maryland
health services
cost review commission

To: Chief Financial Officers for Hospitals with Fiscal Year Ending June 30, 2023

From: Dennis Phelps, Deputy Director, Audit & Integrity

Date: July 26, 2023

Re: Special Audit Procedures to be performed by the Independent CPAs for all Maryland for FY 2023 – June Hospitals

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The Special Audit Procedure Report will be due 140 days from the close of the fiscal year or November 17, 2023, for hospital with June 30 year ends. As a reminder, pursuant to regulation, COMAR 10.37.01.03R, any required report submitted to the Commission which is substantially incomplete or inaccurate may not be considered timely filed. Further, under this regulation, any hospital that does not file a report due under HSCRC law or regulation is liable for a fine of up to $1,000 for each day the filing of the report is delayed.

Departments (Rate Centers) for FY2023:

In procedure C-1, the three specific departments to be reviewed by the outside auditors for acute hospitals are Operating Room (OR), Pulmonary (PUL), and Labor and Delivery (DEL). If the hospital does not have one of the departments selected for review, the alternate department is Anesthesiology (ANS). For the three specific departments to be reviewed, submit a listing of all procedures for which the units of service were assigned "By Report." Please provide this listing in the format provided in Attachment C.

Additional Instructions:

Alternative Rate Setting

(Performed at the end of the Related Entity's Fiscal Year and submitted 140 days from the close of the Related Entity's Fiscal Year under separate cover).

Audit procedures are to be performed on HSCRC-approved Alternative Method of Rate Determination arrangements. The audit procedures to be performed on procedure-based or case-based bundled rates arrangements have been added as step I. The audit procedures to be performed on capitation and global price arrangements are included in Supplement I. These audit procedures involve visiting the risk-taking hospital-related entity in order to ascertain the accuracy of the information reported in the HSCRC-mandated reports. In procedure A-4, capitation, the three expense centers from schedule AR1 to be reviewed by the auditors are: Med/Surg/Ped/Def, line 10; Emergency Department, line 21, and Imaging, line 31. The alternative, if one of the centers selected for review had no activity, is Pharmacy, line 40.

Consolidated Financial Statements

Supplementary Schedules to Audited Financial Statements

Identify and report the methodologies used to allocate the parent entity's cost (i.e., overhead, capital etc.), to its subsidiaries in the supplementary schedules appended to the audited financial statements. This report should take the form of a table listing all material allocations, the amount allocated to the subject hospital, and the basis for the allocation. The material allocation threshold is $500,000. Determine that the allocation methodologies were applied consistently and accurately.

Please have your auditors contact Wayne Nelms (wayne.nelms2@maryland.gov) to obtain Case Mix data (Procedure D), quarterly reports for Hospice samples (Procedure G), and quarterly reports for Cosmetic Surgery (Procedure H).

Enclosure(s)

HEALTH SERVICES COST REVIEW COMMISSION
SPECIAL AUDIT PROCEDURES

A. Expenses

1. Review the reconciliation of the base year actual expenses on Schedules UA, C, D, E-1 thru E-9, F-1 thru F-4, OADP, P2I, P3I, P4I, PSI and URI thru URl0 of the budget submission financial statements.

    - Prepare a summary worksheet, in the format described in Attachment A, disclosing the reconciling items between the Rate Review System and the audited trial balance. This reconciliation worksheet must be included in your report.

2. During cash disbursements and payroll compliance testing, perform attribute statistical sampling (using a 95% confidence and 5% maximum error rate) to test departmental classification of expenses. List results of testing, including the number of test items and number of error occurrences.

B. Revenue

1. Review the reconciliation of the base year actual revenue for the year by department as accumulated on the monthly Experience Report to the year-end trial balance.

    - Verify that only regulated revenue has been reported on the Monthly Experience report.
    - Prepare a summary worksheet in the format described in Attachment B, disclosing the reconciling items between the departmental revenue reported on the monthly submission and the year-end trial balance. This reconciliation worksheet must be included in your report.
    - List the amount and a description of all classifications made in reconciling revenue between the monthly and the year-end trial balance. This is to be included in your report in journal entry form.

2. Review Schedule RE-R, Statement of Revenues and Expenses - Reconciliation to audited financial statements.

    - Verify that the reconciliation is complete and accurate. Trace the revenue, deductions from revenue and expenses to the general ledger.
    - Determine by inquiry of the appropriate personnel and review of applicable hospital records that the classification of revenue and allocation of expenses are in conformance with HSCRC regulation and policy. Report results of your inquiry in detail.

C. Statistics

1. For three (3) departments (two departments for private psychiatric hospitals) asstipulated by the Executive Director of the Commission.

- Determine by inquiry of the appropriate clinical and financial personnel and reference to department source data that the department is using the standard unit of measure as prescribed in the Health Services Cost ReviewCommission's Accounting and Budget Manual. Please review any variances found with hospital staff and note how the hospital is going to fix the variances noted.
- Utilize a representative sample of the procedures from one month's data. A selection of the high-volume procedures that constitute at least 50% of the department's volume is recommended.
    - Trace the number of units reported to the HSCRC on the monthly PS schedule per procedure to the number of units assigned in Appendix D of the manual.
    - Submit a list of discrepancies found.
    - For each of the discrepancies, determine how long the incorrect number of units has been utilized for reporting and billing purposes.
- Obtain a list from the appropriate clinical and financial personnel of the departments designated for review of the procedures for which the units of service were assigned "By Report". Provide this list to the Commission using Excel format (see Attachment C) with this report. List the "By Report" procedures for the rate centers under review as follows:

CPT Code	Descriptions	RVUs Assigned

- Summarize the actual base year department statistics (inpatient, outpatientand total) by month and reconcile them to the base year units as reported on the hospital's monthly Experience Report and to the total reported on Schedule V3, Line O of the Annual Report. Test a two (2) month's accumulation of these statistics by tracing them to the source document data to the monthly and Annual Reports. Identify the source document.
- To ensure that patients are charged appropriately and that the HSCRC receives accurate data, hospitals are directed to establish procedures to review their Charge Master on at least an annual basis. Please review these procedures and obtain from the Chief Financial Officer written verification as to when the charge master was last reviewed and whether processes have been established to regularlyreview the hospital's Charge Master.

- Obtain a copy of the Hospital's Charge Master Review procedures. Include these procedures in your report.

D. Case Mix Data

Acute Hospital- Inpatient

1. The Commission staff will supply the auditor with a sample hospital of medical record abstracts from the Commission's database. The sample listings will include the following information for each patient:

    - Patient medical records Number
    - Third Party Payor (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)
    - Zip Code
    - Total Patient Charges
    - Daily hospital services and admission services charges
    - Operating room charges
    - Admission from the Emergency Room

2. For each patient, the auditor will verify back to the hospital's billing records for items:

    - That the major third-party payor classification on the Commission's listing agrees with the hospital's billing records. If errors in payor classification exceed 5% of cases, list the number of errors by category, i.e., self-pay should be Medicaid, etc. (show percentage of all errors and apercentage less errors involving Medicaid admissions).
    - That the zip code on the Commission's listing agrees with the Hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.
    - That the total patient charges, for regulated services, agree with the hospital's billing records.
    - That the total Daily Hospital services and Admission Services chargesagree with the hospital's billing records.
    - That the total Operating Room charges agree with the hospital's billing records. Whether there are Emergency Service charges on the hospital's billing records for each case coded as "Admitted from Emergency Room" in the case mix sample.

    (Differences in dollar amounts in bullets 3 through 6 above, which areless than 1% should not be counted as errors.)

3. In its report the auditor will describe the results of this work and the data complied will be summarized in the following manner:

a.	Hospital Name	Total Charges per HSCRC Computer Listing	Verified Final Charges	Difference Over (Under)	Percentage Variances	
b.	Hospital Name	Case Mix Sample Size	Number of Variances in Charge Reported	Error Rate	Number of Variance in Payor Sources	Error Rate
c.	Hospital Name	Case Mix Sample Size	Var. in Daily Serv. & Admin. Charges	Error Rate	Num of Var. in OR. Rm Charges	Error Rate
d.	Hospital Name	Number of Cases coded as admitted from ER	Number of Cases coded as admitted. from ER without ER Charges	Error Rate		

Private Psychiatric Hospitals

1. The Commission staff will supply the auditor with sample by hospital of medical records abstracts from the Commission' s data base. The sample listing will includethe following information for each patient:

    - Patient Medical Records Number
    - Third Party Payer (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)
    - Zip Code
    - Total Patient Charges
    - Daily hospital services and admission services charges
    - Therapy charges

2. For each patient, the auditor will verify back to the hospital's billing records foritems:

    - That the major third-party payor classification on the Commission's listing agrees with the hospital's billing records. If errors in payor classification exceed 5% of cases, list the number of errors by category, i.e., self-pay should be Medicaid, etc.

- That the zip code on the Commission's listing agrees with the Hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.
- That the total patient charges, for regulated services, agree with the hospital's billing records.
- That the total Daily Hospital services and Admission Services charges agree with the hospital's billing records.
- That the therapy charges agree with the hospital's billing records.

(Differences in dollar amounts in bullets 3 through 5 above, which are less than 1% should not be counted as errors.)

3. In its report the auditor will describe the results of this work and the datacomplied will be summarized in the following manner:

a.	Hospital Name	Total Charges per HSCRC Computer Listing	Verified Final Charges	Difference Over (Under)	Percentage Variances	
b.	Hospital Name	Case Mix Sample Size	Number of Variances in Charge Reported	Error Rate	Number of Variance in Payor Sources	Error Rate
c.	Hospital Name	Case Mix Sample Size	Var. in Daily Serv. & Admin. Charges	Error Rate	Num of Var. in OR. Rm Charges	Error Rate
d.	Hospital Name	Number of Cases coded as admitted from ER	Number of Cases coded as admitted. from ER without ER Charges	Error Rate		

Ambulatory Care

1. The Commission staff will supply the auditor with sample by hospital of medical records abstracts from the Commission's data base. The sample listing will include the following information for each patient:

    - Patient Medical Records Number
    - Third Party Payer (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)

- Zip Code
- Operating Room and Same Day Surgery Charges
- Clinic and Emergency Department Charges
- Medical Surgical Supplies Charges
- Drugs Charges
- Other Charges

2. For each patient, the auditor will verify back to the hospital's billing records foritems:

    - That the major third-party payor classification on the Commission's listing agrees with the hospital's billing records. If errors in payor classification exceed 5% of cases, list the number of errors by category, i.e., self-pay should be Medicaid, etc.
    - That the zip code on the Commission's listing agrees with the Hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.
    - That the total patient charges, for regulated services, agree with the hospital's billing records.
    - That the total Operating Room and Same Day Surgery charges agree with the hospital's billing records.
    - That the total Clinic and Emergency Department Charges agree with the hospital's billing records.
    - That the total Medical Surgical Supplies charges agree with the hospital's billing records.
    - That the total Drugs charges agree with the hospital's billing records.
    - Identify and report the charges in the "Other Charges" category.

    (Differences in dollar amounts in bullets 3 through 8 above, which areless than 1% should not be counted as errors.)

3. In its report the auditor will describe the results of this work and the data complied will be summarized in the following manner:

a.	Hospital Name	Total Charges per HSCRC Computer Listing	Verified Final Charges	Difference Over (Under)	Percentage Variances	
b.	Hospital Name	Sample Size	Case Mix in Charge Reported	Error Rate	Variances in Payor Sources	Variances Error Rate
c.	Hospital Name	Case Mix Sample Size	Number of Var. in O/R and SDS Charges	Error Rate	Number of Var. in M/SS Charges	Error Rate
d.	Hospital Name	Case Mix Sample Size	Number of Var. in CL and ER Charges	Error Rate	Number of Var. in CDS Charges	Error Rate

E. Uncompensated Care and Denials Reconciliation

1. Maryland hospitals report deductions from patient revenue in their required annual filings. The deduction categories include charity care, bad debts, contractual adjustments, denials, and other deductions from revenue. See Attachment D for a copy of the relevant section of the HSCRC Accounting and Budget Manual.

    - Perform an analysis of the bad debt write off activity more than $1,000 but not less than 50% of the total dollars written off, for a calendar month of the fiscal year. Determine those accounts unpaid by third party payors for medically unnecessary care are not included. Obtain a letter of representation from the Patient Accounting Manager and Chief Financial Officer that the bad debt expense does not include medically unnecessary care, denials or other courtesy discounts provided to police, fire, hospital employees, etc.
    - Disclose in your report whether the hospital maintains these denials.
    - In a separate account pending final resolution of appeal.

2. For fiscal year 2023, provide reconciliation between the amount of uncompensated care per the hospital's trial balance to the supporting documentation.

3. For fiscal year 2023, provide reconciliation between the amount of uncompensated care per the hospital's trial balance and that reported on Schedule PDA of the Annual Report of Revenues, Expenses and Volumes.

4. Reconcile the Charity Care amount per the hospital's trial balance to the hospital's supporting documentation. Provide reconciliation between the hospital's trial balance and that reported on Schedule RE Line G Column 3 of theAnnual Report of Revenues, Expenses and Volumes. Note any differences.

5. Reconcile the Provision for Bad Debt amount per the hospital's trial balance to the hospital's supporting documentation. Provide reconciliation between the amount in the hospital's trial balance and the amount reported on Schedule RE line F Column 3 of the Annual Report of Revenue, Expenses and Volumes. Note any differences.

6. For fiscal year 2023, provide reconciliations between the number of denials per the hospital's trial balance and that reported on Schedule RE of the Annual Reportof Revenue, Expenses and Volume and the quarterly Denials Report.

The reconciliations shall be provided in the following format:

Trial Balance

Bad debts	$
Charity Care	_____
Uncompensated Care	$

Trial Balance

Bad Debt Write-offs	$
Charity Write-offs	
Change in Balance Sheet Reserve	
Bad Debt Recoveries	
*Other	_____
Uncompensated Care per Trial Balance	$

*Explain in Detail.

Annual Report of Revenues, Expenses and Volumes

Uncompensated Care- Schedule PDA	$
Unregulated Charity & Bad Debts	
* Uncompensated Care Fund	
** Other	
Uncompensated Care per Annual Report	$

Denials

Denials per the Trial Balance

$ _____

Less Unregulated Denials per the Trial Balance

$ _____

Schedule RE Line H2 Column 3,

Annual Report of Revenues, Expenses and Volumes

$ _____

Quarterly Denials Report

$ _____

***Variance

$ _____

*Hospitals with unregulated services are expected to have unregulated bad debt.

**Explain in detail.
***Explain in detail the variance.

7. Determine by inquiry of the appropriate hospital personnel and report whether bad debt write-offs include denials, collection agency's or attorney's expenses.

F. Financial Assistance, Credit & Collection Policies and

Financial Assistance

1. Hospitals are required by regulation (COMAR 10.37.10.26 A-2 (5)) to post notices in conspicuous places throughout the hospital informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

    - Determine whether such notices are posted.
    - Describe the content of the notices and list where they are posted in the hospital.
    - Determine by inquiry of the appropriate hospital personnel if patients are informed of the availability of financial assistance in any way other than by the posted notices.

2. Hospitals are also required by regulation (COMAR 10.37.10.26 A-2 (5)) to develop an information sheet that shall be provided to the patient, the patient's family, or the patient's authorized representative before the patient receives scheduled medical services; before discharge, with the hospital bill, on request, and in each written communication to the patient regarding collection of the hospital bill.

    - Determine by inquiry of the appropriate personnel if an information sheet is provided before discharge, with the hospital bill, upon request, and in each written communication to the patient regarding collection of the hospital bill.
    - Verify that the information sheet includes the following items:

        - Description of the hospital's financial assistance policy;
        - Description of patient's rights and obligations regarding hospital billing and collection;
        - Contact information for the individual or office at the hospital that is available to assist patient or the patient representative in understanding the hospital bill and how to apply for free and reduced cost care;
        - Contact information for the Maryland Medical Assistance Program;
        - Statements that physician charges are not included in the hospital bill and are billed separately.

3. Review the hospital's Financial Assistance Policy to determine whether the Policy includes the minimum criteria for providing free and reduced-cost care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill, as mandated in COMAR 10.37.10.26A-2(2). Confirm the following language is stated in the hospital's policy:

    - Free medically necessary care to patients with family income at or below 200 percent of the poverty level;
    - Reduced cost medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital;

- A maximum patient payment for reduced-cost care not to exceed the charges minus the hospital mark-up, no interest or fees may be assessed;
- A payment plan available to uninsured patients with family income between 200 and 500 percent of the federal poverty level who requested assistance; and
- A mechanism for a patient to request the hospital to reconsider the denial of free or reduced care.

4. Select a representative sample of 50 cases, from the period April 1st through June 30, 2023, of patients who have applied for financial assistance. The sample shall include both patients approved for financial assistance and those who were denied.

   • Determine whether the Financial Assistance Policy was followed:

   - Provide the number of cases and percentage of sample in which the policy was followed 100%.
   - Provide the number and percentage of cases in which the policy was not followed.
   - When the policy was not followed, provide examples of deviation from the policy and the frequency of each exception in the sample tested.

5. Select a representative sample of 25 cases with charges greater than $1,000 that were written off to bad debts and turned over to a collection agency.

   • Determine whether these patients were screened by either the hospital, or, the collection agency, to determine their eligibility under the Financial Assistance Policy, prior to any collection attempt:

   - Report the number of patients:
     - Screened using documentation provided by the patient.
     - Screened by searching publicly available information.
     - Screened utilizing a combination of documentation provided by the patient and by searching publicly available information.
     - Not screened before an attempt was made by the collection agency to collect the outstanding debt.

   • Determine by inquiry of the appropriate personnel and report the reason for failure to screen for each patient not screened.

   *Screening requires that the following actions be taken prior to collection efforts. HSCRC understands that some outstanding accounts for patients who have not completed a financial assistance application, or whose eligibility for financial assistance cannot be determined, may be written off to bad debt and sent to a collection agency. The hospital is responsible to ensure that the collection agency conducts a search of publicly available records before collection activity begins. To document that this search has been

conducted appropriately, the hospital must show that it or its agent acting on behalf of the hospital has performed the following steps:

1. Attempted to initiate in person contact with the patient informing him/her of the availability of financial assistance and inquire of possible need. (Note: sending the information sheet with the hospital bill does not satisfy this step)
2. Compared the patient's income to the federal poverty level.**
3. Determined whether the patient is an active participant in a means-tested social services program that may qualify him/her for financial assistance.**
4. If the Hospital is a participant, determined whether the patient is eligible for Medicaid under the "Hospital Presumptive Eligibility" provision of the ACA.

**Can be achieved through:
Searching any publicly available financial information, e.g., credit score, to ascertain whether the patient may be presumed to be eligible for financial assistance.
Verifying insurance status, income, etc. through official documentation provided by the patient.

6. Determine by inquiry of the appropriate personnel whether the Hospital is participating in the Medicaid "Hospital Presumptive Eligibility" provision of the Affordable Care Act.

- If the Hospital is not participating, ascertain and report the reason whythey are not participating.
- For participating hospitals, ascertain and report the process utilized to obtain the necessary patient information to implement the presumptive eligibility process.
- Report the number of patients that have applied for presumptive eligibilityin FY 2023.

7. Hospitals are required by regulation (COMAR 10.37.10.26 A-2 (2)) to provide eligibility for free care to patients that receive benefits under the following programs and are not eligible for the Maryland Medical Assistance Program or Maryland Children's Health Program:

i. Households with children in the free or reduced cost meal program;
ii. Supplemental Nutritional Assistance Program (SNAP);
iii. Low-income-household energy assistance program;
iv. Women, Infants and Children (WIC);
v. Any other social service program as determined by the Maryland Department of Health and the Commission.

- Ascertain, by inquiry of the appropriate personnel, and report the process through which the hospital determines if the patient is eligible for free care by meeting any of the criteria in 7i through 7vi.
- Report the number of patients who qualified for free care by being eligible for benefits in one of these programs.

8. Credit and Collection Policy

   Review the hospital's Credit & Collection Policy. Select arepresentative sample of 50 cases that have required collection effort within the last twelve months. The sample shall include both inpatient and outpatient cases and shall include cases from insured as well as self-pay patients, as well as patients who have been granted partial financial assistance, if applicable.

   i. Determine whether the Credit and Collection Policy was followed:
      - Provide the number of cases and percentage of sample in which the policy was followed 100%
      - Provide the number and percentages of cases in which the policy was not followed.
      - When the policy was not followed, provide examples of deviation from the policy and the frequency of each exception in the sample tested.

9. Debt Collection and Financial Assistance (DCFA)

   Hospitals must prepare a DCFA Schedule annually using the HSCRC pre-formatted Excel file. This schedule should include specific debt collection and financial assistance information for all patients applying for and/or receiving aid during the 12-month fiscal year.

   Also, hospitals must provide their policies and procedures for assigning debt to a collection agent and the method of compensating such collection agents for these services. These agreements should be submitted using PDF file format.

   TAB 1 – Credit & Collections

   Line 1, Column 1:
   Enter the complete name of the hospital.

   Line 2, Column 1:
   Enter the four-digit hospital number assigned by the HSCRC to the reporting hospital, e.g., 0015.

   Line 3, Column 1:
   Enter the fiscal year being reported, e.g. 2023

   Lines 4, 5, & 6:
   Enter, on a separate line, the name (s) of each collection agent (s) used during the fiscal year.

   Line 7, Column 1:
   Enter the total number of liens placed on patient's residences during the reported fiscal year.

Line 8, Column 1:
Enter the total number of extended payment plans exceeding 5 years that was established with patients during the reported fiscal year.

TAB 2 – Financial Assistance

Line 9a, Column 1:
Enter the total number of unique patients (per MRN) who completed a financial assistance application.

Line 9b, Column 1:
Enter the total inpatient admissions for patients who completed a financial assistance application.

Line 9c, Column 1:
Enter the total outpatient visits for patients who completed a financial assistance application.

Line 10a, Column 1:
Enter the total number of unique patients (per MRN) who partially completed a financial assistance application.

Line 10b, Column 1:
Enter the total inpatient admissions for patients who partially completed a financial assistance application.

Line 10c, Column 1:
Enter the total outpatient visits for patients who partially completed a financial assistance application.

Line 11a, Column 1:
Enter the total number of unique patients (per MRN) who received free care.

Line 11b, Column 1:
Enter the total inpatient admissions for patients who received free care.

Line 11c, Column 1:
Enter the total outpatient visits for patients who received free care.

Line 11d, Column 1:
Enter the total hospital charges ($), inpatient and outpatient, for patients who received free care.

Line 11e, Column 1:
Enter the total amount ($) written off for patients who received free care.

Line 12a, Column 1:
Enter the total number of unique patients (per MRN) who received reduced-cost care.

Line 12b, Column 1:
Enter the total inpatient admissions for patients who received reduced-cost care.

Line 12c, Column 1:
Enter the total outpatient visits for patients who received reduced-cost care.

Line 12d, Column 1:
Enter the total hospital charges ($), inpatient and outpatient, for patients who received reduced-cost care.

Line 12e, Column 1:
Enter the total amount ($) written off for patients who received reduced-cost care.

Line 12f, Column 1:
Enter the total amount ($) billed to patients (after discount) who received reduced-cost care.

Line 13a, Column 1:
Enter the total number of unique patients (per MRN) who received financial assistance.

Line 13b, Column 1:
Enter the total inpatient admissions for patients who received financial assistance.

Line 13c, Column 1:
Enter the total outpatient visits for patients who received financial assistance.

Line 13d, Column 1:
Enter the total hospital charges ($), inpatient and outpatient, for patients who received financial assistance.

Line 13e, Column 1:
Enter the total amount ($) written off for patients who received financial assistance.

Line 13f, Column 1:
Enter the total amount ($) billed to patients (after the discount) who received financial assistance.

TAB 3 – Financial Assistance (Demographics)

The race columns (5-13) are mutually exclusive. The totals from each filter should be the same.

Line 14, Column 1 thru Column 18:
Enter in the applicable columns the total number of patients (per MRN) who received financial assistance by ethnicity, race, **and** gender.

Line 15, Column 1 thru Column 18:
Enter in the applicable columns the total number of patients (per MRN) who were denied financial assistance by ethnicity, race, **and** gender.

TAB 4 – Debt Collection

Line 16, Column 1:
Enter the total number of unique patients (per MRN) against whom hospitals, or a debt collector used by the hospital, filed an action to collect a debt owed on a hospital bill.

Line 17, Column 1:
Enter the total number of unique patients (per MRN) with respect to whom the hospital has reported or classified a bad debt.

Line 18, Column 1:
Enter the total number of unique patients (per MRN) with respect to whom the hospital has **not** reported or classified a bad debt.

Line 19, Column 1:
Enter the total amount ($) of charges for hospital services for insured patients **not** collected by the hospital.

Line 20, Column 1:
Enter the total out-of-pocket amount ($) of charges for hospital services for insured patients **not** collected by the hospital.

Line 21, Column 1:
Enter the total amount ($) of charges for hospital services for uninsured patients **not** collected by the hospital.

Line 22, Column 1:
Enter the total out-of-pocket amount ($) of charges for hospital services for uninsured patients **not** collected by the hospital.

TAB 5 – Debt Collection (Demographics)

The race columns (5-13) are mutually exclusive. The totals from each filter should be the same.

Line 23, *Column 1 thru Column 18*:
Enter the total amount of unique patients (per MRN) against whom the hospital, or a debt collect used by the hospital, filed an action to collect debt owed on a hospital bill by ethnicity, race, **and** gender.

Line 24, *Column 1 thru Column 18*:
Enter the total amount of unique patients (per MRN) with respect to whom the hospital has reported or classified a bad debt by ethnicity, race, **and** gender.

Line 25, *Column 1 thru Column 18:*
Enter the total amount of unique patients (per MRN) with respect to whom the hospital has **not** reported or classified a bad debt by ethnicity, race, **and** gender.

TAB 6 – Debt Collection (Zip Codes)

Line 26, *Column 1*
Enter the primary service area (PSA) zip codes (5 digit) as defined in the GBR contract for the hospital.

Line 26, *Columns 2*:
Enter the total number of unique patients (per MRN) against whom the hospital, or a debt collector used by the hospital, filed an action to collect a debt owed on a hospital bill for each PSA zip code listed in Column 1.

Line 26, *Columns 3*:
Enter the total number of unique patients (per MRN) with respect to whom the hospital has reported or classified a bad debt for each PSA zip code listed in Column 1.

Line 26, *Columns 4*:
Enter the total number of unique patients (per MRN) with respect to whom the hospital has **not** reported or classified a bad debt for each PSA zip code listed in Column 1.

10. Recoveries

Select a representative sample of 25 cases, from the period April 1st through June 30, 2023, where recoveries of bad debts were made (add cases from prior recent calendar quarters to reach sample size if necessary).

- Determine if the hospital's uncompensated care for the year of recovery was reduced by the full amounts recovered and that the recovered amount is not reduced by collection agency fees or othercollection expenses.

- Provide the number of cases and the percentage of the sample in which any part of the recovery was applied to the hospital's baddebt expense or reserve.

- Of the cases where all or part of the recovery was applied to the hospital's bad debt expense or reserve:

    1) Provide the number of cases and percentages of thesample in which the gross amount of the bill recovered was applied to the hospital's bad debt expense or reserve; and

2) Provide the number of cases and percentages of thesample in which the gross amount of the bill recovered was not applied to the hospital's bad debtexpense or reserve.

G. Hospice General Inpatient Services

In March 2001, the Commission approved a Demonstration Project for the provision of general inpatient care to hospice patients to registered Medicare Hospice patients at Maryland hospitals. The project was approved with the following provisions:

- Hospices must bill HSCRC approved rates;
- Hospital may agree to accept reimbursement on a per diem amount other than HSCRC approved rates;
- The balance remaining of the hospital bill for each individual hospice patient payment of the agreed amount must be written off by the hospital as a voluntary contractual allowance. These voluntary contractual allowances may not be included as uncompensated care in reports submitted to the HSCRC.

1. Determine by inquiry of appropriate hospital personnel and report whether the hospital has signed an agreement to provide inpatient services to hospice patients. Provide a list of hospices involved in the agreement.

2. Obtain the following data from the hospital records and reconcile the data to thehospital's quarterly reports:

   i. the number of hospice patients admitted in FY 2023;
   ii. the total of HSCRC approved charges billed for inpatient services provided tohospice patients;
   iii. the total reimbursement received on behalf of hospice patients;
   iv. the amount of revenue written off associated with the difference between HSCRC charges billed for inpatient services provided to hospice patients and thetotal reimbursement received on behalf of hospice patients;
   v. the account to which the revenue, described in bullet 4 above, was written off.

H. Outpatient Plastic/Cosmetic Surgery

1. Reconcile Columns 2-5 of the hospital's Outpatient Plastic/Cosmetic SurgeryPricing worksheet to their Plastic/Cosmetic Surgery quarterly reports.

2. Ensure that the total difference in Col. 6 per the Outpatient

Plastic/Cosmetic Pricing worksheet agrees with the hospital's Cosmetic Surgery contractual allowance account.

I. Audit of Trauma Costs

Hospitals with designated trauma centers incur incremental trauma costs to meet the Maryland Institute for Emergency Services System (MIEMMS) regulatory requirements. Such incremental costs are the costs associated with operating a hospital with a designated trauma center that are over and above the costs normally associated with hospitals that do not have a designated trauma center. These incremental costs consist of the costs associated with a Trauma Director, Trauma Department, Trauma Protocol, Specialized Trauma Staff, Education and Training andSpecial Equipment included in the costs of the Emergency on Schedule D-18.

For each of the following schedules trace the amounts to the hospital source documents. Review the method used to allocate costs between trauma requirementsand normal emergency room operations. Include the method of allocation in your report.

Schedule MTC – A Trauma Director

Schedule MTC – B Trauma Department

Schedule MTC – C Trauma Protocol

Schedule MTC – D Specialized Trauma Staff

Schedule MTC – E Education and Training Costs

Schedule MTC – F Specialized Equipment

Schedule MTC – Incremental MIEMMS Requirements for Trauma Hospitals

Hospitals with designated trauma centers incur for trauma physicians to "standby". Trauma physicians' standby cost is defined as the costs generated because of the necessity to have the physical presence of a trauma physician, under a formal arrangement, to render services to trauma patients. These physicians must be on the hospital premises in reasonable proximity of the Emergency Department or trauma center and may not be "on-call".

Trace the reported amounts on the following schedules to the hospital source document.

Schedule SBC I standby Costs Trauma Physicians - Hourly or Salary Based Arrangement.

Schedule SBC II Standby Costs Trauma Physicians - Minimum Guaranteed Arrangements.

J. Community Benefit Report

1. Reconcile the Charity Care amount per the FY 2022 Community Benefit Report (line H) to the RE Schedule per the FY 2022 Annual Filing. Note any differences.

K. Supplemental Schedule UR6-A Physician Part B Service

1. Reconcile the information provided on Supplemental Schedule UR6-A to the information provided on Schedule UR6 submitted by the hospital.

L. Report

1. Prepare a report in accordance with SAS 75, as amended, to be submitted to thehospital (with a copy mailed by the auditing firm to the Health Services CostReview Commission) summarizing the procedures performed and the results.Prepare the report in accordance with the following specific report format instructions.

    - After the "Report of Independent Public Accountants", each step will be detailed in the following manner:

        i. Reference specific audit step
        ii. State the procedures performed to accomplish each audit step.
        iii. Summarize your audit findings for each step.

2. This report is to be filed with the Commission 140 days after the end of thehospital's fiscal year.

ATTACHMENT A

Expense Reconciliation

We compared the reconciliation of the base year actual expense on Schedules UA, OADP, P21, P3H, P41, PSI, C, D, El through E9, Fl through F4 and UR-l through UR-7 of the annual report to the Commission with the year-end trial balance used to prepare the audited financial statements.

The following is a reconciliation between the annual report and June 30, 2023 audit financial statements:

Balance per annual report:

Description	Source	Amounts (In Thousands)
Cafeteria, Parking, Data	Sch. OADP, Line C1, Col.4	
Unassigned Expenses	Sch. UA, Line A, Col. 10	
Medical Staff Services	Sch. P2I, Line A, Col. 3	
Physician Support Staff	Sch. P3H, Line Col.7	
Resident & Intern Services – Eligible	Sch. P4I, Line D, Col. 7	
General Services Centers	Sch. C, Lines C1-C4, Col. 7	
Patient Care Centers	Sch. D, Lines D1-D81, Col. 5	
Auxiliary Enterprises	Schs. E1-E9, Line B, Col. 3	
Other Institutional Programs	Schs. F1-F7, Line B, Col. 3	
Unregulated Services	Schs. UR1-UR10	
*Reconciliation Amount		
HSCRC TOTAL OPERATING EXPENSES		

Balance per audited financial statements:

Description	Amounts
Salaries and Wages	
Employee Benefits	
Supplies	
Services and Other	
Depreciation and Amortization	
Interest	
TOTAL OPERATING EXPENSES PER AUDITED FINANCIAL STATEMENTS	

ATTACHMENT B

Revenue Reconciliation

We compared the reconciliation of the base year actual revenue for the year by department as reported on monthly reporting schedules RSA, RSB, and RSC to the hospitals year-end trial balance.

The following is a reconciliation between the departmental revenue reported on the monthly submissions and the year-end trial balance.

Reconciliation of Operating Revenues
Per Schedule RS
For the Base Year Ended
June 30, 2023

	Revenue Per Schedule RS	Revenue Per Audited Trail Balance	Variance	Explanation
Medical/Surgical				
Pediatrics				
Obstetrics				
ICU				
Nursery				
Emergency Room				
Part A and B				
Admissions				
Labor and Delivery				
Operating Room				
Anesthesiology				
Laboratory				
Blood Bank				
EKG				
Radiology Diagnostic				
Nuclear Medicine				
Cat Scanner				
Respiratory Therapy				
Physical Therapy				
Medical/Surgical Supplies				
Drugs				
Psychiatrics				
Clinical Services				
Ambulatory Surgery				

Explanation of Reclassifications

ATTACHMENT C

Hospital Name
FYE
Special Audit Procedure C Statistics - By Report
Rate Center

CPT Code	Description	RVUs Assigned

ATTACHEMENT D

HEALTH SERVICES COST REVIEW COMMISION

ALTERNATIVE METHOD OF RATE DETERMINATION ARRANGEMENTS

SPECIAL AUDIT PROCEDURES

As a result of the adoption and implementation of the Commission's Alternative Method of Rate Determination Policy, audit procedures must be performed by an independent CPA to ensure that the information provided concerning approved alternative rate setting arrangements is accurate. This will require the independent CPA to visit the offices and review the appropriate documents and records of the risk-taking entity. These audit procedures will be due in a report under separate cover 140 days from the close of the fiscal year of the risk-taking related entity.

A. Capitation- Schedules AR-1 and AR-2

1. Member Months - For each contract trace to source document the number of membermonths for the fiscal year on line A, Schedule AR-1.

2. Revenue - For each contract, reconcile the actual revenue for the year as reported onSchedule AR-1 by component to the trial balance and source documents.

    - Prepare a summary worksheet, reconciling the revenue reported on the quarterly AR-1 schedules and the year-end trial balance. This reconciliation worksheet must be included in your report.
    - List the amount and a description of all reclassifications made in reconciling revenue between the quarterly reports and the year-end trial balance. This is to be included in your report in journal entry form. Prepare a reconciliation between the total amounts above and the amounts in the audited financial statement. Include this reconciliation in your report.

3. Expenses - For each contract, reconcile the actual expense as reported on quarterlyand annual Schedules AR-1 to the trial balance.

    - Prepare a summary worksheet, disclosing the reconciling items between theAR-1 schedule and the trial balance. This reconciliation worksheet must be included in your report.

4. Expenses and Statistics - For each contract for each of the three expense centers as stipulated by the Executive Director of the Commission:

    - Determine by inquiry of appropriate personnel and reference to source data whether the standard unit of measure as prescribe in the Health ServicesCost Review Commission's Accounting and Budget Manual is being used and reported on Schedule AR-2.
    - Summarize base year actual expenses and statistics by quarter and reconcile to theactual statistics and expenses reported on Schedules AR-1 and AR-2. Test one quarter's accumulation of these expenses and statistics by tracing source data. Include in your report the reconciliation of the source document to the quarterly and annual reports. Determine that expense are reported in the appropriate category, e.g., capitated, fee for service, related entity, out-of-network, etc., identify the sources documents.

5. Overhead Allocation

    - Determine by review and by inquiry of the appropriate personnel the method used to allocate overhead expenses to each contract. Disclose the methodology and verify that the methodology was properly utilized.

6. Stop-Loss.

   Ascertain by review and inquiry of the appropriate personnel and disclose the cost,terms, (e.g., when stop loss kicks in) and coverage of all reissuances, stop-loss contracts and/or other arrangements to limit risk associated with each contract.

B. Global Price - Schedule AR-3

1. Revenue - For each contract reconcile the global payments as reported on Schedule AR-3 by DRG to the trial balance and source documents.

   - Prepare a summary worksheet reconciling the revenue reported on the quarterly AR-3 schedules and the year-end trial balance. This reconciliation must be included in your report.

2. Number of Cases, Patient Days and Hospital Charges - For each contract; reconcile the number of cases, patient days and hospital charges by DRG as reported on AR-3 schedule to the appropriate source documents.

   - Test one quarter's hospital charges as reported on AR-3 schedule for 2 DRG's by examining the hospital bills of individual cases.