AHM-250 Dumps

Healthcare Management: An Introduction

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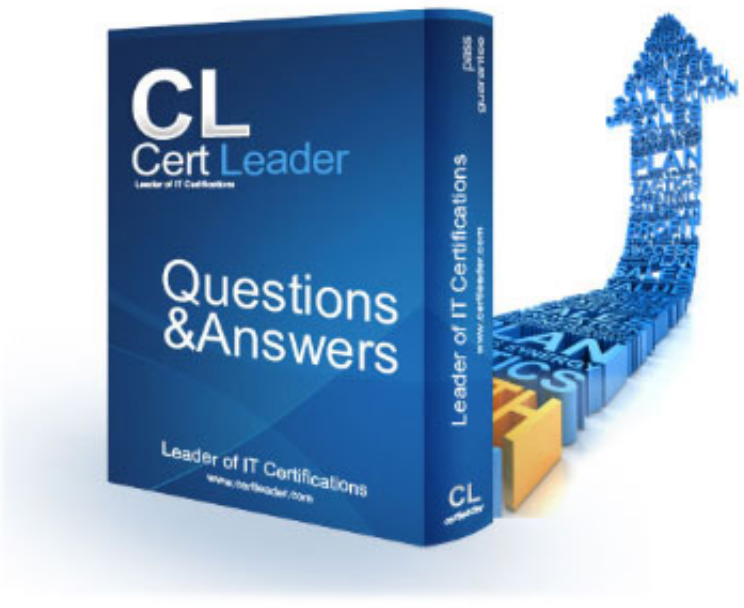

NEW QUESTION 1
- (Topic 1)
During an open enrollment period in 1997, Amy Hadek enrolled through her employer for group health coverage with the Owl Health Plan, a federally qualified HMO. At the time of her enrollment, Ms. Hadek had three pre-existing medical conditions: angina, fo

A. the angina, the high blood pressure, and the broken ankle
B. the angina and the high blood pressure only
C. none of these conditions
D. the broken ankle only

Answer: A

NEW QUESTION 2
- (Topic 1)
From the answer choices below, select the response that correctly identifies the rating method that Mr. Sybex used and the premium rate PMPM that Mr. Sybex calculated for the Koster group.

A. Rating Method book rating Premium Rate PMPM $132
B. Rating Method book rating Premium Rate PMPM $138
C. Rating Method blended rating Premium Rate PMPM $132
D. Rating Method blended rating Premium Rate PMPM $138

Answer: C

NEW QUESTION 3
- (Topic 1)
From the following answer choices, choose the description of the ethical principle that best corresponds to the term Beneficence

A. Health plans and their providers are obligated not to harm their members
B. Health plans and their providers should treat each member in a manner that respects the member's goals and values, and they also have a duty to promote the good of the members as a group
C. Health plans and their providers should allocate resources in a way that fairly distributes benefits and burdens among the members
D. Health plans and their providers have a duty to respect the right of their members to make decisions about the course of their lives

Answer: B

NEW QUESTION 4
- (Topic 1)
All CDHP products provide federal tax advantages while allowing consumers to save money for their healthcare.

A. True
B. False

Answer: A

NEW QUESTION 5
- (Topic 1)
In claims administration terminology, a claims investigation is correctly defined as the process of

A. reporting management information about services provided each time a patient visits a provider for purposes of analyzing utilization and provider practice patterns
B. obtaining all the information necessary to determine the appropriate amount to pay on a given claim
C. routinely reviewing and processing a claim for either payment or denial
D. assigning to each diagnosis or treatment reported on a claim special codes that briefly and specifically describe each diagnosis and treatment

Answer: B

NEW QUESTION 6
- (Topic 1)
In 1999, the United States Congress passed the Financial Services Modernization Act, referred to as the Gramm-Leach-Bliley (GLB) Act. The primary provisions included under
the GLB Act require financial institutions, including health plans, to take several

A. Notify customers of any sharing of non-public personal financial information with nonaffiliated third parties.
B. Prohibit customers from having the opportunity to 'opt-out' of sharing non-public personal financial information.
C. Disclose to affiliates, but not to third parties, their privacy policies regarding the sharing of nonpublic personal financial information.
D. Agree not to disclose personally identifiable financial information or personally identifiable health information.

Answer: A

NEW QUESTION 7
- (Topic 1)
HMOs can't medically underwrite any group – incl small groups.

A. State

B. Not-for-profit
C. For-profit
D. Federally qualified

Answer: B

NEW QUESTION 8
- (Topic 1)
Each of the following statements describes a health plan that is using a method of managing institutional utilization. Select the answer choice that describes a health plan's use of retrospective review to decrease utilization of hospital services.

A. The Serenity Healthcare Organization requires a plan member or the provider in charge of the member's care to obtain authorization for inpatient care before the member is admitted to the hospital.
B. UR nurses employed by the Friendship Health Plan monitor length of stay to identify factors that might contribute to unnecessary hospital days.
C. The Optimum Health Group evaluates the medical necessity and appropriateness of proposed services and intervenes, if necessary, to redirect care to a more appropriate care setting.
D. The Axis Medical Group examines provider practice patterns to identify areas in which services are being underused, overused, or misused and designs strategies to prevent inappropriate utilization in the future.

Answer: D

NEW QUESTION 9
- (Topic 1)
By offering a comprehensive set of healthcare benefits to its members, an HMO ensures that its members obtain quality, cost-effective, and appropriate medical care. Ways that an HMO provides comprehensive care include

A. coordinating care across a variety of benefits
B. emphasizing preventive care by covering many preventive services either in full or with a small copayment
C. offering its members access to wellness programs
D. All of the above

Answer: D

NEW QUESTION 10
- (Topic 1)
In most cases, medical errors are caused by breakdowns in the healthcare system rather than by provider mistakes.

A. True
B. False

Answer: A

NEW QUESTION 10
- (Topic 1)
In preparation for its expansion into a new service area, the Regal MCO is meeting with Dr. Nancy Buhner, a cardiologist who practices in Regal's new service area, in order to convince her to become one of the plan's participating providers. As part of the

A. ensure that D
B. Buhner complies with all of the provisions of the Ethics in Patient Referrals Act
C. learn whether D
D. Buhner is a licensed medical practitioner
E. confirm D
F. Buhner's membership in the National Committee for Quality Assurance (NCQA)
G. learn whether D
H. Buhner has had a medical malpractice claim filed or other disciplinary actions taken against her

Answer: D

NEW QUESTION 12
- (Topic 1)
Health savings accounts were created by which of the following laws:

A. COBRA
B. HIPAA
C. Medicare Modernization Act
D. None of the Above

Answer: C

NEW QUESTION 16
- (Topic 1)
In 1999, the United States Congress passed the Financial Services Modernization Act, which is referred to as the Gramm-Leach-Bliley (GLB) Act. The following statement(s) can correctly be made about this act:

A. The GLB Act allows convergence among the transaction
B. A only
C. Both A and B

D. B only
E. Neither A nor B

Answer: B

NEW QUESTION 19
- (Topic 1)
HMOs typically employ several techniques to manage provider utilization and member utilization of medical services. One technique that an HMO uses to manage member utilization is

A. the use of physician practice guidelines
B. the requirement of copayments for office visits
C. capitation
D. risk pools

Answer: B

NEW QUESTION 24
- (Topic 1)
In accounting terminology, the items of value that a company owns—such as cash, cash equivalents, and receivables—are generally known as the company's

A. revenue
B. net income
C. surplus
D. assets

Answer: D

NEW QUESTION 27
- (Topic 1)
Amendments to the HMO act 1973 do not permit federally qualified HMO’s to use

A. Retrospective experience rating
B. Adjusted community rating
C. Community rating by class
D. Community rating

Answer: A

NEW QUESTION 30
- (Topic 1)
Health plans' use of the Internet to provide plan members with health-related information has grown rapidly in recent years. One advantage the Internet has over other forms of communication is that

A. users can access the Internet using a number of different types of computer systems
B. access to the Internet is available only to members of the health plan's network
C. the Internet is immune to internal security breaches by employees or trading partners within the network
D. users can contact a single controlling organization to rectify disruptions in Internet service

Answer: A

NEW QUESTION 33
- (Topic 1)
As part of its utilization management (UM) system, the Creole Health Plan uses a process known as case management. The following individuals are members of the Creole Health Plan:
? Jill Novacek, who has a chronic respiratory condition.
? Abraham Rashad.

A. M
B. Novacek, M
C. Rashad, and M
D. Devereaux
E. M
F. Novacek and M
G. Rashad only
H. M
I. Novacek and M
J. Devereaux only
K. None of these members

Answer: A

NEW QUESTION 35
- (Topic 1)
A physician-hospital organization (PHO) may be classified as an open PHO or a closed PHO. With respect to a closed PHO, it is correct to say that

A. the specialists in the PHO are typically compensated on a capitation basis

B. the specialists in the PHO are typically compensated on a capitation basis
C. it typically limits the number of specialists by type of specialty
D. it is available to a hospital's entire eligible medical staff
E. physician membership in the PHO is limited to PCPs

Answer: B

NEW QUESTION 37
- (Topic 1)
Health plans sometimes contract with independent organizations to provide specialty services, such as vision care or rehabilitation services, to plan members. Specialty services that have certain characteristics are generally good candidates for health pl

A. Low or stable costs.
B. Appropriate, rather than inappropriate, utilization rates.
C. A benefit that cannot be easily defined.
D. Defined patient population.

Answer: D

NEW QUESTION 39
- (Topic 1)
Following a report by the Institute of Medicine on the incidence and consequences of medical errors, a national task force recommended implementation of a nationwide mandatory system of collecting, analyzing, and reporting standardized information about m

A. random change
B. structural change
C. haphazard change
D. reactive change

Answer: D

NEW QUESTION 42
- (Topic 1)
A health plan may use one of several types of community rating methods to set premiums for a health plan. The following statements are about community rating. Select the answer choice containing the correct statement.

A. Standard (pure) community rating is typically used for large groups because it is the most competitive rating method for large groups.
B. Under standard (pure) community rating, a health plan charges all employers or other group sponsors the same dollar amount for a given level of medical benefits or health plan, without adjusting for factors such as age, gender, or experience.
C. In using the adjusted community rating (ACR) method, a health plan must consider the actual experience of a group in developing premium rates for that group.
D. The Centers for Medicare and Medicaid Services (CMS) prohibits health plans that assume Medicare risk from using the adjusted community rating (ACR) me

Answer: B

NEW QUESTION 47
- (Topic 1)
In addition to the credentialing activities that an health plan performs when initially accepting a provider into its network, the health plan must also perform recredentialing of the same providers on an ongoing basis. Many of the same activities are per

A. verification of a network provider's medical education and residency
B. performance of site inspections in a provider's facilities
C. review of information from a provider's quality improvement activities
D. verification of a provider's licensure and certification

Answer: A

NEW QUESTION 50
- (Topic 1)
In order to measure the expenses of institutional utilization, Holt Healthcare Group uses the standard formula to calculate hospital bed days per 1,000 plan members per year. On October 23, Holt used the following information to calculate the bed days per

A. 278
B. 397
C. 403
D. 920

Answer: B

NEW QUESTION 54
- (Topic 1)
Immediate evaluation and treatment of illness or injury can be provided in any of the following care settings:

A. Hospital emergency departments
B. Physician's offices
C. Urgent care centersIf these settings are ranked in order of the cost of providing c
D. A, B, C
E. A, C, B

F. B, C, A
G. C, A, B

Answer: B

NEW QUESTION 57
- (Topic 1)
Health plans may use different capitation arrangements for different levels of service. One typical capitation arrangement provides a capitation payment that may include primary care only, or both primary and secondary care, but not ancillary services. The

A. global capitation arrangement
B. gatekeeper arrangement
C. carve-out arrangement
D. partial capitation arrangement

Answer: D

NEW QUESTION 58
- (Topic 1)
By definition, the marketing process of defining a certain place or market niche for a product relative to competitors and their products and then using the marketing mix to attract certain market segments is known as

A. branding
B. positioning
C. database marketing
D. personal selling

Answer: B

NEW QUESTION 60
- (Topic 1)
Employer-sponsored benefit plans that provide healthcare benefits must comply with the Employee Retirement Income Security Act (ERISA). One of the most significant features of ERISA is that it

A. contains a provision stating that the terms of ERISA generally take precedence over any state laws that regulate employee welfare benefit plans
B. standardizes the conversion of group healthcare benefits to individual healthcare benefits
C. mandates that self-funded healthcare plans must pay state premium taxes
D. requires that all active employees, regardless of age, must be eligible for coverage under employer-sponsored benefit plans

Answer: A

NEW QUESTION 61
- (Topic 1)
In order to help review its institutional utilization rates, the Sahalee Medical Group, a health plan, uses the standard formula to calculate hospital bed days per 1,000 plan members for the month to date (MTD). On April 20, Sahalee used the following inf

A. 67
B. 274
C. 365
D. 1,000

Answer: B

NEW QUESTION 64
- (Topic 1)
A health savings account must be coupled with an HDHP that meets federal requirements for minimum deductible and maximum out-of-pocket expenses. Dollar amounts are indexed
annually for inflation. For 2006, the annual deductible for self-only coverage must

A. $525
B. $1,050
C. $2,100
D. $5,250

Answer: B

NEW QUESTION 69
- (Topic 1)
Al Marak, a member of the Frazier Health Plan, has asked for a typical Level One appeal of a decision that Frazier made regarding Mr. Marak's coverage. One true statement about this Level One appeal is that

A. M
B. Marak has the right to appeal to the next level if the Level One appeal upholds the original decision
C. It requires Frazier and M
D. Marak to submit to arbitration in order to resolve the dispute
E. It is considered to be an informal appeal
F. It will be handled by an independent review organization (IRO)

Answer: A

NEW QUESTION 72
- (Topic 1)
By definition, a health plan's network refers to the

A. organizations and individuals involved in the consumption of healthcare provided by the plan
B. relative accessibility of the plan's providers to the plan's participants
C. group of physicians, hospitals, and other medical care providers with whom the plan has contracted to deliver medical services to its members
D. integration of the plan's participants with the plan's providers

Answer: C

NEW QUESTION 73
- (Topic 1)
In certain situations, a health plan can use the results of utilization review to intervene, if necessary, to alter the course of a plan member's medical care. Such intervention can be based on the results of

A. Prospective review
B. Concurrent review
C. B and C only
D. A, B, and C
E. A and B only
F. A and C only
G. B only

Answer: D

NEW QUESTION 74
- (Topic 1)
For providers, integration occurs when two or more previously separate providers combine under common ownership or control, or when two or more providers combine business operations that they previously carried out separately and independently. Such provi

A. higher costs for health plans, healthcare purchasers, and healthcare consumers
B. improved provider contracting position with health plans
C. an increase in providers' autonomy and control over their own work environment
D. all of the above

Answer: B

NEW QUESTION 78
- (Topic 1)
Historically most HMOs have been

A. Closed-access HMO
B. Closed-panel HMO
C. Open-access HMO
D. Open-panel HMO

Answer: B

NEW QUESTION 81
- (Topic 1)
Allgood Medical, Inc., a health plan, has contracted with Mercy Memorial Hospital to provide inpatient medical services to Allgood's plan members. The terms of the contract specify that Allgood will reimburse Mercy Memorial on the basis of a negotiated ch

A. per diem agreement
B. fee-for-service agreement
C. withhold agreement
D. diagnostic related group (DRG) agreement

Answer: A

NEW QUESTION 84
- (Topic 1)
An exclusive provider organization (EPO) operates much like a PPO. However, one difference between an EPO and a PPO is that an EPO

A. Is regulated under federal HMO legislation
B. Generally provides no benefits for out-of-network care
C. Has no provider network of physicians
D. Is not subject to state insurance laws

Answer: B

NEW QUESTION 86

- (Topic 1)
For this question, select the answer choice containing the terms that correctly complete the blanks labeled A and B in the paragraph below.
NCQA offers Quality Compass, a national database of performance and accreditation information submitted by managed

A. Health Plan Employer Data and Information Set (HEDIS) mandatory
B. Health Plan Employer Data and Information Set (HEDIS) voluntary
C. ORYX mandatory
D. ORYX voluntary

Answer: B

NEW QUESTION 87
- (Topic 1)
Federal legislation has placed the primary responsibility for regulating health insurance companies and HMOs that service private sector (commercial) plan members at the state level.
This federal legislation is the

A. Clayton Act
B. Federal Trade Commission Act
C. McCarran-Ferguson Act
D. Sherman Act

Answer: C

NEW QUESTION 89
- (Topic 1)
A health plan's ability to establish an effective provider network depends on the characteristics of the proposed service area and the needs of proposed plan members. It is generally correct to say that

A. health plans have more contracting options if providers are affiliated with single entities than if providers are affiliated with multiple entities
B. urban areas offer more flexibility in provider contracting than do rural areas
C. consumers and purchasers in markets with little health plan activity are likely to be more receptive to HMOs than to loosely managed plans such as PPOs
D. large employers tend to adopt health plans more slowly than do small companies

Answer: B

NEW QUESTION 91
- (Topic 1)
From the following answer choices, choose the description of the ethical principle that best corresponds to the term Beneficence

A. Health plans and their providers are obligated not to harm their members
B. Health plans and their providers should treat each member in a manner that respects the member's goals and values, and they also have a duty to promote the good of the members as a group
C. Health plans and their providers should allocate resources in a way that fairly distributes benefits and burdens among the members
D. Health plans and their providers have a duty to respect the right of their members to make decisions about the course of their lives

Answer: B

NEW QUESTION 94
- (Topic 1)
In order to compensate for lost revenue resulting from services provided free or at a significantly reduced cost to other patients, many healthcare providers spread these unreimbursed costs to paying patients or third-party payors. This practice is known

A. dual choice
B. cost shifting
C. accreditation
D. defensive medicine

Answer: B

NEW QUESTION 96
- (Topic 1)
Before the Hill Health Maintenance Organization (HMO) received a certificate of authority (COA) to operate in State X, it had to meet the state's licensing requirements and financial standards which were established by legislation that is identical to the

A. Receive compensation based on the volume and variety of medical services they perform for Hill plan members, whereas the specialists receive compensation based solely on the number of plan members who are covered for specific services.
B. Have no financial incentive to practice preventive care or to focus on improving the health of their plan members, whereas the specialists have a positive incentive to help their plan members stay healthy.
C. Receive from the IPA the same monthly compensation for each Hill plan member under the PCP's care, whereas the specialists receive compensation based on a percentage discount from their normal fees.
D. Receive compensation based on a fee schedule, whereas the specialists receive compensation based on per diem charges.

Answer: C

NEW QUESTION 99
- (Topic 1)

Because many patients with behavioral health disorders do not require round-the-clock nursing care and supervision, behavioral healthcare services can be delivered effectively in a variety of settings. For example, post-acute care for behavioral health di

A. Hospital observation units or psychiatric hospitals.
B. Psychiatric hospitals or rehabilitation hospitals.
C. Subacute care facilities or skilled nursing facilities.
D. Psychiatric units in general hospitals or hospital observation units.

Answer: C

NEW QUESTION 103
- (Topic 1)
Although the process is voluntary for health plans, external accreditation is becoming more and more important as states and purchasers require health plans undergo as many states and purchasers require health plans undergo some type of external review pr

A. Is voluntary for health plans.
B. Requires all change accreditation organizations to use the same standards of accreditation.
C. Typically requires the accrediting organization to conduct a medical record review and a review of a health plan's credentialing processes, but not an evaluation of the health plans' member service systems processes.
D. Cannot assure that a health plan meets a specified level of quality.

Answer: A

NEW QUESTION 108
- (Topic 1)
Bart Vereen is insured by both a traditional indemnity health insurance plan, which is his primary plan, and a managed care plan. Both plans have a typical coordination of benefits (COB) provision, but neither plan has a nonduplication of benefits provision

A. 380
B. 130
C. 550

Answer: A

NEW QUESTION 109
- (Topic 1)
Ed Murray is a claims analyst for a managed care plan that provides a higher level of benefits for services received in-network than for services received out-of-network. Whenever Mr. Murray receives a health claim from a plan member, he reviews the claim

A. A, B, C, and D
B. A and C only
C. A, B, and D only
D. B, C, and D only

Answer: A

NEW QUESTION 112
- (Topic 1)
In the paragraph below, a sentence contains two pairs of words enclosed in parentheses. Determine which word in each pair correctly completes the sentence. Then select the answer choice containing the two words that you have chosen. Many pharmacy benefit

A. Therapeutic / always
B. Generic / always
C. Generic / never
D. Therapeutic / never

Answer: A

NEW QUESTION 113
- (Topic 1)
Federal Employee Health Benefits Program (FEHBP) requires health plans offering services to federal employees and their dependents to provide

A. Immediate access to emergency services
B. Urgent Appointments within 24 hours
C. Routine appointments once a m
D. D
E. A
F. B & C
G. All of the listed options

Answer: F

NEW QUESTION 118
- (Topic 1)
In the following sections, we will describe some of the measures health plans use to evaluate the quality of the services and healthcare they offer their members. Which of the following is the best description of what a 'Process measure' evaluates?

A. The nature, quantity, and quality of the resources that a health plan has available for member service and patient care.
B. The methods and procedures a health plan and its providers use to furnish service and care.
C. The extent to which services succeed in improving or maintaining satisfaction and patient health.
D. None of the above

Answer: B

NEW QUESTION 121
- (Topic 2)
In the United States, the Department of Defense offers ongoing healthcare coverage to military personnel and their families through the TRICARE health plan. One true statement about TRICARE is that

A. hospitals participating in TRICARE program are exempt from JCAHO accreditation and Medicare certification
B. TRICARE enrollees are not entitled to appeal authorization coverage decisions
C. active duty personnel are automatically considered enrolled in TRICARE Prime
D. TRICARE covers inpatient and outpatient services, physician and hospital charges, and medical supplies, but not mental health services

Answer: C

NEW QUESTION 122
- (Topic 2)
The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement. In early efforts to manage healthcare costs, traditional indemnity health insurers included in their health pla

A. cost shifting
B. deductibles
C. underwriting
D. copy

Answer: B

NEW QUESTION 127
- (Topic 2)
John Kerry's employer has contracted to receive healthcare for its employees from the Democratic Healthcare System. Mr. Kerry visits his PCP, who sends him to have some blood tests. The PCP then refers Mr. Kerry to a specialist who hospitalizes him for on

A. a physician practice organization
B. a physician-hospital organization
C. a management services organization
D. an integrated delivery system

Answer: D

NEW QUESTION 129
- (Topic 2)
The contract between the Honolulu MCO and Beverley Hills Hospital contains a 90 day cure provision. The Beverley Hills Hospital breached one of the contract requirements on July 31, 2004. The hospital remedied the problem by October 31, 2004. Which of the

A. The contract would not be terminated as Beverley Hills hospital rectified the problem within 90 days.
B. The contract would be terminated as Beverley Hills hospital was required to notify Honolulu MCO about the problem at least 90 days in advance.
C. The contract would be terminated as Beverley Hills hospital was required to rectify the problem within 90 days.
D. The contract would not be terminated as Beverley Hills hospital may escape adherence to the cure provision.

Answer: C

NEW QUESTION 131
- (Topic 2)
One typical characteristic of preferred provider organization (PPO) benefit plans is that PPOs:

A. Assume full financial risk for arranging medical services for their members.
B. Require plan members to obtain a referral before getting medical services from specialists.
C. Use a capitation arrangement, instead of a fee schedule, to reimburse physicians.
D. Offer some coverage, although at a higher cost, for plan members who choose to use the services of non-network providers.

Answer: D

NEW QUESTION 133
- (Topic 2)
One way that MCOs involve providers in risk sharing is by retaining a percentage of the providers' payment during a plan year. At the end of the plan year, the MCO may use the amount retained to offset or pay for any cost overruns for referral or hospital

A. withholds
B. usual, customary, and reasonable (UCR) fees
C. risk pools
D. per diems

Answer: A

NEW QUESTION 136
- (Topic 2)
Katrina Lopez is a claims analyst for a health plan that provides a higher level of benefits for services received in-network than for services received out-of-network. Ms. Lopez reviewed a health claim for answers to the following questions:
Question A -

A. A, B, C, and D
B. A, B, and D only
C. B, C, and D only
D. A and C only

Answer: A

NEW QUESTION 141
- (Topic 2)
The administrative simplification standards described under Title II of HIPAA include
privacy standards to control the use and disclosure of health information. In general, these privacy standards prohibit

A. all health plans, healthcare providers, and healthcare clearinghouses from using any protected health information for purposes of treatment, payment, or healthcare operations without an individual's written consent
B. patients from requesting that restrictions be placed on the accessibility and use of protected health information
C. transmission of individually identifiable health information for purposes other than treatment, payment, or healthcare operations without the individual's written authorization
D. patients from accessing their medical records and requesting the amendment of incorrect or incomplete information

Answer: D

NEW QUESTION 146
- (Topic 2)
One characteristic of disease management programs is that they typically

A. focus on individual episodes of medical care rather than on the comprehensive care of the patient over time
B. are used to coordinate the care of members with any type of disease, either chronic or nonchronic
C. focus on managing populations of patients who have a specific chronic illness or medical condition, but do not focus on patient populations who are at risk of developing such an illness or condition
D. use clinical practice processes to standardize the implementation of best practices among providers

Answer: D

NEW QUESTION 149
- (Topic 2)
Medicaid is a jointly funded federal and state program that provides hospital and medical expense coverage to low-income individuals and certain aged and disabled individuals. One characteristic of Medicaid is that

A. providers who care for Medicaid recipients must accept Medicaid payment as payment in full for services rendered
B. Medicaid requires recipients to pay deductibles, copayments, and coinsurance amounts for all services
C. Medicaid is always the primary payer of benefits
D. benefits offered by Medicaid programs are federally mandated and do not vary by state

Answer: A

NEW QUESTION 154
- (Topic 2)
Janet Riva is covered by a traditional indemnity health insurance plan that specifies a $250 deductible and includes a 20% coinsurance provision. When Ms. Riva was hospitalized, she incurred $2,500 in medical expenses that were covered by her health plan.

A. $1,750
B. $1,800
C. $2,000
D. $2,250

Answer: B

NEW QUESTION 157
- (Topic 2)
One of the most influential pieces of legislation in the advancement of managed care within the United States was the HMO Act of 1973. One provision of the HMO Act of 1973 was that it

A. emphasized compensating physicians based solely on the volume of medical services they provide
B. exempted HMOs from all state licensure requirements
C. established a process under which HMOs could elect to be federally qualified
D. required federally qualified HMOs to relate premium levels to the health status of the individual enrollee or employer group

Answer: C

NEW QUESTION 162

- (Topic 2)
The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement. Advances in computer technology have revolutionized the processing of medical and drug claims. Claims processing i

A. Lower
B. Higher
C. Same
D. No change

Answer: B

NEW QUESTION 165
- (Topic 2)
The Advantage Health Plan recently added the following features to its member services program:
1. IVR
2. Active member outreach program
3. Advantage's member services staffing needs are likely to increase as a result of

A. 1
B. 2
C. 1 & 2
D. Neither 1 nor 2

Answer: B

NEW QUESTION 168
- (Topic 2)
The following programs are part of the Alcove Health Plan's utilization management (UM) program:
? Preventive care initiatives
? A telephone triage program
? A shared decision-making program
? A self-care program
With regard to the UM programs, it is most

A. Preventive care initiatives include immunization programs but not health promotion programs.
B. Telephone triage program is staffed by physicians only.
C. Shared decision-making program is appropriate for virtually any medical condition.
D. Self-care program is intended to complement physicians' services, rather than to supersede or eliminate these services.

Answer: D

NEW QUESTION 171
- (Topic 2)
One characteristic of the accreditation process for MCOs is that

A. an accrediting agency typically conducts an on-site review of an MCO's operations, but it does not review an MCO's medical records or assess its member service systems
B. each accrediting organization has its own standards of accreditation
C. the accrediting process is mandatory for all MCOs
D. government agencies conduct all accreditation activities for MCOs

Answer: B

NEW QUESTION 175
- (Topic 2)
Parul Gupta has been covered by a group health plan for eighteen months. For the past four months, she has been undergoing treatment for diabetes. Last week, Ms. Gupta began a new job and immediately enrolled in her new company's group health plan, which

A. can exclude coverage for treatment of M
B. Gupta's diabetes for one year, because she did not have at least two years of creditable coverage under her previous health plan
C. cannot exclude M
D. Gupta's diabetes as a pre-existing condition, because the one-year pre-existing condition provision is offset by at least one year of continuous coverage under her previous health plan
E. can exclude coverage for treatment of M
F. Gupta's diabetes for one year, because HIPAA does not impact a group health plan's pre-existing condition provision
G. can exclude coverage for treatment of M
H. Gupta's diabetes for four months, because that is the length of time she received treatment for this medical condition prior to her enrollment in the new health plan

Answer: B

NEW QUESTION 178
- (Topic 2)
The following organizations are the primary sources of accreditation of healthcare organizations:

A. National Committee for Quality Assurance (NCQA)
B. American Accreditation HealthCare Commission/URAC Of these organizations, performance data is included i
C. A only

D. B only
E. A and B
F. none of the above

Answer: A

NEW QUESTION 181
- (Topic 2)
One feature of the Employee Retirement Income Security Act (ERISA) is that it:

A. Requires self-funded employee benefit plans to pay premium taxes at the state level.
B. Contains a pre-emption provision, which typically makes the terms of ERISA take precedence over any state laws that regulate employee welfare benefit plans.
C. Contains strict reporting and disclosure requirements for all employee benefit plans except health plans.
D. Requires that state insurance laws apply to all employee benefit plans except insured plans.

Answer: B

NEW QUESTION 186
- (Topic 2)
Medicare Advantage product options include:

A. Coordinated care plans, medical savings accounts and national PPOs.
B. Private Fee for Service plans, health care prepayment plans and medical savings accounts
C. Coordinated care plans, regional PPOs and private fee for service plans
D. Cost contracts, coordinated care programs and medical savings accounts.

Answer: C

NEW QUESTION 187
- (Topic 2)
Individuals can use HSAs to pay for the following types of health coverage:.

A. Qualified disability insurance
B. COBRA continuation coverage.
C. Medigap coverage (for those over 65).
D. All of the above.

Answer: B

NEW QUESTION 192
- (Topic 2)
Janet Riva is covered by a indemnity health insurance plan that specifies a $250 deductible and includes a 20% coinsurance provision. When Ms. Riva was hospitalized, she incurred
$2,500 in medical expenses that were covered by her health plan. She incurred

A. $1,750
B. $1,800
C. $2,000
D. $2,250

Answer: B

NEW QUESTION 194
- (Topic 2)
One true statement regarding ethics and laws is that the values of a community are reflected in

A. both ethics and laws, and both ethics and laws are enforceable in the court system
B. both ethics and laws, but only laws are enforceable in the court system
C. ethics only, but only laws are enforceable in the court system
D. laws only, but both ethics and laws are enforceable in the court system

Answer: B

NEW QUESTION 199
- (Topic 2)
Members who qualify to participate in a health plan's case management program are typically assigned a case manager. During the course of the member's treatment, the case manager is responsible for

A. Coordinating and monitoring the member's care
B. Approve
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: B

NEW QUESTION 204
- (Topic 2)
The Courtland PPO maintains computerized records that include clinical, demographic, and administrative data about individual plan members. The data in these records is available to plan providers, ancillary service departments, pharmacies, and others inv

A. a data warehouse
B. a decision support system
C. an outsourcing system
D. an electronic medical record (EMR) system

Answer: D

NEW QUESTION 206
- (Topic 2)
Ronald Canton is a member of the Omega MCO. He receives his nonemergency medical care from Dr. Kristen High, an internist. When Mr. Canton needed to visit a cardiologist about his irregular heartbeat, he first had to obtain a referral from Dr. High to see

A. D
B. High serves as the coordinator of care for the medical services that M
C. Canton receives.
D. Omega's network of providers includes D
E. High, but not D
F. Miller.
G. Omega's system allows its members open access to all of Omega's participating providers.
H. Omega used a financing arrangement known as a relative value scale (RVS) to compensate D
I. Miller.

Answer: A

NEW QUESTION 211
- (Topic 2)
One component of information systems used by health plans incorporates membership data and information about provider reimbursement arrangements and analyzes transactions according to contract rules. This information system component is known as

A. A contract management system
B. A credentialing system
C. A legacy system
D. An interoperable communication system

Answer: A

NEW QUESTION 212
- (Topic 2)
One distinction that can be made between a staff model HMO and a group model HMO is that, in a staff model HMO, participating physicians are Back to Top

A. Employees of the HMO
B. Employees of a group practice that has contracted with the HMO
C. Compensated primarily through capitation
D. Limited to primary care physicians (PCPs)

Answer: A

NEW QUESTION 215
- (Topic 2)
Pharmacy benefit management (PBM) companies typically interact with physicians and pharmacists by performing such clinical services as physician profiling. Physician profiling from a PBM's point of view involves

A. ascertaining that physicians in the plan have the necessary and appropriate credentials to prescribe medications
B. compiling data on physician prescribing patterns and comparing physicians' actual prescribing patterns to expected patterns within select drug categories
C. monitoring patient-specific drug problems through concurrent and retrospective review
D. establishing protocols that require physicians to obtain certification of medical necessity prior to drug dispensing

Answer: B

NEW QUESTION 219
- (Topic 2)
The prudent layperson standard described in the Balanced Budget Act (BBA) of 1997 requires all hospitals that receive Medicare or Medicaid reimbursement to screen and, if necessary, stabilize all patients who come to their emergency departments.

A. True
B. False

Answer: B

NEW QUESTION 220
- (Topic 2)
The Conquest Corporation contracts with the Apex health plan to provide basic medical

and surgical services to Conquest employees. Conquest entered into a separate contract with the Bright Dental Group to provide and manage a dental care program for employee

A. a negotiated rebate agreement
B. a carve-out arrangement
C. an indemnity plan
D. PBM

Answer: B

NEW QUESTION 225
- (Topic 2)
The application of health plan principles to workers' compensation insurance programs has presented some unique challenges because of the differences between health plan for traditional group healthcare and workers' compensation. One key difference is that

A. limits coverage to eligible employees and excludes part-time employees
B. specifies an annual lifetime benefit maximum on dollar coverage for medical costs
C. provides benefits regardless of the cause of an injury or illness
D. provides benefits for both healthcare costs and lost wages

Answer: D

NEW QUESTION 229
- (Topic 2)
The data evaluation stage of utilization review (UR) includes both administrative reviews and medical reviews. One true statement about these types of reviews is that:

A. An administrative review must be conducted by a health plan staff member who is a medical professional.
B. The primary purpose of an administrative review is to evaluate the appropriateness of a proposed medical service.
C. UR staff members typically conduct a medical review of a proposed medical service before they conduct an administrative review for that same service.
D. One purpose of a medical review is to evaluate the medical necessity of a proposed medical service.

Answer: D

NEW QUESTION 234
- (Topic 2)
One of the distinguishing characteristics of healthcare marketing is that many of the markets for health plans are national, not local markets.

A. True
B. False

Answer: B

NEW QUESTION 236
- (Topic 2)
One way in which a health plan can support an ethical environment is by

A. requiring organizations with which it contracts to adopt the plan's formal ethical policy
B. developing and maintaining a culture where ethical considerations are integrated into decision making at the top organizational level only
C. establishing a formal method of managing ethical conflicts, such as using an ethics task force or bioethics consultant
D. maintaining control of policy development by removing providers and members from the process of developing and implementing policies and procedures that provide guidance to providers and members confronted with ethical issues

Answer: C

NEW QUESTION 239
- (Topic 2)
Patrick Flaherty's employer has contracted to receive healthcare for its employees from the Abundant Healthcare System. Mr. Flaherty visits his primary care physician (PCP), who sends him to have some blood tests. The PCP then refers Mr. Flaherty to a special

A. an integrated delivery system (IDS)
B. a Management Services Organization (MSO)
C. a Physician Practice Management (PPM) company
D. a physician-hospital organization (PHO)

Answer: A

NEW QUESTION 240
- (Topic 2)
One typical characteristic of an integrated delivery system (IDS) is that an IDS.

A. Is more highly integrated structurally than it is operationally.
B. Provides a full range of healthcare services, including physician services, hospital services, and ancillary services.
C. Cannot negotiate directly with health plans, plan sponsors, or other healthcare purchasers.
D. Performs a single business function, such as negotiating with health plans on behalf of all of the member providers.

Answer: B

NEW QUESTION 244
- (Topic 2)
The prudent layperson standard described in the Balanced Budget Act (BBA) of 1997 requires all hospitals that receive Medicare or Medicaid reimbursement to screen and, if necessary, stabilize all patients who come to their emergency departments.

A. True
B. False

Answer: B

NEW QUESTION 245
- (Topic 3)
The following statements are about issues associated with marketing healthcare plans to
small groups and large groups. Select the answer choice that contains the correct statement.

A. In the large group market, large group accounts that have employees in more than one geographic area who are covered through a single national contract for healthcare coverage are known as large local groups.
B. Because providing healthcare coverage for employees is often a burden for small businesses, price is typically the most critical consideration for small businesses in selecting a healthcare plan.
C. health plans typically treat an employer purchasing coalition as a small group for marketing purposes.
D. Large groups rarely use self-funding to finance their healthcare plans.

Answer: B

NEW QUESTION 250
- (Topic 3)
The following statements apply to Archer medical savings accounts. Select the answer choice that contains the correct statement.

A. MSAs were established as a demonstration project under the Medicare Modernization Act.
B. MSAs were seen as an improvement over FSAs because they are portable, allowing employees to take the funds with them when they change jobs.
C. The popularity of MSAs has been limited because funds may not be rolled over from year to year.
D. MSAs are one of the fastest growing Types of Consumer-Directed Health Plans.

Answer: B

NEW QUESTION 253
- (Topic 3)
The statements below describe technology used by two MCOs to respond to incoming telephone calls:
? The Morton MCO uses an automated system that answers telephone calls with recorded or synthesized speech and prompts the caller to respond to a menu of opt

A. Autumn's device is best described as an interactive voice response (IVR) system.
B. Both Morton's system and Autumn's device are applications of computer/telephony
C. integration (CTI).
D. Morton's system is best described as an automatic call distributor (ACD).
E. Morton's system can be correctly characterized as an expert system.

Answer: B

NEW QUESTION 255
- (Topic 3)
Certificate of Authority (COA) is subject to:

A. Contract between health plan and employer
B. State laws require an HMO not to be organized as a corporation
C. Compliance with CMS
D. an HMO may have to be licensed as an HMO or insurance company in each state in which it conducts business

Answer: D

NEW QUESTION 258
- (Topic 3)
The Gable MCO sometimes experience-rates small groups by underwriting a number of small groups as if they constituted one large group and then evaluating the experience of
the entire large group. This practice, which allows small groups to take advantage

A. prospective experience rating
B. pooling
C. retrospective experience rating
D. positioning

Answer: B

NEW QUESTION 262
- (Topic 3)
The feature that formed the foundation of Health Maintenance Act of 1973

A. Federal Qualification Requirements
B. Exemption from state laws
C. All of the above

Answer: C

NEW QUESTION 263
- (Topic 3)
A differences between managed indemnity & traditional indemnity

A. Include precertification and utilization review techniques
B. Both are the same
C. Include network and quality review techniques
D. A & B

Answer: C

NEW QUESTION 266
- (Topic 3)
The NAIC adopted the HMO Model Act in order to provide a system of ongoing regulatory monitoring of HMOs. All of the following statements are correct about the HMO Model Act EXCEPT that it:

A. Regulates HMO operations in two critical areas: financial responsibility and healthcare delivery.
B. Requires each HMO to send state regulators an annual report describing the HMO's finances and operations.
C. Focuses on three key aspects of healthcare delivery: network adequacy, quality assurance, and grievance procedures.
D. Requires state insurance departments to conduct annual examinations of an HMO's operations, quality assurance programs, and provider networks.

Answer: D

NEW QUESTION 268
- (Topic 3)
Each time a patient visits a provider he has to pay a fixed dollar amount?

A. Deductible
B. Copayment
C. Capitation
D. Co-insurance

Answer: B

NEW QUESTION 272
- (Topic 3)
Select the correct statement regarding TRICARE Extra plan options to military personnel’s.

A. Out of pocket expenses are generally high in tricare extra than TRICARE standard
B. Enrollment is not necessary to participate in TRICARE Extra
C. TRICARE Extra provides coordinated care managed by primary care case manager

Answer: C

NEW QUESTION 273
- (Topic 3)
The Polestar Company's sole business is the ownership of Polaris Medical Group, a health plan and subsidiary of Polestar. Some members of Polestar's board of directors hold positions with Polestar in addition to their positions on the board; the rest are

A. Polestar's relationship to Polaris: partnership Type of board member: operations director
B. Polestar's relationship to Polaris: partnership Type of board member: outside director
C. Polestar's relationship to Polaris: holding company Type of board member: operations director
D. Polestar's relationship to Polaris: holding company Type of board member: outside director

Answer: D

NEW QUESTION 278
- (Topic 3)
The existing committees at the Majestic Health Plan, a health plan that is subject to the requirements of HIPAA, include the Executive Committee and the Corporate Compliance Committee. The Executive Committee serves as a long-term advisory body on issues related to overall organizational policy. The Corporate Compliance Committee are convened to address specific management concerns. The following statement(s) can correctly be made about these committees:

A. Majestic's Executive Committee is an example of a Specific committee.
B. The Corporate Compliance Committee is an Example of an Adhoc company.
C. A & B

Answer: B

NEW QUESTION 280

- (Topic 3)
The National Association of Insurance Commissioners' (NAIC's) Unfair Claims Settlement Practices Act specifies standards for the investigation and handling of claims. The Act defines unfair claims practices and notes that such practices are improper if the

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

Answer: A

NEW QUESTION 284
- (Topic 3)
The measures used to evaluate healthcare quality are generally divided into three categories: process, structure and outcomes. An example of a process measure that can be used to evaluate an MCO's performance is the

A. percentage of board certified physicians within the MCO's network
B. number of hospital admissions for plan members with certain medical conditions
C. number of plan members contracting an infection in the hospital
D. percentage of adult plan members who receive regular medical checkups

Answer: D

NEW QUESTION 289
- (Topic 3)
To set up and contribute to an HSA, an individual must:

A. Be covered by a high-deductible health plan that meets federal requirements.
B. Not have other health insurance.
C. Not be enrolled in Medicare.
D. All of the above.

Answer: D

NEW QUESTION 292
- (Topic 3)
The following statements are about preferred provider organizations (PPOs). Select the answer choice that contains the correct statement.

A. PPOs generally assume full financial risk for arranging medical services for their members.
B. PPOs generally pay a larger portion of a member's medical expenses when that member uses in-network providers than when the member uses out-of-network providers.
C. PPO networks may include primary care physicians and hospitals, but generally do not include specialists.
D. In a PPO, the most common method used to reimburse physicians is capitation.

Answer: B

NEW QUESTION 293
- (Topic 3)
The following statements are about concepts related to the underwriting function within a health plan. Select the answer choice containing the correct statement.

A. Anti selection refers to the fact that individuals who believe that they have a less-than-
B. average likelihood of loss tend to seek healthcare coverage to a greater extent than do individuals who believe that they have an average or greater-than-average like
C. Federally qualified HMOs are required to medically underwrite all groups applying for coverage.
D. Typically, a health plan guarantees the premium rate for a group health contract for a period of five years.
E. When evaluating the risk for a group policy, underwriters typically focus on such factors as the size of the group, the stability of the group, and the activities of the group.

Answer: D

NEW QUESTION 297
- (Topic 3)
Who will be covered by TRICARE PRIME by applying for enrollment

A. Active duty military personnel
B. Active duty Dependents
C. Retires
D. B and C

Answer: D

NEW QUESTION 298
- (Topic 3)
In order to be more effective, changes to structure and processes must be carefully

A. Planned
B. Implemented

C. Documented
D. Evaluated
E. All the above

Answer: E

NEW QUESTION 301
- (Topic 3)
The Granite Health Plan is a coordinated care plan (CCP) that participates in the Medicare+Choice program. This information indicates that Granite

A. must comply with all state-mandated benefits and provider requirements
B. must offer each of its enrollees a Medicare supplement
C. places primary care t the censer of the delivery system and focuses on managing patient care at all levels
D. most likely must cover Medicare Part A, but not Medicare Part B, benefits

Answer: C

NEW QUESTION 303
- (Topic 3)
To determine fee reimbursements to be paid to physicians, the Triangle Health Plan assigns a weighted value to each medical procedure or service and multiplies the weighted value by a money multiplier. Triangle and the providers negotiate the value of the

A. Diagnosis-related group (DRG) system
B. Relative value scale (RVS)
C. Partial capitation arrangement
D. Capped fee system

Answer: B

NEW QUESTION 304
- (Topic 3)
Wellborne HMO provides health-related information to its plan members through an
Internet Web site. Laura Knight, a Wellborne plan member, visited Wellborne's Web site to gather uptodate information about the risks and benefits of various treatment option

A. shared decision making
B. self-care
C. preventive care
D. triage

Answer: A

NEW QUESTION 309
- (Topic 3)
The main purpose of the Health Plan Employer Data and Information Set (HEDIS) is to provide

A. expert consultation to end-users for solving specialized and complex healthcare problems through the use of a knowledge-based computer system
B. a comprehensive accreditation for PPOs
C. measurements of plan performance and effectiveness that potential healthcare purchasers can use to compare quality offered by different healthcare plans
D. a mathematical model that can predict future claim payments and premiums

Answer: C

NEW QUESTION 310
- (Topic 3)
The following statements are about information management in health plans. Three of the statements are true and one statement is false. Select the answer choice containing the FALSE statement:

A. Health plans find EDI useful for transmitting data among different health plan locations.
B. EDI is different from eCommerce in the EDI is the transfer of data, typically in batches, while ecommerce is a back-and-forth exchange of information concerning individual transactions.
C. The majority of health plan eCommerce occurs via proprietary computer networks.
D. Benefits that health plans can receive from using electronic data interchange.

Answer: C

NEW QUESTION 311
- (Topic 3)
George was covered by a united health care insurance policy. This policy says that Geroge has to pay $300 out of pocket for the medical expenses in that year before united health care will start to reimburse the medical expense incurred for George. What is the term used to call the out of pocket payment made by George.

A. Co-payment
B. Deductible
C. Coinsurance
D. None of the above

Answer: B

NEW QUESTION 315
- (Topic 3)
The owners of an MCO typically delegate authority for governing the operation of the MCO by electing the MCO's

A. quality management committee
B. medical director
C. board of directors
D. chief executive officer

Answer: C

NEW QUESTION 319
- (Topic 3)
Which of the following population groups are eligible for Medicare coverage

A. Individuals aged 65 & above, regardless of income & medical history
B. Individuals suffering from end stage renal disease, regardless of age
C. Individuals aged 50 or above suffering from qualifying disabilities
D. Both A & B

Answer: D

NEW QUESTION 320
- (Topic 3)
When determining the rates it will charge a small group, the Eagle HMO, a federally qualified HMO, divides its members into classes or groups based on demographic factors such as geography, family composition, and age. Eagle then charges all members of a

A. Retrospective experienced rating.
B. Adjusted community rating (ACR).
C. Pure community rating.
D. Standard community rating.

Answer: B

NEW QUESTION 325
- (Topic 3)
The following statements apply to health reimbursement arrangements. Select the answer choice that contains the correct statement.

A. Only employers are permitted to establish and fund HRAs.
B. The popularity of HRAs waned following a 2002 ruling by U.
C. Treasury Department regarding their treatment in the tax code.
D. HRAs must be offered in conjunction with a high-deductible health plan.
E. The guaranteed portability feature of HRAs has contributed to their popularity.

Answer: A

NEW QUESTION 326
- (Topic 3)
The provision of mental health and chemical dependency services is collectively known as behavioral healthcare. The following statements are about behavioral healthcare. Select the answer choice containing the correct statement.

A. In most preferred provider organizations (PPOs) and open access plans, plan members must receive a referral before accessing behavioral healthcare services from a specialist.
B. To manage the delivery of behavioral healthcare services, managed behavioral health organizations (MBHOs) typically use alternative treatment levels and alternative treatment methods rather than crisis intervention or alternative treatment settings.
C. Managed behavioral health organizations (MBHOs) typically are prohibited from negotiating with network providers for reduced fees in exchange for increased patient volume.
D. The treatment approaches for behavioral healthcare most often include drug therapy, psychotherapy, and counseling.

Answer: B

NEW QUESTION 327
- (Topic 3)
IROs stands for

A. Internal Review Organizations
B. International review Organizations
C. Independent review organizations
D. None of the above

Answer: C

NEW QUESTION 332

- (Topic 3)
The Meadowcreek Group is an organization comprised of individual physicians and physicians in small group practices. Meadowcreek enters into contracts with health plans, and then Meadowcreek contracts separately with its physician members. In situations w

A. a group practice without walls (GPWW)
B. a messenger model
C. an individual practice association (IPA)
D. a Physician Practice Management (PPM) company

Answer: C

NEW QUESTION 336
- (Topic 3)
Two MCOs in a single service area divided purchasers into two groups and agreed to each market their products to only one purchaser group. This information indicates that these two MCOs violated antitrust requirements because they engaged in an activity k

A. horizontal group boycott
B. horizontal division of markets
C. a tying arrangement
D. price fixing

Answer: B

NEW QUESTION 341
- (Topic 3)
The health plan determines what it considers to be the acceptable fee for a service or procedure and the physician agrees to accept that amount as payment in full for the procedure

A. Usual, Customary, and Reasonable fee
B. Discounted FFS
C. Fee Maximum
D. Relative Value Scale

Answer: B

NEW QUESTION 346
- (Topic 3)
Arrange the following provider organizations in the order ranging from least integrated.

A. Physician Practice Management (PPM) companyI
B. Integrated Delivery System (IDS)II
C. Group Practice Without Walls (GPWW)I
D. Independent Practice Association (IPA)
E. I, II, III, IV
F. IV, III, I, II
G. I, II, IV, III
H. I, IV, II, III

Answer: B

NEW QUESTION 348
- (Topic 3)
Prescription drug benefits in Medicare can be obtained through:

A. Stand alone prescription drug pl (PDPs)
B. Traditional fee for service (FFS) Medicare
C. Medicare Advantage pl
D. Both A & C

Answer: A

NEW QUESTION 351
- (Topic 3)
Which of the following is an example of physician only model of operational integration?

A. Consolidated medical group
B. Integrated Delivery System
C. Medical Foundation
D. Both B & C

Answer: A

NEW QUESTION 353
- (Topic 3)
The contract between an employer and an insurer or other TPA is called

A. Claims

B. Bond
C. ASO
D. None of the above

Answer: C

NEW QUESTION 354
- (Topic 3)
What are the characteristics that the underwriter has to consider while determining the premium rate for health insurance coverage for a group?

A. Level of benefits
B. Geographic location
C. Group size
D. All the above

Answer: D

NEW QUESTION 356
- (Topic 3)
Health plans often carve out specialty services that have one or more of the following characteristics

A. A poorly defined patient population
B. High or increasing costs
C. Appropriate utilization
D. All the above

Answer: B

NEW QUESTION 361
- (Topic 3)
Keith Murray is a 45 year old chartered accountant & is employed in Livingstone consultancy firm. He has been paying payroll taxes for the past 15 years. Which of the following statements is true regarding Medicare Part A entitlement?

A. Keith shall be entitled to Part A benefits when he attains 65 years of age
B. Keith’s wife shall be entitled to Part A benefits when she attains 65 years of age
C. Keith’s wife shall be required to pay a monthly premium in order to receive Medicare Part A benefits
D. Both a & b

Answer: D

NEW QUESTION 364
- (Topic 3)
Utilization review offers health plans a means of managing costs by managing

A. Cost effectiveness of healthcare services.
B. Cost of paying healthcare benefits.
C. Both of the above

Answer: C

NEW QUESTION 369
- (Topic 3)
Which of the following best describes an organization that is owned by a hospital or group of investors and provides management and administrative support services to individual physicians or small group practices?

A. Independent Practice Association (IPA).
B. Group Practice Without Walls (GPWW)
C. Management Services Organization (MSO).
D. Consolidated Medical Group.

Answer: C

NEW QUESTION 371
- (Topic 3)
Graff Scott is a member of the ABC Health Plan. Whenever she needs non-emergency medical care, sees Dr. Michael Chan, an internist. Ms. Scott cannot self-refer to a specialist, so she saw Dr. Michael Chan when she experienced headaches. Dr. Michael Chan referred her to Dr. Bruce Lee, a neurologist, who had hospitalized at the Polo Hospital for tests. ABC has contracts with Dr. Michael Chan, Dr. Lee, and Polo to provide medical services to its members. The following statements are about Polo's organized system of healthcare. Select the answer choice containing the correct statement

A. Within Polo's system, M
B. Scott received primary care from both D
C. Michael Chan and D
D. Lee
E. Polo's system allows its members open access to all of Ultra's participating providers
F. Polo's network of providers includes D
G. Michael Chan and D
H. Lee but not Polo Hospital

I. Within Polo's system, D
J. Michael Chan serves as a coordinator of care or gatekeeper for the medical services that M
K. Scott receives

Answer: D

NEW QUESTION 374
- (Topic 3)
Which of the following statements about EPO & HMO models is FALSE?

A. In-network visit is allowed only on PCP's referral in HMO model.
B. Out-of-network visit is not allowed in HMO model.
C. Out-of-network visit is not allowed in EPO model.
D. In-network visit is allowed only on PCP's referral in EPO model.

Answer: A

NEW QUESTION 375
- (Topic 3)
Which of the following features differentiates a 'Clinic without walls1 from a consolidated medical group?

A. Unlike a consolidated medical group, physicians in a 'Clinic without walls' maintain their practices independently in multiple locations.
B. Unlike a consolidated medical group, a 'Clinic without walls' performs or arranges for business operations for the member physicians.
C. Both A & B

Answer: A

NEW QUESTION 379
- (Topic 3)
The Polestar Company's sole business is the ownership of Polaris Medical Group, a health plan and subsidiary of Polestar. Some members of Polestar's board of directors hold positions with Polestar in addition to their positions on the board; the rest are professionals in academia and businesspeople who do not work for Polestar. Dr. Carolyn Porter, a university president, is on Polestar's board. From the following answer choices, select the response containing the term that correctly identifies Polestar's relationship to Polaris and the term that describes the type of board member represented by Dr. Porter

A. Polestar's relationship to Polaris: partnership: Type of board member: operations director
B. Polestar's relationship to Polaris: partnership: Type of board member: outside director
C. Polestar's relationship to Polaris: holding company: Type of board member: operations director
D. Poles tar's relationship to Polaris: holding company: Type of board member: outside director

Answer: D

NEW QUESTION 381
- (Topic 3)
The NAIC designed a small group model law to enable small groups to obtain accessible, yet affordable, group health benefits. Specifically, the model law limits the rate spread. According to this model law, if the lowest rate that an HMO charges a small g

A. $80
B. $120
C. $160
D. $240

Answer: C

NEW QUESTION 382
- (Topic 3)
Which of the following statements is true?

A. A declining economy can lead to lower healthcare costs as a result of an older population with greater healthcare needs.
B. A larger patient population increases pressure on the health plan to offer larger panels.
C. Provider networks are not affected by the federal and state laws that apply to health plans
D. Network management standards established by independent accrediting organizations have no influence on health plan network design.

Answer: B

NEW QUESTION 387
- (Topic 3)
The Mirror Health Plan uses a form of computer/telephony integration (CTI) to manage telephone calls coming into its member services department. When a member calls the plan's central telephone number, a device answers the call with a recorded message and

A. a member outreach program
B. a complaint resolution procedure (CRP)
C. an automatic call distributor (ACD)
D. an interactive voice response (IVR) system

Answer: C

NEW QUESTION 392
- (Topic 3)
Traditional Medicare includes two parts: Medicare Part A and Medicare Part B. With regard to the ways these parts differ from each other, it is correct to say that Medicare Part A

A. provides benefits for physicians' professional services, whereas Medicare Part B provides basic hospitalization insurance
B. is financed through premiums paid by covered persons and from the federal government's general tax revenues, whereas Medicare Part B is funded primarily through a payroll tax imposed on employers and workers
C. provides 100% coverage for eligible medical expenses, whereas Medicare Part B includes annual deductible and coinsurance provisions
D. is provided automatically to most eligible persons, whereas Medicare Part B is a voluntary program

Answer: D

NEW QUESTION 394
- (Topic 3)
Disease management is typically set up as a voluntary outreach and support program for plan members with certain diseases

A. Acute
B. Chronic
C. None of the above

Answer: B

NEW QUESTION 398
- (Topic 3)
The process of calculating the appropriate premium to charge purchasers, given the degree of risk represented by the individual or group, the expected costs to deliver medical services, and the expected marketability and competitiveness of the health plan

A. financing
B. rating
C. underwriting
D. budgeting

Answer: B

NEW QUESTION 399
- (Topic 3)
System classifies hundreds of hospital services based on a number of criteria, such as primary and secondary diagnosis, surgical procedures, age, gender, and the presence of complications.

A. Carve-out
B. DRG
C. Global capitation
D. Partial capitation

Answer: B

NEW QUESTION 400
- (Topic 3)
The following statements describe violations of antitrust legislation:
Situation A - Two health plans in a single service area divided purchasers into two groups and agreed to each market their products to only one purchaser group.
Situation B - A spec

A. Situation A - horizontal division of markets Situation B - tying arrangement.
B. Situation A - horizontal division of markets Situation B - price fixing.
C. Situation A - horizontal group boycott Situation B - tying arrangement.
D. Situation A - horizontal group boycott Situation B - price fixing.

Answer: A

NEW QUESTION 402
- (Topic 3)
The Helm MCO segmented the non-group market for its new healthcare product by using factors such as education level, gender, and household composition. The Amberly MCO segmented the non-group market for its products based on the approaches by which it sol

A. demographic product or benefit
B. geographic distribution channel
C. demographic distribution channel
D. geographic product or benefit

Answer: C

NEW QUESTION 405
- (Topic 3)
Ancillary services are

A. General medical care that is provided directly to a patient without referral from another physician

B. Also known as secondary care (Medical care that is delivered by specialist)
C. Supplemental services needed as part of providing other care
D. Outpatient services provided by a hospital or other qualified ambulatory care facility which require inpatient stay

Answer: C

NEW QUESTION 409
- (Topic 3)
The following statements apply to flexible spending arrangements. Select the answer choice that contains the correct statement.

A. FSAs were designed to help increase health insurance coverage among self-employed individuals.
B. Only employers may contribute funds to FSAs.
C. The popularity of FSAs has been limited because funds may not be rolled over from
D. year to year.
E. A popular feature of FSAs is their portability, which allows employees to take the funds with them when they change jobs.

Answer: C

NEW QUESTION 413
- (Topic 3)
In Order to act as a TPA an organization must

A. Establish written procedures for adverse determinations and appeals
B. Obtain a certificate of authority from the state insurance department
C. Designating the organization as a TPA
D. All of the above

Answer: B

NEW QUESTION 415
- (Topic 3)
Exclusive provider organizations (EPO) is similar and operates like a PPO in administration, structure but however in an EPO an out-of-network care is

A. Partially Covered
B. Covered with more out of pocket
C. Not covered

Answer: C

NEW QUESTION 419
- (Topic 3)
The Koster Company plans to purchase a health plan for its employees from Intuitive HMO. Intuitive will administer the plan and will bear the responsibility of guaranteeing claim payments by paying all incurred covered benefits. Koster will pay for the he

A. fully funded plan
B. stop-loss plan
C. self-pay plan
D. self-funded plan

Answer: A

NEW QUESTION 420
- (Topic 3)
The Neptune Hospital provides medical care to paying patients, as well as to people who either have no healthcare coverage and cannot afford to pay for the care by themselves or who receive services at reduced rates because they are covered under govern me

A. cost shifting
B. Anti selection
C. receivership
D. Underwriting

Answer: A

NEW QUESTION 423
- (Topic 3)
The following statement(s) can correctly be made about the Joint Commission on Accreditation of Healthcare Organizations (JCAHO):

A. JCAHO's accreditation process for MCOs and healthcare networks consists of complete on-site surveys conducted every three
B. A only
C. Neither A nor B
D. Both A and B
E. B only

Answer: A

NEW QUESTION 424

- (Topic 3)
An HMO's quality assurance program must include

A. A statement of the HMO's goals and objectives for evaluating and improving enrollees' health status
B. Documentation of all quality assurance activities
C. System for periodically reporting program results to the HMO's board of directors, its providers, and regulators
D. All the above

Answer: D

NEW QUESTION 429
- (Topic 3)
The Venus Hospital provides medical care to paying patients, as well as to people who either have no healthcare coverage and cannot pay for the care by themselves or who receive services at reduced rates because they are covered under government sponsored

A. anti selection
B. cost shifting
C. receivership
D. underwriting

Answer: B

NEW QUESTION 433
- (Topic 3)
Renewal underwriting involves a reevaluation of

A. The group's experience
B. Level of participation in the health plan
C. Both A and B
D. None of the Above

Answer: C

NEW QUESTION 435
- (Topic 3)
When determining physicians' fee reimbursements, the Blossom Managed Healthcare Group assigns a weighted value to each medical procedure or service and multiplies the weighted value by a money multiplier, as shown below:
Weighted value for service × Money

A. discounted fee-for-service system
B. global capitation arrangement
C. withhold arrangement
D. relative value scale (RVS)

Answer: D

NEW QUESTION 440
- (Topic 3)
One among the following is a reason that limit access to health care for US people.

A. Life Style of the people
B. Concentration of physicians in highly populated areas.
C. Advancement in information technology

Answer: B

NEW QUESTION 444
- (Topic 3)
The HMO Act of 1973 was significant in that the Act

A. mandated certain requirements that all HMOs had to meet in order to conduct business
B. required that all HMOs be licensed as insurance companies
C. offered HMOs federal financial assistance through grants and loans, and provided access to the employer-based insurance market
D. encouraged the use of pre-existing condition exclusion provisions in all HMO contracts

Answer: C

NEW QUESTION 446
- (Topic 3)
The following statements are about the various Health Plan Accountability Models adopted by the NAIC.

A. Under the terms of the Health Plan Network Adequacy Model Act, all health plans would be required to hold covered persons harmless against provider collections and provide continued coverage for uncompleted treatment in the event of plan insolvency
B. The Health Carrier Grievance Procedure Model Act requires all health carriers to maintain a first-level grievance review, but it does not require any second-level review
C. According to the Health Care Professional Credentialing Verification Model Act, a health plan must select all providers who meet the plan's credentialing criteria
D. The Quality Assessment and Improvement Model Act exempts closed plans from

E. implementing a quality improvement program.

Answer: A

NEW QUESTION 448
- (Topic 3)
The following statements are about federal laws that affect healthcare organizations. Select the answer choice containing the correct response.

A. The Women's Health and Cancer Rights Act (WHCRA) of 1998 requires health plans to offer mastectomy benefits.
B. The Health Care Quality Improvement Act (HCQIA) requires hospitals, group practices, and HMOs to comply with all standard antitrust legislation, even if these entities adhere to due process standards that are outlined in HCQIA.
C. The Newborns' and Mothers' Health Protection Act (NMHPA) of 1996 mandates that coverage for hospital stays for childbirth must generally be a minimum of 24 hours for normal deliveries and 48 hours for cesarean births.
D. Although the Mental Health Parity Act (MHPA) does not require health plans to offer mental health coverage, it imposes requirements on those plans that do offer mental health benefits.

Answer: D

NEW QUESTION 450
- (Topic 3)
Which of the following is NOT a preventive care initiative often used by health plans?

A. Screening for high blood pressure
B. Maternity management programs
C. Vaccines
D. Physical therapy

Answer: D

NEW QUESTION 452
- (Topic 3)
The Hill Health Plan designed a set of benefits that it packaged in the form of a PPO product. Hill then established a pricing structure that allowed its product to compete in the small group market, and it developed advertising designed to inform potential

A. An indemnity wraparound plan
B. A self-funded plan
C. An aggregate stop-loss plan
D. A fully funded plan

Answer: D

NEW QUESTION 457
- (Topic 3)
The following types of CDHPs allow federal tax advantages including the ability to roll funds from one year to the next:

A. MSAs, HRAs, HSAs
B. FSAs, MRAs, HRAs
C. FSAs, HRAs, HSAs
D. FSAs, MRAs HSAs

Answer: A

NEW QUESTION 458
- (Topic 3)
Using a code for a procedure or diagnosis that is more complex than the actual procedure or diagnosis and that results in higher reimbursement to the provider is called

A. Coding error
B. Overcharging
C. Upcoming
D. Unbundling

Answer: C

NEW QUESTION 460
- (Topic 3)
Advantages of EDI over manual data management systems

A. Speed of data refer
B. Loss of data integrity
C. All of the above
D. None of the above

Answer: B

NEW QUESTION 465

- (Topic 3)
Bill the member for the balance of the fee above the maximum allowable amount under the fee schedule reimbursement method

A. UCR fee
B. Capitation fee
C. Balance bill
D. Discounted fee-for-service

Answer: C

NEW QUESTION 470
- (Topic 3)
The following statements are about the non-group market for managed care products in the United States. Select the answer choice containing the correct statement.

A. In order to promote a product to the individual market, MCOs typically rely on personal selling by captive agents rather than on promotional tools such as direct mail, telemarketing, and advertising.
B. Managed Medicare plans typically are allowed to reject a Medicare applicant on the basis of the results of medical underwriting of the applicant.
C. HCFA (now known as the Centers for Medicare and Medicaid Services) must approve all membership and enrollment materials used by MCOs to market managed care products to the Medicare population.
D. Managed care plans are not allowed to health screen individual market customers who are under age 65, even if the health screen could help prevent anti selection.

Answer: C

NEW QUESTION 473
- (Topic 3)
Integration of provider organizations is said to occur when

A. Previously separate providers combine & come under common ownership or control.
B. Two or more providers combine their business operations that they previously carried out separately.
C. Both A & B
D. None of the above

Answer: C

NEW QUESTION 474
- (Topic 3)
The Hill Health Plan designed a set of benefits that it packaged in the form of a PPO product. Hill then established a pricing structure that allowed its product to compete in the small group market, and it developed advertising designed to inform potential

A. A decision as to which exclusions or limitations would apply for this product.
B. A decision as to how to establish the network of participating providers for this product
C. A determination of the level at which this product would cover out-of-network services.
D. All of the above.

Answer: D

NEW QUESTION 479
- (Topic 3)
The nature of the claims function within health plans varies by type of plan and by the compensation arrangement that the plan has made with its providers. For example, it is generally correct to say that, in a

A. Preferred provider organization (PPO), the
B. Both A and B
C. A only
D. B only
E. Neither A nor B

Answer: A

NEW QUESTION 482
- (Topic 3)
Which of the following factors have contributed to the limited popularity of FSAs

A. "Use it or lose it" provision
B. Lack of portability
C. Only self-employed individuals are eligible for establishing FSAs.
D. Both A &B

Answer: D

NEW QUESTION 486
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