AHIP

Exam Questions AHM-540

Medical Management

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

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

Answer: B

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

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

Answer: A

NEW QUESTION 3
One method that health plans use to address provider compliance with formularies is academic detailing.

A. True
B. False

Answer: A

NEW QUESTION 4
Serena Wilson, a registered nurse, is employed at a TRICARE Service Center (TSC) located at a military installation. Ms. Wilson serves as a primary point of contact between enrollees and the TRICARE system and answers enrollees' questions about plan options, eligibility, provider selection, and claims. This information indicates that Ms. Wilson serves as a

A. lead agent
B. beneficiary services representative
C. health plan support contractor
D. primary care manager (PCM)

Answer: B

NEW QUESTION 5
In order to be effective, a clinical pathway must improve quality and decrease costs.

A. True
B. False

Answer: B

NEW QUESTION 6
The following statement(s) can correctly be made about the use of screening for secondary prevention:
* 1. Screening activities may involve specialty care providers as well as primary care providers (PCPs) and the health plan
* 2. Secondary prevention often results in more utilization of services immediately following screening
* 3. Screening focuses on members who have not experienced any symptoms of a particular illness

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

Answer: A

NEW QUESTION 7
This agency has authority over Programs of All-inclusive Care for the Elderly (PACE) and the State Children's Health Insurance Program (SCHIP).

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

Answer: C

NEW QUESTION 8
The Quality Assessment Performance Improvement (QAPI) is a quality initiative designed to strengthen health plans' efforts to protect and improve the health and satisfaction of Medicare and Medicaid health plan enrollees. The Centers for Medicare and Medicaid Services (CMS) requires compliance with QAPI from

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

Answer: B

NEW QUESTION 9
Determine whether the following statement is true or false:
The key to successfully managing the quality and cost-effectiveness of healthcare services for Medicaid enrollees is to merge Medicaid recipients into existing plans.

A. True
B. False

Answer: B

NEW QUESTION 10
The paragraph below contains two pairs of terms enclosed in parentheses. Select the term in each pair that correctly completes the paragraph. Then select the answer choice containing the two terms that you have chosen.
Under a delegation arrangement, the (delegate / delegator) is responsible for performing the delegated function according to established standards, and the (delegate / delegator) is ultimately accountable for any deficiencies in the performance of the function.

A. delegate / delegate
B. delegate / delegator
C. delegator / delegate
D. delegator / delegator

Answer: B

NEW QUESTION 10
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 15
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 17
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 18
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
Each quality standard used by a health plan is associated with quality indicators. A _____ indicator is a form of aggregate data indicator that produces results that fit within a specified range, such as the length of time to schedule an appointment.

A. yes/no
B. sentinel event
C. discrete variable
D. continuous variable

Answer: D

NEW QUESTION 22
CMS has developed two prototype programs—Programs of All-inclusive Care for the Elderly (PACE) and the Social Health Maintenance Organization (SHMO) demonstration project—to deliver healthcare services to Medicare beneficiaries. From the answer choices below, select the response that correctly identifies the features of these programs.

A. PACE-annual limits on benefits for nursing home and community-based care SHMO-no limits on long-term care benefits
B. PACE-provide long-term care only SHMO-provide acute and long-term care
C. PACE-enrollees must be age 65 or older SHMO-enrollees must be age 55 or older
D. PACE-enrollment open to nursing home certifiable Medicare beneficiaries only SHMO- enrollment open to all Medicare beneficiaries

Answer: D

NEW QUESTION 27
Health plans that choose to contract with external organizations for pharmacy services typically contract with pharmacy benefit managers (PBMs). Functions that a PBM typically performs for a health plan include
* 1.Managing the costs of prescription drugs
* 2.Promoting efficient and safe drug use
* 3.Determining the health plan's internal management responsibilities for pharmacy services

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

Answer: B

NEW QUESTION 29
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 33
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Select the term or phrase in each pair that correctly completes the paragraph. Then select the answer choice containing the two terms or phrases you have chosen.
TRICARE enrollees have the right to challenge authorization and coverage decisions. Such challenges are referred to as (appeals / grievances) and are typically handled by the (TRICARE contractor / Area Field Office).

A. appeals / TRICARE contractor
B. appeals / Area Field Office
C. grievances / TRICARE contractor
D. grievances / Area Field Office

Answer: A

NEW QUESTION 38
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 41
The following statements are about chronic and disabling conditions among children eligible for Medicaid. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. Children with chronic conditions use more physician and nonphysician professional services than do children in the general population.
B. The majority of chronic conditions affecting children in Medicaid programs are the same as those affecting children in the general population.
C. Medicaid-eligible children are at risk for seriousmental and physical conditions.
D. Children in Medicaid programs have a higher incidence of chronic disabling conditions than do children in the general population.

Answer: B

NEW QUESTION 43
The following statements are about the use of provider profiling for pharmacy benefits. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

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

Answer: D

NEW QUESTION 48
Skilled nursing facilities (SNFs) are required by law to have formal programs for quality improvement and to monitor these programs using established standards. These requirements are described in
* 1.The Omnibus Budget Reconciliation Act (OBRA) of 1986
* 2.The Balanced Budget Act (BBA) of 1997

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 or 2

Answer: B

NEW QUESTION 51
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 54
The Garnet Health Plan uses provider profiling to measure and improve provider performance. Provider profiling most likely allows Garnet to

A. evaluate all providers without considering differences in risk
B. focus on specific clinical decisions of Garnet’s providers rather than on patterns of care
C. identify the outliers and high-value providers in its provider network
D. measure the effectiveness, but not the efficiency, of Garnet’s providers

Answer: C

NEW QUESTION 55
In order for a health plan’s performance-based quality improvement programs to be effective, the desired outcomes must be

A. achievable within a specified timeframe
B. defined in terms of multiple results
C. expressed in subjective, qualitative terms
D. all of the above

Answer: A

NEW QUESTION 59
Determine whether the following statement is true or false:
Independent review organizations (IROs) can mediate disputes and offer advisory opinions to health plans on UR issues, but they cannot render binding decisions on appeals.

A. True
B. False

Answer: B

NEW QUESTION 62
Patient safety and medical errors are important concerns for both quality management (QM) and risk management. The following statement(s) can correctly be made about medical errors:
* 1. The complexity of modern medicine and healthcare delivery systems increases patients’ exposure to the risks of medical errors
* 2. Licensing boards for healthcare professionals in all states provide a consistent system of quality oversight and accountability
* 3. Provider compliance with internal incident reporting requirements is low

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

D. 3 only

Answer: C

NEW QUESTION 64
Accreditation is intended to help purchasers and consumers make decisions about healthcare coverage.
The following statements are about accreditation. Select the answer choice containing the correct statement.

A. At the request of health plans, accrediting agencies gather the data needed for accreditation.
B. Most purchasers and consumers review accreditation results when making decisions to purchase or enroll in a specific health plan.
C. Accreditation is typically conducted by independent, not-for-profit organizations.
D. All health plans are required to participate in the accreditation process.

Answer: C

NEW QUESTION 67
MCOs usually have a formal program for the oversight of delegated activities. The following statements concern typical delegation oversight programs. Select the answer choice containing the correct statement.

A. A letter of intent is the contractual document that describes the delegated functions and the responsibilities of the MCO and the delegate.
B. In most cases, the evaluation of a candidate for delegation is based entirely on the candidate's application and supporting documentation and does not include an on-site assessment of the candidate.
C. Under most delegation agreements, an MCO cannot terminate the agreement before the end date stated in the agreement.
D. One objective for a delegation oversight program is to integrate any delegated activities into the MCO's overall programs for medical management and other functions.

Answer: D

NEW QUESTION 70
Comorbidity can have a significant impact on the effective implementation of disease management programs. Comorbidity can correctly be defined as the

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

Answer: D

NEW QUESTION 71
The Fairview Health Plan uses a dual database approach to integrate information needed for its disease management program. This information indicates that Fairview uses an information management system that

A. combines all existing information from all data sources into a single comprehensive system
B. connects multiple databases with a central interface engine that acts as an information clearinghouse
C. provides an outside vendor with pertinent data that the vendor compiles into an integrated database
D. creates a separate database that pulls pertinent information from the health plan's claims database, formats the information for easy analysis, and stores it in the separate database

Answer: D

NEW QUESTION 75
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 78
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 80
Patricia McLeod is a member of the Enterprise Health Plan, which operates in State X. Ms. McLeod is scheduled to undergo a unilateral mastectomy for the

treatment of breast cancer. The surgical procedure will be performed by Dr. Kim Lee, a surgical oncologist.
Based on Enterprise's medical policy, the contract with the purchaser, and Ms. McLeod's medical condition, Enterprise's UR staff have determined that the appropriate course of care for Ms.
McLeod includes a 24-hour stay in the hospital following her surgery. State X, however, has a benefit mandate specifying health plan coverage for 48 hours of inpatient post- mastectomy care. In this situation, the length of hospital stay for which Enterprise must offer coverage is

A. the length of stay deemed appropriate by D
B. Lee
C. the 24-hour stay determined to be appropriate by Enterprise's UR staff
D. the length of stay deemed appropriate by M
E. McLeod
F. the 48-hour length of stay specified by State X

Answer: D

NEW QUESTION 84
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
To manage the delivery of healthcare services to their members, health plans use clinical practice parameters. _____ is the type of clinical practice parameter that a health plan uses to make coverage decisions concerning medical necessity and appropriateness.

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

Answer: B

NEW QUESTION 88
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 93
As a follow-up to a performance improvement plan for member services, the Stellar Health Plan conducted an evaluation of the success of the plan. Stellar conducted its evaluation as the plan was being carried out. The evaluation focused on specific activities and assessed the relative importance of those activities to the plan as a whole. This information indicates that Stellar's evaluation of the plan was both

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

Answer: A

NEW QUESTION 97
The following statements describe situations in which health plan members have medical problems that require care. Select the statement that describes a situation in which self- care most likely would not be appropriate.

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

Answer: A

NEW QUESTION 101
Adele Stanley, a member of the Greenhouse Health Plan, recently went to a network pharmacy to have a prescription filled. The pharmacist informed Ms. Stanley that the prescribed drug was not in the plan formulary and that reimbursement for the drug was not available except in extraordinary circumstances. The pharmacist asked Ms. Stanley if she would accept a generic substitute.
If Ms. Stanley agrees to the generic substitution, she will receive a drug that

A. has not been tested for safety and efficacy in large clinical trials
B. is available without a prescription at a reasonable cost
C. has been classified by the Food and Drug Administration (FDA) as safe, but that has not been proven fully effective
D. contains active ingredients that are identical to those of the prescribed brand-name drug

Answer: D

NEW QUESTION 105
To measure performance for quality management, health plans collect and analyze three types of data: financial data, clinical data, and customer satisfaction data. The following statement(s) can correctly be made about the sources of clinical data:
* 1.Patient surveys are the most widely used source of disease-specific clinical information
* 2.Outcomes research studies sponsored by academic institutions and professional organizations have limited usefulness for particular health plans or individual providers
* 3.The SF-36 and the HSQ-39 (Health Status Questionnaire) surveys address both physical and mental health status

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

Answer: C

NEW QUESTION 110
Step-therapy is a form of prior authorization that reserves the use of more expensive medications for cases in which the use of less expensive medications has been unsuccessful. Step-therapy is appropriate for situations in which
* 1.A significant percentage of those treated with the initial therapy will require the second therapy
* 2.The delay created when a patient moves from one therapy to the next therapy will not cause serious or permanent effects

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

Answer: C

NEW QUESTION 114
Determine whether the following statement is true or false:
The utilization review (UR) process produces the greatest number of case management referrals.

A. True
B. False

Answer: A

NEW QUESTION 118
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 121
The following statement(s) can correctly be made about performance measurement systems:
* 1.The most difficult purpose for a performance measurement system to address is to measure changes in outcomes caused by modifications in administrative or clinical treatment processes
* 2.A health plan needs different performance measurement systems to evaluate its administrative services and the clinical performance of its providers

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

Answer: C

NEW QUESTION 123
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 127

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 128
Health plans often use accreditation as a means of evaluating the quality of care delivered to plan members. Accreditation of subacute care providers is available from the

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

Answer: B

NEW QUESTION 130
For this question, if answer choices (a) through (c) are all correct, select answer choice (d). Otherwise, select the one correct answer choice.
Well-crafted clinical practice guidelines (CPGs) can benefit healthcare delivery processes and outcomes by

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

Answer: D

NEW QUESTION 131
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 134
By definition, the development and implementation of parameters for the delivery of healthcare services to a health plan's members is known as

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

Answer: D

NEW QUESTION 138
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 140
One way that health plans evaluate their UR programs is by monitoring utilization rates. By definition, utilization rates typically

A. indicate changes in the total amount of medical expenses or claim dollars paid for particular procedures
B. measure the number of services provided per 1,000 members per year
C. indicate standard approaches to care for many common, uncomplicated healthcare services
D. report the number of times that a particular provider performs or recommends a service excluded from the benefit plan

Answer: B

NEW QUESTION 143
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 147
The following statements are about health plans' use of electronic data interchange (EDI). Three of the statements are true and one is false. Select the answer choice containing the FALSE ALSE statement.

A. One advantage of EDI over manual data management systems is improved data integrity.
B. EDI may use the Internet as the communication link between the participating parties.
C. EDI involves back-and-forth exchanges of information concerning individual transactions.
D. The data format for EDI is agreed upon by the sending and receiving parties.

Answer: C

NEW QUESTION 150
Vision care is typically separated into two categories: routine eye care and clinical eye care. The standard benefit plans offered by most health plans include coverage for
* 1. Routine eye care
* 2. Clinical eye care

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

Answer: C

NEW QUESTION 155
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 160
Demetrius Farrell, age 82, is suffering from a terminal illness and has consulted his health plan about the care options available to him. In order to avoid unwanted, futile interventions, Mr. Farrell signed an advance directive that indicates the types of end-of-life medical treatment he wants to receive. His family is to use this document as a guide should Mr. Farrell become incapacitated.
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
Decisions regarding Mr. Farrell's end-of-life care are legally the right and responsibility of

A. M
B. Farrell and his family
C. M
D. Farrell's physician
E. M
F. Farrell's health plan
G. All of the above

Answer: A

NEW QUESTION 164
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 167
Most health plans require a PCP referral or precertification for CAM benefits.

A. True
B. False

Answer: B

NEW QUESTION 172
To facilitate electronic commerce (eCommerce), a health plan may establish a secured extranet. One true statement about a secured extranet is that it is

A. based on Web-based technologies
B. available only to the employees of the health plan
C. publicly available, so the potential exists for unauthorized access to a health plan's proprietary systems
D. used to handle the majority of health plan eCommerce

Answer: A

NEW QUESTION 173
In order to achieve changes in outcomes, health plans make changes to existing structures and processes. The introduction of preauthorization as an attempt to control overuse of services is an example of a reactive change. Reactive changes are typically

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

Answer: C

NEW QUESTION 176
Administrative action plans are used when performance problems or opportunities are related to the way the organization itself operates. The following statement(s) can correctly be made about administrative action plans:
* 1.Administrative action plans allow health plans to coordinate management activities
* 2.One function of administrative action plans is to integrate service across all levels of the organization
* 3.Administrative action plans are designed to improve outcomes by helping plan members assume responsibility for their own health

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

Answer: B

NEW QUESTION 179
Some health plans administer a questionnaire known as the Behavioral Risk Factor Surveillance System (BRFSS) as part of their health risk assessment (HRA) processes. The following statements are about the BRFSS. If statements (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct statement.

A. This questionnaire was designed specifically for use by health plans.
B. Each health plan must use the same form of the questionnaire, with no additions or modifications.
C. This questionnaire monitors the prevalence of the major behavioral risks associated with illness and injury among adults.
D. All of the above statements are correct.

Answer: C

NEW QUESTION 182
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 187
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 188
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 189
The Midwest Health Plan delegated utilization review (UR) activities to the Tri-City Utilization Review Organization. After Tri-City improperly recommended denial of payment for services to a Midwest plan member, the plan member filed suit. The court ruled that Midwest was responsible for Tri-City's actions because of the relationship between Midwest and Tri-City. This situation is an illustration of a legal concept known as

A. vicarious liability
B. fraud
C. a tying arrangement
D. subdelegation

Answer: A

NEW QUESTION 194
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 199
The BBA of 1997 allows states to provide Medicaid benefits to children through the State Children's Health Insurance Program (SCHIP). Under the terms of the BBA, states can implement SCHIP as
* 1. Part of their existing Medicaid programs
* 2.Separate commercial insurance programs

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

Answer: A

NEW QUESTION 200
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