



## **FINANCIAL REPORTING GUIDE FOR ALTCS CONTRACTORS**

**Effective Date October 1, 2022**

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## **DEFINITIONS**

The definitions in this Financial Reporting Guide are in addition to the contractual definitions found in Section C in the ALTCS EPD Contract.

### **ADMINISTRATIVE COSTS**

Administrative expenses incurred to manage the health system, including, but not limited to provider relations and contracting; provider billing; provider sub-capitation administration provision; non-encounterable PBM fees (e.g., discrete administrative fee for pharmacy network development/management, pharmacy discount negotiating, drug utilization management/review, coordination of specialty drugs, pharmacy claims processing, pharmacy call center operations, reporting, etc.); quality improvement activities; accounting; information technology services; processing and investigating grievances and appeals; legal services, which includes legal representation of the Contractor at administrative hearings; planning; program development; program evaluation; personnel management; staff development and training; provider auditing and monitoring; utilization review and quality assurance. Administrative costs do not include expenses incurred for the direct provision of health care services, including behavioral health provider-delivered case management, or integrated health care services.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS):** Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program, and described in A.R.S. Title 36, Chapter 29.

**AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM):** The ACOM provides policy information related to AHCCCS Contractor operations and is available on the AHCCCS website at [www.azahcccs.gov](http://www.azahcccs.gov).

**ALTERNATIVE PAYMENT MODEL (APM) (FORMERLY VALUE BASED PURCHASING):** A model which aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality. APM strategies for this initiative may include any combination of Primary Care Incentives, Performance-Based Contracts, Bundled/Episode Payments, Shared Savings, Shared Risk and Capitation + Performance-Based Contracts purchasing strategies as defined in ACOM 307, Alternative Payment Model Performance Based Payments to Providers.

**AFFILIATE:** A party that directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with an enterprise. Control refers to the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract or otherwise.

### **BEHAVIORAL HEALTH SERVICES:**

The assessment, diagnosis, or treatment of an individual's behavioral health issue and includes services for both mental health and substance abuse conditions.

**CAPITATION:** Payment to a Contractor by AHCCCS, of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.

**CARE MANAGEMENT**

Care Management is a group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery. Refer to also AMPM 1000.

**CASE MANAGEMENT**

Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

**COMMUNITY REINVESTMENT:** Community Reinvestment is a strategy that requires Contractors to reinvest a designated portion of profits into the local community.

**CONTRACT YEAR**

The period from October 1, through September 30.

**CONTRACTOR:** An organization or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. §36-2904, §36-2940, or §36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.

**COST SHARING:** Contractor payment on behalf of recipients for Medicare and private insurer costs, including premiums, deductibles and coinsurance.

**DAY:** Calendar day unless otherwise specified.

**DIAGNOSTIC IMAGING:** The techniques and processes used to create images of the human body for clinical purposes.

**DURAL ELIGIBLE:** A member who is eligible for both Medicare and Medicaid.

**DURABLE MEDICAL EQUIPMENT:** An item or appliance that is not an orthotic or prosthetic and that is: designed for a medical purpose, is generally not useful to a person in the absence of an illness or injury, can withstand repeated use, and is generally reusable by others.

**ENROLLMENT:** The process by which an eligible person becomes a member of a Contractor's health plan.

**FINANCIAL PACKAGE:** The package of financial documents to be submitted to AHCCCS/DHCM (Division of Health Care Management).

**FEDERALLY QUALIFIED HEALTH CENTER:** A public or private non-profit health care organization that has been identified by the Health Resources and Services Administration (HRSA) and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1950(1)(2)(B) of the Social Security Act.

**FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE:** A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of “health center” under Section 330 of the Public Health Service Act, but does not receive grant funding under Section 330.

**FEE-FOR-SERVICE:** A method of payment to registered providers on an amount per service basis.

**FQHC/RHC VISIT:** Face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

**HEALTH CARE QUALITY IMPROVEMENT:** Activities that improve health outcomes, prevent hospital readmission, improve patient safety and reduce medical errors, wellness and health promotion activities and health information technology expenses related to improving health care quality.

**HEALTH INSURER FEE:** Section 9010 of the Patient Protection and Affordable Care Act (ACA) requires that the Contractor, if applicable, pay a Health Insurer Fee (HIF) annually beginning in calendar year 2014 based on its respective market share of premium revenues from the preceding year. Insurer market share excludes premiums related to accident and disability insurance, coverage for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, long-term care insurance, and Medicare supplement insurance.

**HEALTH AND COMMUNITY BASED SERVICES (HCBS):** Home and community-based services, as defined in A.R.S. § 36-2931 and 36-2939.

**HOME HEALTH:** Health and supportive services provided in an AHCCCS member's home. This service shall be provided under the direction of a physician to prevent hospitalization or institutionalization and may include nursing, therapies, supplies and home health aide services. It shall be provided on a part-time or intermittent basis.

**INCURRED BUT NOT REPORTED CLAIMS (IBNR):** Incurred but not reported liability for services rendered for which claims have not been received.

**INPATIENT:** A patient who is provided with room, board, and general nursing services in a hospital setting and is expected to occupy a bed and remain at least overnight.

**INSTITUTIONAL:** Inpatient room, board, and nursing services provided to members who require services on a continuous basis but who do not require hospital care or direct daily care from a physician.

**INTERPRETATION/TRANSLATION SERVICES:** Interpretation is the conversion of oral communication from English into the members preferred language while maintaining the original intent. Translation is the conversion of written communication from English into the member's preferred language while maintaining original intent. For additional information, refer to ACOM 405, Cultural Competency, Language Access Plan and Family/Member Centered Care.

**MANAGED CARE:** Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.

**MEDICAL EXPENSE:** Expenses reported through fully adjudicated encounters and sub-capitated/block purchase expenses incurred by the Contractor for covered services with dates of service related to the contract year being reconciled.

**MEDICAL SERVICES:** Medical care and treatment provided by a Primary Care Provider, attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.

**NURSING FACILITY ASSESSMENT FUNDS:** Nursing facility assessment funds are matched with Federal Medicaid dollars; the majority of the funds are paid to ALTCS EPD Contractors so that they can pass through enhanced payments to nursing facilities in accordance with Federal and State laws and regulations and CMS approval.

**NURSING FACILITY ENHANCED PAYMENT REVENUE:** Provider supplemental payments related to Fee-For-Service utilization are made directly to nursing facility providers from the Administration.

**OUTPATIENT:** A patient who is not confined overnight in a health care institution.

**PHARMACY:** An establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist, who is registered pursuant to A.R.S. Title 32, Chapter 18.

**PHYSICIAN SERVICES:** Services provided within the scope of the practice of medicine or osteopathy, as defined by State law, or under the personal supervision of an individual, licensed under State law to practice medicine or osteopathy. Physician services exclude those services routinely performed and not directly related to the medical care of the individual patient.

**PRIOR PERIOD COVERAGE (PPC):** The period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time frame is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1.

**PROGRAM INTEGRITY FRAUD, WASTE, AND ABUSE PREVENTION EXPENSES:** Improvement to infrastructure that prevent fraud, waste, and abuse on a going forward basis.

**PROVIDER:** Any person or entity who contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.

**RECEIVED BUT UNPAID CLAIMS (RBUC):** Claims that have been received by the Contractor but have not been paid. A claim is considered received the day it is physically received by the Contractor.

**REINSURANCE:** A risk-sharing program provided by AHCCCS to the contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.

**RELATED PARTY TRANSACTIONS:** Transactions with a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. "Related parties" or "Affiliates" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

**RURAL HEALTH CLINIC:** A clinic located in an area designated by the Bureau of census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.

**SHARE OF COST (SOC):** ALTCS members' contribution toward the cost of their care based on their income and type of placement.

**SUB-CAPITATION:** A fixed premium paid by a Contractor to a provider of health care services with which the Contractor has a contract. The provider is at risk for the designated services.



**SUBCONTRACT:** An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract, as defined in 9 A.A.C. 22 Article 1.

**SUBCONTRACTOR:** 1. A provider of health care who agrees to furnish covered services to members. 2. A person, agency, or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities. 3. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.

**THIRD PARTY:** An individual, entity, or program that is, or may be, liable to pay all, or part of, the medical cost of injury, disease, or disability of an AHCCCS applicant or member as defined in R9-22-1001.

**VALUE-ADDED SERVICES:** Value-added services (VAS) are extra benefits offered by MCOs beyond the Medicaid services that are covered by AHCCCS and are not funded by capitation revenue. VAS may be actual health care services, benefits or positive incentives that promote healthy lifestyles and improve health outcomes among members, including items previously defined as member incentive items.

## *ACRONYMS*

AHCCCS	Arizona Health Care Cost Containment System
AICPA	American Institute of Certified Public Accountants
ALTCS	Arizona Long Term Care Services
CPT	Current Procedure Terminology
DES	Department of Economic Security
DDD	Division of Development Disabilities
DHCM	Division of Health Care Management
FASB	Financial Accounting Standards Board
GAAP	Generally Accepted Accounting Principles
GSA	Geographic Service Area
HCBS	Home and Community Based Services
HCPCS	HCFA Common Procedure Coding System
IBNR	Incurred But Not Reported (claim)
MAO	Medicare Advantage Organization
PPC	Prior Period Coverage
RBUC	Reported But Unpaid Claim
SOC	Share of Cost
VAS	Value-added Services

## 1.00 GENERAL INFORMATION

### 1.01 Purpose and Objective of the Guide

The purpose of the Financial Reporting Guide (Guide) for the ALTCS contractors with the AHCCCS is to set forth the monthly, quarterly, annual, and ad hoc financial related reporting requirements for ALTCS Contractors and the DDD Contractor. The primary objective of the Guide is to establish consistency and uniformity in financial reporting. This Guide is neither intended to limit the scope of audit procedures to be performed during the Contractor's annual certified audit, nor to replace the independent Certified Public Accountant's judgment as to the work to be performed. It is instead intended to define certain additional procedures and analysis to be performed and reported on by the applicable Contractor management on a periodic basis and by the independent Certified Public Accountants on an annual basis.

The contract with AHCCCS requires that Contractors furnish information from their records relating to the performance under the contract. Certain financial and statistical data are outlined in the contract as minimum reporting requirements.

Included in the minimum reporting requirement is the disclosure of Non-Compliance with Financial Viability Standards and Performance Guidelines (Footnote 12). Any non-compliance with Financial Viability Standards and Performance Guidelines and the factors causing the non-compliance and the Contractor's action to resolve the issue(s) must be disclosed at the time the financial package is submitted. Waiting until information is requested by AHCCCS is not acceptable. In the case of equity per member deficiencies, measures should be taken to cure the deficiencies immediately upon discovery and supporting documentation (monthly balance sheet) for all capital contributions should be submitted as soon as the deficiency is identified.

AHCCCS has developed a standard set of forms (Financial Statement Reporting Template) and a CUBE Flat File to be used to satisfy the financial reporting requirements as well as guidelines and minimum reporting requirements for the annual audited financial statements. This Guide is intended to outline these requirements and also provides examples of required reports in the Appendix to the guide. This guide is not intended nor should it be construed as an all-inclusive manual. The format and content of the required reports are subject to change. Questions regarding the content or format of a report are to be directed to the Contractor's assigned Financial Consultant.

Contractors are required to utilize the most recent Financial Statement Reporting Template provided by the Division of Health Care Management (DHCM) for submission of all required quarterly and annual reports. Any alterations to the templates provided will result in the financial reporting package being returned to the Contractor for resubmission and this may result in a sanction.

If the Contractor is a Medicare Advantage Organization licensed through the Department of Insurance and Financial Institutions (DIFI), quarterly reporting to AHCCCS is required for informational purposes only. AHCCCS will accept a copy of

the NAIC filing submitted to the DIFI. AHCCCS acknowledges that the quarter ending 12/31/xx filing to DIFI is due 90 days after quarter end and thus is due to AHCCCS at the same time it is filed with DIFI. If the Contractor is a Medicare Advantage Plan certified by AHCCCS, then for quarterly reporting to AHCCCS the Contractor shall use the applicable AHCCCS Financial Reporting Guide and the related Financial Statement Reporting Template.

Financial statements must be prepared and presented on the accrual basis of accounting and in accordance with Generally Accepted Accounting Principles (GAAP) and all other applicable authoritative literature. If there are any inconsistencies between the Guide and any contract provisions, the contract provisions shall prevail. This Guide is not intended nor should it be construed as an all-inclusive manual. The format and content of the required reports are subject to change. Questions regarding the format of a report are to be directed to the Contractor's assigned Financial Consultant.

## **1.02 Effective Dates and Reporting Time Frames**

The provisions and requirements of this Guide are effective for reporting periods beginning October 1 of every contract year. As deemed necessary, amendments and/or updates to this Guide may be issued by AHCCCS.

Monthly reporting, when required, is due within 30 days of each month end, using either the Contractor's internal financial statement format or the AHCCCS Reporting Guide format as determined by AHCCCS.

Quarterly reporting is due within 60 days of each quarter end, using the most recent AHCCCS Reporting Guide format.

A draft of the annual audited financial statements, supplemental schedules, and annual reconciliation are due within 90 days of the Contractor's fiscal year end. AHCCCS must approve the Contractor's draft audit prior to the Contractor's auditors issuing the final audit report and financial statements. The final annual audited financial statements, annual reconciliation, management letter and all other annual financial reports are due within 150 days of the Contractor's fiscal year end.

If a due date falls on a weekend or a State recognized holiday, reports will be due the following business day.

Extensions must be requested in writing and addressed to the Contractors' assigned Financial Consultant. Requests must be submitted to AHCCCS at least five (5) business days prior to the due date and must include the reason for the extension and the revised submission date. Requests for extensions will be reviewed and acknowledged.

Any changes in fiscal year-end, for example, as a result of a merger/acquisition, require prior approval from AHCCCS DHCM at least 180 days prior to the effective date. Changes to specific AHCCCS reporting requirements may vary by Contractor and circumstance.

Refer to Section 2.00 for a complete listing of monthly, quarterly, and annual filing requirements.

### **1.03 Sanctions**

Failure to file with AHCCCS, accurate, timely, and complete financial statements and related deliverables may result in monetary penalties until such statements or deliverables are received by AHCCCS.

If a Contractor knowingly and willfully makes, or causes to be made, any false statement or misrepresentation of a material fact in any statement or disclosure filed pursuant to this policy, the Contractor may be fined pursuant to ACOM Policy 408.

AHCCCS may refuse to enter into a contract and may suspend or terminate an existing contract if the Contractor fails to disclose ownership or control information and related party transactions as required by AHCCCS policy.

For sanctions assessed by AHCCCS, the full amount of the sanction will be withheld from the Contractor's monthly payment. Revenue from specific programs will be reduced by the amount of the sanction. The Contractor should ensure that they report the full amount of the program's revenue then report the sanction in the same program as an administrative expense on line 83005-01, Other Administrative Expenses.

## **2.00 FINANCIAL REPORTING REQUIREMENTS**

The table on the following page represents the financial reporting requirements and the applicable due dates. Detailed descriptions of the required reports may be found in Section 3.00 and Section 4.00 of this Guide.

<b>REPORT DUE DATES</b>	<b>Monthly Financial Reporting (Only if requested by AHCCCS)</b>	<b>Quarterly Financial Reporting</b>	<b>Draft Audit Financial Reporting</b>	<b>Final Audit Financial Reporting</b>
<b>Report Name</b>	<b>30 days after month end</b>	<b>60 days after quarter end</b>	<b>90 days after Contractor's fiscal year end</b>	<b>150 days after year end</b>
Certification Statement	X	X	X	X
Financial Statement Template Audit Report		X		
Statement of Financial Position or Balance Sheet	X	X	X	X
Income Statement	X	X	X	X
FN11 Balance Sheet and Income Statement	X	X	X	X
Financial Viability	X	X	X	X
Receivables/Payables Report	X	X	*	*
Other Assets Report	X	X	*	*
Other Liabilities Report	X	X	*	*
Alternative Payment Model Report (by provider by year)	X	X	*	*
Lag Reports for Medical Claims Payable	X	X	*	*
Long Term Debt Report	X	X	*	*
Other Account Report	X	X	*	*
Profitability by GSA (not applicable to DDD)	X	X	*	*
Sub-Capitated & Block Expenses Report / Detail	X	X	*	*
Sub-Capitated & Block Expense Detail by Risk group on a Contract-Year-End Basis			X	X
Prior Contract Year Adjustment Schedule	X	X	*	*
Footnote Disclosure Requirements (AHCCCS format for Quarterlies or GAAP/GASB format for audits)	X	X	X	X
FQHC/RHC Member Months Report		X		
Parent Company (if applicable) Financial statements		X		X
Independent Auditor's Report			X	X
Statement of Cash Flows (if required by GAAP/GASB)			X	X
Management Letter				X
Management Representation Letter				X
Annual Reconciliation			X	X
Independent Auditor's Attestation of Sub-capitated Expenses Report by risk group on a CYE basis			X	X
Monthly Financial (only if requested by AHCCCS)	X			
Annual IBNR Actuarial Certification				X
Audit Recon Balance Sheet F-1a				X
Audit Recon Income Statement F-1b				X
Audit Recon Entries F-1c				X
Related Party Transactions				X
Community Reinvestment Calculation I-1			X	X
Annual Financial Viability F-1d			X	X
Medical Loss Ratio (H-1) & MLR Proof (H-2)	X	X	X	X

<b>REPORT DUE DATES</b>	<b>Monthly Financial Reporting (Only if requested by AHCCCS)</b>	<b>Quarterly Financial Reporting</b>	<b>Draft Audit Financial Reporting</b>	<b>Final Audit Financial Reporting</b>
<b>Report Name</b>	<b>30 days after month end</b>	<b>60 days after quarter end</b>	<b>90 days after Contractor's fiscal year end</b>	<b>150 days after year end</b>
Independent Auditor's Attestation of Annual Medical Loss Ratio on a Contract Year End basis (required every three years)			<b>X</b>	<b>X</b>
Contract Year Annual Supplement		<b>X</b>		

**\*Required submissions only if audit adjustments have impacted amounts previously reported or Contractor revised financial statements subsequent to the submission of the Annual Financial Reporting Template to AHCCCS. Refer to Paragraph 4.17.**



## **3.00 INSTRUCTIONS FOR COMPLETION OF QUARTERLY AND ANNUAL REPORTING**

### **3.01 General Instructions**

All reports must be compiled using the accrual basis of accounting. The Contractor shall submit these forms electronically on or before the due date to AHCCCS via the SharePoint using the Financial Statement Reporting Template provided by the DHCM. The Financial Statement Reporting Template is to be used for each quarter of the fiscal year, and submitted again with the draft and final audit packages. The date the file is uploaded to SharePoint will be the date used for timeliness purposes. The electronic copy must contain the Reporting Guide Template in MS Excel including all supplemental schedules. The certification page needs to bear all signatures written or electronic and be inserted into the Excel template. If the contractor opts to use a written signature, then the certification page will need to be submitted in PDF format and inserted into the Excel template. Any additional information needs to be submitted in MS Excel. Amounts reported to AHCCCS under this guide are to represent the AHCCCS ALTCS line of business independent of any other line of business in which the Contractor may be engaged. The financial statements must at least separate these lines of business in the form of additional supplemental schedules if they are not separately presented in the financial statements themselves.

Quarterly financial statements are to be reported by Dual Eligible member amounts and Non-Dual Eligible member amounts and by Geographical Service Areas (GSA) and for all GSAs combined. The Department of Economic Security/Division of Developmental Disabilities (DES/DDD) is excluded from this requirement.

Draft annual audited financial statements and supplemental reports should be complete with all attachments and schedules and be as close to final as possible. There should be only minimal changes between the draft and final submissions. Any changes between the quarterly financial statement and the draft and final audit must be reported in detail by providing a list of actual journal entries made. The draft and final audit report, audited financial statements and footnotes should be in accordance with GAAP or GASB. Footnotes and supplemental schedules should agree to amounts included in the audited financial statements. The final audit financial statements, including all supplemental schedules (unless pre-approval from AHCCCS is received to exclude certain supplemental schedules), will be posted to the AHCCCS website.

Contractors shall provide a copy of the Financial Reporting Guide to the selected audit firm prior to engagement or a review of AHCCCS financial requirements. Contractors should review the Sarbanes-Oxley Act and consider applying the best practices contained within the Act; including rotating at least the lead and reviewing partners of the audit firm every five (5) years.

Report line titles and columnar headings are detailed in the report specific paragraphs below. Utilize predefined categories or classifications before reporting an amount as "Other." For any amounts included in the "Other" category, provide details regarding

the content of the account(s). Refer to the Financial Reporting Template, Other Account tab.

If information is not available or applicable, write "None," not applicable (N/A), or "-0-" in the space provided. When a Contractor changes any line item, for a prior quarter, the change must be reported one of two ways: (1) submit corrected prior quarter report or (2) record the change in the current quarter report. If a corrected prior quarter report is submitted, notification to AHCCCS must take place in addition to an explanation for the revision. If material revisions are submitted after the AHCCCS due date, then sanctions may be imposed for untimely or inaccurate reporting. An explanation of adjustments made for prior periods are to be disclosed in the Prior Period Footnote.

### **3.01.1 Nursing Facility Enhanced Payment Revenue**

There are two options for reporting Nursing Facility Enhanced Payment Revenue. First is recording the payment from AHCCCS entirely on the Balance Sheet between Cash and Liabilities. The second is recording the payment from AHCCCS between the Balance Sheet and the Income Statement by booking the amount between Cash and Other Revenue. If the Other Revenue is chosen, with an associated expense, a liability should be recorded for the amounts to be passed through to the Nursing Facilities. This will ensure the calculation of viability standards will not be affected by the amount recorded to Other Revenue.

### **3.02 Certification Statement**

The purpose of the certification statement is to attest that the information submitted in the reports is current, complete, and accurate. The statement should include the Contractor name, month ended, or quarter ended, preparer information, and Chief Executive Officer (CEO) and Chief Financial Officer (CFO) signatures, written or electronic. Refer to Appendix A for an example of the Certification Statement.

### **3.03 Financial Statement Reporting Template Audit Report**

The Financial Statement Reporting Template Audit Report lists the required audit criteria that must be passed prior to the submission of quarterly financial statements. If the audit check figures do not match, data should be corrected, or an explanation should be provided in writing and submitted with the quarterly financial statement reporting package. Refer to Appendix B for an example of this report.

### **3.04 Balance Sheet (Statement of Net Assets - governmental entities)**

The Balance Sheet illustrates the financial position of the Contractor as of the reporting date. It is the primary source of information about the Contractor's liquidity and financial stability. Refer to Appendix C-1 for an example of this report.

## **CURRENT ASSETS**

Current Assets are assets that are converted into cash, used, or consumed within one year from the balance sheet date. Restricted assets for the performance bond, contracts, reserves, etc., are not to be included as current assets.

### Account 10105-01 - Cash and Cash Equivalents

Include: Cash and cash equivalents, available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.

Exclude: Restricted cash (and equivalents) and any cash (and equivalents) pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

### Account 10110-01 - Short-term Investments

Include: Investments that are readily marketable and that are expected to be redeemed or sold within one year of the balance sheet date.

Exclude: Investments maturing 90 days or less from the date of purchase and restricted securities. Also exclude investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

### Account 10115-01 - Capitation/Non-Title XIX/XXI Funding/Supplement/Risk Adj Receivable

Include: Net amounts receivable from AHCCCS for capitation, Delivery Supplements, and risk adjustment as of the balance sheet date. Refer to Capitation, Supplement, and Risk Adjustment Receivable Report (Paragraph 4.02) for required detail of this line item.

### Account 10120-01 - Reinsurance Receivable

Include: Billed and unbilled reinsurance due from AHCCCS. Refer to discussion of Reinsurance in Paragraph 5.02.

### Account 10125-01 - Reconciliations/Settlements Receivable

Include: Amounts receivable from AHCCCS for Tiered and Share of Cost (SOC) Cost Settlements and reconciliations. Refer to Receivables/Payables Report (Paragraph 4.03) for required detail of this line item. In addition, any settlement amounts **due from AHCCCS** relating to Alternative Payment Model initiatives should be recorded in this account.

Exclude: Any amounts **due from providers** relating to Alternative Payment Model Initiatives and PBP amounts related to MAO Agreements. Amounts due from AHCCCS for lump-sum directed payments including Access to Professional Services Initiatives (APSI), Pediatric Services Initiatives (PSI), Nursing Facility Assessment (NFA), and Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII). Refer to Account 10145-01 Other Current Assets.

Account 10130-01 - Investment Income Receivable

Include: Income earned but not yet received from cash equivalents, investments, on-balance sheet performance bonds, and short and long-term investments.

Account 10135-01 - Current Due from Affiliates/Other Funds

Include: The net amount of receivables due from affiliates expected to be collected within one year of the balance sheet date. Note that only the net amount is reported. Therefore, there should not be a Due from and a Due to Affiliates concurrently. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due from affiliate amounts should be described in the notes to the financial statements. Refer to Paragraph 3.06 #10.

Exclude: Amounts due from affiliates resulting from medical claims payable, capitation payable or other medical expense related items and non-current amounts due from affiliates.

Account 10140-01 - Alternative Payment Model Receivable From Providers

Include: Any amounts **due from providers** relating to Alternative Payment Model Initiatives between the Contractor and the provider.

Account 10145-01 - Other Current Assets

Include: The total current portion of Other Assets (e.g., income taxes receivable, net amounts receivable from AHCCCS related to lump-sum directed payments including APSI, PSI, NFA, and HEALTHII) not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for in this line item and should not be netted against the IBNR liability. Refer to Other Assets Report for required detail of this line item. The details of these amounts are to be included in Report 4.04.

**OTHER ASSETS**

Account 10205-01 - General Performance Bond

Include: All cash and investments pledged to meet the AHCCCS performance bond requirement.

Exclude: Surety bonds or letters of credit that do not represent actual assets of the Contractor.

Account 10210-01 - Restricted Cash and Other Assets

Include: Cash, securities, receivables, etc., whose use is restricted.

Exclude: Cash and/or investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

Account 10215-01 - Long-term Investments

Include: Investments that are expected to be held longer than one year.

Exclude: Investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

Account 10220-01 - Non-current Due from Affiliates/Other Funds

Include: The net amount of receivables due from affiliates not expected to be collected within one year of the balance sheet date. Note that only the net amount is reported. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Non-current Due from affiliate amounts should be described in the notes to the financial statements.

Exclude: Amounts due from affiliates resulting from medical claims payable, capitation payable or other medical expense related items and current amounts due from affiliates.

Account 10225-01 - Other Non-Current Assets

Include: The total non-current portion of Other Assets, which will include all other non-current assets not accounted for elsewhere on the balance sheet, including intangible assets net of any amortization and non-current portion of Alternative Payment Model Initiatives. The details of these amounts are to be included in Report 4.04.

**PROPERTY AND EQUIPMENT**

Property and Equipment consists of tangible assets including land, buildings, leasehold improvements, furniture, equipment, etc.

Account 10305-01 - Land

Include: Real estate owned by the Contractor.

Account 10305-05 - Buildings

Include: Buildings owned by the Contractor, including buildings under a capital lease, and improvements to buildings owned by the Contractor.

Exclude: Improvements made to leased or rented buildings or offices.

Account 10305-10 - Leasehold Improvements

Include: Capital improvements to facilities not owned by the Contractor.

Account 10305-15 - Furniture and Equipment

Include: Medical equipment, office equipment, data processing hardware, and software (where permitted), and furniture owned by the Contractor, as well as similar assets held under capital leases.

Account 10305-20 - Other Property and Equipment

Include: All other fixed assets not falling under one of the other specific fixed asset categories. The details of these amounts are to be included in Report 4.04.

Account 10330-01 - Accumulated Depreciation and Amortization

Include: The total of all depreciation and amortization accounts relating to the various fixed asset accounts.

**CURRENT LIABILITIES**

Obligations whose liquidation is reasonably expected to occur within one year from the balance sheet date.

Account 20105-01 - Accounts Payable

Include: Amounts due to creditors for the acquisition of goods and services (trade and administrative vendors) on a credit basis.

Exclude: Amounts due to providers related to the delivery of health care services.

Account 20110-01 - Accrued Administrative Expenses

Include: Accrued expenses and management fees and any other amounts, estimated as of the balance sheet date (i.e., payroll, taxes). Also include accrued interest payable on debts.

Account 20115-01 - Payable to Providers

Include: Net amounts owed to providers for monthly capitation, block payments, and other non-FFS payment arrangements payments (pharmacy should be included in IBNR).

Exclude: Capitation amounts payable to AHCCCS as a result of an overpayment. (This amount should be reported in Account 20145-01 - Other Current Liabilities.)

Account 20120-30 - Medical Claims Payable

Include: The total will include the total of reported but unpaid claims (RBUCs) and incurred but not reported claims (IBNRs). Refer to the discussion on Medical Claims Liability in Paragraph 5.01.

Account 20125-01 - Reconciliations/Settlements Payable

Include: Amounts payable to AHCCCS for Tiered, Share of Cost (SOC) and Home and Community Based Services (HCBS) and Cost Settlement reconciliations. Refer to Receivables/Payables Report (Paragraph 4.03) for required detail of this line item. This should equal only the sum of all payable amounts detailed on the Receivables/Payables Report (Paragraph 4.03). In addition, any settlement amounts **due to AHCCCS**

relating to Alternative Payment Model initiatives should be recorded in this account.

Exclude: Amounts **due to providers** relating to Alternative Payment Model Initiatives.

Amounts due from AHCCCS for lump-sum directed payments APSI, PSI, NFA and HEALTHII and PBP amounts related to MAO Agreements. Refer to Account 20145-01 Other Current Liabilities.

Account 20130-01 - Alternative Payment Model Payable to Providers

Include: Current portion of payable amounts **due to providers** relating to Alternative Payment Model Initiatives should be reported on this line.

Account 20135-01 - Current Portion of Long-term Debt

Include: The total current portion from the detail listed in the Long-term Debt Report (Other than Affiliates) which will include the principal amount on loans, notes, and capital lease obligations due within one year of the balance sheet date. Refer to Report 4.08.

Exclude: Long-term portion of, and accrued interest on loans, notes, and capital lease obligations.

Account 20140-01 - Current Due to Affiliates/Other Funds

Include: The net amount of payables due to affiliates/due to other funds expected to be paid within one year of the balance sheet date. Note only the net amount is reported. Therefore, there should not be a Due from and a Due to Affiliates/Other Funds concurrently. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to affiliate/Due to Other Funds amounts must be described in the notes to the financial statements. Refer to Paragraph 3.06 #10.

Exclude: Amounts due to affiliates/due to other funds resulting from medical claims payable, capitation payable, or other medical expense related items and non-current amounts due to affiliates/due to other funds.

Account 20145-01 - Other Current Liabilities

Include: The total current portion from the detail listed in the Other Liabilities Report, which will include those current liabilities not specifically identified elsewhere (e.g., deferred revenue or income taxes payable, APSI, PSI, NFA and HEALTHII). Label each item as due to AHCCCS or due to Provider and the applicable contract year. Refer to Other Liabilities Report, Paragraph 4.05.

## **OTHER LIABILITIES**

Those obligations whose liquidation is not reasonably expected to occur within one year of the date of the balance sheet.

### **Account 20205-01 - Non-current Portion of Long-term Debt**

Include: The total non-current portion from the detail listed in the Long-term Debt report which will include the long-term portion of principal on loans, notes, and capital lease obligations. Refer to Long-Term Debt (Other than Affiliates) Report 4.08 for required detail of this line item.

Exclude: Current portion of, and accrued interest on loans, notes, and capital lease obligations.

### **Account 20210-01 - Non-current Due to Affiliates/Other Funds**

Include: The net amount of payables due to affiliates/due to other funds not expected to be paid within one year of the balance sheet date. Note that only the net amount is reported. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to affiliate/due to other funds amounts should be described in the notes to the financial statements. Refer to Paragraph 3.06 #10.

Exclude: Amounts due to affiliates/due to other funds resulting from medical claims payable, capitation payable, or other medical expense related items and current amounts due to affiliates.

### **Account 20215-01 - Other Non-current Liabilities**

Include: The total non-current portion of Other Liabilities, which will include those non-current liabilities not specifically identified elsewhere. Non-current portion of Alternative Payment Model Initiatives should be reported on this line. Label each item as due to AHCCCS or due to Provider and the applicable contract year. Refer to Other Liabilities Report (Paragraph 4.05) for required detail of this line item.

## **EQUITY/NET ASSETS**

Includes preferred stock, common stock, treasury stock, additional paid in capital, contributed capital, restricted net assets, unrestricted net assets, unrealized gains and losses on investments, and retained earnings/fund balance.

### **Account 30105-01 - Preferred Stock**

Include: The total par value of Preferred Stock, or in the case of no-par shares, the stated or liquidation value.



Account 30110-01 - Common Stock

Include: The total par value of Common Stock, or in the case of no-par shares, the stated value.

Account 30115-01 - Treasury Stock

Include: The amount of Treasury Stock reported using the Par Value or Cost Method.

Account 30120-01 - Additional Paid-in Capital

Include: Amounts paid and contributed in excess of the par or stated value of shares issued. Also include adjustments from purchases and revaluations recorded in accordance with ASC 805, Business Combinations.

Account 30125-01 - Contributed Capital

Include: Donated capital to the Contractor. Describe the nature of the donation as well as any restrictions on this capital in the notes to financial statements.

Account 30130-01 - Restricted Net Assets

Include: Net Assets restricted for any purpose.

Account 30140-01 Retained Earnings/Fund Balance - Beginning

Include: The undistributed and unappropriated amount of earned surplus. Beginning retained earnings balance for a new fiscal year should agree to the ending retained earnings balance from the previous fiscal year and should remain constant during the fiscal year.

Account 30140-05 Net Income/(Loss) YTD

Include: Amounts must agree with the YTD Income Statement without rounding.

Account 30140-15 Transfer In/Out

Include: Amounts transferred in/out (Government Entities) and equity distributions in this line.

Account 30150-01 Unrealized Gains/(Loss)

Include: report unrealized gains or losses in this line.

### **3.05 Income Statement**

The statement of activity must be separated by Dual Eligible Member amounts and Non-Dual Eligible Member amounts. Member months will be included on the Income Statement/Income Statement by dual and non-dual on both the Consolidated Statement and the Statements by GSA.

In addition to completing this report at a combined level (Report 3.05), financial statements are to be reported by GSA (Report 4.10).

All expenses must be reported in accordance with the AHCCCS contracts, applicable AMPM and ACOM policies and AHCCCS' Financial Reporting Guides. The AHCCCS Medical Coding Unit is responsible for posting and updating Medical Service coding and Behavioral Health Services Matrix information to the AHCCCS website. The link to the webpage is as follows:

<https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>.

For Medical Service coding and Behavioral Health Services Matrix questions, recommended changes and updates, follow the instructions provided on the aforementioned webpage.

## **REVENUES**

### Account 40105-01 - Capitation

Include: Revenue recognized on a prepaid basis from AHCCCS for provision of health care services for AHCCCS eligible ALTCS members or eligible DDD members.

Exclude: All other capitation, such as ACC, CRS, DES/DDD and MAPD.

### Account 40115-01 - Alternative Payment Model Initiatives Reconciliation Settlement

Include: Alternative Payment Model (APM) settlements from AHCCCS related to Withholds, Incentives, Alternative Payment Model Initiatives previously Payment Reform Initiatives/Shared Savings Arrangements. (ACOM 306) and Performance Based Payments (ACOM 307). The related balance sheet amounts should be recorded in account 10125-01 and/or account 20125-01.

### Account 40130-01 - Tiered Reconciliation Settlement

Include: All tiered reconciliation settlement amounts. Estimated tiered reconciliation settlement amounts should be accrued in the period that they are earned. Any adjustments to prior contract years need to be disclosed on the Prior Contract Year Adjustment Report. Refer to Prior Contract Year Adjustment Report (Paragraph 4.11) for the required detail on this item. Also, in the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements (Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

Account 40145-01 - Other Reconciliation Settlements

Include: All other reconciliation settlements not specifically identified in one of the categories defined.

Account 40150-01 - Share of Cost Reconciliation Settlement (SOC)

Include: Expected/Received SOC reconciliation payments due from or due to AHCCCS as of the statement date.

Account 40305-01 - Investment Income

Include: All investment income earned during the period. Interest income and interest expense should not be netted together.

Account 40310-01 - Other Income (Specify)

Include: Revenue from sources not identified in the other revenue categories. The details of these amounts are to be included in Report 4.09.

Account 40315-01 - Patient Contributions

Include: Revenue received by the Contractor from members contributing toward the cost of their long-term care services. This is also termed Member Share of Cost (MSOC).

Exclude: Patient contribution collected by the nursing facilities or other providers.

**EXPENSES** All expenses must be reported net of Medicare/TPL reimbursement and net of quick pay discounts.

**Institutional Care Expenses** include only those expenses for Institutional Care Services (Nursing Facilities). Expense must be reported net of patient SOC contributions, if collected by the nursing facilities. Included in these expenses are therapeutic leave and bed hold days. Therapeutic days should not exceed nine (9) days per year, and bed hold days should not exceed twelve (12) days per year.

Account 50340-01a - NF ICF Bed Holds

Account 50340-01b - Level I

Account 50340-01c - Level II

Account 50340-01d - Level III

Account 50340-01e - Institutional Care

Include: Expenses for Nursing facilities, RTC, IMD or ICF.

Account 50340-01g - Other Institutional Care

Include: All other expenses not specifically identified in one of the categories defined above. The details of these amounts are to be included in Report 4.09.

**Home and Community Based Services (HCBS)** include compensation for services for members that reside in the defined HCBS setting which include adult foster care, DD group home, individual home, assisted living home, assisted living center, BH Level I, BH Level II, and TBI treatment facility.

Account 50340-05a - Home Health Nurse

Include: Expenses incurred for intermittent skilled nursing services in a home and community based setting. Skilled nursing services may include health maintenance, continued treatment, or supervision of a health condition.

Account 50340-05b – Home Health Aide

Include: Expenses incurred for medically supervised and physician ordered intermittent health maintenance, continued treatment or monitoring of a health condition and supporting care with activities of daily living in a home and community based setting.

Account 50340-05c - Personal Care

Include: Expenses incurred for assistance in meeting essential personal physical needs.

Account 50340-05d - Homemaker

Include: Expenses incurred for household maintenance in a home and community based setting.

Account 50340-05e - Home Delivered Meals

Include: All expenses relating to the delivery of meals to members in a home and community based setting.

Account 50340-05f - Respite Care

Include: Expenses incurred for short-term or intermittent care and supervision in order to provide an interval of rest or relief to family members.

Account 50340-05g - Attendant Care

Include: Expenses incurred for assistance with homemaking, personal care, general supervision, and companionship to members in a home and community based setting.

Account 50340-05h - Assisted Living Home

Include: Expenses incurred for the alternative residential setting to provide supervision, personal care and/or custodial care services for up to ten (10) adults.

Account 50340-05i - Assisted Living Center

Include: Expenses incurred for the approved alternative residential setting composed of individual apartments to provide general supervision, as well as coordinate supportive living services to members on a 24-hour basis.

Account 50340-05j - Adult Day Health

Include: Expenses incurred for planned care and supervision, assistance with medication, recreation, socialization, personal care, personal living skills training, congregate meals, health monitoring and related services such as preventive therapeutic, and restorative health care.

Account 50340-05k - Adult Foster Care

Include: Expenses incurred for supervision and assistance with activities of daily living and coordination within a family type environment for up to four (4) adult residents.

Account 50340-05l - Group Respite

Include: Expenses incurred for short-term or intermittent care and supervision, in a group setting, in order to provide an interval of rest or relief to family members.

Account 50340-05m - Hospice

Include: Expenses incurred for palliative and support care for terminally ill members and their family, or caregivers.

Account 50340-05n - Environmental Modifications

Include: All expenses incurred for environmental modifications for HCBS members.

Account 50340-05p - Other HCBS Expense

Include: All other expenses not specifically identified in one of the categories defined above. The details of these amounts are to be included in Report 4.09.

**Acute Care Expenses** include Compensation for all acute care services provided to ALTCS members.

Account 50105-01 - Hospital Inpatient

Include: All contracted or fee for service expenses for hospital inpatient services, including room, board, and ancillary expenses.

Account 50110-01 - Hospital Inpatient – Behavioral Health Services

Include: All contracted or fee for service expenses for hospital inpatient services, including room, board, and ancillary expenses, for behavioral health services.

Account 50205-01 - Primary Care Physician Services

Include: Those expenses for primary care delivery and other practitioners, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This also includes urgent care facility expenses.

Account 50210-01 - Behavioral Health Physician Services

Include: Those expenses for physician services related to Behavioral Health services.

Account 50215-01 - Referral Physician Services

Include: All forms of compensation paid for referral (specialist) physician services.

Account 50220-01 - PH FQHC/RHC Services

Include: FQHC/RHC services should be recorded to this line if the services meet the definition of a visit or are **incidental to the visit**.

Account 50305-01 - Emergency Facility Services

Include: Those PH and BH expenses relating to emergency room services provided on an outpatient basis.

Account 50310-01 - Pharmacy

Include: Pharmacy expenses incurred for outpatient services and psychotropic medications expenses. These are amounts paid to the retail or mail-order pharmacy for drug ingredient costs and dispensing fees.

Exclude: Pharmacy expenses incurred for dental, and PBM non-encounterable components. Refer to discussion of PBM in Paragraph 5.07.

Account 70310-05 - Pharmacy Rebates

Include: Amounts related to pharmacy rebates. Prescription drug rebates should be reported regardless of source of the rebate (manufacturer, retail pharmacy, incentive payments or other items of value).

Account 70310-10 - Pharmacy Performance Guarantees

Include: Amounts related to Pharmacy Performance Guarantees. Report any payments from the Pharmacy Benefit Manager (PBM) to the Contractor as the result of a performance guarantee.

**\*NOTE: AHCCCS treats these recoveries as a contra-expense account.**

**\*NOTE: Accounts 70310-05 and 70310-10 should be reported as negative numbers, to allow the Financial Statement Reporting Template to properly net the amounts out of medical expense.**

Account 50315-01 - Laboratory, Radiology & Medical Imaging

Include: Pathology, Laboratory and Radiology (medical imaging, X-ray) expenses incurred for outpatient services.

Account 50320-01 - Outpatient Facility

Include: Outpatient facility expenses incurred for outpatient services.

Exclude: Physician expense for surgery (this should be included in account 50215-01).

Account 50320-05 - Outpatient Behavioral Health Facility

Include: All outpatient behavioral health related expenses such as: screening, evaluation, individual therapy and counseling, group and/or family therapy and counseling, partial care, emergency/crisis behavioral health care, behavior management, psychosocial rehabilitation.

Exclude: Inpatient behavioral health expenses, lab, radiology and psychotropic medications and monitoring.

Account 50325-01 - Durable Medical Equipment

Include: Medical supplies, medical equipment, prosthetic devices, and oxygen expenses incurred for outpatient services.

Account 50330-01 - Dental

Include: Dental expenses incurred for outpatient services, including outpatient surgery, prescription drugs, lab, and radiology specifically related to a dental diagnosis

Account 50335-01 - Transportation

Include: Medically necessary transportation expenses incurred for inpatient and outpatient services, both emergency and non-emergency.

Account 50345-01 - Therapies

Include: Expenses include rehabilitation therapies (occupational, physical and speech) and respiratory therapy incurred for outpatient services.

**Other Medical Expenses** include all other outpatient expenses not specifically identified in one of the categories defined above.

Account 50350-01 - Alternative Payment Model Performance Based Payments to Providers

Include: Performance Based Payments (PBP) expenses (disbursements/recoupments to/from providers) related to the Alternative

Payment Model (APM) (formerly Value Based Purchasing) contracting arrangements with providers as defined in the definition section of this guide. Expenses should be recorded in the period in which they occurred or were earned. The related balance sheet amounts should be recorded in account 10140-01, account 20130-01, and/or account 20215-01.

Account 50355-01 - Behavioral Health Day Program

Include: Medical, home and community expenses incurred for services provided to members in a Behavioral Health Day Program including supervised day program, therapeutic day program, and medical day program.

Account 50355-05 - Behavioral Health Case Management Services

Include: Case management performed by a provider related to behavioral health services, including salaries, benefits, travel, and training expenses for the case manager(s), and case management supervisors.

Account 50355-06 - Peer/Family Support

Include: Peer support and family support expenses.

Account 50355-07 - Support Services

Include: Include Personal Care Services, Therapeutic Foster Care for Children and Adult Behavioral Health Therapeutic Home and Unskilled Respite Care.

Account 50355-10 - Behavioral Health Crisis Intervention Services

Include: Expenses incurred for Crisis Intervention Services provided to members including mobile, stabilization, and telephone. This includes crisis stabilization starting on the 24th hour and beyond. Do not report crisis related services on any other medical expense line other than this line.

Account 50355-11 - Living Skills Training

Include: Living Skills Training.

Account 50355-12 - Supported Employment

Include: Supported Employment.

Account 50355-15 - Behavioral Health Rehabilitation Services

Include: Expenses incurred for Rehabilitation Services provided to members including living skills training, Cognitive Rehab, Health Promotion, and Supported Employment Services.

Account 50355-20 - Behavioral Health Residential Services

Include: Expenses incurred for Residential Services provided to members including Level II and Level III Behavioral Health Residential Facility Room and Board.



Account 50355-21 - Counseling

Include: Individual, Family and Group Counseling.

Account 50355-22 - Assessment, Evaluation and Screening

Include: Assessment, Evaluation and Screening.

Account 50355-23 - Treatment Services

Include: Other Professional Services.

Account 50355-25 - All Other Behavioral Health Services

Include: Miscellaneous support services incurred for All Other Behavioral Health Services provided to members.

Account 50365-01 - Case Management

Include: Case management expenses, including salaries, benefits, and travel and training expenses for the case manager(s), and case management supervisors.

Account 50370-01 - Other Medical Expenses

Include: All other medical expenses that have not specifically been identified in the categories defined above. The details of these amounts are to be included in Report 4.09.

**Exclude: (For DDD only) Any Administrative Expenses paid to Subcontractors should be reported under Other Administrative Expenses section and list all detailed expenses in Report 4.09 Other Amount tab separately for the amounts paid to Subcontractors. No materiality threshold.**

Account 70105-01 – Reinsurance Recoveries

Include: Reinsurance earned, billed and unbilled, as of the statement date. Refer to discussion in Paragraph 5.02.

**NOTE: AHCCCS treats the reinsurance revenue account as a contra-expense account.**

Account 70205-02 - Third-Party Liability

Include: Revenue from settlement of accident claims or other third-party sources.

**NOTE: AHCCCS treats the TPL revenue account as a contra-expense account.**

Account 70305-01 – Claim Overpayment Recoveries

Include: Revenue from settlement of provider claims. **NOTE: AHCCCS treats these recoveries as a contra-expense account.**

**NOTE: Accounts 70105-01, 70205-02 and 70305-01 should be reported as negative numbers, to allow the Financial Statement Reporting Template to properly net the amounts out of medical expense.**

**Administrative Expenses** are those costs associated with the overall management and operation of the Contractor. All administrative expenses must be allowable, reasonable and appropriately reported in the pre-defined administrative expense lines. Management fees must be separately identified and reported in the pre-defined administrative expense lines as well. In addition, management fees may not be increased without prior written approval from AHCCCS. Expenses related to the pre-defined administrative expense lines should not be reported under Account 83005-01, Other Administrative Expenses.

Account 80105-01 - Compensation

Include: All forms of compensation, including employee benefits and taxes, to administrative personnel. This includes medical director compensation, whether on salary or contract.

Account 80205-01 - Occupancy

Include: Occupancy expenses incurred, such as rent and utilities, on facilities that are not used to deliver health care services to members.

Account 80305-01 – Depreciation/Amortization

Include: Depreciation and amortization on those assets that are not used to deliver health care services to members.

Account 80405-01 - Care Management/Care Coordination

Include: Care Managers expenses incurred for activities performed as defined in Contract and AMPM 1020. These expenses must be separately identified for capitation rate setting purposes. Include case management expenses delivered by the MCO or delivered by a non-provider. Do not report these expenses under other administrative expense lines.

Exclude: Case management expenses delivered by a provider.

Account 80505-01 – Professional and Outside Services

Include: Fees and expenses of professional consultants and others for general services such as accounting, auditing, actuarial and legal.

Account 80605-01 – Office Supplies and Equipment

Include: Expenses for office supplies and equipment used for normal business operations.

Account 80705-01 – Travel

Include: Expenses for transportation, meals, lodging and other travel-related expenses incurred by employees who are in travel status on official business.

Account 80805-01 - Repair and Maintenance

Include: Expenses incurred to restore an asset to a previous operating condition or to keep an asset in its current operating condition.

Account 80905-01 – Bank Service Charge

Include: Any charges and fees assessed by the bank.

Account 81005-01 – Insurance

Include: Expenses related to insurance.

Exclude: Reinsurance premiums. Report these expenses under Account 83005-01, Other Administrative Expenses.

Account 81105-01 - Marketing

Include: Expenses related to any form of exchange whereby the intent is to promote or increase the membership of the Contractor.

Account 81205-01 -Interest Expense

Include: Interest expense incurred on outstanding debt and interest paid to providers on late claims during the period. Interest income and interest expense should not be netted together.

Account 81305-01 – Pharmacy Benefit Manager Expenses

Include: Discrete administrative fee expenses for pharmacy network development/management, pharmacy discount negotiating, drug utilization management/review, coordination of specialty drugs, pharmacy claims processing, pharmacy call center operations, reporting and other PBM-related costs. Refer to discussion of PBM in Paragraph 5.07.

Account 81405-01 – Fraud Reduction Expenses

Include: Expenses related to fraud reduction activities. The amount of Fraud Recovery expenses must not include Fraud Prevention Activities.

Account 81505-01 – Third Party Activities

Include: Expenses for third party vendors for secondary network savings, network development, administrative fees, claims processing, and utilization management.

Other examples of administrative functions/delegated managed care activities CMS considers non-claim costs: Amounts paid to third party vendors for secondary network savings; Network development; Claims processing; Utilization review/management; Eligibility and coverage verification; Fines and Penalties; Professional services or Administrative services that do not represent compensation or reimbursement for State Plan services; Activities designed primarily to control or contain costs;

Expenses allocated to non-Medicaid lines of business; Provider credentialing; Marketing expenses; Costs associated with administering enrollee incentives; Expenditures for Health Information Technology not meeting the requirements of 45 CFR §158.151; and PBM administrative and spread costs.

Account 81605-01 – Sub Capitation Block Administration

Include: Amounts for professional or administrative services that do not represent compensation or reimbursement for the direct provision of Medicaid covered services provided to a Medicaid enrollee that are paid to a provider/subcontractor..

Costs paid for professional or administrative services to subcontractors related to delegated managed care activities and associated reporting requirements unless the activities are quality improvement activities which would be reported in account 81705-01 Health Care Quality Improvement. Delegated managed care activities associated with APM contracts should be reported as Sub Capitation Block Administration not as Performance Based Payments in account 50350-01 Alternative Payment Model Performance Based Payments to Providers.

Other examples of administrative functions/delegated managed care activities CMS considers non-claim costs: Amounts paid under a sub-capitated arrangement for secondary network savings; Network development; Claims processing; Utilization review/management; Eligibility and coverage verification; Fines and Penalties; Professional services or Administrative services that do not represent compensation or reimbursement for State Plan services; Activities designed primarily to control or contain costs; Expenses allocated to non-Medicaid lines of business; Provider credentialing; Marketing expenses; Costs associated with administering enrollee incentives; Expenditures for Health Information Technology not meeting the requirements of 45 CFR §158.151; and PBM administrative and spread costs.

Include: (For DDD only) Amounts paid to DDD’s Subcontracted Health Plan for administrative services provided by the Subcontracted Health Plan including; but not limited to: claims processing, including pharmacy claims; credentialing; management service agreements and service level agreements with any division or subsidiary of a corporate parent owner.

Exclude: Sub-Capitated/Block Payment amounts paid to providers/subcontractors for the direct provision of Medicaid covered services provided to a Medicaid enrollee when the functions are performed by the subcontractor’s own employees and not through a contracted network of providers.

Account 81705-01 – Health Care Quality Improvement

Include: Expenses that increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements or provide health improvements or are grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations. For example, improvement of health outcomes, activities to prevent hospital readmission, improvement of patient safety and reduce medical errors, wellness and health promotion activities, health information technology expenses related to improving health care quality and activities related to external quality review. These include member incentives related to quality.

Exclude: Member incentives not related to quality.

Account 81810-01 – Program Integrity Fraud, Waste and Abuse Prevention Expenses

Include: Expenses for improvements to infrastructure that prevent fraud, waste, and abuse on a going forward basis.

Exclude: Fraud reduction expenses.

Account 82505-01 - Interpretation/Translation Services

Include: Interpretation, sign language or translation services.

Account 83005-01 - Other Administrative Expenses

Include: Administrative expenses not specifically identified in the categories above. Also include sanctions

Account 88999-01 – Non-Operations – Investment Income

Include: All investment income earned during the period. This account is linked to account 40305-01.

Account 88999-02 – Non-Operations - Other

Include: Gains and losses on fixed assets during the period and any other non-operating income or loss.

Account 90105-01 - Income Taxes

Include: Provision for income taxes for the period.

Account 90205-01 - Premium Taxes

Include: Provision for premium taxes for the period.

Account 990105-01 - Community Reinvestment (CRI)

Include: Expense amounts accrued for the six percent (6%) community reinvestment contractual requirement.

Account 990205-01 - Non-Covered Services

Include: Encounterable value-added services and amounts for services not covered by Medicaid. (e.g., Non-Title XIX/XXI covered services including housing expenses such as rental subsidies or eviction prevention, the portion of non-emergency dental that exceeds the \$1,000 per member limit for adults, non-emergency adult optometry).

Exclude: Interpretive/sign language and Translation expenses. These are treated as administrative expenses and are reported in Account 82505-01. Exclude non-encounterable value-added services as well. Report these services in Account 990405-01 Value-Added Services.

Account 990305-01 – Unreimbursed Performance Based Payments

Include: Amounts for Performance Based Payments expenses above the AHCCCS reimbursed threshold. See ACOM 307 for more information on Performance Based Payments.

Exclude: Performance Based Payments reimbursed by AHCCCS

Account 990405-01 - Value-Added Services

Include: Non-encounterable value-added services may be non-AHCCCS covered services, benefits, or positive incentives that promote healthy lifestyles and improve health outcomes among members, including items previously defined as member incentive items. Examples include smoking cessation incentives, member lifestyle management, weight management and disease prevention and self-management.

Exclude: Encounterable value-added services. Report these services in account 990205-01, Non-Covered Services.

### **3.06 Footnote Disclosure Requirements**

Footnote disclosures are required in order to supplement AHCCCS' understanding of the financial statements and supplemental schedules. Refer to Appendix D. The following list represents minimum expected disclosures and is not intended to be all-inclusive. Disclosures required by

GAAP or GASB should also be included. A prepopulated footnote template has been included in the Financial Reporting Template, with instructions. The footnote template should not be submitted with any red cells, indicating a response is required. If the disclosure does not apply, indicate so by selecting “No” from the drop down menu and the footnote will indicate no response is needed. See the Financial Reporting Template for further instructions.

1) Organizational Structure:

Discuss the organization structure, location of its headquarters, and a brief summary of the operations of the Contractor.

2) Summary of Significant Accounting Policies:

Discuss accounting policies relating to significant Balance Sheet/ Statement of Net Assets line items such as, but not limited to, cash and cash equivalents, investments and medical claims payable. Specifically, the medical claims payable policy should discuss the methodology used in calculating IBNR balances.

On an annual basis with the quarter ending December submission, or in the event of a change, discuss the expense allocation methodology by geographic service area and dual and non-dual as well as the inclusion of any new geographic service areas.

Discuss revenue and expense recognition policies for the following:

- Capitation revenue
- Supplemental payment revenue
- PPC Settlement revenue
- Reinsurance revenue
- Other revenue
- Medical expenses
- Administrative expenses
- Alternative Payment Model Initiatives
- Federal and State Income Taxes

Discuss any changes in accounting methodologies, including cost allocation changes, which have taken place during the current contract year.

3) Pledges/Assignments and Guarantees: ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

Describe any pledges, assignments, or collateralized assets and any guaranteed liabilities not disclosed on the balance sheet.

- 4) Material Adjustments:  
  
Disclose and describe any material adjustments made during the current reporting period.
- 5) Medical Claims Payable Analysis:  
  
Explain large fluctuations and/or revisions in estimates and the factors that contributed to the change in the Medical Claims Payable balances from the prior quarter. Specifically, address changes of more than 10% (on per member per month basis). Include discussions related to IBNR. Explanations should detail the amount of the adjustments by quarter and by risk group.
- 6) Contingent Liabilities:  
  
Provide details of any malpractice or other claims asserted against the Contractor, as well as the status of the case, potential financial exposure and expected resolution.
- 7) Investments:  
  
Long-term investments that may be liquidated without significant penalty within 24 hours, which the Contractor would like treated as current assets for calculation of the current ratio, must be disclosed in the footnotes. Descriptions by asset type (equity securities, debt securities, etc.) and amounts should be disclosed and should include indication of whether or not the investments are restricted or unrestricted. (Note that significant penalty in this instance is any penalty greater than 20% of the total long-term investment.) Also disclose the amount of Unrealized Gains or Losses reported on the financial statements associated with these investments.
- 8) Due from/to Affiliates (Current and Non-Current):  
  
Describe, in detail, the composition of the due to/from affiliates including the name of the affiliate, a description of the affiliation, amount due to/from the affiliate and a written description of any change in balances due from/to each affiliate.
- 9) Equity Activity:  
  
Disclose and provide a written explanation for all activity in equity, other than net income or net loss.
- 10) Non-Compliance with Financial Viability Standards and Performance Guidelines:  
  
Disclose any non-compliance with Financial Viability Standards and Performance Guidelines, the factors causing the non-compliance and the plan of action to resolve



the issue(s), including specifying the expected month that the compliance will be evidenced in the financial statements.

Disclose the driving factors for any current contract year-to-date profit/loss incurred, unrelated to any prior year activity (even if within the profit corridor).

11) Changes in Financial Statement Line Items:

Balance Sheet: Describe changes in balance sheet asset items if the current or previous quarter amount is equal to or greater than +/-5% of Total Assets for that quarter and if the change from the prior quarter amount is equal to or greater than +/-5%.

Describe changes in balance sheet liability line items if the current or previous quarter amount is equal to or greater than +/-5% of Total Liabilities for that quarter and if the change from the prior quarter is equal to or greater than +/-5%.

Describe changes in balance sheet Net Equity/Net Assets line items if the current or previous quarter amount is equal to or greater than +/-5% of the Total Net Equity/Net Assets for that quarter and if the change from the prior quarter amount is equal to or greater than +/- 5%.

Balance Sheet changes should be calculated on a dollar basis.

Describe changes in Statement of Revenue and Expense items if the current or previous quarter amount is equal to or greater than +/-5% of Total Revenues and if the change from the prior quarter amount is equal to or greater than +/-5%.

The first quarter in a Contractor's fiscal year should be compared to the fourth quarter in the previous fiscal year versus the final audit report.

The Statement of Revenue and Expense percentages will be calculated using two separate calculations.

The percentage change quarter over quarter for Statement of Revenue and Expense line items should be calculated using PMPM amounts.

When calculating the individual line item amount as a percent of Total Revenue use whole dollars.

The following example demonstrates that no explanation of variance is required.

**Example**

	QE03/31/xx	QE06/30/xx
Member Months	20,000	25,000
Total Revenue	\$ 5,000,000	\$ 6,500,000
Outpatient Facility Expense	\$ 300,000	\$ 380,000

	QE 03/31/xx	QE 06/30/xx	PMPM % Change	% of Revenue
Outpatient Facility	\$ 15.00	\$ 15.20	1%	6%

12) Accrued Sanctions, Fines and Penalties

Report any accrued sanctions, fines or penalties assessed by AHCCCS or another regulatory authority. List the amounts by quarter and, separately by type.

13) Member and Provider Incentives

Separately report the amount of member and provider incentives for the quarter and contract year to date. For member incentives, also report the previous contract year. (Do not include provider incentives that are part of APM Performance Based Payments to Providers). Indicate the Administrative Income Statement line number(s) and risk group in the financial statements where these are reported. Report influenza gift cards amounts expended in this footnote disclosure.

14) Prior Contract Year Adjustments

Provide all amounts specific to prior contract years on the Prior Contract Year Adjustments Schedule and a detailed explanation for any material adjustment(s).

15) Premium Deficiency Reserve: ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

Include the cumulative amount of the reserve and all line items included in the entry.

16) Social Risk Factors: ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

Provide the Social Risk Factors and Health Equity activities expended in the fiscal year by quarter and by fund source. Indicate the line number in the financial statements where these are reported. It is not necessary to include administration related to managing members with Social Risk Factors. Only identify items that have been actually spent and not accrued to be spent.

Social Risk Factors and health equity activities (e.g., Housing, Food Access, Physical Activity, Activities to combat Social Isolation, Education, etc.) will typically be non-encounterable, Non-Medicaid covered services (thus not funded by Title XIX/XXI medical services funding), however, there could be exceptions to this rule. For purposes of this footnote, any service covered by Non-Title XIX/XXI services funding paid to a RBHA by AHCCCS should not be included in this footnote (e.g., Housing expenditures funded by AHCCCS Non-Title XIX/XXI services funding should not be included). The Social Risk Factors items, activities, or services should not be reported as medical services within the statement of revenues and expenditures but should instead be reported as non-covered services.

Community Reinvestment expenditures spent on Social Risk Factors should be included in this footnote only after it had been expended.

Z codes can be used to identify potential members for which Social Risk Factors services may have been provided. Social Risk Factors services for these members may be included in this footnote as long as the service is not a Medicaid covered service funded by Title XIX/XXI medical services funding or any service covered by AHCCCS Non-Title XIX/XXI funding. A list of Z codes can be found on the AHCCCS website

[https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/Exhibit\\_4-1SocialDeterminantsHealthICD-10List.pdf](https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/Exhibit_4-1SocialDeterminantsHealthICD-10List.pdf)

- 17) Management Fees: ANNUAL FINANCIAL REPORTING TEMPLATE ONLY  
Disclose the quarterly Management Fee percentage and amounts expended on a fiscal year-to-date basis by each Administrative Expense account number where Management Fees are reported.
- 18) Non-Operating Profit (Loss)  
Provide a breakdown by activity for all non-operating profit (loss).
- 19) Non-Encounterable Health Care Quality Improvement (HCQI) Medical Expenses  
Provide a breakdown by activity, Account Line# by quarter for Non-Encounterable Health Care Quality Improvement Medical Expenses.

#### **4.00 SUPPLEMENTAL REPORTS**

Refer to Appendix E and F for examples of supplemental reports.

##### **4.01 Reserved for Future Use**

This paragraph is reserved for future use.

#### **4.02 Capitation, Supplement, and Risk Adjustment Receivables**

List the amounts, by type, that are included in the Balance Sheet – Account 10115-01. Amounts related to Capitation, Delivery Supplement and Risk Adjustment should be detailed out by contract year if applicable.

#### **4.03 Receivables/Payables Report**

List the amounts, by type, that are included in the Balance Sheet – account 10125-01 and account 20125-01. Used the prepopulated reconciliation names provided in the template. Accruals for the Share of Cost reconciliation, HCBS Placement reconciliation needs to be identified by amount and the contract year.

DDD: Include any DDD reconciliation receivable or payable and delineate reconciliations by type and year. This will include reconciliation/cost settlements. Also include any receivable or payable related to DDD's reconciliation with its Subcontracted Health Plans in accordance with DDD's contract with its Subcontracted Health Plans. DDD will submit the reconciliation to AHCCCS for approval. Refer to DDD contract for more information. For CYE22 and CYE23, a line for the COVID 19 Vaccine Settlement has been included on this schedule. Contractors are required to report the applicable amounts related to COVID 19 Vaccine Settlement on these lines provided.

#### **4.04 Other Assets Report**

Include all activity for accounts 10145-01, 10225-01 and 10325-01 in the appropriate categories provided. List separately any asset related to lump-sum directed payments including APSI (CYE 20 and forward), PSI, NFA, and HEALTHII. The ending balances for current or non-current assets should agree to Account balances of the Statement of Financial Position, Net Assets or Balance Sheet for these account numbers.

#### **4.05 Other Liabilities Report**

Include all other current liabilities (current and non-current) in the appropriate categories provided. List separately any liability related to lump-sum directed payments including APSI (CYE 20 and forward), PSI, NFA, and HEALTHII. The ending balances for current liabilities should agree to Account 20145-01 and non-current liabilities to Account 20215-01 of the balance sheet.

#### **4.06 Alternative Payment Model Performance Based Payment Payable to Providers Report**

List the amounts that are included in the Balance Sheet – accounts 10140-01, 20130-01 and 20115-01. Information should be detailed by provider and by contract year. Exclude PBP amounts related to MAO Agreements.

#### **4.07 Lag Report for Medical Claims Payable**

A claim liability is established when an event occurs that creates an obligation to pay benefits, but complete payment has not yet been made as of the reporting date. Lag Reports are used to track historical payment patterns and an integral part of the methodology to calculate the liability. If the Lag Report is not the primary methodology, the Contractor should use lag information as a validation test for accruals calculated using other methods. The instructions below apply to the Hospitalization Lag, Medical Compensation Lag, and Other Lag report in total.

The schedule is arranged with dates of service horizontally and quarter of payment vertically. Therefore, payments made during the current quarter for services rendered during the current quarter are reported on row 1, column 2, while payments made during the current quarter for services rendered in prior quarters are reported on row 1, columns 3 through 9. All previous quarters with a remaining claims reserve/estimated claims payable should be reported in column 10. Do not include adjustments or sub-capitation payments in this schedule. Reported but Unpaid Claims (RUBC) will be reported in the RUBC Payable row and not included with payments.

Claims Ultimate reported in the current period on the Lag Report should equal the expenses reported in the Income Statement less Alternative Payment Model Performance Based Payments to Providers account 50350-01 and the expenses reported in the sub-capitated expense report by hospital, medical compensation, and other in total. The Claims Payable on all Lag Reports should agree to the Medical Claims Payable total as reported on the Balance Sheet. There is a tie out on this schedule that is required to be completed and net to zero prior to submission.

The schedule allows for the inclusion of an adjustment (e.g., for provider refunds, lag schedule adjustments) amount to the lag schedule. An adjustment made to a previously paid claim will be reported in the Actual Paid Adjustment row. An adjustment to estimated claim expenses will be reported in the Ultimate Adjustment row. A general explanation of any adjustments should be included in the footnotes as well as additional detail if any adjustment is greater than 10% of total medical claims payable.

#### **4.08 Long Term Debt (Other than Affiliates/Due to Others) Report**

Include all other non-current liabilities accounts 20135-01 and 20205-01 in the appropriate categories provided. List all loans, notes payable and capital lease obligations by lender by long term portions of outstanding principle at the end of the quarter (exclude debt to affiliates, this is to be reported on the Due (to) from Affiliates line/Due to Others).

#### **4.09 Other Account Report**

Include all other Revenue and Expense accounts 40310-01, 50340-01g, 50340-05p, 50370-01 and 83005-01 in the appropriate categories provided.

#### **4.10 Profitability by GSA**

This report provides an analysis of revenues and expenses by GSA. This report is also used in capitation rate setting. A report is to be completed for each GSA in which the Contractor operates, and in total. The instructions for the Statement of Revenues and Expenses are to be utilized in defining line items on this report. The sum totals of all line items for all counties should equal the Statement of Revenues and Expenses.

#### **4.11 Sub-Capitated / Block Purchase Expenses Report**

This report is a summary of sub-capitation/block expenses, by individual expense line item by date of service for the contract year end. Only the accounts listed in this report should have associated sub-capitation expenses. Sub-capitated/block purchase expenses SHOULD NOT be reported for Account 50350-01, Alternative Payment Model Performance Based Payments to Providers. This information assists in calculating any reconciliation and is used in capitation rate setting.

Effective with audits submitted to AHCCCS after September 30, 2021, a separate Independent Auditor's Attestation of the Sub-capitated/Block Expense Report is required as a part of the draft and final annual audit for the BH and PH prior contract year sub-capitated/block expense reports by risk group, including any adjustments that occurred on a date of service basis. For example, if the Contractor's fiscal year-end is December 31, 2020, an attestation for the sub-capitated/block expense report by risk group with any adjustments on a date of service basis for contract year-ended September 30, 2020 would be required. In addition, if changes were made to the previously audited contract year sub-capitated/block expense report, the revised report must be audited and attested to in the next audit to help ensure the accuracy of the changes. For example, if the Contractor's fiscal year end is December 31, 2020 and changes were made to the contract year 2019 sub-capitated/block expense reports after the fiscal year December 31, 2019 audit was completed, then both the revised contract year 2019 and the contract year 2020 sub-capitated/block expense reports by risk group must be audited and attested to during the Contractor's fiscal year December 31, 2020 audit. The audited sub-capitated/block expense reports by risk group will be considered to be final and utilized in the applicable interim and final Reconciliations.

AHCCCS follows CMS' MLR categorization of claims and non-claims cost for purposes of the financial statements including the Sub-Capitated / Block Purchase Expenses Report. Per the CMS Informational Bulletin, dated May 15, 2019, "Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors", CMS identifies that incurred claims must exclude non-claims costs, which include amounts paid to third-

party vendors for secondary network savings; network development, administrative fees, claims processing, and utilization management; amounts paid to a provider for professional or administrative services that do not represent compensation or reimbursement for State Plan services or services meeting the definition for in-lieu-of services in 42 CFR 438.3(e) and provided to an enrollee; and Fines and penalties assessed by regulatory authorities. (See 42 CFR 438.8 (e)(2)(v)(A)). These non-claims costs should not be included in the Sub-Capitated / Block Purchase Expenses Report.

The Contractor may only include in incurred claims for Medicaid covered services the amount that the subcontractor actually pays the medical provider for providing Medicaid covered services to enrollees. Where the subcontractor is performing an administrative function such as, but not limited to, eligibility and coverage verification, claims processing, utilization review, or network development, expenditures and profits on these functions would be considered a non-claims administrative expense as described in 42 CFR 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations nor included as a medical expense in the Sub-Capitated /Block Purchase Expenses Report. An exception to this general approach applies when a subcontractor, through its own employees, provides Medicaid covered services directly to enrollees. In this circumstance, the entire portion of the amount the Contractor pays to the third-party vendor that is attributable to the third-party vendor's direct provision of Medicaid covered services should be included in incurred claims, even if such amount includes reimbursement for the third-party vendor's own administrative costs related to the direct provision of Medicaid covered services. The phrase "through its own employees" does not include a subcontractor's contracted network of providers because such network providers are not considered employees of the third-party vendor.

Additionally, when the subcontractor is also performing an administrative function not attributable to its direct provision of Medicaid covered services, such as, but not limited to, eligibility and coverage verification, claims processing, utilization review, or network development, payment by the Contractor to the subcontractor for such functions are a non-claims administrative expense as described in 42 CFR 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations nor included as a medical expense in the Sub-Capitated /Block Purchase Expenses Report.

The portion of the sub-capitation/block purchase payment that is explicitly attributable to the provision of administrative services or delegated managed care activities and associated reporting requirements by the provider, and the activities listed above from 42 CFR 438.8 (e)(2)(v)(A), should be excluded from the Sub-Capitated/Block Expenses Report and the calculation of the MLR. The exception is for the direct provision of Medicaid covered services to Medicaid enrollees by a provider/subcontractor when the functions are performed by the provider/subcontractor's own employees and not through a contracted network of providers. Refer to account 81605-01 – Sub Capitation Block Administration for additional information.

#### **4.12 Prior Contract Year Adjustment Schedule**

This report is intended to be a summary of all adjustments that apply to prior contract years. Please list all balance sheet and income statement adjustments on the appropriate line. All IBNR and Reinsurance adjustments need to be broken out by AHCCCS contract year on this schedule. The adjustments need to be broken out among the previous AHCCCS contract years.

#### **4.13 Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Member Month Report**

List the quarterly member month information by category (i.e., Categorical by SSI, Categorical Linked Expansion, Federal Non-Categorical Linked Expansion, and Federal Non-Categorical Linked Conversion). Any member assigned to the FQHC/RHC on the 1st day of the month should be counted as one member month. Partial months will not be counted. Please ensure use of the most current schedule Appendix E-9 and do not alter the current template.

Contractors are responsible for maintaining a detailed listing, by month, of members receiving services at an FQHC/RHC. Listing should include member name, AHCCCS ID#, primary care physician, Provider Type code, FQHC/RHC assigned, AHCCCS Provider Id, rate code at date of service, and amounts paid. This list maybe subject to AHCCCS review. The listing should not be submitted with the quarterly FQHC/RHC Report. It should be maintained internally and provided upon request.

#### **4.14 Consolidated or Parent Company (if applicable) Financial Statements**

Contractors that are a wholly owned subsidiary of another organization must submit quarterly unaudited financial information of the parent or sponsoring organization (Statement of Financial Position, Net Assets or Balance Sheet and Income Statement only).

#### **4.15 Annual IBNR Actuarial Certification**

Contractors are required to submit a copy of the IBNR Actuarial Certification performed on an annual basis with the annual financial reporting package. If this is not available, the Contractor must explain the alternative procedure and request a waiver from AHCCCS.

#### **4.16 Related Party Transaction Reports**

Related Party Transaction statements must be submitted to AHCCCS 150 days after year-end. Refer to Appendix G. Refer to the AHCCCS website for the Microsoft Excel version of this report at:

<https://www.azahcccs.gov/Resources/Contractor/Manuals/financialReporting.html>.



The Contractor shall include transactions between the Contractor and any related party in which a transaction or series of transactions during any one fiscal year exceeds the lesser of \$50,000 or two percent (2%) of the total operating expenses of the Contractor.

#### **4.17 Audited Financial Statements and Annual Reconciliation**

In addition to the annual audited financial statements, a reconciliation of the Contractor's final year to date quarterly financial statements to the draft annual audited statements must be submitted with the draft audited statements. This reconciliation schedule must also be submitted with the final audited statements. No new account classifications should be added, Contact your Financial Consultant for technical assistance.

Any footnotes or supplemental schedules that are impacted by draft or final audit adjustments must be resubmitted to agree to the audited amounts in the draft and final audit and resubmitted with these reports.

#### **4.18 Parent Company (if applicable) Annual Audit Report**

Contractors that are wholly owned subsidiaries must submit audited financial statements of the parent or sponsoring organization no later than 150 days after the parent company's fiscal year end. The audited financial statements must be the complete financial statement package, including all footnote disclosures. For parent or sponsoring organizations that file with the Securities and Exchange Commission, the entire 10-K report is required.

#### **4.19 Medical Loss Ratio Report:**

The Medical Loss Ratio (MLR) calculation shall be performed quarterly in the same manner as the Annual Medical Loss Ratio Report (Refer to Appendix H for the Annual Medical Loss Ratio Reporting Instructions).

#### **4.20 Contract Year Annual Supplement:**

This supplement is an annual deliverable on a contract year basis and is due 60 days after September 30. Submit the requested information using the Contract Year Annual Supplement Template saved on the AHCCCS' website.

#### **4.21 Additional Details Report:**

Contractors are required to fill out the tables and provide, in complete detail, all items considered Health Care Quality Improvement (regardless of the account in which the item is booked), and all items within the 990205-01 Non-Covered Services and 990405-01 Value-Added Services accounts.

## 5.00 ACCOUNTING AND REPORTING ISSUES

### 5.01 Medical Claims Liability (Including Claim Estimations RBUCs and IBNRs)

There are three primary components of claims expense:

- Paid claims,
- Received but unpaid claims (RBUCs). A claim is considered an RBUC immediately upon receipt by the Contractor and should be tracked as such. The processing status of an RBUC is either pended, in process or payable, and
- Incurred but not reported claims (IBNRs).

The first two components of claims expense are readily identifiable as part of the basic accounting systems utilized by the Contractors. Since these components, along with a well-established prior authorization and referral system, form the basis for estimation of IBNRs, it is important that Contractors have adequate claims accrual and payment systems. These systems must be capable of reporting claims on an incurred or date of service basis, have the capacity to highlight large outlier cases, possess sufficient internal controls to prevent and detect payment errors, and conform to regular payment patterns. Once IBNR estimates have been established, it is imperative that the Contractors continually monitor them with reference to paid claims.

Claims expense cannot be properly evaluated without adequate consideration of current trends and conditions. The following summarizes claims environment factors that should be considered:

- Changes in policy, practice, or coverage
- Fluctuations in enrollment by rate code category
- Expected inflationary trends
- Trends in claims lag time
- Trends in the length of hospital inpatient stay by rate code category
- Changes in rate code case mix
- Changes in contractual agreements

#### Elements of an IBNR System

IBNRs are difficult to estimate because the quantity of service and exact service cost are not always known until claims are actually received. Since medical claims are the major expenses incurred by AHCCCS Contractors, it is extremely important to accurately identify costs for outstanding unbilled services. To accomplish this, a reliable claims system and a logical IBNR methodology are required.

Selection of the most appropriate system for estimating IBNR claims expense requires judgment based on a Contractor's own circumstances, characteristics, and the availability and reliability of various data sources. Using a primary estimation methodology, along with supplementary analysis, usually produces the most accurate IBNR estimates. Other common elements needed for a successful IBNR system are:

1. An IBNR system must function as part of the overall financial management and claims system. These systems combine to collect, analyze, and share claims data. They require effective referral, prior authorization, utilization review and discharge planning functions. Also, the Contractor must have a full accrual accounting system. Full accrual accounting systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to the Contractor's members.
2. An effective IBNR system requires the development of reliable lag tables that identify the length of time between provision of service, receipt of claims, and processing and payment of claims by major provider type (hospital, medical compensation and other medical). Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficient, accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification, on a pro-forma basis, to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e., paid claims).
3. Accurate, complete, and timely claims data should be monitored, collected, compiled, and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e., prior authorization records). Prior authorization data together with claims data and other relevant information should be used to identify claims liabilities.
4. Claims data should also be segregated to permit analysis by major rate code, county, major provider, and category of service.
5. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine a Contractor's IBNR methodology if applicable.

There are several different methods that may be used to determine the IBNR amount. Examples include, but are not limited to, Case Basis, Average Cost and Lag Tables (see below). The Contractor should employ the one that best meets its needs and accurately estimates its IBNR. The IBNR methodology used by the Contractor must be evaluated by their independent Certified Public Accountant or actuary for reasonableness. A description of the process should also be included in the footnotes to the financial statements under the Summary of Significant Accounting Policies.

#### Case Basis Method

Accruals are based on estimates of individual claims/episodes. This method is generally used for those types of claims where the amount of the cost will be large,

requiring prior authorization. The final estimated cost can be made after the services have been authorized by the Contractor. For example, if a Contractor knows how many hospital days were authorized for a certain time period, and can incorporate the contracted reimbursement arrangement(s) with the hospital(s), a reasonable estimate should be attainable. This is also the most common and can be the most accurate method for small and medium sized organizations.

#### Average Cost Method

As the name suggests, average costs of services are used to estimate total expense. The expenses estimated using average costs are then reduced by claims that have been paid or claims that have been received but are unpaid (RBUCs). There are two primary average cost methods which are discussed below. It is important to note that each method may be used by a Contractor to estimate different categories of IBNRs (i.e., hospitalization vs. all other medical).

#### Per Member Per Month (PMPM) Averages

Under this method the average costs are based on the population rate for each risk group over a given time period. The average cost may cover one or more service categories and is multiplied by the number of members in the specific population to estimate the total expense of the service category. Any claims paid and RBUCs for the service category are subtracted from the expense estimate which results in the IBNR liability estimate for that service category.

#### Per Diem or Per Service Averages

Averages for this method are of specific occurrences known by the Contractor at the time of the estimation. Therefore, it is first necessary to know how many hospital days, procedures or visits were authorized as of the date for which the IBNR is being estimated. Again, once the total expense has been estimated, the amount of related paid claims and RBUCs should be subtracted to get to the IBNR liability. This method is primarily used for hospitalization IBNRs as Contractors generally know the number of hospital days authorized at any given time.

If the Contractor is considering a method different from that previously described, a written description of the process must be submitted to AHCCCS for approval prior to its use.

## **5.02 Reinsurance**

Reinsurance provides reimbursement to the Contractors when extraordinary costs associated with a member are incurred during a contract year. Specific deductible amounts and reimbursement rates are in the current contract between AHCCCS and the Contractors, including any amendments.

Reinsurance receivable should include all expected reinsurance from AHCCCS, billed and unbilled.

### **5.03 Related Parties/Affiliates**

AHCCCS monitors the existence of related party transactions in order to determine if any significant conflicts of interest exist in the Contractor's ability to meet AHCCCS objectives. A related party or affiliate may be defined as anyone who has the power to control or significantly influence the Contractor or be controlled or significantly influenced by the Contractor. Accordingly, subsidiaries, parent companies, sister companies, and entities accounted for by the equity method are considered related parties, as are principal owners, Board of Director members, management, and their immediate families, and other entities controlled or managed by any of the previously listed entities or persons, including management companies. Related party transactions include all transactions between the Contractor and such related parties, regardless of whether they are conducted in an arm's length manner or are not reflected in the accounting records (e.g., the provision of services without charge or guarantees of outstanding debt).

Transactions with related parties may or may not be in the normal course of business. In the normal course of business, there may be numerous routine and recurring transactions with parties who meet the definition of a related party. Although each party may be appropriately pursuing its respective best interest, transactions between them must be disclosed and reviewed for reasonableness.

The Contractor shall submit Annual Related Party Transactions report along with the Final Audited Report package. Activities between the Contractor and any related party in which a transaction or series of transactions during any one fiscal year exceeds the lesser of \$50,000 or two percent (2%) of the total operating expenses of the Contractor shall be included.

### **5.04 Non-Title XIX Services**

Based on available funding, ALTCS contractors are responsible for providing medically necessary and clinically appropriate auricular acupuncture, supported housing and traditional healing services for TXIX ALTCS E/PD members with an SMI designation.

ALTCS contractors should submit monthly Contractor Expenditure Reports (CERs) for reimbursement of expenditures for each service type, along with supporting documentation (for housing, also include the Housing Rental Subsidy CER Documentation Tracking Sheet) to [BHSInovices@azahcccs.gov](mailto:BHSInovices@azahcccs.gov) in order to receive reimbursement for these services including an administrative add on component equivalent to the bid Title XIX administrative percentage.

Quarterly, the Non-Title XIX detail should be separately disclosed in footnote #26 on a state fiscal year to date basis, July 1 – June 30, by type of service, service amount and bid administrative amount. Funding is not available for room and board, housing acquisition or renovation of housing stock.

Non-Title XIX funding is not subject to the following: profit, and premium tax.

#### **5.05 Financial Viability Standards and Performance Guidelines Report**

The Contractor must comply with the AHCCCS-established financial viability standards. This report is to be completed on a quarterly and annual basis to demonstrate adherence to these standards. AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: Current Ratio; Equity per Member; Contract Year to Date Medical Loss Ratio; and the Contract Year to Date Administrative Cost Percentage.

The quarterly Financial Viability Reports and Medical Loss Ratio Reports are included in the Financial Reporting Template. The Contractor's Current Ratio and Equity per Member are calculated using the balances as of the quarter-end date and the Contractor's Administrative Cost Percentage and Medical Loss Ratio are measured on a contract year-to-date basis.

Accumulated Fund Deficit: The DDD Contractor must review financial statements for accumulated fund deficits on a quarterly and annual basis. If at any time during the term of this Contract the Contractor determines that its funding is insufficient, it shall notify AHCCCS in writing and shall include in the notification recommendations on resolving the shortage. The Contractor, with AHCCCS, may request additional money from the Governor's Office of Strategic Planning and Budgeting.

Sanctions may be imposed if the Contractor does not meet these financial viability standards. If a critical combination of the Financial Viability Standards is not met, or if the Contractor's experience differs significantly from other Contractors, additional monitoring, such as monthly reporting, may be required.

#### ***FINANCIAL VIABILITY STANDARDS***

##### **Current Ratio**

Current assets less due from affiliates divided by current liabilities.

Current assets may include any long-term investments that can be converted to cash within three business days without significant loss of value, (i.e. greater than 10%).

Other Assets deemed restricted by AHCCCS are excluded from this ratio. The Contractor may request a waiver from AHCCCS to include the prorated portion of the due from affiliates balance resulting from cash/bank account sweep arrangements with other AHCCCS lines of business.

Standard:       At least 1.00

### **Equity Per Member**

Standard: At least \$2,000.

(Unrestricted equity, less on-balance sheet performance bond due from affiliates, guarantees of debts/pledges/assignments and other assets determined to be restricted, divided by the number of members as the end of the period) For this calculation use members as reported on the first day of the month following the end of the quarter (i.e. for quarter ending March 31, xx use April 1st enrollment).

Access the enrollment information using the following link:

<https://www.azahcccs.gov/Resources/Reports/providerpopreport.html>

Use the report titled Enrollment by Health Plan by County.

Additional information regarding the Equity per Member requirement may be found in the ACOM Policy 305.

The Contractor may request a waiver from AHCCCS to include the prorated portion of the due from affiliates balance resulting from cash/bank account sweep arrangements with other AHCCCS lines of business.

### **Contract YTD Administrative Cost Percentage**

Total administrative expenses (line 84999), excluding case management, premium tax and income taxes divided by total payments received from AHCCCS (lines 40105-01 through 40155-01, excluding line 40160-01 Health Insurer Fee) + Patient Contributions (MSOC) (line 40315-01)-Reinsurance Recoveries (line 70105-01) less premium tax

Standard: No greater than 8%

### **Medical Loss Ratio**

The Medical Loss Ratio (MLR) numerator includes Incurred Claims and Expenditures for activities that improve Health Care Quality. The denominator is Premium revenue less Taxes and licensing and regulatory Fees. A credibility adjustment is added, when applicable to the overall calculation. AHCCCS requires performance of the MLR calculation quarterly for monitoring of financial viability using the MLR template included in the financial statement package. For additional instructions Refer to Appendix H. The Contractor shall provide the required information as outlined in Section F. Attachment F3. of its Contract with AHCCCS.

Standard: At least 85%

**When calculated on a contract year end basis**

**Annual Financial Viability Report** – The Annual Financial Viability Report is on a contract-year-to-date basis and shall be submitted annually with the Draft and Final Audit Report. The Annual Financial Viability report will include audit adjustments. If audit adjustments result in the financial standards being out of compliance, provide a narrative explanation with a plan to remediate. Refer to Appendix Fin Viability F-1d.

**Annual Excel Medical Loss Ratio Report (Excel)** – The Medical Loss Ratio (MLR) calculation shall be performed annually in accordance with 42 C.F.R 438.8 (refer to Appendix H for the Annual Medical Loss Ratio Reporting Template, Attestation and Instructions). This report is due April 1<sup>st</sup> following the contract year end. Any retroactive changes to capitation rates after the contract year end will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to AHCCCS, a new report incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment by AHCCCS. All components of the calculation should include annual audit adjustments and true up of any estimates to present on an incurred date of service basis.

**Audited Annual Medical Loss Ratio Report** - Beginning 10/01/2020, an Independent Auditor's Attestation is required for the Annual MLR report on a CYE basis every three years as required by CMS as part of the draft and final audit. As part of the draft and final audit package submission, the audited prior-contract year-to-date CYE2023 Annual MLR report, with two annual adjustments columns (one column is for prior year adjustments and the other column represents estimates on an incurred basis) shall be included. The individual quarters do not need to be presented in the audit report. For example, if the Contractors fiscal year-end is December 31, 2020, the Annual MLR report with audit adjustments for contract year-ending September 30, 2020 would be required. If the Contractors fiscal year-end is June 30, 2021, the Annual MLR report with audit adjustments for contract year-ending September 30, 2020 would be required. For any Contractor with a fiscal year-end that aligns with the contract year, the audit performed at September 30, 2020 will include an Independent Auditor's Attestation for the Annual MLR at September 30, 2020. All components of the calculation should include annual audit adjustments and true up of any estimates to present on an incurred date of service basis.

## **5.06 Community Reinvestment**

The Contractor shall designate and spend a minimum of six percent (6%) of after-tax profits from each line of business on a Contract Year End (CYE) basis (October 1 through September 30) for Community Reinvestment activities in communities served by the Contractor. Refer to ACOM 303 for additional information.

Community Reinvestment expense should be reported in the financial statements on the Revenues and Expenses Line 990105-01 Community Reinvestment. Report the liability in account 20145-01 and disclose by contract year-end on the Other Liabilities Report. Community Reinvestment can be accrued for on a quarterly basis



if the Contractor can reasonably estimate the amount to be allocated. Community Reinvestment accrued and recorded in one fiscal year, would become a balance sheet only transaction when paid out in subsequent years.

The Community Reinvestment Calculation tab of the Financial Reporting Template is required as part of the Contractors Draft Audit and should include audit adjustments completed for the current fiscal year, as well as the prior fiscal year, if applicable, in order to properly calculate the contract year-end profit subject to the six percent (6%). An audit adjustment for the recognition of Community Reinvestment should also be recorded and/or trued-up (for those who accrue quarterly) as part of the Draft Audit.

The Contractor shall submit a plan detailing its anticipated Community Reinvestment activities as specified in ACOM 303, Attachment A. The Contractor shall also submit an annual Community Reinvestment Report as specified in ACOM 303, Attachment B. Submit one file with separate tabs for each line of business. Continue to submit this report annually to AHCCCS on all previous year commitments until the full required community reinvestment amount has been reinvested into the community. If the reinvestment relates to a commitment in a previous year, indicate this on the Community Reinvestment Report under the applicable Commitment Year Column.

#### **5.07 Pharmacy Benefit Manager (PBM)**

**The Contractor must ensure the PBM calculates incurred claims as the amounts paid to the retail or mail-order pharmacy (e.g., drug ingredient costs and dispensing fees) minus any prescription drug rebates and accounts for any other applicable requirements in 42 CFR 438.8(e)(2).**

The Contractor must ensure the PBM reports to the Contractor all of the information necessary for the Contractor to meet its MLR obligations under 42 CFR 438.8. The Contractor must ensure the PBM classifies and reports revenues and expenditures associated with the administration of the Medicaid covered outpatient drug benefit to the Contractor in the same manner that the Contractor would be required itself to classify and report this information if the Contractor had administered the covered outpatient drug benefit directly.

Even if the Contractor pays the PBM a capitated amount in a risk-based arrangement, the Contractor and PBM must classify and report revenues and expenditures associated with the administration of the Medicaid covered outpatient drug benefit consistent with 42 CFR 438.8. The Contractor may not report the entire capitated payment to the PBM as incurred claims/pharmacy expenditures.

The Contractor must ensure other expenditures by the PBM under subcontract with the Contractor (e.g., activities that improve health care quality, non-claims costs for administrative services, taxes and fees, etc.) are classified appropriately and

reported to the Contractor to facilitate the Contractor's MLR calculations and reporting.

#### Pharmacy Rebates

If a Contractor has a contractual arrangement where the PBM is retaining pharmacy rebates or other items of value in lieu of charging a separate administrative fee, then the amount of the rebates retained would need to be treated as a reduction to incurred expenses/pharmacy expenditures for MLR reporting purposes. The retained rebates or other items of value should be considered administrative costs of the Contractor (assuming the PBM would assess explicit charges to the Contractor in the absence of the retention of rebates or other items) and recorded in account 81305-01 – Pharmacy Benefit Manager Expenses.

## 6.00 APPENDICES

**Appendix A:** Certification Statement

**Appendix B:** Financial Statement Reporting Template Audit Report

**Appendix C:** Financial Statements

**Appendix D:** Financial Statement Footnote Disclosures

**Appendix E:** Supplemental Reports

**Appendix F:** Audit Reconciliation Report

**Appendix G:** Supplemental Report: Related Party Transactions

**Appendix H:** Supplemental Report: **Annual** Medical Loss Ratio Reporting Template, Attestation and Instructions

**Appendix I:** Contract Year Annual Supplement