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AHIP AHM-530

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Topic Break Down

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QUESTION NO: 1

State Medicaid agencies can contract with health plans through open contracting or selective contracting. One advantage of selective contracting is that it

A. Allows enrollees to choose from among a greater variety of health plans

B. Reduces the competition among health plans

C. Increases the ability of new, local plans to participate in Medicaid programs

D. Encourages the development of products that offer enhanced benefits and more effective approaches to health plans

ANSWER: D

QUESTION NO: 2

The following activities are the responsibility of either the Nova Health Plan's risk management department or its medical management department:

A. Protecting Nova's members against harm from medical care

A, B, and C

B. Improving the overall health status of Nova members by coordinating care across individual episodes of care and the different providers who treat the member

A, C, and D

C. Protecting Nova against financial loss associated with the delivery of healthcare

A and C

D. Establishing outreach programs to encourage the use of preventive health services by Nova's members of these activities, the ones that are more likely to be the responsibility of Nova's risk management department rather than its medical management department are activities:

B and D

ANSWER: C

QUESTION NO: 3

One true statement about the responsibilities of providers under typical provider contracts is that most provider contracts:

A. include a clause which states that providers must maintain open communications with patients regarding appropriate treatment plans, unless the services are not covered by the member's health plan

B. hold that the responsibility of the provider to deliver services is usually subject to the provider's receipt of information regarding the eligibility of the member

C. contain a gag clause or a gag rule

D. include a clause that explicitly places the responsibility for medical care on the health plan rather than on the provider of medical services

ANSWER: B

QUESTION NO: 4

The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement.

One important activity within the scope of network management is ensuring the quality of the health plan's provider networks. A primary purpose of _____ is to review the clinical competence of a provider in order to determine whether the provider meets the health plan's preestablished criteria for participation in the network.

A. authorization

B. provider relations

C. credentialing

D. utilization management

ANSWER: C

QUESTION NO: 5

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

A. In order to supply a provider network to furnish healthcare to workers' compensation beneficiaries, a health plan typically uses the network that has already been created for the group health plan.

B. Typically, case managers for workers' compensation programs are physical therapists.

C. Most states prohibit the use of fee schedules in order to curb the rising workers' compensation healthcare costs.

D. Networks serving workers' compensation patients typically include higher concentrations of specialists than do other provider networks.

ANSWER: D

QUESTION NO: 6

With regard to the compensation of dental care providers in a managed dental care system, it is correct to state that, typically:

A. dental PPOs compensate dentists on a capitated basis

B. group model dental HMOs (DHMOs) compensate general dental practitioners on a salaried basis

C. independent practice association (IPA)-model dental HMOs (DHMOs) capitate general dental practitioners

D. staff model dental HMOs (DHMOs) compensate dentists on an FFS basis

ANSWER: C

QUESTION NO: 7

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

A. A case mix/severity adjustment

B. An external performance standard

C. Structural measures

D. Behavior modification

ANSWER: A

QUESTION NO: 8

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

A. physician has a patient panel that exceeds 25,000 patients

B. physician receives a bonus that is based solely on quality of care, patient satisfaction, or physician participation

C. difference between the physician's maximum potential payments and his or her minimum potential payments is less than 25% of the maximum potential payments

D. physician is subject to a withhold that is greater than 25% of his or her potential payments

ANSWER: D

QUESTION NO: 9

The following statements are about the inclusion of unified pharmacy benefits in health plan healthcare packages. Select the answer choice containing the correct statement.

A. When pharmacy benefits management is incorporated into an health plan's operations as a unified benefit, the health plan establishes pharmacy networks, but a pharmacy benefits management (PBM) company manages their operations.

B. Under a unified pharmacy benefit, an health plan cannot use mail-order services to provide drugs to its members.

C. Compared to programs that do not manage pharmacy benefits in-house, unified pharmacy benefits programs typically give health plans more control over patient access to prescription drugs.

D. Compared to programs that do not manage pharmacy benefits in-house, unified pharmacy benefits programs make drug therapy interventions for plan members more difficult.

ANSWER: C

QUESTION NO: 10

The Enterprise Health Plan has indicated an interest in delegating its medical records review activities to the Teal Group and has forwarded a typical letter of intent to Teal. One true statement about this letter of intent is that it:

A. Is a contract that creates a legally binding relationship between Enterprise and Teal

B. Cannot include a confidentiality clause

C. Serves as a delegation agreement between Enterprise and Teal

D. Outlines the delegation oversight process

ANSWER: D

QUESTION NO: 11

The Portway Hospital is qualified to receive Medicaid subsidy payments as a disproportionate share hospital (DHS). The DHS payments that Portway receives are

A. Made for services rendered to specific patients

B. Made with matching state and federal funds

C. Included in the Medicaid capitation payment made to patients' health plans

D. Defined as cost-based reimbursement (CBR) equal to 100% of Portway's reasonable costs of providing services to Medicaid recipients

ANSWER: B

QUESTION NO: 12

An increasing number of health plans offer coverage for alternative healthcare services. One such alternative healthcare service is biofeedback. Biofeedback is an approach that

A. is based on an ancient Chinese system of healing in which needles are inserted into specific sites on the body to relieve pain

B. treats diseases with tiny doses of substances which, in healthy people, are capable of producing symptoms like those of the disease being treated

C. uses electronic monitoring devices to teach a patient to develop conscious control of involuntary bodily functions, such as heart rate and body temperature

D. incorporates a variety of therapies, such as homeopathy, lifestyle modification, and herbal medicines, to support and maintain the body's ability to heal itself

ANSWER: C

QUESTION NO: 13

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 allowed competitive medical plans (CMPs) to participate in the Medicare program on a risk basis. Under the terms of Medicare risk contracts, CMPs were required to deliver all medically necessary Medicare-covered services in return for a

A. fixed monthly capitation payment from CMS

B. fee-for-service payment from the appropriate state Medicare agency

C. mandatory premium paid by plan enrollees

D. fee equal to twice the actuarial value of the Medicare deductible and coinsurance paid by plan enrollees

ANSWER: A

QUESTION NO: 14

The provider contract that the Danube Health Plan has with the Viola Home Health Services Organization states that Danube will use a typical flat rate reimbursement arrangement to compensate Viola for the skilled nursing services it provides to Danube's plan members. A portion of the contract's reimbursement schedule is shown below:

Home Health Licensed Practical Nurse (LPN): $45 per visit or $90 per diem

Home Health Registered Nurse (RN): $50 per visit or $110 per diem

Last month, an LPN from Viola visited a Danube plan member and provided 1½ hours of home healthcare, and an RN from Viola visited another Danube plan member and provided 7 hours of home healthcare. The following statement(s) can correctly be made about Danube's payment to Viola for these services:

A. Danube most likely owes $90 for the LPN's skilled nursing services and $110 for the RN's skilled nursing services.

Both A and B

B. Danube's payment amount could be different from the amount called for in the reimbursement schedule if the level of care provided to one of these plan members was significantly different from the level of care normally provided by Viola's RNs and LPNs.

A only

C. B only

D. Neither A nor B

ANSWER: C

QUESTION NO: 15

The following statements describe two types of HMOs:

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

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

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

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

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

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

The following statements can correctly be made about the reimbursement for Drugs A and B under the MAC pricing system:

A. Treble most likely is obligated to reimburse Manor 14 cents per tablet for Drug A.

B. Manor most likely is allowed to bill the subscriber 2 cents per tablet for Drug A.

C. Treble most likely is obligated to reimburse Manor 5 cents per tablet for Drug B.

D. All of the above statements are correct.

ANSWER: C