Mercy Care

Provider Financial Reporting Guide

Effective October 1, 2019

Mercy Care Complete Care (MCCC)
Mercy Care Regional Behavioral Health Authority (Mercy RBHA)

It is the responsibility of each contractor to read the contract and understand the financial accountability requirements of the contract.

Contents

DEFINITIONS

TERM	DEFINITION
Mercy Care	AHCCCS Complete Care and The Regional Behavioral Health Authority.
ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System.
Administrative Costs	Includes administrative expenses incurred to manage the behavioral health system, including, but not limited to: provider relations and contracting, provider billing, accounting, information technology services, processing and investigating grievances and appeals, legal services (including any legal representation of the Contractor at administrative hearings concerning the Contractor's decisions, and actions), planning, program development, program evaluation, personnel management, staff development and training, provider auditing and monitoring, utilization review and quality assurance. Administrative costs do not include expenses related to direct provision of behavioral health services including case management.
AICPA	American Institute of Certified Public Accountants.
Capitation	Capitation is a method by which Mercy Care is paid by AHCCCS to deliver covered services to eligible persons based on a fixed rate per member per month notwithstanding (a) the actual number of eligible persons who receive care from Mercy Care and (b) the amount of services provided to any enrolled person; a cost containment alternative to fee-for-service.
CFDA or CFDA #	Catalogue of Federal Domestic Assistance – Numbers assigned that are used by the federal government to track funding and programs.
DDD	Arizona Department of Economic Security, Division of Development Disabilities
Direct	Direct Mercy Care - Contracts held directly with Mercy Care FFS.
Direct Expense	Direct Expense means expenses incurred to provide covered services to enrolled members by the clinical team. The clinical team consists of employed staff and contracted persons who carry out direct care in the providers' outpatient service sites.
FASB	Financial Accounting Standards Board.

FTE	Full Time Equivalent employee (both contracted and non-contracted).
GAAP	Generally Accepted Accounting Principles. Sources of GAAP include, but are not limited to, publications, pronouncements and opinions of the American Institute of Certified Public Accountants (AICPA), the Accounting Principles Board (APB), the Financial Accounting Standards Board (FASB), and the Office of Management and Budget (OMB).
Indirect	Indirect Mercy Care - Contracts held with a Mercy Care Provider (i.e. a Child PNO).
MHBG	Mental Health Block Grant. The Community Mental Health Services Performance Partnership Program Pursuant to Division B, Title XXXII, and Section 3204 of the Children's Health Act of 2000. CFDA # 93.958
OMB	United States Office of Management and Budget.
OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations	Provides guidance for compliance with the Single Audit Act.
RBHA	Regional Behavioral Health Authority.
SABG	Substance Abuse Block Grant. Performance partnership program pursuant to Division B. Title XXXIII, Section 3303 of The Children's Health Act of 2000 pursuant to Section 1921 – 1954 of the Public Health Service Act and 45 CFR Part 96 Interim Final Rules. CFDA # 93.959.
Single Audit Act	Provides for consistent and uniform financial audits of states, local governments, and non-profit organizations receiving federal awards. Mandates the OMB to provide guidance. Includes the Single Audit Act of 1984 (P.L. 98-502) and the Single Audit Act Amendments of 1996 (P.L. 104-156).
SOA	Statement of Activities
SOP	Statement of Financial Position (or Balance Sheet)

Subrecipient per OMB A-133	Defined as a non-federal entity that expends federal awards to carry out a federal program. Characteristics of a subrecipient include: a) Determines who is eligible to receive federal financial assistance. b) Performance is measured against whether or not the objectives of the federal program are being met. c) Is responsible for making decisions about the program. d) Is responsible for adhering to applicable federal program compliance requirements. e) Uses the federal funds to carry out a program of the organization as opposed to providing goods or services for a program of the pass-through entity. OMB indicates that all of the characteristics may not be present and that judgement will be necessary to make the determination of subrecipient or vendor.

OVERVIEW

This guide has been developed to ensure that all Mercy Care subcontracted providers and vendors develop and understand the financial requirements and responsibilities inherent in their contract with Mercy Care. The primary objectives of this reporting guide are to establish consistency and uniformity in financial reporting and to provide guidelines to assist providers in meeting contractual reporting requirements. The requirements for reporting and formats apply to all providers, including non-profit and for-profit entities.
This guide is not intended, nor should it be construed, as an all-inclusive manual. Neither is it intended to limit the scope of audit procedures to be performed during the provider's annual certified financial audit nor should it be used to replace the independent certified public accountants judgment as to the work to be performed.

SECURE FILE TRANSFER PROTOCOL (SFTP)

Secure file transfer protocol (SFTP) is available for document transfers with Mercy Care Finance. If a provider has previously signed up for SFTP with another Mercy Care department, then the provider will be able to use it with Mercy Care Finance. If a provider wants the ability to utilize SFTP and is not currently signed up for it, the Network Relations Consultants can facilitate this request.

GENERAL ACCOUNTING REQUIREMENTS

Financial Standards
Financial Statements must be prepared and presented in accordance with GAAP and all other applicable authoritative literature. It is the provider's responsibility to ensure that all reports submitted are accurate, complete and timely. An explanation of adjustments made for prior periods and any auditor's adjustments made are to be disclosed on Attachment C.

Defined Cost Record Keeping System
All financial records shall be maintained in such detail that accurately reflects each service provided and all costs and expenses associated to the payment made to the provider. Each provider must maintain an official accounting system which properly records all financial transactions and equitably allocates expenses to programs or services in accordance with generally accepted accounting procedures. The provider's accounting system is to provide an audit trail wherein the financial data reported can be later verified.

Fiscal Monitoring
Mercy Care has a mandated responsibility to monitor providers, to report applicable financial information to AHCCCS & DDD, and to review the operational and financial systems of providers. The format and content of the required reports are subject to change. Providers will be given a reasonable time period for review and comment regarding any proposed changes. AHCCCS/DDD and/or Mercy Care may request financial or other information from provider.

Upon receipt of a request for information, provider shall provide complete and accurate information no later than thirty (30) days after the receipt of the request unless otherwise specified by AHCCCS/DDD or Mercy Care.
Questions regarding the content or format of a report are to be directed to the Mercy Care Finance Department at Finance@MercyCareAZ.org.

AHCCCS/DDD Requirements

AHCCCS/DDD requires its providers to have an internal control system that at the minimum addresses the following objectives:

- Separate accounting for contract funds received and related expenditures, or a consistently applied cost allocation system, which accurately documents the costs of contracted programs or units of service.
- Segregation of and accumulation of budget item expenditures to give a ready reference for compiling the expenditure reports.
- Expenditures of contract funds in accordance with contract requirements. This objective typically includes the following:
    - Expenditure of funds within the contract period.
    - Expenditure within the proper account classification.
    - Expenditure and/or allocation of direct and indirect costs that are directly related to or properly allocable to the contracted services.
    - Adequate documentation for all expenditures.
    - Adequate documentation of the occurrence of services billed to the department under contract.

Profit Determination and Limitations

Net profit is defined as Total Revenue less Total Expenses, excluding sanctions and encounter withhold penalties. Net loss is defined Total Revenue less Total Expenses, excluding sanctions and encounter withhold penalties.
The maximum allowable profit is 4% of Total Revenue for the following programs:

- Title XIX Child and Adult programs
- Title XXI Child and Adult programs
- Federal SABG and MHBG programs
- Non-Title SMI services

The maximum profit is 0% for the following programs:

- State Crisis programs
- Supported Housing programs

Note: Performance incentives, prior year payments distributed in the current year, capitated payments, or fee for service (FFS) payments are not included as current year revenue for calculating profit or loss amounts. Direct Mercy Care contracts will be treated separately from each indirect Mercy Care contract. Federal Programs like SABG and MHBG will also be treated separately from direct & indirect Mercy Care contracts. Special contracts that do not require encounters reporting will be subject to a zero profit limitation.

STANDARD BLOCK GRANT FUNDING (STATE)

Block Funding is a payment methodology utilized by Mercy Care as a pre-payment for services to be delivered. A funding amount is awarded to a provider, and then is distributed to that provider in monthly installments depending on the time period set for the Block Amount. Providers are required to submit service claims at an agreed encounter level for the funding received. Providers receive a quarterly compensation schedule with awarded funding amounts by funding category.

FEDERAL BLOCK GRANT FUNDING

In many situations Mercy Care pays health care providers for services with block grant funding. Providers are given a set amount of funding on a monthly basis, and revenue is recognized as the services are provided to Mercy Care members (encounters). A provider's funding can be adjusted either up or down as Mercy Care's funding and/or membership needs dictate.
The services allowed are determined by both the contract and by the specific block funding source. Depending on the contract and the funding source, block funding that is not encountered during the contract year will be recouped by Mercy Care. In some cases, un-encountered funding may be deferred to the following contract if Mercy Care determines a need for additional services.
The provider shall comply with all terms, conditions and requirements of the MHBG and SABG (Children's Health Act of 2000, P.L. 106-310 Part B of Title XIX of the 23 Public Health Service Act [42 U.S.C. 300 x et seq.] and 45 CFR Part 96 as amended).
Financial, performance, and program data subject to audit, shall be retained by the provider and shall be made available at the request of Mercy Care or AHCCCS/DDD as documentation of compliance with federal requirements.

- SABG: The provider is authorized to expend funds for planning, performing, and evaluating activities to prevent and treat substance abuse as well as related activities addressing HIV and tuberculosis services.
- MHBG: The provider is authorized to expend funds for services for adults and NTXIX with serious mental illnesses and children with serious emotional disturbances. Also covers First Episode Psychosis.
- Other federal grant funding as allocated by AHCCCS/DDD as directed for purposes set forth in the federal grant requirements.

Federal Block Grant Funding Requirements:

- Establish fiscal controls consistent with the Provider Manual, which is the framework for behavioral health accounting, auditing and financial reporting procedures.
- Ensure that funds are accounted for in a manner that permits separate reporting of mental health and substance abuse grant funds and services.
- Ensure that funds are accounted for in a manner that permits separate reporting of program type. SABG funding includes General Services, Pregnant and Parenting

prevention, and HIV Prevention. MHBG funding includes Children with SED and Adult with SMI.

- ❖ Upon request, provide Mercy Care with information relative to block grant expenditures.
- ❖ Manage, record, and report Federal grant funds in accordance with the practices, procedures, and standards in the AHCCCS Accounting and Auditing Procedures Manual.
- ❖ Report financial information related to federal grants in conformance with the AHCCCS Financial Reporting Guide.
- ❖ Comply with prevention funds management in conformance with the AHCCCS Framework for Prevention in Behavioral Health.
- ❖ Comply with all terms, conditions, and requirements for any federal grant funding allocated by AHCCCS/DDD.

Provider shall ensure delivery of grant services and submission of data for certain allocations of the SABG:

- ❖ Alcohol/drug abuse treatment services.
- ❖ Primary prevention services.
- ❖ Specialty programs and services for pregnant women and women with dependent children.
- ❖ Crisis Services.
- ❖ HIV Early Intervention Services.

Funds paid to the provider shall be available for obligation and expenditure until the end of the fiscal year for which the funds were paid. Mercy Care will comply and follow all rules set forth in accordance with Federal Block Grant Funds Transfers Cash Management Improvement Act of 1990 and any rules or regulations promulgated by the U.S. Department of Treasury including 31 CFR Part 205.

On a quarterly basis providers must submit a SABG and MHBG Distribution Report to Mercy Care for the period July 1, 20yy through June 30, 20yy. This report should be provided in the format provided by Mercy Care (Attachment I in the Financial Reporting Guide Attachments). Actual provider self-reported SABG expenditures must be reported by category (Pregnant/Parenting, Prevention, etc.). Actual provider self-reported MHBG expenditures must be reported by SED (children) or SMI (adult). Both SABG and MHBG information must be reported by service location.

Non-Discrimination: The provider may not discriminate against non-governmental organizations on the basis of religion in the distribution of grant funds.

All federal funding (SABG and MHBG) must be spent by June 30, 20yy or returned to Mercy Care by July 10, 20yy (of the current contract year).

Prohibited Expenditures

Provider may **not** expend Federal Block Grant funds for the following:

- ❖ Inpatient services.
- ❖ Physical health care services.
- ❖ Cash payments to intended recipients.
- ❖ Purchasing or improving land.

- Purchasing, constructing or permanently improving (other than minor remodeling) any building or facility.
- Major medical equipment.
- Financial assistance to any entity other than a public or non-profit private entity.
- Programs of distributing sterile needles for the hypodermic injection of any illegal drug.
- Testing for the etiologic agent for acquired immune deficiency syndrome unless such testing is accompanied by appropriate pre-testing counseling and appropriate post-test counseling.
- Paying the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of $175,700 per year.
- Treatment services in penal or correctional institutions.

FEDERAL COST REIMBURSEMENT GRANT FUNDING

Currently, there are Substance Abuse and Mental Health Service Administration (SAMHSA) Invoice-Based Grants that are recognized and passed through AHCCCS, and Mercy Care is a sub-recipient. Mercy Care contracts with specific providers for these invoice-based-grants. SAMHSA makes grant funds available through the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Center for Mental Health Services. Funding opportunities support educational programs for substance use disorders and mental illness. The following requirements are to be adhered to if provider is participating in this program and reimbursement is being requested. If documentation is not properly submitted, this could significantly delay payments to the provider. To make this process more efficient, provider should submit all items correctly, accurately and timely.

Invoicing Timeline:

- Frequency – Monthly
- Due Date – 5th of Month for prior grant period expenditures (if the 5th falls on a weekend/holiday invoice is due the following business day)
- Mercy Care Review and Follow Up – within 7 business days of receipt
- Revisions from provider – within 7 days of Review/Follow Up
- Mercy Care processes payments on Tuesdays and Thursdays.

Invoicing Format:

The following templates will be the only accepted formats:

- Excel Invoice Template
- Excel Monthly Expense Detail Template

Invoicing Requirements:

- Include only actual approved expenditures in the budget, not estimates or pre-paid expenses
- Only invoice amounts, which match exactly to the Expense Detail Template
- Back-billing is only allowed with prior Mercy Care permission within grant contract year
- Include documentation for direct costs (receipts, invoices, payroll journals, mileage logs, etc.)
- Mileage logs should include full address (street address, city, state, zip code), site name, purpose of the trip (which must specifically be grant related) and miles traveled for each

individual trip. Mileage is checked by both Mercy Care and AHCCCS, and any unreasonable submissions will be returned for revision.

- Adhere to the State Travel Policy: https://gao.az.gov/publications/saam.
  - Ensure to only invoice for Travel/Mileage that does pertain to the Grant Program Objectives
  - Ensure to only invoice for Travel expenses within the State Travel Policy Limits
- Include Full Time Equivalent (FTE) for the hours worked for each Person/Position
- Include allocation calculations/notation for all allocated direct costs that directly support the grant program
- Include attestation of the expenditures being invoiced

Budget Revisions:

Occasionally budget revisions may be necessary based on monitoring budget trends and/or staff changes. If budget revisions are necessary, the following process must occur PRIOR to any invoices being submitted with revisions:

- Notify Mercy Care of proposed changes
- Mercy Care will notify AHCCCS of potential budget revisions
- Provider will submit revised budget to Mercy Care by agreed upon deadline
- Mercy Care Clinical Operations and Finance must approve budget; if required, Mercy Care may re-send budgets to providers to make necessary changes
- Once approved by Mercy Care, proposed budget revisions will be submitted to AHCCCS for approval
- If a budget revision requires more than a 10% shift between line-items, this will need to be submitted to SAMHSA for approval
- Providers will be notified upon approval and be sent back the approved budget

If there are staff changes to the budget, please notify Mercy Care in writing along with the submission of the monthly invoice.

Final Reminders:

- Keep receipts, documentation, and monthly financial statements well organized and accessible
- Monitor grant expenditures monthly to ensure that over-spending or under-spending can be addressed before the end of the grant period
- Keep time allocations if personnel cross multiple funding streams; periodically, personnel activity reports may be requested as evidence of a time-tracking system being in place.
- Program staff and finance staff should communicate to be aware of both the program and finances, both invoicing and budgeting.

Additional questions can be asked to your direct point of contact.

STATE GENERAL FUNDS

In accordance with A.R.S. 35-190, State General Funds are appropriated by legislature and must be expended (based on dates of service) by June 30 of each state fiscal year at the provider level.

Mercy Care will monitor provider expenditures to ensure that State General Funds are spent by June 30. Providers are not allowed to defer State General Funds and shall provide Mercy Care with projected unexpended State General dollars by fund source via email or letter by March 31 of each state fiscal year. In addition, providers shall provide Mercy Care with projected unexpended State General dollars by fund source via email or letter, as requested.
Providers must return unexpended State General Funds to Mercy Care by July 10, 20yy every year. Unexpended funds held by providers may be withheld from future payments by Mercy Care.

REQUIREMENTS FOR REPORTING

Providers are subject to the following reporting requirements based on the highest combined direct and indirect contract revenue amount per contract-year or on request. Certain reporting is also required for providers that receive Federal Block Grant Funds and State General Funds. Note that providers that offer only physical services are not required to provide the following reporting:

Contract revenues less than $250,000
Provider must submit annual unaudited financial statements to the Mercy Care's Finance Department 30 days after the contract year-end, ending 09/30/xx, or provider termination date. Final reconciliations (inclusive of any year-end adjustments) for annual unaudited statements are due no later than 120 days after the contract year-end. Provider must comply with interim financial report requests.

Contract revenues between $250,000 and $499,999
On a quarterly basis providers must submit contract year-to-date unaudited financial statements to the Mercy Care's Finance Department 30 days after the quarter-end, or provider termination date. Final reconciliations of a provider's financial statements (inclusive of any year-end adjustments) for the complete contract year are due no later than 120 days after the contract year-end.

Contract revenues of $500,000 or more
On a quarterly basis providers must submit contract year-to-date unaudited financial statements 30 days after the quarter-end, or provider termination date and an annual audited financial report along with any management letters to the Mercy Care's Finance Department 120 days after provider's year end if different from the contract year end. Provider final contract year Statement of Activities must be included as an audit item.

OMB Circular A-133 audit
Some providers may receive substantial Federal funding ($750,000 or more, SABG and/or MHBG) through Mercy Care and other sources, or otherwise be deemed a sub-recipient of Federal funds and required to obtain an OMB Circular A-133 audit. In such cases, the provider must submit two (2) copies of the A-133 audit report to the Mercy Care's Finance Department

within 30 days after receipt of the audit report and no later than 120 days after the provider's year-end.

SABG/MHBG Distribution

Any providers who receive SABG (substance abuse block grants) or MHBG (mental health block grants) federal funding are required to submit a distribution report detailing the revenue and expenses relating to federal block grants received. ***Information should be submitted using the July-June fiscal year***. This reporting is due to Mercy Care on a quarterly basis.

State Only Funding

Any providers that receive non-title 19/21 funding and/or SABG/MHBG block grant funding are required to report the expenses of the state only funds on an annual basis. This report is due to Mercy Care by March 31.

All providers must comply with updates, supplemental, and interim financial report requests.

REPORTING PACKAGES AND TIME FRAMES

Quarterly & Annual Unaudited Financial Statements

Quarterly and/or annual unaudited financial statements are due to Mercy Care 30 days after the end of each period and must include the following reports:

- Certification Statement (Attachment A).
- Statement of Financial Position (Attachment B).
- Disclosures Statement (Attachment C).
- Statement of Activities (contract year-to-date) (Attachment D).
- Statement of Cash Flows (Indirect Method) (Attachment E).
- Financial Ratio Analysis (Attachment F).
- Conflict of Interest Disclosure (Attachment G).
- Cost Allocation Plan (only required with first submission of contract year) (Attachment H).
- Financial Reporting Request for Extension (if needed) (Attachment I).
- SABG and MHBG Distribution Report (if applicable) (Attachment J).
- Fee Schedule Exception Template (Attachment K).

Mercy Care recognizes that interim financial statements are based on information available at the end of the reporting period, which may be incomplete. Revisions to a prior period will invalidate the previously submitted report. If material revisions are submitted after the Mercy Care due date, and Mercy Care is not notified, then sanctions may be imposed for untimely reporting. Final reconciliations (inclusive of any year-end adjustments) for annual unaudited financial statements are due no later than 120 days after the contract year-end.

For tracking purposes, quarterly & annual unaudited financial statements should be submitted via email to: Finance@MercyCareAZ.org

Audited Annual Financial Statements (no OMB Circular A-133 audit required)

Due to Mercy Care 120 days after the contract year-end or the provider's year end if different, and must include the following reports:

- An annual certified financial audit report along with any management and opinion letters.
- Supplemental Disclosures Statement (Attachment C).
- Supplemental Statement of Activities (Attachment D).

Providers that are required to submit annual audit reports 120 days after year-end must also submit unaudited 4th quarter statements 30 days after year-end.

Audited Annual Financial Statements (OMB Circular A-133 audit required)

Due to Mercy Care within 30 days after receipt of the audit report and no later than 120 days after the contract year-end or provider's year end and must include the following reports:

- A annual certified financial audit report along with any management and opinion letters.
- Supplemental Disclosures Statement (Attachment C).
- Supplemental Statement of Activities (Attachment D).
- One copy of an OMB Circular A-133 audit and program specific schedules.

Providers are required to submit annual audit reports 120 days after year-end and must also submit unaudited 4th quarter statements 30 days after quarter-end.

SABG/MHBG Distribution

Providers who are SABG and MHBG block grant recipients are required to submit a distribution report detailing the revenue and expenses relating to federal block grants received. This is due to Mercy Care on a quarterly basis. The time frame for this report is the Block Grant contract year, which is July 1 to June 30. Attachment J from the Mercy Care FRG attachments is the template for this reporting.

State Only Funding

Providers that receive non-title 19/21 funding and/or SABG/MHBG block grant funding are required to report the expenses of the state only funds on an annual basis. This report is due to Mercy Care by March 31. As the time frame for the report is the AHCCCS/DDD contract year which is July 1 to June 30, the last months will be an estimate. Attachment D from the Mercy Care FRG attachments is the template for this reporting.

The preferred method for submission is via email. Mercy Care requests providers submit all quarterly and annual unaudited financial statements in an electronic format. Acceptable formats are Microsoft Excel (.xls) for all financial statements and Adobe (.pdf) for the Certification Statement. Financial reports may be emailed, mailed, or hand delivered and should be sent to the following address:

Mercy Care
Attention: Finance Department
P.O. Box 90640
Phoenix, AZ 85066
Email: Finance@MercyCareAZ.org

Reporting

Providers must include contract year-to-date data when compiling financial reports. If a provider's year end differs from the contract year, they may report based on their year-end for Annual Audited Financial Submission only. Quarterly and unaudited annual submissions must be on a contract year-to-date basis. Please note that the annual contract year-to-date unaudited financial reporting requirement applies to all providers. All financial reports should clearly identify the time period by listing the start and end dates.

An explanation of adjustments made for prior periods or other items are to be disclosed in a footnote to the subject statement and disclosed on Attachment C. Material items included as "other" must be itemized on a supporting schedule.

Depreciation on properties directly purchased or reimbursed with any State funding source will not be allowable for the Statement of Activities, or for purposes of evaluating a provider's profit limitation. This provision applies to Community Living or like properties where recipients are temporarily housed during a course or program of treatment. These depreciation amounts should instead be listed under the non-Mercy Care column within the Statement of Activities section of the template.

Quarterly and annual reports are required by Mercy Care's contract with AHCCCS and by contracts with the providers. If there are any inconsistencies between this reporting guide and any contract provision, the contract provisions shall prevail. Any inconsistencies should be reported to the Mercy Care's Finance Department. This reporting guide is neither intended to limit the scope of audit procedures performed during the provider's annual certified audit nor to replace the independent certified public accountant's judgment as to the work performed. It is merely a supplement to the contract.

Mercy Care will issue a letter referred to as an "Incomplete Checklist" to providers noting any missing items required to meet the minimum financial reporting requirements. A provider may be subject to sanctions if they do not meet the minimum financial reporting requirements for each applicable reporting period.

UNAUDITED ANNUAL & QUARTERLY REPORTS

Certification Statement (Attachment A)

Unaudited annual and quarterly reports must contain a Certification Statement cover sheet, which is to be signed and dated by the Chief Financial Officer of the provider. This signature is confirmation the reports have been reviewed for accuracy and completeness. Unsigned or unlabeled reports will not be accepted. Electronic signatures are permitted. If the provider submits financial reports electronically, the Certification Statement may be faxed or mailed separately if electronic signatures are not available. A sample of the Certification Statement may be found in Attachment A.

Statement of Financial Position (Balance Sheet) (Attachment B)

The Statement of Financial Position illustrates the financial position of the provider as of the reporting date. It is the primary source of information about liquidity and financial flexibility. Current and Non-Current Assets and Liabilities must be clearly identified. The required format for the Statement of Financial Position may be found in Attachment B.

Disclosures Statement (Attachment C)

The Disclosures Statement provides additional detail regarding items that relate to Mercy Care Programs. Providers should submit this statement when there are accounts receivable, deferred revenue, or any other line-item that is specific to Mercy Care. The required format for Disclosures Statement may be found in Attachment C. If there are no disclosures for the corresponding period the provider must submit a zero-filled Disclosure Statement; or insert a page stating, “There are no disclosures for the current period.”

Accounts Receivable

Providers should report Statement of Financial Position’s Accounts Receivable attributable directly to Mercy Care Programs.

Deferred Revenue

Provider must report the amount of liabilities attributable directly to Mercy Care Programs and include the Funding Source and Program (if applicable).

In regard to deferred revenue, providers must clearly identify what amount of deferred revenue is attributable to Mercy Care. Mercy Care deferred revenue should be further identified as prior contract year and/or current contract year. Any deferred revenue from a prior contract year should be reclassified on the Statement of Financial Position as a Payable to Mercy Care. Any deferred revenue received during and remaining at the end of the current year should also be reclassified as a payable to Mercy Care in the 4th quarter statements and annual audit report. Providers are not to spend any deferred revenue after the end of the contract year (September 30) without Mercy Care’s approval. Any request to do so should be directed to your organization’s Network Relations Consultant. If it is determined that there is a specific need for additional services in the following contract year, a meeting with Mercy Care’s Chief Financial Officer and System of Care group will be scheduled to discuss programmatic specifics.

Mercy Care regularly determines whether there will be unspent funds by the end of the contract year or state fiscal year in the case of general funds and Block Grant Funds. If general funds remain at the end of the state fiscal year, providers are prohibited from recording deferred revenue. Instead, these unspent general funds must be reported as a payable to the Mercy Care and returned within ten (10) days after the completion of the contract year for subsequent return to AHCCCS. TXIX/TXXI, grant, and county revenue may be deferred at the end of the provider's fiscal year only under extenuating circumstances and after prior written approval of Mercy Care and AHCCCS. Providers must provide details of the circumstances to Mercy Care no later than 45 days prior to the end of the state fiscal year for review and prior approval.

Mercy Care Contracts Revenue Reconciliation

Providers must reconcile variances between the reported Revenue on the Statement of Activities by program to contracted amounts found on the Mercy Care Compensation Exhibit.

Mercy Care Income Tax Provision Reconciliation

After year-end for-profit providers claiming income tax provisions must reconcile the actual income taxes related to net gain from Mercy Care operations to prior reported (un-audited) income tax provisions. If variances exist, the provider must submit a final reporting package with applicable changes to Mercy Care's Chief Financial Officer.

Other Disclosures/Adjustments

Provider may use this line to disclose any other item related to Mercy Care programs that requires disclosure.

Statement of Activities (Attachment D)

The Statement of Activities section encompasses accumulated (year-to-date) and comprehensive revenue and expenses within geographic area for the provider. All items are to be reported using the accrual method of accounting. The intent of the statement is to capture, on an accrual basis, the revenue by program of the provider and to match that revenue with the related expenses. An example of the required format for the Statement of Activities is included in Attachment D.

Headers

The column headings in the Statement of Activities must represent a provider's contracted programs. Providers should categorize programs using their respective contracts and may add their own program descriptions to these headings if further clarification is desired. Providers should use their best judgment when reporting programs.

The Mercy Care columns should be used by providers that hold contracts directly with Mercy Care. Providers that hold Mercy Care contracts must list each contract and programs separately in their respective column headers. Programs like SABG will require their own header by program & type (SABG General, SABG HIV, etc.)

Revenue

Revenue lines must include service revenue by program and may include prior year adjustment, Other Revenue, Interest Income, and Unrelated Business Activities line items, with associated expenses.

If the provider assesses and collects co-payments, their value should be indicated on the Statement of Activities under the Other Revenue line item. Mercy Care recognizes that, depending on the fact pattern, the preferred GAAP method might be to record co-payments as a contra-expense. To maintain consistency with AHCCCS/DDD and for our own reporting purposes, however, we require the co-payment information be listed under revenue. Providers should maintain a monthly member roster of all consumers who have been assessed and/or collected for co-payments. This roster should specifically tie to the values listed in the Statement of Activities and should be made available to Mercy Care upon request. Please refer to the Provider Manual, Section 8 for more information regarding co-payments.

Expenses

Expenses should be grouped into one of two categories: Clinical Services Expenses or Administrative Expenses.

Expenses in the Clinical Services category are directly associated with the provision of behavioral health services to consumers. Clinical Services expenses are distinguished from Administrative expenses by being an expense or portion of expense related to the direct service to recipients or the support thereof. Administration expenses that are an integral part in providing services may include, but are not limited to: quality, claims processing, front desk staff, medical records, clinical directors, clinical management, licensing and compliance, call center staff, and training. Salaries should include all labor types for direct staff. Labor types that are outsourced should be included in the temp/contract labor line.

Administrative expenses are those expenses incurred for the common benefit of the overall organization. This may include contracted labor and services or services not directly identifiable as clinical services. These expense areas may include Human Resources, Finance, Executive staff (not to include clinical leadership) and Management Fees/Corporate Administrative allocations.

Full Time Employees (FTEs)

The number of employees that are allocated to each program.

Statement of Cash Flows (Attachment E)

The primary purpose of the Statement of Cash Flows is to provide information about an organization's cash inflows and cash outflows during the accounting period. Cash flows are classified in terms of operating, investing, and financing activities. Significant non-cash investing and financing activities not affecting cash must also be disclosed in the Statement of Cash Flows. The indirect method is used for financial reporting. For further guidance, providers should refer to SFAS 117.

Conflict of Interest Disclosure (Attachment F)

As a recipient of funds through Mercy Care, your organization is required to comply with regulations pertaining to Conflict of Interest as defined under (A.R.S 35-705) (A.R.S 38-503). Your organization must provide Mercy Care with a certification of compliance with Conflict of Interest (COI) Policies. Providers are required to disclose conflicts of interest with each financial reporting package.

Conflict of Interest Disclosure (Attachment G)

As a recipient of funds through Mercy Care, your organization is required to comply with regulations pertaining to Conflict of Interest as defined under (A.R.S 35-705) (A.R.S 38-503). Your organization must provide Mercy Care with a certification of compliance with Conflict of Interest (COI) Policies. Providers are required to disclose conflicts of interest with each financial reporting package.

Cost Allocation Plan (Attachment H)

All providers must submit a Cost Allocation Plan for approval. The Cost Allocation Plan is a narrative explanation for the allocation of indirect costs (both by expense lines and across by program). It must be submitted with the first financial statement submission of the fiscal year, or by October 31st of each year. Direct expenses should be recorded directly to the applicable program(s) and expense categories, if identifiable. Providers may apply the principles described in OMB Circular A-122 (Cost Principles for Non-Profit Organizations).

Allocations

Many expenses require allocations. There may be costs that are shared between categories (clinical and administrative) and would need to be allocated appropriately and according to the organization's Cost Allocation Plan and statistical basis methodologies. This split of allocation needs to be uniquely identifiable either to clinical or administrative.

Other allocated costs may cross multiple categories of expense and may become quite complex in nature. As there are no universal rules that could be applied across provider agencies, each agency must determine what is appropriate for them based on how their organization is structured. Some allocated costs may also cross programs within a single category of expense.

Providers are required to ensure Mercy Care and non-Mercy Care expenses are charged appropriately between the funding sources.

Allocation Methodology

Allocation methodologies should be specifically outlined in your Cost Allocation Plan and should use a basis that results in an equitable and reasonable distribution. Allocation methodologies should explain rationale used to identity and appropriately match expense to revenue, and to allocate across the various programs, grants, contracts and agreements.

Use the method that is most appropriate to the particular cost being prorated. These may include, but are not limited to time studies, square footage, number of clients/beds, bed days, direct service hours, direct service expense, FTEs, salaries, and accumulated expense.

Allowable & Unallowable Costs

Unallowable costs will not be expensed against any Mercy Care funded programs. Based on your provider type please refer to one of the guides:

- Circular A122 provides costs principles for non-profit organizations for guidance related to allowable and unallowable expenditures;
- Chapter 15 of the Medicare Benefit Policy Manual or Title 42 of the Code of Federal Regulations.

Request for Extension (Attachment I)

If a provider is unable to meet a financial reporting deadline, a Request for Extension must be submitted to Mercy Care Finance. Items that must be on the Request for Extension include the provider's name, the date of request, the financial report that requires the extended due date, the reason for the request, and the new due date be requested. Financial reporting extensions must be made at least two weeks prior to the due date, and will be limited to at most one month past the due date.

SABG/MHBG Distribution Reporting (Attachment J)

Providers who receive federal SABG and MHBG funds are required to monitor and track all federal block grant funds and the expenses related to that funding. All SABG/MHBG revenue and expenses must be broken out by category (**SABG:** General Services, Pregnant/Parenting Women, Prevention, HIV Prevention; **MHBG:** SED or SMI), and by the specific locations at which the services are provided. This reporting should be completed using AHCCCS's fiscal year (July 1, 20yy-June 30, 20yy), and is required on a quarterly basis.

Fee Schedule Exemption Template (Attachment K)

If a provider wants to make a request to have a fee schedule adjustment, the Fee Schedule Exception Template should be used. Current fee schedule, utilization data, and other information supporting the request should be entered on Attachment K and emailed to Mercy Care Finance.

AUDITED FINANCIAL REPORTING

AUDITED ANNUAL REPORT

The audited annual report package is due 120 days after the contract year-end, or the provider's year-end, if different. This package must include the Supplemental Schedules described below.

If an audit confirmation is needed to complete the audit report, please submit any requests in writing or by email to the Mercy Care Finance Department.

If the audit report will not be ready for submission within 120 days after the provider's year end or contract-year-end, the provider must submit a letter from their auditing firm stating the reason(s) for the delay and include the date the report will be submitted. This letter must be received by Mercy Care via postal service prior to the 120th day. Financial sanctions may be applied as described in Sanctions Procedure section below.

Supplemental Schedules

When submitting annual certified audit reports, providers must also include a Supplemental Schedule of Financial Position Disclosures and Supplemental Schedule of Activities. The Supplemental Schedules must be presented in the same formats as the 4th quarter unaudited statements submitted for the fiscal year (Attachments C & D).

The Supplemental Schedule of Financial Position Disclosures must clearly identify any deferred revenue as direct Mercy Care, indirect Mercy Care or non-Mercy Care. The Supplemental Schedule of Activities must be organized by applicable Mercy Care Funding Source and Programs. The schedule must clearly identify the revenues and expenses attributable to the Mercy Care contracts, and reconcile any differences between the unaudited contract year-to-date report(s) and the annual certified financial audit.

The Supplemental Schedules shall be reviewed as an integral part of each provider's annual certified audit. Mercy Care expects the auditors employed by the provider to test the provider's compliance with the Cost Allocation Plan and any issues of non-compliance must be included in the certified audit report.

OMB CIRCULAR A-133 REPORT

Non-federal entities that receive $750,000 or more in a year in federal awards shall have a single or program-specific audit conducted for that year in accordance with the provisions of OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations." Providers can identify the amount of federal funding they receive as part of their Mercy Care contract by referring to the funding section, Exhibit C. Any dollars attributable to SABGs and/or MHBGs are federally funded.

An auditee may be a recipient, a subrecipient, and/or a vendor. Recipient means a non-federal entity that expends federal awards received directly from a federal awarding agency to carry out a federal program. Subrecipient means a non-federal entity that expends federal awards received from a pass-through entity to carry out a federal program, but does not include an individual that is a beneficiary of such a program. A subrecipient may also be a recipient of other federal awards directly from a federal awarding agency. Vendor means a dealer, distributor, merchant, or other seller providing goods or services that are required for the conduct of a federal program. These goods or services may be for an organization's own use or for the use of beneficiaries of the federal program.

Federal awards expended as a recipient or a subrecipient would be subject to an A-133 audit. The payments received for goods or services provided as a vendor would not be considered

Federal awards. Together with our auditors, Mercy Care has determined that providers who receive SABG (CFDA number 93.959) or MHBG (CFDA number 93.958) funding are considered to be a subrecipient. Medicaid Funds (Title XIX and XXI) are excluded from OMB Circular No. A-133. Although AHCCCS requires Mercy Care to include Title XIX and Title XXI funds in our OMB Circular A-133 Audit Reports, we do not currently require providers to do so.

Providers who receive SABG or MHBG funds will be notified via a Federal Award Letter stating the amount of their federal funding, their award status, the applicable CFDA title & number, and Issuing Agency; as well as an explanation of their requirements under OMB Circular No. A-133.

If your agency is required to submit an OMB Circular A-133 Audit Report, Mercy Care requires that you provide a copy of the report to the Mercy Care's Finance Department, either by mail or email, within 30 days after your agency receives it and no later than 120 days from the end of the fiscal year.

CAPITATED CONTRACTS

In certain circumstances Mercy Care provides compensation to providers via capitated contracts. In its basic form, a capitated contract will pay a provider a per member per month (pmpm) dollar amount base on the membership being served in a specific population or program. The total number of member months will be trued up periodically as retroactivity occurs in reported roster data. For questions regarding capitated contract payments contact Finance@MercyCareAZ.org.

NON-EMERGENCY TRANSPORTATION

Non-emergency transportation is provided for all members including persons and/or families who are unable to arrange or pay for their transportation or who do not have access to free transportation in order to access medically necessary covered health services.
It is the provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment if the required documentation is not maintained or covered services cannot be verified. The following elements for record-keeping are recommended for documentation of non-emergency transportation services:

- Complete Service Provider's Name and Address;
- Name and signature of the driver who provided the service;
- Vehicle Identification (car, van, wheelchair van, etc.);
- Member (being transported) name;
- Recipient's AHCCCS ID;
- Complete date of service, including month, day and year;
- Complete address of the pick-up site;

- Complete address of drop off destination;
- Type of trip (round trip or one way);
- Escort (if any) must be identified by name and relationship to the member being transported;
- Signature of recipient, verifying services were rendered.

Providers may arrange medically necessary non-emergent transportation for Mercy Care by calling Member Services at 800-564-5465. For any other questions regarding member transportation please consult the Mercy Care Provider Manual.

BLOCK ENCOUNTER VALUE RECOUPMENT POLICY

Communication of Fiscal Provider Funding Levels

Barring any delays in the receipt of funding information from AHCCCS, Mercy Care will communicate quarterly block funding levels by mid-September of each fiscal year, and quarterly thereafter. While quarterly block funding levels are being established, Mercy Care will provide interim funding. Interim funding will be reconciled against final contract amounts for the fiscal year. Mercy Care communicates provider funding levels via Compensation Exhibits. Compensation Exhibits display funding by program type and by month, and are distributed to providers whenever funding changes in a contract year.

Retroactive Adjustments to Funding by AHCCCS

To the extent AHCCCS makes an adjustment to Mercy Care's funding, subsequent to the establishment of block provider funding levels, Mercy Care reserves the right to pass such adjustments on to providers. Providers will be notified of such funding adjustments. Mercy Care's standard policy will be to apply retroactive reductions in funding over a three (3) month period. Refunds and lump-sum deductions will also be considered.

Encounter Value Reporting

Mercy Care will have encounter data reporting available which the providers can utilize to track their encounter value against funding. This data will be available on a monthly basis from Mercy Care Finance. In the event that a provider is in disagreement about the encounter values, the provider may request a meeting to review the encounters through their Network Relations Consultants.

AHCCCS requires periodic encounter reporting throughout the fiscal year to ensure encounter requirements are being met by providers. AHCCCS uses the percentages in the table below as a benchmark for encounter completion. The objective is to ensure a steady inflow of submitted encounters.

MINIMUM PERCENTAGE OF ENCOUNTERS TABLE (AHCCCS Fiscal Year)

QTR 1 (Oct – Dec)	QTR 2 (Oct –Mar)	QTR 3 (Oct – June)	QTR 4 (Oct – Sept)	Final (Oct – Mar)
35%	65%	75%	85%	100%

Mercy Care may request, on a quarterly basis, explanations regarding provider over- or under-encountering.

Interim Block Adjustments

- **Timing:** Mercy Care will regularly monitor and review provider encounter levels and make adjustments prospectively, based on the providers encounter values against funding.
- **Notice:** Prior to the imposition of prospective adjustments, Mercy Care will make every effort to notify the provider of the decision, explain the basis for the decision, and outline what the provider must do to have the adjustments rescinded.
- **Withhold of Funds:** The application of these prospective interim block adjustments will continue until the provider has met the criteria established and communicated during the notice period. During the period in which a provider is having adjustments applied to his/her monthly block funding payments, further adjustments (upward or downward) can be applied based on the provider's progress in encounter values.

Review and Recoupment Process

- **Timing:** Formal reviews of the encounter values against funding will be performed in the months of November (interim) and May (final) of each year. The interim review in November will cover the months of service, October-March of the preceding year (allowing for 180 days of run-out for the period). The final review in May will cover all months in the preceding contract year (allowing for 180 days of run-out for the period).
- **Notice:** Providers will be notified of recoupment decisions. A meeting with the provider will be requested and setup through the Network Relations Consultants.
- **Withhold of Funds:** Mercy Care's standard policy is for providers to refund unencountered block funding at the end of the contract year. Block funding deductions will also be considered. Providers will have the ability to earn back any recoupment related to the interim review and recoupment process, based on their final encounter value for the fiscal year. The amount earned back, however, will not exceed the amount contracted for the respective fiscal year, will be subject to the 4% profit limitation, and is subject to funding availability.
- **Recoupments:** Block funding recoupments will be determined in the following manner:
    - Title 19 and Title 21 Funding: Title 19 (T-19) and Title 21 (T-21) funding must be encountered at 100%, and the encountered percentage will be determined and recouped by T-19 Child funding and T-19 Adult funding. Quarterly adjustments may be made to T-19/21 funding based on encounter percentages.
    - Non Titled Funding: Non Titled (NT) funding must be encountered at 100%. Quarterly adjustments may be made to NT funding based on encounter percentages. Crisis Funding: Crisis funding must be encountered at 85%. Quarterly adjustments may be made to T-19/21 funding based on encounter percentages. Quarterly adjustments may be made to crisis funding based on encounter percentages. SABG and MHBG Funding: SABG and MHBG funding

must be encountered at 85% Quarterly adjustments may be made to SABG or MHBG funding based on encounter percentages..

- **Recoupments:** FFS recoupments will be determined as needed and will be processed according to claims processing guidelines.

Timely Filing Extensions

Requests for timely filing extensions must be submitted in writing (or email) and be directed to their Provider Relations Consultant. These requests must outline the period(s) for which the extension is being requested, causal issues, a list of the RBHA staff that the provider has been working with to resolve the issue, and the anticipated date the issue is to resolve. Mercy Care will consider, review, and communicate a decision on the request within 30 days.

FEE SCHEDULE AND FUNDING REQUESTS

Fee Schedule Change Requests

Fee Schedule change requests can be submitted by providers to coincide with financial reporting submissions. The following documents are required for requests to be considered:

1. Production or utilization data, (see Attachment K - Fee Schedule Exception Template) for the top 80% of provider's services in excel format.
2. Written description of the programmatic differences or practices that necessitate the need for higher reimbursement, specifically medical justification.
3. Cost build-up information for the service code.

Request for fee schedule increases should be submitted to the organization's Network Relations Consultant.

Funding Requests

Funding requests will only be considered during the following time-frames. All funding requests will be reviewed by Mercy Care during Quarter 4 of the Contracting Year. Providers will be notified of the final decision.

Contracting Year	LOB/Funding	Proposal Acceptance Dates	Proposal Due by
July 1 – June 30	NTXIX, SABG, MHBG	Q3 = Jan-March	March 31
Oct 1 – Sept 30	All MC / RBHA TXIX	Q3 = April - June	June 30

It is the provider's responsibility to manage their block funding and the services provided accordingly. In order for funding requests to be submitted and considered by Mercy Care, a

provider must provide a letter, including the following information, and meet the following general criteria:

1. Projected loss of 2% or greater;
2. Over encounter of 10% or greater;
3. Detailed cost justification by major line item of the Statement of Activities (SOA).
4. Clinical and financial justification.

Request for additional funding should be submitted to the organization's Provider Representative.

INTERPRETIVE SERVICES

The following codes are to be used for Interpretive Services as defined by the Mercy Care Provider Manual (4.25 - Cultural Competency and Health Literacy):

MCPC'S Code	Modifier	Description
T1013		Staff delivering services is also interpreting.
T1013	Q6	Separate but employed staff is interpreting.
T1013	CR	External vendor used.

Billed rates and supporting documentation are subject to periodic review.

For services provided by external vendors providers are to show all expenses associated on the Interpretive Services line of the Statement of Activities (SOA).

SANCTION PROCEDURES

Financial Reporting Sanctions

Mercy Care has the right to impose sanctions or financial penalties on providers for failure to perform their contractual obligations. Failure of a provider to submit accurate, complete, and timely financial reports in accordance with Mercy Care's Provider Financial Reporting Guide may result in one or more sanctions listed in the contract. It is the policy of Mercy Care and AHCCCS/DDD to sanction in the full amount if reports are not accurate, complete, and received by the due date. It is the responsibility of providers to comply with these requirements.

Mercy Care will send a General Provider Communication email within three (3) business days following the last day of the current quarter indicating that financials are due within the next 30 days. Mercy Care will also send a General Provider Communication email announcing changes and updates to the Provider Financial Reporting Guide. Changes to the Provider Financial Reporting Guide will be in effect for the current reporting period. Updates, resubmissions, prior

period adjustments, or financials not yet submitted will be subject to the new reporting requirements.

Extensions may be granted, and must be requested using Mercy Care's extension request form (Attachment H). Requests for extensions of two (2) weeks or less should be sent via e-mail to Mercy Care's Finance email: Finance@MercyCareAZ.org. Requests for extensions greater than two (2) weeks require detailed justification. All requests for extensions must be received at least five (5) business days prior to Mercy Care's filing date and must include the reason for the extension and the revised filing date. Requests for filing extensions will be reviewed and considered on a case-by-case basis.

If providers do not meet the minimum financial reporting requirements or do not submit by the filing date:

- Mercy Care will notify the provider via postal service and/or e-mail that the provider is not in compliance with the financial reporting guidelines. The communication will include a list of those items that are not in compliance and/or are missing.
- In the interim Mercy Care will deny and/or put on hold all finance related requests until the provider becomes compliant.
- Subsequently, Mercy Care may issue a Notice-to-Cure letter indicating financial sanctions of $500 per day, not to exceed 50% of their monthly contract.
- Mercy Care will apply sanctions on the 10th business day from the date of the Sanction letter and place a hold on all payments until the provider becomes compliant.
- Sanctions cannot offset profit and will be excluded from the 4% profit limitation outlined in provider contracts.

No extensions will be granted after the due date has passed. Sanctions are non-negotiable and will be taken against future Block or Fee-for-Service payments.

It is the provider's responsibility to ensure their financial reporting has reached Mercy Care. The preferred delivery method is to submit financials to Mercy Care's Finance email address at Finance@MercyCareAZ.org. The SFTP method is also acceptable.

CONTRACTUAL NON-PERFORMANCE SANCTIONS

Mercy Care may impose financial sanctions to providers for contractual non-performance. A sanction for non-performance may be passed down from any governing agency including but not limited to AHCCCS, DDD, CMS, or Mercy Care. Unless explicitly stated otherwise in Mercy Care's Provider Participation Agreement or document incorporated by reference, as applicable, AHCCCS or DDD or Mercy Care, at its sole discretion, may consider the following factors when imposing financial sanctions:

- Substantial failure to provide required medically necessary covered services to an individual under this Agreement;
- Imposition of charges on enrollees that are in excess of the charges permitted under the Medicaid program;

- Discrimination toward enrollees on the basis of their health status or need for health care services;
- Misrepresentation or falsification of information furnished to AHCCCS , DDD or Mercy Care;
- Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, sub-provider, or health care provider;
- Failure to comply with the requirements for physician incentive plans, in accordance with 42 CFR §§ 422.438(6)(h) and 422.210, which prohibit such plans from directly or indirectly making payments to a physician or group as an inducement to limit or refuse medically necessary services to an enrollee;
- Direct or indirect distribution of marketing materials without prior AHCCCS/DDD approval or that contain false or materially misleading information;
- Violation of any of the other applicable requirements of sections 1903(m) or 1932 of the SSA and any implementing regulations;
- Non-compliance with requirement of the Agreement that has a negative effect on the service delivery system or that causes potential harm or results in actual harm to an enrollee;
- Non-compliance with any Agreement term may result in a financial sanction.

For providers receiving a sanction for a non-performance failure:

- Mercy Care will notify the provider via postal service and/or e-mail that the provider is being sanctioned for non-performance failure, the amount of the sanction, and the due date of the sanction.
- In the interim Mercy Care will deny and/or put on hold all finance related requests until the provider becomes compliant.
- Sanctions are non-negotiable and may be taken against future Block or Fee-for-Service payments.
- Sanctions cannot offset profit and will be excluded from the 4% profit limitation outlined in provider contracts.

LINKS

Mercy Care Website:
https://www.mercycareaz.org/
Mercy Care Financial Reporting Guide and Attachments:
http://www.mercyCare.org/providers/resources/reference_materials_and_guides
AHCCCS Financial Reporting Guide:
https://www.azahcccs.gov/Resources/Contractor/Manuals/financialReporting.html
-Department of Developmental Disabilities Policy Manuals
https://des.az.gov/services/disabilities/developmental-disabilities/policies-and-rules/policies
OMB Circular A-133 Audit:
http://www.whitehouse.gov/omb/circulars/
Cost principles for non-profit organizations (OMB Circular A-122):
https://www.whitehouse.gov/omb/circulars
SABG and MHBG FAQs:
https://www.azahcccs.gov/Resources/Downloads/Grants/FrequentlyAskedQuestions.pdf
Arizona Conflict of Interest Statutes:
http://azleg.gov/ars/35/00705.htm
http://www.azleg.gov/ars/38/00503.htm
Social Security Administration section 1903:
http://www.ssa.gov/OP_Home/ssact/title19/1903.htm
Social Security Administration section 1932:
http://www.ssa.gov/OP_Home/ssact/title19/1932.htm
Statement of Financial Accounting Standard (SFAS) 117:
http://www.fasb.org/summary/stsum117.shtml
45 Code of Federal Regulations part 96:
http://www.gpo.gov/fdsys/granule/CFR-2005-title45-vol1/CFR-2005-title45-vol1-part96
31 Code of Federal Regulations part 205:
https://www.fms.treas.gov/fedreg/31cfr205final.pdf
Cash Management Improvement Act of 1990:
https://www.fms.treas.gov/cmia/statute.html
42 Code of Federal Regulations 422.210:
§422.210 Assurances to CMS.
Chapter 15 of the Medicare Benefit Policy Manual:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
A.R.S. 35-190:
http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/35/00190.htm&Title=35&DocType=ARS
A.R.S. 35-705:
http://azleg.gov/ars/35/00705.htm

A.R.S. 35-503:
https://www.azleg.gov/viewDocument/?docName=http://www.azleg.gov/ars/35/00503.htm
Children's Health Act of 2000 (Public Law 106-310):
http://www.gpo.gov/fdsys/pkg/PLAW-106publ310/content-detail.html

LIST OF ATTACHMENTS

Attachment	Title
Attachment A	QUARTERLY CERTIFICATION STATEMENT FOR THE QUARTER ENDED XXX XX, 20XX
Attachment B	STATEMENT OF FINANCIAL POSITION
Attachment C	MERCY CARE DISCLOSURES STATEMENT
Attachment D	MERCY CARE STATEMENT OF ACTIVITIES
Attachment E	STATEMENT OF CASH FLOWS
Attachment F	FINANCIAL RATIO ANALYSIS COMPARISON
Attachment G	CONFLICT OF INTEREST (COI) DISCLOSURE
Attachment H	AGENCY COST ALLOCATION PLAN
Attachment I	PROVIDER FINANCIAL REPORTING REQUEST FOR EXTENSION
Attachment J	SABG and MHBG Funding and Expenses
Attachment K	Fee Schedule Exception Template

FAQs

Q: What if I need an extension for any of my required financial reporting?
A: (Mercy Care FRG pg. 20). Fill out Attachment I, making sure to enter the extension date being requested and the reason for the delay. Extension requests must be made prior to the actual due date of the reporting. Send request to Finance@MercyCareAZ.org.

Q: What format is best for submitting unaudited financials (extension requests, SABG/MHBG Distribution Reporting, etc.)?
A: The Mercy Care Provider Financial Reporting Guide Attachments (Attachments A-L) used for financial submissions and other requests are located here:
http://www.mercyCare.org/providers/resources/reference_materials_and_guides

Q: What sanctions may be incurred if financial reporting requirements are not met?
A: (Mercy Care FRG pp. 28-30). Financial sanctions of $500 per day, not to exceed 50% of their monthly contract may be incurred. Sanctions cannot offset profit and will be excluded from the 4% profit limitation outlined in provider contracts.

Q: Where can an accountant go to get questions answered for an audit?
A: Mail a copy of the request to:

Mercy Care
Attention: Finance Department
P.O. Box 90640
Phoenix, AZ 85066

An email copy should also be sent to:
Finance@MercyCareAZ.org

Q: How do I determine the funding source from the ach payment we received?
A: At the bottom of a provider's most recent compensation exhibit, payments are broken out by funding source. If the funding changes, either permanently or for temporary adjustments, a new compensation exhibit will be sent.

Q: What if we have a question that's not answered in the FRG?
A: Send all questions and requests to Finance@MercyCareAZ.org.

Q: What are the due dates for the financial reporting?
A: Below are the due dates for the financial reporting due to Mercy Care by provider funding amount. Please note that all reports may not be required by all providers, and that other reporting may be requested on an ad-hoc basis:

Reporting Type	Reporting Period	Due to Mercy Care	Funding Less than 250,000	Funding Between 250,000-499,999	Funding Greater than 500,000	Funding Greater than 750,000
Q1 Year to date	10/01/20yy-12/31/20yy	01/31/20yy	No	Unaudited Attachments A-H	Unaudited Attachments A-H	Unaudited Attachments A-H
Q2 Year to date	10/01/20yy-03/31/20yy	04/30/20yy	No	Unaudited Attachments A-H	Unaudited Attachments A-H	Unaudited Attachments A-H
Q3 Year to date	10/01/20yy-06/30/20yy	07/31/20yy	No	Unaudited Attachments A-H	Unaudited Attachments A-H	Unaudited Attachments A-H
Q4 Year to date	10/01/20yy-09/30/20yy	10/31/20yy	Unaudited Attachments A-H	Unaudited Attachments A-H	Unaudited Attachments A-H	Unaudited Attachments A-H
Audited Financials	Provider Fiscal Year	04/30/20YY	No	No	Yes	Yes
A-133 Audit	Provider Fiscal Year	04/30/20YY	No	No	No	SABG/MHBG >$750,000
State Only Funding	07/01/20yy-06/30/20yy	03/30/20yy	Yes	Yes	Yes	Yes

Q1 SABG/MHBG Report	07/01/20yy-09/30/20yy	10/31/20yy	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount
Q2 SABG/MHBG Report	07/01/20yy-12/31/20yy	01/31/20yy	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount
Q3 SABG/MHBG Report	07/01/20yy-03/31/20yy	04/30/20yy	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount
Q4 SABG/MHBG Report	07/01/20yy-06/30/20yy	07/31/20yy	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount	Any SABG / MHBG $ Amount
Unexpended Non Title State Only Funding	07/01/20yy-06/30/20yy	06/30/20yy	Any Unexpended State Only Funds	Any Unexpended State Only Funds	Any Unexpended State Only Funds	Any Unexpended State Only Funds
Unexpended SABG/MHBG Funding	07/01/20yy-06/30/20yy	06/30/20yy	Any Unexpended SABG/MHBG Funds	Any Unexpended SABG/MHBG Funds	Any Unexpended SABG/MHBG Funds	Any Unexpended SABG/MHBG Funds