DEPARTMENT OF HEALTH

Rural Alternative Payment Model Experiences

INTERVIEWS WITH RURAL HOSPITAL LEADERS

Background

Alternative payment models (APM) are healthcare reimbursement models that aim to improve health outcomes while simultaneously saving money. There are many different payment structures that fall under this category, including value-based purchasing, value-based reimbursement, outcomes-based payments, pay-for-performance, global budgeting, and more. These models aim to improve health outcomes by financially rewarding participating organizations for improving quality of care. In reverse, the participant is often financially penalized for not meeting these goals. Small, rural hospitals and critical access hospitals (CAHs) are not widely participating in these types of models (U.S. Government Acountability Office, 2021).

Previous qualitative work on the national level has shown that rural hospitals have distinct priorities and needs when considering APM participation. Key considerations include a desire to participate in models designed for rural health care systems, a need for flexibility in planning and operation, and support with up-front infrastructure investments and program implementation (Mueller, MacKinney, Lundblad, & Weng, 2020).

The goal of the interviews discussed in this brief was to learn about Minnesota-specific rural hospital experiences with payment arrangements beyond fee-for-service, goals when entering into agreements, interest in future agreements and concerns about moving forward. The term alternative payment model (APM) was used to capture any type of reimbursement or care delivery model that uses payment to incentivize improved quality to better understand the barriers and goals of participation in any model and not to focus on one specific type of model.

Participants have a variety of experiences with alternative payment models and this brief will summarize the benefits and barriers to participation noted by the eight participating CAHs.

Participant overview

Participants were randomly selected from a sample of 91 rural hospitals in Minnesota. Seventeen hospitals, representing all regions and including hospitals affiliated with health systems as well as independent facilities, were invited to participate. Eight agreed to be interviewed. All participating hospitals were licensed as a critical access hospital. Participants were geographically distributed across most of the state with no participants from southeast Minnesota. Only one facility had an affiliation with a larger health system and 2 had management agreements with larger systems. The lack of participation from system affiliated hospitals is notable. When invited, those facilities declined to participate, stating they do not have decision-making control over their site’s participation in specific payment models.

Individuals familiar with each rural hospital’s experience with APMs were interviewed. Hospitals were encouraged to invite as many staff as needed to participate. In most cases these individuals were administrators, Chief Executive Officers, or Chief Financial Officers. This data

reflects the perceptions and understanding of those interviewed. Objective measures were not collected or used in this analysis.

While these interviews generated helpful insight from rural hospitals across the state, findings should not be generalized to all rural hospital experiences.

Summary of experiences with Alternative Payment Models

Six of eight participants were engaged, either currently or in the past, in some type of alternative payment model. Five were engaged in a model with a public payor, either a Medicare ACO or a Minnesota Medical Assistance (Medicaid) Integrated Health Partnership (IHP).

One hospital interviewed had participated in a private payor alternative payment model—and one hospital had some experience with an APM, but the model type and payor were unknown.

All facilities participating in an APM were involved in no-risk stages of their models. One of the hospitals was scheduled to move into a risk-sharing model in 2023—notably, this participant expressed that they may choose to end participation once this is required.

Common themes among facilities participating in alternative payment models

Participants that were currently involved in an APM, or had participated in the past, were asked to share their experiences with APMs. They described benefits for participating, including the goals and outcomes they had in mind when they joined. These benefits included:

- **Incentive payments**: All participants were engaged in a no-risk stage of their model at the time of the interview. These models were attractive due to the opportunity to earn incentive payments for meeting certain metrics without added risk or possibility of financial loss.
- **Data collection and data application**: Several hospitals engaged in these models found benefit in the data made available to them through participation. These hospitals were able to gain additional insight into their performance metrics and costs and, in some cases, pass along additional incentives to providers based on this data.
- **Quality improvement**: Facilities shared that APMs are generally aligned with their goals to improve outcomes and quality of care.
- **Financial sustainability**: While there were concerns over long-term sustainability and uncertain reimbursement levels, incentives earned during no-risk stages were cited as a key benefit to participation. Additionally, one hospital shared that by working with a private payor APM, they avoided annual renegotiation with the payor and experienced increased stability in reimbursement rates.
- **Preparing for a shift towards APM based systems:** Finally, several participants expressed interest in becoming involved in APMs because they understood that healthcare payment is moving in this direction.

Participants also shared key barriers rural hospitals face when joining an alternative payment model:

- **Payor relations**: Most hospitals experienced some level of challenge working with the public or private payor administering the APM. Notably, participants described a lack of trust and concern that existing models were not well-suited for rural facilities and that—due to their low patient volumes—payors may not be motivated to consider the needs and realities of these hospitals.
- **Attributable lives**: Participants described additional barriers related to having low volumes of attributable lives. Specifically, facilities were hesitant to engage in risk sharing models because they were operating at such a small scale; even a very small number of poor patient outcomes can have a significant impact on the hospitals' overall performance measures and targets. Therefore, outliers had the potential to impact reimbursement and disqualify small facilities from earning incentives.
- **Strain on providers and staff**: Participants expressed increased concern for clinical staff working under APMs. Two participants described how APMs can place extra strain on providers to meet performance measures while also aiming to reduce overall costs. Difficulty recruiting and maintaining providers in rural areas was an additional theme for participating hospitals.
- **Administrative burden**: Several participants described lack of internal administrative capacity to drive the data analysis and related decision-making systems needed to effectively engage in APMs.
- **Data collection**: Similarly, participating facilities had difficulties collecting robust internal data and expressed disappointment and lack of trust in the data sharing built into current APMs.
- **APM learning curve**: This challenge included lack of experience, minimal knowledge of options, and desire for more educational resources around APMs.
- **Lack of compatibility with cost-based reimbursement**: Finally, three hospitals expressed concern that APMs will interfere with cost-based reimbursement—which CAHs are eligible to receive through Medicare— if they continue expanding to include all payers. While APMs offer the possibility of incentives and positive reimbursement, moving away from the more certain cost-based reimbursement model in favor of risk-based models was a key barrier and downside to participation.

Common themes among facilities not participating in an alternative payment model

Participants that had not yet joined any type of model were asked to share the challenges they faced to engaging in APMs or the reasons why they had not yet decided to participate. Notably, only two of the hospitals interviewed had no current or past engagement. These participants identified the following barriers:

- **Learning curve**: Participants expressed having little or no experience participating in APMs, not knowing what models were available, and described a lack of educational resources available to bridge these barriers.
- **Attributable lives**: One participant expressed hesitancy to participate due to low volume of attributable lives and concern that a small number of poor outcomes could have a disproportionately negative impact on reimbursement.
- **Payer relations**: Among those not participating, one participant shared that their hospital had not been approached or invited to engage in any APM. This participant hypothesized lack of interest from payors due to the small size of the rural facility.
- **Operational control**: Of the participants with no prior engagement, one did not own the rural health clinic in their community and the other was affiliated with a larger healthcare system; this system employed most of the hospital's physicians and ran the primary care clinics. As a result, these facilities did not control the preventive or primary care services available to their patients—this was noted as a key barrier to participation.

Sustainability of current participation

Finally, all eight hospitals were asked if their participation was sustainable and/or if they would consider engaging in APMs in the future

The two hospitals with no prior or current experience in APMs expressed openness to future involvement. For these participants, lack of operational control over primary care was identified as the main barrier to future engagement. However, interest in the learning experience and a desire to get involved in APMs as healthcare payment shifts away from the fee-for-service model were shared as motivations to engage.

The other six hospitals brought up mixed considerations when thinking about continued future participation. Specifically, participants expressed concern about financial sustainability and their ability to continue engaging if asked to move into risk-based participation. Strain on clinical and administrative capacity, lack of trust that existing models can meet their needs, concern about how low volume of attributable lives may impact metrics, and lack of knowledge and confidence in navigating the various models were additional sources of uncertainty.

Vision for health in rural communities

Participants were asked how they identify, respond to, and address social determinants of health in their communities. Most participants reported that they gathered information about social determinants and community needs using formal community health needs assessments; participants then worked to address these determinants through a variety of actions including innovated care delivery systems, community partnerships, initiatives to reduce cost burden on patients, efforts to improve health literacy in their community, and efforts to get patients insured.

Additionally, participants discussed how APMs could help them meet goals for the future of rural healthcare. When envisioning an APM that will effectively meet the needs of their community, participants identified the following characteristics:

- **Compatibility with rural healthcare delivery**: A key consideration for the facilities interviewed was ongoing financial sustainability. Participants expressed that for a critical access hospital, participation in an APM would need to result in levels of reimbursement that are at least equal to what the hospital would receive under cost-based reimbursement. Further, those interviewed emphasized the importance of reliable reimbursement levels and expressed hesitance to engage in risk-based models.
- **Keeping care local**: Additionally, participants shared that APMs should support their facilities in continuing to provide local care as much as possible. When making decisions about referrals, consideration should be placed on total cost burden on the patient—including cost to travel, time off work, and time away from home.
- **Quality improvement and access to data:** Participants wanted to engage in APMs that would support them in improving health outcomes and quality of care in their communities. They expressed that these models should increase a rural facility's ability to do this through timely and comprehensive access to data on performance metrics and outcomes. One facility emphasized that, to avoid additional strain on capacity, models should be administratively simple.

Supporting Future Participation in APMs

Finally, hospitals were asked what types of support they may need to participate in new APMs in the future. Key considerations and requests for support included the following:

- **Educational resources**: Most participants expressed a desire to learn more about APM options and better understand how these models may work for their facility and community. Two of the eight hospitals specifically identified educational resources as a necessary support as they look towards future engagement with APMs.
- **Risk considerations**: Several participants shared that they may be willing to engage in risk-based models, but that risk would need to be minimal and—preferably—engagement would be in a no-risk stage.
- **Infrastructure support**: Finally, participants identified a need for support developing systems to be successful within APMs. This includes support with data collection and utilization systems, decision making tools, etc.

Conclusions

These interviews provided insight into considerations and priorities for Minnesota rural hospitals when deciding to engage in an APM. Notably, these insights aligned with previous findings while also providing additional information about values, challenges, and goals specific to each participant. As health care payment systems continue to shift away from standard fee-

for-service models, it is important to consider the unique challenges and needs of rural hospitals.

While lack of administrative capacity and educational resources are barriers to entry, incentive-based models—specifically those which do not require the hospital to take on additional risk—have the potential to work well for rural systems. As models change and new APMs are developed, the following areas should be considered to better fit the needs of rural health care systems in Minnesota:

- Transparency and reliably in reimbursement rates and incentive structures.
- Structures that account for the scale and low patient volume of rural hospitals
- Administrative simplicity with support to develop infrastructure and systems.
- Robust data-sharing

APMs have the potential to support rural hospitals as they continue to provide essential local care within their communities, address social determinants of health, improve quality of care, and aim to remain financially solvent into the future.

Sources

Mueller, K., MacKinney, C., & Lundblad, J., Weng, K. (2020). How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report.

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