HFMA Business of Health Care®
Key Concepts Guide

hfma™
healthcare financial management association

HFMA Business of Health Care® Key Concepts Guide
(Supplement to the HFMA Business of Health Care® online program)
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Table of Contents

Introduction

HFMA's certification program is designed for those seeking to understand the current healthcare industry. The healthcare business environment results from two primary aims: to reduce cost and increase value. These objectives require savvy healthcare professionals who understand the importance of collaboration, cooperation and innovation as the way business is done. There is much to do and much to learn.

This guide is intended to assist your progression through the module by specifying important ideas, trends and practices that comprise the healthcare business environment. Candidates taking the time to use and/or customize this guide can develop a handy review tool. This guide consists of two sections for each course: learning exercises which are intended to provide practice in applying important ideas and concepts learned and key terms and concepts in a glossary format.

Course 1: Healthcare Finance - The Big Picture

Introduction

The health care industry currently comprises nearly 20 percent of our nation's gross domestic product. Health care will be a significant factor in the national economy for the foreseeable future. This course provides a comprehensive overview of this all-important industry.

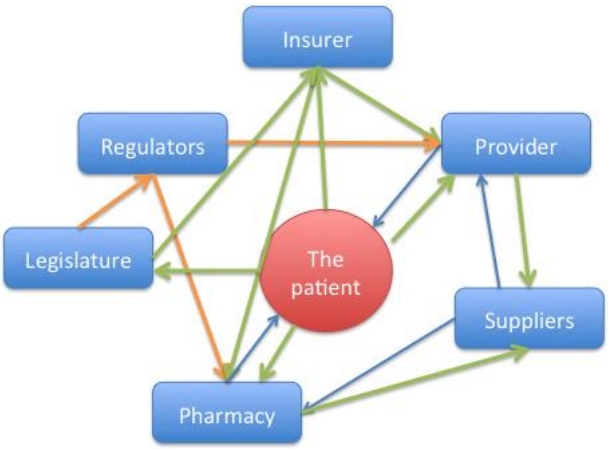
Upon completing this course, you should be able to:

- Identify the current trends of the healthcare delivery models in the U.S.
- Determine the future methods of payment for healthcare services
- Identify the impact of healthcare reform on the healthcare system
- Define the role of financial management in healthcare organizations

Learning Exercises

The following diagram presents an overview of the US healthcare system.

Review the diagram and answer the questions below.



1. Explain the transactions that the patient is involved in.

2. Describe the transactions that the provider is involved in.

3. Describe the legislative-regulatory transactions as depicted in the diagram.
4. Describe the interactions that the insurer is involved in.

Complete the following chart regarding healthcare stakeholders.

Who	Does What	For Whom
Primary care physician		
Specialist		
Third party payer		
Regulators		

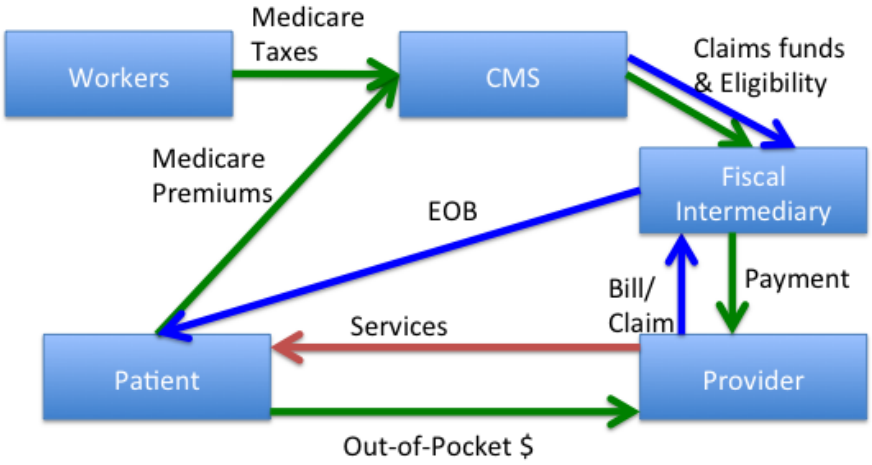
Financing Healthcare - The patient is ultimately responsible for payment for services. The patient is likely to have several options in play. *Complete the following chart regarding payment for services.*

Patient Payment Vehicle	Definition
Commercial indemnification (insurance)	
Deductible	
Co-Pay	

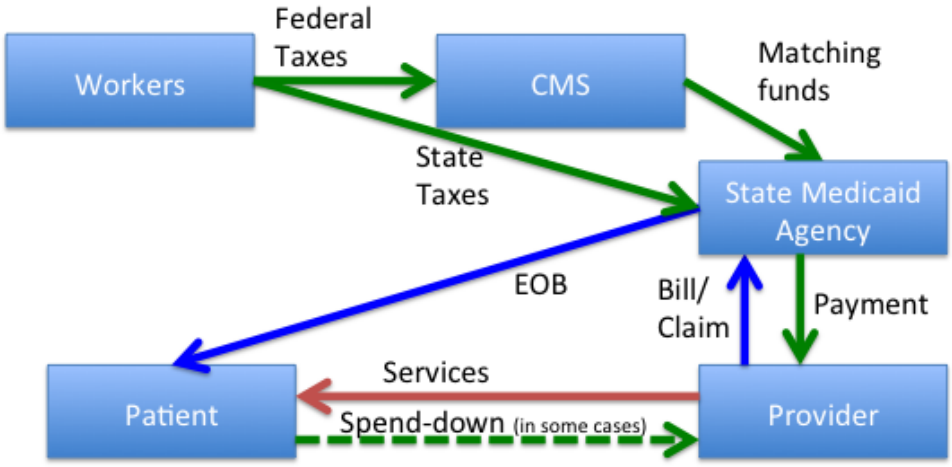
Co-insurance	
Governmental indemnification	

Match each Medicare program to the correct definition.

Medicare Program	Definition
Part A	This a voluntary program where a patient who meets the age or medical condition requirements for Medicare (but not the requirement to pay taxes for 40 calendar quarters) may participate in this insurance benefit. The plan is funded by a combination of patient premium and Medicare tax funds. Medicare Program (?) _____
Part B	Funded primarily by Medicare taxes paid by current workers to fund the costs of current beneficiaries. Patients are usually eligible for this program if they are a US citizen over age 65, disabled or have ESRD and have paid Medicare wage taxes for at least forty (40) calendar quarters. Medicare Program (?) _____
Part D	This program covers outpatient prescription medicines for persons otherwise eligible for Medicare benefits. Medicare Program (?) _____
Medicare Advantage	In this plan, a private health plan provides an alternative for patients that do not wish to receive services through the traditional Medicare. Medicare Program (?) _____



Using the diagram above, describe the role and activities of a Fiscal Intermediary.



Using the chart above, explain how Medicaid payments to a provider are funded and delivered.

Health Care Reform - Short answers

1. What does PPACA stand for? What is it?
2. What is the Medical-Loss Ratio?
3. Distinguish between the individual and employer mandates?
4. What is an Insurance Exchange?
5. What does ACO stand for? How does it work?
6. What is value-based purchasing?
7. Explain the following calculation: $\boldsymbol{Value} = \frac{\boldsymbol{Quality}}{\boldsymbol{Payment}}$

Notes:

Course 1: Healthcare Finance - The Big Picture
Key Terms and Concepts

Accountable Care Organization (ACO)	Accountable Care Organizations (ACOs) are groups of Medicare providers and suppliers that work together to coordinate care for traditional Medicare patients. Their goal is to deliver seamless, high-quality care instead of the fragmented care that often results from a fee-for-service payment system. The following groups of providers can form an ACO: physicians or certain non-physician practitioners in group practices, hospitals employing physicians, certain critical access hospitals, federally qualified health centers and rural health clinics.
Beneficiary	Insurers usually refer to the patient for which services are paid as the beneficiary.
Benefit payment	Once the insurer has determined the claim is appropriate, a payment is made to the provider. This payment is officially termed a benefit payment.
Bundled payments	A bundled payment is a single prospective payment by a health plan to all providers involved in a patient's episode of care where the providers divide the payment among themselves.
Centers for Medicare and Medicaid Services (CMS)	The federal government, through the Centers for Medicare and Medicaid Services or CMS, oversees all parts of the Medicare and Medicaid programs. CMS can waive a state's requirement to participate in traditional Medicaid if the state offers beneficiaries plans with better benefits.
Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program, signed into law in 1997, serves uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid.
Claim	Claim is another word for a bill for healthcare services provided.
Coinsurance	Coinsurance is a percentage of the insurance payment amount that is paid by the patient, along with the amount paid by the insurer.
Copay	A copay is a flat amount that a patient pays at each time of service.
Covered benefit	The services for which the insurer will pay are usually referred to as a covered benefit.

Deductible	A deductible is a pre-determined amount that the patient pays before the insurer begins to pay for service.
Denial	The insurer may determine that the claim from the provider is not a covered benefit and will not pay the claim. This is known as a denial.
Employer Mandate	The Employer Mandate requires employers with 50 or more full-time equivalent employees (FTEs) to offer health insurance coverage.
Facility provider	A facility provider is an acute care hospital, long-term care hospital, inpatient rehab hospital, psychiatric facility, skilled nursing facility, assisted living facility, home health agency, hospice agency, clinic, or ambulatory surgery center.
Fiscal Intermediary	A fiscal intermediary is an organization that contracts with CMS to pay Medicare claims and educate providers. A newer term is Medicare Administrative Contractor (MAC).
Individual Mandate	The Individual Mandate requires individuals and families without employer-provided insurance to purchase health insurance or pay a penalty. The Supreme Court in 2012 characterized the penalty as a tax. The penalty ranges from $695 per year to a maximum of three times that amount ($2,085) per family or 2.5% of household income.
Insurance Exchange	Insurance Exchanges are federal or state-run health insurance markets designed to make health insurance affordable and broadly available. They are more correctly referred to as Health Insurance Marketplaces. Individuals who purchase health insurance on an exchange (in the marketplace) may qualify for premium subsidies. 85% of enrollees receive such a subsidy. The subsidies are not available on the individual market.
Medicaid	Medicaid is a joint federal and state program established by Title XIX of the Social Security Act in 1965 for low-income and medically needy people. It is the single largest source of health coverage in the United States. Medicaid covers low income families, qualified pregnant women and children and individuals receiving Supplemental Security Income (SSI). Medicaid includes benefits not normally

	covered by Medicare, such as nursing home care and personal care services. Each state has different rules about eligibility and applying for Medicaid.
Medical loss ratio	Medical loss ratio refers to the percentage of premiums that insurers/health plans must spend on clinical services and quality improvement. The Affordable Care Act requires health insurance issuers to spend at least 80% to 85% of premium dollars on claims and quality initiatives.
Medicare Cost Report	A Medicare Cost Report is an annual report that institutional providers participating in the Medicare program must submit to their Medicare Administrative Contractor. For providers paid prospectively, the cost report determines reimbursement for certain add-on payments but does not affect the overall payment rate. For providers paid retrospectively, the cost report determines the payment rate. CMS uses cost report data to update DRG and APC weights and determine market basket updates.
Medicare Part A	Medicare Part A (Hospital Insurance) is one of two parts of the original Medicare program established by Title XVIII of the Social Security Act in 1965. It pays for hospital inpatient, skilled nursing facility, hospice, and some home health care. Part A is a premium-free benefit funded by FICA payroll deductions (2.9% payroll tax). *Categorical* eligibility starts when a U.S citizen who paid FICA taxes for at least 40 calendar quarters turns 65. Disabled individuals under 65 who have received Social Security for 24 months also qualify for Medicare.
Medicare Part B	Medicare Part B (Supplemental Medical Insurance) is the voluntary part of original Medicare. It pays for physician services, outpatient hospital and clinic care and some home health services. While beneficiaries over 65 pay a monthly premium tied to their prior year income, about 75% of the total cost is paid from general tax revenues. Since Part B is voluntary and not everyone may qualify for Part A, it is possible for a patient to have Medicare Part B but not Medicare Part A or vice versa.
Medicare Advantage (Medicare Part C)	Medicare Advantage plans, launched in 1997, are commercial insurance plans (HMOs, PPOs or fee-for-service plans) that offer Medicare beneficiaries an

	alternative to traditional Medicare. About 30% of Medicare beneficiaries select Advantage plans because benefits frequently exceed those of traditional Medicare. Beneficiaries pay the normal monthly Part B premium to CMS and sometimes also a separate Medicare Advantage premium to the commercial payer. Most plans have narrower provider choices than traditional Medicare. CMS pays Medicare Advantage plans a fixed, risk-adjusted monthly fee per beneficiary that slightly exceeds the estimated cost of providing similar services under traditional Medicare.
Medicare Prescription Drug benefit (Medicare Part D)	The Medicare Part D program, launched in 2006, covers prescription medications for Medicare beneficiaries. Commercial plans have monthly premiums and vary in the cost and kinds of drugs covered. Plans are allowed to negotiate discounts with drug manufacturers.
Medicare Trust Fund	The Medicare Trust Fund is the pool of FICA taxes that pays for Medicare Part A and B. Unless Medicare is reformed or payroll taxes are increased, the trust fund is expected to be depleted within the next ten years.
Out-of-pocket payment	Payments made by patients in addition to what their health insurance plan pays are known as out-of-pocket payments.
Patient Protection and Affordable Care Act	The Affordable Care Act was passed in 2010 and accomplished three things: (1) it reformed the health insurance market (healthcare exchanges or marketplaces, individual and employer mandates, and benefit standardization for all marketplace, individual, and employer-sponsored plans), (2) expanded Medicaid coverage from 100% to 133% of FPL for "expansion" states and (3) accelerated the transformation of the healthcare the delivery system through three key CMS-administered programs (ACOs, value-based purchasing and bundled payments). The 2015 legislation that reformed physician payments (MACRA) is not part of the ACA.
Pre-authorization	Insurers may require providers to contact them to pre-authorize certain high-cost services before treatment. A pre-authorization is an

	acknowledgement by the payer that it considers the service medically necessary and will pay for it.
Primary care	Primary care physicians are trained and board-certified in family practice, general practice, general internal medicine, and pediatrics. They frequently coordinate a patient's care and refer patients to specialists.
Professional provider	A professional provider is a physician, pharmacist, registered nurse or allied professional provider (APP) rendering a medical service to a patient. (Clinical social workers and physical therapists are examples of APPs).
Provider - general	A provider is a licensed professional or entity that provides a medical service to a patient.
Provider networks	Provider networks are groups of providers (panels) that contract with insurers as preferred or in-network in order to attract patients (steerage). The insurer steers patients to its panel of network providers by paying a higher proportion of the patient's costs of care. Some provider networks are known as narrow or ultra-narrow.
Remittance advice	A remittance advice is a written explanation accompanying an insurer's payment (or non-payment) of a patient account to a provider. The copy sent to the patient is known an Explanation of Benefits (EOB).
Specialist	A specialist is a physician who specializes in a specific disease, body system or type of healthcare.
Third-party payer	A third-party payer is a health insurance plan paying a provider for healthcare services delivered to its insured patients. The other two parties in a healthcare business transaction are the patient and the provider.
Value-Based Purchasing (VBP)	Medicare's Value-Based Purchasing (VBP) program started in 2012 as a part of the Affordable Care Act. It reduces payments to providers that do not meet CMS's quality of care standards. Participation in VBP is mandatory.

Course 2: Financial Accounting Concepts

Introduction

This course will provide you with a broad overview of financial accounting. This course is intended for those individuals who need a clear understanding of financial accounting concepts.

Upon completing this course, you should be able to:

- Identify the basic elements of the accounting function
- Differentiate between key financial statements and the information they provide
- Determine an organization's financial condition with the use of financial statements and analysis tools

Managing any business, a physician office, health plan, hospital, laboratory, imaging center, or department in a large health care organization requires a basic understanding of financial management. Remember that as managers, we make decisions on how to use resources to get work done – give a patient examination, complete a diagnostic imaging study, pay a claim, treat a patient in the emergency room, or dispense a medication to a patient. Accounting is a way of keeping track of those resources – be it for a hospital department, a clinic with hundreds of physicians, or a health plan with millions of covered lives. If you know what resources you are using, you can be more effective in controlling them and make your organization – or part of it – more efficient.

Learning Exercises

Fill in the blanks.

In accounting:

1. What you have or are owed – is known as an _____.
2. What you owe – is known as a _____.
3. What you get to keep (or retain) is known as _____.
4. The financial statement that summarizes revenues, expenses, and income for an organization over a specified period of time (month, quarter, or year) is a(n) _____.

5. A description of an organization's assets, liabilities, and net assets at a specified point in time – usually the end of the accounting period (month, quarter, or year) is called the _____.
6. The statement of cash flows is used to determine the sources and uses of_____.

Match each term to the correct definition.

Term	Definition
Operational metric	The sum of the patient days of all inpatients discharged over a given period divided by the number of discharges in the same period. Term (?) _____
The average length of stay	Used in businesses to assist managers in understanding the relationships between elements in the financial statements. Term (?)_____
Ratio analysis	Measures the extent to which the entity is generating a surplus. Term (?) _____
Liquidity	Measure the ability of an entity to pay its current obligations as they come due. Term (?) _____
Profitability	Measures how the assets for an entity are financed, as well as its ability to pay its long-term debts. Term (?) _____
Capital Structure	Simple ratios that describe the volume of services provided to patients or members or the resources used to provide services. Term (?) _____

Complete the following financial statements by filling in the blanks.

Income Statement For the Month of March	
(?)	10,600
Expenses	
Salaries	5,200
Supplies	500
Rent	1,000
Insurance	50
Total Expenses	(?)
Net Income	(?)

Balance Sheet Month, Year	
Assets	
Cash	(?)
Accounts Receivable	200
Advertising Supplies	1,000
Prepaid Insurance	550
Other Equipment	4,960
Total Assets	21,910

Liabilities and Stockholder's Equity	
(?)	
Notes Payable	5,000
Accounts Payable	2,500
Interest Payable	50
Unearned Revenue	800
Salaries Payable	1,200
Total Liabilities	(?)

Stakeholder's Equity	
Common Stock	10,000
Returned Earnings	2,360
Total Stockholder's Equity	(?)
Total Liabilities and Stockholder Equity	(?)

Statement of Cash Flows For the Month Ended March		
Cash Flow from Operating Activities		
Cash from Operating Activities	11,200	
Cash Payments for		
Operating Activities	(5,500)	
Net Cash Provided by		
Operating Activities		(?)
Cash Flows from Investing Opportunities		
Purchased Office Equipment	(5,000)	
Net Cash Used by Investing Activities		(?)
Cash Flows from Financing Activities		
Issuance of Common Stock	10,000	
Issued Note Payable	5,000	
Payment of Dividend	(500)	
Net Cash Provided by Financing Activities		(?)
Net Increase in Cash		(?)
Cash at Beginning of Period		(?)
Cash at End of Period		(?)

Course 2: Financial Accounting Concepts
Key Terms and Concepts

Accounting Equation	The formula for the accounting equation is Assets equal Liabilities plus Net Assets (for a not-for-profit entity) OR: Assets equal Liabilities plus Equity (for a for-profit entity). Sometimes also referred to as the accounting identity.
Accrual	An accrual is an accounting entry that records an asset (a receivable) for a service (revenue) rendered but for which payment has not been collected and a liability (a payable) for a matching cost (expense) incurred but not yet paid. Accrual basis accounting (an accounting system that uses accruals) is required by Generally Accepted Accounting Principles (GAAP) of all but the smallest business entities.
Asset	Resources owned or owed.
Balance Sheet or Statement of Financial Position	The balance sheet describes the organization's assets, liabilities, and net assets at a specified point in time – usually the end of the accounting period (month, quarter or year).
Capital structure	Capital structure ratios measure the relationship of an entity's debt to its net assets or equity and an entity's ability to meet its long-term obligations from its income. Examples: debt-to-equity ratio and debt service coverage ratio.
Cash basis accounting	Cash basis accounting is the alternative to accrual basis accounting. It does not follow the matching principle. Under cash basis accounting, Revenue equals Cash receipts and Expenses equals Cash disbursements.
Double entry system	In double entry bookkeeping, each accounting transaction has two sides that are equal or *in balance*.
Income Statement or Statement of Activities	The income statement summarizes revenues, expenses, and income for an organization over a specified period of time (a month, quarter or year). The income statement ties to the balance sheet through net assets: Net assets at beginning of the period (the previous balance sheet date) plus Net income during the period equal Net assets at the end of the period (the current balance sheet date).
Liability	What you owe; a financial obligation.

Liquidity	Liquidity ratios measure the ability of an entity to pay its current obligations as they come due (current = obligations due in less than one year). Examples: current ratio and days-cash-on-hand ratio.
Matching Principle	According to the matching principle in accounting, revenues earned in a given period (a month, a quarter or a year) must be matched with the corresponding expenses incurred in earning that revenue.
Net assets or equity	Total assets minus total liabilities.
Profitability	Profitability ratios measure an entity's earning power. Example: operating margin and total margin.
Statement of Cash Flows	The statement of cash flows shows the sources and uses of cash using the accrual basis of accounting. This statement reconciles the change in the cash balance during the period to net income during the period. The statement breaks down cash flows into operating, investing and financing activities.

Course 3: Cost Analysis Principles

Introduction

As mentioned in the prior course, health care is a business. With the operation of any business comes the necessity to manage costs while keeping customers happy and maintaining revenues. In health care this can sometimes appear as conflicting priorities. Managers in the healthcare industry certainly have a high degree of responsibility for taking care of patients. However, at the same time, the expenses incurred to pay for patient care (such as salaries, supplies, medicines) are increasing. Regardless of one's position in the health care industry – physician office, hospital, or health insurer – cost is an important concern.

Upon completing this course, you should be able to:

- Define the term *cost* for healthcare services
- Differentiate the ways cost can be determined for healthcare services
- Identify various methods for cost-allocation in healthcare organizations
- Determine how costs are used to identify prices in healthcare organizations

Learning Exercises

Define each term.

Term	Definition
Direct cost	
Indirect cost	
Variable cost	

Match each term to the correct statement.

Term	Statement
Direct cost	The basis upon which a cost pool is allocated among different revenue producing functions. Term (?) _____
Indirect cost	This remains constant within a range of operational volumes, regardless of the volume of services provided. Term (?) _____
Fixed cost	As the name implies, these are shifting directly with the volume of services provided. Term (?) _____
Variable cost	The amount of overhead cost to be allocated. Term (?) _____
Cost allocation	Those costs that are incurred to provide the services of a health care entity. Term (?) _____
Cost pool	This is made up of those costs necessary to operate the business but is not incurred in the provision of services to patients, customers, or clients. Term (?) _____

Fill in the blanks.

1. The process of _____analysis can be broken into two steps: (1) gathering total data and activity statistics and (2) allocating the costs of activities to a service
2. _____ approach, where all direct cost, overhead cost, and a desired level of profit are factored into price.
3. Determining how much cost can be included in the price charged to a customer based on a value judgment of how much customer volume will be gained for that lower price is called _____.

4. The _____is the sum of variable and fixed costs in a health care organization.
5. Community rating is _____; whereas group rating is_____.

Discover each scrambled term by using the clue.

Clue	Scrambled Term
Analyzing volume needed to cover costs	vnebarkee Term (?) _____
A cost incurred in providing a service	tdisorccet Term (?) _____
Lower prices in exchange for increased volume	mgcoarintprignics Term (?) _____

Course 3: Cost Analysis Principles
Key Terms and Concepts

Activity-based costing	Activity-based costing (ABC) is a bottom-up costing technique that assigns costs to individual services based on actual cost consumption, frequently on the basis of time.
Break-even analysis	Break-even analysis is a technique for analyzing the relationship between cost, volume and profit.
Community rating	Community rating is an approach used by insurance companies to set premiums based on the costs of providing healthcare services to all members in a community.
Contribution margin	The formula for contribution margin is Revenue minus Variable cost or Price per unit minus Variable cost per unit. The result is the contribution available for paying fixed costs and, once fixed costs are met, to the entity's profit or margin.
Cost allocation	Cost allocation is a process by which indirect (overhead) costs are allocated to revenue-producing services in a top-down fashion either directly or via a step-down method.
Cost driver	Cost driver is an activity-based costing term. A cost driver is the method by which a cost pool is assigned to revenue producing functions. Time is a key cost driver in healthcare.
Cost pool	The amount of indirect or overhead cost to be allocated to revenue-producing departments is called a cost pool.
Cost shifting price setting	Cost shifting is a strategy of compensating for lower payments from some payers (like Medicare and Medicaid) by charging other payers more (such as commercial and contracted payers).
Direct cost	Direct costs are costs directly incurred in providing healthcare services. Direct costs can be variable, such as nursing salaries and medical supplies, or fixed, such as supervisor salaries and equipment costs.

Fixed cost	Fixed costs are constant, regardless of the volume of services provided.
Full cost pricing	In Full-cost pricing, direct and indirect costs and a desired level of profit are factored into a price. In full-cost pricing, costs are fully passed on to customers.
Group rating	Group rating breaks a community down into smaller groups and bases insurance premiums on a group's relative risk or consumption of healthcare services.
Indirect cost	Indirect costs are costs necessary to operate the business but not directly incurred in service delivery. Examples are administration, finance, billing, information technology, facility maintenance and security. Indirect costs can be variable or fixed. Also referred to as overhead.
Marginal cost price setting	In marginal costing, some costs are omitted from pricing decisions. Marginal costing occurs in markets where competitors exert price pressure.
Total cost	Total cost is the sum of variable and fixed costs.
Variable cost	Variable costs change with the volume of services provided.

Course 4: Strategic Financial Issues

Introduction

Use of financial statements is a valuable skill for managers in the healthcare field. Financial statements allow the interpretation of data to identify opportunities to improve revenues or collections, optimize operating costs, or improve profitability. However, without some context, financial statements are of limited value.

Upon completing this course, you should be able to:

- Identify how strategic planning influences the budgeting process
- Differentiate between various methods for developing a budget
- Identify key components of a budget
- Identify budget variance concepts
- Determine the value of benchmarking to the budgeting process

Learning Exercises

The context for successful use of financial statement data comes from planning and budgeting. While these terms are sometimes used interchangeably, they are in fact two distinct and important functions. Planning entails preparing the business for future operation in a big picture sense. Budgeting is a subset of the planning process and is intended to express the organization's plans in financial terms.

Fill in the blanks.

1. Planning and budgeting are closely related. Planning is _____ while budgeting is _____.
2. A mission statement is intended to _____, while the vision statement is intended to _____.
3. A broad plan to guide the organization toward fulfillment of its mission is called a _____.

Match each term to the correct statement.

Term	Statement
Operating budget	This provides a necessary foundation for other elements in the budget process by defining the volume and nature of units of service expected to be provided. Term (?) _____
Statistical budget	This provides a benchmark for the normal, day-to-day activities of the business.
Revenue budget	Support areas that usually do not generate revenues and tend to incur indirect costs. Term (?) _____
Expense budget	This results from developing estimates of expenses by knowing operational relationships. Term (?) _____
Cost center	Once an understanding of service volumes is established, managers then apply expected collection rates or premium rates to estimated volume. Term (?) _____

Define each term.

Term	Definition
Capital budget	
Margin capital	
Strategic capital	
Net Present Value Period	

Fill in the blanks to balance each financial sheet.

Sample Physician Office and Hospital Operating Budget

	Physician Office	**Hospital**
Statistical Budget	*Office visits*	*Patient Discharges*
Insurer #1	10,000	25,000
Insurer #2	5,000	25,000
Total	(?)	(?)
Revenue Budget (per unit)		
Insurer #1	$100.00	$7,000.00
Insurer #2	125.00	5,000.00
Expense Budget		
Variable costs		
Direct labor/unit	$70.00	$3,500.00
Supplies/unit	10.00	1,000.00
Fixed costs		
Fixed labor	$250,000	25,000,000
Overhead	145,000	45,000,000
Income Statement Forecast		
Revenues		
Insurer #1	(?)	$175,000,000
Insurer #2	625,000	(?)
Total revenue	$1,625,000	$300,000,000
Expenses		
Variable costs	$1,200,000	$225,000,000
Fixed costs	375,000	70,000,000
Total expense	(?)	(?)
Forecasted margin	*$30,000*	*$5,000,000*

What do these budgets indicate?

Sample Health Plan Operating Budget

Statistical Budget	*Member Months*
Medicare Advantage	120,000
Commercial Line #1	120,000
Commercial Line #2	60,000
Total	(?)
Revenue Budget (per unit)	
Medicare Advantage	$450.00
Commercial Line #1	200.00
Commercial Line #2	250.00
Investment income	$1,250,000
Expense Budget	
Variable costs (per unit)	
Medicare Advantage claims	$373.50
Commercial Line #1 Claims	160.00
Commercial Line #2 Claims	212.50
Behavioral health carve-out (all members)	10.00
Fixed Costs	
Fixed labor	$7,000,000
Overhead	4,500,000
Income Statement Forecast	
Revenues	
Medicare Advantage	(?)
Insurer #1	(?)
Insurer #2	(?)
Total premium revenue	(?)
Investment income	**1,250,000**
Total revenue	(?)
Expenses	
Medical claims costs	$79,770,000
Fixed costs	11,500,000
Total expense	(?)
Forecasted margin	(?)

What do these budgets indicate?

Sample Hospital Cash Budget

Sources of cash:	
Drawdown of cash	
Income from operations	+3,000,000
Depreciation & amortization	+4,000,000
Non-operating income	+1,000,000
Gift from hospital foundation	+3,000,000
Sale of old equipment	+400,000
Total sources of cash	***11,400,000***
Less: Uses of cash	
Construction of new Emergency Room	-13,000,000
New diagnostic equipment	-2,000,000
Current payments on debt	-1,500,000
Total uses of cash	***(?)***
Cash needed	***(?)***

What do these budgets indicate?

Sample Budget Variance Analysis Physician Clinic

	Simple Budget	Actual Result	Variance Amount
Statistical Budget	*Office visits*		
Insurer #1	10,000	9,500	(?)
Insurer #2	5,000	6,000	(?)
Total	15,000	15,500	(?)
Revenue Budget (per unit)			
Insurer #1	$100.00	(?)	$5
Insurer #2	125.00	$123.00	(2)
Expense Budget			
Direct labor/unit	$70.00	$71.00	(?)
Supplies/unit	10.00	10.50	(?)
Fixed labor	$250,000	270,000	(?)
Overhead	145,000	150,000	(?)
Income Statement Forecast			
Revenues			
Insurer #1	$1,000,000	$997,500	(?)
Insurer #2	625,000	738,000	(?)
Total revenue	$1,625,000	$1,683,000	$110,500
Expenses			
Variable costs	$1,200,000	$1,263,250	($63,250)
Fixed costs	395,000	420,000	(25,000)
Total expense	$1,595,000	$1,683,250	($88,250)
Forecasted margin	*$30,000*	*$52,250*	*$22,250*

What do these budgets and statements indicate?

Flexible Budget Variance Analysis for Physician Clinic

	Flexible Budget	Actual Result	Variance Amount
Statistical Budget	*Office visits*		
Insurer #1	9,500	9,000	(?)
Insurer #2	6,000	7,000	(?)
Total	15,500	15,000	(?)
Revenue Budget (per unit)			
Insurer #1	(?)	105.00	$5.00
Insurer #2	125.00	(?)	(2.00)
Expense Budget			
Direct labor/unit	$70.00	(?)	($1.00)
Supplies/unit	10.00	(?)	(0.50)
Fixed labor	$250,000	(?)	(20,000)
Overhead	145,000	(?)	(5,000)
Income Statement Forecast			
Revenues			
Insurer #1	$950,000	$997,500	$47,500
Insurer #2	750,000	738,000	(12,000)
Total revenue	(?)	(?)	(?)
Expenses			
Variable costs	$1,240,000	$1,263,250	($23,250)
Fixed costs	395,000	420,000	(25,000)
Total expense	(?)	(?)	(?)
Forecasted margin	*$65,000*	*$52,250*	*($12,750)*

What do these budgets and statements indicate?

Match each term to the correct definition.

Term	Definition
Working capital	A large number of payables on hand in terms of claims awaiting adjudication. Term (?) _____
Inventory	A long-term rental of facilities or equipment. Term (?) _____
Accounts payable	Supplies on-hand. Term (?) _____
Line of credit	A loan that is offered not only to a bank but to private individuals, all collectively acting as a lender to the business. Term (?) _____
Operating or capital lease	The difference between current assets (cash, receivables, and inventory) and current liabilities (salaries payable and accounts payable). Term (?) _____
Bond issues	The ability of an organization to draw funds as needed to meet immediate cash needs. Term (?) _____

Course 4: Strategic Financial Issues
Key Terms and Concepts

Benchmarking	Benchmarking is the comparison of key performance measures relative to best practices or to other organizations.
Budgeting	A budget expresses an organization's plans in financial terms.
Capital budget	The capital budget contains an entity's long-term investment decisions. It allocates scarce resources (cash) to capital investments such as land purchases, building projects and the acquisition of other long-lived assets.
Cost center	Overhead departments such as administration and housekeeping are cost centers that do not directly produce revenue but are necessary for operating the entity. Other cost centers, such as the emergency department or radiology, are revenue-producing cost centers.
Expense budget	An expense budget projects the expenses associated with the expected revenues.
Flexible variance analysis	Flexible variance analysis adjusts the budget for changes in volume by applying revenue and expense-per-unit standards to actual volume.
Maintenance capital	Capital investments made to replace existing capabilities or maintain current service levels are known as maintenance capital.
Mission statement	The mission statement states the purpose of a business (why it exists).
Operating budget	The operating budget converts estimates of service volumes into revenues and expenses.
Planning	Planning entails preparing the business for future operation in a big picture sense.
Rate or price variance	Rate variance (also referred to as price variance) is an estimate of how much of a total budget variance is due to the rate per unit of revenue or expense being different than the budget estimate for the entity. The formula to calculate the rate variance is: (Actual rate or price minus Budget rate or price) multiplied by Actual volume

Revenue budget	A revenue budget converts service volumes into expected revenues.
Simple variance analysis	Simple variance analysis does not account for changes in volume. Formulas: Actual revenue minus Budgeted revenue equal Revenue variance AND: Budgeted expense minus Actual expense equal Expense variance.
Strategic plan	A strategic plan guides an organization over a period of 3 to 5 years.
Strategic capital	Investments made to expand capacity, add new capabilities or enter new service lines are termed strategic capital.
Statistical budget	A statistical budget defines the volumes and units of service expected to be provided.
Variance analysis	Variance analysis investigates why actual performance differs from budgeted or expected performance. Variances can be caused by changes in volumes, changes in prices and changes in productivity.
Vision statement	A vision statement expresses an organization's aspirations.
Volume variance	The volume variance is an estimate of the extent to which the total budget variance in a budget line item is a result of actual volumes being different from those used in the budget projection. The formula for calculating the volume variance is: (Actual volume minus Budget volume) multiplied by Budget rate

Course 5: Managing Financial Resources

Introduction

Other units in this module have addressed revenue for physicians or hospitals and claim expenses for health plans. Revenue to a hospital or physician clinic is an expense to a health plan. In that sense, a physician or hospital billing for services, and the health insurer paying for such services, constitute a process known as the revenue cycle.

Upon completing this course, you should be able to:

- Identify the components of the revenue cycle
- Compare how healthcare providers are reimbursed for services
- Determine the processes by which a hospital or a physician clinic bills and collects for services
- Identify various metrics used to manage the revenue cycle
- Determine the methods used by healthcare organizations to fund capital expenditures
- Define the terms compliance, fraud, and abuse

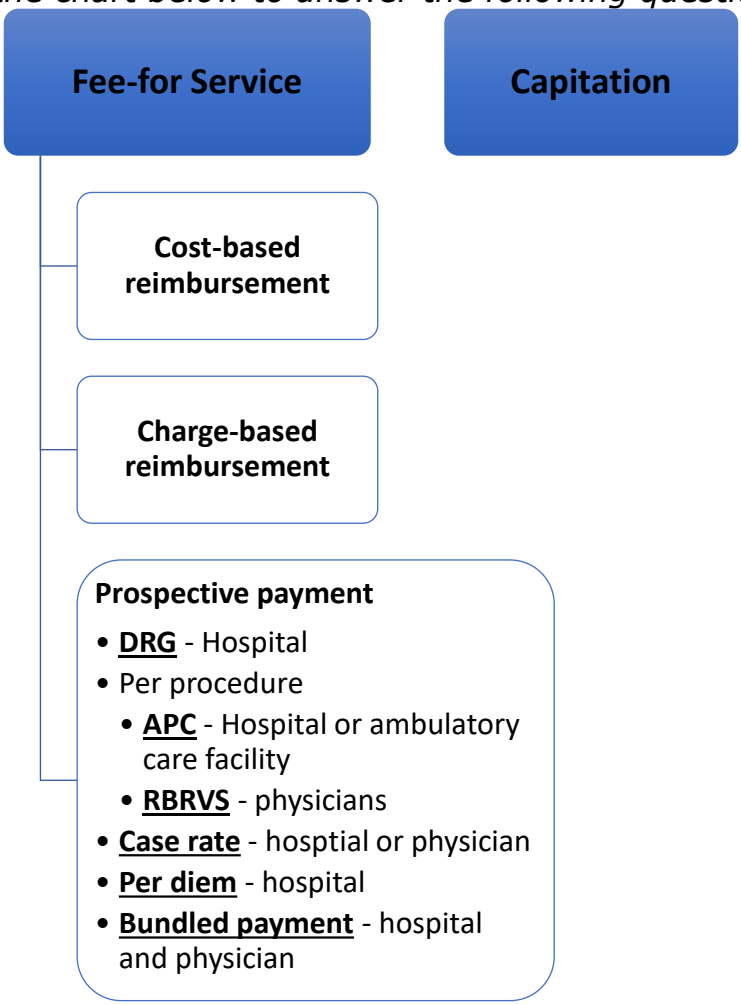
The revenue cycle in health care can be described as the flow of money between the patient, the insurer, and the provider of healthcare services. For more information on this topic, review Course 1, Healthcare Finance: The Big Picture.

It is important to remember that the patient is ultimately responsible for payment for services to a physician or hospital. A contract between an insurer and a provider may limit the ability for the provider to collect from a patient for denial of payment for covered benefits. However, the patient may have to pay a provider for any services not determined to be a covered benefit under the patient contract with the insurer.

This course focuses on the submission of a claim to an insurer by a provider of healthcare services. This billing and collection function between a hospital or physician and an insurer is one of the most important resource management challenges in today's healthcare industry.

Learning Exercises

Use the chart below to answer the following questions.



1. What does the chart present?
2. Distinguish between cost-based and charge-based reimbursement.
3. Define capitation. What is the financial objective of capitation?
4. What are DRG, APC and RBRVS? How are they used?

Define each term.

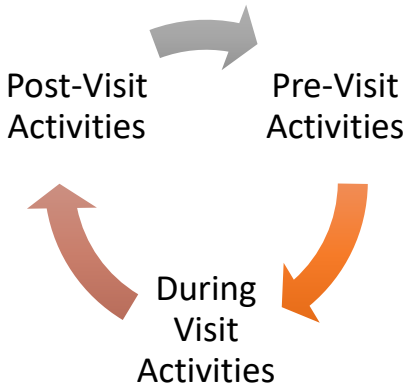
Term	Definition
Case rate	
Per diem	
Bundled payment	

Payment Reform and Risk-Management

	Provider incentive to increase volume of services ⟷ Provider incentive to decrease volume of services						
	Provider incentive to maximize costs ⟷ Provider incentive to minimize costs						
	Cost Based	Charge Based	DRG	Per-Procedure	Per Diem	Bundled Payment	Capitation
Providers	*Lowest financial risk* ⟷ *Highest financial risk*						
Payers	*Highest financial risk* ⟷ *Lowest financial risk*						
Consumers	*Risk of overtreatment* ⟷ *Risk of under treatment*						
Employers	*Risk of high costs from inefficiency* ⟷ *Risk of high costs from under treatment*						

Be prepared to use the following chart to explain the current payment system. Note, especially the risk-management/risk transfer instruments, which providers, physicians and payers employ and be able to explain each one.

The Revenue Cycle



Explain what the diagram above illustrates.

Define and explain the importance of each of the following activities.

Stage	Activities	Definition	Significance
Pre-visit	Patient scheduling		
	Eligibility verification		
	Registration		
	Point of service collection		

Stage	Activities	Definition	Significance
Patient visit	Treatment		
	Utilization review		
	Charge capture		
	Discharge		
	Medical record completion		

Stage	Activities	Definition	Significance
Post-visit	Medical record analysis and coding		
	Billing		
	Payment processing by health plan (claims adjudication) Claim logging Eligibility Adjudication Remittance		
	Denial management		
	Payment posting and follow up		
	Account closure		

Course 5: Managing Financial Resources
Key Terms and Concepts

Accounts payable	Accounts payable is money owed to suppliers and vendors. It is shown as a liability on the balance sheet.
Balance billing	Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or any amounts that may remain on the patient's annual deductible) that exceed the health plan's payment for a covered service. In-network providers are contractually prohibited from balance billing health plan members, but balance billing by out-of-network providers is common.
Billing	Billing refers to the process of creating a bill (or claim) from charges, diagnosis information, procedure data and demographic information and submitting it electronically or (less frequently) on a paper claim form to the health plan.
Bond issue	A bond is a long-term debt instrument issued by a debtor and sold to investors. The interest rate is often lower than for a bank loan.
Bundled payments	One form of value-based payment is bundled payment, in which a health plan pays a single prospective rate for all services provided by the physician, hospital and post-acute provider (the "bundle") and the providers divide the payment among themselves.
Care purchaser	Individuals and entities that contribute to the purchase of healthcare services.
Capital lease or operating lease	A capital lease is a long-term rental agreement with a bargain purchase option at the end. Capital leases are shown as a liability on the balance sheet. An operating lease is a shorter time rental without a purchase option. Starting in 2018 most operating leases, a common form of off-balance sheet debt, must be capitalized and included on the balance sheet.
Capitation	Capitation pays a fixed payment amount per person per month to a provider in advance in return for all services necessary to care for the patient. Capitation payments are normally expressed as an amount per member per

	month (PMPM). Capitation revenue is considered premium revenue, not patient service revenue.
Case mix index (CMI)	The average resource consumption of all inpatients taken together is known as the case mix index. The formula: (Sum of all inpatients' relative DRG weights) divided by (Number of inpatients).
Charge	The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.
Chargemaster (also called Charge Description Master or CDM)	The chargemaster is a computer file that lists every service or item a healthcare provider "provides." It includes each item's description, retail price and other information needed for billing, such as revenue codes and CPT-4/HCPCS codes.
Charge-based payment	The payment mechanism that pays either list price or a percentage of it is called charge-based payment. This payment system was widely used in the early days of commercial insurance but has fallen out of use as health plans have adopted other payment methods.
Charge capture	When a provider charges a patient for services and aggregates the charges in the patient's account the provider is performing a task known as charge capture. Charge capture typically takes place at the time the service is rendered but can also occur later (for example during coding).
Claims adjudication	Once a bill has been received by a health plan, it is validated for eligibility, screened for omissions and errors and priced. This process is known as claims adjudication.
Coding	During coding, the patient's medical record is analyzed and coded (assigned a machine-readable set of ICD-10 diagnosis and ICD-10-PCS/CPT-4 procedure codes) by a professional coder before the account can be billed.
Coinsurance	Coinsurance is the percentage of the insurance company's allowable amount for covered services that is paid by the patient.
Concurrent review	Hospitals and health plans monitor length of stay in a process called concurrent review to ensure that patients are discharged in a timely manner. Concurrent review can be performed onsite or remotely. Concurrent review is one form of utilization review.

Copay	A copay is a flat amount that a patient pays at each time of service.
Cost (to the patient)	The amount payable out of pocket for healthcare services, which may include deductibles, copayments, coinsurance, amounts payable by the patient for services that are not included in the patient's benefit design, and amounts "balance billed" by out-of-network providers. Health insurance premiums constitute a separate category of healthcare costs for patients, independent of healthcare utilization.
Cost (to the provider)	The expense (direct and indirect) incurred to deliver healthcare services to patients.
Cost (to the insurer)	The amount payable to the provider (or reimbursable to the patient) for services rendered.
Cost (to the employer)	The expense related to providing health benefits (premiums or claims paid).
Days cash on hand	Another important measure of liquidity, Days Cash on Hand measures how many days an entity could theoretically continue to operate without any further inflow of cash from operations, instead spending down its entire cash holdings and "near-cash" deposits and liquid investments. The formula: Cash and cash equivalents from the balance sheet divided by Average daily cash operating expenses from the income statement.
Days in A/R	A key measure of an entity's liquidity, Days in A/R measures an entity's efficiency in converting its accounts receivable quickly into cash. The correct name of this ratio is "Days Net Revenue in Net Accounts Receivable." The formula: Net A/R from the balance sheet divided by Average daily net patient service revenue from the income statement.
Days in inventory	Hospitals track supply inventory levels via the days in inventory ratio. The formula: Inventory divided by (Average daily supply expense)
Deductible	A deductible is a pre-determined amount that a patient pays before the insurer begins to pay for covered services.
Diagnosis-Related Group (DRG)	Medicare's inpatient prospective payment system (IPPS) assigns inpatients to diagnosis-related groups (DRGs) that take into account the patient's severity of illness,

	risk of mortality and relative resource consumption. There are approximately 750 DRGs in Medicare's inpatient prospective payment system. CMS modified its DRG system in 2007 to better account for resource utilization and renamed it MS-DRGs (the MS stands for Medicare Severity). A third, proprietary DRG system is called AP-DRG (all-payer DRG).
Discharged Not Final Billed (DNFB)	The dollar amount of patient charges (or days revenue) between discharge and final billing is known as Discharged Not Final Billed (DNFB). Physicians complete their documentation, coders code charts, and departments complete their charge capture during this time.
DRG relative weight	Each DRG has a relative weight based on the DRG's relative resource consumption. Each DRG also has a length of stay associated with it calculated by CMS as the geometric mean length of stay of all Medicare admissions for that DRG.
Eligibility verification	Providers can verify a patient's eligibility for health benefits with the health plan either by checking a health plan's website or calling the plan.
EMTALA	EMTALA (Emergency Medical Treatment and Active Labor Act) is a 1986 federal law that requires hospital emergency rooms to examine and stabilize patients with emergent medical conditions before asking for insurance information or payment. EMTALA was enacted to prohibit a practice known as patient "dumping."
Fee-for-service	Fee-for-service is a payment mechanism in which the provider is paid a separate amount for each discrete service.
Fee schedule	A fee schedule is a list of prices that a payer or the government pays a provider for a service. It is usually considerably less than a provider's list price in its chargemaster.
Line of credit	A line of credit is a pre-approved loan on which an entity can draw as needed to meet its short-term cash needs.
Lessee; lessor	The lessee is the entity that acquires an asset for use over a specified period of time as defined in a lease agreement with a lessor who owns and rents the asset to the lessee.

Long-term debt	Long-term debt is debt with a maturity of one year or more. It is typically secured with an asset or the entity's revenue.
Mortgage	A mortgage is a bank loan typically secured with the asset being financed (frequently real property).
Net revenue	The gross charges for healthcare services at list prices, less contractual adjustments, discounts, bad debt and charity, is referred to as patient service net revenue. Provider organizations can also have forms of revenue, such as premium revenue, other operating revenue and non-operating revenue.
Out-of-pocket payment	The portion of the total payment for medical services and treatment for which the patient is responsible, including copayments, coinsurance, and deductibles. Out-of-pocket payment also includes amounts for services that are not included in the patient's benefit design and amounts for services balance billed by out-of-network providers.
Payer	An organization that negotiates or sets rates for provider services, collects revenue through premium payments or tax dollars, processes provider claims for service, and pays provider claims using collected premium or tax revenues.
Per diem	In a per-diem arrangement, a health plan reimburses a facility a fixed amount per day for care to a patient.
Point-of-service collections	Collection by the provider of patient deductibles, copayments or coinsurance at time of service is known as point-of-service collections.
Price	The total amount a provider expects to be paid by payers and patients for healthcare services.
Price transparency	In health care, readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.
Prospective payment system (PPS)	In response to the open-ended nature of healthcare payments through the 1960s and 1970s, Medicare and Medicaid adopted a prospective payment system for hospital inpatient services (IPPS) in 1983 and for hospital outpatient services (OPPS) in 2000. Healthcare

	services rendered in other settings are now paid by the government and many commercial payers on a prospective basis as well. As the name implies, under prospective payment the payment for a service is determined ahead of time (prospectively) regardless of how many resources as consumed delivering the service in a particular instance.
Provider	An entity, organization, or individual that furnishes a healthcare service.
Reimbursement	Reimbursement is the traditional term to describe the amount paid by an insurer or a government payer to a provider. A better term is payment.
Remittance advice	The written explanation accompanying an insurer's payment (or non-payment) of a patient account to a provider is called a remittance advice. The copy sent to the patient is known an Explanation of Benefits (EOB).
Revenue Cycle	The collection of sequential, interrelated processes that start with scheduling a patient and end with getting paid are referred to as the revenue cycle in healthcare. Note that this definition views the revenue cycle primarily from the perspective of a provider and not a health plan.
Risk transfer	Risk transfer refers to a payment mechanism whereby the cost of care for a group of patients (risk) is transferred from the health plan to the provider. Capitation is the most extreme form of risk transfer because it shifts risk entirely from the payer to the provider.
Short-term debt	Short-term debt is debt due to be repaid in a year or less. The most common forms of short-term debt are accounts payable and a revolving line of credit from a bank.
Utilization review	Utilization review is like concurrent review but can also encompass review activities before a patient is admitted or after a patient has been discharged.
Value	The quality of a healthcare service in relation to the total price paid for the service by care purchasers.
Working capital	The difference between current assets (cash, receivables, and inventory) and current liabilities (accrued payroll and accounts payable) is called working capital.

Course 6: Looking to the Future

Introduction

The healthcare industry is changing quickly. It has been in what seems a constant state of change since implementation of the Prospective Payment System by CMS (then referred to as HCFA) in 1983. As controversy continues to swirl around the entire industry and how much of the US economy should be taken by health care services, it seems certain that managers will need to stay up to date with regulations and policy changes. A great resource for such updates can be found at www.hfma.org.

Upon completing this course, you should be able to:

- Identify new models to reimburse healthcare providers for services
- Identify the use of business intelligence concepts in healthcare organizations
- Determine new models for collaboration between finance professionals, physicians and payers
- Define the trend of population health in future healthcare delivery models

Learning Exercises

The Patient Protection and Affordable Care Act (PPACA) include provisions for a new approach to reimbursing hospitals and physicians for their services.

Determine which of the following statements are true regarding new approaches. If a statement is false, state why the reason why.

New Payment Approach	True	False Reason Why
Current payment methods do not encourage providers to work together to keep patients healthy.		
An ACO is a network of physicians, hospitals, and patients organized together to share		

New Payment Approach	True	False Reason Why
the financial responsibility for care provided.		
An ACO provides incentives for cooperation among providers to share data and avoid unnecessary tests or procedures.		
ACO must meet quality of care targets.		

Course 6: Looking to the Future
Key Terms and Concepts

Accountable Care Organization (ACO)	An ACO is a network of healthcare providers that can include physicians, hospitals, and other providers (such as nursing homes or retail pharmacies) organized together to share the financial and clinical responsibility for the care of a designated group of patients. Medicare ACOs may not prevent patients with Medicare Part A and B from obtaining services from providers outside the ACO to which they are attributed.
Bundled payment	A bundled payment is a single prospective payment by a health plan to all providers involved in a patient's episode of care where the providers divide the payment among themselves.
Business intelligence	Business intelligence is a process by which data available in the organization is analyzed and converted into information usable by decision-makers.
Consumerism	Merriam-Webster offers two very different definitions of consumerism: (1) the promotion of the consumer's interest and (2) the theory that an increasing consumption of goods is economically desirable. As used in healthcare, the term consumerism follows the first definition and refers to recent efforts by health plans and providers to understand the needs, wants and preferences of patients and tailor their products and services to satisfy those needs, wants and preferences.
Population health	Managing population health entails a group of providers and a health plan collaborating to improve performance on measures of overall health (such as hypertension or diabetes or cancer screenings) for a specific group of patients.
Value	Value is quality in relation to the total payment for care.
Quality	Quality is a composite of patient outcomes, process of care, patient safety, and patient experience with caregivers.

Concluding Learning Exercise

Word Search

Use the clues below to discover the hidden words in the following grid.

	A	B	C	D	E	F	G	H	I	J	K
1	X	S	T	N	E	I	T	A	P	Y	X
2	E	H	R	W	S	M	E	R	A	F	U
3	Y	I	E	O	E	U	N	E	V	E	R
4	T	P	E	A	C	A	I	B	A	I	U
5	I	A	U	A	O	S	Y	H	L	A	P
6	L	A	S	Y	S	F	Q	S	U	N	A
7	A	H	A	S	T	R	A	T	E	G	Y
8	U	U	Q	H	U	D	C	L	J	E	M
9	Q	W	R	A	T	I	O	D	S	O	E
10	K	S	A	T	E	S	I	T	A	E	N
11	C	O	L	A	B	E	R	A	T	E	T

- Electronic Health Care Record
- A critical financial management function - _____ analysis
- The Patient Protection and Affordable Care Act
- Changes in payment models are forcing health care entities to exam business _____
- Accountable Care Organization
- A financial decision-making tool
- _____ Based Purchasing
- Health insurance portability, privacy and data security
- Finance, physicians and payers strive to _____
- Healthcare stakeholders include providers, physicians, health plans and _____
- Cost and improved clinical outcomes are indicators of _____
- _____ Claims may be punished by a civil monetary penalty
- _____Cycle
- Fiscal capability requires strong _____ flow

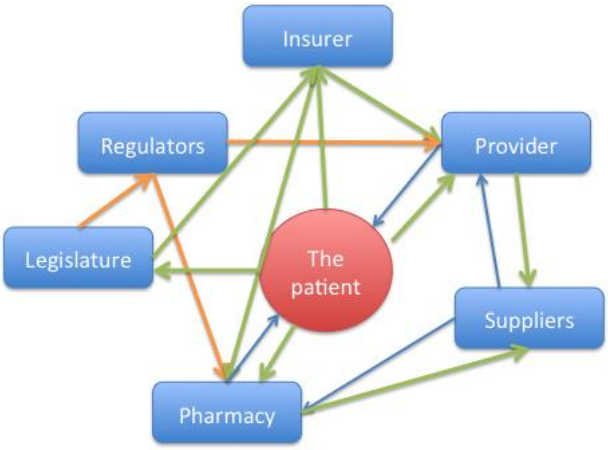
Cross out all descriptions and requirements that do not apply.

An ACO	Requires a group of primary care physicians that serve in a lead role in managing the care of a patient.
	Creates incentives for clinical cooperation.
	Pays providers on a negotiated case-rate basis.
	May have to pay a penalty if cost and quality performance does not meet established targets.
	The ACO model of payment is currently in use by the Medicare program.
	The health plan has full charge over the medical care decisions made by ACO providers.
	Can have valuable cooperation with payers through referral of patients and assistance with the collection and analysis of cost and quality data.

Fill in the blanks.

1. When a health plan pays a single prospective rate to all providers involved in a patient's care, it is making a _____.
2. The processing of data available in the organization being analyzed and converted into information usable by decision-makers is known as _____.
3. *Quality in relation to the total payment for care* is the definition of _____.
4. _____ entails a group of providers and a health plan collaborating to improve performance on measures of overall health (such as hypertension or diabetes or cancer screenings) for a specific group of patients.

Answer Key



1. Explain the transactions that the patient is involved in.

Provider, insurer, legislature, pharmacy

2. Describe the transactions that the provider is involved in.

Suppliers, regulators, insurers

3. Describe the legislative-regulatory transactions as depicted in the diagram.

Legislature: regulators, insurers, patients; regulators in turn with insurers and providers

4. Describe the interactions that the insurer is involved in.

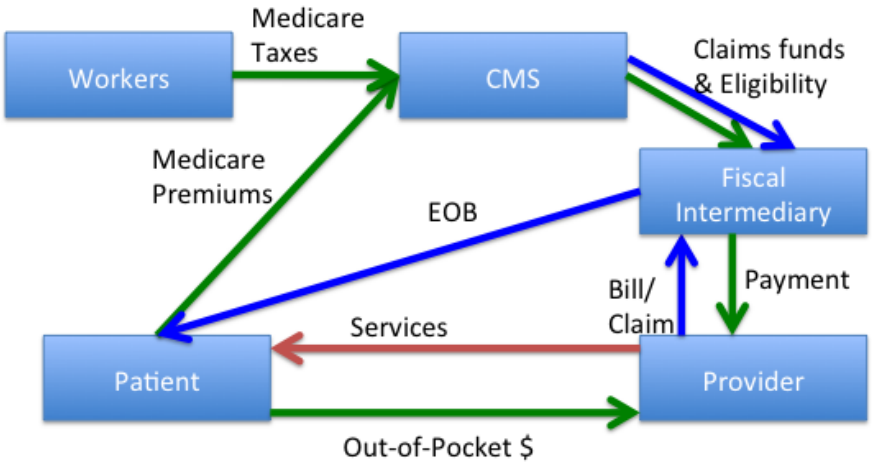
Patient, provider, pharmacy, legislature

Who	Does What	For Whom
Primary care physician	**General health care; wellness care**	**Individual patients**
Specialist	**Provides focused health care in an area of medicine, e.g. cardiac**	**Patients referred by a primary care doctor and/or an attending physician**
Third party payer	**Provides reimbursement for medical treatment. Reimbursement is normally made directly to the providers**	**Medical service(s) provider(s)**
Regulators	**Issues directive standards to implement legislation**	**Regulations are for providers, clinicians and health plans**

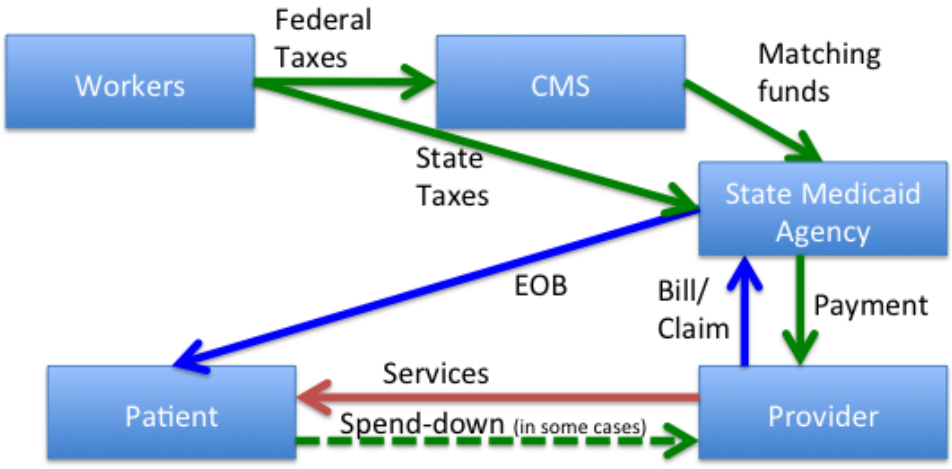
Patient Payment Vehicle	Definition
Commercial indemnification (insurance)	**Indemnity insurance is an insurance policy designed to protect professionals and business owners when they are found to be at fault for a specific event such as misjudgment.**
Deducible	**A deductible is the amount you pay each year for eligible medical services or medicines *before* your insurance plan kicks in.**
Co-Pay	**A copay (or copayment) is a flat fee that you pay on the spot each time you go to your doctor or fill a prescription.**
Co-insurance	**Coinsurance is a portion of medical cost that you pay when your health plan kicks in. Your plan kicks in after you hit your deductible. Coinsurance is just a way of saying that you and your insurance carrier each pay a share of eligible costs to add up to 100%.**

Governmental indemnification	**Indemnification of government contractors for third-party liability involves the following issue: Who should bear the risk of liability for injury or damage to a third party caused by products and services supplied by government contractors?** **This issue is especially significant when the products and services involve are high-risk or hazardous governmental activities.**

Medicare Program	Definition
Part B	This a voluntary program where a patient who meets the age or medical condition requirements for Medicare (but not the requirement to pay taxes for 40 calendar quarters) may participate in this insurance benefit. The plan is funded by a combination of patient premium and Medicare tax funds.
Part A	Funded primarily by Medicare taxes paid by current workers to fund the costs of current beneficiaries. Patients are usually eligible for this program if they are a US citizen over age 65, disabled or have ESRD and have paid Medicare wage taxes for at least forty (40) calendar quarters.
Part D	This program covers outpatient prescription medicines for persons otherwise eligible for Medicare benefits.
Medicare Advantage	In this regard, a private health plan provides an alternative for patients that do not wish to receive services through the traditional Medicare.



- **Authorized on behalf of CMS to receive claims and process reimbursement**
- **Receives claims/bill from provider and remits payment; works with providers on denied claims**
- **Sends Explanation of Benefits (EOB) to patient**



- **Federal income taxes for Medicaid are provided through CMS to a state's Medicaid agency**
- **State income taxes are sent directly to the state Medicaid agency.**
- **The state Medicaid agency provides Medicaid reimbursement to the provider.**
- **In some cases, the patient may be involved in a Medicaid spend down to reimburse the provider**

1. What does PPACA stand for? What is it?

   PPACA is the Patient Protection and Affordable Care Act. This is federal legislation designed to reform the U.S. healthcare system by 1) reducing cost 2) increasing quality outcomes [quality] and 3) increasing patient satisfaction [value].

2. What is the Medical-Loss Ratio?

   The Medical Loss Ratio (MLR) requirement – limits the portion of premium dollars that health insurers may spend on administration, marketing and profits. Under healthcare reform, health insurers must publicly report the portion of premium dollars spent on health care and quality improvement and other activities in each state they operate.

3. Distinguish between the individual and employer mandates?

   The healthcare reform legislation that became law in 2010, known officially as the Affordable Care Act and as Obamacare, requires most Americans to have a basic level of health insurance coverage. This requirement is commonly referred to as the law's individual mandate. The law imposes a tax penalty on those who fail to have the required coverage.

   The employer mandate is a requirement that all businesses with 50 or more full-time equivalent employees (FTE) provide health insurance to at least 95% of their full-time employees and dependents up to age 26 or pay a fee.

4. What is an 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 the Patient

Protection and Affordable Care Act. Marketplaces provide a set of government-regulated and standardized health care plans from which individuals may purchase health insurance policies eligible for federal subsidies.

5. What does ACO stand for? How does it work?

   Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.

   The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

   When an ACO succeeds both in delivering high-quality care and spending healthcare dollars more wisely, it will share in the savings it achieves with the Medicare program.

6. What is value-based purchasing?

   Hospitals are no longer paid solely on the quantity of services they provide. Under the Hospital VBP Program, Medicare makes incentive payments to hospitals based on either (1) How well they perform on each measure or (2) How much they improve their performance on each measure compared to their performance during a baseline period.

7. Explain the following calculation: $\boldsymbol{Value} = \frac{\boldsymbol{Quality}}{\boldsymbol{Payment}}$

   The illustration is a definition of value – quality treatment outcomes at reasonable cost. The illustration directly connects quality outcomes and payment for services. Pursuit of value is intended to drive quality outcomes, contain cost and thereby increase patient satisfaction.

Course 2: Financial Accounting Concepts

In accounting:

1. What you have or are owed – is known as an **asset**.
2. What you owe – is known as a **liability**.
3. What you get to keep (or retain) is known as **equity**.
4. The financial statement that summarizes revenues, expenses, and income for an organization over a specified period of time (month, quarter, or year) is a(n) **income statement**.
5. A description of an organization's assets, liabilities, and net assets at a specified point in time – usually the end of the accounting period (month, quarter, or year) is called the **balance sheet**.
6. The Statement of Cash Flows is used to determine the sources and uses of **cash**.

Term	Definition
The average length of stay	The sum of the patient days of all inpatients discharged over a given period divided by the number of discharges in the same period.
Ratio analysis	Used in businesses to assist managers in understanding the relationships between elements in the financial statements.
Profitability	Measures the extent to which the entity is generating a surplus.
Liquidity	Measure the ability of an entity to pay its current obligations as they come due.
Capital Structure	Measures how the assets for an entity are financed, as well as its ability to pay its long-term debts.
Operational metric	Simple ratios that describe the volume of services provided to patients or members or the resources used to provide services.

Income Statement For the Month of March	
Revenue	10,600
Expenses	
Salaries	5,200
Supplies	500
Rent	1,000
Insurance	50
Total Expenses	**6,750**
Net Income	**3,850**

Balance Sheet Month, Year	
Assets	
Cash	**15,200**
Accounts Receivable	200
Advertising Supplies	1,000
Prepaid Insurance	550
Other Equipment	4,960
Total Assets	21,910

Liabilities and Stockholder's Equity	
Liabilities	
Notes Payable	5,000
Accounts Payable	2,500
Interest Payable	50
Unearned Revenue	800
Salaries Payable	1,200
Total Liabilities	**9,550**

Stakeholder's Equity	
Common Stock	10,000
Returned Earnings	2,360
Total Stockholder's Equity	**12,360**
Total Liabilities and Stockholder Equity	**21,910**

Statement of Cash Flows For the Month Ended March		
Cash Flow from Operating Activities		
Cash from Operating Activities	11,200	
Cash Payments for		
Operating Activities	(5,500)	
Net Cash Provided by		
Operating Activities		**5,700**
Cash Flows from Investing Opportunities		
Purchased Office Equipment	(5,000)	
Net Cash Used by Investing Activities		**(5,000)**
Cash Flows from Financing Activities		
Issuance of Common Stock	10,000	
Issued Note Payable	5,000	
Payment of Dividend	(500)	
Net Cash Provided by Financing Activities		**14,500**
Net Increase in Cash		**15,200**
Cash at Beginning of Period		**00**
Cash at End of Period		**15,200**

Course 3: Cost Analysis Principles

Term	Definition
Direct cost	**Direct costs can be traced directly to a cost object such as a product or a department.**
Indirect cost	**Indirect costs do not vary substantially within certain production volumes or other indicators of activities, and so are considered to be fixed costs. Examples are legal and accounting fees, advertising, office rent, etc.**
Variable cost	**A variable cost is a cost that varies in relation to changes in the volume of activity.**

Term	Statement
Cost allocation	The basis upon which a cost pool is allocated among different revenue producing functions.
Fixed cost	This remains constant within a range of operational volumes, regardless of the volume of services provided.
Variable cost	As the name implies, these are shifting directly with the volume of services provided.
Indirect cost	The amount of overhead cost to be allocated.
Direct cost	Those costs that are incurred to provide the services of a health care entity.
Cost pool	This is made up of those costs necessary to operate the business but is not incurred in the provision of services to patients, customers, or clients.

1. The process of **Activity-based** analysis can be broken into two steps: (1) gathering total data and activity statistics and (2) allocating the costs of activities to a service
2. **Full cost pricing** approach, where all direct cost, overhead cost, and a desired level of profit are factored into price.

3. Determining how much cost can be included in the price charged to a customer based on a value judgment of how much customer volume will be gained for that lower price is called **marginal cost pricing**.
4. The **contribution margin** is the sum of variable and fixed costs in a health care organization.
5. Community rating is **focused on providing services to all members of a local community**; whereas group rating **breaks a community down into smaller parts or groups and determines the prices they pay based on the risk of needing services**.

Clue	Scrambled Term
Analyzing volume needed to cover costs	**Break even**
A cost incurred in providing a service	**Direct cost**
Lower prices in exchange for increased volume	**Margin cost pricing**

Course 4: Strategic Financial Issues

1. Planning and budgeting are closely related. Planning is **setting a direction** while budgeting is **an expression of its strategic plan in numeric terms. The budget defines the organization's plans for earning revenues and using resources over a given time period**.
2. A mission statement is intended to **state the purpose of the business in terms of delivering a service or selling a product,** while the vision statement is intended to **concisely express the organization's aspirations**.
3. A broad plan to guide the organization toward fulfillment of its mission is called a **strategic plan.**

Term	Statement
Operating Budget	This provides a benchmark for the normal, day-to-day activities of the business.
Cost center	Support areas that usually do not generate revenues and tend to incur indirect costs.
Expense budget	This results from developing estimates of expenses by knowing operational relationships.
Revenue Budget	Once an understanding of service volumes is established, managers then apply expected collection rates or premium rates to estimated volume.

Term	Definition
Capital budget	**Determining capital investments is an important next step in the budgeting and planning process, since capital investments can be a significant use of scarce resources for a healthcare business. These decisions are detailed in a capital budget.**

Margin capital	**Capital investments to replace existing capabilities or maintain service levels are examples of maintenance capital**
Strategic capital	**Investments made to expand capacity, capabilities, or enter new service lines are termed strategic capital.**
Net Present Value Period	**Net present value analysis estimates the total cash taken in by a healthcare business over the future useful life of the item (net of the item cost and cost to operate the item) and expresses it in today's dollars.**

Sample Physician Office and Hospital Operating Budget

	Physician Office	**Hospital**
Statistical Budget	*Office visits*	*Patient Discharges*
Insurer #1	10,000	25,000
Insurer #2	5,000	25,000
Total	**15,000**	**50,000**
Revenue Budget (per unit)		
Insurer #1	$100.00	$7,000.00
Insurer #2	125.00	5,000.00
Expense Budget		
Variable costs		
Direct labor/unit	$70.00	$3,500.00
Supplies/unit	10.00	1,000.00
Fixed costs		
Fixed labor	$250,000	25,000,000
Overhead	145,000	45,000,000
Income Statement Forecast		
Revenues		
Insurer #1	**$1,000,000**	$175,000,000

Insurer #2	625,000	**$125,000,000**
Total revenue	$1,625,000	$300,000,000
Expenses		
Variable costs	$1,200,000	$225,000,000
Fixed costs	375,000	70,000,000
Total expense	**$1,575,000**	**$295,000,000**
Forecasted margin	*$30,000*	*$5,000,000*

Sample Health Plan Operating Budget

Statistical Budget	*Member Months*
Medicare Advantage	120,000
Commercial Line #1	120,000
Commercial Line #2	60,000
Total	**$300,000**
Revenue Budget (per unit)	
Medicare Advantage	$450.00
Commercial Line #1	200.00
Commercial Line #2	250.00
Investment income	$1,250,000
Expense Budget	
Variable costs (per unit)	
Medicare Advantage claims	$373.50
Commercial Line #1 Claims	160.00
Commercial Line #2 Claims	212.50
Behavioral health carve-out (all members)	10.00
Fixed Costs	
Fixed labor	$7,000,000
Overhead	4,500,000
Income Statement Forecast	
Revenues	
Medicare Advantage	**$54,000,000**
Insurer #1	**24,000,000**
Insurer #2	**15,000,000**
Total premium revenue	**$93,000,000**
Investment income	**1,250,000**

Total revenue	**$94,250,000**
Expenses	
Medical claims costs	$79,770,000
Fixed costs	11,500,000
Total expense	**$91,270,000**
Forecasted margin	**$2,980,000**

Sample Hospital Cash Budget

Sources of cash:	
Drawdown of cash	
Income from operations	+3,000,000
Depreciation & amortization	+4,000,000
Non-operating income	+1,000,000
Gift from hospital foundation	+3,000,000
Sale of old equipment	+400,000
Total sources of cash	***11,400,000***
Less: Uses of cash	
Construction of new Emergency Room	-13,000,000
New diagnostic equipment	-2,000,000
Current payments on debt	-1,500,000
Total uses of cash	***$16,500,000***
Cash needed	***$5,100,000***

Sample Budget Variance Analysis Physician Clinic

	Simple Budget	**Actual Result**	**Variance Amount**
Statistical Budget	*Office visits*		
Insurer #1	10,000	9,500	**-500**
Insurer #2	5,000	6,000	**1,000**
Total	15,000	15,500	**500**
Revenue Budget (per unit)			
Insurer #1	$100.00	**105**	$5
Insurer #2	125.00	$123.00	(2)
Expense Budget			
Direct labor/unit	$70.00	$71.00	**($1)**
Supplies/unit	10.00	10.50	**($.50)**
Fixed labor	$250,000	270,000	**($20,000)**

Overhead	145,000	150,000	**($5,000)**
Income Statement Forecast			
Revenues			
Insurer #1	$1,000,000	$997,500	**($2,500)**
Insurer #2	625,000	738,000	**$113,000**
Total revenue	$1,625,000	$1,683,000	$110,500
Expenses			
Variable costs	$1,200,000	$1,263,250	($63,250)
Fixed costs	395,000	420,000	(25,000)
Total expense	$1,595,000	$1,683,250	($88,250)
Forecasted margin	*$30,000*	*$52,250*	*$22,250*

Flexible Budget Variance Analysis for Physician Clinic

	Flexible Budget	**Actual Result**	**Variance Amount**
Statistical Budget	*Office visits*		
Insurer #1	9,500	9,000	**-500**
Insurer #2	6,000	7,000	**1,000**
Total	15,500	16,000	**500**
Revenue Budget (per unit)			
Insurer #1	**100.00**	105.00	$5.00
Insurer #2	125.00	**123.00**	(2.00)
Expense Budget			
Direct labor/unit	$70.00	**$71.00**	($1.00)
Supplies/unit	10.00	**$10.50**	(0.50)
Fixed labor	$250,000	**$270,000**	(20,000)
Overhead	145,000	**$150,000**	(5,000)
Income Statement Forecast			
Revenues			
Insurer #1	$950,000	$997,500	$47,500
Insurer #2	750,000	738,000	(12,000)
Total revenue	**$1,700,000**	**$1,735,500**	**$35,500**
Expenses			
Variable costs	$1,240,000	$1,263,250	($23,250)

Fixed costs	395,000	420,000	(25,000)
Total expense	**$1,635,000**	**$1,683,250**	**($48,250)**
Forecasted margin	*$65,000*	*$52,250*	*($12,750)*

Term	Definition
Working capital	The difference between current assets (cash, receivables, and inventory) and current liabilities (salaries payable and accounts payable).
Inventory	Supplies on-hand.
Accounts payable	A large number of money owed to suppliers and vendors or claims awaiting adjudication.
Line of credit	The ability of an organization to draw funds as needed to meet immediate cash needs.
Operating or capital lease	A long-term rental of facilities or equipment.
Bond issues	A loan that is offered not only to a bank but to private individuals, all collectively acting as a lender to the business.

Course 5: Managing Financial Resources

1. What does the chart present?

There are two broad categories of payment for healthcare services - fee-for-service and capitation. Each category may have different methods of structuring the payment to the provider. Each variation in the way a provider is reimbursed creates different business incentives and risks for both providers and health plans.

2. Distinguish between *cost-based* and *charge-based* reimbursement.

Cost-based reimbursement calls for the insurer to pay the hospital based on the costs of providing services, with a nominal allowance for margin. Charge based reimbursement is when the amount paid is a flat rate per discharge and is adjusted based on the relative severity of the patient's condition and resources used to treat the condition as determined by the DRG for that condition.

3. Define capitation. What is the financial objective of capitation?

Capitation is the exact opposite of fee-for-service payment. Capitations pays a fixed amount per person per month to a provider in advance as payment for all services necessary to the patient.

4. What are DRG, APC and RBRVS? How are they used?

DRG = Diagnostic Related Groups

APC = Ambulatory Payment Classifications

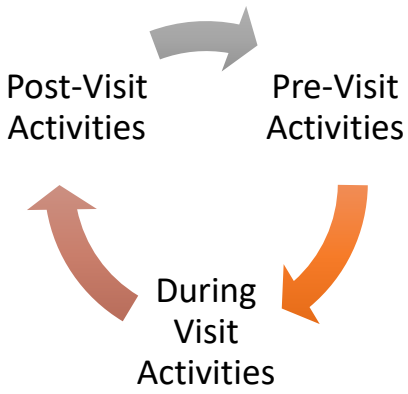
RBRVS = The Resource-Based Relative Value Scale

These are classification systems for medical services that are used in current payment systems to determine reimbursement.

Term	Definition
Case rate	**The number of cases of a particular infection or exposure during a unit of time, divided by the population during that period; CRs are often expressed in terms of a population of 100,000**

Per diem	**The hospital practice of charging daily rates, where the expenses incurred daily are averaged over the entire hospital census**
Bundled payment	**Bundled payment (also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, global bundled payment, global payment, package pricing or packaged pricing) is defined as the reimbursement of healthcare providers (such as hospitals and physicians) on the basis of expected costs for clinically-defined episodes of care. It has been described as a middle ground between fee-for-service reimbursement (in which providers are paid for each service rendered to a patient) and capitation (in which providers are paid a lump sum per patient regardless of how many services the patient receives), given that risk is shared between payer and provider.**

The Revenue Cycle



This diagram outlines the three phases of a patient-centric revenue cycle. Financial operations occur in pre, point of and post service.

Stage	Activities	Definition	Significance
Pre-visit	Patient scheduling	**Establishing treatment schedule.**	**Initial contact with patient and first data capture.**

	Eligibility verification	**Verifying that the patient has insurance and is covered for the planned treatments.**	**Insurance-health plans may require preauthorization before treatment. Failure to verify may result in non-payment.**
	Registration	**The process of obtaining all necessary information to treat and bill the patient.**	**Inaccurate data capture can lead to non-payment and denied claims.**
	Point of service collection	**Obtaining all out-of-pocket up-front patient payments such as deductibles.**	**This activity is a chance to educate patients regarding financial responsibilities and ascertain financial difficulty for the patient.**

Stage	Activities	Definition	Significance
Patient visit	Treatment	**Medical care**	**Revenue generation.**
	Utilization review	**Working Capital**	**Determine where dollars are used and what is left.**
	Charge capture	**Proper recording of all services provided to a patient**	**Essential to receiving proper reimbursement.**
	Discharge	**Releasing the patient from**	**Proper follow-up care needs to be arranged. All**

		inpatient treatment.	**financial activity conducted at the point-of-service must be completed.**
	Medical record completion	**Medical record is completed to initiate billing**	**The medical record needs to be completed in a timely and accurate manner so that billing may occur.**

Stage	Activities	Definition	Significance
Post-visit	Medical record analysis and coding	**Review for thoroughness and documentation of medical necessity.**	**This is done to insure accurate and proper billing.**
	Billing	**Filling claims with the patient's health plan.**	**This is the initial step in collecting payment.**
	Payment processing by health plan (claims adjudication) Claim logging Eligibility Adjudication Remittance	**The health plan "adjudicates" (review and process) the claim**	**The health plan is processing claims for payment.**
	Denial management	**The health plan may reject claim due to inaccuracies, incomplete information, lack of authorization, etc.**	**Providers denial management begins with data collection upfront. It is costly to rework and resubmit claims.**

	Payment posting and follow up	**Posting of reimbursement received to move the account towards a zero balance**	**Follow-up is important for prompt payment. An important goal is to prevent accounts from becoming aged receivables.**
	Account closure	**Account is closed out at zero balance (or moved into a more intense collection process)**	**Open balances prevent reimbursement and revenue from being obtained.**

Course 6: Looking to the Future

New Payment Approach	True	False Reason Why
Current payment methods do not encourage providers to work together to keep patients healthy.		**Reimbursement today is heavily dependent upon "clinical collaboration" across the continuum of care**

New Payment Approach	True	False Reason Why
An ACO is a network of physicians, hospitals, and patients organized together to share the financial responsibility for care provided.	**X**	
An ACO provides incentives for cooperation among providers to share data and avoid unnecessary tests or procedures.	**X**	
ACO must meet quality of care targets.	**X**	

	A	B	C	D	E	F	G	H	I	J	K
1	X	S	T	N	E	I	T	A	P	Y	X
2	E	H	R	W	S	M	E	R	A	F	U
3	Y	I	E	O	E	U	N	E	V	E	R
4	T	P	E	A	C	A	I	B	A	I	U
5	I	A	U	A	O	S	Y	H	L	A	P
6	L	A	S	Y	S	F	Q	S	U	N	A
7	A	H	A	S	T	R	A	T	E	G	Y
8	U	U	Q	H	U	D	C	L	J	E	M
9	Q	W	R	A	T	I	O	D	S	O	E
10	K	S	A	T	E	S	I	T	A	E	N
11	C	O	L	A	B	E	R	A	T	E	T

- Electronic Health Care Record **EHR**
- A critical financial management function - **Cost** analysis
- The Patient Protection and Affordable Care Act **ACA**
- Changes in payment models are forcing health care entities to exam business **strategy**
- Accountable Care Organization **ACO**
- A financial decision-making tool **Ratio**
- **Value** Based Purchasing
- Health insurance portability, privacy and data security **HIPAA**
- Finance, physicians and payers strive to **collaborate**
- Healthcare stakeholders include providers, physicians, health plans and **patients**
- Cost and improved clinical outcomes are indicators of **quality**
- **False** Claims may be punished by a civil monetary penalty
- **Revenue** Cycle
- Fiscal capability requires strong **cash** flow

An ACO	Requires group of primary care physicians that serve in a lead role in managing the care of a patient.

	Creates incentives for clinical cooperation.
	~~**Pays providers on a negotiated case-rate basis.**~~
	May have to pay a penalty if cost and quality performance does not meet established targets.
	The ACO model of payment is currently in use by the Medicare program.
	~~**The health plan has full charge over the medical care decisions made by ACO providers.**~~
	Can have valuable cooperation with payers through referral of patients and assistance with the collection and analysis of cost and quality data.

1. When a health plan pays a single prospective rate to all providers involved in a patient's care, it is making a **bundled payment**.
2. The processing of data available in the organization being analyzed and converted into information usable by decision-makers is known as **Business Intelligence (or Business Analytics)**.
3. "*Quality in relation to the total payment for care*" is the definition of **value**.
4. **Population Health Management** entails a group of providers and a health plan collaborating to improve performance on measures of overall health (such as hypertension or diabetes or cancer screenings) for a specific group of patients.

HFMA Business of Health Care® Sample Assessment Questions

Please note that these are examples of the types of questions on the HFMA Business of Health Care ® final assessment and ***not*** a predictor of success. Course content is not covered within these sample questions. *This is not a practice CHFP exam. Correct answers start on Page 78.*

Sample Questions

1) Insurers, regulators, and suppliers are:
   a) Outside the scope of health care reform enacted in the PPACA
   b) Participants in the delivery of medical care that are not directly involved in treatment
   c) Being positioned as a set of checks and balances for cost management
   d) Challenged to be "patient-focused" in their operations

2) Purchasing health care is a process best described as:
   a) The purchaser always pays after the service is delivered
   b) The purchaser is totally unaware of prices and has no warranties
   c) The purchaser may pay a portion of the cost
   d) The purchaser is likely to contract with a third party to pay for services

3) The "revenue cycle" in health care is:
   a) The flow of money between the patient, the insurer and the health care services provider
   b) The sum of the internal processes that providers employ to receive payment
   c) The number of days between medical treatment and resolution of the patient's financial obligations
   d) A series of process benchmarks correlated to cash flows

4) Prior to passage of the Patient Protection and Affordable Care Act (ACA), insurance that was usually provided by an employer to the employee as an additional form of compensation, was known as:
   a) An employee entitlement
   b) An employee benefit
   c) An employer "opt –in" compensation choice
   d) An employer incentive

5) Insurers often require some out-of-pocket payment by the patient to:
   a) Serve as a down payment and guarantee of full reimbursement
   b) Have providers initiate service
   c) Incentive patients to use services only when necessary
   d) Trigger the contractual obligations of the insurer

6) Medicare is over seen by:
   a) Congress' Ways and Means Committee
   b) Health and Human Services, Department of Medicare Services
   c) State Medicare Offices
   d) The federal Center for Medicare and Medicaid Services (CMS)

7) A fiscal intermediary is:
   a) A provider sponsored financial counselor
   b) An organization acting on behalf of CMS to administer Medicare payments
   c) An organization acting on behalf of providers to resolve insurance claims
   d) Regional banks which hold federal funding for Medicare and Medicaid claims

8) Medicaid, the insurance program for the poor and medically needy, is operated:
   a) By the individual states
   b) As a joint program between the federal government and the states
   c) As regional collaborative between states
   d) As a joint program between the states and federally qualified insurers

9) Much of the reform legislated in the Patient Protection and Affordable Care Act was targeted at:
   a) Slowing consumption of health care services
   b) Shifting the health care industry to a "wellness" and prevention approach
   c) Reforming the insurance marketplace
   d) Increasing safety for patients

10) All of the following are key provisions of the PPACA **EXCEPT**:
   a) Medical Loss Ratio
   b) Insurance Exchanges
   c) Accountable Care Organizations
   d) Patient Safety Standards

Correct Answers

1) Insurers, regulators, and suppliers are:
   a) Outside the scope of health care reform enacted in the PPACA
   b) Participants in the delivery of medical care that are not directly involved in treatment
   c) Are being positioned as a set of checks and balances for cost management
   d) Are challenged to be "patient-focused" in their operations

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About HFMA

The Healthcare Financial Management Association (HFMA) equips its more than 56,000 members nationwide to navigate a complex healthcare landscape. Finance professionals in the full range of work settings, including hospitals, health systems, physician practices and health plans, trust HFMA to provide the guidance and tools to help them lead their organizations, and the industry, forward. HFMA is a not-for-profit, nonpartisan organization that advances healthcare by collaborating with other key stakeholders to address industry challenges and providing guidance, education, practical tools and solutions, and thought leadership. We lead the financial management of healthcare. HFMA website: www.hfma.org

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