I am Libby Coyte. I am a physician assistant (PA) who has been worked in a rural health clinic (RHC) for the last 20 years. The federally qualified rural health clinic program began in 1977 with the passage of a bill by Congress by US Senator Dick Clark. The program was originally designed to reverse the migration of doctors from small towns. For a clinic to qualify as a rural health clinic, it must be located in a rural and medically underserved area. The clinic must provide physician services, routine diagnostic and laboratory services, establish a referral system for medically necessary services not available at the clinic, provide first response emergency care and expand the physician medical services and increase access to medical care to the citizens in the community by employing a PA, nurse practitioner, or a certified nurse midwife. Payment for Medicare and Medicaid visits to a RHC are based on the actual cost of providing these services as determined by a yearly cost report. Presently, the reimbursement for most RHCs is caped at a little over $70 per visit.

Over the last 27 years, the RHC program has been an extremely successful safety-net program for health care services in Iowa and across rural America. RHCs have reversed the loss of medical services from small towns in Iowa and across the US. Currently there are 139 RHCs in Iowa, many located in small towns, which would have no local health care without the RHC. Though it is a successful program, RHCs still financially vulnerable due to the numbers of uninsured and underinsured patients and aging equipment and building where they are located. To support vital program, three areas need to be improved to maintain the financial viability of RHCs.

1. Assistance is needed to help offset the cost of the 10-15% of patients seen in RHCs who have no health insurance and an even larger percentage of underinsured patients. As these patients are part of the community, they are seen by the RHC even if they are unable to pay for the care. Since the cost per visit is calculated by taking the number of visits divided into the total cost, every uninsured patient seen will lower the cost of a visit and the clinic has no way to recoup these costs. The current system has a built in disincentive to see uninsured patients. This should be reversed and the RHC should be encouraged to see uninsured patients by providing them with some compensation for these visits.

2. It would be helpful if there were funds available for RHCs to use for capital improvement and equipment purchases. Other safety net provider programs have access to grant funds for capital improvements and equipment purchases but RHCs do not.

3. RHC would benefit if preventive services such as adult tetanus immunization, flu vaccine, health maintenance physicals and visits were reimbursed if provided at a RHC. Unfortunately, many preventative services are not reimbursable and therefore are discouraged under current RHC regulations.

By treating illness and injury locally where costs are substantially less, RHCs reduce expenses to both the system and to the patient. For instance if a respiratory infection is treated locally before it becomes pneumonia and requires hospitalization, the costs are substantially less. Studies have shown that treatment at rural health clinics is 1/3 as expensive as treatment at hospital emergency rooms. And the locally treated worker loses less time from their job. Most importantly, some life threatening conditions such as heart attacks and severe allergic reactions to bee stings can be life saving when treated locally and promptly.

The Rural Health Clinic program is a proven successful medical care safety net program, which has provided stability to the infrastructure of many Iowa small towns over the last 27 years. This program deserves our support to insure that rural health clinics will continue to be financially viable in the years to come so they can continue to efficiently increase access to medical care in rural communities in Iowa.

Iowa Association of Rural Health Clinics
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Contact: Heather Olson 283-9397 or Ed Friedmann 833-2301