AMMIS MAR User Manual

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Table of Contents

1 DOCUMENT CONTROL 1
1.1 DOCUMENT INFORMATION PAGE 1
1.2 AMENDMENT HISTORY 1
1.3 RELATED DOCUMENTATION 2
2 MAR INTRODUCTION 3
2.1 MAR USER MANUAL OVERVIEW 3
2.2 MAR USER MANUAL OBJECTIVE 3
3 MAR OVERVIEW 4
3.1 INTRODUCTION TO MAR 4
4 MAR GETTING STARTED 5
4.1 OVERVIEW 5
4.2 SYSTEM SECURITY 5
4.3 LOGGING IN/LOGGING OUT 5
4.3.1 Logging into the AMMIS 5
4.3.2 Logging off the AMMIS 6
4.1 SCREEN DISPLAY FEATURES 7
4.1.1 To Set System Text Size 7
5 SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS 8
5.1 PAGE LAYOUT 8
5.2 SHORTCUT KEYS 9
5.3 SEARCH OPTIONS 10
5.3.1 Search Panels 10
5.3.2 Search Results 10
5.3.3 Hot Links 11
5.3.4 Pop-Up Search 12
5.4 PANEL LAYOUT 12
5.4.1 Panel Type and Functions 12
5.4.2 Help Functionality 13
5.4.3 Question Mark Icon ? 13
5.4.4 Field Level Help 14
5.4.4.1 Field Level Help Description 14
6 MAR PANELS 15
6.1 MAR REPORTS - EXPENDITURES PAGE OVERVIEW 16
6.1.1 MAR Reports - Expenditures Page Narrative 16
6.1.2 MAR Reports - Expenditures Page Layout 16
6.1.3 MAR Reports - Expenditures Page Field Descriptions 16
6.1.4 MAR Reports - Expenditures Page Field Edit Error Codes 16
6.1.5 MAR Reports - Expenditures Page Extra Features 16
6.1.6 MAR Reports - Expenditures Page Accessibility 17
6.1.6.1 To Access Expenditures Page 17
6.2 EXPENDITURES BY COS - SEARCH PANEL OVERVIEW 18
6.2.1 Expenditures By COS - Search Panel Narrative 18
6.2.2 Expenditures By COS - Search Panel Layout 18
6.2.3 Expenditures By COS - Search Panel Field Descriptions 18
6.2.4 Expenditures By COS - Search Panel Field Edit Error Codes 19
6.2.5 Expenditures By COS - Search Panel Extra Features 19
6.2.6 Expenditures By COS - Search Panel Accessibility 20
6.2.6.1 To Access and View Expenditure Analysis by COS Report 20

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6.2.7 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Narrative 21
6.2.8 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Layout 22
6.2.9 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Field Descriptions 23
6.3 PARTICIPATION BY AID CATEGORY PANEL OVERVIEW 24
6.3.1 Participation By Aid Category Panel Narrative 24
6.3.2 Participation By Aid Category Panel Layout 24
6.3.3 Participation By Aid Category Panel Field Descriptions 24
6.3.4 Participation By Aid Category Panel Field Edit Error Codes 25
6.3.5 Participation By Aid Category Panel Extra Features 25
6.3.6 Participation By Aid Category Panel Accessibility 26
6.3.6.1 To Access and View Participation by Aid Category Report 26
6.3.7 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Narrative 26
6.3.8 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Layout 27
6.3.9 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Field Descriptions 28
6.4 PARTICIPATION BY COS PANEL OVERVIEW 29
6.4.1 Participation By COS Panel Narrative 29
6.4.2 Participation By COS Panel Layout 29
6.4.3 Participation By COS Panel Field Descriptions 29
6.4.4 Participation By COS Panel Field Edit Error Codes 30
6.4.5 Participation By COS Panel Extra Features 30
6.4.6 Participation By COS Panel Accessibility 31
6.4.6.1 To Access and View Participation By COS Report 31
6.4.7 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Narrative ... 31
6.4.8 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Layout 32
6.4.9 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Field Descriptions 33
6.5 PAYMENT BY COS PANEL OVERVIEW 34
6.5.1 Payment By COS Panel Narrative 34
6.5.2 Payment By COS Panel Layout 34
6.5.3 Payment By COS Panel Field Descriptions 34
6.5.4 Payment By COS Panel Field Edit Error Codes 35
6.5.5 Payment By COS Panel Extra Features 36
6.5.6 Payment By COS Panel Accessibility 36
6.5.6.1 To Access and View Payment By COS Report 36
6.5.7 Payment Comparison by Category of Service Report (MAR.ComparisonByCOS.rdl) Narrative 36
6.5.8 Payment Comparison by Category of Service (MAR.ComparisonByCOS.rdl) Report Layout 37
6.5.9 Payment Comparison by Category of Service (MAR.ComparisonByCOS.rdl) Report Field Descriptions 37
6.6 PAYMENT BY PROVIDER TYPE PANEL OVERVIEW 39
6.6.1 Payment By Provider Type Panel Narrative 39
6.6.2 Payment By Provider Type Panel Layout 39
6.6.3 Payment By Provider Type Panel Field Descriptions 39
6.6.4 Payment By Provider Type Panel Field Edit Error Codes 40
6.6.5 Payment By Provider Type Panel Extra Features 40
6.6.6 Payment By Provider Type Panel Accessibility 41
6.6.6.1 To Access and View Payment by Provider Type Report 41
6.6.7 Payment Statistics by Provider Type (MAR.PaymentByProvType.rdl) Report Narrative .. 41

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6.6.9 Payment Statistics by Provider Type (MAR.PaymentByProvType.rdl) Report Field Descriptions 43
6.7 PLACE OF SERVICE ANALYSIS PANEL OVERVIEW 44
6.7.1 Place Of Service Analysis Panel Narrative 44
6.7.2 Place Of Service Analysis Panel Layout 44
6.7.3 Place Of Service Analysis Panel Field Descriptions 44
6.7.4 Place Of Service Analysis Panel Field Edit Error Codes 45
6.7.5 Place Of Service Analysis Panel Extra Features 46
6.7.6 Place Of Service Analysis Panel Accessibility 46
6.7.6.1 To Access and View Place Of Service Analysis Report 46
6.7.7 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Narrative 46
6.7.8 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Layout 47
6.7.9 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Field Descriptions 48
6.8 MAR REPORTS - LONG TERM CARE PAGE OVERVIEW 49
6.8.1 MAR Reports - Long Term Care Page Narrative 49
6.8.2 MAR Reports - Long Term Care Page Layout 49
6.8.3 MAR Reports - Long Term Care Page Field Descriptions 49
6.8.4 MAR Reports - Long Term Care Page Field Edit Error Codes 49
6.8.5 MAR Reports - Long Term Care Page Extra Features 49
6.8.6 MAR Reports - Long Term Care Page Accessibility 49
6.8.7 To Access Long Term Care Page 49
6.9 LONG TERM BY REVENUE PANEL OVERVIEW 50
6.9.1 Long Term By Revenue Panel Narrative 50
6.9.2 Long Term By Revenue Panel Layout 50
6.9.3 Long Term By Revenue Panel Field Descriptions 50
6.9.4 Long Term By Revenue Panel Field Edit Error Codes 51
6.9.5 Long Term By Revenue Panel Extra Features 52
6.9.6 Long Term By Revenue Panel Accessibility 52
6.9.6.1 To Access and View Long Term Care by Revenue Report 52
6.9.7 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Narrative 52
6.9.8 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Layout53
6.9.9 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Field Descriptions 54
6.10 MAR REPORTS - OPERATIONS PAGE OVERVIEW 55
6.10.1 MAR Reports - Operations Page Narrative 55
6.10.2 MAR Reports - Operations Page Layout 55
6.10.3 MAR Reports - Operations Page Field Descriptions 55
6.10.4 MAR Reports - Operations Page Field Edit Error Codes 55
6.10.5 MAR Reports - Operations Page Extra Features 56
6.10.6 MAR Reports - Operations Page Accessibility 56
6.10.6.1 To Access MAR Reports – Operations Page 56
6.11 ERROR CODE ANALYSIS PANEL OVERVIEW 57
6.11.1 Error Code Analysis Panel Narrative 57
6.11.2 Error Code Analysis Panel Layout 57
6.11.3 Error Code Analysis Panel Field Descriptions 57
6.11.4 Error Code Analysis Panel Field Edit Error Codes 59
6.11.5 Error Code Analysis Panel Extra Features 59
6.11.6 Error Code Analysis Panel Accessibility 59
6.11.6.1 To Access and View Error Code Analysis Report 59
6.11.7 Error Code Analysis (MAR.ErrorCode.rdl) Report Narrative 60
6.11.8 Error Code Analysis (MAR.ErrorCode.rdl) Report Layout 61
6.11.9 Error Code Analysis (MAR.ErrorCode.rdl) Report Field Descriptions 62
6.12 OPER PERFORMANCE - AVG & PCT PANEL OVERVIEW 63
6.12.1 Oper Performance – Avg & Pct Panel Narrative 63

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6.12.2 Oper Performance – Avg & Pct Panel Layout 63
6.12.3 Oper Performance – Avg & Pct Panel Field Descriptions 63
6.12.4 Oper Performance – Avg & Pct Panel Field Edit Error Codes 64
6.12.5 Oper Performance - Avg & Pct Panel Extra Features 64
6.12.6 Oper Performance - Avg & Pct Panel Accessibility 65
6.12.6.1 To Access and View Operational Performance –Averages & Percents Report 65
6.12.7 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Narrative 65
6.12.8 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Layout 66
6.12.9 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Field Descriptions 67
6.13 OPER PERFORMANCE - DOLLARS PANEL OVERVIEW 68
6.13.1 Oper Performance - Dollars Panel Narrative 68
6.13.2 Oper Performance - Dollars Panel Layout 68
6.13.3 Oper Performance - Dollars Panel Field Descriptions 68
6.13.4 Oper Performance - Dollars Panel Field Edit Error Codes 69
6.13.5 Oper Performance - Dollars Panel Extra Features 69
6.13.6 Oper Performance - Dollars Panel Accessibility 70
6.13.6.1 To Access and View Operational Performance -Dollars Report 70
6.13.7 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Narrative 70
6.13.8 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Layout71
6.13.9 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Field Descriptions 72
6.14 OPER PERFORMANCE - PROVIDER PANEL OVERVIEW 73
6.14.1 Oper Performance - Provider Panel Narrative 73
6.14.2 Oper Performance - Provider Panel Layout 73
6.14.3 Oper Performance - Provider Panel Field Descriptions 73
6.14.4 Oper Performance - Provider Panel Field Edit Error Codes 74
6.14.5 Oper Performance - Provider Panel Extra Features 74
6.14.6 Oper Performance - Provider Panel Accessibility 75
6.14.6.1 To Access and View Oper Performance - Provider Report 75
6.14.7 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Narrative 75
6.14.8 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Layout 76
6.14.9 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Field Descriptions 77
6.15 PROVIDER ERROR ANALYSIS PANEL OVERVIEW 78
6.15.1 Provider Error Analysis Panel Narrative 78
6.15.2 Provider Error Analysis Panel Layout 78
6.15.3 Provider Error Analysis Panel Field Descriptions 78
6.15.4 Provider Error Analysis Panel Field Edit Error Codes 79
6.15.5 Provider Error Analysis Panel Extra Features 80
6.15.6 Provider Error Analysis Panel Accessibility 80
6.15.6.1 To Access and View Provider Error Analysis Report 80
6.15.7 Provider Error Analysis Report (MAR.ProviderError.rdl) Narrative 80
6.15.8 Provider Error Analysis Report (MAR.ProviderError.rdl) Report Layout 81
6.15.9 Provider Error Analysis Report (MAR.ProviderError.rdl) Report Field Descriptions 81
6.16 PROVIDER FILING ANALYSIS PANEL OVERVIEW 83
6.16.1 Provider Filing Analysis Panel Narrative 83
6.16.2 Provider Filing Analysis Panel Layout 83
6.16.3 Provider Filing Analysis Panel Field Descriptions 83
6.16.4 Provider Filing Analysis Panel Field Edit Error Codes 84
6.16.5 Provider Filing Analysis Panel Extra Features 85

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6.16.6 Provider Filing Analysis Panel Accessibility ... 85
6.16.6.1 To Access and View Provider Filing Analysis Report ... 85
6.16.7 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Narrative ... 85
6.16.8 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Layout ... 86
6.16.9 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Field Descriptions ... 87
6.17 THRUPUT ANALYSIS - DOR TO DOA PANEL OVERVIEW ... 89
6.17.1 Thruput Analysis - DOR to DOA Panel Narrative ... 89
6.17.2 Thruput Analysis - DOR to DOA Panel Layout ... 89
6.17.3 Thruput Analysis - DOR to DOA Panel Field Descriptions ... 89
6.17.4 Thruput Analysis - DOR to DOA Panel Field Edit Error Codes ... 90
6.17.5 Thruput Analysis - DOR to DOA Panel Extra Features ... 90
6.17.6 Thruput Analysis - DOR to DOA Page Accessibility ... 91
6.17.6.1 To Access and View Thruput Analysis DOR to DOA Report ... 91
6.17.7 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Narrative ... 91
6.17.8 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Layout ... 92
6.17.9 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Field Descriptions ... 93
6.18 THRUPUT ANALYSIS - DOR TO DOP PANEL OVERVIEW ... 94
6.18.1 Thruput Analysis - DOR to DOP Panel Narrative ... 94
6.18.2 Thruput Analysis - DOR to DOP Panel Layout ... 94
6.18.3 Thruput Analysis - DOR to DOP Panel Field Descriptions ... 94
6.18.4 Thruput Analysis - DOR to DOP Panel Field Edit Error Codes ... 95
6.18.5 Thruput Analysis - DOR to DOP Panel Extra Features ... 95
6.18.6 Thruput Analysis - DOR to DOP Panel Accessibility ... 96
6.18.6.1 To Access and View Thruput Analysis DOR to DOP Report ... 96
6.18.7 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Narrative ... 96
6.18.8 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Layout ... 97
6.18.9 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Field Descriptions ... 98
6.19 MAR REPORTS - PROVIDER PAGE OVERVIEW ... 99
6.19.1 MAR Reports - Provider Page Narrative ... 99
6.19.2 MAR Reports - Provider Page Layout ... 99
6.19.3 MAR Reports - Provider Page Field Descriptions ... 99
6.19.4 MAR Reports - Provider Page Field Edit Error Codes ... 99
6.19.5 MAR Reports - Provider Page Extra Features ... 99
6.19.6 MAR Reports - Provider Page Accessibility ... 100
6.19.6.1 To Access MAR Reports – Provider Page ... 100
6.20 PAYMENT COMPARISON BY COS PANEL OVERVIEW ... 101
6.20.1 Payment Comparison By COS Panel Narrative ... 101
6.20.2 Payment Comparison By COS Panel Layout ... 101
6.20.3 Payment Comparison By COS Panel Field Descriptions ... 101
6.20.4 Payment Comparison By COS Panel Field Edit Error Codes ... 102
6.20.5 Payment Comparison By COS Panel Extra Features ... 102
6.20.6 Payment Comparison By COS Panel Accessibility ... 102
6.20.6.1 To Access and View Payment Comparison by Category of Service Report ... 102
6.20.7 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Narrative ... 102
6.20.8 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Layout ... 103
6.20.9 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Field Descriptions 104
6.21 PAYMENT COMPARISON BY PROVIDER TYPE PANEL OVERVIEW ... 105
6.21.1 Payment Comparison By Provider Type Panel Narrative ... 105
6.21.2 Payment Comparison By Provider Type Panel Layout ... 105
6.21.3 Payment Comparison By Provider Type Panel Field Descriptions ... 106

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6.21.4 Payment Comparison By Provider Type Panel Field Edit Error Codes 106
6.21.5 Payment Comparison By Provider Type Panel Extra Features..... 107
6.21.6 Payment Comparison By Provider Type Panel Accessibility..... 107
6.21.6.1 To Access and View Payment Comparison by Provider Type Report 107
6.21.7 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Narrative 107
6.21.8 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Layout108
6.21.9 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Field Descriptions 109
6.22 PAYMENT COMPARISON BY PROVIDER TYPE – MONTHLY PANEL OVERVIEW 110
6.22.1 Payment Comparison By Provider Type - Monthly Panel Narrative..... 110
6.22.2 Payment Comparison By Provider Type - Monthly Panel Layout..... 110
6.22.3 Payment Comparison By Provider Type - Monthly Panel Field Descriptions..... 110
6.22.4 Payment Comparison By Provider Type - Monthly Panel Field Edit Error Codes 111
6.22.5 Payment Comparison By Provider Type - Monthly Panel Extra Features..... 111
6.22.6 Payment Comparison By Provider Type - Monthly Panel Accessibility..... 111
6.22.6.1 To Access and View Payment Comparison by Provider Type - Monthly Report..... 111
6.22.7 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Narrative 112
6.22.8 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Layout 113
6.22.9 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Field Descriptions 114
6.23 PROVIDER PARTICIPATION AVG PANEL OVERVIEW 115
6.23.1 Provider Participation Avg Panel Narrative 115
6.23.2 Provider Participation Avg Panel Layout..... 115
6.23.3 Provider Participation Avg Panel Field Descriptions 115
6.23.4 Provider Participation Avg Panel Field Edit Error Codes 116
6.23.5 Provider Participation Avg Panel Extra Features 117
6.23.6 Provider Participation Avg Panel Accessibility 117
6.23.6.1 To Access and View Provider Participation Average Report..... 117
6.23.7 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Narrative 117
6.23.8 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Layout 118
6.23.9 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Field Descriptions . 119
6.24 PROVIDER PARTICIPATION TOTAL PANEL OVERVIEW 120
6.24.1 Provider Participation Total Panel Narrative 120
6.24.2 Provider Participation Total Panel Layout 120
6.24.3 Provider Participation Total Panel Field Descriptions 120
6.24.4 Provider Participation Total Panel Field Edit Error Codes..... 122
6.24.5 Provider Participation Total Panel Extra Features 123
6.24.6 Provider Participation Total Panel Accessibility 123
6.24.6.1 To Access and View Provider Participation Total Report..... 123
6.24.7 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Narrative 123
6.24.8 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Layout..... 124
6.24.9 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Field Descriptions ... 125
6.25 PROVIDER RANKING PANEL OVERVIEW 126
6.25.1 Provider Ranking Panel Narrative..... 126
6.25.2 Provider Ranking Panel Layout..... 126
6.25.3 Provider Ranking Panel Field Descriptions..... 127
6.25.4 Provider Ranking Panel Field Edit Error Codes 129
6.25.5 Provider Ranking Panel Extra Features..... 129
6.25.6 Provider Ranking Panel Accessibility..... 129
6.25.6.1 To Access and View Provider Ranking Report 129
6.25.7 Provider Ranking (MAR.ProviderRanking.rdl) Report Narrative..... 129
6.25.8 Provider Ranking (MAR.ProviderRanking.rdl) Report Layout 130

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6.25.9 Provider Ranking (MAR.ProviderRanking.rdl) Report Field Descriptions 131
6.26 THIRD PARTY PAYMENT RANKING PANEL OVERVIEW 132
6.26.1 Third Party Payment Ranking Panel Narrative 132
6.26.2 Third Party Payment Ranking Panel Layout 132
6.26.3 Third Party Payment Ranking Panel Field Descriptions 132
6.26.4 Third Party Payment Ranking Panel Field Edit Error Codes 133
6.26.5 Third Party Payment Ranking Panel Extra Features 133
6.26.6 Third Party Payment Ranking Panel Accessibility 134
6.26.6.1 To Access and View Third Party Payment Ranking Report 134
6.26.7 Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Narrative 134
6.26.8 Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Layout 135
6.26.9 Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Field Descriptions 136
6.27 MAR REPORTS - RECIPIENT PAGE OVERVIEW 138
6.27.1 MAR Reports - Recipient Page Narrative 138
6.27.2 MAR Reports - Recipient Page Layout 138
6.27.3 MAR Reports - Recipient Page Field Descriptions 138
6.27.4 MAR Reports - Recipient Page Field Edit Error Codes 138
6.27.5 MAR Reports - Recipient Page Extra Features 138
6.27.6 MAR Reports - Recipient Page Accessibility 139
6.27.6.1 To Access MAR Reports - Recipient Page 139
6.28 MEDICARE PARTICIPATION PART A PANEL OVERVIEW 140
6.28.1 Medicare Participation Part A Panel Narrative 140
6.28.2 Medicare Participation Part A Panel Layout 140
6.28.3 Medicare Participation Part A Panel Field Descriptions 140
6.28.4 Medicare Participation Part A Panel Field Edit Error Codes 141
6.28.5 Medicare Participation Part A Panel Extra Features 141
6.28.6 Medicare Participation Part A Panel Accessibility 142
6.28.6.1 To Access and View Medicare Participation Part A Report 142
6.28.7 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Narrative 142
6.28.8 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Layout 143
6.28.9 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Field Descriptions 144
6.29 MEDICARE PARTICIPATION PART A B PANEL OVERVIEW 145
6.29.1 Medicare Participation Part A B Panel Narrative 145
6.29.2 Medicare Participation Part A B Panel Layout 145
6.29.3 Medicare Participation Part A B Panel Field Descriptions 145
6.29.4 Medicare Participation Part A B Panel Field Edit Error Codes 146
6.29.5 Medicare Participation Part A B Panel Extra Features 146
6.29.6 Medicare Participation Part A B Panel Accessibility 146
6.29.6.1 To Access and View Medicare Participation Part A and B Report 146
6.29.7 146
6.29.8 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Narrative 147
6.29.9 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Layout 148
6.29.10 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Field Descriptions149
6.30 MEDICARE PARTICIPATION PART B PANEL OVERVIEW 150
6.30.1 Medicare Participation Part B Panel Narrative 150
6.30.2 Medicare Participation Part B Panel Layout 150
6.30.3 Medicare Participation Part B Panel Field Descriptions 150
6.30.4 Medicare Participation Part B Panel Field Edit Error Codes 151
6.30.5 Medicare Participation Part B Panel Extra Features 151
6.30.6 Medicare Participation Part B Panel Accessibility 152
6.30.6.1 To Access and View Medicare Participation Part B Report 152
6.30.7 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Narrative 152
6.30.8 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Layout 153
6.30.9 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Field Descriptions 154
6.31 RECIPIENT COPAY PANEL OVERVIEW 155

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6.31.1 Recipient Copay Panel Narrative 155
6.31.2 Recipient Copay Panel Layout 155
6.31.3 Recipient Copay Panel Field Descriptions 155
6.31.4 Recipient Copay Panel Field Edit Error Codes 156
6.31.5 Recipient Copay Panel Extra Features 156
6.31.6 Recipient Copay Panel Accessibility 156
6.31.6.1 To Access and View Recipient Copayment by Aid Category Report 156
6.31.7 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Narrative 157
6.31.8 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Layout 158
6.31.9 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Field Descriptions 159
6.32 RECIPIENT PARTICIPATION BY COUNTY PANEL OVERVIEW 160
6.32.1 Recipient Participation By County Panel Narrative 160
6.32.2 Recipient Participation By County Panel Layout 160
6.32.3 Recipient Participation By County Panel Field Descriptions 160
6.32.4 Recipient Participation By County Panel Field Edit Error Codes 161
6.32.5 Recipient Participation By County Panel Extra Features 161
6.32.6 Recipient Participation By County Panel Accessibility 162
6.32.6.1 To Access and View Recipient Participation by County Report 162
6.32.7 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Narrative 162
6.32.8 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Layout 163
6.32.9 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Field Descriptions 164
6.33 RECIPIENT RANKING PANEL OVERVIEW 165
6.33.1 Recipient Ranking Panel Narrative 165
6.33.2 Recipient Ranking Panel Layout 165
6.33.3 Recipient Ranking Panel Field Descriptions 165
6.33.4 Recipient Ranking Panel Field Edit Error Codes 166
6.33.5 Recipient Ranking Panel Extra Features 166
6.33.6 Recipient Ranking Panel Accessibility 167
6.33.6.1 To Access and View Recipient Ranking Report 167
6.33.7 Recipient Ranking (MAR.RecipientRanking.rdl) Report Narrative 168
6.33.8 Recipient Ranking (MAR.RecipientRanking.rdl) Report Layout 169
6.33.9 Recipient Ranking (MAR.RecipientRanking.rdl) Report Field Descriptions 170
7 MAR REPORTS 171
7.1 MAR-0111-M -- MAR MONTHLY RECONCILIATION REPORT 172
7.1.1 MAR-0111-M -- MAR Monthly Reconciliation Report Narrative 172
7.1.2 MAR-0111-M -- MAR Monthly Reconciliation Report Layout 172
7.1.3 MAR-0111-M -- MAR Monthly Reconciliation Report Field Descriptions 173
7.2 MAR-0310-O – EXPENDITURE BY COS REPORT 176
7.2.1 MAR-0310-O – Expenditure By COS Report Narrative 176
7.2.2 MAR-0310-O – Expenditure By COS Report Layout 176
7.2.3 MAR-0310-O – Expenditure By COS Report Field Descriptions 176
7.3 MAR-0320-O – PARTICIPATION BY COS REPORT 178
7.3.1 MAR-0320-O – Participation By COS Report Narrative 178
7.3.2 MAR-0320-O – Participation By COS Report Layout 178
7.3.3 MAR-0320-O – Participation By COS Report Field Descriptions 178
7.4 MAR-2100-M -- MONTHLY ABORTION DETAIL REPORT 180
7.4.1 MAR-2100-M -- Monthly Abortion Detail Report Narrative 180
7.4.2 MAR-2100-M -- Monthly Abortion Detail Report Layout 180
7.4.3 MAR-2100-M -- Monthly Abortion Detail Report Field Descriptions 180
7.5 MAR-2110-M -- MONTHLY STERILIZATION DETAIL REPORT 183
7.5.1 MAR-2110-M -- Monthly Sterilization Detail Report Narrative 183
7.5.2 MAR-2110-M -- Monthly Sterilization Detail Report Layout 183
7.5.3 MAR-2110-M -- Monthly Sterilization Detail Report Field Descriptions 183

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7.6 MAR-4812-A -- CMS 372 ANNUAL REPORT ON HCBS ID WAIVER (SHORT) REPORT 186
7.6.1 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Narrative 192
7.6.2 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Layout ... 192
7.6.3 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Field Descriptions 201
7.7 MAR-4822-A -- CMS 372 ANNUAL REPORT ON HCBS ED WAIVER (SHORT) REPORT 208
7.7.1 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Narrative 208
7.7.2 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Layout .. 208
7.7.3 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Field Descriptions 216
7.8 MAR-4832-A -- CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER (SHORT) REPORT 219
7.8.1 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Narrative 219
7.8.2 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Layout 219
7.8.3 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Field Descriptions 229
7.9 MAR-4842 – CMS 372 ANNUAL REPORT ON HCBS TA WAIVER (SHORT) REPORT 235
7.9.1 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Narrative 235
7.9.2 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Layout .. 235
7.9.3 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Field Descriptions 243
7.10 MAR-4852-A -- CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER (SHORT) REPORT 245
7.10.1 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Narrative 245
7.10.2 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Layout 245
7.10.3 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Field Descriptions 253
7.11 MAR-4862-A -- CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER (SHORT) REPORT 256
7.11.1 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Narrative 256
7.11.2 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Layout 256
7.11.3 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Field Descriptions 264
7.12 MAR-4872-A -- CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER (SHORT) REPORT 267
7.12.1 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Narrative 267
7.12.2 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Layout 268
7.12.3 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Field Descriptions 278

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
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Approved by:	
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1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
09/19/2013	1.0		Application of CO 8367	6.19 – MAR Reports – Provider Page - update layout
10/03/2013	2.0		Application of ICD-10 production change orders	CO 10259 – MAR-2100-M -- Monthly Abortion Detail Report – Add ICD Version code MAR-2110-M -- Monthly Sterilization Detail Report – Add ICD Version code MAR-2100-A -- Annual Abortion Detail Report – Add ICD Version Codes MAR-2110-A -- Annual Sterilization Detail Report – add ICD Version Codes
05/11/2016	3.0		Application of CO 12819:	Update 4.3.1 Logging onto the AMMIS Update 4.3.2 Logging off the AMMIS
03/28/2018	4.0		Application of CO 14858	Removal of PHI/PII

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1.3 RELATED DOCUMENTATION

Document	Description	url

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2 MAR INTRODUCTION

2.1 MAR USER MANUAL OVERVIEW

The Alabama Medicaid Management Information System (AMMIS) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Management and Administrative Reporting (MAR) functional area.

This manual covers the following:

- MAR Overview
- MAR Getting Started
- System Wide Common Terminology and Layouts
- MAR Panels
- MAR Reports

2.2 MAR USER MANUAL OBJECTIVE

The objective of the AMMIS MAR User Manual is to provide system users with detailed descriptions of the online system, including panel and report field descriptions, panel functionality descriptions and graphical representations of panels and report layouts.

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3 MAR OVERVIEW

3.1 INTRODUCTION TO MAR

The purpose of the Management and Administrative Reporting (MAR) function is to provide programmatic, financial, and statistical reports to assist the state and federal government with fiscal planning, control, monitoring, program and policy development, and evaluation of the State Medical Assistance Programs.

The MAR function is a comprehensive management tool which provides information on program status and trends, has the ability to analyze historical trends, and predicts the impact of policy changes on programs. This function uses key information from other Alabama Medicaid Management Information System (AMMIS) functions to generate standard reports.

The major inputs to MAR are data from all the claims processing functions as well as the financial, recipient, reference and provider areas. The major process is the generation of reports and program data, and the major outputs are the financial, statistical, and summary reports and data required by federal regulations, and other reports and data that assist the state in the management and administration of State Medical Assistance Programs.

This function is flexible enough to meet both existing and proposed changes in format and data requirements of federal and state management statistical reporting without major reprogramming or expense, and provide maximum flexibility to accommodate future changes.

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4 MAR GETTING STARTED

4.1 OVERVIEW

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 SYSTEM SECURITY

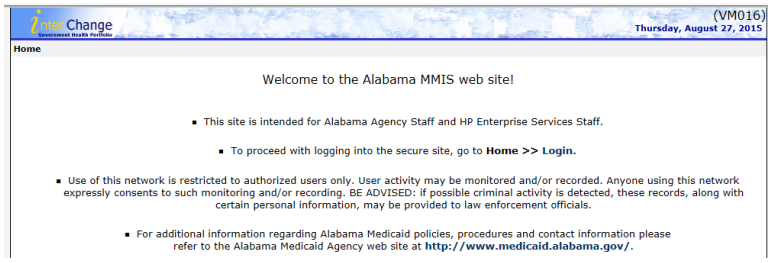
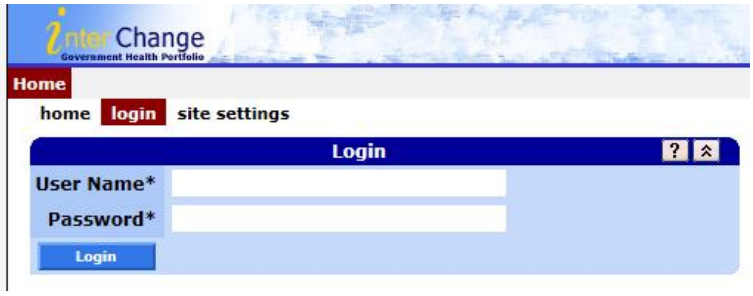
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 LOGGING IN/LOGGING OUT

Users must successfully log in to the AMMIS in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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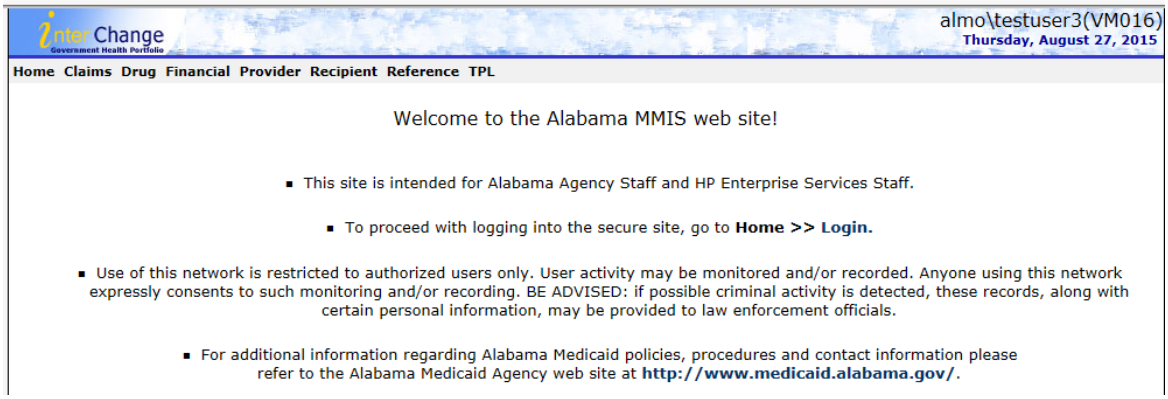
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

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4.1 SCREEN DISPLAY FEATURES

The AMMIS 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.

4.1.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

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5 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 recipients, 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 described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt +shortcut key)
- Main Menu bar
- Panel
- Mini Search panel
- Hot Link
- Help Functionality

5.1 PAGE LAYOUT

A page is defined as the entire screen that appears in the Web browser. The page contains a Page Header 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 DXC.technology 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 open 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.

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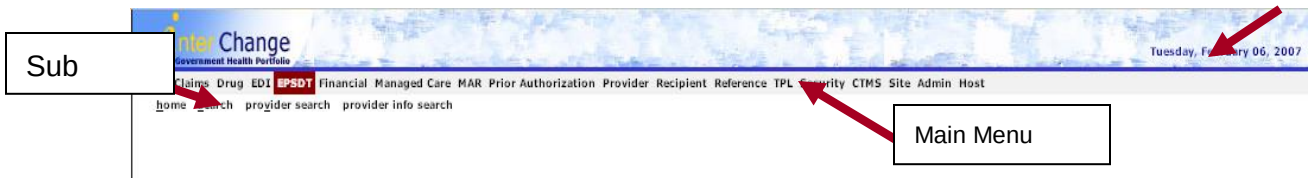
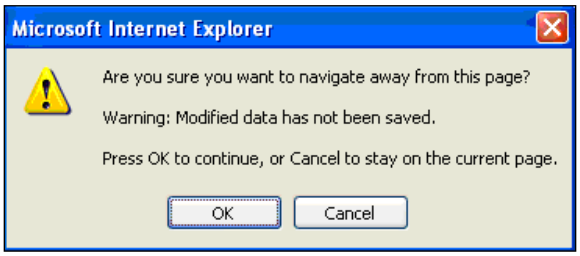


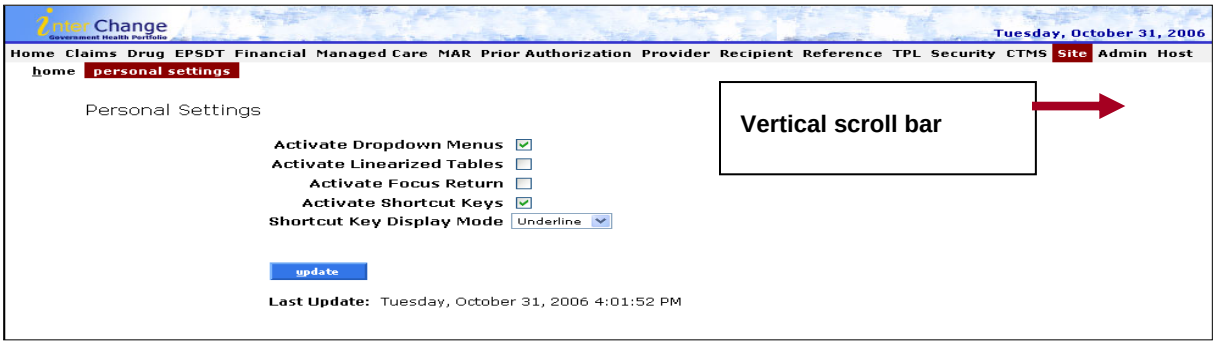
If a user attempts to add, update or delete information within a page the system prompts the user to “Save” or “Cancel” their changes via a pop-up window message prior to navigating away from the page. When the system generates the message, the detail panel is locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



5.2 SHORTCUT KEYS

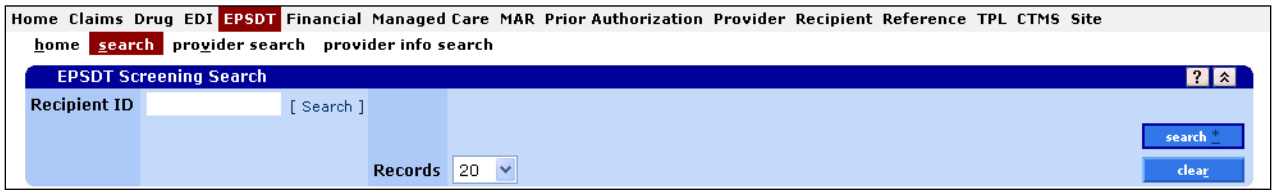
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated panel.

To activate the shortcut key, click on the Site link, select Personal Settings, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the EPSDT Sub Menu, the user can use the shortcut keys to quickly navigate from the EPSDT Search panel to the EPSDT Provider Search panel by using the following shortcut key combination: (Ctrl + Alt + V) since the letter “V” is found within the horizontal bars on the Sub Menu provider search link.



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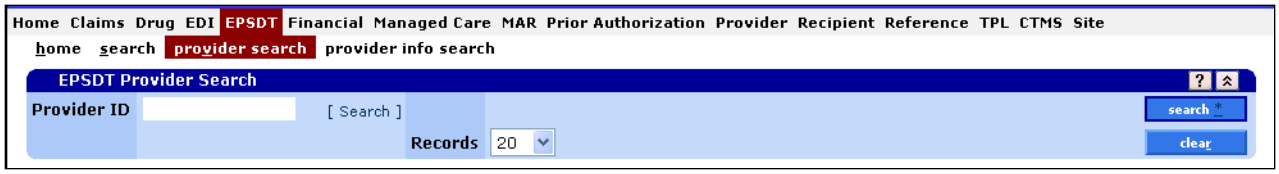
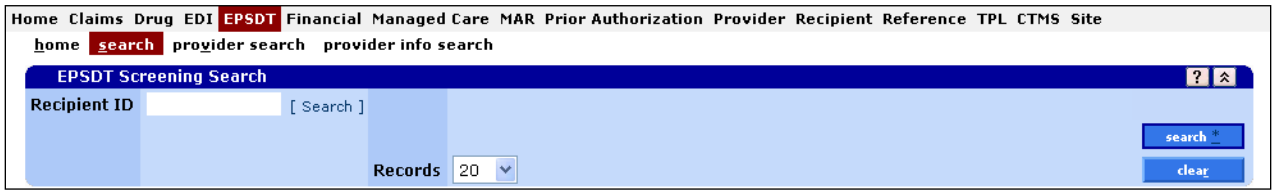


5.3 SEARCH OPTIONS

There are several search options available within interChange.

5.3.1 Search Panels

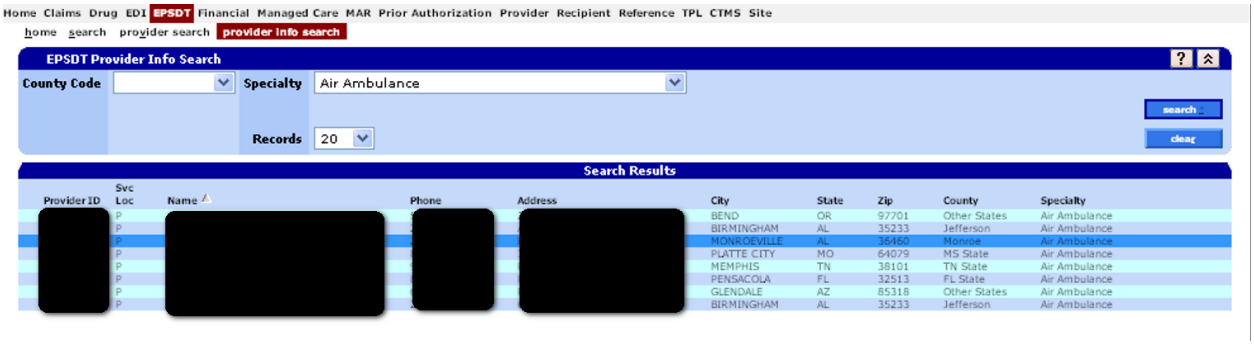
The AMMIS contains two types of search panels: Search and Advanced Search. An example of the EPSDT Screening Search panel with the Search button displaying is shown below:



Note: The Advanced Search button functionality does not exist in the EPSDT subsystem.

5.3.2 Search Results

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.



If the user clicks once on a search result row, the associated information panel opens. For example, the user clicked the 3rd row of the EPSDT Provider Info Search Results panel (as shown above) and the associated Provider Information panel displayed.

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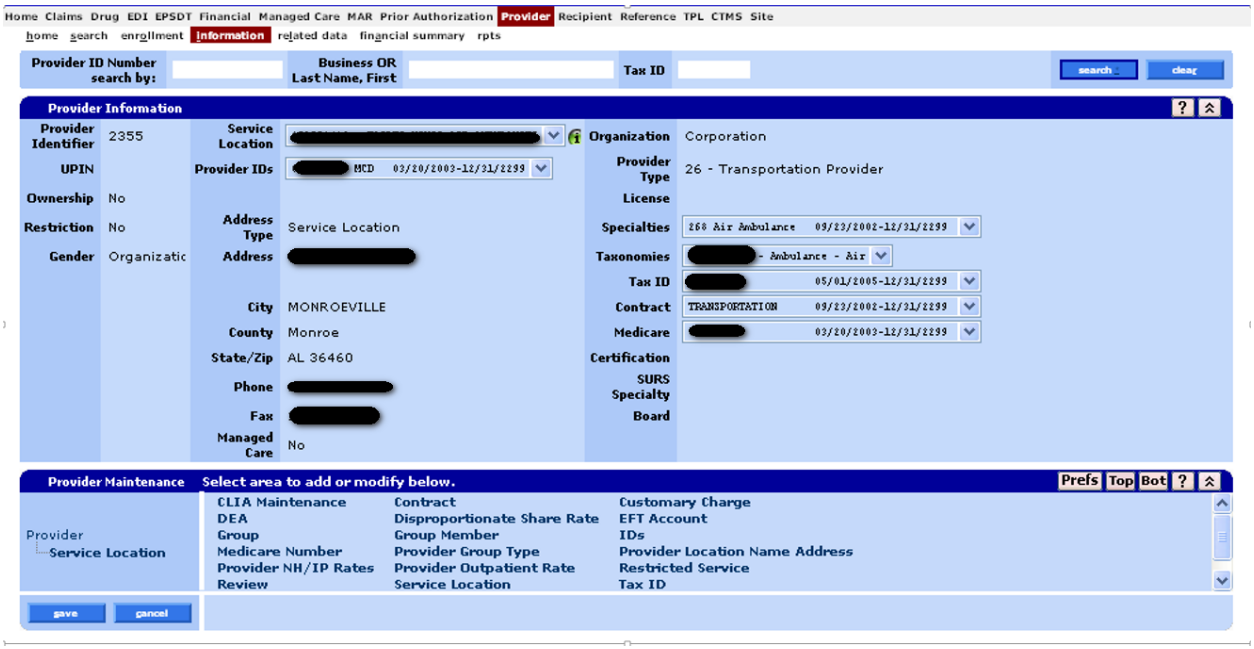
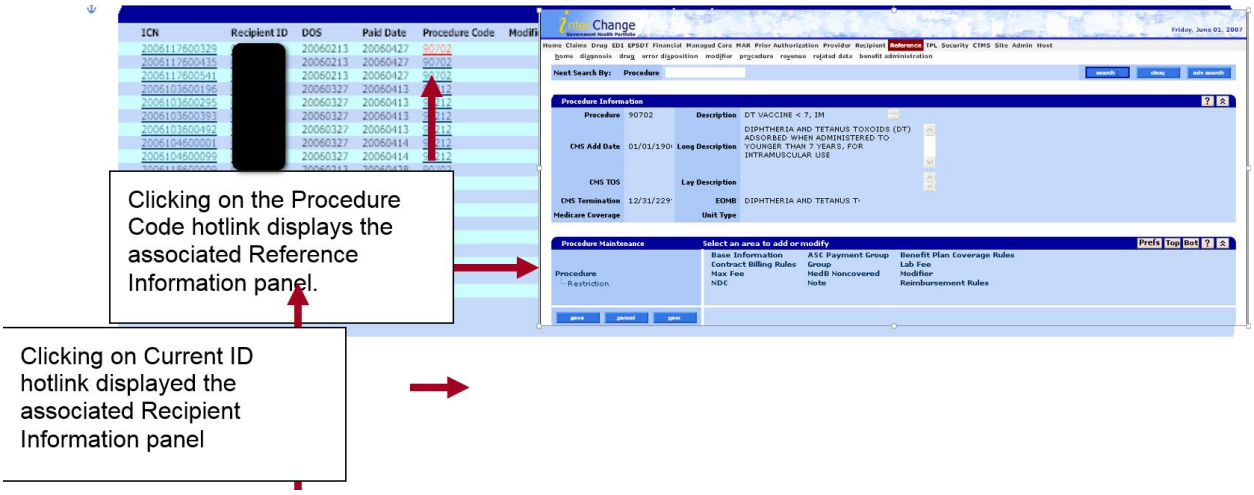


5.3.3 Hot Links

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. Users are provided with additional information related to a field by clicking the hotlink, as shown below.



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5.3.4 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.

5.4 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.

5.4.1 Panel Type 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 panels within the EPSDT system:

Name	Icon	Description
Clear Button	clear	Clears all actions to all panels on the page. Can be found on the navigation panel.
Close Button	✕	Closes a panel.
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.
[Search]	[Search]	Opens a search panel associated to a particular field. Allows the user to search for unknown information, such as a Provider ID, using other information, such as the Provider Name.
Search	search	Searches for information based on criteria entered into field(s) on panel.

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5.4.2 Help Functionality

The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.4.3 Question Mark Icon ?

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.4.3.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:

The second item displayed is the **Panel Layout**:

The third item displayed is the **Field Description** information related to the panel:

Field	Description	Field Type	Data Type	Length
Clear	Clears previous searches	Button	N/A	0
Search	Searches through Recipient records	Button	N/A	0
Recipient ID	Recipient identification number of the Recipient. Must be 12 characters in length.	Field	Number	12
Records	Number of records to display per page.	Field	Drop Down List Box	0
[Search]	Hyperlink to a list of Recipients	Hyperlink	N/A	0

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field	Field Type	Error Code	Error Message	To Correct
Recipient ID	Field	0	Validate	Recipient ID must be numeric.
	Field	1	Validate	Recipient ID must be entered for search criteria.

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The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as; Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

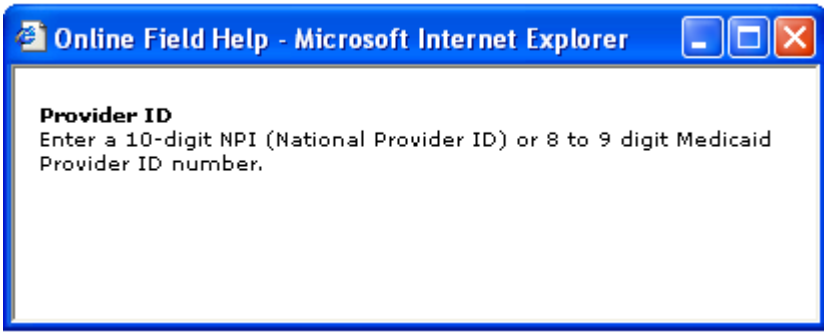
5.4.4 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

5.4.4.1 Field Level Help Description

When hovering the cursor over a field name, such as **Provider ID**, a question mark appears as part of the cursor.

Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6 MAR PANELS

This section gives a brief description of each panel, shows a sample, and describes all associated panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in panel images are fictitious and are not representative of an actual person.

The panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each panel covers the following:

- Panel Narrative
- Panel Layout
- Panel Field Descriptions
- Panel Field Edit Error Code Tables
- Panel Extra Features
- Panel Accessibility

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6.1 MAR REPORTS - EXPENDITURES PAGE OVERVIEW

6.1.1 MAR Reports - Expenditures Page Narrative

The MAR Reports – Expenditures page is the access point within the MAR system that allows users to view reports that fall under the category of expenditures.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures]

6.1.2 MAR Reports - Expenditures Page Layout

6.1.3 MAR Reports - Expenditures Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Expenditures By COS	Link to Expenditures By COS panel.	Hyperlink	N/A	0
Participation By Aid Category	Link to Participation By Aid Category panel.	Hyperlink	N/A	0
Participation By COS	Link to Participation By COS panel.	Hyperlink	N/A	0
Payment By COS	Link to Payment By COS panel.	Hyperlink	N/A	0
Payment By Provider Type	Link to Payment By Provider Type panel.	Hyperlink	N/A	0
Place of Service Analysis	Link to Place of Service Analysis panel.	Hyperlink	N/A	0

6.1.4 MAR Reports - Expenditures Page Field Edit Error Codes

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

6.1.5 MAR Reports - Expenditures Page Extra Features

Field	Field Type
No extra features found for this page.	

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6.1.6 MAR Reports - Expenditures Page Accessibility

6.1.6.1 To Access Expenditures Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.

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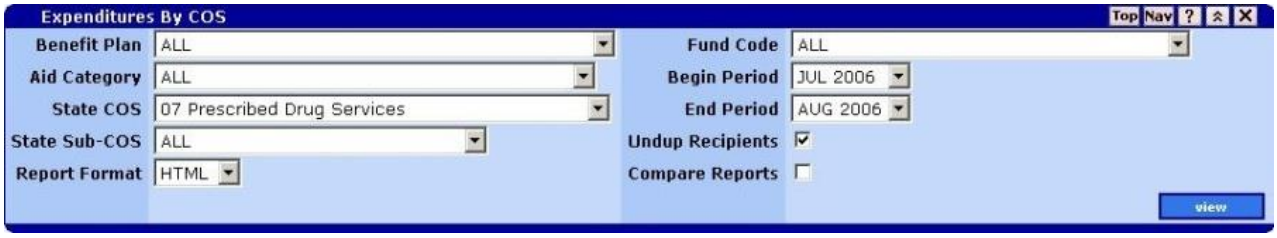
6.2 EXPENDITURES BY COS - SEARCH PANEL OVERVIEW

6.2.1 Expenditures By COS - Search Panel Narrative

The Expenditures by COS panel allows users to generate a report that displays paid claim data grouped by State Category of Service (COS) and aid category. It includes recipient, units and paid dollars as applicable for paid claims. When the user selects the Undup Recipients check box, the number of unduplicated recipients is displayed for the listed COS, aid category combination.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Expenditures By COS]

6.2.2 Expenditures By COS - Search Panel Layout



6.2.3 Expenditures By COS - Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each category of service.	Combo Box	Check Box	0
View	Allows the user to view the Expenditures By COS report.	Button	N/A	0

6.2.4 Expenditures By COS - Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than Six months after the Begin Period.	Change Begin Period to be within 6 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than Six months after the Begin Period.	Change End Period to be within 6 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.2.5 Expenditures By COS - Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.2.6 Expenditures By COS - Search Panel Accessibility

6.2.6.1 To Access and View Expenditure Analysis by COS Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Expenditures by COS** hyperlink on the Expenditures page.	Expenditures by COS panel displays.
5	Select report parameters from drop down list and click **View**.	A separate panel opens and the Expenditure Analysis by Category of Service report displays.

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6.2.7 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Narrative

The Expenditure Analysis By Category of Service report displays paid claim data grouped by State category of service and aid category. It includes recipient, units and paid dollars as applicable for paid claims.

This report is designed to consistently display fee-for-service or encounter information.

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6.2.8 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Layout

9/8/2006 9:14

State of Alabama

Expenditure Analysis By Category of Service

Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
State COS	07 Prescribed Drug Services	**Aid Category**	ALL
State Sub-COS	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

State Category of Service	Aid Category	*Undup Recip	Units of Service	Paid Amount	*Avg Paid per Recip
0710 Prescribed Drugs - Legend	A Public Assistance, Aged	3	3	$164	$55
0710 Prescribed Drugs - Legend	E Public Assistance, Blind	3	3	$240	$80
0710 Prescribed Drugs - Legend	I Public Assistance, Disabled	6	8	$848	$141
0710 Prescribed Drugs - Legend	I1 Institutionalized with income less than 300%, Aged	1	1	$3	$3
0710 Prescribed Drugs - Legend	I3 Institutionalized with income < 300%, Disabled	1	2	$281	$281
0710 Prescribed Drugs - Legend	M Public Assistance, TANF	16	17	$619	$39
0710 Prescribed Drugs - Legend	N Medical Assistance, Categorically Needy, TANF	10	8	$731	$73
0720 Prescribed Drugs - Non-Legend	E Public Assistance, Blind	3	3	$50	$17
0720 Prescribed Drugs - Non-Legend	G Medical Assistance, Categorically Needy, Blind	1	1	$32	$32
0720 Prescribed Drugs - Non-Legend	M Public Assistance, TANF	3	3	$31	$10
0720 Prescribed Drugs - Non-Legend	N Medical Assistance, Categorically Needy, TANF	3	3	$38	$13
Totals:		**51**	**52**	**$3,037**	**$60**

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6.2.9 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	Average of dollars paid per recipient for claims adjudicated for payments during the reporting period.	10	Number (Decimal)
*Undup Recip	Count of unique recipients served in the selection criteria for claims finalized during the reporting period.	8	Number (Integer)
Aid Category	Eligibility category for which a recipient is assigned.	30	Character
Paid Amount	Amount reimbursed for all paid claims for each State Category of Service, Aid Category combination. This total reflects the criteria selected by the user.	15	Number (Decimal)
State Category of Service	Displays the combined high-level State Category of Service (COS) and detail-level State Sub-COS value. The State category of service is a derived value assigned to each record reported in MAR.	30	Character
Totals	Totals for corresponding columns.	15	Number (Integer)
Units of Service	Total units of service for paid claims for each State Category of Service, Aid Category combination. This total reflects the criteria selected by the user.	10	Number (Integer)

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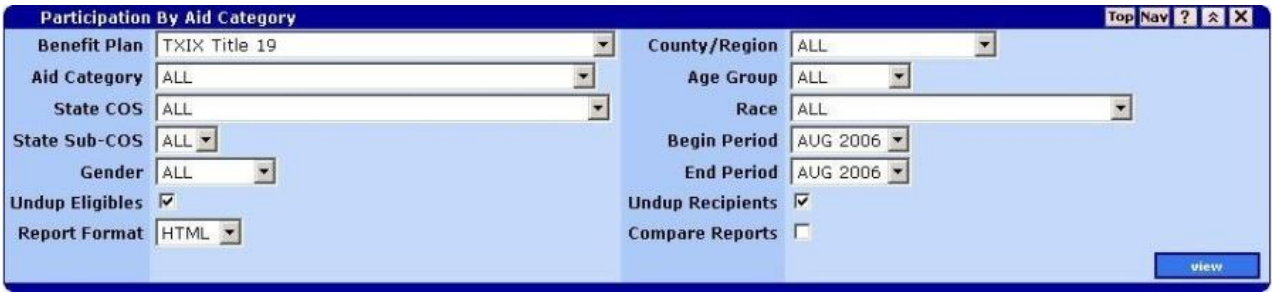
6.3 PARTICIPATION BY AID CATEGORY PANEL OVERVIEW

6.3.1 Participation By Aid Category Panel Narrative

The Participation by Aid Category panel allows users to generate a report that displays number of eligible recipients, recipients receiving a service and paid claims along with the billed, allowed and paid amounts for paid claims. The panel results are grouped by aid category.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Participation By Aid Category]

6.3.2 Participation By Aid Category Panel Layout



6.3.3 Participation By Aid Category Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Group	Allows the user to select a specific recipient age grouping to limit the data returned on this report.	Combo Box	Drop Down List Box	0
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Gender	Allows the user to select a specific recipient gender to limit data returned on this report.	Combo Box	Drop Down List Box	0
Race	Allows the user to select a specific recipient race when returning data for this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Eligibles	This check box is used to request and display unduplicated eligible statistics for each aid category.	Combo Box	Check Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each aid category.	Combo Box	Check Box	0
View	Allows the user to view the Participation By Aid Category report.	Button	N/A	0

6.3.4 Participation By Aid Category Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.3.5 Participation By Aid Category Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.3.6 Participation By Aid Category Panel Accessibility

6.3.6.1 To Access and View Participation by Aid Category Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Participation by Aid Category** hyperlink on the Expenditures page.	Participation by Aid Category panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Locality Participation Analysis by Aid Category report displays.

6.3.7 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Narrative

The Locality Participation Analysis by Aid Category report displays number of eligible recipients, recipients receiving a service, and paid claims along with the billed, allowed and paid amounts for paid claims. When the user selects the Undup Recipient checkbox, the number of participating recipients and average payment per recipient is displayed. When the user selects the Undup Eligibles checkbox, the number of eligibles and the average payment per eligible recipient is displayed. When both checkboxes are selected, the eligibles and participating counts are displayed. The window results are grouped by aid category. Selection criteria for this window is: benefit plan, region/county, state category of service, state sub-category of service, aid category, age group, race, gender and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.3.8 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Layout

9/8/2006 9:39

State of Alabama

Locality Participation Analysis By Aid Category

Fee For Service

Report Criteria			
Benefit Plan	TXIX Title 19	**Age Group**	ALL
County/Region	ALL	**Race**	ALL
Aid Category	ALL	**Gender**	ALL
State COS	ALL		
State Sub-COS	ALL	**Begin/End Period**	AUG 2006 / AUG 2006

Aid Category	*Eligibles	*Undup Recip	*Pct Elig Prtcp	Claims Paid	Billed Amount	Allowed Amount	Paid Amount	*Avg Paid per Elig	*Avg Paid per Recip
A Public Assistance, Aged	529	2	0.4%	2	$129	$104	$102	$0	$51
I Public Assistance, Disabl	79	6	7.6%	16	$2,328	$1,969	$1,949	$25	$325
I1 Institutionalized with in	15	1	6.7%	1	$25	$0	$3	$0	$3
K Medical Assistance, Categ	60	2	3.3%	5	$1,164	$1,039	$560	$9	$280
M Public Assistance, TANF	271	7	2.6%	9	$805	$173	$162	$1	$23
N Medical Assistance, Categ	182	7	3.8%	11	$1,100	$596	$543	$3	$78
T1 TEFRA Nursing Facility	2	1	50.0%	7	$2,475	$789	$728	$364	$728
Totals:	**1,320**	**26**	**2.0%**	**51**	**$8,026**	**$4,670**	**$4,047**	**$3**	**$156**

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6.3.9 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Elig	Average of dollars paid per eligible for claims adjudicated for payments during the reporting period.	10	Number (Decimal)
*Avg Paid per Recip	Average of dollars paid per recipient for claims adjudicated for payments during the reporting period.	10	Number (Decimal)
*Eligibles	Count of recipients eligible for service during the reporting period.	8	Number (Integer)
*Pct Elig Prtcp	When both checkboxes are selected, the percentage of all eligible recipients who participate in the program.	6	Number (Decimal)
*Undup Recip	Count of unique recipients served in the selection criteria for claims finalized during the reporting period.	8	Number (Integer)
Aid Category	Eligibility category for which a recipient is assigned.	50	Character
Allowed Amount	Total dollars allowed for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Billed Amount	Displays the total dollars billed for services rendered in the selection criteria during the reporting period.	15	Number (Decimal)
Claims Paid	Displays the number of claims in the selected criteria finalized for payment during the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollars paid for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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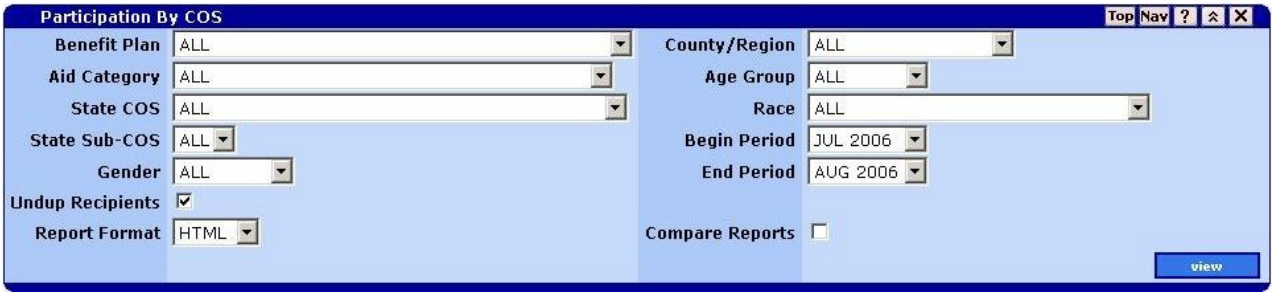
6.4 PARTICIPATION BY COS PANEL OVERVIEW

6.4.1 Participation By COS Panel Narrative

The Participation by COS panel allows users to generate a report that displays recipient and claim counts and dollars for paid claims. When the user selects the Undup Recipients checkbox, the number of recipients participating recipient information and average paid per recipient are displayed. The report is grouped by state category of service. Selection criteria for this panel includes: benefit plan, region/county, state category of service, state sub-category of service, aid category, age group, race, gender, and reporting period date range.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Participation By COS]

6.4.2 Participation By COS Panel Layout



6.4.3 Participation By COS Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Group	Allows the user to select a specific recipient age grouping to limit the data returned on this report.	Combo Box	Drop Down List Box	0
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Gender	Allows the user to select a specific recipient gender to limit data returned on this report.	Combo Box	Drop Down List Box	0
Race	Allows the user to select a specific recipient race when returning data for this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. When a State COS is selected, the report displays the State sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each category of service.	Combo Box	Check Box	0
View	View the Participation By COS report.	Button	N/A	0

6.4.4 Participation By COS Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than Six Months after the Begin Period.	Change Begin Period to be within 6 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than Six Months after the Begin Period.	Change End Period to be within 6 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.4.5 Participation By COS Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.4.6 Participation By COS Panel Accessibility

6.4.6.1 To Access and View Participation By COS Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Participation by COS** hyperlink on the Expenditures page.	Participation by COS panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Locality Participation Analysis by State COS report displays.

6.4.7 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Narrative

The Locality Participation Analysis by State COS report displays recipient and claim counts and dollars for paid claims. When the user selects the Undup Recipients checkbox, the number of recipients participating recipient information and average paid per recipient are displayed. The report is grouped by state category of service. Selection criteria for this window includes: benefit plan, region/county, state category of service, state sub-category of service, aid category, age group, race, gender, and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.4.8 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Layout

9/8/2006 9:27

State of Alabama

Locality Participation Analysis By State COS

Fee For Service

Report Criteria			
Benefit Plan	ALL	**Age Group**	ALL
County/Region	ALL	**Race**	ALL
State COS	ALL	**Gender**	ALL
State Sub-COS	ALL		
Aid Category	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

State Category of Service	*Undup Recip	*Pct Elig Prtcp	Claims Paid	Billed Amount	Allowed Amount	Paid Amount	*Avg Paid per Recip
03 Outpatient Services	7	0.5%	9	$9,191	$1,354	-$7	-$1
06 Physician Services	29	1.9%	65	$9,228	$4,626	$4,350	$150
07 Prescribed Drug Services	51	3.3%	58	$7,274	$3,086	$3,037	$60
08 MSDG Services	8	0.5%	15	$1,651	$1,597	$1,535	$192
10 Clinic Services	1	0.1%	1	$100	$57	$47	$47
15 ICF-MR Services	2	0.1%	2	$5,891	$2,986	$0	$0
29 Eyewear Services	2	0.1%	4	$1,264	$1,159	$745	$373
30 Dental Services	11	0.7%	24	$8,060	$3,385	$2,452	$223
42 Advanced Practice Nurse (APN) Services	27	1.8%	37	$3,960	$2,008	$2,008	$74
99 Unknown Services by Record Type	1	0.1%	-1	-$200	-$17	-$17	-$17
Totals:	**184**	**12.0%**	**214**	**$46,419**	**$20,241**	**$14,150**	**$77**

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6.4.9 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	Average of dollars paid per recipient for claims adjudicated for payments during the reporting period.	10	Number (Decimal)
*Pct Elig Prtcp	When both checkboxes are selected, the percentage of all eligible recipients who participate in the program.	6	Number (Decimal)
*Undup Recip	Count of unique recipients served in the selection criteria for claims finalized during the reporting period.	8	Number (Integer)
Allowed Amount	Total dollars allowed for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Billed Amount	Displays the total dollars billed for services rendered in the selection criteria during the reporting period.	15	Number (Decimal)
Claims Paid	Displays the number of claims in the selected criteria finalized for payment during the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollars paid for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
State Category of Service	Displays the combined high-level State category of service (COS) and detail-level State Sub-COS value. The State category of service is a derived value assigned to each record reported in MAR.	50	Character
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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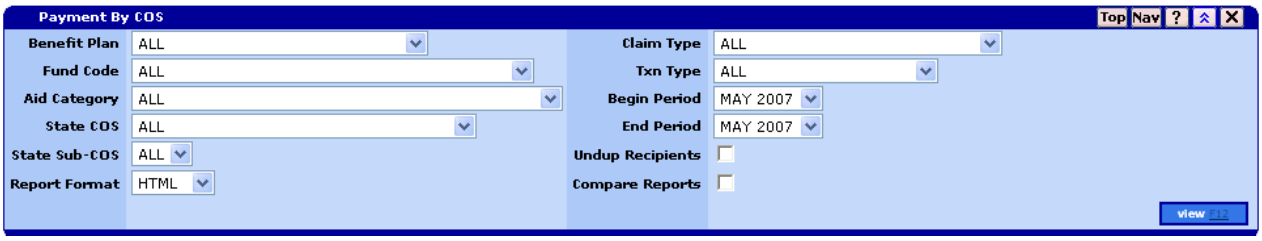
6.5 PAYMENT BY COS PANEL OVERVIEW

6.5.1 Payment By COS Panel Narrative

The Payment By COS panel allows the user to generate a report that displays a comparison of payments listed by State Category of Service (COS) and State-Sub COS. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year, and SFYTD last year.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Payment By COS]

6.5.2 Payment By COS Panel Layout



6.5.3 Payment By COS Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	This field allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	This field allows the user to select the beginning report month that represents the first paid month for which data will be displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	This field allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	This field allows the user to select the ending report month that represents the last paid month for which data will be displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Txn Type	This field allows the user to select a specific transaction type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each category of service.	Check Box	Check Box	0
View	Allows the user to view the Payment By COS report.	Button	N/A	0

6.5.4 Payment By COS Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.5.5 Payment By COS Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 Payment By COS Panel Accessibility

6.5.6.1 To Access and View Payment By COS Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditure page displays.
4	Click **Payment By COS** hyperlink on the Provider page.	Payment By COS panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Payment Comparison by Category of Service report displays.

6.5.7 Payment Comparison by Category of Service Report (MAR.ComparisonByCOS.rdl) Narrative

The Payment Comparison by Category of Service report displays a comparison of payments listed by State Category of Service (COS) and State-Sub COS. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year, and SFYTD last year. Selection criteria for this window are: benefit plan, fund code, region/county, state category of service, state sub-category of service and reporting period.

This report is designed to consistently display fee-for-service or encounter information.

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6.5.8 Payment Comparison by Category of Service (MAR.ComparisonByCOS.rdl) Report Layout

9/21/2006 9:35

State of Alabama

Payment Comparison By Category of Service

Fee For Service

Report Criteria			
Benefit Plan	ALL	County/Region	ALL
State COS	07 Prescribed Drug Services	Fund Code	ALL
State Sub-COS	ALL	Reporting Period	MAY 2006

	|------- This Month ------|		|- Same Month Last Year -|		|---- SFYTD This Year ----|		|---- SFYTD Last Year ---|	
State Category of Service	Paid Claims	Paid Amount	Paid Claims	Paid Amount	Paid Claims	Paid Amount	Paid Claims	Paid Amount
0710 Prescribed Drugs - Legend	38	$765	2	$1,425	45	$748	143	$19,180
0720 Prescribed Drugs - Non-Legend	3	$124	0	$0	5	$124	2	$36
0730 Prescribed Drugs - Compounds	9	$728	-4	-$482	10	$728	57	$1,958
Totals:	**50**	**$1,617**	**-2**	**$943**	**60**	**$1,600**	**202**	**$21,174**

6.5.9 Payment Comparison by Category of Service (MAR.ComparisonByCOS.rdl) Report Field Descriptions

Field	Description	Length	Data Type
SFYTD Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the prior state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, through the prior state fiscal year reporting period for the month indicated.	15	Number (Decimal)
SFYTD This Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD This Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	15	Number (Decimal)
Same Month Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	10	Number (Integer)
Same Month Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	15	Number (Decimal)

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Field	Description	Length	Data Type
State Category of Service	Displays the combined high-level State category of service (COS) and detail-level State Sub-COS value. The State category of service is a derived value assigned to each record reported in MAR.	50	Character
This Month - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the selected reporting period.	10	Number (Integer)
This Month - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, claims during the month indicated.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.6 PAYMENT BY PROVIDER TYPE PANEL OVERVIEW

6.6.1 Payment By Provider Type Panel Narrative

The Payment By Provider Type panel allows the user to generate a report that displays paid and denied claim statistics grouped by provider type and specialty. It includes claim counts, billed and paid dollars as applicable for paid and denied claims. The data results are grouped by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Payment By Provider Type]

6.6.2 Payment By Provider Type Panel Layout

6.6.3 Payment By Provider Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Transaction Type	Allows the user to select a specific transaction type to limit data returned on this report.	Combo Box	Drop Down List Box	0
View	Allows the user to view the Payment By Provider Type report.	Button	N/A	0

6.6.4 Payment By Provider Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.6.5 Payment By Provider Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.6.6 Payment By Provider Type Panel Accessibility

6.6.6.1 To Access and View Payment by Provider Type Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Payment by Provider Type** hyperlink on the Expenditures page.	Payment Comparison by Provider Type panel displays.

6.6.7 Payment Statistics by Provider Type (MAR.PaymentByProvType.rdl) Report Narrative

The Payment Statistics by Provider Type report displays paid and denied claim statistics grouped by provider type and specialty. It includes claim counts, billed and paid dollars as applicable for paid and denied claims. The data results are grouped by provider type and specialty. Selection criteria for this report includes: benefit plan, fund code, provider type, provider specialty, claim type, transaction type and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.6.8 Payment Statistics by Provider Type (MAR.PaymentByProvType.rdl) Report Layout

8/15/2006 11:09

State of Alabama

Payment Statistics By Provider Type

Fee For Service

Report Criteria			
Benefit Plan	TXIX Title 19	**Claim Type**	ALL
Fund Code	ALL	**Transaction Type**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

	Paid			Denied	
Provider Type / Provider Specialty	**Claims**	**Units of Service**	**Paid Amount**	**Claims**	**Billed Amount**
01 Hospital	0	0	$0	7	$73,050
02 Ambulatory Surgical Center (ASC)	6	0	$130	0	$0
08 Clinic	0	0	$0	5	$1,065
09 Advance Practice Nurse	30	0	$6,068	0	$0
19 Optician	9	0	$1,688	18	$7,500
24 Pharmacy	89	89	$20,740	74	$13,588
25 DME/Medical Supply Dealer	12	2	$156	0	$0
27 Dentist	21	21	$7,614	31	$3,717
31 Physician	94	0	$12,227	81	$10,136
Totals:	**261**	**112**	**$48,623**	**216**	**$109,056**

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6.6.9 Payment Statistics by Provider Type (MAR.PaymentByProvType.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Denied - Billed Amount	Amount billed for all denied claims for each provider type and specialty. This total reflects the criteria selected by the user.	15	Number (Decimal)
Denied - Claims	Number of claims that have been denied for each provider type and specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Paid - Claims	Number of claims that have been paid for each provider type and specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Paid - Paid Amount	Amount reimbursed for all paid claims for each provider type and specialty. This total reflects the criteria selected by the user.	15	Number (Decimal)
Paid - Units of Service	Total units of service for paid claims for each provider type and specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Totals	Totals for corresponding columns.	15	Number (Integer & Decimal)

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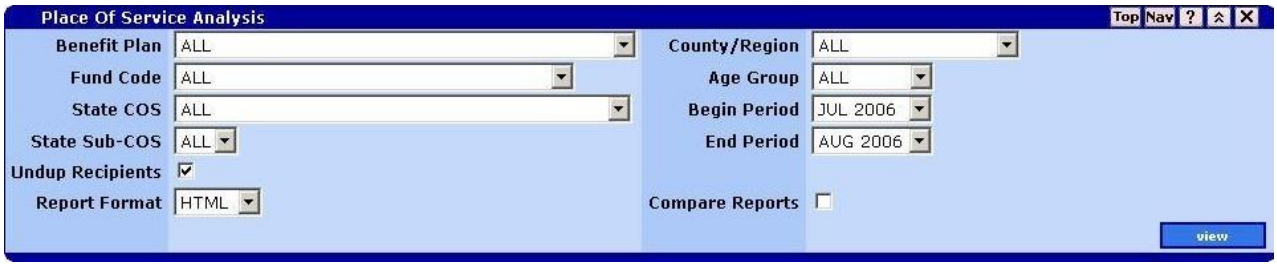
6.7 PLACE OF SERVICE ANALYSIS PANEL OVERVIEW

6.7.1 Place Of Service Analysis Panel Narrative

The Place of Service Analysis panel allows the user to generate a report that provides analysis of recipients and dollars paid for each state category of service by region/county and location (place) of service. It includes the number of unduplicated recipients, claims and dollars paid and average paid per claim and recipient.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Place Of Service Analysis]

6.7.2 Place Of Service Analysis Panel Layout



6.7.3 Place Of Service Analysis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Group	Allows the user to select a specific recipient age grouping to limit the data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each aid category.	Combo Box	Check Box	0
View	Allows user to view the Place of Service Analysis report.	Button	N/A	0

6.7.4 Place Of Service Analysis Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.7.5 Place Of Service Analysis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Place Of Service Analysis Panel Accessibility

6.7.6.1 To Access and View Place Of Service Analysis Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Place of Service Analysis** hyperlink on the Expenditures page.	Place of Service Analysis panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Place of Service Analysis report displays.

6.7.7 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Narrative

The Place of Service Analysis report provides analysis of recipients and dollars paid for each state category of service by region/county and location (place) of service. It includes the number of unduplicated recipients, claims and dollars paid and average paid per claim and recipient. When the user selects the Undup Recipients checkbox, the number of recipients and average expenditures per recipient are displayed. Selection criteria for this report are: benefit plan, region/county, state category of service, state sub-category of service, age group and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.7.8 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Layout

9/8/2006 9:43

State of Alabama

Place Of Service Analysis

Fee For Service

Report Criteria			
Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Age Group**	ALL
State COS	ALL		
State Sub-COS	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

Place Of Service	*Undup Recip	Claims Paid	Paid Amount	Avg Paid per Claim	*Avg Paid per Recip
## Unknown	1	2	$4	$2	$4
00 Pharmacy	80	98	$20,858	$213	$261
11 Office	63	132	$14,034	$106	$223
12 Home	4	5	$52	$10	$13
21 Inpatient Hospital	5	16	$1,542	$96	$308
22 Outpatient Hospital	55	115	$17,810	$155	$324
23 Emergency Room - Hospital	1	1	$33	$33	$33
31 Skilled Nursing Facility	2	4	$0	$0	$0
42 Ambulance - Air or Water	2	7	$1,172	$167	$586
Totals:	**182**	**380**	**$55,505**	**146**	**$305**

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6.7.9 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	Displays an average of the dollars reimbursed per recipient for the count of unduplicated recipients for claims finalized for payment during the reporting period.	10	Number (Decimal)
*Undup Recip	Displays a count of the unique recipients served at the location for claims finalized during the reporting period. This count only includes recipients from paid claims.	8	Number (Integer)
Avg Paid per Claim	Displays an average of the dollars paid per claim for claims finalized for payment during the reporting period.	10	Number (Decimal)
Claims Paid	Displays the number of paid claims for the listed location for the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollars paid for services rendered at the location for claims finalized during the reporting period.	15	Number (Decimal)
Place Of Service	Displays the location (place) of service where claims paid with criteria selected.	50	Character
Totals	Totals for the corresponding columns. Unduplicated recipients is the unduplicated total across all the places of service displayed.	15	Number (Integer & Decimal)

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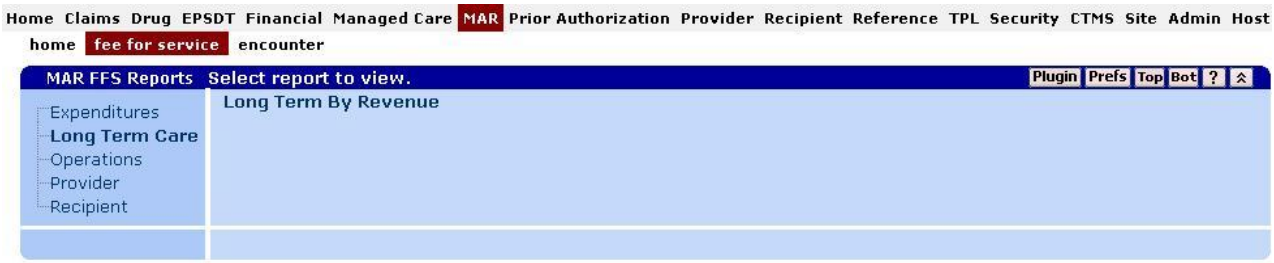
6.8 MAR REPORTS - LONG TERM CARE PAGE OVERVIEW

6.8.1 MAR Reports - Long Term Care Page Narrative

The MAR Reports – Long Term Care page is the access point within the MAR system that allows users to view reports that fall under the category of Long Term Care.

[MAR] – [Fee for Service or Encounter] – [Long Term Care]

6.8.2 MAR Reports - Long Term Care Page Layout



6.8.3 MAR Reports - Long Term Care Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Long Term By Revenue	Link to Long Term By Revenue panel.	Hyperlink	N/A	0

6.8.4 MAR Reports - Long Term Care Page Field Edit Error Codes

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

6.8.5 MAR Reports - Long Term Care Page Extra Features

Field	Field Type
No extra features found for this page.	

6.8.6 MAR Reports - Long Term Care Page Accessibility

6.8.7 To Access Long Term Care Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Long Term Care** hyperlink.	Long Term Care page displays.

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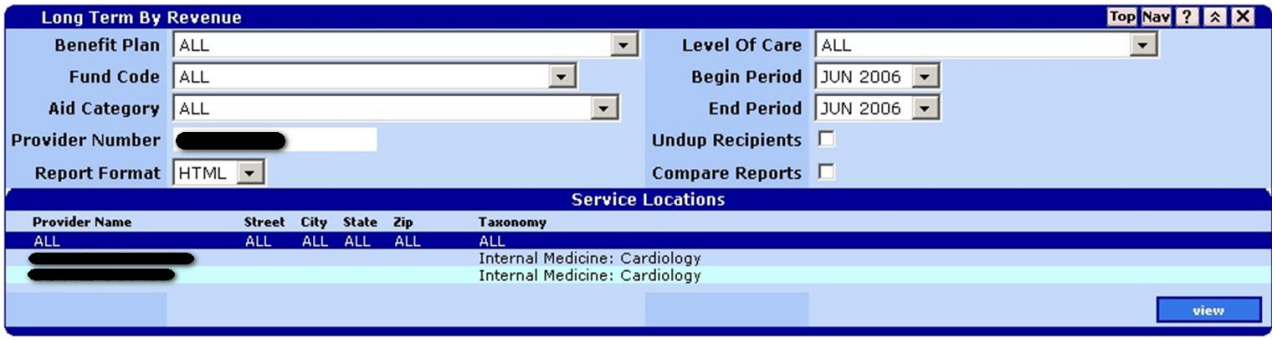
6.9 LONG TERM BY REVENUE PANEL OVERVIEW

6.9.1 Long Term By Revenue Panel Narrative

The Long Term by Revenue panel allows the user to generate a report that displays paid long term care claim information. The top section of the data results includes averages and amounts based on the criteria selected by the user. The bottom section of the data results displays the unduplicated recipient count, days of care and billed amount by revenue code for the user selected criteria.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Long Term Care] - [Long Term By Revenue]

6.9.2 Long Term By Revenue Panel Layout



6.9.3 Long Term By Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the provider on this service location.	Field	Character	30
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Level Of Care	Allows the user to select the recipient's level of care to limit data results on this report.	Combo Box	Drop Down List Box	0
Provider Name	Name of the provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each aid category.	Combo Box	Check Box	0
View	Allows the user to view the Long Term By Revenue report.	Button	N/A	0
Zip	Zip Code for the provider on this service location.	Field	Number (Integer)	5

6.9.4 Long Term By Revenue Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Provider Number	Field	2	The Provider Number entered is invalid or not on file.	Enter a valid provider ID.

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6.9.5 Long Term By Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.9.6 Long Term By Revenue Panel Accessibility

6.9.6.1 To Access and View Long Term Care by Revenue Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Long Term Care** hyperlink.	Long Term Care page displays.
4	Click **Long Term by Revenue** hyperlink on the Long Term Care page.	Long Term by Revenue panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Long Term Care Payments by Revenue Code report displays.

6.9.7 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Narrative

The Long Term Care Payments by Revenue Code report displays paid long term care claim information. The top section of the data results includes averages and amounts based on the criteria selected by the user. The bottom section of the data results displays the unduplicated recipient count, days of care and billed amount by revenue code for the user selected criteria. When the user selects the Undup Recipients box, the number of recipients and average paid per recipient are displayed. Selection criteria for this window includes: benefit plan, aid category, level of care, provider number and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.9.8 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Layout

9/8/2006 8:59

State of Alabama

Long Term Care Payments By Revenue Code

Fee For Service

Report Criteria			
Benefit Plan	ALL	Fund Code	ALL
Aid Category	ALL	Provider Number	
Level Of Care	ALL	Begin/End Period	FEB 2005 / OCT 2005

Avg Paid per Patient Day	$88	Allowed Amount	$54,191
Avg Paid per Provider	$9,623	Other Insurance Amount	$0
Avg Applied Income per Patient Day	$10	Patient Liability Amount	$5,185
*Avg Paid per Recip	$5,346	Paid Amount	$48,117
Total Number Providers	5		

Revenue Code	*Undup Recip	Days Of Care	Billed Amount
120 SEMI-PRIVATE ROOM	9	469	$45,815
130 ROOM-BOARD/3&4 BED	5	76	$6,743
Totals:	**9**	**545**	**$52,558**

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6.9.9 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	Displays the average of the dollars reimbursed per the count of unique recipients served for claims paid during the reporting period.	10	Number (Decimal)
*Undup Recip	Displays a count of the unique recipients for who services paid during the reporting period.	8	Number (Integer)
Allowed Amount	Total dollars allowed for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Avg Applied Income per Patient Day	Displays the average of the dollar amount of applied income per recipient days of care for claims paid during the reporting period.	10	Number (Decimal)
Avg Paid per Patient Day	This field displays the average of dollars reimbursed per recipient days of care for claims paid during the reporting period.	10	Number (Decimal)
Avg Paid per Provider	Displays the average of dollars reimbursed per the unique number of providers for claims paid during the reporting period.	10	Number (Decimal)
Billed Amount	Displays the total dollars billed for services rendered in the selection criteria during the reporting period.	15	Number (Decimal)
Days Of Care	Displays the total number of the days of care rendered for claims paid during the reporting period.	10	Number (Integer)
Other Insurance Amount	Displays the amount of any third party payments for long term care claims finalized for payment during the reporting period.	15	Number (Decimal)
Paid Amount	Displays the total dollars paid for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Patient Liability Amount	Displays the payment liability for the recipients.	15	Number (Decimal)
Revenue Code	Displays the code and description representing the services allowed for claims finalized during the reporting period.	50	Character
Total Number Providers	Displays the total number of providers paid for services rendered during the reporting period.	8	Number (Integer)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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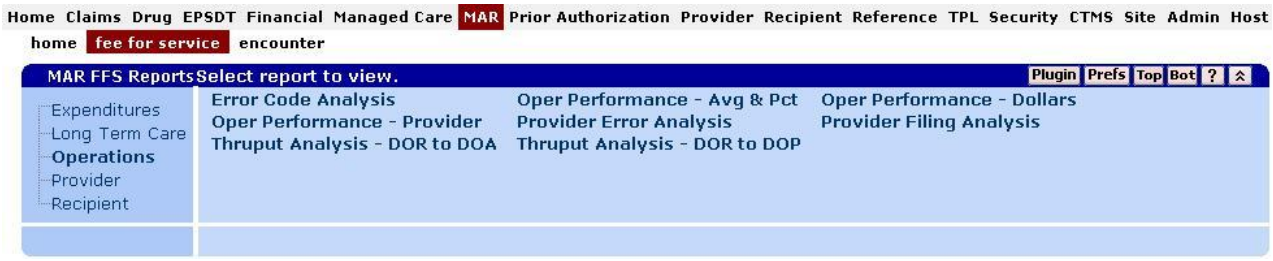
6.10 MAR REPORTS - OPERATIONS PAGE OVERVIEW

6.10.1 MAR Reports - Operations Page Narrative

The MAR Reports – Operations page is the access point within the MAR system that allows users to view reports that fall under the category of Operations.

Navigation Path: [MAR] – [Fee for Service or Encounter] – [Operations]

6.10.2 MAR Reports - Operations Page Layout



6.10.3 MAR Reports - Operations Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Error Code Analysis	Link to Error Code Analysis panel.	Hyperlink	N/A	0
Oper Performance – Avg & Pct	Link to Oper Performance – Avg & Pct panel.	Hyperlink	N/A	0
Oper Performance – Dollars	Link to Oper Performance – Dollars panel.	Hyperlink	N/A	0
Oper Performance – Provider	Link to Oper Performance – Provider panel.	Hyperlink	N/A	0
Provider Error Analysis	Link to Provider Error Analysis panel.	Hyperlink	N/A	0
Provider Filing Analysis	Link to Provider Filing Analysis panel.	Hyperlink	N/A	0
Thruput Analysis – DOR to DOA	Link to Thruput Analysis – DOR to DOA panel.	Hyperlink	N/A	0
Thruput Analysis – DOR to DOP	Link to Thruput Analysis – DOR to DOP panel.	Hyperlink	N/A	0

6.10.4 MAR Reports - Operations Page Field Edit Error Codes

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

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6.10.5 MAR Reports - Operations Page Extra Features

Field	Field Type
No extra features found for this page.	

6.10.6 MAR Reports - Operations Page Accessibility

6.10.6.1 To Access MAR Reports – Operations Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.

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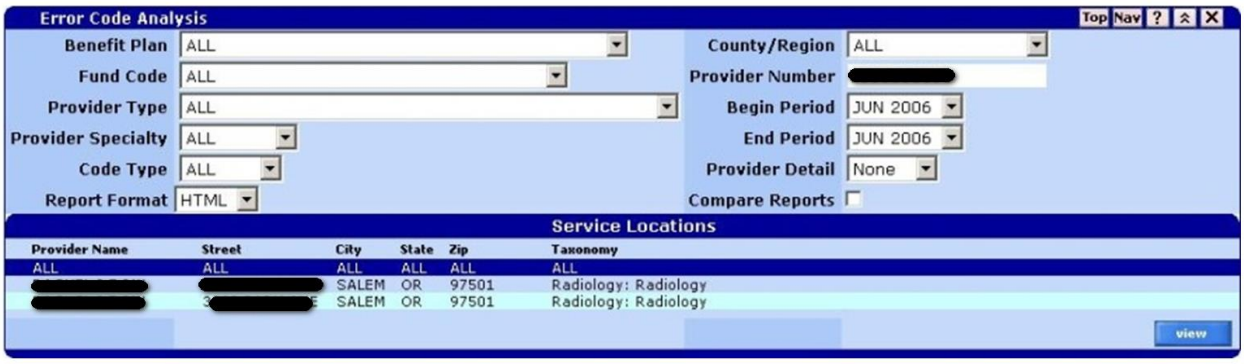
6.11 ERROR CODE ANALYSIS PANEL OVERVIEW

6.11.1 Error Code Analysis Panel Narrative

The Error Code Analysis panel allows the user to generate a report that displays the most common provider billing errors in a selected time period and includes the number of error claims and the percent of total errors. This highlights the overall provider understanding of billing procedures and program policies. The type of detail lines (all, override, or denial) reported in the data window is controlled by the code types selection criteria.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Error Code Analysis]

6.11.2 Error Code Analysis Panel Layout



6.11.3 Error Code Analysis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the provider on this service location.	Field	Character	30
Code Type	Allows the user to select a specific error code type.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
End Period	This field allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Detail	Allows the user to request and display provider detail statistics for each error code. The choices are Top 10 or Top 20 providers.	Combo Box	Drop Down List Box	0
Provider Name	Name of the provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
View	Allows the user to view the Error Code Analysis report.	Button	N/A	0
Zip	Zip Code for the provider on this service location.	Field	Number (Integer)	5

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6.11.4 Error Code Analysis Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	Change Begin Period to be within 12 months of End Period.	End Period must be no longer than 1 year after the Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	Change End Period to be within 12 months of Begin Period.	End Period must be no longer than 1 year after the Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Provider Number	Field	0	The Provider Number entered is invalid or not on file.	Enter a valid provider ID.

6.11.5 Error Code Analysis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Error Code Analysis Panel Accessibility

6.11.6.1 To Access and View Error Code Analysis Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Error Code Analysis** hyperlink on the Operations page.	Error Code Analysis panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Error Code Analysis report displays.

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6.11.7 Error Code Analysis (MAR.ErrorCode.rdl) Report Narrative

The Error Code Analysis report displays the most common provider billing errors in a selected time period and includes the number of error claims and the percent of total errors. This highlights the overall provider understanding of billing procedures and program policies. The type of detail lines (all, override, or denial) reported in the data window is controlled by the code types selection criteria. For example if the user selects the Code Types - All radio button, the data window displays denial and override error code detail lines. When the user selects the Provider Detail check box, the provider detail is displayed. Selection criteria for report are benefit plan, region/county, provider type, provider specialty, provider number and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.11.8 Error Code Analysis (MAR.ErrorCode.rdl) Report Layout

9/26/2006 12:53

State of Alabama
Error Code Analysis
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Provider Number**	
Provider Type	01 Hospital	**Code Type**	DENIAL
Provider Specialty	ALL	**Begin/End Period**	AUG 2006 / AUG 2006

Error Code	Error Claims	*Provider Number	*Provider Claims	*Percent of Total
5001 EXACT DUPLICATE	39			30.7%
1030 ANCIL NOT COVERED IN BIRTH CNTR GRP	28			22.0%
6162 EMERGENCY ROOM CONFLICT	25			19.7%
5007 EXACT DUPLICATE - HEADER	21			16.5%
3007 NO PRIOR AUTHORIZATION FOR LEVEL OF CARE	7			5.5%
4133 NO PROVIDER OR PEER GROUP RATE FOUND FOR DOS	7			5.5%
Totals:	**127**			

9/26/2006 12:54

State of Alabama
Error Code Analysis
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Provider Number**	
Provider Type	01 Hospital	**Code Type**	DENIAL
Provider Specialty	ALL	**Begin/End Period**	AUG 2006 / AUG 2006

Error Code	Error Claims	*Provider Number	*Provider Claims	*Percent of Total
5001 EXACT DUPLICATE	39			30.7%
		[redacted]	18	46.2%
			7	17.9%
			7	17.9%
			6	15.4%
			1	2.6%
1030 ANCIL NOT COVERED IN BIRTH CNTR GRP	28			22.0%
		[redacted]	21	75.0%
			7	25.0%
6162 EMERGENCY ROOM CONFLICT	25			19.7%
		[redacted]	9	36.0%
			7	28.0%
			7	28.0%
			1	4.0%
			1	4.0%
5007 EXACT DUPLICATE - HEADER	21			16.5%
		[redacted]	21	100.0%
3007 NO PRIOR AUTHORIZATION FOR LEVEL OF CARE	7			5.5%
		[redacted]	7	100.0%
4133 NO PROVIDER OR PEER GROUP RATE FOUND FOR DOS	7			5.5%
		[redacted]	7	100.0%
Totals:	**127**			

9/26/2006 12:58

State of Alabama
Error Code Analysis
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Provider Number**	1000000971
Provider Type	01 Hospital	**Code Type**	DENIAL
Provider Specialty	ALL	**Begin/End Period**	AUG 2006 / AUG 2006

Error Code	Error Claims	*Provider Number	*Provider Claims	*Percent of Total
1030 ANCIL NOT COVERED IN BIRTH CNTR GRP	21			48.8%
5007 EXACT DUPLICATE - HEADER	21			48.8%
6162 EMERGENCY ROOM CONFLICT	1			2.3%

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6.11.9 Error Code Analysis (MAR.ErrorCode.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Provider Claims	Displays the total number of provider claims receiving this error code for the top providers if the Provider Detail option is selected.	10	Number (Integer)
*Provider Number	Displays the top provider numbers receiving the error code if the Provider Detail option is selected. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Error Claims	Displays the total number of claims receiving the error code.	10	Number (Integer)
Error Code	Displays the edit or audit code and description for paid and denied claims.	50	Character
Percent of Total	Displays the total number of claims with this code as a percent of the total number of claims with all codes. On a provider detail line, this field displays the total code claims for this provider as a percent of the total code claims.	6	Number (Decimal)
Totals	Totals for the corresponding columns.	10	Number (Integer & Decimal)

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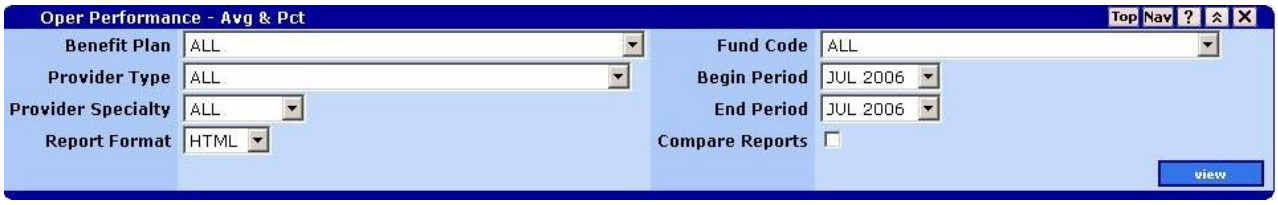
6.12 OPER PERFORMANCE - AVG & PCT PANEL OVERVIEW

6.12.1 Oper Performance – Avg & Pct Panel Narrative

The Oper Performance – Avg & Pct panel allows the user to generate a report that displays percents and averages of original paid claims, denied claims, corrected claims, adjudicated without correction, average number of days from service to receipt, service to payment and service to adjudication. The data results are grouped by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Oper Performance - Avg & Pct]

6.12.2 Oper Performance – Avg & Pct Panel Layout



6.12.3 Oper Performance – Avg & Pct Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the Oper Performance - Avg & Pct report.	Button	N/A	0

6.12.4 Oper Performance – Avg & Pct Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.12.5 Oper Performance - Avg & Pct Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.12.6 Oper Performance - Avg & Pct Panel Accessibility

6.12.6.1 To Access and View Operational Performance –Averages & Percents Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Oper Performance – Avg & Pct** hyperlink on the Operations page.	Oper Performance – Avg & Pct panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Operational Performance Summary – Averages and Percents report displays.

6.12.7 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Narrative

The Operational Performance Summary – Averages & Percents report displays percents and averages of original paid claims, denied claims, corrected claims, adjudicated without correction, average number of days from service to receipt, service to payment and service to adjudication. The data results are grouped by provider type and specialty. Selection criteria for this report are: benefit plan, fund code, provider type, provider specialty and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.12.8 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Layout

8/15/2006 11:36

State of Alabama

Operational Performance Summary - Averages & Percents

Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

Provider Type / Provider Specialty	Pct Paid	Pct Adjud w/o Corr	Pct Denied	Pct Corrected	Avg DOS to DOR	Avg DOS to DOA	Avg DOS to DOP
01 Hospital	17.1%	0.0%	82.9%	100.0%	225.5	225.7	230.2
02 Ambulatory Surgical Center (ASC)	100.0%	0.0%	0.0%	100.0%	41.3	41.3	41.9
03 Extended Care Facility	25.0%	0.0%	75.0%	100.0%	1179.6	1179.6	1180.6
05 Home Health Agency	14.3%	0.0%	85.7%	100.0%	64.8	64.8	153.8
08 Clinic	12.5%	0.0%	87.5%	100.0%	233.6	233.6	234.6
09 Advance Practice Nurse	91.1%	0.0%	8.9%	100.0%	58.8	58.8	59.1
19 Optician	33.3%	0.0%	66.7%	100.0%	92.1	92.1	93.3
24 Pharmacy	50.3%	0.0%	49.7%	100.0%	53.7	60.2	68.6
25 DME/Medical Supply Dealer	85.7%	0.0%	14.3%	100.0%	122.0	122.0	122.5
27 Dentist	35.4%	0.0%	64.6%	100.0%	111.5	111.5	111.5
31 Physician	46.7%	0.0%	53.3%	100.0%	88.2	88.2	89.4
Totals:	**43.7%**	**0.0%**	**56.3%**	**100.0%**	**118.4**	**120.2**	**124.5**

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6.12.9 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg DOS to DOA	Average number of days from date of service to date of adjudication. Note: Date of adjudication is the date the claim was either paid or denied.	6	Number (Decimal)
Avg DOS to DOP	Average number of days from date of service to date of payment.	6	Number (Decimal)
Avg DOS to DOR	Average number of days from date of service to date of receipt. Note: Date of receipt is the date the claim was received into interChange.	6	Number (Decimal)
Pct Adjud w/o Corr	Displays the percent of the paid and denied claims that were adjudicated without being corrected.	6	Number (Decimal)
Pct Corrected	Displays the percent of the paid and denied claims that were corrected, (corrected paid + corrected denied) / (total paid + total denied).	6	Number (Decimal)
Pct Denied	Displays the percent of the paid and denied claims that were denied.	6	Number (Decimal)
Pct Paid	Displays the percent of the paid and denied claims that were paid.	6	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Totals	Totals for the corresponding columns.	6	Number (Decimal)

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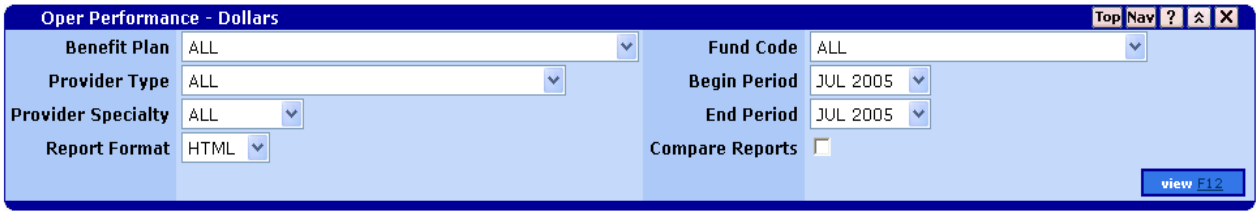
6.13 OPER PERFORMANCE - DOLLARS PANEL OVERVIEW

6.13.1 Oper Performance - Dollars Panel Narrative

The Oper Performance - Dollars panel allows the user to generate a report that displays for original claims and financial transactions the billed amount for paid, denied and pending claims, total charges submitted (the sum of the paid, denied and pending billed amounts) and the difference between the paid claims billed amount and the reimbursement amount. Results are listed by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Oper Performance - Dollars]

6.13.2 Oper Performance - Dollars Panel Layout



6.13.3 Oper Performance - Dollars Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Oper Performance - Dollars report.	Button	N/A	0

6.13.4 Oper Performance - Dollars Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.13.5 Oper Performance - Dollars Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.13.6 Oper Performance - Dollars Panel Accessibility

6.13.6.1 To Access and View Operational Performance -Dollars Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Oper Performance - Dollars** hyperlink on the Operations page.	Oper Performance - Dollars panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Operational Performance Summary - Dollars report displays.

6.13.7 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Narrative

The Operational Performance Summary - Dollars report displays for original claims and financial transactions the billed amount for paid, denied and pending claims, total charges submitted (the sum of the paid, denied and pending billed amounts), and the difference between the paid claims billed amount and the reimbursement amount. Results are listed by provider type and specialty. Selection criteria for this report are: benefit plan, fund code, provider type, provider specialty and reporting period date range.

The report is designed to consistently display fee-for-service or encounter information.

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6.13.8 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Layout

8/15/2006 12:36

State of Alabama

Operational Performance Summary - Dollars

Fee For Service

Report Criteria			
Benefit Plan	ALL	**Fund Code**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

	Billed Amount				
Provider Type / Provider Specialty	**Paid Claims**	**Denied Claims**	**Pending Claims**	**Total Charges Submitted**	**Paid Billed - Paid Amt**
## Unknown	$1,516	$7,652	$134,407	$143,575	$0
01 Hospital	$27,533	$316,693	$3,064,486	$3,408,712	$17,740
02 Ambulatory Surgical Center (ASC)	$1,130	$0	$945	$2,075	$1,000
03 Extended Care Facility	$5,891	$17,674	$230,353	$253,918	$5,891
05 Home Health Agency	$2,000	$8,450	$161,408	$171,858	$2,000
08 Clinic	$3,331	$8,265	$52,235	$63,831	$2,500
09 Advance Practice Nurse	$12,078	$345	$2,945	$15,368	$5,442
19 Optician	$2,070	$7,500	$5,292	$14,862	$382
24 Pharmacy	$32,880	$14,468	$14,675	$62,023	$12,130
25 DME/Medical Supply Dealer	$480	$60	$180	$720	$324
27 Dentist	$13,867	$4,393	$57,230	$75,490	$5,480
31 Physician	$35,818	$16,679	$549,335	$601,832	$18,267
Totals:	**$138,594**	**$402,179**	**$4,273,491**	**$4,814,264**	**$71,156**

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6.13.9 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Billed Amount - Denied Claims	Billed amount for denied claims.	15	Number (Decimal)
Billed Amount - Paid Claims	Billed amount for paid claims.	15	Number (Decimal)
Billed Amount - Pending Claims	Billed amount for pending claims.	15	Number (Decimal)
Paid Billed - Paid Amount	Displays the difference between the billed amount for paid claim and the reimbursement amount for paid claims.	15	Number (Decimal)
Provider Type/ Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Total Charges Submitted	Total billed amount for paid, denied and suspended claims.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Decimal)

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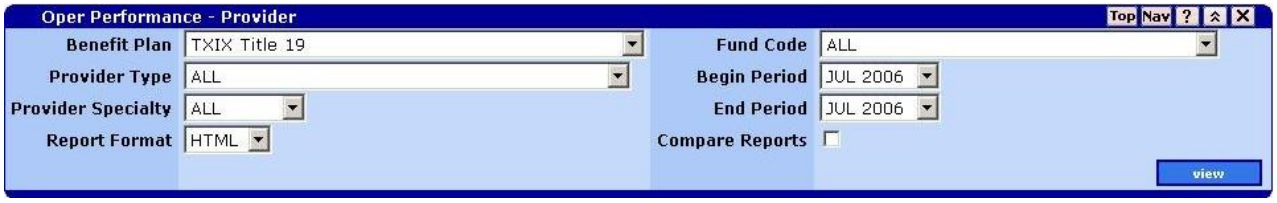
6.14 OPER PERFORMANCE - PROVIDER PANEL OVERVIEW

6.14.1 Oper Performance - Provider Panel Narrative

The Oper Performance – Provider panel allows the user to generate a report that displays the counts of claims processed, original claims paid, original claims denied, claims pending, adjustment claims paid, adjustment claims denied and billed amount for pending claims. Results are listed by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Oper Performance - Provider]

6.14.2 Oper Performance - Provider Panel Layout



6.14.3 Oper Performance - Provider Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the Oper Performance - Provider report.	Button	N/A	0

6.14.4 Oper Performance - Provider Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.14.5 Oper Performance - Provider Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.14.6 Oper Performance - Provider Panel Accessibility

6.14.6.1 To Access and View Oper Performance - Provider Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Oper Performance - Provider** hyperlink on the Operations page.	Oper Performance - Provider panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Operational Performance Summary - Provider report displays.

6.14.7 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Narrative

The Operation Performance Summary - Provider report displays the counts of claims processed, original claims paid, original claims denied, claims pending, adjustment claims paid, adjustment claims denied and billed amount for pending claims. Results are listed by provider type and specialty. Selection criteria for this report are: benefit plan, fund code, provider type, provider specialty and reporting period date range.

Pending claims do not have a Fund Code Assignment, therefore, each Fund Code category reports all claims pending billed amount.

This report is designed to consistently display fee-for-service or encounter information.

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6.14.8 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Layout

8/15/2006 11:22

State of Alabama
Operational Performance Summary - Provider
Fee For Service

Report Criteria			
Benefit Plan	TXIX Title 19	**Fund Code**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

					|------- Adjustments -----|		
Provider Type / Provider Specialty	**Claims Processed**	**Claims Paid**	**Claims Denied**	**Claims Pending**	**Claims Paid**	**Claims Denied**	**Pending Billed Amt**
01 Hospital	600	0	7	592	1	0	$1,992,399
02 Ambulatory Surgical Center (ASC)	16	6	0	10	0	0	$945
08 Clinic	46	0	5	40	1	0	$3,349
09 Advance Practice Nurse	63	30	0	33	0	0	$1,250
19 Optician	45	9	18	18	0	0	$5,292
24 Pharmacy	317	89	74	149	5	0	$13,078
25 DME/Medical Supply Dealer	18	12	0	6	0	0	$180
27 Dentist	229	21	31	177	0	0	$10,060
31 Physician	1,525	94	81	1,350	0	0	$504,773
Totals:	**2,859**	**261**	**216**	**2,375**	**7**	**0**	**$2,531,326**

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6.14.9 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Adjustments - Claims Denied	Count of denied adjustment claims.	8	Number (Integer)
Adjustments - Claims Paid	Count of paid adjustment claims.	8	Number (Integer)
Claims Denied	Count of denied claims.	8	Number (Integer)
Claims Paid	Count of paid claims.	8	Number (Integer)
Claims Pending	Count of pending claims.	8	Number (Integer)
Claims Processed	Count of claims processed - paid and denied original and adjustment claims, and pending claims. Non-claim financial transactions are not included.	8	Number (Integer)
Pending Billed Amount	Billed amount for pending claims.	15	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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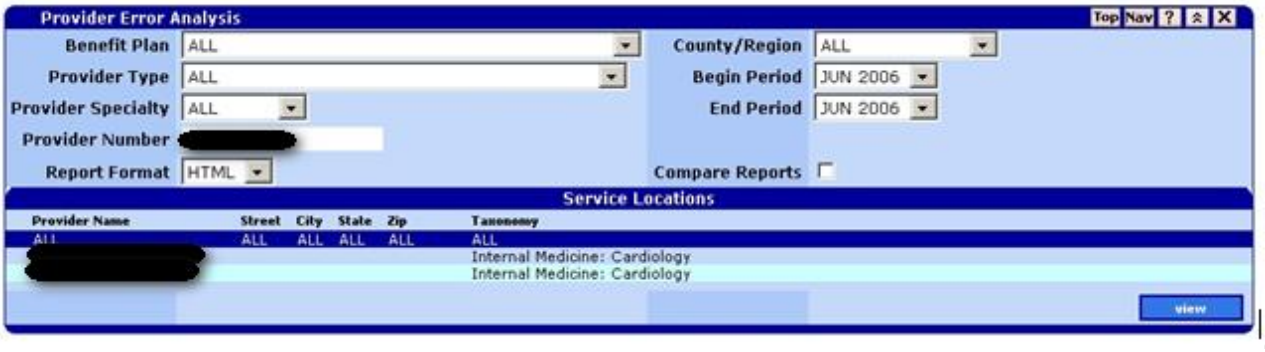
6.15 PROVIDER ERROR ANALYSIS PANEL OVERVIEW

6.15.1 Provider Error Analysis Panel Narrative

The Provider Error Analysis panel allows the user to generate a report that displays statistical data about errors and claims payment percentages in order to highlight the overall provider understanding of billing procedures and program policies. Results are given by individual provider and provider peer group total.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Provider Error Analysis]

6.15.2 Provider Error Analysis Panel Layout



6.15.3 Provider Error Analysis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	This field allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	This field allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the provider on this service location.	Field	Character	30
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	This field allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Name	Name of the provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
View	Allows the user to view the Provider Error Analysis report.	Button	N/A	0
Zip	Zip Code for the provider on this service location.	Field	Character	5

6.15.4 Provider Error Analysis Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	Change Begin Period to be within 12 months of End Period.	End Period must be no longer than 1 year after the Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	Change End Period to be within 12 months of Begin Period.	End Period must be no longer than 1 year after the Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Provider Number	Field	2	The Provider Number entered is invalid or not on file.	Enter a valid provider ID.

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6.15.5 Provider Error Analysis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Provider Error Analysis Panel Accessibility

6.15.6.1 To Access and View Provider Error Analysis Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Provider Error Analysis** hyperlink on the Operations page.	Provider Error Analysis panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Error Analysis report displays.

6.15.7 Provider Error Analysis Report (MAR.ProviderError.rdl) Narrative

The Provider Error Analysis report displays statistical data about errors and claims payment percentages in order to highlight the overall provider understanding of billing procedures and program policies. Results are given by individual provider and provider peer group total. Selection criteria for this window are: benefit plan, region/county, provider type, provider specialty, provider number and report period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.15.8 Provider Error Analysis Report (MAR.ProviderError.rdl) Report Layout

9/26/2006 13:43

State of Alabama

Provider Error Analysis

Fee For Service

Report Criteria

Benefit Plan	ALL	County/Region	ALL
Provider Type	ALL	Provider Number	[redacted]
Provider Specialty	ALL	Begin/End Period	OCT 2005 / AUG 2006

	Individual Provider	Provider Peer Group
Total Claims	465	10,505
Claims Paid	425	1,278
Claims Denied	40	9,227
Total Claims Corrected	465	10,527
Paid After Corrected	425	1,302
Pct Paid After Corrected	91.4%	12.4%
Pct Paid w/ No Error	0.0%	82.8%
Pct w/Error Override	0.0%	0.1%
Pct Denied	8.6%	87.8%
Avg Error per Adjud Claim	0.1	0.9

6.15.9 Provider Error Analysis Report (MAR.ProviderError.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg Error per Adjud Claim	Average number of errors per adjudicated claim for the selected provider group.	5	Number (Integer)
Claims Denied	Displays the number of claims for the selected provider/group finalized during the reporting period denied for payment.	10	Number (Integer)
Claims Paid	Displays the number of claims for the selected provider/group finalized during the reporting period that processed for payment.	10	Number (Integer)
Individual Provider	When a provider number is entered in the selection criteria, this column displays the data for that provider.	0	Character
Paid After Corrected	Displays the number of claims for the selected provider/group that required error correction to finalize for payment during the reporting period.	10	Number (Integer)
Pct Denied	Displays the number of paid claims for the selected provider/group that were denied as a percent of the total number of paid and denied claims finalized during the reporting period for the same provider/group.	6	Number (Decimal)
Pct Paid After Corrected	Displays the number of corrected claims as a percentage of the total paid claims finalized during the reporting period for the selected provider/group.	6	Number (Decimal)

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Field	Description	Length	Data Type
Pct Paid w/No Error	Displays the number of paid claims that did not require correction as a percentage of the total paid claims finalized during the reporting period for the selected provider/group.	6	Number (Decimal)
Pct w/Error Override	Displays the number of claims for the selected provider/group that were overridden as a percent of the total number of paid and denied claims finalized during the reporting period for the same provider/group.	6	Number (Decimal)
Provider Peer Group	Displays the data for all providers with claim data that matches the selection criteria. When a provider number is entered in the selection criteria, the data for that provider is included in this column as well as in the Individual Provider column.	0	Character
Total Claims	Displays the number of claims submitted by the selected provider/group finalized during the reporting period.	10	Number (Integer)
Total Claims Corrected	Displays a count of error corrections or adjudications to claims submitted by the provider/group and finalized during the reporting period.	10	Number (Integer)

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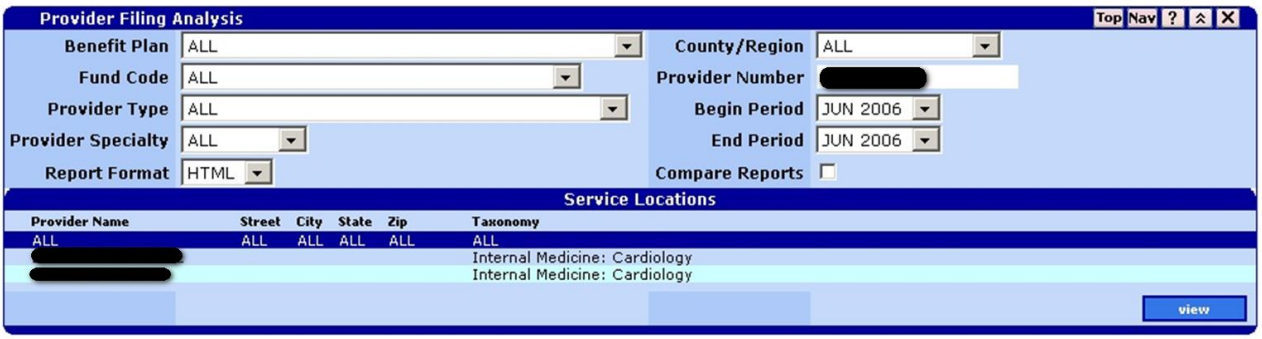
6.16 PROVIDER FILING ANALYSIS PANEL OVERVIEW

6.16.1 Provider Filing Analysis Panel Narrative

The Provider Filing Analysis panel allows the user to generate a report that provides statistical data about provider filing trends. Results are given by individual provider and provider peer group total.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Provider Filing Analysis]

6.16.2 Provider Filing Analysis Panel Layout



6.16.3 Provider Filing Analysis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the provider on this service location.	Field	Character	30
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Name	Name of the provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
View	Allows the user to view the Provider Filing Analysis report.	Button	N/A	0
Zip	Zip Code for the provider on this service location.	Field	Number (Integer)	5

6.16.4 Provider Filing Analysis Panel Field Edit Error Codes

Field Type	Field	Error Code	Error Message	To Correct
Combo Box	Begin Period	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
Combo Box		1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Combo Box	End Period	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
Combo Box		1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Field	Provider Number	2	The provider Number entered is invalid or not on file.	Enter a valid provider ID.

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6.16.5 Provider Filing Analysis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 Provider Filing Analysis Panel Accessibility

6.16.6.1 To Access and View Provider Filing Analysis Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Provider Filing Analysis** hyperlink on the Operations page.	Provider Filing Analysis panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Filing Analysis report displays.

6.16.7 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Narrative

The Provider Filing Analysis report provides statistical data about provider filing trends. Results are given by individual provider and provider peer group total. Selection criteria for this report are: benefit plan, region/county, provider type, provider specialty, provider number and reporting period date range.

Extra Feature: If a provider number is entered in the provider number field, the individual provider column displays for that provider the search results that meet the user's selections.

This report is designed to consistently display fee-for-service or encounter information.

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6.16.8 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Layout

10/11/2006 14:11

State of Alabama
Provider Filing Analysis
Fee For Service

Report Criteria			
Benefit Plan	ALL	County/Region	ALL
Fund Code	ALL	Provider Number	[redacted]
Provider Type	ALL		
Provider Specialty	ALL	Begin/End Period	AUG 2006 / AUG 2006

	Individual Provider	Provider Peer Group
Avg DOS to DOR	57	150
Avg DOR to DOP	2	2
Avg DOS to DOP	59	152

DOS to DOR	Number of Claims	Percent of Total	Number of Claims	Percent of Total
1 - 7 Days	0	0.0%	13	2.2%
8 - 14 Days	3	13.0%	25	4.2%
15 - 30 Days	0	0.0%	76	12.7%
31 - 60 Days	13	56.5%	111	18.5%
61 - 90 Days	0	0.0%	85	14.2%
> 90 Days	7	30.4%	290	48.3%
Total Claims	**23**	**100.0%**	**600**	**100.0%**

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6.16.9 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg DOR to DOP	Average number of days from date of receipt to date of payment for the provider/group.	6	Number (Integer)
Avg DOS to DOP	Average number of days from date of service to date of payment for the provider/group.	6	Number (Integer)
Avg DOS to DOR	Average number of days from date of service to date of receipt for the provider/group.	6	Number (Integer)
Individual Provider	When a provider number is entered in the selection criteria, this column displays the data for that provider.	0	Character
Number of Claims - 1-7 Days	Displays the number of claims received from the provider/group within seven days from the date of service.	10	Number (Integer)
Number of Claims - 8-14 Days	Displays the number of claims received from the provider/group between eight and 14 days from the date of service.	10	Number (Integer)
Number of Claims - 15-30 Days	Displays the number of claims received from the provider/group between 15 and 30 days from the date of service.	10	Number (Integer)
Number of Claims - 31-60 Days	Displays the number of claims received from the provider/group between 31 and 60 days from the date of service.	10	Number (Integer)
Number of Claims - 61-90 Days	Displays the number of claims received from the provider/group between 61 and 90 days from the date of service.	10	Number (Integer)
Number of Claims - >90 Days	Displays the number of claims received from the provider/group more than 90 days from the date of service.	10	Number (Integer)
Number of Claims - Total Claims	Displays the total number of claims received from the provider/group in the reporting period.	10	Number (Integer)
Percent of Total - 1-7 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received within seven days from the date of service.	6	Number (Decimal)
Percent of Total - 8-14 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received between 8 and 14 days from the date of service.	6	Number (Decimal)
Percent of Total - 15-30 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received between 15 and 30 days from the date of service.	6	Number (Decimal)
Percent of Total - 31-60 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received between 31 and 60 days from the date of service.	6	Number (Decimal)

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Field	Description	Length	Data Type
Percent of Total - 61-90 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received between 61 and 90 days from the date of service.	6	Number (Decimal)
Percent of Total - >90 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received more than 90 days from the date of service.	6	Number (Decimal)
Percent of Total - Total Claims	Displays the total number of claims as a percent of the total number of received claims from the provider/group during the reporting period.	6	Number (Decimal)
Provider Peer Group	Displays the data for all providers with claim data that matches the selection criteria. When a provider number is entered in the selection criteria, the data for that provider is included in this column as well as in the Individual Provider column.	0	Character

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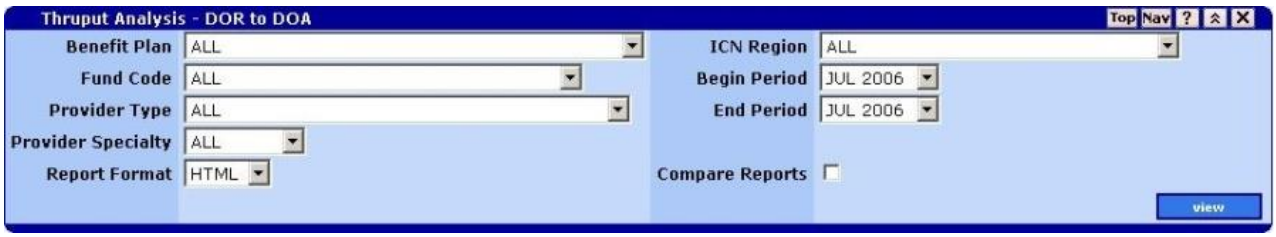
6.17 THRUPUT ANALYSIS - DOR TO DOA PANEL OVERVIEW

6.17.1 Thruput Analysis - DOR to DOA Panel Narrative

The Thruput Analysis – DOR (Date of Receipt) to DOA (Date of Adjudication) Search panel allows the user to generate a report that displays the percentage of claims paid based on the length of time between receipt of a claim to adjudication. The percentages are reported in seven categories to provide the user with a summary of timeliness on claims adjudication. The data results are grouped by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Thruput Analysis - DOR to DOA]

6.17.2 Thruput Analysis - DOR to DOA Panel Layout



6.17.3 Thruput Analysis - DOR to DOA Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
ICN Region	Allows the user to select a specific claim Internal Control Number (ICN) region code to limit data returned on this report. The ICN region code is the first two characters of the claim ICN.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Thruput Analysis - DOR to DOA report.	Button	N/A	0

6.17.4 Thruput Analysis - DOR to DOA Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.17.5 Thruput Analysis - DOR to DOA Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.17.6 Thruput Analysis - DOR to DOA Page Accessibility

6.17.6.1 To Access and View Thruput Analysis DOR to DOA Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Thruput Analysis DOR to DOA** hyperlink on the Operations page.	Thruput Analysis DOR to DOA panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Thruput Analysis DOR to DOA report displays.

6.17.7 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Narrative

The Claims Processing Throughput Analysis report displays the percentage of claims paid based on the length of time between receipt of a claim to adjudication. The percentages are reported in seven categories to provide the user with a summary of timeliness on claims adjudication. The data results are grouped by provider type and specialty. Selection criteria for this report includes: benefit plan, fund code, claim type, provider type, provider specialty, ICN region code and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.17.8 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Layout

8/15/2006 11:31

State of Alabama

Claims Processing Throughput Analysis - DOR to DOA

Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
Provider Type	ALL	**ICN Region Code**	ALL
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

Provider Type / Provider Specialty	Total Claims	2 Days	4 Days	7 Days	14 Days	21 Days	30 Days	60 Days	Over 60 Days	Avg Days to Adjud
## Unknown	83	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
01 Hospital	123	99.2%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	1.2
02 Ambulatory Surgical Center (ASC)	7	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
03 Extended Care Facility	8	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
05 Home Health Agency	7	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
08 Clinic	16	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
09 Advance Practice Nurse	45	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
19 Optician	27	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
24 Pharmacy	177	99.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	7.4
25 DME/Medical Supply Dealer	14	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
27 Dentist	2	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
31 Physician	229	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
Totals:	**738**	**99.7%**	**0.0%**	**0.0%**	**0.0%**	**0.1%**	**0.0%**	**0.0%**	**0.1%**	**2.6**

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6.17.9 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Field Descriptions

Field	Description	Length	Data Type
2 Days	Percent of total claims for the provider type and provider specialty that were adjudicated within two days of being received.	6	Number (Decimal)
4 Days	Percent of total claims for the provider type and provider specialty that were adjudicated within four days of being received.	6	Number (Decimal)
7 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in five to seven days of being received.	6	Number (Decimal)
14 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in eight to 14 days of being received.	6	Number (Decimal)
21 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in 15 to 21 days of being received.	6	Number (Decimal)
30 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in 22 to 30 days of being received.	6	Number (Decimal)
60 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in 31 to 60 days of being received.	6	Number (Decimal)
Avg Days to Adjud	Average number of days from being received to adjudication for the provider type and provider specialty. This average reflects the criteria selected by the user.	6	Number (Decimal)
Over 60 Days	Percent of total claims for the provider type and provider specialty that were adjudicated over 60 days of being received.	6	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Total Claims	Total number of claims that have been adjudicated for the provider type and provider specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Totals	Totals for the corresponding columns. For the percentage columns, the values are calculated for the total claims displayed.	10	Number (Integer & Decimal)

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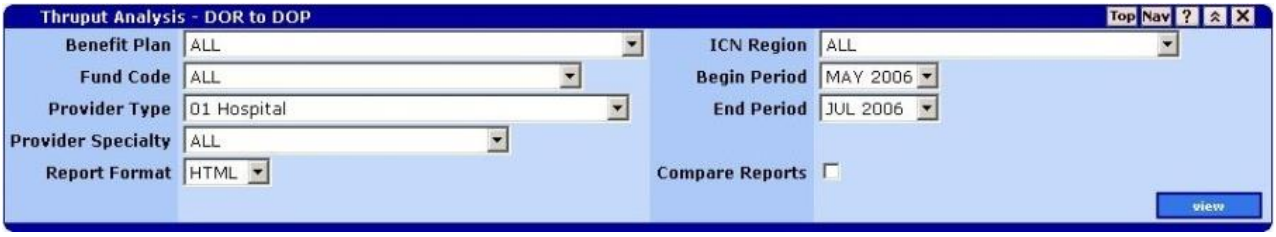
6.18 THRUPUT ANALYSIS - DOR TO DOP PANEL OVERVIEW

6.18.1 Thruput Analysis - DOR to DOP Panel Narrative

The Thruput Analysis – DOR (Date of Receipt) to DOP (Date of Payment) Search panel allows the user to generate a report that displays the percentage of claims paid based on the length of time between claim receipt date to claim payment date. The percentages are reported in seven categories to provide the user with a summary of timeliness on claims payment. The data results are grouped by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Thruput Analysis - DOR to DOP]

6.18.2 Thruput Analysis - DOR to DOP Panel Layout



6.18.3 Thruput Analysis - DOR to DOP Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
ICN Region	Allows the user to select a specific claim Internal Control Number (ICN) region code to limit data returned on this report. The ICN region code is the first two characters of the claim ICN.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Thruput Analysis - DOR to DOP report.	Button	N/A	0

6.18.4 Thruput Analysis - DOR to DOP Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.18.5 Thruput Analysis - DOR to DOP Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.18.6 Thruput Analysis - DOR to DOP Panel Accessibility

6.18.6.1 To Access and View Thruput Analysis DOR to DOP Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Thruput Analysis DOR to DOP** hyperlink on the Operations age.	Thruput Analysis DOR to DOP panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Thruput Analysis DOR to DOP report displays.

6.18.7 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Narrative

The Claims Processing Throughput Analysis – DOR to DOP report displays the percentage of claims paid based on the length of time between claim receipt date to claim payment date. The percentages are reported in seven categories to provide the user with a summary of timeliness on claims payment. The data results are grouped by provider type and specialty. Selection criteria for this report includes: benefit plan, fund code, claim type, provider type, provider specialty, ICN region code and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.18.8 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Layout

8/15/2006 12:33

State of Alabama

Claims Processing Throughput Analysis - DOR to DOP

Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
Provider Type	01 Hospital	**ICN Region Code**	ALL
Provider Specialty	ALL	**Begin/End Period**	MAY 2006 / JUL 2006

Provider Type / Provider Specialty	Total Claims	7 Days	14 Days	21 Days	30 Days	60 Days	90 Days	Over 90 Days	Avg Days to Paid
01 Hospital 010 Acute Care	595	35.6%	8.7%	2.2%	3.9%	37.8%	7.4%	4.4%	33.0
01 Hospital 011 Psychiatric	17	47.1%	0.0%	5.9%	5.9%	0.0%	0.0%	41.2%	96.1
01 Hospital 012 Rehabilitation	7	57.1%	14.3%	14.3%	0.0%	0.0%	0.0%	14.3%	53.0
01 Hospital 015 Childrens Specialty	1	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
01 Hospital 016 Emergency	386	39.9%	10.4%	4.4%	6.0%	33.4%	6.0%	0.0%	24.9
Totals:	**1,006**	**37.7%**	**9.2%**	**3.2%**	**4.7%**	**35.2%**	**6.7%**	**3.4%**	**31.1**

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6.18.9 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Field Descriptions

Field	Description	Length	Data Type
7 Days	This is the percent of total claims for the provider type and provider specialty that were paid within seven days of being received.	6	Number (Decimal)
14 Days	This is the percent of total claims for the provider type and provider specialty that were paid in eight to 14 days of being received.	6	Number (Decimal)
21 Days	This is the percent of total claims for the provider type and provider specialty that were paid in 15 to 21 days of being received.	6	Number (Decimal)
30 Days	This is the percent of total claims for the provider type and provider specialty that were paid in 22 to 30 days of being received.	6	Number (Decimal)
60 Days	This is the percent of total claims for the provider type and provider specialty that were paid in 31 to 60 days of being received.	6	Number (Decimal)
90 Days	This is the percent of total claims for the provider type and provider specialty that were paid in 61 to 90 days of being received.	6	Number (Decimal)
Avg Days to Paid	This is the average number of days from being received to paid for the provider type and provider specialty. This average reflects the criteria selected by the user.	6	Number (Decimal)
Over 90 Days	This is the percent of total claims for the provider type and provider specialty that were paid over 90 days after being received.	6	Number (Decimal)
Provider Type / Provider Specialty	This field displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Total Claims	This is the total number of claims that have been paid for the provider type and provider specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Totals	These are the totals for the corresponding columns. For the percentage columns, the values are calculated for the total claims displayed.	10	Number (Integer & Decimal)

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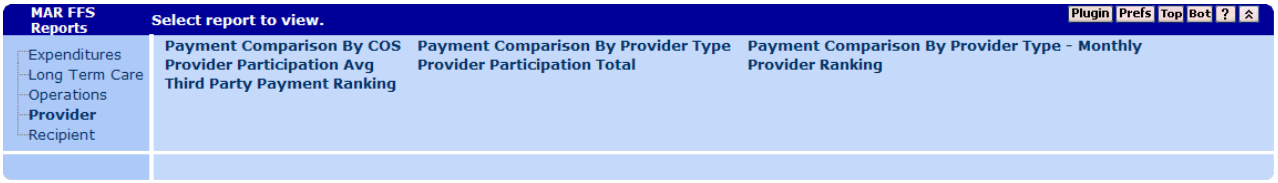
6.19 MAR REPORTS - PROVIDER PAGE OVERVIEW

6.19.1 MAR Reports - Provider Page Narrative

The MAR Reports – Provider page is the access point within the MAR system that allows users to view reports that fall under the category of Provider.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider]

6.19.2 MAR Reports - Provider Page Layout



6.19.3 MAR Reports - Provider Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Payment Comparison By COS	Link to Payment Comparison By COS panel.	Hyperlink	N/A	0
Payment Comparison By Provider Type	Link to Payment Comparison By Provider Type panel.	Hyperlink	N/A	0
Payment Comparison By Provider Type - Monthly	Link to Payment Comparison By Provider Type panel - Monthly.	Hyperlink	N/A	0
Provider Participation Avg	Link to Provider Participation Avg panel.	Hyperlink	N/A	0
Provider Participation Total	Link to Provider Participation Total panel.	Hyperlink	N/A	0
Provider Ranking	Link to Provider Ranking panel.	Hyperlink	N/A	0
Third Party Payment Ranking	Link to Third Party Payment Ranking panel.	Hyperlink	N/A	0

6.19.4 MAR Reports - Provider Page Field Edit Error Codes

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

6.19.5 MAR Reports - Provider Page Extra Features

Field	Field Type
No extra features found for this page.	

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6.19.6 MAR Reports - Provider Page Accessibility

6.19.6.1 To Access MAR Reports – Provider Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.

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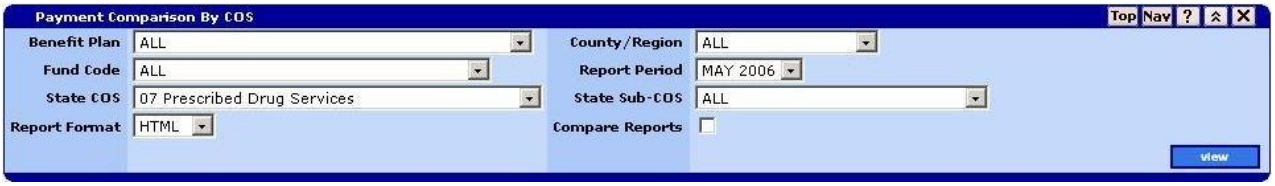
6.20 PAYMENT COMPARISON BY COS PANEL OVERVIEW

6.20.1 Payment Comparison By COS Panel Narrative

The Payment Comparison by COS panel allows the user to generate a report that displays a comparison of payments listed by State Category of Service (COS) and State-Sub COS. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Payment Comparison By COS]

6.20.2 Payment Comparison By COS Panel Layout



6.20.3 Payment Comparison By COS Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report displays in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Report Period	Period requested that the report Payment Comparison By COS will include.	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
View	Allows the user to view the Payment By Provider Type report.	Button	N/A	0

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6.20.4 Payment Comparison By COS Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.20.5 Payment Comparison By COS Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 Payment Comparison By COS Panel Accessibility

6.20.6.1 To Access and View Payment Comparison by Category of Service Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Payment Comparison by COS** hyperlink on the Provider page.	Payment Comparison by COS panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Payment Comparison by Category of Service report displays.

6.20.7 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Narrative

The Payment Statistics by COS report displays paid and denied claim statistics grouped by State category of service. It includes recipient, claim, billed and paid dollars as applicable for paid and denied claims. When the user selects the Unduplicated Recipients box, the number of unduplicated recipients is displayed for the listed category of service. The data results are grouped by the four character State COS. Selection criteria for this window includes: benefit plan, fund code, state category of service, state sub-category of service, aid category, claim type, transaction type and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.20.8 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Layout

9/8/2006 9:23

State of Alabama

Payment Statistics By State COS

Fee For Service

Report Criteria			
Benefit Plan	ALL	**Aid Category**	ALL
Fund Code	ALL	**Claim Type**	ALL
State COS	ALL	**Transaction Type**	ALL
State Sub-COS	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

		Paid			Denied	
State Category of Service	***Undup Recip**	**Claims**	**Units of Service**	**Paid Amount**	**Claims**	**Billed Amount**
01 Inpatient Services	0	0	0	$0	52	$493,000
02 Psychiatric Services	0	0	0	$0	20	$13,700
03 Outpatient Services	7	9	9	-$7	50	$40,251
06 Physician Services	29	65	0	$4,350	287	$39,677
07 Prescribed Drug Services	51	58	58	$3,037	176	$20,888
08 MSDG Services	8	15	7	$1,535	22	$829
10 Clinic Services	1	1	0	$47	11	$7,065
15 ICF-MR Services	2	2	33	$0	14	$40,794
29 Eyewear Services	2	4	0	$745	25	$9,250
30 Dental Services	11	24	22	$2,452	138	$19,669
42 Advanced Practice Nurse (APN) Services	27	37	0	$2,008	11	$870
99 Unknown Services by Record Type	1	-1	-1	-$17	2	$130
Totals:	**184**	**214**	**128**	**$14,150**	**808**	**$686,123**

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6.20.9 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Undup Recip	Count of unduplicated recipients for all finalized claims that meet the selected criteria.	8	Number (Integer)
Denied - Billed Amount	Amount billed for all denied claims for each State Category of Service. This total reflects the criteria selected by the user.	15	Number (Decimal)
Denied - Claims	Number of claims that have been denied for each State Category of Service. This total reflects the criteria selected by the user.	10	Number (Integer)
Paid - Claims	Number of claims that have been paid for each State Category of Service This total reflects the criteria selected by the user.	10	Number (Integer)
Paid - Paid Amount	Amount reimbursed for all paid claims for each State Category of Service. This total reflects the criteria selected by the user.	15	Number (Decimal)
Paid - Units of Service	Total units of service for paid claims for each State Category of Service. This total reflects the criteria selected by the user.	10	Number (Integer)
State Category of Service	Displays the combined high-level State category of service and detail-level State Sub-Category of Service value. The State category of service is a derived value assigned to each record reported in MAR.	50	Character
Totals	Totals for corresponding columns.	15	Number (Integer & Decimal)

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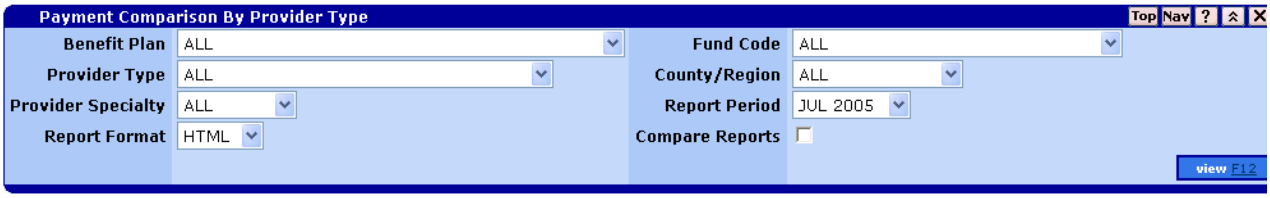
6.21 PAYMENT COMPARISON BY PROVIDER TYPE PANEL OVERVIEW

6.21.1 Payment Comparison By Provider Type Panel Narrative

The Payment Comparison By Provider Type panel allows the user to generate a report that displays a comparison of provider payments listed by provider type and specialty. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Payment Comparison By Provider Type]

6.21.2 Payment Comparison By Provider Type Panel Layout



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6.21.3 Payment Comparison By Provider Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Report Period	Period requested that the report Payment Comparison By Provider Type will include.	Combo Box	Drop Down List Box	0
View	View the Payment Comparison By Provider Type report.	Button	N/A	0

6.21.4 Payment Comparison By Provider Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.21.5 Payment Comparison By Provider Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 Payment Comparison By Provider Type Panel Accessibility

6.21.6.1 To Access and View Payment Comparison by Provider Type Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Payment Comparison by Provider Type** hyperlink on the Provider page.	Payment Comparison by Provider Type panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Payment Comparison by Provider Type report displays.

6.21.7 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Narrative

The Payment Comparison by Provider Type report displays a comparison of provider payments listed by provider type and specialty. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year. Selection criteria for this window are: benefit plan, fund code, region/county, provider type, provider specialty and reporting period.

This report is designed to consistently display fee-for-service or encounter information.

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6.21.8 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Layout

8/15/2006 16:18

State of Alabama

Payment Comparison By Provider Type

Fee For Service

Report Criteria			
Benefit Plan	ALL	**County/Region**	ALL
Provider Type	ALL	**Fund Code**	ALL
Provider Specialty	ALL	**Reporting Period**	JUN 2006

	|------- This Month ------|		|- Same Month Last Year -|		|---- SFYTD This Year ----|		|---- SFYTD Last Year ---|	
Provider Type / Specialty	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**
## Unknown	-4	$725	2	$9,076	-4	$725	4,623	$385,031
01 Hospital	8	$2	3	$3	130	$537	218	$526,622
02 Ambulatory Surgical Center (ASC)	0	$0	0	$0	0	$0	13	$858
03 Extended Care Facility	2	$0	0	$0	14	$0	28	$51,139
05 Home Health Agency	1	$18	0	$0	13	$172	28	$4,731
07 Capitation Provider	0	$0	2	$33	5	$20	71	$6,961
08 Clinic	2	$70	0	$0	28	$3,280	21	$698
09 Advance Practice Nurse	5	$232	0	$0	5	$232	2	$243
11 Mental Health Provider	0	$0	0	$0	0	$0	45	$7,604
15 Chiropractor	0	$0	0	$0	1	$20	17	$623
17 Therapist	0	$0	0	$0	0	$0	9	$255
18 Optometrist	0	$0	0	$0	1	$27	41	$3,616
19 Optician	1	$250	0	$0	1	$250	1	$31
21 Case Manager (Targeted)	-1	$398	0	$0	-1	$398	23	$822
24 Pharmacy	14	$234	0	$0	65	$3,359	204	$31,686
25 DME/Medical Supply Dealer	6	$610	0	$0	12	$1,015	30	$5,466
26 Transportation Provider	1	$2,953	0	$0	2	$3,343	36	$3,124
27 Dentist	1	$1,197	0	$0	485	$46,780	138	$15,351
28 Laboratory	0	$0	0	$0	2	$0	6	$190
30 End-Stage Renal Disease (RSD) Clinic	0	$0	0	$0	0	$0	0	$0
31 Physician	4	$6,569	0	$9,897	132	$12,885	658	$519,041
36 Personal Care Services	0	$0	0	$0	2	$679	27	$441
Totals:	**40**	**$13,258**	**7**	**$19,009**	**893**	**$73,722**	**6,239**	**$1,564,533**

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6.21.9 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Provider Type / Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
SFYTD Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the prior state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, through the prior state fiscal year reporting period for the month indicated.	15	Number (Decimal)
SFYTD This Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD This Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	15	Number (Decimal)
Same Month Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	10	Number (Integer)
Same Month Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	15	Number (Decimal)
This Month - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the selected reporting period.	10	Number (Integer)
This Month - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, claims during the month indicated.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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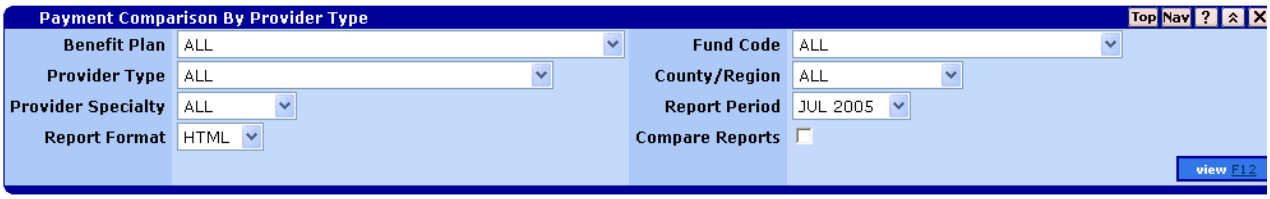
6.22 PAYMENT COMPARISON BY PROVIDER TYPE – MONTHLY PANEL OVERVIEW

6.22.1 Payment Comparison By Provider Type - Monthly Panel Narrative

The Payment Comparison By Provider Type - Monthly panel allows the user to generate a report that displays a comparison of provider payments listed by provider type and specialty. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Payment Comparison By Provider Type- Monthly]

6.22.2 Payment Comparison By Provider Type - Monthly Panel Layout



6.22.3 Payment Comparison By Provider Type - Monthly Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Report Period	Period requested that the report Payment Comparison By Provider Type - Monthly will include.	Combo Box	Drop Down List Box	0
View	View the Payment Comparison By Provider Type - Monthly report.	Button	N/A	0

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6.22.4 Payment Comparison By Provider Type - Monthly Panel Field Edit Error Codes

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

6.22.5 Payment Comparison By Provider Type - Monthly Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.22.6 Payment Comparison By Provider Type - Monthly Panel Accessibility

6.22.6.1 To Access and View Payment Comparison by Provider Type - Monthly Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Payment Comparison by Provider Type - Monthly** hyperlink on the Provider page.	Payment Comparison by Provider Type - Monthly panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Payment Comparison by Provider Type - Monthly report displays.

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6.22.7 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Narrative

The Payment Comparison by Provider Type - Monthly report displays a comparison of provider payments listed by provider type and specialty. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year. Selection criteria for this window are: benefit plan, fund code, region/county, provider type, provider specialty and reporting period.

This report is designed to consistently display fee-for-service or encounter information.

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6.22.8 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Layout

8/8/2013 10:23

State of Alabama

Payment Comparison By Provider Type - Monthly

Fee For Service

Report Criteria			
Benefit Plan	ALL	**County/Region**	ALL
Provider Type	ALL	**Fund Code**	ALL
Provider Specialty	ALL	**Reporting Period**	MAR 2005

	|------- This Month ------|		|- Same Month Last Year -|		|---- SFYTD This Year ----|		|---- SFYTD Last Year ---|	
Provider Type / Specialty	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**
	483	$239,805	0	$0	4,868	$681,206	0	$0
01 Hospital	0	$0	0	$0	0	$0	0	$0
03 Nursing Home/Hospital Swing Bed	28	$737	0	$0	30	$787	0	$0
05 Home Health Agency	6	$190	0	$0	6	$190	0	$0
Totals:	**517**	**$240,732**	**0**	**$0**	**4,904**	**$682,183**	**0**	**$0**

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6.22.9 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Provider Type / Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
SFYTD Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the prior state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, through the prior state fiscal year reporting period for the month indicated.	15	Number (Decimal)
SFYTD This Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD This Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	15	Number (Decimal)
Same Month Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	10	Number (Integer)
Same Month Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	15	Number (Decimal)
This Month - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the selected reporting period.	10	Number (Integer)
This Month - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, claims during the month indicated.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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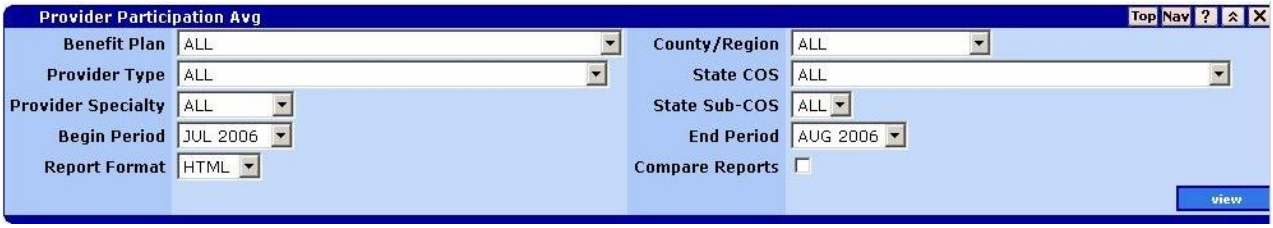
6.23 PROVIDER PARTICIPATION AVG PANEL OVERVIEW

6.23.1 Provider Participation Avg Panel Narrative

The Provider Participation Avg panel allows the user to generate a report that displays provider participation by averages of provider activity, including recipients, paid claims, denied claims, reimbursement, and billed amounts per participating provider. Participation is defined as claim or non-claim activity within the selection criteria. Detail lines are grouped by provider type and provider specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Provider Participation Avg]

6.23.2 Provider Participation Avg Panel Layout



6.23.3 Provider Participation Avg Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
View	Allows the user to view the Provider Participation Avg report.	Button	N/A	0

6.23.4 Provider Participation Avg Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.23.5 Provider Participation Avg Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.23.6 Provider Participation Avg Panel Accessibility

6.23.6.1 To Access and View Provider Participation Average Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Provider Participation Avg** hyperlink on the Provider page.	Provider Participation Avg panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Participation Average report displays.

6.23.7 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Narrative

The Provider Participation Average report provides analysis of provider participation by averages of provider activity, including recipients, paid claims, denied claims, reimbursement and billed amounts per participating provider. Participation is defined as claim or non-claim activity within the selection criteria. Detail lines are grouped by provider type and provider specialty. Selection criteria for this report are: benefit plan, fund code, region/county, provider type, provider specialty and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.23.8 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Layout

8/15/2006 16:27

State of Alabama
Provider Participation Average
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Provider Type	ALL	**State COS**	ALL
Provider Specialty	ALL	**State Sub-COS**	ALL
		Begin/End Period	JUL 2006 / AUG 2006

Provider Type / Provider Specialty	Recips per Provider	Paid Claims per Prov	Denied Claims per Prov	Paid per Provider	Paid per Recip	Billed per Paid Claim	Billed per Denied Claim
## Unknown	1	5	20	$3,893	$3,893	$779	$383
01 Hospital	1	1	8	$553	$684	$1,032	$3,615
02 Ambulatory Surgical Center (ASC)	3	4	0	$65	$26	$161	$0
03 Extended Care Facility	2	4	15	$0	$0	$2,946	$2,916
05 Home Health Agency	0	0	2	$0	$0	$2,000	$1,408
08 Clinic	1	1	2	$165	$331	$775	$590
09 Advance Practice Nurse	39	61	11	$9,929	$255	$263	$79
19 Optician	3	12	25	$2,183	$728	$257	$370
24 Pharmacy	6	7	17	$2,376	$381	$449	$131
25 DME/Medical Supply Dealer	7	19	2	$2,520	$360	$153	$30
27 Dentist	1	3	15	$847	$605	$527	$137
31 Physician	1	3	8	$611	$441	$352	$145
Totals:	**2**	**4**	**9**	**$939**	**$515**	**$447**	**$853**

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6.23.9 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Billed per Denied Claim	Displays an average of the dollars billed for denied claims per the quantity of the denied claims.	10	Number (Decimal)
Billed per Paid Claim	Displays an average of the dollars billed for paid claims per the quantity of the paid claims.	10	Number (Decimal)
Denied Claims per Prov	Displays an average of the number of denied claims per the number of participating providers.	8	Number (Integer)
Paid Claims per Prov	Displays an average of the number of paid claims per the number of participating providers.	8	Number (Integer)
Paid per Provider	Displays an average of the total reimbursement per participating provider.	10	Number (Decimal)
Paid per Recip	Displays an average of the total reimbursement per participating eligible.	10	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Recips per Provider	Displays an average of the number of participating eligibles per the number of participating providers for claims finalized for payment within the reporting period.	8	Number (Integer)
Totals	Totals for the corresponding columns.	10	Number (Integer & Decimal)

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6.24 PROVIDER PARTICIPATION TOTAL PANEL OVERVIEW

6.24.1 Provider Participation Total Panel Narrative

The Provider Participating Total panel allows the user to generate a report that displays totals of provider participation including number of providers enrolled, number of providers participating, percent participating, number unduplicated recipients, claims paid and denied and reimbursement amount. Participation is defined as claim or non-claim activity within the selection criteria.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Provider Participation Total]

6.24.2 Provider Participation Total Panel Layout

6.24.3 Provider Participation Total Panel Field Descriptions

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Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each aid category.	Combo Box	Check Box	0
View	View the Provider Participation Total report.	Button	N/A	0

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6.24.4 Provider Participation Total Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.24.5 Provider Participation Total Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 Provider Participation Total Panel Accessibility

6.24.6.1 To Access and View Provider Participation Total Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Provider Participation Total** hyperlink on the Provider page.	Provider Participation Total panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Participation Total report displays.

6.24.7 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Narrative

The Provider Participation Total report provides analysis of totals of provider participation including number of providers enrolled, number of providers participating, percent participating, number unduplicated recipients, claims paid and denied and reimbursement amount. Participation is defined as claim or non-claim activity within the selection criteria. When the user selects the Undup Recipients box, the average payment per participating recipient is displayed. Results are grouped by provider type and provider specialty. Selection criteria for this report are: benefit plan, fund code, county/region, provider type, provider specialty and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.24.8 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Layout

9/21/2006 9:21

State of Alabama
Provider Participation Total
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Provider Type	ALL	**State COS**	ALL
Provider Specialty	ALL	**State Sub-COS**	ALL
		Begin/End Period	JUL 2006 / JUL 2006

Provider Type / Provider Specialty	Providers Enrolled	Providers Prtcp	Pct Prov Prtcp	*Undup Recip	Claims Paid	Claims Denied	Paid Amount
## Unknown	0	1	0.0%	1	4	20	$2,004
01 Hospital	63	21	33.3%	17	26	103	$9,853
02 Ambulatory Surgical Center (ASC)	9	2	22.2%	5	7	0	$130
03 Extended Care Facility	36	1	2.8%	2	2	6	$0
05 Home Health Agency	36	3	8.3%	1	1	6	$0
08 Clinic	75	7	9.3%	3	3	14	$856
09 Advance Practice Nurse	11	1	9.1%	21	41	4	$6,636
19 Optician	3	1	33.3%	2	9	18	$1,688
24 Pharmacy	26	12	46.2%	72	89	88	$20,776
25 DME/Medical Supply Dealer	30	1	3.3%	6	12	2	$156
27 Dentist	34	9	26.5%	11	23	42	$8,387
31 Physician	443	37	8.4%	51	106	122	$19,597
Totals:	**787**	**96**	**12.2%**	**157**	**323**	**425**	**$70,083**

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6.24.9 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Undup Recip	Displays an unduplicated count of the number of participating eligibles that meet the criteria selected. This count only includes recipients from paid claims that finalized during the reporting period.	8	Number (Integer)
Claims Denied	Displays the number of submitted claims that meet the criteria selected that denied.	10	Number (Integer)
Claims Paid	Displays the number of submitted claims that meet the criteria selected that processed for payment.	10	Number (Integer)
Paid Amount	Displays the dollar amount paid for finalized claims.	15	Number (Decimal)
Pct Prov Prtcp	Displays the number of participating providers as a percentage of the total enrolled providers.	6	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Providers Enrolled	Displays the total number of providers enrolled that meet the criteria selected.	8	Number (Integer)
Providers Prtcp	Displays the number of enrolled providers with claims that processed to pay during the reporting period.	8	Number (Integer)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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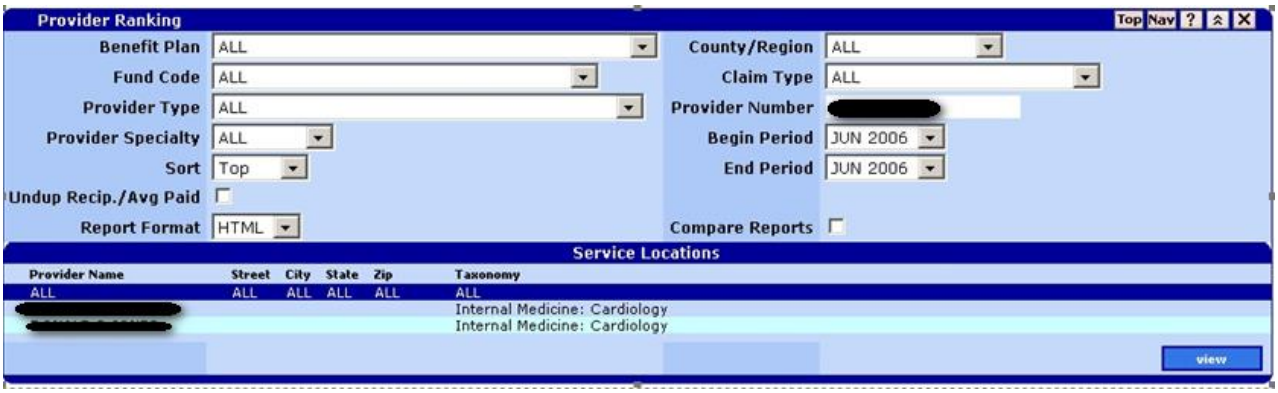
6.25 PROVIDER RANKING PANEL OVERVIEW

6.25.1 Provider Ranking Panel Narrative

The Provider Ranking panel allows the user to generate a report that displays provider performance ranking among selected groups of like providers. Results can be displayed as either the top 100 ranked providers or the bottom 100 ranked providers, via the Sort option. The providers are ranked by paid amount, paid claims and denied claims.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Provider Ranking]

6.25.2 Provider Ranking Panel Layout



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6.25.3 Provider Ranking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the Provider on this service location.	Field	Character	30
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Name	Name of the Provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Sort	Allows the user to select either to view the top 100 ranking list or bottom 100 ranking list.	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the Provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
Undup Recip./Avg Paid	This check box is used to request and display the average payment per recipient.	Combo Box	Check Box	0
View	Allows the user to view the Provider Ranking report.	Button	N/A	0
Zip	Zip Code for the Provider on this service location.	Field	Number (Integer)	5

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6.25.4 Provider Ranking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Provider Number	Field	0	The Provider Number entered is invalid or not on file.	Enter a valid provider ID.

6.25.5 Provider Ranking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 Provider Ranking Panel Accessibility

6.25.6.1 To Access and View Provider Ranking Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Provider Ranking** hyperlink on the Provider page.	Provider Ranking panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Ranking report displays.

6.25.7 Provider Ranking (MAR.ProviderRanking.rdl) Report Narrative

The Provider Ranking report displays provider performance ranking among selected groups of like providers. Results can be displayed as either the top 100 ranked providers or the bottom 100 ranked providers, via the Sort option. The providers are ranked by paid amount, paid claims and denied claims. When the user selects the Undup Recip/Avg Paid checkbox, the average payment per unique recipient is displayed. Selection criteria for this report are: benefit plan, fund code, claim type, region/county, provider type, provider specialty, provider number and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.25.8 Provider Ranking (MAR.ProviderRanking.rdl) Report Layout

9/26/2006 13:17

State of Alabama
Provider Ranking
Fee For Service

Report Criteria

Benefit Plan	ALL	**Provider Type**	24 Pharmacy
Fund Code	ALL	**Provider Specialty**	ALL
Claim Type	P PHARMACY CLAIMS	**Provider Number**	
County/Region	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

Provider Number	Provider Name	Claims Paid	Claims Denied	Paid Amount	Billed Amt Paid Claims	Billed Amt Denied Claims	Avg Paid	Pct Paid	Pct Billed	*Avg Paid per Recip	Rank
[redacted]	[redacted]	26	68	$16,929	$21,876	$6,939	$651	81.2%	68.6%		1
[redacted]	[redacted]	21	51	$1,773	$2,514	$9,284	$84	8.5%	7.9%		2
[redacted]	[redacted]	11	20	$668	$690	$1,270	$61	3.2%	2.2%		3
[redacted]	[redacted]	13	22	$649	$723	$829	$50	3.1%	2.3%		4
[redacted]	[redacted]	3	4	$294	$300	$400	$98	1.4%	0.9%		5
[redacted]	[redacted]	1	3	$249	$2,000	$5,500	$249	1.2%	6.3%		6
[redacted]	[redacted]	13	14	$157	$3,100	$1,650	$12	0.8%	9.7%		7
[redacted]	[redacted]	6	15	$135	$550	$1,450	$23	0.6%	1.7%		8
[redacted]	[redacted]	1	7	$4	$25	$175	$4	0.0%	0.1%		9
[redacted]	[redacted]	1	2	$2	$100	$200	$2	0.0%	0.3%		10
[redacted]	[redacted]	1	3	$0	$0	$21	$0	0.0%	0.0%		11
[redacted]	[redacted]	0	7	$0	$0	$350	$0	0.0%	0.0%		12
Totals:		**97**	**216**	**$20,860**	**$31,878**	**$28,068**	**$215**	**100.0%**	**100.0%**		

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6.25.9 Provider Ranking (MAR.ProviderRanking.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	When undup recip/avg paid checkbox is selected, this field displays an average dollar amount of the total payments made to the provider per the participating eligibles of that provider for claims finalized for payment during the reporting period.	10	Number (Decimal)
Avg Paid	Displays the average dollar amount reimbursed to the individual provider per total number of claims paid to the provider type and specialty.	10	Number (Decimal)
Billed Amt Denied Claims	Displays the total dollars billed for all denied claims during the reporting period.	15	Number (Decimal)
Billed Amt Paid Claims	Displays the total dollars billed for all claims finalized for payment to the provider during the reporting period.	15	Number (Decimal)
Claims Denied	Displays the number of claims submitted by the provider denied during the reporting period.	10	Number (Integer)
Claims Paid	Displays the number of claims submitted by the provider finalized for payment during the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollar amount reimbursed on claims finalized for the provider during the reporting period.	15	Number (Decimal)
Pct Billed	Displays this provider's billed amount for paid claims as a percentage of the total billed amount for paid claims for all providers meeting the selection criteria.	6	Number (Decimal)
Pct Paid	This field displays this provider's paid amount as a percentage of the total reimbursed amount for all providers meeting the selection criteria.	6	Number (Decimal)
Provider Name	This field displays the name of the provider.	40	Character
Provider Number	This field displays the numeric value assigned to identify each provider. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Rank	Displays the numeric ranking of total payments for a provider with the same type and specialty during the reporting period.	3	Number (Integer)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.26 THIRD PARTY PAYMENT RANKING PANEL OVERVIEW

6.26.1 Third Party Payment Ranking Panel Narrative

The Third Party Payment Ranking panel allows the user to generate a report that displays third party payment trends by provider. It displays claim counts, dollar amounts, related percentages, and rankings of the information in a selected provider grouping for paid claims with third party payment considerations. The top 100 providers, ranked by Third Party Liability (TPL) dollars, that fit the selection criteria, are displayed.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Third Party Payment Ranking]

6.26.2 Third Party Payment Ranking Panel Layout

6.26.3 Third Party Payment Ranking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Third Party Payment Ranking report.	Button	N/A	0

6.26.4 Third Party Payment Ranking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.26.5 Third Party Payment Ranking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.26.6 Third Party Payment Ranking Panel Accessibility

6.26.6.1 To Access and View Third Party Payment Ranking Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Third Party Payment Ranking** hyperlink on the Provider page.	Third Party Payment Ranking panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Third Party Payment Ranking report displays.

6.26.7 Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Narrative

This report analyzes third party payment trends by provider. It displays claim counts, dollar amounts, related percentages, and rankings of the information in a selected provider grouping for paid claims with third party payment considerations. The top 100 providers, ranked by TPL dollars, that fit the selection criteria, are displayed. Selection criteria for this report are: benefit plan, fund code, claim type, provider type, provider specialty and reporting period date range.

The Third Party Payment Report is designed to consistently display fee-for-service or encounter information.

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6.26.8 Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Layout

9/21/2006 9:29

State of Alabama

Third Party Payment Ranking

Fee For Service

Report Criteria

Benefit Plan	ALL	**Claim Type**	ALL
Fund Code	ALL	**County/Region**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	OCT 2005 / AUG 2006

Provider Number	Provider Name	Claims Paid	TPL Claims	TPL / Claim Pct	Total Billed	TPL Dollars	TPL Dollars / Billed Pct	Rank TPL / Paid
[redacted]	[redacted]	18	1	5.6%	$3,518	$90	2.6%	1
[redacted]	[redacted]	16	1	6.3%	$3,340	$70	2.1%	2
[redacted]	[redacted]	24	1	4.2%	$35,038	$22	0.1%	3
[redacted]	[redacted]	21	1	4.8%	$2,514	$15	0.6%	4
[redacted]	[redacted]	24	1	4.2%	$3,138	$10	0.3%	5
[redacted]	[redacted]	34	1	2.9%	$26,622	$1	0.0%	6
Totals:		**137**	**6**	**4.4%**	**$74,170**	**$208**	**0.3%**	

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Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Field DescriptionsField	Description	Length	Data Type
Claims Paid	Displays the number of claims submitted by the provider finalized for payment during the reporting period.	10	Number (Integer)
TPL Claims	Displays the number of paid claims with payment from a third party not including Medicare.	10	Number (Integer)
Provider Name	Displays the name of the provider matching the number listed in the Provider Number column of the data report.	40	Character
Provider Number	Displays the numeric value assigned to identify each provider. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Rank TPL/Paid	Displays the numeric ranking of the provider according to the amount of third party dollars per dollars billed for paid claims for the reporting period. Only the top 100 providers that fit the selection criteria are displayed.	3	Number (Integer)
TPL Dollars	Displays the dollar amount paid by a third party for claims paid to the provider during the reporting period.	15	Number (Decimal)
TPL Dollars/Billed Pct	Displays the dollar amount paid by a third party as a percentage of the total dollars billed for claims paid during the reporting period.	6	Number (Decimal)

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Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Field DescriptionsField	Description	Length	Data Type
TPL/Claim Pct	Displays the number of paid claims with third party dollars, as a percentage of the total number of claims paid to the provider during the reporting period.	6	Number (Integer)
Total Billed	Displays the total dollars billed by the provider for claims paid during the reporting period.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.27 MAR REPORTS - RECIPIENT PAGE OVERVIEW

6.27.1 MAR Reports - Recipient Page Narrative

The MAR Reports – Recipient page is the access point within the MAR system that allows users to view reports that fall under the category of Recipient.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient]

6.27.2 MAR Reports - Recipient Page Layout

6.27.3 MAR Reports - Recipient Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Medicare Participation Part A	Link to Medicare Participation Part A panel.	Hyperlink	N/A	0
Medicare Participation Part A B	Link to Medicare Participation Part A B.	Hyperlink	N/A	0
Medicare Participation Part B	Link to Medicare Participation Part B panel.	Hyperlink	N/A	0
Recipient Copay	Link to Recipient Copay panel.	Hyperlink	N/A	0
Recipient Participation By County	Link to Recipient Participation By County panel.	Hyperlink	N/A	0
Recipient Ranking	Link to Recipient Ranking panel.	Hyperlink	N/A	0

6.27.4 MAR Reports - Recipient Page Field Edit Error Codes

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

6.27.5 MAR Reports - Recipient Page Extra Features

Field	Field Type
No extra features found for this page.	

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6.27.6 MAR Reports - Recipient Page Accessibility

6.27.6.1 To Access MAR Reports - Recipient Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.

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6.28 MEDICARE PARTICIPATION PART A PANEL OVERVIEW

6.28.1 Medicare Participation Part A Panel Narrative

The Medicare Participation Part A panel allows the user to generate a report that displays number of Part A claims paid, Medicaid paid amount for Part A claims, Medicaid allowed for Part A claims, Medicare paid amount for Part A claims and the Medicaid paid amount as a percent of total Medicare and Medicaid payments. It also displays the number of Part A eligible, buy in premium, and the percent of buy in as compared to Medicare paid.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Medicare Participation Part A]

6.28.2 Medicare Participation Part A Panel Layout

6.28.3 Medicare Participation Part A Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Eligibles	This check box is used to request and display unduplicated eligible statistics for each aid category.	Combo Box	Check Box	0
View	Allows the user to view the Medicare Participation Part A report.	Button	N/A	0

6.28.4 Medicare Participation Part A Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.28.5 Medicare Participation Part A Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.28.6 Medicare Participation Part A Panel Accessibility

6.28.6.1 To Access and View Medicare Participation Part A Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Medicare Participation Part A** hyperlink on the Recipient page.	Medicare Participation Part A panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Medicare Participation Part A report displays.

6.28.7 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Narrative

The Medicare Participation Part A report displays number of Part A claims paid, Medicaid paid amount for Part A claims, Medicaid allowed for Part A claims, Medicare paid amount for Part A claims and the Medicaid paid amount as a percent of total Medicare and Medicaid payments. It also displays the number of Part A eligibles, buyin premium, and the percent of buyin as compared to Medicare paid. When the user selects the Eligibles box, the eligibles with Part A coverage, Part A buy-in premium amount, and Part A buy-in premium as a percent of the Medicare paid amount are displayed. Selection criteria for this window are: benefit plan, state category of service, state sub-category of service, aid category and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.28.8 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Layout

8/15/2006 16:45

State of Alabama
Medicare Participation Part A
Fee For Service

Report Criteria			
Benefit Plan	ALL	State COS	ALL
Fund Code	ALL	State Sub-COS	ALL
Aid Category	ALL	Begin/End Period	SEP 2005 / AUG 2006

Aid Category	*Eligibles	Claims Paid	Medicaid Allowed Amount	Medicaid Paid Amount	Medicare Paid Amount	Pct Paid of Total Paid	*Buyin Premium	*Pct Buyin of Medicare Paid
A Public Assistance, Aged	21	2	$32	$22	$0	100.0%	$1	0.0%
E Public Assistance, Blind	0	7	$90	$40	$0	100.0%	$0	0.0%
M Public Assistance, TANF	7	8	$102	$92	$0	100.0%	$0	0.0%
Totals:	**109**	**17**	**$225**	**$155**	**$0**	**100.0%**	**$9**	**0.0%**

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6.28.9 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Buyin Premium	Displays the paid amount by Medicaid toward Medicare Part A buy-in premiums during the reporting period.	15	Number (Decimal)
*Eligibles	Displays the current unduplicated number of eligibles who also qualify for Medicare Part A benefits.	8	Number (Integer)
*Pct Buyin of Medicare Paid	Displays the paid amount by Medicaid toward Medicare Part A buy-in premiums as a percentage of the Part A paid amount by Medicare during the reporting period. Formula = Medicare Buyin / Amount Paid by Medicare.	6	Number (Decimal)
Aid Category	Eligibility category for which a recipient is assigned.	50	Character
Claims Paid	Displays the number of claims with some portion of the total bill paid by Medicare Part A paid during the reporting period.	10	Number (Integer)
Medicaid Allowed Amount	Displays the allowed amount by Medicaid for Part A claims during the reporting period.	15	Number (Decimal)
Medicaid Paid Amount	Displays the paid amount by Medicaid for Part A claims during the reporting period.	15	Number (Decimal)
Medicare Paid Amount	Displays the paid amount by Medicare for Part A claims during the reporting period.	15	Number (Decimal)
Pct Paid of Total Paid	Displays the percent paid by Medicaid on Part A crossover claims as a percentage of the total Part A paid amount by both Medicaid and Medicare paid during the reporting period.	6	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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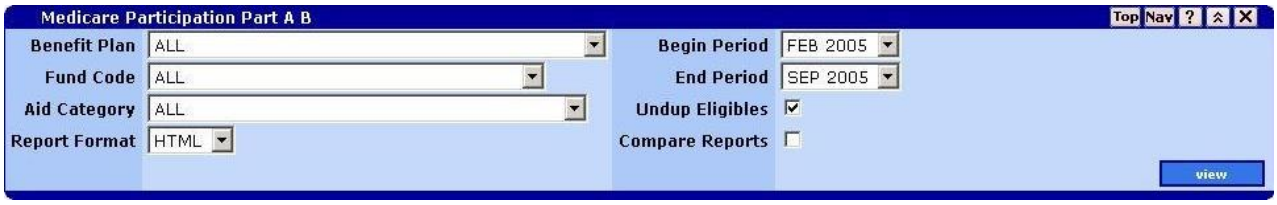
6.29 MEDICARE PARTICIPATION PART A B PANEL OVERVIEW

6.29.1 Medicare Participation Part A B Panel Narrative

The Medicare Participating Part A & B panel allows the user to generate a report that displays total Medicaid payment for Medicaid/Medicare eligible, total Medicaid/Medicare payment for Medicaid/Medicare eligible, total Medicaid payments as a percent of total Medicare and Medicaid payments as well as the total eligible with Part A and Part B.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Medicare Participation Part A B]

6.29.2 Medicare Participation Part A B Panel Layout



6.29.3 Medicare Participation Part A B Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Undup Eligibles	This check box is used to request and display unduplicated eligible statistics for each aid category.	Combo Box	Check Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the Medicare Participation Part A B report.	Button	N/A	0

6.29.4 Medicare Participation Part A B Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.29.5 Medicare Participation Part A B Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 Medicare Participation Part A B Panel Accessibility

6.29.6.1 To Access and View Medicare Participation Part A and B Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Medicare Participation Part A B** hyperlink on the Recipient page.	Medicare Participation Part A B panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Medicare Participation Part A and B report displays.

6.29.7

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6.29.8 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Narrative

The Medicare Participation Part A and B report displays total Medicaid payment for Medicaid/Medicare eligibles, total Medicaid/Medicare payment for Medicaid/Medicare eligibles, total Medicaid payments as a percent of total Medicare and Medicaid payments as well as the total eligibles with Part A and Part B. When the user selects the Options - Eligibles box, the total eligibles with Part A and B coverage is displayed. Selection criteria for this window are: benefit plan, aid category fund code and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.29.9 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Layout

8/15/2006 17:03

State of Alabama

Medicare Participation Part A and B

Fee For Service

Report Criteria			
Benefit Plan	ALL	Aid Category	ALL
Fund Code	ALL	Begin/End Period	FEB 2005 / SEP 2005

Total Eligibles with Part A and B	79
Total for Medicaid / Medicare Eligibles:	
Total Medicaid Paid	$9,794
Total Medicare Paid	$1,594
Total Medicare and Medicaid Paid	$11,389
Percent of Medicaid Payment	86.0%

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6.29.10 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Percent of Medicaid Payment	Displays the dollars paid by Medicaid on all crossover claims as a percentage of the total dollars reimbursed by both Medicaid and Medicare for claims paid during the reporting period.	6	Number (Decimal)
Total Eligibles with Part A and B	Displays the current number of eligibles who also qualify for Medicare Part A or B benefits.	8	Number (Integer)
Total Medicaid Paid	Displays the dollars paid by Medicaid for the claims with Medicare Part A or B payments.	15	Number (Decimal)
Total Medicare and Medicaid Paid	This field displays the sum of the Total Medicare Paid and Total Medicaid Paid fields. It represents the dollars paid by both Medicaid and Medicare for claims with Medicare Part A or B payments.	15	Number (Decimal)
Total Medicare Paid	Displays the total dollars paid by Medicare for the claims with Medicare Part A or B payments	15	Number (Decimal)

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6.30 MEDICARE PARTICIPATION PART B PANEL OVERVIEW

6.30.1 Medicare Participation Part B Panel Narrative

The Medicare Participation Part B panel allows the user to generate a report that displays number of Part B claims paid, Medicaid paid amount for Part B claims, Medicaid allowed for Part B claims, Medicare paid amount for Part B claims, and the Medicaid paid amount as a percent of total Medicare and Medicaid payments. It also displays the number of Part B eligible, buy in premium, and the percent of buy in as compared to Medicare paid.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Medicare Participation Part B]

6.30.2 Medicare Participation Part B Panel Layout

6.30.3 Medicare Participation Part B Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Eligibles	This check box is used to request and display unduplicated eligible statistics for each aid category.	Combo Box	Check Box	0
View	Allows the user to view the Medicare Participation Part B report.	Button	N/A	0

6.30.4 Medicare Participation Part B Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.30.5 Medicare Participation Part B Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.30.6 Medicare Participation Part B Panel Accessibility

6.30.6.1 To Access and View Medicare Participation Part B Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Medicare Participation Part B** hyperlink on the Recipient page.	Medicare Participation Part B panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Medicare Participation Part B report displays.

6.30.7 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Narrative

The Medicare Participation Part B report displays number of Part B claims paid, Medicaid paid amount for Part B claims, Medicaid allowed for Part B claims, Medicare paid amount for Part B claims, and the Medicaid paid amount as a percent of total Medicare and Medicaid payments. It also displays the number of Part B eligibles, buyin premium, and the percent of buyin as compared to Medicare paid. When the user selects the Options - Eligibles box, the eligibles with Part B coverage, Part B buy-in premium amount, and Part B buy-in premium as a percent of the Medicare paid amount are displayed. Selection criteria for this window are: benefit plan, state category of service, state sub-category of service, aid category, fund code and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.30.8 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Layout

8/15/2006 17:16

State of Alabama

Medicare Participation Part B

Fee For Service

Report Criteria

Benefit Plan	ALL	**Aid Category**	ALL
State COS	ALL	**State Sub-COS**	ALL
Fund Code	ALL	**Begin/End Period**	FEB 2005 / OCT 2005

Aid Category	*Eligibles	Claims Paid	Medicaid Allowed Amount	Medicaid Paid Amount	Medicare Paid Amount	Pct Paid of Total Paid	*Buyin Premium	*Pct Buyin of Medicare Paid
## Unknown	0	1	$0	$0	$25	0.0%	$0	0.0%
A Public Assistance, Aged	19	8	$0	$40	$679	5.6%	$0	0.0%
C Medical Assistance, Categorica	2	1	$0	$0	$20	0.0%	$0	0.0%
I Public Assistance, Disabled	15	1	$0	$0	$200	0.0%	$0	0.0%
K Medical Assistance, Categorica	31	4	$0	$74	$270	21.5%	$0	0.0%
M Public Assistance, TANF	6	2	$0	$37	$50	42.5%	$0	0.0%
N Medical Assistance, Categorica	4	9	$0	$77	$350	17.9%	$0	0.0%
Totals:	**96**	**26**	**$0**	**$228**	**$1,594**	**12.5%**	**$0**	**0.0%**

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6.30.9 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Buyin Premium	Displays the paid amount by Medicaid toward Medicare Part B buy-in premiums during the reporting period.	15	Number (Decimal)
*Eligibles	Displays the current unduplicated number of eligibles who also qualify for Medicare Part B benefits.	8	Number (Integer)
*Pct Buyin of Medicare Paid	Displays the paid amount by Medicaid toward Medicare Part B buy-in premiums as a percentage of the Part B paid amount by Medicare during the reporting period. Formula = Medicare Buyin / Amount Paid by Medicare.	6	Number (Decimal)
Aid Category	Eligibility category for which a recipient is assigned.	50	Character
Claims Paid	Displays the number of claims with some portion of the total bill paid by Medicare Part B paid during the reporting period.	10	Number (Integer)
Medicaid Allowed Amount	Displays the allowed amount by Medicaid for Part B claims during the reporting period.	15	Number (Decimal)
Medicaid Paid Amount	Displays the paid amount by Medicaid for Part B claims during the reporting period.	15	Number (Decimal)
Medicare Paid Amount	Displays the paid amount by Medicare for Part B claims during the reporting period.	15	Number (Decimal)
Pct Paid of Total Paid	Displays the percent paid by Medicaid on Part B crossover claims as a percentage of the total Part B paid amount by both Medicaid and Medicare paid during the reporting period.	6	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.31 RECIPIENT COPAY PANEL OVERVIEW

6.31.1 Recipient Copay Panel Narrative

The Recipient Copay panel allows the user to generate a report that provides a method of tracking claim counts and expenditures saved as a result of copayment policies. It includes claims paid, total claims paid, percentage of claims with copay, copay deducted and claim amounts. Results are listed by aid category depending on user selection of the type of copayment.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Recipient Copay]

6.31.2 Recipient Copay Panel Layout

6.31.3 Recipient Copay Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
Co-payment Type	Allows the user to select a specific category of copayment claims to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the Recipient Copay report.	Button	N/A	0

6.31.4 Recipient Copay Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.31.5 Recipient Copay Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.31.6 Recipient Copay Panel Accessibility

6.31.6.1 To Access and View Recipient Copayment by Aid Category Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Recipient Copay** hyperlink on the Recipient page.	Recipient Copay panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Recipient Copayment by Aid Category report displays.

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6.31.7 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Narrative

The Recipient Copayment by Aid Category report provides a method of tracking claim counts and expenditures saved as a result of copayment policies. It includes claims paid, total claims paid, percentage of claims with copay, copay deducted and claim amounts. Results are listed by aid category depending on user selection of the type of copayment. Selection criteria for this report are: benefit plan, fund code, copayment type and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.31.8 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Layout

8/15/2006 16:35

State of Alabama

Recipient Copayment By Aid Category

Fee For Service

Report Criteria			
Benefit Plan	ALL	**Co-payment Type**	400 Prescribed Drug
Aid Category	ALL		
Fund Code	ALL	**Begin/End Period**	SEP 2005 / AUG 2006

Aid Category	Paid Claims with Copay	Total Claims Paid	Pct Claims Copay	Copay Deducted	Billed Amount	Allowed Amount	Paid Amount
A Public Assistance, Aged	12	14	85.7%	$12	$786	$762	$297
B Medical Assistance, Medic	1	1	100.0%	$1	$65	$19	$18
E Public Assistance, Blind	7	7	100.0%	$14	$715	$327	$290
G Medical Assistance, Categ	1	1	100.0%	$2	$100	$34	$32
I Public Assistance, Disabl	18	18	100.0%	$36	$1,104	$4,586	$988
I1 Institutionalized with in	1	1	100.0%	$2	$25	$0	$3
I2 Institutionalized with in	2	2	100.0%	$2	$476	$508	$463
I3 Institutionalized with in	2	2	100.0%	$4	$285	$277	$281
K Medical Assistance, Categ	8	36	22.2%	$8	$200	$30	$22
M Public Assistance, TANF	26	26	100.0%	$44	$3,907	$1,605	$1,098
N Medical Assistance, Categ	20	21	95.2%	$29	$2,975	$1,113	$873
Totals:	**98**	**129**	**76.0%**	**$154**	**$10,638**	**$9,261**	**$4,365**

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6.31.9 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Aid Category	Eligibility category for which a recipient is assigned.	50	Character
Allowed Amount	Allowed amount for the claims that had copayment collected.	15	Number (Decimal)
Billed Amount	Displays the billed amount for the claims that had copayment collected.	15	Number (Decimal)
Copay Deducted	Copayment amount deducted from the total allowed for claims finalized during the reporting period that met the criteria set for co-payment deduction.	15	Number (Decimal)
Paid Amount	Displays the paid amount for the claims that had copayment collected.	15	Number (Decimal)
Paid Claims with Copay	Displays the number of claims finalized during the reporting period with co-pay deducted from the total allowed amount.	10	Number (Integer)
Pct Claims Copay	Displays the percentage of the totals claims paid that had copayment collected.	6	Number (Decimal)
Total Claims Paid	Total number of claims finalized during the reporting period. This total includes claims with co-pay deducted and without co-pay deducted.	10	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.32 RECIPIENT PARTICIPATION BY COUNTY PANEL OVERVIEW

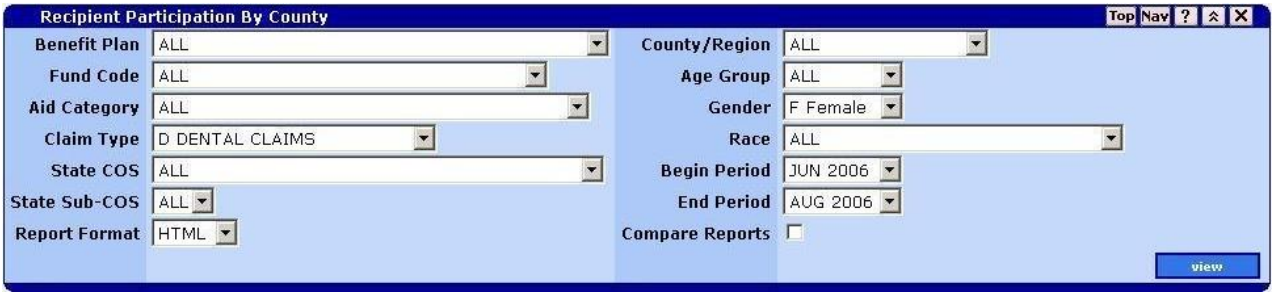
6.32.1 Recipient Participation By County Panel Narrative

The Recipient Participating by County panel allows the user to generate a report that displays recipient utilization grouped by county code and description. Selection criteria for this report includes: benefit plan, fund code, region/county, claim type, state category of service, state sub-category of service, aid category and reporting period date range.

The report is designed to consistently display fee-for-service or encounter information.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Recipient Participation By County]

6.32.2 Recipient Participation By County Panel Layout



6.32.3 Recipient Participation By County Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Group	Allows the user to select a specific recipient age grouping to limit the data returned on this report.	Combo Box	Drop Down List Box	0
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Gender	Allows the user to select a specific recipient gender to limit data returned on this report.	Combo Box	Drop Down List Box	0
Race	Allows the user to select a specific recipient race when returning data for this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
View	Allows the user to view the Recipient Participation By County report.	Button	N/A	0

6.32.4 Recipient Participation By County Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.32.5 Recipient Participation By County Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.32.6 Recipient Participation By County Panel Accessibility

6.32.6.1 To Access and View Recipient Participation by County Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Recipient Participation by County** hyperlink on the Recipient page.	Recipient Participation by County panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Recipient Participation by County report displays.

6.32.7 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Narrative

The Recipient Participation Summary by County report displays recipient utilization grouped by county code and description. Selection criteria for this report includes: benefit plan, fund code, region/county, claim type, state category of service, state sub-category of service, aid category and reporting period date range.

The report is designed to consistently display fee-for-service or encounter information.

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6.32.8 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Layout

8/15/2006 16:58

State of Alabama

Recipient Participation Summary By County

Fee For Service

Report Criteria			
Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Age Group**	ALL
Aid Category	ALL	**Gender**	F Female
Claim Type	D DENTAL CLAIMS	**Race**	ALL
State COS	ALL		
State Sub-COS	ALL	**Begin/End Period**	JUN 2006 / AUG 2006

County	Eligibles	Undup Recip	Pct of Elig Prtcp	Paid Amount	Avg Paid per Elig	Avg Paid Prtcp Recip
14 Cleveland	11	1	9.1%	$12	$1	$12
23 Ellis	3	1	33.3%	$26	$9	$26
26 Grady	15	1	6.7%	$1,322	$88	$1,322
45 McCurtain	22	1	4.5%	$3,000	$136	$3,000
55 Oklahoma	241	2	0.8%	$3,099	$13	$1,550
Totals:	**934**	**6**	**0.6%**	**$7,459**	**$8**	**$1,243**

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6.32.9 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg Paid Per Elig	Average of the dollars paid per eligible for claims adjudicated for payment during the reporting period.	10	Number (Decimal)
Avg Paid Prtcp Recip	Average of the dollars paid per recipient for claims adjudicated for payment during the reporting period.	10	Number (Decimal)
County	Displays the county description associated with the detail line totals. This county description is based on the recipient county code.	50	Character
Eligibles	Displays the total number of persons enrolled in the selected program and eligible to receive services during the reporting period.	8	Number (Integer)
Paid Amount	Displays the total dollar amount paid for claims finalized during the reporting period.	15	Number (Decimal)
Pct of Elig Recip	Displays the unduplicated count of recipients as a percent of the total number of beneficiaries during the reporting period.	6	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)
Undup Recip	Displays a unique count of recipients for claims finalized during the reporting period.	8	Number (Integer)

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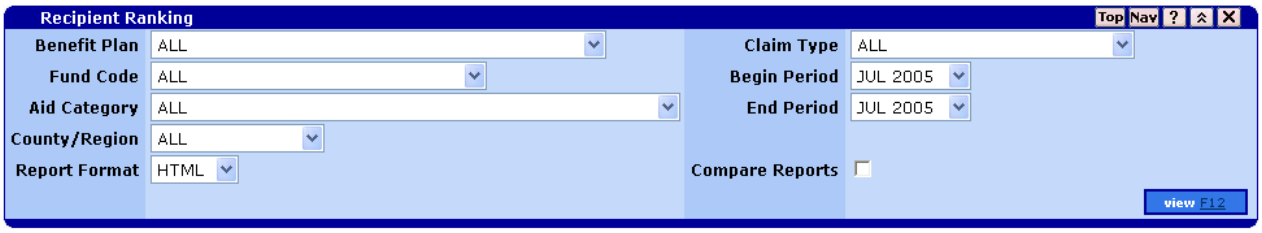
6.33 RECIPIENT RANKING PANEL OVERVIEW

6.33.1 Recipient Ranking Panel Narrative

The Recipient Ranking panel allows the user to generate a report that displays recipient usage ranking among selected groups of like recipients. The top 100 recipients, ranked by paid amount, paid claims and denied claims that fit the selection criteria, are displayed.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Recipient Ranking]

6.33.2 Recipient Ranking Panel Layout



6.33.3 Recipient Ranking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Recipient Ranking report.	Button	N/A	0

6.33.4 Recipient Ranking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.33.5 Recipient Ranking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.33.6 Recipient Ranking Panel Accessibility

6.33.6.1 To Access and View Recipient Ranking Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Recipient Ranking** hyperlink on the Recipient page.	Recipient Ranking panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Recipient Ranking report displays.

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6.33.7 Recipient Ranking (MAR.RecipientRanking.rdl) Report Narrative

The Recipient Ranking report displays recipient usage ranking among selected groups of like recipients. The top 100 recipients, ranked by paid amount, paid claims and denied claims that fit the selection criteria, are displayed. Selection criteria includes: benefit plan, region/county, claim type, aid category, fund code and reporting period date range.

Note: This report only displays the most recent rolling 6 months of data.

This report is designed to consistently display fee-for-service or encounter information.

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6.33.8 Recipient Ranking (MAR.RecipientRanking.rdl) Report Layout

8/15/2006 17:09

State of Alabama
Recipient Ranking
Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
Claim Type	D DENTAL CLAIMS	**County/Region**	ALL
Aid Category	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

RID	Claims Paid	Claims Denied	Paid Amount	Billed Amt Paid Claims	Billed Amt Denied Claims	Avg Paid	Percent Paid	Percent Billed	Rank
[redacted]	2	0	$3,099	$3,100	$0	$1,550	40.7%	26.1%	1
[redacted]	1	0	$3,000	$3,000	$0	$3,000	39.4%	25.3%	2
[redacted]	10	12	$1,322	$2,065	$683	$132	17.4%	17.4%	3
[redacted]	1	3	$100	$100	$195	$100	1.3%	0.8%	4
[redacted]	2	2	$26	$200	$200	$13	0.3%	1.7%	5
[redacted]	1	0	$26	$100	$0	$26	0.3%	0.8%	6
[redacted]	1	0	$26	$100	$0	$26	0.3%	0.8%	6
[redacted]	1	0	$12	$200	$0	$12	0.2%	1.7%	8
[redacted]	1	0	$2	$2	$0	$2	0.0%	0.0%	9
[redacted]	1	0	$0	$3,000	$0	$0	0.0%	25.3%	10
[redacted]	0	12	$0	$0	$1,200	$0	0.0%	0.0%	11
[redacted]	0	6	$0	$0	$996	$0	0.0%	0.0%	12
[redacted]	0	6	$0	$0	$996	$0	0.0%	0.0%	12
[redacted]	0	4	$0	$0	$260	$0	0.0%	0.0%	14
[redacted]	0	1	$0	$0	$65	$0	0.0%	0.0%	15
[redacted]	0	0	$0	$0	$0	$0	0.0%	0.0%	16
Totals:	**21**	**46**	**$7,613**	**$11,867**	**$4,595**	**$363**	**100.0%**	**100.0%**	

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6.33.9 Recipient Ranking (MAR.RecipientRanking.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg Paid	Displays the average dollar amount paid on behalf of the recipient per total number of paid claims.	10	Number (Decimal)
Billed Amt Denied Claims	Displays the total dollars billed for all denied claims during the reporting period.	15	Number (Decimal)
Billed Amt Paid Claims	Displays the total dollars billed for all claims finalized for payment on behalf of the recipient during the reporting period.	15	Number (Decimal)
Claims Denied	Displays the number of claims submitted on behalf of the recipient and denied during the reporting period.	10	Number (Integer)
Claims Paid	Displays the number of claims submitted on behalf of the recipient and finalized for payment during the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollar amount paid for claims finalized on behalf of the recipient during the reporting period.	15	Number (Decimal)
Percent Billed	Displays this recipient's billed amount for paid claims as a percentage of the total billed amount for paid claims for all recipients meeting the selection criteria.	6	Number (Decimal)
Percent Paid	Displays this recipient's paid amount as a percentage of the total paid amount for all recipients meeting the selection criteria.	6	Number (Decimal)
RID	Displays the recipient identification number (RID).	30	Number (Integer)
Rank	Displays the numeric ranking of total payments for the recipient during the reporting period.	3	Number (Integer)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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7 MAR REPORTS

The MAR User Manual provides the following information for each report:

- Narrative: Provides a brief description of the report functionality and usage.
- Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.
- Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 MAR-0111-M -- MAR MONTHLY RECONCILIATION REPORT

7.1.1 MAR-0111-M -- MAR Monthly Reconciliation Report Narrative

The MAR Monthly Reconciliation report compares input data from the Data Warehouse with numbers from various tables in the MAR summary database, to help verify the results of the MAR monthly summary process.

7.1.2 MAR-0111-M -- MAR Monthly Reconciliation Report Layout

```
Report  : MAR-0111-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : MARJM111                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   99:99:99
Location: MRM0111                              MAR MONTHLY RECONCILIATION                                  Page:        999
                                         DATE RANGE:  MM/DD/CCYY  -  MM/DD/CCYY

                         NUMBER OF     NUMBER OF      ---------------------------- DOLLARS ----------------------------
PAID CLAIMS                 CLAIMS    RECIPIENTS            BILLED           ALLOWED              PAID               TPL
--------------          -----------    ----------      ------------      ------------     ------------     ------------
DATA WAREHOUSE           99,999,999    99,999,999      $999,999,999      $999,999,999     $999,999,999     $999,999,999
MAR
   T_MR_PROV             99,999,999           N/A      $999,999,999      $999,999,999     $999,999,999     $999,999,999
   T_MR_RECIP            99,999,999           N/A      $999,999,999      $999,999,999     $999,999,999              N/A
   T_MR_RE_CNTY          99,999,999           N/A      $999,999,999      $999,999,999     $999,999,999              N/A
   T_MR_RE                      N/A     9,999,999               N/A               N/A              N/A              N/A
   T_MR_POS_RE                  N/A     9,999,999               N/A               N/A              N/A              N/A

DENIED CLAIMS
--------------
DATA WAREHOUSE           99,999,999           N/A      $999,999,999               N/A              N/A              N/A
MAR
   T_MR_PROV             99,999,999           N/A      $999,999,999               N/A              N/A              N/A
   T_MR_RECIP            99,999,999           N/A      $999,999,999               N/A              N/A              N/A

                         NUMBER OF     NUMBER OF        CAPITATION
CAPITATION PMTS           PAYMENTS    RECIPIENTS            AMOUNT
---------------         -----------    ----------      ------------
DATA WAREHOUSE           99,999,999    99,999,999      $999,999,999
MAR                      99,999,999    99,999,999      $999,999,999


                                                  *** END OF REPORT ***
```


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7.1.3 MAR-0111-M -- MAR Monthly Reconciliation Report Field Descriptions

Field	Description	Length	Data Type
Capitation Pmts - Capitation Amount - Data Warehouse	Total amount of capitation payments in the data warehouse.	12	Number (Decimal)
Capitation Pmts - Capitation Amount - Mar	Total amount of capitation payments in the T_MR_PROV table.	12	Number (Decimal)
Capitation Pmts - Number Of Payments - Data Warehouse	Number of capitation payments in the data warehouse.	10	Number (Decimal)
Capitation Pmts - Number Of Payments - Mar	Number of capitation payments in the T_MR_PROV table.	10	Number (Decimal)
Capitation Pmts - Number Of Recipients - Data Warehouse	Number of recipients on capitation payments in the data warehouse.	10	Number (Decimal)
Capitation Pmts - Number Of Recipients - MAR	Number of recipients on capitation payments in the T_MR_PROV_RE table.	10	Number (Decimal)
Denied Claims - Dollars Billed - Data Warehouse	Dollars billed on denied claims in the data warehouse.	12	Number (Decimal)
Denied Claims - Dollars Billed - T_Mr_Prov	Dollars billed on denied claims in the T_MR_PROV table.	12	Number (Decimal)
Denied Claims - Dollars Billed - T_Mr_Recip	Dollars billed on denied claims in the T_MR_PROV table.	12	Number (Decimal)
Denied Claims - Number Of Claims - Data Warehouse	Number of denied claims in the T_MR_PROV table.	10	Number (Decimal)
Denied Claims - Number Of Claims - T_MR_Prov	Number of denied claims in the T_MR_PROV table.	10	Number (Decimal)
Denied Claims - Number Of Claims - T_MR_Recip	Number of denied claims in the T_MR_RECIP table.	10	Number (Decimal)
Paid Claims - Dollars Allowed - Data Warehouse	Dollars allowed on paid claims in the data warehouse.	12	Number (Decimal)

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Field	Description	Length	Data Type
Paid Claims - Dollars Allowed - T_MR_Prov	Dollars allowed on paid claims in the T_MR_PROV table.	12	Number (Decimal)
Paid Claims - Dollars Allowed - T_MR_Recip	Dollars allowed on paid claims in the T_MR_RECIP table.	12	Number (Decimal)
Paid Claims - Dollars Allowed - T_MR_RE_Cnty	Dollars allowed on paid claims in the T_MR_RE_CNTY table.	12	Number (Decimal)
Paid Claims - Dollars Billed - Data Warehouse	Dollars billed on paid claims in the data warehouse.	12	Number (Decimal)
Paid Claims - Dollars Billed - T_MR_Prov	Dollars allowed on paid claims in the T_MR_PROV table.	12	Number (Decimal)
Paid Claims - Dollars Billed - T_MR_Recip	Dollars billed on paid claims in the T_MR_RE_CNTY table.	12	Number (Decimal)
Paid Claims - Dollars Billed - T_MR_RE_Cnty	Dollars billed on paid claims in the T_MR_RE_CNTY table.	12	Number (Decimal)
Paid Claims - Dollars Paid - Data Warehouse	Dollars paid on paid claims in the data warehouse.	12	Number (Decimal)
Paid Claims - Dollars Paid - T_MR_Prov	Dollars paid on paid claims in the T_MR_PROV table.	12	Number (Decimal)
Paid Claims - Dollars Paid - T_MR_Recip	Dollars paid on paid claims in the T_MR_RECIP table.	12	Number (Decimal)
Paid Claims - Dollars Paid - T_MR_RE_Cnty	Dollars paid on paid claims in the T_MR_RE_CNTY table.	12	Number (Decimal)
Paid Claims - Dollars TPL - Data Warehouse	Dollars paid on paid claims in the data warehouse.	12	Number (Decimal)
Paid Claims - Dollars TPL - T_MR_Prov	Dollars paid on paid claims in the T_MR_PROV table.	12	Number (Decimal)
Paid Claims - Number of Claims - Data Warehouse	Number of paid claims in the data warehouse.	10	Number (Decimal)
Paid Claims - Number of Claims - T_MR_Prov	Number of paid claims in the T_MR_PROV table.	10	Number (Decimal)

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Field	Description	Length	Data Type
Paid Claims - Number of Claims - T_MR_Recip	Number of paid claims in the T_MR_RECIP table.	10	Number (Decimal)
Paid Claims - Number of Claims - T_MR_RE_Cnty	Number of paid claims in the T_MR_RE_CNTY table.	10	Number (Decimal)
Paid Claims - Number of Recipients - Data Warehouse	Number of recipients on paid claims in the data warehouse.	10	Number (Decimal)
Paid Claims - Number of Recipients - T_Mr_POS_REe	Number of recipients on paid claims in the T_MR_POS_RE table.	9	Number (Decimal)
Paid Claims - Number Of Recipients - T_MR_RE	Number of recipients on paid claims in the T_MR_RE table.	9	Number (Decimal)

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7.2 MAR-0310-O – EXPENDITURE BY COS REPORT

7.2.1 MAR-0310-O – Expenditure By COS Report Narrative

This report displays paid claim data grouped by State category of service and aid category. It includes recipient, units and paid dollars as applicable for paid claims. When the reporting period is specified through table t_system_parms, the number of unduplicated recipients is displayed for the listed category of service, aid category combination during that period.

7.2.2 MAR-0310-O – Expenditure By COS Report Layout

```
Report  : MAR-0310-O                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MARJO310                   MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   HH:MM:SS
Location: MAR0310O                              EXPENDITURE BY COS                            Page:        999,999
                                        REPORTING PERIOD  MM/DD/CCYY  -  MM/DD/CCYY

COS     COS DESCRIPTION          AID    AID CAT DESCRIPTION                UNDUP        UNITS OF          PAID        AVG PAID
                                 CAT                                       RECIP         SERVICE        AMOUNT      PER RECIPS
01 UNKNOWN                       R3 Retro-full Medicaid with QMB Plus   99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
01 UNKNOWN                       M  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
02 UNKNOWN                       A  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
02 UNKNOWN                       N  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
06 UNKNOWN                       M  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
21 UNKNOWN                       N  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
44 UNKNOWN                       N  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
53 UNKNOWN                       M  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
99 UNKNOWN                       N  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
-- Total:                                                              99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999

                                                   *** END OF REPORT ***
```

7.2.3 MAR-0310-O – Expenditure By COS Report Field Descriptions

Field	Description	Length	Data Type
Aid Cat	Code identifying the type of aid for which a recipient is eligible.	2	Character
Aid Cat Description	Describes the type of aid for which a recipient is eligible.	50	Character
Avg Paid Per Recips	(The accumulation of the paid amounts for the paid claims for the reporting period)/ (Unique identification number for the recipient)	13	Number (Integer)
COS	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	2	Character

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Field	Description	Length	Data Type
COS Description	Description for the Category of Service value.	50	Character
Paid Amount	The accumulation of the paid amounts for the paid claims for the reporting period.	13	Number (Integer)
Undup Recip	Count of unduplicated rows of the recipient.	11	Number (Integer)
Units of Service	The accumulation of the units of service for the paid claims for the reporting period.	14	Number (Integer)

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7.3 MAR-0320-O – PARTICIPATION BY COS REPORT

7.3.1 MAR-0320-O – Participation By COS Report Narrative

This report displays recipient and claim counts and dollars for paid claims. When the date range is specified through the table t_system_parms, the number of recipients participating in the COS, total claims paid and average paid per recipient are displayed during that date range.

7.3.2 MAR-0320-O – Participation By COS Report Layout

```
Report  : MAR-0320-O                                ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : MARJO320                         MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MAR03200                                  PARTICIPATION BY COS                                     Page:        999,999
                                          REPORTING PERIOD  MM/DD/CCYY - MM/DD/CCYY

COS      COS DESCRIPTION                UNDUP    ELIG       CLAIMS           BILLED         ALLOWED            PAID       AVG PAID
                                        RECIP   PRTCP         PAID           AMOUNT          AMOUNT          AMOUNT     PER RECIPS
01 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
02 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
06 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
14 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
18 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
38 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
42 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
47 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
48 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
52 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
53 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
99 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
-- TOTAL:                           99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999

                                                   *** END OF REPORT ***
```

7.3.3 MAR-0320-O – Participation By COS Report Field Descriptions

Field	Description	Length	Data Type
Allowed Amount	The accumulation of the allowed amounts for the paid claims for the reporting period.	13	Number (Integer)
Avg Paid Per Recip	Round((T_MR_RE_CNTY.AMT_PAID / T_MR_RE.ID_MEDICAID),0)	13	Number (Integer)
Billed Amount	The accumulation of the billed amounts for the paid claims during the reporting period.	14	Number (Integer)

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Field	Description	Length	Data Type
Claims Paid	The total number of claims paid during the reporting period.	11	Number (Integer)
COS	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	2	Character
COS Description	Description for the Category of Service value.	50	Character
Elig Prtcp	Round(((T_MR_RE.ID_MEDICAID / T_MR_ELIG.ID_MEDICAID)*100),1)	5	Number (Decimal)
Paid Amount	The accumulation of the paid amounts for the paid claims for the reporting period.	13	Number (Integer)
Undup Recip	Count of unduplicated rows of the recipient.	11	Number (Integer)

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7.4 MAR-2100-M -- MONTHLY ABORTION DETAIL REPORT

7.4.1 MAR-2100-M -- Monthly Abortion Detail Report Narrative

The Monthly Abortion Detail report provides a monthly list of abortion services claims. For each claim, details such as recipient number, ICN, provider number, ICD version codes, procedure codes, diagnosis codes, claim type, fund code, date paid, and amount paid are reported. Information from this report supports the appropriate HCFA64.9 and MSIS data.

7.4.2 MAR-2100-M -- Monthly Abortion Detail Report Layout

```
Report  : MAR-2100-M                                    ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/CCYY
Process : MARJM100                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:
HH:MM:SS
Location: MRM2100                                     MONTHLY ABORTION DETAIL REPORT                                  Page:
999,999
                                                              PERIOD: MM/CCYY

RECIPIENT ID  ICN            PROVIDER         ICD PROCEDURE  ICD PRIMARY  ICD SECOND  CLM   FUND  POS   COS   SVC  AGE  SEX  SVC DT  PMT DT
AMT BILLED   AMT PAID
                            NUMBER              CODE MOD       DIAG         DIAG   TYPE  CODE              UNT

XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X  XXXXXX XX   X   XXXXXXX  X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX  X  XXXXXXX   X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX  X  XXXXXXX  X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99

PROFESSIONAL DOLLARS : $999,999,999.99
OUTPATIENT   DOLLARS : $999,999,999.99
INPATIENT    DOLLARS : $999,999,999.99
TOTAL        DOLLARS : $999,999,999.99

                                                      *** END OF REPORT ***
```

7.4.3 MAR-2100-M -- Monthly Abortion Detail Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the recipient on the date of service.	3	Number (Integer)
Amt Billed	Amount billed for this claim.	10	Number (Decimal)
Amt Paid	Amount paid for this claim.	10	Number (Decimal)
Clm Type	Claim type for this claim.	1	Character
COS (State)	State Category of Service for this claim. **XX**-XX	2	Character

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Field	Description	Length	Data Type
COS (Sub)	State Sub-COS for this claim. XX-**XX**	2	Character
Fund Code	Fund code assigned to this claim.	3	Character
ICD	The version code of an ICD procedure or diagnosis code. Valid values are '9' for an ICD 9 procedure or diagnosis code, and '0' for an ICD 10 procedure or diagnosis code. For HCPC procedure codes or claims that do not have secondary diagnosis codes, this field will be blank.	1	Character
ICN	Internal control number assigned to this claim.	13	Number (Integer)
Inpatient Dollars	Sum of amounts paid for inpatient claims (claim types A and I).	14	Number (Decimal)
Outpatient Dollars	Sum of amounts paid for outpatient claims (claim types C and O).	14	Number (Decimal)
Pmt Dt	Date this claim was paid.	6	Date (MM/DD/YY)
POS	Place of service code for this claim.	2	Character
Primary Diag	Primary diagnosis code for this claim.	7	Character
Procedure Code	Procedure code for this claim. In cases where a claim has multiple procedure codes, this is the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_PROC_PRIM. For all UB92 claim types, this data element is either T_CA_ICD9_PROC - CDE_PROC_ICD9 or T_CA_HDR_DTL - CDE_PROC.	6	Character
Procedure Mod	Procedure code modifier for this claim. In cases where a claim has multiple procedure codes, this is the modifier for the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_MODIFIER_1. For all UB92 claim types, this data element is T_CA_HDR_DTL - CDE_MODIFIER_1 if the procedure code is a HCPCS code. If the procedure code is an ICD9 code, the modifier is blank.	2	Character
Professional Dollars	Sum of amounts paid for professional claims (claim types B and M).	14	Number (Decimal)

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Field	Description	Length	Data Type
Provider Number	Provider number for this claim. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Recipient ID	Recipient identification number for this claim.	12	Character
Second Diag	Secondary diagnosis code for this claim.	7	Character
Sex	Sex (gender) of the recipient.	1	Character
SVC Dt	Date of first service for this claim.	6	Date (MM/DD/YY)
SVC Unt	Number of units of service provided for this claim.	3	Number (Integer)
Total Dollars	Sum of amounts paid for all claims.	14	Number (Decimal)

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7.5 MAR-2110-M -- MONTHLY STERILIZATION DETAIL REPORT

7.5.1 MAR-2110-M -- Monthly Sterilization Detail Report Narrative

The Monthly Sterilization Detail report provides a monthly list of sterilization services claims. For each claim, details such as recipient number, ICN, provider number, ICD version codes, procedure codes, diagnosis codes, claim type, fund code, date paid, and amount paid are reported. Information from this report supports the appropriate HCFA64.9 and MSIS data.

7.5.2 MAR-2110-M -- Monthly Sterilization Detail Report Layout

```
Report  : MAR-2110-M                                        ALABAMA MEDICAID AGENCY                                          Run Date:
MM/DD/CCYY
Process : MARJM100                                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:
HH:MM:SS
Location: MRM2100                                        MONTHLY STERILIZATION DETAIL REPORT                                    Page:
999,999
                                                                     PERIOD: MM/CCYY

RECIPIENT ID  ICN            PROVIDER       ICD PROCEDURE  ICD PRIMARY ICD  SECOND  CLM   FUND  POS   COS   SVC  AGE  SEX  SVC DT  PMT DT  AMT
BILLED   AMT PAID
                             NUMBER               CODE  MOD      DIAG         DIAG    TYPE  CODE              UNT
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX   X  XXXXXXX   X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX X   XXXXXX XX   X  XXXXXXX   X   XXXXXXXX    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX X   XXXXXX XX   X  XXXXXXX   X   XXXXXXXX    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99

PROFESSIONAL DOLLARS : $999,999,999.99
OUTPATIENT   DOLLARS : $999,999,999.99
INPATIENT    DOLLARS : $999,999,999.99
TOTAL        DOLLARS : $999,999,999.99

                                                          *** END OF REPORT ***
```

7.5.3 MAR-2110-M -- Monthly Sterilization Detail Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the recipient on the date of service.	3	Number (Integer)
Amt Billed	Amount billed for this claim.	10	Number (Decimal)
Amt Paid	Amount paid for this claim.	10	Number (Decimal)
Clm Type	Claim type for this claim.	1	Character
COS (State)	State Category Of Service for this claim. **XX**-XX	2	Character

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Field	Description	Length	Data Type
COS (Sub)	State Sub-COS for this claim. XX-**XX**	2	Character
Fund Code	Fund code assigned to this claim.	3	Character
ICD	The version code of an ICD procedure or diagnosis code. Valid values are '9' for an ICD 9 procedure or diagnosis code, and '0' for an ICD 10 procedure or diagnosis code. For HCPC procedure codes or claims that do not have secondary diagnosis codes, this field will be blank.	1	Character
ICN	Internal control number assigned to this claim.	13	Number (Integer)
Inpatient Dollars	Sum of amounts paid for inpatient claims (claim types A and I).	14	Number (Decimal)
Outpatient Dollars	Sum of amounts paid for outpatient claims (claim types C and O).	14	Number (Decimal)
Pmt Dt	Date this claim was paid.	6	Date (MM/DD/YY)
POS	Place of service code for this claim.	2	Character
Primary Diag	Primary diagnosis code for this claim.	7	Character
Procedure Code	Procedure code for this claim. In cases where a claim has multiple procedure codes, this is the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_PROC_PRIM. For all UB92 claim types, this data element is either T_CA_ICD9_PROC - CDE_PROC_ICD9 or T_CA_HDR_DTL - CDE_PROC.	6	Character
Procedure Mod	Procedure code modifier for this claim. In cases where a claim has multiple procedure codes, this is the modifier for the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_MODIFIER_1. For all UB92 claim types, this data element is T_CA_HDR_DTL - CDE_MODIFIER_1 if the procedure code is a HCPCS code. If the procedure code is an ICD9 code, the modifier is blank.	2	Character
Professional Dollars	Sum of amounts paid for professional claims (claim types B and M).	14	Number (Decimal)
Provider Number	Provider number for this claim. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric

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Field	Description	Length	Data Type
Recipient ID	Recipient identification number for this claim.	12	Character
Second Diag	Secondary diagnosis code for this claim.	7	Character
Sex	Sex (gender) of the recipient.	1	Character
Svc Dt	Date of first service for this claim.	6	Date (MM/DD/YY)
Svc Unt	Number of units of service provided for this claim.	3	Number (Integer)
Total Dollars	Sum of amounts paid for all claims.	14	Number (Decimal)

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7.6 MAR-2100-A -- ANNUAL ABORTION DETAIL REPORT

7.6.1 MAR-2100-A -- Annual Abortion Detail Report Narrative

The Annual Abortion Detail report provides an annual list of abortion services claims. For each claim, details such as recipient number, ICN, provider number, ICD version codes, procedure codes, diagnosis codes, claim type, fund code, date paid, ICD version codes, and amount paid are reported. Information from this report supports the appropriate HCFA64.9 and MSIS data.MAR-2100-A -- Annual Abortion Detail Report Layout

```
Report  : MAR-2100-A                                    ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/CCYY
Process : MARJM100                              MEDICAID MANAGEMENT INFORMATION SYSTEM                             Run Time:
HH:MM:SS
Location: MRA2100                                   ANNUAL ABORTION DETAIL REPORT                                    Page:
999,999
                                                            PERIOD: MM/CCYY

RECIPIENT ID  ICN            PROVIDER         ICD PROCEDURE  ICD PRIMARY  ICD SECOND  CLM   FUND  POS   COS   SVC  AGE  SEX  SVC DT  PMT DT
AMT BILLED   AMT PAID
                           NUMBER              CODE MOD       DIAG         DIAG   TYPE  CODE              UNT

XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X  XXXXXX XX   X   XXXXXXX  X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX  X  XXXXXXX   X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX  X  XXXXXXX  X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99

PROFESSIONAL DOLLARS : $999,999,999.99
OUTPATIENT   DOLLARS : $999,999,999.99
INPATIENT    DOLLARS : $999,999,999.99
TOTAL        DOLLARS : $999,999,999.99

                                                        *** END OF REPORT ***
```


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7.6.2 MAR-2100-A -- Annual Abortion Detail Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the recipient on the date of service.	3	Number (Integer)
Amt Billed	Amount billed for this claim.	10	Number (Decimal)
Amt Paid	Amount paid for this claim.	10	Number (Decimal)
Clm Type	Claim type for this claim.	1	Character
COS (State)	State Category of Service for this claim. **XX**-XX	2	Character
COS (Sub)	State Sub-COS for this claim. XX-**XX**	2	Character
Fund Code	Fund code assigned to this claim.	3	Character
ICD	The version code of an ICD procedure or diagnosis code. Valid values are '9' for an ICD 9 procedure or diagnosis code, and '0' for an ICD 10 procedure or diagnosis code. For HCPC procedure codes or claims that do not have secondary diagnosis codes, this field will be blank.	1	Character
ICN	Internal control number assigned to this claim.	13	Number (Integer)
Inpatient Dollars	Sum of amounts paid for inpatient claims (claim types A and I).	14	Number (Decimal)
Outpatient Dollars	Sum of amounts paid for outpatient claims (claim types C and O).	14	Number (Decimal)
Pmt Dt	Date this claim was paid.	6	Date (MM/DD/YY)
POS	Place of service code for this claim.	2	Character
Primary Diag	Primary diagnosis code for this claim.	7	Character
Procedure Code	Procedure code for this claim. In cases where a claim has multiple procedure codes, this is the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_PROC_PRIM. For all UB92 claim types, this data element is either T_CA_ICD9_PROC - CDE_PROC_ICD9 or T_CA_HDR_DTL - CDE_PROC.	6	Character

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Field	Description	Length	Data Type
Procedure Mod	Procedure code modifier for this claim. In cases where a claim has multiple procedure codes, this is the modifier for the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_MODIFIER_1. For all UB92 claim types, this data element is T_CA_HDR_DTL - CDE_MODIFIER_1 if the procedure code is a HCPCS code. If the procedure code is an ICD9 code, the modifier is blank.	2	Character
Professional Dollars	Sum of amounts paid for professional claims (claim types B and M).	14	Number (Decimal)
Provider Number	Provider number for this claim. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Recipient ID	Recipient identification number for this claim.	12	Character
Second Diag	Secondary diagnosis code for this claim.	7	Character
Sex	Sex (gender) of the recipient.	1	Character
SVC Dt	Date of first service for this claim.	6	Date (MM/DD/YY)
SVC Unt	Number of units of service provided for this claim.	3	Number (Integer)
Total Dollars	Sum of amounts paid for all claims.	14	Number (Decimal)

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7.7 MAR-2110-A -- ANNUAL STERILIZATION DETAIL REPORT

7.7.1 MAR-2110-A -- Annual Sterilization Detail Report Narrative

The Annual Sterilization Detail report provides an annual list of sterilization services claims. For each claim, details such as recipient number, ICN, provider number, ICD version codes, procedure codes, diagnosis codes, claim type, fund code, date paid, and amount paid are reported. Information from this report supports the appropriate HCFA64.9 and MSIS data.

7.7.2 MAR-2110-A -- Annual Sterilization Detail Report Layout

```
Report  : MAR-2110-A                                    ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/CCYY
Process : MARJM100                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:
HH:MM:SS
Location: MRA2100                                   ANNUAL STERILIZATION DETAIL REPORT                               Page:
999,999
                                                              PERIOD: MM/CCYY

RECIPIENT ID  ICN            PROVIDER       ICD PROCEDURE  ICD PRIMARY ICD  SECOND  CLM   FUND  POS   COS   SVC  AGE  SEX  SVC DT  PMT DT  AMT
BILLED   AMT PAID
                             NUMBER               CODE  MOD      DIAG         DIAG    TYPE  CODE             UNT
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX   X  XXXXXXX   X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX X   XXXXXX XX   X  XXXXXXX   X   XXXXXXXX    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX X   XXXXXX XX   X  XXXXXXX   X   XXXXXXXX    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99

PROFESSIONAL DOLLARS : $999,999,999.99
OUTPATIENT   DOLLARS : $999,999,999.99
INPATIENT    DOLLARS : $999,999,999.99
TOTAL        DOLLARS : $999,999,999.99

                                                        *** END OF REPORT ***
```

7.7.3 MAR-2110-A -- Annual Sterilization Detail Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the recipient on the date of service.	3	Number (Integer)
Amt Billed	Amount billed for this claim.	10	Number (Decimal)
Amt Paid	Amount paid for this claim.	10	Number (Decimal)
Clm Type	Claim type for this claim.	1	Character
COS (State)	State Category Of Service for this claim. **XX**-XX	2	Character

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Field	Description	Length	Data Type
COS (Sub)	State Sub-COS for this claim. XX-**XX**	2	Character
Fund Code	Fund code assigned to this claim.	3	Character
ICD	The version code of an ICD procedure or diagnosis code. Valid values are '9' for an ICD 9 procedure or diagnosis code, and '0' for an ICD 10 procedure or diagnosis code. For HCPC procedure codes or claims that do not have secondary diagnosis codes, this field will be blank.	1	Character
ICN	Internal control number assigned to this claim.	13	Number (Integer)
Inpatient Dollars	Sum of amounts paid for inpatient claims (claim types A and I).	14	Number (Decimal)
Outpatient Dollars	Sum of amounts paid for outpatient claims (claim types C and O).	14	Number (Decimal)
Pmt Dt	Date this claim was paid.	6	Date (MM/DD/YY)
POS	Place of service code for this claim.	2	Character
Primary Diag	Primary diagnosis code for this claim.	7	Character
Procedure Code	Procedure code for this claim. In cases where a claim has multiple procedure codes, this is the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_PROC_PRIM. For all UB92 claim types, this data element is either T_CA_ICD9_PROC - CDE_PROC_ICD9 or T_CA_HDR_DTL - CDE_PROC.	6	Character
Procedure Mod	Procedure code modifier for this claim. In cases where a claim has multiple procedure codes, this is the modifier for the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_MODIFIER_1. For all UB92 claim types, this data element is T_CA_HDR_DTL - CDE_MODIFIER_1 if the procedure code is a HCPCS code. If the procedure code is an ICD9 code, the modifier is blank.	2	Character
Professional Dollars	Sum of amounts paid for professional claims (claim types B and M).	14	Number (Decimal)
Provider Number	Provider number for this claim. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric

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Field	Description	Length	Data Type
Recipient ID	Recipient identification number for this claim.	12	Character
Second Diag	Secondary diagnosis code for this claim.	7	Character
Sex	Sex (gender) of the recipient.	1	Character
Svc Dt	Date of first service for this claim.	6	Date (MM/DD/YY)
Svc Unt	Number of units of service provided for this claim.	3	Number (Integer)
Total Dollars	Sum of amounts paid for all claims.	14	Number (Decimal)

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7.8 MAR-4812-A -- CMS 372 ANNUAL REPORT ON HCBS ID WAIVER (SHORT) REPORT

7.8.1 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Narrative

The CMS 372 Annual Report on HCBS ID Waiver (Short) report contains information on the participation of recipients in the ID (Intellectual Disability) waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.8.2 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Layout

```
Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                              Page:          1
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                    ICF-MR
I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS
A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    DAY HABILITATION SERVICES - LEVEL 1                                      9,999,999,999
A.2    DAY HABILITATION SERVICES - LEVEL 2                                      9,999,999,999
A.3    DAY HABILITATION SERVICES - LEVEL 3                                      9,999,999,999
A.4    DAY HABILITATION SERVICES - LEVEL 4                                      9,999,999,999
A.5    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                              9,999,999,999
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                              9,999,999,999
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                              9,999,999,999
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                              9,999,999,999
A.9    RESIDENTIAL HABILITATION                                                 9,999,999,999
A.10   IN-HOME RESPITE                                                          9,999,999,999
A.11   OUT-OF-HOME RESPITE                                                      9,999,999,999
A.12   INSTITUTIONAL RESPITE                                                    9,999,999,999
A.13   RESIDENTIAL HABILITATION-OTHER LIVING ARRANGEMENTS                       9,999,999,999
A.14   SUPPORTED EMPLOYMENT SERVICES                                            9,999,999,999
A.15   PREVOCATIONAL SERVICES                                                   9,999,999,999
A.16   PHYSICAL THERAPY                                                         9,999,999,999
A.17   OCCUPATIONAL THERAPY                                                     9,999,999,999
A.18   SPEECH AND LANGUAGE THERAPY                                              9,999,999,999
A.19   PERSONAL CARE                                                            9,999,999,999
A.20   PERSONAL CARE ON WORKSITE                                                9,999,999,999
A.21   PERSONAL CARE TRANSPORTATION                                             9,999,999,999
A.22   COMPANION SERVICES                                                       9,999,999,999
A.23   BEHAVIOR THERAPY - LEVEL 1                                               9,999,999,999
A.24   BEHAVIOR THERAPY - LEVEL 2                                               9,999,999,999
A.25   BEHAVIOR THERAPY - LEVEL 3                                               9,999,999,999
A.26   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                  9,999,999,999
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A.27   ASSISTIVE TECHNOLOGY                                                    9,999,999,999
A.28   SKILLED NURSING-RN                                                      9,999,999,999
A.29   SKILLED NURSING-LPN                                                     9,999,999,999
A.30   SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES                                9,999,999,999
A.31   COMMUNITY SPECIALIST                                                    9,999,999,999
A.32   CRISIS INTERVENTION                                                     9,999,999,999
B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                 9,999,999,999
       RECIPIENTS SERVED
Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                    Page:          2
                                                     EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                              ICF-MR

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES           $9,999,999,999.99

A.1    DAY HABILITATION SERVICES - LEVEL 1                                     $9,999,999,999.99
A.2    DAY HABILITATION SERVICES - LEVEL 2                                     $9,999,999,999.99
A.3    DAY HABILITATION SERVICES - LEVEL 3                                     $9,999,999,999.99
A.4    DAY HABILITATION SERVICES - LEVEL 4                                     $9,999,999,999.99
A.5    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                             $9,999,999,999.99
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                             $9,999,999,999.99
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                             $9,999,999,999.99
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                             $9,999,999,999.99
A.9    RESIDENTIAL HABILITATION                                                $9,999,999,999.99
A.10   IN-HOME RESPITE                                                         $9,999,999,999.99
A.11   OUT-OF-HOME RESPITE                                                     $9,999,999,999.99
A.12   INSTITUTIONAL RESPITE                                                   $9,999,999,999.99
A.13   RESIDENTIAL HABILITATION-OTHER LIVING ARRANGEMENTS                      $9,999,999,999.99
A.14   SUPPORTED EMPLOYMENT SERVICES                                           $9,999,999,999.99
A.15   PREVOCATIONAL SERVICES                                                  $9,999,999,999.99
A.16   PHYSICAL THERAPY                                                        $9,999,999,999.99
A.17   OCCUPATIONAL THERAPY                                                    $9,999,999,999.99
A.18   SPEECH AND LANGUAGE THERAPY                                             $9,999,999,999.99
A.19   PERSONAL CARE                                                           $9,999,999,999.99
A.20   PERSONAL CARE ON WORKSITE                                               $9,999,999,999.99
A.21   PERSONAL CARE TRANSPORTATION                                            $9,999,999,999.99
A.22   COMPANION SERVICES                                                      $9,999,999,999.99
A.23   BEHAVIOR THERAPY - LEVEL 1                                              $9,999,999,999.99
A.24   BEHAVIOR THERAPY - LEVEL 2                                              $9,999,999,999.99
A.25   BEHAVIOR THERAPY - LEVEL 3                                              $9,999,999,999.99
A.26   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                 $9,999,999,999.99
A.27   ASSISTIVE TECHNOLOGY                                                    $9,999,999,999.99
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A.28   SKILLED NURSING-RN                                                    $9,999,999,999.99
A.29   SKILLED NURSING-LPN                                                   $9,999,999,999.99
A.30   SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES                              $9,999,999,999.99
A.31   COMMUNITY SPECIALIST                                                  $9,999,999,999.99
A.32   CRISIS INTERVENTION                                                   $9,999,999,999.99
B.1.   AVERAGE PER CAPITA SECTION 1915C                                      $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA481                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: MR372RPT                       CMS 372 ANNUAL REPORT ON HCBS MR WAIVER                   Page:          3
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : MR WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                             ICF-MR

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                  $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                 D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                          9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                   9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
```


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```
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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```
Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                              Page:          4
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          ICF-MR

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
```


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Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                             Page:          5
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                      ICF-MR

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    DAY HABILITATION SERVICES - LEVEL 1                                          9,999,999,999
A.2    DAY HABILITATION SERVICES - LEVEL 2                                          9,999,999,999
A.3    DAY HABILITATION SERVICES - LEVEL 3                                          9,999,999,999
A.4    DAY HABILITATION SERVICES - LEVEL 4                                          9,999,999,999
A.5    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                  9,999,999,999
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                  9,999,999,999
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                  9,999,999,999
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                  9,999,999,999
A.9    RESIDENTIAL HABILITATION                                                     9,999,999,999
A.10   IN-HOME RESPITE                                                              9,999,999,999
A.11   OUT-OF-HOME RESPITE                                                          9,999,999,999
A.12   INSTITUTIONAL RESPITE                                                        9,999,999,999
A.13   RESIDENTIAL HABILITATION-OTHER LIVING ARRANGEMENTS                           9,999,999,999
A.14   SUPPORTED EMPLOYMENT SERVICES                                                9,999,999,999
A.15   PREVOCATIONAL SERVICES                                                       9,999,999,999
A.16   PHYSICAL THERAPY                                                             9,999,999,999
A.17   OCCUPATIONAL THERAPY                                                         9,999,999,999
A.18   SPEECH AND LANGUAGE THERAPY                                                  9,999,999,999
A.19   PERSONAL CARE                                                               9,999,999,999
A.20   PERSONAL CARE ON WORKSITE                                                    9,999,999,999
A.21   PERSONAL CARE TRANSPORTATION                                                 9,999,999,999
A.22   COMPANION SERVICES                                                           9,999,999,999
A.23   BEHAVIOR THERAPY - LEVEL 1                                                   9,999,999,999
A.24   BEHAVIOR THERAPY - LEVEL 2                                                   9,999,999,999
A.25   BEHAVIOR THERAPY - LEVEL 3                                                   9,999,999,999
A.26   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                      9,999,999,999
A.27   ASSISTIVE TECHNOLOGY                                                         9,999,999,999
A.28   SKILLED NURSING-RN                                                           9,999,999,999
A.29   SKILLED NURSING-LPN                                                          9,999,999,999
A.30   SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES                                     9,999,999,999
A.31   COMMUNITY SPECIALIST                                                         9,999,999,999
A.32   CRISIS INTERVENTION                                                          9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                      9,999,999,999
       RECIPIENTS SERVED
```


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Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                              Page:          6
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                      ICF-MR

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                $9,999,999,999.99

A.1    DAY HABILITATION SERVICES - LEVEL 1                                          $9,999,999,999.99
A.2    DAY HABILITATION SERVICES - LEVEL 2                                          $9,999,999,999.99
A.3    DAY HABILITATION SERVICES - LEVEL 3                                          $9,999,999,999.99
A.4    DAY HABILITATION SERVICES - LEVEL 4                                          $9,999,999,999.99
A.5    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                  $9,999,999,999.99
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                  $9,999,999,999.99
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                  $9,999,999,999.99
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                  $9,999,999,999.99
A.9    RESIDENTIAL HABILITATION                                                     $9,999,999,999.99
A.10   IN-HOME RESPITE                                                              $9,999,999,999.99
A.11   OUT-OF-HOME RESPITE                                                          $9,999,999,999.99
A.12   INSTITUTIONAL RESPITE                                                        $9,999,999,999.99
A.13   RESIDENTIAL HABILITATION-OTHER LIVING ARRANGEMENTS                           $9,999,999,999.99
A.14   SUPPORTED EMPLOYMENT SERVICES                                                $9,999,999,999.99
A.15   PREVOCATIONAL SERVICES                                                       $9,999,999,999.99
A.16   PHYSICAL THERAPY                                                             $9,999,999,999.99
A.17   OCCUPATIONAL THERAPY                                                         $9,999,999,999.99
A.18   SPEECH AND LANGUAGE THERAPY                                                  $9,999,999,999.99
A.19   PERSONAL CARE                                                                $9,999,999,999.99
A.20   PERSONAL CARE ON WORKSITE                                                    $9,999,999,999.99
A.21   PERSONAL CARE TRANSPORTATION                                                 $9,999,999,999.99
A.22   COMPANION SERVICES                                                           $9,999,999,999.99
A.23   BEHAVIOR THERAPY - LEVEL 1                                                   $9,999,999,999.99
A.24   BEHAVIOR THERAPY - LEVEL 2                                                   $9,999,999,999.99
A.25   BEHAVIOR THERAPY - LEVEL 3                                                   $9,999,999,999.99
A.26   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                      $9,999,999,999.99
A.27   ASSISTIVE TECHNOLOGY                                                         $9,999,999,999.99
A.28   SKILLED NURSING-RN                                                           $9,999,999,999.99
A.29   SKILLED NURSING-LPN                                                          $9,999,999,999.99
A.30   SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES                                     $9,999,999,999.99
A.31   COMMUNITY SPECIALIST                                                         $9,999,999,999.99
A.32   CRISIS INTERVENTION                                                          $9,999,999,999.99
B.1.   AVERAGE PER CAPITA SECTION 1915C                                             $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
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Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                              Page:          7
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          ICF-MR

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                   9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                            9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.
```


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```
       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                            Page:          8
                                                       EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          ICF-MR

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________


                                                   *** END OF REPORT ***
```

7.8.3 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Field Descriptions

Field	Description	Length	Data Type
I. A.1 Day Habilitation Services -Level 1	Total unduplicated count of waiver recipients receiving day habilitation services - level 1 within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
I. A.2 Day Habilitation Services –Level 2	Total unduplicated count of waiver recipients receiving day habilitation services - level 2 services within the waiver year.	11	Number (Decimal)
I. A.3 Day Habilitation Services- Level 3	Total unduplicated count of waiver recipients receiving s day habilitation services - level 3 services within the waiver year.	11	Number (Decimal)
I. A.4 Day Habilitation Services -Level 4	Total unduplicated count of waiver recipients receiving day habilitation services - level 4 services within the waiver year.	11	Number (Decimal)
I. A.5 Day Habilitation – W/Transportation –Level 1	Total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 1 services within the waiver year.	11	Number (Decimal)
I. A.6 Day Habilitation - W/Transportation –Level 12	Total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 2 services within the waiver year.	11	Number (Decimal)
I. A.7 Day Habilitation W/Transportation - Level 3	Total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 3 services within the waiver year.	11	Number (Decimal)
I. A.8 Day Habilitation - W/Transportation - Level 4	Total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 4 services within the waiver year.	11	Number (Decimal)
I. A. 9 Residential Habilitation	Total unduplicated count of waiver recipients receiving residential habilitation services within the waiver year.	11	Number (Decimal)
I. A. 10 In-Home Respite	Total unduplicated count of waiver recipients receiving in-home respite services within the waiver year.	11	Number (Decimal)
I. A. 11 Out-Of-Home Respite	Total unduplicated count of waiver recipients receiving respite out-of-home respite services within the waiver year.	11	Number (Decimal)
I. A. 12 Institutional Respite	Total unduplicated count of waiver recipients receiving institutional respite services within the waiver year.	11	Number (Decimal)
I. A 13 Residential Habilitation-Other Living Arrangements	Total unduplicated count of waiver recipients receiving residential habilitation-other living arrangements services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
I. A.14 Supported Employment Services	Total unduplicated count of waiver recipients receiving supported employment services within the waiver year.	11	Number (Decimal)
I. A.15 Prevocational Services	Total unduplicated count of waiver recipients receiving prevocational services within the waiver year.	11	Number (Decimal)
I. A.16 Physical Therapy	Total unduplicated count of waiver recipients receiving physical therapy services within the waiver year.	11	Number (Decimal)
I. A.17 Occupational Therapy	Total unduplicated count of waiver recipients receiving occupational therapy services within the waiver year.	11	Number (Decimal)
I. A.18 Speech/Language Therapy	Total unduplicated count of waiver recipients receiving speech/language therapy services within the waiver year.	11	Number (Decimal)
I. A.19 Personal Care	Total unduplicated count of waiver recipients receiving personal care services within the waiver year.	11	Number (Decimal)
I. A.20 Personal Care On Worksite	Total unduplicated count of waiver recipients receiving personal care on worksite services within the waiver year.	11	Number (Decimal)
I. A.21 Personal Care Transportation	Total unduplicated count of waiver recipients receiving personal care transportation services within the waiver year.	11	Number (Decimal)
I. A.22 Companion Services	Total unduplicated count of waiver recipients receiving companion services within the waiver year.	11	Number (Decimal)
I. A.23 Behavior Therapy - Level 1	Total unduplicated count of waiver recipients receiving behavior therapy - level 1 services within the waiver year.	11	Number (Decimal)
I. A.24 Behavior Therapy - Level 2	Total unduplicated count of waiver recipients receiving behavior therapy - level 2 services within the waiver year.	11	Number (Decimal)
I. A.25 Behavior Therapy - Level 3	Total unduplicated count of waiver recipients receiving behavior therapy - level 3 services within the waiver year.	11	Number (Decimal)
I. A.26 Environmental Accessibility Adaptations	Total unduplicated count of waiver recipients receiving environmental accessibility adaptations services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
I. A.27 Assistive Technology	Total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	11	Number (Decimal)
I. A.28 Skilled Nursing-RN	Total unduplicated count of waiver recipients receiving skilled nursing-RN services within the waiver year.	11	Number (Decimal)
I. A.29 Skilled Nursing-LPN	Total unduplicated count of waiver recipients receiving skilled nursing-LPN services within the waiver year.	11	Number (Decimal)
I. A.30 Specialized Medical Equipment & Supplies	Total unduplicated count of waiver recipients receiving specialized medical equipment & supplies services within the waiver year.	11	Number (Decimal)
I. A.31 Community Specialist	Total unduplicated count of waiver recipients receiving community specialist services within the waiver year.	11	Number (Decimal)
I. A.32 Crisis Intervention	Total unduplicated count of waiver recipients receiving crisis intervention services within the waiver year.	11	Number (Decimal)
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	Total unduplicated count of waiver recipients receiving waiver services within the waiver year.	11	Number (Decimal)
II. A. Total CMS Approved Section 1915 (C) Waiver Services Expenditures	Total expenditures on waiver services during the waiver year.	17	Number (Decimal)
II A.1 Day Habilitation – Level 1	Total unduplicated count of waiver recipients receiving day habilitation-level 1 services within the waiver year.	11	Number (Decimal)
II A.2 Day Habilitation – Level 2	Total unduplicated count of waiver recipients receiving day habilitation services - level 2 services within the waiver year.	11	Number (Decimal)
II. A.3 Day Habilitation Services – Level 3	Total unduplicated count of waiver recipients receiving day habilitation services - level 3 services within the waiver year.	11	Number (Decimal)
II. A.4 Day Habilitation Services – Level 4	Total unduplicated count of waiver recipients receiving day habiliation-level 4 services within the waiver year.	11	Number (Decimal)
II. A.5 Day Habilitation - W/Transportation-Level 1	Total unduplicated count of waiver recipients receiving day habilitation - w/transportation-level 1 services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
II. A.6 Day Habilitation – W/Transportation-Level 2	Total unduplicated count of waiver recipients receiving day habilitation –w/transportation-level 2 services within the waiver year.	11	Number (Decimal)
II A.7 Day Habilitation – W/Transportation-Level 3	Total unduplicated count of waiver recipients receiving day habilitation –w/transportation-level 3 services within the waiver year.	11	Number (Decimal)
II. A.8 Day Habilitation - W/Transportation-Level 4	Total unduplicated count of waiver recipients receiving day habilitation -w/transportation-level 4 services within the waiver year.	11	Number (Decimal)
II. A.9 Residential Habiliation	Total unduplicated count of waiver recipients receiving residential habiliation services within the waiver year.	11	Number (Decimal)
II. A.10 In-Home Respite	Total unduplicated count of waiver recipients receiving in-home respite services within the waiver year.	11	Number (Decimal)
II. A.11 Out-Of-Home Respite	Total unduplicated count of waiver recipients receiving out-of-home respite services within the waiver year.	11	Number (Decimal)
II. A.12 Institutional Respite	Total unduplicated count of waiver recipients receiving institutional respite services within the waiver year.	11	Number (Decimal)
II. A.13 Residential Habilitation-Other Living Arrangements	Total unduplicated count of waiver recipients receiving residential habilitation-other living arrangements services within the waiver year.	11	Number (Decimal)
II. A.14 Supported Employment Services	Total unduplicated count of waiver recipients receiving supported employment services within the waiver year.	11	Number (Decimal)
II. A.15 Prevocational Services	Total unduplicated count of waiver recipients receiving prevocational services within the waiver year.	11	Number (Decimal)
II. A.16 Physical Therapy	Total unduplicated count of waiver recipients receiving physical therapy services within the waiver year.	11	Number (Decimal)
II. A.17 Occupational Therapy	Total unduplicated count of waiver recipients receiving occupational therapy services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
II. A.18 Speech/Language Therapy	Total unduplicated count of waiver recipients receiving speech/language therapy services within the waiver year.	11	Number (Decimal)
II. A.19 Personal Care	Total unduplicated count of waiver recipients receiving personal care services within the waiver year.	11	Number (Decimal)
II. A.20 Personal Care on Worksite	Total unduplicated count of waiver recipients receiving personal care on worksite services within the waiver year.	11	Number (Decimal)
II. A.21 Personal Care Transporation	Total unduplicated count of waiver recipients receiving personal care transporation services within the waiver year.	11	Number (Decimal)
II. A.22 Companion Services	Total unduplicated count of waiver recipients receiving companion services within the waiver year.	11	Number (Decimal)
II. A.23 Behavior Therapy - Level 1	Total unduplicated count of waiver recipients receiving behavior therapy - level 1 services within the waiver year.	11	Number (Decimal)
II. A.24 Behavior Therapy - Level 2	Total unduplicated count of waiver recipients receiving behavior therapy - level 2 services within the waiver year.	11	Number (Decimal)
II. A.25 Behavior Therapy - Level 3	Total unduplicated count of waiver recipients receiving behavior therapy - level 3 services within the waiver year.	11	Number (Decimal)
II. A.26 Environmental Accessibility Adaptations	Total unduplicated count of waiver recipients receiving environmental accessibility adaptations services within the waiver year.	11	Number (Decimal)
II. A.27 Assistive Technology	Total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	11	Number (Decimal)
II. A.28 Skilled Nursing-RN	Total unduplicated count of waiver recipients receiving skilled nursing-RN services within the waiver year.	11	Number (Decimal)
II. A.29 Skilled Nursing-LPN	Total unduplicated count of waiver recipients receiving skilled nursing-LPN services within the waiver year.	11	Number (Decimal)
II. A.30 Specialized Medical Equipment & Supplies	Total unduplicated count of waiver recipients receiving specialized medical equipment & supplies services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
II. A.31 Community Specialist	Total unduplicated count of waiver recipients receiving community specialist services within the waiver year.	11	Number (Decimal)
II. A.32 Crisis Intervention	Total unduplicated count of waiver recipients receiving crisis intervention services within the waiver year.	11	Number (Decimal)
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	Average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
III. Average Per Capita Annual Expenditure for all Other Medicaid Services	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver recipients receiving services while in the waiver within the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
V. A. 1. Total Days of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	11	Number (Decimal)
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	17	Number (Decimal)

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7.9 MAR-4822-A -- CMS 372 ANNUAL REPORT ON HCBS ED WAIVER (SHORT) REPORT

7.9.1 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Narrative

The CMS 372 Annual Report on HCBS Waiver (Short) report contains information on the participation of recipients in the E&D (Elderly & Disabled) waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.9.2 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Layout

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Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                              Page:          1
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT                                                                     9,999,999,999
A.2    PERSONAL CARE                                                                       9,999,999,999
A.3    ADULT DAY HEALTH                                                                    9,999,999,999
A.4    RESPITE CARE - SKILLED                                                              9,999,999,999
A.5    RESPITE CARE - UNSKILLED                                                            9,999,999,999
A.6    HOMEMAKER                                                                           9,999,999,999
A.7    COMPANION                                                                           9,999,999,999
A.8    WAIVER FROZEN MEALS                                                                 9,999,999,999
A.9    WAIVER SHELF-STABLE MEALS                                                           9,999,999,999
A.10   WAIVER BREAKFAST MEALS                                                              9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                             9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                       $9,999,999,999.99

A.1    CASE MANAGEMENT                                                                     $9,999,999,999.99
A.2    PERSONAL CARE                                                                       $9,999,999,999.99
A.3    ADULT DAY HEALTH                                                                    $9,999,999,999.99
A.4    RESPITE CARE - SKILLED                                                              $9,999,999,999.99
A.5    RESPITE CARE - UNSKILLED                                                            $9,999,999,999.99
A.6    HOMEMAKER                                                                           $9,999,999,999.99
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A.7    COMPANION                                                          $9,999,999,999.99
A.8    WAIVER FROZEN MEALS                                                $9,999,999,999.99
A.9    WAIVER SHELF-STABLE MEALS                                          $9,999,999,999.99
A.10   WAIVER BREAKFAST MEALS                                             $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                   $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA482                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: MR372RPT                       CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                   Page:          2
                                                       EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                            NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH AND EXPANDED                $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                 D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                        9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                 9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.
```


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C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                            Page:          3
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
```


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```
Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                            Page:          4
                                                       EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT                                                              9,999,999,999
A.2    PERSONAL CARE                                                                9,999,999,999
A.3    ADULT DAY HEALTH                                                             9,999,999,999
A.4    RESPITE CARE - SKILLED                                                       9,999,999,999
A.5    RESPITE CARE - UNSKILLED                                                     9,999,999,999
A.6    HOMEMAKER                                                                    9,999,999,999
A.7    COMPANION                                                                    9,999,999,999
A.8    WAIVER FROZEN MEALS                                                          9,999,999,999
A.9    WAIVER SHELF-STABLE MEALS                                                    9,999,999,999
A.10   WAIVER BREAKFAST MEALS                                                       9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                      9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES               $9,999,999,999.99

A.1    CASE MANAGEMENT                                                             $9,999,999,999.99
A.2    PERSONAL CARE                                                               $9,999,999,999.99
A.3    ADULT DAY HEALTH                                                            $9,999,999,999.99
A.4    RESPITE CARE - SKILLED                                                      $9,999,999,999.99
A.5    RESPITE CARE - UNSKILLED                                                    $9,999,999,999.99
A.6    HOMEMAKER                                                                   $9,999,999,999.99
A.7    COMPANION                                                                   $9,999,999,999.99
A.8    WAIVER FROZEN MEALS                                                         $9,999,999,999.99
A.9    WAIVER SHELF-STABLE MEALS                                                   $9,999,999,999.99
A.10   WAIVER BREAKFAST MEALS                                                      $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
```


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Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                              Page:          5
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                  D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                          9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                  9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
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```
Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                            Page:          6
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                      *** END OF REPORT ***
```


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7.9.3 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Field Descriptions

Field	Description	Length	Data Type
I. A.1 Case Management	Total unduplicated count of waiver recipients receiving case management services within the waiver year.	11	Number (Decimal)
I. A.2 Personal Care	Total unduplicated count of waiver recipients receiving personal care services within the waiver year.	11	Number (Decimal)
I. A.3 Adult Day Health	Total unduplicated count of waiver recipients receiving adult day health services within the waiver year.	11	Number (Decimal)
I. A.4 Respite Care- Skilled	Total unduplicated count of waiver recipients receiving skilled respite care services within the waiver year.	11	Number (Decimal)
I. A.5 Respite Care- Unskilled	Total unduplicated count of waiver recipients receiving unskilled respite care services within the waiver year.	11	Number (Decimal)
I. A.6 Homemaker	Total unduplicated count of waiver recipients receiving homemaker services within the waiver year.	11	Number (Decimal)
I. A.7 Companion	Total unduplicated count of waiver recipients receiving companion services within the waiver year.	11	Number (Decimal)
I. A.8 Waiver Frozen Meals	Total unduplicated count of waiver recipients receiving waiver frozen meal services within the waiver year.	11	Number (Decimal)
I. A.9 Waiver Shelf Stable Meals	Total unduplicated count of waiver recipients receiving waiver shelf stable meal service within the waiver year.	11	Number (Decimal)
I. A.10 Waiver Breakfast Meals	Total unduplicated count of waiver recipients receiving home delivered breakfast meal services within the waiver year.	11	Number (Decimal)
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients Served	Total unduplicated count of waiver recipients receiving waiver services within the waiver year.	11	Number (Decimal)
II. A. Total Approved Section 1915 (C) Waiver Services Expenditures	Total expenditures on waiver services during the waiver year.	17	Number (Decimal)
II. A.1 Case Management	Total Medicaid expenditures for case management services for the waiver year.	17	Number (Decimal)

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Field	Description	Length	Data Type
II. A.2 Personal Care	Total Medicaid expenditures for personal care services for the waiver year.	17	Number (Decimal)
II. A.3 Adult Day Health	Total Medicaid expenditures for adult day health services for the waiver year.	17	Number (Decimal)
II. A.4 Respite Care -Skilled	Total Medicaid expenditures for skilled respite care services for the waiver year.	17	Number (Decimal)
II. A.5 Respite Care- Unskilled	Total Medicaid expenditures for unskilled respite care services for the waiver year.	17	Number (Decimal)
II. A.6 Homemaker	Total Medicaid expenditures for adult homemaker services for the waiver year.	17	Number (Decimal)
II A.7 Companion	Total Medicaid expenditures for companion services-for the waiver year.	17	Number (Decimal)
II. A.8 Waiver Frozen Meals	Total unduplicated count of waiver recipients receiving waiver frozen meal services within the waiver year.	11	Number (Decimal)
II. A.9 Waiver Shelf Stable Meals	Total unduplicated count of waiver recipients receiving waiver shelf stable meals service within the waiver year.	11	Number (Decimal)
II. A.10 Waiver Breakfast Meals	Total unduplicated count of waiver recipients receiving home delivered meals (breakfast) services within the waiver year.	11	Number (Decimal)
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	Average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
III. Average Per Capita Annual Expenditure for all Other Medicaid Services	The average acute care service expenditures accumulated by the waiver members during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver members receiving services while in the waiver within the waiver year.	17	Number (Decimal)

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Field	Description	Length	Data Type
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver members during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of members in Section V. B.1.	17	Number (Decimal)
V. A. 1. Total Days of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	11	Number (Decimal)
V. A. 2. Average Length of Waiver Coverage By Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	17	Number (Decimal)

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7.10 MAR-4832-A -- CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER (SHORT) REPORT

7.10.1 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Narrative

The CMS 372 Annual Report on HCBS Living at Home Waiver (Short) report contains information on the participation of recipients in the Living At Home waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.10.2 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Layout

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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                       Page:          1
                                                      EXHIBIT B

STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                      ICF-MR

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    IN-HOME RESIDENTIAL HABILITATION                                            9,999,999,999
A.2    DAY HABILITATION SERVICES - LEVEL 1                                         9,999,999,999
A.3    DAY HABILITATION SERVICES - LEVEL 2                                         9,999,999,999
A.4    DAY HABILITATION SERVICES - LEVEL 3                                         9,999,999,999
A.5    DAY HABILITATION SERVICES - LEVEL 4                                         9,999,999,999
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                 9,999,999,999
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                 9,999,999,999
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                 9,999,999,999
A.9    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                 9,999,999,999
A.10   SUPPORTED EMPLOYMENT                                                        9,999,999,999
A.11   PREVOCATIONAL SERVICES                                                      9,999,999,999
A.12   RESPITE IN-HOME                                                             9,999,999,999
A.13   RESPITE OUT-OF-HOME                                                         9,999,999,999
A.14   PERSONAL CARE                                                              9,999,999,999
A.15   PERSONAL CARE ON WORKSITE                                                  9,999,999,999
A.16   PERSONAL CARE TRANSPORATION                                                9,999,999,999
A.17   PHYSICAL THERAPY                                                            9,999,999,999
A.18   OCCUPATIONAL THERAPY                                                       9,999,999,999
A.19   SPEECH THERAPY                                                             9,999,999,999
A.20   BEHAVIOR THERAPY - LEVEL 1                                                 9,999,999,999
A.21   BEHAVIOR THERAPY - LEVEL 2                                                 9,999,999,999
A.22   BEHAVIOR THERAPY - LEVEL 3                                                 9,999,999,999
A.23   SKILLED NURSING-RN                                                          9,999,999,999
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A.24   SKILLED NURSING-LPN                                                  9,999,999,999
A.25   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                              9,999,999,999
A.26   SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES                               9,999,999,999
A.27   COMMUNITY SPECIALIST                                                 9,999,999,999
A.28   CRISIS INTERVENTION                                                  9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                              9,999,999,999
       RECIPIENTS SERVED
Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA483                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: MR372RPT                  CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER            Page:          2
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                            ICF-MR

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES        $9,999,999,999.99

A.1    IN-HOME RESIDENTIAL HABILITATION                                     $9,999,999,999.99
A.2    DAY HABILITATION SERVICES - LEVEL 1                                  $9,999,999,999.99
A.3    DAY HABILITATION SERVICES - LEVEL 2                                  $9,999,999,999.99
A.4    DAY HABILITATION SERVICES - LEVEL 3                                  $9,999,999,999.99
A.5    DAY HABILITATION SERVICES - LEVEL 4                                  $9,999,999,999.99
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                          $9,999,999,999.99
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                          $9,999,999,999.99
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                          $9,999,999,999.99
A.9    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                          $9,999,999,999.99
A.10   SUPPORTED EMPLOYMENT                                                 $9,999,999,999.99
A.11   PREVOCATIONAL SERVICES                                               $9,999,999,999.99
A.12   RESPITE IN-HOME                                                      $9,999,999,999.99
A.13   RESPITE OUT-OF-HOME                                                  $9,999,999,999.99
A.14   PERSONAL CARE                                                        $9,999,999,999.99
A.15   PERSONAL CARE ON WORKSITE                                            $9,999,999,999.99
A.16   PERSONAL CARE TRANSPORATION                                          $9,999,999,999.99
A.17   PHYSICAL THERAPY                                                     $9,999,999,999.99
A.18   OCCUPATIONAL THERAPY                                                 $9,999,999,999.99
A.19   SPEECH THERAPY                                                       $9,999,999,999.99
A.20   BEHAVIOR THERAPY - LEVEL 1                                           $9,999,999,999.99
A.21   BEHAVIOR THERAPY - LEVEL 2                                           $9,999,999,999.99
A.22   BEHAVIOR THERAPY - LEVEL 3                                           $9,999,999,999.99
A.23   SKILLED NURSING-RN                                                   $9,999,999,999.99
A.24   SKILLED NURSING-LPN                                                  $9,999,999,999.99
A.25   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                              $9,999,999,999.99
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A.26   SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES                                  $9,999,999,999.99
A.27   COMMUNITY SPECIALIST                                                    $9,999,999,999.99
A.28   CRISIS INTERVENTION                                                     $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                        $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)

Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA483                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER             Page:          3
                                                     EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                               ICF-MR

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                    $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                 D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                          9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                   9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.
```


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```
C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                     Page:          4
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                        ICF-MR

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                     Page:          5
                                                       EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                        ICF-MR

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    IN-HOME RESIDENTIAL HABILITATION                                              9,999,999,999
A.2    DAY HABILITATION SERVICES - LEVEL 1                                           9,999,999,999
A.3    DAY HABILITATION SERVICES - LEVEL 2                                           9,999,999,999
A.4    DAY HABILITATION SERVICES - LEVEL 3                                           9,999,999,999
A.5    DAY HABILITATION SERVICES - LEVEL 4                                           9,999,999,999
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                   9,999,999,999
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                   9,999,999,999
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                   9,999,999,999
A.9    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                   9,999,999,999
A.10   SUPPORTED EMPLOYMENT                                                          9,999,999,999
A.11   PREVOCATIONAL SERVICES                                                        9,999,999,999
A.12   RESPITE IN-HOME                                                               9,999,999,999
A.13   RESPITE OUT-OF-HOME                                                           9,999,999,999
A.14   PERSONAL CARE                                                                 9,999,999,999
A.15   PERSONAL CARE ON WORKSITE                                                     9,999,999,999
A.16   PERSONAL CARE TRANSPORATION                                                   9,999,999,999
A.17   PHYSICAL THERAPY                                                              9,999,999,999
A.18   OCCUPATIONAL THERAPY                                                          9,999,999,999
A.19   SPEECH THERAPY                                                                9,999,999,999
A.20   BEHAVIOR THERAPY - LEVEL 1                                                    9,999,999,999
A.21   BEHAVIOR THERAPY - LEVEL 2                                                    9,999,999,999
A.22   BEHAVIOR THERAPY - LEVEL 3                                                    9,999,999,999
A.23   SKILLED NURSING-RN                                                            9,999,999,999
A.24   SKILLED NURSING-LPN                                                           9,999,999,999
A.25   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                       9,999,999,999
A.26   SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES                                        9,999,999,999
A.27   COMMUNITY SPECIALIST                                                          9,999,999,999
A.28   CRISIS INTERVENTION                                                           9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                       9,999,999,999
       RECIPIENTS SERVED
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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                     Page:          6
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                      ICF-MR

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                $9,999,999,999.99

A.1    IN-HOME RESIDENTIAL HABILITATION                                             $9,999,999,999.99
A.2    DAY HABILITATION SERVICES - LEVEL 1                                          $9,999,999,999.99
A.3    DAY HABILITATION SERVICES - LEVEL 2                                          $9,999,999,999.99
A.4    DAY HABILITATION SERVICES - LEVEL 3                                          $9,999,999,999.99
A.5    DAY HABILITATION SERVICES - LEVEL 4                                          $9,999,999,999.99
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                  $9,999,999,999.99
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                  $9,999,999,999.99
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                  $9,999,999,999.99
A.9    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                  $9,999,999,999.99
A.10   SUPPORTED EMPLOYMENT                                                         $9,999,999,999.99
A.11   PREVOCATIONAL SERVICES                                                       $9,999,999,999.99
A.12   RESPITE IN-HOME                                                              $9,999,999,999.99
A.13   RESPITE OUT-OF-HOME                                                          $9,999,999,999.99
A.14   PERSONAL CARE                                                               $9,999,999,999.99
A.15   PERSONAL CARE ON WORKSITE                                                   $9,999,999,999.99
A.16   PERSONAL CARE TRANSPORATION                                                 $9,999,999,999.99
A.17   PHYSICAL THERAPY                                                             $9,999,999,999.99
A.18   OCCUPATIONAL THERAPY                                                        $9,999,999,999.99
A.19   SPEECH THERAPY                                                              $9,999,999,999.99
A.20   BEHAVIOR THERAPY - LEVEL 1                                                  $9,999,999,999.99
A.21   BEHAVIOR THERAPY - LEVEL 2                                                  $9,999,999,999.99
A.22   BEHAVIOR THERAPY - LEVEL 3                                                  $9,999,999,999.99
A.23   SKILLED NURSING-RN                                                          $9,999,999,999.99
A.24   SKILLED NURSING-LPN                                                         $9,999,999,999.99
A.25   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                     $9,999,999,999.99
A.26   SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES                                      $9,999,999,999.99
A.27   COMMUNITY SPECIALIST                                                         $9,999,999,999.99
A.28   CRISIS INTERVENTION                                                          $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                       Page:          7
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          ICF-MR

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                   9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                            9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                     Page:          8
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                        ICF-MR

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                      *** END OF REPORT ***
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7.10.3 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Field Descriptions

Field	Description	Data Type	Length
I. A.1 In-Home Residential Habilitation	A total unduplicated count of waiver recipients receiving in-home residential habilitation services within the waiver year.	Number (Decimal)	11
I. A.10 Supported Employment	A total unduplicated count of waiver recipients receiving supported employment services within the waiver year.	Number (Decimal)	11
I. A.11 Prevocational Services	A total unduplicated count of waiver recipients receiving prevocational services within the waiver year.	Number (Decimal)	11
I. A.12 Respite In-Home	A total unduplicated count of waiver recipients receiving respite in-home services within the waiver year.	Number (Decimal)	11
I. A.13 Respite Out-Of-Home	A total unduplicated count of waiver recipients receiving respite out-of-home services within the waiver year.	Number (Decimal)	11
I. A.14 Personal Care	A total unduplicated count of waiver recipients receiving personal care services within the waiver year.	Number (Decimal)	11
I. A.15 Personal Care On Worksite	A total unduplicated count of waiver recipients receiving personal care on worksite services within the waiver year.	Number (Decimal)	11
I. A.16 Personal Care Transporation	A total unduplicated count of waiver recipients receiving personal care transporation services within the waiver year.	Number (Decimal)	11
I. A.17 Physical Therapy	A total unduplicated count of waiver recipients receiving physical therapy services within the waiver year.	Number (Decimal)	11
I. A.18 Occupational Therapy	A total unduplicated count of waiver recipients receiving occupational therapy services within the waiver year.	Number (Decimal)	11
I. A.19 Speech Therapy	A total unduplicated count of waiver recipients receiving speech therapy services within the waiver year.	Number (Decimal)	11
I. A.2 Day Habilitation Services - Level 1	A total unduplicated count of waiver recipients receiving day habilitation - level 1 serviceswithin the waiver year.	Number (Decimal)	11

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Field	Description	Data Type	Length
I. A.20 Behavior Therapy - Level 1	A total unduplicated count of waiver recipients receiving behavior therapy - level 1 services within the waiver year.	Number (Decimal)	11
I. A.21 Behavior Therapy - Level 2	A total unduplicated count of waiver recipients receiving behavior therapy - level 2 services within the waiver year.	Number (Decimal)	11
I. A.22 Behavior Therapy - Level 3	A total unduplicated count of waiver recipients receiving behavior therapy - level 3 services within the waiver year.	Number (Decimal)	11
I. A.23 Skilled Nursing-RN	A total unduplicated count of waiver recipients receiving skilled nursing-RN services within the waiver year.	Number (Decimal)	11
I. A.24 Skilled Nursing-LPN	A total unduplicated count of waiver recipients receiving skilled nursing-LPN services within the waiver year.	Number (Decimal)	11
I. A.25 Environmental Accessibility Adaptations	A total unduplicated count of waiver recipients receiving environmental accessibility adaptations services within the waiver year.	Number (Decimal)	11
I. A.26 Specialized Medical Equipment/Supplies	A total unduplicated count of waiver recipients receiving specialized medical equipment/supplies services within the waiver year.	Number (Decimal)	11
I. A.27 Community Specialist	A total unduplicated count of waiver recipients receiving community specialist services within the waiver year.	Number (Decimal)	11
I. A.28 Crisis Intervention	A total unduplicated count of waiver recipients receiving cisis intervention services within the waiver year.	Number (Decimal)	11
I. A.3 Day Habilitation Services - Level 2	A total unduplicated count of waiver recipients receiving day habilitation - level 2 services within the waiver year.	Number (Decimal)	11
I. A.4 Day Habilitation Services - Level 3	A total unduplicated count of waiver recipients receiving day habilitation level 3 services within the waiver year.	Number (Decimal)	11
I. A.5 Day Habilitation Services - Level 4	A total unduplicated count of waiver recipients receiving day habilitation - level 4 services within the waiver year.	Number (Decimal)	11

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Field	Description	Data Type	Length
I. A.6 Day Habilitation W/Transportation - Level 1	A total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 1 services within the waiver year.	Number (Decimal)	11
I. A.7 Day Habilitation W/Transportation - Level 2	A total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 2 services within the waiver year.	Number (Decimal)	11
I. A.8 Day Habilitation W/Transportation - Level 3	A total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 3 services within the waiver year.	Number (Decimal)	11
I. A.9 Day Habilitation W/Transportation - Level 4	A total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 4 services within the waiver year.	Number (Decimal)	11
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	The total unduplicated count of waiver recipients receiving waiver services within the waiver year.	Number (Decimal)	11
II. A. Total Approved Section 1915 (C) Waiver Services Expenditures	The total expenditures on waiver services during the waiver year.	Number (Decimal)	17
II. A.1 In-Home Residential Habilitation	The total Medicaid expenditures for in-home residential habilitation services for the waiver year.	Number (Decimal)	17
II. A.10 Supported Employment	The total Medicaid expenditures for supported employment services for the waiver year.	Number (Decimal)	17
II. A.11 Prevocational Services	The total Medicaid expenditures for prevocational services services for the waiver year.	Number (Decimal)	17
II. A.12 Respite In-Home	The total Medicaid expenditures for respite in-home services for the waiver year.	Number (Decimal)	17
II. A.13 Respite Out-Of-Home	The total Medicaid expenditures for respite out-of-home services for the waiver year.	Number (Decimal)	17
II. A.14 Personal Care	The total Medicaid expenditures for personal care services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.15 Personal Care On Worksite	The total Medicaid expenditures for personal care on worksite services for the waiver year.	Number (Decimal)	17
II. A.16 Personal Care Transporation	The total Medicaid expenditures for personal care transporation services for the waiver year.	Number (Decimal)	17
II. A.17 Physical Therapy	The total Medicaid expenditures for physical therapy services for the waiver year.	Number (Decimal)	17
II. A.18 Occupational Therapy	The total Medicaid expenditures for occupational therapy services for the waiver year.	Number (Decimal)	17
II. A.19 Speech Therapy	The total Medicaid expenditures for speech therapy services for the waiver year.	Number (Decimal)	17
II. A.2 Day Habilitation Services - Level 1	The total Medicaid expenditures for day habilitation level 1 services for the waiver year.	Number (Decimal)	17
II. A.20 Behavior Therapy - Level 1	The total Medicaid expenditures for behavior therapy - level 1 services for the waiver year.	Number (Decimal)	17
II. A.21 Behavior Therapy - Level 2	The total Medicaid expenditures for behavior therapy - level 2 services for the waiver year.	Number (Decimal)	17
II. A.22 Behavior Therapy - Level 3	The total Medicaid expenditures for behavior therapy - level 3 services for the waiver year.	Number (Decimal)	17
II. A.23 Skilled Nursing-RN	The total Medicaid expenditures for skilled nursing-RN services for the waiver year.	Number (Decimal)	17
II. A.24 Skilled Nursing-LPN	The total Medicaid expenditures for skilled nursing-LPN services for the waiver year.	Number (Decimal)	17
II. A.25 Environmental Accessibility Adaptations	The total Medicaid expenditures for environmental accessibility adaptations services for the waiver year.	Number (Decimal)	17
II. A.26 Specialized Medical Equipment/Supplies	The total Medicaid expenditures for specialized medical equipment/supplies services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.27 Community Specialist	The total Medicaid expenditures for community specialist services for the waiver year.	Number (Decimal)	17
II. A.28 Crisis Intervention	The total Medicaid expenditures for crisis intervention services for the waiver year.	Number (Decimal)	17
II. A.3 Day Habilitation Services - Level 2	The total Medicaid expenditures for day habilitation - level 2 services for the waiver year.	Number (Decimal)	17
II. A.4 Day Habilitation Services - Level 3	The total Medicaid expenditures for day habilitation - level 3 services for the waiver year.	Number (Decimal)	17
II. A.5 Day Habilitation Services - Level 4	The total Medicaid expenditures for day habilitation - Level 4 services for the waiver year.	Number (Decimal)	17
II. A.6 Day Habilitation W/Transportation - Level 1	The total Medicaid expenditures for day habilitation w/transportation - level 1 services for the waiver year.	Number (Decimal)	17
II. A.7 Day Habilitation W/Transportation - Level 2	The total Medicaid expenditures for day habilitation w/transportation - level 2 services for the waiver year.	Number (Decimal)	17
II. A.8 Day Habilitation W/Transportation - Level 3	The total Medicaid expenditures for day habilitation w/transportation - level 3 services for the waiver year.	Number (Decimal)	17
II. A.9 Day Habilitation W/Transportation - Level 4	The total Medicaid expenditures for day habilitation w/transportation - level 4 services for the waiver year.	Number (Decimal)	17
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
III. Average Per Capita Annual Expenditure for All Other Medicaid Services	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915 C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver recipients receiving services while in the waiver within the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1	Number (Decimal)	17
Levels of Care In Approved Waiver	All institutional care claims within a waiver year are associated with ICF-MR.	Character	20
V. A. 1. Total Days Of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	Number (Decimal)	11
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	Number (Decimal)	17

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7.11 MAR-4842 – CMS 372 ANNUAL REPORT ON HCBS TA WAIVER (SHORT) REPORT

7.11.1 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Narrative

The CMS 372 Annual Report On HCBS TA Waiver (Short) report contains information on the participation of recipients in the TA (Technology Assisted Waiver For Adults) waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.11.2 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Layout

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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                              Page:          1
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    PRIVATE DUTY NURSING-RN                                                     9,999,999,999
A.2    PRIVATE DUTY NURSING-LPN                                                    9,999,999,999
A.3    PERSONAL CARE/ATTENDANT SERVICE                                             9,999,999,999
A.4    MEDICAL SUPPLIES AND APPLIANCES                                             9,999,999,999
A.5    ASSISTIVE TECHNOLOGY                                                        9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                     9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES               $9,999,999,999.99

A.1    PRIVATE DUTY NURSING-RN                                                     $9,999,999,999.99
A.2    PRIVATE DUTY NURSING-LPN                                                    $9,999,999,999.99
A.3    PERSONAL CARE/ATTENDANT SERVICE                                             $9,999,999,999.99
A.4    MEDICAL SUPPLIES AND APPLIANCES                                             $9,999,999,999.99
A.5    ASSISTIVE TECHNOLOGY                                                        $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                              Page:          2
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                  D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                          9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                  9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                              Page:          3
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                            Page:          4
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    PRIVATE DUTY NURSING-RN                                                     9,999,999,999
A.2    PRIVATE DUTY NURSING-LPN                                                    9,999,999,999
A.3    PERSONAL CARE/ATTENDANT SERVICE                                             9,999,999,999
A.4    MEDICAL SUPPLIES AND APPLIANCES                                             9,999,999,999
A.5    ASSISTIVE TECHNOLOGY                                                        9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                     9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES               $9,999,999,999.99

A.1    PRIVATE DUTY NURSING-RN                                                     $9,999,999,999.99
A.2    PRIVATE DUTY NURSING-LPN                                                    $9,999,999,999.99
A.3    PERSONAL CARE/ATTENDANT SERVICE                                             $9,999,999,999.99
A.4    MEDICAL SUPPLIES AND APPLIANCES                                             $9,999,999,999.99
A.5    ASSISTIVE TECHNOLOGY                                                        $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
```


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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                              Page:          5
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                           $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                  D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                   9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                            9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                            Page:          6
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                      *** END OF REPORT ***
```


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7.11.3 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Field Descriptions

Field	Description	Length	Data Type
I. A.1 Private Duty Nursing RN	Total unduplicated count of waiver recipients receiving private duty nursing (RN) services within the waiver year.	11	Number (Decimal)
I. A.2 Private Duty Nursing LPN	Total unduplicated count of waiver recipients receiving private duty nurse (LPN) services within the waiver year.	11	Number (Decimal)
I. A.3 Personal Care/ Attendant Services	Total unduplicated count of waiver recipients receiving personal care attendant services within the waiver year.	11	Number (Decimal)
I. A.4 Medical Supplies and Appliances	Total unduplicated count of waiver recipients receiving medical supplies and appliances services within the waiver year.	11	Number (Decimal)
I. A.5 Assistive Technology	Total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	11	Number (Decimal)
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	Total unduplicated count of waiver recipients receiving waiver services within the waiver year.	11	Number (Decimal)
II. A. Total CMS Approved Section 1915(C) Waiver Services Expenditures	Total expenditures on waiver services during the waiver year.	17	Number (Decimal)
II. A.1 Private Duty Nursing RN	The total Medicaid expenditures for Private Duty Nurse RN services for the waiver year.	17	Number (Decimal)
II. A.2 Private Duty Nursing LPN	The total Medicaid expenditures for Private Duty Nurse LPN services for the waiver year.	17	Number (Decimal)
II. A.3 Personal Care/ Attendant Services	The total Medicaid expenditures for Personal Care Attendant services for the waiver year.	17	Number (Decimal)
II. A.4 Medical Supplies and Appliances	The total Medicaid expenditures for Medical Supplies and Appliances services for the waiver year.	17	Number (Decimal)
II.. A.5 Assistive Technology	The total Medicaid expenditures for Assistive Technology services for the waiver year.	17	Number (Decimal)

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Field	Description	Length	Data Type
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
III. Average Per Capita Annual Expenditure for all Other Medicaid Services	The average acute care service expenditures accumulated by the waiver members during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver members receiving services while in the waiver within the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D')	Unduplicated count of waiver recipients receiving physician services while in the waiver within the waiver year.	17	Number (Decimal)
Levels of Care in Approved Waiver	The average acute care service expenditures accumulated by the waiver members during the waiver year.	20	Character
V. A. 1. Total Days of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	11	Number (Decimal)
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	17	Number (Decimal)

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7.12 MAR-4852-A -- CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER (SHORT) REPORT

7.12.1 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Narrative

The CMS 372 Annual Report On HCBS SAIL Waiver (Short) report contains information on the participation of recipients in the SAIL (State of Alabama Independent Living) waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.12.2 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Layout

```
Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA485                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                            Page:          1
                                                     EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  : X   LAG REPORT:
LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF
I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT                                                                     9,999,999,999
A.2    PERSONAL CARE                                                                       9,999,999,999
A.3    ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                             9,999,999,999
A.4    MEDICAL SUPPLIES                                                                    9,999,999,999
A.5    PERSONAL EMERGENCY RESPONSE SYSTEMS-INITIAL                                         9,999,999,999
A.6    PERSONAL EMERGENCY RESPONSE SYSTEMS-MONTHLY                                         9,999,999,999
A.7    ASSISTIVE TECHNOLOGY                                                                9,999,999,999
A.8    MINOR ASSISTIVE TECHNOLOGY                                                          9,999,999,999
A.9    PERSONAL ASSISTIVE SERVICES                                                         9,999,999,999
A.10   EVALUATION FOR ASSISTIVE TECHNOLOGY                                                 9,999,999,999
A.11   ASSISTIVE TECHNOLOGY REPAIRS                                                        9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                             9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                       $9,999,999,999.99

A.1    CASE MANAGEMENT                                                                     $9,999,999,999.99
A.2    PERSONAL CARE                                                                       $9,999,999,999.99
A.3    ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                             $9,999,999,999.99
A.4    MEDICAL SUPPLIES                                                                    $9,999,999,999.99
A.5    PERSONAL EMERGENCY RESPONSE SYSTEMS-INITIAL                                         $9,999,999,999.99
A.6    PERSONAL EMERGENCY RESPONSE SYSTEMS-MONTHLY                                         $9,999,999,999.99
A.7    ASSISTIVE TECHNOLOGY                                                                $9,999,999,999.99
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A.8    MINOR ASSISTIVE TECHNOLOGY                                          $9,999,999,999.99
A.9    PERSONAL ASSISTIVE SERVICES                                         $9,999,999,999.99
A.10   EVALUATION FOR ASSISTIVE TECHNOLOGY                                 $9,999,999,999.99
A.11   ASSISTIVE TECHNOLOGY REPAIRS                                        $9,999,999,999.99
B.1.   AVERAGE PER CAPITA SECTION 1915C                                    $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA485                      MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: MR372RPT                     CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                   Page:          2
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                             NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                        9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                 9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.
```


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C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA485                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                     CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                           Page:          3
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA485                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                     CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                           Page:          4
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT                                                              9,999,999,999
A.2    PERSONAL CARE                                                                9,999,999,999
A.3    ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                      9,999,999,999
A.4    MEDICAL SUPPLIES                                                             9,999,999,999
A.5    PERSONAL EMERGENCY RESPONSE SYSTEMS-INITIAL                                  9,999,999,999
A.6    PERSONAL EMERGENCY RESPONSE SYSTEMS-MONTHLY                                  9,999,999,999
A.7    ASSISTIVE TECHNOLOGY                                                         9,999,999,999
A.8    MINOR ASSISTIVE TECHNOLOGY                                                   9,999,999,999
A.9    PERSONAL ASSISTIVE SERVICES                                                  9,999,999,999
A.10   EVALUATION FOR ASSISTIVE TECHNOLOGY                                          9,999,999,999
A.11   ASSISTIVE TECHNOLOGY REPAIRS                                                 9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                      9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES               $9,999,999,999.99

A.1    CASE MANAGEMENT                                                             $9,999,999,999.99
A.2    PERSONAL CARE                                                               $9,999,999,999.99
A.3    ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                     $9,999,999,999.99
A.4    MEDICAL SUPPLIES                                                            $9,999,999,999.99
A.5    PERSONAL EMERGENCY RESPONSE SYSTEMS-INITIAL                                 $9,999,999,999.99
A.6    PERSONAL EMERGENCY RESPONSE SYSTEMS-MONTHLY                                 $9,999,999,999.99
A.7    ASSISTIVE TECHNOLOGY                                                        $9,999,999,999.99
A.8    MINOR ASSISTIVE TECHNOLOGY                                                  $9,999,999,999.99
A.9    PERSONAL ASSISTIVE SERVICES                                                 $9,999,999,999.99
A.10   EVALUATION FOR ASSISTIVE TECHNOLOGY                                         $9,999,999,999.99
A.11   ASSISTIVE TECHNOLOGY REPAIRS                                                $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
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Process : MARJA485                    MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                   CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                            Page:          5
                                                   EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                          $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                   9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                            9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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```
Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA485                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                     CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                           Page:          6
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                        *** END OF REPORT ***
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7.12.3 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Field Descriptions

Field	Description	Length	Data Type
I. A.1 Case Management	Total unduplicated count of waiver recipients receiving case management services within the waiver year.	11	Number (Decimal)
I. A.2 Personal Care	Total unduplicated count of waiver recipients receiving personal care services within the waiver year.	11	Number (Decimal)
I. A.3 Environmental Accessibility Adaptations	Total unduplicated count of waiver recipients receiving environmental accessibility adaptations services within the waiver year.	11	Number (Decimal)
I. A.4 Medical Supplies	Total unduplicated count of waiver recipients receiving medical supplies services within the waiver year.	11	Number (Decimal)
I. A.5 Personal Emergency Response System (Initial)	Total unduplicated count of waiver recipients receiving personal emergency response system (initial) services within the waiver year.	11	Number (Decimal)
I. A.6 Personal Emergency Response System (Monthly)	Total unduplicated count of waiver recipients receiving personal emergency response system (monthly) services within the waiver year.	11	Number (Decimal)
I. A.7 Assistive Technology	Total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	11	Number (Decimal)
I. A.8 Minor Assistive Technology	Total unduplicated count of waiver recipients receiving evaluations for minor assistive technology services within the waiver year.	11	Number (Decimal)
I. A.9 Personal Assistive Services	Total unduplicated count of waiver recipients receiving personal assistive service within the waiver year.	11	Number (Decimal)
I. A.10 Evaluation for Assitive Technology	Total unduplicated count of waiver recipients receiving evaluation for assistive technology services within the waiver year.	11	Number (Decimal)
I. A.11 Assistive Technology Repairs	The total Medicaid expenditures for assistive technology repairs services for the waiver year.	17	Number (Decimal)
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients Served	Total unduplicated count of waiver recipients receiving waiver services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
II. A. Total CMS Approved Section 1915 (C) Waiver Services Expenditures	Total expenditures on waiver services during the waiver year.	17	Number (Decimal)
II. A.1 Case Management	Total Medicaid expenditures for case management services for the waiver year.	17	Number (Decimal)
II. A.2 Personal Care	Total Medicaid expenditures for personal care services for the waiver year.	17	Number (Decimal)
II. A.3 Environmental Accessibility Adaptations	Total Medicaid expenditures for environmental accessibility adaptation services for the waiver year.	17	Number (Decimal)
II. A.4 Medical Supplies	Total Medicaid expenditures for medical supplies services for the waiver year.	17	Number (Decimal)
II. A.5 Personal Emergency Response System (Initial)	Total Medicaid expenditures for personal emergency response system (initial) services for the waiver year.	17	Number (Decimal)
II. A.6 Personal Emergency Response System (Monthly)	Total Medicaid expenditures for personal emergency response system (monthly) services for the waiver year.	17	Number (Decimal)
II. A.7 Assistive Technology	Total Medicaid expenditures for assistive technology services for the waiver year.	17	Number (Decimal)
II. A.8 Minor Assistive Technology	Total Medicaid expenditures for evaluations for minor assistive technology service for the waiver year.	17	Number (Decimal)
II. A.9 Assistive Technology Repairs	Total Medicaid expenditures for assistive technology repair service for the waiver year.	17	Number (Decimal)
II. A.10 Personal Assistance Services	Total Medicaid expenditures for personal assistance services within the year.	17	Number (Decimal)
II. A.11 Assistive Technology Repairs	The total Medicaid expenditures for assistive technology repairs services for the waiver year.	17	Number (Decimal)

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Field	Description	Length	Data Type
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures (Actual Factor D Values)	Average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
III. Average Per Capita Annual Expenditure for all Other Medicaid Services	The average acute care service expenditures accumulated by the waiver members during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver members receiving services while in the waiver within the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver members during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver members during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of members in Section V. B.1.	17	Number (Decimal)
V. A. 1. Total Days Of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	11	Number (Decimal)
V. A. 2. Average Length Of Waiver Coverage By Level Of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	17	Number (Decimal)

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7.13 MAR-4862-A -- CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER (SHORT) REPORT

7.13.1 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Narrative

The CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) report contains information on the participation of recipients in the HIV / AIDS waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.13.2 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Layout

```
Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                      Page:          1
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT SERVICES                                                   9,999,999,999
A.2    PERSONAL CARE                                                              9,999,999,999
A.3    RESPITE CARE-SKILLED                                                       9,999,999,999
A.4    RESPITE CARE-UNSKILLED                                                     9,999,999,999
A.5    HOMEMAKER SERVICES                                                         9,999,999,999
A.6    SKILLED NURSING                                                            9,999,999,999
A.7    COMPANION SERVICE                                                          9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                    9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES              $9,999,999,999.99

A.1    CASE MANAGEMENT SERVICES                                                   $9,999,999,999.99
A.2    PERSONAL CARE                                                              $9,999,999,999.99
A.3    RESPITE CARE-SKILLED                                                       $9,999,999,999.99
A.4    RESPITE CARE-UNSKILLED                                                     $9,999,999,999.99
A.5    HOMEMAKER SERVICES                                                         $9,999,999,999.99
A.6    SKILLED NURSING                                                            $9,999,999,999.99
A.7    COMPANION SERVICE                                                          $9,999,999,999.99
B.1.   AVERAGE PER CAPITA SECTION 1915C                                           $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
```


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```
       FACTOR D VALUE/S)


Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                        Page:          2
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                                $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                            9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                     9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                      Page:          3
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                      Page:          4
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT SERVICES                                                     9,999,999,999
A.2    PERSONAL CARE                                                                9,999,999,999
A.3    RESPITE CARE-SKILLED                                                         9,999,999,999
A.4    RESPITE CARE-UNSKILLED                                                       9,999,999,999
A.5    HOMEMAKER SERVICES                                                           9,999,999,999
A.6    SKILLED NURSING                                                              9,999,999,999
A.7    COMPANION SERVICE                                                            9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                      9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                $9,999,999,999.99

A.1    CASE MANAGEMENT SERVICES                                                     $9,999,999,999.99
A.2    PERSONAL CARE                                                                $9,999,999,999.99
A.3    RESPITE CARE-SKILLED                                                         $9,999,999,999.99
A.4    RESPITE CARE-UNSKILLED                                                       $9,999,999,999.99
A.5    HOMEMAKER SERVICES                                                           $9,999,999,999.99
A.6    SKILLED NURSING                                                              $9,999,999,999.99
A.7    COMPANION SERVICE                                                            $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                             $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
```


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```
Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                        Page:          5
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                                   NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                              $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                            9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                     9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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```
Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                      Page:          6
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                        *** END OF REPORT ***
```


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7.13.3 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Field Descriptions

Field	Description	Data Type	Length
I. A.1 Case Management Services	A total unduplicated count of waiver recipients receiving case management services within the waiver year.	Number (Decimal)	11
I. A.2 Personal Care	A total unduplicated count of waiver recipients receiving personal care services within the waiver year.	Number (Decimal)	11
I. A.3 Respite Care-Skilled	A total unduplicated count of waiver recipients receiving respite care-skilled services within the waiver year.	Number (Decimal)	11
I. A.4 Respite Care-Unskilled	A total unduplicated count of waiver recipients receiving respite care-unskilled services within the waiver year.	Number (Decimal)	11
I. A.5 Homemaker Services	A total unduplicated count of waiver recipients receiving homemaker services services within the waiver year.	Number (Decimal)	11
I. A.6 Skilled Nursing	A total unduplicated count of waiver recipients receiving skilled nursing services within the waiver year.	Number (Decimal)	11
I. A.7 Companion Service	A total unduplicated count of waiver recipients receiving companion services within the waiver year.	Number (Decimal)	11
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	The total unduplicated count of waiver recipients receiving waiver services within the waiver year.	Number (Decimal)	11
II. A. Total Approved Section 1915 (C) Waiver Services Expenditures	The total expenditures on waiver services during the waiver year.	Number (Decimal)	17
II.A.1 Case Management Services	The total Medicaid expenditures for case management services for the waiver year.	Number (Decimal)	17
II.A.2 Personal Care	The total Medicaid expenditures for personal care services for the waiver year.	Number (Decimal)	17
II.A.3 Respite Care-Skilled	The total Medicaid expenditures for respite care-skilled services for the waiver year.	Number (Decimal)	17
II. A.4 Respite Care-Unskilled	The total Medicaid expenditures for respite care-unskilled services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.5 Homemaker Services	The total Medicaid expenditures for homemaker services for the waiver year.	Number (Decimal)	17
II. A.6 Skilled Nursing	The total Medicaid expenditures for skilled nursing services for the waiver year.	Number (Decimal)	17
II. A.7 Companion Service	The total Medicaid expenditures for companion services for the waiver year.	Number (Decimal)	17
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
III.Average Per Capita Annual Expenditure For All Other Medicaid Services	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver recipients receiving services while in the waiver within the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
Levels Of Care In Approved Waiver	All institutional care claims within a waiver year are associated with NF.	Character	20
V. A. 1. Total Days Of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	Number (Decimal)	11

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Field	Description	Data Type	Length
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	Number (Decimal)	17

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7.14 MAR-4872-A -- CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER (SHORT) REPORT

7.14.1 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Narrative

The CMS 372 Annual Report On HCBS ACT Waiver (Short) report contains information on the participation of recipients in the ACT waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

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7.14.2 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Layout

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Report  : MAR-4872-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA487                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                   CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER                          Page:          1
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                      NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT SERVICES                                                  9,999,999,999
A.2    TRANSITIONAL ASSISTANCE                                                   9,999,999,999
A.3    PERSONAL CARE                                                             9,999,999,999
A.4    HOMEMAKER                                                                 9,999,999,999
A.5    ADULT DAY HEALTH                                                          9,999,999,999
A.6    HOME DELIVERED MEAL                                                       9,999,999,999
A.7    WAIVER SHELF STABLE                                                       9,999,999,999
A.8    BREAKFAST MEALS                                                           9,999,999,999
A.9    RESPITE CARE SKILLED                                                      9,999,999,999
A.10   RESPITE CARE UNSKILLED                                                    9,999,999,999
A.11   SKILLED NURSING RN                                                        9,999,999,999
A.12   SKILLED NURSING LPN                                                       9,999,999,999
A.13   ADULT COMPANION                                                           9,999,999,999
A.14   HOME MODIFICATIONS                                                        9,999,999,999
A.15   ASSISTIVE TECHNOLOGY                                                      9,999,999,999
A.16   PERS INSTALLATION                                                         9,999,999,999
A.17   PERS MONTHLY FEE                                                          9,999,999,999
A.18   MEDICAL EQUIPMENT SUPPLIES                                                9,999,999,999
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B.1.	TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED	9,999,999,999
II.	ANNUAL SECTION 1915C WAIVER EXPENDITURES	
A.	TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES	$9,999,999,999.99
A.1	CASE MANAGEMENT SERVICES	$9,999,999,999.99
A.2	TRANSITIONAL ASSISTANCE	$9,999,999,999.99
A.3	PERSONAL CARE	$9,999,999,999.99
A.4	HOMEMAKER SERVICES	$9,999,999,999.99
A.5	ADULT DAY HEALTH	$9,999,999,999.99
A.6	HOME DELIVERED MEAL	$9,999,999,999.99
A.7	WAIVER SHELF STABLE	$9,999,999,999.99
A.8	BREAKFAST MEALS	$9,999,999,999.99
A.9	RESPITE CARE SKILLED	$9,999,999,999.99
A.10	RESPITE CARE UNSKILLED	$9,999,999,999.99
A.11	SKILLED NURSING RN	$9,999,999,999.99
A.12	SKILLED NURSING LPN	$9,999,999,999.99
A.13	ADULT COMPANION	$9,999,999,999.99
A.14	HOME MODIFICATIONS	$9,999,999,999.99
A.15	ASSISTIVE TECHNOLOGY	$9,999,999,999.99
A.16	PERS INSTALLATION	$9,999,999,999.99
A.17	PERS MONTHLY FEE	$9,999,999,999.99
A.18	MEDICAL EQUIPMENT SUPPLIES	$9,999,999,999.99
B.1.	AVERAGE PER CAPITA SECTION 1915C WAIVER SERVICES EXPENDITURES (ACTUAL FACTOR D VALUE/S)	$9,999,999,999.99

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Report  : MAR-4872-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA487                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                   CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER                            Page:          2
                                                       EXHIBIT B

STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                        9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                9,999,999,999.99
```


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       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
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Report  : MAR-4872-A                  ALABAMA MEDICAID AGENCY                 Run Date: MM/DD/YYYY
Process : MARJA487           MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   HH:MM:SS
Location: MR372RPT          CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER              Page:          3
                                          EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ?????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                    NF
FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)
       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR
       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES WERE DETECTED, (NOTE: INDIVIDUAL
REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND
       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED AS WELL AS AN EXPLANATION OF WHAT STEPS
HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.
CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4872-A                ALABAMA MEDICAID AGENCY                  Run Date: MM/DD/YYYY
Process : MARJA487           MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:   HH:MM:SS
Location: MR372RPT          CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER         Page:          4
                                         EXHIBIT B

STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  : LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                  NF
I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS
A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS
A.1    CASE MANAGEMENT SERVICES                                              9,999,999,999
A.2    TRANSITIONAL ASSISTANCE                                               9,999,999,999
A.3    PERSONAL CARE                                                         9,999,999,999
A.4    HOMEMAKER                                                             9,999,999,999
A.5    ADULT DAY HEALTH                                                      9,999,999,999
A.6    HOME DELIVERED MEAL                                                   9,999,999,999
A.7    WAIVER SHELF STABLE                                                   9,999,999,999
A.8    BREAKFAST MEALS                                                       9,999,999,999
A.9    RESPITE CARE SKILLED                                                  9,999,999,999
A.10   RESPITE CARE UNSKILLED                                                9,999,999,999
A.11   SKILLED NURSING RN                                                    9,999,999,999
A.12   SKILLED NURSING LPN                                                   9,999,999,999
A.13   ADULT COMPANION                                                       9,999,999,999
A.14   HOME MODIFICATIONS                                                    9,999,999,999
A.15   ASSISTIVE TECHNOLOGY                                                  9,999,999,999
A.16   PERS INSTALLATION                                                     9,999,999,999
A.17   PERS MONTHLY FEE                                                      9,999,999,999
A.18   MEDICAL EQUIPMENT SUPPLIES                                            9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                               9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES
```


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A.	TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES	$9,999,999,999.99
A.1	CASE MANAGEMENT SERVICES	$9,999,999,999.99
A.2	TRANSITIONAL ASSISTANCE	$9,999,999,999.99
A.3	PERSONAL CARE	$9,999,999,999.99
A.4	HOMEMAKER SERVICES	$9,999,999,999.99
A.5	ADULT DAY HEALTH	$9,999,999,999.99
A.6	HOME DELIVERED MEAL	$9,999,999,999.99
A.7	WAIVER SHELF STABLE	$9,999,999,999.99
A.8	BREAKFAST MEALS	$9,999,999,999.99
A.9	RESPITE CARE SKILLED	$9,999,999,999.99
A.10	RESPITE CARE UNSKILLED	$9,999,999,999.99
A.11	SKILLED NURSING RN	$9,999,999,999.99
A.12	SKILLED NURSING LPN	$9,999,999,999.99
A.13	ADULT COMPANION	$9,999,999,999.99
A.14	HOME MODIFICATIONS	$9,999,999,999.99
A.15	ASSISTIVE TECHNOLOGY	$9,999,999,999.99
A.16	PERS INSTALLATION	$9,999,999,999.99
A.17	PERS MONTHLY FEE	$9,999,999,999.99
A.18	MEDICAL EQUIPMENT SUPPLIES	$9,999,999,999.99
B.1.	AVERAGE PER CAPITA SECTION 1915C WAIVER SERVICES EXPENDITURES (ACTUAL FACTOR D VALUE/S)	$9,999,999,999.99

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```
Report  : MAR-4872-A                    ALABAMA MEDICAID AGENCY                 Run Date: MM/DD/YYYY
Process : MARJA487              MEDICAID MANAGEMENT INFORMATION SY              Run Time:   HH:MM:SS
Location: MR372RPT            CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER          Page:          5
                                            EXHIBIT B

STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  :     LAG REPORT:  X

LEVEL/S OF CARE IN APPROVED WAIVER                                                    NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                     $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                            9,999,999,999
```


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```
   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                          9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.
C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR LICENSED, AND CORRECTIVE ACTIONS HAVE
BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)
       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND STANDARDS UNDER THE WAIVER.

Report  : MAR-4872-A                ALABAMA MEDICAID AGENCY                 Run Date: MM/DD/YYYY
Process : MARJA487           MEDICAID MANAGEMENT INFORMATION SYSTEM         Run Time:   HH:MM:SS
Location: MR372RPT           CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER       Page:          6
                                          EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ?????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                    NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES WERE DETECTED, (NOTE: INDIVIDUAL
REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND
```


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[ ] 7. ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION: I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNED: _____

TITLE: _____

DATE: _____

CONTACT PERSON: _____

TELEPHONE NUMBER: _____

*** END OF REPORT ***

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7.14.3 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Field Descriptions

Field	Description	Data Type	Length
I. A.1 Case Management Services	A total unduplicated count of waiver recipients receiving case management services within the waiver year.	Number (Decimal)	11
I. A.2 Transitional Assistance	A total unduplicated count of waiver recipient's transitional assistance services within the waiver year.	Number (Decimal)	11
I. A.3 Personal Care	A total unduplicated count of waiver recipients receiving personal care services within the waiver year.	Number (Decimal)	11
I. A.4 Homemaker Services	A total unduplicated count of waiver recipients receiving homemaker services within the waiver year.	Number (Decimal)	11
I. A.5 Adult Day Health	A total unduplicated count of waiver recipients receiving adult day health services within the waiver year.	Number (Decimal)	11
I. A.6 Home Delivered Meal	A total unduplicated count of waiver recipients receiving home delivered meal services within the waiver year.	Number (Decimal)	11
I. A.7 Waiver Shelf Stable	A total unduplicated count of waiver recipients receiving waiver shelf stable services within the waiver year.	Number (Decimal)	11
I. A.8 Breakfast Meals	A total unduplicated count of waiver recipients receiving breakfast meal services within the waiver year.	Number (Decimal)	11
I. A.9 Respite Care-Skilled	A total unduplicated count of waiver recipients receiving respite care-skilled services within the waiver year.	Number (Decimal)	11
I. A.10 Respite Care-Unskilled	A total unduplicated count of waiver recipients receiving respite care-unskilled services within the waiver year.	Number (Decimal)	11
I. A.11 Skilled Nursing RN	A total unduplicated count of waiver recipients receiving skilled nursing RN services within the waiver year.	Number (Decimal)	11

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Field	Description	Data Type	Length
I. A.12 Skilled Nursing LPN	A total unduplicated count of waiver recipients receiving skilled nursing LPN services within the waiver year.	Number (Decimal)	11
I. A.13 Adult Companion	A total unduplicated count of waiver recipients receiving adult companion services within the waiver year.	Number (Decimal)	11
I. A.14 Home Modifications	A total unduplicated count of waiver recipients receiving home modification services within the waiver year.	Number (Decimal)	11
I. A.15 Assistive Technology	A total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	Number (Decimal)	11
I. A.16 PERS Installation	A total unduplicated count of waiver recipients receiving PER installation services within the waiver year.	Number (Decimal)	11
I. A.17 PERS Monthly Fee	A total unduplicated count of waiver recipients receiving PER monthly fee services within the waiver year.	Number (Decimal)	11
I. A.18 Medical Equipment Supplies	A total unduplicated count of waiver recipients receiving medical equipment supplies services within the waiver year.	Number (Decimal)	11
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	The total unduplicated count of waiver recipients receiving waiver services within the waiver year.	Number (Decimal)	11
II. A. Total Approved Section 1915 (C) Waiver Services Expenditures	The total expenditures on waiver services during the waiver year.	Number (Decimal)	17
II.A.1 Case Management Services	The total Medicaid expenditures for case management services for the waiver year.	Number (Decimal)	17
II. A.2 Transitional Assistance	The total Medicaid expenditures for transitional assistance services for the waiver year.	Number (Decimal)	17
II. A.3 Personal Care	The total Medicaid expenditures for personal care services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.4 Homemaker Services	The total Medicaid expenditures for homemaker services for the waiver year.	Number (Decimal)	17
II. A.5 Adult Day Health	The total Medicaid expenditures for adult day health services for the waiver year.	Number (Decimal)	17
II. A.6 Home Delivered Meal	The total Medicaid expenditures for home delivered meal services for the waiver year.	Number (Decimal)	17
II. A.7 Waiver Shelf Stable	The total Medicaid expenditures for waiver shelf stable services for the waiver year.	Number (Decimal)	17
II. A.8 Breakfast Meals	The total Medicaid expenditures for breakfast meal services for the waiver year.	Number (Decimal)	17
II. A.9 Respite Care-Skilled	The total Medicaid expenditures for respite care-skilled services for the waiver year.	Number (Decimal)	17
II. A.10 Respite Care-Unskilled	The total Medicaid expenditures for respite care-unskilled services for the waiver year.	Number (Decimal)	17
II. A.11 Skilled Nursing RN	The total Medicaid expenditures for skilled nursing RN services for the waiver year.	Number (Decimal)	17
II. A.12 Skilled Nursing LPN	The total Medicaid expenditures for skilled nursing LPN services for the waiver year.	Number (Decimal)	17
II. A.13 Adult Companion	The total Medicaid expenditures for adult companion services for the waiver year.	Number (Decimal)	17
II. A.14 Home Modifications	The total Medicaid expenditures for home modification services for the waiver year.	Number (Decimal)	17
II. A.15 Assistive Technology	The total Medicaid expenditures for assistive technology services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.16 PERS Installation	The total Medicaid expenditures for PER installation services for the waiver year.	Number (Decimal)	17
II. A.17 PERS Monthly Fee	The total Medicaid expenditures for PER monthly fee services for the waiver year.	Number (Decimal)	17
II. A.18 Medical Equipment Supplies	The total Medicaid expenditures for medical equipment supplies services for the waiver year.	Number (Decimal)	17
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
III.Average Per Capita Annual Expenditure For All Other Medicaid Services	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver recipients receiving services while in the waiver within the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
Levels Of Care In Approved Waiver	All institutional care claims within a waiver year are associated with NF.	Character	20

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Field	Description	Data Type	Length
V. A. 1. Total Days Of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	Number (Decimal)	11
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	Number (Decimal)	17

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