



AHIP

Exam Questions AHM-510

Governance and Regulation

NEW QUESTION 1

The Tidewater Life and Health Insurance Company is owned by its policy owners, who are entitled to certain rights as owners of the company, and it issues both participating and nonparticipating insurance policies. Tidewater is considering converting to the type of company that is owned by individuals who purchase shares of the company's stock. Tidewater is incorporated under the laws of Illinois, but it conducts business in the Canadian provinces of Ontario and Manitoba. Tidewater established the Diversified Corporation, which then acquired various subsidiary firms that produce unrelated products and services. Tidewater remains an independent corporation and continues to own Diversified and the subsidiaries. In order to create and maintain a common vision and goals among the subsidiaries, the management of Diversified makes decisions about strategic planning and budgeting for each of the businesses. In order to become the type of company that is owned by people who purchase shares of the company's stock, Tidewater must undergo a process known as

- A. management buy-out
- B. piercing the corporate veil
- C. demutualization
- D. mutualization

Answer: C

NEW QUESTION 2

In the paragraph below, a statement contains two pairs of terms enclosed in parentheses. Determine which term in each pair correctly completes the statement. Then select the answer choice containing the two terms that you have chosen.

One type of acquisition is called a stock purchase. In a typical stock purchase, a company acquires (51% / 100%) of the voting shares of another company's stock, thereby making the acquired company a subsidiary. The (acquired / acquiring) company holds all of the assets and liabilities of the acquired company.

- A. 51% / acquired
- B. 51% / acquiring
- C. 100% / acquired
- D. 100% / acquiring

Answer: C

NEW QUESTION 3

The Tidewater Life and Health Insurance Company is owned by its policy owners, who are entitled to certain rights as owners of the company, and it issues both participating and nonparticipating insurance policies. Tidewater is considering converting to the type of company that is owned by individuals who purchase shares of the company's stock. Tidewater is incorporated under the laws of Illinois, but it conducts business in the Canadian provinces of Ontario and Manitoba. Tidewater established the Diversified Corporation, which then acquired various subsidiary firms that produce unrelated products and services. Tidewater remains an independent corporation and continues to own Diversified and the subsidiaries. In order to create and maintain a common vision and goals among the subsidiaries, the management of Diversified makes decisions about strategic planning and budgeting for each of the businesses. By combining under Diversified a group of businesses that produce unrelated products and by consolidating the management of the businesses, Tidewater has achieved the type(s) of integration known as

- A. Conglomerate integration and operational integration
- B. Horizontal integration and operational integration
- C. Horizontal integration and virtual integration
- D. Conglomerate integration only

Answer: A

NEW QUESTION 4

Regulators of health plans have set standards in a number of areas of plan operations. Requirements with which health plans must comply typically include

- A. providing enrollees and prospective enrollees with detailed information about various aspects of health plan policies and operations
- B. maintaining internal grievance and appeals processes to resolve enrollee complaints against the organization
- C. maintaining quality assurance programs that reflect the plan's activities in monitoring quality
- D. all of the above

Answer: D

NEW QUESTION 5

The Department of Health and Human Services (HHS) has delegated its responsibility for development and oversight of regulations under the Health Insurance Portability and Accountability Act (HIPAA) to an office within the Centers for Medicaid & Medicare Services (CMS). The CMS office that is responsible for enforcing the federal requirements of HIPAA is the

- A. Center for Health Plans and Providers (CHPPs)
- B. Center for Medicaid and State Operations
- C. Center for Beneficiary Services
- D. Center for Managed Care

Answer: B

NEW QUESTION 6

Antitrust laws can affect the formation, merger activities, or acquisition initiatives of a health plan. In the United States, the two federal agencies that have the primary responsibility for enforcing antitrust laws are the

- A. Internal Revenue Service (IRS) and the Department of Justice (DOJ)
- B. Office of Inspector General (OIG) and the Department of Defense (DOD)
- C. Federal Trade Commission (FTC) and the Department of Labor (DOL)
- D. Federal Trade Commission (FTC) and the Department of Justice (DOJ)

Answer: D

NEW QUESTION 7

The National Association of Insurance Commissioners (NAIC) adopted the Health Maintenance Organization Model Act (HMO Model Act) to regulate the development and operations of HMOs. One true statement regarding the HMO Model Act is that the act

- A. includes mental health services in its definition of basic healthcare services
- B. authorizes only one state agency-the department of insurance-to regulate HMOs
- C. requires HMOs to place a deposit in trust with the state insurance commissioner for the purpose of protecting the interests of enrollees should an HMO become financially impaired
- D. requires HMOs that wish to offer a point-of-service (POS) product to contract with a licensed insurance company to provide POS options to plan members

Answer: C

NEW QUESTION 8

Indigo Health Plan advertised a specific individual health insurance policy through a direct mail advertisement that provided detailed information about the product. In order to comply with the NAIC Model Rules Governing Advertisements of Accident and Sickness Insurance, Indigo must disclose whether the advertised policy contains any exceptions, reductions, or limitations. Thus, Indigo disclosed in the advertisement that one policy provision limits coverage for dental exams to \$50 per exam and to one exam per calendar year. This information indicates that, with respect to the definitions in the NAIC Model Rules, Indigo's advertisement is an example of an

- A. Invitation to contract, and it discloses a policy provision known as an exception
- B. Invitation to contract, and it discloses a policy provision known as a reduction
- C. Invitation to inquire, and it discloses a policy provision known as an exception
- D. Invitation to inquire, and it discloses a policy provision known as a reduction

Answer: B

NEW QUESTION 9

Several states have adopted clinical practice guidelines for treating workers' compensation injuries. Clinical practice guidelines can best be described as

- A. Fee schedules that specify the maximum amount providers may charge for treating workers' compensation patients
- B. A utilization management and quality management mechanism designed to aid providers in making decisions about the most appropriate course of treatment for a specific case
- C. Detailed plans of medical treatment designed to facilitate a patient's return to the workplace
- D. Payment practices that might technically violate the provisions of the anti-kickback statute but that will not be considered illegal and for which providers and health plans will not be subject to penalties

Answer: B

NEW QUESTION 10

While traditional workers' compensation laws have restricted the use of managed care techniques, many states now allow managed workers' compensation. One common characteristic of managed workers' compensation plans is that they

- A. Discourage injured employees from returning to work until they are able to assume all the duties of their jobs
- B. Use low copayments to encourage employees to choose preferred providers
- C. Cover an employee's medical costs, but they do not provide coverage for lost wages
- D. Rely on total disability management to control indemnity benefits

Answer: D

NEW QUESTION 10

The Good & Well Pharmacy, a Medicaid provider of outpatient drugs, is subject to the prospective drug utilization review (DUR) mandates of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). One component of prospective DUR is screening. In this context, when Good & Well is involved in the process of screening, the pharmacy is

- A. Updating a formulary to represent the current clinical judgment of providers and experts in the diagnosis and treatment of disease
- B. Reviewing patient profiles for the purpose of identifying potential problems
- C. Consulting directly with prescribers and patients in the planning of drug therapy
- D. Denying coverage for the off-label use of approved drugs

Answer: B

NEW QUESTION 11

SoundCare Health Services, a health plan, recently conducted a situation analysis. One step in this analysis required SoundCare to examine its current activities, its strengths and weaknesses, and its ability to respond to potential threats and opportunities in the environment. This activity provided SoundCare with a realistic appraisal of its capabilities. One weakness that SoundCare identified during this process was that it lacked an effective program for preventing and detecting violations of law. SoundCare decided to remedy this weakness by using the 1991 Federal Sentencing Guidelines for Organizations as a model for its compliance program.

By definition, the activity that SoundCare conducted when it examined its strengths, weaknesses, and capabilities is known as

- A. An environmental analysis
- B. An internal assessment
- C. An environmental forecast
- D. A community analysis

Answer: B

NEW QUESTION 12

The Opal Health Plan complies with all of the provisions of the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). Samantha Hill and Debra Chao are Opal enrollees. Ms. Hill was hospitalized for a cesarean birth, and Ms. Chao was hospitalized for a normal delivery. From the following answer choices, select the response that indicates the minimum hospital stay for which Opal, under NMHPA, must provide benefits for Ms. Hill and Ms. Chao.

- A. M
- B. Hill: 72 hours; M
- C. Chao: 24 hours
- D. M
- E. Hill: 72 hours; M
- F. Chao: 48 hours
- G. M
- H. Hill: 96 hours; M
- I. Chao: 24 hours
- J. M
- K. Hill: 96 hours; M
- L. Chao: 48 hours

Answer: D

NEW QUESTION 15

The following situations illustrate per se violations of federal antitrust laws:

Situation A - Two groups of providers agreed among themselves that each provider will do business with health plans only on a fee-for-service basis.

Situation B - In order to avoid competing with each other, two independent, competing physician/hospital organizations (PHOs) divide the geographic areas in which they will market their services.

From the following answer choices, select the response that correctly identifies the types of per se violations illustrated by these situations.

- A. Situation A: price fixing; Situation B: horizontal division of markets
- B. Situation A: price fixing; Situation B: tying arrangement
- C. Situation A: horizontal group boycott; Situation B: horizontal division of markets
- D. Situation A: horizontal group boycott; Situation B: tying arrangement

Answer: A

NEW QUESTION 18

Antitrust laws can affect the formation, merger activities, or acquisition initiatives of a health plan. In the United States, the two federal agencies that have the primary responsibility for enforcing antitrust laws are the

- A. Internal Revenue Service (IRS) and the Department of Justice (DOJ)
- B. Office of Inspector General (OIG) and the Department of Defense (DOD)
- C. Federal Trade Commission (FTC) and the Department of Labor (DOL)
- D. Federal Trade Commission (FTC) and the Department of Justice (DOJ)

Answer: D

NEW QUESTION 21

In the paragraph below, a statement contains two pairs of terms enclosed in parentheses. Determine which term in each pair correctly completes the statement. Then select the answer choice containing the two terms that you have chosen.

Every employee benefit plan governed by the Employee Retirement Income Security Act (ERISA) must distribute a summary plan description (SPD) to participants within (90 / 120) days after the date on which the plan is adopted or made effective. Thereafter, if the plan is amended, a new SPD must be distributed every (5 / 10) years.

- A. 90 / 5
- B. 90 / 10
- C. 120 / 5
- D. 120 / 10

Answer: C

NEW QUESTION 26

From the following answer choices, choose the term that best corresponds to this description. The

SureQual Group is a group of practicing physicians and other healthcare professionals paid by the federal government to review services ordered or furnished by other practitioners in the same medical fields for the purpose of determining whether medical services provided were reasonable and necessary, and to monitor the quality of care given to Medicare patients.

- A. Health insuring organization (HIO)
- B. Independent practice association (IPA)
- C. Physician practice management (PPM) company
- D. Peer review organization (PRO)

Answer: D

NEW QUESTION 28

From the following answer choices, choose the term that best corresponds to this description. Barrington Health Services, Inc. contracts with a state Medicaid agency as a fiscal intermediary. Barrington does not provide medical services, but contracts with medical providers on behalf of the state Medicaid agency.

- A. Health insuring organization (HIO)
- B. Independent practice association (IPA)
- C. Physician practice management (PPM) company
- D. Peer review organization (PRO)

Answer: A

NEW QUESTION 31

The board of directors of the Garnet Health Plan, an integrated delivery system (IDS), includes physicians and hospital representatives who sometimes feel compelled to represent a specific organization that is only one part of the IDS. Such a circumstance can lead to , which is a situation in which the members of the board focus on the best interests of component parts of the enterprise rather than on the best interests of Garnet as a whole.

- A. An enterprise-focused board
- B. Representational governance
- C. Enterprise liability
- D. Boundary spanning

Answer: B

NEW QUESTION 34

SoundCare Health Services, a health plan, recently conducted a situation analysis. One step in this analysis required SoundCare to examine its current activities, its strengths and weaknesses, and its ability to respond to potential threats and opportunities in the environment. This activity provided SoundCare with a realistic appraisal of its capabilities. One weakness that SoundCare identified during this process was that it lacked an effective program for preventing and detecting violations of law. SoundCare decided to remedy this weakness by using the 1991 Federal Sentencing Guidelines for Organizations as a model for its compliance program.

With respect to the Federal Sentencing Guidelines, actions that SoundCare should take in developing its compliance program include

- A. Creating a system through which employees and other agents can report suspected misconduct without fear of retribution
- B. Holding management accountable for the misconduct of their subordinates
- C. Assigning a high-level member of management to the position of compliance coordinator or administrator
- D. All of the above

Answer: D

NEW QUESTION 39

The Hanford Health Plan has delegated the credentialing of its providers to the Sienna Group, a credential verification organization (CVO). If the contract between Hanford and Sienna complies with all of the National Committee for Quality Assurance (NCQA) guidelines for delegation of credentialing, then this contract

- A. Transfers to Sienna all rights to terminate or suspend individual practitioners or providers in Hanford's provider network
- B. Describes the process by which Hanford evaluates Sienna's performance in credentialing providers
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: C

NEW QUESTION 40

Arthur Dace, a plan member of the Bloom Health Plan, tried repeatedly over an extended period to schedule an appointment with Dr. Pyle, his primary care physician (PCP). Mr. Dace informally surveyed other Bloom plan members and found that many people were experiencing similar problems getting an appointment with this particular provider. Mr. Dace threatened to take legal action against Bloom, alleging that the health plan had deliberately allowed a large number of patients to select Dr. Pyle as their PCP, thus making it difficult for patients to make appointments with Dr. Pyle.

Bloom recommended, and Mr. Dace agreed to use, an alternative dispute resolution (ADR) method that is quicker and less expensive than litigation. Under this ADR method, both Bloom and Mr. Dace presented their evidence to a panel of medical and legal experts, who issued a decision that Bloom's utilization management practices in this case did not constitute a form of abuse. The panel's decision is legally binding on both parties.

This information indicates that Bloom resolved its dispute with Mr. Dace by using an ADR method known as:

- A. Corporate risk management
- B. An ombudsman program
- C. An ethics committee
- D. Arbitration

Answer: D

NEW QUESTION 44

Greenpath Health Services, Inc., an HMO, recently terminated some providers from its network in response to the changing enrollment and geographic needs of the plan. A provision in Greenpath's contracts with its healthcare providers states that Greenpath can terminate the contract at any time, without providing any reason for the termination, by giving the other party a specified period of notice.

The state in which Greenpath operates has an HMO statute that is patterned on the NAIC HMO Model Act, which requires Greenpath to notify enrollees of any material change in its provider network. As required by the HMO Model Act, the state insurance department is conducting an examination of Greenpath's operations. The scope of the on-site examination covers all aspects of Greenpath's market conduct operations, including its compliance with regulatory requirements. The contracts between Greenpath and its healthcare providers contain a termination provision known as

- A. An 'economic credentialing' termination provision
- B. A 'breach of contract' termination provision
- C. A 'fair procedure' termination provision

D. A 'without cause' termination provision

Answer: D

NEW QUESTION 47

One example of health plan's influence on the practice of medicine is that, during the past decade, the focus of healthcare has moved toward , which is designed to reduce the overall need for healthcare services by providing patients with decision-making information.

- A. Demand management
- B. Managed competition
- C. Comprehensive coverage
- D. Private inurement

Answer: A

NEW QUESTION 50

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