

Restoring the Partnership for American Health

Counties in a 21st Century Health System

Full Partners:

County governments are integral to America's current health system and will be crucial partners in achieving successful reform. At the most basic level, county officials are elected to protect the health and welfare of their constituents. County governments set the local ordinances and policies which govern the built environment, establishing the physical context for healthy, sustainable communities. County public health officials work to promote healthy lifestyles and to prevent injuries and diseases. Counties provide the local health care safety net infrastructure, financing and operating hospitals, clinics and health centers. County governments also often serve as the payer of last resort for the medically indigent. County jails must offer their inmates health care as required by the U.S. Supreme Court. Counties operate nursing homes and provide services for seniors. County behavioral health authorities help people with serious mental health, developmental disability and substance abuse problems who would have nowhere else to turn. And as employers, county governments provide health benefits to the nearly three million county workers and their retirees nationwide. Clearly, county tax payers contribute billions of dollars to the American health care system every year and their elected representatives must be at the table as full partners in order to achieve the goal of one hundred percent access and zero disparities.

Local Delivery Systems – Access for All:

NACo believes that reform must focus on access and delivery of quality health services. Coverage is not enough. County officials, particularly in remote rural or large urban areas know that even those with insurance may have difficulty gaining access to the services of a health care provider, which can be exacerbated by the severity of their illness. Insurance carriers participating in public programs should be required to extend coverage into rural areas and to contract with local providers. Local delivery systems should coordinate services to ensure efficient and cost-effective access to care, particularly primary and preventive care, for underserved populations. County governments are uniquely qualified to convene the appropriate public and private partners to build these local delivery systems in a way that will respect the unique needs of individuals and their communities. A restored federal commitment to such partnerships is necessary for equity's sake.

Public Health and Wellness:

NACo believes that a greater focus on disease and injury prevention and health promotion is a way to improve the health of our communities and to reduce health care costs. Disease and injury prevention and health promotion services can be delivered by a health care professional one patient at a time. Local health departments, in partnership with community based organizations and traditional health care providers, deliver community-based prevention services targeted at an entire population. Population-based prevention services can save money by keeping people healthy and reducing the costs of treating unchecked chronic disease. These critical services include assessment of the health status of communities to identify the unique and most pressing health problems of each community and health education to provide individuals with the knowledge and skills to maintain and improve their own health. The public health response to emergencies should be fully integrated into each county's emergency management plan. Local public health considerations likewise should be systematically integrated into land use planning and community design processes to help prevent injuries and chronic disease. Policies are also needed to address health inequity, the systemic, avoidable, unfair and unjust differences in health status and mortality rates, as well as the distribution of disease and illness across population groups. Investing in wellness and prevention across all communities will result in better health outcomes, increased productivity and reduce costs associated with chronic diseases.

Expanding Coverage:

NACo supports universal health insurance coverage. Existing public health insurance systems should be strengthened and expanded, including Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP). As states and counties attempt to shoulder their legislatively mandated responsibilities to provide care for the indigent and uninsured, federal regulatory barriers should be removed to allow flexibility and innovation at the local level. Restrictions on the expansion of County Organized Health Systems should be lifted and they should be authorized to serve as a public plan option in their service areas. Furthermore, in the effort to expand coverage, reformers should not forget that the coverage must be meaningful, without imposing additional mandates on county governments. The benefit package must be defined so as to provide the full range of services people need, including prevention services, pharmaceuticals, dental, full parity for behavioral health, substance abuse and developmental disability services. Barriers to cost-effective treatments, like living organ donation, should be removed.

Maintaining a Safety Net:

NACo believes that the intergovernmental partnership envisioned in the Medicaid statute should be restored and strengthened. Medicaid reimbursement rates should be enhanced and increases to the Medicaid federal medical assistance percentage (FMAP) should be passed through to counties contributing to the non-federal share. Local safety nets, supported by Medicaid and disproportionate share hospital (DSH) payments, should not be dismantled to “pay for” universal coverage. We must not allow the safety net infrastructure to be undermined. County hospitals and health systems provide surge capacity, emergency and trauma services and other critical high cost services like neo-natal, HIV/AIDS and burn care. Safety net hospitals will continue to need extra support to carry out their missions, including addressing health disparities. Health care is not just coverage it is also access and it is the safety net hospitals where translation services for hundreds of languages can be found.

DSH payments address two otherwise unreimbursed costs: (1) services provided to the uninsured and underinsured; and (2) Medicaid reimbursement rates that pay less than the cost of providing health services. It is too early to predict the net effect of Medicaid expansion and reimbursement reform. In addition, unfortunately, there will always be some individuals who will remain uninsured. These and other at-risk populations financed by DSH are unlikely to be among the groups to be covered in the initial stages of reform. All individuals, including the uninsured, should receive treatment and DSH supports that care. Therefore DSH payments should not be phased out or down until health care reform is fully implemented and its effects on DSH payments can be accurately assessed. Assumptions should not be made that DSH can be cut by any arbitrary amount on some arbitrary timeline during the implementation of health care reform.

Health Workforce:

NACo believes that the health professional and paraprofessional workforce must be supported and enhanced. It is important that we sustain training programs and sites of service that enable us to develop a complement of health professionals that can address the needs of a changing, growing and aging population.

Public hospitals have often been teaching hospitals. The sites of service include hospitals, outpatient clinics, and community health centers. These settings provide access for patients seeking care, and a diverse set of patient conditions and cultures that make for a

comprehensive learning experience. Reasonable medical education funding is an integral part of the business model of these institutions.

Every effort should be made to recruit, train, license and retain health professionals, and allied professionals and paraprofessionals, on an expedited basis. A large body of evidence supports the contribution of direct care staff, nurses and nursing assistants, to quality outcomes. Funding for existing education and training programs – in secondary, post-secondary and vocational educational settings – should be increased and targeted towards initiatives to expand and diversify the health workforce. Partnerships between local economic developers and workforce development professionals should be encouraged to meet growing health care sector demand. Targeted incentives including scholarships, loan forgiveness and low-interest loan repayment programs should be developed to encourage more providers to enter and remain in primary care and public health careers. Primary care providers should be empowered to – and compensated for – case management services.

Health IT:

The federal government should support the integration of health information technologies into the local health care delivery system. NACo supports the President's goal of implementing a nation-wide system of electronic health records in five years. NACo supports efforts to promote the use of a range of information technologies to facilitate appropriate access to health records and improve the standard of care available to patients, while protecting privacy. This includes deployment of broadband technologies to the widest possible geographic footprint. Other tools facilitate evidence-based decision making and e-prescribing. Using broadband technologies, telemedicine applications enable real-time clinical care for geographically distant patients and providers. Remote monitoring can also facilitate post-operative care and chronic disease management without hospitalization or institutionalization.

Long Term Care:

Federal policies should encourage the elderly and disabled to receive the services they need in the least restrictive environment. Since counties provide and otherwise support long term care and other community based services for the elderly and disabled, state and federal regulations and funding programs should give them the flexibility to support the full continuum of home, community-based or institutional care for persons needing assistance with activities of daily living. Nursing home regulatory oversight should be reformed in order to foster more person-centered care environments.

Jail Health:

Reforming America's health care system must include reforms to its jail system. Counties are responsible for providing health care for incarcerated individuals as required by the U.S. Supreme Court in *Estelle v. Gamble*, 429 U.S. 97 (1976). This unfunded mandate constitutes a major portion of local jail operating costs and a huge burden on local property tax payers. The federal government should lift the unfunded mandate by restoring its obligation for health care coverage for eligible inmates, pre-conviction. Furthermore, a true national partnership is needed to divert the non-violent mentally ill from jail and into appropriate evidence-based treatment in community settings, if possible. Finally, resources should be made available to counties to implement timely, comprehensive reentry programs so that former inmates have access to all the health and social services, including behavioral health and substance abuse treatment, to avoid recidivism and become fully integrated into the community.