## Side-by-Side: NACo-House-Senate Health Reform Legislation

| NACO POLICY<br>*Restoring the Partnership for American Health: Counties in a 21st Century Health System*<br>**("White Paper")** | HOUSE LEADERSHIP<br>**Affordable Health Care for America Act (H.R. 3962)** | SENATE LEADERSHIP<br>**Patient Protection and Affordable Care Act (H.R. 3590)** |
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| **Local Delivery Systems – Access for All**<br><br>**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. | • Sec. 1152. Require the Secretary to develop a plan to reform Medicare payments for post-acute services, including bundled payments, to improve the coordination, quality and efficiency of such services and improve outcomes. (Effective January 1, 2011)<br><br>• Sec. 1301. Conduct Medicare and Medicaid pilot program to test payment incentive models for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes. Adopt these models on a large scale if pilot programs prove successful at reducing costs. (Implementation of medical home pilots upon enactment; implementation of accountable care organization pilots by January 1, 2012)<br><br>• Sec. 1907. Establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both. (Effective January 1, 2011)<br><br>• Sec. 1157. Require the Institute of Medicine to conduct a study on geographic adjustment factors in Medicare and require the Secretary to issue regulations to revise the geographic adjustment factors based on the recommendations. (Report due one year following enactment; proposed regulations issued following | • Sec. 3023. Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; develop expansion implementation plan, if called for, by January 1, 2016)<br><br>• Sec. 3021. Establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both. (Effective January 1, 2011)<br><br>• Sec. 2602. Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010) |

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| | submission of report)<br>• Sec. 1905. Require the Secretary to improve coordination of care for dual eligibles through a new office or program within CMS. (Report of activities due within one year of enactment)<br>• Sec. 1907. Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. (Effective dates vary)<br>• Sec. 2534. Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, manage chronic conditions, and reduce emergency department use for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning FY 2011)<br>• Division B, Title II, Subtitle B. Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services, providing Medicare demonstration grants to reimburse culturally and linguistically appropriate services and developing standards for the collection of data on race, ethnicity, and primary language. (Report due to Congress one year following enactment) | • Sec. 2703. Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. (Effective January 1, 2011)<br>• Sec. 2704. Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); Sec. 2705. Make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); Sec. 2706. Allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); Sec. 2707. Provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).<br>• Sec. 10333. Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)<br>• Title III, Subtitle A, Part II. Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for |

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| | | the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011)<br><br>• Sec. 4302. Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)<br><br>• Sec. 4101. Improve access to care by establishing new programs to support school-based health centers (effective fiscal year 2010); Sec. 5208. Nurse-managed health clinics (effective fiscal year 2010); Sec. 5601. Enhance funding for federally qualified health centers (initial appropriation in fiscal year 2010).<br><br>• Sec. 10502. Provides funding to HHS for construction or debt service on hospital construction costs for a new health facility meeting certain criteria.<br><br>• Sec. 10503. Establishes a Community Health Centers and National Health Service Corps Fund. The fund will create an expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act and the National Health Service Corps. |

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| **Public Health and Wellness:**<br><br>**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. | • Division C, Title III. Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.<br><br>• Sec. 3161. Establish a grant program to support state, local and tribal core public health infrastructure.<br><br>• Sec. 3151. Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at reducing health disparities. Train community health workers to promote positive health behaviors in medically underserved communities.<br><br>• Sec. 2535. Provide grants to plan and implement programs to prevent obesity among children and their families. (Funds appropriated for five years beginning FY 2011) | • Sec. 4001. Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment)<br><br>• Sec. 4002. Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010)<br><br>• Sec. 4003. Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment)<br><br>• Sec. 4105-Sec. 4106. Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective January 1, 2011) For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services. Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011)<br><br>• Sec. 4103. Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. (Health risk assessment |

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| | | model developed within 18 months following enactment) Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010)<br><br>• Sec. 1302. Require qualified health plans to provide coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, and preventive care for infants, children, and adolescents and additional preventive care and screenings for women. (Effective six months following enactment)<br><br>• Sec. 10408. Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011)<br><br>• Sec. 4303. Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment)<br><br>• Sec. 1201. Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must |

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| | | offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)<br><br>• Sec. 4205. Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)<br><br>• Sec. 10501 (g). Establishes a national diabetes prevention program at the CDC. State, local, and tribal public health departments and non-profit entities can use funds for community-based prevention activities, training and outreach, and evaluation. |

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| **Expanding Coverage:**<br>**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 | • Division A, Titles III, IV and V. Require individuals to have health insurance. Create a Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or $73,240 for a family of three in 2009). Require employers to provide coverage to employees or pay into a Health Insurance Exchange | • Title I. Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 100-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase |

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| 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. | Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market.<br><br>• Division B, Title VII. Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL. Provide Medicaid coverage for all newborns who lack acceptable coverage and provide optional Medicaid coverage to low-income HIV-infected individuals (with enhanced matching funds) until 2013 and for family planning services to certain low-income women. In addition, increase Medicaid payment rates for primary care providers to 100% of Medicare rates by 2012. Require states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program. The coverage expansions (except the optional expansions) and the enhanced provider payments will be financed with 100% federal financing through 2014 and 91% federal financing beginning in year 2015. (Effective January 1, 2013)<br>• Sec. 1703. Repeal the Children's Health Insurance Program (CHIP) and require CHIP enrollees with incomes above 150% FPL to obtain coverage through the Health Insurance Exchange beginning in 2014. CHIP enrollees with incomes between 100% and 150% FPL would be transitioned to Medicaid and states would receive the CHIP enhanced match rate for children above current levels and up to 150% FPL. Require a report to Congress with recommendations to ensure that coverage in the Health Insurance Exchange is comparable to coverage | coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets.<br><br>• Title II, Subtitle A and Sec. 10201. Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI). All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. Require states to provide premium assistance to any Medicaid beneficiary with access to employer-sponsored insurance if it is cost-effective for the state. Sec. 2101. Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges. |

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| | under an average CHIP plan and that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or with a written plan of treatment. (Report due by December 31, 2011)<br><br>• Division A, Title II, Subtitle C. Create an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,000/individual and $10,000/family, does not require cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. Prohibit abortion coverage from being required as part of the essential benefits package. (Health Benefits Advisory Council report due one year following enactment; essential benefits package becomes effective January 1, 2013)<br><br>• All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package. (Effective January 1, 2013)<br><br>• Require a report on including oral health benefits in the essential benefits package. (Report due one year following enactment) | |

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| **Maintaining a Safety Net:**<br>**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 | • Sec. 1701. The Medicaid coverage expansions (except the optional expansions) and the enhanced provider payments will be 100% federally financed through 2014 and 90% federally financed beginning in year 2015.<br>• Sec. 1704. Reduces federal DSH payments by $1.5 billion in FY 2017; $2.5 billion in FY 2018 and $6 billion in FY 2019 using a formula that imposes the largest percentage reductions on states that have the lowest percentages of uninsured.<br>• Requires a report on the continued role of DSH by January 1, 2016. The report would also include recommendations about targeting DSH within states and distributing DSH across states. | • Sec. 2001 and Sec. 10201. To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), states will receive 100% federal funding for 2014 through 2016. Beginning in 2017, financing for the newly eligible will be shared between the states and the federal government through an increase in the federal medical assistance percentage (FMAP). For states that already cover adults with incomes above 100% FPL, the percentage point increase in the FMAP will be 30.3 in 2017 and 31.3 in 2018. For all other states, the percentage point increase in the FMAP will be 34.3 in 2017 and 33.3 in 2018, except Nebraska, which will continue receiving 100% federal funding for newly eligibles after 2017. Beginning in 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. Certain states not eligible for the enhanced federal funding because they had already expanded Medicaid to adults with incomes above 133% FPL will receive a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014 through 2019 or a .5 percentage point increase in the FMAP for 2014 through 2016. (Effective January 1, 2014)<br>• Sec. 10201 (c). Requires states to share the benefit of increased federal match with counties that contribute to the non-federal share of Medicaid costs. |

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| 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 heath care reform. | | • Sec. 2551 and Sec. 10201 (e). Reduce a state's Medicaid DSH allotment by 50%, or 25% for low DSH states, (and by lesser percentages for states meeting certain criteria) once the state's uninsured rate decreases by at least 45%. DSH allotments will be further reduced, not to fall below 50% of the total allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. (Effective October 1, 2011)<br><br>• Sec. 9007 and Sec. 10903. Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment) |

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| **Health Workforce:**<br>**NACo believes that the health professional and paraprofessional workforce must be supported and enhanced.** It is important that we sustain training programs | • Sec. 2261. Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy. (Funds appropriated beginning FY | • Sec. 5101. Establish a multi-stakeholder National Health Care Workforce Commission to develop a national workforce strategy. (Appointments made by September 30, 2010) |

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| 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.<br>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.<br>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. | 2011)<br><br>• Division B, Title V. Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings, including through a Teaching Health Center demonstration project. (Effective July 1, 2011)<br>• Division C, Title II, Subtitle A. Support training of health professionals through scholarships and loans; establish a primary care training and capacity building program; establish a loan repayment program for professionals who work in health professions needs areas; establish a public health workforce corps; promote training of a diverse workforce; and provide cultural competence training for health care professionals. Support the development of interdisciplinary mental and behavioral health training programs and establish a training program for oral health professionals. (Funds appropriated beginning FY 2011)<br><br>• Division C, Title II, Subtitle B. Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing.<br><br>• Division C, Title II, Subtitle D. Support the development of interdisciplinary health training programs that focus on team-based models, including medical home models and models that integrate physical, mental, and oral health services. (Funds appropriated beginning FY 2011) | • Sec. 5506. Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); Sec. 5504. Increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Sec. 5508. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. (Initial appropriation in fiscal year 2010)<br><br>• Title V, Subtitles C through E. Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; establish a public health workforce loan repayment program; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010) Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a |

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| | | career ladder to nursing. (Initial appropriation in fiscal year 2010)<br><br>• Sec. 5403. Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)<br><br>• Sec. 10501 (k) Creates a state grant program to support health care providers who treat a high percentage of medically underserved populations.<br><br>• Sec. 10501 (l) Authorizes grants for medical schools to establish programs that recruit students from underserved rural areas who have a desire to practice in their hometowns. Programs would provide students with specialized training in rural health issues, and assist them in finding residencies that specialize in training doctors for practice in underserved rural communities. |

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| **Health IT:**<br>**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 | (HIT was provided for in the American Recovery and Investment Act of 2009) | |

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| 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. | | |

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| **Long Term Care:**<br>**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. | • Sec. 3201 ff. Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective 2010) | • Title VIII. Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)<br>• Sec. 2403. Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016. (effective 30 days following enactment)<br>• Sec. 2405 Allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014).<br>• Sec. 2402. Provide states with new options for offering |

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| | | home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010)<br>• Sec. 2401. Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2010) |

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| **Jail Health:**<br>**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 | • Sec. 1729. Requires states to suspend, rather than terminate Medicaid coverage for youths under 18 and ensure that they are enrolled on or before release if they are still eligible. | • Sec. 1312 (f)(1)(B). Disqualifies individuals who are incarcerated from enrolling in coverage on the exchange, unless they are in custody pending disposition of charges. |

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| 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. | | |

Sources:

Restoring the Partnership for American Health: Counties in a 21st Century Health System:

http://www.naco.org/healthpolicy

Affordable Health Care for America Act (H.R. 3962):

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3962eh.txt.pdf

Patient Protection and Affordable Care Act (H.R. 3590):

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590as.txt.pdf

The Henry J. Kaiser Family Foundation:

http://healthreform.kff.org/