HFMA Operational Excellence Key Concepts Guide

hfma
healthcare financial management association

HFMA Operational Excellence Key Concepts Guide
(Supplement to the HFMA Operational Excellence assessment)
Last Revised June 2021

Table of Contents

1. Introduction – Key Concepts Approach and Focus

"High Value Health Care" is the aim of the health care industry wide reforms underway. The "high-value" goal has a definite shape: quality outcomes, patient engagement and satisfaction, and reduced costs. This industry reform shape is known as the "Triple-aim" and it is requiring substantial rethinking of business and care delivery models.

The module II Operational Excellence assessment, explores your ability to make practical application of the knowledge you gained in module I, HFMA Business of Health Care®. Rethinking business models requires not only broad industry knowledge, but the ability to recognize the challenges and business driver at plan. This learner's guide is intended to assist certification candidates in earning the *Certified Healthcare Financial Professional (*CHFP) designation by identifying the primary business challenges faced by providers, physicians and payers today.

It is recommended that candidates preview the key-concept guide prior to working through the assessment. The time allowed for completion of this assessment is three (3) hours. This preview indicates the key business challenges that will be presented and attunes candidates to areas of professional practice that may be less familiar. The learner guide can then be used to focus additional outside reading and study on unfamiliar issues.

Trends and concepts to know for the assessment:

Operating a Healthcare Business in a New Business Environment

The fundamental shape of the healthcare business environment is captured in the expansion of the healthcare lexicon to include a number of words and phrases inspired by the PPACA: Collaborative, multidisciplinary, multi-specialty integrated, continuum of care, quality outcomes, cost reduction value, access, new payment models, evidence-based, patient centered, insurance coverage, population health and clinical collaboration. The myriad of terms expresses evolved perspectives on health care, reinforcements of nascent business approaches and amplification of the idea of reform and notions of change.

Three stakeholders' groups operate in this business environment: payers, physicians and providers. They are, in effect, the backbones of the industry. The changes alluded to above impact these stakeholder groups significantly and inter dependently. These stakeholders share integrating business imperatives.

2. Payers

Historically, health insurance companies have been an attractive segment to do business with. From information technology vendors to reinsurers, consultants to third party administrators, many companies depend on dollars expended by health plans for administrative services. A larger number of vendors, e.g., physicians and other health practitioners, receive medical expense dollars that health insurers dispense as claims payments. Pharmaceutical manufacturers, medical equipment vendors and biotech companies also look to and work with insurance carriers to ensure their services will be paid for as needed. Hospitals, laboratories and durable medical equipment vendors all provide services that are paid through health insurance companies. These are only a few examples of the multitude of vendors from whom health insurance companies purchase goods and services.

Under the Medical Loss Ratio (MLR) Rule, health insurers are required to spend at least 80 cents of every premium dollar on medical care and health care quality or else rebate the difference back to subscribers or their employers. Large employer groups are required to spend 85 cents of every premium dollar. These regulations have inspired health insurers to reduce costs through improving process quality, automation, integration, and procurement and sourcing improvements.

The challenges insurers are facing center on how they can more effectively manage their operations, manage risk, and grow. Key business issues include:

1. Modernizing finance, actuarial, and risk management functions
2. The regulatory environment
3. Strategy, including the future of health insurance, improving the customer experience and data analytics, and the value-based environment
4. Effectively managing policy administration systems transformations
5. Taxation

Payer business challenges and activity in the reform environment includes the following:

- Payers entering into Accountable Care Organization agreements
- The limitation of premium growth in the reform environment
- The guarantees of coverage
- Health Insurance exchanges
- The reform environment profit-limiting impact
- Payer consolidations
- Payer differentiations
- Payer process improvements
- The rise of business process outsourcing

Terms and concepts to know for the assessment

Term – Concept	Meaning
Accountable Care Organizations and Payers	Private and public insurers continue to pursue implementation of the accountable care organization (ACO) model, a value-based payment and delivery model in which a group of providers is held accountable for the cost and quality of care for an assigned patient population. ACO arrangements involve providers and payers forming risk-sharing agreements to improve outcomes and reduce costs
Business Process Outsourcing	Business Process Outsourcing is defined as the contracting of distinct and routine business duties and functions to an outside or third-party provider.
Guaranteed Issue	Guaranteed issue is a term used in health insurance to describe a situation where a policy is offered to any eligible applicant without regard to health status
Insurance Exchange	Health insurance marketplaces, also called health exchanges, are organizations set up to facilitate the purchase of health insurance in each state in accordance with Patient Protection and Affordable Care Act.
Payer	Payer in health care generally refers to entities other than the patient that finance or reimburse the cost of health services. In most cases, this term refers to insurance carriers, other third-party payers, or health plan sponsors (employers or unions).
Payer Differentiation	As payers continue to make the necessary business changes to comply with reform, increase administrative efficiency and improve the cost and quality of care, these organizations face a fourth challenge - competing to win in an emerging retail market. To compete effectively, it is imperative that payers stand out from the crowd and differentiate themselves with new products that drive value, increase transparency and create opportunities for collaboration with providers and important healthcare stakeholders.

Payment System	Funding mechanisms for healthcare. There are currently two major payment models being discussed as alternatives to the existing fee-for-service payments: 1) Episode Payment, i.e., paying a single price for all of the healthcare services needed by a patient for an entire episode of care and 2) Comprehensive Care Payment (also called condition-adjusted capitation, or risk-adjusted global fees), i.e., paying a single price for all of the services needed by a specific group of people for a fixed period of time (e.g., all of the care needed during the course of a year by the people who work for a particular employer or by people who have chronic diseases).
Payer Consolidation	In business, consolidation or amalgamation is the merger and acquisition of many smaller companies into much larger ones. In the context of financial accounting, consolidation refers to the aggregation of financial statements of a group company as consolidated financial statements. The country's largest health insurers continue to merge and consolidate. Payer consolidation is eating more and more into providers' revenue.
Population Health Management and Payers	One thing that is clear to payers is the need to understand individuals as consumers as well as patients. Certain payers have a leg up on others in the makeup of their patient populations. The ones that have more of a target population, such as the Medicaid and Medicare Advantage plans, have an advantage over the larger national plans because their patient population is a lot more focused and more centered geographically as opposed to those plans that are trying to cover everybody in different market segments

3. Physicians

Population health and accountable care models continue to gain traction as the industry shifts away from the traditional fee-for-service provider payment structure. In the wake of these initiatives, provider organizations are reassessing their business models and relationships with physicians. Physicians today are confronted with a business environment that has one fundamental imperative: alignment. The business challenge for physicians is how to position themselves for clinical and business success.

Population health management stands in direct opposition to the long-standing hospital and physician business strategy of maximizing admissions as the alignment efforts. As the healthcare industry shifts away from fee-for-service and focus on volume, more treatment will take place in outpatient and ambulatory environments and the patient mix will change in those settings as well as at acute care hospitals. This raises the question of the sustainability of the fee-for-service payment system.

The business environment shift is from volume to value, loosely defined as quality outcomes and patient safety at reduced costs. Payment models are focused now on value and quality. Additionally, payments are bundled – one payment made for an episode of care to be divided among the providers of the care. These dynamics are a driving force behind clinical collaboration efforts that are redesigning how care is delivered. Accountable Care Organizations (ACO) are one of the models designed to foster clinical collaboration and manage the shift to value.

Physician business issues and activity in the health care reform environment center on physician and hospital alignment. The concerns include:

- Consolidations: The industry is seeing increased consolidation at the hospital, physician and payer level.
- Employment of physicians seems to be the preferred method of engagement for health systems if they can afford it.
- Sustainability: A key question is whether hospitals will be able to maintain the huge investment in employing physicians.
- Systems which are not highly focused on employment are examining other models of engagement.
- Increasingly systems cannot afford to not have financial relationships with their doctors.
- A key question is whether hospitals will be able to maintain the huge investment in employing physicians as the reimbursement world substantially changes.
- Looming physician shortages.
- Hospitals increasingly concerned about “leakage” from aligned physicians.

Terms and concepts to know for the assessment

Term or Concept	Definition
Physician Alignment	The term refers to hospital and physician relationships desired to meet three objectives: 1) Maximize the population served 2) Emphasize quality outcomes 3) Focus on patient safety and the patient experience.
Physician consolidation	The phrase refers to the national trend of solo- or small-practice physicians moving into employment with medical groups or hospitals for economies of scale and managed care contracting.
Physician employment	In a quest to gain market share, hospital employment of physicians has accelerated in recent years to shore up referral bases and capture admissions.
Physician engagement	Health organizations and systems have taken note that there are potential returns from having more engaged employees and their physician colleagues. Research underscores that when physicians are engaged their organizations tend to perform better, have higher satisfaction levels, lower turnover rates, and improved patient satisfaction scores and patient outcomes.
Physician leakage	“Leakage” is the term used in healthcare business development to describe when primary care physicians refer patients to providers outside their system, rather than staying within their network.

Term or Concept	Definition
Physician compensation models	Today, most compensation models are primarily based on either a salary or a net- or gross-revenues basis, with some type of bonus or incentive component. Most income packages that new physicians are offered are determined primarily by regional market factors and compensation surveys conducted by organizations such as the Medical Group Management Association, the American Medical Group Association, and the American Medical Association, among others. Compensation may also include some contract terms regarding time to partnership, work schedules, or incentive structures
Physician Payment	Several new physician payment models are being developed and tested. These include: • Pay-for-performance • Episodes of care • Shared savings • Advanced medical home

4. Providers

Provider entities have entered the age of "high-value health care" and find themselves more accountable for patient outcomes, patient experience, and the cost of care and population health. Success is dependent upon hospitals and health-systems (and other provider types) demonstrating their value to the patients they treat and the communities they serve.

Demonstrating value is requiring considerable change to providers' infrastructure and processes. The hard work of rethinking business and care delivery models is yielding results – better outcomes are being achieved, there is greater engagement of patients in their treatment and the beginnings of substantial cost savings. This is the beginning.

Providers face a number of business challenges. Strategies for business success include the following:

- Aligning hospitals, physicians and other providers across the care continuum
- Utilizing evidence-based practices to improve quality and patient safety
- Improving efficiency through productivity and financial management
- Developing integrated information systems
- Joining and growing integrated provider networks and care systems
- Educating and engaging employees and physicians to create leaders
- Strengthening finances to facilitate reinvestment and innovation
- Partnering with payers
- Advancing through scenario-based strategic, financial and operational planning
- Seeking population health improvement through pursuit of the "triple aim"
  (Source: American Hospital Association [AHA])

Terms and concepts to know for the assessment

Term or Concept	Definition
Continuum of Care	Continuum of Care is a concept involving a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. The Continuum of Care covers the delivery of healthcare over a period of time and may refer to care provided from birth to end of life. Healthcare services are provided for all levels and stages of care.
Evidence –based practice	Evidence-based practice is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Hospital consolidations	Independent community hospitals are finding it increasingly difficult to compete. Consolidation (mergers and acquisitions) is a common strategy now employed by hospitals to improve their competitive positing. 5 major forces are driving these consolidations: 1) Reform unleashed by the PPACA 2) The need for economies of scale 3) The need for access to capital 4) Bargaining power and leverage and 5) Patient care coordination

Term or Concept	**Definition**
Integrate Delivery System	An integrated delivery system (IDS) is a network of health care organizations under a parent holding company. Some IDS have an HMO component, while others are a network of physicians only, or of physicians and hospitals. Thus, the term is used broadly to define an organization that provides a continuum of health care services
Provider Payment System	The current issues: Having experimented with different ways of paying providers of health care services, countries increasingly want to know not only what to do when paying providers, but also how to do it, particularly how to design, manage, and implement the transition from current to reformed systems
The “Triple Aim”	The triple aim of healthcare reform is: 1) quality clinical outcomes 2) reduced cost and 3) patient satisfaction with the treatment experiences

5. Business Case Sample

Provider Facilities Maintenance

Based in Pleasant, Montana, the Pleasant Healthcare System is the among the state's largest operator of hospitals and healthcare facilities. Pleasant owns and manages 3 hospitals and 2 freestanding surgery centers across the state.

The Business Challenge: Pleasant Healthcare is looking to engage a partner that would be able to provide a turnkey approach for many of the typical building and maintenance projects that Pleasant undertakes in its healthcare facilities. The ongoing projects include energy and water usage reduction, HVAC, chiller and cooling tower replacements, fire protection/fire alarm installations and upgrades, electrical power distribution upgrades, and emergency power installations.

The consulting firm Pleasant engaged quickly discovered that Building Care Solutions, a subsidiary of All Things Construction Inc, has provided engineering, consulting, construction administration and implementation services under a state sponsored business development initiative. To date, Building Care Solutions has performed more than $50 million of facilities overhaul, upgrade and maintenance at more than 20 hospitals. Building Care Solutions continues to perform its services as a prime contractor for work conducted under the state development initiative. Building Care Solutions provide all labor, equipment, materials and incidentals required to complete the scope of work for any given facilities upgrade and maintenance project.

Professional services, including project engineering, design, construction administration and construction inspection services are coordinated with the parent company, All Things Construction, under Building Care Solutions contracts. Building Care Solutions commits to minimizing inconvenience to patients, professional staff, volunteers and visitors.

The consultant team is recommending to you that Building Care Solutions be contracted to manage all facility maintenance projects. The initial contract would be for two years at a cost of $200,000. Major construction outside the proposed agreement would be addressed in a separate contract negotiation.

1. The first steps in considering the consulting teams recommendation is:
    a) Ask Building Care Solutions for references
    b) Specify business objective(s) and verify that Building Care Solutions has the capability to help meet the business objectives

c) Develop a “pro forma” budget to study the financial implications of an agreement
d) Conduct a capital planning assessment

2. A contracted agreement with Building Care Solutions, in the current fiscal year, would impact the:
   a) The capital budget
   b) The operating budget
   c) The statistical budget
   d) The revenue budget

3. If a contracted agreement with Building Care Solutions is reached and the appropriate budget(s) are adjusted to reflect the new expense, the adjusting is known as:
   a) Accruing expenses
   b) “matching” i.e. revenue and expenses are matched in a defined fiscal period
   c) Flexible budgeting
   d) Variance analysis

6. Module II: Case Study Index

CHFP candidates will be presented random case studies drawn from the following case study bank. Candidates are encouraged to understand the business challenges in each situation. Below are some of the case study topics included in Operational Excellence.

Payer Business Environment – Case Studies:

Accountable Care Organizations – Payer Cancers
Premium Growth in a Shifting Environment
Denials of coverage
Limitations on profits
Health Insurance Exchanges
Payer consolidations
Unsustainable rates
Payer Differentiation
Rise of Business Process Outsourcing

Physician Business Environment – Case Studies:

Consumerism and physicians
Physician –Hospital alignment
Demand for Physician Collegiality
Emerging Ancillary Positions
Physician Burnout

Physician Independence
Physician Shortages (Leakage)
Physicians as Entrepreneurs
Reform and Physician Liability
Physician – Hospital Financial Relationships

Provider Business Environment – Case Studies:

Hospital Consolidations
Hospital – Physician Alignment
Hospital Facing Bankruptcy
Provider- Payer Consolidations
Physician Engagement and Leadership
Integrated Care Delivery
Physicians Remaining Independent
Accountable Care Organizations
Sustainability of Physician Employment

7. Module II Assessment Sample Case Studies

Please note that these are **examples of the types of questions** in HFMA's Operational Excellence assessment. Course content is not covered within these sample questions: this document is ***not*** a predictor of success. ***This is not a practice CHFP assessment.***

Correct answers are on pages 25 and 26.

Sample Case Study 1 - Physician Alignment

New General Hospital is a 227-bed hospital (Average Daily Census of 166) that provides strong community care to a growing, affluent, suburban market with no dominant competitors. The hospital has a private practice physician model and above-average financial indicators, with an operating margin of 5.9%.

This hospital has strong alignment of purpose, but average alignment in clinical activity and economic areas. Moreover, market indicators suggest that the urgency of creating stronger physician alignment is lower than average.

Detailed investigation of New General Hospital shows that hospital leadership has been actively working to create a common vision with its physicians. This common vision has led to direct physician leadership in setting the strategic course of New General Hospital.

However, while New General Hospital has kept up with the national trends, it has not been overly aggressive at using the strategies that might advance clinical activity or economic alignment. For instance, the Hospital does not employ any physicians; pay- only limited amounts for ER call and has only a very limited number of other contractual and business service activities which involve its physicians.

With the relatively weaker alignment within clinical activity and economic elements, New General Hospital has embarked on investigating the strategies to strengthen these two areas of alignment. However, in this market, the urgency for change is lower than average. As such, New General Hospital has been investigating moderate impact strategies with lower risk in the contracts and business services categories.

Today, New General Hospital has made extending the electronic medical record to all physicians on the medical staff its key priority on its way to building out a strong alignment of purpose to create a clinically integrated physician network. This will allow New General Hospital and its physicians to deliver better care coordination and allow the physicians and hospital to contract together, creating increases in economic alignment.

Additionally, to improve clinical activity alignment, medical directorships are being reevaluated to ensure they advance the vision of the hospital's operations, and a clinical co-management relationship in cardiology is under development.

Questions:

1) New General Hospital put a strong foundation for physician alignment in place by:
    a) Conducting market research to first insure market position
    b) Inviting physician leaders to participate in crafting a strategic vision

c) Conducting a strategic operations alignment review to determine the level of desired alignment
d) Seeking to understand the economic issues faced by the physicians

2) Key business reasons for extending the electronic medical record to all physicians would be including all the following **EXCEPT:**

a) The medical record is the basis of payment for physicians and hospitals and needs to include all physician services
b) Bundled payments in which payment is jointly shared by physicians and hospitals
c) Assist physicians and hospitals in building economies of scale and economic alignment
d) Assist physicians in determining patient co-pays

3) In working on aligning with physicians, New General Hospital must become increasingly multi-disciplinary in its business discussions and decisions. This will require hospital leaders to build trust and confidence in the business case by:

a) Employing evidence-based best practices with the physicians
b) Ensuring physician buy-in on compensation plans
c) Educate physicians on business and finance
d) Ensuring finance has access to clinical data regarding outcomes

Sample Case Study 2 - A Critique of Accountable Care Organizations

Accountable Care Organizations (ACOs) have been heralded as a promising model for improving the quality of care and reducing unnecessary costs through coordination and collaboration among providers. The concept envisions a transformation in the way that care is organized and delivered across the care continuum.

The American Hospital Association (AHA) recently shared the experiences and lessons learned from four organizations that have embarked on this journey in its report, *The Work Ahead: Activities and Costs to Develop an Accountable Care Organization*.

This report identifies a total of 23 different capabilities that must be developed across four categories to achieve this transformation: 1) network development and management; 2) care coordination, quality improvement and utilization management; 3) clinical information systems; and 4) data analytics. The costs associated with developing these capabilities range from $5.3 to $12.0 million for prototype ACOs.

Questions:

1) All of the following are features of an Accountable Care Organization (ACO) **EXCEPT:**

a) An ACO is a network of providers
b) An ACOs key feature is primary care physicians in lead role
c) An ACO shares clinical and financial responsibilities
d) An ACO is exempt from population health reimbursement mandates

2) Overall, the ACA provisions regarding ACOs, and payment reforms were intended to create a business environment where providers:

a) Must have a clear strategic plan and the business model to achieve it
b) Need to compete more on quality and price
c) Are challenged to include the patient as a stakeholder
d) Must work together to generate more positive patient outcomes

3) An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients. The primary reason ACOs were created is to:

a) Address the issue that patients are getting each part of their health care separately causing unnecessary spending
b) Provide increased availability of primary care for Medicare and Medicaid patients
c) Realign reimbursement models to include coverage of the un-insured
d) Incentivize greater commitment consumer demands

Sample Case Study 3 - The Patient-Centered Medical Home

Greater Up-State Health is a multi-provider, multi-payer collaboration involving essentially all primary care practices serving about 200,000 residents in a five-county region.

The impetus for this initiative was a crisis in the region's ability to attract and retain primary care physicians. In the past three years, the region lost nearly two dozen primary care physicians, significantly eroding its already small base of primary care physicians.

The providers and the community viewed this crisis as an opportunity to effect real change and identified the patient-centered medical home model as their best chance of improving primary care for physicians and patients alike.

Over a four-year planning period, physicians, payers, state officials, and community leaders worked to achieve broad consensus on the structure and funding of this Greater Up-State Health. The business aim of this planning was twofold:

1. To strengthen the region's ability to attract and retain primary care physicians by improving their quality of life and increasing their income, and
2. To transform the delivery of primary care in the region by increasing quality and continuity of care, reducing avoidable utilization and costs, and improving the health of the community.

To achieve these ambitious goals, the participating physicians committed to meeting criteria necessary for their practices to become NCQA-certified patient-centered medical homes, and to defining and ultimately achieving a variety of access, quality, and utilization goals over a five-year period.

The patient-centered medical home (PCMH) is a model intended to improve access to primary care while enhancing care coordination. It incorporates advanced health information technology and revolves around provision of evidence-based preventive and chronic care coordination services delivered by a team of providers led by a physician with whom the patient has an ongoing relationship.

The participating payers agreed to reimburse participating providers $7 per member per month over and above the normal fee-for-service payments for office visits to cover the costs of the expanded services of a PCMH. These payments enable the practices to put in place the elements of a PCMH, with the expectation that this model of care will result in fewer avoidable emergency department visits and hospital admissions in the future.

Over a five-year period, the participating physician practices are being held to a series of performance benchmarks to ensure that the new payments are financing improvements in patient care and generating cost savings that exceed their investment.

Questions:

1) The PCMH model has potential to advance the *Triple Aim* goals of health reform: 1) A healthy

population, 2) Extraordinary patient care, and

a) Sustainable profitability
b) Reasonable costs
c) Ensuring access to care
d) Affordability of care

2) Greater Up-State Health's patient centered medical home is a business strategy that is heavily reliant on:

a) Payers' willingness to invest capital into the medical home
b) Patient satisfaction
c) Capabilities of the IT infrastructure
d) Primary Care Physicians in lead roles.

3) Greater Up-State Health can significantly impact the cost of health care in its service areas. It does so by

a) Establishing transparent pricing
b) Upgrading its IT infrastructure
c) Addressing the issue of treatment bring received in disparate locations
d) Connecting business process tighter to those of payers.

If you have any questions about the above questions, please contact HFMA Career Services Department at 1-800-252-4362 or careerservices@hfma.org.

About HFMA

With more than 69,000 members, the Healthcare Financial Management Association (HFMA) is the nation's premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions for the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. We help healthcare stakeholders achieve optimal results by creating and providing education, analysis, and practical tools and solutions. Our mission is to lead the financial management of health care. For additional information on HFMA, visit hfma.org.

Contact Information:
Healthcare Financial Management Association (HFMA)
Career Services Department
Three Westbrook Corporate Center, Suite 600
Westchester, IL 60154

www.hfma.org
Phone: 1-800-252-4362, ask for Career Services
Fax: (708) 531-0032
E-mail: careerservices@hfma.org