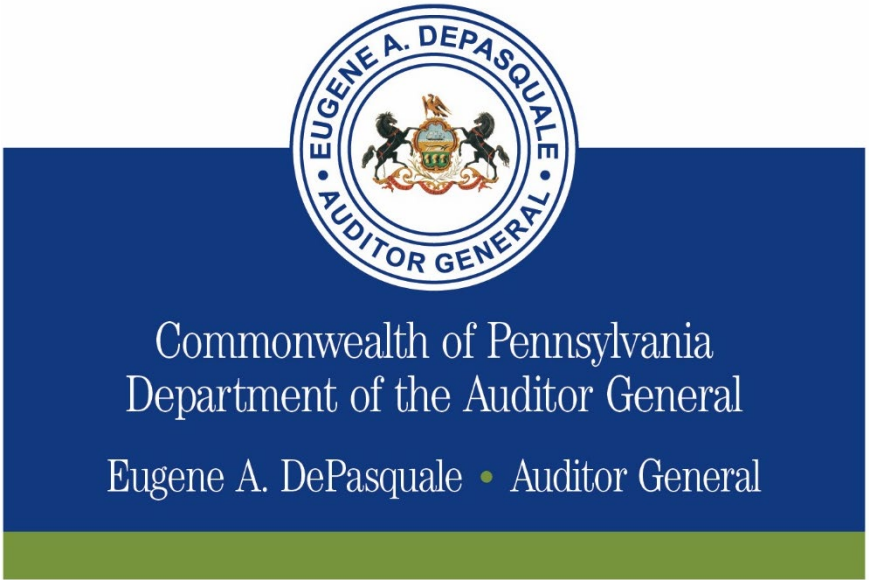
TOBACCO SETTLEMENT PROGRAM

Milton S. Hershey Medical Center

Tobacco Settlement Payment Data Review
Year 2021

August 2020



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

July 21, 2020

Ms. Tracy Williams
Director of Accounting and Budgeting
Milton S. Hershey Medical Center
Penn State College of Medicine, Financial Services A420
90 Hope Drive
Hershey, PA 17033

Re: Milton S. Hershey Medical Center

Dear Ms. Williams:

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 Milton S. Hershey Medical Center'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 45 potentially eligible extraordinary expense claims for review. The results of our review disclosed that 19 of the 45 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 19 of the 45 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 (Y/N) – Reason for Not Qualifying	Adjustment(s) Needed
1	$1,544,475.48	$1,481,689.48	$18,437.02	Yes	An adjustment is needed to total charges
2	$685,860.30	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
3	$603,649.91	$0	$0	No – Not a self-pay claim	Claim should be removed from self-pay listing
4	$555,496.45	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
5	$519,939.52	$518,025.52	$0	Yes	An adjustment is needed to total charges
6	$498,819.42	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
7	$440,824.55	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
8	$415,984.05	$0	$0	No – Paid by MA	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 (Y/N) – Reason for Not Qualifying	Adjustment(s) Needed
9	$410,593.75	$410,593.75	$123,178.12	Yes	Not Applicable
10	$389,413.00	$389,413.00	$116,823.90	Yes	Not Applicable
11	$378,924.94	$378,924.94	$0	Yes	Not Applicable
12	$374,077.69	$374,077.69	$0	Yes	Not Applicable
13	$366,711.46	$366,711.46	$0	Yes	Not Applicable
14	$358,810.18	$358,642.18	$107,475.05	Yes	An adjustment is needed to total charges
15	$347,861.75	$347,861.75	$104,358.52	Yes	Not Applicable
16	$339,910.31	$339,910.31	$0	Yes	Not Applicable
17	$337,170.40	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
18	$329,087.99	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
19	$327,009.40	$327,009.40	$0	Yes	Not Applicable
20	$320,674.67	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
21	$306,035.23	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
22	$275,948.30	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
23	$271,310.35	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
24	$261,887.75	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
25	$258,448.15	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
26	$252,573.03	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
27	$244,802.75	$0	$0	No – Still an active claim	Claim should be removed from self-pay listing
28	$242,735.26	$242,735.26	$72,820.58	Yes	Not Applicable

Claim No.	Originally Reported Total Charges	Substantiated Total Charges Based on Account Notes	Patient Payments Applied to Account	Qualify (Y/N) – Reason for Not Qualifying	Adjustment(s) Needed
29	$236,416.71	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
30	$235,837.86	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
31	$233,877.83	$231,496.83	$63,161.30	Yes	An adjustment is needed to total charges
32	227,279.45	$0	$0	No – Still an active claim	Claim should be removed from self-pay listing
33	$219,806.80	$0	$0	No – Still an active claim	Claim should be removed from self-pay listing
34	$214,050.25	$213,169.25	$63,950.77	Yes	An adjustment is needed to total charges
35	$209,820.70	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
36	$204,841.65	$203,450.65	$61,035.19	Yes	An adjustment is needed to total charges
37	$204,069.41	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
38	$199,752.49	$199,752.49	$59,925.75	Yes	Not Applicable
39	$197,467.05	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing
40	$197,322.12	$196,722.12	$0	Yes	An adjustment is needed to total charges
41	$188,068.67	$187,636.67	$0	Yes	An adjustment is needed to total charges
42	$183,080.45	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
43	$182,085.35	$0	$0	No – Paid by MA	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 (Y/N) – Reason for Not Qualifying	Adjustment(s) Needed
44	$180,660.35	$180,660.35	$0	Yes	Not Applicable
45	$172,652.51	$0	$0	No – Paid by patient	Claim should be removed from self-pay listing

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	170,142	170,142	Not Applicable

For FYE 6/30/18	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
FFS Days	5,809	5,809	Not Applicable

For FYE 6/30/18 HMO Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Aetna Better Health Plan	4,548	4,548	Not Applicable
Amerihealth Caritas	7,218	7,218	Not Applicable
Gateway Health Plan	11,490	11,490	Not Applicable
Geisinger Family	525	525	Not Applicable
Health Partners	23	23	Not Applicable
Keystone First Health Plan	134	134	Not Applicable
UHC Community Plan	4,705	4,705	Not Applicable
UPMC for Best Health	3,582	3,582	Not Applicable

For FYE 6/30/18 OOS Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Delaware	3	3	Not Applicable
Maryland	17	17	Not Applicable

For FYE 6/30/18 OOS Days (Continued)	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
New Jersey	59	59	Not Applicable
New York	40	40	Not Applicable
West Virginia	63	63	Not Applicable
Other	34	0	No overall variance[2]
Other – Alabama	0	6	
Other – California	0	24	
Other – Connecticut	0	4	
Other	22	0	No overall variance[2]
Other – Florida	0	12	
Other – Georgia	0	8	
Other - Massachusetts	0	2	
Other	5	0	No overall variance[2]
Other – Maine	0	2	
Other – North Carolina	0	2	
Other - Oklahoma	0	1	
Other	17	0	No overall variance[2]
Other – Oregon	0	1	
Other – Puerto Rico	0	7	
Other - Texas	0	9	

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.

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 $165,146.71. 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

[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.

submitted additional claims data will be detailed in individualized reports sent to each respective hospital that submitted additional claims.

We thank the staff of Milton S. Hershey Medical Center for the cooperation extended to us during the course of our review. If you have any questions, please feel free to contact Tracie Fountain, CPA, Director, Bureau of Children and Youth Services Audits at 717-787-1159.

Sincerely,

Eugene A. DePasquale
Auditor General

MILTON S. HERSHEY MEDICAL CENTER
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2021 TOBACCO SETTLEMENT PAYMENT DATA

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