**Health Information Management (HIM)**

**Question 1. Medicare and Medicaid**

The United States government's health insurance system is a complicated structure. Medicare is the health insurance system that covers people aged 65 and over, as well as some disabled or condition-specific individuals of a younger age. The program is further subdivided into four parts to make sure it covers certain areas of healthcare requirements. Part A includes inpatient hospital stays, skilled nursing care, hospice, and a portion of home healthcare. Part B covers outpatient care, physician care, preventive care, and durable medical equipment. In Part C, also known as the Medicare Advantage, the beneficiaries can join private insurance plans that are approved by Medicare. Such schemes frequently involve additional benefits. Part D provides prescription drug benefits by employing private companies that are contracted with Medicare. Drugs are cost-shared and paid by beneficiaries.

Medicaid is a federal and state insurance program that covers low-income individuals and families in terms of healthcare. The eligibility criteria depend on the state and usually consist of pregnant women, children, the elderly, and people with disabilities. Medicaid covers a wide range of services, such as hospital and physician visits, prescription medications, mental treatment, and long-term care. In contrast to Medicare, funding is provided at both the federal and state levels, with the federal government matching state-level expenditures on Medicaid (Barr & Brannan, 2024). Medicaid is an essential safety net, and it guarantees care to vulnerable groups.

**Question 2. Retrospective and Prospective Reimbursement Methods.**

Reimbursement procedures define the way healthcare professionals are remunerated. Retrospective reimbursement entails payment to the providers according to the actual expenditures incurred when delivering care. The providers file claims that describe the services and costs, and the payers compensate them. Prospective reimbursement, on the contrary, makes payment rates upfront, before care delivery. These rates take into account the features of the diagnosis, procedure, or patient.

The retrospective reimbursement had monetary rewards that led to higher expenditures. The cost was reimbursed to the providers and this meant there was no incentive to manage the cost. This may result in excessive use of services, unwarranted procedures, and exaggerated prices. The system actually encouraged wastefulness, and this led to the increased healthcare costs. The absence of cost control measures through the retrospective payment model eventually resulted in its decline and the use of prospective methods to enhance the efficiency and value of healthcare delivery (Nojomi et al., 2022). Prospective payment systems challenge providers to manage their costs efficiently without compromising the quality of care.

**References**

Barr, E., & Brannan, G. (2024). Medicare and Medicaid. *StatPearls*.

Nojomi, M., Tehrani-Banihashemi, A., Safarani, S., & Ahangar, A. (2022). Health economics; Retrospective (FFS) versus prospective (DRG, global, ...) reimbursement systems and COVID-19 in the health sectors of Iran and the world. *International Journal of Preventive Medicine*, *13*, 124.