ABMCN CMCN Exam

Volume: 396 Questions

Question: 1
Which plan did the American Hospital Association develop in the 1920s to stabilize hospitals and guarantee payment of bills during The Depression?

A. Blue Cross

B. Kaiser Permanente

C. Blue Cross Blue Shield

D. None of the above

Answer: A

Explanation: Blue Cross was developed by the American Hospital Association in the 1920s.
The American Hospital Association initiated the “Blue Cross Concept” in the 1920s to stabilize hospitals and guarantee payment of bills. The Depression sent many hospitals into financial downfall. Kaiser Permanent and Blue Shield were plans developed in later years.

Question: 2
What plan did Congress initiate in response to the health care crisis in 1965?

A. Medicare and Medicaid

B. Free insurance

C. Blue Cross Blue Shield

D. Kaiser Permanente

E. None of the above

Answer: A

Explanation: Medicare and Medicaid were initiated in 1965 as a response to the health care crisis.
Unlike Blue Cross Blue Shield and other health plans, these plans are federally based and federally funded.

Question: 3
When did the first commercial insurance plan come into existence?

A. During the Great Depression of the 1920s

B. After World War II

C. During the Vietnam War

D. During World War I

Answer: B

Explanation: The first commercial insurance plan came into existence after World War II. This era was considered to be part of the Industrial Age. It was a time of increased growth for America and, in turn, the healthcare field as the importance of wellness gained increase value.

Question: 4
What plans offered the first indemnity benefit?

A. Blue Cross

B. Blue Cross Blue Shield

C. Commercial insurance

D. CMS

Answer: C

Explanation: Commercial insurance offered the first indemnity benefit.
Blue Cross Blue Shield eventually adapted in order to stay competitive.

Question: 5
Which of the following statements reflects the intent for the introduction of managed care organizations?

A. Create a plan for physicians to treat all patients with a “cookie cutter” plan of care

B. Impact efficiency, access, cost, and quality of health care

C. Decrease private practice clinics

D. All of the above

Answer: B

Explanation: Impacting efficiency, access, cost, and quality of health care reflects the intent of the introduction of managed care organizations.

Question: 6
Select the best description of a traditional indemnity insurance plan.

A. Money follows the member

B. Member can select which provider to use

C. Involves copayments or deductibles

D. All of the above

Answer: D

Explanation: Traditional indemnity insurance plans involve copayments or deductibles, the member can select their provider, and the money follows the member.
This plan allows the providers to submit for reimbursement based on “fee-for-service.”

Question: 7
One of the first examples cited of health care maintenance was in:

A. 1910 - Washington

B. 1929 - Oklahoma

C. 1942 - California

D. 1937 - Colorado

Answer: A

Explanation: One of the first examples cited of health care maintenance was in Washington in 1910.

In 1910, one of the first examples of health care maintenance was with private physicians at the Western Clinic of Tacoma, Washington. This insurance was offered to lumber mill owners and employees. The plan had a variety of services with requirement of a monthly premium.

Question: 8
Which Act of 1973 was a major impetus to the HMO plan movement?

A. Social Security Act

B. Federal Health Maintenance Organization Act

C. Medicaid Preadmission Authorization Act

D. None of the above

Answer: B

Explanation: The Federal Health Maintenance Organization Act was a major impetus to the HMO plans movement.
Dr. Paul Elwood in 1970 began conversations with what was then the U.S. Department of Health and Human Services. The idea was to offer seed money and access to employer-based healthcare markets.

Question: 9
Who authorized the Health Planning Act of 1966?

A. President Lyndon B. Johnson

B. The Federal Health Maintenance Organization

C. President Robert F. Kennedy

D. President Richard M. Nixon

Answer: A

Explanation: President Lyndon B. Johnson authorized the Health Planning Act of 1966.
President Johnson worked with Dr. Paul Ellwood to write this Act on behalf of funding and increase of access to the employer-based health insurance market. Dr. Ellwood also consulted with President Nixon on finding ways to reduce healthcare costs for Medicare.

Question: 10
Which historical person is sometimes referred to as “the father of the modern HMO movement?”

A. President Lyndon B. Johnson

B. Dr. Paul Ellwood

C. Dr. Henry J Kaiser

D. President Richard M. Nixon

Answer: B

Explanation: Dr. Paul Ellwood is sometimes referred to as “the father of the modern HMO movement.”
He played a vital role in the foundational work with HMOs to include being a catalyst for the HMO Act of 1973 and the Medicare capitation system.

Question: 11
In what year was the Medicare capitation system implemented?

A. 1966

B. 1963

C. 1988

D. 1982

Answer: D

Explanation: The Medicare capitation system was implemented in 1982.
During the Nixon administration, the president consulted with Dr. Paul Ellwood on finding ways to control Medicare health care costs. Dr. Paul Ellwood played a vital role in the foundational work with HMOs to include being a catalyst for the HMO Act of 1973 and the Medicare capitation system.

Question: 12
Select the answer that best describes the earliest and most accurate historical indications of utilization management.

A. Utilization management appeared around 1950 in the private healthcare sector, prior to the existence of HMOs.

B. California increased requirements around the Medicaid program in 1970 to include preadmission and concurrent review of hospital admissions.

C. In 1959, healthcare agencies in Pennsylvania began to look at retrospective data related to hospital claim outliers.

D. In early 1950, healthcare agencies in Washington State under the direction of Dr. Ellwood formed a peer organization to review retrospective data from hospital admissions.

Answer: C

Explanation: The earliest and most accurate historical indications of utilization management was in 1959 with healthcare agencies in Pennsylvania. These agencies began to look at retrospective data related to hospital claim outliers.
A group of healthcare professional organizations in Pennsylvania, including Blue Cross of Western Pennsylvania formed a conglomeration. The goal was to retrospectively review hospital claims that fell outside of the average cost range. There is no indication of utilization management in the private sector in 1950 or with Dr. Ellwood playing a direct role in the UM process. The statements about California are true; however do not reflect the earliest indication of UM.

Question: 13
What statement describes a critical catalyst to the early beginnings of Blue Cross Blue Shield and other HMOs?

A. Patients were demanding low-cost insurance plans to avoid direct out of pocket health care expenses.

B. Non-healthcare businesspersons desired to open for-profit entities.

C. Health care providers wanted to sustain and grow profits.

D. Health care agencies began to look at retrospective data related to hospital claims.

Answer: C

Explanation: A critical catalyst in the early beginnings of Blue Cross Blue Shield and other HMOs was related to health care providers' desire to sustain and grow profits.

Question: 14
Which statement best describes the structure of a HMO model? (Choose all that apply)

A. HMO structure depends upon cost-containing measures like the use of mid-level providers to care for patients.

B. The HMO structure depends upon private pay members to sustain revenues and does not accept members with federally funded healthcare insurance.

C. HMOs financial structure is dependent upon a certain monthly rate per member/per month.

Answer: A,B,C

Explanation: The structure of an HMO model includes cost-containing measures like the use of mid-level providers to care for patients and a financial structure that is dependent upon a certain monthly rate per member per month.

Question: 15
Select the answer that best describes HIAA.

A. Organization that merged with the AAHP in 2003 to form the AHIP

B. Conglomeration of healthcare plans that provide free healthcare to impoverished U.S. citizens within the federal poverty income parameters

C. Ensures and funds free insurance for underprivileged households

D. None of the above

Answer: A

Explanation: HIAA is the organization that merged with the AAHP in 2003 to form the AHIP.

Question: 16
Which of the following describe managed care phases of development. (Choose all that apply)

A. Managing patient “throughput” project in the emergency room

B. Managing access through utilization review

C. Outcome measures and comprehensive medical services

Answer: B,C

Explanation: Managing access through utilization review and outcomes measures and comprehensive medical services are considered managed care phases of development.
The managed care concept has gone through four conceptual phases of development since the 1980s.

Question: 17
Which statement is incorrect about HIAA?

A. Involved in health insurance plans research

B. Provides public education about insurance plans

C. Advocate for healthcare insurance reforms

D. Functions as a for-profit association group working for federal healthcare systems

Answer: D

Explanation: Functions as a for-profit association group working for federal healthcare systems is an incorrect statement about HIAA.
The Health Insurance Association of America (HIAA) functions as a trade association group working for private insurance plans.

Question: 18
Which statement is correct about indemnity and managed care plans?

A. Managed care plan members utilize inpatient services less frequently than indemnity plan members.

B. There is no out-of-pocket health care expense with either the indemnity or managed care plans.

C. Indemnity plan members utilize preventative services more often than managed care members..

D. Patients can obtain additional inpatient amenities, i.e. private rooms at no additional costs with indemnity plans.

Answer: A

Explanation: Managed care members utilize inpatient services less frequently than indemnity plan members.

Question: 19
Which statement most closely describes the managed care concept?

A. Implementation of utilization review, utilization management, and outcome measures to analyze and improve care

B. Conglomeration of providers caring for groups of members

C. Implementation of cost-containment measures through proven efficiencies in quality monitoring and improvement and preventive and health education

D. All of the above

Answer: D

Explanation: The managed care concept is a conglomeration of providers caring for groups of members. UR, UM, and outcome results were implemented to analyze and improve care. Proven efficiencies in quality monitoring and improvement in preventative health education were implemented as cost-containing measures.

Question: 20
Which statement provides a correct description of how managed care impacts health care costs?

A. The managed care financial structure is based on fee-for-service. This allows for cost containment as there is only money exchanged when a service is provided.

B. The responsibility for member health care coordination is upon the managed care programs

C. A and B

Answer: B

Explanation: Managed care impacts health care costs through the responsibility for member health care coordination.
The managed care program has the responsibility to coordinate member health care. The managed care programs are owned by health insurance companies and providers. This is one of the concepts that has proven cost-containment efficiencies.

Question: 21
What was the cost of health care according to the National Health Expenditure Data for CMS (2015)?

A. $2.3 billion

B. $4.2 billion

C. $1.5 trillion

D. $3.2 trillion

Answer: D

Explanation: The cost of health care according to the National Health Expenditure Data for CMS (2015) was $3.2 trillion.
This equals approximately $9,999 per person.

Question: 22
During a quarterly review of an organization's managed care chronic illness caseload, you identify the following:
Three hundred (300) medical record numbers appear 50% more often than the average for emergency room visits and hospitalizations. The total number of cases is 1,000.
Select the best description of action steps to reduce the organization's health care costs.

A. No action required. This is not abnormal for members with chronic illness.

B. Run a report specific for the 300 medical records and compare with the next quarters report.

C. Run a specific report for the 300 medical record numbers. Analyze the data for common factors, variables, variances, and outlier data against the sample average.

D. Ensure this information is sent to the CFO. This is not relevant data for your role as a CMCN.

Answer: C

Explanation: The best description of actions steps to impact organizations health care costs includes running a specific report for the 300 medical record numbers. Analyze the data for common factors, variances and outlier data against the sample average.
This task is definitely a part of the CMCN role as it relates to health care costs and quality care monitoring.