The Future of the Frontier Extended Stay Clinic

Introduction

Accessing emergency care in rural America can be very challenging,[1,2] especially in frontier areas no matter how they are defined.[1] Hospitals are few and far between, and transporting patients may be significantly delayed because of weather, lack of traversable roads or airports, darkness, and other difficulties.[3] In these cases, frontier clinics must care for patients until it is possible to transfer them. However, these clinics do not qualify for Medicare or other reimbursement for extended patient management services. In an environment where rural clinics are already struggling financially, providing uncompensated clinic-based extended stay services is financially unsustainable.

Additionally, some patients require short-term monitoring, but may not require emergency medical services (EMS) transfers or hospitalization if managed locally. In these cases it may be more cost effective, safer and generally more appropriate to treat and monitor patients locally than to transfer them to a hospital.

In response to these concerns, Congress authorized the Frontier Extended Stay Clinic (FESC) demonstration project, which the Centers for Medicaid and Medicare Services (CMS) launched in 2010. The FESC demonstration tested a new Medicare payment classification pertaining to (1) emergency treatment of patients staying in the clinic for over four hours when transporting them to a hospital was not possible, and (2) short-term (up to 48 hours) monitoring and observation of patients in cases where an EMS transfer or hospital emergency room visit or stay was unnecessary. Participating clinics received enhanced reimbursements for providing these services to Medicare beneficiaries, and in Alaska the Medicaid program also provided enhanced reimbursements for eligible encounters with Medicaid patients.

To qualify to participate in the FESC demonstration, clinics were required to be located at least 75 miles from the nearest hospital or inaccessible by public road.[3] Starting in 2004, five clinics in Alaska (n=4) and Washington (n=1) worked together under a Health Resources and Services Administration (HRSA) Office of Rural Health Policy (ORHP) cooperative agreement to prepare for the CMS FESC demonstration and meet the Conditions of Participation (COPs), collect data, and inform policy-makers about the FESC project. These same clinics participated in the FESC demonstration from 2010 to 2013.

Independent evaluations of the FESC model have demonstrated that it benefitted patients, participating clinics and CMS because:

- Unnecessary transfers to hospital emergency rooms were avoided, which was less stressful and risky for patients and saved CMS money;[5]
- Demonstration clinics improved their emergency response capacity using the funds from ORHP. Clinics acquired the equipment and medical supplies necessary to treat emergency and low-risk monitoring and observation patients, and improved emergency communications and staffing.[5]

The CMS FESC demonstration ended in 2013, however the discussion of how to use the

results of the demonstration to improve frontier health care is just beginning. The FESC provider model shows a great deal of promise. Congressional legislation is required in order for CMS to build off of the initial successes of the FESC demonstration and use the lessons learned to create a permanent extended stay primary care provider type. Because the FESC is a relatively new development in frontier health care, the National Rural Health Association (NRHA) does not currently have an official policy position on this topic. The time has come to develop a NRHA policy position on this issue.

Data

Effectiveness of the FESC model

The CMS FESC demonstration ended in April 2013. The final CMS evaluation of the demonstration is scheduled to be presented to Congress in April 2014. However, two additional evaluation studies, one completed in 2012 by the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis at the University of Iowa College of Public Health[6] and the other completed in 2011 by the Institute of Social and Economic Research at the University of Alaska, Anchorage[4] speak to the effectiveness of this model. Financially, FESCs appear to be cost efficient. Although an in-depth financial analysis is still underway, current financial data demonstrates cost savings, primarily in avoided medevacs. The RUPRI report states that the FESC program conservatively saved health insurers nearly $14 million in avoided transfer costs in the first five years of the ORHP FESC demonstration.[6] In regard to patient outcomes, FESCs have also shown positive results. Analysis of the first five years of the ORHP FESC demonstration has shown that the quality of care at FESCs was consistent regardless of the original provider type of the clinic, that clinical quality and the patient/family experience improved, and that the treatment provided was consistently within the scope of services which FESCs can provide.[4,6]

Challenges encountered during the FESC demonstration

Rural and frontier areas experience some of the most acute medical professional shortages in the nation.[7,8] Sixty-six percent of the Health Professional Shortage Areas in the U.S. are found in rural areas.[8] The personal and professional isolation of health professionals in frontier areas makes it difficult for frontier clinics to recruit and retain staff. In addition, relatively low numbers of patient encounters make it difficult to adequately fund frontier clinics and provide incentives to attract health professionals. During the FESC demonstration, these staffing challenges made it difficult for FESCs to comply with the original staffing COPs, which required a registered nurse, nurse practitioner, physician assistant, or physician to be available any time there was an extended-stay patient at the clinic.[5,7] In addition, providing after-hours care to FESC patients constituted around 45% of all reimbursable FESC encounters during the demonstration, placing an added burden on clinic staff which resulted in additional stress and burnout, especially among support staff.[5] In 2009, CMS amended the COPs to allow qualified licensed practical nurses and clinical nurse specialists to monitor patients, as well.[4] CMS also allowed Alaskan FESCs that could demonstrate that they were unable to recruit the aforementioned health professionals to apply for a waiver allowing Emergency Medical Technicians or Mobile Intensive Care Paramedics with an expanded scope of practice to monitor patients. This solution gave Alaskan FESCs more flexibility in staffing, especially outside regular clinic hours, and reduced stress on staff while ensuring that the medical professionals

observing and monitoring patients have the competencies needed to insure patient safety.[4] If an extended stay primary care model based on the FESC model is created, this provision would be helpful to clinics that experience staff shortages both in Alaska and beyond. Allowing frontier clinics flexibility in staffing, especially after-hours, will be crucial to the success of future extended stay primary care models.

During the FESC demonstration, a second limitation to appropriate implementation of the model was the requirement that a FESC be located at least 75 miles by road from the nearest hospital or inaccessible by public road. As a result of this requirement, the number of potential FESCs was extremely limited: it has been estimated that fewer than ten existing clinics in the lower 48 states would be eligible to become FESCs based on this mileage requirement.[9] Additionally, this criterion does not take into account differences in road conditions, infrastructure, topography, speed limits, seasonal variations, and other factors that affect patient transfer time. The time it takes to transfer a patient 75 miles can vary widely due to these factors. If an extended stay primary care model based on the FESC model is created, this distance should be reduced and should also take other factors that affect patient transfer time and cost into account.

Financial sustainability of the FESC demonstration

The FESC billing system was based on four-hour blocks; demonstration clinics received FESC reimbursements for every four hours they provided extend stay services to a patient. Encounters under four hours were not eligible to receive enhanced Medicare reimbursement under the FESC demonstration. However, encounters that lasted less than four hours and ultimately resulted in a patient transfer were expensive for FESCs. Demonstration clinics needed to have highly trained staff and expensive specialized equipment and supplies available to deal with transfers, but did not receive enhanced reimbursement to cover these costs when the duration of an encounter was under four hours.[5] Additionally, FESCs provided costly emergency care, but many of these encounters were only reimbursed at a regular encounter rate because they lasted under four hours and FESCs were not permitted to bill for emergency care. Emergency encounters lasting under four hours made up a substantial portion of encounters at FESCs.[4] When clinics provide costly services that are not reimbursed, their financial sustainability is put in jeopardy.

Starting in 2004, FESCs paid for the emergency and extended-stay services they provided using grants from HRSA/ORHP. A substantial financial investment was needed for clinics to comply with the CMS FESC demonstration COPs, and the funding provided by HRSA/ORHP was "essential to the demonstration facilities meeting the requirement for the physical plant and staffing levels."[4] However, this source of funding ended with the CMS FESC demonstration. Without funding to support the emergency care provided by FESCs, it would not have been possible for these clinics to provide these services, unless the encounter rate increased and/or the billable services expanded to include emergency services and exceptional services provided for stays under four hours.[4] It would also be difficult for a clinic to become a FESC without funding to cover the substantial upfront costs of transition.

During the five years of data collection, the average percentage of patient encounters at FESCs lasting more than four hours that were eligible for reimbursement by Medicare and Medicaid was only 36.4% of the total number of encounters, and at one clinic (Iliuliuk Family Health Services) only 14.5% of encounters were eligible for FESC reimbursement.[4] This was because not all patients seeking treatment at FESCs were eligible for Medicare or Medicaid.

Such a low volume of reimbursable extended stays made it difficult for clinics to pay for extended stay services without operating support, such as that provided by HRSA/ORHP. Payment from commercial insurers would be critical to the long term financial viability of an extended stay primary care model.

Policy Recommendations and Justification

Recommendation 1: Use the FESC model as a foundation to create a permanent extended stay primary care provider type.

The FESC demonstration has shown that it is possible to improve health care services in frontier communities, increase frontier clinic emergency preparedness and observation and monitoring capacities, and reduce costs for CMS. In short, the FESC demonstration has proven to be successful in many ways and CMS should consider building off of these successes and use the lessons learned to create a permanent extended stay primary care provider type. CMS should permanently incorporate such a provider type into its policy as one of the provider classifications that are eligible to receive payments for providing emergency and extended stay services.

Recommendation 2: Use the lessons learned from the FESC demonstration to create an extended stay primary care provider type that will benefit more frontier communities.

The FESC demonstration has demonstrated the potential viability of an extended stay primary care model and illustrated which aspects of the FESC model should be improved. For more frontier communities to benefit from an extended stay primary care model, CMS should take the following four aspects into account:

2.1. Allow an expanded role for emergency medical technicians and paramedics in observation and monitoring at extended stay clinics.

During the FESC demonstration, clinics in Alaska unable to recruit an RN, NP, PA, or MD/DO, or LPN could apply for a waiver allowing Emergency Medical Technicians or Mobile Intensive Care Paramedics who have expanded scope of practice authority to monitor patients, when appropriate. This increased flexibility in clinic staffing while ensuring patient safety and quality of care, and should be allowed at all extended stay primary care clinics.

2.2. Implement more inclusive location requirements.

The requirement that FESCs be located at least 75 miles from the nearest hospital or be inaccessible by public road disqualified many frontier clinics that could have benefitted from FESC certification. If an extended stay primary care model based on the FESC model is created, this distance should be reduced to 35 miles, and other factors that affect patient transfer time and cost should be taken into account. Thirty-five miles is the same distance requirement used for Critical Access Hospitals. The FESC model provides another health care delivery option for rural communities, especially those that are facing hospital and other existing healthcare provider closures due to local and regional population and economy changes.

2.3. Allow extended stay clinics to bill for all emergency care services.

During the FESC demonstration, FESCs provided emergency care services to

patients for which they were not reimbursed. To ensure the financial viability of an extended stay primary care model, extended stay clinics must be able to bill for emergency care and related services using emergency CPT codes starting upon a patient's arrival at the clinic.

2.4. Provide start-up and operating support.

Without grant funding provided by ORHP between 2004 and 2013, it would not have been possible for the FESC demonstration clinics to maintain the additional staff and equipment necessary to comply with the CMS COPs. It would also have been difficult for clinics with low volumes of reimbursable extended stay encounters to pay for the services they provided. To make it possible for more clinics to adopt an extended stay primary care model, additional funding would need to be provided to cover the costs of transition and to allow clinics to operate despite low patient volumes. Alternatively, extended stay payments could be increased to provide incentive for clinics to take on the responsibilities and costs of becoming an extended stay clinic.

Sources

1. National Rural Health Association. Designation of Frontier Health Professional Shortage Areas. Kansas City: National Rural Health Association; 2010: Policy Brief. (Available from http://www.ruralhealthweb.org/popup.cfm?objectID=B3426F74-3048-651A-FECB7D5ABF819E53)
2. National Rural Health Association. Rural/Women's Access to Health Services. Kansas City: National Rural Health Association; 2005: Policy Brief. (Available from http://www.ruralhealthweb.org/popup.cfm?objectID=463A9974-3048-651A-FE05DC89B7409E5A)
3. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. Frontier Extended Stay Clinic Demonstration (CMS-5030-N). Washington, DC: US Department of Health and Human Services; 2006: Notice. (Available from https://www.cms.gov/DemoProjectsEvalRpts/downloads/FESC_Fed_Reg_Notice.pdf)
4. Institute of Social and Economic Research. Frontier Extended Stay Clinic Demonstration Volume 1. *Office of Rural Health Policy.* In press 2011.
5. Alaska Center for Rural Health. Frontier Extended Stay Clinic Project: Report on 36 Months of Data. Anchorage: Alaska Center for Rural Health; 2009. (Available from http://www.alaskafesc.org/_attachments/FESC_12_month_data_report_year_3.pdf)
6. Rural Policy Research Institute for Rural Health Policy Analysis. Frontier Extended Stay Clinic Evaluation. April 2012
7. Alaska FESC Consortium. Frontier Extended Stay Clinic Demonstration: Medical Staffing Requirements Discussion. Sitka: Alaska FESC Consortium; 2008. (Available from http://www.alaskafesc.org/_attachments/FESC_Staffing_Challenges.pdf)
8. U.S. Department of Health and Human Services, Office of Shortage Designation. Designated Health Professional Shortage Area (HPSA) Statistics. Available at: http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2. Accessed on November 28, 2011.
9. US Department of Health and Human Services, Office of Rural Health Policy. Modeling The Frontier Extended Stay Clinic Conditions of Participation and Reimbursement Methodologies. Washington, DC: US Department of Health and Human Services; 2004.

(Available from ftp://ftp.hrsa.gov/ruralhealth/FESCModelingProject.pdf)

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