# Solvency Standards Recommendations After the Implementation of Tailored Plans

## Session Law 2022-74 s. 9D.13(b)

**Report to**

**Joint Legislative Oversight Committee on Medicaid**

**Joint Legislative Oversight Committee on Health and Human Services**

**and**

**Fiscal Research Division**

**By**

**North Carolina Department of Health and Human Services**

**May 18, 2023**

## LEGISLATIVE REPORT REQUIREMENT IN S.L. 2022-74

Session law 2022-74 directed the NC Department of Health and Human Services (DHHS) to provide recommendations on solvency standards after BH IDD Tailored Plans (Tailored Plan) begin as follows:

> **SECTION 9D.13.(b)** Until December 31, 2023, G.S. 122C-124.2(b)(1) and G.S. 122C-125.2 shall not apply to any local management entity/managed care organization (LME/MCO) under a Tailored Plan contract with the Department of Health and Human Services (DHHS). For this period of time, any solvency and capital reserve requirements for an LME/MCO shall be set by DHHS in its tailored plan contract. No later than March 1, 2023, DHHS shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division that contains detailed recommendations on solvency standards applicable to all LME/MCOs post-implementation of the Tailored Plans, including any legislative changes to G.S. 108D-124.2 and G.S. 122C-125.2.[1]

## BACKGROUND

DHHS will begin Tailored Plans on October 1, 2023. On April 1, 2023, DHHS began an additional LME/MCO operated behavioral health plan contract – Medicaid Direct Prepaid Inpatient Health Plan (MDPIHP).[2] MDPIHP was not finalized at the time SL 2022-74 was being considered and will require similar contractual solvency standards. As a result, this report will address solvency standards that DHHS proposes to apply to both Tailored Plan and MDPIHP contracts.

## RECOMMENDATIONS

### Contract Based Solvency Standards

DHHS believes the updated solvency standards are best governed by contract rather than statute to provide flexibility as the implementation of Tailored Plans and MDPIHPs progresses. Having the controlling standards in contract rather than statute enables DHHS, as the contract owner and primary oversight entity, to adjust solvency standards as needed as the State's behavioral health climate evolves, and as federal regulations change, potentially making standards obsolete. It is nimbler to amend contractual solvency standards than statutory standards.

This flexibility may be crucial, for example, if Tailored Plans become licensed under Chapter 58 or as new contracts under varying CMS authorities, such as the new MDPIHP contract, are developed. Therefore DHHS recommends permanently repealing G.S. 122C-125.2 and adjusting G.S.122-124.2(b)(1) to reference contractual, rather than statutory solvency measures and any associated required corrective action plans.

---

1 This report assumes that the reference to" G.S. 108D-124.2" in the last sentence of the legislation above is an error and was meant to read "G.S. 122C-124.2" to correspond to the first sentence of section 9D.13.(b) of S.L. 2022-74. Chapter 108D of the General Statutes does not contain a section-124.2.

2 This is a capitated arrangement authorized by G.S. 108D-60(b).

Each of the contracts establish analogous solvency requirements, monitoring plans, corrective action plans and require adherence to industry standard financial accounting measures, all of which are discussed in the body of this report.

**Industry-Standard Financial Accounting Measures**
DHHS proposes to use standardized review and analysis of monthly financial statements submitted by the Tailored Plans and MDPIHPs. This recommendation is consistent with the respective contracts and the "BH I/DD Tailored/Medicaid Direct Health Plan Financial Reporting Template" to monitor the financial health of each plan and LME/MCO.

To this end, in place of the quarterly reports that had been required by G.S. 122C-125.2, beginning on October 1, 2023, DHHS will use the data derived from monthly financial statements and contractually required financial reporting deliverables to produce quarterly web-based dashboards of each MDPIHP's adherence to the established solvency standards. DHHS similarly will produce these web-based dashboards for the Tailored Plans beginning on April 1, 2024.

These dashboards will consist of the following industry-standard financial accounting measures:

- Current Ratio (Ratio of Current Assets to Liabilities)
- Defensive Interval Ratio (Ratio of Current Assets to Average Monthly Expenditure)
- Capital Reserves (Capital Reserves are defined as unobligated assets net of liabilities)
- Profit/Loss, as reported on the Income Statement

**Contractual Reporting Requirements**
Each Tailored Plan/MDPIHP (Plan) is required contractually to supply NC Medicaid with monthly financial reports that contain the data needed to calculate the financial accounting measures listed above. DHHS will make the measures available publicly on web-based dashboards. In any instance where a Plan does not meet the contractual solvency standards, DHSS will develop, in collaboration with the Plan, a Corrective Action Plan (CAP).

**Details of Contractual Solvency Reporting Requirements**
The details of the contractual solvency standards that Plan must meet on a regular, ongoing basis, are as follows:

**Current Ratio:** Each Tailored Plan/MDPIHP shall maintain a Current Ratio above 1.0, as determined from the monthly, quarterly and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. Current Assets include any short-term investments that can be converted to cash within five (5) Business Days without significant penalty. A significant penalty is a penalty greater than twenty percent (20%).

If a Tailored Plan/MDPIHP's Current Ratio falls below 1.0 at any point in time, the Plan must submit a report to DHHS that describes the reason for the decline, proposed corrective action to increase the ratio and projections of the impact of the corrective actions.

**Defensive Interval Ratio:** The Tailored Plan/MDPIHP shall maintain a Defensive Interval Ratio above thirty (30) Calendar Days as determined from the monthly, quarterly, and annual financial

reporting schedules. The Defensive Interval is defined as Cash plus Cash Equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the Period Measured in Days. If a Tailored Plan/MDPIHP's Defense Interval Ratio falls below 30 days at any point in time, the Tailored Plan/MDPIHP must submit a report to DHHS that describes the reason for the decline, proposed corrective action to increase the ratio and projections of the impact of the corrective actions.

**Capital Reserves:** The Tailored Plan/MDPIHP must, by day 1 of Tailored Plan/MDPIHP launch, fully fund Tailored Plan/MDPIHP capital reserves at twelve and a half percent (12.5%) of total expected annual Tailored Plan/MDPIHP Medicaid capitation.

If a Tailored Plan/MDPIHP fails to meet the Medicaid twelve and a half percent (12.5%) reserves requirement by day 1 of Tailored Plan/MDPIHP launch, the Tailored Plan/MDPIHP must submit a viable plan outlining how the Tailored Plan/MDPIHP will meet these requirements by the end of Contract Year 2, for approval at the discretion of DHHS.

For a Tailored Plan/MDPIHP to be considered viable, the Tailored Plan/MDPIHP must document capital reserves of at least 9.0% of total expected annual Tailored Plan/MDPIHP Medicaid Capitation by day 1 of Tailored Plan/MDPIHP launch.

If a Tailored Plan/MDPIHP's capital reserves fall below 9.0% of total expected annual Tailored Plan/MDPIHP Medicaid Capitation in any quarterly statement, the Tailored Plan/MDPIHP must submit a report to DHHS that describes the reason for the decline in capital reserves, proposed corrective action to increase capital reserves and projections of the impact of the corrective actions on the capital reserve levels.

If a Tailored Plan/MDPIHP's capital reserves fall below 6.25% of total expected annual Tailored Plan/MDPIHP Medicaid Capitation in any quarterly statement, the Tailored Plan/MDPIHP must submit a report to DHHS for Department review. DHHS reserves the right to stipulate required corrective action for the Tailored Plan/MDPIHP.

If a Tailored Plan/MDPIHP's capital reserves fall below 4.0% of total expected annual Tailored Plan/MDPIHP Medicaid Capitation in any quarterly statement, DHHS reserves the right to place the Tailored Plan/MDPIHP Plan under the control of the regulator or initiate further actions.

**In addition to meeting the above solvency standards, each Plan must report its Profit/Loss, as follows:**

**Profit/Loss:** Profit or Loss for the Tailored Plan/MDPIHP will be reported in the quarterly executive summary. This operating statement will help determine the current financial position of the Tailored Plan/MDPIHP. The Profit or Loss is defined as Total Revenues minus Total Expenses & Risk Reserve Set-Aside minus Total Non-Operating Expenses. This measure is used as an additional tool that provides insight into a Plan's financial health, but there is no requirement for a Plan to operate with a profit or specific level of profit. Since there is no specific target for each Plan to meet on this measure, there will be no required corrective action associated with a Plan's quarterly profit or loss.

## CORRECTIVE ACTION PLAN (CAP)

In the event that a Tailored Plan/MDPIHP does not meet the solvency standards discussed above for a given monthly reporting period, DHHS shall work with the Plan to create a CAP, through the following process:

**Step 1:** DHHS notifies Plan of non-compliance with contractual solvency measures and discusses options for corrective action.

**Step 2**: Plan submits proposed CAP to DHHS.

**Step 3**: DHHS either accepts the CAP or works with the Plan to reach an acceptable CAP, and then establishes a schedule for reviewing the Tailored Plan/MDPIHP's progress on the CAP.

**Step 4:** When the Plan completes its corrective action to the satisfaction of DHHS (i.e., when the Plan is once again compliant with the contractual solvency measures), DHHS sends a letter to the Plan officially closing the review.

## ADDITIONAL RECOMMENDATIONS

DHHS recommends suspending the Secretary's certification required by G.S. 122C-124.2(b)(1) to allow time for twelve months of financial data on the services under each contract to be collected. The underlying audits for the certification require a full year of data for evaluation before they can be performed.

DHHS also recommends removal of the requirement that the Secretary's certification be included in the External Quality Review contract. The elements of the certification do not align with the core items required for the External Quality Review. DHB needs flexibility to contract directly with vendors that have expertise to complete this certification rather than relying on the External Qualify Review contractor to subcontract with an entity that has the appropriate expertise.

Finally, DHHS recommends amending the title of G.S. 122C-124.2 to reflect the fact that the CMS authorities under with behavioral health services are delivered has changed over time. As a conforming change, the definition of "Contract" in G.S. 122C-124.2 should be amended to include the additional types of contracts that an LME/MCO could have with DHHS and for which DHHS may take action to ensure effective management of behavioral health services under Medicaid.

**PROPOSALS TO AMEND LEGISLATION**

**Section xx.(a).** G.S. 124.2 reads as rewritten:

**"§ 122C-124.2. Actions by the Secretary to ensure effective management of behavioral health services under ~~the 1915(b)/(c)~~ Medicaid ~~Waiver~~.**

(a) For all local management entity/managed care organizations, the Secretary shall certify whether the LME/MCO is in compliance or is not in compliance with all requirements of subdivisions (1) through (3) of subsection (b) of this section. The Secretary's certification shall be made every six months beginning August 1, 2013. In order to ensure accurate evaluation of administrative, operational, actuarial and financial components, and overall performance of the LME/MCO, the Secretary's certification shall be based upon an internal and external assessment made by an independent external review agency in accordance with applicable federal and State laws and regulations. ~~Beginning on February 1, 2014, and for all subsequent assessments for certification, the independent review will be made by an External Quality Review Organization approved by the Centers for Medicare and Medicaid Services and in accordance with applicable federal and State laws and regulations.…~~

(b) The Secretary's certification under subsection (a) of this section shall be in writing and signed by the Secretary and shall contain a clear and unequivocal statement that the Secretary has determined the local management entity/managed care organization to be in compliance with all of the following requirements:

(1) The LME/MCO has made adequate provision against the risk of insolvency and either (i) is not required to be under a corrective action plan in in accordance with ~~G.S. 122C-125.2~~ its Contracts or (ii) is in compliance with a corrective action plan required under ~~G.S. 122C-125.2~~ its Contracts.

…

(g) As used in this section, the following terms mean:

(2) Contract. – The contract between the Department of Health and Human Services and a local 221management entity for the operation of the 1915(b)/(c) Medicaid Waiver, the BH IDD Tailored Plan or the contract pursuant to G.S. 108D-60(b)."

**Section xx.(b).** The Secretary's certification required by G.S. 122C-124.2(b)(1) is suspended for twelve months from the date Tailored Plans or the contract authorized by G.S. 108D-60(b) begin, whichever is later.

**Section xx.(c).** G.S. 122C-125.2 is repealed in its entirety.