# AHIP

## Exam Questions AHM-540

Medical Management

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

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

**Answer:** A

**NEW QUESTION 2**
The Medicaid population can be divided into subgroups based on their relative size and the costs of providing benefits. From the answer choices below, select the response that correctly identifies the subgroups that represent the largest percentages of the total Medicaid population and of total Medicaid expenditures. Largest % of Medicaid Population- Largest % of Medicaid Expenditures-

A. Largest % of Medicaid Population-dual eligibles Largest % of Medicaid Expenditures- children and low-income adults
B. Largest % of Medicaid Population-chronically ill or disabled individuals not eligible for MedicareLargest % of Medicaid Expenditures-dual eligibles
C. Largest % of Medicaid Population-children and low-income adults Largest % of Medicaid Expenditures-chronically ill or disabled individuals not eligible for Medicare
D. Largest % of Medicaid Population-chronically ill or disabled individuals not eligible for Medicare Largest % of Medicaid Expenditures-children and low-income adults

**Answer:** C

**NEW QUESTION 3**
Determine whether the following statement is true or false:
Immunization programs are a direct means of reducing health plan members' needs for healthcare services and are typically cost-effective.

A. True
B. False

**Answer:** A

**NEW QUESTION 4**
Determine whether the following statement is true or false:
With respect to the size of a managed care organization (MCO) and its medical management operations, it is correct to say that large health plans typically have more integration among activities and less specialization of roles than do small MCOs.

A. True
B. False

**Answer:** B

**NEW QUESTION 5**
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
Ways that workers' compensation health plans can help control the costs of job-related injuries and illnesses include

A. applying strict definitions of medical necessity
B. developing prevention and recovery programs
C. applying out-of-network benefit reductions
D. all of the above

**Answer:** B

**NEW QUESTION 6**
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
Definitions of quality healthcare vary; however, four dimensions are essential to quality healthcare services. _____ is the quality dimension indicating that services result in the best care for a given cost or the lowest cost for a given level of care.

A. Accessibility
B. Effectiveness
C. Acceptability
D. Efficiency

**Answer:** D

**NEW QUESTION 7**
Increased demands for performance information have resulted in the development of various health plan report cards. With respect to most of the report cards currently available, it is correct to say

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

D. all of the above

**Answer:** D

**NEW QUESTION 8**
To see that utilization guidelines are consistently applied, UR programs rely on authorization systems. Determine whether the following statement about authorization systems is true or false:
Only physicians can make nonauthorization decisions based on medical necessity.

A. True
B. False

**Answer:** A

**NEW QUESTION 9**
The Carlyle Health Plan uses the following clinical outcome measures to evaluate its diabetes and asthma disease management programs:
Measure 1: The percentage of diabetic patients who receive foot exams from their providers according to the program's recommended guidelines Measure 2: The number of asthma patients who visited emergency departments for acute asthma attacks
From the answer choices below, select the response that correctly identifies whether these measures are true outcome measures or intermediate outcome measures. Measure 1- Measure 2-

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

**Answer:** C

**NEW QUESTION 10**
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the terms or phrases that you have chosen.
The Millway Health Plan received a 15% reduction in the price of a particular pharmaceutical based on the volume of the drug Millway purchased from the manufacturer. This reduction in price is an example of a (rebate / price discount) and (is / is not) dependent on actual provider prescribing patterns.

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

**Answer:** D

**NEW QUESTION 10**
The following statement(s) can correctly be made about the scope of case management:
* 1. Case management incorporates activities that may fall outside a health plan's typical responsibilities, such as assessing a member's financial situation
* 2. Case management generally requires a less comprehensive and complex approach to a course of care than does utilization review
* 3. Case management is currently applicable only to medical conditions that require inpatient hospital care and are categorized as catastrophic in terms of health and/or costs

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

**Answer:** D

**NEW QUESTION 14**
The following statements are about health plans' development of medical policies. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. Technology assessment is applicable only to medical policy development for new medical procedures, devices, drugs, and tests.
B. Technology assessment provides the scientific rationale for the medical policy section that specifies when a medical service is appropriate and when it is not.
C. The medical policy development process includes both a clinical and an operational review of a proposed medical policy.
D. The decision to accept or reject a proposed medical policy often depends on how a new technology compares to currently used interventions.

**Answer:** A

**NEW QUESTION 15**
Health plan performance measures include structure measures, process measures, and outcome measures. The following statements are about the characteristics of these three types ofperformance measures. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. The most widely used structure measures relate to physician education and training.
B. One advantage of structure measures over process measures is that structures are often linked directly to healthcare outcomes.
C. Process measures are useful in identifying underuse, overuse, and inappropriate use of services.
D. One disadvantage of outcome measures is that they can be influenced by factors outside the control of the health plan.

**Answer:** B

**NEW QUESTION 20**
Home healthcare encompasses a wide variety of medical, social, and support services delivered at the homes of patients who are disabled, chronically ill, or terminally ill. The time period(s) when health plans typically use home healthcare include
* 1. The period prior to a hospital admission
* 2. The period following discharge from a hospital

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

**Answer:** A

**NEW QUESTION 24**
The paragraph below contains two pairs of terms in parentheses. Determine which term in each pair correctly completes the paragraph. Then select the answer choice containing the two terms that you have chosen.
Health plans use both internal and external standards to assess the quality of the services that they provide. (Internal / External) standards are based on information such as published industry-wide averages or best practices of recognized industry leaders. Health plans primarily rely on (internal / external) standards to evaluate healthcare services.

A. Internal / internal
B. Internal / external
C. External / internal
D. External / external

**Answer:** D

**NEW QUESTION 29**
The following statement(s) can correctly be made about accrediting agency standards for delegation:
* 1. The National Committee for Quality Assurance (NCQA) allows health plans to delegate
all medical management functions, including the responsibility to perform delegation oversight activities
* 2. In some cases, accreditation standards for delegation oversight are reduced if the delegate has already been certified or accredited by the delegator's accrediting agency

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

**Answer:** C

**NEW QUESTION 32**
Nilay Sharma suffered a small wound while working in his yard and was taken to a local hospital for treatment. A triage nurse at the hospital evaluated Mr. Sharma's condition and directed him to an outpatient unit in the hospital where a physician assistant examined, cleaned, and sutured the wound. Mr. Sharma returned home following treatment. The care Mr. Sharma received at the hospital is an example of the type of care known as

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

**Answer:** C

**NEW QUESTION 33**
Michelle Durden, who is enrolled in a dental health maintenance organizations (DHMO) offered by her employer, is due for a routine dental examination. If the plan is typical of most DHMOs, then Ms. Durden

A. must pay the entire cost of the examination
B. must obtain a referral to a dentist from her primary care provider (PCP)
C. can schedule the examination without preauthorization of payment by the DHMO
D. can schedule an unlimited number of examinations and cleanings per year

**Answer:** C

**NEW QUESTION 35**
The following statements are about QAPI as it applies to Medicare+Choice plans and Medicaid health plan entities. Select the answer choice containing the correct statement.

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

**Answer:** D

**NEW QUESTION 39**
Three general categories of coverage policy—medical policy, benefits administration policy, and administrative policy—are used in conjunction with purchaser contracts to determine a health plan's coverage of healthcare services and supplies. With respect to the characteristics of the three types of coverage policy, it is correct to say that a health plan's

A. medical policy evaluates clinical services against specific benefits language rather than against scientific evidence
B. benefits administration policy determines whether a particular service is experimental or investigational
C. benefits administration policy focuses on both clinical and nonclinical coverage issues
D. administrative policy contains the guidelines to be followed when handling member and provider complaints and disputes

**Answer:** D

**NEW QUESTION 42**
The Mental Health Parity Act (MHPA) of 1996 is a federal law that establishes requirements for behavioral healthcare coverage for group plan members. The MHPA

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

**Answer:** B

**NEW QUESTION 44**
Elaine Newman suffered an acute asthma attack and was taken to a hospital emergency department for treatment. Because Ms. Newman's condition had not improved enough following treatment to warrant immediate release, she was transferred to an observation care unit. Transferring Ms. Newman to the observation care unit most likely

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

**Answer:** D

**NEW QUESTION 45**
Federal laws, such as the Employee Retirement Income Security Act (ERISA), the Balanced Budget Act (BBA) of 1997, and the Health Insurance Portability and Accountability Act (HIPAA), have affected medical management activities by health plans. Consider the following provisions of federal regulations:
Provision 1—Limits damage awards in lawsuits related to noncoverage of benefits based on medical necessity decisions to the cost of noncovered treatment and does not allow health plan members to obtain compensatory or punitive damages
Provision 2—Establishes electronic data security standards, which define the security measures that healthcare organizations must take to protect the confidentiality of electronically stored and transmitted patient information From the answer choices below, select the response that correctly identifies the federal laws that include Provision 1 and Provision 2, respectively.

A. Provision 1- ERISA Provision 2- HIPAA
B. Provision 1- HIPAA Provision 2- ERISA
C. Provision 1- BBA of 1997 Provision 2- HIPAA
D. Provision 1- ERISA Provision 2- BBA of 1997

**Answer:** A

**NEW QUESTION 48**
Performance variance can be classified as either common cause variance or special cause variance. The following statement(s) can correctly be made about special cause variance:
* 1. Inadequate staffing levels, employee errors, and equipment malfunctions are examples of special cause variance
* 2. Special cause variance is typically more difficult to detect and correct than is common cause variance

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

**Answer:** B

**NEW QUESTION 52**
Benchmarking is a quality improvement strategy used by some health plans. With regard to benchmarking, it is correct to say that

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

**Answer:** D

**NEW QUESTION 55**
The following statements are about disease management programs. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. The focus of disease management is on responding to the needs of individual members for extensive, customized healthcare supervision.
B. Disease management programs serve to improve both clinical and financial outcomes for healthcare services related to chronic conditions.
C. Tools such as preventive care, self-care, and decision support programs are used to support both case management and disease management.
D. Disease management programs apply to both diseases and medical conditions that are not diseases, such as high-risk pregnancy, severe burns, and trauma.

**Answer:** A

**NEW QUESTION 58**
Since its inception, Medicare has undergone a number of changes because of legal and regulatory action. One result of the Balanced Budget Act (BBA) of 1997 has been to

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

**Answer:** A

**NEW QUESTION 62**
The following statements are about health plans' complaint resolution procedures (CRPs). Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. An health plan's CRPs reduce the likelihood of errors in decision making.
B. CRPs typically provide for at least two levels of appeal for formal appeals.
C. CRPs include only formal appeals and do not apply to informal complaints.
D. Most complaints are resolved without proceeding through the entire CRP process.

**Answer:** C

**NEW QUESTION 67**
Many health plans use clinical pathways to help manage the delivery of acute care services to plan members. One true statement about clinical pathways is that they

A. determine which healthcare services are medically necessary and appropriate for a particular patient in a particular situation
B. outline the services that will be delivered, the providers responsible for delivering the services, the timing of delivery, the setting in which services are delivered, and the expected outcomes of the interventions
C. cover only services delivered in an acute inpatient setting
D. address medical conditions that affect a small segment of a given population and with which the majority of providers are unfamiliar

**Answer:** B

**NEW QUESTION 70**
Determine whether the following statement is true or false:
All health plans participating in the Federal Employee Health Benefits Program (FEHBP) are required to use the Consumer Assessment of Health Plans (CAHPS) to measure customer satisfaction.

A. True
B. False

**Answer:** A

**NEW QUESTION 71**
To improve members’ abilities to make appropriate care decisions about specific medical problems, some health plans use a form of decision support known as telephone triage programs. The following statements are about telephone triage programs. Select the answer choice containing the correct statement.

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

**Answer:** B

**NEW QUESTION 74**
One of the steps in drug utilization review (DUR) is defining optimal drug use, which can be accomplished by applying diagnosis criteria and drug-specific criteria. Drug-specific criteria are standards that identify the

A. appropriate dosages, duration of treatment, and other elements related to the use of a particular drug
B. actual prescribing and dispensing patterns for a particular drug
C. types of diseases, conditions, or patients for which a drug should be used
D. cost-effectiveness of all possible drug treatments for a particular condition

**Answer:** A

**NEW QUESTION 78**
Comparing the quality of managed Medicare programs with the quality of FFS Medicare programs is often difficult. Unlike FFS Medicare, managed Medicare programs

A. can measure and report quality only at the provider level
B. use a single system to deliver services to all plan members
C. provide an organizational focus for accountability
D. can use the same performance measures for all products and plans

**Answer:** C

**NEW QUESTION 79**
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
In most commercial health plans, the case management process is directed by a case manager whose responsibilities typically include

A. focusing on a disabled member's vocational rehabilitation and training
B. approving all care decisions for patients under case management
C. reducing the fragmentation of care that often results when individuals obtain services from several different providers
D. all of the above

**Answer:** C

**NEW QUESTION 81**
When conducting performance assessment, a health pln may classify the key processes associated with its services into the following categories: high-risk, high-volume, problem- prone, and high-cost.
The following statements are about this classification of processes. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

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

**Answer:** B

**NEW QUESTION 86**
Health plans have a specified number of working days to respond to Level One appeals, as stated by company policy or regulatory requirements. With regard to the timeframes for appeals, it is generally correct to say
* 1. That the typical timeframe requires a health plan to respond to appeals in fewer than 20 days
* 2. That the timeframe is accelerated for expedited appeals
* 3. That the review period begins when the appeal arrives at a health plan

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

**Answer:** D

**NEW QUESTION 89**
Access to services is an important issue for both fee-for-service (FFS) Medicaid and managed Medicaid programs. Access to services under managed Medicaid is affected by the

A. lack of qualified providers in provider networks
B. lack of resources necessary to establish case management programs for patients with complex conditions
C. unstable eligibility status of Medicaid recipients
D. inability of Medicaid recipients to change health plans or PCPs

**Answer:** C

**NEW QUESTION 92**
The following statement(s) can correctly be made about the hospitalist approach to inpatient care management:
* 1. Management of inpatient care by hospitalists may significantly reduce the length of stay and the total costs of care for a hospital admission
* 2. Most health plans that use hospitalists do so through a voluntary hospitalist program
* 3.A hospitalist's familiarity with utilization management (UM) and quality management (QM) standards for inpatient care may reduce unnecessary variations in care and improve clinical outcomes

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

**Answer:** A

**NEW QUESTION 94**
Health plans conduct evaluations on the efficiency and effectiveness of their quality improvement activities. With regard to the effectiveness of quality improvement

plans, it is correct to say that

A. effectiveness is the relationship between what the organization puts into an improvement plan and what it gets out of the plan
B. effectiveness is measured by reviewing outcomes to determine the accuracy or appropriateness of the strategy and the adequacy of resources allocated to that strategy
C. the effectiveness of an action plan is typically measured with a concurrent evaluation
D. an evaluation of plan effectiveness produces one of two results: the plan either (a) achieved the desired outcomes or (b) did not achieve the desired outcomes and is unlikely to do so under current conditions

**Answer:** B

**NEW QUESTION 98**
Health plans communicate proposed performance changes through action statements. Select the answer choice containing an action statement that includes all of the required elements.

A. The proportion of adult members who are screened for hypertension will increase by ten percent.
B. Primary care providers (PCPs) will increase the proportion of children under the age of two who are up-to-date on immunizations by seven percent within one year.
C. The QM program director will evaluate the level of provider compliance with clinicalpractice guidelines (CPGs).
D. The disease management program director will increase participation by asthmatic children in the health plan's pediatric asthma disease management program.

**Answer:** B

**NEW QUESTION 101**
Among this agency's accreditation programs are accreditation for preferred provider organizations (PPOs), health plan call centers, and case management organizations. This agency classifies its standards as either "shall" standards or "should" standards.

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

**Answer:** A

**NEW QUESTION 104**
Readiness is an important consideration for the development of health promotion programs. Readiness refers to

A. the availability of previously established health promotion programs to an health plan's members through employers, providers, or community service agencies
B. the appropriateness of a program's educational approach, given the language, literacy level, and cultural sensitivities of the target population
C. a member's level of knowledge about existing health risks and problems and the member's ability and willingness to adopt new health-related behaviors
D. a member's access to information technology, such as a video cassette recorder, a computer, or the Internet

**Answer:** C

**NEW QUESTION 106**
A health plan's preventive care initiatives may be classified into three main categories: primary prevention, secondary prevention, and tertiary prevention. Secondary prevention refers to activities designed to

A. develop an appropriate treatment strategy for patients whose conditions require extensive, complex healthcare
B. educate and motivate members to prevent illness through their lifestyle choices
C. prevent the occurrence of illness or injury
D. detect a medical condition in its early stages and prevent or at least delay disease progression and complications

**Answer:** D

**NEW QUESTION 109**
A health plan's coverage policies are linked to its purchaser contracts. The following statement(s) can correctly be made about the purchaser contract and coverage decisions:
* 1. In case of conflict between the purchaser contract and a health plan's medical policy or benefits administration policy, the contract takes precedence
* 2. Purchaser contracts commonly exclude custodial care from their coverage of services and supplies
* 3. All of the criteria for coverage decisions must be included in the purchaser contract

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

**Answer:** B

**NEW QUESTION 114**
Many health plans use HRA to target their preventive care programs to the healthcare needs of their members. With regard to HRA, it is correct to say that

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

**Answer:** B

**NEW QUESTION 115**
The American Accreditation HealthCare Commission/URAC (URAC) has an accreditation program specifically for case management services. From the answer choices below, select the response that correctly identifies the type(s) of case management services addressed by URAC's standards and the type(s) of organizations to which these standards may be applied.

A. Type(s) of Services-on-site services only Type(s) of Organization-health plans only
B. Type(s) of Services-on-site services only Type(s) of Organization-any organization that performs case management functions
C. Type(s) of Services-both telephonic and on-site services Type(s) of Organization-health plans only
D. Type(s) of Services-both telephonic and on-site services Type(s) of Organization-any organization that performs case management functions

**Answer:** D

**NEW QUESTION 119**
One way that health plans can make their benefits more appealing to employers and
employees is to offer coverage for specialty services. It is correct to say that specialty services typically

A. involve the same types of providers and delivery systems as do standard medical services
B. are a subset of a health plan's standard medical-surgical services
C. are not monitored by health plans for quality or utilization
D. require specialized knowledge for service delivery and management

**Answer:** D

**NEW QUESTION 120**
For this question, if answer choices (1) through (3) are all correct, select answer choice (4). Otherwise, select the one correct answer choice.
Health plans sometimes delegate selected medical management activities to their providers or other external entities. Activities that are frequently delegated include

A. utilization review (UR)
B. quality management (QM)
C. preventive health services
D. all of the above

**Answer:** A

**NEW QUESTION 123**
One true statement about state regulation of case management activities is that the majority of states

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

**Answer:** B

**NEW QUESTION 127**
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
The QAPI (Quality Assessment Performance Improvement Program) is a Centers for Medicaid and Medicare Services (CMS) initiative designed to strengthen health plans' efforts to protect and improve the health and satisfaction of Medicare beneficiaries. QAPI quality assessment standards apply to

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

**Answer:** D

**NEW QUESTION 130**
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