Basic Contact Information
Frontier Community Health Integration Project

General Description
The CMS Demonstration was based on a model developed in response to the 2008 Medicare improvements to Patients and Providers Act Frontier specifying four eligible states: Montana (MT), North Dakota (ND), Wyoming (WY) and Alaska (AK).

A Frontier Health System—that aligns all frontier health care service delivery by means of a single set of frontier health care service delivery regulations and an integrated (not fragmented) payment and reimbursement system. For the Medicare beneficiary, the new Frontier Health System would serve as a single point of contact and patient-centered medical home for the coordination and delivery of preventive and primary care, extended care (including Visiting Nurse Services (VNS) with therapies), long term care and specialty care.

In essence, the local Frontier Health System would aggregate all health care service volume within its service area under one integrated organizational, regulatory and cost-based payment umbrella, spreading fixed cost and producing lower-cost care. In addition, budget-neutral, pay-for-quality incentives would be implemented by the local Frontier Health System to demonstrate high quality care provided to frontier patients at lower cost, with savings shared with the Medicare Program.

Frontier-eligible states: Montana (MT), North Dakota (ND), Wyoming (WY) and Alaska (AK)

Excerpts from the proposal outline the characteristics of the Frontier Health System:

1. Provide cost-based reimbursement of care coordinator expenses for Medicare and Medicaid beneficiaries for Frontier Health Systems only. This expense would be paid for with Frontier Health System Pay-For-Outcomes shared savings.

2. Create a new Frontier Health System provider type with a new COP. The COP would be the same as the CAH COP, with some modifications or “waivers” to existing regulations as outlined below.

   a) Change the CAH 25-bed limit to 35 beds for Frontier Health Systems only. Specifically, modify C-351 of the CAH COP to: “The FHS organization must be certified as a Frontier Health System and may have no more than 35 beds, which may be used for acute and swing bed patients.” To qualify, the facility’s annual average daily census cannot exceed 5, and the facility must meet MIPPA criteria for the F-CHIP demonstration, which limits application of the 35-bed limit to only 71 CAHs in AK, MT, WY and ND.

   b) Allow the delivery of, and cost-based reimbursement of, physical, occupational and speech therapy services as well as services delivered by a home health aide in the frontier home setting through the Rural Health Clinic VNS home care program for Frontier Health Systems only.
Specifically, change the Conditions for Coverage for Visiting Nurse Services in the Medicare Benefit Manual, Regulation 90.5, RHC 412.5 “Services furnished by a licensed nurse” (Rev. 1, 10-1-03) to: “Services furnished by a licensed nurse, therapist or home health aide—The services must be furnished by a registered nurse, a licensed practical nurse, a licensed vocational nurse, a home health aide or a licensed physical therapist, licensed occupational therapist or licensed speech therapist.”

Expansion of VNS home services for frontier patients will prevent costly unnecessary ER visits as well as acute care and long term care admissions and readmissions, increase access to home health services for frontier Medicare beneficiaries, and will alleviate workforce shortages.

c) Allow a waiver for Frontier Health Systems only permitting Frontier Health System-owned ambulance services to operate in their rational service areas, which often encompass hundreds or even thousands of square miles, even if another ambulance service (even if owned by a CAH or another Frontier Health System) is located within 35-miles.

The specific recommendation is to change the ambulance fee schedule guidance (Rev. 103; Issued 02-20-09; Effective Date: 02-05-09; Implementation Date: 03-20-09) to: “Payment for ambulance items and services furnished by a CAH, or by an entity that is owned and operated by a CAH, is based on reasonable cost if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH. CMS may waive the 35-mile driving distance separation requirement for ambulance items and services furnished by a Frontier Health System, or by an entity that is owned or operated by a Frontier Health System, if such Frontier Health System is furnishing services only within its historical and rational service area.”

d) Eliminate productivity screens for Rural Health Clinic medical providers practicing in Frontier Health Systems. The volume of RHC visits to clinics owned and operated by Frontier Health Systems is too small to meet the productivity screens. The productivity screens were designed for low volume Rural Health Clinics, not very-low-volume frontier Rural Health Clinics. Not meeting the productivity screens could jeopardize Rural Health Clinic status and loss of access to a medical provider by frontier beneficiaries.

Specifically, change RHC-503, 40.3 – Screening Guidelines for RHC/FQHC Health Care Staff Productivity (Rev. 1, 10-01-03). This regulation requires “at least 4,200 visits per year per full time equivalent physician” and “at least 2,100 visits per year per full time equivalent physician assistant or nurse practitioner” for every physician, physician assistant or nurse practitioner employed by the clinic. Add “Physicians, physician assistants and nurse practitioners employed at Rural Health Clinics owned or operated by a Frontier Health System are exempt from the 4,200 visits per year per full time equivalent physician and 2,100 visits per year per full time equivalent physician assistant and nurse practitioner requirements.”

e) Increase the 10-bed limit to 25 beds for frontier CAHs to qualify for the alternative care coverage waiver for ER staffing. The 10-bed limit currently prevents very small “one medical provider” frontier CAHs from providing swing bed services to Medicare beneficiaries up to 25 beds, which is currently allowed for all other CAHs. This requirement limits access to swing bed services for Medicare beneficiaries in those few frontier CAHs using the alternative coverage waiver. Increasing to 25 beds is budget neutral because CAHs can already provide acute and swing bed services to patients, including Medicare beneficiaries, and receive cost based reimbursement. NOTE: A facility choosing to utilize this waiver, however, would not be eligible to increase overall beds to 35 under the Frontier Health System model. It would be restricted to 25 beds total.
f) Allow flexibility in the cost report to provide integrated, coordinated health care for patients residing in frontier communities.53

Specifically:
  o Allow the expense of patient care coordination as an allowable expense on the cost report.
  o Allow all expenses for preventive care such as annual physicals, patient education and teaching and monitoring of chronic conditions as allowable expenses on the cost report.
  o Allow the square footage and administrative support (including billing services) provided to public health and non-owned ambulance services as allowable expenses on the cost report.
  o Allow nursing and medical staff expenses to train frontier community ambulance service EMTs or paramedics.


g) Allow the use of interactive audio-video communication systems for Frontier Health Systems to replace the face-to-face visit required every two weeks to provide medical direction and supervision to Physician Assistant and Nurse Practitioner mid-level providers. Instead of traveling to CAHs/Frontier Health Systems every two weeks, physicians (MDs and DOs) could use interactive audio-video telehealth communication systems to provide medical direction to mid-level providers, eliminating the cost-reimbursed travel expense. This is a cost-saver for CMS. 54

Specifically change CAH COP C-0261 as follows, “A doctor of medicine or osteopathy is present for sufficient periods of time, at least once every 2 week period...to provide medical direction...” by adding “If a doctor of medicine or osteopathy is present every 2 weeks or available via interactive audio video telehealth communication, this COP requirement is met.”

There are three reimbursement proposals for Medicare beneficiaries in the new Frontier Health System model that require additional funding from CMS:

  Care Coordinator and Pay For Outcomes technical assistance expense for the frontier care coordination network, and;

  Expansion of RHC VNS services to allow reimbursement of visits to homebound Medicare beneficiaries for PT, OT and speech therapy services, and;

  Permitting a 35-mile waiver for frontier ambulance services in a few frontier communities to preserve access to pre-hospital emergency medical services for beneficiaries.

Budget neutrality is achieved regarding these three expenses in the new model through cost savings generated by improving care coordination and preventing the unnecessary admission/readmission of Medicare beneficiaries to more-expensive emergency, acute and long-term care settings.

Rural Health Visioning TAG Discussion:

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<tr>
<th>Principles Addressed:</th>
<th>Likes:</th>
<th>Barriers:</th>
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<tbody>
<tr>
<td>Improve Health - yes</td>
<td>Coordinated Care</td>
<td>Kansas not eligible</td>
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<tr>
<td>Provide Access - yes</td>
<td>Expanded Access</td>
<td>Not regionally collaborative</td>
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<tr>
<td>Encourage Collaboration – Partial</td>
<td>Paid for doing right things</td>
<td>Forces local integration</td>
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<tr>
<td>Pursue Quality - no</td>
<td>Telemedicine approach</td>
<td>Still hit by sequestration?</td>
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<tr>
<td>Promote Efficiencies &amp; Value - yes</td>
<td>EMS expansion and role</td>
<td>Kansas hospitals too close together for this model</td>
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<td>Embrace Technology - yes</td>
<td>Financial hold harmless</td>
<td>Long term impact on cost report as savings are achieved</td>
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<tr>
<td>Reimbursed Fairly - yes</td>
<td>Reduces adm overhead</td>
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<td></td>
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<td>Some population health</td>
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Updated: May 2014