Module I of the CHFP Program: HFMA's Business of Health Care course
Sample Exam Questions

HFMA's Business of Health Care is a comprehensive online program that presents an overview of today's healthcare environment and highlights the shift in healthcare service delivery and evolving payment models. The online program consists of six courses. Each course is designed to assist you in learning at your own pace. In addition, there is a downloadable Concept Guide that can be used as a study guide as you review each course.

Please note that these are **examples of the types of questions** on the final assessment of HFMA's Business of Health Care. Not all of the content of the course is covered within these sample questions: this document is ***not*** a predictor of success. ***This is not a practice CHFP exam.***

Correct answers start on Page 10.

Sample Questions – Module I, the Business of Health Care

1) Insurers, regulators, and suppliers are:
   a) Outside the scope of health care reform enacted in the PPACA
   b) Participants in the delivery of medical care that are not directly involved in treatment
   c) Being positioned as a set of checks and balances for cost management
   d) Challenged to be "patient-focused" in their operations

2) Purchasing health care is a process best described as:
   a) The purchaser always pays after the service is delivered
   b) The purchaser is totally unaware of prices and has no warranties
   c) The purchaser may pay a portion of the cost
   d) The purchaser is likely to contract with a third party to pay for services

3) The "revenue cycle" in health care is:
   a) The flow of money between the patient, the insurer and the health care services provider
   b) The sum of the internal processes that providers employ to receive payment
   c) The number of days between medical treatment and resolution of the patient's financial obligations
   d) A series of process benchmarks correlated to cash flows

4) Prior to passage of the Patient Protection and Affordable Care Act (ACA), insurance that was usually provided by an employer to the employee as an additional form of compensation, was known as:
   a) An employee entitlement
   b) An employee benefit
   c) An employer "opt –in" compensation choice
   d) An employer incentive

5) Insurers often require some out-of-pocket payment by the patient to:
   a) Serve as a down payment and guarantee of full reimbursement
   b) Have providers initiate service
   c) Incentive patients to use services only when necessary
   d) Trigger the contractual obligations of the insurer

6) Medicare is over seen by:
   a) Congress' Ways and Means Committee
   b) Health and Human Services, Department of Medicare Services
   c) State Medicare Offices
   d) The federal Center for Medicare and Medicaid Services (CMS)

7) A fiscal intermediary is:
   a) A provider sponsored financial counselor
   b) An organization acting on behalf of CMS to administer Medicare payments
   c) An organization acting on behalf of providers to resolve insurance claims
   d) Regional bans which hold federal funding for Medicare and Medicaid claims

8) Medicaid, the insurance program for the poor and medically needy, is operated:
   a) By the individual states
   b) As a joint program between the federal government and the states
   c) As regional collaborative between states
   d) As a joint program between the states and federally qualified insurers

9) Much of the reform legislated in the Patient Protection and Affordable Care Act was targeted at:
   a) Slowing consumption of health care services
   b) Shifting the health care industry to a "wellness" and prevention approach
   c) Reforming the insurance marketplace
   d) Increasing safety for patients

10) All of the following are key provisions **EXCEPT**:
   a) Medical Loss Ration
   b) Insurance Exchanges
   c) Accountable Care Organizations
   d) Patient Safety Standards

11) The "individual mandate" refers to the requirement that:
   a) Individuals without employer-provided insurance purchase health insurance through health insurance exchanges
   b) Businesses with 25 or more full-time employees provide either group insurance or health savings account (HSA)
   c) States create an insurance pool to cover all individuals below the federal poverty level

d) Insurers do not deny individuals coverage based on pre-existing conditions

12) The business opportunity in which health care providers collaborate in managing the health care of a select population of patients while reducing the cost of care and improving quality is known as:

a) A Medical Home
b) A care Continuum
c) A Joint Venture
d) An Accountable Care Organization

13) The "triple aim" of healthcare reform is Quality Outcomes, Reduced Cost and:

a) Increased Patient Safety and Satisfaction with Treatment
b) Reduction in the number of uninsured and under-insured
c) Increased community wellness
d) Reduction of readmissions for the same condition and reduction of Hospital Acquired Infections (HAI)

14) The accounting system used in most health care organizations – physician offices, hospitals, dental clinics, or health plans – is based on:

a) Cash received
b) A "double –entry" capturing the 2 sides of every financial transaction
c) Volume of services projections
d) The operating budget targets

15) What you own or are owed is an asset; what you owe is a liability, what you keep is known as:

a) Reserves
b) Working capital
c) Net asset or equity
d) Available funds

16) Matching the revenues earned in a given time period (a month, a quarter, or a year) with the expenses incurred to earn that revenue is known as:

a) A "pre-close"
b) Accounts reconciliation
c) The Accounting Identify
d) The Matching Principle

17) The accrual basis of accounting is the process of:

a) Using a reasonable estimate for revenues and expenses until the true amount is known
b) "Rolling forward" financial reports to guide the business in the next period until actual results are known
c) Forecasting anticipated expense and "drawing down" on budgeted revenue
d) Auditing actual financial returns against budget

18) The three financial statements used in managing a health care business are the income statement, the statement of cash flows and:

a) Management notes
b) The Audit Review
c) The balance sheet
d) The operating budget

19) The statement summarizing revenues, expenses, and income for an organization *over a specified period of time – month, quarter, or year* is the:

a) Annual report
b) Income statement
c) Balance sheet
d) Cash flow statement

20) The accounting difference between bad debt and charity care is:

a) Bad debt is when the patient is unwilling to pay what is owed and charity care is when a patient has no insurance of means to pay what is owed
b) Bad debt is reimbursable under federal law in the event of bankruptcy
c) Bad debt carries flexibility in that it may be deemed "charitable" to assist in maintaining a non-profit tax status
d) Charity care can potentially affect a provider organization's credit rating in an adverse manner

21) The balance sheet describes the organizations:

a) Profitability as a specified point in time
b) Assets, liabilities, and net assets at a specified point in time
c) Credit –worthiness
d) Liquidity and capacity to take on debt

22) The income statement and the balance sheet are closely linked. The most significant link is:

a) Current liabilities on both statements
b) Receivables on both statements
c) The time period specified
d) Net assets available

23) Operational metrics, from a financial perspective:

a) Are simple ratios that describe business activity
b) Define what is budgeted
c) Are most robust when stakeholder satisfaction in include
d) Are the clearest indicator of strategic accomplishment

24) Ratio analysis includes all of the following business uses **EXCEPT**:

a) Understand the relationships of various parts of the financial sheets
b) Benchmark performance against other organizations
c) Deterring creditworthiness
d) Substantiate strategic budget assumptions

25) The measure of the ability of an entity to pay its current obligations as they come due is:

a) Debt capacity
b) Liquidity
c) Solvency
d) Profitability

26) The three types of financial ratios used to monitor financial performance are liquidity, profitability and:

a) Equity
b) Debt capacity
c) Capital structure
d) Debt structure

27) The costs directly associated with providing services or products is the:

a) Unit (of service) cost
b) Direct cost
c) Retail price
d) Break-even point

28) Almost all discussions of cost behavior assume:

a) Accurate transaction recording
b) Spending and purchasing that is relatively stable
c) Short-term time frame
d) Predictable expense cycles

29) A situation in which a manager needs to determine the costs of a specific service to determine a price of that service for the purposes of negotiating a specific payment rate is an example of:

a) Activity based costing
b) Overhead
c) Cost allocation
d) Cost reporting

30) Under a full-cost pricing approach, the price for services:

a) Is set to be commensurate with competition prices for a similar service
b) Must be established to cover all costs for providing the service
c) Is established to cover all costs for offering the service plus a desired margin
d) Is built with consideration of the market's price sensitivity for out-of-pocket payment amounts

31) A marginal cost pricing approach requires:

a) Willingness to adjust margin expectations depending on market response to prices
b) Determining how much cost to include in pricing
c) Clearly establishing the minimal cost that a unit of service can be provided
d) Deciding on an acceptable level of ROI on a unit of service

32) A contribution margin is:

a) The amount that a consumer pays
b) The total resources used to provide service
c) The amount of the price leftover after direct expense
d) The percentage of gross revenues generated by an individual service line

33) The practice of making the assumption that some customers will be profitable and others may not – but in the aggregate a price offered to all buyers will be profitable is known as:

a) Aggregate pricing
b) Loss mitigation pricing
c) Risk absorption pricing
d) Target cost pricing

34) Health plans apply target cost pricing through a process known as group rate setting. This approach:

a) Sets prices based on the costs incurred to provide services to all members of a local market area
b) Sets prices based on historical all DRG claims in a given market area
c) Provides pricing discounts to health plan members based on claims history
d) Breaks a population down into groups and sets prices based on the risk of the group likely needing services

35) Budgeting is the process of quantifying:

a) An organization's strategic plan
b) Resource allocations
c) An organization's fiscal structure
d) Market strategy

36) All of the following are critical elements of working with a budget **EXCEPT:**

a) Budgets need flexibility as the business environment shifts
b) Budgets are a management tool, not a financial tool
c) Budgets are critical to accurately benchmarking organization performance
d) Budgets are the concern of upper management only

37) The process where managers start each budget projection as if there were no past experience and each item in the budget must be justified as to its reasonableness each year is known as:

a) Evidence based budgeting
b) Zero-based budgeting
c) Strategic budgeting
d) Expense-bases budgeting

38) The operating budget provides:

a) A benchmark for the normal, day-to-day operation of the business
b) An understanding of the expected volume of services provided
c) Estimates of expenses by knowing operational relationships
d) Determination of capital investments

39) The analysis process that determines the variance between actual results and a budget projection that has been "flexed" to the actual service volume experienced is:

a) Simple variance analysis
b) Budgeted volume variance analysis
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40) The comparison of an organizations performance on key performance measures relative to the competition, other organizations, or groups of organization is known as:

a) Market analysis
b) Key Performance Indicators management
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41) A health plan incentive for the patient to use insurance only when needed is:

a) A high premium
b) Out-of-pocket patient co-pays
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42) The average time it takes for a hospital or physician to be paid for services by a health plan is measured by:

a) Days in accounts receivable ratio
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43) The price set by a hospital or physician for their services is:

a) An estimate of cost absent full loaded fees
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44) There are two broad categories of payment for healthcare services. They are fee-for-service and:

a) Bundled services payments
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c) Capitation
d) Preferred provider rates

45) The Affordable Care Act initiated two fundamental reimbursement reforms. These are:

a) A cap on "out-of-pocket" expenses and mandatory health insurance coverage
b) Value-based purchasing and bundled payments
c) Reduction in Medicare Physician Reimbursement and bundled payments
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46) The difference between current assets and current liabilities is called:

a) Net assets available
b) Uncovered reserves
c) Working capital
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47) A "Medical Home" is:

a) A primary care delivery model intended to organize providers into a coordinated team to meet the majority of a patient's health care needs
b) A care delivery model in which a primary care physician coordinates all care needed in a treatment incident
c) The term used for the healthcare provider that has the primary responsibility for treatment and holds priority position in reimbursement
d) The provider entity identified by the patient as the resource for health care that the patient prefers to use.

48) All of the following are features of an Accountable Care Organization (ACO) **EXCEPT:**

a) An ACO is a network of providers
b) An ACOs key feature is primary care physicians in lead role
c) An ACO shares clinical and financial responsibilities
d) An ACO is exempt from population health reimbursement mandates

49) Overall, the medical home, ACO, and bundled payment models all create a business environment where providers:

a) Must have a clear strategic plan and the business model to achieve it
b) Need to compete more on quality and price
c) Are challenged to include the patient as a stakeholder
d) Must work together to generate more positive patient outcomes

50) Population health management entails a group of providers and a health plan collaborating primarily to:

a) Manage costs and increase efficiency in treatment
b) Improve performance on measures of overall health for a specific group of patients
c) Shift to a collaborative consumer directed treatment approach
d) Create an integrate, unified localized health care delivery system

Correct Answers

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If you have any questions about the above questions, please contact HFMA Career Services Department at 1-800-252-4362 x 311, or careerservices@hfma.org