2015 THCI Residency Rotation - Knowledge Assessment Pre-Survey

2015 Residency Rotation, “Practicing Medicine in the Era of Health Reform”

Your responses to this survey will provide an indication of your familiarity with topics we will be discussing during the Tufts Health Care Institute Residency Rotation. Answers to all questions are required.

If you do not know the answer, please select "Don't know" rather than guessing.

Please note: The survey should take approximately 20 minutes. Questions are distributed over two pages. If you exit the survey before completing all questions on a page, none of those answers will be saved. Please plan to complete the entire survey in one session.

Please complete the survey by Friday, July 24.

* 1. Which type of health insurance plan generally provides specialty referrals visits at the lowest cost to an enrolled patient?

- a. Preferred Provider Organizations (PPO)
- b. Point-of-Service Health Plans (POS)
- c. Health Maintenance Organizations (HMO)
- d. Indemnity insurance
- e. Don’t know

* 2. What is attribution in the Accountable Care Organization model?

- a. A method of associating patients with providers for payment
- b. A formula for determining the rate of specialty services per primary care visit
- c. A method to decide if the hospital or the physician receives payment for a service
- d. A technique of segmented marketing to target selected consumers to certain ACOs
- e. Don’t know

* 3. Which one of the following statements about federal and state government roles in providing Medicaid is true?

- a. All state Medicaid programs are required to cover outpatient prescription drugs as a mandatory benefit.
- b. The percentage funding from the Federal government is the same for all states.
- c. States have flexibility regarding certain covered services and around eligibility for the Medicaid program.
- d. The federal government sets the rates for reimbursement of services in all Medicaid programs.
- e. Don't know

* 4. Which one of the following statements describes the origin of employer-sponsored health insurance coverage in the U.S.?

- a. Began in the 1920's, to deal with medical costs related to high injury rates in the work place.
- b. Began in the 1930's, as a New Deal program to help people meet rising health care costs.
- c. Began in the 1940's during World War II, offered as a fringe benefit to recruit workers when wages were frozen by the government.
- d. Began in the 1950's, in response to demands from the major unions.
- e. Don't know

* 5. Which one of the following is not a Patient Experience measure typically used in publicly reported performance-based quality data?

- a. Patient satisfaction related to office co-pays and deductibles
- b. The patient's perception of office staff responsiveness
- c. The primary care physician's knowledge of outcomes from a visit to a specialist
- d. The primary care physician's knowledge of the patient's medical history
- e. Don't know

* 6. How is "value" in health care commonly defined?

- a. Value = Health outcomes / Patient satisfaction
- b. Value = Hours of care / Morbidity & mortality
- c. Value = Medical errors / Patient visits
- d. Value = Cost of care / Quality of care
- e. Don't know

* 7. Accepted definitions and standards for Patient-Centered Medical Homes include all the following except for:

- a. Focused on patient-centered care
- b. Committed to quality and safety
- c. Team-based to meet physical and mental health care needs
- d. Participates in pay-for-performance contracts with health insurers
- e. Don't know

* 8. Your Medicare patient is thinking of joining a Medicare Advantage plan, such as a Medicare HMO, in which you participate. Which of the following is true of the services he will receive under this plan? The patient will:

- a. Have fewer covered services than traditional Medicare
- b. Be required to use a designated provider network
- c. Have unlimited access to specialists, without needing a referral
- d. Pay higher deductibles than in traditional Medicare
- e. Don't know

* 9. The Healthcare Effectiveness Data and Information Set (HEDIS) used by health plans measures performance across 5 domains of care, including Effectiveness of Care. Which of the following is not included among these domains?

- a. The patient's experience of care
- b. Health plan descriptive information
- c. Utilization and relative resource use
- d. Provider unit financial stability
- e. Don't know

* 10. In which of the following ways did the Affordable Care Act impact employer-based insurance?

- a. Young adults are now covered by their working parents' policy until age 30.
- b. Annual limits on benefits paid out by the insurer were removed, but lifetime limits remain.
- c. People seeking coverage cannot be excluded because of a pre-existing condition.
- d. Premiums cannot increase beyond a certain level set by Congress.
- e. Don't know

* 11. Which one of the following statements about chronic care is true?

- a. As adult Americans adopt more healthy lifestyles, the number of people with chronic conditions is projected to decrease steadily.
- b. Annual medical expenditures for an adult with a chronic condition increases by as much as 50% when the individual also has a mental health or behavioral health condition.
- c. Among the elderly, most people with a chronic condition have only one condition; a minority have two or more conditions.
- d. The use of care teams including care managers has been shown to be less effective in treating chronic conditions than more frequent visits to the primary care physician.
- e. Don't know

* 12. Which one of the following factors contributed to a shift in health insurance coverage from traditional health insurance to HMOs in the 1980s and early 1990s?

- a. Employers paid most or all of the premium for the less expensive HMO plan, and required employees to pay the difference between that plan and the more expensive, traditional insurance plans.
- b. Most employers stopped offering other options besides HMOs once they became available.
- c. State governments required employees who were offered an HMO option to enroll in that plan in order to reduce health expenditures.
- d. The best local physicians joined HMOs and dropped other insurance plans.
- e. Don’t know

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* 13. One measure of health care expenditures in the U.S. is their share of the Gross Domestic Product (GDP). Which of the following reflects historic and projected changes in health care spending?

- a. From 6% of GDP in 1985, to 12% in 2014, to projected 20% in 2023.
- b. From 10% of GDP in 1985, to 17% in 2014, to projected 19% in 2023.
- c. From 10% of GDP in 1985, to 17% in 2014, to projected 14% in 2023.
- d. From 6% of GDP in 1985, to 20% in 2014, to projected 26% in 2023.
- e. Don’t know

* 14. What is meant by the term “dual eligibles”?

- a. Families with both spouses having access to employer-based insurance
- b. Veterans with both VA and Medicare insurance
- c. Physicians who contract with two health plans
- d. Persons who qualify for insurance coverage by both Medicare and Medicaid
- e. Don’t know

* 15. A growing phenomenon in health insurance is pay-for-performance (P4P) contracts, in which insurers set financial and quality targets for their participating providers and offer financial incentives and other rewards for performance. Which one of the following statements about P4P programs is true?

- a. Insurers publicize their providers' performance on P4P measures in order to impact members' choice of physician.
- b. Some P4P contracts include measures of infrastructure, like information technology, along with clinical quality and patient satisfaction measures.
- c. To qualify for financial incentives under P4P contracts, providers must be among the top performers in their regions.
- d. P4P programs are utilized for reimbursing hospitals, not physician practices.
- e. Don’t know

* 16. Health plans review new medical technology periodically to determine if they will provide this technology as a covered benefit. In determining coverage for a new technology, a health plan considers only the body of scientific evidence, and not psycho-social factors. True or false?

- a. True
- b. False
- c. Don't know

* 17. Why is coordination of care more difficult under fee-for-service than under global payment?

- a. Fee-for-service (FFS) only covers services delivered by physicians.
- b. Providers are paid less under FFS than global payment.
- c. FFS historically has had no procedure codes (CPTs) for primary care activities outside of office-based visits.
- d. FFS arrangements prohibit providers from hiring physician-extenders.
- e. Don't know

* 18. Which one of the following entities is the largest payer of health insurance premiums in the U.S.?

- a. Employers
- b. State governments
- c. Federal government
- d. Individual enrollees
- e. Don't know

* 19. Looking at the distribution of health care costs across the population, the most costly 10% of patients account for approximately how much of total health care spending?

- a. 20%
- b. 33%
- c. 66%
- d. 85%
- e. Don't know

* 20. Measuring quality by individual physicians is difficult for a number of reasons, including small numbers of patients with specific conditions. Which one of the following strategies can be most helpful to overcome this obstacle?

- a. Use data for a practice with multiple physicians and attribute the same performance to each of the member physicians.
- b. Use all performance data, since even small samples are statistically reliable.
- c. Allow physicians to voluntarily opt out of performance measurement initiatives.
- d. Measure attributes of the patient's experience, like physician communication, that are relevant regardless of the patient's specific condition.
- e. Don't know

* 21. In comparing and contrasting fee-for-service with capitation and global budgets, which one of the following statements is true?

- a. Both fee-for-service (FFS) and capitation/global budgets give incentives for efficiency.
- b. FFS creates incentives for underuse; capitation/global budgets for overuse.
- c. Capitation/global budgets allows providers to implement management tools that are not covered by FFS.
- d. Care management is equally desirable for patients and providers under both FFS and capitation/global budgets.
- e. Don't know

* 22. Which one of the following statements is<u>true</u> of reimbursement through a "global payment" arrangement?

- a. This type of payment is rarely combined with P4P incentives.
- b. The payment amount is calculated to cover the cost of routine outpatient services only.
- c. Global payment is a hospital-based reimbursement model used to cover inpatient services.
- d. Global payment establishes a fixed amount each year for every patient covered, and payment for all of his/her care is provided from this pool.
- e. Don't know

* 23. Which one of the following statements is true of Accountable Care Organizations (ACOs)?

- a. ACOs are based on a shared savings model, including bonuses for performance.
- b. ACOs can be established with relatively small populations.
- c. Patients are limited to receiving services within the ACO network.
- d. ACOs usually limit enrollment to patients with chronic conditions.
- e. Don't know

* 24. The term “Triple Aim” is commonly referred to in health care reform initiatives. Which of the following elements is not an element of the Triple Aim?

- a. Improving Patient Experience
- b. Improving Workforce Satisfaction
- c. Improving Population Health
- d. Controlling Healthcare Spending
- e. Don’t know

* 25. Changes in reimbursement to physician groups away from traditional fee-for-service to global or bundled payments are intended to achieve a number of goals. Which of the following is not a goal in these new arrangements between payer and provider?

- a. Achieving greater coordination of care
- b. Providing coverage to persons currently uninsured
- c. Controlling total costs of care
- d. Eliminating unnecessary care
- e. Don’t know

* 26. Which one of the following statements about geriatric care management is true?

- a. A recommended sequence to manage a panel of elderly patients is: high risk screening, assessment, triage to care management.
- b. Geriatric care management is typically implemented after a patient has been hospitalized, rather than as a way to prevent admissions.
- c. Helping seniors to manage their medications is omitted from geriatric care management models and generally left instead to the physician and pharmacist.
- d. Geriatric care management is effective with global budgets and risk contracts, but does not have an impact in a fee-for-service environment.
- e. Don’t know

* 27. Your name. Please note: We ask for your name (first name and last name) so we can track who has completed the assessments. Responses will be reported in the aggregate only.

Thank you for completing this survey. We look forward to seeing you at the THCI Residency Rotation, from August 10-13.