Healthcare Funds Flow, Private Pay, and Third-Party Reimbursement

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The 21st-century healthcare sector is characterized by a number of health reforms that are meant to ensure that every person has access to good healthcare at a lower cost. This has led to the development of insurance companies or third-party payers that have almost completely replaced private pay, as it is considered more expensive than third-party reimbursement.

However, third-party payments have also come with other challenges, such as increased fraud and inefficiencies. This paper will explain the two modes of payment, private pay and third-party pay, and how to prevent increased fraud due to third-party reimbursement. In addition to that, the paper will discuss the challenges the consumer faces in private insurance and, finally, how healthcare facilities can empower their consumers or patients so as to achieve the desired outcomes.

Funds flow is the net of all cash outflows and inflows within an organization. This cash movement is recorded in the funds flow accounts statement of various financial assets. These measurements are taken monthly or on a quarterly basis. The funds flow statement of an organization reports the changes in an entity's net working capital between the beginning and end of the fiscal period. The net working capital is the organization's current assets minus its current liabilities. A flow focuses on cash movements, reflecting only the net movements after examining the inflows and outflows of cash in the organization (Patel et al., 2014). This monetary movement can include payments to investors and payments made by the organization when buying goods and services. In our case, the money is spent to buy hospital supplies and pay hospital bills.

In the hospital setting, fund inflows come from private pay and third-party reimbursement. Private pay is the case when a patient chooses to pay the medical bills by himself or herself rather than using health insurance coverage. This form of payment is the most accepted as it brings in direct cash to the hospital. Third-party reimbursement is the case when hospital bills and costs are covered by a third party, mostly health insurance, under which the patient is covered. Examples of health insurance programs and companies include Blue Shield and Medicaid. Third-party reimbursements can be in full or in part, depending on the subscriber's contributions to his or her coverage.

How Can You Prevent Abuses And Inefficiencies In Third Party Payments?

Third-party payments by insurance companies are filled with inappropriate payments and inefficiencies due to errors, abuse, and fraud. Health systems have been and are trying to develop strategies to stop the large amount of fraud and inefficiencies witnessed when it comes to third-party payments. There are a number of verified methods that can be used to stop the development of fraud and inefficiencies experienced in third-party payments. Among them is knowledge discovery from a database, an approach that combines statistical methods and automated methods to extract a subscriber's information for further assessment. This concept is referred to as data mining (Byrd, Powell, and Smith, 2013). This helps insurance companies ascertain whether the payment they are making is fraudulent or legitimate.

Another approach that can be used to curb inefficiencies and abuse is the stepwise approach, which prevents the wastage of resources. This will not only solve the root causes of how claims become problematic but also improve cost management and increase efficiency in delivering care and third-party payment programs. The coordination between healthcare providers and the payer will be tightened, thus limiting any chance of fraud or inefficiencies (Joudaki et al., 2016).

Briefly Define The Flow Of Funds In The Care Organization.

Funds flow in the medicine continuum refers to remuneration that reflects the agreed-upon value of a transaction. This term can be used to refer to any arrangements between partnering organizations (Cleverley, 2017). These arrangements include an accountable care model in which cost and quality incentives are shared among hospitals and physicians, allocation of bundled payments, and many more arrangements that have monetary value in them. As the number of partnerships increases, a need for an agreed-upon approach to promote funds flow develops (Ginter, Duncan, and Swayne, 2018). This approach helps define and organize individual agreements between parties. Therefore, an effective funds flow framework addresses not only the partner organizations' challenges but also potential changes within the organization. These frameworks are unique to every organization and partnership that applies them.

Challenges Faced By Consumers Who Are Enrolled In Private Insurance:

Consumers enrolled in private insurance face various challenges. Most private payers face financial losses on health insurance exchanges. These exchanges, which came into being after the passage of

the Affordable Care Act, have failed to serve as an effective marketplace for private insurance payers. The ACA policies affect how payers act (Rosenbaum and Sommers, 2013). The policies governing the commercial exchange for commercial payers call for costly care from providers, which results in high financial losses for consumers.

Most consumers with private insurance coverage have little knowledge about what they bought. Coverage and denial procedures and policies benefit approximately 10% of their policyholders who have complicated medical needs. This coverage only favors seniors and those requiring complex medical care (Pashchenko and Porapakkarm, 2013). This has made most consumers lose trust in their health insurers because the private coverage plan fails to satisfy their expectations.

Methods To Use In Consumer Empowerment:

Patient engagement and consumer empowerment are key elements in healthcare markets that are seeking to produce better-quality outcomes. However, most healthcare facilities have been struggling to find the best ways to engage and empower their patients. Most of them achieve engagement, but they cannot achieve the desired outcomes if the engagement does not lead to positive behavior in patients and consumers. To achieve this outcome, healthcare facilities have to:

- Help consumers become more literate about the healthcare sector. They can do this through websites, blogs, wikis, and many other platforms that can reach their consumers. This will help inform consumers about their own health. The use of the internet and the development of such apps as eHealth also help educate the public about their health and the steps they can take to maintain it (McGuckin and Govednik, 2013).
- Help patients comprehend and retain the advice that they learn from the doctor’s or clinician’s office. Most people forget the information they learn when they go to the hospital immediately after they feel better. According to research, patients only retain 20 percent of what they are told by a doctor, and that value is reduced in older people and sicker patients (McGuckin and Govednik, 2013). To help such patients remember post-discharge instructions, healthcare facilities should come up with easy-to-use and easy-to-understand applications that could help caregivers and patients understand and actively manage patients, thus improving outcomes.
- Help consumers learn how to formulate and frame questions during sessions and medical checkups (Hibbard and Greene, 2013). This will help eliminate the cursory yes-or-no answers doctors receive from patients just because they don’t understand what they are asked. If providers develop open-ended questions that don’t require yes/no answers, they might be able to identify and address gaps in consumer understanding of diagnosis and treatment.
- Finally, healthcare facilities should design solutions with the consumer in mind. A good solution should give consumers more control over the management of their health. It should also be simple and easy to navigate (Hibbard and Greene, 2013). The solution must be readily and regularly accessible, and finally, it should provide reliable, actionable, and accurate information.

In conclusion, it is evident that the 21st century is characterized by an increased rate of third-party reimbursements. This is due to healthcare acts that are meant to ensure that every citizen is covered and thus able to access quality healthcare at any time. But this comes with many challenges, such as increased fraud and inefficiencies in payment. However, the application of data mining and a stepwise approach can help curb the inefficiencies and fraud seen in the healthcare sector due to third-party reimbursements. Finally, consumer empowerment is the key to the success of any organization. Therefore, healthcare facilities have to ensure that their patients are empowered so as to achieve the desired outcomes.

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