TABLE OF CONTENTS

1  Introduction

2  Definitions

3  Key Findings

6  Survey Results
   01  Provider viewpoints on point-of-service collections  7
   02  Patient access tools for point-of-service payments  11

16  Background and Methodology
INTRODUCTION

Provider revenues. From declining Medicare reimbursements and growing numbers of high-deductible health plans (HDHPs), to the introduction of value-based payment models, managing financial performance has become trickier than ever.

One of the biggest trends affecting the provider revenue cycle? Consumerism—particularly the evolution from “patient” to “patient-as-payer.”

Much of the consumerism trend is being driven by the explosive growth in HDHPs over the past several years, shifting more responsibility for health care costs to patients. More than 66 percent of employers with 1,000+ employees offered a high-deductible health plan in 2013.1 Forecasts say 81% of large employers will offer HDHPs in 2015.2 Employees covered by such plans have increased from four percent to 20 percent since 2006.3 And providers report that 75 percent of patients with insurance exchange coverage have an HDHP.4

Given these changes, patients have become far more aware of what their health care costs, making them increasingly selective in the providers they choose to see. Not only does this dynamic drive increased competition among providers for patients, it also makes collecting from patients at or before the point of service critical to good financial performance. Why? Because the likelihood of collecting from patients after they leave the office drops dramatically. According to ACA International’s Top Collections Market Survey for 2013, the recovery rate on aged receivables was a mere 15.3 percent for hospitals and 21.8 percent for practices. When the patient owes the entire balance, the impact is even greater.

Collecting point-of-service payments can be challenging for the provider community. Decades of processes built around health plan collections do not change overnight, but need to evolve for providers to protect cash flows and financial health. And the change begins with the patient access process—that part of the revenue cycle where providers first engage with patients.

The question is: how important do providers believe it is to collect from patients at the point of service, and are they prepared to do so effectively?

The Impact of Consumerism on Provider Revenues study evaluates provider opinions about consumerism with a focus on collecting from patients at the point of service, current processes for doing so, and future outlook. It offers insight into the use of patient access tools for up-front patient payments, perceived importance, and expectations. Those findings are presented here.

---

DEFINITIONS

For the purpose of this study, Availity uses the following definitions:

**Consumerism**
A trend in which individuals are becoming more involved in—and responsible for—their health care purchases and decisions.

**High-deductible health plan**
A high-deductible health plan (HDHP) is a health insurance plan with lower premiums and higher deductibles than a traditional health plan.

**Patient access**
Processes enabling the patient’s access to care, including pre-registration, pre-authorization, payment responsibility estimation, and up-front or point-of-service collections.

**Providers**
Includes physician practices, hospitals, and health systems.

**Value-based payment model**
Payment arrangements that reward physicians, hospitals, medical groups, and other health care providers based on measures including quality, efficiency, and positive patient experience.

Examples referenced in this study include:

- Accountable Care Organization
- Patient-Centered Medical Home
- Payment-for-Coordination
- Pay-for-Performance
- Bundled Payment
KEY FINDINGS

Providers are keenly aware of the evolving role of the patient to that of primary payer.

- 85% of providers agree that patient financial responsibilities are growing.
- Approximately 55% note that self-pay is on the rise and about 60% see more individual plans than in recent years.
- More than 90% of providers state that high-deductible plans are becoming much more common.

Given this evolution, providers overwhelmingly agree that it is important to obtain patient payments at or before the point of service, but only a fraction of these fees are being collected up front.

- An average 90% of physician practices and facilities agree that collecting patient financial responsibilities before the patient leaves the office is important to the health of their businesses.
- More than 85% of providers agree that collecting from patients post-visit is a difficult task.
- Physician practices report collecting from 59% of patients while they are in the office, representing 35% of fees due from patients.
- Hospitals report collecting from 35% of patients at the point of service, representing just 19% of patient-owed fees.
KEY FINDINGS

To address the growing importance of up-front patient payments, providers are investing in tools and staff to establish new patient collection processes.

- **81%** have made recent investments in software and staff to manage up-front payments and collections.
- Nearly **90%** of providers leverage either payment plans or **post-visit billing** to complement their up-front collections.
  - Providers report that on average, **less than half of patients** engaged in payment discussions at the point of service are able to pay the full amount due.
  - **Payment plans** are the top choice of 41% of physician practices and 52% of hospitals when patients are unable to pay up front.
  - **Post-visit billing** is cited by 47% of physician practices and 37% of hospitals for patients who cannot pay up front.

**Patient access solutions are valued for improving up-front collections, but are used by less than half of physician practices.**

- More than **85%** of providers agree that patient access tools significantly improve up-front collections; **greater than 82%** agree the tools improve cash flow.
- **71%** of hospitals use a patient access solution today, compared with only **45%** of physician practices.
- Of those not using a patient access solution, **50% of physician practice non-users** and **60% of hospital non-users** say they are likely to buy a solution in the next three years.
KEY FINDINGS

Providers using a patient access tool report lower utilization of functionality designed specifically for patient collections, as compared to more traditional patient access features.

- Eligibility and benefits is noted as the number one patient access feature/function utilized by providers (>82%), followed by patient registration (>80%).
- Of the more specific patient collection features:
  - Only 26% of physician practices and 52% of hospitals use patient payment estimator functionality.
  - Just 22% of physicians and 34% of hospitals leverage online scripting for patient payment discussions.
  - A mere 14% of physician practices and 31% of hospitals use patient capacity-to-pay tools.

SUMMARY

1. Providers understand—and are prioritizing—the impact of higher patient deductibles on the financial health of their organizations.
2. Providers agree it’s important to collect from patients at or before the point of service, and are taking steps to acquire and implement tools and processes to address this need.
3. Providers are in the early stages of defining the most efficient and effective point-of-service collection workflows for their organizations.
4. Providers need to engage internal and/or external subject matter experts to:
   a. Identify and implement the best tools and workflows
   b. Train staff to encourage rapid adoption and utilization
   c. Accelerate ROI through increased cash flow and reduced bad debt.
SURVEY RESULTS

01 Provider viewpoints on point-of-service collections
02 Patient access tools for point-of-service payments
Awareness of Growing Patient Financial Responsibility

Providers are quick to recognize the financial evolution regarding patient health plans and high deductibles, as well as compounding trends such as uncompensated care and self-pay patients that affect their overall financial health.

Actions to Safeguard Revenues

In addition to acknowledging that margins are leaner than ever, the majority of providers are taking action through investments in tools and solutions to collect from patients at or before the point of service and protect revenues.

Figure 1.1

Provider awareness of shifting patient responsibility

Thinking about your (practice/facility), do you agree with the following statements?

- High-deductible health plans are much more common today than in recent years
  - Practices: 93%
  - Facilities: 91%

- An increasing portion of health care costs are moving to the patient
  - Practices: 84%
  - Facilities: 86%

- Uncompensated care has increased in recent years
  - Practices: 76%
  - Facilities: 75%

- Patients who self-pay are much more common today than in recent years
  - Practices: 52%
  - Facilities: 58%

- Individual health plans are much more common today than in recent years
  - Practices: 63%
  - Facilities: 59%

Figure 1.2

Provider assessment of financial situation

Thinking about your (practice/facility), do you agree with the following statements?

- It is increasingly important for the business health of our practice/facility that we collect the patient’s portion of payment up front or at point of service
  - Practices: 91%
  - Facilities: 87%

- Patient payments not collected up front become much harder to collect
  - Practices: 85%
  - Facilities: 88%

- Margins for our practice/facility are much thinner than they used to be
  - Practices: 88%
  - Facilities: 78%

- In the past few years, our practice/facility has increased investments in additional staff and software tools to deal with increased up-front processes and collections
  - Practices: 81%
  - Facilities: 81%
01 PROVIDER VIEWPOINTS
ON POINT-OF-SERVICE COLLECTIONS

Current and Forecasted Point-of-Service Collections
Over the next few years, providers anticipate collecting more patient-owed fees at the point of service: practices expect to collect from 68% of patients by 2017, while hospitals expect to collect from 52% (Fig. 1.3). Approximately 17% more physician practices and 16% more hospitals forecast collecting some revenue from 100% of patients at or before the point of service by 2017 (Fig. 1.3a). At the same time, 10% more physician practices expect to collect 100% of patient-owed dollars up front, while only 4% more facilities expect to do the same (Fig. 1.4a).

Figure 1.3
Average percentage of patients collected from up front
Up-front collections have increased since 2011 and are expected to continue increasing.

Figure 1.3a
Percentage of patients collected from up front, distribution
Of the 59% of practices collecting from patients up front, about a quarter are collecting some fees from 100% of their patients today. By 2017, 44% of practices expect to be collecting some fees up front from all of their patients.
Figure 1.4
Average percentage of revenue collected from patients up front
Physician practices and hospitals forecast increases in the amount of patient-owed fees they collect up front over the next few years (9% and 12%, respectively).

Figure 1.4a
Percentage of revenue collected from patients up front, distribution
Both physician practices and hospitals anticipate a trend representing higher patient collections at or before the point of service.
Provider Viewpoints on Point-Of-Service Collections

Patient Ability to Pay and Payment Plans
When pursuing payment at the point of service, providers report that less than half of patients are able to pay their full financial responsibilities up front: 56% are able to pay in full at physician practices and 34% at hospitals. To address this reality, providers typically offer payment plans or post-visit billing.

Figure 1.5
Average percentage of patients in 2014 who can pay the full requested amount

Figure 1.6
Policy if patient is unable to pay amount requested up front
Providers reported their number one policies when patients are unable to pay the full amount owed up front.
02 PATIENT ACCESS TOOLS FOR POINT-OF-SERVICE PAYMENTS

Provider Attitudes Toward Patient Access Value

The vast majority of providers agree that patient access tools help improve point-of-service collections from patients and increase cash flows. They also agree that the tools help improve accuracy, increase overall revenue, and are valuable to maintaining financial health. Nearly 70% state patient access tools reduce the amount of staff needed for payment collections and improve patient satisfaction.

Figure 2.1

Patient access value
Practices and facilities feel patient access solutions improve their organizations’ finances and cash flows, although they are less likely to believe they impact quality of care or population health.

Do you agree with the following statements regarding patient access solutions?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Practices (%)</th>
<th>Facilities (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly improve up-front collections</td>
<td>84%</td>
<td>90%</td>
</tr>
<tr>
<td>Improve cash flow</td>
<td>82%</td>
<td>91%</td>
</tr>
<tr>
<td>Improve accuracy/eliminate errors</td>
<td>84%</td>
<td>88%</td>
</tr>
<tr>
<td>Are valuable tools to maintain financial health/stability</td>
<td>82%</td>
<td>90%</td>
</tr>
<tr>
<td>Increase your overall revenue</td>
<td>81%</td>
<td>88%</td>
</tr>
<tr>
<td>Improve standardization/consistency of processes</td>
<td>80%</td>
<td>87%</td>
</tr>
<tr>
<td>Make it easy to understand, track, and project your earnings</td>
<td>78%</td>
<td>75%</td>
</tr>
<tr>
<td>Improve the patient experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve employee satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce the amount of staff needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve patient satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce per capita costs of health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are best suited for large practices/facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve overall quality of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve population health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Provider Utilization of Patient Access Tools**

While providers greatly agree that patient access tools offer significant value to the financial stability of their businesses, only 45% of physician practices use them compared with 71% of hospitals. Of those providers without a solution, more than half expect to implement one by 2017.

Of the physician practices that do use a patient access solution, 67% use a comprehensive solution from a single vendor, while 68% of hospital customers use a series of solutions from multiple vendors.

**Figure 2.2**  
**Providers currently using a patient access tool**  
Facilities are much more likely to be using patient access solutions.

**Figure 2.3**  
**Likelihood to purchase a patient access tool**  
A majority of practices and facilities not currently using patient access solutions expect to purchase a system in the next three years.

**Figure 2.4**  
**Comprehensive vs. multi-vendor solutions**  
Facilities are more likely to be using multiple ‘bolt-on’ solutions.
Top Patient Access Uses and Most Important Features

The same five patient access features were ranked by providers as both most used by their organizations and most important to their businesses. Eligibility and benefits, patient registration, payment processing, treatment authorization, and address and identity verification topped both lists.

While there were slight differences in specific feature rankings between physician practice respondents and hospital respondents (for example, hospitals ranked medical necessity checks notably higher than practices), the overall results demonstrate consistent patterns of use and prioritization between the groups. Detailed rankings for physician practices and hospitals are found in Figs. 2.5a and 2.5b, respectively.

**Most-used vs. most important patient access features: All Providers**

The following illustrates the ranking of most-used and most important patient access features across all providers (physician practices and hospitals combined).

* Indicates a tie

<table>
<thead>
<tr>
<th>MOST USED</th>
<th>MOST IMPORTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1* Eligibility and benefits</td>
<td>1 Eligibility and benefits</td>
</tr>
<tr>
<td>1* Patient registration</td>
<td>2 Patient registration</td>
</tr>
<tr>
<td>3 Payment processing</td>
<td>3* Treatment authorization</td>
</tr>
<tr>
<td>4 Treatment authorization</td>
<td>3* Payment processing</td>
</tr>
<tr>
<td>5* Address and identity verification</td>
<td>5 Address and identity verification</td>
</tr>
<tr>
<td>5* Set up payment plans</td>
<td>6 Patient payment estimator</td>
</tr>
<tr>
<td>7 Financial/charity assistance</td>
<td>7 Set up automatic payments</td>
</tr>
<tr>
<td>8 Medical necessity checks</td>
<td>8 Medical necessity checks</td>
</tr>
<tr>
<td>9 Patient payment estimator</td>
<td>9* Set up payment plans</td>
</tr>
<tr>
<td>10 Set up automatic payments</td>
<td>9* Capacity/propensity to pay</td>
</tr>
<tr>
<td>11 Online scripting for patient communication</td>
<td>11 Financial/charity assistance</td>
</tr>
<tr>
<td>12 Capacity/propensity to pay</td>
<td>12 Online scripting for patient communication</td>
</tr>
</tbody>
</table>

* Indicates a tie
### Figure 2.5a
Most-used vs. most important patient access features: Physician Practices

* Indicates a tie

#### MOST USED

<table>
<thead>
<tr>
<th></th>
<th>MOST USED</th>
<th>MOST IMPORTANT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Eligibility and benefits</td>
<td>1 Eligibility and benefits</td>
<td>88%</td>
</tr>
<tr>
<td>2</td>
<td>Patient registration</td>
<td>2 Payment processing</td>
<td>70%</td>
</tr>
<tr>
<td>3</td>
<td>Payment processing</td>
<td>3 Patient registration</td>
<td>58%</td>
</tr>
<tr>
<td>4</td>
<td>Treatment authorization</td>
<td>4 Treatment authorization</td>
<td>57%</td>
</tr>
<tr>
<td>5*</td>
<td>Set up payment plans</td>
<td>5 Address and identity verification</td>
<td>50%</td>
</tr>
<tr>
<td>5*</td>
<td>Address and identity verification</td>
<td>6 Patient payment estimator</td>
<td>39%</td>
</tr>
<tr>
<td>7</td>
<td>Financial/charity assistance</td>
<td>7 Set up automatic payments</td>
<td>32%</td>
</tr>
<tr>
<td>8</td>
<td>Medical necessity checks</td>
<td>8 Medical necessity checks</td>
<td>29%</td>
</tr>
<tr>
<td>9</td>
<td>Patient payment estimator</td>
<td>9 Capacity/propensity to pay</td>
<td>26%</td>
</tr>
<tr>
<td>10</td>
<td>Set up automatic payments</td>
<td>10 Financial/charity assistance</td>
<td>20%</td>
</tr>
<tr>
<td>11</td>
<td>Online scripting for patient communication</td>
<td>11 Set up payment plans</td>
<td>18%</td>
</tr>
<tr>
<td>12</td>
<td>Capacity/propensity to pay</td>
<td>12 Online scripting for patient communication</td>
<td>13%</td>
</tr>
</tbody>
</table>
### Figure 2.5b
Most-used vs. most important patient access features: Facilities
* Indicates a tie

<table>
<thead>
<tr>
<th><strong>MOST USED</strong></th>
<th><strong>MOST IMPORTANT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eligibility and benefits</td>
<td>1. Eligibility and benefits</td>
</tr>
<tr>
<td>2. Patient registration</td>
<td>2. Payment processing</td>
</tr>
<tr>
<td>3* Payment processing</td>
<td>3. Patient registration</td>
</tr>
<tr>
<td>3* Treatment authorization</td>
<td>4. Treatment authorization</td>
</tr>
<tr>
<td>5. Set up payment plans</td>
<td>5. Address and identity verification</td>
</tr>
<tr>
<td>6. Address and identity verification</td>
<td>6. Patient payment estimator</td>
</tr>
<tr>
<td>7. Financial/charity assistance</td>
<td>7. Set up automatic payments</td>
</tr>
<tr>
<td>8. Medical necessity checks</td>
<td>8. Medical necessity checks</td>
</tr>
<tr>
<td>10. Set up automatic payments</td>
<td>10* Financial/charity assistance</td>
</tr>
<tr>
<td>11. Online scripting for patient communication</td>
<td>10* Set up payment plans</td>
</tr>
<tr>
<td>12. Capacity/propensity to pay</td>
<td>12. Online scripting for patient communication</td>
</tr>
</tbody>
</table>
The Impact of Consumerism on Provider Revenues study, sponsored by Availity, was conducted to assess provider attitudes related to the growing shift of health care financial responsibility to the patient. A web-based survey was conducted by Decision Analyst, a leading research and analytics consulting firm. Statistical significance testing was performed at the 95 percent confidence level.

A representative sample of practice- and facility-based professionals completed the survey:

- N=337 practice-based professionals, including a mix of primary care physicians (n=148) and specialists (n=189) with:
  - N=153 at practices with 3-10 physicians
  - N=101 at practices with 11-49 physicians
  - N=83 at practices with 50+ physicians

- N=219 facility-based professionals, with a mix of hospital and system sizes:

<table>
<thead>
<tr>
<th>Facility bed size</th>
<th>System bed size</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤199 n=37</td>
<td>200–999 n=68</td>
</tr>
<tr>
<td>200–399 n=89</td>
<td>1000–2999 n=56</td>
</tr>
<tr>
<td>≥400 n=93</td>
<td>≥3000 n=39</td>
</tr>
</tbody>
</table>
ABOUT AVAILITY

Availity delivers revenue cycle and related business solutions for health care professionals who want to build healthy, thriving organizations. Availity has the powerful tools, actionable insights and expansive network reach that medical businesses need to get an edge in an industry constantly redefined by change.

Whether health care professionals use Availity’s Advanced Clearinghouse, Revenue Cycle Management, Patient Access or Web Portal services, they’ll be able to drive measurable and meaningful organizational improvements, and enjoy the vitality of a healthy business.

For more information about Availity, please visit www.availity.com.