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QUESTION NO: 1

Benchmarking is a quality improvement strategy used by some health plans. With regard to benchmarking, it is correct to say that

A. cost-based benchmarking reveals why some areas of a health plan perform better or worse than comparable areas of other organizations

B. diagnosis-related groups (DRGs) are a source of benchmarking data that describe individual procedures and cover both inpatient and outpatient care

C. patient billing records provide a much more accurate account of procedure costs for benchmarking than do current procedural terminology (CPT) codes

D. the focus of benchmarking for health plan has shifted from identifying the lowest cost practices to identifying best practices

ANSWER: D

Explanation:

The focus of benchmarking for health plan has shifted from identifying the lowest cost practices to identifying best practices. In health-plan quality improvement, benchmarking is not simply a cost-comparison exercise. It is a structured process of comparing performance measures, processes, and outcomes with those of high-performing peer organizations to identify practices that can be adapted to improve results. Although efficient resource use remains important, the meaningful objective is to learn how superior performance is achieved and to apply those operational or clinical-management practices within the plan's own setting.

This approach supports continuous quality improvement because comparison data establish a performance reference point, while investigation of leading practices helps turn a measured gap into actionable change. Measures may include care outcomes, service experience, access, safety, utilization, and cost, considered together rather than treating the lowest expenditure as the sole indicator of success. The Baldrige Excellence Framework describes benchmarking as comparing processes and performance results with those of other organizations to identify opportunities for improvement. Likewise, AHRQ provides quality indicators and comparative data resources that organizations can use to assess and improve healthcare performance. See the Baldrige benchmarking guidance and AHRQ Quality Indicators.

QUESTION NO: 2

To see that utilization guidelines are consistently applied, UR programs rely on authorization systems. Determine whether the following statement about authorization systems is true or false:

Only physicians can make nonauthorization decisions based on medical necessity.

A. True

B. False

ANSWER: A

Explanation:

True is correct. In utilization review, an authorization system helps apply clinical guidelines consistently while assigning decisions to personnel with the proper level of clinical authority. A nonauthorization decision based on medical necessity is an adverse utilization-management decision: it concludes that requested care does not meet applicable medical-necessity criteria. Because this determination requires professional medical judgment, it must be made by a physician rather than by nonphysician utilization-review staff. Nurses and other qualified personnel may collect clinical information, apply established screening criteria, communicate with providers, and approve services when the criteria are clearly met. However, they cannot independently make the medical-necessity determination that results in nonauthorization.

This physician-review safeguard supports clinically appropriate, defensible decisions and provides an appropriate foundation for communicating the determination and any available appeal rights. The principle is also reflected in federal Medicare Advantage requirements: when a request is denied based on medical necessity, the organization must have a physician with appropriate expertise make the determination. See 42 CFR § 422.629 and CMS's Medicare Managed Care Manual.

QUESTION NO: 3

Various government and independent agencies have created tools to measure and report the quality of healthcare. One performance measurement tool that was developed by the Agency for Healthcare Research and Quality (AHRQ) is

A. the Health Plan Employer Data and Information Set (HEDIS®), which is a report card system for hospitals and long-term care facilities

B. HEDIS, which is a performance measurement tool that addresses both effectiveness of care and plan member satisfaction

C. the Consumer Assessment of Health Plans (CAHPS®), which was established to develop and implement a national strategy for quality measurement and reporting

D. CAHPS, which is a tool that measures consumer satisfaction with specific aspects of health plan services

ANSWER: D

Explanation:

CAHPS, which is a tool that measures consumer satisfaction with specific aspects of health plan services, is correct. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program was initiated by the Agency for Healthcare Research and Quality to develop standardized surveys that capture patients' and health plan members' experiences with care. The health-plan version of the survey asks members to report on their actual experiences with important service and care domains, such as obtaining needed care, obtaining care quickly, customer service, care coordination, and communication. These standardized measures allow results to be compared across plans and reported in a consistent, meaningful manner for consumers, purchasers, regulators, and healthcare organizations. CAHPS is therefore a patient- or consumer-experience performance measurement tool, rather than a clinical-outcomes measure. AHRQ supports the CAHPS program, its survey instruments, and guidance for administering and using survey results to improve healthcare quality. The official CAHPS site describes the program and its surveys at AHRQ: About CAHPS. Information on the health-plan survey and the experience domains it measures is available at AHRQ: CAHPS Health Plan Survey.

QUESTION NO: 4

Determine whether the following statement is true or false:

Immunization programs are a direct means of reducing health plan members' needs for healthcare services and are typically cost-effective.

A. True

B. False

ANSWER: A

Explanation:

True is correct. Immunization is a primary-prevention intervention: it prevents or reduces the likelihood and severity of vaccine-preventable disease before members require diagnostic testing, office visits, emergency treatment, hospitalization, or care for complications. Consequently, a health plan's immunization efforts can directly reduce avoidable utilization of healthcare services while improving member health. Vaccination programs are also typically cost-effective because the costs of purchasing, administering, and promoting recommended vaccines are commonly outweighed by avoided medical expenditures and productivity losses associated with illness. The economic value can vary by vaccine, population, disease incidence, and analytic perspective, but vaccination is broadly recognized as one of the most effective public-health and preventive-care strategies. Health plans can support these benefits through covered preventive services, reminder and recall

outreach, provider performance initiatives, and efforts to remove access barriers. The Centers for Disease Control and Prevention describes vaccination as a safe, effective way to protect people and communities from serious diseases, and its economic analyses document the substantial health and financial benefits attributable to routine immunization. See the CDC's immunization schedules and its overview of the benefits of vaccination.

QUESTION NO: 5

In order to provide a true measure of quality, the data collected by a quality indicator should accurately represent the service dimension being measured. This information indicates that the indicator should exhibit the characteristic known as

A. clarity

B. reliability

C. validity

D. feasibility

ANSWER: C

Explanation:

The correct answer is **validity**. In quality measurement, validity means that an indicator actually measures the specific service dimension or construct it is intended to measure. Thus, when data collected through a quality indicator accurately represent the aspect of care, service, outcome, or process being evaluated, the resulting measure has validity. This characteristic is essential because quality-improvement decisions, performance comparisons, and accountability activities depend on measures that reflect the real-world quality domain of interest rather than an unrelated or distorted proxy. For example, a measure intended to assess timely access to care must capture information that genuinely reflects the timeliness of access. Validity may be supported through careful indicator design, clear specifications, appropriate data definitions, and evidence that the measure corresponds to the intended quality concept. The Agency for Healthcare Research and Quality identifies validity as a core attribute of quality measures and emphasizes that a valid measure accurately captures the concept it purports to assess. Similarly, the Centers for Medicare & Medicaid Services describes measure validity as the degree to which a measure assesses what it is intended to assess. See AHRQ's overview of quality measures and CMS's guidance on measure validity and reliability.

QUESTION NO: 6

Determine whether the following statement is true or false:

Independent review organizations (IROs) can mediate disputes and offer advisory opinions to health plans on UR issues, but they cannot render binding decisions on appeals.

A. True

B. False

ANSWER: B

Explanation:

False is correct because an independent review organization (IRO) can issue a binding decision in an eligible external appeal. In utilization review (UR), an IRO provides an impartial, independent clinical review of a health plan's adverse benefit determination, such as a denial based on medical necessity, appropriateness, health care setting, level of care, or effectiveness. The reviewer considers the plan materials, the enrollee's information, and applicable clinical standards, then determines whether the denial should be upheld or reversed.

For Affordable Care Act external review protections, the IRO's final decision is binding on both the health plan and the covered person, except to the extent another remedy may be available under state or federal law. Thus, the IRO's role is not limited to mediation or nonbinding advice. A binding external review determination promotes an objective resolution process

by placing the disputed clinical decision before reviewers who do not have a financial stake in the health plan's original coverage decision.

CMS describes the federal external review process at External Review Process. Additional consumer-facing guidance is available from HealthCare.gov's external review overview.

QUESTION NO: 7

The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the terms or phrases that you have chosen.

One component of UR is an administrative review. An administrative review compares the proposed medical care to the applicable (medical policy / contract provision). This type of review (can / cannot) be conducted by a nonclinical staff member.

A. medical policy / can

B. medical policy / cannot

C. contract provision / can

D. contract provision / cannot

ANSWER: C

Explanation:

contract provision / can correctly completes the paragraph because an administrative utilization-review determination addresses whether a requested service is covered under the member's benefit agreement. The reviewer applies the applicable contract language, including such matters as eligibility, enrollment status, benefit limitations, exclusions, required authorization, or whether the service is a covered benefit. This is distinct from a clinical review, which evaluates the medical facts of a case against clinical criteria or medical policy to determine medical necessity, appropriateness, level of care, or similar clinical issues.

Because administrative review is based on benefit and contractual information rather than clinical judgment, it can be performed by appropriately trained nonclinical staff. The staff member must be able to accurately apply plan documents and follow the organization's established procedures, but a clinical license is not inherently required for this type of review. Medicare managed-care guidance similarly distinguishes coverage and administrative determinations from decisions requiring medical-necessity review, while federal requirements establish the framework for organization determinations. See the CMS Medicare Managed Care Manual, Chapter 13 and 42 CFR § 422.566.

QUESTION NO: 8

Determine whether the following statement is true or false:

The key to successfully managing the quality and cost-effectiveness of healthcare services for Medicaid enrollees is to merge Medicaid recipients into existing plans.

A. True

B. False

ANSWER: B

Explanation:

False is correct because successful Medicaid medical management depends on designing and operating services around Medicaid members' particular clinical, social, benefit, and regulatory needs—not simply placing them into an existing commercial plan. Medicaid serves many people with complex or chronic conditions, disabilities, behavioral-health needs, maternity needs, and social barriers that can affect access and outcomes. Effective programs therefore require care

coordination, provider-network capacity, culturally and linguistically appropriate services, links to community-based supports, and performance measures that meet the applicable state Medicaid contract and federal requirements.

A managed care organization may build on capabilities already used in other lines of business, but it must adapt those capabilities to the covered population, benefits, delivery system, and accountability requirements of the Medicaid program it serves. CMS describes Medicaid managed care as a state-administered arrangement in which plans deliver Medicaid benefits under state contracts and must meet program-specific standards. This emphasis on tailored plan operations and state oversight supports the conclusion that merging recipients into existing plans is not itself the key to quality or cost-effectiveness. See CMS's Medicaid Managed Care overview and the federal Medicaid Managed Care regulations.

QUESTION NO: 9

For this question, if answer choices (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.

The QAPI (Quality Assessment Performance Improvement Program) is a Centers for Medicaid and Medicare Services (CMS) initiative designed to strengthen health plans' efforts to protect and improve the health and satisfaction of Medicare beneficiaries. QAPI quality assessment standards apply to

A. standard medical-surgical services

B. mental health and substance abuse services

C. services offered to Medicare enrollees as optional supplementary benefits

D. all of the above

ANSWER: D

Explanation:

The correct answer is *all of the above*. A Medicare Advantage organization's quality assessment and performance improvement program must be comprehensive: it addresses the quality of clinical care and services furnished to enrollees across the plan's benefit package. That scope includes standard medical-surgical services, behavioral-health care such as mental health and substance-use services, and services provided as optional supplemental benefits to Medicare enrollees. Including each of these service categories is essential because quality oversight is intended to evaluate the enrollee's overall experience, access to appropriate care, outcomes, and satisfaction rather than only a narrow subset of covered clinical services.

CMS requires Medicare Advantage organizations to maintain an ongoing quality improvement program that includes measurement of performance, assessment of quality, and implementation of performance-improvement projects. The governing Medicare Advantage regulation specifically requires the program to cover all services provided under the organization's contract. This broad requirement supports coordinated, beneficiary-centered quality management across both core and supplemental offerings. See 42 CFR § 422.152, Quality improvement program and CMS's Part C and Part D performance data resources.

QUESTION NO: 10

Utilization management (UM) review that is conducted before a member receives a proposed healthcare service is known as

A. concurrent review

B. prospective review

C. retrospective review

D. focused review

ANSWER: B

Explanation:

Prospective review is correct. Prospective review occurs before a service is delivered and is used to determine whether the proposed service meets applicable benefit, medical necessity, and authorization requirements. Prior authorization is a common prospective-review process.

Concurrent review occurs while care is being delivered, such as during an inpatient admission. Retrospective review occurs after services have been provided. CMS describes prior authorization as a process through which a plan reviews certain services before they are furnished; see CMS Prior Authorization.

QUESTION NO: 11

Vision care is typically separated into two categories: routine eye care and clinical eye care. The standard benefit plans offered by most health plans include coverage for

1. Routine eye care

2. Clinical eye care

A. Both 1 and 2

B. 1 only

C. 2 only

D. Neither 1 nor 2

ANSWER: C

Explanation:

2 only is correct because clinical eye care consists of medically necessary services for diagnosing, treating, and managing diseases, injuries, and disorders of the eye and related structures. Examples include evaluation and treatment of glaucoma, cataracts, eye infections, diabetic eye disease, retinal conditions, and eye injuries. These services are generally part of a health plan's standard medical benefit because they address medical conditions and may be provided by ophthalmologists or optometrists acting within their scope of practice.

Routine eye care is different: it generally concerns refractive assessments and products or services associated with correcting vision, such as routine vision examinations, eyeglasses, contact lenses, and frames. Health plans commonly administer these benefits separately, often through a vision-benefit arrangement or as an optional supplemental benefit rather than as part of the standard medical benefit. The distinction is important in medical management because clinical eye services are evaluated as covered medical care when medically necessary, while routine vision benefits follow the plan's separate vision-benefit design.

CMS describes coverage of medically necessary eye examinations and treatment for certain eye diseases in its eye-exam coverage guidance. The National Eye Institute also explains the role of comprehensive dilated eye examinations in identifying eye disease: Keep Your Eyes Healthy.

QUESTION NO: 12

Some health plans administer a questionnaire known as the Behavioral Risk Factor Surveillance System (BRFSS) as part of their health risk assessment (HRA) processes. The following statements are about the BRFSS. If statements (A) through (C) are all correct, select answer choice (D). Otherwise, select the one correct statement.

A. This questionnaire was designed specifically for use by health plans.

B. Each health plan must use the same form of the questionnaire, with no additions or modifications.

C. This questionnaire monitors the prevalence of the major behavioral risks associated with illness and injury among adults.

D. All of the above statements are correct.

ANSWER: C

Explanation:

This questionnaire monitors the prevalence of the major behavioral risks associated with illness and injury among adults. The Behavioral Risk Factor Surveillance System is a long-running, population-based health survey system operated by the Centers for Disease Control and Prevention in partnership with U.S. states, territories, and other participating jurisdictions. Its purpose is to collect information from adults about health-related behaviors, chronic health conditions, preventive-service use, and related factors that influence health outcomes. The resulting surveillance data enable public-health organizations, policymakers, and health-focused organizations to measure the frequency and distribution of modifiable risks, identify trends, recognize disparities, and support interventions directed at important health concerns. Topics have included tobacco use, physical activity, nutrition, alcohol use, preventive screening, and other behavioral or health-status measures associated with chronic illness, injury, and premature death. Thus, BRFSS data are well aligned with the risk-identification objectives that may also be addressed in a health risk assessment, even though BRFSS itself is principally a public-health surveillance system. CDC describes BRFSS as the nation's premier system of health-related telephone surveys and explains that it gathers state-level data about health-related risk behaviors and chronic conditions. See the CDC BRFSS overview and the CDC BRFSS annual data documentation.

QUESTION NO: 13

The paragraph below contains two pairs of terms or phrases enclosed in parentheses. Determine which term or phrase in each pair correctly completes the paragraph. Then select the answer choice containing the terms or phrases that you have chosen.

The Millway Health Plan received a 15% reduction in the price of a particular pharmaceutical based on the volume of the drug Millway purchased from the manufacturer. This reduction in price is an example of a (rebate / price discount) and (is / is not) dependent on actual provider prescribing patterns.

A. rebate / is

B. rebate / is not

C. price discount / is

D. price discount / is not

ANSWER: D

Explanation:

price discount / is not is correct. A price discount is a direct reduction from the pharmaceutical product's price that is determined by the purchaser's buying volume. In this situation, Millway receives a stated 15% lower price because of the quantity of drug it purchases from the manufacturer. The relevant measure is therefore the plan's purchase volume, rather than the clinical decisions made by individual providers.

This distinction matters in pharmacy benefit management because a discount changes the price paid for a product at the time of purchase or invoicing. Whether a specific provider prescribed the drug, and how often that provider did so, does not independently establish the discount. Provider prescribing produces utilization that may contribute to the plan's aggregate purchases, but the contractual price reduction described is based on the plan's volume purchased, not on actual provider prescribing patterns. The Department of Health and Human Services Office of Inspector General describes discounts as reductions in the amount a buyer is charged for an item or service, including volume-related arrangements. See the HHS OIG guidance on discounts. For related federal treatment of drug-pricing concessions and their reporting, see CMS's Part D rebates and negotiated price information.

QUESTION NO: 14

With respect to the relationship between quality management (QM) and risk management, it is correct to say that risk management primarily focuses on

A. identifying and reducing exposure to loss associated with adverse events and potential liability

B. determining the premium rate for each purchaser group

C. negotiating fee schedules with network providers

D. establishing member eligibility rules

ANSWER: A

Explanation:

identifying and reducing exposure to loss associated with adverse events and potential liability is correct. Risk management concentrates on protecting members and the organization by identifying hazards, investigating adverse events, reducing the likelihood of harm, and managing legal and financial exposure. Activities can include incident reporting, claims review, risk assessment, and implementation of loss-prevention measures.

QM and risk management often use similar information, particularly when patient-safety concerns are identified, but their primary purposes differ. QM is directed toward systematic improvement of care and service quality, whereas risk management emphasizes prevention and control of loss and liability. AHRQ discusses patient-safety event reporting and learning systems at AHRQ PSNet: Incident Reporting.

QUESTION NO: 15

The following statement(s) can correctly be made about the hospitalist approach to inpatient care management:

1. Management of inpatient care by hospitalists may significantly reduce the length of stay and the total costs of care for a hospital admission

2. Most health plans that use hospitalists do so through a voluntary hospitalist program

3. A hospitalist's familiarity with utilization management (UM) and quality management (QM) standards for inpatient care may reduce unnecessary variations in care and improve clinical outcomes

A. All of the above

B. 1 and 2 only

C. 1 and 3 only

D. 2 only

ANSWER: A

Explanation:

All of the above is correct. Hospitalists focus their clinical practice on hospitalized patients, which gives them substantial experience with inpatient workflows, timely diagnostic and treatment decisions, discharge planning, and coordination with hospital-based clinicians. This focused presence can help shorten avoidable delays, support an appropriate length of stay, and reduce total admission costs while maintaining attention to the patient's clinical needs. Health plans have commonly implemented hospitalist arrangements as voluntary programs, allowing a patient's primary care physician to elect whether inpatient management will be transferred to a hospitalist. This structure can encourage physician acceptance while providing access to clinicians whose practice is centered in the hospital. In addition, hospitalists' routine familiarity with utilization management and quality management expectations supports consistent application of evidence-based care processes, appropriate resource use, and reduced unwarranted variation in inpatient treatment. Such standardization and coordination are central mechanisms by which hospital medicine can improve care quality and clinical outcomes. The Society of Hospital Medicine describes hospital medicine as a specialty devoted to comprehensive care of hospitalized patients and improving hospital care systems: What Is Hospital Medicine?. AHRQ also identifies care coordination and reducing unnecessary variation as important components of quality improvement: Care Coordination.

QUESTION NO: 16

The Shoreside Health Plan recently added coverage for behavioral healthcare services to its benefit package. In order to support the quality of its behavioral healthcare services, Shoreside plans to seek accreditation for its behavioral healthcare program. Accreditation specifically designed for behavioral healthcare programs is available through

1. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

2. The National Committee for Quality Assurance (NCQA)

3. The American Accreditation HealthCare Commission/URAC (URAC)

A. All of the above

B. 1 and 2 only

C. 2 and 3 only

D. 1 only

ANSWER: B

Explanation:

1 and 2 only is correct. The Joint Commission, historically called the Joint Commission on Accreditation of Healthcare Organizations, offers Behavioral Health Care and Human Services Accreditation. This program is designed for organizations that provide behavioral health treatment, rehabilitation, and related human services. Its standards assess important operational and clinical-quality areas, including safe care, treatment planning, patient rights, leadership, performance improvement, and information management. The Joint Commission describes the program and its applicability to behavioral health organizations at https://www.jointcommission.org/accreditation-and-certification/behavioral-health-care-and-human-services/.

NCQA also has accreditation specifically focused on managed behavioral health organizations. Its Managed Behavioral Healthcare Organization Accreditation program evaluates organizations that arrange, manage, or deliver behavioral healthcare benefits and services. The accreditation framework supports consistent access, quality oversight, care coordination, utilization management, and member protections in behavioral healthcare programs. This makes NCQA directly relevant to a health plan seeking external validation of the quality infrastructure for its behavioral health benefit. NCQA's accreditation offerings are available at https://www.ncqa.org/programs/health-plans/. Together, these two accrediting bodies provide behavioral-health-specific accreditation pathways appropriate for Shoreside's stated objective.

QUESTION NO: 17

Breanna Osborn is a case manager for a regional health plan. One component of Ms. Osborn's job is the collection and evaluation of medical, financial, social, and psychosocial information about a member's situation. This component of Ms. Osborn's job is known as

A. case identification

B. case management planning

C. healthcare coordination

D. case assessment

ANSWER: D

Explanation:

case assessment is correct because it is the systematic collection and evaluation of information needed to understand a member's needs, strengths, risks, circumstances, and available resources. In health plan case management, assessment considers the whole person rather than only a diagnosis or immediate clinical issue. Accordingly, it includes medical information, functional status, financial circumstances, social supports, psychosocial factors, environmental concerns, and the member's preferences and goals. The results establish a meaningful baseline for determining the intensity of case-management services and for developing an individualized plan of care. Assessment is also an ongoing activity: a case manager updates it when the member's condition, support system, benefits, care setting, or goals change. This

comprehensive approach helps ensure that interventions address barriers to appropriate care and support coordinated, member-centered outcomes. The Case Management Society of America describes case management as a collaborative process involving assessment, planning, facilitation, care coordination, evaluation, and advocacy; assessment is therefore a foundational distinct function within the process. See the Case Management Society of America's description of case management and the CMS overview of patient assessment instruments.

QUESTION NO: 18

One difference between a health plan medical policy and a clinical practice guideline (CPG) is that a medical policy generally

A. addresses coverage of a particular service or technology under defined circumstances

B. establishes treatment recommendations without regard to benefit coverage

C. is developed solely by the member's treating physician

D. replaces the purchaser contract as the source of covered benefits

ANSWER: A

Explanation:

The correct answer is that a medical policy addresses coverage of a particular service or technology under defined circumstances. Medical policies use available scientific evidence, professional standards, regulatory requirements, and benefit provisions to support consistent coverage determinations. They commonly specify indications, limitations, and criteria used to determine whether a service is medically necessary or investigational for coverage purposes.

A clinical practice guideline, in contrast, provides evidence-based recommendations to assist clinicians and patients in making decisions about appropriate clinical care. Although a medical policy may draw on CPGs and other evidence, the two documents serve different primary functions. AHRQ describes clinical practice guidelines as systematically developed statements intended to assist practitioner and patient decisions; see AHRQ Clinical Practice Guidelines.

QUESTION NO: 19

A health plan uses claims data to identify members who may be candidates for care management. One limitation of claims data is that the data generally

A. do not provide a complete, current picture of a member's clinical condition

B. cannot be aggregated for population-level analysis

C. contain no information about healthcare services

D. are collected only from members enrolled in capitated plans

ANSWER: A

Explanation:

do not provide a complete, current picture of a member's clinical condition is correct. Claims data are useful for identifying diagnoses, procedures, prescription fills, service utilization, and cost patterns across large populations. However, claims are generated principally for payment purposes and may not contain current symptoms, clinical findings, functional status, treatment adherence, social needs, or services that have not yet been billed.

For this reason, health plans commonly combine claims data with other sources, such as pharmacy data, laboratory results, health risk assessments, electronic clinical data, and direct member or provider contact. CMS discusses the role of claims and encounter data in program administration at CMS Program Statistics and Data.