

AHM-510 Dumps

Governance and Regulation

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NEW QUESTION 1

Some health plans qualify as tax-exempt organizations under Sections 501(c)(3) and 501(c)(4) of the Internal Revenue Code. One true statement regarding a health plan that qualifies as a 501(c)(4) social welfare organization, in comparison to a health plan that qualifies as a 501(c)(3) charitable organization, is that a

- A. 501(c)(4) social welfare organization is allowed to distribute profits for the benefit of individuals, whereas a 501(c)(3) charitable organization can use surplus only for the benefit of the organization, the community, or a charity
- B. 501(c)(4) social welfare organization can raise operating funds through the sale of tax-exempt bonds, whereas a 501(c)(3) charitable organization does not have this advantage
- C. 501(c)(4) social welfare organization has less flexibility in determining use of funds for social or political activities than does a 501(c)(3) charitable organization
- D. 501(c)(4) exemption is easier to obtain than a 501(c)(3) exemption, because 501(c)(4) social welfare organizations are allowed to benefit a comparatively smaller group of individuals

Answer: D

NEW QUESTION 2

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 3

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 4

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 5

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 6

The Nonprofit Institutions Act allows the Neighbor Hospital, a not-for-profit hospital, to purchase at a discount drugs for its 'own use'. Consider whether the following sales of drugs were not for Neighbor's own use and therefore were subject to antitrust enforcement:

Elijah Jamison, a former patient of Neighbor, renewed a prescription that was originally dispensed when he was discharged from Neighbor.

Neighbor filled a prescription for Camille Raynaud, who has no connection to Neighbor other than that her prescribing physician is located in a nearby physician's office building.

Neighbor filled a prescription for Nigel Dixon, who is a friend of a Neighbor medical staff member. With respect to the United States Supreme Court's definition of 'own use,' the drug sales that were not for Neighbor's own use were the sales that Neighbor made to

- A. M
- B. Jamison, M
- C. Raynaud, and M
- D. Dixon
- E. M
- F. Jamison and M
- G. Raynaud only

- H. M
- I. Dixon only
- J. None of these individuals

Answer: A

NEW QUESTION 7

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 8

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 9

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 10

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 10

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 13

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 18

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 20

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 23

There are several approaches to the interagency division of responsibility for managed care entity (MCE) oversight. In State M, the state Medicaid agency, the state department of health, and the state insurance department are all responsible for ensuring that quality improvement programs are in place among the same group of MCEs and that these programs meet each agency's rules and regulations for such programs. This information indicates that State M uses the approach known as the

- A. Parallel model
- B. Shared model
- C. Concurrent model
- D. PACE model

Answer: C

NEW QUESTION 25

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.

Different types of compensation arrangements in managed care plans, from fee-for-service (FFS) arrangements to capitation arrangements, lead to different types of fraud and abuse. From the answer choices below, select the response that identifies the form of abuse in which Bloom is allegedly engaging, according to Mr. Dace's complaint, and whether this form of abuse is more likely to occur in FFS compensation arrangements or in capitation arrangements.

- A. Type of abuse underutilizationType of compensation arrangement FFS arrangement
- B. Type of abuse underutilizationType of compensation arrangement capitation arrangement
- C. Type of abuse overutilizationType of compensation arrangement FFS arrangement
- D. Type of abuse overutilizationType of compensation arrangement capitation arrangement

Answer: B

NEW QUESTION 29

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 33

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 38

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 42

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 45

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 50

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 55

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 59

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