Community Mental Health Centers in New Hampshire

FINANCIAL PERFORMANCE AND CONDITION

by: Nancy Kane, D.B.A.
Harvard School of Public Health

January, 2010

Underwritten by:

Endowment for Health/
Health Strategies of NH

Overview of the Financial Health of Ten New Hampshire Community Mental Health Centers

2004–2009

Submitted to the Endowment for Health by
Kane Consulting
January 25th, 2010

Introduction

This report analyzes the six-year financial history and current financial condition of the ten community mental health centers (the "Centers" or "CMHC") currently serving close to 50,000 mental health clients in the State of New Hampshire. It is based primarily on financial data and related information contained in the audited financial statements of the Centers for the fiscal years 2004–2009. It is the third in a series of reports on the financial condition of health providers in New Hampshire, with one on acute hospitals and another on community health centers.

The ten Centers, all organized as nonprofit New Hampshire corporations, are in alphabetical order: CLM Center for Life Management, Community Council of Nashua, Inc., Community Partners, Genesis Behavioral Health, The Mental Health Center of Greater Manchester, Monadnock Family Services, Northern Human Services, Inc., Riverbend Community Mental Health, Inc., Seacoast Mental Health Center, Inc., and West Central Behavioral Health.[1]

[1] Using d/b/a/ names where applicable

Under annually renewable contracts with the New Hampshire Department of Health and Human Services, each Center provides mental health services to residents of a specific geographic area of the State.

Summary

The Centers (CMHCs) had combined annual revenues in the most recent fiscal year, FY09, of just over $150 million. However, annual surpluses after operating expenses have been low or negative throughout the study period.

Medicaid payments account for approximately 75% of total revenue sources (which includes grants and contracts as well as patient service revenues), and roughly 85% of patient service revenue alone. As a percentage of total revenue sources, Medicaid ranges from about 65% at some centers to 80% in others. Thus the Centers' future financial viability depends on continued support from the Medicaid program.

The Centers' assets, totaling $65 million as of FY09, consist primarily of working capital and clinic and administrative premises. In some cases, premises are rented to the centers by nonprofit affiliates.

While the Centers have not experienced acute financial problems in this period, most do not have sufficient financial reserves to fund substantial operating losses.

I. Aggregate Financial Performance–Revenues and Expenses

The six-year aggregate income statement shows that the Centers had moderate revenue growth but only minimal profitability, with deficits in two of the six years. Revenues and expenses grew at roughly the same rate, and operating margins fluctuated around breakeven over the period. Grant and contract revenue has declined over the period, so all of the growth has come from patient service revenue (mostly Medicaid, with some revenues from self-paying and very few privately-insured clients). Non-operating revenues, primarily realized investment gains and donor contributions, make a minimal contribution to profitability, less than 1% of operating revenues and on a declining trend since 2007.

Table 1. Aggregate Income Statement for 10 New Hampshire CMHCs ($000s).

	2004	2005	2006	2007	2008	2009	Change 2004–2009	Average Annual Change
OPERATING REVENUE								
Net Patient Service Revenue	105,417	106,766	111,398	123,667	130,692	140,356	33%	
Other Operating Revenue:								
Grants	9,594	9,675	10,124	10,553	9,235	8,904	-7%	
Assets Released From Restricts–Operations	163	178	182	181	340	258	58%	
Other	7,882	7,165	6,885	5,940	6,329	5,464	-31%	
Total Other Operating Revenues	17,782	17,161	17,334	16,817	16,108	14,626	-18%	
Total Operating Revenue	**123,184**	**123,926**	**128,732**	**140,484**	**146,800**	**154,982**	**26%**	**4.67%**
OPERATING EXPENSES								
Salaries, Payroll Taxes, Fringes	88,998	90,858	94,334	101,639	108,043	110,574	24%	
Depreciation	1,952	1,981	1,969	1,969	2,234	2,331	19%	
Interest	520	473	696	689	904	806	55%	
Other operating expenses	30,528	32,365	30,593	35,986	38,049	39,808	30%	
Total operating expenses	**121,998**	**125,677**	**127,592**	**140,283**	**149,230**	**153,519**	**26%**	**3.29%**
Net Operating Income	**1,186**	**-1,751**	**1140**	**201**	**-2,430**	**1,463**	**23%**	
Interest and Dividends	68	152	242	454	353	265	290%	
Realized Gains (Losses)	190	120	628	1,392	2	-358	-288%	
Other Income (Expense)	865	1,114	837	838	978	1,009	17%	
Total non-operating revenue	972	1,243	1564	2,541	1,129	916	-6%	
Excess of revenue over expenses	2,166	-508	2,704	2,742	-1,301	2,379	10%	
Extraordinary Gains (Losses)	0	0	2	641	0	0	0%	
Total Surplus/Deficit	**2,166**	**-508**	**2,706**	**3,386**	**-1,300**	**2,378**	**9%**	
Aggregate Operating Margin	**0.96%**	**-1.41%**	**0.89%**	**0.14%**	**-1.66%**	**0.94%**		
Aggregate Total Margin	**1.75%**	**-0.41%**	**2.08%**	**2.37%**	**-0.88%**	**1.53%**		

Note: All details not disclosed so only major categories will tally.

- Aggregate operating revenues and expenses have grown at a similar pace, with average annual growth in operating revenues (4.67%) exceeding average annual growth of operating expenses (3.29%) by about 1.3 percentage points.
- Operating income has fluctuated with losses in two years; adding it across all six years yields a net loss of $191,000.
- Total surplus was lower in FY09 than in FY06 and FY07. The weakening trend was due to a drop in grant revenue as well as non-operating revenue, primarily reductions in realized gains from investments (reflecting general capital markets).Adding total surplus across all six years yielded just over $8 million, or less than 1% of total operating and non-operating revenue.
- Aggregate operating and total margins fluctuate around breakeven (plus or minus 2%).

II. Aggregate Financial Performance–Cash Flow

The five-year aggregate cash flow (sources and uses) analysis shows a healthy pattern in aggregate, with cash from operating activities financing a larger cash cushion and some moderate investment in property and plant.

Table 2. Aggregate CMHC Cash Flows, 2005 – 2009 ($000s)[2]

Sources	$	%	Uses	$	%
Total Surplus/Deficit	6,621	17%	Investments in securities	-6,331	17%
Non-cash expenses (revenues)	8,539	22%	Other noncurrent assets	-1,280	3%
Working capital	3,323	9%	PP&E	-17,960	47%
Sale of Fixed Assets	3,660	10%	Repay LTD	-5,540	14%
Issue LTD	13,122	35%	Other Noncurrent Liabilities	-3,87	1%
Transfers from other Entities	2,721	7%	Increase Cash[3]	-6,715	18%
Other	227	1%			
Total	**37,986**		**Total**	**-38,213**	

- Positive cash flow from operating sources (surplus, noncash expenses, working capital) totaled 48% of total sources of cash; another 10% of cash was generated by selling fixed assets (at four CMHCs).
- Outside sources of capital are primarily long-term debt (35% of total sources), with some assistance from related entities (7% of total sources). The average equity financing ratio (amount of equity versus debt: higher is better) was 47%, improving slightly from 45% in 2004. Debt service appears adequate in 2009, with average debt service coverage of 3.7 times (but significantly lower at certain centers).
- The largest use of cash is investment in clinic and administrative premises (referred to as Property, Plant, and Equipment or PP&E). Five centers spent over $1 million on PP&E over the five years; however, average age of plant in 2009 was almost 20 years, up from 13 years in 2004. Some centers operate from premises that are owned by affiliates whose financial statements are not combined with those of the center, so the full picture is not complete on CMHC capital requirements and their ability to meet them.
- Most of the rest of the cash was used to increase working capital cash (18% of total uses) or investments in marketable securities (17%), which generate non-operating revenues; days cash on hand (all sources including marketable securities investments) improved to 57 in 2009, up from only 27 days in 2004.[4]

[2] Excludes FY 2009 cash flow data for West Central, which became available only after this report was prepared; however, it was not material to the aggregate cash flows depicted in this table.

[3] Increases to cash balances are treated as a use of cash therefore a minus sign is attached.

[4] The positive cumulative cash generation shown is consistent with analysis of the bank lines of credit maintained by the Centers. Most of the Centers had lines of credit of $1 million or less with local banks during this period, but most lines remained unused and only one Center borrowed to any significant degree.

III. New Hampshire Community Mental Health Centers Compared to New Hampshire Community Health Centers

Figure 1: Comparison of Total Margins of CHCs and CMHCs in New Hampshire

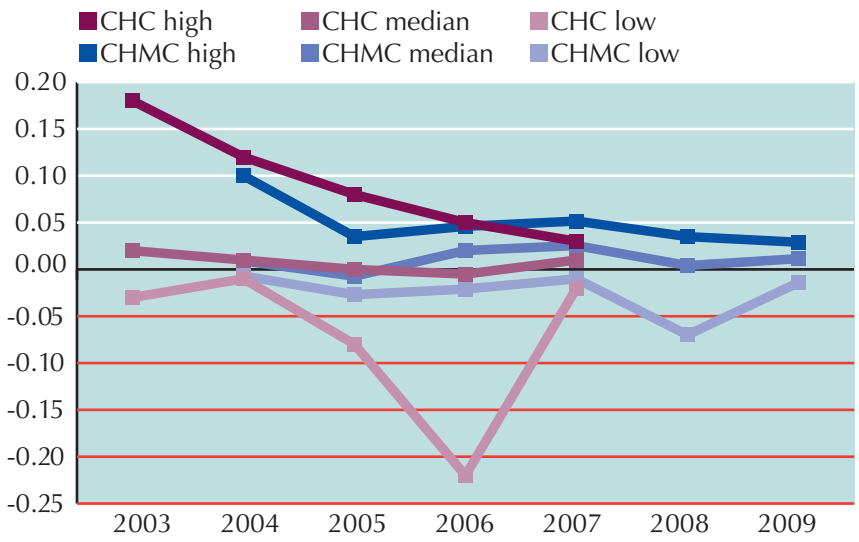
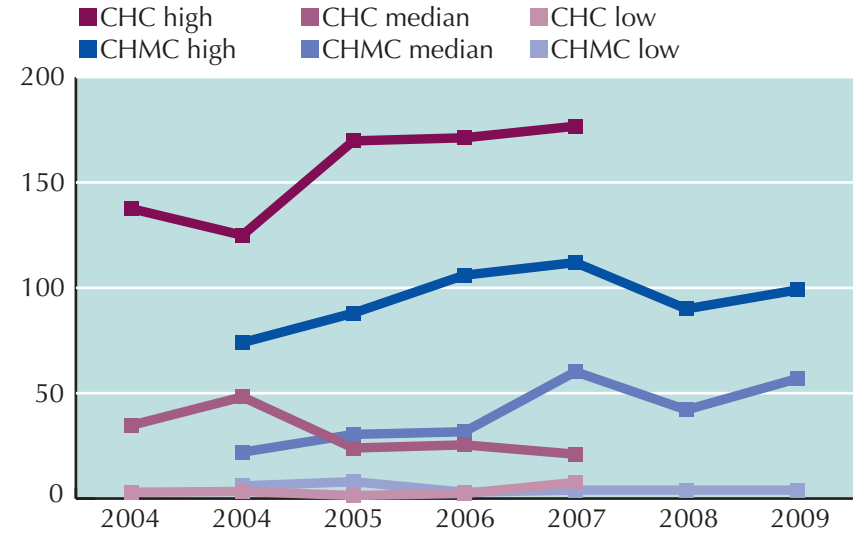


Figure 2: Comparison of CHC and CMHC Days Cash On Hand



Compared to our earlier analysis (2002–2007) of community health centers (CHCs) in New Hampshire, CMHCs show a narrower range of performance (not as weak as the weakest CHCs nor as strong as the strongest). Appendix A provides a definition of the ratios used in this analysis.

Figure 1 compares the trend in total margins between CHCs and CHMCs. Over the period 2002–2007, CHCs generally experienced declining total margins and a convergence toward the middle, with the exception of the worst-performing quartile, which recovered somewhat in 2007 after suffering very large deficits in 2006. The CMHCs' quartile trends range between -.02 and +.03 over the period, with no clear upward or downward trend over the period 2004–2009. The 2009 interquartile range is less than two percentage points, compared to six percentage points for the CHCs; thus financial performance in the sector is more uniform across the individual centers than with the CHCs.

Figure 2 compares the minimum, median, and maximum values for CHC and CMHC days cash on hand, a common measure of liquidity. CHC's show a wide disparity in the distribution of liquidity, with the bottom 50% having very low and/or deteriorating liquidity, while the top

center experiencing rapidly growing liquidity, going well beyond 100 days cash on hand in 2009. In contrast, the CMHC's have a positive upward trend generally, but a smaller range, tilted toward the lower end of liquidity. The lowest ratio of days cash on hand in 2009 among the CMHC's was only 4 days, and no CHMC's days cash on hand reached 100 days as of 2009.

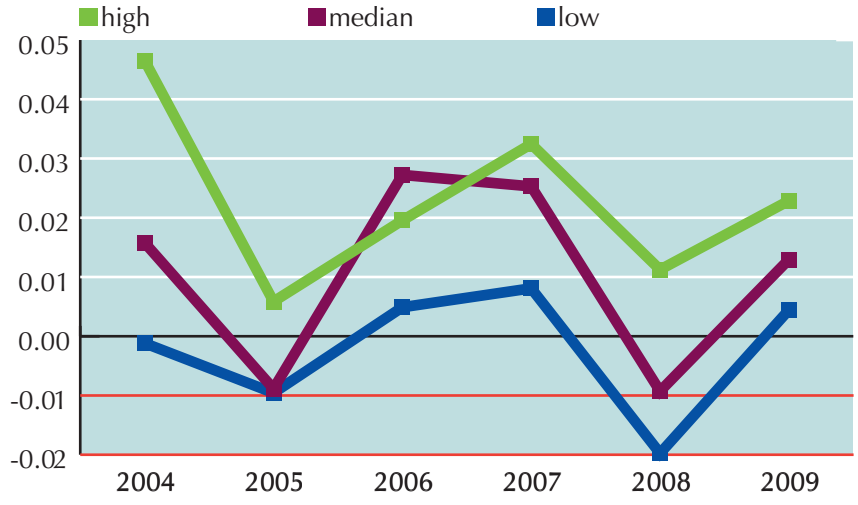
IV. Community Mental Health Center Financial Analysis by Groups of Relative Strength

With less disparity than the eight CHCs, the ten CMHCs still vary in their financial performance. This section provides a picture of the differences in financial performance among three groups of CMHCs over the period 2004 – 2009. Group 1 ("low") consists of the three CMHCs with the lowest profitability margins over the period; Group 2 ("medium") are the four CMHCs with margins in the middle of the range; and Group 3 ("high) are the three CMHCs with margins at the high end of the range. Since none of the CMHCs are financially strong, it is best to think of these three groups as "high, medium, and low" relative to each other, but not in an absolute sense (e.g., high does not mean very healthy, and low does not mean in severe financial distress). Mean values for each group are shown in the figures below.

Two of the centers in the medium performance group deliver developmental services in addition to mental health services, and revenues and expenses associated with developmental services are substantial in both cases. The two lines of service are governed by separate contracts with New Hampshire DHHS and funded under separate Medicaid arrangements. Separate income statements, not shown here, were prepared for these centers using only mental health-related revenues and expenses. Although partly based on estimates, the results of this analysis indicated that the two centers would remain in the medium group in terms of total and operating margins shown in Figures 3 and 4. With the data available, we concluded that providing mental health services was not materially more or less profitable than providing developmental services.

Figure 3 shows total profitability for full operations of all Centers; it includes the profits from operations as well as investment income (inter-

Figure 3: Total Margins by CMHC Financial Group



est, dividends, realized gains). Major findings include:

- All three groups experienced no clear trend across the years.
- The "high" group centers almost always achieved positive total margins.
- Both "medium" and "low" centers fell into negative margins in 2005 and 2008.
- Lower performers tended to be smaller (in terms of annual revenues).

Figure 4: Operating Margins by CMHC Financial Group

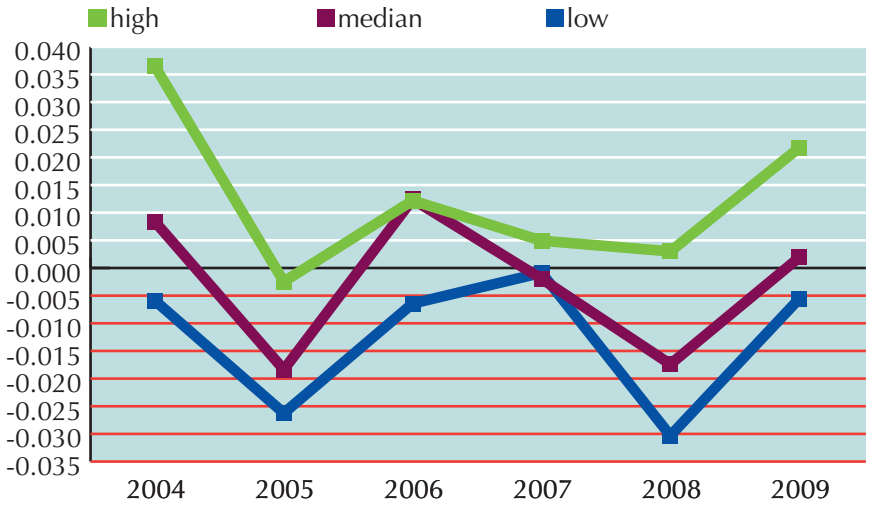


Figure 4 shows operating profitability of all Centers, which excludes investment income and other nonoperating revenues from the numerator and denominator. Results track closely to total profitability results in the preceding chart because investment income is not significant for most centers:

- Again, no clear trend in profitability is apparent for any group.
- However, the three centers in the "low" category lost money over all six years of our analysis.
- The "medium" group experienced operating profits at or above 1% in only two of the six years; these basically were at "breakeven" on operations.
- The "high" group achieved 2% or higher operating margins in only two of the six years; mean profit margins for the other four years hovered between 0 and 1%.

Figure 5: Current Ratio by CMHC Financial Group

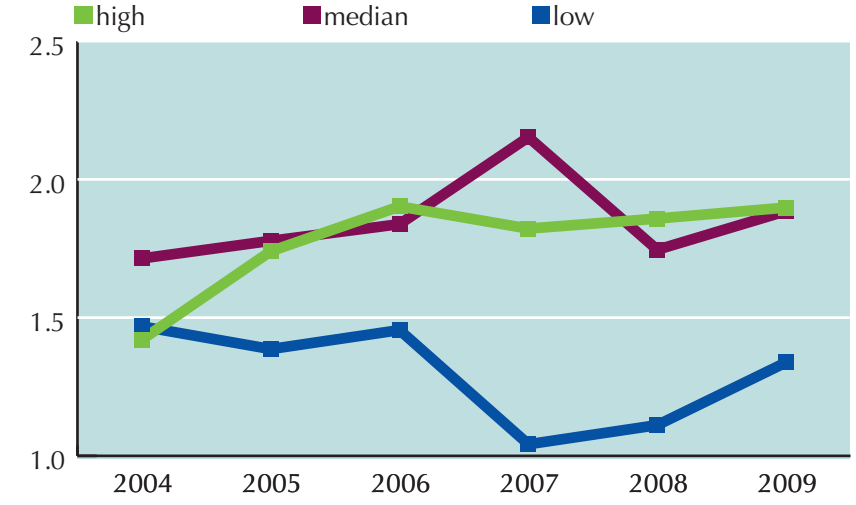


Figure 5 shows generally rising liquidity for the "high" and "medium" groups, but deteriorating liquidity for the "low" group. Both the "high" and "medium" groups maintained a satisfactory ratio of current assets to current obligations; only one center fell below the commonly accepted sufficient ratio of 1.5 in multiple years. However, the "low" group centers averaged below the 1.5 benchmark and some experienced a current ratio below one in some years, indicating a challenge in meeting everyday cash needs like payroll and paying suppliers.

Figure 6: Days in Accounts Receivable by CMCH Financial Group

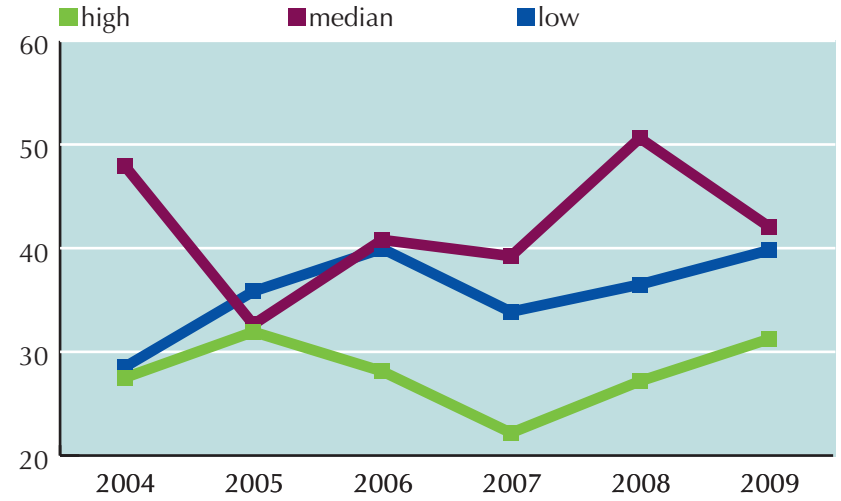


Figure 7: Days Cash on Hand by CMHC Financial Group

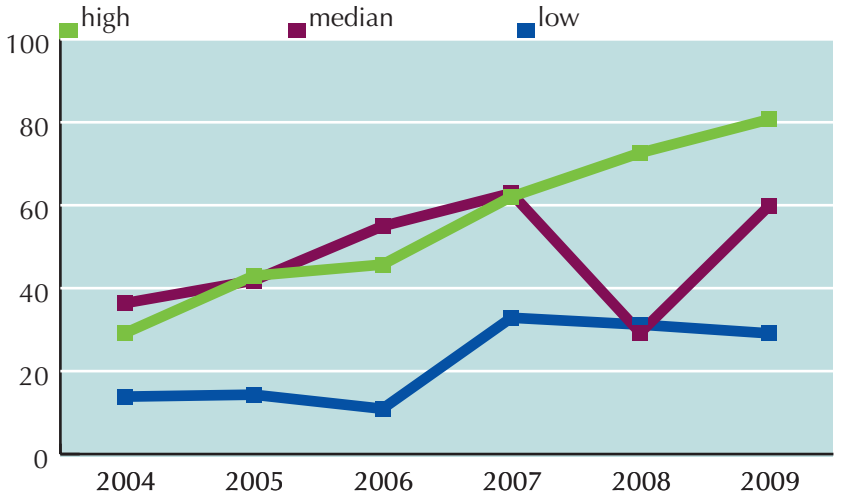


Figure 8: Equity Financing for CMHC Financial Groups

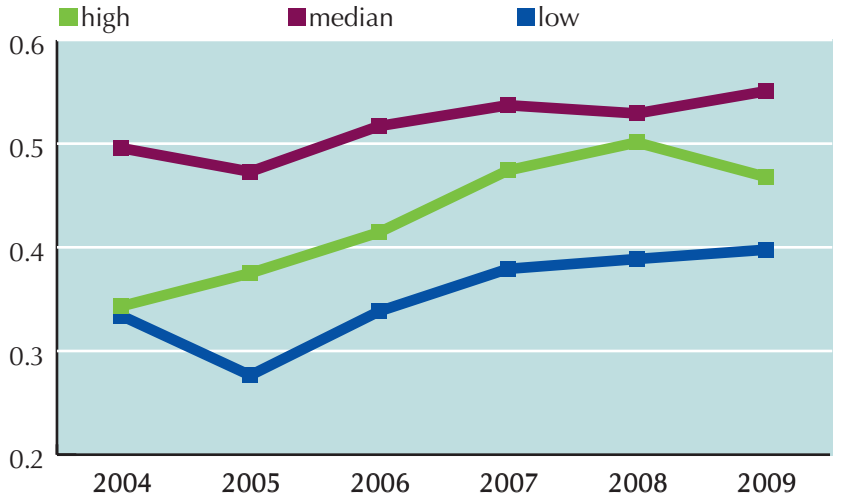


Figure 6 indicates that higher performers had the lowest days in accounts receivable, collecting on their accounts more quickly than either the medium or lower performing centers. All financial groups are collecting receivables within two months, which is generally good (for example, hospitals average 60 days to collect receivables).

Figure 7 shows a generally rising trend in days cash on hand , including marketable securities and cash accounts, a favorable financial trend for the sector. The large dip in 2008 for medium performers resulted from a combination of plant investments (using cash to build offices/clinics/add equipment) and significant negative margins for the year.

However, two centers have precariously low levels of cash; in 2009, one had enough cash to cover only 4 days of expenses, and the other only 8. While there are no "industry standards" of cash levels for community mental health centers, in the hospital sector 100 days of cash on hand is considered good. In our earlier New Hampshire CHC analysis, the median ranged between 20 and 50 days cash.

Figure 8 shows a favorable, upward trend for the amount of equity (relative to debt) that the Centers had on their balance sheets over time. Medium performers had the least debt, financing the largest portion of their assets through equity (accumulated profits). Centers in the low category financed the largest portion of their assets through debt and liabilities,[5] as

[5] Low performers' equity financing ratio may be overstated because two Centers in this category guarantee debt of unconsolidated affiliates, to whom they have long-term property rental obligations.

Figure 9: Debt Service Coverage by CMHC Financial Group

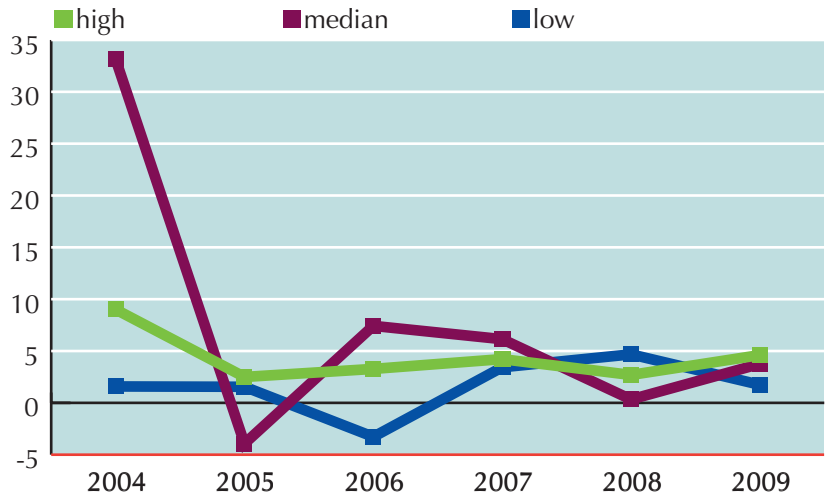
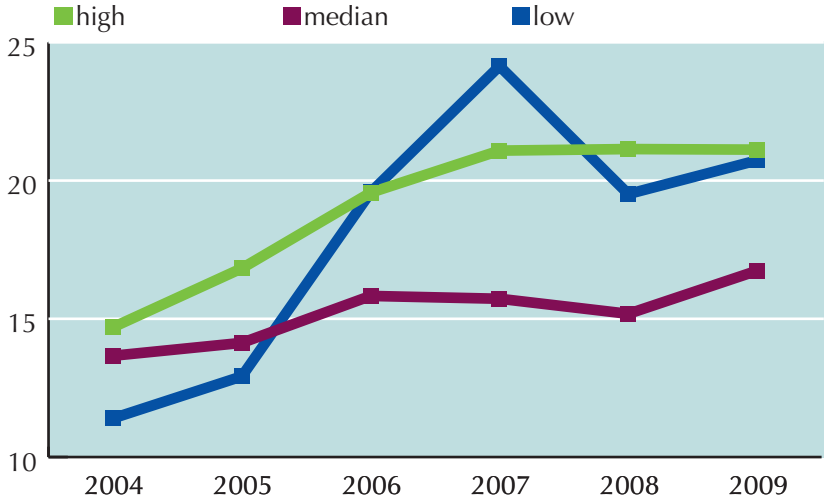


Figure 10: Plant Age by CMHC Financial Group



they lacked the accumulated profits needed to finance their asset needs. Low performers tended to rely on short-term bank and affiliate loans and liabilities to other creditors, as only one center in this category had long-term debt. Relative to NH community health centers, where the median equity financing ratio ranged between 20–40%, CMHCs had higher (more favorable) equity financing ratios. However, their heavy reliance on short-term sources of debt means that they are very vulnerable to being unable to repay loans or to access new debt if they experience significant deterioration in their financial performance.

Debt service coverage measures the ability of the Centers to repay their long-term debt (so those with only short-term debt and no long-term debt are not included). Higher performers consistently earned, on average, two to four times their annual interest and principle payment requirements. However, medium and low performers experienced dramatic volatility in this ratio, as it is tied to total margins and debt repayment cycles.

Figure 10 shows that plant and equipment grew older over the study period for each category. While this aging trend is not as meaningful as in a medical context where equipment technology plays a critical role, the centers still need to maintain buildings and invest in information technology. Due to the number of centers whose properties are, or were in some years, owned by non-consolidated real estate affiliates, these numbers may not be comparable over time (some started consolidating these affiliates in only the last 2–3 years) or across centers (two have not yet consolidated their real estate affiliates).

IV. Projected Impact of Medicaid Cuts in FY 2010

Information received from NH State authorities indicates that total Medicaid payment reductions to the Centers for mental health services will approach $8 million for FY10, or about 7% of Medicaid FY09 payment levels. The payment reductions will take the form of reduced reimbursement rates for specific services performed by the Centers. Table 3 reflects the estimated reductions in FY10 Medicaid reimbursements, as prepared by each of the CMHCs.

Because Medicaid is 75% or more of total operating revenue, and a still higher percentage of net patient service revenue, overall financial performance is impacted severely by Medicaid payment and coverage policies, as Table 3 shows.

Table 3. Estimated Impact of FY10 Medicaid cuts as of December, 2009 on CMHC Surplus and Net Worth.[6]

Center	Surplus FY09 ($$000s)	Surplus FY10 (est.) ($$000s)	Estimated Medicaid cuts FY10	Pro Forma Surplus (Loss) with cuts	Loss as a % of 2009 Net Worth
A	363	363	1,655	(1,292)	30%
B	186	0	490	(490)	24%
C	595	100	814	(714)	15%
D	426	426	1,173	(747)	8%
E	41	268	854	(586)	49%
F	103	103	564	(461)	16%
G	549	0	800	(800)	24%
H	109	84	568	(484)	22%
I	-23	-373	372	(745)	118%
J	50	-7	396	(403)	34%
Total	**$2,399**	**$964**	**$7,686**	**$(6,722)**	**20%**

The estimated Medicaid reductions for each center vary according to both the volume and particular mix of services performed by that center; the exact financial impact on each center will not be known until the fiscal year closes on 6/30/10. However, all Centers will be forced to make significant adjustments to avoid large operating losses for the fiscal year. The $6.7 million in potential losses is nearly three times greater than the largest operating loss experienced by the Centers in any year between 2004–2009 ($2.4 million in 2008–see Table 1). These cuts would wipe out roughly 20% of the aggregate 2009 net worth of the Centers; individual Centers would lose between 8% and 118% of their 2009 net worth.

[6] Three Centers did not provide income statement estimates for FY10, this analysis uses FY09 income statements for these Centers.

Financial options such as covering losses with investment reserves are limited. Most of the Centers do not have financial assets that can be liquidated on the scale required, and to the extent that these are used in 2010, there would be no financial cushion for losses in subsequent years. Employee compensation reductions may not be practical or desirable without impacting the quality of service delivery. Centers that have bank lines of credit are not likely to be able to use them to cover recurring operating losses. Two centers were already forecasting losses that would be amplified by the Medicaid cuts.

The only practicable response to the Medicaid payment reductions may be to reduce the volume of services, which could come in several forms, including tighter eligibility rules, longer wait times, and decreased visit frequencies. In practice, each Center will improvise its own adjustment based on its specific operating context. Table 4 below illustrates just one perspective by using average revenues per client to express the reduction in Medicaid dollars in terms of number of patients served. This model indicates a 7% reduction in patient volume affecting over 3,000 people.

Table 4. Average Revenues per Medicaid Client at NH CMHCs.

Center	FY09 Program Service Fees(NPSR)[7] $000s	Mental health clients at 6/30/09	Revenues client $$	Number of clients equiv. to Medicaid cuts
A	16,430	7,409	2,220	745
B	7,619	2,230	3,420	143
C	18,952	9,000	2,110	386
D	11,920	4,060	2,999	391
E	10,135	4,386	2,310	370
F	8,876	5,079	1,750	322
G	7,890	2,969	2,657	301
H	9,520	4,773	1,990	285
I	8,908	3,394	2,620	142
J	7,317	4,093	1,790	221
Total	**$114,884**	**47,393**	**(avg) $2,424**	**3,306**

In conclusion, the Community Mental Health Centers have improved their financial position over the last six years from fragile to more secure, but they have not accumulated the financial reserves to withstand major cuts in revenues from Medicaid, their primary source of revenue. The likely outcome of such cuts will be a reduction in service levels for the population at a time when the demand for mental health services may well be rising due to growing unemployment and a slow economic recovery.

[7] Mental health program service fees only in the case of the two Centers that also provide developmental services.

Appendix A: Definition of Ratios Used in Report

Profitability:	**Purpose**	**Calculation**
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources. Higher is better.	Ratio of (Operating Income and Non-operating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues. Higher is better	Ratio of Operating Income/Total Operating Revenue
Liquidity:	**Purpose**	**Calculation**
Current Ratio	Measures the extent to which current assets are available to meet current liabilities. Higher (above 1.5) is better.	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers (lower is better)	Patient Accounts Receivable/ (Net Patient Service Revenue / 365)
Days Cash on Hand	Measures how many days the organization could continue to operate if no additional cash were collected (higher is better)	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:	**Purpose**	**Calculation**
Equity Financing Ratio	Measures the percentage of the organization's capital structure that is equity (as opposed to debt, which must be repaid). Higher is better.	Unrestricted Net Assets/Total Assets
Average Age of Plant	Measures the relative age of fixed assets (Lower is better)	Accumulated Depreciation/ Depreciation Expense