HEALTHCARE FINANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. **In addition to reducing costs and improving access and quality care for the Medicare beneficiary, the PPACA will help to tighten up and reduce the overpayments to the insurance companies.**

   A. True

   B. False

   C. Partially true

   D. Not addressed

2. **PPO stands for which of the following?**

   A. Preferred Provider Organization

   B. Primary Provider Organization

   C. Preferred Public Organization

   D. Primary Public Organization

3. **A hospital with a higher Case Mix Index (CMI) will generally experience DRG reimbursements that are:**

   A. Decreased due to complexity

   B. Higher due to complexity

   C. Unchanged regardless of case mix

   D. Variable only with volume

4. **Which statement best defines days payable outstanding (DPO) and what it indicates for a healthcare organization?**

   A. DPO = average accounts payable divided by cost of goods sold per day; indicates how long the organization takes to pay suppliers and its liquidity management.

   B. DPO = average accounts payable divided by total revenue per day; indicates sales cycle efficiency.

   C. DPO = cost of goods sold per day divided by average accounts payable; indicates supplier leverage.

   D. DPO = average accounts receivable divided by average daily COGS; indicates cash conversion cycle.

5. How is break-even analysis useful for a healthcare facility considering a new service line?

A. It estimates the maximum profit possible.

B. It projects cash flows using discount rates.

C. It identifies the minimum volume or revenue required to cover all fixed and variable costs.

D. It helps determine the most profitable pricing strategy.

6. These groups manage care delivered by multiple providers and facilities; the _____ generally provides the full spectrum of care from physician services to skilled nursing facility services.

A. Integrated Delivery Systems

B. IPO

C. GPWW

D. None of these are correct.

7. _____ started by providing access to prescription drug discount cards for no more than $30.00 annually. Then, the program transitioned into providing subsidized access to prescription drug coverage.

A. Medicare Part A

B. Medicare Part B

C. Medicare Part C

D. Medicare Part D

8. How do cash collection rate and charge capture impact hospital revenue?

A. Charge capture quality affects patient satisfaction; collection rate measures hospital marketing reach.

B. Charge capture affects only coding accuracy; collection rate equals net revenue.

C. Charge capture quality affects gross charges; collection rate measures days in accounts receivable.

D. Charge capture quality affects billed charges; collection rate measures how much of billed charges are collected; both determine revenue realization.

9. _____ is where an organization provides a service to a customer, and this customer agrees to pay for the service after it is completed.

A. Accounts payable

B. Accounts receivable

C. Inventory

D. None of these are correct.

10. In revenue cycle management, which activity primarily addresses denied claims to pursue payment?

A. Denied claims and pursuing payment adjustments.

B. Patient eligibility and enrollment.

C. Coding accuracy.

D. Budgeting and forecasting.

Answers

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

Explanations

1. In addition to reducing costs and improving access and quality care for the Medicare beneficiary, the PPACA will help to tighten up and reduce the overpayments to the insurance companies.

A. True

B. False

C. Partially true

D. Not addressed

The main idea here is Medicare payment reform: the PPACA includes provisions that curb excessive payments to private insurers that administer Medicare Advantage. Historically, MA plans received higher per beneficiary payments than traditional Medicare costs due to their benchmark rules and risk-adjusted payments. The law tightens these overpayments by phasing in reductions, adjusting risk adjustment, and tying payments more closely to actual costs and plan quality. This part of the act aims to slow Medicare spending growth while maintaining beneficiary access and quality of care. So, the statement is true.

2. PPO stands for which of the following?

A. Preferred Provider Organization

B. Primary Provider Organization

C. Preferred Public Organization

D. Primary Public Organization

The main idea being tested is recognizing common health insurance plan abbreviations. PPO stands for Preferred Provider Organization. In this arrangement, the insurer contracts with a network of providers who agree to discounted rates. You typically pay less by using in-network providers, but you can also see out-of-network providers and still receive some coverage, though at higher out-of-pocket costs. Often you don't need a referral to see a specialist, which gives you more flexibility compared with some other plans. The other options aren't standard terms for insurance plans: the term about a primary provider is about the doctor who coordinates care rather than the plan itself, and the "public organization" phrases aren't used in this context.

3. A hospital with a higher Case Mix Index (CMI) will generally experience DRG reimbursements that are:

A. Decreased due to complexity

B. Higher due to complexity

C. Unchanged regardless of case mix

D. Variable only with volume

A higher Case Mix Index signals that the hospital is treating more complex, resource-intensive cases. In the DRG payment system, each discharge is assigned a DRG weight that reflects the expected cost of that case. Payments are calculated as a base rate multiplied by the DRG weight, with some adjustments. The hospital's CMI is the average of those DRG weights across all discharges. When CMI rises, the average DRG weight is higher, so the average payment per discharge increases. Therefore, DRG reimbursements tend to be higher with a higher CMI. Volume can affect total revenue, but the increase in reimbursements comes from the higher case weights associated with greater complexity, not from volume alone.

4. Which statement best defines days payable outstanding (DPO) and what it indicates for a healthcare organization?

A. DPO = average accounts payable divided by cost of goods sold per day; indicates how long the organization takes to pay suppliers and its liquidity management.

B. DPO = average accounts payable divided by total revenue per day; indicates sales cycle efficiency.

C. DPO = cost of goods sold per day divided by average accounts payable; indicates supplier leverage.

D. DPO = average accounts receivable divided by average daily COGS; indicates cash conversion cycle.

Days payable outstanding shows how long, on average, a healthcare organization takes to pay its suppliers. It's calculated by taking average accounts payable and dividing by the cost of goods sold on a daily basis (or equivalently 365 times average accounts payable divided by annual COGS). This metric reveals how the organization uses supplier credit to fund operations and manage liquidity—the longer the DPO, the more cash is retained inside the organization before paying bills, though it can affect supplier relations if payments are consistently delayed. So the best description is that DPO measures the time to pay suppliers and reflects liquidity management. The other formulations don't fit: using revenue per day targets sales activity rather than payables; reversing the ratio would not represent standard DPO; and using accounts receivable mixes in inflows rather than payables, which changes the metric entirely.

5. How is break-even analysis useful for a healthcare facility considering a new service line?

A. It estimates the maximum profit possible.

B. It projects cash flows using discount rates.

C. It identifies the minimum volume or revenue required to cover all fixed and variable costs.

D. It helps determine the most profitable pricing strategy.

The main idea is to find the point at which total revenues cover all costs, so the service line starts to contribute to profit. In healthcare terms, fixed costs include things you incur regardless of patient volume—facility space, equipment depreciation, salaried staff, and administrative overhead. Variable costs vary with each patient or visit—consumables, per-visit supplies, and direct labor tied to a patient encounter. Break-even analysis uses these to determine the minimum volume or revenue needed to cover every cost. The practical value is clear: it tells you whether pursuing a new service line is feasible given expected demand, pricing, and costs. By calculating the break-even volume, you set a target for patient visits or encounters and assess whether your payer mix, reimbursement levels, and capacity support going forward. It also helps you plan operations—staffing levels, scheduling, and equipment use—and it can guide pricing decisions or cost-reduction efforts. A simple way to think about it is: break-even volume = fixed costs divided by (price per service minus variable cost per service). For example, if fixed costs are $600,000 annually, the service is priced at $350 per visit, and variable costs are $180 per visit, the contribution margin per visit is $170. You'd need about 3,529 visits per year to break even (600,000 / 170). If expected demand is lower, you'd need to adjust strategy—perhaps increase volume targets, reduce fixed or variable costs, or adjust pricing. Keep in mind this analysis assumes costs and prices stay constant and doesn't account for the time value of money or non-financial factors; it's a planning tool that's most powerful when paired with sensitivity analyses across volume, price, and cost scenarios.

6. These groups manage care delivered by multiple providers and facilities; the _____ generally provides the full spectrum of care from physician services to skilled nursing facility services.

A. Integrated Delivery Systems

B. IPO

C. GPWW

D. None of these are correct.

Coordinated care across multiple providers and settings that covers the full spectrum—from physician services to skilled nursing facilities—is provided by Integrated Delivery Systems. IDSs align physicians, hospitals, and post-acute care under one organizational and financing approach, ensuring seamless care transitions and a complete continuum of services. An IPO is about raising capital, not delivering care; Group Practice Without Walls is a primary-care organizational model that doesn't inherently span the full post-acute continuum; and "none of these" isn't accurate because the integrated delivery model fits this description.

7. _____ started by providing access to prescription drug discount cards for no more than $30.00 annually. Then, the program transitioned into providing subsidized access to prescription drug coverage.

A. Medicare Part A

B. Medicare Part B

C. Medicare Part C

D. Medicare Part D

This item tests how prescription drug coverage evolved within Medicare. It began with a voluntary prescription drug discount card program—eligible beneficiaries could pay up to about $30 a year to receive discounts on medications. That approach was a stepping stone that led to a fuller, subsidized prescription drug benefit delivered under Part D, which provides actual coverage for prescription drugs and income-based subsidies to help low-income beneficiaries. It's distinct from Parts A and B, which cover hospital and medical services, and from Part C, Medicare Advantage, which bundles A and B (and sometimes D) through private plans. The scenario described aligns with Part D, the prescription drug benefit.

8. How do cash collection rate and charge capture impact hospital revenue?

A. Charge capture quality affects patient satisfaction; collection rate measures hospital marketing reach.

B. Charge capture affects only coding accuracy; collection rate equals net revenue.

C. Charge capture quality affects gross charges; collection rate measures days in accounts receivable.

D. Charge capture quality affects billed charges; collection rate measures how much of billed charges are collected; both determine revenue realization.

The key idea is that a hospital's revenue depends on both how accurately services are billed and how effectively those charges are collected. Charge capture quality determines billed charges: if a service isn't captured correctly, the billed amount underrepresents what was actually provided, lowering potential revenue because the claim may be denied or paid at a lower rate. On the other hand, the cash collection rate shows how much of those billed charges are actually paid. Even with perfect charge capture, poor collection means a large portion of billed charges never becomes cash, so revenue realization suffers. Together, these two aspects drive revenue realization: accurate charges reflect what was delivered, and a strong collection rate converts those charges into actual cash. If either is weak, revenue realization declines. The other options misstate the relationships. Charge capture isn't about patient satisfaction or marketing reach, and collection rate isn't simply net revenue. It isn't limited to coding accuracy either, and it isn't measured by days in accounts receivable.

9. ____ is where an organization provides a service to a customer, and this customer agrees to pay for the service after it is completed.

A. Accounts payable

B. Accounts receivable

C. Inventory

D. None of these are correct.

The main idea is accounts receivable. When a service is completed and the customer agrees to pay afterward, the organization has a right to future cash, which is recorded as an asset called accounts receivable. This reflects revenue earned but not yet collected. On the balance sheet it's listed as a current asset, and when the customer eventually pays, cash increases and accounts receivable decreases. This is different from accounts payable, which is what the organization owes to others, or inventory, which are goods held for sale or use. So recognizing the amount due from the customer after the service is performed is the essence of accounts receivable.

10. In revenue cycle management, which activity primarily addresses denied claims to pursue payment?

A. Denied claims and pursuing payment adjustments.

B. Patient eligibility and enrollment.

C. Coding accuracy.

D. Budgeting and forecasting.

Denial management is the focus here. When a claim is denied, the primary activity is to analyze the denial reason, correct any issues if possible (such as documentation, coding, or eligibility), and resubmit the claim or file an appeal to obtain the payment. This direct work on rejected claims drives actual cash collection and helps reduce accounts receivable days. Upstream steps like patient eligibility ensure coverage before service but don't address denials after the fact. Coding accuracy is about preventing denials by getting the coding right from the start, not the post-denial process itself. Budgeting and forecasting are about financial planning, not pursuing payments on denied claims.

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://healthcarefinance.examzify.com

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