Exam Questions AHM-530

Network Management

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NEW QUESTION 1
- (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 2
- (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 3
- (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 4
- (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 5
- (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 6
- (Topic 1)
The Octagon Health Plan includes a typical indemnification clause in its provider contracts. The purpose of this clause is to require Octagon’s network providers to

A. Agree not to sue or file claims against an Octagon plan member for covered services

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

Answer: B

NEW QUESTION 7
- (Topic 1)
With respect to hiring practices, one step that a health plan most likely can take to avoid violating the terms of the Americans with Disabilities Act (ADA) is to

A. Require a medical examination prior to accepting an application for employment
B. Include in the employment application questions pertaining to health status
C. Make a conditional offer of employment, and then require the candidate to have an examination prior to granting specific staff privileges
D. Require applicants to answer questions pertaining to the use of drugs and alcohol

Answer: C

NEW QUESTION 8
- (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.
Autumn's method of reimbursing specialty providers can best be described as a

A. Disease-specific arrangement
B. Contact capitation arrangement
C. Risk adjustment arrangement
D. Withhold arrangement

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 12
- (Topic 1)
In developing a provider network in an large city with a high concentration of young families, the Gypsum Health Plan has set goals focused on the needs of that particular market. The following statements are about this situation. Three of the statements are true, and one of the statements is false. Select the answer choice that contains the FALSE statement.

A. Gypsum should attempt to recruit providers who offer extended office hours.
B. Gypsum can use the cost-effectiveness of its own existing networks as a benchmark for its cost-savings goals in this market.
C. Gypsum will most likely attempt to contract with HMOs.
D. Gypsum most likely should set lower cost-savings goals in this market than it would in a rural market with few young families.

Answer: D

NEW QUESTION 14
- (Topic 1)
The following statements are about some of the issues surrounding the contractual responsibilities of health plans. Select the answer choice containing the correct statement.

A. Typically, health plans are required to pay completed claims within 10 days of submission.
B. Health plans typically are prohibited from examining the financial soundness of a self- funded employer plan that relies on the health plan to pay providers for services received by the plan's members.
C. Patient delivery is one of the most significant factors that health plans consider when determining whether provider services should be reimbursed on a capitated or fee-for- service (FFS) basis.
D. Health plans require all providers to agree to an exclusive provider contract.

Answer: C

NEW QUESTION 15
- (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)
One reason that an health plan would want to use the actual acquisition cost (AAC) pricing system to calculate its drug costs is that, of the systems commonly used to calculate drug costs, the AAC system

A. Provides the lowest level of cost for the health plan
B. Most closely represents what pharmacies are actually charged for prescription drugs
C. Offers the best control over multiple-source pharmaceutical products
D. Is the least expensive pricing system for the health plan to implement

Answer: A

NEW QUESTION 22
- (Topic 1)
Dr. Eve Barlow is a specialist in the Amity Health Plan's provider network. Dr. Barlow's provider contract with Amity contains a typical most-favored-nation arrangement. The purpose of this arrangement is to

A. Require D
B. Barlow and Amity to use arbitration to resolve any disputes regarding the contract
C. Specify that the contract is to be governed by the laws of the state in which Amity has its headquarters
D. Require D
E. Barlow to charge Amity her lowest rate for a medical service she has provided to an Amity plan member, even if the rate is lower than the price negotiated in the contract
F. State that the contract creates an employment or agency relationship, rather than an independent contractor relationship, between D
G. Barlow and Amity

Answer: C

NEW QUESTION 23
- (Topic 1)
Before incurring the expense of assembling a new PPO network, the Protect Health Plan conducted a cost analysis in order to determine the cost-effectiveness of renting an existing PPO network instead. In calculating the overall cost of renting the network, Protect assumed a premium of $2.52 per member per month (PMPM) and estimated the total number of members to be 9,000. This information indicates that Protect would calculate its annual network rental cost to be

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

Answer: C

NEW QUESTION 27
- (Topic 1)
The following statements can correctly be made about the advantages and disadvantages to an health plan of using the various delivery options for pharmacy

services.

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

Answer: A

NEW QUESTION 32
- (Topic 1)
One true statement about the compensation arrangement known as the case rate system is that, under this system,

A. Providers stand to gain or lose based on the number and types of treatments used for each case
B. Providers have no incentives to take an active role in managing cost and utilization
C. Payors cannot adjust standard case rates to reflect the severity of the patient's condition or complications that arise from multiple medical problems
D. Payors have the opportunity to benefit from the provider's cost savings

Answer: A

NEW QUESTION 33
- (Topic 1)
With respect to contractual provisions related to provider-patient communications, nonsolicitation clauses prohibit providers from

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

Answer: A

NEW QUESTION 34
- (Topic 1)
A population's demographic factors—such as income levels, age, gender, race, and ethnicity—can influence the design of provider networks serving that population. With respect to these demographic factors, it is correct to say that

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

Answer: C

NEW QUESTION 36
- (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 40
- (Topic 1)
The Holiday Health Plan is preparing to enter a new market. In order to determine the optimal size of its provider panel in the new market, Holiday is conducting a competitive analysis of provider networks of the market's existing health plans. Consider whether, in conducting its competitive analysis, Holiday should seek answers to the following questions:
Question 1: What are the cost-containment strategies of the health plans with increasing market shares?
Question 2: What are the premium strategies of the health plans with large market shares?
Question 3: What are the characteristics of health plans that are losing market share?
In its competitive analysis, Holiday should most likely obtain answers to questions

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

Answer: A

NEW QUESTION 41
- (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 42
- (Topic 1)
The Aegean Health Plan delegated its utilization management (UM) program to the Silhouette IPA. Silhouette, in turn, transferred authority for case management to Brandon Health Services. In this situation, Brandon is best described as the

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

Answer: C

NEW QUESTION 43
- (Topic 1)
Some states have enacted any willing provider laws. From the perspective of the health plan industry, one drawback of any willing provider laws is that they often result in a reduction of a plan's

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

Answer: B

NEW QUESTION 47
- (Topic 1)
The following statements are about the specialist component of a provider panel. Select the answer choice containing the correct statement.

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

Answer: A

NEW QUESTION 51
- (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 54
- (Topic 2)
The following statements are about the organization of network management functions of health plans. Select the answer choice containing the correct response:

A. Compared to a large health plan, a small health plan typically has more integration among its network management activities and less specialization of roles.
B. It is usually more efficient to have a large health plan's provider relations representatives located in the health plan's corporate headquarters rather than based in regional locations that are close to the provider offices the representatives cover.
C. An health plan's provider relations representatives are usually responsible for conducting an initial orientation of providers and educating providers about health plan developments, rather than recruiting and assisting with the selection of new providers.
D. In general, a health plan that uses a centralized approach for some of its network management activities should not use a decentralized approach for other network management activities.

Answer: A

NEW QUESTION 57
- (Topic 2)

Partial capitation is one common approach to capitation. One typical characteristic of partial capitation is that it:

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

Answer: A

NEW QUESTION 58
- (Topic 2)
The following statements are about Medicaid health plan entities. Select the answer choice containing the correct statement:

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

Answer: C

NEW QUESTION 60
- (Topic 2)
In order to evaluate and manage the performance of individual providers in its provider network, the Quorum Health Plan implemented a program that focuses on identifying the best and worst outcomes and utilization patterns of its providers. This program is also designed to develop and implement strategies such as treatment protocols and practice guidelines to improve the performance of Quorum's providers. This information indicates that Quorum implemented a program known as:

A. An integrated delivery system (IDS)
B. A coordinated care program
C. Ostensible agency
D. Continuous quality improvement (CQI)

Answer: D

NEW QUESTION 65
- (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 66
- (Topic 2)
Stop-loss insurance is designed to protect physicians who face substantial financial risk as a result of physician incentive plans. Medicare+Choice health plans must ensure that a physician has adequate stop-loss protection if the

A. physician has a patient panel that exceeds 25,000 patients
B. physician receives a bonus that is based solely on quality of care, patient satisfaction, or physician participation
C. difference between the physician’s maximum potential payments and his or her minimum potential payments is less than 25% of the maximum potential payments
D. physician is subject to a withhold that is greater than 25% of his or her potential payments

Answer: D

NEW QUESTION 70
- (Topic 2)
The following statements are about network management for behavioral healthcare (BH). Three of these statements are true and one statement is false. Select the answer choice containing the FALSE statement.

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

Answer: D

NEW QUESTION 75

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

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

Answer: A

NEW QUESTION 76
- (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 79
- (Topic 2)
The following statements are about fee-for-service (FFS) payment systems. Select the answer choice containing the correct statement:

A. A discounted fee-for-service (DFFS) system is usually easier for a health plan to administer than is a fee schedule system.
B. A case rate payment system offers providers an incentive to take an active role in managing cost and utilization.
C. One reason that health plans use a relative value scale (RVS) payment system is that RVS values for cognitive services have traditionally been higher than the values for procedural services.
D. One reason that health plans use a resource-based relative value scale (RBRVS) is that this system includes weighted unit values for all types of procedures.

Answer: B

NEW QUESTION 80
- (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 85
- (Topic 2)
The Foxfire Health Plan, which has 20,000 members, contracts with dermatologists on a contact capitation basis. The contact capitation arrangement has the following features:
Foxfire distributes the money in the contact capitation fund once each quarter and the distribution is based on the point totals accumulated by each dermatologist.
Foxfire's per member per month (PMPM) capitation for dermatology services is $1.
The dermatologist receives 1 point for each new referral that is not classified as a complicated referral and 1.5 points for each new referral that is classified as complicated.
During the first quarter, Foxfire's PCPs made 450 referrals to dermatologists and 100 of these referrals were classified as complicated. One dermatologist, Dr. Shareef Rashad, received 42 of these referrals; 6 of his referrals were classified as complicated. Statements that can correctly be made about Foxfire's contact capitation arrangement include:

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

Answer: A

NEW QUESTION 87
- (Topic 2)
The Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) established the Programs of All-Inclusive Care for the Elderly (PACE). One characteristic of the PACE programs is that:

A. They are available to United States citizens only after they reach age 65.
B. They have an upper dollar limit.
C. They receive a monthly capitation that is set at 100% of the Adjusted Average Per Capita Cost (AAPCC).
D. PACE providers receive capitated payments only through the PACE agreement.

Answer: D

NEW QUESTION 91
- (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 92
- (Topic 2)
Although ambulatory payment classifications (APCs) bear some resemblance to diagnosis- related groups (DRGs), there are significant differences between APCs and DRGs. One of these differences is that APCs:

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

Answer: A

NEW QUESTION 97
- (Topic 2)
Grant Pelham is covered by both a workers' compensation program and a group health plan provided by his employer. The Shipwright Health Plan administers both programs. Mr. Grant was injured while on the job and applied for benefits.
Mr. Pelham's group health insurance plan and workers' compensation both provide benefits to cover expenses incurred as a result of illness or injury. However, unlike traditional group insurance coverage, workers' compensation

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

Answer: A

NEW QUESTION 99
- (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 104
- (Topic 2)
The Crimson Health Plan, a competitive medical plan (CMP), has entered into a Medicare risk contract. One true statement about Crimson is that, as a:

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

Answer: D

NEW QUESTION 105
- (Topic 2)
Before or during the orientation process, health plans generally provide new network providers with a provider manual. One of the primary purposes of the provider manual is to

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

Answer: D

NEW QUESTION 110

- (Topic 2)
The provider contract that Dr. Bijay Patel has with the Arbor Health Plan includes a no- balance-billing clause. The purpose of this clause is to:

A. prohibit D
B. Patel from collecting payments from Arbor plan members for medical services that he provided them, even if the services are explicitly excluded from the benefit plan
C. allow D
D. Patel to bill patients for services only if the services are considered to be medically necessary
E. establish the guidelines used to determine if Arbor is the primary payor of benefits in a situation in which an Arbor plan member is covered by more than one health plan
F. require D
G. Patel to accept Arbor's payment as payment in full for medical services that he provides to Arbor plan members

Answer: D

NEW QUESTION 113
- (Topic 2)
The provider contract that the Canyon health plan has with Dr. Nicole Enberg specifies that she cannot sue or file any claims against a Canyon plan member for covered services, even if Canyon becomes insolvent or fails to meet its financial obligations. The contract also specifies that Canyon will compensate her under a typical discounted fee-for-service (DFFS) payment system.
During its recredentialing of Dr. Enberg, Canyon developed a report that helped the health plan determine how well she met Canyon's standards. The report included cumulative performance data for Dr. Enberg and encompassed all measurable aspects of her performance. This reportincluded such information as the number of hospital admissions Dr. Enberg had and the number of referrals she made outside of Canyon's provider network during a specified period. Canyon also used process measures, structural measures, and outcomes measures to evaluate Dr. Enberg's performance.
The report that helped Canyon determine how well Dr. Enberg met the health plan's standards is known as:

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

Answer: C

NEW QUESTION 115
- (Topic 2)
State Medicaid agencies can contract with health plans through open contracting or selective contracting. One advantage of selective contracting is that it

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

Answer: D

NEW QUESTION 116
- (Topic 2)
CMS Medicare+Choice regulations include a provision that allows health plans to deny benefits for any services the health plan objects to on moral or religious grounds. The provision that exempts health plans from providing such services is known as

A. a conscience protection exception
B. a hold harmless clause
C. a medical necessity determination
D. an intermediate sanction

Answer: A

NEW QUESTION 119
- (Topic 2)
The provider contract that Dr. Ted Dionne has with the Optimal Health Plan includes an arrangement that requires Dr. Dionne to notify Optimal if he contracts with another health plan at a rate that is lower than the rate offered to Optimal. Dr. Dionne must also offer this lower rate to Optimal. This information indicates that the provider contract includes a:

A. Most-favored-nation arrangement
B. Warranty arrangement
C. Locum tenens arrangement
D. Nesting arrangement

Answer: A

NEW QUESTION 123
- (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 125
- (Topic 2)
The Portway Hospital is qualified to receive Medicaid subsidy payments as a disproportionate share hospital (DHS). The DHS payments that Portway receives are

A. Made for services rendered to specific patients
B. Made with matching state and federal funds
C. Included in the Medicaid capitation payment made to patients' health plans
D. Defined as cost-based reimbursement (CBR) equal to 100% of Portway's reasonable costs of providing services to Medicaid recipients

Answer: B

NEW QUESTION 129
- (Topic 2)
The Ventnor Health Plan requires the physicians in its provider network to be board certified. Ventnor has received requests to become a part of the network from the following specialists:
Cheryl Stovall, who is currently in the process of completing a residency in her field ofspecialization.
Thomas Kalil, who has completed a residency in his field of specialization and has passed a qualifying examination in that field within two years of completing his residency.
Roger Todd, who has completed a residency in his field of specialization but has not passed a qualifying examination in that field.
Ventnor's requirement of board certification is met by:

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

Answer: C

NEW QUESTION 130
- (Topic 2)
As part of the credentialing process, many health plans use the National Practitioner Data Bank (NPDB) to learn information about prospective members of a provider network. One true statement about the NPDB is that:

A. It is maintained by the individual states
B. It primarily includes information about any censures, reprimands, or admonishments against any physicians who are licensed to practice medicine in the United States
C. The information in the NPDB is available to the general public
D. It was established to identify and discipline medical practitioners who act unprofessionally

Answer: D

NEW QUESTION 131
- (Topic 2)
An increasing number of health plans offer coverage for alternative healthcare services. One such alternative healthcare service is biofeedback. Biofeedback is an approach that

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

Answer: C

NEW QUESTION 135
- (Topic 2)
Health plans can often reduce workers' compensation costs by incorporating 24-hour coverage into their workers' compensations programs. Twenty-four-hour coverage reduces costs by

A. Maximizing the effects of cost shifting
B. Eliminating the need for utilization management
C. Requiring members to use separate points of entry for job-related and non-job related services
D. Combining administrative services for workers' compensation and non-workers' compensation healthcare and disability coverage

Answer: D

NEW QUESTION 138
- (Topic 2)
Assume that the national average cost per covered employee for PPO rental networks is
$3 per member per month (PMPM) and that the average monthly healthcare premium PMPM is $300. This information indicates that, if the number of health plan members is 10,000, then the annual network rental cost to the health plan would be:

A. $30,000
B. $360,000
C. $9,000,000
D. $12,000,000

Answer: B

NEW QUESTION 139
- (Topic 2)
The Zephyr Health Plan identifies members for whom subacute care might be an appropriate treatment option. The following individuals are members of Zephyr:
Selena Tovar, an oncology patient who requires radiation oncology services, chemotherapy, and rehabilitation.
Dwight Borg, who is in excellent health except that he currently has sinusitis.
Timothy O'Shea, who is beginning his recovery from brain injuries caused by a stroke. Subacute care most likely could be an appropriate option for:

A. M
B. Tovar, M
C. Borg, and M
D. O'Shea
E. M
F. Tovar and M
G. O'Shea only
H. M
I. O'Shea only
J. M
K. Borg only

Answer: B

NEW QUESTION 142
- (Topic 2)
The following activities are the responsibility of either the Nova Health Plan's risk management department or its medical management department:

A. Protecting Nova's members against harm from medical care
B. Improving the overall health status of Nova members by coordinating care across individual episodes of care and the different providers who treat the member
C. Protecting Nova against financial loss associated with the delivery of healthcare
D. Establishing outreach programs to encourage the use of preventive health services by Nova's members of these activities, the ones that are more likely to be the responsibility of Nova's risk management department rather than its medical management department are activities:
E. A, B, and C
F. A, C, and D
G. A and C
H. B and D

Answer: C

NEW QUESTION 145
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