Small and rural hospitals have the advantage of being nimble and having to corral fewer people to consensus than large hospitals, but finding IT skills and funds is often a constant struggle. The non-traditional financing approaches highlighted in this article may help shrink the IT disparity between small/rural and large/urban hospitals.
Given the high cost and complexity of electronic health record (EHR) implementation, it is not surprising that small and rural hospitals continue to lag behind: Only 13.9 percent of small hospitals and 12.9 percent of rural hospitals were in a position to qualify for Stage 1 meaningful use incentives at the end of 2011, according to a May 2012 Health Affairs study. In comparison, 29.7 percent of large hospitals and 20.3 percent of urban hospitals qualified.

In fact, this EHR gap grew from 2010 to 2011: Small and rural hospitals that had some form of EHR jumped about 10 percent in that time, compared with 17.3 percent and 12.1 percent growth for large and urban hospitals, respectively.

Yet, says Tracey Mayberry, partner, CSC Healthcare Group, most organizations understand that, even if they can’t move fast enough to meet the deadlines for meaningful use incentive payments, they must act in time to avoid the penalties for noncompliance that go into effect in 2015. To do otherwise “is really almost an admission that you’re done as a hospital.”

The problem, of course, is resources—or rather, the lack of them. “Hospitals in the rural market find it difficult to make the significant investment in EHRs due to constraints in available financing, competing priorities for limited capital dollars, and thin operating margins,” says HFMA’s Todd Nelson, technical director for senior financial executives/accounting.

While bank loans and other traditional financing options may be an option for some well-positioned small/rural facilities, others may find better luck with philanthropy and nontraditional financing approaches, such as the ones highlighted in this article.

**Government Funding Opportunities**
Small and rural hospitals have a number of government-sponsored funding options to explore, says Aaron Fischbach, public health analyst, Federal Office of Rural Health Policy.

**Community Facility Direct and Guaranteed Loan Program.** Under the auspices of the U.S. Department of Agriculture’s (USDA’s) Rural Development offices, the Community Facility program covers health IT and is intended to foster compliance with meaningful use in not-for-profit and public hospitals and clinics in communities of less than 10,000 people.

The Community Facility program has little grant money, says Fischbach. However, hospitals can use anticipated meaningful use incentive funds as collateral to borrow funds from the Community Facility program. The terms on these loans give hospitals enough time to implement an EHR, attest to meaningful use, and then use the incentive payments to repay at least a major portion of the loan.

Clinics need to take a more circuitous route. Unlike hospitals, clinics do not qualify for direct EHR incentive payments; instead, the Centers for Medicare and Medicaid Services (CMS) program pays their clinicians, who typically reassign the payments to the clinic under their employment agreements.

**USDA and Small Business Administration loans.** To the extent that for-profit hospitals can prove that job retention and/or creation is involved, they can apply for loans or loan guarantees to cover IT improvements from the USDA Rural Development’s Business & Industry Program or from the Small Business Administration’s capital loan programs.

USDA Rural Development also sponsors three other programs where hospitals can look for funding assistance with telecommunications software, hardware, and connectivity:
meaningful use 101: medicare versus medicaid

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
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<tbody>
<tr>
<td>Federal government will implement (will be an option nationally).</td>
<td>Voluntary for states to implement (may not be an option in every state).</td>
</tr>
<tr>
<td>Fee schedule reductions begin in 2015 for providers that are not &quot;meaningful users&quot; by 2015.</td>
<td>No Medicaid fee schedule reductions.</td>
</tr>
<tr>
<td>Must be a &quot;meaningful user&quot; in year one.</td>
<td>There is an adopt/implement/upgrade option for first participation year.</td>
</tr>
<tr>
<td>Maximum incentive is $44,000 for eligible providers.</td>
<td>Maximum incentive is $63,750 for eligible providers.</td>
</tr>
<tr>
<td>Meaningful use definition will be common for Medicare.</td>
<td>States can adopt a more rigorous definition (based on common definition).</td>
</tr>
<tr>
<td>Medicare Advantage eligible providers have special eligibility accommodations.</td>
<td>Medicare Advantage Care providers must meet regular eligibility requirements.</td>
</tr>
<tr>
<td>Last year an eligible provider may initiate program is 2014.</td>
<td>Last year an eligible provider may initiate program is 2015.</td>
</tr>
<tr>
<td>Last payment year in program is 2016; payment adjustments begin in 2015.</td>
<td>Last payment year in program is 2021.</td>
</tr>
<tr>
<td>Only physicians, subsection (d) acute care hospitals, and critical access hospitals are eligible.</td>
<td>Five types of eligible providers and two types of hospitals are eligible.</td>
</tr>
</tbody>
</table>

Source: Mike Allen, Winona Health Services, tailored this exhibit based on information pulled together by Cerner.

there is a lot of money that isn't being spent right now."

networking opens other doors

One way small hospitals can obtain IT resources is by joining networks and consortia that take advantage of discounted pricing and economies of scale. Mayberry has seen a number of community hospitals leverage strategic partnerships—either by affiliating or by joining large, mature independent delivery networks—to gain access to solutions, products, and talent they might not otherwise be able to afford.

"Smaller organizations with non-overlapping geographies can form collaboratives to work on IT initiatives, especially if they have a common vendor. For example, they might start a shared service organization, essentially combining their IT operations," she says.

Fischbach cites another advantage of affiliation. "Small, independent hospitals tend to be the last priority for vendors that can make more money working with a big health system like Mayo or Kaiser Permanente. So if the small hospitals can group together, they can not only save on hardware purchases but they can also probably get the attention of a vendor sooner."

To encourage collaboration among rural providers, HHS allocated $12 million in 2011 for grants to networks of rural healthcare organizations in support of IT adoption and and meaningful use. The money must be used for purchasing technology, installing broadband networks, and training staff.

In 2011, when 25-bed Jersey Shore Hospital in north central Pennsylvania decided to team up with 21-bed Fulton County Medical Center in McConnellsburg, 2.5 hours away, the two CAHs didn't even know about the availability of these HHS grants. They were just looking for a means to share IT resources needed to achieve
meaningful use, including joint installation of an EHR that would otherwise have cost each organization an estimated $2.3 million, according to Carey Plummer, Jersey Shore’s CEO.

Thanks to the Pennsylvania Mountains Healthcare Alliance, a 19-hospital collaborative to which both belong, they found each other, a partnership that has saved each some $300,000 on EHR implementation—and provided grant money, too. Both hospitals expect to attest to stage 1 meaningful use criteria by Sep. 1, 2013. (For more details, see the case study on page 6 of this newsletter.)

**Vendor Relationships**

Not all small and rural healthcare organizations are struggling to find IT dollars and meet meaningful use deadlines; some of them were close to the finish line when the American Recovery and Reinvestment Act was enacted. Winona Health Services, a Minnesota system consisting of one 99-bed hospital, a nursing home, an assisted living community, and 45 employed physicians, started its EHR journey more than 10 years ago and was ready to attest in November 2011, says CFO and treasurer Michael M. Allen, FHFMA, CPA.

“We really just needed to go the last mile. There were a few small pieces of functionality to put in place, and there was still work to do with the medical staff to bring a few operational processes in line with meaningful use criteria.”

Central to Winona’s success, according to Allen, is something he recommends that every small hospital pursue: a close, strategic, integrated relationship with its EHR provider.

“As a small, independent system that wanted to accomplish big things, we knew we’d get lost in the shuffle with any vendor if the relationship was simply based on a transaction. The EHR is so critical to the goals of the organization and of the community. You need to feel comfortable with your partner, and be able to work together over the long haul.”

Despite due diligence, Allen cautions that hospitals are not going to fully understand what they’re getting from a vendor at proposal time; it’s just too complex.

“Increasingly, however. EHR systems are going to cost about the same and have about the same functionality. If you have a strong, give-and-take relationship, the cost and other issues will fall into line.”

What does a give-and-take relationship look like from the provider side? Feedback plays a prominent role. Allen himself sits on the vendor’s client care council with 35 or 40 other hospitals and systems.

“We get together at least twice a year and at other times on the phone, and work on improvements and solutions to problems in the delivery or use of software or the billing for software—whatever it might be. It’s rewarding from my perspective because I’ve got colleagues from all these other places in the room, and we learn from each other.”

Likewise, Winona physicians sit on the vendor’s physician council, which focuses on how physicians use the software to improve patient care and workflows, and how changes could enhance and accelerate those improvements.

“We also open ourselves up for site visits by other small hospitals that want to see how the system is working,” says Allen. “The vendor organizes the visits, but it still takes a day of our time every time.”

In return, Allen explains, the vendor helps Winona mature its software. “Maybe they need a beta partner for some new software, which is exciting and interesting but also very time intensive. So, typically, they will end up giving us that functionality or discounting it significantly.”

Sometimes there are gray areas in the agreement, things the provider and vendor don’t see eye to eye on. Because Winona has been generous in working with the vendor, “they’re going to be more flexible and understanding,” says Allen.

“If all you do is take, at some point the relationship is just not going to be there when you need it most,” he continues. “You need to make investments of money and effort both. Structure the contract in a way that you can manage financially, then roll up your sleeves and put in the time.”

**Maximum Value**

Once a hospital has an EHR in place that will allow it to qualify for meaningful use
Reform at Half-Time: ACA Versus the Economy

The Supreme Court’s ruling on the Affordable Care Act is not the end of the reform game. It’s half-time. Here’s my color commentary on what we’ve seen so far, and what we might expect as play continues.

The Affordable Care Act (ACA) was enacted at the end of a bruising first quarter. Nothing much happened in the second as everyone waited for judges to decide if the game was being played according to the rules. Assuming the same teams return after half-time elections, lobbyists playing for both sides will dominate the third period. An underrated player—the economy—will determine the outcome in the final quarter.

Why? The 2012 Roberts decision upheld a 2010 law built on unrealistic projections that the economy would recover before the mandate goes into effect in 2014. The economy has not rebounded as hoped, and today’s consensus forecast suggests neither governments nor patients will be able to meet their financial obligations under the law. If lobbyists don’t neutralize key provisions over the next two years, economic stagnation will likely defeat the ACA.

Economic Forces at Play

Two economic forces make it difficult for ObamaCare to win, even though the referees decided the game can continue. First, ACA makes mandatory insurance “affordable” by dramatically cutting the covered portion of care. Today’s average health plan pays approximately 80 percent of a patient’s health costs, leaving 20 percent to be billed to the beneficiary. Mandated coverage in 2014 will be priced on an actuarial assumption that basic insurance pays only 60 percent—leaving the insured patient with a 40 percent out-of-pocket obligation. Many ACA fans will cry foul when they discover this unpleasant play in the game plan. (As Chief Justice Roberts noted, the Supreme Court only decides whether a law is constitutional, not whether it is viable.)

The second trend is ongoing decline in spending capacity. Personal wealth, employment income, consumer confidence, and other key components of purchasing power have fallen dramatically since 2008 and are unlikely to rebound by 2014. The student loan bubble will probably burst in the meantime, the banking system is digging itself into a deeper hole, and the global economic outlook is depressing (literally). Taxes are also likely to rise over the next two years because austerity is not re-igniting economic growth.

Hence, as an economist unabashedly committed to reinventing the way we deliver health care, I simply cannot see how consumers will be able to hold up their end of the reform bargain when the mandate goes into play. The ACA will not generate more money for healthcare providers because there won’t be more money in government coffers or consumers’ pocketbooks. Odds are that economics will defeat ObamaCare.

The Providers’ Card

Can providers survive under such dismal circumstances? Yes, as long as strategic financial leaders work relentlessly to harness the abundant waste in current operations and redirect recovered resources to creating an efficient and effective delivery system—doing health care right all the time, as inexpensively as possible. Some innovative American health systems have already proven that it can be done without the ACA.

As an economist unabashedly committed to reinventing the way we deliver health care, I simply cannot see how consumers will be able to hold up their end of the reform bargain when the mandate goes into play.