

Options for Supporting Primary Care

There are ten options for supporting primary care (other than fee-for-service) and related outpatient services in rural areas.

State Offices of Rural Health and hospitals are AT GREAT RISK if they assume that 'one size fits all.' What works in Colorado may not be the best option in New Hampshire. What works for one hospital in any state may not be the best option for other hospitals in the same state.

**When you have seen one rural primary care practice,
you have seen one rural primary care practice**

Some of the variables that affect the decision about which option is best:

- The type of shortage area designation the community that the practice is LOCATED IN has
- The type of shortage area designation the communities that the practice SERVES have
- What type of control the hospital wants/needs to retain over the practice
- Whether or not the hospital wants to/needs to get the practice deficit off the hospital balance sheet
- Whether or not the practice/community can meet the eligibility criteria for a Community Health Center grant
- What types of services the practice provides (or wants to), i.e., dental receives better reimbursement in an FQHC than in private practices, but is not reimbursable in an RHC or an outpatient department of a hospital
- Whether or not Medicaid is reimbursing CAHs (and other hospitals) cost or fee-for-service
- Whether or not the state has a state 'clinic' status that might provide Medicaid reimbursement better than any other option
- Whether or not a change would trigger a state CON process
- What the state PPS policy is for Medicaid reimbursement for RHCs and FQHCs
- Whether or not Medicaid is a managed care program in the state
- Whether or not the status is fully utilizing the Governor designation for RHC status AND the Governor requested Exceptional MUP status for FQHC status
- Medicare and Medicaid payer mix in the hospital/CAH and practice
- Cost structure of the practice

Examples of what can go wrong:

- In a state where Medicaid is not reimbursing CAHs on the basis of cost, a CAH might be better off keeping RHC status to assure cost reimbursement from Medicaid.
- The CAH may make a change based on the reimbursement difference for the practice, without taking into consideration how that change affects the costs that remain (or are taken away from) the CAH. A hospital could gain some benefit for the practice, but lose big benefits for the CAH.
- Some hospitals choose to keep practices out of the hospital so that JCAHO surveys will not include the practice.
- Hospitals with fewer than 50 available beds with provider-based RHCs need to be very careful of changing from that status (which provides uncapped Medicare reimbursement) to CAH outpatient department status (which provides Medicare reimbursement at 115% of the Medicare fee schedule).
- Some hospitals may not realize that it will be possible for RHCs and FQHCs to make a profit under Medicaid PPS payments.

PLEASE BE VERY CAREFUL ABOUT ASSUMING THAT ONE MODEL IS 'BEST' IN ANY SITUATION

The following table presents a VERY BASIC overview of the eight options. PLEASE do not assume that this is a complete discussion. There are many issues for each option that need to be reviewed in full.

Ten Options for Supporting Primary Care

Provider Type	Medicare Reimbursement	Medicaid Reimbursement	Shortage Area Requirements	BASIC Eligibility Criteria	BASIC Other Benefits
Hospital Outpatient Department					
Non-CAH Rural Hospital < 100 beds	Prof. fee schedule + APC Rates	State specific	None	Must be a department of the hospital	Access to 340B Low Cost Drug Program, IF hospital is DSH or public entity (with some restrictions)
Non-CAH Rural Hospital > 100 beds	Prof. fee schedule + APC Rates				
CAH electing all inclusive payments	115% OP prof. fees, cost for facility part				
CAH not electing all inclusive payments	100% OP prof. fees, cost for facility part				Medicare DSH status does not apply to CAHs
Rural Health Clinic					
Freestanding	Cost-based-capped at \$70.78 (2005)	PPS based on an average of historic cost for 1999-2000	<ul style="list-style-type: none"> • Facility Based HPSA (existing RHCs) • Primary Care HPSA ≤ 3 yrs old • MUA ≤ 3 yrs old • Not MUP status • Must be located in a MUA/HPSA 	<ul style="list-style-type: none"> • MLP employment • Any type of corporate status 	12/02-Health Care Safety Net Amendments authorized grants (about \$50,000) for training and technology in underserved areas, but no appropriation yet
Provider-based <50 available beds	Cost-based- uncapped	Or		<ul style="list-style-type: none"> • MLP employment • Must meet 'provider based' requirements 	
Provider-based ≥50 available beds	Cost based- capped at \$70.78 (2005)	Rate for another RHC in near proximity (PPS rates set by state)		<ul style="list-style-type: none"> • MLP employment • Must meet 'provider based' requirements 	
Federally Qualified Health Center					
Look-Alike	Cost-based-capped at \$94.48 for rural and \$109.88 for urban (2005)	PPS based on historic cost for 1999-2000	Must serve population designated as MUA or MUP	<ul style="list-style-type: none"> • Must meet CHC requirement • Cannot be owned by another entity • Must be fully operational at time of application 	<ul style="list-style-type: none"> • Could help get CHC grant • 340B provider • Cost reimbursement for dental, mental health, etc.
Grantee		Or	Rate for another FQHC in near proximity (PPS rates set by state)	Must serve population designated as MUA or MUP	<ul style="list-style-type: none"> • Must meet CHC requirement • Cannot be owned by another entity • Have 90 days post funding to become fully operational
State Specific 'Clinic' Status (in some states)					