Network Management

1. By definition, a measure of the extent to which a health plan member can obtain necessary medical services in a timely manner is known as

A. Network management

B. Quality

C. Cost-effectiveness

D. Accessibility

Answer(s): D

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2. Decide whether the following statement is true or false:
The organizational structure of a health plan's network management function often depends on the size and geographic scope of the health plan. With respect to the size of a health plan, it is correct to say that smaller health plans typically have less integration and more specialization of roles than do larger health plans.

A. True

B. False

Answer(s): B

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3. The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement.
One important activity within the scope of network management is ensuring the quality of the health plan's provider networks. A primary purpose of is to review the clinical competence of a provider in order to determine whether the provider meets the health plan's preestablished criteria for participation in the network.

A. authorization

B. provider relations

C. credentialing

D. utilization management

Answer(s): C

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4. One important aspect of network management is profiling, or provider profiling. Profiling is most often used to

A. measure the overall performance of providers who are already participants in the network

B. assess a provider's overall satisfaction with a plan's service protocols and other operational areas

C. verify a prospective provider's professional licenses, certifications, and training

D. familiarize a provider with a plan's procedures for authorizations and referrals

Answer(s): A

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5. Network managers rely on a health plan's claims administration department for much of the information needed to manage the performance of providers who are not under a capitation arrangement. Examining claims submitted to a health plan's claims administration department enables the health plan to

A. determine the number of healthcare services delivered to plan members

B. monitor the types of services provided by the health plan's entire provider network

C. evaluate providers' practice patterns and compliance with the health plan's procedures for the delivery of care

D. all of the above

Answer(s): D

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6. The Avignon Company discontinued its contract with a traditional indemnity insurer and contracted exclusively with the Minaret Health Plan to provide the sole healthcare plan to Avignon's employees. By agreeing to an exclusive contract with Minaret, Avignon has entered into a type of healthcare contract known as

A. a carrier guarantee arrangement

B. open access

C. total replacement coverage

D. selective contract coverage

Answer(s): C

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7. 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(s): B

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8. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which increased the continuity and portability of health insurance coverage. One statement that can correctly be made about HIPAA is that it

A. Applies to group health insurance plans only

B. Limits the length of a health plan's pre-existing condition exclusion period for a previously covered individual to a maximum of six months after enrollment.

C. Guarantees access to healthcare coverage for small businesses and previously covered individuals who meet specified eligibility requirements.

D. Guarantees renewability of group and individual health coverage, provided the insureds are still in good health

Answer(s): C

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9. After HIPAA was enacted, Congress amended the law to include the Mental Health Parity Act (MHPA) of 1996, a federal requirement relating to mental health benefits. One true statement about the MHPA is that it

A. requires all health plans to provide coverage for mental health services

B. requires health plans to carve out mental/behavioral healthcare from other services provided by the plans

C. allows health plans to require patients receiving mental health services to pay higher copayments than patients seeking treatment for physical illnesses

D. prohibits health plans that offer mental health benefits from applying more restrictive limits on coverage for mental illness than on coverage for physical illness

Answer(s): D

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10. From the following answer choices, choose the term that best matches the description.
An integrated delivery system (IDS), which controls most providers in a particular specialty, agrees to provide that specialty service to a health plan only on the condition that the health plan agree to contract with the IDS for other services.

A. Group boycott

B. Horizontal division of territories

C. Tying arrangements

D. Concerted refusal to admit

Answer(s): C

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11. From the following answer choices, choose the term that best matches the description. Members of a physician-hospital organization (PHO) denied membership to a physician solely because the physician has admitting privileges at a competing hospital.

A. Group boycott

B. Horizontal division of territories

C. Tying arrangements

D. Concerted refusal to admit

Answer(s): A

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12. Some states have enacted any willing provider laws. From the perspective of the health plan industry, one drawback of any willing provider laws is that they often result in a reduction of a plan's

A. Premium rates

B. Ability to monitor utilization

C. Number of primary care providers (PCPs)

D. Number of specialists and ancillary providers

Answer(s): B

13. In the paragraph below, two statements each contain a pair of terms enclosed in parentheses. Determine which term correctly completes each statement. Then select the answer choice that contains the two terms you have chosen.
In most states, a health plan can be held responsible for a provider's negligent malpractice. This legal concept is known as (vicarious liability / risk sharing). One step that health plans can take to reduce their exposure to malpractice lawsuits is to state in health plan-provider agreements, marketing collateral, and membership literature that the providers are (employees of the health plan / independent contractors).

A. Vicarious liability / employees of the health plan

B. Vicarious liability / independent contractors

C. Risk sharing / employees of the health plan

D. Risk sharing / independent contractors

Answer(s): B

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14. The National Committee for Quality Assurance (NCQA) has integrated accreditation with Health Employer Data and Information Set (HEDIS) measures into a program called Accreditation '99. One statement that can correctly be made about these accreditation standards is that

A. Health plans are required by law to report HEDIS results to NCQA

B. HEDIS restricts its reporting criteria to a narrow group of quantitative performance measures, while NCQA includes a broad range of qualitative performance measures

C. Private employer groups purchasing health care coverage increasingly require both NCQA accreditation and HEDIS reporting

D. HEDIS includes measures of a health plan's effectiveness of care rather than its cost of care

Answer(s): C

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15. The National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act defines specific adequacy and accessibility standards that health plans must meet. In addition, the Model Act requires health plans to

A. Hold plan members responsible for unreimbursed charges or unpaid claims

B. Allow providers to develop their own standards of care

C. Adhere to specified disclosure requirements related to provider contract termination

D. File written access plans and sample contracts with the Centers for Medicaid and Medicare Services (CMS)

Answer(s): C

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16. The following statement(s) can correctly be made about the TRICARE managed healthcare program of the U.S. Department of Defense.
1. Active-duty military personnel are automatically enrolled in TRICARE's HMO option (TRICARE Prime).
2. Eligible family members and dependents can enroll in TRICARE Prime, the PPO plan (TRICARE Extra), or an indemnity plan (TRICARE Standard).

A. Both 1 and 2

B. 1 only

C. 2 only

D. Neither 1 nor 2

Answer(s): A

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17. For this question, if answer choices (A) through C) are all correct, select answer choice (D). Otherwise, select the one correct answer choice.
Understanding the level of health plan penetration in a particular market can help a health plan determine which products are most appropriate for that market. Indicators of a mature health plan market include

A. Areduction in the rate of growth in health plan premium levels

B. Areduction in the level of outcomes management and improvement

C. An increase in the rate of inpatient hospital utilization

D. All of the above

Answer(s): A

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18. The Holiday Health Plan is preparing to enter a new market. In order to determine the optimal size of its provider panel in the new market, Holiday is conducting a competitive analysis of provider networks of the market's existing health plans. Consider whether, in conducting its competitive analysis, Holiday should seek answers to the following questions:
QUESTION 1: What are the cost-containment strategies of the health plans with increasing market shares? QUESTION 2: What are the premium strategies of the health plans with large market shares?
QUESTION 3: What are the characteristics of health plans that are losing market share? In its competitive analysis, Holiday should most likely obtain answers to questions

A. 1, 2, and 3

B. 1 and 2 only

C. 1 and 3 only

D. 2 and 3 only

Answer(s): A

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19. The sizes of the businesses in a market affect the types of health programs that are likely to be purchased. Compared to smaller employers (those with fewer than 100 employees), larger employers (those with more than 1,000 employees) are

A. more likely to contract with indemnity health plans

B. more likely to offer their employees a choice in health plans

C. less likely to contract with health plans

D. less likely to require a wide variety of benefits

Answer(s): B

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20. Provider panels can be either narrow or broad. Compared to a similarly sized health plan that uses a broad provider panel, a health plan that uses a narrow provider panel most likely can expect to

A. Experience higher contracting costs

B. Encounter increased difficulty in utilization management

C. Have to charge higher health plan premiums

D. Experience lower provider relations costs

Answer(s): D