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)
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 Walton Health Plan uses the fee-for-service pharmaceutical reimbursement approach known as the maximum allowable cost (MAC) method. If Walton's MAC list specifies a cost of 8 cents per tablet for a particular drug but the participating pharmacy pays 10 cents per tablet for the drug, then Walton will be obligated to reimburse the pharmacy for

A. 8 cents per tablet, but the pharmacy can bill the subscriber for the remaining 2 cents per tablet
B. 8 cents per tablet, and the pharmacy cannot bill the subscriber for the remaining 2 cents per tablet
C. 10 cents per tablet, but the pharmacy must refund the extra 2 cents per tablet to the subscriber
D. 10 cents per tablet, and the pharmacy is not required to refund the extra 2 cents per tablet to the subscriber

Answer: B

NEW QUESTION 4
- (Topic 1)
From the following answer choices, choose the term that best matches the description.
An integrated delivery system (IDS), which controls most providers in a particular specialty, agrees to provide that specialty service to a health plan only on thecondition that the health planagree to contract with the IDS for other services.

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

Answer: C

NEW QUESTION 5
- (Topic 1)
Four types of APCs are ancillary APCs, medical APCs, significant procedure APCs, and surgical APCs. An example of a type of APC known as

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

Answer: C

NEW QUESTION 6
- (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 following statement(s) can correctly be made about Gardenia's establishment of the PPO and the staff model HMO in its new market:
* 1. When establishing its PPO network, Gardenia most likely initiated outcomes measurement tools and developed collaborative process improvement relationships with providers.
* 2. To avoid high overhead expenses in the early stages of market evelopment, Gardenia's HMO most likely contracted with specialists and ancillary providers until the plan's membership grew to a sufficient level to justify employing these specialists.

A. Both 1 and 2
B. Neither 1 nor 2
C. 1 Only

D. 2 Only

Answer: D

NEW QUESTION 7
- (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 8
- (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 9
- (Topic 1)
Dr. Janet Dubois is a radiologist who practices exclusively at the Rightway Healthcare Center. This information indicates that Dr. Dubois is employed by Rightway as

A. An academic practitioner
B. An independent practitioner
C. Anetwork manager
D. Ahospital-based specialist

Answer: D

NEW QUESTION 10
- (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 10
- (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 11
- (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. A credentials verification organization (CVO) can be certified to verify certain pertinent credentialing information, including

A. Liability claims histories of prospective providers

B. Hospital privileges of prospective providers
C. Malpractice insurance on prospective providers
D. All of the above

Answer: D

NEW QUESTION 12
- (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 13
- (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 15
- (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 17
- (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 21
- (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 24
- (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 29
- (Topic 1)
One true statement about the compensation arrangement known as the case rate system is that, under this system,

A. Providers stand to gain or lose based on the number and types of treatments used for each case
B. Providers have no incentives to take an active role in managing cost and utilization
C. Payors cannot adjust standard case rates to reflect the severity of the patient's condition or complications that arise from multiple medical problems
D. Payors have the opportunity to benefit from the provider's cost savings

Answer: A

NEW QUESTION 32
- (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 35
- (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 39
- (Topic 1)
Health plan contract negotiations with an integrated delivery system (IDS) or a hospital are usually lengthier and more complex than negotiations with a single-specialty provider.

A. True
B. False

Answer: A

NEW QUESTION 44
- (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 45

- (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 49
- (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 53
- (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 58
- (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 62
- (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 65
- (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 69
- (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 surgicalprocedure, 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 70
- (Topic 2)
The following statement(s) can correctly be made about financial arrangements between health plans and emergency departments of hospitals:

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

Answer: C

NEW QUESTION 71
- (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 74
- (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 77
- (Topic 2)
Dr. Sarah Carmichael is one of several network providers who serve on one of the Apex Health Plan's organizational committees. The committee reviews cases against providers identified through complaints and grievances or through clinical monitoring activities. If needed, the committee formulates, approves, and monitors corrective action plans for providers. Although Apex administrators and other employees also serve on the committee, only participating providers have voting rights. The committee that Dr. Carmichael serves on is a

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

Answer: B

NEW QUESTION 79
- (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 81
- (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 reportincluded 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. Aprovider profile
D. An access to care report

Answer: C

NEW QUESTION 86
- (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 90
- (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 94
- (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 ofspecialization.
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 99
- (Topic 2)
Social health maintenance organizations (SHMOs) and Programs of All-Inclusive Care for the Elderly (PACE) are federal programs designed to provide coordinated healthcare services to the elderly. Unlike PACE, SHMOs

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

Answer: D

NEW QUESTION 102
- (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 103
- (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 104
- (Topic 2)
Assume that the national average cost per covered employee for PPO rental networks is $3 per member per month (PMPM) and that the average monthly healthcare premium PMPM is $300. This information indicates that, if the number of health plan members is 10,000, then the annual network rental cost to the health plan would be:

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

Answer: B

NEW QUESTION 106
- (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 110
- (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 113
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