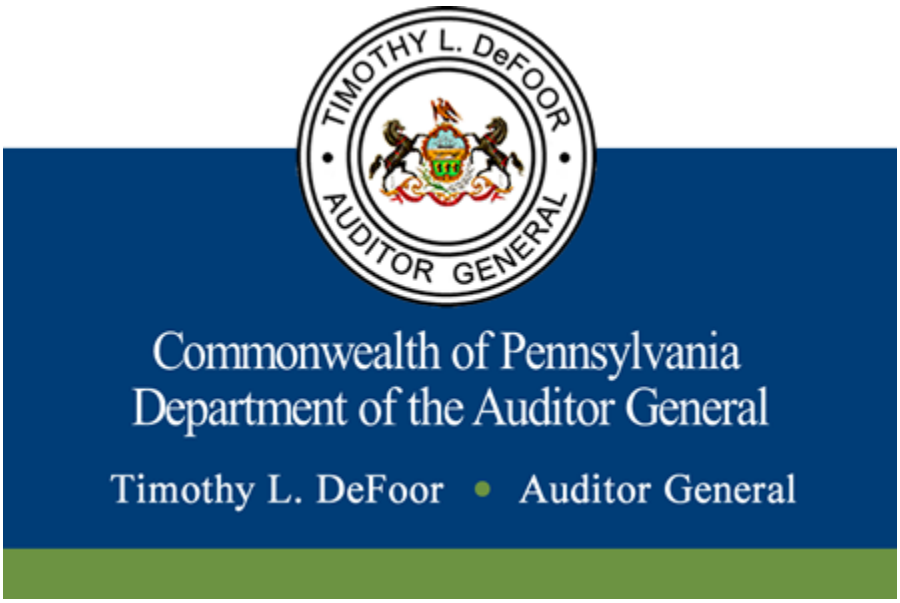
TOBACCO SETTLEMENT PROGRAM

Wellspan York Hospital
Tobacco Settlement Payment Data
Year 2024

September 2023



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TIMOTHY L. DEFOOR
AUDITOR GENERAL

September 8, 2023

Ms. Laura Buczkowski
Chief Financial Officer
Wellspan Health
45 Monument Road, Suite 200
York, PA 17403

Re: Wellspan York Hospital

Dear Ms. Buczkowski:

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 approach is based on the hospital's uncompensated care score. The uncompensated care score 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. The extraordinary expense approach is based on the total costs of the 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.

Upon request from DHS, we developed procedures to be performed for each facility that may be eligible to receive a payment for the provision of uncompensated care services to determine the eligibility of reported claims and the accuracy of days data reported by the facility. DHS agreed that the procedures were appropriate to meet its needs and approved the procedures. We obtained records from Wellspan York Hospital (facility) and performed the established procedures to substantiate the claims data and days data it submitted to the Pennsylvania Health Care Cost Containment Council (PHC4) and DHS, respectively.[1]

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

The purpose of this engagement was to determine whether this facility reported any potentially eligible extraordinary expense claims for the fiscal year ended June 30, 2022 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 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, 2021. We obtained computer processed data from the facility (i.e. account notes and billing information for claims and census reports for days) to determine the eligibility of reported claims and the accuracy of days data reported by the facility. Because of the extensive amount of time that would be required to visit the facility and perform procedures to evaluate the reliability of this data in the facility's information system, DHS management stated that the performance of such procedures is not necessary to meet DHS' needs. As such, we have classified this computer processed data as data of undetermined reliability.

The results of our procedures are as follows:

For Reported Claims:

Based on the PHC4 claims database for the fiscal year ended June 30, 2022, the facility reported 38 potentially eligible extraordinary expense claims. The results of our procedures disclosed that 18 of the 38 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 your facility should make to the PHC4 Database. Since we determined that 18 of the 38 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 2024 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	$891,914.85	$891,914.85	$0.00	Yes	Not Applicable
2	$705,503.93	$704,523.93	$0.00	Yes	An adjustment is needed to total charges
3	$558,894.50	$558,894.50	$0.00	Yes	Not Applicable
4	$500,811.25	$500,811.25	$100,162.25	Yes	Not Applicable
5	$491,683.97	$0.00	$0.00	No – Still an Active Claim	Claim should be removed from self-pay listing
6	$401,211.88	$0.00	$0.00	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
7	$363,683.57	$0.00	$0.00	No – Paid by Medicaid	Claim should be removed from self-pay listing
8	$363,574.75	$363,574.75	$0.00	Yes	Not Applicable
9	$318,523.31	$318,523.31	$0.00	Yes	Not Applicable
10	$294,075.51	$293,095.51	$0.00	Yes	An adjustment is needed to total charges
11	$293,943.94	$293,714.94	$0.00	Yes	An adjustment is needed to total charges
12	$292,744.50	$291,764.50	$0.00	Yes	An adjustment is needed to total charges
13	$288,024.75	$288,024.75	$46,172.87	Yes	Not Applicable
14	$285,591.41	$0.00	$0.00	No – Not a Self-Pay Claim	Claim should be removed from self-pay listing
15	$282,436.12	$282,436.12	$47,994.99	Yes	Not Applicable
16	$273,404.00	$0.00	$0.00	No – Paid by Medicaid	Claim should be removed from self-pay listing
17	$271,295.75	$0.00	$0.00	No – Paid by Medicaid	Claim should be removed from self-pay listing
18	$248,681.66	$247,701.66	$0.00	Yes	An adjustment is needed to total charges
19	$231,765.75	$231,765.75	$0.00	Yes	Not Applicable
20	$231,184.32	$231,184.32	$0.00	Yes	Not Applicable
21	$224,149.09	$0.00	$0.00	No – Paid by Insurance	Claim should be removed from self-pay listing
22	$223,539.90	$223,539.90	$44,707.97	Yes	Not Applicable
23	$217,982.26	$217,716.26	$0.00	Yes	An adjustment is needed to total charges
24	$211,025.73	$211,025.73	$0.00	Yes	Not Applicable
25	$208,297.64	$0.00	$0.00	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
26	$198,991.78	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
27	$198,618.68	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
28	$172,335.75	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
29	$169,029.89	$0.00	$0.00	No – Paid by Medicaid	Claim should be removed from self-pay listing
30	$168,504.70	$0.00	$0.00	No – Paid by Medicaid	Claim should be removed from self-pay listing
31	$156,038.54	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
32	$155,031.80	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
33	$152,416.87	$0.00	$0.00	No – Paid by Medicaid	Claim should be removed from self-pay listing
34	$151,914.20	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
35	$148,307.43	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
36	$147,702.75	$0.00	$0.00	No – Paid by Medicaid	Claim should be removed from self-pay listing
37	$144,074.87	$144,029.07	$29,317.45	Yes	Not Applicable[2]
38	$143,936.52	$0.00	$0.00	No – Paid by Insurance	Claim should be removed from self-pay listing

[2] The difference between the originally reported total charges and the substantiated total charges based on account notes is immaterial, therefore, no adjustment is needed.

For Total Inpatient Days and Total MA Days:

For the total inpatient days and total MA days for fiscal year ended June 30, 2021, our results are as follows:

For FYE 6/30/21	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Total Inpatient Days	176,691	176,691	Not Applicable
For FYE 6/30/21	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
FFS Days	6,036	6,036	Not Applicable

For FYE 6/30/21 HMO Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Amerihealth Mercy	5,931	5,933	Reporting Error
Gateway Health Plan	5,012	4,696	Reporting Error
United Healthcare	7,101	6,735	Reporting Error
Aetna Better Health	2,977	2,938	Reporting Error
UPMC	3,577	3,368	Reporting Error
Health Partners	15	15	Not Applicable
Keystone Mercy	98	85	Reporting Error
Priority Partners	446	0	Reporting Error
Performcare	655	693	Reporting Error
Community Care Behavioral Health	4,402	5,313	Reporting Error
Magellan Behavioral Health	4	22	Reporting Error
PA Health & Wellness	280	271	Reporting Error
Blue Cross Out of State Medicaid	0	2	Reporting Error
Generic Medicaid Managed Care	0	448	Reporting Error

For FYE 6/30/21 OOS Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Maryland	535	546	Reporting Error
New Jersey	9	26	Reporting Error
New York	76	72	Reporting Error
Virginia	8	9	Reporting Error
West Virginia	2	2	Not Applicable
Florida	12	21	Reporting Error

For FYE 6/30/21 OOS Days (Continued)	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Colorado	11	11	Not Applicable
Indiana	14	7	Reporting Error
Alabama	0	9	Reporting Error
Delaware	0	6	Reporting Error
Minnesota	0	15	Reporting Error
North Carolina	0	5	Reporting Error
Ohio	0	1	Reporting Error
Texas	0	22	Reporting Error
Unspecified State	0	44	Reporting Error

PHC4 will contact you with instructions regarding entering adjustments to your facility's originally submitted claims during the self-verification process. The facility's failure to remove any claims identified as not qualifying as extraordinary expense claims from the PHC4 self-pay claims listing during the self-verification process will result in the facility's records in the PHC4 database being inaccurate and DHS concluding that the facility is ineligible for payment under the extraordinary expense method. In addition to completing adjustments in the PHC4 database, any revisions to originally submitted days data on your facility's MA-336 Cost Report should be submitted through the iPACRs system based on the results of our procedures.

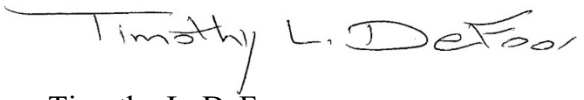
We are in the process of conducting engagements for all facilities that are potentially eligible for a 2024 Tobacco Settlement subsidy entitlement payment. After all the engagements are completed, we will prepare for DHS' use a report detailing the results of all of our engagements.

DHS will use each hospital's revised MA-336 Cost Report and PHC4 database to pull 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 2024 Tobacco Settlement subsidy entitlement payment. DHS establishes the date that these payments will be distributed to all eligible hospitals.

As a reminder, this facility may submit any claims coded as having Medicare, Medicaid, or any other insurance when submitted to the PHC4 for the fiscal year ended June 30, 2022, which the facility now believes qualify as self-pay claims, and which have total charges above this facility's threshold of $135,707.63. We refer to these types of claims as "additional claims" and these additional claims must be submitted to us no later than October 31, 2023. We will include the results of our procedures for each facility's submitted additional claims data in individualized reports sent to each respective hospital that submitted additional claims.

We thank the staff of Wellspan Health for the cooperation extended to us during the course of our engagement. If you have any questions, please feel free to contact the Bureau of County Audits – Hospital and Tobacco Division at 717-787-1159.

Sincerely,



Timothy L. DeFoor
Auditor General

WELLSPAN YORK HOSPITAL
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2024 TOBACCO SETTLEMENT PAYMENT DATA

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