

Expenditures Summary for Minnesota's Community Health Services System in 2016

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COMMUNITY HEALTH SERVICES SYSTEM IN 2016

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EXPENDITURES SUMMARY FOR MINNESOTA'S
COMMUNITY HEALTH SERVICES SYSTEM IN 2016

This report summarizes 2016 community health services system expenditures, which Minnesota community health boards submitted to the Minnesota Department of Health (MDH) in 2017. Community health boards report expenditures by funding source (see [Appendix A](#) for more information) and area of public health responsibility (see [Appendix B](#)).

In 2016, Minnesota's community health services system consisted of 49 community health boards: 26 single-county community health boards, 19 multi-county community health boards, and four city community health boards.

MDH calculated per capita calculations based on 2016 population estimates from the [Minnesota Center for Health Statistics](#). We split community health boards into geographic regions for analysis (see [Appendix C](#) for a map).

Statewide Expenditures Summary

System-wide expenditures were \$335 million in 2016, representing no change from 2015. Overall, 23 community health boards (47 percent) had decreases in total expenditures from 2015. The median decrease was 4 percent with a range of less than 1 percent to 42 percent. A similar number of community health boards (24, 49 percent) reported an increase in expenditures. The median increase was 4 percent, with a range of less than 1 percent to 14 percent. Two community health boards (4 percent) are not included in comparisons because of composition changes in 2015 to 2016.

Table 1. Minnesota Community Health Services System funding sources, 2016

Funding	2016 dollars	2016 % of total
Local tax levy	\$108,035,575	32.2%
Other federal funds	\$71,217,473	21.2%
Medicaid	\$31,726,921	9.5%
Other fees	\$28,051,984	8.4%
Local Public Health Grant state funds	\$21,371,796	6.4%
Other state funds	\$28,504,798	8.5%
Other local funds	\$15,842,326	4.7%
Medicare	\$10,559,586	3.1%
Federal TANF	\$6,831,444	2.0%
Federal Title V	\$6,507,759	1.9%
Client fees	\$2,428,061	0.7%
Private insurance	\$4,396,757	1.3%
Total	\$335,474,480	100.0%

The single largest funding source was local tax levy, accounting for 32 percent of all expenditures (**Table 1**). Other federal funds, which include WIC and public health preparedness funds, accounted for 21 percent of expenditures. The Local Public Health Grant state funds accounted for 6.4 percent

of all expenditures. Other state funds decreased by \$5 million or 15 percent from 2015. Funding sources are defined in [Appendix A](#).

Figure 2 shows that a majority of the Community Health Services 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 38 percent. Together, state and federal funds represent over half of community health board expenditures.

Figure 2. Minnesota community health services system funding, 2016

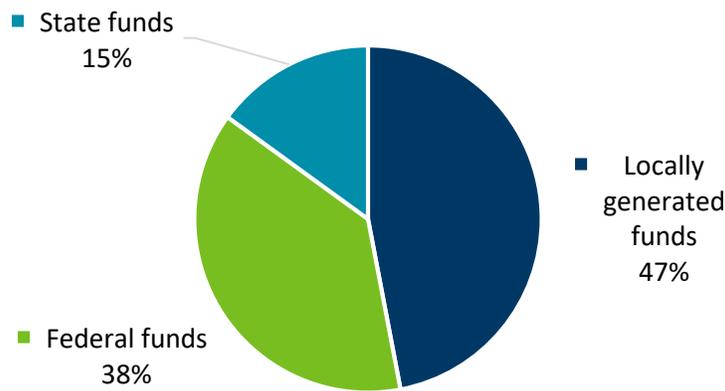
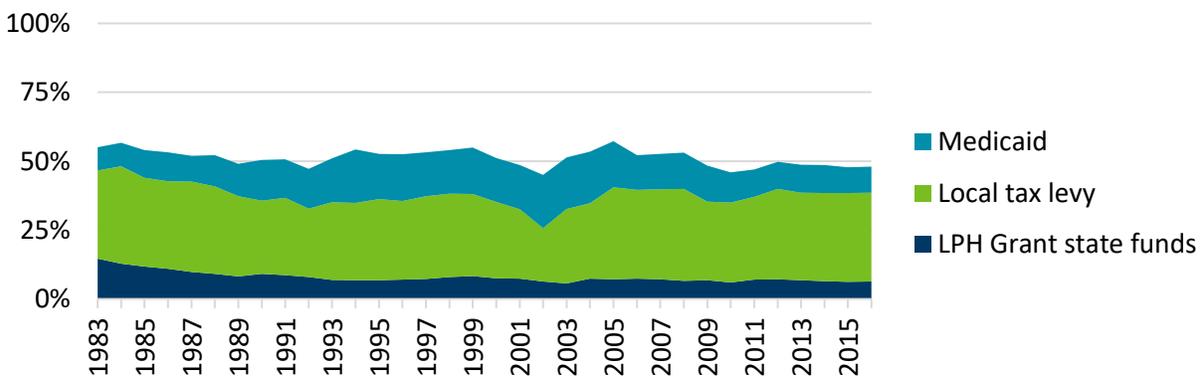


Figure 3 shows the trends of three funding sources as a percentage of total expenditures. The Local Public Health Grant state funds have decreased as a percentage of total expenditures over time. The local tax levy, as a percentage of total expenditures, has generally fluctuated between 25 percent and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

In 2016 Medicaid accounted for 9 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 13 percent over the past decade. Reimbursement rates and the number of community health boards providing home health care services affect the Medicaid percentage.

Figure 3. Local Public Health Grant state funds, local tax levy, and Medical Assistance (Medicaid) as a percentage of total local health department expenditures, Minnesota, 1983-2016



The Local Public Health 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 39 percent in 2016. 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 community health boards have a range of “flexible funding” from 8 percent to 76 percent with a median of 32 percent.

Figure 4. Flexible funding as a percentage of total public health funding, Minnesota local health departments, 1979-2016

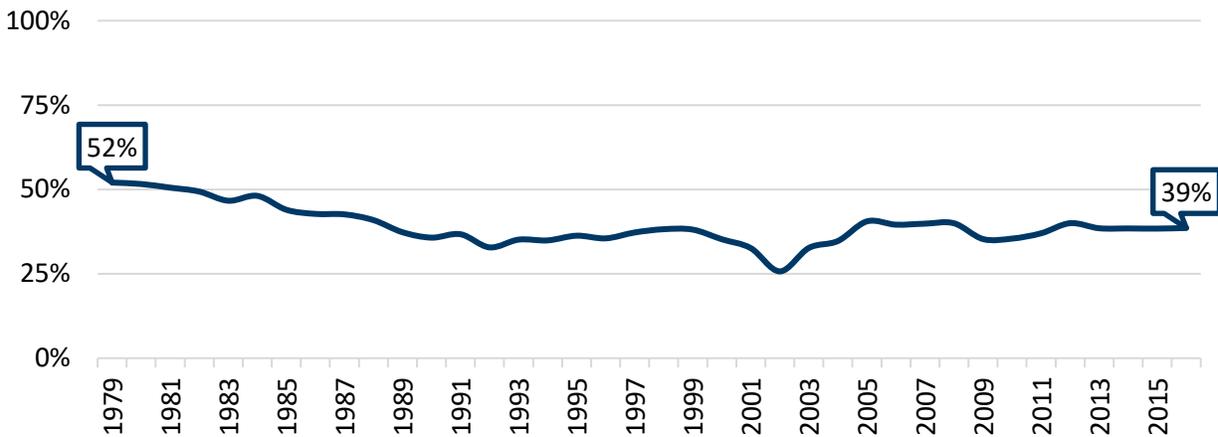


Figure 5 shows that 8 community health boards (16 percent) had total expenditures of less than \$1.5 million and 12 community health boards (24 percent) had total expenditures of less than \$2.5 million. The median total expenditure was \$3.2 million with a range of \$576,660 to \$82 million. The smallest quartile of community health boards accounted for 5 percent of total Community Health Services System expenditures. The largest community health board in terms of population represented 24 percent of total expenditures system-wide; the two largest community health boards represented 40 percent of total expenditures. Of the eleven community health boards spending over \$6.5 million, four are multi-county community health boards, 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, 2016

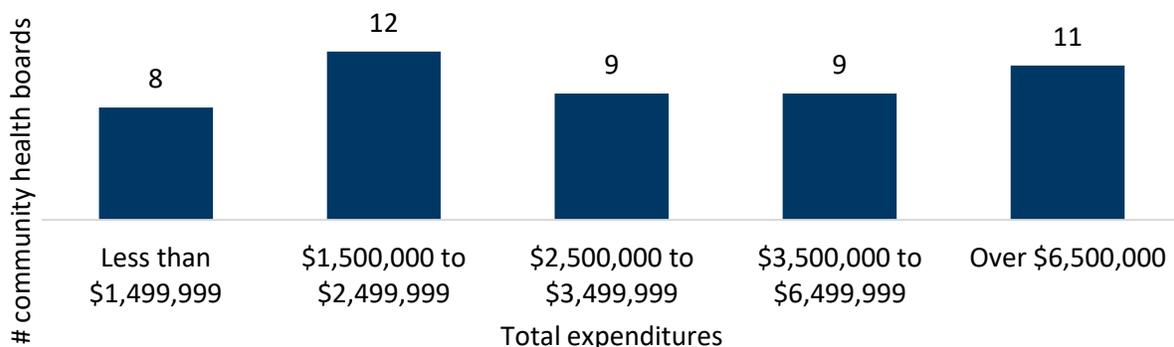


Figure 6 shows per capita expenditures by community health boards. Eighteen community health boards had per capita expenditures of less than \$40. Per capita expenditures by community health boards ranged from \$12 to \$125, with a median per capita of \$55. Of the six community health boards with expenditures greater than \$80 per capita, three provided direct care services to the correctional population in county facilities and two of these also provided home health services to smaller, rural populations.

Figure 6. Per capita public health expenditure distribution among Minnesota community health boards, 2016

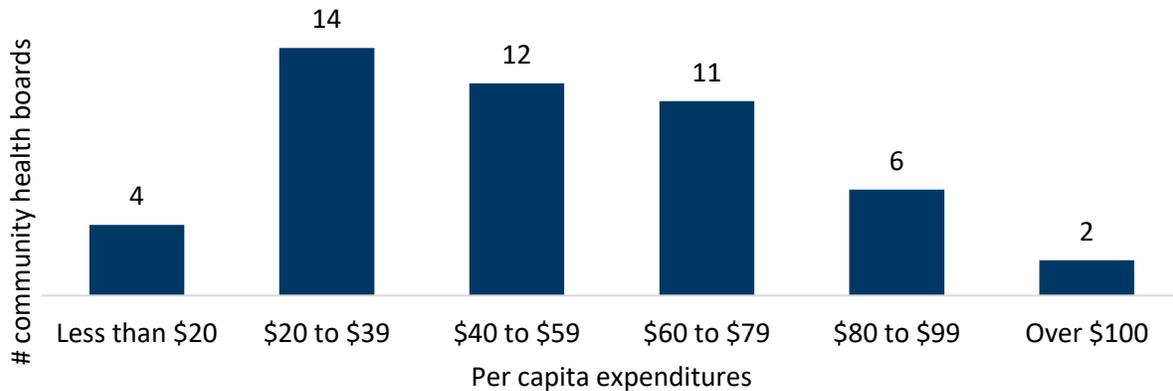


Table 7 shows the dollar amount and percentage of total expenses in each area of public health responsibility. Each area of public health responsibility was funded through a mix of funding sources. Brief funding summaries for each area of public health responsibility are described below.

Table 7. Expenditures by area of public health responsibility, Minnesota community health boards, 2016

Area of public health responsibility	2016 dollars (in millions)	2016 % of total spending
Promote healthy communities and healthy behaviors	\$116.0	35%
Assure the quality and accessibility of health services	\$112.0	33%
Protect against environmental health hazards	\$48.5	14%
Assure an adequate local public health infrastructure	\$33.2	10%
Prevent the spread of infectious disease	\$19.0	6%
Prepare for and respond to disaster, and assist communities in recovery	\$6.8	2%
Total Spending	\$335.5	100%

Assure Health Services

Expenditures in the area of assuring health services were the second largest, totaling \$112 million. This is \$2 million more than in 2015, an increase of 2 percent. Sixteen community health boards had decreases in this area of responsibility. Thirty-one community health boards had increases. Two

community health boards were not included in comparisons because of community health boards changes from 2015 to 2016. The median community health board spending was \$961,000 with a range from \$0 to \$45.1 million, with significant variation depending on population. These expenditures were supported primarily by local tax levy (34 percent), Medicaid (20 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 36 percent of expenditures in this area and 12 percent of total expenditures. Twenty percent of health services spending was on emergency medical services and six percent was on correctional health. Eleven percent (\$12 million) of health services spending was on home health care and hospice services. Twenty-one community health boards reported spending \$0 on direct services in 2016. Twenty-eight community health boards reported expenditures on at least one type of direct service. It is important to note that one community health board expended \$22 million dollars on emergency medical services, accounting for 20 percent of overall expenditures.

Promote Healthy Communities and Healthy Behavior

Nearly \$116 million (35 percent of total expenditures) were expended in the area of healthy communities, a decrease of \$3.9 million dollars (3.2 percent) from 2015. Fourteen community health boards (of 47 available for comparison) had increases in healthy community spending. The median community health board spending in 2016 was \$1 million with a range of \$251,000 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-five percent of healthy community expenditures (\$40 million) were supported by other federal funds and local tax levy provided 23 percent (\$26.9 million). Other state funds, accounted for 13 percent (\$15 million). Other funds came from Medicaid (7 percent), TANF funds (6 percent), and Local Public Health Grant state funds (6 percent).

Protect Against Environmental Health Hazards

Environmental health expenditures increased by 2 percent (\$1 million) from 2015 to \$48 million in 2016. Eighteen community health boards had decreases in environmental health funding. Fourteen community health boards spent less than \$10,000 on environmental health expenditures, including three community health boards that reported no expenditures in 2016. The median community health board spending was \$79,000 with a range from \$0 to \$23 million. Fees supported 53 percent (\$25 million) of the environmental health expenditures. Other funding sources included local tax levy (29 percent) and other state funds (7 percent). Five metro area community health boards spent more than \$1 million on this area. They spent \$43 million and they accounted for 88 percent of total environmental health spending.

Assure an Adequate Local Public Health Infrastructure

Ten percent of total expenditures were in the area of infrastructure, an increase of \$2 million (6 percent) more than 2015. Eighteen community health boards reported a decrease in spending. The median community health board spending was \$372,000 with a range from \$4,400 to \$5.2 million. Local tax levy funded 69 percent of \$33 million in infrastructure expenditures. The other significant funding sources for this area of public health responsibility included Local Public Health Grant state general funds (21 percent) and other local sources (4 percent). Five community health boards do not use local tax levy and three community health boards do not use Local Public Health Grant state general funds to fund infrastructure.

Prevent the Spread of Communicable Diseases

The area of infectious disease accounted for less than 6 percent (\$19 million) of total expenditures. This is a slight increase of \$423,000 (2.3 percent) from 2015. The median community health board spending in 2016 was \$110,000 with a range of \$3,000 to \$8 million. Other federal funds supported 45 percent (\$8.5 million) of infectious disease spending. Other funding sources included local tax levy (27 percent), Local Public Health Grant state funds (12 percent), and client fees (2 percent). Two community health boards spent \$11.5 million on infectious disease expenditures. This accounted for 61 percent of all infectious diseases spending.

Prepare and Respond to Emergencies

Emergency preparedness expenditures comprised the smallest proportion of the six areas of public health responsibility, with \$6.8 million or 2 percent of total expenditures. Emergency preparedness expenditures decreased by \$2 million (20 percent) from 2015 to 2016. The median community health board spending in 2016 was \$88,000 ranging from \$21,000 to \$1.1 million. Seventy-six percent (\$5.1 million) of the emergency preparedness funding was from other federal funds and 20 percent (\$1.3 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 \$90.19. The northeast region had the smallest at \$35.26. Nearly all regions had an increase in total expenditures. Overall, total expenditures for the state increased by less than 0.5 million (0.1 percent) from 2015. 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, 2016

Region	Total expenditures (in millions)	Per capita expenditures
Northwest	\$10.0	\$58.85
Northeast	\$11.0	\$35.26
West Central	\$21.0	\$90.19
Central	\$28.0	\$37.31
Metro	\$199.4	\$54.93
Southwest	\$14.0	\$63.87
South Central	\$18.5	\$63.81
Southeast	\$33.6	\$66.54
All Regions	\$335.5	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 percentage of expenditures allocated for infectious disease (from 2 percent to 7 percent of total expenditures) and emergency preparedness (from 1 percent to 4 percent). The area with the most variation (about 21 percentage points) across regions is healthy communities. Regional environmental health expenditures vary from less than one percent to 22 percent. Expenditures on infrastructure vary from 8 percent to 15 percent by region.

Healthy communities had the highest percentage of expenditures in six regions (central, northeast, northwest, southwest, south central, and southeast). In the metro 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, 2016

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	12.1%	43.3%	3.2%	0.5%	2.8%	37.9%
Northeast	12.2%	53.4%	2.2%	2.7%	3.0%	26.6%
West Central	11.7%	33.6%	1.5%	3.0%	1.3%	48.9%
Central	12.4%	50.8%	4.5%	2.9%	3.7%	25.6%
Metro	8.0%	29.4%	7.0%	22.1%	1.8%	31.7%
Southwest	12.1%	43.7%	7.3%	4.7%	2.9%	29.2%
South Central	9.7%	37.7%	3.4%	4.3%	2.5%	42.3%
Southeast	15.5%	37.5%	3.4%	3.8%	1.5%	38.3%
All Regions	9.9%	34.6%	5.6%	14.5%	2.0%	33.4%

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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 Local Public Health Grant state general funds accounted for between 5 percent and 14 percent of total expenditures for all regions.

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	9%	3%	2%	18%	5%	3%	10%	1%	0%	6%	10%	32%
Northeast	14%	4%	5%	11%	1%	2%	21%	2%	0%	2%	11%	27%
West Central	5%	1%	2%	18%	17%	1%	11%	4%	4%	3%	12%	22%
Central	9%	3%	3%	12%	6%	0%	22%	0%	2%	2%	14%	28%
Metro	6%	2%	2%	5%	0%	2%	39%	0%	12%	6%	6%	21%
Southwest	9%	2%	3%	15%	5%	1%	24%	1%	3%	3%	12%	21%
South Central	6%	2%	2%	15%	13%	1%	29%	1%	3%	4%	9%	16%
Southeast	6%	2%	2%	22%	5%	0%	28%	2%	3%	3%	11%	16%
All Regions	6%	2%	2%	9%	3%	1%	32%	1%	8%	5%	8%	21%

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: Assure an adequate local public health infrastructure by maintaining the basic foundational capacities to a well-functioning public health system that includes data analysis and utilization; health planning; partnership development and community mobilization; policy development, analysis, and decision support; communication; and public health research, evaluation, and quality improvement.

Promote healthy communities and healthy behavior: Promote healthy communities and healthy behavior through activities that improve health in a population, such as investing in healthy families; engaging communities to change policies, systems, or environments to promote positive health or prevent adverse health; providing information and education about healthy communities or population health status; and addressing issues of health equity, health disparities, and the social determinants to health.

Prevent the spread of communicable diseases: Prevent the spread of communicable disease by preventing diseases that are caused by infectious agents through detecting acute infectious diseases, ensuring the reporting of infectious diseases, preventing the transmission of infectious diseases, and implementing control measures during infectious disease outbreaks.

Protect against environmental health hazards: Protect against environmental health hazards by addressing aspects of the environment that pose risks to human health, such as monitoring air and water quality; developing policies and programs to reduce exposure to environmental health risks and promote healthy environments; and identifying and mitigating environmental risks such as food and waterborne diseases, radiation, occupational health hazards, and public health nuisances.

Prepare and respond to emergencies: Prepare and respond to emergencies by engaging in activities that prepare public health departments to respond to events and incidents and assist communities in recovery, such as providing leadership for public health preparedness activities with a community; developing, exercising, and periodically reviewing response plans for public health threats; and developing and maintaining a system of public health workforce readiness, deployment, and response.

Assure health services: Assure health services by engaging in activities such as assessing the availability of health-related services and health care providers in local communities, identifying 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

