AAPC
CVBA
AAPC Certified Value-Based Administrator

Latest Version: 6.0

Question: 1

A care management vendor supporting a value-based contract asks the health system to send complete medical records for every attributed member each month. The vendor states that full records are easier to store than targeted data extracts. Which response best supports compliant administration?

A. Send the complete monthly record set, because the business associate agreement and the contract authorize broader vendor use
B. Provide only the information reasonably necessary for the contracted care management function
C. Provide complete records for higher-risk members and withhold lower-risk extracts
D. Withhold member data until the vendor documents a research protocol and obtains individual patient authorization

Answer: B

Question: 2

A health system assigns its value-based care transformation entirely to the finance department because contracts involve reimbursement. Clinical, quality, analytics, and operations teams receive updates only after financial targets are set.
Which CVBA recommendation is most appropriate?

A. Establish multidisciplinary leadership so financial goals are integrated with clinical, operational, quality, and data strategies
B. Establish an analytics-owned transformation office because dashboards determine contract success
C. Keep finance as the single owner because value-based contracts are ultimately a reimbursement calculation
D. Have finance set the targets first, then brief clinical, quality, and operations leaders on the results

Answer: A

Question: 3

A new EHR alert notifies providers when attributed patients have open value-based care gaps. After go-live, providers report that some alerts are incorrect, but no team owns review of alert tickets or rule updates.
Which governance structure should the CVBA recommend?

A. Allow any individual user to reconfigure alert logic whenever errors appear, escalate, and remain undocumented
B. Disable all value-based care alerts until accuracy improves, complaints stop, and providers request reinstatement
C. Instruct providers to disregard incorrect alerts until scheduled annual upgrades, quarterly releases, and subsequent builds
D. Assign alert ownership with a ticket review process, rule-change approval, and feedback loop to end users

Answer: D

Question: 4

A provider group waits until the end of the contract year to review quality, cost, and attribution performance. The final reconciliation shows missed shared savings due to preventable emergency department use and incomplete annual wellness visits. What process change should the CVBA recommend?

A. Interim utilization reporting without assigned ownership or gap-closure deadlines
B. Escalate every missed wellness visit to executive leadership and finance
C. Shift to monthly or quarterly performance reviews with accountable action plans for gaps
D. Advance the reconciliation assessment and retain the annual reporting cadence

Answer: C

Question: 5

A value-based care team discovers that hospital discharge notifications for attributed patients arrive in the primary care EHR seven to ten days after discharge. As a result, follow-up calls and medication reconciliation often occur too late to prevent readmissions.
Which technology-related action should the CVBA prioritize?

A. Improve admission-discharge-transfer data exchange and route timely alerts into care management workflows
B. Rely on the payer claims extract, considered more complete than hospital discharge notifications for post-discharge outreach
C. Build a monthly reconciliation file listing admissions, discharges, and transfers
D. Monitor hospital census listings manually each morning

Answer: A

Question: 6

A rural clinic's quality score for a vascular screening measure drops from 100% to 75% after one eligible patient misses the screening. The clinic has only four eligible patients in the denominator. Leadership wants to classify the clinic as a poor performer.
Which CVBA response is most appropriate?

A. Interpret the result in context of denominator size and review whether additional trend data are needed
B. Apply a locally-defined minimum denominator threshold for all internal reporting
C. Pool the four-patient denominator into a larger regional aggregate, and report the combined performance rate
D. Exclude the patient who missed screening if documentation indicates any access limitation

Answer: B

Question: 7

An ACO pilot partnering with a local food pantry improves follow-up attendance among patients with food insecurity. The ACO wants to expand the intervention across all clinics but has not defined referral criteria, data-sharing expectations, or capacity limits with the community partner.
Which CVBA action should occur before scaling?

A. Expand to every clinic first, then add referral criteria, capacity limits, and data-sharing terms as issues surface
B. Formalize referral criteria, partner capacity, data-sharing terms, and outcome tracking before expansion
C. Replace the community partner with a contracted vendor so the ACO controls referral volume directly
D. Monitor follow-up attendance exclusively, since improvement already occurred

Answer: B

Question: 8

Providers complain that value-based care alerts in the EHR appear during every visit, including visits unrelated to preventive care or chronic disease management. Many clinicians are dismissing all alerts without review.
Which EHR optimization would best address this issue?

A. Require a written response to each alert before any encounter note can be closed by staff
B. Configure role- and visit-relevant alerts that prioritize actionable gaps at appropriate workflow points
C. Broadcast every identical care-gap notification to front-desk personnel, nursing queues, and billing administrators simultaneously
D. Turn off the value-based alerts and rely on a year-end chart review to find missed gaps

Answer: B

Question: 9

Two departments report different readmission rates for the same attributed population. The analytics team uses claims paid through the end of the month, while the care management team uses admission notifications from the health information exchange. Executives ask which number is correct.
What should the CVBA recommend?

A. Publish both rates side by side, label each data source, note the timing, and let executives choose
B. Escalate the discrepancy to the payer and adopt whichever definition the payer applies
C. Adopt claims-based reporting alone because paid encounters remain auditable
D. Establish a data governance process defining source, timing, purpose, and reconciliation rules

Answer: D

Question: 10

Different departments define “high-risk patient” differently. Care management uses recent hospitalization, finance uses high cost, and analytics uses a predictive score threshold. Reports using the same term produce different patient counts.
Which CVBA action would best improve consistency?

A. Keep departmental definitions but publish every cohort under identical high-risk labeling
B. Create a data dictionary that defines each risk category, source, calculation logic, and intended use
C. Publish only consolidated high-risk counts and label them organizational denominators
D. Adopt the finance definition across utilization, cost, quality, and predictive stratification reporting

Answer: B

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