

HFMA Business of Health Care Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

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. What dual challenge do healthcare providers face in light of competition?**
 - A. Lowering labor costs while enhancing services**
 - B. Maintaining competitive prices and high care quality**
 - C. Reducing operational hours and increasing patient coverage**
 - D. Enhancing technology use and decreasing staff size**
- 2. What is the focus of strategic planning in a healthcare organization?**
 - A. Setting financial benchmarks for immediate sales**
 - B. Creating specific short-term operational goals**
 - C. Establishing the overall operational framework and goals**
 - D. Analyzing past financial performance only**
- 3. Who is responsible for coding the medical records for billing purposes?**
 - A. A physician**
 - B. A trained coding professional**
 - C. A healthcare administrator**
 - D. A medical biller**
- 4. Which type of variance indicates revenues greater than budget?**
 - A. Neutral variance**
 - B. Favorable variance**
 - C. Unfavorable variance**
 - D. Negative variance**
- 5. Which factor can significantly affect the billed charges of a healthcare provider?**
 - A. Operational efficiency of the facility**
 - B. The average age of patients served**
 - C. The type of insurance held by patients**
 - D. An analysis of operating expenses and expected income**

- 6. What was a key provision of the Affordable Care Act regarding health insurance market reform?**
- A. Guaranteed issue and renewability of coverage for everyone**
 - B. Elimination of all healthcare subsidies**
 - C. Increased age rating variation to 5 to 1 ratio**
 - D. Mandatory exclusion for pre-existing conditions**
- 7. What are direct costs in a healthcare setting?**
- A. Costs that cannot be traced to a specific service**
 - B. Costs associated with administrative functions**
 - C. Costs that can be traced directly to a department or service**
 - D. Costs that relate to facility maintenance**
- 8. What form can healthcare reform take according to various views?**
- A. A national healthcare system funded and delivered by the government**
 - B. Only new tax incentives for insurers**
 - C. Restrictions on existing insurance providers**
 - D. Self-regulation by healthcare providers**
- 9. What characterizes variable costs in a health plan?**
- A. Costs that remain constant over time**
 - B. Costs that vary with changes in the volume of services**
 - C. Costs related to administrative overhead**
 - D. Costs incurred during long-term projects**
- 10. What is a primary characteristic of marginal cost pricing in competitive healthcare markets?**
- A. Prices are set above full costs to maximize profits**
 - B. Prices are set below full costs to attract customers**
 - C. Discounts are avoided for higher profit margins**
 - D. Fixed costs are eliminated from pricing decisions**

Answers

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

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Explanations

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1. What dual challenge do healthcare providers face in light of competition?

- A. Lowering labor costs while enhancing services**
- B. Maintaining competitive prices and high care quality**
- C. Reducing operational hours and increasing patient coverage**
- D. Enhancing technology use and decreasing staff size**

Healthcare providers face the dual challenge of maintaining competitive prices while ensuring high-quality care. In a competitive market, providers must manage costs effectively to offer prices that attract patients; however, doing so should not compromise the quality of care delivered. High care quality is essential as it influences patient satisfaction, health outcomes, and overall reputation in the market. As patients have more choices than ever, balancing affordability and quality is critical for healthcare providers to remain competitive and sustain their operations. The other options, while they involve various operational aspects, do not encapsulate the essence of the dual challenge as comprehensively as maintaining competitive pricing and high quality of care does. Factors like labor costs, operational hours, and technology use are significant but are subsets of the broader need to align pricing strategies with service excellence in a competitive healthcare landscape.

2. What is the focus of strategic planning in a healthcare organization?

- A. Setting financial benchmarks for immediate sales**
- B. Creating specific short-term operational goals**
- C. Establishing the overall operational framework and goals**
- D. Analyzing past financial performance only**

The focus of strategic planning in a healthcare organization is centered on establishing the overall operational framework and goals that will guide the organization's direction over the long term. This process encompasses a comprehensive assessment of the internal and external environments, allowing the organization to align its mission, vision, and resources with the changing healthcare landscape. By defining overarching goals, strategic planning ensures that all departments and stakeholders work in harmony towards common objectives. This long-range perspective is crucial in navigating challenges such as regulatory changes, population health trends, and technological advancements, thereby positioning the organization for sustained success and adaptability. In contrast, setting financial benchmarks for immediate sales emphasizes short-term financial targets, which may not align with the broader strategic vision. Creating specific short-term operational goals tends to focus on immediate tasks rather than the long-term trajectory of the organization. Similarly, analyzing past financial performance only provides historical insight but does not contribute directly to formulating future strategies necessary for growth and innovation.

3. Who is responsible for coding the medical records for billing purposes?

- A. A physician
- B. A trained coding professional**
- C. A healthcare administrator
- D. A medical biller

The responsibility for coding medical records for billing purposes lies primarily with trained coding professionals. These individuals have specialized training in various coding systems, such as ICD-10 for diagnoses and CPT for procedures, which are essential for translating the clinical information documented by healthcare providers into standardized codes. This coding is crucial not only for accurate billing but also for healthcare analytics, quality reporting, and compliance with regulations. Trained coding professionals ensure that all services rendered to patients are properly captured and coded correctly so that healthcare providers can be reimbursed for their services. They reconcile the clinical information with coding guidelines and payer requirements, reducing the likelihood of denied claims due to coding errors. In contrast, while physicians document the clinical encounters and may provide initial information regarding procedures and diagnoses, they typically do not engage in the detailed coding process. Healthcare administrators primarily oversee operations and strategies within healthcare organizations rather than focusing on the technical aspects of coding. Medical billers work closely with coding professionals, but their role is more about submitting claims and ensuring payment rather than the initial coding of medical records. Thus, the role of the trained coding professional is essential and specific to the process of coding for billing purposes.

4. Which type of variance indicates revenues greater than budget?

- A. Neutral variance
- B. Favorable variance**
- C. Unfavorable variance
- D. Negative variance

The type of variance that indicates revenues greater than what was budgeted is referred to as a favorable variance. This occurs when actual revenues exceed the planned budget, signaling that the financial performance of the organization is better than anticipated. Favorable variances are vital for organizations as they suggest increased income, which can contribute to improved financial health and can provide opportunities for further investments or growth. In contrast, neutral variance typically indicates that there is no significant difference between actual performance and budgeted expectations and does not necessarily indicate financial performance. Unfavorable variance, on the other hand, denotes situations where actual revenues fall short of budget, leading to potential concerns about financial performance. Negative variance is usually synonymous with unfavorable variance, indicating a decline in performance as well. Therefore, in the context of revenues being greater than budget, the concept of a favorable variance accurately captures the positive financial outcome.

5. Which factor can significantly affect the billed charges of a healthcare provider?

- A. Operational efficiency of the facility**
- B. The average age of patients served**
- C. The type of insurance held by patients**
- D. An analysis of operating expenses and expected income**

The correct choice demonstrates how the analysis of operating expenses and expected income can significantly impact the billed charges of a healthcare provider. Billed charges are often influenced by the financial considerations of the provider, including the need to cover costs and ensure profitability. By conducting a thorough analysis of operating expenses—such as staffing, equipment, overhead, and other operational costs—providers can determine how much they need to charge to maintain financial viability. This evaluation also takes into account expected income, which may be based on patient volume and payer mix. This understanding is essential for setting charges that not only reflect the costs incurred but also align with potential reimbursement rates from various payers. Therefore, being strategic about billed charges through such analyses allows healthcare providers to remain competitive while ensuring financial health. Factors such as operational efficiency, average patient age, and the type of insurance may influence overall financial performance or operational dynamics, but they do not directly dictate the necessary level of billed charges to sustain and grow the provider's financial position.

6. What was a key provision of the Affordable Care Act regarding health insurance market reform?

- A. Guaranteed issue and renewability of coverage for everyone**
- B. Elimination of all healthcare subsidies**
- C. Increased age rating variation to 5 to 1 ratio**
- D. Mandatory exclusion for pre-existing conditions**

The Affordable Care Act (ACA) introduced significant reforms aimed at improving access to health insurance and making it more equitable. One of its key provisions was the requirement for guaranteed issue and renewability of coverage, which ensures that health insurers cannot deny coverage based on a person's health status or pre-existing conditions. This means that everyone, regardless of their medical history, is entitled to obtain health insurance, and insurers must renew coverage as long as the premiums are paid. This reform was essential in addressing issues of discrimination against people with pre-existing conditions, which had been a common practice in the insurance industry prior to the ACA. By mandating that insurance companies offer coverage to all applicants and continue that coverage indefinitely, the ACA aimed to expand the number of insured individuals and made health insurance more accessible to a broader range of the population, thereby contributing to a healthier society. In contrast, the other options either misrepresent the provisions of the ACA or suggest changes that were not part of the law. The ACA did not eliminate healthcare subsidies; in fact, it created subsidies to make insurance more affordable for lower-income individuals. Moreover, rather than increasing age rating variation, the ACA limited it to a 3 to 1 ratio, ensuring that older individuals are not charged excessively more.

7. What are direct costs in a healthcare setting?

- A. Costs that cannot be traced to a specific service
- B. Costs associated with administrative functions
- C. Costs that can be traced directly to a department or service**
- D. Costs that relate to facility maintenance

Direct costs in a healthcare setting refer to expenses that can be specifically attributed to a particular department, service, or patient care activity. This means that these costs are directly related to the provision of healthcare services and can be clearly identified with a specific function or activity. For example, if a hospital department uses medical supplies, pays staff salaries, or incurs expenses for equipment that are solely dedicated to that department's operations, these would all be classified as direct costs. Understanding the concept of direct costs is crucial for healthcare financial management since it helps institutions allocate resources effectively and assess the profitability of specific services. By identifying and analyzing direct costs, healthcare organizations can make informed decisions about cost control, pricing, and resource allocation that directly impact service delivery and operational efficiency.

8. What form can healthcare reform take according to various views?

- A. A national healthcare system funded and delivered by the government**
- B. Only new tax incentives for insurers
- C. Restrictions on existing insurance providers
- D. Self-regulation by healthcare providers

A national healthcare system funded and delivered by the government is one of the most comprehensive forms of healthcare reform, reflecting a view that emphasizes government involvement in ensuring access to healthcare for all citizens. This approach often advocates for a single-payer system where the government takes on the role of a primary insurer, centralizing healthcare funding and potentially simplifying the administration of care. It aims to decrease costs by reducing administrative inefficiencies while ensuring that healthcare is treated as a right rather than a privilege. In this model, access to healthcare services becomes more equitable, as it is designed to eliminate financial barriers that can prevent patients from seeking necessary medical care. Additionally, this approach can lead to standardized healthcare services across the population, potentially improving overall public health outcomes by emphasizing preventive care and early intervention. Other forms of healthcare reform, such as new tax incentives for insurers or self-regulation by healthcare providers, tend to address specific aspects of the healthcare system but do not fundamentally alter the structure of healthcare delivery in the same way a national system would. Restrictions on existing insurance providers may aim to regulate the market but often do not expand access or improve equity in healthcare delivery as fundamentally as a national healthcare system would.

9. What characterizes variable costs in a health plan?

- A. Costs that remain constant over time
- B. Costs that vary with changes in the volume of services**
- C. Costs related to administrative overhead
- D. Costs incurred during long-term projects

Variable costs in a health plan are defined as costs that fluctuate based on the volume of services provided. This means that as more services are rendered, variable costs increase, and if fewer services are required, these costs decrease correspondingly. This characteristic is particularly relevant in healthcare, where certain expenditures, such as treatment supplies or clinician services, can increase or decrease depending on patient demand and utilization rates. For instance, if a health plan experiences a rise in the number of patients seeking care, associated costs such as medication, medical supplies, and even some staffing costs will also rise, reflecting a direct relationship with service volume. Recognizing variable costs is crucial for health plan administrators as it aids in budgeting, financial forecasting, and resource allocation strategies. In contrast, costs that remain constant over time do not fit the definition of variable costs because such costs do not change with service demand. Similarly, costs related to administrative overhead are typically more fixed in nature rather than variable, and costs incurred during long-term projects would generally not be classified as variable because they can relate to fixed costs that are spread out over an extended timeframe. Hence, variable costs are inherently tied to the immediate operational demands of the health plan.

10. What is a primary characteristic of marginal cost pricing in competitive healthcare markets?

- A. Prices are set above full costs to maximize profits
- B. Prices are set below full costs to attract customers**
- C. Discounts are avoided for higher profit margins
- D. Fixed costs are eliminated from pricing decisions

Marginal cost pricing in competitive healthcare markets focuses on setting prices that reflect the additional cost of providing one more unit of service. This approach is predicated on the understanding that by pricing services at or just below marginal costs, providers can attract more patients, leading to increased volume and potentially better overall profitability due to economies of scale. By setting prices below full costs, healthcare providers cater to price-sensitive consumers, which is crucial in a competitive environment where numerous healthcare options are available. This pricing strategy aims to maximize patient enrollment and usage, thereby leading to better resource utilization. In contrast, other options reflect different pricing strategies or misconceptions about how marginal costs interact with overall pricing. Therefore, the essence of marginal cost pricing as a characteristic helps to clarify how healthcare providers strategically position themselves in competitive markets to maintain or grow their patient base while balancing cost considerations.

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://hfmabusinesshealthcare.examzify.com>

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