AHIP AHM-530 Practice Questions

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Question 1

Question Type: MultipleChoice

To protect providers against business losses, many health plan-provider contracts include carve-out provisions to help providers manage financial risk. The following statements are examples of such provisions:

The Apex Health Plan carves out immunizations from PCP capitations. Apex compensates PCPs for immunizations on a case rate basis.

The Bengal Health Plan carves out behavioral healthcare services from the scope of PCP services because these services require specialized knowledge and skills that most PCPs do not possess.

From the answer choices below, select the response that best identifies the types of carve-outs used by Apex and Bengal.

Options:

A- Apex: disease-specific carve-out Bengal: specialty services carve-out
B- Apex: disease-specific carve-out Bengal: specific-service carve-out
C- Apex: specific-service carve-out Bengal: specialty services carve-out
D- Apex: specific-service carve-out Bengal: disease-specific carve-out

Answer:

C

Question 2

Question Type: MultipleChoice

Network managers rely on a health plan's claims administration department for much of the information needed to manage the performance of providers who are not under a capitation arrangement. Examining claims submitted to a health plan's claims administration department enables the health plan to

Options:

A- determine the number of healthcare services delivered to plan members
B- monitor the types of services provided by the health plan's entire provider network
C- evaluate providers' practice patterns and compliance with the health plan's procedures for

the delivery of care
D- One benefit to a health plan in contracting with an integrated delivery system (IDS) is the ability to have a network in rapid order and to enter into a new market or one that is already competitive.

Answer:

D

Question 3

Question Type: MultipleChoice

The provider contract that Dr. Bijay Patel has with the Arbor Health Plan includes a no-balancebilling clause. The purpose of this clause is to:

Options:

A- prohibit Dr. Patel from collecting payments from Arbor plan members for medical services that he provided them, even if the services are explicitly excluded from the benefit plan
B- allow Dr. Patel to bill patients for services only if the services are considered to be medically necessary
C- establish the guidelines used to determine if Arbor is the primary payor of benefits in a situation in which an Arbor plan member is covered by more than one health plan
D- require Dr. Patel to accept Arbor's payment as payment in full for medical services that he provides to Arbor plan members

Answer:

D

Question 4

Question Type: MultipleChoice

An health plan enters into a professional services capitation arrangement whenever the health plan

Options:

A- Contracts with a medical group, clinic, or multispecialty IPA that assumes responsibility for

the costs of all physician services related to a patient's care
B- Pays individual specialists to provide only radiology services to all plan members
C- Transfers all financial risk for healthcare services to a provider organization and the provider, in turn, covers virtually all of a patient's medical expenses
D- Contracts with a primary care provider to cover primary care services only

Answer:

A

Question 5

Question Type: MultipleChoice

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which increased the continuity and portability of health insurance coverage. One statement that can correctly be made about HIPAA is that it

Options:

A- Applies to group health insurance plans only
B- Limits the length of a health plan's pre-existing condition exclusion period for a previously covered individual to a maximum of six months after enrollment.
C- Guarantees access to healthcare coverage for small businesses and previously covered individuals who meet specified eligibility requirements.
D- Guarantees renewability of group and individual health coverage, provided the insureds are still in good health

Answer:

C

Question 6

Question Type: MultipleChoice

Dr. Sarah Carmichael is one of several network providers who serve on one of the Apex Health Plan's organizational committees. The committee reviews cases against providers identified through complaints and grievances or through clinical monitoring activities. If needed, the committee formulates, approves, and monitors corrective action plans for providers. Although Apex administrators and other employees also serve on the committee, only participating providers have voting rights. The committee that Dr. Carmichael serves on is a

Options:

A- Utilization management committee
B- Peer review committee
C- Medical advisory committee
D- Credentialing committee

Answer:

B

Question 7

Question Type: MultipleChoice

Edward Patillo has established a Medicare+Choice medical savings account (MSA). This MSA will allow Mr. Patillo to:

Options:

A- Carry over any money remaining in his MSA at the end of the benefit year to the next benefit year
B- Make withdrawals at any time from the MSA, but only for medical expenses
C- Obtain payment at 100% of the Medicare allowable payment for all Medicare-covered services he receives, without having to pay any deductibles or out-of-pocket expenses
D- Make withdrawals from the MSA to meet qualified medical expenses that are not paid by his high-deductible health insurance policy, but these withdrawals are taxed as income to Mr. Patillo

Answer:

A

Question 8

Question Type: MultipleChoice

Jay Mercer is covered under his health plan's vision care plan, which includes coverage for clinical eye care but not for routine eye care. Recently, Mr. Mercer had a general eye examination and got a prescription for corrective lenses. Mr. Mercer's vision care plan will cover.

Options:

A- both the general eye examination and the prescription for corrective lenses
B- the general eye examination only
C- the prescription for corrective lenses only
D- neither the general eye examination nor the prescription for corrective lenses

Answer:

D

Question 9

Question Type: MultipleChoice

Health plans are required to follow several regulations and guidelines regarding the access and adequacy of their provider networks. The Federal Employee Health Benefits Program (FEHBP) regulations, for example, require that health plans

Options:

A- Allow members direct access to OB/GYN services
B- Allow members direct access to prescription drug services
C- Provide access to Title X family-planning clinics
D- Provide average office waiting times of no more than 30 minutes for appointments with plan providers

Answer:

D

Question 10

Question Type: MultipleChoice

The BBA of 1997 specifies the ways in which a Medicare+Choice plan can establish and use provider networks. A Medicare+Choice plan that operates as a private fee for service (PFFS) plan is allowed to

Options:

A- limit the size of its network to the number of providers necessary to meet the needs of its enrollees
B- require providers to accept as payment in full an amount no greater than 115% of the Medicare payment rate
C- refuse payment to non-network providers who submit claims for Medicare-covered expenses
D- shift all risk for Medicare-covered services to network providers

Answer:

B

Question 11

Question Type: MultipleChoice

Grant Pelham is covered by both a workers' compensation program and a group health plan provided by his employer. The Shipwright Health Plan administers both programs. Mr. Grant was injured while on the job and applied for benefits.

Because Mr. Pelham was injured on the job, he is entitled to receive benefits through workers' compensation. Under the terms of the state-mandated exclusive remedy doctrine included in the workers' compensation agreement, Mr. Pelham will most likely be prohibited from

Options:

A- Receiving workers' compensation benefits unless he can show that the employer was at fault for his injury
B- Obtaining care from providers who are not members of a workers' compensation network
C- Suing his employer for additional benefits
D- Claiming benefits from both workers' compensation and his group health plan

Answer:

C

Question 12

Question Type: MultipleChoice

Participating providers in a health plan's network must undergo recredentialing on a regular basis. During recredentialing, a health plan typically reviews

Options:

A- a provider's current, updated application information, as well as provider's peer reviews and performance reports on the provider
B- a provider's current, updated application information, as well as the provider's education and prior work history
C- a provider's education and prior work history only
D- peer reviews and performance reports on a provider and the provider's prior work history only

Answer:

A

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