AHIP

Exam AHM-250

Healthcare Management: An Introduction

Version: 4.0

[Total Questions: 367]

Topic break down

Topic	No. of Questions
Topic 1: Volume A	100
Topic 2: Volume B	100
Topic 3: Volume C	167

Topic 1, Volume A

Question No : 1 - (Topic 1)

In order to cover some of the gap between FFS Medicare coverage and the actual cost of services, beneficiaries often rely on Medicare supplements. Which of the following statements about Medicare supplements is correct?

A. The initial ten (A-J) Medigap policies offer a basic benefit package that includes coverage for Medicare Part A and Medicare Part B coinsurance.
B. Each insurance company selling Medigap must sell all the different Medigap policies.
C. Medicare SELECT is a Medicare supplement that uses a preferred provider organization (PPO) to supplement Medicare Part A coverage.
D. Medigap benefits vary by plan type (A through L), and are not uniform nationally.

Answer: A

Question No : 2 - (Topic 1)

Brokers are one type of distribution channel that health plans use to market their health plans. One true statement about brokers for health plan products is that, typically, brokers

A. Are not required to be licensed by the states in which they market health plans
B. Are compensated on a salary basis
C. Represent only one health plan or insurer
D. Are considered to be an agent of the buyer rather than an agent of the health plan or Insurer

Answer: D

Question No : 3 - (Topic 1)

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

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

Answer: B

Question No : 4 - (Topic 1)

From the following answer choices, choose the description of the ethical principle that best corresponds to the term Beneficence

A. Health plans and their providers are obligated not to harm their members
B. Health plans and their providers should treat each member in a manner that respects the member's goals and values, and they also have a duty to promote the good of the members as a group
C. Health plans and their providers should allocate resources in a way that fairly distributes benefits and burdens among the members
D. Health plans and their providers have a duty to respect the right of their members to make decisions about the course of their lives

Answer: B

Question No : 5 - (Topic 1)

Before the Hill Health Maintenance Organization (HMO) received a certificate of authority (COA) to operate in State X, it had to meet the state's licensing requirements and financial standards which were established by legislation that is identical to the

A. Hill had to have an initial net worth of at least $1.5 million in order to obtain a COA.
B. The COA most likely exempts Hill from any of State X's enabling statutes.
C. Hill had to be organized as a partnership in order to obtain a COA
D. The COA in no way indicates that Hill has demonstrated that it is fiscally sound.

Answer: A

Question No : 6 - (Topic 1)

From the following answer choices, choose the description of the ethical principle that best corresponds to the term Beneficence

A. Health plans and their providers are obligated not to harm their members

B. Health plans and their providers should treat each member in a manner that respects the member's goals and values, and they also have a duty to promote the good of the members as a group
C. Health plans and their providers should allocate resources in a way that fairly distributes benefits and burdens among the members
D. Health plans and their providers have a duty to respect the right of their members to make decisions about the course of their lives

Answer: B

Question No : 7 - (Topic 1)

Dr. Julia Phram is a cardiologist under contract to Holcomb HMO, Inc., a typical closed-panel plan. The following statements are about this situation. Select the answer choice containing the correct statement.

A. All members of Holcomb HMO must select Dr. Phram as their primary care physician (PCP).
B. Any physician who meets Holcomb's standards of care is eligible to contract with Holcomb HMO as a provider.
C. Dr. Phram is either an employee of Holcomb HMO or belongs to a group of physicians that has contracted with Holcomb HMO
D. Holcomb HMO plan members may self-refer to Dr. Phram at full benefits without first obtaining a referral from their PCPs.

Answer: A

Question No : 8 - (Topic 1)

By offering a comprehensive set of healthcare benefits to its members, an HMO ensures that its members obtain quality, cost-effective, and appropriate medical care. Ways that an HMO provides comprehensive care include

A. coordinating care across a variety of benefits
B. emphasizing preventive care by covering many preventive services either in full or with a small copayment
C. offering its members access to wellness programs
D. All of the above

Answer: D

Question No : 9 - (Topic 1)

As part of its quality management program, the Lyric Health Plan regularly compares its practices and services with those of its most successful competitor. When Lyric concludes that its competitor's practices or services are better than its own, Lyric im

A. Benchmarking.
B. Standard of care.
C. An adverse event.
D. Case-mix adjustment.

Answer: A

Question No : 10 - (Topic 1)

In response to the demand for a method of assessing outcomes, accrediting organizations and other government and commercial groups have developed quantitative measures of quality that consumers, purchasers, regulators, and others can use to compare health

A. quality standards
B. accreditation decisions
C. standards of care
D. performance measures

Answer: D

Question No : 11 - (Topic 1)

In 1999, the United States Congress passed the Financial Services Modernization Act, referred to as the Gramm-Leach-Bliley (GLB) Act. The primary provisions included under the GLB Act require financial institutions, including health plans, to take several

A. Notify customers of any sharing of non-public personal financial information with nonaffiliated third parties.
B. Prohibit customers from having the opportunity to 'opt-out' of sharing non-public personal financial information.

C. Disclose to affiliates, but not to third parties, their privacy policies regarding the sharing of nonpublic personal financial information.
D. Agree not to disclose personally identifiable financial information or personally identifiable health information.

Answer: A

Question No : 12 - (Topic 1)

Ed Murray is a claims analyst for a managed care plan that provides a higher level of benefits for services received in-network than for services received out-of-network. Whenever Mr. Murray receives a health claim from a plan member, he reviews the claim

A. A, B, C, and D
B. A and C only
C. A, B, and D only
D. B, C, and D only

Answer: A

Question No : 13 - (Topic 1)

If left unresolved, member complaints about the actions or decisions made by a health plan or its providers can lead to formal appeals. One procedure health plans can use to address formal appeals is to submit the original decision and any supporting info

A. A Level One appeal, and the member has the right to a further appeal
B. A Level Two appeal, and the reviewer's decision is final and binding
C. An independent external appeal, and the member has the right to a further appeal
D. Arbitration, and the reviewer's decision is final and binding

Answer: A

Question No : 14 - (Topic 1)

Health plans require utilization review for all services administered by its participating physicians.

A. True
B. False

Answer: B

Question No : 15 - (Topic 1)

HMOs typically employ several techniques to manage provider utilization and member utilization of medical services. One technique that an HMO uses to manage member utilization is

A. the use of physician practice guidelines
B. the requirement of copayments for office visits
C. capitation
D. risk pools

Answer: B

Question No : 16 - (Topic 1)

Health plans can organize under a not-for-profit form or a for-profit form. One true statement regarding not-for-profit health plans is that these organizations typically

A. are exempt from review by the Internal Revenue Service (IRS)
B. are organized as stock companies for greater flexibility in raising capital
C. rely on income from operations for the large cash outlays needed to fund long-term projects and expansion
D. engage in lobbying or political activities in order to maintain their tax-exempt status

Answer: C

Question No : 17 - (Topic 1)

Emily Brown works for Integral Health Plan and represents the company as a board member for the board of directors. Which best describes Emily's position?

A. Community Representative

B. Inside Director
C. Outside Director
D. None of these

Answer: B

Question No : 18 - (Topic 1)

In order to generate exchanges with consumers, healthcare plan marketers use the four elements of the marketing mix: product, price, place (distribution), and

A. segmentation
B. publicity
C. promotion
D. plan design

Answer: C

Question No : 19 - (Topic 1)

In 1999, the United States Congress passed the Financial Services Modernization Act, which is referred to as the Gramm-Leach-Bliley (GLB) Act. The following statement(s) can correctly be made about this act:

A. The GLB Act allows convergence among the transaction
B. A only
C. Both A and B
D. B only
E. Neither A nor B

Answer: B

Question No : 20 - (Topic 1)

A public employer, such as a municipality or county government would be considered which of the following?

A. Employer-employee group
B. Multiple-employer group
C. Affinity group
D. Debtor-creditor group

Answer: A

Question No : 21 - (Topic 1)

During an open enrollment period in 1997, Amy Hadek enrolled through her employer for group health coverage with the Owl Health Plan, a federally qualified HMO. At the time of her enrollment, Ms. Hadek had three pre-existing medical conditions: angina, fo

A. the angina, the high blood pressure, and the broken ankle
B. the angina and the high blood pressure only
C. none of these conditions
D. the broken ankle only

Answer: A

Question No : 22 - (Topic 1)

For providers, integration occurs when two or more previously separate providers combine under common ownership or control, or when two or more providers combine business operations that they previously carried out separately and independently. Such provi

A. higher costs for health plans, healthcare purchasers, and healthcare consumers
B. improved provider contracting position with health plans
C. an increase in providers' autonomy and control over their own work environment
D. all of the above

Answer: B

Question No : 23 - (Topic 1)

Before an HMO contracts with a physician, the HMO first verifies the physician's credentials.