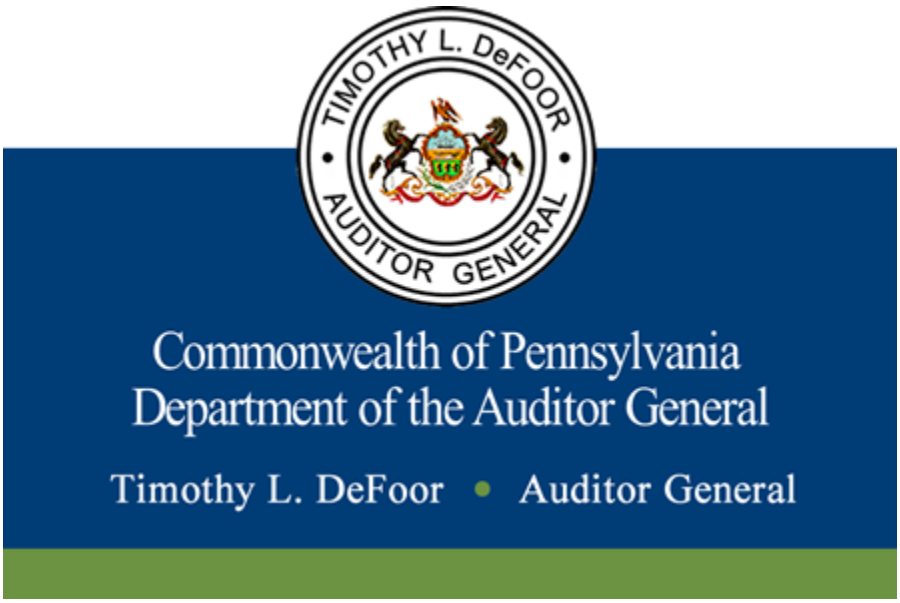
TOBACCO SETTLEMENT PROGRAM

UPMC Pinnacle

Tobacco Settlement Payment Data
Year 2025

November 2024



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TIMOTHY L. DEFOOR
AUDITOR GENERAL

October 29, 2024

Mr. Ronald Struckus
Director of Reimbursement
UPMC Central PA Region
409 South 2nd Street, Suite 4E
Harrisburg, PA 17104

Re: UPMC Pinnacle

Dear Mr. Struckus:

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 UPMC Pinnacle (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, 2023 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, 2022. 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, 2023, the facility reported 46 potentially eligible extraordinary expense claims. The results of our procedures disclosed that 24 of the 46 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 24 of the 46 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 2025 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	$862,149.05	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
2	$510,959.90	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
3	$366,972.15	$366,942.15	$0.00	Yes	Not Applicable[2]
4	$362,681.47	$363,012.47	$0.00	Yes	An adjustment is needed to total charges

[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.

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
5	$362,073.65	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
6	$326,552.10	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
7	$323,835.26	$0.00	$0.00	No – No Documentation Provided	Claim should be removed from self-pay listing
8	$323,556.53	$323,556.53	$0.00	Yes	Not Applicable
9	$303,742.09	$303,742.09	$0.00	Yes	Not Applicable
10	$266,653.45	$266,653.45	$0.00	Yes	Not Applicable
11	$258,865.02	$258,865.02	$0.00	Yes	Not Applicable
12	$255,189.62	$255,189.62	$0.00	Yes	Not Applicable
13	$248,421.43	$248,421.43	$0.00	Yes	Not Applicable
14	$244,065.25	$244,065.25	$0.00	Yes	Not Applicable
15	$227,643.30	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
16	$224,830.03	$224,830.03	$0.00	Yes	Not Applicable
17	$220,611.50	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
18	$204,415.00	$0.00	$0.00	No – No Documentation Provided	Claim should be removed from self-pay listing
19	$198,898.30	$0.00	$0.00	No – Paid by Medical Assistance	Claim should be removed from self-pay listing
20	$194,339.71	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
21	$193,988.28	$0.00	$0.00	No – No Documentation Provided	Claim should be removed from self-pay listing
22	$179,886.84	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
23	$168,769.74	$168,769.74	$0.00	Yes	Not Applicable
24	$159,944.72	$159,944.72	$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
25	$155,498.53	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
26	$152,788.85	$152,788.85	$0.00	Yes	Not Applicable
27	$152,020.25	$152,020.25	$0.00	Yes	Not Applicable
28	$148,441.72	$148,441.72	$0.00	Yes	Not Applicable
29	$147,200.99	$147,200.99	$0.00	Yes	Not Applicable
30	$146,283.42	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
31	$142,575.75	$142,575.75	$0.00	Yes	Not Applicable
32	$140,357.60	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
33	$138,853.35	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
34	$136,012.99	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
35	$134,950.10	$134,950.10	$26,990.02	Yes	Not Applicable
36	$129,848.85	$0.00	$0.00	No – No Documentation Provided	Claim should be removed from self-pay listing
37	$128,147.06	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
38	$126,948.35	$126,948.35	$0.00	Yes	Not Applicable
39	$125,756.86	$125,756.86	$0.00	Yes	Not Applicable
40	$124,499.93	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
41	$122,318.39	$122,318.39	$0.00	Yes	Not Applicable
42	$121,645.46	$121,645.46	$0.00	Yes	Not Applicable
43	$117,831.31	$0.00	$0.00	No – Paid by the Patient	Claim should be removed from self-pay listing
44	$117,273.85	$117,243.85	$0.00	Yes	Not Applicable[2]
45	$114,504.50	$114,504.50	$0.00	Yes	Not Applicable
46	$107,869.64	$0.00	$0.00	No – Paid by the 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, 2022, our results are as follows:

For FYE 6/30/22	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Total Inpatient Days	201,133	186,017	Change in Patient Status

For FYE 6/30/22	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
FFS Days	4,835	4,105	Change in Payer Class

For FYE 6/30/22 HMO Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Aetna Better Health	3,142	3,142	Not Applicable
Gateway	9,605	9,605	Not Applicable
UHC Commplan/ Family	3,503	3,503	Not Applicable
UHC Commplan/ Kids	1	1	Not Applicable
Keystone First Community Healthchoices	5	5	Not Applicable
UPMC for You CHIP	20	20	Not Applicable
UPMC for You	3,667	3,667	Not Applicable
Aetna Better Health Kids	110	110	Not Applicable
Amerihealth Caritas	3,467	3,467	Not Applicable
Keystone First	37	37	Not Applicable
Amerihealth VIP Care	303	176	Change in Payer Class
Health Partners Plans	118	118	Not Applicable
Geisinger Family	109	109	Not Applicable
Amerihealth Caritas Community HC	1,059	1,059	Not Applicable
PA Health Wellness	54	54	Not Applicable
PA Health Wellness Comm HC	459	459	Not Applicable
UPMC Community Healthchoices	756	756	Not Applicable

For FYE 6/30/22 HMO Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Senior Life	10	10	Not Applicable
MA HMO Other	0	1	Change in Payer Class

For FYE 6/30/22 OOS Days	Originally Submitted Number of Days	Substantiated Number Based on Source Documents	Explanation of Difference
Delaware	2	2	Not Applicable
Maryland	95	95	Not Applicable
New Jersey	40	40	Not Applicable
New York	154	154	Not Applicable
Virginia	1	1	Not Applicable
AZ, CT, FL, GA, IA, IL	29	29	No Overall Variance
Arizona	0	3	
Connecticut	0	12	
Florida	0	1	
Georgia	0	5	
Iowa	0	3	
Illinois	0	5	
IN, KY, LA, MA	8	8	No Overall Variance
Indiana	0	2	
Kentucky	0	2	
Louisiana	0	1	
Massachusetts	0	3	
MI, MO, NC	27	27	No Overall Variance
Michigan	0	17	
Missouri	0	4	
North Carolina	0	6	
TX, WA	23	0	No Overall Variance
Texas	0	4	
Nevada	0	9	
South Carolina	0	10	

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 2025 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 verified PHC4 database and revised MA-336 Cost Report 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 2025 Tobacco Settlement subsidy entitlement payment. DHS establishes the date that these payments will be distributed to all eligible hospitals.

As a reminder, this facility was to submit, by October 31, 2024, any claims coded as having Medicare, Medicaid, or any other insurance when submitted to the PHC4 for the fiscal year ended June 30, 2023, which the facility believed qualified as self-pay claims, and which had total charges above the facility's threshold of $107,089.40; we refer to these types of claims as "additional claims." As of October 31, 2024, UPMC Pinnacle submitted eight additional claims for review. For facilities that submitted additional claims, we will send the results of our procedures separately to each respective hospital.

We thank the staff of UPMC Central PA Region 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

Timothy L. DeFoor
Auditor General

UPMC PINNACLE
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2025 TOBACCO SETTLEMENT PAYMENT DATA

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