HCD HEALTHCARE PAYMENT AND DELIVERY MODELS EXAM 2 PRACTICE (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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 statements characterize the QUALITY METRICS category of APMs?

A. Reimbursements include quality metrics that vary widely

B. Providers choose what they are graded on

C. Both of the above

D. Neither of the above

2. Which entity is responsible for determining whether a hospital qualifies for IRF PPS payment under the 60% rule?

A. IRF Admissions Office

B. Centers for Medicare & Medicaid Services (CMS) via policy rules

C. Hospital finance committee

D. State health department

3. Which combination best indicates readiness for bundled payment implementation?

A. Fragmented IT systems, no standardized pathways, no data sharing

B. Poor post-acute care planning; ad hoc data sharing

C. Aligned IT systems, standardized pathways, data sharing with partners, and clear post-acute care arrangements

D. High physician turnover and limited data access

4. How do readmission penalties influence discharge planning and care transitions?

A. They incentivize shorter discharge times with less planning.

B. They incentivize better discharge planning, post-acute care arrangements, and patient education to reduce early readmissions.

C. They have no impact on planning.

D. They only affect the hospital's marketing.

5. Which statement best captures the core philosophy shift under Alternative Payment Models?

A. They ignore quality metrics

B. They maintain volume-based incentives

C. They shift from volume to VALUE and use quality metrics

D. They reduce the role of payers

6. Which element is included in DRG consideration?

A. Patient's immunization history

B. Admitting diagnosis

C. Insurance coverage type

D. Patient's family history

7. How does HRRP aim to reduce avoidable readmissions and what system changes support this?

A. By increasing penalties for all hospital readmissions regardless of timeframe.

B. By penalizing poor performance on 30-day readmissions and supporting better discharge planning, transitions, and post-discharge follow-up.

C. By mandating identical readmission rates across all hospitals.

D. By removing penalties for readmissions and focusing on admissions prevention.

8. Which statement best describes the relationship between quality and payments in hospital Value-Based Purchasing programs?

A. Payments are unrelated to quality.

B. Payments are reduced for better performance.

C. Payments are linked to performance on targeted quality and efficiency measures.

D. Payments are only volume-based.

9. In value-based care, telemedicine can be included in what aspects?

A. Not reimbursed.

B. Replaces all in-person care.

C. Quality measures and reimbursement.

D. Only in research.

10. What is the purpose of the MACRA Quality Payment categories (Quality, Cost, Improvement Activities, Advancing Care Information) in clinician payment?

A. To determine overall pay adjustments based on performance in each category.

B. To determine staffing levels for clinics.

C. To set hospital admission rates.

D. To allocate capital expenditures.

Answers

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

Explanations

1. Which statements characterize the QUALITY METRICS category of APMs?

A. Reimbursements include quality metrics that vary widely

B. Providers choose what they are graded on

C. Both of the above

D. Neither of the above

Quality metrics in APMs are all about tying payments to performance on care quality. Reimbursements in these models are driven by how well providers perform on quality measures, and the specific metrics used can differ across different APMs, leading to wide variation in what counts for payment. In many quality-focused arrangements, providers also have some ability to influence or choose which measures they are graded on, giving them flexibility to align evaluation with their care priorities. Because of these two aspects—payments tied to quality performance and variability in metrics (with some provider choice)—both statements describe this category accurately.

2. Which entity is responsible for determining whether a hospital qualifies for IRF PPS payment under the 60% rule?

A. IRF Admissions Office

B. Centers for Medicare & Medicaid Services (CMS) via policy rules

C. Hospital finance committee

D. State health department

The main idea here is that Medicare's policy determines whether an IRF uses the PPS payment method under the 60% rule. CMS sets the rule, defines which diagnoses count toward the 60% threshold, and decides how the threshold is measured and applied across facilities. Hospitals collect patient data and apply those criteria, but the authority to determine PPS eligibility rests with CMS through its policy rules. If a facility doesn't meet the 60% requirement, it doesn't qualify for IRF PPS payments for those admissions. The other roles described—admissions intake, internal budgeting, or state licensure—don't decide Medicare payment eligibility; CMS does.

3. Which combination best indicates readiness for bundled payment implementation?

A. Fragmented IT systems, no standardized pathways, no data sharing

B. Poor post-acute care planning; ad hoc data sharing

C. Aligned IT systems, standardized pathways, data sharing with partners, and clear post-acute care arrangements

D. High physician turnover and limited data access

Bundled payment readiness requires cross-setting coordination, data visibility, and clearly defined care pathways so costs and quality can be managed across the entire episode. The best option shows all of these pieces: aligned IT systems that can share data, standardized care pathways to reduce variation, data sharing with partner organizations to track performance, and clearly defined post-acute care arrangements to manage transitions and downstream costs. When IT is fragmented, pathways aren't standardized, and data isn't shared, it's impossible to monitor episode performance or hold partners accountable. Similarly, poor post-acute planning and ad hoc data sharing leave costs and outcomes unpredictable, while high clinician turnover and limited data access undermine continuity, trust, and the ability to drive improvements.

4. How do readmission penalties influence discharge planning and care transitions?

A. They incentivize shorter discharge times with less planning.

B. They incentivize better discharge planning, post-acute care arrangements, and patient education to reduce early readmissions.

C. They have no impact on planning.

D. They only affect the hospital's marketing.

Readmission penalties create a financial incentive for hospitals to invest in how patients are discharged and how care is coordinated after they leave. When penalties loom for avoidable 30 day readmissions, hospitals focus on strengthening discharge planning, arranging appropriate post acute care (such as home health, skilled nursing facilities, or rehab services), and educating patients and families about medications, follow up steps, and warning signs to watch for at home. They implement risk assessments to identify high risk patients and use standardized transition protocols, timely post discharge follow up appointments, and clear handoffs to primary care and outpatient providers. All of these elements work together to reduce early readmissions by ensuring patients understand their treatment plan, have necessary supports in place, and receive appropriate care as they transition from hospital to home or another setting. The other options don't fit because rushing discharge with less planning undermines safety, there is indeed an impact on planning, and the penalties are not about marketing but about patient outcomes and costs.

5. Which statement best captures the core philosophy shift under Alternative Payment Models?

A. They ignore quality metrics

B. They maintain volume-based incentives

C. They shift from volume to VALUE and use quality metrics

D. They reduce the role of payers

The key idea is to move from paying for the quantity of care to paying for the value of care. Alternative Payment Models aim to reward better health outcomes and lower costs, not simply more services. That's why using quality metrics to measure performance is central—they provide the standard by which value is judged and payments are adjusted accordingly (for example, through shared savings, bundled payments, or risk-based arrangements). This shift encourages providers to coordinate care, avoid unnecessary tests, and focus on what actually improves patient health. The other statements don't fit because ignoring quality metrics would undermine the value-based approach, and sticking with volume-based incentives keeps the old, less effective model. The idea isn't to reduce the role of payers; APMs involve payers actively shaping metrics and incentives to drive value.

6. Which element is included in DRG consideration?

A. Patient's immunization history

B. Admitting diagnosis

C. Insurance coverage type

D. Patient's family history

DRG consideration centers on categorizing hospital stays by expected resource use, driven mainly by the principal (admitting) diagnosis. This diagnosis identifies why the patient was admitted and maps to a DRG with a specific payment level. Items like immunization history, insurance coverage type, or family history do not influence DRG assignment; they relate to care planning, payer eligibility, or risk assessment but not the DRG grouping. Other factors that can influence DRG include additional diagnoses, procedures performed, patient age and sex, and discharge status, but the admitting diagnosis remains the key driver.

7. How does HRRP aim to reduce avoidable readmissions and what system changes support this?

A. By increasing penalties for all hospital readmissions regardless of timeframe.

B. By penalizing poor performance on 30-day readmissions and supporting better discharge planning, transitions, and post-discharge follow-up.

C. By mandating identical readmission rates across all hospitals.

D. By removing penalties for readmissions and focusing on admissions prevention.

Reducing avoidable readmissions is pursued by tying Medicare payments to how well a hospital limits 30-day readmissions and by backing those efforts with system changes that support safer transitions from hospital to home. The program imposes penalties when 30-day readmission rates are worse than expected for certain conditions, with risk adjustment to avoid unfairly penalizing hospitals that treat sicker patients. This creates a clear financial incentive to invest in processes that prevent unnecessary returns. To support these improvements, hospitals implement stronger discharge planning, clear and thorough discharge instructions, and careful medication reconciliation. They also focus on seamless transitions of care and timely post-discharge follow-up, often scheduling a visit or outreach within a week after discharge. System changes include enhanced care coordination, involvement of care managers or transitions teams, closer communication with primary care and post-acute providers, and use of data and analytics to identify high-risk patients and track improvement. This combination—penalizing poor 30-day performance while funding and guiding better discharge and post-discharge care—drives the targeted reductions in avoidable readmissions.

8. Which statement best describes the relationship between quality and payments in hospital Value-Based Purchasing programs?

A. Payments are unrelated to quality.

B. Payments are reduced for better performance.

C. Payments are linked to performance on targeted quality and efficiency measures.

D. Payments are only volume-based.

In hospital Value-Based Purchasing, what you get paid is tied to how well you perform on predefined quality and efficiency targets. Medicare and other payers adjust payments based on a composite score that reflects performance across domains like clinical quality, patient safety, care coordination, patient experience, and cost efficiency. Hospitals that meet or exceed these targets can earn higher payments or bonuses, while those with lower performance may face reduced payments. This pay-for-performance approach contrasts with strategies that reward volume or ignore quality, making the correct description that payments are linked to performance on targeted quality and efficiency measures.

9. In value-based care, telemedicine can be included in what aspects?

A. Not reimbursed.

B. Replaces all in-person care.

C. Quality measures and reimbursement.

D. Only in research.

In value-based care, telemedicine is integrated to support both how we measure performance and how care is paid for. It enables ongoing management of chronic conditions, timely follow-ups, remote monitoring, and better care coordination, all of which generate data for quality measures such as access, responsiveness, patient engagement, and clinical outcomes. When these activities align with value-based payment models—shared savings, bundled payments, or other reimbursement arrangements—telemedicine visits can be reimbursed and counted toward achieving performance targets. This is why the option describing quality measures and reimbursement is the best fit. Telemedicine is not inherently not reimbursed, does not replace all in-person care, and is not restricted to research; it serves real-world clinical delivery and payment in value-based care.

10. What is the purpose of the MACRA Quality Payment categories (Quality, Cost, Improvement Activities, Advancing Care Information) in clinician payment?

A. To determine overall pay adjustments based on performance in each category.

B. To determine staffing levels for clinics.

C. To set hospital admission rates.

D. To allocate capital expenditures.

The idea behind MACRA's Quality Payment Program is to tie clinician pay to performance across four areas: Quality, Cost, Improvement Activities, and Advancing Care Information. How a clinician does in these areas feeds into a total score that determines the payment adjustment applied to Medicare Part B reimbursements in that year. A higher overall performance can lead to a positive adjustment, while lower performance can result in a negative adjustment. It's about rewarding value and improvement in care, efficiency, and the use of meaningful health IT. It isn't about staffing levels, hospital admission rates, or capital expenditures, which are unrelated to how Medicare adjusts payments under this program.

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!