

# HEALTH

## STATEMENT OF BASIC PHILOSOPHY

County governments are integral to America's current health care system and will be crucial partners in achieving any 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 disease. 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, including many veterans. County jails must offer their inmates health care as required by the U.S. Supreme Court. Counties operate nursing homes for low-income seniors. County behavioral health authorities help people with serious mental health, developmental disability, and substance abuse problems that would have nowhere else to turn. And as employers, county governments provide health insurance to the nearly three million county workers 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.

## HEALTH SYSTEM REFORM

- A. Vision and Purpose:** County governments are integral to America's current health system and will be crucial partners in achieving successful ongoing and continuous reform. At the most basic level, county officials are elected to protect the health and welfare of their constituents. 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 goals of access for all improved quality of care, improved cost efficiency of services and the elimination of disparities. NACo supports implementing – and making improvements to – the Affordable Care Act (ACA), by regulation and additional legislation, in order to enhance the ability of county governments to build healthy, safe and resilient communities. To that end, NACo endorses the following components of health system reform:
- B. Local Delivery Systems and Access for All:** NACo supports ongoing system reform that focuses on improving access to and delivery of quality health services for all. Health insurance coverage is not enough. Insurance carriers participating in public programs should be required to extend coverage into rural areas and to contract and coordinate with local providers. Local delivery systems should coordinate services to ensure efficient and cost-effective access to care, including primary and preventive care, behavioral health vision care and oral health, 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 and should be offered financial incentives and regulatory flexibility to do so. Also, County governments are uniquely positioned to optimize the local service delivery system by implementing cost-effective services and eliminating redundancy and waste in the delivery system.
- C. Public Health and Wellness:** NACo supports an ongoing enhanced 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. Healthy communities depend upon a full array of interrelated county services and programs which include access to healthy foods, community development plans, and public works

infrastructure projects that promote healthy living and access to affordable housing and shelter. Local public health considerations should be systematically integrated into land use planning and community design processes to help prevent injuries and chronic disease. Likewise, the public health response to emergencies should be fully integrated into each county's emergency management plan. 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.

- D. Expanding Coverage:** NACo supports universal health care for all with universal health insurance coverage. Existing public health insurance systems should be strengthened and expanded, including Medicare, Medicaid and the Children's Health Insurance Program (CHIP). 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.
- E. Maintaining a Safety Net:** NACo believes that the intergovernmental partnership envisioned in the Medicaid statute should be strengthened. NACo supports the enhanced Medicaid reimbursement rate for the ACA expansion population and the provision requiring the federal medical assistance percentage (FMAP) to be passed through to counties contributing to the nonfederal share. Local safety nets, supported by Medicaid and disproportionate share hospital (DSH) payments, should not be dismantled to "pay for" universal coverage. DSH payments should not be phased out or down until health insurance coverage expansion and other delivery system reforms are fully implemented and the 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.
- F. 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. Because public hospitals have often been teaching hospitals, NACo supports reasonable medical education funding as an integral part of the business model of these institutions.

NACo supports initiatives and programs to recruit, train, license and retain health professionals, and allied professionals and paraprofessionals, on an expedited basis. 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.

- G. Health IT:** NACo believes the federal government should support the integration of health information technologies into the local health care delivery system, including the behavioral health and substance use treatment systems and county jail health systems. 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.
- H. 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.
- I. Jail Health:** NACo believes the federal government should provide health care coverage for otherwise eligible county detainees (including many veterans), pending disposition of charges. 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 pre-trial and re-entry programs so that justice involved individuals will have access to all needed health and social services, including behavioral health and substance abuse treatment, to avoid recidivism and become fully integrated into the community.

## **MEDICAL LIABILITY REFORM**

NACo supports medical liability reform that:

- Is a means to prevent a patient's loss of access to needed medical care;
- Requires pre-trial professional review of cases to discourage frivolous lawsuits without obstructing the rights of citizens to due process;
- Requires medical liability insurance carriers to justify rate increases that exceed the established state rate; and
- Subjects providers of inadequate medical care to professional discipline.

NACo opposes medical liability reform that imposes mandates or usurps state authority.

## **HEALTH CARE FINANCING**

NACo supports:

- Federal and state governments' efforts to appropriately and adequately fund essential health services;
- Providing adequate funding to local governments to carry out essential health and administrative functions;

- The use of intergovernmental transfers (IGTs) as an essential means for maximizing the utilization of public funding from all three levels of government;
- An emphasis on primary prevention and health education services as the best tools to contain costs;
- National reporting on health trends or activities that recognize and include the services provided by county government;
- Proposals that enhance federal assistance and increase funding to counties for health services;
- Requiring individuals to pay for their public program coverage on an ability to pay, sliding fee scale basis;
- Providing county public hospitals, participating in the 340B program, with the same discount for inpatient prescription drugs they receive for outpatient prescription drugs. The 340B program should be expanded to include county behavioral health authorities;
- Encouraging case managers and managed health care entities to recognize and use county and other public providers and reimburse them for care provided to Medicaid managed care patients;
- Using alternative delivery methods and treatment settings to reduce costs;
- Redesigning federal and state reimbursement systems to reflect the unique responsibilities of county run health care facilities;
- Ensuring that county health programs are eligible for the same federal reimbursements available to federally funded entities;
- Public reimbursement for services provided to the uninsured and special populations by any provider or profession licensed or authorized by the state to provide health services; and
- A variety of strategies which assist in cost containment for prescription drugs.

NACo opposes:

- Capping federal health care entitlement programs;
- Measures that shift costs to counties; and
- Activities that hamper counties' ability to negotiate the best possible prices for prescription drugs.

## **PUBLIC HEALTH**

**A. Infrastructure:** Each county should be served by a strong local public health agency. The elements of a strong infrastructure include a skilled workforce, integrated electronic information and communication systems and effective organization and management. NACo supports:

- The concepts and standards for local public health departments as outlined in the voluntary Public Health Accreditation Standards and Measures;
- Active partnerships among the county's health care community and other public and private organizations concerned with health;
- Sustained federal support for building and maintaining a local public health infrastructure that is linked with state and federal public health systems; and
- Federal scholarships, loan repayment programs, and direct support for training of all public health professionals particularly those in shortage areas.

**B. Preparedness:** Local governments and local public health departments are the first responders to public health emergencies. Every county must be protected by a fully prepared governmental public health system. NACo supports:

- Sustained and ample federal funding for public health preparedness;
- Full integration of the public health response to emergencies into each county's emergency management plan; and
- Federal requirements that allocate a substantial proportion of federal funds to localities.

**C. Chronic Disease Prevention:** Successful chronic disease prevention requires a combination of individual responsibility for health behaviors and community support for healthy living. NACo supports:

- Collective action at the federal, state, and county levels to create programs, policies, and practices that encourage and facilitate healthy living and appropriate behavioral change;
- Systematic integration of local public health considerations into land use planning and community design processes;
- Policies and programs to improve wellness;
- FDA regulation of tobacco without preemption of stronger local laws and regulations; and
- Federal and state governments and the private sector to collaborate with counties in reducing health care costs associated with preventable disease and disability by creating and supporting programs and actions that promote healthy behavior and the early detection and treatment of preventable diseases.

**D. Infectious Disease Control:** County public health is responsible for the control of communicable diseases.

**1. Immunizations:** NACo supports:

- Increased federal appropriations for immunization programs to provide vaccines to under/uninsured children and other at-risk populations; to build sustainable infrastructure for immunization assessments and immunization outreach and coverage. Immunization programs should include public health departments and public health nurses as access points for vaccines; and
- Federal purchase and distribution of influenza vaccine during pandemic seasons to address problems of vaccine shortages, delays in deliveries and vaccine availability.

**2. HIV/AIDS:** NACo supports:

- Policies that facilitate local flexibility in the use of funds for HIV/AIDS prevention;
- Full funding and reauthorization for the Ryan White CARE Act;
- Uniform federal requirements for reporting of HIV testing and a national voluntary partner notification program; and
- Continuous training on infection control techniques for all health care workers.

**3. Tuberculosis Control:** NACo supports:

- Federal funding for local public health departments to provide effective community based TB control services, including supervised therapy; and
- Federal immigration policies that support TB assessment and control before immigrants enter the United States.

**E. Environmental Health:** Public health departments at the county level work to prevent diseases caused by environmental factors such as unsafe food, housing, and waste management. NACo supports:

- The formation of a federal/state/local partnership in the establishment, delivery and funding of environmental health protective services;
- The early and continuous involvement of county officials, as the lead contact, and public health authorities in steps taken under the Environmental Protection Agency's (EPA) Superfund statute to assess hazardous waste and disaster sites, place them on the National Priorities List, and establish and implement appropriate cleanup plans. EPA's involvement with local authorities should include immediate notification of site discovery;
- Appropriate testing for lead poisoning according to the Centers for Disease Control and Prevention guidelines, providing appropriate medical and environmental follow-up incentives based on financial need to help finance solutions to lead related hazards and the reporting of cases of lead poisoning to state and local health departments; and
- Establishment of a national collaborative science-based food safety system that will integrate and fund food safety activities, provide support for county authorities who have primary front-line responsibility for the inspection and compliance of food service establishments and address consumers' behavior related to safe food handling practices.

**F. Injury Prevention:** Injuries and resulting deaths, particularly those from intentional and unintentional violence, including those from the use of firearms and other weapons, are critical public health and safety concerns. NACo supports:

- Enhanced federal assistance and increased funding for public health science, programs, and services to prevent injuries;
- Collaboration among public safety, law enforcement, and public health departments; and
- Promotion of all strategies to reduce injury-caused disability and death.

**G. Clinical Preventive Services and Health Education:** Public health departments at the county level provide clinical preventive services and health education through such programs as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), family planning clinics, and health and sexuality education programs for adolescents. NACo supports:

- The WIC program and other vital child nutrition programs and urges continued funding for them;
- Comprehensive sexuality education for adolescents, including education about abstinence, resisting peer pressure, pregnancy, sexually transmitted diseases, and HIV/AIDS; and
- Family planning programs that provide information on a wide range of family planning methods with sensitivity to the religious beliefs of the client or recipient. Physician-patient communications should not be dictated, defined or restricted by laws or regulations that restrict a patient's right to medical information and legal medical procedures.

## **RURAL HEALTH**

NACo supports:

- Elimination of the urban-rural difference in Medicare payments for hospitals;
- Full funding of the geographic blend for Medicare + Choice;

- Tax relief for National Health Service Corps scholarships;
- Tax incentives for health professionals practicing in rural/underserved areas;
- The Rural Hospital Flexibility Grant program for facilities examining their service and financial role in the community;
- Reforms to the Graduate Medical Education program to produce more primary care providers;
- The J-1 visa program which allows foreign medical graduates to practice in underserved areas of the United States;
- Extended Medicare reimbursement for telemedicine to all rural areas and expanded coverage;
- Health Services Outreach grants to enhance services to vulnerable populations;
- Initiatives to enhance rural health research, farm safety, and health and state rural health clearinghouses;
- Initiatives that encourage the assignment of dental students' participation in the oral health of underserved communities; and
- Initiatives that integrate the efforts of multiple health disciplines in an approach to promote total health and well-being.

### **INDIAN HEALTH SERVICE**

NACo supports requiring the U.S. Department of Health and Human Services' Indian Health Service to pay for the full cost of health care for enrolled tribal members who live on Indian trust lands, including reimbursement for care given at county facilities.

### **LONG-TERM CARE**

County governments provide and purchase long-term health care. Federal policies and funding must recognize the role and responsibilities of county governments as safety net providers, in assuring necessary and effective services for the elderly and disabled, including community-based and long-term care services. NACo supports:

- Services provided in the least restrictive environment;
- Additional administrative flexibility in federal health financing programs to encourage and enable the expansion of community-based care as a means of avoiding unnecessary institutional care;
- A continuum of home, community-based or institutional care services, including room and board, for persons needing assistance with activities of daily living (ADL);
- The availability of Supplemental Security Income (SSI) and Medicaid to persons residing in community-based and home-based services;
- The availability of long-term care tax credits; and
- Incentives and support for informal caregivers.

**A. Medicare Reimbursement for Skilled Nursing Facilities (SNFs):** SNFs provide needed rehabilitation and skilled nursing for their residents. To ensure access and quality care, NACo supports reimbursement formulas that account for high cost, medically complex patients and that reflect annual changes in the prices of SNF outputs.

**B. Survey and Certification:** NACo supports:

- The use of benchmarking and outcome measurement systems to determine quality of long-term care services. Those systems should provide objective results that can be easily compared with other providers;
- Collaboration between providers and regulators to fix problems and empower staff to improve quality;
- Clear distinctions between serious offenses and minor offenses;
- Reinvesting fines collected from providers to improve care;
- Devoting more survey resources to poor performing providers; and
- Recognition of providers that are outstanding performers.

**C. Staffing Requirements:** Staff turnover is a major obstacle to continuity and quality of care. NACo supports:

- Staff empowerment rather than mandated staff ratios to achieve quality care and retention;
- Medicaid and Medicare funding which recognizes the cost and importance of adequate staff; and
- The ability to hire and train more staff of varying skill levels to help provide long-term care services.

## **BEHAVIORAL HEALTH**

**Vision and Purpose:** The National Association of Counties (NACo) seeks to (1) improve the responsiveness, coordination, accountability, and integration of person-centered behavioral health services to provide timely and appropriate help to individuals, families, and communities; (2) reduce mental health crises, homelessness, and incarceration by strengthening community based services, including early intervention, outreach, engagement, prevention, crisis support, rehabilitation, housing, employment and peer run services for persons of all ages; and (3) ensure that all Americans with mental illnesses, substance use conditions, or intellectual/developmental disabilities, and their families can gain access to evidence-based and emerging best practices based on the values and principles of trauma-informed care and mental health recovery, delivered in a culturally and linguistically competent manner, to ensure that they can fully participate and/or regain full lives in the most integrated settings within their chosen communities.

**NACo Positions:** Counties represent a major cornerstone for behavioral healthcare services in the United States. They plan, operate and finance public community-based services for persons with mental illnesses, substance use conditions or intellectual/ developmental disabilities. For this reason, NACo has endorsed the positions summarized below.

### **NACo Supports:**

#### **Services Development**

- Improved community-based care and services enabling individuals to live in the least restrictive environment;
- Implementation of evidence-based prevention and health promotion services;
- Efforts to increase the number of public sector behavioral health professionals and paraprofessionals;
- Efforts to reduce health disparities in behavioral health services with health literacy, language services, and cultural competency training.



**Financing of Services**

- Extension of Medicaid and VA health care benefits to persons detained in county jails, pending disposition of charges;
- Medicaid waivers for essential behavioral health innovations;
- States' managed care waiver requests which offer sole source provisions for providing behavioral health services.

**Insurance Reform**

- Private and public insurance coverage of behavioral health services, including non-medical interventions;
- Parity in coverage and availability of behavioral health services with other health services, regardless of payer source;
- The removal of Employee Retirement Income Security Act (ERISA) exemption of self-insured plans from state insurance regulation, including extending federal behavioral health parity requirements to such plans;
- Parity of mental health and substance use benefits in Medicare, in Medicaid beyond the Medicaid expansion, and in all private health insurance plans, including small business plans.
- Cost controls allowing the availability of the most effective medications at the lowest cost.

**Federal Government Support**

- Federal funding and legislation to divert non-violent persons with mental illness, substance use and intellectual/developmental disability conditions from county jails and into appropriate care;
- Federal government support and development of behavioral health information, services and research; particularly into causes and cures and the promotion of those findings;
- The National Institute of Mental Health's efforts to promote systems that finance and deliver care in community settings including reducing federal categorical restrictions;
- Full funding and reauthorization for the Substance Abuse and Mental Health Services Administration (SAMHSA);
- Increased federal funding for school-based behavioral health services targeted to at-risk youth.

**Regulatory Reform**

- State and local flexibility in using substance use and mental health block grants funds to address local problems, including services for persons with co-occurring disorders;
- State flexibility for integrated and concurrent treatment programs for persons with co-occurring disorders;
- Amending Medicaid's Institutions for Mental Disease (IMD) exclusion to promote better access to services;
- Federal policies that support the development and funding of long-term mental health support services to counties which experience major natural and manmade disasters;
- State flexibility in determining the length of participation in mental health or substance use treatment that would count toward Temporary Assistance for Needy Families (TANF) work requirements.

**NACo Opposes:**

## **Regulatory Reform**

- Federal regulations that may exempt state licensing and certification standards or regulations;
- Federal mandates that require states to have a competitive bidding process for when counties are acting as purchasers on behalf of the state; and
- Federal categorical restrictions that limit needed services available to persons with mental illness, substance use or intellectual/developmental disability conditions.

## **MEDICAID AND INDIGENT CARE**

The current Medicaid program reflects four decades of national consensus that the federal government bears primary responsibility for providing health care to the country's most vulnerable citizens. This consensus and the unique federal, state and county partnerships in administering and financing Medicaid services should inform all changes to the system. Such reforms must require state Medicaid agencies to include county officials in state decisions regarding the design and administration of the Medicaid program in each state. NACo supports:

- Fiscal relief to state and local governments to protect the Medicaid program;
- An increase in the federal medical assistance percentage (FMAP):
  - Any proposal for an increase in the FMAP should protect current eligibility for Medicaid and have a memorandum of understanding (MOU) that current Medicaid eligibility within a state will be sustained;
  - To the greatest extent possible, any proposal for an increase in the FMAP should be exclusively in the form of an increase in the state's FMAP and not in the form of a block grant; and
  - Any FMAP increase must be passed through to counties commensurate with their financial contributions to the program.
- The state option to use provider taxes to raise a portion of their non-federal share for Medicaid as long as that mechanism increases the resources going to health care;
- Medicaid coverage of all legal immigrants and HIV infected individuals, while maintaining traditional preventive and case management services by local public health programs;
- Swift action to help counties serve the growing population of patients seeking uncompensated care in the nation's county emergency rooms and hospitals;
- Expanding Medicaid eligibility and enrollment education for women and children, as well as providing greater flexibility to states in using the State Children's Health Insurance Program (SCHIP) funds, including increasing the length of time that individual states have to spend their unexpended federal allotment and increasing federal funds for outreach;
- Allow redistribution of fifty percent of unspent SCHIP funds to states that spent all their allotment while allowing the other unspent funds to be retained by states three years after enactment of such legislation extending use of the funds;
- Fund efforts to reach qualified but unenrolled children and expand SCHIP to cover the parents of SCHIP qualified children;
- Legislation to restore Medicaid and SCHIP eligibility to all legal immigrants;
- A stronger disproportionate share hospital (DSH) program that assists systems serving large numbers of the medically uninsured and Medicaid recipients;
- Keep DSH funds separate from other Medicaid funds and strengthen and protect the DSH program in any Medicaid reform proposal;

- Increase allotments for low DSH states in future legislation, but not at the expense of other states;
- Any federal programmatic changes to explicitly address and support the dual, interrelated roles of counties in providing personal and public health services to the uninsured, the underinsured and entire communities;
- Comprehensive reform of the Medicaid waiver requirements and process to enable counties and states to implement clinically efficient and cost-effective health services;
- Legislation that would create a state option to create a Medicaid buy-in to expand Medicaid coverage to children with disabilities up to age 21, who would be eligible for SSI disability benefits but for their income or resources;
- Legislation to create a new Medicaid option for states to finance an array of intensive community-based services for adults with severe and persistent mental illnesses and children with serious mental and emotional disturbances;
- All Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services will continue to be available regardless of enrollment in any benefit package; and
- Continued utilization of Home and Community Based waivers as a service model for the future with a county government voice and influence in how those waiver programs are designed and implemented in states where counties are responsible for administering them or for paying all or part of the non-federal share of the waivers.

**NACo opposes:**

- Cuts to all Medicaid programs;
- Capping the amount of the federal contribution to Medicaid or Medicare;
- Any action to restrict the definition of allowable services under the Rehabilitation Option;
- Citizenship and identity documentation requirements for Medicaid eligibility that delay service delivery;
- Administrative approval of state benefit packages that exempt services under a State Medicaid plan or require “contracts” between the beneficiary and the plan; and
- A definition of third party liability that shifts financial responsibility to county governments.

**HEALTH FACILITIES CONSTRUCTION AND CAPITAL FINANCING**

**NACo supports:**

- Funding of health and hospital construction grant programs;
- Financing and taxing mechanisms for health facilities and providers that incorporate attention to the provision of indigent care;
- Expansion or construction of all health care facilities, the acquisition of equipment and allocation of health care resources to be carefully managed through a local planning process;
- Maintenance of the county-based infrastructure for assuring delivery of care;
- Priority to be given to new construction projects for public health care facilities and to modernization and renovation projects for existing public facilities;
- Priority to be given to purchasing and equipping mobile, clinical or health service outreach facilities; and
- Enforcement of regulations prohibiting refusal of care for financial reasons or transfer of patients for financial reasons.

## **FEDERAL ROLE**

The federal government should be responsible for assuring that all citizens have access to adequate and appropriate health care services, and that persons with disabilities can retain health benefits upon returning to work. NACo supports:

- Federal research into serious diseases that affect a large part of the population;
- Adequate funding of federal health care programs so that they do not increase the burden on the local tax base;
- Efforts to control the rate of growth of health care expenditures;
- Reforms to the Medicare and Medicaid systems that will insure optimal benefits to beneficiaries and full reimbursement to county providers;
- Federal health insurance programs as the primary payer of benefits and services provided to all eligible beneficiaries, particularly those who are dually eligible;
- Reimbursement to counties for providing preventive services, prenatal health care, treatment and testing of communicable diseases, dialysis, and chemotherapy treatments to all immigrants;
- U.S. Citizenship and Immigration Services (USCIS) reimbursement to counties for the care provided to injured or sick undocumented immigrants that Border Patrol officers apprehend;
- Federal government reimbursement to counties for the care provided to humanitarian parolees;
- The ability of states and counties to use their own funds to provide health care services to immigrants regardless of their status, without a reduction of federal financial responsibility for those services;
- The federal government to require states, in consultation with county governments, to set Medicaid reimbursement rates at levels that do not discourage providers from accepting Medicaid patients;
- Measures to reform these programs in the context of the entire system of financing health care, including costs to deliver services and utilization of a wage index formula that does not unfairly perpetuate low wages and geographic wage inequities;
- Efforts by the federal government to develop a single claims form and development of electronic billing as a means to reduce administrative costs in consultation with state and county governments, insurers and providers;
- Changes in the current federal policy that will allow a person receiving federal benefits who has been charged with a crime but not convicted to continue to be eligible for such entitlements including, but not limited to, Medicare, Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Veterans, and Children's Health Insurance Program (CHIP) benefits until such time as they may be convicted and sentenced to an institution;
- Protecting the privacy of individual medical records in a way that does not impede the flow of information necessary to coordinate care among multiple providers efficiently and cost-effectively;
- The importation of Food and Drug Administration (FDA) approved prescription drugs manufactured in FDA approved facilities to increase access to safe, affordable prescription drugs;
- Changes in the current federal policy that will allow a person receiving federal benefits who has been charged with a crime but not convicted to continue to be eligible for such entitlements including, but not limited to, Medicare, Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), VA health care, and Children's Health Insurance Program (CHIP) benefits until such time as they may be convicted and sentenced to an institution; and

- Fully funding veterans' services especially those that support community treatment for mental illness and that allow for reimbursement to community agencies for services provided to veterans.

NACo opposes the imposition of restrictions upon reimbursement monies.

## **HEALTH RESOLUTIONS**

### **Resolution Urging the Federal Government to Suspend, Instead of Terminate, Medicaid Coverage for Incarcerated Individuals**

**Issue:** Medicaid benefits may be withdrawn when an individual is incarcerated as opposed to convicted.

**Adopted Policy:** The National Association of Counties (NACo) urges Congress to pass legislation that: a) amends federal law to prohibit states from terminating eligibility for individuals who are inmates of public institutions or residents of Institutes for Mental Disease (IMD) based solely on their status as inmates or residents; and b) requires states to establish a process under which an inmate or resident of an Institute for Mental Disease (IMD), who continues to meet all applicable eligibility requirements, is placed in a suspended status so that the state does not claim federal financial participation (FFP) for services the individual receives, but the person remains on the state's rolls as being eligible for Medicaid; and c) once release or discharge from the facility is anticipated, require states to take whatever steps are necessary to ensure that an eligible individual is placed in payment status so that he or she can begin receiving Medicaid-covered services immediately upon leaving the facility.

**Adopted | July 15, 2019**

### **Resolution to Extend Federal Medical Payments to Detainees in County Jails Who Are Pre-Adjudicated**

**Issue:** Extending federal Medicaid payments to detainees in county jails who are pre-adjudicated.

**Adopted Policy:** The National Association of Counties (NACo) supports federal legislation to require the federal Medicaid program to contribute the federal Medicaid match for health and mental health care that is provided while a pre-adjudicated detainee is actually incarcerated.

**Adopted | July 15, 2019**

### **Resolution to Prohibit Insurers from Denying Health Benefits to Pre-Adjudicated Persons**

**Issue:** Private insurance companies' "inmate exclusion" shifts health care costs from pre-adjudicated inmates to counties.

**Adopted Policy:** The National Association of Counties (NACo) urges the U.S. Department of Health and Human Services (HHS) to prohibit insurers from denying reimbursement under health benefit plans for covered services provided to pre-adjudicated persons in the custody of local supervisory authorities.

**Adopted | July 15, 2019**

### **Resolution on Integration of Mental Health and Addiction Care in Treatment Centers**

**Issue:** Although substance use disorders such as opioid addiction frequently follows the onset of depression, and substance use disorders such as opioid addiction frequently triggers depression within as

few as 30 days, our patterns of care organization and funding do not make provision for a necessary linkage between mental health and substance use care.

**Adopted Policy:** The National Association of Counties (NACo) urges the federal government, specifically, Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), Center for Disease Control and Prevention (CDC) and Center for Medicare and Medicaid Services (CMS), to modify grant, technical assistance and service funding programs that support the development and operation of integrated care in treatment centers to include provision for the integration of mental health and addiction care, including care for depression and substance use disorders such as opioid addiction.

**Adopted | July 15, 2019**

### **Resolution on the Importance of the ACA and Medicaid Expansion**

**Issue:** Covering over 70 million individuals, Medicaid is the country's largest program providing health coverage and health care services to the nation's low-income population. The Affordable Care Act (ACA) allowed states to expand their Medicaid programs, which provides billions of federal dollars to counties for indigent health care services, behavioral health services, preventative care, public health and coordinated care.

**Adopted Policy:** The National Association of Counties (NACo) supports maintaining the Medicaid program as a means-tested entitlement and further supports provisions in current law that allow for expanded program eligibility and coverage standards. NACo urges Congress and the administration not to repeal the Medicaid expansion. Maintaining eligibility and coverage under the current program is essential to sustain the strong federal-state-local partnership that underpins our nation's health system.

**Adopted | July 15, 2019**

### **Resolution Regarding the National Health Service Corps Loan Repayment Program**

**Issue:** County jails are not eligible for designation as health professional shortage areas for the purpose of the National Health Service Corps.

**Adopted Policy:** The National Association of Counties (NACo) urges Congress to amend the National Health Service Corps loan repayment program and allow county and municipal jails to be eligible for the program. Current law excludes county jails from being designated as health professional shortage areas, and NACo urges Congress to review this designation and allow county and municipal jails to be named health professional shortage areas.

**Adopted | July 15, 2019**

## **Resolution to Support Funding for Alzheimer’s Disease/Other Related Dementias Research, Community Education and Outreach and Caregiver Support**

**Issue:** Lack of sufficient funding for Alzheimer's Disease research/ other related dementias, Alzheimer's community education and outreach, and resources for caregivers, family members and individuals with Alzheimer's Disease/ other related dementias.

**Adopted Policy:** The National Association of Counties (NACo) supports the continuous and increased use of federal funding to support Alzheimer's Disease/ other related dementias research, Alzheimer's community education and outreach, and resources for caregivers, family members and individuals with Alzheimer's Disease/ other related dementias.

**Adopted | July 15, 2019**

## **Resolution on Federal Policy Changes Related to Immigrant Eligibility for Federal Benefits**

**Issue:** Changes to existing immigration policy that limits eligibility for federally funded health care and public health programs could negatively impact county governments.

**Adopted Policy:** The National Association of Counties (NACo) opposes specific changes to existing immigration policy that would lead to increases in uncompensated care and shift federal and state costs and the administrative burden to counties, including preventing access to and/or penalizing immigrants for the use of federally-funded health care and public health programs including Medicaid and the Children’s Health Insurance Program (CHIP).

**Adopted | July 15, 2019**

## **Resolution Supporting Local Efforts for Mobile Support Teams**

**Issue:** There is more support needed at the federal level for local health departments’ mobile support teams, who work closely with law enforcement agencies to promote safety and emotional stability when a behavioral crisis occurs.

**Adopted Policy:** The National Association of Counties (NACo) supports legislative efforts at the federal and state levels to fully fund and promote mobile support teams within a local health department or local jurisdiction. NACo urges federal and state matching funds to maximize financial support for local jurisdictions in implementing mobile support teams.

**Adopted | July 15, 2019**

## **Resolution on Reducing Disparities in African American Child Deaths**

**Issue:** African American children die at disproportionate rates across the United States, impacting families and communities.



**Adopted Policy:** The National Association of Counties (NACo) supports federal legislative efforts to fund local initiatives to reduce African American child deaths through collective impact models and targeted, community-based programs to reduce risks.

**Adopted | July 15, 2019**

### **Resolution in Support for Funding the Supporting and Improving Rural EMS Needs Grants**

**Issue:** Rural fire and emergency medical services (EMS) agencies currently struggle to fund their EMS operations. In December 2018, Congress passed the Supporting and Improving Rural EMS Needs Act (SIREN Act), as part of the Agriculture Improvement Act of 2018 (P.L. 115-334), which restored and revised a grant program for rural EMS agencies. While the SIREN grants have been authorized, Congress must provide strong appropriations for this program.

**Adopted Policy:** The National Association of Counties (NACo) urges Congress to fund the Supporting and Improving Rural EMS Needs Act (SIREN) grants at \$20 million for FY 2020. The SIREN grants will provide funding for rural fire and EMS agencies to recruit personnel, procure emergency medical supplies and provide emergency medical services (EMS) training classes. Only public and nonprofit agencies are eligible to receive these funds.

**Adopted | July 15, 2019**

### **Resolution Supporting Improved Compliance through Better Regulation in Nursing Homes**

**Issue:** Better regulation is needed to support compliance, while ensuring unnecessary regulatory burdens do not take precedence over care, treatment, and outcomes

**Adopted Policy:** NACo supports strengthening efforts by the Centers for Medicare and Medicaid Services (CMS) to improve compliance through collaborative efforts with healthcare providers and stakeholders to reduce administrative burdens, increase effective and efficient conformity with regulations and improve the beneficiary experience by removing regulatory obstacles that diminish the ability to put patients/residents first over paperwork.

**Adopted | July 15, 2019**

### **Resolution Supporting Better Staffing in Nursing Homes**

**Issue:** Nursing homes need adequate staffing levels to provide high quality care, safe care, person-directed care, and care that is consistent with state and federal regulations.

**Adopted Policy:** The National Association of Counties (NACo) urges Congress to amend federal law to allow disapproval for nurse aide training programs to be discretionary rather than mandatory and support the Nursing Home Workforce Quality Act.

**Adopted | July 15, 2019**

## **Resolution to Support Federal Action to Obtain Better Research on Kratom and to Promote Dissemination of Best Public Health Practices Related to Kratom**

**Issue:** Local communities need better data and research related to kratom that will aide the development of public health best practices related to the use of kratom in communities across the United States.

**Adopted Policy:** The National Association of Counties (NACo) should urge Congress to pass legislation and/or federal agency directives to fund and support efforts to research the health impacts related to the use of kratom. This includes federal action steps to devote the appropriate agency and staff resources to complete both: (1) a review of existing research on kratom in order to provide counties and other local government jurisdictions with immediate guidance on the most appropriate public health best practices related to kratom; and (2) to pursue more comprehensive research on kratom that can inform longer-term public health approaches related to the use of kratom.

**Adopted | July 15, 2019**

## **Resolution to Support Amending 42 CFR Part 2 SUD Privacy Rules to Improve Care Coordination**

**Issue:** Need to align privacy requirements for substance use disorder (SUD) patient records with those for medical care records under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in order to improve care coordination for patients undergoing SUD treatment.

**Adopted Policy:** The National Association of Counties (NACo) supports amending 42 Code of Federal Regulations (CFR) Part 2 (Part 2) privacy provisions to improve care coordination for patients undergoing treatment for SUD by aligning the privacy requirements for SUD patient records as governed by Part 2 with those in HIPAA for medical care. This would permit information sharing between SUD treatment providers, behavioral health providers and medical care providers for the purposes of health care treatment, payment, and operations (TPO), while also bolstering efforts to identify high utilizers of public services and hospital emergency departments.

**Adopted | July 15, 2019**

## **Interim Resolution on New Restrictions on State and Local Flexibility to Finance the Non-Federal Share of Medicaid**

**Issue:** State and county flexibility to finance the non-federal share of Medicaid.

**Adopted Policy:** The National Association of Counties (NACo) supports the current rules that undergird the federal-state-local partnership for financing the Medicaid program, including Disproportionate Share Hospital (DSH) payments and other supplemental payments. These rules permit using an array of public funds for intergovernmental transfers (IGTs), certified public expenditures (CPEs) and other financing mechanisms. Counties encourage maximum flexibility for states and counties to finance the non-federal share of Medicaid. Counties oppose any new restrictions on that flexibility which could shift costs to state and local taxpayers and/or limit the ability to plan and reduce access to essential health care services for low-income, uninsured and underinsured residents.

**Adopted | March 2, 2020**

### **Interim Resolution to Increase Resources for Suicide Prevention**

**Issue:** Suicide is the tenth leading cause of death in the United States and the second leading cause of death among individuals between the ages of 10 and 34.

**Adopted Policy:** The National Association of Counties (NACo) urges the strengthening of services through additional funding and resources for those suffering from mental illness and other factors, who may be at risk for suicide.

**Adopted | March 2, 2020**

### **Interim Resolution on the U.S. Food and Drug Administration Regulations of Cannabidiol and Other Cannabinoids**

**Issue:** The U.S. is in the midst of a “CBD craze.” Purveyors of cannabidiol (CBD) make vastly exaggerated claims about its effects for a very broad array of health conditions. These claims have not been tested for accuracy. In this context, persons with mental health and substance use conditions are at great risk of using CBD to attempt to “cure” their conditions, rather than adhering to more appropriate and effective medications. Other consumers are likely to take the same actions with respect to other health conditions because of the wild claims made about CBD products.

Clinical trials also demonstrate that there are adverse health effects associated with inappropriate use of CBD, including drug-induced liver injury and drug-drug interactions. Adverse effects such as these can be monitored and managed with physician oversight, which occurs with prescription medicines. But for CBD consumer products, individuals will be self-administering CBD without physician supervision. Thus, the CBD craze poses a major public health risk.

**Adopted Policy:** The National Association of Counties (NACo) urges the Food and Drug Administration (FDA) to develop appropriate pathways for the testing and approval of cannabinoids as medications using rigorous standards. To date only one cannabidiol (CBD) based medication, Epidiolex, has been approved for the treatment of refractory epilepsy in small children. NACo further urges the FDA to develop appropriate pathways for the testing and approval of food supplements and cosmetics that contain low concentration levels of CBD, as well as other cannabinoids, using rigorous standards. These standards should address important issues of safety, purity and consistency. Finally, NACo urges FDA to require physicians to share with their patients’ appropriate information and resources regarding the safety of CBD products and the status of the products approved by FDA.

**Adopted | March 2, 2020**

## **Interim Resolution Supporting an Amendment to the Federally Supported Health Centers Assistance Act Clarifying that County Mental Health and Behavioral Health Treatments Involving Court Ordered Patients are Covered by the Federal Torts Claim Act**

**Issue:** As more and more counties turn to addressing issues at the intersection of public safety and behavioral health, protecting counties from related litigation must be a part of that conversation. Courts are partners in these policy evolutions and already enjoy wide ranging immunity for their actions. When courts order defendants into community treatment within a Federally Qualified Health Center (FQHC), it is imperative that counties are clear on the federal protections provided to their employees to be considered a federal employee in the event of a lawsuit. The National Association of Counties (NACo) seeks clarifying language that will make the original intent of Congress clear, such that counties are not exposed to excessive litigation or forced to bring suit against the federal government for protections which exist under the Federally Supported Health Centers Assistance Act and the Federal Tort Claims Act. This resolution does not remove or diminish access to justice, rather it shifts the source of potential remedies from counties to the federal government.

**Adopted Policy:** The National Association of Counties (NACo) supports the following amendments to the Federally Supported Health Centers Act:

- Amend 42 USC § 233 (g) (1) (c) to clarify that an individual ordered into treatment at a Federally Qualified Health Center (FQHC) by a court is a patient of the entity.

The intent of this first amendment is to clearly establish that not all patients of a FQHC are voluntarily seeking treatment and that not all FQHC are voluntarily providing treatment. Patients may well have existing criminal charges pending or have otherwise been ordered by a court to receive treatment from a FQHC to establish their competency to aid and assist in their own defense or as part of an alternative-to-incarceration sentencing framework.

- Amend 42 USC § 233 (a) to clarify that behavioral and mental health treatment is a related function (to medical, surgical and dental functions)

The intent of this amendment is to more clearly establish that behavioral and mental health treatment is included as an exclusive remedy. The Federally Supported Health Centers Assistance Act suggests damages arising from death and injury “resulting from the performance of medical, surgical, dental, or related functions...shall be exclusive of any other civil action or proceeding...”

**Adopted | March 2, 2020**

## **Interim Resolution Supporting Urgent Congressional Action for COVID-19 Response and Protecting Local Public Health Funding**

**Issue:** The U.S. Department of Health and Human Services (HHS) Secretary Azar has declared COVID-19 a public health emergency. Response from local public health and other county emergency services, as well as state and federal partners, requires urgent additional appropriation.

**Adopted Policy:** The National Association of Counties (NACo) urges Congress to pass a Fiscal Year 2020 supplemental appropriation to expand and strengthen global, federal, state, territorial, tribal and local capacity and coordination to adequately respond to this infectious disease outbreak. NACo requests that the Department of Defense maintain jurisdiction over cases within their health system if there is adequate capacity to treat and contain the risk. Furthermore, NACo requests that the federal government use the long-standing communication practices in use in previous public health emergencies.

**Adopted | March 2, 2020**