Technology to the Rescue: Putting the Flow Back into Front-Office Workflow
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THE FRONT OFFICE’S EXPANDING ROLE

Today’s medical practice front office faces more challenges than ever.

Not too long ago, the front office’s responsibilities centered on scheduling, greeting, and checking-in patients. But today’s practice scheduling and reception staff must understand increasingly complex health plan terms – and clearly explain them to patients. They are the front lines of collecting revenue from patients. And they must do it all while conveying the warmth and compassion that is expected from a patient-centered practice.

PRACTICE PROFITABILITY AT STAKE

Knowing that your practice contracts with an insurance company is no longer enough to avoid unintentionally seeing patients out-of-network. And mistakes are costly – and not just financially.

Even as recently as the early 2000s, the lion’s share of revenue from insured patients was paid by health plans. Front desk collections were mostly limited to copays, and collecting them was a relatively straightforward matter: the receptionist simply checked the amount printed on the patient’s insurance card. And because the amounts due were much smaller, practices could still be profitable even if their copay collection process wasn’t perfect.

Verification of coverage was much less complicated, too. Health insurance companies offered a limited number of plans, and a practice could easily determine if their doctors participated.

Fast-forward a dozen or so years, and the number and type of health plans patients can participate in has exploded. Knowing that your practice contracts with an insurance company is no longer enough to avoid unintentionally seeing patients out-of-network. And mistakes are costly – and not just financially. Frustrated patients who unintentionally see a physician outside their coverage may be inclined to blame the physician for the error. Online sharing of that frustration can damage a practice’s reputation.

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1For example, a 2013 Department of Labor study found that the number of self-insured employer health plans grew from 42,647 in 2001 to 47,851 in 2010. These types of plans are often administered by a major carrier — meaning the employee may possess an insurance card from that carrier, even though the terms are non-standard and set by the employer. “Self-Insured Health Benefit Plans, 2013,” Michael J. Brien, PhD, Constantijn W. A. Panis, PhD.
The revenue mix for practices has also changed dramatically, as health plans increasingly require patients to share in the costs of their care. Copayments are now typically significant dollar amounts (sometimes charged as percentage of fees for more costly services\(^2\)). And health plans of all types, even employer plans, are much more likely to include a deductible now than ten or even five years ago. Average deductible amounts have also been growing steadily each year\(^3\).

The mushrooming of health plan options and increasing patient financial responsibility for the costs of their care have had a dramatic impact on practice profitability.

Uncollectible accounts receivable, bad debt, and write-offs have increased in most practices. Practices have found that amounts due from patients that are not collected at the time of service are much more likely never to be collected at all. Repeated follow-up via mailed statements and phone is also costly, further impacting net revenue. And if an account goes to collections, as little as 15% of the value will ultimately be collected\(^4\).

With patient responsibility pegged at as much as 40% under some health plans\(^5\), ineffective time of service collection puts clearly practice profitability at risk. It’s no wonder that practices have knitted together changes to practice flow to try to solve these important problems – even if those ad hoc solutions aren’t always efficient or optimal to meet today’s challenges.

Practices have found that amounts due from patients that are not collected at the time of service are much more likely never to be collected at all.

\(^2\)This is commonly referred to as co-insurance.
\(^3\)A 2014 Kaiser Foundation study found that 55% of employer plans included a deductible with single coverage in 2006, but that figure jumped to 80% in 2014. The average deductible amount increased even more dramatically, more than doubling from $584 in 2006 to $1,217 in 2014. See The Henry J. Kaiser Family Foundation, “2014 Employee Benefits Survey,” Exhibits F and G.
\(^4\)The Medical Group Management Association found that an average of 3.3 statements was required to collect payments that were not collected at the time of service. They also found that practices collect an average of just $15.77 of every $100 sent to an external collection agency for handling. “Perspective on Patient Payments,” MGMA Connexion, April, 2010.
\(^5\)The bronze plan level on the Affordable Care Act Exchange has a target patient financial responsibility of 40%. See “Marketplace Insurance Categories” on Healthcare.gov.
CONFUSION, SURPRISE
STRAIN COLLECTIONS –
AND RELATIONSHIPS

As health plans have evolved to include more ways for patients to share financial responsibility, their terms have also become more confusing to patients.

Studies by the Kaiser Family Foundation\(^6\) and Consumer Reports\(^7\) have found that consumers have a weak understanding of insurance terms related to out-of-pocket expenses, and that many Americans find themselves surprised by the medical bills they receive. This confusion contributes significantly to patients’ unpaid medical debts\(^8\). Even among patients who pay promptly, unpredictable bills strain trust in medical practices and health plans.

Practices have long understood that confusion and surprise makes patients reluctant to pay. (The deluge of phone calls to their billing departments after statements are mailed provides a ready source of feedback.) But helping patients understand their obligations at the time of service, so that they’re comfortable paying, has long been a challenge. Ever-changing health plan terms have been as hard for staff to understand as for patients. And reliable, real-time information about patient financial obligations has not always been readily available.

The workflow changes most practices have typically adopted would best be described as work-arounds: patchwork solutions compensating for a lack of reliable technology in the practice.

REACTIVE CHANGES, PATCHWORK WORKFLOW

Many practices have responded with workflow adaptations to try to address these costly challenges. But the rate of change over the past ten to fifteen years has been very dramatic, and the natural evolution of tasks in the front office has not often led to an optimal solution. The workflow changes most practices have typically adopted would best be described as work-arounds: patchwork solutions compensating for a lack of reliable technology in the practice.

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\(^7\)“Consumer Reports Survey Finds Nearly One Third of Privately Insured Americans Hit With Surprise Medical Bills,” Consumer Reports, May 5, 2015.

\(^8\)“42.9 Million Americans Have Unpaid Medical Bills,” by Associated Press, Modern Healthcare, December 11, 2014.
For example, as practices learned that insurance coverage can’t be verified with a patient’s card alone, they implemented work rules to compensate. But these procedures are often very clunky. Some payers may have online lookup tools that schedulers can use, provided the practice registers at a provider portal. In other cases, schedulers must call the payer – potentially spending considerable time on hold waiting for an answer. (And the scheduler likely relies on a hand-made matrix, taped on a computer monitor or wall, to decide which approach applies for each payer.)

Adaptations like these help protect the practice and the patient from an unintended out-of-network service, but they add many extra steps. Usually, schedulers need to manually document each verification. And these awkward solutions are also frequently unreliable. Some practices compensate for that by doing multiple verifications – doubling a workload that already involves many manual steps.

Similarly, as deductibles and higher copayments led to more patient accounts receivable, practices have looked for ways to collect at the time of scheduling and the time of service. But up-to-date billing and financial responsibility information has not always been available to all staff.

Billers might try to help by adding alerts on patient appointment records. The alerts would then prompt schedulers to contact billing for more information about the patient’s balance, so that patients could then be asked to pay at the time of service. But if patients wanted more information about their balance, or to make a payment immediately, they would need to either be transferred to the billing department or wait until their visit. If the biller was unavailable to take their call, an opportunity to collect would likely be missed. And all of these additional steps disrupt workflow and take staff attention away from their primary responsibilities.

Collecting deductible amounts at the time of service – widely considered a best practice – has been even more challenging to implement. Without reliable, immediate information about patient out-of-pocket obligations, practices needing quick estimates have had no choice but to guess. But over-collecting can irritate patients, and refunds add to billing department workloads. Some practices have simply given up on collecting these obligations at the front desk, even though not doing so puts considerable revenue at risk.

...a wave of technology innovation has been quietly underway for several years, and it is poised to bring practices much-needed relief.
AT LAST: TECHNOLOGY TO THE RESCUE

Many practices have expected their practice management platforms to solve these insurance-driven problems, and been frustrated. And they’ve felt forced into time-consuming workarounds like logging in to payers’ online portals or calling health plans for help. But a wave of technology innovation has been quietly underway for several years, and it is poised to bring practices much-needed relief.

Unlike a typical practice management system (PMS) – which serves a broad range of needs, from appointment scheduling, to reminding, to processing claims and managing receivables – these new technologies have been built with a distinct focus on problems related to patients’ changing insurance plans and payment responsibilities.

These systems also tend to be agnostic – meaning they work alongside any PMS or electronic medical record (EMR) platform, and also aim to connect universally with third parties and devices. They can, for example, connect practices with an array of payers for current eligibility information through one useful, usable interface. And they can make it easier for patients to understand, and comply with, their payment obligations.

THESE NEW SYSTEMS OFFER SOLUTIONS SUCH AS:

Real-time insurance verification and eligibility checking from a practices mix of payers

Convenient, secure patient payment options, including mobile and online

Estimation tools that project patient out-of-pocket payment obligations

Credit-card-on-file storage programs, for secure, automatic payments
PRACTICE-FOCUSED AND CONSUMER-FRIENDLY

Gun-shy practices that have endured multiple EMR implementations, with results that fell short of expectations, will find the innovations in front office payment, estimation, and eligibility verification tools to be a breath of fresh air.

Unlike EMR technologies, whose adoption was significantly boosted by Meaningful Use incentives and penalties, these tools were created entirely in response to practice needs. They are designed to be implemented quickly and easily on any platform that connects to the Internet. And their transaction-based fee structures are affordable and tied to the value they deliver to practices.

And patients benefit enormously, too. Practices can use these new tools to provide patients with information directly from their health plans about their payment obligations. This helps patients plan for expenses and avoid unpleasant surprises.

What’s more, these tools allow patients to use the convenient online and mobile payment options they increasingly prefer. Patients not only pay more promptly when offered options that eliminate the need to mail a check, they think more highly of the organization they’re paying. Practices no longer need to be shackled to mailed statements requesting payment by check, even if that’s all their current billing technology supports.

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AN EMPOWERED FRONT OFFICE

Each non-clinical staff member who connects with a patient has an opportunity to help that patient understand how their insurance works and meet their payment obligations.

Schedulers and receptionists have been asked to fill this role – but they often haven’t had the right tools. Practice billers are usually eager to help them contribute to collections, but relying on billing as the primary source of insurance information creates a bottleneck, and a lot of extra steps. It also often means interruptions for billers, which can slow down processing of insurance claims.

Deploying easy-to-use, cloud-based technology solutions for eligibility checking, payment estimation, and payment processing can cure that bottleneck and immediately increase efficiency. These tools give the entire front office access to the same, up-to-date patient coverage information. Every staff member a patient connects with, from scheduling through to billing, can help that patient understand and comply with his payment obligations. And they can do it without interrupting each other or repeating steps.

9Fiserv’s 2014 Billing Household Survey found that 60% of respondents reported increased overall satisfaction with their biller if a mobile payment option was offered. 46% said e-billing options increased their satisfaction. Consumers surveyed use an average of three payment options per month, and value choice.
GETTING STARTED

Getting started is as simple as evaluating the available technologies and learning how they can support – and even streamline – your workflow related to insurance eligibility checking, out-of-pocket cost estimation, and patient payment options.

It’s always important to ask about your own roster of contracted plans – be sure you know whether they’re connected. Remember, too, that these modern systems are designed to play nice with one another. Unlike a PMS or EMR, there’s usually no need to choose just one system. You can use them together to fulfill all the information needs for your empowered front-office team.

KEY FEATURES TO LOOK FOR:

• Cloud/web-based solutions – no hardware to purchase, set-up or manage
• Real-time eligibility checking
• Online out-of-pocket cost estimation
• Convenient options for patients to pay in your office via a smartphone app, tablet or kiosk
• Convenient online and mobile payments options for patients to use at home

ABOUT THE AUTHOR

Laurie Morgan of Capko & Morgan is a medical practice management consultant, speaker, and author. Her consulting work focuses on helping practices generate and capture more revenue, optimize their workflows, and use technology to improve profitability.

Laurie is a frequent contributor to healthcare publications and blogs such as Repertoire, PracticeLink, and Physicians Practice. She is also the creator of the popular “ManagementRx” series of practice management ebooks.

Laurie is a graduate of Brown University and Stanford University.
Wellero, Inc., offers innovative technologies that empower medical practice front offices to efficiently and quickly manage insurance-related tasks like eligibility checking, patient out-of-pocket estimation, and online and mobile payments. Our tools help patients connect with their insurance companies to understand their health plans, comply with payment terms, and pay through convenient web and app interfaces. By connecting patients and practices to health insurance information in real-time, Wellero supports both better collection rates for practices and more clarity and confidence about cost data for patients and practices alike.

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