

# AHIP

## Exam Questions AHM-530

Network Management



#### NEW QUESTION 1

- (Topic 1)

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

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

**Answer: D**

#### NEW QUESTION 2

- (Topic 1)

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

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

**Answer: A**

#### NEW QUESTION 3

- (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 4

- (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 5

- (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 6

- (Topic 1)

The following statement(s) can correctly be made about the TRICARE managed healthcare program of the U.S. Department of Defense.

\* 1. Active-duty military personnel are automatically enrolled in TRICARE's HMO option (TRICARE Prime).

\* 2. Eligible family members and dependents can enroll in TRICARE Prime, the PPO plan (TRICARE Extra), or an indemnity plan (TRICARE Standard).

- A. Both 1 and 2
- B. 1 only
- C. 2 only
- D. Neither 1 nor 2

**Answer:** A

#### NEW QUESTION 7

- (Topic 1)

The following statements are about managed dental care. Three of these statements are true, and one is false. Select the answer choice containing the FALSE statement.

- A. Managed dental care is federally regulated.
- B. Dental HMOs typically need very few healthcare facilities because almost all dental services are delivered in an ambulatory care setting.
- C. Currently, there are no nationally recognized standards for quality in managed dental care.
- D. Processes for selecting dental care providers vary greatly according to state regulations on managed dental care networks and the health plan's standards.

**Answer:** A

#### NEW QUESTION 8

- (Topic 1)

The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement.

One important activity within the scope of network management is ensuring the quality of the health plan's provider networks. A primary purpose of \_\_\_\_\_ is to review the clinical competence of a provider in order to determine whether the provider meets the health plan's preestablished criteria for participation in the network.

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

**Answer:** C

#### NEW QUESTION 9

- (Topic 1)

For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.

Understanding the level of health plan penetration in a particular market can help a health plan determine which products are most appropriate for that market. Indicators of a mature health plan market include

- A. A reduction in the rate of growth in health plan premium levels
- B. A reduction in the level of outcomes management and improvement
- C. An increase in the rate of inpatient hospital utilization
- D. All of the above

**Answer:** A

#### NEW QUESTION 10

- (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 10

- (Topic 1)

To protect providers against business losses, many health plan-provider contracts include carve-out provisions to help providers manage financial risk. The following statements are examples of such provisions:

The Apex Health Plan carves out immunizations from PCP capitations. Apex compensates PCPs for immunizations on a case rate basis.

The Bengal Health Plan carves out behavioral healthcare services from the scope of PCP services because these services require specialized knowledge and skills that most PCPs do not possess.

From the answer choices below, select the response that best identifies the types of carve-outs used by Apex and Bengal.

- A. Apex: disease-specific carve-out Bengal: specialty services carve-out
- B. Apex: disease-specific carve-out Bengal: specific-service carve-out
- C. Apex: specific-service carve-out Bengal: specialty services carve-out
- D. Apex: specific-service carve-out Bengal: disease-specific carve-out

**Answer:** C

#### NEW QUESTION 13

- (Topic 1)

One reimbursement method that health plans can use for hospitals is the ambulatory payment classifications (APCs) method. APCs bear a resemblance to the

diagnosis-related groups (DRGs) method of reimbursement. However, when comparing APCs and DRGs, one of the primary differences between the two methods is that only the APC method

- A. is typically used for outpatient care
- B. assigns a single code for treatment
- C. applies to treatment received during an entire hospital stay
- D. is considered to be a retrospective payment system

**Answer:** A

#### NEW QUESTION 16

- (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 21

- (Topic 1)

Health plans are required to follow several regulations and guidelines regarding the access and adequacy of their provider networks. The Federal Employee Health Benefits Program (FEHBP) regulations, for example, require that health plans

- A. Allow members direct access to OB/GYN services
- B. Allow members direct access to prescription drug services
- C. Provide access to Title X family-planning clinics
- D. Provide average office waiting times of no more than 30 minutes for appointments with plan providers

**Answer:** D

#### NEW QUESTION 22

- (Topic 1)

The following statements are about the negotiation process of provider contracting. Three of the statements are true and one of the statements is false. Select the answer choice containing the FALSE statement.

- A. While preparing for negotiations, the health plan usually sends the provider an application to join the provider network, a list of credentialing requirements, and a copy of the proposed provider contract, which may or may not include the proposed reimbursement schedule.
- B. In general, the ideal negotiating style for provider contracting is a collaborative approach.
- C. Typically, the health plan and the provider negotiate the reimbursement arrangement between the parties before they negotiate the scope of services and the contract language.
- D. The actual signing of the provider contract typically takes place after negotiations are completed.

**Answer:** C

#### NEW QUESTION 25

- (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 27

- (Topic 1)

The following statements are about some of the issues surrounding the contractual responsibilities of health plans. Select the answer choice containing the correct statement.

- A. Typically, health plans are required to pay completed claims within 10 days of submission.
- B. Health plans typically are prohibited from examining the financial soundness of a self-funded employer plan that relies on the health plan to pay providers for services received by the plan's members.
- C. Patient delivery is one of the most significant factors that health plans consider when determining whether provider services should be reimbursed on a capitated or fee-for-service (FFS) basis.
- D. Health plans require all providers to agree to an exclusive provider contract.

**Answer:** C

#### NEW QUESTION 29

- (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 34

- (Topic 1)

The Brice Health Plan submitted to Clarity Health Services a letter of intent indicating Brice's desire to delegate its demand management function to Clarity. One true statement about this letter of intent is that it

- A. creates a legally binding relationship between Brice and Clarity
- B. most likely contains a confidentiality clause committing Brice and Clarity to maintain the confidentiality of documents reviewed and exchanged in the process
- C. prohibits Clarity from performing similar delegation activities for other health plans
- D. most likely contains a detailed description of the functions that Brice will delegate to Clarity

**Answer: B**

#### NEW QUESTION 35

- (Topic 1)

The method of pharmaceutical reimbursement under which a plan member obtains prescription drugs from participating network pharmacies by presenting proper identification and paying a specified copayment is the

- A. Wholesale acquisition cost (WAC) approach
- B. Reimbursement approach
- C. Service approach
- D. Cognitive approach

**Answer: C**

#### NEW QUESTION 39

- (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.

One statement that can correctly be made about Gardenia's two-level POS product is that

- A. members who self-refer without first seeing their PCPs will receive no benefits
- B. both Gardenia and the PCPs stand to benefit if the non-provider panels are kept relatively narrow
- C. members will pay higher coinsurance or copayments if they first see their PCPs each time
- D. the plan offers no financial incentives to members to choose an in-network specialist over a non-network specialist

**Answer: D**

#### NEW QUESTION 40

- (Topic 1)

The actual number of providers included in a provider network may be based on staffing ratios. Staffing ratios relate the number of

- A. Potential providers in a plan's network to the number of individuals in the area to be served by the plan
- B. Providers in a plan's network to the number of enrollees in the plan
- C. Providers outside a plan's network to the number of providers in the plan's network
- D. Support staff in a plan's network to the number of medical practitioners in the plan's network

**Answer: B**

#### NEW QUESTION 44

- (Topic 1)

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

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

**Answer: B**

#### NEW QUESTION 49

- (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 53

- (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 58

- (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 59

- (Topic 1)

Before incurring the expense of assembling a new PPO network, the Protect Health Plan conducted a cost analysis in order to determine the cost-effectiveness of renting an existing PPO network instead. In calculating the overall cost of renting the network, Protect assumed a premium of \$2.52 per member per month (PMPM) and estimated the total number of members to be 9,000. This information indicates that Protect would calculate its annual network rental cost to be

- A. \$42,857
- B. \$56,700
- C. \$272,160
- D. \$680,400

**Answer: C**

#### NEW QUESTION 62

- (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 66

- (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 68

- (Topic 1)

From the following answer choices, choose the term that best matches the description.

Members of a physician-hospital organization (PHO) denied membership to a physician solely because the physician has admitting privileges at a competing hospital.

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

**Answer:** A

#### NEW QUESTION 71

- (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 75

- (Topic 1)

The Holiday Health Plan is preparing to enter a new market. In order to determine the optimal size of its provider panel in the new market, Holiday is conducting a competitive analysis of provider networks of the market's existing health plans. Consider whether, in conducting its competitive analysis, Holiday should seek answers to the following questions:

Question 1: What are the cost-containment strategies of the health plans with increasing market shares?

Question 2: What are the premium strategies of the health plans with large market shares?

Question 3: What are the characteristics of health plans that are losing market share?

In its competitive analysis, Holiday should most likely obtain answers to questions

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

**Answer:** A

#### NEW QUESTION 79

- (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 81

- (Topic 1)

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

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

**Answer:** C

#### NEW QUESTION 86

- (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 90

- (Topic 1)

Participating providers in a health plan's network must undergo recredentialing on a regular basis. During recredentialing, a health plan typically reviews

- A. a provider's current, updated application information, as well as provider's peer reviews and performance reports on the provider
- B. a provider's current, updated application information, as well as the provider's education and prior work history
- C. a provider's education and prior work history only
- D. peer reviews and performance reports on a provider and the provider's prior work history only

**Answer: A**

#### NEW QUESTION 94

- (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 96

- (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 97

- (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 101

- (Topic 2)

The Bruin Health Plan is a Social Health Maintenance Organization (SHMO). As an SHMO, Bruin:

- A. Must provide Medicare participants with standard HMO benefits, as well as with limited long-term care benefits
- B. Does not need as great a variety of provider types or as complex a reimbursement method as does a traditional HMO
- C. Receives a payment that is based on reasonable costs and reasonable charges

D. Most likely provides fewer supportive services than does a traditional HMO, because one of Bruin's goals is to minimize the use of community-based care

**Answer:** A

#### NEW QUESTION 104

- (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 108

- (Topic 2)

Partial capitation is one common approach to capitation. One typical characteristic of partial capitation is that it:

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

**Answer:** A

#### NEW QUESTION 110

- (Topic 2)

The Elizabethan Health Plan uses a direct referral program, which means that

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

**Answer:** A

#### NEW QUESTION 111

- (Topic 2)

Since 1981, states have had the option to experiment with new approaches to their Medicaid programs under the "freedom of choice" waivers. Under one such waiver, a Section 1915(b) waiver, states are allowed to

- A. Give Medicaid recipients complete freedom in choosing healthcare providers
- B. Give Medicaid recipients the option to choose not to enroll in a healthcare plan
- C. Mandate certain categories of Medicaid recipients to enroll in health plans
- D. Establish demonstration projects to test new approaches for delivering care to Medicaid recipients

**Answer:** C

#### NEW QUESTION 115

- (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 119

- (Topic 2)

The employees of the Trilogy Company are covered by a typical workers' compensation program. Under this coverage, Trilogy employees are bound by the exclusive remedy doctrine, which most likely:

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

**Answer:** C

**NEW QUESTION 124**

- (Topic 2)

Dr. Leona Koenig removed the appendix of a plan member of the Helium health plan. In order to increase the level of reimbursement that she would receive from Helium, Dr. Koenig submitted to the health plan separate charges for the preoperative physical examination, the surgical procedure, and postoperative care. All of these charges should have been included in the code for the surgical procedure itself. Dr. Koenig's submission is a misuse of the coding system used by health plans and is an example of:

- A. Upcoding
- B. A wrap-around
- C. Churning
- D. Unbundling

**Answer:** D

**NEW QUESTION 127**

- (Topic 2)

The Adobe Health Plan complies with all of the provisions of the Newborns' and Mothers' Health Protection Act (NMHPA) of 1996. Kristen Netzger, an Adobe enrollee, was hospitalized for a cesarean delivery. Amy Davis, also an Adobe enrollee, was hospitalized for a normal delivery. From the following answer choices, select the response that indicates the minimum length of time for which Adobe, under NMHPA, most likely must provide benefits for the hospitalizations of Ms. Netzger and Ms. Davis.

- A. M
- B. Netzger = 48 hours M
- C. Davis = 48 hours
- D. M
- E. Netzger = 72 hours M
- F. Davis = 72 hours
- G. M
- H. Netzger = 96 hours M
- I. Davis = 48 hours
- J. M
- K. Netzger = 96 hours M
- L. Davis = 72 hours

**Answer:** C

**NEW QUESTION 131**

- (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 135**

- (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 140**

- (Topic 2)

The following statements are about the delegation of network management activities from a health plan to another party. Three of the statements are true and one statement is false. Select the answer choice containing the FALSE statement:

- A. The NCQA requires a health plan to conduct all delegation oversight functions rather than delegating the responsibility for oversight to another entity.
- B. Credentialing and UM activities are the most frequently delegated functions, whereas delegation is less common for quality management (QM) and preventive health services.
- C. One reason that a health plan may choose to delegate a function is because the health plan's staff seeks external expertise for the delegated activity.
- D. When the health plan delegates authority for a function, it transfers the power to conduct the function on a day-to-day basis, as well as the ultimate accountability for the function.

**Answer:** D

#### NEW QUESTION 145

- (Topic 2)

The Edgewood Health Plan uses a combination of structural, process, outcomes, and customer satisfaction measures to evaluate its network providers' performance. Edgewood would correctly use outcomes measures to evaluate a provider's

- A. Compliance with specific regulatory or accrediting requirement
- B. Appropriate use of specified procedures
- C. Patient progress following treatment
- D. Patient perceptions about how well the provider addresses medical problems

**Answer: C**

#### NEW QUESTION 148

- (Topic 2)

In most states, workers' compensation is first-dollar and last-dollar coverage, which means that workers' compensation programs

- A. Can place limits on the benefits they will pay for a given claim
- B. Can deny coverage for work-related illness or injury if the employer is not at fault
- C. Must pay 100% of work-related medical and disability expenses
- D. Can hold employers liable for additional amounts that result from court decisions

**Answer: C**

#### NEW QUESTION 152

- (Topic 2)

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

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

**Answer: B**

#### NEW QUESTION 156

- (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 158

- (Topic 2)

One difference between a fee-for-service (FFS) reimbursement arrangement and capitation is that the FFS arrangement:

- A. Is a prospective payment system, whereas capitation is a retrospective payment system
- B. Has a potential to induce providers to underutilize medical resources, whereas capitation does not have this potential disadvantage
- C. Bases the amount of reimbursement on the actual medical services delivered, whereas reimbursement under capitation is independent of the actual volume and cost of services provided
- D. Is most often used by health plans to reimburse healthcare facilities, whereas capitation is most often used by health plans to reimburse specialty care providers

**Answer: C**

#### NEW QUESTION 162

- (Topic 2)

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 allowed competitive medical plans (CMPs) to participate in the Medicare program on a risk basis. Under the terms of Medicare risk contracts, CMPs were required to deliver all medically necessary Medicare-covered services in return for a

- A. fixed monthly capitation payment from CMS
- B. fee-for-service payment from the appropriate state Medicare agency
- C. mandatory premium paid by plan enrollees
- D. fee equal to twice the actuarial value of the Medicare deductible and coinsurance paid by plan enrollees

**Answer:** A

**NEW QUESTION 165**

- (Topic 2)

The provider contract that Dr. Nick Mancini has with the Utopia Health Plan includes a clause that requires Utopia to reimburse Dr. Mancini on a fee-for-service (FFS) basis until 100 Utopia members have selected him as their primary care provider (PCP). At that time, Utopia will begin reimbursing him under a capitated arrangement. This clause in Dr. Mancini's provider contract is known as:

- A. an antidisparagement clause
- B. a low-enrollment guarantee clause
- C. a retroactive enrollment changes clause
- D. an eligibility guarantee clause

**Answer:** B

**NEW QUESTION 169**

- (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 174**

- (Topic 2)

Dr. Ahmad Shah and Dr. Shantelle Owen provide primary care services to Medicare+Choice enrollees of health plans under the following physician incentive plans:

Dr. Shah receives \$40 per enrollee per month for providing primary care and an additional

\$10 per enrollee per month if the cost of referral services falls below a specified level

Dr. Owen receives \$30 per enrollee per month for providing primary care and an additional

\$15 per enrollee per month if the cost of referral services falls below a specified level The use of a physician incentive plan creates substantial risk for

- A. Both D
- B. Shah and D
- C. Owen
- D. D
- E. Shah only
- F. D
- G. Owen only
- H. Neither D
- I. Shah nor D
- J. Owen

**Answer:** C

**NEW QUESTION 179**

- (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 180**

- (Topic 2)

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

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

**Answer:** D

**NEW QUESTION 185**

- (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 187

- (Topic 2)

Although ambulatory payment classifications (APCs) bear some resemblance to diagnosis-related groups (DRGs), there are significant differences between APCs and DRGs. One of these differences is that APCs:

- A. typically allow for the assignment of multiple classifications for an outpatient visit
- B. always apply to a patient's entire hospital stay
- C. typically serve as a payment system for inpatient services
- D. typically include reimbursements for professional fees

**Answer: A**

#### NEW QUESTION 190

- (Topic 2)

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

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

**Answer: A**

#### NEW QUESTION 193

- (Topic 2)

Before or during the orientation process, health plans generally provide new network providers with a provider manual. One of the primary purposes of the provider manual is to

- A. Provide a directory of contracted providers
- B. Help providers and their staffs develop methods of improving the operation of their practices
- C. Provide feedback to providers regarding their performance
- D. Reinforce and document contractual provisions

**Answer: D**

#### NEW QUESTION 194

- (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 199

- (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 202

- (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.

Because Mr. Pelham was injured on the job, he is entitled to receive benefits through workers' compensation. Under the terms of the state-mandated exclusive remedy doctrine included in the workers' compensation agreement, Mr. Pelham will most likely be prohibited from

- A. Receiving workers' compensation benefits unless he can show that the employer was at fault for his injury
- B. Obtaining care from providers who are not members of a workers' compensation network
- C. Suing his employer for additional benefits
- D. Claiming benefits from both workers' compensation and his group health plan

**Answer: C**

#### NEW QUESTION 204

- (Topic 2)

One true statement about the Medicaid program in the United States is that:

- A. The federal financial participation (FFP) in a state's Medicaid program ranges from 20% to 40% of the state's total Medicaid costs
- B. Medicaid regulations mandate specific minimum benefits, under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, for all Medicaid recipients younger than age 30
- C. The individual states have responsibility for administering the Medicaid program
- D. Non-disabled adults and children in low-income families account for the majority of direct Medicaid spending

**Answer: C**

#### NEW QUESTION 208

- (Topic 2)

The Walnut Health Plan provides a number of specialty services for its members. Walnut offers coverage of alternative healthcare, including coverage of treatment methods such as homeopathy and naturopathy. Walnut also offers home healthcare services, and it contracts with home healthcare providers on a non-risk basis to the health plan. The following statements are about the specialty services offered by Walnut. Select the answer choice containing the correct statement:

- A. Homeopathy treats diseases by using small doses of substances which, in healthy people, are capable of producing symptoms like those of the disease being treated.
- B. Naturopathy is an approach to healthcare that uses electronic monitoring devices to teach a patient to develop conscious control of involuntary bodily functions, such as heart rate.
- C. Under a non-risk contract, Walnut most likely transfers the responsibility for arranging home healthcare to the home healthcare provider organizations.
- D. Federal law allows Walnut to contract with a home healthcare provider organization only if the provider organization has received accreditation by the Utilization Review Accreditation Commission (URAC).

**Answer: A**

#### NEW QUESTION 210

- (Topic 2)

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

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

**Answer: A**

#### NEW QUESTION 211

- (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 213

- (Topic 2)

The Portway Hospital is qualified to receive Medicaid subsidy payments as a disproportionate share hospital (DHS). The DHS payments that Portway receives are

- A. Made for services rendered to specific patients
- B. Made with matching state and federal funds
- C. Included in the Medicaid capitation payment made to patients' health plans
- D. Defined as cost-based reimbursement (CBR) equal to 100% of Portway's reasonable costs of providing services to Medicaid recipients

**Answer: B**

#### NEW QUESTION 218

- (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 220

- (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 222

- (Topic 2)

The provider contracts that the Indigo Health Plan has with its providers include a clause which states that Indigo's denial of payment for a certain medical procedure does not constitute a medical opinion and is not intended to interfere with the provider-patient relationship. This information indicates that Indigo's provider contracts include:

- A. A business confidentiality clause.
- B. A scope of services clause.
- C. An informed refusal clause.
- D. An exculpation clause.

**Answer: D**

#### NEW QUESTION 223

- (Topic 2)

There are several approaches to providing Medicaid health plan. One such approach involves the use of organizations who contract with the state's Medicaid agency to provide primary care as well as administrative services. These organizations are known as

- A. Enrollment brokers
- B. Primary care case managers (PCCMs)
- C. Certified medical assistants (CMAs)
- D. Prepaid health plans (PHPs)

**Answer: B**

#### NEW QUESTION 224

- (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 227

- (Topic 2)

In 1996, the NAIC adopted a standard for health plan coverage of emergency services. This standard is based on a concept known as the:

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

**Answer: D**

#### NEW QUESTION 228

- (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 233

- (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 235

- (Topic 2)

One true statement about the Employee Retirement Income Security Act of 1974 (ERISA) is that:

- A. ERISA applies to all issuers of health insurance products, such as HMOs
- B. pension plans and employee welfare plans are exempt from any regulation under ERISA
- C. ERISA requires self-funded plans to comply with all state mandates affecting health insurance companies and health plans
- D. the terms of ERISA generally take precedence over any state laws that regulate employee welfare benefit plans

**Answer: D**

#### NEW QUESTION 237

- (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 240

- (Topic 2)

Franklin Pitt selected a Medicare+Choice option under which he is covered by a catastrophic health insurance policy with a high annual deductible and a \$6,000 out-of-pocket expense maximum. CMS pays the premiums for the insurance policy out of the usual Medicare+Choice payment and deposits any difference between the capitated amount and the policy premium in a savings account. Mr. Pitt can use funds in the savings account to pay qualified medical expenses not covered by his insurance policy. At the end of the benefit year, Mr. Pitt can carry any remaining funds into the next benefit year. The Medicare+Choice option Mr. Pitt selected is known as a

- A. coordinate care plan (CCP)
- B. medical savings account (MSA) plan
- C. competitive medical plan (CMP)
- D. Medicare Risk HMO program

**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 248

- (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 250

- (Topic 2)

The following activities are the responsibility of either the Nova Health Plan's risk management department or its medical management department:

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

**Answer: C**

#### NEW QUESTION 252

- (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 253

- (Topic 2)

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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.

The following statements can correctly be made about the reimbursement for Drugs A and B under the MAC pricing system:

- A. Treble most likely is obligated to reimburse Manor 14 cents per tablet for Drug A.
- B. Manor most likely is allowed to bill the subscriber 2 cents per tablet for Drug A.
- C. Treble most likely is obligated to reimburse Manor 5 cents per tablet for Drug B.
- D. All of the above statements are correct.

**Answer: C**

#### **NEW QUESTION 256**

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