Exam Questions AHM-540

Medical Management

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NEW QUESTION 1
The Glenway Health Plan's pharmacy and therapeutics (P&T) committee conducted pharmacoeconomic research to measure both the clinical outcomes and costs of two new cholesterol-reducing drugs. Results were presented as a ratio showing the cost required to produce a 1 mcg/l decrease in cholesterol levels. The type of pharmacoeconomic research that Glenway conducted in this situation was most likely

A. cost-effectiveness analysis (CEA)
B. cost-minimization analysis (CMA)
C. cost-utility analysis (CUA)
D. cost of illness analysis (COI)

Answer: A

NEW QUESTION 2
Serena Wilson, a registered nurse, is employed at a TRICARE Service Center (TSC) located at a military installation. Ms. Wilson serves as a primary point of contact between enrollees and the TRICARE system and answers enrollees' questions about plan options, eligibility, provider selection, and claims. This information indicates that Ms. Wilson serves as a

A. lead agent
B. beneficiary services representative
C. health plan support contractor
D. primary care manager (PCM)

Answer: B

NEW QUESTION 3
The Medicaid population can be divided into subgroups based on their relative size and the costs of providing benefits. From the answer choices below, select the response that correctly identifies the subgroups that represent the largest percentages of the total Medicaid population and of total Medicaid expenditures. Largest % of Medicaid Population- Largest % of Medicaid Expenditures-

A. Largest % of Medicaid Population-dual eligibles Largest % of Medicaid Expenditures- children and low-income adults
B. Largest % of Medicaid Population-chronically ill or disabled individuals not eligible for MedicareLargest % of Medicaid Expenditures-dual eligibles
C. Largest % of Medicaid Population-children and low-income adults Largest % of Medicaid Expenditures-chronically ill or disabled individuals not eligible for Medicare
D. Largest % of Medicaid Population-chronically ill or disabled individuals not eligible for Medicare Largest % of Medicaid Expenditures-children and low-income adults

Answer: C

NEW QUESTION 4
The following statement(s) can correctly be made about the use of screening for secondary prevention:
* 1. Screening activities may involve specialty care providers as well as primary care providers (PCPs) and the health plan
* 2. Secondary prevention often results in more utilization of services immediately following screening
* 3. Screening focuses on members who have not experienced any symptoms of a particular illness

A. All of the above
B. 1 and 3 only
C. 2 and 3 only
D. 1 only

Answer: A

NEW QUESTION 5
Emilio Martinez, a member of the Bloom Health Plan, has recently been diagnosed with prostate cancer by his physician, Dr. Robert Cohen. Mr. Martinez has decided to participate in Bloom's shared decision-making program for prostate cancer. On the basis of this information, it is most likely correct to say
* 1. That verification of Mr. Martinez's understanding about his care options protects both Dr. Cohen and Bloom against charges of malpractice
* 2. That Mr. Martinez and Dr. Cohen will discuss the care options available to Mr. Martinez, but the ultimate decision about care is up to Dr. Cohen

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: D

NEW QUESTION 6
Determine whether the following statement is true or false:
Immunization programs are a direct means of reducing health plan members' needs for healthcare services and are typically cost-effective.

A. True
B. False

Answer: A

NEW QUESTION 7
Determine whether the following statement is true or false:

The delegation of medical management functions to providers can occur without the transfer of financial risk.

A. True
B. False

Answer: A

NEW QUESTION 8
Breanna Osborn is a case manager for a regional health plan. One component of Ms. Osborn's job is the collection and evaluation of medical, financial, social, and psychosocial information about a member's situation. This component of Ms. Osborn's job is known as

A. case identification
B. case management planning
C. healthcare coordination
D. case assessment

Answer: D

NEW QUESTION 9
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
Ways that workers' compensation health plans can help control the costs of job-related injuries and illnesses include

A. applying strict definitions of medical necessity
B. developing prevention and recovery programs
C. applying out-of-network benefit reductions
D. all of the above

Answer: B

NEW QUESTION 10
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
Definitions of quality healthcare vary; however, four dimensions are essential to quality healthcare services. _____ is the quality dimension indicating that services result in the best care for a given cost or the lowest cost for a given level of care.

A. Accessibility
B. Effectiveness
C. Acceptability
D. Efficiency

Answer: D

NEW QUESTION 10
The Carlyle Health Plan uses the following clinical outcome measures to evaluate its diabetes and asthma disease management programs:
Measure 1: The percentage of diabetic patients who receive foot exams from their providers according to the program's recommended guidelines Measure 2: The number of asthma patients who visited emergency departments for acute asthma attacks
From the answer choices below, select the response that correctly identifies whether these measures are true outcome measures or intermediate outcome measures. Measure 1- Measure 2-

A. Measure 1-true outcome measure Measure 2-true outcome measure
B. Measure 1-true outcome measure Measure 2-intermediate outcome measure
C. Measure 1-intermediate outcome measure Measure 2-true outcome measure
D. Measure 1-intermediate outcome measure Measure 2-intermediate outcome measure

Answer: C

NEW QUESTION 12
The Strathmore Health Plan uses clinical pathways to manage its acute care services. In order to reduce the risk of financial liability associated with the use of clinical pathways, Strathmore and its network hospitals should

A. base pathways on relevant evidence reported in medical literature
B. restrict each pathway to a single medical condition
C. use pathways to establish a new standard of care
D. allow providers to use only those interventions listed in the pathways

Answer: A

NEW QUESTION 13
One difference between outcomes research and clinical research is that outcomes research

A. provides an absolute measure of treatment results, whereas clinical research provides a relative measure of results
B. focuses on treatment effectiveness, whereas clinical research focuses on treatmentefficacy
C. examines diseases and treatments in isolation, whereas clinical research considers the effects of changes in health status and quality of life
D. gathers outcomes data from controlled clinical trials, whereas clinical research collects and analyzes clinical, financial, and administrative data

Answer: B

NEW QUESTION 15
This agency's accreditation decisions are based on the results of an on-site survey of clinical and administrative systems and processes, as well as the health plan's performance on selected effectiveness of care and member satisfaction measures.

A. American Accreditation HealthCare Commission/URAC (URAC)
B. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
C. Community Health Accreditation Program (CHAP)
D. National Committee for Quality Assurance (NCQA)

Answer: D

NEW QUESTION 17
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Select the term or phrase in each pair that correctly completes the paragraph. Then select the answer choice containing the two terms or phrases you have chosen.
TRICARE enrollees have the right to challenge authorization and coverage decisions. Such challenges are referred to as (appeals / grievances) and are typically handled by the (TRICARE contractor / Area Field Office).

A. appeals / TRICARE contractor
B. appeals / Area Field Office
C. grievances / TRICARE contractor
D. grievances / Area Field Office

Answer: A

NEW QUESTION 18
The following statement(s) can correctly be made about the scope of case management:
* 1. Case management incorporates activities that may fall outside a health plan's typical responsibilities, such as assessing a member's financial situation
* 2. Case management generally requires a less comprehensive and complex approach to a course of care than does utilization review
* 3. Case management is currently applicable only to medical conditions that require inpatient hospital care and are categorized as catastrophic in terms of health and/or costs

A. All of the above
B. 1 and 2 only
C. 2 and 3 only
D. 1 only

Answer: D

NEW QUESTION 20
Maxwell Midler's health plan operates a drug formulary that includes a typical three-tier copayment structure with required copayments of $5, $10, and $25. Mr. Midler recently filled a prescription for a $75 drug that was not included in the formulary. According to the plan's formulary copayment structure, the amount that Mr. Midler was required to pay for his prescription was

A. $5
B. $10
C. $25
D. $75

Answer: C

NEW QUESTION 21
Demetrius Farrell, age 82, is suffering from a terminal illness and has consulted his health plan about the care options available to him. In order to avoid unwanted, futile interventions, Mr. Farrell signed an advance directive that indicates the types of end-of-life medical treatment he wants to receive. His family is to use this document as a guide should Mr. Farrell become incapacitated.
The document that Mr. Farrell is using to communicate his end-of-life healthcare wishes to his family is known as a

A. medical power of attorney
B. patient assessment and care plan
C. living will
D. healthcare proxy

Answer: C

NEW QUESTION 26
The following statements are about health plans' development of medical policies. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. Technology assessment is applicable only to medical policy development for new medical procedures, devices, drugs, and tests.
B. Technology assessment provides the scientific rationale for the medical policy section that specifies when a medical service is appropriate and when it is not.
C. The medical policy development process includes both a clinical and an operational review of a proposed medical policy.
D. The decision to accept or reject a proposed medical policy often depends on how a new technology compares to currently used interventions.

Answer: A

NEW QUESTION 30
All states have laws describing the conditions under which pharmacists can substitute a generic drug for a brand-name drug. With respect to these laws, it is correct to say that in every state,

A. pharmacists must obtain physician approval before substituting generics for brand-name drugs
B. pharmacists must obtain authorization from the health plan before substituting generics for brand-name drugs
C. prescribers must obtain authorization from the health plan before prescribing a brand- name drug
D. prescribers have some mechanism that allows them to prevent pharmacists from substituting generics for brand-name drugs

Answer: D

NEW QUESTION 31
The following statements are about the use of provider profiling for pharmacy benefits. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. Health plans typically use provider profiles to improve the quality of care associated with the use of prescription drugs.
B. Provider profiles identify prescribing patterns that fall outside normal ranges.
C. Health plans can motivate providers to change their prescribing patterns by sharing profile information with plan members and the general public.
D. Provider profiles are effective in modifying individual prescribing patterns, but they have little effect on group prescribing patterns.

Answer: D

NEW QUESTION 33
DUR can be conducted prospectively, concurrently, or retrospectively. One true statement about prospective DUR is that it

A. involves periodic audits of the medical records of a certain group of patients
B. is based on historical data
C. focuses on the drug therapy for a single patient rather than overall usage patterns
D. is conducted by physicians, without input from pharmacists

Answer: C

NEW QUESTION 36
In order for a health plan's performance-based quality improvement programs to be effective, the desired outcomes must be

A. achievable within a specified timeframe
B. defined in terms of multiple results
C. expressed in subjective, qualitative terms
D. all of the above

Answer: A

NEW QUESTION 41
Determine whether the following statement is true or false:
Independent review organizations (IROs) can mediate disputes and offer advisory opinions to health plans on UR issues, but they cannot render binding decisions on appeals.

A. True
B. False

Answer: B

NEW QUESTION 43
Designing effective medical management programs for Medicare beneficiaries requires an understanding of the unique health needs of the Medicare population. One characteristic of Medicare beneficiaries is that they typically

A. do not experience mental health problems
B. consume more than half of all prescription drugs
C. are likely to equate quality with the technical aspects of clinical procedures
D. require longer and more costly recovery periods following acute illnesses or injuries than does the general population

Answer: D

NEW QUESTION 46
Michelle Durden, who is enrolled in a dental health maintenance organizations (DHMO) offered by her employer, is due for a routine dental examination. If the plan is typical of most DHMOs, then Ms. Durden

A. must pay the entire cost of the examination
B. must obtain a referral to a dentist from her primary care provider (PCP)
C. can schedule the examination without preauthorization of payment by the DHMO
D. can schedule an unlimited number of examinations and cleanings per year

Answer: C

NEW QUESTION 49
Patricia McLeod is a member of the Enterprise Health Plan, which operates in State X. Ms. McLeod is scheduled to undergo a unilateral mastectomy for the treatment of breast cancer. The surgical procedure will be performed by Dr. Kim Lee, a surgical oncologist.
Based on Enterprise's medical policy, the contract with the purchaser, and Ms. McLeod's medical condition, Enterprise's UR staff have determined that the appropriate course of care for Ms.

McLeod includes a 24-hour stay in the hospital following her surgery. State X, however, has a benefit mandate specifying health plan coverage for 48 hours of inpatient post- mastectomy care. In this situation, the length of hospital stay for which Enterprise must offer coverage is

A. the length of stay deemed appropriate by D
B. Lee
C. the 24-hour stay determined to be appropriate by Enterprise's UR staff
D. the length of stay deemed appropriate by M
E. McLeod
F. the 48-hour length of stay specified by State X

Answer: D

NEW QUESTION 52
The Mental Health Parity Act (MHPA) of 1996 is a federal law that establishes requirements for behavioral healthcare coverage for group plan members. The MHPA

A. requires health plans to offer mental health benefits to all eligible members
B. prohibits health plans that offer mental health benefits from imposing lower annual or lifetime dollar limits on mental illnesses than they do on physical illnesses
C. provides an exemption for health plans that can demonstrate cost savings of more than 1 percent
D. prohibits health plans from limiting the number of outpatient visits or inpatient dayscovered under the plan

Answer: B

NEW QUESTION 53
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
To manage the delivery of healthcare services to their members, health plans use clinical practice parameters. _____ is the type of clinical practice parameter that a health plan uses to make coverage decisions concerning medical necessity and appropriateness.

A. A clinical practice guideline (CPG)
B. Medical policy
C. Benefits administration policy
D. A standard of care

Answer: B

NEW QUESTION 54
This agency oversees fraud and abuse matters as they relate to medical management.

A. Health Resources and Services Administration (HRSA)
B. Office of Personnel Management (OPM)
C. Department of Health and Human Services (HHS)
D. Department of Justice (DOJ)

Answer: D

NEW QUESTION 59
The following statements describe situations in which health plan members have medical problems that require care. Select the statement that describes a situation in which self- care most likely would not be appropriate.

A. Two days after bruising her leg, Avis Bennet notices that the pain from the bruise has increased and that there are red streaks and swelling around the bruised area.
B. Calvin Dodd has Type II diabetes and requires blood glucose monitoring tests several times each day.
C. Caroline Evans has severe arthritis that requires regular exercise and oral medication to reduce pain and help her maintain mobility.
D. Oscar Gracken is recovering from a heart attack and requires ongoing cardiac rehabilitation.

Answer: A

NEW QUESTION 63
To measure performance for quality management, health plans collect and analyze three types of data: financial data, clinical data, and customer satisfaction data. The following statement(s) can correctly be made about the sources of clinical data:
* 1.Patient surveys are the most widely used source of disease-specific clinical information
* 2.Outcomes research studies sponsored by academic institutions and professional organizations have limited usefulness for particular health plans or individual providers
* 3.The SF-36 and the HSQ-39 (Health Status Questionnaire) surveys address both physical and mental health status

A. All of the above
B. 1 and 2 only
C. 2 and 3 only
D. 3 only

Answer: C

NEW QUESTION 68
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
Medical management programs often require the analysis of many types of data and information. _____ is an automated process that analyzes variables to help detect patterns and relationships in the data.

A. Unbundling
B. Outsourcing
C. Data mining
D. Drilling down

Answer: C

NEW QUESTION 72
Step-therapy is a form of prior authorization that reserves the use of more expensive medications for cases in which the use of less expensive medications has been unsuccessful. Step-therapy is appropriate for situations in which
* 1.A significant percentage of those treated with the initial therapy will require the second therapy
* 2.The delay created when a patient moves from one therapy to the next therapy will not cause serious or permanent effects

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: C

NEW QUESTION 73
The Harbor Health Plan's formulary policy encourages network pharmacists who are asked to fill a prescription for a costly, brand-name drug to dispense a different chemical entity within the same drug class in order to reduce costs. This type of drug substitution is referred to as

A. generic substitution, and prescriber approval is not required
B. generic substitution, and prescriber approval is always required
C. therapeutic substitution, and prescriber approval is not required
D. therapeutic substitution, and prescriber approval is always required

Answer: D

NEW QUESTION 76
The following statements are about disease management programs. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. The focus of disease management is on responding to the needs of individual members for extensive, customized healthcare supervision.
B. Disease management programs serve to improve both clinical and financial outcomes for healthcare services related to chronic conditions.
C. Tools such as preventive care, self-care, and decision support programs are used to support both case management and disease management.
D. Disease management programs apply to both diseases and medical conditions that are not diseases, such as high-risk pregnancy, severe burns, and trauma.

Answer: A

NEW QUESTION 81
Since its inception, Medicare has undergone a number of changes because of legal and regulatory action. One result of the Balanced Budget Act (BBA) of 1997 has been to

A. expand Medicare benefits by mandating coverage for certain preventive services
B. reduce the number of organizations that can deliver covered services
C. encourage growth of managed Medicare programs in all markets
D. increase the number of "zero premium" plans available to Medicare beneficiaries

Answer: A

NEW QUESTION 82
Many health plans use clinical pathways to help manage the delivery of acute care services to plan members. One true statement about clinical pathways is that they

A. determine which healthcare services are medically necessary and appropriate for a particular patient in a particular situation
B. outline the services that will be delivered, the providers responsible for delivering the services, the timing of delivery, the setting in which services are delivered, and the expected outcomes of the interventions
C. cover only services delivered in an acute inpatient setting
D. address medical conditions that affect a small segment of a given population and with which the majority of providers are unfamiliar

Answer: B

NEW QUESTION 85
Determine whether the following statement is true or false:
All health plans participating in the Federal Employee Health Benefits Program (FEHBP) are required to use the Consumer Assessment of Health Plans (CAHPS) to measure customer satisfaction.

A. True
B. False

Answer: A

NEW QUESTION 89

For this question, if answer choices (a) through (c) are all correct, select answer choice (d). Otherwise, select the one correct answer choice.
Well-crafted clinical practice guidelines (CPGs) can benefit healthcare delivery processes and outcomes by

A. providing a framework for care while also allowing for patient-specific variations, based on physician judgment
B. serving as a basis for evaluating whether providers are practicing in accordance with accepted standards
C. focusing on the prevention or early detection of a particular condition
D. all of the above

Answer: D

NEW QUESTION 94
One of the steps in drug utilization review (DUR) is defining optimal drug use, which can be accomplished by applying diagnosis criteria and drug-specific criteria.
Drug-specific criteria are standards that identify the

A. appropriate dosages, duration of treatment, and other elements related to the use of a particular drug
B. actual prescribing and dispensing patterns for a particular drug
C. types of diseases, conditions, or patients for which a drug should be used
D. cost-effectiveness of all possible drug treatments for a particular condition

Answer: A

NEW QUESTION 95
Comparing the quality of managed Medicare programs with the quality of FFS Medicare programs is often difficult. Unlike FFS Medicare, managed Medicare programs

A. can measure and report quality only at the provider level
B. use a single system to deliver services to all plan members
C. provide an organizational focus for accountability
D. can use the same performance measures for all products and plans

Answer: C

NEW QUESTION 96
Drugs included in a health plan's formulary can be classified according to how freely they can be prescribed. By definition, a drug that requires some sort of review or approval by a plan physician or group of physicians before the prescription can be filled is

A. an unrestricted drug
B. a monitored drug
C. a restricted drug
D. a conditional drug

Answer: B

NEW QUESTION 99
When conducting performance assessment, a health pln may classify the key processes associated with its services into the following categories: high-risk, high-volume, problem- prone, and high-cost.
The following statements are about this classification of processes. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. In some instances, relatively inexpensive processes can qualify as high-cost processes.
B. Each process must be classified into a single category.
C. High-risk processes most often involve medical interventions or treatment plans for acute illnesses or case management processes for complex conditions.
D. Administrative processes such as scheduling appointments are examples of high- volume processes.

Answer: B

NEW QUESTION 101
Examples of alternative healthcare practitioners are chiropractors, naturopaths, and acupuncturists. The only well-established credentialing standards for alternative healthcare practitioners are those available from NCQA. These NCQA credentialing standards apply to

A. chiropractors
B. naturopaths
C. acupuncturists
D. all of the above

Answer: A

NEW QUESTION 105
Vision care is typically separated into two categories: routine eye care and clinical eye care. The standard benefit plans offered by most health plans include coverage for
* 1. Routine eye care
* 2. Clinical eye care

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: C

NEW QUESTION 106
Health plans conduct evaluations on the efficiency and effectiveness of their quality improvement activities. With regard to the effectiveness of quality improvement plans, it is correct to say that

A. effectiveness is the relationship between what the organization puts into an improvement plan and what it gets out of the plan
B. effectiveness is measured by reviewing outcomes to determine the accuracy or appropriateness of the strategy and the adequacy of resources allocated to that strategy
C. the effectiveness of an action plan is typically measured with a concurrent evaluation
D. an evaluation of plan effectiveness produces one of two results: the plan either (a) achieved the desired outcomes or (b) did not achieve the desired outcomes and is unlikely to do so under current conditions

Answer: B

NEW QUESTION 109
Various government and independent agencies have created tools to measure and report the quality of healthcare. One performance measurement tool that was developed by the Agency for Healthcare Research and Quality (AHRQ) is

A. the Health Plan Employer Data and Information Set (HEDIS®), which is a report card system for hospitals and long-term care facilities
B. HEDIS, which is a performance measurement tool that addresses both effectiveness of care and plan member satisfaction
C. the Consumer Assessment of Health Plans (CAHPS®), which was established to develop and implement a national strategy for quality measurement and reporting
D. CAHPS, which is a tool that measures consumer satisfaction with specific aspects of health plan services

Answer: D

NEW QUESTION 113
Health plans communicate proposed performance changes through action statements. Select the answer choice containing an action statement that includes all of the required elements.

A. The proportion of adult members who are screened for hypertension will increase by ten percent.
B. Primary care providers (PCPs) will increase the proportion of children under the age of two who are up-to-date on immunizations by seven percent within one year.
C. The QM program director will evaluate the level of provider compliance with clinicalpractice guidelines (CPGs).
D. The disease management program director will increase participation by asthmatic children in the health plan’s pediatric asthma disease management program.

Answer: B

NEW QUESTION 114
Among this agency’s accreditation programs are accreditation for preferred provider organizations (PPOs), health plan call centers, and case management organizations. This agency classifies its standards as either “shall” standards or “should” standards.

A. American Accreditation HealthCare Commission/URAC (URAC)
B. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
C. Community Health Accreditation Program (CHAP)
D. National Committee for Quality Assurance (NCQA)

Answer: A

NEW QUESTION 117
Administrative action plans are used when performance problems or opportunities are related to the way the organization itself operates. The following statement(s) can correctly be made about administrative action plans:
* 1.Administrative action plans allow health plans to coordinate management activities
* 2.One function of administrative action plans is to integrate service across all levels of the organization
* 3.Administrative action plans are designed to improve outcomes by helping plan members assume responsibility for their own health

A. All of the above
B. 1 and 2 only
C. 1 and 3 only
D. 2 and 3 only

Answer: B

NEW QUESTION 118
Many health plans use HRA to target their preventive care programs to the healthcare needs of their members. With regard to HRA, it is correct to say that

A. Health plans rarely delegate HRA activities to external entities
B. Health plans typically focus their HRA efforts on newly enrolled members
C. HRA focuses on clinical data for an entire population and does not include demographic information that might identify individual members
D. HRA is generally a reliable predictor of medical resource utilization

Answer: B

NEW QUESTION 121

The American Accreditation HealthCare Commission/URAC (URAC) has an accreditation program specifically for case management services. From the answer choices below, select the response that correctly identifies the type(s) of case management services addressed by URAC's standards and the type(s) of organizations to which these standards may be applied.

A. Type(s) of Services-on-site services only Type(s) of Organization-health plans only
B. Type(s) of Services-on-site services only Type(s) of Organization-any organization that performs case management functions
C. Type(s) of Services-both telephonic and on-site services Type(s) of Organization-health plans only
D. Type(s) of Services-both telephonic and on-site services Type(s) of Organization-any organization that performs case management functions

Answer: D

NEW QUESTION 126
One way that health plans can make their benefits more appealing to employers and
employees is to offer coverage for specialty services. It is correct to say that specialty services typically

A. involve the same types of providers and delivery systems as do standard medical services
B. are a subset of a health plan's standard medical-surgical services
C. are not monitored by health plans for quality or utilization
D. require specialized knowledge for service delivery and management

Answer: D

NEW QUESTION 130
One true statement about state regulation of case management activities is that the majority of states

A. have enacted laws that list specific quality management requirements for a case management program
B. consider case management files to be medical records that must be retained for a specified length of time
C. view case management similarly and follow similar patterns with their laws and regulations
D. have enacted laws or regulations requiring licensure or certification of case managers

Answer: B

NEW QUESTION 135
The BBA of 1997 allows states to provide Medicaid benefits to children through the State Children's Health Insurance Program (SCHIP). Under the terms of the BBA, states can implement SCHIP as
* 1. Part of their existing Medicaid programs
* 2.Separate commercial insurance programs

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: A

NEW QUESTION 139
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