Reporting of Debt Collection and Financial Assistance

Guidelines for Hospitals

Updated 3/30/26

Effective 3/10/25

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Addressing Medical Debt Through Data Collection

On October 3rd, 2023, the Los Angeles County (County) Board of Supervisors (Board) adopted a motion "Reducing Medical Debt in Los Angeles County Through Improved Data Collection and Innovative Strategies to Retire Medical Debt" that directed the Director of the Department of Public Health (DPH), the Chief Executive Officer (CEO), Department of Consumer and Business Affairs (DCBA), and County Counsel to develop an ordinance within 90 days to require collection of data and policies on debt collection and financial assistance activities from hospitals operating in Los Angeles County (County). This information must be posted publicly and updated regularly on an online dashboard on the Department of Public Health's website with the option to provide printed copies upon request.

After careful drafting and extensive stakeholder engagement, on August 6th, 2024, the County Board adopted an ordinance to "Amend Title 11 – Health and Safety Code of the Los Angeles County Code to Amend Section 11.02.085 To Clarify Applicability and Add Chapter 11.41, Addressing Medical Debt Through Data Collection."

These guidelines provide the necessary instructions and interpretations for reporting. DPH greatly values its collaboration with healthcare providers in responding to the medical debt crisis in the County and looks forward to continued partnership.

Background

Medical debt poses a significant public health problem in the County. Medical debt burden often results in adverse consequences, causing both physical and mental health issues, as well as financial instability for affected patients and families. Consequently, patients may struggle to afford necessities such as food and housing and may even postpone essential medical treatments. Even patients with insurance coverage find themselves grappling with mounting costs, leading to substantial debts.

Beginning March 10, 2025, hospitals in the County are required to provide reports on debt collection and financial assistance activities to support the County in its efforts to address medical debt and achieve our mission to protect the health, prevent disease, and promote the health and well-being for all persons in the County.

Purpose

Data on debt collection and financial assistance activities play a crucial role in helping DPH and hospitals describe, assess, and forecast issues and identify suitable strategies to improve operations that prevent medical debt, particularly among the indigent.

Key Definitions

- **Consumer Reporting Agency:** any Person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties, and which uses any means or facility of interstate commerce for the purpose of preparing or furnishing consumer reports.
- **Debt:** Money owed by a Patient for health care services or goods the patient received from a Hospital.
- **Debt Collection:** any act or practice in connection with the collection of Debt from a Patient, including but not limited to, the following:
    - 1. The first attempt to contact a patient to seek payment for each separate Debt more than one hundred-eighty (180) days after the initial billing, including, but not limited to, the following communication methods:
        - Mail;
        - Email;
        - Text;
        - Phone Calls; and
        - In-person.
    - 2. The sale or assignment of a Patient's Debt to a third party.
    - 3. Reporting adverse information about the Patient to a Consumer Reporting Agency.
    - 4. Undertaking actions to initiate a civil action, including but not limited to:
        - Placing a lien on a Patient's property;
        - Attaching or seizing a Patient's bank account or any other personal property;
        - Obtaining an order for examination pursuant to California Code of Civil Procedure section 708.120; or
        - Garnishing a Patient's wages.
    - 5. Delaying or denying care based on a Debt.
- **Financial Assistance:** free or discounted care provided to Patients as required by the Hospital Fair Pricing Act and Internal Revenue Service (IRS) regulations (26 C.F.R. Section 1.501(r)-4(b)), or under the Hospital's own policies.
- **Guarantor:** A Person who agrees to accept financial responsibility for a patient's hospital bill or debt. This can include the patient themselves, a spouse, a parent or legal guardian (in cases where the patient is a minor or incapacitated adult), or another individual who explicitly agrees to be responsible for payment.
- **Hospital:** any facility in the County of Los Angeles licensed by the California Department of Public Health as a general acute care hospital, as defined in Health and Safety Code section 1250(a).
- **Patient:** an individual who has received treatment at a Hospital, or the parent or other financially responsible person of that individual.
- **Person:** any individual, partnership, corporation, trust, estate, cooperative, association, government or governmental subdivision or agency, or other entity.
- **Report:** a written or electronic form containing debt data for all Hospital patient Debts.
- **Safety Net Hospital:** any Hospital with a low-income percent of seventy (70) or higher as determined by the most recent California Department of Health Care Services Disproportionate Share Hospital Program eligibility list (https://www.dhcs.ca.gov/formsandpubs/publications/Pages/DSH_Eligibility.aspx).

Overview of Submission of Patients Sent to Debt Collections

- All Hospitals in unincorporated areas of the County and Cities adopting the ordinance are required to report.
- Each row (line) corresponds to one patient account.
- Each column corresponds to a reporting attribute/variable.
- Files must be in .xlsx format (Excel workbook).
- Each Hospital that is not considered a Safety Net Hospital must prepare and submit a Report with Debt data to DPH within thirty (30) days of initiating any Debt Collection.
- Each Safety Net Hospital as defined shall prepare and submit a Report with Debt data to DPH within sixty (60) days of initiating any Debt Collection.

Overview of Submission of Aggregate Debt Collection and Financial Assistance Activities

- Hospitals are required to provide reporting on aggregate medical debt and financial assistance activities.
  Each column corresponds to a reporting attribute/variable.
- Files must be in .xlsx format (Excel workbook).
- Each Hospital that is not a Safety Net Hospital shall prepare and submit to DPH a quarterly statement with aggregate Debt data and Financial Assistance activities. The first quarterly statement shall list information from the preceding three (3) months and each subsequent quarterly statement shall include new information for that quarter.
- Each Safety Net Hospital as defined shall prepare and submit to DPH an annual statement with aggregate Debt data and Financial Assistance activities. The first annual statement shall list information from the preceding twelve (12) months and each subsequent annual statement shall include new information for that year.

Patient and Aggregate Level Debt Collection Data

Report/File Preparation and Design

Reporting Schedule

1. **How often are reports required?**
   - **a. Patient Account Level Data**
     - i. Each Hospital that is not a Safety Net Hospital must prepare and submit a Report with Debt data to DPH within thirty (30) days of initiating any Debt Collection.
     - ii. Each Safety Net Hospital as defined shall prepare and submit a Report with Debt data to DPH within sixty (60) days of initiating any Debt Collection.
     - iii. To stay in compliance with the ordinance, Hospitals should notify DPH if there are any issues creating ongoing delays in reporting.
   - **b. Aggregate Level Data**
     - i. Each Hospital that is not a Safety Net Hospital shall prepare and submit to DPH a quarterly statement with aggregate Debt data and Financial Assistance activities. The first quarterly statement shall list information from the preceding three (3) months and each subsequent quarterly statement shall include new information for that quarter.
     - ii. Each Safety Net Hospital as defined shall prepare and submit to DPH an annual statement with aggregate Debt data and Financial Assistance activities. The first annual statement shall list information from the preceding twelve (12) months and each subsequent annual statement shall include new information for that year.
     - iii. Quarterly report should include data for financial assistance determinations made during that period.
     - iv. To stay in compliance with the ordinance, Hospitals should notify DPH if there are any issues creating ongoing delays in reporting.

Reporting Facilities

2. **Which facilities are required to submit reports?**
   - a. Any facility in the unincorporated area of County of Los Angeles and in Cities that adopt the ordinance licensed by the California Department of Public Health as a general acute care hospital, as defined in Health and Safety Code section 1250(a) are required to provide reports.
   - b. Hospitals in the County of Los Angeles not required to provide reports are however, strongly encouraged to voluntarily provide reports.
   - c. DPH will notify hospitals of changes to their classification as a Safety Net Hospital as defined.
   - d. Cities that have adopted the ordinance include:
     - i. City of Los Angeles (3/30/2026)
     - ii.
   - e. DPH will notify newly obligated hospitals at least 30 days prior to their reporting start date.

Patient Types Required to be Included in the Patient and Aggregate Level Report

3. **Which patients are facilities required to include in their reports?**

a. Any patient registered with the Hospital in any setting (example: inpatient, emergency room (ER), etc.).

4. **What should be reported as hospital debt?**
   a. Only accounts and amounts owed to the hospital should be reported (Accounts Receivable). The hospital is not responsible for reporting debt incurred during the hospitalization that is owed to another entity (i.e. contracted physician group).

Report/File Design

File Format

5. **What file type should be used for the patient and aggregate level report?**
   a. Files can be submitted in one of the following file format:
      i. Excel .xlsx (Excel workbook)
      *NOTE: Hospitals should NOT submit word documents, PDFs, or Smartsheets

File Naming Convention of Reports

The following file naming convention is required and is the only acceptable format for submission. Files that do not follow this naming convention may be rejected and may need to be resubmitted.

6. **How should the files for patient account level report be named?**
   a. The following name convention should be followed:
      "HospitalNameCollectionReport_mmddyyyy"
      Example: ABCHospitalCollectionReport_0812025.xlsx
      - mmddyyyy should represent the submission date.

7. **How should the files for the aggregate level report be named?**
   a. The following name convention should be followed:
   "HospitalNameAggregateReport_mmddyyyy"
   Example: ABCHospitalAggregateReport_08122025.xlsx
      - mmddyyyy should represent the submission date.

Workbook Design

8. **Where should the headers be located?**
   a. Headers must be placed on the first row of the worksheet.

9. **How many tabs should be included in the report?**
   a. Only one tab should be included for the report.

Data Element Preparation and Design

Data Element Format and Structure

Rows/Columns

10. **How should the data elements in each patient account level report be structured?**

a. Columns: Each attribute/variable/column header should be a column.
b. Rows: Each patient account associated with any Debt collection initiation is represented in its own row.

11. **How should the data elements in each aggregate level report be structured?**
    a. Columns: Each attribute/variable/column header should be a column.
    b. **Rows:** Data for the attribute/variable/column should be in the row.

Multiple incidences of Debt Collection

12. **How should patient account level reports be submitted when multiple incidences of debt collection exist for the same patient?**
    a. Each row is a unique occurrence of Debt collection for one patient account. If a patient has multiple accounts sent to debt collection, they will have multiple corresponding rows.
13. **Does a hospital have to continue reporting on the same debt if it continues to involve collection activity?**
    a. No, a hospital only needs to report the initial transfer or assignment to collections for a specific debt of a specific patient.

File Submission Restrictions

14. **Can a facility use this portal to submit other files or reports required by DPH or any other state or federal entity?**
    a. No, this data portal can only be used for submitting patient account and aggregate level reports on debt collection and financial assistance.
    b. DO NOT submit other types of reporting to this portal.

File Submission Options

15. **How are files submitted to DPH?**
    a. DPH has a dedicated secure portal for reports (see below)
        i. **Data Portal:** https://dph.mft.lacounty.gov/Web/Account/Login.htm
        ii. **Username and Password:** Each facility staff member is provided with a unique username and password. The unique username and password are for individuals, not for the facility.
        iii. **Upload** the file.
16. **Can the files be submitted through email?**
    a. No, emailing the report is not accepted.
    b. The report MUST be submitted through the portal.
17. **How often should reports be submitted within the reporting period?**
    a. It is up to the discretion of hospitals on how they would like to submit data within the reporting deadlines. It is acceptable to bundle the data or submit the data daily, per the preference of the hospital designee.

Data Security

18. How is data transmission secured?

a. Reports are stored securely and only accessed by DPH staff to analyze data.
b. In compliance with the Health Insurance Portability and Accountability Act (HIPAA), analysis and reports produced by DPH will not include information that identifies individual patients.

19. Is the data secure pursuant to HIPAA guidelines?

a. Yes, the submitted report from hospitals include protected health information (PHI). This makes it necessary to only submit the report through the secure data portal described above.
b. Similar to all required reporting systems, hospitals are not liable for any data breach of the portal.

20. Should each facility maintain a backup of each file they submit?

a. Yes, each facility should keep a secure back-up of submitted report files.
b. Do not rerun the report as it may introduce changes to the original submitted data.

Support and Technical Assistance

For all questions or concerns including IT, please contact the Healthcare Consumer Protection team at hccpdata@ph.lacounty.gov

Frequently Asked Questions (FAQ)

21. Are Hospitals required to submit a report if they have no patient accounts sent to debt collection?

a. Yes, each Hospital must still submit a blank report with the required header variables.

22. Our facility is not a general acute care hospital, do we need to submit data?

a. Only general acute care hospitals, including long-term acute hospitals, must report. Psychiatric hospitals, behavioral health centers, and substance abuse treatment centers are not required to submit this data.

23. What is the correction process for posted information?

a. The request must be submitted in writing via email to hccp@ph.lacounty.gov within 90 days of the date when the information was posted by DPH.
b. The request should clearly state the reason(s) for the correction requested. These reasons must be supported by specific evidence, including relevant documentation.
c. The request must also include: Hospital's name and HCAI ID.
d. DPH will review the request and issue a final determination.

24. What is considered a violation of this ordinance?

a. A violation is significant noncompliance with data reporting requirements, persistent non-timely submissions of data, or repeated failures to respond to DPH's attempts to contact the Hospital.

Submitting reports with missing data, when those data are not available, does not automatically constitute a violation. However, if there are persistent and substantial

issues with data reporting and a failure to improve the completeness of the reports, it may be deemed a violation.

If a possible violation is identified, the Hospital will be contacted by email to the listed portal contact(s) and the CEO and required to respond to the Department's inquiry within thirty (30) days from the date of inquiry.

25. Appeal process

a. Hospitals may submit a written appeal for violations or denied corrections to the DPH Director through the following process:

b. The appeal must be made in writing and submitted via email to dphdirector@ph.lacounty.gov within 10 business days of a violation notification or correction denial.

c. The appeal must detail the reason(s) for the appeal and why the hospital believes DPH erred in its decision. These reasons must be supported by specific evidence, including any documentation supporting the reasons for appeal.

d. An administrative hearing officer will complete a review of the certification determination and any evidence submitted by the hospital and issue a final determination.

26. Will the impact of this ordinance be evaluated?

a. Yes, DPH will evaluate the impact of the ordinance in partnership with stakeholders 12 months after widespread implementation and regularly thereafter.

27. What is the duration of data retention?

a. Individual data will be retained for 5 years.

The following pages identify the required data elements and the exact column headers to be used in each submission. Adherence to the prescribed data element names and header naming conventions is required under these Rules and Guidelines. Excel templates containing the required headers for aggregate level report and patient account level report will be provided with these Rules and Guidelines.

Data Elements

Patient level debt collection

*$=Character; $#= number of characters in the entry

Category	Required	Attribute/Variable/Column Header Label	Description	Type	Format*	Standard Values (Output)
Account						
	*	HCAIID	HCAI ID.	Text	$9	
	*	DateIndividual	Date that this report was produced.	Date	mm/dd/yyyy	
	*	AccountNumber	The unique identifier for an account advanced to collections. *Not a service ID (which is for individual services)	Text	$	
	*	FAApproved	Was the patient granted financial assistance?	Text (binary)	$	Yes No
	*	FAAmtGiven	If facility approved, the dollar amount of financial assistance granted.	Text	$	
	*	OriginalBalance	Total initial bill for the patient before any adjustments. This is before any adjustments, patient payments, deductions, discounts, insurance payments, and price concessions.	Text	$	

	*	CurrentBalance	Dollar amount owed after all adjustments, patient payments, deductions, discounts, insurance payments, and price concessions as of the reporting date.	Text	$	
	*	PatientPayment	Total of patient payments.	Text	$	
	*	Adjustments	Total adjustments, deductions and discounts.	Text	$	
	*	InsurancePayments	Total of insurance payments.	Text	$	
	*	BillingStart	Start of billing associated with the patient account.	Date	mm/dd/yyyy	
	*	BillingEnd	End of billing associated with the patient account. Note: StartBilling and EndBilling can be the same date.	Date	mm/dd/yyyy	
	*	PatientGuarantor	Is the patient the guarantor?	Text (binary)	$	Yes - if the patient is financially responsible for the debt. No - if another Person (i.e., guarantor) is financially responsible for the debt.

Patient						
	*	PatientLastName	Last name of the patient.	Text	$	
	*	PatientFirstName	First name of the patient.	Text	$	
	*	PatientMiddleName	Middle name of the patient.	Text	$	
	*	PatientSuffix	Suffix of the patient.	Text	$	
	*	ParentLastName	*If patient under 18 – Last name of the parent or guardian.	Text	$	
	*	ParentFirstName	*If patient under 18 – First name of the parent or guardian.	Text	$	
	*	ParentDOB	*If patient under 18 – Date of birth of the parent or guardian.	Date	mm/dd/yyyy	
		Parent Phone	*If patient under 18 – Primary phone number of the parent or guardian.	Text	$	5551234567 (include country code if international)
	*	PatientAddress1	Line 1 of home address of the patient.	Text	$	
		PatientAddress2	Line 2 of home address of the patient.	Text	$	
	*	PatientCity	Home city of the patient.	Text	$	
	*	PatientState	Home state of the patient.	Text	$2	
	*	PatientZip	Home zip code of the patient.	Text	$	
	*	PatientDOB	Date of birth of the patient.	Date	mm/dd/yyyy	
	*	PatientSSN	Social Security number of the patient.			

		PatientPhone	Primary phone number of the patient.	Text	$	5551234567 (include country code if international)
	*	PatientGender	Gender identity of the patient.	Text	$	
	*	PatientRace	Race of the patient.	Text	$	
	*	PatientEthnicity	Ethnicity of the patient.	Text	$	
		PatientEmail	Email address of the patient.	Text	$	
	*	InsuranceCompName	Insurance company name of the patient.	Text	$	
	*	InsuranceGroupNum	Group number of the patient's insurance.	Text	$	
	*	InsuranceID	Member ID of Insurance policy for the patient.	Text	$	
	*	InsurancePolicyholder	Name of the insurance policyholder.	Text	$	
	*	PolicyholderRelationship	Relationship of insurance policyholder to the patient.	Text	$	Suggested Possible Values: Self Spouse Dependent
Patient Guarantor (Only required if patient is not the guarantor)						
	*	GuarantorLastName	Last name of the guarantor.	Text	$	

	*	GuarantorFirstName	First name of the guarantor.	Text	$	
	*	GuarantorMiddleName	Middle name of the guarantor.	Text	$	
	*	GuarantorSuffix	Suffix of the guarantor.	Text	$	
	*	GuarantorAddress1	Line 1 of home address of the guarantor.	Text	$	
		GuarantorAddress2	Line 2 of home address of the guarantor.	Text	$	
	*	GuarantorCity	Home city of the guarantor.	Text	$	
	*	GuarantorState	Home state of the guarantor.	Text	$2	
	*	GuarantorZip	Home zip code of the guarantor.	Text	$	
	*	GuarantorDOB	Date of birth of the guarantor.	Date	mm/dd/yyyy	
	*	GuarantorSSN	Social Security number of the guarantor.			
	*	GuarantorPhone	Primary phone number of the guarantor.	Text	$	5551234567 (include country code if international)
		GuarantorEmail	Email address of the guarantor.	Text	$	
	*	GuarantorInsuranceCompName	Insurance company name of the guarantor.	Text	$	
	*	GuarantorInsuranceGroupNum	Group number of the guarantor's insurance.	Text	$	
	*	GuarantorInsuranceID	Member ID of Insurance policy for the guarantor.	Text	$	
	*	GuarantorRelationship	Relationship of guarantor to the patient.	Text	$	
Collection						

	*	CollectionMethod	Method of collection (internal collection or external collection or legal collection).	Text (Ternary)	$	External - for third-party collections Internal - for Hospital collections Legal - for court, lawyer/law office collections
	*	DateDebtSent	The date the medical debt was sent or assigned to collections.	Date	mm/dd/yyyy	
	*	DebtCollectionName	If external or legal collections, the name of debt collection agency or office.	Text	$	

Aggregate debt and financial assistance

*$=Character; $#= number of characters in the entry

Category	Required	Attribute/Variable/Column Header Label	Description	Type	Format*	Standard Values (Output)

	*	DateAggregate	The final date that the data reports.	Date	mm/dd/yyyy	
	*	FAAppReceived	Number of applications for financial assistance received during the reporting period.	Text	$	
	*	FARecApproved	Number of received financial assistance applications that were approved during the reporting period.	Text	$	
	*	FARecApprovedFull	Number of received financial assistance applications that were approved during the reporting period for full financial assistance.	Text	$	
	*	FARecApprovedFullAmt	Total amount approved from received financial assistance applications that were approved during the reporting period for full financial assistance (full waiver of patient/guarantor bill or financial liability).	Text	$	
	*	FARecApprovedPartial	Number of received financial assistance applications that were approved during the reporting period for partial financial assistance.	Text	$	
	*	FARecApprovedPartialAmt	Total dollar amount approved from received financial assistance applications that were approved during the reporting period for partial financial assistance (partial	Text	$	

			waiver of patient/guarantor bill or financial liability).			
	*	FARecApprovedTotal	Total dollar amount approved from received financial assistance applications.	Text	$	
	*	FAApproved	The number of patients who received financial assistance without completing the hospital's financial assistance application process during the reporting period.	Text	$	
	*	FANoAppFull	The number of patients who received full financial assistance without completing the hospital's financial assistance application during the reporting period.	Text	$	
	*	FANoAppPartial	The number of patients who received partial financial assistance without completing the hospital's financial assistance application process during the reporting period.	Text	$	
	*	FANoAppFullAmt	Total dollar amount approved for full financial assistance from patients who received financial assistance without completing the hospital's financial assistance application process during the reporting period.	Text	$	
	*	FANoAppPartialAmt	Total dollar amount approved for partial financial assistance from patients who received financial assistance without	Text	$	

			completing the hospital's financial assistance application process during the reporting period.			
	*	FANoAppTotalAmt	Total dollar amount approved for financial assistance from patients who received financial assistance without completing the hospital's financial assistance application process during the reporting period.	Text	$	
	*	FAAmtApproved	The total dollar amount of financial assistance (Patient liability waived) approved during the reporting period. Note: do not include debt that is sold to an external agency that will be forgiven.	Text	$	
	*	FARecComplete	Number of received financial assistance applications that were considered complete by the hospital during the reporting period.	Text	$	
	*	FARecDenied	Number of received financial assistance applications that were denied during the reporting period.	Text	$	
	*	FADeniedRecIncomplete	Number of received financial assistance applications denied because they were considered incomplete by the hospital during the reporting period.	Text	$	

	*	FADeniedRecIncome	Number of received financial assistance applications denied because the patient's income was above eligibility threshold by the hospital during the reporting period.	Text	$	
	*	FADeniedRecAssets	Number of received financial assistance applications denied because the patient's assets were above eligibility threshold by the hospital during the reporting period.	Text	$	
	*	FADeniedRecThirdParty	Number of received financial assistance applications denied because a third-party payer covered the debt by the hospital during the reporting period.	Text	$	
	*	FADeniedRecOther	Number of received financial assistance applications denied because of other reasons (not one of the pre-determined data variable options) by the hospital during the reporting period. Note: please specify the reason.	Text	$	
	*	FAvendorPEincome	Vendor used to screen patients for eligibility, income estimation or presumptive eligibility.	Text	$	
	*	AverageDebt	Average outstanding or past due debt owed to the hospital	Text	$	

			by patients during the reporting period.			
	*	MedianDebt	Median outstanding or past due debt owed to the hospital by patients during the reporting period.	Text	$	
	*	TotalDebt	Total outstanding or past due debt owed to the hospital by patients during the reporting period.	Text	$	
	*	TotalDebtSold	Total dollar amount of outstanding or past due debt sold to external agencies.	Text	$	
	*	TotalDebtSoldAmt	Total dollar amount received for the sale of outstanding or past due debt sold to external agencies.	Text	$	
	*	TotalPatientsForgiven	Total number of patients that had their debt forgiven by the hospital during the reporting period.	Text	$	
	*	AverageDebtForgiven	Average dollar amount of debt forgiven by the hospital during the reporting period.	Text	$	
	*	MedianDebtForgiven	Median dollar amount of debt forgiven by the hospital during the reporting period.	Text	$	
	*	TotalDebtNumberPatients	Total number of patients with outstanding or past due debt during the reporting period.	Text	$	
	*	CollectionSentNumber	Number of patients that are referred to a debt collector or collection agency during the reporting period.	Text	$	

	*	ECASentNumber	Transferred for extraordinary collection actions during the reporting period.	Text	$	
	*	AverageColDebt	Average dollar amount of debt owed to the hospital by patients, that was placed in collections during the reporting period.	Text	$	
	*	MedianColDebt	Median dollar amount of debt owed to the hospital by patients, that was placed in collections during the reporting period.	Text	$	
	*	TotalColDebt	Total dollar amount of debt owed to the hospital by patients, that was placed in collections during the reporting period.	Text	$	
	*	TotalColPatients	Total number of patients that was placed in collections during the reporting period.	Text	$	
	*	TotalColAccounts	Total number of accounts that were sent to debt collection. Note: one patient can represent more than one account if they are sent more than once to debt collection.	Text	$	