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Question 1

Question Type: MultipleChoice

The Crimson Health Plan, a competitive medical plan (CMP), has entered into a Medicare risk contract. One true statement about Crimson is that, as a:

Options:

A- CMP, Crimson is regulated by the federal government under the terms of the Tax Equity and Fiscal Responsibility Act (TEFRA)

B- CMP, Crimson is not allowed to charge a Medicare enrollee a premium for any additional benefits it provides over and above Medicare benefits

C- Provider under a Medicare risk contract, Crimson receives for its services a capitated payment equivalent to 85% of the AAPCC

D- Provider under a Medicare risk contract, Crimson is required to deliver to members all Medicare-covered services, without regard to the cost of those services

Answer:

D

Question 2

Question Type: MultipleChoice

The vision benefits offered by the Omni Health Plan include clinical eye care only. The following statements describe vision care received by Omni plan members:

Brian Pollard received treatment for a torn retina he suffered as a result of an accident

Angelica Herrera received a general eye examination to test her vision

Megan Holtz received medical services for glaucoma

Of these medical services, the ones that most likely would be covered by Omni's vision coverage would be the services received by:

Options:

A- Mr. Pollard, Ms. Herrera, and Ms. Holtz

B- Mr. Pollard and Ms. Herrera only

C- Mr. Pollard and Ms. Holtz only

D- Ms. Herrera and Ms. Holtz only

Answer:

C

Question 3

Question Type: MultipleChoice

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

Options:

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 4

Question Type: MultipleChoice

The Walnut Health Plan provides a number of specialty services for its members. Walnut offers coverage of alternative healthcare, including coverage of treatment methods such as homeopathy and naturopathy. Walnut also offers home healthcare services, and it contracts with home healthcare providers on a non-risk basis to the health plan. The following statements are about the specialty services offered by Walnut. Select the answer choice containing the correct statement:

Options:

A- Homeopathy treats diseases by using small doses of substances which, in healthy people, are capable of producing symptoms like those of the disease being treated.

B- Naturopathy is an approach to healthcare that uses electronic monitoring devices to teach a patient to develop conscious control of involuntary bodily functions, such as heart rate.

C- Under a non-risk contract, Walnut most likely transfers the responsibility for arranging home healthcare to the home healthcare provider organizations.

D- Federal law allows Walnut to contract with a home healthcare provider organization only if the provider organization has received accreditation by the Utilization Review Accreditation Commission (URAC).

Answer:

A

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 IP

Options:

A- 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

Question 6

Question Type: MultipleChoice

A health plan has several options for delivering pharmacy services to its subscribers. Each option has potential advantages to a health plan. An advantage to a health plan of using:

Options:

A- performance-based open networks is that they tend to increase participation in the pharmacy network.

B- closed networks is that they improve the health plan's ability to set standards and implement cost-control programs for pharmacy services.

C- customized networks is that they typically are inexpensive to operate.

D- open networks is that they tend to improve the health plan's ability to control pharmaceutical costs.

Answer:

B

Question 7

Question Type: MultipleChoice

In health plan pharmacy networks, service costs consist of two components: costs for services associated with dispensing prescription drugs and costs for cognitive services. Cognitive services typically include:

Options:

A- making generic substitutions of drugs

B- counseling patients about prescriptions

C- providing patient monitoring

D- switching prescription drugs to preferred drugs

Answer:

B

Question 8

Question Type: MultipleChoice

The following statements describe two types of HMOs:

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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.

To calculate its drug costs, Elm uses a pricing system known as:

Options:

A- Estimated acquisition cost (EAC)

B- Package rate cost (PRC)

C- Actual acquisition cost (AAC)

D- Wholesale acquisition cost (WAC)

Answer:

A

Question 9

Question Type: MultipleChoice

Reimbursement for prescription drugs and services in a third-party prescription drug plan typically follows one of two approaches: a reimbursement approach or a service approach. One true statement about these approaches is that:

Options:

A- Payments under the reimbursement method typically are not subject to any copayment or deductible requirements

B- Payments under the reimbursement approach are typically based on a structured reimbursement schedule rather than on usual, customary, and reasonable (UCR) charges

C- Most major medical plans follow a service approach

D- Most current health plan prescription drug plans are service plans

Answer:

D

Question 10

Question Type: MultipleChoice

The Pine Health Plan has incorporated pharmacy benefits management into its operations to form a unified benefit. Potential advantages that Pine can receive from this action include:

Options:

A- the fact that unified benefits improve the quality of patient care and the value of pharmacy services to Pine's plan members

B- the fact that control over the formulary and network contracting can give Pine control over patient access to prescription drugs and to pharmacies

C- the fact that managing pharmacy benefits in-house gives Pine a better chance to meet customer needs by integrating pharmacy services into the plan's total benefits package

D- all of the above

Answer:

D