January 6, 2017

The Honorable Kevin McCarthy
Majority Leader
United States House of Representatives
U.S. Capitol Building, Room H-107
Washington, D.C. 20515

The Honorable Kevin Brady
Chairman, Committee on Ways and Means
United States House of Representatives
1011 Longworth House Office Building
Washington, D.C. 20515

The Honorable Greg Walden
Chairman, Committee on Energy and Commerce
United States House of Representatives
2185 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Virginia Foxx
Chairwoman, Committee on Education and the Workforce
United States House of Representatives
2262 Rayburn House Office Building
Washington, D.C. 20515

Dear U.S. House Leadership:

Re: December 2, 2016 Letter to Governors and Insurance Commissioners Seeking Health Care Recommendations

On behalf of the National Association of Counties (NACo) and the 3,069 counties we represent, we thank you for soliciting input on major health reforms to strengthen and improve the health of all Americans. A strong federal-state-local partnership is critical to the success of our local health systems, which serve our most vulnerable citizens. Although each state is different, county governments play an integral role in paying for and providing health services, including financing and delivering Medicaid services. As you consider changes to the nation's health care system, especially Medicaid, we respectfully urge you to consider implications of reforms that would merely shift federal and state Medicaid costs to counties and local taxpayers.

Nationally, counties invest $83 billion annually in community health for more than 300 million residents nationwide. Through 961 county-supported hospitals, 883 county-owned and supported long-term care facilities, 750 county behavioral health authorities and 1,943 county public health departments, counties deliver health services to millions of Americans, including many Medicaid beneficiaries. Our county-supported health systems are the cornerstones of care in our communities.

Counties have always served as a social safety net in our communities, including providing health care for America's low-income populations. Over the past 50 years, the Medicaid program has been crucial in helping counties fulfill this obligation. The majority of states mandate counties to provide some level of health care for low-income, uninsured, or underinsured residents—care that is often not reimbursed. In Harris County, Texas, for example, residents pay more than $500 million per year in property taxes to cover the cost of uncompensated care in the county's public hospitals.

If changes are made to shift additional federal and state health and Medicaid responsibilities and costs to counties, this will create an even more challenging dynamic at the local level as many states already restrict counties' ability to raise revenue. In fact, thirty-eight states impose some limitation on counties' property tax rates and property assessments, which are typically the primary revenue sources for counties. Nonetheless, counties continue to invest in local health systems, even during economic downturns.

In 26 states, counties contribute to the non-federal share of Medicaid. In fact, local governments, including counties, may contribute up to 60 percent of the non-federal share of Medicaid costs in each state. For instance, counties in New York send approximately $140 million per week to the state for Medicaid costs. In Fiscal Year 2012 alone, local governments contributed $28 billion overall to the Medicaid program. Proposals to institute block grants or per capita caps for the Medicaid program would further shift federal and state Medicaid costs to counties and compromise our ability to provide health coverage, especially during economic recessions.

Counties have made the most of Medicaid's flexibility to construct health systems that serve a disproportionate share of low income populations, including the underinsured and uninsured, the homeless and those cycling in and out of county jails. County supported health safety net systems provide specialized care that is often unavailable elsewhere while operating on lower margins than other providers. Already, these health systems are subject to impending federal cuts to the Medicaid disproportionate share hospital (DSH) payments. Without sustained funding, these county hospitals will not be able to keep doors open.

Over 70 percent of America's counties have populations of less than 50,000, and the Medicaid program is especially important to these small and rural counties. Medicaid covers 21 percent of rural residents, compared to only 16 percent of those who reside in urban areas. Rural clinics receive enhanced Medicaid reimbursements and Medicaid payments account for more than 14 percent of rural hospitals' gross revenue. More than 75 rural hospitals have closed since 2010, and further cuts would endanger many more.

Health workforce shortage is also a key challenge, especially in our small and rural counties. The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas. Nearly one-third of rural physicians receive at least 25 percent of patient revenues from Medicaid reimbursements. This revenue is essential to helping these counties retain much needed health professionals, especially as they care for an older population than their urban counterparts.

As drug overdose deaths outpace car accidents as the leading cause of accidental deaths, it must be reinforced that Medicaid is still the largest source of funding for behavioral health services in the U.S. Our county public health departments and behavioral health authorities are engaged in key prevention and treatment initiatives from educating patients and families to expanding access to medication-assisted treatments. As the nation struggles to combat the opioid epidemic, counties are at the frontlines and need a strong federal partner to reverse course.

In addition to being the front door to our nation's health system, counties are also the entry point into the criminal justice system. Counties are required by federal law to provide health care for the 11.4 million individuals who pass through 3,100 local jails each year, 91 percent of which are operated by counties. Unlike in federal or state-operated prisons, the

majority of individuals in local jails are pre-trial and low-risk and the average length of stay is only 23 days.

Federal statute prohibits federal Medicaid matching funds from being used for medical care provided to individuals in jails, even for those who are awaiting trial and presumed innocent until proven otherwise. This population is much sicker than the general population, with 64 percent having a mental illness, 68 percent a history of substance abuse and 40 percent a chronic health condition (e.g., cervical cancer, hepatitis, arthritis, asthma or hypertension). 95 percent of these individuals will return to their communities, bringing their health conditions with them. Our goal is to ensure that they receive appropriate treatment in jail that allows them to successfully integrate back into society and contribute to local economies.

To make matters more challenging, many states terminate, instead of suspend, Medicaid for justice-involved individuals the moment they are booked into jail, even before they are given due process. These individuals then must completely re-enroll in Medicaid after being released from jail, which can take months. Not only does this coverage gap leave health conditions like mental illnesses and substance abuse untreated, it can lead to re-arrests and increased recidivism, putting further strain on law enforcement professionals and other social services. As you consider providing further flexibility in the Medicaid program, we urge you to look at models that improve care coordination and health outcomes for those involved in the justice system.

Counties' multifaceted role in health care extends beyond that of a health payer, provider and administrator; counties also provide health insurance to our workforce. Offering competitive health care benefits is one of the primary ways counties attract and maintain a quality workforce. Counties provide health benefits to an estimated 2.5 million employees and nearly 2.4 million of their dependents. For health insurance premiums alone, counties spend an estimated $20 billion to $24 billion annually. We urge you to fully repeal the Cadillac Tax and protect employer-sponsored health coverage.

As one of the earliest units of local government established in the original thirteen colonies that would become the United States, our counties have always evolved in order to serve our residents in partnership with states and the federal government. We stand ready to work with you to identify new and innovative strategies to strengthen our nation's health system and provide high-quality coverage and access to care for all of our residents while being responsible stewards of local taxpayer dollars.

If you have any questions, please feel free to contact Brian Bowden, NACo's Associate Legislative Director for Health, at bbowden@naco.org or 202.942.4275.

Sincerely,

Matthew D. Chase
Executive Director
National Association of Counties