AHIP AHM-530 Exam

Volume A~B: 202 Questions

Volume A

Question No: 1
By definition, a measure of the extent to which a health plan member can obtain necessary medical services in a timely manner is known as

A. Network management

B. Quality

C. Cost-effectiveness

D. Accessibility

Answer: D

Question No: 2
Decide whether the following statement is true or false:
The organizational structure of a health plan's network management function often depends on the size and geographic scope of the health plan. With respect to the size of a health plan, it is correct to say that smaller health plans typically have less integration and more specialization of roles than do larger health plans.

A. True

B. False

Answer: B

Question No: 3
The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement.
One important activity within the scope of network management is ensuring the quality of the health plan's provider networks. A primary purpose of _____ is to review the clinical competence of a provider in order to determine whether the provider meets the health plan's preestablished criteria for participation in the network.

A. authorization

B. provider relations

C. credentialing

D. utilization management

Answer: C

Question No: 4
One important aspect of network management is profiling, or provider profiling. Profiling is most often used to

A. measure the overall performance of providers who are already participants in the network

B. assess a provider's overall satisfaction with a plan's service protocols and other operational areas

C. verify a prospective provider's professional licenses, certifications, and training

D. familiarize a provider with a plan's procedures for authorizations and referrals

Answer: A

Question No: 5
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

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. all of the above

Answer: D

Question No: 6
The Avignon Company discontinued its contract with a traditional indemnity insurer and contracted

exclusively with the Minaret Health Plan to provide the sole healthcare plan to Avignon's employees. By agreeing to an exclusive contract with Minaret, Avignon has entered into a type of healthcare contract known as

A. a carrier guarantee arrangement

B. open access

C. total replacement coverage

D. selective contract coverage

Answer: C

Question No: 7
Federal laws–including the Ethics in Patient Referrals Act, the Health Maintenance Organization (HMO) Act of 1973, the Employee Retirement Income Security Act (ERISA), and the Federal Trade Commission Act–have impacted the ways that health plans conduct business. For instance, the Mosaic Health Plan must comply with the following federal laws in order to operate:
Regulation 1: Mosaic must establish a mandated grievance resolution mechanism, including a method for members to address grievances with network providers.
Regulation 2: Mosaic must not allow its providers to refer Medicare and Medicaid patients to entities in which they have a financial or ownership interest.
From the answer choices below, select the response that correctly identifies the federal legislation on which Regulation 1 and Regulation 2 are based.

A. Regulation 1 - The Ethics in Patient Referrals Act Regulation 2 - The HMO Act of 1973

B. Regulation 1 - The HMO Act of 1973 Regulation 2 - The Ethics in Patient Referrals Act

C. Regulation 1 - ERISA Regulation 2 - The Federal Trade Commission Act

D. Regulation 1 - The Federal Trade Commission Act Regulation 2 - ERISA

Answer: B

Question No: 8
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

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 No: 9
After HIPAA was enacted, Congress amended the law to include the Mental Health Parity Act (MHPA) of 1996, a federal requirement relating to mental health benefits. One true statement about the MHPA is that it

A. requires all health plans to provide coverage for mental health services

B. requires health plans to carve out mental/behavioral healthcare from other services provided by the plans

C. allows health plans to require patients receiving mental health services to pay higher copayments than patients seeking treatment for physical illnesses

D. prohibits health plans that offer mental health benefits from applying more restrictive limits on coverage for mental illness than on coverage for physical illness

Answer: D

Question No: 10
From the following answer choices, choose the term that best matches the description.
An integrated delivery system (IDS), which controls most providers in a particular specialty, agrees to provide that specialty service to a health plan only on the condition that the health plan agree to contract with the IDS for other services.

A. Group boycott

B. Horizontal division of territories

C. Tying arrangements

D. Concerted refusal to admit

Answer: C

Question No: 11
From the following answer choices, choose the term that best matches the description.
Members of a physician-hospital organization (PHO) denied membership to a physician solely because the physician has admitting privileges at a competing hospital.

A. Group boycott

B. Horizontal division of territories

C. Tying arrangements

D. Concerted refusal to admit

Answer: A

Question No: 12
Some states have enacted any willing provider laws. From the perspective of the health plan industry, one drawback of any willing provider laws is that they often result in a reduction of a plan's

A. Premium rates

B. Ability to monitor utilization

C. Number of primary care providers (PCPs)

D. Number of specialists and ancillary providers

Answer: B

Question No: 13
In the paragraph below, two statements each contain a pair of terms enclosed in parentheses.
Determine which term correctly completes each statement. Then select the answer choice that contains the two terms you have chosen.
In most states, a health plan can be held responsible for a provider's negligent malpractice. This legal