



# Implications of Federal Health Reform: Health Clinics

Insure the Uninsured Project  
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## Insurance Eligibility and Expansion

Legislative Language in Reform Bills, House (H) and Senate (S), Implementation Year	Effect on Clinics
<p><b>Medicaid Expansion to 150% FPL (H) or 133% FPL (S) for families and medically indigent adults (MIAs), as soon as 2011</b></p>	<ul style="list-style-type: none"> <li>• Increase in number of insured patients, particularly families and MIAs</li> <li>• Increase in utilization for very low income patients</li> <li>• Decrease in uncompensated care, increase in Medi-Cal revenues</li> <li>• Some new responsibility or opportunity to assist in enrollment for newly eligible (no wrong door policy)</li> <li>• May be difficult for clinics with limited capacity to increase their services</li> </ul>
<p><b>Individual Mandate, Penalties and Hardship Exemptions (H,S), 2014</b></p>	<ul style="list-style-type: none"> <li>• Increase in number of insured clinic patients and</li> <li>• Decrease in uncompensated care for patients reluctant to enroll in coverage</li> <li>• Increase in utilization by newly insured</li> <li>• Extent of exemptions impacts degree of uncompensated care</li> </ul>

<p><b>Federal subsidies for citizens and nationals up to 400% Federal Poverty Level (FPL) through national (H) or state-based (S) Health Insurance Exchanges, 2013 or 2014</b></p>	<ul style="list-style-type: none"> <li>• Increase in number of insured patients, decrease in uncompensated care for higher income uninsured</li> <li>• Increase in utilization by newly insured</li> <li>• Clinics need to be a part of the plans and networks which are the most successful competitors in attracting Exchange enrollees, as plans will be required to include these essential community providers</li> <li>• Clinics not normally part of commercial insurance networks may face transition difficulty</li> </ul>
<p><b>Establishment of minimum benefits package (H,S), 2014</b></p>	<ul style="list-style-type: none"> <li>• Increase in utilization, decrease in uncompensated care for those who are underinsured</li> <li>• Individuals purchasing “young invincibles” and “bronze” policies may face substantial out of pocket costs, impacting use of covered services</li> </ul>
<p><b>Full coverage and elimination of cost sharing for preventive services (H,S), 2010</b></p>	<ul style="list-style-type: none"> <li>• Increase in utilization of preventive services</li> <li>• Decrease in uncompensated care</li> </ul>
<p><b>Barring use of federal subsidies for undocumented workers and new legal immigrants for first 5 years (H,S), except for emergencies, 2014</b></p>	<ul style="list-style-type: none"> <li>• Limits new federal funding for a number of clinic patients</li> </ul>

<b>Changes to Reimbursement Rates</b>	
<b>Legislative Language in Reform Bills, House (H) and Senate (S), Implementation Year</b>	<b>Effect on Clinics</b>
<b>Increase in Medicaid reimbursement for primary care to Medicare level (H), 2011</b>	<ul style="list-style-type: none"> <li>• Increase in total reimbursement for Medicaid patients for clinics who are not FQHC or look-a-likes</li> <li>• Increase in primary care physician willingness to see Medi-Cal patients</li> </ul>
<b>Medicare Advantage payment reduction (H,S), 2011</b>	<ul style="list-style-type: none"> <li>• Limited effect on most clinics</li> </ul>
<b>Elimination of Medicare Part D donut hole (H,S), begins 2010</b>	<ul style="list-style-type: none"> <li>• Limited effect on most clinics</li> </ul>
<b>Negotiated rates/discounts for Medicare Part D (H), 2014</b>	<ul style="list-style-type: none"> <li>• Limited effect on most clinics</li> </ul>
<b>10% primary care reimbursement increases in Medicare (H,S) 2011</b>	<ul style="list-style-type: none"> <li>• Expands access to needed primary care providers</li> <li>• Improves clinic revenue for non FQHC clinics</li> </ul>
<b>Payment refusals for readmissions, hospital-acquired infections, duplicative services, errors (H,S) 2012</b>	<ul style="list-style-type: none"> <li>• Some Medicare/Medicaid claim denials for hospitals</li> </ul>
<b>Payment reform programs in Medicare (bundled payments, P4P, accountable care organizations, medical home models) (H,S), 2013</b>	<ul style="list-style-type: none"> <li>• Grant opportunities for qualifying clinics</li> <li>• Bonus payments/incentives for enrolled clinics with superior performance</li> <li>• Improved care coordination/delivery</li> </ul>
<b>Modified payment formulas in Medicare (H,S) for FQHCs, as soon as 2012</b>	<ul style="list-style-type: none"> <li>• Increase in clinic revenue for primary care services, decrease in reimbursement rates for some specialty services</li> </ul>

<b>Federal Financing and Grants</b>	
<b>Legislative Language in Reform Bills, House (H) and Senate (S), Implementation Year</b>	<b>Effect on Clinics</b>
<b>\$34B in expanded funding for FQHCs (H,S), 2010-2015</b>	<ul style="list-style-type: none"> <li>• Expanded access to FQHC clinics</li> <li>• Increase in funding for existing and new FQHCs</li> <li>• Difficulty for clinics not “FQHC” certified</li> </ul>
<b>Increase in funding for community health centers and school-based health centers (H,S), 2012</b>	<ul style="list-style-type: none"> <li>• Increase in federal awards and grants to bolster infrastructure</li> </ul>
<b>\$50M in grants for nurse-managed health clinics (S), 2010</b>	<ul style="list-style-type: none"> <li>• Strengthens safety net funding</li> </ul>
<b>\$50M in grants to co-locate and integrate primary/specialty care in community-based mental health settings (H,S), 2010</b>	<ul style="list-style-type: none"> <li>• Increase in productivity and disease management</li> <li>• Decrease in costs as a result of integrated services</li> </ul>
<b>Reduction of Disproportionate Share Hospital payments (DSH) (H,S), 2014</b>	<ul style="list-style-type: none"> <li>• Limited effect on clinics</li> </ul>
<b>New fees imposed on drug and device manufacturers (H,S), 2010</b>	<ul style="list-style-type: none"> <li>• May increase the cost of medical devices</li> </ul>
<b>Establishment of Center for Comparative Effectiveness and CMS Innovation Center (H,S), 2011</b>	<ul style="list-style-type: none"> <li>• Provide clinics with information, best practice guidelines and innovative health system processes</li> <li>• May allow clinics to streamline infrastructure and delivery, reducing costs and improving quality</li> <li>• Innovative payment reform models will reward effective clinics and improve revenue streams</li> </ul>

<b>Clinical Workforce</b>	
<b>Legislative Language in Reform Bills, House (H) and Senate (S), Implementation Year</b>	<b>Effect on Clinics</b>
<b>Graduate Medical Education reform, opening residency training spots in non-hospital locations (H,S), 2011</b>	<ul style="list-style-type: none"> <li>• Increase in provider workforce</li> <li>• May offset increase in utilization demand</li> </ul>
<b>Enhanced health care workforce training, 2010</b>	<ul style="list-style-type: none"> <li>• Increase in provider workforce (nurse practitioners, PAs, etc.)</li> <li>• May offset increase in utilization demand</li> </ul>
<b>Shared responsibility for employers (H,S), 2014</b>	<ul style="list-style-type: none"> <li>• Larger clinics may be subject to employer fees/pay-or-play provisions</li> </ul>
<b>Small low wage business tax credits to those small business who pay for employee coverage (H,S), 2010 or 2011</b>	<ul style="list-style-type: none"> <li>• Improved affordability of coverage for small low wage clinics</li> <li>• Non-profit clinics receive smaller tax credit (35% of employer premium) compared to for-profit (50%)</li> </ul>
<b>Clinic Operations</b>	
<b>Legislative Language in Reform Bills, House (H) and Senate (S), Implementation Year</b>	<b>Effect on Clinics</b>
<b>Required data reporting from drug and device manufacturers on financial incentives to providers, 2010</b>	<ul style="list-style-type: none"> <li>• Increase in administrative activity</li> <li>• May reduce distribution of free drugs and medical devices</li> </ul>
<b>Required utilization and outcome data reporting, begins 2012</b>	<ul style="list-style-type: none"> <li>• Increase in administrative activity</li> <li>• May improve delivery efficiency incentives (P4P) long-term</li> </ul>
<b>Standardized administrative forms (claims, etc.) (H,S), 2013</b>	<ul style="list-style-type: none"> <li>• Decrease in administrative costs</li> <li>• Increase in productivity</li> </ul>

<p><b>Transparency provisions for public program reimbursement (H,S), 2014</b></p>	<ul style="list-style-type: none"> <li>• Moderate increase in administrative activity</li> <li>• May increase or decrease public reimbursement based on geographic variation (Dartmouth Atlas)</li> </ul>
<p><b>Health Information Technology standards and protocols (H,S), 2013</b></p>	<ul style="list-style-type: none"> <li>• Expanded access to EHR systems and telemedicine</li> <li>• Improved interoperability between EHR systems</li> </ul>

Sources:

Senate: HR 3590: <http://democrats.senate.gov>

House: HR 3962: [http://rules.house.gov/bills\\_details.aspx?NewsID=4483](http://rules.house.gov/bills_details.aspx?NewsID=4483)

ITUP Comparative Health Reform Matrix:

[http://www.itup.org/Reports/Health%20Reform/Senate\\_House\\_HR\\_Comparison\\_11\\_19\\_09.pdf](http://www.itup.org/Reports/Health%20Reform/Senate_House_HR_Comparison_11_19_09.pdf)