AHM-510 Q&As

Governance and Regulation

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QUESTION 1

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

Correct Answer: C

QUESTION 2

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. Ms. Hill: 72 hours; Ms. Chao: 24 hours

B. Ms. Hill: 72 hours; Ms. Chao: 48 hours

C. Ms. Hill: 96 hours; Ms. Chao: 24 hours

D. Ms. Hill: 96 hours; Ms. Chao: 48 hours

Correct Answer: D

QUESTION 3

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

Correct Answer: B

QUESTION 4

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

Correct Answer: A

QUESTION 5

Directors on a health plan\\'s board must demonstrate their compliance with three duties in all their decisions. Directors who exercise their duties in good faith and with the same degree of diligence and skill that an ordinary, reasonable person would be expected to display in the same situation are meeting the duty known as the

A. Duty of loyalty

B. Duty to supervise

C. Duty of care

D. Trustee duty

Correct Answer: C

QUESTION 6

Certificate of need (CON) laws apply to health plans in a variety of ways, depending upon the state. By definition, CON

laws are laws that are designed to

A. Regulate the construction, renovation, and acquisition of healthcare facilities as well as the purchase of major medical equipment in a geographical area

B. Protect commerce from unlawful restraint of trade, price discrimination, price fixing, reduced competition, and monopolies

C. Determine benefit payments when a person is covered by more than one plan, such as two group health plans

D. License and regulate health plans that wish to establish and operate an HMO

Correct Answer: A

QUESTION 7

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Services for which states can require copayments from Medicaid recipients include:

A. Emergency services

B. Family planning services

C. Both A and B

D. A only

E. B only

F. Neither A nor B

Correct Answer: D

QUESTION 8

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.

Tidewater\\'s participating policy owners have the right to

A. Elect the board of directors on the basis of one vote per policy owner

B. Elect the board of directors on the basis of one vote for each policy a person owns

C. Participate in developing a corporate mission statement and strategic plans

D. Receive stock dividends for each policy they own

Correct Answer: A

QUESTION 9

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

Correct Answer: C

QUESTION 10

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

Correct Answer: C

QUESTION 11

Determine whether the following statement is true or false:

Failing to adopt and implement standards for the prompt investigation and settlement of claims is an example of an activity that would be considered an improper claims practice according to the NAIC Model Unfair Claims Settlement Practices Act.

A. True

B. False

Correct Answer: A

QUESTION 12

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

Correct Answer: A

QUESTION 13

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

Correct Answer: D

QUESTION 14

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.

With respect to the type of change that constitutes a material change under the HMO Model Act\\'s disclosure requirements, the termination of one healthcare provider from Greenpath\\'s provider network

A. Always qualifies as a material change in the plan, and Greenpath must report the change to all plan enrollees

B. Always qualifies as a material change in the plan, and Greenpath must report the change to only those plan enrollees who have received care from the terminated provider

C. Qualifies as a material change in the plan only if the provider is a primary care provider, and in such a case Greenpath must report the change to all plan enrollees

D. Qualifies as a material change in the plan only if the provider is a primary care provider, and in such a case Greenpath must report the change to only those plan enrollees who receive primary care from the terminated provider

Correct Answer: D

QUESTION 15

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

Correct Answer: C