

Expenditures Summary for Minnesota’s Community Health Services System in 2014

November 2015

The following report summarizes 2014 expenditures of the Community Health Services (CHS) System. This information is submitted by Minnesota’s Community Health Boards (CHBs) to the Minnesota Department of Health. CHBs report expenditures by funding source and area of public health responsibility. The funding sources are: local tax levy, other federal funds, Medicaid, other local funds, Local Public Health (LPH) Grant state funds, other state funds, other fees, Medicare, Title V funds, Temporary Assistance for Needy Families (TANF) funds, client fees, and private insurance. The areas of public health responsibility are: assure health services, healthy communities, environmental health, infrastructure, infectious disease, and emergency preparedness. Complete explanations of the funding sources and areas of public health responsibility can be found in Appendices A and B.

In 2014, Minnesota’s community health services system consisted of 50 Community Health Boards (CHBs). Of the 50 included in this report, 26 are single-county CHBs, 20 are multi-county CHBs, and four are city CHBs.

Per capita calculations are based on the 2014 population estimates from the Minnesota Center for Health Statistics.

The CHBs are split into geographic regions for analysis. Appendix C contains a map of the regions.

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STATEWIDE EXPENDITURES SUMMARY

CHS System expenditures were \$323 million in 2014, representing an increase of \$10.7 million (3.4 percent) from 2013. Overall, 12 CHBs (24 percent) had decreases in total expenditures from 2013. The median decrease was 6 percent with a range of less than 1 percent to 17 percent. The thirty-eight CHBs (76 percent) with increases had increases that ranged from less than 1 percent to 31 percent with a median of 7 percent.

The single largest funding source was local tax levy, accounting for 32 percent of all expenditures (**Table 1**). This proportion increased slightly from 31.7 percent in 2013. Other federal funds, which include WIC and public health preparedness funds, accounted for 22 percent of expenditures. The LPH Grant state funds accounted for 6.5 percent of all expenditures and decreased 1 percent from 2013. Other state funds increased by \$2 .5 million or 11 percent from 2013.

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TABLE 1. MINNESOTA COMMUNITY HEALTH SERVICES SYSTEM FUNDING SOURCES, 2014

FUNDING SOURCE	2014 DOLLARS	2014 PERCENTAGE OF TOTAL
Local tax levy	\$103,407,863	32.0%
Other federal funds	\$70,925,951	21.9%
Medicaid	\$32,940,045	10.2%
Other fees	\$28,129,985	8.7%
LPH Grant state funds	\$20,928,989	6.5%
Other state funds	\$24,280,880	7.5%
Other local funds	\$13,163,484	4.1%
Medicare	\$11,424,257	3.5%
Federal TANF	\$6,921,556	2.1%
Federal Title V	\$5,266,301	1.6%
Client fees	\$2,586,779	0.8%
Private insurance	\$3,458,153	1.1%
Total	\$323,434,243	100.0%

Figure 2 shows that a majority of the CHS 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 14 percent of total expenditures and federal funds accounted for 39 percent. Together, state and federal funds represent over half of CHB expenditures.

FIGURE 2. MINNESOTA COMMUNITY HEALTH SERVICES SYSTEM FUNDING, 2014

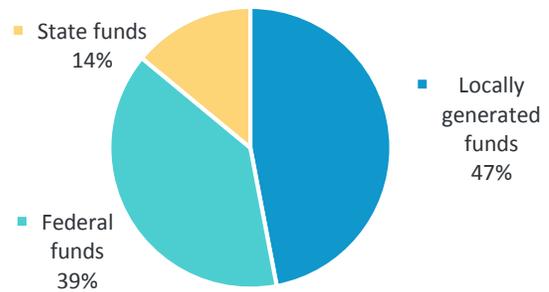
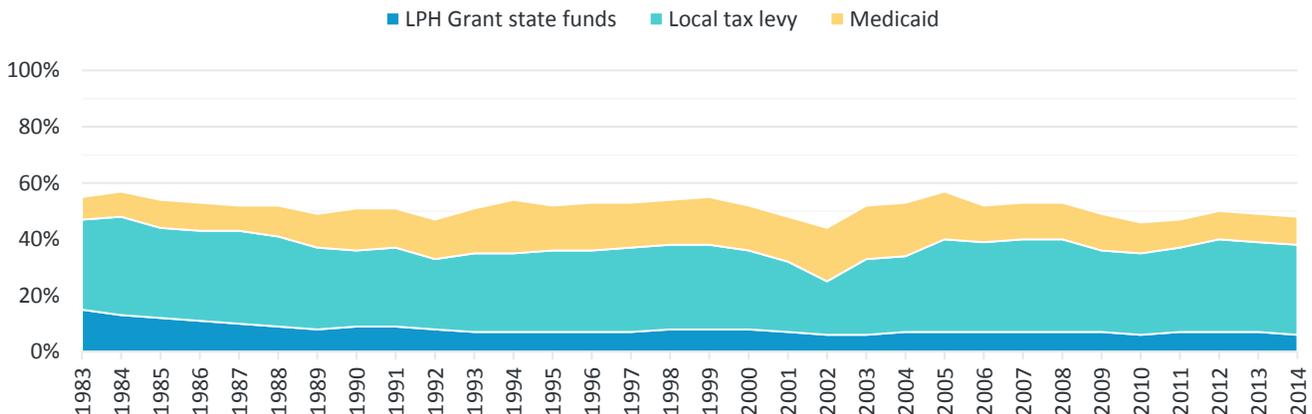


Figure 3 shows the trends of three funding sources as a percentage of total expenditures. The LPH Grant state funds have decreased as a percentage of total expenditures over time. The local tax levy, as percentage of total expenditures, has generally fluctuated between 25 percent and 35 percent, with one outlier in 2002.

In 2014 Medicaid accounted for 10 percent of total expenditures. In 1983, the first year it was tracked, Medicaid represented 8 percent of total expenditures and has fluctuated between 10 percent and 19 percent over the past decade. Reimbursement rates and the number of CHBs providing home health care services affect the Medicaid percentage.

FIGURE 3. LPH GRANT STATE FUNDS, LOCAL TAX LEVY, AND MEDICAL ASSISTANCE (MEDICAID) AS A PERCENTAGE OF TOTAL LOCAL HEALTH DEPARTMENT EXPENDITURES, MINNESOTA, 1983-2014



The LPH Grant state funds and local tax levy are “flexible funding,” meaning that these two funding sources are not associated with a particular program, but instead can be used to address high priority public health issues and infrastructure needs. **Figure 4** shows the proportion of flexible funding has decreased from 52 percent in 1979 to 38 percent in 2014, and has sustained a 2 percent decrease in the proportion of flexible funding since 2013. In 2002, flexible funding dipped to a low of 26 percent of total expenditures. After climbing 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 CHBs have a range of “flexible funding” from 9 percent to 79 percent with a median of 30 percent.

FIGURE 4. FLEXIBLE FUNDING AS A PERCENTAGE OF TOTAL PUBLIC HEALTH FUNDING, MINNESOTA LOCAL HEALTH DEPARTMENTS, 1979-2014

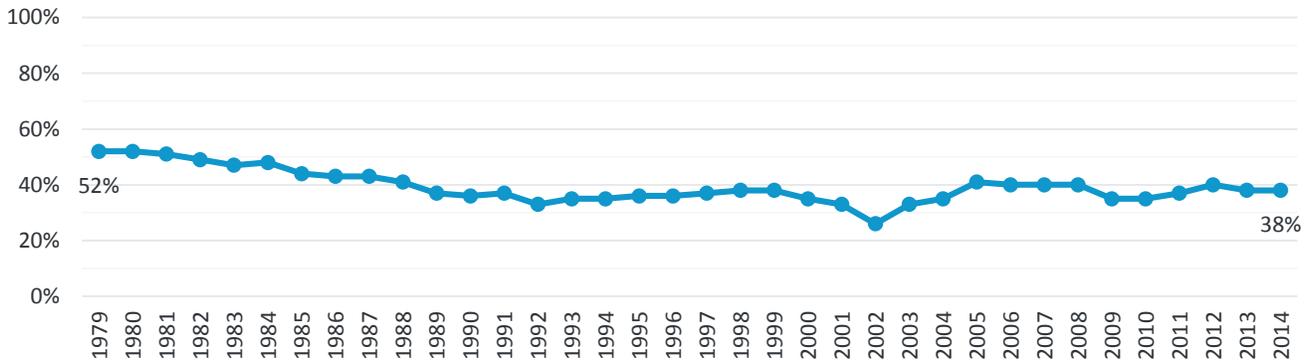


Figure 5 shows that 6 CHBs (12 percent) had total expenditures of less than \$1.5 million and 14 CHBs (28 percent) had total expenditures of less than \$2.5 million. The median total expenditure was \$2.8 million with a range of \$523,589 to \$78.5 million. The smallest quartile of CHBs accounted for 5 percent of total CHS system expenditures. The largest CHB in terms of population represented 24 percent of total expenditures of the CHS System; the two largest CHBs represented 40 percent of total expenditures. Of the nine CHBs spending over \$6.5 million, two are multi-county CHBs, one contains the state’s third-largest city and six are in the metro region.

FIGURE 5. DISTRIBUTION OF TOTAL PUBLIC HEALTH EXPENDITURES, BY COMMUNITY HEALTH BOARD, MINNESOTA, 2014

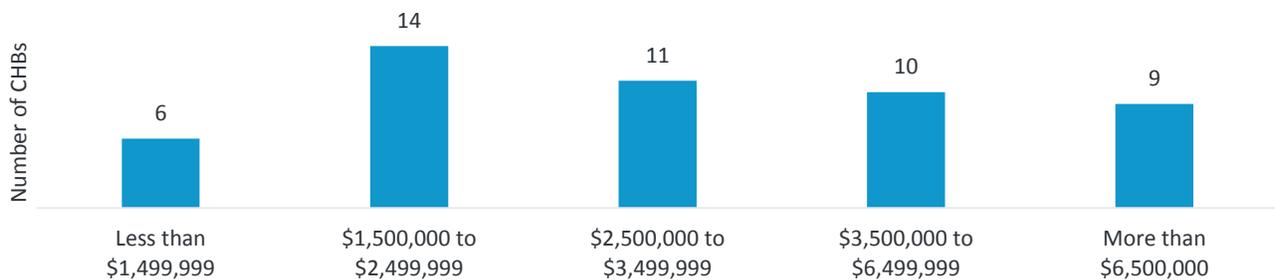


Figure 6 shows per capita expenditures by CHBs. Sixteen CHBs had per capita expenditures of less than \$40. Per capita expenditures by CHBs ranged from \$11 to \$122, with a median per capita of \$50. Of the seven CHBs with expenditures greater than \$80 per capita, six provided direct care services to the correctional population in county facilities and four of these also provided home health services to smaller, rural populations. The CHB with the highest per capita expenditures (\$122) provided hospice services.

FIGURE 6. PER CAPITA PUBLIC HEALTH EXPENDITURE DISTRIBUTION AMONG MINNESOTA COMMUNITY HEALTH BOARDS, 2014

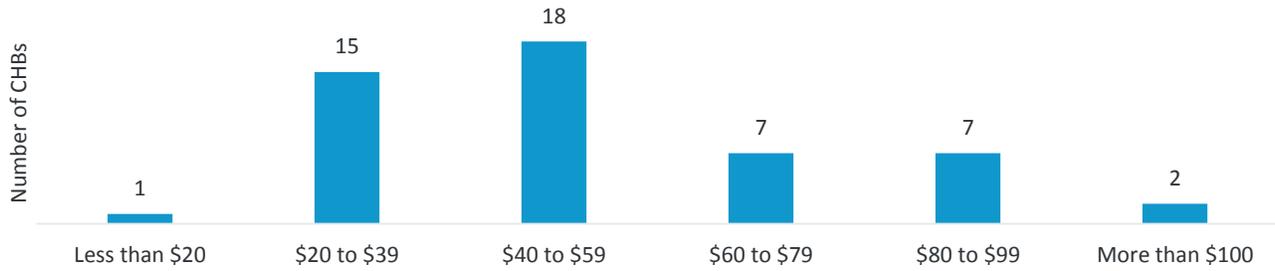


Table 7 shows the dollar amount and percentage of total expenses in each area of public health responsibility. Each area of public health responsibility was funded through a different mix of funding sources. Brief funding summaries for each area of public health responsibility are described below.

TABLE 7. EXPENDITURES BY AREA OF PUBLIC HEALTH RESPONSIBILITY, MINNESOTA COMMUNITY HEALTH BOARDS, 2014

AREA OF PUBLIC HEALTH RESPONSIBILITY	2014 DOLLARS (IN MILLIONS)	2014 PERCENTAGE OF TOTAL SPENDING
Assure the quality and accessibility of health services	\$114.3	35.3%
Promote healthy communities and healthy behaviors	\$113.0	34.9%
Protect against environmental health hazards	\$43.0	13.3%
Assure an adequate local public health infrastructure	\$28.0	8.7%
Prevent the spread of infectious disease	\$18.0	5.6%
Prepare for and respond to disaster, and assist communities in recovery	\$7.1	2.2%
Total Spending	\$323.4	100.0%

ASSURE THE QUALITY AND ACCESSIBILITY OF HEALTH SERVICES

Expenditures in the area of assuring health services were the largest, totaling \$114 million. This is \$1 million more than in 2013, an increase of 1 percent. Eighteen CHBs had decreases in this area of responsibility. Thirty-two CHBs had increases. The median CHB spending was \$897,000 with a range from \$0 to \$43.8 million, with significant variation depending on population. These expenditures were supported primarily by local tax levy (35 percent), Medicaid (22 percent) and Medicare (9 percent).

A significant part of assuring health services includes providing services through home health care, hospice, correctional health, and emergency medical services programs. These direct services accounted for 38 percent of expenditures in this area and 13 percent of total expenditures. Twenty-three percent of health services spending was on emergency medical services and five percent was on correctional health. Almost ten percent (\$11 million) of health services spending was on home health care and hospice services. Twenty-two CHBs reported spending \$0 on direct services in 2014. Twenty-eight CHBs reported expenditures on at least one type of direct service. It is important to note that one CHB expended \$24 million dollars on emergency medical services, accounting for 21 percent of overall expenditures.

PROMOTE HEALTHY COMMUNITIES AND HEALTHY BEHAVIORS

Nearly \$113 million (35 percent of total expenditures) were expended in the area of healthy communities, an increase of \$6 million dollars (5.7 percent) from 2013. Thirty-four CHBs (of 50 available for comparison) had increases in healthy community spending. The median CHB spending in 2014 was \$1 million with a range of \$260,000 to \$20 million. This area of

public health responsibility includes activities to promote positive health behaviors and the prevention of adverse health behaviors in all populations across the lifespan. Activities touch a wide range of health concerns and can range from increasing opportunities for physical activity and improving access to healthy food to creating asthma action plans, promoting healthy youth development, and addressing cardiovascular disease and stroke. See Appendix B for more information.

All funding sources contributed to expenditures in this area. Thirty-nine percent of healthy communities expenditures (\$44 million) were supported by other federal funds and local tax levy provided 22 percent (\$24.6 million). Other state funds, accounted for 10 percent (\$11.7 million). Other funds came from Medicaid (7 percent), TANF funds (6 percent), and LPH Grant state funds (6 percent).

PROTECT AGAINST ENVIRONMENTAL HEALTH HAZARDS

Environmental health expenditures increased by 11 percent (\$4 million) from 2013 to \$43 million in 2014. Twenty-one CHBs had decreases in environmental health funding. Fifteen CHBs spent less than \$10,000 on environmental health expenditures, including five CHBs that reported no expenditures in 2014. The median CHB spending was \$50,000 with a range from \$0 to \$19 million. Fees supported 53 percent (\$23 million) of the environmental health expenditures. Other funding sources included local tax levy (27 percent) and other state funds (7 percent). Five metro area CHBs spent more than \$1 million on this area. They spent \$38.1 million and they accounted for 88 percent of total environmental health spending.

ASSURE AN ADEQUATE LOCAL PUBLIC HEALTH INFRASTRUCTURE

Just under 9 percent of total expenditures were in the area of infrastructure, a decrease of \$116,000 (0.42 percent) under 2013. Twenty-two CHBs experienced a decrease in spending. The median CHB spending was \$332,000 with a range from \$2,500 to \$3.8 million. Local tax levy funded 71 percent of \$28 million in infrastructure expenditures. The other significant funding sources for this area of public health responsibility included LPH Grant state general funds (19 percent) and other local sources (5 percent). Four CHBs do not use local tax levy and five CHBs do not use LPH Grant state general funds to fund infrastructure.

PREVENT THE SPREAD OF INFECTIOUS DISEASE

The area of infectious disease accounted for less than 6 percent (\$17.8 million) of total expenditures. This is a slight decrease of \$494,000 (2.7 percent) from 2013. The median CHB spending in 2014 was \$104,000 with a range of \$3,500 to \$8 million. Other federal funds supported 43 percent (\$7.7 million) of infectious disease spending. Other funding sources included local tax levy (27 percent), LPH Grant state funds (13 percent), and client fees (3 percent). Two CHBs spent \$10.5 million on infectious disease expenditures. This accounted for 59 percent of all infectious diseases spending.

PREPARE FOR AND RESPOND TO DISASTER, AND ASSIST COMMUNITIES IN RECOVERY

Emergency preparedness expenditures comprised the smallest proportion of the six areas of public health responsibility, with \$7.1 million or 2.2 percent of total expenditures. Emergency preparedness expenditures decreased by \$498,000 (7 percent) from 2013 to 2014. The median CHB spending in 2014 was \$81,000 ranging from \$17,000 to \$1.1 million. Sixty-four percent (\$4.5 million) of the emergency preparedness funding was from other federal funds and 26 percent (\$1.8 million) was from the local tax levy.

REGIONAL EXPENDITURES COMPARISONS

Table 8 shows total and per capita expenditures by region. The west central region had the highest per capita spending at \$86.76. The northeast region had the smallest at \$33.82. Nearly all regions had an increase in total expenditures. Overall, total expenditures for the state increased 11 million (3.5 percent) from 2014. Regions with high per capita expenditures often provide direct services such as home health, hospice, correctional, and environmental health.

TABLE 8. REGIONAL AND PER CAPITA PUBLIC HEALTH EXPENDITURES, MINNESOTA, 2014

REGION	TOTAL EXPENDITURES (IN MILLIONS)	PER CAPITA EXPENDITURES
Northwest	\$12.4	\$60.80
Northeast	\$11.0	\$33.82
West Central	\$16.7	\$86.76
Central	\$29.0	\$39.10
Metro	\$193.1	\$54.09
Southwest	\$13.2	\$60.23
South Central	\$17.0	\$57.47
Southeast	\$31.5	\$62.84
All Regions	\$323.6	n/a

Percent of expenditures by area of public health responsibility for each region are shown in **Table 9**. There is little variation between regions in the areas of infectious disease and emergency preparedness with ranges between 2 percent and 7 percent. The area with the most variation (about 30 percentage points) across regions is healthy communities. Regional environmental health expenditures vary from less than one percent to 21 percent. Expenditures on infrastructure vary from 6 percent to 16 percent by region.

Healthy communities had the highest percentage of expenditures in five regions (northeast, central, northwest, south west and south east). In the metro, south central, and west central regions, expenditures were highest in the assure health services area of responsibility.

TABLE 9. PERCENT OF REGIONAL PUBLIC HEALTH EXPENDITURES BY AREA OF PUBLIC HEALTH RESPONSIBILITY, MINNESOTA, 2014

REGION	INFRA- STRUCTURE	HEALTHY COMMU- NITIES	INFECTIOUS DISEASE	ENVIRON- MENTAL HEALTH	EMERGENCY PREPARED- NESS	ASSURE HEALTH SERVICES
Northwest	9.7%	45.5%	3.2%	0.2%	2.4%	39.1%
Northeast	12.9%	57.6%	2.9%	2.5%	5.4%	18.7%
West Central	10.2%	32.5%	1.8%	2.5%	1.5%	51.5%
Central	11.1%	52.3%	4.1%	2.3%	3.4%	26.7%
Metro	6.3%	28.8%	6.8%	20.5%	1.9%	35.7%
Southwest	12.9%	44.8%	6.9%	4.3%	3.2%	27.9%
South Central	8.0%	38.3%	2.9%	4.4%	2.6%	43.8%
Southeast	16.1%	39.9%	3.6%	3.7%	1.4%	35.3%
All Regions	8.6%	35.0%	5.5%	13.4%	2.2%	35.5%

Table 10 compares the funding sources of each region. Local tax levy as a percentage of total expenditures ranged from 10 percent to 39 percent. The LPH Grant state general funds accounted for between 5 percent and 14 percent of total expenditures for all regions.

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TABLE 10. REGIONAL COMPARISON OF PUBLIC HEALTH FUNDING SOURCES, MINNESOTA, 2014

REGION	STATE FUNDS (LPH 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	8%	2%	2%	18%	4%	2%	10%	1%	0%	5%	17%	31%
Northeast	14%	3%	5%	4%	0%	3%	23%	2%	0%	1%	13%	32%
West Central	5%	1%	2%	21%	20%	1%	13%	4%	3%	5%	9%	16%
Central	8%	2%	3%	11%	6%	0%	24%	1%	2%	3%	12%	28%
Metro	6%	1%	2%	6%	0%	1%	39%	0%	13%	4%	5%	22%
Southwest	8%	2%	3%	13%	4%	1%	23%	1%	5%	8%	11%	20%
South Central	7%	2%	2%	17%	14%	0%	21%	1%	2%	9%	11%	15%
Southeast	5%	1%	2%	21%	8%	0%	27%	2%	3%	4%	11%	16%
All Regions	6%	2%	2%	10%	4%	1%	32%	1%	9%	4%	8%	22%

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.

LPH 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 (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 Behaviors (Healthy Communities): This area of public health responsibility includes activities to promote positive health behaviors and the prevention of adverse health behaviors – 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 Infectious Disease (Infectious Disease): 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 (Environmental Health): 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 for and Respond to Disasters, and Assist Communities in Recovery (Emergency Preparedness): 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 the Quality and Accessibility of Health Services (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: SCHSAC REGIONS

SCHSAC: State Community Health Services Advisory Committee

