AHIP

Exam AHM-530

Network Management

Version: 4.0

[Total Questions: 202]

Topic break down

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Topic 1, Volume A

Question No : 1 - (Topic 1)

Health plans are required to follow several regulations and guidelines regarding the access and adequacy of their provider networks. The Federal Employee Health Benefits Program (FEHBP) regulations, for example, require that health plans

A. Allow members direct access to OB/GYN services
B. Allow members direct access to prescription drug services
C. Provide access to Title X family-planning clinics
D. Provide average office waiting times of no more than 30 minutes for appointments with plan providers

Answer: D

Question No : 2 - (Topic 1)

The Octagon Health Plan includes a typical indemnification clause in its provider contracts. The purpose of this clause is to require Octagon's network providers to

A. Agree not to sue or file claims against an Octagon plan member for covered services
B. Reimburse Octagon for costs, expenses, and liabilities incurred by the health plan as a result of a provider's actions
C. Maintain the confidentiality of the health plan's proprietary information
D. Agree to accept Octagon's payment as payment in full and not to bill members for anything other than contracted copayments, coinsurance, or deductibles

Answer: B

Question No : 3 - (Topic 1)

The Gardenia Health Plan has a national reputation for quality care. When Gardenia entered a new market, it established a preferred provider organization (PPO), a health maintenance organization (HMO), and a point-of-service product (POS) to serve the plan members in this market. All of the providers included in the HMO or the POS are included in the broader provider panel of the PPO. The POS will be a typical two-level POS that offers a cost-based incentive plans for PCPs, and the HMO is a typical staff model HMO.

The following statement(s) can correctly be made about Gardenia's establishment of the PPO and the staff model HMO in its new market:

1. When establishing its PPO network, Gardenia most likely initiated outcomes measurement tools and developed collaborative process improvement relationships with providers.

2. To avoid high overhead expenses in the early stages of market evelopment, Gardenia's HMO most likely contracted with specialists and ancillary providers until the plan's membership grew to a sufficient level to justify employing these specialists.

A. Both 1 and 2
B. Neither 1 nor 2
C. 1 Only
D. 2 Only

Answer: D

Question No : 4 - (Topic 1)

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 : 5 - (Topic 1)

Promise, Inc., a corporation that specializes in cancer services, employs its physicians and

support staff and provides facilities and ancillary services for cancer patients. Promise has contracted with the Cordelia Health Plan to provide all specialty services for Cordelia plan members who are undergoing cancer treatment. In return, Promise receives a capitated amount from Cordelia. Promise is an example of a type of specialty services organization known as a

A. Specialty IPA
B. Disease management company
C. Single specialty management specialist
D. Specialty network management company

Answer: B

Question No : 6 - (Topic 1)

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: A

Question No : 7 - (Topic 1)

The provider contract between the Ocelot Health Plan and Dr. Enos Zorn, one of the health plan's participating providers, is a brief contract which includes, by reference, an Ocelot provider manual. This manual contains much of the information found in Ocelot's comprehensive provider contracts. The following statements are about Dr. Zorn's provider contract. Select the answer choice containing the correct statement.

A. All statements in the provider contract shall be deemed to be warranties, because all statements of facts contained in the contract must be true only in those respects material to

the contract.
B. Because the provider manual is part of the contract, Ocelot must make sure that its provider manual is comprehensive and up-to-date.
C. Because the provider contract is a brief contract, Ocelot most likely is prohibited from amending the contract unilaterally, even if it gives Dr. Zorn advance notice of its intent to amend the contract.
D. Areas that should be covered in the provider manual, and not in the body of the contract, include any specific legal issues relevant to the contract.

Answer: B

Question No : 8 - (Topic 1)

The Gladspell HMO has contracted with the Ellysium Hospital to provide subacute care to its plan members. Gladspell pays Ellysium by using a per diem reimbursement method.

If Gladspell's per diem contract with Ellysium is typical, then the per diem payment will cover such medical costs as

A. Laboratory tests
B. Respiratory therapy
C. Semiprivate room and board
D. Radiology services

Answer: C

Question No : 9 - (Topic 1)

During the credentialing process, a health plan verifies the accuracy of information on a prospective network provider's application. One true statement regarding this process is that the health plan

A. has a legal right to access a prospective provider's confidential medical records at any time
B. must limit any evaluations of a prospective provider's office to an assessment of quantitative factors, such as the number of double-booked appointments a physicianaccepts at the end of each day
C. is prohibited by law from conducting primary verification of such data as a prospective provider's scope of medical malpractice insurance coverage and federal tax identification number

D. must complete the credentialing process before a provider signs the network contract or must include in the signed document a provision that the final contract is contingent upon the completion of the credentialing process

Answer: D

Question No : 10 - (Topic 1)

The following statement(s) can correctly be made about hospitalists.

1. The hospitalist's main function is to coordinate diagnostic and treatment activities to ensure that the patient receives appropriate care while in the hospital.

2. The hospitalist's role clearly supports the health plan concept of disease management.

A. Both 1 and 2
B. 1 only
C. 2 only
D. Neither 1 nor 2

Answer: B

Question No : 11 - (Topic 1)

The method of pharmaceutical reimbursement under which a plan member obtains prescription drugs from participating network pharmacies by presenting proper identification and paying a specified copayment is the

A. Wholesale acquisition cost (WAC) approach
B. Reimbursement approach
C. Service approach
D. Cognitive approach

Answer: C

Question No : 12 - (Topic 1)

The method that the Autumn Health Plan uses for reimbursing dermatologists in its

provider network involves paying them out of a fixed pool of funds that is actuarially determined for this specialty. The amount of funds that Autumn allocates to dermatologists is based on utilization and costs of services for that discipline.

Under this reimbursement method, a dermatologist who is under contract to Autumn accumulates one point for each new referral made to the specialist by Autumn's PCPs. If the referral is classified as complicated, then the dermatologist receives 1.5 points. The value of Autumn's dermatology services fund for the first quarter was $15,000. During the quarter, Autumn's PCPs made 90 referrals, and 20 of these referrals were classified as complicated.

In determining the first quarter payment to dermatologists, Autumn would accurately calculate the value of each referral point to be

A. $111.11
B. $125.00
C. $150.00
D. $166.67

Answer: C

Question No : 13 - (Topic 1)

From the following answer choices, choose the type of clause or provision described in this situation.

The Idlewilde Health Plan includes in its provider contracts a clause or provision that allows the terms of the contract to renew unchanged each year.

A. Cure provision
B. Hold-harmless provision
C. Evergreen clause
D. Exculpation clause

Answer: C

Question No : 14 - (Topic 1)

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

Question No : 15 - (Topic 1)

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: C

Question No : 16 - (Topic 1)

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 : 17 - (Topic 1)

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: B

Question No : 18 - (Topic 1)

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.

A formulary lists the drugs and treatment protocols that are considered to be the preferred therapy for a given managed population. The Fairfax Health Plan uses the type of formulary which covers drugs that are on its preferred list as well as drugs that are not on its preferred list. This information indicates that Fairfax uses the (closed / open) formulary method. In using the formulary approach to pharmacy benefits management, Fairfax most likely experiences (higher / lower) costs for its members' prescription drugs than it would if it did not use a formulary.

A. closed / higher
B. closed / lower
C. open / higher
D. open / lower

Answer: D

Question No : 19 - (Topic 1)

The provider contract between the Regal Health Plan and Dr. Caroline Quill contains a type of termination clause known as termination without cause. One true statement about this