AHIP AHM-510 Practice Questions

Shared by Howell on 10-11-2026

For More Free Questions and Preparation Resources

Check the Links on Last Page

Question 1

Question Type: MultipleChoice

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.

Options:

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

Question 2

Question Type: MultipleChoice

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

Options:

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- One effect of Section 231(h) of HIPAA, which amended the Social Security Act, has been to permit health plans with Medicare contracts to provide enrollees with value-added services such as discounted memberships to health clubs.

Answer:

D

Question 3

Question Type: MultipleChoice

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

Options:

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

Question 4

Question Type: MultipleChoice

The following statements are about various provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Three of the statements are true and one statement is false. Choose the answer choice that contains the FALSE statement.

Options:

A- HIPAA permits group health plans that offer coverage through an HMO to impose affiliation periods during which no benefits or services are provided to a plan member.
B- HIPAA created a new category of federal healthcare crimes, called federal healthcare offenses that apply to private healthcare plans as well as to federally funded healthcare programs.
C- One effect of Section 231(h) of HIPAA, which amended the Social Security Act, has been to permit health plans with Medicare contracts to provide enrollees with value-added services such as discounted memberships to health clubs.
D- HIPAA provides that any fines and penalties recovered through regulatory proceedings to enforce the federal fraud and abuse statutes will be turned over to enforcement agencies to conduct additional investigations.

Answer:

C

Question 5

Question Type: MultipleChoice

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

Options:

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

Answer:

C

Question 6

Question Type: MultipleChoice

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.

Options:

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

Question 7

Question Type: MultipleChoice

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

Options:

A- Mr. Jamison, Ms. Raynaud, and Mr. Dixon

B- Mr. Jamison and Ms. Raynaud only
C- Mr. Dixon only
D- None of these individuals

Answer:

A

Question 8

Question Type: MultipleChoice

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.

Options:

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

Answer:

B

To Get Premium Files for AHM-510 Visit

https://www.p2pexams.com/products/ahm-510

For More Free Questions Visit

https://www.p2pexams.com/ahip/pdf/ahm-510

