NeighborWorks® AMERICA

Healthcare Financing: A 101 for Community Development Organizations

April 2016

Working Together for Strong Communities®

NeighborWorks® AMERICA

Healthy Homes & Communities

21,000 NEW HOMEOWNERS

RENTAL HOMES OWNED AND/OR MANAGED **154,100**

More than **53,600** JOBS created and maintained

$91:$1 CONGRESSIONAL APPROPRIATION LEVERAGE

Investment per dollar of NeighborWorks America's federal appropriation

Working Together for Strong Communities®

NeighborWorks® AMERICA

Healthy Homes & Communities

Through **grants**, **training**, and **technical assistance**, NeighborWorks America supports the efforts of NeighborWorks member organizations and the community development field to develop healthy homes and communities.

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Healthcare Financing

A 101 for Community Development Organizations

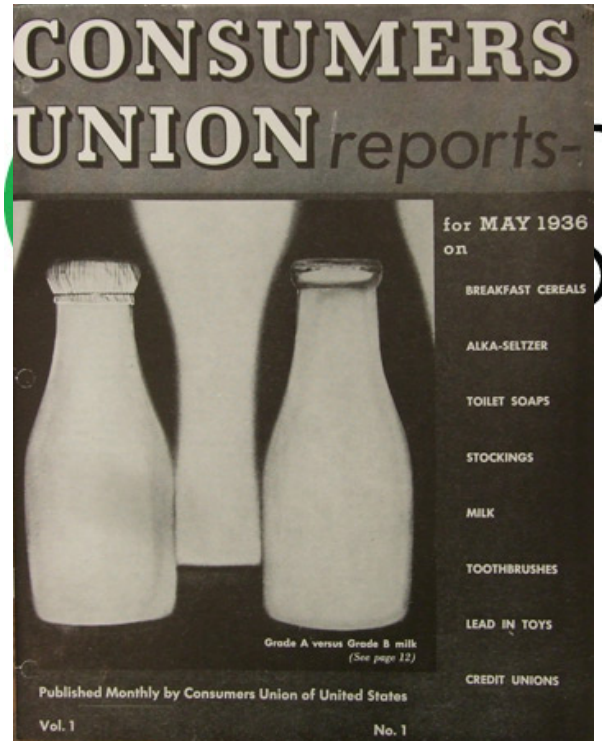
Lynn Quincy
April 6, 2017

Goals for the Webinar

- Knowledge of/comfort with health financing -- incentives and vocabulary

- Introduce partnership opportunities created by new funding flexibility/financial incentives

Yes, THAT *Consumer Reports*



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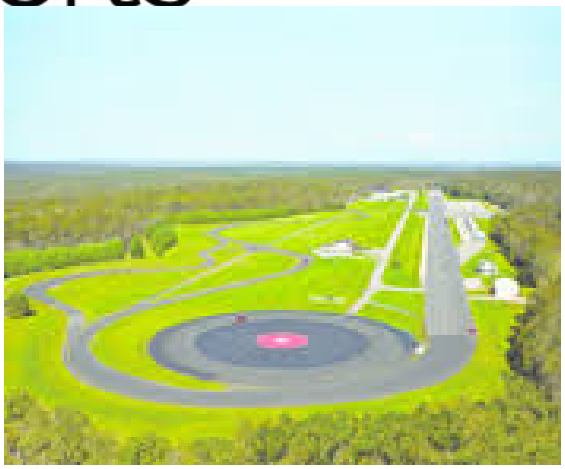
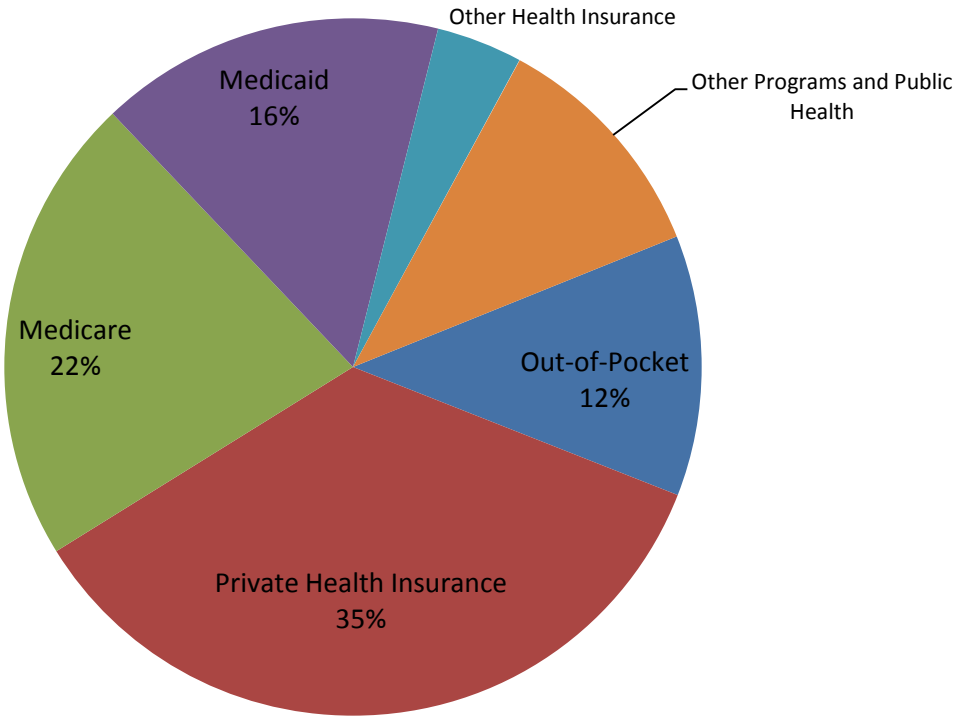


Who pays for healthcare?

The $2.7 trillion we spend on doctor services, tests, drugs, hospitals, etc is paid by:



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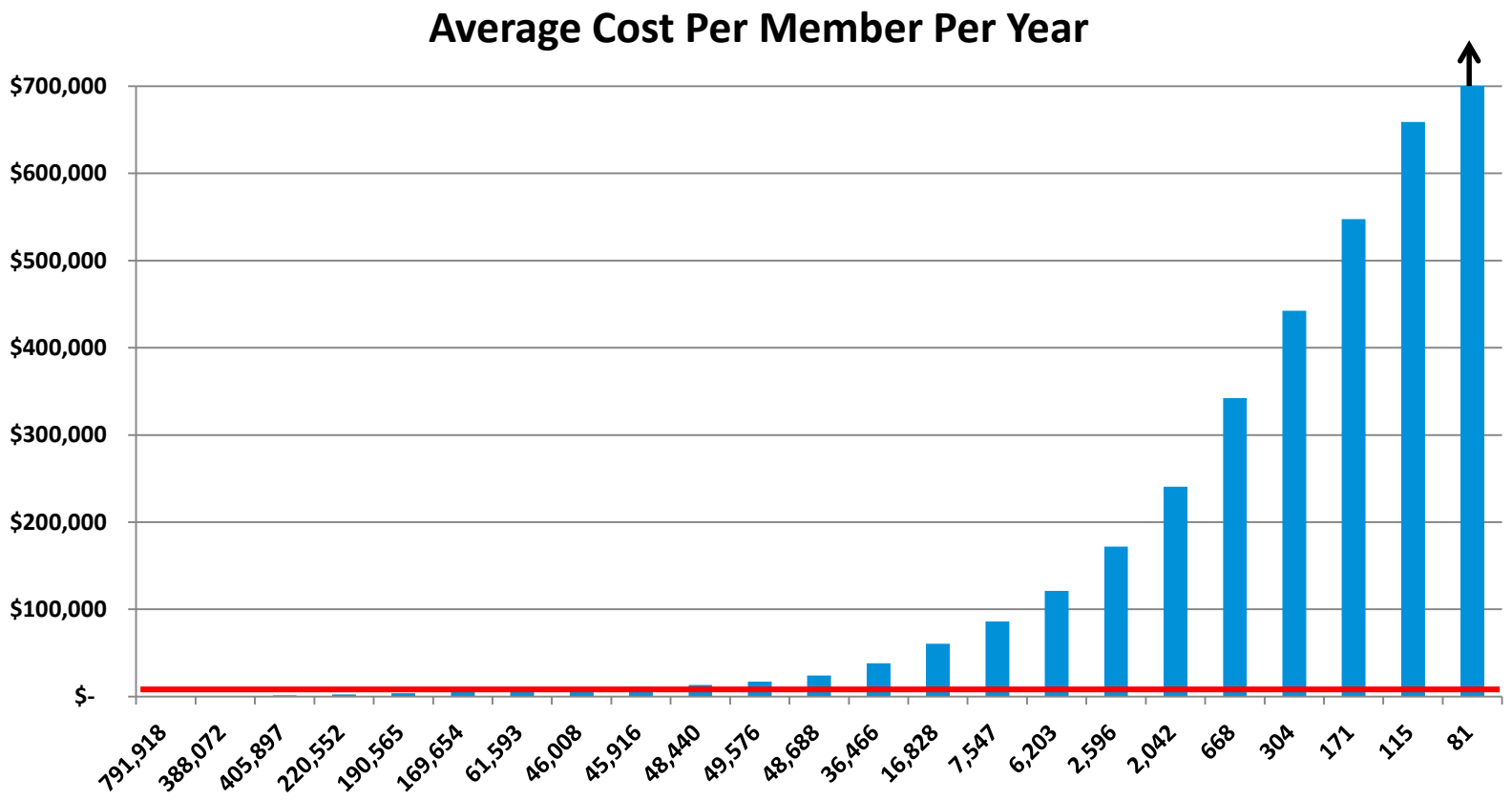
Why Do We Need Insurance?



More on the largest sources of coverage

Private Coverage

Employer Sponsored	
Eligible Population	Workers and their dependents, *but not all workers*
Financing	Employee premiums, employee cost-sharing, employer contribution, tax preferences
Administered by	Employers, with either state (fully insured) or federal (self-insured) regulatory oversight

What is cost-sharing?

Premium:
Monthly Cost for Insurance- whether or not you use services

Cost-sharing:	What you pay out-of-pocket when you use services/Rx/Devices
Deductible	Pay in full until deductible met
Copay	Fixed cost per service/Rx/device
Coinsurance	Pay a percentage of the allowed cost
Out-of-pocket Maximum	Plan pays 100% once you've paid this much

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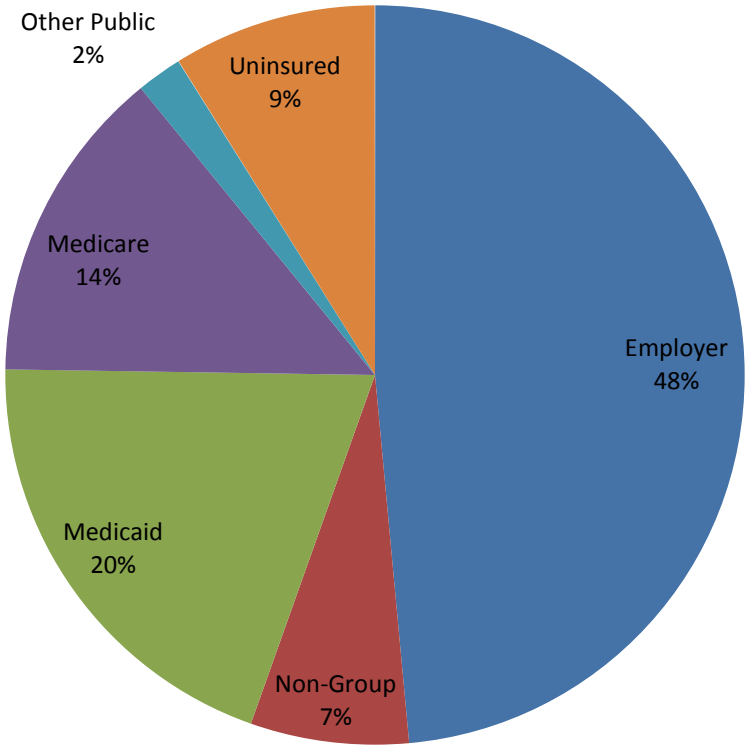
Employer coverage covers more people than other types of coverage



Private Coverage

Non-Group Coverage	*(coverage you buy on your own)*
Eligible Population	Anyone
Financing	Individual bears entire cost of premiums and cost-sharing, unless eligible for Obamacare subsidies
Administered by	state regulatory oversight

Medicaid

Medicaid	
Eligible Population	Depends on the state but generally, **very low income** children, parents, seniors, disabled and sometimes childless adults <age 65
Financing	State and Federal revenues; very rarely modest cost-sharing or premiums
Administered by	Jointly administered by State and Federal Governments

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What is Federal Poverty Level (FPL)?

A measure of income used to determine eligibility for certain programs.

Family Size	Federal Poverty Level (FPL)	200% FPL	300% FPL	400% FPL
1	$12,060	$24,120	$36,180	$48,240
2	$16,240	$32,480	$48,720	$64,960
3	$20,420	$40,840	$61,260	$81,680
4	$24,600	$49,200	$73,800	$98,400
Larger families	Add $4,180 for each additional person	+$8,360	+$12,540	+$16,720

Source: U.S. Department of Health and Human Services

State Variation in Medicaid Eligibility

State	Parents (family of three)	Other Adults (for an individual)
Texas/Alabama	18% FPL	0% FPL
⋮	⋮	⋮
Connecticut	155%	138%
District of Columbia	221%	215%

Source: Kaiser State Health Facts

Medicaid Covered Services

(this will be important later)

Mandatory	Inpatient hospital , Outpatient hospital, EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services, Nursing Facility, Home health, Physician , Rural health clinic, Federally qualified health center, Laboratory and X-ray services, Family planning , Nurse Midwife, Certified Pediatric and Family Nurse Practitioner services, Transportation to medical care, Tobacco cessation counseling for pregnant women
Optional	Prescription Drugs, Clinic services, Physical therapy, Occupational therapy, Speech, hearing and language disorder services, Respiratory care services, Other diagnostic, screening, preventive and rehabilitative services, Podiatry services Optometry services, Dental Services, Case management and more

Children's Health Insurance Plan

CHIP	
Eligible Population	**Children** in families that earn too much money to qualify for Medicaid. In some states, **CHIP** covers pregnant women.
Financing	State and Federal revenues; rarely modest cost-sharing or premiums
Administered by	Jointly administered by State and Federal Governments

Source: Kaiser State Health Facts

Medicare

Medicare	
Eligible Population	Seniors 65+, long-term disabled, ESRD
Financing	Beneficiary Premiums, Medicare Taxes, General Federal revenues
Administered by	Federal Government (CMS)

Medicare – What's Covered?

Medicare		Premiums?	Cost-sharing?
Part A	Hospital Care		√
Part B	Doctor services	√	√
Part D	Drugs	√	√

Medicare Advantage		Premiums?	Cost-sharing?
Part C	Hospital Care, Doctor services and usually drugs	√	√

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Medicare Supplement Plan = Medigap Plan

Medigap Benefits	Medigap Plans									
	A	B	C	D	F	G	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit	N/A	N/A	N/A	N/A	N/A	N/A	$5,120	$2,560	N/A	N/A

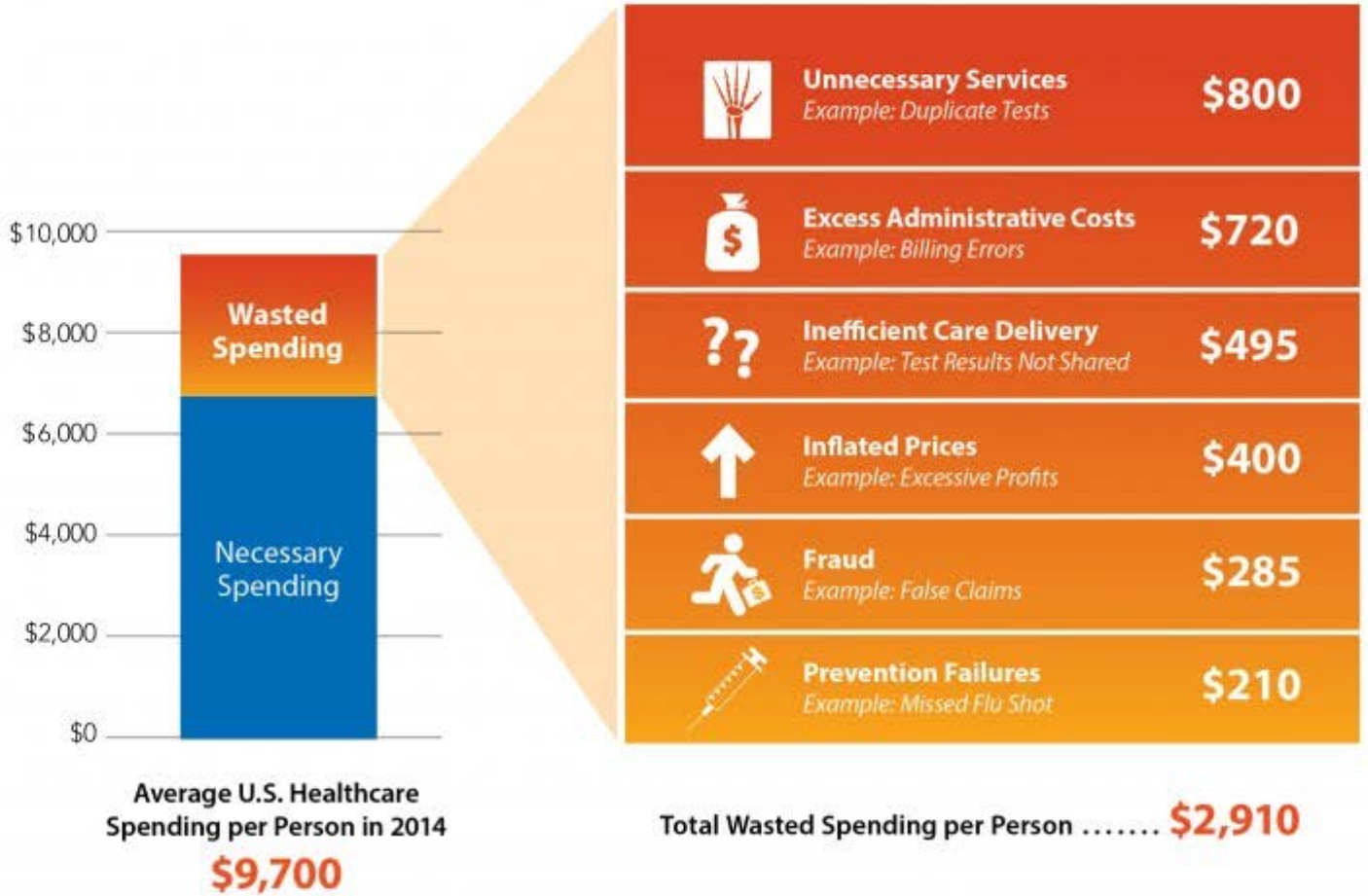
Who pays for healthcare *REALLY*?

The consumer.

And consumers are overpaying for healthcare and getting uneven quality as a result. What we call “poor healthcare value.”

Approximately 1 in 3 Health Care Dollars is Waste

Can We Afford This?



Average U.S. Healthcare Spending per Person in 2014

$9,700

Total Wasted Spending per Person $2,910

Of all the ways to get to better healthcare value, for discussion today:

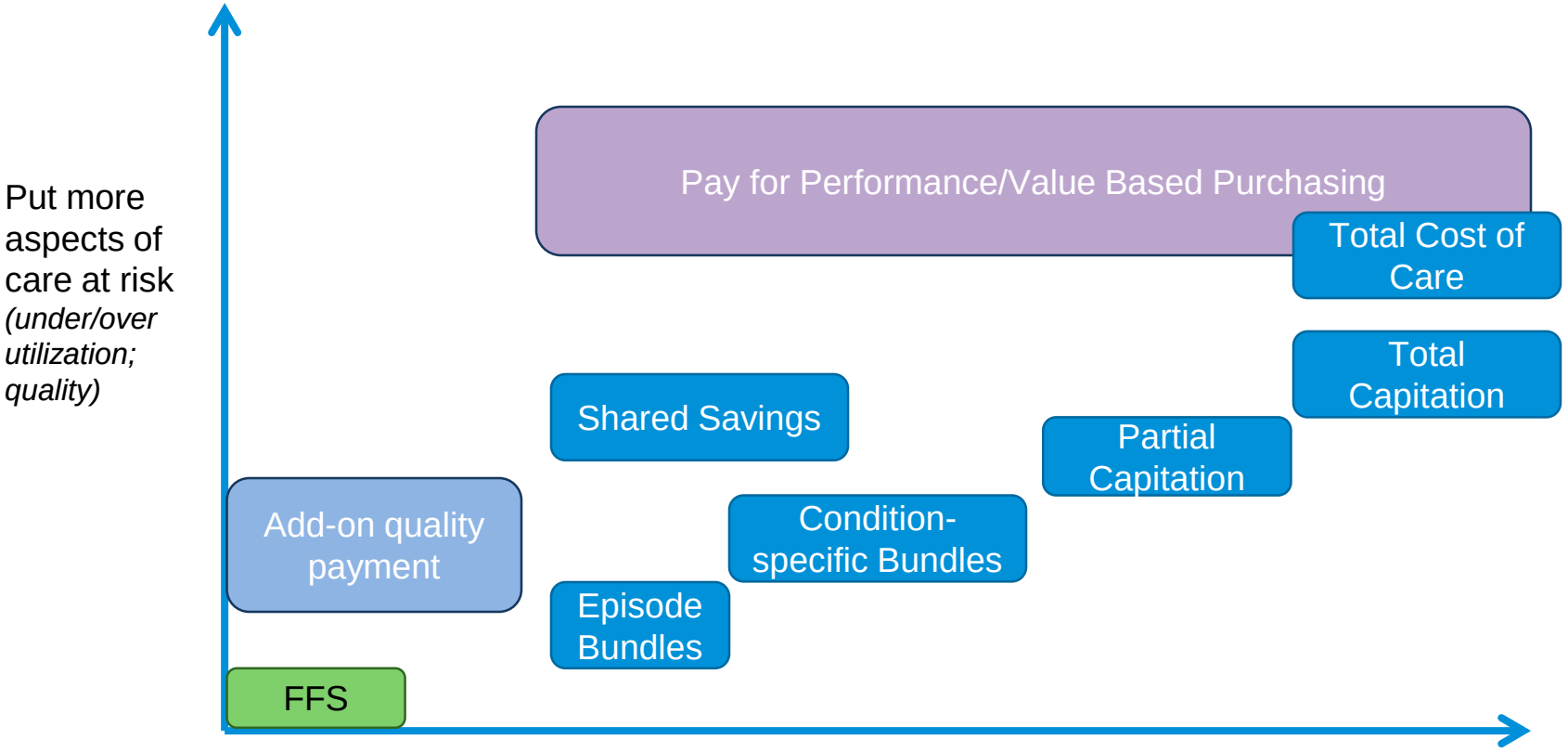
- **Paying providers differently**
- **Addressing social determinants of health**

Paying Providers Differently

Fee for Service (FFS)

Doctors and other health care providers are paid for each service performed.

Provider Payment Reform



Payment Reform: Bundled Payments

A fixed payment that covers all services delivered by provider(s) for all services to treat:

- a given condition (diabetes); or
- provide a given treatment (knee replacement) or
- to care for a population for a year (capitation).

Pros: Incentive for providers to avoid overprescribing and the overutilization of services.

Cons: Providers may underutilize services. Strong outcome metrics can counteract this concern.

Payment Reform: Value-Based Purchasing

Also known as *Value-Based Reimbursement* and *Pay-for-Performance*, this form of payment reform includes incentives that reward outcomes.

Incentives may reward for (1) measuring and reporting comparative performance and/or (2) meeting performance/quality targets.

Pros: Rewarding quality should improve outcomes by driving coordination and patient centered care; counteracts the tendency to undertreat when bundling.

Cons: May incentivize providers to avoid complex patients.

Patient Centered Medical Homes (PCMH) & Accountable Care Organizations(ACO) = payment reform+

- These delivery system reform models DO bundle together services, include quality targets and almost always include financial incentives.
- **But the models go further.** Clinical and non-clinical provider integration is expected, along with an overarching organizational structure that strives to ensure care is coordinated and patient centered.

PCMH vs. ACO

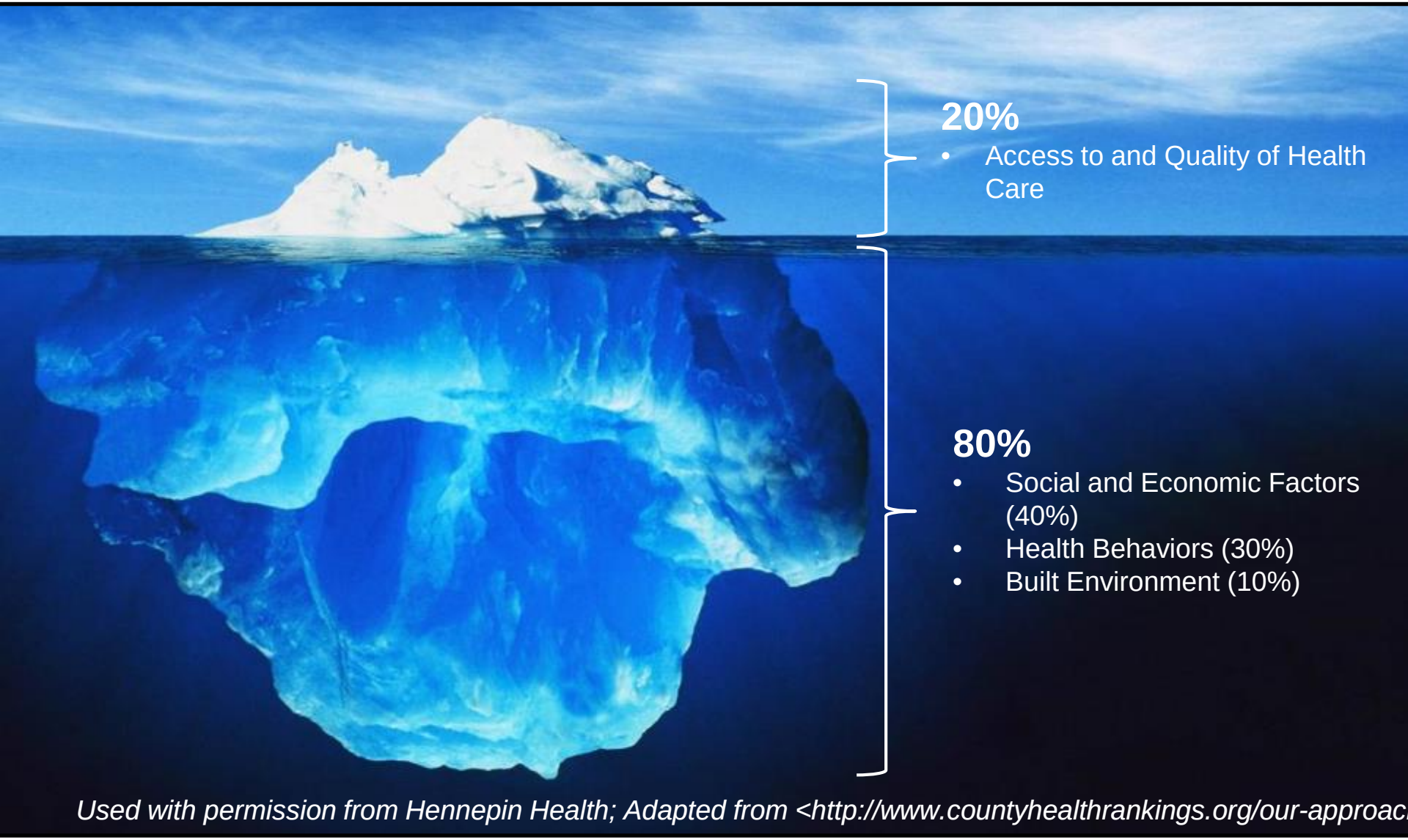
PCMH	ACO
Primary Care Services	Primary and Secondary Services
Better care coordination, patient centered	Better care coordination, patient centered
Provider payment likely to include a bonus for hitting quality targets, along with payments that reimburse for new activities.	Likely to include up and downside shared savings, often risk adjusted, with quality bonuses also possible.

Better to be incentive neutral?

Mayo Clinic, Kaiser Permanente, military and Veterans Affairs health systems pay their physicians salaries.

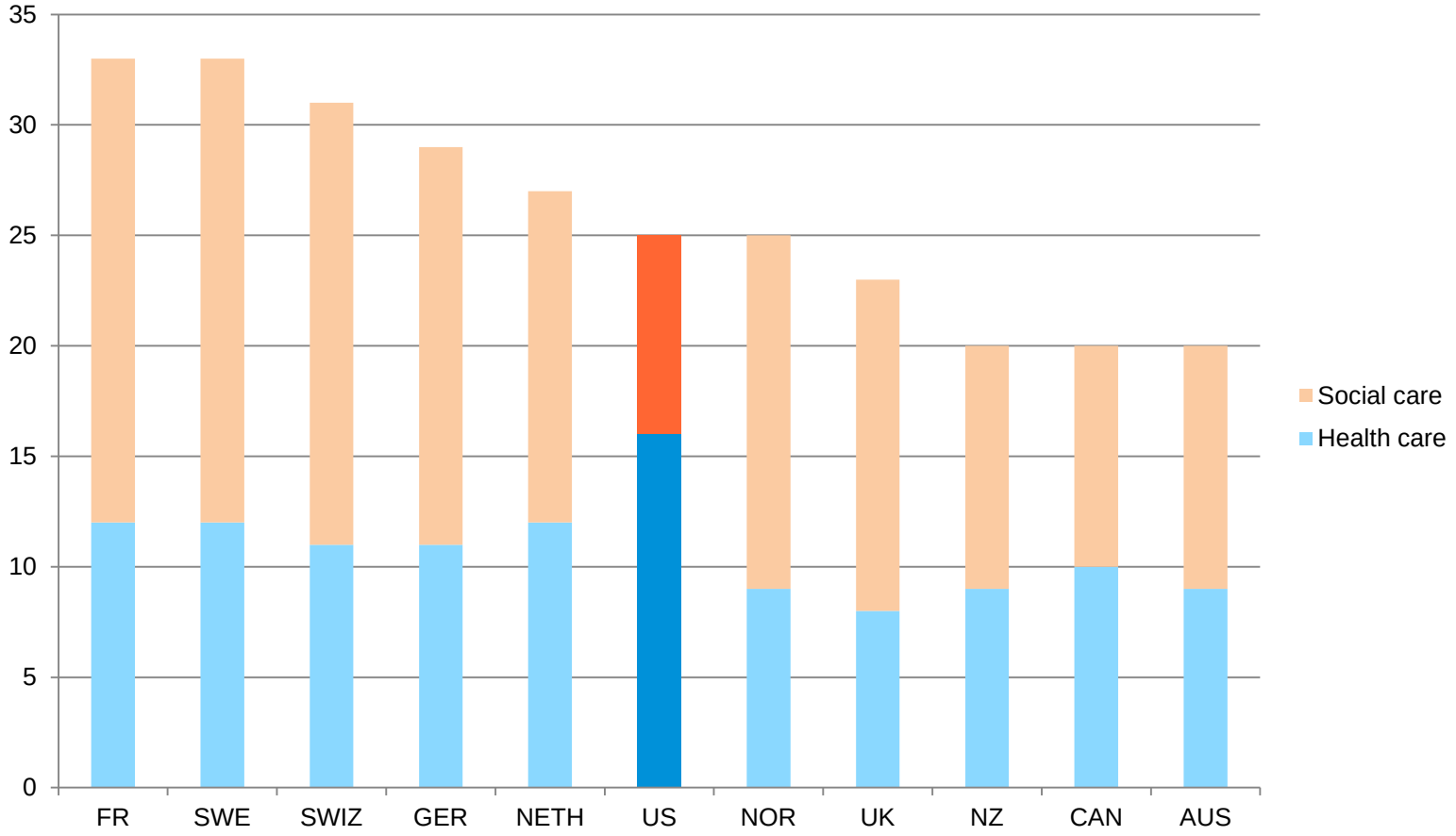
Getting to good outcomes means thinking outside the clinic and hospital

Modifiable factors influencing health outcomes



Used with permission from Hennepin Health; Adapted from <http://www.countyhealthrankings.org/our-approac

Health and Social Care Spending as a Percentage of GDP



Note: GDP refers to gross domestic product.
Source: E.H. Bradley and L.A. Taylor, *The American Health Care Paradox: Why Spending More is Getting Us Less*, Public Affairs, 2013.

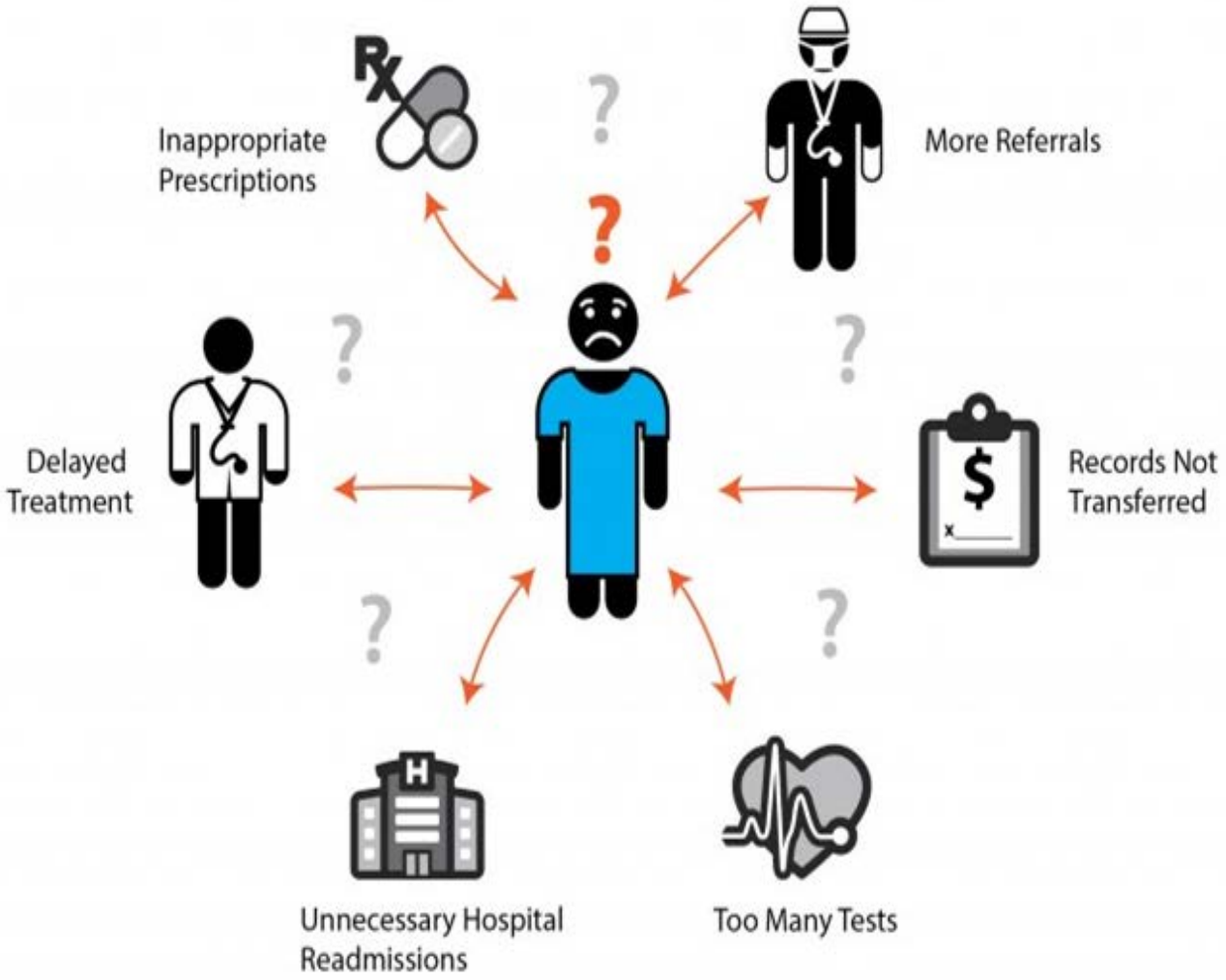
Patients with unmet social and medical needs

A 65-year-old man with severe hypertension and kidney disease is repeatedly hospitalized for worsening heart and kidney failure. Doctors don't know that his utilities have been disconnected, leaving him without air conditioning or a refrigerator in the sweltering summer heat.

A 42-year-old morbidly obese woman with severe cardiovascular problems and bipolar disorder spends more than 300 days in the hospital and nursing home because she can't afford a special bed or to arrange services that would enable her to live at home.

Too Many Patients Have to Manage Their Own Care

Uncoordinated Care Results in Worse Outcomes, Higher Costs & Patient Frustration



Non-profit hospitals have an obligation to provide "community benefit" in exchange for tax relief. What's changed?

Traditional:

Focused within the Hospital

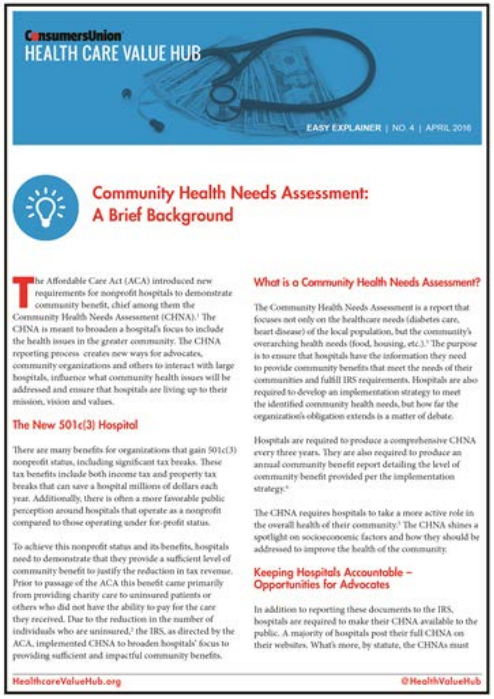
Financial Assistance:
- Charity Care
- Discounted care
- Unreimbursed cost of participation in Medicaid

VS

New Obamacare Requirement:

Look beyond charity care to improve *overall* health and access to care in a community:

- Community Health Needs Assessment
- Implementation Strategy
- Annual Benefit Report



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EASY EXPLAINER | NO. 4 | APRIL 2016

Community Health Needs Assessment: A Brief Background

The Affordable Care Act (ACA) introduced new requirements for nonprofit hospitals to demonstrate community benefit, chief among them the Community Health Needs Assessment (CHNA).[1] The CHNA is meant to broaden a hospital's focus to include the health issues in the greater community. The CHNA reporting process creates new ways for advocates, community organizations and others to interact with large hospitals, influence what community health issues will be addressed and ensure that hospitals are living up to their mission, vision and values.

The New 501c(3) Hospital

There are many benefits for organizations that gain 501c(3) nonprofit status, including significant tax breaks. These tax benefits include both income tax and property tax breaks that can save a hospital millions of dollars each year. Additionally, there is often a more favorable public perception around hospitals that operate as a nonprofit compared to those operating under for-profit status.

To achieve this nonprofit status and its benefits, hospitals need to demonstrate that they provide a sufficient level of community benefit to justify the reduction in tax revenue. Prior to passage of the ACA this benefit came primarily from providing charity care to uninsured patients or others who did not have the ability to pay for the care they received. Due to the reduction in the number of individuals who are uninsured,[2] the IRS, as directed by the ACA, implemented CHNA to broaden hospitals' focus to providing sufficient and impactful community benefits.

What is a Community Health Needs Assessment?

The Community Health Needs Assessment is a report that focuses not only on the healthcare needs (diabetes care, heart disease) of the local population, but the community's overarching health needs (food, housing, etc.).[3] The purpose is to ensure that hospitals have the information they need to provide community benefits that meet the needs of their communities and fulfill IRS requirements. Hospitals are also required to develop an implementation strategy to meet the identified community health needs, but how far the organization's obligation extends is a matter of debate.

Hospitals are required to produce a comprehensive CHNA every three years. They are also required to produce an annual community benefit report detailing the level of community benefit provided per the implementation strategy.[4]

The CHNA requires hospitals to take a more active role in the overall health of their community.[5] The CHNA shines a spotlight on socioeconomic factors and how they should be addressed to improve the health of the community.

Keeping Hospitals Accountable – Opportunities for Advocates

In addition to reporting these documents to the IRS, hospitals are required to make their CHNA available to the public. A majority of hospitals post their full CHNA on their websites. What's more, by statute, the CHNAs must

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What is a Community Health Needs Assessment?

- **Defines the healthcare needs of the local population but also the community's overarching health needs.**
- **Information used to prioritize how hospital will provide community benefit.**
- **Performed every three years.**
- **Must incorporate input from community. Must be publicly posted.**

A Promising Model: Social-Medical partnerships to address unmet medical and social needs.

Partnerships Address a Variety of Unmet Social Needs

- **Food**
- **Employment supports**
- **Enable home care**
- **Transportation**
- **Housing supports**
- **And more….**

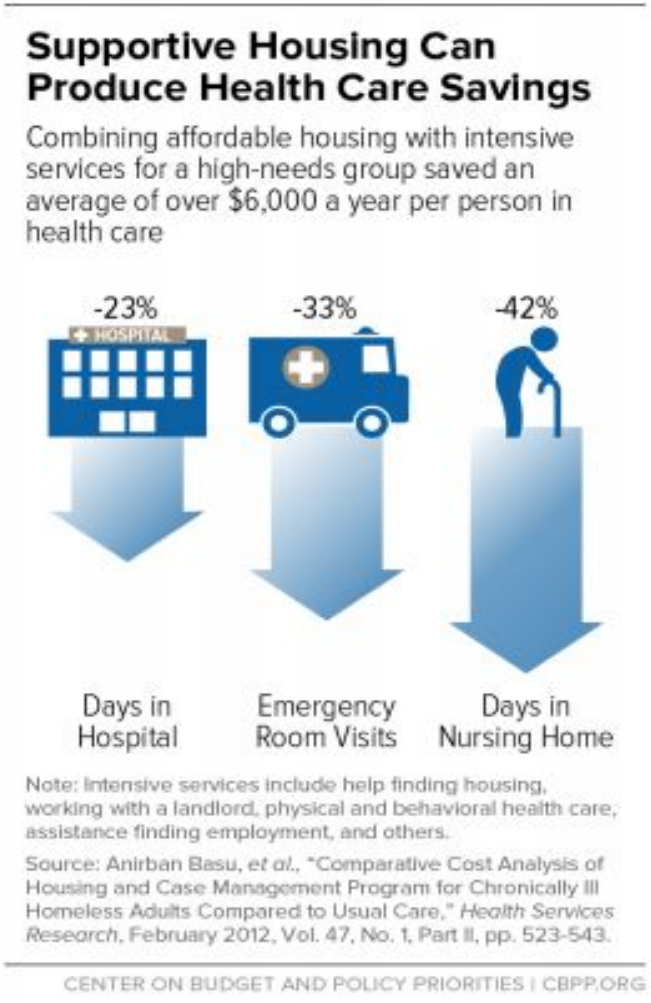
Linkages Between Housing and Health

Housing Attribute	Health Impact
Quality	Housing that is safe, dry, ventilated, free from pests and contaminants (lead, radon, etc), reduces negative health outcomes.
Affordability	Affordable housing frees up money for other basic necessities such as food, utilities and medical care.
Location	Easy to jobs, schools, parks, recreation, healthy food, medical care and supportive safe neighbors means better health through less violence, less stress, better physical and mental health.

Benefits of Supportive Housing

- Significant savings could be achieved **if** a very high-cost group is served. Must be highly targeted.

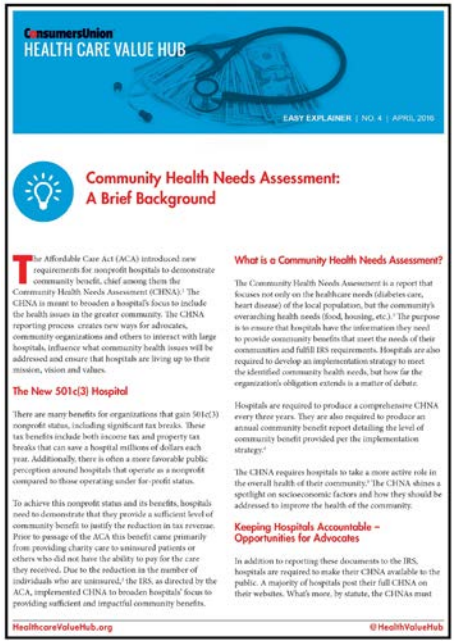
- Seattle: median per person costs for services used by chronically homeless people with severe alcohol problems:
  - $4,066 per **month** when homeless
  - $1,492 after 6 months in housing
  - $958 after 12 months in housing



Housing Investments Often Not Made, Despite ROI

- **Financial Silos:** Future Health Savings vs Immediate Housing Outlays

- **Options:**
  - Better communication across social and medical service agencies
  - Maximizing latitude within the financing silo
  - Medicaid Waivers
  - Center for Medicare & Medicaid Innovation (CMMI)-*Accountable Health Communities*
  - State and community pilot projects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Resources

- **Research Briefs, "Easy Explainers"**
- **Links to key studies, curated news**
- **Graphics/Infographics**
- **Glossaries**
- **Webinar Slides/Recording**
- **Consumer stories (w/ CU.org)**
- **Custom webinars**

All available at: HealthcareValueHub.org

Your Questions?

Thank you!

Contact Lynn Quincy at lquincy@consumer.org
with your follow-up questions.

Visit us at *HealthcareValueHub.org and ConsumersUnion.org*

Thank you!

- Tools and Resources Folder
- Evaluation
- Health Care Financing 101 Webinar Part II
  - -DATE: May 4
  - -TIME: 1:00 – 2:00 p.m. ET
  - -TOPIC: Partnerships - Health & Community Development
  - -REGISTRATION is required

Questions? Email: Health@nw.org