



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

Effective Date October 1, 2021

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DEFINITIONS

ADMINISTRATIVE COSTS

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

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

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

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

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: Refer to Related Party Transactions definition.

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

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

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

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

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

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

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

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

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

COMPREHENSIVE HEALTH PLAN (CHP): Effective April 1, 2021, Comprehensive Medical and Dental Program will be known as the Comprehensive Health Plan.

COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP): A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for children in the custody of Department of Child Safety either in a foster home or other place setting in Arizona. Refer to A.R.S. §8-512. Effective April 1, 2021, CMDP will be referred to as Comprehensive Health Plan.

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

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

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

DAY: Calendar day unless otherwise specified.

DES: Department of Economic Security

DCS: Department of Child Safety

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

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

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

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

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

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

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

FQHC/RHC VISIT: Face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not

incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

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

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

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

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

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

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

MANAGEMENT DECISION

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

MANAGEMENT SERVICES AGREEMENT

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

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

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

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

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

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

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

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

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

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

STATE ONLY TRANSPLANT MEMBERS: Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income may become eligible for one of two extended eligibility options as specified in A.R.S. 36-2907.10 and A.R.S. 36-2907.11.

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

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

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

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

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

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

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 and the CMDP Contractor. The primary objective of the Guide is to establish consistency and uniformity in reporting. This Guide is neither intended to limit the scope of audit procedures to be performed during the Contractor's annual certified audit, nor to replace the independent Certified Public Accountant's judgment as to the work to be performed. It is instead intended to define certain additional procedures and analysis to be performed and reported on by the applicable Contractor management on a periodic basis and by the independent Certified Public Accountants on an annual basis.

The contract with AHCCCS requires that Contractors furnish information from their records relating to the performance under the contract. Certain financial and statistical data are outlined in the contract as minimum reporting requirements. AHCCCS has developed a standard set of forms and a CUBE Flat File to be used to satisfy the financial reporting requirements, as well as guidelines and minimum reporting requirements for the annual audited financial statements. This guide is intended to outline these requirements and provide examples of required reports in the Appendix to the guide. This guide is not intended nor should it be construed as an all-inclusive manual. The format and content of the required reports are subject to change. Questions regarding the content or format of a report are to be directed to the Contractor's assigned Financial Consultant.

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

If the Contractor is a Medicare Advantage Plan licensed through the Department of Insurance and Financial Institutions (DIFI), quarterly reporting to AHCCCS is required for informational purposes only. AHCCCS will accept a copy of the NAIC filing submitted to DIFI. AHCCCS acknowledges that the quarter ending 12/31/xx filing to DIFI is due 90 days after quarter end and thus is due to AHCCCS at the same time it is filed with DIFI. If the Contractor is a Medicare Advantage Plan certified by AHCCCS, then the Contractor is required to submit its quarterly reports to AHCCCS as outlined in Attachment F3 Contractor Chart of Deliverables of its Contract with AHCCCS using the Financial Reporting Guide for AHCCCS Complete Care Contractors and the related report templates for quarterly reporting.

If there are any inconsistencies between this reporting guide and any contract provision, the contract provision shall prevail. This guide is not intended nor should it be construed as an all-inclusive manual. The format and content of the required reports are subject to change. Questions regarding the content or format of a report are to be directed to the Contractors' assigned Financial Consultant.

1.02 Effective Dates and Reporting Time Frames

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

Monthly reporting, when required, is due within 30 days of each month end, using either the Contractor's internal financial statement format or the AHCCCS Reporting Guide format as determined by AHCCCS. Quarterly reporting is due within 60 days of each quarter end, using the most recent AHCCCS Reporting Guide format.

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

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

1.03 Sanctions

Pursuant to ACOM 408, failure to file with AHCCCS, accurate, timely, and complete financial statements and related deliverables may result in monetary penalties until such statements or deliverables are received by AHCCCS. If a Contractor knowingly and willfully makes, or causes to be made, any false statement or misrepresentation of a material fact in any statement or disclosure filed pursuant to this policy, the Contractor may be fined pursuant to ACOM Policy 408.

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

For sanctions assessed by AHCCCS, the full amount of the sanction will be withheld from the Contractor's monthly payment. Revenue from specific programs will be reduced by

the amount of the sanction. The Contractor should ensure that they report the full amount of the program's revenue then report the sanction in the same program as an administrative expense on line 83005-01, Other Administrative Expenses.

2.00 FINANCIAL REPORTING REQUIREMENTS

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

REPORT DUE DATES

REPORT

Monthly Reporting (Only if requested by AHCCCS) **Quarterly/Financial Reporting** **Draft Audit Financial Reporting** **Final Audit Financial Reporting**

Due Date: _____ →

	30 days after month end	60 days after quarter end	90 days after Contractor's fiscal year end	120 days after Contractor's fiscal year end
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	X	X
Receivables/Payables Report (4.02 & 4.03)	X	X	*	*
Other Assets Report	X	X	*	*
Alternative Payment Model Report (by provider by year)	X	X	*	*
Other Liabilities Report	X	X	*	*
Claims Lag Report (Hospitalization, Medical & Other)	X	X	*	*
Long-term Debt Report (other than Affiliates)	X	X	*	*
Profitability by Risk Group ¹	X	X	*	*
Sub-Capitated Expenses Report	X	X	*	*
Sub-Capitated Expense Detail	X	X	*	*
Sub-Capitated/Block Purchase Expense Detail by Risk Group on a Contract-Year-End Basis				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		

¹ Not applicable to CMDP/CHP.

Parent Company (if applicable) Financial Statements
 Independent Auditor's Report
 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 by risk group on a Contract Year-End basis
 Annual IBNR Actuarial Certification
 Audit Recon Balance Sheet F-1a
 Audit Recon Income Statement F-1b
 Audit Recon Entries F-1c
 Annual Financial Viability F-1d
 Related Party Transactions
 Community Reinvestment Calculation I-1
 Medical Loss Ratio Report H-1 and H-2
 Independent Auditor's Attestation of Annual Medical Loss Ratio on a Contract Year End basis (required every three years)
 Contract Year Annual Supplement

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

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

3.00 INSTRUCTIONS FOR COMPLETION OF QUARTERLY AND ANNUAL REPORTING

3.01 General Instructions

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

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

Draft annual audited financial statements and supplemental reports should be complete with all attachments and schedules and be as close to final as possible. There should be only minimal changes between the draft and final submissions. The draft and final audit report audited financial statements and footnotes should be in accordance with GAAP or GASB. Footnotes and supplemental schedules should agree to amounts included in the audited financial statements. The final audited financial statements, including all supplemental schedules (unless pre-approval from AHCCCS is received to exclude certain supplemental schedules), will be posted to the AHCCCS website.

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

Report line titles and columnar headings are detailed in the report specific paragraphs below. Utilize predefined categories or classifications before reporting an amount as "Other." For any material amounts included in the "Other" category, provide details and explanations in the footnotes regarding the content of the account(s). Refer to Footnote 3 for specific thresholds related to materiality.

If information is not available or applicable, write "None," not applicable (N/A), or "-0-" in the space provided.

When a Contractor changes any line item, for a prior quarter, the change must be reported one of two ways: (1) submit corrected prior quarter report or (2) record the change in the current quarter report. If a corrected prior quarter report is submitted, notification to AHCCCS must take place in addition to an explanation for the revision. If material revisions are submitted after the AHCCCS due date, then sanctions may be imposed for untimely or inaccurate reporting. An explanation of adjustments made for prior periods are to be disclosed in the Prior Period Footnote.

3.02 Certification Statement

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

3.03 Financial Statement Reporting Template Audit Report

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

3.04 Balance Sheet (Statement of Net Assets - Governmental Entities)²

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

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

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.

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

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. Refer to Capitation, Supplement, and Risk Adjustment Receivable Report (Paragraph 4.02) for required detail of this line item.

A/C 10120-01 - Reinsurance Receivable

Include: Billed and unbilled reinsurance. Refer to 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. Refer to Receivables/Payables Report (Paragraph 4.03) for required detail of this line item. This should equal only the sum of all receivable amounts listed on the Receivables/Payables Report (Paragraph 4.03). In addition, any settlement amounts **due from AHCCCS** relating to alternative payment model and access to professional services initiatives (CYE 19) should be recorded in this account.

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

Amounts due from AHCCCS for lump-sum directed payments including Access to Professional Services Initiatives (APSI) CYE 20 forward, Pediatric Services Initiatives (PSI), Targeted Investments (TI), and Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII). Refer to A/C 10145-01- Other Current Assets.

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. Refer to Paragraph 3.06 - #10.

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

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, net amounts receivable from AHCCCS related to lump-sum directed payments including APSI (CYE 20 forward), PSI, TI, and HEATHII) not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for in this line item and should not be netted against the IBNRs. Refer to Other Assets Report (Paragraph 4.04) for required detail of this line item.

OTHER ASSETS

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. Refer to Paragraph 3.06 - #10).

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

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. Refer to Other Assets Report (Paragraph 4.04) for required detail of this line item.

PROPERTY AND EQUIPMENT consists of fixed assets including land, buildings, leasehold improvements, furniture, equipment, etc.

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 consist 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). Refer to 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. Refer to Receivables/Payables Report (Paragraph 4.03) for required detail of this line item. This should equal only the sum of all payable amounts detailed on the Receivables/Payables Report (Paragraph 4.03). In addition, any settlement amounts **due to AHCCCS** relating to alternative payment model and access to professional services initiatives CYE 19 should be recorded in this account.

Exclude: Amounts **due to providers** related to PBP amounts relating to MAO Agreements and amounts **due to AHCCCS** related to lump-sum directed payments including APSI CYE 20 forward, PSI, TI, and HEALTHIII. Refer to A/C 20145-01- Other Current Liabilities.

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. Refer to Long-Term Debt (Other than Affiliates) Report, Paragraph 4.08.

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

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

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

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

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, lump-sum directed payments including APSI (CYE 20 forward), PSI, TI, and HEATHII). Label each item as due to AHCCCS or due to Provider and the applicable contract year. Refer to Other Liabilities Report, Paragraph 4.05.

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

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. Refer to Long-Term Debt (Other than Affiliates) Report (Paragraph 4.08) for required detail of this line item.

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

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

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

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

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. Label each item as due to AHCCCS or due to Provider and the applicable contract year. Refer to Other Liabilities Report (Paragraph 4.05) for required detail of this line item.

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

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.

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 805, Business Combinations

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/ Fund Balance /Net Assets (Liabilities)

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

30140-05 *Net Income/ (Loss) YTD* – must agree with the YTD 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.

30140-20 - Reserved for Future Use

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.

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

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

For Medical Service coding and Behavioral Health Services Matrix questions, recommended changes and updates, follow the instructions provided on the aforementioned webpage. Refer to Appendix C-2 for an example of this report

REVENUES

A/C40105-01 - Capitation

Include: Revenue recognized on a prepaid basis from AHCCCS for provision of health care services for eligible AHCCCS Complete Care or eligible CMDP 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. Refer to required detail on this item. Also, in the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements (Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

A/C 40140-01 - RESERVED

A/C 40145-01 - Other Reconciliation Settlements

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

A/C 40160-01 - RESERVED 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. Refer to discussion of PBM in Paragraph 5.06.

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

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, Therapeutic Foster Care for Children, Adult Behavioral Health Therapeutic Home, 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 24th 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. Refer to 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.

A/C 70310-05 - 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 70310-10 - Pharmacy Performance Guarantees

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

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

***NOTE: A/C's 70105-01, 70205-02, 70305-01, 70310-05 and 70310-10 should be reported as negative numbers, to allow the Financial Statement Reporting Template to properly net the amounts out of medical expense.**

Administrative Expenses are those costs associated with the overall management and operation of the Contractor. All administrative expenses must be allowable, reasonable, and appropriately reported by funding source/risk group in the pre-defined administrative expense lines. Management fees must be separately identified and reported in the pre-defined administrative expense lines as well. In addition, management fees may not be increased without prior written approval from AHCCCS. Expenses related to the pre-defined administrative expense lines should not be reported under A/C 83005-01, 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. These expenses must be separately identified for capitation rate setting purposes. **Include case management expenses delivered by the MCO or delivered by a non-provider.** Do not report these expenses under other administrative expense lines.

Exclude: Case management expenses delivered by a provider.

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. Refer to discussion of PBM in Paragraph 5.06.

A/C 81405-01 – Fraud Reduction Expenses:

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

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

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.

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.

Other examples of administrative functions/delegated managed care activities CMS considers non-claims cost include, but are not limited to: Amounts paid under a subcapitated arrangement for secondary network savings; Network development; Claims processing including pharmacy claims; Utilization review/management; Eligibility and coverage verification; Fines and Penalties; Professional service or Administrative services that do not represent compensation or reimbursement for State

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

CMDP/CHP

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

Exclude: Sub-Capitated/Block Payment amounts paid to 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. These include member incentives related to quality.

Exclude: Member incentives not related to quality improvement.

A/C 82505-01 - Interpretation/Translation Services

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

A/C 83005-01 - Other Administrative Expenses

Include: Administrative expenses not specifically identified in the categories above. Also include sanctions. Member incentives not related to health care quality improvement

CMDP: The details of the amount of Other Administrative Expenses are to be included in Footnote 3. All items must be reported, there is no reporting threshold.

Exclude: Member incentives related to health care quality improvement

A/C 88999-01 - 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.

A/C 90205-01 - Premium Taxes

Include: Provision for premium taxes for the period.

A/C 90305-01 - RESERVED RESERVED

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.

A/C 990305-01 – Unreimbursed Performance Based Payments

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

Exclude: Performance Based Payments reimbursed by AHCCCS.

3.06 Footnote Disclosure Requirements

Footnote disclosures are required in order to supplement AHCCCS' understanding of the financial statements and supplemental schedules. Refer to *Appendix D*. The following list

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

1) Organizational Structure:

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

2) Summary of Significant Accounting Policies:

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

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

Discuss revenue and expense recognition policies for the following:

- Capitation revenue; Delivery Supplement revenue; Reconciliation Settlements,
- Reinsurance revenue,
- Other revenue,
- Medical expenses,
- Administrative expenses,
- Alternative Payment Model Initiatives,
- Federal and State Income Taxes.

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

3) 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: ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

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.
- 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). Include discussions related to IBNR. 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) Financial Viability Standards and Performance Guidelines:
Disclose any non-compliance with Financial Viability Standards and Performance Guidelines, the factors causing the non-compliance and the plan of action to resolve the issue(s), including specifying the expected month that the compliance will be evidenced in the financial statements.

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

- 13) Changes in Financial Statement Line Items:

Balance Sheet

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

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

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

Balance Sheet changes should be calculated on a dollar basis.

Statement of Revenue and Expense

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.

14) Reserved

15) Reserved

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

18) Reserved

- 19) Reserved
- 20) Reserved
- 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) Reserved
- 23) Premium Deficiency Reserve – ANNUAL FINANCIAL REPORTING TEMPLATE ONLY
Include the cumulative amount of the reserve as well as the current quarter amount and all line items included in the entry. RESERVED
- 24) Reserved
- 25) Reserved
- 26) Management Fees - ANNUAL FINANCIAL REPORTING TEMPLATE ONLY
Disclose the quarterly amounts expended for Management Fees on a fiscal year-to-date basis, the fee percentage and indicate whether the fee percentage changed during the quarter. Also, disclose each individual administrative expense amount by the 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) Reserved
- 29) Social Risk Factors – ANNUAL FINANCIAL REPORTING TEMPLATE ONLY
Provide the Social Risk Factor and Health Equity activities expended in the fiscal year by quarter and fund source. Indicate the line number in the financial statements where these are reported. Only identify items that have been spent in the reporting period.

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

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

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

https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/Exhibit_4-1SocialDeterminantsHealthICD-10List.pdf

4.00 SUPPLEMENTAL REPORTS

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

4.01 Financial Viability

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

4.02 Capitation, Supplement, and Risk Adjustment Receivables

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

4.03 Receivables/Payables Report

List the amounts, by type, that are included in the Balance Sheet – A/C 10125 and A/C 20125. Use the prepopulated reconciliation names provided in the template. Amounts related to Tiered and Adults >106%, reconciliations/cost settlements (both receivables and payables where applicable) should be detailed by contract year. For CYE22, a line for the COVID 19 Vaccine Settlement has been included on this schedule. Contractors are required to report the applicable amounts related to COVID 19 Vaccine Settlement on these lines provided.

CMDP: For the period from 10/01/2020 through 03/31/2021, include any CMDP reconciliation receivable or payable and delineate reconciliations by type and year. This will include reconciliations/cost settlements. Use the prepopulated reconciliation names provided in the template.

CHP: For the period 04/01/2021 through 09/30/2021, include any receivable or payable related to CHP's reconciliation with its Subcontracted Health Plan in accordance with CHP's contract with the Subcontracted Health Plan. CHP will submit the reconciliation to AHCCCS for approval. Refer to the CHP contract for more information.

4.04 Other Assets Report

Include all other assets (current and non-current) in the appropriate categories provided. List separately any asset related to lump-sum directed payments including APSI (CYE 20 forward), PSI, TI, and HEALTHII, any other individual assets greater than 10% of total other assets separately and list the total of others not individually greater than 10%. The ending balances for current assets should agree to A/C 10145-01 and non-current assets to A/C 10225-01 of the Balance Sheet.

4.05 Other Liabilities Report

Include all other liabilities (current and non-current) in the appropriate categories provided. List separately any liability related to lump-sum directed payments including APSI (CYE 20 forward), PSI, TI, and HEALTHII, any other individual liabilities greater than 10% of total

other liabilities separately and list the total of others not individually greater than 10%. The ending balances for current liabilities should agree to A/C 20145-01 and non-current liabilities to A/C 20215-01 of the Balance Sheet.

4.06 Alternative Payment Model Performance Based Payment Payable to Providers Report

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

4.07 Lag Report for Medical Claims Payable

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

The schedule is arranged with dates of service horizontally and quarter of payment vertically. Therefore, payments made during the current quarter for services rendered during the current quarter are reported on row 1, column 2, while payments made during the current quarter for services rendered in prior quarters are reported on row 1, columns 3 through 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/Other Than Funds) Report

List all loans, notes payable and capital lease obligations by lender as well as by current and long-term portions of outstanding principle at the end of the quarter (exclude debt to affiliates, this is to be reported on the Due (to) from Affiliates line/Due to Others). The totals should equal the amounts reported on the Balance Sheet – A/C's 20135-01 and 20205-01.

4.09 Analysis of Profitability by Risk Group Report³

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/Block Expenses Report

This report is a summary of sub-capitation expenses, by risk group, by individual expense line item by date of service. 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.

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

The portion of the sub-capitation payment that is explicitly attributable to the provision of administrative services or delegated managed care activities and associated reporting requirements by the provider should be excluded from the calculation of the MLR. Refer to account 81605-01 – Sub-Capitation Block Administration for additional information.

³ Not applicable to CMDP / CHP.

4.11 Block Purchases Expense Report

This report is a summary of block purchases expenses, by risk group and by individual expense line item. Only list amounts in this report for expenses that have block purchasing arrangements. This information assists in calculating any reconciliation and is used in capitation rate setting.

4.12 Prior Contract Year Adjustment Schedules

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

4.13 FQHC/RHC Member Months

List the quarterly member month information by category (i.e., Categorical by SSI, Categorical Linked Expansion, Federal Non-Categorical Linked Expansion, and Federal Non-Categorical Linked Conversion, SCHIP) for each FQHC/RHC. Effective October 1, 2009, Title XXI (Kids Care) member months **should** be reported in the appropriate column. Any member assigned to the FQHC/RHC on the 1st day of the month should be counted as one member month. Partial months will not be counted. Exclude State Only transplant member months. Please ensure to use the most current schedule Appendix E-9 and do not alter the current template.

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

4.14 Consolidated or Parent Company (if applicable) Financial Statements

Contactors that are a wholly owned subsidiary of another organization must submit quarterly unaudited financial information of the parent of sponsoring organization (balance sheet and state of revenues and expenses only).

4.15 Annual IBNR Actuarial Certification

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

4.16 Related Party Transaction Reports

Related Party Transaction statements must be submitted to AHCCCS 120 days after year-end. Refer to Appendix G. Refer to the AHCCCS website for links to the templates for these

reports

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

4.17 Audited Financial Statements and Annual Reconciliation

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

Any footnotes or supplemental schedules that are impacted by draft or final audit adjustments must be resubmitted to agree to the audited amounts in the draft and final audit and resubmitted with these reports. Refer to Appendix F for examples of the annual audit reconciliation reports.

4.18 Parent Company (if applicable) Annual Audit Report

Contractors that are wholly owned subsidiaries must submit audited financial statements of the parent or sponsoring organization no later than 120 days after the parent company's fiscal year end. The audited financial statements must be the complete financial statement package, including all footnote disclosures. For parent or sponsoring organizations that file with the Securities and Exchange Commission, the entire 10-K report is required.

4.19 Medical Loss Ratio Report

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

4.20 Contract Year Annual Supplement

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

5.00 ACCOUNTING AND REPORTING ISSUES

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

There are three primary components of claims expense:

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

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

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

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

Elements of an IBNR System

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

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

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

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

1. The individual IBNR amounts, once established, should be monitored for adequacy, and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine a Contractor's IBNR methodology if applicable.

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

Case Basis Method

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

Average Cost Method

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

Per Member Per Month (PMPM) Averages

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

Per Diem or Per Service Averages

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

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

5.02 Reinsurance

Reinsurance provides reimbursement to the Contractors when extraordinary costs associated with a member are incurred during a contract year. Specific deductible amounts and reimbursement rates are in the AHCCCS Complete Care Contract and the CMDP Contract between AHCCCS and the Contractor. Reinsurance receivable should include all expected reinsurance from AHCCCS, billed and unbilled.

5.03 Related Parties/Affiliates

AHCCCS monitors the existence of related party transactions in order to determine if any significant conflicts of interest exist in the Contractor's ability to meet AHCCCS objectives. A related party or affiliate may be defined as anyone who has the power to control or significantly influence the Contractor or be controlled or significantly influenced by the Contractor. Accordingly, subsidiaries, parent companies, sister companies, and entities accounted for by the equity method are considered related parties, as are principal owners, Board of Director members, management, and their immediate families, and other entities controlled or managed by any of the previously listed entities or persons, including management companies. Related party transactions include all transactions between the Contractor and such related parties, regardless of whether they are conducted in an arm's

length manner or are not reflected in the accounting records (e.g., the provision of services without charge or guarantees of outstanding debt).

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 Report⁴

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

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

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

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

FINANCIAL VIABILITY STANDARDS

Current Ratio Current assets less due from affiliates divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 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

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

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 1st 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 \$250 per member for CYE 2021 Additional information regarding the Equity per Member requirement may be found in the ACOM policy 305.

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

Contract YTD Administrative Cost Percentage

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

Standard: No more than 10%

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

Medical Loss Ratio

The Medical Loss Ratio (MLR) numerator includes Incurred Claims and Expenditures for activities that improve Health Care Quality. The denominator is Premium revenue less Taxes and licensing and regulatory fees. A credibility adjustment is added, when applicable, to the overall calculation. AHCCCS requires performance of the MLR calculation quarterly for monitoring of financial viability using the MLR template included in the financial statement package. For additional instructions, refer to *Appendix*

J. The Contractor shall provide the required information as outlined in Attachment F 3 of its Contract with AHCCCS.

Standard: At least 85%

When calculated on a contract year end basis

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

Annual Medical Loss Ratio Report – The Medical Loss Ratio (MLR) calculation shall be performed annually in accordance with 42 C.F.R 438.8 (refer to Appendix H for the Annual Medical Loss Ratio Reporting Template, Attestation and Instructions). This report is due April 1st following the contract year end. Any retroactive changes to capitation rates after the contract year end will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to AHCCCS, a new report incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment by AHCCCS.

Beginning 10/01/2020, an Independent Auditor's Attestation is required for the Annual MLR report on a CYE basis every three years as required by CMS as part of the draft and final audit. As part of the draft and final audit package submission, the audited prior-contract year CYE 20 Annual MLR report with audit adjustments is required. For example, if the Contractor's fiscal year-end is December 31, 2020, the Annual MLR report with audit adjustments for contract year-ending September 30, 2020 would be required. If the Contractor's fiscal year-end is June 30, 2021, the Annual MLR report with audit adjustments for contract year-ending September 30, 2020 would be required. For any Contractor with a fiscal year-end that aligns with the contract year, the audit performed at September 30, 2020 will include an Independent Auditor's Attestation for the Annual MLR at September 30, 2020.

5.05 Community Reinvestment

Contractors are required to allocate six percent (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 990105-01 Community Reinvestment. Report the liability in account 20145-01 and disclose by contract year-end on the Other Liabilities Report. Community Reinvestment can be accrued for on a quarterly basis if the Contractor can reasonably estimate the amount to be allocated. Community Reinvestment accrued and recorded in one fiscal year, would become a balance sheet only transaction when paid out in subsequent years.

The Community Reinvestment Calculation tab of the Financial Reporting Template is required as part of the Contractor's Draft Audit and should include audit adjustments completed for the current fiscal year, as well as the prior fiscal year, if applicable, in order to properly calculate the contract year-end profit subject to the 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 period. 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 commitment in a previous year, indicate this on the Community Reinvestment Report under the Commitment Year Column.

5.06 Pharmacy Benefit Manager (PBM)

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

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

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

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

Pharmacy Rebates

If a Contractor has a contractual arrangement where the PBM is retaining pharmacy rebates or other items of value in lieu of charging a separate administrative fee, then the amount of the rebates retained would need to be treated as a reduction to incurred expenses/pharmacy expenditures for MLR reporting purposes. The retained rebates or other items of value should be considered administrative costs of the Contractor (assuming the PBM would

assess explicit charges to the Contractor in the absence of the retention of rebates or other items) and recorded in account 81305-01 – Pharmacy Benefit Manager Expenses.

6.00 APPENDICES

Appendix A: Certification Statement

Appendix B: Financial Statement Reporting Template Instructions and Audit Report

Appendix C: Financial Statements

Appendix D: Financial Statement Footnote Disclosures

Appendix E: Supplemental Reports

Appendix F: Audit Reconciliation Report

Appendix G: Supplemental Report: Related Party Transactions

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

Appendix I: Supplemental Report: Community Reinvestment Activities Report - Annual Financial Reporting Template:

Appendix J: Contract Year Annual Supplement