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Question 1

Question Type: MultipleChoice

The following statements are about the delegation of network management activities from a health plan to another party. Three of the statements are true and one statement is false. Select the answer choice containing the FALSE statement:

Options:

A- The NCQA requires a health plan to conduct all delegation oversight functions rather than delegating the responsibility for oversight to another entity.

B- Credentialing and UM activities are the most frequently delegated functions, whereas delegation is less common for quality management (QM) and preventive health services.

C- One reason that a health plan may choose to delegate a function is because the health plan's staff seeks external expertise for the delegated activity.

D- When the health plan delegates authority for a function, it transfers the power to conduct the function on a day-to-day basis, as well as the ultimate accountability for the function.

Answer:

D

Question 2

Question Type: MultipleChoice

Assume that the national average cost per covered employee for PPO rental networks is $3 per member per month (PMPM) and that the average monthly healthcare premium PMPM is $300. This information indicates that, if the number of health plan members is 10,000, then the annual network rental cost to the health plan would be:

Options:

A- $30,000

B- $360,000

C- $9,000,000

D- $12,000,000

Answer:

B

Question 3

Question Type: MultipleChoice

The actual number of providers included in a provider network can be based on staffing ratios. One true statement about staffing ratios is that, typically:

Options:

A- A small health plan needs fewer physicians per 1,000 than does a large plan.

B- A closely managed health plan requires fewer providers than does a loosely managed plan.

C- Physician-to-enrollee ratios can be used directly only by network-within-a-network model HMOs.

D- Medicare products require fewer providers than do employer-sponsored plans of the same size.

Answer:

B

Question 4

Question Type: MultipleChoice

With regard to the laws and regulations on access and adequacy of provider networks, it can correctly be stated that:

Options:

A- most access and adequacy guidelines relate to preferred provider organizations (PPOs) or managed indemnity products

B- corporate practice of medicine laws require staff model HMOs to hire physicians directly, even if the physicians do not own the HMO

C- any willing provider laws prevent a health plan from making exclusive or semi-exclusive arrangements with a provider or a group of providers

D- the NAIC Managed Care Plan Network Adequacy Model Act requires states to use provider-enrollee ratios as the sole measure of network adequacy

Answer:

C

Question 5

Question Type: **MultipleChoice**

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.

From the following answer choices, select the response that best identifies Elm and Treble:

Options:

A- Elm: open access (OA) HMO Treble: direct access HMO

B- Elm: open access (OA) HMO Treble: gatekeeper HMO

C- Elm: direct access HMO Treble: open access (OA) HMO

D- Elm: direct access HMO Treble: gatekeeper HMO

Answer:

C

Question 6

Question Type: MultipleChoice

Factors that are likely to indicate increased health plan market maturity include:

Options:

A- Increased consolidation among health plans.

B- Increased rate of growth in health plan premium levels.

C- Areduction in the market penetration of HMO and point-of-service (POS) products.

D- Areduction in the frequency of performance-based reimbursement of providers.

Answer:

A

Question 7

Question Type: MultipleChoice

Following statements are about accreditation of health plans:

Options:

A- The National Committee for Quality Assurance (NCQA) serves as the primary accrediting agency for most health maintenance organizations (HMOs).

B- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has developed standards that can be used for the accreditation of hospitals, but not for the accreditation of health plan provider networks or health plan plans.

C- States are required to adopt the model standards developed by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators that develops standards to promote uniformity in insurance regulations.

D- Accreditation is an evaluative process in which a health plan undergoes an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the federal government or by the state governments.

Answer:

A

Question 8

Question Type: MultipleChoice

The Tuba Health Plan recently underwent an accreditation process under a program known as Accreditation '99, which includes selected Health Employer Data and Information Set (HEDIS) measures. Under Accreditation '99, Tuba received a rating of Excellent. The following statement(s) can correctly be made about this quality assessment of Tuba's operations:

Options:

A- In arriving at its rating of Excellent for Tuba, the Accreditation '99 program most likely focused on Tuba's demonstrated results and evaluated the processes that Tuba used to achieve those results.

B- Tuba is required to report all HEDIS results to the NAIC.

C- Both A and B

D- A only

E- B only

F- Neither A nor B

Answer:

B

Question 9

Question Type: MultipleChoice

If a member of the Green Health Plan reasonably believes that a provider in Green's provider network was acting as Green's employee or agent while providing negligent care, then the member may have cause to bring action against the health plan. This legal concept is known as vicarious liability. Steps that Green can take to reduce its exposure to vicarious liability claims include:

Options:

A- Placing restrictions on provider-member communication involving treatment decisions.

B- Implementing risk management and quality assurance programs for its provider network.

C- Including in its provider agreements and marketing and membership literature a statement that members of the Green provider network are not independent contractors.

D- All of the above.

Answer:

B

Question 10

Question Type: **MultipleChoice**

The following situations illustrate violations of federal antitrust laws:

Situation A Two HMOs split a large employer group by agreeing to let one HMO market to some company employees and to let the second HMO market to different company employees.

Situation B Members of a physician-hospital organization (PHO) that has significant market share jointly agreed to exclude a physician from joining the PHO solely because that physician has admitting privileges at a competing hospital.

From the following answer choices, select the response that best identifies the types of violations illustrated by these situations:

Options:

A- Situation A: horizontal division of territories; Situation B: group boycott

B- Situation A: horizontal division of territories; Situation B: exclusive arrangement

C- Situation A: exclusive arrangement; Situation B: group boycott

D- Situation A: exclusive arrangement; Situation B: tying arrangement

Answer:

A

Question 11

Question Type: MultipleChoice

The Adobe Health Plan complies with all of the provisions of the Newborns' and Mothers' Health Protection Act (NMHPA) of 1996. Kristen Netzger, an Adobe enrollee, was hospitalized for a cesarean delivery. Amy Davis, also an Adobe enrollee, was hospitalized for a normal delivery. From the following answer choices, select the response that indicates the minimum length of time for which Adobe, under NMHPA, most likely must provide benefits for the hospitalizations of Ms. Netzger and Ms. Davis.

Options:

A- Ms. Netzger = 48 hours Ms. Davis = 48 hours

B- Ms. Netzger = 72 hours Ms. Davis = 72 hours

C- Ms. Netzger = 96 hours Ms. Davis = 48 hours

D- Ms. Netzger = 96 hours Ms. Davis = 72 hours

Answer:

C

Question 12

Question Type: MultipleChoice

One true statement about the Employee Retirement Income Security Act of 1974 (ERISA) is that:

Options:

A- ERISA applies to all issuers of health insurance products, such as HMOs

B- pension plans and employee welfare plans are exempt from any regulation under ERISA

C- ERISA requires self-funded plans to comply with all state mandates affecting health insurance companies and health plans

D- the terms of ERISA generally take precedence over any state laws that regulate employee welfare benefit plans

Answer:

D