

Healthcare Funding Reimbursement and Financial Policy

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All organizations require funds to perform their activities, and efficient management of funds is essential for the survival of organizations. Healthcare organizations receive funds either directly from their patients or through [third-party reimbursement](#). In the USA, healthcare organizations are paid by government programs, including Medicare and Medicaid and some private health insurance plans. Health care is one of the expensive sectors around the world, the US government spends trillions of dollars on health care. To ensure that every individual achieves good health facilities, the healthcare sector has undergone a number of health reforms. These reforms led the system to replace private payments by third-party payers or insurance companies. Private pay is considered more expensive than the third-party reimbursement plan. However, in the third party reimbursement plan, there are more chances of fraud and funds inefficiencies.

The flow of funds is the total cash inflows and outflows within the organization, such movement of cash is recorded in the accounts statements by the accounting experts. These activities are recorded on a regular basis, such as daily, monthly, quarterly and annually. There are certain statements and standards used by accountants to ensure transparency and accuracy in the flow of funds. These financial statements include cash flow statements, income statements, balance sheets, ledgers, etc. The changes in the working capital of the organization are measured by the net current assets of the organization minus the total current liabilities. In hospitals, the cash outflows contain the expenses incurred against the purchase of hospital supplies, bills, rent, and payment of salaries. At the same time, the cash inflow comes from the payment made by the patients and third party reimbursement. The private pay is the most acceptable mode of payment because it brings cash directly to the hospitals, on the other hand, third party payment takes time and paid by insurance companies or government organizations after the completion of treatment.

Prevention Of Abuses And Inefficiencies In Third-Party Reimbursement

Third-party payments sometimes create problems for hospitals because of their inefficiencies and inappropriate payments. There are many flaws in the system adopted by the insurance companies, which led to a virtual battle between hospitals and third-party payers. Insurance companies negotiate down the payments they make to the hospitals, and the hospitals are trying to negotiate up what they receive from insurers. Large hospitals are having more bargaining power to reimburse their payments, for this purpose mergers of hospitals became a common practice nowadays. Hospitals are charging more from Medicare and Medicaid than any service provided by private physicians. They are

charging facility fees, which is considered a bad thing. When a particular service increases rapidly, the insurance companies revise their plans, and they consider it as a cash cow because of being overpaid. They reevaluate their CPT code and reduce the reimbursement code.

Most of the patient visit hospitals and ask for the services covered in their insurance plan; they avoid the facilities which are not covered in their plan. This is one of the major issues because most of the patient are reluctant to receive the treatment they need but not covered in their insurance plan. Efficiency is important for the sustainability of the healthcare system. According to the US Institute of Medicine, the amount used by health care has failed to achieve the best results and to avoid the waste of resources such as supplies, equipment, energy and ideas. According to Spitzer et al. (2017), fraud means the misrepresentation or intentional deception by a person to achieve some unauthorized benefits to himself or other people. At the same time, abuse refers to the inconsistent practices of providers, which can incur some unnecessary costs to the insurance companies or government organizations to reimburse more money for services which are not medically required by the patients.

The Flow Of Funds In Health Care Organizations

Medicare and Medicaid are usually not reimbursing the total amount spent on the patients, hospitals lose a huge amount in some cases. The private insurance companies, on the other hand, are charged more by the hospitals to cover their losses on serving patients of Medicare and Medicaid, whose bills are often not paid in full (Maeda & Nelson, 2018). The per-diems paid by insurance companies are negotiated annually between hospitals and insurers. The hospitals may negotiate with several dozen or hundred insurance companies. A schedule of list prices is maintained by each hospital, and these schedules of charges are negotiated, and the discount is negotiated with insurers according to the budget and the financial position of the patient. The chargemaster of each hospital is different and it is being revised periodically. In the USA, most of the population is insured by private insurance companies and government organizations. They pay all the expenses covered in their plan on behalf of the patients. The payment is reimbursed to the hospitals after completion of proper documentation. Every insurance company has its unique policy about payment, and the services covered in their agreement with patients are disclosed to the hospital's management.

Challenges Faced By Private Insured Patients

Most Americans have Medicare and Medicaid insurance coverage. However, some of the services are not covered by them, so people also have private insurance. Many Americans do not qualify for the requirements of Medicare and Medicaid, so they have private insurance plans (Schulman & Milstein, 2019). Affording the premium of insurance is one of the challenges faced by the consumer in private insurance. Another issue is reimbursement and claims approval. Mostly, consumers face difficulties in claiming their expenses from insurance companies. Private insurers cover limited services, and they

are trying to reduce the risk of losses, so they have set strict criteria to pass the claims of their patients. The consumers have little knowledge about the policy they have bought. They often visit hospitals and ask there about the expenses covered by insurance, so they lose trust in their insurer and pay their bills from their pocket.

Methods Of Consumer Empowerment

To empower the consumer's health care facilities to communicate with consumers and their insurers and play the role of mediator. The purpose of healthcare organizations is to provide the best services to their patients and assist them in covering their expenses from their insurers. Most patients are not completely aware of the insurance policy they have purchased. According to research, most of the patients are unaware of their health issues and the services they need, especially the elder citizens. Hospital staff provide them with easy-to-use applications which can help the caregivers and patients learn about the outcomes and manage the patient actively. Patients are not only concerned about their treatment plans but they are also concerned about the expenses because health services are highly expensive. The healthcare staff must be highly cooperative and polite to learn about the problems of their patients.

Therefore, it is believed that in the 21st century, the third-party reimbursement plan is widely increased around the world. People are paying monthly premiums from their earnings to cover their medical expenses. However, some of the services are not covered by third-party insurers, and patients are paying huge premiums, which is all in vain. Moreover, healthcare organizations also face problems in reimbursing their expenses from these third parties. There are potential challenges for health care organizations to manage their cashflows. For efficient management of cash flows, they required a proper policy to bind these third parties and overcome their losses.

References

- Maeda, J. L. K., & Nelson, L. (2018). How do the hospital prices paid by Medicare Advantage plans and commercial plans compare with Medicare fee-for-service prices?. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 55, 0046958018779654.
- Schulman, K. A., & Milstein, A. (2019). The implications of "Medicare for All" for US hospitals. *JAMA*, 321(17), 1661-1662.
- Spitzer, S. A., Staudenmayer, K. L., Tennakoon, L., Spain, D. A., & Weiser, T. G. (2017). Costs and financial burden of initial hospitalizations for firearm injuries in the United States, 2006-2014. *American journal of public health*, 107(5), 770-774.