Indiana Department of Health

Welcome to the Governor's Public Health Commission

November 18, 2021

Indiana Department of Health

Governance Structures Primer

Kristina M. Box, MD, FACOG
State Health Commissioner

November 18, 2021

Local Functions

Every local health department, regardless of size, must perform dozens of statutory and regulatory functions. Some key activities include:

- Immunizations
- Vital Records
- Case management (TB, lead, STIs, etc.)
- Public Health Emergency Preparedness
- Communicable disease reporting, investigation, and monitoring outbreaks
- Septic permitting, pool monitoring, and other respond to environmental concerns
- Inspect and license restaurants, lodging, festivals/gatherings, and other facilities
- Administration (Board, local health officer, and public health administrator)

Governance	
Centralized	75%+ served by LHDs that are units of the SHA
Decentralized	75%+ served by LHDs that are units of local gov't
Shared	75%+ served by LHDs where state & local officials share authority
Mixed	Varied governance systems, less than 75% of one type

Structure	
Free-standing/ Independent	Independent agency within the state government
Umbrella/Super	Agency is a unit of a larger combined health and human services organization

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Source: Association of State and Territorial Health Officials (ASTHO), July 14, 2021.

2019 State Health Agency Classification

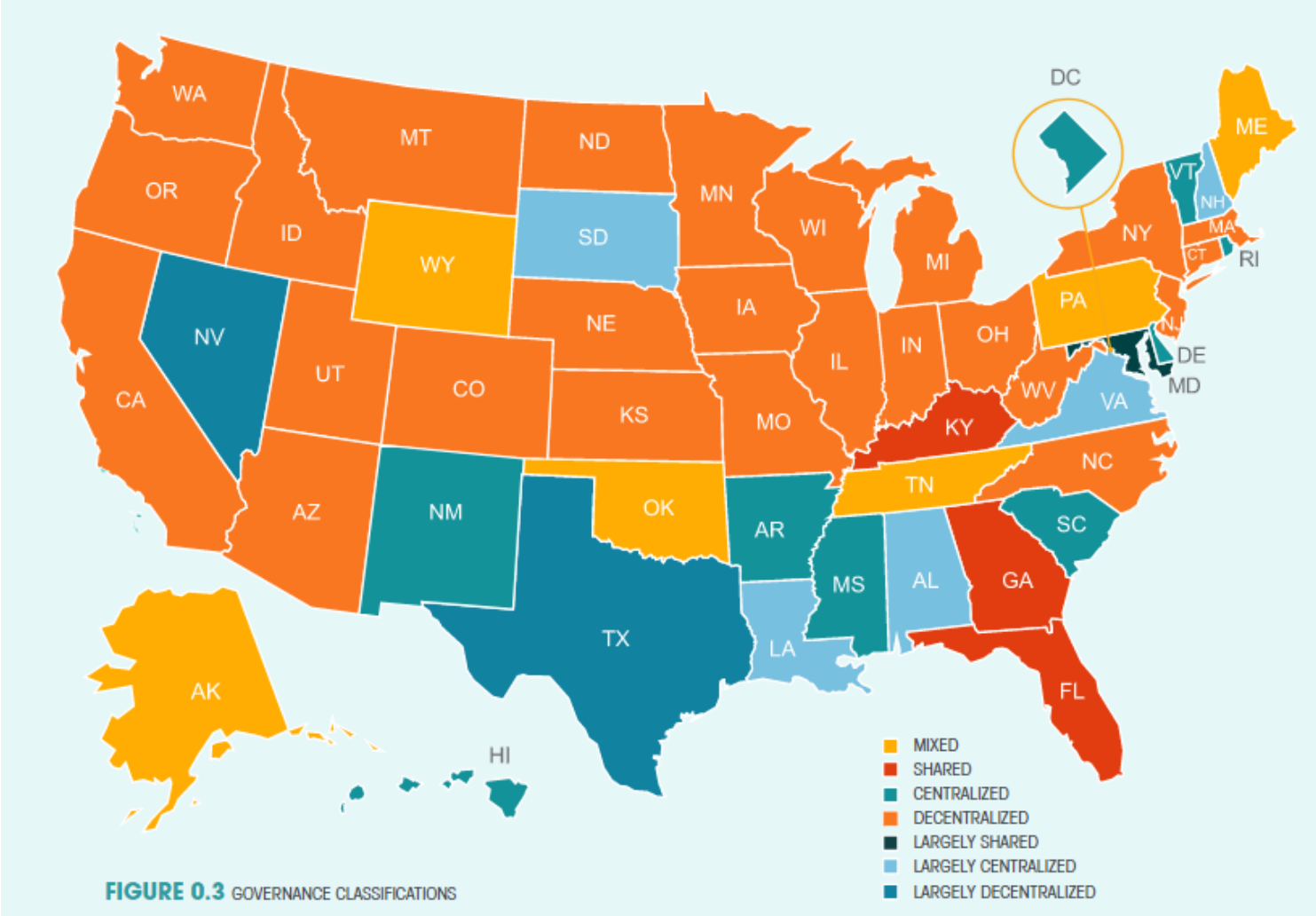

FIGURE 0.3 GOVERNANCE CLASSIFICATIONS

Source: Association of State and Territorial Health Officials (ASTHO), July 14, 2021.

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Public Health Funding and Financing

Shane Hatchett, MS

Chief of Staff

November 18, 2021

Note of Thanks

Our work included interviews with the following individuals. We thank them for their time and expertise.

Dr. Betty Bekemeier

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Dr. JP Leider

Scott Maitland

Nancy Marsh

Stephanie Mellinger

David Reynolds

Fred Van Dorp

Mindy Waldron

Susanne Weirick

Public Health Funding is complicated, fragmented, unequal, and inadequate – across the country and in Indiana

"In the United States, public health and prevention strategies are financed through a complex and often ad hoc patchwork of funding streams with federal, state, local, and private sources that vary widely among communities and exhibit considerable instability"

National Academy of Medicine

$24 Billion

Estimated gap between the amount currently spent on PH and the amount needed to provide a minimum package of foundational PH services in the US.

National Academy of Medicine, 2012

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SOURCES: National Academy of Medicine, *For the Public's Health,: Investing in a Healthier Future*, 2012; IU Richard M. Fairbanks School of Public Health, *Indiana Public Health System Review*, December 2020.

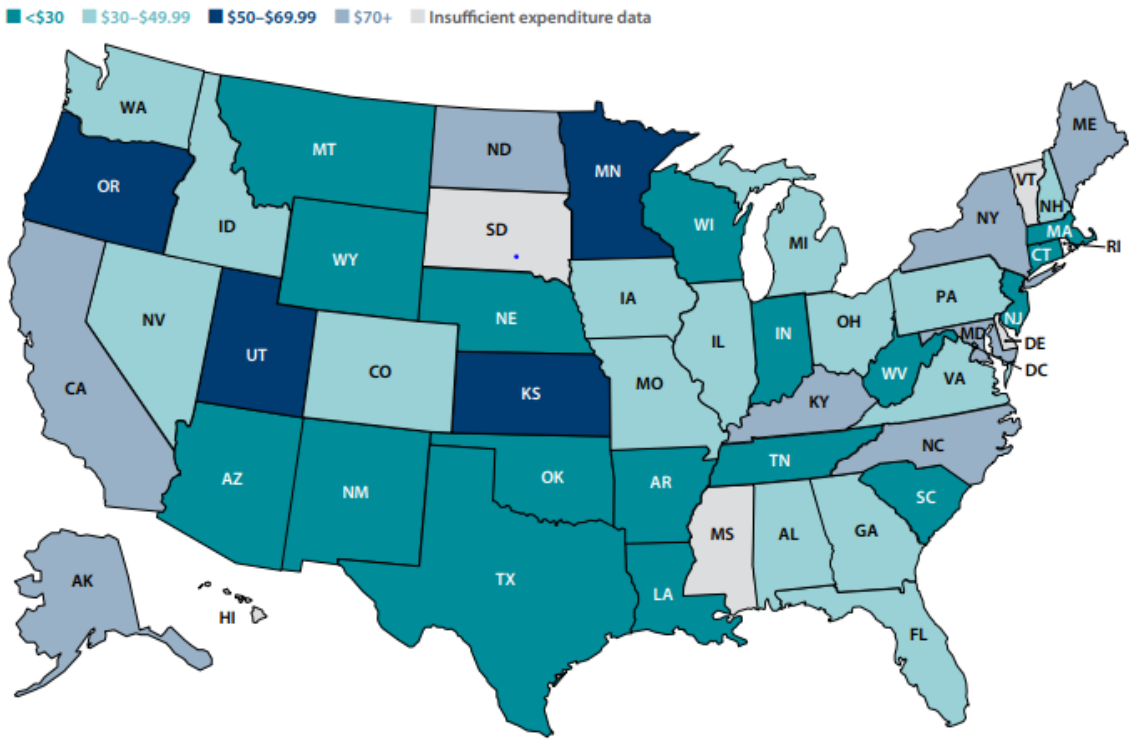
Indiana Per Capita PH funding levels are low at both the state and local levels

Per Capita Ranking	IN	IL	KY	MI	OH
CDC Program Funding (2020)	50	45	28	43	47
CDC COVID-19 Response Funding	30	49	40	25	43
HRSA Select Programs (2017)	40	27	28	34	43
State Govt. PH Expenditures (2018)	45	39	16	26	42

"One thing that is consistent is that public health investments in Indiana are consistently below US averages and frequently among the lowest across neighboring, companion, and exemplar states . . . "

IU Richard M. Fairbanks School of Public Health

Overall Median Annual LHD Expenditures per capita, by state, 2019



SOURCES: IU Richard M. Fairbanks School of Public Health, Indiana Public Health System Review, December 2020; Trust for America's Health, (TFAH) *The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2021,* May 2021; TFAH, *A funding crisis for public health and safety: state-by-state public health funding and key health facts, 2018,* 2018; Y. Natalia Alfonso et al, *US Public Health Neglected: Flat Or Declining Spending Left States Ill Equipped To Respond To COVID-19,* Health Affairs, Vol. 40 No. 4; March 25, 2021; National Association of County & City Health Officials (NACCHO), National Profile of Local Health Departments, 2019.

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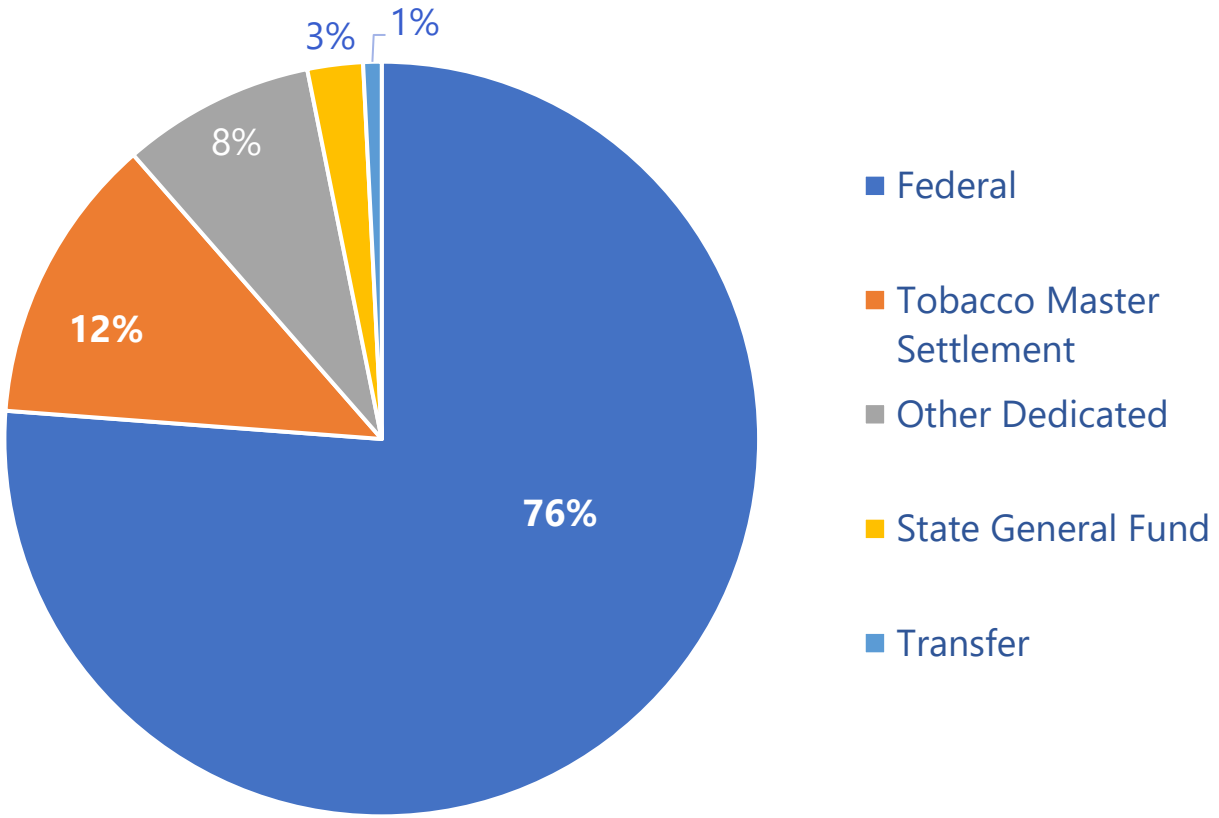
The State Department of Health (IDOH) budget is heavily reliant on federal funds (76%) and Tobacco Settlement funds (12%)

Federal Fund sources include:

- Dept of Agriculture (WIC program)
- Dept of Health and Human Services (Other health programs)
- Dept of Transportation (Other health programs)
- Dept of Homeland Security (Bioterrorism, preparedness, and response)
- Environmental Protection Agency (EPA programs)
- American Rescue Plan

*This includes **$161M** in COVID-19 Supplemental Funding*
These funds are not long-term and represent a cliff.

IDOH FY 2022 Budget: $534,969,270

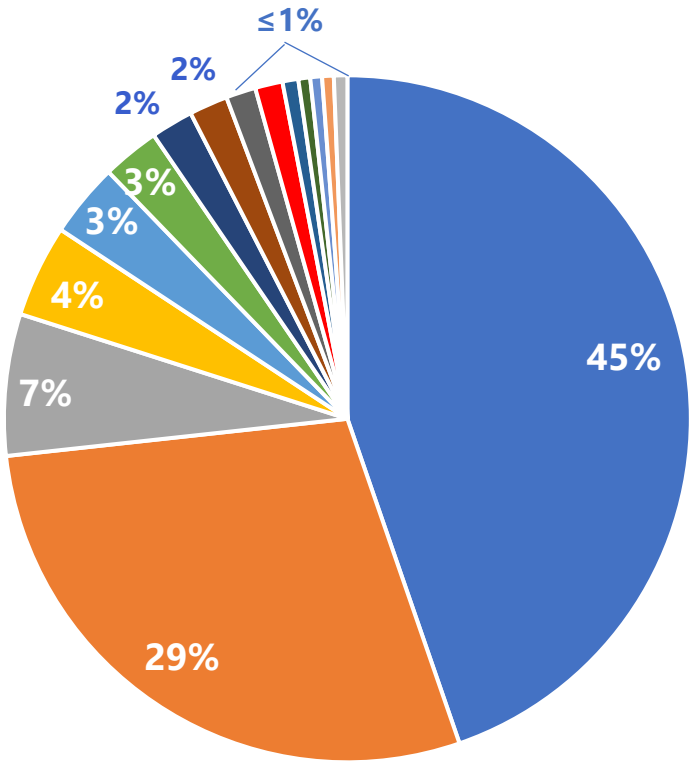


SOURCE: Indiana State Budget Agency. 2021-2023 As-passed Budget; IDOH Financial records as of November 2021.

The largest share of IDOH expenditures are for DHHS funded programs (e.g., CDC, HRSA grants) (45%) followed by WIC (29%)

IDOH FY 2022 Budget: $534,969,270

In FY20 and FY21, IDOH passthrough funds accounted for 40% and 55% of agency budget.



- DHHS and Other Health Programs
- Women, Infants, and Children Program
- Community and Family Health Services
- Administration
- Maternal and Child Health Services
- Community Health Centers
- Immunization Programs
- Long-term Care Services
- Tobacco Use Prevention and Cessation
- Local Health
- Health Education
- Deaf and Hard of Hearing Services
- HIV/AIDS and Other STD Services
- Other

Includes:
Health Improvement Grants — $25M

Includes:
Local Health Department Account — $3M
Local Health Maintenance Fund – $3.9M

SOURCE: Indiana State Budget Agency. 2021-2023 As-passed Budget.

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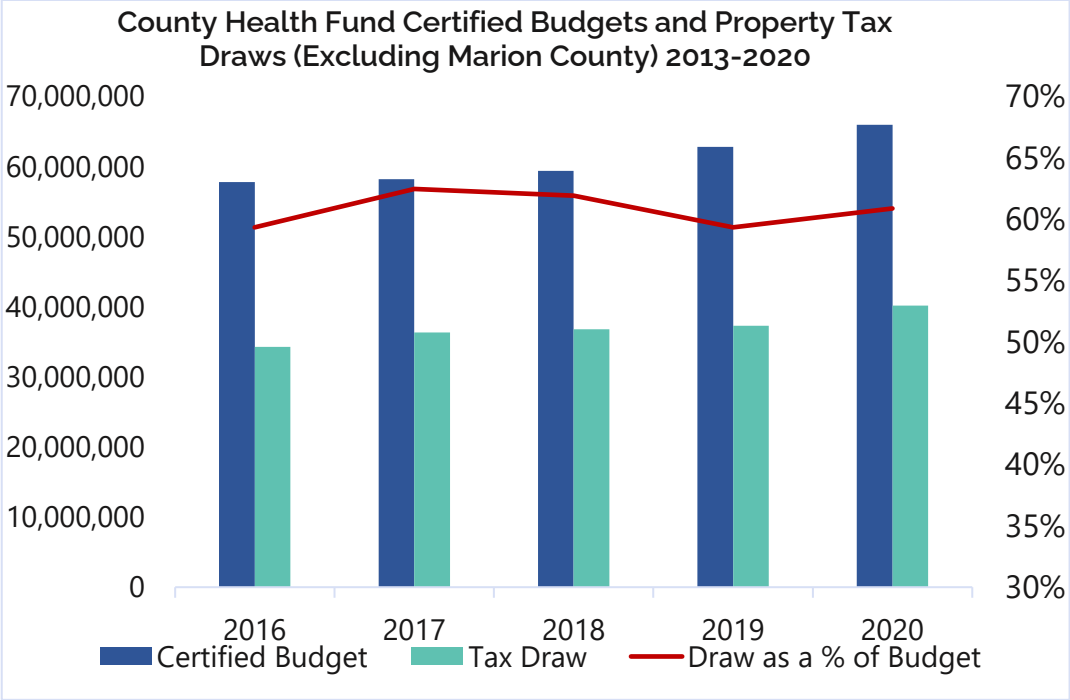
Local health departments (LHDs) are heavily reliant on property tax funding but per capita funding levels vary widely across counties

County Health Fund (CHF) property tax distributions equate to roughly 60% of Certified CHF budgets



SOURCE: IN Dept. of Local Govt Finance
**Municipal LHDs not included*

IN CHF property tax distributions vary significantly per capita

CHF Property Tax Draws Per Capita, 2021	
Per Capita Range	**# of Counties***
$43.93	1 (Marion)
$19.80	1 (Brown)
$8.01 -- $12.50	14
$5.01 -- $8.00	29
$3.01 -- $5.00	31
< $3.00	13
Average (excluding Marion) = $5.46	

**Tippecanoe, Warren, and Wayne Counties not reported or NA*
**Municipal LHDs not included*

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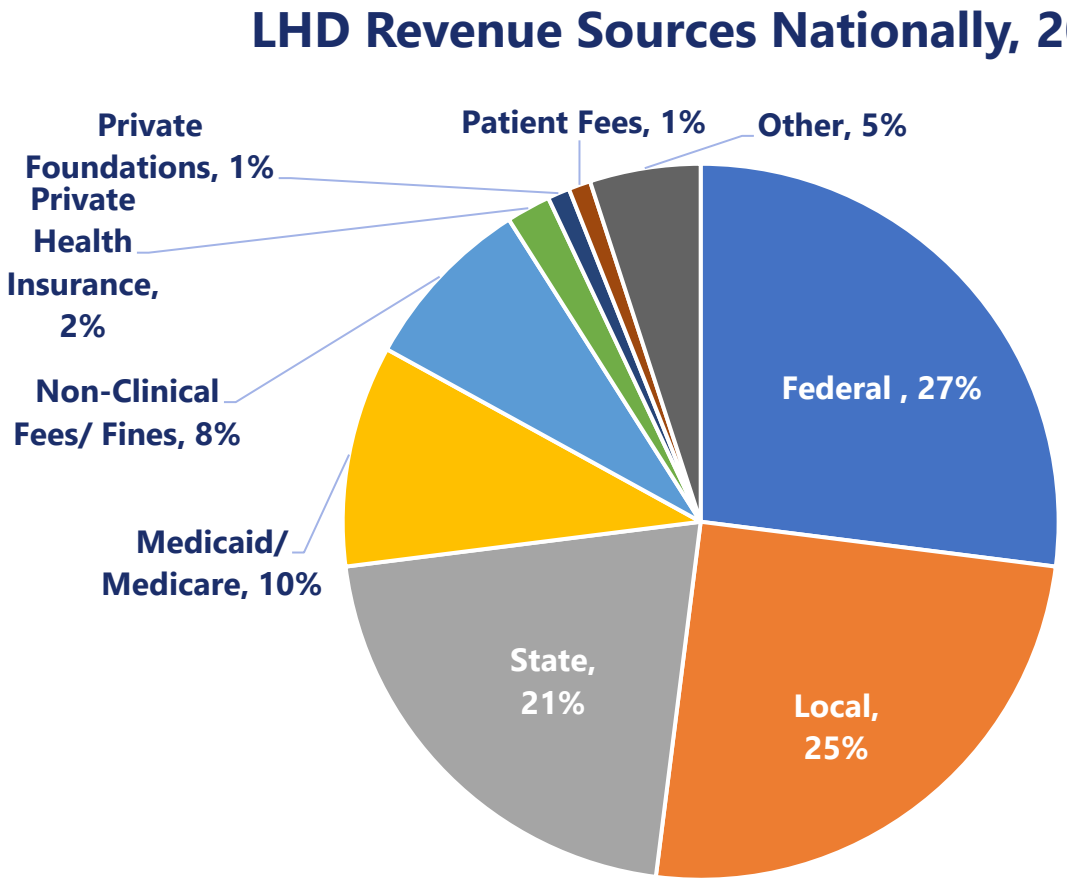
LHD reliance on property tax funding carries both advantages and disadvantages

Advantages	Disadvantages
• Flexible, uses not restricted • Can be adapted to local priorities • Generally less volatile than income or consumption taxes during economic downturns • Roughly progressive	• Can generate funding disparities between wealthier and less wealthy jurisdictions • State "circuit breaker" limits are difficult to estimate/project • Not linked to ability to pay

SOURCES: Funding workstream interviews; Jay K. Rosengard, *The Tax Everyone Loves to Hate: Principles of Property Tax Reform*, Harvard Kennedy School M-RCBG Faculty Working Paper Series, 2012; Citizens Research Council of Michigan, *The Benefits of Local Revenue Diversification Persist, Even if Income Taxes Cratered with COVID,* February 26, 2021, Blog post; accessed at https://crcmich.org/the-benefits-of-local-revenue-diversification-persist-even-if-income-taxes-cratered-with-covid.

In other states, LHDs rely more heavily on federal and state funding



- Nationally, LHDs receive the largest percentage of their revenue from federal sources
- Tracking state and local public health expenditures is complicated by differences in definitions about the scope of public health and the programs and services it includes.

SOURCE: National Association of County & City Health Officials (NACCHO), *National Profile of Local Health Departments,* 2019.

Indiana LHDs are often unable to maximize available federal and state grant funding

LHDs rely on local and state funding to support core public health services and basic infrastructure. They need funding sources that are:

- Flexible
- Sustainable

Grant Utilization Barriers:

- **Grant periods and submission deadlines:** Not aligned with county budget cycle/approval timelines and processes
- **Temporary funding:** Sustainability not assured, making it difficult to gain approval to add new staff positions
- **'Cash in hand' requirements:** Hiring and project work placed on hold until funding is secured slows implementation start dates
- **Spending specificity:** Grant expenditures requirements may be very prescriptive and fail to align with actual county public health needs
- **Reporting requirements and systems:** Individualized and detailed reporting requirements are often duplicative, administratively burdensome, and fail to provide data feedback for program improvements
- **Funding supplanted:** Secured grant funds prompt reallocation of budgeted LHD funds to other county priorities instead of supplementing approved budget

SOURCE: Stakeholder interviews, October and November 2021.

About half (46) of all LHDs received Medicaid reimbursements over the past 12 months

Medicaid Claiming Barriers:

- Challenges dealing with multiple payers
- Limitations of current billing software
- Lack of needed training/ billing assistance
- MCO staff not trained to deal with a PH entity
- Time-consuming to keep up with billing issues/paperwork
- Changes in MCO payment policies

- According to the Office of Medicaid Policy and Planning, **46 LHDs received a total of approximately $1.24M** in Medicaid reimbursements between 11/1/2020 and 11/1/2021
- Based on the IDOH 2020 LHD Annual survey (n = 56), some LHDs are unable to bill all Medicaid MCOs and fewer LHDs bill Medicare:

2020 IDOH Annual LHD Survey: Billing for Medical Services (n = 56)	
	# of LHDs
Medicaid enrolled	38
Credentialed with all 4 MCOs	28
Actively billing	34
Medicaid reimbursements reported for 2020	21
Medicare reimbursements reported for 2020	9
Other charges for medical services	39

SOURCE: OMPP; IDOH 2020 LHD Survey

State approaches to addressing public health funding challenges

Generally, states that are tackling public health funding challenges:

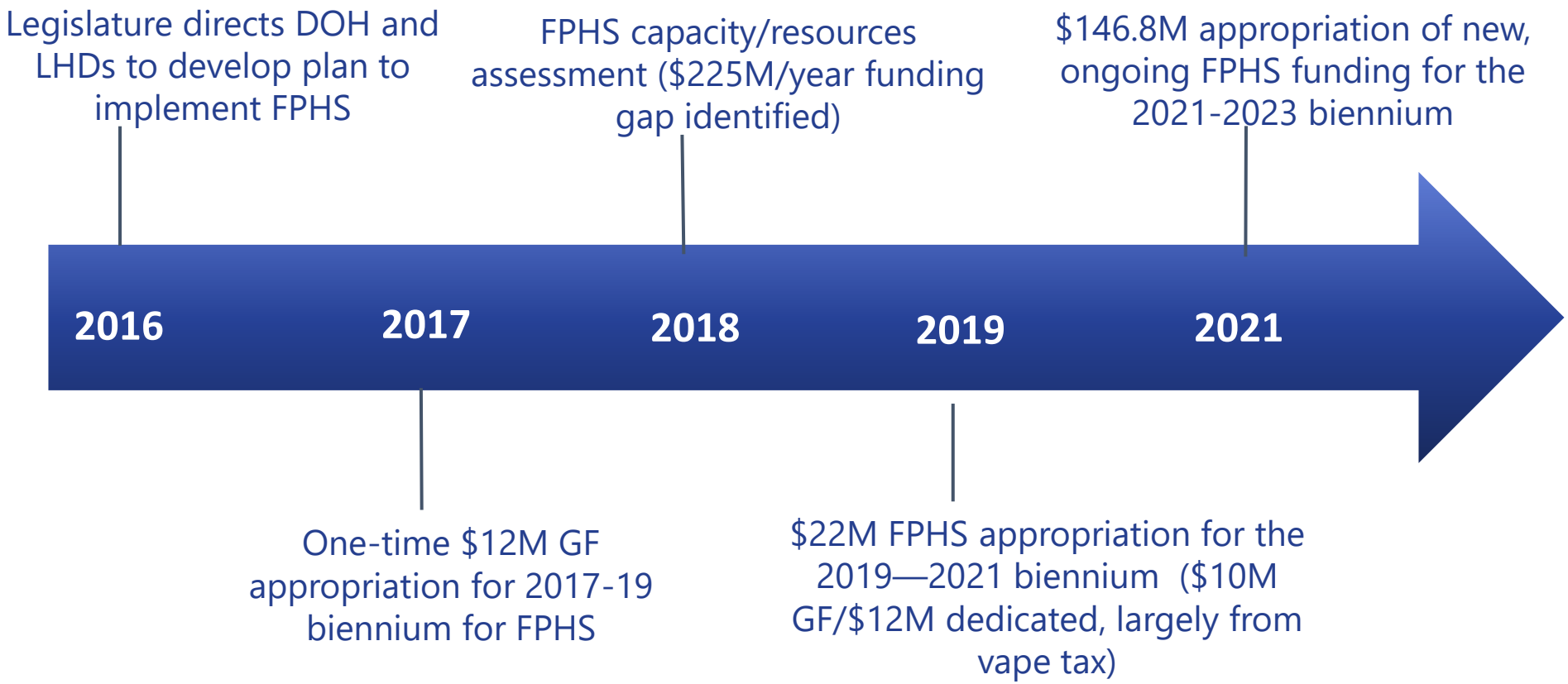
- Define the problem
- Define what minimum PH services/capabilities should be available statewide
- Prepare a gap analysis (comparing current state to desired services/capabilities)
- Calculate the new funding needed to fill the gap (taking into consideration possible efficiencies, resource sharing, etc.)
- Identify possible funding sources

Three examples follow: Washington, Kentucky, and Ohio

Washington State: Incremental investments to fund "Foundational Public Health Services" (FPHS)

Similarities to IN:

- Decentralized governance model
- Significant, although lower, reliance on local funding for LHDs (33% in 2018)
- Wide variability/service gaps across the state



SOURCES: Foundational Public Health Services In Washington State: 2017-2019 Investment Report, SFY 2019; accessed at https://phnci.org/uploads/resource-files/WA-FPHS-2017-2019-Investment-Report.pdf; Washington State Public Health Association 2021 Legislative Successes; accessed at https://www.wspha.org/policy-and-advocacy.

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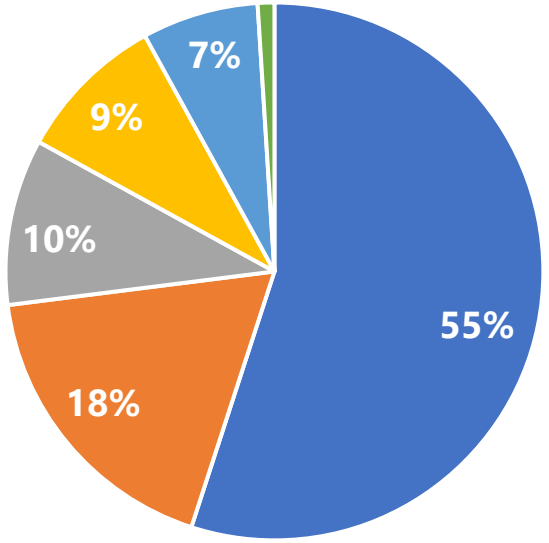
Washington State: Where they started in 2017

$11M for Communicable Disease Prevention and Response



- Disease investigations
- Other capabilities (business office, communications, etc.)
- Increasing immunization rates
- Communicable disease data and planning
- Community health assessment
- Emergency preparedness

$1M for Shared Services Pilots

Statewide TB Resource Center, Lead: Public Health-Seattle & King County
The team triages requests and provides TB support statewide, or finds DOH or local health programs that have the tools, expertise or resources needed for TB response.

Health Information for Providers, Lead: Tacoma-Pierce County Health District
Provides expertise and technical assistance to multiple local health jurisdictions for making timely information available to health care providers in their communities.

Shared Epidemiology Services, Lead: Spokane Regional Health District
Epidemiology and community health assessment expertise to multiple local health jurisdictions in Eastern Washington.

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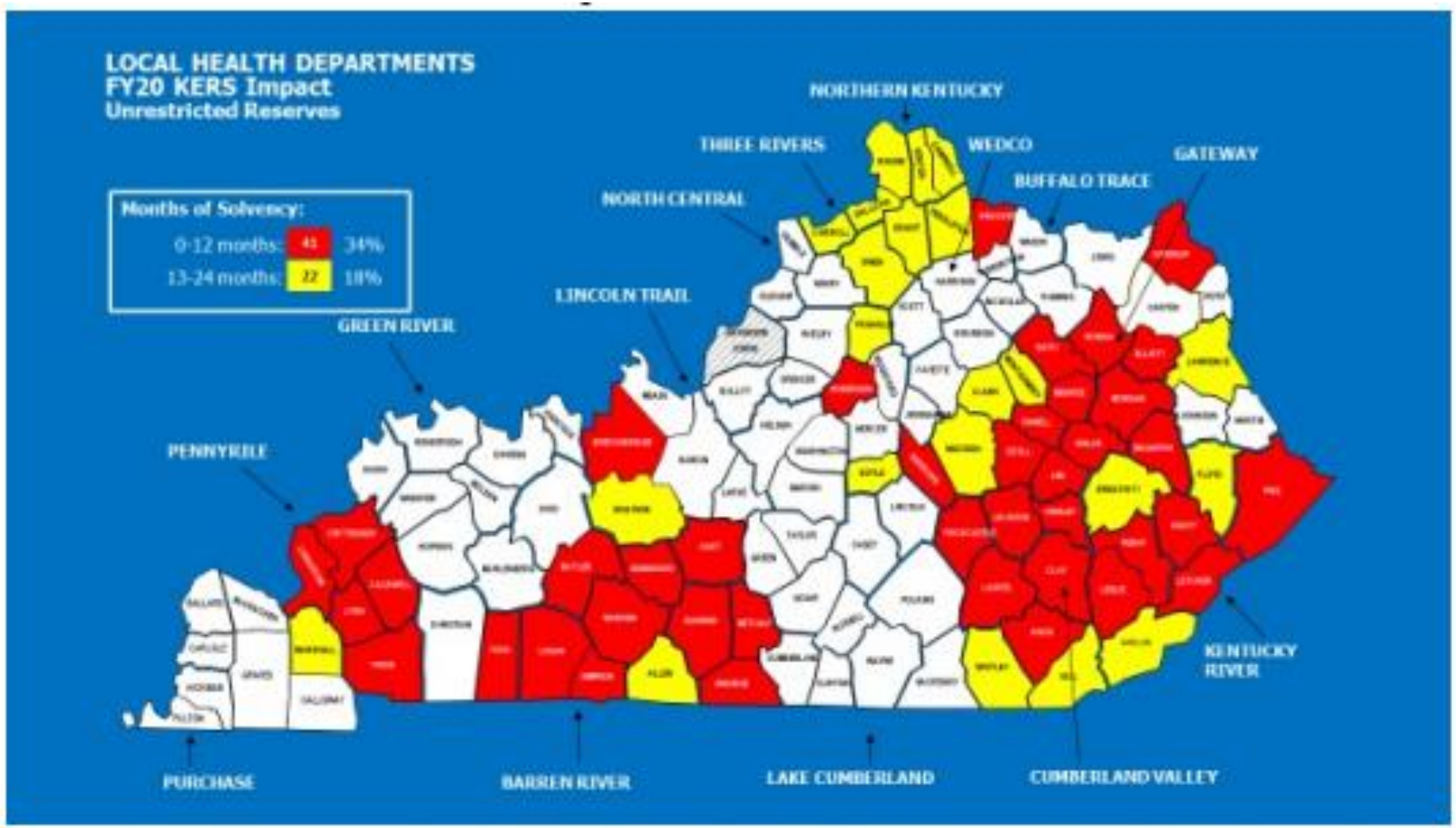
SOURCE: Public Health is Essential website, *A Good Return on Investment*; accessed at http://publichealthisessential.org/return-on-investment.

Kentucky: Public health transformation driven by LHD financial (pension) crisis



Kentucky HB 129 (2020): Creates a state FPHS funding formula

- Defines FPHS
- Codifies a state FPHS funding formula based on population and each county's ability to generate revenue through a local health tax. Formula based on:
  - A minimum of 3 FTEs per county with an additional FTE for each 5,000 over 15,000 of population
  - Each county imposing a minimum PH tax of 1.8 cents per $100 of assessed property value (not a new requirement, however)
  - LHDs that have more local resources would get less state funding.
- Allows fee/permit increases to fund FPHS, but caps annual increases

Kentucky public health transformation timeline

SOURCE: Jan Chamness, Director Division of Women's Health and PHT Project Lead, *Public Health Transformation from Planning to Implementation,* August 19,2021 Webinar presentation; accessed at https://www.healthy-ky.org/res/uploads/media/FHK-HealthforaChangeSeries-081921.pdf.

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Ohio's incremental efforts focus on practical solutions for public health infrastructure, data collection, and delivery efficiencies

- Formed expert consortium to assess FPHS capacity and gaps, provide recommendations
- Piloted a standardized method to collect FPHS cost information
- Required national accreditation for small LHDs; provided:
  - Dedicated funding to support accreditation efforts and success
  - Technical assistance/support (e.g., training, website, accreditation documentation repository, etc.)
- Encouraged thoughtful consolidation with flexible funding to support costs for mergers
  - Recognized that mergers can take time to develop
  - Required smaller LHDs to assess status quo vs. consolidation
- Aligned PH and hospital community health assessments to increase synergy between clinical medicine and public health

SOURCES: IU Richard M. Fairbanks School of Public Health, *Indiana Public Health System Review*, December 2020. PHNCI, *Transforming Public Health Systems: Stories for 21st Century States, PART II*, January 2018. Tyler Buchanan, *Some City Health Depts. In Ohio May Be Forced To Merge With Counties*, April 2021. Ohio Dept of Health, *National Public Health Accreditation*, n.d.

Ohio legal and financial investments continue to support increased activity around LHD accreditation and consolidation

2012

Assn. of OH Health Commissioners report looking at FPHS model and addressing need for increased funding and capacity.

Recommendations address collaboration and consolidation; statutory mandates; financial incentives; and national public health department accreditation standards

2013

Legislation enacted requiring public health accreditation.

LHDs can pursue accreditation on their own; join with other jurisdictions to form a single operating unit, or merge with other LHDs

2016

Ohio receives RWJF grant for systems transformation.

LHD surveys and costing tool look at FPHS capabilities, gaps, cost to close gaps, and sharing across LHDs

FY 2017-2019 State Budget

$1M to align community health needs assessment timing and questions with hospital CHNAs

$12,500 incentive per LHD to address 2 of 3 population health areas: MH/addiction; maternal/child health; and chronic disease.

$3.5M to support infrastructure and accreditation efforts for merging LHDs

2021

HB 110 requires cities with a population <50,000 with a board of health or a city health district to study efficiency/effectiveness of merging with county health district (potentially impacting 18-20 LHDs)

FY 2022 budget earmarks up to $6M of existing non-GRF funds

As of 8/24/2021, 56 of 113 LHDs are accredited

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SOURCES: IU Richard M. Fairbanks School of Public Health, *Indiana Public Health System Review*, December 2020. PHNCI, *Transforming Public Health Systems: Stories for 21st Century States, PART II*, January 2018. Ohio HB 110, June 2021. Meg Shaw, *Ohio House Bill 110 calls for study of small health departments, leading to possible elimination*, May 2021. PHAB, Accreditation Activity as of August 24, 2021, August 2021.

Pros and cons to each funding source

Solutions to increase sustainable and equitable PH funding must balance local flexibility with improving PH funding equity

	'Municipal Corporation' Model	Property tax increases	Other Local taxes/user fees	State PH dedicated tax	Base+ per capita funding formula (GF?)	Non-Tobacco Settlement Dollars
Increases Funding	-	+	+	+	+	+
Sustainable	+	-	+	+	+	-
Equitable	+	-	-	+	+	?
Local Flexibility	+	+	+	-	-	+/-
Accountability to state PH goals	-	-	-	+	+	+

An Ambulance or a Fence?

The prevention versus cure argument has raged since the advent of the public health profession.

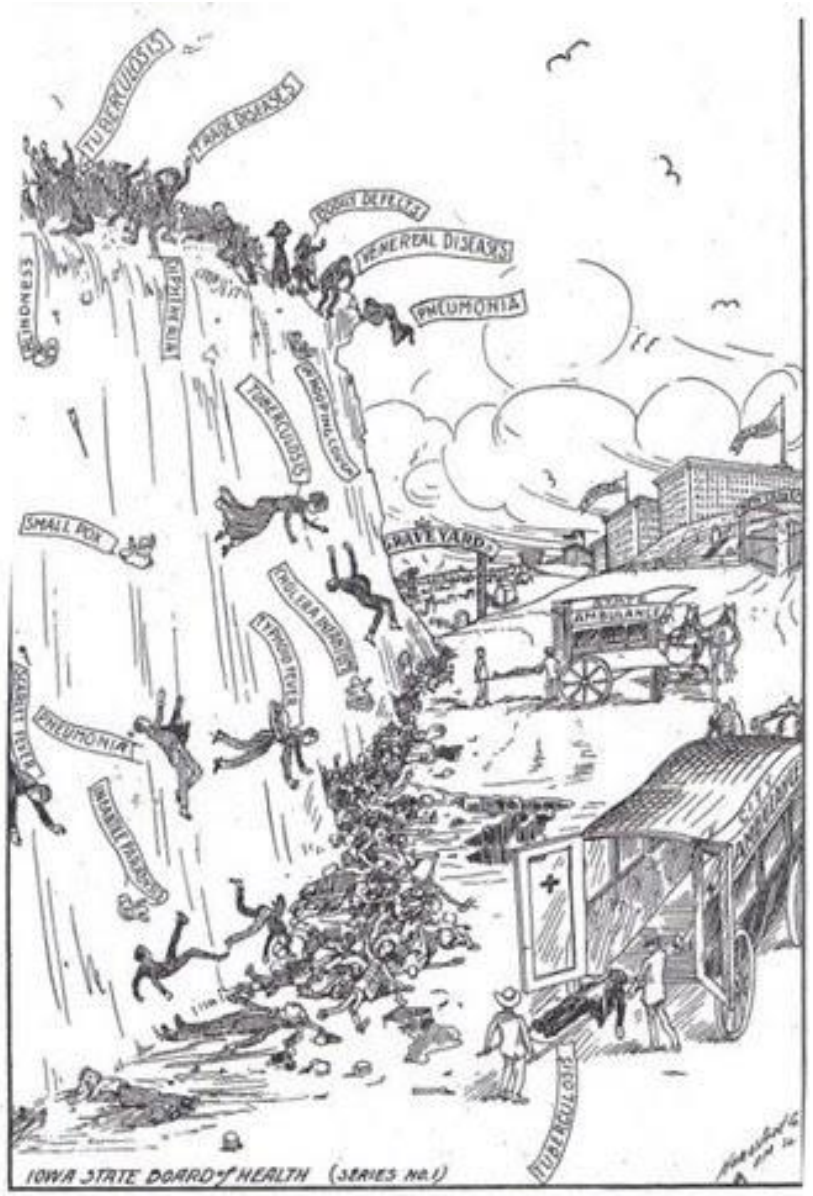

FIG. 2.—Illustrating the dangerous cliff without a fence.

Questions

Thank you for your time!