



**AHIP**

## **Exam Questions AHM-510**

Governance and Regulation

#### NEW QUESTION 1

The Sawgrass Health Center is an institution that trains healthcare professionals and performs various clinical and other types of healthcare-related research. Because Sawgrass receives government funding, it is required to provide medical care for the poor. Of the following types of health plans, Sawgrass can best be described as:

- A. A medical foundation
- B. An academic medical center (AMC)
- C. A healthcare cooperative
- D. A community health center (CHC)

**Answer: B**

#### 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

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 5

The Wentworth Corporation uses a self-funded plan to provide its employees with healthcare benefits. One consequence of Wentworth's approach to providing healthcare benefits is that selffunding

- A. Requires that Wentworth self-administer its healthcare benefit plan
- B. Requires that Wentworth pay higher state premium taxes than do insurers and health plans
- C. Eliminates the need for Wentworth to pay a risk charge to an insurer or health plan
- D. Increases the number of benefit and rating mandates that apply to Wentworth's plan

**Answer: C**

#### NEW QUESTION 6

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 7

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 8

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 9

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. From the following answer choices, select the response that identifies the type of market conduct examination that is being performed on Greenpath and the frequency with which the HMO Model Act requires state insurance departments to conduct an examination of an HMO's operations.

- A. Type of examination: comprehensive; Required frequency: annually
- B. Type of examination: comprehensive; Required frequency: at least every three years
- C. Type of examination: target; Required frequency: annually
- D. Type of examination: target; Required frequency: at least every three years

**Answer:** B

#### NEW QUESTION 10

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 10

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 13

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 16

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 17

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 19

Congress enacted three clauses relating to the preemptive effect of the Employee Retirement Income Security Act of 1974 (ERISA). One of these clauses preserves from ERISA preemption any state law that regulates insurance, banking, or securities, with the exception of the exemption for self-funded employee benefit plans. This clause is called the

- A. Savings clause
- B. Preemption clause
- C. Deemer clause
- D. De novo clause

**Answer:** A

### Explanation:

The savings clause preserves from preemption any state law that regulates insurance, banking or securities except as provided by the deemer clause.

### NEW QUESTION 20

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.

In the case of *Pacificare of Oklahoma, Inc. v. Burrage*, the U.S. Court of Appeals for the Tenth Circuit considered whether ERISA preempts medical malpractice claims against health plans based on certain liability theories. In this case, the Tenth Circuit court held that ERISA (should / should not) preempt a liability claim against an HMO for the malpractice of one of its primary care physicians, and therefore the HMO was subject to a claim of (subordinated / vicarious) liability.

- A. Should / subordinated
- B. Should / vicarious
- C. Should not / subordinated
- D. Should not / vicarious

**Answer:** D

### NEW QUESTION 25

The following statements are about the Federal Employees Health Benefits Program (FEHBP), which is administered by the Office of Personnel Management (OPM). Three of the statements are true and one statement is false. Select the answer choice that contains the FALSE statement.

- A. For every plan in the FEHBP, OPM annually determines the lowest premium that is actuarially sound and then negotiates with each plan to establish that premium rate.
- B. Once a health plan has submitted its rate proposals for a contract year to the OPM, it cannot adjust its premium rate for any reason.
- C. To cover its administrative costs, OPM sets aside 1% of all FEHBP premiums.
- D. Each spring, OPM sends all plan providers its call letter, a document that specifies the kinds of benefits that must be available to plan participants and cost

goals and procedural changes that the plans need to adopt.

**Answer:** A

#### NEW QUESTION 26

Solvency standards for Medicare provider-sponsored organizations (PSOs) are divided into three parts: (1) the initial stage, (2) the ongoing stage, and (3) insolvency. In the initial stage, prior to CMS approval, a Medicare PSO typically must have a minimum net worth of

- A. \$750,000
- B. \$1,000,000
- C. \$1,500,000
- D. \$2,000,000

**Answer:** C

#### NEW QUESTION 30

The Balanced Budget Act (BBA) of 1997 created the Medicare+Choice plan. One provision of the BBA under Medicare+Choice is that the BBA

- A. Requires health plans to qualify as either a competitive medical plan (CMP) or a federally qualified HMO in order to participate in the Medicare program
- B. Eliminates funding for demonstration projects such as the Medicare Enrollment Demonstration Project
- C. Narrows the geographic variations in payments to Medicare health plans by lowering the growth rate of payments in high-payment counties and raising the rates in low-payment counties
- D. Increases Graduate Medical Education (GME) payments to hospitals for the training and cost of educating and training residents

**Answer:** C

#### NEW QUESTION 35

There are several exceptions to the Ethics in Patient Referrals Act and its amendments (the Stark laws), which prohibit a physician from referring Medicare or Medicaid patients for certain designated services or supplies provided by entities in which the physician has a financial interest. Consider whether the situations described below qualify as exceptions to the Stark laws:

Situation A: Dr. Wong is a physician in the Marvel Health Plan's provider network and has a financial relationship with Marvel arising from the health plan's compensation for his services. Marvel is not a prepaid health plan.

Situation B: Dr. Ryder is a physician in the provider network of the Glen Health Plan, which is not a prepaid health plan. In situations of medical necessity, Dr. Ryder refers Glen patients to a physical therapy clinic that leases office space from him.

Situation C: Dr. Yost has a compensation arrangement with a health plan for providing health services under the Medicare+Choice program.

An arrangement that is exempt from the Stark laws is described in

- A. All of these situations
- B. Situations A and C only
- C. Situation B only
- D. Situation C only

**Answer:** D

#### NEW QUESTION 38

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 43

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 47

The government uses various tools within the realm of two broad categories of public policy: allocative policies and regulatory policies. In the context of public policy, laws that fall into the category of allocative policy include

- A. The Balanced Budget Act (BBA) of 1997
- B. The Health Insurance Portability and Accountability Act (HIPAA) of 1996
- C. Laws affecting health plan quality oversight
- D. Laws specifying procedures for health plan handling of consumer appeals and grievances

**Answer:** A

#### NEW QUESTION 51

The following answer choices describe various approaches that a health plan can take to voice its opinions on legislation. Select the answer choice that best describes a health plan's use of grassroots lobbying.

- A. The Delancey Health Plan is launching a media campaign in an effort to persuade the public that proposed health care legislation will increase the cost of healthcare.
- B. The Stellar Health Plan is using direct mail and telephone calls to encourage people who support a patient rights bill to contact key legislators and voice their support for the bill.
- C. The Bestway Health Plan is encouraging its employees to contribute to a political action committee (PAC) that is funding the political campaign of a pro-health plan candidate.
- D. A representative of the Palmer Health Plan is attending a one-on-one meeting with a legislator to present Palmer's position on pending managed care legislation.

**Answer:** B

#### NEW QUESTION 55

Health plans should monitor changes in the environment and emerging trends, because changes in society will affect the managed care industry. One true statement regarding recent changes in the environment in which health plans operate is that

- A. Women as a group receive more healthcare and interact more often with health plans than do men over the course of a lifetime
- B. The focus of healthcare during the past decade has shifted away from outpatient care to inpatient hospital treatment
- C. The uninsured population in the United States has been decreasing in recent years
- D. The decline in overall inflation in the 1990s failed to slow the growth in healthcare inflation

**Answer:** A

#### NEW QUESTION 60

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