Exam Questions AHM-530

Network Management

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NEW QUESTION 1
- (Topic 1)
Network managers rely on a health plan's claims administration department for much of the information needed to manage the performance of providers who are not under a capitation arrangement. Examining claims submitted to a health plan's claims administration department enables the health plan to

A. determine the number of healthcare services delivered to plan members
B. monitor the types of services provided by the health plan's entire provider network
C. evaluate providers' practice patterns and compliance with the health plan's procedures for the delivery of care
D. all of the above

Answer: D

NEW QUESTION 2
- (Topic 1)
Although a health plan is allowed to delegate many activities to outside sources, the National Committee for Quality Assurance (NCQA) has determined that some activities are not delegable.
These activities include

A. evaluation of new medical technologies
B. overseeing delegated medical records activities
C. developing written statements of members' rights and responsibilities
D. all of the above

Answer: D

NEW QUESTION 3
- (Topic 1)
From the following answer choices, choose the type of clause or provision described in this situation.
The provider contract between Dr. Olin Norquist and the Granite Health Plan specifies a time period for the party who has breached the contract to remedy the problem and avoid termination of the contract.

A. Cure provision
B. Hold-harmless provision
C. Evergreen clause
D. Exculpation clause

Answer: A

NEW QUESTION 4
- (Topic 1)
Many health plans opt to carve out behavioral healthcare (BH) services. However, one argument against carving out BH services is that this action most likely can result in

A. Slower access to BH care for plan members
B. Increased collaboration between BH providers and PCPs
C. Fewer specialized BH services for plan members
D. Decreased continuity of BH care for plan members

Answer: D

NEW QUESTION 5
- (Topic 1)
If a third party is responsible for injuries to a plan member of the Hope Health Plan, then Hope has a contractual right to file a claim for the resulting healthcare costs against the third party. This contractual right to recovery from the third party is known as

A. Subrogation
B. Partial capitation
C. Coordination of benefits
D. Aremedy provision

Answer: A

NEW QUESTION 6
- (Topic 1)
Four types of APCs are ancillary APCs, medical APCs, significant procedure APCs, and surgical APCs. An example of a type of APC known as

A. An ancillary APC is a biopsy
B. Amedical APC is radiation therapy
C. Asignificant procedure APC is a computerized tomography (CT) scan
D. Asurgical APC is an emergency department visit for cardiovascular disease

Answer: C

NEW QUESTION 7
- (Topic 1)

In open panel contracting, there are several types of delivery systems. One such delivery system is the faculty practice plan (FPP). One likely result that a health plan will experience by contracting with an FPP is that the health plan will

A. be able to select most of the physicians in the FPP
B. achieve the highest level of cost effectiveness possible
C. experience limited control over utilization
D. achieve the most effective case management possible

Answer: C

NEW QUESTION 8
- (Topic 1)
With respect to hiring practices, one step that a health plan most likely can take to avoid violating the terms of the Americans with Disabilities Act (ADA) is to

A. Require a medical examination prior to accepting an application for employment
B. Include in the employment application questions pertaining to health status
C. Make a conditional offer of employment, and then require the candidate to have an examination prior to granting specific staff privileges
D. Require applicants to answer questions pertaining to the use of drugs and alcohol

Answer: C

NEW QUESTION 9
- (Topic 1)
The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement.
One important activity within the scope of network management is ensuring the quality of the health plan's provider networks. A primary purpose of _____ is to review the clinical competence of a provider in order to determine whether the provider meets the health plan's preestablished criteria for participation in the network.

A. authorization
B. provider relations
C. credentialing
D. utilization management

Answer: C

NEW QUESTION 10
- (Topic 1)
In most health plan pharmacy networks, the cost component of the reimbursement formula is based on the average wholesale price (AWP). One true statement about the AWP for prescription drugs is that

A. AWPs tend to vary widely from region to region of the United States
B. The AWP is often substantially higher than the actual price the pharmacy pays for prescription drugs
C. A health plan's contracted reimbursement to a pharmacy for prescription drugs is typically the AWP plus a percentage, such as 5%
D. The AWP usually is lower than the estimated acquisition cost (EAC) for most prescription drugs

Answer: B

NEW QUESTION 10
- (Topic 1)
An health plan enters into a professional services capitation arrangement whenever the health plan

A. Contracts with a medical group, clinic, or multispecialty IPA that assumes responsibility for the costs of all physician services related to a patient's care
B. Pays individual specialists to provide only radiology services to all plan members
C. Transfers all financial risk for healthcare services to a provider organization and the provider, in turn, covers virtually all of a patient's medical expenses
D. Contracts with a primary care provider to cover primary care services only

Answer: A

NEW QUESTION 12
- (Topic 1)
The Sweeney Health Plan uses the discounted fee-for-service (DFFS) method to compensate some of its providers. Under this method of compensation, Sweeney calculates payments based on

A. The standard fees of indemnity health insurance plans, adjusted by region
B. The Medicare fee schedules used by other health plans, adjusted by region
C. Whichever amount is higher, the billed charge or the DFFS amount
D. Whichever amount is lower, the billed charge or the DFFS amount

Answer: D

NEW QUESTION 17
- (Topic 1)
Jay Mercer is covered under his health plan's vision care plan, which includes coverage for clinical eye care but not for routine eye care. Recently, Mr. Mercer had a general eye examination and got a prescription for corrective lenses. Mr. Mercer's vision care plan will cover.

A. both the general eye examination and the prescription for corrective lenses
B. the general eye examination only

C. the prescription for corrective lenses only
D. neither the general eye examination nor the prescription for corrective lenses

Answer: D

NEW QUESTION 22
- (Topic 1)
The following statements are about the responsibilities that providers are expected to assume under most provider contracts with health plans. Select the answer choice containing the correct statement.

A. All health plans now include in their provider contracts a statement that explicitly places responsibility for the medical care of plan members on the health plan rather than on the provider.
B. According to the wording of most provider contracts, the responsibility of providers to deliver medical services to a plan member is not contingent upon the provider's receipt of information regarding the member's eligibility for these services.
C. Most health plans include in their provider contracts a clause which requires providers to maintain open communication with plan members regarding appropriate treatment plans, even if the services are not covered by the member's health plan.
D. Most provider contracts require participating providers to discuss health plan payment arrangements with patients who are covered by the plan.

Answer: C

NEW QUESTION 24
- (Topic 1)
The provider contract that Dr. Huang Kwan has with the Poplar Health Plan includes a typical scope of services provision. The medical service that Dr. Kwan provided to Alice Meyer, a Poplar plan member, is included in the scope of services. The following statement(s) can correctly be made about this particular medical service:

A. D
B. Kwan most likely was required to seek authorization from Poplar before performing this particular service.
C. D
D. Kwan most likely was paid on a FFS basis for providing this service.
E. Both A and B
F. A only
G. B only
H. Neither A nor B

Answer: D

NEW QUESTION 29
- (Topic 1)
The following statements are about factors that health plans should consider as they develop provider networks in rural and urban markets. Three of the statements are true, and one of the statements is false. Select the answer choice that contains the FALSE statement.

A. Compared to providers in urban areas, providers in rural areas are less likely to offer discounts to health plans in exchange for directed patient volume.
B. In urban areas, limiting the number of specialists on a panel usually affects the network's market appeal more than does limiting the number of primary care physicians.
C. The greatest opportunity to create competition in rural areas is among the specialty providers in other nearby communities.
D. Typically, hospital contracting is easier in urban areas than in rural areas.

Answer: B

NEW QUESTION 30
- (Topic 1)
The NPDB specifies the entities that are eligible to request information from the data bank, as well as the conditions under which requests are allowed. In general, entities that are eligible to request information from the NPDB include

A. medical malpractice insurers and the general public
B. medical malpractice insurers and professional societies that are screening applicants for membership
C. the general public and state licensing boards
D. state licensing boards and professional societies that are screening applicants for membership

Answer: D

NEW QUESTION 33
- (Topic 1)
The sizes of the businesses in a market affect the types of health programs that are likely to be purchased. Compared to smaller employers (those with fewer than 100 employees), larger employers (those with more than 1,000 employees) are

A. more likely to contract with indemnity health plans
B. more likely to offer their employees a choice in health plans
C. less likely to contract with health plans
D. less likely to require a wide variety of benefits

Answer: B

NEW QUESTION 38
- (Topic 1)
A population's demographic factors—such as income levels, age, gender, race, and ethnicity—can influence the design of provider networks serving that population.

With respect to these demographic factors, it is correct to say that

A. higher-income populations have a higher incidence of chronic illnesses than do lowerincome populations
B. compared to other groups, young men are more likely to be attached to particular providers
C. a population with a high proportion of women typically requires more providers than does a population that is predominantly male
D. Health plans should not recognize, in either the design of networks or the evaluation of provider performance, racial and ethnic differences in the member population

Answer: C

NEW QUESTION 40
- (Topic 1)
The Ross Health Plan compensates Dr. Cecile Sanderson on a FFS basis. In order to increase the level of reimbursement that she would receive from Ross, Dr. Sanderson submitted the code for a comprehensive office visit. The services she actually provided represented an intermediate level of service. Dr. Sanderson's action is an example of a type of false billing procedure known as

A. Cost shifting
B. Churning
C. Unbundling
D. Upcoding

Answer: D

NEW QUESTION 44
- (Topic 1)
From the following answer choices, choose the term that best matches the description.
Members of a physician-hospital organization (PHO) denied membership to a physician solely because the physician has admitting privileges at a competing hospital.

A. Group boycott
B. Horizontal division of territories
C. Tying arrangements
D. Concerted refusal to admit

Answer: A

NEW QUESTION 46
- (Topic 1)
Lakesha Frazier, a member of a health plan in a rural area, had been experiencing heart palpitations and shortness of breath. Ms. Frazier's primary care provider (PCP) referred her to a local hospital for an electrocardiogram. The results of the electrocardiogram were transmitted for diagnosis via high-speed data transmission to a heart specialist in a city 500 miles away. This information indicates that the results of Ms. Frazier's electrocardiogram were transmitted using a communications system known as

A. Anarrow network
B. An integrated healthcare delivery system
C. Telemedicine
D. Customized networking

Answer: C

NEW QUESTION 47
- (Topic 1)
Health plans use a variety of sources to find candidates to recruit for their provider networks. In general, two of the most effective methods of finding candidates are through

A. Word of mouth and on-site training programs
B. Word of mouth and direct mail
C. Advertisements in local newspapers and on-site training programs
D. Advertisements in local newspapers and direct mail

Answer: B

NEW QUESTION 51
- (Topic 1)
The Aegean Health Plan delegated its utilization management (UM) program to the Silhouette IPA. Silhouette, in turn, transferred authority for case management to Brandon Health Services. In this situation, Brandon is best described as the

A. delegator, and Aegean is ultimately responsible for Brandon's performance
B. delegator, and Silhouette is ultimately responsible for Brandon's performance
C. subdelegate, and Aegean is ultimately responsible for Brandon's performance
D. subdelegate, and Silhouette is ultimately responsible for Brandon's performance

Answer: C

NEW QUESTION 55
- (Topic 1)
Some states have enacted any willing provider laws. From the perspective of the health plan industry, one drawback of any willing provider laws is that they often

result in a reduction of a plan's

A. Premium rates
B. Ability to monitor utilization
C. Number of primary care providers (PCPs)
D. Number of specialists and ancillary providers

Answer: B

NEW QUESTION 59
- (Topic 1)
One type of fee schedule payment system assigns a weighted unit value for each medical procedure or service based on the cost and intensity of that service. Under this system, the unit values for procedural services are generally higher than the unit values for cognitive services. This system is known as a

A. Wrap-around payment system
B. Relative value scale (RVS) payment system
C. Resource-based relative value scale (RBRVS) system
D. Capped fee system

Answer: B

NEW QUESTION 64
- (Topic 1)
After HIPAA was enacted, Congress amended the law to include the Mental Health Parity Act (MHPA) of 1996, a federal requirement relating to mental health benefits. One true statement about the MHPA is that it

A. requires all health plans to provide coverage for mental health services
B. requires health plans to carve out mental/behavioral healthcare from other services provided by the plans
C. allows health plans to require patients receiving mental health services to pay higher copayments than patients seeking treatment for physical illnesses
D. prohibits health plans that offer mental health benefits from applying more restrictive limits on coverage for mental illness than on coverage for physical illness

Answer: D

NEW QUESTION 67
- (Topic 1)
The National Committee for Quality Assurance (NCQA) has integrated accreditation with Health Employer Data and Information Set (HEDIS) measures into a program called Accreditation '99. One statement that can correctly be made about these accreditation standards is that

A. Health plans are required by law to report HEDIS results to NCQA
B. HEDIS restricts its reporting criteria to a narrow group of quantitative performance measures, while NCQA includes a broad range of qualitative performance measures
C. Private employer groups purchasing health care coverage increasingly require both NCQA accreditation and HEDIS reporting
D. HEDIS includes measures of a health plan's effectiveness of care rather than its cost of care

Answer: C

NEW QUESTION 72
- (Topic 1)
The introductory paragraph of a provider contract is generally followed by a section called the recitals. The recitals section of the contract typically specifies the

A. Purpose of the agreement
B. Manner in which the provider is to bill for services
C. Definitions of key terms to be used in the contract
D. Rate at which the provider will be compensated

Answer: A

NEW QUESTION 75
- (Topic 1)
Some jurisdictions have enacted corporate practice of medicine laws. One effect that corporate practice of medicine laws have had on HMO provider networks is that these laws typically

A. require incorporated HMOs to practice medicine through licensed employees
B. require HMOs to form exclusive contracts with physician groups who agree to dedicate all or most of their practices to HMO patients in return for a set payment or revenue-sharing
C. restrict the ability of staff model HMOs to hire physicians directly, unless the physiciansown the HMO
D. encourage incorporated HMOs to obtain profits from their provisions of physician professional services

Answer: C

NEW QUESTION 80
- (Topic 2)
The vision benefits offered by the Omni Health Plan include clinical eye care only. The following statements describe vision care received by Omni plan members:
•Brian Pollard received treatment for a torn retina he suffered as a result of an accident
•Angelica Herrera received a general eye examination to test her vision
•Megan Holtz received medical services for glaucoma
Of these medical services, the ones that most likely would be covered by Omni's vision coverage would be the services received by:

A. M
B. Pollard, M
C. Herrera, and M
D. Holtz
E. M
F. Pollard and M
G. Herrera only
H. M
I. Pollard and M
J. Holtz only
K. M
L. Herrera and M
M. Holtz only

Answer: C

NEW QUESTION 82
- (Topic 2)
Dr. Michelle Kubiak has contracted with the Gem Health Plan, a Medicare+Choice health plan, to provide medical services to Gem's enrollees. Gem pays Dr. Kubiak $40 per enrollee per month for providing primary care. Gem also pays her an additional $10 per enrollee per month if the cost of referral services falls below a targeted level. This information indicates that, according to the substantial financial risk formula, Dr. Kubiak's referral risk under this contract is equal to:

A. 20%, and therefore this arrangement puts her at substantial financial risk
B. 20%, and therefore this arrangement does not put her at substantial financial risk
C. 25%, and therefore this arrangement puts her at substantial financial risk
D. 25%, and therefore this arrangement does not put her at substantial financial risk

Answer: B

NEW QUESTION 84
- (Topic 2)
The Azure Health Plan strives to ensure for its plan members the best possible level of care from its providers. In order to maintain such high standards, Azure uses a variety of quantitative and qualitative (behavioral) measures to determine the effectiveness of its providers. Azure then compares the clinical and operational practices of its providers with those of other providers outside the network, with the goal of identifying and implementing the practices that lead to the best outcomes.
Qualitative measures that Azure could use to assess provider performance include an evaluation of how

A. Quickly the provider responds to plan members' inquiries
B. Effectively the provider communicates with plan members
C. Often the provider refers plan members for ancillary services
D. Many plan members visit the provider per month

Answer: C

NEW QUESTION 88
- (Topic 2)
Partial capitation is one common approach to capitation. One typical characteristic of partial capitation is that it:

A. Includes only primary care services
B. Covers such services as immunizations and laboratory tests
C. Can be used only if the provider's panel size is less than 50 providers
D. Covers such services as cardiology and orthopedics

Answer: A

NEW QUESTION 92
- (Topic 2)
The Elizabethan Health Plan uses a direct referral program, which means that

A. PCPs in Elizabethan's network can make most referrals without obtaining prior authorization from Elizabethan
B. PCPs in Elizabethan's network must always refer plan members to other specialists within the network
C. Elizabethan's plan members can bypass the PCP and obtain medical services from a specialist without a referral
D. Elizabethan's plan members must obtain referrals directly from Elizabethan

Answer: A

NEW QUESTION 95
- (Topic 2)
The following statements describe two types of HMOs:
The Elm HMO requires its members to select a PCP but allows the members to go to any other provider on its panel without a referral from the PCP.
The Treble HMO does not require its members to select a PCP. Treble allows its members to go to any doctor, healthcare professional, or facility that is on its panel without a referral from a primary care doctor. However, care outside of Treble's network is not reimbursed unless the provider obtains advance approval from the HMO.
Both HMOs use delegation to transfer certain functions to other organizations. Following the guidelines established by the NCQA, Elm delegated its credentialing activities to the Newnan Group, and the agreement between Elm and Newnan lists the responsibilities of both parties under the agreement. Treble delegated utilization management (UM) to an
IPA. The IPA then transferred the authority for case management to the Quest Group, an organization that specializes in case management.
Both HMOs also offer pharmacy benefits. Elm calculates its drug costs according to a pricing system that requires establishing a purchasing profile for each

pharmacy and basing reimbursement on the profile. Treble and the Manor Pharmaceutical Group have an arrangement that requires the use of a typical maximum allowable cost (MAC) pricing system to calculate generic drug costs under Treble's pharmacy program. The following statements describe generic drugs prescribed for Treble plan members who are covered by Treble's pharmacy benefits:
The MAC list for Drug A specifies a cost of 12 cents per tablet, but Manor pays 14 cents per tablet for this drug.
The MAC list for Drug B specifies a cost of 7 cents per tablet, but Manor pays 5 cents per tablet for this drug.
To calculate its drug costs, Elm uses a pricing system known as:

A. Estimated acquisition cost (EAC)
B. Package rate cost (PRC)
C. Actual acquisition cost (AAC)
D. Wholesale acquisition cost (WAC)

Answer: A

NEW QUESTION 100
- (Topic 2)
The Blanchette Health Plan uses a method of claims submission that allows its providers to submit claims directly to Blanchette through a computer application-to-application exchange of claims using a standard data format. This information indicates that Blanchette allows its providers to submit claims using technology known as

A. Telemedicine
B. An electronic referral system
C. Electronic data interchange
D. Encounter reporting

Answer: C

NEW QUESTION 104
- (Topic 2)
The Argyle Health Plan has contracted to obtain the services of the providers in the Column Medical Group, a faculty practice plan (FPP). The following statement(s) can correctly be made about this contract:

A. Column most likely contracted with the legal group representing the FPP rather than with the individual physicians within the FPP.
B. Column most likely will provide only highly specialized care to Argyle's plan members.
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: B

NEW QUESTION 109
- (Topic 2)
The employees of the Trilogy Company are covered by a typical workers' compensation program. Under this coverage, Trilogy employees are bound by the exclusive remedy doctrine, which most likely:

A. Allows Trilogy to deny benefits for an employee's on-the-job injury or illness, but only if Trilogy is not at fault for the injury or illness.
B. Allows Trilogy to place limits on the amount of coverage payable for a given claim under the workers' compensation program.
C. Requires the employees to accept workers' compensation as their only compensation in cases of work-related injury or illness.
D. Provides the employees with 24-hour coverage.

Answer: C

NEW QUESTION 112
- (Topic 2)
A provider group purchased from an insurer individual stop-loss coverage for primary and specialty care services with an $8,000 attachment point and 10% coinsurance. If the group's accrued cost for the primary and specialty care treatment of one patient is $10,000, then the amount that the insurer would be responsible for reimbursing the provider group for these costs is:

A. $200
B. $1,000
C. $1,800
D. $9,000

Answer: C

NEW QUESTION 116
- (Topic 2)
The Azure Health Plan strives to ensure for its plan members the best possible level of care from its providers. In order to maintain such high standards, Azure uses a variety of quantitative and qualitative (behavioral) measures to determine the effectiveness of its providers. Azure then compares the clinical and operational practices of its providers with those of other providers outside the network, with the goal of identifying and implementing the practices that lead to the best outcomes.
The comparative method of evaluation that Azure uses to identify and implement the practices that lead to the best outcomes is known as

A. Case mix analysis
B. Outcomes research
C. Benchmarking
D. Provider profiling

Answer: C

NEW QUESTION 120
- (Topic 2)
The following statement(s) can correctly be made about financial arrangements between health plans and emergency departments of hospitals:

A. These arrangements typically include payments for services rendered in the emergency department by a health plan's primary or specialty care providers.
B. Most of these arrangements are structured through the health plan's contract with the hospital.
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: C

NEW QUESTION 124
- (Topic 2)
Health plans typically conduct two types of reviews of a provider's medical records: an evaluation of the provider's medical record keeping (MRK) practices and a medical record review (MRR). One true statement about these types of reviews is that:

A. An MRK covers the content of specific patient records of a provider.
B. The NCQA requires an examination of MRK with all of a health plan's office evaluations.
C. An MRR includes a review of the policies, procedures, and documentation standards the provider follows to create and maintain medical records.
D. The NCQA requires MRR for both credentialing and recredentialing of providers in a health plan's network.

Answer: A

NEW QUESTION 129
- (Topic 2)
Under the compensation arrangement that the Falcon Health Plan has with some of its providers, Falcon holds back 10% of the negotiated payments to these providers in order to offset or pay for any claims that exceed the budgeted costs for referral or hospital services. If the providers keep costs within the budgeted amount, Falcon distributes to them the entire amount of money held back. This way of motivating providers to control costs while providing high-quality, appropriate care is known as a:

A. Risk pool arrangement
B. Withhold arrangement
C. Cost-shifting arrangement
D. Bonus pool arrangement

Answer: B

NEW QUESTION 132
- (Topic 2)
The following statements are about network management for behavioral healthcare (BH). Three of these statements are true and one statement is false. Select the answer choice containing the FALSE statement.

A. Two measures of BH quality are patient satisfaction and clinical outcomes assessments.
B. For a health plan, one argument in favor of contracting with a managed behavioral healthcare organization (MBHO) is that the health plan's members can gain faster access to BH care.
C. In their contracts with health plans, managed behavioral healthcare organizations (MBHOs) usually receive delegated authority for network development and management.
D. Health plans generally compensate managed behavioral healthcare organizations (MBHOs) on an FFS basis.

Answer: D

NEW QUESTION 137
- (Topic 2)
The following statements are about waivers and the Medicaid program. Select the answer choice containing the correct statement:

A. The Balanced Budget Act (BBA) of 1997 eliminated the need for states to make formal applications for waivers.
B. Section 1115 waivers allow states to bypass the Medicaid program's usual requirement of giving recipients complete freedom of choice in selecting providers.
C. Title XVIII waivers allow states to mandate certain categories of Medicaid recipients to enroll in health plan plans.
D. Section 1915(b) waivers allow states to establish demonstration projects in order to test new approaches to benefits and services provided by Medicaid.

Answer: A

NEW QUESTION 139
- (Topic 2)
The following statement(s) can correctly be made about contracting and reimbursement of specialty care physicians (SCPs):

A. Typically, a health plan should attempt to control utilization of SCPs before attempting to place these providers under a capitation arrangement.
B. Forms of specialty physician reimbursement used by health plans include a retainer and a bundled case rate.
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: A

NEW QUESTION 143
- (Topic 2)
The Foxfire Health Plan, which has 20,000 members, contracts with dermatologists on a contact capitation basis. The contact capitation arrangement has the following features:
Foxfire distributes the money in the contact capitation fund once each quarter and the distribution is based on the point totals accumulated by each dermatologist.
Foxfire's per member per month (PMPM) capitation for dermatology services is $1.
The dermatologist receives 1 point for each new referral that is not classified as a complicated referral and 1.5 points for each new referral that is classified as complicated.
During the first quarter, Foxfire's PCPs made 450 referrals to dermatologists and 100 of these referrals were classified as complicated. One dermatologist, Dr. Shareef Rashad, received 42 of these referrals; 6 of his referrals were classified as complicated. Statements that can correctly be made about Foxfire's contact capitation arrangement include:

A. that the value of each referral point for the first quarter was $120
B. that the value of Foxfire's contact capitation fund for dermatologists for the first quarter was $20,000
C. that the payment that Foxfire owed D
D. Rashad for the first quarter was $6,120
E. all of the above

Answer: A

NEW QUESTION 144
- (Topic 2)
Member satisfaction surveys help an health plan determine whether its providers are consistently delivering services to plan members in a manner that lives up to member expectations. Member satisfaction surveys allow the health plan to gather information about

A. Amember’s reaction to services received during a specific encounter
B. The reactions of specific subsets of the health plan’s membership
C. Members’ positive and negative experience with the plan’s services
D. All of the above

Answer: D

NEW QUESTION 148
- (Topic 2)
Grant Pelham is covered by both a workers’ compensation program and a group health plan provided by his employer. The Shipwright Health Plan administers both programs. Mr. Grant was injured while on the job and applied for benefits.
The provider network that Shipwright uses to furnish services for its workers’ compensation program will most likely

A. Emphasize primary care and consist mostly of generalists
B. Focus treatment approaches on rapid recovery rather than cost
C. Offer workers’ compensation beneficiaries the same types and levels of treatment that Shipwright’s traditional network furnishes to group health plan members
D. Exempt participating providers from meeting standard credentialing requirements

Answer: B

NEW QUESTION 152
- (Topic 2)
The Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) established the Programs of All-Inclusive Care for the Elderly (PACE). One characteristic of the PACE programs is that:

A. They are available to United States citizens only after they reach age 65.
B. They have an upper dollar limit.
C. They receive a monthly capitation that is set at 100% of the Adjusted Average Per Capita Cost (AAPCC).
D. PACE providers receive capitated payments only through the PACE agreement.

Answer: D

NEW QUESTION 154
- (Topic 2)
Dr. Sarah Carmichael is one of several network providers who serve on one of the Apex Health Plan’s organizational committees. The committee reviews cases against providers identified through complaints and grievances or through clinical monitoring activities. If needed, the committee formulates, approves, and monitors corrective action plans for providers. Although Apex administrators and other employees also serve on the committee, only participating providers have voting rights. The committee that Dr. Carmichael serves on is a

A. Utilization management committee
B. Peer review committee
C. Medical advisory committee
D. Credentialing committee

Answer: B

NEW QUESTION 156
- (Topic 2)
The Enterprise Health Plan has indicated an interest in delegating its medical records review activities to the Teal Group and has forwarded a typical letter of intent to Teal. One true statement about this letter of intent is that it:

A. Is a contract that creates a legally binding relationship between Enterprise and Teal
B. Cannot include a confidentiality clause
C. Serves as a delegation agreement between Enterprise and Teal
D. Outlines the delegation oversight process

Answer: D

NEW QUESTION 161
- (Topic 2)
The following statement(s) can correctly be made about the Balanced Budget Act (BBA) of 1997:

A. The BBA requires Medicare+Choice organizations to be licensed as non-risk-bearing entities under federal law.
B. The Centers for Medicaid and Medicare Services (CMS) is responsible for implementing the BBA.
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: C

NEW QUESTION 164
- (Topic 2)
One true statement about the responsibilities of providers under typical provider contracts is that most provider contracts:

A. include a clause which states that providers must maintain open communications with patients regarding appropriate treatment plans, unless the services are not covered by the member's health plan
B. hold that the responsibility of the provider to deliver services is usually subject to theprovider's receipt of information regarding the eligibility of the member
C. contain a gag clause or a gag rule
D. include a clause that explicitly places the responsibility for medical care on the health plan rather than on the provider of medical services

Answer: B

NEW QUESTION 167
- (Topic 2)
Dr. Sylvia Cimer and Dr. Andrew Donne are obstetrician/gynecologists who participate in
the same provider network. Dr. Comer treats a large number of high-risk patients, whereas Dr. Donne's patients are generally healthy and rarely present complications. As a result, Dr. Comer typically uses medical resources at a much higher rate than does Dr. Donne. In order to equitably compare Dr. Comer's performance with Dr. Donne's performance, the health plan modified its evaluation to account for differences in the providers' patient populations and treatment protocols. The health plan modified Dr. Comer's and Dr. Donne's performance data by means of

A. Acase mix/severity adjustment
B. An external performance standard
C. Structural measures
D. Behavior modification

Answer: A

NEW QUESTION 171
- (Topic 2)
Factors that are likely to indicate increased health plan market maturity include:

A. Increased consolidation among health plans.
B. Increased rate of growth in health plan premium levels.
C. Areduction in the market penetration of HMO and point-of-service (POS) products.
D. Areduction in the frequency of performance-based reimbursement of providers.

Answer: A

NEW QUESTION 173
- (Topic 2)
The provider contract that Dr. Ted Dionne has with the Optimal Health Plan includes an arrangement that requires Dr. Dionne to notify Optimal if he contracts with another health plan at a rate that is lower than the rate offered to Optimal. Dr. Dionne must also offer this lower rate to Optimal. This information indicates that the provider contract includes a:

A. Most-favored-nation arrangement
B. Warranty arrangement
C. Locum tenens arrangement
D. Nesting arrangement

Answer: A

NEW QUESTION 174
- (Topic 2)
As an authorized Medicare+Choice plan, the Brightwell HMO must satisfy CMS requirements regulating access to covered services. In order to ensure that its network provides adequate access, Brightwell must

A. Allow enrollees to determine whether they will receive primary care from a physician, nurse practitioner, or other qualified network provider

B. Base a provider's participation in the network, reimbursement, and indemnification levels on the provider's license or certification
C. Define its service area according to community patterns of care
D. Require enrollees to obtain prior authorization for all emergency or urgently needed services

Answer: C

NEW QUESTION 175
- (Topic 2)
A health plan that delegates designated credentialing activities to an NCQA-centered or a Commission/URAC-centered credentials verification organization (CVO) is exempt from the due-diligence oversight requirements specified in the NCQA credentialing standards for all
verification services for which the CVO has been certified:

A. True
B. False

Answer: A

NEW QUESTION 176
- (Topic 2)
Social health maintenance organizations (SHMOs) and Programs of All-Inclusive Care for the Elderly (PACE) are federal programs designed to provide coordinated healthcare services to the elderly. Unlike PACE, SHMOs

A. are reimbursed solely through Medicaid programs
B. provide extensive long-term care
C. are reimbursed on a fee-for-service basis
D. limit benefits to a specified maximum amount

Answer: D

NEW QUESTION 178
- (Topic 2)
In 1996, the NAIC adopted a standard for health plan coverage of emergency services. This standard is based on a concept known as the:

A. Due process standard
B. Subrogation standard
C. Corrective action standard
D. Prudent layperson standard

Answer: D

NEW QUESTION 179
- (Topic 2)
Health plans can often reduce workers' compensation costs by incorporating 24-hour coverage into their workers' compensations programs. Twenty-four-hour coverage reduces costs by

A. Maximizing the effects of cost shifting
B. Eliminating the need for utilization management
C. Requiring members to use separate points of entry for job-related and non-job related services
D. Combining administrative services for workers' compensation and non-workers' compensation healthcare and disability coverage

Answer: D

NEW QUESTION 183
- (Topic 2)
The two basic approaches that Medicaid uses to contract with health plans are open contracting and selective contracting. One true statement about these approaches to contracting is that:

A. Open contracting requires health plans to meet minimum performance standards outlined in a state's request for proposal (RFP)
B. Open contracting makes it possible for the Medicaid agency to offer enrollment volume guarantees
C. Selective contracting requires any health plan that meets the state's performance standards and the federal Medicaid requirements to enter into a Medicaid contract
D. Selective contracting requires health plans to bid competitively for Medicaid contracts

Answer: D

NEW QUESTION 184
- (Topic 2)
In health plan pharmacy networks, service costs consist of two components: costs for services associated with dispensing prescription drugs and costs for cognitive services. Cognitive services typically include:

A. making generic substitutions of drugs
B. counseling patients about prescriptions
C. providing patient monitoring
D. switching prescription drugs to preferred drugs

Answer: B

NEW QUESTION 188
- (Topic 2)
Assume that the national average cost per covered employee for PPO rental networks is
$3 per member per month (PMPM) and that the average monthly healthcare premium PMPM is $300. This information indicates that, if the number of health plan members is 10,000, then the annual network rental cost to the health plan would be:

A. $30,000
B. $360,000
C. $9,000,000
D. $12,000,000

Answer: B

NEW QUESTION 193
- (Topic 2)
The following activities are the responsibility of either the Nova Health Plan's risk management department or its medical management department:

A. Protecting Nova's members against harm from medical care
B. Improving the overall health status of Nova members by coordinating care across individual episodes of care and the different providers who treat the member
C. Protecting Nova against financial loss associated with the delivery of healthcare
D. Establishing outreach programs to encourage the use of preventive health services by Nova's members of these activities, the ones that are more likely to be the responsibility of Nova's risk management department rather than its medical management department are activities:
E. A, B, and C
F. A, C, and D
G. A and C
H. B and D

Answer: C

NEW QUESTION 195
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