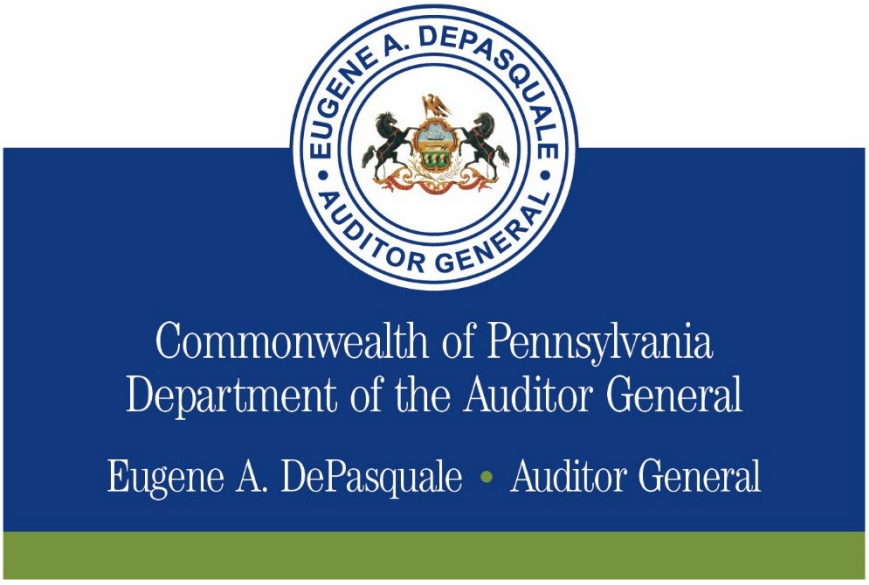
TOBACCO SETTLEMENT PROGRAM

Wellspan York Hospital
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

August 24, 2020

Mr. Michael O'Connor
Chief Financial Officer
Wellspan Health
1011 South George Street
York, PA 17405

Re: Wellspan York Hospital

Dear Mr. O'Connor:

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 Wellspan York 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 third party payers such as Medicare, Medicaid, or Blue Cross. Payments made by the patients

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

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 70 potentially eligible extraordinary expense claims for review. The results of our review disclosed that 19 of these 70 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 these 70 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	$1,142,375.00	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
2	$506,332.69	$0	$0	No – Not a self-pay claim	Claim should be removed from self-pay listing
3	$403,370.00	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
4	$313,403.99	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
5	$307,432.64	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
6	$291,691.25	$291,691.25	$0	Yes	Not Applicable
7	$288,332.75	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
8	$288,296.64	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
9	$278,988.46	$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
10	$238,327.90	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
11	$234,108.75	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
12	$218,134.50	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
13	$215,997.94	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
14	$201,415.78	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
15	$195,861.10	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
16	$194,812.82	$194,812.82	$0	Yes	Not Applicable
17	$188,603.41	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
18	$169,150.97	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
19	$165,412.96	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
20	$163,501.55	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
21	$158,034.45	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
22	$156,180.02	$156,180.02	$0	Yes	Not Applicable
23	$153,088.23	$153,088.23	$0	Yes	Not Applicable
24	$151,931.50	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
25	$150,027.30	$150,027.30	$0	Yes	Not Applicable

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
26	$149,372.54	$0	$0	No – Not a self-pay claim	Claim should be removed from self-pay listing
27	$146,698.50	$146,698.50	$0	Yes	Not Applicable
28	$144,869.99	$0	$0	No – Not a self-pay claim	Claim should be removed from self-pay listing
29	$144,863.08	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
30	$143,795.48	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
31	$142,011.75	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
32	$138,841.67	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
33	$135,194.94	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
34	$128,732.68	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
35	$128,088.75	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
36	$126,889.81	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
37	$126,695.50	$126,695.50	$0	Yes	Not Applicable
38	$125,693.08	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
39	$125,572.12	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
40	$123,799.51	$0	$0	No – Paid by insurance	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
41	$123,673.25	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
42	$119,379.58	$119,379.58	$0	Yes	No
43	$118,389.55	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
44	$117,293.48	$117,293.48	$0	Yes	Not Applicable
45	$109,487.88	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
46	$109,417.69	$109,417.69	$0	Yes	Not Applicable
47	$108,844.50	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
48	$108,424.00	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
49	$108,233.50	$108,233.50	$0	Yes	Not Applicable
50	$107,989.75	$0	$0	No – Paid by the patient	Claim should be removed from self-pay listing
51	$107,039.24	$107,062.24	$0	Yes	Not Applicable
52	$106,604.54	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
53	$106,076.56	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
54	$105,035.54	$105,035.54	$0	Yes	Not Applicable
55	$103,870.85	$0	$0	No – Paid by Medicare	Claim should be removed from self-pay listing
56	$102,274.00	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
57	$102,158.27	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
58	$100,176.75	$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 (Yes/No) – Reason for Not Qualifying	Adjustment(s) Needed
59	$99,943.00	$99,943.00	$0	Yes	Not Applicable
60	$98,438.25	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
61	$98,348.25	$98,348.25	$0	Yes	Not Applicable
62	$97,127.61	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
63	$96,994.00	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
64	$95,792.00	$95,792.00	$0	Yes	Not Applicable
65	$94,579.46	$0	$0	No – Paid by MA	Claim should be removed from self-pay listing
66	$94,094.07	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
67	$92,935.90	$92,935.90	$0	Yes	Not Applicable
68	$91,553.07	$91,553.07	$0	Yes	Not Applicable
69	$91,261.27	$0	$0	No – Paid by insurance	Claim should be removed from self-pay listing
70	$91,087.61	$91,087.61	$0	Yes	Not Applicable

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	169,634	169,634	Not Applicable

For FYE 6/30/18	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
FFS Days	5,434	5,434	Not Applicable

For FYE 6/30/18 HMO Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Amerihealth Mercy	5,924	5,924	Not Applicable
Gateway Health Plan	5,820	5,820	Not Applicable
United Health Care	4,896	4,896	Not Applicable
Aetna Better Health	2,776	2,776	Not Applicable
UPMC	1,751	1,751	Not Applicable
Health Partner	8	0	Reporting Error
Keystone Mercy	15	15	Not Applicable
Priority Partners	25	25	Not Applicable
Performance	478	478	Not Applicable
Community Care Behavioral Health	6,181	6,181	Not Applicable

For FYE 6/30/18 OOS Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Delaware	26	26	Not Applicable
Maryland	115	215	Reporting Error
New Jersey	4	4	Not Applicable
New York	29	29	Not Applicable
Virginia	2	2	Not Applicable
West Virginia	5	5	Not Applicable
Other	16	0	Reporting Error
Florida	0	10	
Kentucky	0	5	
Illinois	0	4	
Washington	0	4	
Iowa	0	2	
Other	13	0	No overall variance[2]
District of Columbia	0	8	
Indiana	0	5	
Other – Nevada	9	9	Not Applicable
Other – Texas	7	7	Not Applicable

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 $90,673.03. 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 Wellspan York Hospital 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

WELLSPAN YORK HOSPITAL
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2021 TOBACCO SETTLEMENT PAYMENT DATA

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