



County Health Officials of New York

Leading the Way to Healthier Communities

2022 Joint Legislative Budget Hearing

New York State Association of County Health Officials (NYSACHO) Testimony on Executive Budget Proposal

NYSACHO's MISSION:

NYSACHO supports, advocates for, and empowers local health departments in their work to promote health and wellness and prevent disease, disability and injury throughout New York State.

NYSACHO is incorporated as a not-for-profit, non-partisan charitable organization with 501(c)(3) tax exempt status.

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Introduction

The public health system in New York State is in crisis. Numerous elements have conspired to weaken our public health response infrastructure to a point of unprecedented fragility: ten consecutive years of disinvestment by the state; a malignant and ongoing loss of public health workers; a demoralized public health system diminished by inadequately supported workload demands; the ongoing response to the covid pandemic; and the specter of an anticipated wave of public health staff retirements that will further diminish our public health response and prevention capabilities.

We are at what is perhaps the most meaningful public health inflection point in our lifetime, where only sound policy and resource decisions will steer us back to a path that will ensure our public health system is prepared for even greater challenges that we know will come.

In short, your leadership and support has never been needed more to protect the lives and health of the people of New York.

Within this confluence of factors, however, we see opportunity. The public better understands the real and deadly impact of public health threats, and the immeasurable value of a fully prepared public health system; our governor understands and honors the value of local partners, and the value of partnership and collaboration with the Legislature; and historic levels of state resources are available as we enter the coming budget season.

For the first time in decades, we fully comprehend the value and the needs of our public health system, and at the same time possess the financial means and public support to effectively address these needs.

These factors align to beg a simple question: If not now, then when?

The answer is clear. It must be now.

NYSACHO's 2022-2023 Article 6 State Budget Request- The NYS PREPARE Act

The public health reinvestment and emergency pandemic adaptability, readiness, and efficiency (PREPARE) act is designed to increase the infrastructural state funding supporting local health departments' provision of the core public health services needed to provide a base level of

protection to the communities they serve. State reinvestment in the funding for local health departments will help retain and sustain a responsive, skilled public health workforce necessary to take prompt action in public health emergencies. Over the past decade, the local public health workforce has decreased by one-third while public health emergencies have been increasing. The PREPARE act contains the following provisions, some of which are reflected in the proposed executive budget:

1. **SUPPORT for proposal to Increase Article 6 base grant for full service LHDs (37) to \$750,000 or \$1530 per capita.**

Total increase over current base grant= \$15.19 million

2. **SUPPORT for proposal to Increase Article 6 base grant for partial service LHDs (21) to \$577,500.**

Total increase over current base grant=\$1.62 million

3. **SUPPORT AND AMEND proposal to permit *fringe benefits* as an eligible expense under article 6 state aid. Amend to remove the cap of 50% on the county fringe rate.**

Total estimated cost of fringe reimbursement at 36%=\$56 million

4. **Restore NYC to 36% reimbursement beyond the base grant under Article 6 state aid.**

Total cost NYC restoration=\$60 million annually

5. **Provide state reimbursement of 50% for pathology and toxicology services provided by county medical examiners.**

Total estimated cost=\$53.4 million (based on 2018 budgets).

6. **Fully fund the implementation of the 2019 Elevated Blood Lead Level Mandate**

Total estimated cost=\$30.3 million

Proposed FY 23 Executive Budget Reaction and Recommendations

Article 6 State Aid

While we are pleased to see an increase to the article 6 state aid appropriation in the proposed FY 23 budget, we have several requests and recommendations for the Executive and Legislature to consider during negotiations. County Health Officials support funding invested to Article 6 state aid within the proposed Executive Budget proposal:

- Article 6 Base Grant:
 - The Executive Budget proposes an increase to the Article 6 base grant from the current \$650,000 or .65 per capita to \$750,000 or \$1.30 per capita, whichever is greater in full-service counties.

- The base grant for partial service LHDs will increase to \$577,500.
- Employee benefits as a Reimbursable Expenditure under Article 6:
 - The Executive Budget proposal proposes eligibility of fringe benefits, up to a fringe rate of 50%. **We however, recommend removal of the 50% fringe cap, which would allow 100% of local health department fringe rates to be eligible for reimbursement either within the base grant or beyond the base grant at 36%.**
 - At least 29 LHDs have fringe rates above 50%. Any of those are between 50-60%, but there are a number over 60% and a few higher than 70%.
 - Factors generally out of the municipalities' control: Age/Retirement tier of workforce, health benefits (family vs. individual, employees who take the insurance vs. those who don't), federal contribution requirements, rates set by insurers.

The increased appropriation to Article 6 funding will be phased in over a two-year period between FY 22-23 and FY 23-24. While New York City Department of Health and Mental Hygiene (NYCDHMH) is included in the per capita and fringe increase, the NYC beyond the base reimbursement (reduced in 2019) remains cut in the proposed FY 23 budget at 20% while the ROS receives 36%. **NYSACHO requests that NYCDHMH's reimbursement rate is restored and respectfully requests the legislature take action to do so during budget negotiations.**

Elevated Blood Lead Levels

While county health officials appreciate the Executive's investment in addressing infrastructure funding needs of local health departments that there is a need for infrastructure funding for local health departments, we must highlight the importance of fully funding new public health mandates when they are passed into law. In 2019 the state lowered the actionable elevated blood lead level from 10 ug/dL to 5 ug/dL, this is exemplary public health policy that we fully support, however we have still not been provided the resources to implement this work locally. Local health departments just received award totals for their lead prevention grants which is passed through by the state. The State department of health has changed their funding allocation so that more counties are eligible for funding, while other jurisdictions lost up to \$200,000 of their award total. This unanticipated loss of funding will impact some of the largest jurisdictions in their effort to prevent and eliminate lead exposure. Any decrease in funding to local health departments due to a change in funding formula should be reimbursed by the state. The 13 counties that are receiving decreased funding have made progress preventing lead exposures and should not be penalized by a change in formula. The pandemic has interrupted

children's routine pediatric appointments and recommended blood lead level testing which we are concerned may exacerbate the number of children localities and providers will need to provide services to in order to prevent permanent and lasting negative health outcomes.

In addition, the Centers for Disease Control and Prevention have made a recommendation to lower the actionable EBLL from 5 ug/dL to 3.5 ug/dL which without an increase to lead prevention grant funding, will further strain our local ability to implement if this actionable level is passed in New York State. We ask the legislature to act swiftly to provide full funding to localities so that we can adequately and equitably protect children from exposure to lead in New York State. Further, we are eager to discuss the cost of primary prevention strategies that can be initiated in New York State to ensure we are doing all we can to eliminate the risk of exposure and long-term health effects for communities.

To read more about the PREPARE act, visit: https://www.nysacho.org/wp-content/uploads/2021/12/PREPARE-Act-Canva_12.22.21.pdf

Health Worker Bonus Program

A provision within the Governor's \$10B health care workforce plan includes a one-time direct health worker bonus program. This program applies to Article 28 and Article 36 facilities, which includes staff at local health departments who meet the proposed criteria. Most local health departments in New York are classified under such licensures. However, to maintain equitable distribution of such bonus incentives, it is imperative that all local health department staff, including those without direct clinical responsibilities, be included under this program. These professionals have been engaged other important pandemic response activities and without them, those clinical services would not be possible. Without the administrative support provided by staff within local health departments, vaccinating millions of New Yorkers at county run clinics would not have been feasible. Each local health department staff member, of which there are an estimated 14949 statewide, is deserving of this bonus award.

What Local Health Departments Do

Local Health Department's Role in Emergency Response

Public health emergency preparedness and response includes planning, training, and maintaining readiness for public health. Prior to COVID-19, the threat of a global pandemic was theoretical to most - but not to local health departments. LHDs have been responding to public health emergencies for over a century, and starting in 2002, they began to formalize their

emergency response processes. Through learning and adapting emergency management tools, LHDs integrated public health into broader county all-hazards emergency plans. LHDs successfully deployed pandemic response plans during the 2009 H1N1 Influenza pandemic. LHDs also maintain continuity of operations plans, conduct drills and exercises with staff and partners, and use core public health activities, such as annual flu vaccination clinics, to test and improve their ability to deliver medical countermeasures.

Communicable disease control is where public health began. LHDs work daily to mitigate the spread of infectious diseases. Public health activities include disease surveillance and epidemiological programs to detect diseases in their early stages, immunizations, investigation and prevention of transmission through contact tracing, and isolation or quarantine, when needed. Contact tracing is the “who, how, why, when and where” of disease control that LHDs conduct daily to identify individuals infected with or exposed to emerging diseases, vaccine-preventable diseases and sexually transmitted infections. Isolation and quarantine measures were most recently used during the 2019 Measles Outbreak. These were among the first public health defenses employed by New York’s LHDs as federal recommendations to identify travelers at risk of having COVID-19 were put in place.

Professionals employed by local health departments are on the front lines of this pandemic, working to protect communities from exposure to COVID-19. Since the start of the pandemic, they have provided oversight of the following responsibilities:

1. Activating and mobilizing emergency preparedness plans during local emergency or outbreak response;
2. Serving as communicable disease experts. During disease outbreaks, epidemiological experts conduct investigations, contract tracing, monitor suspected cases, enforce isolation and quarantine protocols and set up mass clinics;
3. Assisting and connecting vulnerable or under resourced individuals to life-sustaining resources like housing, nutritious meals, utilities and health or mental health services;
4. Supporting community partners and working hand in hand with the New York State Department of Health and the Centers for Disease Control and Prevention. They also serve as a lynchpin for community partnerships with hospitals, clinicians, colleges, schools, businesses, community-based organizations and volunteer groups;
5. Vaccinating thousands of New Yorkers, focusing on those most vulnerable including BIPOC, individuals living in congregate settings, students and children, migrant workers, etc.

6. Upholding state and local laws. Public Health law grants authority to local health officials to respond to disease threats. **New York's local health departments are the only boots-on-the-ground entities legally responsible for the control of communicable diseases;**
7. Informing, advising and reassuring their respective communities by answering questions, providing up-to-date situational updates before, during forward through the pandemic, and making recommendations for how best to protect your family from exposure.

Information about funding for local health departments during public health emergencies

Article Six

Article Six of the Public Health Law provides a process to declare an Imminent Threat to Public Health (ITPH). This can be a statewide declaration or can be approved for one or more counties. Under an ITPH, a municipality must first expend the state approved funding for a core public health service necessary for the emergency response. After that, the state will reimburse additional emergency expenses at 50% state/local share of eligible expenditures. Article 6 is always considered the payer of last resort, which means they reimburse only eligible expenses not covered by other emergency funding sources.

State Emergency Funding

The state may provide direct funding or in-kind resources to localities to support an emergency response. This is typically at the discretion of the state. Examples of in-kind resources during COVID-19 would be the Virtual Contact Tracers program and the state-run COVID-19 vaccination and testing sites. They may also choose to allow staff funded on grants to support emergency response, with the county still allowed to charge that staff time to the grant.

Federal Emergency Funding

The federal government awards emergency funds through many agencies. FEMA reimbursement is typically coordinated through the county emergency management office. Congress may appropriate additional emergency funding to other federal agencies to distribute to states, localities and territories. The largest metropolitan areas in the country receive direct awards from the federal government (NYC in NYS). For other localities funds go to the state first. Funding allocations for localities may be set by the federal government (usually an overall percentage of the award that must go to fund localities, but typically the state decides how much

of the federal funding local health departments receive. Funds may be added to existing state/local contracts or may require new grant contracts. Federal funds are time-limited and come with restrictions on what costs the funds can be used to cover. Restrictions are often related to how Congress authorized the funding. Federal funding prohibits supplanting of state or local funding.

While these sources of funding are important to our collective ability to respond to public health emergencies, it is important to note that stop gap emergency appropriations are not a sustainable substitute for the foundational, long-term funding needed to ensure our statewide capacity for public health response is strong enough and fully staffed in preparation for future emergency response.

Background and Trends in New York's Public Health Workforce

New York State's local public health workforce is responsible for promoting and protecting the health of New York's communities. Working for one of New York State's 58 local health departments, the local public health workforce - made up of public health nurses, disease control investigators, sanitarians, community health workers and other professionals – is responsible for preventing disease, protecting the health of New Yorkers, and keeping our communities safe.

Activities led by New York's LHDs are paramount to our collective ability to achieve Prevention Agenda goals, address health disparities, improve health outcomes and ensure community safety and stability.

Most of the staff in the state's local health departments (LHDs) work to deliver one or more of six core public health services: community health assessment, communicable disease control, chronic disease prevention, maternal and child health services, emergency preparedness services and in 31 of the 58 local health departments, environmental health services. These six core responsibilities are set forth in statute and are known as Article 6 services as they are reimbursed by the state through the statutory mechanisms authorized in Article 6 of the public health law. The six core, or basic, services provide the minimum foundational public health responsibilities delivered by local health departments; however, additional statutory and programmatic mandates fall under these six broad service areas.

Unfortunately, over the past five years in New York State, the number of LHD staff delivering Article 6 core services has declined. According to data from the New York State Department of Health, the number of FTEs working on Article 6 services declined by 7% between 2015 and 2020. During this same period, the population of the state increased by 3%. This reduction in staff has made it harder for the state's local health departments to address the public health challenges facing their communities, including responding to the COVID-19 pandemic. While the largest reduction in staff was experienced by the New York City Department of Health and Mental Hygiene, other LHDs also experienced a decline.

In fact, most of New York's LHDs do not have sufficient staff needed to provide a basic package of public health services. According to the Public Health Center for Innovations and the de Beaumont Foundation, local health departments nationally need approximately 54,000 new staff to be able to provide adequate infrastructure and a minimum package of public health services.¹ When applying this formula for how many local public health workers each community needs to New York's LHDs, an estimate showed that 90% of LHDs do not have enough staff to adequately provide basic foundational public health services to their communities. In total, over 1,000 additional Full-Time staff are needed to be able to provide an adequate infrastructure and a minimum package of public health services.

Public Health Burnout and the Experiences of Public Health Workers

According to a survey led by SUNY Oneonta, Bassett Healthcare Network Research Institute and the New York State Association of County Health Officials, *Pain and Perseverance*, public health workers have been subject to targets of protests and have experienced overwhelming burnout while responding to the pandemic. Of the two-hundred and nine public health workers who completed the survey, data indicates:

- 90.4% of respondents have felt overwhelmed by workload.
- 75.6% felt disconnected from family and friends because of workload
- 65% felt unappreciated at work and 75% felt inadequately compensated.
- Over half of respondents reported experiencing stigma or discrimination during the crisis.
- 35% received job-related threats because of work by members of the public.
- 55% felt bullied or harassed because of work by the members of the public.
- 30% have received any sort of hate mail/email/messages from the public.

Staffing Up: Workforce Levels Needed to Provide Basic Public Health Services for All Americans. De Beaumont PHNCI October 2021. <https://debeaumont.org/staffing-up/> U.S. Census Bureau (2015-2020). Population and Housing Estimates. Retrieved from [<https://www.census.gov/programs-surveys/popest.html>].

To protect and retain the dedicated workers employed by local health departments, investments need to be made to article 6 state aid funding to ensure that these public health entities are appropriately staffed and thus able to allow employees to manage work-life balance and avoid burnout. Making such investments will protect and ensure longevity in the state's public health workforce. Despite all this, local health departments have stood up to the challenges faced to address the pandemic all the while vaccinating tens of thousands of New Yorkers and continue to do so as we face a possible third surge this winter

New York's Looming Retirement Crisis

Based on a survey conducted by NYSACHO, the state is approaching the loss of decades upon decades of public health expertise through local retirements. It is only a matter of time before a large segment of the public health workforce begins to retire and we need to be realistically prepared to rebuild the public health system when we are confronted with another public health crisis. Retirement survey findings indicate:

- 42 LHD respondents reported a total of 1257 LHD employees statewide were eligible to retire in 2020.
 - Of these, 743 were in NYC and 514 in rest of state. This represents a total of *22% of the LHD workforce statewide who were eligible for retirement in 2020*, with 25% of the NYC LHD workforce eligible to retire, and 19% of the total LHD workforce outside of NYC eligible to retire.
- Out of 45 LHDs responding, 23 indicated that they had employees who intended to retire in 2021, for a total of 69 employees statewide.
- Out of 43 LHDs respondents, 33 indicated that they had employees who had, or intended to retire by the end of 2020, for a total of 236 employees statewide.
- Since the start of the COVID-19 pandemic, New York has seen 9 out of 58 local health officials (leadership positions within health department) retire and 5 county health officials leave for other/unidentified reasons.

Solutions: Investing in New York's Public Health Infrastructure

Infrastructure for Public Health Work

Public health work, particularly response to emergencies like the COVID-19 pandemic, requires trained, highly educated workforce. New York State sets minimum qualifications for 13 public health titles; all but one of these requires a minimum of a bachelor's degree and several require advanced degrees. Given other employment opportunities and the typically lower salary rates of

public vs. private sector jobs, fringe benefits are critical for recruitment and retention of a qualified, experienced workforce. Provision of the core public health services required by New York State under Article Six requires that LHDs maintain this educated and highly trained workforce.

Emergency funding for public health threats does not sustain workforce investment. LHDs cannot retain and utilize experienced staff hired for emergency response when funding is time limited. Skills needed and core services provided during COVID-19 and other public health emergencies are those that are used every day for core public health services.

The current fringe ineligibility set forth under Article 6 does not work efficiently in a post clinical care public health model. When Article Six was initially enacted, clinical care revenues reduced, or often fully covered fringe expenses; at that time, localities were the safety net providers of primary and clinical home care services in a fee-for-service payment model, to provide basic care for un- and under-insured populations. New payment models and expansion of the availability of health care meant that LHDs were largely no longer needed as safety net providers. Rather than reinvesting public health dollars from clinical care to population health services, public health funding was simply reduced. Concurrently, while the state disinvested in existing population health services and expertise provided by local health departments, it directed funding towards pushing clinical care providers towards population health services; rather than coordinating the two, too often, clinical care simply duplicated public health services. COVID-19 showed why clinical care and public health have unique and complementary roles to play, with clinical care focused on individual health and public health focused on population health.

The decade plus of disinvestment and erosion in public health has left little opportunity for succession planning and development of the next generation of public health professionals. Additionally, shortages in fields such as nursing and engineering have resulted in longer periods for recruitment to fill vacancies, as well as competition from the private sector that impacts employee retention. Local governments will be hard-pressed to address the convergence of looming retirements and profession shortages under the current funding structure.

Fully fund the implementation of the 2019 Elevated Blood Lead Level Mandate

Lead Poisoning Prevention Activities delivered by local health departments are supported through a variety of funding mechanisms, including the Lead Poisoning Prevention Program, Childhood Lead Poisoning Primary Prevention Program (15 counties), Healthy Neighborhood

Program (some counties), and reimbursement through Article Six Public Health Law General Public Health Work funding. When the definition of elevated blood lead level was lowered to 5 ug/dL or greater, the state also allocated an additional \$9.7 million to Article Six state aid. This investment falls short of the \$30.3 million in funding needed and places the majority of the cost burden on the local tax levy, including 100% of fringe costs associated with any new staff hired to provide public health interventions and case management for the additional children requiring services. This estimated need is based on an average cost per case of nursing case management of \$713 and an average cost of \$2123 per case for environmental management activities.

Local health departments just received award totals for their lead prevention grants which is passed through by the state. The State department of health has changed their funding allocation so that more counties are eligible for funding, while other jurisdictions lost up to \$200,000 of their award total. This unanticipated loss of funding will impact some of the largest jurisdictions in their effort to prevent and eliminate lead exposure.

We recommend that all monies allocated for funding the expanded mandate (current and future) be appropriated into the Lead Poisoning Prevention program of the New York State Department of Health. We further recommend that this funding then be distributed to the local health departments through existing grant mechanisms to support implementation the expanded mandate. Allocating existing and new investments to support the lower EBLL through this program will allow local health departments to secure and maintain the necessary staffing and other resources required accomplish the goals set forth by the state mandate, whilst ensuring that New York State keeps its promise to property taxpayers through its enactment of a permanent property tax cap.

Medical Examiner/Coroner Services: Lack of State Support for Vital Death Investigations

Death investigations are a critical public health activity. While the popular view of these services focuses on investigations related to criminal activity, under New York state statute, coroners or medical examiners have jurisdiction and authority to investigate every death within their county, or body found within the county, which is or appears to be violent, suicide-related, criminal in nature, suspicious in nature, unattended by a physician, or a death of a person confined in an institution.

In addition to deaths related to criminal activity, commonly encountered reportable unnatural deaths include: opioid related, motor vehicle accidents, infectious deaths following an injury, hip

fractures, subdural hematomas, death by asphyxiation, head injuries, traumatic deaths or cases where there is uncertainty or inadequate clinical information at the time of admission or death.

Many medical examiners offices also provide pathology and toxicology services to counties served by coroners. In 2019, the 20 counties operating medical examiner programs accounted for roughly \$108M of the \$122M or roughly 88.5% of the total 2018 budget for coroner and medical examiner services across all of the counties in NYS.

Prior to 2011, county coroners and medical examiners were recognized as a core public health service, with medical examiner services reimbursed up to 36 percent with state aid from Article 6 funding to local health departments.

In 2011, the State Budget recommended shifting the reimbursement for medical examiners from the New York State Department of Health (NYSDOH) to the New York State Department of Criminal Justice Services (DCJS). County objections over the need for objectivity and distance from criminal justice agencies were recognized as a valid concern, however, rather than returning funding to Article Six reimbursement, the funding simply was no longer available as the state continued to deem this activity to be a public safety and not a public health function.

Since that loss of state support for ME services, the public health need for these services has grown. Death investigations and data are a critical piece in addressing the ongoing Opioid epidemic, particularly as many opioid-related deaths are unattended. Similarly, toxicology results help identify new trends in street drugs, such as the rise in drugs mixed with fentanyl. A key part of the COVID-19 response, particularly in the early time period of the epidemic, was equally critical to informing disease incidence, contributing health factors for COVID deaths, as well as death rates.

The Governor and State lawmakers must restore funding to counties to help offset the increasing costs for state-mandated autopsy services in recognition of the critical public health data provided by death investigations. Given the 2011 loss of funding, and subsequent increases in costs and challenges facing county coroner and medical examiner services, NYSACHO joins the New York State Association of Counties (NYSAC) and the New York State Association of County Coroners and Medical Examiners (NYSACCME) to request that the state to fund 50 percent of the autopsy and toxicology services impacting counties due to the changing pathology landscape in NYS and the opioid epidemic.

Conclusion

New York State continues to confront a growing number of monumental public health challenges. Using just the past three years as an example, recent public health threats included: in 2018, vaping related lung illness and death; 2019, a massive measles outbreak hit the city and Hudson valley region; and in 2020-2021 the first global pandemic in the past 100 years from a previously unknown virus. Continuing into 2022, we persevere through to the most significant public health crisis of our generation with the worldwide COVID-19 pandemic. All these events coincide with ongoing public health issues, such as an increase in rates of sexually transmitted infection; Hepatitis A outbreaks; opioid overdose and deaths; suicide fatalities; an increase in reports of children with elevated blood lead levels due to a change in public health law and other severe public health crises. Currently, local health departments continuing to vaccinate New Yorkers to achieve the level of herd immunity needed to reduce the potential for variants and prevent large waves of community transmission.

We ask you, New York's respected lawmakers, to support the article 6 proposal in the executive budget and to push beyond that, to restore New York City's reimbursement rate; guarantee a 50/50 state-local match for Medical Examiner pathology and toxicology services and allocate funding to cover the cost of implementing the lowered actionable EBLL. By doing so, you will be demonstrating your commitment to the foundational services that underpin the public health preparedness and safety measures needed to protect residents in New York State.

On behalf of the 58 local health departments in New York State, it is an honor to submit budget testimony to the joint legislative committees on Health and Finance and Ways and Means. LHDs implement state public health policy in each of your counties, through the provision of core public health services. As new threats emerge, local health departments are your public health first responders.

The County Health Officials of New York and their association, NYSACHO, look forward to working with you to develop the policies and identify the resources and services necessary to rebuild New York's public health infrastructure. If not now, then when?

Public Health Infrastructure: A Decade of Disinvestment



2009

Despite the ongoing impact of the Great Recession, Local Health Departments responded to the H1N1 Pandemic, implementing pandemic plans and mass vaccination PODs.



2010-12

Total Disinvestment-
-\$44,746,002

In 2010-11, NYS eliminates funding for enhanced or "optional" public health services, including funding for Medical Examiner/Coroner services and cuts several categorical funding lines; in 2012 a statewide property tax cap goes into effect for all counties, except for NYC.



2013-14

Total Investment-
+\$7,024,925

As part of a modernization of Article Six public health foundational services and funding, NYS increases base grants for local health departments.



2014-15

Total Disinvestment-
-\$9,452,179

NYS cancels out its base grant investment through administrative cuts to LHDs by reducing the allowable revenue amounts localities could use to offset some of their ineligible fringe and indirect costs.



2013-17

Total Disinvestment-
-\$16,858,000

The state property tax cap impacts the LHD workforce outside of NYC, which shrinks by 33%. LHDs continue to respond to new public health threats and mandates: The opioid epidemic, Ebola, Zika, Legionella, Mumps, Measles, Hepatitis A, Vaping, Harmful Algal Blooms (HABs), PFOAs, and other emerging contaminants in drinking water, and lead poisoning prevention mandates.



2017-18

Total Disinvestment-
-\$47,186,430

In 2017, NYS cuts several core public health categorical programs by 20%, followed by the 2018 elimination of the categorical COLA. Services lost/reduced include migrant worker outreach, immunization clinics, water supply sampling, and other health education and outreach activities.



2019

Total Disinvestment-
-\$54,000,000

In 2019, NYS cuts NYC state aid reimbursement above the base grant from 36% to 20%.



2020-21

LHDs respond to COVID-19 with a reduced and aging workforce. Retirements rise, recruitment and retention are challenging and local governments are wary of short-term funding fixes. Will NYS return to dismantling local public health, or will we reinvest and rebuild?

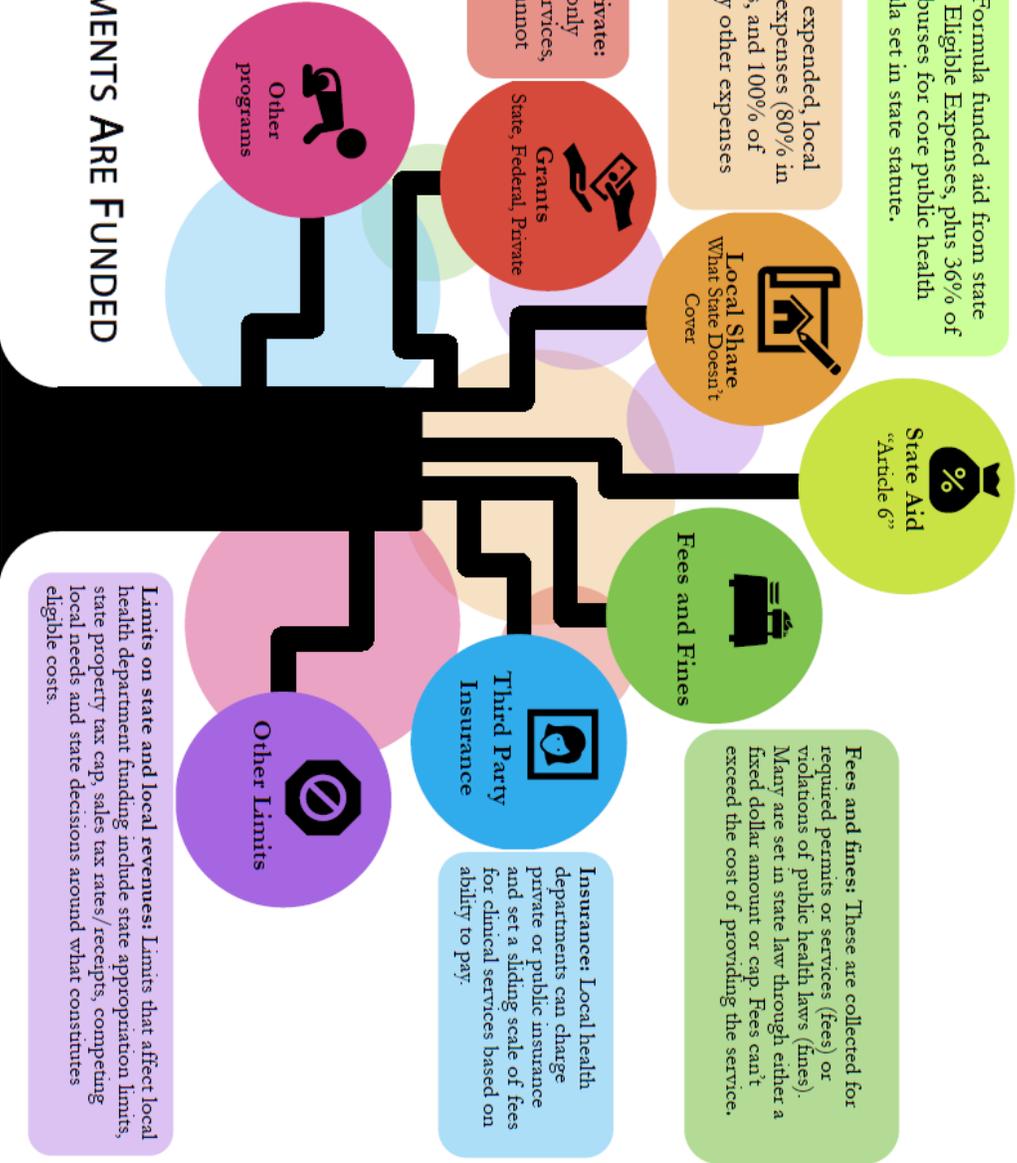


State Aid for General Public Health Work: Formula funded aid from state provides a base grant that reimburses 100% of Eligible Expenses, plus 36% of expenses over base (20% for NYC); Only reimburses for core public health services set forth in statute; services and formula set in state statute.

Local Share: After the base grant is expended, local government share = 64% of eligible expenses (80% in NYC) for core public health services, and 100% of ineligible expenses; also 100% of any other expenses for local initiatives.

Grants: state, federal (usually state pass-through) or private: Awarded for specific programs/purposes. Funds Can only be used for grant requirements, usually includes personal services, fringe expenses and non-personal services. Federal funds cannot supplant (be used instead of) state or local funds.

Other Programs: Many local health departments provide services for other state programs that receive separate state reimbursement with varying local share amounts. Examples include Early Intervention and PreK Services for Children with Special Health Care Needs. Some provide services such as medical examiners which are 100% local share.



Fees and fines: These are collected for required permits or services (fees) or violations of public health laws (fines). Many are set in state law through either a fixed dollar amount or cap. Fees can't exceed the cost of providing the service.

Insurance: Local health departments can charge private or public insurance and set a sliding scale of fees for clinical services based on ability to pay.

Limits on state and local revenues: Limits that affect local health department funding include state appropriation limits, state property tax cap, sales tax rates/receipts, competing local needs and state decisions around what constitutes eligible costs.

HOW NYS LOCAL HEALTH DEPARTMENTS ARE FUNDED

ARTICLE 6 CLAIMING PROCESS

FOR STATE AID TO LOCAL HEALTH DEPARTMENTS (LHDs)



APPLICATION



1. State Aid Application (SAA) is submitted to NYSDOH 2 months after start of the Fiscal Year

2. NYSDOH Office of Public Health Practice reviews and disapproves/approves SAA



3. When SAA is approved, LHD renders services and programs according to approved SAA

5. The total state aid reimbursement is calculated as follows:

Gross Costs – Ineligible Costs*

= Total Eligible Costs/Expenditures

Total Eligible Costs/Expenditures

– Eligible Earned Revenue

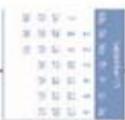
– Eligible Grant Revenue

= Net Eligible Costs/Expenditures



*Fringe/indirect costs are generally the largest ineligible expense

4. Quarterly Expenditure Report (QER) is prepared, using a cash accounting method, taking the actual payments made in the quarter. QER is submitted two months after quarter ends



CLAIMING



REVIEW/ REIMBURSEMENT/ PAYMENT

6. Net Eligible Costs – Base Grant **
= Balance Reimbursable Amount at 36%

** Base grant covers 100% reimbursement of net eligible costs up to a rate set in statute.
LHDs currently receive a base grant of \$650,000 or .65 per capita, whichever is higher.

7. Reimbursable Amount – Disallowances*
= Payment

* Disallowances often occur despite an approved SAA, creating unbudgeted expenses for the LHD

8. Unreimbursed eligible costs (64% of remaining eligible costs) and 100% of ineligible costs (including all fringe costs) are paid by the local taxpayers



The New York State PREPARE Act

Public Health Professionals serve as both a safety net and first responders against population health threats.

Reinvestment is the right thing to do. COVID-19 revealed both the strength and the fragility of our public health system. Investing long-term in public health assures that the highly trained and skilled workforce is available when a crisis occurs.

Emergencies and pandemics are not extraordinary events in public health. While the COVID-19 pandemic has been characterized as unprecedented, it is not the first pandemic in this century, not the first emerging public health threat; it is merely exceptional in its scope. Whether it is H1N1, Ebola, Zika, COVID-19 or emerging contaminants in drinking water, the truth is that public health emergencies can, and do, occur frequently. Public health workers respond to emergencies, regardless of scale, every year.

Adaptability is a cornerstone of public health. During COVID-19, local health departments adapted their pandemic response, tracking, implementing, or monitoring 122 Executive orders and close to 500 guidance documents. In the United States alone, there have been 10 SARS CoV-2 variants monitored, including the Delta variant which resulted in changes in response for vaccinated individuals. Similarly, the availability of vaccine and processes for distribution have evolved as supply has expanded and new groups have become eligible. And COVID-19 disease and vaccine misinformation has required local health departments to continually monitor and adapt messaging to assure that science-based, accurate information is communicated with the public.

Readiness is the hallmark of public health. Many disease threats require immediate and swift public health responses. Similarly, other emergencies, such as weather events or harmful algal blooms, require rapid action to reduce the threat of illness, injury, and loss of life. It is through their daily work and ongoing emergency preparedness drills and response that the public health workforce assures a high-level of readiness for emergency events.

Efficiency in funding is needed to provide optimal stewardship of public resources. The continued pattern at the state and federal level of providing short-term, time limited funding for specific public health emergencies does not allow local health departments to develop and maintain the highly trained workforce necessary for response. Just-in-time training and reliance on volunteers does not provide continuity of response, nor does it allow ongoing system improvements through drills, exercises and every-day public health activities that are the cornerstone of a strong public health infrastructure.