FinThrive

Patient Collections Insight Guide

# Know Before You Bill

A Smarter Approach to Patient Collections



# Why Patient Collections Needs a New Starting Point

Patient financial responsibility keeps climbing as high-deductible health plans become the norm for more Americans. That shift created a challenge most hospital finance teams didn't have a decade ago: collecting from patients, not just payers. Patients should have a stake in their own financial and physical health, but rising out-of-pocket costs opened a new source of bad debt: insured patients who can't cover what they owe.

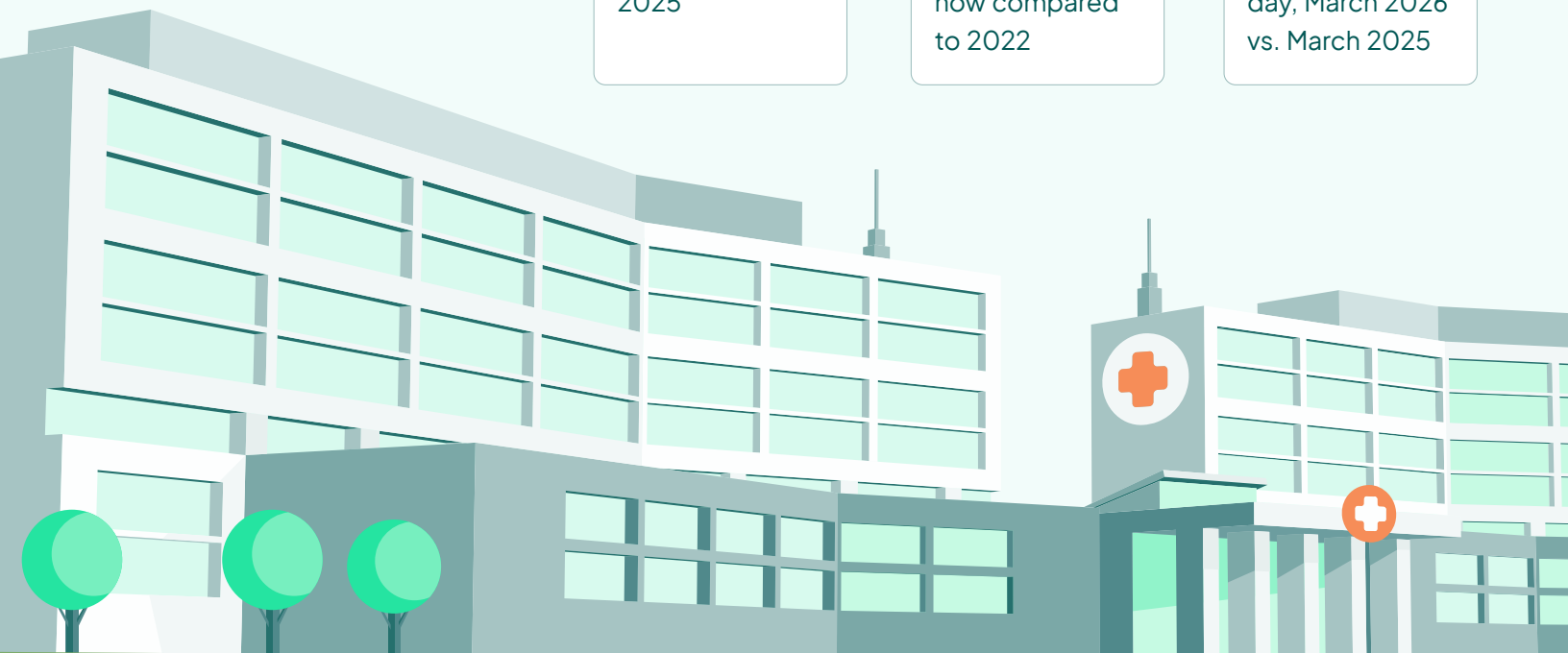
The numbers show how much pressure that's putting on hospital finance teams. Hospital bad debt and charity care were up 10% in 2025 and 40% higher than in 2022. Bad debt and charity care per calendar day rose another 18% in March 2026 compared to March 2025, and the trend hasn't slowed. The American Hospital Association reports hospitals spent $43 billion in 2025 trying to collect payments from insurers for care they'd already delivered.

A better approach starts earlier. Instead of waiting until a balance is overdue, hospitals that screen for financial need and payment ability before a bill goes out can clear patients financially before care even happens. This guide walks through how to build that approach step by step, and it closes with the one piece most collections advice still leaves out: knowing who needs help before you bill them at all.

**10%**
Rise in hospital bad debt and charity care in 2025

**40%**
How much higher bad debt and charity care are now compared to 2022

**18%**
Increase in bad debt and charity care per calendar day, March 2026 vs. March 2025



# Build a Stronger Patient Collections Process. Here's How.

## Establish Your Baseline

If you haven't already, take stock of your current collections rate so you know how much you need to improve. The Healthcare Financial Management Association recommends aiming for point-of-service collections averaging around 3% to 5% of net patient revenue, but that metric can vary widely by facility and payer mix, so make sure you get your baseline right to understand your opportunity. Looking at the patient responsibility your organization is currently billing is also a good way to back into the true opportunity, a check and balance between your front-end and back-end results.

**3% to 5%** HFMA-recommended average for point-of-service collections

## Establish Goals and Share Them with Your Team

Goals vary by organization and location, particularly with respect to your state's legislation, but set an objective that's challenging and still obtainable compared to your baseline. Document how often you'll report against those goals, whether that's monthly or quarterly. Goals can be measured in dollar amounts or percentages, as long as they're clearly stated and assessed often.

## Get Buy-in from Your Clinical Team

Your clinical staff need to understand their role in the organization's bottom line. Meet with them so everyone's aligned and so they're not unintentionally slowing down the collections process.




## Can't Pay or Won't Pay? Know the Difference.

Not every patient who doesn't pay is unwilling to pay. Some can't, and telling the two apart is the hardest part of reducing bad debt. That's the starting point of our Charity Care and Bad Debt Prevention Toolkit, which includes a financial clearance and charity checklist, a high-balance self-pay workflow and a quick revenue cycle assessment you can use to see where your own process stands.

# Build a Stronger Patient Collections Process. Here's How.

## Make Sure Someone on Your Team is Trained to Request Payments

Asking patients for money is a difficult job. Assess your teams and their job descriptions, then align training to match. If there's a knowledge gap, run a training session so your finance staff understand patients' financial responsibility and can help them set up payment arrangements. Digital tools help, but they shouldn't replace a person talking a patient through their options.

## Build in Prior Authorization Checks

Prior authorization is still a major friction point for hospitals. Automate authorization rules and status checks so your team catches every service that needs one before care happens, not after.

## Run an Internal Knowledge Check and Fill the Gaps

Does your finance team get the information it needs about the care a patient received? If diagnosis and CPT codes aren't accurate, work on closing the gap between your administrative and clinical staff.

## Keep Patient and Payment Information Accurate to Cut Back-end Denials

Use digital tools to verify insurance, identity and contact information so your claims and patient responsibility stay accurate, and flag registration issues in real time before they turn into downstream denials.

## Build a Process for Financial Clearance

Fold eligibility, charity screening and payment into the digital check-in process so you can financially clear a large share of patients before they ever arrive for their appointment. Patients also respond well to tools like text-to-pay.

## Give Patients an Accurate Estimate Before They're Billed

A majority of patients will make at least a partial payment if they get a pre-service estimate upfront. Get that estimate to patients as early as possible in the scheduling process. They need time to plan, make arrangements and learn what their options are, and the goal is to remove stress from the process, not create it. Give patients a way to build their own estimate online, with accuracy in the 95% to 99% range, and you'll see the difference it makes.

# Know Who Needs Help Before You Bill

Everything above happens on the back end of collections: training staff, verifying information, chasing a balance once it's already on the books. Almost none of it asks the question that matters most. Before you send a bill, do you know who can pay it?

Charity screening and propensity to pay usually live in separate workflows. Charity screening asks who qualifies for financial assistance, and today only 29% of patients who qualify for hospital financial assistance actually receive it. Propensity to pay asks who's likely to pay, and when. Both questions belong in the same workflow. A patient's situation can be temporary, or they might be moving from full-time work to disability or retirement, and answering the questions separately misses that context. Teams spend time working accounts that were never going to pay, and patients who qualify for help move further into billing before anyone catches it.

Put those two questions together, early and consistently, and the outcome changes. Understanding each patient's full picture before the conversation even starts helps your staff guide the patient through their options and gives your organization more control of the process. Screen for eligibility and payment propensity together, so patients who qualify for assistance get routed to it before a balance turns into bad debt, and patients who can pay get a clear answer about what they owe before they're surprised by a bill. Organizations that take this approach have seen charity care identification increase by up to 181%. It's a different way to think about collections: less about how hard your team chases a balance and more about how well you understand each patient before you ever send one.

## Want to Go Deeper?

Read our blog, "See, Score, Serve: A Smarter Approach to Charity Screening and Propensity to Pay," to learn how these workflows work better together.

## Ready to Improve Financial Clearance Performance?

Download the Charity Care and Bad Debt Prevention Toolkit for practical checklists and strategies to help identify patients who may qualify for assistance while reducing preventable bad debt.

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