

On the Edge:

The Financial Health of Human-Service Providers

Many human-service and health-focused nonprofit organizations, particularly community-based organizations, do not recover the full cost of services, which translates into deficits that put them at risk.

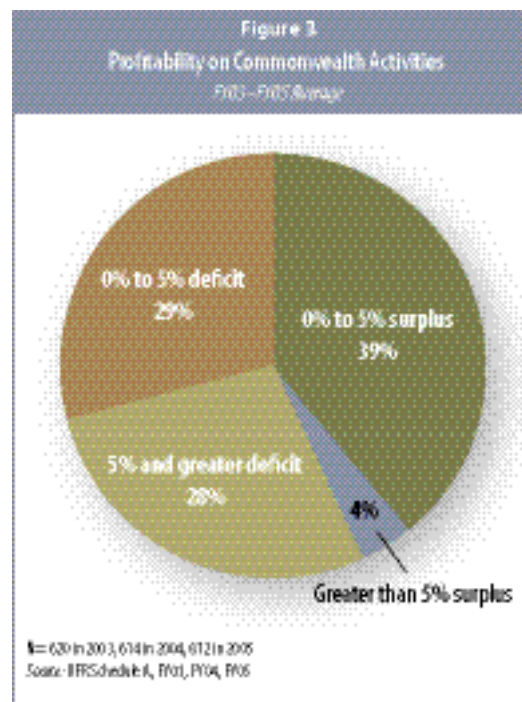
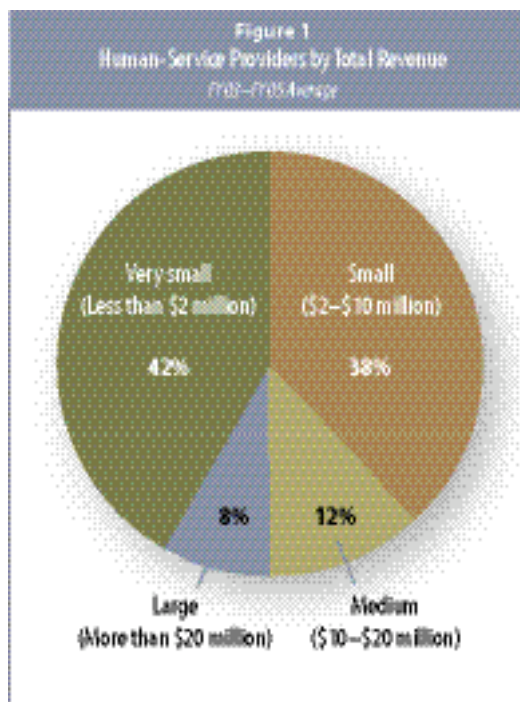
Editors' note : *This article is based on excerpts from "Financial Health of Providers in the Massachusetts Human Service System" commissioned by the Commonwealth of Massachusetts Executive Office of Health and Human Services and is authored by DMA Health Strategies, October 2007.¹*

THE MORTGAGE CRISIS AND THE TURBULENCE of financial markets have gotten the attention of policy makers, who fear that additional failures in these sectors could push the country further into recession. In light of these housing and banking failures, who is analyzing the health of the nonprofit sector? Particularly for human-service organizations, a similar exploration into nonprofit financial health would help to understand why so many nonprofits consistently live on the financial edge.

Policy makers at the Massachusetts Executive Office of Health and Human Services (EOHHS) recently commissioned a study to bring objective analysis to bear on indications that the overall financial stability of purchase-of-service (POS) providers is at risk. The study identifies reasons for differences in financial health and explores the relationship between the state's purchasing practices and providers' financial health. The study highlights why so many nonprofits are financially fragile: many human-



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service and health-focused nonprofit organizations, particularly community-based organizations, do not recover the full cost of services, which translates into deficits that put them at risk.

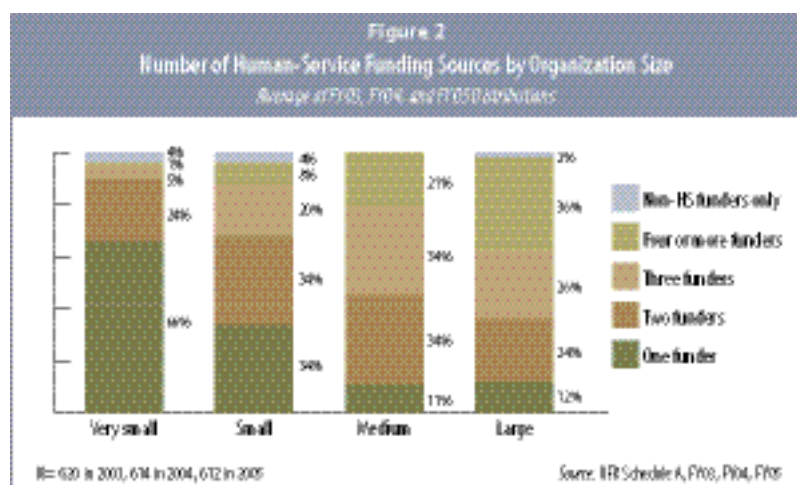
In fiscal year 2007, EOHHS and its 16 agencies purchased more than \$2.4 billion in services from its network of 1,100-plus largely nonprofit providers, which in turn delivered care and support to more than 1 million state residents. Services include homes for adults with chronic mental illness or cognitive and physical disabilities, public health, substance abuse treatment, juvenile justice, child welfare, family support programs, and other social services.

The Funding System

Since the 1960s and 1970s, when Massachusetts was a leader in developing strategies to move individuals out of institutional settings and into less restrictive, more humane community environments, the state and human-service organizations have become interdependent. Over the past several decades, the choice to purchase these services reflects the state's determination that noninstitutional community settings best serve human-services clients. Further, privately operated community settings generally afford the state and the public a higher degree of cost-effectiveness, program diversity, and creativity than the state alone can provide.

Total spending has risen from an estimated \$25 million (inflation adjusted) in 1974 to the current spending level of \$2.4 billion. Today, nearly half of the human-service provider organizations that deliver care under state contracts depend on contract sources for more than 50 percent of their revenue. In short, the state depends on these organizations to deliver high-quality care, and conversely the financial stability of these organizations depends largely on state purchasing practices.

Massachusetts also relies on the human-service industry as a significant force within the larger state economy. These organizations employ more than 185,000 workers, which equals more



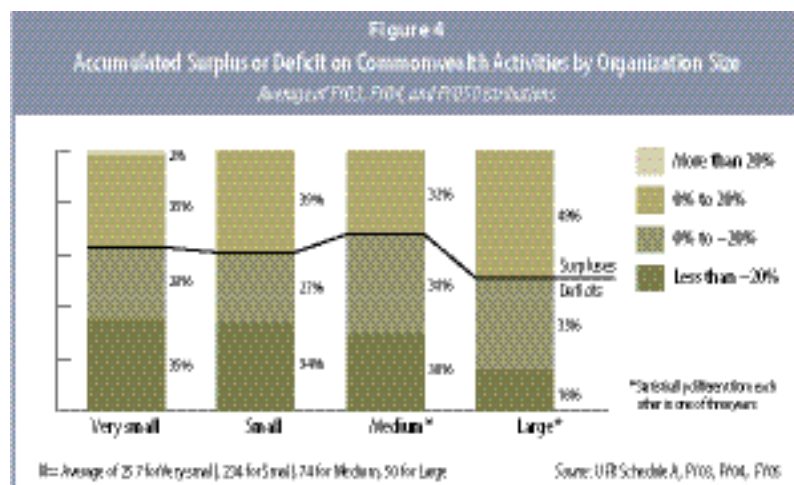
Scope and Research Methodology

The study drew on the Uniform Financial Report (UFR) submissions required annually of most purchase-of-service (POS) providers in Massachusetts. The UFR includes the submission of financial statements and detailed program budgets. The analysis reviewed the financial data for the more than 600 providers that derive at least 5 percent of total revenue from the POS system of the Executive Office of Health and Human Services. The sample excluded hospitals, universities, and foundations (whose “core business” does not include the provision of POS services) or Aging Services Access Points (whose role as financial intermediaries skews their financial condition), as well as organizations in which 40 percent or more of total revenue comes from nonprogram sources (since such organizations are substantially different from organizations reliant on program service fees). The final sample of 615 organizations accounts for 87 percent of all POS revenues reported on UFRs and consists of organizations that are representative of the providers on which Massachusetts depends for the delivery of care to vulnerable populations.

than 3 percent of the state’s total workforce (and is comparable in size to the state’s telecommunications industry). Economic census data indicates that the industry generated \$4.6 billion in revenue in 2003, and industry payroll exceeded \$2 billion. Worker spending contributes more than \$112 million in state and local taxes.

Jobs available in the human-service sector are dispersed throughout Massachusetts. Unlike many commercial industries, nonprofits are often located precisely in the areas that are most in need of jobs. Moreover, many positions are suitable for individuals seeking entry-level, relatively low-skill employment. These factors combine to make this industry critical to the state’s overall economy, with particular relevance for communities that often lack viable employment opportunities.

Like for-profit businesses, human-service organizations must meet certain basic requirements to survive: they must have sufficient resources to cover their expenses, they must be



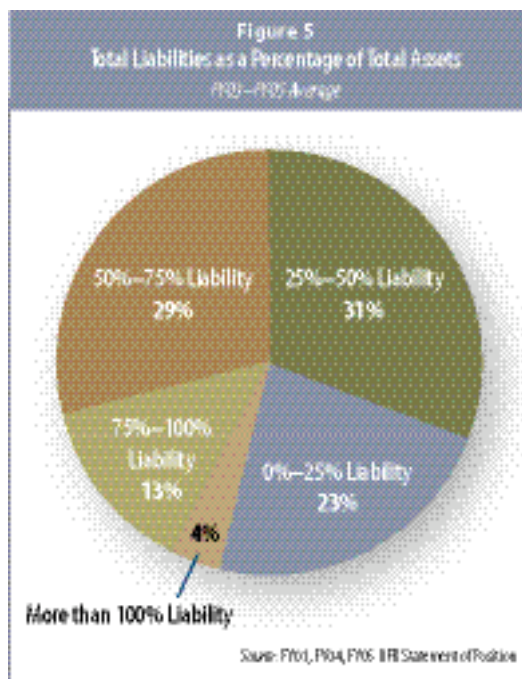
solvent, and they must be capable of securing lines of credit. In addition, just like any business, healthy not-for-profit providers must end the year with a modest surplus, which they can reinvest in their organizations. Providers with the adequate resources to operate do not need to constantly manage crises and can devote efforts to innovating, improving, and, when appropriate, expanding services. Stable organizations better attract and retain high-quality staff, which enhances continuity of care, service quality, and administrative efficiency.

But it is clear that there is a spectrum of financial health among nonprofit organizations. Organizations that are financially healthy and stable include universities and hospitals, which have multiple funding sources, can charge for the full cost of services, have high-overhead reimbursement rates and a healthy base of large and long-time institutional donors. In contrast, many human-service agencies rely on the POS system to fund program services. They are much more financially unstable because of their heavy reliance on restricted funding, low-overhead reimbursement rates, and the need to raise matching and unrestricted funds from typically small donor bases.

The POS system in Massachusetts is funded primarily by line items in the state budget, along with pass-through federal grants from a variety of federal agencies. In many cases, these services are delivered via multiyear contracts with nonprofit organizations that have multiple annual renewals. Often multiyear contract obligations are level-funded throughout the life of the contract and its renewals, despite annual increases in costs. With some exceptions, POS

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reimbursement rates generally aren't based on an analysis of actual cost. Rather, a rate in the POS system is typically the maximum obligation of a contract, which is dependent on the availability of state funds divided by the number of units the provider agrees to deliver. Further, many contracts in the POS system are executed on a cost-reimbursement basis in which no rate exists. Under cost-reimbursement contracts, agencies generally dictate exact inputs and costs, and providers have limited incentive for efficiency and innovation.

As indicated by the study's provider advisory group, these factors' impact on providers can take many forms:

- Staff salaries and fringe benefits do not keep pace with increases in overall cost of living.
- The relatively low wages that provider organizations can offer employees limit the level of experience and qualification for many direct-care workers, and also lead to rapid staff turnover and increased replacement costs. Providers may also leave positions vacant in order to realize savings, which can have adverse quality and regulatory implications.
- Providers may defer routine support costs, such as facility maintenance, information systems, and other critical infrastructure investments.

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The Next Steps

In January 2008, the Massachusetts Executive Office of Health and Human Services (EOHHS) followed up its groundbreaking 2007 report with "EOHHS Report to Administration and Finance: Recommendations for Reforming the Purchase of Service System." It details EOHHS's proposals to address the challenges created by the purchase-of-service (POS) system—which, according to the report, makes up 10 percent of the Commonwealth's budget—and articulates a framework that EOHHS will use to address these challenges. The principles include the following:

1. **Community first.** Families and individuals are best served in the community, not in institutional settings. The Commonwealth's community system must be stable and capable of meeting the highest standards of care.
2. **A fair wage.** Workers employed in the Commonwealth's POS system must earn a fair wage.
3. **Rate reform.** Rates of reimbursement for community providers must cover the reasonable costs incurred by an efficient and economical provider, must be based on a transparent rate-setting methodology, and should be reviewed regularly for adequacy.
4. **Quality and accountability.** Human service contracts should focus on achievement of measurable quality and outcome benchmarks and, where relevant, provide incentives for quality and outcome attainment.
5. **Cross-secretariate efficiency and consistency.** The entire POS system should be reviewed for efficiency of management and delivery. Wherever appropriate, business practice, administration, and contract management should be consistent throughout agencies.

ness. Unless these organizations have other financial resources to make up the shortfall, they begin to fall further behind, first running annual deficits and ultimately reporting negative net assets.

The Service Providers

Ninety percent of the providers are tax-exempt 501(c)(3) organizations; most were incorporated in the 1970s and 1980s. Figure 1 (on page 24) shows the breakdown of the sample based on budget size. Nearly 40 percent of organ-

izations have budgets of less than \$2 million, and another 35 percent have budgets of between \$2 million and \$10 million.

As shown in figure 2 (on page 24), 43 percent of providers have revenue from only one EOHHS agency (funding source); 30 percent have revenues from two. Very small and small providers are most likely to have only one or two EOHHS agency funding sources. About 60 percent of providers have a predominant funding source (i.e., one that is 40 percent or more of total revenue). Providers with three EOHHS agency funding sources have higher net incomes than those with two or less. Those with a single or a dominant funding source (representing 40% or more of total revenues) do not report higher net incomes.

Results of the Analysis

This study confirmed that, in many areas, the financial health of human-service providers in Massachusetts is suffering, and state policies have a negative impact on financial health outcomes. The approximately 615 provider respondents show subpar and precarious results in three important areas of financial health: profitability, solvency, and liquidity. As figure 3 (on page 24) shows, the majority of respondents report deficits in state contract activities each year.

Figure 4 (on page 25) shows the distribution of historical surplus and deficit among organizations of different size. Overall, about 60 percent of respondents have cumulative deficits from their state-funded activities in the 2003 to 2005 period.

One of the most statistically significant factors affecting providers' overall ability to break even or generate a surplus is the profitability of a provider's contract with the state. There are several possible explanations for annual and cumulative deficits on state contracts: First, the Commonwealth of Massachusetts limits the surplus a nonprofit can earn in a single year on state contracts to five percent and to 20 percent cumulative. As a result, contracting practices are designed to ensure that annual surplus is nominal. Cost reimbursement contracts, which account for 16 percent of total program revenue, show a consistent negative relationship to financial health. Organizations are not allowed to generate a surplus under this type of contract and are thus unable to build a cushion to fall back on in harder times or to invest in infrastructure or staff training. These organizations also have little incentive to strive for efficiencies

Recommendations for Contracting with State Agencies

The Executive Office of Health and Human Services released a follow-up report in January 2008 presenting principles for future POS contracts (see related sidebar on page 26). In the meantime, Elizabeth Keating, a visiting assistant professor at Boston College and contributor to the 2007 report, makes the following recommendations for state agencies contracting with human-service providers.

- **Pay 100 percent for contracted services.** This should include (1) reasonable and frequent adjustments for inflation and costs of living; (2) reasonably sufficient overhead rates to fully cover support service costs, such as the cost of reporting on its activities to the state; (3) funds to support necessary infrastructure investments or upgrades; and (4) timely payment.
- **Pass a single nongovernmental organization funding act similar to the Single Audit Act.** Nonprofits spend inordinate amounts of time presenting their case to various governmental agencies using differing forms and applications and then separately reporting on those activities. This is wasteful for everyone involved. Government agencies, especially those within the same executive office, should standardize grant applications and reporting as well as have standard contract applications and reporting.
- **Revise nonprofit accounting standards and regulations.** Nonprofits should engage in fair disclosure as is required for publicly traded firms. This would entail making financial statements and grant reports available to the public, not just select donors. The standard setters and regulators should encourage more consistent accounting practices, such as the use of the Uniform Chart of Accounts and a standardized operating measure that allows for cross-organizational comparisons and sector-wide analysis. A classified balance sheet that distinguishes current from noncurrent assets and liabilities would facilitate better financial analysis of nonprofit health. Nonprofits should be required to provide a management discussion and analysis that explains and interprets financial statements.
- **Require reporting on results-based metrics, from input and activity levels to outputs and outcomes and cost-benefit relationships.** Data on both programmatic and nonprogrammatic endeavors should be reported, ideally in a format that allows for cross-organizational comparisons. This would enable the state to manage human services not just by minimizing cost but by managing value.

because they cannot enjoy the savings. In addition, these organizations may face costs for which they are unable to receive reimbursement, such as principal payments and unanticipated expenses incurred after the deadline for contract amendments. These limitations can lead to program losses and reduce providers' ability to build net assets. As a result, they have fewer resources to support financial stability.

A second possible cause is that EOHHS agencies generally issue multiyear, usually level-

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funded contracts with repeated annual renewals with few, if any, price increases. In accordance with Operational Service Division guidelines, agencies may renew contracts for up to 11 years. As a result, long periods often elapse with relatively few competitive procurements. While an 11-year contract may offer clients and state agencies the benefit of continuity and stability, in recent decades new funding has rarely been available to adjust contract budgets at the time of annual budget negotiations. As the general cost of doing business has increased, state agencies and providers must often modify program staffing and overall program budgets to fit available resources.

Ongoing operating deficits have pushed many providers to the financial limit. Almost half of these providers (45 percent) fail to generate sufficient cash each year to pay for operations. In addition, 60 percent of providers have less than one month of cash on hand at year-end, with one-third having less than 15 days of cash. An organization can survive for several years in this situation by forgoing investments, liquidating assets, or borrowing. But over the long term, the pattern is unsustainable. Unexpected delays in

receipt of income can push an organization with limited cash into a crisis situation.

Many providers operate under considerable financial constraints that are exacerbated by limited state funding, translating into low cash balances and inadequate or negative expendable net assets. Some smaller providers may not have access to lines of credit or be able to qualify for mortgages, while a significant percentage of larger providers are heavily leveraged, relying on liabilities rather than net assets to finance their operations. In fact, as figure 5 (on page 26) indicates, almost half of all providers have liabilities that are 50% or more of total assets, while 4 percent have liabilities that exceed total assets (i.e., they are insolvent). Leverage ratios vary significantly with organization size. Organizations under \$10 million in total revenues are most likely to be insolvent, while those larger than \$10 million are more likely to be highly leveraged.

Certain provider characteristics are associated with better financial health, such as staying in business for a longer period of time and having larger total revenue. Providers that can generate more income from nonprogram sources, such as investments, contributions, and commercial

revenue are associated with stronger financial results, since they can augment state surpluses or offset deficits. Not surprisingly, providers that have established adequate cash balances and liquid assets also fare better financially.

Next Steps

Given the vital role that the industry and its workforce play as an economic contributor to the state and as a partner in delivering care to vulnerable citizens, it is in the state's interest to ensure that provider organizations are financially stable and that their workforce is paid a living wage.

The challenges facing Massachusetts and the sector did not develop overnight. They are the result of historic underfunding of providers and the piecemeal, organic evolution of state public policy governing human-service purchasing, reimbursement, and provider performance management.

ENDNOTES

1. The editors would like to acknowledge the collaboration of EOHHS and DMA in producing this article, which remains the responsibility of *NPQ* editors. In particular, we would like to thank Matt

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How does your service-provider organization fall on the spectrum of financial health? Let us know at feedback@npqmag.org. Reprints of this article may be ordered from <http://store.nonprofitquarterly.org>, using code 150204.

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