CHAPTER 21:

Financial Reporting Guide

Reviewed/Revised: 10/1/18; 11/1/18; 7/1/19, 1/1/20, 7/1/20, 10/1/20, 6/1/21

21.0 INTRODUCTION

It is the policy of Health Choice Arizona to require Providers to perform certain tasks, which are required by the Arizona Health Care Cost Containment System (AHCCCS) and Health Choice Arizona, in a manner that is both timely and of acceptable quality.

21.1 PROVIDER FINANCIAL REPORTING

All provider financial documents submitted in response to these requirements are to be prepared in accordance with Generally Accepted Accounting Principles (GAAP), AHCCCS Accounting and Auditing Procedures Manual for AHCCCS-Funded Programs, and the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for federal awards. If the provider believes there is any inconsistency between the guidelines of this policy with the above listed regulations, the provider may direct those concerns to the Health Choice Arizona Director of Financial Planning and Analysis and/or CFO. Provider responsibility for reporting financial information requires full disclosure of all relevant information.

Health Choice Arizona has a required format for the **Substance** Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) Expenditure Form (Exhibit 21.1). The Health Choice Arizona Financial Analyst and Director of Financial Planning and Analysis - in conjunction with the Health Choice Arizona Chief Financial Officer (CFO) - are responsible for format reviews. The format for all other reports is determined by the provider.

Providers are subject to a Health Choice Arizona audit at any reasonable time. Health Choice Arizona may conduct surprise audits during the regular business hours of any provider. The Health Choice Arizona Director of Financial Planning and Analysis, in conjunction with the CFO, is responsible for this function.

Health Choice Arizona may provide limited technical assistance in the preparation of these financial reports. Financial reports submitted by providers that do not meet the criteria of this policy or the standards indicated under References may be required to be resubmitted within a timely fashion. The Health Choice Arizona Sanction Policy covers these requirements (See Section: Sanctions).

21.2 REPORT OVERVIEW AND SCHEDULE

The following outlines the frequency and due dates of required reporting:

ITEM	FREQUENCY	DUE DATE	PROVIDER TYPE
Provider Budget	Minimum Annually	Ten (10) days after Board approval (each time) or each time there is a significant change, whether Board approved or not.	Health Homes (HHs), Network Purchase Providers (NPPs) and other providers as required by Contract or Letter
Cost Allocation Plan	Annually	October 1 each year whether that is the fiscal year of the provider or not	HHs, NPPs and other providers as required by Contract or Letter
Balance Sheet (Statement of Financial Position)	Monthly	Twenty-five (25) days after month end	HHs, NPPs and other providers as required by Contract or Letter
YTD Income Statement	Monthly	Twenty-five (25) days after month end	HHs, and other providers as required by Contract or Letter
Independent Audit	Annually	One hundred forty-five days (145) after fiscal year-end or as stated in Contract	HHs, NPPs and other providers as required by Contract or Letter
Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) Expenditure Form (Exhibit 21.1).	Quarterly	Twenty five (25) days after quarter end and fiscal year-end	HHs, NPPs and other providers as required by Contract or Letter
Block Grant Policies	Annually – or as requested by Health Choice Arizona	October 1 each year whether that is the fiscal year of the provider or not	HHs, NPPs and other providers as required by Contract or Letter

21.3 REPORT DETAILS

The following represents additional report-specific requirements:

- **Provider Budget -** This document is submitted by the provider each time it is approved by its Board and/or each time there is a significant change, whether Board-approved or not. Provider budgets are to be submitted in their original formatting, Board-approved or internal, as applicable. See the Financial Viability Standards section for detailed requirements.
- **Cost Allocation Plan -** Each year the provider is required to submit a plan which describes its intended methods of charging direct cost, and also allocating items of shared expense to programs for purposes of completing the program income statement and Cost Center/Procedure Code Budgets, as well as ad-hoc reports. Nonprofit providers or state, local or tribal governments use Uniform Administrative Requirements, Cost Principles, and Audit Requirements for federal awards for guidance. The Health Choice Arizona Financial Analyst reviews the plan for appropriate allocation of costs (see the Provider Cost Accounting section for more details).
- **Balance Sheet (Statement of Financial Position) -** This report is to be prepared in accordance with the current GAAP standards. In addition, Health Choice Arizona requires – at a minimum - full disclosure of the following items:
  - Health Choice Arizona Receivables and Health Choice Arizona Payables separated by prior fiscal year and current fiscal year (may include the vendor accounts payable for immaterial invoices);
  - Incurred But Not Reported (IBNR) Liabilities separated by prior fiscal year and current fiscal year;
  - Health Choice Arizona Deferred (or Unearned) Revenue separated from other deferred revenue sources. Title XIX/XXI and Federal Block Grant funds cannot be deferred without approval from Health Choice and AHCCCS; and
  - Net Income for both the current month and year to date.

  Providers may also footnote other financial statement disclosures at their discretion. This report must be provided in Microsoft Excel Workbook format (.xls, .xlsx) or in a similar format.

- **YTD Income Statement** This report is to be prepared in accordance with the current GAAP standards and based on the provider's fiscal year. In addition, Health Choice Arizona requires – at a minimum - full disclosure of the following items:
  - Health Choice Arizona Revenues;
  - Out of Area Expenses, including: (1) fee-for-service expenses Health Choice Arizona has paid on the behalf of the provider, (2) will pay, and (3) increases/decreases to the IBNR used in the independent audit of the previous fiscal year; and
  - Medications expensed through the Pharmacy Benefit Manager contracted with Health Choice Arizona.

  This report must be provided in Microsoft Excel Workbook format (.xls, .xlsx) or in a similar format. Health Choice Arizona may audit provider methods used in preparation of the Income Statement on an ad hoc basis.

- **Independent Audit -** Each provider submits an audit report covering its activities for the previous fiscal year. This report must be prepared by an independent Certified Public Accountant and must adhere to current Generally Accepted Auditing Standards. See the Independent Audits section for more details.

  Note: Non-Profit providers who receive $750,000 or more in federal funding (excluding Medicare/Medicaid) are required to follow the guidelines of Uniform Administrative Requirements, Cost Principles, and Audit Requirements for federal awards. Providers who do not meet the requirement of a Single Audit will be required to submit a standard audit.

- **Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) Expenditure Form (Exhibit 21.1) –** This quarterly report summarizes the federal revenue received and expenses for the SABG/MHBG federal block grant according to the AHCCCS prescribed format (Exhibit 21.1). The four quarterly reports will be summarized and submitted as a deliverable to AHCCCS.

- **Block Grant Policies –** This annual deliverable requires providers to have internal policies and procedures related to the SABG & MHBG federal block grant funding and other federal and state funding.

21.4 PROVIDER FINANCIAL REPORTING REVIEW

Health Choice Arizona providers are required to submit specific reports in a timely and accurate manner. The reports shall be in accordance with current GAAP standards, in the formats described by this policy. The Health Choice Arizona Financial Analyst summarizes and reports findings to the Health Choice Arizona Director of Financial Planning and Analysis. The Financial Analyst will provide appropriate information for the Provider Deliverables Report. The report is shared with the Health Choice Arizona Executive Team. The Health Choice Arizona CEO or CFO is notified of any notable findings regarding the provider financial reports.

Preparation of the YTD Income Statement

All Health Choice Arizona Health Homes (HHs) are required to submit a year-to-date Income Statement based on the provider's fiscal year by the due date established in the Provider Financial Reporting section. The Income Statement is to be prepared using the accrual method of accounting to recognize both revenues and expenses, and represent all activities of the organization, whether related to business activities in which Health Choice Arizona funds are utilized or not.

Note: Health Choice Arizona's fiscal year is October 1st – September 30th which may not align with the Provider's fiscal year.

21.5 FINANCIAL VIABILITY STANDARDS

Health Choice Arizona utilizes certain viability standards to assist in the monitoring of Health Homes (HHs) and Network Purchase Providers (NPPs). The following standards will be used to evaluate provider financial viability, however, these may not be the only standards utilized.

HHs and NPPs remain financially viable at all times by meeting the following standards:

- Assets must exceed liabilities (Ratio of Assets to Liabilities).
- There must be adequate cash and cash flow to meet near-term cash obligations (Current Ratio).
- There must be 30 Days Cash on Hand. Days Cash on Hand is defined as Cash and Cash Equivalents plus Current Investments divided by the Average Daily Expenses. Average Daily Expenses are year-to-date expenses less depreciation and amortization divided by the number of days included in the year-to-date expenses.
- Providers must strive to have total revenues equal or exceed total expenses under a full accrual method of accounting.

A budget must exist which:

- Enables achievement of organizational goals;
- Has been passed by the Board of the organization, or other responsible parties in the absence of a Board;
- Is monitored by the HH and NPP through internal financial reporting, which goes to the Board and Executive Management;
- Total provider revenue must equal or exceed total provider expenses under a full accrual method of accounting; and
- Service funds must be expended in an effort to provide service and make service value for each funding category.

HHs and NPPs not meeting Health Choice Arizona financial standards may be declared "non-compliant" by Health Choice Arizona's Chief Executive Officer, Chief Financial Officer, or Executive Team. HHs and NPPs declared "non-compliant" by Health Choice Arizona may be required to submit a corrective action plan for achievement of Health Choice Arizona financial viability standards. HHs and NPPs declared "non-compliant" by Health Choice Arizona may be required to submit extra financial information, be audited at their own expense as a special audit, or required to undergo special financial scrutiny of any type determined by Health Choice Arizona. HHs and NPPs declared "non-compliant" by Health Choice Arizona may be removed from the sub-capitation/risk share funding mechanism and placed on a fee-for-service/prior-authorization-required funding status or other funding status as determined by Health Choice Arizona.

Review of Financial Viability

The Health Choice Arizona CFO or Director of Financial Planning and Analysis assesses HHs' and NPPs' compliance with standards described above by analyzing HH and NPP financial reports, including:

- Monthly Balance Sheet,
- Year-to-Date Income Statement,
- Annual Independent Audit, and
- Other reports and audit information about the HH and NPP.

Provider Profitability
AHCCCS reserves the right to require the RBHAs to limit provider profit and administrative percentages.

21.6 INDEPENDENT AUDITS

It is the policy of Health Choice Arizona that providers obtain appropriate annual independent audit coverage. It is the expectation of Health Choice Arizona that providers comply with audit requirements of Health Choice Arizona, the federal and state governments, and other funding sources. The audit shall include the preparation of certain schedules and other information which Health Choice Arizona and others require. The providers will allow Health Choice Arizona staff to obtain information readily from their independent auditors. Health Choice Arizona uses information obtained from independent audit reports and auditors for decisions about credentialing, contracting, compensation, and other matters.

Providers obtain appropriate audit coverage by:

- Complying with the audit requirements of Uniform Administrative Requirements, Cost Principles, and Audit Requirements for federal awards.
- Complying with the audit requirements of the contract between AHCCCS and Health Choice Arizona.
- Complying with the audit requirements of Health Choice Arizona, including certain schedules and information as Health Choice Arizona requires.
- Providers can appeal to the Health Choice Arizona CFO for substitution of a review or compilation report. The decision for acceptance of a review or compilation report will be at AHCCCS' discretion. Health Choice Arizona shall advise providers of this determination.
- Ensuring that all independent audits or substitute compilations and reviews are performed by an independent Certified Public Accountant licensed in Arizona, and who meets the Continuing Education standards for performing such an audit, as established by the Arizona State Board of Accountancy, or the similar agency in another state if services were provided to Health Choice Arizona members in another state or if the provider is based in another state. Providers are responsible for the costs of obtaining all required audits.
- Providers submit all their independent audit reports, including management letters, to Health Choice Arizona no later than 145 days after the end of the fiscal year or by a date stated in the contract, if different. If submitting a Single Audit as guided by Uniform Administrative Requirements, Cost Principles, and Audit Requirements for federal awards the following items must be submitted as part of the report:
    - Financial Statement and Single Audit including Schedule of Expenditures of Federal Awards (include identifiers and contract numbers for pass-through funds)
    - Copy of the "Data Collection Forms" (SF-SCA) upon request
    - Schedule of Findings and Questioned Costs (if any)
    - Any Financial Statement Findings (if any)
    - Federal Awards findings and Questioned costs
    - Prior Audit Findings (if any)

- Corrective Action Plan (CAP)
- Management Letter (if applicable)

Thirty (30) days following the submission of the audit reports, the current year balance sheet submission shall reflect the previous year's audit adjustments.

Review of Independent Audits

The Financial Analyst and Director of Financial Planning and Analysis will assess providers' compliance with auditing standards with the inclusion of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for federal awards, as applicable. The CFO will be advised of any provider found to have a qualified opinion, significant deficiencies or material findings.

21.7 UNCOMPENSATED CARE

There are two types of Uncompensated Care: Bad Debts and Charitable Care. An example of bad debts is the result of a patient with the financial capacity to pay but is unwilling to settle the claim. Charitable Care is provided to patients who have demonstrated an inability to pay.

Charitable care may include community benefits such as education, research, and essential or unprofitable services.

Charitable care should fulfill the mission of the agency. Charitable care can support the reason the non-profit agency qualifies for tax exempt status.

The criteria for charitable care include:

- Establishment of policies and practices that align with the mission statement and the agency's financial ability. The policy should identify the compliance to state laws.
- The policy must be approved by the agency's governing board.
- The agency should communicate to the members and the community the existence of the charitable care; identifying the eligibility criteria.
- Charitable care is not to be reported in revenue or receivables on the financial statements.

Charitable Care is to be disclosed in the footnotes of the audited financial statements including the valuation method used to determine the cost of services. The footnote should also include the charitable care policy and the amount of charitable care provided.

In addition to hospitals, other health organizations such as outpatient clinic may be affected by charitable care regulations and accounting policies. These regulations apply to both taxable and tax exempt organizations.

21.8 PROVISION FOR BAD DEBT AND THE ALLOWANCE FOR DOUBTFUL ACCOUNTS

FASB has issued Accounting Standards Update (ASU) No. 2011-07. "Health Care Entities (Topic 954): Presentation and Disclosure of patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities." This update requires certain health care entities to change the presentation in the statements by reclassifying the provision for bad debt associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts).

21.9 FEDERAL BLOCK GRANT REQUIREMENTS

Health Choice Arizona ensures that Federal Block Grant (FBG) funds received from the Arizona Health Care Cost Containment System (AHCCCS) are accounted for, reported, and used by providers in a manner consistent with the requirements of those funds.

Health Choice Arizona providers are to comply with all other FBG requirements, including those established in the contract between AHCCCS and Health Choice Arizona, and to have internal policies and procedures related to Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) funding. Providers are also required to have I-BHS numbers for each location.

For further information please see the SAMHSA website.
https://wwwdasis.samhsa.gov/dasis2/isatsonline.htm

Health Choice Arizona allocates FBG funds to providers by separately identifying the FBG funds in the system budget document.

Health Choice Arizona providers separately account for FBG funds and report according to Health Choice Arizona and AHCCCS' guidelines. Each quarter, providers submit a Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) Expenditure Form (Exhibit 21.1) for the current quarter which includes the following columns: SABG General Services, SABG Detox/Stabilization Crisis, SABG Women's Services Pregnant/Parenting, SABG Children Services, HIV and SABG Prevention (by prevention program). MHBG – FEP/SMI/SED. Health Choice Arizona utilizes this data to report SABG and MHBG activity to AHCCCS.

Health Choice Arizona identifies members eligible for SABG and MHBG services based on enrollment and treating diagnosis data. If this data is not provided to Health Choice Arizona or the services provided are not authorized under the FBG guidelines the claims/encounters are denied.

Per AMPM 320-T1 (pg. 11, #7), providers will be required to submit demographic information for priority populations (Pregnant Women, Women with Dependent Children and IV Users Drug Users "PWID", into the AHCCCS 'Dugless' Portal.

Health Choice Arizona utilizes the monthly Analysis of Encounters (AOE) report to monitor the utilization of the FBG funds. This report is distributed monthly and made available on the 'ICE' portal.

FBG funding may only be deferred when approved by Health Choice Arizona and AHCCCS. FBG funds deferred at June 30th must be expended by September 30th of the same year and reported in the same program as AHCCCS originally remitted.

Health Choice Arizona requires providers to adhere to the restrictions on the use of FBG funds. In addition, Health Choice Arizona and providers shall not spend FBG funds:

- To provide inpatient hospital services;
- To make cash payments to intended recipients of health services;
- To purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal Funds (Maintenance of Effort);
- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS (SABG funds only);
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year; see http://grants.nih.gov/grants/policy/salcap_summary.htm;
- To purchase treatment services in penal or correctional institutions of the State of Arizona;
- To provide acute care or physical health care services including payments of co-pays;
- Flex funds purchases; or
- Sponsorship for events and conferences.
- To subsidize member rents and utilities

Other restrictions on provider expenditures of FBG funds may be included in other policies. For additional information on federal block grants please visit the AHCCCS website for the latest version of the AHCCCS Medical Policy Manual (AMPM) Policy 320-T.

Substance Abuse Block Grant (SABG)

Room and Board (H0046 SE) services funded by SABG are limited to Children/Adolescents with a Substance Use Disorder/Dependence (SUD, and adult priority population members (pregnant females, females with dependent child(ren), and intravenous drug users with a SUD).

Mental Health Block Grant (MHBG)

The definition of children with SED is as follows: (Cited from: Arizona Department of Health Services Division of Behavioral Health Services Center for Mental Health Services Block Grant (MHBG) Frequently Asked Questions June 19, 2018)

1. Children from birth up to age 18

AND

2. Currently or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the Diagnostic and Statistical Manual, Fifth Edition (DSM-5);

AND

3. The mental, behavioral or emotional disorder has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Such roles or functioning include achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

MHBG Services that can be utilized

- Services for SED children are targeted to those not covered by Medicaid for TXIX children. These services may include traditional healing, acupuncture, or room and board, etc. As funding is available, non-TXIX children with SED may be served.
- It is an appropriate use of MHBG SED funds to be used for Room and Board.
- MHBG funds cannot be utilized for supportive case management services with the purpose of discharge planning for persons with SMI or SED who are incarcerated, with the exception of SED children in juvenile detention facilities.
- MHBG funds may be used to support transition services for SED children in juvenile detention centers. These services include case management, family support, and other appropriate services identified by the child and Family Team. The MHBG is to be used as the payer of last resort.

For Adults with Serious Mental Illness, the funding is available for both TXIX and NTXIX individuals:

- TXIX: services not covered by Medicaid except for Room and Board
- NTXIX Service Package (see AHCCCS Medical Policy Manual (AMPM) Chapter 300-2B).

21.10 UNEXPENDED STATE GENERAL FUNDS

In accordance with A.R.S. 35-190, State General Funds are appropriated by legislature and must be expended by June 30 of each year at both the RBHA and provider levels. Providers are not allowed to defer State General Funds. This includes state funds for NT19SMI, Crisis and supported housing like rent subsidies.

Providers must return unexpended State General Funds to the RBHA; and subsequently, the RBHA must return the funds to AHCCCS upon request. Unexpended funds may be withheld from future payments.

The Contractor shall add this requirement to their provider contracts, provider financial reporting guides or otherwise communicate this requirement to providers.

21.11 ENCOUNTER REPORTING REQUIREMENTS

The value of service (VOS) standard is 100%. If any program (funding source) drops below 100% the Provider will be subject to Health Choice Arizona's Reconciliation of Funds Paid by Health Choice Arizona and Amounts Earned by Providers process (see Reconciliation of Funds below). From time to time Providers may be requested to submit explanation for over/under production by funding source including barriers to encountering.

21.12 RECONCILIATION OF FUNDS PAID BY HEALTH CHOICE ARIZONA AND AMOUNTS EARNED BY PROVIDERS

It is the policy of Health Choice Arizona (HCA) to reconcile amounts available to Health Homes and Network Purchase Providers with the amounts those providers earn and/or are expected to earn in a fiscal year. Providers who don't earn and/or those who are not projected to earn, the amounts available to them may have their funds reduced by HCA.

The following procedures are conducted by HCA in reconciling and making decisions about funding changes for Health Homes and Network Purchase Providers based on those providers Value of Service (VOS), and/or projected Value of Service (VOS):

- The standard against which Value of Service is measured is the amount assigned to providers in the most current HCA System Budget
- At its discretion, HCA measures provider performance in each fund or in the aggregate and exercises truing on either basis.
- HCA makes a formal analysis of the projected provider VOS - in combined form from all respective sub-funds - compared to the standard at any point in the fiscal year. In addition, HCA reviews projected VOS each month. As the fiscal year progresses, the analysis is cumulative for the fiscal year-to-date. HCA may make adjustments at any point during the fiscal year. In addition, HCA may make a final determination after the fiscal year ends.
- The HCA analysis may take into account the issuance date of the System Budget, the time necessary to implement new requirements by providers, changes in providers claiming methods, existing revenue on a per-active-member basis, and other relevant decision-making factors.

Providers with projected VOS of less than 100%, can potentially have their funds reduced.

- Funds reduced as a result of this policy may be used by HCA for:
    - Making paybacks as required by AHCCCS based on VOS

    - Funding other providers who are earning VOS on the funds available to them
    - Service Expansion
    - Enrollment Expansion and changing enrollment patterns
    - Addressing funding reductions by AHCCCS, AHCCCS or other fund sources available from HCA
    - Funding services in subsequent fiscal years
    - Other purposes as determined by HCA
- Providers who have their funds reduced as a result of this policy are eligible to have those funds restored in that fiscal year based on increased VOS or projected VOS, if adequate funding is available to HCA in an appropriate fund source, as determined by HCA and subject to the continued availability of those funds.
- Reductions of funding indicated above are for that fiscal year. However, there are no guarantees that amounts reduced will be restored in the following fiscal year, as enrollment patterns and funding available to HCA in the following fiscal year can influence HCA's ability to restore the funding reduction.
- Providers with VOS short falls, or projected short falls, may have their funding re-based (i.e. permanent reduction) for the following fiscal year at a reduced level that reflects their VOS over that period.
- Providers may be assessed additional amounts in order to make a payback to AHCCCS under any other process used by AHCCCS to recoup funds from HCA for failure to meet VOS requirements. HCA determines amounts to assess providers based on their respective share of region-wide VOS shortfalls in T19, T21 and non-19/21 categories.
- HCA determines which provider fund(s) is (are) reduced.
- The HCA Leadership makes decisions about funding changes under this policy.
- Providers are notified of a change to their funding within five working days after the decision is made.
- HCA staff notifies the HCA Leadership about funding reductions based on this policy. Such changes are indicated in the HCA System Budget.
- This policy is subject to change as circumstances require.

21.13 SANCTIONS

Health Choice Arizona's (HCA's) provider requirements and provider contract deliverables and submission due dates are described in the provider contract.

As the due date for a specific deliverable arrives, the applicable HCA department staff notes whether specific providers have complied. In addition, HCA monitors whether other provider requirements are being met. That department staff may contact non-compliant providers to obtain the deliverable.

For each instance of non-compliance by a provider, the department staff may take information of the non-compliance to the HCA CEO for placement on the agenda of the next HCA Executive Team meeting.

Providers who fail to submit the required item(s) or otherwise fail to meet its requirements with acceptable quality are subject to sanction as determined by the HCA Executive Team. Sanctions are levied in the discretion of the HCA Executive Team.

If the HCA Executive Team determines that a sanction is appropriate, the HCA CEO or designee sends a letter to the provider stating the instance of non-compliance and the sanction levied by the HCA Executive Team. This letter is either faxed, sent via registered mail, or regular mail. Providers who have been sanctioned are expected to provide the deliverable item within five (5) working days after the notice is received if the sanction is about a deliverable. Failure of a provider to perform within the allowed five (5) working days after notice is received can result in the process described above being repeated by HCA until the provider performs the required task.

In addition, when the HCA Executive Team determines that a sanction is appropriate, the HCA Accounting Unit or designee sends an invoice to the provider. The provider has twenty (20) days to make payment after the date of the invoice. If payment is not made by the provider within the twenty (20) days, HCA may withhold the amount from its next payment to the provider.

Any sanction(s) instituted by the AHCCCS against HCA for failure to comply with contract requirements are passed on to providers in proportion to their contribution to the region-wide non-compliance. Providers are given notice of their share of the AHCCCS sanction via a billing sent by the HCA Accounting Unit or designee. The provider has twenty (20) days to make payment after the date of the invoice. If the provider does not make payment within the twenty (20) days, HCA may withhold the amount from its next payment to the provider.

21.14 BILLS DISPUTED BY PROVIDERS

The **Health Choice Arizona** (HCA) Accounting Manager or designee gives the provider twenty (20) days to respond to and/or pay an invoice/billing statement. Any correspondence from the provider is kept with the invoice/billing statement information in the **HCA** Accounts Receivable files.

If no payment is received within twenty-five (25) days, a second invoice/billing statement is sent and HCA may assess interest on any unpaid balance. The HCA Accounting Clerk or designee will also contact the provider's CFO, Director of Finance, or Business Manager as appropriate and remind them of the invoice/billing statement.

If no payment is received after thirty (30) days, HCA retains the right to recoup the invoice/billing statement amount from the provider's payment. Once the amount is, any negotiation of a lesser amount or refund/rebate is solely up to the HCA CEO and CFO.

21.15 REFERENCES

Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) Expenditure Form (Exhibit 21.1)
Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards

AHCCCS Financial Reporting Guide for RBHA Contractors

AHCCCS Provider Manual Link:
https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS AMPM: https://azahcccs.gov/shared/MedicalPolicyManual/

- AMPM 310-B, Behavioral Health Services Benefit:
- AMPM 320-T1, Block Grants and Discretionary Grants
- AMPM 320-T2, Non-Title XIX/XXI Services and Funding (excluding Block Grants and Discretionary)

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