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To: **Maryland Hospital's Chief Financial Officers**

From: **Dennis Phelps, Deputy Director, Audit & Integrity**

Date: **December 6, 2023**

Re: **FY 2023 Debit Collection and Financial Assistance Guidance**

The HSCRC is providing updated guidance for filing the FY 2023 Debit Collection and Financial Assistance (DCFA) schedule. The attached instructions **supersede** all other previously issued instructions that are included in Appendix 1. Hospitals are required to submit the FY 2023 DCFA schedule on **December 20, 2023**.

If you have any questions, please contact Wayne Nelms at wayne.nelms2@maryland.gov.

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 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 17, Column 1 (Revised):
Enter the total number of unique patients (per MRN) who received services in fiscal year 2023 and 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 18 – Column 1 (Revised):
Enter the total number of unique patients (per MRN) who received services in fiscal year 2023 and have not been reported or classified as bad debt.

~~*Line 19, Column 1:*~~

~~Enter the total amount ($) of charges for hospital services for insured patients not collected by the hospital.~~

Line 19 – Column 1 (Revised):
Enter the total amount of charges for insured patients who received services in fiscal year 2023 who have been reported or classified as bad debt. This amount should exclude charges for non-insured patients.

~~*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 20 – Column 1 (Revised):
Enter the total patient portion of charges for insured patients (reported on Line 19) who received services in fiscal year 2023 who have been reported or classified as bad debt. This should exclude payments from third-party payers.

~~*Line 21, Column 1:*~~

~~Enter the total amount ($) of charges for hospital services for uninsured patients not collected by the hospital.~~

Line 21 – Column 1 (Revised):
Enter the total amount of charges for uninsured patients who received services in fiscal year 2023 who have been reported or classified as bad debt. This amount should exclude charges for insured patients.

~~*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 fo 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.

Appendix 1 – Updated Guidance, including edits to guidance previously issues on 09/19/2023 and 10/26/2023

This appendix includes, for each reporting item that HSCRC is (or has) provided additional guidance, 1) a copy of the reporting instructions for that item 2) One or more questions about that item from hospitals, and 3) guidance from HSCRC responding to those questions. HSCRC had previously provided guidance on 9/19/2023 and 10/26/2023. This appendix repeats, and in some cases, edits that prior guidance. New content as of 12/6/23 is highlighted. Content that has been deleted is struck through.

Tab 2 – Financial Assistance

Line 9a-c, Column 1:

Reporting Instruction:

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.

Questions:

1. Should they be considered in the total number of patients who completed the financial assistance application? They completed an application. Should we count them in row [Line] 9 even though we would not say they received free care because they did not have charges.

Guidance issued on 12/6/23:

Yes

2. We have two hospitals… but one financial assistance policy. So [what] do I do if one person has services and receives financial assistance at both hospitals. Are they counted as two? How do I separate the two hospitals?

Guidance issued on 12/6/23:

You complete the DCFA schedule for each hospital. HSCRC expects that this patient will appear on the schedule for each hospital.

3. The way our financial assistance works is that we may have one patient, but they do the financial assistance for their whole family. And maybe some children have not had service yet. Do we count it for each person on the application or do we just count it for the one patient or two patients that have had service.

Guidance issued on 12/6/23:

Hospital financial assistance is based on the family. HSCRC is only interested in the count of the patients, not the count of the whole family, as some of the family members may have no hospital services in the year.

4. For Line 9, the total number of unique patients who completed a financial assistance application. So is this to include everybody – all patients that were approved, denied, or so pending approval.

Guidance issued on 12/6/23:

HSCRC is looking for the number of applications completed. Line 9 is not asking about the status of that application.

Line 10a-c, Column 1:

Reporting Instruction:

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.

Question:

1. Is Line 10 a component of Line 9.

Guidance issued on 12/6/23:

They are separate or independent counts. This is not a subset of line 9.

Line 13a-f, Column 1:

Reporting Instruction:

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.

Question:

1. Should this include patients who were prospectively approved for Financial Assistance but do not yet have charges classified?

Guidance issued on 10/26/2023, revised 12/6/23:

If you are referring to patients who have been pre-approved for financial assistance, but their incurred charges have not been classified as bad debt charity care, the answer is No.

Tab 4 – Debt Collection

Line 17, Column 1:

Reporting Instruction:

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

Questions:

1. Should the number of patients against whom the hospital has reported or classified a bad debt include patients whose accounts were marked as a bad debt in the system without any actions taken against them yet, or should this only include patients against whom actions have been taken to collect a bad debt?
2. Does action mean taken to court or just sent to a collection agency?

Guidance issued on 10/26/2023:

If the patient has been classified (regardless of whether action was taken against them), they are reported.

Line 18 – Column 1:

Reporting Instructions (Revised 12/6/23):
Enter the total number of unique patients (per MRN) who received services in fiscal year 2023 and have not been reported or classified as bad debt.

Guidance issued 9/19/23, revised 12/6/23

- This is the total number of patients less the amount determined for Line 17, Column 1.
- ~~This number should include all patients, not just those added in FY 2023~~.

1. *The additional guidance provided by the HSCRC indicates that "this number should include all patients, not just those added in FY2023." Are we correct to assume this number should be calculated as the total patients seen in FY2023,*

less the number reported in Line 18? If not, what is the time period for "all patients?"

Guidance issued on 10/26/2023:

The answer is Yes. It is the total number of patients in FY 2023 less the number reported on Line 17.

Line 19 – Column 1

Reporting Instruction (Revised 12/6/23):
Enter the total amount of charges for insured patients who received services in fiscal year 2023 who have been reported or classified as bad debt. This amount should exclude charges for non-insured patients.

Guidance issued 9/19/23, revised 12/6/23:

- This **should not** include contractual write-offs and denials.
- ~~This total should include all patients, not just those added in FY 2023~~.

Questions:

1. Is this just the payor's portion of all of what was written off to bad debt during the fiscal year? I'm taking the second bullet that says 'not just those added in Fy23' to mean that we report any bad debt on the financial statement in FY23 even if it is related to accounts from prior years.

Guidance Issued on 10/26/2023:

The answer is No. This represents the out of pocket and payor portion. Only report charges for patients who received services ~~discharged~~ in the reported fiscal year.

2. Is the intention of this to report the charges that correspond with the patients reported as having a bad debt in Line 17? Especially for patients seen towards the end of the fiscal year, there may be charges that have not been collected but would not yet be considered a bad debt.

Guidance issued on 10/26/2023:

If the patient was not included in Line 17, he/she should not be included.

3. How should charges be treated for patients with a bill that crosses fiscal years (e.g., service from 6/15/23 to 7/15/23)?

Guidance issued on 10/26/2023, revised 12/6/23:

The charges should be included based on the patient's discharge date. We are only seeking activity for fiscal year 2023.

4. Should this include the out-of-pocket charges reported in Line 20?

Guidance issued on 10/26/2023:

The answer is Yes and should be based on the patient's discharge date.

Line 20 – Column 1:

Reporting Instruction (Revised 12/6/23):
Enter the total patient portion of charges for insured patients (reported in line 19) who received hospital services in fiscal year 2023 who have been reported or classified as bad debt. This should exclude payments from third party payers.

Additional Guidance issued 9/19/23, revised 12/6/23:

- ~~This total should include all patients, not just those added in FY 2023.~~

~~Questions:~~

1. ~~Same thought as the above but this is meant to be only the self-pay portion of the report bad debt write offs for insured patients?~~

~~Guidance issued on 10/26/2023, revised 12/6/23:~~

~~The answer is No. This represents only the out of pocket and payor portion of the charges. Only report charges for services discharged in the reported fiscal year.~~

2. ~~There will be charges not yet adjudicated by insurance; therefore, it will not be known whether they are out-of-pocket. How should these charges be handled?~~

~~Guidance issued on 10/26/2023:~~

~~The answer is No. Do not include charges until costs are certain.~~

3. ~~Should charges reported in this line include only those related to patients treated in FY2023?~~

~~Additional Guidance issued on 10/26/2023:~~

~~The answer is Yes.~~

~~Line 21 Column 1:~~

~~Reporting Instruction (Revised 12/6/23):~~
~~Enter the total amount of charges for uninsured patients who received services in fiscal year 2023 who have been reported or classified as bad debt. This amount should exclude charges for insured patients.~~

~~Questions:~~

1. ~~Is this the uninsured self-pay portion of bad debt write offs reported in the fiscal year?~~

~~Guidance Issued on 10/26/2023:~~

~~The answer is Yes.~~

2. ~~Some patients who have insurance will have a self-pay balance because the hospital is out of network or because they chose not to use their insurance. Should these balances be included in lines 21 and 22?~~

~~Guidance issued on 10/26/2023: If the insurance does not pay the full balance, the total charges should be reported in Line 19 and 20. If insurance is not used, charges should be reported in line 21 and 22.~~

Line 22, Column 1:

Reporting Instruction (Revised 12/6/23):

~~Enter the total out-of-pocket amount ($) of charges for hospital services for uninsured patients not collected by the hospital.~~

~~Additional Guidance issued 9/19/23:~~

~~This question is required to be reported. The total should equal Line 21, Column 1~~

~~Guidance issued on 12/6/2023:~~

~~Line 22 was duplicative of Line 21. Hospitals are no longer required to report line 22.~~

Tab 6 – Debt Collection (Zip Code)

Line 26, Column 4

Reporting Instruction:

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.

Guidance issued 9/19/23:

- For Specialty Hospitals, the definition for Primary Service Area (PSA) is the zip codes that account for **60 percent of your Inpatient stays** when sorted in descending order by volume.
- This is the total number of patients **less** Line 26, Column 3.