Exam Questions AHM-530

Network Management

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NEW QUESTION 1
- (Topic 1)
From the following answer choices, choose the type of clause or provision described in this situation.
The provider contract between Dr. Olin Norquist and the Granite Health Plan specifies a time period for the party who has breached the contract to remedy the problem and avoid termination of the contract.

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

Answer: A

NEW QUESTION 2
- (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 3
- (Topic 1)
The Walton Health Plan uses the fee-for-service pharmaceutical reimbursement approach known as the maximum allowable cost (MAC) method. If Walton's MAC list specifies a cost of 8 cents per tablet for a particular drug but the participating pharmacy pays 10 cents per tablet for the drug, then Walton will be obligated to reimburse the pharmacy for

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

Answer: B

NEW QUESTION 4
- (Topic 1)
Four types of APCs are ancillary APCs, medical APCs, significant procedure APCs, and surgical APCs. An example of a type of APC known as

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

Answer: C

NEW QUESTION 5
- (Topic 1)
In contracting with providers, a health plan can use a closed panel or open panel approach. One statement that can correctly be made about an open panel health plan is that the participating providers

A. must be employees of the health plan, rather than independent contractors
B. are prohibited from seeing patients who are members of other health plans
C. typically operate out of their own offices
D. operate according to their own standards of care, rather than standards of care established by the health plan

Answer: C

NEW QUESTION 6
- (Topic 1)
Decide whether the following statement is true or false:
The organizational structure of a health plan's network management function often depends on the size and geographic scope of the health plan. With respect to the size of a health plan, it is correct to say that smaller health plans typically have less integration and more specialization of roles than do larger health plans.

A. True
B. False

Answer: B

NEW QUESTION 7
- (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 8
- (Topic 1)
The following statement(s) can correctly be made about hospitalists.
* 1. The hospitalist's main function is to coordinate diagnostic and treatment activities to ensure that the patient receives appropriate care while in the hospital.
* 2. The hospitalist's role clearly supports the health plan concept of disease management.

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

Answer: B

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)
The following statements can correctly be made about the TRICARE managed healthcare program of the U.S. Department of Defense.
* 1. Active-duty military personnel are automatically enrolled in TRICARE's HMO option (TRICARE Prime).
* 2. Eligible family members and dependents can enroll in TRICARE Prime, the PPO plan (TRICARE Extra), or an indemnity plan (TRICARE Standard).

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

Answer: A

NEW QUESTION 11
- (Topic 1)
To protect providers against business losses, many health plan-provider contracts include carve-out provisions to help providers manage financial risk. The following statements are examples of such provisions:
The Apex Health Plan carves out immunizations from PCP capitations. Apex compensates PCPs for immunizations on a case rate basis.
The Bengal Health Plan carves out behavioral healthcare services from the scope of PCP services because these services require specialized knowledge and skills that most PCPs do not possess.
From the answer choices below, select the response that best identifies the types of carve- outs used by Apex and Bengal.

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

Answer: C

NEW QUESTION 13
- (Topic 1)
One reimbursement method that health plans can use for hospitals is the ambulatory payment classifications (APCs) method. APCs bear a resemblance to the diagnosis-related groups (DRGs) method of reimbursement. However, when comparing APCs and DRGs, one of the primary differences between the two methods is that only the APC method

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

Answer: A

NEW QUESTION 17
- (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 18
- (Topic 1)
Dr. Janet Dubois is a radiologist who practices exclusively at the Rightway Healthcare Center. This information indicates that Dr. Dubois is employed by Rightway as

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

Answer: D

NEW QUESTION 23
- (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 24
- (Topic 1)
The Festival Health Plan is in the process of recruiting physicians for its provider network. Festival requires its network physicians to be board certified. The following individuals are provider applicants whose qualifications are being considered:
Applicant 1 has completed his surgical residency, and he recently passed a qualifying examination in his field.
Applicant 2 has completed her residency in dermatology, and she is scheduled to take qualifying examinations in the next Six months.
Applicant 3 completed his residency in pediatric medicine six years ago, but he has not yet passed a qualifying examination in his field.
With regard to these applicants, it can correctly be stated that only

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

Answer: C

NEW QUESTION 26
- (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 28
- (Topic 1)
The following statements are about the responsibilities that providers are expected to assume under most provider contracts with health plans. Select the answer choice containing the correct statement.

A. All health plans now include in their provider contracts a statement that explicitly places responsibility for the medical care of plan members on the health plan rather than on the provider.
B. According to the wording of most provider contracts, the responsibility of providers to deliver medical services to a plan member is not contingent upon the provider's receipt of information regarding the member's eligibility for these services.
C. Most health plans include in their provider contracts a clause which requires providers to maintain open communication with plan members regarding appropriate treatment plans, even if the services are not covered by the member's health plan.
D. Most provider contracts require participating providers to discuss health plan payment arrangements with patients who are covered by the plan.

Answer: C

NEW QUESTION 30
- (Topic 1)
By definition, a measure of the extent to which a health plan member can obtain necessary medical services in a timely manner is known as

A. Network management
B. Quality
C. Cost-effectiveness
D. Accessibility

Answer: D

NEW QUESTION 33
- (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 38
- (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 43
- (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 47
- (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 50
- (Topic 1)
Before incurring the expense of assembling a new PPO network, the Protect Health Plan conducted a cost analysis in order to determine the cost-effectiveness of renting an existing PPO network instead. In calculating the overall cost of renting the network, Protect assumed a premium of $2.52 per member per month (PMPM) and estimated the total number of members to be 9,000. This information indicates that Protect would calculate its annual network rental cost to be

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

Answer: C

NEW QUESTION 51
- (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 54
- (Topic 1)
The following statements can correctly be made about the advantages and disadvantages to an health plan of using the various delivery options for pharmacy services.

A. A disadvantage of using open pharmacy networks is that the health plan's control over costs is limited to setting reimbursement levels.
B. An advantage of using performance-based systems is that they tend to increase participation in the health plan's pharmacy network.
C. A disadvantage of using customized pharmacy networks is that these networks typically can be implemented only in companies with fewer than 500 employees.
D. All of these statements are correct.

Answer: A

NEW QUESTION 59
- (Topic 1)
Determine whether the following statement is true or false:
The NCQA has established a Physician Organization Certification (POC) program for the purpose of certifying medical groups and independent practice associations for delegation of certain NCQA standards, including data collection and verification for credentialing and recredentialing.

A. True
B. False

Answer: A

NEW QUESTION 62
- (Topic 1)
With respect to contractual provisions related to provider-patient communications, nonsolicitation clauses prohibit providers from

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

Answer: A

NEW QUESTION 67
- (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 70
- (Topic 1)
A population's demographic factors—such as income levels, age, gender, race, and ethnicity—can influence the design of provider networks serving that population. With respect to these demographic factors, it is correct to say that

A. higher-income populations have a higher incidence of chronic illnesses than do lowerincome populations
B. compared to other groups, young men are more likely to be attached to particular providers
C. a population with a high proportion of women typically requires more providers than does a population that is predominantly male
D. Health plans should not recognize, in either the design of networks or the evaluation of provider performance, racial and ethnic differences in the member population

Answer: C

NEW QUESTION 75
- (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 76
- (Topic 1)
The provider contract between the Ocelot Health Plan and Dr. Enos Zorn, one of the health plan's participating providers, is a brief contract which includes, by reference, an Ocelot provider manual. This manual contains much of the information found in Ocelot's comprehensive provider contracts. The following statements are about Dr. Zorn's provider contract. Select the answer choice containing the correct statement.

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

Answer: B

NEW QUESTION 77
- (Topic 1)
The Holiday Health Plan is preparing to enter a new market. In order to determine the optimal size of its provider panel in the new market, Holiday is conducting a competitive analysis of provider networks of the market's existing health plans. Consider whether, in conducting its competitive analysis, Holiday should seek answers to the following questions:
Question 1: What are the cost-containment strategies of the health plans with increasing market shares?
Question 2: What are the premium strategies of the health plans with large market shares?
Question 3: What are the characteristics of health plans that are losing market share?
In its competitive analysis, Holiday should most likely obtain answers to questions

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

Answer: A

NEW QUESTION 78
- (Topic 1)
Health plans use a variety of sources to find candidates to recruit for their provider networks. In general, two of the most effective methods of finding candidates are through

A. Word of mouth and on-site training programs
B. Word of mouth and direct mail
C. Advertisements in local newspapers and on-site training programs

D. Advertisements in local newspapers and direct mail

Answer: B

NEW QUESTION 80
- (Topic 1)
The Aegean Health Plan delegated its utilization management (UM) program to the Silhouette IPA. Silhouette, in turn, transferred authority for case management to Brandon Health Services. In this situation, Brandon is best described as the

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

Answer: C

NEW QUESTION 83
- (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 85
- (Topic 1)
The Athena Medical Group has purchased from the Corinthian Insurance Company individual stop-loss insurance coverage for primary and specialty care services with a
$5,000 attachment point and 10 percent coinsurance. One of Athena's patients accrued
$8,000 of medical costs for primary and specialty care treatment. In this situation, Athena will be responsible for paying an amount equal to

A. $300, and Corinthian is obligated to reimburse Athena in the amount of $2,700
B. $2,700, and Corinthian is obligated to reimburse Athena in the amount of $5,300
C. $5,300, and Corinthian is obligated to reimburse Athena in the amount of $2,700
D. $7,700, and Corinthian is obligated to reimburse Athena in the amount of $300

Answer: C

NEW QUESTION 87
- (Topic 1)
One type of fee schedule payment system assigns a weighted unit value for each medical procedure or service based on the cost and intensity of that service. Under this system, the unit values for procedural services are generally higher than the unit values for cognitive services. This system is known as a

A. Wrap-around payment system
B. Relative value scale (RVS) payment system
C. Resource-based relative value scale (RBRVS) system
D. Capped fee system

Answer: B

NEW QUESTION 90
- (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 94
- (Topic 1)
During the credentialing process, a health plan verifies the accuracy of information on a prospective network provider's application. One true statement regarding this process is that the health plan

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

is contingent upon the completion of the credentialing process

Answer: D

NEW QUESTION 96
- (Topic 1)
The following statements are about the specialist component of a provider panel. Select the answer choice containing the correct statement.

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

Answer: A

NEW QUESTION 97
- (Topic 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 99
- (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 102
- (Topic 1)
Some jurisdictions have enacted corporate practice of medicine laws. One effect that corporate practice of medicine laws have had on HMO provider networks is that these laws typically

A. require incorporated HMOs to practice medicine through licensed employees
B. require HMOs to form exclusive contracts with physician groups who agree to dedicate all or most of their practices to HMO patients in return for a set payment or revenue-sharing
C. restrict the ability of staff model HMOs to hire physicians directly, unless the physiciansown the HMO
D. encourage incorporated HMOs to obtain profits from their provisions of physician professional services

Answer: C

NEW QUESTION 106
- (Topic 1)
From the following answer choices, choose the type of clause or provision described in this situation.
The Aviary Health Plan includes in its provider contracts a clause or provision that places the ultimate responsibility for an Aviary plan member's medical care on the provider.

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

Answer: D

NEW QUESTION 108
- (Topic 2)
The vision benefits offered by the Omni Health Plan include clinical eye care only. The following statements describe vision care received by Omni plan members:
•Brian Pollard received treatment for a torn retina he suffered as a result of an accident
•Angelica Herrera received a general eye examination to test her vision
•Megan Holtz received medical services for glaucoma
Of these medical services, the ones that most likely would be covered by Omni's vision coverage would be the services received by:

A. M
B. Pollard, M
C. Herrera, and M
D. Holtz
E. M
F. Pollard and M
G. Herrera only
H. M
I. Pollard and M
J. Holtz only
K. M
L. Herrera and M
M. Holtz only

Answer: C

NEW QUESTION 112
- (Topic 2)
Dr. Michelle Kubiak has contracted with the Gem Health Plan, a Medicare+Choice health plan, to provide medical services to Gem's enrollees. Gem pays Dr. Kubiak $40 per enrollee per month for providing primary care. Gem also pays her an additional $10 per enrollee per month if the cost of referral services falls below a targeted level. This information indicates that, according to the substantial financial risk formula, Dr. Kubiak's referral risk under this contract is equal to:

A. 20%, and therefore this arrangement puts her at substantial financial risk
B. 20%, and therefore this arrangement does not put her at substantial financial risk
C. 25%, and therefore this arrangement puts her at substantial financial risk
D. 25%, and therefore this arrangement does not put her at substantial financial risk

Answer: B

NEW QUESTION 117
- (Topic 2)
If a member of the Green Health Plan reasonably believes that a provider in Green's provider network was acting as Green's employee or agent while providing negligent care, then the member may have cause to bring action against the health plan. This legal concept is known as vicarious liability. Steps that Green can take to reduce its exposure to vicarious liability claims include:

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

Answer: B

NEW QUESTION 121
- (Topic 2)
The Azure Health Plan strives to ensure for its plan members the best possible level of care from its providers. In order to maintain such high standards, Azure uses a variety of quantitative and qualitative (behavioral) measures to determine the effectiveness of its providers. Azure then compares the clinical and operational practices of its providers with those of other providers outside the network, with the goal of identifying and implementing the practices that lead to the best outcomes.
Qualitative measures that Azure could use to assess provider performance include an evaluation of how

A. Quickly the provider responds to plan members' inquiries
B. Effectively the provider communicates with plan members
C. Often the provider refers plan members for ancillary services
D. Many plan members visit the provider per month

Answer: C

NEW QUESTION 124
- (Topic 2)
Partial capitation is one common approach to capitation. One typical characteristic of partial capitation is that it:

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

Answer: A

NEW QUESTION 125
- (Topic 2)
The Elizabethan Health Plan uses a direct referral program, which means that

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

Answer: A

NEW QUESTION 128
- (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 129
- (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 133
- (Topic 2)
The following statement(s) can correctly be made about financial arrangements between health plans and emergency departments of hospitals:

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

Answer: C

NEW QUESTION 137
- (Topic 2)
In most states, workers' compensation is first-dollar and last-dollar coverage, which means thatworkers' compensation programs

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

Answer: C

NEW QUESTION 138
- (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 141
- (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 145
- (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 146
- (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 147
- (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)
One characteristic of the workers' compensation program is that:

A. workers' compensation coverage is available to all employees, regardless of their eligibility for health insurance coverage
B. indemnity benefits currently account for less than 10% of all workers' compensation benefits
C. workers' compensation programs in most states require eligible employees to obtain medical treatment only from members of a provider network
D. workers' compensation programs include deductibles and coinsurance requirements

Answer: A

NEW QUESTION 149
- (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 150
- (Topic 2)
Member satisfaction surveys help an health plan determine whether its providers are consistently delivering services to plan members in a manner that lives up to member expectations. Member satisfaction surveys allow the health plan to gather information about

A. Amember's reaction to services received during a specific encounter
B. The reactions of specific subsets of the health plan's membership
C. Members' positive and negative experience with the plan's services
D. All of the above

Answer: D

NEW QUESTION 154
- (Topic 2)
The BBA of 1997 specifies the ways in which a Medicare+Choice plan can establish and use provider networks. A Medicare+Choice plan that operates as a private fee for service (PFFS) plan is allowed to

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

Answer: B

NEW QUESTION 156
- (Topic 2)
Although ambulatory payment classifications (APCs) bear some resemblance to diagnosis- related groups (DRGs), there are significant differences between APCs and DRGs. One of these differences is that APCs:

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

Answer: A

NEW QUESTION 157
- (Topic 2)
Grant Pelham is covered by both a workers' compensation program and a group health plan provided by his employer. The Shipwright Health Plan administers both programs. Mr. Grant was injured while on the job and applied for benefits.
Mr. Pelham's group health insurance plan and workers' compensation both provide benefits to cover expenses incurred as a result of illness or injury. However, unlike traditional group insurance coverage, workers' compensation

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

Answer: A

NEW QUESTION 162
- (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 164
- (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 168
- (Topic 2)
Dr. Sylvia Cimer and Dr. Andrew Donne are obstetrician/gynecologists who participate in
the same provider network. Dr. Comer treats a large number of high-risk patients, whereas Dr. Donne's patients are generally healthy and rarely present complications. As a result, Dr. Comer typically uses medical resources at a much higher rate than does Dr. Donne. In order to equitably compare Dr. Comer's performance with Dr. Donne's performance, the health plan modified its evaluation to account for differences in the providers' patient populations and treatment protocols. The health plan modified Dr. Comer's and Dr. Donne's performance data by means of

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

Answer: A

NEW QUESTION 171
- (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 173
- (Topic 2)
Before or during the orientation process, health plans generally provide new network providers with a provider manual. One of the primary purposes of the provider manual is to

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

Answer: D

NEW QUESTION 174
- (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 177
- (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 179
- (Topic 2)
The provider contract that the Canyon health plan has with Dr. Nicole Enberg specifies that she cannot sue or file any claims against a Canyon plan member for covered services, even if Canyon becomes insolvent or fails to meet its financial obligations. The contract also specifies that Canyon will compensate her under a typical discounted fee-for-service (DFFS) payment system.
During its recredentialing of Dr. Enberg, Canyon developed a report that helped the health plan determine how well she met Canyon's standards. The report included cumulative performance data for Dr. Enberg and encompassed all measurable aspects of her performance. This reportincluded such information as the number of hospital admissions Dr. Enberg had and the number of referrals she made outside of Canyon's provider network during a specified period. Canyon also used process measures, structural measures, and outcomes measures to evaluate Dr. Enberg's performance.
The report that helped Canyon determine how well Dr. Enberg met the health plan's standards is known as:

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

Answer: C

NEW QUESTION 180
- (Topic 2)
State Medicaid agencies can contract with health plans through open contracting or selective contracting. One advantage of selective contracting is that it

A. Allows enrollees to choose from among a greater variety of health plans
B. Reduces the competition among health plans
C. Increases the ability of new, local plans to participate in Medicaid programs
D. Encourages the development of products that offer enhanced benefits and more effective approaches to health plans

Answer: D

NEW QUESTION 182
- (Topic 2)
Grant Pelham is covered by both a workers' compensation program and a group health plan provided by his employer. The Shipwright Health Plan administers both programs. Mr. Grant was injured while on the job and applied for benefits.
Because Mr. Pelham was injured on the job, he is entitled to receive benefits through workers' compensation. Under the terms of the state-mandated exclusive remedy doctrine included in the workers' compensation agreement, Mr. Pelham will most likely be prohibited from

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

Answer: C

NEW QUESTION 187
- (Topic 2)
One true statement about the Medicaid program in the United States is that:

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

Answer: C

NEW QUESTION 192
- (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)
The provider contract that Dr. Ted Dionne has with the Optimal Health Plan includes an arrangement that requires Dr. Dionne to notify Optimal if he contracts with another health plan at a rate that is lower than the rate offered to Optimal. Dr. Dionne must also offer this lower rate to Optimal. This information indicates that the provider contract includes a:

A. Most-favored-nation arrangement

B. Warranty arrangement
C. Locum tenens arrangement
D. Nesting arrangement

Answer: A

NEW QUESTION 198
- (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 201
- (Topic 2)
The Ventnor Health Plan requires the physicians in its provider network to be board certified. Ventnor has received requests to become a part of the network from the following specialists:
Cheryl Stovall, who is currently in the process of completing a residency in her field ofspecialization.
Thomas Kalil, who has completed a residency in his field of specialization and has passed a qualifying examination in that field within two years of completing his residency.
Roger Todd, who has completed a residency in his field of specialization but has not passed a qualifying examination in that field.
Ventnor's requirement of board certification is met by:

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

Answer: C

NEW QUESTION 205
- (Topic 2)
Social health maintenance organizations (SHMOs) and Programs of All-Inclusive Care for the Elderly (PACE) are federal programs designed to provide coordinated healthcare services to the elderly. Unlike PACE, SHMOs

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

Answer: D

NEW QUESTION 208
- (Topic 2)
Prior to the enactment of the Balanced Budget Act (BBA) of 1997, payment for Medicare- covered primary and acute care services was based on the adjusted average per capita cost (AAPCC). The AAPCC is defined as the

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

Answer: C

NEW QUESTION 209
- (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 212
- (Topic 2)
The Tuba Health Plan recently underwent an accreditation process under a program known as Accreditation '99, which includes selected Health Employer Data and Information Set (HEDIS) measures. Under Accreditation '99, Tuba received a rating of Excellent. The following statement(s) can correctly be made about this quality assessment of Tuba's operations:

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

Answer: B

NEW QUESTION 213
- (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 218
- (Topic 2)
In health plan pharmacy networks, service costs consist of two components: costs for services associated with dispensing prescription drugs and costs for cognitive services. Cognitive services typically include:

A. making generic substitutions of drugs
B. counseling patients about prescriptions
C. providing patient monitoring
D. switching prescription drugs to preferred drugs

Answer: B

NEW QUESTION 223
- (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 224
- (Topic 2)
Franklin Pitt selected a Medicare+Choice option under which he is covered by a catastrophic health insurance policy with a high annual deductible and a $6,000 out-of- pocket expense maximum. CMS pays the premiums for the insurance policy out of the usual Medicare+Choice payment and deposits any difference between the capitated amount and the policy premium in a savings account. Mr. Pitt can use funds in the savings account to pay qualified medical expenses not covered by his insurance policy. At the end of the benefit year, Mr. Pitt can carry any remaining funds into the next benefit year. The Medicare+Choice option Mr. Pitt selected is known as a

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

Answer: B

NEW QUESTION 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 229
- (Topic 2)
Martin Breslin, age 72 and permanently disabled, is classified as dually-eligible. This information indicates that Mr. Breslin qualifies for coverage by both

A. Medicare and private indemnity insurance, and Medicare provides primary coverage
B. Medicare and Medicaid, and Medicare provides primary coverage
C. Medicaid and private indemnity insurance, and Medicaid provides primary coverage
D. Medicare and Medicaid, and Medicaid provides primary coverage

Answer: B

NEW QUESTION 230
- (Topic 2)
The following statements describe two types of HMOs:
The Elm HMO requires its members to select a PCP but allows the members to go to any other provider on its panel without a referral from the PCP.
The Treble HMO does not require its members to select a PCP. Treble allows its members to go to any doctor, healthcare professional, or facility that is on its panel without a referral from a primary care doctor. However, care outside of Treble's network is not reimbursed unless the provider obtains advance approval from the HMO.
Both HMOs use delegation to transfer certain functions to other organizations. Following the guidelines established by the NCQA, Elm delegated its credentialing activities to the Newnan Group, and the agreement between Elm and Newnan lists the responsibilities of both parties under the agreement. Treble delegated utilization management (UM) to an IPA. The IPA then transferred the authority for case management to the Quest Group, an organization that specializes in case management.
Both HMOs also offer pharmacy benefits. Elm calculates its drug costs according to a pricing system that requires establishing a purchasing profile for each pharmacy and basing reimbursement on the profile. Treble and the Manor Pharmaceutical Group have an arrangement that requires the use of a typical maximum allowable cost (MAC) pricing system to calculate generic drug costs under Treble's pharmacy program. The following statements describe generic drugs prescribed for Treble plan members who are covered by Treble's pharmacy benefits:
The MAC list for Drug A specifies a cost of 12 cents per tablet, but Manor pays 14 cents
per tablet for this drug.
The MAC list for Drug B specifies a cost of 7 cents per tablet, but Manor pays 5 cents per tablet for this drug.
From the following answer choices, select the response that best identifies Elm and Treble:

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

Answer: C

NEW QUESTION 233
- (Topic 2)
The Medicaid program subsidizes indigent care through payments to disproportionate share hospitals (DSHs). The Preamble Hospital is a DSH. As a DSH, Preamble most likely:

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

Answer: B

NEW QUESTION 235
- (Topic 2)
The following statements are about workers' compensation provider networks. Select the answer choice containing the correct statement:

A. In order to supply a provider network to furnish healthcare to workers' compensation beneficiaries, a health plan typically uses the network that has already been created for the group health plan.
B. Typically, case managers for workers' compensation programs are physical therapists.
C. Most states prohibit the use of fee schedules in order to curb the rising workers' compensation healthcare costs.
D. Networks serving workers' compensation patients typically include higher concentrations of specialists than do other provider networks.

Answer: D

NEW QUESTION 239
- (Topic 2)
The provider contract that the Canyon health plan has with Dr. Nicole Enberg specifies that she cannot sue or file any claims against a Canyon plan member for covered services, even if Canyon becomes insolvent or fails to meet its financial obligations. The contract also specifies that Canyon will compensate her under a typical discounted fee-for-service (DFFS) payment system.
During its recredentialing of Dr. Enberg, Canyon developed a report that helped the health plan determine how well she met Canyon's standards. The report

included cumulative performance data for Dr. Enberg and encompassed all measurable aspects of her performance. This report included such information as the number of hospital admissions Dr. Enberg had and the number of referrals she made outside of Canyon's provider network during a specified period. Canyon also used process measures, structural measures, and outcomes measures to evaluate Dr. Enberg's performance.
The clause which specifies that Dr. Enberg cannot sue or file any claims against a Canyon plan member for covered services is known as:

A. Atermination with cause clause
B. Ahold-harmless clause
C. An indemnification clause
D. Acorrective action clause

Answer: B

NEW QUESTION 240
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