Checking Your Financial Pulse: Benchmarking of Key Fiscal Indicators

Mental Health and Substance Abuse
Corporations of Massachusetts

and

Dougherty Management Associates, Inc.

National Council of Community Behavioral Health
Annual Training Conference
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Session Objectives

- Learn why financial benchmarks are widely used by other industries and in general healthcare
- Learn how one state association developed financial benchmarks for its industry
- Learn how that state association has used this information to shape external policy, technical assistance needs / plans, and other business operations.

Why do industries and organizations use financial benchmarks?

- To understand financial structure and financial performance in order to assess one's capacity to carry out mission
- To assess the impact of existing and proposed financing methods (e.g. risk tolerance)
- To understand one's competitive position in the market place
- To analyze relative components of financial performance (e.g. airlines)
- For Performance Improvement

The Impetus to Analyze Financial Data

- This is a fundamental function of a trade association
- MHSACM had no data available on industry / membership, financial structure or performance to:
  - Understand our membership
  - Advocate with policy-makers
  - Assess changes over time
- Absence of data creates vulnerability
  - Anecdotal analysis by policy-makers
  - Anecdotal analysis by members

Context: The Massachusetts Human Service System

- State administered human service system
- Contracted network of non-profit providers
- The market is mature
  - Medicaid managed care penetration is high
  - Most other services are paid on a fee-for-service basis
- MHSACM has 110 members who provide a variety of mental health and substance abuse services including:
  - Residential
  - Group homes
  - Outpatient
  - In-home services
  - Crisis Teams
  - Detoxification
  - Methadone
  - Community support

Goals of Benchmarking

- Understand financial structure and performance of membership
  - Compare with other Massachusetts human service providers
  - Compare with other healthcare providers
- Provide membership with benchmarking opportunities relative to industry
- Utilize database in analysis of public policy proposals

How Benchmarks were Developed: Source of Data

- Massachusetts requires state contracted human service providers to complete an annual financial statement in a standard format that meets the Single Audit reporting requirements.
- MHSACM commissioned Dougherty Management Associates, Inc. (DMA) to analyze data from this standard report.
- Massachusetts Uniform Financial Statement (UFR)
  - Standard financial statements must be audited
  - Supplemental schedules breaking out revenues, expenses and staffing by program must tie to audited statements
- DMA has now produced reports for Fiscal Years 1999, 2000 and 2001.

Other States Require Financial Reporting

- Standardized Reporting Systems
  - Texas Cost Report
  - New York State Consolidated Fiscal Report (CFR)
- Other states with financial reporting requirements – a partial list
  - West Virginia Community Mental Health Centers use common financial software and share data with the state
  - North Carolina also uses data from financial software for rate setting
  - Ohio – detailed Medicaid cost reporting
  - Connecticut
  - Michigan

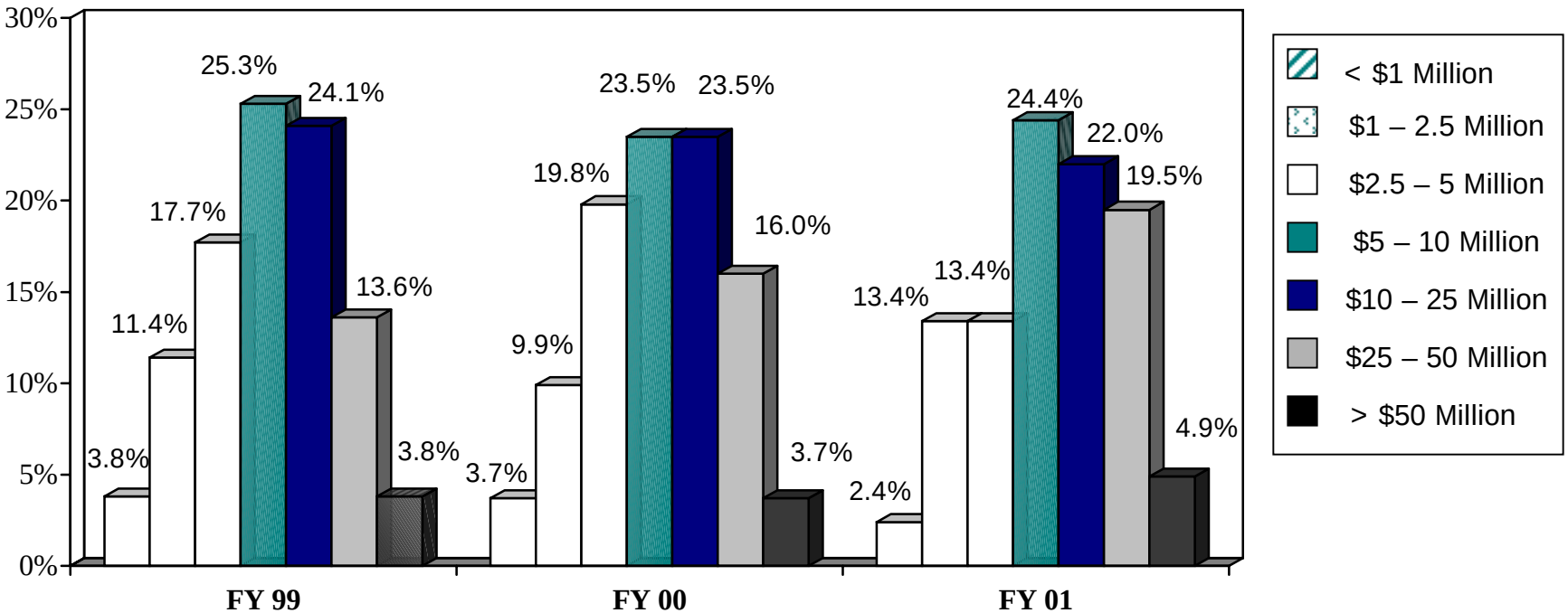
Standardized reporting technologies are being developed

- **eXtensible Business Reporting Language (XBRL)** is an XML-based, royalty-free, and open standard being developed by a consortium of over 170 companies and agencies. (See www.xbrl.org)
- XBRL provides a common platform for critical business reporting processes and improves the reliability and ease of communicating financial data among users internal and external to the reporting enterprise.
- XBRL is already being used by a number of large for-profit companies.
- Bryant College in RI has developed XBRL reporting categories for non-profits.

Methodology

- Access database was converted to Excel & SPSS for analysis
- Measures of financial condition
  - Fund Balance
  - Operating Gain or Loss as a percentage of Total Revenues
  - Working Capital: Current Ratio
  - Total Liabilities as a percentage of Fund Balance
  - Long-term Debt as a percentage of Fund Balance
  - Short-Term Debt as a Percentage of Fund Balance
  - Quick Assets
  - Average Days' Sales in Receivables
- Revenue Profile
  - Human Service contracts
  - Other state contracts
  - Third party funds
  - Gifts and private grants
  - Other
- Expense Profile
  - Direct Care staff expenses
  - Occupancy
  - Other Program expenses
  - Program administration
  - Administration

MHSACM Membership by Organization Size (Total Revenue)

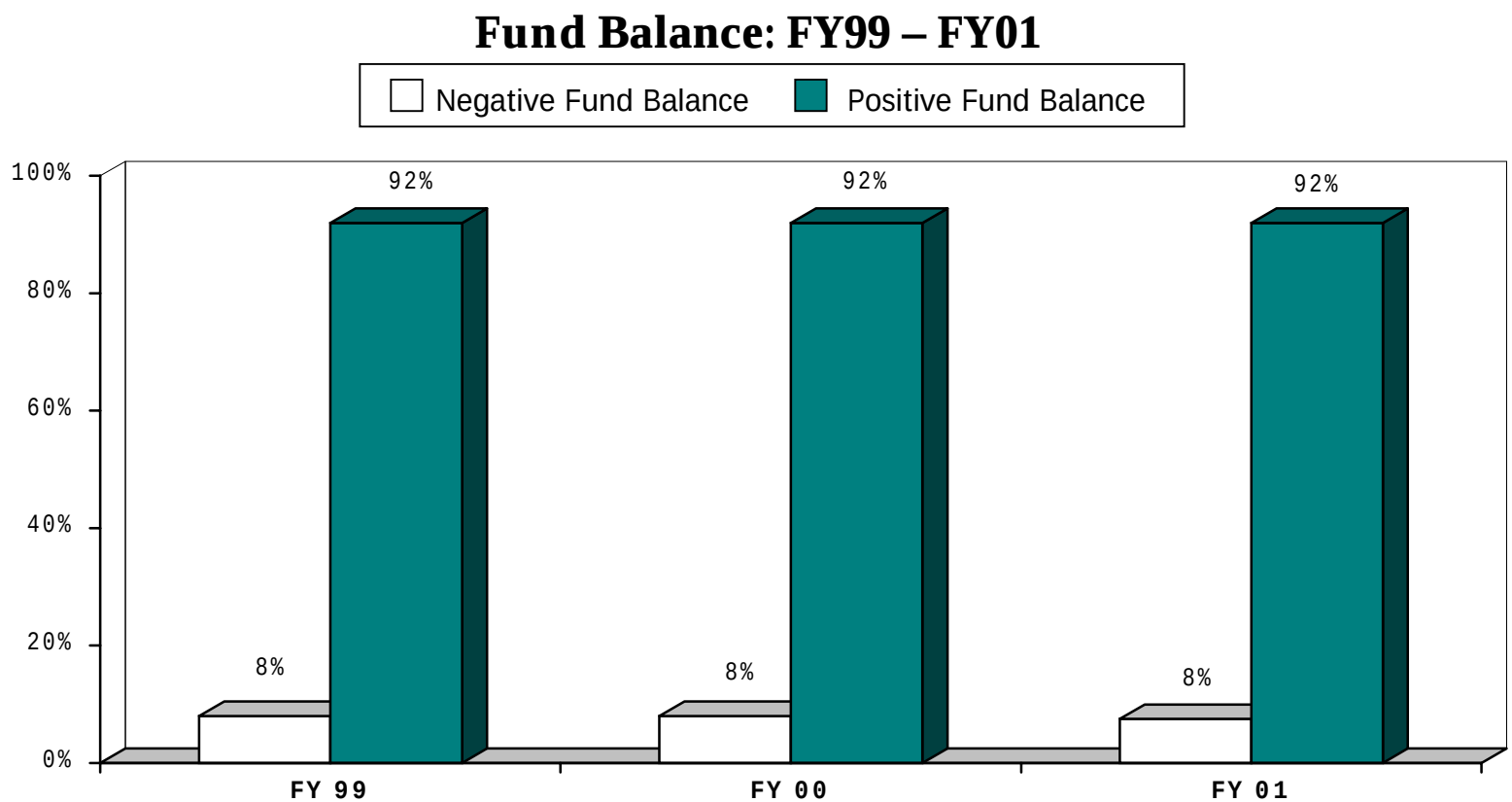


N = 81 in FY99 & FY00 , 82 in FY01 - Source: FY99, FY00 & FY01 UFR Activities and Revenue Schedules

- Most members, 68 had increased revenues between FY99 and FY01. However, 11 members' revenues decreased – in several cases quite substantially.

	FY 99	FY 00	FY 01
Total Annual Revenues	**$1.0 bil.**	**$1.1 bil.**	**$1.4 bil.**
Average Annual Revenues	**$12.8 mil.**	**$13.9 mil.**	**$16.7 mil.**
Median Annual Revenues	**$7.1 mil**	**$8.2 mil**	**$9.3 mil**

While most MHSACM members were solvent, a significant minority showed negative fiscal results.

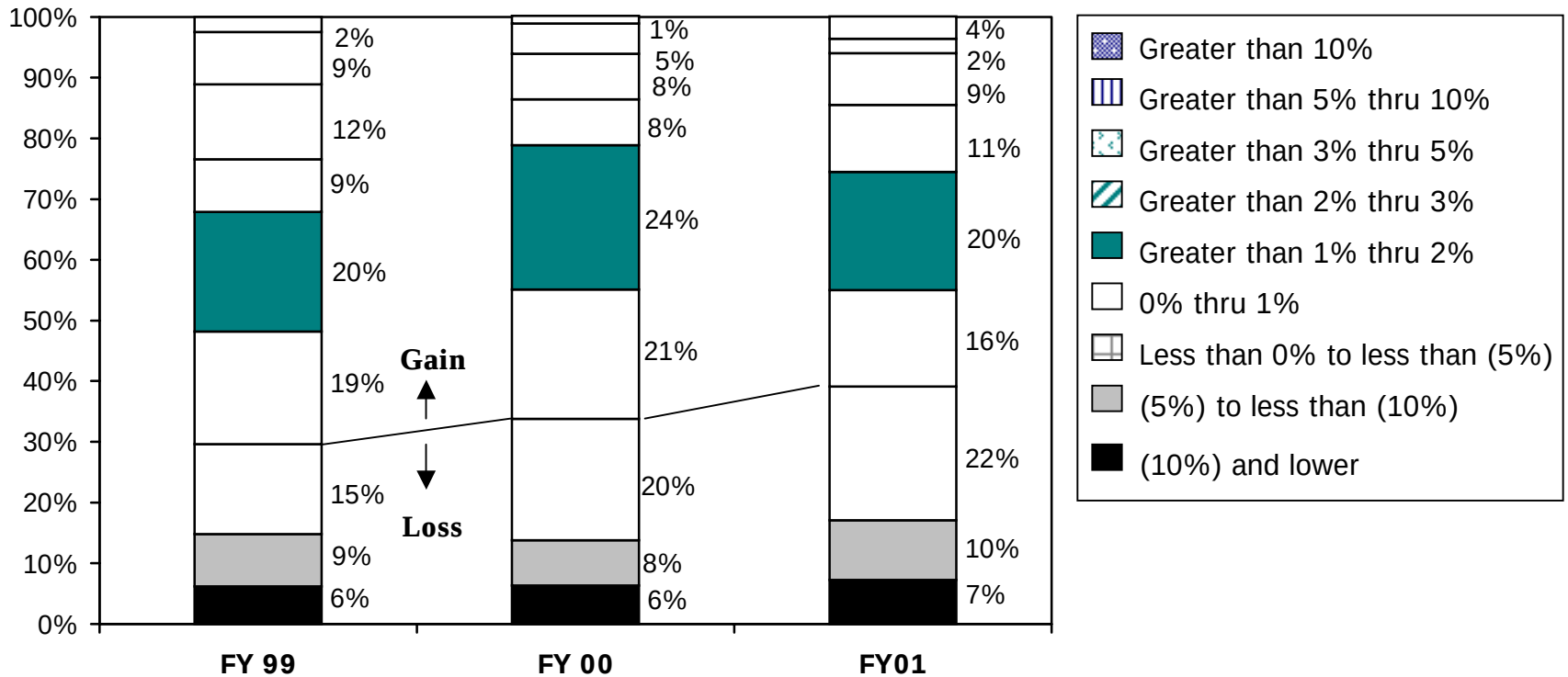


N=77* in FY99, 78 in FY00, 80 in FY01 - *Source: FY99, FY00 & FY01 UFR Balance Sheet Schedule*

*Excludes 2 providers with greater than 20% Special Education revenue.

Growing numbers of MHSACM members experienced losses on operations.

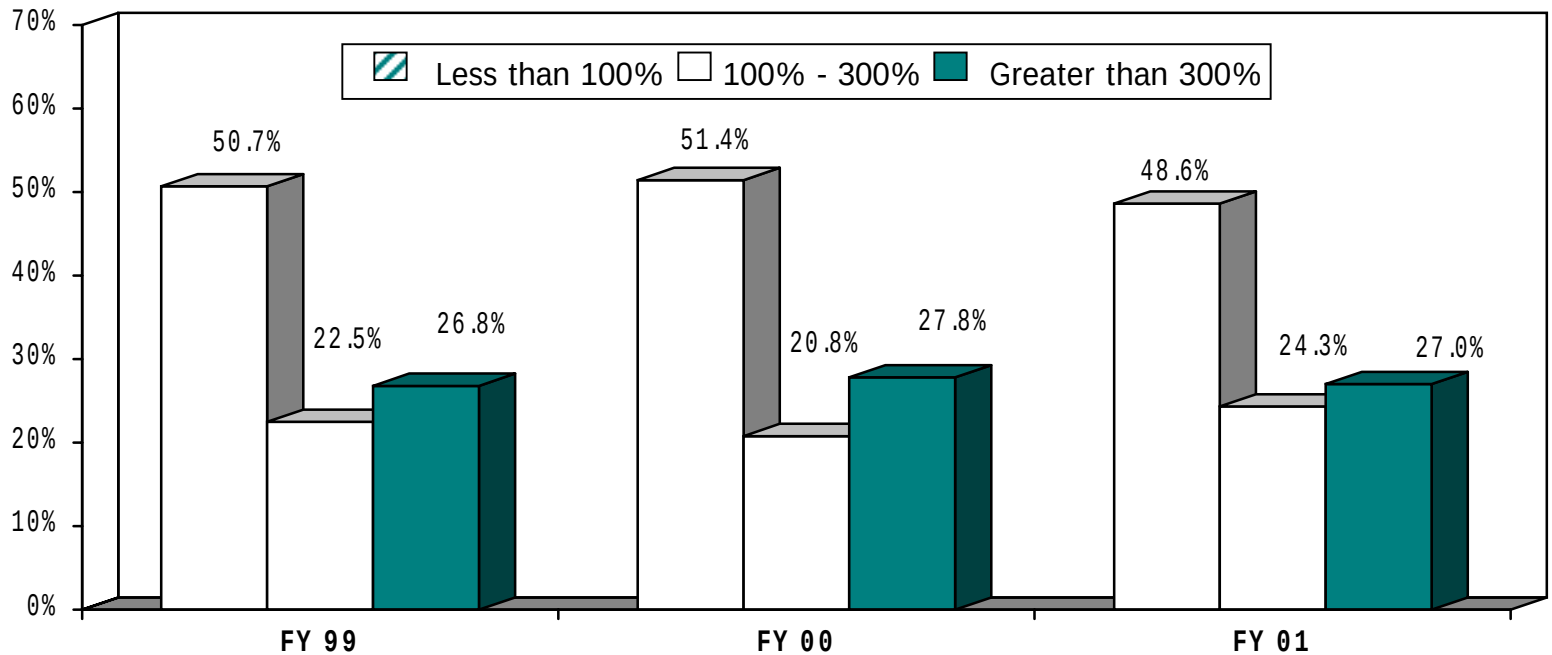
Operating Gain or Loss as a Percentage of Program Revenue: FY99 – FY01



N = 81 in FY99 & FY00, 82 in FY01 - Source: UFR Balance Sheet Schedule

Virtually half of MHSACM members had total liabilities that exceeded their fund balance.

Total Liabilities as a Percentage of Fund Balance: FY99 – FY01

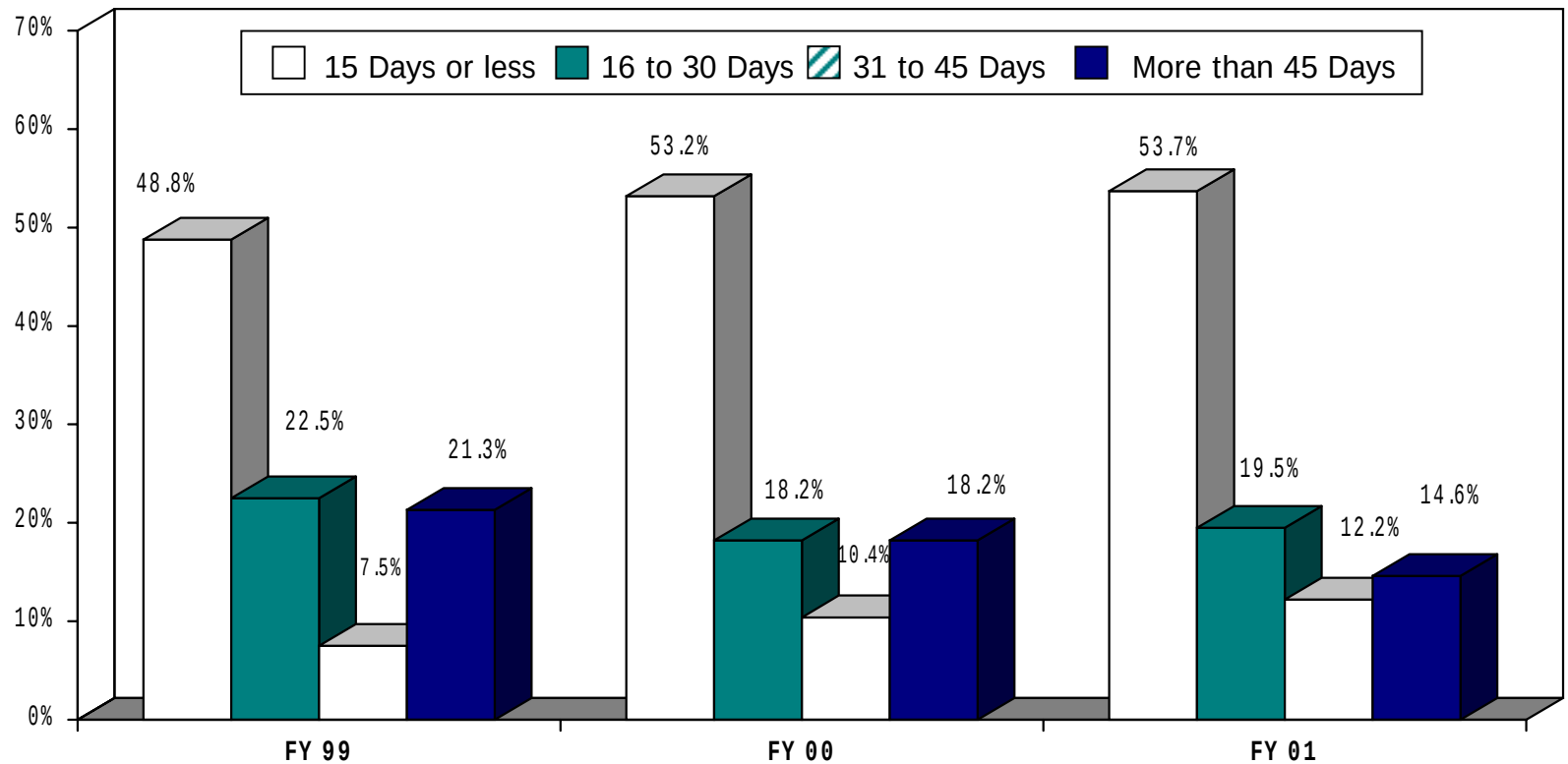


N=71* in FY99, 72 in FY00, 74 in FY01 (Excludes 6 providers for Zero or Negative Fund Balance in each year)
Source: UFR Balance Sheet Schedule

*Excludes 2 providers with greater than 20% Special Education revenue.

Member cash positions were low and declined throughout the period.

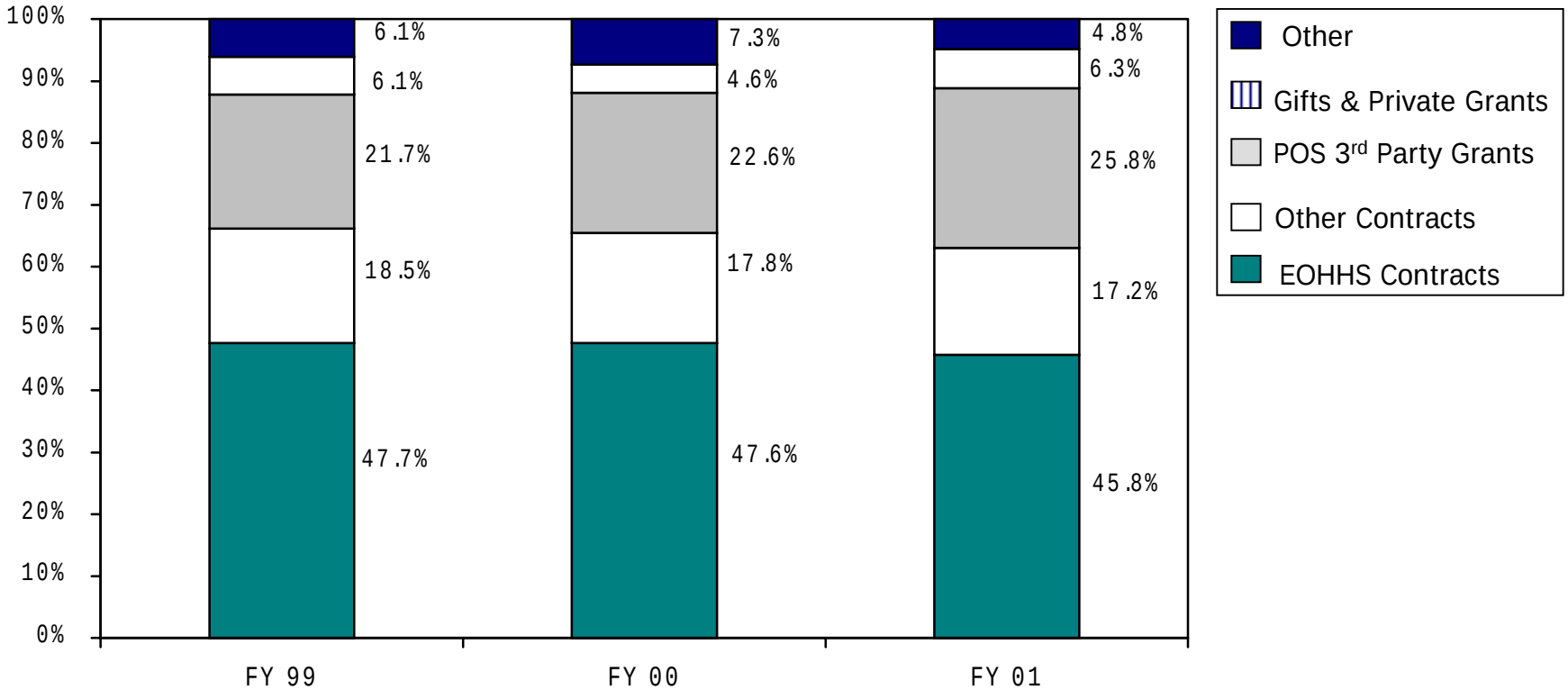
Quick Assets: Average Day's Operating Expenses in Cash FY99 – FY01



N=80 in FY99, 77 in FY00, 82 in FY01 - *Source: UFR Balance Sheet Schedule*

The revenue profile of MHSACM members began to show some changes in FY01.

Total Revenues by Source: FY99 – FY01

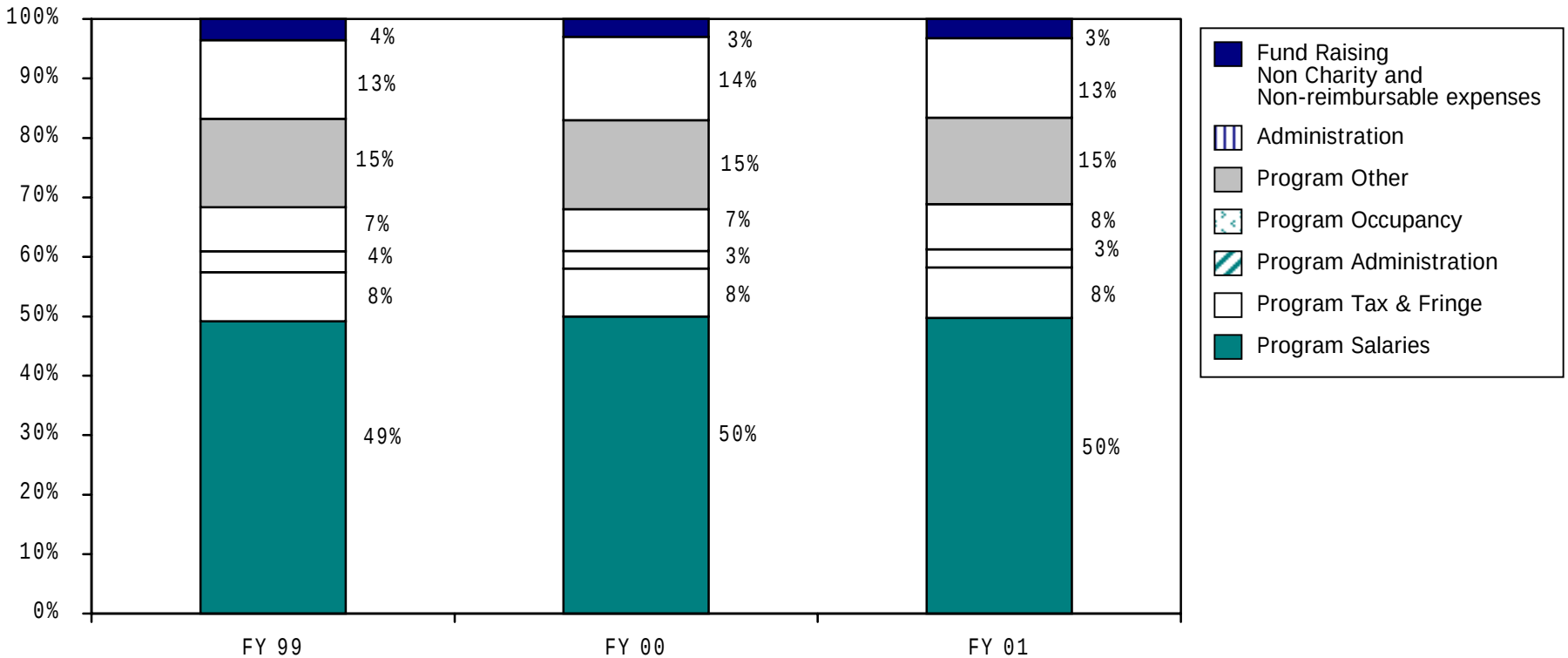


N=79* in FY99, 81 in FY00, 82 in FY01 - *Source: UFR Revenue Schedules*

***** Excludes 2 members with 20% or more of Special Education revenues.

The expense profile of MHSACM members was very stable between years.

Total Expenses by Category: FY99 – FY01



N= 79* in FY99, 80 in FY00, 82 in FY01 - *Source: UFR Expense Schedules*

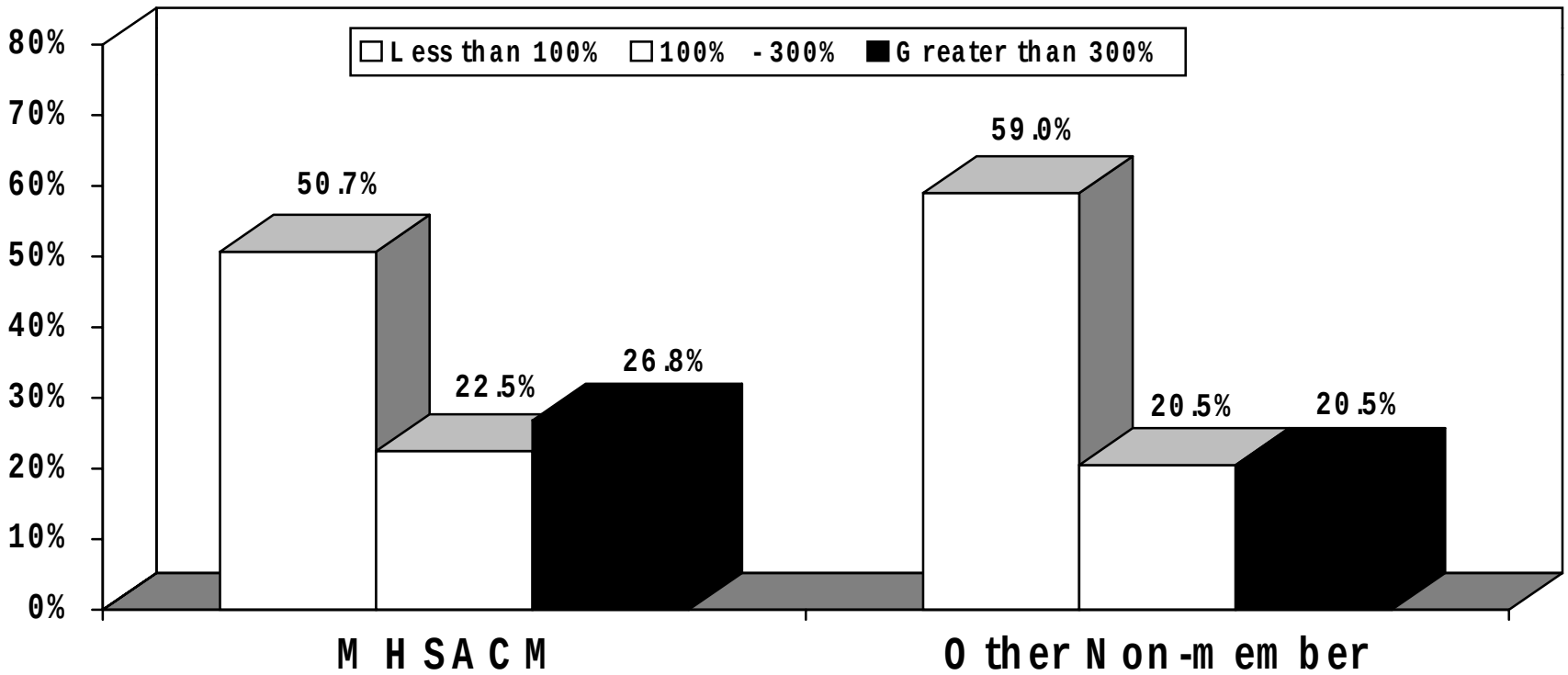
***** Excludes 2 members with 20% or more of Special Education revenues.

Other Types of Analysis

- Understand how organization size affects financial condition
- Analyze the financial structure of specific service types
- Determine how MHSACM members compare to other Massachusetts human service providers

MHSACM members were more likely to carry debt than non-members.

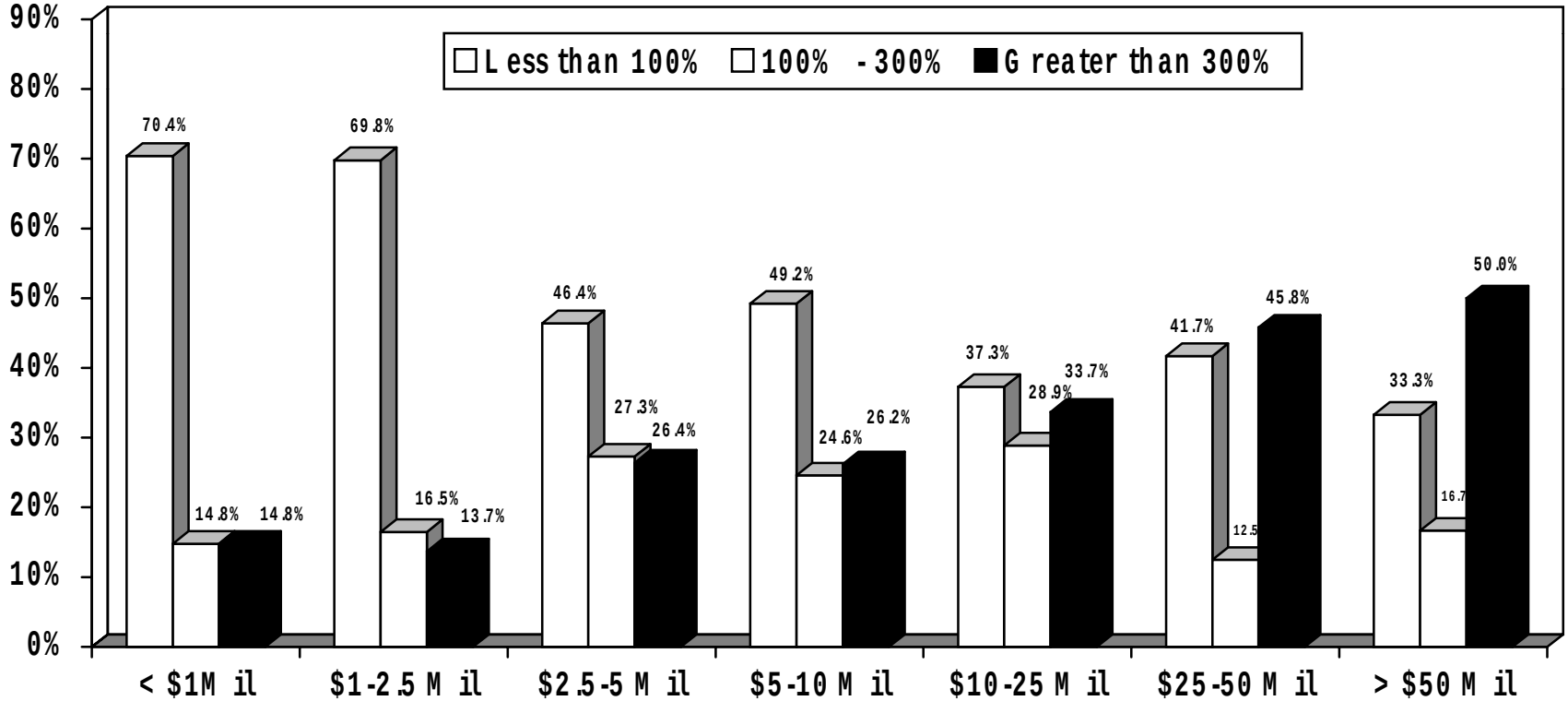
FY99 Total Liabilities as a Percentage of Fund Balance by MHSACM Membership



N=685 (Excludes 53 providers with Zero or Negative Fund Balance)
Source: FY99 UFR Balance Sheet Schedule

Larger organizations carry more debt than smaller organizations

FY99 Total Liabilities as a Percentage of Fund Balance by Organization Size (Total Revenues)



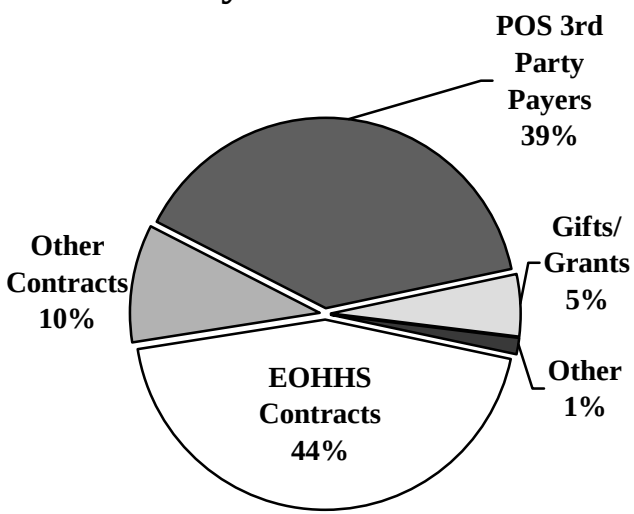
N=738 (Excludes 53 of providers for Zero or Negative Fund Balance)

Source: FY99 UFR Balance Sheet Schedule

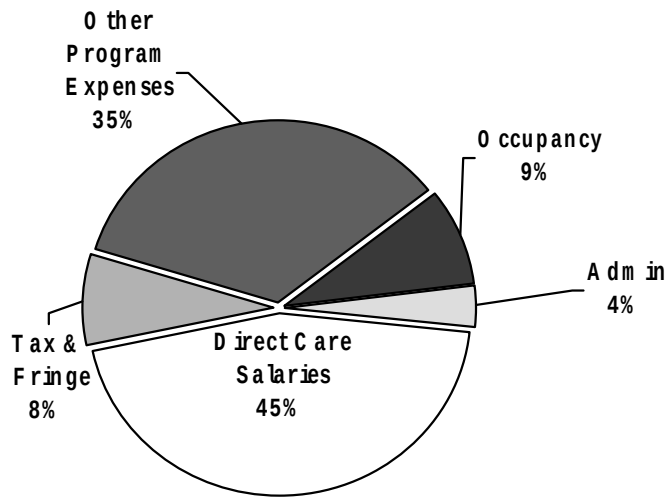
Adult Outpatient programs receive similar levels of support from contracts and third party revenues.

FY99 DMH Adult Outpatient Program Revenues and Expenses MMARS Code 3050

Program Revenues by Source



Program Expenses by Category



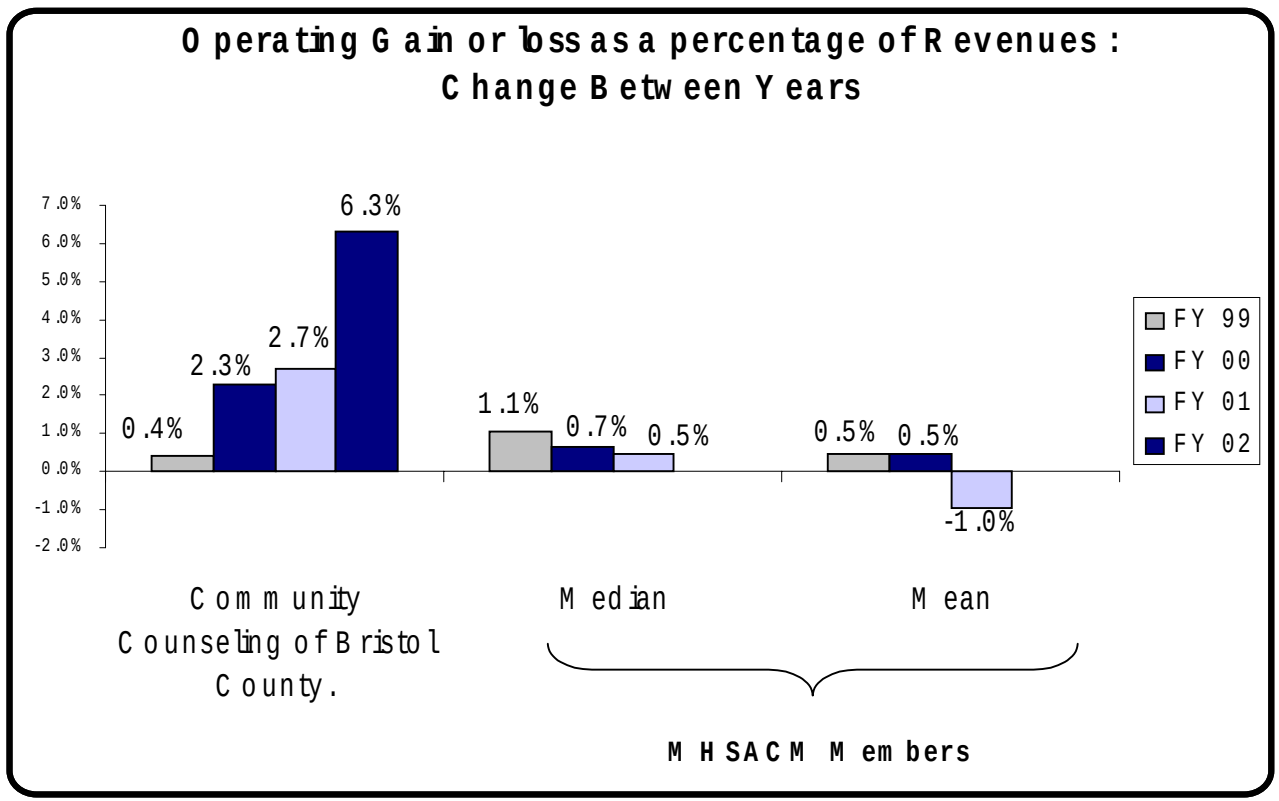
N= 28 - *Source: FY99 UFR Program Revenue and Expense Schedules*

Individual Provider Benchmarks

- Individual providers can compare themselves to their Massachusetts colleagues
- Graphical format is useful for board presentations
- Providers can request additional analyses to help them investigate why they differ from their colleagues

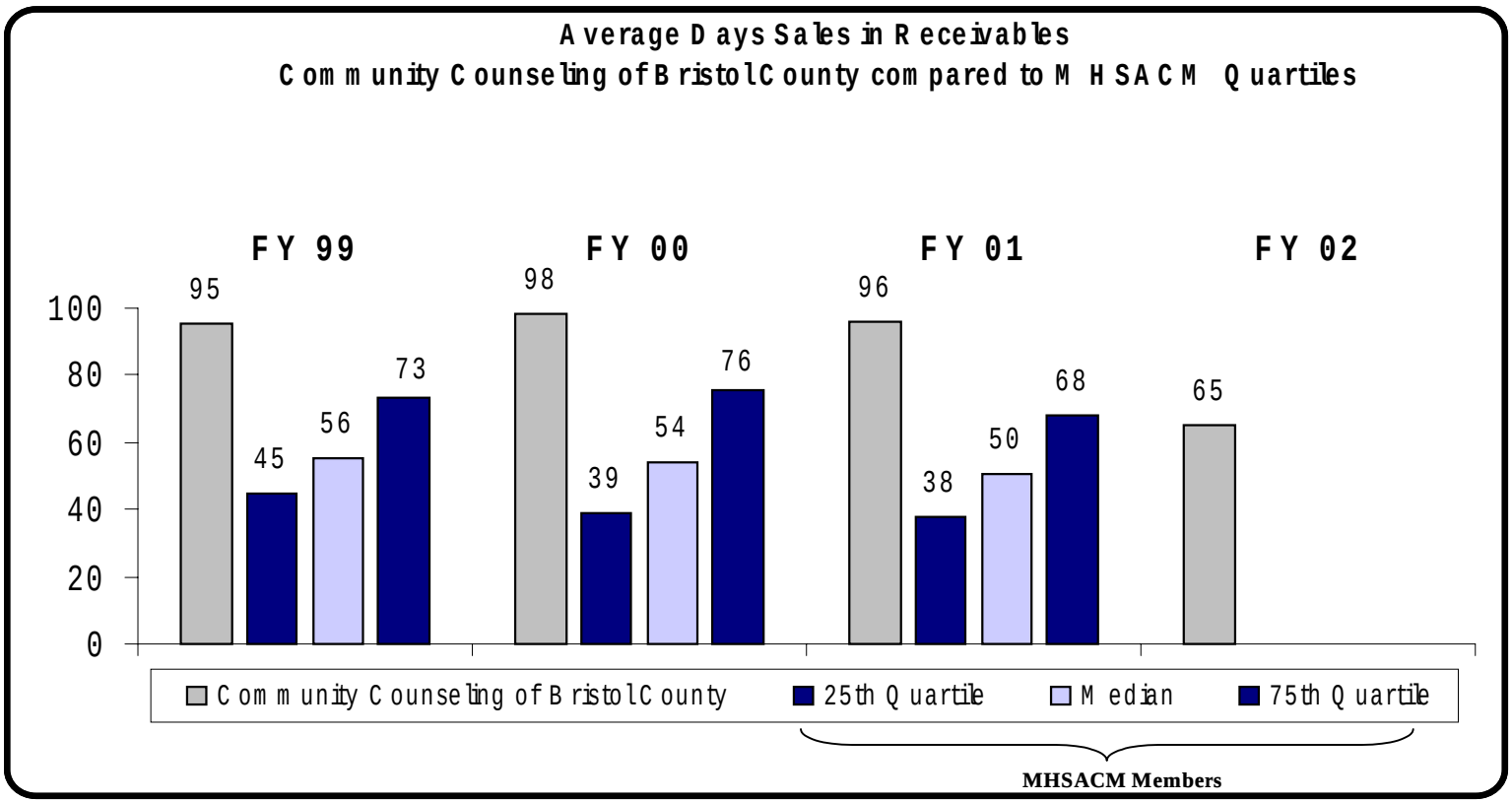
Individual Benchmarking

Community Counseling of Bristol County's (CCBC) profitability has improved over the last four years, while that of MHSACM members has eroded.



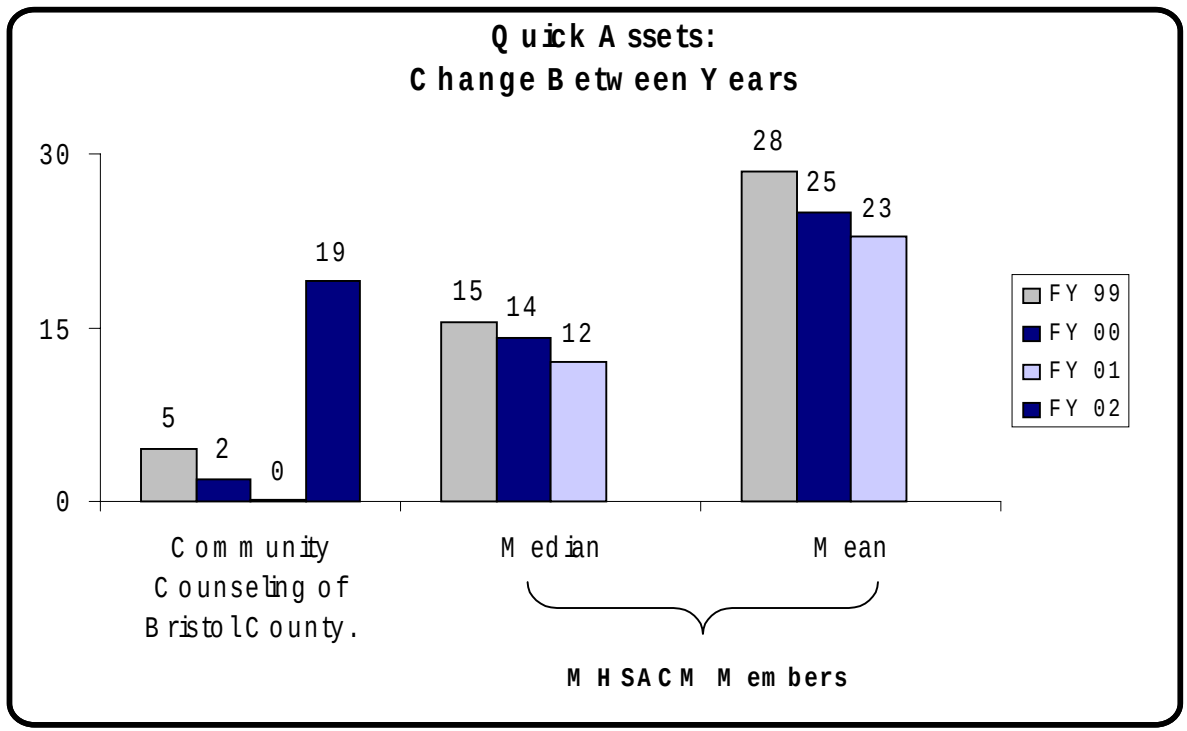
Individual Benchmarking, cont.

Community Counseling of Bristol County's (CCBC) days' sales in receivables have come into the range of other association members.



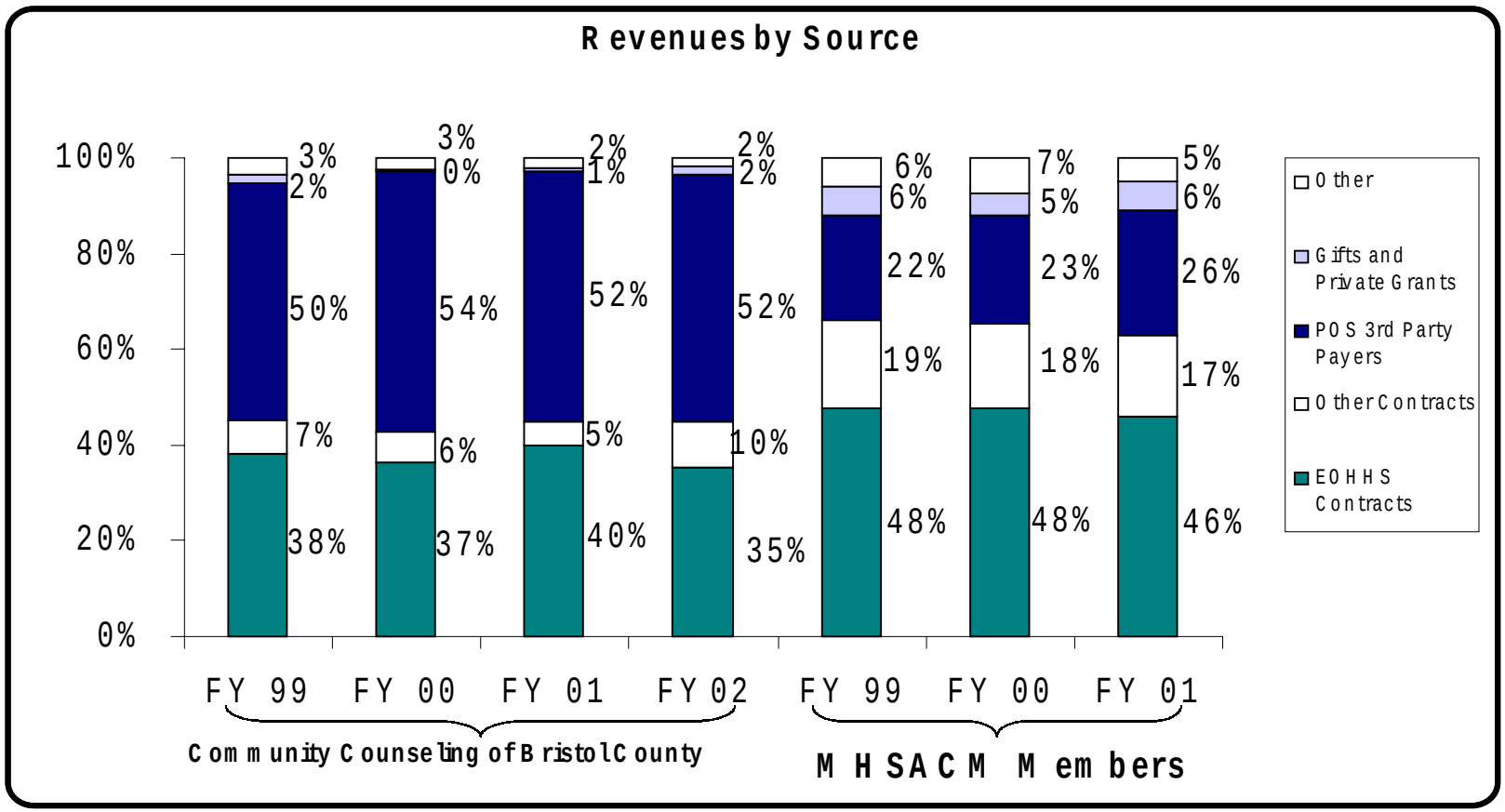
Individual Benchmarking, cont.

CCBC's days of cash at year end improved markedly in FY 02, while that of MHSACM members overall eroded.



Individual Benchmarking, cont.

CCBC has put more emphasis on development as a result of comparing itself to other MHSACM members.



Analysis for Advocacy

- Analysis of UFR data has been a significant tool in addressing proposed Medicaid cuts
  - Estimate the impact of outpatient cuts
  - Basic data on number, cost, and staffing of day treatment and detoxification programs
  - Determine the extent to which residential programs report client fees to offset program costs

Impact of Cuts in Medicaid Outpatient Rates

Distribution of Estimated Operating Gains and Losses on Outpatient Programs Operated by MHSACM Members by Size of Medicaid Rate Cut					
Operating Profit/Loss	**FY2000 Actual**	**With estimated 2% cut to Medicaid rate**	**With estimated 3% cut to Medicaid rate**	**With estimated 4% cut to Medicaid rate**	**With estimated 5% cut to Medicaid rate**
>10% gain	9	9	9	9	9
>5% thru 10% gain	5	3	3	3	2
> 3% thru 5%	3	3	2	1	2
> 2% thru 3%	4	2	2	1	
> 1% thru 2%	6	6	3	5	2
0% thru 1%	3	4	5	3	4
Subtotal with gains	***30***	***27***	***24***	***22***	***19***
Less than 0 to (5%)	16	18	19	21	23
(5%) to < (10%)	13	10	11	10	10
< (10%)	27	31	32	33	34
Subtotal with losses	***56***	***59***	***62***	***64***	***67***

Identifying Clients and Staff that would be affected by eliminating Day Treatment Programs

Massachusetts Day Treatment Programs
Staff, Service and Financial Results from FY2001 UFR

Vendor Name	Location	Total direct program staff	Unduplicated Clients Served				Total Units of Service				Financial Results		
			Public	Private	Free Care	Total	Public	Private	Free Care	Total	Expenditures	Revenues	Operating Results
Vendor A	New Bedford	6.41	0	0	0	0	7,187	0	0	7,187	$450,584	$429,914	-$20,670
Vendor A	Lexington	8.55	133	9	8	150	9,165	618	881	10,664	$648,997	$637,625	-$11,372
Vendor A	Taunton	5.15	135	5	6	146	5,355	108	14	5,477	$241,858	$337,172	$95,314
Vendor C	Beverly	14.34	322	214	0	536	7,842	2,342	0	10,184	$847,027	$703,670	-$143,357
Vendor D	Cambridge	5.07	29	3	0	32	5,032	204	0	5,236	$290,341	$266,004	-$24,337
Vendor E	Cambridge	6.16	38	0	0	39	7,406	53	64	7,522	$396,019	$357,106	-$38,913
Vendor F	East Boston	14.58	198	2	0	200	13,517	339	0	13,856	$1,079,788	$1,120,603	$40,815
Vendor G	Location?	16.29	270	20	0	290	16,000	1,500	0	17,500	$954,951	$940,659	-$14,292
Total		**133.37**	**2,013**	**378**	**15**	**2,407**	**121,470**	**7,453**	**1,078**	**130,000**	**$8,112,760**	**$8,229,759**	**$116,999**

Determining the volume of client service fees reported by residential programs

Client Fee Reporting and Revenue for MH and SA Residential Programs in FY99 For All Filers and for MHSACM Members

Service Type	MMARS Code	Total Programs	Number of programs reporting client fees	Total Client Fees Reported	Client Fees as a Percentage of Total Program Revenues
MH Adult Residential	3049	172	110	$8,497,198	4.2%
MHSACM		114	78	$6,211,077	4.6%
Intensive Residential Treatment	3080	8	6	$105,236	0.7%
MHSACM		4	3	$33,413	0.6%
SA Residential Treatment	3386	54	44	$1,809,884	5.4%
MHSACM		26	23	$825,471	
Specialized SA Res. For Women	3455	13	4	$87,821	1.3%
MHSACM		8	4	$87,821	2.2%
Total		**247**	**164**	**$10,500,139**	**51.%**
MHSACM		**152**	**108**	**$7,157,782**	**4.4%**

Source: FY99 UFR Program Revenue Schedule

Strengths and Limitations of the Analysis

- Limitations
  - Lag time from year end to availability of complete database
  - Balance sheet measures are point-in-time and may not be representative of the entire year
  - Incorrect reporting – Medicaid revenues not reported in correct categories
  - State contracting regulations affect how providers allocate expenses to cost-reimbursement programs
  - Providers define / combine their programs differently
- Degree of reliability
  - Data from audited financial statements are most reliable
  - Data that must tie to financial statements are next most reliable
  - Data, such as staff FTEs, that aren't tied to the financial statements are least reliable

Recommendations and Conclusions

- Establish consensus that there is a need for financial benchmarks
- Create a committee of interested members
- Identify a source of data
- Agree on measures to be calculated
- Recommendations for implementation
  - Start small – calculate standard financial measures from financial statements
  - Assess technical challenges of undertaking programmatic analysis and possible limitations of the data
  - Undertake only those programmatic analyses for which you have a specific need, and for which the limitations are acceptable
  - Ensure that reports preserve anonymity of providers