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### Question: 388

In a managed care setting, which of the following models best aligns incentives for providers to deliver high-quality care while controlling costs?

- A. Fee-for-service model
- B. Volume-based reimbursement
- C. Capitation model with shared savings
- D. Per diem payment model

Answer: C

Explanation: The capitation model with shared savings aligns incentives for providers by rewarding them for delivering high-quality care efficiently. This model encourages providers to focus on population health and preventive care, ultimately controlling costs while improving patient outcomes.

### Question: 389

When a member files a grievance in a managed care organization, which of the following steps is most critical in the grievance process to ensure compliance with legal and regulatory standards?

- A. Documenting the grievance and conducting a thorough investigation in a timely manner
- B. Ignoring the grievance until it escalates
- C. Informing the member that their complaint is unwarranted
- D. Resolving the grievance without any documentation

Answer: A

Explanation: It is critical to document the grievance and conduct a thorough investigation in a timely manner to ensure compliance with legal and regulatory

standards while addressing the member's concerns appropriately.

**Question: 390**

Which of the following strategies is commonly employed by managed care organizations to control pharmaceutical costs?

- A. Allowing unlimited access to all medications regardless of cost
- B. Encouraging patients to use only generic medications without exceptions
- C. Implementing formulary restrictions and prior authorization for high-cost drugs
- D. Providing financial incentives for patients to choose brand-name drugs

Answer: C

Explanation: Managed care organizations often use formulary restrictions and prior authorization to manage and control costs associated with high-priced medications.

**Question: 391**

Which of the following describes the significance of the "Patient Protection and Affordable Care Act" (ACA) for managed care organizations?

- A. It eliminated all managed care plans
- B. It restricted the number of patients that could enroll in managed care plans
- C. It mandated coverage for preventive services without cost-sharing and expanded access to care
- D. It reduced the regulatory requirements for managed care organizations

Answer: C

Explanation: The ACA expanded access to healthcare by mandating coverage

for preventive services without cost-sharing, positively impacting managed care organizations and their members.

**Question: 392**

What is the most critical economic principle that managed care organizations must apply to ensure the sustainability of healthcare delivery in a resource-constrained environment?

- A. Cost Efficiency
- B. Price Regulation
- C. Resource Allocation
- D. Demand Forecasting

Answer: C

Explanation: Effective Resource Allocation is crucial for managed care organizations to optimize the use of limited resources, ensuring that healthcare delivery meets population health needs while maintaining financial sustainability.

**Question: 393**

Which of the following is a key component of a successful utilization management program that directly influences patient care decisions?

- A. The integration of clinical guidelines and evidence-based practices into the decision-making process
- B. A focus solely on cost reduction strategies
- C. The exclusion of interdisciplinary collaboration among healthcare providers
- D. A centralized approach that disregards individual patient circumstances

Answer: A

Explanation: Integrating clinical guidelines and evidence-based practices into utilization management decisions helps ensure that patient care is appropriate and effective while balancing cost considerations.

**Question: 394**

The primary purpose of a Utilization Review (UR) in managed care is to:

- A. Evaluate the quality of care provided by hospitals
- B. Limit patient access to specialized treatment
- C. Assess the appropriateness of services provided to patients
- D. Increase the volume of services billed to insurance

Answer: C

Explanation: Utilization Review (UR) aims to assess whether the services provided to patients are necessary and appropriate, helping to control costs and improve the quality of care.

**Question: 395**

Which of the following statements about patient engagement in managed care is accurate?

- A. Patient engagement is not a priority in managed care settings
- B. Engaged patients are more likely to adhere to treatment plans and utilize preventive services
- C. Patient engagement solely focuses on financial aspects of care
- D. It is primarily the responsibility of healthcare providers without patient involvement

Answer: B



Explanation: Patient engagement is critical in managed care, as engaged individuals are more likely to adhere to treatment and utilize preventive services, leading to better health outcomes.

**Question: 396**

A nurse is accused of negligence after a patient suffers complications from a procedure. What must be demonstrated for a successful malpractice claim against the nurse?

- A. That the nurse had a duty of care
- B. That the nurse acted in good faith
- C. That the patient signed informed consent
- D. That the nurse followed hospital policy

Answer: A

Explanation: To establish malpractice, it must be shown that the nurse had a duty of care to the patient, which was breached, leading to harm.

**Question: 397**

The concept of "health equity" in managed care is primarily concerned with:

- A. Ensuring equal access to healthcare services regardless of socioeconomic status
- B. Promoting luxury healthcare services for affluent populations
- C. Standardizing treatment protocols across all patient demographics
- D. Focusing solely on the financial performance of healthcare providers

Answer: A

Explanation: Health equity is an essential principle in managed care, emphasizing the need for equal access to healthcare services for all individuals, regardless of their socioeconomic status or other barriers.

**Question: 398**

The principle of "accountable care organizations" (ACOs) in managed care emphasizes:

- A. Collaboration among providers to coordinate care and improve health outcomes while sharing financial risks and rewards
- B. Individual provider autonomy without accountability for patient outcomes
- C. The focus on hospital-based care only
- D. The limitation of services to reduce overall healthcare spending

Answer: A

Explanation: Accountable care organizations (ACOs) promote collaboration among providers to coordinate care, improve patient outcomes, and share financial risks and rewards, ensuring a more integrated approach to healthcare delivery.

**Question: 399**

The term "population health management" refers to:

- A. The strategy of managing the health of an individual patient
- B. The process of managing healthcare costs for high-risk individuals
- C. The approach of analyzing health outcomes and health determinants within a specific group to improve care quality and reduce costs
- D. The implementation of disease-specific protocols across all patient populations

Answer: C

Explanation: Population health management focuses on improving health outcomes for a specific population by analyzing data and addressing health determinants, ultimately aiming to enhance care quality and reduce costs.

**Question: 400**

Which of the following best captures the legal implications of a nurse's actions when providing care in a managed care environment, particularly regarding adherence to established protocols?

- A. Adhering to established protocols can protect nurses from legal liability in malpractice cases
- B. Nurses are free to deviate from established protocols without consequences
- C. Protocols are optional guidelines with no legal bearing
- D. Nurses are solely responsible for creating their own care protocols

Answer: A

Explanation: Adhering to established protocols can protect nurses from legal liability in malpractice cases, as it demonstrates compliance with accepted standards of care.

**Question: 401**

In evaluating the effectiveness of telehealth services within a managed care framework, which factor is most critical to assess?

- A. The technological literacy of patients
- B. Patient health outcomes post-telehealth consultation
- C. The geographical distribution of providers
- D. The number of telehealth visits conducted



Answer: B

Explanation: Assessing patient health outcomes post-telehealth consultation is critical for evaluating the effectiveness of telehealth services, as it provides direct insight into the quality and impact of care delivered remotely.

**Question: 402**

What is the significance of patient-centered care in the context of disease state management programs?

- A. It shifts the focus away from clinical outcomes to patient preferences only.
- B. It fosters a collaborative approach that enhances treatment adherence and satisfaction.
- C. It solely emphasizes the use of technology in managing patient data.
- D. It disregards the importance of clinical guidelines in treatment decisions.

Answer: B

Explanation: Patient-centered care emphasizes collaboration between patients and healthcare providers, leading to improved adherence to treatment plans and higher patient satisfaction.

**Question: 403**

Which of the following best describes the concept of "shared savings" in the context of value-based care arrangements within managed care organizations?

- A. A fixed payment amount received by providers for each patient
- B. A system that rewards providers based on patient satisfaction scores
- C. A penalty system for providers who exceed budgeted costs
- D. A financial incentive model where providers share in the savings generated

by reducing healthcare costs while maintaining quality

Answer: D

Explanation: Shared savings arrangements incentivize providers to reduce costs while maintaining or improving quality, allowing them to share in the financial benefits of efficient care delivery.

**Question: 404**

Which of the following terms refers to the practice of managing healthcare costs by limiting the types of services and providers available to a patient within a health plan?

- A. Utilization review
- B. Risk adjustment
- C. Care coordination
- D. Network restriction

Answer: D

Explanation: Network restriction refers to the practice of managing healthcare costs by limiting the types of services and providers available to a patient within a health plan, affecting patient choice.

**Question: 405**

A patient is dissatisfied with their treatment and seeks to resolve the issue through an alternative dispute resolution (ADR) process. Which of the following best describes the advantages of mediation over arbitration in this context?

- A. Mediation encourages collaboration and open dialogue.
- B. Mediation typically involves a more formal process.
- C. Mediation allows for legally binding decisions.
- D. Mediation is less costly than litigation but not arbitration.

Answer: A

Explanation: Mediation encourages collaboration and open dialogue, allowing parties to reach mutually agreeable solutions, whereas arbitration often results in a binding decision made by a third party.

**Question: 406**

Which of the following best describes the role of a nurse navigator in a managed care setting?

- A. A nurse who provides administrative support to physicians
- B. A nurse who focuses solely on conducting health assessments
- C. A nurse responsible for coordinating care and assisting patients through the healthcare system
- D. A nurse who manages insurance claims for patients

Answer: C

Explanation: A nurse navigator plays a critical role in helping patients navigate the complexities of the healthcare system, coordinating care, and ensuring that patients receive the services they need in a timely manner.

**Question: 407**

In the context of managed care, what does the acronym "PCMH" stand for, and what is its primary goal?

- A. Preferred Care Management Hub; to reduce administrative costs
- B. Patient-Centered Medical Home; to provide coordinated, comprehensive care
- C. Primary Care Management Health; to increase the number of primary care providers
- D. Patient Care Management Health; to enhance patient satisfaction

Answer: B

Explanation: PCMH stands for Patient-Centered Medical Home, which aims to provide coordinated and comprehensive care to improve patient outcomes and satisfaction.

**Question: 408**

When assessing the impact of social determinants of health (SDOH) on patient care, which of the following factors should be prioritized in managed care evaluations?

- A. Economic stability and access to resources
- B. Patient health insurance status
- C. Availability of healthcare providers in the area
- D. Frequency of healthcare visits

Answer: A

Explanation: Economic stability and access to resources are critical factors to prioritize when assessing the impact of social determinants of health (SDOH) on patient care, as they significantly influence health outcomes and access to necessary services.

**Question: 409**

Which of the following best describes the concept of "value-based care" in relation to quality management in a managed care setting?

- A. An approach that prioritizes patient outcomes and satisfaction over the volume of services delivered
- B. A focus on maximizing the volume of services provided to patients
- C. A system that emphasizes cost-cutting measures without regard for quality
- D. A model that relies on financial incentives for providers to increase service usage

Answer: A

Explanation: Value-based care emphasizes prioritizing patient outcomes and satisfaction, ensuring that healthcare delivery is centered around the quality of care rather than the quantity of services provided.







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