Exam Questions AHM-540

Medical Management

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NEW QUESTION 1
Health plans that offer complementary and alternative medicine (CAM) services face potential liability because many types of CAM services

A. must be offered as separate supplemental benefits or separate products
B. lack clinical trials to evaluate their safety and effectiveness
C. are not covered by state or federal consumer protection statutes
D. focus on a specific illness, injury, or symptom rather than on the whole body

Answer: B

NEW QUESTION 2
The Glenway Health Plan's pharmacy and therapeutics (P&T) committee conducted pharmacoeconomic research to measure both the clinical outcomes and costs of two new cholesterol-reducing drugs. Results were presented as a ratio showing the cost required to produce a 1 mcg/l decrease in cholesterol levels. The type of pharmacoeconomic research that Glenway conducted in this situation was most likely

A. cost-effectiveness analysis (CEA)
B. cost-minimization analysis (CMA)
C. cost-utility analysis (CUA)
D. cost of illness analysis (COI)

Answer: A

NEW QUESTION 3
The following statement(s) can correctly be made about the use of screening for secondary prevention:
* 1. Screening activities may involve specialty care providers as well as primary care providers (PCPs) and the health plan
* 2. Secondary prevention often results in more utilization of services immediately following screening
* 3. Screening focuses on members who have not experienced any symptoms of a particular illness

A. All of the above
B. 1 and 3 only
C. 2 and 3 only
D. 1 only

Answer: A

NEW QUESTION 4
The paragraph below contains two pairs of terms enclosed in parentheses. Select the term in each pair that correctly completes the paragraph. Then select the answer choice containing the two terms you have chosen.
A primary distinction between skilled care and subacute care relates to the extent and medical complexity of the patient's needs. Generally, subacute care patients require (more
/ fewer) services from physicians and nurses and (more / less) extensive rehabilitation services than do skilled care patients.

A. more / more
B. more / less
C. fewer / more
D. fewer / less

Answer: A

NEW QUESTION 5
The Quality Assessment Performance Improvement (QAPI) is a quality initiative designed to strengthen health plans' efforts to protect and improve the health and satisfaction of Medicare and Medicaid health plan enrollees. The Centers for Medicare and Medicaid Services (CMS) requires compliance with QAPI from

A. both Medicare+Choice plans and Medicaid health plans
B. Medicare+Choice plans only
C. Medicaid health plans only
D. neither Medicare+Choice plans nor Medicaid health plans

Answer: B

NEW QUESTION 6
The Hall Health Plan gathered objective clinical information about the recommended uses and dosages of angiotensin-converting enzyme (ACE) inhibitors and presented the information to network providers to illustrate the appropriate use of these frequently prescribed and expensive drugs. This information indicates that Hall most likely educated its network providers through the use of

A. detailing
B. cognitive services
C. counter detailing
D. drug efficacy study implementation (DESI)

Answer: C

NEW QUESTION 7
Determine whether the following statement is true or false:
Immunization programs are a direct means of reducing health plan members' needs for healthcare services and are typically cost-effective.

A. True
B. False

Answer: A

NEW QUESTION 8
Helena Ray, a member of the Harbrace Health Plan, suffers from migraine headaches. To treat Ms. Ray's condition, her physician has prescribed Upzil, a medication that has Food and Drug Administration (FDA) approval only for the treatment of depression. Upzil has not been tested for safety or effectiveness in the treatment of migraine headache. Although Harbrace's medical policy for migraine headache does not include coverage of Upzil, Harbrace has agreed to provide extra-contractual coverage of Upzil for Ms. Ray.
In this situation, the prescribing of Upzil for Ms. Ray's headaches is an example of

A. a cosmetic service
B. an investigational service
C. an off-label use
D. a quality-of-life service

Answer: C

NEW QUESTION 9
Determine whether the following statement is true or false:
The delegation of medical management functions to providers can occur without the transfer of financial risk.

A. True
B. False

Answer: A

NEW QUESTION 10
The Shoreside Health Plan recently added coverage for behavioral healthcare services to its benefit package. In order to support the quality of its behavioral healthcare services, Shoreside plans to seek accreditation for its behavioral healthcare program. Accreditation specifically designed for behavioral healthcare programs is available through
* 1.The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
* 2.The National Committee for Quality Assurance (NCQA)
* 3.The American Accreditation HealthCare Commission/URAC (URAC)

A. All of the above
B. 1 and 2 only
C. 2 and 3 only
D. 1 only

Answer: B

NEW QUESTION 10
In recent years, the demand for prescription drugs has increased dramatically. Factors that have contributed to this increase include

A. increased education regarding the purpose and benefits of drug formularies
B. reductions in the cost of prescription drugs
C. increased use of direct-to-consumer (DTC) advertising
D. all of the above

Answer: C

NEW QUESTION 15
Increased demands for performance information have resulted in the development of various health plan report cards. With respect to most of the report cards currently available, it is correct to say

A. that they are focused primarily on health maintenance organization (HMO) plans
B. that they are based on data collected for the Health Plan Employer Data and Information Set (HEDIS) 3.0
C. that they are used to rank the performance of various health plans
D. all of the above

Answer: D

NEW QUESTION 19
To see that utilization guidelines are consistently applied, UR programs rely on authorization systems. Determine whether the following statement about authorization systems is true or false:
Only physicians can make nonauthorization decisions based on medical necessity.

A. True
B. False

Answer: A

NEW QUESTION 21

The Carlyle Health Plan uses the following clinical outcome measures to evaluate its diabetes and asthma disease management programs:
Measure 1: The percentage of diabetic patients who receive foot exams from their providers according to the program's recommended guidelines Measure 2: The number of asthma patients who visited emergency departments for acute asthma attacks
From the answer choices below, select the response that correctly identifies whether these measures are true outcome measures or intermediate outcome measures. Measure 1- Measure 2-

A. Measure 1-true outcome measure Measure 2-true outcome measure
B. Measure 1-true outcome measure Measure 2-intermediate outcome measure
C. Measure 1-intermediate outcome measure Measure 2-true outcome measure
D. Measure 1-intermediate outcome measure Measure 2-intermediate outcome measure

Answer: C

NEW QUESTION 22
The following statements are about the use of hospitalists to manage inpatient care. Select the answer choice containing the correct statement.

A. A patient who has been transferred to a hospitalist for management of inpatient care usually continues to receive care from the hospitalist after discharge.
B. Hospitalists are used primarily to manage care for obstetric, pediatric, and oncology patients.
C. In order to serve as a hospitalist, a physician must have a background in critical care medicine.
D. Hospitalists typically spend at least one-quarter of their time in a hospital setting.

Answer: D

NEW QUESTION 26
One difference between outcomes research and clinical research is that outcomes research

A. provides an absolute measure of treatment results, whereas clinical research provides a relative measure of results
B. focuses on treatment effectiveness, whereas clinical research focuses on treatmentefficacy
C. examines diseases and treatments in isolation, whereas clinical research considers the effects of changes in health status and quality of life
D. gathers outcomes data from controlled clinical trials, whereas clinical research collects and analyzes clinical, financial, and administrative data

Answer: B

NEW QUESTION 28
The following statement(s) can correctly be made about the characteristics of peer review:
* 1.Peer review is applicable to either single episodes of care or to entire programs of care
* 2.Most peer review is conducted concurrently
* 3.Under the Health Care Quality Improvement Program (HCQIP), peer review is required for services furnished to Medicare and Medicaid recipients enrolled in health plans

A. All of the above
B. 1 and 2 only
C. 1 and 3 only
D. 2 and 3 only

Answer: C

NEW QUESTION 31
In order to provide a true measure of quality, the data collected by a quality indicator should accurately represent the service dimension being measured. This information indicates that the indicator should exhibit the characteristic known as

A. clarity
B. reliability
C. validity
D. feasibility

Answer: C

NEW QUESTION 34
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the terms or phrases that you have chosen.
The Millway Health Plan received a 15% reduction in the price of a particular pharmaceutical based on the volume of the drug Millway purchased from the manufacturer. This reduction in price is an example of a (rebate / price discount) and (is / is not) dependent on actual provider prescribing patterns.

A. rebate / is
B. rebate / is not
C. price discount / is
D. price discount / is not

Answer: D

NEW QUESTION 39
The following statement(s) can correctly be made about the scope of case management:
* 1. Case management incorporates activities that may fall outside a health plan's typical responsibilities, such as assessing a member's financial situation
* 2. Case management generally requires a less comprehensive and complex approach to a course of care than does utilization review
* 3. Case management is currently applicable only to medical conditions that require inpatient hospital care and are categorized as catastrophic in terms of health and/or costs

A. All of the above
B. 1 and 2 only
C. 2 and 3 only
D. 1 only

Answer: D

NEW QUESTION 44
Maxwell Midler's health plan operates a drug formulary that includes a typical three-tier copayment structure with required copayments of $5, $10, and $25. Mr. Midler recently filled a prescription for a $75 drug that was not included in the formulary. According to the plan's formulary copayment structure, the amount that Mr. Midler was required to pay for his prescription was

A. $5
B. $10
C. $25
D. $75

Answer: C

NEW QUESTION 45
Demetrius Farrell, age 82, is suffering from a terminal illness and has consulted his health plan about the care options available to him. In order to avoid unwanted, futile interventions, Mr. Farrell signed an advance directive that indicates the types of end-of-life medical treatment he wants to receive. His family is to use this document as a guide should Mr. Farrell become incapacitated.
The document that Mr. Farrell is using to communicate his end-of-life healthcare wishes to his family is known as a

A. medical power of attorney
B. patient assessment and care plan
C. living will
D. healthcare proxy

Answer: C

NEW QUESTION 49
The following statements are about risk management for case management. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. The use of a signed consent authorization form is consistent with accrediting agency standards for patient privacy and confidentiality of medical information.
B. Case management that is initiated after a member has incurred substantial medical expenses is more likely to be viewed as a tool to cut costs rather than to improve outcomes.
C. Health plan documents indicating that any case management delegates are separate, independent entities may reduce an health plan's exposure to risk.
D. A case management file cannot be used to support the health plan's position in the event of a lawsuit.

Answer: D

NEW QUESTION 51
This agency oversees the Federal Employee Health Benefits Program (FEHBP).

A. Health Resources and Services Administration (HRSA)
B. Office of Personnel Management (OPM)
C. Department of Health and Human Services (HHS)
D. Department of Justice (DOJ)

Answer: B

NEW QUESTION 54
Helena Ray, a member of the Harbrace Health Plan, suffers from migraine headaches. To treat Ms. Ray's condition, her physician has prescribed Upzil, a medication that has Food and Drug Administration (FDA) approval only for the treatment of depression. Upzil has not been tested for safety or effectiveness in the treatment of migraine headache. Although Harbrace's medical policy for migraine headache does not include coverage of Upzil, Harbrace has agreed to provide extra-contractual coverage of Upzil for Ms. Ray.
The following statement(s) can correctly be made about Harbrace's use of extra- contractual coverage:
* 1. Harbrace's medical policy most likely establishes the procedure that Harbrace used to evaluate the value of Upzil for treating Ms. Ray
* 2. One way for Harbrace to reduce the risk associated with extra-contractual coverage is by including an alternative care provision in its contracts with purchasers

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

Answer: C

NEW QUESTION 55
Health plan performance measures include structure measures, process measures, and outcome measures. The following statements are about the characteristics of these three types ofperformance measures. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. The most widely used structure measures relate to physician education and training.
B. One advantage of structure measures over process measures is that structures are often linked directly to healthcare outcomes.

C. Process measures are useful in identifying underuse, overuse, and inappropriate use of services.
D. One disadvantage of outcome measures is that they can be influenced by factors outside the control of the health plan.

Answer: B

NEW QUESTION 60
All states have laws describing the conditions under which pharmacists can substitute a generic drug for a brand-name drug. With respect to these laws, it is correct to say that in every state,

A. pharmacists must obtain physician approval before substituting generics for brand-name drugs
B. pharmacists must obtain authorization from the health plan before substituting generics for brand-name drugs
C. prescribers must obtain authorization from the health plan before prescribing a brand- name drug
D. prescribers have some mechanism that allows them to prevent pharmacists from substituting generics for brand-name drugs

Answer: D

NEW QUESTION 65
Medicare beneficiaries can obtain healthcare benefits through fee-for-service (FFS) Medicare programs, Medicare medical savings account (MSA) plans, Medigap insurance, or coordinated care plans (CCPs). Unlike other coverage options, CCPs

A. provide only those benefits covered by Medicare Part A and Part B
B. are not subject to federal or state regulation
C. place primary care at the center of the delivery system
D. are structured as indemnity plans

Answer: C

NEW QUESTION 66
The following statements are about the characteristics of a utilization review (UR) program. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. A primary goal of UR is to address practice variations through the application of uniform standards and guidelines.
B. UR evaluates whether the services recommended by a member's provider are covered under the benefit plan.
C. UR recommends the procedures that providers should perform for plan members.
D. A health plan's UR program is usually subject to review and approval by the state insurance and/or health departments.

Answer: C

NEW QUESTION 68
The following statements are about the use of provider profiling for pharmacy benefits. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. Health plans typically use provider profiles to improve the quality of care associated with the use of prescription drugs.
B. Provider profiles identify prescribing patterns that fall outside normal ranges.
C. Health plans can motivate providers to change their prescribing patterns by sharing profile information with plan members and the general public.
D. Provider profiles are effective in modifying individual prescribing patterns, but they have little effect on group prescribing patterns.

Answer: D

NEW QUESTION 69
The Westchester Health Plan classifies its key processes into the following categories: high-risk, high-volume, problem-prone, and high-cost. Westchester also prioritizes the categories in terms of importance. The process category that Westchester most likely ranks highest in importance is

A. High-risk processes
B. High-volume processes
C. Problem-prone processes
D. High-cost processes

Answer: A

NEW QUESTION 70
Determine whether the following statement is true or false: Participation in disease management programs is currently voluntary.

A. True
B. False

Answer: A

NEW QUESTION 74
Home healthcare encompasses a wide variety of medical, social, and support services delivered at the homes of patients who are disabled, chronically ill, or terminally ill. The time period(s) when health plans typically use home healthcare include
* 1. The period prior to a hospital admission
* 2. The period following discharge from a hospital

A. Both 1 and 2

B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: A

NEW QUESTION 75
PBMs are accredited by the same organizations that accredit health plans.

A. True
B. False

Answer: B

NEW QUESTION 79
The Brighton Health Plan regularly performs prospective UR for surgical procedures. Brighton's prospective UR activities are likely to include

A. documenting the clinical details of the patient's condition and care
B. tracking the length of inpatient stay
C. completing the discharge planning process
D. determining the most appropriate setting for the proposed course of care

Answer: D

NEW QUESTION 82
Private employers are key purchasers of health plan services. The following statement(s) can correctly be made about employer expectations about the quality and cost- effectiveness of healthcare services:
* 1. For both health maintenance organizations (HMOs) and non-HMO plans, employers typically have access to accreditation results and performance measurement reports to help them evaluate the quality of healthcare and service
* 2. Because of employers' concern about the quality and costs of healthcare services available through health plans, direct contracting has become a dominant model among employers who sponsor health benefit programs for their employees

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

Answer: D

NEW QUESTION 86
Patient safety and medical errors are important concerns for both quality management (QM) and risk management. The following statement(s) can correctly be made about medical errors:
* 1. The complexity of modern medicine and healthcare delivery systems increases patients' exposure to the risks of medical errors
* 2. Licensing boards for healthcare professionals in all states provide a consistent system of quality oversight and accountability
* 3. Provider compliance with internal incident reporting requirements is low

A. All of the above
B. 1 and 2 only
C. 1 and 3 only
D. 3 only

Answer: C

NEW QUESTION 91
Comorbidity can have a significant impact on the effective implementation of disease management programs. Comorbidity can correctly be defined as the

A. degree to which the progression of a disease or condition is understood
B. prevalence or rate of a sickness or injury within a given population
C. degree of severity of a particular disease or condition
D. presence of a chronic condition or added complication other than the condition that requires medical treatment

Answer: D

NEW QUESTION 94
The following statement(s) can correctly be made about accrediting agency standards for delegation:
* 1. The National Committee for Quality Assurance (NCQA) allows health plans to delegate
all medical management functions, including the responsibility to perform delegation oversight activities
* 2. In some cases, accreditation standards for delegation oversight are reduced if the delegate has already been certified or accredited by the delegator's accrediting agency

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

Answer: C

NEW QUESTION 95
Nilay Sharma suffered a small wound while working in his yard and was taken to a local hospital for treatment. A triage nurse at the hospital evaluated Mr. Sharma's condition and directed him to an outpatient unit in the hospital where a physician assistant examined, cleaned, and sutured the wound. Mr. Sharma returned home following treatment. The care Mr. Sharma received at the hospital is an example of the type of care known as

A. specialty referral
B. primary prevention
C. urgent care
D. emergency care

Answer: C

NEW QUESTION 100
The delivery of quality, cost-effective healthcare is a primary goal of both group healthcare and workers' compensation programs. One difference between group healthcare and workers' compensation is that workers' compensation

A. provides health and disability benefits to employees injured on the job only if the employer is at fault for the injury
B. provides coverage for a variety of direct and indirect healthcare, disability, and workplace costs
C. manages costs by including employee cost-sharing features in its benefit design
D. places limits on benefits by restricting the amount of benefit payments or the number of covered hospital days or provider office visits

Answer: B

NEW QUESTION 104
The following statements are about QAPI as it applies to Medicare+Choice plans and Medicaid health plan entities. Select the answer choice containing the correct statement.

A. QAPI provides separate sets of standards for Medicaid MCEs and Medicare+Choice plans.
B. Medicaid primary care case management (PCCM) programs are required to comply with all QAPI standards.
C. QISMC standards for quality measurement and improvement apply only to clinical services delivered to Medicare and Medicaid enrollees.
D. States that require Medicaid MCEs to comply with QAPI standards are considered to be in compliance with CMS quality assessment and improvement regulations.

Answer: D

NEW QUESTION 107
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the terms or phrases that you have chosen.
One component of UR is an administrative review. An administrative review compares the proposed medical care to the applicable (medical policy / contract provision). This type of review (can / cannot) be conducted by a nonclinical staff member.

A. medical policy / can
B. medical policy / cannot
C. contract provision / can
D. contract provision / cannot

Answer: C

NEW QUESTION 112
The Mental Health Parity Act (MHPA) of 1996 is a federal law that establishes requirements for behavioral healthcare coverage for group plan members. The MHPA

A. requires health plans to offer mental health benefits to all eligible members
B. prohibits health plans that offer mental health benefits from imposing lower annual or lifetime dollar limits on mental illnesses than they do on physical illnesses
C. provides an exemption for health plans that can demonstrate cost savings of more than 1 percent
D. prohibits health plans from limiting the number of outpatient visits or inpatient dayscovered under the plan

Answer: B

NEW QUESTION 116
Elaine Newman suffered an acute asthma attack and was taken to a hospital emergency department for treatment. Because Ms. Newman's condition had not improved enough following treatment to warrant immediate release, she was transferred to an observation care unit. Transferring Ms. Newman to the observation care unit most likely

A. resulted in unnecessarily expensive charges for treatment
B. prevented M
C. Newman from receiving immediate attention for her condition
D. gave M
E. Newman access to more effective and efficient treatment than she could have obtained from other providers in the same region
F. allowed clinical staff an opportunity to determine whether M
G. Newman required hospitalization without actually admitting her

Answer: D

NEW QUESTION 117
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
To manage the delivery of healthcare services to their members, health plans use clinical practice parameters. _____ is the type of clinical practice parameter

that a health plan uses to make coverage decisions concerning medical necessity and appropriateness.

A. A clinical practice guideline (CPG)
B. Medical policy
C. Benefits administration policy
D. A standard of care

Answer: B

NEW QUESTION 121
Acute care refers to healthcare services for medical problems that

A. are expected to continue for a minimum of 30 days
B. are typically treated in a provider's office or outpatient facility
C. require prompt, intensive treatment by healthcare providers
D. require low utilization of resources

Answer: C

NEW QUESTION 123
As a follow-up to a performance improvement plan for member services, the Stellar Health Plan conducted an evaluation of the success of the plan. Stellar conducted its evaluation as the plan was being carried out. The evaluation focused on specific activities and assessed the relative importance of those activities to the plan as a whole. This information indicates that Stellar's evaluation of the plan was both

A. concurrent and formative
B. concurrent and summative
C. retrospective and formative
D. retrospective and summative

Answer: A

NEW QUESTION 126
The following statements describe situations in which health plan members have medical problems that require care. Select the statement that describes a situation in which self- care most likely would not be appropriate.

A. Two days after bruising her leg, Avis Bennet notices that the pain from the bruise has increased and that there are red streaks and swelling around the bruised area.
B. Calvin Dodd has Type II diabetes and requires blood glucose monitoring tests several times each day.
C. Caroline Evans has severe arthritis that requires regular exercise and oral medication to reduce pain and help her maintain mobility.
D. Oscar Gracken is recovering from a heart attack and requires ongoing cardiac rehabilitation.

Answer: A

NEW QUESTION 127
The Riverside Health Plan is considering the following provider compensation options to use in its contracts with several provider groups and hospitals:
* 1. A discounted fee-for-service (DFFS) payment system
* 2. A case rate system
* 3. Capitation
If Riverside wants to use only those compensation methods that encourage the efficient use of resources, then the compensation method(s) that Riverside should consider for its new contracts include

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

Answer: C

NEW QUESTION 129
To measure performance for quality management, health plans collect and analyze three types of data: financial data, clinical data, and customer satisfaction data. The following statement(s) can correctly be made about the sources of clinical data:
* 1.Patient surveys are the most widely used source of disease-specific clinical information
* 2.Outcomes research studies sponsored by academic institutions and professional organizations have limited usefulness for particular health plans or individual providers
* 3.The SF-36 and the HSQ-39 (Health Status Questionnaire) surveys address both physical and mental health status

A. All of the above
B. 1 and 2 only
C. 2 and 3 only
D. 3 only

Answer: C

NEW QUESTION 133
Benchmarking is a quality improvement strategy used by some health plans. With regard to benchmarking, it is correct to say that

A. cost-based benchmarking reveals why some areas of a health plan perform better or worse than comparable areas of other organizations

B. diagnosis-related groups (DRGs) are a source of benchmarking data that describe individual procedures and cover both inpatient and outpatient care
C. patient billing records provide a much more accurate account of procedure costs for benchmarking than do current procedural terminology (CPT) codes
D. the focus of benchmarking for health plan has shifted from identifying the lowest cost practices to identifying best practices

Answer: D

NEW QUESTION 134
Determine whether the following statement is true or false:
The utilization review (UR) process produces the greatest number of case management referrals.

A. True
B. False

Answer: A

NEW QUESTION 139
Since its inception, Medicare has undergone a number of changes because of legal and regulatory action. One result of the Balanced Budget Act (BBA) of 1997 has been to

A. expand Medicare benefits by mandating coverage for certain preventive services
B. reduce the number of organizations that can deliver covered services
C. encourage growth of managed Medicare programs in all markets
D. increase the number of “zero premium” plans available to Medicare beneficiaries

Answer: A

NEW QUESTION 140
Health plans often use accreditation as a means of evaluating the quality of care delivered to plan members. Accreditation of subacute care providers is available from the

A. National Committee for Quality Assurance (NCQA)
B. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
C. American Accreditation HealthCare Commission/URAC (URAC)
D. Foundation for Accountability (FACCT)

Answer: B

NEW QUESTION 144
For this question, if answer choices (a) through (c) are all correct, select answer choice (d). Otherwise, select the one correct answer choice.
Well-crafted clinical practice guidelines (CPGs) can benefit healthcare delivery processes and outcomes by

A. providing a framework for care while also allowing for patient-specific variations, based on physician judgment
B. serving as a basis for evaluating whether providers are practicing in accordance with accepted standards
C. focusing on the prevention or early detection of a particular condition
D. all of the above

Answer: D

NEW QUESTION 148
To improve members’ abilities to make appropriate care decisions about specific medical problems, some health plans use a form of decision support known as telephone triage programs. The following statements are about telephone triage programs. Select the answer choice containing the correct statement.

A. The primary role of telephone triage clinical staff is to diagnose the caller’s condition and give medical advice.
B. Quality management (QM) for telephone triage programs typically focuses on the clinical information provided rather than on the quality of service.
C. Currently, none of the major accrediting agencies offers an accreditation program specifically for telephone triage programs.
D. A telephone triage program may also include a self-care component.

Answer: B

NEW QUESTION 153
By definition, the development and implementation of parameters for the delivery of healthcare services to a health plan’s members is known as

A. utilization management (UM)
B. quality management (QM)
C. care management
D. clinical practice management

Answer: D

NEW QUESTION 154
Comparing the quality of managed Medicare programs with the quality of FFS Medicare programs is often difficult. Unlike FFS Medicare, managed Medicare programs

A. can measure and report quality only at the provider level
B. use a single system to deliver services to all plan members

C. provide an organizational focus for accountability
D. can use the same performance measures for all products and plans

Answer: C

NEW QUESTION 155
When conducting performance assessment, a health pln may classify the key processes associated with its services into the following categories: high-risk, high-volume, problem- prone, and high-cost.
The following statements are about this classification of processes. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. In some instances, relatively inexpensive processes can qualify as high-cost processes.
B. Each process must be classified into a single category.
C. High-risk processes most often involve medical interventions or treatment plans for acute illnesses or case management processes for complex conditions.
D. Administrative processes such as scheduling appointments are examples of high- volume processes.

Answer: B

NEW QUESTION 160
Examples of alternative healthcare practitioners are chiropractors, naturopaths, and acupuncturists. The only well-established credentialing standards for alternative healthcare practitioners are those available from NCQA. These NCQA credentialing standards apply to

A. chiropractors
B. naturopaths
C. acupuncturists
D. all of the above

Answer: A

NEW QUESTION 164
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the two terms or phrases that you have selected.
The process for collecting and analyzing data differs for quality assessment (QA) and quality improvement (QI). For QA, data collection focuses on (objective / both objective and subjective) data, and data analysis identifies the (degree / cause) of variance.

A. objective / degree
B. objective / cause
C. both objective and subjective / degree
D. both objective and subjective / cause

Answer: A

NEW QUESTION 167
Occasionally, employers combine workers' compensation, group healthcare, and disability programs into an integrated product known as 24-hour coverage. One true statement about 24-hour coverage is that it typically

A. increases administrative costs
B. requires plans to maintain separate databases of patient care information
C. exempts plans from complying with state workers' compensation regulations
D. allows plans to apply disability management and return-to-work techniques to nonoccupational conditions

Answer: D

NEW QUESTION 172
The following statement(s) can correctly be made about medical management considerations for the Federal Employee Health Benefits Program (FEHBP):
* 1. FEHBP plan members who have exhausted the health plan's usual appeals process for a disputed decision can request an independent review by the Office of Personnel Management (OPM)
* 2. All health plans that cover federal employees are required to develop and implement patient safety initiatives

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

Answer: A

NEW QUESTION 177
Various government and independent agencies have created tools to measure and report the quality of healthcare. One performance measurement tool that was developed by the Agency for Healthcare Research and Quality (AHRQ) is

A. the Health Plan Employer Data and Information Set (HEDIS®), which is a report card system for hospitals and long-term care facilities
B. HEDIS, which is a performance measurement tool that addresses both effectiveness of care and plan member satisfaction
C. the Consumer Assessment of Health Plans (CAHPS®), which was established to develop and implement a national strategy for quality measurement and reporting
D. CAHPS, which is a tool that measures consumer satisfaction with specific aspects of health plan services

Answer: D

NEW QUESTION 181
Outcomes management is a tool that health plans use to maximize all the results
associated with healthcare processes. The following statement(s) can correctly be made about outcomes management:
* 1. The goal of outcomes management is to identify and implement treatments that are cost- effective and deliver the greatest value
* 2. Outcomes management introduces performance as a critical factor in the assessment and improvement of outcomes

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

Answer: A

NEW QUESTION 184
In order to achieve changes in outcomes, health plans make changes to existing structures and processes. The introduction of preauthorization as an attempt to control overuse of services is an example of a reactive change. Reactive changes are typically

A. both planned and controlled
B. planned, but they are rarely controlled
C. controlled, but they are rarely planned
D. neither planned nor controlled

Answer: C

NEW QUESTION 185
Among this agency's accreditation programs are accreditation for preferred provider organizations (PPOs), health plan call centers, and case management organizations. This agency classifies its standards as either "shall" standards or "should" standards.

A. American Accreditation HealthCare Commission/URAC (URAC)
B. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
C. Community Health Accreditation Program (CHAP)
D. National Committee for Quality Assurance (NCQA)

Answer: A

NEW QUESTION 190
A health plan's choice of structure measures, process measures, and outcome measures to evaluate performance depends in part on the scientific soundness of the measures. One approach that a health plan can use to enhance scientific soundness is stratification, which refers to the

A. identification and removal of unusual cases, such as patients with contraindications to a particular treatment, from consideration
B. statistical adjustment of outcome measures to account for differences in the severity of illness or the presence of other medical conditions
C. specification of a target population for a procedure and the data collection and analysis methods to be used
D. elimination of variation within a patient population by dividing the population into groups that are at a similar level of risk

Answer: D

NEW QUESTION 192
A health plan's coverage policies are linked to its purchaser contracts. The following statement(s) can correctly be made about the purchaser contract and coverage decisions:
* 1. In case of conflict between the purchaser contract and a health plan's medical policy or benefits administration policy, the contract takes precedence
* 2. Purchaser contracts commonly exclude custodial care from their coverage of services and supplies
* 3. All of the criteria for coverage decisions must be included in the purchaser contract

A. All of the above
B. 1 and 2 only
C. 2 only
D. 3 only

Answer: B

NEW QUESTION 193
Many health plans use HRA to target their preventive care programs to the healthcare needs of their members. With regard to HRA, it is correct to say that

A. Health plans rarely delegate HRA activities to external entities
B. Health plans typically focus their HRA efforts on newly enrolled members
C. HRA focuses on clinical data for an entire population and does not include demographic information that might identify individual members
D. HRA is generally a reliable predictor of medical resource utilization

Answer: B

NEW QUESTION 195
One true statement about state regulation of case management activities is that the majority of states

A. have enacted laws that list specific quality management requirements for a case management program
B. consider case management files to be medical records that must be retained for a specified length of time
C. view case management similarly and follow similar patterns with their laws and regulations

D. have enacted laws or regulations requiring licensure or certification of case managers

Answer: B

NEW QUESTION 198
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
The QAPI (Quality Assessment Performance Improvement Program) is a Centers for Medicaid and Medicare Services (CMS) initiative designed to strengthen health plans' efforts to protect and improve the health and satisfaction of Medicare beneficiaries. QAPI quality assessment standards apply to

A. standard medical-surgical services
B. mental health and substance abuse services
C. services offered to Medicare enrollees as optional supplementary benefits
D. all of the above

Answer: D

NEW QUESTION 200
Health plans arrange for the delivery of various levels of healthcare, including
* 1.Emergency care
* 2. Urgent care
* 3. Primary care delivered in a provider's office
In a ranking of these levels of care according to cost, beginning with the least expensive level of care and ending with the most expensive level of care, the correct order would be

A. 1—2—3
B. 2—3—1
C. 3—1—2
D. 3—2—1

Answer: D

NEW QUESTION 203
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