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Value ~ Added

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Lawmakers Shape New Uncompensated Care Pool Regulations

As officials on Beacon Hill grapple with the final changes to the State Fiscal Year 2004 Budget, Bay State hospitals anxiously await the codification of the revised regulations that will govern the Uncompensated Care Pool. While the exact details of the new legislation will be sorted out over the next few weeks, the final budget has adopted significant reform proposals for the Pool. Among the most substantial items of the new law include: a change to a quasi-prospective payment system; one-time transfers from reserve funds and a significant shift in funding liability from hospitals to private insurers; a clarification to the mission of the Pool; and a requirement that the Secretary of Health Human Services present a formal alternative for the care of the un- and underinsured residents of the Commonwealth by the start of the 2004 Pool fiscal year (October 1, 2003).

While Pool liabilities and reimbursements are currently determined through a monthly reporting and calculation process, the Division of Health Care Finance and Policy will now identify each provider's total liability to and reimbursement from the Uncompensated Care Pool prior to the start of the 2004 Pool fiscal year (PFY04). This "prospective" determination of each hospital's net payment (or receipt) from the Pool is expected to help providers identify their cash flow needs and preclude any unforeseen adjustments due to Pool shortfalls. Though these prospective calculations will be predicated on 2002 experience and will incorporate any anticipated shortfall for the year, the legislation will guarantee that at least 85% of the projected free care costs at

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the top 12 disproportionate share hospitals will be reimbursed.

Funding levels for next year are also slated to change substantially from 2003. To reduce the burden on hospitals, the Pool will receive $118 million in one-time transfers from other Commonwealth funds. While these transfers, as in previous years, are welcome additions to the funding of the Pool, their use today may limit the availability of such reserves in the future. Providers will also gain in PFY04 from the legislation's shift of $57.5 million in funding from the liability of hospitals to that of private insurers, who will face the additional cost through an increased surcharge assessment. Also of import for 2004, particularly with regard to the projected shortfall, is the restoration of a limited Medicaid benefit for the long-term unemployed, many of whom lost coverage when the MassHealth Basic plan was terminated on April 1, 2003. This revived plan is expected to relieve approximately $110 million in costs from the Pool. As directed by both the Senate and the House, all funding dynamics have focused on extending efforts to garner the greatest possible federal matching revenues (via the government's federal financial participation, or FFP). Accordingly, certain reimbursements may be administered through the Division of Medical Assistance, for which the Commonwealth is eligible for such matching revenues.

Additional budget items of significance include the refinement of the Pool's mission and what services the Pool covers, as well as a direction for the Secretary of Health and Human Services, Ronald Preston, to offer a formal alternative to the Pool. The new law is expected to define free care as "emergency, urgent, and critical access services provided by acute hospitals, services provided by community health centers, and services provided to patients with medical and financial hardship". While the fiscal implications of this clarified definition are still uncertain, industry organizations will be closely monitoring any developments towards limiting coverage based on this new language. Finally, less than one year after the Special Commission on Uncompensated Care adjourned without a consensus on how to reform the massive social program, legislators are calling for Secretary Preston to offer a formal alternative to providing health benefits to the un- and under-insured residents of the Commonwealth. While a report is required by October 1, most industry followers expect that the proposal may take longer to complete.

The Comprehensive Error Rate Testing Program (CERT)

Created in August 2000 by the Centers for Medicare and Medicaid Services, (known at the time as the Health Care Financing Administration), the Comprehensive Error Rate Testing program measures the claim accuracy of payments made by Medicare contractors.

The CERT program evaluates paid claim error rates on a national level, as well as for individual contractors, provider types, and benefit categories. The CERT evaluates the work of contractors like our local fiscal intermediary ‾ Associated Hospital Services ‾ and the proficiency of providers in submitting claims (and claim documentation) correctly and appropriately.

As part of the CERT program, an independent contractor has been chosen to select random samples of about 200 claims processed by each Medicare contractor on a monthly basis. The independent contractor's medical review staff will then verify that decisions regarding the claims were accurate and "based on sound policy." CMS and AHS will use these findings to determine the reasons for errors, and implement corrective actions.

DynCorp of Richmond, Virginia was selected as the independent contractor for CERT, but on July 18, Associated Hospital Services issued a MediMessage announcing that DynCorp recently changed their name to **AdvanceMed Corporation**.

Some providers have received requests for information from DynCorp to provide medical record documentation, certificates of medical necessity, etc. related to sampled claims. Following DynCorp's name-change, providers need to be aware that any requests from AdvanceMed are also related to the CERT program.

Failure to respond to a request can result in the failure of a claim by AdvanceMed's medical review staff for lack of documentation. Any inaccurate or ill-documented claims discovered by AdvanceMed will become "targets for improvement." It is critical that providers respond to the CERT requests for documentation in a timely manner, and that they respond with the same level of care and attention to detail with which they would reply to a request from AHS or the Inspector General. Any inaccurate or improper claims reviewed by AdvanceMed will be referred to AHS for adjustment/recoupment. For this reason some providers have not yet made the connection between CERT requests and payment adjustments.

Medicare Outpatient Prospective Payment System - Update on Significant Changes

The implementation of the Medicare Outpatient Prospective Payment System (OPPS) is a continuously evolving process. As hospitals attempt to adjust their processes and procedures to support the OPPS, many are having a difficult time keeping up with the fast pace of regulatory changes. Between changes to the Outpatient Code Editor (OCE), issued quarterly, and Program Memoranda, which are issued as needed, the Center of Medicare and Medicaid Services (CMS) is constantly issuing changes to the OPPS regulations.

Let's review several of the most recent significant changes, presented in Program Memorandum A-03-035 Reporting of Revenue Codes under OPPS, and Program Memorandum A-03-051 July 2003 Update of OPPS.

Appropriate Revenue Codes - Implantable Devices

Implantable devices that have been granted pass-through status under OPPS (payment status indicator "H") should be billed using an appropriate HCPCS code with one of the following revenue codes: 0272, 0275, 0276, 0278, 0279, 0280, 0289 or 0624.

Revenue codes 0274 and 0290 are no longer acceptable for reporting implantable orthotic and prosthetic devices and implantable durable medical equipment furnished in the hospital outpatient setting by a hospital that is subject to OPPS. These devices must be reported under another revenue code such as 0278 – other implants.

Proper Matching of Costs, Charges, and Medicare Program Charges

Where CMS does not provide instructions on the assignment of HCPCS codes to revenue codes, hospitals should report their charges using the revenue code that will result in the charges being assigned to the same cost center to which the costs of those services are assigned in the cost report. This is a critical compliance concern and one that many hospitals have been somewhat remiss in addressing.

New HCPCS Codes and Their Status Under OPPS

PM A-03-051 sets forth 23 new HCPCS codes that are effective July 1, 2003; however, only 7 new codes provide you reimbursement under OPPS:

HCPCS	APC	Description	Status Indicator	National Payment Rate
C1818	1818	Integrated keratoprosthesis	H	Pass-through Device
C8918	0284	MRA w/ cont, pelvis	S	$377.48
C8919	0336	MRA w/o cont, pelvis	S	$344.13
C8920	0337	MRA w/o fol w/cont, pelv	S	$482.08
C9205	9205	Oxaliplatin	G	$96.46
Q4052	1207	Octreotide Injection, depot	K	$74.28
Q4053	9119	Pegilgrastim, per a mg	G	$467.08

Note that Q4052 and Q4053 replace C1207 and C9119, respectively. These two C codes were deleted effective July 1, 2003. Hospitals should update their Charge Description Masters immediately to reflect these new HCPCS codes and these deleted C Codes.

Observation Services

In February 2003, CMS instructed hospitals through PM A-02-129 to use modifier -25 with G0263 in order to receive payment for G0244. CMS has now changed its mind and states that you are no longer required to report modifier–25 with G0263. In addition, CMS states that if a patient is admitted directly to observation from a physician's office, then diagnostic services performed the day before would not automatically count toward satisfying the observation requirements. However, if the observation encounter resulted from an Evaluation and Management (E/M) visit, then any ancillary tests performed during that E/M visit would be allowed toward the observation criteria.

Drug-eluting Stents

Hospitals should use G0290 (transcatheter placement of a drug-eluting stents intracoronary stent(s) with or without other therapeutic intervention, any method; single vessel) and G0291 (transcatheter placement of a drug-eluting intracoronary stent(s) with or without other therapeutic intervention, any method; each additional vessel) beginning July 1, 2003 for The Food and Drug Administration approved drug-eluting stents. Payment for the placement of the stents, and the stents themselves, will be made under APC 0656. The codes will be reimbursed at an unadjusted payment rate of $5,045.69.

CMS will continue to make significant changes to OPPS on an ongoing basis. It is imperative that hospitals monitor all changes to OPPS and make necessary changes to their policies and procedures in a timely manner. Prompt compliance allows the facility to capture the full reimbursement under OPPS, while minimizing the risk of compliance exposure.

CMS Program Memorandums

ICD-9-CM Coding Requirements for Claims Submitted to Medicare Carriers

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 6-6-03, Transmittal No. B-03-045, Change Request 2725.

Beneficiary Notice of Implementation of Outpatient Therapy Service Limitations

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 6-10-03, Transmittal No. AB-03-085, Change Request 2792.

Revision to Billing for Swing Bed Services Under Skilled Nursing Facility Prospective Payment System (SNF PPS)

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 6-20-03, Transmittal No. A-03-052, Change Request 2257.

Changes to Correct Coding Edits, Version 9.3, Effective October 1, 2003

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 6-20-03, Transmittal No. B-03-047, Change Request 2756.

Amendment to the Interim Final Regulation for Mental Health Parity

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: Amendment to interim final regulation.

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 6-20-03, Transmittal No. AB-03-091, Change Request 2763.

Shared System Maintainer Hours for Resolution of Problems Detected During HIPAA Transaction Release Training

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 5-2-03, Transmittal No. AB-03-055, Change Request 2654.

Reporting of Revenue Codes Under the Outpatient Prospective Payment System (OPPS)

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 5-2-03, Transmittal No. A-03-035, Change Request 2614.

Program Memorandum on Written Statements of Intent (SOI) to Claim Medicare Benefits.

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 5-2-03, Transmittal No. AB-03-061, Change Request 1050.

Implementation of the Financial Limitation for Outpatient Rehabilitation Services

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 5-2-03, Transmittal No. AB-03-057, Change Request 2709.

New Common Working File (CWF) Medicare Secondary Payer (MSP) Edit to Reject MSP Records for Medicare Beneficiaries Who Are Only Entitled to Medicare Part B, and Are Covered by a Group Health Plan (GHP)

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 5-2-03, Transmittal No. AB-03-063, Change Request 1922.

New Common Working File (CWF) Edits and Standard System Responses on Skilled Nursing Facility (SNF) Claims

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 5-2-03, Transmittal No. AB-03-062, Change Request 1778.

Audit Guidance Pertaining to Write-offs of Small Debit Balances in Patients' Accounts Receivable

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 5-2-03, Transmittal No. AB-03-062, Change Request 1778.

The CMS is aware that some hospitals have a policy for writing off small debit balances in patients' accounts receivable. It is not productive for the Medicare program to spend audit resources to examine these policies for consistent treatment among all classes of payers. Therefore, you are instructed to forego doing a review of such policies for debit balances under ten dollars ($10.00).

However, during the review/audit of Medicare bad debts, ensure that amounts claimed for other than indigent patients do not include the small debit balances that were written off in accordance with the hospital's policy, unless the hospital followed appropriate collection effort.

Common Working File (CWF) Reject and Utilization Edits and Carrier Resolution for Consolidated Billing for Skilled Nursing Facility (SNF) Residents

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/4/03, Transmittal No. AB-03-041, Change Request 1764.

Advance Beneficiary Notices Must Be Given To Beneficiaries and Demand Bills Must Be Submitted By Home Health Agencies (HHAs)—Action

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/4/03, Transmittal No. A-03-024, Change Request 1467.

Correct Payment of January and February 2003 Physician Services

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/11/03, Transmittal No. B-03-023, Change Request 2669.

Program Memorandums continued from page 4

Standard System Acceptance of Primary Payer Information at the Line Level

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/18/03, Transmittal No. B-03-026, Change Request 1287.

Single Drug Pricer (SDP) Clarifications

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/18/03, Transmittal No. AB-03-047, Change Request 2659.

Clarification of Payment Responsibilities of Fee-for-Service Contractors as it Relates to Hospice Members Enrolled in Managed Care Organizations (MCOs) and Claims Processing Instructions for Processing Rejected Claims

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/18/03, Transmittal No. AB-03-049, Change Request 2013.

Durable Medical Equipment Regional Carriers (DMERC) – ICD-9-CM Coding

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/18/03, Transmittal No. B-03-028, Change Request 2672.

Managed Care Reasonable Charge Data Disclosure Requirements for Ambulance Services

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/25/03, Transmittal No. B-03-029, Change Request 2561.

Type of Service (TOS) Corrections

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 4/25/03, Transmittal No. B-03-030, Change Request 2703.

Installation of Version 28.0 Second Add-On of the Provider Statistical and Reimbursement (PS&R) Report

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 3-7-03, Transmittal No. A-03-018, Change Request 2605.

270/271 Implementation and Direct Date Entry (DDE) Eligibility

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 3-14-03, Transmittal No. AB-03-036, Change Request 2576.

Use of Statistical Sampling for Overpayment Estimation When Performing Administrative Reviews of Part B Claims

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 3-21-03, Transmittal No. B-03-022, Change Request 1363.

Procedure for Granting Extensions to File Requests for Appeal Under the New 120-Day Timeframe Created by î521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 3-28-03, Transmittal No. AB-03-039, Change Request 2492.

Installation of Version 29.0 of the Provider Statistical and Reimbursement (PS&R) Reporting System-Modification

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 3-28-03, Transmittal No. A-03-022, Change Request 2660.

Implementation of the Temporary Equalization of Urban and Rural Standardized Payment Amounts Under the Medicare Inpatient Hospital Prospective Payment System (IPPS) as Required By Section 402(b) of Public Law 108-7

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)
Action: 3-28-03, Transmittal No. AB-03-039, Change Request 2492.

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Health Care Roundtable Seminars

As you know, Feeley & Driscoll, P.C. is hosting a series of complimentary roundtables designed to help you and your staff stay abreast of breaking issues impacting your institution's financial position.

Each roundtable will include discussions lead by a combination of experts from Feeley & Driscoll's Healthcare Services Group and outside agencies, payors and regulators.

We encourage you to send a member (or members) of your team to participate in these valuable, timely and informative sessions. All meetings will be held at F&D's Training Center, 200 Portland Street, Boston, MA 02114. Please call Scott Cavallo at (617)742-7788 x369 or e-mail ScottC@fdcpa.com to find out more about these programs. We look forward to seeing you.

Visit our web site at www.fdcpa.com/seminars.asp for the 2003 schedule of Reimbursement Roundtables!

Federal Register Summary

Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities-Update

6-10-03 (Vol. 68, No. 111 Pages 34767-34773)
Agencies: Centers for Medicare & Medicaid (CMS), HHS
Action: Proposed Rule.

Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems

6-9-03 (Vol. 68, No. 110, pages 34493-34515)
Agencies: Centers for Medicare & Medicaid (CMS), DHHS
Action: Final Rule.

Prospective Payment System for Long-Term Care Hospitals: Annual Payment Rate Updates and Policy Changes

6-6-03 (Vol. 68, No. 109, pages 34121-34190)
Agencies: Centers for Medicare & Medicaid (CMS), DHHS
Action: Final Rule.

Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates

5-19-03 (Vol. 68, No. 96 Pages 27153-27202)
Agencies: Centers for Medicare & Medicaid (CMS), HHS
Action: Proposed Rule.

Inpatient Rehabilitation Facility Prospective Payment System for FY 2004

5-16-03 (Vol. 68, No. 95, pages 26785-26837)
Agencies: Centers for Medicare & Medicaid (CMS), DHHS
Action: Proposed Rule.

Medicaid Program; Provider Qualifications for Audiologists

4/2/03 (Vol. 68, No. 63, Pages 15973-15978)
Agencies: Centers for Medicare & Medicaid (CMS), HHS
Action: Proposed Rule.

Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships: Extension of Partial Delay of Effective Date

4/25/03 (Vol. 68, No. 80, pages 20347-20348)
Agencies: Centers for Medicare & Medicaid (CMS), DHHS
Action: Final rule; extension of partial delay in effective date.

Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System

3-5-03 (Vol. 68, No. 43, Pages 10420-10429)
Agencies: Centers for Medicare & Medicaid (CMS),HHS
Action: Proposed Rule.

Prospective Payment System for Long-Term Care Hospitals: Implementation and FY 2003 Rates; Correcting Amendment

3-7-03 (Vol. 68, No. 45, Pages 10987-10988)
Agencies: Centers for Medicare & Medicaid (CMS),HHS
Action: Final Rule; correcting amendment.

Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates and Policy Changes

3-7-03 (Vol. 68, No. 45, Pages 11233-11292)
Agencies: Centers for Medicare & Medicaid (CMS),HHS
Action: Proposed Rule.

Current List of Laboratories Which Meet Minimum Standards To Engage in Urine Drug Testing for Federal Agencies

3-6-03 (Vol. 68, No.44, pages 10745-10746)
Agency: Substance Abuse and Mental Health Services Administration, HHS
Action: Notice.

Update of Ambulatory Surgical Center List of Covered Procedures Effective July 1, 2003.

3-28-03 (Vol. 68, No. 68, Pages 15267-15312)
Agencies: Centers for Medicare & Medicaid (CMS),HHS
Action: Final rule with comment period.

OIG Compliance Program Guidance for Ambulance Suppliers

3-24-03 (Vol. 68, No.56, pages 14245-14255)
Agency: Office of Inspector General, HHS
Action: Notice.

An update on recent activity by the Department of Health and Human Services Office of Inspector General (HHS-OIG)

The OIG is responsible for conducting audits, evaluations, and both criminal and civil investigations for all HHS agencies. These functions are performed by the OIG's Office of Audit Services (OAS), Office of Evaluation and Inspections (OEI), and Office of Investigations (OI), respectively.

Trends in Rural and Urban Hospital Closure: 1990 – 2000 - The OIG released two reports on Rural and Urban Hospital Closure trends. These two reports combine 11 years of hospital closure data and describe trends that are specific to hospitals that closed in rural communities as well as hospitals that closed in urban communities. The reports focus on extent, characteristics, reasons for, and impact of hospitals that closed from 1999 through 2000.

Of all rural hospitals, 7.8% or 206 hospitals closed during this time frame. The rural hospitals that did close were generally smaller and treated fewer patients than rural hospitals nationally. Such closures resulted from business related decisions or a low number of patients.

Of all urban hospitals, 10.6% or 296 hospitals closed during this time frame. The urban hospitals that closed were generally smaller and treated fewer patients than urban hospitals nationally. Generally, urban hospital closures resulted from competition, business related decisions, or a low number of patients.

To read the report for Rural Hospitals, go to:
http://oig.hhs.gov/oei/reports/oei-04-02-00610.pdf

To read the report for Urban Hospitals, go to:
http://oig.hhs.gov/oei/reports/oei-09-02-00421.pdf

Review of Claims for Multiple Procedures Performed in the Same Operative Session in Ambulatory Surgery Centers - This has been a hot topic with the OIG over the last few months. Since March, the OIG has released 14 reports on this subject. The reports review insurance corporations claim processing systems to determine if they adequately identify payment reductions for multiple Ambulatory Surgical Center (ASC) procedures.

Regulations require that when multiple services are provided in the same operative session, the highest paying procedure is reimbursable at the full payment rate while any other procedures are reimbursed at one-half the normal payment rate. The purpose of these reviews was to determine if the insurance corporations software identified these situations correctly.

The OIG found all 14 carrier software systems failed in determining payments for multiple procedures, which resulted in overpayments.

To read the last published report, go to:
http://www.oig.hhs.gov/oas/reports/region7/70102625.pdf

Review of Medicaid Drug Rebates at State Medicaid Agencies - The OIG has released 13 reports on this topic in 2003. The purpose of the reports was to determine whether or not each state had established adequate accountability over the Medicaid drug rebate program.

Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients.

To read the latest report for the state of Rhode Island, go to:
http://oig.hhs.gov/oas/reports/region1/10300001.pdf

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Please visit *www.fdcpa.com/healthcare.htm* to receive the latest health care news and the dates and agendas of our upcoming Reimbursement Roundtables for Hospitals and Long Term Care Providers

If you have any questions or would like to discuss further any of the issues discussed in Value Added with one of our health care specialists, please contact us at (617) 742-7788 or

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Challenging Times - Leadership Challenges

Leading a hospital to successful performance that is sustained over time has never been easy and all the indicators point to it becoming even more difficult. Successful performance is strongly related to two key aspects of leadership – strategy and execution – both of which present key opportunities in many organizations. For example, many large hospitals have deployed a strategy of growth through combinations of acquisition, merger and affiliation to broaden market presence and achieve higher levels of integration across the care continuum – a strategy endorsed by many. Yet, this strategy has met with mixed success, in part, because it is easier to strategize than it is to execute.

A common theme found in a number of such large systems and in many medium and smaller hospitals is the difficulty encountered in developing attainable strategy and, the ability to execute all of the operational implications of selected strategy across all facets of the enterprise on a timely basis. Inadequate operating income is an easy gross indicator of the above circumstance. A closer look may reveal combinations of: inadequate infrastructure to support goals; missed volume targets; labor cost excesses due to shortages and retention challenges; niche market competition; lack of revenue cycle optimization; insufficient capital for reinvestment; information system issues; reluctance to embrace strong customer driven service improvement; real or perceived quality issues; excessive consumption of clinical resources relative to contemporary practice; a culture of employment entitlement; slow decision-making and conflict avoidance.

How then does an organization manage its way to success? First, strategy formulation should be seen as an opportunity to address and resolve alignment and integration of stakeholder interests rather than as an exercise to define a desired, but perhaps unrealistic dream. Many hospitals and systems avoid this critical step because the resolve to do otherwise has not been generated at the highest leadership positions. Often, true partnering of ideas, strategies, tactics and responsibility is not yet part of the culture. Strategic reassessment and planning can be the tool to address such inertia.

To achieve a realistic strategy that gets "traction" requires management, physicians and trustees to find common interest and synergy. On that foundation, an operational assessment of functions critical to goal and/or organizational success identifies precisely where and to what extent change is necessary to achieve and sustain a goal. By reconciling strategy and current operational capability, a template for managing the change necessary begins to form. In many cases, an organization will identify a need for significant improvement in its philosophy and culture regarding accountability for results. Whatever the causes, be they insufficient investment in management, unclear performance expectation, inappropriate structure or other, continued adherence to business as usual does not produce the desired results. The leadership challenge is to be more effective at strategy formulation and execution to achieve stakeholder alignment and support and, a culture of performance and accountability that routinely produces the right thing, done the right way at the right time.

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