

# Exam Questions AHM-530

Network Management

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#### NEW QUESTION 1

- (Topic 1)

Although a health plan is allowed to delegate many activities to outside sources, the National Committee for Quality Assurance (NCQA) has determined that some activities are not delegable.

These activities include

- A. evaluation of new medical technologies
- B. overseeing delegated medical records activities
- C. developing written statements of members' rights and responsibilities
- D. all of the above

**Answer: D**

#### NEW QUESTION 2

- (Topic 1)

Many health plans opt to carve out behavioral healthcare (BH) services. However, one argument against carving out BH services is that this action most likely can result in

- A. Slower access to BH care for plan members
- B. Increased collaboration between BH providers and PCPs
- C. Fewer specialized BH services for plan members
- D. Decreased continuity of BH care for plan members

**Answer: D**

#### NEW QUESTION 3

- (Topic 1)

The provider contract between the Regal Health Plan and Dr. Caroline Quill contains a type of termination clause known as termination without cause. One true statement about this clause is that it

- A. Requires Regal to send a report to the appropriate accrediting agency if the health plan terminates D
- B. Quill's contract without cause
- C. Requires that Regal must base its decision to terminate D
- D. Quill's contract on clinical criteria only
- E. Allows either Regal or D
- F. Quill to terminate the contract at any time, without any obligation to provide a reason for the termination or to offer an appeals process
- G. Allows Regal to terminate D
- H. Quill's contract at the time of contract renewal only, without any obligation to provide a reason for the termination or to offer an appeals process

**Answer: C**

#### NEW QUESTION 4

- (Topic 1)

From the following answer choices, choose the term that best matches the description.

An integrated delivery system (IDS), which controls most providers in a particular specialty, agrees to provide that specialty service to a health plan only on the condition that the health plan agree to contract with the IDS for other services.

- A. Group boycott
- B. Horizontal division of territories
- C. Tying arrangements
- D. Concerted refusal to admit

**Answer: C**

#### NEW QUESTION 5

- (Topic 1)

Four types of APCs are ancillary APCs, medical APCs, significant procedure APCs, and surgical APCs. An example of a type of APC known as

- A. An ancillary APC is a biopsy
- B. A medical APC is radiation therapy
- C. A significant procedure APC is a computerized tomography (CT) scan
- D. A surgical APC is an emergency department visit for cardiovascular disease

**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)

The following statements are about incentive programs used for providers. Select the answer choice containing the correct statement.

- A. Risk pools based on aggregate provider performance eliminate problems associated with “free riders.”
- B. A hospital bonus pool is usually split between the health plan and the PCPs.
- C. Bonus pools based on the performance of specific providers are usually easier to administer than those based on the performance of the plan as a whole.
- D. For providers, withhold arrangements eliminate the risk of losing base income.

**Answer: B**

#### 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)

The Gardenia Health Plan has a national reputation for quality care. When Gardenia entered a new market, it established a preferred provider organization (PPO), a health maintenance organization (HMO), and a point-of-service product (POS) to serve the plan members in this market. All of the providers included in the HMO or the POS are included in the broader provider panel of the PPO. The POS will be a typical two-level POS that offers a cost-based incentive plans for PCPs, and the HMO is a typical staff model HMO.

The following statement(s) can correctly be made about Gardenia’s establishment of the PPO and the staff model HMO in its new market:

- \* 1. When establishing its PPO network, Gardenia most likely initiated outcomes measurement tools and developed collaborative process improvement relationships with providers.
- \* 2. To avoid high overhead expenses in the early stages of market development, Gardenia’s HMO most likely contracted with specialists and ancillary providers until the plan’s membership grew to a sufficient level to justify employing these specialists.

- A. Both 1 and 2
- B. Neither 1 nor 2
- C. 1 Only
- D. 2 Only

**Answer: D**

#### NEW QUESTION 10

- (Topic 1)

The Octagon Health Plan includes a typical indemnification clause in its provider contracts. The purpose of this clause is to require Octagon’s network providers to

- A. Agree not to sue or file claims against an Octagon plan member for covered services
- B. Reimburse Octagon for costs, expenses, and liabilities incurred by the health plan as a result of a provider’s actions
- C. Maintain the confidentiality of the health plan’s proprietary information
- D. Agree to accept Octagon’s payment as payment in full and not to bill members for anything other than contracted copayments, coinsurance, or deductibles

**Answer: B**

#### NEW QUESTION 10

- (Topic 1)

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 13

- (Topic 1)

Open panel health plans can contract with individual providers or with various provider groups when developing their networks. The following statements are about factors that an open panel health plan might consider in contracting with different types of provider organizations. Select the answer choice that contains the correct statement.

- A. One limitation of contracting with multispecialty groups is that a health plan obtains only specialty consultants, but not PCPs.
- B. One benefit to a health plan in contracting with an integrated delivery system (IDS) is the ability to have a network in rapid order and to enter into a new market or one that is already competitive.
- C. A health plan that contracts with an individual practice association (IPA) has a greater ability to select and deselect individual physicians than when contracting directly with the providers.

D. A health plan that contracts with an IDS is able to eliminate the antitrust risk that exists when contracting with an IPA.

**Answer:** B

#### NEW QUESTION 16

- (Topic 1)

The following statement(s) can correctly be made about the TRICARE managed healthcare program of the U.S. Department of Defense.

\* 1. Active-duty military personnel are automatically enrolled in TRICARE's HMO option (TRICARE Prime).

\* 2. Eligible family members and dependents can enroll in TRICARE Prime, the PPO plan (TRICARE Extra), or an indemnity plan (TRICARE Standard).

A. Both 1 and 2

B. 1 only

C. 2 only

D. Neither 1 nor 2

**Answer:** A

#### NEW QUESTION 21

- (Topic 1)

The following statements are about managed dental care. Three of these statements are true, and one is false. Select the answer choice containing the FALSE statement.

A. Managed dental care is federally regulated.

B. Dental HMOs typically need very few healthcare facilities because almost all dental services are delivered in an ambulatory care setting.

C. Currently, there are no nationally recognized standards for quality in managed dental care.

D. Processes for selecting dental care providers vary greatly according to state regulations on managed dental care networks and the health plan's standards.

**Answer:** A

#### NEW QUESTION 26

- (Topic 1)

For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.

Understanding the level of health plan penetration in a particular market can help a health plan determine which products are most appropriate for that market.

Indicators of a mature health plan market include

A. A reduction in the rate of growth in health plan premium levels

B. A reduction in the level of outcomes management and improvement

C. An increase in the rate of inpatient hospital utilization

D. All of the above

**Answer:** A

#### NEW QUESTION 31

- (Topic 1)

To protect providers against business losses, many health plan-provider contracts include carve-out provisions to help providers manage financial risk. The following statements are examples of such provisions:

The Apex Health Plan carves out immunizations from PCP capitations. Apex compensates PCPs for immunizations on a case rate basis.

The Bengal Health Plan carves out behavioral healthcare services from the scope of PCP services because these services require specialized knowledge and skills that most PCPs do not possess.

From the answer choices below, select the response that best identifies the types of carve-outs used by Apex and Bengal.

A. Apex: disease-specific carve-out Bengal: specialty services carve-out

B. Apex: disease-specific carve-out Bengal: specific-service carve-out

C. Apex: specific-service carve-out Bengal: specialty services carve-out

D. Apex: specific-service carve-out Bengal: disease-specific carve-out

**Answer:** C

#### NEW QUESTION 35

- (Topic 1)

Provider panels can be either narrow or broad. Compared to a similarly sized health plan that uses a broad provider panel, a health plan that uses a narrow provider panel most likely can expect to

A. Experience higher contracting costs

B. Encounter increased difficulty in utilization management

C. Have to charge higher health plan premiums

D. Experience lower provider relations costs

**Answer:** D

#### NEW QUESTION 40

- (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 43

- (Topic 1)

The following statements are about the negotiation process of provider contracting. Three of the statements are true and one of the statements is false. Select the answer choice containing the FALSE statement.

- A. While preparing for negotiations, the health plan usually sends the provider an application to join the provider network, a list of credentialing requirements, and a copy of the proposed provider contract, which may or may not include the proposed reimbursement schedule.
- B. In general, the ideal negotiating style for provider contracting is a collaborative approach.
- C. Typically, the health plan and the provider negotiate the reimbursement arrangement between the parties before they negotiate the scope of services and the contract language.
- D. The actual signing of the provider contract typically takes place after negotiations are completed.

**Answer:** C

#### NEW QUESTION 44

- (Topic 1)

Dr. Janet Dubois is a radiologist who practices exclusively at the Rightway Healthcare Center. This information indicates that Dr. Dubois is employed by Rightway as

- A. An academic practitioner
- B. An independent practitioner
- C. A network manager
- D. A hospital-based specialist

**Answer:** D

#### NEW QUESTION 45

- (Topic 1)

The Festival Health Plan is in the process of recruiting physicians for its provider network. Festival requires its network physicians to be board certified. The following individuals are provider applicants whose qualifications are being considered:

Applicant 1 has completed his surgical residency, and he recently passed a qualifying examination in his field.

Applicant 2 has completed her residency in dermatology, and she is scheduled to take qualifying examinations in the next Six months.

Applicant 3 completed his residency in pediatric medicine six years ago, but he has not yet passed a qualifying examination in his field.

With regard to these applicants, it can correctly be stated that only

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

**Answer:** C

#### NEW QUESTION 47

- (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 the confidentiality 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 51

- (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 53

- (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 55

- (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 57

- (Topic 1)

The National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act defines specific adequacy and accessibility standards that health plans must meet. In addition, the Model Act requires health plans to

- A. Hold plan members responsible for unreimbursed charges or unpaid claims
- B. Allow providers to develop their own standards of care
- C. Adhere to specified disclosure requirements related to provider contract termination
- D. File written access plans and sample contracts with the Centers for Medicaid and Medicare Services (CMS)

**Answer:** C

#### NEW QUESTION 62

- (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 67

- (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 70

- (Topic 1)

Determine whether the following statement is true or false:

The NCQA has established a Physician Organization Certification (POC) program for the purpose of certifying medical groups and independent practice associations for delegation of certain NCQA standards, including data collection and verification for credentialing and recredentialing.

- A. True
- B. False

**Answer:** A

#### NEW QUESTION 73

- (Topic 1)

The sizes of the businesses in a market affect the types of health programs that are likely to be purchased. Compared to smaller employers (those with fewer than 100 employees), larger employers (those with more than 1,000 employees) are

- A. more likely to contract with indemnity health plans
- B. more likely to offer their employees a choice in health plans
- C. less likely to contract with health plans
- D. less likely to require a wide variety of benefits

**Answer:** B

#### NEW QUESTION 77

- (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 82

- (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 87

- (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 88

- (Topic 1)

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

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

**Answer:** B

#### NEW QUESTION 90

- (Topic 1)

The 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 91

- (Topic 2)

The vision benefits offered by the Omni Health Plan include clinical eye care only. The following statements describe vision care received by Omni plan members:

- Brian Pollard received treatment for a torn retina he suffered as a result of an accident
- Angelica Herrera received a general eye examination to test her vision
- Megan Holtz received medical services for glaucoma

Of these medical services, the ones that most likely would be covered by Omni's vision coverage would be the services received by:

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

**Answer:** C

#### NEW QUESTION 94

- (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 conforms to standards for prescribing controlled substances
- 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 98

- (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 101

- (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 104

- (Topic 2)

The Bruin Health Plan is a Social Health Maintenance Organization (SHMO). As an SHMO, Bruin:

- A. Must provide Medicare participants with standard HMO benefits, as well as with limited long-term care benefits
- B. Does not need as great a variety of provider types or as complex a reimbursement method as does a traditional HMO
- C. Receives a payment that is based on reasonable costs and reasonable charges
- D. Most likely provides fewer supportive services than does a traditional HMO, because one of Bruin's goals is to minimize the use of community-based care

**Answer:** A



#### NEW QUESTION 109

- (Topic 2)

The following statements describe two types of HMOs:

The Elm HMO requires its members to select a PCP but allows the members to go to any other provider on its panel without a referral from the PCP.

The Treble HMO does not require its members to select a PCP. Treble allows its members to go to any doctor, healthcare professional, or facility that is on its panel without a referral from a primary care doctor. However, care outside of Treble's network is not reimbursed unless the provider obtains advance approval from the HMO.

Both HMOs use delegation to transfer certain functions to other organizations. Following the guidelines established by the NCQA, Elm delegated its credentialing activities to the Newnan Group, and the agreement between Elm and Newnan lists the responsibilities of both parties under the agreement. Treble delegated utilization management (UM) to an

IPA. The IPA then transferred the authority for case management to the Quest Group, an organization that specializes in case management.

Both HMOs also offer pharmacy benefits. Elm calculates its drug costs according to a pricing system that requires establishing a purchasing profile for each pharmacy and basing reimbursement on the profile. Treble and the Manor Pharmaceutical Group have an arrangement that requires the use of a typical maximum allowable cost (MAC) pricing system to calculate generic drug costs under Treble's pharmacy program. The following statements describe generic drugs prescribed for Treble plan members who are covered by Treble's pharmacy benefits:

The MAC list for Drug A specifies a cost of 12 cents per tablet, but Manor pays 14 cents per tablet for this drug.

The MAC list for Drug B specifies a cost of 7 cents per tablet, but Manor pays 5 cents per tablet for this drug.

To calculate its drug costs, Elm uses a pricing system known as:

- A. Estimated acquisition cost (EAC)
- B. Package rate cost (PRC)
- C. Actual acquisition cost (AAC)
- D. Wholesale acquisition cost (WAC)

**Answer: A**

#### NEW QUESTION 110

- (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 112

- (Topic 2)

The employees of the Trilogy Company are covered by a typical workers' compensation program. Under this coverage, Trilogy employees are bound by the exclusive remedy doctrine, which most likely:

- A. Allows Trilogy to deny benefits for an employee's on-the-job injury or illness, but only if Trilogy is not at fault for the injury or illness.
- B. Allows Trilogy to place limits on the amount of coverage payable for a given claim under the workers' compensation program.
- C. Requires the employees to accept workers' compensation as their only compensation in cases of work-related injury or illness.
- D. Provides the employees with 24-hour coverage.

**Answer: C**

#### NEW QUESTION 113

- (Topic 2)

The Azure Health Plan strives to ensure for its plan members the best possible level of care from its providers. In order to maintain such high standards, Azure uses a variety of quantitative and qualitative (behavioral) measures to determine the effectiveness of its providers. Azure then compares the clinical and operational practices of its providers with those of other providers outside the network, with the goal of identifying and implementing the practices that lead to the best outcomes.

The comparative method of evaluation that Azure uses to identify and implement the practices that lead to the best outcomes is known as

- A. Case mix analysis
- B. Outcomes research
- C. Benchmarking
- D. Provider profiling

**Answer: C**

#### NEW QUESTION 115

- (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 116

- (Topic 2)

The following statements are about the delegation of network management activities from a health plan to another party. Three of the statements are true and one statement is false. Select the answer choice containing the FALSE statement:

- A. The NCQA requires a health plan to conduct all delegation oversight functions rather than delegating the responsibility for oversight to another entity.
- B. Credentialing and UM activities are the most frequently delegated functions, whereas delegation is less common for quality management (QM) and preventive health services.
- C. One reason that a health plan may choose to delegate a function is because the health plan's staff seeks external expertise for the delegated activity.
- D. When the health plan delegates authority for a function, it transfers the power to conduct the function on a day-to-day basis, as well as the ultimate accountability for the function.

Answer: D

#### NEW QUESTION 120

- (Topic 2)

The provider contract that Dr. Laura Cartier has with the Sailboat health plan includes a section known as the recitals. Dr. Cartier's contract includes the following statements:

- A. A statement that identifies the purpose of the contract
- B. A statement that defines in legal terms the parties to the contract
- C. A statement that identifies the Sailboat products to be covered by the contract
- D. Of these statements, the ones that are likely to be included in the recitals section of D
- D. Cartier's contract are statements:
- E. A, B, and C
- F. A and B only
- G. A and C only
- H. B and C only

Answer: A

#### NEW QUESTION 123

- (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 125

- (Topic 2)

One characteristic of the workers' compensation program is that:

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

Answer: A

#### NEW QUESTION 126

- (Topic 2)

The following statement(s) can correctly be made about contracting and reimbursement of specialty care physicians (SCPs):

- A. Typically, a health plan should attempt to control utilization of SCPs before attempting to place these providers under a capitation arrangement.
- B. Forms of specialty physician reimbursement used by health plans include a retainer and a bundled case rate.
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: A

#### NEW QUESTION 130

- (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 134

- (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 137

- (Topic 2)

The provider contract that Dr. Lorena Chau has with the Fiesta Health Plan includes an evergreen clause. The purpose of this clause is to:

- A. Allow Fiesta to change or amend the contract without D
- B. Chau's approval as long as the modifications are made in order to comply with new legal and regulatory requirements
- C. Prohibit D
- D. Chau from encouraging her patients to switch from Fiesta to another health plan
- E. Prohibit D
- F. Chau from encouraging her patients to switch from Fiesta to another health plan
- G. Assure that D
- H. Chau provides Fiesta members with healthcare services in a timely manner appropriate to the member's medical condition

**Answer: C**

#### NEW QUESTION 138

- (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 141

- (Topic 2)

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

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

**Answer: A**

#### NEW QUESTION 146

- (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 147

- (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 150

- (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 152

- (Topic 2)

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

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

**Answer:** D

#### NEW QUESTION 156

- (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 160

- (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 162

- (Topic 2)

One true statement about the Employee Retirement Income Security Act of 1974 (ERISA) is that:

- A. ERISA applies to all issuers of health insurance products, such as HMOs
- B. pension plans and employee welfare plans are exempt from any regulation under ERISA
- C. ERISA requires self-funded plans to comply with all state mandates affecting health insurance companies and health plans
- D. the terms of ERISA generally take precedence over any state laws that regulate employee welfare benefit plans

**Answer:** D

#### NEW QUESTION 164

- (Topic 2)

In health plan pharmacy networks, service costs consist of two components: costs for services associated with dispensing prescription drugs and costs for cognitive services. Cognitive services typically include:



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

**Answer:** B

#### NEW QUESTION 165

- (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 168

- (Topic 2)

The following statements describe two types of HMOs:

The Elm HMO requires its members to select a PCP but allows the members to go to any other provider on its panel without a referral from the PCP.

The Treble HMO does not require its members to select a PCP. Treble allows its members to go to any doctor, healthcare professional, or facility that is on its panel without a referral from a primary care doctor. However, care outside of Treble's network is not reimbursed unless the provider obtains advance approval from the HMO.

Both HMOs use delegation to transfer certain functions to other organizations. Following the guidelines established by the NCQA, Elm delegated its credentialing activities to the Newnan Group, and the agreement between Elm and Newnan lists the responsibilities of both parties under the agreement. Treble delegated utilization management (UM) to an IPA. The IPA then transferred the authority for case management to the Quest Group, an organization that specializes in case management.

Both HMOs also offer pharmacy benefits. Elm calculates its drug costs according to a pricing system that requires establishing a purchasing profile for each pharmacy and basing reimbursement on the profile. Treble and the Manor Pharmaceutical Group have an arrangement that requires the use of a typical maximum allowable cost (MAC) pricing system to calculate generic drug costs under Treble's pharmacy program. The following statements describe generic drugs prescribed for Treble plan members who are covered by Treble's pharmacy benefits:

The MAC list for Drug A specifies a cost of 12 cents per tablet, but Manor pays 14 cents

per tablet for this drug.

The MAC list for Drug B specifies a cost of 7 cents per tablet, but Manor pays 5 cents per tablet for this drug.

From the following answer choices, select the response that best identifies Elm and Treble:

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

**Answer:** C

#### NEW QUESTION 173

- (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 178

- (Topic 2)

The following statements are about workers' compensation provider networks. Select the answer choice containing the correct statement:

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

**Answer:** D

#### NEW QUESTION 180

- (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 184

- (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.

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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 185

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