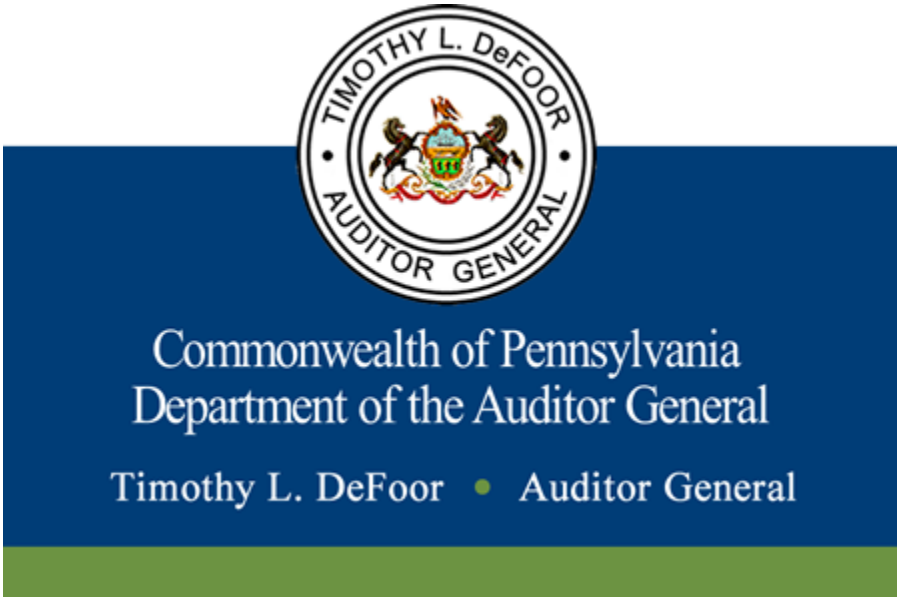
TOBACCO SETTLEMENT PROGRAM

Lehigh Valley Hospital
Tobacco Settlement Payment Data
Year 2022

August 2021



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TIMOTHY L. DEFOOR
AUDITOR GENERAL

August 13, 2021

Mr. Thomas Marchozzi
Executive Vice President and Chief Financial Officer
Lehigh Valley Health Network
LVHN – One City Center
707 Hamilton Street, Executive Suite, 9th Floor
Post Office Box 1806
Allentown, PA 18105

Re: Lehigh Valley Hospital

Dear Mr. Marchozzi:

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.

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 Lehigh Valley 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]

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, 2020 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, 2019. 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, 2020, the facility reported 63 potentially eligible extraordinary expense claims. The results of our procedures disclosed that 34 of the 63 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 34 of the 63 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 2022 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	$2,321,964.65	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
2	$1,621,352.92	$1,621,352.92	$0.00	Yes	Not Applicable
3	$1,336,227.67	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing

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

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
4	$1,181,303.19	$1,185,793.70	$0.00	Yes	An adjustment is needed to total charges.
5	$1,141,079.59	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
6	$846,573.78	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
7	$840,409.24	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
8	$795,281.22	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
9	$787,050.91	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
10	$781,769.99	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
11	$697,876.22	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
12	$641,513.34	$641,474.51	$0.00	Yes	An adjustment is needed to total charges.
13	$601,463.32	$601,463.32	$0.00	Yes	Not Applicable
14	$596,827.43	$557,503.58	$0.00	Yes	An adjustment is needed to total charges.
15	$554,894.78	$554,894.78	$0.00	Yes	Not Applicable
16	$533,257.65	$533,257.65	$0.00	Yes	Not Applicable
17	$528,279.08	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
18	$525,334.96	$525,334.96	$0.00	Yes	Not Applicable
19	$491,297.56	$491,297.56	$0.00	Yes	Not Applicable
20	$463,425.94	$463,425.94	$0.00	Yes	Not Applicable
21	$456,625.19	$0.00	$0.00	No – Per provider, claim was paid	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
22	$418,994.87	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
23	$401,472.51	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
24	$372,350.42	$372,350.42	$0.00	Yes	Not Applicable
25	$339,777.34	$340,429.12	$0.00	Yes	An adjustment is needed to total charges.
26	$307,352.00	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
27	$304,387.03	$304,387.03	$0.00	Yes	Not Applicable
28	$303,936.19	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
29	$296,417.91	$296,417.91	$0.00	Yes	Not Applicable
30	$292,388.35	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
31	$291,624.77	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
32	$290,584.34	$291,574.34	$0.00	Yes	An adjustment is needed to total charges.
33	$284,325.08	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
34	$275,679.42	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
35	$273,057.58	$275,045.75	$0.00	Yes	An adjustment is needed to total charges.
36	$261,439.54	$261,439.54	$0.00	Yes	Not Applicable
37	$243,441.63	$243,441.63	$0.00	Yes	Not Applicable
38	$243,402.97	$0.00	$0.00	No – Per provider, claim was paid	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	$242,892.77	$0.00	$0.00	No – Still an Active Claim	Claim should be removed from self-pay listing
40	$240,956.67	$240,956.67	$0.00	Yes	Not Applicable
41	$235,778.03	$235,778.03	$0.00	Yes	Not Applicable
42	$226,080.12	$226,080.12	$0.00	Yes	Not Applicable
43	$218,766.70	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
44	$218,091.72	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
45	$217,268.68	$217,268.68	$0.00	Yes	Not Applicable
46	$213,986.80	$213,986.80	$0.00	Yes	Not Applicable
47	$210,811.58	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
48	$206,888.24	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
49	$206,466.32	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
50	$205,319.29	$206,271.15	$0.00	Yes	An adjustment is needed to total charges.
51	$204,064.70	$204,064.70	$0.00	Yes	Not Applicable
52	$200,897.02	$200,897.02	$0.00	Yes	Not Applicable
53	$199,170.17	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
54	$196,938.70	$197,153.84	$0.00	Yes	An adjustment is needed to total charges.
55	$194,978.70	$194,978.70	$0.00	Yes	Not Applicable
56	$194,436.58	$194,436.58	$0.00	Yes	Not Applicable
57	$194,026.32	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
58	$193,825.03	$193,825.03	$0.00	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
59	$193,289.50	$0.00	$0.00	No – Per provider, claim was paid	Claim should be removed from self-pay listing
60	$188,237.28	$188,237.28	$0.00	Yes	Not Applicable
61	$185,382.79	$185,382.79	$0.00	Yes	Not Applicable
62	$184,332.77	$184,332.77	$0.00	Yes	Not Applicable
63	$184,023.55	$184,023.55	$0.00	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, 2019, our results are as follows:

For FYE 6/30/19	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Total Inpatient Days	301,134	301,134	Not Applicable

For FYE 6/30/19	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
FFS Days	25,616	25,616	Not Applicable

For FYE 6/30/19 HMO Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Health Partners	85	85	Not Applicable
Amerihealth Mercy Health Plan	17,754	17,754	Not Applicable
Gateway Health Plan	7,444	7,444	Not Applicable
Keystone Mercy Health	1,080	1,080	Not Applicable
Magellan	5,866	5,866	Not Applicable
UPMC For You	2,554	2,554	Not Applicable
Aetna Better Health	1,869	1,869	Not Applicable
United Health Care	2,544	2,544	Not Applicable
Geisinger Family	2,008	2,008	Not Applicable
PA Health & Wellness Medicaid	30	30	Not Applicable
Health Choices	141	141	Not Applicable

For FYE 6/30/19 OOS Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Delaware	81	81	Not Applicable
Maryland	10	10	Not Applicable
New Jersey	194	194	Not Applicable
New York	715	715	Not Applicable
Ohio	15	15	Not Applicable
Virginia	55	55	Not Applicable
Connecticut	25	25	Not Applicable
Florida	43	43	Not Applicable
North Carolina	13	13	Not Applicable
All Others	175	0	No Overall Variance[2]
Arizona	0	2	
California	0	48	
Colorado	0	14	
Georgia	0	5	
Illinois	0	5	
Iowa	0	5	
Kentucky	0	7	
Massachusetts	0	30	
Michigan	0	1	
Oregon	0	11	
Rhode Island	0	2	
South Carolina	0	13	
Texas	0	2	
Washington	0	5	
Wisconsin	0	25	

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 2022 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.

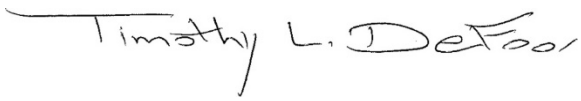
[2] There is no overall variance when comparing the submitted out-of-state days to the provider's supporting documentation, however, the supporting documentation included the breakdown between the states as noted.

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 2022 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, 2020, which the facility now believes qualify as self-pay claims, and which have total charges above this facility's threshold of $180,260.08. We refer to these types of claims as "additional claims" and these additional claims must be submitted to us no later than October 31, 2021. We will include the results of our procedures for each facilities' submitted additional claims data in individualized reports sent to each respective hospital that submitted additional claims.

We thank the staff of Lehigh Valley Health Network for the cooperation extended to us during the course of our engagement. 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,



Timothy L. DeFoor
Auditor General

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2022 TOBACCO SETTLEMENT PAYMENT DATA

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