ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

FINANCIAL STATEMENTS,
REQUIRED SUPPLEMENTARY
INFORMATION, AND UNIFORM
GUIDANCE SUPPLEMENTARY REPORTS

Year Ended June 30, 2024

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CBIZ CPAs

INDEPENDENT AUDITORS' REPORT

To the Director of the

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS, an agency of the state of Arizona)

Report on the Audit of the Financial Statements

Qualified Opinions

We have audited the accompanying financial statements of the governmental activities, the general fund, and the aggregate remaining fund information of AHCCCS as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise AHCCCS' basic financial statements as listed in the table of contents.

In our opinion, except for effects of any potential adjustments pertaining to the possible effect of the matter described in the Basis for Qualified Opinions on the Governmental Activities and General Fund section of our report, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities, the general fund, and the aggregate remaining fund information of AHCCCS, as of June 30, 2024, and the respective changes in financial position thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Qualified Opinions on the Governmental Activities and General Fund

In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers while it and law enforcement agencies complete an investigation. A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney's General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. See Note 8 to the financial statements for further information. As a result of these matters, we were unable to obtain sufficient appropriate audit evidence for AHCCCS' receivables and other, federal revenue and due to the federal government line items as of and for the year ended June 30, 2024. AHCCCS did not make any financial statement adjustments for potential recoveries because it lacked evidence to complete the determinations necessary to support the amounts of monies it would be required to return to the U.S. government. Consequently, we were unable to determine whether any adjustments of these amounts or additional disclosures were necessary.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America ("GAAS") and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of AHCCCS and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified audit opinions.

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Emphasis of a Matter

As discussed in Note 1, the financial statements of AHCCCS are intended to present the financial position and the changes in financial position of only that portion of the governmental activities, the general fund and the aggregate remaining fund information of the State of Arizona that is attributable to the transactions of AHCCCS. They do not purport to, and do not, present fairly, the financial position of the State of Arizona at June 30, 2024, or the changes in the financial position for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about AHCCCS' ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of AHCCCS' internal control. Accordingly, we express no such opinion.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about AHCCCS' ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the audit's planned scope and timing, significant audit findings, and certain internal control related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 5 through 23, budgetary comparison schedule – general fund on page 69, schedule of the agency's proportionate share of the net pension liability – cost sharing plan on page 70, schedule of the agency's pension contributions on page 71 and schedule of changes in the agency's total OPEB liability and related ratios on page 72 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context.

We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the required supplementary information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise AHCCCS' basic financial statements. The Schedule of Expenditures of Federal Awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the Schedule of Expenditures of Federal Awards is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

AHCCCS' Schedule of Expenditures of Federal Awards is intended to present expenditures of the federal programs of the State of Arizona that are administered by AHCCCS. AHCCCS' Schedule of Expenditures of Federal Awards does not purport to, and does not, present fairly, all the expenditures of federal awards of the State of Arizona.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated April 30, 2025 on our consideration of AHCCCS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of AHCCCS' internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering AHCCCS' internal control over financial reporting and compliance.

CBIZ CPAs P.C.

April 30, 2025

MANAGEMENT'S DISCUSSION AND ANALYSIS

Management's Discussion and Analysis
For the Fiscal Year Ended June 30, 2024

Management of the Arizona Health Care Cost Containment System ("AHCCCS" or the "Agency") provides this Management's Discussion and Analysis for the benefit of the readers of the AHCCCS financial statements. This narrative overview and analysis of the financial activities of AHCCCS is for the fiscal year ended June 30, 2024. The intent of this discussion and analysis is to look at AHCCCS' performance as a whole. We encourage readers to consider this information in conjunction with the basic financial statements and related footnotes that follow this section.

Financial Highlights

Government-Wide

The assets and deferred outflow of resources of AHCCCS exceeded its liabilities and deferred inflow of resources at fiscal year end June 30, 2024, by $504.2 million. AHCCCS' net position at June 30, 2024 is comprised of a restricted net position of $90.5 million, an unrestricted net position of $395.6 million and net investment in capital assets of $18.1 million.

AHCCCS' net position increased by $25.0 million during fiscal year 2024. The increase is primarily due to a decrease in enrollment of 6.5 percent from June 30, 2023 to June 30, 2024. With fewer members, the costs of providing healthcare services, including medical claims and program administration, dropped significantly. This reduction in expenses naturally led to some revenue loss, as funding scaled with enrollment; however, the savings from lower expenditures was greater than the decline in revenue, resulting in a net financial gain. Additionally, another factor increasing net position is due to surplus appropriation, whereby unspent allocations were retained from decreased enrollment, bolstering reserves. Together, these factors enabled AHCCCS to enhance its fiscal position and strengthen financial stability when cost reductions and retained funds outpace revenue declines.

Fund Level

As of the close of fiscal year 2024, AHCCCS' total governmental funds reported an ending fund balance of $586.0 million, an increase of $42.8 million from fiscal year 2023.

AHCCCS is a $21,306.1 million cash or near cash basis program providing comprehensive physical and behavior health, substance abuse and related services for eligible Arizona citizens. The $42.8 million ending fund balance increase is primarily due to decreases in enrollment of 6.5 percent from June 30, 2023 to June 30, 2024. On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted, which further clarified that states could begin redeterminations in February 2023 with the disenrollments beginning April 2023. The fund balance is also affected from the result of normal operations due to the variances that can occur in how covered members utilize health care service expenditures, as well as the impact of year-end accrual transactions for such items as the multiple open contract year-end risk sharing reconciliations AHCCCS has with the contracted managed care organizations along with earned differential adjustment payments to certain qualifying providers.

More detailed information regarding the government-wide financial statements and fund level financial statements can be found below.

Overview of the Financial Statements

AHCCCS' basic financial statements are comprised of three components: 1) government-wide financial statements, 2) fund financial statements and 3) notes to the financial statements.

Government-Wide Financial Statements (Reporting AHCCCS as a Whole)

The Government-Wide Financial Statements are designed to provide readers with a broad overview of AHCCCS' finances that are comparable to a private-sector business. The Statement of Net Position and the Statement of Activities are two financial statements that report information about AHCCCS as a whole and its activities. The presentation in these statements is intended to help answer the question: is AHCCCS, as a whole, better off or worse off financially as a result of this year's activities? These financial statements are prepared using the flow of economic resources measurement focus and the full accrual basis of accounting. They take into account all revenues and expenses connected with the fiscal year even if the cash involved has not been received or paid out.

The Statement of Net Position (page 24) presents information on all of AHCCCS' assets and deferred outflow of resources and liabilities and deferred inflow of resources, with the difference between the two reported as "net position". Over time, increases or decreases in net position, along with other financial information, serve as indicators of AHCCCS' financial position and whether it is improving or deteriorating.

The Statement of Activities (page 25) presents information showing how AHCCCS' net position changed during the most recent fiscal year. All changes in net position are reported as soon as the underlying events giving rise to the change occur, regardless of the timing of related cash flows. Therefore, revenues and expenses are reported in this statement for some items that will result in cash flows in future fiscal periods (e.g. incurred but not paid or reported fee-for-service and reinsurance claims, managed care organization risk sharing medical loss reconciliation, revenue from future Tobacco Master Settlement Agreement payments, prescription drug rebate receipts, earned but unused vacation leave, and unfunded pension benefit). Governmental Activities include state appropriations along with federal, county, and other local government intergovernmental revenues and member premium collections that primarily support the activities in this category.

The governmental activities of AHCCCS consist of programs authorized by the Social Security Act Titles XIX ("Medicaid") and XXI (Children's Health Insurance Program ("CHIP")) and behavioral health services funded from Federal Block Grants and state appropriations targeted to specific needs of individuals with serious mental illness ("SMI"). All these services are concentrated on the health and related needs of the citizens of Arizona primarily through direct health care service payments, supplemental payments to qualifying hospital facilities and prevention services provided throughout the State. The majority of the activities are reported in these categories.

The government-wide financial statements can be found on pages 24 and 25.

Fund Financial Statements (Reporting AHCCCS' Major Funds)

A fund is a legislatively authorized fiscal and accounting entity with a self-balancing set of accounts that AHCCCS uses to keep track of specific sources of funding and spending for specific activities or objectives. AHCCCS, like other State agencies, uses fund accounting to ensure and demonstrate compliance with legislative appropriation funding requirements.

Governmental funds - Governmental funds are used to account for essentially the same functions reported as governmental activities in the government-wide financial statements. However, unlike the government-wide financial statements, the governmental funds financial statements focus on near- term inflows and outflows of spendable resources, as well as on balances of spendable resources available at the end of the fiscal year. Such information may be useful in evaluating a government's near-term financial position and requirements. This approach is known as using the flow of current financial resources measurement focus and the modified accrual basis of accounting. These financial statements provide a short-term view of AHCCCS' finances that assists management in determining whether there will be adequate financial resources available to meet current needs. When an asset is recorded in governmental fund financial statements, but the revenue is not available, AHCCCS reports a deferred inflow of resources until such time as the revenue becomes available. Because the focus of governmental funds is narrower than that of the government-wide financial statements, it is useful to compare the information presented for governmental funds with similar information presented for governmental activities in the government-wide financial statements. By doing so, readers may better understand the long-term impact of the State's near-term financial decisions. Both the governmental fund balance sheet and the governmental fund statement of revenues, expenditures and changes in fund balances provide a reconciliation to facilitate this comparison between governmental funds and governmental activities. The basic governmental fund financial statements and related reconciliation can be found on pages 26 through 28 of this report.

AHCCCS reports two fund categories: General Fund and Other Governmental Funds. Information on these funds is presented separately in the governmental fund balance sheet and in the governmental fund statement of revenues, expenditures, and changes in fund balances.

Annually, the Legislature adopts an appropriated budget for AHCCCS that funds fully integrated acute care and long-term care services categorized as Traditional Medicaid services, Proposition 204 (includes childless adults up to 105% of the federal poverty level FPL) services, Patient Protection and Affordable Care Act ("ACA") Adult Expansion (childless adults between 106% and 136% of the FPL), KidsCare, Arizona Long Term Care Services (ALTCS), and the Department of Child Safety Comprehensive Health Plan. Additionally, supplemental payments are made to the Disproportionate Share Hospital ("DSH"), Rural Hospital; Graduate Medical Education ("GME"), nursing facility programs, non-Title XIX SMI, substance abuse and supported housing services, targeted investments program for incentive payments to certain providers who develop clinical processes that integrate physical and behavioral health care delivery and for AHCCCS administration costs. The annual appropriation is made separately for both the State share of the required matching funds and federal financial participation funds from Title XIX Medicaid and Title XXI CHIP. In addition to the appropriations and expenditure authority approved by the Legislature, AHCCCS also expends continuously appropriated funds for medical service payments from third party liability recovery program activities, electronic health records infrastructure development, certain payments to hospitals for unfunded emergency department readiness costs and level 1 trauma center costs, and behavioral health block and discretionary grants. A budgetary comparison statement has been provided for the General Fund only to demonstrate compliance with the legislative budget on page 69.

Notes to the Financial Statements

The notes to the financial statements provide additional information that is essential to a full understanding of the data provided in the government-wide and fund financial statements. The notes to the financial statements can be found on pages 29 to 68.

Government-Wide Financial Analysis

As noted earlier, the net position may serve over time as a useful indicator of a government agency's financial position.

AHCCCS Net Position
(in thousands of dollars)

	Governmental Activities	
	2024	**2023**
Current assets	$ 4,622,633	$ 5,079,541
Noncurrent assets	20,889	36,891
Total assets	4,643,522	5,116,432
Deferred outflows of resources	19,126	20,082
Current liabilities	4,037,795	4,538,089
Long-term liabilities	95,151	100,223
Total liabilities	4,132,946	4,638,312
Deferred inflows of resources	25,541	19,045
Net position		
Net investment in capital assets	18,115	32,861
Restricted	90,523	-
Unrestricted	395,523	446,296
Total net position	$ 504,161	$ 479,157

For AHCCCS, assets and deferred outflows of resources exceeded liabilities and deferred inflows of resources by $504.2 million at June 30, 2024, as compared to assets and deferred outflows of resources in excess of liabilities and deferred inflows of resources in the amount of $479.2 million at June 30, 2023.

The total government-wide net position increased by $25.0 million. This increase is primarily due to a decrease in enrollment of 6.5 percent from June 30, 2023 to June 30, 2024. In addition, there were increases in the funding received for certain health programs where the final determination of costs is dependent on future reconciliations that are not estimable at the present and are dependent on provider performance to meet certain criteria and or thresholds. Additionally, excess hospital assessment collections will be available to fund future eligible costs but are dependent on legislative appropriations.

AHCCCS Changes in Net Position
(in thousands of dollars)

	Governmental Activities	
	2024	**2023**
Revenues		
Program revenues		
Charges for services	$ 15	$ 16
Other operating grants and contributions	2,312,636	1,826,460
Federal operating grants	15,924,241	18,729,526
General revenues		
State appropriations	3,148,063	2,730,381
Tobacco Tax	104,758	105,961
Other	(190)	-
Total Revenue	21,489,523	23,392,344
Expenses		
Health care	21,306,064	23,425,393
Excess before transfers	183,459	(33,049)
Transfers, net	(158,455)	(130,414)
Change in net position	25,004	(163,463)
Net position - beginning of year	479,157	642,620
Net position - end of year	$ 504,161	$ 479,157

COVID-19

On March 11, 2020, the World Health Organization declared the outbreak of a respiratory disease caused by a new coronavirus as a "pandemic". First identified in late 2019 and now known as COVID-19, the outbreak has impacted millions of individuals worldwide. In response, many countries implemented measures to combat the outbreak which have impacted global business operations.

In response to the growing COVID-19 pandemic, on March 18, 2020, President Trump signed into law H.R. 6021, the Families First Coronavirus Response Act ("FFCRA") (Pub. L. 116-127). Section 6008 of the FFCRA provided a temporary 6.2 percent increase to the Federal Medical Assistance Percentage (“FMAP”) extending through the last day of the calendar quarter in which the Public Health Emergency (“PHE”) terminates. One of the conditions of receipt of the enhanced federal match was a maintenance of effort ("MOE") requirement, prohibiting the agency from terminating the enrollment of any individual that was enrolled in the program as of the date of the beginning of the PHE period, as well as individuals enrolled during the PHE period. This condition had a significant impact on AHCCCS' enrollment. It required that the state continue coverage for members who may have had a change in income that would otherwise result in discontinuance. On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted, which further clarified that states could begin redeterminations in February 2023 with the disenrollments beginning April 2023 and prescribed that the 6.2 percentage point increase to the FMAP will be phased out over the course of Calendar Year 2023. The enhanced FMAP was 6.2 percentage points through the quarter ended March 31, 2023, 5.0 percentage points in the quarter ended June 30, 2023, 2.5 percentage points in the quarter ended September 30, 2023, and 1.5 percentage points in the quarter ended December 31,

2023. Although the FMAP increase is no longer directly tied to the end of the PHE, the Department of Health and Human Services expired the PHE as of May 11, 2023. Effective April 2023, AHCCCS began processing eligibility redeterminations. In April 2023, AHCCCS enrollment was 2,492,034. By June 30, 2024, AHCCCS enrollment was 2,204,281, a decrease of 287,753.

Following the national and state emergency declarations in March 2020, AHCCCS received authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. Some of these flexibilities are: expanded coverage of telehealth and telephonic codes reimbursed at the same level of reimbursement offered for in-person services; initiatives to support use of influenza vaccinations during the COVID outbreak; increase in annual hours of respite care; reimbursement of Home and Community Based Services provided by parents; elimination of the 40 hour limit on family caregiver services provided by a member's spouse; expand the provision of home delivered meals to members enrolled in Department of Economic Security/Developmental Disabilities (DES/DD"); and allowance for students to receive medically necessary services from managed care organizations ("MCOs") rather than the Medicaid School Based Claiming program as children attend school virtually from home. The CMS approvals were granted in late March to early April 2020.

In addition to the program flexibilities, COVID-19 impacted some of the agency's collection activities. CMS approved AHCCCS' request for emergency authorities to support Arizona's response to COVID-19. For the duration of the PHE, AHCCCS waived payment of the provider enrollment application fee as well as suspended the application of premiums for children enrolled in Arizona's CHIP program (KidsCare) and adults in the Freedom-to Work program. AHCCCS resumed billing providers the enrollment application fee in April 2022. In addition, AHCCCS resumed billing premiums for adults in the Freedom-to-Work program in September 2024.

The Substance Abuse and Mental Health Services Administration ("SAMHSA") awarded AHCCCS grants to address the behavioral health impacts due to the pandemic. These grants include the following:

- Arizona COVID-19 Emergency Response for Suicide Prevention
- Emergency Grant to Address Mental and Substance Use Disorders During COVID-19 (ECOVID)
- COVID-19 Block Grants for Prevention and Treatment of Substance Abuse
- COVID-19 Block Grants for Community Mental Health Services

American Rescue Plan Act (ARPA)

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 ("ARPA") (Pub.L.117-2) into law. Some of the provisions of the ARPA include:

- Section 9811 of the ARPA establishes a temporary Medicaid FMAP of 100 percent for amounts expended by a state for medical assistance for the administration of COVID-19 vaccines. It also provides a temporary 100 percent CHIP EFMAP for state expenditures for the administration of COVID-19 vaccines. In May 2022, AHCCCS claimed $7.8 million federal dollars for this provision.
- Section 9815 of the ARPA provides 100 percent FMAP for expenditures for services received by all Medicaid beneficiaries through Urban Indian Organizations. In March 2023, AHCCCS recycled $5.6 million in claims through the Urban Indian Organizations to draw an additional $1.0 million in federal dollars.
- Section 9817 of the ARPA provides qualifying states with a temporary 10 percentage point increase to the FMAP for certain Medicaid expenditures for home and community-based services (“HCBS”) incurred from April 1, 2021, through March 31, 2022. Originally, the funding is to be used as State Match for future HCBS related directed payments or initiatives through March 31, 2024. On June 3, 2022, CMS extended the deadline to expend the funds to March 31, 2025. Any unexpended funding is required to be returned to CMS. In March 2022,

AHCCCS drew $430.2 million as the additional 10 percent. In addition, AHCCCS paid $480.6 million in Managed Care Organization direct payments which required $371.5 million additional federal funds in fiscal 2022.

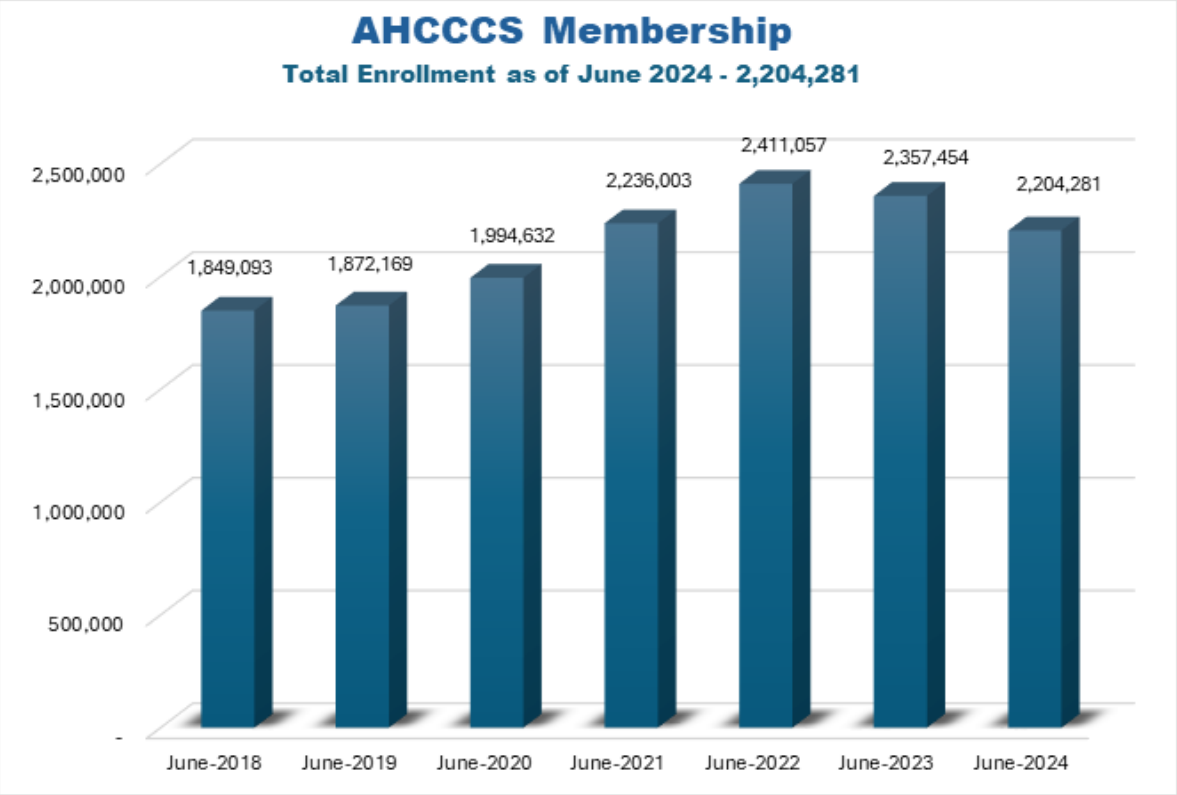
- In fiscal year 2023, AHCCCS paid $1,013.5 million in ARPA Administrative Initiative and Programmatic Expenditures utilizing $242.0 million of the previously mentioned additional 10 percent and drew another $771.5 million Federal dollars.
- In fiscal year 2024, AHCCCS paid $408.3 million in ARPA Administrative Initiative and Programmatic Expenditures utilizing $136.1 million of the previously mentioned additional 10 percent and drew in another $272.3 million Federal dollars.

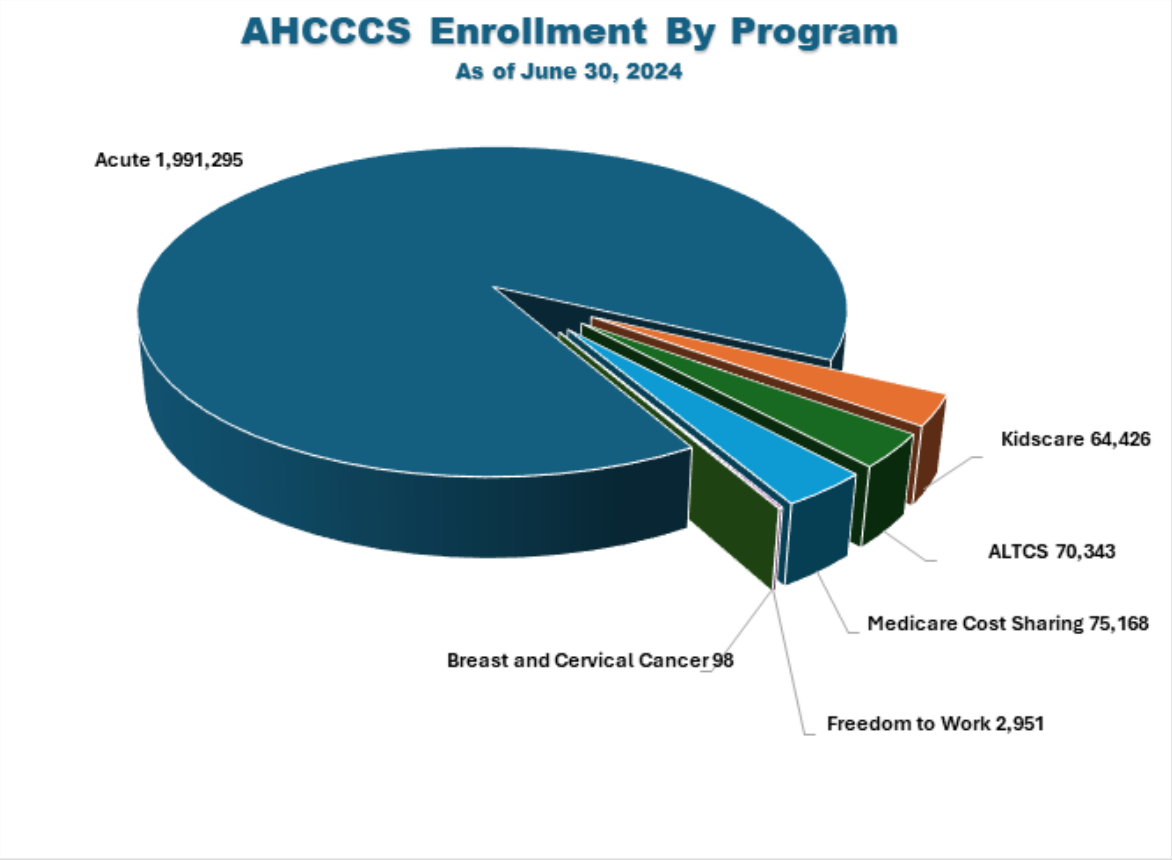
Governmental Activities

The primary driver of agency expenditures is enrollment in AHCCCS programs. In fiscal year 2024, total enrollment for all of AHCCCS' programs at June 1, 2024, was 2,204,281, a decrease of 153,173 members (6.50 percent decrease) from June 1, 2023. The fiscal year 2024 decrease comes after a 53,603 decrease from fiscal year 2023. In February 2023, AHCCCS began redeterminations and disenrollments began in April 2023. AHCCCS' Medicaid program in Arizona covers approximately one-third of the Arizona population, two-thirds of nursing facility days, and more than fifty-two percent of all births in the state.

AHCCCS' actual enrollment decreased in fiscal years 2023 and 2024 in contrast to the steady increases in fiscal years 2022, 2021, 2020 and 2019 after the decline experienced in fiscal year 2018. Overall, the enrollment of full-service members decreased by 149,794 members from 2,144,944 to 1,995,150 for the current fiscal year.

The following charts depict AHCCCS membership growth and enrollment by program for the reporting periods:





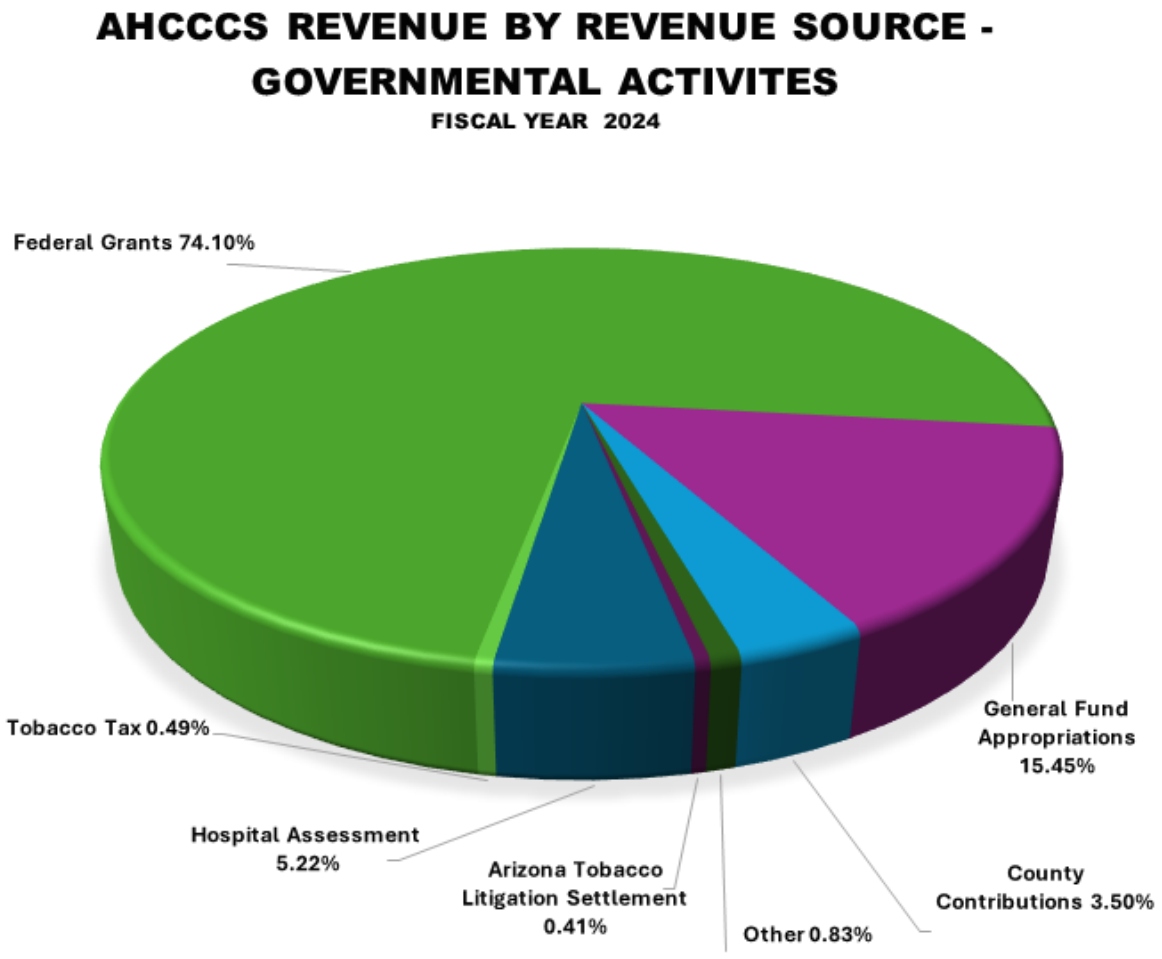
The cost of health care programs, including Medicaid, CHIP, and non-Medicaid behavioral health, totaled $21,306.1 million in fiscal year 2024, a $2,119.3 million or 9.1 percent decrease from the $23,425.4 million reported in fiscal year 2023. The decrease in current fiscal year program expenditures is attributable to a decrease in enrollment of 6.5 percent from June 30, 2023, to June 30, 2024. In addition, ARPA payments decreased from fiscal year 2023 to 2024. As shown in the statement of activities, the proportionate amount of expenditures funded from federal grants through CMS and SAMHSA decreased slightly and was $15,924.2 million (74.7 percent of total) in fiscal year 2024 as compared to $18,729.5 million (80.0 percent of total) in fiscal year 2023. In June 2021, the Supreme Court ruled that the challengers to the Affordable Care Act lacked standing, effectively throwing out the lawsuit argued by 18 Republican state attorney generals and the Trump administration. There were no meaningful discussions at a national level regarding the construct of the Medicaid program as the federal level was consumed with determining the end of the COVID-19 pandemic PHE which the Department of Health and Human Services expired as of May 11, 2023. However, with the 2024 elections, there is a strong possibility that healthcare and Medicaid will once again garner a considerable amount of debate at the Federal level due to the significant share of total tax receipts the program consumes at both the Federal and State level.

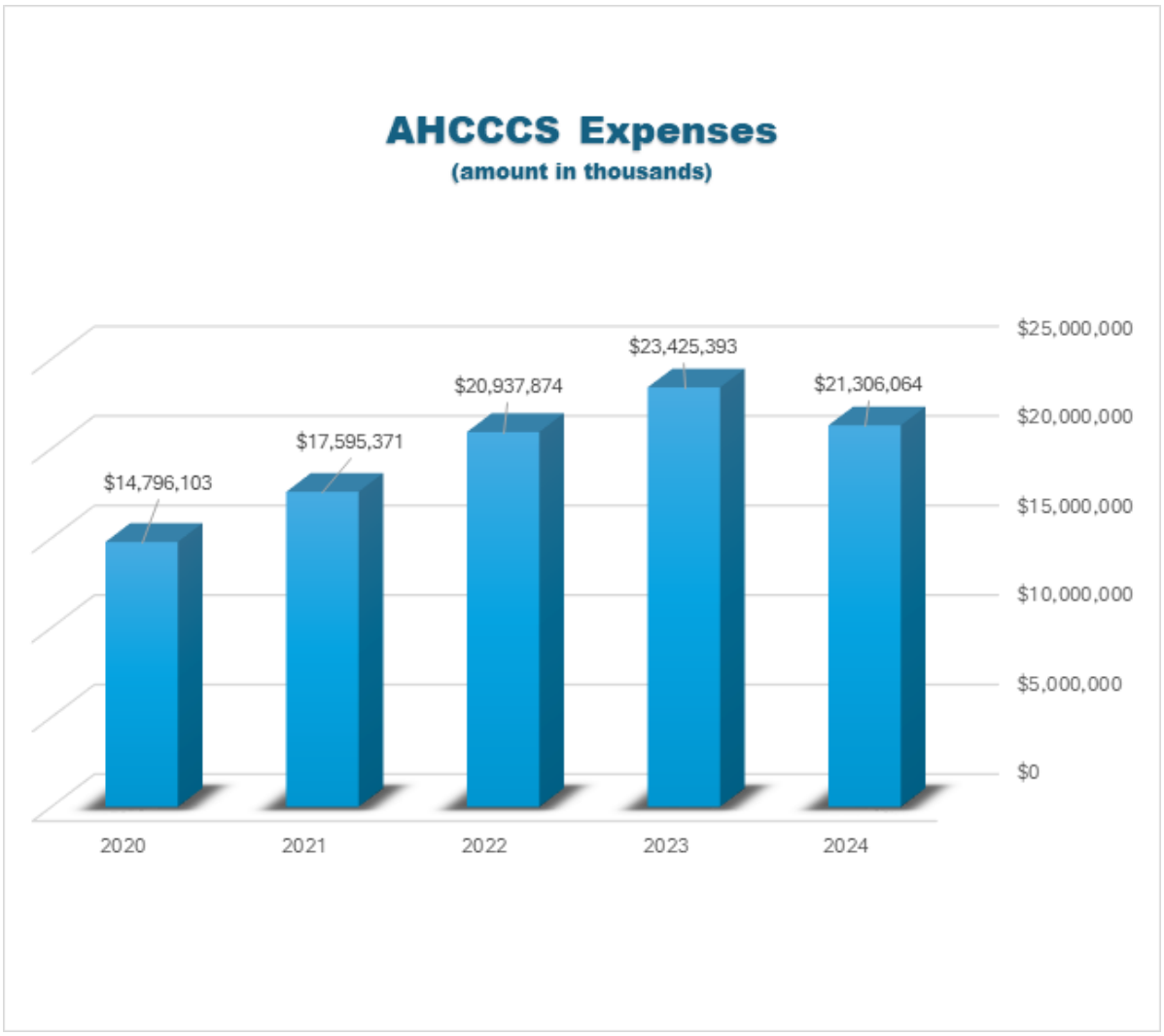
Current program funding remains significantly financed from federal financial participation primarily determined through the FMAP rate used to provide the amount of federal matching funds for qualifying State medical assistance expenditures. The FMAP is based on the relationship between Arizona's per capita personal income and the national average per capita personal income over three calendar years. The FMAP is recalculated each federal fiscal year and was at 69.56 percent through the first quarter of fiscal year 2024. The FMAP rate was reduced to 66.29 percent for the second through fourth quarters of state fiscal year 2024. Effective January 1, 2020, the Federal government enacted the Families First Coronavirus Response Act which provided an increase in the FMAP rate of 6.2 percent. In addition to the FMAP, the ACA introduced multiple new rates for the various new eligibility categories covered under the expansion. In Arizona, additional rates are applied to ACA expansion (adults and children) and Proposition 204 restoration (adult) covered populations. These new rates were all in excess of the "regular" 70.01 percent FMAP with the rates for both the expansion state (childless adults – 0 % to 105% FPL) and the newly eligible adults (adults - 106% to 135% FPL) remaining the same for both federal fiscal year 2021 and federal fiscal year 2022. On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted and prescribed that the 6.2 percentage point increase to the FMAP would be phased out over the course of calendar year 2023. The enhanced FMAP was 6.2 percentage points through the quarter ended March 31, 2023, 5.0 percentage points in the quarter ended June 30, 2023, 2.5 percentage points in the quarter ended September 30, 2023, and 1.5 percentage points in the quarter ended December 31, 2023.

State, county and miscellaneous funding sources combined to provide $5,565.3 million in State funding sources and appropriations in fiscal year 2024, a $902.5 million increase over the $4,662.8 million reported in fiscal year 2023. This increase is related to county contributions, capitation rate increases, increases in hospital assessments and opioid substance use disorders. The following are the components of the State match funding sources utilized in fiscal year 2024. State General Fund revenues raised primarily in the form of income and sales taxes directed to AHCCCS amounted to $2,210.4 million, and an additional $937.6 million was passed through from other State agencies in order to provide the State's share for Medicaid eligible medical assistance expenditures. Arizona counties contributed $924.4 million as determined by statutory funding formulas, session law and other intergovernmental agreements. Tax collections on tobacco products provided $104.8 million in State match funding. An additional $88.3 million in State revenue funding was provided by Arizona's share of tobacco litigation settlement funds. The master settlement agreement ("MSA") revenues are recorded in accordance with the Governmental Accounting Standards Board ("GASB") Technical Bulletin No. 2004-1, *Tobacco*

Settlement Recognition and Financial Reporting Entity Issues, which clarifies how payments made to AHCCCS pursuant to the MSA with major tobacco companies, are recorded. The MSA payment decreased in fiscal year 2024. AHCCCS has accrued $51.0 million for the period January 1, 2024 through June 30, 2024, based on Arizona's Joint Legislative Budget Committee 2024 estimated payment. The amounts of the payments are dependent upon several adjustments, the magnitude of which will not be fully known until an independent auditor provides its calculations in February or March of each year. Other factors that could also affect the MSA payment amount AHCCCS ultimately receives include default or bankruptcy by one or more tobacco companies and other unforeseen withheld payment amounts. Finally, Tribal gaming receipts determined by statutory formula distributed to AHCCCS provided $39.8 million in additional funding.

The following charts depict revenues by source of the governmental activities for the fiscal year and expenses for the reporting period:




AHCCCS Expenses
(amount in thousands)
$14,796,103
$17,595,371
$20,937,874
$23,425,393
$21,306,064
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
2020
2021
2022
2023
2024

Financial Analysis of AHCCCS' Governmental Funds

Governmental Funds

AHCCCS' governmental funds reported combined ending fund balances totaling $586.0 million, a $42.8 million net increase from the prior year's $543.2 million ending fund balances. The increase was partially due to an increase in the Hospital Assessment Fund due to a decrease in the Proposition 204 and Adult Expansion enrollment. This resulted from the Hospital Assessment being set prior to the fiscal year, based on budgeted assumptions, including projected enrollment growth, which are codified in rule and difficult to adjust mid-year. When actual enrollment declined instead of growing as anticipated, the pre-determined assessment amount exceeded the funds needed for disbursement, causing the fund balance to rise, with adjustments typically deferred to the following year's assessment due to the complexity of mid-year changes.

The General Fund is the chief operating fund of the AHCCCS Traditional Medicaid, KidsCare, Department of Child Safety Comprehensive Health Plan, ALTCS for both physical and behavioral health services, DSH, Rural Hospital, and services for non-Medicaid eligible members with SMI programs. The Other Governmental Fund, which includes the Hospital Assessment Fund, is the chief operating fund of the Proposition 204 services and ACA Adult Expansion programs. These programs primarily utilize a State general fund appropriation and or revenue sources from the hospital assessments, annual tobacco litigation settlement proceeds, taxes on tobacco products, contributions from Arizona counties, certified public expenditure methodologies, prescription drug rebate collections, voluntary contributions of the required state match from political subdivisions and certain provider type assessed taxes to provide the required state matching funds for federal Medicaid revenue. AHCCCS also has authority to make supplemental distributions to hospitals for the GME and DSH programs funded by voluntary contributions of the required state match from political subdivisions.

The Other Governmental Funds consist of twelve individual funds comprising the $157.2 million of the total $586.0 million fund balance available for qualifying activities. The Other Governmental Funds' fiscal year 2024 fund balances consist of restricted fund balances of $1.5 million, committed fund balances of $155.1 million, and assigned fund balances in the amount of $0.6 million. Revenue from taxes on cigarettes and other related tobacco products generated $72.9 million for the current year compared to $74.6 million in fiscal year 2023. Since the passage of Proposition 203 in November 2006, tobacco tax collections remain significantly lower than the $148.1 million collection high point in fiscal year 2006. Revenues from the Proposition 204 hospital assessment generated $628.2 million in fiscal year 2024 in available state matching monies for program services that increased from the $574.0 million collected in fiscal year 2023.

Budgetary Highlights

Differences totaling a decrease of $32.4 million occurred between the original and the final amended administrative and programmatic expenditure budgets. As a result of the implementation of the KidsCare Expansion which began in April 2024, legislation was passed during the 2024 session regarding a supplemental appropriation. On June 18, 2024, Governor Hobbs signed a supplemental bill that granted AHCCCS $7.5 million for CHIP. Conversely, as a result of the decrease in enrollment, on the same day, Governor Hobbs signed an ex-appropriation for the General Fund in the amount of $39.9 million. Additionally, the appropriated amounts for the voluntary payments from political subdivisions related to DSH and GME supplemental hospital payments are eligible to be increased for any political subdivision funds including the federal matching monies in excess of the original appropriation. For fiscal year 2024, the voluntary line items for GME Federal expenditure authority were not increased. For fiscal year 2024, there was no increase for the voluntary line items for DSH. For fiscal year 2024, the voluntary line items for Nursing Facilities Federal expenditure authority were not increased. Other differences relate to special line-item adjustments that utilized surpluses from one line item to offset shortfalls in another line item. These appropriation transfers are approved by the General Accounting Office and the Governor's Office of Strategic Planning and Budgeting and are in accordance with legislative authority.

Laws 2024, Chapter 209, Sections 106 and 107 provided the special line items which are briefly summarized as follows:

- $39.9 million decrease to the Traditional Services program as passed by the Legislature based on anticipated General Fund for enrollment decrease due to the disenrollment after the PHE.
- $7.5 million increase to the KidsCare Services program as passed by the Legislature based on anticipated CHIP Fund for enrollment growth due to the KidsCare Expansion.

For the year ended June 30, 2024, actual cash basis appropriated program expenditures for the General Fund were $859.8 million less than budgetary estimates.

Capital Asset Administration

AHCCCS' investment in capital assets for its governmental activities as of June 30, 2024, is $20.9 million, net of accumulated depreciation and amortization. This investment in capital assets includes furniture, vehicles, equipment, and internally generated software (intangible assets) for projects started after June 30, 2009. Land, buildings and improvements are under the management of the State and are separately accounted for on the State's annual comprehensive financial report. Total net capital assets decreased $16.0 million or 43.4 percent over the prior fiscal year balance. The largest component of AHCCCS' investment in capital assets continues to relate to internally developed software. The remaining capital asset changes are for disposals in excess of additions including depreciation of vehicles, furniture and equipment.

	Governmental Activities	
	2024	2023
Vehicles, furniture & equipment	$ 132	$ 204
Software	18,085	32,556
Right-to-use asset – Building	952	1,360
Right-to-use asset – Subscriptions	1,720	2,771
Total investment in capital assets	$ 20,889	$ 36,891

Additional information on AHCCCS' capital assets can be found in Note 2 to the accompanying financial statements.

Contingent Liabilities

In January 2001, AHCCCS obtained a Waiver from CMS to receive federal funding for certain non-categorically linked populations including those made eligible by the November 2000 passage of Proposition 204. The Waiver requires that over the term of the original agreement (April 1, 2001 through September 30, 2011) and the new agreement (October 1, 2011 through September 30, 2021), that the population covered by the Waiver be budget neutral for CMS. It should be noted that on September 30, 2021, the waiver was extended for one additional federal fiscal year ending September 30, 2022. On September 27, 2022, CMS approved a temporary extension of the Waiver to October 28, 2022, in order to allow Arizona and CMS to continue negotiations over the extension application. On October 14, 2022, CMS extended the Waiver through September 30, 2027. Budget neutral means that CMS will not pay more for medical services with the Waiver than it would without the Waiver. The Waiver Special Terms and Conditions include a monitoring arrangement that requires AHCCCS to report the financial results of the Waiver on a quarterly basis. For the demonstration period beginning on October 1, 2016, the net variance is phased down by an applicable percent. The percentages are determined based on how long the Medicaid population has been enrolled in managed care subject to the demonstration. Under the terms, AHCCCS is limited to only retaining 25 percent of the total variance as future savings. The budget neutrality calculation is dependent on a number of variables including the number of members and the eligibility category of members. Other factors that impact the variance are the general economy and its impact on unemployment, medical inflation and policy decisions made by the Legislature that may impact program costs. Through June 30, 2024, AHCCCS remains under the cumulative reporting limit threshold for the current waiver. Accordingly, management is projecting zero liability as of June 30, 2024 to CMS related to the budget neutrality agreement and the accompanying financial statements have not been adjusted for the impact of any liability AHCCCS may have related to the Waiver budget neutrality agreement.

In fiscal 2017, the U.S Department of Health and Human Services (“DHHS”) Office of the Inspector General (“OIG”) commenced a review of managed care drug rebates in Arizona for 2010 – 2013. The HHS OIG issued a report in February 2018 for their review of managed care drug rebates in Arizona from April through March 2013. The OIG’s report noted instances in which physician-administered

drugs were not properly submitted to the drug manufacturers for rebate. The HHS OIG recommended AHCCCS bill and collect from manufacturers, work with CMS to determine other physician-administered drugs were eligible for rebates and, if so, return the federal share.

This audit, Arizona Pharmacy Rebate Audit – AZ Audit A-09-16-02031, has been pending with CMS for several years, and no adverse findings have been issued. Their latest communication to AHCCCS, dated August 16, 2022, states they have been working with federal OIG and the CMS Division of Pharmacy and are close to a decision on the audit.

It is unclear if AHCCCS will be able to collect rebates from the drug manufacturers on such old claims. As such, AHCCCS views any recoveries as a gain contingency and will not record any amounts until received. Further, as the repayments to CMS are predicated on the receipt of the drug rebates, AHCCCS has not recorded any liability to CMS as of June 30, 2024.

AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in outpatient behavioral health services. AHCCCS connected the irregular billing with alleged criminal activity targeting tribal communities and other Arizonans.

Under 42 C.F.R. 455.23, when the State Medicaid Agency has conducted a preliminary investigation and a reliable indicia of fraud has been identified, the agency must suspend payments to a provider if a law enforcement agency accepts the State's referral. In AHCCCS's case, a Memorandum of Understanding governs the referral relationship between AHCCCS Office of the Inspector General and the Arizona Attorney General's Office, Health Care Fraud & Abuse Section. At the point a referral is made and payment is suspended (unless good cause not to suspend payments is established) only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation, AHCCCS may terminate a provider's enrollment, or exclude them participating in AHCCCS in the future, and require repayment of the identified overpayment while also determining ability to collect the overpayment as previously identified. Repayment of the overpayment is not required if the provider is out of business or is bankrupt.

Since May 16, 2023, AHCCCS has suspended payments to 313 providers and additional Credible Allegation of Fraud payment suspensions will be imposed if AHCCCS, through its investigation, determines there is a credible allegation of fraud concerning these additional providers. Despite the scale of potential Behavioral Health services fraud, AHCCCS has taken rapid steps to limit potential liability through comprehensive, system-wide strategies to find and eliminate fraudulent billing, including recommendations from the Arizona Attorney General's Office. These include, but are not limited to the following:

- Moved five behavioral health provider types to the high-risk category for new applicants and revalidating providers, which requires on-site visits, fingerprinting, background checks, a registration fee, and additional disclosures.
- Reviewed all existing claims edits and set specific rates for current "by report" billing that pay a percentage of the total billed amount instead of a standard rate.
- Created a trend report of all providers registering for the at-risk provider types and closely monitoring any billing anomalies.
- Created systems flagging concerning claims (volume, services per day, services for minors) for review prior to payment.
- Set billing thresholds to deny claims for multiple services that should not be billed on the same day, and more.
- Eliminated retroactive billing.
- Implemented ID.me identity verification for AHCCCS Online.
- Required providers to disclose any third-party billing relationships.
- Worked with the Arizona Corporation Commission to flag suspicious registrations.
- Required all providers to transition to Electronic Funds Transfer.

AHCCCS will continue to perform investigations, identify areas of concern and implement necessary system improvements.

A determination of potential liability cannot be made at this time as AHCCCS is still in the process of investigating provider billings. As of December 2024, 46 providers suspended on or since May 16, 2023, have received final administrative decisions following hearings in front of an Administrative Law Judge at the Office of Administrative Hearings, and all of these provider suspensions have been ultimately upheld. Independently, AHCCCS may resolve a provider's civil liability and demand repayment of funds improperly paid. AHCCCS may also remove a provider suspension when further investigation has identified there is no longer a reliable indicia of fraud relating to the provider's conduct. However, regardless of whether the provider's conduct amounted to fraud or other error, in such cases, the provider may still owe AHCCCS an overpayment for improperly paid claims. AHCCCS has lifted the Credible Allegation of Fraud determination in 34 cases of provider suspensions, and allowed the provider to return to active status.

AHCCCS OIG's identification and recovery of overpayment, pursuant to investigations of currently suspended providers, involves review of each provider's billing data, assessment of the legitimacy of any of those services, and calculation of the loss to AHCCCS (overpayment) caused by those illegitimate services. The likelihood of recovering the total amount paid to suspended providers is exceedingly low, because the actual loss to AHCCCS suffered in each case is not equivalent to the total amount AHCCCS paid to that provider. The reason for the lower recovery in such instances is because some suspended providers were paid by AHCCCS for both legitimate services rendered to AHCCCS members as well as illegitimate services which were not rendered. Therefore, OIG's investigations include a manual process to distinguish these payments.

AHCCCS' ability to collect funds identified as overpayments is further dependent on outside factors, including the progress of criminal prosecution, provider solvency, and attempts to disguise and move funds beyond the reach of authorities.

Recovery of funds may happen through criminal proceedings with restitution orders or by civil recoveries undertaken by AHCCCS. Distinguishing between these routes of recovery involves collaboration with law enforcement to identify cases that are appropriate for civil recovery led by AHCCCS rather than criminal prosecution.

All of the above factors make it challenging to accurately forecast future recoupment totals. Pursuant to 42 C.F.R. 433, Subpart F, AHCCCS is required to refund the Federal share of all overpayments made to providers unless the provider is out of business or bankrupt. The Federal share generally equates to approximately 75% of the total amount overpaid to a provider. The repayment must occur within one year of the discovery of an overpayment as calculated beginning with the date AHCCCS provides written notice to a provider of an overpayment determination. Note, the repayment obligation is applicable without regard to whether AHCCCS is successful in recovery of an overpayment from the provider, however, as noted there is an exception if a provider is out of business or bankrupt. Given the extent of the fraud, AHCCCS anticipates that overpayment written determinations, which trigger the legal obligation to refund federal funds, will occur on an individual case-by-case basis as investigations are concluded over the next months and years.

The Federal government will likely conduct a review to ensure that AHCCCS has correctly identified and determined overpayments as well as appropriately refunded federal funds. If a negative finding is made, future federal funding may be disallowed in the amount of the federal funds not remitted. AHCCCS has retained outside counsel experienced federal repayment matters to advise the Administration with respect to legal issues that may arise.

Beginning in fiscal year 2024, several complaints were filed against AHCCCS, DHS, and the State of Arizona. The lawsuits seek damages from the death or injuries sustained by current members allegedly arising from the failure of these individuals to receive appropriate addiction treatment and/or damages for the wrongful death of an AHCCCS member due to the behavioral health/sober living home fraud

scheme. Two of these lawsuits have been dismissed entirely, and AHCCCS has been dismissed as a party in three of them. The remaining lawsuit named the State of Arizona, but not AHCCCS as a defendant. From August 2023 through present, the State of Arizona, and AHCCCS, have received 42 Notices of Claim and served with seven individual lawsuits (some alleging wrongful death), and the class action lawsuit discussed below.

Management, upon consultation with internal and external counsel, notes that these matters are in the early stages and for the 42 Notices of Claim, no lawsuits have been filed except as noted above. Plaintiffs have in the aggregate claimed approximately $139,220,000 in damages. However, given that no lawsuits have been filed in connection for the majority of the Notices of Claim, and for those matters in litigation, no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

In August 2024, the State of Arizona received a Class Action Notice of Claim identifying subclasses for certain AHCCCS members and alleging injuries or wrongful death of the claimants. The lawsuit was subsequently filed in December 2024. AHCCCS intends to vigorously defend these matters. Management, upon consultation with internal and external counsel, notes that these matters are in the early stages, and a Motion to Dismiss has been filed. Plaintiffs have in the aggregate claimed approximately $395,000,000 in damages, however, given that the lawsuit is in the early stages, and no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS intends to vigorously defend these matters.

Additionally, in fiscal year 2024, AHCCCS was served with several lawsuits and several Notices of Claim from AHCCCS behavioral health providers alleging AHCCCS improperly suspended and/or terminated provider participation agreements, “blacklisted” the providers, and “slow paid” claims. Management, upon consultation with internal and external counsel, notes that many of these claims are in the early stages. The provider-claimants have in the aggregate claimed approximately $2,275,058,000 in damages. However, given that the matters are in the early stages, no discovery or disclosures have been exchanged, no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

Lastly, in August 2024, the Arizona Attorney General’s Office received a letter from attorneys purporting to represent a group of providers/facilities, and facility owners with potential claims against AHCCCS/the State arising from the suspension and/or termination of medical provider licenses or payments to providers. A number of these claimants have submitted Notices of Claim which are discussed above. Others appear to have not yet asserted claims. Management, upon consultation with internal and external counsel, notes that these matters are in the very early stages. Plaintiffs have in the aggregate claimed approximately $1,162,288,000 in damages. Additionally, in January 2025, a group of providers filed suit against several parties including the State, AHCCCS and the AHCCCS Director alleging negligence, gross negligence, racial discrimination, lack of due process, breach of contract among others. Management, upon consultation with internal and external counsel, notes that these matters are in the early stages. Plaintiffs have in the aggregate claimed approximately $1,000,000,000 in damages. Given these matters are in the early stages, and no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

On September 25, 2023, Director Heredia was appointed by the Honorable Governor Hobbs to serve AHCCCS as its Cabinet Executive Officer and Executive Deputy Director. Director Heredia served in this capacity until she was officially nominated as Director by Governor Hobbs on August 29, 2024. An

allegation presented in some of the lawsuits noted above that were filed against AHCCCS challenges Director Heredia's authority to issue decisions on behalf of the Agency, including Director's Decisions during Director Heredia's interim title of Cabinet Executive Officer and Executive Deputy Director. (Similar arguments have also been asserted against other Agency Directors.) While these lawsuits arguably pose a potential risk, AHCCCS believes the legal positions it has taken in the litigation are correct and that Director Heredia's actions and decisions are valid during the time period in which she was appointed Cabinet Executive Officer and Executive Deputy Director. AHCCCS continues to monitor these legal challenges and does not anticipate any material impact on its financial statements.

Economic Factors and Next Year's Budgets and Rates

AHCCCS enrollment overall, for the period June 2023 to June 2024, experienced an enrollment decrease from 2,357,454 to 2,204,281, a loss of 153,173 members for a 6.50 percent decrease. The decrease is primarily attributable to a decrease in the 1931 Families/Children and SOBRA Children/Pregnant Women of 71,464, Proposition 204 restoration adults decrease of 38,817, Adult Expansion decrease of 26,640, KidsCare decrease of 1,063, and Emergency Services decrease of 7,425 totaling a decrease of 145,409.

The slight decrease in the unemployment rate did lead to a decrease in enrollment during fiscal year 2024. According to the Office of Economic Opportunity, the Arizona unemployment rate for June 2023 was 3.8%. In June 2024, the unemployment rate was 3.3% and in November 2024, it was 3.7%.

AHCCCS enrollment overall, for the period June 2024 to June 2025, is currently forecasted to go from 2,204,281 to 2,106,805, which would represent a loss of 97,476 members for a 4.4 percent decrease.

The total fiscal year 2025 appropriation for AHCCCS is $21,059.3 million compared to the final $20,039.0 million appropriation for fiscal year 2024.

For the contract year ending 2025, AHCCCS' overall weighted capitation rate increased by 3.6 percent across all lines of business except the Department of Economic Security/Developmental Disabilities program. An increase of 2.0 percent in the capitation rates is attributable to COVID-19, primarily driven by the expectation that as part of the unwinding of the COVID-19 PHE, and the end of the continuous coverage requirement, lower cost members will disenroll from Medicaid during contract year 2024 and contract year 2025 causing an increase in the average cost profile of the remaining Medicaid members. The contract year 2025 Acute Care capitation rates increased by 3.3 percent as compared to the 1.0 percent decrease for contract year 2024. The contract year 2025 Arizona Long Term Care System ("ALTCS") Elderly and Physically Disabled ("EPD") capitation rates increased by 1.35 percent as compared to the 4.0 percent increase for contract year 2024. The 2025 increase is primarily based on baseline utilization and unit trends, changes in pharmacy expenses and adjustments to reflect the costs to administer and manage the programs. It is important to note that federal law requires rates to be actuarially sound and the AHCCCS actuaries develop rates based on expected cost and utilization trends. In addition, AHCCCS must conduct an access to care analysis of its rates to assure that sufficient numbers of providers are willing to serve AHCCCS members. Therefore, depending on the results of this analysis and of AHCCCS' actuarial determination of the expected costs of the managed care organizations, the actual capitation rates could differ from projections.

AHCCCS' budget request for fiscal year 2026 was submitted to the Governor in September 2024. Factors such as Federal law changes, CMS decisions, COVID-19 PHE, legal decisions, economic conditions impacting case load changes compared to projections and the eligibility system shifts in population categories may require a supplemental appropriation for fiscal year 2025.

There are current discussions at both the federal and state levels to modify Medicaid funding methodologies which could significantly decrease Medicaid funding, and/or shift expenditures from the Federal government to the State. At the federal level, proposals under consideration include reductions

to the expansion population FMAP contributions, limitations on provider taxes, work requirements, and/or changing Medicaid from an entitlement program to a per-capita cap or block grant program. Concurrently, state-level proposals seek to tighten eligibility criteria to address budget constraints, further amplifying the potential for funding shortfalls. The potential exists that certain funding changes passed into law could trigger either the session law or statutory requirement that AHCCCS stop collection of the Hospital Assessment if the ACA is repealed or if the FMAP for the expansion and restoration populations, as authorized by the ACA, falls below 80.0 percent. Such an outcome would likely disrupt the revenue stream supporting the Hospital Assessment Fund, leading to insufficient funding to maintain current program levels. Consequently, AHCCCS would most likely need to adjust eligibility standards, scale back services, or reduce provider reimbursement to align with the reduced available funds, potentially impacting access to care for enrolled populations.

Request for Information

This financial report is designed to provide a general overview of AHCCCS' finances for the State's citizens and taxpayers, and its members, providers, and creditors. Questions concerning any of the information provided in this report or requests for additional financial information should be addressed to the Arizona Health Care Cost Containment System, Division of Business and Finance, Attention: Finance Administrator, MD 5400, 801 East Jefferson, Phoenix, Arizona 85034.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

STATEMENT OF NET POSITION

June 30, 2024
(amounts expressed in thousands)

	Governmental Activities
ASSETS	
CURRENT ASSETS	
Cash	$ 705,507
Designated cash	135,196
Restricted cash	210,347
Due from state and local governments	138,848
Due from federal government	1,475,095
Tobacco settlement receivable	51,000
Receivables and other	1,906,640
TOTAL CURRENT ASSETS	4,622,633
NONCURRENT ASSETS	
Capital assets:	
Furniture, vehicles, equipment and software, net of accumulated depreciation	18,217
Right-to-use asset - building, net of accumulated amortization	952
Right-to-use asset - subscriptions, net of accumulated amortization	1,720
TOTAL NONCURRENT ASSETS	20,889
TOTAL ASSETS	4,643,522
DEFERRED OUTFLOWS OF RESOURCES	
Pension and OPEB	19,126
LIABILITIES	
CURRENT LIABILITIES	
Accounts payable	77,082
Other accrued liabilities	3,640
Unearned revenue	40,318
Due to state and county governments	610,563
Due to federal government	1,523,293
Accrued programmatic claims	1,776,017
Compensated absences	5,733
Lease liability, current portion	422
Subscription liability, current portion	420
OPEB liability, current portion	307
TOTAL CURRENT LIABILITIES	4,037,795
NONCURRENT LIABILITIES	
Lease liability, net of current portion	590
Subscription liability, net of current portion	1,342
Net Pension liability	85,974
OPEB liability, net of current portion	7,245
TOTAL NONCURRENT LIABILITIES	95,151
TOTAL LIABILITIES	4,132,946
DEFERRED INFLOWS OF RESOURCES	
Pension and OPEB	25,541
COMMITMENTS AND CONTINGENCIES	
NET POSITION	
NET INVESTMENT IN CAPITAL ASSETS	18,115
RESTRICTED	90,523
UNRESTRICTED	395,523
TOTAL NET POSITION	$ 504,161

See Notes to Financial Statements

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

STATEMENT OF ACTIVITIES

Year Ended June 30, 2024
(amounts expressed in thousands)

	Program Expenses	Program Revenues: Charges for Services	Program Revenues: Federal Operating Grants	Program Revenues: Other Operating Grants and Contributions	Net (Expense) Revenue and Changes in Net Position: Governmental Activities
PROGRAMS					
Government activities:					
Health care programs	$ 21,306,064	$ 15	$ 15,924,241	$ 2,312,636	$ (3,069,172)
TOTAL PROGRAMS	$ 21,306,064	$ 15	$ 15,924,241	$ 2,312,636	$ (3,069,172)
General revenues:					
State appropriations					3,148,063
Tobacco tax					104,758
Other					(190)
Total general revenues					3,252,631
Transfers:					
Transfers out					(158,455)
Total general revenues and transfers					3,094,176
CHANGE IN NET POSITION					25,004
NET POSITION, BEGINNING OF YEAR					479,157
NET POSITION, END OF YEAR					$ 504,161

See Notes to Financial Statements

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BALANCE SHEET - GOVERNMENTAL FUNDS

June 30, 2024
(amounts expressed in thousands)

	General Fund	Other Governmental Funds	Total Governmental Funds
ASSETS			
Cash	$ 528,616	$ 176,891	$ 705,507
Designated cash	135,196	-	135,196
Restricted cash	201,702	8,645	210,347
Due from state and local governments	116,269	22,579	138,848
Due from federal government	1,457,619	17,476	1,475,095
Due from other funds	7,664	-	7,664
Tobacco settlement receivable	51,000	-	51,000
Receivables and other	1,245,712	307	1,246,019
TOTAL ASSETS	$ 3,743,778	$ 225,898	$ 3,969,676
LIABILITIES			
Accounts payable	$ 66,430	$ 10,652	$ 77,082
Other accrued liabilities	3,186	454	3,640
Unearned revenue	37,900	2,418	40,318
Due to state and county governments	472,605	381	472,986
Due to federal government	1,000,249	-	1,000,249
Due to general fund	-	7,664	7,664
Accrued programmatic claims	1,352,945	47,081	1,400,026
TOTAL LIABILITIES	2,933,315	68,650	3,001,965
DEFERRED INFLOWS OF RESOURCES			
Unavailable revenue	381,725	-	381,725
COMMITMENTS AND CONTINGENCIES			
FUND BALANCES			
Restricted	89,035	1,488	90,523
Committed	305,401	155,179	460,580
Assigned	213	581	794
Unassigned	34,089	-	34,089
TOTAL FUND BALANCES	428,738	157,248	585,986
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND FUND BALANCES	$ 3,743,778	$ 225,898	

Amounts reported for governmental activities in the statement of net position are different because:	
Capital assets used in governmental activities are not financial resources and, therefore, are not reported in the funds.	20,889
Lease liability related to the right-to-use asset - building amount not reported in the funds.	(1,012)
Subscription-based technology agreements liabilities not reported in the funds	(1,762)
Some liabilities, including net pension and other postemployment benefits liabilities, are not due and payable in the curent period and, therefore, are not reported in the funds.	(93,526)
Deferred outflows and inflows of of resources related to pensions and OPEBs are applicable to future reporting periods and, therefore, are not reported in the funds.	(6,415)
A portion of liabilities for accrued paid time off of this amount is not due and payable from current financial resources and, therefore is not reported in the funds.	(5,733)
Receivables, offsetting the above accrued paid time off liability, will not be collected in the current period, therefore are not reported in the funds.	5,733
A portion of amounts due to state, county and federal governments will not be paid in the current period, therefore is not reported in the funds.	(660,621)
Unavailable revenue is reported in the funds but not in the entity-wide statements.	381,725
A portion of accrued programmatic claims is not due and payable from current financial resources and, therefore is not reported in the funds.	(375,991)
A portion of receivables and other will not be collected in the current period, therefore is not reported in the funds.	654,888
	$ 504,161

See Notes to Financial Statements

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS

Year Ended June 30, 2024

(amounts expressed in thousands)

	General Fund	Other Governmental Funds	Total Governmental Funds
REVENUES			
State government:			
Appropriations	$ 2,191,587	$ -	$ 2,191,587
State pass through funds	937,633	-	937,633
Federal government:			
Acute care	11,556,632	120,277	11,676,909
Long-term care	1,403,630	59,636	1,463,266
ISA/IGA pass through funds	2,626,464	1,737	2,628,201
Federal COVID-19	-	29,405	29,405
County and other local government:			
Acute care	126,051	-	126,051
Long-term care	430,328	-	430,328
IGA pass through funds	368,007	-	368,007
Tobacco litigation settlement revenue	88,273	-	88,273
Tobacco tax revenue	31,815	72,943	104,758
Gaming revenue	-	39,785	39,785
Nursing facility tax assessment	-	31,823	31,823
Hospital assessment	494,387	628,227	1,122,614
HAPA intergovernmental agreement revenue	972	28,223	29,195
Premium revenue	15	-	15
Other	75,018	1,541	76,559
TOTAL REVENUES	20,330,812	1,013,597	21,344,409
PROGRAMMATIC EXPENDITURES			
Medical Services:			
Traditional services	6,204,452	27,946	6,232,398
Proposition 204 services	6,455,388	529,168	6,984,556
Newly eligible adults	576,829	36,008	612,837
Comprehensive Health Plan (CHP)	153,740	-	153,740
KidsCare services	161,293	76	161,369
Long-term care services	4,996,376	108,180	5,104,556
School-based services	114,453	-	114,453
Behavioral health services	4,769	-	4,769
Hospital Payments:			
Disproportionate share	180,460	-	180,460
Rural and critical access hospital	30,257	-	30,257
Graduate medical education	487,980	-	487,980
Trauma center services	-	39,785	39,785
Other:			
Medicare Part D clawback	169,500	-	169,500
Behavioral support services	180,366	128,039	308,405
Targeted investments	61,649	-	61,649
TOTAL PROGRAMMATIC EXPENDITURES	19,777,512	869,202	20,646,714
ADMINISTRATIVE EXPENDITURES	419,505	51,319	470,824
ADMINISTRATIVE EXPENDITURES PASSED THROUGH	25,657	-	25,657
TOTAL EXPENDITURES	20,222,674	920,521	21,143,195
EXCESS OF REVENUES OVER EXPENDITURES	108,138	93,076	201,214
OTHER FINANCING SOURCES (USES)			
Transfers from (to) other State agencies:			
State General Fund	(82,759)	-	(82,759)
Arizona Department of Economic Security	(18,008)	-	(18,008)
Arizona Department of Education	158	-	158
Arizona Department of Health Services	5,000	(8,051)	(3,051)
Arizona Department of Liquor Licenses and Control	-	(666)	(666)
Arizona Department of Revenue	(836)	-	(836)
Arizona Attorney General	(1,036)	-	(1,036)
Governor's Office	14,336	(4,123)	10,213
Arizona Department of Administration	(55,509)	-	(55,509)
Arizona Department of Child Safety	-	(2,145)	(2,145)
Arizona Department of Juvenile Correction	-	(116)	(116)
Arizona Department of Early Childhood Development	-	(82)	(82)
Arizona Board of Nursing	(4,618)	-	(4,618)
Transfers between funds:			
AHCCCS General Fund	(105)	105	-
AHCCCS General Fund 49TI 91TI	170	(170)	-
TOTAL OTHER FINANCING SOURCES (USES)	(143,207)	(15,248)	(158,455)
NET CHANGE IN FUND BALANCES	(35,069)	77,828	42,759
FUND BALANCES, BEGINNING OF YEAR	463,807	79,420	543,227
FUND BALANCES, END OF YEAR	$ 428,738	$ 157,248	$ 585,986

See Notes to Financial Statements

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

RECONCILIATION OF THE GOVERNMENTAL FUNDS STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS TO THE GOVERNMENT-WIDE STATEMENT OF ACTIVITIES

Year Ended June 30, 2024
(amounts expressed in thousands)

Amounts reported for governmental activities in the Statement of Activities (page 25) are different because:

Change in fund balances - total governmental funds (page 27)	$	42,759
AHCCCS pension contributions are reported as expenditures in the governmental funds when made. However, they are reported as deferred outflows of resources in the Statement of Net Position because the reported net position liability is measured a year before AHCCCS' report date. Pension expense, which is the change in the net pension liability adjusted for changes in deferred outflows and inflows of resources related to pensions, is reported in the Statement of Activities.		(4,062)
Certain expenses reported in the Statement of Activities do not require the use of current financial resources and, therefore, are not reported as expenditures in the governmental funds.		1,053
With the adoption of GASB Statement No. 87, amortization of the right-to-use asset - building in the Statement of Activities exceeds the lease expense reported in the governmental funds.		(3)
Subscription-based technology agreements expense		(200)
Governmental funds report capital outlays as expenditures. However, in the Statement of Activities, the cost of those assets is allocated over their estimated useful lives and reported as depreciation expense. This is the amount by which depreciation exceeded capital outlays in the current period.		(14,543)
Change in net position of governmental activities (page 25)	$	25,004

(1) Description of reporting entity and summary of significant accounting policies

The accounting policies of the **Arizona Health Care Cost Containment System** ("AHCCCS" or the "Agency") conform to the accounting principles generally accepted in the United States of America applicable to governmental units. The financial statements of AHCCCS, as an agency of the State of Arizona ("State"), are not intended to represent the related financial statement information of the primary government.

A. Reporting entity

The Arizona Legislature ("Legislature") established AHCCCS in November 1981 to administer health care for the State's indigent population. AHCCCS is a state agency managed by an independent cabinet level administration created by the Legislature and is funded by a combination of federal, State, county and local funds. The federal portion is funded through the Centers for Medicare and Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("DHHS") under a Section 1115 Waiver ("Waiver") approved by CMS, which exempts the AHCCCS program from certain requirements of conventional Medicaid programs.

Under Section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that such demonstrations are likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration

On October 14, 2022 CMS approved a request for a five year extension of the state's section 1115 demonstration project entitled "Arizona Health Care Cost Containment System (AHCCCS)" (Project Number 11-W-00275/9), in accordance with sections 1115 (a) of the Social Security Act. The approval includes the extension of 1) AHCCCS Complete Care ("ACC"), the statewide managed care system, which provides physical and behavioral health services to the majority of Arizona's Medicaid population; 2) the Arizona Long Term Care System ("ALTCS"), which provides physical, behavioral, long-term care services and supports, including home-and-community based services, to targeted populations; 3) the Comprehensive Health Plan ("CHP") for children in foster care; and 4) the AHCCCS Complete Care - Regional Behavioral Health Agreement ("ACCRBHA"), which provides integrated care for individuals with a serious mental illness ("SMI"). The extension approval will also continue the existing waiver of retroactive eligibility. The Waiver extension is for the period from October 14, 2022 through September 30, 2027.

AHCCCS provides acute and long-term health care coverage to eligible residents of Arizona. Eligible residents include those who qualify under Section 1931(b) of the Social Security Act, individuals who are aged, blind or disabled, children who meet certain age requirements from families receiving supplemental nutrition assistance, children and pregnant women whose household income meets eligibility requirements, certain single adults, childless couples, uninsured women needing active treatment for breast and/or cervical cancer and individuals with disabilities who want to work and who meet certain Supplemental Security Income ("SSI") eligibility criteria. Beginning on January 1, 2014, AHCCCS implemented the Patient Protection and Affordable Care Act ("ACA") of 2010. The ACA implementation included (a) the restoration of the childless adults (expansion state adults) who were previously eligible for AHCCCS under the voter mandated Proposition 204, (b) expanded coverage for adults from 100% to 133% of the federal poverty limit ("FPL") and (c) the mandatory child expansion for children ages 6-19 from 100% to 133% of the FPL. These three distinct populations all have enhanced federal financial participation matching rates effective January 1, 2014.

(1) Description of reporting entity and summary of significant accounting policies (continued)

The extension Waiver includes the following new Medicaid eligibility categories: (a) Indian Health Services, providing broader range of Medicaid services to the American Indian population, (b) Housing Initiative for the Housing and Health Opportunities ("H2O") services for health-related social needs ("HRSN"), including housing supports to targeted population, and (c) Targeted Investment ("TI") 2.0 which provides incentive payments to participating providers to improve health quality for targeted populations through addressing social determinants of health ("SDOH"). Through Housing and H2O, CMS is authorizing increased coverage of certain services that address health-related social needs, as evidence indicates that these HRSN services are a critical driver of an individual's access to health services that help to keep them well.

On February 16, 2024, CMS approved an amendment with 2 policies, “Parents as Paid Caregivers” (PPCG) and “KidsCare Expansion,” to the demonstration titled, “Arizona Health Care Cost Containment System (AHCCCS)” (Project Number 11-W-00275/9 and 21-W-00074/9), in accordance with section 1115(a) of the Social Security Act.

Approval of the Parents as Paid Caregivers amendment will allow the state to continue to reimburse legally responsible parents of minor children for providing direct care to their minor children, helping to mitigate the direct care worker shortage and improve access to timely, effective care in the home and community. The amendment also establishes a Family Support service as part of the home and community-based services (HCBS) benefit package. The Family Support service aims to support primary caregivers, including parents, and improve access to timely, effective care in the home and community. Additionally, the KidsCare Expansion amendment will allow the state to increase the Children’s Health Insurance Program eligibility thresholds from 200 percent of the federal poverty level (FPL) up to and including 225 percent of the FPL, with the flexibility for KidsCare coverage to go up to and include 300 percent of the FPL, subject to approval by the state legislature. The approval is effective as of the aforementioned date and will remain in effect through the demonstration approval period, which is set to expire September 30, 2027.

CMS’s approval of this section 1115(a) demonstration, as amended, is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions, and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid or CHIP state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

In Arizona, health-related social needs services will be provided for individuals experiencing life transitions, including individuals who are experiencing homelessness and meet specific clinical and social risk criteria, such as beneficiaries with a health need as documented in their medical record, including but not limited to a Serious Mental Illness (“SMI”), high-cost high-needs chronic health conditions or co-morbidities, or enrolled in the Arizona Long Term Care System (“ALTCS”).

AHCCCS receives quarterly federal grants for the Title XIX Medicaid program and annual grant awards for the Title XXI Children’s Health Insurance Program (“CHIP”) from CMS (as matching funds) to cover a portion of the health care costs of the eligible residents of the State. State appropriations and county funding levels are based on annual budgets as dictated by the Legislature and as specified by Arizona Statutory funding formula and Session Law. For fiscal year 2024, funding also includes behavioral health services funded from Federal Block Grants received from the DHHS Substance Abuse and Mental Health Services Administration (“SAMHSA”) and state appropriations targeted to specific needs of individuals with serious mental illness (“SMI”). In addition, AHCCCS receives several other grants from SAMHSA for behavioral health services which include the provision of services to Title XIX and Title XXI members as well as non-Title XIX individuals with SMI and include specific funding for crisis, substance abuse, housing, supported housing services as well as emergency use grants to address mental, substance use disorders and suicide prevention during COVID-19.

(1) Description of reporting entity and summary of significant accounting policies (continued)

Federal funding for CHIP was reauthorized at the Federal level in late 2017 with an additional extension in early 2018 and AHCCCS expects that sufficient CHIP allotment funding will be available to continue both M-CHIP and KidsCare programs through Federal fiscal year 2027. Laws 2019, Chapter 270, Section 10 amended A.R.S. § 36-2985 to remove the language requiring AHCCCS to stop processing all new applications for KidsCare if the effective FMAP is less than one hundred percent. AHCCCS required a supplemental appropriation for fiscal year 2024 that included an additional $7.5 million in expenditure authority for the CHIP program due to the increased enrollment related to the KidsCare Expansion policy. Specifically, the KidsCare Expansion policy allows Arizona to increase the CHIP eligibility thresholds from 200 percent of the federal poverty level (FPL) up to and including 225 percent of the FPL. The supplemental appropriation was signed into law on June 18, 2024.

Under AHCCCS, health care coverage is provided substantially through a competitive bidding process with private and county-sponsored health plans bidding for the enrollment of AHCCCS eligibles by geographical service area. In addition, AHCCCS purchases health care services directly from providers. During fiscal year 2019, AHCCCS moved forward with the largest integration effort in the history of the program. On October 1, 2018, AHCCCS' managed care organizations began to provide services that are designed to coordinate the provision of physical and behavioral health care services. Integrated health care delivery benefits by aligning all physical and behavioral health services under a single plan. With one provider network and one payer, health care providers are better able to coordinate care across the continuum of services and supports and members are able to more easily navigate the system, resulting in improved health outcomes.

B. Basis of presentation

The basic financial statements include both government-wide and fund financial statements. The government-wide financial statements report information on the entire Agency while the fund financial statements focus on major funds. Each presentation provides valuable information that can be analyzed and compared between years to enhance the usefulness of the information.

The government-wide financial statements (i.e., the statement of net position and the statement of activities) report information on the entire Agency. The effect of all significant interfund activity has been removed from these financial statements.

The statement of activities demonstrates the degree to which the governmental activities' direct expenses are offset by program revenues. Direct expenses are those that are clearly identifiable with a specific function. Program revenues include appropriations, contributions and grants that are restricted for the operational or capital requirements of a particular function or segment.

Fund financial statements provide information about the Agency's funds. The General Fund is the Agency's primary operating fund, and it accounts for all financial resources except those required to be accounted for in another fund. AHCCCS did not have any major funds for fiscal year 2024; accordingly, all governmental funds other than the General Fund are aggregated and reported as other governmental funds.

C. Measurement focus, basis of accounting and financial statement presentation

The government-wide financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows.

(1) Description of reporting entity and summary of significant accounting policies (continued)

The governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period. Revenues are considered to be available when they are collectible within the current period or soon enough thereafter to pay liabilities of the current period. When an asset is recorded in the governmental fund financial statements, but the revenue is not available, AHCCCS reports a deferred inflow of resources until such time as the revenue becomes available. The governmental funds' unearned revenue consists of revenue received in advance for services not yet provided. Expenditures generally are recorded when a liability is incurred, as under accrual accounting. Accrued programmatic costs include received but unpaid claims and estimates for incurred but not reported claims paid in the 31-day period following the end of the fiscal year or shortly thereafter. Actual results for accrued programmatic costs may differ from such estimates. These differences are recorded in the period in which they are identified. However, expenditures related to compensated absences are recorded only when payment is due.

In fiscal year 2024, AHCCCS reports the following significant funds:

a. The General Fund is the primary operating fund for the Title XIX Medicaid program and the Title XXI State Children's Health Insurance Program.

b. Special Revenue Funds, reported as other governmental funds, account for various health and administrative programs.

The General Fund is the only major governmental fund of AHCCCS.

D. Cash and investments

Substantially all of the cash and investments maintained by AHCCCS are held by the State of Arizona Office of the Treasurer ("Treasurer") with other State monies in an internal cash and investment pool. Investment income is allocated to AHCCCS on a pro rata basis. Amounts held by the Treasurer are recorded at fair value and totaled $1,051,050, at June 30, 2024, including designated and restricted funds of $345,543.

The State is statutorily limited (by ARS §35-312 and §35-313) to certain investment types. Additionally, State statutes require investments made to be in accordance with the "Prudent Person" rule. This rule imposes the responsibility of making investments with the judgment and care that persons of ordinary prudence would exercise in the management of their own affairs when considering both the probable safety of their capital and the probable income from that capital. The Treasurer issues a separately published Annual Financial Report that provides additional information relative to the Treasurer's total investment activities.

Designated cash in the General Fund has been internally designated by AHCCCS in the amount of $135,196 for the Interagency Service Agreement ("ISA") Fund. The ISA Fund is used to properly account for, control, and report receipts and disbursements associated with ISAs which are not required to be reported in other funds.

Fund receipts consist of monies received from other entities and are utilized to match federal funding under the Medicaid and CHIP programs under the terms stated in the ISAs. Cash in the Other Governmental Funds is legally restricted in the amount of $7,209 for the Hawaii Arizona PMMIS Alliance ("HAPA") Fund, as described in Note 4.

(1) Description of reporting entity and summary of significant accounting policies (continued)

In accordance with the Federal Cash Management Improvement Act of 1990 guidelines, AHCCCS may only request federal funds under specified funding techniques. The application of required funding techniques is automated within the AZ360 system and controls the timing of federal funding draw downs. Any interest penalty accrued through the automated process is paid by the State from interest earned on the cash investments.

E. Capital assets

Capital assets, which consist of furniture, vehicles and equipment, and internally generated computer software, are reported in the government-wide Statement of Net Position. Tangible capital assets are defined as assets with an initial, individual cost of more than $5 and an estimated useful life in excess of one year. Such assets are recorded at historical cost and are depreciated over their estimated useful lives ranging from three to five years. Intangible capital assets consist of internally generated computer software with an initial cost greater than $1,000. Software is amortized over an estimated useful life of five to ten years. Expenditures for incomplete projects are reported as software under development. The costs of normal maintenance and repairs that do not add to the value of the asset or materially extend assets' lives are not capitalized.

AHCCCS accounts for internally generated computer software in accordance with GASB Statement No. 51, *Accounting and Financial Reporting for Intangible Assets*. In accordance with Statement No. 51, outlays associated with activities in the preliminary project stage should be expensed as incurred. Outlays related to activities in the application development stage are capitalized. Capitalization of such outlays will cease no later than the point at which the computer software is substantially complete and operational.

AHCCCS accounts for capital assets in accordance with the provisions of GASB Statement No. 42, *Accounting and Financial Reporting for Impairment of Capital Assets and for Insurance Recoveries*. GASB Statement No. 42 requires that capital assets be reviewed for impairment whenever events or changes in circumstances indicate a significant, unexpected decline in the service utility of a capital asset. If such assets are considered to be impaired and are still in use, the impairment can be recognized using the following methods: restoration cost approach, service unit approach, and a deflated depreciated replacement cost approach. If such assets are considered to be impaired and are no longer used, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. At June 30, 2024, management did not believe impairment indicators were present, and there were no idle capital assets.

Capital assets also include the right-to-use asset – building and right-to-use asset – subscriptions in accordance with GASB Statements No. 87 and GASB 96, respectively. See further information in Notes T and U below.

F. Deferred outflows and inflows of resources

The statement of net position and balance sheet – governmental fund include separate sections for deferred outflows of resources and deferred inflows of resources. Deferred outflows of resources represent a consumption of net position that applies to future periods that will be recognized as an expense or expenditure in future periods. Deferred inflows of resources represent an acquisition of net position or fund balance that applies to future periods and will be recognized as revenue in future periods.

(1) Description of reporting entity and summary of significant accounting policies (continued)

G. Pensions

For purposes of measuring the net pension (asset and) liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the Arizona State Retirement System ("ASRS") pension plan's fiduciary net position and additions to/deductions from the ASRS plan's fiduciary net position have been determined on the same basis as they are reported by the ASRS plan. For this purpose, ASRS benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms.

H. Net position / fund balance

The difference between fund assets and liabilities is "Net Position" on the government-wide statements. Net position is reported in three categories:

- Net investment in capital assets, consists of capital assets net of depreciation and the right- to-use asset – building and right-to-use asset – subscriptions, net of amortization and the related lease and subscription liabilities.
- Restricted net position is restricted due to legal restrictions from laws and regulations of other governments, or legally enforceable through enabling legislation of the State.
- Unrestricted net position consists of net position which does not meet the definition of the two preceding categories.

These categories are based primarily on the extent to which AHCCCS is bound to honor constraints on the specific purposes for which the amounts in those funds can be spent. In the governmental fund financial statements, fund balances are classified as nonspendable and spendable and are defined as follows:

Nonspendable fund balance

Nonspendable fund balance - this includes amounts that cannot be spent because they are either not spendable in form (such as inventory) or legally or contractually required to be maintained intact (such as endowments). At June 30, 2024, AHCCCS had no nonspendable fund balance.

Spendable fund balance

Restricted fund balance - this includes amounts that can be spent only for specific purposes stipulated by legal requirements imposed by other governments, external resource providers, or creditors. AHCCCS imposed restrictions do not create a restricted fund balance unless the legal document that initially authorized the revenue (associated with that portion of the fund balance) also included language that specified the limited use for which the authorized revenues were to be expended. At June 30, 2024, AHCCCS' restricted fund balance totaled $90,523.

(1) Description of reporting entity and summary of significant accounting policies (continued)

Committed fund balance - this includes amounts that can only be used for specific purposes pursuant to constraints imposed by formal action of the Legislature. Those committed amounts cannot be used for any other purpose unless the Legislature removes or changes the specified use by taking the same type of action (for example, statute, session law, etc.) that it employed to previously commit those amounts. If the Legislative action that limits the use of the funds was separate from the action that initially created the revenues that form the basis for the fund balance, then the resultant fund balance is considered to be committed, not restricted. AHCCCS considers a resolution, a statute, or a session law action to constitute a formal action of the Legislature for the purposes of establishing committed fund balance. At June 30, 2024, AHCCCS' committed fund balance totaled $460,580.

Assigned fund balance - this includes amounts constrained by the Legislature for specific purposes. Assigned fund balances include all remaining amounts (except negative amounts) that are reported in the governmental funds, other than the general fund, that are not classified as nonspendable and are neither restricted nor committed and amounts in the general fund that are intended to be used for a specific purpose. By reporting particular amounts that are not restricted or committed in a special revenue fund, AHCCCS has assigned those amounts to the purpose of the respective funds. At June 30, 2024, AHCCCS' assigned fund balance totaled $794.

Unassigned fund balance - this includes the remaining spendable amounts which are not included in one of the other classifications. At June 30, 2024, AHCCCS' unassigned fund balance totaled $34,089.

AHCCCS has neither adopted a minimum fund balance policy nor any agency specific policy for the order of spending fund balances; rather, AHCCCS follows the policies of the State and adheres to the purpose of legislative appropriations or federal grant regulations.

When an expenditure is incurred for purposes for which restricted, committed, and unassigned fund balance is available, the State considers restricted, committed, and unassigned amounts to have been spent in that order.

I. Capitation payments

Contracted health plans ("Contractors") receive fixed capitation payments, generally in advance, based on actuarially determined rates for each AHCCCS member enrolled with the plan. The plans are required to provide all covered health care services to their members, regardless of the cost of care.

For each contract year for the contracted health plans, reconciliations are performed to recoup the excess funds from each plan above a certain profit corridor or if the costs exceed the amount of the capitation and reinsurance payments to make a payment to cover the loss below a certain corridor. Therefore, profits in excess of the percentages set forth in the AHCCCS policy shall be recouped by AHCCCS and losses in excess of the percentages set forth in the AHCCCS policy shall be paid to the Contractor. This methodology ensures that profit and loss are subject to certain risk mitigation limitations.

AHCCCS pays prospective capitation as well as prior period coverage ("PPC"). The PPC period generally is from the effective date of eligibility to the day a member is enrolled with a contracted health plan. There are several risk mitigation strategies where AHCCCS offers the Contractors a risk corridor for both PPC and prospective expenses which protects the Contractors from excessive losses, while at the same time placing an upper limit on profits.

(1) Description of reporting entity and summary of significant accounting policies (continued)

J. Reinsurance payments

AHCCCS provides a stop-loss reinsurance program for its contracted health plans for partial reimbursement, after a deductible is met, of qualifying covered medical services incurred for members. AHCCCS is self-insured for the reinsurance program which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible level. The deductible is the responsibility of the Contractor. This reinsurance provides partial reimbursement of reinsurance eligible covered services and will reimburse 75% of eligible costs above the deductible of covered expenses. The deductible effective October 1, 2020, for AHCCCS Complete Care ("ACC") and Regional Behavioral Health Authorities ("RBHA") contractors is $150,000. Annual deductible levels apply to all members except for State Only Transplant members.

The reinsurance program also provides reimbursement for covered organ transplantation. Annual deductible levels do not apply to State Only Transplant members. The reinsurance for catastrophic disorders covers certain high-cost behavioral health, blood related disorders and biologic/high-cost specialty drug. For catastrophic reinsurance cases, there is no deductible level with the coinsurance of 85% of the eligible expenses.

Transplant reinsurance coverage is available to partially reimburse Contractors for the cost of care for an enrolled member who meets transplant reinsurance criteria. Individuals who qualify for transplant services, but who are later determined ineligible, due to excess income, may qualify for extended eligibility (refer to State Only Transplants Option 1 and Option 2).

Reinsurance coverage for State Only Option 1 and Option 2 members for transplants received at an AHCCCS contracted facility is paid at the lesser of 1) 100% of the AHCCCS contract amount for the transplantation services rendered, less the transplant share of cost; or 2) 100% of the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplant services rendered less the transplant share of cost, or the Contractor paid amount, less the transplant share of cost.

K. Fee-for-service payments

The AHCCCS program is responsible for the cost of providing behavioral health and medical services on a fee-for-service basis for certain member categories. Tribal Regional Behavioral Health Authorities ("TRBHAs") coordinate the delivery of comprehensive mental health services for American Indian/Alaskan Native ("AI/AN") members. In addition, the fee-for-service program serves AI/AN members who choose to receive their coverage through the American Indian Health Program ("AIHP"). Furthermore, the American Indian Medical Home ("AIMH") program supports Primary Care Case Management ("PCCM"), diabetes education and care coordination for its AIHP members. The Tribal Arizona Long Term Care System ("Tribal ALTCS") program provides Medicaid services to elderly and/or physically disabled American Indians who are determined eligible for ALTCS. Finally, persons enrolled in the Emergency Services Program ("ESP") prior quarter coverage for members enrolled in a health plan and persons enrolled in a health plan for less than 30 days may receive services on a fee-for-service basis.

(dollar amounts expressed in thousands)

(1) Description of reporting entity and summary of significant accounting policies (continued)

The ESP provides for emergency medical care to persons who are not eligible for full AHCCCS coverage due to their lack of United States citizenship or lawful alien status. Outpatient medical services for the ESP, prior quarter coverage, members enrolled in a health plan for less than 30 days and American Indian program enrolled members that receive services at a non-Indian Health Services ("IHS")/638 facility are reimbursed using the AHCCCS Outpatient Hospital Fee Schedule. Inpatient medical services for these populations are reimbursed based on the category of service provided and an inpatient per-diem reimbursement rate system or at the outlier reimbursement rate. Professional and non-hospital services for these populations are reimbursed at the AHCCCS fee for service rates.

Inpatient and outpatient medical services provided at an IHS facility are reimbursed at rates determined by the U.S. Department of Health and Human Services, Indian Health Services. Tribal-owned facilities contracted with IHS are reimbursed at rates determined by the U.S. Department of Health and Human Services, Indian Health Services or at the AHCCCS fee-for-service rates. Off-reservation services provided by non-IHS/638 providers are reimbursed based on the AHCCCS fee-for-service rates, AHCCCS inpatient per-diem reimbursement rate system or at the outlier reimbursement rate and the AHCCCS Outpatient Hospital Fee Schedule.

L. Incurred but not reported programmatic expenditures

In the accompanying financial statements, health care services expenditures include paid claims, received but unpaid programmatic claims, and an estimate made by management for incurred but not reported ("IBNR") programmatic claims. These IBNR programmatic claims include charges by physicians, hospitals and other health care providers for services rendered to eligible members during the period for which claims have not yet been submitted as well as prior period capitation payments for members enrolled retrospectively.

The estimates for IBNR programmatic claims are developed using historical data for payment patterns and other relevant factors. Such liabilities are necessarily based on assumptions and estimates, and while management believes the amount is adequate, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed by management and adjustments are reflected in the period determined. Activity included in the liability for accrued programmatic claims and medical services expenditures for the year ended June 30, 2024 is as follows:

Claims unpaid as of June 30, 2023	$ 733,854
Incurred related to:	
Current year	2,603,043
Prior years	(196,916)
Total incurred	2,406,127
Paid related to:	
Current year	(2,029,409)
Prior years	(521,170)
Total paid	(2,550,579)
Claims unpaid as of June 30, 2024	$ 589,402

(1) Description of reporting entity and summary of significant accounting policies (continued)

M. Hospital Assessment Fund

The hospital assessment fund, established pursuant to ARS §36-2901.09 on January 1, 2014, consists of monies collected from an assessment on hospitals for the purpose of funding a portion of the non-federal share of costs for the Proposition 204 eligible population. AHCCCS recorded assessment revenues in the amount of $628,227 and expenditures in the amount of $550,026 during fiscal year 2024 ending with a net fund balance of $141,387 at June 30, 2024.

N. Hospital and nursing facility payments

CMS and the Legislature authorized AHCCCS to make Disproportionate Share, Graduate Medical Education, Rural Hospital, Critical Access Hospital, Trauma Center and Nursing Facility supplemental expenditures in fiscal year 2024. Disproportionate share expenditures to Arizona hospitals that provided care to a disproportionate share (as defined) of the State's indigent population totaled $180,460. Graduate Medical Education expenditures to reimburse hospitals with GME programs for the additional costs of treating AHCCCS members utilizing graduate medical students totaled $487,980. Critical Access Hospital expenditures to provide increased reimbursement to small rural hospitals that are federally designated as critical access hospitals and Rural Hospital expenditures to increase inpatient reimbursement rates for qualifying rural hospitals totaled $30,257. Trauma center services to reimburse hospitals in Arizona for unrecovered trauma center readiness costs and unrecovered emergency services costs totaled $39,785. Nursing Facility supplemental expenditures utilize a quality assessment on health care items and services provided by nursing facilities to qualify for federal matching funds for supplemental payments for covered Medicaid expenditures, not to exceed the Medicare upper payment limit. The expenditures are included with long-term care health care services and totaled $91,459.

O. Health Care Investment Fund

Arizona House Bill 2668 Chapter 46 from March 25, 2020 establishes the Health Care Investment Fund and a second hospital assessment on hospitals' revenue for the purpose of funding the non-federal share of the Directed Payments made to the hospitals pursuant to 42 Code of Federal Regulations ("CFR") 438.6(c). These Directed Payments supplement the base reimbursement level for hospital services for AHCCCS recipients and increase base reimbursement rates for the dental and physician fee schedules to rates in effect before fiscal year 2008-2009. This initiative is known as the "Hospital Enhanced Access Leading to Health Improvements Initiative" ("HEALTHII") program.

The HEALTHII program uniform percentage increases are based on a fixed payment pool that is allocated to each hospital class based on the additional funding needed to achieve each class aggregate targeted pay-to-cost ratio for Medicaid managed care services. The quarterly payments started in the quarter ending December 2020. The amount of the Directed HEALTHII payments for the period July 1, 2023 to June 30, 2024 was $2,174,207 which includes $1,698,408 federal share and $475,799 non-federal share covered by the hospital assessments collected in Health Care Investment Fund.

For fiscal year 2024, the revenue collected in the Health Care Investment Fund, which is part of the General Fund, totaled $494,387, the expenditures totaled $505,856, and transfers to the Arizona Department of Economic Security totaled $37,164 resulting in fund balance of $147,594 as of June 30, 2024. These revenues and expenditures are presented in the Hospital Assessment line item on the accompanying Statement of Revenues, Expenditures, and Changes in Fund Balances – Governmental Funds.

(1) Description of reporting entity and summary of significant accounting policies (continued)

P. Taxes

AHCCCS is an agency of the State of Arizona and is not subject to income taxes.

Q. Management's use of estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities, and the reported amounts of revenues and expenditures at June 30, 2024. Actual results may differ from these estimates. Material estimates potentially susceptible to change in the near term relate to the accrued programmatic claims liability.

R. CMS 1115 Waiver and 100% Federal poverty level expansion

Section 1115 Waiver - On October 14, 2022, CMS approved request for a five year extension of the state's section 1115 demonstration project entitled "Arizona Health Care Cost Containment System (AHCCCS)" (Project Number 11-W-00275/9), in accordance with sections 1115 (a) of the Social Security Act. The approval includes the extension of 1) AHCCCS Complete Care ("ACC"), the statewide managed care system, which provides physical and behavioral health services to the majority of Arizona's Medicaid population; 2) the Arizona Long Term Care System ("ALTCS"), which provides physical, behavioral, long-term care services and supports, including home-and-community based services, to targeted populations; 3) the Comprehensive Health Plan ("CHP") for children in foster care; and 4) the AHCCCS Complete Care - Regional Behavioral Health Agreement ("ACCRBHA"), which provides integrated care for individuals with a serious mental illness (SMI). The extension approval will also continue the existing waiver of retroactive eligibility.

With this extension, CMS is updating expenditure authority language that authorizes payment to participating IHS facilities and participating facilities operated by tribes under the Indian Self Determination and Education Assistance Act ("ISDEAA") for services that were previously covered under Arizona's state plan.

CMS is also approving a new Targeted Investments ("TI") 2.0 program with the approval of this extension. TI 2.0 will direct managed care organizations to make specific incentive payments to providers that meet the criteria for receiving these payments with the goal of improving health equity for targeted populations through addressing health-related social needs ("HRSN").

In this demonstration extension, CMS also is authorizing the state to provide coverage of certain services that address certain HRSN through the Housing and Health Opportunities ("H2O") amendment. These services include pre-tenancy and tenancy supports, community and transitional housing supports for individuals with a clinical need or transitioning out of institutional care, congregate settings, a homeless shelter or out of homelessness, or the child welfare system.

Finally, CMS approved reimbursement to Indian Health Services and Tribal 638 facilities for dental services provided to American Indian/American Native adults beyond the existing $1,000 limit. The approval included Arizona's request to modernize its Medicaid program and continue many of the existing authorities allowing AHCCCS to maintain its unique and successful managed care model, use home and community-based services for members with long-term care needs and other innovations that make AHCCCS one of the most cost-effective Medicaid programs in the nation. The Waiver allows Arizona to run its managed care model and exempts Arizona from certain provisions of the Social Security Act and includes expenditure authority for costs not otherwise matched by the federal government. Waiver programs are required to be budget neutral for the federal government - not cost more federal dollars than without a waiver.

(1) Description of reporting entity and summary of significant accounting policies (continued)

Under Section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that such demonstrations are likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration.

Section 1115 Waiver Amendment – On February 16, 2024, CMS approved an amendment with 2 policies, "Parents as Paid Caregivers" (PPCG) and "KidsCare Expansion," to the demonstration titled, "Arizona Health Care Cost Containment System (AHCCCS)" (Project Number 11-W-00275/9 and 21-W-00074/9), in accordance with section 1115(a) of the Social Security Act.

Approval of the Parents as Paid Caregivers amendment allows the state to continue to reimburse legally responsible parents of minor children for providing direct care to their minor children, helping to mitigate the direct care worker shortage and improve access to timely, effective care in the home and community. The amendment also establishes a Family Support service as part of the home and community-based services ("HCBS") benefit package. The Family Support service aims to support primary caregivers, including parents, and improve access to timely, effective care in the home and community. Additionally, the KidsCare Expansion amendment will allow the state to increase the Children's Health Insurance Program eligibility thresholds from 200 percent of the federal poverty level ("FPL") up to and including 225 percent of the FPL, with the flexibility for KidsCare coverage to go up to and include 300 percent of the FPL, subject to approval by the state legislature. The approval is effective as of the aforementioned date and will remain in effect through the demonstration approval period, which is set to expire September 30, 2027.

CMS' approval of this section 1115(a) demonstration, as amended, is subject to the limitations specified in the waiver and expenditure authorities, special terms and conditions, and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid or CHIP state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

On November 7, 2000, the Arizona voters approved ballot Proposition 204. One of its primary components directed AHCCCS to increase the minimum qualifying income eligibility level up to 100% of the Federal Poverty Level. Proposition 204 also designated AHCCCS as the administrator of the tobacco litigation settlement funds awarded to the State for compensation of costs incurred in providing its citizens with health care and other services necessitated by the use of tobacco products.

AHCCCS has classified the Arizona Tobacco Litigation Settlement Fund, created by ballot Proposition 204, as part of its General Fund. These funds are restricted for use as specified in the litigation settlement and/or legislation. Annual settlement payments, based on cigarette sales from the preceding calendar year are made in April. In addition, supplemental payments may be received as tobacco companies enter into the tobacco master settlement agreement. AHCCCS received annual and strategic contribution fund payments of $88,273 in fiscal year 2024 for the period from January 1, 2023 to December 31, 2023 (received in April 2024). Revenue for the period from July 1, 2023 to December 31, 2023 totaled approximately $37,273. Additionally, revenue and a related receivable of $51,000 were accrued for the period of January 1, 2024 through June 30, 2024 and are included in Tobacco Settlement Receivable and Other Operating Grants and Contributions in the accompanying Statement of Net Position and Statement of Activities.

Per Laws 2020, Chapter 46, AHCCCS implemented a new Health Care Investment Assessment that was effective October 1, 2020. The funding, $494.4 million for fiscal year 2024, supports hospitals and provider reimbursement through directed payments and capitation rate increases for certain services.

(dollar amounts expressed in thousands)

(1) Description of reporting entity and summary of significant accounting policies (continued)

S. Prescription drug rebate program

The ACA included a provision to extend drug rebates to managed care programs and to increase the rebate amount drug manufacturers are required to pay under the Medicaid drug rebate program. AHCCCS received CMS approval on January 26, 2011 to participate in the drug rebate program, both managed care and fee-for-service, for drugs dispensed on or after March 23, 2010. AHCCCS received rebate reimbursements and delinquent account interest in the amount of $1,412,918 in fiscal year 2024. Of this amount, $948,253 was returned to the Federal government in fiscal 2024 and $172,991 was returned subsequent to June 30, 2024. This amount is netted against the due from the Federal government in the accompanying financial statements. The remaining $291,674 is available to offset a portion of General Fund current and future fiscal year expenditures. Additionally, AHCCCS has accrued the unpaid invoice balance of $355,259 as of June 30, 2024 which is included in receivables and other in the accompanying Statement of Net Position. Of this accrued receivable, $277,640 will be returned to the Federal government and is netted against the due from the Federal government in the accompanying financial statements and $77,619 is available to offset future fiscal year expenditures, which is netted against the due from state and local governments in the accompanying financial statements.

T. Leases

GASB Statement No. 87 (GASB 87), *Leases*, establishes a single model for lease accounting based on the principle that leases are financings of the right to use an underlying asset. Under GASB 87, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about government's leasing activities.

AHCCCS adopted GASB 87 as of July 1, 2021. AHCCCS is the lessee of a leased building (office space). The lease agreement expires on October 31, 2026. The lease is not subject to a sublease, sale-leaseback or lease-leaseback. The base rent is inclusive of any and all applicable local government rental taxes. This is a full-service lease. Upon adoption of GASB 87, *Leases*, on July 1, 2021, AHCCCS recognized a right-to-use asset - building and lease liability of $2,176 based on the estimated future cash flows over the remaining lease term of 64 months and an estimated discount rate of 0.0980%. There were no new leases entered into in fiscal year 2024 nor any remeasurements.

Lease liability activity for the year ended June 30, 2024 is as follows:

Balance, July 1, 2023	$	1,417
Increases		-
Remeasurements		-
Decreases		(405)
Balance, June 30, 2024		1,012
Less: Current portion		(422)
Long-term portion	$	590

(dollar amounts expressed in thousands)

(1) Description of reporting entity and summary of significant accounting policies (continued)

The following schedule details the minimum lease payments to maturity for AHCCCS' lease liability at June 30, 2024:

Years Ending June 30	Principal	Interest	Total
2025	$ 422	$ 10	$ 432
2026	440	5	445
2027	150	-	150
Total	$ 1,012	$ 15	$ 1,027

U. Subscription-Based Information Technology Agreements (SBITA)

GASB Statement No. 96 (GASB 96), *Subscription-Based Information Technology Arrangements* ("SBITA"), is defined as a contract that conveys control of the right to use another party's information technology software, alone or in combination with tangible capital assets, as specified in the contract for a period of time in an exchange or exchange-like transaction. GASB 96 is effective for fiscal years beginning after June 15, 2022, and all reporting periods thereafter.

AHCCCS adopted GASB 96 as of July 1, 2022. AHCCCS has entered into SBITAs for software related to the statewide Enterprise Resource Planning and healthcare systems. The SBITAs expire through March 2032. Upon adoption of GASB 96 on July 1, 2022, AHCCCS recognized a right-to-use asset - subscriptions and subscriptions liability of $4,703 based on the estimated future cash flows over the remaining subscription terms and estimated discount rates. There were no new subscription-based technology agreements entered into in fiscal year 2024. During fiscal year 2024, a subscription was terminated and AHCCCS recognized a loss on termination of approximately $190.

Subscription liability activity for the year ended June 30, 2024 is as follows:

Balance, July 1, 2023	$ 2,613
Increases	-
Remeasurements	-
Decreases	(851)
Balance, June 30, 2024	1,762
Less: Current portion	(420)
Long-term portion	$ 1,342

The following schedule details the minimum agreement payments to maturity for AHCCCS' SBITA liability at June 30, 2024:

Years Ending June 30	Principal	Interest	Total
2025	$ 420	$ 31	$ 451
2026	428	23	451
2027	334	15	349
2028	225	10	235
2029	94	6	100
Thereafter	261	8	269
Total	$ 1,762	$ 93	$ 1,855

(dollar amounts expressed in thousands)

(2) Capital assets

Capital asset balances and current fiscal year activity are as follows:

Governmental Activities:	Balance June 30, 2023	Increases	Decreases	Balance June 30, 2024
Capital assets, being depreciated:				
Vehicles, Furniture & Equipment	$ 4,959	$ -	$ -	$ 4,959
Software	153,089	-	-	153,089
Total capital assets, being depreciated	158,048	-	-	158,048
Less accumulated depreciation for:				
Vehicles, Furniture & Equipment	(4,754)	(73)	-	(4,827)
Software	(120,534)	(14,470)	-	(135,004)
Total accumulated depreciation	(125,288)	(14,543)	-	(139,831)
Total capital assets being depreciated, net	$ 32,760	$ (14,543)	$ -	$ 18,217
Total governmental activities capital assets, net	$ 32,760	$ (14,543)	$ -	$ 18,217

For the year ended June 30, 2024, depreciation expense on capital assets totaled approximately $14,543.

(dollar amounts expressed in thousands)

(2) Capital assets (continued)

Software includes the costs of developing and implementing the new ACA compliant eligibility system. The automated eligibility system qualified AHCCCS for 75 percent enhanced FFP for certain eligibility determination administrative functions that previously were eligible for the 50 percent FFP rate.

Right-to-use asset activity for leases and subscriptions for the year ended June 30, 2024 is as follows:

	Balance July 1, 2023	Increases	Remeasure-ments	Decreases	Balance June 30, 2024
Right-to-use assets:					
Subscriptions	$ 4,703	$ -	$ -	$ (2,140)	$ 2,563
Buildings	2,176	-	-	-	2,176
Total right-to-use assets	6,879	-	-	$ (2,140)	4,739
Less accumulated amortization for:					
Subscriptions	(1,932)	(422)	-	1,511	(843)
Buildings	(816)	(408)	-	-	(1,224)
Total accumulated amortization	(2,748)	(830)	-	1,511	(2,067)
Total right-to-use assets, net	$ 4,131	$ (830)	$ -	$ (629)	$ 2,672

(3) Compensated absences

It is the State's policy to permit employees to accumulate earned but unused vacation, compensatory and sick pay benefits. Employees may accumulate up to 240 or 320 hours of vacation depending upon their position classification. Vacation hours in excess of the maximum amount that are unused at the calendar year end are forfeited. There is no liability recorded on AHCCCS' financial statements for sick leave as any amounts eligible for payment when employees separate from State service are the responsibility of the Arizona Department of Administration. The amount recorded in the government-wide financial statements consists of employees' vested accrued vacation and accrued compensatory time benefits. All compensated absences are due within one year. Balances and current fiscal year activity are as follows:

Balance, June 30, 2023	$ 5,312
Additions	8,943
Reductions	(8,522)
Balance, June 30, 2024	$ 5,733

(4) Other governmental funds

At June 30, 2024, the other governmental fund balance included activity within the following funds:

- Tobacco Tax and Health Care Fund, Medically Needy Account ("MNA") - The Arizona Department of Revenue allocates funding to the MNA which provides funding for services provided through the Title XIX Medicaid and other legislatively authorized health related services or programs. Revenue sources for the MNA include tobacco tax proceeds and investment income.

(4) Other governmental funds (continued)

- Tobacco Products Tax Fund, Emergency Health Services Account ("EHSA") - The Arizona Department of Revenue allocates the tobacco tax revenue to the EHSA which is used solely for the reimbursement of uncompensated care, primary care services and trauma center readiness costs. Monies remaining unexpended and unencumbered in the account on June 30th of each year revert to the Proposition 204 Protection Account, a general fund. Revenue sources for the EHSA include tobacco tax proceeds and investment income.

- Trauma and Emergency Services Fund - This fund is comprised of gaming revenues to be used to reimburse hospitals in Arizona for unrecovered trauma center readiness costs and unrecovered emergency services costs.

- Nursing Facility Assessment Fund - This fund consists of monies received from the nursing facility assessment, federal monies received as a result of expenditures made attributable to monies deposited in the fund, interest, legislative appropriations, grants, gifts, contributions and devices. The monies in this fund shall be used to qualify for federal matching funds for supplemental payments for nursing facility services and administrative cost to administer the fund.

- Hospital Assessment Fund - This fund consists of monies collected from an assessment on hospitals for the purposes of funding a portion of the non-federal share of the Medicaid expansion and the entire Proposition 204 population on and after January 1, 2014.

- Third Party Liability and Recovery Audit Fund - This fund is comprised of monies recovered from first and third party payers under various AHCCCS recovery programs prior to disbursement to the appropriate parties, contractors and programs. These programs primarily include casualty, special treatment trusts, estate, health insurance recoveries, and recovery audit collections.

- Substance Abuse Services Fund - This fund consists of monies received from a surcharge in the amount of thirteen percent on every fine, penalty and forfeiture imposed and collected by the courts for criminal offenses and civil penalties pursuant to ARS § 12-116.02. AHCCCS may expend monies in the fund for administration of the fund and for drug screening, education or treatment for persons who have been ordered by the court to attend and who do not have sufficient financial ability to pay.

- Substance Abuse Services Fund - Alcohol - This fund consists of monies received from a surcharge in an amount of thirteen percent on every fine, penalty and forfeiture imposed and collected by the courts for criminal offenses and civil penalties pursuant to ARS § 12-116.02. AHCCCS may expend monies in the fund for administration of the fund and for alcohol screening, education or treatment for persons who have been ordered by the court to attend and who do not have sufficient financial ability to pay.

- Seriously Mentally Ill Housing Trust Fund - This fund consists of monies received from the sale of abandoned property and investment earnings. AHCCCS may expend monies for housing projects and rental assistance for seriously mentally ill persons.

- Miscellaneous Funds - These funds account for various grants and other money received for specific purposes including the Hawaii Arizona PMMIS Alliance ("HAPA"). HAPA represents AHCCCS' project with Hawaii whereby AHCCCS provides data processing services for Hawaii's Medicaid program. The Federal Grants Fund includes the behavioral health grants awarded to the agency by the SAMHSA.

(dollar amounts expressed in thousands)

(4) Other governmental funds (continued)

Other governmental funds earned, expended and transferred during the fiscal year ended June 30, 2024 were as follows:

	Fund Balance June 30, 2023	Revenues	Interest Earned	Expenditures	Transfers In/(Out)	Fund Balance June 30, 2024
Tobacco Tax and Health Care Fund, Medically Needy Account	$ -	$ 57,793	$ -	$ (57,093)	$ (700)	$ -
Tobacco Products Tax Fund, Emergency Health Services Account	-	15,150	-	(15,150)	-	-
Trauma and Emergency Services Fund	-	39,785	-	(39,785)	-	-
Nursing Facility Assessment Fund	-	91,459	-	(91,459)	-	-
Hospital Assessment Fund	63,186	628,227	-	(550,026)	-	141,387
Third Party Liability and Recovery Audit Fund	-	(2,293)	-	2,293	-	-
Substance Abuse Services Fund	242	1,036	-	(1,168)	-	110
Substance Abuse Services Fund - Alcohol	600	686	-	(1,082)	-	204
Seriously Mentally Ill Housing Trust Fund	11,490	2,000	576	(590)	-	13,476
Miscellaneous Funds	3,902	178,991	187	(166,461)	(14,548)	2,071
	$ 79,420	$1,012,834	$ 763	$ (920,521)	$ (15,248)	$ 157,248

(dollar amounts expressed in thousands)

(5) Retirement plan

AHCCCS contributes to the Arizona State Retirement System ("ASRS" or the "Plan") described below. The Plan is a component unit of the State of Arizona.

Statement of Net Position and Statement of Activities	Governmental Activities
Net pension assets	$ -
Net pension liabilities	85,974
Deferred outflows of resources	13,706
Deferred inflows of resources	3,567
Pension expenses	12,864

AHCCCS' accrued payroll and employee benefits includes no amounts of outstanding pension contribution amounts payable to all pension plans for the year ended June 30, 2024. In addition, AHCCCS reported $8,774 of pension contributions as expenditures in the governmental funds related to all pension plans to which it contributes.

Plan description - AHCCCS employees participate in the ASRS. The ASRS administers a cost-sharing multiple-employer defined benefit pension plan, a cost-sharing multiple-employer defined benefit health insurance premium benefit ("OPEB") plan, and a cost-sharing multiple-employer defined benefit long-term disability ("OPES") plan. The Arizona State Retirement System Board governs the ASRS according to the provisions of A.R.S. Title 38, Chapter 5, Articles 2 and 2.1. The ASRS issues a publicly available financial report that includes its financial statements and required supplementary information. The report is available on its Web site at www.azasrs.gov.

Benefits provided - The ASRS provides retirement, health insurance premium supplement, long-term disability, and survivor benefits. State statute establishes benefit terms. Retirement benefits are calculated on the basis of age, average monthly compensation, and service credit as follows:

ASRS	Retirement Initial membership date:	
	Before July 1, 2011	On or after July 1, 2011
Years of service and age required to receive benefit	Sum of years and age equals 80 10 years age 62 5 years age 50* any years age 65	30 years age 55 25 years age 60 10 years age 62 5 years age 50* any years age 65
Final average salary is based on	Highest 36 consecutive months of last 120 months	Highest 60 consecutive months of last 120 months
Benefit percent per year of service	2.1% to 2.3%	2.1% to 2.3%

*With actuarially reduced benefits.

(5) Retirement plan (continued)

Retirement benefits for members who joined the ASRS prior to September 13, 2013, are subject to automatic cost-of-living adjustments based on excess investment earning. Members with a membership date on or after September 13, 2013, are not eligible for cost-of-living adjustments. Survivor benefits are payable upon a member's death. For retired members, the survivor benefit is determined by the retirement benefit option chosen. For all other members, the beneficiary is entitled to the member's account balance that includes the member's contributions and employer's contributions, plus interest earned.

Contributions - In accordance with state statutes, annual actuarial valuations determine active member and employer contribution requirements. The combined active member and employer contribution rates are expected to finance the costs of benefits employees earn during the year, with an additional amount to finance any unfunded accrued liability. For the year ended June 30, 2024, active ASRS members were required by statute to contribute at the actuarially determined rate of 12.29 percent (12.14 percent for retirement and 0.15 percent for long-term disability) of the members' annual covered payroll, and AHCCCS was required by statute to contribute at the actuarially determined rate of 12.29 percent (12.03 percent for retirement, 0.11 percent for health insurance premium benefit, and 0.15 percent for long-term disability) of the active members' annual covered payroll. In addition, AHCCCS was required by statute to contribute at the actuarially determined rate of 9.99 percent (9.94 percent for retirement, 0.00 percent for health insurance premium benefit, and 0.05 percent for long-term disability) of annual covered payroll of retired members who worked for AHCCCS in positions that would typically be filled by an employee who contributes to the ASRS.

During fiscal year 2024, AHCCCS paid for ASRS pension contributions as follows: 95.21 percent from the General Fund and 4.79 percent from other governmental funds.

Pension liability - At June 30, 2024, AHCCCS reported a liability of $85,974 for its proportionate share of the ASRS' net pension liability. The net pension liability was measured as of June 30, 2023. The total pension liability was determined by an actuarial valuation as of June 30, 2022, and rolled forward using generally accepted actuarial procedure to June 30, 2023. AHCCCS' proportion of the net pension liability was based on AHCCCS' actual contributions to the plan relative to the total of all participating employers' contributions for the year ended June 30, 2023. AHCCCS' proportion measured as of June 30, 2023, was 0.53131 percent, which was an increase of 0.02945 from its proportion measured as of June 30, 2022 of 0.50186 percent.

(dollar amounts expressed in thousands)

(5) Retirement plan (continued)

Pension expense and deferred outflows/inflows of resources - For the year ended June 30, 2024, AHCCCS recognized pension expense for ASRS of $12,864. At June 30, 2024, AHCCCS reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

ASRS	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 1,943	$ -
Change in assumptions	-	-
Net difference between projected and actual earnings on pension plan investments	-	3,042
Changes in proportion and differences between AHCCCS contributions and proportionate share of contributions	2,989	525
AHCCCS contributions subsequent to the measurement date	8,774	-
Total	$ 13,706	$ 3,567

The $8,774 reported as deferred outflows of resources related to ASRS pensions resulting from AHCCCS contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ending June 30, 2025. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to ASRS pension will be recognized as an increase (decrease) in pension expense as follows:

Years Ending June 30	
2025	$ (2,232)
2026	3,278
2027	(378)

Actuarial assumptions – The significant actuarial assumptions used to measure the total pension liability are as follows:

ASRS	
Actuarial valuation date	June 30, 2022
Actuarial roll forward date	June 30, 2023
Actuarial cost method	Entry age normal
Asset valuation Method	Fair Value
Discount rate of return	7.0%
Projected salary increases	2.9 – 8.4%
Inflation	2.3%
Permanent benefit increase	Included
Mortality rates	2017 SRA Scale U-MP

Actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the 5-year period ended June 30, 2020.

The actuarial assumptions pertain to assumptions utilized for financial reporting purposes. They differ from the assumptions utilized for funding purposes. The principal difference between the actuarial assumptions for financial reporting purposes and those utilized for funding purposes are the amortization methodology and the valuation of assets.

(dollar amounts expressed in thousands)

(5) Retirement plan (continued)

The actuarial assumptions related to funding were selected on the basis of an experience study which was performed for the five-year period ending June 30, 2020. The ASRS Board adopted the experience study which recommended changes, and those changes were effective as of the June 30, 2021 actuarial valuation.

The long-term expected rate of return on ASRS pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target allocation and best estimates of geometric real rates of return for each major asset class are summarized in the following table:

ASRS	Target Asset Allocation	Real Return Geometric Basis	Long-term Contribution to Expected Real Return
Public Equity	44%	3.50%	1.54%
Credit	23%	5.90%	1.36%
Real Estate	17%	5.90%	1.00%
Private Equity	10%	6.70%	0.67%
Interest Rate Sensitive	6%	1.50%	0.09%
Total	100%		4.66%

Discount rate - The discount rate used to measure the ASRS total pension liability was 7.0 percent. The projection of cash flows used to determine the discount rate assumed that contributions from participating employers will be made based on the actuarially determined rates based on the ASRS Board's funding policy, which establishes the contractually required rate under Arizona statute. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Sensitivity of AHCCCS' proportionate share of the ASRS net pension liability to changes in the discount rate - The following table presents AHCCCS' proportionate share of the net pension liability calculated using the discount rate of 7.0 percent, as well as what AHCCCS' proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1 percentage point lower (6.0 percent) or 1 percentage point higher (8.0 percent) than the current rate:

	1% Decrease	Current Discount Rate	1% Increase
	(6.0%)	(7.0%)	(8.0%)
AHCCCS' proportionate share of the net pension liability	$ 128,776	$ 85,974	$ 50,284

Pension plan fiduciary net position - Detailed information about the pension plan's fiduciary net position is available in the separately issued ASRS financial report.

OPEB provided as part of state employment include the ASRS sponsored cost-sharing plan for the Long-Term Disability Fund and the Health Benefit Supplement Fund, as well as the Arizona Department of Administration sponsored single employer defined benefit post-employment plan.

(dollar amounts expressed in thousands)

(5) Retirement plan (continued)

Cost-sharing plan - The ASRS provides health insurance premium supplemental benefits and disability benefits to retired members, disabled members, and eligible dependents through the Health Benefit Supplement Fund ("HBS") and the Long-Term Disability Fund ("LTD"), which are cost-sharing, multiple-employer defined benefit postemployment plans. Title 38, Chapter 5 of the Arizona Revised Statutes ("ARS"). assigns the authority to establish and amend the benefit provisions of the HBS plan and the LTD plan to the Arizona State Legislature.

(6) Other postemployment benefits (OPEB)

The ASRS issues a publicly available financial report that includes the financial information and disclosure requirements for the HBS plan and the LTD plan. That report may be obtained by visiting www.azasrs.gov.

Contributions - For the ASRS HBS and LTD plans, contributions are recognized as revenues when due, pursuant to statutory and contractual requirements. Benefits and refunds are recognized when due and payable and expenses are recorded when the corresponding liabilities are incurred, regardless of when contributions are received or payments are made.

Funding policy - The contribution requirements of plan members and AHCCCS are established by Title 38, Chapter 5 of the ARS. These contribution requirements are established and may be amended by the Arizona State Legislature. For the year ended June 30, 2024, active ASRS members and AHCCCS were each required by statute to contribute at the actuarially determined rate of 0.15 percent of the members' annual covered payroll for LTD. AHCCCS also contributed 0.11 percent for the HBS. In addition, AHCCCS was required to contribute 0.05 percent for long-term disability based on annual covered payroll for retired members who worked for AHCCCS in positions that an employee who contributes to ASRS would typically fill. However, in 2024 AHCCCS was not required to contribute to the health benefits supplemental fund (HBS) for these employees. AHCCCS' contributions for the current and two preceding years for OPEB, all of which were equal to the required contributions, were as follows:

Fiscal Year	Health Benefit Supplemental Fund	Long-term Disability Fund
2024	$ 80	$ 109
2023	76	97
2022	125	113

Changes in AHCCCS' OPEB liability (asset) for the HBS and LTD plans during fiscal year 2024 were as follows:

	HBS	LTD	TOTAL
Beginning balances	$ (2,862)	$ 47	$ (2,815)
Increases	1,771	266	2,037
Decreases	(1,836)	(243)	(2,079)
Ending balances	$ (2,927)	$ 70	$ (2,857)

For the year ended June 30, 2024, OPEB expense totaled approximately $(295).

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

At June 30, 2024, AHCCCS reported deferred outflows of resources and deferred inflows of resources related to the HBS and LTD OPEB plans from the following sources:

ASRS	HBS + LTD Deferred Outflows of Resources	HBS + LTD Deferred Inflows of Resources
Differences between expected and actual experience	$ 187	$ 1,131
Change in assumptions	19	160
Change in proportions	21	73
Difference between projected and actual investment earnings	-	134
AHCCCS contributions subsequent to the measurement date	189	-
Total	$ 416	$ 1,498

Actuarial assumptions - The actuarial assumptions used to determine the OPEB liability for the HBS and LTD plans are presented in the following table:

ASRS	
Actuarial valuation date	June 30, 2022
Measurement date	June 30, 2023
Actuarial cost method	Entry age normal
Asset valuation method	Fair value
Investment rate of return	7.0%
Inflation	2.3%
Mortality rates (HBS)	2017 SRS Scale U-MP
Recovery rates (LTD)	2012 GLDT

Actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the 5-year period ended June 30, 2020.

The actuarial assumptions pertain to assumptions utilized for financial reporting requirements and differ from the assumptions utilized for funding purposes. The principal differences between the actuarial assumptions for financial reporting purposes and those utilized for funding purposes are the amortization methodology and valuation of assets.

The long-term expected rate of return on HBS and LTD plan investments is the same as that for ASRS pension plan investments. The method used to derive this rate is described in Note 5.

Discount rate - The discount rate used to measure the total HBS and LTD liability was 7.0 percent. The projection of cash flows used to determine the discount rate assumed that contributions from participating employers will be made based on the actuarially determined rates based on the ASRS Board's funding policy, which establishes the contractually required rate under Arizona statute. Based on those assumptions, the fiduciary net position of the HBS and LTD Funds was projected to be available to make all projected future benefit payments of current members. Therefore, the long-term expected rate of return on investments was applied to all periods of projected benefit payments to determine the total HBS and LTD liability

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

Sensitivity of AHCCCS' proportionate share of the net ASRS OPEB liability to changes in the discount rate - The following table presents AHCCCS' proportionate share of the net ASRS OPEB liability calculated using the discount rate of 7.0 percent, as well as what AHCCCS' proportionate share of the net ASRS OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (6.0 percent) or 1 percentage point higher (8.0 percent) than the current rate:

	1% Decrease	Current Discount Rate	1% Increase
	(6.0%)	(7.0%)	(8.0%)
AHCCCS' proportionate share of the net HBS liability	$ (2,046)	$ (2,927)	$ (3,676)
AHCCCS' proportionate share of the net LTD Liability	$ 103	$ 70	$ 38

Schedule of Net Deferred Outflows and Inflows of Resources by Employer to be Recognized in HBS and LTD expense:

Fiscal Year	HBS	LTD
2024	$ (500)	$ (9)
2025	(549)	(20)
2026	(80)	1
2027	(80)	(19)
2028	4	(17)

Single-employer plan

The Arizona Department of Administration ("ADOA") administers a single employer defined benefit post-employment plan (ADOA Plan) that provides medical and accidental benefits to retired State employees and their dependents. Title 38, Chapter 4 of the ARS assigns the authority to establish and amend the benefit provisions of the ADOA Plan to the Arizona State Legislature. The ADOA pays the medical costs incurred by retired employees, net of related premiums, which are paid entirely by the retiree or on behalf of the retiree. These premium rates are based on a blend of active employee and retiree experience, resulting in a contribution basis that is lower than the expected claim costs for retirees, creating an implicit subsidization of retirees by the ADOA Plan. ADOA does not issue a separate, publicly available financial report for the ADOA Plan; however, the State of Arizona Annual Comprehensive Financial Report presents state-wide prior year information, which can be obtained by visiting gao.az.gov. A portion of the ADOA Plan's implicit rate subsidy, if not fully funded, represents an obligation of AHCCCS for its proportionate share of the net OPEB obligation.

Since the plan does not have a formal trust, GASB Statement No. 75 requires state and local government employers to recognize the total OPEB liability and the OPEB expense on their financial statements, along with the related deferred outflows and inflows of resources.

In addition to the deferred outflows/inflows related to plan experience and assumption changes, GASB Statement No. 75 states the benefit payments and administrative costs incurred subsequent to the measurement date and before the end of the employer's reporting period should be reported as a deferred outflow of resources.

Funding policy - The ADOA's current funding policy is pay-as-you-go for OPEB benefits. There are no dedicated assets at this time to offset the actuarial accrued liability.

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

OPEB expense and total OPEB liability - AHCCCS' proportionate share of OPEB expense and changes in the OPEB liability of the ADOA Plan for year ended June 30, 2024, are as follows:

Statement of OPEB Expenses

Service Cost	$	1,540
Interest on total OPEB liability		743
Expensed portion of current-period changes of assumptions		-
Recognition of beginning of the year deferred inflows as OPEB expense		(1,271)
Amortization of current year outflows (inflows) due to liabilities		(1,273)
OPEB expense	$	(261)

Schedule of Change of Total OPEB Liability and Related Ratios:

Service Cost	$	1,540
Interest on total OPEB liability		743
Changes of benefit terms		-
Difference between expected and actual experience of the total OPEB liability		(10,298)
Difference between expected and actual experience from the change in Proportionate Share		(298)
Changes of assumptions		373
Expected benefit payments		(519)
Net change in total OPEB liability		(8,459)
Total OPEB liability at 6/30/2023		18,868
Total OPEB liability at 6/30/2024	$	10,409

At June 30, 2024, AHCCCS reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

ADOA	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 1,122	$ 14,954
Change in assumptions	3,575	5,522
AHCCCS contributions subsequent to the measurement date	307	-
Total	$ 5,004	$ 20,476

Deferred Outflows and Deferred Inflows to be Recognized in Future OPEB Expense:

Years Ending June 30	
2025	$ (2,214)
2026	(1,922)
2027	(2,428)
2028	(3,016)
2029	(2,759)
Thereafter	(3,440)
Total	$ (15,779)

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

Statement of Outflows and Inflows Arising from Current Reporting Period:

	Recognition Period (or amortization years)	Total (Inflow) or Outflow	2024 Recognized in current OPEB expense	Deferred (Inflow) or Outflow in future expense
Due to Liabilities:				
Differences in expected and actual experience	8.0458	$ (10,595)	$ (1,317)	$ (9,278)
Assumption changes	8.0458	373	46	327
Total		$ (10,222)	$ (1,271)	$ (8,951)

Actuarial methods and assumptions - The actuarial assumptions used to value the liabilities include assumptions of the health care trend assumptions, the aging factors as well as the cost method used to develop the OPEB expenses. The demographic assumptions are based on the assumptions that were developed based on the defined benefits plans in which the Plan participates. Since the prior measurement date, the discount rate changed from 3.69% as of June 30, 2022 to 3.86% as of June 30, 2023.

The ADOA Plan's actuarial methods and significant assumptions for a measurement date as of June 30, 2023 are as follows:

Actuarial valuation date		June 30, 2023
Measurement date		June 30, 2023
Reporting date		June 30, 2024
Actuarial cost method		Individual entry age normal
Discount rate		3.86% as of June 30, 2023
Inflation		2.30%
Salary increases		0.00% to 5.50%, not including wage inflation of 2.90%
Health care cost trend rates		Pre-65: Initial rate of 7.20% declining to an ultimate rate of 4.25% after 16 years; Post-65: Initial rate of 5.10% declining to an ultimate rate of 4.25% after 10 years
Mortality rates	Healthy Employee	Pub-2010 General Employee Mortality table Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2017.
	Healthy Retirees and Spouses	2017 State Retirees of Arizona mortality table. Generational mortality improvements in accordance with the Ultimate MP scales (through 2020) and projected from the year 2017.
	Disabled Retirees	Pub-2010 Disabled Retiree Mortality. Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2017.

(dollar amounts expressed in thousands)

(6) Other postemployment benefits (OPEB) (continued)

Discount rate – The discount rate for ADOA OPEB funded entirely on a pay-as-you-go basis is the yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA or higher (or equivalent quality on another rating scale). For the measurement date of June 30, 2023, the index value of Bond Buyer 20-Bond General Obligation Municipal Bond was used.

The discount rate equals the tax-exempt municipal bond rates based on the index of 20-year general obligation bonds with an average AA credit rating as of the measurement date. For the purposes of this valuation the municipal bond rate is 3.86%. The discount rate was 3.69% as of the prior measurement date.

Sensitivity of AHCCCS' proportionate share of the ADOA OPEB liability to changes in the discount rate and health care cost trend rates - The following table presents AHCCCS' proportionate share of the ADOA OPEB liability calculated using the discount rate of 3.86%, as well as what AHCCCS' proportionate share of the ADOA OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (2.86%) or 1 percentage point higher (4.86%) than the current rate.

Also shown is the OPEB liability computed with the current health care cost trend rates and with the trend rates that are 1 percentage point lower or 1 percentage point higher than the current rates:

	1% Decrease	Current Discount Rate	1% Increase
	(2.86%)	(3.86%)	(4.86%)
Sensitivity of Total OPEB Liability to the Discount Rate Assumption	$ 11,986	$ 10,409	$ 9,127

	1% Decrease	Current Healthcare Cost Trend Rate Assumption	1% Increase
Sensitivity of Total OPEB Liability to the Healthcare Cost Trend Rate Assumption	$ 8,819	$ 10,409	$ 12,437

(7) Budgetary basis of accounting

The financial statements of AHCCCS are prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). AHCCCS, like other State agencies, prepares its annual operating budget on a basis that differs from the GAAP basis. Encumbrances as of June 30th can be liquidated during a four-week administrative period known as the 13th month. The budget basis expenditures reported in the financial statements include both the fiscal year paid and the 13th month activity. The State does not have a legally adopted budget for revenues. AHCCCS' controlling statute for programmatic payments administrative adjustment procedures varies from the statutory requirement of other State agencies. AHCCCS is permitted to pay for approved system covered medical services presented after the close of the fiscal year in which they were incurred with either remaining prior year or current year available appropriations.

(dollar amounts expressed in thousands)

(7) Budgetary basis of accounting (continued)

The following is a reconciliation of the GAAP Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds to the budgetary comparison schedules for the year ended June 30, 2024:

	General Fund Actual
Budgetary Basis Fund Balance, June 30, 2024	$ 859,751
Budgetary Basis of Accounting	
Increases to fund balance:	
Due from state, county and local governments	116,269
Due from the federal government (net)	457,370
Due from other fund	7,664
Tobacco settlement receivable	51,000
Receivables and other	1,241,664
Total increases	1,873,967
Decrease to fund balance:	
Cash	$ (7,282)
Unearned revenue	(37,900)
Due to state, county and local governments	(472,605)
Accrued programmatic costs	(1,352,945)
Payables and other	(52,523)
Unavailable revenue, net	(381,725)
Total decreases	(2,304,980)
Total GAAP basis fund balance	$ 428,738

Non-appropriated expenditures of $3,171,818 in the General Fund consist primarily of federal and state matching pass-through payments to other agencies.

(8) Contingencies, risks and uncertainties

COVID-19 - On March 11, 2020, the World Health Organization declared the outbreak of a respiratory disease cause by a new coronavirus as a "pandemic". First identified in late 2019 and now known as COVID-19, the outbreak has impacted millions of individuals worldwide. In response, many countries have implemented measures to combat the outbreak which have impacted global business operations.

In response to the growing COVID-19 pandemic, on March 18, 2020, President Trump signed into law H.R. 6021, the Families First Coronavirus Response Act ("FFCRA") (Pub. L. 116-127). Section 6008 of the FFCRA provided a temporary 6.2 percent increase to the FMAP extending through the last day of the calendar quarter in which the Public Health Emergency (“PHE”) terminates. One of the conditions of receipt of the enhanced federal match was a maintenance of effort ("MOE") requirement, prohibiting AHCCCS from terminating the enrollment of any individual enrolled in the program as of the date of the beginning of the PHE period, as well as individuals enrolled during the PHE period. This condition had a significant impact on AHCCCS' enrollment. It required the state continue coverage for members who may have had a change in income that would otherwise result in discontinuance. On December 29, 2022, the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023) was enacted, which further clarified states could begin redeterminations in February 2023 with the disenrollments beginning April 2023 and prescribed the 6.2 percentage point increase to the FMAP was phased out over the course of Calendar Year 2023. The enhanced FMAP was 6.2 percentage points through the quarter ended March 31, 2023, 5.0 percentage points in the quarter ended June 30, 2023,

(8) Contingencies, risks and uncertainties (continued)

2.5 percentage points in the quarter ended September 30, 2023, and 1.5 percentage points in the quarter ended December 31, 2023. Although the FMAP increase is no longer directly tied to the end of the PHE, the Department of Health and Human Services expired the PHE as of May 11, 2023. Effective April 2023, AHCCCS began processing eligibility redeterminations. In April 2023 AHCCCS enrollment was 2,492,034. By June 30, 2024, AHCCCS enrollment was 2,204,281, a decrease of 287,753.

Following the national and state emergency declarations in March 2020, AHCCCS received authority from CMS to implement numerous program flexibilities in response to the COVID-19 outbreak. Some of these flexibilities are: expanded coverage of telehealth and telephonic codes reimbursed at the same level of reimbursement offered for in-person services; initiatives to support use of influenza vaccinations during the COVID outbreak; increase in annual hours of respite care; reimbursement of Home and Community Based Services provided by parents; elimination of the 40 hour limit on family caregiver services provided by a member's spouse; expand the provision of home delivered meals to members enrolled in Department of Economic Security/Developmental Disabilities ("DES/DD"); and allowance for students to receive medically necessary services from managed care organizations ("MCOs") rather than the Medicaid School Based Claiming program as children attend school virtually from home. The CMS approvals were granted in late March to early April 2020.

In addition to the program flexibilities, COVID-19 impacted some of the agency's collection activities. CMS approved AHCCCS' request for emergency authorities to support Arizona's response to COVID-19. For the duration of the PHE, AHCCCS waived payment of the provider enrollment application fee as well as suspended the application of premiums for children enrolled in Arizona's CHIP program (KidsCare) and adults in the Freedom-to-Work program.

Finally, the Substance Abuse and Mental Health Services Administration ("SAMHSA") awarded AHCCCS new grants to address the behavioral health impacts due to the pandemic. These grants include the following:

- Arizona COVID-19 Emergency Response for Suicide Prevention
- Emergency Grant to Address Mental and Substance Use Disorders During COVID-19 (ECOVID)
- Substance Abuse Block Grant COVID-19 Emergency Funding
- Mental Health Block Grant COVID-19 Emergency Funding

In addition to the FFCRA, on March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (“ARPA”) (Pub.L. 117-2) into law. Section 9817 of the ARPA provides qualifying states with a temporary 10 percentage point increase to the “FMAP” for certain Medicaid expenditures for “HCBS”. On May 13, 2021, CMS published State Medicaid Director Letter (“SMDL”) #21-003, which further clarified the qualifying services, improvement activities, and reporting requirements expected of states under Section 9817 of the ARPA. The increased FMAP was available for qualifying expenditures between April 1, 2021, and March 31, 2022.

In accordance with Section 9817(b) of the ARPA, states must comply with two program requirements to receive the increased FMAP rate for “HCBS” expenditures: (1) federal fund attributable to the increased FMAP must be used to supplement existing state funds, (2) states must use the state funds equivalent to the amount of federal funds attributable to the increased FMAP rate, to implement or supplement the implementation of one or more activities to strengthen HCBS under the Medicaid program.

(8) Contingencies, risks and uncertainties (continued)

On January 19, 2022, CMS granted conditional approval to AHCCCS' spending plan. Arizona has identified four key populations at the center of the efforts outlined in its spending plan. They include: (a) Arizona's seniors, (b) individuals with disabilities, (c) individuals living with a Serious Mental Illness ("SMI"), and (d) children with behavioral health needs. Additionally, this spending plan will allow for transformational change of the delivery system, which will enhance care delivery to individuals who are accessing general mental health and substance use services.

In fiscal year 2024, AHCCCS recorded a total of $408,341 in ARPA-related payments in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds. Administrative ARPA expenditures totaled $32,052, while MCO, FFS, and ARPA initiative payments totaled $376,289. The federal share for these payments totaled $272,282 while the State's share was $136,059.

States will be permitted to use the state funds equivalent to the amount of the federal funds attributable to the increase FMAP rate through March 31, 2025, on activities aligned with the goals of ARPA.

Budget neutrality agreement - In January 2001, AHCCCS obtained a Waiver from CMS to receive federal funding for certain non- categorically linked populations including those made eligible by the November 2000 passage of Proposition 204. The Waiver requires over the term of the original agreement (April 1, 2001 through September 30, 2011) and the new agreement (October 1, 2011 through September 30, 2021), the population covered by the Waiver be budget neutral for CMS.

It should be noted on September 30, 2021, the waiver was extended for one additional federal fiscal year ending September 30, 2022. On September 27, 2022, CMS approved a temporary extension of the Waiver to October 28, 2022 in order to allow Arizona and CMS to continue negotiations over the extension application. On October 14, 2022, CMS extended the Waiver through September 30, 2027. As part of this extension, the five-year period from October 1, 2022 through September 30, 2027 has a budget neutrality agreement specific to those five years. Effective with the January 1, 2014 implementation of the eligibility expansion under the ACA to include the new adult group, members with income between 100% and 133% of the FPL, the budget neutrality measurement is performed separately for the new adult population.

Budget neutral means CMS will not pay more for medical services with the Waiver than it would without the Waiver. The Waiver Special Terms and Conditions include a monitoring arrangement that requires AHCCCS to report the financial results of the Waiver on a quarterly basis. For the demonstration period beginning on October 1, 2016, the net variance is phased down by an applicable percent. The percentages are determined based on how long the Medicaid population has been enrolled in managed care subject to the demonstration. Under the terms, AHCCCS is limited to only retaining 25 percent of the total variance as future savings. The budget neutrality calculation is dependent on a number of variables including the number of members and the eligibility category of members. Other factors that impact the variance are the general economy and its impact on unemployment, medical inflation and policy decisions made by the Legislature may impact program costs. Through September 30, 2022, AHCCCS remained under the cumulative reporting limit threshold and does not project any liability related to the budget neutrality agreement.

With the new extension waiver flexibilities, the budget neutrality limit on Title XIX funding still needs to be monitored per the Special Terms and Conditions, "XVI. MONITORING BUDGET NEUTRALITY". The budget neutrality expenditure limit is determined either by using a per capita cost method or aggregate basis, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing Federal Financial Participation without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations,

(8) Contingencies, risks and uncertainties (continued)

CMS assures the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. The Agency projects it will stay within the budget neutrality limits during the demonstration period from October 1, 2022, through September 30, 2027. Therefore, AHCCCS does not currently anticipate the need for federal funding to be returned to CMS due to exceeding the budget neutrality limitations. However, there can be no assurance AHCCCS will not exceed the budget neutrality limitations and federal funding will be returned to CMS.

Litigation and investigations - AHCCCS has been named as a defendant in a variety of litigation, all of which are being defended by in-house and external legal counsel. It is the opinion of AHCCCS upon consultation with legal counsel, that none of the claims are likely to have a material adverse effect on AHCCCS' financial statements. In addition, AHCCCS believes the funding of any material adverse judgment, sanction or repayment obligation in excess of its appropriation would require a special appropriation by the State or would qualify for coverage by the Arizona Department of Administration, Risk Management Division which is tasked with the management and mitigation of liability, property and workers' compensation claims.

Compliance with laws and regulations - AHCCCS is subject to numerous laws, regulations and oversight by the federal government. These laws and regulations include, but are not necessarily limited to, matters such as government health care program participation requirements, reimbursement for member services and Medicaid fraud and abuse. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of significant financial sanctions.

Managed care drug rebates - In fiscal 2017, the DHHS OIG commenced a review of managed care drug rebates in Arizona for 2010 – 2013. The HHS OIG issued a report in February 2018 for their review of managed care drug rebates in Arizona from April through March 2013. The OIG's report noted instances in which physician-administered drugs were not properly submitted to the drug manufacturers for rebate. The HHS OIG recommended AHCCCS bill and collect from manufacturers, work with CMS to determine other physician-administered drugs were eligible for rebates and, if so, return the federal share.

AHCCCS plans to bill and collect the appropriate amount of rebates for single-source and top-20 multiple source physician-administered drugs during the audit period after thoroughly reviewing the disputed utilization records with the contracted rebate vendor. However, AHCCCS disagrees with the OIG finding that Arizona was required to obtain rebates for other physician-administered drugs during the audit period and is communicating with CMS to determine whether these drugs were eligible for rebates.

This audit, Arizona Pharmacy Rebate Audit – AZ Audit A-09-16-02031, has been pending with CMS for several years, and no adverse findings have been issued. Their latest communication to AHCCCS dated August 16, 2022, states they have been working with federal OIG and the CMS Division of Pharmacy and are close to a decision on the audit. No further communication has been received from CMS regarding this matter as of the date of this report.

It is unclear if AHCCCS will be able to collect rebates from the drug manufacturers on such old claims. As such, AHCCCS views any recoveries as a gain contingency and will not record any amounts until received. Further, as the repayments to CMS are predicated on the receipt of the drug rebates, AHCCCS has not recorded any liability to CMS through June 30, 2024.

Provider billing matter – AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in outpatient behavioral health services. AHCCCS connected the irregular billing with alleged criminal activity targeting tribal communities and other Arizonans.

(8) Contingencies, risks and uncertainties (continued)

Under 42 C.F.R. 455.23, when the State Medicaid Agency has conducted a preliminary investigation and a reliable indicia of fraud has been identified, the agency must suspend payments to a provider if a law enforcement agency accepts the State's referral. In AHCCCS's case, a Memorandum of Understanding governs the referral relationship between AHCCCS Office of the Inspector General and the Arizona Attorney General's Office, Health Care Fraud & Abuse Section. At the point a referral is made and payment is suspended (unless good cause not to suspend payments is established) only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation, AHCCCS may terminate a provider's enrollment, or exclude them participating in AHCCCS in the future, and require repayment of the identified overpayment while also determining ability to collect the overpayment as previously identified. Repayment of the overpayment is not required if the provider is out of business or is bankrupt.

Since May 16, 2023, AHCCCS has suspended payments to 313 providers and additional Credible Allegation of Fraud payment suspensions will be imposed if AHCCCS, through its investigation, determines there is a credible allegation of fraud concerning these additional providers. Despite the scale of potential Behavioral Health services fraud, AHCCCS has taken rapid steps to limit potential liability through comprehensive, system-wide strategies to find and eliminate fraudulent billing, including recommendations from the Arizona Attorney General's Office. These include, but are not limited to the following:

- Moved five behavioral health provider types to the high-risk category for new applicants and revalidating providers, which requires on-site visits, fingerprinting, background checks, a registration fee, and additional disclosures.
- Reviewed all existing claims edits and set specific rates for current "by report" billing that pay a percentage of the total billed amount instead of a standard rate.
- Created a trend report of all providers registering for the at-risk provider types and closely monitoring any billing anomalies.
- Created systems flagging concerning claims (volume, services per day, services for minors) for review prior to payment.
- Set billing thresholds to deny claims for multiple services that should not be billed on the same day, and more.
- Eliminated retroactive billing.
- Implemented ID.me identify verification for AHCCCS Online.
- Required providers to disclose any third-party billing relationships.
- Worked with the Arizona Corporation Commission to flag suspicious registrations.
- Required all providers to transition to Electronic Funds Transfer.

AHCCCS will continue to perform investigations, identify areas of concern and implement necessary system improvements.

A determination of potential liability cannot be made at this time as AHCCCS is still in the process of investigating provider billings. As of December 2024, 46 providers suspended on or since May 16, 2023, have received final administrative decisions following hearings in front of an Administrative Law Judge at the Office of Administrative Hearings, and all of these provider suspensions have been ultimately upheld. Independently, AHCCCS may resolve a provider's civil liability and demand repayment of funds improperly paid. AHCCCS may also remove a provider suspension when further investigation has identified there is no longer a reliable indicia of fraud relating to the provider's conduct. However, regardless of whether the provider's conduct amounted to fraud or other error, in such cases, the provider may still owe AHCCCS an overpayment for improperly paid claims. AHCCCS has lifted the Credible Allegation of Fraud determination in 34 cases of provider suspensions and allowed the provider to return to active status.

(8) Contingencies, risks and uncertainties (continued)

AHCCCS OIG's identification and recovery of overpayment, pursuant to investigations of currently suspended providers, involves review of each provider's billing data, assessment of the legitimacy of any of those services, and calculation of the loss to AHCCCS (overpayment) caused by those illegitimate services. The likelihood of recovering the total amount paid to suspended providers is exceedingly low, because the actual loss to AHCCCS suffered in each case is not equivalent to the total amount AHCCCS paid to that provider. The reason for the lower recovery in such instances is because some suspended providers were paid by AHCCCS for both legitimate services rendered to AHCCCS members as well as illegitimate services which were not rendered. Therefore, OIG's investigations include a manual process to distinguish these payments.

AHCCCS' ability to collect funds identified as overpayments is further dependent on outside factors, including the progress of criminal prosecution, provider solvency, and attempts to disguise and move funds beyond the reach of authorities.

Recovery of funds may happen through criminal proceedings with restitution orders or by civil recoveries undertaken by AHCCCS. Distinguishing between these routes of recovery involves collaboration with law enforcement to identify cases that are appropriate for civil recovery led by AHCCCS rather than criminal prosecution.

All of the above factors make it challenging to accurately forecast future recoupment totals. Pursuant to 42 C.F.R. 433, Subpart F, AHCCCS is required to refund the Federal share of all overpayments made to providers unless the provider is out of business or bankrupt. The Federal share generally equates to approximately 75% of the total amount overpaid to a provider. The repayment must occur within one year of the discovery of an overpayment as calculated beginning with the date AHCCCS provides written notice to a provider of an overpayment determination. Note, the repayment obligation is applicable without regard to whether AHCCCS is successful in recovery of an overpayment from the provider, however, as noted, there is an exception if a provider is out of business or bankrupt. Given the extent of the fraud, AHCCCS anticipates that overpayment written determinations which trigger the legal obligation to refund federal funds will occur on an individual case-by-case basis as investigations are concluded over the next months and years.

The Federal government will likely conduct a review to ensure that AHCCCS has correctly identified and determined overpayments as well as appropriately refunded federal funds. If a negative finding is made, future federal funding may be disallowed in the amount of the federal funds not remitted. AHCCCS has retained outside counsel in federal repayment matters to advise the Administration with respect to legal issues that may arise.

Beginning in fiscal year 2024, several complaints were filed against AHCCCS, DHS, and the State of Arizona. The lawsuits seek damages from the death or injuries sustained by current members allegedly arising from the failure of these individuals to receive appropriate addiction treatment and/or damages for the wrongful death of an AHCCCS member due to the behavioral health/sober living home fraud scheme. Two of these lawsuits have been dismissed entirely, and AHCCCS has been dismissed as a party in three of them. The remaining lawsuit named the State of Arizona, but not AHCCCS as a defendant. From August 2023 through present, the State of Arizona, and AHCCCS, have received 42 Notices of Claim and served with seven individual lawsuits (some alleging wrongful death), and the class action lawsuit discussed below.

Management, upon consultation with internal and external counsel, notes that these matters are in the early stages and for the 42 Notices of Claim, no lawsuits have been filed except as noted above. Plaintiffs have in the aggregate claimed approximately $139,220 in damages. However, given that no lawsuits have been filed in connection for the majority of the Notices of Claim, and for those matters in litigation, no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

(8) Contingencies, risks and uncertainties (continued)

In August 2024, the State of Arizona received a Class Action Notice of Claim identifying subclasses for certain AHCCCS members and alleging injuries or wrongful death of the claimants. The lawsuit was subsequently filed in December 2024. AHCCCS intends to vigorously defend these matters. Management, upon consultation with internal and external counsel, notes that these matters are in the early stages, and a Motion to Dismiss has been filed. Plaintiffs have in the aggregate claimed approximately $395,000 in damages, however, given that the lawsuit is in the early stages, and no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS intends to vigorously defend these matters.

Additionally, in fiscal year 2024, AHCCCS was served with several lawsuits and several Notices of Claim from AHCCCS behavioral health providers alleging AHCCCS improperly suspended and/or terminated provider participation agreements, “blacklisted” the providers, and “slow paid” claims. Management, upon consultation with internal and external counsel, notes that many of these claims are in the early stages. The provider-claimants have in the aggregate claimed approximately $2,275,058 in damages. However, given that the matters are in the early stages, no discovery or disclosures have been exchanged, no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

Lastly, in August 2024, the Arizona Attorney General’s Office received a letter from attorneys purporting to represent a group of providers/facilities, and facility owners with potential claims against AHCCCS/the State arising from the suspension and/or termination of medical provider licenses or payments to providers. A number of these claimants have submitted Notices of Claim which are discussed above. Others appear to have not yet asserted claims. Management, upon consultation with internal and external counsel, notes that these matters are in the very early stages. Plaintiffs have in the aggregate claimed approximately $1,162,288 in damages. Additionally, in January 2025, a group of providers filed suit against several parties including the State, AHCCCS and the AHCCCS Director alleging negligence, gross negligence, racial discrimination, lack of due process, breach of contract among others. Management, upon consultation with internal and external counsel, notes that these matters are in the early stages. Plaintiffs have in the aggregate claimed approximately $1,000,000 in damages. Given these matters are in the early stages, and no discovery or disclosures have been exchanged, AHCCCS notes that no evidence has been disclosed to support such a figure and the amounts of potential loss in these matters cannot be estimated with accuracy based on the information available at this time. AHCCCS denies liability and intends to vigorously defend these matters.

On September 25, 2023, Director Heredia was appointed by the Honorable Governor Hobbs to serve AHCCCS as its Cabinet Executive Officer and Executive Deputy Director. Director Heredia served in this capacity until she was officially nominated as Director by Governor Hobbs on August 29, 2024. An allegation presented in some of the lawsuits noted above that were filed against AHCCCS challenges Director Heredia’s authority to issue decisions on behalf of the Agency, including Director’s Decisions during Director Heredia’s interim title of Cabinet Executive Officer and Executive Deputy Director. (Similar arguments have also been asserted against other Agency Directors.) While these lawsuits arguably pose a potential risk, AHCCCS believes the legal positions it has taken in the litigation are correct and that Director Heredia’s actions and decisions are valid during the time period in which she was appointed Cabinet Executive Officer and Executive Deputy Director. AHCCCS continues to monitor these legal challenges and does not anticipate any material impact on its financial statements.

(8) Contingencies, risks and uncertainties (continued)

AHCCCS Pauses ALTCS-EPD Member Transition - AHCCCS paused member transition activities related to the procurement of new contracts for the Arizona Long Term Care System/Elderly & Physically Disabled ("ALTCS-EPD") program that were scheduled to go live on October 1, 2024. AHCCCS reviewed the August 9th Administrative Law Judge ("ALJ") Decision which recommended that the Mercy Care, Banner, and Health Choice EPD appeals be granted. The ALJ concluded that there were flaws in the procurement process and recommended that the procurement be canceled and that a new request for proposal be issued. By law, AHCCCS had 30 days following the ALJ's Decision to accept, reject or modify the Decision. On September 8th, AHCCCS issued a Director's Decision ("Decision") which denies the appeals. The Decision found that AHCCCS properly exercised its discretion in the procurement process in accordance with law and that the non-awarded health plans failed to timely protest alleged procurement deficiencies as required by state administrative rules.

Further, the Decision found that even if the non-awarded health plans timely filed protests, they failed to show that the alleged errors created a disadvantage to them, that the procurement process operated in a manner contrary to the law, or that they had a substantial chance at receiving an award. AHCCCS applied the procurement process fairly to all bidders, including the non-awarded health plans. Based on the Director's Decision to deny the appeal, AHCCCS plans to move forward with the award of the ALTCS-EPD contracts to Health Net Access, Inc. (dba Arizona Complete Health-Long Term Care Plan) and Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan). In September 2024, AHCCCS announced that they plan to extend the current Arizona Long Term Care System for Elderly and/or Physically Disabled ("ALTCS-EPD") Contracts with Banner-University Family Care, Mercy Care, and UnitedHealthcare Community Plan for one year, through September 30, 2025. In light of the Director's Decision, AHCCCS is comprehensively evaluating operations and processes for transition to the newly awarded ALTCS-EPD health plans which is anticipated to begin on October 1, 2025. Members continue to be the agency's primary focus throughout this process. The health plans that were awarded EPD contracts that will begin on October 1, 2025 are Health Net Access, Inc. (dba Arizona Complete Health-Long Term Care Plan) and Arizona Physicians IPA, Inc. (dba UnitedHealthcare Community Plan).

By law, the non-awarded health plans have the opportunity to either file a Motion for Rehearing or Review with the agency or file an appeal in Superior Court to seek judicial review. In September 2024, the three health plans have filed appeals in Superior Court to seek judicial review. The parties are presently involved in briefing the Superior Court regarding procedural matters and scheduling issues. Once such matters are resolved and the three appellant entities file their opening briefs, AHCCCS will then have 45 days to file any responsive briefing, and the appellants will have another 20 days to file a reply brief.

This matter does not seek any damages; rather, it seeks a ruling that would require the agency to reverse its contract award decisions and restart the procurement process. It is possible that the appellants would, if they prevail, seek to have the court award them attorneys' fees and expenses. We do not have an estimate on what such amounts would be, or whether any such request would be successful, and we believe that any Superior Court decision in this matter could likely result in further appeals which would likely stay any such award until further resolution on appeal. The appellants are represented by counsel, and two of them have had multiple firms acting on their behalf throughout the underlying administrative proceedings. The appellants have all likely incurred hundreds of thousands of dollars in attorneys' fees across the entire scope of the agency process, the underlying administrative appeal, and the pending Superior Court matter.

(dollar amounts expressed in thousands)

(9) Interfund receivables, payables and transfers

Interfund activity is defined as transactions between funds administered by AHCCCS. The interfund balances as of June 30, 2024 consist of transfers from the Other Funds to the General Fund in the amount of $7,664.

In the government-wide statement of activities, the interfund activity has been eliminated. The total net transfers out of $158,455 reported on the statement of activities represents transfer activities to other State agencies.

(10) Transactions with other State agencies and counties

Transactions with other State agencies and counties - AHCCCS contracts for administrative and programmatic services from other State agencies. Charges for administrative services are based on the performing agencies' actual cost. Charges for programmatic services are generally based on actuarially determined capitation rates. The following is a summary of contracted services provided:

Administrative services - The Arizona Department of Economic Security ("ADES") charges AHCCCS to determine eligibility for certain AHCCCS members. The Arizona Department of Administration charges AHCCCS for data center services, communication lines, risk management and training. The Arizona Department of Health Services ("ADHS") charges AHCCCS for licensure and screening services and administrative costs associated with the CHIP Vaccine for Children program and the Arizona State Immunization Information System. The Arizona Board of Nursing charges AHCCCS for the cost of administering the nurse aid training program for nurse assistants. The Arizona Office of Administrative Hearings charges AHCCCS for administrative hearing services. These expenditures are included in administrative expenditures or other sources (uses) in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds.

The following is a summary of transactions with these State agencies for the administrative services described above for the year ended June 30, 2024:

	Expenditures
Arizona Department of Economic Security	$ 145,742
Arizona Department of Administration	24,398
Arizona Department of Health Services	73
Arizona Board of Nursing	210
Arizona Office of Administrative Hearings	528
	$ 170,951

Programmatic services - Certain health care related programmatic services are provided by ADES. AHCCCS receives the State and federal funds for these services and transfers them to ADES pursuant to the terms of an intergovernmental agreement.

The amount of $3,229,989 passed through to ADES for the year ended June 30, 2024 is classified as long-term care services expenditures in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds.

The amount of $6,642 paid to the Department of Health Services in fiscal year 2024 is for the vaccine costs based on the CDC Federal Contract Price sheet.

Long-term care revenues include $366,205 from Arizona counties during fiscal year 2024. AHCCCS refunded to the counties $21,635 for fiscal year 2024 representing excess of revenue over expenditures.

(dollar amounts expressed in thousands)

(11) Other pass-through funds

Arizona school districts are eligible for federal matching funds for the administrative functions related to Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") outreach services at the school level. Arizona school districts also are eligible for federal matching funds on a fee-for-service basis for the provision of certain AHCCCS program services provided to eligible students. These amounts are included within federal pass-through funds in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds.

Arizona county and local governments contributed $113,321 to qualify for matching federal funds for the Graduate Medical Education, Disproportionate Share Hospital program payments and for the provision of qualifying services to hospitalized inmates. These amounts are included within county IGA pass through funds in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds.

Arizona counties contributed $4,669 as determined by statutory calculation for administrative costs incurred by ADES for eligibility determinations and other operating costs associated with Proposition 204.

For the year ended June 30, 2024, AHCCCS recorded the following pass through revenue in the accompanying Statement of Revenues, Expenditures and Changes in Fund Balances - Governmental Funds:

	Funds Passed Through
Arizona School Districts	
Administrative Services Federal Funds	$ 18,009
Program Services Federal Funds	112,781
Arizona Department of Economic Security	
County Contribution for Administrative Costs	4,669
	$ 135,459

(12) Subsequent events

AHCCCS has evaluated subsequent events through April 30, 2025, which is the date the financial statements were available to be issued.

AHCCCS enrollment – AHCCCS has met the requirements of state statute A.R.S. §36-2905.05 to determine Medicaid eligibility for members who had maintained coverage during the pandemic despite potentially being over the income limit.

When the PHE began in March 2020, the federal government required states to maintain Medicaid coverage for all enrollees regardless of known changes in their income that may have put them over the Medicaid income limit.

Because AHCCCS continued its renewal processes throughout the pandemic, the agency was able to estimate that approximately 675,000 individuals were potentially no longer eligible (known as the "COVID Override" group).

Within the COVID Override group, members who were "factually ineligible," meaning over the Medicaid income limit, represented about half of the total and were prioritized for eligibility redetermination when regular renewal procedures began in April 2023. Between April 2023 and March 2024, eligibility for every AHCCCS member was redetermined. Members who were found factually or procedurally ineligible were disenrolled, and AHCCCS referred those deemed factually ineligible to the federal Healthcare Marketplace.

(12) Subsequent events (continued)

AHCCCS enrollment overall, for the period June 2024 to June 2025, is currently forecasted to go from 2,204,281 to approximately 2,106,805, which would represent a loss of approximately 97,476 members for a 4.4 percent decrease. Subsequent to year-end, member disenrollment has declined, and enrollment numbers are stabilizing as the effects of the PHE unwinding has subsided. With this transition complete, operations have returned to normal, reflecting a more consistent membership trend aligned with pre-pandemic levels.

Contract year 2025 capitation rates - For the contract year ending 2025, AHCCCS' overall weighted capitation rate increased by 3.6 percent across all lines of business except the Department of Economic Security/Developmental Disabilities program. An increase of 2.0 percent in the capitation rates is attributable to COVID-19, primarily driven by the expectation that as part of the unwinding of the COVID-19 PHE, and the end of the continuous coverage requirement, lower cost members will disenroll from Medicaid during contract year 2024 and contract year 2025 causing an increase in the average cost profile of the remaining Medicaid members. The contract year 2025, Acute Care capitation rates increased by 3.3 percent as compared to the 1.0 percent decrease for contract year 2024. The contract year 2025 Arizona Long Term Care System ("ALTCS" Elderly and Physically Disabled ("EPD")) capitation rates increased by 1.35 percent as compared to the 4.0 percent increase for contract year 2024. The 2025 increase is primarily based on baseline utilization and unit trends, changes in pharmacy expenses and adjustments to reflect the costs to administer and manage the programs. It is important to note that federal law requires rates to be actuarially sound and the AHCCCS actuaries develop rates based on expected cost and utilization trends. In addition, AHCCCS must conduct an access to care analysis of its rates to assure that sufficient numbers of providers are willing to serve AHCCCS members. Therefore, depending on the results of this analysis and of AHCCCS' actuarial determination of the expected costs of the managed care organizations, the actual capitation rates could differ from projections.

AHCCCS fiscal 2025 and 2026 appropriations - The total fiscal year 2025 appropriation for AHCCCS is $21,059 million, compared to the final $20,039 million appropriation for fiscal year 2024. AHCCCS' budget request for fiscal year 2026 and budget revision, was submitted to the Governor in September 2024 and November 2024, respectively. Factors such as Federal law changes, CMS decisions, COVID-19 PHE, other global health emergencies, legal decisions, economic conditions impacting case load changes compared to projections and the eligibility system shifts in population categories did not require the need of a supplemental appropriation for fiscal year 2025. Subsequent to year-end, member disenrollment has declined, and enrollment numbers are stabilizing as the effects of the PHE unwinding has subsided. With this transition complete, operations have returned to normal, reflecting a more consistent membership trend aligned with pre-pandemic levels.

Adjustments for Disaster-Recovery States to the Fiscal Year 2024 and Fiscal Year 2025 FMAP Rates – On November 29, 2024, the Health and Human Services Department announced an adjusted Federal Medical Assistance Percentage ("FMAP") rates for the Fiscal Year 2024 and Fiscal Year 2025 for disaster-recovery FMAP adjustment States made available under the Social Security Act (the "Act"), as enacted in section 2006 of the Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act"). The Social Security Act adjusts the regular FMAP rate for qualifying states that have experienced a major, statewide disaster. The percentages listed are for Fiscal Year 2024, retroactively effective from October 1, 2023, through September 30, 2024, and for Fiscal Year 2025, effective October 1, 2024, through September 30, 2025. The disaster-recovery adjusted FMAP rates for fiscal year 2024 and 2025 are 67.93% (up from 66.29%) and 65.65% (up from 64.89%), respectively. AHCCCS is actively working with CMS to determine timing of updated federal claim and financial impact.

(12) Subsequent events (continued)

Centene Entities Settlement – In December 2024, the State received a settlement of $33,694 from the Centene Entities related to pharmacy pricing and Centene overcharging the state. Of this amount, $26,093, representing the federal share, was returned to CMS and reflected in the CMS-64 report for the quarter ending December 31, 2024. The remaining $7,601 constituted the state share of the settlement. Of this, $7,000 was returned to the Attorney General's Office and deposited into the Consumer Protection-Consumer Fraud Revolving Fund pursuant to A.R.S. § 44-1531.02(B). The remaining $601 was deposited into the State General Fund to reimburse the initial expense.

There are current discussions at both the federal and state levels to modify Medicaid funding methodologies which could significantly decrease Medicaid funding, and/or shift expenditures from the Federal government to the State. At the federal level, proposals under consideration include reductions to the expansion population FMAP contributions, limitations on provider taxes, work requirements, and/or changing Medicaid from an entitlement program to a per-capita cap or block grant program. Concurrently, state-level proposals seek to tighten eligibility criteria to address budget constraints, further amplifying the potential for funding shortfalls. The potential exists that certain funding changes passed into law could trigger either the session law or statutory requirement that AHCCCS stop collection of the Hospital Assessment if the ACA is repealed or if the FMAP for the expansion and restoration populations, as authorized by the ACA, falls below 80.0 percent. Such an outcome would likely disrupt the revenue stream supporting the Hospital Assessment Fund, leading to insufficient funding to maintain current program levels. Consequently, AHCCCS would most likely need to adjust eligibility standards, scale back services, or reduce provider reimbursement to align with the reduced available funds, potentially impacting access to care for enrolled populations.

REQUIRED SUPPLEMENTARY INFORMATION

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BUDGETARY COMPARISON SCHEDULE - GENERAL FUND

Year Ended June 30, 2024
(Unaudited)
(amounts expressed in thousands)

	Original Appropriation (Budget)	Final Appropriation (Budget)	Actual	Variance with Final Budget
REVENUES				
State appropriations	$ -	$ -	$ 2,263,715	$ -
State ISA pass through funds	-	-	989,937	-
Federal government	-	-	13,181,610	-
Federal ISA/IGA pass through funds	-	-	2,500,002	-
County and other local government	-	-	495,366	-
County IGA pass through funds	-	-	253,456	-
Tobacco tax revenue	-	-	32,340	-
Tobacco litigation settlement	-	-	88,273	-
Other	-	-	570,326	-
Total revenues	-	-	20,375,025	-
OTHER FINANCING SOURCES				
Operating transfers in	-	-	170	-
TOTAL REVENUES AND OTHER FINANCING SOURCES	-	-	20,375,195	-
PROGRAMMATIC EXPENDITURES				
Traditional services	7,533,582	7,466,697	6,853,599	613,098
Proposition 204 services	6,332,480	6,412,480	6,431,860	(19,380)
Newly eligible adults	847,821	857,821	643,856	213,965
CMDP	195,910	195,910	151,588	44,322
KidsCare services	178,568	185,010	158,894	26,116
Targeted investment	26,000	26,000	3,657	22,343
Disproportionate share	5,087	5,087	708	4,379
Rural and critical access hospitals	41,074	41,074	30,258	10,816
Voluntary Political Subdivision Programs	496,267	496,267	439,425	56,842
Long-term care services	2,623,341	2,508,341	2,099,118	409,223
Behavioral health services	95,018	95,018	85,556	9,462
Behavioral support services	81,716	81,716	21,424	60,292
TOTAL PROGRAMMATIC EXPENDITURES	18,456,864	18,371,421	16,919,943	1,451,478
ADMINISTRATIVE EXPENDITURES	310,309	363,334	325,641	37,693
TOTAL APPROPRIATED EXPENDITURES	18,767,173	18,734,755	17,245,584	1,489,171
PRIOR YEAR APPROPRIATED EXPENDITURES	-	-	-	-
NON-APPROPRIATED EXPENDITURES	-	-	3,171,818	-
REVENUES AND OTHER FINANCING SOURCES OVER EXPENDITURES	-	-	(42,207)	-
FUND BALANCES, BEGINNING OF YEAR	-	-	901,958	-
FUND BALANCES, END OF YEAR	$ -	$ -	$ 859,751	$ -

See Notes to Financial Statements
See Independent Auditors' Report

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF THE AGENCY'S PROPORTIONATE SHARE OF THE NET PENSION LIABILITY - COST SHARING PLAN

(Unaudited)

(amounts expressed in thousands)

	Reporting Fiscal Year (Measurement Date)										
	2024 (2023)	2023 (2022)	2022 (2021)	2021 (2020)	2020 (2019)	2019 (2018)	2018 (2017)	2017 (2016)	2016 (2015)	2015 (2014)	2014 through 2006
Agency's proportion of the net pension liability	0.531310%	0.501860%	0.512800%	0.504300%	0.522860%	0.537230%	0.529910%	0.470770%	0.455146%	0.470599%	Information
Agency's proportionate share of the net pension liability	$ 85,974	$ 81,915	$ 67,380	$ 87,378	$ 76,082	$ 74,925	$ 82,550	$ 75,987	$ 70,896	$ 69,633	not available
Agency's covered payroll	$ 69,354	$ 59,542	$ 59,622	$ 54,760	$ 54,785	$ 53,128	$ 49,620	$ 42,430	$ 42,770	$ 43,181	
Agency's proportionate share of the net pension liability as a percentage of its covered payroll	123.96%	137.58%	113.01%	159.57%	138.87%	141.03%	166.36%	179.09%	165.76%	161.26%	
Plan fiduciary net position as a percentage of the total pension liability	75.47%	74.26%	78.58%	69.33%	73.24%	73.40%	69.92%	67.06%	68.35%	69.49%	

See Notes to Financial Statements
See Independent Auditors' Report

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF THE AGENCY'S PENSION CONTRIBUTIONS
(Unaudited)
(amounts expressed in thousands)

	Fiscal Year									
	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Statutorily required contribution	$ 8,774	$ 8,267	$ 7,151	$ 6,946	$ 6,270	$ 6,125	$ 5,792	$ 5,349	$ 4,604	$ 4,548
Agency's contributions in relation to the statutorily required contribution	8,774	8,267	7,151	6,946	6,270	6,125	5,792	5,349	4,604	4,548
Agency's contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Agency's covered payroll	$ 72,934	$ 69,354	$ 59,542	$ 59,622	$ 54,760	$ 54,785	$ 53,128	$ 49,620	$ 42,430	$ 42,770
Agency's contributions as a percentage of its covered payroll	12.03%	11.92%	12.01%	11.65%	11.45%	11.18%	10.90%	10.78%	10.85%	10.63%

See Notes to Financial Statements
See Independent Auditors' Report

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
SCHEDULE OF CHANGES IN THE AGENCY'S TOTAL OPEB LIABILITY AND RELATED RATIOS

(Unaudited)
(amounts expressed in thousands)

	Reporting Fiscal Year (1) (Measurement Date)						
	2024 (2023)	2023 (2022)	2022 (2021)	2021 (2020)	2020 (2019)	2019 (2018)	2018 (2017)
Total OPEB Liability							
Service cost	$ 1,540	$ 2,313	$ 2,376	$ 2,063	$ 1,526	$ 1,043	$ 1,397
Interest on the total OPEB liability	743	482	774	801	636	555	532
Changes of benefit term	-	-	-	-	-	-	(1,452)
Difference between expected and actual experience	(10,298)	-	(9,360)	-	768	-	(436)
Difference between expected and actual experience - Change in Proportion	(298)	-	809	-	1,174	-	-
Changes of assumptions or other inputs	373	(6,470)	(520)	3,403	5,038	(687)	(3,783)
Benefit payments	(519)	(467)	(601)	(532)	(481)	(448)	(478)
Net changes	$ (8,459)	$ (4,142)	$ (6,522)	$ 5,735	$ 8,661	$ 463	$ (4,220)
Total OPEB liability - beginning	18,868	23,010	29,532	23,797	15,136	14,673	18,893
Total OPEB liability - ending (2)	$ 10,409	$ 18,868	$ 23,010	$ 29,532	$ 23,797	$ 15,136	$ 14,673
Covered-employee payroll	$ 70,565	$ 60,259	$ 58,560	$ 56,671	$ 55,181	$ 50,072	$ 48,756
Total OPEB liability as a percentage of covered-employee payroll	14.75%	31.31%	39.29%	52.11%	43.13%	30.23%	30.09%

(1) AHCCCS implemented GASB 75 in fiscal year 2018. Therefore, 10 years of data is not yet available, but will accumulate over time.
(2) There are no dedicated assets at this time to offset the total OPEB liability.

UNIFORM GUIDANCE SUPPLEMENTARY REPORTS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended June 30, 2024
(amounts expressed in thousands)

Federal Grantor/Pass Through Agency/Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Grantor Identifying Number	Contract Number	Passed through to Subrecipients	Federal Expenditures
U.S. Department of Health and Human Services					
Centers for Medicare and Medicaid Services					
Medical Assistance Program (Medicaid; Title XIX)	93.778	N/A	11-W-00275/09	$ -	$ 15,441,956
COVID-19 Medical Assistance Program (Medicaid; Title XIX)	93.778	N/A	11-W-00275/09	-	275,199
Total Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster				-	15,717,155
Centers for Medicare and Medicaid Services					
Children's Health Insurance Program (Title XXI)	93.767	N/A	21-W-00064/09	-	267,089
COVID-19 Children's Health Insurance Program (Title XXI)	93.767	N/A	21-W-00064/09	-	589
Total Children's Health Insurance Program (Title XXI)				-	267,678
Substance Abuse and Mental Health Services Administration					
COVID-19 - Emergency Grants to address Mental and Substance Use Disorders During COVID-19	93.665	N/A	6H79FG000250	45	45
Substance Abuse and Mental Health Services Administration					
Block Grants for Community Mental Health Services	93.958	N/A	B09SM087334, B09SM089599, B09SM085982, B09SM083780, B09SM085862, B09SM087276	26,086	27,317
COVID-19 Block Grants for Community Mental Health Services	93.958	N/A	B09SM083960, B09SM085335	16,225	17,382
Total Block Grants for Community Mental Health Services				42,311	44,699
Substance Abuse and Mental Health Services Administration					
Block Grants for Prevention and Treatment of Substance Abuse	93.959	N/A	B08TO083435, B08TI084630, B08TI085792, B08T0087024	37,225	45,502
COVID-19 Block Grants for Prevention and Treatment of Substance Abuse	93.959	N/A	B08TI083525	15,325	21,645
Total Block Grants for Prevention and Treatment of Substance Abuse				52,550	67,147
Substance Abuse and Mental Health Services Administration					
Projects for Assistance in Transition from Homelessness (PATH)	93.150	N/A	X06SM088801	1,433	1,491
Substance Abuse and Mental Health Services Administration					
Projects of Regional and National Significance (93.243)					
Arizona Pilot Program for Treatment for Pregnant and Postpartum Women	93.243	N/A	H79TI083173	3,187	3,466
Centers for Disease Control and Prevention					
Activities to Support State, Tribal, Local and Territorial (STLT) Health Department Response to Public Health and Healthcare Crises	93.391	N/A	6NU58DP006992-03-03	-	474
Centers for Disease Control and Prevention					
COVID-19 Community Health Workers For Public Health Response and Resilient	93.495	N/A	NU58DP006992	858	1,734
Substance Abuse and Mental Health Services Administration					
State Opioid Response (SOR)	93.788	N/A	H79TI081709, H79TI083320, H79TI085739	20,981	30,752
Total US. Department of Health and Human Services				121,365	16,134,641
U.S. Department of Treasury					
Passed through the Office of the Arizona Governor					
COVID-19 - The Coronavirus State and Local Fiscal Recovery Funds (SLFRF)	21.027	EL9HZNBAN1B9	ISA-ARPA-AHCCCS-110122-01 & ISA-AHCCCS-ARPA-070121-01	-	19,703
TOTAL EXPENDITURES OF FEDERAL AWARDS				$ 121,365	$ 16,154,344

See Independent Auditors' Report
See Notes to Schedule of Expenditures of Federal Awards

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended June 30, 2024

(1) Basis of presentation

The accompanying Schedule of Expenditures of Federal Awards (the "Schedule") includes the federal grant activity of the ***Arizona Health Care Cost Containment System*** ("***AHCCCS")*** under programs of the federal government for the year ended June 30, 2024. The information in the Schedule is presented in accordance with the requirements of *Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Because the Schedule presents only a selected portion of the operations of ***AHCCCS,*** it is not intended to and does not present the financial position, changes in net position or cash flows of ***AHCCCS.***

Additionally, our audit of ***AHCCCS'*** major federal programs was conducted as part of the State of Arizona's Single Audit for the year ended June 30, 2024. The State of Arizona's major federal programs were determined by the Office of the Auditor General by applying the risk-based approach for determining major federal programs in accordance with the Uniform Guidance. Our Report on Compliance for Each Major Federal Program relates only to the portion of the programs that were administered by ***AHCCCS*** and does not purport to, and does not, report on compliance over other portions, if any, of the major federal programs or any other major federal programs of the State of Arizona.

(2) Summary of significant accounting policies

Expenditures reported on the Schedule are reported on the accrual basis of accounting, except for amounts passed through to subrecipients which are reported when disbursed to the subrecipient. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Negative amounts, if any, shown on the Schedule represent adjustments or credits made in the normal course of business to amounts reported as expenditures in prior years. ***AHCCCS*** has elected not to use the ten percent de minimis indirect cost rate allowed under the Uniform Guidance.

CBIZ CPAs

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Director of

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS, an agency of the state of Arizona)

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the governmental activities, the general fund, and the aggregate remaining fund information of ***Arizona Health Care Cost Containment System*** **("AHCCCS")** as of and for the year ended June 30, 2024 and the related notes to the financial statements, which collectively comprise AHCCCS' basic financial statements and have issued our qualified report thereon dated April 30, 2025.

We have qualified our opinion on the governmental activities and general fund because we were unable to obtain sufficient appropriate audit evidence for any amounts due to the federal government or federal revenues as a result of the provider billing matter described in Note 8 as of and for the year ended June 30, 2024. Consequently, we were unable to determine whether any adjustments of these amounts or additional disclosures were necessary.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered ***AHCCCS'*** internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of ***AHCCCS'*** internal control. Accordingly, we do not express an opinion on the effectiveness of ***AHCCCS'*** internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We identified deficiencies in internal control, described in the accompanying schedule of findings and questions costs as items 2024-001, 2024-002, and 2024-003 that we consider to be material weaknesses.

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Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether ***AHCCCS'*** financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and which is described in the accompanying schedule of findings and questioned costs as item 2024-001.

AHCCCS' Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the findings identified in our audit and described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

CBIZ CPAs P.C.

April 30, 2025

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

To the Director of

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS, an agency of the state of Arizona)

Report on Compliance for Each Major Federal Program

Qualified and Unmodified Opinions

We have audited ***Arizona Health Care Cost Containment System's ("AHCCCS")*** compliance with the types of compliance requirements identified as subject to audit in the U.S. Office of Management and Budget ("OMB") Compliance Supplement that could have a direct and material effect on ***AHCCCS'*** major federal programs for the year ended June 30, 2024. ***AHCCCS'*** major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Qualified Opinion on ALN 93.778 – Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster

In our opinion, except for the noncompliance described in the Basis for Qualified and Unmodified Opinions section of our report, ***AHCCCS*** complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on ALN 93.778 – Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster for the year ended June 30, 2024.

Unmodified Opinion on the Other Major Federal Programs (ALN 93.767 Children's Health Insurance Program (Title XXI), ALN 93.958 Block Grants for Community Mental Health Services, and ALN 21.027 COVID-19 Coronavirus State and Local Fiscal Recovery Funds (SLFRF))

In our opinion, ***AHCCCS*** complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on its other major federal programs *(ALN 93.767 Children's Health Insurance Program (Title XXI), ALN 93.958 Block Grants for Community Mental Health Services, and ALN 21.027 COVID-19 Coronavirus State and Local Fiscal Recovery Funds (SLFRF))* identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs for the year ended June 30, 2024.

Basis for Qualified and Unmodified Opinions

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*); and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of ***AHCCCS*** and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified and unmodified opinions on compliance for each major federal program. Our audit does not provide a legal determination of ***AHCCCS'*** compliance with the compliance requirements referred to above.

Matters Giving Rise to Qualified Opinion on ALN 93.778 – Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster

As described in the accompanying schedule of findings and questioned costs, ***AHCCCS*** did not comply with requirements regarding ALN 93.778 – Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster as described in finding number 2024-004 for Special Tests and Provisions – Utilization Control and Program Integrity.

Compliance with such requirements is necessary, in our opinion, for ***AHCCCS*** to comply with the requirements applicable to that program.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to ***AHCCCS'*** federal programs.

Auditors' Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on ***AHCCCS'*** compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about ***AHCCCS'*** compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding ***AHCCCS'*** compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of ***AHCCCS'*** internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of ***AHCCCS'*** internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Our audit of ***AHCCCS'*** major federal programs was conducted as part of the State of Arizona's Single Audit for the year ended June 30, 2024. The State of Arizona's major federal programs were determined by the Office of the Auditor General applying the risk-based approach for determining major federal programs in accordance with the Uniform Guidance. Our Report on Compliance for Each Major Federal Program relates only to the portion of the programs that were administered by ***AHCCCS*** and does not purport to, and does not, report on compliance over other portions, if any, of the major federal programs or any other major federal programs of the State of Arizona.

Other Matters

The results of our auditing procedures disclosed instances of noncompliance which are required to be reported in accordance with the Uniform Guidance and which are described in the accompanying schedule of findings and questioned costs as items 2024-005 and 2024-006. Our opinion on each major federal program is not modified with respect to these matters.

AHCCCS' Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the noncompliance findings identified in our compliance audit described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

Report on Internal Control Over Compliance

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, we did identify certain deficiencies in internal control over compliance that we consider to be material weaknesses.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance. We consider the deficiencies in internal control over compliance described in the accompanying schedule of findings and questioned costs as items 2024-004, 2024-005 and 2024-006 to be material weaknesses.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

Government Auditing Standards requires the auditor to perform limited procedures on ***AHCCCS'*** response to the internal control over compliance findings identified in our compliance audit described in the accompanying schedule of findings and questioned costs. ***AHCCCS'*** response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

CBIZ CPAs P.C.

April 30, 2025

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2024

Section I – Summary of Auditors' Results

Financial Statements

1.	Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	Qualified
2.	Is a going concern emphasis-of-matter paragraph included in the auditors' report?	No
3.	Internal control over financial reporting:	
	a. Material weakness(es) identified?	Yes
	b. Significant deficiency(ies) identified?	None reported
4.	Noncompliance material to financial statements noted?	No

Federal Awards

1.	Internal control over major federal programs:	
	a. Material weakness(es) identified?	Yes
	b. Significant deficiency(ies) identified?	None reported
2.	Type of Auditor's report issued on compliance for major federal program:	93.778 – Qualified 93.767 – Unmodified 93.958 – Unmodified 21.027 – Unmodified
3.	Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	Yes
4.	Identification of major federal programs:	

Assistance Listing Number	Name of Federal Program or Cluster
93.778	Medical Assistance Program (Medicaid; Title XIX), part of the Medicaid Cluster
93.767	Children's Health Insurance Program (Title XXI)
93.958	Block Grants for Community Mental Health Services
21.027	COVID-19 - Coronavirus State and Local Fiscal Recovery Funds (SLFRF)

5.	Dollar threshold used to distinguish between type A and type B programs:	State of Arizona threshold $42,273,296
6.	Auditee qualified as a low-risk auditee?	No

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2024

Section II – Financial Statement Findings

Item: 2024-001

Subject: Timeliness in Reporting and Adequacy of Staffing

Criteria or Specific Requirement: AHCCCS' close and financial reporting processes involve a significant volume of complex accounting transactions and estimates that require sufficient personnel with the requisite skills, knowledge and expertise to ensure the accuracy and timeliness of the year-end close and financial reporting process as well as the accuracy and timeliness of other quarterly financial reporting. Additionally, State law requires State agencies submit their financial and federal award information to the Arizona Department of Administration ("ADOA") by a specified date to meet the State's financial reporting and single audit deadlines. For fiscal 2024, AHCCCS' financial reporting and federal award information was due to ADOA by November 15, 2024.

Condition: For the year ended June 30, 2024, AHCCCS encountered delays in the close and financial reporting process. Additionally, AHCCCS experienced delays in certain required quarterly reporting and required extensions from various funding agencies, most notably the Centers for Medicare & Medicaid Services ("CMS"). For fiscal 2024, AHCCCS' financial reporting and federal award information was due to ADOA by November 15, 2024 and was not submitted to ADOA until March 14, 2025.

Cause: The delays in AHCCCS' close and financial reporting process were caused by delays in the fiscal 2023 audit which was not finalized and issued until September 2024. As a result, the fiscal 2024 audit did not begin until November 2024. Additionally, AHCCCS' Division of Business and Finance continued to experience employee turnover into fiscal 2024. These matters were exacerbated as a result of the COVID-19 pandemic, the end of the Public Health Emergency and related disenrollment, and the myriad of federal and state responses that continue to impact the Medicaid program. This continues to increase the volume and complexity of accounting activity within AHCCCS. Although the fiscal year 2024 audit began late, the procedural improvements implemented resulted in the fiscal 2024 audit being completed in a far more timely manner.

Effect: The State was not able to meet its financial reporting and audit requirements and deadlines. This also impacted decision-makers' ability to rely on financial information that is not provided in a timely manner. Additionally, the delay in the federal award reporting resulted in the State's delay in issuing its single audit reporting package, which is due March 31, 2025, and could result in actions being taken by federal grantors on various federal awards. This is deemed to be a material weakness in internal control over financial reporting.

Identification as a Repeat Finding: Repeat finding – prior year 2023-001

Recommendation: AHCCCS should submit financial reporting and federal award information to ADOA within the required timelines. We recommend that AHCCCS continue to review the overall size of the finance and accounting department within the Division of Business and Finance and consider adding additional resources such that the compliment of finance and accounting professionals is sufficient to timely close the books and complete year-end and quarterly reporting timely. We also recommend that given the growth of the program and as a result of turnover, that management assess the skills, knowledge and experience of the accounting department to ensure that resources are sufficient to facilitate timely financial reporting.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Item: 2024-002

Subject: Audit Adjustments

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: In connection with our audit, we encountered several audit adjustments to present the financial statements and schedule of expenditures of federal awards of AHCCCS in accordance with GAAP. For the year ended June 30, 2024, several audit adjustments were made to properly adjust accruals, reconcile balances, correct errors and properly present financial information in the financial statements and schedule of expenditures of federal awards. We noted 7 adjusting entries which resulted in a decrease of approximately $20.1 million to assets, a decrease of approximately $13.4 million to liabilities, a decrease of approximately $6.7 million to net position and a decrease of $6.7 million to net income. Additionally, we noted the adjusting entries resulted in a net decrease in the total expenditures of federal awards of approximately $24.6 million as presented on the Schedule of Expenditures of Federal Awards.

Cause: The audit adjustments were caused largely by turnover within AHCCCS' Division of Business and Finance, poor or nonexistent process documentation, an extensive learning curve of the newly assembled AHCCCS audit team responsible for the coordination and administration of the audit, and financial/accounting system challenges. Specifically, the financial/accounting system challenges stemmed from a shift in the methodology used to compile financial statements. In fiscal year 2022 and prior, AHCCCS relied on a data warehouse to compile financial statements, which followed a defined data-driven process. However, due to the absence of process documentation, the new audit team was unable to replicate or effectively utilize the data warehouse processes in the past 2 audit cycles. As a result, AHCCCS pivoted to a manual process for compiling financial statements.

Effect: While the necessary adjustments were posted to correct the financial statements and the schedule of expenditures of federal awards, AHCCCS' unadjusted financial statements and schedule of expenditures could be materially misstated and not presented in accordance with accounting principles generally accepted in the United States of America. This could result in conflicting information for management and outside users. This is deemed to be a material weakness in internal control over financial reporting.

Identification as a Repeat Finding: Repeat finding – prior year 2023-003

Recommendation: We recommend that AHCCCS continue to review the overall size of the finance and accounting department within the Division of Business and Finance and consider adding additional resources such that the compliment of finance and accounting professionals is sufficient to timely close the books and complete year-end and quarterly reporting timely. We also recommend that given the growth of the program and as a result of turnover, that management assess the skills, knowledge and experience of the accounting department to ensure that resources are sufficient to facilitate timely financial reporting. We also recommend that AHCCCS' Division of Business and Finance enhance their existing documentation of accounting policies, procedures and processes to ensure that any future impact on the year end close and financial reporting processes are minimal. We also recommend the establishment of a year-end close manual and checklist to ensure accruals, financial statement and the schedule of expenditures of federal awards are complete and accurate.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Item: 2024-003

Subject: Provider Billing Matter

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services in its Medical Assistance Program (noncompliance in a federal program as described in finding 2024-004, that had a direct and material effect on the determination of financial statement amounts). These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting

Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud (CAF) payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. See also compliance finding at 2024-004 below.

A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney's General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. Therefore, AHCCCS could not determine whether any financial statement adjustments or additional disclosure were necessary as a result of the federal noncompliance.

Cause: AHCCCS did not make any financial statement adjustments for potential repayment or recoveries because it lacked evidence to complete the determinations necessary to support the amount of monies it would be required to return to the U.S. government. The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post- payment review of behavioral health claims, as noted in the compliance finding at 2024-004.

Effect: As a result of this matter, we were unable to obtain sufficient appropriate audit evidence for AHCCCS' receivables and other, federal revenue, and due to the federal government line items and have issued a qualified opinion on the basic financial statements as of and for the year ended June 30, 2024. Material unrecorded receivables, federal revenue and due to the federal government may exist.

Identification as a Repeat Finding: Repeat finding – prior year 2023-004

Recommendation: We recommend that AHCCCS continue its investigations and refer Credible Allegations of Fraud ("CAF") cases to law enforcement officials. Additionally, we recommend AHCCCS continue to work with CMS to determine what, if any, amounts may be required to be remitted to CMS. We also recommend that once amounts are known, AHCCCS should record the balances within the financial statements in accordance with GAAP. Lastly, we recommend AHCCCS review their internal controls to ensure the controls in place are sufficient to timely detect unnecessary utilization and care of service.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2024

Section III – Federal Award Findings

Item: 2024-004

Assistance Listing Number: 93.778

Program: Medical Assistance Program (Medicaid; Title XIX)

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Number: 11-W-00275/09

Award Year: July 1, 2023 – June 30, 2024

Compliance Requirement: Special Tests and Provisions – Utilization Control and Program Integrity

Criteria: AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).

AHCCCS must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. AHCCCS must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. AHCCCS may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud ("CAF") payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes

that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. For example, providers billed for:

- Excessive hours of services in a 24-hour period for a single member,
- Multiple services for the same member at the same time,
- AHCCCS members who were not physically present ("ghost billing"),
- Services after a member's date of death, and
- Services that were not medically necessary.

Questioned Costs: Unknown

Context: Under 42 C.F.R. § 455.23 and the terms of the Provider Participation Agreement, AHCCCS may suspend payments to a provider if a Credible Allegation of Fraud ("CAF") has been identified. Providers are informed of the reason for their suspension in a Notice of CAF Suspension. CAF suspensions are based on preliminary findings of reliable indicia of fraud and may be lifted if AHCCCS determines there is no fraud occurring and/or good cause has been established under 42 C.F.R. § 455.23. Upon the conclusion of an investigation, AHCCCS may terminate a provider and/or lift their suspension at that time. At the point a referral is made, and payment is suspended, only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation, AHCCCS will terminate a provider's enrollment and require repayment of the identified overpayment. The investigation is on-going and AHCCCS is not currently able to estimate a total overpayment or amount of improper payments made to the providers. Therefore, we are unable to estimate any questioned costs related to the fraud allegations.

Effect: In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers.

Once a credible allegation of fraud determination is made, AHCCCS is required to suspend all payments to a provider unless there is good cause not to while investigations are conducted. The credible allegation of fraud determination results from the agency's preliminary investigation, and the agency must then make a fraud referral to the Arizona Attorney General's Healthcare Fraud and Abuse Section or a federal law enforcement agency for a full investigation. During this time, providers may continue to bill AHCCCS for services provided, but any reimbursement to these providers is withheld pending the outcome of further investigation. Under state statute, providers are entitled to appeal a suspension placed by AHCCCS. AHCCCS is working closely with the Arizona Attorney General's Healthcare Fraud and Abuse Section, the Federal Bureau of Investigation ("FBI"), the U.S. Department of Health and Human Services ("HHS"), the U.S. Attorney's Office, the Internal Revenue Service ("IRS"), and local and tribal law enforcement to disrupt organized bad actors, apprehend them, and prosecute them to the full extent allowed by law. At present, the investigation is on-going and a determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney's General's Office for prosecution of substantiated claims which is a highly complex and manual process and can

take many years to finalize. As a result, we have issued a qualified opinion on the basic financial statements as of and for the year ended June 30, 2024.

As a result of this matter, we have concluded that AHCCCS did not comply with the compliance requirements and have issued a qualified opinion on compliance. This matter is deemed to be a material weakness in internal control of compliance.

Cause: The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post- payment review of behavioral health claims. AHCCCS' claims processing system uses the CMS required claim edit protocols to look for improperly billed claims as noted in the National Correct Coding Initiative ("NCCI") and such edit protocols are updated regularly per CMS requirements. However, AHCCCS could have implemented additional controls that may have detected these issues more timely. While not required by CMS, AHCCCS did not have sufficient edits to restrict the inappropriate use of per diem codes or restrict some behavioral health codes from being billed for the same member on the same date of service. Further, AHCCCS did not have sufficient controls in which claims were reviewed by a medical professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

Identification as a Repeat Finding: Repeat finding – prior year 2023-005

Recommendation: We recommend that AHCCCS continue its investigations and refer Credible Allegations of Fraud ("CAF") cases to law enforcement officials. Additionally, we recommend AHCCCS continue to work with CMS to determine what, if any, amounts may be required to be remitted to CMS.

We also recommend that AHCCCS review and enhance existing policies and procedures and related controls to ensure sufficient processes and controls are in place to timely detect unnecessary utilization of care and services and to prevent fraud. For example, AHCCCS could implement additional edits to restrict the inappropriate use of per diem codes or restrict some behavioral health codes from being billed for the same member on the same date of service. Further, AHCCCS could add additional controls in which claims are reviewed by a medical professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

We further recommend that AHCCCS continue to examine the existing Medicaid payment system and continue to implement system-wide improvements. These improvements should include the establishment of additional reporting to flag concerning claims for pre-payment review, setting of billing thresholds and establishing prepayment review for various behavioral health claim types. We also recommend that AHCCCS establish sufficient controls in which claims are reviewed by a medical professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended June 30, 2024

Views of Responsible Officials:	Management of AHCCCS concurs in part with the finding. See Corrective Action Plan.
Item:	2024-005
Assistance Listing Number:	93.778 and 93.767
Program:	Medical Assistance Program (Medicaid; Title XIX) and Children's Health Insurance Program (CHIP)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09 and 21-W-00064/09
Award Year:	July 1, 2023 – June 30, 2024
Compliance Requirement:	Special Tests and Provisions – Utilization Control and Program Integrity
Criteria:	AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state MFCU or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21). Additionally, in accordance with AHCCCS policy, the AHCCCS Office of Inspector General is required to regularly follow up on deferred investigations and provide updates at least every 90 days to the State MFCU.
Condition:	AHCCCS did not follow up in a timely manner for certain deferred member investigations.
Questioned Costs:	Unknown
Context:	In a population of 1,494 deferred member and provider cases with identified credible allegations of provider and member fraud assigned during fiscal year 2024, we conducted a non-statistical sample of 40 member and provider investigations to ascertain if AHCCCS performed a preliminary investigation of potential incidents of fraud or abuse committed by members and providers on a timely basis. We also reviewed to ensure AHCCCS was following up on any deferred member and provider cases in a timely manner. In our sample of 40 member and provider investigations, we noted that for 39 of 40 member investigations, in which the investigation had been deferred, AHCCCS did not follow up in a timely manner in accordance with their internal policy on those deferred investigations.

Effect: Untimely follow up on fraud or abuse incident investigations could result in AHCCCS making unnecessary payments and compromise its ability to investigate cases. This is deemed to be a material weakness in internal control over compliance.

Cause: Management has reported to us that insufficient investigative staff and increased volumes of provider and member investigations impacted AHCCCS' ability to investigate and follow up on potential fraud or abuse incidents in a timely manner. In fiscal year 2023, the process of holding quarterly reviews of deferred cases did not occur due to resources being diverted to focus on Strike Force activities involved in addressing the Behavioral Health ("BH") crisis. Additionally, OIG announced a re-organization in December 2023 that resulted in permanent transitions to other teams for several staff. Teams were given time to finalize cases and move items to other investigators in order to limit disruption to cases. By April 2024, after the Strike Force initiative had been unwound and the member team structure changes for personnel were finalized, the member team restarted its process of quarterly deferred case reviews. At the first review in April 2024, cases in the deferred backlog that were not completed in the timeframe set for the reviews were postponed to the next quarterly review in July.

Identification as a Repeat Finding: Repeat finding – prior year 2023-006

Recommendation: We recommend that AHCCCS conduct a workload/cost analysis to evaluate whether its funding and staffing levels are sufficient to timely investigate member and provider fraud or abuse incidents. We also recommend AHCCCS reassign staff/resources to deferred member/provider investigations. Lastly, we recommend that AHCCCS follow its existing policy which includes clear timeframes in which follow up on deferred investigations occurs.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

Item: 2024-006

Assistance Listing Number: 93.778 and 93.767

Program: Medical Assistance Program (Medicaid; Title XIX) and Children's Health Insurance Program (CHIP)

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Number: 11-W-00275/09 and 21-W-00064/09

Award Year: July 1, 2023 – June 30, 2024

Compliance Requirement: Special Tests and Provisions – Refunding of Federal Share of Medicaid Overpayments to Providers

Criteria: 42 CFR 433 Subpart F outlines the requirements State Medicaid Agencies ("SMAs") are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Act (the Act) (42 USC 1396b), states have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS regardless of whether recovery is made from the provider.

Condition: AHCCCS did not return the federal share of fraud and abuse recoupments back to CMS in a timely manner.

Questioned Costs: $5,245,026 for AL#93.778 and $111,638 for AL#93.767

Context: In a population of 4,117 member and provider cases during fiscal year 2024, we conducted a non-statistical sample of 60 member and 60 provider investigations to ascertain if AHCCCS had properly remitted to CMS any recoupments as a result of the investigations. For 1 of 60 provider fraud cases, we noted AHCCCS did not timely return the federal share of fraud and abuse recoupments back to CMS. We then obtained from AHCCCS OIG a detail of all recoupments received during the period July 1, 2022 through June 30, 2024 noting a total of 392 unique OIG cases for which recoupments were received. Of this total of 392 cases, 136 cases were identified for which the federal share of the total recoupment amount was not properly reported on the CMS-64 report and therefore the funds were not properly remitted to CMS for a total of $5,356,664.

Effect: Recoupments were not reported and repaid timely to CMS. This is deemed to be a material weakness in internal control of compliance.

Cause: Management has reported to us that this was a result of staffing turnover as well as a breakdown of inter and intra-departmental communication and collaboration between AHCCCS OIG and the Division of Business and Finance.

Identification as a Repeat Finding: Repeat finding – prior year 2023-007

Recommendation: We recommend that AHCCCS timely report and remit recoupments to CMS. We also recommend that AHCCCS review and update their policies and procedures to ensure the federal share of any recoveries are reported and remitted to CMS timely. We also recommend that AHCCCS enhance their communication between divisions to facilitate and ensure the timely and accurate communication on recoveries.

Views of Responsible Officials: Management of AHCCCS concurs with the finding. See Corrective Action Plan.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Item: 2023-001

Subject: Timeliness in Reporting and Adequacy of Staffing

Criteria or Specific Requirement: AHCCCS' close and financial reporting processes involve a significant volume of complex accounting transactions and estimates that require sufficient personnel with the requisite skills, knowledge and expertise to ensure the accuracy and timeliness of the year-end close and financial reporting process as well as the accuracy and timeliness of other quarterly financial reporting. Additionally, State law requires State agencies submit their financial and federal award information to the Arizona Department of Administration ("ADOA") by a specified date to meet the State's financial reporting and single audit deadlines. For fiscal 2023, AHCCCS' financial reporting and federal award information was due to ADOA by November 9, 2023.

Condition: For the year ended June 30, 2023, AHCCCS encountered significant delays in the close and financial reporting process. Additionally, AHCCCS experienced delays in certain required quarterly reporting of up to 45 days in some instances and required extensions from various funding agencies, most notably the Centers for Medicare & Medicaid Services ("CMS"). For fiscal 2023, AHCCCS' financial reporting and federal award information was due to ADOA by November 9, 2023.

Cause: The significant delays in AHCCCS' close and financial reporting process were caused by employee turnover within AHCCCS' Division of Business and Finance, as well as a lack of resources as a result of reduced staffing from retirements. Additionally, poor or nonexistent process documentation, an extensive learning curve of the newly assembled AHCCCS audit team responsible for the coordination and administration of the audit, and financial/accounting system issues contributed to the delay. These matters were exacerbated as a result of the COVID-19 pandemic and the myriad of federal and state responses that continue to impact the Medicaid program. This has increased the volume and complexity of accounting activity within AHCCCS.

Effect: The State was not able to meet its financial reporting and audit requirements and deadlines. This also impacted decision-makers' ability to rely on financial information that is not provided in a timely manner. Additionally, the delay in the federal award reporting resulted in the State's delay in issuing its single audit reporting package which was due March 31, 2024 and could result in actions being taken by federal grantors on various federal awards. This is deemed to be a material weakness in internal control over financial reporting.

Type of Finding: Material weakness in internal control over financial reporting

Current Status: Partial corrective action taken. AHCCCS hired additional resources in fiscal 2024 and implemented certain procedural improvements which resulted in a significant improvement in the timing of the fiscal 2024 audit. However, since the fiscal 2024 audit was not completed within the state's prescribed timeline, this appears as a repeat finding at 2024-001.

Reasons for recurrence: The delays in AHCCCS' close and financial reporting process were caused by delays in the fiscal 2023 audit which was not finalized and issued until September 2024. As a result, the fiscal 2024 audit did not begin until October 2024. Additionally, AHCCCS' Division of Business and Finance continued to experience employee turnover into fiscal 2024. These matters were

exacerbated as a result of the COVID-19 pandemic, the end of the Public Health Emergency and related disenrollment, and the myriad of federal and state responses that continue to impact the Medicaid program. This continues to increase the volume and complexity of accounting activity within AHCCCS.

Actions taken: AHCCCS implemented the following measures to increase timeliness of the audit completion; however, it should be noted many of the complexities and federal initiatives related to COVID and ARPA have contributed to the delay and will be continuing through the FY25 audit.

- Staffing
    - AHCCCS created and filled a new Deputy Assistant Director of Business Finance to provide a higher level of oversight of the audit process. The Reporting Administrator position was filled with a very experienced and knowledgeable professional. In addition, a new Audit Manager position was created, recruited and hired with the skills, knowledge and experience to be directly responsible for the accounting positions who complete the audit. Finally, two existing and one new Accountant IV positions were hired to assist with year-end accruals, adjustments and financial statement preparation.
- Overall Efficiencies
    - Increased collaboration with external auditing firm to develop comprehensive workplan for meeting deadlines and ensuring that external resources are available to meet targeted deadlines.
    - Increased inter-agency collaboration to ensure resources from outside the Division of Business and Finance understand and are committed to targeted deadlines.
    - Implemented certain procedural improvements which resulted in a significant improvement in the timing and accuracy of the fiscal 2024 audit.

Actions remaining:

- Over the next few years, redesign and automate other internal processes agency-wide to increase efficiency and provide the audit team members with additional time to address the financial statements.
- Continue to implement procedural improvements including standardizing work, workpaper indexing, and workpaper referencing to improve efficiency and accuracy.
- Continue to increase inter-agency, Arizona Department of Administration (“ADOA”) and external auditor collaboration to develop comprehensive workplan for meeting deadlines and ensuring that resources are available to meet targeted deadlines.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Item:	2023-002
Subject:	Data Breach
Criteria or Specific Requirement:	AHCCCS is required to implement policies and procedures and security measures over IT systems to adequately protect data and to prevent the breach of sensitive data.
Condition:	On May 11, 2023, AHCCCS became aware of a breach of personal information affecting 2,632 out of over 2.4 million individuals in Arizona who are enrolled Medicaid members.
Cause:	Due to a programming error with the Health-e-Arizona Plus (HEAPlus, the AHCCCS eligibility system) the system toolbar allowed some household accounts in the HEAPlus system to be viewable to individuals not included in their household.
Effect:	As a result of the breach, 2,632 individuals in Arizona who are enrolled Medicaid members were impacted as some household accounts in the HEAPlus system were viewable to individuals not included in their household. The viewable details included first and last name, address and the last 4 digits of social security numbers. At the point of discovery, AHCCCS disabled the HEAPlus system toolbar that allowed members to view this information. On July 3, 2023, AHCCCS began to notify, in writing, those members whose personal information was compromised and offered free credit reports and credit report monitoring. AHCCCS also notified the U.S. Department of Health and Human Services (HHS)/Office of Civil Rights (OCR) of the breach. This is deemed to be a material weakness in internal control over financial reporting.
Type of Finding:	Material weakness in internal control over financial reporting
Current Status:	Corrective action taken.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Item: 2023-003

Subject: Audit Adjustments

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: In connection with our audit, we encountered several audit adjustments to present the financial statements and schedule of expenditures of federal awards of AHCCCS in accordance with GAAP. For the year ended June 30, 2023, several audit adjustments were made to properly adjust accruals, reconcile balances, correct errors and properly present financial information in the financial statements and schedule of expenditures of federal awards. We noted 21 adjusting entries which resulted in increases of approximately $208.8 million to assets, $33.7 million to liabilities, $175.2 million to net position and $94.5 million to net income. Additionally, we noted the adjusting entries resulted in a net decrease in the total expenditures of federal awards of approximately $593.9 million as presented on the Schedule of Expenditures of Federal Awards.

Cause: The audit adjustments were caused largely by turnover within AHCCCS' Division of Business and Finance, poor or nonexistent process documentation, an extensive learning curve of the newly assembled AHCCCS audit team responsible for the coordination and administration of the audit, and financial/accounting system issues.

Effect: While the necessary adjustments were posted to correct the financial statements and the schedule of expenditures of federal awards, AHCCCS' unadjusted financial statements and schedule of expenditures could be materially misstated and not presented in accordance with accounting principles generally accepted in the United States of America. This could result in conflicting information for management and outside users. This is deemed to be a material weakness in internal control over financial reporting.

Type of Finding: Material weakness in internal control over financial reporting

Current Status: Partial corrective action taken. In fiscal 2024, we noted a significant decrease in both the number and size of audit adjustments. However, this appears as a repeat finding at 2024-002.

Reason for recurrence: The audit adjustments were caused largely by turnover within AHCCCS' Division of Business and Finance, poor or nonexistent process documentation, an extensive learning curve of the newly assembled AHCCCS audit team responsible for the coordination and administration of the audit, and financial/accounting system challenges. Specifically, the financial/accounting

system challenges stemmed from a shift in the methodology used to compile financial statements. In fiscal year 2022 and prior, AHCCCS relied on a data warehouse to compile financial statements, which followed a defined data-driven process. However, due to the absence of process documentation, the new audit team was unable to replicate or effectively utilize the data warehouse processes in the past 2 audit cycles. As a result, AHCCCS pivoted to a manual process for compiling financial statements.

Actions taken:

- AHCCCS reviewed the size, requisite skills, knowledge, and expertise required to ensure adequate resources are in place to timely complete the year end close and financial reporting process as well as to ensure the accuracy and timeliness of other quarterly financial reporting. To that end, AHCCCS created and filled a new Deputy Assistant Director of Business Finance to provide a higher level of oversight of the audit process. The Reporting Administrator position was filled with a very experienced and knowledgeable professional. In addition, a new Audit Manager position was created, recruited and hired with the skills, knowledge and experience to be directly responsible for the accounting positions who complete the audit. Finally, two existing and one new Accountant IV positions were hired to assist with year-end accruals, adjustments and financial statement preparation.
- AHCCCS worked in partnership with ADOA to establish a preliminary review of financial statements and supporting schedules prior to being submitted to our external auditors for their consideration.
- AHCCCS implemented certain procedural improvements which resulted in a significant decrease in both the number and size of audit adjustments from the prior year.

Actions remaining: AHCCCS will continue to implement procedural improvements including standardizing work, workpaper indexing, and workpaper referencing to improve efficiency and accuracy.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Item: 2023-004

Subject: Provider Billing Matter

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services in its Medical Assistance Program (noncompliance in a federal program as described in finding 2023-005, that had a direct and material effect on the determination of financial statement amounts). These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud (CAF) payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. See also compliance finding at 2023-005 below.

A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney's General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. Therefore, AHCCCS could not determine whether any financial statement adjustments or additional disclosure were necessary as a result of the federal noncompliance.

Cause: AHCCCS did not make any financial statement adjustments for potential repayment or recoveries because it lacked evidence to complete the determinations necessary to support the amount of monies it would be required to return to the U.S. government. Further, AHCCCS did not have sufficient controls in place to safeguard against unnecessary utilization of care and services and to prevent fraud. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post- payment review of behavioral health claims, as noted in the compliance finding at 2023-005.

Effect: As a result of this matter, we were unable to obtain sufficient appropriate audit evidence for AHCCCS' receivables and other, federal revenue, and due to the federal government line items and have issued a qualified opinion on the basic financial statements as of and for the year ended June 30, 2023. Material unrecorded receivables, federal revenue and due to the federal government may exist.

Type of Finding: Material weakness in internal control over financial reporting

Current Status: Partial corrective action taken. Due to the timing of the provider billing matter, AHCCCS was not able to implement all the corrective actions until subsequent to June 30, 2024. This appears as a repeat finding at 2024-003.

Reason for recurrence: AHCCCS did not make any financial statement adjustments for potential repayment or recoveries because it lacked evidence to complete the determinations necessary to support the amount of monies it would be required to return to the U.S. government. The fraud was a result of several bad actors colluding against the program. AHCCCS did not have complementary controls in place to detect unnecessary utilization of care and services in a timely manner. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post- payment review of behavioral health claims, as noted in the compliance finding at 2024-004.

Actions taken: In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program.

Actions remaining: AHCCCS is continuing its investigations and refers Credible Allegations of Fraud (CAF) cases to law enforcement officials. AHCCCS will comply with all federal regulations regarding repayments of federal share and will work with CMS as the CAF cases continue through the law enforcement process. See also Corrective Actions for item 2024-004 below.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Item: 2023-005

Assistance Listing Number: 93.778

Program: Medical Assistance Program (Medicaid; Title XIX)

Federal Agency: U.S. Department of Health and Human Services

Pass-Through Agencies: N/A

Contract Number: 11-W-00275/09

Award Year: July 1, 2022 – June 30, 2023

Compliance Requirement: Special Tests and Provisions – Utilization Control and Program Integrity

Criteria: AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).

AHCCCS must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. AHCCCS must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. AHCCCS may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

Condition: In our testing of fee-for-service payments, out of a non-statistical sample of 40, we identified 3 of 40 providers had been subsequently listed on the Suspension List related to the provider fraud matter. The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud ("CAF") payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the

named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. For example, providers billed for:

- Excessive hours of services in a 24-hour period for a single member,
- Multiple services for the same member at the same time,
- AHCCCS members who were not physically present ("ghost billing"),
- Services after a member's date of death, and
- Services that were not medically necessary.

Questioned Costs: Unknown

Context: Under 42 C.F.R. § 455.23 and the terms of the Provider Participation Agreement, AHCCCS may suspend payments to a provider if a Credible Allegation of Fraud ("CAF") has been identified. Providers are informed of the reason for their suspension in a Notice of CAF Suspension. CAF suspensions are based on preliminary findings of reliable indicia of fraud and may be lifted if AHCCCS determines there is no fraud occurring and/or good cause has been established under 42 C.F.R. § 455.23. Upon the conclusion of an investigation, AHCCCS may terminate a provider and/or lift their suspension at that time. At the point a referral is made, and payment is suspended, only a preliminary investigation has been conducted and no total overpayment or amount of improper payments made to the provider has been identified. At the conclusion of the investigation, AHCCCS will terminate a provider's enrollment and require repayment of the identified overpayment. The investigation is on-going and AHCCCS is not currently able to estimate a total overpayment or amount of improper payments made to the providers. Therefore, we are unable to estimate any questioned costs related to the fraud allegations.

Effect: In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers.

Once a credible allegation of fraud determination is made, AHCCCS is required to suspend all payments to a provider unless there is good cause not to while investigations are conducted. The credible allegation of fraud determination results from the agency's preliminary investigation, and the agency must then make a fraud referral to the Arizona Attorney General's Healthcare Fraud and Abuse Section or a federal law enforcement agency for a full investigation. During this time, providers may continue to bill AHCCCS for services provided, but any reimbursement to these providers is withheld pending the outcome of further investigation. Under state statute, providers are entitled to appeal a suspension placed by AHCCCS. AHCCCS is working closely with the Arizona Attorney General's Healthcare Fraud and Abuse Section, the Federal Bureau of Investigation ("FBI"), the U.S. Department of Health and Human Services ("HHS"), the U.S. Attorney's Office, the Internal Revenue Service ("IRS"), and local and tribal law enforcement to disrupt organized bad actors, apprehend them, and prosecute them to the full extent allowed by law. At present, the investigation is on-going and A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney's General's Office for prosecution

of substantiated claims which is a highly complex and manual process and can take many years to finalize. As a result, we have issued a qualified opinion on the basic financial statements as of and for the year ended June 30, 2023.

As a result of this matter, we have concluded that AHCCCS did not comply with the compliance requirements and have issued a qualified opinion on compliance. This matter is deemed to be a material weakness in internal control of compliance.

Cause: AHCCCS did not have sufficient controls in place to safeguard against unnecessary utilization of care and services and to prevent fraud. Additionally, AHCCCS did not have sufficient procedures for the ongoing pre- and post-payment review of behavioral health claims. While AHCCCS' claims processing system uses the CMS required claim edit protocols to look for improperly billed claims as noted in the National Correct Coding Initiative ("NCCI") and such edit protocols are updated regularly per CMS requirements, AHCCCS did not have sufficient additional claim edits that were necessary for behavioral health claims. For example, AHCCCS did not have sufficient edits to restrict the inappropriate use of per diem codes or restrict some behavioral health codes from being billed for the same member on the same date of service. Further, AHCCCS did not have sufficient controls in which claims were reviewed by a medical professional pre- and post- payment to assess if the claim was medically necessary and to assess if the codes being used were excessive and age appropriate.

Type of Finding: Material weakness in internal control of compliance

Current Status: Partial corrective action taken. Due to the timing of the provider billing matter, AHCCCS was not able to implement all the corrective actions until subsequent to June 30, 2024. This appears as a repeat finding at 2024-004.

Reasons for recurrence: Due to the timing of the discovery of the provider billing matter, AHCCCS was not able to fully address and resolve the matter as of June 30, 2024.

Actions taken: In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program. As the extent of the fraud was revealed, AHCCCS recognized the need for comprehensive, system-wide strategies. AHCCCS partnered with the Attorney General and Governor's Office to develop a comprehensive plan to address the loopholes fraudulent providers were exploiting.

- Increased scrutiny of claims based on claims volume.
- Issued a moratorium on new provider registrations for impacted provider types.
- Prevented reimbursement of claims for impossibly rendered services.
- Claims for substance abuse services for children under the age of 12 to require clinical review prior to payment.
- Set thresholds for services to initiate a prepayment review.
- Required claims to be billed for specific dates of service rather than ranges.
- Flagged claims for services of the same style/overlapping codes.

- Created a prepayment review process for providers utilizing suspicious billing practices.
- Eliminated retroactive billing.
- Credible allegation of fraud (“CAF”) suspensions to include both provider entities and owners/behavioral health (“BH”) practitioners.
- Implemented ID.Me identity verification for AHCCCS online.
- Required providers to disclose any third-party billing relationships.
- Behavioral Health Providers are now considered high-risk provider types for provider enrollment.
- Per Diem codes have been set to only be able to be billed once per day.
- Practitioners, including Behavioral Health Technicians, can no longer be patients at the same provider.
- Worked with the Arizona Corporation Commission to flag suspicious registrations.
- Ensured AHCCCS coding adhered to National Correct Coding Initiative (“NCCI”) standards and confirmed no edits had been turned off.
- Streamlined AHCCCS reporting of bad actors to the appropriate professional oversight boards.
- Creation and publication of the Covered Behavioral Health Services Guide to connect all relevant AHCCCS policies and explain how they interact in the Behavioral Health System of Care.
- Robust changes to our AHCCCS Provider Enrollment System to address FWA issues.
- Update to the Behavioral Health Residential Facilities policy to provide greater detail and clarity for providers and members about what should and should not be included in services rendered by this provider type.
- Creation of the prepayment review process for FFS claims and inclusion of data measurement to allow for agile modification going forward to respond to over utilization or abuse of codes.
- Creation of the Community Partner Assistor Organization Reviews to prevent abuse of access to the HEA+ system.
- Designated pathways of partnering on large scale quality of care investigations between the Division of Fee for Services and MCOs to prevent unnecessary member impact.
- Social media campaign to encourage the public to report FWA/abuse & neglect.
- Requirement of all providers to transition to Electronic Funds Transfer.
- Removed the phone attestation option for AIHP enrollment and are in the process of implementing the AIHP verification process with tribal partners and IHS based on utilization.
- MOUs with AZ Board of BH Examiners and Board of Nursing to promote interagency information sharing and referrals, as well as the close referral relationship with ADHS.
- Regular Public BH System Cross-Agency Collaboration meetings including all agencies, boards, commissions and the GO in the public health space.
- Updates to the provider enrollment policy in AMPM 610, explicitly requiring many more disclosures of providers, and making it clear without full and transparent registration information, providers will be terminated or denied enrollment with AHCCCS.
- Implemented policies which required Behavioral Health Professionals, required to oversee the clinical services provided at BHRFs and

Outpatient Behavioral Health Clinics, to be reported upon registration and be listed on claims submissions.
- Mandatory transition to Electronic Fund Transfer (direct deposit) for all AHCCCS provider reimbursements.
- Linking BHP to BH companies and facilities they work for.

Actions Remaining (but not limited to):
- Implementation of Alivia-a new AI powered data analytics platform for pre-pay and post-pay claims analysis, currently in the development and planning stage.
- Implementing eligibility integrity requirements for AIHP enrollment.
- Conduct onsite quality of care reviews for patients in treatment longer than 90 days.
- Require medical records to define specialized services.
- Implement a new pre/post pay claims system.

AHCCCS continuously monitors our systems and investigates instances of fraud, waste, or abuse. Any areas of concern which are identified are then addressed and system improvements are made. Furthermore, AHCCCS utilizes data analysis to confirm that these system improvements are having the intended impacts and that the provider networks remain robust.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Item:	2023-006
Assistance Listing Number:	93.778
Program:	Medical Assistance Program (Medicaid; Title XIX)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09
Award Year:	July 1, 2022 – June 30, 2023
Compliance Requirement:	Special Tests and Provisions – Utilization Control and Program Integrity
Criteria:	AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state MFCU or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21). Additionally, in accordance with AHCCCS policy, the AHCCCS Office of Inspector General is required to regularly follow up on deferred investigations and provide updates at least every 90 days.
Condition:	AHCCCS did not follow up in a timely manner for certain deferred member investigations.
Questioned Costs:	Unknown
Context:	In a population of 5,141 member and provider cases with identified credible allegations of provider and member fraud assigned during fiscal year 2023, we conducted a non-statistical sample of 40 member and 40 provider investigations to ascertain if AHCCCS performed a preliminary investigation of potential incidents of fraud or abuse committed by members and providers on a timely basis. We also reviewed to ensure AHCCCS was following up on any deferred member and provider cases in a timely manner. In our sample of 40 member and 40 provider investigations, we noted that for 3 of 40 member investigations, in which the investigation had been deferred, AHCCCS did not follow up in a timely manner and in accordance with their internal policy on those deferred investigations.
Effect:	Untimely follow up on fraud or abuse incident investigations could result in AHCCCS making unnecessary payments and compromise its ability to investigate cases. This is deemed to be a material weakness in internal control over compliance.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Cause: Management has reported to us that insufficient investigative staff and increase volumes of provider and member investigations impacted AHCCCS' ability to investigate and follow up on potential fraud or abuse incidents in a timely manner.

Type of Finding: Material weakness in internal control of compliance

Current Status: Partial corrective action taken. This appears as a repeat finding at 2024-005.

Reason for recurrence: Management has reported to us that insufficient investigative staff and increased volumes of provider and member investigations impacted AHCCCS' ability to investigate and follow up on potential fraud or abuse incidents in a timely manner. In fiscal year 2023, the process of holding quarterly reviews of deferred cases did not occur due to resources being diverted to focus on Strike Force activities involved in addressing the Behavioral Health ("BH") crisis.

Actions taken: OIG announced a re-organization in December 2023 that resulted in permanent transitions to other teams for several staff. Teams were given time to finalize cases and move items to other investigators in order to limit disruption to cases. By April 2024, after the Strike Force initiative had been unwound and the member team structure changes for personnel were finalized, the member team restarted its process of quarterly deferred case reviews. At the first review in April 2024, cases in the deferred backlog that were not completed in the timeframe set for the reviews were postponed to the next quarterly review in July.

Actions remaining: AHCCCS OIG commits to a review of the current Deferred Process and will determine areas of improvement to include timeliness for deferred case review completion, quarterly completed deferred case review reports, and required documentation for all deferred case processes.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Item:	2023-007
Assistance Listing Number:	93.778
Program:	Medical Assistance Program (Medicaid; Title XIX)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09
Award Year:	July 1, 2022 – June 30, 2023
Compliance Requirement:	Special Tests and Provisions – Refunding of Federal Share of Medicaid Overpayments to Providers
Criteria:	42 CFR 433 Subpart F outlines the requirements State Medicaid Agencies ("SMAs") are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Act (the Act) (42 USC 1396b), states have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS regardless of whether recovery is made from the provider.
Condition:	AHCCCS did not return the federal share of fraud and abuse recoupments back to CMS in a timely manner.
Questioned Costs:	$9,813,624
Context:	In a population of 5,141 member and provider cases during fiscal year 2023, we conducted a non-statistical sample of 40 member and 40 provider investigations to ascertain if AHCCCS had properly remitted to CMS any recoupments as a result of the investigations. For 1 of 40 provider fraud cases, we noted AHCCCS did not timely return the federal share of fraud and abuse recoupments back to CMS. We then obtained from AHCCCS OIG a detail of all recoupments received during the period July 1, 2022 through June 30, 2023 noting a total of 392 unique OIG cases for which recoupments were received. Of this total of 392 cases, 150 cases were identified for which the federal share of the total recoupment amount was not properly reported on the CMS-64 and therefore the funds were not properly remitted to CMS for a total of $9,813,624.
Effect:	Recoupments were not reported and repaid timely to CMS. This is deemed to be a material weakness in internal control of compliance.
Cause:	Management has reported to us that this was a result of staffing turnover as well as a breakdown of inter and intra-departmental communication and collaboration between AHCCCS OIG and the Division of Business and Finance.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Type of Finding: Material weakness in internal control of compliance

Current Status: Partial corrective action taken. This appears as a repeat finding at 2024-006.

Reason for recurrence: Management has reported to us that this was a result of staffing turnover as well as a breakdown of inter and intra-departmental communication and collaboration between AHCCCS OIG and the Division of Business and Finance. Due to the timing of the discovery of the finding, AHCCCS was not able to implement all the corrective actions until subsequent to June 30, 2024.

Actions taken:

- AHCCCS has filled the related following positions that experienced turnover: Accounting Supervisor, Reporting Administrator, and 2 Accounting Specialists.
- Increased collaboration across the respective departments and divisions to ensure the federal share of all case recoupments is timely returned to CMS.
- AHCCCS has revised standard work processes to include quarterly reconciliations of case recoupments among the various departments and divisions.

Actions Remaining: AHCCCS anticipates having reported and returned the federal share to CMS for all case recoupments identified by June 30, 2025.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended June 30, 2024

Item:	2023-008
Assistance Listing Number:	93.778
Program:	Medical Assistance Program (Medicaid; Title XIX)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09
Award Year:	July 1, 2022 – June 30, 2023
Compliance Requirement:	Eligibility - Disenrollment
Criteria:	AHCCCS is required to inform members of any adverse action, including discontinuance of eligibility (42 CFR 435.917(b)(2)).
Condition:	AHCCCS did not timely inform members of discontinuance of eligibility.
Questioned Costs:	Unknown
Context:	In a population of 426,615 member disenrollments occurring during fiscal year 2023, we conducted a non-statistical sample of 40 disenrollments to ascertain if AHCCCS performed timely and accurate disenrollments. In our sample of disenrollments, 1 of 40 disenrollments lacked sufficient documentation to show the disenrolled member had been informed of the discontinuance of eligibility.
Effect:	AHCCCS is not in compliance with the requirement to inform members of any adverse action, including discontinuance of eligibility in accordance with 42 CFR 435.917(b)(2). This is deemed to be a significant deficiency in internal control over compliance.
Cause:	Management has reported to us that this was an oversight.
Type of Finding:	Significant deficiency in internal control over compliance
Current Status:	Corrective action taken.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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KATIE HOBBS
GOVERNOR

CARMEN HEREDIA
DIRECTOR

CORRECTIVE ACTION PLAN

Item:	2024-001
Subject:	Timeliness in Reporting and Adequacy of Staffing
Criteria or Specific Requirement:	AHCCCS' close and financial reporting processes involve a significant volume of complex accounting transactions and estimates that require sufficient personnel with the requisite skills, knowledge and expertise to ensure the accuracy and timeliness of the year-end close and financial reporting process as well as the accuracy and timeliness of other quarterly financial reporting. Additionally, State law requires State agencies submit their financial and federal award information to the Arizona Department of Administration ("ADOA") by a specified date to meet the State's financial reporting and single audit deadlines. For fiscal 2024, AHCCCS' financial reporting and federal award information was due to ADOA by November 15, 2024.
Condition:	For the year ended June 30, 2024, AHCCCS encountered delays in the close and financial reporting process. Additionally, AHCCCS experienced delays in certain required quarterly reporting and required extensions from various funding agencies, most notably the Centers for Medicare & Medicaid Services ("CMS"). For fiscal 2024, AHCCCS' financial reporting and federal award information was due to ADOA by November 15, 2024 and was not submitted to ADOA until March 14, 2025.
Name of Contact Person:	Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance
Phone Number:	(602) 417-4705
Anticipated Completion Date:	December 31, 2025
Views of Responsible Officials and Corrective Actions:	AHCCCS will be implementing the following measures to increase timeliness of the audit completion; however, it should be noted many of the complexities and federal initiatives related to COVID and ARPA have contributed to the delay and will be continuing through the FY25 audit. • Staffing ○ AHCCCS' current finance staff work efficiently, effectively and diligently on the audit. The audit team is a valuable asset to the agency. During FY 24, AHCCCS experienced significant employee turnover of AHCCCS' team which is responsible for coordinating and administering the audit AHCCCS reviewed the size, requisite skills, knowledge, and expertise required to ensure adequate resources are in place to timely complete the year end close and financial reporting process as well as to ensure the accuracy and timeliness of other quarterly financial reporting.

- To that end, AHCCCS created and filled a new Deputy Assistant Director of Business Finance to provide a higher level of oversight of the audit process. The Reporting Administrator position was filled with a very experienced and knowledgeable professional. In addition, a new Audit Manager position was created, recruited and hired with the skills, knowledge and experience to be directly responsible for the accounting positions who complete the audit. Finally, two existing and one new Accountant IV positions were hired to assist with year-end accruals, adjustments and financial statement preparation.

- Overall Efficiencies
  - Increased collaboration with external auditing firm to develop comprehensive workplan for meeting deadlines and ensuring that external resources are available to meet targeted deadlines.
  - Increased inter-agency collaboration to ensure resources from outside the Division of Business and Finance understand and are committed to targeted deadlines.
  - Implemented certain procedural improvements which resulted in a significant improvement in the timing and accuracy of the fiscal 2024 audit.
- Actions Remaining:
  - Over the next few years, redesign and automate other internal processes agency-wide to increase efficiency and provide the audit team members with additional time to address the financial statements.
  - Continue to implement procedural improvements including standardizing work, workpaper indexing, and workpaper referencing to improve efficiency and accuracy.
  - Continue to increase inter-agency, Arizona Department of Administration ("ADOA") and external auditor collaboration to develop comprehensive workplan for meeting deadlines and ensuring that resources are available to meet targeted deadlines.

Item: 2024-002

Subject: Audit Adjustments

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition:	In connection with our audit, we encountered several audit adjustments to present the financial statements and schedule of expenditures of federal awards of AHCCCS in accordance with GAAP. For the year ended June 30, 2024, several audit adjustments were made to properly adjust accruals, reconcile balances, correct errors and properly present financial information in the financial statements and schedule of expenditures of federal awards. We noted 7 adjusting entries which resulted in a decrease of approximately $20.1 million to assets, a decrease of approximately $13.4 million to liabilities, a decrease of approximately $6.7 million to net position and a decrease of $6.7 million to net income. Additionally, we noted the adjusting entries resulted in a net decrease in the total expenditures of federal awards of approximately $24.6 million as presented on the Schedule of Expenditures of Federal Awards.
Name of Contact Person:	Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance
Phone Number:	(602) 417-4705
Anticipated Completion Date:	December 31, 2025
Views of Responsible Officials and Corrective Actions:	AHCCCS acknowledges the audit adjustments noted in the finding. These adjustments have been reviewed in detail by our financial management team. AHCCCS has taken immediate action to rectify the identified adjustments to ensure accuracy and compliance. The primary causes for the adjustments were identified as employee turnover, poor or nonexistent process documentation, an extensive learning curve of the newly assembled audit team, and financial/accounting system issues.

Actions Taken:

- During FY 24, AHCCCS experienced significant employee turnover of AHCCCS' team which is responsible for coordinating and administering the audit. AHCCCS reviewed the size, requisite skills, knowledge, and expertise required to ensure adequate resources are in place to timely complete the year end close and financial reporting process as well as to ensure the accuracy and timeliness of other quarterly financial reporting. To that end, AHCCCS created and filled a new Deputy Assistant Director of Business Finance to provide a higher level of oversight of the audit process. The Reporting Administrator position was filled with a very experienced and knowledgeable professional. In addition, a new Audit Manager position was created, recruited and hired with the skills, knowledge and experience to be directly responsible for the accounting positions who complete the audit. Finally, two existing and one new Accountant IV positions were hired to assist with year-end accruals, adjustments and financial statement preparation.
- AHCCCS worked in partnership with ADOA to establish a preliminary review of financial statements and supporting schedules prior to being submitted to our external auditors for their consideration.
- Implemented certain procedural improvements which resulted in a significant decrease in both the number and size of audit adjustments from the prior year.

Actions Remaining:

- Continue to implement procedural improvements including standardizing work, workpaper indexing, and workpaper referencing to improve efficiency and accuracy.

Item: 2024-003

Subject: Provider Billing Matter

Criteria or Specific Requirement: Accounting principles generally accepted in the United States of America ("GAAP") require that AHCCCS' government-wide financial statements be reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows. AHCCCS' governmental fund financial statements are presented using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized only to the extent that they are susceptible to accrual, meaning that they are both measurable and available to finance expenditures of the fiscal period.

Condition: The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services in its Medical Assistance Program (noncompliance in a federal program as described in finding 2024-004, that had a direct and material effect on the determination of financial statement amounts). These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud (CAF) payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. See also compliance finding at 2024-004 below.

A determination of the amount of fraud or improper payments, potential recovery from the providers, or amount that may be due back to the federal government cannot be made at this time as AHCCCS is still in the process of investigating and working with the Attorney's General's Office for prosecution of substantiated claims which is a highly complex and manual process and can take many years to finalize. Therefore, AHCCCS could not determine whether any financial statement adjustments or additional disclosure were necessary as a result of the federal noncompliance.

Name of Contact Person:	Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance
Phone Number:	(602) 417-4705
Anticipated Completion Date:	December 31, 2027
Views of Responsible Officials and Corrective Actions:	In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program. AHCCCS is continuing its investigations and refers Credible Allegations of Fraud (CAF) cases to law enforcement officials. AHCCCS will comply with all federal regulations regarding repayments of federal share and will work with CMS as the CAF cases continue through the law enforcement process. See also Corrective Actions for item 2024-004 below.
Item:	2024-004
Assistance Listing Number:	93.778
Program:	Medical Assistance Program (Medicaid; Title XIX)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09
Award Year:	July 1, 2023 – June 30, 2024
Compliance Requirement:	Special Tests and Provisions – Utilization Control and Program Integrity
Criteria:	AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud (“CAF”) cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21).

AHCCCS must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. AHCCCS must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. AHCCCS may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

Condition:

The AHCCCS Office of Inspector General and the Arizona Attorney General's Office became aware of potential fraudulent billing practices including significant increases in billing for outpatient behavioral health services. These circumstances triggered a multi-agency review and investigation of potential fraud, waste and abuse. Ultimately, this led AHCCCS to connect the irregular billing of these services with alleged criminal activity targeting Indigenous peoples and other vulnerable Arizonans. In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers. These provider suspensions are known as Credible Allegations of Fraud ("CAF") suspensions.

The Credible Allegation of Fraud ("CAF") payment suspensions noted above are associated with wide-ranging investigations into fraudulent Medicaid billing by the named providers. The investigations are ongoing. However, AHCCCS believes that credible evidence has been established that individuals were targeted and aggressively recruited with false promises of food, treatment, and housing, only to be taken to locations where providers billed for services that were not provided or were not appropriate or necessary. For example, providers billed for:

- Excessive hours of services in a 24-hour period for a single member,
- Multiple services for the same member at the same time,
- AHCCCS members who were not physically present ("ghost billing"),
- Services after a member's date of death, and
- Services that were not medically necessary.

Name of Contact Person:

Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance

Phone Number:

(602) 417-4705

Anticipated Completion Date:

December 31, 2027

Views of Responsible Officials and Corrective Actions:

In May 2023, AHCCCS announced its initial findings of credible and willful fraud by sober-living providers across the state. Since then, AHCCCS has suspended more than 300 providers, assisted over 10,000 individuals with the humanitarian response, and implemented more than 20 new initiatives to combat fraud, waste, and abuse in the Medicaid program. As the extent of the fraud was revealed, AHCCCS recognized the need for comprehensive, system-wide strategies. AHCCCS partnered with the Attorney General and Governor's Office to develop a comprehensive plan to address the loopholes fraudulent providers were exploiting.

Actions Taken:

- Increased scrutiny of claims based on claims volume.
- Issued a moratorium on new provider registrations for impacted provider types.
- Prevented Reimbursement of Claims for Impossibly Rendered Services.
- Claims for Substance Abuse Services for Children under the age of 12 to Require Clinical Review Prior to Payment.
- Set thresholds for services to initiate a prepayment review.
- Required claims to be billed for specific dates of service rather than ranges.
- Flagged claims for services of the same style/overlapping codes.
- Created a prepayment review process for providers utilizing suspicious billing practices.
- Eliminated retroactive billing.
- Credible Allegation of Fraud (“CAF”) suspensions include both provider entities and owners/ behavioral health (“BH”) practitioners.
- Implemented ID.Me identity verification for AHCCCS Online.
- Required providers to disclose any third-party billing relationships.
- Behavioral Health Providers are now considered high-risk provider types for provider enrollment.
- Per Diem codes have been set to only be able to be billed once per day.
- Practitioners, including Behavioral Health Technicians, can no longer be patients at the same provider.
- Worked with the Arizona Corporation Commission to flag suspicious registrations.
- Ensured AHCCCS coding adhered to National Correct Coding Initiative (“NCCI”) standards and confirmed no edits had been turned off.
- Streamlined AHCCCS reporting of bad actors to the appropriate professional oversight boards.
- Creation and publication of the Covered Behavioral Health Services Guide to connect all relevant AHCCCS policies and explain how they interact in the Behavioral Health System of Care.
- Robust changes to our AHCCCS Provider Enrollment System to address FWA issues.
- Update to the Behavioral Health Residential Facilities policy (to be published shortly) to provide greater detail and clarity for providers and members about what should and should not be included in services rendered by this provider type.
- Creation of the prepayment review process for FFS claims and inclusion of data measurement to allow for agile modification going forward to respond to over utilization or abuse of codes.
- Creation of the Community Partner Assistor Organization Reviews to prevent abuse of access to the HEA+ system.
- Designated pathways of partnering on large scale quality of care investigations between the Division of Fee for Service and MCOs to prevent unnecessary member impact.
- Social media campaign to encourage the public to report FWA/abuse & neglect.
- Requirement of all providers to transition to Electronic Funds Transfer.

- Removed the phone attestation option for AIHP enrollment, and are in the process of implementing the AIHP verification process with tribal partners and IHS based on utilization.
- MOUs with AZ Board of BH Examiners and Board of Nursing to promote interagency information sharing and referrals, as well as the close referral relationship with ADHS.
- Regular Public BH System Cross-Agency Collaboration meetings including all agencies, boards, commissions and the GO in the public health space
- Updates to the provider enrollment policy in AMPM 610, explicitly requiring many more disclosures of providers, and making it clear without full and transparent registration information, providers will be termination or denied enrollment with AHCCCS.
- Implemented policies which required Behavioral Health Professionals, required to oversee the clinical services provided at BHRFs and Outpatient Behavioral Health Clinics, to be reported upon registration and be listed on claims submissions
- Mandatory transition to Electronic Fund Transfer (direct deposit) for all AHCCCS provider reimbursements
- Linking BHP to BH companies and facilities they work for

Actions Remaining (but not limited to):
Implementing eligibility integrity requirements for AIHP enrollment.

- Implementation of Alivia – a new AI powered data analytics platform for pre-pay and post-pay claims analysis, currently in the development and planning stage
- Conduct onsite quality of care reviews for patients in treatment longer than 90 days.
- Require medical records to define specialized services.
- Implement a new pre/post pay claims system.

AHCCCS continuously monitors our systems and investigates instances of fraud, waste or abuse. Any areas of concern which are identified are then addressed and system improvements are made. Furthermore, AHCCCS utilizes data analysis to confirm that these systems improvements are having the intended impacts and that provider networks remain robust.

Item:	2024-005
Assistance Listing Number:	93.778 and 93.767
Program:	Medical Assistance Program (Medicaid; Title XIX) and Children's Health Insurance Program (CHIP)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09 and 21-W-00064/09
Award Year:	July 1, 2023 – June 30, 2024
Compliance Requirement:	Special Tests and Provisions – Utilization Control and Program Integrity
Criteria:	AHCCCS is required to provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, AHCCCS must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring Credible Allegations of Fraud ("CAF") cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the state MFCU or an appropriate law enforcement agency in states with no certified MFCU (42 CFR Part 455.21). Additionally, in accordance with AHCCCS policy, the AHCCCS Office of Inspector General is required to regularly follow up on deferred investigations and provide updates at least every 90 days to the State MFCU.
Condition:	AHCCCS did not follow up in a timely manner for certain deferred member investigations.
Name of Contact Person:	Vanessa Templeman, Inspector General, AHCCCS Office of Inspector General; Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance
Phone Number:	(602) 877-9066; (602) 528-4705
Anticipated Completion Date:	December 31, 2025

Views of Responsible Officials and Corrective Actions:	In fiscal year 2023, the process of holding quarterly reviews of deferred cases did not occur due to resources being diverted to focus on Strike Force activities involved in addressing the BH crisis. Additionally, OIG announced a re-organization in December 2023 that resulted in permanent transitions to other teams for several staff. Teams were given time to finalize cases and move items to other investigators in order to limit disruption to cases. By April 2024, after the Strike Force initiative had been unwound and the member team structure changes for personnel were finalized, the member team restarted its process of quarterly deferred case reviews. At the first review in April 2024, cases in the deferred backlog that were not completed in the timeframe set for the reviews were postponed to the next quarterly review in July. AHCCCS OIG commits to a review of the current Deferred Process and will determine areas of improvement to include timeliness for deferred case review completion, quarterly completed deferred case review reports, and required documentation for all deferred case processes.
Item:	2024-006
Assistance Listing Number:	93.778 and 93.767
Program:	Medical Assistance Program (Medicaid; Title XIX) and Children's Health Insurance Program (CHIP)
Federal Agency:	U.S. Department of Health and Human Services
Pass-Through Agencies:	N/A
Contract Number:	11-W-00275/09 and 21-W-00064/09
Award Year:	July 1, 2023 – June 30, 2024
Compliance Requirement:	Special Tests and Provisions – Refunding of Federal Share of Medicaid Overpayments to Providers
Criteria:	42 CFR 433 Subpart F outlines the requirements State Medicaid Agencies ("SMAs") are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Act (the Act) (42 USC 1396b), states have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS regardless of whether recovery is made from the provider.
Condition:	AHCCCS did not return the federal share of fraud and abuse recoupments back to CMS in a timely manner.
Name of Contact Person:	Jeff Tegen, Assistant Director, AHCCCS Division of Business and Finance

Phone Number: (602) 417-4705

Anticipated Completion Date: June 30, 2025

Views of Responsible Officials and Corrective Actions:

AHCCCS would like to note this matter was discovered through internal review of OIG recoupment documentation and filings with CMS. This matter was reviewed in detail by our financial management team and AHCCCS determined this was caused by a few factors: (1) staffing issues and employee turnover in all units involved in the process to return OIG recoupments to CMS. (2) A breakdown of inter and intra-departmental communication and collaboration.

Actions Taken:

- Filling the related following positions that experienced turnover: Accounting Supervisor, Reporting Administrator, and 2 Accounting Specialists.
- Increased collaboration across the respective departments and divisions to ensure the federal share of all case recoupments is timely returned to CMS.
- Revised our standard work processes to include quarterly reconciliations of case recoupments among the various departments and divisions.

Actions Remaining:

- AHCCCS anticipates having reported and returned the federal share to CMS for all case recoupments identified by June 30, 2025.