CALPHO
Colorado Association of Local Public Health Officials

Issue Brief

Public Health Funding Structures: Fractured, Wasteful, & Well-Intentioned

Excerpted and Adapted from the 2020 Core Public Health Services Needs Assessment Report

In response to Colorado's "Shaping a State of Health: Colorado's Plan for Improving Public Health and the Environment, 2015-2019" (PHIP), The Colorado Department of Public Health and Environment (CDPHE) and the Colorado Association of Local Public Health Officials (CALPHO) formed a workgroup to explore ways of maximizing public health funding in Colorado. The group recommended initiating an effort to transform the governmental public health system into one that is not just adequately funded, but predictably and sustainably funded. That effort continues through the Public Health Transformation Movement.

Types of Funding

For the purposes of understanding public health funding challenges, there are two principal types of funding: (1) categorical funds; and (2) flexible funds.

- *Categorical Funds*: Categorical funding is any revenue stream where the funds are limited to a particular use. Most grant funds and fee revenues fall into this category.

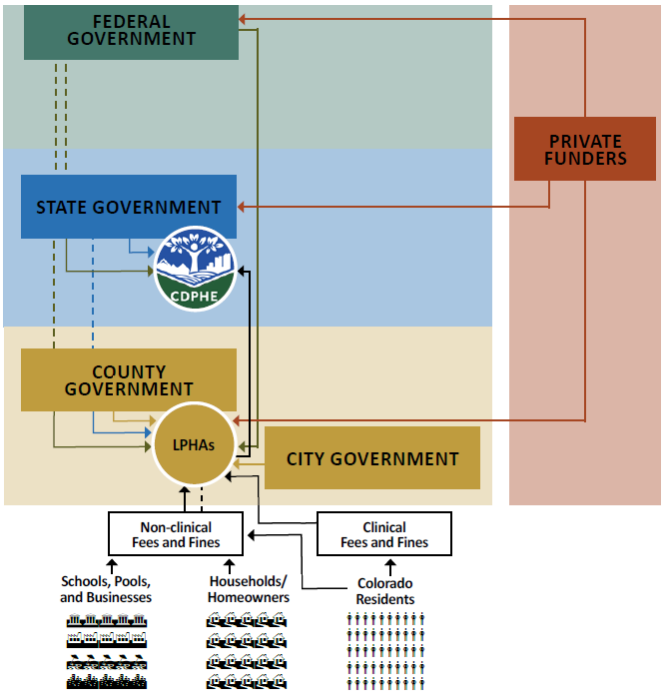
- *Flexible Funds:* Flexible funds represent revenue streams which can generally be used to cover the full range of eligible public health activities. Some grants can be flexible, but most flexible funds come from general purpose taxes. Flexible funding often supports agencies' organizational infrastructure, which can improve the efficiency and effectiveness of categorical spending.

Main Sources of Funding

Governmental public health in Colorado is funded by a complex web of funders. It's useful to understand the two primary sources of governmental public health funding and the flows of those funding sources.

- *Federal Sources*: CDPHE and LPHAs are eligible for and receive federal grants and contracts, which primarily represent categorical funding for specific governmental public health activities (e.g., WIC or Title X family planning services). Some of these grants and contracts are "pass through" grants whereby the State of Colorado, through CDPHE, is the grant recipient and disburses the grant funding to LPHAs and others.
- *State Sources:* CDPHE receives state funding from the general fund, Amendment 35, and tobacco litigation settlement and marijuana tax cash funding. Amendment 35 was a tax increase on tobacco products, the revenues from which were designated for health care services and tobacco education. Tobacco litigation settlement funding and marijuana tax cash funding is allocated per Colorado HB16-1408.

Figure 1: Governmental Public Health Funding Flows

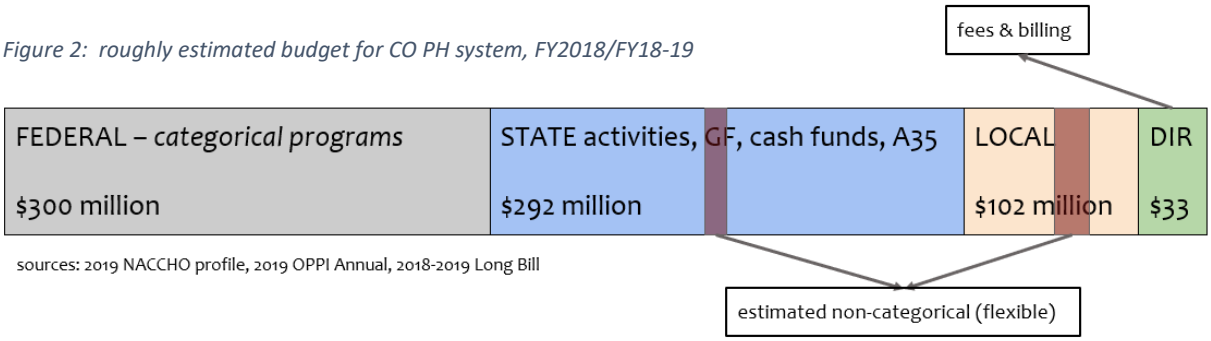


Source: Adapted from NASEM, *For the Public's Health: Investing in a Healthier Future*, 2012. Habile, 2019.

Amendment 35 and cash funds (tobacco litigation settlement and marijuana tax cash funding) are the only tax mechanisms and/or cash sources in Colorado that directly allocate funding to public health. In 2022, LPHAs began receiving some program funding from the opioid settlement funds that flow through the Colorado Attorney General's office and the Regional Opioid Abatement Councils.

CDPHE's Office of Public Health Practice, Planning, & Local Partnerships (OPHP) distributes the only state flexible funding to LPHAs – about $18 million annually for 55 agencies through a co-developed funding formula. The formula ensures that each LPHA receives a base amount of funding (which includes a regional distribution for multi-county LPHAs), while the rest is allocated on a per capita basis that factors in local and regional health disparities.

Figure 2: roughly estimated budget for CO PH system, FY2018/FY18-19



In most situations, federal and state categorical funding is distributed via reimbursement. This means that agencies don't receive the funding until after they have made the expenditure. Despite the statutory obligation to maintain a public health fund, not all agencies have the cash flow to support ongoing operations while waiting for reimbursement. This is one of the issues that has historically led to a significant reversion of revenues throughout the system. In SFY 2018, $139,294,352.11 of federal and state revenues were known to have reverted.

Local Sources

LPHAs are often broadly supported by their counties, municipalities, and quasi-governmental organizations. From a revenue perspective, these relationships are highly variable, examples include:

- Cash appropriations LPHAs receive directly
- Rent and/or supportive services that CDPHE or LPHAs receive in-kind
- Direct services that other agencies provide that CDPHE or LPHAs do not pay for, such as information technology systems

Figure 3: Dr. Florence Sabin in 1946 (Denver Post)

This highlights the ambiguity around what is appropriately considered revenue (cash or in-kind) captured by the governmental public health system, and whether that is a cost incurred by the LPHA versus a cost incurred by its supporting government.

Counties are obligated to provide $1.50 per capita for public health services in order to be eligible for state public health assistance. The $1.50 per capita figure was established in 1946 through the visionary work of Florence Sabin, and has not been revised since that time. General price inflation since 1946 has effectively reduced its purchasing power from $1.50 to about 10 cents per capita. Alternately, an equivalent level of local funding in 2023 dollars would be $22.83 per capita.

Cost Recovery (Fees and Fines)
CDPHE and LPHAs are both authorized to charge a variety of fees, including:

- *Non-clinical fees and fines:* These fees and fines are most often related to environmental health inspections and testing like those for retail food inspection, but may also be charged as permitting fees, as in the case of onsite wastewater treatment system (OWTS) permitting. Some of these fees are set by the State in statute, while others are set at the discretion of governmental public health agencies and counties.

- *Clinical fees and fines:* These fees and fines include Medicare/Medicaid, charges to private health insurance and patient personal fees for clinical services like immunizations, family planning, and chronic disease monitoring. In most cases, governmental public health agencies decide what services to charge fees for and the rate of those fees, although some of the fee or reimbursement rates are set by Medicare/Medicaid and private health insurance. In many cases, LPHAs use medical billing services to bill these clinical fees and fines.

Evidence suggests that these fees and fines often do not fully recover the cost of delivering the services, and LPHAs rely on county general funds or state support to fill the gaps. Sometimes fees are intentionally lower as an equity measure or to incentivize compliance.

High in Calories, Low in Fiber: Categorical Funding Challenges

Most public health funding is through categorical sources that can only be spent on specific activities. While these programs are a critical part of public health funding, they can damage systems that lack the flexible funding to support infrastructure and a permanent workforce. As a result, agencies need to carefully blend and braid funding sources to account for these restrictions while also supporting core organizational capacities, such as IT and accounting. The indirect rates allowed on many grants are generally insufficient to cover the full indirect costs of these program revenues.

Categorical programs are usually designed at the federal level and assume a level of agency infrastructure and capacity that has never existed in many parts of the country. Restrictions originally intended to support quality, standardization, and accountability are often unrealistic on the ground, especially in rural areas. These provisions may also include matching fund requirements that siphon from already limited flexible funding streams. Many have unique, arduous reporting requirements or mandate the use (and training for) siloed data systems.

Funding amounts often reduce from cycle to cycle at the whim of whoever is in power, or legislatures raid them to cover gaps in other health programs. This makes long-term workforce retention and recruitment for specific program areas all but impossible. Also, when overall program funding is cut at the federal level, state and federal program managers are forced to limit availability to the most populous areas or create a more competitive grant process, pitting LPHAs against nonprofits and each other.

Colorado mandates that its public health agencies be responsive to priorities set by their constituents, but it does not fund the assessment and planning required to do this. Furthermore, one-design-fits-all categorical programs do not accommodate the flexibility to respond to locally-determined priorities or provide resources to foster community leadership of those activities.

In short, the structure of public health funding works against its mission to protect and promote the health of communities by eroding workforce, infrastructure, and trust with the community served.