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Network Management

AHIP AHM-530

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Topic Break Down

Topic	No. of Questions
Topic 1, Volume A	99
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QUESTION NO: 1

Federal laws—including the Ethics in Patient Referrals Act, the Health Maintenance Organization (HMO) Act of 1973, the Employee Retirement Income Security Act (ERISA), and the Federal Trade Commission Act—have impacted the ways that health plans conduct business. For instance, the Mosaic Health Plan must comply with the following federal laws in order to operate:

Regulation 1: Mosaic must establish a mandated grievance resolution mechanism, including a method for members to address grievances with network providers.

Regulation 2: Mosaic must not allow its providers to refer Medicare and Medicaid patients to entities in which they have a financial or ownership interest.

From the answer choices below, select the response that correctly identifies the federal legislation on which Regulation 1 and Regulation 2 are based.

A. Regulation 1 - The Ethics in Patient Referrals Act Regulation 2 - The HMO Act of 1973

B. Regulation 1 - The HMO Act of 1973 Regulation 2 - The Ethics in Patient Referrals Act

C. Regulation 1 - ERISA Regulation 2 - The Federal Trade Commission Act

D. Regulation 1 - The Federal Trade Commission Act Regulation 2 - ERISA

ANSWER: B

QUESTION NO: 2

The following statement(s) can correctly be made about contracting and reimbursement of specialty care physicians (SCPs):

A. Typically, a health plan should attempt to control utilization of SCPs before attempting to place these providers under a capitation arrangement.

Both A and B

B. Forms of specialty physician reimbursement used by health plans include a retainer and a bundled case rate.

A only

C. B only

D. Neither A nor B

ANSWER: A

QUESTION NO: 3

The Foxfire Health Plan, which has 20,000 members, contracts with dermatologists on a contact capitation basis. The contact capitation arrangement has the following features:

Foxfire distributes the money in the contact capitation fund once each quarter and the distribution is based on the point totals accumulated by each dermatologist.

Foxfire's per member per month (PMPM) capitation for dermatology services is $1.

The dermatologist receives 1 point for each new referral that is not classified as a complicated referral and 1.5 points for each new referral that is classified as complicated.

During the first quarter, Foxfire's PCPs made 450 referrals to dermatologists and 100 of these referrals were classified as complicated. One dermatologist, Dr. Shareef Rashad, received 42 of these referrals; 6 of his referrals were classified as complicated. Statements that can correctly be made about Foxfire's contact capitation arrangement include:

A. that the value of each referral point for the first quarter was $120

B. that the value of Foxfire's contact capitation fund for dermatologists for the first quarter was $20,000

C. that the payment that Foxfire owed Dr. Rashad for the first quarter was $6,120

D. all of the above

ANSWER: A

QUESTION NO: 4

Most health plan contracts provide an outline of the criteria that a healthcare service must meet in order to be considered “medically necessary.” Typically, in order for a healthcare service to be considered medically necessary, the service provided by a physician or other healthcare provider to identify and treat a member’s illness or injury must be

A. Consistent with the symptoms of diagnosis

B. Furnished in the least intensive type of medical care setting required by the member’s condition

C. In compliance with the standards of good medical practice

D. All of the above

ANSWER: D

QUESTION NO: 5

The following statements are about the inclusion of unified pharmacy benefits in health plan healthcare packages. Select the answer choice containing the correct statement.

A. When pharmacy benefits management is incorporated into an health plan’s operations as a unified benefit, the health plan establishes pharmacy networks, but a pharmacy benefits management (PBM) company manages their operations.

B. Under a unified pharmacy benefit, an health plan cannot use mail-order services to provide drugs to its members.

C. Compared to programs that do not manage pharmacy benefits in-house, unified pharmacy benefits programs typically give health plans more control over patient access to prescription drugs.

D. Compared to programs that do not manage pharmacy benefits in-house, unified pharmacy benefits programs make drug therapy interventions for plan members more difficult.

ANSWER: C

QUESTION NO: 6

The Aegean Health Plan delegated its utilization management (UM) program to the Silhouette IPA. Silhouette, in turn, transferred authority for case management to Brandon Health Services. In this situation, Brandon is best described as the

A. delegator, and Aegean is ultimately responsible for Brandon's performance

B. delegator, and Silhouette is ultimately responsible for Brandon's performance

C. subdelegate, and Aegean is ultimately responsible for Brandon's performance

D. subdelegate, and Silhouette is ultimately responsible for Brandon's performance

ANSWER: C

QUESTION NO: 7

One reason that an health plan would want to use the actual acquisition cost (AAC) pricing system to calculate its drug costs is that, of the systems commonly used to calculate drug costs, the AAC system

A. Provides the lowest level of cost for the health plan

B. Most closely represents what pharmacies are actually charged for prescription drugs

C. Offers the best control over multiple-source pharmaceutical products

D. Is the least expensive pricing system for the health plan to implement

ANSWER: A

QUESTION NO: 8

The actual number of providers included in a provider network may be based on staffing ratios. Staffing ratios relate the number of

A. Potential providers in a plan's network to the number of individuals in the area to be served by the plan

B. Providers in a plan's network to the number of enrollees in the plan

C. Providers outside a plan's network to the number of providers in the plan's network

D. Support staff in a plan's network to the number of medical practitioners in the plan's network

ANSWER: B

QUESTION NO: 9

The Argyle Health Plan has contracted to obtain the services of the providers in the Column Medical Group, a faculty practice plan (FPP). The following statement(s) can correctly be made about this contract:

A. Column most likely contracted with the legal group representing the FPP rather than with the individual physicians within the FPP.

Both A and B

B. Column most likely will provide only highly specialized care to Argyle's plan members.

A only

C. B only

D. Neither A nor B

ANSWER: B

QUESTION NO: 10

Dr. Sylvia Cimer and Dr. Andrew Donne are obstetrician/gynecologists who participate in the same provider network. Dr. Comer treats a large number of high-risk patients, whereas Dr. Donne's patients are generally healthy and rarely present complications. As a result, Dr. Comer typically uses medical resources at a much higher rate than does Dr. Donne. In order to equitably compare Dr. Comer's performance with Dr. Donne's performance, the health plan modified its evaluation to account for differences in the providers' patient populations and treatment protocols. The health plan modified Dr. Comer's and Dr. Donne's performance data by means of

A. A case mix/severity adjustment

B. An external performance standard

C. Structural measures

D. Behavior modification

ANSWER: A

QUESTION NO: 11

When evaluating the success of providers in meeting standards, a health plan must make adjustments for case mix or severity. One true statement about case mix/severity adjustments is that they:

A. Typically are more important in measuring the performance of PCPs than they are in measuring the performance of specialists

B. Help compensate for any unusual factors that may exist in a provider's patient population or in a particular patient

C. Tend to increase the number of providers who are considered to be outliers

D. Allow for a more equitable comparison of data between providers of outpatient care but not providers of inpatient care

ANSWER: B

QUESTION NO: 12

The employees of the Trilogy Company are covered by a typical workers' compensation program. Under this coverage, Trilogy employees are bound by the exclusive remedy doctrine, which most likely:

A. Allows Trilogy to deny benefits for an employee's on-the-job injury or illness, but only if Trilogy is not at fault for the injury or illness.

B. Allows Trilogy to place limits on the amount of coverage payable for a given claim under the workers' compensation program.

C. Requires the employees to accept workers' compensation as their only compensation in cases of work-related injury or illness.

D. Provides the employees with 24-hour coverage.

ANSWER: C

QUESTION NO: 13

Lakesha Frazier, a member of a health plan in a rural area, had been experiencing heart palpitations and shortness of breath. Ms. Frazier’s primary care provider (PCP) referred her to a local hospital for an electrocardiogram. The results of the electrocardiogram were transmitted for diagnosis via high-speed data transmission to a heart specialist in a city 500 miles away. This information indicates that the results of Ms. Frazier’s electrocardiogram were transmitted using a communications system known as

A. A narrow network

B. An integrated healthcare delivery system

C. Telemedicine

D. Customized networking

ANSWER: C

QUESTION NO: 14

The provider contract that Dr. Laura Cartier has with the Sailboat health plan includes a section known as the recitals. Dr. Cartier's contract includes the following statements:

A. A statement that identifies the purpose of the contract

A, B, and C

B. A statement that defines in legal terms the parties to the contract

A and B only

C. A statement that identifies the Sailboat products to be covered by the contract
Of these statements, the ones that are likely to be included in the recitals section of Dr. Cartier's contract are statements:

A and C only

D. B and C only

ANSWER: A

QUESTION NO: 15

Many health plans opt to carve out behavioral healthcare (BH) services. However, one argument against carving out BH services is that this action most likely can result in

A. Slower access to BH care for plan members

B. Increased collaboration between BH providers and PCPs

C. Fewer specialized BH services for plan members

D. Decreased continuity of BH care for plan members

ANSWER: D