



**FINANCIAL REPORTING GUIDE FOR
AHCCCS COMPLETE CARE AND AHCCCS
COMPLETE CARE - REGIONAL
BEHAVIORAL HEALTH AGREEMENT
CONTRACTORS**

Effective Date October 1, 2022

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DEFINITIONS

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 behavior health provider-delivered case management, or integrated health care services.

ADMINISTRATIVE SERVICES SUBCONTRACT/SUBCONTRACTOR: An agreement that delegates any of the requirements of the contract with AHCCCS, including but not limited to the following:

1. Claims processing, including pharmacy claims,
2. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization),
3. Management Service Agreements,
4. Service Level Agreements with any Division or subsidiary of a corporate parent owner,
5. CHP Subcontracted Health Plan(s).

A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

AFFILIATE: Refer to Related Party Transactions definition.

AHCCCS: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM. A State agency, as described in A.R.S. Title 36, Chapter 29, which is responsible for the provision of hospitalization and medical care to members through contracts with Contractors. AHCCCS is Arizona's Medicaid program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program

AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM): The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at 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.

BEHAVIORAL HEALTH DIAGNOSIS: Behavioral health diagnoses are identified as “mental disorders” in the latest ICD code set in use.

BLOCK GRANT: Federal monies allocated to states, cities, or counties for distribution to community groups, charities and other social service providers, most often administrated under the allocated agencies rules and regulations.

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 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.

COMPREHENSIVE HEALTH PLAN (CHP): A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for children in the custody of Department of Child Safety either in a foster home or other place setting in Arizona. Refer to A.R.S. §8-512.

CONTRACT YEAR: The period from October 1, through September 30.

CONTRACTOR: An organization or entity that has a prepaid capitated contract with the AHCCCS administration pursuant to A.R.S. §36-2904 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.

DES: Department of Economic Security

DCS: Department of Child Safety

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.

EMERGENCY MEDICAL CONDITION: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

EMERGENCY SERVICES: Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

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

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(l)(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.

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.

INTERPRETATION/TRANSLATION SERVICES: Interpretation is the conversion of oral communication from English into the member's 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.

MANAGEMENT DECISION

The evaluation of the audit findings and corrective action plan and the issuance of a written decision to the auditee as to what corrective action are necessary.

MANAGEMENT SERVICES AGREEMENT

A type of subcontract with an entity in which the owner of the Contractor delegates some or all the comprehensive management and administrative services necessary for the operation of the Contractor.

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.

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.

STATE ONLY TRANSPLANT MEMBERS: Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose

Title XIX eligibility due to excess income may become eligible for one of two extended eligibility options as specified in A.R.S. 36-2907.10 and A.R.S. 36-2907.11.

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.

SUPPLEMENTAL SECURITY INCOME (SSI): Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind, or disabled and have household income levels at or below 100% of the FPL.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF): A Federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It replaced Aid to Families with Dependent Children (AFDC).

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.

1.00 GENERAL INFORMATION

1.01 Purpose and Objective of the Guide

The purpose of the AHCCCS Financial Reporting Guide for is to set forth the monthly, quarterly, and annual reporting requirements for the following Contractors: AHCCCS Complete Care (ACC), ACC-Regional Behavioral Health Agreement (ACC-RBHA), Comprehensive Health Plan (CHP) and Medicare Advantage Prescription Drug. . The primary objective of the Guide is to establish consistency and uniformity in 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. AHCCCS has developed a standard set of forms 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 provide 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 and CUBE Flat File provided by the Division of Health Care Management (DHCM) for submission of all required quarterly and annual reports.

If the Contractor is a Medicare Advantage Plan 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 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 the Contractor is required to submit its quarterly reports to AHCCCS as outlined in Attachment F3 Contractor Chart of Deliverables of its Contract with AHCCCS using the Financial Reporting Guide for AHCCCS Complete Care Contractors and the related report templates for quarterly reporting.

If there are any inconsistencies between this reporting guide and any contract provision, the contract provision 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 content or format of a report are to be directed to the Contractors' 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

Pursuant to ACOM 408, 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.

REPORT DUE DATES

REPORT

**Monthly Reporting
(Only if requested by AHCCCS)**

**Quarterly/
Financial Reporting**

**Draft Audit
Financial Reporting**

**Final Audit
Financial Reporting**

**ACOM 323
Financial Reporting
(ACC-RBHA only)**

Due Date: _____ →	30 days after month end	60 days after quarter end	90 days after Contractor's fiscal year end	150 days after Contractor's fiscal year end	30 days after Final Audit Submission
Certification Statement	X	X	X	X	X
Financial Statement Template Audit Report		X			
Balance Sheet Report - Part A: Assets	X	X	X	X	
Balance Sheet Report - Part B: Liabilities & Equity	X	X	X	X	
TXIX Income Statement	X	X	X	X	
ACC-RBHA only: NTXIX Income Statement	X	X	X	X	X
FN 11 Balance Sheet and Income Statement	X	X	X	X	
Financial Viability	X	X	X	X	
Receivables/Payables Report (4.02 & 4.03)	X	X	*	*	
Other Assets Report	X	X	*	*	
Alternative Payment Model Report (by provider by year)	X	X	*	*	
Other Liabilities Report	X	X	*	*	
Additional Details Report	X	X	*	*	
Claims Lag Report (Hospitalization, Medical & Other)	X	X	*	*	
TXIX/XXI Other Account	X	X	X	X	
Long-term Debt Report (other than Affiliates)	X	X	*	*	
ACC-RBHA only: Consolidated Profitability	X	X	X	X	
Profitability by Risk Group ¹	X	X	*	*	

¹ Not applicable to CHP.

ACC-RBHA only: NTXIX Income Statement and Disclosure	X	X	X	X	
ACC-RBHA only: Block Grant Break-Out C-2a.1	X	X	X	X	
Sub-Capitated and Block Expenses Report	X	X	*	*	
Sub-Capitated and Block Expense Detail	X	X	*	*	
Sub-Capitated/Block Purchase Expense Detail by Risk Group on a Contract-Year-End Basis				X	
ACC-RBHA only: SFYTD NTXIX Income Statement and Disclosure	X	X	X	X	
ACC-RBHA only: SFYTD Block Grant Break-Out C-2a.1	X	X	X	X	
ACC-RBHA only: SFY Revenue Recon and Allocation Tracking	X	X	X	X	X
ACC-RBHA only: Non-Title XIX/XXI Profit Limit Template as of June 30	X	X			
ACC-RBHA only: Final Non-Title XIX/XXI Profit Limit Template (if applicable. Only required if changes are made after the June QE submission)					X
ACC-RBHA only: Grant Disclosures	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 Member Months Report		X			
Parent Company (if applicable) Financial Statements		X		X	
Independent Auditor's Report			X	X	
ACC-RBHA only: Single Audit 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 Contract Year-End basis			X	X	
Annual IBNR Actuarial Certification				X	

Audit Recon Balance Sheet F-1a
 Audit Recon Income Statement F-1b
 Audit Recon Entries F-1c
 Annual Financial Viability F-1d
 ACC-RBHA only: Annual Audited NTXIX/XXI Income Statement F-1e
 ACC-RBHA only: Annual Audited NTXIX/XXI Income Statement Schedule A Disclosure F-1f
 Related Party Transactions
 Community Reinvestment Calculation I-1
 Medical Loss Ratio Report H-1 and H-2
 Independent Auditor's Attestation of Annual Medical Loss Ratio on a Contract Year End basis (required every three years)
 Contract Year Annual Supplement

		*	*	
		X	X	
			X	
			X	
		X	X	
X	X	X	X	
		X	X	
	X			

* 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

Financial statements must be prepared and presented on an accrual basis (cash basis, if directed by AHCCCS), and in accordance with GAAP and all other applicable authoritative literature. Financial reporting by an HCSO for Medicare Reporting must follow statutory accounting rules as prescribed by the Arizona DIFI (if licensed by DIFI or AHCCCS Financial Reporting Guide if certified by AHCCCS).

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 Division of Health Care Management (DHCM). The Financial Statement Reporting Template to be used 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 Complete Care 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.

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. 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 audited 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 for 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 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, Title XIX/XXI 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.

3.02 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, quarter ended, preparer information, and Chief Executive Officer and Chief Financial Officer 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)²

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 are assets that are expected to be converted into cash or 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.

² Balance Sheet will be used interchangeably throughout the Financial Reporting Guide to mean Balance Sheet or Statement of Net Assets.

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 Adjustment Receivable

ACC 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.

ACC-RBHA Include:

Net amounts receivable from AHCCCS for capitation and Non-Title XIX/XXI funding as of the balance sheet date. Refer to Capitation and Non-Title XIX/XXI Funding Receivable Report (Paragraph 4.02) for required detail of this line item.

Account 10120-01 - Reinsurance Receivable

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

Account 10125-01 - Reconciliations/Settlements Receivable

Include: Amounts receivable from AHCCCS, reconciliations/cost settlements. Refer to Receivables/Payables Report (Paragraph 4.03) for required detail of this line item. This should equal only the sum of all receivable amounts listed on the Receivables/Payables Report (Paragraph 4.03). In addition, any settlement amounts **due from AHCCCS** relating to alternative payment model and access to professional services initiatives should be recorded in this account.

Exclude: Amounts **due from providers** relating to alternative payment model initiatives and PBP amounts related to Medicare Advantage Organization (MAO) Agreements.

Amounts due from AHCCCS for lump-sum directed payments including Access to Professional Services Initiatives (APSI), Pediatric Services Initiatives (PSI), Targeted Investments (TI), 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 any assets (e.g., income taxes receivable, net amounts receivable from AHCCCS related to lump-sum directed payments including APSI, PSI, TI, and HEATHII) 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 IBNRs. Refer to Other Assets Report (Paragraph 4.04) for required detail of this line item.

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. 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 current amounts due from affiliates.

Account 10225-01 - Other Non-Current Assets

Include: The total non-current portion of any assets not accounted for elsewhere on the balance sheet including any non-current portion of Alternative Payment Model Initiatives. Refer to Other Assets Report (Paragraph 4.04) for required detail of this line item.

PROPERTY AND EQUIPMENT consists of fixed 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.

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 consist of 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 - Other Current Liabilities.)

Account 20120-99 - 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, Tiered, Non-Title XIX/XXI Profit Limit, General Fund profits and other reconciliations/cost settlements. 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 and access to professional services initiatives should be recorded in this account.

Exclude: Amounts **due to providers** related to PBP amounts relating to MAO Agreements and amounts **due to AHCCCS** related to lump-sum directed payments including APSI, PSI, TI, and HEALTHII. 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.

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 Long-Term Debt (Other than Affiliates) Report, Paragraph 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 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 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 (i.e., income taxes payable, lump-sum directed payments including APSI, PSI, TI, and HEATHII). 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 are 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 (Paragraph 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 include preferred stock, common stock, treasury stock, additional paid-in capital, contributed capital, 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.

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 30135 - Reserved for Future Use

Account 30140-01 - Retained Earnings/ Fund Balance /Net Assets (Liabilities)

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.

30140-05 *Net Income/ (Loss) YTD* – must agree with the YTD Income Statement without rounding.

30140-15 *Transfer In/Out* – report amounts transferred in/out (Government Entities) and equity distributions in this line.

30150-01 *Unrealized Gains/ (Loss)* – report unrealized gains or losses in this line.

3.05 Income Statement

The Income Statement includes the following risk groups, Age <1, Age 1-20, Age 21+, Duals, SSI w/o Med, Prop 204 Childless Adults, Expansion Adults, Title XIX/XXI SMI, Title XIX/XXI Crisis (24 Hours) and State Only Transplants.

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. Refer to Appendix C-2 for an example of this report

REVENUES

Account 40105-01 - Capitation

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

Exclude: All other capitation, such as CRS, DES/DDD, ALTCS 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 and/or account 20125.

Account 40120-01 - Delivery Supplement

Include: Delivery supplement revenue earned as of the statement date.

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 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: ACC Administrative Reconciliation Settlement, APSI Reconciliation Settlement or any other reconciliation settlements.

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.

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

Hospitalization Expenses include only those expenses for Inpatient hospital services.

Account 50105-01 - Hospital Inpatient

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

Medical Compensation Expenses include compensation paid for physician and non-physician services. Expenses should include all contracted, non-contracted, fee for service and sub-capitated expenses.

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.

A/C 60305-20 - Physician Services

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

Account 50215-01 - Referral Physician Services

Include: Those expenses 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 50225-01 - Other Professional Services

Include: All other professional services not specifically identified in one of the categories defined above.

Other Medical Expenses include services provided to members on an outpatient basis. Services include emergency services, pharmacy, lab, radiology, etc. Expenses should include all contracted, non-contracted, fee for service and sub-capitated expenses for these services.

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. 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 5.06.

Account 50315-01 - Laboratory, Radiology and 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 above).

Account 50325-01 - Durable Medical Equipment

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

Account 50330-01 - Dental

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

Account 50335-01 - Transportation

Include: Transportation expenses incurred for inpatient and outpatient services, both emergency and non-emergency.

Account 50340-00 - Nursing Facility, Home Health Care

Include: Expenses relating to nursing facility (NF) and home health care including durable medical equipment expense incurred in a NF or home health care setting. Examples include: Intermediate Care Facility and Skilled Nursing Facility.

Account 50345-01 - Therapies

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

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, account 20130, and/or account 20215.

Account 50370-01 - Other Medical Expenses

Include: Outpatient expenses not specifically identified in one of the categories defined above.

Behavioral Health Expenses

Account 60805-xx- 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 60405-01 - Case Management Services

Include: Case management expenses 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.

Exclude: ACC-RBHA only: BH case management performed at the MCO level.

Account 60405-10 - Family Support

Include: Family support expenses.

Account 60405-15 - Peer Support

Include: Peer Support expenses.

Account 60405-45 – Other Support Services

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

Account 60505-xx – Crisis Intervention Services

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

Include: (For ACC-RBHA only) Expenses incurred for Crisis Intervention Services provided to members within the first 24 hours of a crisis episode for Title XIX/XXI individuals.

Account 60205-01 - Living Skills Training

Include: Living Skills Training expenses incurred for Rehabilitation Services provided to members.

Account 60205-05 - Cognitive Rehabilitation

Include: Expenses related to the facilitation of recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible.

Account 60205-10 - Health Promotion

Include: Expense education and training about health-related topics that can be provided in single or multiple sessions provided to an individual or a group of people and/or their families.

Account 60205-15 - Supported Employment Services

Include: Supported Employment Expenses incurred for Rehabilitation Services provided to members.

Account 60605-01 Inpatient Services Hospital

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

Account 60605-05 Inpatient Services Sub acute Facility

Include: All contracted or fee for service expenses for subacute inpatient services.

Account 60605-05 Inpatient Services Residential Treatment Center (RTC)

Include: All contracted or fee for service expenses for RTC inpatient services.

Account 60605-15 Inpatient Services, Professional

Include: All contracted or fee for service expenses for professional inpatient services.

A/C 60705-xx - 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 60105-01 - Counseling

Include: Individual, Family and Group Counseling.

Account 60105-05 - Assessment, Evaluation and Screening

Include: Assessment, Evaluation and Screening.

Account 60105-15 - Treatment Services

Include: Other Professional Services.

Account 61100-01 PPC BH Title XIX

Include: PPC expenses resulting from when a Non-Title XIX GMH/SU and CHP and non-CHP child member retroactively becomes eligible for Medicaid. This expense should only be reported under the Title XIX/XXI Crisis (24 Hours) column.

Exclude: Title XXI members are not eligible for PPC services.

Account 61105-01 - Other BH Services Not Reported Above

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

Account 61205-01 BH FQHC/RHC Services

Include: BH 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 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.

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 70105-01, 70205-02, 70305-01, 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.**

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 by funding source/risk group 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, 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 5.06.

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-claims cost include, but are not limited to: Amounts paid to third party vendors for secondary network savings; Network development; Claims processing including pharmacy claims; Utilization review/management; Eligibility and coverage verification; Fines and Penalties; Professional service 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; 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-claims cost include, but are not limited to: Amounts paid under a sub capitated arrangement for secondary network savings; Network development; Claims processing including pharmacy claims; Utilization review/management; Eligibility and coverage verification; Fines and Penalties; Professional service 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; PBM administrative and spread costs.

Include: (For CHP only) Amounts paid to CHP's Subcontracted Health Plan for administrative services provided by the Subcontracted Health Plan including management service agreements and service level agreements with any division or subsidiary of a corporate parent owner. Refer to examples provided above of administrative functions/delegated managed care activities considered non-claims cost.

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 improvement.

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

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 sale of investments and 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, non-emergency dental 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.

For ACC-RBHA, also exclude amounts for services covered by another Non-Title XIX/XXI funding source (e.g. room and board, housing, child care, acupuncture, traditional healing. These would be reported in the applicable Non-Title XIX/XXI funding columns).

Account 990305-01 – Unreimbursed Performance Based Payments

Include: Amounts for Performance Based Payment 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, risk group and the inclusion of any new geographic service areas.

Discuss revenue and expense recognition policies for the following:

- Capitation revenue; Delivery Supplement revenue; Reconciliation Settlements,
- 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 amount 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 %.) 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) 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). For ACC-RBHA, also disclose the State Fiscal 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 the 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 the 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 Equity/Net Assets line items if the current or previous quarter amount is equal to or greater than +/-5% of the 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.

Income Statement

Describe changes in Income Statement 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 Income Statement line items should be calculated using PMPM amounts.

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

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) Additional Expense Explanations Requested by AHCCCS (ACC-RBHA only)

Use this footnote to disclose additional information as requested by AHCCCS during the contract year.

- a. Disclose the SFYTD total amount of County dollars expended on children. Of that amount, how much was expended on remanded juveniles by expense type.
- b. Disclose the SFYTD amount expended on incarcerated adults and children justice programs by Non-Title XIX/XXI funding source.
- c. Disclose the Title XIX/XXI CYTD crisis expense amount provided within the first 24 hours at a stabilization unit for procedure codes other than S9484 and S9485. If this does not apply, indicate that the only crisis services provided were billed using S9484 and S9485.
- d. Provide confirmation that Alcohol and/or drug services were not provided with NTXIX/XXI SMI, MHBG SMI and MHBG SED funding. These services are unallowable with these funding sources.
- e. Provide confirmation that Multisystemic Therapy for Juveniles were not provided with NTXIX/XXI SMI and MHBG SMI funding. This service is unallowable with these funding sources.
- f. Provide confirmation that Sponsorships for events and conferences were not provided with SABG and MHBG funding. Sponsorships are unallowable with these funding sources.
- g. Provide confirmation that Transcranial Magnetic Stimulation services were not provided with MHBG SED and SABG funding. This service is unallowable with these funding sources.
- h. For each separate funding source reported in the Non-Title XIX/XXI Other Column, provide the SFY Allocation and the total amount expended by service expense and admin expense.
- i. Provide an allocation by population of your current State Fiscal Year Non-Title XIX/XXI Crisis General Fund expenditures (only required in QE June submission)

15) 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).

16) Premium Deficiency Reserve – ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

Include the cumulative amount of the reserve as well as the current quarter amount and all line items included in the entry. RESERVED

17) Social Risk Factors – ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

Provide the Social Risk Factor and Health Equity activities expended in the fiscal year by quarter and fund source. Indicate the line number in the financial statements where these are reported. Only identify items that have been spent in the reporting period.

Social Risk Factor 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 Factor 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 for Social Risk Factor services should be included in this footnote only after being spent.

Z codes can be used to identify potential members for which social risk factor services may have been provided. Social Risk Factor 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

18) 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.

19) Non-Operating Profit (Loss)

Provide a breakdown by activity for all non-operating profit(loss). Refer to the table in the Sample Footnotes for Financial Disclosure section.

4.00 SUPPLEMENTAL REPORTS

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

4.01 Financial Viability

This report is for analysis purposes. Calculate each ratio or performance standard as outlined in the tab. Refer to Paragraph 5.04 for additional information.

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 – accounts 10125 and 20125. Use the prepopulated reconciliation names provided in the template. Amounts related to AHCCCS reconciliations/cost settlements (both receivables and payables where applicable) should be detailed by contract year. 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. Use the prepopulated reconciliation names provided in the template.

CHP: Include any receivable or payable related to CHP's reconciliation with its Subcontracted Health Plan in accordance with CHP's contract with the Subcontracted Health Plan. CHP will submit the reconciliation to AHCCCS for approval. Refer to the CHP contract for more information.

4.04 Other Assets Report

Include all other assets (current and non-current) in the appropriate categories provided. List separately any asset related to lump-sum directed payments including APSI, PSI, TI, and HEALTHII, any other individual assets greater than 10% of total other assets separately and list the total of others not individually greater than 10%. The ending balances for current assets should agree to account 10145-01 and non-current assets to account 10225-01 of the Balance Sheet.

4.05 Other Liabilities Report

Include all other liabilities (current and non-current) in the appropriate categories provided. List separately any liability related to lump-sum directed payments including APSI, PSI, TI, and HEALTHII, any other individual liabilities greater than 10% of total other liabilities separately and list the total of others not individually greater than 10%. 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, 20130 and 20215. 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. Do not include adjustments or sub-capitation payments in the payment triangle. All previous quarters with a remaining claims reserve/estimated claims payable should be reported only in the Claims Ultimate Row in column 10 (7th Prior). D. Reported but Unpaid Claims (RBUC) will be reported in the RBUC Payable row and not included with payments. Incurred but not Reported (IBNR) will be reported separately on the IBNR row.

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/Other Than Funds) Report

List all loans, notes payable and capital lease obligations by lender as well as by current and 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). The

totals should equal the amounts reported on the Balance Sheet – accounts 20135-01 and 20205-01.

4.09 Analysis of Profitability³

These reports provide an analysis of revenues and expenses on a consolidated basis or by GSA by major risk group classification. The reports are 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 Income Statement 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.

Investment Income and Total Administration expense are to be allocated to the risk groups.

4.10 Sub-capitated/Block Expenses Report

This report is a summary of sub-capitation expenses, by risk group, by individual expense line item by date of service for the contract year end. Only list the accounts in this report that have sub-capitation expenses. Sub-capitated expenses SHOULD NOT be reported for account 50350 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 part of the draft and final audit for the prior-contract year sub-capitated/block expense report by risk group sub-capitated expenses report by risk group including any adjustments. For example, if the Contractors fiscal year-end is December 31, 2020, an attestation for the sub-capitated/block expense 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 a 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 Purchases 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

³ Not applicable to CHP.

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 Purchases 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 Purchases 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 Purchases Expenses Report.

The portion of the sub-capitation 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.

4.11 Block Purchases Expense Report

This report is a summary of block purchases expenses, by risk group and by individual expense line item. Only list amounts in this report for expenses that have block purchasing

arrangements. This information assists in calculating any reconciliation and is used in capitation rate setting.

4.12 Prior Contract Year Adjustment Schedules

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 FQHC/RHC Member Months

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, SCHIP) for each FQHC/RHC. Effective October 1, 2009, Title XXI (Kids Care) member months **should** be reported in the appropriate column. 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. Exclude State Only transplant member months. Please ensure to use 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. Listing should include member name, AHCCCS ID#, primary care physician, Provider Type code, FQHC/RHC assigned, FQHC/RHC AHCCCS Provider Id, rate code at date of service, and amounts paid. This list may be 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

Contactors that are a wholly owned subsidiary of another organization must submit quarterly unaudited financial information of the parent of sponsoring organization (balance sheet and state of revenues and expenses 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 links to the templates for these reports

<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, see 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. Refer to Appendix F for examples of the annual audit reconciliation 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 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 contractual agreements
- Changes in policy, practice, or coverage
- Fluctuations in enrollment by rate code category
- Expected inflationary trend
- Trends in claims lag time
- Trends in the length of hospital inpatient stay by rate code category
- Changes in rate code case mix

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:

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. 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 are 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). 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.

Claims data should also be segregated to permit analysis by major rate code, county, major provider, and category of service.

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 AHCCCS Complete Care Contract and the CHP Contract between AHCCCS and the Contractor. 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).

5.04 Financial Viability Standards and Performance Guidelines Report⁴

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

Standard: At least 1.00

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.

⁴ For CHP, refer to contract for Financial Viability Standards.

Equity per Member

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 Title XIX/XXI members enrolled at 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) at the following link:

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

Use report titled Enrollment by Health Plan by County.

ACC *Standard: At least \$250 per member*

ACC-RBHA Standard: At least \$250 per ACC member and at least \$1,300 per Title XIX/XXI member with SMI assigned to the ACC-RBHA for the Central GSA; or at least \$1,200 per Title XIX/XXI member *with SMI assigned to the ACC-RBHA* for the North and South GSAs.

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 (account #84999) divided by the sum of total [Capitation (line # 40105-01), Alternative Payment Model Initiatives Reconciliation/Settlement (line #40115-01), Delivery Supplement (line #40120), Prospective Tiered Recon Settlement (line #40130-01), Other Reconciliation Settlements (line #40145)] less Reinsurance Recoveries (line #70105-01) less premium tax

Standard: No more than 10%

When calculated on a contract-year-to-date basis

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 Attachment F 3 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 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 1st 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 CYE 20 Annual MLR report with audit adjustments is required. For example, if the Contractor's 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 Contractor's 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.

5.05 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 Contractor's 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.

5.06 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 Instructions and 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

**FINANCIAL REPORTING GUIDE FOR ACC-RBHA CONTRACTORS
NON-TITLE XIX/XXI**

ACRONYMS

CER	Contractor Expenditure Report
FAC	Federal Audit Clearinghouse
FAQs	Frequently Asked Questions
MHBG	Mental Health Block Grant
RTC	Residential Treatment Center
SABG	Substance Abuse Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SUD	Substance Use Disorder
SMI	Seriously Mental Ill

DEFINITIONS

Block Grant

Federal monies allocated to states, cities or counties for distribution to community groups, charities and other social service providers, most often administered under the allocated agencies rules and regulations.

Management Decision

The evaluation of the audit findings and corrective action plan and the issuance of a written decision to the auditee as to what corrective action are necessary.

Non-Federal Entity

Non-Federal entity means a state, local government, Indian tribe, institution of higher education (IHE), or nonprofit organization that carries out a federal award as a recipient or subrecipient.

State Fiscal Year

The period from July 1 through June 30.

1.00 GENERAL INFORMATION

1.01 Purpose and Objective of the Guide

The purpose of the AHCCCS Financial Reporting Guide for ACC-RBHA Contractors with Non-Title XIX/XXI funding is to set the periodic financial reporting requirements for the contracted ACC-RBHAs (hereafter referred to as Contractors).

Contractors are required to utilize the most recent Financial Statement Reporting Template and CUBE Flat File provided by the DHCM for submission of all required quarterly and annual reports.

If there are any inconsistencies between this reporting guide and any contract provision, the contract provision 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 content or format of a report are to be directed to the Contractors' assigned Financial Consultant.

1.02 Effective Dates and Reporting Time Frames

Refer to Title XIX/XXI Section.

ACC-RBHA Non-Title XIX/XXI quarterly reporting is due within 60 days of each quarter end, using the most recent AHCCCS Reporting Template and CUBE Flat File.

1.03 Sanctions

In the event the Contractor fails to demonstrate compliance with contractual requirements, AHCCCS may elect to impose an Administrative Action. AHCCCS reserves the right to issue an Administrative Action for any occurrence of non-compliance. Each occurrence of non-compliance will be evaluated for determination and issuance of potential Administrative Action. Administrative Actions may include issuance of any or all of the following: Notice of Concern, a mandate for Corrective Action Plan (CAP), Notice to Cure (NTC), and Sanctions, including but not limited to monetary penalties, reducing the amount of the allocation, terminating the allocation, or denying future funding. The Administrative Actions are non-exclusive; that is, the issuance of an Administrative Action or the imposition of any particular Sanction by AHCCCS does not preclude AHCCCS from pursuing any other remedy available in law or Contract. Proposed sanctions will be evaluated by the AHCCCS Compliance Committee, as specified in ACOM Policy 408.

The Contractor may dispute the decision to impose a Sanction as specified in A.A.C. R9-34-401 et seq.

2.00 FINANCIAL REPORTING REQUIREMENTS

Refer to Title XIX/XXI Section.

3.00 INSTRUCTIONS FOR COMPLETION OF QUARTERLY AND ANNUAL REPORTING FORMS

Refer to Title XIX/XXI Section.

3.01 General Instructions

Refer to Title XIX/XXI Section.

3.02 Certification Statement

Refer to Title XIX/XXI Section.

3.03 Financial Statement Reporting Template Audit Report

Refer to Title XIX/XXI Section.

3.04 Balance Sheet

Refer to Title XIX/XXI Section.

3.05 Income Statement

Refer to Title XIX/XXI Section. In addition, the Non-Title XIX/XXI Income Statement encompasses revenue and expenses for State, Federal, County and Other programs for the applicable quarter. The intent of the statement is to capture the revenue of the Contractor and to match that revenue with related expenses by each funding program.

Revenue and expenses shall be reported under the applicable funding program column in the line indicated in these instructions.

Revenue is to be calculated and accrued as follows:

- a. Non-Title XIX/XXI revenue is to be accrued on a state fiscal year basis using 1/12th of the annual allocation (or 1/9th of the allocation, if applicable) as reported on the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current. Revisions to the allocation may occur throughout the year, but until the Contractor is notified in writing of any changes, the amount reported on the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current, is the best and most probable estimate of what AHCCCS will pay out. Prior written approval must be obtained from AHCCCS for any deviations from the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current.
- b. Other revenue sources should be accrued in accordance with GAAP (e.g. CERs and revenue sources other than AHCCCS).

Calculate BH expenses as part of the IBNR calculation and allocate on a consistent basis in accordance with GAAP within each funding program. Refer to the Title XIX/XXI and Non-Title XIX/XXI Lag Reports (Paragraph 4.07) for more information.

BH medical expenses should be allocated to service line items and to each funding program based on current year service utilization/encounter data. Medical expenses should be allocated to service line items based on sufficient encounter experience. Contractors should use sufficient encounter history (e.g., a rolling 12 months) to allocate block payment expenditures.

Report BH medical expenses in accordance with contractual requirements and AHCCCS Guides and Manuals. Refer to additional guidance regarding expense reporting in the Expenses section of Section 3.05. Non-Title XIX/XXI administrative expenses shall be reported in conformance with the Contractor's internal cost allocation plan. Refer to Paragraph 5.10 for more information.

Funding and related expenses received from non-AHCCCS sources should be reported in the Mgmt & Gen column. Report revenue on line 40205-01 and expenses on the applicable expense lines and disclose on Schedule A for items with an '*' in the account title.

Report expenses related to State Only Transplants in the Mgmt & Gen column on the applicable service line(s).

Refer to Appendix C-2, C-2a and C-2a.1 for examples of the Income Statement, Schedule A Disclosure and Block Grant Detail by Funding Source. For revenue and expense lines with an asterisk after the title, Contractors are required to disclose the details on the Income Statement, Schedule A Disclosure.

Contractors are also required to complete the Non-Title XIX/XXI Income Statement Summaries quarterly on a state fiscal year basis. Refer to Appendix FS-NTXIX Income Statement for an example.

The SFYTD Non-Title XIX/XXI Income Statement C-3, Schedule A Disclosure C-3a and SFY Block Grant Detail by Funding Source C-3a.1 are required to be updated in the December, March and June quarter end financial reporting packages.

A SFYTD Non-Title XIX/XXI Income Statement C-3 and Schedule A Disclosure C-3a are due 30 days after May month end or June 30th.

The SFYTD Non-Title XIX/XXI Revenue Reconciliation and Allocation Tracking tab is required to be updated each quarter. Refer to Appendix C-3b for an example of this report.

Non-Title XIX/XXI includes the following funding sources/programs: Crisis, SMI, Housing Trust Fund, SABG, MHBG, Other Federal, County and Other. These funding sources/programs may be comprised of other programs or sub-categories as allocated by AHCCCS.

REVENUE

Account 40205-01 Non-Title XIX/XXI Revenue

Include: Revenue recognized from AHCCCS for the provision of covered BH medical expenses for Non-Title XIX/XXI members and BH expenses for Title XIX/XXI members that are not covered by Title XIX/XXI funding.

Account 40210-01 Specialty and Other Grants Revenue

Include: Revenue earned from specialty and other grants received from AHCCCS. This line is used as directed by AHCCCS for revenue not subject to performance ratio calculations.

Account 40215-01 Non-Title XIX/XXI Profit Limit

Include: Non-Title XIX/XXI Profit Limit amounts due to AHCCCS. Estimated amounts should be accrued in the period that they are earned. 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 40310-01 Other Income (Specify)

Include: Non-Title XIX/XXI revenue from sources not identified in the aforementioned other revenue categories; and revenue not subject to performance ratio calculations as directed by AHCCCS.

EXPENSES

All Non-Title XIX/XXI expenses must be reported in accordance with the AHCCCS ACC-RBHA Non-Title XIX/XXI contract, the AMPM and ACOM policies, including but limited to AMPM 310 Covered Services and Exhibits 300, AMPM 320-U, AMPM 320-T1 Block Grants and Discretionary Grants and AMPM 320-T2 Non-Title XIX/XXI Services and Funding (Excluding Block Grants and Discretionary Grants). In addition, all expenses must be reported net of Medicare/TPL reimbursement, interest and net of quick pay discounts. If any inconsistencies exist between this reporting guide and another reference source, please reach out to AHCCCS for a final determination. There may be pending changes to a policy that has not yet to be posted to the website. Use the "CBHSG Service Description Subcategory" column in the Behavioral Health Services Matrix to determine where codes should be reported in the ACC-RBHA financial statements. The Behavioral Health Services Matrix is located on AHCCCS' website on the Medical Coding Resources webpage under the Behavioral Health Service Matrix section via this link <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.

Behavioral Health Medical Expenses

Account 60105-xx Treatment Services

Include: The following treatment services are covered under the behavioral health benefit when medically necessary and should be reported on the applicable Income Statement Treatment expense line:

- Assessment, Evaluation (non-court ordered)*, and Screening Services
- Behavioral Health Counseling and Therapy, and
- Psychophysiological Therapy and Biofeedback.

*Refer to AMPM Policy 320-U for Court-Ordered Evaluation responsibilities.

Mental Health Services (formerly Traditional Healing) and Auricular Acupuncture services may be provided using General Funds, SABG or MHBG funding. These services are only available through Non-Title XIX/XXI funding.

Multisystemic Therapy may be provided with MHBG SED and SABG funding. For SABG, this service is only available for adolescents up until the age of 18 who have an identified Substance Use Disorder.

For General Funds, MHBG SED and MHBG SMI, exclude Alcohol and Drug Services.

Account 60205-xx Rehabilitation Services

Include: Rehabilitation services include the provision of educating, coaching, training and demonstrating. These services include Living Skills Training, Cognitive Rehabilitation, Health Promotion and Supported Employment Services. Report these services on the applicable Rehabilitation expense line.

Account 60305-xx Medical Services

Include: Medical services are provided or ordered by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a person's symptoms and improve or maintain functioning. These services include Medication Services, Medical Management, Laboratory, Radiology, Medical Imaging and Electro-Convulsive Therapy and Transcranial Magnetic Stimulation. Report these services on the applicable Medical Services expense line.

Exclude: For SABG and MHBG SED, exclude Electro-Convulsive Therapy and Transcranial Magnetic Stimulation.

Account 60405-xx Support Services

Include: Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. These services include Case Management (services **performed by BH providers**), Personal Care Services, Family Support, Peer Support, Therapeutic Foster Care for Children and Adult BH Therapeutic Home, Unskilled Respite Care, Supported Housing Services (wraparound services) and Transportation.

Unskilled Respite Care using may be provided using Non-Title XIX/XXI SMI, SABG or MHBG funding.

Exclude: Interpretation, sign language and Translation expenses. These are treated as administrative expenses and are reported in account 82505-01. BH case management performed at the ACC-RBHA level.

For General Funds, SABG and MHBG SMI, exclude Therapeutic Foster Care.

For General Funds, MHBG SED and SMI, exclude Child Care.

Account 60505-xx Crisis Intervention Services

Include: Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided in a variety of settings or over the telephone and may include screening, (e.g., triage and arranging for the provision of additional crisis services), counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation. **Report all crisis-related services as Mobile, Stabilization or Telephone on service expense lines 60505-01, 60505-02 or 60505-03 as applicable. Do not report crisis-related services on any other service expense line other than 60505-01, 60505-02, or 60505-03.** Refer to the following link for additional information: https://www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf.

For crisis services provided within the first 24 hours at a stabilization unit and for procedure codes other than S9484 and S9485, footnote these crisis service expenses. Provide the expense amount on a CYTD basis by crisis procedure code in footnote #14. If this does not apply, indicate that the only crisis services provided were billed using S9484 and S9485.

Account 60605-xx Inpatient Services

Include: Inpatient services (including room and board) are provided by a DLS licensed Level I behavioral health agency including Hospitals, Subacute Facilities and Residential Treatment Centers. These services include Psychiatric, Detoxification and Professional Inpatient Services and should be reported on the applicable Inpatient expense line under the correct facility type. Inpatient Services may be provided using Non-Title XIX/XXI SMI funding in Subacute and RTC settings if funding is available.

Exclude: For General Funds, SABG and MHBG funding, exclude Hospital Inpatient Services.

Account 60705-xx Residential Services

Include: Residential services are provided by a licensed behavioral health agency. These agencies provide a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional. Report these services as Behavioral Health Residential Facilities and Room and Board on the applicable Residential Services expense line. Services may be provided at Behavioral Health Residential Facilities using Non-Title XIX/XXI SMI funding if available.

Exclude: For Non-Title XIX/XXI Other, Other Federal, and PASRR, exclude Room and Board. For applicable use of County funding, refer to the IGA.

Account 60805-xx Behavioral Health Day Program

Include: Behavioral health day program services are scheduled on a regular basis either hourly, half day or full day and may include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance abuse programs. These programs can be provided to a person, group of individuals and/or families in a variety of settings.

Based on the level/type of staffing, day programs are grouped as Supervised, Therapeutic and Psychiatric/Medical and should be reported on the applicable Behavioral Health Day Program expense line.

Account 60905-xx HIV Services

Include: HIV services promote the health of persons, families, and communities through education, engagement, service provision and outreach. These services are only allowed with SABG funding.

Account 61005-01 BH Pharmacy Expenses

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

Exclude: Pharmacy expenses incurred for dental, PH and PBM non-encounterable fees.

Account 61100-01 PPC BH Title XIX

Include: PPC expenses resulting from when a Non-Title XIX GMH/SU and CHP and non-CHP child member retroactively becomes eligible for Medicaid. This expense should only be reported under the Title XIX/XXI Crisis (24 Hours) column.

Exclude: Title XXI members are not eligible for PPC services.

Account 61105-01 Other Services Not Reported Above

Include: BH expenses not specifically identified in one of the categories defined above, including but not limited to, First Episode Psychosis, Child care and SABG Oxford House. Report any Oxford House expenses deriving from State Opioid Response Grant separately from other State Opioid Response Grant expenses. Similarly, report any Oxford House expenses deriving from Opioid STR separately from other Opioid STR expenses. All expenses reported in account 61105-01 should also be disclosed on Schedule A separately with a clear description

Account 61205-01 BH FQHC/RHC Services

Include: BH 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 61305-01 Specialty and Other Grant Expenses

Include: Specialty and Other Grant Expenses; and as directed by AHCCCS, expenses that are not subject to the performance ratios.

Refer to the Title XIX/XXI Section for accounts 70105-01, 70205-02, 70305-01, 70310-05 and 70310-10.

Administrative Expenses

Administrative Expenses are those costs associated with the overall management and operations of the Contractor. All administrative expenses must be allowable, reasonable and appropriately reported by funding source/risk group 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. **All** administrative expenses **not** related to the pre-defined administrative expense lines should be reported in account 83005-01, Other Administrative Expenses. Separately report each individual expense on the Schedule A Disclosure.

Ensure that Title XIX/XXI administration does not supplant Non-Title XIX/XXI and vice versa. For example, Title XIX/XXI Interpretation, sign language or translation services shall be paid with Title XIX/XXI administrative funding and Non-Title XIX/XXI Interpretation, sign language or translation services shall be paid with Non-Title XIX/XXI administrative funding.

Refer to the Title XIX/XXI Section for accounts and descriptions. Additional Non-Title XIX/XXI administrative accounts are below:

Account 83105-01 Encounter Valuation Sanctions

Include: Encounter Valuation Sanctions assessed for not meeting the annual required contractual requirement of 85%. This account is for Non-Title XIX/XXI only. Refer to paragraph 5.08 for additional information.

Exclude: All other sanctions, including pending encounter sanctions, not assessed as a result of the Encounter Valuation Report prepared by DHCM Finance.

Account 83205-01 Administrative Expense from Specialty and Other Grants

Include: Administrative expenses from Specialty and Other Grants activities. This line is used as directed by AHCCCS for administrative expenses not subject to performance ratio calculations.

Refer to the Title XIX/XXI Section for any 990xxx-xx account.

3.06 Footnote Disclosure Requirements

Refer to Title XIX/XXI footnote disclosure requirements. Where applicable, include Non-Title XIX/XXI footnote requirements in the same footnote disclosure as Title XIX/XXI. In addition the following Non-Title XIX/XXI footnote requirements are required:

Footnote 2 Summary of Significant Accounting Policies

Describe the internal Cost Allocation Plan as it relates to Non-Title XIX/XXI funding and disclose any changes. As per the 2 CFR Part 200 Subpart E, actual conditions shall be taken into account in selecting the base to be used in allocating the expenses in each grouping to benefiting functions. The essential consideration in selecting a method or a base is that it is the one best suited for assigning the pool of

costs to cost objectives in accordance with benefits derived; a traceable cause and effect relationship; or logic and reason. When an allocation can be made by assignment of a cost grouping directly to the function benefited, the allocation shall be made in that manner. In accordance with 2 CFR Part 200 Subpart E, expenses should be recorded directly to the applicable program(s), if identifiable. If the program(s) cannot be readily identified, pro-rate the expense using the percentage of AHCCCS medical expense for each program. The use of revenue as the base for the allocation of all allowable general and administrative cost including corporate overhead is not acceptable. Revenue is not an equitable base for allocation because it has no relationship to cost nor does it have a relationship to the provision of services.

Footnote 10 Non-Title XIX/XXI Financial Viability Standards and Performance Guidelines:

Disclose any non-compliance with Non-Title XIX/XXI 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 state fiscal-year-to-date profit/(loss) incurred, unrelated to any prior year activity (even if within the profit corridor). The factors should be disclosed separately for Title XIX/XXI (contract-year-to-date basis) and Non-Title XIX/XXI (state-fiscal-year-to-date basis).

Footnote 14 Additional Expense Explanations Requested by AHCCCS

Refer to Title XIX/XXI Footnote Section.

4.00 SUPPLEMENTAL REPORTS

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

4.01 Financial Viability

This report is for analysis purposes. Calculate each Non-Title XIX/XXI ratio or performance standard as outlined in the tab. Refer to Paragraph 5.04 for additional information.

4.02 Non-Title XIX/XXI Funding Receivables

Amounts should be detailed out by funding source, program description and state fiscal year.

4.03 Receivables/Payables Report

List the amounts that are included in the Balance Sheet – account 10115-01. The subtotal should agree with the Balance Sheet account 10115-01.

Where applicable, use the prepopulated reconciliation names provided in the template. The subtotals should agree with the Balance Sheet account 10125-01 and account 20125-01.

4.04 Other Assets Report

Refer to Title XIX/XXI Section.

4.05 Other Liabilities Report

Refer to Title XIX/XXI Section. Amounts should be detailed out by funding source, program description and state fiscal year. Deferred amounts should also include the words Deferred Revenue in the liability description.

4.06 Alternative Payment Model Performance Based Payments Payable to Providers Report

Refer to Title XIX/XXI Section.

4.07 Non-Title XIX/XXI Lag Report

Lag Reports are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. 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 all Lag Schedules.

Each 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 8. Do not include sub-capitation and block payments in this schedule. Pharmacy Expenses should be included in the Lag Schedules.

Non-Title XIX/XXI BH expenses reported in the current period on the Non-Title XIX/XXI BH Lag Report should equal the Non-Title XIX/XXI BH expenses reported in the Income Statement less the Non-Title XIX/XXI BH expenses reported in the sub-capitated expense and block payment reports in total.

There is a tie out test for each 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. 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.

A separate Lag Report should be prepared for Title XIX/XXI and BH Non-Title XIX/XXI. The Remaining Balance on all Lag Reports combined should agree to the Medical Claims Payable total as reported on the Balance Sheet.

4.08 Long-term Debt (Other than Affiliates) Report

Refer to Title XIX/XXI Section.

4.09 Grant Disclosures

Disclose the following information in the Grant Disclosure tab of the Financial Reporting Template:

a. For SABG and MHBG, insert tables by category with the following required allocation, expense and member information (excluding MBHG FEP) on a state fiscal year-to-date basis, July 1 – June 30. Indicate whether the Contractor is on track to fully expend the funding by SFYE.

Otherwise, provide sufficient details explaining why the funding is unexpended; if the funding is expected to be deferred to the next SFY and spent by September 30 (unless otherwise indicated by AHCCCS); and whether the Contractor is experiencing barriers to spending these funds. Indicate whether a re-allocation request has been/will be submitted and when. Refer to 5.09 for additional information.

b. For any other grant funding received during the SFY, provide the SFY allocation and total actual expense (separately by service and administrative) on state fiscal year-to-date basis, July 1 – June 30. Indicate whether the Contractor is on track to fully expend the funding by SFYE.

Otherwise, provide sufficient details explaining why the funding is unexpended and if the Contractor is experiencing barriers to spending these funds. Indicate whether a re-allocation request has been/will be submitted and when. Refer to 5.09 for additional information.

4.10 BH and PH Sub-capitated/Block Expense Reports

Refer to Title XIX/XXI Section.

4.11 BH and PH Block Purchases Expense Reports

Refer to Title XIX/XXI Section.

4.12 Prior Contract Year Adjustment Schedules

These reports are intended to be a summary of all adjustments that apply to prior contract years. List all balance sheet and income statement adjustments on the appropriate line. IBNR adjustments need to be broken out on this schedule by AHCCCS contract year and by Title XIX/XXI or Non-Title XIX/XXI

4.13 FQHC/RHC Member Months

Refer to Title XIX/XXI Section.

4.14 Consolidated or Parent Company, if applicable, Financial Statements

Refer to Title XIX/XXI Section.

4.15 Annual IBNR Actuarial Certification

Refer to Title XIX/XXI Section.

4.16 Related Party Transaction Reports

Refer to Title XIX/XXI Section.

4.17 Audited Financial Statements and Annual Reconciliation

Refer to the Title XIX/XXI Section. Also, refer to Appendix F for examples of the annual audit reconciliation reports.

The Draft and Final Audited Financial Statements must also include an annual Contract Year End Title XIX/XXI and Non-Title XIX/XXI Income Statement and Schedule A Disclosure audited by program (include in audit report and provide an excel version using the same format as the reporting template and insert in Appendix F-1e and F-1f), an Independent Auditor's attestation of sub-capitated and block expenses and a Single Audit. AHCCCS requires for-profit ACC-RBHAs to also adhere to the Single Audit requirements. Refer to the Due Date Matrix in Section 2.0 for the reporting that is due as a part of the Draft and Audit Financial Reporting Packages.

If there are any audit adjustments impacting the June QE Non-Title XIX/XXI Profit Limit Analysis, a final Non-title XIX/XXI Profit Limit Analysis is due 30 days after the final audit submission. Refer to ACOM 323 for additional information.

4.18 Parent Company, if applicable, Annual Audit Report

Refer to Title XIX/XXI Section.

4.19 Medical Loss Ratio Report

This report does not apply to Non-Title XIX/XXI funding.

4.20 Contract Year Annual Supplement

Refer to Title XIX/XXI Section.

5.00 ACCOUNTING AND REPORTING ISSUES

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

Refer to Title XIX/XXI Section.

5.02 Reinsurance Recoveries

Refer to Title XIX/XXI Section.

5.03 Related Parties/Affiliates

Refer to Title XIX/XXI Section.

5.04 Financial Viability Standards and Performance Guidelines Report

Refer to Title XIX/XXI Section. In addition, AHCCCS will review the following Non-Title XIX/XXI ratios and performance guidelines with the purpose of monitoring the financial health of the Contractor: Contract Year to Date Non-Title XIX/XXI Medical Expense Ratio; Contract Year to Date Non-Title XIX/XXI Administrative Cost Percentage and Maintenance of Minimum Capitalization.

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.

The quarterly Financial Viability Reports are included in the Financial Reporting Template. See below for information related to the Non-Title XIX/XXI financial viability standards.

NON-TITLE XIX/XXI FINANCIAL VIABILITY STANDARDS

State Fiscal YTD Non-Title XIX/XXI Medical Expense Ratio Non-Title XIX/XXI Subtotal BH Medical Expenses divided by the sum of Non-Title XIX/XXI Revenue (line #40205-01) + Non-Title XIX/XXI Profit Limit (line #40215-01)
Standard: At least 88.3%
When calculated on a state fiscal year-to-date basis

State fiscal YTD Non-Title XIX/XXI Administrative Cost Percentage Non-Title XIX/XXI Subtotal Administrative Expenses divided by the sum of Non-Title XIX/XXI Revenue (line #40205-01) + Non-Title XIX/XXI Profit Limit (line #40215-01)
Standard: No more than 8%
When calculated on a state fiscal year-to-date basis

Maintenance of Minimum Capitalization Net assets (not including the value of the on-Balance Sheet Performance Bond, due from affiliates, guarantees of debts/pledges/assignments, and Other Assets deemed restricted by AHCCCS) shall be greater than or equal to ninety percent (90%) of the monthly Non-Title XIX/XXI payment to the Contractor. AHCCCS will use the last month of the reporting period to determine compliance (i.e. for quarter ending March 31, xx payments made during March will be utilized).

5.05 Block Payment Arrangements

AHCCCS reserves the right to limit the Contractor's percentage of block payment arrangements with its subcontractors.

5.06 State General Funds

State General Funds are appropriated by legislature and must be expended (based on dates of service) by June 30 of each state fiscal year at both the Contractor and provider levels. These funds are noted as State General Funds in the AHCCCS Allocation Schedule.

The Contractor is expected to monitor provider expenditures to ensure that State General Funds are spent by June 30. In general, expend State General Funds before County funds. Grant funding should be the payer of last resort. Certain exceptions may be allowed. The Contractor and its providers are not allowed to defer State General Funds; and shall provide AHCCCS with projected unexpended State General dollars by fund source via email or letter by March 31 of each state fiscal year. The Contractor should also include in this report all Non-Title XIX/XXI funding that is projected to be unexpended by June 30, including but not limited to County, Block Grant and other allocated grant funding. The Unexpended Funds Report should outline by funding source

any contracted amounts anticipated to be unspent by June 30. The report should not include funding reallocation requests for any funding source. Funding reallocation requests should be submitted separately to the Non-Title XIX/XXI and Grants Finance Administrator.

The Contractor is also expected to have internal Non-Title XIX/XXI policies and procedures that at a minimum include the following:

- Accounting for Non-Title XIX/XXI funding in a manner that permits separate reporting by Non-Title XIX/XXI funding source;
- Communication to providers on how to spend Non-Title XIX/XXI funding;
- Process for accounting for unexpended funds;
- Process for monitoring provider expenditures

Providers must return unexpended State General Funds to the Contractor; and subsequently, the Contractor must return the funds to AHCCCS upon request. Unexpended funds held by the Contractor and/or Contractor providers may be withheld from future payments by AHCCCS or must be returned to AHCCCS upon request. The Contractor shall add this requirement to their provider contracts, provider financial reporting guides or otherwise communicate this requirement to providers.

5.07 Non-Title Crisis, SMI and Housing

The Contractor shall expend a minimum of 92.0% of State Funds on services and administrative expenses are limited to 8.0% for Non-Title XIX/XXI Crisis, Non-Title XIX/XXI SMI, and Housing Trust Fund. Contractors may expend administrative funding on service expenses but may not expend service funding on administrative expenses. If the 92.0% Medical Expense Ratio is not met, the Contractor must return the difference between the medical expenses and 92.0% of total revenue. State Funds not expended on services and administration must be returned to AHCCCS.

Throughout the contract year, the Contractor shall accrue a payable for estimated profit in Non-Title XIX/XXI Crisis, Non-Title XIX/XXI SMI, and Housing Trust Fund and report the amount in the Income Statement in account 40215-01. For additional information, refer to ACOM 323.

Housing Trust Funding must be spent in accordance with approved housing plans. Approval must be obtained from AHCCCS prior to deviating from approved plans. Should these funds have been expended for any purpose other than that outlined in the current year approved housing plan, these expenditures will need to be re-classified to a Non AHCCCS funding source or net assets as appropriate. Housing Trust expenditures should be reported on the Income Statement, under the Housing Trust Fund column on line 60405-30, and disclosed on the Income Statement, Schedule A Disclosure accordingly using the drop down menu.

5.08 Encounter Reporting Requirements

The Contractor is required to submit encounters or claims for every service rendered to a member in accordance with encounter and claims submission requirements outlined in AHCCCS Guides and Manuals.

Accurate encounter data shall be submitted timely to assist AHCCCS in evaluating the Contractor's performance and for establishing capitation rates. For a complete list of service codes by provider type refer to the AHCCCS Covered Services Guide, Appendix B-2 or its successor. Annual encounter reporting analysis shall be performed regularly by AHCCCS no sooner than 8 months after the end of the contract year.

The Contractor must develop statistically sound encounter rates. The value used by Contractor subcontractors to encounter services shall be determined by the contracted rate established at the beginning of the contract year.

Any retrospective changes to contracted rates that may result in the adjustment or voiding and replacement of encounters must be pre-approved by AHCCCS as specified by Contract. For details regarding recoupments or reprocessing of FFS claims, refer to the ACOM 412.

Non-Title XIX/XXI Encounter Valuation Report

AHCCCS shall, at least annually, calculate the Contract Year value of encounters (based on dates of service) submitted by the Contractor. The calculation will be performed in order to measure timeliness and completeness of encounter submissions. For purposes of the Encounter Valuation Report, encounter reporting as submitted to AHCCCS may be considered complete when the Contractor's accepted/approved encounter values reach the minimum percentage levels specified in the table below as compared to the service (non-administrative) revenue (92.0% of total AHCCCS revenue) for each evaluation period. Service revenue will include profit limit revenue adjustments.

Revenue not required by AHCCCS to be encountered will be excluded from the encounter reporting calculation (also known as encounter relief). An example would be Oxford House.

Non-Title XIX/XXI Annual Encounter Valuation Sanction

The Contractor will have eight (8) months following the end of the contract year to meet the required contractual requirement of 85%. AHCCCS shall have the discretion to assess sanctions on Non-Title XIX/XXI if the Contractor fails to meet the annual required encounter percentage.

For the Non-Title XIX/XXI annual encounter Valuation sanction, whether assessed by AHCCCS or accrued by the Contractor, the entire sanction shall be reported on the Income Statement, line 83105-01, Encounter Valuation Sanctions, under the program(s) applicable to the sanction and disclosed on the Contractor Income Statement, Schedule A

Disclosure. Recoupment of this sanction from providers should also be reported on line 83105-01 and disclosed on a separate line in the Income Statement, Schedule A Disclosure as an offset to this sanction.

Block Payment Provider Encounter Monitoring

The Contractor shall define block payment provider encountering expectations and recoupment processes in provider contracts and/or the Contractor Financial Reporting Guide. The Contractor is expected to hold their block payment providers to the block payment provider contractual provisions and established expectations for encountering services.

When monitoring block payment provider encounters and evaluating for funding recoupment and re-allocation, the Contractor should at a minimum consider encounter values, block payment provider performance and block payment provider profit levels.

On an ad hoc basis, AHCCCS will request evidence that a Contractor regularly monitors the volume of encounters submitted by their block payment providers. The report will include the following:

- A. Total Revenue Paid to each block payment provider by individual program (funding source)
- B. Total Encounter Value submitted by each block payment provider by individual program (funding source)
- C. Percentage of letter B (above) divided by letter A (above)
- D. Audited block payment provider profit in dollars and percentage
- E. Contractor Encounter Submission Standard
- F. Explanation for under/over production of encounters by block payment provider by funding source. Also, describe the efforts made by the Contractor to address problems related to block payment provider under/over encountering.
- G. Amount the Contractor has recouped or will recoup from block payment providers for under-encountering by individual program or funding source. List total recoupment from each block payment provider and include the month/year of recoupment whether planned or completed. If no funding will be recouped, explain why.
- H. If applicable, list overall barriers to encountering, summarized by Title XIX/XXI and Non-Title XIX/XXI, experienced by the block payment providers during the contract year.

AHCCCS reserves the right to require the Contractor to limit block payment provider's profit and administrative percent.

5.09 Block Grants and Other Federal Grants

The practices, procedures and standards specified in and required by the State of Arizona Accounting Manual and any Uniform Financial Reporting Requirements shall be used by the Contractor in the management, recording and reporting of federal block grant funds. The Contractor shall establish fiscal controls to ensure that funds are accounted for in a manner that permits separate reporting of mental health and substance abuse grant funds and services. SABG and MHBG funds should be allocated and monitored in accordance with the AHCCCS' Allocation Schedule or Payment Report, whichever is the most current. Note that AHCCCS does not provide interim financing for the Block Grants (SABG and MHBG). Disbursements will occur after receipt of the Notice of Grant Award from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Prior written approval must be obtained from AHCCCS for any deviations from the AHCCCS Allocation Schedule or Payment Report, whichever is the most current. Any deviation that an ACC-RBHA may want to make between funding categories (e.g., between SABG or MHBG categories, etc.) on the allocation schedule (or payment schedule) must also have prior written approval from AHCCCS. Funds paid to the Contractor for a state fiscal year shall be available for obligation and expenditures until the end of the state fiscal year for which the funds were paid unless otherwise noted in the Allocation Schedules or AHCCCS Contract/IGA/ISA and/or Allocation Letters. Similarly, funds paid to the Contractor for a contract year shall be available for obligation and expenditures until the end of the contract year for which funds were paid.

By March 31, the Contractor shall notify AHCCCS of all federal block grant and other allocated grant funds projected to be unexpended by June 30 (refer to Paragraph 5.06 State General Funds for additional Non-Title XIX/XXI funding that should be included). The Unexpended Funds Report should outline by funding source any contracted amounts anticipated to be unspent by June 30. The report should not include funding reallocation requests for any funding source. Funding reallocation requests should be submitted separately to the Non-Title XIX/XXI and Grants Finance Administrator.

With AHCCCS' approval, the unexpended revenue may be expended after June 30 and reported in the same program as AHCCCS originally remitted or will be recouped by AHCCCS.

The Contractor shall comply with all terms, conditions and requirements of the SABG and MHBG. SABG and MHBG must be audited as major programs and paid for by the ACC-RBHA even if these programs are not determined to be major programs by the Independent Auditor. In addition, SABG and MHBG Financial, performance and program data subject to audit shall be retained by the Contractor as documentation of compliance with federal requirements.

AHCCCS will perform a Federal Grants Operational Review periodically. Federal grants financial monitoring shall encompass the following:

- Maintenance of policies and procedures that outline internal monitoring of federal grant requirements.
- Notification to providers of required subaward information as required by 2 CFR Part 200.331.
- Notification to providers of Single Audit submission requirements. Non-Federal entities that expend \$750,000 or more in a year in federal awards shall have a Single Audit conducted for that year in accordance with 2 CFR Part 200 Subpart F. AHCCCS requires for-profit entities to also adhere to this requirement.
- Maintenance of tracking tool to monitor receipt of Single Audits. At a minimum, the tool should contain the following information: Provider Name, Federal Audit Clearinghouse Acceptance (FAC) Date, Audit Received Date, Management Decision Letter Date, Audit Findings (Y/N) and Date Response/Corrective Action Plan Received.
- Issuance of management decision for audit findings as required by §200.521 Management decision.
- Communication of prohibited uses of federal grant funds to providers as outlined in ACC-RBHA Non-Title XIX/XXI contract and/or AHCCCS policies and procedures.
- Monitoring of provider expenditures to ensure compliance with approved indirect cost agreements and/or use of a de minimis rate.
- Tracking of grant funding by grant and by category, including unexpended funds, for appropriate allocation/reporting by category, recoupment and/or return to AHCCCS.
- Monitoring of grant activities to ensure grant funds are expended for authorized purposes.
- Any additional requirements of 2 CFR Part 200 Subpart F.

Compliance with 2 CFR Part 200 Subpart F shall be incorporated into provider contracts. In addition, the Contractor should require all grant providers to have internal policies and procedures related to SABG, MHBG and other federal grants that include required monitoring as per 2 CFR Part 200. The policy and procedure should include, but are not limited to, a listing of prohibited expenditures, references to the SABG and MHBG FAQs, AMPM 320-T1, AMPM 320-T2, Exhibits 300-2b, monitoring and reporting of funding by each individual funding source received (i.e. SABG General Services, SABG Pregnant/Parenting Women, SABG HIV, SABG CRRSAA, SABG ARPA, MHBG SED, MHBG SMI, MHBG FEP, MHBG CRRSAA, MHBG ARPA, SOR, Supplemental Grants, etc.) As per contract or upon request, the Contractor is required to submit SABG and MHBG information for federal reporting purposes in the manner and format provided by AHCCCS. The above financial monitoring items will be reviewed as a part of the Federal Grants Operational Review.

5.10 Cost Allocation Plan

The financial statements shall be based on a cost allocation plan and disclosed accordingly in Footnote 2. Where applicable, for Non-Title XIX/XXI, the cost principles described in 2 CFR Part 200 Subpart E shall be the standard applied to Cost Allocation Plans. This also applies to for-profit entities. The Income Statement shall be reviewed by the Contractor's Auditor for adherence to the Contractor's cost allocation plan and shall be an integral part of the Contractor's annual certified audit. Any issues of non-compliance with federal guidelines must be included in the certified audit report. All instances of questioned costs or procedural deficiencies related to Indirect Cost Plans, as identified in the certified audit reports, will be investigated by AHCCCS, and are subject to repayment to AHCCCS.

5.11 Community Reinvestment

Refer to Title XIX/XXI Section.

5.12 Deferred Revenue

The Contractor is expected to regularly determine from their providers whether there will be unspent funds by the end of the contract year or state fiscal year in the case of general funds and block grant funds. If general funds remain at the end of the fiscal year, providers are prohibited from recording deferred revenue; instead, these unspent general funds must be reported as a Payable to the Contractor and returned to the Contractor immediately for subsequent return to AHCCCS. Title XIX/XXI, Grant and County revenue may be deferred at the end of the provider's fiscal year only under extenuating circumstances.

5.13 Pharmacy Benefit Manager

Refer to Title XIX/XXI Section.

6.00 APPENDICES

Refer to Title XIX/XXI Section.