

**Healthcare Financial Management Association**  
**Certification Course 2009-2010**

**Managed Care Specialty**  
**Course Overview**

*For examination period January 2009 through December 2010*

Updated by William J. DeMarco (CEO and Vice President, DeMarco and Associates), with assistance from members of the HFMA Board of Examiners Managed Care group.

## HFMA Certification Course 2009-2010

### Managed Care Specialty



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**Delivery Method:** Self Study    **Field of Study:** Specialized Knowledge and Application

**Program content:** Key areas related to the managed care environment including financial and medical management, operations, contracting and negotiating, regulation/accreditation, and Medicare and Medicaid, as well as forces driving state and federal health policy. Specific **learning objectives** are on the following pages.

**Program Level:** Intermediate. The *intended audience* is anyone who will be completing the corresponding Managed Care Specialty certification exam. This course can also serve as a reference for individuals working in related areas of the healthcare industry. The *estimated completion time* is time is about 14.0 hours, based on the actual average completion time of persons who completed this course. Actual completion times may vary based on current knowledge level, learning style, and other factors.

**Pre-requisites:** Working knowledge of the managed care industry    **Advance Preparation:** None

**Amount of CPE:** This course is eligible for *14.0 CPE* when the course activities are completed at the minimum required level, as stated in the course, and required documentation submitted within one year of purchasing the course and prior to the expiration date of the course materials (12/31/10). CPE will not be issued if the required documentation is submitted after 12/31/10.

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**Contact Information:** For questions or comments about this program, please contact the HFMA certification departments at 1-800-252-4362, ask for certification, or send an e-mail to [certification@hfma.org](mailto:certification@hfma.org)

## HFMA Certification Course 2009-2010

### Managed Care Specialty

The topics in this course are as follows. The topic outline and learner objectives for each chapter are on the pages that follow.

|           |  |
|-----------|--|
|           | Introduction                                   |
| Chapter 1 | Overview of Managed Care                       |
| Chapter 2 | The Healthcare Delivery System                 |
| Chapter 3 | Financial Management                           |
| Chapter 4 | Managed Care Operations                        |
| Chapter 5 | Contracting and Negotiating                    |
| Chapter 6 | Medical Management                             |
| Chapter 7 | Regulation and Accreditation                   |
| Chapter 8 | Forces Driving State and Federal Health Policy |
| Chapter 9 | Medicare and Medicaid                          |

## Managed Care Specialty

### Chapter 1. Overview of Managed Care

- 1.0 Here's What You'll Learn
- 1.1 Introduction: Evolution of Managed Care
- 1.2 Managed Care Today
- 1.3 Public Policy and Market Performance Issues Facing Managed Care
- 1.4 Healthcare Industry in the United States Versus Other Countries
- 1.5 Self Assessment Exercise

#### Learner Objectives

- Identify key factors that influenced the development of managed care.
- Recognize the magnitude of today's healthcare costs and share of the Gross Domestic Product (GDP).
- Identify the forces influencing today's healthcare delivery system.
- Describe the major differences between the health delivery and financing of the United States, Canada, and the United Kingdom.

### Chapter 2. The Healthcare Delivery System

- 2.0 Here's What You'll Learn
- 2.1 Managed Care Models and the General Roles of Providers and Payers
- 2.2 Provider and Payer Financial Relationships
- 2.3 Tiered Networks and Pricing
- 2.4 Self Assessment Exercise

#### Learner Objectives

- Describe the various managed care models (HMO, PPO, POS, etc.).
- Explain the components of cost sharing (copays, coinsurance, and deductibles).
- Describe the characteristics of a high-deductible plan.
- Define the insurer Medical Cost Ratio (MCR) and reinsurance.
- Explain how an insurer uses quality reports and financial reports.
- Explain how an insurer uses provider screening and financial screening.
- Define the concept of tiered networks and pricing.

## Managed Care Specialty

### Chapter 3. Financial Management

3.0 Here's What You'll Learn

3.1 Introduction: Financial Management

3.2 Basic Reimbursement Methodologies–Hospital

3.3 Basic Reimbursement Methodologies–Professional

3.4 Challenges in Aligning Incentives: The Risk That FFS Reimbursement Can Potentially Work Against Managed Care

3.5 Risk Management and Funding Mechanisms

3.6 Self Assessment Exercise

#### Learner Objectives

- Explain the basic reimbursement methodologies for hospitals.
- Explain the basic reimbursement methodologies for physicians.
- Describe the inaccuracies in aligning incentives among providers.
- Identify the advantages and disadvantages of various provider reimbursement methodologies.
- Discuss how payers evaluate their risks.

### Chapter 4. Managed Care Operations

4.0 Here's What You'll Learn

4.1 Introduction

4.2 Provider Managed Care Operations

4.3 Payer Managed Care Operations

4.4 Claims Administration for the Provider and the Payer – A Daily Concern

4.5 Claims Adjudication

4.6 HIPAA Transaction Standards

4.7 Self Assessment Exercise

#### Learner Objectives

- Discuss the importance of EDI.
- Explain the role of providers six areas involved in the revenue cycle: the board, senior management, managed care, finance, billing, and registration.
- Discuss the importance of authorization.
- Explain how payer operation ensures appropriate volume of service and eligibility for claims administration.
- Describe the goal of denial management.
- Discuss claim adjudication and a clean claim.
- Discuss how HIPAA affected EDI.

## Managed Care Specialty

### Chapter 5. Contracting and Negotiating

- 5.0 Here's What You'll Learn
- 5.1 How to Evaluate a Contract–Provider/Payer
- 5.2 General Issues in Contracting–Provider/Payer
- 5.3 Common Contract Clauses and Key Contract Provisions
- 5.4 Direct Contracting
- 5.5 Third-Party Contracting
- 5.6 Silent PPOs and Nondirected PPOs
- 5.7 Self Assessment Exercise

#### Learner Objectives

- Describe how to evaluate a contract.
- Explain reimbursement methodologies.
- Discuss key contract terms, clauses, and criteria.
- Explain how cost is also a component of payer reimbursement.
- Describe various tools to measure contract performance.
- Explain contract negotiation tactics and strategies.
- Describe a silent Preferred Provider Organization (PPO).
- Provide the two distinct definitions for *carve-out*.
- Differentiate methodologies used for inpatient and outpatient contracting.
- Define *direct contracting*.

## Managed Care Specialty

### Chapter 6. Medical Management

- 6.0 Here's What You'll Learn
- 6.1 Introduction
- 6.2 Case (Care) Management and Clinical Integration Components
- 6.3 Utilization Management
- 6.4 Management of Patient Care
- 6.5 Demand Management
- 6.6 Self Assessment Exercise

#### Learner Objectives

- Identify the trends and direction of case management in today's healthcare delivery system.
- Identify the clinical integration components associated with case management.
- Differentiate prospective, concurrent, and retrospective utilization management.
- Describe the case management standards.
- Describe the importance disease management plays in lowering healthcare costs and improving the health of the patient.
- Explain the increasing role demand management programs serve in offsetting the cost of increasing healthcare premiums.

## Managed Care Specialty

### Chapter 7. Regulation and Accreditation

7.0 Here's What You'll Learn

7.1 Introduction

7.2 Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security

7.3 Emergency Medical Treatment and Active Labor Act (EMTALA)

7.4 Prompt Payment Regulations and Issues

7.5 National Practice Database

7.6 HMO Solvency

7.7 ERISA

7.8 Consolidated Omnibus Budget Reconciliation Act (COBRA)

7.9 Electronic Health Record (EHR)

7.10 Joint Commission

7.11 URAC

7.12 NCQA - Performance Measures and Benchmarking

7.13 Self Assessment Exercise

#### Learner Objectives

- Identify the major agencies that certify healthcare organizations.
- Describe the major provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Identify critical legislation that affects healthcare delivery and explain why that legislation was deemed necessary.

## Managed Care Specialty

### Chapter 8. Forces Driving State and Federal Health Policy

- 8.0 Here's What You'll Learn
- 8.1 Introduction
- 8.2 Employer Advocacy
- 8.3 Effect of Consumer Awareness
- 8.4 Pay-for-Performance Programs
- 8.5 Evidence Based Medicine
- 8.6 Hospitals Still Represent Highest Cost to MCO
- 8.7 Self Assessment Exercise

#### Learner Objectives

- Discuss the effect of increased consumer awareness.
- Describe the various Consumer-Driven Healthcare Plans (CDHPs).
- Identify the benefits and implications of CDHP to providers.
- Describe initiatives around pay-for-performance programs and report cards.

### Chapter 9. Medicare and Medicaid

- 9.0 Here's What You'll Learn
- 9.1 Brief History of Medicare
- 9.2 Recent Changes in the Law Affecting Medicare Managed Care Contracting and the Significance of Those Changes
- 9.3 Advanced Beneficiary Notice (ABN)
- 9.4 Rights and Responsibilities of Medicare Enrollees
- 9.5 Medicare Part D Pharmacy Benefit
- 9.6 Managed Medicaid Successes and Failures
- 9.7 Self Assessment Exercise

#### Learner Objectives

- Provide an overview of Medicare and its history.
- Discuss the relevant changes affecting Medicare managed care.
- Describe the key elements of Advanced Beneficiary Notice (ABN).
- Identify the rights and responsibilities of Medicare enrollees.
- Describe Medicare Part D.
- Describe the successes and failures of Medicare managed care.