

**PUBLIC GOODS POOL
GENERAL INSTRUCTIONS FOR COMPLETING
PAYOR ANNUAL REPORTING FORMS**

Payors that have elected to remit their public goods liability directly to the Department's Office of Pool Administration are required to file electronically to calculate and remit the annual payment to the Public Goods Pools.

If you were previously advised by the Department that your organization meets the criteria for filing an annual Public Goods Pool report and payment for the current reporting year and you did not timely submit the supplied form to the Office of Pool Administration to change your filing designation from annual to monthly, you must file an annual Public Goods Pool report and payment, even if you erroneously continued to file monthly reports for the reporting year.

The reports and payments must be submitted to the Office of Pool Administration on or before the 30th day following the last day (December 31st) of the reporting year, adjusted for weekends and holidays. Since payors cannot determine their annual Public Goods Pool liability until sometime following the last day of the reporting year, all annual reports submitted prior to the end of the reporting year will be returned. If an annual reporter erroneously submitted monthly reports and payments during the current reporting year, the payor's annual report must be net of the patient services payments and covered lives amounts reported on the monthly reports erroneously submitted.

TPAs submitting reports on behalf of annual and monthly filers, must submit the annual reports separate from the monthly reports. Reports submitted on behalf of annual filers may not be combined with reports filed on behalf of monthly reporters. Further, if an annual reporting submission represents a consolidated report filed on behalf of a parent company with a number of subsidiaries, the parent company and each represented subsidiary must have been notified by the Department that they qualify for annual reporting. Subsidiaries that have not qualified for annual reporting must file separate monthly reports.

Generally, annual reporters must certify their Public Goods Pool report and submit the two most recent service year portions of the Report of Patient Services Payments and Report of Covered Lives Assessment.

A payor's Public Goods Pool reporting submission must include only those surcharge and/or covered lives payment obligations relating to the service period during which the payor is an electing payor. Payors must continue to remit surcharge obligations, relating to service periods that are not covered by a valid election, directly to designated providers of services. For example, payors whose elections to remit surcharges directly to the Public Goods Pool do not become effective until January 1st of the current reporting year do not report their surcharge/assessment obligations for the previous service years on the Public Goods Pool report forms since they are required to continue to remit any applicable surcharges/assessments for such service years to designated providers of services. Conversely, payors that rescind their election effective December 31st of the previous reporting year do not report their surcharge/assessment obligations for subsequent service years on the Public Goods Pool report forms since they are required to remit any applicable surcharges for such service years to designated providers of services.

Further, a payor's Public Goods Pool reporting obligation does not cease when the payor rescinds its election application. The payor's Public Goods Pool reporting obligation, for the service period during which the entity was an electing payor, will continue for a period of one year following the end of the year in which the election was rescinded or until all claims for such service period have been adjudicated. Once all claims have been adjudicated, the payor must submit a final report and a completed DOH 4402 – Payor Status Change Form indicating the effective date when all claims were adjudicated. Additionally, a payor's Public Goods Pool

reporting obligation does not cease when the payor has a change of status (i.e., self-insured to fully insured). For important information concerning a payor's reporting obligations when the payor has a change of status, please refer to the specific forms located on the HCRA website at www.health.ny.gov/regulations/hcra/.

Pursuant to the New York Health Care Reform Act of 1996, each service year's pool receipts are dedicated to specific purposes and in specific amounts. As a result, the Annual report filed by payors must segregate patient services payments and the related surcharges into service year portions. For example, payors must include total patient service payments for services provided in 2006 in the 2006 portion of the report even if such payments are made in a subsequent service year.

Note that the guidance offered in these instructions is not all-inclusive. Please refer to the New York Health Care Reform Acts and related correspondence previously disseminated by the Department, which is available on the HCRA website.

INSTRUCTIONS FOR REPORT OF PATIENT SERVICES PAYMENTS AND SURCHARGE OBLIGATIONS (ALL POOL YEARS)

No Patient Services Liability

Check this box if the payor has made no patient services payments during the report month for services rendered during the service year and has no adjustments to patient services payments previously reported for the service year.

COLUMNAR DESCRIPTIONS

Column A - Description: This column itemizes total patient services payments and the related surcharge liability.

Patient services payments subject to the surcharges include all monies paid during the reporting year to designated providers of service, including capitation payments allocable to the particular service, less refunds, for discharges occurring or for visits made or services performed on or after January 1st, or contracted service obligations for periods on or after January 1st, of the report service year.

Excluded from surcharge requirements are:

- effective January 1, 1997, payments for physician practice or faculty practice plan discrete billings for private practicing physician services, and effective with dates of service April 1, 2011, and after, payments for discrete billings for physician services;
- residential health care facility services;
- inpatient and outpatient hospice services;
- adult day health care services;
- home care services;
- services provided to subscribers of a Health Maintenance Organization (HMO) operating in accordance with Article 43 of the Insurance Law or Article 44 of the Public Health Law in situations where such HMO operates the clinic or laboratory providing the service (this applies whether or not such services are covered services by the HMO).
- services provided to Medicare beneficiaries are also excluded except where a payor is making payments to a designated provider of service as a result of a person's exhaustion of Medicare benefits, or lack of Medicare benefits for a particular service. In these instances, the services are subject to the surcharge.
- payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/TRICARE and VA;
- laboratory tests performed on laboratory specimens collected outside New York State;

- pursuant to the provisions of the New York Health Care Reform Act of 2000 (HCRA 2000), surcharges are eliminated for referred ambulatory clinical laboratory hospital visits made or services performed on and after October 1, 2000.

Referred (ordered) ambulatory care laboratory services are defined as clinical laboratory services provided to non-registered patients upon the order and referral of a qualified physician, physician's assistant, dentist, or podiatrist to test or diagnose a specimen taken from a patient. For purposes of the specific service being ordered for a specific patient, the specified provider ordering the service may not be employed by or under contract to provide direct patient care for the facility.

Referred (ordered) ambulatory care laboratory services do not include clinical laboratory services provided to a patient admitted to any of such hospital's inpatient units; an emergency outpatient defined as one who is admitted to the emergency, accident or equivalent service of the hospital (Title 10, Sect. 441.104); nor clinical laboratory services provided to a clinic outpatient defined as one who is registered with a formally organized hospital service unit known as a clinic (Title 10, Sect. 441.65).

Column B - Inpatient Hospital: This column is to be used to report patient services payments and the related surcharge liability for all inpatient services provided by general hospitals.

Column C - Outpatient Hospital: This column is to be used to report patient services payments and related surcharge liability for all outpatient services provided by general hospitals including referred ambulatory services, emergency services, ambulatory surgical services, hospital based laboratory services and all other hospital and health-related services. Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in either Column C or Column E (Comprehensive Primary Health Care Clinic).

Column D - Freestanding Ambulatory Surgery: This column is to be used to report patient services payments and the related surcharge liability for all ambulatory surgical services of freestanding diagnostic and treatment centers providing ambulatory surgical services. Note that payments to a comprehensive primary health care clinic for ambulatory surgical services must be reported in Column E (Comprehensive Primary Health Care Clinic).

Column E - Comprehensive Primary Health Care Clinic: This column is to be used to report patient services payments and the related surcharge liability for all services of freestanding diagnostic and treatment centers providing a comprehensive range of primary health care services. Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in either Column E or Column C (Outpatient Hospital).

Column F - Freestanding Clinical Laboratory: This column appears only on the 1997 through 2000 service year portions of the report since it is to be used to report patient services payments and the related surcharge liability for or on account of clinical laboratory visits made or services (relating to human specimens) performed prior to October 1, 2000¹, by freestanding clinical laboratories issued a permit pursuant to Title V of Article 5 of the Public Health Law. Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in Column B (Hospital Outpatient Services) and Column E (Comprehensive Primary Health Care Clinic), respectively.

¹ Pursuant to the provisions of HCRA 2000, surcharges are eliminated for or on account of freestanding clinical laboratory services and on referred laboratory services provided by hospitals and/or comprehensive clinics on and after October 1, 2000.

LINEAR DESCRIPTIONS

Line 1(a) - Current Year: This line is to be used for reporting all patient services payments made during the current reporting year that are subject to the surcharge (for services rendered during the specified service year). If the payor erroneously submitted monthly reports during the current reporting year, Line 1(a) of the annual report must be net of the patient services payment amounts reported on Line 1(a) of the monthly reports erroneously submitted for the specified service year. Payments must be reported according to the categories listed in Columns B through E.

Patient services payments subject to the surcharge include payments to designated providers by:

- New York State governmental agencies;
- local governmental agencies (of New York State) **ONLY** for services provided to correctional facility inmates;
- Health Maintenance Organizations (HMOs) or Prepaid Health Services Plans (PHSPs) for services provided to Medicaid beneficiaries enrolled in the HMO or PHSP; and,
- approved organizations for services provided to subscribers eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law.

Line 1(b) - Prior Period Adjustment: This line is to be used for reporting adjustments due to an overpayment reporting error (for the specified service year) for patient services payments subject to the surcharge. The adjustments must be reported according to the categories listed in Columns B through E. The adjustment amounts may only be negative but may not result in the Total Public Goods Pool Liability Payable to be less than zero. Detailed records are to be maintained since all data is subject to audit.

Line 1(c) - Adjusted Patient Services Payments: Line 1(a) plus Line 1(b).

Line 1(d) - Surcharge Liability: Line 1(c) multiplied by the applicable surcharge.

Line 2(a) - Current Year: This line is to be used for reporting all patient services payments made during the current reporting year that are subject to the surcharge (for services rendered during the specified service year). If the payor erroneously submitted monthly reports during the current reporting year, Line 2(a) of the annual report must be net of the patient services payment amounts reported on Line 2(a) of the monthly reports erroneously submitted for the specified service year. The payments must be reported according to the categories listed in Columns B through E. Patient services payments subject to the surcharge include payments by:

- corporations organized and operating in accordance with Article 43 of the Insurance law;
- organizations operating in accordance with the provisions of Article 44 of the Public Health Law;
- corporations that are commercial insurers licensed in New York State;
- self-insured funds;
- payors pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law and the volunteer ambulance workers' benefit law;
- other insurers not licensed or organized under New York State statute;
- and any other rate, charge, or negotiated rate payment payor.

Do not include payments for patient services provided to persons who are eligible for payments as beneficiaries of Title XVIII of the federal Social Security Act (Medicare) *except* where the payor has made payments to a designated provider of service as a result of a person's exhaustion of Medicare benefits, or lack of Medicare benefits for a particular service. In these instances, the services are subject to the surcharge and should be

reported on this line. Additionally, do not include payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/TRICARE and VA.

Line 2(b) - Prior Period Adjustment: This line is to be used for reporting adjustments due to an overpayment reporting error (for the specified service year) for patient services payments subject to the surcharge. The adjustments must be reported according to the categories listed in Columns B through E. The adjustment amounts may only be negative.

Line 2(c) - Adjusted Patient Services Payments: Line 2(a) plus Line 2(b).

Line 2(d) - Surcharge Liability: Line 2(c) multiplied by the applicable surcharge.

Line 2(e) – Co-Payment and Deductible Surcharge Payments: Enter all surcharges the third-party payor is remitting directly to the Department’s Office of Pool Administration for patient co-payment and deductible payments, which would otherwise be paid to a provider in accordance with the billing example on the Department of Health’s HCRA website at www.health.ny.gov/regulations/hcra/examples.htm.

Payors to directly remit surcharge amounts attributable to patient co-payment and deductible payments must have procedures in place to adequately notify the billing provider, in writing, of such action in a timely manner.

Line 3 - Total: Total of Lines 1(d), 2(d) and 2(e).

Line 4 - Total Surcharge Obligation on Patient Services Payments: Total of Line 3, Columns B through E.

REPORT OF COVERED LIVES ASSESSMENT (ALL POOL YEARS)

No Covered Lives Liability

Check this box if the payor has a statutory obligation to pay the Professional Education Pool and had no New York State residents on their membership rolls for the entire report month and no prior period adjustments to covered lives information previously reported for the service year. This box may not be used where a payor’s share under an apportionment agreement is zero. Payors that apportion their covered lives obligations with another payor must report the covered lives subject to apportionment and their respective apportionment percentage on lines C through H of the Report of Covered Lives Assessment.

No Statutory Covered Lives Obligation

Check this box if the payor has no statutory obligation to the Professional Education Pool. Only those payors that are not specifically mentioned in PHL Section 2807-s (1-a)(b)² as having a professional education pool surcharge or covered lives obligation may check this box.

² Corporations organized and operating in accordance with Article 43 of the NYS Insurance Law; organizations operating in accordance with the provisions of Article 44 of the NYS Public Health Law; self-insured funds; and effective April 1, 2009, HMOs and insurers licensed outside NYS, authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis are required to pay the Professional Education Pool surcharges or the covered lives assessment.

Covered Lives - Lines (A) and (B): Enter the number of monthly individual covered lives and family unit covered lives (summarized for the entire year) residing in New York State during the reporting year, for whom the payor provides coverage for inpatient hospital services, which were included on the payor's membership rolls for all or any part of a month, by region. The payor must, pursuant to statute, determine and report the total number of individual and family unit covered lives on the membership rolls for each month during the reporting year, aggregate the results, and enter the sum for all months.

For example, if after the calculation, an annual filer had an aggregate of 1,200 individual covered lives on their membership roles for the first six months of the reporting year, and an aggregate of 240 individual covered lives for the last six months of the year, and three individual covered lives on their membership roles for two weeks during the month of January of the reporting year, then the payor would report 1,443 individual covered lives under the appropriate regional designation on Line (A) of this section of the report.

If an annual reporter erroneously submitted monthly reports during the current reporting year, Lines (A) and (B) of the annual report must be net of the covered lives amounts reported on Lines (A) and (B) of the monthly reports erroneously submitted.

Line (A) # Individuals: Enter the number of individual covered lives.

Line (B) # Family Units: Enter the number of family unit covered lives.

Apportionment of Covered Lives - Lines (C) through (H): For payors that have reached an agreement to apportion the cost of their covered lives assessments with another inpatient payor providing unduplicated coverage for a single contract holder, data would be entered in this section of the form. All apportioning entities must be electing payors and the resultant apportionment between such electing payors must add up to 100% of the covered lives being apportioned. The payor must identify the number of covered lives, from within the total number of covered lives reported in Section I on Lines (A) and (B), which are the subject of apportionment.

Line (C) # Individuals Subject to Apportionment: Enter the total number of individual covered lives subject to apportionment.

Line (F) # Family Units Subject to Apportionment: Enter the total number of family unit covered lives subject to apportionment.

The apportionment percentage is the percentage of assessment cost which the reporting entity will be paying in the HCRA period. Where a payor has multiple apportionment agreements, the apportionment percentage entered on Lines (D) and (G) should reflect a composite percentage weighted to reflect the relative number of covered lives in each agreement. An example weighted average apportionment calculation is provided on the last page of these instructions. The apportionment percentages reported must reflect the agreements the payors have on file.

Line (D) Apportionment Percentage: Enter the apportionment percentages for individual covered lives.

Line (G) Apportionment Percentage: Enter the apportionment percentages for family unit covered lives.

Line (E) Apportioned # of Individual Covered Lives: $\text{Line (C)} \times \text{Line (D)}$.

Line (H) Apportioned # of Family Unit Covered Lives: $\text{Line (F)} \times \text{Line (G)}$.

Net Covered Lives - Lines (I) and (J): Net covered lives after apportionment and before prior period adjustments are derived by the following calculation: total number of covered lives less covered lives subject to apportionment plus apportioned covered lives.

Line (I) Net # Individuals: (Line A - Line C) + Line E.
Line (J) Net # Family Units: (Line B - Line F) + Line H.

Net Covered Lives Prior Periods - Lines (K) and (L): Prior period adjustments do not normally apply to the current service year portion of the report; therefore, there would not normally be any entries on Lines (K) and (L) of the current service year portion of the report. However, if an annual reporter erroneously submitted monthly reports during the current reporting year and has reporting adjustments to covered lives information previously reported for the current service year, on those monthly reports, enter the number of covered lives over reported for prior periods (Prior Period Adjustments), by region. Prior period adjustments include retroactive deletions to membership. Since covered lives payments are due for any plan participant on the membership rolls for all or any part of a month, retroactive deletions apply only when the individual or family unit is being retroactively deleted for full monthly periods.

For example, if one family unit covered life was originally included in the January through June monthly reports erroneously submitted during the current reporting year and was subsequently deleted effective January 5th, the payor would enter - 5 under the appropriate family unit regional designation on Line (L) of the annual report to reflect the deletion of one family unit covered life for five months (February through June). Further, the net number of monthly covered lives over reported for prior periods must reflect any apportionments if the lives being adjusted were previously subject to apportionment. For example, if ten family unit covered lives that were included in monthly reports erroneously submitted were being retroactively deleted for one month and pursuant to an apportionment agreement this payor shared costs at a fifty percent (50%) level, only - 5 lives would be shown under the appropriate family unit regional designation on Line (L) of this section of the annual report.

Total Covered Lives - Lines (M) and (N): Carry forward the amounts reported on Lines (I) and (J), unless the annual reporter erroneously submitted monthly reports during the current reporting year. If an annual reporter erroneously submitted monthly reports during the current reporting year and the payor reported adjustment amounts on Lines (K) and (L), add the regional amounts reported on Line (I) to the respective amounts reported on Line (K) and enter the result on Line (M) and add the regional amounts reported on Line (J) to the respective amounts reported on Line (L) and enter the result on Line (N).

Annual Assessment Rate - Lines (O) and (P): The regional covered lives annual assessment rates for individual and family unit covered lives are provided in Line (O) and Line (P), respectively. These rates may not be changed by reporting entities.

Annual Assessment - Lines (Q) through (T):

Line (Q) Individual Unit: Line (M) multiplied by Line (O).

Line (R) Family Units: Line (N) multiplied by Line (P).

Line (S) Totals: Line (Q) plus Line (R).

Line (T) Total Covered Lives Payment Liability: Line (S) divided by 12.

Total Covered Lives Assessment Balance Due for the Year - Line VIII: The total covered lives assessment balance due for the year is the sum of the regional amounts entered on Line (T).

**GENERAL INSTRUCTIONS FOR COMPLETING PRIOR SERVICE YEAR PORTIONS OF THE
REPORT OF COVERED LIVES ASSESSMENT**

The only amounts to be reported on prior service year portions of the Report of Covered Lives Assessment are prior period adjustments. Thus, the instructions for prior service year portions of the Report of Covered Lives Assessment begin with Lines (M) and (N).

Total Covered Lives - Lines (M) and (N): Enter the number of covered lives over reported for prior periods (Prior Period Adjustments), by region. For example, if the payor failed to report four family unit covered lives that were on the payor's membership roles for all or any part of six months, the payor would enter 24 under the appropriate family unit regional designation on Line (N) of this section of the report. Prior period adjustments include retroactive deletions to membership. Since covered lives payments are due for any plan participant on the membership rolls for all or any part of a month, retroactive deletions apply only when the individual or family unit is being retroactively deleted for full monthly periods.

For example, if one family unit covered life was originally included in the January 2002 through June 2002 monthly reports and was subsequently deleted effective January 5, 2002, the payor would enter - 5 under the appropriate family unit regional designation on Line (N) of the report to reflect the deletion of one family unit covered life for five months (February through June 2002). Further, the net number of monthly covered lives under or over-reported for prior periods must reflect any apportionments if the lives being adjusted were previously subject to apportionment. For example, if ten family unit covered lives were being retroactively deleted for one month and pursuant to an apportionment agreement this payor shared costs at a fifty percent (50%) level, only - 5 lives would be shown under the appropriate family unit regional designation on Line (N) of this section of the report.

Annual Assessment Rate - Lines (O) and (P): The regional covered lives annual assessment rates for individual and family unit covered lives are provided in Line (O) and Line (P), respectively. These rates may not be changed by reporting entities.

Annual Assessment - Lines (Q) through (T):

Line (Q) Individual Unit: Line (M) multiplied by Line (O).

Line (R) Family Units: Line (N) multiplied by Line (P).

Line (S) Totals: Line (Q) plus Line (R).

Line (T) Total Covered Lives Payment Liability: Line (S) divided by 12.

Total Covered Lives Assessment Balance Due for the Year - Line VIII: The total covered lives assessment balance due for the year is the sum of the regional amounts entered on Line (T).

Example - Weighted Average Apportionment Calculation

NYC Region	1,000 Lives - All Individual 100 Lives Subject to Apportionment
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Agreement #	# of Lives Subject to Apportionment.	This Payors Apportionment %	Apportioned Covered Lives
1	30	20%	6
2	50	30%	15
3	20	0%	0
Total	100		21

Apportionment Percentage = 21 / 100 or 21%

or 21 lives at \$116.04 = \$2,436.84

PROOF:

Individual Covered Lives Rate	Agreement #	# of Lives Subject to Apport.	Full Assessment Calculation	Apportionment %	Apportioned Liability
\$ 116.04	1	30	3481.20	20	\$ 696.24
\$ 116.04	2	50	5802.00	30	1,740.60
\$ 116.04	3	20	2320.80	0	0
					\$ 2,436.84