



**FINANCIAL REPORTING GUIDE FOR  
AHCCCS COMPLETE CARE  
CONTRACTORS**

**Effective Date October 1, 2019**

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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 case management, or integrated health care services.

**ADULT GROUP AT OR BELOW 106% FPL (Formerly TWG Non-Med):** Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL). Also referred to as: **Adults <=106%**

**AFFILIATE:** See Related Party Transactions.

**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](http://www.azahcccs.gov).

### **ALTERNATIVE PAYMENT MODEL (APM) (formerly Value Based Purchasing)**

A model which aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality. APM strategies for this initiative may include any combination of Primary Care Incentives, Performance-Based Contracts, Bundled/Episode Payments, Shared Savings, Shared Risk and Capitation + Performance-Based Contracts purchasing strategies as defined in ACOM 307.

**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. See also AMPM 1000.

**CASE MANAGEMENT**

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

**COMMUNITY REINVESTMENT:** Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. See 45 CFR §158.162(c)

**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.

**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.

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

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

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

**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 Article1.

**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 at 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.

**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.

**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

**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.

**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.



## **1.00 GENERAL INFORMATION**

### **1.01 Purpose and Objective of the Guide**

The purpose of the AHCCCS Financial Reporting Guide for AHCCCS Complete Care Contractors (Guide) is to set forth the monthly, quarterly, and annual reporting requirements for AHCCCS Complete Care Contractors. 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 also 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 Contractors' 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, quarterly reporting to AHCCCS is required for informational purposes only. AHCCCS will accept a copy of the NAIC filing submitted to the Arizona Department of Insurance (DOI). AHCCCS acknowledges that the quarter ending 12/31/xx filing to DOI is due 90 days after quarter end and thus is due to AHCCCS at the same time it is filed with DOI. If the Contractor is a Medicare Advantage Plan certified by AHCCCS, then the Contractor shall use the applicable AHCCCS Financial Reporting Guide and the related report template (the E-6 series, *Profitability by GSA* is not required) for quarterly reporting to AHCCCS.

## **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 120 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.

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

## **1.03 Sanctions**

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

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

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

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

## **2.00 FINANCIAL REPORTING REQUIREMENTS**

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

**REPORT DUE DATES**

**REPORT**

	<b>Monthly Reporting (Only if requested by AHCCCS)</b>	<b>Quarterly Reporting</b>	<b>Draft Annual Financial Reporting</b>	<b>Annual Financial Reporting</b>
<b>Due Date:</b>	<b>30 days after month end</b>	<b>60 days after quarter end</b>	<b>90 days after year end</b>	<b>120 days after year end</b>
Monthly/Quarterly Certification Statement	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
Revenue & Expense Statement	X	X	X	X
Financial Viability	X	X		
Capitation, Supplement, Risk Adjustment Receivable Report	X	X	*	*
Receivables/Payables Report	X	X	*	*
Other Assets Report	X	X	*	*
Alternative Payment Model Report (by provider by year)	X	X	*	*
Other Liabilities Report	X	X	*	*
Claims Lag Report (Hospitalization, Medical & Other)	X	X	*	*
Long-term Debt Report (other than Affiliates)	X	X	*	*
Profitability by Risk Group	X	X	*	*
Sub-Capitated Expenses Report	X	X	*	*
Sub-Capitated Expense Detail	X	X	*	*
Sub-Capitated/Block Purchase Expense Detail Contract-Year-End				X
Block Purchases Expenses Report	X	X	*	*
Block Purchases Expense Detail	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

Statement of Cash Flows (if required by GAAP/GASB)  
 Management Letter  
 Management Representation Letter  
 Annual Reconciliation  
 Independent Auditor's Attestation of Sub-capitated Expenses Report on a  
 CYE basis  
 Annual IBNR Actuarial Certification  
 Related Party Transactions  
 Community Reinvestment Calculation  
 Medical Loss Ratio  
 Supplemental Pharmacy Rebates Receivable

		X	X
			X
			X
		X	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 4<sup>th</sup> quarter reports submitted to AHCCCS. See Paragraph 4.16

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

#### **3.01 General Instructions**

All reports must be compiled using the accrual basis of accounting. The Contractor shall submit these forms electronically on or before the due date to AHCCCS via the SharePoint using the Financial Statement Reporting Template provided by the Division of Health Care Management (DHCM). The sent date will be used as the receipt date 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.

Contractors should review the Sarbanes-Oxley Act and consider applying the best practices contained within the Act; including rotating at least the lead and reviewing partners of the audit firm every five (5) years.

Report line titles and columnar headings are detailed in the report specific paragraphs below. Utilize predefined categories or classifications before reporting an amount as "Other." For any material amounts included in the "Other" category, provide details and explanations in the footnotes regarding the content of the account(s). For this purpose, material is defined as an amount  $\geq 10\%$  of the total for each section. For example, if Other Income is reported and it is less than 10% of Total Revenues, no disclosure is necessary. However, if Other Income was 10% of Total Revenues, disclosure is necessary (see Paragraph 3.06 for Footnote Disclosure Requirements).

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: one; submit corrected prior quarter report or two; 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. See 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. See Appendix B for an example of this report.

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

See 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.

#### A/C 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.

#### A/C 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.

A/C 10115-01 - Capitation/Non-Title XIX/XXI Funding/Supplement/Risk Adjustment Receivable

Include: Net amounts receivable from AHCCCS for capitation, Delivery Supplements, and risk adjustment as of the balance sheet date. See Capitation, Supplement, and Risk Adjustment Receivable Report (Paragraph 4.02) for required detail of this line item. Also include the Health Insurance Providers Fee revenues in this line.

A/C 10120-01 - Reinsurance Receivable

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

A/C 10125-01 - Reconciliations/Settlements Receivable

Include: Amounts receivable from AHCCCS, Tiered and Adults >106% reconciliations/cost settlements. See 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.

A/C 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.

A/C 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. See 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.

A/C 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.

A/C 10145-01 - Other Current Assets

Include: The total current portion of any assets (e.g. income taxes receivable) 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. See Other Assets Report (Paragraph 4.04) for required detail of this line item.

**OTHER ASSETS**

A/C 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.

A/C 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.

A/C 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.

A/C 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. See 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.

A/C 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. See 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.

A/C 10305-01 - Land

Include: Real estate owned by the Contractor.

A/C 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.

A/C 10305-10 - Leasehold Improvements

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

A/C 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.

A/C 10305-20 - Other Property and Equipment

Include: All other fixed assets not falling under one of the other specific fixed asset categories.

A/C 10330-01 - Accumulated Depreciation and Amortization

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

**CURRENT LIABILITIES** consists of obligations whose liquidation is reasonably expected to occur within one year from the balance sheet date.

A/C 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.

A/C 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.

A/C 20115-01 - Payable to Providers

Include: Net amounts owed to providers for monthly capitation.

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

A/C 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). See the discussion on Medical Claims Liability in Paragraph 5.01.

A/C 20125-01 - Reconciliations/Settlements Payable

Include: Amounts payable to AHCCCS, Tiered and Adults >106% reconciliations/cost settlements. See 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** relating to alternative payment model initiatives.

A/C 20130-01 - Alternative Payment Model Payable to Providers

Include: Current portion of payable amounts **due to providers** relating to alternative payment model initiatives.

A/C 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. See 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.

A/C 20140-01 - Current Due to Affiliates/Other Funds

Include: The net amount of payables due to affiliates 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 concurrently. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

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

A/C 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). See Other Liabilities Report, Paragraph 4.05. Also include the current portion of the Health Insurance Providers Fee liability in this line.

**OTHER LIABILITIES** are those obligations whose liquidation is not reasonably expected to occur within one year of the date of the balance sheet.

A/C 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. See 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.

A/C 20210-01 - Non-current Due to Affiliates/Other Funds

Include: The net amount of payables due to affiliates 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 amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

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

A/C 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. See Other Liabilities Report (Paragraph 4.05) for

required detail of this line item. Also include the non-current portion of the Health Insurance Providers Fee liability in this line.

**EQUITY/NET ASSETS** includes preferred stock, common stock, treasury stock, additional paid-in capital, contributed capital, and retained earnings/fund balance.

A/C 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.

A/C 30110-01 - Common Stock

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

A/C 30115-01 - Treasury Stock

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

A/C 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 850, Business Combinations and EITF 88-16, Basis in Leverage Buyout Transactions.

A/C 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.

A/C 30130-01 - Restricted Net Assets

Include Net Assets restricted for any purpose.

A/C 30135 - Reserved for Future Use

A/C 30140-01 Retained Earnings/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 Statement of Revenue and Expenses without rounding.

30140-10      *Unrealized Gains/ (Loss)* – report unrealized gains or losses in this line.

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

### **3.05 Statement of Revenues and Expenses**

The Statement of Revenues and Expenses includes the following risk groups, Age <1, Age 1-20, Age 21+, Duals, SSI w/o Med, Prop 204 Childless Adults, Expansion Adults and State Only Transplants.

See Appendix C-2 for an example of this report

#### **REVENUES**

##### A/C40105-01 - Capitation

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

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

##### A/C 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 A/C 10125 and/or A/C 20125.

##### A/C 40120-01 - Delivery Supplement

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

##### A/C 40125-01 – Adults >106% Reconciliation Settlement

Include: Adults >106% reconciliation settlement amounts. Estimated reconciliation settlement amounts should be accrued in the period they are earned.

##### A/C 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. See Prior Contract Year Adjustment Report (Paragraph 4.12) for the required detail on this item. Also, in the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements (Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

A/C 40140-01 - PPC Settlement

Include: Prior Period Coverage (PPC) reconciliation settlement amounts. Estimated PPC 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. See Prior Contract Year Adjustment Report (Paragraph 4.12) for the required detail on this item.

A/C 40145-01 - Other Reconciliation Settlements

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

A/C 40160-01 - Health Insurance Providers Fee Revenue

Include: An accrual for the revenue that will be paid to the Contractor from AHCCCS to cover the Health Insurance Providers Fee.

A/C 40305-01 - Investment Income

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

A/C 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.

A/C 50105-01 - Hospital Inpatient

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

A/C 50110-01 - Hospital Inpatient - Behavioral Health Services

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

**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.



A/C50205-01 - 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 50210-01 - Behavioral Health Physician Services

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

A/C 50215-01 - Referral Physician Services

Include: Those expenses for referral (specialist) physician services.

A/C 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**.

A/C 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.

A/C 50305-01 - Emergency Facility Services

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

A/C 50310-01 PH 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.

A/C 50310-05 PH 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)

A/C 50310-10 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.

A/C 50315-01 - Laboratory, Radiology and Medical Imaging

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

A/C 50320-01 - Outpatient Facility

Include: Outpatient facility expenses incurred for outpatient services.

Exclude: Physician expense for surgery (this should be included in A/C 50215 above).

A/C 50325-01 - Durable Medical Equipment

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

A/C 50330-01 - Dental

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

A/C 50335-01 - Transportation

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

A/C 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.

A/C 50345-01 - Therapies

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

A/C 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 A/C 10140, A/C 20130, and/or A/C 20215.

A/C 50355-01 Behavioral Health Day Program

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

A/C 50355-05 Behavioral Health Case Management Services

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

A/C 50355-06 Peer/Family Support

Include: Peer support and family support expenses.

A/C 50355-07 Support Services

Include: Include Personal Care Services, Home Care Training to Home Care Client and Unskilled Respite Care.

A/C 50355-10 Behavioral Health Crisis Intervention Services

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

A/C 50355-11 Living Skills Training

Include: Living Skills Training.

A/C 50355-12 Supported Employment

Include: Supported Employment.

A/C 50355-15 Behavioral Health Rehabilitation Services

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

A/C 50355-20 Behavioral Health Residential Services

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

A/C 50355-21 Counseling

Include: Individual, Family and Group Counseling.

A/C 50355-22 Assessment, Evaluation and Screening

Include: Assessment, Evaluation and Screening.

A/C 50355-23 Treatment Services

Include: Other Professional Services.

A/C 50355-25 All Other Behavioral Health Services

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

A/C 50370-01 - Other Medical Expenses

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

A/C 70105-01 - Reinsurance

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

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

A/C 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.**

A/C 70305-01 – Claim Overpayment Recoveries

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

**NOTE: A/C's 70105, 70205 and 70305 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 A/C 81405, Other Administrative Expenses.

A/C 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.

A/C 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.

A/C 80305-01 - Depreciation

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

A/C 80405-01 - Care Management/Care Coordination

Include: Care Managers expenses incurred for activities performed as defined in Contract and AMPM 1020.

A/C 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.

A/C 80605-01 – Office Supplies and Equipment

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

A/C 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.

A/C 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.

A/C 80905-01 – Bank Service Charge

Include: Any charges and fees assessed by the bank.

A/C 81005-01 – Insurance

Include: Expenses related to insurance.

Exclude: Reinsurance premiums. Report these expenses under A/C 83005, Other Administrative Expenses.

A/C 81105-01 - Marketing

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

A/C 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.

A/C 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.

A/C 81405-01 – Fraud Reduction Expenses:

Include: Expenses related to fraud reduction activities.

A/C 81505-01 – Third Party Activities:

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

A/C 81605-01 – Sub Capitation Block Administration:

Include: Amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee.

Include: 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. Delegate 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.

Exclude: Sub-Capitated/Block Payment amounts paid to subcontractors who provide Medicaid-covered services directly to Medicaid enrollees, as long as the functions are performed by the subcontractor's own employees and not through a contracted network of providers.

A/C 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.

A/C 83005-01 - Other Administrative Expenses

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

A/C 88999 - Profit (Loss) from Non-Operating

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

A/C 90105-01 - Income Taxes

Include: Provision for income taxes for the period, including taxes associated with the Health Insurance Providers Fee.

A/C 90205-01 - Premium Taxes

Include: Provision for premium taxes for the period.

A/C 90305-01 - Health Insurance Providers Fee

Include: Provision for Health Insurance Providers Fee for the period. In accordance with FASB 720-50-25-1, the liability related to the annual fee shall be estimated and recorded in full once the entity provides qualifying health insurance for health insurers in the applicable calendar year in which the fee is payable. The liability for the Health Insurance Providers Fee should be fully recognized by the end of the contract year. Therefore, Contractors should begin recognizing 1/9th of the liability in January.

Exclude: Taxes associated with the Health Insurance Providers Fee.

A/C 990105-01- Community Reinvestment (CRI)

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

A/C 990205-01 - Non-Covered Services

Include: 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 A/C 83005-01.

### **3.06 Footnote Disclosure Requirements**

Footnote disclosures are required in order to supplement AHCCCS' understanding of the financial statements and supplemental schedules. See 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. If the disclosure does not apply, indicate so by writing "None" or "Not Applicable (N/A)" next to the numbered footnote. Refer to 7.00 Exhibits Sample Footnotes for Quarterly Financial Reports.

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 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
- Health Insurance Providers Fee and related tax
- Federal and State Income Tax

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

3) Other Amounts:

Describe material amounts included in the "other" and "miscellaneous" categories in the Balance Sheet and Statement of Revenues and Expenses. Material amounts are considered greater than 10% of the related total category (i.e., assets, liabilities, revenues, and total other medical expenses). For administrative expenses, material amounts are considered to be greater than 5% of total administrative expenses.

4) Pledges/Assignments and Guarantees:

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

5) RESERVED



- 6) Material Adjustments:
- Disclose and describe any material adjustments made during the current reporting period. Include those adjustments that may relate to a prior period, specifically IBNR adjustments, that affect the financial statements and provide detail for which period(s) the adjustment(s) relate.
- 7) 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). Explanations should detail the amount of the adjustments by quarter and by risk group.
- 8) 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.
- 9) 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.
- 10) 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.
- 11) Equity Activity:
- Disclose and provide a written explanation for all activity in equity, other than net income or net loss.
- 12) Non-Compliance with Financial Viability Standards and Performance Guidelines:
- Disclose any non-compliance with Financial Viability Standards and Performance Guidelines, the factors causing the non-compliance and the plan of action to resolve

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

Disclose the driving factors for any current contract year-to-date profit/loss incurred, unrelated to any prior year activity .

13) Changes in Financial Statement Line Items:

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.

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

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

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

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

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

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

**Example**

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

	QE03/31/xx	QE06/30/xx	PMPM% Change	% of Revenue
Outpatient Facility	\$ 15.00	\$ 15.20	1%	6%

14) Drug Rebates/Discounts

Provide the dollar amount of drug rebates or discounts **received (actual received, not accrued)** by therapeutic class (using Medispan Therapeutic Classification System, levels one, two and three and the GPI level) that the Contractor has received for the current contract year-to-date for dates of service in CY20. Indicate whether or not the drug rebates were received by the Contractor (MCO level) or were retained by the PBM (PBM level).

In addition, provide a written statement confirming that rebates do not include drugs that are listed in the AHCCCS Rebate Program.

15) RESERVE

16) 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.

17) Member and Provider Incentives

Separately report the amount of member and provider incentives reported for the period. (Do not include provider incentives that are part of APM Performance Based Payments to Providers). Indicate the Income Statement line number(s) and risk group in the financial statements where these are reported.

18) Alternative Payment Model Initiatives

Report the total amounts by contract year (current year and previous two years) of any APM (formerly known as value based purchasing) Performance Based Payment (PBP) arrangements included in the financial statements. Include a column for amounts reported in the Interim (270 day) APM certification submitted

to AHCCCS and a column for amounts reported in the Final (19 month) certification submitted to AHCCCS and explain large changes in the current amount versus amounts reported in the Interim and Final certifications (if the variance exceeds 5%). The total amount per contract year should include actual dollars paid plus adjustments and accruals. Exclude PBP amounts related to Medicare DSNP Agreements and/or amounts for the AHCCCS quality measure performance incentive reconciliations.

19) RESERVED

20) Risk Adjustment SUSPENDED

Provide the amount of risk adjustment recorded in the current contract year financial statements by year. Indicate the line number on the Statement of Revenue and Expenses where these are reported and include the detail by risk group.

21) 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).

22) Non-Capped Newborn Costs

Where applicable, disclose all medical costs incurred in the quarter, for dates of services from the date of birth to the day before a tardy notification which are considered non-capped expenses.

23) Premium Deficiency Reserve

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

24) RESERVED

25) Access to Professional Services Initiative (APSI)

Separately disclose APSI-related revenue less expenditure amounts, for CYE 18 and CYE 19, on a Contract-year-to-date basis. Do not deduct Premium Tax from revenue. Also, provide the APSI profit/(loss) as a percentage of revenue. Identify the expense lines in the Statement of Revenue and Expense Report where APSI is reported.

26) Management Fees

Disclose both the quarterly and fiscal year-to-date amount expended for Management Fees, the fee percentage and indicate whether the fee percentage

changed during the quarter. Also, disclose each individual administrative expense account number where Management Fees are reported.

27) 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.

28) Additional Expense Explanations Requested By AHCCCS

Disclose the Title XIX/XXI CYTD amount of BH-related expenses reported in account 50305-01, Emergency Facility Services, by procedures code.

29) Social Determinants of Health (SDOH)

Provide the Social Determinants of Health (SDOH) activities expended for the quarter by fund source. Indicate the Income Statement line number in the financial statements where these are reported.

30) Pharmacy Benefit Manager Expenses

Provide the detail of PBM admin expenses recorded in A/C 81305-01 including amounts incurred by pharmacy claims processing, pharmacy network development/management, pharmacy discount negotiating, drug utilization management/review, coordination of specialty drugs, pharmacy call center operations, reporting and other PBM-related costs.

Provide the CYE 2019 Pharmacy Benefit Manager Expenses recorded as medical services in the financial statements and/or included in encounters. Please identify if the expenses were previously only reported as medical expenses in the financial statements, or only included in encounters, or reported in both places. Identify when PBM Transparency was/will be implemented. Provide the CYE20 Pharmacy Benefit Manager Expenses recorded as medical services in the financial statements and/or included in encounters prior to implementation of PBM Transparency. Provide the increased amount of discrete Pharmacy Benefit Manager (PBM) Expenses recorded in A/C 81305-01 after implementation of PBM transparency for CYE 2020 that were previously reported as medical services in the financial statements and/or included in encounters prior to implementation of PBM transparency. Please identify if the expenses were previously only reported as medical expenses in the financial statements, or only included in encounters, or reported in both places.

Provide amounts paid by PBMs related to current contract year performance guarantees by subcategory (Brand, Generic, Specialty and Biosimilar, and Mail Order) for dates of service October through March and April through September.

Using the report(s) supplied by the PBM, provide computations used for the Guaranteed Discount Calculation that indicate how the Contractor met the Guarantee Discount contractual requirement by the categories below.

1. Guaranteed Brand Drug Discount
2. Generic Drug Guarantee
3. Guaranteed Discount Rate for Specialty and Biosimilar Drugs
4. Guaranteed Discount Rate for Mail Order Prescriptions Services

## **4.00 SUPPLEMENTAL REPORTS**

See Appendix E and F for examples of supplemental reports.

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

This paragraph is reserved for future use.

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

List the amounts, by type, that are included in the Balance Sheet – A/C 10115. 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 – A/C 10125 and A/C 20125. Amounts related to Tiered and Adults >106%, reconciliations/cost settlements (both receivables and payables where applicable) should be detailed by contract year.

### **4.04 Other Assets Report**

Include all other assets (current and non-current) in the appropriate categories provided. List all 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 A/C 10145 and non-current assets to A/C 10225 of the Balance Sheet.

### **4.05 Other Liabilities Report**

Include all other liabilities (current and non-current) in the appropriate categories provided. List all 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 A/C 20145 and non-current liabilities to A/C 20215 of the Balance Sheet.

### **4.06 Alternative Payment Model Performance Based Payment Report**

List the amounts that are included in the Balance Sheet – A/C 10140 and A/C 20130 and A/C 20215. Information should be detailed by provider and by contract year.

#### **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 8. Do not include sub-capitation payments in this schedule.

Expense reported in the current period on the Lag Report should equal the expenses reported in the Statement of Revenues and Expenses 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 remaining balance 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. 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) 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). The totals should equal the amounts reported on the Balance Sheet – A/C's 20135 and 20205.

#### **4.09 Analysis of Profitability by Risk Group Report**

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



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

#### **4.10 Sub-capitated Expenses Report**

This report is a summary of sub-capitation expenses, by risk group, by individual expense line item. Only list the accounts in this report that have sub-capitation expenses. Sub-capitated expenses SHOULD NOT be reported for A/C 50350 Alternative Payment Model Performance Based Payments to Providers. This information assists in calculating any reconciliation and is used in capitation rate setting. Independent Auditor's Attestation is required for the sub-capitated expenses report on a CYE basis as part of the draft and final audit. As part of the final audit package submission, a prior-contract year-to-date with audit adjustments sub-capitated expense report is required. For example, if the Contractor's fiscal year-end is June 30, 2019, the sub-capitated expense report with audit adjustments for contract year-ending September 30, 2018 would be required. For MLR calculation purposes, the portion of the sub-capitation payment that is explicitly attributable to the provision of administrative services for delegated managed care activities and associated reporting requirements by the provider should be excluded from the calculation of the MLR. See account 81605-01 – Sub Capitation Block Administration for additional information. The Contractor's fiscal year end sub-capitated/block expense report by risk group does not need to be audited; and therefore does not require an attestation.

#### **4.11 Block Purchases Expense Report**

This report is a summary of block purchases expenses, by risk group, 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.

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 or sponsoring organization (balance sheet and statement 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 120 days after year-end. See Appendix G. See the AHCCCS website for links to the templates for these reports (<https://www.azahcccs.gov/Resources/Contractor/Manuals/financialReporting.html>).

#### **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. See Appendix F for an example of the annual audit reconciliation report.

#### **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 120 days after the parent company's fiscal year end.

#### **4.19 Quarterly 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 (see Appendix H for the Annual Medical Loss Ratio Reporting Instructions).

#### **4.20 Supplemental Pharmacy Rebates Received Report:**

List the supplemental pharmacy rebates received by Therapeutic Drug Class including the Therapeutic Class Code, the Drug Name and Strength, the NDC, the Manufacturer, the Number of Units Submitted for Rebate, the Rebate per Unit, the Number of Units Rebated and the Total Amount of Rebates Received. Report Pharmacy rebate amounts on a Cash basis by quarter. See Appendix J.

### **5.00 ACCOUNTING AND REPORTING ISSUES**

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

There are three primary components of claims expense:

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

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

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

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

#### Elements of an IBNR System

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

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

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

4. Claims data should also be segregated to permit analysis by major rate code, county, major provider, and category of service.
5. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine a Contractor's IBNR methodology if applicable.

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

#### Case Basis Method

Accruals are based on estimates of individual claims/episodes. This method is generally used for those types of claims where the amount of the cost will be large, requiring prior authorization. The final estimated cost can be made after the services have been authorized by the Contractor. For example, if a Contractor knows how many hospital days were authorized for a certain time period, and can incorporate the contracted reimbursement arrangement(s) with the hospital(s), a reasonable estimate should be attainable. This is also the most common and can be the most accurate method for small and medium sized organizations.

#### Average Cost Method

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

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

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

#### Per Diem or Per Service Averages

Averages for this method are of specific occurrences known by the Contractor at the time of the estimation. Therefore, it is first necessary to know how many hospital

days, procedures or visits were authorized as of the date for which the IBNR is being estimated. Again, once the total expense has been estimated, the amount of related paid claims and RBUCs should be subtracted to get to the IBNR liability. This method is primarily used for hospitalization IBNRs as Contractors generally know the number of hospital days authorized at any given time.

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

## **5.02 Reinsurance**

Reinsurance provides reimbursement to the Contractors when extraordinary costs associated with a member are incurred during a contract year. Specific deductible amounts and reimbursement rates are in the AHCCCS Complete Care Contract between AHCCCS and the Contractors.

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

## **5.03 Related Parties/Affiliates**

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

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

## 5.04 Financial Viability Standards and Performance Guidelines Report

The Contractor must comply with the AHCCCS-established financial viability standards. This report is to be completed on a quarterly 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.

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 24 hours without significant penalty (i.e., greater than 20%).

*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.

***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 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 1<sup>st</sup> enrollment) at the following link:

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

Use report titled Enrollment by Health Plan by County.

*Standard: At least \$150 per member for CYE 2019*

*At least \$200 per member for CYE 2020*

*At least \$250 per member for CYE 2021 and thereafter*

Additional information regarding the Equity per Member requirement

may be found in the *Performance Bond and Equity per Member Requirements* policy in ACOM 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 divided by the sum of total Capitation (lines # 40105) + Alternative Payment Model Initiatives Reconciliation/Settlement (line #40115) + Delivery Supplement (line #40120) + Adults >106% (line #40125) + Prospective Tiered Recon Settlement (line #40130) + PPC Settlement (line #40140) + Other Reconciliation Settlements (line #40145) - Reinsurance (line #70105) 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 see Appendix H. The Contractor shall provide the required information as outlined in Attachment F3 of its Contract with AHCCCS.

Standard: At least 85%

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

**Annual Medical Loss Ratio Report** – The Medical Loss Ratio (MLR) calculation shall be performed annually in accordance with 42 C.F.R 438.8 (see Appendix H for the Annual Medical Loss Ratio Reporting Template, Certification and Instructions). This report is due five months 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. For CYE21, an Independent Auditor’s Attestation is required for the Annual MLR report on a CYE basis as part of the draft and final audit. As part



of the final audit package submission, the audited prior-contract year-to-date (CYE20) Annual MLR report with audit adjustments is required. For example, if the Contractors fiscal year-end is December 31, 2020, the Annual MLR report with audit adjustments for contract year-ending September 30, 2020 would be required.

## **5.05 Community Reinvestment**

Contractors are required to allocate 6% of annual net profits, on a contract-year-to-date basis, as Community Reinvestment activities. The Contractor shall submit a plan detailing its anticipated Community Reinvestment activities, including expected beneficiaries and how they will benefit, within 60 days of the start of the contract year.

Community Reinvestment expense should be reported in the financial statements on the Revenues and Expenses Line 990105 Community Reinvestment. Report the liability in account 20145-01, and disclose by contract year-end on the Other Liabilities Report. Community Reinvestment can be accrued for on a quarterly basis if the Contractor can reasonably estimate the amount to be allocated. Community Reinvestment accrued and recorded in one fiscal year, would become a balance sheet only transaction when paid out in subsequent years.

The Community Reinvestment Calculation tab of the Financial Reporting Template is required as part of the Contractors Draft Audit and should include audit adjustments completed for the current fiscal year, as well as the prior fiscal year, if applicable, in order to properly calculate the contract year-end profit subject to the 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 an annual Community Reinvestment Report to AHCCCS nine months after the contract year-end with an 8-month cut off. 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. Refer to Appendix I for template. If the reinvestment relates to a previous years' commitment, indicate this on the report under the Commitment Year Column.

## **6.00 APPENDICES**

**Appendix A:** Certification Statement

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

**Appendix C:** Financial Statements

**Appendix D:** Financial Statement Footnote Disclosures

**Appendix E:** Supplemental Reports

**Appendix F:** Audit Reconciliation Report

**Appendix G:** Related Party Transactions

**Appendix H:** Annual Medical Loss Ratio Reporting Template, Certification and Instructions

**Appendix I:** Community Reinvestment Activities Report

**Appendix J:** Supplemental Pharmacy Rebates Received Report

## **7.00 EXHIBITS**

### **Exhibit 1: Sample Footnotes for Quarterly Financial Reports**

#### **Paragraph 3.06**

**Quarter ended MM/DD/YYYY**

#### **Footnotes**

### **1. ORGANIZATIONAL STRUCTURE**

#### **Organizational Structure**

Company ABC (ABC) was established on October 1, 1982, as a division of Company XYZ Health Services Network (XYZ), an Arizona not-for-profit corporation.

#### **Location of Headquarters**

Company ABC is located at 123 Main Street in Phoenix, Arizona, and is contracted with AHCCCS to administer healthcare services to qualified residents in Maricopa, Pinal, Gila, Apache, Coconino, Mohave, Navajo, Pima, and Yavapai counties.

The Balance Sheet and Statement of Revenues and Expenses reflect only the financial condition and the results of operations of the services provided under the contract with the Arizona Health Care Cost Containment System (“AHCCCS”).

### **2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

#### **Allocation Methodology for allocating medical expenses to each risk group and geographic service area**

Company ABC uses several sources of information for allocating the revenues and expenses on the Profitability by Risk Group by Geographic Service Area Schedule. For capitation revenue and member months, the actual 820 files received by AHCCCS are utilized. For hospital expenses Company ABC utilizes a combination of paid claims and prior authorizations. Company ABC then uses a combination of provider contracts (for sub capitated arrangements), member months and actual paid claims data, updated quarterly for all other medical expense categories.

#### **Cash and Cash Equivalents**

The majority of the change between the prior and current quarter is due to the timing of the sweep transfer from the cash concentration account to the cash zero-balance account.

#### **Short-term Investments**

All short term investment can be converted to cash within 24 hours

#### **Capitation Revenue**

Capitation revenue is recognized when the AHCCCS administration provides information that a member is assigned to the Contractor program on membership rosters.

**Delivery Supplement Revenue**

Delivery supplement revenue is recognized upon a delivery of a child by a member during a prospective enrollment period assigned to the Contractor. This supplemental payment excludes those members who deliver in a prior period coverage time period.

**Reinsurance Receivable**

Contractor reviews claims payments to determine claims that are eligible for reinsurance. These are reported on the financial statements in the amount expected to be collected from AHCCCS.

**Investment Income Receivable**

Income that is earned but not yet received is recognized in the month identified.

**Other Current Assets**

Current portion of fixed assets which are not captured elsewhere on the balance sheet. Any receivables from providers are accounted for on this line and are not netted against IBNRs.

**Long-term Investments**

Long-term Investments are those expected to be held longer than one year. Long-term investments listed in the Investments Report (Paragraph 4.01) are subject to prior approval from AHCCCSA. Currently, Contractor has no long-term securities.

**Property, Plant and Equipment**

Contractor has no Property, Plant, or Equipment.

**Administrative Expenses**

Administrative expenses are recognized monthly as incurred in accordance with Company ABC's Cost Allocation Plan and as defined by AHCCCS. These costs are indirect cost as they are incurred for the common benefit of multiple direct program service activities and are grouped according to the nature of the cost.

**Medical Claims Payable**

Medical expenses payable are calculated monthly based on historical experience and are reviewed monthly by an outside actuary. Further information regarding the calculation of IBNR balances can be found in the Contractor IBNR policy. All medical expenses payable are reported net of Medicare.

**Received but Unprocessed Claims (RBUC's)**

Medical claims are logged into the Contractor's claim system when received. Any claims in the claims department that haven't been logged at quarter end are summarized. An estimated amount due for these received but unprocessed claims is reported on the Medical Claims Payable report. Claims that have been processed but for which no check has been issued are also included as well as any unpaid pharmacy invoices for which an invoice has been received.

There are a number of claims for which the claim category (medical, hospital, other) is unknown. These claims are distributed among the different claim categories based on the total accrual for each category with adjustments made to this distribution as appropriate.

The RBUC lag for all unprocessed claims is based on the actual lag between date received and the end of the reporting period. The lag for unpaid pharmacy invoices and processed claims for which no check has been issued is assumed to be "current."

### **Taxes**

The Company participates in a tax allocation agreement with Company XYZ and other members of an affiliated group for federal taxes. Within the Company, taxes are allocated to the AHCCCS Complete Care, Medicare and ALTCS lines of business using the Company's estimated blended effective rate.

### **Membership**

Members are included in the member month calculation for each month, or portion of a month they were enrolled with Contractor. Members who were enrolled less than a month are counted proportionally to the part of the month they were enrolled.

### **Medical Expenses**

Medical expenses are accrued in the period that services are rendered and are based, in part, on estimates. The total amount of medical expenses recognized includes actual claims payments, capitation payments, and an estimated amount due for claims that have been received but haven't been processed and an estimated amount due for claims that have been incurred but have not been received. All medical expenses are reported net of Medicare.

### **Changes in accounting methodologies**

In 2011, due to the potential change in rebate receipts, rebates were not recorded until rebates were actually received. In Q/E 3/31/12, rebates were accrued monthly based on historical data.

## **3. OTHER AMOUNTS**

### **Other Income**

The amounts reported for other income consists of the miscellaneous revenue.

### **Miscellaneous Medical Expenses**

Non-physician medical expenses and optical expenses are included here.

### **Other Administrative Expenses**

### **Other Current Assets**

This includes short-term deferred taxes and expected third party liability revenue. These assets are depicted in the Other Assets Report.

### **Other Non-Current Assets**

Other Non-Current Assets include Long-term deferred taxes.

### **Other Current Liabilities**

This includes premium taxes due to the Department of Insurance, and estimated sanction accruals.

## Other Non-Current Liabilities

There are no amounts for non-current liabilities reported.

## 4. PLEDGES AND ASSIGNMENTS AND GUARANTEES

Contractor has no pledges, assignments, or collateralized assets. There are also no guaranteed liabilities not disclosed on the balance sheet.

## 5. RESERVED

## 6. MATERIAL ADJUSTMENTS

An adjustment was made this quarter per the actuary's recommendations for balance sheet reserves. These adjustments occurred in the normal course of business for the Contractor.

## 7. MEDICAL CLAIMS PAYABLE ANALYSIS

A. Medical claims payable (A/C 20120) increased \$11.6M, or 31.6% over prior quarter. Medical expenses payable are calculated monthly based on historical experience and are reviewed monthly by an outside actuary. Company ABC booked expense and related reserves for Maricopa County based on actuary's review. For inpatient expense, Company ABC recorded expense based on actual referral days expenses by tier by hospital. Company ABC has had enough historical data to calculate balance sheet reserves since May 2006. As such, March's income statement reflects any adjustments made to the reserves.

PMPM comparison quarter to quarter on medical claims payable:

Dollar basis:	QE 0812	QE 0903	% Change from Prior Quarter	PMPM basis:	QE 0812	QE 0903	% Change from Prior Quarter
Inpatient	11,610,000	14,135,000	21.7%	Inpatient	97.46	100.09	2.7%
Medical Comp	3,840,000	4,740,000	23.4%	Medical Comp	32.23	33.57	4.1%
Other Medical	7,661,438	10,289,135	34.3%	Other Medical	64.31	72.86	13.3%
PPC Total	13,520,000	19,048,000	40.9%	PPC Total	587.28	767.00	30.6%
Total	<u>\$36,631,438</u>	<u>\$48,212,135</u>	31.6%	Total	257.69	290.34	12.7%

B. With the beginning of the new contract year in October 2008 and Company ABC's place in the auto-assign algorithm, the increased member months are driving the majority of the increases in the liabilities on the balance sheet. Member months increased 1,813, or 7.9% over prior quarter and member months increased 22,087, or 18.5% over prior quarter. In total, member months increased 16.8% over prior quarter.

Member months increase comparison:

	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Total QE 0812	Total QE 0903	Change from prior quarter	change to prior quarter
PPC	8,390.1	6,608.1	8,023.1	7,189.8	8,325.8	9,318.8	23,021.3	24,834.4	1,813.1	7.9%
Prospective	37,135.9	39,744.7	42,250.8	44,307.6	46,813.8	50,096.7	119,131.4	141,218.1	22,086.7	18.5%
Total	45,526.0	46,352.8	50,274.0	51,497.4	55,139.7	59,415.5	142,152.7	166,052.5	23,899.8	16.8%

## 8. CONTINGENT LIABILITIES

In the opinion of management, no legal matters exist that would have a material adverse effect on the financial position of Contractor.

## 9. INVESTMENTS

Contractor has no long-term investments that the Contractor would like treated as current assets for calculation of the current ratio.

## 10. DUE FROM/TO AFFILIATES (CURRENT AND NON-CURRENT)

There is currently are no amounts due from or due to affiliates.

## 11. EQUITY ACTIVITY

Disclose all activity in equity, other than net income or net loss.

The following equity adjustments were made during the quarter ended June 30, 20XX:

Month Ending	Unrealized Gain/(Loss)	Equity Distribution	Profit(Loss)	Equity Chg
April	157,895	-	4,482,335	4,640,230
May	342,155	-	3,715,345	4,057,500
June	(15,478)	-	2,804,288	2,788,810
<b>Total</b>	<b>484,572</b>	<b>-</b>	<b>11,001,969</b>	<b>11,486,541</b>

During the months of April and May of the QE June 30, 20XX, unrealized gains were recognized in the amount of \$157,895, and \$342,155, respectively. For the month of June, an unrealized loss was recorded in the amount (\$15,478).

## 12. NON-COMPLIANCE WITH FINANCIAL VIABILITY STANDARDS AND PERFORMANCE GUIDELINES

### FINANCIAL VIABILITY STANDARDS - Year to Date Current Ratio

Indicate whether Contractor meets standard, if not explain.

### Equity per Member

Indicate whether Contractor meets standard, if not explain.

### PERFORMANCE GUIDELINES

#### Medical Loss Ratio

Indicate whether Contractor meets standard, if not explain.

#### Administrative Cost Percentage

Indicate whether Contractor meets standard, if not explain.

## 13. CHANGES IN FINANCIAL STATEMENT LINE ITEMS

Changes in Financial Statement Line items based on current standards as identified under Section 3.06 Footnote Disclosure Requirements:

A. Cash and cash equivalents (A/C 10105) increased by \$17,526,336, or 50% from the previous reporting quarter. This is the result of increased capitation premiums received related to the new

contract October 1, 2008 and the Contractor's place in the algorithm. Member months increased 18.6% and member months increased by 7.9% over prior quarter. The capitation increases were offset by an increase in claims payment volume of \$8,885,065 compared to prior quarter.

**B.** Capitation/Supplement/Reconciliation Receivable (A/C 10115) decreased by \$2,065,466, or -19.2% from the previous reporting quarter. The premiums receivable decreased \$291,726 due to month-end timing on capitation. Reconciliation receivables decreased by \$787,563 over prior quarter. Tiered reconciliation receivables decreased by \$988,327 in the current quarter due to normal reconciliation activity.

**C.** Total medical claims payable (A/C 20120) have increased by \$11,580,697, or 31.6% over last quarter. Please refer to the detailed analysis in Footnote 7 above for the discussion of the changes within this line item.

**D.** Hospitalization IBNR increased by \$2,525,000, or 21.75% over the previous quarter. While the claims paid out on average in the current quarter were \$264K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in member months in this quarter versus last quarter.

**E.** Physicians IBNRs increased by \$900,000, or 23.4% over the previous quarter. While the claims paid out on average in the current quarter were \$74K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in member months in this quarter versus last quarter.

**F.** Other IBNRs increased by \$2,627,697, or 34.3% over the previous quarter. While the claims paid out on average in the current quarter were \$24K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in member months in this quarter versus last quarter.

**G.** IBNRs increased by \$5,528,000, or 41% over the previous quarter. While the claims paid out on average in the current quarter were \$294K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in prospective member months in this quarter versus last quarter.

**H.** Other current liabilities (A/C 20145) of \$4,063,993 increased \$1.9M, or 89% over prior quarter with the accrual of the anticipated adjustment for capitation risk scores of \$1,854,171 and plan administration accrual of \$79,109 in the current quarter.

**I.** Capitation revenue (A/C 40105) increased \$7,876,838, or 22.7% from previous quarter due to the increased member months over prior quarter. \$6,444,236 of the total increase is due to the increase in member months of 22,087 over the previous quarter to 141,218. The remainder of the increase is the result of a shift in member mix and as a result, the capitation increased from \$291.71 PMPM in the prior quarter to \$301.92 PMPM in the current quarter.



**J.** Capitation revenue (A/C 40105) increased \$3,807,328, or 27.5% from previous quarter due to the increased member months over prior quarter of 1,813 and a shift in member mix from TANF 1-13 to AHCCCS Care.

**K.** Delivery supplement revenue (A/C 40120) increased \$343,003, or 21.42% from previous quarter due to the increased number of births received for the current quarter. There were 289 births in the current quarter compared to 238 births in the prior quarter.

**Insert chart of births by quarter for past six quarters here**

**L.** PPC Settlement revenue (A/C 40140) decreased by \$676,653 over the previous quarter. While PPC member mix stayed consistent with prior quarter with the exception of TANF 1-13 and AHCCCS Care, the PPC settlement decreased from -\$4.82 PMPM in the prior quarter to -\$31.71 PMPM in the current quarter.

**M.** Inpatient expense (A/C 50105) increased by \$1,548,254, or 12.2% from the previous quarter which was due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to the steady increase in member months in this quarter versus last quarter. While the claims paid out on average in the current quarter was \$264K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in member months in this quarter versus last quarter. Average length of stay increased from prior quarter of 3.42 to 3.79 this quarter and inpatient admits increased from 2,953 prior quarter to 3,282 for the current quarter. Inpatient days increased from 10,098 last quarter to 12,247 days for the current quarter.

**N.** Referral physician expense (A/C 50215) increased by \$1,075,475, or 21.6% from the previous quarter which was due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to increased member months in this quarter versus last quarter.

**O.** Emergency care expenses (A/C 50305) increased by \$185,771, or 6.4% from the previous quarter due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to the increase in member months in this quarter versus last quarter.

**P.** Pharmacy expenses (A/C 50310-1) increased by \$1,125,956, or 49% from the previous quarter due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to the increase in member months in this quarter versus last quarter.

**14. DRUG REBATES/DISCOUNTS**

\$XXX,XXX of total Pharmacy Manufacturers Rebates for the current contract year ended 9/30/20 as follows:

<b>Therapeutic Class</b>	<b>Rx Rebates Amount</b>
	\$XX,XXX
	\$XX,XXX
	\$XX,XXX

Total	\$XXX,XXX
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\$XXX,XXX of Pharmacy Rebates were received from ABC PBM for the current contract year ended 9/30/20 as follows:

Therapeutic Class	Rx Rebates Amount
	\$XX,XXX
	\$XX,XXX
	\$XX,XXX
Total	\$XXX,XXX

\$XX,XXX of Pharmacy Rebates were retained by ABC PBM for the quarter ended 9/30/20 as follows:

Therapeutic Class	Rx Rebates Amount
	\$XX,XXX
	\$XX,XXX
Total	\$XXX,XXX

Pharmacy rebates are not reflected in the lag report.  
The rebate program with ABC PBM does not include drugs that are included in the AHCCCS rebate program.

#### 16. ACCRUED SANCTIONS, FINES AND PENALTIES

ABC accrued for sanctions of \$20,000, fines of \$5,000 and no penalties during the quarter ended MM/DD/YYYY. The expense related to these sanctions is included in A/C 83005. Total accrued sanctions of \$20,000 and fines of \$5,000 are included on the balance sheet in A/C 20105.

	Quarter	IS Line#	AHCCCS	Other Regulatory	Total
Sanctions	31-Dec	83005	\$ 20,000		\$ 20,000
Fines	31-Dec	83005		\$ 5,000	\$ 5,000
Penalties	N/A				\$ -
			\$ 20,000	\$ 5,000	\$ 25,000

#### 17. PROVIDER INCENTIVES

ABC paid no provider incentives during the quarter ended MM/DD/YYYY. ABC paid \$7,025 in member incentives reported in line XXXXX-01 for risk group Age 21+.

#### 18. ALTERNATIVE PAYMENT MODEL INITIATIVES

	APM Paid	Accruals	Adjustments	Total	270 Day	Variance	Explanation	Final 19 Month	Variance	Explanation
CYE18	\$ 3,500,000	\$ 3,000	\$ 120,000	\$ 3,623,000	\$ 3,500,000	3.40%	No Explanation Needed	3,502,000	3.33%	No explanation needed
CYE17	\$ 820,000	\$ 17,000	\$ 70,000	\$ 907,000						
CYE16	\$ 340,000		\$ 32,000	\$ 372,000						
	\$ 4,660,000	\$ 20,000	\$ 222,000	\$ 4,902,000	\$ 3,500,000			\$ 3,502,000		

#### 19. RESERVED

#### 20. RISK ADJUSTMENT

During the quarter, Company ABC accrued \$4.5 million for risk adjustment for the year ending MM/DD/YYYY.

## 21. PRIOR CONTRACT YEAR ADJUSTMENTS

During the quarter, company ABC recorded an adjusting entry to Reinsurance revenues decreasing the revenues by a total of \$1,500,000, of that amount \$500,000 is related to the current year with \$1,000,000 adjusting revenues in the prior year due to encounters which did not adjudicate through to the reinsurance case within the 15 month timely filing deadline.

## 22. NON-CAPPED NEWBORN COSTS

During the quarter, Company ABC incurred \$48,123 for newborn costs for 2 births for which capitation was not received.

## 23. PREMIUM DEFICIENCY RESERVE

During the quarter the Contractor recorded an increase to the Premium Deficiency Reserves in the amount of \$2,500,000 to other current liabilities line A/C 20145 and other revenue line A/C 40310. Total Reserves equal \$5,000,000.

## 24. RESERVED

## 25. ACCESS TO PROFESSIONAL SERVICES INITIATIVE (APSI)

APSI-related and revenue and expenditure amounts for contract year to date 3/31/XX.

APSI	2018	2019
Capitation	489,306	569,357
Total Expenditures	485,669	521,005
Total Revenue over Expenditures	\$ 3,637	\$ 48,352
Percentage of Capitation	0.74%	8.49%

## 26. MANAGEMENT FEES

During the quarter, Company ABC expended \$5M on Management Fees and had \$17M expended on a fiscal year-to-date basis. The Fee percentage of 5% did not increase during the quarter.

## 27. NON-OPERATING PROFIT (LOSS)

Description	Q/E 12/31/2018
Investment Fees	\$ (49,528)
Investment Income (Realized Gains)	305,850
Community Reinvestment	12,000
Total	\$ 268,322

28. ADDITIONAL EXPENSE EXPLANATIONS REQUESTED BY AHCCCS

CYTD \$1.7M was expended for Title XIX/XXI BH-related emergency facility services. These expenses are reported in a/c 50305-01.

Code	Amount
99281	\$ 426,457
99282	185,623
99283	94,251
99284	493,419
99285	500,250
Total	\$ 1,700,000

29. Social Determinants of Health (SDOH)

During the quarter, Company ABC expended \$500,000 on housing expenses from the CYE19 Community Reinvestment funds (line XXXXX-XX) and \$20,000 from Administration (line XXXXX-01).

30. Pharmacy Benefit Manager Expenses. The detail of PBM admin expenses recorded in A/C 81305-01 includes the following:

Pharmacy Benefit Manager Expenses Detail	Quarter End	CYE20 YTD
Pharmacy claims processing		
Pharmacy network development/management		
Pharmacy discount negotiating		
Drug utilization management/review		
Coordination of specialty drugs		
Pharmacy call center operations		
Reporting		
Other PBM-related costs		
Total		

ABC recorded \$XX,XXX of PBM Expenses in CYE 2019 that were recorded as medical services in the financial statements and included in encounters. ABC implemented PBM Transparency on January 1, 2020. ABC recorded \$XX,XXX of PBM Expenses prior to implementation of PBM Transparency as medical services in the financial statements and included in encounters during CYE 2020. The amount of the increased Pharmacy Benefit Manager Expenses recorded in A/C 81305-01 that were previously included in encounters was \$XX,XXX for the quarter ended 3/31/20 and \$XX,XXX for the current Contract YTD. These were previously included as both encounters and reported as medical expenses in the financial statements.

The amount paid by ABC PBM for performance guarantees related to Average Wholesale Price savings was \$XX,XXX for the dates of service 04/01/20-09/30/20.

Performance Guarantees	Dates of Service 10/01/19-03/31/20	Dates of Service 04/01/20-09/30/20
Brand	\$XX,XXX	\$XX,XXX
Generic	\$XX,XXX	\$XX,XXX
Specialty/Biosimilar	\$XX,XXX	\$XX,XXX
Mail Order	\$XX,XXX	\$XX,XXX
Total	\$XX,XXX	\$XX,XXX

