



AHIP

Exam Questions AHM-250

Healthcare Management: An Introduction

NEW QUESTION 1

- (Topic 1)

From the following choices, choose the definition that best matches the term health risk assessment (HRA)

- A. A technique used to educate plan members on how to distinguish between minor problems and serious conditions and effectively treat minor problems themselves
- B. A technique used to determine if a health condition is present even if a member has not experienced symptoms of the problem
- C. A technique in which information about a plan member's health status, personal and family health history, and health-related behaviors is used to predict the member's likelihood of experiencing specific illnesses or injuries
- D. A technique used to evaluate the medical necessity, appropriateness, and cost- effectiveness of healthcare services for a given patient

Answer: C

NEW QUESTION 2

- (Topic 1)

If most of the physicians, or many of the physicians in a particular specialty, are affiliated with a single entity, then a health plan building a network in the service area

.

- A. Has many contracting options available.
- B. Should not contract with that entity
- C. Most likely needs to contract with that entity
- D. Should attempt to disband the existing affiliations

Answer: C

NEW QUESTION 3

- (Topic 1)

Greentree Medical, a health plan, is currently recruiting PCPs in preparation for its expansion into a new service area. Abigail Davis, a recruiter for Greentree, has been meeting with Melissa Cortelyou, M.D., in an effort to recruit her as a PCP in Green

- A. Greentree is prevented by law from offering a contract to D
- B. Cortelyou until the credentialing process is complete
- C. any contract signed by D
- D. Cortelyou should include a clause requiring the successful completion of the credentialing process within a defined time frame in order for the contract to be effective
- E. Greentree must offer a standard contract to D
- F. Cortelyou, without regard to the outcome of the credentialing process
- G. Greentree will abandon the credentialing process now that D
- H. Cortelyou has agreed to participate in Greentree's network

Answer: B

NEW QUESTION 4

- (Topic 1)

Col. Martin Avery, on active duty in the U.S. Army, is eligible to receive healthcare benefits under one of the three TRICARE health plan options. If Col Avery elects to participate in TRICARE Prime, he will be

- A. able to obtain full benefits for services obtained from network and non-network providers
- B. subject to copayment, deductible, and coinsurance requirements for any medical care he receives
- C. required to formally enroll for coverage and pay an enrollment fee
- D. assigned to a primary care manager who is responsible for coordinating all his care

Answer: D

NEW QUESTION 5

- (Topic 1)

All CDHP products provide federal tax advantages while allowing consumers to save money for their healthcare.

- A. True
- B. False

Answer: A

NEW QUESTION 6

- (Topic 1)

A common physician-only integrated model is a group practice without walls (GPWW). One characteristic of a typical GPWW is that the

- A. GPWW combines multiple independent physician practices under one umbrella organization
- B. GPWW generally has a lesser degree of integration than does an IPA
- C. member physicians cannot own the GPWW
- D. GPWW's member physicians must perform their own business operations

Answer: A

NEW QUESTION 7

- (Topic 1)

In 1999, the United States Congress passed the Financial Services Modernization Act, referred to as the Gramm-Leach-Bliley (GLB) Act. The primary provisions included under the GLB Act require financial institutions, including health plans, to take several

- A. Notify customers of any sharing of non-public personal financial information with nonaffiliated third parties.
- B. Prohibit customers from having the opportunity to 'opt-out' of sharing non-public personal financial information.
- C. Disclose to affiliates, but not to third parties, their privacy policies regarding the sharing of nonpublic personal financial information.
- D. Agree not to disclose personally identifiable financial information or personally identifiable health information.

Answer: A

NEW QUESTION 8

- (Topic 1)

Health plans require utilization review for all services administered by its participating physicians.

- A. True
- B. False

Answer: B

NEW QUESTION 9

- (Topic 1)

In 1999, the United States Congress passed the Financial Services Modernization Act, which is referred to as the Gramm-Leach-Bliley (GLB) Act. The following statement(s) can correctly be made about this act:

- A. The GLB Act allows convergence among the transaction
- B. A only
- C. Both A and B
- D. B only
- E. Neither A nor B

Answer: B

NEW QUESTION 10

- (Topic 1)

HMOs typically employ several techniques to manage provider utilization and member utilization of medical services. One technique that an HMO uses to manage member utilization is

- A. the use of physician practice guidelines
- B. the requirement of copayments for office visits
- C. capitation
- D. risk pools

Answer: B

NEW QUESTION 10

- (Topic 1)

In accounting terminology, the items of value that a company owns—such as cash, cash equivalents, and receivables—are generally known as the company's

- A. revenue
- B. net income
- C. surplus
- D. assets

Answer: D

NEW QUESTION 11

- (Topic 1)

In response to the demand for a method of assessing outcomes, accrediting organizations and other government and commercial groups have developed quantitative measures of quality that consumers, purchasers, regulators, and others can use to compare health

- A. quality standards
- B. accreditation decisions
- C. standards of care
- D. performance measures

Answer: D

NEW QUESTION 12

- (Topic 1)

Identify the CORRECT statement(s):

- (A) Smaller the group, the more likely it is that the group will experience losses similar to the average rate of loss that was predicted.
- (A) (B) Gender of the group's participants has no effect on the likelihood of loss.

- A. All of the listed options

- B. B & C
- C. None of the listed options
- D. A & C

Answer: C

NEW QUESTION 13

- (Topic 1)

From the following choices, choose the definition that best matches the term Screening

- A. A technique used to educate plan members on how to distinguish between minor problems and serious conditions and effectively treat minor problems themselves
- B. A technique used to determine if a health condition is present even if a member has not experienced symptoms of the problem
- C. A technique in which information about a plan member's health status, personal and family health history, and health-related behaviors is used to predict the member's likelihood of experiencing specific illnesses or injuries
- D. A technique used to evaluate the medical necessity, appropriateness, and cost- effectiveness of healthcare services for a given patient

Answer: B

NEW QUESTION 16

- (Topic 1)

The following statements describe two types, or models, of HMOs:

The Quest HMO has contracted with only one multi-specialty group of physicians. These physicians are employees of the group practice, have an equity interest in the practice, and provide

- A. A captive group a staff model
- B. A captive group a network model
- C. An independent group a network model
- D. An independent group a staff model

Answer: B

NEW QUESTION 19

- (Topic 1)

Amendments to the HMO act 1973 do not permit federally qualified HMO's to use

- A. Retrospective experience rating
- B. Adjusted community rating
- C. Community rating by class
- D. Community rating

Answer: A

NEW QUESTION 23

- (Topic 1)

Health plans sometimes contract with independent organizations to provide specialty services, such as vision care or rehabilitation services, to plan members. Specialty services that have certain characteristics are generally good candidates for health pl

- A. Low or stable costs.
- B. Appropriate, rather than inappropriate, utilization rates.
- C. A benefit that cannot be easily defined.
- D. Defined patient population.

Answer: D

NEW QUESTION 24

- (Topic 1)

Emily Brown works for Integral Health Plan and represents the company as a board member for the board of directors. Which best describes Emily's position?

- A. Community Representative
- B. Inside Director
- C. Outside Director
- D. None of these

Answer: B

NEW QUESTION 26

- (Topic 1)

Following a report by the Institute of Medicine on the incidence and consequences of medical errors, a national task force recommended implementation of a nationwide mandatory system of collecting, analyzing, and reporting standardized information about m

- A. random change
- B. structural change
- C. haphazard change
- D. reactive change

Answer: D

NEW QUESTION 29

- (Topic 1)

In order to measure the expenses of institutional utilization, Holt Healthcare Group uses the standard formula to calculate hospital bed days per 1,000 plan members per year. On October 23, Holt used the following information to calculate the bed days per

- A. 278
- B. 397
- C. 403
- D. 920

Answer: B

NEW QUESTION 31

- (Topic 1)

Dr. Julia Phram is a cardiologist under contract to Holcomb HMO, Inc., a typical closed- panel plan. The following statements are about this situation. Select the answer choice containing the correct statement.

- A. All members of Holcomb HMO must select D
- B. Phram as their primary care physician (PCP).
- C. Any physician who meets Holcomb's standards of care is eligible to contract with Holcomb HMO as a provider.
- D. D
- E. Phram is either an employee of Holcomb HMO or belongs to a group of physicians that has contracted with Holcomb HMO
- F. Holcomb HMO plan members may self-refer to D
- G. Phram at full benefits without first obtaining a referral from their PCPs.

Answer: A

NEW QUESTION 34

- (Topic 1)

Employer-sponsored benefit plans that provide healthcare benefits must comply with the Employee Retirement Income Security Act (ERISA). One of the most significant features of ERISA is that it

- A. contains a provision stating that the terms of ERISA generally take precedence over any state laws that regulate employee welfare benefit plans
- B. standardizes the conversion of group healthcare benefits to individual healthcare benefits
- C. mandates that self-funded healthcare plans must pay state premium taxes
- D. requires that all active employees, regardless of age, must be eligible for coverage under employer-sponsored benefit plans

Answer: A

NEW QUESTION 39

- (Topic 1)

Al Marak, a member of the Frazier Health Plan, has asked for a typical Level One appeal of a decision that Frazier made regarding Mr. Marak's coverage. One true statement about this Level One appeal is that

- A. M
- B. Marak has the right to appeal to the next level if the Level One appeal upholds the original decision
- C. It requires Frazier and M
- D. Marak to submit to arbitration in order to resolve the dispute
- E. It is considered to be an informal appeal
- F. It will be handled by an independent review organization (IRO)

Answer: A

NEW QUESTION 44

- (Topic 1)

Brokers are one type of distribution channel that health plans use to market their health plans. One true statement about brokers for health plan products is that, typically, brokers

- A. Are not required to be licensed by the states in which they market health plans
- B. Are compensated on a salary basis
- C. Represent only one health plan or insurer
- D. Are considered to be an agent of the buyer rather than an agent of the health plan or Insurer

Answer: D

NEW QUESTION 48

- (Topic 1)

By definition, a health plan's network refers to the

- A. organizations and individuals involved in the consumption of healthcare provided by the plan
- B. relative accessibility of the plan's providers to the plan's participants
- C. group of physicians, hospitals, and other medical care providers with whom the plan has contracted to deliver medical services to its members
- D. integration of the plan's participants with the plan's providers

Answer: C

NEW QUESTION 49

- (Topic 1)

An exclusive provider organization (EPO) operates much like a PPO. However, one difference between an EPO and a PPO is that an EPO

- A. Is regulated under federal HMO legislation
- B. Generally provides no benefits for out-of-network care
- C. Has no provider network of physicians
- D. Is not subject to state insurance laws

Answer: B

NEW QUESTION 54

- (Topic 1)

For this question, select the answer choice containing the terms that correctly complete the blanks labeled A and B in the paragraph below.
NCQA offers Quality Compass, a national database of performance and accreditation information submitted by managed

- A. Health Plan Employer Data and Information Set (HEDIS) mandatory
- B. Health Plan Employer Data and Information Set (HEDIS) voluntary
- C. ORYX mandatory
- D. ORYX voluntary

Answer: B

NEW QUESTION 57

- (Topic 1)

According to the IRS, which of the following is not an allowable preventive care service?

- A. Smoking cessation programs.
- B. Periodic health examinations.
- C. Health club memberships.
- D. Immunizations for children and adults.

Answer: C

NEW QUESTION 59

- (Topic 1)

A health plan's ability to establish an effective provider network depends on the characteristics of the proposed service area and the needs of proposed plan members. It is generally correct to say that

- A. health plans have more contracting options if providers are affiliated with single entities than if providers are affiliated with multiple entities
- B. urban areas offer more flexibility in provider contracting than do rural areas
- C. consumers and purchasers in markets with little health plan activity are likely to be more receptive to HMOs than to loosely managed plans such as PPOs
- D. large employers tend to adopt health plans more slowly than do small companies

Answer: B

NEW QUESTION 62

- (Topic 1)

Ed O'Brien has both Medicare Part A and Part B coverage. He also has coverage under a PBM plan that uses a closed formulary to manage the cost and use of pharmaceuticals. Recently, Mr. O'Brien was hospitalized for an aneurysm. Later, he was transferred by

- A. Confinement in the extended-care facility after his hospitalization.
- B. Transportation by ambulance from the hospital to the extended-care facility.
- C. Physicians' professional services while he was hospitalized.
- D. physicians' professional services while he was at the extended-care facility.

Answer: A

NEW QUESTION 64

- (Topic 1)

In health plan terminology, demand management, as used by health plans, can best be described as

- A. an evaluation of the medical necessity, efficiency, and/or appropriateness of healthcare services and treatment plans for a given patient
- B. a series of strategies designed to reduce plan members' needs to utilize healthcare services by encouraging preventive care, wellness, member self-care, and appropriate use of healthcare services
- C. a technique that prevents a provider who is being reimbursed under a fee schedule arrangement from billing a plan member for any fees that exceed the maximum fee reimbursed by the plan
- D. a system of identifying plan members with special healthcare needs, developing a healthcare strategy to meet those needs, and coordinating and monitoring the care

Answer: B

NEW QUESTION 66

- (Topic 1)

Before the Hill Health Maintenance Organization (HMO) received a certificate of authority (COA) to operate in State X, it had to meet the state's licensing requirements and financial standards which were established by legislation that is identical to the

- A. Receive compensation based on the volume and variety of medical services they perform for Hill plan members, whereas the specialists receive compensation based solely on the number of plan members who are covered for specific services.
- B. Have no financial incentive to practice preventive care or to focus on improving the health of their plan members, whereas the specialists have a positive incentive to help their plan members stay healthy.
- C. Receive from the IPA the same monthly compensation for each Hill plan member under the PCP's care, whereas the specialists receive compensation based on a percentage discount from their normal fees.
- D. Receive compensation based on a fee schedule, whereas the specialists receive compensation based on per diem charges.

Answer: C

NEW QUESTION 67

- (Topic 1)

Although the process is voluntary for health plans, external accreditation is becoming more and more important as states and purchasers require health plans undergo as many states and purchasers require health plans undergo some type of external review pr

- A. Is voluntary for health plans.
- B. Requires all change accreditation organizations to use the same standards of accreditation.
- C. Typically requires the accrediting organization to conduct a medical record review and a review of a health plan's credentialing processes, but not an evaluation of the health plans' member service systems processes.
- D. Cannot assure that a health plan meets a specified level of quality.

Answer: A

NEW QUESTION 71

- (Topic 1)

Ed Murray is a claims analyst for a managed care plan that provides a higher level of benefits for services received in-network than for services received out-of-network. Whenever Mr. Murray receives a health claim from a plan member, he reviews the claim

- A. A, B, C, and D
- B. A and C only
- C. A, B, and D only
- D. B, C, and D only

Answer: A

NEW QUESTION 76

- (Topic 1)

In the paragraph below, a sentence contains two pairs of words enclosed in parentheses. Determine which word in each pair correctly completes the sentence. Then select the answer choice containing the two words that you have chosen. Many pharmacy benefit

- A. Therapeutic / always
- B. Generic / always
- C. Generic / never
- D. Therapeutic / never

Answer: A

NEW QUESTION 78

- (Topic 1)

In large health plans, management functions such as provider recruiting, credentialing, contracting, provider service, and performance management for providers are typically the responsibility of the

- A. chief executive officer (CEO)
- B. network management director
- C. board of directors
- D. director of operations

Answer: B

NEW QUESTION 81

- (Topic 2)

One ethical principle in health plans is the principle of non-maleficence, which holds that health plans and their providers:

- A. Should allocate resources in a way that fairly distributes benefits and burdens among the members.
- B. Have a duty to present information honestly and are obligated to honor commitments.
- C. Are obligated not to harm their members.
- D. Should treat each plan member in a manner that respects his or her goals and values.

Answer: C

NEW QUESTION 84

- (Topic 2)

Natalie Chan is a member of the Ultra Health Plan. Whenever she needs non-emergency medical care, she sees Dr. David Craig, an internist. Ms. Chan cannot self-refer to a specialist, so she saw Dr. Craig when she experienced headaches. Dr. Craig referred h

- A. Within Ultra's system, M

- B. Chan received primary care from both D
- C. Craig and D
- D. Lee.
- E. Ultra's system allows its members open access to all of Ultra's participating providers.
- F. Within Ultra's system, D
- G. Craig serves as a coordinator of care or gatekeeper for the medical services that M
- H. Chan receives.
- I. Ultra's network of providers includes D
- J. Craig and D
- K. Lee but not Arrow Hospital.

Answer: C

NEW QUESTION 86

- (Topic 2)

The Citywide Health Group is a large provider-based health plan that includes physician groups, hospitals, and other facilities. In order to oversee and manage the operation of the organization, Citywide has established an enterprise scheduling system. The

- A. provide information to Citywide's management regarding provider licensure, certification, and malpractice history
- B. detect instances of overutilization, underutilization, or inappropriate utilization of medical resources
- C. allow Citywide's different components to function as a single organization in arranging access to facilities and resources
- D. facilitate the processing of requests for authorization of payment of benefits

Answer: C

NEW QUESTION 88

- (Topic 2)

John Kerry's employer has contracted to receive healthcare for its employees from the Democratic Healthcare System. Mr. Kerry visits his PCP, who sends him to have some blood tests. The PCP then refers Mr. Kerry to a specialist who hospitalizes him for on

- A. a physician practice organization
- B. a physician-hospital organization
- C. a management services organization
- D. an integrated delivery system

Answer: D

NEW QUESTION 93

- (Topic 2)

One way that MCOs involve providers in risk sharing is by retaining a percentage of the providers' payment during a plan year. At the end of the plan year, the MCO may use the amount retained to offset or pay for any cost overruns for referral or hospital

- A. withholds
- B. usual, customary, and reasonable (UCR) fees
- C. risk pools
- D. per diems

Answer: A

NEW QUESTION 94

- (Topic 2)

Most contracts between health plans and providers contain a provision which forbids providers from seeking compensation from patients if the health plan fails to compensate the provider because of insolvency or for any other reason. Such a provision is kn

- A. due process provision
- B. cure provision
- C. hold-harmless provision
- D. risk-sharing provision

Answer: C

NEW QUESTION 98

- (Topic 2)

Some states mandate that an independent enrollment broker or benefits counselor contractor selected by the state must manage enrollment of the eligible Medicaid population into managed care. In other states a health plan can engage independent brokers and

- A. Many states have regulations that prohibit health plans from using door-to-door and/or telephone solicitation to market health plan products to the Medicaid population.
- B. Health plans are never allowed to medically underwrite individual market customers who are under age 65.
- C. To promote a health plan product to the individual market, health plans typically use captive agents who give sales presentations to potential customers, rather than using promotion tools such as direct mail, telemarketing, or advertising.
- D. Health plans typically are allowed to medically underwrite all individual market customers who are covered by Medicare and can refuse to cover such customers.

Answer: A

NEW QUESTION 103

- (Topic 2)

Katrina Lopez is a claims analyst for a health plan that provides a higher level of benefits for services received in-network than for services received out-of-network. Ms. Lopez reviewed a health claim for answers to the following questions:

Question A -

- A. A, B, C, and D
- B. A, B, and D only
- C. B, C, and D only
- D. A and C only

Answer: A

NEW QUESTION 104

- (Topic 2)

One characteristic of disease management programs is that they typically

- A. focus on individual episodes of medical care rather than on the comprehensive care of the patient over time
- B. are used to coordinate the care of members with any type of disease, either chronic or nonchronic
- C. focus on managing populations of patients who have a specific chronic illness or medical condition, but do not focus on patient populations who are at risk of developing such an illness or condition
- D. use clinical practice processes to standardize the implementation of best practices among providers

Answer: D

NEW QUESTION 105

- (Topic 2)

The Clover Group is a for-profit MCO that operates in the United States. The Valentine Group owns all of Clover's stock. The Valentine Group's sole business is the ownership of controlling interests in the shares of other companies. This information indic

- A. holding company of the Valentine Group
- B. sister corporation of the Valentine Group
- C. parent company of the Valentine Group
- D. subsidiary of the Valentine Group

Answer: D

NEW QUESTION 108

- (Topic 2)

Primary care case managers (PCCMs) provide case management services to eligible Medicaid recipients. With regard to PCCMs it is correct to say that:

- A. PCCMs typically receive a case management fee, rather than reimbursement for medical services on a FFS basis, for the services they provide to Medicaid recipients.
- B. All Medicaid recipients who live in rural areas must be given a choice of at least four PCCMs.
- C. PCCMs receive a case management fee in addition to reimbursement for medical services on a FFS basis.
- D. PCCMs contract directly with the federal government to provide case management services to Medicaid recipients.

Answer: C

NEW QUESTION 109

- (Topic 2)

The Cleopatra Group, a third-party administrator (TPA), has entered into a TPA agreement with the Alexander MCO with regard to the administration of a particular health plan. This agreement complies with all of the provisions of the NAIC TPA Model Law. On

- A. hold all funds it receives on behalf of Alexander in trust
- B. assume full responsibility for determining the claim payment procedures for the plan
- C. assume full responsibility for ensuring that the health plan is administered properly
- D. obtain from the federal government a certificate of authority designating the Cleopatra Group as a TPA

Answer: A

NEW QUESTION 113

- (Topic 2)

Managed behavioral health organizations (MBHOs) use several strategies to manage the delivery of behavioral healthcare services. The following statements are about these strategies.

Select the answer choice that contains the correct statement.

- A. MBHOs generally provide benefits for mental health services but not for chemical dependency services.
- B. The level of care needed to treat behavioral disorders is the same for all patients and all disorders.
- C. By using outpatient treatment more extensively, MBHOs have decreased the use of costly inpatient therapies.
- D. PCP gatekeeper systems for behavioral healthcare generally result in more accurate diagnoses, more effective treatment, and more efficient use of resources than do centralized referral systems.

Answer: C

NEW QUESTION 116

- (Topic 2)

Merle Spencer has coverage under both Medicare Part A and Medicare Part B. Ms. Spencer recently was hospitalized for chest pains, and she incurred charges

for:

- ? The cost of hospitalization for two days
- ? Diagnostic tests performed in the hospital
- ? Trans

- A. ambulance and the diagnostic tests
- B. ambulance, the diagnostic tests, and the physician's professional services
- C. cost of hospitalization
- D. cost of hospitalization and the physician's professional services

Answer: D

NEW QUESTION 121

- (Topic 2)

Khalyn Drury's employer includes managed dental care in its employee benefits package. During open enrollment, Ms. Drury enrolled in the dental plan, which provides dental services to its members in exchange for a prepayment (the premium). Dental services

- A. dental preferred provider organization (PPO)
- B. traditional fee-for-service (FFS) dental plan
- C. plan with a dental point of service (POS) option
- D. dental health maintenance organization (DHMO)

Answer: D

NEW QUESTION 122

- (Topic 2)

The Advantage Health Plan recently added the following features to its member services program:

1. IVR
2. Active member outreach program
3. Advantage's member services staffing needs are likely to increase as a result of

- A. 1
- B. 2
- C. 1 & 2
- D. Neither 1 nor 2

Answer: B

NEW QUESTION 123

- (Topic 2)

Many HMOs are compensated for the delivery of healthcare to members under a prepaid care arrangement. Under a prepaid care arrangement, a plan member typically pays a

- A. fixed amount in advance for each medical service the member receives
- B. a small fee such as \$10 or \$15 that a member pays at the time of an office visit to a network provider
- C. a fixed, monthly premium paid in advance of the delivery of medical care that covers most healthcare services that a member might need, no matter how often the member uses medical services
- D. specified amount of the member's medical expenses before any benefits are paid by the HMO

Answer: C

NEW QUESTION 128

- (Topic 2)

Paul Gilbert has been covered by a group health plan for two years. He has been undergoing treatment for angina for the past three months. Last week, Mr. Gilbert began a new job and immediately enrolled in his new company's group health plan, which has a

- A. Can exclude coverage for treatment of M
- B. Gilbert's angina for one year, because HIPAA does not impact a group health plan's pre-existing condition provision.
- C. Can exclude coverage for treatment of M
- D. Gilbert's angina for one year, because M
- E. Gilbert did not have at least 36 months of creditable coverage under his previous health plan.
- F. Can exclude coverage for treatment of M
- G. Gilbert's angina for three months, because that is the length of time he received treatment for this medical condition prior to his enrollment in the new health plan.
- H. Cannot exclude his angina as a pre-existing condition, because the one-year pre-existing condition provision is offset by at least one year of continuous coverage under his previous health plan.

Answer: D

NEW QUESTION 130

- (Topic 2)

Marlee Whitcomb was covered as a dependent under the group health plan provided by her father's employer. That health plan complied with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. When Ms. Whitcomb married, she c

- A. can continue her group coverage for a period not to exceed 48 months
- B. can continue her group coverage for a period not to exceed 36 months
- C. cannot continue her group coverage, but has the right to convert the group coverage to an individual health plan
- D. can continue her group coverage indefinitely

Answer: B

NEW QUESTION 131

- (Topic 2)

One feature of the Employee Retirement Income Security Act (ERISA) is that it:

- A. Requires self-funded employee benefit plans to pay premium taxes at the state level.
- B. Contains a pre-emption provision, which typically makes the terms of ERISA take precedence over any state laws that regulate employee welfare benefit plans.
- C. Contains strict reporting and disclosure requirements for all employee benefit plans except health plans.
- D. Requires that state insurance laws apply to all employee benefit plans except insured plans.

Answer: B

NEW QUESTION 132

- (Topic 2)

One non-group market segment to which health plans market health plan products is the senior market, which is comprised mostly of persons over age 65 who are eligible for Medicare benefits. One factor that affects a health plan's efforts to market to the

- A. The Centers for Medicare and Medicaid Services (CMS) must approve all marketing materials used by health plans to market health plan products to the Medicare population
- B. managed Medicare plans typically require Medicare beneficiaries to purchase Medigap insurance to supplement gaps in coverage
- C. managed Medicare plans can refuse to cover persons with certain health problems
- D. the CMS prohibits health plans from using telemarketing to market health plan products to the Medicare population

Answer: B

NEW QUESTION 135

- (Topic 2)

Individuals can use HSAs to pay for the following types of health coverage:.

- A. Qualified disability insurance
- B. COBRA continuation coverage.
- C. Medigap coverage (for those over 65).
- D. All of the above.

Answer: B

NEW QUESTION 140

- (Topic 2)

Members who qualify to participate in a health plan's case management program are typically assigned a case manager. During the course of the member's treatment, the case manager is responsible for

- A. Coordinating and monitoring the member's care
- B. Approve
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: B

NEW QUESTION 143

- (Topic 2)

Several marketplace factors helped fuel the movement toward consumer choice. Which one of the following statements is NOT accurate with regard to these factors?

- A. After a period of relative stability, annual growth in private health spending per capita began to increase rapidly in 2002.
- B. During the height of the recent cost upswing, insurance premiums were increasing by more than 13% annually.
- C. Increased utilization was the largest factor contributing to the rise in premiums, accounting for 43% of the increase.
- D. Employer payers began seeking ways to control spiraling utilization rates and provide lower cost health coverage options.

Answer: A

NEW QUESTION 147

- (Topic 2)

Some providers use electronic medical records (EMRs) to document their patients' care in an electronic form. The following statement(s) can correctly be made about EMRs:

- A. EMRs are computerized records of a patient's clinical, demographic, and administrator
- B. B only
- C. Both A and B
- D. Neither A nor B
- E. A only

Answer: D

NEW QUESTION 152

- (Topic 2)

PBM plans operate under several types of contractual arrangements. Under one contractual arrangement, the PBM plan and the employer agree on a target cost per employee per month. If the actual cost per employee per month is greater than the target cost, t

- A. fee-for-service arrangement
- B. risk sharing contract
- C. capitation contract
- D. rebate contract

Answer: B

NEW QUESTION 154

- (Topic 2)

Katrina Lopez is a claims analyst for a health plan that provides a higher level of benefits for services received in-network than for services received out-of-network. Ms. Lopez reviewed a health claim for answers to the following questions:

Question A —

- A. A, B, C, and D
- B. A, B, and D only
- C. B, C, and D only
- D. A and C only

Answer: A

NEW QUESTION 156

- (Topic 2)

One component of information systems used by health plans incorporates membership data and information about provider reimbursement arrangements and analyzes transactions according to contract rules. This information system component is known as

- A. A contract management system
- B. A credentialing system
- C. A legacy system
- D. An interoperable communication system

Answer: A

NEW QUESTION 160

- (Topic 2)

One distinction that can be made between a staff model HMO and a group model HMO is that, in a staff model HMO, participating physicians are Back to Top

- A. Employees of the HMO
- B. Employees of a group practice that has contracted with the HMO
- C. Compensated primarily through capitation
- D. Limited to primary care physicians (PCPs)

Answer: A

NEW QUESTION 163

- (Topic 2)

Pharmacy benefit management (PBM) companies typically interact with physicians and pharmacists by performing such clinical services as physician profiling. Physician profiling from a PBM's point of view involves

- A. ascertaining that physicians in the plan have the necessary and appropriate credentials to prescribe medications
- B. compiling data on physician prescribing patterns and comparing physicians' actual prescribing patterns to expected patterns within select drug categories
- C. monitoring patient-specific drug problems through concurrent and retrospective review
- D. establishing protocols that require physicians to obtain certification of medical necessity prior to drug dispensing

Answer: B

NEW QUESTION 166

- (Topic 2)

One type of physician-only integration model is a consolidated medical group. Typical characteristics of a consolidated medical group include

- A. that it may be a single-specialty or multi-specialty practice
- B. operates in one or a few facilities rather than in many independent offices
- C. achieves economies of scale in the group's integrated operations
- D. all of the above

Answer: D

NEW QUESTION 169

- (Topic 2)

The Ark Health Plan, is currently recruiting providers in preparation for its expansion into a new service area. A recruiter for Ark has been meeting with Dr. Nan Shea, a pediatrician who practices in Ark's new service area, in order to convince her to be

- A. Has ever participated in any quality improvement activities.
- B. Is a participating provider in a health plan that will compete with Ark in its new service area.
- C. Meets the requirements of the Ethics in Patient Referrals Act.
- D. Has had a medical malpractice claim filed or other disciplinary actions taken against her.

Answer: D

NEW QUESTION 172

- (Topic 2)

One way in which health plans differ from traditional indemnity plans is that health plans typically

- A. provide less extensive benefits than those provided under traditional indemnity plans
- B. place a greater emphasis on preventive care than do traditional indemnity plans
- C. require members to pay a percentage of the cost of medical services rendered after a claim is filed, rather than a fixed copayment at the time of service as required by indemnity plans
- D. contain cost-sharing requirements that result in more out-of-pocket spending by members than do the cost-sharing requirements in traditional indemnity plans

Answer: B

NEW QUESTION 175

- (Topic 2)

One device that PBM plans use to manage both the cost and use of pharmaceuticals is a formulary. A formulary is defined as

- A. a listing of drugs classified by therapeutic category or disease class that are considered preferred therapy for a given managed population and that are to be used by a health plan's providers in prescribing medications
- B. a reduction in the price of a particular pharmaceutical obtained by the PBM from the pharmaceutical manufacturer
- C. drugs ordered and delivered through the mail to the PBM's plan members at a reduced cost
- D. an identification card issued by the PBM to its plan members

Answer: A

NEW QUESTION 177

- (Topic 2)

The criteria used to identify and measure healthcare quality are generally divided into three categories: structure, process, and outcomes measures. Structure measures, which relate to the nature and quality of the resources that a health plan has available

- A. length of time patients have to wait at the office to be seen by a provider
- B. percentage of plan physicians who are board-certified
- C. percentage of children receiving immunizations
- D. number of patients contracting an infection in the hospital

Answer: B

NEW QUESTION 182

- (Topic 2)

One of the distinguishing characteristics of healthcare marketing is that many of the markets for health plans are national, not local markets.

- A. True
- B. False

Answer: B

NEW QUESTION 184

- (Topic 3)

The following statements apply to Archer medical savings accounts. Select the answer choice that contains the correct statement.

- A. MSAs were established as a demonstration project under the Medicare Modernization Act.
- B. MSAs were seen as an improvement over FSAs because they are portable, allowing employees to take the funds with them when they change jobs.
- C. The popularity of MSAs has been limited because funds may not be rolled over from year to year.
- D. MSAs are one of the fastest growing Types of Consumer-Directed Health Plans.

Answer: B

NEW QUESTION 189

- (Topic 3)

Certificate of Authority (COA) is subject to:

- A. Contract between health plan and employer
- B. State laws require an HMO not to be organized as a corporation
- C. Compliance with CMS
- D. an HMO may have to be licensed as an HMO or insurance company in each state in which it conducts business

Answer: D

NEW QUESTION 190

- (Topic 3)

The following statements describe individuals who are applying for individual health insurance coverage:

Six months ago, Wilbur Lee lost his health insurance coverage due to a reduction in work hours and has exhausted his coverage under COBRA. Mr. Lee has

- A. both M
- B. Lee and M
- C. Beeker
- D. M
- E. Lee only
- F. M
- G. Beeker only
- H. neither M
- I. Lee nor M
- J. Beeker

Answer: A

NEW QUESTION 195

- (Topic 3)

The Gable MCO sometimes experience-rates small groups by underwriting a number of small groups as if they constituted one large group and then evaluating the experience of

the entire large group. This practice, which allows small groups to take advantage

- A. prospective experience rating
- B. pooling
- C. retrospective experience rating
- D. positioning

Answer: B

NEW QUESTION 196

- (Topic 3)

Salient features of a Health Savings Account include all of the following except

- A. Funding by both employer & the employee
- B. Employer account ownership
- C. Account portability & roll over of funds from year to year
- D. Investment opportunities

Answer: B

NEW QUESTION 200

- (Topic 3)

When the Knoll Company purchased group health coverage from the Castle Health Maintenance Organization (HMO), the agreement between the two parties specified that the plan would be a typical fully funded plan. Because Knoll had been covered under a previous

- A. 230
- B. 270
- C. 220
- D. 180

Answer: C

NEW QUESTION 204

- (Topic 3)

The measures used to evaluate healthcare quality are generally divided into three categories: process, structure and outcomes. An example of a process measure that can be used to evaluate an MCO's performance is the

- A. percentage of board certified physicians within the MCO's network
- B. number of hospital admissions for plan members with certain medical conditions
- C. number of plan members contracting an infection in the hospital
- D. percentage of adult plan members who receive regular medical checkups

Answer: D

NEW QUESTION 206

- (Topic 3)

The National Association of Insurance Commissioners (NAIC) developed the Small Group Model Act to enable small groups to obtain accessible, yet affordable, group health benefits. The model law limits the rate spread, which is the difference between the highest and lowest rates that a health plan charges small groups, to a particular ratio.

According to the Model Act, for example, if the lowest rate an HMO charges a small group for a given set of medical benefits is \$40, then the maximum rate the HMO can charge for the same set of benefits is

- A. \$60
- B. \$80
- C. \$120
- D. \$160

Answer: B

NEW QUESTION 210

- (Topic 3)

The act which requires each group health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage is:

- A. ERISA
- B. COBRA

Answer: B

NEW QUESTION 214

- (Topic 3)

Who will be covered by TRICARE PRIME by applying for enrollment

- A. Active duty military personnel
- B. Active duty Dependents
- C. Retires
- D. B and C

Answer: D

NEW QUESTION 216

- (Topic 3)

The Houston Company, a United States company, offers its eligible employees health insurance coverage through a group health plan. Houston hired the Dallas Company to handle the plan's claim administration and membership services, but Houston is financial

- A. Houston is required to purchase stop-loss insurance to cover its losses under this group health plan
- B. Houston's plan is a self-funded plan
- C. Dallas is the plan's sponsor
- D. Houston's plan is not exempt from any state insurance regulations under ERISA

Answer: B

NEW QUESTION 218

- (Topic 3)

Wellborne HMO provides health-related information to its plan members through an Internet Web site. Laura Knight, a Wellborne plan member, visited Wellborne's Web site to gather uptodate information about the risks and benefits of various treatment option

- A. shared decision making
- B. self-care
- C. preventive care
- D. triage

Answer: A

NEW QUESTION 222

- (Topic 3)

When the Knoll Company purchased group health coverage from the Castle Health Maintenance Organization (HMO), the agreement between the two parties specified that the plan would be a typical fully funded plan. Because Knoll had been covered under a previo

- A. Castle is responsible for paying for all incurred covered benefits
- B. Knoll is solely responsible for guaranteeing claim payments
- C. Knoll makes no premium payments to Castle
- D. Castle has no responsibilities for administering the health plan

Answer: A

NEW QUESTION 223

- (Topic 3)

The National Association of Insurance Commissioners (NAIC) developed the Small Group Model Act to enable small groups to obtain accessible, yet affordable, group health benefits. The model law limits the rate spread, which is the difference between the hi

- A. \$60
- B. \$80
- C. \$120
- D. \$160

Answer: B

NEW QUESTION 224

- (Topic 3)

The following statements are about standards set forth in the Quality Improvement System for Managed Care (QISMC), established by the Health Care Financing Administration (HCFA, now known as the Centers for Medicare and Medicaid Services).

- A. As a result of the Balanced Budget Refinement Act (BBRA), PPOs are required to meet all QISMC quality requirements.
- B. QISMC standards typically do not apply to such Medicare services as mental health or substance abuse services.
- C. Medicaid primary care case manager (PCCM) programs are subject to the same QISMC quality standards and performance measures as are all other Medicare and Medicaid programs.
- D. QISMC standards and guidelines are required for Medicare MCOs, but they are applicable to Medicaid MCOs at the discretion of the individual states.

Answer: D

NEW QUESTION 229

- (Topic 3)

The following statements are about information management in health plans. Three of the statements are true and one statement is false. Select the answer choice containing the FALSE statement:

- A. Health plans find EDI useful for transmitting data among different health plan locations.
- B. EDI is different from eCommerce in the EDI is the transfer of data, typically in batches, while ecommerce is a back-and-forth exchange of information concerning individual transactions.
- C. The majority of health plan eCommerce occurs via proprietary computer networks.
- D. Benefits that health plans can receive from using electronic data interchange.

Answer: C

NEW QUESTION 231

- (Topic 3)

The following statements are about the underwriting function within a health plan. Select the answer choice containing the correct statement.

- A. The underwriting function in a health plan is primarily concerned with ensuring that the group being underwritten does not include any individuals who are likely to have higher than average utilization of medical services.
- B. Compared to a health plan with relaxed underwriting requirements, a similar health plan with very strict underwriting requirements can expect to experience increased healthcare costs and to have significantly higher plan enrollment.
- C. Typically, a health plan guarantees the premium rate for a group health contract for a period of no more than six months.
- D. In order to determine the actual premium to charge a group, a group underwriter typically considers such factors as level of participation, benefits, and the age and gender distribution of group members.

Answer: D

NEW QUESTION 233

- (Topic 3)

Which of the following population groups are eligible for Medicare coverage

- A. Individuals aged 65 & above, regardless of income & medical history
- B. Individuals suffering from end stage renal disease, regardless of age
- C. Individuals aged 50 or above suffering from qualifying disabilities
- D. Both A & B

Answer: D

NEW QUESTION 235

- (Topic 3)

The Meadowcreek Group is an organization comprised of individual physicians and physicians in small group practices. Meadowcreek enters into contracts with health plans, and then Meadowcreek contracts separately with its physician members. In situations w

- A. a group practice without walls (GPWW)
- B. a messenger model
- C. an individual practice association (IPA)
- D. a Physician Practice Management (PPM) company

Answer: C

NEW QUESTION 240

- (Topic 3)

Two MCOs in a single service area divided purchasers into two groups and agreed to each market their products to only one purchaser group. This information indicates that these two MCOs violated antitrust requirements because they engaged in an activity k

- A. horizontal group boycott
- B. horizontal division of markets
- C. a tying arrangement
- D. price fixing

Answer: B

NEW QUESTION 242

- (Topic 3)

The parties to the contractual relationship that provides Castle's group health coverage to Knoll employees are

- A. Castle and Knoll only
- B. Knoll and all covered Knoll employees only
- C. Castle, Knoll, and all covered Knoll employees
- D. Castle and all covered Knoll employees only

Answer: A

NEW QUESTION 246

- (Topic 3)

Utilization data can be transmitted to the health plan manually, by telephone, or electronically. Compared to other methods of data transmittal, manual transmittal is generally

- A. less cumbersome and labor intensive
- B. faster and more accurate
- C. more acceptable to physicians
- D. subject to greater scrutiny by regulatory bodies

Answer: C

NEW QUESTION 247

- (Topic 3)

Which of the following is an example of physician only model of operational integration?

- A. Consolidated medical group
- B. Integrated Delivery System
- C. Medical Foundation
- D. Both B & C

Answer: A

NEW QUESTION 250

- (Topic 3)

The contract between an employer and an insurer or other TPA is called

- A. Claims
- B. Bond
- C. ASO
- D. None of the above

Answer: C

NEW QUESTION 254

- (Topic 3)

What are the characteristics that the underwriter has to consider while determining the premium rate for health insurance coverage for a group?

- A. Level of benefits
- B. Geographic location
- C. Group size
- D. All the above

Answer: D

NEW QUESTION 255

- (Topic 3)

Health plans often carve out specialty services that have one or more of the following characteristics

- A. A poorly defined patient population
- B. High or increasing costs
- C. Appropriate utilization
- D. All the above

Answer: B

NEW QUESTION 258

- (Topic 3)

Keith Murray is a 45 year old chartered accountant & is employed in Livingstone consultancy firm. He has been paying payroll taxes for the past 15 years. Which of the following statements is true regarding Medicare Part A entitlement?

- A. Keith shall be entitled to Part A benefits when he attains 65 years of age
- B. Keith's wife shall be entitled to Part A benefits when she attains 65 years of age
- C. Keith's wife shall be required to pay a monthly premium in order to receive Medicare Part A benefits
- D. Both a & b

Answer: D

NEW QUESTION 259

- (Topic 3)

The following statements describe common types of physician/hospital integrated models:

The Iota Company, which is owned by a group of investors, is a for-profit legal entity that buys entire physician practices, not just the tangible assets of the practice

- A. Iota- physician hospital organization (PHO) Casa- physician practice management (PPM) company.
- B. Iota- physician hospital organization (PHO) Casa- medical foundation.
- C. Iota- physician practice management (PPM) Casa- physician hospital organization (PHO) company.
- D. Iota- medical foundation Casa- management services organization (MSO).

Answer: C

NEW QUESTION 263

- (Topic 3)

Which of the following statements is NOT a requirement for a service to be deemed a 'medically necessary service'?

- A. Furnished in the least intensive type of medical care setting required by the member's condition.
- B. Solely for the convenience of the member.
- C. In accordance with the standards of good medical practice.
- D. Consistent with the symptoms of the member's condition.

Answer: B

NEW QUESTION 268

- (Topic 3)

Which of the following statements about Family and Medical Leave Act (FMLA) is WRONG?

- A. Employers need to maintain the coverage of group health insurance during this period
- B. Employees can take upto 12 weeks of unpaid leave in a 36 month period
- C. Protects people faced with birth/adoption or seriously ill family members
- D. Employers that have > 50 employees need to comply

Answer: B

NEW QUESTION 269

- (Topic 3)

The National Committee for Quality Assurance (NCQA) is a nonprofit organization that accredits health plans and other healthcare organizations. Under the current NCQA accreditation program, a health plan's accreditation score is determined, in part, by pe

- A. is a performance-measurement tool designed to help healthcare purchasers and consumers compare quality offered by different plans.
- B. divides performance measures into 8 domains, and organizes reporting measures under these domains.
- C. is updated annually and measures are changed or new measures added.
- D. all of the above

Answer: D

NEW QUESTION 272

- (Topic 3)

The NAIC designed a small group model law to enable small groups to obtain accessible, yet affordable, group health benefits. Specifically, the model law limits the rate spread. According to this model law, if the lowest rate that an HMO charges a small g

- A. \$80
- B. \$120
- C. \$160
- D. \$240

Answer: C

NEW QUESTION 275

- (Topic 3)

Traditional Medicare includes two parts: Medicare Part A and Medicare Part B. With regard to the ways these parts differ from each other, it is correct to say that Medicare Part A

- A. provides benefits for physicians' professional services, whereas Medicare Part B provides basic hospitalization insurance
- B. is financed through premiums paid by covered persons and from the federal government's general tax revenues, whereas Medicare Part B is funded primarily through a payroll tax imposed on employers and workers
- C. provides 100% coverage for eligible medical expenses, whereas Medicare Part B includes annual deductible and coinsurance provisions
- D. is provided automatically to most eligible persons, whereas Medicare Part B is a voluntary program

Answer: D

NEW QUESTION 276

- (Topic 3)

Which of the following job descriptions best match the job of a telephone triage staff member?

- A. Check patient vitals, write prescriptions, administer drugs.
- B. Greet patients at the door, collect insurance information, schedule appointments, collect payments.

- C. Determine urgency of the condition, notify emergency department, schedule appointments, authorize referrals, provide self-care information.
- D. None of the above.

Answer: C

NEW QUESTION 278

- (Topic 3)

Disease management is typically set up as a voluntary outreach and support program for plan members with certain diseases

- A. Acute
- B. Chronic
- C. None of the above

Answer: B

NEW QUESTION 282

- (Topic 3)

System classifies hundreds of hospital services based on a number of criteria, such as primary and secondary diagnosis, surgical procedures, age, gender, and the presence of complications.

- A. Carve-out
- B. DRG
- C. Global capitation
- D. Partial capitation

Answer: B

NEW QUESTION 286

- (Topic 3)

The following statements describe violations of antitrust legislation:

Situation A - Two health plans in a single service area divided purchasers into two groups and agreed to each market their products to only one purchaser group.
Situation B - A spec

- A. Situation A - horizontal division of markets Situation B - tying arrangement.
- B. Situation A - horizontal division of markets Situation B - price fixing.
- C. Situation A - horizontal group boycott Situation B - tying arrangement.
- D. Situation A - horizontal group boycott Situation B - price fixing.

Answer: A

NEW QUESTION 291

- (Topic 3)

The following statements describe corporate transactions: Transaction A – An MCO acquired another MCO.

Transaction B – A group of providers formed an organization to carry out billings, collections, and contracting with MCOs for the entire group of provide

- A. A and C only
- B. A, B, and C
- C. B and C only
- D. A and B only

Answer: A

NEW QUESTION 292

- (Topic 3)

Ancillary services are

- A. General medical care that is provided directly to a patient without referral from another physician
- B. Also known as secondary care (Medical care that is delivered by specialist)
- C. Supplemental services needed as part of providing other care
- D. Outpatient services provided by a hospital or other qualified ambulatory care facility which require inpatient stay

Answer: C

NEW QUESTION 294

- (Topic 3)

Which of the following people would be considered part of the individual market segment?

- A. John is eligible for Medicare.
- B. Julie has coverage through an employer group.
- C. James works for an employer that does not offer health coverage.
- D. Jenny is eligible for Medicaid.

Answer: C

NEW QUESTION 298

- (Topic 3)

The following statements apply to flexible spending arrangements. Select the answer choice that contains the correct statement.

- A. FSAs were designed to help increase health insurance coverage among self-employed individuals.
- B. Only employers may contribute funds to FSAs.
- C. The popularity of FSAs has been limited because funds may not be rolled over from year to year.
- D. year to year.
- E. A popular feature of FSAs is their portability, which allows employees to take the funds with them when they change jobs.

Answer: C

NEW QUESTION 300

- (Topic 3)

Exclusive provider organizations (EPO) is similar and operates like a PPO in administration, structure but however in an EPO an out-of-network care is

- A. Partially Covered
- B. Covered with more out of pocket
- C. Not covered

Answer: C

NEW QUESTION 303

- (Topic 3)

The Hill Health Plan designed a set of benefits that it packaged in the form of a PPO product. Hill then established a pricing structure that allowed its product to compete in the small group market, and it developed advertising designed to inform potential

- A. The number of specialists in Hill's network of providers.
- B. The price for the PPO product.
- C. Hill's ability to report utilization data.
- D. Hill's use of brokers to market its PPO product.

Answer: B

NEW QUESTION 306

- (Topic 3)

Abbreviation for JCAHO is

- A. Joint Coordination on Accreditation of Healthcare Organizations
- B. Joint Commission on Accreditation of Healthcare Organizations
- C. Joint Corporation on Accreditation of Healthcare Organizations
- D. Joint Connection on Accreditation of Healthcare Organizations

Answer: B

NEW QUESTION 309

- (Topic 3)

Which of the following is NOT a factor that is used by MCOs to determine which services will undergo utilization review?

- A. Cost per procedure
- B. Concurrent review
- C. Cost of review
- D. Access requirements

Answer: D

NEW QUESTION 314

- (Topic 3)

The Stateside Health Plan uses the following outcomes measures to evaluate the quality of its diabetes disease management program.

Measure A: Incidence of foot ulcers among long-term diabetes patients Measure B: Ability of long-term diabetes patients to m

- A. Measure A clinical status Measure B patient perception
- B. Measure A clinical status Measure B functional status
- C. Measure A functional status Measure B patient perception
- D. Measure A functional status Measure B clinical status

Answer: B

NEW QUESTION 318

- (Topic 3)

Calculate the hospital bed days per 1000 members for the Month to date (MTD) on 25 April, with plan membership of 25,000 and total gross hospital bed days in MTD is 300 for an XYZ Health plan?

- A. 175
- B. 480
- C. 1000
- D. 365

Answer: A

NEW QUESTION 323

- (Topic 3)

Maternity management programs are commonly included in?

- A. Screening Programs
- B. Health promotion Programs
- C. Immunization programs

Answer: C

NEW QUESTION 328

- (Topic 3)

The HMO Act of 1973 was significant in that the Act

- A. mandated certain requirements that all HMOs had to meet in order to conduct business
- B. required that all HMOs be licensed as insurance companies
- C. offered HMOs federal financial assistance through grants and loans, and provided access to the employer-based insurance market
- D. encouraged the use of pre-existing condition exclusion provisions in all HMO contracts

Answer: C

NEW QUESTION 331

- (Topic 3)

The agreement by two or more independent competitors on the prices or fees that they will charge for services is known as:

- A. Tying arrangements
- B. Price fixing
- C. Horizontal group boycott
- D. Horizontal division of markets

Answer: B

NEW QUESTION 332

- (Topic 3)

Which of the following is NOT a preventive care initiative often used by health plans?

- A. Screening for high blood pressure
- B. Maternity management programs
- C. Vaccines
- D. Physical therapy

Answer: D

NEW QUESTION 333

- (Topic 3)

To achieve widespread use of electronic data interchange (EDI) in the healthcare industry, all entities within the industry need to agree on industry standards regarding the information format and software to be used. Several organizations are making cont

- A. Computer-based Patient Records Institute (CPRI)
- B. American National Standards Institute (ANSI)
- C. American Health Information Management Association (AHIMA)
- D. American Medical Association (AMA)

Answer: B

NEW QUESTION 336

- (Topic 3)

The Hill Health Plan designed a set of benefits that it packaged in the form of a PPO product. Hill then established a pricing structure that allowed its product to compete in the small group market, and it developed advertising designed to inform potential

- A. An indemnity wraparound plan
- B. A self-funded plan
- C. An aggregate stop-loss plan
- D. A fully funded plan

Answer: D

NEW QUESTION 341

- (Topic 3)

Using a code for a procedure or diagnosis that is more complex than the actual procedure or diagnosis and that results in higher reimbursement to the provider is called

- A. Coding error

- B. Overcharging
- C. Upcoming
- D. Unbundling

Answer: C

NEW QUESTION 342

- (Topic 3)

The Mosaic health plan uses a typical electronic medical record (EMR) to document the medical care its members receive. One characteristic of Mosaic's EMR is that it:

- A. Does not provide any clinical decision support for Mosaic's providers.
- B. Is designed to supply information at the site of care.
- C. Contains a Mosaic member's clinical data only.
- D. Is organized by the type of treatment or by provider.

Answer: B

NEW QUESTION 343

- (Topic 3)

The following statements describe healthcare services delivered to health plan members by plan providers. Select the statement that describes a service that would most likely require utilization review and authorization.

- A. Adele Farnsworth visited a dermatologist to have a mole removed from her arm.
- B. Jonathan Lang underwent an electrocardiogram (EKG) during an office visit with his cardiologist.
- C. Corinne Maxwell underwent physical therapy after being hospitalized for hip replacement surgery.
- D. Jose Redriguez, a 70-year-old Medicare patient, received a flu shot as part of his annual physical examination.

Answer: C

NEW QUESTION 344

- (Topic 3)

Bill the member for the balance of the fee above the maximum allowable amount under the fee schedule reimbursement method

- A. UCR fee
- B. Capitation fee
- C. Balance bill
- D. Discounted fee-for-service

Answer: C

NEW QUESTION 347

- (Topic 3)

The Hill Health Plan designed a set of benefits that it packaged in the form of a PPO product. Hill then established a pricing structure that allowed its product to compete in the small group market, and it developed advertising designed to inform potential

- A. A decision as to which exclusions or limitations would apply for this product.
- B. A decision as to how to establish the network of participating providers for this product
- C. A determination of the level at which this product would cover out-of-network services.
- D. All of the above.

Answer: D

NEW QUESTION 351

- (Topic 3)

The nature of the claims function within health plans varies by type of plan and by the compensation arrangement that the plan has made with its providers. For example, it is generally correct to say that, in a

- A. Preferred provider organization (PPO), the
- B. Both A and B
- C. A only
- D. B only
- E. Neither A nor B

Answer: A

NEW QUESTION 354

- (Topic 3)

Which of the following factors have contributed to the limited popularity of FSAs

- A. "Use it or lose it" provision
- B. Lack of portability
- C. Only self-employed individuals are eligible for establishing FSAs.
- D. Both A & B

Answer: D

NEW QUESTION 358

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