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
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 3
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 4
Determine whether the following statement is true or false:
The key to successfully managing the quality and cost-effectiveness of healthcare services for Medicaid enrollees is to merge Medicaid recipients into existing plans.

A. True
B. False

Answer: B

NEW QUESTION 5
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 6
Determine whether the following statement is true or false:
With respect to the size of a managed care organization (MCO) and its medical management operations, it is correct to say that large health plans typically have more integration among activities and less specialization of roles than do small MCOs.

A. True
B. False

Answer: B

NEW QUESTION 7
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 8
State governments serve as both regulators and purchasers of health plan services. The influence of state governments as purchasers is focused on

A. Medicare and TRICARE programs
B. Medicaid and workers' compensation programs
C. Medicare and Medicaid programs
D. TRICARE and workers' compensation programs

Answer: B

NEW QUESTION 9
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
Increased demands for performance information have resulted in the development of various health plan report cards. With respect to most of the report cards currently available, it is correct to say

A. that they are focused primarily on health maintenance organization (HMO) plans
B. that they are based on data collected for the Health Plan Employer Data and Information Set (HEDIS) 3.0
C. that they are used to rank the performance of various health plans
D. all of the above

Answer: D

NEW QUESTION 10
To see that utilization guidelines are consistently applied, UR programs rely on authorization systems. Determine whether the following statement about authorization systems is true or false:
Only physicians can make nonauthorization decisions based on medical necessity.

A. True
B. False

Answer: A

NEW QUESTION 15
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 16
The following statement(s) can correctly be made about the characteristics of peer review:
* 1.Peer review is applicable to either single episodes of care or to entire programs of care
* 2.Most peer review is conducted concurrently
* 3.Under the Health Care Quality Improvement Program (HCQIP), peer review is required for services furnished to Medicare and Medicaid recipients enrolled in health plans

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

Answer: C

NEW QUESTION 19
Recent laws and regulations have established new requirements for Medicaid eligibility. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 affected Medicaid eligibility by

A. severing the link between Medicaid and public assistance
B. eliminating the need for applications for Medicaid and public assistance
C. allowing states to provide healthcare benefits to groups outside the traditional Medicaid population
D. providing supplemental funding for dual eligibles in the form of five-year block grants

Answer: A

NEW QUESTION 20
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 23
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 27
The following statements are about chronic and disabling conditions among children eligible for Medicaid. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. Children with chronic conditions use more physician and nonphysician professional services than do children in the general population.
B. The majority of chronic conditions affecting children in Medicaid programs are the same as those affecting children in the general population.
C. Medicaid-eligible children are at risk for seriousmental and physical conditions.
D. Children in Medicaid programs have a higher incidence of chronic disabling conditions than do children in the general population.

Answer: B

NEW QUESTION 30
Helena Ray, a member of the Harbrace Health Plan, suffers from migraine headaches. To treat Ms. Ray's condition, her physician has prescribed Upzil, a medication that has Food and Drug Administration (FDA) approval only for the treatment of depression. Upzil has not been tested for safety or effectiveness in the treatment of migraine headache. Although Harbrace's medical policy for migraine headache does not include coverage of Upzil, Harbrace has agreed to provide extra-contractual coverage of Upzil for Ms. Ray.
The following statement(s) can correctly be made about Harbrace's use of extra- contractual coverage:
* 1. Harbrace's medical policy most likely establishes the procedure that Harbrace used to evaluate the value of Upzil for treating Ms. Ray
* 2. One way for Harbrace to reduce the risk associated with extra-contractual coverage is by including an alternative care provision in its contracts with purchasers

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

Answer: C

NEW QUESTION 32
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 37
Medicare beneficiaries can obtain healthcare benefits through fee-for-service (FFS) Medicare programs, Medicare medical savings account (MSA) plans, Medigap insurance, or coordinated care plans (CCPs). Unlike other coverage options, CCPs

A. provide only those benefits covered by Medicare Part A and Part B
B. are not subject to federal or state regulation
C. place primary care at the center of the delivery system
D. are structured as indemnity plans

Answer: C

NEW QUESTION 39
The paragraph below contains an incomplete statement. Select the answer choice containing the term that correctly completes the paragraph.
The Balanced Budget Act (BBA) of 1997 established the use of _____ to determine coverage of emergency services for Medicare and Medicaid enrollees in health plans.

A. utilization management standards
B. the prudent layperson standard
C. preauthorization
D. diagnosis-based retrospective review

Answer: B

NEW QUESTION 43
The following statements are about the characteristics of a utilization review (UR) program. Three of the statements are true and one is false. Select the answer choice containing the FALSE statement.

A. A primary goal of UR is to address practice variations through the application of uniform standards and guidelines.
B. UR evaluates whether the services recommended by a member's provider are covered under the benefit plan.
C. UR recommends the procedures that providers should perform for plan members.
D. A health plan's UR program is usually subject to review and approval by the state insurance and/or health departments.

Answer: C

NEW QUESTION 47
Determine whether the following statement is true or false: Participation in disease management programs is currently voluntary.

A. True
B. False

Answer: A

NEW QUESTION 52
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 53
PBMs are accredited by the same organizations that accredit health plans.

A. True
B. False

Answer: B

NEW QUESTION 56
The Brighton Health Plan regularly performs prospective UR for surgical procedures. Brighton's prospective UR activities are likely to include

A. documenting the clinical details of the patient's condition and care
B. tracking the length of inpatient stay
C. completing the discharge planning process
D. determining the most appropriate setting for the proposed course of care

Answer: D

NEW QUESTION 57
The Garnet Health Plan uses provider profiling to measure and improve provider performance. Provider profiling most likely allows Garnet to

A. evaluate all providers without considering differences in risk
B. focus on specific clinical decisions of Garnet's providers rather than on patterns of care
C. identify the outliers and high-value providers in its provider network
D. measure the effectiveness, but not the efficiency, of Garnet's providers

Answer: C

NEW QUESTION 62
Determine whether the following statement is true or false:
Under a carve-out arrangement for disease management, patients typically maintain their existing relationships with primary care providers (PCPs) for all care,

including disease management.

A. True
B. False

Answer: B

NEW QUESTION 67
Private employers are key purchasers of health plan services. The following statement(s) can correctly be made about employer expectations about the quality and cost- effectiveness of healthcare services:
* 1. For both health maintenance organizations (HMOs) and non-HMO plans, employers typically have access to accreditation results and performance measurement reports to help them evaluate the quality of healthcare and service
* 2. Because of employers' concern about the quality and costs of healthcare services available through health plans, direct contracting has become a dominant model among employers who sponsor health benefit programs for their employees

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

Answer: D

NEW QUESTION 71
Patient safety and medical errors are important concerns for both quality management (QM) and risk management. The following statement(s) can correctly be made about medical errors:
* 1. The complexity of modern medicine and healthcare delivery systems increases patients' exposure to the risks of medical errors
* 2. Licensing boards for healthcare professionals in all states provide a consistent system of quality oversight and accountability
* 3. Provider compliance with internal incident reporting requirements is low

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

Answer: C

NEW QUESTION 74
Accreditation is intended to help purchasers and consumers make decisions about healthcare coverage.
The following statements are about accreditation. Select the answer choice containing the correct statement.

A. At the request of health plans, accrediting agencies gather the data needed for accreditation.
B. Most purchasers and consumers review accreditation results when making decisions to purchase or enroll in a specific health plan.
C. Accreditation is typically conducted by independent, not-for-profit organizations.
D. All health plans are required to participate in the accreditation process.

Answer: C

NEW QUESTION 79
MCOs usually have a formal program for the oversight of delegated activities. The following statements concern typical delegation oversight programs. Select the answer choice containing the correct statement.

A. A letter of intent is the contractual document that describes the delegated functions and the responsibilities of the MCO and the delegate.
B. In most cases, the evaluation of a candidate for delegation is based entirely on the candidate's application and supporting documentation and does not include an on-site assessment of the candidate.
C. Under most delegation agreements, an MCO cannot terminate the agreement before the end date stated in the agreement.
D. One objective for a delegation oversight program is to integrate any delegated activities into the MCO's overall programs for medical management and other functions.

Answer: D

NEW QUESTION 81
Comorbidity can have a significant impact on the effective implementation of disease management programs. Comorbidity can correctly be defined as the

A. degree to which the progression of a disease or condition is understood
B. prevalence or rate of a sickness or injury within a given population
C. degree of severity of a particular disease or condition
D. presence of a chronic condition or added complication other than the condition that requires medical treatment

Answer: D

NEW QUESTION 86
The case management team at the Hightower Health Plan reviewed the medical records of the following two plan members to determine the type of care each one needs and the most appropriate setting for that care:
Ira Morton was hospitalized for a severe stroke. Although his medical condition is stable, the stroke left him partially paralyzed and he will require extensive rehabilitation and 24- hour medical care.
Theresa Finley is recovering from a total hip replacement and is in need of short-term physical therapy and twice-weekly visits from a licensed nurse to check her blood pressure and the healing of her incision.

From the answer choices below, select the response that correctly identifies the level of care that would be most appropriate for Mr. Morton and Ms. Finley.

A. M
B. Morton-acute care M
C. Finley-subacute care
D. M
E. Morton-palliative care M
F. Finley-acute care
G. M
H. Morton-subacute care M
I. Finley-skilled care
J. M
K. Morton-skilled care M
L. Finley-palliative care

Answer: C

NEW QUESTION 90
With respect to the activities of MCO medical directors, it is correct to say that medical directors typically perform all of the following activities EXCEPT

A. maintaining clinical practices
B. delivering performance feedback to providers
C. participating in utilization management (UM) activities
D. educating other MCO staff about new clinical developments or provider innovations that might impact clinical practice management

Answer: A

NEW QUESTION 93
The Fairview Health Plan uses a dual database approach to integrate information needed for its disease management program. This information indicates that Fairview uses an information management system that

A. combines all existing information from all data sources into a single comprehensive system
B. connects multiple databases with a central interface engine that acts as an information clearinghouse
C. provides an outside vendor with pertinent data that the vendor compiles into an integrated database
D. creates a separate database that pulls pertinent information from the health plan's claims database, formats the information for easy analysis, and stores it in the separate database

Answer: D

NEW QUESTION 95
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 96
The delivery of quality, cost-effective healthcare is a primary goal of both group healthcare and workers' compensation programs. One difference between group healthcare and workers' compensation is that workers' compensation

A. provides health and disability benefits to employees injured on the job only if the employer is at fault for the injury
B. provides coverage for a variety of direct and indirect healthcare, disability, and workplace costs
C. manages costs by including employee cost-sharing features in its benefit design
D. places limits on benefits by restricting the amount of benefit payments or the number of covered hospital days or provider office visits

Answer: B

NEW QUESTION 100
When analyzing and applying HRA results, the Multistate Health Plan noted sampling bias. This information indicates that the HRA results

A. do not accurately depict the characteristics of the Multistate member population under study because of errors in data collection
B. are more accurate for individual Multistate members than they are for the total population
C. cannot be stated in numerical terms
D. indicate variation in the number, types, and severity of behavioral risks presented by Multistate's members

Answer: A

NEW QUESTION 104
The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the terms or phrases that you have chosen.
One component of UR is an administrative review. An administrative review compares the proposed medical care to the applicable (medical policy / contract provision). This type of review (can / cannot) be conducted by a nonclinical staff member.

A. medical policy / can
B. medical policy / cannot
C. contract provision / can
D. contract provision / cannot

Answer: C

NEW QUESTION 107
Health plans that offer healthcare programs for Medicare beneficiaries have a strong financial incentive for identifying high-risk seniors as early as possible. The identification of high-risk seniors is typically accomplished through the use of

A. case management
B. geriatric evaluation and management (GEM)
C. intervention identification
D. interdisciplinary home care (IHC)

Answer: C

NEW QUESTION 109
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 111
Acute care refers to healthcare services for medical problems that

A. are expected to continue for a minimum of 30 days
B. are typically treated in a provider's office or outpatient facility
C. require prompt, intensive treatment by healthcare providers
D. require low utilization of resources

Answer: C

NEW QUESTION 115
Federal laws, such as the Employee Retirement Income Security Act (ERISA), the Balanced Budget Act (BBA) of 1997, and the Health Insurance Portability and Accountability Act (HIPAA), have affected medical management activities by health plans. Consider the following provisions of federal regulations:
Provision 1—Limits damage awards in lawsuits related to noncoverage of benefits based on medical necessity decisions to the cost of noncovered treatment and does not allow health plan members to obtain compensatory or punitive damages
Provision 2—Establishes electronic data security standards, which define the security measures that healthcare organizations must take to protect the confidentiality of electronically stored and transmitted patient information From the answer choices below, select the response that correctly identifies the federal laws that include Provision 1 and Provision 2, respectively.

A. Provision 1- ERISA Provision 2- HIPAA
B. Provision 1- HIPAA Provision 2- ERISA
C. Provision 1- BBA of 1997 Provision 2- HIPAA
D. Provision 1- ERISA Provision 2- BBA of 1997

Answer: A

NEW QUESTION 117
As a follow-up to a performance improvement plan for member services, the Stellar Health Plan conducted an evaluation of the success of the plan. Stellar conducted its evaluation as the plan was being carried out. The evaluation focused on specific activities and assessed the relative importance of those activities to the plan as a whole. This information indicates that Stellar's evaluation of the plan was both

A. concurrent and formative
B. concurrent and summative
C. retrospective and formative
D. retrospective and summative

Answer: A

NEW QUESTION 118
Adele Stanley, a member of the Greenhouse Health Plan, recently went to a network pharmacy to have a prescription filled. The pharmacist informed Ms. Stanley that the prescribed drug was not in the plan formulary and that reimbursement for the drug was not available except in extraordinary circumstances. The pharmacist asked Ms. Stanley if she would accept a generic substitute.
If Ms. Stanley agrees to the generic substitution, she will receive a drug that

A. has not been tested for safety and efficacy in large clinical trials
B. is available without a prescription at a reasonable cost
C. has been classified by the Food and Drug Administration (FDA) as safe, but that has not been proven fully effective

D. contains active ingredients that are identical to those of the prescribed brand-name drug

Answer: D

NEW QUESTION 123
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 128
Benchmarking is a quality improvement strategy used by some health plans. With regard to benchmarking, it is correct to say that

A. cost-based benchmarking reveals why some areas of a health plan perform better or worse than comparable areas of other organizations
B. diagnosis-related groups (DRGs) are a source of benchmarking data that describe individual procedures and cover both inpatient and outpatient care
C. patient billing records provide a much more accurate account of procedure costs for benchmarking than do current procedural terminology (CPT) codes
D. the focus of benchmarking for health plan has shifted from identifying the lowest cost practices to identifying best practices

Answer: D

NEW QUESTION 131
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 133
Determine whether the following statement is true or false:
The utilization review (UR) process produces the greatest number of case management referrals.

A. True
B. False

Answer: A

NEW QUESTION 137
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 139
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 144
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 147
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
In most commercial health plans, the case management process is directed by a case manager whose responsibilities typically include

A. focusing on a disabled member's vocational rehabilitation and training
B. approving all care decisions for patients under case management
C. reducing the fragmentation of care that often results when individuals obtain services from several different providers
D. all of the above

Answer: C

NEW QUESTION 149
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 154
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 159
The Noble Health Plan conducted a cost/benefit analysis of the following four prescription drugs:
BenefitCost Drug A$525$350 Drug B$450$250
Drug C$400$200 Drug D$350$100
According to this analysis, the drug that represents the most efficient use of resources is

A. Drug A
B. Drug B
C. Drug C
D. Drug D

Answer: D

NEW QUESTION 161
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 163
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 168
Adele Stanley, a member of the Greenhouse Health Plan, recently went to a network pharmacy to have a prescription filled. The pharmacist informed Ms. Stanley that the prescribed drug was not in the plan formulary and that reimbursement for the drug was not available except in extraordinary circumstances. The pharmacist asked Ms. Stanley if she would accept a generic substitute.
The paragraph below contains two pairs of terms enclosed in parentheses. Determine which term in each pair correctly completes the paragraph. Then select the answer choice containing the two terms that you have chosen.
Greenhouse's prescription drug reimbursement policy indicates that the plan formulary is classified as (open / closed), and that compliance by patients and providers is (mandatory / voluntary).

A. open / mandatory
B. open / voluntary
C. closed / mandatory
D. closed / voluntary

Answer: C

NEW QUESTION 173
A health plan's preventive care initiatives may be classified into three main categories: primary prevention, secondary prevention, and tertiary prevention. Secondary prevention refers to activities designed to

A. develop an appropriate treatment strategy for patients whose conditions require extensive, complex healthcare
B. educate and motivate members to prevent illness through their lifestyle choices
C. prevent the occurrence of illness or injury
D. detect a medical condition in its early stages and prevent or at least delay disease progression and complications

Answer: D

NEW QUESTION 177
A health plan's coverage policies are linked to its purchaser contracts. The following statement(s) can correctly be made about the purchaser contract and coverage decisions:
* 1. In case of conflict between the purchaser contract and a health plan's medical policy or benefits administration policy, the contract takes precedence
* 2. Purchaser contracts commonly exclude custodial care from their coverage of services and supplies
* 3. All of the criteria for coverage decisions must be included in the purchaser contract

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

Answer: B

NEW QUESTION 178
The Midwest Health Plan delegated utilization review (UR) activities to the Tri-City Utilization Review Organization. After Tri-City improperly recommended denial of payment for services to a Midwest plan member, the plan member filed suit. The court ruled that Midwest was responsible for Tri-City's actions because of the relationship between Midwest and Tri-City. This situation is an illustration of a legal concept known as

A. vicarious liability
B. fraud
C. a tying arrangement
D. subdelegation

Answer: A

NEW QUESTION 181
For this question, if answer choices (1) through (3) are all correct, select answer choice (4). Otherwise, select the one correct answer choice.
Health plans sometimes delegate selected medical management activities to their providers or other external entities. Activities that are frequently delegated include

A. utilization review (UR)
B. quality management (QM)
C. preventive health services
D. all of the above

Answer: A

NEW QUESTION 185
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 186
For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
The QAPI (Quality Assessment Performance Improvement Program) is a Centers for Medicaid and Medicare Services (CMS) initiative designed to strengthen health plans' efforts to protect and improve the health and satisfaction of Medicare beneficiaries. QAPI quality assessment standards apply to

A. standard medical-surgical services
B. mental health and substance abuse services
C. services offered to Medicare enrollees as optional supplementary benefits
D. all of the above

Answer: D

NEW QUESTION 191
Health plans arrange for the delivery of various levels of healthcare, including
* 1.Emergency care
* 2. Urgent care
* 3. Primary care delivered in a provider's office
In a ranking of these levels of care according to cost, beginning with the least expensive level of care and ending with the most expensive level of care, the correct order would be

A. 1—2—3
B. 2—3—1
C. 3—1—2
D. 3—2—1

Answer: D

NEW QUESTION 196
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