Expenditures summary for Minnesota's local public health system in 2017

The following report summarizes 2017 expenditures of Minnesota's local public health system. Minnesota's community health boards submit this information to the Minnesota Department of Health. Community health boards report expenditures by funding source and area of public health responsibility.

Funding sources supporting public health include: Local Public Health Grant (state general funds), Federal Title V funds, Federal TANF funds (Temporary Assistance for Needy Families), Medicaid (in Minnesota, this is called Medical Assistance), Medicare, private insurance, local tax levies, client fees, other fees (non-client), other local funds, other state funds, and other federal funds. To learn more, visit Appendix A. Funding sources.

Areas of public health responsibility in which community health boards work include: Assure an adequate local public health infrastructure, promote healthy communities and healthy behavior, prevent the spread of communicable diseases, protect against environmental health hazards, prepare and respond to emergencies, and assure health services. To learn more, visit Appendix B. Areas of public health responsibility.

In 2017, Minnesota's local public health system consisted of 51 community health boards. Of the 51 included in this report, 29 are single-county community health boards, 18 are multi-county community health boards, and four are city community health boards. MDH divides community health boards into eight geographic regions for analysis; to view a map of those regions, visit Appendix C. Regions of the State Community Health Services Advisory Committee.

MDH based per capita calculations on 2017 population estimates from the Minnesota Center for Health Statistics.

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Statewide expenditures summary

Minnesota's local public health system spent a total of $349 million on public health in 2017.

Local tax levy accounted for the single largest funding source supporting this work—36 percent of all expenditures (**Table 1**). Other federal funds, including WIC (Women, Infants, and Children) and public health preparedness funds, accounted for 20 percent of expenditures. Local Public Health Grant state funds accounted for 6 percent of all expenditures.

Table 1. Minnesota local public health system funding sources, 2017

Funding source	2017 dollars	2017 percentage of total funding
Local tax levy	$124,774,986	35.8%
Other federal funds	$69,620,835	20.0%
Medicaid	$32,385,051	9.3%
Other state funds	$31,329,573	9.0%
Other fees	$26,536,616	7.6%
Local Public Health Grant state funds	$21,449,656	6.1%
Other local funds	$13,284,044	3.8%
Medicare	$10,178,941	2.9%
Federal TANF	$7,168,079	2.1%
Federal Title V	$5,880,350	1.7%
Private insurance	$3,928,572	1.1%
Client fees	$2,420,008	0.7%
Total	**$348,956,711**	**100.0%**

Figure 2 shows that inflation-adjusted, per capita public health expenditures fell sharply from 2007 to 2012, and have remained since then far below pre-recession levels at approximately $60.

Figure 2. Per capita expenditures across Minnesota's local public health system, 2007-2017

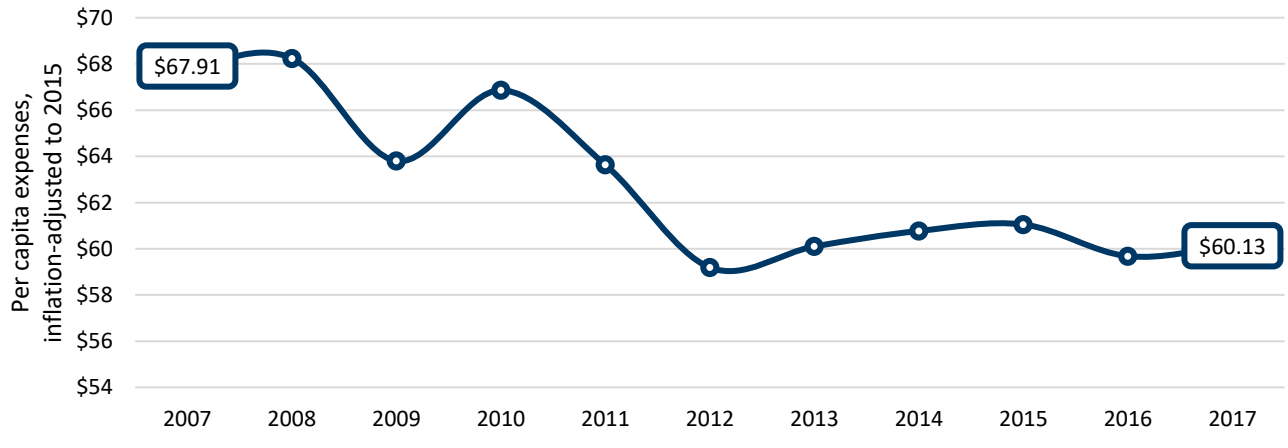


Figure 3 shows that a majority of the community health service system's funding came from locally-generated funds, which include reimbursements and fees for services, local tax levy, and other local funds. State funds

accounted for 15 percent of total expenditures, and federal funds accounted for 36 percent. Together, state and federal funds represent just over half of community health board expenditures.

Figure 3. Minn. local public health system funding sources, 2017

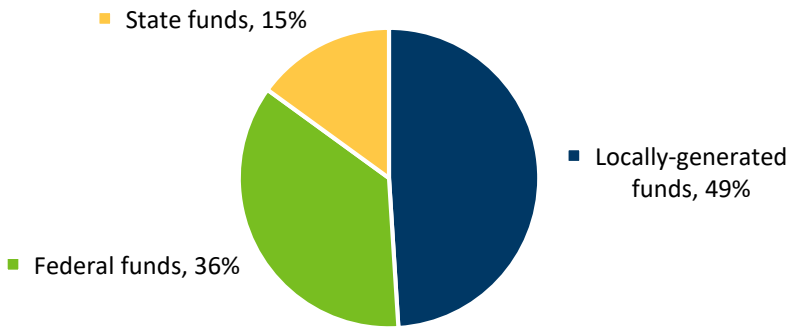
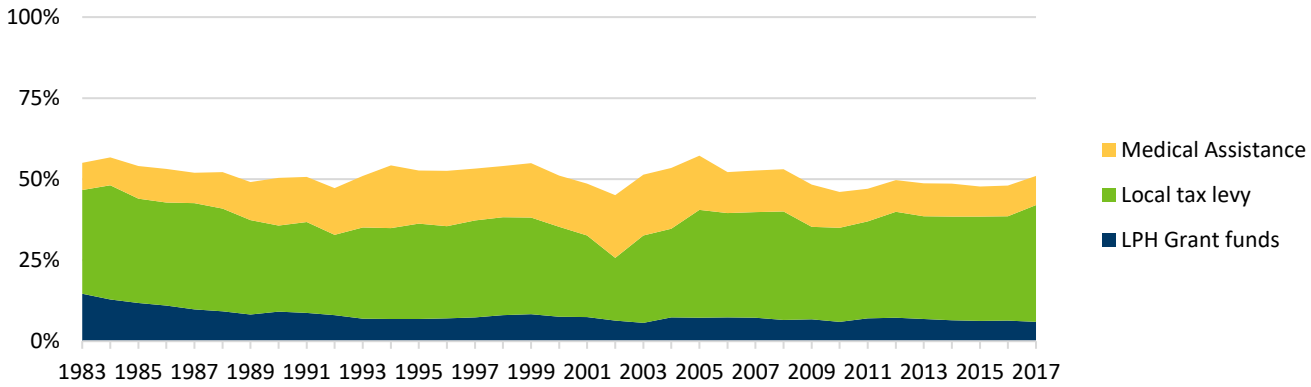


Figure 4 shows the trends of three funding sources as a percentage of total expenditures. Local Public Health Grant state funds have decreased as a percentage of total expenditures over time. The local tax levy, as percentage of total expenditures, has generally fluctuated between 25 percent and 36 percent, with one outlier in 2002.

Figure 4. Local Public Health Grant funds, local tax levy, and Medical Assistance as a percentage of total local health department expenditures, Minnesota, 1983-2017



In 2017, Medical Assistance (Medicaid) accounted for 9 percent of total expenditures. In 1983, the first year it was tracked, Medical Assistance represented 8 percent of total expenditures and has fluctuated between 9 percent and 13 percent over the past decade. Reimbursement rates and the number of community health boards providing home health care services affect the proportion of expenditures covered by Medical Assistance.

Local Public Health Grant state funds and local tax levy are flexible funding sources, meaning they are not associated with a particular program but instead can be used to address high priority public health issues and infrastructure needs. **Figure 5** shows the proportion of flexible funding has decreased from 52 percent in 1979 to 42 percent in 2017. In 2002, flexible funding dipped to a low of 26 percent of total expenditures. After growing to 41 percent of total expenditures in 2005, flexible funding remained stable until a decline to 35 percent of total

expenditures in 2009 and 2010. Individual community health boards have a range of flexible funding amounts available to them, from 8 percent to 76 percent, with a median of 33 percent of their funding deemed flexible.

Figure 5. Flexible funding as a percentage of total public health funding, Minnesota local health departments, 1979-2017

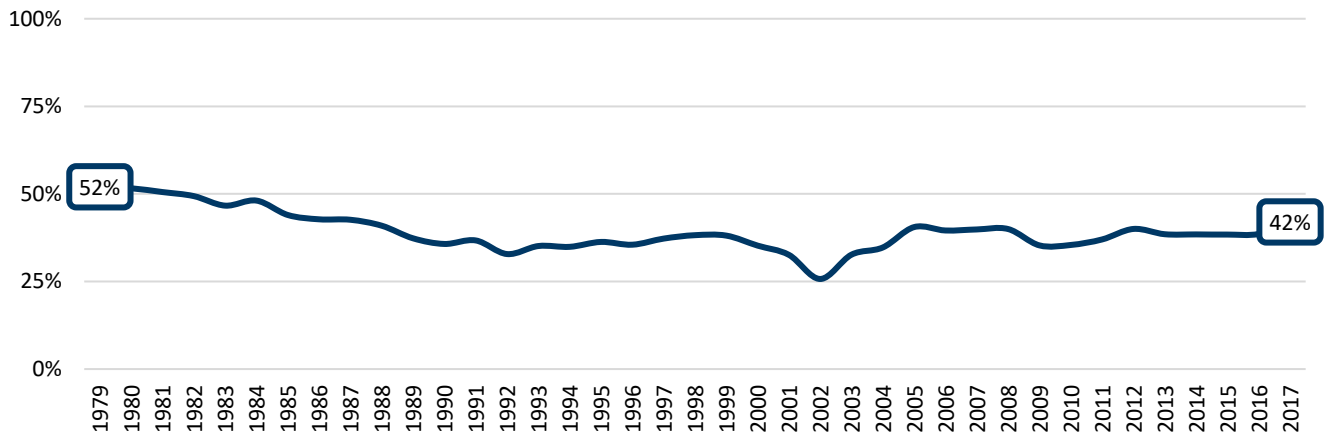


Figure 6 shows that 10 community health boards (20 percent) spent less than $1.5 million on public health in 2017, and 13 community health boards (25 percent) spent between $1.5 and $2.5 million. Community health boards spent a median of $3.1 million on public health in 2017, and ranged from $592,809 to $92 million.

Among community health boards that spent the least on public health in 2017, the bottom quarter of community health boards accounted for a total of 4 percent of the entire system's expenditures.

The community health board with the largest population accounted for 26 percent of the local public health system's total expenditures; the two largest community health boards represented 42 percent of total expenditures. Of the ten community health boards spending over $6.5 million, three are multi-county community health boards, one contains the state's third-largest city, and six are located in the metro region (see Appendix C for a map of regions).

Figure 6. Distribution of total public health expenditures (in millions) among community health boards, Minnesota, 2017

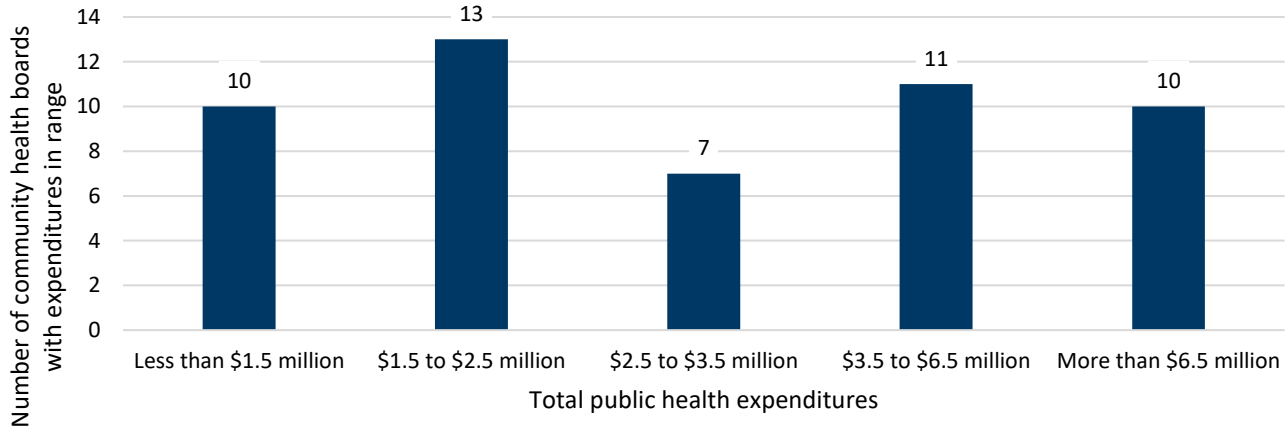
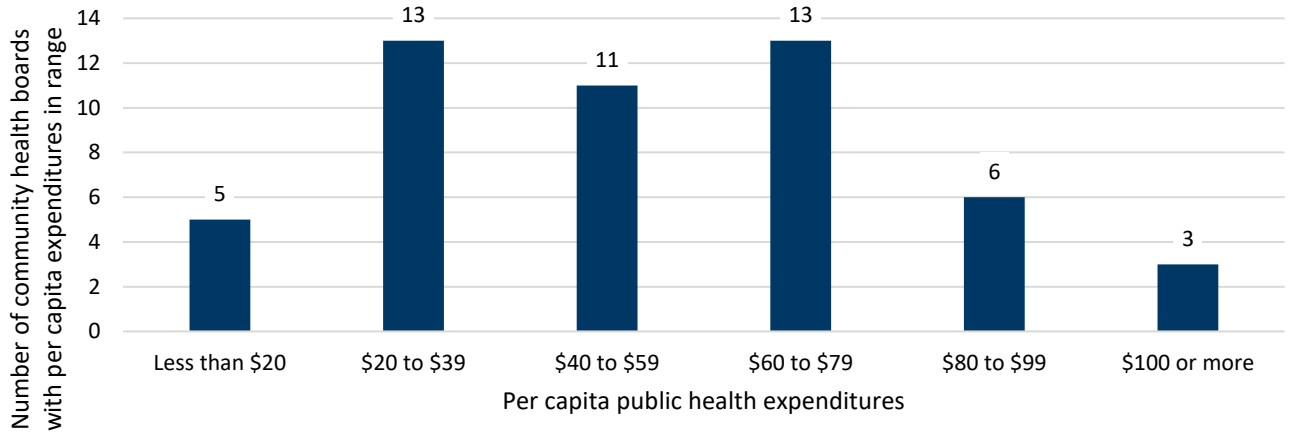


Figure 7 shows the distribution of per capita expenditures among community health boards. In 2017, 18 community health boards spent less than $40 per capita. Community health board spending ranged from $14 to $193 per capita, with a median of $55 per capita.

Of the six community health boards with expenditures greater than $80 per capita, four provided direct care services to the correctional population in county facilities, and one of those four also provided home health services to smaller, rural populations.

Figure 7. Per capita public health expenditure distribution among Minnesota community health boards, 2017



Expenditures by area of public health responsibility

Table 8 shows the distribution and total expenses of the local public health system in 2017 by area of public health responsibility. Community health boards support activities with different mixes of funding depending on the area of public health responsibility.

Table 8. Expenditures by area of public health responsibility, Minnesota local public health system, 2017

Area of public health responsibility	2017 dollars (in millions)	2017 percentage of total spending
Promote healthy communities and healthy behavior	$123.8	35%
Assure health services	$115.5	33%
Protect against environmental health hazards	$48.7	14%
Assure an adequate local public health infrastructure	$33.0	9%
Prevent the spread of communicable diseases	$21.0	6%
Prepare and respond to emergencies	$7.0	2%
Total spending	**$349.0**	**100%**

Promote healthy communities and healthy behavior

The local public health system spent nearly 35 percent of its total funding ($124 million) in this area of responsibility. Community health board spending ranged from $126,832 to $24 million in this area, with a median of $1.1 million.

Across the local public health system, all funding sources contributed to expenditures in this area of responsibility. Other federal funds supported nearly one-third of the total spending in this area ($39 million), and local tax levy provided 29 percent of this area's total funding ($36 million). The remainder of funding came from other state funds (14 percent), Medicaid (6 percent), TANF funds (6 percent), and the Local Public Health Grant (5 percent).

Assure health services

This area of responsibility accounted for the second-largest amount of system expenditures in 2017 ($115.5 million), 3 percent ($3.5 million) more than in 2016. Fourteen community health boards decreased spending in this area of responsibility; 34 increased spending. Community health board spending ranged from nothing to $47.1 million in this area of responsibility, with a median of $1 million; spending varied significantly depending on the community health board's population. These expenditures were supported primarily by local tax levies (36 percent), Medicaid (21 percent), and Medicare (8 percent).

A significant portion of the funding in this area of responsibility represent services provided through home health care, hospice, correctional health, and emergency medical services program; these direct services accounted for 36 percent of expenditures in this area in 2017, and 12 percent of total system expenditures. Emergency medical services accounted for 19 percent of spending in this area, correctional health for 6 percent, and home care and hospice services for 11 percent ($13 million). Over 40 percent of community health boards reported spending nothing on direct services in 2017; one community health board spent $22 million on emergency medical services, accounting for 19 percent of overall expenditures in this area.

Protect against environmental health hazards

Environmental health expenditures totaled $49 million in 2017. Seventeen community health boards spent less than $10,000 on environmental health; six community health boards spent nothing in this area in 2017. Community health board spending ranged from nothing to $20 million in this area of responsibility, with a median of $25,213.

Fees supported 49 percent ($24 million) of the environmental health expenditures. Other funding sources included local tax levy (32 percent) and other state funds (8 percent). Five metro area community health boards spent more than $1 million on this area. They spent $43 million and they accounted for 89 percent of total environmental health spending.

Assure an adequate local public health infrastructure

Community health board spending ranged from nothing to $5 million in this area of responsibility, with a median of $292,000.

Local tax levy supported 73 percent of $24 million total spent in this area of responsibility; other significant funding sources included the Local Public Health Grant (21 percent) and other local sources (2 percent). Six community health boards do not use local tax levy for funding in this area, and six community health boards do not use Local Public Health Grant state general funds.

Prevent the spread of communicable diseases

The area of infectious disease accounted for 6 percent ($21 million) of total system expenditures. Community health board spending ranged from $1,317 to $10 million in this area of responsibility, with a median of $101,000.

Other federal funds supported 44 percent ($9.1 million) of infectious disease spending. Other funding sources supporting this area included local tax levy (29 percent), Local Public Health Grant state funds (11 percent), and client fees (2 percent). Two community health boards spent $13 million in this area of responsibility, accounting for 64 percent of all spending in this area.

Prepare and respond to emergencies

Emergency preparedness expenditures comprised the smallest proportion of the six areas of public health responsibility, with $7 million or 2 percent of total expenditures. Community health board spending ranged from nothing to $1.6 million in this area of responsibility, with a median of $70,000.

Two-thirds ($4.6 million) of emergency preparedness funding came from other federal funds, and 29 percent ($2 million) came from local tax levies.

Expenditures by region

Table 9 shows total and per capita expenditures by region; see Appendix C for a map of the Minnesota's regions by county. The state's West Central region spent the most per capita on public health, $95.63. The Northeast region spent the least, $36.33. Regions with high per capita expenditures often provide direct services such as home health, hospice, correctional, and environmental health.

Table 9. Regional and per capita public health expenditures, Minnesota, 2017

Region	Total expenditures (in millions)	Per capita expenditures
Northwest	$10.0	$57.58
Northeast	$12.0	$36.33
West Central	$22.0	$95.63
Central	$29.0	$38.06
Metro	$210.0	$57.08
Southwest	$14.0	$66.91
South Central	$18.0	$62.22
Southeast	$34.0	$66.66
All Regions	**$349.0**	**n/a**

Percent of expenditures by area of public health responsibility for each region are shown in **Table 10**. There is little variation between regions in the areas of infectious disease and emergency preparedness (between 2

percent and 7 percent). The assure health services area of responsibility saw the most variation across regions (spanning about 26 percentage points). Regional environmental health expenditures as a proportion of total spending vary from less than 1 percent to 21 percent. Expenditures on infrastructure as a portion of total spending vary from 7 percent to 17 percent by region.

Five regions spent the highest proportion of funding to promote healthy communities and healthy behavior (Central, Metro, Northeast, Northwest, and Southwest). The South Central, Southeast, and West Central regions spent the largest proportion of their funding to assure health services.

Table 10. Percent of regional public health expenditures by area of public health responsibility, Minnesota, 2017

Region	Assure an adequate local public health infrastructure	Promote healthy communities and healthy behavior	Prevent the spread of communicable diseases	Protect against environmental health hazards	Prepare and respond to emergencies	Assure health services
Northwest	13.0%	42.6%	3.3%	0.3%	2.6%	38.1%
Northeast	15.8%	49.7%	1.6%	2.1%	2.1%	28.7%
West Central	9.0%	33.1%	1.3%	4.2%	1.3%	51.1%
Central	11.9%	53.8%	4.4%	1.3%	3.6%	25.1%
Metro	7.4%	31.1%	7.6%	21.3%	1.8%	30.8%
Southwest	10.6%	46.2%	6.1%	5.0%	2.9%	29.3%
South Central	9.6%	37.8%	4.3%	3.7%	2.3%	42.3%
Southeast	16.9%	35.4%	3.2%	3.1%	1.6%	39.7%
All Regions	**9.5%**	**35.5%**	**5.9%**	**14.0%**	**2.0%**	**33.1%**

Table 11 compares each region's funding sources. Local tax levy accounted for 11 percent to 44 percent of total expenditures for all regions. Local Public Health Grant state general funds accounted for between 5 percent and 14 percent of total expenditures for all regions.

Table 11. Regional comparison of public health funding sources, Minnesota, 2017

	State funds (Local Public Health Grant)	Federal Title V	Federal TANF	Medical Assistance	Medicare	Private insurance	Local tax	Client funds	Other fees	Other local funds	Other state funds	Other federal funds
Northwest	9%	2%	3%	21%	3%	2%	12%	1%	0%	6%	12%	27%
Northeast	14%	3%	5%	10%	1%	1%	25%	1%	1%	1%	11%	27%
West Central	5%	1%	2%	19%	16%	1%	11%	5%	6%	2%	10%	22%
Central	8%	2%	3%	10%	6%	0%	23%	0%	1%	2%	17%	27%
Metro	5%	2%	2%	4%	0%	1%	44%	0%	11%	5%	7%	19%
Southwest	8%	2%	2%	15%	5%	1%	28%	1%	4%	2%	12%	19%
South Central	6%	1%	2%	16%	14%	0%	27%	1%	3%	4%	10%	16%
Southeast	5%	1%	2%	24%	4%	0%	31%	1%	2%	2%	11%	15%
All Regions	**6%**	**2%**	**2%**	**9%**	**3%**	**1%**	**36%**	**1%**	**8%**	**4%**	**9%**	**20%**

Appendix A. Funding sources

Client Fees: Expenditures that had revenue received as a client fee (i.e., sliding fees for a health care or MCH service) as their source.

Local Public Health Grant State Funds: Expenditures that had the state general funds portion of the Local Public Health Grant allocation as their source.

Local Tax Levy: Expenditures that had revenue from local tax levies as their source.

Medical Assistance [Medicaid] (Title XIX of the Social Security Act): Expenditures that had revenue from Medicaid reimbursements as their source. This includes Prepaid Medical Assistance Plans (PMAPs), community based purchasing and community alternative care (CAC), community alternatives for disabled individuals (CADI), development disabled (DD) (formerly known as mental retardation or related conditions (MR/RC)), elderly (EW), and traumatic brain injury (TBI) waivers. This does not include alternative care (AC) which is reported in other state funds.

Medicare (Title XVIII of the Social Security Act): Expenditures that had Medicare reimbursements as their source. Also include revenue from Minnesota Health Senior Options (MSHO).

Other Federal Funds: Report expenditures of revenue from the Federal Government other than those specified elsewhere in the glossary (i.e. Medicaid, Medicare, TANF, and Title V). This includes dollars that come directly and as pass thru funds. Any funds with a Catalog of Federal Domestic Assistance (CFDA) number are federal funds. Examples include WIC, Veteran's Administration, Pandemic Flu Supplemental Funding, and Public Health Preparedness. This does NOT include Medicaid, Medicare, Medicaid waivers, Title V, and TANF funds. If a grant is funded by both state and federal sources (e.g., 30 percent state funds and 70 percent federal funds) divide the amount appropriately between Other State Funds and Other Federal Funds.

Other Fees (non-client): Expenditures from revenue received as a fee for service, or for a license or permit. Usually the charge has been set by statute, charter, ordinance, or board resolution.

Other Local Funds: Expenditures from other local funds including in-kind and contracts, grants or gifts from local agencies such as schools, social service agencies, community action agencies, hospitals, regional groups, nonprofits, corporations or foundations. Please confirm that these funds do not originate from a federal source.

Other State Funds: Expenditures of dollars spent from state funds other than those specified including grants and contracts from the Minnesota Department of Health and other state agencies that are not "pass thru" dollars from the federal government. Funds with a CFDA number are federal dollars. Examples of other state funding include alternative care and family planning special project grants. Please confirm that these funds do not originate from a federal source. If a grant is funded by both state and federal sources (e.g., 30 percent state funds and 70 percent federal funds) divide the amount appropriately between other state funds and other federal funds

Private Insurance: Expenditures that had reimbursements received from private insurance companies as their source.

TANF (Federal): Total of invoices sent to MDH for reimbursement for the period of January 1 to December 31 that had federal TANF from the Local Public Health Grant allocation as their funding source.

Title V (Federal): Expenditures of dollars that had the federal Title V (MCH) portion of the Local Public Health Grant as their source.

Appendix B. Areas of public health responsibility

Assure an adequate local public health infrastructure

This area of public health responsibility describes aspects of the public health infrastructure that are essential to a well-functioning public health system—including assessment, planning, and policy development. This includes those components of the infrastructure that are required by law for community health boards. It also includes activities that assure the diversity of public health services and prevents the deterioration of the public health system.

Promote healthy communities and healthy behavior

This area of public health responsibility includes activities to promote positive health behavior and the prevention of adverse health behavior—in all populations across the lifespan in the areas of alcohol, arthritis, asthma, cancer, cardiovascular/stroke, diabetes, health aging, HIV/AIDS, Infant, child, and adolescent growth and development, injury, mental health, nutrition, oral/dental health, drug use, physical activity, pregnancy and birth, STDs/STIs, tobacco, unintended pregnancies, and violence. It also includes activities that enhance the overall health of communities.

Prevent the spread of communicable diseases

This area of responsibility focuses on infectious diseases that are spread person to person, as opposed to diseases that are initially transmitted through the environment (e.g., through food, water, vectors and/or animals). It also includes the public health department activities to detect acute and communicable diseases,

assure the reporting of communicable diseases, prevent the transmission of disease (including immunizations), and implement control measures during communicable disease outbreaks.

Protect against environmental health hazards

This area of responsibility includes aspects of the environment that pose risks to human health (broadly defined as any risk emerging from the environment), but does not include injuries. This area also summarizes activities that identify and mitigate environmental risks, including foodborne and waterborne diseases and public health nuisances.

Prepare and respond to emergencies

This area of responsibility includes activities that prepare public health to respond to disasters and assist communities in responding to and recovering from disasters.

Assure health services

This area of responsibility includes activities to assess the availability of health-related services and health care providers in local communities. It also includes activities related to the identification of gaps and barriers in services; convening community partners to improve community health systems; and providing services identified as priorities by the local assessment and planning process.

Appendix C. Regions of the State Community Health Services Advisory Committee (SCHSAC)