The Frontier Extended Stay Clinic

A Promising Model for Frontier Communities

A report by the National Center for Frontier Communities prepared in consultation with the Frontier and Rural Expert Panel.

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Executive Summary

Background
Accessing emergency care in rural America can be very challenging, especially in frontier areas no matter how they are defined. 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. 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. The Frontier Extended Stay Clinic (FESC) demonstration was created to in response to these concerns.

CMS launched the FESC demonstration project in 2010. The FESC is a Medicare payment classification pertaining to (1) emergency treatment of patients staying in the clinic for over four hours when transporting them to a hospital is 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 is unnecessary. FESCs must be located at least 75 miles from the nearest hospital or inaccessible by public road to qualify for the demonstration. A clinic must be prepared to care for emergency patients and monitor and observe patients prior to receiving FESC certification. This means that the clinic must have the staff, equipment, drugs, and facilities needed to care for FESC patients available 24 hours a day.

Conclusions
Evaluations of the FESC demonstration to date have shown that access to FESCs has improved patient services through increased clinic staffing, improved equipment and facilities, and the ability to treat and monitor patients locally when necessary or appropriate. However, the financial investment required to achieve these improvements is not covered by current reimbursement levels – FESCs do not receive enhanced compensation from private insurers for providing extended stay services, or any compensation for providing necessary emergency care. There is also no stable source of funding to cover the start-up costs for new clinics wishing to convert to FESCs.

The FESC model has not yet been permanently incorporated into CMS policy as a provider classification that is eligible to receive Medicaid and Medicare payments for providing emergency and extended stay services. Legislative action must be taken if the FESC model is to be maintained beyond the 3-year demonstration period and expanded to other frontier states.

The current FESC COP requirement that a FESC be located at least 75 miles from the nearest hospital or inaccessible by public road limits the appropriate implementation of the FESC model to very few clinics in the lower 48 states.
1 Introduction
Accessing emergency care in rural America can be very challenging,\textsuperscript{1,2} especially in frontier areas no matter how they are defined.\textsuperscript{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.\textsuperscript{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. The Frontier Extended Stay Clinic (FESC) model was created to in response to these concerns.

2 The FESC model

2.1 History
In the 2003 Medicare and Medicaid Authorization Act, Congress authorized the Centers for Medicaid and Medicare Services (CMS) Frontier Extended Stay Clinic (FESC) demonstration project, which CMS launched in 2010. The FESC is a Medicare payment classification pertaining to (1) emergency treatment of patients staying in the clinic for over four hours when transporting them to a hospital is 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 is unnecessary. FESCs must be located at least 75 miles from the nearest hospital or inaccessible by public road to qualify for the demonstration.\textsuperscript{3} The Alaska Medicaid program is also participating in the demonstration, making FESC payments for eligible encounters with Medicaid patients.

Five clinics in Alaska (4 clinics) and Washington (1 clinic) are participating in the CMS FESC demonstration. These same clinics have been working together since 2004 under a Health Resources and Services Administration (HRSA) Office of Rural Health Policy (ORHP) cooperative agreement to prepare for the CMS demonstration and meet the FESC demonstration Conditions of Participation (COP), collect data, and inform policy-makers about the FESC project. The ORHP grant and the CMS FESC demonstration are scheduled to end in 2013. To date, ORHP has invested approximately $10 million in infrastructure development grants to allow FESC clinics to meet COP requirements. The investments break out to approximately $6 million for staffing to provide 24/7 services (overwhelmingly considered the most important investment); $1 million for diagnostic and treatment equipment; $300,000 for facility upgrades; and the remaining amount for additional investments not categorized (e.g. administration, evaluation, supplies, miscellaneous).\textsuperscript{4} During the demonstration period CMS has allowed a payment demonstration to reimburse FESCs $541.24 per four-hour block of FESC services.
2.2 Requirements for Certification

A clinic must be prepared to care for emergency patients and monitor and observe patients prior to receiving FESC certification. This means that the clinic must have the staff, equipment, drugs, and facilities needed to care for FESC patients available 24 hours a day. Outside office hours, a staff person must be on call and no more than 30 minutes away from the FESC at all times. A doctor of medicine or osteopathy must also be available by radio or phone at all times for consultation with other FESC staff and in case of an emergency. Each FESC must develop an emergency preparedness plan, including insuring emergency power and water supplies. Additionally, all FESCs must have a transfer agreement with at least one acute care hospital, and must also make a quality improvement and staff credentialing agreement with a hospital. The FESC must also have a quality assessment and performance improvement program focused on improving patient safety, quality of care, and patient satisfaction.

A limitation to the potential for appropriate implementation of the FESC model is the current requirement that a FESC be located at least 75 miles by road from the nearest hospital or inaccessible by public road. As a result, the number of potential FESCs is extremely limited: it has been estimated that fewer than ten existing clinics in the lower 48 states would be eligible to become FESCs. 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.

2.3 Preliminary Evaluation Results

As the CMS FESC demonstration is still in process, a final evaluation of the 3 year CMS demonstration has not been completed. The University of Alaska Anchorage collected and reported on detailed encounter data at each of the demonstration clinics for the first five years that the clinics received funding from ORHP. Building on that, there are two additional funded evaluations of the FESC model. One study was funded by ORHP and conducted by the RUPRI Center for Rural Health Policy Analysis at the University of Iowa. The RUPRI research began in 2011 and a final report was submitted to ORHP in April 2012. At the time of writing, the RUPRI report was pending approval for release by ORHP. The second study is being funded by CMS and conducted by Mathematica, Inc. The CMS study began in 2011 and is scheduled to be completed in 2014.

2.3.1 RUPRI Report

The goal of the RUPRI research was to use qualitative and quantitative measures to answer the following questions:

- Does FESC serve the “Triple Aim” of better health, better care, and lower costs?
- Does FESC improve quality of life for both patients and health care providers?
- Did FESC grant funding improve community services and facilities?
- For those patients in whom medical evacuation was avoided, did payers save money?
- Once established, how will the FESC program become sustainable without grant funding?
- What are the characteristics of other remote communities that would benefit from FESC?

Key research results presented by the RUPRI Center at the University of Iowa speak to the effectiveness of the FESC model. The research found that FESCs provided “critical and potentially life-
saving emergency and extended-care services to isolated rural communities.” Clinical quality at FESC demonstration sites improved due to the program, clinic services were augmented, the experiences of patients and families improved, and frontier communities were supportive of the program. Regarding the frontier health care workforce, the availability of FESC services did not uniformly help or hinder health care professional recruitment and retention.4

The results regarding the financial aspects of FESCs were mixed. RUPRI conservatively estimated that the FESC program saved health insurers $13.8 million in avoided transfer costs in the first five years of the program, an average of approximately $500,000 per clinic per year. However, health care cost savings overwhelmingly accrued to private health insurers compared to Medicare and Medicaid. Private insurers do not pay FESCs differentially for after-hours and extended-stay services, while the additional costs to clinics to provide these services are estimated at $1 million per clinic per year. Current health insurer payments are not sufficient for FESCs to recoup the costs of providing after-hours and extended-stay services. However, the RUPRI research did find that additional compensation related to providing FESC services had a strong positive impact on the economic vitality of the local area.

Based on the above findings, the RUPRI report makes the following recommendations:4

- Recognize the FESC as a new and permanent Medicare provider type.
- Revisit the distance criteria for FESC designation (75 miles by road, or isolation by water, from the nearest hospital).
- Provide start-up funding for clinics transitioning to FESC status.
- Reduce the minimum time for FESC service billing from four hours to two hours.
- Aggregate additional FESC revenue sources for the sole purpose of funding 24/7 emergency and extended-stay care.
- Optimize individual FESC financial performance.
- Engage private health insurers and self-insured employers to pay for FESC services.
- To address provider shortages, allow FESC providers to practice at their optimal level of licensure, education, and experience.
- Develop tele-emergency services for FESCs.
- Investigate freestanding emergency department (FED) designation as an alternative revenue option.
- Continue to evaluate the FESC model of care and study its applicability to other rural health care settings.

2.3.2 Previous Evaluations

Research by the Alaska Center for Rural Health and the Institute of Social and Economic Research has shown that the FESC program has had a positive impact on clinical quality. Analysis of the first five years
of the ORHP FESC demonstration showed that the quality of care at FESCs was consistent regardless of the original provider type of the clinic, and that the treatment provided was consistently within the scope of services which FESCs can provide. Demonstration clinics have also improved their emergency response capacity using the funds provided by ORHP. Clinics have acquired the equipment and medical supplies necessary to treat emergency and low-risk monitoring and observation patients, and have improved emergency communications and staffing.

3 Workforce Issues

Rural and frontier areas experience some of the most acute medical professional shortages in the nation. Sixty-six percent of the Health Professional Shortage Areas in the U.S. are found in rural areas. The personal and professional isolation experienced by 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.

These staffing challenges made it difficult for demonstration FESCs to comply with the original FESC demonstration COP, which required a registered nurse, nurse practitioner, physician assistant, or physician available any time there was an extended-stay patient at the clinic. In 2009, CMS amended the FESC demonstration COP to allow qualified licensed practical nurses and clinical nurse specialists to monitor patients, as well. CMS has also allowed Alaskan FESCs, which can demonstrate that they have been unable to recruit the aforementioned health professionals, to apply for a waiver allowing Emergency Medical Technicians or Mobile Intensive Care Paramedics who have an expanded scope of practice to monitor patients.

This solution has given 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. If the demonstration were extended and expanded, this provision would be helpful to clinics outside Alaska that experience staff shortages, because providing after-hours care to FESC patients constitutes around 45% of all reimbursable FESC encounters and results in additional stress and burnout, especially among support staff.

4 Funding and Financial Sustainability

Some of the funding and financial sustainability issues pertaining to FESCs were already discussed in section 2.3, as they were part of the findings of RUPRI’s evaluation of the FESC demonstration. These findings are in line with the outcomes of several other FESC evaluations, which are discussed below.

At present, FESCs are funded by two sources: an ORHP grant and Medicare and Medicaid reimbursements (billing code G-9140). FESCs are paid a fixed rate ($541.24) by Medicare or Medicaid for every four hour block of care provided to a patient who stays at the clinic for more than four hours. These reimbursements are based on a prospective payment system.

In practice, the amount of money FESCs received from Medicare and Medicaid has been a small part of their overall revenues. There are several reasons for this. First, encounters under four hours are
not eligible to receive enhanced reimbursement under the current FESC regulations. However, encounters that ultimately result in a patient transfer, but last less than four hours, are expensive for frontier clinics. These clinics must have highly trained staff and expensive specialized equipment and supplies available to deal with transfers, but they do not receive enhanced reimbursement to cover these costs. Additionally, FESCs provide costly emergency care, but many of these encounters are only reimbursed at a regular encounter rate because they last under four hours and FESCs are not permitted to bill for emergency care. Emergency encounters lasting under four hours make up a substantial portion of encounters at FESCs. When clinics provide costly services that are not reimbursed, their financial sustainability is put in jeopardy.

Since 2004, FESCs have paid for much of the emergency and extended-stay services they provide using grants from HRSA/ORHP. A substantial financial investment is needed for clinics to comply with the CMS FESC demonstration COP, and the funding provided by HRSA/ORHP has been “essential to the demonstration facilities meeting the requirement for the physical plant and staffing levels.” However, this source of funding is slated to end in 2013. Thereafter, it will be very difficult to sustain existing FESCs unless the encounter rate is increased and/or the billable services expanded to include emergency services and exceptional services provided for stays under 4 hours. It will also be difficult for more clinics to become FESCs without funding to cover the costs of transition.

During the first five years of data collection, the average percentage of encounters lasting more than four hours that were eligible for reimbursement by Medicare or 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 enhanced reimbursement. This is due to the fact that not all FESC patients are eligible for Medicare or Medicaid. Such a low volume of reimbursable extended stays makes it difficult for clinics to pay for extended stay services without operating support, such as that provided by HRSA/ORHP. Payment from commercial insurers is also being sought and will be critical in the long term financial viability of FESCs.

5 Policy and Regulatory Issues

5.1 CMS Provider Definitions
Currently, the FESC model is a demonstration project, but the FESC has not yet been permanently incorporated into CMS policy. For this model to continue to exist, CMS will need to recognize it as one of the provider classifications that are eligible to receive Medicaid and Medicare payments for providing emergency and extended stay services.

5.2 The Role of Emergency Medical Technicians and Paramedics
Currently, FESCs in Alaska unable to recruit adequate numbers of RNs, NPs, PAs, MD/DOs, or LPNs may apply for a waiver allowing Emergency Medical Technicians or Mobile Intensive Care Paramedics who have an expanded scope of practice to monitor patients, when appropriate. This has increased flexibility in clinic staffing while ensuring patient safety and quality of care. However, FESCs outside Alaska do not currently enjoy the same amount of regulatory flexibility, creating potential FESC staffing challenges.
5.3 Location Requirements
The requirement that FESCs be located at least 75 miles from the nearest hospital or inaccessible by public road disqualifies many frontier clinics that could benefit from FESC certification. This regulation will limit the appropriate implementation of the FESC model to very few clinics in the lower 48 states.

5.4 Billing for Emergency Care
Currently, FESCs provide emergency care services to patients for which they are not reimbursed. To ensure the financial viability of this model, FESCs must be able to bill for emergency care and related services using emergency CPT codes starting upon a patient’s arrival at the FESC. This would require that CMS billing codes for FESCs be amended.

5.5 Start-up and Operating Costs
Without grant funding provided by ORHP between 2004 and 2012, it would not have been possible for the current FESCs to maintain the additional staff and equipment necessary to comply with the CMS FESC demonstration COP. 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 the FESC model, additional funding will be needed to cover the costs of this transition and to allow clinics to operate despite low patient volumes. Alternatively, FESC payments could be increased to provide incentive for clinics to take on the responsibilities and costs of becoming a FESC.

6 Conclusions
Evaluations of the FESC demonstration to date have shown that access to FESCs has improved patient services through increased clinic staffing, improved equipment and facilities, and the ability to treat and monitor patients locally when necessary or appropriate. However, the financial investment required to achieve these improvements is not covered by current reimbursement levels – FESCs do not receive enhanced compensation from private insurers for providing extended stay services, or any compensation for providing necessary emergency care. There is also no stable source of funding to cover the start-up costs for new clinics wishing to convert to FESCs.

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