AHM-250 Dumps

Healthcare Management: An Introduction

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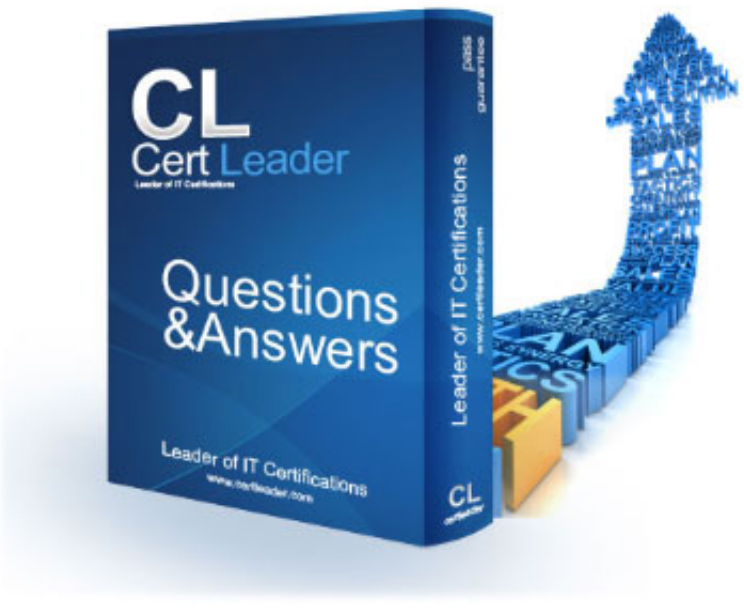

NEW QUESTION 1
- (Topic 1)
From the following choices, choose the definition that best matches the term health risk assessment (HRA)

A. A technique used to educate plan members on how to distinguish between minor problems and serious conditions and effectively treat minor problems themselves
B. A technique used to determine if a health condition is present even if a member has not experienced symptoms of the problem
C. A technique in which information about a plan member's health status, personal and family health history, and health-related behaviors is used to predict the member's likelihood of experiencing specific illnesses or injuries
D. A technique used to evaluate the medical necessity, appropriateness, and cost- effectiveness of healthcare services for a given patient

Answer: C

NEW QUESTION 2
- (Topic 1)
If most of the physicians, or many of the physicians in a particular specialty, are affiliated with a single entity, then a health plan building a network in the service area
.

A. Has many contracting options available.
B. Should not contract with that entity
C. Most likely needs to contract with that entity
D. Should attempt to disband the existing affiliations

Answer: C

NEW QUESTION 3
- (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 4
- (Topic 1)
Col. Martin Avery, on active duty in the U.S. Army, iseligibleto receive healthcare benefits under one of the three TRICARE health plan options. If Col Avery elects to participate in TRICARE Prime, he will be

A. able to obtain full benefits for services obtained from network and non-network providers
B. subject to copayment, deductible, and coinsurance requirements for any medical care he receives
C. required to formally enroll for coverage and pay an enrollment fee
D. assigned to a primary care manager who is responsible for coordinating all his care

Answer: D

NEW QUESTION 5
- (Topic 1)
Before the Leo 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 for medical services they perform for Leo 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 Leo 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 6
- (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: B

NEW QUESTION 7
- (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 8
- (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 9
- (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 10
- (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)
Health plans require utilization review for all services administered by its participating physicians.

A. True
B. False

Answer: B

NEW QUESTION 12
- (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 13

- (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 14
- (Topic 1)
Bill Clinton is a member of Lewinsky's PBM plan which has a three-tier copayment structure. Bill fell ill and his doctor prescribed him AAA, a brand-name drug which was included in the Lewinsky's formulary; BBB, a non-formulary drug; and CCC, a generic dr

A. CCC, AAA, BBB
B. BBB, CCC, AAA
C. BBB, AAA, CCC
D. CCC, BBB, AAA

Answer: A

NEW QUESTION 15
- (Topic 1)
From the following choices, choose the definition that best matches the term Screening

A. A technique used to educate plan members on how to distinguish between minor problems and serious conditions and effectively treat minor problems themselves
B. A technique used to determine if a health condition is present even if a member has not experienced symptoms of the problem
C. A technique in which information about a plan member's health status, personal and family health history, and health-related behaviors is used to predict the member's likelihood of experiencing specific illnesses or injuries
D. A technique used to evaluate the medical necessity, appropriateness, and cost- effectiveness of healthcare services for a given patient

Answer: B

NEW QUESTION 20
- (Topic 1)
The following statements describe two types, or models, of HMOs:
The Quest HMO has contracted with only one multi-specialty group of physicians. These physicians are employees of the group practice, have an equity interest in the practice, and provide

A. A captive group a staff model
B. A captive group a network model
C. An independent group a network model
D. An independent group a staff model

Answer: B

NEW QUESTION 23
- (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 27
- (Topic 1)
Ian Vladmir wants to have a routine physical examination to ascertain that he is in good health. Mr. Vladmir is a member of a health plan that will allow him to select the physician of his choice, either from within his plan's network or from outside of h

A. a traditional HMO plan
B. a managed indemnity plan
C. a point of service (POS) option
D. an exclusive provider organization (EPO)

Answer: C

NEW QUESTION 31
- (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 36
- (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)
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 39
- (Topic 1)
In order to generate exchanges with consumers, healthcare plan marketers use the four elements of the marketing mix: product, price, place (distribution), and

A. segmentation
B. publicity
C. promotion
D. plan design

Answer: C

NEW QUESTION 42
- (Topic 1)
A particular health plan offers a higher level of benefits for services provided in-network
than for out-of-network services. This health plan requires preauthorization for certain medical services.
With regard to the steps that the health plan's claims e

A. should assume that all services requiring preauthorization have been preauthorized
B. should investigate any conflicts between diagnostic codes and treatment codes before approving the claim to ensure that the appropriate payment is made for the claim
C. need not verify that the provider is part of the health plan's network before approving the claim at the in-network level of benefits
D. need not determine whether the member is covered by another health plan that allows for coordination of benefits

Answer: B

NEW QUESTION 46
- (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 49
- (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 52
- (Topic 1)
Health plans can organize under a not-for-profit form or a for-profit form. One true statement regarding not-for-profit health plans is that these organizations typically

A. are exempt from review by the Internal Revenue Service (IRS)
B. are organized as stock companies for greater flexibility in raising capital
C. rely on income from operations for the large cash outlays needed to fund long-term projects and expansion
D. engage in lobbying or political activities in order to maintain their tax-exempt status

Answer: C

NEW QUESTION 54
- (Topic 1)
In assessing the potential degree of risk represented by a proposed insured, a health underwriter considers the factor of anti selection. Anti selection can correctly be defined as the

A. inability of a proposed insured to share with the insurer the financial risks of healthcare coverage
B. possibility that a proposed insured will profit from an illness by receiving benefits that exceed the total amount of his or her eligible medical expenses
C. inability of a proposed insured to provide sufficient evidence that proves he or she is an insurable risk
D. tendency of people who have a greater-than-average likelihood of loss to apply for or continue insurance protection to a greater extent than people who have an average or less than average likelihood of the same loss

Answer: D

NEW QUESTION 59
- (Topic 1)
If a state commissioner of insurance places an HMO under administrative supervision, then the purpose of this action most likely is to:

A. Transfer all of the HMO's business to other carriers.
B. Allow the state commissioner, acting for a state court, to take control of and administer the HMO's assets and liabilities.
C. Sell the HMO's assets in order to satisfy the HMO's obligations.
D. Place the HMO's operations under the direction and control of the state commissioner or a person appointed by the commissioner.

Answer: D

NEW QUESTION 63
- (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 68
- (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 71

- (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 73
- (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 78
- (Topic 1)
Before an HMO contracts with a physician, the HMO first verifies the physician's credentials.
Upon becoming part of the HMO's organized system of healthcare, the physician is typically subject to

A. both recredentialing and peer review
B. recredentialing only
C. peer review only
D. neither recredentialing nor peer review

Answer: C

NEW QUESTION 79
- (Topic 1)
Health plans often program into their claims processing systems certain criteria that, if unmet, will prompt further investigation of a claim. In an automated claims processing system, these criteria may signal the need for further review when, for example

A. Encounter reports
B. Diagnostic codes
C. Durational ratings
D. Edits

Answer: D

NEW QUESTION 81
- (Topic 1)
A public employer, such as a municipality or county government would be considered which of the following?

A. Employer-employee group
B. Multiple-employer group
C. Affinity group
D. Debtor-creditor group

Answer: A

NEW QUESTION 82
- (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 83
- (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 85
- (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 89
- (Topic 1)
Consumer-directed health plans are not a new concept. They actually got their start in the late 1970s with the advent of:

A. Health savings accounts (HSAs)
B. Health reimbursement arrangements (HRAs)
C. Medical savings accounts (MSAs)
D. Flexible spending arrangements (FSAs)

Answer: D

NEW QUESTION 93
- (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 97
- (Topic 1)
If left unresolved, member complaints about the actions or decisions made by a health plan or its providers can lead to formal appeals. One procedure health plans can use to address formal appeals is to submit the original decision and any supporting info

A. A Level One appeal, and the member has the right to a further appeal
B. A Level Two appeal, and the reviewer's decision is final and binding
C. An independent external appeal, and the member has the right to a further appeal
D. Arbitration, and the reviewer's decision is final and binding

Answer: A

NEW QUESTION 102
- (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 103
- (Topic 1)
From the following answer choices, choose the description of the ethical principle that best corresponds to the term Autonomy

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: D

NEW QUESTION 108
- (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 110
- (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 112
- (Topic 2)
One ethical principle in health plans is the principle of non-malfeasance, which holds that health plans and their providers:

A. Should allocate resources in a way that fairly distributes benefits and burdens among the members.
B. Have a duty to present information honestly and are obligated to honor commitments.
C. Are obligated not to harm their members.
D. Should treat each plan member in a manner that respects his or her goals and values.

Answer: C

NEW QUESTION 117
- (Topic 2)
One true statement about community rating, a rating method commonly used by health plans, is that:

A. It requires a health plan to set premiums for financing medical care according to the health plan's expected cost of providing medical benefits to a sub-group within the community.
B. A health plan usually uses community rating to set premiums for large groups.
C. It tends to lead to greater fluctuations in premium rates than do other rating methods.
D. A health plan seldom uses community rating to set premiums for large groups.

Answer: D

NEW QUESTION 119
- (Topic 2)
Natalie Chan is a member of the Ultra Health Plan. Whenever she needs non-emergency medical care, she sees Dr. David Craig, an internist. Ms. Chan cannot self-refer to a
specialist, so she saw Dr. Craig when she experienced headaches. Dr. Craig referred h

A. Within Ultra's system, M
B. Chan received primary care from both D
C. Craig and D
D. Lee.
E. Ultra's system allows its members open access to all of Ultra's participating providers.
F. Within Ultra's system, D
G. Craig serves as a coordinator of care or gatekeeper for the medical services that M
H. Chan receives.
I. Ultra's network of providers includes D
J. Craig and D
K. Lee but not Arrow Hospital.

Answer: C

NEW QUESTION 124
- (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 127
- (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 130
- (Topic 2)
More procedures or services may be fully covered within the PPO network than those out of network.

A. True
B. False

Answer: A

NEW QUESTION 133
- (Topic 2)
The following programs are part of the Alcove MCO's utilization management (UM) program:
? A telephone triage program
? Preventive care initiatives
? A shared decision-making program
? A self-care program
With regard to the UM programs, it is most likely cor

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

Answer: A

NEW QUESTION 136
- (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 139
- (Topic 2)
The Acme HMO recruits and contracts directly with a wide range of physicians—both PCPs and specialists—in its geographic area on a non-exclusive basis. There is no separate legal entity that represents and negotiates the contracts for the physicians. The

A. an independent practice association (IPA) model HMO
B. a staff model HMO
C. a direct contract model HMO
D. a group model HMO

Answer: C

NEW QUESTION 143
- (Topic 2)
Merle Spencer has coverage under both Medicare Part A and Medicare Part B. Ms. Spencer recently was hospitalized for chest pains, and she incurred charges for:
? The cost of hospitalization for two days
? Diagnostic tests performed in the hospital
? Trans

A. ambulance and the diagnostic tests
B. ambulance, the diagnostic tests, and the physician's professional services
C. cost of hospitalization
D. cost of hospitalization and the physician's professional services

Answer: D

NEW QUESTION 148
- (Topic 2)
Khalyn Drury's employer includes managed dental care in its employee benefits package. During open enrollment, Ms. Drury enrolled in the dental plan, which provides dental services to its members in exchange for a prepayment (the premium). Dental services

A. dental preferred provider organization (PPO)
B. traditional fee-for-service (FFS) dental plan
C. plan with a dental point of service (POS) option
D. dental health maintenance organization (DHMO)

Answer: D

NEW QUESTION 150
- (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 153
- (Topic 2)
One of the most influential pieces of legislation in the advancement of health plans within the United States was the Health Maintenance Organization (HMO) Act of 1973. One of the provisions of the Act was that it

A. exempted HMOs from all state licensure requirements.
B. required all employers that offered healthcare coverage to their employees to offer only one type of federally qualified HMO.
C. eliminated funding that supported the planning and start-up phases of new HMOs.
D. established a process by which HMOs could obtain federal qualification

Answer: D

NEW QUESTION 154
- (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 157
- (Topic 2)
Member satisfaction is a critical element of a health plan's quality management program. A health plan can obtain information about member satisfaction with various aspects of the
health plan from

A. surveys completed by members following a visit to a provider
B. surveys sent to plan members who have not received healthcare services during a specified time period
C. periodic reports of complaints received by member services personnel
D. all of the above

Answer: D

NEW QUESTION 160
- (Topic 2)
Parable Healthcare Providers, a health plan, recently segmented the market for a new healthcare service. Parable began the process by dividing the healthcare market into two broad categories: non-group and group. Next, Parable further segmented the non-gr

A. channel segmentation
B. geographic segmentation
C. demographic segmentation
D. product segmentation

Answer: C

NEW QUESTION 165

- (Topic 2)
Many HMOs are compensated for the delivery of healthcare to members under a prepaid care arrangement. Under a prepaid care arrangement, a plan member typically pays a

A. fixed amount in advance for each medical service the member receives
B. a small fee such as $10 or $15 that a member pays at the time of an office visit to a network provider
C. a fixed, monthly premium paid in advance of the delivery of medical care that covers most healthcare services that a member might need, no matter how often the member uses medical services
D. specified amount of the member's medical expenses before any benefits are paid by the HMO

Answer: C

NEW QUESTION 169
- (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 172
- (Topic 2)
Paul Gilbert has been covered by a group health plan for two years. He has been undergoing treatment for angina for the past three months. Last week, Mr. Gilbert began a new job and immediately enrolled in his new company's group health plan, which has a

A. Can exclude coverage for treatment of M
B. Gilbert's angina for one year, because HIPAA does not impact a group health plan's pre-existing condition provision.
C. Can exclude coverage for treatment of M
D. Gilbert's angina for one year, because M
E. Gilbert did not have at least 36 months of creditable coverage under his previous health plan.
F. Can exclude coverage for treatment of M
G. Gilbert's angina for three months, because that is the length of time he received treatment for this medical condition prior to his enrollment in the new health plan.
H. Cannot exclude his angina as a pre-existing condition, because the one-year pre- existing condition provision is offset by at least one year of continuous coverage under his previous health plan.

Answer: D

NEW QUESTION 176
- (Topic 2)
Marlee Whitcomb was covered as a dependent under the group health plan provided by her father's employer. That health plan complied with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. When Ms. Whitcomb married, she c

A. can continue her group coverage for a period not to exceed 48 months
B. can continue her group coverage for a period not to exceed 36 months
C. cannot continue her group coverage, but has the right to convert the group coverage to an individual health plan
D. can continue her group coverage indefinitely

Answer: B

NEW QUESTION 177
- (Topic 2)
Phillip Tsai is insured by both a indemnity health insurance plan, which is his primary plan, and a health plan, which is his secondary plan. Both plans have typical coordination of benefits (COB) provisions, but neither has a nonduplication of benefits p

A. $0
B. $300
C. $400
D. $900

Answer: C

NEW QUESTION 179
- (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 182
- (Topic 2)
The following statement can be correctly made about Medicare Advantage eligibility:

A. Individuals enrolled in a MA plan must enroll in a stand-alone Part D prescription drug plan.
B. Individuals enrolled in a MA plan do not have to be eligible for Medicare Part A
C. Individuals enrolled in an MSA plan or a PFFS plan without Medicare drug coverage can enroll in Medicare Part D.
D. Individuals can enroll in MA plan in multiple regions.

Answer: C

NEW QUESTION 185
- (Topic 2)
One non-group market segment to which health plans market health plan products is the senior market, which is comprised mostly of persons over age 65 who are eligible for Medicare benefits. One factor that affects a health plan's efforts to market to the

A. The Centers for Medicare and Medicaid Services (CMS) must approve all marketing materials used by health plans to market health plan products to the Medicare population
B. managed Medicare plans typically require Medicare beneficiaries to purchase Medigap insurance to supplement gaps in coverage
C. managed Medicare plans can refuse to cover persons with certain health problems
D. the CMS prohibits health plans from using telemarketing to market health plan products to the Medicare population

Answer: B

NEW QUESTION 189
- (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 192
- (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 195
- (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 199
- (Topic 2)
PBM plans operate under several types of contractual arrangements. Under one contractual arrangement, the PBM plan and the employer agree on a target cost per employee per month. If the actual cost per employee per month is greater than the target cost, t

A. fee-for-service arrangement
B. risk sharing contract
C. capitation contract

D. rebate contract

Answer: B

NEW QUESTION 203
- (Topic 2)
The Blaine Healthcare Corporation seeks to manage its quality by first identifying the best practices and best outcomes for a given procedure. Blaine can then determine areas in which it can emulate the best practices in order to equal or surpass the best

A. provider profiling
B. benchmarking
C. peer review
D. quality assessment

Answer: B

NEW QUESTION 204
- (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 208
- (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 211
- (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 214
- (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 218
- (Topic 2)
One device that PBM plans use to manage both the cost and use of pharmaceuticals is a formulary. A formulary is defined as

A. a listing of drugs classified by therapeutic category or disease class that are considered preferred therapy for a given managed population and that are to be used by a health plan's providers in prescribing medications
B. a reduction in the price of a particular pharmaceutical obtained by the PBM from the pharmaceutical manufacturer
C. drugs ordered and delivered through the mail to the PBM's plan members at a reduced cost
D. an identification card issued by the PBM to its plan members

Answer: A

NEW QUESTION 220
- (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 225
- (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 230
- (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 235
- (Topic 2)
Medicare Part C can be delivered by the following Medicare Advantage plans:

A. HCCP, HMO, PPO (local or regional), PFFS or MSA.
B. CCPs, PFFS or MSA.
C. HMO, HSA, PPO (local or regional), PFFS or MSA.
D. HMO, PPO (local or regional), POS, or MSA.

Answer: B

NEW QUESTION 239
- (Topic 2)
Natalie Chan is a member of the Ultra Health Plan, a health plan. Whenever she needs nonemergency medical care, she sees Dr. David Craig, an internist. Ms. Chan cannot self- refer to a specialist, so she saw Dr. Craig when she experienced headaches. Dr. Cr

A. Within Ultra's system, M
B. Chan received primary care from both D
C. Craig and D
D. Lee
E. Ultra's system allows its members open access to all of Ultra's participating providers.
F. Within Ultra's system, D
G. Craig serves as a coordinator of care or gatekeeper for the medical services that M
H. Chan receives.
I. Ultra's network of providers includes D
J. Craig and D
K. Lee but not Arrow Hospital

Answer: C

NEW QUESTION 241
- (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 245
- (Topic 3)
To address the problems associated with multiple data management systems, the Kayak Health Plan has begun to use a data warehouse. One likely characteristic

of Kayak's data warehouse is that:

A. It requires Kayak's individual databases to store large amounts of data that are not needed for daily operations.
B. It contains data from internal sources only.
C. It stores historical data rather than current data.
D. The data in the warehouse are linked by a common subject.

Answer: D

NEW QUESTION 247
- (Topic 3)
The following statement(s) can correctly be made about electronic data interchange (EDI):

A. EDI differs from eCommerce in that EDI involves back-and-forth exchanges of information concerning individual transactions, whereas eCommerce is the transfer of d
B. Both A and B
C. A only
D. B only
E. Neither A nor B

Answer: C

NEW QUESTION 250
- (Topic 3)
The Madison Health Plan, a national MCO, and a local hospital system that operates its own managed healthcare network recently created a new and separate managed healthcare organization, the Pineapple Health Plan. Madison and the hospital system share own

A. a consolidation
B. a joint venture
C. a merger
D. an acquisition

Answer: B

NEW QUESTION 254
- (Topic 3)
The following statement(s) can correctly be made about the characteristics of reports that should be provided to managers for use in managing a healthcare delivery system:

A. Users typically need access to all the raw data used to generate reports
B. Info
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: D

NEW QUESTION 257
- (Topic 3)
Salient features of a Health Savings Account include all of the following except

A. Funding by both employer & the employee
B. Employer account ownership
C. Account portability & roll over of funds from year to year
D. Investment opportunities

Answer: B

NEW QUESTION 258
- (Topic 3)
Diabetic patients with high glucose levels requiring stabilization following treatment of an acute attack would best be served in an

A. Emergency Department
B. Urgent Care Centre
C. Hospice Care
D. Observation Care Unit

Answer: D

NEW QUESTION 263
- (Topic 3)
When the Knoll Company purchased group health coverage from the Castle Health Maintenance Organization (HMO), the agreement between the two parties specified that the plan would be a typical fully funded plan. Because Knoll had been covered under a previous

A. 230
B. 270

C. 220
D. 180

Answer: C

NEW QUESTION 264
- (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 269
- (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 270
- (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 272
- (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 277
- (Topic 3)
The following statement(s) can correctly be made about Medicaid managed care plans:

A. A state may mandate health plan enrollment if it offers enrollees in non-rural areas a choice of at least two health plans and offers rural enrollees a choice of at lea
B. Both A and B
C. A only
D. B only
E. Neither A nor B

Answer: A

NEW QUESTION 279
- (Topic 3)
The Houston Company, a United States company, offers its eligible employees health insurance coverage through a group health plan. Houston hired the Dallas Company to handle the plan's claim administration and membership services, but Houston is financial

A. Houston is required to purchase stop-loss insurance to cover its losses under this group health plan
B. Houston's plan is a self-funded plan
C. Dallas is the plan's sponsor
D. Houston's plan is not exempt from any state insurance regulations under ERISA

Answer: B

NEW QUESTION 284
- (Topic 3)
Common characteristics of POS products are

A. Lack of Freedom of choice
B. Absence of Primary care physician
C. Cost-cutting efforts and the structure of coverage
D. All of the above

Answer: C

NEW QUESTION 286
- (Topic 3)
In the CPT system, each service or procedure is identified by

A. Three-digit with decimal point
B. Three-digit
C. Five-digit with decimal point
D. Five-digit

Answer: D

NEW QUESTION 287
- (Topic 3)
The National Association of Insurance Commissioners (NAIC) developed the Small Group Model Act to enable small groups to obtain accessible, yet affordable, group health benefits. The model law limits the rate spread, which is the difference between the hi

A. $60
B. $80
C. $120
D. $160

Answer: B

NEW QUESTION 292
- (Topic 3)
Which of the following statements is FALSE?

A. The license that HMOs get in each state is called ‘Certificate of Authority’
B. The HMO contracts directly with the individual physicians who provide the medical services to the HMO members in a variation of the IPA model called direct contract model HMO.
C. All medicare/mediclaim beneficiaries should comply with utilization management requirements set forth by HCFA
D. HMO’s usually impose high coinsurance or deductible requirements

Answer: D

NEW QUESTION 295
- (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 300
- (Topic 3)
The participating physicians remain independent practitioners who operate out of their own offices and can treat other patients in addition to Kayak plan members. Kayak can correctly be characterized as

A. a closed-panel HMO
B. an open-panel HMO
C. a direct contract model HMO
D. a dual choice HMO

Answer: B

NEW QUESTION 301
- (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 306
- (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 308
- (Topic 3)
The process that Mr. Sybex used to identify and classify the risk represented by the Koster Group so that Intuitive can charge premiums that are adequate to cover its expected costs is known as

A. coinsurance
B. plan funding
C. underwriting
D. pooling

Answer: C

NEW QUESTION 310
- (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 313
- (Topic 3)
The parties to the contractual relationship that provides Castle's group health coverage to Knoll employees are

A. Castle and Knoll only
B. Knoll and all covered Knoll employees only
C. Castle, Knoll, and all covered Knoll employees
D. Castle and all covered Knoll employees only

Answer: A

NEW QUESTION 315
- (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 317
- (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 321
- (Topic 3)
Utilization data can be transmitted to the health plan manually, by telephone, or electronically. Compared to other methods of data transmittal, manual transmittal is generally

A. less cumbersome and labor intensive
B. faster and more accurate
C. more acceptable to physicians
D. subject to greater scrutiny by regulatory bodies

Answer: C

NEW QUESTION 323
- (Topic 3)
The Robust Health Plan sometimes uses prospective experience rating to calculate the premiums for a group. Under prospective experience rating, Robust most likely will:

A. At the end of a rating period, the financial gains and losses experienced by the group during that rating period and, if the group's experience during the period is better than expected, refund part of the group's premium in the form of an experience ratio
B. Use Robust's average experience with all groups to calculate this particular group's premium.
C. Use the group's past experience to estimate the group's expected experience for the next period.
D. All of the above

Answer: C

NEW QUESTION 328
- (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 331
- (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 335
- (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 337
- (Topic 3)
The following statements describe common types of physician/hospital integrated models:
The Iota Company, which is owned by a group of investors, is a for-profit legal entity that buys entire physician practices, not just the tangible assets of the practice

A. Iota- physician hospital organization (PHO)Casa- physician practice management (PPM) company.
B. Iota- physician hospital organization (PHO)Casa- medical foundation.
C. Iota- physician practice management (PPM) Casa- physician hospital organization (PHO) company.
D. Iota- medical foundation Casa- management services organization (MSO).

Answer: C

NEW QUESTION 341
- (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 343
- (Topic 3)
Medigap policies were standardized into ten standard benefit pl ranging from A-J by the

A. Omnibus Budget Reconciliation Act (OBRA) of 1990
B. Tax Equity & Fiscal Responsibility Act (TEFRA) of 1982
C. Medicare Modernization Act (MMA) of 2003
D. Balanced Budget Act (BBA) of 1997

Answer: A

NEW QUESTION 344
- (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 347
- (Topic 3)
The main advantage of using outcomes measures to evaluate healthcare quality is that they Typically

A. are easy to identify and report
B. demonstrate improved clinical and functional status over time
C. are insensitive to changes in structures or processes
D. provide meaningful feedback on care delivery even when the delay between treatment and outcome stretches over several years

Answer: B

NEW QUESTION 352
- (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 354
- (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. $140
B. $170
C. $180
D. $210

Answer: B

NEW QUESTION 355
- (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 358
- (Topic 3)
Which of the following job descriptions best match the job of a telephone triage staff member?

A. Check patient vitals, write prescriptions, administer drugs.
B. Greet patients at the door, collect insurance information, schedule appointments, collect payments.
C. Determine urgency of the condition, notify emergency department, schedule appointments, authorize referrals, provide self-care information.
D. None of the above.

Answer: C

NEW QUESTION 359
- (Topic 3)
The following statements are about accreditation in health plans. Select the answer choice that contains the correct statement.

A. Accreditation is typically performed by a panel of physicians and administrators employed by the health plan under evaluation.
B. All accrediting organizations use the same standards of accreditation.
C. Results of accreditation evaluations are provided only to state regulatory agencies and are not made available to the general public.
D. Accreditation demonstrates to an health plan's external customers that the plan meets established standards for quality care.

Answer: D

NEW QUESTION 361
- (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 366
- (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 367
- (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 369
- (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 a health plan's performance is the:

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

Answer: A

NEW QUESTION 372

- (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 377
- (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 378
- (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 380
- (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 385
- (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 387
- (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 389
- (Topic 3)
Which of the choices below contains the four tools used by marketers that make up the 'promotion mix'?

A. Advertising, personal selling, sales promotion, and publicity.
B. Advertising, price, sales promotion, and publicity.
C. Admissions, personal selling, sales promotion, and publicity.
D. Advertising, personal selling, sales promotion, and privacy.

Answer: A

NEW QUESTION 393
- (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. The number of specialists in Hill's network of providers.
B. The price for the PPO product.
C. Hill's ability to report utilization data.
D. Hill's use of brokers to market its PPO product.

Answer: B

NEW QUESTION 397
- (Topic 3)
The Panacea Healthcare System is a single large medical practice based in Oakland, California. The physicians of Panacea operate through a single office located in the Beverly Hills region of Oakland & do have access to the same medical records. Panacea is owned by Queen's hospital & before Panacea acquired the practices of its participating physicians, these physicians were independent practitioners. Which of the following terms best describes Panacea?

A. Physician Practice Management Compare
B. Physician Hospital Organization
C. Consolidated Medical Group
D. None of the above

Answer: C

NEW QUESTION 399
- (Topic 3)
Which of the following is NOT a factor that is used by MCOs to determine which services will undergo utilization review?

A. Cost per procedure
B. Concurrent review
C. Cost of review
D. Access requirements

Answer: D

NEW QUESTION 401
- (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 404
- (Topic 3)
When determining the premium rates it will charge a particular group, the Blue Jay Health Plan used a rating method known as community rating by class (CRC). Under this rating method, Blue Jay

A. was allowed to use no more than four rating classes when determining how much to charge the group for health coverage
B. was required to make the average premium in each class no more than 105% of the average premium for any other class
C. divided its members into rating classes based on demographic factors, experience, or industry characteristics, and then charged each member in a rating class the same premium
D. charged all employers or other group sponsors the same dollar amount for a given level of medical benefits, without adjustments for age, gender, industry, or experience

Answer: C

NEW QUESTION 405
- (Topic 3)
Which of the following statements about the Title VII of the Civil Rights Act is WRONG?

A. Employers with more than 15 employees engaged in interstate commerce need to comply
B. Pregnancy Discrimination Act (an amendment to this act) requires health plans to provide coverage during childbirth and related medical conditions on the same basis as they provide coverage for other medical conditions
C. Allows HMOs to set different policies for people from different races, religions, sex or national origin to safeguard their interests.
D. Protects all employees

Answer: C

NEW QUESTION 407
- (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 411
- (Topic 3)
What is a mathematical process that involves using a number of hypothetical situations that, in total, will reasonably reflect an event that will occur in real life

A. Forecasting
B. Modelling
C. Both a and b
D. None of the above

Answer: B

NEW QUESTION 412
- (Topic 3)
Consolidation of patient information in a single location as can be used by independent providers is an example of

A. Structural Integration
B. Operational Integration
C. Business Integration
D. None of the above

Answer: D

NEW QUESTION 413
- (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 414
- (Topic 3)
Which is an advantage of a for-profit health plan?

A. Flexibility in raising capital
B. Double taxation
C. Exemption from paying federal income taxes.
D. None of the above.

Answer: A

NEW QUESTION 415
- (Topic 3)
High deductible health plans (HDHP) are characterized by all of the following features except

A. A HDHPs have a higher deductible than other traditional insurance products such as HMOs & PPOs.
B. HDHPs generally cost more than traditional heathcare coverage.
C. Some HDHPs cover preventive care on a first-dollar coverage basis.
D. All of the above

Answer: A

NEW QUESTION 420
- (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 422
- (Topic 3)
The following statements describe common types of physician/hospital integrated models:
(A) The Alpha Company, which is owned by a group of investors, is a for-profit legal entity that buys entire physician practices, not just the tangible assets of the p

A. Physician hospital organization physician practice management company
B. Physician practice management company physician hospital organization
C. Medical foundation management services company
D. Physician hospital organization medical foundation

Answer: B

NEW QUESTION 426
- (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 430
- (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 435
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