

AHM-510 Dumps

Governance and Regulation

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NEW QUESTION 1

Regulatory and legislative bodies are among the important environmental forces in the health plan industry. The following statements are about such regulation and legislation. Select the answer choice that contains the correct statement.

- A. Federal guidelines exist to direct health plans on compliance issues when a health plan encounters conflicting state laws in a given service area.
- B. Administrative rules and regulations do not carry the force of law.
- C. As stakeholders in the health plan industry, federal and state governments exert tremendous influence over a health plan's formation and operations.
- D. In recent years, the number of health plan bills in the state and the federal legislatures has decreased.

Answer: C

NEW QUESTION 2

The Surrey Medical Supply Company was formed as a limited partnership. In this partnership, Victoria Lewin is one of the limited partners and Oscar Gould is a general partner. This information indicates that, with respect to the typical characteristics of limited partnerships,

- A. M
- B. Lewin has more freedom to opt out of the partnership than does M
- C. Gould
- D. M
- E. Lewin has more liability for the debts of Surrey than does M
- F. Gould
- G. both M
- H. Lewin and M
- I. Gould participate in the day-to-day management of Surrey
- J. the partnership will continue upon the death of M
- K. Gould, whereas it will end with the death of M
- L. Lewin

Answer: A

NEW QUESTION 3

In the course of doing business, health plans conduct basic corporate transactions. For example, when a health plan engages in the corporate transaction known as aggressive sourcing, the health plan

- A. Chooses to contract with vendors who provide specific functions that would otherwise be performed in-house, such as paying claims
- B. Seeks to obtain the best deals from various vendors for equipment, supplies, and services such as telephones, overnight mail, computer hardware and software, and copy machines
- C. Merges with one or more companies to form an entirely new company
- D. Joins with one or more companies, but retains its autonomy and relies on the other companies to perform specific functions

Answer: B

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

Third party administrators (TPAs) provide various administrative services to health plans or groups that provide health benefit plans to their employees or members. Many state laws that regulate TPAs are based on the NAIC Third Party Administrator Model Statute. One provision of the TPA Model Law is that it

- A. Prohibits TPAs from performing insurance functions such as underwriting and claims processing
- B. Prohibits TPAs from entering into an agreement under which the amount of the TPA's compensation is based on the amount of premium or charges the TPA collects
- C. Requires TPAs, upon the termination of a TPA agreement with a group, to immediately transfer all its records relating to the group to the new administrator
- D. Requires TPAs to notify the state insurance department immediately following any material change in the TPA's ownership or control

Answer: D

NEW QUESTION 7

Any willing provider laws have their share of proponents and opponents. Arguments commonly made in opposition to any willing provider laws include

- A. That such laws reduce the number of providers in a health plan's network
- B. That such laws limit consumer choice to coverage options that are more costly than networkbased plans
- C. That such laws encourage providers to offer discounts in exchange for patient volume
- D. All of the above

Answer: B

NEW QUESTION 8

Nightingale Health Systems, a health plan, operates in a state that requires health plans to allow enrollees to visit obstetricians and gynecologists without a referral from a primary care provider. This information indicates that Nightingale must comply with a type of mandate known as a:

- A. Direct access law
- B. Scope-of-practice law
- C. Provider contracting mandate
- D. Physician incentive law

Answer: A

NEW QUESTION 9

State X issued a nonresident license to Tamara Pensky, a sales representative of the Verity Health Plan. In doing so, State X imposed a countersignature requirement, which requires that

- A. An officer of Verity sign a written statement which indicates that Verity appoints M
- B. Pensky as an agent who is authorized to market Verity's products
- C. An officer of Verity sign a written statement which certifies that Verity has investigated M
- D. Pensky's qualifications and background and believes she is trustworthy and competent
- E. Applications solicited by M
- F. Pensky must be signed by an individual who holds a resident License
- G. Applications solicited by M
- H. Pensky must be signed by an officer of Verity

Answer: C

NEW QUESTION 10

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 15

The following statements describe various state benefit mandates. Select the answer choice that describes a state law pertaining to off-label uses for drugs.

- A. State A mandates that health plans provide benefits for experimental drugs for the treatment of terminal diseases such as AIDS and cancer.
- B. State B mandates that health plans have a procedure in place to allow a patient to have a nonformulary drug covered under certain conditions.
- C. State C mandates that, in dispensing generic drugs, pharmacies must label drug containers with the name of the substituted generic medication.
- D. State D mandates that health plans provide benefits for the treatment of one form of cancer with specific drugs that had originally been approved by the Food and Drug Administration (FDA) to treat other forms of cancer.

Answer: D

NEW QUESTION 16

The following statements are about market conduct examinations of health plans. Select the answer choice that contains the correct statement.

- A. Multistate examinations are not appropriate for financial examinations, because regulatory requirements concerning a health plan's financial condition tend to vary from state to state.
- B. Market conduct examinations of a health plan's advertising and sales materials include comparing the advertising materials to the policies they advertise.
- C. Once an examination report is provided to the state insurance department, a health plan is not given an opportunity to present a formal objection to the report.

D. In imposing sanctions on health plans, state insurance departments are required to follow federal sentencing guidelines.

Answer: B

NEW QUESTION 21

Health maintenance organizations (HMOs) seeking federal qualification under the HMO Act of 1973 and its amendments must meet requirements in four basic operational areas. One operational requirement for qualification is that an HMO must

- A. Ensure that at least 1/3 of its policy-making body is comprised of HMO members
- B. Ensure that there is adequate representation of underserved communities on its policy-making body
- C. Have an ongoing quality assurance program that meets the requirements of the Centers for Medicaid & Medicare Services (CMS), stresses health outcomes, and provides for review by health professionals
- D. Test, safeguard, and promote quality of care by following detailed programmatic techniques that are explained in CMS's Federally Qualified HMO (FQHMO) Manual

Answer: C

NEW QUESTION 25

A federal law that significantly affects health plans is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to comply with HIPAA provisions, issuers offering group health coverage generally must.

- A. Renew group health policies in both small and large group markets, regardless of the health status of any group member
- B. Provide a plan member with a certificate of creditable coverage at the time the member enrolls in the group plan
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: B

NEW QUESTION 30

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 32

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 physicianhospital 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 36

Determine whether the following statement is true or false:

Although most-favored-nation (MFN) clauses in contracts between health plans and healthcare providers are not per se illegal, they should be reviewed under the rule of reason analysis for antitrust purposes.

- A. True, because the Federal Trade Commission (FTC) ruled that MFN clauses are not per se illegal and the FTC encourages health plans to include them in provider contracts.
- B. True, because although MFN clauses are not per se illegal, they violate antitrust laws if they have a predatory purpose and an anticompetitive effect.
- C. False, because MFN clauses involve decisions by providers concerning the level of fees to charge, and thus they are per se illegal.
- D. False, because MFN clauses are not per se illegal, and thus they are exempt from antitrust laws and regulation by the FTC.

Answer: B

NEW QUESTION 39

In 1994, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) revised their 1993 healthcare-specific antitrust guidelines to include analytical principles relating to multiprovider networks. Under the new guidelines, the regulatory agencies will use the rule of reason to analyze joint pricing activities by competitors in physician or multiprovider networks only if

- A. Provider integration under the network is likely to produce significant efficiencies that benefit consumers
- B. The providers in a network share substantial financial risk
- C. The combining of providers into a joint venture enables the providers to offer a new product
- D. All of the above

Answer: A

NEW QUESTION 43

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 47

TRICARE, a military healthcare program, offers eligible beneficiaries three options for healthcare services: TRICARE Prime, TRICARE Extra, and TRICARE Standard. With respect to plan features, both an annual deductible and claims filing requirements must be met, regardless of whether care is delivered by network providers, under

- A. TRICARE Prime and TRICARE Extra only
- B. TRICARE Extra and TRICARE Standard only
- C. TRICARE Standard only
- D. None of these healthcare options

Answer: C

NEW QUESTION 49

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 51

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 53

One typical difference between a for-profit health plan's board of directors and a not-for-profit health plan's board of directors is that the directors in a for-profit health plan

- A. Can serve on the board for a period of no more than ten years, whereas the terms of service for a not-for-profit board's directors are usually unlimited by the director's age or by a preset maximum number of years of service
- B. Must participate in raising capital for the health plan, whereas a not-for-profit board's directors are prohibited from participating directly in raising capital for the health plan
- C. Are directly accountable to shareholders, whereas a not-for-profit board's directors are accountable to plan members and the community
- D. Are not compensated for board participation, whereas a not-for-profit board's directors are compensated for board participation

Answer: C

NEW QUESTION 58

SoundCare Health Services, an MCO, 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 60

The following statements appear in the Twilight Health Plan's strategic plan:

Increase the percentage of preventive health interventions for total eligible membership during each of the next three calendar years for the following services: mammography, Pap smears, immunizations, and first trimester visits for prenatal mothers

Improve customer satisfaction on an annual basis for each of the next three calendar years, as measured by satisfaction surveys for members, providers, and employer groups

Increase by 30% the number of claims processed by the automated claim payment system and reduce by 10% the cost of paying claims during the next three years

These statements are examples of Twilight's

- A. Corporate objectives
- B. Company mission
- C. Company vision
- D. Corporate strategies

Answer: A

NEW QUESTION 64

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 68

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 70

Health plans are allowed to appeal rules or regulations that affect them. Generally, the grounds for such appeals are limited either to procedural grounds or jurisdictional grounds. The Kabyle Health Plan appealed the following new regulations:

Appeal 1 - Kabyle objected to this regulation on the ground that this regulation is inconsistent with the law.

Appeal 2 - Kabyle objected to this regulation because it believed that the subject matter was outside the realm of issues that are legal for inclusion in the regulatory agency's regulations. Appeal 3 - Kabyle objected to the process by which this regulation was adopted.

Of these appeals, the ones that Kabyle appealed on jurisdictional grounds were

- A. Appeals 1, 2, and 3
- B. Appeals 1 and 2 only
- C. Appeals 1 and 3 only
- D. Appeals 2 and 3 only

Answer: B

NEW QUESTION 72

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