AHM-530 Dumps

Network Management

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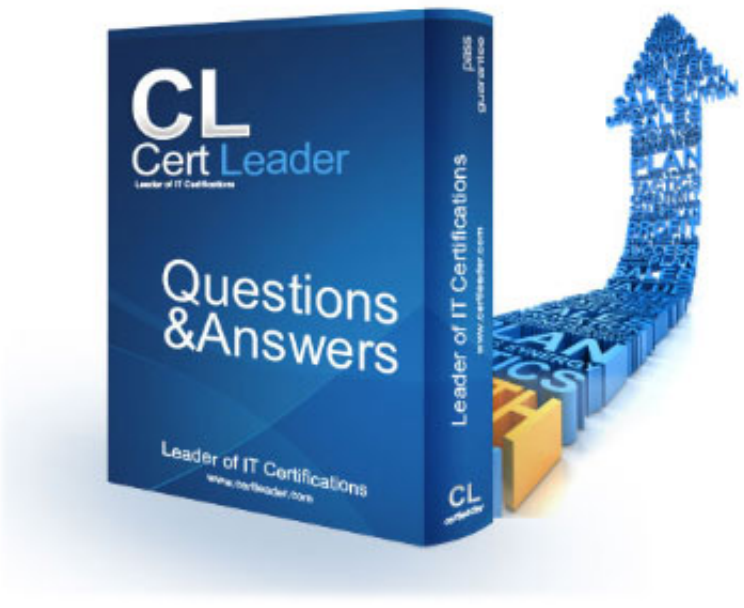

NEW QUESTION 1
- (Topic 1)
Although a health plan is allowed to delegate many activities to outside sources, the National Committee for Quality Assurance (NCQA) has determined that some activities are not delegable.
These activities include

A. evaluation of new medical technologies
B. overseeing delegated medical records activities
C. developing written statements of members' rights and responsibilities
D. all of the above

Answer: D

NEW QUESTION 2
- (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 3
- (Topic 1)
Most health plan contracts provide an outline of the criteria that a healthcare service must meet in order to be considered "medically necessary." Typically, in order for a healthcare service to be considered medically necessary, the service provided by a physician or other healthcare provider to identify and treat a member's illness or injury must be

A. Consistent with the symptoms of diagnosis
B. Furnished in the least intensive type of medical care setting required by the member's condition
C. In compliance with the standards of good medical practice
D. All of the above

Answer: D

NEW QUESTION 4
- (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 5
- (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 6
- (Topic 1)
If the Oconee Health Plan reimburses its specialty care physicians (SCPs) under a typical retainer method, then Oconee pays SCPs

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

Answer: C

NEW QUESTION 7
- (Topic 1)
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 8
- (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 9
- (Topic 1)
The Octagon Health Plan includes a typical indemnification clause in its provider contracts. The purpose of this clause is to require Octagon’s network providers to

A. Agree not to sue or file claims against an Octagon plan member for covered services
B. Reimburse Octagon for costs, expenses, and liabilities incurred by the health plan as a result of a provider’s actions
C. Maintain the confidentiality of the health plan’s proprietary information
D. Agree to accept Octagon’s payment as payment in full and not to bill members for anything other than contracted copayments, coinsurance, or deductibles

Answer: B

NEW QUESTION 10
- (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 regulationson managed dental care networks and the health plan’s standards.

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 14
- (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 18
- (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 22
- (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 26
- (Topic 1)
An health plan enters into a professional services capitation arrangement whenever the health plan

A. Contracts with a medical group, clinic, or multispecialty IPA that assumes responsibility for the costs of all physician services related to a patient’s care
B. Pays individual specialists to provide only radiology services to all plan members
C. Transfers all financial risk for healthcare services to a provider organization and the provider, in turn, covers virtually all of a patient’s medical expenses
D. Contracts with a primary care provider to cover primary care services only

Answer: A

NEW QUESTION 30
- (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 31
- (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 36
- (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 theconfidentiality 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 37
- (Topic 1)
The Sweeney Health Plan uses the discounted fee-for-service (DFFS) method to compensate some of its providers. Under this method of compensation, Sweeney calculates payments based on

A. The standard fees of indemnity health insurance plans, adjusted by region
B. The Medicare fee schedules used by other health plans, adjusted by region
C. Whichever amount is higher, the billed charge or the DFFS amount
D. Whichever amount is lower, the billed charge or the DFFS amount

Answer: D

NEW QUESTION 38
- (Topic 1)
The Gladspell HMO has contracted with the Ellysium Hospital to provide subacute care to its plan members. Gladspell pays Ellysium by using a per diem reimbursement method.
If the Ellysium subacute care unit is typical of most hospital-based subacute skilled nursing units, then this unit could be used for patients who no longer need to be in the hospital's acute care unit but who still require

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

Answer: D

NEW QUESTION 41
- (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 45
- (Topic 1)
Jay Mercer is covered under his health plan's vision care plan, which includes coverage for clinical eye care but not for routine eye care. Recently, Mr. Mercer had a general eye examination and got a prescription for corrective lenses. Mr. Mercer's vision care plan will cover.

A. both the general eye examination and the prescription for corrective lenses
B. the general eye examination only
C. the prescription for corrective lenses only
D. neither the general eye examination nor the prescription for corrective lenses

Answer: D

NEW QUESTION 46
- (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.
In most states, a health plan can be held responsible for a provider's negligent malpractice. This legal concept is known as (vicarious liability / risk sharing). One step that health plans can take to reduce their exposure to malpractice lawsuits is to state in health plan-provider agreements,marketing collateral, and membership literature that the providers are (employees of the health plan / independent contractors).

A. Vicarious liability / employees of the health plan
B. Vicarious liability / independent contractors
C. Risk sharing / employees of the health plan
D. Risk sharing / independent contractors

Answer: B

NEW QUESTION 48
- (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 51
- (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 56
- (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 60
- (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 64
- (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 65
- (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 68
- (Topic 1)
The National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act defines specific adequacy and accessibility standards that health plans must meet. In addition, the Model Act requires health plans to

A. Hold plan members responsible for unreimbursed charges or unpaid claims
B. Allow providers to develop their own standards of care
C. Adhere to specified disclosure requirements related to provider contract termination
D. File written access plans and sample contracts with the Centers for Medicaid and Medicare Services (CMS)

Answer: C

NEW QUESTION 72
- (Topic 1)
The Ionic Group, a provider group with 10,000 plan members, purchased for its hospital risk pool aggregate stop-loss insurance with a threshold of 110% of projected costs and a 10% coinsurance provision. Ionic funds the hospital risk pool at $40 per member per month (PMPM).
If Ionic's actual hospital costs are $5,580,000 for the year, then, under the aggregate stop- loss agreement, the stop-loss insurer is responsible for reimbursing Ionic in the amount of

A. $30,000
B. $270,000
C. $300,000
D. $702,000

Answer: B

NEW QUESTION 75
- (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 79
- (Topic 1)
Determine whether the following statement is true or false:
The NCQA has established a Physician Organization Certification (POC) program for the purpose of certifying medical groups and independent practice associations for delegation of certain NCQA standards, including data collection and verification for credentialing and recredentialing.

A. True
B. False

Answer: A

NEW QUESTION 84
- (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 86
- (Topic 1)
An health plan's contract negotiation team consists of several skilled individuals from different areas. At least one of the members is responsible for evaluating the wording of specific clauses to ensure that the health plan's rights are protected, as well as to ensure that the contract is in compliance with state and federal regulation. By profession, this member of the contract negotiation team is typically

A. Amedical director
B. An attorney
C. Afinancial manager
D. Aclaims manager

Answer: B

NEW QUESTION 91
- (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 92
- (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 96
- (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 99
- (Topic 1)
Some states have enacted any willing provider laws. From the perspective of the health plan industry, one drawback of any willing provider laws is that they often result in a reduction of a plan's

A. Premium rates
B. Ability to monitor utilization
C. Number of primary care providers (PCPs)
D. Number of specialists and ancillary providers

Answer: B

NEW QUESTION 100
- (Topic 1)
The Avignon Company discontinued its contract with a traditional indemnity insurer and contracted exclusively with the Minaret Health Plan to provide the sole healthcare plan to Avignon's employees. By agreeing to an exclusive contract with Minaret, Avignon has entered into a type of healthcare contract known as

A. a carrier guarantee arrangement
B. open access
C. total replacement coverage
D. selective contract coverage

Answer: C

NEW QUESTION 101
- (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 104
- (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.
The per diem reimbursement method will require Gladspell to pay Ellysium a

A. Fixed rate for each day a plan member is treated in Ellysium's subacute care facility
B. Discounted charge for all subacute care services given by Ellysium
C. Rate that varies depending on patient category
D. Fixed rate per enrollee per month

Answer: A

NEW QUESTION 106
- (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 109
- (Topic 1)
Promise, Inc., a corporation that specializes in cancer services, employs its physicians and support staff and provides facilities and ancillary services for cancer patients. Promise has contracted with the Cordelia Health Plan to provide all specialty services for Cordelia plan members who are undergoing cancer treatment. In return, Promise receives a capitated amount from Cordelia. Promise is an example of a type of specialty services organization known as a

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

Answer: B

NEW QUESTION 110
- (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 113
- (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.
To calculate its drug costs, Elm uses a pricing system known as:

A. Estimated acquisition cost (EAC)
B. Package rate cost (PRC)
C. Actual acquisition cost (AAC)
D. Wholesale acquisition cost (WAC)

Answer: A

NEW QUESTION 117
- (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 120
- (Topic 2)
The Blanchette Health Plan uses a method of claims submission that allows its providers to submit claims directly to Blanchette through a computer application-to-application exchange of claims using a standard data format. This information indicates that Blanchette allows its providers to submit claims using technology known as

A. Telemedicine
B. An electronic referral system
C. Electronic data interchange
D. Encounter reporting

Answer: C

NEW QUESTION 123
- (Topic 2)
The following statements are about Medicaid health plan entities. Select the answer choice containing the correct statement:

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

Answer: C

NEW QUESTION 126
- (Topic 2)
The Aztec Health Plan has a variety of organizational committees related to quality and utilization management. These committees include the medical advisory committee, the credentialing committee, the utilization management committee, and the quality management committee. Of these committees, the one that most likely is responsible for providing oversight of Aztec's inpatient concurrent review process is the:

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

Answer: C

NEW QUESTION 129
- (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 130
- (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 132
- (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 137
- (Topic 2)
Health plans typically conduct two types of reviews of a provider's medical records: an evaluation of the provider's medical record keeping (MRK) practices and a medical record review (MRR). One true statement about these types of reviews is that:

A. An MRK covers the content of specific patient records of a provider.
B. The NCQA requires an examination of MRK with all of a health plan's office evaluations.
C. An MRR includes a review of the policies, procedures, and documentation standards the provider follows to create and maintain medical records.
D. The NCQA requires MRR for both credentialing and recredentialing of providers in a health plan's network.

Answer: A

NEW QUESTION 139
- (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 142
- (Topic 2)
The following statements are about network management for behavioral healthcare (BH). Three of these statements are true and one statement is false. Select the answer choice containing the FALSE statement.

A. Two measures of BH quality are patient satisfaction and clinical outcomes assessments.
B. For a health plan, one argument in favor of contracting with a managed behavioral healthcare organization (MBHO) is that the health plan's members can gain faster access to BH care.
C. In their contracts with health plans, managed behavioral healthcare organizations (MBHOs) usually receive delegated authority for network development and management.
D. Health plans generally compensate managed behavioral healthcare organizations (MBHOs) on an FFS basis.

Answer: D

NEW QUESTION 143
- (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 144
- (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 145
- (Topic 2)
The provider contract that Dr. Laura Cartier has with the Sailboat health plan includes a section known as the recitals. Dr. Cartier's contract includes the following statements:

A. A statement that identifies the purpose of the contract
B. A statement that defines in legal terms the parties to the contract
C. A statement that identifies the Sailboat products to be covered by the contractOf these statements, the ones that are likely to be included in the recitals section

of D
D. Cartier's contract are statements:
E. A, B, and C
F. A and B only
G. A and C only
H. B and C only

Answer: A

NEW QUESTION 148
- (Topic 2)
The following statements are about waivers and the Medicaid program. Select the answer choice containing the correct statement:

A. The Balanced Budget Act (BBA) of 1997 eliminated the need for states to make formal applications for waivers.
B. Section 1115 waivers allow states to bypass the Medicaid program's usual requirement of giving recipients complete freedom of choice in selecting providers.
C. Title XVIII waivers allow states to mandate certain categories of Medicaid recipients to enroll in health plan plans.
D. Section 1915(b) waivers allow states to establish demonstration projects in order to test new approaches to benefits and services provided by Medicaid.

Answer: A

NEW QUESTION 151
- (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 153
- (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 155
- (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 156
- (Topic 2)
The Foxfire Health Plan, which has 20,000 members, contracts with dermatologists on a contact capitation basis. The contact capitation arrangement has the following features:
Foxfire distributes the money in the contact capitation fund once each quarter and the distribution is based on the point totals accumulated by each dermatologist.
Foxfire's per member per month (PMPM) capitation for dermatology services is $1.
The dermatologist receives 1 point for each new referral that is not classified as a complicated referral and 1.5 points for each new referral that is classified as complicated.
During the first quarter, Foxfire's PCPs made 450 referrals to dermatologists and 100 of these referrals were classified as complicated. One dermatologist, Dr. Shareef Rashad, received 42 of these referrals; 6 of his referrals were classified as complicated. Statements that can correctly be made about Foxfire's contact

capitation arrangement include:

A. that the value of each referral point for the first quarter was $120
B. that the value of Foxfire's contact capitation fund for dermatologists for the first quarter was $20,000
C. that the payment that Foxfire owed D
D. Rashad for the first quarter was $6,120
E. all of the above

Answer: A

NEW QUESTION 159
- (Topic 2)
The Enterprise Health Plan has indicated an interest in delegating its medical records review activities to the Teal Group and has forwarded a typical letter of intent to Teal. One true statement about this letter of intent is that it:

A. Is a contract that creates a legally binding relationship between Enterprise and Teal
B. Cannot include a confidentiality clause
C. Serves as a delegation agreement between Enterprise and Teal
D. Outlines the delegation oversight process

Answer: D

NEW QUESTION 163
- (Topic 2)
The provider contract that Dr. Lorena Chau has with the Fiesta Health Plan includes an evergreen clause. The purpose of this clause is to:

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

Answer: C

NEW QUESTION 168
- (Topic 2)
One true statement about the responsibilities of providers under typical provider contracts is that most provider contracts:

A. include a clause which states that providers must maintain open communications with patients regarding appropriate treatment plans, unless the services are not covered by the member's health plan
B. hold that the responsibility of the provider to deliver services is usually subject to theprovider's receipt of information regarding the eligibility of the member
C. contain a gag clause or a gag rule
D. include a clause that explicitly places the responsibility for medical care on the health plan rather than on the provider of medical services

Answer: B

NEW QUESTION 173
- (Topic 2)
Medicaid beneficiaries pose a challenge for health plans attempting to establish Medicaid provider networks. Compared to membership in commercial health plans, Medicaid enrollees typically

A. Require access to greater numbers of obstetricians and pediatricians
B. Have stronger relationships with primary care providers
C. Are less reliant on emergency rooms as a source of first-line care
D. Need fewer support and ancillary services

Answer: A

NEW QUESTION 175
- (Topic 2)
A health plan has several options for delivering pharmacy services to its subscribers. Each option has potential advantages to a health plan. An advantage to a health plan of using:

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

Answer: B

NEW QUESTION 178
- (Topic 2)
The Crimson Health Plan, a competitive medical plan (CMP), has entered into a Medicare risk contract. One true statement about Crimson is that, as a:

A. CMP, Crimson is regulated by the federal government under the terms of the Tax Equity and Fiscal Responsibility Act (TEFRA)
B. CMP, Crimson is not allowed to charge a Medicare enrollee a premium for any additional benefits it provides over and above Medicare benefits
C. Provider under a Medicare risk contract, Crimson receives for its services a capitated payment equivalent to 85% of the AAPCC
D. Provider under a Medicare risk contract, Crimson is required to deliver to members all Medicare-covered services, without regard to the cost of those services

Answer: D

NEW QUESTION 180
- (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 185
- (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. Areduction in the market penetration of HMO and point-of-service (POS) products.
D. Areduction in the frequency of performance-based reimbursement of providers.

Answer: A

NEW QUESTION 189
- (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 193
- (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 195
- (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 199
- (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 202
- (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 204
- (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 208
- (Topic 2)
An increasing number of health plans offer coverage for alternative healthcare services. One such alternative healthcare service is biofeedback. Biofeedback is an approach that

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

Answer: C

NEW QUESTION 212
- (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 214
- (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 219
- (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 222
- (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 225
- (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 226
- (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 231
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