



## **FINANCIAL REPORTING GUIDE FOR RBHA CONTRACTORS**

**Effective Date October 1, 2020**



## TABLE OF CONTENTS

<b>ACRONYMS</b> .....	<b>4</b>
<b>DEFINITIONS</b> .....	<b>7</b>
<b>1.00 GENERAL INFORMATION</b> .....	<b>14</b>
1.01 PURPOSE AND OBJECTIVE OF THE GUIDE .....	14
1.02 EFFECTIVE DATES AND REPORTING TIME FRAMES .....	15
1.03 SANCTIONS .....	16
<b>2.00 FINANCIAL REPORTING REQUIREMENTS</b> .....	<b>16</b>
<b>3.00 INSTRUCTIONS FOR COMPLETION OF QUARTERLY AND ANNUAL REPORTING FORMS</b> .....	<b>20</b>
3.01 GENERAL INSTRUCTIONS .....	20
3.02 CERTIFICATION STATEMENT .....	21
3.03 FINANCIAL STATEMENT REPORTING TEMPLATE AUDIT REPORT .....	21
3.04 BALANCE SHEET .....	22
3.05 STATEMENT OF ACTIVITIES.....	29
3.06 FOOTNOTE DISCLOSURE REQUIREMENTS.....	44
<b>4.00 SUPPLEMENTAL REPORTS</b> .....	<b>50</b>
4.01 FINANCIAL VIABILITY.....	50
4.02 CAPITATION AND NON-TITLE XIX/XXI FUNDING RECEIVABLES .....	50
4.03 RECEIVABLES/PAYABLES REPORT .....	50
4.04 OTHER ASSETS REPORT .....	51
4.05 OTHER LIABILITIES REPORT .....	51
4.06 ALTERNATIVE PAYMENT MODEL PERFORMANCE BASED PAYMENTS PAYABLE TO .....	51
PROVIDERS REPORT.....	51
4.07 TITLE XIX/XXI AND NON-TITLE XIX/XXI LAG REPORTS .....	52
4.08 LONG-TERM DEBT (OTHER THAN AFFILIATES) REPORT .....	52
4.09 GRANT DISCLOSURES .....	53
4.10 BH AND PH SUB-CAPITATED EXPENSE REPORTS .....	53
4.11 BH AND PH BLOCK PURCHASES EXPENSE REPORT .....	54
4.12 PRIOR CONTRACT YEAR ADJUSTMENT SCHEDULES .....	54
4.13 FQHC/RHC MEMBER MONTHS .....	54
4.14 CONSOLIDATED OR PARENT COMPANY, IF APPLICABLE, FINANCIAL STATEMENTS.....	55
4.15 ANNUAL IBNR ACTUARIAL CERTIFICATION .....	55
4.16 RELATED PARTY TRANSACTION REPORTS .....	55
4.17 AUDITED FINANCIAL STATEMENTS AND ANNUAL RECONCILIATION .....	56
4.18 PARENT COMPANY, IF APPLICABLE, ANNUAL AUDIT REPORT .....	56
4.19 MEDICAL LOSS RATIO REPORT.....	56
4.20 CONTRACT YEAR ANNUAL SUPPLEMENT .....	56
<b>5.00 ACCOUNTING AND REPORTING ISSUES</b> .....	<b>57</b>
5.01 MEDICAL CLAIMS LIABILITY (INCLUDING CLAIM ESTIMATIONS RBUCs AND IBNRs) .....	57
5.02 REINSURANCE.....	59
5.03 RELATED PARTIES/AFFILIATES .....	60

5.04 FINANCIAL VIABILITY STANDARDS AND PERFORMANCE GUIDELINES REPORT .....	60
5.05 BLOCK PAYMENT ARRANGEMENTS .....	63
5.06 STATE GENERAL FUNDS .....	64
5.07 NON-TITLE CRISIS, SMI AND HOUSING .....	64
5.08 ENCOUNTER REPORTING REQUIREMENTS .....	65
5.09 BLOCK GRANTS AND OTHER FEDERAL GRANTS .....	67
5.10 COST ALLOCATION PLAN .....	69
5.11 COMMUNITY REINVESTMENT .....	69
5.12 DEFERRED REVENUE .....	70
5.13 BEHAVIORAL HEALTH PPC EXPENSES .....	70
5.14 PHARMACY BENEFIT MANAGER .....	71
<b>6.00 APPENDICES .....</b>	<b>72</b>
<b>7.00 EXHIBITS .....</b>	<b>73</b>

## ACRONYMS

ACA	Affordable Care Act
ACC	AHCCCS Complete Care
ACOM	AHCCCS Contractor Operations Manual
AHCCCS	Arizona Health Care Cost Containment System
AICPA	American Institute of Certified Public Accountants
AIHP	American Indian Health Program
ALTCS	Arizona Long Term Care System
AMPM	AHCCCS Medical Policy Manual
APM	Alternative Payment Model
APSI	Access to Professional Services Initiatives
A. R. S.	Arizona Revised Statutes
ASC	Accounting Standards Codification
BH	Behavioral Health
CER	Contractor Expenditure Report
CFR	Code of Federal Regulations
CMS	Center for Medicare and Medicaid Services
CRI	Community Reinvestment
DCS	Department of Child Safety
DHCM	Division of Healthcare Management
DHHS	Department of Health and Human Services
DIFI	Department of Insurance and Financial Institutions
D-SNP	Dual Eligible Special Needs Plan

FAC	Federal Audit Clearinghouse
FAQs	Frequently Asked Questions
FASB	Financial Accounting Standards Board
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC/RHC	Federally Qualified Healthcare Centers/Rural Healthcare Clinics
FQHC/RHC LA	Federally Qualified Healthcare Centers/Rural Healthcare Clinic Look-Alike
GAAP	Generally Accepted Accounting Principles
GAGAS	Generally Accepted Governmental Auditing Standards
HCSO	Health Care Service Organization
HEALTHII	Health Enhanced Access Leading to Health Improvements Initiative
IBNR	Incurred But Not Reported
ICD	International Classification of Diseases
MAO	Medicare Advantage Organization
MHBG	Mental Health Block Grant
MLR	Medical Loss Ratio
PBM	Pharmacy Benefit Manager
PCP	Primary Care Physician
PH	Physical Health
PL	Public Law
PPC	Prior Period Coverage
PPS	Prospective Payment System
PSI	Pediatric Services Initiative

RBUC	Reported But Unpaid Claim
RTC	Residential Treatment Center
SABG	Substance Abuse Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SUD	Substance Use Disorder
SFAS	FASB Statement of Financial Accounting Standards
SMI	Seriously Mental Ill
TI	Targeted Investments

## **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 BH provider-delivered case management, or integrated health care services.

### **AFFILIATE**

Refer to Related Party Transactions definition.

### **AHCCCS**

AHCCCS is Arizona's Medicaid program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.

### **AHCCCS CONTRACTOR OPERATIONS MANUAL**

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

### **ALTERNATIVE PAYMENT MODEL (APM)**

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 in advance per eligible member, for which the provider 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 1020.

**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.

**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.

**CONTRACT YEAR**

The period from October 1 through September 30.

**COST SHARING**

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

**DAY**

Calendar day unless otherwise specified.

**DURABLE MEDICAL EQUIPMENT**

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



**EMERGENCY MEDICAL CONDITION**

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

**EMERGENCY SERVICES**

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

**ENROLLMENT**

The process by which an eligible person becomes a member of the 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 1905(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.

**FEDERALLY QUALIFIED HEALTH CENTER/REGIONAL HEALTH CENTER VISIT**

A 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.

**FEE-FOR-SERVICE**

A method of payment to registered providers on an amount per service basis.

## **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 a Title XIX/XXI 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**

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 the 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.

**NON-FEDERAL ENTITY**

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

**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**

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 (usually the first day of the month of application) to the date the member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1.

**PROVIDER**

A person or entity that contracts with a Contractor to provide covered services directly 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.

**RATE CODE**

Eligibility classification for capitation payment purposes.

**RECEIVED BUT UNPAID CLAIMS**

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 FISCAL YEAR**

The period from July 1 through June 30.

**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 the 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.

**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 RBHA Contractors (Guide) is to set the periodic financial reporting requirements for the contracted RBHAs (hereafter referred to as Contractors). The primary objectives of the reporting guide are to establish consistency and uniformity in financial reporting and to provide guidelines to assist the Contractor in meeting contractual reporting requirements. 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 by the applicable Contractor's 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 to be used to satisfy the financial reporting requirements as well as guidelines and minimum reporting requirements for the annual audited financial statements. This guide is intended to outline these requirements and also provide examples of required reports in the Appendices to the guide and CUBE Flat File necessary for submission.

Contractors are required to contract with CMS for a Medicare Advantage D-SNP (companion D-SNP) or offer a D-SNP through one of the equity partners (equity D-SNP) in the organization. Refer to ACOM 107 for requirements to operate as a D-SNP.

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

If the Contractor is a Medicare Advantage Plan licensed through the Arizona DIFI or contracts with an equity D-SNP plan that is licensed through DIFI, quarterly reporting to AHCCCS is required for informational purposes only. If the Contractor contracts with an equity D-SNP plan certified by AHCCCS or establishes a D-SNP plan certified by AHCCCS, the D-SNP plan 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 template 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.

RBHA quarterly reporting is due within 45 days of each quarter end, using the most recent AHCCCS Reporting Template and CUBE Flat File.

A draft of the annual audited financial statements, supplemental schedules, and annual reconciliation are due within 90 days of 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 representation letter, management letter to the board of directors and all other annual financial reports are due within 120 days of 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 applicable Financial Consultant. Requests must be received at least 5 business days prior to AHCCCS' due date and must include the reason for the extension and the revised filing 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. In addition, Contractors are subjected to monetary penalties if for misrepresentation or falsification of information furnished to CMS or AHCCCS. 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, then disclose on the Statement of Activities Schedule A Disclosure.

## **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 Financial Reporting (Only if requested by AHCCCS)	Quarterly/ Annual Financial Reporting	Draft Audit Financial Reporting	Final Audit Financial Reporting	ACOM 323 Financial Reporting
Due Date: _____ →	30 days after month end	45 days after quarter end	90 days after Contractor's fiscal year end	120 days after Contractor's fiscal year end	30 days after Final Audit Submission
Certification Statement	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
Financial Statement Template Audit Report	<b>X</b>	<b>X</b>			
Balance Sheet Report - Part A: Assets	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	
Balance Sheet Report - Part B: Liabilities & Equity	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	
Statement of Activities	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	
Annual Contract Year Statement of Activities (Title and Non-Title XIX/XXI) Audited by Program and Schedule A Disclosure (include in Audit Report and provide excel version using reporting template format)			<b>X</b>	<b>X</b>	
SFYTD Non-Title XIX/XXI Statement of Activities and Schedule A Disclosure (due 30 days after January, February, April and May month end; and 45 days after December, March and June quarter end)	<b>X</b>	<b>X</b>			
Annual Non-Title XIX/XXI SFY Statement of Activities and Schedule A Disclosure by Program (only applicable if NTXIX adjustments are made during the audit process. Otherwise, the June report will be considered to be the final SFY report)			<b>X</b>	<b>X</b>	<b>X</b>
SFYTD Non-Title XIX/XXI Revenue Reconciliation	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
SFYTD Non-Title XIX/XXI Allocation Tracking	<b>X</b>	<b>X</b>			
Title XIX/XXI Statement of Activities Quarterly Summary (Contract Year basis)	<b>X</b>	<b>X</b>	*	*	
Non-Title XIX/XXI Statement of Activities Quarterly Summary (State Fiscal Year basis)	<b>X</b>	<b>X</b>	*	*	

Footnote Disclosure Requirements (AHCCCS format for Excel reporting templates or GAAP/GAGAS format for audit reports)	X	X	X	X	
Non-Title XIX/XXI Profit Limit Template as of June 30	X	X			
Final Non-Title XIX/XXI Profit Limit Template (if applicable. Only required if changes are made after the June QE submission)					X
Financial Viability	X	X	X	X	
Receivables/Payables Report (includes 4.02 and 4.03)	X	X	*	*	
Payables to Providers Report	X	X	*	*	
Other Assets Report	X	X	*	*	
Other Liabilities Report	X	X	*	*	
Alternative Payment Model Report (by provider by year)	X	X	*	*	
Lag Reports – (TXIX and NTXIX)	X	X	*	*	
Long-term Debt Report (other than Affiliates)	X	X	*	*	
Sub-Capitated Expenses Report	X	X	*	*	
Sub-Capitated Expense Detail	X	X	*	*	
Block Purchase Expenses Report	X	X	*	*	
Block Purchase Expense Detail	X	X	*	*	
Sub-Capitated/Block Purchase Expense Detail by Risk Group on a Contract Year End Basis			X	X	
Prior CY Adjustment Schedules (Bal Sheet & Statement of Activities)	X	X	*	*	
FQHC/RHC Member Months Report (due 60 days after QE)					
Parent Company, if applicable, Financial Statements	X	X		X	
Independent Auditor's Report			X	X	
Single Audit Report			X	X	
Statement of Cash Flows (if required by GAAP/GAGAS)			X	X	
Management Letter				X	
Management Representation Letter				X	
Annual Reconciliation			X	X	
Independent Auditor's Attestation of Sub-Capitated and Block Expenses Report by risk group on a Contract Year End basis			X	X	

Independent Auditor's Attestation of Annual Medical Loss Ratio on a Contract Year End basis (required every 3 years)			X	X	
Annual IBNR Actuarial Certification				X	
Related Party Transactions				X	
Community Reinvestment Calculation			X	X	
Medical Loss Ratio	X	X	X	X	
Contract Year Annual Supplement		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 FORMS**

### **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 SharePoint using the most recent Financial Statement Reporting Template provided by the DHCM Finance. The Financial Statement Reporting Template consists of a quarterly template, to be used for the first three quarters of the Contractor's fiscal year; and an annual template, that is to be used for the Contractor's fourth 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 Financial Reporting Template in MS Excel including all supplemental schedules. The Certification Statement 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 Statement 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 Contractor 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 completed 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 GAGAS. 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 the review of AHCCCS' financial requirements. Contractors should review the Sarbanes-Oxley Act and consider applying the best practices contained within the Act; including rotating at least the lead and reviewing partners of the audit firm every five years.

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

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. An explanation of adjustments made for prior contract years are to be disclosed in the Prior Contract Year Footnote #21. Revisions to a prior period will invalidate the previously submitted report. If material revisions are submitted after the AHCCCS due date, then sanctions may be imposed for untimely or inaccurate reporting.

If there are insufficient instructions for a specific category, the Contractor shall request direction from the assigned AHCCCS DHCM Financial Consultant. A perceived lack of instruction is not sufficient grounds for failure to report accurately. AHCCCS has provided the required reporting formats to ensure consistent reporting among Contractors. It is the Contractor's responsibility to ensure that all reports submitted are accurate, complete and timely. Adherence to GAAP is the overriding responsibility of the Contractor. If there is a conflict between GAAP and these instructions, the Contractor should advise the assigned AHCCCS DHCM Financial Consultant of such conflict.

### **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 Certification should include the Contractor's name, quarter ended, preparer information, and Chief Executive Officer and Chief Financial Officer signatures, written or electronic. Refer to the Final Template, 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

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.

#### 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/Supplemental/Risk Adj Receivable

Include: Net amounts receivable from AHCCCS for capitation and Non-Title XIX/XXI funding as of the balance sheet date. Refer to Capitation and Non-Title XIX/XXI Funding Receivable Report (Paragraph 4.02) for required detail of this line item. Also include the Health Insurance Provider Fee revenues in this line.

#### A/C 10120-01 Reinsurance Receivable

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

A/C 10125-01 Reconciliation/Settlement Receivable

Include: Amounts receivable from AHCCCS for Title XIX/XXI Reconciliations/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) for account 10125-01. This also includes provider incentive payments reimbursed by AHCCCS. In addition, any settlement amounts due from AHCCCS relating to alternative payment model and APSI (CYE 2019) should be recorded in this account.

Exclude: Amounts **due from providers** relating to Alternative Payment Model initiatives and PBP amounts related to MAO Agreements. Also exclude amounts due from AHCCCS for lump-sum directed payments including APSI (CYE 2020 forward), PSI, TI and HEALTHII. Refer to account 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 for the same Affiliate. 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, block payment 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 arrangements 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 amount receivable from AHCCCS related to lump-sum directed payments including APSI (CYE 2020 forward), PSI, TI and HEALTHII not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for in this line item and should not be netted against the 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: Unrestricted 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, block payment 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/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 behavioral and physical 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 (e.g., 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, block payments, and other non-FFS payment arrangements payments (pharmacy should be included in IBNR).

Exclude: Capitation amounts payable to AHCCCS as a result of an overpayment. (This amount should be reported in A/C 20145-01 - 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 Reconciliation/Settlement Payable

Include: Amounts payable to AHCCCS for Title XIX/XXI Reconciliations/Settlements, Non-Title XIX/XXI Profit Limit and General Fund profits. This should equal the sum of all payable amounts detailed on the Receivables/Payables Report for account 20125-01 (Paragraph 4.03). In addition, any amounts **due to AHCCCS** relating to alternative payment model initiatives and APSI (CYE 2019) should be recorded in this account.

Exclude: Amounts **due to providers** relating to Alternative Payment Model initiatives and PBP amounts related to MAO Agreements. Also exclude amounts due to AHCCCS for lump-sum directed payments including APSI (CYE 2020 forward), PSI, TI and HEALTHII. Refer to account 20140-01 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 arrangements.

A/C 20135-01 Current Portion - 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 expected to be paid within one year of the balance sheet date. Note only the net amount is reported. Therefore, there should not be a Due from and a Due to Affiliates concurrently. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to affiliate amounts should be described in the notes to the financial statements. Refer to Paragraph 3.06 - #10.

Exclude: Amounts Due to Affiliates resulting from medical claims payable, capitation payable, block payment payable or other medical expense related items and non-current amounts Due to Affiliates.

A/C 20145-01 Other Current Liabilities

Include: The total current portion from the detail listed in the Other Liabilities Report, which will include those current liabilities not specifically identified elsewhere (e.g., deferred revenue, income taxes payable, APSI (CYE 2020 forward), PSI, TI and HEALTHII). Label each item as due to AHCCCS or due to Provider and include the applicable contract year/state fiscal year. Refer to Other Liabilities Report, Paragraph 4.05. Also include the current portion of the Health Insurance Provider Fee liability in this line.

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

A/C 20205-01 Non-Current Portion of Long-term Debt

Include: The total non-current portion from the detail listed in the Long-term Debt report which will include the long-term portion of principal on loans, notes, and capital lease obligations. 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 not expected to be paid within one year of the balance sheet date. Note that only the net amount is reported. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to Affiliate amounts should be described in the notes to the financial statements. Refer to Paragraph 3.06 - #10.

Exclude: Amounts due to affiliates resulting from medical claims payable, capitation payable, block payment 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. Refer to Other Liabilities Report (Paragraph 4.05) for required detail of this line item. Label each item as due to AHCCCS or due to Provider and the applicable contract year/state fiscal year. Also include the non-current portion of the Health Insurance Provider Fee liability in this line.

**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 value.

A/C 30115-01 Treasury Stock

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

A/C 30120-01 Additional Paid-in Capital

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

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

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

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

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

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

### 3.05 Statement of Activities

The Statement of Activities encompasses revenue and expenses for Title XIX/XXI, Non-Title XIX/XXI, Federal and County programs for the applicable quarter. The intent of the statement is to capture the revenue of the Contractor and to match that revenue with related expenses by each funding program. Any expense allocation shall be made in a consistent manner and shall be in compliance with the cost allocation plan (refer to paragraph 5.10).

Prospective and PPC member months should be obtained from the BHS Weekly 820 files.

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

Revenue is to be calculated and accrued as follows:

- a. Title XIX/XXI revenue should be accrued using the projected number of eligible members provided by AHCCCS multiplied by the approved capitation rates currently being paid, unless the most recent proposed capitation rates were already approved and are awaiting payment. Any deviations from the above must be pre-approved in writing.
- b. Non-Title XIX/XXI revenue is to be accrued on a state fiscal year basis using 1/12<sup>th</sup> of the annual allocation (or 1/9<sup>th</sup> of the allocation, if applicable) as reported on the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current. Revisions to the allocation may occur throughout the year, but until the Contractor is notified in writing of any changes, the amount reported on the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current, is the best and most probable estimate of what AHCCCS will pay out. Prior written approval must be obtained from AHCCCS for any deviations from the AHCCCS Allocation Schedule or AHCCCS Payment Report, whichever is the most current.
- c. Other revenue sources should be accrued in accordance with GAAP (e.g. CERs and revenue sources other than AHCCCS).

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

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

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

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

Refer to Appendix C-2 and C-2a for an example of the Statement of Activities and Schedule A Disclosure. For revenue and expense lines with an asterisk after the title, Contractors are required to disclose the details on the Statement of Activities, Schedule A Disclosure.

A SFYTD Non-Title XIX/XXI Statement of Activities and Schedule A Disclosure C-3 and C-3a are due monthly 30 days after the following month-ends: January, February, April and May. In addition, the SFYTD Non-Title XIX/XXI Statement of Activities and Schedule A Disclosure C-3 and C-3a are required to be updated in the December, March and June quarter end financial reporting packages. Also, the SFYTD Non-Title XIX/XXI Revenue Reconciliation tab is required to be updated each quarter. Refer to Appendix C-3b for an example of this report.

The Non-Title XIX/XXI Allocation Tracking tab shall also be updated during QE March and QE June on a SFYTD basis. Refer to Appendix C-3c for an example of this report.

Contractors are also required to complete the Title XIX/XXI and Non-Title XIX/XXI Statement of Activities YTD Summaries on a quarterly basis. The Title XIX/XXI Summary should be completed on a contract year basis and Non-Title XIX/XXI on a state fiscal year basis. Refer to Appendix C-2b and C-2c for examples of these reports.

Title XIX/XXI includes the following programs: CMDP Child, SMI, Other Adult (Crisis) and Other Child (Crisis). Please note that CMDP Child will be transferring from RBHA effective April 1, 2021 and their name will change to Comprehensive Health Plan.

Non-Title XIX/XXI includes the following programs: Crisis, SMI Services, SMI Housing, Supported Housing, Housing Trust Fund, MHBG SED, MHBG SMI, MHBG FEP, SABG, Other Federal, County and Other.

## **REVENUE**

### **A/C 40105-01 Capitation**

Include: Revenue recognized on a prepaid basis from AHCCCS for provision of behavioral and physical health care services for AHCCCS eligible members. Also, include revenue received for the provision of Premium Taxes.

A/C 40115-01 Alternative Payment Model Initiatives Reconciliation/Settlement

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

A/C 40135-01 Title XIX/XXI Reconciliation Settlement

Include: Title XIX/XXI reconciliation settlement amounts as defined by ACOM 323. Estimated reconciliation settlement amounts should be accrued in the period they are earned. Any adjustments to prior contract years need to be disclosed on the Prior Contract Year Adjustment Report. Refer to Prior Contract Year Adjustment Report (Paragraph 4.12) for the required detail on this item. Also, in the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements (Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

A/C 40145-01 Other Reconciliation Settlements

Include: BH PPC Reconciliation and any other reconciliation settlement not reported in a/c 40135-01.

Exclude: Title XIX/XXI Reconciliations as defined by ACOM 323.

A/C 40160-01 Health Insurance Provider Fee Revenue

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

A/C 40205-01 Non-Title XIX/XXI Revenue

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

A/C 40210-01 Specialty and Other Grants Revenue

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

A/C 40215-01 Non-Title XIX/XXI Profit Limit

Include: Non-Title XIX/XXI Profit Limit amounts due to AHCCCS. Estimated amounts should be accrued in the period that they are earned. In the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements

(Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

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; and as directed by AHCCCS, revenue not subject to performance ratio calculations.

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

**Behavioral Health Medical Expenses**

A/C 60105-xx Treatment Services

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

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

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

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



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

Exclude: For Title XIX/XXI, exclude treatment services provided by qualified traditional healers for mental health or substance use problems. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability.

Also, for Title XIX/XXI, exclude Auricular Acupuncture services provided by a certified acupuncturist practitioner pursuant to: A.R.S. 32-3922 of auricular acupuncture needles to the pinna, lobe or auditory meatus to treat alcoholism, substance abuse or chemical dependency.

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

A/C 60205-xx Rehabilitation Services

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

A/C 60305-xx Medical Services

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

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

A/C 60405-xx Support Services

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

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

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

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

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

#### A/C 60505-xx Crisis Intervention Services

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

For crisis services provided within the first 24 hours at a stabilization unit and for procedure codes other than S9484 and S9485, footnote these crisis service expenses. Provide the expense amount on a CYTD basis by crisis procedure code in footnote #20. If this does not apply, indicate that the only crisis services provided were billed using S9484 and S9485.

#### A/C 60605-xx Inpatient Services

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

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

A/C 60705-xx Residential Services

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

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

A/C 60805-xx Behavioral Health Day Program

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

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

A/C 60905-xx Prevention Services

Include: Prevention and HIV services promote the health of persons, families, and communities through education, engagement, service provision and outreach. Report these services on the applicable expense line. These services are only allowed with SABG funding. Effective July 1, 2021, prevention services will no longer be contracted through the RBHAs.

A/C 61005-01 BH Pharmacy Expenses

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

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

A/C 61100-01 PPC BH Title XIX

Include: PPC expenses resulting from when a Non-Title XIX GMH/SU and CMDP (beginning 4/1/2021) and non-CMDP child member retroactively becomes eligible for Medicaid. This line should be reported under Other Title XIX/XXI Children (Crisis) and Other Title XIX/XXI Adult (Crisis) columns only.

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

A/C 61105-01 Other Services Not Reported Above

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

A/C 61205-01 BH FQHC/RHC Services

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

A/C 61305-01 Specialty and Other Grant Expenses

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

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 third party liability revenue account as a contra-expense account.**

A/C 70305-01 Claim Overpayment Recoveries

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

A/C 70310-05 Pharmacy Rebates

Include: Pharmacy rebates received related to BH and PH outpatient services. 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 BH and PH Pharmacy Performance Guarantees. Report any payments from the Pharmacy Benefit Manager to the Contractor as the result of a performance guarantee.

**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.

**Physical Health Medical Expenses**

**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.

Exclude: Expenses where behavioral health is the principle diagnosis as per ACOM 432.

A/C 50110-01 Behavioral Health Hospital Inpatient

Include: All contracted or fee for service expenses for hospital inpatient services, including room, board, and ancillary expenses where behavioral health is the principle diagnosis as per ACOM 432. Hospital inpatient expenses related to SMI Integrated members should be reported in A/C 50105-01.

Exclude: Expenses where behavioral health is not the principle diagnosis.

**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/C 50205-01 Primary Care Physician Services

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

A/C 50210-01 Behavioral Health Physician Services

Include: Those expenses for physician services related to Behavioral Health services as per ACOM 432. PCP expenses related to SMI Integrated members should be reported in A/C 50205-01.

A/C 50215-01 Referral Physician Services

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

A/C 50220-01 PH FQHC/RHC Services

Include: PH 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 PH outpatient services. These are amounts paid to the retail or mail-order pharmacy for drug ingredient costs and dispensing fees. Refer to discussion of PBM in Paragraph 5.14.

Exclude: Pharmacy expenses incurred for dental, BH and PBM non-encounterable components.

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 50215-01 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: PBP expenses (disbursements/recoupments to/from providers) related to the Alternative Payment Model (APM) 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 10140-01, A/C 20130-01, and/or A/C 20215-01.

Exclude: BH APM expenses for Performance Based Payments to Providers.

A/C 50370-01 Other Medical Expenses

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

**Administrative Expenses** are those costs associated with the overall management and operations of the Contractor. All administrative expenses must be allowable, reasonable and appropriately reported by funding source/risk group in the pre-defined administrative expense lines. Management fees must be separately identified and reported in the pre-defined administrative expense lines as well. In addition, management fees may not be increased without prior written approval from AHCCCS. Expenses related to the pre-defined administrative expense lines should not be reported under A/C 83005-01, Other Administrative Expenses. **All** administrative expenses **not** related to the pre-defined administrative expense lines should be individually reported in A/C 83005-01, Other Administrative Expenses. Separately report each expense.

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 RBHA or 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 83005-01, 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 5.14.

A/C 81405-01 Fraud Reduction Expenses

Include: Expenses related to fraud reduction activities.

A/C 81505-01 Third Party Activities

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

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

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

*A/C 81705-01 Health Care Quality Improvement*

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

*A/C 82505-01 Interpretation/Translation Services*

Include: Interpretation, sign language or translation services.

In accordance with the Fee-For-Service Provider Billing Manual Non-Title XIX/XXI Services Exhibit 19-1, sign language and oral interpretive services are services provided to a person and/or their family with limited English proficiency or other communication barriers (i.e. sight or sound) when a healthcare provider is delivering instructions on how to access services, providing counseling, and/or during treatment activities that will ensure appropriate delivery of mental health services. For MCO

enrolled members, providers shall submit claims for T1013 to the members health plan, which shall reimburse the provider through administrative funds.

Title XIX/XXI Interpretation, sign language or translation services shall be paid with Title XIX/XXI administrative funding and Non-Title XIX/XXI Interpretation, sign language or translation services shall be paid with Non-Title XIX/XXI administrative funding.

A/C 83005-01 Other Administrative Expenses

Include: Administrative expenses not specifically identified in the categories above including but not limited to sanctions.

Exclude: Sanctions assessed annually by DHCM Finance as a result of the Encounter Valuation Report.

A/C 83105-01 Encounter Valuation Sanctions

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

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

A/C 83205-01 Administrative Expense from Specialty and Other Grants

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

A/C 88999-01 Profit/(Loss) from Other, Non AHCCCS and Non-operating

Include: The net amount of any profit/(loss) from received from sources other than AHCCCS or that cannot be classified as Specialty and Other Grants, should be reported here. These amounts are not figured into the Performance Ratios, Title XIX/XXI Reconciliations and Non-Title XIX/XXI Profit Limit Analysis (e.g. Contractor assessed Sanctions).

A/C 90105-01 Income Taxes

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

A/C 90205-01 Premium Taxes

Include: Provision for premium taxes for the period.

A/C 90305-01 Health Insurance Provider Fee

Include: Provision for Health Insurance Provider Fee for the period. Expenses

should be allocated among the Title XIX/XXI programs based on previous year's revenue. In accordance with ASC 720-50-25-1, the liability related to the annual fee shall be estimated and recorded in full once the entity provides qualifying health insurance for health insurers in the applicable calendar year in which the fee is payable. The liability for the Health Insurance Provider Fee should be fully recognized by the end of the contract year. Therefore, Contractors should begin recognizing 1/9<sup>th</sup> of the liability in January. The Health Insurance Provider Fee reimbursement is only applicable to Title XIX/XXI programs.

Exclude: Taxes associated with the Health Insurance Provider Fee.

A/C 990105-01 Community Reinvestment

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-emergency dental for adults, non-emergency adult optometry, Non-Title XIX/XXI covered services where no other Non-Title XIX/XXI funding is available).

Exclude: Interpretive/sign language and Translation expenses. These are treated as administrative expenses and are reported in A/C 83005-01. Also exclude amounts for services covered by another Non-Title XIX/XXI funding source (e.g. room and board, housing, child care, acupuncture, traditional healing. These would be reported in the applicable Non-Title XIX/XXI funding columns).

### **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 should also be included. If the disclosure does not apply, indicate so by writing "None" or "Not Applicable (N/A)" next to the numbered footnote. Refer to Section 7.00 Exhibits for Sample Footnotes.

- 1) Organizational Structure:  
Discuss the organization structure, location of its headquarters, and a brief summary of the operations of the Contractor.

- 2) Summary of Significant Accounting Policies:  
Discuss accounting policies relating to significant balance sheet line items such as, but not limited to, cash and cash equivalents, investments and methodologies used for BH (Title XIX/XXI and Non-Title XIX/XXI) and PH medical claims payable.

On an annual basis with the quarter ending December submission, or in the event of a change, discuss the expense allocation methodology by program. Include the encounter timeframe used to allocate expenses.

Discuss revenue and expense recognition policies for the following:

- Capitation revenue, Non-Title XIX/XXI Revenue and Reconciliation Settlements
- Reinsurance revenue
- Other revenue
- Medical expenses
- Administrative Expenses
- Alternative Payment Model Initiatives
- Health Insurance Provider Fee and related Tax
- 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 amounts included in the "other" categories in the Balance Sheet and Statement of Activities.

- 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 greater than +/-5% of the Total Liabilities for that quarter or the previous quarter if the amount is equal to or greater than +/-

5%). Include discussions related to IBNR. Explanations should detail the amount of the adjustments by quarter and by category.

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 (Current and Non-Current):

Long-term investments that may be liquidated without significant penalty within 24 hours, which the Contractor would like treated as current assets for calculations of the current ratio, must be disclosed in the footnotes. Descriptions by asset type (equity securities, debt securities, etc.) and amounts should be disclosed and should include indication of whether or not the investments are restricted or unrestricted. (Note that significant penalty in this instance is any penalty greater than 20%.) 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 contract-year-to-date profit/(loss) incurred, unrelated to any prior year activity (even if within the profit corridor). The factors should be disclosed separately for Title XIX/XXI and Non-Title XIX/XXI.

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. It is only necessary to describe changes impacting Medical Claims Payable in footnote #7.

Title XIX/XXI Statement of Activities Summaries

Using the Title XIX/XXI Statement of Activities Summaries, describe changes in the Statement of Activities 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%.

For Revenue and Administrative Expenses, describe changes by **individual line item**.

The percentage change quarter over quarter for the Statement of Activities medical expense line items should be calculated using **categorical subtotals** (i.e., treatment services, rehabilitation services, medical services, support services, crisis services, inpatient services, residential services, behavioral health day program, prevention services, pharmacy, other services, BH FQHC/RHC, specialty and other grants, reinsurance, third party liability, claims overpayment recoveries, hospitalization, medical compensation, and other medical expenses) for Title XIX/XXI.

Provide the calculation for the quarter over quarter change by category and identify the primary reasons for the change by individual expense line items. If the primary driver is related to specific population(s), include that information in the explanation.

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.

When calculating the categorical 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 PBPs to Providers). Indicate the Administrative Income Statement line number and program in the financial statements where these are reported. Report influenza gift cards amounts expended in this footnote disclosure.
- 18) Reserved
- 19) Reserved
- 20) Additional Expense Explanations Requested by AHCCCS  
Use this footnote to disclose additional information as requested by AHCCCS during the contract year.
- a. Disclose the **SFYTD** total amount of County dollars expended on children. Of that amount, how much was expended on remanded juveniles by expense type.
  - b. Disclose the **SFYTD** amount expended on incarcerated adults and children justice programs by Non-Title XIX/XXI funding source.
  - c. On a contract year basis, how many expenditures and members were covered by Medicaid that had been previously covered through Non-Title XIX/XXI funding?
  - d. Disclose the Title XIX/XXI **CYTD** crisis expense amount provided within the first 24 hours at a stabilization unit for procedure codes other than S9484 and S9485. If this does not apply, indicate that the only crisis services provided were billed using S9484 and S9485.
  - e. Provide confirmation that case management services were not provided to CMDP members that are covered under the AHCCCS/DCS Interagency Service Agreement. Continue providing this confirmation until the BH portion has been transferred to CMDP. When the transfer occurs, RBHAs are no longer required to provide this confirmation.
  - f. Provide confirmation that Alcohol and/or drug services were not provided with NTXIX/XXI SMI, MHBG SMI and MHBG SED funding. These services are unallowable with these funding sources.
  - g. Provide confirmation that Multisystemic Therapy for Juveniles were not provided with NTXIX/XXI SMI and MHBG SMI funding. This service is unallowable with these funding sources.
  - h. Provide confirmation that Sponsorships for events and conferences were not provided with SABG and MHBG funding. Sponsorships are unallowable with these funding sources.



- i. Provide confirmation that Transcranial Magnetic Stimulation services were not provided with MHBG SED and SABG funding. This service is unallowable with these funding sources.
- j. For each separate funding source reported in the Non-Title XIX/XXI Other Column, provide the SFY Allocation and the total amount expended by service expense and admin expense.

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 the adjustment(s).

22) Reserved

23) Premium Deficiency Reserve ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

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

24) Social Risk Factors ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

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

Social Risk 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 Factors items, activities, or services should not be reported as medical services within the statement of revenues and expenditures but should instead be reported as non-covered services. Community Reinvestment expenditures spent on social risk factors should be included in this footnote only after it had been expended.

Z codes can be used to identify potential members for which social risk factors services may have been provided. Social Risk 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](https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/Exhibit_4-1SocialDeterminantsHealthICD-10List.pdf)

- 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 from the prior quarter. Also, disclose each individual administrative expense amount by the account number where Management Fees are reported.

## **4.00 SUPPLEMENTAL REPORTS**

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

### **4.01 Financial Viability**

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

### **4.02 Capitation and Non-Title XIX/XXI Funding Receivables**

List the amounts that are included in the Balance Sheet – A/C 10115-01. Amounts related to Capitation and Non-Title XIX/XXI should be detailed out by program and contract year or state fiscal year.

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

List each individual amount by funding source, program description, contract year or state fiscal year. Use the prepopulated reconciliation names provided in the template. The totals should agree with the Balance Sheet – A/C 10125-01 and A/C 20125-01.

#### 4.03.1 Payable to Providers Report

The Contractor shall promptly contract and distribute funds to subcontracted providers to avoid a build-up of payables toward the final quarters of the contract year. AHCCCS will monitor the flow of service dollars from the Contractor to its subcontracted providers to ensure service dollars are getting to the provider community timely so they can be appropriately encountered.

AHCCCS reserves the right to request additional detailed information regarding the subcontracted provider payables, payouts and reversal of accruals, as necessary.

A Payable to AHCCCS liability should be recorded for all non-contracted service funds received by the Contractor from AHCCCS but not distributed to providers. This excludes Medical Claims Payable, Alternative Payment Model Initiatives and payment timing delays. A Payable to Provider liability should be recorded for all contracted funds due to providers.

The Contractor shall not retain excess provider payable amounts that are not assigned by provider to pay out to providers after the contract year end. Funds may be recouped from under-performing providers and paid to providers who have over-encountered and are exceeding performance expectations. An Analysis/Itemization of Provider Payables by fiscal year, provider, contract type, amount, funding category and description must be submitted quarterly as a part of the Financial Reporting Package. For the NTXIX/XXI payables, the description must include the state fiscal year and funding source.

The Payable to Providers Report should tie to the Payable to Provider line under A/C 20115-01.

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

Include all other assets (current and non-current) in the appropriate categories provided. List all individual assets greater than 10% of total other assets separately and list the total of others not individually greater than 10%. The ending balances for current assets should agree to A/C 10145-01 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 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 Payments Payable to Providers Report**

List the amounts that are included in the Balance Sheet – A/C 10140-01 and A/C 20130-01 and A/C 20215-01. Information should be detailed by provider and by contract year. Exclude PBP amounts related to MAO Agreements.

#### **4.07 Title XIX/XXI and Non-Title XIX/XXI Lag Reports**

Lag Reports are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. If the Lag Report is not the primary methodology, the Contractor should use lag information as a validation test for accruals calculated using other methods. The instructions below apply to all Lag Schedules.

Each schedule is arranged with dates of service horizontally and quarter of payment vertically. Therefore, payments made during the current quarter for services rendered during the current quarter are reported on row 1, column 2, while payments made during the current quarter for services rendered in prior quarters are reported on row 1, columns 3 through 8. Do not include sub-capitation and block payments in this schedule. Pharmacy Expenses should be included in the Lag Schedules.

Title XIX/XXI BH and PH expenses reported in the current period on the Title XIX/XXI Lag Report should equal the Title XIX/XXI BH and PH expenses reported in the Statement of Activities less the Title XIX/XXI BH and PH expenses reported in the sub-capitated expense and block payment reports in total and less amounts reported under account 61105-01 for BH APM expenses and account 50350-01 Alternative Payment Model Performance Based Provider Payments.

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

There is a tie out test for each schedule that is required to be completed and net to zero prior to submission.

The schedule allows for the inclusion of an adjustment (e.g., for provider refunds, lag schedule adjustments) amount to the lag schedule. A general explanation of any adjustments should be included in the footnotes as well as additional detail if any adjustment is greater than 10% of total medical claims payable.

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

#### **4.08 Long-term Debt (Other than Affiliates) Report**

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

#### 4.09 Grant Disclosures

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

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

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

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

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

#### 4.10 BH and PH Sub-capitated Expense Reports

This report is a summary of sub-capitation expenses, by Title XIX/XXI program, by individual expense line item. Only list the accounts in this report that have sub-capitation expenses. Sub-capitated expenses **SHOULD NOT** be reported for Account 50350-01, Alternative Payment Model Performance Based Payments to Providers and Account 61105-01 for BH expenses. This information assists in calculating any reconciliation and is used in capitation rate setting.

An Independent Auditor's Attestation is required as a part of the draft and final annual audit for the BH and PH prior contract year sub-capitated/block expense reports by risk group, including any adjustments that occurred on a date of service basis. For example, if the Contractor's fiscal year-end is December 31, 2020, an attestation for the sub-capitated/block expense report by risk group with any adjustments on a date of service basis for contract year-ended September 30, 2020 would be required. In addition, if changes were made to 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 Title XIX/XXI RBHA 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 for delegated managed care activities and associated reporting requirements by the provider should be excluded from the calculation of the MLR Report. Refer to account 81605-01 Sub Capitation Block Administration for additional information.

#### **4.11 BH and PH Block Purchases Expense Report**

This report is a summary of block purchases expenses, by Title XIX/XXI program, by individual expense line item. Only list amounts in this report for expenses that have block purchasing arrangements.

Block purchase expenses SHOULD NOT be reported for Account 50350-01, Alternative Payment Model Performance Based Payments to Providers and Account 61105-01 for BH APM expenses. This information assists in calculating any reconciliation and is used in capitation rate setting.

An Independent Auditor's Attestation is required for the BH and PH Block purchases expenses report as a part of the draft and final annual audit.

#### **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. IBNR and Reinsurance adjustments need to be broken out on this schedule by AHCCCS contract year and Title XIX/XXI risk group, where applicable. The adjustments need to be broken out among previous AHCCCS contract years.

For prior period adjustments impacting TXIX GMH/SA, TXIX Child, DD Child and DD Adult, report these adjustments on the applicable service line in the Statement of Activities C-2, under the TXIX Other Child (Crisis) and TXIX Other Adult (Crisis) columns.

#### **4.13 FQHC/RHC Member Months**

For FQHC/RHC claims, Procedure code T1015 should be used for reporting physical health, behavioral health and dental visits for purposes of reimbursing PPS-eligible visits.

A claim for an FQHC, FQHC-LA or RHC visit must include all appropriate procedure codes describing the services rendered in addition to visit code T1015. A visit will be identified by, and reimbursement for the visit will be associated with, HCPCS code T1015; all other services reported on the claim will be bundled into the visit and valued at \$0.00.

BH FQHC/RHC expenses should be reported on line number 61205-01 of the Statement of Activities, and PH FQHC/RHC expenses on line 50220-01.

Contractors are required to report member month information by risk group for each FQHC/RHC where a SMI PCP assignment has been made for physical health. Any member assigned to the FQHC/RHC on the first 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. This report is due to AHCCCS 60 days after the quarter.

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

The rate code on the 834 AHCCCS eligibility loop should be used to identify the categories for reporting. Refer to Rate Codes To Be Included in Main Risk Groups Report using the following link:

<https://www.azahcccs.gov/PlansProviders/Downloads/CapitationRates/RiskPooltoEligibilityCategorytoRateCode.pdf>

#### **4.14 Consolidated or Parent Company, if applicable, Financial Statements**

Contactors that are a wholly owned subsidiary of another organization must submit quarterly unaudited financial information of the parent or sponsoring organization (balance sheet and statement of activities 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 contract year-end. Refer to the AHCCCS website for the template for this report:

<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. The reconciliation schedules must also be submitted with the final audited statements. No new account classifications should be added, refer to 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.

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

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

#### **4.18 Parent Company, if applicable, Annual Audit Report**

Contractors that are wholly owned subsidiaries must submit audited financial statements of the parent or sponsoring organization no later than 120 days after the parent company's fiscal year end.

#### **4.19 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 45 days after September 30. Submit the requested information using the Contract Year Annual Supplement Template saved on the 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 policy, practice, or coverage
- Fluctuations in enrollment by BH categories/rate code category
- Expected inflationary trends
- Trends in claims lag time
- Trends in the length of hospital inpatient stay by BH categories/rate code category
- Changes in BH categories/rate code case mix
- Changes in contractual agreements

#### Elements of an IBNR System

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

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

1. An IBNR system must function as part of the overall financial management and claims system. These systems combine to collect, analyze, and share claims data. They require effective referral, prior authorization, utilization review and discharge planning functions. Also, the Contractor must have a full accrual accounting system. Full accrual accounting systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to the Contractor's members.
2. An effective IBNR system requires the development of reliable lag tables that identify the length of time between provision of service, receipt of claims, and processing and payment of claims by major provider type (hospital, medical compensation and other medical). Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficient, accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification, on a proforma basis, to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e., paid claims).
3. Accurate, complete, and timely claims data should be monitored, collected, compiled, and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e., prior authorization records). Prior authorization data, together with claims data and other relevant information, should be used to identify claims liabilities.
4. Claims data should also be segregated to permit analysis by behavioral health/major rate code, county, major provider, and category of service.
5. Subcontract agreements should clearly state each party's responsibility for claims/encounter submission, prior notification, authorization, and reimbursement rates. These agreements should be in writing, clearly understood, and followed consistently by each party.
6. 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 methodology to determine BH and PH IBNR should also be included in the footnotes to the financial statements under Footnote #2.

#### 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.

## **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 RBHA TXIX/XXI Contract between AHCCCS and the RBHAs.

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

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

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

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

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

The Contractor must comply with the AHCCCS-established financial viability standards. This report is to be completed on a quarterly and annual basis to demonstrate adherence to these standards. AHCCCS will review the following ratios and performance guidelines with the purpose of monitoring the financial health of the Contractor: Current Ratio; Equity per Title XIX/XXI Member; Contract Year to Date Title XIX/XXI Medical Loss Ratio; Contract Year to Date Non-Title XIX/XXI Medical Expense Ratio; Contract Year to Date Title XIX/XXI Administrative Cost Percentage; Contract Year to Date Non-Title XIX/XXI Administrative Cost Percentage and Maintenance of Minimum Capitalization. On an annual basis, AHCCCS will review the Medical Loss Ratio.

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

The quarterly Financial Viability Reports and Medical Loss Ratio Reports are included in the Financial Reporting Template. On a quarterly basis, the Contractor's Current Ratio and Equity Per Member are calculated using the balances as of the quarter-end date. See below for information related to all financial viability standards.

## **FINANCIAL VIABILITY STANDARDS**

***Current Ratio*** Current assets less due from affiliates divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 24 hours without significant penalty (i.e., greater than 20%).

*Standard: At least 1.00*

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

***Equity per Title XIX/XXI 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 enrolled Title XIX/XXI members at the end of the period. The Contractor may request a waiver from AHCCCS to include the prorated portion of the due for affiliates balance resulting from cash/bank account sweep arrangements with other AHCCCS lines of business.

For this calculation use members as reported on the first day of the month following the end of the quarter (i.e. for quarter ending March 31, xx use April 1<sup>st</sup> enrollment) at the following link for SMI Integrated:

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

Use report titled Enrollment by Health Plan by County.

Use eligibility counts from the BHS Weekly 820 files using the monthly payment and including adjustments throughout the month (do not include the daily member month amounts).

*Greater Arizona Standard: At least \$1,200 per Title XIX/XXI member assigned to the Contractor eligible to receive behavioral health services only, and \$1,200 per Title XIX/XXI member enrolled with the Contractor for integrated SMI services.*

*Maricopa County Standard: At least \$1,300 per Title XIX/XXI member assigned to the Contractor eligible to receive behavioral health services only, and \$1,300 per Title XIX/XXI member enrolled with the Contractor for integrated SMI services.*

Additional information regarding the Equity per Title XIX/XXI Member requirement may be found in ACOM 305.

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

**State Fiscal YTD  
Non-Title  
XIX/XXI  
Medical Expense  
Ratio** Non-Title XIX/XXI Subtotal BH Medical Expenses divided by the sum of Non-Title XIX/XXI Revenue (line #40205-01) + Non-Title XIX/XXI Profit Limit (line #40215-01)

*Standard: At least 88.3%*

*When calculated on a state fiscal year-to-date basis*

**Contract YTD  
Title XIX/XXI  
Administrative  
Cost Percentage** Title XIX/XXI Subtotal Administrative Expenses divided by the sum of total [Capitation (line #40105-01), Alternative Payment Model Initiatives Reconciliation/Settlement (line #40115-01), Title XIX/XXI Reconciliation (line #40135-01), Other Reconciliation Settlements (line #40145-01)] less Reinsurance (line #70105-01) less Premium Tax (line 90205-01)

*Standard: No more than 10%*

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

**State fiscal YTD  
Non-Title  
XIX/XXI  
Administrative  
Cost Percentage** Non-Title XIX/XXI Subtotal Administrative Expenses divided by the sum of Non-Title XIX/XXI Revenue (line #40205-01) + Non-Title XIX/XXI Profit Limit (line #40215-01)

*Standard: No more than 8%*

*When calculated on a state fiscal year-to-date basis*

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

**Medical Loss  
Ratio** The MLR numerator includes Incurred Claims, Quality Improvement Expense and Expenditures for activities that improve Health Care Quality. The denominator is premium revenue less Taxes, licensing and regulatory Fees. A credibility adjustment is added when applicable to the overall calculation. AHCCCS requires performance of the MLR calculation quarterly for monitoring of financial viability

using the MLR template included in the financial statement package. For additional instructions refer to Appendix H. The Contractor shall provide the required information as outlined in Attachment F3 Contractor Chart of Deliverables 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 Financial Viability Greater Arizona (GA) F-1d tab or Financial Viability Maricopa County (MC) F-1d as applicable.

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

Beginning 10/1/2020, an Independent Auditor's Attestation is required for the Annual MLR report on a CYE basis every three years as required by CMS as part of the draft and final audit. As part of the draft and final audit package submission, the audited prior-contract year-to-date CYE 2020 Annual MLR report with audit adjustments is required. For example, if the Contractors fiscal year-end is December 31, 2020, the Annual MLR report with audit adjustments for contract year-ending September 30, 2020 would be required. If the Contractor's fiscal year-end is June 30, 2021, the Annual MLR Report with 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 the Annual MLR at September 30, 2020.

## **5.05 Block Payment Arrangements**

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

## **5.06 State General Funds**

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

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

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

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

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

## **5.07 Non-Title Crisis, SMI and Housing**

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



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

Funds allocated for Supported Housing, Housing Trust Fund and Non-Title XIX/XXI SMI Supported Housing must be spent in accordance with approved housing plans. Approval must be obtained from AHCCCS prior to deviating from approved plans. Should these funds have been expended for any purpose other than that outlined in the current year approved housing plan, these expenditures will need to be re-classified to a Non AHCCCS funding source or net assets as appropriate. Housing expenditures, with the exception of Bridge Subsidy, should be reported on the Statement of Activities, under the applicable program on line 60405-30 and disclosed on the Statement of Activities, Schedule A Disclosure accordingly using the drop down menu.

### **5.08 Encounter Reporting Requirements**

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

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

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

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

#### Non-Title XIX/XXI Encounter Valuation Report

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

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

#### Non-Title XIX/XXI Annual Encounter Valuation Sanction

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

For the Non-Title XIX/XXI annual encounter Valuation sanction, whether assessed by AHCCCS or accrued by the Contractor, the entire sanction shall be reported on the Statement of Activities, line 83105-01, Encounter Valuation Sanctions, under the program(s) applicable to the sanction and disclosed on the Contractor Statement of Activities, Schedule A Disclosure. Recoupment of this sanction from providers should also be reported on line 83105-01 and disclosed on a separate line in the Statement of Activities, Schedule A Disclosure as an offset to this sanction.

#### Block Payment Provider Encounter Monitoring

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

When monitoring block payment provider encounters and evaluating for funding recoupment and re-allocation, the Contractor should at a minimum consider encounter values, block payment provider performance and block payment provider profit levels. On an ad hoc basis, AHCCCS will request evidence that a Contractor regularly monitors the volume of encounters submitted by their block payment providers. The report will include the following:

- A. Total Revenue Paid to each block payment provider by individual program (funding source)
- B. Total Encounter Value submitted by each block payment provider by individual program (funding source)
- C. Percentage of letter B (above) divided by letter A (above)
- D. Audited block payment provider profit in dollars and percentage
- E. Contractor Encounter Submission Standard
- F. Explanation for under/over production of encounters by block payment provider by funding source. Also, describe the efforts made by the Contractor to address problems related to block payment provider under/over encountering.
- G. Amount the Contractor has recouped or will recoup from block payment providers for under-encountering by individual program or funding source. List total recoupment from each block payment provider and include the month/year of

recoupment whether planned or completed. If no funding will be recouped, explain why.

- H. If applicable, list overall barriers to encountering, summarized by Title XIX/XXI and Non-Title XIX/XXI, experienced by the block payment providers during the contract year.

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

## **5.09 Block Grants and Other Federal Grants**

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

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

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

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

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

AHCCCS will perform a Federal Grants Operational Review on an annual basis. Federal grants financial monitoring shall encompass the following:

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

Compliance with 2 CFR Part 200 Subpart F shall be incorporated into provider contracts. In addition, the Contractor should require all grant providers to have internal policies and procedures related to SABG, MHBG and other federal grants that include required monitoring as per 2 CFR Part 200. The policy and procedure should include, but are not limited to, a listing of prohibited expenditures, references to the SABG and MHBG FAQs, AMPM 320-T1, AMPM 320-T2, Exhibits 300-2b, monitoring and reporting of funding by each individual funding source received (i.e. SABG General Services, SABG

Pregnant/Parenting Women, SABG HIV, SABG Prevention, MHBG SED, MHBG SMI, MHBG FEP, etc.) As per contract or upon request, the Contractor is required to submit SABG and MHBG information for Federal Reporting purposes in the manner and format provided by AHCCCS. The above financial monitoring items will be reviewed as a part of the Federal Grants Operational Review.

### **5.10 Cost Allocation Plan**

The Contractor shall prepare an indirect cost allocation plan in conformance with appropriate federal regulations such as 2 CFR Part 200 Subpart E Cost Principles for Non-Profit Organizations. The cost principles described in 2 CFR Part 200 Subpart E will be the standard applied to Cost Allocation Plans submitted by the Contractor including for-profit entities. A list of individual costs to be allocated, along with the applicable base should be included in all Cost Allocation Plans. As per the 2 CFR Part 200 Subpart E, actual conditions shall be taken into account in selecting the base to be used in allocating the expenses in each grouping to benefiting functions. The essential consideration in selecting a method or a base is that it is the one best suited for assigning the pool of costs to cost objectives in accordance with benefits derived; a traceable cause and effect relationship; or logic and reason. When an allocation can be made by assignment of a cost grouping directly to the function benefited, the allocation shall be made in that manner. In accordance with 2 CFR Part 200 Subpart E, expenses should be recorded directly to the applicable program(s), if identifiable. If the program(s) cannot be readily identified, prorate the expense using the percentage of AHCCCS medical expense for each program. The use of revenue as the base for the allocation of all allowable general and administrative cost including corporate overhead is not acceptable. Revenue is not an equitable base for allocation because it has no relationship to cost nor does it have a relationship to the provision of services. This plan shall be submitted to AHCCCS for approval by August 1 of each contract year and should identify items of cost and its allocation base.

The Statement of Activities shall be reviewed by the Contractor's Auditor for adherence to the Contractor's cost allocation plan and shall be an integral part of the Contractor's annual certified audit. Any issues of non-compliance with federal guidelines must be included in the certified audit report. All instances of questioned costs or procedural deficiencies related to Indirect Cost Plans, as identified in the certified audit reports, will be investigated by AHCCCS, and are subject to repayment to AHCCCS.

### **5.11 Community Reinvestment**

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

Community Reinvestment expense should be reported in the financial statements on the Statement of Activities Line 990105-01, Community Reinvestment, under the Mgmt & Gen Column. Report the liability in a/c 20145-01, Other Current Liabilities, and disclose

by contract year in 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 Annual Financial Reporting Template is required as part of the Contractors Draft Audit and should include audit adjustments completed for the current fiscal year, as well as the prior fiscal year, if applicable, in order to properly calculate the contract year-end profit subject to the 6%. An audit adjustment for the recognition of Community Reinvestment should also be recorded and/or tried-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 eight month cut off. Continue to submit this report annually to AHCCCS on all previous year commitments until the full required community reinvestment amount has been reinvested into the community. If the reinvestment relates to a previous years' commitment, indicate this on the report under the Commitment Year Column. Refer to Appendix I for template.

## **5.12 Deferred Revenue**

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

## **5.13 Behavioral Health PPC Expenses**

Behavioral health covered service medical expenses provided during the prior period coverage timeframe to GMH/SU and CMDP (beginning 4/1/2021) and non-CMDP child members who are initially eligible as Non-Title XIX/XXI and assigned to a RBHA and who then transition to Title XIX/XXI eligibility. The Contractor shall report these PPC related expenses in the Other Title XIX/XXI Children (Crisis) or Other Title XIX/XXI Adult (Crisis) columns as applicable, on expense line 61100-01. AHCCCS shall make a payment to the Contractor for Title XIX/XXI behavioral health covered service medical expenses provided during the prior period coverage timeframe to GMH/SU and non-CMDP child members who are initially eligible as Non-Title XIX/XXI and assigned to a RBHA and who then transition to Title XIX/XXI eligibility. The payment shall include administrative funding and premium tax components. These expenses and revenue are excluded from any other reconciliation of the Contractor's service expenses.

## 5.14 Pharmacy Benefit Manager

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 Reports

**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

**Appendix J:** Contract Year Annual Supplement



## 7.00 EXHIBITS

### Exhibit 1: Sample Footnotes

#### Paragraph 3.06

Quarter ended MM/DD/YYYY

#### Footnotes

##### 1. Organizational Structure

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

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

Company ABC is located at 123 Main Street in Phoenix, Arizona, and is contracted with AHCCCS to administer behavioral and physical health services on an integrated basis to Medicaid eligible adults determined to be Seriously Mentally Ill, and to operate as the Regional Behavioral Health Authority to coordinate the delivery of health care services to eligible persons in Marion and Lakewood counties.

##### 2. Summary of Significant Accounting Policies

*Discuss accounting policies relating to significant balance sheet line items such as, but not limited to, cash and cash equivalents, investments and methodologies used for BH (Title XIX/XXI and Non-Title XIX/XXI) and PH medical claims payable.*

*On an annual basis with the quarter ending December submission, or in the event of a change, discuss the expense allocation methodology by program. Include the encounter timeframe used to allocate expenses.*

*Discuss revenue and expense recognition policies for the following:*

- Capitation revenue, Non-Title XIX/XXI Revenue and Reconciliation Settlements*
- Reinsurance revenue*
- Other revenue*
- Medical expenses*
- Administrative Expenses*
- Alternative Payment Model Initiatives*
- Health Insurance Provider Fee and related Tax*
- Federal and State Income Taxes*

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

**Cash and Cash Equivalents**

Cash includes cash deposits in banks and cash equivalents. Company ABC considers all highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents. Amounts at each institution are insured in limited amounts by the Federal Deposit Insurance Corporation (FDIC).

**Short-term Investments**

All short term investments can be converted to cash within 24 hours.

**Reinsurance Receivable**

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

**Reconciliation/Settlement Receivable**

Monthly, an amount estimated by program to be due to or due from AHCCCS is calculated and reported on the financial statements.

**Investment Income Receivable**

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

**Other Current Assets**

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

**Long Term Investments**

\$500,000 are restricted U.S. government securities held by a bank required to remain in trust by the State of Arizona, Department of Insurance for the duration of the contract with AHCCCS. This is related only to the Medicare Business.

**Property, Plant and Equipment**

Contractor has no Property, Plant, or Equipment.

**Medical Claims Payable**

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

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

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

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

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

### **Methodology for allocating revenue and medical expenses to each program**

Company ABC uses several sources of information for allocating the revenues and expenses on the Statement of Activities. For capitation revenue and member months, the BHS Weekly 820 files received from AHCCCS are utilized. The AHCCCS Allocation Schedule or payment report, whichever is most current, is used for Non-Title XIX/XXI Revenue.

Medical Expenses paid via block payment are allocated to the fund types (Title XIX/XXI CMDP Child, SMI, Other Child (Crisis) and Other Adult (Crisis) based on the year-to-date block payments.

Within a fund type, the allocation by service line is based on the year-to-date encountered claims data. FFS expenses include both paid claims and estimated IBNR. IBNR is based on the historical experience that is available and is reviewed by the actuarial department. Pharmacy expenses are booked to the fund types based on actual pharmacy expenses paid year-to-date.

Non-encounterable services are as follows (list each non-encounterable service): SABG Prevention and SABG HIV. These services are directly allocated based on actual and estimated expenses incurred year-to-date.

For hospital expenses Company ABC utilizes a combination of paid claims and prior authorizations. Company ABC then uses a combination of provider contracts (for sub capitated arrangements), member months and actual paid claims data, updated quarterly for all other medical expense categories.

### **Capitation Revenue**

Capitation revenue is accrued and recognized using the number of eligible clients provided by AHCCCS multiplied by the approved rate currently being paid, unless the most recent proposed capitation rates were already approved and are awaiting payment.

### **Non-Title XIX/XXI Revenue**

Non-Title XIX/XXI revenue is accrued and recognized based on the current AHCCCS Allocation Schedule and as documented by Contractor Expenditure Report.

### **Medical Expenses**

BH and PH medical expenses are accrued in the period that services are rendered and are based, in part, on payments and estimates. The total amount of medical expenses recognized includes actual claims payments, capitation payments, and an estimated amount due for claims that have

been received but have not been processed and an estimated amount due for claims that have been incurred but have not been received. All medical expenses are reported net of Medicare.

### **Administrative Expenses**

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

### **Taxes**

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

### **Membership**

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

### **Changes in accounting methodologies**

None

## **3. OTHER AMOUNTS**

*Describe amounts included in the "other" categories in the Balance Sheet and Statement of Activities.*

### **Other Income**

The \$500 reported as Other Income in the Management and General column are for contributions from Company MLN.

### **Other Medical Expenses**

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

### **Other Administrative Expenses**

The amounts reported as Other Administrative Expenses are detailed in the Statement of Activities Schedule A Disclosure.

### **Other Current Assets**

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

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

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

### Other Current Liabilities

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

### Other Non-Current Liabilities

There are no amounts for non-current liabilities reported.

## 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.*

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

## 5. Reserved

## 6. Material Adjustments

*Disclose and describe any material adjustments made during the current reporting period.*

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

## 7. Medical Claims Payable Analysis

*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 greater than +/-5% of the Total Liabilities for that quarter or the previous quarter if the amount is equal to or greater than +/-5%). Include discussions related to IBNR. Explanations should detail the amount of the adjustments by quarter and by category.*

Overall, Medical claims payable (line 20120-99) increased \$3.2M, or 10.33% over prior quarter.

Amounts:	QE 3/31/2016	QE 06/30/2016	Difference	% Change:
Title XIX/XXI	\$ 17,582,126	\$ 19,357,951	\$ 1,775,825	10.10%
Non-Title XIX/XXI	13,247,841	14,657,841	1,410,000	10.64%
<b>Total:</b>	<b>\$ 30,829,967</b>	<b>\$ 34,015,792</b>	<b>\$ 3,185,502</b>	<b>10.33%</b>

Both Title and Non-XIX/XXI Claims Payable increased primarily due to an increase in authorizations for inpatient services and Therapeutic Foster Care.

Hospital Compensation increased due to an increase in ICU and Rehab unit cost trend. Medical Compensation increased due to an increase in Primary Care Physician Utilization during the quarter. Other Medical increased due to increased unit cost trends primarily in Outpatient and Ambulatory Services.

Comparison quarter to quarter on medical claims payable:

<b>Amounts:</b>	<b>QE 3/31/2016</b>	<b>QE 06/30/2016</b>	<b>Difference</b>	<b>% Change:</b>
Hospital	\$ 10,578,123	\$ 15,369,745	\$ 4,791,622	45.30%
Med Comp	11,589,577	15,220,417	3,630,840	31.33%
Other	9,875,525	10,258,147	382,622	3.87%
PPC	5,446,104	5,500,963	54,859	1.01%
<b>Total:</b>	<b>\$ 37,489,329</b>	<b>\$ 46,349,272</b>	<b>\$ 8,859,943</b>	<b>23.63%</b>

Claim payment weeks for QE 3/31 = 13 claim payment weeks and QE 6/30 = 13 claim payment weeks. Medical expenses payable is calculated monthly based on historical experience and are reviewed monthly by a certified actuary. The Statement of Activities reflects any adjustments made to the reserves. Reserve adjustments are noted on Lag Reports E-4.

### 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.*

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

### 9. Investments (Current And Non-Current)

*Long-term investments that may be liquidated without significant penalty within 24 hours, which the Contractor would like treated as current assets for calculations of the current ratio, must be disclosed in the footnotes. Descriptions and amounts should be disclosed and should include indication of whether or not the investments are restricted or unrestricted. (Note that significant penalty in this instance is any penalty greater than 20%) Also disclose the amount of Unrealized Gains or Losses reported on the financial statements associated with these investments.*

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

### 10. Due From/To Affiliates (Current And Non-Current)

*Describe in detail the composition of the due from/(to) affiliates including the name of the affiliate, a description of the affiliation, amount due from/(to) the affiliate and a written description of any change in balances due from/to each affiliate.*

<i>Amount Due From/(To)</i>				
<b>Name</b>	<b>QE 03/31/2016</b>	<b>QE 06/30/2016</b>	<b>% Change</b>	<b>Desc of Change</b>
Company M	160,000	140,000	13%	Cash Transactions
Company N	(300,000)	(700,241)	133%	Cash Transactions
Company O	(70,775)	(195,124)	175%	Cash Transactions
<b>Total</b>	<b>(210,775)</b>	<b>(775,365)</b>	<b>268%</b>	

Cash transactions are managed through a main concentration bank account that is recorded on the ACC books.

## 11. Equity Activity

*Disclose and provide a written explanation for all activity in equity, other than net income or net loss.*

The following equity adjustments were made during the quarter ended June 30, 2016:

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

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

## 12. 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 contract-year-to-date profit/(loss) incurred, unrelated to any prior year activity (even if within the profit corridor). The factors should be disclosed separately for Title XIX/XXI and Non-Title XIX/XXI.*

### **Financial Viability Standards - Year to Date**

#### **Current Ratio**

Company ABC is in compliance with the Current Ratio.

#### **Equity per Title XIX/XXI Member**

Company ABC is in compliance with the Equity Per Title XIX/XXI Member.

### **Performance Guidelines**

#### **Title XIX/XXI Medical Loss Ratio**

Company ABC is in compliance with the Title XIX/XXI Medical Loss Ratio when calculated on a contract year to date basis.

#### **Non-Title XIX/XXI Medical Expense Ratio**

Company ABC is in compliance with the Non-Title XIX/XXI Medical Expense Ratio when calculated on a state fiscal year to date basis.

#### **Title XIX/XXI Administrative Cost Percentage**

Company ABC is in compliance with the Title XIX/XXI Administrative Cost Percentage when calculated on a contract year to date basis.

### Non-Title XIX/XXI Administrative Cost Percentage

Company ABC is in compliance with the Non-Title XIX/XXI Administrative Cost Percentage when calculated on a state fiscal year to date basis.

### Factors leading to Title XIX/XXI Profit/(Loss)

Company ABC is reporting a net profit of \$4.0M in Title XIX/XXI contract year to date. The primary drivers are an increase in capitation due to increased membership in Title XIX/XXI SMI; decreased utilization in treatment services and decreased utilization in residential services.

### Factors leading to Non-Title XIX/XXI Profit/(Loss)

Company ABC is reporting a net loss of \$1.0M in Non-Title XIX/XXI contract year to date. The primary drivers are increased utilization in supported housing related to rental subsidies and increased utilization in case management services.

## 13. Changes in Financial Statement Items

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

### Balance Sheet – Assets

A/C	Description	QE 03/31/16	QE 06/30/16	\$ Change	QTR % Change	% of Total Assets	Explanation
10105	Cash and cash equivalents	46,850,112	44,487,955	(2,362,157)	-5%	38.9%	Decreased due to TXIX Recon recoupment related to CY15

*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%.*

### Balance Sheet - Liabilities

A/C	Description	QE 03/31/16	QE 06/30/16	\$ Change	QTR % Change	% of Total Liabilities	Explanation
20115	Payable to Providers	7,890,125	4,325,784	(3,564,341)	-45%	7.9%	Decreased primarily due to payments to PQR Company and STU Company



Using the Title XIX/XXI Statement of Activities Summary, describe changes by BH and PH expense category 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%.

**Statement of Activities**

TXIX		QE 3/31/19	QE 6/30/19				
A/C	Description	Dollars	Dollars	Dollar Change	QTR % Change	% of Total TXIX Revenue	Explanation
40105-01	Capitation	\$ 50,272,056	\$ 50,548,789	\$ 276,733	1%	100%	No explanation required.
60199	Total Treatment Services	\$ 4,126,748	\$ 5,874,500	\$ 1,747,752	42%	11.6%	Treatment services increased quarter over quarter primarily due to increased utilization in Counseling services provided to Title XIX/XXI Other Adult members during the quarter.
60299	Total Rehabilitation Services	\$ 1,578,365	\$ 3,457,147	\$ 1,878,782	119%	6.8%	Rehabilitation services increased due to increased utilization in living skills training provided during the quarter for Title XIX/XXI Other Adult
50299	Total Medical Comp	\$ 5,584,580	\$ 3,400,895	\$ (2,183,685)	-39%	6.7%	Medical Compensation decreased quarter over quarter primarily due to less utilization in referral physician services.
50399	Total Other Medical	\$ 6,555,789	\$ 7,657,489	\$ 1,101,700	17%	15.1%	Total Other Medical increased quarter over quarter due to increased utilization in outpatient facilities and pharmacy expenses.
83005-01	Other Admin Expenses	\$ 2,300,458	\$ 3,159,633	\$ 859,175	37%	6.3%	Other Admin Expenses increased quarter over quarter primarily due to increased interpreter/translation services.

**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.

Company ABC accrued for sanctions of \$20,000, fines of \$5,000 and no penalties during the quarter ended MM/DD/YYYY. Total accrued sanctions of \$20,000 and fines of \$5,000 are included on the balance sheet in A/C 20105-01.

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

## **17. 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 PBPs to Providers). Indicate the Administrative Income Statement line number and program in the financial statements where these are reported. Report influenza gift cards amounts expended in this footnote disclosure.*

Company ABC paid \$5,000 in gift card incentives during the quarter ended March 31, 2020 and \$7,500 as of CY2021. This was reported in line 83005-01 under TXIX/XXI Other Adult.

## **18. Reserved**

## **19. Reserved**

## **20. Additional Expense Explanations Requested By AHCCCS**

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

*a. Disclose the SFYTD total amount of County dollars expended on children. Of that amount, how much was expended on remanded juveniles by expense type.*

*b. Disclose the SFYTD amount expended on incarcerated adults and children justice programs by Non-Title XIX/XXI funding source.*

*c. On a contract year basis, how many expenditures and members were covered by Medicaid that had been previously covered through Non-Title XIX/XXI funding?*

*d. Disclose the Title XIX/XXI CYTD crisis expense amount provided within the first 24 hours at a stabilization unit for procedure codes other than S9484 and S9485. If this does not apply, indicate that the only crisis services provided were billed using S9484 and S9485.*

*e. Provide confirmation that case management services were not provided to CMDP members that are covered under the AHCCCS/DCS Interagency Service Agreement. Continue providing this confirmation until the BH portion has been transferred to CMDP. When the transfer occurs, RBHAs are no longer required to provide this confirmation.*

*f. Provide confirmation that Alcohol and/or drug services were not provided with NTXIX/XXI SMI, MHBG SMI and MHBG SED funding. These services are unallowable with these funding sources.*

*g. Provide confirmation that Multisystemic Therapy for Juveniles were not provided with NTXIX/XXI SMI and MHBG SMI funding. This service is unallowable with these funding sources.*

*h. Provide confirmation that Sponsorships for events and conferences were not provided with SABG and MHBG funding. Sponsorships are unallowable with these funding sources.*

*i. Provide confirmation that Transcranial Magnetic Stimulation services were not provided with MHBG SED and SABG funding. This service is unallowable with these funding sources.*

*j. For each separate funding source reported in the Non-Title XIX/XXI Other Column, provide the SFY Allocation and the total amount expended by service expense and admin expense.*

a. Company AB expended \$5M of County dollars on Children Services. Of the \$5M, \$1M was expended on remanded juveniles primarily for case management services.

b. SFYTD, Company ABC expended \$2M on incarcerated adults and children justice programs. Of the \$2M, \$1M was from County dollars and \$1M was from Non-Title XIX/XXI SMI.

c.

Non-Title XIX/XXI (Dates of Service)	Service Expense for CMDP	Service Expense for GMH/SU and non-CMDP Child	Total Service Expenditures	Total Member Count
QE December	\$ -	\$ -	\$ -	-
QE March	\$ -	\$ -	\$ -	-
QE June	\$ -	\$ -	\$ -	-
QE September	\$ -	\$ -	\$ -	-
Total	\$ -	\$ -	\$ -	-

d. CYTD Company ABC expended \$694K in TXIX/XXI crisis services other than S9484 and S9485 within the first 24 hours in a stabilization setting. The breakdown by procedure code is as follows:

Code	Amount
H0031	\$ 237,220
H0038 GT	102,225
H0038 HQ	89,452
90791 GT	39,558
T1002	225,430
	\$ 693,885

e. Company ABC is hereby confirming that case management services were not provided to CMDP members that are covered under the AHCCCS/DCS Interagency Service Agreement.

f. Company ABC is hereby confirming that Alcohol and/or drug services were not provided with NTXIX/XXI SMI, MHBG SMI and MHBG SED funding.

g. Company ABC is hereby confirming that Multisystemic Therapy for Juveniles were not provided with NTXIX/XXI SMI and MHBG SMI funding.

h. Company ABC is hereby confirming that Sponsorships for events and conferences were not provided with SABG and MHBG funding.

i. Company ABC is hereby confirming that Transcranial Magnetic Stimulation services were not provided with MHBG SED and SABG funding.

j.

Funding Sources Reported in NTXIX/XXI Other	SFY Allocation (per latest Pymnt Rpt. Use Adjusted Contract Amount)	Service	Admin	Total	Remaining Allocation
Children's BH Services	\$ -	\$ -	\$ -	\$ -	\$ -
SUDS	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	\$ -	\$ -	\$ -	\$ -	\$ -

## 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 the adjustment(s).*

During the quarter, company ABC recorded an adjusting entry of \$500K decreasing Medical Claims Payable for the prior contract year 2015. The details of this adjustment are on schedules E-8a and E-8b.

## 22. Reserved

## 23. Premium Deficiency Reserve ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

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

Total Reserves equal \$5,000,000 and is recorded in Other Current Liabilities line A/C 20145-01 and Other Revenue line A/C 40310-01.

## 24. Social Risk Factors ANNUAL FINANCIAL REPORTING TEMPLATE ONLY

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

In the fiscal year ended September 30, 2021, Company ABC expended \$50,500 in activities to mitigate social risk factors. The details of the social risk initiatives funds during the quarter are reflected in the table below by source including the account number where reported in the financial statements. The following initiatives are non-encounterable initiatives:

Social Risk Activities - September 30, 2021											
		QE 12/31/2020		QE 03/31/2020		QE 06/30/2021		QE 09/30/2021		FYE Totals	
Program	A/C Line #	G&A	Medical	G&A	Medical	G&A	Medical	G&A	Medical	G&A	Medical
Care Coordination Certificate Program - Medical Providers	83005-01	100	-	500	-	-	-	-	-	600	-
Community Health Workers Certificate Program	83005-01	3,500	-	-	-	-	-	-	-	3,500	-
Sponsorships Related to Social Risk Initiatives	83005-01	1,000	-	5,000	-	-	-	-	-	6,000	-
Regional Mental Health First Aid (MHFA) training	83005-01	200	-	200	-	-	-	-	-	400	-
Steps to Recovery Homes - Sober Living License	83005-01	-	-	-	-	7,500	-	-	-	7,500	-
Prevent Child Abuse AZ - Virtual Conference	83005-01	-	-	-	-	-	-	25,000	-	25,000	-
Williams Unified School Distr-Fit Kids Program	83005-01	-	-	-	-	7,500	-	-	-	7,500	-
	<b>Totals</b>	<b>\$ 4,800</b>	<b>\$ -</b>	<b>\$ 5,700</b>	<b>\$ -</b>	<b>\$15,000</b>	<b>\$ -</b>	<b>25,000</b>	<b>-</b>	<b>\$50,500</b>	<b>\$ -</b>

## 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 from the prior quarter. Also, disclose each individual administrative expense amount by the account number where Management Fees are reported.*

<b>Management Fee Allocation</b>	<b>Quarter Ended</b>				<b>FYTD</b>
	<b>03/31/20</b>	<b>06/30/20</b>	<b>09/30/20</b>	<b>12/31/20</b>	
<b>Administrative Expenses</b>					
80105-01 Compensation	\$ 11,979,954	\$ 11,158,803	\$ -	\$ -	\$ 23,138,757
80205-01 Occupancy	117,234	111,351	0	0	228,585
80305-01 Depreciation	0	0	0	0	0
80405-01 Care Management/Care Coordination	2,961,937	3,470,607	0	0	6,432,544
80505-01 Professional and Outside Services	7,242,987	6,820,684	0	0	14,063,671
80605-01 Office Supplies and Equipment	1,186,028	993,740	0	0	2,179,768
80705-01 Travel	82,972	7,418	0	0	90,390
80805-01 Repair and Maintenance	9,688	9,876	0	0	19,564
80905-01 Bank Service Charge	285	473	0	0	758
81005-01 Insurance	167,149	234,565	0	0	401,714
81105-01 Marketing	0	0	0	0	0
81205-01 Interest Expense	0	0	0	0	0
81305-01 Pharmacy Benefit Manager Expenses	559,334	471,122	0	0	1,030,456
81405-01 Fraud Reduction Expenses	0	0	0	0	0
81505-01 Third Party Activities	0	0	0	0	0
81605-01 Sub Capitation Block Administration	14,916	9,923	0	0	24,839
81705-01 Health Care Quality Improvement	5,794,893	5,552,851	0	0	11,347,744
82505-01 Interpretation/Translation Services	0	0	0	0	0
83005-01 Other Administrative Expenses	44,879	61,023	0	0	105,902
<b>Total</b>	<b>\$ 30,162,256</b>	<b>\$ 28,902,436</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 59,064,692</b>

Company ABC's management fees were \$28,902,436 for the quarter ended June 30, 2020; and, for the fiscal year to date, management fees totaled \$59,064,692. The management fee percentage is 7% and did not change during the quarter.