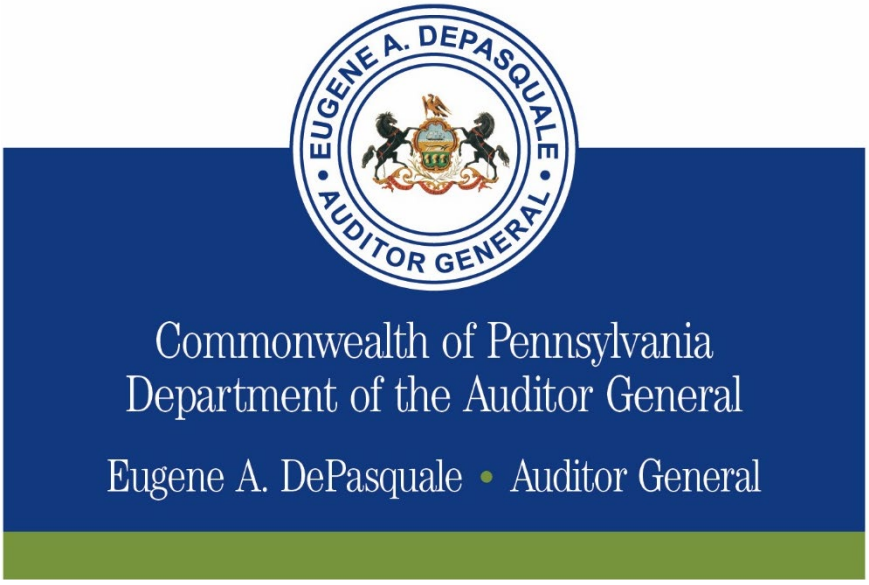
TOBACCO SETTLEMENT PROGRAM

Lancaster General Hospital
Tobacco Settlement Payment Data Review
Year 2021

July 2020



Commonwealth of Pennsylvania
Department of the Auditor General
Harrisburg, PA 17120-0018
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EUGENE A. DEPASQUALE
AUDITOR GENERAL

July 14, 2020

Mr. Joe Byorick
Chief Financial Officer
Lancaster General Hospital
555 North Duke Street
Post Office Box 3555
Lancaster, PA 17604

Re: Lancaster General Hospital

Dear Mr. Byorick:

The Tobacco Settlement Act of June 26, 2001 (P.L. 755, No. 77), as amended, 35 P.S. § 5701.101 et seq., mandated the Department of Human Services (DHS) to make payments to hospitals for a portion of uncompensated care services provided by these facilities. Hospitals that qualify can receive payments using either an uncompensated care approach or an extraordinary expense approach. The uncompensated care score of each hospital is determined by using three-year averages from five main data elements (for a total of fifteen data elements). These data elements are uncompensated care costs, net patient revenues, Medicare supplemental security income (Medicare SSI) days, Medical Assistance (MA) days and total inpatient days. A hospital qualifies for an extraordinary expense payment based on their number of qualified claims. Qualified claims are those claims in which the cost of the claim exceeds twice the average cost of all claims for that particular facility and for which the hospital provided inpatient services to an uninsured patient.

At the request of DHS, the Department of the Auditor General performed a review[1] of Lancaster General Hospital's (facility) records to substantiate the claims data and days data it submitted to the Pennsylvania Health Care Cost Containment Council (PHC4) and DHS, respectively.

The purpose of our review was to determine whether this facility reported any potentially eligible extraordinary expense claims for the fiscal year ended June 30, 2019 and, if so, verify whether corresponding patients were uninsured and the facility received no compensation from

[1] This review was not required to be and was not conducted in accordance with professional auditing or attestation standards.

third party payers such as Medicare, Medicaid, or Blue Cross. Payments made by the patients themselves toward their financial obligations may have reduced the allowable costs of the respective claim when determining eligibility. We also determined whether this facility could substantiate total inpatient days and total MA days as reported on its submitted MA-336 cost reports, if filed with DHS, for the fiscal year ended June 30, 2018.

The results of our review are as follows:

For Reported Claims:

Based on the PHC4 claims database for the fiscal year ended June 30, 2019, the facility reported 65 potentially eligible extraordinary expense claims for review. The results of our review disclosed that 42 of the 65 reported potentially eligible extraordinary expense claims met the criteria to qualify as extraordinary expense claims. The chart below details our results and explains any adjustments that should be made to the PHC4 Database. Since we determined that 42 of the 65 reported claims submitted by the facility qualify as extraordinary expense claims, this facility could be eligible for payment under the extraordinary expense method for the 2021 Tobacco Settlement Payment Year.

Claim No.	Originally Reported Total Charges	Substantiated Total Charges Based on Account Notes	Patient Payments Applied to Account	Qualify (Yes/No) – Reason for Not Qualifying	Adjustment(s) Needed
1	$592,059.80	$592,059.80	$0	Yes	No
2	$356,594.95	$356,594.95	$0	Yes	No
3	$334,533.75	$334,533.75	$0	Yes	No
4	$327,120.40	$327,120.40	$0	Yes	No
5	$311,208.65	$0	$0	No – Claim is still active	Claim should be removed from self-pay listing
6	$302,600.75	$302,600.75	$0	Yes	No
7	$298,055.50	$298,055.50	$0	Yes	No
8	$265,422.70	$265,422.70	$36,893.76	Yes	No
9	$261,546.47	$181,466.65	$0	Yes	An adjustment is needed to total charges
10	$239,661.70	$239,661.70	$0	Yes	No
11	$223,200.85	$223,200.85	$0	Yes	No
12	$214,848.85	$0	$0	No – Claim is still active	Claim should be removed from self-pay listing
13	$209,428.05	$209,428.05	$0	Yes	No
14	$194,060.35	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
15	$183,598.90	$183,598.90	$0	Yes	No
16	$181,802.35	$181,802.35	$0	Yes	No

Claim No.	Originally Reported Total Charges	Substantiated Total Charges Based on Account Notes	Patient Payments Applied to Account	Qualify (Yes/No) – Reason for Not Qualifying	Adjustment(s) Needed
17	$180,499.65	$180,499.65	$0	Yes	No
18	$174,941.40	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
19	$173,657.88	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
20	$171,660.20	$171,660.20	$23,860.70	Yes	No
21	$165,384.30	$165,384.30	$0	Yes	No
22	$165,126.55	$165,126.55	$0	Yes	No
23	$158,257.95	$158,257.95	$20,415.28	Yes	No
24	$157,415.30	$157,415.30	$0	Yes	No
25	$154,388.15	$154,388.15	$0	Yes	No
26	$152,417.35	$152,417.35	$0	Yes	No
27	$147,742.70	$147,742.70	$0	Yes	No
28	$146,277.40	$146,277.40	$0	Yes	No
29	$143,728.90	$143,728.90	$0	Yes	No
30	$138,643.90	$0	$0	No – Claim is still active	Claim should be removed from self-pay listing
31	$135,416.45	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
32	$125,293.70	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
33	$121,433.60	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
34	$121,124.85	$0	$0	No – Claim is still active	Claim should be removed from self-pay listing
35	$120,240.02	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
36	$117,758.35	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
37	$117,747.65	$117,747.65	$49,100.77	Yes	No
38	$117,429.95	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing

Claim No.	Originally Reported Total Charges	Substantiated Total Charges Based on Account Notes	Patient Payments Applied to Account	Qualify (Yes/No) – Reason for Not Qualifying	Adjustment(s) Needed
39	$117,207.70	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
40	$116,472.55	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
41	$114,468.47	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
42	$113,812.90	$113,812.90	$1,402.11	Yes	No
43	$113,688.85	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
44	$112,958.50	$112,958.50	$0	Yes	No
45	$102,309.45	$0	$0	No – Patient was not self-pay	Claim should be removed from self-pay listing
46	$102,189.15	$102,189.15	$0	Yes	No
47	$102,169.10	$102,169.10	$14,201.50	Yes	No
48	$101,309.85	$101,309.85	$28,164.14	Yes	No
49	$100,781.30	$100,781.30	$0	Yes	No
50	$98,027.40	$97,863.06	$0	Yes	An adjustment is needed to total charges
51	$97,173.00	$97,173.00	$0	Yes	No
52	$97,037.85	$0.	$0	No – Paid by MA	Claim should be removed from self-pay listing
53	$95,981.35	$0.00	$0.00	No – Patient was not self-pay	Claim should be removed from self-pay listing
54	$95,484.00	$0.00	$0.00	No – Claim is still active	Claim should be removed from self-pay listing
55	$94,543.40	$94,543.40	$0	Yes	No
56	$93,739.65	$93,739.65	$0	Yes	No
57	$91,789.10	$91,789.10	$0	Yes	No
58	$90,870.95	$90,870.95	$0	Yes	No
59	$90,289.30	$90,289.30	$0	Yes	No
60	$89,335.33	$89,335.33	$0	Yes	No

Claim No.	Originally Reported Total Charges	Substantiated Total Charges Based on Account Notes	Patient Payments Applied to Account	Qualify (Yes/No) – Reason for Not Qualifying	Adjustment(s) Needed
61	$88,998.85	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
62	$88,403.35	$88,403.35	$0	Yes	No
63	$85,460.70	$85,460.70	$0	Yes	No
64	$84,770.35	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
65	$84,246.05	$84,246.05	$0	Yes	No

For Total Inpatient Days and Total MA Days:

For the total inpatient days and total MA days for fiscal year ended June 30, 2018, our results are as follows:

For FYE 6/30/18	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Total Inpatient Days	155,580	155,580	Not Applicable

For FYE 6/30/18	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
FFS Days	4,787	4,801	Change in Payer Type

For FYE 6/30/18 HMO Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Aetna Better Health	446	448	Change in Payer Type
Amerihealth Caritas Health Plan	8,527	8,525	Change in Payer Type
Amerihealth Caritas Northeast	17	16	Change in Payer Type
CBH of Philadelphia	19	19	Not Applicable
Comm Care Behavioral Health	180	183	Change in Payer Type
Keystone First	224	224	Not Applicable
MA gateway Health Plan	6,864	6,858	Change in Payer Type
Medicaid HMO Generic	54	0	Change in Payer Type

For FYE 6/30/18 HMO Days (Continued)	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
UHC Community Kids	23	23	Not Applicable
UHC Community Plan	2,426	2,421	Change in Payer Type
UPMC for You	2,572	2,573	Change in Payer Type
Performcare	2,924	2,923	Change in Payer Type
Health Partners Medicaid	35	35	Not Applicable

For FYE 6/30/18 OOS Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Delaware	90	90	Not Applicable
Maryland	53	53	Not Applicable
New Jersey	4	4	Not Applicable
New York	69	69	Not Applicable
Virginia	9	9	Not Applicable
West Virginia	1	1	Not Applicable
Other	65	0	No overall variance[2]
Florida	0	49	
Texas	0	11	
Illinois	0	5	
Other	22	0	No overall variance[2]
Other	17	0	
Massachusetts	0	32	
Michigan	0	2	
Puerto Rico	0	4	
Washington	0	1	
Other	8	0	No overall variance[2]
Arizona	0	3	
Connecticut	0	3	
Iowa	0	2	

DHS will use all substantiated reported claims and number of days to calculate this facility's eligibility to receive, and if deemed eligible, its subsidy entitlement under both the extraordinary expense and uncompensated care methods. If eligible under both methods, DHS will allow the facility to choose the method to be used to calculate the facility's 2021 Tobacco Settlement subsidy entitlement payment. DHS establishes the date that these payments will be distributed to all eligible hospitals.

[2] There is no overall variance when comparing the submitted out-of-state days to the provider's supporting documentation, however, the supporting documentation included the breakdown between the states noted.

Our office is currently reviewing all facilities that are potentially eligible for a 2021 Tobacco Settlement subsidy entitlement payment. After all the reviews are completed, we will prepare for DHS' use a report detailing the results of all of our reviews. PHC4 and DHS will contact you with instructions regarding entering adjustments to your facility's originally submitted claims and MA days data based on the results of our review, as applicable.

As a reminder, this facility may submit for our review any claims coded as having Medicare, Medicaid, or any other insurance when submitted to the PHC4 for the fiscal year ended June 30, 2019, which the facility now believes qualify as self-pay claims, and which have total charges above this facility's threshold of $82,769.58. We refer to these types of claims as "additional claims" and these additional claims must be submitted to the Department of the Auditor General no later than October 31, 2020. The results of our review of each facility's submitted additional claims data will be detailed in individualized reports sent to each respective hospital that submitted additional claims.

We thank the staff of Lancaster General Hospital for the cooperation extended to us during the course of our review. If you have any questions, please feel free to contact the Bureau of Children and Youth Services Audits at 717-787-1159.

Sincerely,

Eugene A. DePasquale
Auditor General

LANCASTER GENERAL HOSPITAL
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2021 TOBACCO SETTLEMENT PAYMENT DATA

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