Free Questions for AHM-510 by vceexamstest

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Question 1

Question Type: MultipleChoice

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Services for which states can require copayments from Medicaid recipients include:

Options:

A- Emergency services

B- Family planning services

C- Both A and B

D- A only

E- B only

F- Neither A nor B

Answer:

D

Question 2

Question Type: MultipleChoice

From the following answer choices, choose the term that best corresponds to this description. The SureQual Group is a group of practicing physicians and other healthcare professionals paid by the federal government to review services ordered or furnished by other practitioners in the same medical fields for the purpose of determining whether medical services provided were reasonable and necessary, and to monitor the quality of care given to Medicare patients.

Options:

A- Health insuring organization (HIO)

B- Independent practice association (IPA)

C- Physician practice management (PPM) company

D- Peer review organization (PRO)

Answer:

D

Question 3

Question Type: MultipleChoice

The Balanced Budget Act (BBA) of 1997 created the Medicare+Choice plan. One provision of the BBA under Medicare+Choice is that the BBA

Options:

A- Requires health plans to qualify as either a competitive medical plan (CMP) or a federally qualified HMO in order to participate in the Medicare program

B- Eliminates funding for demonstration projects such as the Medicare Enrollment Demonstration Project

C- Narrows the geographic variations in payments to Medicare health plans by lowering the growth rate of payments in high-payment counties and raising the rates in low-payment counties

D- Increases Graduate Medical Education (GME) payments to hospitals for the training and cost of educating and training residents

Answer:

C

Question 4

Question Type: MultipleChoice

Solvency standards for Medicare provider-sponsored organizations (PSOs) are divided into three parts:

(1) the initial stage,

(2) the ongoing stage, and

(3) insolvency. In the initial stage, prior to CMS approval, a Medicare PSO typically must have a minimum net worth of

Options:

A- $750,000

B- $1,000,000

C- $1,500,000

D- $2,000,000

Answer:

C

Question 5

Question Type: MultipleChoice

TRICARE, a military healthcare program, offers eligible beneficiaries three options for healthcare services: TRICARE Prime, TRICARE Extra, and TRICARE Standard. With respect to plan features, both an annual deductible and claims filing requirements must be met, regardless of whether care is delivered by network providers, under

Options:

A- TRICARE Prime and TRICARE Extra only

B- TRICARE Extra and TRICARE Standard only

C- TRICARE Standard only

D- None of these healthcare options

Answer:

C

Question 6

Question Type: **MultipleChoice**

The following statements are about the Federal Employees Health Benefits Program (FEHBP), which is administered by the Office of Personnel Management (OPM). Three of the statements are true and one statement is false. Select the answer choice that contains the

FALSE statement.

Options:

A- For every plan in the FEHBP, OPM annually determines the lowest premium that is actuarially sound and then negotiates with each plan to establish that premium rate.

B- Once a health plan has submitted its rate proposals for a contract year to the OPM, it cannot adjust its premium rate for any reason.

C- To cover its administrative costs, OPM sets aside 1% of all FEHBP premiums.

D- Each spring, OPM sends all plan providers its call letter, a document that specifies the kinds of benefits that must be available to plan participants and cost goals and procedural changes that the plans need to adopt.

Answer:

A

Question 7

Question Type: MultipleChoice

In the paragraph below, a statement contains two pairs of terms enclosed in parentheses. Determine which term in each pair correctly completes the statement. Then select the answer choice containing the two terms that you have chosen.

In the case of Pacificare of Oklahoma, Inc. v. Burrage, the U.S. Court of Appeals for the Tenth Circuit considered whether ERISA preempts medical malpractice claims against health plans based on certain liability theories. In this case, the Tenth Circuit court held that ERISA (should / should not) preempt a liability claim against an HMO for the malpractice of one of its primary care physicians, and therefore the HMO was subject to a claim of (subordinated / vicarious) liability.

Options:

A- Should / subordinated

B- Should / vicarious

C- Should not / subordinated

D- Should not / vicarious

Answer:

D