HCD Healthcare Payment and Delivery Models Exam 2 Practice (Sample)

Study Guide

Everything you need from our exam experts!

Table of Contents

Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- **Practice answering questions under realistic conditions,**
- **Improve accuracy and speed,**
- **Review explanations to strengthen weak areas, and**
- **Approach the exam with greater confidence.**

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here’s how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don’t just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There’s no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

1. Which statement accurately describes Accountable Care Organizations (ACOs)?

- **A. Groups of providers who agree to take on responsibility for costs and quality of a large group of patients (5,000 up to 250,000)**
- **B. ACOs operate without any collaboration**
- **C. They rely solely on capitation**
- **D. They are hospital-only arrangements**

2. What are CATEGORY I CPT Codes?

- **A. Supplemental codes for performance measurement**
- **B. Temporary alphanumeric codes for new technology**
- **C. Procedure or Service: sub-categories based on procedure type and anatomy**
- **D. Immunization codes**

3. What describes the Resource-Based Relative Value Scale (RBRVS)?

- **A. A physician payment system based on resource costs of providing those services.**
- **B. A framework for hospital accreditation**
- **C. A method for patient scheduling**
- **D. A pricing model for CPT codes**

4. What are the categories of APMs?

- **A. Financial Incentives and Utilization**
- **B. Patient Experience and Access**
- **C. Drug Pricing and Formularies**
- **D. Quality Metrics and Risk**

5. What does it mean if payment is RISK ADJUSTED?

- **A. Payments lower for healthier populations**
- **B. Payments higher for populations with more complex conditions**
- **C. Payments are fixed**
- **D. No change in payments based on health status**

6. Which factor is NOT considered in DRG determination?

- **A. Admitting diagnosis**
- **B. Immunization status**
- **C. Severity of Condition**
- **D. Comorbidities**

7. What is Current Procedure Terminology (CPT) codes?

- **A. They are immunization codes**
- **B. They are diagnostic imaging codes for radiology**
- **C. They are historical codes no longer used**
- **D. They are standardized coding system for all medical services used to determine payment**

8. Which option best describes one-sided risk?

- **A. Provider is penalized if costs are more but not rewarded if costs are less**
- **B. Provider benefits if costs are less but NOT penalized if costs are more**
- **C. Provider benefits if costs are more**
- **D. No penalties and no rewards**

9. In what year was the ICD created?

- **A. 1980**
- **B. 1900**
- **C. 1950**
- **D. 1875**

10. Which CPT codes are used for Smoking Cessation?

- **A. 90837 and 90853**
- **B. 99406 and 99407**
- **C. 99605 and 99606**
- **D. 99490 and 99491**

Answers

1. A
2. C
3. A
4. D
5. B
6. B
7. D
8. B
9. B
10. B

Explanations

1. Which statement accurately describes Accountable Care Organizations (ACOs)?

A. Groups of providers who agree to take on responsibility for costs and quality of a large group of patients (5,000 up to 250,000)

B. ACOs operate without any collaboration

C. They rely solely on capitation

D. They are hospital-only arrangements

ACOs bring together different providers to take joint responsibility for both the costs and the quality of care for a defined patient population. The aim is to coordinate care across settings—primary care, specialists, hospitals, and other professionals—so that care is more efficient, outcomes improve, and unnecessary spending is reduced. Financial incentives are tied to meeting agreed-upon cost and quality targets, with potential shared savings if those targets are met. Payment models aren't limited to one method; while capitation can be used, many ACOs rely on blended arrangements that mix shared savings or performance-based payments with other risk-sharing approaches. They are not hospital-only and do involve collaboration across the care team.

2. What are CATEGORY I CPT Codes?

A. Supplemental codes for performance measurement

B. Temporary alphanumeric codes for new technology

C. Procedure or Service: sub-categories based on procedure type and anatomy

D. Immunization codes

Category I CPT codes are the standard five-digit codes used to report medical procedures and services. They are organized into subcategories based on the type of procedure and the anatomy involved, which helps coders and payers consistently describe what was done and for billing purposes. These codes are developed and maintained by the CPT Editorial Panel and form the primary language for reimbursement across Medicare, Medicaid, and private payers. They differ from Category II codes (used for performance measurement) and Category III codes (temporary codes for new or emerging technologies). While immunization administration codes exist within the CPT system, the essence of Category I codes is that they represent the broad set of procedures and services, not a narrow subset.

3. What describes the Resource-Based Relative Value Scale (RBRVS)?

A. A physician payment system based on resource costs of providing those services.

B. A framework for hospital accreditation

C. A method for patient scheduling

D. A pricing model for CPT codes

RBRVS is a physician payment system that ties payments to the resources required to provide services. Each CPT-coded service gets a relative value based on three components: physician work (time, effort, skill), practice expenses (overhead for the office and supplies), and malpractice insurance costs. These relative values are adjusted for geography and summed to form a total value, which is then multiplied by a conversion factor to determine the payment amount. This approach standardizes payments across different services and locations and is used by Medicare and many private payers. It isn't about hospital accreditation, nor about patient scheduling, and while CPT codes are the basis for valuation, the key idea is a resource-based framework for valuing and paying physician services.

4. What are the categories of APMs?

A. Financial Incentives and Utilization

B. Patient Experience and Access

C. Drug Pricing and Formularies

D. Quality Metrics and Risk

APMs are defined by tying how providers get paid to both the quality of care and the level of financial risk they share. This means payments are linked to measuring performance on specific quality metrics and to financial outcomes that reflect cost control and risk-bearing. That combination—quality metrics plus risk sharing—is what distinguishes APMs from traditional fee-for-service, which pays regardless of outcomes. While financial incentives, patient experience, access, and drug pricing can appear within APMs or related policies, the core idea that defines APMs is the integration of quality measurement with risk-based payment.

5. What does it mean if payment is RISK ADJUSTED?

A. Payments lower for healthier populations

B. Payments higher for populations with more complex conditions

C. Payments are fixed

D. No change in payments based on health status

Risk adjustment means adjusting payment amounts to reflect how costly it is to care for patients based on their health status and complexity. When a population has more complex conditions, the expected cost of care is higher, so the payment increases to cover those costs. This approach helps ensure providers aren't disincentivized to avoid sicker patients and supports fair access to care. So the option stating that payments are higher for populations with more complex conditions best captures what risk-adjusted payments mean. Fixed payments or no change with health status don't account for varying costs, and saying payments are lower for healthier populations ignores the need to align payments with higher-cost cases.

6. Which factor is NOT considered in DRG determination?

A. Admitting diagnosis

B. Immunization status

C. Severity of Condition

D. Comorbidities

DRGs group hospital stays by expected resource use, so the main drivers are the patient's clinical presentation and the therapies needed during the stay. The base DRG is anchored to the principal (admitting) diagnosis, and the level of severity plus any comorbidities or complications (often captured as CCs or MCCs) adjust the weight to reflect greater resource use. Immunization status, on the other hand, is preventive care and does not alter the medical complexity, procedures required, or the resources a particular inpatient stay will consume, so it does not influence DRG assignment. Therefore, immunization status is not considered in DRG determination, while admitting diagnosis, severity of condition, and comorbidities are.

7. What is Current Procedure Terminology (CPT) codes?

A. They are immunization codes

B. They are diagnostic imaging codes for radiology

C. They are historical codes no longer used

D. They are standardized coding system for all medical services used to determine payment

Current Procedure Terminology codes are a standardized coding system used to describe medical services and procedures for reimbursement. Maintained by the American Medical Association, CPT covers a broad range of services—from office visits and surgeries to imaging, laboratories, and anesthesia. Payers use CPT codes, in combination with diagnosis codes (ICD-10-CM), to determine payment amounts and processing. They are not limited to immunizations, not exclusive to diagnostic imaging, and they are not historical; CPT is actively updated each year to reflect new procedures and technologies. This is why the correct answer describes CPT as a standardized coding system for all medical services used to determine payment.

8. Which option best describes one-sided risk?

A. Provider is penalized if costs are more but not rewarded if costs are less

B. Provider benefits if costs are less but NOT penalized if costs are more

C. Provider benefits if costs are more

D. No penalties and no rewards

One-sided risk means you can gain a reward if performance is favorable, but there's no penalty if performance is unfavorable. In this context, the provider would benefit when costs are kept below the target, yet there is no penalty if costs go above the target. That setup creates upside potential without downside penalties, which is exactly what one-sided risk describes. The other descriptions either introduce penalties for higher costs, no incentives at all, or incentives tied to worse performance, none of which capture the idea of a reward with no downside in this arrangement.

9. In what year was the ICD created?

A. 1980

B. 1900

C. 1950

D. 1875

The date to remember is when the first edition of the ICD was published. It began as the Bertillon Classification of Causes of Death, created by French statistician Jacques Bertillon in the late 19th century, and the first edition appeared in 1900. This launched ICD as an international standard for coding causes of death and later diseases, with updates over the years by WHO. So, 1900 is the correct year. The other dates correspond to later editions or prior work, not the initial creation.

10. Which CPT codes are used for Smoking Cessation?

A. 90837 and 90853

B. 99406 and 99407

C. 99605 and 99606

D. 99490 and 99491

CPT codes for smoking cessation are the ones created specifically for counseling a patient who uses tobacco to quit. They are time-based and designate that the visit is focused on tobacco-use counseling. The first code covers a counseling session up to 10 minutes, and the second code covers an intensive session longer than 10 minutes (often up to 30 minutes). This framing ensures the service is billed as dedicated tobacco cessation counseling, including discussions about risks, benefits, and plans for quitting, possibly including pharmacotherapy and follow-up. Other codes shown don't fit because they describe different services: psychotherapy codes are for mental health treatment, not tobacco-use cessation counseling; the remaining options are for different care services (such as other types of patient visits or chronic care management) and not the targeted tobacco-use counseling codes.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://hcdhealthcarepaymentdeliverymodels2.examzify.com

We wish you the very best on your exam journey. You've got this!