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. Identify common challenges in implementing bundled payment models.

A. Defining episode boundaries for marketing campaigns.

B. Inaccurate cost data is accepted.

C. Lack of provider alignment is not a concern.

D. Defining episode boundaries, aggregating costs across settings, data sharing, ensuring provider alignment, and patient selection.

2. Identify the four MIPS performance categories used under MACRA.

A. Quality, Cost, Improvement Activities, and Promoting Interoperability.

B. Quality, Technology, Compliance, Interoperability.

C. Safety, Equity, Experience, Cost.

D. Quality, Access, Efficiency, Outcome.

3. Which condition must be met to qualify for post-acute reimbursement in SNFs?

A. Admission to SNF within 7 days of hospital discharge regardless of therapy

B. 3 night hospital stay, certified need for physical or occupational therapy within 30 days

C. Must have Medicare Part B coverage

D. 1 night hospital stay with any therapy

4. What is the '60% rule' in the Inpatient Rehabilitation Facility (IRF) PPS?

A. At least 60% of IRF patients must have specified conditions for the IRF PPS classification.

B. IRF PPS classification is based on the length of stay alone.

C. IRF must maintain a patient-to-staff ratio of 60%.

D. At least 60% of IRF patients must have specified conditions for the IRF PPS classification.

5. In risk-adjusted payment models, which practices help mitigate selection bias?

A. Risk adjustment alone.

B. Quality benchmarking alone.

C. Risk adjustment, quality benchmarking, and credible measurement.

D. None of the above.

6. What is the difference between DRG weight and the DRG base rate?

A. The DRG weight is a fixed number; base rate changes with patient age.

B. DRG weight reflects relative resource use to determine payment amounts, while the base rate is the dollar amount multiplied by the weight.

C. DRG weight is the dollar amount; base rate reflects resources.

D. DRG weight is irrelevant to payment; only base rate matters.

7. Promoting Interoperability in MIPS is primarily about which aspect?

A. It measures hospital cafeteria menu quality.

B. It scores ambulance response times.

C. It tracks physician license renewal.

D. Promoting Interoperability is the MIPS category assessing EHR use and data exchange; higher performance supports better Medicare payments.

8. What is the hallmark of Fee For Service reimbursement?

A. Payment for each good or service provided

B. Payment adjusted based on quality of care

C. Fixed monthly payment per patient

D. Payment based on patient satisfaction scores

9. Which payer funds nursing home post-acute care primarily?

A. Medicare

B. Medicaid

C. Private insurance

D. Out-of-pocket

10. IDNs GOALS include focusing on what?

A. Deliver value-based care, quality, safety, outcomes while reducing costs

B. Increase fragmentation and costs

C. Expand only inpatient services

D. Fragment patient care

Answers

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

Explanations

1. Identify common challenges in implementing bundled payment models.

A. Defining episode boundaries for marketing campaigns.

B. Inaccurate cost data is accepted.

C. Lack of provider alignment is not a concern.

D. Defining episode boundaries, aggregating costs across settings, data sharing, ensuring provider alignment, and patient selection.

Bundled payment implementations hinge on coordinating what's included, how costs are measured across settings, and how the involved providers are aligned. The major challenges fall into five interconnected areas: defining the episode boundaries—deciding which services and time frame are part of the bundle; aggregating costs across settings—patients move across hospitals, clinics, home health, and post-acute care, so you need a consistent way to pull together costs from multiple settings; data sharing—providers must exchange timely, accurate information to plan, monitor, and report performance; ensuring provider alignment—many clinicians and facilities must agree on shared goals, workflows, and how savings or risk are shared; and patient selection—ensuring the bundled population is appropriate and not incented to exclude higher-risk patients. The other options miss these core aspects: marketing-episode boundaries aren't about care episodes; assuming cost data will be accurate isn't realistic, but accurate data is essential; and assuming lack of provider alignment isn't a concern is simply false.

2. Identify the four MIPS performance categories used under MACRA.

A. Quality, Cost, Improvement Activities, and Promoting Interoperability.

B. Quality, Technology, Compliance, Interoperability.

C. Safety, Equity, Experience, Cost.

D. Quality, Access, Efficiency, Outcome.

MACRA's approach for rewarding clinicians centers on four performance categories that together capture quality, cost, improvement efforts, and health IT use. The four categories are Quality, Cost, Improvement Activities, and Promoting Interoperability. Quality measures gauge how well care aligns with evidence and best practices. Cost looks at the actual resources used to treat attributed patients. Improvement Activities reward steps a practice takes to enhance care delivery, coordination, and population health. Promoting Interoperability focuses on the use of certified EHR technology and the ability to exchange health information securely. These four areas combine into the MIPS composite score that determines Medicare payment adjustments. The other options mix terms that aren't official MIPS categories, so they don't reflect how MACRA organizes performance measurement.

3. Which condition must be met to qualify for post-acute reimbursement in SNFs?

A. Admission to SNF within 7 days of hospital discharge regardless of therapy

B. 3 night hospital stay, certified need for physical or occupational therapy within 30 days

C. Must have Medicare Part B coverage

D. 1 night hospital stay with any therapy

The key idea is eligibility for post-acute SNF reimbursement under Medicare. To qualify, a patient must have had an inpatient hospital stay of at least three consecutive days and then be admitted to a SNF within 30 days of hospital discharge, with a physician-certified need for skilled services (such as physical or occupational therapy). This combination—three prior hospital days plus a timely SNF admission with documented need for skilled therapy—is exactly what this option describes, making it the correct choice. The other options miss essential elements: a seven-day window is not correct, the requirement is within 30 days; a one-night stay is insufficient because it does not meet the three-day hospitalization criterion; and SNF coverage is tied to Medicare Part A, not Part B.

4. What is the '60% rule' in the Inpatient Rehabilitation Facility (IRF) PPS?

A. At least 60% of IRF patients must have specified conditions for the IRF PPS classification.

B. IRF PPS classification is based on the length of stay alone.

C. IRF must maintain a patient-to-staff ratio of 60%.

D. At least 60% of IRF patients must have specified conditions for the IRF PPS classification.

In this context, the 60% rule means that for a facility to be paid under the IRF PPS, at least 60% of its admitted patients must have one of a defined set of qualifying diagnoses, such as stroke, spinal cord injury, brain injury, congenital deformity, amputation, major trauma, burns, or other similar conditions. This threshold ensures reimbursement aligns with the specialized, intensive rehab services IRFs are designed to provide. If the patient mix doesn't meet the 60% requirement, those cases aren't paid under the IRF PPS, and different Medicare payment arrangements apply. The rule isn't about length of stay or staffing ratios.

5. In risk-adjusted payment models, which practices help mitigate selection bias?

A. Risk adjustment alone.

B. Quality benchmarking alone.

C. Risk adjustment, quality benchmarking, and credible measurement.

D. None of the above.

In risk-adjusted payment models, balancing incentives to treat all patients fairly with accurate performance signals is the goal. Risk adjustment addresses differences in patient health status and complexity, so providers aren't rewarded for avoiding high-risk patients or penalized for sicker populations. But adjusting for risk alone can fall short if the payment signals aren't benchmarked against external standards or if the data used to compute risk and outcomes aren't trustworthy. Quality benchmarking adds an external yardstick, helping to prevent narrow focus on a few metrics and encouraging consistent performance across patient groups. Yet benchmarks are only meaningful when the underlying data are solid. Credible measurement ensures data are accurate, complete, and verifiable, which supports reliable risk adjustment and trustworthy benchmarks. Put together, risk adjustment, quality benchmarking, and credible measurement create a robust framework that reduces selection bias and aligns payments with true value and outcomes.

6. What is the difference between DRG weight and the DRG base rate?

A. The DRG weight is a fixed number; base rate changes with patient age.

B. DRG weight reflects relative resource use to determine payment amounts, while the base rate is the dollar amount multiplied by the weight.

C. DRG weight is the dollar amount; base rate reflects resources.

D. DRG weight is irrelevant to payment; only base rate matters.

DRG weight is a relative measure of how much hospital resources a case in a given diagnosis-related group uses, compared with the average case. It reflects resource intensity, not a dollar amount. The DRG base rate is the fixed dollar amount assigned per DRG unit, effectively the price per unit of resource use. Payment is calculated by multiplying the base rate by the DRG weight (with possible adjustments for geography or other factors). For example, with a base rate of $5,000 and a DRG weight of 1.2, the payment would be $6,000 before adjustments. This shows how the weight indicates more or less resource use, while the base rate provides the price per unit of that resource use. The other options conflate dollars with resources or introduce age, which isn't how DRG payment is determined.

7. Promoting Interoperability in MIPS is primarily about which aspect?

A. It measures hospital cafeteria menu quality.

B. It scores ambulance response times.

C. It tracks physician license renewal.

D. Promoting Interoperability is the MIPS category assessing EHR use and data exchange; higher performance supports better Medicare payments.

Promoting Interoperability centers on how clinicians use certified EHR technology to share information and engage with patients. It's the MIPS category that measures EHR use, data exchange, and interoperability, with better performance leading to higher Medicare payments. This includes activities like electronic prescribing, exchanging clinical data with other providers, enabling patient access to their records, secure messaging, and reporting to public health programs. The other options focus on menu quality, ambulance response times, or license renewals, which aren't about interoperable EHR use or data exchange.

8. What is the hallmark of Fee For Service reimbursement?

A. Payment for each good or service provided

B. Payment adjusted based on quality of care

C. Fixed monthly payment per patient

D. Payment based on patient satisfaction scores

The defining idea is that providers are paid for each individual service delivered. In fee-for-service, every visit, test, procedure, or other service is billed separately, so revenue tends to rise with the volume of care provided. This contrasts with models where payment is a fixed amount per patient (capitation) or is adjusted based on quality or outcomes (value-based or pay-for-performance). So, the hallmark is payment for each service rendered, not a bundled or outcome-based approach.

9. Which payer funds nursing home post-acute care primarily?

A. Medicare

B. Medicaid

C. Private insurance

D. Out-of-pocket

When a patient moves to a nursing home for post-acute care, the main funding source for long-term or custodial nursing home needs is Medicaid, provided the individual is eligible. Medicare does cover short-term post-acute rehabilitation after a qualifying hospital stay, but this is limited to a finite number of days and mainly focuses on skilled services, with cost-sharing after a certain point. In contrast, Medicaid is designed to pay for long-term nursing home care for those who meet income and asset criteria, making it the predominant payer for ongoing nursing home stays. Private insurance can help in some cases, but most policies have caps and exclusions for custodial long-term care, and paying out-of-pocket for extended stays is usually not feasible.

10. IDNs GOALS include focusing on what?

A. Deliver value-based care, quality, safety, outcomes while reducing costs

B. Increase fragmentation and costs

C. Expand only inpatient services

D. Fragment patient care

Integrated Delivery Networks aim to coordinate care across the full patient journey so care is high quality, safe, and patient-centered, while also being cost-conscious. The emphasis is on value-based care: delivering better outcomes and safety, improving quality and patient experiences, and reducing unnecessary costs and waste. This comes from integrating providers across settings (hospitals, clinics, post-acute care, home health) and using data to drive improvements and align incentives with patient outcomes. That's why the best option highlights delivering value-based care, quality, safety, and outcomes while reducing costs. Options that talk about increasing fragmentation, expanding only inpatient services, or fragmenting patient care don't align with how IDNs operate. They reflect a focus on siloed, less-coordinated care or a narrow, inpatient-centric view, which runs counter to what IDNs are designed to achieve.

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!