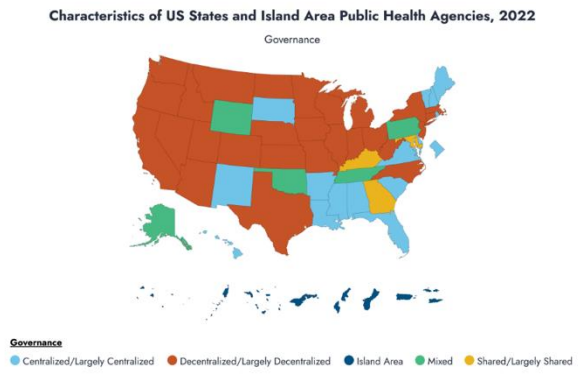
State Funding Requirements for Core Public Health Services in Local Health Agencies: A Legal Overview

Background

States are granted broad powers to protect the health and safety of their residents, with many states delegating responsibility for promoting and protecting population health to public health agencies. These agencies are often tasked with specific duties under state law, ranging from licensing well water purification companies to establishing childhood immunization requirements and investigating disease outbreaks or abating nuisances. The specific activities falling under public health's purview are usually established in state law, with many functions aligning with national frameworks for providing core public health services like CDC's 10 Essential Public Health Services and PHAB's Foundational Public Health Services.

Each state's public health system is unique, with some state agencies providing services for the entire state while other jurisdictions rely on local health agencies to provide core public health services. ASTHO's agency profile captures some of this complexity, categorizing state health departments into four governance classifications: (1) centralized/largely centralized, (2) decentralized/largely decentralized, (3) mixed, and (4) largely shared/shared.



Data from the 2022 profile identified 15 states with a centralized/largely centralized structure, meaning that at least 75% of people were served by health units led by state employees and that the state retains authority over decisions relating to public health orders, selection of health officials, and budget. There are 27 states with a decentralized/largely decentralized structure, where at least 75% of people are served by local health agencies led by local governments, with local officials retaining authority of public health orders, budgets, and/or the selection of health officials.

Additionally, five states are categorized as mixed (no single arrangement predominates the state) and three are categorized as shared/largely shared (e.g., local health units are led by state employees, although the local government retains authority over many decisions).

The legal research and analyses provided in this report is to provide public health leaders a national snapshot of a policy issue and does not constitute legal advice.

With the majority of states relying on at least some local health departments (LHDs) to provide core public health services, it is often important for state public health leaders to build relationships with local health leaders and develop structures to support LHDs in protecting the health of their residents.

States provide significant financial support to LHDs either through allocating state dollars or by distributing federal funding. Local 2022 profile data estimates LHDs received more than half of their funding from federal sources (25% direct funding, 26% distributed through a state agency), 21% from state sources, and 14% from local sources. Below is a review of legal requirements for state health agencies to provide financial support to LHDs for core public health services.

Research Methodology

ASTHO staff conducted a 50-state scan using a legal research database (Lexis) with natural language search terms "local public health funding" to identify statutes and/or regulations requiring a state health agency to provide funding for local health departments or local boards of health to provide essential or foundational public health services. If a jurisdiction had a unique phrase to describe core local public health funding (e.g., "grant-in-aid"), ASTHO staff ran an additional search using that term. Additionally, staff used an internet search engine to identify potential resources outlining the jurisdiction's method to allocate local public health funding (if any) by running a natural language search of the jurisdiction's name and "local public health funding."

Statutes or regulations requiring a state health agency to provide general financial assistance to an LHD were included in the data, with the required assistance categorized as direct funding (allocation or transfer directly to the LHD), reimbursement (LHDs needed to share expenses for reimbursement from the state), or grant (LHD had to apply for funding). Requirements for the state to fund specific public health programs, such as family planning services or allocating opioid settlement dollars, were excluded. Requirements for the state to allocate funds to LHDs which did not pass through the state health agency (e.g., allocating funding to a special fund managed by the state treasurer for distribution without input from the health agency) were also excluded.

Findings

At least 24 states require their state health agency to provide financial support to local health agencies for core public health services by law. Of those, 20 have a decentralized governance structure (Appendix A), two have a mixed governance structure (Appendix B), and two have a shared/largely shared governance structure (Appendix C). No state with a centralized governance structure has such a requirement.

Of 24 states that require state health agencies to fund local health agencies in statute or rule, 14 of them provided funding directly to LHDs (e.g., through a contract or direct disbursement), eight states did so through a grant in which the local health department needed to apply, and

two states provided reimbursements of local funds spent on certain core services. Each state establishes the level of required state funding differently, with 12 states establishing funding levels through a formula—usually based on population and disease burden—and four states providing flat, per capita funding. The remaining states had a range of ways to determine funding, including establishing requirements for local governments to match state funds, requiring certain groups to reach a consensus on the distribution of state funds, and strict reimbursement programs.

Discussion

Regardless of how a state agency is structured, each state has a duty to provide core public health services. To do so, state public health leaders can build strong relationships with local community leaders to identify their public health needs and allocate resources accordingly and as able. For the 15 states that maintain a centralized/largely centralized governance structure, the state is directly responsible for the provision of core public health services to their residents. In other structures, where local health agencies provide some or all core public health services, it is even more important for state public health leaders to develop strong relationships with its local counterparts to ensure all residents of the state are able to equitably access core public health services.

From this legal scan, 20 of 27 decentralized/largely decentralized health agencies have legal requirements for the state health agency to fund LHDs for core public health services. Although seven jurisdictions do not have this requirement, many of them provide funding to their LHDs through contracts and other means to ensure they can meet their responsibilities for providing core public health services. This may empower the state to act more quickly to address differing needs across the state than can be done through legislation or rulemaking.

Only two out of five mixed jurisdictions require funding for LHDs in state law, both of which provide that funding through a grant program. Lastly, two of the three shared/largely shared jurisdictions require the state to fund local health departments. While both require direct funding, one requirement is based on the minimum staffing needs of the local health department (the state providing for average costs) and the other has set up a cost-sharing system where local governments are required to match a certain percentage of state funding.

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Appendix A: Decentralized/Largely Decentralized Jurisdictions Requiring States Health Agencies to Fund Local Health Departments

State	Funding Mechanism	Conditions on Funding	Determination of Funding Level
Arizona	Grant (A.A.C. Title 9, Ch. 1, Art. 6)	Department application with budget showing proportionate share from local funding. (A.A.C. § R9-1-604)	State health agency will match up to 50% of a local health department's budget for a maximum of $1.25 per capita. (A.R.S. § 36-189)
California	Direct (Cal Health & Saf Code § 101230)	Funds cannot be used for medical care services other than communicable disease control efforts (Cal Health & Saf Code § 101230)	Local health departments are provided the greater of $100,000 or $.212426630 per capita (Cal Health & Saf Code § 101230)
Colorado	Direct (C.R.S. 25-1-512)	Local health department must contribute a minimum $1.50 per capita for its local health services (or services within a public health district). (C.R.S. 25-1-512)	Formula (C.R.S. 25-1-503)
Connecticut	Grant (Conn. Gen. Stat. § 19a-245 and Conn. Gen. Stat. § 19a-202)	Provide a budget for a public health program which provides foundational public health services and appropriate at least $1 per capita for the municipality or district. (Conn. Gen. Stat. § 19a-245 and Conn. Gen. Stat. § 19a-202)	$1.93 per capita for municipalities (Conn. Gen. Stat. § 19a-202) $2.50 per capita for health districts (Conn. Gen. Stat. § 19a-245)
Illinois	Grant (77 Ill. Adm. Code 615.210)	Local health departments are certified by the state health agency for meeting minimum standards and must be substantially compliant with those standards following a review from the department. (77 Ill. Adm. Code 615.220)	Inflation adjusted funding from the previous year with a possibility of additional funding allocated based on population. 77 Ill. Adm. Code 615.210
Indiana	Direct (Burns Ind. Code Ann. § 16-46-10-3)	All jurisdictions receiving funding must provide an annual report accounting for how funds were spent the previous year and a proposed spending plan for the upcoming year. Burns Ind. Code Ann. § 16-46-10-2.3	Formula (Burns Ind. Code Ann. § 16-46-10-2.2)

Iowa	Direct (641 IAC 80.5 & 641 IAC 80.6)	Local boards of health must submit an annual workplan. (641 IAC 80.3)	Formula (641 IAC 80.5 & 641 IAC 80.6)
Kansas	Direct (K.S.A. § 65-244)	Local health departments must submit an application. K.S.A. § 65-242	Formula (K.S.A. § 65-242)
Michigan	Reimbursement (MCLS § 333.2475)	Local health departments must show they are substantially compliant with agency rules, meeting minimum standards. (MCLS § 333.2484)	The state reimburses 50% of "reasonable and allowable" costs, which excludes capital expenditures and those reimbursed from another source (e.g., federal funding programs). MCLS § 333.2475-MCLS § 333.2476)
Minnesota	Grant (Minn. Stat. § 145A.131)	Local health departments (funded through community health boards) must provide at least a 75% match with local funds (can include nonfederal grants) and meet minimum standards. (Minn. Stat. § 145A.131, Minn. Stat. § 145A.03-Minn. Stat. § 145A.04)	Formula (Minn. Stat. § 145A.131)
Nebraska	Direct (R.R.S. Neb. § 71-1628.08)	Funds cannot replace existing local public health funding. (R.R.S. Neb. § 71-1628.08)	Based on population. (R.R.S. Neb. § 71-1628.08)
New Jersey	Grant (N.J. Stat. § 26:2F-6.1.)	Local health agencies must meet performance standards from their previous work plan. (N.J. Stat. § 26:2F-13)	Formula (N.J. Stat. § 26:2F-6.1.)
New York	Reimbursement (NY CLS Pub Health § 605)	Local health agencies must provide certain core services, conduct a community needs assessment, and have policies and plans to address community needs. (NY CLS Pub Health § 602)	The greater of $1.30 per capita or $750,000. (NY CLS Pub Health § 605).
Ohio	Direct (OAC Ann. 3701-36-10)	Local governments must spend at least $3 per capita on public health services and cannot decrease local public health funds in anticipation of state subsidies. The local health department must also be in compliance with certain	Formula (OAC Ann. 3701-36-10)

		minimum standards. (OAC Ann. 3701-36-10)	
Oregon	Direct (ORS § 431.380)	None identified in statute or regulation.	Formula (ORS § 431.380)
Texas	Grant (25 TAC § 83.1-13)	Grant recipients must cooperate with state department in preparing a legislative report (25 TAC § 83.12).	Formula (Tex. Health & Safety Code § 121.0065)
Utah	Direct (Utah Code Ann. § 26A-1-115)	State funds may not replace other funds used for local health services; local jurisdictions must match state funding at a percentage determined by the department. (Utah Code Ann. § 26A-1-115)	Formula (U.A.C, Health, R380-50.)
Washington	Direct (Rev. Code Wash. (ARCW) § 43.70.515)	Local health departments and tribal health agencies are to coordinate with the state board of health to report on the changes in capacity to the governmental public health system, improvement of health outcomes, and service delivery models. (Rev. Code Wash. (ARCW) § 43.70.515)	Consensus of state local health agency association, state board of health, and federally recognized tribes. (Rev. Code Wash. (ARCW) § 43.70.515).
West Virginia	Direct (W. Va. CSR § 64-67-4.)	Local health departments must meet certain public health standards. (W. Va. CSR § 64-73-9)	Formula (W. Va. CSR § 64-67-4.)
Wisconsin	Direct (Wis. Stat. § 20.435)	Local health departments must share financial statements accounting for the use of funds. (Wis. Stat. § 252.185)	Formula (Wis. Stat. § 252.185)

Appendix B: Mixed Jurisdictions Requiring States Health Agencies to Fund Local Health Departments

State	Funding Mechanism	Conditions on Funding	Determination of Funding Level
Pennsylvania	Grant (16 P.S. § 12025.)	Must comply with any and all regulations prescribing minimum public health activities and performance standards. (28 Pa. Code § 15.15 and 16 P.S. § 12025.)	Up to 50% of eligible expenditures, but not greater than $6 per capita. (16 P.S. § 12025.)
Tennessee	Grant (Tenn. Code Ann. § 68-2-901)	Counties must submit an annual expenditure plan. (Tenn. Code Ann. § 68-2-901)	State law requires a base allocation to provide for "a minimum core staff." (Tenn. Code Ann. § 68-2-901)

Appendix C: Shared/Largely Shared Jurisdictions Requiring States Health Agencies to Fund Local Health Departments

State	Funding Mechanism	Conditions on Funding	Determination of Funding Level
Kentucky	Direct (KRS § 211.186)	Local health departments or districts must provide certain minimum staffing and local funding levels. KRS § 211.186.	Calculated based on average cost of required FTE public health workers and average agency operating expenses. KRS § 211.186.
Maryland	Direct (Md. Code, Health-Gen. § 2-302)	Local jurisdictions must match a percentage of state funding (Md. Code, Health-Gen. § 2-303) with current match level equivalent to the level in FY1996 (COMAR 10.04.01.04)	State law outlines funding allocations for FY25 through FY27 with later appropriations to be adjusted for inflation and population growth. Md. Code, Health-Gen. § 2-302.