AHIP

Exam Questions AHM-530

Network Management

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)
Most health plan contracts provide an outline of the criteria that a healthcare service must meet in order to be considered “medically necessary.” Typically, in order for a healthcare service to be considered medically necessary, the service provided by a physician or other healthcare provider to identify and treat a member’s illness or injury must be

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

Answer: D

NEW QUESTION 3
- (Topic 1)
If a third party is responsible for injuries to a plan member of the Hope Health Plan, then Hope has a contractual right to file a claim for the resulting healthcare costs against the third party. This contractual right to recovery from the third party is known as

A. Subrogation
B. Partial capitation
C. Coordination of benefits
D. Aremedy provision

Answer: A

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

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

Answer: C

NEW QUESTION 6
- (Topic 1)
A provider contract describes the responsibilities of each party to the contract. These responsibilities can be divided into provider responsibilities, health plan responsibilities, and mutual obligations. Mutual obligations typically include

A. provisions for marketing the plan’s product
B. payment arrangements between the plan and the provider
C. verification of the plan’s eligibility to do business
D. management of the contents of members’ medical records

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)
When the Rialto Health Plan determines which of the emergency services received by its plan members should be covered by the health plan, it is guided by a standard which describes emergencies as medical conditions manifesting themselves by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy. This standard, which was adopted by the NAIC in 1996, is referred to as the

A. medical necessity standard
B. prudent layperson standard
C. "all-or-none" standard
D. reasonable and customary standard

Answer: B

NEW QUESTION 9
- (Topic 1)
From the following answer choices, choose the type of clause or provision described in this situation.
The Idlewilde Health Plan includes in its provider contracts a clause or provision that allows the terms of the contract to renew unchanged each year.

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

Answer: C

NEW QUESTION 10
- (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 10
- (Topic 1)
Health plans are required to follow several regulations and guidelines regarding the access and adequacy of their provider networks. The Federal Employee Health Benefits Program (FEHBP) regulations, for example, require that health plans

A. Allow members direct access to OB/GYN services
B. Allow members direct access to prescription drug services
C. Provide access to Title X family-planning clinics
D. Provide average office waiting times of no more than 30 minutes for appointments with plan providers

Answer: D

NEW QUESTION 11
- (Topic 1)
An health plan enters into a professional services capitation arrangement whenever the health plan

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

Answer: A

NEW QUESTION 13
- (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 18
- (Topic 1)
The Sweeney Health Plan uses the discounted fee-for-service (DFFS) method to compensate some of its providers. Under this method of compensation, Sweeney calculates payments based on

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

Answer: D

NEW QUESTION 20
- (Topic 1)
The Gladspell HMO has contracted with the Ellysium Hospital to provide subacute care to its plan members. Gladspell pays Ellysium by using a per diem reimbursement method.
If the Ellysium subacute care unit is typical of most hospital-based subacute skilled nursing units, then this unit could be used for patients who no longer need to be in the hospital's acute care unit but who still require

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

Answer: D

NEW QUESTION 22
- (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 26
- (Topic 1)
The actual number of providers included in a provider network may be based on staffing ratios. Staffing ratios relate the number of

A. Potential providers in a plan's network to the number of individuals in the area to be served by the plan
B. Providers in a plan's network to the number of enrollees in the plan
C. Providers outside a plan's network to the number of providers in the plan's network
D. Support staff in a plan's network to the number of medical practitioners in the plan's network

Answer: B

NEW QUESTION 30
- (Topic 1)
The method that the Autumn Health Plan uses for reimbursing dermatologists in its provider network involves paying them out of a fixed pool of funds that is actuarially determined for this specialty. The amount of funds that Autumn allocates to dermatologists is based on utilization and costs of services for that discipline.
Under this reimbursement method, a dermatologist who is under contract to Autumn accumulates one point for each new referral made to the specialist by Autumn's PCPs. If the referral is classified as complicated, then the dermatologist receives 1.5 points. The value of Autumn's dermatology services fund for the first quarter was $15,000. During the quarter, Autumn's PCPs made 90 referrals, and 20 of these referrals were classified as complicated.
In determining the first quarter payment to dermatologists, Autumn would accurately calculate the value of each referral point to be

A. $111.11
B. $125.00
C. $150.00
D. $166.67

Answer: C

NEW QUESTION 33
- (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 38
- (Topic 1)
The Gladspell HMO has contracted with the Ellysium Hospital to provide subacute care to its plan members. Gladspell pays Ellysium by using a per diem reimbursement method.
If 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 39
- (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 41
- (Topic 1)
In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which increased the continuity and portability of health insurance coverage. One statement that can correctly be made about HIPAA is that it

A. Applies to group health insurance plans only
B. Limits the length of a health plan's pre-existing condition exclusion period for a previously covered individual to a maximum of six months after enrollment.
C. Guarantees access to healthcare coverage for small businesses and previously covered individuals who meet specified eligibility requirements.
D. Guarantees renewability of group and individual health coverage, provided the insureds are still in good health

Answer: C

NEW QUESTION 43
- (Topic 1)
The Omni Health Plan is interested in expanding the specialty services it offers to its plan members and is considering contracting with the following providers of specialty services:
The Apex Company, a managed vision care organization (MVCO) The Baxter Managed Behavioral Healthcare Organization (MBHO) The Cheshire Dental Health Maintenance Organization (DHMO)
As part of its credentialing process, Omni would like to verify that each of these providers has met NCQA's accreditation standards. However, with regard to these three specialty service providers, an NCQA accreditation program currently exists for

A. Apex and Baxter only
B. Apex and Cheshire only
C. Baxter and Cheshire only
D. Baxter only

Answer: D

NEW QUESTION 44
- (Topic 1)

The Ross Health Plan compensates Dr. Cecile Sanderson on a FFS basis. In order to increase the level of reimbursement that she would receive from Ross, Dr. Sanderson submitted the code for a comprehensive office visit. The services she actually provided represented an intermediate level of service. Dr. Sanderson's action is an example of a type of false billing procedure known as

A. Cost shifting
B. Churning
C. Unbundling
D. Upcoding

Answer: D

NEW QUESTION 47
- (Topic 1)
Health plan contract negotiations with an integrated delivery system (IDS) or a hospital are usually lengthier and more complex than negotiations with a single-specialty provider.

A. True
B. False

Answer: A

NEW QUESTION 51
- (Topic 1)
One important aspect of network management is profiling, or provider profiling. Profiling is most often used to

A. measure the overall performance of providers who are already participants in the network
B. assess a provider's overall satisfaction with a plan's service protocols and other operational areas
C. verify a prospective provider's professional licenses, certifications, and training
D. familiarize a provider with a plan's procedures for authorizations and referrals

Answer: A

NEW QUESTION 55
- (Topic 1)
Lakesha Frazier, a member of a health plan in a rural area, had been experiencing heart palpitations and shortness of breath. Ms. Frazier's primary care provider (PCP) referred her to a local hospital for an electrocardiogram. The results of the electrocardiogram were transmitted for diagnosis via high-speed data transmission to a heart specialist in a city 500 miles away. This information indicates that the results of Ms. Frazier's electrocardiogram were transmitted using a communications system known as

A. Anarrow network
B. An integrated healthcare delivery system
C. Telemedicine
D. Customized networking

Answer: C

NEW QUESTION 57
- (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 62
- (Topic 1)
The National Committee for Quality Assurance (NCQA) has integrated accreditation with Health Employer Data and Information Set (HEDIS) measures into a program called Accreditation '99. One statement that can correctly be made about these accreditation standards is that

A. Health plans are required by law to report HEDIS results to NCQA
B. HEDIS restricts its reporting criteria to a narrow group of quantitative performance measures, while NCQA includes a broad range of qualitative performance measures
C. Private employer groups purchasing health care coverage increasingly require both NCQA accreditation and HEDIS reporting
D. HEDIS includes measures of a health plan's effectiveness of care rather than its cost of care

Answer: C

NEW QUESTION 65
- (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 70
- (Topic 1)
Promise, Inc., a corporation that specializes in cancer services, employs its physicians and support staff and provides facilities and ancillary services for cancer patients. Promise has contracted with the Cordelia Health Plan to provide all specialty services for Cordelia plan members who are undergoing cancer treatment. In return, Promise receives a capitated amount from Cordelia. Promise is an example of a type of specialty services organization known as a

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

Answer: B

NEW QUESTION 74
- (Topic 2)
The following situations illustrate violations of federal antitrust laws:
Situation A Two HMOs split a large employer group by agreeing to let one HMO market to some company employees and to let the second HMO market to different company employees.
Situation B Members of a physician-hospital organization (PHO) that has significant market share jointly agreed to exclude a physician from joining the PHO solely because that physician has admitting privileges at a competing hospital.
From the following answer choices, select the response that best identifies the types of violations illustrated by these situations:

A. Situation A: horizontal division of territories; Situation B: group boycott
B. Situation A: horizontal division of territories; Situation B: exclusive arrangement
C. Situation A: exclusive arrangement; Situation B: group boycott
D. Situation A: exclusive arrangement; Situation B: tying arrangement

Answer: A

NEW QUESTION 79
- (Topic 2)
Since 1981, states have had the option to experiment with new approaches to their Medicaid programs under the “freedom of choice” waivers. Under one such waiver, a Section 1915(b) waiver, states are allowed to

A. Give Medicaid recipients complete freedom in choosing healthcare providers
B. Give Medicaid recipients the option to choose not to enroll in a healthcare plan
C. Mandate certain categories of Medicaid recipients to enroll in health plans
D. Establish demonstration projects to test new approaches for delivering care to Medicaid recipients

Answer: C

NEW QUESTION 81
- (Topic 2)
The Argyle Health Plan has contracted to obtain the services of the providers in the Column Medical Group, a faculty practice plan (FPP). The following statement(s) can correctly be made about this contract:

A. Column most likely contracted with the legal group representing the FPP rather than with the individual physicians within the FPP.
B. Column most likely will provide only highly specialized care to Argyle's plan members.
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: B

NEW QUESTION 85
- (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 90
- (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 95
- (Topic 2)
The provider contract that Dr. Nick Mancini has with the Utopia Health Plan includes a clause that requires Utopia to reimburse Dr. Mancini on a fee-for-service (FFS) basis until 100 Utopia members have selected him as their primary care provider (PCP). At that time, Utopia will begin reimbursing him under a capitated arrangement. This clause in Dr. Mancini's provider contract is known as:

A. an antidisparagement clause
B. a low-enrollment guarantee clause
C. a retroactive enrollment changes clause
D. an eligibility guarantee clause

Answer: B

NEW QUESTION 100
- (Topic 2)
Reimbursement for prescription drugs and services in a third-party prescription drug plan typically follows one of two approaches: a reimbursement approach or a service approach. One true statement about these approaches is that:

A. Payments under the reimbursement method typically are not subject to any copayment or deductible requirements
B. Payments under the reimbursement approach are typically based on a structured reimbursement schedule rather than on usual, customary, and reasonable (UCR) charges
C. Most major medical plans follow a service approach
D. Most current health plan prescription drug plans are service plans

Answer: D

NEW QUESTION 103
- (Topic 2)
The actual number of providers included in a provider network can be based on staffing ratios. One true statement about staffing ratios is that, typically:

A. A small health plan needs fewer physicians per 1,000 than does a large plan.
B. A closely managed health plan requires fewer providers than does a loosely managedplan.
C. Physician-to-enrollee ratios can be used directly only by network-within-a-network model HMOs.
D. Medicare products require fewer providers than do employer-sponsored plans of the same size.

Answer: B

NEW QUESTION 108
- (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.
The provider network that Shipwright uses to furnish services for its workers' compensation program will most likely

A. Emphasize primary care and consist mostly of generalists
B. Focus treatment approaches on rapid recovery rather than cost
C. Offer workers' compensation beneficiaries the same types and levels of treatment that Shipwright's traditional network furnishes to group health plan members
D. Exempt participating providers from meeting standard credentialing requirements

Answer: B

NEW QUESTION 109
- (Topic 2)
Dr. Sarah Carmichael is one of several network providers who serve on one of the Apex Health Plan's organizational committees. The committee reviews cases against providers identified through complaints and grievances or through clinical monitoring activities. If needed, the committee formulates, approves, and monitors corrective action plans for providers. Although Apex administrators and other employees also serve on the committee, only participating providers have voting rights. The committee that Dr. Carmichael serves on is a

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

Answer: B

NEW QUESTION 111

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

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

Answer: D

NEW QUESTION 114
- (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 117
- (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 118
- (Topic 2)
With regard to the laws and regulations on access and adequacy of provider networks, it can correctly be stated that:

A. most access and adequacy guidelines relate to preferred provider organizations (PPOs) or managed indemnity products
B. corporate practice of medicine laws require staff model HMOs to hire physicians directly,even if the physicians do not own the HMO
C. any willing provider laws prevent a health plan from making exclusive or semi-exclusive arrangements with a provider or a group of providers
D. the NAIC Managed Care Plan Network Adequacy Model Act requires states to use provider-enrollee ratios as the sole measure of network adequacy

Answer: C

NEW QUESTION 121
- (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 126
- (Topic 2)
As an authorized Medicare+Choice plan, the Brightwell HMO must satisfy CMS requirements regulating access to covered services. In order to ensure that its network provides adequate access, Brightwell must

A. Allow enrollees to determine whether they will receive primary care from a physician, nurse practitioner, or other qualified network provider
B. Base a provider’s participation in the network, reimbursement, and indemnification levels on the provider’s license or certification
C. Define its service area according to community patterns of care
D. Require enrollees to obtain prior authorization for all emergency or urgently needed services

Answer: C

NEW QUESTION 130
- (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 134
- (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 136
- (Topic 2)
The two basic approaches that Medicaid uses to contract with health plans are open contracting and selective contracting. One true statement about these approaches to contracting is that:

A. Open contracting requires health plans to meet minimum performance standards outlined in a state's request for proposal (RFP)
B. Open contracting makes it possible for the Medicaid agency to offer enrollment volume guarantees
C. Selective contracting requires any health plan that meets the state's performance standards and the federal Medicaid requirements to enter into a Medicaid contract
D. Selective contracting requires health plans to bid competitively for Medicaid contracts

Answer: D

NEW QUESTION 141
- (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 142
- (Topic 2)
Following statements are about accreditation of health plans:

A. The National Committee for Quality Assurance (NCQA) serves as the primary accrediting agency for most health maintenance organizations (HMOs).
B. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has developed standards that can be used for the accreditation of hospitals, but not for the accreditation of health plan provider networks or health plan plans.
C. States are required to adopt the model standards developed by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators that develops standards to promote uniformity in insurance regulations.
D. Accreditation is an evaluative process in which a health plan undergoes an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the federal government or by the state governments.

Answer: A

NEW QUESTION 147
- (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 NewnanGroup, 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.
The following statements can correctly be made about the reimbursement for Drugs A and B under the MAC pricing system:

A. Treble most likely is obligated to reimburse Manor 14 cents per tablet for Drug A.
B. Manor most likely is allowed to bill the subscriber 2 cents per tablet for Drug A.
C. Treble most likely is obligated to reimburse Manor 5 cents per tablet for Drug B.
D. All of the above statements are correct.

Answer: C

NEW QUESTION 150
.....

Thank You for Trying Our Product

We offer two products:

1st - We have Practice Tests Software with Actual Exam Questions

2nd - Questons and Answers in PDF Format

AHM-530 Practice Exam Features:

* AHM-530 Questions and Answers Updated Frequently

* AHM-530 Practice Questions Verified by Expert Senior Certified Staff

* AHM-530 Most Realistic Questions that Guarantee you a Pass on Your FirstTry

* AHM-530 Practice Test Questions in Multiple Choice Formats and Updatesfor 1 Year