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Topic Break Down

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Topic 1, Volume A	103
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QUESTION NO: 1

The sizes of the businesses in a market affect the types of health programs that are likely to be purchased. Compared to smaller employers (those with fewer than 100 employees), larger employers (those with more than 1,000 employees) are

A. more likely to contract with indemnity health plans

B. more likely to offer their employees a choice in health plans

C. less likely to contract with health plans

D. less likely to require a wide variety of benefits

ANSWER: B

Explanation:

“more likely to offer their employees a choice in health plans” is correct because large employers typically have a sufficiently broad and diverse workforce to support multiple health-plan options. Their greater enrollment volume gives them stronger purchasing leverage and makes it more feasible to negotiate, administer, and communicate a menu of coverage choices. A larger employee population can also have meaningful differences in geography, provider preferences, family composition, and desired balance between premium cost and access to providers. Offering more than one plan lets the employer address these varied needs while maintaining a competitive benefits package for recruitment and retention. Large employers may offer choices among plan designs, such as PPOs, HMOs, high-deductible health plans paired with health savings accounts, or other network arrangements. Employer-benefit survey data consistently distinguish larger firms from smaller firms in their capacity to provide benefit options and manage more complex health-plan offerings. The Kaiser Family Foundation’s annual employer health benefits survey provides detailed national data on health-benefit offerings by firm size: KFF Employer Health Benefits Survey. Additional context on employer-sponsored coverage and plan choices is available from CMS.

QUESTION NO: 2

If the Oconee Health Plan reimburses its specialty care physicians (SCPs) under a typical retainer method, then Oconee pays SCPs

A. A separate amount for each service provided, and the payment amount is based solely on a resource-based relative value scale (RBRVS)

B. A specified fee that remains the same regardless of how much or how little time or effort is spent on the medical service performed

C. A set amount each month, and Oconee reconciles its payment at periodic intervals on the basis of actual utilization

D. A set amount of cash equivalent to a defined time period’s expected reimbursable charges

ANSWER: C

Explanation:

A set amount each month, and Oconee reconciles its payment at periodic intervals on the basis of actual utilization is correct because a retainer arrangement gives a specialty care physician a predictable periodic payment, commonly monthly, for being available to provide specialty services to the health plan’s members. The initial payment is based on anticipated use of the specialist’s services rather than being calculated separately for every individual service at the time it is delivered. The plan subsequently compares the retainer payments with actual utilization during established reconciliation periods and makes appropriate adjustments. This approach helps the plan maintain specialist access and budget for expected specialty-care needs while still aligning total reimbursement with members’ actual use of services. It is therefore a prospective payment arrangement with a retrospective utilization-based reconciliation component. This general approach is consistent with managed-care payment structures, which may use prospective payments and contractual mechanisms to account for covered services and utilization. See the CMS Medicare Advantage risk-adjustment resources for background on prospective managed-care payment, and CMS’s Physician Fee Schedule resources for context on how physician reimbursement methodologies differ from service-by-service payment.

QUESTION NO: 3

A provider contract describes the responsibilities of each party to the contract. These responsibilities can be divided into provider responsibilities, health plan responsibilities, and mutual obligations. Mutual obligations typically include

A. provisions for marketing the plan's product

B. payment arrangements between the plan and the provider

C. verification of the plan's eligibility to do business

D. management of the contents of members' medical records

ANSWER: B

Explanation:

payment arrangements between the plan and the provider is correct because compensation is inherently a reciprocal contractual commitment. The provider agrees to furnish covered services under the network agreement, and the health plan agrees to compensate the provider according to defined terms. A complete payment arrangement normally identifies the reimbursement methodology, such as fee-for-service, capitation, or a negotiated fee schedule; the services to which the methodology applies; billing and claims-submission procedures; payment timing; and any applicable incentive, withholding, reconciliation, or audit provisions. Both parties must understand and perform these terms for claims to be processed and for the contractual relationship to function.

This shared nature is why payment language is commonly treated as a mutual obligation rather than solely as a duty of either the provider or the health plan. The arrangement establishes what the provider may collect for covered care and what the plan must pay under the agreement, while also supporting compliance with network adequacy, member access, and financial-administration requirements. CMS likewise requires Medicare Advantage organizations to maintain written arrangements with providers and to ensure those arrangements support required services and oversight. See CMS Medicare Managed Care Manual and 42 CFR § 422.504.

QUESTION NO: 4

The National Committee for Quality Assurance (NCQA) has integrated accreditation with Health Employer Data and Information Set (HEDIS) measures into a program called Accreditation â€™99. One statement that can correctly be made about these accreditation standards is that

A. Health plans are required by law to report HEDIS results to NCQA

B. HEDIS restricts its reporting criteria to a narrow group of quantitative performance measures, while NCQA includes a broad range of qualitative performance measures

C. Private employer groups purchasing health care coverage increasingly require both NCQA accreditation and HEDIS reporting

D. HEDIS includes measures of a health planâ€™s effectiveness of care rather than its cost of care

ANSWER: C

Explanation:

Private employer groups purchasing health care coverage increasingly require both NCQA accreditation and HEDIS reporting. NCQA accreditation provides an independent evaluation of a health plan's systems and performance against established quality standards, while HEDIS supplies standardized performance measures that allow purchasers to compare plans on consistent dimensions of care and service. For employer-sponsored coverage, these tools support informed purchasing decisions: employers and other purchasers can evaluate whether a plan has undergone a rigorous organizational review and can compare reported results across competing plans. The integration described as Accreditation '99 reflected NCQA's effort to connect accreditation with measured performance, making quality oversight more meaningful to organizations selecting health coverage for their employees. NCQA continues to describe HEDIS as a standardized set of performance measures used to compare health-plan performance, and it identifies employers and other purchasers among the audiences that use these quality data. This combination of accreditation status and comparable reported measures

therefore became an increasingly important purchaser expectation rather than merely an internal health-plan activity. See NCQA's HEDIS overview and its Health Plan Accreditation program information.

QUESTION NO: 5

An increasing number of health plans offer coverage for alternative healthcare services. One such alternative healthcare service is biofeedback. Biofeedback is an approach that

A. is based on an ancient Chinese system of healing in which needles are inserted into specific sites on the body to relieve pain

B. treats diseases with tiny doses of substances which, in healthy people, are capable of producing symptoms like those of the disease being treated

C. uses electronic monitoring devices to teach a patient to develop conscious control of involuntary bodily functions, such as heart rate and body temperature

D. incorporates a variety of therapies, such as homeopathy, lifestyle modification, and herbal medicines, to support and maintain the body's ability to heal itself

ANSWER: C

Explanation:

Biofeedback "uses electronic monitoring devices to teach a patient to develop conscious control of involuntary bodily functions, such as heart rate and body temperature" because it makes normally automatic physiological activity observable to the patient in real time. Sensors may measure functions such as muscle tension, breathing rate, heart rate, skin temperature, or sweat-gland activity. The monitoring equipment converts those measurements into signals a person can see or hear, allowing the person to recognize how stress, thoughts, breathing, and relaxation techniques affect the measured function. With guided practice, patients can learn skills intended to influence these responses voluntarily, such as relaxing tense muscles, slowing breathing, or reducing physiologic arousal. Biofeedback is therefore a training approach rather than a single drug, procedure, or diagnosis-specific treatment. It may be used as part of a broader care plan, particularly for concerns involving stress management, pain, headache, or muscle-related symptoms, with the precise technique selected according to the clinical goal and measurement involved. The National Center for Complementary and Integrative Health describes biofeedback as a technique that uses instruments to provide information about bodily processes and help people learn to control them. See NCCIH: Biofeedback and MedlinePlus: Biofeedback.

QUESTION NO: 6

The introductory paragraph of a provider contract is generally followed by a section called the recitals. The recitals section of the contract typically specifies the

A. Purpose of the agreement

B. Manner in which the provider is to bill for services

C. Definitions of key terms to be used in the contract

D. Rate at which the provider will be compensated

ANSWER: A

Explanation:

The purpose of the agreement is correct. In a provider contract, the recitals are introductory "whereas" statements that provide the agreement's background and context. They identify the parties' general circumstances, intentions, and reasons for entering into the contractual relationship—for example, that a health plan seeks to establish a provider network and that the provider wishes to furnish covered health care services to the plan's members. Thus, recitals frame the overall purpose and business objective of the contract before the operative provisions begin. They help readers understand the setting in which the parties negotiated the agreement and can assist in interpreting the parties' intent if an operative term is

ambiguous. The substantive obligations governing network participation, including administrative processes and financial arrangements, are ordinarily addressed later in the agreement's operative clauses and exhibits. Contract-drafting guidance likewise describes recitals as preliminary statements that explain the transaction and its purpose rather than the provisions that create the parties' enforceable duties. See Cornell Law School's definition of a contract recital and the American Bar Association's discussion of the importance of recitals in contracts.

QUESTION NO: 7

Open panel health plans can contract with individual providers or with various provider groups when developing their networks. The following statements are about factors that an open panel health plan might consider in contracting with different types of provider organizations. Select the answer choice that contains the correct statement.

A. One limitation of contracting with multispecialty groups is that a health plan obtains only specialty consultants, but not PCPs.

B. One benefit to a health plan in contracting with an integrated delivery system (IDS) is the ability to have a network in rapid order and to enter into a new market or one that is already competitive.

C. A health plan that contracts with an individual practice association (IPA) has a greater ability to select and deselect individual physicians than when contracting directly with the providers.

D. A health plan that contracts with an IDS is able to eliminate the antitrust risk that exists when contracting with an IPA.

ANSWER: B

Explanation:

One benefit to a health plan in contracting with an integrated delivery system (IDS) is the ability to have a network in rapid order and to enter into a new market or one that is already competitive. An IDS typically brings together a broad, organized set of healthcare resources, often including primary care physicians, specialists, hospitals, and ancillary services. Rather than constructing a provider network one practice or physician at a time, the health plan can establish a contractual relationship with an organization that already has an aligned delivery infrastructure and an established provider base. This can substantially accelerate network development, which is especially valuable when the plan is launching coverage in a new service area or needs to become competitive quickly in an existing market.

The arrangement may also support more coordinated care delivery because the participating clinicians and facilities are connected through the IDS's organizational structure. For background on integrated delivery systems and their role in organizing providers and services, see the National Library of Medicine's overview of integrated delivery systems. The Agency for Healthcare Research and Quality's health-system resources also describe how organized delivery systems can coordinate care across provider settings.

QUESTION NO: 8

The Octagon Health Plan includes a typical indemnification clause in its provider contracts. The purpose of this clause is to require Octagon's network providers to

A. Agree not to sue or file claims against an Octagon plan member for covered services

B. Reimburse Octagon for costs, expenses, and liabilities incurred by the health plan as a result of a provider's actions

C. Maintain the confidentiality of the health plan's proprietary information

D. Agree to accept Octagon's payment as payment in full and not to bill members for anything other than contracted copayments, coinsurance, or deductibles

ANSWER: B

Explanation:

Reimburse Octagon for costs, expenses, and liabilities incurred by the health plan as a result of a provider's actions is correct because indemnification is a contractual risk-allocation provision. In a provider agreement, it generally requires the provider to protect the health plan from financial loss arising from the provider's acts, omissions, negligence, breach of contract, or failure to comply with applicable law. Depending on the contract's wording, this protection may include reimbursing damages, settlements, judgments, reasonable legal fees, and other defense-related expenses that the plan incurs in connection with a claim attributable to the provider. Such provisions help ensure that the party whose conduct created the liability bears the resulting financial responsibility, rather than shifting that burden to the health plan. Indemnification language is therefore an important component of provider-network contracting, along with insurance requirements and other provisions intended to manage operational and legal risk. The general legal meaning of indemnity is an obligation to compensate another party for a loss or damage; see the Cornell Legal Information Institute's definition of indemnity. For broader background on managed-care provider contracting and network arrangements, see the CMS Managed Care resources.

QUESTION NO: 9

The following statements can correctly be made about the advantages and disadvantages to an health plan of using the various delivery options for pharmacy services.

A. A disadvantage of using open pharmacy networks is that the health plan's control over costs is limited to setting reimbursement levels.

B. An advantage of using performance-based systems is that they tend to increase participation in the health plan's pharmacy network.

C. A disadvantage of using customized pharmacy networks is that these networks typically can be implemented only in companies with fewer than 500 employees.

D. All of these statements are correct.

ANSWER: A

Explanation:

A disadvantage of using open pharmacy networks is that the health plan's control over costs is limited to setting reimbursement levels. In an open network, the plan generally permits broad participation by pharmacies that agree to its terms, rather than selectively contracting with a limited set of pharmacies or using an exclusive arrangement. This broad access can be valuable to members because it offers convenience and pharmacy choice, but it reduces the plan's leverage to direct prescription volume to a smaller group of providers in exchange for deeper price concessions or more tightly managed service arrangements. Consequently, reimbursement terms are the principal network-specific mechanism available to influence pharmacy dispensing costs. The plan may still operate other pharmacy-benefit tools, such as formulary management and utilization management, but those are benefit-management strategies rather than control derived from the open pharmacy delivery arrangement itself. CMS recognizes that prescription drug plans establish pharmacy networks through contracted pharmacies and must make network access available to enrollees; the structure and breadth of that network materially affect contracting and cost-management flexibility. See CMS, Medicare Prescription Drug Benefit Manual, Chapter 5 and Federal Trade Commission, Pharmacy Benefit Managers Report.

QUESTION NO: 10

Dr. Sarah Carmichael is one of several network providers who serve on one of the Apex Health Planâ€™s organizational committees. The committee reviews cases against providers identified through complaints and grievances or through clinical monitoring activities. If needed, the committee formulates, approves, and monitors corrective action plans for providers. Although Apex administrators and other employees also serve on the committee, only participating providers have voting rights. The committee that Dr. Carmichael serves on is a

A. Utilization management committee

B. Peer review committee

C. Medical advisory committee

D. Credentialing committee

ANSWER: B

Explanation:

Peer review committee is correct because its central role is evaluating the professional conduct, competence, and quality of care provided by practitioners. Here, the committee examines provider cases arising from complaints, grievances, and clinical-monitoring findings, then can develop, approve, and oversee provider corrective action plans. Those are core peer-review activities: evaluating a practitioner's performance and taking appropriate quality-improvement or disciplinary follow-up when concerns are substantiated.

The membership and voting arrangement also supports this conclusion. Health-plan employees and administrators may provide operational, quality-management, and legal support, but clinical judgments about another provider's professional practice are made by peers. Restricting voting rights to participating providers preserves the practitioner-led character of peer review and ensures that determinations about clinical performance are made by individuals with appropriate professional expertise. This structure supports fair, clinically informed oversight of network providers and ongoing quality improvement. Federal peer-review protections similarly recognize professional review bodies as bodies that conduct professional review actions through physician participation. See the Health Care Quality Improvement Act and CMS's Quality Improvement Organization program for related quality-review context.

QUESTION NO: 11

The Medicaid program subsidizes indigent care through payments to disproportionate share hospitals (DSHs). The Preamble Hospital is a DSH. As a DSH, Preamble most likely:

A. Receives financial assistance from the federal government but not a state government.

B. Is at a higher risk of operating at a loss than are most other hospitals.

C. Receives no payments directly from Medicaid for services rendered but rather receives a portion of the capitation payment that Medicaid makes to the health plans with which Preamble contracts.

D. Is eligible for capitation rates that are significantly higher than the FFS average for all covered Medicaid services.

ANSWER: B

Explanation:

Is at a higher risk of operating at a loss than are most other hospitals. Disproportionate share hospitals serve a disproportionately large number of patients who are low income, uninsured, or enrolled in Medicaid. These populations often require substantial services while generating lower reimbursement than the hospital's costs of furnishing care. Uninsured patients may be unable to pay at all, and Medicaid payment rates can be below the rates paid by commercial insurers. Consequently, a hospital with a high concentration of such patients has greater exposure to uncompensated care and payment shortfalls, creating a heightened risk of financial losses.

Medicaid DSH payments are supplemental payments intended to help qualifying hospitals offset the costs associated with serving Medicaid-enrolled and uninsured individuals. The payments recognize the financial burden of maintaining access to hospital care for vulnerable communities; they do not eliminate the underlying financial risk created by a payer mix heavily weighted toward low-income patients. Federal law establishes the DSH framework, while state Medicaid programs administer payments within federal requirements and limits. CMS describes DSH payments and hospital-specific limits at Medicaid.gov: Disproportionate Share Hospitals. Additional policy context on the role of DSH payments is available from MACPAC: Disproportionate Share Hospital Payments.

QUESTION NO: 12

The provider contract that the Canyon health plan has with Dr. Nicole Enberg specifies that she cannot sue or file any claims against a Canyon plan member for covered services, even if Canyon becomes insolvent or fails to meet its financial obligations. The contract also specifies that Canyon will compensate her under a typical discounted fee-for-service (DFFS) payment system.

During its recredentialing of Dr. Enberg, Canyon developed a report that helped the health plan determine how well she met Canyon's standards. The report included cumulative performance data for Dr. Enberg and encompassed all measurable

aspects of her performance. This report included such information as the number of hospital admissions Dr. Enberg had and the number of referrals she made outside of Canyon's provider network during a specified period. Canyon also used process measures, structural measures, and outcomes measures to evaluate Dr. Enberg's performance.

The clause which specifies that Dr. Enberg cannot sue or file any claims against a Canyon plan member for covered services is known as:

A. A termination with cause clause

B. A hold-harmless clause

C. An indemnification clause

D. A corrective action clause

ANSWER: B

Explanation:

A hold-harmless clause is the contractual protection that prevents a participating provider from seeking payment from an enrollee for covered services when the health plan has not paid the provider, including when the plan is insolvent or otherwise fails to meet its financial obligations. Its central purpose is to protect members from financial liability created by disputes or failures between the provider and the health plan. Thus, Dr. Enberg agrees that her payment recourse for covered services is against Canyon under the provider contract, not against Canyon's members.

This protection is an important network-management and consumer-protection feature of provider agreements. It helps ensure that an enrollee can obtain covered care without later receiving a bill or being pursued for the amount the plan was contractually responsible for paying. Federal Medicaid managed-care regulations expressly require provider agreements to protect enrollees from liability for covered services when the managed-care organization does not pay because of insolvency or another failure to meet its financial responsibility. See 42 CFR § 438.106. CMS also describes managed-care protections and contractual requirements in its Medicaid managed care regulations guidance.

QUESTION NO: 13

Partial capitation is one common approach to capitation. One typical characteristic of partial capitation is that it:

A. Includes only primary care services

B. Covers such services as immunizations and laboratory tests

C. Can be used only if the provider's panel size is less than 50 providers

D. Covers such services as cardiology and orthopedics

ANSWER: A

Explanation:

Includes only primary care services is correct because partial capitation pays a provider a fixed, prospective per-member amount for a defined, limited portion of a member's covered care rather than for the full continuum of medical services. A common application is primary-care capitation: the primary care practice accepts responsibility for furnishing and managing primary care for its assigned members in return for a periodic payment. Services outside that specifically defined scope remain the responsibility of another contracted entity, may be paid under a separate arrangement, or may be subject to fee-for-service payment. The key feature is therefore the limited scope of services included in the capitation payment, with primary care being the usual example. This structure gives the participating primary care provider a predictable revenue stream while creating an incentive to coordinate preventive care, routine treatment, referrals, and appropriate use of resources for the enrolled population. Capitation payment is generally made prospectively on a per-person basis, and the covered service scope must be clearly specified in the provider agreement. See the CMS glossary for health-plan payment terminology and the Agency for Healthcare Research and Quality's primary care resources for the central role of primary care in coordinated delivery.

QUESTION NO: 14

Since 1981, states have had the option to experiment with new approaches to their Medicaid programs under the “freedom of choice” waivers. Under one such waiver, a Section 1915(b) waiver, states are allowed to

A. Give Medicaid recipients complete freedom in choosing healthcare providers

B. Give Medicaid recipients the option to choose not to enroll in a healthcare plan

C. Mandate certain categories of Medicaid recipients to enroll in health plans

D. Establish demonstration projects to test new approaches for delivering care to Medicaid recipients

ANSWER: C

Explanation:

“Mandate certain categories of Medicaid recipients to enroll in health plans” is correct because a Section 1915(b) waiver permits a state to waive Medicaid’s usual freedom-of-choice requirement and operate specified managed care delivery arrangements. This authority can support mandatory enrollment of defined Medicaid populations into managed care plans, including arrangements in which the state contracts with plans to furnish covered services. The waiver is intended to allow states to design service-delivery systems that coordinate care, promote efficient use of Medicaid resources, and meet federal requirements for beneficiary protections and access to appropriate services. A state must submit its proposed program to the Centers for Medicare & Medicaid Services for approval and demonstrate that the waiver meets the applicable statutory and regulatory standards, including cost-effectiveness and safeguards for enrollees. The Centers for Medicare & Medicaid Services describes Section 1915(b) waivers as a mechanism through which states may provide services using managed care delivery systems or otherwise limit beneficiaries’ choice of providers. This is why mandatory plan enrollment for certain recipient categories is a central permitted use of this waiver authority. See CMS: Section 1915(b) Waivers and 42 U.S.C. § 1396n.

QUESTION NO: 15

One difference between a fee-for-service (FFS) reimbursement arrangement and capitation is that the FFS arrangement:

A. Is a prospective payment system, whereas capitation is a retrospective payment system

B. Has a potential to induce providers to underutilize medical resources, whereas capitation does not have this potential disadvantage

C. Bases the amount of reimbursement on the actual medical services delivered, whereas reimbursement under capitation is independent of the actual volume and cost of services provided

D. Is most often used by health plans to reimburse healthcare facilities, whereas capitation is most often used by health plans to reimburse specialty care providers

ANSWER: C

Explanation:

“Bases the amount of reimbursement on the actual medical services delivered, whereas reimbursement under capitation is independent of the actual volume and cost of services provided” is correct. Under a fee-for-service arrangement, a provider submits claims for discrete covered services, and payment is tied to the services furnished. The total reimbursement therefore generally rises or falls with the number, type, and applicable payment rates of services delivered. This makes FFS a service-volume-based payment method.

Capitation instead establishes a fixed, prospective payment—typically a per-member, per-month amount—to a provider or provider organization for providing or arranging a defined set of covered services for an enrolled population during a specified period. The capitated payment is determined in advance and ordinarily does not change merely because an individual enrollee uses more or fewer covered services, or because the provider’s actual cost of furnishing those services differs from expectations. The provider assumes responsibility for managing the care and financial consequences within the agreed scope of services. This core distinction between payment for individual services and a fixed payment for a population

is central to health-plan provider reimbursement arrangements. See the CMS glossary and CMS Medicaid managed care guidance.

QUESTION NO: 16

The Medea Clinic is a network provider for Delphic Healthcare. Delphic transferred the contract it held with Medea to the Elixir HMO, an entity that was not party to the original contract. The process by which Delphic transferred the contract it held with Medea to Elixir is known as

A. Most-favored- nation arrangement

B. A limit on action

C. A consideration

D. An assignment

ANSWER: D

Explanation:

An assignment is the transfer of contractual rights from one party to another. In this situation, Delphic Healthcare, the original party holding the provider contract with Medea Clinic, transferred its contractual interest to Elixir HMO, which was not an original party to that agreement. That transaction is properly described as an assignment. In network-management arrangements, assignment provisions are important because they specify whether a health plan or provider may transfer its rights under the agreement—for example, in connection with a merger, acquisition, organizational restructuring, or delegation of plan operations—and whether the other contracting party must consent before the transfer is effective. The party making the transfer is generally called the assignor, while the party receiving the transferred rights is the assignee. The underlying contract's assignment clause governs the parties' authority and any required notice or consent process. This use of assignment is consistent with the general legal definition of an assignment as a transfer of rights or property from one person or entity to another. See Cornell Law School's Legal Information Institute: Assignment and American Bar Association: Assignment and Delegation.

QUESTION NO: 17

The Edgewood Health Plan uses a combination of structural, process, outcomes, and customer satisfaction measures to evaluate its network providers' performance. Edgewood would correctly use outcomes measures to evaluate a provider's

A. Compliance with specific regulatory or accrediting requirement

B. Appropriate use of specified procedures

C. Patient progress following treatment

D. Patient perceptions about how well the provider addresses medical problems

ANSWER: C

Explanation:

Patient progress following treatment is the appropriate focus of an outcomes measure. In the widely used Donabedian framework for evaluating health care quality, outcome measures assess the effects of health care on a patient's health status. They therefore examine whether treatment produced meaningful results, such as improvement in symptoms or function, recovery, reduced complications, survival, or other changes in clinical condition. Measuring patient progress after treatment directly evaluates the result of the care delivered, rather than merely whether resources, procedures, or patient-experience activities were present. Health plans can use these measures in network-provider performance evaluation to identify patterns in clinical results and support quality-improvement efforts. For example, outcomes data may show whether patients experience improvement after a course of treatment or whether the provider's care is associated with avoidable adverse events. The Agency for Healthcare Research and Quality describes outcome measures as reflecting the impact of

health care services or interventions on patients' health status, and CMS similarly uses outcome measures to assess results of care. See AHRQ: Types of Quality Measures and CMS: Quality Measures.

QUESTION NO: 18

The following statements are about the responsibilities that providers are expected to assume under most provider contracts with health plans. Select the answer choice containing the correct statement.

A. All health plans now include in their provider contracts a statement that explicitly places responsibility for the medical care of plan members on the health plan rather than on the provider.

B. According to the wording of most provider contracts, the responsibility of providers to deliver medical services to a plan member is not contingent upon the provider's receipt of information regarding the member's eligibility for these services.

C. Most health plans include in their provider contracts a clause which requires providers to maintain open communication with plan members regarding appropriate treatment plans, even if the services are not covered by the member's health plan.

D. Most provider contracts require participating providers to discuss health plan payment arrangements with patients who are covered by the plan.

ANSWER: C

Explanation:

Most health plans include in their provider contracts a clause which requires providers to maintain open communication with plan members regarding appropriate treatment plans, even if the services are not covered by the member's health plan. This reflects the central clinical and ethical responsibility of a participating provider: giving the patient complete, medically appropriate information so the patient can make informed decisions about care. A provider's discussion of treatment alternatives should not be limited to services that happen to be covered under a particular benefit design. In practical terms, open communication includes discussing relevant diagnostic or treatment choices, their expected benefits and risks, and available alternatives when those alternatives are clinically appropriate. This expectation helps preserve the patient-provider relationship and supports informed consent rather than allowing coverage limitations to determine what the clinician may discuss. Federal patient-protection law also provides that a group health plan or health insurance issuer may not prohibit a provider from discussing treatment options with an enrollee, including options for which plan benefits are not available. See 42 U.S.C. § 300gg-19a(c), available through Cornell Law School's Legal Information Institute. This protection is consistent with the broader patient protections described by CMS.

QUESTION NO: 19

Health plans are required to follow several regulations and guidelines regarding the access and adequacy of their provider networks. The Federal Employee Health Benefits Program (FEHBP) regulations, for example, require that health plans

A. Allow members direct access to OB/GYN services

B. Allow members direct access to prescription drug services

C. Provide access to Title X family-planning clinics

D. Provide average office waiting times of no more than 30 minutes for appointments with plan providers

ANSWER: A

Explanation:

Allow members direct access to OB/GYN services is correct. The Federal Employees Health Benefits Program includes a specific requirement for plans to make direct access to obstetric and gynecological care available. This policy supports timely, appropriate women's health care by allowing an enrollee to obtain covered OB/GYN services from an appropriate participating clinician without first having to obtain a referral through a primary care provider. In network-management terms, this is an access requirement: a plan's network design, referral rules, member materials, and utilization-management processes must all accommodate direct access to this category of care. The requirement is established in federal law

governing contracts under the FEHB Program, which provides that contracts must include direct access to obstetric and gynecological care. This reflects the FEHB Program's role in setting benefit and access standards for participating carriers, while plans remain responsible for operating provider networks that can deliver those services to enrolled members. The statutory requirement can be reviewed in 5 U.S.C. § 8904. Additional program context and enrollee information are available from the U.S. Office of Personnel Management's Federal Employees Health Benefits Program page.

QUESTION NO: 20

The following statements are about Medicaid health plan entities. Select the answer choice containing the correct statement:

A. To keep Medicaid enrollment costs as low as possible, states typically prohibit the use of third-party entities known as enrollment brokers to handle the recruitment and enrollment of Medicaid recipients in health plan plans

B. Primary care case managers (PCCMs) are individuals who contract with a state's Medicaid agency to provide primary care services mainly to urban areas.

C. Typically, Medicaid beneficiaries must be given a choice between at least two health plan entities.

D. Medicaid health plan entities are responsible for providing primary coverage for all dually-eligible beneficiaries.

ANSWER: C

Explanation:

Typically, Medicaid beneficiaries must be given a choice between at least two health plan entities. This reflects the beneficiary-choice protection applicable to mandatory Medicaid managed-care enrollment. Under section 1932(a)(3) of the Social Security Act, a state generally may not require a beneficiary to enroll in a managed care organization or primary care case manager unless the beneficiary has a choice of at least two such entities. The purpose is to preserve meaningful enrollee choice while states use managed-care arrangements to organize and finance covered services. This requirement supports informed plan selection and allows beneficiaries to consider factors such as provider-network participation, access to care, service coordination, and plan performance when selecting their coverage arrangement. The statutory framework also recognizes that operational circumstances may differ, including circumstances involving rural areas, but the general rule tested here is that beneficiaries are offered at least two available health plan entities. CMS describes managed care as a principal delivery-system option through which states contract with entities to provide Medicaid services, subject to federal beneficiary protections and state administration requirements. See the statutory text at Social Security Act §1932 and CMS's Medicaid Managed Care resource.

QUESTION NO: 22

With respect to contractual provisions related to provider-patient communications, nonsolicitation clauses prohibit providers from

A. Encouraging patients to switch from one health plan to another

B. Disclosing confidential information about the health plan's reimbursement structure

C. Dispersing confidential financial information regarding the health plan

D. Discussing alternative treatment plans with patients

ANSWER: A

Explanation:

"Encouraging patients to switch from one health plan to another" is correct because a nonsolicitation provision is intended to protect a health plan's relationship with its enrolled members. In a provider contract, this type of clause limits a participating provider's use of the provider-patient relationship to solicit, induce, or encourage a patient to leave the plan for a competing health plan. The provision addresses plan-switching advocacy or recruitment activity, rather than ordinary clinical communications. It is therefore a network-management tool designed to prevent a contracted provider from steering a plan member away from the plan through solicitation.

Importantly, contractual restrictions involving communications must be applied consistently with applicable law and member-protection standards. For example, Medicare Advantage requirements preserve enrollees' ability to receive information needed to make informed health care decisions, while plans may establish provider-contract terms that govern marketing and solicitation conduct. CMS's Medicare Communications and Marketing guidance discusses restrictions and standards relevant to marketing activity and plan enrollment decisions. See CMS Medicare Communications and Marketing Materials and 42 C.F.R. § 422.2260.

QUESTION NO: 23

Dr. Sylvia Cimer and Dr. Andrew Donne are obstetrician/gynecologists who participate in the same provider network. Dr. Comer treats a large number of high-risk patients, whereas Dr. Donne's patients are generally healthy and rarely present complications. As a result, Dr. Comer typically uses medical resources at a much higher rate than does Dr. Donne. In order to equitably compare Dr. Comer's performance with Dr. Donne's performance, the health plan modified its evaluation to account for differences in the providers' patient populations and treatment protocols. The health plan modified Dr. Comer's and Dr. Donne's performance data by means of

A. Acase mix/severity adjustment

B. An external performance standard

C. Structural measures

D. Behavior modification

ANSWER: A

Explanation:

Acase mix/severity adjustment is the appropriate method because the two physicians serve patient populations with materially different clinical risks and expected resource needs. Case-mix, or severity, adjustment modifies performance data to account for patient characteristics that can affect outcomes, service utilization, and costs independently of the physician's quality or efficiency. Relevant characteristics can include diagnoses, comorbidities, pregnancy risk factors, prior complications, age, and other factors associated with the complexity of care.

In this situation, unadjusted resource-use data would reflect not only each physician's practice patterns but also the fact that one physician treats substantially more high-risk obstetric patients. Applying a severity adjustment creates a comparison based on expected utilization for each physician's particular mix of patients. The plan can then assess whether observed resource use is higher or lower than would reasonably be anticipated given the patients' clinical needs. This supports a fairer provider-performance evaluation and reduces the incentive to avoid patients with complex conditions. Risk adjustment is a foundational component of valid healthcare quality measurement, as described by the CMS Measures Management System and AHRQ's resources on risk adjustment.

QUESTION NO: 24

Edward Patillo has established a Medicare+Choice medical savings account (MSA). This MSA will allow Mr. Patillo to:

A. Carry over any money remaining in his MSA at the end of the benefit year to the next benefit year

B. Make withdrawals at any time from the MSA, but only for medical expenses

C. Obtain payment at 100% of the Medicare allowable payment for all Medicare-covered services he receives, without having to pay any deductibles or out-of-pocket expenses

D. Make withdrawals from the MSA to meet qualified medical expenses that are not paid by his high-deductible health insurance policy, but these withdrawals are taxed as income to Mr. Patillo

ANSWER: A

Explanation:

Carry over any money remaining in his MSA at the end of the benefit year to the next benefit year is correct. A Medicare Medical Savings Account plan combines a high-deductible Medicare health plan with a bank account funded by Medicare. The annual deposit is made to the account for the beneficiary's use in paying health-care costs. Funds that are not spent during the year remain in the account rather than being forfeited at year-end. This rollover feature allows the account balance to accumulate and can help the beneficiary meet the plan's deductible or pay qualified medical expenses in a later year.

The account belongs to the beneficiary, and the balance remains available even when it is carried into a new coverage year. Medicare describes that unused money in an MSA rolls over from year to year, while the high-deductible plan provides coverage once applicable deductible obligations have been met. The rollover characteristic is therefore a central feature of this Medicare plan design. Current Medicare guidance is available through Medicare.gov's Medical Savings Account Plans overview and CMS's Medicare Medical Savings Account Plans page.

QUESTION NO: 25

The method that the Autumn Health Plan uses for reimbursing dermatologists in its provider network involves paying them out of a fixed pool of funds that is actuarially determined for this specialty. The amount of funds that Autumn allocates to dermatologists is based on utilization and costs of services for that discipline.

Under this reimbursement method, a dermatologist who is under contract to Autumn accumulates one point for each new referral made to the specialist by Autumn's PCPs. If the referral is classified as complicated, then the dermatologist receives 1.5 points. The value of Autumn's dermatology services fund for the first quarter was $15,000. During the quarter, Autumn's PCPs made 90 referrals, and 20 of these referrals were classified as complicated.

Autumn's method of reimbursing specialty providers can best be described as a

A. Disease-specific arrangement

B. Contact capitation arrangement

C. Risk adjustment arrangement

D. Withhold arrangement

ANSWER: B

Explanation:

Contact capitation arrangement is correct because Autumn establishes a predetermined, actuarially calculated fund specifically for dermatology and distributes that fund according to each contracted dermatologist's weighted referral contacts. The points reflect the relative resource use of the services: an ordinary referral earns one point, while a complicated referral earns 1.5 points. In this quarter, the 70 noncomplicated referrals generate 70 points and the 20 complicated referrals generate 30 points, for 100 total points. Therefore, the $15,000 specialty fund has a value of $150 per point. Each dermatologist's payment is determined by multiplying that point value by the number of points the dermatologist accumulated. This approach gives the plan a predictable aggregate expenditure for the specialty while recognizing that some referrals require more complex care. Capitation is a prospective payment approach in which a fixed amount is established for a defined population or service arrangement rather than paying separately for every individual service. See the CMS glossary for the definition of capitation and the CMS payment-methods overview for context on prospective payment approaches.