Joint Legislative Oversight Committee On Health and Human Services

Discussion of Cash Balance versus Fund Balance

Steve Owen
Fiscal Research Division

September 27, 2016

Discussion Guide

- Background and Impact of Section 12F.2 of the 2015 Appropriations Act - single stream funding reduction
- Cash Balance and Fund Balance Defined
- Financial Statement Basics
- Current Financial Position
- Key Questions
- Summary

Framing the Discussion

- Section 12F.2 of the 2015 Appropriations Act reduced single stream funding for 2 years, non-recurring. The discussion to reduce funding stemmed from questions over cash balances accumulated by the LME/MCOs.

- The terms "cash balance" and "fund balance" have been incorrectly used interchangeably and have often diverted discussions from critical policy decisions to confusion over accounting theory.

- This presentation is intended to clarify and provide factual information on cash and fund balances in an attempt to shift the discussion from accounting theory to behavioral health program policy. Some key takeaways are:
  - *Neither cash balance or fund balance alone will provide a complete financial picture of an LME/MCO.*
  - *Two of the underlying policy issues that are at the core of the financial discussion.*
    - *Without defined solvency standards it is impossible to assess the sufficiency or excessiveness of either the cash balance or fund balance. (See Attachment "B" for a discussion of solvency.)*
    - *Without a published comprehensive plan based on a determination of needs that defines the State's goals and objectives for a behavioral health system, it is difficult to objectively assess the LME/MCOs performance in terms of outcomes and the appropriateness or adequacy of their reinvestment plans and commitments on fund balance.*
  - *Changes to provisions, statutes and regulations over the years that have been applied to LMEs and LME/MCOs have been more additive than reformative*.

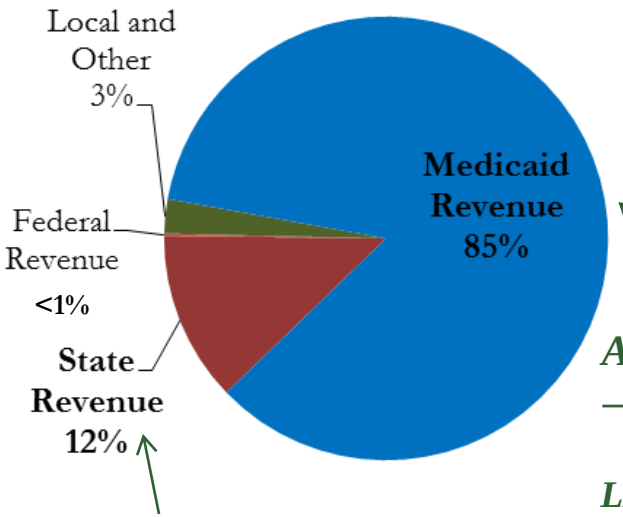
- Section 12F.10 of the 2016 Appropriations Act was written to refocus the policy discussion to a state-wide plan based on current behavioral health needs, with outcome measures and solvency standards.

Background

- LME/MCOs are local governmental entities that are contracted to manage the State's funding for behavioral health services.
- Total number has decreased from 42 LMEs to the current 7 LME/MCOs covering the entire state as of September 2016.
- Core services funded with State appropriations are defined in G.S. 122C-2 in addition to contracts with DMH/DD/SAS and DMA

FY 2015-16 Total Requirements paid to LME/MCO over $3 billion

Sources of LME/MCO Total Budget:

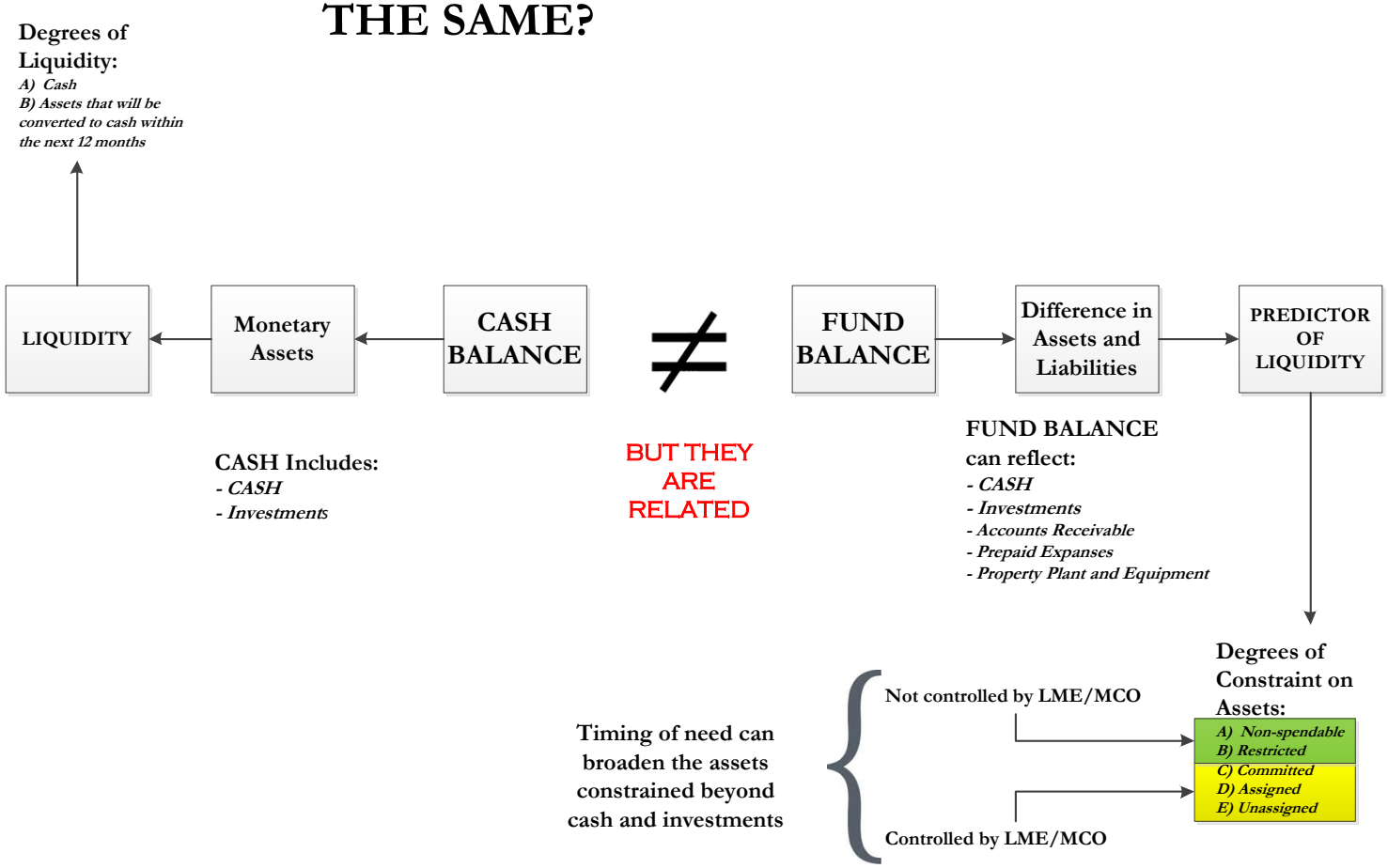


34% State Appropriations – Fully capitated contract: LME/MCO bears risk for utilization and State retains risk for enrollment

100% State Appropriations – State allots funds for the uninsured population

Cash Balance and Fund Balance Defined

ARE CASH BALANCE AND FUND BALANCE THE SAME?



Financial Statement Basics

- Basic Statements
- Balance Sheet
- Balance Sheet and Income Statement
- Presents the financial position of an entity at a point in time; comprised of ***Assets, Liabilities and Fund Balance***
- Income Statement
- Presents the results of operations for an accounting period; comprised of ***Revenues, Expenditures and Net Profit or Loss***

Current LME/MCO Financial Position
Balance Sheet at August 31, 2016

ASSETS		LIABILITIES AND FUND BALANCE	
Cash and Investments	$ 513,525,232	Accounts Payable and Accrued Liabilities	$ 47,923,131
Short Term Restricted Cash	285,085,717	Claims Liability	137,530,991
Accounts Receivable	66,648,030	Other Current Liabilities	13,527,217
Prepaids	31,982,506		
Total Current Assets	$ 897,241,486	Total Current Liabilities	$ 198,981,339
Restricted Cash and Investments	202,551,553	Long Term Liabilities	18,380,579
Net Capital Assets	53,689,397	FUND BALANCE	
Other Assets	45,374,967	Non-Spendable	20,278,937
		Restricted	262,170,972
		Commited	281,442,268
		Assigned	12,833,608
		Unassigned	404,769,700
TOTAL ASSETS	$ 1,198,857,403	TOTAL LIABILITIES AND FUND BALA	$ 1,198,857,402

Current assets are those items that are expected to be converted to cash within the next 12 months

Current liabilities are those items that are expected to require cash within the next 12 months

The statements above are prepared on an accrual basis using Generally Accepted Accounting Principles (GAAP) and submitted to the Division of Medical Assistance every month. Annually the LME/MCOs are also required to prepare a set of financial statements on a "modified accrual" basis

SOURCE: August 2016 Financial statements submitted by LME/MCOs and audited financials.

Current LME/MCO Financial Position
Cash Balance compared to Fund Balance

LME/MCO FINANCIAL INFORMATION AND COMPARISONS

	2013 Audit	*2014 Audit*	*2015 Audit*	*2016 Reported*	*August 2016*
Cumulative LME/MCO Short Term Cash	$ 357,258,577	$ 566,351,622	$ 761,426,460	$ 835,845,912	$ 798,610,949
Cumulative LME/MCO Restricted and Long Term Cash	42,990,679	89,212,980	138,123,679	194,413,862	202,551,553
TOTAL CASH BALANCES	$ 400,249,256	$ 655,564,602	$ 899,550,139	$ 1,030,259,774	$ 1,001,162,503*

CASH BALANCE DOES NOT EQUAL FUND BALANCE

Restricted by Legislative Action	$ 42,990,679	$ 89,212,980	$ 138,123,677	$ 187,488,350	$ 195,612,774
Other Restricted Fund Balance	40,705,202	56,571,199	76,986,836	66,098,851	66,558,197
Committed or Assigned by LME/MCO	78,437,453	97,496,048	265,583,239	300,364,452	294,275,876
GASB54 Non-Spendable	8,108,526	5,964,096	11,708,136	23,657,869	20,278,937
UNASSIGNED FUND BALANCE	143,172,136	284,975,601	355,018,627	392,957,249	404,769,701
Cumulative LME/MCO Fund Balance	$ 313,413,996	$ 534,219,924	$ 847,420,515	$ 970,566,772	$ 981,495,484

Not controlled by LME/MCOs

NOTE: LME/MCO cash in August is $36 million lower than expected because single stream payments for July and August were not made until later in September.

*** - Cash balances include short and long term cash and investments as well as Medicaid Risk Reserve**

SOURCE: August 2016 Financial statements submitted by LME/MCOs and audited financials.

Current LME/MCO Financial Position and Trends
for Cash, Profit(Loss) and Fund Balance by LME/MCO

	Alliance	Cardinal	Trillium	Partners	Sand Hills	Smoky	Eastpointe	TOTAL
Cash and Investments	$ 109,328,884	$ 179,989,599	$ 103,297,070	$ 105,699,581	$ 133,507,077	$ 87,884,978	$ 78,903,760	$ 798,610,949
Medicaid Risk Reserve and LT Inv	27,549,236	57,249,523	32,997,093	19,071,281	19,860,264	25,910,841	19,913,315	202,551,553
Total Cash and Investments	$ 136,878,120	$ 237,239,122	$ 136,294,163	$ 124,770,862	$ 153,367,341	$ 113,795,820	$ 98,817,075	$ 1,001,162,503
Total Fund Balance	$ 122,081,825	$ 223,779,481	$ 135,329,169	$ 121,389,730	$ 148,438,196	$ 104,908,365	$ 125,568,718	$ 981,495,484
Committed/Assigned FB included :	$ 12,281,818	$ 15,333,608	$ 59,997,235	$ 80,122,061	$ 7,500,000	$ 61,628,152	$ 57,413,001	$ 294,275,876
YTD Profit/Loss 2017	$ 16,119,956	$ 1,906,968	$ (4,402,535)	$ (401,724)	$ (4,579,295)	$ 1,896,529	$ (1,004,796)	$ 9,535,102
Profit/Loss 2016	$ 9,197,697	$ 27,245,094	$ (4,945,795)	$ 7,891,362	$ 2,164,647	$ (2,096,381)	$ 15,975,766	$ 55,432,390
Audited Profit/Loss 2015	$ 62,440,479	$ 45,148,839	$ 31,686,930	$ 44,910,278	$ 73,747,815	$ 22,487,236	$ 22,158,810	$ 325,072,635
Audited Profit/Loss 2014	$ 10,381,282	$ 5,229,350	$ 32,157,870	$ 29,226,119	$ 50,721,821	$ 19,644,078	$ 18,552,890	$ 181,381,896
Audited Profit/Loss 2013	$ 10,585,321	$ 7,167,930	$ 27,454,007	$ 7,312,252	$ 9,943,565	$ 5,911,053	$ (126,924)	$ 70,548,283
YTD Profit/Loss 2017	19.7%	1.4%	-7.0%	-0.8%	-9.6%	3.1%	-2.0%	1.9%
Profit/Loss 2016	1.9%	3.2%	-1.4%	2.5%	0.7%	-0.5%	5.1%	1.8%
Audited Profit/Loss 2015	12.7%	6.7%	7.9%	13.8%	21.3%	6.0%	7.2%	10.5%
Audited Profit/Loss 2014	2.4%	1.2%	8.4%	9.4%	15.1%	6.4%	6.0%	6.8%
Audited Profit/Loss 2013	4.8%	2.0%	9.1%	4.4%	6.5%	3.8%	-0.1%	4.3%
Total Cash Reported 2016	$ 143,610,742	$ 253,478,574	$ 141,209,510	$ 127,505,408	$ 152,270,551	$ 118,822,970	$ 93,362,019	$ 1,030,259,774
Total Cash Audit 2015	$ 93,638,253	$ 198,649,578	$ 136,943,669	$ 117,121,120	$ 153,595,416	$ 122,295,569	$ 77,306,534	$ 899,550,139
Total Cash Audit 2014	$ 72,679,828	$ 139,892,537	$ 118,136,161	$ 69,398,254	$ 88,268,304	$ 98,708,872	$ 68,480,646	$ 655,564,602
Total Cash Audit 2013	$ 42,792,351	$ 113,516,382	$ 88,158,670	$ 37,547,719	$ 34,267,418	$ 32,498,318	$ 51,468,398	$ 400,249,256

Legislative actions that impacted results:

$110.8 M reduction in single stream funding;

$17.2 M transfer to Medicaid and

$30 M reinstatement of single stream funding

SOURCE: August 2016 Financial statements submitted by LME/MCOs and audited financials.

Current LME/MCO Financial Position
Cash Available as of August 31, 2016

		TOTAL	
Cash Balances	$	1,001,162,503	
Restricted Cash - Medicaid Risk Reserve		(195,612,774)	Not controlled
Restricted Cash - State Statute		(66,558,197)	by LME/MCO
Net Cash Available to LME/MCO	$	738,991,531	
** Committed Reinvestments		(281,442,268)	All projects
Assigned Reinvestments		(12,833,608)	funded and
			controlled by
Unconstrained Net Cash Available to the LME/MCOs	$	444,715,655	the LME/MCOs

Separating constraints on cash based on the degree of control by the LME/MCO helps focus discussion.

Timing of constraint is another key element in the assessment of which assets are constrained.

This is the point where solvency standards (see Attachment "B") would provide a basis to assess adequacy or excessiveness of cash balances.

***** - This analysis also highlights the question of consistency of the $294 million committed and assigned fund balance by the LME/MCOs with the State's objectives.***

SOURCE: August 2016 Financial statements submitted by LME/MCOs and audited financials.

Other Key Questions

- Should DHHS and/or the General Assembly consider providing clearer guidance regarding LME/MCO cash balances?
- Are reinvestments plans and other constraints on fund balance consistent with the State's goals and objectives?
- Are LME/MCOs allowed to use profits or savings from Medicaid for non-Medicaid purposes?
- What does it mean when an LME/MCO states: "My fund balance is totally committed or restricted"?

Should DHHS and/or the General Assembly consider providing clearer guidance regarding LME/MCO cash balances?

- Cash balances are one indicator of solvency; currently, the only current direct measures of solvency are in the Medicaid contracts.
- If the answer to this question is yes, then the next important question to answer is: ***How?***
- Approaches could include:
  - *Regulations to restrict the level of cash balances.*
  - *Establishment of solvency standards (see Attachment "B") that will create a range of acceptable measures. This could work to set a floor to ensure viability as well as a cap.*
  - *Expansion of the medical expense ratio approach to all services funded with State appropriations that would mandate spending of cash balances on services. This also assumes there are effective oversight and enforcement processes, and oversight and that the Department will required compliance.*
  - *Establishment of quantifiable measures for the LME/MCOs that define the State's expectation for health status and outcomes for behavioral health services.*

Defining what the State's goals are for solvency (see Attachment "B") and assessing all positive and negative impacts on services will be a key part of this decision.

Are reinvestments plans/constraints on fund balance consistent with the State's goals and objectives?

- A single, formal, comprehensive plan for the State's behavioral health services that is based on need and defined outcomes has not been written so it is difficult answering this question, but is a integral component of Section 12F.10 of the 2016 Appropriations Act.

- Contracts with DMH/DD/SAS currently contain a series of performance measures that are largely process measures, e.g., the requirement is that the LME/MCO performance be the statewide average for the previous year, rather than State defined goals for the measures, which is a integral component of Section 12F.10 of the 2016 Appropriations Act.

Are LME/MCOs allowed to use profits or savings from Medicaid for non-Medicaid purposes?

- Yes, per CMS letter (see Attachment "A" for complete letter)

"….. Some States have required in their contracts with MCOs and PHPs that any savings within their capitated payment, minus an allowed profit, if any, be used to provide health services to persons who are not eligible for Medicaid.

We view this practice as an inappropriate subsidy for services for the uninsured. (See section 1903(m)(2)(A)(iii) of the Social Security Act, which states that capitated programs are intended for Medicaid recipients.)

However, we recognize that when a capitated payment is made to an MCO or PHP, that entity is required to meet its contractual obligations to serve Medicaid beneficiaries within the money provided, and that except for limits that may be set on allowed profits (in for-profit entities), the MCO or PHP can use its savings as it wishes. In effect, it is no longer "Medicaid money." In fact, should an MCO or PHP voluntarily choose to serve people who are not Medicaid eligible, it is free to do so. However, we believe it is not appropriate for the State Medicaid agency to require in its contract with an MCO or PHP that savings from capitated payments be used to provide health services to individuals not otherwise eligible for Medicaid. ……."

What does it mean when an LME/MCO states that "My fund balance is totally committed or restricted"?

- The Governmental Accounting Standards Board (GASB) defines how a governmental entity should report its fund balance as either:
  - *Non-Spendable* established by GASB
  - *Restricted by legislation* established by NC General Assembly
  - *Committed* established by formal LME/MCO Board action
  - *Assigned* established by less formal LME/MCO action
  - *Unassigned* remainder of fund balance
- This means that, in addition to restrictions outside their control, the LME/MCO has identified projects or initiatives that they plan to do that consume the remaining fund balance.
- Fund Balance is not Cash Balance.

Some Key Takeaways

- Neither cash balance or fund balance alone will provide a complete financial picture of an LME/MCO.
- Two of the underlying policy issues that are at the core of the financial discussion.
  - *Without defined solvency standards it is impossible to assess the sufficiency or excessiveness of either the cash balance or fund balance.*
  - *Without a published comprehensive plan based on a determination of needs that defines the State's goals and objectives for a behavioral health system, it is difficult to objectively assess the LME/MCOs performance in terms of outcomes and the appropriateness or adequacy of their reinvestment plans and commitments on fund balance.*
- Changes to provisions, statutes, and regulations over the years that have been applied to LMEs and LME/MCOs have been more additive than reformative.

New Focus

- Section 12F.10 of 2016 Appropriations Act calls for a strategic plan to be developed by DHHS and submitted to the General Assembly by January 1, 2018. The plan must:
  - *Identify the DHHS Division with lead responsibility for the organization and delivery of publicly-funded behavioral health services.*
  - *Ensure that all State contracts for behavioral health service contain outcome measures.*
  - *Conduct a state wide needs assessment for behavioral health services.*
  - *Define specific solvency standards to be included in LME/MCO contracts.*
  - *Include any other component DHHS deems necessary to achieve the goal of improving the effective and efficient delivery and coordination of publicly-funded behavioral health services.*

QUESTIONS

Steve Owen – steve.owen@ncleg.net
919-733-4910

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Attachment "A"

June 24, 1998

Dear State Medicaid Director:

A policy concern relating to certain contract requirements on managed care organizations (MCOs) or prepaid health plans (PHPs) has been undergoing Administration review. This is to inform you how we have considered this issue and what decision we have reached.

Some States have required in their contracts with MCOs or PHPs that any savings within their capitated payment, minus an allowed profit, if any, be used to provide health services to persons who are not eligible for Medicaid.

We view this practice as an inappropriate subsidy for services for the uninsured. (See section 1903(m)(2)(A)(iii) of the Social Security Act, which states that capitated programs are intended for Medicaid recipients.)

However, we recognize that when a capitated payment is made to an MCO or a PHP, the entity is required to meet its contractual obligations to serve Medicaid beneficiaries within the money provided, and that except for limits that may be set on allowed profits (in for-profit entities), the MCO or PHP can use its savings as it wishes. In effect, it is no longer "Medicaid money." Jn fact, sfi:ould an MCO or PHP voluntarily choose to serve people who are not Medicaid eligible, it is free to do so. However, we believe it is not appropriate for the State Medicaid agency to require in its contract with an MCO or PHP that savings from capitated payments be used to provide health services to individuals not otherwise eligible for Medicaid.

Therefore, for any new or pending section 1915(b) or J J 15 waivers (including applications for renewals) or any other Medicaid managed care situation (e.g., State plan option under the Balanced Budget Act), as a matter of policy, we will not approve any State Medicaid agency waiver application that contains a requirement for MCOs or PHPs to use savings under the capitation rate for non-Medicaid eligibles. Furthermore, in our normal review of waivers, Requests for Proposals, and contracts, we will also ascertain whether or not States are in compliance with this policy directive.

Ifyou have any questions about this policy, please contact Wayne Smith at (410) 786-6762.

Sincerely,

/s/

Sally K. Richardson,
Director

cc:

All HCFA Regional Administrators
All HCFA Associate Regional Administrators for Medicaid and State Operations
Lee Partridge American Public Welfare Association
Joy Wilson National Conference of State Legislatures
Jennifer Baxendell National Governors' Association

Solvency and Solvency Standards

www.investopedia.com

Solvency is the ability of a company to meet its long-term financial obligations. Solvency is essential to staying in business as it asserts a company's ability to continue operations into the foreseeable future. While a company also needs liquidity to thrive, liquidity should not be confused with solvency.

While solvency represents a company's ability to meet long-term obligations, liquidity represents a company's ability to meet its short-term obligations. In order for funds to be considered liquid, they must be either immediately accessible or easily converted into usable funds. Cash is considered the most liquid payment vehicle. A company that lacks liquidity can be forced to enter bankruptcy even if it is solvent if it cannot convert its assets into funds that can be used to meet financial obligations.

North Carolina DOI uses a risk based capital model to assess solvency of health insurance companies. "*Risk-Based Capital (RBC) is a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile."*
*(*http://www.naic.org/cipr_topics/topic_risk_based_capital.htm)

DMA Contracts

There are no solvency measures in the DMH/DD/SAS contracts with LME/MCOs. The Medicaid or DMA contracts contain three measures for solvency or financial performance that include:

Total Expenses, including IBNR, must not exceed 100% of monthly capitation in any three consecutive months – ***August 2016 = 97%***

Current ratio (current assets/current liabilities) can not be less than 1.0 at any time – ***August 2016 = 4.3***

LME/MCOs must have at least 30 days of expenses in cash at all times – ***August = 106.8 days***