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Healthcare Management: An Introduction

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Topic 1, Volume A

QUESTION NO: 1

The following statements describe two types, or models, of HMOs:

The Quest HMO has contracted with only one multi-specialty group of physicians. These physicians are employees of the group practice, have an equity interest in the practice, and provide

A. A captive group a staff model
B. A captive group a network model
C. An independent group a network model
D. An independent group a staff model

Answer: B
Explanation:

QUESTION NO: 2

_____ HMOs can't medically underwrite any group – incl small groups.

A. State
B. Not-for-profit
C. For-profit
D. Federally qualified

Answer: B
Explanation:

QUESTION NO: 3

A common physician-only integrated model is a group practice without walls (GPWW). One characteristic of a typical GPWW is that the

A. GPWW combines multiple independent physician practices under one umbrella organization
B. GPWW generally has a lesser degree of integration than does an IPA
C. member physicians cannot own the GPWW
D. GPWW's member physicians must perform their own business operations

Answer: A

Explanation:

QUESTION NO: 4

A health plan may use one of several types of community rating methods to set premiums for a health plan. The following statements are about community rating. Select the answer choice containing the correct statement.

A. Standard (pure) community rating is typically used for large groups because it is the most competitive rating method for large groups.
B. Under standard (pure) community rating, a health plan charges all employers or other group sponsors the same dollar amount for a given level of medical benefits or health plan, without adjusting for factors such as age, gender, or experience.
C. In using the adjusted community rating (ACR) method, a health plan must consider the actual experience of a group in developing premium rates for that group.
D. The Centers for Medicare and Medicaid Services (CMS) prohibits health plans that assume Medicare risk from using the adjusted community rating (ACR) me

Answer: B
Explanation:

QUESTION NO: 5

A health plan's ability to establish an effective provider network depends on the characteristics of the proposed service area and the needs of proposed plan members. It is generally correct to say that

A. health plans have more contracting options if providers are affiliated with single entities than if providers are affiliated with multiple entities
B. urban areas offer more flexibility in provider contracting than do rural areas
C. consumers and purchasers in markets with little health plan activity are likely to be more receptive to HMOs than to loosely managed plans such as PPOs
D. large employers tend to adopt health plans more slowly than do small companies

Answer: B
Explanation:

QUESTION NO: 6

A health savings account must be coupled with an HDHP that meets federal requirements for minimum deductible and maximum out-of-pocket expenses. Dollar amounts are indexed annually for inflation. For 2006, the annual deductible for self-only coverage must

A. $525
B. $1,050
C. $2,100
D. $5,250

Answer: B
Explanation:

QUESTION NO: 7

A medical foundation is a not-for-profit entity that purchases and manages physician practices. In order to retain its not-for-profit status, a medical foundation must

A. Provide significant benefit to the community
B. Employ, rather than contract with, participating physicians
C. Achieve economies of scale through facility consolidation and practice management
D. Refrain from the corporate practice of medicine

Answer: A
Explanation:

QUESTION NO: 8

A particular health plan offers a higher level of benefits for services provided in-network than for out-of-network services. This health plan requires preauthorization for certain medical services.

With regard to the steps that the health plan's claims e

A. should assume that all services requiring preauthorization have been preauthorized
B. should investigate any conflicts between diagnostic codes and treatment codes before approving the claim to ensure that the appropriate payment is made for the claim
C. need not verify that the provider is part of the health plan's network before approving the claim at the in-network level of benefits
D. need not determine whether the member is covered by another health plan that allows for coordination of benefits