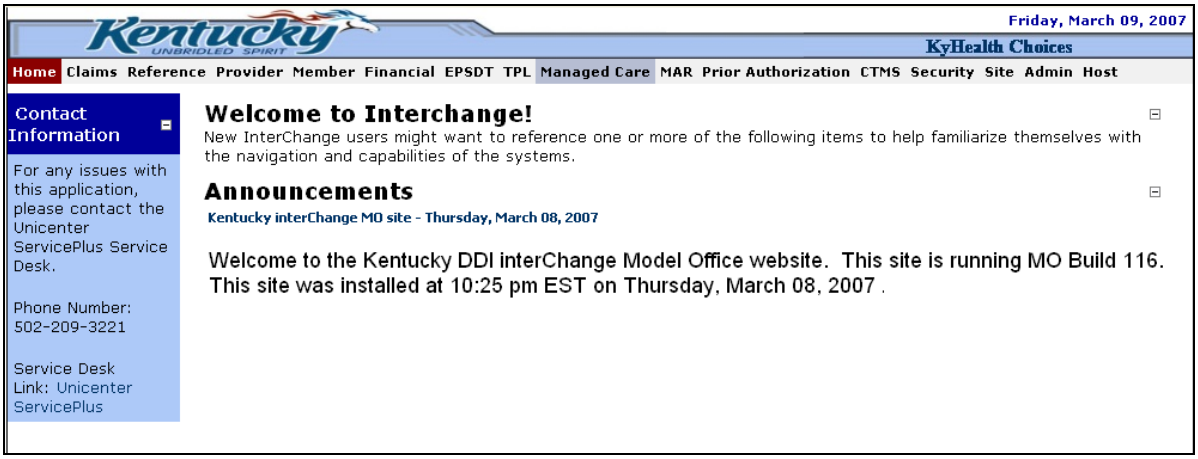
9.21.2 Managed Care/ Related Data/ Codes/ MC Assignment Reason Panel Button Descriptions

Button	Description
Add	To add a new record to the panel.

9.22 How to Update/Add HIPPA/MMIS Assignment Reason Xref Information

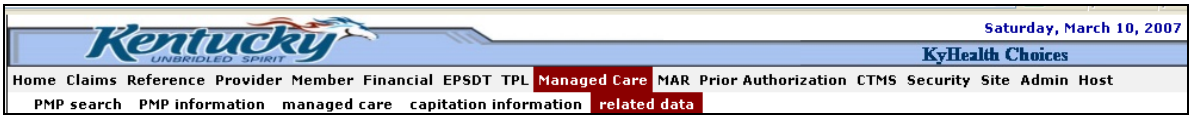
STEP 1. Access InterChange.

STEP 2. Select “Managed Care” from the main menu.



InterChange Home Page

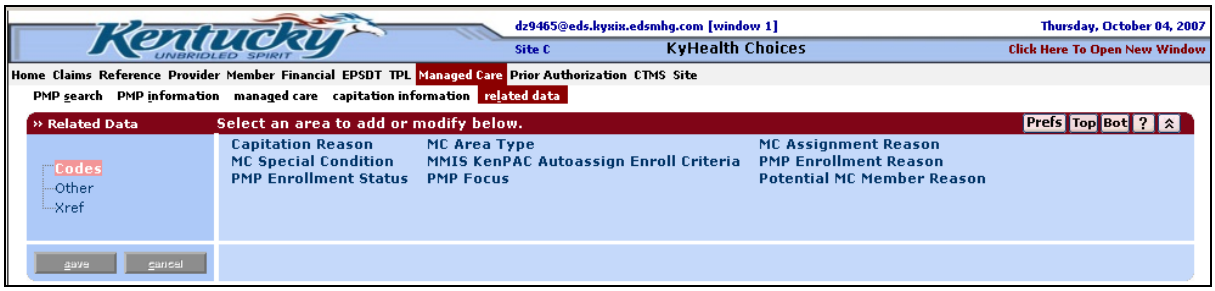
STEP 3 Select Related Data from the Managed Care subsystem by clicking on it one time.



The Related Data Panel will open.

STEP 4 Select Xref on the left side of the Related Data panel by clicking on it one time.

STEP 5 Select HIPPA/MMIS Assignment Reason Xref link by clicking on it one time.

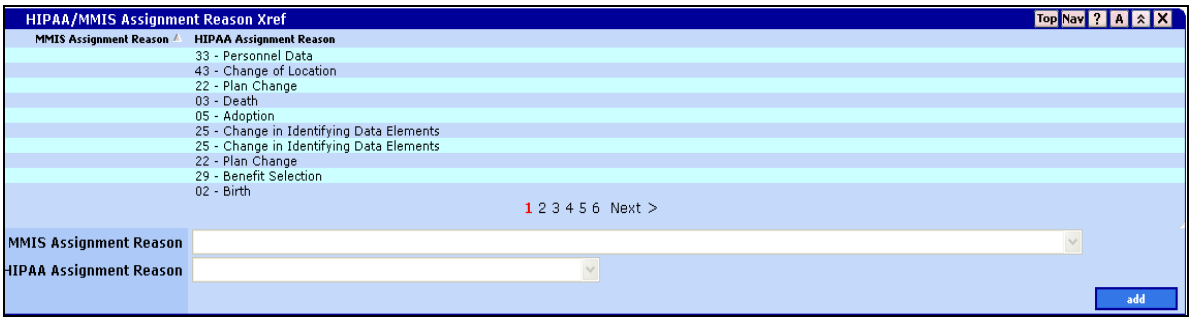


Related Data Panel

The HIPPA/MMIS Assignment Reason Xref panel will open.

There are ten rows of results and there are page numbers under the tenth row. “Next” allows the user to move page by page through the results.

STEP 6 <u>To Add a new file</u> click on the “Add” button.



HIPPA/MMIS Assignment Reason Xref Panel

9.22.1 Managed Care/ Related Data/ XRef/ HIPAA/MMIS Assignment Reason Panel Field Descriptions

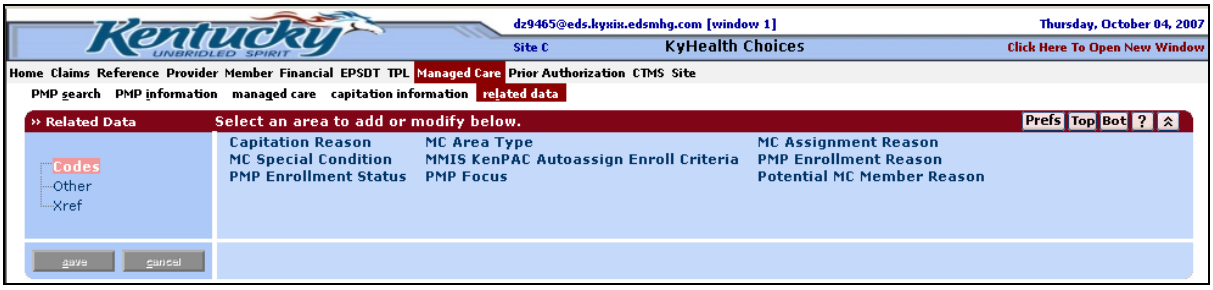
Field	Description
MMIS Assignment Reason	Contains PMP assignment reason codes and descriptions used to begin and end a member's assignment to a PMP.
HIPAA Assignment Reason	Managed care eligibility reason codes for HIPAA.

9.22.2 Managed Care/ Related Data/ XRef/ HIPAA/MMIS Assignment Reason Panel Button Descriptions

Button	Description
add	To add a new record to the panel.

STEP 7 Update information in the fields.

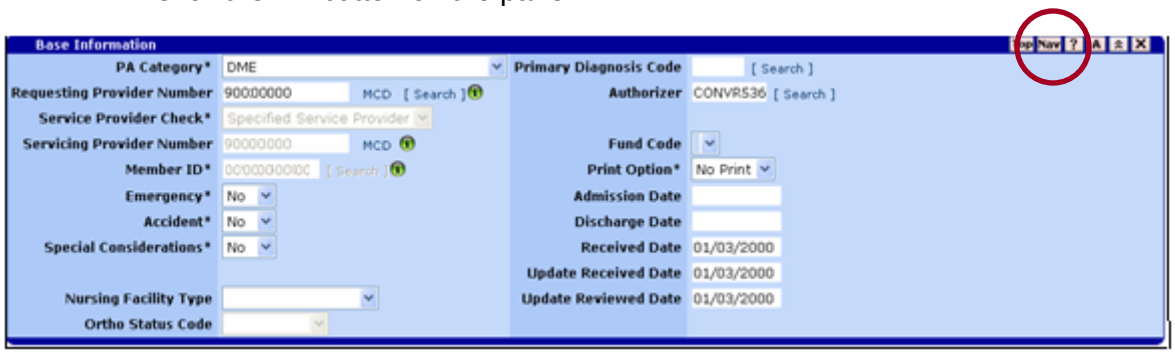
STEP 8 Save updated information by going to the Maintenance panel and clicking on the blue “Save” button in the Maintenance panel. A message box with a black border will inform you if the save was successful or in error.



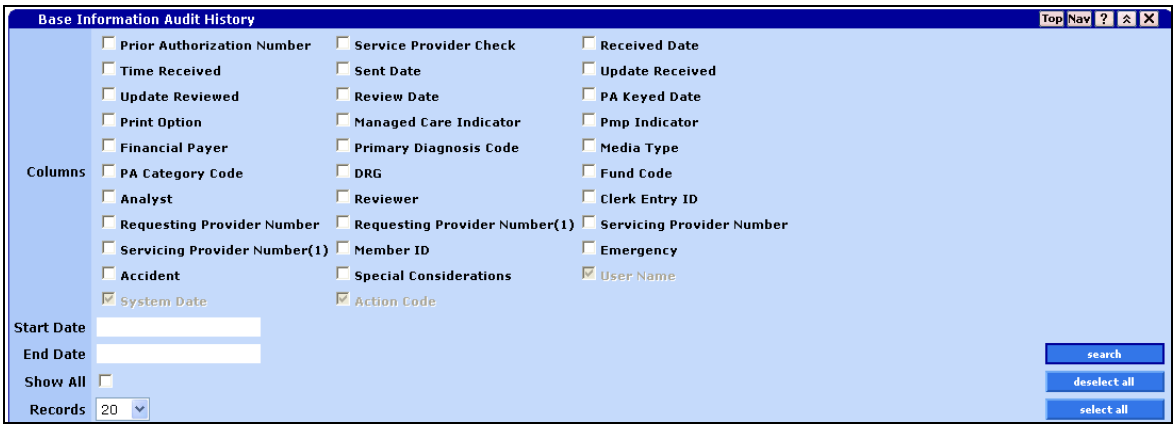
10 Appendix C – Using the Audit Trail

The Audit Trail provides information about changes and updates to the MMIS. Each panel which has add/update functionality has an audit trail. This is accessed via the "A" button in the top right corner of the panel.

STEP 1. Click the "A" button on the panel.



The Audit History panel will open.

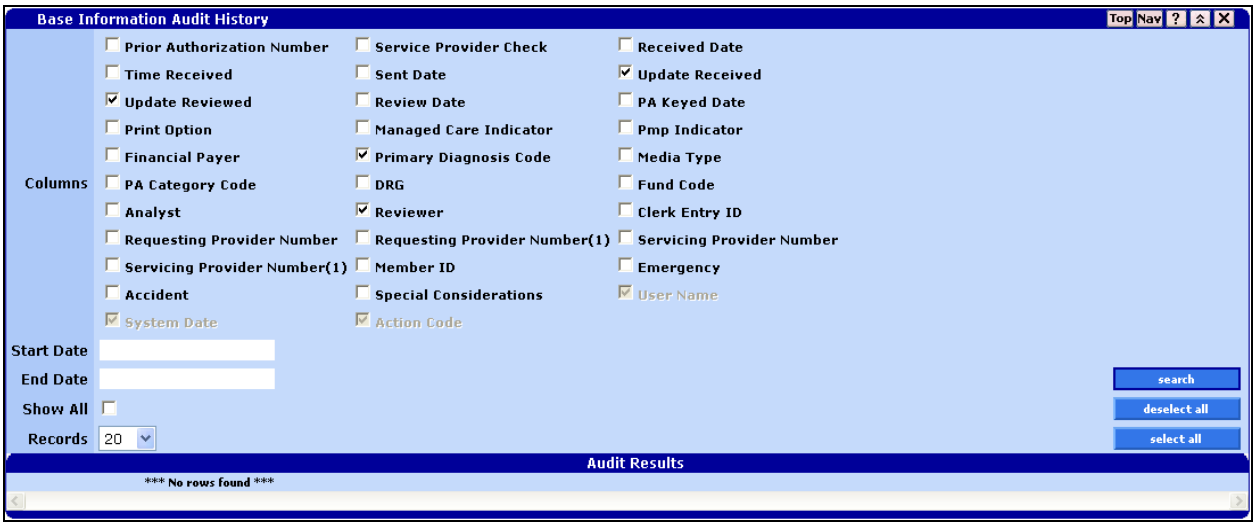


Audit History Panel

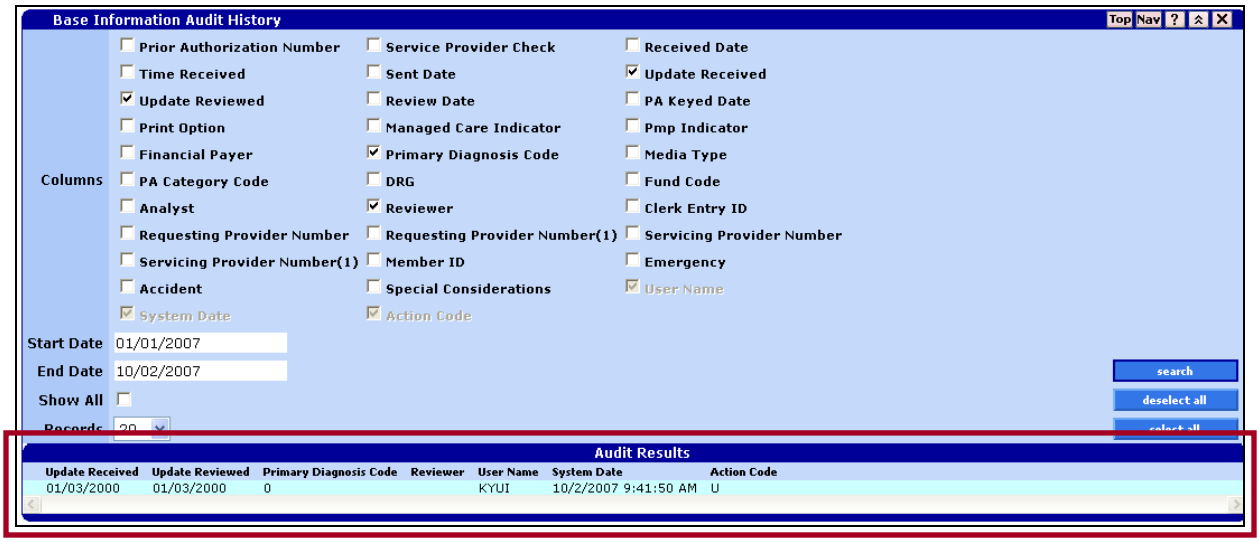
The Audit History panel will show a "check box" for each updatable field on the panel. Clicking a box instructs interChange to display the update/change record for that field. You may limit the time frame of your search by entering "Start Date" and "End Date," or, you may click "Show All" to see all change records for the fields in question.

EXAMPLE: If you wanted to see if a change was made in the PA Category Code after a claim paid in June 2005, but before a claim paid in October 2005, you would click the box to the right of "PA Category Code" and enter a Start Date after June 2005, and an end date before October 2005.

STEP 2. Select the fields and enter a date range, if applicable.



Search results will be displayed at the bottom of the Audit History panel.



Audit Results

10.1 Audit Results Field Descriptions

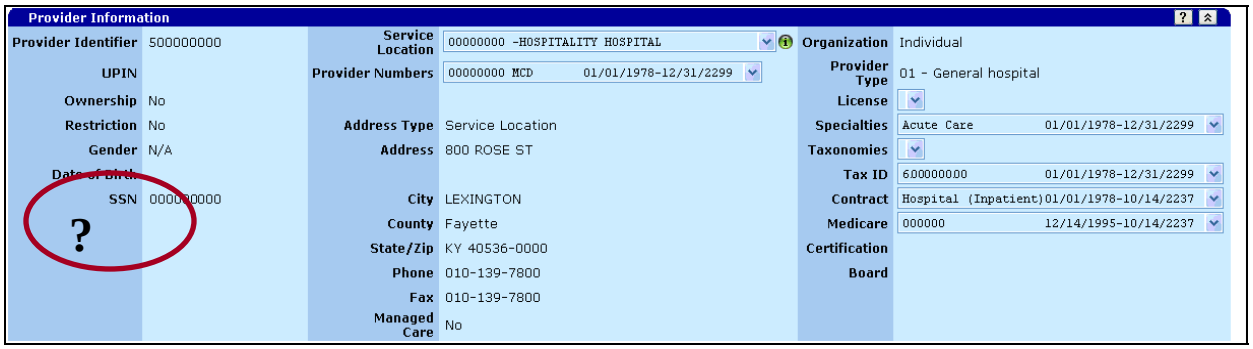
Field	Description
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.
Updated Field Name (selected from Audit History Panel by User)	Previous value; the information which appeared in the field prior to the update.

Field	Description
User Name	The User who made the change/update.
System Date	Date the change/update was made.
Action Code	What type of change was made; U= Update, D= Delete, A= Add.

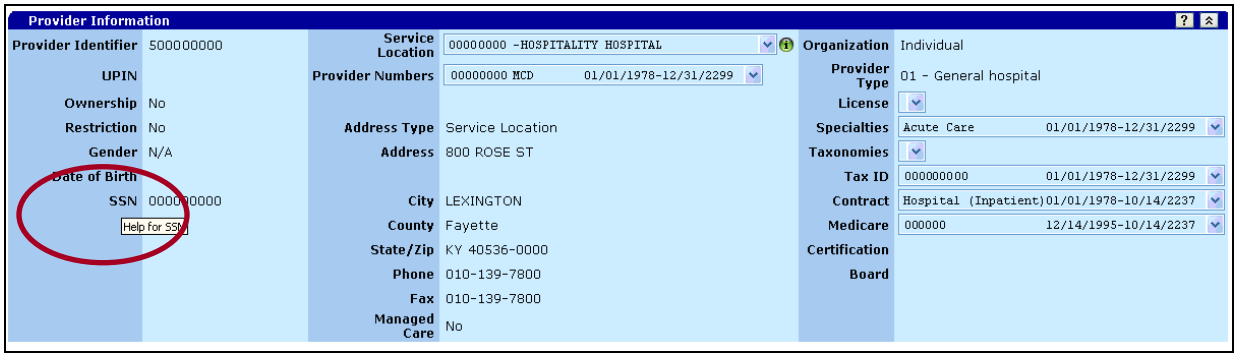
11 Appendix D – Using the Help Functions

interChange includes built in “Help” functions on each panel.

Each field label displays a question mark on mouse-over, alerting the user that help is available.



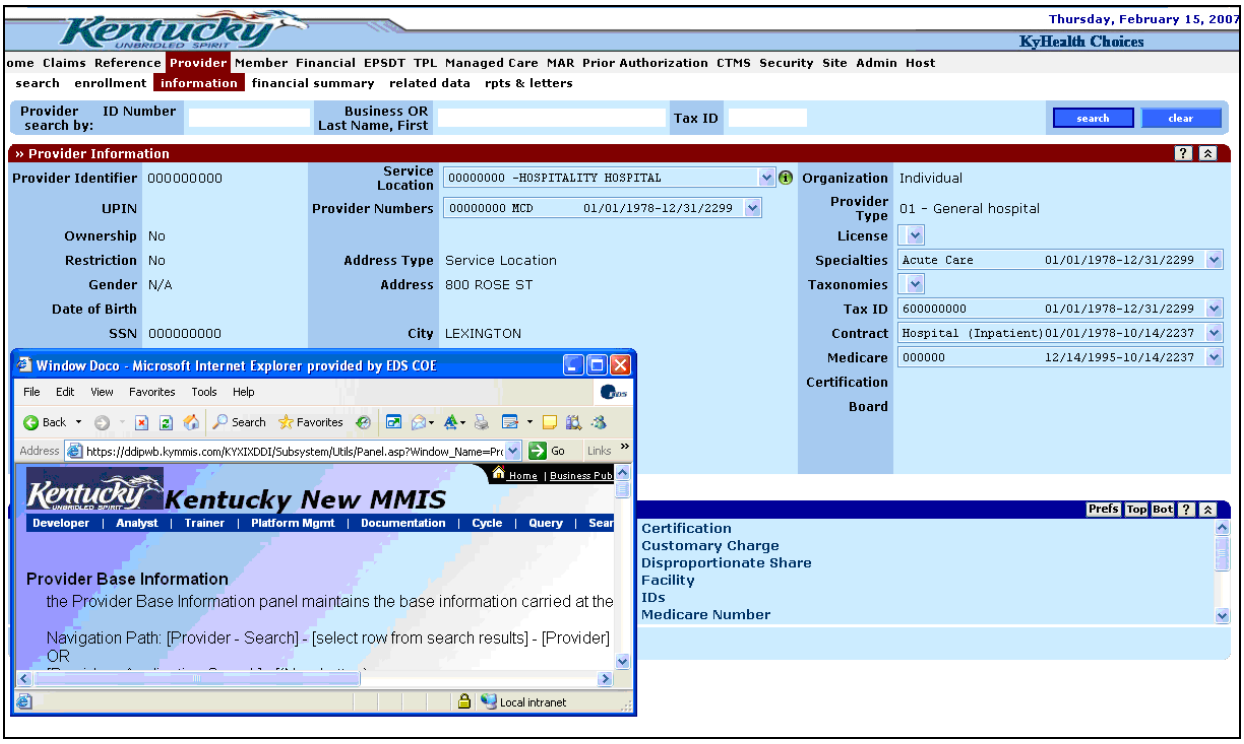
An alt tag will appear if the mouse “hovers” over a field label. The alt tag alerts the user that clicking the field label will go to “Help.”



11.1 Accessing Help for a Field

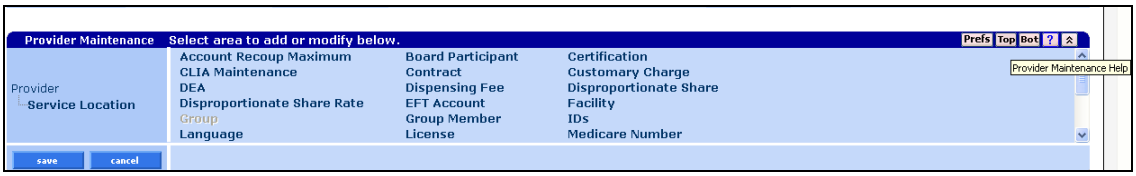
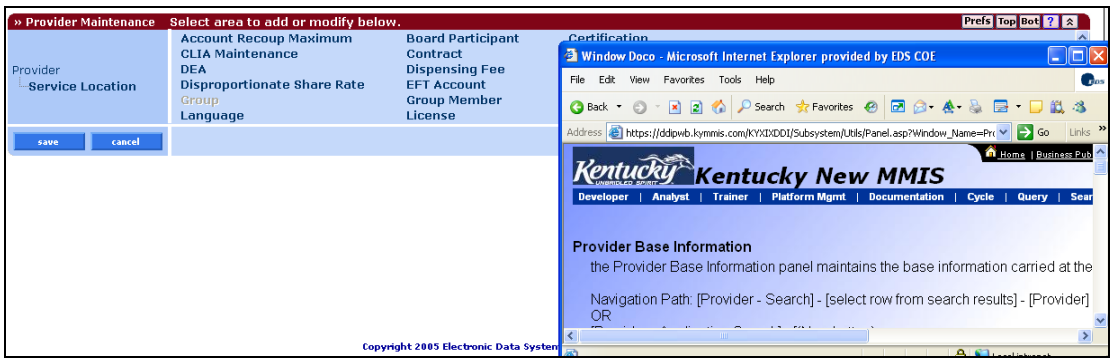
STEP 1. Click the field label.

A new browser will open. The Project Workbook page for the panel will be displayed.



11.2 Accessing Help for a Panel

STEP 1. Click the question mark button in the upper right corner of the panel.



A new browser will open. The Project Workbook page for the panel will be displayed.