County Health Officials of New York
Leading the Way to Healthier Communities

2020 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

2019 presented New York State with monumental public health challenges including a massive measles outbreak; increase in rates of sexually transmitted infection; vaping related lung illness and death; Hepatitis A outbreaks; opioid overdose and deaths; suicide fatalities; and an increase in reports of children with elevated blood lead levels due to a change in public health law. Currently, local health departments are working with providers and the public to mitigate the spread of novel Coronavirus which has made its way to the United States from China.

Notwithstanding our best efforts and the tireless work of our front-line staff, the ever-increasing public health mission we face is quickly exhausting the resources necessary to meet incoming threats and sustain core public health services provided in each jurisdiction. Year after year, we see decreasing appropriations proposed within the Article 6 funding line for local health departments. We ask the legislature to consider the recommendations we provide within this testimony which will enhance public health infrastructure throughout the state.

The mission of the New York State Association of County Health Officials (NYSACHO) is to support, advocate for, and empower the 58 local health departments (LHDs) in their work to prevent disease, disability and injury and promote health and wellness throughout New York State. LHDs are your partners and operational extensions, working in the forefront of communities as chief health strategists, addressing public health issues and serving as the first line of defense against all public health crises.

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 the first responders.

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. Local health departments have not received an increase in core public health aid in more than six years, nor have they received adequate state funding support needed to respond to emerging health issues. In fact, State Budget appropriations for public health spending have been flat-funded or reduced year after year. New funding streams for emergency response activities are frequently accompanied with stringent federal spending or supplanting restrictions, which restricts how funds can be utilized and reduces flexibility to respond to local community need.

We ask of you, New York's respected lawmakers, to initiate a call to action for a reinvestment of resources into public health and safety infrastructure in New York State through bolstered funding of Article 6. By doing so, you will be demonstrating your commitment to public health preparedness and safety measures aimed to protect residents in New York State. NYSACHO's testimony provides a background on services provided by local health departments as well as a description of the Article 6 claiming process.

Public Health's Successes Rely on Local Health Department Infrastructure

Public Health is the great success story of the 20th century. The Centers for Disease Control and Prevention (CDC) looked at the monumental gains in life expectancy realized in the 20th century. After reviewing the data, they estimated that 25 of the 30 years of increased life expectancy – over 83% - can be directly attributed to the core public health interventions that led to reductions in child mortality, such as expanded immunization coverage, clean water, sanitation, and other child-survival measures.

Those additional years of life expectancy, and the strong public health policies you enact to support them, came about by addressing health threats at the population level. They came about because we, as communities, states and nations invested in public health. To keep up with the work needed to support our public health system, we hope to partner with you to

protect these public health policies and demonstrate continued promise to mitigating threats to public health infrastructure.

The Governor has again put forward an ambitious public health policy agenda but has not provided an equally substantive public health resource investment. Furthermore, while the workload is growing, public health infrastructure is shrinking. The public health workforce is central to New York State's public health infrastructure, yet is dwindling due to public-sector budget restraints such as the local property tax cap which limits our ability to hire, competition, shortages of workers who are approaching retirement and the ability to recruit new workers throughout the state. These factors culminate in significant workforce retention challenges, straining our ability to take on new programming or regulatory enforcement mandates. New York State does not allow local health departments to recover any of its necessary indirect or fringe expenses for local health department personnel under Article 6.

Function of Local Health Departments

LHDs are agencies of county government that work closely with the New York State Department of Health (DOH). They operate under the statutory authority of Article 3 and Article 6 of the Public Health Law (PHL).

Through our local health departments, counties provide essential, population-based health services that promote and protect the health of all who live, work, and play in counties throughout New York. County LHDs protect the public's health by:

- Developing and maintaining individual and community preparedness for public health hazards and events;
- Investigating, preventing, and controlling communicable diseases;
- Preventing environmental health hazards through assessment, regulation, and remediation;
- Preventing chronic diseases through outreach and education to promote healthy lifestyles;

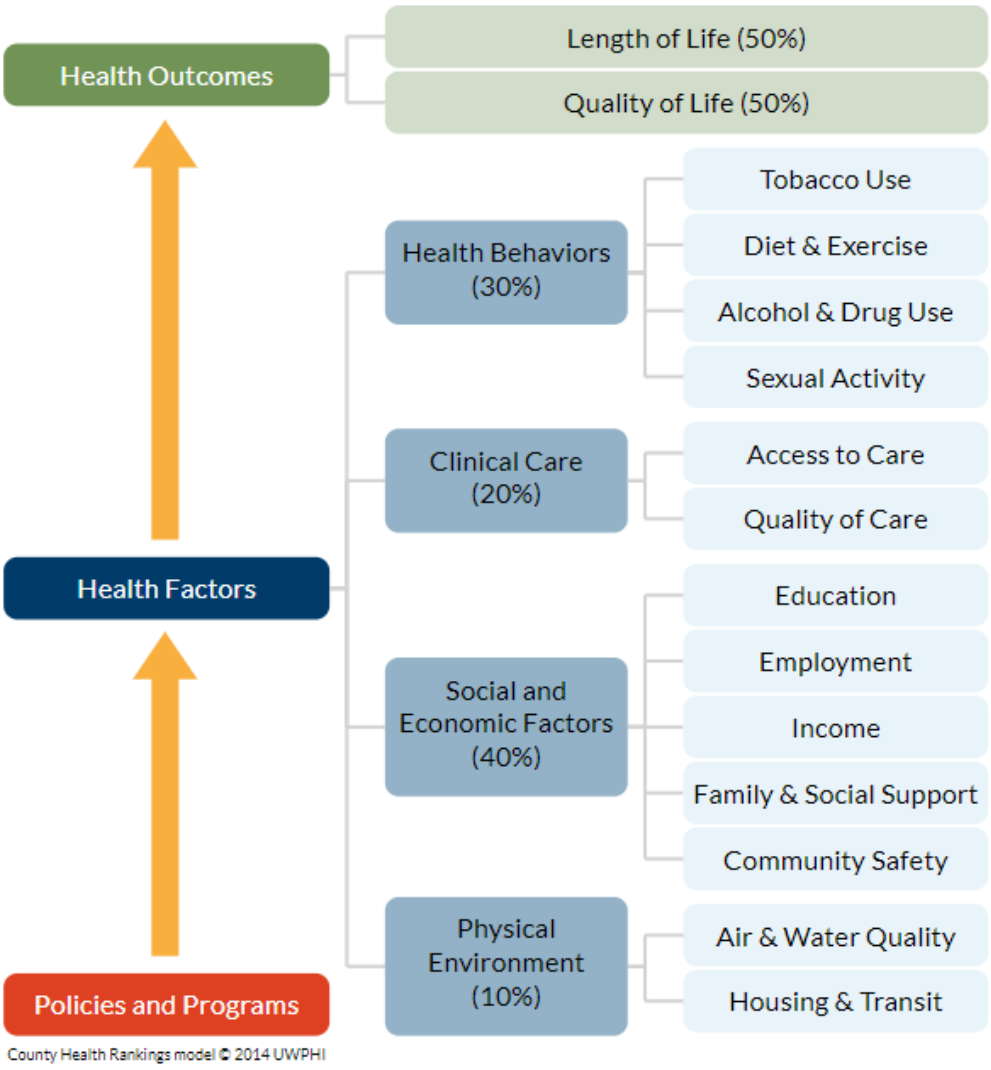
- Protecting our communities from unintentional injuries and violence;
- Providing services to women, children, and families to support healthy outcomes.

In New York, 57 county health departments and the New York City Department of Health and Mental Hygiene assumes the major responsibility for public health services at the local level. LHDs operate under the administrative authority of local governments (Article 3 of the PHL) and the general supervision of the State Commissioner of Health (Article 2 of the PHL, Section 206). While federal and state public health statutes and regulations guide services, each LHD addresses the unique needs of its own community as determined through ongoing assessment. In many counties, the county legislature or board of supervisors serves as the governing authority of the LHD. Others are governed by a local board of health, the county executive, or a combination of these entities.

Under New York State law (Article 3 of the PHL) and regulations, LHDs must be served by a full-time public health director or a full-time Commissioner. Public health directors can be appointed in counties with populations of 250,000 or less. All other counties must appoint a commissioner, who must be a physician. Both positions are appointed for six-year terms and must be approved by the State Commissioner of Health. If need be, smaller counties can share a public health official who is allowed to serve up to three counties, with a combined population of 150,000 or less, or a county with a population of 35,000 or less may choose to share a commissioner with a larger county, regardless of their combined populations. Variability exists across the county spectrum.

Social Determinants of Health: What Factors Affect Our Health?

According to the County Health Rankings, "The County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors)." Local Health Departments and the core public health services they are mandated to provide address these factors, contributing to 70% of health outcomes including length and quality of life. Clinical care contributes to only 20% of community health outcomes. This model demonstrates the need for increased public health infrastructure in New York State.



Article 6 Claiming Process and State Aid and Why This Matters in the Context of Continued Cuts to New York City Department of Health and Mental Hygiene

Funding to local health departments comes from a variety of sources including: the county property tax levy and/or sales tax revenues; fees, fines or reimbursement for services (i.e., restaurant permit fees, civil penalties for failure to comply with Public Health Law, etc.); state aid for general public health work (Article 6 funding); and state, federal and private grants.

Article 6 of the Public Health Law provides statutory authority for state aid for general public health work. The program provides reimbursement for expenses incurred by LHDs for core public health areas as defined in law. Counties are eligible to receive a flat base grant of $650,000 or a per capita rate of 65 cents per person, whichever is higher. Currently, this means that counties with populations of 1,000,000 or less receive the flat base of $650,000. Counties with more than 1,000,000 residents receive the per capita rate of 65 cents per person.

The flat base grant ensures that even our least populated counties receive enough state aid to support their core public health work. If municipalities with populations of 75,000 or less received the current per capita rate, most could barely afford a single full-time employee. A flat base grant might cover a majority, or in a few instances all, of the eligible public health expenses for smaller counties.

Eligible expenses are reimbursed 100% by the state up to the amount of the base grant. Once a county exceeds its base grant reimbursement funding, LHDs receive 36% reimbursement from the state, and pay the remaining 64%, plus 100% of the costs associated with services that are ineligible for reimbursement, such as employee benefits. During the 2019-2020 Budget Process, a 16% cut in reimbursement to New York City Department of Health and Mental Hygiene was enacted. This translates to a loss of $59 million less revenue to support essential public health programs to New York City residents.

Article 6 is an entitlement program, meaning it is a government program that guarantees certain benefits and the reimbursement provided to LHDs for providing these services is not capped. As the program costs are not capped (because the services must be provided), the state has an obligation to pay out eligible claims based on the statutory formula regardless of what the state appropriation is for Article 6 in any given year. The cost of this program varies from year to year, because the extent of public health needs and threats vary from year to year. Reimbursement through Article 6 is provided based on the net expenses of each LHD. The net expenses are determined by subtracting revenues obtained from third party reimbursement, fees and grants from a county's gross expenditures for public health services. The remaining balance is what a LHD can submit for reimbursement for core services. Please refer to appendix document I for more information on the Article 6 claiming process.

Cuts to Article 6 threaten the State's public health infrastructure and have a negative impact upon the important essential public health programs led by local health departments. During this time of extreme need for public health awareness and intervention, it is imperative that the State provide flexible and sustained funding to local health departments. With additional funding, programs that protect communities will be strengthened and yield in a substantial cost-savings to the state.

NYSACHO's 2019-2020 State Budget and Legislative Priorities

The Executive Budget proposes several promising public health proposals of which our members support including tobacco control; antimicrobial resistance prevention and pharmacy adult immunization expansion.

Local health departments have reached a critical juncture. Year after year, we are faced with new emerging issues and unfunded mandates. A growing need for public health resources, coupled with inability to cover fringe expenses under Article 6 funding has brought us to this precipice. To adequately maintain core public health services and address emerging threats, NYSACHO respectfully requests:

1. **Allocation** of $13.1M to Article 6 base grants to ensure public health services are eligible for full reimbursement of local expenditures for state mandated programs.

    a. From $650,000 to $750,000 in full services LHDs and $500,000 to $550,000 in partial service LHDs, and an increase in the per capita reimbursement amount from 0.65¢ to $1.30.

    b. Allowance of reimbursement of fringe and indirect costs, either fully, or phased in, in recognition of these costs are part of retaining a quality public health workforce.

    c. **Restoration** of the proposed 10% cut to State Aid Reimbursement which reflects the reduction in reimbursement to New York City implemented as part of last Year's budget. All counties are concerned about the impact of this cut to their communities, as residents and visitors frequently travel between New York City and other parts of the state.

2. **Funding County Lead Poisoning Prevention Activities.** Last year, New York State enhanced lead prevention activities by lowering the actionable blood lead level to 5 micrograms per deciliter (µg/dL). However, the current state investment of $9.7 million falls far short of the costs of Implementing of the new lower elevated blood lead level. $46 million dollars is needed to address true cost of protecting children from exposure to lead hazards. This total factors in the average case cost and total anticipated increase in number of children requiring case coordination and environmental management follow-up.

    a. To better protect children, allocate $46M which reflects the true cost of local implementation.

    b. Any funding should be re-appropriated from Article 6 to the Lead Poisoning Prevention grant mechanism within the State budget.

3. **Consideration** of a slow, cautious and evidence-based approach to legalization of an adult-use marijuana program with the interest of public health and mental health at the forefront of decision making by:

    a. Engaging in research and clinical trials prior enactment of an adult-use cannabis market in New York State to ensure there is evidence demonstrating the long-term and short-term health and safety impacts.

    b. If passed, ensuring local health departments receive flexible funding to expand workforce capacity. Protecting public health must be the first major pillar of a regulated marijuana program and must be funded sufficiently to ensure harm reduction.

    c. Guaranteeing local health departments, through NYSACHO, have a seat at the table as regulations and policies are developed.

4. ***Phase II of the Delivery System Reform Incentive Program (DSRIP):*** As community health strategists, local health departments are confident in their ability to support the State's Medicaid Redesign initiatives. County Health Officials are responsible for the population health of their communities, know how to reach vulnerable populations, regularly convene diverse stakeholders and are fully engaged in initiatives that address social determinants of health. County Health Officials request inclusion of local health departments during the development of phase II of the Delivery System Reform Incentive Payment (DSRIP) Program as key stakeholders if New York State's waiver amendment submission is approved by the Centers for Medicare & Medicaid Services. In addition to playing a proactive leadership role in this population health initiative, local health departments should be invited to provide input into the process of funding distribution to ensure DSRIP objectives are fully achieved.

5. **Support for, and reinforcement** of the Executive's proposed policies around:

    a. tobacco control policies which will protect millions of New Yorkers from exposure to dangerous tobacco products;

b. Pharmacy adult immunization expansion which will expand the list of adult immunizations that pharmacists can administer to include other Advisory Committee on Immunization Practices (ACIP) approved immunizations, and extend and expand provisions that authorize pharmacists to perform collaborative drug therapy management;

c. Antimicrobial Resistance Prevention requiring general hospitals and nursing homes to establish antibiotic stewardship programs and antimicrobial resistance and infection prevention training programs.

6. **Recognition that Unfunded Public Health Policy Results in Poor Policy.** Local health departments are committed to supporting and carrying out strong public health policy, but the success of new or expanded policies can only be achieved with investments that provide full and flexible funding to allow for effective implementation at the local level. State support for new and/or significantly expanded state policy mandates needs to be provided through more flexible grant funding, which can support necessary staffing and other costs needed to accomplish new state policy goals. Recommendation:

    a. **All monies allocated for funding expanded mandates (current and future) be appropriated and distributed to the local health departments through existing grant mechanisms to support implementation the expanded mandate.**

    b. Provide 100% reimbursement for the first full year of any new and/or significantly expanded mandates emerging from law, rule or regulation including reimbursement of salary and fringe expenses under Article 6 State Aid Appropriation.

7. **Increasing Commercial Payer Responsibility for Reimbursing Early Intervention Provider Claims.**

    The Executive Budget proposals includes anticipated savings related to the proposed implementation of statute regarding third party commercial reimbursement to providers called “Pay and Pursue”. NYSACHO supports any efforts to hold third party

insurers accountable for their obligations to pay for Early Intervention services. As outlined in the Governor's briefing book, "While 42% of children receiving early intervention services have commercial insurance, only 2 percent of early intervention services are paid for by commercial health insurance".

a. NYSACHO is developing recommendations that will strengthen the proposed "Early Intervention Pay and Pursue", ensuring that commercial payers participate in reimbursement of life-saving services for New York's youthful and vulnerable populations.

b. Expansion of the 5% provider rate increase to include all Early Intervention service provider types including service coordinators and evaluators using State invested dollars, while ensuring counties are held free from fiscal impact caused by such a rate increase

8. **Protecting Public Water Supply**. To sustain the important work the State Department of Health and local health departments oversee with respect to protection of public water supply, we request:

a. Restoration of the drinking water enhancement grant funding to original 2007-2008 appropriation in funding at $6M.
b. Increase of drinking water enhancement grant funding to equal 1% of Clean Water Infrastructure Act appropriation, totaling $30M.
c. Legislative consideration for policy recommendations that strengthen and facilitate partnerships across state agencies and between those state and local government entities that share primary responsibility for assuring access to safe drinking water.
d. State level recognition of the impact the last several years of funding constraints on both the local and state public health workforce and work together to identify ways to maintain and enhance the capacity of our public health infrastructure. It is better to invest money into prevention and protection of drinking water now rather than wait for the next public health threat or emergency to occur.

9. **Combating the Opioid Epidemic through public health initiatives.** Local health departments stand at the front line of this epidemic, working with partners to coordinate an array of opioid-focused interventions including Naloxone administration trainings; medication take back programs; and providing awareness and education to providers as well as the public. Funding local health departments specifically for this work would empower local communities to develop comprehensive response plans. New York's 62 counties are geographically, culturally, socially, and economically diverse. Strategy and action plans need to be developed and implemented with a knowledge of the characteristics of the local community.

    a. Recognition of the impact this crisis has had on all counties within New York and identification of funding opportunities that reaches every county, rather than select ones.
    b. Provision of a 50-50 state and local match for counties investigating unattended deaths to support efforts by coroners and medical examiners to perform autopsy, pathology, and toxicology services.

Lead Poisoning Prevention

Full service local health departments play a vital role in carrying out activities to address lead poisoning, prevention and follow-up. These activities include: finding and reducing sources of lead before they can harm children; teaching the public, health care providers and community about lead; promotion of lead testing for children; helping children with lead poisoning by making sure children get the testing, education and treatment they need, and helping families find the sources of lead in their homes.

On October 1, 2019 the State's actionable blood lead level was lowered from 10 ug/dL to 5 µg/dL, with additional discretionary language that allows the Commissioner of Health to lower it further through regulation. When considered solely on the public health protections it provides the children in our community, this proposal is the type of science-based public policy action that we should strive for as a public health community. Lowering the BLL aligns with the

science regarding lead poisoning and with the Centers for Disease Control and Preventions recommendations. Earlier identification and intervention protects children from lifelong damaging health effects posed by exposure to lead. NYSACHO continues to support any initiative aimed to protect children from exposure to lead IF there is adequate and flexible funding to ensure successful local level implementation.

During the FY 2020 budget process, the Executive allocated $9.4 million dollars in funding to support the expanded workload. With a six-fold increase in workload equating to over 17,000 new cases of exposure to follow, we anticipate the full cost of this program will be $46M. Given that many of the costs associated with adding additional staff are ineligible for Article 6 reimbursement, local governments have been unable to hire and appropriately resource this mandate. **We respectfully request that in FY 2021, a $46M investment be appropriated to the lead poisoning prevention and assistance program. All funding allocated to this mandate should be removed from the Department of Health aid for general public health work (PHL Article 6 state aid) and appropriated into the allocation in the Department of Financial Services for the lead poisoning prevention and assistance program**.

Adult Use Cannabis

NYSACHO opposes the State's intention to propose legislation to legalize adult-use cannabis in New York State as we firmly believe an adult-use cannabis program will lead to dangerous public health outcomes. It is for this reason, we recommend consideration of a slow and cautious approach, with the interest of public health and mental health at the forefront of decision making.

- Public health must be a major pillar of a regulated marijuana program and must be funded sufficiently to ensure harm reduction. We also respectfully request a seat at the table if or when legalization occurs in order to strategize around public health implications.

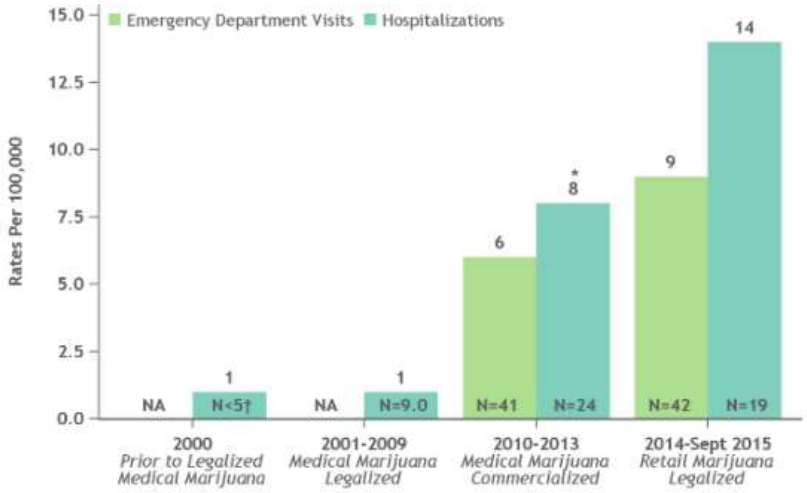
- If adult-use cannabis is legalized, local health departments will need flexible funding to expand workforce capacity in community education, prevention, intervention, enforcement and oversight.

Research and findings from our colleagues at Colorado Department of Public Health & Environment[1] and other evidence-based research reveals the following public health considerations:

Unintentional Exposures in Children

- At least 14,000 children in Colorado are at risk of accidentally ingesting marijuana products that are not safely stored, and at least 16,000 are at risk of being exposed to secondhand marijuana smoke in the home.
- Legal marijuana access is strongly associated with increased numbers of unintentional exposures in children which can lead to hospitalizations. A recent study identified measurable levels of tetrahydrocannabinol in breast milk samples up to 6 days after reported maternal marijuana use.

Figure 1. Children under 9 years of age; Rates of hospitalizations (HD) and emergency department (ED) visits with poisoning possibly due to marijuana in Colorado



Produced by: EEOHT, CDPHE 2016
*Rate significantly increased from previous time period with a p-value <0.001.
†ICD-9-CM codes 969.6 and E854.1, poisoning and accidental poisoning by psychodysleptics, were used to determine HD and ED visits with poisonings possibly due to marijuana.
‡The Ns are the total number of HD or ED visits with poisoning possibly due to marijuana in the specified time period.
§Data Source: Colorado Hospital Association 2000-Sept 2015 (2011-Sept 2015 for ED visits).

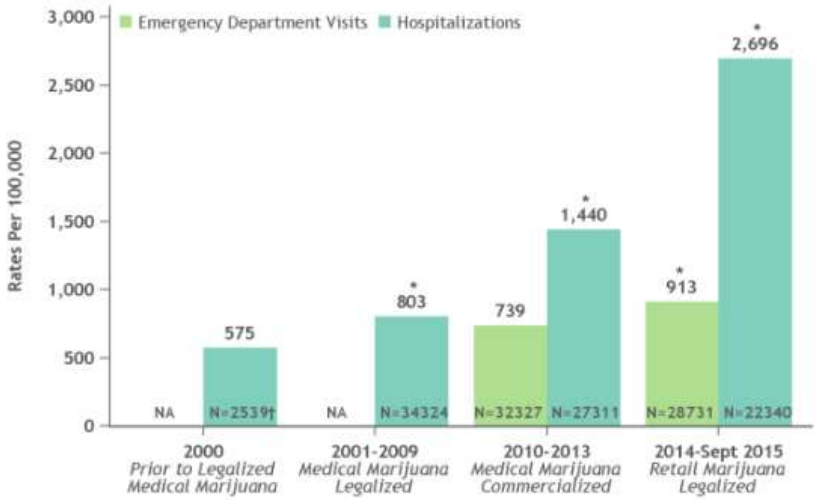
Cardiovascular Effects

- Marijuana use may be associated with increased risk of stroke in individuals younger than 55 years of age.
- Acute marijuana use may be associated with increased risk of heart attack among adults.

Marijuana Use and Driving

- Driving soon after using marijuana increases the risk of a motor vehicle crash.
- Using alcohol and marijuana together increases impairment and the risk of a motor vehicle crash more than using either substance alone.

Figure 3. Rates of hospitalizations (HD) and emergency department (ED) visits with marijuana-related billing codes in Colorado.



Produced by: EEOHT, CDPHE 2016
*Rate significantly increased from previous time period with a p-value <0.001.
†The Ns are the total number of HD or ED visits with marijuana-related billing codes in the specified time period.
‡ICD-9-CM codes 305.20-305.23, 304.30-304.33, 969.6, and E854.1 were used to determine HD and ED visits with marijuana-related billing codes.
§Data Source: Colorado Hospital Association 2000-Sept 2015 (2011-Sept 2015 for ED visits).

Respiratory Effects

- Marijuana smoke may deposit more particulate matter in the lungs per puff compared to tobacco smoke.
- Daily or near-daily marijuana smoking is strongly associated with chronic bronchitis, including chronic cough, sputum production and wheezing.

Cognitive and Academic Effects

- Weekly or more frequent marijuana use by adolescents and young adults is associated with impaired learning, memory, math and reading achievement, even 28 days after last use.
- Weekly or more frequent marijuana use by adolescents is strongly associated with failure to graduate from high school.
- Weekly or more frequent marijuana use by adolescents and young adults is associated with not attaining a college degree.
- Daily or near-daily marijuana use by adolescents and young adults is associated with developing a psychotic disorder such as schizophrenia in adulthood.

Substance Use, Abuse and Addiction

- Marijuana use by adolescents and young adults – even less-than-weekly use- is associated with future high-risk use of tobacco, and other drugs like cocaine, ecstasy, opioids and methamphetamine.

In addition to the above-mentioned findings, local health departments in NYS are committed to working to curb opioid addiction, overdose and death. As you know, New York State Department of Health recently funded 24 local health departments to run evidence-based opioid prevention projects. As public health professionals fighting on the frontlines of our current opioid epidemic, it is counterintuitive for us to condone the use of marijuana. According to the New England Journal of Medicine, "epidemiologic and preclinical data suggest that the use of marijuana in adolescence could influence multiple addictive behaviors in adulthood".

Recently, a new report from the federal Centers for Disease Control and Prevention (CDC) has confirmed a direct link between legally obtained adult use cannabis and the nation's outbreak of vaping related illnesses and deaths. The study found that the vast majority (82 percent) of patients suffering from a vaping illness had used a cannabis product. The study further found that at least one in six cases (16 percent) of reported THC-related vaping illnesses were caused by cannabis products purchased from legal sources, including dispensaries. Additionally, the study found 78 percent of the THC-related illnesses were linked to cannabis products that the user obtained from family, friends and other sources, some or much of which may have also been initially acquired from legal sources. County Health Officials are concerned about the intersection between legalization of adult-use cannabis and the upward trend in e-cigarette use among our youth.

We believe these concerns warrant at least a delay in legislative action on this issue. If policy on regulated marijuana does moves forward, this will increase workload for the already taxed public health workforce. We anticipate LHDs, who are reliably at the front line of all emerging public health crises, will need to expand workforce capacity in community education, surveillance, intervention strategies, enforcement, and beyond if regulated marijuana is

legalized. If this time should come, it is critical that adequate funding is dedicated to prevention strategies led by LHDs.

Executive Tobacco Control Policies

The Executive Budget Proposal contains several tobacco control provisions long supported by NYSACHO, and we urge the legislature to continue New York's historical leadership in addressing the health threats posed by tobacco use. These proposed policy changes would:

- Prohibit the sale of any flavored electronic cigarettes, liquid nicotine, or vapor products, except for tobacco flavored;
- Clarify the clean indoor air act's prohibition on smoking in places of employment covers all roofed areas;
- Prohibit the sale of tobacco products, herbal cigarettes, vapor product or electronic cigarettes in a pharmacy or in a retail establishment that contains a pharmacy;
- Prohibit the use of price-reduction instruments for tobacco or vaping products;
- Prohibit vapor products from being shipped to anyone in the state other than a registered vapor products dealer;
- Clarify that the Department has the authority to promulgate regulations that prohibit or restrict the sale of distribution carrier oils;
- Prohibit the display of tobacco products or electronic cigarettes in stores;
- Prohibit vapor product advertisements targeted at youth;
- Require manufacturers of vapor products to submit a list of ingredients to the Commissioner for publication;
- Increase penalties that may be assessed against retailers selling tobacco products to minors.

NYSACHO supports prohibition of the sale and distribution of all flavored tobacco products, including mint and menthol flavors. A U.S Department of Health and Human Service's 2014 report regarding tobacco use estimates that over 480,000 Americans die annually from tobacco-caused disease, making it the leading cause of preventable death. Tobacco products exact a high financial toll on New York taxpayers. Each year, New York spends an estimated $10.4 billion on tobacco-related health care needs, of which Medicaid covers $3.3 billion. An additional $6 billion annually can be attributed to lost productivity from smoking.

While conventional cigarette use had declined, electronic cigarette use continues to climb, and use of other tobacco products, such as smokeless tobacco, or hookah use, while not increasing, still appeals to adolescents and young adults. 81% of youth who ever tried tobacco chose flavored tobacco as their first tobacco product and this population is more likely to used flavored products compared to older adults. An October 2019 MMWR report noted that while use of flavored tobacco products other than e cigarettes has declined in middle and high school populations, of those who use at least one tobacco product, 64.1% reported using at least at least one flavored tobacco product in the past 30 days. Of that number, 65.2% used flavored e-cigarettes, 45.7% used menthol cigarettes, and 43.6%, 38.9 and 37.5% respectively used flavored cigars, bidis or smokeless tobacco.

Flavor bans work. In 2013 New York City prohibited the sale of flavored tobacco products and sales decreased by 87%. This bill would eliminate tobacco companies' ability to use flavors to entice young people into becoming regular users of tobacco products. Federal law bans flavors in cigarettes, but other flavored tobacco products can still be sold. Flavors such as mango, cotton candy, cinnamon roll and other fruit and dessert-like products are sold in bright packaging and are more often sold individually and cheaply, all characteristics specifically designed to appeal to adolescents and young adults. The continued sale of these products puts the public health gains related to strong tobacco control policies and education at risk.

Enforcement of tobacco control related statutes are under the jurisdiction of local health departments, or in some counties, the state department of health. Enforcement activities are conducted through spot checks of registered retailers, or as a result of complaints received

regarding potential non-compliance by retailers. Enforcement actions and any civil penalties are against the seller, and typically also involve additional education and information to assure that the retailer is aware of their legal compliance obligations. Under current law and in this proposal, there is no enforcement or penalties targeted at those who use or try to purchase regulated tobacco products. Public health activities regarding tobacco use focuses on education of children, adolescents and adults regarding the harm caused by these products and outreach to those who use tobacco products to encourage quitting and facilitate linkages to cessation services.

Early Intervention Program

The Executive Budget proposals includes anticipated savings related to the proposed implementation of statute regarding third party commercial reimbursement to providers, called "Pay and Pursue". The provisions of the proposal would:

- Require insurers to pay participating network providers, through the state fiscal agent, where the insurer's obligation to pay is "reasonably clear" regardless of whether there is a dispute regarding whether the EI service was medically necessary or not;

- Allow insurers to initiate a non-expedited external appeal or pursue a determination from an independent third-party review agent agreed upon by the insurer and provider to determine if the disputed service was medically necessary. The decision of the external agent or independent third party would be final and binding. If the decision finds that the service was not medically necessary, the insurer can recoup, offset or require a refund, which shall be a charge to the municipality and state, payable by the state fiscal agent within 90 days if the determination;

- Allow for insurer review of an EI service provider claims for medical necessity prior to making payments if an external agent or independent third party determines that the services of a provider were not medically necessary, in part of in whole, more than 60% of the time in a 12 month period;

- Permit insurers to continue to require preauthorization for EI services, and preauthorization requests denied by the insurer are not subject to the proposed statute.

While NYSACHO supports any effort to hold third party insurers accountable for their obligations to pay for Early Intervention services, our membership is working to compile recommendations that will strengthen the intent of this proposal. We look forward to working with the Governor and Legislature to improve the Early Intervention program which protects many children in New York State.

As you know, the Early Intervention program is facing severe erosion of provider capacity for this program, creating access issues for eligible families and children. During FY 2020, a 5% provider rate increase for specific service provider types was enacted. This rate increase, which applies to occupational therapy, physical therapy and speech language therapy services was a positive first step to addressing statewide provider capacity barriers. This action resulted in unforeseen consequence when providers outside of the eligible professions decided to leave the EI program due to perceived lack of recognition received from being excluded from the 5% rate increase. For this reason, NYSACHO requests the State expand the 5% provider rate increase to include all Early Intervention service provider types including service coordinators and evaluators using State invested dollars, while ensuring counties are held free from fiscal impact caused by such a rate increase.

Protecting Public Water Supply from Harmful Contaminants

Full service LHDs conduct oversight and monitoring activities and provide technical assistance to assure that public water supply operations achieve and maintain compliance with all state and federal laws and regulations. Environmental activities led by the State and Counties include: carrying out sanitary surveys; providing notice and reminders to public water supply operators regarding testing and reporting requirements; creating annual sampling schedules prepared through New York's Safe Drinking Water Information System (SDWIS); and monitoring to assure that testing is performed at the appropriate times throughout the year.

Environmental health staff employed at full-service LHDs work hard to assure the quality of drinking water and routinely face emerging issues that pose significant threats to water quality including road salt contamination, emergence of unregulated chemicals in drinking water, water main breaks and infrastructure damage, extreme weather conditions, agricultural impacts and harmful algal blooms.

In the face of these threats to our drinking water, LHDs continue to face ongoing resource limitations that undermine their capacity to respond and the 2% New York State property tax cap constrains local government budgets. When coupled with stagnant state funding, the result is that local health departments too often struggle to maintain current programs, much less enhance their ability to respond to the growing challenges of providing safe water for drinking and recreation. Extraordinary events, such as those faced in Hoosick Falls, stretch local health department resources and threaten to erode our already limited capacity to maintain other critical public health services. At both the federal and state levels, when a new public health threat emerges, there is a scramble to identify emergency funding for response and while emergency funding is helpful, it does not address the long term need for sufficient and stable funding to maintain a high-quality public health infrastructure and workforce, ready and trained to respond to new threats as they emerge.

New York State has made significant fiscal and programmatic enhancements to assist municipalities in protecting drinking water, the same cannot be said for support for the county-level role of monitoring and regulation of drinking water supplies. This year, the Executive Budget proposed an allocation of $2.5 billion over a 5-year period for Clean Water Infrastructure and Water Quality Protection. The total investment for Drinking Water Enhancement grants is only 0.2% of the entire appropriation for Clean Water Infrastructure and Water Quality Protection. the original appropriation for Drinking Water Enhancement grants was $6M, between 2009-2010 SFY and the 2013-14 SFY, the grants were cut by a cumulative 16%, and then have remained flat funded since 2013-14 despite growing public health needs and mandates.

To sustain the important work the State Department of Health and local health departments oversee with respect to protection of public water supply, we request:

1. Restoration of the drinking water enhancement grant funding to original 2007-2008 appropriation in funding at $6M.
2. Increase of drinking water enhancement grant funding to equal 1% of Clean Water Infrastructure Act appropriation, totaling $30M.
3. Legislative consideration for policy recommendations that strengthen and facilitate partnerships across state agencies and between those state and local government entities that share primary responsibility for assuring access to safe drinking water.
4. State level recognition of the impact the last several years of funding constraints on both the local and state public health workforce and work together to identify ways to maintain and enhance the capacity of our public health infrastructure. It is better to invest money into prevention and protection of drinking water now rather than wait for the next public health threat or emergency to occur.

Public Health Infrastructure and Funding to Localities for Medical Examiners and Coroners

Public health data, including data related to suicides, relies on multiple sources, including death reporting from medical examiners and coroners. Up until 2011, medical examiner services related to public health work were reimbursable under Article Six state aid. At that time, the state decided to remove that funding from the general public health work appropriation and move it to the Division of Criminal Justice Services. Local health departments, Medical Examiners and Coroners objected to this, due to a need to maintain independence from law enforcement when their work intersected with criminal investigations. The result was that state support for Medical Examiner services simply disappeared from the state budget.

These services have been a 100% county cost since that time, even though the state has relied increasingly on the Medical Examiner, Coroner system for public health surveillance. Their work is particularly vital to surveillance of emerging public health concerns related to the opioid epidemic and suicide prevention. NYSACHO urges the legislature to recognize the valuable

public health role of Medical Examiners and Coroners in the data collection, research and surveillance needed to identify trends and develop interventions, and work with NYSACHO and other county organizations to address the lack of state funding support for this critical public service.

There is a need for comprehensive, real-time data to inform interventions. According to one county, "Receiving data in a timely manner is a challenge as coroners may not show suicide as cause of death, especially if there is no clear evidence of depression prior to death. With the increase of opioid deaths in our counties, it is a challenge to determine whether the deaths are related to opioids or suicide." The need for real-time, standardized data is evident. The more comprehensive data LHDs must guide prevention activities, the more effective we will be in lowering rates.

Our recommendation is for the State of New York to provide for a 50-50 state and local match for counties investigating unattended deaths. Funding will support efforts by coroners and medical examiners to perform autopsy, pathology, and toxicology services including the identification of real-time trends such as prescription medication and drug abuse, lethal activities, and to alert the appropriate county and State agencies, and the public of these dangers.

Conclusion

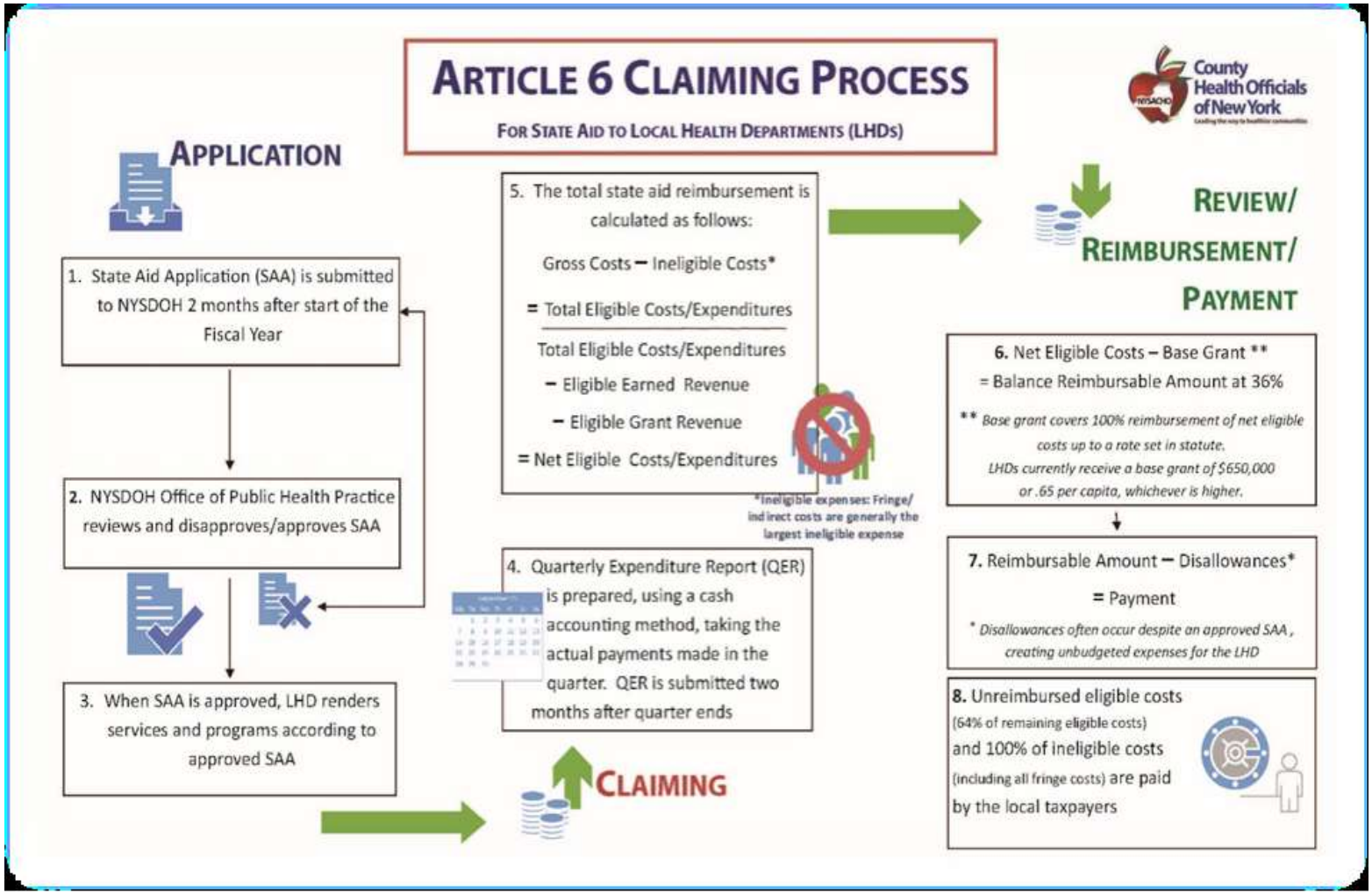
Public health work is rapidly moving from prevention to triage. With each new state mandated public health policy, we grapple with legal, fiscal and ethical choices. Do we cut back on restaurant inspections to monitor cooling towers for legionella? Will we have to delay lead remediation interventions for a child with elevated blood lead levels because the mandated costs of the Early Intervention program have forced us to eliminate or leave public health positions unfilled? Will we reduce or eliminate our maternal-child health home visits because we need our public health nurses to address communicable disease outbreaks? These are real life decisions that can have long-term, life-altering, and potentially deadly consequences. We

must engage in frank assessments of what is best for our citizens in terms of progressive public health policy, including both local and state resource availability and needs, if the state is committed to achieving our public health goals.

We believe that you are so committed, and we ask for your support to ensure we are provided with the state resources necessary to fulfill our many critical missions.

Resources

1. Monitoring health concerns related to marijuana in Colorado, 2015: changes in marijuana use patterns, systematic literature review, and possible marijuana-related health effects. Colorado Department of Public Health and Environment, Retail Marijuana Public Health Advisory Committee-2017.
2. Bertrand KA, Hanan NJ, Honerkamp-Smith G, et al. Marijuana Use by Breastfeeding Mothers and Cannabinoid Concentrations in Breast Milk. Pediatrics. 2018; 142(3):e20181076.
3. Health Impact Assessment, Marijuana Regulation in Vermont, 2016. Vermont Department of Public Health.
4. Volkow, ND, Baler, RD, Compton, WM, et al. Adverse Health Effects of Marijuana Use. N Engl J Med. 2014; 370:2219-27.
5. Ellington, S, Salvatore, P, Ko, J, et al. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report (MMWR). Update: Product, Substance-Use, and Demographic Characteristics of Hospitalized Patients in a Nationwide Outbreak of E-Cigarette, or Vaping, Product Use-Associated Lung Injury-United States, August 2019-January 2020.
6. County Health Rankings Model. Retrieved from: https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model on January 28, 2020.


ARTICLE 6 CLAIMING PROCESS
FOR STATE AID TO LOCAL HEALTH DEPARTMENTS (LHDS)
County Health Officials of New York
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
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
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
*Ineligible expenses: Fringe/ indirect costs are generally the largest ineligible expense
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