KOGUT'S MANAGED CARE PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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

1. Which statement best describes typical strategies to address social determinants of health within managed care?

A. Screenings, risk stratification, community partnerships, and services addressing housing, transportation, food, and social support.

B. Eliminating social services

C. Focusing only on pharmaceutical interventions

D. Relying solely on ED interventions

2. What is the purpose of stop-loss in risk-sharing arrangements?

A. It sets a fixed premium regardless of claims.

B. It reimburses claims above a predetermined threshold, limiting risk exposure.

C. It standardizes provider payments.

D. It provides partial subsidies to patients' premiums.

3. In coverage determinations, which type of evidence is central to decision-making?

A. Clinical and Economic Evidence

B. Anecdotes from Patients

C. Manufacturer Marketing Materials

D. Celebrity Endorsements

4. Which of the following describes the complete set of health care outcomes used for evaluation?

A. Equity of care

B. Quality improvements and patient satisfaction

C. Utilization and risk factors

D. Cost, quality, access, and equity

5. Which statement about applying social determinants of health (SDoH) in care management is most accurate?

A. Screen for SDoH only after a patient experiences difficulty accessing care.

B. Addressing SDoH requires only clinical care and no external resources.

C. Screen for SDoH, partner with social services, provide navigation and support for housing, transportation, and food security.

D. Screen for SDoH, partner with social services, provide navigation and support for housing, transportation, and food security, and track outcomes to measure impact.

6. Which formulary tier corresponds to specialty drugs (high cost, coinsurance)?

A. Formulary Tiers 1

B. Formulary Tiers 2

C. Formulary Tiers 3

D. Formulary Tiers 4

7. What are the primary types of Drug Utilization Review (DUR)?

A. Prospective DUR and Retrospective DUR

B. Prospective DUR only

C. Retrospective DUR only

D. Concurrent DUR only

8. Which statement best defines capitation with quality metrics?

A. Capitation with quality metrics ties fixed payments per member to performance on quality and efficiency.

B. Capitation with quality metrics means a variable payment per service with no quality criteria.

C. Capitation with quality metrics means the payer covers only outpatient services.

D. Capitation with quality metrics requires patient cost-sharing to exceed a fixed amount.

9. Which statement best describes network adequacy metrics?

A. Geographic distribution is not relevant to network adequacy.

B. Wait times for appointments are not a typical metric.

C. Provider-to-member ratios alone determine adequacy.

D. Appointment availability, geographic distribution, provider-to-member ratios, and wait times are all typical metrics used to assess network adequacy.

10. Capitation is defined as which of the following statements?

A. Fixed payment per patient per month regardless of services used

B. Payment per service rendered

C. Insurance premium per year

D. Variable payment based on patient age

Answers

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

Explanations

1. Which statement best describes typical strategies to address social determinants of health within managed care?

A. Screenings, risk stratification, community partnerships, and services addressing housing, transportation, food, and social support.

B. Eliminating social services

C. Focusing only on pharmaceutical interventions

D. Relying solely on ED interventions

Addressing social determinants of health within managed care means identifying nonmedical barriers that affect access to care and health outcomes, then connecting members to the right supports. Screenings in care settings help uncover issues like housing instability, food insecurity, transportation gaps, and weak social support. Risk stratification uses data to pinpoint individuals with high social needs who are at greater risk for expensive care, so resources can be targeted where they'll have the most impact. Building strong community partnerships with housing programs, food assistance, transportation services, and social support organizations enables seamless referrals and action. Services that address housing, transportation, food, and social support remove practical barriers to care, support treatment adherence, and can reduce hospitalizations and costs. In managed care, these components are implemented through care management processes, with referrals, coordinators, and follow-up to monitor outcomes. Options that focus only on eliminating social services, on pharmaceuticals alone, or on emergency department interventions miss these upstream, proactive strategies and tend to be less effective and more costly.

2. What is the purpose of stop-loss in risk-sharing arrangements?

A. It sets a fixed premium regardless of claims.

B. It reimburses claims above a predetermined threshold, limiting risk exposure.

C. It standardizes provider payments.

D. It provides partial subsidies to patients' premiums.

Stop-loss acts as a safety net that limits financial risk from unusually high claims by reimbursing them only after a preset threshold is reached. In risk-sharing arrangements, this means the plan covers costs up to the threshold, and the stop-loss carrier pays the excess, preventing a few extreme claims from destabilizing budgets. This protection brings budgeting stability and makes participating in risk-sharing more feasible, especially for self-funded or pooled arrangements. It's not about setting a fixed premium, standardizing provider payments, or subsidizing patients' premiums.

3. In coverage determinations, which type of evidence is central to decision-making?

A. Clinical and Economic Evidence

B. Anecdotes from Patients

C. Manufacturer Marketing Materials

D. Celebrity Endorsements

Clinical and economic evidence drive coverage determinations. Decisions hinge on whether a treatment provides meaningful clinical benefit—improved outcomes, safety, and how it stacks up against alternatives—along with evidence on its value from an economic standpoint, such as cost-effectiveness and budget impact. This combination helps determine not only if a therapy works, but whether its benefits justify its costs within a payer's resources. Anecdotes from patients lack generalizability and rigorous methods; marketing materials are biased and not objective evidence; celebrity endorsements do not reflect medical value or cost considerations. Together, rigorous clinical data and solid economic analysis form the basis for deciding if a service should be covered.

4. Which of the following describes the complete set of health care outcomes used for evaluation?

A. Equity of care

B. Quality improvements and patient satisfaction

C. Utilization and risk factors

D. Cost, quality, access, and equity

Evaluating health care outcomes comprehensively means looking at four interconnected areas: cost, quality, access, and equity. Cost reflects the economic impact and efficiency of care. Quality covers how well care achieves desired health outcomes, including safety and effectiveness. Access measures how readily people can obtain care, including availability and timeliness. Equity addresses fairness and the extent to which outcomes are consistent across different populations. If you focus on only one aspect, you don't get the full picture. Equity of care concentrates on fairness alone and misses cost, access, and quality. Quality and patient satisfaction emphasize the experience and effectiveness but don't by themselves account for cost or disparities. Utilization and risk factors examine resource use and determinants, not the complete set of outcomes used to evaluate overall performance. Therefore, combining cost, quality, access, and equity provides the full set of health care outcomes used for evaluation.

5. Which statement about applying social determinants of health (SDoH) in care management is most accurate?

A. Screen for SDoH only after a patient experiences difficulty accessing care.

B. Addressing SDoH requires only clinical care and no external resources.

C. Screen for SDoH, partner with social services, provide navigation and support for housing, transportation, and food security.

D. Screen for SDoH, partner with social services, provide navigation and support for housing, transportation, and food security, and track outcomes to measure impact.

Addressing social determinants of health in care management means acting proactively to identify and remove barriers that affect health outcomes. Screening for SDoH uncovers issues like housing instability, transportation gaps, and food insecurity that can derail treatment and adherence. Partnering with social services creates a bridge to resources, while providing navigation and support helps patients actually access and use those resources for housing, transportation, and food needs. Tracking outcomes is essential to show whether these efforts improve access, adherence, health status, and utilization, and to guide refinements over time. This approach goes beyond clinical care alone by integrating external supports and measuring real-world impact, which is why it is the most accurate representation of applying SDoH in care management.

6. Which formulary tier corresponds to specialty drugs (high cost, coinsurance)?

A. Formulary Tiers 1

B. Formulary Tiers 2

C. Formulary Tiers 3

D. Formulary Tiers 4

Drug formulary tiers group medications by cost and how they're managed; higher tiers mean greater cost-sharing for the patient. Specialty drugs are extremely expensive and require extra oversight, so plans place them in the top tier to reflect their high cost. In that tier, cost-sharing is typically through coinsurance rather than a small fixed copay, which means the patient pays a percentage of the drug price rather than a flat amount. This setup helps the plan manage the financial impact of these high-cost therapies while still providing access when clinically appropriate. Lower tiers cover generics and more common brand-name drugs and usually involve smaller out-of-pocket costs.

7. What are the primary types of Drug Utilization Review (DUR)?

A. Prospective DUR and Retrospective DUR

B. Prospective DUR only

C. Retrospective DUR only

D. Concurrent DUR only

Drug Utilization Review focuses on preventing inappropriate drug use by examining prescribing and dispensing at different times. The two main phases are prospective DUR, which screens a prescription before it's filled to catch issues like harmful interactions, allergies, duplicate therapies, or improper dosing, and retrospective DUR, which analyzes dispensing and claims data after the fact to identify patterns of misuse, safety concerns, or suboptimal therapy across patients. This combination provides both real-time prevention and population-level insight for quality improvement. While some programs also use concurrent DUR to assess care as it happens, the primary concepts taught are prospective and retrospective, which is why that option is the best answer.

8. Which statement best defines capitation with quality metrics?

A. Capitation with quality metrics ties fixed payments per member to performance on quality and efficiency.

B. Capitation with quality metrics means a variable payment per service with no quality criteria.

C. Capitation with quality metrics means the payer covers only outpatient services.

D. Capitation with quality metrics requires patient cost-sharing to exceed a fixed amount.

Capitation with quality metrics focuses on fixed payments per member per month that are tied to performance on quality and efficiency. Under capitation, providers receive a set PMPM to care for a defined population and service scope, which shifts financial risk toward the provider. When quality metrics are included, payment is adjusted based on how well care meets predefined quality targets and efficiency goals. This creates an incentive to improve outcomes and manage resources, rather than simply increasing the number of services. The other descriptions don't fit because a variable payment per service with no quality criteria describes pure fee-for-service without quality incentives; covering only outpatient services misstates the scope of capitation; and requiring patient cost-sharing to exceed a fixed amount isn't how capitation works, which uses fixed per-member payments rather than per-service charges or thresholds.

9. Which statement best describes network adequacy metrics?

A. Geographic distribution is not relevant to network adequacy.

B. Wait times for appointments are not a typical metric.

C. Provider-to-member ratios alone determine adequacy.

D. Appointment availability, geographic distribution, provider-to-member ratios, and wait times are all typical metrics used to assess network adequacy.

Network adequacy is about ensuring members have timely, convenient access to in-network care. To evaluate adequacy, you look at multiple metrics that capture different access dimensions: appointment availability shows whether you can get an appointment within a reasonable timeframe; geographic distribution assesses whether providers are located where members live or work; provider-to-member ratios indicate whether there are enough providers relative to the covered population; wait times reflect the actual time patients spend waiting to receive care after seeking it. Taken together, these metrics provide a complete picture of access. Therefore, the statement that lists appointment availability, geographic distribution, provider-to-member ratios, and wait times as typical metrics is the best description. Focusing on just one aspect, like counts of providers alone or geographic spread alone, would miss other barriers to access such as long wait times or insufficient provider availability in certain areas.

10. Capitation is defined as which of the following statements?

A. Fixed payment per patient per month regardless of services used

B. Payment per service rendered

C. Insurance premium per year

D. Variable payment based on patient age

Capitation means you receive a fixed amount per patient per month, regardless of how many services that patient uses. This shifts cost risk to the provider and encourages efficient, preventive care, since the provider must cover all needed services within that fixed payment. It differs from paying for each service rendered (fee-for-service), and from a simple annual insurance premium, which isn't tied to a per-member monthly rate for delivering care. It's not defined by age alone; while risk adjustments may account for age or health status, the defining feature is the fixed per-member monthly payment.

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!