

# PUBLIC HEALTH FINANCE TUTORIAL SERIES

## Module I

### FINANCING PUBLIC HEALTH SERVICES

---

#### **MODULE THEME: HOW THE NATION PAYS FOR ITS PUBLIC HEALTH SYSTEM**

The purpose of the public health system is to promote physical and mental health and prevent disease, injury, and disability. Definitions vary but, in practical terms, the public health system can be thought of as the federal, state, and local public health organizations and the resources needed to meet system goals. These governmental organizations form the “nerve center” of the system,” which then interacts with a variety of partners to promote the public health of the U.S. population.

To get a feel for the diversity of organizations involved in public health, here are some of the governmental and nongovernmental entities that comprise the system:

- Over 3,000 county and city health departments and local boards of health.
- 59 state and territorial health departments.
- Tribal health departments.
- More than 160,000 public and private laboratories.
- Parts of multiple federal departments and agencies.
- Hospitals and other healthcare providers.
- Volunteer organizations such as the Red Cross.

Of course, to keep such a system “up and running” a very large amount of financial resources (funding) is required. To illustrate, roughly \$60 billion annually has been spent on public health activities in recent years.

Because of the diversity of the public health system, there is a wide range of funding sources. By the end of this module, you will have a much better understanding of the U.S. public health system and how it is financed.

#### **Learning Objectives**

After studying this module, you should be able to do the following:

- Describe the way that public health services are funded by federal, state, and local governments.
- List the sources of revenue for local health departments.
- Describe the various types of federal grants.
- Explain the types of information required in federal grant applications and discuss some of the most important features of good grant management.
- Describe the major categories of health insurers.
- Explain the key features of alternative health services reimbursement methodologies.
- Briefly discuss the purpose and features of medical coding.
- Explain the key features of debt and lease financing.

## INTRODUCTION

Public health programs are financed through a combination of federal, state, and local governmental appropriations and, especially at the local level, from fees and other reimbursements received directly for services provided. In this financing structure, each level of government has different, but important responsibilities for protecting the public's health.

Despite the relatively small role that medical care plays in population health, the health resources of the U.S. are disproportionately allocated to the provision of care as opposed to the promotion of health. Nationally, only about 3 percent of the total funds spent on healthcare are allocated to public health. For example, of the roughly \$2.6 trillion total health expenditures in 2010, less than one percent was spent on public health activities. Federal spending accounted for about 30 percent of total public health expenditures while state and local spending covered the rest. Unfortunately, data on public health spending are not completely reliable because of the large number of funding sources, differences in accounting practices, and even problems in separating public health activities from other healthcare expenditures.

Understanding the financing of public health services is critical to understanding the public health system. In essence, the "follow the money" rule helps public health managers understand the role that different entities play in providing public health services to the U.S. population. The purpose of this tutorial is to introduce the financing structure of the public health system. In addition, several related topics are covered, including types of governmental appropriations, reimbursement methods used by third-party payers, and the importance of grants and grant management.

## PUBLIC HEALTH FINANCING AT THE FEDERAL LEVEL

In partnerships with states and localities, the *federal government* has the following public health responsibilities:

- Assure the capacity for all levels of government to provide essential public health services.
- Act when health threats may span many states, regions, or the whole country.
- Act where the solution may be beyond the jurisdiction of individual states.
- Act to assist the states when they do not have the expertise or resources to mount an effective response in a public health emergency such as a natural disaster, bioterrorism, or an emerging disease.
- Facilitate the formulation of public health goals in collaboration with state and local governments and other relevant stakeholders.
- Be transparent and accountable for public health investments.
- Disseminate innovation and best practices from state and local public health departments.

These responsibilities are met primarily by certain offices and operating divisions within the Department of Health and Human Services (HHS). For example, the Office of the Assistant Secretary for Health oversees 14 core public health offices, including the Office of the Surgeon General and the U.S. Public Health Service Corps, as well as 10 regional health offices and 10 presidential and departmental advisory committees. The Surgeon General is the senior advisor to the HHS secretary on public health matters and is considered the nation's spokesperson on public health issues. Some of the other offices that fall under the Office of the Assistant Secretary for Health include the Office of HIV/AIDS Policy, the Office on Women's Health, the Office of Minority Health, the Office of Disease Prevention and Health Promotion, the National Vaccine Program Office, and the Office of Healthcare Quality. Examples of advisory committees that are under the Assistant Secretary for Health include the President's Council on Fitness, Sports, and Nutrition and the Advisory Committee on Blood Safety and Availability.

The 11 HHS operating divisions are as follows:

- Administration for Children and Families
- Administration on Aging
- Agency for Toxic Substances and Disease Registry
- Agency for Healthcare Research and Quality
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Food and Drug Administration
- Health Resources and Services Administration
- Indian Health Service
- National Institutes of Health
- Substance Abuse and Mental Health Services Administration

Of these divisions, the primary ones involved with funding state and local public health efforts are the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC). HRSA distributes approximately 90 percent of its total funding in grants to states and territories, public and private healthcare providers, and health professions training programs. The bulk of HRSA funds are in its two largest programs, the community and migrant health centers and the Ryan White Act HIV programs, which are awarded on a competitive basis and/or based on disease burden. At this time, HRSA distributes about \$7.5 billion annually to a variety of public health entities, which works out to about \$25 per person (per capita).

Approximately 75 percent of CDC's budget is distributed to states, localities, and other public and private partners to support services and programs. Some of CDC's funding is based on the number of people in a state or on a need-based formula. Other funds are based on competitive grants. States can apply to CDC for grants for a specific program area, but typically there are insufficient monies available to fund all requests. Currently, CDC distributes about \$6 billion annually to various public health entities, which translates to a per capita amount of less than \$20.

#### Key Concept: Federal Public Health Funding

The two primary sources of federal funding for public health services are the *Health Resources and Services Administration (HRSA)* and the *Centers for Disease Control and Prevention (CDC)*, both of which are located in the *Department of Health and Human Services (HHS)*. Together, these two agencies provide about \$13.5 billion annually to state and local public health entities.

Considering both HRSA and CDC, the combined annual federal funding to state and local public health entities is approximately \$13.5 billion, or about \$45 per person. Note, however, that this funding is not evenly spread across the states. For example, in a recent year Alaska received about \$158.25 in per capita funding while Ohio received \$29.25. Although there is some rationality to the differences in per capita amounts distributed to states, it is likely that the variances do not totally represent disparities in public health needs.

Currently, most of the federal funding from CDC for states is distributed for specific programs (categories). While each category provides important funding for serious public health concerns, the funding is not allocated based on priority goals for reducing disease and injury rates, such as those outlined in

the Healthy People 2020 initiative or to programs that have demonstrated effectiveness in reducing disease.

Furthermore, although many federal programs do help alleviate a number of health problems, the funding typically is not well coordinated among federal agencies or with state and local funding programs.

## Self-Test Questions

1. Name a few of the public health responsibilities of the federal government.
2. Federal public health responsibilities are carried out primarily by the Department of Health and Human Services (HHS).
  - a. What are some of the HHS offices that have public health responsibilities?
  - b. What are some of the HHS operating departments that have public health responsibilities?
  - c. What are the two HHS departments that provide the most funding for state and local public health services?
3. When HRSA and CDC funding to state and local public health entities are combined, what is the approximate per capita amount distributed?
4. Are the federal monies distributed to states evenly?

## PUBLIC HEALTH FINANCING AT THE STATE AND LOCAL LEVELS

States and localities have the following public health responsibilities:

- Fulfill core public health functions such as diagnosing and investigating health threats, informing and educating the public, mobilizing community partnerships, protecting against natural and manmade disasters, and enforcing state health laws.
- Provide relevant information on the community's health and the availability of essential public health services. This information should be integrated with reporting from local hospitals and healthcare providers to show how well public concerns and health threats are being addressed. Furthermore, this information should be publicly available and utilized by public health departments to work collaboratively with hospitals, physicians, and others that have a role in public health to set health goals.
- Work collaboratively with the multiple stakeholders who influence public health at the community level in designing appropriate programs and interventions that address key health problems and improve the health of the region.
- Deal with complex, poorly understood problems by acting as "policy laboratories" to take advantage of the fact that states and localities are closer to the people and to the problems causing ill health than is the federal government.

There are three types of organizational structures for state public health departments: stand alone, umbrella, and mixed function. *Stand alone* public health agencies are independent from other agencies in the state and have a dedicated public health mission. State public health agencies that fall under larger agencies like a State Department of Health Services are called *umbrella* agencies. Lastly, *mixed function* state agencies function independently but perform other functions in addition to public health such as Medicaid and health insurance regulation. Although organizational differences have a significant impact on the administration of the state public health function, organizational structure does not appear to affect the amount of state funding devoted to public health activities.

There are approximately 2,800 local health departments (LHDs) in the United States serving a diverse assortment of populations ranging from less than 1,000 residents in some rural jurisdictions to about nine million people, the number served by the New York City Department of Health. LHDs are structured differently, depending on state, and may be *centralized* (controlled at the state level) or *decentralized* (controlled at the local level). Therefore, the level of responsibility and services provided by LHDs varies among states, and consequently so does the way that funding levels are established and allocated.

States and local communities have chosen a variety of ways to fund public health activities and services and hence the amount of funding is highly variable. To illustrate, according to a 2008 report by the National Association of County and City Health Officials (NACCHO), although the median per capita expenditure on public health activities at the local level was \$36, funding ranged from under \$10 to over \$100 and the annual budgets of LHD's ranged from less than \$10,000 to more than \$1 billion. Roughly 25 percent of LHDs had annual expenditures of less than \$500,000, while 17 percent had expenditures of more than \$5 million.

**Key Concept: State and Local Funding**

In addition to federal funding, state and local governments contribute significant amounts to help finance public health activities. To illustrate, at the local health department level, federal funds, on average, amount to 19 percent of the total budget; state and local funds contribute 45 percent; while the remaining 36 percent come from fees, reimbursements for healthcare services, and non-governmental (private) grants.

Exhibit 1 lists the revenues (funding) of LHDs by source. On average nationally, local and state sources provide 45 percent of the funding, while federal sources provide 19 percent of the funding, for total governmental funding of 64 percent. That means that, on average, 36 percent, or over one-third, of the funding of LHDs comes from sources other than appropriations. These sources include inspection and clinical services fees (12%), Medicaid reimbursements (10%), and Medicare reimbursements (5%). Other non-appropriation sources consist primarily of private foundation grants.

Exhibit 1 also contains the revenue mix for Tangelo County Health Department (TCHD). Note that local sources include only 6 percent governmental appropriations—the remainder (28 percent) comes from agreements with the Department of Corrections, Healthy Start, and other programs and coalitions that TCHD receives funding for on a contractual basis. For TCHD, only 48 percent of its funding comes from governmental appropriations; the remaining 52 percent comes from contracts and fees.

The data in Exhibit 1 highlight two important points. First, a significant proportion of public health funding at the local level comes from contracts, fees, and grant funds, which typically can be influenced by local managerial actions more than the amount of governmental appropriations. Second, national average data are just that: averages. Thus, revenue percentages at the local health department level are highly variable. For example, some LHDs do not provide clinical services to individuals, and hence their revenues do not include clinical services fees. But at those LHDs that do provide clinical services, such as TCHD, managers must understand fee-for-service reimbursement methodologies. Furthermore, managers at all LHDs must know how to apply for, obtain, and manage grant resources from both private and public sources. (These topics are discussed in later sections in this module.)

EXHIBIT 1 Local Health Department Revenue Sources

<u>Source</u>	<u>National Average</u>	<u>Tangelo County HD</u>
Local	25%	34%
State direct	20	33
Federal pass-through	17	9
Fees	12	8
Medicaid	10	12
Other	9	3
Medicare	5	1
Federal direct	<u>2</u>	<u>0</u>
	<u>100%</u>	<u>100%</u>

## Self-Test Questions

1. Name a few of the public health responsibilities of state and local governments.
2. Is public health spending at the local level relatively consistent across states?
3. Who funds most of the spending at local health departments (LHDs)?
4. Why should LHD managers pay attention to non-appropriation revenue sources?

## FEDERAL FUNDING MECHANISMS

As discussed in an earlier section, federal funds are distributed through its system of agencies. It is the agency's responsibility to manage the distribution of funds utilized for public health services, including ensuring that the funds are used for the purposes stated in the enabling legislation and in a prudent manner. The funds are provided to beneficiaries, or *recipients*, such as states, local health departments, and other health services providers, through hundreds of individual *programs*, such as the Maternal and Child Health program. Each program, which is assigned a unique name to distinguish it from other programs, is created for a specific purpose. For administrative purposes, programs are assigned to offices or operating divisions within a federal agency and may include administrative personnel which work directly or indirectly with the program.

Program funds are distributed to recipients through federal *grants* (awards), which use funds that are allocated from general revenues. Recipients must first apply for the award directly to the federal agency which administers the program. The agency must then determine the amount of assistance to be awarded and notify the recipient of the award. In order for an award to be considered official, a grant agreement (contract) between the agency and the recipient, which delineates the purpose of the award as well as restrictions and limitations, is signed by both parties.

Federal awards typically specify a time period, called the *period of availability*, during which the recipient may use the funds. Most grants have a term of one year (although some may have a longer lifespan), and the recipient must use the grant funds within that time frame. The expiration of funds is a consequence of the federal budget process, which dictates that any funds not used within the specified time limit revert to other uses. As a condition of receiving federal grants, recipients must agree to comply with the applicable laws and regulations related to the program and its agency, as well as any provisions included in the grant agreement entered into between the recipient and the agency. Failure to do so may lead to sanctions, including fines and penalties, exclusion or suspension from participating in federal programs and activities, and/or criminal charges.

## Types of Federal Grants

The federal government has several different types of grants, each with its own unique way of awarding and/or operating.

- **Categorical grants**, which are the main source of federal aid to state and local governments, can only be used for specific purposes and often require state and/or local governments to provide matching funds. Categorical grants can be either on a project basis or formula basis.
  - **Project grants** are awarded competitively. Project grants are the most common form of grants in terms of numbers (not dollar value), and most grants are found in scientific research, technology development, education, social services, and the arts. Examples of project grants for health services include the Community Health Centers, Head Start, and Health Disparities in Minorities programs.
  - **Formula grants** are awarded on the basis of a precise formula specified in the legislation that creates the program. Formula grants are typically funded on the basis of measurable factors, such as overall population, proportion of population below the poverty level, and infant mortality rate. The specified formula informs potential recipients, typically states, precisely how they can calculate the quantity of aid to which they are entitled, as long as the recipient qualifies for such assistance under the stipulations of the program. Usually, the elements in the formula are chosen to reflect characteristics related to the purpose of the aid. Examples of formula grant programs include the Ryan White HIV Care and Mental Health Services programs.
- **Block grants** typically are large amounts of funding awarded to state or local governments with only general provisions as to the way the grant is to be spent. This is in contrast to categorical grants, which contain very specific provisions regarding how the funds are to be used. An advantage of block grants is that they allow state and local governments to use different approaches to solving problems as well as allow the funds to be used to address the needs determined to be most worthwhile. The opposite side of the coin is that state and local governments are able to use the money as if they collected it through their own taxation systems and spend it with very few restrictions from the federal granting agency.
- **Earmark grants** are explicitly specified in appropriations of the U.S. Congress. They are not competitively awarded, and have become controversial because of the involvement of political lobbyists in the award process.

## Federal Pass-Through Grants

The federal government allows certain recipients to act as *pass-through entities*, which allows the initial recipient to provide the funds to another recipient. The pass-through entity is still considered the recipient of the grant, but the assistance provided in the grant may be “passed on” or “passed through” to another recipient. The entity which receives the assistance from a pass-through entity is considered a *sub-recipient*. This process is used when the federal granting agency does not have the organizational capability to provide assistance directly to the final recipient and hence requires administrative support from another entity.

### Key Concept: Federal Grant Types

There are several categories and classes of federal grants. These include **categorical grants**, which can be used only for designated purposes; **block grants**, which typically are very large awards with only general provisions as to use; and **pass-through grants**, which are awards given to one recipient, often a state, and then “passed through” to other recipients, such as local governments.

For example, the Women, Infants, and Children (WIC) program is a federally funded nutrition program that provides nutrition assessments, diet counseling, and food coupons to low-income women. The funds are granted to states (and similar governmental jurisdictions), but then are further allocated through *sub-grants* to counties and municipalities, typically ending up in local health departments. The original recipients, the states, are the pass-through entities and the



counties and cities are the sub-recipients, all of which share the responsibility of supporting the original purpose of the program. Sub-recipients may in turn pass some or all of the funds to another sub-recipient if it supports the purpose of the program. Therefore, a recipient may be considered a pass-through entity and a sub-recipient at the same time.

Pass-through entities and sub-recipients are equally responsible for the management of federal aid received. The federal government monitors the federal aid provided to any recipient and requires all pass-through entities to monitor the aid they pass on. Noncompliance of a federal regulation on the part of a sub-recipient may be attributed to the pass-through entity because it is still responsible for the management of the funds that it passes on.

### **Self-Test Questions**

1. What is a period of availability?
2. What is the difference between a block grant and a categorical grant?
3. What is a pass-through entity? A sub-recipient?

### **GRANT MANAGEMENT**

Because a significant amount of public health funding comes in the form of grants, grant management is an important part of the financing process. In this section, we briefly discuss the grant application process as well as management by the grant receiver (grantee) once a grant is obtained.

#### **Applying for Grants**

Although the application process varies depending on the granting agency and the nature of the grant, most grant applications follow a similar pattern regarding the types of information required. To illustrate, consider the format of Form PHS 5161-1, which is used to apply for a variety of grant programs administered by the Public Health Service (PHS). The application consists of a set of instructions, followed by six additional sections that comprise the standard application.

The first section of the application form requests basic information about the applicant and the project. Examples include the proposed start and end dates, name and type of requesting organization, overall amount requested, amounts requested or promised from other contributors, and whether the application is new or a continuation or revision of a previous grant.

The second section contains detailed information on the applicant's financial plan for carrying out the program. For example, the applicant must provide budget amounts for each function (activity) within the program, including funds obtained external to the grant. In addition to function amounts, the financial plan must include a cost break down by object class categories, such as personnel, fringe benefits, travel, equipment, supplies, and overhead (indirect) costs. In addition to cost information, any program income, typically from fees or reimbursements, must be specified. Finally, if the proposal is for a multi-year program, estimates of future funding needs must be included.

The third section requires the applicant to certify (or assure) that it will comply with 18 requirements set forth by the grantor if the grant is awarded. Such requirements are called *assurances*. Here are a few of the most important assurances.

- The applicant has the legal authority to apply for federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-federal share of project costs) to ensure proper planning, management, and completion of the project described in this application.
- The applicant will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award.



- The applicant will establish a proper accounting system in accordance with generally accepted accounting principles or agency directives.
- The applicant will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
- The applicant will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
- The applicant will comply with all federal statutes relating to nondiscrimination, including discrimination on the basis of race, color or national origin; discrimination on the basis of sex; discrimination on the basis of handicaps; and discrimination on the basis of age.

The fourth section requires the applicant to certify that the primary participant (individual) at the applying organization meets certain requirements, such as not having been debarred (prohibited) from engagement in contracts with the federal government. This section, like the previous one, must be signed by a duly authorized official of the applying organization.

The fifth section, the program narrative, requests the applicant to describe the objectives of the program and to relate how those objectives will be attained. For projects funded beyond the first year, this section is used to describe the objectives and activities to be undertaken during the next period of support and also as a progress report for activities previously undertaken. The narrative provides a major means by which the application is evaluated and ranked to compete with other applications for available funds. It should be concise and complete and should address the activity for which funds are requested. Supporting documents should be included where they can present information clearly and succinctly. Narratives are evaluated on the basis of substance, not length. Here are the key components of the narrative:

- **Project Description.** Clearly identify the physical, economic, social, financial, institutional, or other problem(s) requiring a solution. The need for assistance must be demonstrated and the principal and subordinate objectives of the project must be clearly stated; supporting documentation or other testimonies from concerned interests other than the applicant may be included. Any relevant data based on planning studies should be included or referenced in footnotes. Applicants are encouraged to provide information on their organizational structure, staff, related experience, and other information considered to be relevant. Awarding offices use this and other information to determine whether the applicant has the capability and resources necessary to carry out the proposed project. It is important, therefore, that this information be included in the application.
- **Results or Benefits Expected.** Identify results and benefits to be derived. For example, when applying for a grant to establish a neighborhood health center, provide a description of who will occupy the facility, how the facility will be used, and how the facility will benefit the general public.
- **Approach.** Outline a plan of action which describes the scope and detail of how the proposed work will be accomplished for each grant function or activity provided in the budget. Cite factors which might accelerate or decelerate the work and state your reasons for taking this approach rather than alternative approaches. Describe any unusual features of the project such as design or technological innovations, reductions in cost or time, or extraordinary social and community involvement. Provide quantitative monthly or quarterly projections of the accomplishments to be achieved for each activity in such terms as the number of people to be served and the number of patients to be treated. Identify the kinds of data to be collected and maintained. List organizations, cooperating entities, consultants, or other key individuals who will work on the project along with a short description of the nature of their effort or contribution.
- **Evaluation.** Address how the grantee will evaluate both the results of the project and the conduct of the program. In addressing the evaluation of results, state how the grantee will determine the extent to which the program has achieved its stated objectives and the extent to which the accomplishment of objectives can be attributed to the program. Discuss the criteria to be used to evaluate results and successes, explain the methodology that will be used to determine if the needs identified and discussed are being met, and if the results and benefits identified above are being achieved.

- **Geographic Location.** Give the precise location of the project or area to be served by the proposed project. Maps or other graphic aids may be attached.
- **Additional Information (If Applicable).** Some programs require a biographical sketch for key personnel appointed and a job description for vacant key positions; others require both for all positions.

The sixth and last section is the checklist, which must be included with all applications. The checklist helps to ensure that the application is complete and contains all necessary information.

## Managing Grants

The good news is that your organization has received a grant. The bad news is that now the grant must be managed. Regardless of whether you're a seasoned professional at the state level or a part-time volunteer at a small rural clinic, the job of grants manager at receiving organizations involves a difficult balancing act: ensuring that program staff have the latitude to accomplish the grant's purpose without violating any of the funding agency's requirements.

### Key Concept: Grant Management

The management of grants is a very important part of revenue generation for state and local health departments. Grantors expect grantees (grant receivers) to follow all grant requirements to the letter of the law (grant agreement). It is especially important that personnel and financial policies are consistent with grant requirements and that compliance is fully documented.

To begin the management process, a good manager will study the terms and conditions of the award and compare them to the approved grant application. Occasionally, the grantor will make a mistake or include inappropriate terms and conditions in the final grant agreement. If corrections or clarifications are needed, it is important to raise the issue as promptly as possible.

The next step is to hold a project initiation briefing with the project manager and all staff responsible for carrying out grant activities. This briefing should ensure that everyone understands the essential terms and conditions of the grant as well as their individual responsibilities. At a minimum, the project manager and staff must have a workable plan of action for carrying out each approved activity. In addition to

the program activities, the grant agreement will contain a set of compliance requirements. To ensure that all compliance responsibilities are met, it is prudent to develop a checklist that lists the compliance actions required, and then document the actions taken to meet each requirement. Often this can be accomplished by placing the compliance documentation in a dedicated file that can be provided to the grantor if necessary.

Another essential component of good grant administration is the establishment and maintenance of a sound financial control system. Good financial control has three major components: (1) An accounting system that meets generally accepted accounting principles for public and nonprofit organizations; (2) A system of controls that ensures proper cost allocation and that complies with cost management requirements imposed by the grantor; and (3) a reporting system that fairly and accurately documents the expensing of grant funds. The process of allocating, charging, and documenting costs is vitally important to good grant management. Grant managers, project administrators, and organizational financial managers must have a thorough understanding of how direct and indirect costs are defined, composed, allocated, and charged to one or more authorized grants.

In many grants, the largest expense item is personnel. Federal grant assurance requirements dictate that organizations maintain a system of personnel administration that is merit-based and nondiscriminatory. In essence, when federal grant funds are used for personnel, the organization must hire on merit and avoid practices that violate state and federal laws concerning discrimination, equal opportunity, and nepotism. Grant-funded personnel must be treated the same as other organizational employees, although they may be considered as conditional employees whose employment is subject to the availability of grant funding.

Occasionally grants require large purchases of equipment and supplies. Virtually all grantors require that grantees develop and maintain a procurement system that is ethical and promotes full and open competition. Note, however, that most grant procurement requirements contain a “small purchase threshold,” which relaxes many of the procurement restrictions applicable to purchases below the threshold. Under the standards applicable to federal grantees, this threshold is \$25,000, but if state or local law or an organization’s own procurement policy sets a lower threshold, the more restrictive rule must be followed. A typical procurement system will have written procedures covering small purchases, competitive bid contracting, and competitive negotiated contracting. In addition to procurement processes, grantees must maintain a satisfactory system of property records. Accurate and current property records help to safeguard grant program assets, document their appropriate use, and ensure appropriate disposition when the grant is concluded.

Regular audits are a sound business practice for any organization. State or local law usually mandates annual audits for municipalities and state-supported institutions, and many foundations are reluctant to award grants to organizations that do not conduct periodic audits. As applied to grant funding, an audit examines to determine whether the financial transactions are properly recorded and documented according to generally accepted accounting principles. A typical audit report will include a compliance report and an opinion letter as to whether or not the grantee is in compliance with grant terms and conditions. Sometimes an auditor will identify problems or issues related to how grant funds are spent or overall compliance with the terms and conditions of the grant. Typically, these issues are categorized as "material" and "non-material." A non-material finding means the organization did not follow the best or preferred practice in handling grant funds or a compliance requirement, whereas a material finding is something that affects the financial or compliance integrity of the grant. Material findings are serious matters that are reported to the grantor and require a formal response from the grantee.

While most grantees have well-run grant programs, a few do not. Unfortunately, even within excellent programs there can be individuals who bend the rules or commit outright fraud or larceny. Organizational and personal conflicts of interest are matters that can affect every type of grant-funded program. All organizations must have written policies that prohibit employees from personal gain associated with grant funding. Employees who work on funded programs should be required to disclose any personal or organizational relationship that might compromise the integrity of the program. To help protect the organization from both personal and property liability, grantees should carry liability insurance that includes grant assets and personnel. Furthermore, key managers and employees who handle grant receipts and payments should be bonded.

Finally, grant managers must monitor program performance in its entirety as well as the progress and completion of grant funded activities. To accomplish this task, managers must create performance metrics that measure program progress and activity completion. This process might indicate that program success will require a reallocation of funds among program activities. Most grantors will permit organizations to make minor budget reallocations, but major budget changes require approval by the grantor.

### **Self-Test Questions**

1. What are some types of information required in a grant application?
2. Describe an *assurance* and its purpose.
3. What are some components of a program narrative?
4. Discuss some sound grant management practices.

### **MAJOR HEALTH INSURERS**

Up to this point, we have discussed two sources of financing for public health organizations: direct governmental appropriations and grants. In addition to these sources, most local health departments receive 10-30 percent of their revenues from the provision of services. Some services generate fees directly from the individuals and businesses requesting such services. Examples include vital records searches and septic tank, swimming pool, and food service permits and inspections. Such fees are collected on the basis of the organization’s established fee schedule.

In addition, many local health departments generate revenues from the provision of clinical services. Some of these revenues are collected directly from patients having the ability to pay some or all of the charges, but other revenues come from clinical services reimbursements paid by health insurers. Health insurance originated in Europe in the early 1800s, when mutual benefit societies were formed to reduce the financial burden associated with illness or injury. Today, *health insurers*, also called *third-party payers*, can be divided into two broad categories: (1) private insurers and (2) public programs.

### **Private Insurers**

In the United States, the concept of public, or government, health insurance is relatively new, while private health insurance has been in existence since the turn of the twentieth century. In this section, we discuss the major private insurers—Blue Cross and Blue Shield, commercial insurers, and self-insurers.

#### ***Blue Cross and Blue Shield***

Blue Cross and Blue Shield organizations trace their roots to the Great Depression, when hospitals and physicians were concerned about their patients' ability to pay healthcare bills. *Blue Cross* originated as a group of separate insurance programs offered by individual hospitals. At the time, many patients were unable to pay their hospital bills, but most individuals, except the poorest, could afford to purchase some type of hospitalization insurance. These programs were all similar in structure; hospitals agreed to provide a set amount of services to members who made fixed periodic payments whether or not hospital services were used. In a short time, these programs were expanded from single hospital programs to communitywide multihospital plans called *hospital service plans*. The American Hospital Association (AHA) recognized the benefits of these plans to hospitals, so AHA and the organizations that offered hospital service plans formed close relationships.

In the early years, several states ruled that the sale of hospital services by prepayment did **not** constitute insurance, so the plans were exempt from regulations that govern the insurance industry. However, it was clear that the legal status of hospital service plans would be subject to scrutiny unless their status was formalized, so one by one, the states passed enabling legislation that provided for the founding of not-for-profit hospital service corporations that were exempt from taxes and from the capital requirements mandated for other insurers. However, state insurance departments had, and continue to have, oversight over most aspects of the plans' operations. The Blue Cross name was officially adopted by most of these plans in 1939.

*Blue Shield* plans developed in a manner similar to that of the Blue Cross plans, except that the providers were physicians instead of hospitals and the professional organization was the American Medical Association (AMA) instead of the AHA. As of 2010, there were 39 Blue Cross and Blue Shield member organizations; some offer only one of the two plans, but most offer both plans. Member organizations are independent corporations that operate locally or statewide under license from a single national association that sets standards that must be met to use the Blue Cross and Blue Shield name. Collectively, the "Blues" provide healthcare coverage for over 100 million people in all 50 states, the District of Columbia, and Puerto Rico.

#### ***Commercial Insurers***

*Commercial health insurance* is issued by life insurance companies, by casualty insurance companies, and by businesses formed exclusively to write health insurance. Commercial insurance companies can be organized either as stock or mutual businesses. *Stock* businesses are shareholder owned and can raise equity capital just like any other for-profit business can. Furthermore, the stockholders assume the risks and responsibilities of ownership and management. A *mutual* business has no shareholders; its management is controlled by a board of directors elected by the firm's policyholders.

Health insurance experienced an influx of commercial insurers following World War II. At that time, the United Auto Workers negotiated the first contract with employers, of which fringe benefits for employees were a major part. The majority of individuals with commercial health insurance are covered under *group policies* with employers, professional and other associations, or labor unions.

### *Self-Insurers*

The third major form of private insurance is *self-insurance*. One might think that all individuals who do not have any other form of health insurance are self-insurers, but this is not technically correct. Self-insurers make a conscious decision to bear the risks associated with healthcare costs and then set aside (or have available) funds to pay future costs as they occur. Except for the wealthy, individuals are not good candidates for self-insurance because they face too much uncertainty concerning future healthcare expenses.

### **Public Insurers**

The government is a major insurer and direct provider of healthcare services. For example, the government provides healthcare services directly to eligible individuals through the Department of Veterans Affairs, Department of Defense, and Public Health Service medical facilities. In addition, the government either provides or mandates a variety of insurance programs, such as workers compensation and TRICARE, but the two major government insurance programs are Medicare and Medicaid.

### *Medicare*

*Medicare* was established by Congress in 1965 primarily to provide medical benefits to individuals aged 65 or older. About 50 million people have Medicare coverage, which pays for about 17 percent of all U.S. healthcare services.

Over the decades, Medicare has evolved to include four major coverages: (1) Part A, which provides hospital and some skilled nursing home coverage; (2) Part B, which covers physician services, ambulatory surgical services, outpatient services, and other miscellaneous services; (3) Part C, which is managed care coverage that can be selected in lieu of Parts A and B; and (4) Part D, which covers prescription drugs. In addition, Medicare covers healthcare costs associated with selected disabilities and illnesses (such as kidney failure), regardless of age.

The Medicare program is the purview of the Department of Health and Human Services (HHS), which creates the specific rules of the program on the basis of federal legislation. Medicare is administered by an agency in HHS called the *Centers for Medicare & Medicaid Services (CMS)*. CMS has regional offices that oversee the Medicare program and ensure that regulations are followed. Medicare payments to providers are not made directly by CMS but by contractors for 15 Medicare Administrative Contractor (MAC) jurisdictions.

### *Medicaid*

*Medicaid* was begun in 1966 as a modest program to be jointly funded and run by the states and the federal government to provide a medical safety net for low-income mothers and children and for elderly, blind, and disabled individuals who receive benefits from the Supplemental Security Income program. Congress mandated that Medicaid cover hospital and physician care, but states were encouraged to expand on the basic package of benefits by either increasing the range of benefits or extending the program to the near poor (i.e., people who are not destitute but whose earnings cover only basic daily needs) through optional eligibility. A mandatory nursing home benefit was added in 1972.

States with large tax bases were quick to expand coverage to many of the optional groups, while states with limited ability to raise funds for Medicaid were forced to construct limited programs. In 2009, Medicaid spending, including both federal and state expenditures, totaled \$370 billion. The federal government picks up about 57 percent of these expenditures and the states pay for the remainder.

In recent years, hospitals have been vocal in their claims that Medicaid reimbursement does not cover the costs of service, and some have even sued their state governments for increased payments on the grounds that Medicaid laws call for “fair market” rate reimbursement. Physicians have also fared badly under Medicaid because states have tried to cut Medicaid costs by freezing physicians’ fees. Citing excess paperwork, high risks, and low fees, many physicians, particularly obstetricians and pediatricians, have either stopped taking Medicaid patients or are limiting the numbers they serve.

## Self-Test Questions

1. Briefly describe some different types of private insurers.
2. Briefly describe the origins and purpose of Medicare.
3. What is Medicaid, and how is it administered?

## AN INTRODUCTION TO INSURER REIMBURSEMENT METHODS

Regardless of insurer (third-party payer), only a limited number of payment methods are used to reimburse providers. Payment methods can be categorized into two broad classifications: (1) fee-for-service and (2) capitation. Under *fee-for-service* payment methods, of which many variations exist, the greater the amount of services provided, the higher the amount of reimbursement. Under *capitation*, a fixed payment is made to providers for each covered life, regardless of the number of services provided.

### Key Concept: Health Services Reimbursement

There are two major approaches to reimbursement for the provision of health services. Under *fee-for-service*, providers are paid for each service performed, and hence the greater the amount of services, the greater the reimbursement. Under *capitation*, providers are paid a fixed amount based on the size of the covered population, so there is a greater incentive to keep patients healthy and less incentive to provide more services.

### Fee-for-Service Methods

The two primary fee-for-service methods used today are charge-based reimbursement and prospective payment. When payers pay *charges*, they pay according to the schedule of charge rates established by the provider in its charge description master file, or *chargemaster*, which contains the service code and “list price” for all services provided. For local health departments, this means payers pay according to the established list of fees.

Many payers that historically reimbursed for healthcare services on the basis of billed charges now pay by *negotiated*, or *discounted*, charges. Such discounts generally range from 20 to 40 percent, or even more, of billed charges. Sometimes *sliding-scale discounts* are used, the amount of which is tied to the amount of volume generated by the payer—the greater the volume, the higher the discount.

In a *prospective payment system*, the rates paid by payers are determined before the services are provided. Furthermore, payments are not directly related to costs or charges. Four common units of payment are used in prospective payment systems:

- **Per procedure.** Under *per procedure* reimbursement, a separate payment is made for each procedure performed on a patient. Because high administrative costs are associated with this method when it is applied to complex diagnoses, per procedure reimbursement is more commonly used in outpatient than inpatient settings.
- **Per diagnosis.** Under the *per diagnosis* reimbursement method, the provider is paid a rate that depends on the patient’s diagnosis. Diagnoses that require higher resource utilization and hence are more costly to treat have higher reimbursement rates. Medicare pioneered this basis of payment in its *diagnosis-related group (DRG)* system, which it first used for hospital reimbursement in 1983.
- **Per diem (per day).** If reimbursement is based on a *per diem* rate, the provider is paid a fixed amount for each day service is provided, regardless of the nature of the services. This type of reimbursement is applicable only to inpatient settings.



- **Bundled (global) pricing.** Under *bundled pricing*, payers make a single prospective payment that covers all services delivered in a single episode, whether the services are rendered by a single or by multiple providers. For example, a global fee may be set for all obstetric services associated with a pregnancy, including all prenatal and postnatal visits as well as the delivery, provided by a single physician. For another example, a global price may be paid for all physician and hospital services associated with a cardiac bypass operation.

## Capitation

Under fee-for-service methods, providers are reimbursed on the basis of the amount of services provided. The service may be defined as a visit, a diagnosis, a hospital day, or in some other manner, but in all cases, the greater the number of services performed, the greater the reimbursement amount. *Capitation*, although a form of prospective payment, is an entirely different approach to reimbursement. Under capitated reimbursement, the provider is paid a fixed amount per covered life per period (usually a month), regardless of the number of services provided. Typically, capitated payments are made to providers on a monthly basis for each member that is covered by the health plan. Thus, capitated payments are called *per member per month (PMPM)* payments.

## Self-Test Questions

1. Briefly describe the following fee-for-service payment methods.
  - a. Charge based and discounted charges
  - b. Per procedure
  - c. Per diagnosis
  - d. Per diem
  - e. Bundled (global)
2. What is the major difference between fee-for-service reimbursement and capitation?

## MEDICAL CODING: THE FOUNDATION FOR THIRD-PARTY PAYER REIMBURSEMENT

In practice, the basis for most fee-for-service reimbursement is the patient's diagnosis (in the case of inpatients) or the procedures performed on the patient (in the case of outpatients). Clinicians indicate diagnoses and procedures by codes, so a brief background on clinical coding will enhance your understanding of reimbursement methods.

### Diagnosis Codes

The *International Classification of Diseases* (most commonly known by the abbreviation *ICD*) is the standard for designating diseases plus a wide variety of signs, symptoms, and external causes of injury. Published by the World Health Organization, *ICD codes* are used internationally to record many types of health events, including hospital inpatient stays and death. (ICD codes were first used in 1893 to report death statistics.)

The codes are periodically revised; the most recent version is ICD-10. However, U.S. hospitals are still using a modified version of the ninth revision, called *ICD-9-CM*, where *CM* stands for *Clinical Modification*. (It is expected that conversion to ICD-10 codes will occur in 2013. The conversion is expected to be time consuming and costly because there are more than five times as many individual codes in ICD-10 as in ICD-9. Of course, the information provided by the new code set will be more detailed and complete.) The ICD-9 codes consist of three, four, or five digits. The first three digits denote the disease category, and the fourth and fifth digits provide additional information. For example, code 410 describes an acute myocardial infarction (heart attack), while code 410.1 is an attack involving the anterior wall of the heart.



In practice, the application of ICD codes to diagnoses is complicated and technical. Hospital coders have to understand the coding system and the medical terminology and abbreviations used by clinicians. Because of this complexity, and because proper coding can mean higher reimbursement from third-party payers, ICD coders require a great deal of training and experience to be most effective.

## Procedure Codes

While ICD codes are used to specify diseases, *Current Procedural Terminology (CPT)* codes are used to specify medical procedures (treatments). *CPT codes* were developed and are copyrighted by the American Medical Association. The purpose of CPT is to create a uniform language (set of descriptive terms and codes) that accurately describes medical, surgical, and diagnostic procedures. CPT terminology and codes are revised periodically to reflect current trends in clinical treatments. To increase standardization and the use of electronic medical records, HIPAA requires that physicians and other clinical providers, including laboratory and diagnostic services, use CPT for the coding and transfer of healthcare information. (HIPAA also requires that ICD-9-CM codes be used for hospital inpatient services.)

### Key Concept: Medical Coding

The basis for most reimbursement for health services is the medical code assigned to a patient. *International Classification of Diseases (ICD)* codes are used to designate diseases as well as a variety of symptoms and injuries. *Current Procedural Terminology (CPT)* codes are used to specify medical procedures (treatments).

To illustrate CPT codes, there are ten codes for physician office visits. Five of the codes apply to new patients, while the other five apply to established patients (repeat visits). The differences among the five codes in each category are based on the complexity of the visit, as indicated by three components: (1) extent of patient history review, (2) extent of examination, and (3) difficulty of medical decision making. For repeat patients, the least complex (typically shortest) office visit is coded 99211, while the most complex (typically longest) is coded 99215.

Although CPT codes are not as complex as the ICD codes, coders still must have a high level of training and experience to use them correctly. As in ICD coding, correct CPT coding ensures correct reimbursement. Coding is so important that many businesses offer services, such as books, software, education, and consulting, to hospitals and medical practices to improve coding efficiency.

## Self-Test Questions

1. Briefly describe the coding system used in hospitals (ICD codes) and medical practices (CPT codes).
2. What is the link between coding and reimbursement?

## DEBT AND LEASE FINANCING

In general, public health organizations do not use debt financing, although its use is common for governmental units at the federal, state, and local (city and county) levels. In rare circumstances, however, the use of debt financing might be required to ensure that funding is available to provide essential services. In contrast to the rare use of debt financing, public health organizations commonly use lease financing to obtain the use of buildings and equipment. This section introduces some basic concepts applicable to debt and lease financing.

## Debt Financing

There are many different types of debt. Some types, such as home mortgages and personal auto loans, are used by individuals, while other types are used primarily by businesses or governmental units. Some debt is used to meet short-term needs, while other debt is for longer terms. When money is borrowed, the borrower (whether a business or an individual) has a contractual obligation to repay the loan, so debt obligations are “fixed by contract.” The repayment of debt consists of two parts: (1) the amount borrowed (or *principal*) and (2) the amount of *interest* stated on the loan.

One important classification of debt is by *maturity*, or when it has to be repaid. *Long-term debt* is defined as having a maturity greater than one year. Thus, the amount borrowed (principal amount) on a long-term loan has to be paid back

### Key Concept: Short-Term versus Long-Term Debt

Debt financing can be either short term or long term. Short-term debt has to be repaid in one year or less, while long-term debt can remain outstanding for many years (typically up to 30). Short-term debt usually is obtained from commercial banks, while long-term debt may be obtained from banks or from the general public in the form of a bond issue. Short-term debt typically is used to meet temporary financing needs, while long-term debt is used to finance long-term assets such as buildings and equipment.

to the lender at some time in the future longer than one year. *Short-term debt*, with a maturity of one year or less, generally is used to finance temporary needs, such as increasing the level of inventories to meet busy-season demand. Short-term debt has several advantages over long-term debt. For example, administrative (accounting, legal, commissions, and so on) costs generally are higher for long-term debt than for short-term debt. Also, long-term loan agreements usually contain more restrictions on the organization’s future actions, whereas short-term debt agreements typically are less onerous in this regard. Finally, the interest rate on short-term debt generally is lower than the rate on long-term debt because longer maturities pose more risk to lenders. On the other hand, the use of short-term debt to fund long-term obligations is risky to borrowers because rising interest rates can cause the cost of the debt to increase over time.

Commercial banks are the primary provider of short-term debt financing. Although banks make longer-maturity loans, the bulk of their lending is on a short-term basis (about two-thirds of all bank loans mature in a year or less). Bank loans to businesses are frequently written as 90-day notes, so the loan must be repaid or renewed at the end of 90 days. Alternatively, a business may obtain short-term financing by establishing a *line of credit* with a bank. This is an agreement that specifies the maximum credit the bank will extend to the borrower over a designated period of time, often a year.

Long-term debt typically is used to finance assets that have a long useful life, such as buildings and equipment. The two major types of long-term debt are term loans and bonds. A *term loan* is long-term debt financing that is arranged directly between the borrower and the lender. In essence, the lender provides the capital and the borrower agrees to pay the stated interest rate over the life of the loan and return the amount borrowed. Typically, the lender is a financial institution such as a commercial bank. Most term loans have maturities of three to ten years. Like personal auto loans, term loans usually are paid off in equal installments over the life of the loan, so part of the principal amount is repaid with each loan payment. The interest rate on a term loan either is fixed for the life of the loan or is variable (*floating rate*). If fixed, the interest rate stays the same over the life of the loan. If variable, the interest rate is usually set at a certain number of percentage points over some index rate. When the index rate goes up or down, so does the interest rate that must be paid on the outstanding balance of the variable-rate loan.

*Bonds*, which are the second major source of long-term debt financing, are nothing more than many small (typically \$1,000 or \$5,000) loans packaged in a single issue but sold to many different buyers (lenders). Bonds are categorized as either government (Treasury), corporate, or municipal. *Treasury bonds* are used to raise money for the federal government, while *corporate bonds* are issued by investor-owned businesses. Of most interest to public health entities are *municipal bonds*, which are issued by states, counties, cities, and by not-for-profit healthcare organizations. The primary attraction of most municipal bonds is the fact that bond owners (lenders) do not have to pay income taxes on the interest earned. Because such bonds are tax-exempt, the interest rate set on municipal bonds is less than the rate set on similar corporate or Treasury bonds. In essence, municipal bond buyers are willing to accept a lower interest rate because they do not have to pay income taxes on the interest payments received.

## Lease Financing

Organizations often own the buildings and equipment needed to meet mission needs, but it is the use of the assets that is important, not their ownership. An alternative to owning is to obtain the use of assets is by leasing. Before the 1950s, leasing was generally associated with real estate (land and buildings), but today it is possible to lease almost any kind of asset. Every lease transaction has two parties: The user of the leased asset is called the *lessee*, while the owner of the property, usually the manufacturer or a leasing company, is called the *lessor*. (The term “lessee” is pronounced “less-ee,” not “lease-ee,” and “lessor” is pronounced “less-or.”)

Leases are commonly classified into two categories: operating leases and financial leases. *Operating leases*, sometimes called *service leases*, generally provide both financing and maintenance. IBM was one of the pioneers of operating

### Key Concept: Lease Financing

Lease financing is an alternative to debt financing. In a lease, the lessee (user) agrees to pay the lessor (owner) a series of monthly payments to have the right to use an asset such as an automobile or a piece of medical equipment. Leases can be operating, which are relatively short term and include maintenance or financial, which are longer term and typically do not include maintenance. Leases have certain advantages over owning, such as protection against technological obsolescence. However, the greater the benefits that accrue to the user, the greater the lease payment will be.

lease contracts, which are used most often for computers and office copying machines as well as for automobiles, trucks, and medical diagnostic equipment. Operating leases typically require the lessor to maintain and service the leased equipment, with the cost of maintenance built into the lease payments. Additionally, operating leases are not fully amortized—that is, the payments required under the lease contract are not sufficient for the lessor to recover the full cost of the equipment. However, operating leases are written for a period that is considerably shorter than the expected useful life of the leased asset, and the lessor expects to recover all costs eventually, either by lease renewal payments or by sale of the equipment. A final feature of operating leases is that they frequently contain a *cancellation clause* that gives the lessee the right to cancel the lease and return the equipment to the lessor prior to the expiration of the lease. This is an important feature to the lessee because it means that the equipment can be returned if it is rendered obsolete by technological developments or if it is no longer needed by the lessee to meet mission requirements.

Lease (rental) payments on operating leases can be structured in two different ways. Under *conventional* terms, fixed payments are made to the lessor periodically, usually monthly. With this type of payment, the cost to the lessee (and the return to the lessor) is known (more or less) with certainty. Under *per procedure* terms, a fixed amount is paid each time the equipment is used. For example, the lessor may charge a public health laboratory \$50 for every test performed using a leased hematology analyzer, or it may charge \$60 per test for the first 100 tests in each month and \$40 for each test above 100. Now, the cost to the lessee and return to the lessor are not known with certainty—rather, they depend on volume. The logic behind per procedure leases is to transfer the risk associated with uncertain usage from the lessee to the lessor. This type lease will cost more to the lessee, but may still be advantageous in circumstances where greater usage means greater revenues to the lessee. In managerial accounting terms, per procedure leases convert a fixed cost, which is independent of volume, into a variable cost, which is directly related to volume.

*Financial leases*, sometimes called *capital leases*, are differentiated from operating leases in that (1) they typically do not provide for maintenance; (2) they typically are not cancelable; (3) they are generally for a period that approximates the useful life of the asset; and hence (4) they are fully amortized. In a typical financial lease, the lessee selects the specific item needed and then negotiates the price and delivery terms with the manufacturer. The lessee then arranges to have a leasing firm (lessor) buy the equipment from the manufacturer, and the lessee simultaneously executes a lease agreement with the lessor. In a financial lease, the lessee’s total payments are sufficient to fully pay for the cost of the leased asset plus provide a rate of return to the lessor. At the end of a financial lease, the ownership of the leased asset is transferred from the lessor to the lessee.

Leasing is an attractive financing alternative for many high-tech items that are subject to rapid and unpredictable technological obsolescence. For example, assume that a public health laboratory plans to acquire an expensive hematology analyzer. If it buys the equipment, it is exposed to the risk of technological obsolescence. In a relatively short time, some new technology might be developed that makes the current system nearly worthless. Conversely, a lessor that specializes in state-of-the-art laboratory equipment might be exposed to significantly less risk. By purchasing and then leasing many different high-tech items, the lessor benefits from portfolio diversification; over time, some items will lose more value than the lessor expected, but these losses will be offset by other items that retain more value than expected. Also, because specialized lessors are familiar with the markets for used medical equipment, they can estimate residual values better and negotiate better prices when the asset is resold (or leased to another organization) than can a laboratory.

Some lessors offer programs that guarantee that the leased asset will be modified as necessary to keep it in line with technological advancements. For an increased rental fee, lessors will provide upgrades to keep the leased equipment current regardless of the cost. To the extent that lessors are better able to forecast such upgrades, negotiate better terms from manufacturers, and, through greater diversification, control the risks involved with such upgrades, it may be cheaper for users to ensure state-of-the-art equipment by leasing than by buying.

### Self-Test Questions

1. Briefly describe the different types of debt financing that might be used by public health organizations.
2. What is the primary difference between taxable and municipal (tax-exempt) debt?
3. What are the two major types of leases?
4. Describe some of the advantages associated with lease financing.

### KEY CONCEPTS

This module describes the sources of financing for public health activities. Although most financing comes from governmental appropriations, local public health departments also generate revenue from the provision of services. Here are the key concepts:

- In partnerships with states and localities, the federal government has the responsibility to assure the capacity for all levels of government to provide essential public health services.
- Federal public health responsibilities are met primarily by offices and operating divisions within the *Department of Health and Human Services (HHS)*. Within HHS, the federal agencies most involved with funding state and local public health efforts are the *Health Resources and Services Administration (HRSA)* and the *Centers for Disease Control and Prevention (CDC)*. Considering both HRSA and CDC, the combined annual federal funding to state and local public health entities is approximately \$13.5 billion, or about \$45 per person.
- There are three types of organizational structures for state public health departments: stand alone, umbrella, and mixed function. *Stand alone* public health agencies are independent from other agencies in the state and have an independent mission. State public health agencies that fall under larger agencies like a State Department of Health Services are called *umbrella* function agencies, while *mixed function* agencies are those that function independently but perform functions other than public health.
- There are approximately 2,800 *local health departments (LHDs)* in the United States. LHDs are structured differently, depending on state, and may be *centralized* (controlled at the state level) or *decentralized* (controlled at the local level). Therefore, the level of responsibility and services provided by LHDs varies as does the way that resources are determined and allocated.

- On average, LHD revenue sources include federal (19%) as well as state and local (45%), for total governmental appropriations of 64 percent. Non-appropriation revenue sources include inspection and clinical fees (12%), Medicaid reimbursements (10%), and Medicare reimbursements (5%). Other non-appropriation sources consist primarily of private foundation grants.
- There are several different types of federal grants, including *project grants*, *formula grants*, *categorical grants*, *block grants*, and *earmark grants*.
- The federal government allows certain recipients to act as *pass-through entities*, which allow the initial recipient to provide the funds to another recipient. For example, some federal grants are awarded to states, which then pass them on to local health departments.
- Because a significant amount of public health funding comes in the form of grants, *grant application and management* is an important part of the financing process.
- *Health insurers* can be divided into two broad categories: (1) *private insurers* and (2) *public programs*.
- The major private insurers are *Blue Cross and Blue Shield*, *commercial insurers*, and *self-insurers*, while the major public programs are *Medicare* and *Medicaid*.
- Regardless of insurer (third-party payer), only a limited number of payment methods are used to reimburse for clinical services. Under *fee-for-service* payment methods, of which several variations exist, the greater the amount of services provided, the higher the reimbursement. Under *capitation*, a fixed payment is made to providers for each covered life, regardless of the amount of services provided.
- In practice, the basis for most fee-for-service reimbursement is the patient's diagnosis (in the case of hospitals) or the procedures performed on the patient (in the case of physicians). Clinicians indicate diagnoses and procedures by *codes*. The *International Classification of Diseases* (most commonly known by the abbreviation *ICD*) is the standard for designating diseases plus a wide variety of signs, symptoms, and external causes of injury. *Current Procedural Terminology (CPT)* codes are used to specify medical procedures (treatments).
- *Debt financing* is sometimes used by local health departments or sponsoring governmental entities, typically to acquire capital assets such as buildings and equipment. Major debt classifications include short term versus long term and taxable versus tax exempt.
- *Leasing* (lease financing) is an alternative to debt financing. Lease transactions have two parties: the *lessee*, who uses the leased asset, and the *lessor*, who owns the leased asset. Leases are classified as either *operating* or *financial*.

This tutorial contains information about how the public health system is financed. The majority of the funding comes from federal, state, and local appropriations, but local public health departments typically receive additional revenues from fees and reimbursements for services rendered.

---

This module was prepared by Louis C. Gapenski, PhD, Department of Health Services Research, Management and Policy, University of Florida. It was supported by a grant from the Robert Wood Johnson Foundation.