

# Healthcare Finance Test 1 Practice (Sample)

## Study Guide



**Everything you need from our exam experts!**

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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

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- 1. There are several types of managed care organizations (MCOs). Regardless of type, all MCOs have an incentive to reduce utilization.**
  - A. Regardless of type, all MCOs have an incentive to reduce utilization.**
  - B. Some MCOs encourage higher utilization to boost revenue.**
  - C. MCOs never influence patient care decisions.**
  - D. All MCOs operate identically in every market.**
  
- 2. Most providers' primary legal concern is**
  - A. Patient privacy**
  - B. Professional liability**
  - C. Antitrust**
  - D. Employment law**
  
- 3. Which factor most directly reduces days in accounts receivable in a hospital setting?**
  - A. Speed of bill submission to payers.**
  - B. Number of beds.**
  - C. Average length of stay.**
  - D. Amount of charity care.**
  
- 4. What is payer contract leakage and why is it important to monitor?**
  - A. Leakage occurs when expected reimbursements are lower than contract terms due to underpayments, denials, or improper coding; monitoring reduces revenue loss.**
  - B. Leakage refers to excess cash on hand.**
  - C. Leakage is the difference between NPR and gross charges.**
  - D. Leakage is the amount of charity care.**

- 5. Which statement accurately describes bundled payments and shared savings arrangements for providers?**
- A. Bundled payments pay one price for a defined episode; shared savings reward efficiency; revenue recognition requires estimating expected payments; risk increases if actual costs exceed the bundle or savings are not achieved.**
  - B. Bundled payments are on a per-service basis; shared savings guarantee profit regardless of cost; revenue recognition is unaffected; risk is minimal.**
  - C. Bundled payments are the same as capitation; shared savings are paid monthly; revenue recognition is upfront; risk decreases.**
  - D. Bundled payments do not affect pricing; shared savings are independent of efficiency; risk is fixed.**
- 6. Which statement describes how ACOs handle performance targets?**
- A. ACOs can distribute bonuses when targets are met and impose penalties when targets are missed.**
  - B. ACOs have no mechanism to pay bonuses.**
  - C. ACOs always guarantee penalties regardless of performance.**
  - D. ACOs ignore quality and cost measures.**
- 7. Which strategy helps optimize the cash conversion cycle?**
- A. Extending customers' payment terms without consideration**
  - B. Shortening supplier payment terms without negotiation**
  - C. Holding more cash and reducing spending**
  - D. Faster collections, extended payables, and better inventory management**
- 8. Which statement about adverse selection and underwriting is incorrect?**
- A. Adverse selection occurs when higher-risk individuals seek insurance.**
  - B. Underwriting helps identify and price risk.**
  - C. Health insurers have unlimited power to set underwriting provisions.**
  - D. Premiums can reflect expected costs after underwriting.**

- 9. Which statement best describes the difference between accrual accounting and cash accounting in healthcare finance?**
- A. Accrual recognizes revenues and expenses when earned or incurred, regardless of cash; cash accounting recognizes cash when received or paid.**
  - B. Accrual recognizes cash when received; cash accounting recognizes revenue when earned.**
  - C. Accrual ignores expenses; cash accounting ignores revenue.**
  - D. Accrual records only assets; cash accounting records only liabilities.**
- 10. In physician payment, which statement best describes the role of relative value units (RVUs)?**
- A. RVUs quantify the relative resources used to deliver a service.**
  - B. RVUs determine the total payment amount without geographic adjustments.**
  - C. RVUs are used only for hospital billing, not physician payments.**
  - D. RVUs measure patient satisfaction.**

## Answers

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

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## **Explanations**

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**1. There are several types of managed care organizations (MCOs). Regardless of type, all MCOs have an incentive to reduce utilization.**

**A. Regardless of type, all MCOs have an incentive to reduce utilization.**

**B. Some MCOs encourage higher utilization to boost revenue.**

**C. MCOs never influence patient care decisions.**

**D. All MCOs operate identically in every market.**

The fundamental idea is cost containment through utilization management. In most MCO arrangements, payments are fixed per member or tied to risk-sharing rather than paid per service. This means every additional unit of care that isn't truly needed adds costs without guaranteed extra revenue, creating a built-in motive to curb unnecessary utilization. To achieve this, MCOs deploy tools like preauthorization, utilization reviews, care management, formulary controls, and carefully designed provider networks to steer care toward cost-effective, appropriate options while maintaining quality. That's why this statement fits best across different MCO types: the incentive to reduce utilization is a common thread, even though the exact mechanisms can vary by contract and market. The other options don't align with how MCO incentives typically work—in many models, encouraging higher utilization would raise costs without corresponding revenue; MCOs do influence patient care decisions through guidelines and approvals; and MCOs do not operate identically in every market due to differing contracts and networks.

**2. Most providers' primary legal concern is**

**A. Patient privacy**

**B. Professional liability**

**C. Antitrust**

**D. Employment law**

The main idea here is that the highest legal risk for healthcare providers comes from professional liability, which covers malpractice claims when care falls below the expected standard and harms a patient. Because medical treatment inherently carries risk and patients can be harmed even with good intentions, providers are routinely exposed to lawsuits, settlements, and defense costs. This drives a large portion of risk management, malpractice insurance, and credentialing practices across all settings. While protecting patient privacy is crucial and subject to strict rules (like HIPAA) and penalties, and antitrust or employment-law issues are important in their own right, they generally do not present the same broad, ongoing financial and operational threat to routine clinical practice as malpractice claims do.

**3. Which factor most directly reduces days in accounts receivable in a hospital setting?**

- A. Speed of bill submission to payers.**
- B. Number of beds.**
- C. Average length of stay.**
- D. Amount of charity care.**

Days in accounts receivable shows how long it takes to convert services into cash, from the time of service to when payment is received. The most direct way to shorten this window is to submit claims to payers as quickly as possible. Prompt billing starts the clock earlier, allowing payer processing and payment to begin sooner, which lowers the average days to collect. The other factors affect volume or payer behavior but don't directly speed up the billing and collection process. So, speeding up bill submission most directly reduces days in accounts receivable.

**4. What is payer contract leakage and why is it important to monitor?**

- A. Leakage occurs when expected reimbursements are lower than contract terms due to underpayments, denials, or improper coding; monitoring reduces revenue loss.**
- B. Leakage refers to excess cash on hand.**
- C. Leakage is the difference between NPR and gross charges.**
- D. Leakage is the amount of charity care.**

Payer contract leakage is the gap between what a payer contract promises in reimbursement and what is actually paid, typically caused by underpayments, denials, or improper coding. Monitoring this leakage matters because it shows how much revenue is slipping away before it even reaches the hospital's bottom line and points to concrete areas to fix. By regularly comparing expected payments (based on contracted rates and charge data) to actual payments across payers and services, you can target improvements: ensure coding and charge capture are accurate, manage and overturn denials efficiently, and push for rate integrity in contract negotiations. This concept is distinct from simply having extra cash on hand, the difference between NPR and gross charges, or charity care, which describe different financial situations.

5. Which statement accurately describes bundled payments and shared savings arrangements for providers?

- A. Bundled payments pay one price for a defined episode; shared savings reward efficiency; revenue recognition requires estimating expected payments; risk increases if actual costs exceed the bundle or savings are not achieved.**
- B. Bundled payments are on a per-service basis; shared savings guarantee profit regardless of cost; revenue recognition is unaffected; risk is minimal.**
- C. Bundled payments are the same as capitation; shared savings are paid monthly; revenue recognition is upfront; risk decreases.**
- D. Bundled payments do not affect pricing; shared savings are independent of efficiency; risk is fixed.**

Bundled payments set one price for an entire defined episode of care, rather than paying for each service separately. Shared savings arrangements give providers a portion of any savings when costs come in under a target and quality standards are met. Revenue recognition in these models requires estimating the expected payments because the final amount depends on performance outcomes, so the provider recognizes revenue as the performance obligations are satisfied and adjusts estimates as results become known. The risk to the provider increases if actual costs exceed the bundled amount or if the anticipated savings aren't realized, since upside is limited to the shared savings and downside can be material within the bundle. This matches how episode-based pricing and incentive-based payments actually work, unlike statements that imply per-service pricing, guaranteed profits, upfront recognition, or fixed risk.

6. Which statement describes how ACOs handle performance targets?

- A. ACOs can distribute bonuses when targets are met and impose penalties when targets are missed.**
- B. ACOs have no mechanism to pay bonuses.**
- C. ACOs always guarantee penalties regardless of performance.**
- D. ACOs ignore quality and cost measures.**

ACOs are designed to be held accountable for both cost and quality. When performance targets are met—costs stay below the benchmark and quality measures meet or exceed thresholds—the organization earns shared savings and can distribute bonuses to participating providers. If targets are missed, the arrangement can lead to penalties or shared losses, meaning money may have to be returned or shared in a way that reduces earnings. This structure creates upside incentives for efficient, high-quality care and downside risk if performance falls short. The other statements don't fit this approach, since bonuses are indeed possible, penalties aren't guaranteed in every track, and quality and cost measures are central to how ACOs are compensated.

7. Which strategy helps optimize the cash conversion cycle?
- A. Extending customers' payment terms without consideration
  - B. Shortening supplier payment terms without negotiation
  - C. Holding more cash and reducing spending
  - D. Faster collections, extended payables, and better inventory management**

The cash conversion cycle measures how long a company's cash is tied up in its core operations—from paying for inventory to collecting cash from sales. Optimizing it means speeding up cash inflows, slowing down cash outflows, and turning over inventory more quickly. Faster collections reduce the time customers take to pay, extended payables delay the cash outflow to suppliers, and better inventory management lowers the time inventory sits in stock. Together, these actions shorten the cycle and improve liquidity, which is why the strategy that combines quicker collections, longer payables, and more efficient inventory management is best. Extending customer terms without regard can push up the time to collect; shortening supplier terms without negotiation reduces the time you can delay payments; and simply holding more cash isn't addressing the cycle's four key flow measures.

8. Which statement about adverse selection and underwriting is incorrect?
- A. Adverse selection occurs when higher-risk individuals seek insurance.
  - B. Underwriting helps identify and price risk.
  - C. Health insurers have unlimited power to set underwriting provisions.**
  - D. Premiums can reflect expected costs after underwriting.

Adverse selection and underwriting hinge on information asymmetry: individuals know their own health risks, while insurers must rely on risk signals to price coverage. Higher-risk people are more inclined to buy insurance if they expect costly medical care, which is why adverse selection matters and underwriting is used to identify and price risk appropriately. The statement that health insurers have unlimited power to set underwriting provisions ignores real-world limits. In practice, underwriting is constrained by regulation, market dynamics, and policy design that often restricts how risks can be screened and priced. Systems with guaranteed issue or community rating, for example, limit how much pricing can diverge based on risk, helping to balance access and costs. Premiums can reflect expected costs after underwriting, which is precisely why underwriting is performed: to align pricing with anticipated health care costs.

**9. Which statement best describes the difference between accrual accounting and cash accounting in healthcare finance?**

- A. Accrual recognizes revenues and expenses when earned or incurred, regardless of cash; cash accounting recognizes cash when received or paid.**
- B. Accrual recognizes cash when received; cash accounting recognizes revenue when earned.**
- C. Accrual ignores expenses; cash accounting ignores revenue.**
- D. Accrual records only assets; cash accounting records only liabilities.**

The main idea being tested is when revenues and expenses are recognized. Accrual accounting records revenues when they are earned and expenses when they are incurred, regardless of when cash actually moves. This follows the matching principle and gives a fuller picture of performance and obligations. Cash accounting, on the other hand, records revenue when cash is received and expenses when cash is paid, which can misrepresent timing if there are outstanding receivables or payables. The statement that accrual records only assets and cash records only liabilities is not accurate. Accrual accounting involves recognizing all types of accounts—assets, liabilities, revenues, and expenses—based on when the economic event occurs, not when cash changes hands.

**10. In physician payment, which statement best describes the role of relative value units (RVUs)?**

- A. RVUs quantify the relative resources used to deliver a service.**
- B. RVUs determine the total payment amount without geographic adjustments.**
- C. RVUs are used only for hospital billing, not physician payments.**
- D. RVUs measure patient satisfaction.**

RVUs quantify the relative resources required to deliver a service. Each medical service has a work value (physician time, skill, and effort), a practice expense value (overhead and supplies), and a malpractice risk value. The total RVU combines these components to reflect how resource-intensive the service is compared with others. However, payment isn't the RVU itself—it's the total RVU multiplied by a conversion factor, with geographic adjustments (GPCI) applied to reflect location differences. This structure shows that RVUs measure resource use, while final reimbursement depends on both the conversion factor and geography. The other statements miss these points: geographic adjustments are part of the payment, RVUs apply to physician payments (not only hospital billing), and RVUs do not measure patient satisfaction.

## 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](mailto:hello@examzify.com).**

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

**<https://healthcarefinance1.examzify.com>**

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

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