

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)

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. Remedy provision

Answer: A

NEW QUESTION 5

- (Topic 1)

The provider contract between the Regal Health Plan and Dr. Caroline Quill contains a type of termination clause known as termination without cause. One true statement about this clause is that it

- A. Requires Regal to send a report to the appropriate accrediting agency if the health plan terminates D
- B. Quill's contract without cause
- C. Requires that Regal must base its decision to terminate D
- D. Quill's contract on clinical criteria only
- E. Allows either Regal or D
- F. Quill to terminate the contract at any time, without any obligation to provide a reason for the termination or to offer an appeals process
- G. Allows Regal to terminate D
- H. Quill's contract at the time of contract renewal only, without any obligation to provide a reason for the termination or to offer an appeals process

Answer: C

NEW QUESTION 6

- (Topic 1)

If the Oconee Health Plan reimburses its specialty care physicians (SCPs) under a typical retainer method, then Oconee pays SCPs

- A. Aseparate amount for each service provided, and the payment amount is based solely on a resource-based relative value scale (RBRVS)
- B. Aspecified fee that remains the same regardless of how much or how little time or effort is spent on the medical service performed
- C. Aset amount each month, and Oconee reconciles its payment at periodic intervals on the basis of actual utilization
- D. Aset amount of cash equivalent to a defined time period's expected reimbursable charges

Answer: C

NEW QUESTION 7

- (Topic 1)

A provider contract describes the responsibilities of each party to the contract. These responsibilities can be divided into provider responsibilities, health plan responsibilities, and mutual obligations. Mutual obligations typically include

- A. provisions for marketing the plan's product
- B. payment arrangements between the plan and the provider
- C. verification of the plan's eligibility to do business
- D. management of the contents of members' medical records

Answer: B

NEW QUESTION 8

- (Topic 1)

Health plans often negotiate compensation arrangements that transfer some or all of the financial risk associated with delivering healthcare services to network providers. The following statements are about these compensation arrangements. Select the answer choice containing the correct statement.

- A. A per diem system typically places a healthcare facility at risk for controlling utilization and costs internally.
- B. One likely reason that a health plan would use a fee schedule system to compensate providers is that this system transfers most of the financial risk to the provider.
- C. Under a salary system, a provider assumes no service risk.
- D. The use of a FFS or a salary system allows a health plan to transfer a greater proportion of financial risk to providers than does the use of capitation.

Answer: A

NEW QUESTION 9

- (Topic 1)

The following statements are about incentive programs used for providers. Select the answer choice containing the correct statement.

- A. Risk pools based on aggregate provider performance eliminate problems associated with "free riders."
- B. A hospital bonus pool is usually split between the health plan and the PCPs.
- C. Bonus pools based on the performance of specific providers are usually easier to administer than those based on the performance of the plan as a whole.
- D. For providers, withhold arrangements eliminate the risk of losing base income.

Answer: B

NEW QUESTION 10

- (Topic 1)

Salvatore Arris is a member of the Crescent Health Plan, which provides its members with a full range of medical services through its provider network. After suffering from debilitating headaches for several days, Mr. Arris made an appointment to see Neal Prater, a physician's assistant in the Crescent network who provides primary care under the supervision of physician Dr. Anne Hunt. Mr. Prater referred Mr. Arris to Dr. Ginger Chen, an ophthalmologist, who determined that Mr. Arris' symptoms were indicative of migraine headaches. Dr. Chen prescribed medicine for Mr. Arris, and Mr. Arris had the prescription filled at a pharmacy with which Crescent has contracted. The pharmacist, Steven Tucker, advised Mr. Arris to take the medicine with food or milk. In this situation, the person who functioned as an ancillary service provider is

- A. M
- B. Prater
- C. D
- D. Hunt
- E. D
- F. Chen
- G. M
- H. Tucker

Answer: D

NEW QUESTION 10

- (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 14

- (Topic 1)

Open panel health plans can contract with individual providers or with various provider groups when developing their networks. The following statements are about factors that an open panel health plan might consider in contracting with different types of provider organizations. Select the answer choice that contains the correct statement.

- A. One limitation of contracting with multispecialty groups is that a health plan obtains only specialty consultants, but not PCPs.
- B. One benefit to a health plan in contracting with an integrated delivery system (IDS) is the ability to have a network in rapid order and to enter into a new market or one that is already competitive.
- C. A health plan that contracts with an individual practice association (IPA) has a greater ability to select and deselect individual physicians than when contracting

directly with the providers.

D. A health plan that contracts with an IDS is able to eliminate the antitrust risk that exists when contracting with an IPA.

Answer: B

NEW QUESTION 19

- (Topic 1)

From the following answer choices, choose the type of clause or provision described in this situation.

The Idlewilde Health Plan includes in its provider contracts a clause or provision that allows the terms of the contract to renew unchanged each year.

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

Answer: C

NEW QUESTION 23

- (Topic 1)

Provider panels can be either narrow or broad. Compared to a similarly sized health plan that uses a broad provider panel, a health plan that uses a narrow provider panel most likely can expect to

- A. Experience higher contracting costs
- B. Encounter increased difficulty in utilization management
- C. Have to charge higher health plan premiums
- D. Experience lower provider relations costs

Answer: D

NEW QUESTION 27

- (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. AWP's 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 28

- (Topic 1)

In developing a provider network in an large city with a high concentration of young families, the Gypsum Health Plan has set goals focused on the needs of that particular market. The following statements are about this situation. Three of the statements are true, and one of the statements is false. Select the answer choice that contains the FALSE statement.

- A. Gypsum should attempt to recruit providers who offer extended office hours.
- B. Gypsum can use the cost-effectiveness of its own existing networks as a benchmark for its cost-savings goals in this market.
- C. Gypsum will most likely attempt to contract with HMOs.
- D. Gypsum most likely should set lower cost-savings goals in this market than it would in a rural market with few young families.

Answer: D

NEW QUESTION 32

- (Topic 1)

The Festival Health Plan is in the process of recruiting physicians for its provider network. Festival requires its network physicians to be board certified. The following individuals are provider applicants whose qualifications are being considered:

Applicant 1 has completed his surgical residency, and he recently passed a qualifying examination in his field.

Applicant 2 has completed her residency in dermatology, and she is scheduled to take qualifying examinations in the next Six months.

Applicant 3 completed his residency in pediatric medicine six years ago, but he has not yet passed a qualifying examination in his field.

With regard to these applicants, it can correctly be stated that only

- A. Applicants 1 and 2 are board certified
- B. Applicants 2 and 3 are board certified
- C. Applicant 1 is board certified
- D. Applicant 3 is board certified

Answer: C

NEW QUESTION 33

- (Topic 1)

The Gladspell HMO has contracted with the Ellysium Hospital to provide subacute care to its plan members. Gladspell pays Ellysium by using a per diem reimbursement method.

If the Ellysium subacute care unit is typical of most hospital-based subacute skilled nursing units, then this unit could be used for patients who no longer need to be in the hospital's acute care unit but who still require

- A. Daily medical care and monitoring
- B. Regular rehabilitative therapy
- C. Respiratory therapy
- D. All of the above

Answer: D

NEW QUESTION 38

- (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 43

- (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 44

- (Topic 1)

Dr. Eve Barlow is a specialist in the Amity Health Plan's provider network. Dr. Barlow's provider contract with Amity contains a typical most-favored-nation arrangement. The purpose of this arrangement is to

- A. Require D
- B. Barlow and Amity to use arbitration to resolve any disputes regarding the contract
- C. Specify that the contract is to be governed by the laws of the state in which Amity has its headquarters
- D. Require D
- E. Barlow to charge Amity her lowest rate for a medical service she has provided to an Amity plan member, even if the rate is lower than the price negotiated in the contract
- F. State that the contract creates an employment or agency relationship, rather than an independent contractor relationship, between D
- G. Barlow and Amity

Answer: C

NEW QUESTION 45

- (Topic 1)

The method that the Autumn Health Plan uses for reimbursing dermatologists in its provider network involves paying them out of a fixed pool of funds that is actuarially determined for this specialty. The amount of funds that Autumn allocates to dermatologists is based on utilization and costs of services for that discipline.

Under this reimbursement method, a dermatologist who is under contract to Autumn accumulates one point for each new referral made to the specialist by Autumn's PCPs. If the referral is classified as complicated, then the dermatologist receives 1.5 points. The value of Autumn's dermatology services fund for the first quarter was \$15,000. During the quarter, Autumn's PCPs made 90 referrals, and 20 of these referrals were classified as complicated.

In determining the first quarter payment to dermatologists, Autumn would accurately calculate the value of each referral point to be

- A. \$111.11
- B. \$125.00
- C. \$150.00
- D. \$166.67

Answer: C

NEW QUESTION 48

- (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 50

- (Topic 1)

The Justice Health Plan is eligible to submit reportable actions against medical practitioners to the National Practitioner Data Bank (NPDB). Justice is considering whether it should report the following actions to the NPDB:

Action 1—A medical malpractice insurer made a malpractice payment on behalf of a dentist in Justice's network for a complaint that was settled out of court.

Action 2—Justice reprimanded a PCP in its network for failing to follow the health plan's referral procedures.

Action 3—Justice suspended a physician's clinical privileges throughout the Justice network because the physician's conduct adversely affected the welfare of a patient.

Action 4—Justice censured a physician for advertising practices that were not aligned with Justice's marketing philosophy.

Of these actions, the ones that Justice most likely must report to the NPDB include Actions

- A. 1, 2, and 3 only
- B. 1 and 3 only
- C. 2 and 4 only
- D. 3 and 4 only

Answer: B

NEW QUESTION 53

- (Topic 1)

The Gladspell HMO has contracted with the Ellysium Hospital to provide subacute care to its plan members. Gladspell pays Ellysium by using a per diem reimbursement method.

If Gladspell's per diem contract with Ellysium is typical, then the per diem payment will cover such medical costs as

- A. Laboratory tests
- B. Respiratory therapy
- C. Semiprivate room and board
- D. Radiology services

Answer: C

NEW QUESTION 56

- (Topic 1)

In the paragraph below, two statements each contain a pair of terms enclosed in parentheses. Determine which term correctly completes each statement. Then select the answer choice that contains the two terms you have chosen.

A formulary lists the drugs and treatment protocols that are considered to be the preferred

therapy for a given managed population. The Fairfax Health Plan uses the type of formulary which covers drugs that are on its preferred list as well as drugs that are not on its preferred list. This information indicates that Fairfax uses the (closed / open) formulary method. In using the formulary approach to pharmacy benefits management, Fairfax most likely experiences (higher / lower) costs for its members' prescription drugs than it would if it did not use a formulary.

- A. closed / higher
- B. closed / lower
- C. open / higher
- D. open / lower

Answer: D

NEW QUESTION 60

- (Topic 1)

Determine whether the following statement is true or false:

The NCQA has established a Physician Organization Certification (POC) program for the purpose of certifying medical groups and independent practice associations for delegation of certain NCQA standards, including data collection and verification for credentialing and recredentialing.

- A. True
- B. False

Answer: A

NEW QUESTION 62

- (Topic 1)

With respect to contractual provisions related to provider-patient communications, nonsolicitation clauses prohibit providers from

- A. Encouraging patients to switch from one health plan to another
- B. Disclosing confidential information about the health plan's reimbursement structure
- C. Dispersing confidential financial information regarding the health plan
- D. Discussing alternative treatment plans with patients

Answer: A

NEW QUESTION 64

- (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 67

- (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 lower-income 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 72

- (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 76

- (Topic 1)

The provider contract between the Ocelot Health Plan and Dr. Enos Zorn, one of the health plan's participating providers, is a brief contract which includes, by reference, an Ocelot provider manual. This manual contains much of the information found in Ocelot's comprehensive provider contracts. The following statements are about Dr. Zorn's provider contract. Select the answer choice containing the correct statement.

- A. All statements in the provider contract shall be deemed to be warranties, because all statements of facts contained in the contract must be true only in those respects material to the contract.
- B. Because the provider manual is part of the contract, Ocelot must make sure that its provider manual is comprehensive and up-to-date.
- C. Because the provider contract is a brief contract, Ocelot most likely is prohibited from amending the contract unilaterally, even if it gives D
- D. Zorn advance notice of its intent to amend the contract.
- E. Areas that should be covered in the provider manual, and not in the body of the contract, include any specific legal issues relevant to the contract.

Answer: B

NEW QUESTION 81

- (Topic 1)

One important aspect of network management is profiling, or provider profiling. Profiling is most often used to

- A. measure the overall performance of providers who are already participants in the network
- B. assess a provider's overall satisfaction with a plan's service protocols and other operational areas
- C. verify a prospective provider's professional licenses, certifications, and training
- D. familiarize a provider with a plan's procedures for authorizations and referrals

Answer: A

NEW QUESTION 86

- (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 88

- (Topic 1)

The Medea Clinic is a network provider for Delphic Healthcare. Delphic transferred the contract it held with Medea to the Elixir HMO, an entity that was not party to

the original contract. The process by which Delphic transferred the contract it held with Medea to Elixir is known as

- A. Most-favored- nation arrangement
- B. Alimit on action
- C. Aconsideration
- D. An assignment

Answer: D

NEW QUESTION 90

- (Topic 1)

During the credentialing process, a health plan verifies the accuracy of information on a prospective network provider's application. One true statement regarding this process is that the health plan

- A. has a legal right to access a prospective provider's confidential medical records at any time
- B. must limit any evaluations of a prospective provider's office to an assessment of quantitative factors, such as the number of double-booked appointments a physician accepts at the end of each day
- C. is prohibited by law from conducting primary verification of such data as a prospective provider's scope of medical malpractice insurance coverage and federal tax identification number
- D. must complete the credentialing process before a provider signs the network contract or must include in the signed document a provision that the final contract is contingent upon the completion of the credentialing process

Answer: D

NEW QUESTION 91

- (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 95

- (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 99

- (Topic 1)

The Gardenia Health Plan has a national reputation for quality care. When Gardenia entered a new market, it established a preferred provider organization (PPO), a health maintenance organization (HMO), and a point-of-service product (POS) to serve the plan members in this market. All of the providers included in the HMO or the POS are included in the broader provider panel of the PPO. The POS will be a typical two-level POS that offers a cost-based incentive plans for PCPs, and the HMO is a typical staff model HMO.

The network strategy that Gardenia is using to establish its range of healthcare plans is known as the

- A. network-within-a-network approach
- B. gatekeeper approach
- C. tiered network approach
- D. preferred tier approach

Answer: A

NEW QUESTION 103

- (Topic 1)

The following statements are about the specialist component of a provider panel. Select the answer choice containing the correct statement.

- A. Ideally, a health plan should have every specialist category represented on its provider panel with appropriate geographic distribution.
- B. Most specialist contracts do not ensure the provider's adherence to UM policies set up by the health plan.
- C. No-balance-billing clauses are not desirable in health plan contracts with specialists.
- D. In geographic regions where there is a shortage of PCPs, a health plan is not permitted to contract with specialists to perform primary care services, even for patients with chronic conditions.

Answer: A

NEW QUESTION 107

- (Topic 1)

The following statements are about the inclusion of unified pharmacy benefits in health plan healthcare packages. Select the answer choice containing the correct statement.

- A. When pharmacy benefits management is incorporated into an health plan's operations as a unified benefit, the health plan establishes pharmacy networks, but a pharmacy benefits management (PBM) company manages their operations.
- B. Under a unified pharmacy benefit, an health plan cannot use mail-order services to provide drugs to its members.
- C. Compared to programs that do not manage pharmacy benefits in-house, unified pharmacy benefits programs typically give health plans more control over patient access to prescription drugs.
- D. Compared to programs that do not manage pharmacy benefits in-house, unified pharmacy benefits programs make drug therapy interventions for plan members more difficult.

Answer: C

NEW QUESTION 112

- (Topic 1)

Promise, Inc., a corporation that specializes in cancer services, employs its physicians and support staff and provides facilities and ancillary services for cancer patients. Promise has contracted with the Cordelia Health Plan to provide all specialty services for Cordelia plan members who are undergoing cancer treatment. In return, Promise receives a capitated amount from Cordelia. Promise is an example of a type of specialty services organization known as a

- A. Specialty IPA
- B. Disease management company
- C. Single specialty management specialist
- D. Specialty network management company

Answer: B

NEW QUESTION 115

- (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 118

- (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 123

- (Topic 2)

The provider contract that the Canyon health plan has with Dr. Nicole Enberg specifies that she cannot sue or file any claims against a Canyon plan member for covered services, even if Canyon becomes insolvent or fails to meet its financial obligations. The contract also specifies that Canyon will compensate her under a typical discounted fee-for-service (DFFS) payment system.

During its recredentialing of Dr. Enberg, Canyon developed a report that helped the health plan determine how well she met Canyon's standards. The report included cumulative performance data for Dr. Enberg and encompassed all measurable aspects of her performance. This report included such information as the number of hospital admissions Dr. Enberg had and the number of referrals she made outside of Canyon's provider network during a specified period. Canyon also used process measures, structural measures, and outcomes measures to evaluate Dr. Enberg's performance.

Canyon used a process measure to evaluate the performance of Dr. Enberg when it evaluated whether:

- A. D
- B. Enberg's young patients receive appropriate immunizations at the right ages
- C. D
- D. Enberg conforms to standards for prescribing controlled substances

- E. The condition of one of D
- F. Enberg's patients improved after the patient received medical treatment from D
- G. Enberg
- H. D
- I. Enberg's procedures are adequate for ensuring patients' access to medical care

Answer: A

NEW QUESTION 128

- (Topic 2)

If a member of the Green Health Plan reasonably believes that a provider in Green's provider network was acting as Green's employee or agent while providing negligent care, then the member may have cause to bring action against the health plan. This legal concept is known as vicarious liability. Steps that Green can take to reduce its exposure to vicarious liability claims include:

- A. Placing restrictions on provider-member communication involving treatment decisions.
- B. Implementing risk management and quality assurance programs for its provider network.
- C. Including in its provider agreements and marketing and membership literature a statement that members of the Green provider network are not independent contractors.
- D. All of the above.

Answer: B

NEW QUESTION 132

- (Topic 2)

The following statements are about the organization of network management functions of health plans. Select the answer choice containing the correct response:

- A. Compared to a large health plan, a small health plan typically has more integration among its network management activities and less specialization of roles.
- B. It is usually more efficient to have a large health plan's provider relations representatives located in the health plan's corporate headquarters rather than based in regional locations that are close to the provider offices the representatives cover.
- C. An health plan's provider relations representatives are usually responsible for conducting an initial orientation of providers and educating providers about health plan developments, rather than recruiting and assisting with the selection of new providers.
- D. In general, a health plan that uses a centralized approach for some of its network management activities should not use a decentralized approach for other network management activities.

Answer: A

NEW QUESTION 133

- (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 137

- (Topic 2)

With regard to the compensation of dental care providers in a managed dental care system, it is correct to state that, typically:

- A. dental PPOs compensate dentists on a capitated basis
- B. group model dental HMOs (DHMOs) compensate general dental practitioners on a salaried basis
- C. independent practice association (IPA)-model dental HMOs (DHMOs) capitate general dental practitioners
- D. staff model dental HMOs (DHMOs) compensate dentists on an FFS basis

Answer: C

NEW QUESTION 140

- (Topic 2)

The following statements are about Medicaid health plan entities. Select the answer choice containing the correct statement:

- A. To keep Medicaid enrollment costs as low as possible, states typically prohibit the use of third-party entities known as enrollment brokers to handle the recruitment and enrollment of Medicaid recipients in health plan plans
- B. Primary care case managers (PCCMs) are individuals who contract with a state's Medicaid agency to provide primary care services mainly to urban areas.
- C. Typically, Medicaid beneficiaries must be given a choice between at least two health plan entities.
- D. Medicaid health plan entities are responsible for providing primary coverage for all dually-eligible beneficiaries.

Answer: C

NEW QUESTION 143

- (Topic 2)

In order to evaluate and manage the performance of individual providers in its provider network, the Quorum Health Plan implemented a program that focuses on

identifying the best and worst outcomes and utilization patterns of its providers. This program is also designed to develop and implement strategies such as treatment protocols and practice guidelines to improve the performance of Quorum's providers. This information indicates that Quorum implemented a program known as:

- A. An integrated delivery system (IDS)
- B. A coordinated care program
- C. Ostensible agency
- D. Continuous quality improvement (CQI)

Answer: D

NEW QUESTION 145

- (Topic 2)

The Aztec Health Plan has a variety of organizational committees related to quality and utilization management. These committees include the medical advisory committee, the credentialing committee, the utilization management committee, and the quality management committee. Of these committees, the one that most likely is responsible for providing oversight of Aztec's inpatient concurrent review process is the:

- A. medical advisory committee
- B. credentialing committee
- C. utilization management committee
- D. quality management committee

Answer: C

NEW QUESTION 149

- (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 150

- (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 154

- (Topic 2)

Medicaid is a joint federal and state program that provides healthcare coverage for low- income, medically needy, and disabled individuals. Under the terms of this joint sponsorship, the

- A. Federal government is responsible for making all claim payments
- B. Federal government is responsible for determining the basic benefits that must be provided to eligible Medicaid beneficiaries
- C. State governments are responsible for setting minimum standards regarding eligibility, benefit coverage, and provider participation and reimbursement
- D. State governments are responsible for establishing overall regulation of the Medicaid program

Answer: B

NEW QUESTION 155

- (Topic 2)

Stop-loss insurance is designed to protect physicians who face substantial financial risk as a result of physician incentive plans. Medicare+Choice health plans must ensure that a physician has adequate stop-loss protection if the

- A. physician has a patient panel that exceeds 25,000 patients
- B. physician receives a bonus that is based solely on quality of care, patient satisfaction, or physician participation
- C. difference between the physician's maximum potential payments and his or her minimum potential payments is less than 25% of the maximum potential payments
- D. physician is subject to a withhold that is greater than 25% of his or her potential payments

Answer: D

NEW QUESTION 159

- (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 161

- (Topic 2)

The provider contract that the Danube Health Plan has with the Viola Home Health Services Organization states that Danube will use a typical flat rate reimbursement arrangement to compensate Viola for the skilled nursing services it provides to Danube's plan members. A portion of the contract's reimbursement schedule is shown below:

Home Health Licensed Practical Nurse (LPN): \$45 per visit or \$90 per diem Home Health Registered Nurse (RN): \$50 per visit or \$110 per diem

Last month, an LPN from Viola visited a Danube plan member and provided 1½ hours of home healthcare, and an RN from Viola visited another Danube plan member and provided 7 hours of home healthcare. The following statement(s) can correctly be made about Danube's payment to Viola for these services:

- A. Danube most likely owes \$90 for the LPN's skilled nursing services and \$110 for the RN's skilled nursing services.
- B. Danube's payment amount could be different from the amount called for in the reimbursement schedule if the level of care provided to one of these plan members was significantly different from the level of care normally provided by Viola's RNs and LPNs.
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: C

NEW QUESTION 165

- (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 167

- (Topic 2)

Reimbursement for prescription drugs and services in a third-party prescription drug plan typically follows one of two approaches: a reimbursement approach or a service approach. One true statement about these approaches is that:

- A. Payments under the reimbursement method typically are not subject to any copayment or deductible requirements
- B. Payments under the reimbursement approach are typically based on a structured reimbursement schedule rather than on usual, customary, and reasonable (UCR) charges
- C. Most major medical plans follow a service approach
- D. Most current health plan prescription drug plans are service plans

Answer: D

NEW QUESTION 171

- (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 175

- (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 177

- (Topic 2)

The BBA of 1997 specifies the ways in which a Medicare+Choice plan can establish and use provider networks. A Medicare+Choice plan that operates as a private fee for service (PFFS) plan is allowed to

- A. limit the size of its network to the number of providers necessary to meet the needs of its enrollees
- B. require providers to accept as payment in full an amount no greater than 115% of the Medicare payment rate
- C. refuse payment to non-network providers who submit claims for Medicare-covered expenses
- D. shift all risk for Medicare-covered services to network providers

Answer: B

NEW QUESTION 178

- (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 181

- (Topic 2)

The provider contract that Dr. Lorena Chau has with the Fiesta Health Plan includes an evergreen clause. The purpose of this clause is to:

- A. Allow Fiesta to change or amend the contract without D
- B. Chau's approval as long as the modifications are made in order to comply with new legal and regulatory requirements
- C. Prohibit D
- D. Chau from encouraging her patients to switch from Fiesta to another health plan
- E. Prohibit D
- F. Chau from encouraging her patients to switch from Fiesta to another health plan
- G. Assure that D
- H. Chau provides Fiesta members with healthcare services in a timely manner appropriate to the member's medical condition

Answer: C

NEW QUESTION 184

- (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.

Mr. Pelham's group health insurance plan and workers' compensation both provide benefits to cover expenses incurred as a result of illness or injury. However, unlike traditional group insurance coverage, workers' compensation

- A. Provides reimbursement for lost wages
- B. Requires employees who suffer a work-related illness or injury to obtain care from specified network providers
- C. Covers all injuries and illnesses, regardless of their cause
- D. Requires employees to share the cost of treatment through deductible, coinsurance, and benefit limits

Answer: A

NEW QUESTION 188

- (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 the provider'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 191

- (Topic 2)

A health plan has several options for delivering pharmacy services to its subscribers. Each option has potential advantages to a health plan. An advantage to a health plan of using:

- A. performance-based open networks is that they tend to increase participation in the pharmacy network.
- B. closed networks is that they improve the health plan's ability to set standards and implement cost-control programs for pharmacy services.
- C. customized networks is that they typically are inexpensive to operate.
- D. open networks is that they tend to improve the health plan's ability to control pharmaceutical costs.

Answer: B

NEW QUESTION 196

- (Topic 2)

The provider contract that Dr. Bijay Patel has with the Arbor Health Plan includes a no- balance-billing clause. The purpose of this clause is to:

- A. prohibit D
- B. Patel from collecting payments from Arbor plan members for medical services that he provided them, even if the services are explicitly excluded from the benefit plan
- C. allow D
- D. Patel to bill patients for services only if the services are considered to be medically necessary
- E. establish the guidelines used to determine if Arbor is the primary payor of benefits in a situation in which an Arbor plan member is covered by more than one health plan
- F. require D
- G. Patel to accept Arbor's payment as payment in full for medical services that he provides to Arbor plan members

Answer: D

NEW QUESTION 198

- (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. A reduction in the market penetration of HMO and point-of-service (POS) products.
- D. A reduction in the frequency of performance-based reimbursement of providers.

Answer: A

NEW QUESTION 199

- (Topic 2)

The provider contract that the Canyon health plan has with Dr. Nicole Enberg specifies that she cannot sue or file any claims against a Canyon plan member for covered services, even if Canyon becomes insolvent or fails to meet its financial obligations. The contract also specifies that Canyon will compensate her under a typical discounted fee-for-service (DFFS) payment system.

During its recredentialing of Dr. Enberg, Canyon developed a report that helped the health plan determine how well she met Canyon's standards. The report included cumulative performance data for Dr. Enberg and encompassed all measurable aspects of her performance. This report included such information as the number of hospital admissions Dr. Enberg had and the number of referrals she made outside of Canyon's provider network during a specified period. Canyon also used process measures, structural measures, and outcomes measures to evaluate Dr. Enberg's performance.

The report that helped Canyon determine how well Dr. Enberg met the health plan's standards is known as:

- A. An encounter report
- B. An external standards report
- C. A provider profile
- D. An access to care report

Answer: C

NEW QUESTION 201

- (Topic 2)

CMS Medicare+Choice regulations include a provision that allows health plans to deny benefits for any services the health plan objects to on moral or religious grounds. The provision that exempts health plans from providing such services is known as

- A. a conscience protection exception
- B. a hold harmless clause
- C. a medical necessity determination
- D. an intermediate sanction

Answer: A

NEW QUESTION 204

- (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 205

- (Topic 2)

The provider contract that the Canyon health plan has with Dr. Nicole Enberg specifies that she cannot sue or file any claims against a Canyon plan member for covered services, even if Canyon becomes insolvent or fails to meet its financial obligations. The contract also specifies that Canyon will compensate her under a typical discounted fee-for-service (DFFS) payment system.

During its recredentialing of Dr. Enberg, Canyon developed a report that helped the health plan determine how well she met Canyon's standards. The report included cumulative performance data for Dr. Enberg and encompassed all measurable aspects of her performance. This report included such information as the number of hospital admissions Dr. Enberg had and the number of referrals she made outside of Canyon's provider network during a specified period. Canyon also used process measures, structural measures, and outcomes measures to evaluate Dr. Enberg's performance. Canyon used a process measure to evaluate the performance of Dr. Enberg when it evaluated whether:

- A. D
- B. Enberg's young patients receive appropriate immunizations at the right ages
- C. D
- D. Enberg's young patients receive appropriate immunizations at the right ages
- E. The condition of one of D
- F. Enberg's patients improved after the patient received medical treatment from D
- G. Enberg
- H. D
- I. Enberg's procedures are adequate for ensuring patients' access to medical care

Answer: A

NEW QUESTION 210

- (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 215

- (Topic 2)

The Ventnor Health Plan requires the physicians in its provider network to be board certified. Ventnor has received requests to become a part of the network from the following specialists:

Cheryl Stovall, who is currently in the process of completing a residency in her field of specialization.

Thomas Kalil, who has completed a residency in his field of specialization and has passed a qualifying examination in that field within two years of completing his residency.

Roger Todd, who has completed a residency in his field of specialization but has not passed a qualifying examination in that field.

Ventnor's requirement of board certification is met by:

- A. Cheryl Stovall, Thomas Kalil, and Roger Todd.
- B. Thomas Kalil and Roger Todd only.
- C. Thomas Kalil only.
- D. None of these individuals.

Answer: C

NEW QUESTION 217

- (Topic 2)

The Pine Health Plan has incorporated pharmacy benefits management into its operations to form a unified benefit. Potential advantages that Pine can receive from this action include:

- A. the fact that unified benefits improve the quality of patient care and the value of pharmacy services to Pine's plan members
- B. the fact that control over the formulary and network contracting can give Pine control over patient access to prescription drugs and to pharmacies
- C. the fact that managing pharmacy benefits in-house gives Pine a better chance to meet customer needs by integrating pharmacy services into the plan's total benefits package
- D. all of the above

Answer: D

NEW QUESTION 221

- (Topic 2)

Prior to the enactment of the Balanced Budget Act (BBA) of 1997, payment for Medicare- covered primary and acute care services was based on the adjusted average per capita cost (AAPCC). The AAPCC is defined as the

- A. average cost of services delivered to all patients living in a specified geographic region
- B. actuarial value of the deductible and coinsurance amounts for basic Medicare-covered benefits
- C. fee-for-service amount that the Centers for Medicaid and Medicare Services (CMS) would pay for a Medicare beneficiary, adjusted for age, sex, and institutional status
- D. average fixed monthly fee paid by all Medicare enrollees in a specified geographic region

Answer: C

NEW QUESTION 226

- (Topic 2)

As part of the credentialing process, many health plans use the National Practitioner Data Bank (NPDB) to learn information about prospective members of a provider network. One true statement about the NPDB is that:

- A. It is maintained by the individual states

- B. It primarily includes information about any censures, reprimands, or admonishments against any physicians who are licensed to practice medicine in the United States
- C. The information in the NPDB is available to the general public
- D. It was established to identify and discipline medical practitioners who act unprofessionally

Answer: D

NEW QUESTION 231

- (Topic 2)

The Tuba Health Plan recently underwent an accreditation process under a program known as Accreditation '99, which includes selected Health Employer Data and Information Set (HEDIS) measures. Under Accreditation '99, Tuba received a rating of Excellent. The following statement(s) can correctly be made about this quality assessment of Tuba's operations:

- A. In arriving at its rating of Excellent for Tuba, the Accreditation '99 program most likely focused on Tuba's demonstrated results and evaluated the processes that Tuba used to achieve those results.
- B. Tuba is required to report all HEDIS results to the NAIC.
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: B

NEW QUESTION 234

- (Topic 2)

An increasing number of health plans offer coverage for alternative healthcare services. One such alternative healthcare service is biofeedback. Biofeedback is an approach that

- A. is based on an ancient Chinese system of healing in which needles are inserted into specific sites on the body to relieve pain
- B. treats diseases with tiny doses of substances which, in healthy people, are capable of producing symptoms like those of the disease being treated
- C. uses electronic monitoring devices to teach a patient to develop conscious control of involuntary bodily functions, such as heart rate and body temperature
- D. incorporates a variety of therapies, such as homeopathy, lifestyle modification, and herbal medicines, to support and maintain the body's ability to heal itself

Answer: C

NEW QUESTION 236

- (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 241

- (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 242

- (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 244

- (Topic 2)

When evaluating the success of providers in meeting standards, a health plan must make adjustments for case mix or severity. One true statement about case mix/severity adjustments is that they:

- A. Typically are more important in measuring the performance of PCPs than they are in measuring the performance of specialists
- B. Help compensate for any unusual factors that may exist in a provider's patient population or in a particular patient
- C. Tend to increase the number of providers who are considered to be outliers
- D. Allow for a more equitable comparison of data between providers of outpatient care but not providers of inpatient care

Answer: B

NEW QUESTION 249

- (Topic 2)

The Zephyr Health Plan identifies members for whom subacute care might be an appropriate treatment option. The following individuals are members of Zephyr: Selena Tovar, an oncology patient who requires radiation oncology services, chemotherapy, and rehabilitation.

Dwight Borg, who is in excellent health except that he currently has sinusitis.

Timothy O'Shea, who is beginning his recovery from brain injuries caused by a stroke. Subacute care most likely could be an appropriate option for:

- A. M
- B. Tovar, M
- C. Borg, and M
- D. O'Shea
- E. M
- F. Tovar and M
- G. O'Shea only
- H. M
- I. O'Shea only
- J. M
- K. Borg only

Answer: B

NEW QUESTION 253

- (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.

From the following answer choices, select the response that best identifies Elm and Treble:

- A. Elm: open access (OA) HMO Treble: direct access HMO
- B. Elm: open access (OA) HMO Treble: gatekeeper HMO
- C. Elm: direct access HMO Treble: open access (OA) HMO
- D. Elm: direct access HMO Treble: gatekeeper HMO

Answer: C

NEW QUESTION 255

- (Topic 2)

The Medicaid program subsidizes indigent care through payments to disproportionate share hospitals (DSHs). The Preamble Hospital is a DSH. As a DSH, Preamble most likely:

- A. Receives financial assistance from the federal government but not a state government.
- B. Is at a higher risk of operating at a loss than are most other hospitals.
- C. Receives no payments directly from Medicaid for services rendered but rather receives a portion of the capitation payment that Medicaid makes to the health plans with which Preamble contracts.
- D. Is eligible for capitation rates that are significantly higher than the FFS average for all covered Medicaid services.

Answer: B

NEW QUESTION 256

- (Topic 2)

Following statements are about accreditation of health plans:

- A. The National Committee for Quality Assurance (NCQA) serves as the primary accrediting agency for most health maintenance organizations (HMOs).
- B. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has developed standards that can be used for the accreditation of hospitals, but not for the accreditation of health plan provider networks or health plan plans.
- C. States are required to adopt the model standards developed by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators that develops standards to promote uniformity in insurance regulations.
- D. Accreditation is an evaluative process in which a health plan undergoes an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the federal government or by the state governments.

Answer: A

NEW QUESTION 260

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