Memorandum

To: State Senator Fabian Donate, Chair, and Members of the Joint Interim Committee on Health and Human Services

From: A Collaborative of Public Health Leaders and Advocates in Nevada

Date: July 18th, 2024

Subject: Reforms to the Public Health Improvement Fund

First, thank you for your commitment to public health improvement in the State of Nevada. With the leadership and administrative support of the Division of Public and Behavioral Health (DPBH), the non-categorical investment provided through Senate Bill (SB)118 to local health districts and to counties will fill critical gaps in the delivery of core public health services and support the development of local public health infrastructure. The $15M one-time State General Fund allocation was the first of its kind in Nevada and is a very welcome first step in the creation of a modernized, efficient, and effective public health system across the state.

Much work has been done by DPBH, the local health authorities, and the Nevada Association of Counties (NACO), among other stakeholders, to develop a better model and allocation of such general fund investment in public health. As such, we were collectively grateful to see that you had already anticipated and thoughtfully addressed many needed changes in your Memorandum to Local Health Districts and Departments earlier this summer. We appreciate your more equitable approach to funding allocations, your efforts to ensure responsiveness and collaboration with the communities we serve, and your commitment to measuring the success of efforts to ensure efficient and effective use of public dollars.

As requested during our meeting on June 28th, we respectfully submit this Memorandum that reflects the collaborative efforts of public health leaders and advocates across the state.

Funding Formula

We welcome your addition of **base funding + per capita allocations**. We have attached a draft formula recommendation based on an assumed $45M/biennium ($22.5M/fiscal year) investment. The new model would consist of percentage allocations for state-based public health and tribal health, then a funding formula that supports funding directly to counties and local health authorities, which consists of a base amount and a population-based, per capita, allocation. The base funding amount of approximately $200K per year, or $400K per biennium, per county would allow enough funding for 1 FTE + minimal operating funds, or potentially 1.5 FTE depending on the role.

Sustainability

While one-time funding can be instrumental in supporting public health crisis measures, shoring up current programs, or making physical infrastructure improvements, our state public health system needs **sustainable, non-categorical funding** to address the foundational, ongoing public health needs of Nevadans. Where there is minimal infrastructure, one-time funds can encourage reactive decision-making. Local jurisdictions and the state would benefit immensely from a guaranteed, or more stabilized, public health funding mechanism that would enable

effective long-term planning. Sustainable funding would allow for the intentional development of a reliable public health system. **We recommend allocating the first $45M of the Insurance Premium Tax (IPT) received by the Department of Taxation at the start of each biennium to support the Public Health Infrastructure Fund.** We also recommend a provision to adjust the amount in future years to keep up with inflation.

The IPT is the fourth largest tax collected into the State General Fund. It is a 3.5% tax on insurance premiums. The IPT has been growing significantly over the past several years, in large part due to the growth in Medicaid Managed Care expenditures. The tax is also paid on the Medicaid capitated payments made to the MCOs. As a large portion of this tax is generated based on an increasing demand for healthcare services, we recommend investing a portion of these dollars in developing a strong, statewide public health system. Health promotion, disease prevention, and addressing the upstream drivers of poor health outcomes–all strategies at the core of public health–can lead to a decrease in healthcare costs and an increase in positive health outcomes.

Oversight

To provide oversight over these funds, we recommend utilizing established public health oversight bodies such as local Boards of Health and the State Board of Health. Currently under SB118, the Division of Public and Behavioral Health (DPBH) works with local Boards of Health to review and approve the prioritization process and identify priorities before a contract is developed. As subject matter experts, DPBH provides critical oversight and guidance. These contracts are also reviewed and approved by the Board of Examiners. We recommend continuing this process which provides for effective fiscal and policy oversight.

To encourage thoughtful statewide infrastructure development and increased oversight of public funds, we recommend the development of a Public Health Improvement Advisory Committee with members appointed by the State Board of Health in alignment with the membership recommendations below. The Public Health Improvement Advisory Committee will review public health improvement plans, advise on the development of standardized metrics and reporting mechanisms to measure improvement, and make recommendations to DPBH regarding the use of the Public Health Infrastructure Fund. DPBH will provide administrative support to the Committee. To ensure appropriate statewide representation of subject matter experts we recommend the following Committee makeup:

1. The membership of the Committee shall include:
    a. The Chief Medical Officer of the Division of Public and Behavioral Health
    b. The Administrator of the Division of Public and Behavioral Health or their designee
    c. The Administrator of the Division of Environmental Protection or their designee
    d. The Administrator of the Division of Emergency Management or their designee
    e. District Health Officer from every health district in the State or their designee; such a designee must be a member of the senior leadership, or management team of the appointing health district.

    And the following members appointed by the State Board of Health:
    f. The Executive Director of the Nevada Association of County Commissioners, or subsequent agency, or their designee
    g. The Executive Director from the Nevada Department of Native American Affairs or their designee

h. A member of the Board of County Commissioners from a county who has a population of 700,000 or more, or their designee.
i. A member of the Board of County Commissioners from a county who has a population less than 700,000 and more than 100,000, or their designee.
j. A member of the Board of County Commissioners from a county who has a population less than 100,000, or their designee.
k. One member who possesses knowledge, skills, and experience in local delivery of public health services in Nevada.
l. One member who is a County Health Officer in the State of Nevada for a county not within a health district.
m. One member of the public who has experience in seeking services from and navigating a local public health system in the State of Nevada.

Usage

To ensure the effective and appropriate use of funds, we suggest utilizing established best practice public health service parameters as guardrails for the allowable uses (see list below and Washington State statute RCW 43.70.515).

We recommend that all of the funding be restricted to public health improvement in the areas listed below, which align with national efforts and frameworks for defining **core public health services**:

1. Control of communicable diseases and other notifiable conditions;
2. Chronic disease and injury prevention;
3. Environmental public health;
4. Maternal, child, and family health;
5. Access to and linkage with medical, oral, and behavioral health services;
6. Vital records;
7. Assessing the health of populations;
8. Public health emergency planning;
9. Communications;
10. Policy development and support;
11. Community partnership development;
12. Business competencies.

All health authorities in the state currently have a Community Health Needs Assessment (CHNA) process that involves robust community engagement and feedback, as well as review through Boards of Health. These assessments are critical tools to guide public health development as they indicate the broader areas in which the community is ready to make progress, however we do not recommend that Public Health Infrastructure Improvement dollars be restricted to CHNA priorities alone. The funding is needed for core services that go largely unrecognized by the general public as a top community need, but nevertheless are critical to healthy communities and constitute core public health (i.e. disease surveillance, environmental health inspections, etc.).

Of course, CHNAs will also guide decision-making, but restricting the usage to the services listed above will allow for the development of a strong public health foundation across the State, and will ensure greater oversight of the funds as local jurisdictions can utilize Public Health Improvement Funds only for the development of core public health services.

Key Stakeholders/Participants:

Nevada Division of Public and Behavioral Health

Northern Nevada Public Health

Southern Nevada Health District

Carson City Health and Human Services

Central Nevada Health District

The Nevada Association of Counties

UNR School of Public Health

Nevada's 21st Century Learning Community for Public Health Modernization delegation

Proposed Bill Draft Request - Sustainable Public Health Funding

NRS 439.### Creation of Account for Public Health; use of money in Account, provision of services funded by money in the Account; administration of the Account

2. The Account for Public Health is hereby created in the State General Fund. The Division of Public and Behavioral Health shall administer the Account.
3. The money in the Account must be expended to address the tribal, county, district, and state public health needs in Nevada.
4. The Account shall be funded with the first $45M per biennium (or $22.5M per fiscal year) of the Insurance Premium Tax collected by the Department of Taxation.
5. A Public Health Improvement Advisory Committee is hereby created as a sub-committee of the State Board of Health.
6. The membership of the Committee shall include:
    a. The Chief Medical Officer of the Division of Public and Behavioral Health
    b. The Administrator of the Division of Public and Behavioral Health or their designee
    c. The Administrator of the Division of Environmental Protection or their designee
    d. The Administrator of the Division of Emergency Management or their designee
    e. District Health Officer from every health district in the State or their designee; such a designee must be a member of the senior leadership, or management team of the appointing health district.

    And the following members appointed by the State Board of Health:
    f. The Executive Director of the Nevada Association of County Commissioners, or subsequent agency, or their designee
    g. The Executive Director from the Nevada Department of Native American Affairs or their designee
    h. A member of the Board of County Commissioners from a county who has a population of 700,000 or more, or their designee.
    i. A member of the Board of County Commissioners from a county who has a population less than 700,000 and more than 100,000, or their designee.

j. A member of the Board of County Commissioners or Board of Supervisors from a county who has a population less than 100,000, or their designee.
k. One member who possesses knowledge, skills, and experience in local delivery of public health services in Nevada.
l. One member who is a County Health Officer in the State of Nevada for a county not within a health district.
m. One member of the public who has experience in seeking services from and navigating a local public health system in the State of Nevada.

7. Each tribe, county, or district shall provide the Public Health Improvement Advisory Committee with a list of public health priorities and associated spending plans per priority approved by their local Board of Health by January 1 of each even number year.
8. The Public Health Improvement Advisory Committee shall review the priorities and process for alignment with requirements pursuant to section 12a-e (below). The Public Health Improvement Advisory Committee shall make recommendations to the Division for approval of use of funds and make biennial progress reports to the State Board of Health.
9. The Division shall develop a contract for each approved entity no later than April 1 of each even number year.
10. Money shall be distributed according to the following formula:
    a. 10% of the total revenue will be allocated to Nevada's tribes
    b. 5% of the total revenue to the Division of Public and Behavioral Health
    c. 1% of the total revenue to each county as public health infrastructure base funding
    d. The remaining revenue is distributed on a per capita basis based on the current calendar year demographic projection prepared by the Nevada State Demographer
    e. Each Health District with more than one county shall be given the base and per capita allocation for the counties within that district
11. If any tribe, county, or health district chooses not to utilize the Account for Public Health or is unable to identify priorities, that funding shall be reallocated to the Division of Public and Behavioral Health to use for public health improvement efforts within that jurisdiction or to support statewide efforts.
12. An entity to which money is allocated shall:
    a. Evaluate the public health needs of residents of the area under the jurisdiction of the entity;

    b. Determine the level of priority of the public health needs identified pursuant to paragraph (a);

    c. Expend the allocated money in accordance with the levels of priority identified pursuant to paragraph (b); and

    d. Expend the allocated money on public health improvement in the following areas to ensure the development of a strong public health foundation across the state:
        i. Control of communicable diseases and other notifiable conditions;
        ii. Chronic disease and injury prevention;
        iii. Environmental public health;

iv. Maternal, child, and family health;
v. Access to and linkage with medical, oral, and behavioral health services;
vi. Vital records;
vii. Assessing the health of populations;
viii. Public health emergency planning;
ix. Communications;
x. Policy development and support;
xi. Community partnership development; and
xii. Business competencies.

e. Submit annual reporting to the Public Health Improvement Advisory Committee and the Division in the format and on the timeline recommended by the Public Health Advisory Committee and approved by the State Board of Health; Not later than 90 days after the end of Fiscal Year 2025-2026 and 2026-2027, respectively:
    i. Prepare a report which must include, without limitation:
        1. A description of the process used by the entity pursuant to paragraph (a) to evaluate the public health needs of residents of the area under the jurisdiction of the entity and the public health needs identified through that process;
        2. A description of the process used by the entity pursuant to paragraph (b) to determine the level of priority of the public health needs identified pursuant to paragraph (a) and the levels of priority assigned to those public health needs through that process;
        3. A description of each expenditure of the allocated money made by the entity pursuant to paragraph (c);
        4. The unexpended balance of the allocated money at the end of the fiscal year.
        5. Reporting and metrics requested by the Public Health Improvement Advisory Committee and approved by the Division and the State Board of Health in the format and on the timeline prescribed by the Division.
    ii. Submit the report to the Division and to the Public Health Improvement Advisory Committee.

13. The Account may retain no more than 2% of the total revenue received in the biennium as a reserve if there are unspent funds remaining at the conclusion of the state fiscal biennium.
    a. The reserve can be redistributed in a future biennium based on public health need.
    b. Any reserve in excess of the 2% is considered excess reserve and will be returned to the State General Fund.