

Summary

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UNIVERSITY™NUR-621 Health Care Reimbursement Training Plan

<u>Name</u>	<u>Viridiana Alcala-Vargas</u>
<u>Unit/Subject</u>	NUR 621 Principles of Health Care Financial Management
<u>Training Summary and Focus</u>	<u><i>In two to three sentences, summarize the training, identifying the central focus based on the content and skills you would like trainees to learn.</i></u> The health care reimbursement training plan creates a strategy to align the reimbursement of healthcare services by Medicare, Medicaid, and other private insurance institutions. The plan establishes the measures taken by Medicare, Medicaid, and private insurance to reimburse health institutions for their services. The training will incorporate all top managers through evaluation criteria, including recommendations to what these organizations should do to compensate for the health services (Gruessner, 2016).
<u>Specific Learning Target(s)/Objectives</u>	<u><i>Learning objectives are designed to identify what the trainer intends to measure learning. Identify at least two objectives for the training. Detail how you would explain to your trainees how Medicare, Medicaid, and private insurance reimburse health care organizations.</i></u> The training plan identifies training assessment and guidelines for proper decision making regarding ways to reimburse health services. The training plan also creates a reliable means to assure training equipment and other training facilities are shared evenly to all employees. The training plan will incorporate the adoption of previous training plans, forming effective decision guidelines on training methodologies, assessing methods and procedures for evaluating the reimbursement training, and review the approaches used to represent training expenses and budgets. Employees need to understand that Medicare, Medicaid, and private insurance reimburse health care services by asserting or denying claims, disallowances, audits, administrative processes, and recoupments in federal and state court. Medicare and Medicaid often oppose state regulatory provisions that pose a burden to health facilities as well as

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Three successive sentences begin wit...: The

Spelling mistake: Gruessner → Guesser

Hyphenation p...: decision maki... → decision-maki...

Three successive sentences begin wit...: The

Spelling mist...: disallowances → dis allowance...

Spelling mistake: recoupments → recipients

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other illegal administrative actions. Medicare, Medicaid, and private insurance organizations can conduct internal investigations of health care provider billing activities to ensure compliance with the required practices

	(Gruessner, 2016). These organizations are also essential in offering third-party payer coverage issues. Lastly, the training will be embedded in enlightening the employees on how Medicare, Medicaid, and private insurance reimburse advice and dispute resolution. Advice and dispute resolution are centered on experience and longstanding relationships.
Training Outline	<u>Outline your training that covers how Medicare, Medicaid, and private insurance reimburse health care organizations for their services.</u> Medicare, Medicaid, and private insurance set tone for the health industry. The training will focus on the incorporation of the three health insurance programs to promote development of value-based care to reduce health costs and improve the quality of health care. The employees will be enlightened on how to change the health industry through value-based care reimbursement. Employees ought to understand the various incentives in Medicare, Medicaid, and private insurance physician payment and their impact on beneficiary access to care and health care costs. This training concentrates on health care providers reimbursement since Medicare, Medicaid, and private insurance account for more than one-fifth of provider's spending. Medicare, Medicaid, and private insurance reimbursement are designed to pay the going rates to the private sector as the health insurance fees are used to represent the payment patterns in the private sector (Gruessner, 2016). Medicare & Medicaid reimbursement is changing from a fee for service to a value-based care reimbursement, meaning if certain goals are met within the specified timeframe the hospital will receive reimbursement. To help cut cost and prevent unnecessary spending Accountable Care Organizations were created. Accountable Care Organizations (ACOs) is a voluntary group of healthcare professionals composed of doctors and hospitals who work together in order to help improve patient care while saving money. They coordinate patient care so that patient receive the appropriate treatment in a timely manner, they help reduce medication errors, and avoid duplication of care and treatments. ACOs share accountability for the quality and cost of care delivered to their patients. ACOs receive financial incentives for meeting or surpassing their savings targets and providing patient with quality care. The Centers for Medicare & Medicaid Services (CMS) payments to ACOs incorporate financial incentives for lowering spending and meeting specified quality goals for their beneficiary population. Accountable Care Organizations understand that quality of care is imperative as well as proper allocation of funds which has led

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	Spelling mistake: Gruessner → Guesser
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	Word repetition: Outline Outline → Outline
	Spelling mistake: Gruessner → Guesser
	Possible wordiness: in a timely manner



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	them to seek innovative models to reduce healthcare cost while improving quality of care. Private insurances reimburse healthcare organization by a fee for service method. Lastly, the training will include detailed information on reimbursement methods, insurance rates for the entire country for various medical processes, and administrative practices to ensure they are available for these insurance programs.
Resources, Materials, Equipment, and Technology	<u>List all resources, materials, equipment, and technology you and the employees will use during the training.</u> • Previous training materials. • Online training registration system. • Management topic resources. • WIFI • Classroom • Internet • Classroom with projector and laptop • PowerPoint
References	Gruessner, V. (2016, October 17). How Medicare, Medicaid, and CHIP Guide the Health Payer Industry. Retrieved from https://healthpayerintelligence.com/features/how-medicare-medicaid-and-chip-guide-the-health-payer-industry Principles of health economics, including the notions of scarcity, supply, and demand, distinctions between need and demand, opportunity cost, discounting, time horizons, margins, efficiency, and equity. (2017, May 9). Retrieved from

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	Possible typo: WIFI → Wi-Fi

<https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4d-health-economics/principles-he>

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