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 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, the Center for Medicaid and Medicare Services (CMS) launched the Frontier Extended Stay Clinic (FESC) demonstration project in 2010. The FESC is a Medicare classification which can bill CMS for providing (1) emergency treatment to 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 programs\(^3\).

Five rural clinics in Alaska (n=4) and Washington (n=1) have been working together since 2004 under a Health Resources and Services Administration (HRSA) Office of Rural Health Policy (ORHP) demonstration to meet the CMS Conditions of Participation (COPs), collect data, and inform policy-makers about the FESC project. These five clinics are the same ones which make up the CMS demonstration\(^5\). Independent evaluations of the FESC model have demonstrated that it is beneficial for patients, participating clinics and CMS because:

- Unnecessary transfers to hospital emergency rooms have been avoided, which is less stressful and risky for patients and has saved CMS money\(^5\);
- Demonstration clinics have improved their emergency response capacity using the funds from the ORHP demonstration. 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\(^5\).

The CMS FESC demonstration is scheduled to end in 2013. Congressional Legislation is required for this successful provider model to continue to exist, and to allow it to be modified so that it can be implemented in other frontier communities throughout the United States. 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. Considering that the FESC demonstrations will soon come to an end, the time has come to develop a NRHA policy position on this issue.

Data

Effectiveness of the current model
As the CMS FESC demonstration is still early in the development process, a final evaluation has not yet been completed. However, preliminary data from the ORHP demonstration speaks 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. It has been estimated that the four Alaskan FESCs saved over $11,000,000 annually by treating low-risk patients at the FESCs rather than transferring them to hospitals by medevac. As far as patient outcomes go, FESCs have also shown positive outcomes. 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, and that the treatment provided was consistently within the scope of services which FESCs can provide.

Challenges to expanding the current model
Rural and frontier areas experience some of the most acute medical professional shortages in the nation. 66% of the Health Professional Shortage Areas (HPSAs) in the U.S. are found in rural areas. The remoteness and 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. These staffing challenges have made it difficult for FESC demonstrations to comply with FESC staffing requirements in the past, because the original Conditions of Participation required a registered nurse, nurse practitioner, physician’s assistant or medical doctor available any time there was an extended-stay patient at the clinic. In 2009 CMS amended the COPs to allow qualified licensed practical nurses and clinical nurse specialists to monitor patients. 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 and reduced stress on staff while ensuring that the medical professionals observing and monitoring patients have the competencies needed to insure patient safety. However, this option is currently only available for Alaskan FESCs. At frontier clinics outside Alaska, which are also experiencing staff shortages, providing after-hours care to FESC patients (45% of all reimbursable FESC encounters occurred after-hours) could cause additional stress and burnout, especially among support staff.

A second limitation to the potential for appropriate implementation of the FESC model is the current requirement that a FESC be located to at least 75 miles by road from the nearest hospital or inaccessible by public road. Due to this requirement, the number of potential FESCs is extremely limited: it has been estimated that less than ten clinics in the lower 48 states are potentially eligible to become FESCs based on this criterion. Additionally, this criterion does
not take differences in road conditions, infrastructure, topography, speed limits, seasonal variations, and other factors that affect patient transfer time into account. The time it takes to transfer a patient 75 miles can vary widely due to these factors.

**Financial sustainability of the current model**

Encounters under four hours are not eligible to receive Medicare 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, expensive specialized equipment and supplies available to deal with transfers, but they do not receive income to cover these costs. Additionally, FESCs provide emergency care that can be very costly, however many of these encounters are not reimbursed 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 non-reimbursed encounters at FESCs. When clinics provide costly services that are not reimbursed, the financial sustainability of these critical frontier service providers is put in jeopardy.

Since 2004, FESCs have paid for 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 COPs, and the funding provided by HRSA/ORHP has been “essential to the demonstration facilities meeting the requirement for the physical plant and staffing levels.” As this source of funding will only remain available through 2012, it will be very difficult to sustain existing FESCs or for more clinics to become FESCs unless additional funding is provided to cover the costs of this transition or billable services for FESCs are increased and/or expanded to include emergency services and services provided for stays under 4 hours.

During the five years of data collection, the average percentage of encounters 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 reimbursement by Medicare and Medicaid. 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. Since 2004, HRSA/ORHP grants have helped provide this support. Payment from commercial insurers is also being sought and will be critical in the long term financial viability of FESCs.

**Policy Recommendations and Justification**

**Recommendation 1: Recognize the FESC as a new and permanent provider type.**

The FESC demonstration has shown that it is possible to improve health care services in frontier communities, increase frontier clinic emergency preparedness, observation and monitoring capacities, and lower health care costs for CMS. In short, the FESC demonstration has proven to be successful in many ways and should be maintained. To make this possible, CMS should permanently incorporate this provider type into its policy by recognizing it as one of the provider
classifications that are eligible to receive payments for providing emergency and extended stay services.

**Recommendation 2: Adjust the current FESC regulations to allow more frontier communities to benefit from this model.**

The FESC demonstrations have proven the viability of this provider model, and they have also illustrated which aspects of the model should be improved. Expanding the FESC program will be difficult if some adjustments to the current conditions for participation are not made. For more frontier communities to benefit from FESC certification, CMS should take the following four aspects into account when they define FESCs in policy:

1. **Allow an expanded role for emergency medical technicians and paramedics in observation and monitoring at all FESCs.**
   
   Currently, FESCs in Alaska unable to recruit an RN, NP, PA, or MD/DO, or LPN may apply for a waiver allowing Emergency Medical Technicians or Mobile Intensive Care Paramedics who have expanded scope of practice to monitor patients when appropriate. This has increased flexibility in clinic staffing while ensuring patient safety and quality of care, and should be allowed at all certified FESCs.

2. **Adjust the certification requirement that FESCs be located at least 35 miles from the nearest hospital.**
   
   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. It is suggested that the requirement be adjusted so that a clinic must be located at least 35 miles by road from the nearest hospital or be inaccessible by public road to qualify for FESC certification. This is the same distance requirement used for Critical Access Hospitals.

3. **Allow FESCs to bill for all emergency care services.**
   
   Currently, FESCs provide emergency care services to patients for which they are not reimbursed. To insure the financial viability of this model, FESCs must be able to bill for emergency care and related services starting upon a patient’s arrival at the FESC.

4. **Allow FESCs to bill for extended stays starting two hours after a patient has been admitted.**
   
   Currently, there is a gap in Medicare payments which FESCs receive for the extended stay services they provide: Clinics can only start billing for the care, observation and monitoring they provide starting four hours after a patient is admitted. If a patient stays for less than four hours, the clinic absorbs the cost of the services provided. This situation is detrimental to the financial sustainability of FESCs. To fill this gap, FESCs should be allowed to bill for extended stays starting two hours after a patient has been admitted.

5. **Provide start-up and operating support**
Without supplemental 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 Conditions of Participation for FESCs. 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 needs to be provided 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.

2.6 All tribal health centers and clinics organized under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) will be deemed FESC eligible. Many tribal communities have limited access to health care services and residents must travel far distances and/or time to access the care needed. Several tribal communities outside of Alaska have voiced interest in the FESC model as an effective, cost efficient and community-based service.

References


The Rural Health Congress approved the paper April 2012 as a vote of confidence. The Congress will revisit the policy after the FESC evaluation is completed.

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