

Kogut's Managed Care Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which measure is primarily used to evaluate clinical performance in plan evaluations?**
 - A. CAHPS**
 - B. Readmission rate**
 - C. Quality-adjusted life year**
 - D. HEDIS**

- 2. Which of the following is NOT a capitation-based payment model?**
 - A. Capitation**
 - B. Discounted Fee-For-Service**
 - C. Pay-For-Performance Incentives**
 - D. Fee-For-Service**

- 3. What is population health management and what are its core activities?**
 - A. Population health management relies solely on patient self-reports.**
 - B. Population health management concentrates on hospital-level efficiency only.**
 - C. Population health management uses data to segment groups, implement targeted interventions, and monitor outcomes to improve overall health and reduce costs.**
 - D. Population health management focuses on marketing and enrollment without data analysis.**

- 4. Which term describes a plan that blends PPO flexibility with HMO gatekeeper?**
 - A. Indemnity Plan (Fee-for-Service)**
 - B. Point of Service (POS) Plan**
 - C. PPO**
 - D. Primary Care Gatekeeper**

- 5. Which statement best describes step therapy, prior authorization, and formulary in drug benefit management?**
- A. Step therapy requires trying cheaper options first; prior authorization requires payer approval; formulary is the covered drug list guiding coverage and cost-sharing.**
 - B. Formulary is a list of all drugs regardless of cost; step therapy requires trying expensive options first; prior authorization is optional.**
 - C. Prior authorization guarantees coverage; step therapy is rarely used; formulary creates provider networks.**
 - D. Step therapy requires expensive options first; formulary is a list of clinicians; prior authorization is only for hospitals.**
- 6. What is the original concept of a Health Maintenance Organization (HMO)?**
- A. Direct patient ownership of clinics**
 - B. Prepaid health plans with fixed budget and provider networks**
 - C. Fee-for-service payments after care**
 - D. Insurance model with out-of-network access**
- 7. Which utilization review occurs during care and includes discharge planning?**
- A. Before care; includes prior authorization**
 - B. During care; price review**
 - C. During care; includes discharge planning**
 - D. After care; evaluates necessity and appropriateness**
- 8. Which of the following is a common career path in managed care?**
- A. Health Plans**
 - B. Governments**
 - C. HEOR**
 - D. Public Relations**

- 9. How do CAHPS and HEDIS differ, and what roles do they play in plan evaluation?**
- A. CAHPS and HEDIS measure the same aspects of care and have identical roles.**
 - B. CAHPS measures patient experience; HEDIS evaluates clinical performance; both inform accreditation, reporting, and consumer choice.**
 - C. CAHPS evaluates clinical performance; HEDIS measures patient experience; neither informs accreditation.**
 - D. CAHPS is used for provider credentialing; HEDIS is used for marketing campaigns.**
- 10. Describe utilization management and common tools used to control care.**
- A. Utilization management reviews the necessity and appropriateness of care; tools include pre-certification, concurrent reviews, discharge planning, and criteria-based approvals.**
 - B. Utilization management analyzes market share and competitor pricing.**
 - C. Utilization management manages provider credentialing and licensure.**
 - D. Utilization management oversees facility branding and patient outreach.**

Answers

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1. D
2. D
3. C
4. B
5. D
6. B
7. C
8. C
9. C
10. A

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Explanations

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1. Which measure is primarily used to evaluate clinical performance in plan evaluations?

- A. CAHPS**
- B. Readmission rate**
- C. Quality-adjusted life year**
- D. HEDIS**

Evaluating clinical performance in plan evaluations relies on standardized, widely used measures that capture how well a plan delivers care. HEDIS (Healthcare Effectiveness Data and Information Set) is designed for this purpose. It provides a broad, standardized set of performance measures across preventive services, chronic disease management, and access to care, and is the primary tool used by plans for quality reporting and NCQA accreditation. Because the measures are comparable across plans, they allow benchmarking and identify areas for improvement. CAHPS focuses on patient experience and satisfaction, not direct clinical outcomes, so it plays a complementary role rather than the primary one. Readmission rate is more hospital-focused and reflects inpatient outcomes rather than overall plan-level clinical performance. Quality-adjusted life year is used in economic analyses, not routine plan performance reporting.

2. Which of the following is NOT a capitation-based payment model?

- A. Capitation**
- B. Discounted Fee-For-Service**
- C. Pay-For-Performance Incentives**
- D. Fee-For-Service**

The essential idea here is how payment is structured in managed care: capitation-based models give providers a fixed amount per enrolled member for a period to cover a defined set of services, shifting financial risk to the provider. In contrast, Fee-for-Service pays providers for each individual service delivered, with payment tied to every procedure, visit, or test rather than to a member's enrollment or a bundled set of services. That per-service, activity-based payment is what makes it not capitation-based. Discounted Fee-For-Service can still be seen within a capitated-style contract because it uses a negotiated rate for services, but the base payment remains tied to services rendered rather than a fixed per-member amount. Pay-for-performance incentives are typically layered on top of capitation arrangements to reward quality and outcomes, rather than paying per member for a bundle of services. So the option that most clearly is not capitation-based is Fee-for-Service, since it lacks the fixed per-member framework that defines capitation.

3. What is population health management and what are its core activities?

- A. Population health management relies solely on patient self-reports.**
- B. Population health management concentrates on hospital-level efficiency only.**
- C. Population health management uses data to segment groups, implement targeted interventions, and monitor outcomes to improve overall health and reduce costs.**
- D. Population health management focuses on marketing and enrollment without data analysis.**

Population health management is a data-driven approach to improving the health outcomes of a defined group by using information to guide actions and coordination across care. Its activities include collecting and analyzing health data to understand patterns, dividing the population into risk groups, implementing targeted interventions for those groups, coordinating care across providers and settings, and continuously monitoring results to assess impact on health and costs and to refine efforts. This aligns with using data to segment groups, implement targeted interventions, and track outcomes to improve health and reduce costs. Relying only on patient self-reports misses objective data and patterns; focusing solely on hospital efficiency ignores prevention and population-wide care; and emphasizing marketing or enrollment without data analysis leaves outcomes unmeasured and un-improved.

4. Which term describes a plan that blends PPO flexibility with HMO gatekeeper?

- A. Indemnity Plan (Fee-for-Service)**
- B. Point of Service (POS) Plan**
- C. PPO**
- D. Primary Care Gatekeeper**

POS plans combine the flexibility of choosing providers with a primary care physician who coordinates care and acts as a gatekeeper. You usually get the lowest costs by staying in-network and obtaining referrals for specialist services, but you also have the option to see out-of-network providers if you want more choice, albeit with higher costs. This blend of in-network gatekeeping and outside-network freedom is what makes a POS plan fit the description. Indemnity plans are typical fee-for-service arrangements with little to no gatekeeping or required referrals, focusing on reimbursing whatever provider you choose. PPO plans emphasize broad provider choice and out-of-network coverage without requiring referrals, so they generally don't include a gatekeeper. The term Primary Care Gatekeeper refers to the role of a PCP, not a plan type that itself blends features.

5. Which statement best describes step therapy, prior authorization, and formulary in drug benefit management?
- A. Step therapy requires trying cheaper options first; prior authorization requires payer approval; formulary is the covered drug list guiding coverage and cost-sharing.
 - B. Formulary is a list of all drugs regardless of cost; step therapy requires trying expensive options first; prior authorization is optional.
 - C. Prior authorization guarantees coverage; step therapy is rarely used; formulary creates provider networks.
 - D. Step therapy requires expensive options first; formulary is a list of clinicians; prior authorization is only for hospitals.**

In drug benefit management, three mechanisms shape how medications are accessed and paid for: formulary, step therapy, and prior authorization. A formulary is the plan's published list of medications that are preferred for coverage, with tiers that influence copayments and which drugs are favored or restricted. Step therapy orders clinicians to try a lower-cost or preferred option first before moving to more expensive or second-line therapies. Prior authorization requires the payer to approve coverage for a medication before it will be covered at the intended level; without this approval, the medication may be denied or limited. The best description among the statements is that step therapy requires trying cheaper options first; prior authorization requires payer approval; formulary is the covered drug list guiding coverage and cost-sharing. This reflects how formulary structures access and cost, how step therapy steers initial treatment choices toward lower-cost options, and how prior authorization acts as a gatekeeper for certain drugs. Statements that misstate these concepts—for example, claiming formulary lists all drugs regardless of cost, or that step therapy enforces expensive options first, or that prior authorization is optional or hospital-only—don't align with how these tools are used to manage costs and ensure appropriate use.

6. What is the original concept of a Health Maintenance Organization (HMO)?
- A. Direct patient ownership of clinics
 - B. Prepaid health plans with fixed budget and provider networks**
 - C. Fee-for-service payments after care
 - D. Insurance model with out-of-network access

The original concept of a Health Maintenance Organization is a prepaid health plan that operates on a fixed budget within a defined network of providers, with care coordinated—often through a primary care physician—and emphasis on prevention rather than paying for each service after it's delivered. This prepaid, capitation-like arrangement controls costs by agreeing in advance on a set amount to cover a broad range of services for each member, and it relies on a defined network to negotiate prices and coordinate care. Because payment is fixed and care is coordinated, the model incentivizes preventive, efficient care and reduces unnecessary services. This fits best because it centers on prepaid plans with a fixed budget and a provider network. The other descriptions align with different models: owning clinics outright isn't the hallmark of an HMO, fee-for-service payments after care describe the traditional indemnity model, and an insurance model allowing out-of-network access resembles a PPO or similar plan, not a typical HMO structure.

7. Which utilization review occurs during care and includes discharge planning?

- A. Before care; includes prior authorization**
- B. During care; price review**
- C. During care; includes discharge planning**
- D. After care; evaluates necessity and appropriateness**

Concurrent review is the utilization review that happens during the course of treatment and often includes discharge planning to arrange post-discharge needs. This approach monitors ongoing care to ensure services remain appropriate while planning for a safe transition out of the acute setting, coordinating with post-acute care, home health, medications, and follow-up. Prospective review occurs before care and focuses on pre-authorization. Retrospective review happens after care to evaluate whether services were necessary and appropriate. Price review is not the standard focus of utilization management.

8. Which of the following is a common career path in managed care?

- A. Health Plans**
- B. Governments**
- C. HEOR**
- D. Public Relations**

In managed care, deciding which treatments to cover and at what price hinges on evidence about value—costs, outcomes, and real-world effectiveness. Health Economics and Outcomes Research (HEOR) provides the methods and analyses to quantify that value, including economic evaluations, budget impact analyses, and comparative effectiveness studies. By translating data into actionable insights for formulary decisions, reimbursement strategies, and value-based contracts, HEOR professionals directly support payer goals of delivering better outcomes at sustainable costs. This built-in focus on value and decision-making makes HEOR a common and essential career path in managed care. The other options describe environments or functions rather than a distinct career path centered on evidence-based value decisions: health plans refer to organizations; governments to policy roles in the public sector; and public relations to communications, which, while important, do not center on the analytic decision processes that drive coverage and cost management.

9. How do CAHPS and HEDIS differ, and what roles do they play in plan evaluation?

- A. CAHPS and HEDIS measure the same aspects of care and have identical roles.**
- B. CAHPS measures patient experience; HEDIS evaluates clinical performance; both inform accreditation, reporting, and consumer choice.**
- C. CAHPS evaluates clinical performance; HEDIS measures patient experience; neither informs accreditation.**
- D. CAHPS is used for provider credentialing; HEDIS is used for marketing campaigns.**

CAHPS and HEDIS address different aspects of quality and combine to inform how plans are evaluated. CAHPS collects patient-reported experience data through surveys, capturing how patients perceive their care—things like communication with providers, access to services, and overall satisfaction. HEDIS uses standardized clinical performance measures drawn from medical records and claims to assess the actual quality of care delivered, such as preventive services, chronic disease management, and health outcomes. In plan evaluation, both sets of data matter: accreditation processes and public reporting often rely on HEDIS for objective quality metrics and on CAHPS for patient experience insights, and together they influence consumer choice by providing a fuller picture of a plan's performance. So the best depiction is that CAHPS measures patient experience, HEDIS evaluates clinical performance, and both inform accreditation, reporting, and consumer choice.

10. Describe utilization management and common tools used to control care.

- A. Utilization management reviews the necessity and appropriateness of care; tools include pre-certification, concurrent reviews, discharge planning, and criteria-based approvals.**
- B. Utilization management analyzes market share and competitor pricing.**
- C. Utilization management manages provider credentialing and licensure.**
- D. Utilization management oversees facility branding and patient outreach.**

Utilization management is about ensuring that care is medically necessary and appropriate while using healthcare resources wisely. The main tools used to control care include pre-certification (prior authorization) to approve services before they start, concurrent reviews to evaluate ongoing care during treatment, discharge planning to arrange appropriate post-acute care and prevent unnecessary stays, and criteria-based approvals that apply evidence-based guidelines to determine necessity and appropriate level of care. Other activities like market analysis, provider credentialing, or marketing and outreach fall outside utilization management and serve different goals rather than directly controlling patient-level care.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://kogutsmanagedcare.examzify.com>

We wish you the very best on your exam journey. You've got this!

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