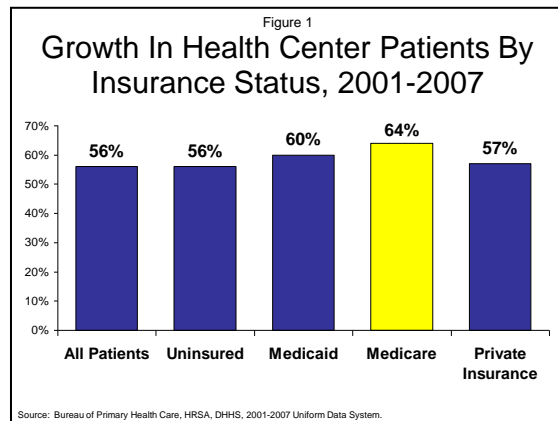


# Health Centers and Medicare: Improving Care for America's Seniors

## *RECIPROCAL RELATIONSHIP: HEALTH CENTERS AND MEDICARE*

Both health centers and Medicare are important means for improving access to needed health care. Millions of elderly and disabled Americans rely on Medicare to finance needed care, while health centers directly deliver high quality, affordable, and accessible primary and preventive health care to anyone in need. For many Medicare beneficiaries, health centers may be the only source of care available to them. Although these patients make up only 7.6% of all health center patients, the number of health center Medicare patients has grown 64% since 2001, making it the fastest growing patient population by insurance status (Figure 1). Interestingly, 21% of all health center patients are aged 45-64, and their numbers are growing much faster than the number of patients aged 65 and over, highlighting health centers' growing role in serving patients who age into Medicare.



Currently, health centers serve 1.2 million Medicare beneficiaries. Because the vast majority of patients are low income, health centers serve disproportionately high numbers of dual eligibles (patients who have both Medicare and Medicaid). Dual eligibles have extensive health care needs and rely on both Medicaid and Medicare to help pay for their care, as well as on health centers to deliver needed care.

## *HEALTH CENTERS REDUCE THE COST OF CARE*

Care received at health centers is ranked among the most cost-effective anywhere. As health care homes for Medicare beneficiaries, health centers not only improve health outcomes but also lower health care spending. Studies document that access to a regular provider for Medicare patients improves overall health and disease-specific health outcomes. Longer physician-patient relationships leads to reduced hospitalizations and lower per patient Medicare costs.

## *HEALTH CENTER MEDICARE PAYMENT STRUCTURE*

**Medicare patients make up 7.6% of health center patients, but only 6% of health center revenue.** Centers are reimbursed on an all-inclusive, per encounter rate that is capped by a payment limit. Health centers with costs higher than this limit therefore lose the difference. In 2007, the limits are \$99.17 for rural health centers and \$115.33 for urban health centers. NACHC's analysis of Medicare cost report data found that health centers are **experiencing Medicare losses of at least \$51 million annually**, with some health centers reporting losses over \$1 million. Another factor contributing to these Medicare losses is the limited number of services for which health centers are reimbursed. This limited list of reimbursable services means that health centers are not paid for providing a number of important services to Medicare patients. In all, **health centers on average collect only 69% of their Medicare costs.** Unless these gaps in Medicare payments to health centers are fixed, **Medicare revenue will only further dwindle, threatening their ability to provide needed community care.**

## *MEDICARE PART D, IMPORTANT NEW PROGRAM*

In 2003, President Bush signed the Medicare Prescription Drug, Improvement and Modernization Act into law. Beginning January 1, 2006 this legislation created Medicare Part D to provide prescription drug benefits. Particularly important to health centers and their patients is the addition of a new prescription drug benefit for low-income seniors. Most importantly, the premium assistance provided through the Low-Income Subsidy (LIS or "Extra Help") has significantly expanded the number of low-income seniors, including health center patients, who finally have affordable drug coverage. Though some health center pharmacies have experienced difficulties contracting with Prescription Drug Providers (PDPs), most are able to participate in the new Medicare Part D drug benefit program.