

**PUBLIC GOODS POOL
GENERAL INSTRUCTIONS FOR COMPLETING REPORT OF
PATIENT SERVICES REVENUE RECEIVED AND SURCHARGE OBLIGATIONS**

COMPREHENSIVE DIAGNOSTIC AND TREATMENT CENTERS

Diagnostic and Treatment Centers (D&TCs), issued an operating certificate pursuant to Article 28 of the Public Health Law (PHL), providing a comprehensive range of primary health care services are required to submit reports electronically for reporting periods on and after January 1, 2005 by accessing the Web at: www.hcrapools.org. Since you are not precluded from submitting reports electronically for periods prior to the date mandated by law, we encourage you to electronically file for reporting periods prior to January 1, 2005.

Providers are required to file the Provider Certification Form and the two most recent service year portions of the Report of Patient Services Revenue and Surcharge Obligations monthly, even if there is no activity to report. Prior service year portions of the report are required only when a provider has net patient services revenue and/or prior period adjustments to report which relate to those service years. Revenue received during the month for surchargeable claims for services rendered during a prior service year must be reported in the appropriate service year. Additionally, adjustments to information previously reported for such service years must be reported as prior period adjustments in the appropriate service year.

A designated provider's monthly Public Goods Pool reporting obligation does not cease when the provider has a change of status (i.e., ceased operations, surrendered license, merged with another provider, etc.) The provider's monthly Public Goods Pool reporting obligation, for the service period during which the entity was a designated provider of services under the Health Care Reform Act of 1996 (HCRA), will continue for a period of one year following the end of the year in which the status change occurred or until all claims for such service period have been adjudicated. Once all claims have been adjudicated, the provider must submit a final monthly report along with a completed DOH 4408 - Provider Status Change form indicating the effective date when all claims were adjudicated. In addition, if you have changed your facility name and/or address, please complete DOH-4407 - Provider Name and Address Change form. Both forms are 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 period's pool receipts are dedicated to specific purposes and for specific amounts. As a result, monthly reports filed by providers must be segregated into service period portions. For example, providers must include revenue received for services provided in 2006 in the 2006 portion of the report even though the revenue was received in a subsequent service period.

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 Web.

**REPORT OF PATIENT SERVICES REVENUE RECEIVED
AND SURCHARGE OBLIGATIONS INSTRUCTIONS**

COLUMNAR DESCRIPTIONS

Column A - Description. This column itemizes total net patient services revenue received, including surcharges.

Column B - Current Month. This column is to be used for reporting total net patient services revenue received during the report month, including surcharges. If there are no prior period adjustments to report in Column C, do not complete this column. See Column D instructions.

Column C - Prior Period Adjustment. This column is to be used for reporting adjustments due to a reporting error or omission in a prior month. This may be either a positive or negative adjustment. Denote negative amounts with brackets (). Detailed records must be maintained since all report information is subject to audit.

Column D - Total. Add the individual amounts reported in Column B to the respective amounts reported in Column C and enter the result on the appropriate line in Column D. If there were no prior period adjustments in Column C, total net patient services revenue received during the month may be entered in Column D only.

NET PATIENT SERVICES REVENUE

definition/assessability

In general, net patient services revenue shall mean all moneys received for or on account of hospital or medical services provided or related to patients whose purpose is the treatment or prevention of human illness, disease, injury or disability. Providers should refer to the Line 1 instructions for a more specific definition for net patient services revenue for diagnostic and treatment centers providing a comprehensive range of primary health care services (PHL Section 2807-j).

Examples of revenue which fall outside this definition include: revenue received for clinical laboratory tests performed in connection with the screening of employees for drug use; revenue received for clinical laboratory tests and/or physical examinations performed in connection with applications for life insurance, health insurance, disability insurance or employment; revenue received for clinical laboratory tests performed for the purpose of establishing paternity; and revenue received for forensic laboratory testing.

It should be noted that certain grants and other revenue would be included and may be considered assessable if representing moneys received for the provision of care or other health-related services to individuals. Note however, that government deficit financing grants are never assessable. Such deficit financing grants would be included in Line 1 and then shown as non-assessable on Line 2(g).

LINEAR DESCRIPTIONS

Note: Refer to Report for applicable surcharge percentage.

Line 1 - Total Net Patient Services Revenue Received, including surcharges: Enter total net patient services revenue received during the report month, including surcharges (be sure to include grant revenue on this line). This amount should also include recoveries received from accounts receivable previously written off as uncollectible. Net patient services revenue includes assessable and non-assessable patient services revenue. Net patient services revenue must be reported in the month in which it is received.

Pursuant to Section 2807-j(3)(b) of the Public Health Law, net patient services revenue for diagnostic and treatment centers providing a comprehensive range of primary health care services shall mean all moneys received for or on account of all services, including capitation payments allocable to diagnostic and treatment center services otherwise covered by the assessment, less refunds, for or on account of visits made or services performed on or after January 1, 1997, or contracted service obligations for periods on or after January 1, 1997. This section of the Public Health Law applies to all service periods subsequent to 1997.

Line 2 - Non-Assessable Revenue: Report non-assessable net patient services revenue received during the report month according to the following categories. **IMPORTANT NOTE:** All these amounts must be included on Line 1 - Total Net Patient Services Revenue Received, including surcharges.

Line 2(a) - Report payments related to Medicare eligible beneficiaries on this line. Payments (by Medicare and other payors) to designated providers of services for patient services provided to persons who are eligible for payments as beneficiaries of Title XVIII of the federal Social Security Act (Medicare) are not subject to the HCRA surcharges. This applies whether Medicare is the primary payor or the secondary payor. Also to be included are related co-payment, deductible and coinsurance revenue received. However, revenue received from payors (including patients) making payments to a designated provider where Medicare benefits have exhausted for a particular service or for an uncovered service, shall be subject to all applicable surcharges. The specific surcharge(s) to be applied will be dictated by whether the payor has voluntarily elected to pay the Department's Office of Pool Administration directly.

Line 2(b) - 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 would be entered on this line. Include related co-payment, deductible and coinsurance revenue received.

Line 2(c) - Report payments received for contracted services performed for other designated providers on this line. Example: A freestanding Article 28 comprehensive clinic has a contractual agreement with an Article 28 general hospital to perform certain x-ray services. The HCRA surcharges do not apply to the amount the freestanding Article 28 comprehensive clinic bills and receives in payment from the Article 28 general hospital.

Line 2(d) - Revenue received for services provided to subscribers of an HMO operating in accordance with the provisions of Article 44 of the PHL or Article 43 of the Insurance Law, which owns and operates the D&TC, would be reported on this line. Note that this would include uncovered services as well as covered services.

Line 2(e) - Effective January 1, 1997, physician practice or faculty practice plan revenue based on discrete billings for private practicing physician services would be reported on this line. This refers to situations where a designated provider processes discrete billings for a private practicing physician service or faculty practice plan. Effective with dates of service April 1, 2011, and after, this line also includes discrete billings for physician services. This refers to situations where a designated provider processes discrete billings for an employed physician or a physician practice or faculty practice plan.

Line 2(f) - Report payments received **directly** from the State or the Pool Administrator on behalf of the State pursuant to PHL Sections 2807-l (Health Care Initiatives) and 2807-v (Tobacco Control and Insurance Initiatives) that are included in Line 1. This would include, but not be limited to grants for the following programs: Health Facility Restructuring, Commissioner's Priority Pool, Health Care Quality and Improvement, Aids Drug Assistance Program, Emergency Medical Services, Children's and Cancer Hospitals, and Health Workforce Retraining.

Line 2(g) - Report government deficit financing grant revenue on this line.

Line 2(h) - Other - Include all other non-assessable patient services revenue received during the report month, which is not reportable on Lines 2(a) through 2(g), on this line. Refer to Section 2807-j(3)(b)(ii)(A) through (F) of the PHL for a list of non-assessable patient service revenue items. Examples include co-payments received from patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law (Medicaid), co-payments received from patients eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Service Law, and Health Care Services Pool and Professional Education Pool distributions. Additionally, report here certain payments made directly by New York State and its local governmental subdivisions that are non-assessable. Refer to the instructions for Lines 5(a), 5(b) and 5(c) for assessable payments received directly from New York State and its governmental subdivisions.

Line 2(i) - Revenue received for or on account of referred ambulatory laboratory clinic visits made or services performed on or after October 1, 2000, is reported on this line.

Referred (ordered) ambulatory care laboratory services are defined as clinical laboratory services provided to non-registered patients (i.e., patients who are not registered with a comprehensive diagnostic and treatment center or ambulatory surgery center for clinical services) at the facility 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.

Line 3 - Total Non-assessable Revenue: Sum of Lines 2(a) through 2(i).

Line 4 - Total Assessable Revenue: Line 1 minus Line 3.

Line 5 - Net Assessable Revenue Received from Direct Pay (Electing) Payors: Electing payors are payors whose names appear on the Public Goods Pool Elector List found on both the HCRA website at www.health.ny.gov/regulations/hcra/ and the Office of Pool Administration's website at www.hcrapools.org. Also included is net assessable revenue received from the State's fee-for-service Medicaid Program.

Net patient services revenue received from direct pay payors must be segregated into the following categories:

Line 5(a) - Medicaid, including HMO/PHSP: Report payments received directly from the Medical Assistance Program as well as from electing Health Maintenance Organizations (HMOs) and Prepaid Health Services Plans (PHSPs), for services provided to patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law (Medicaid) and payments received from electing 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 5(b) - Other Payors: Report payments received directly from electing agencies of the State of New York (e.g., Office of Mental Health payments for services provided to individuals residing in State operated developmental centers) which have as a program component direct reimbursement to hospitals for rendered inpatient services and payments received directly from electing local governments (in New York State) **ONLY** for services provided to county and New York City correctional facility inmates.

Line 5(c) - All Other Direct Pay Payors: Payments received from electing payors whose names appear on the HCRA Elector List found on the websites listed under the Line 5 instructions. Additionally, this would include payments from electing local governments (in New York State) for other than correction facility patients and payments by electing self-insured governmental entities in connection with health benefits for their employees (including Workers' Compensation and No-Fault).

Line 6 - Total Net Assessable Revenue Received from Direct Pay Payors: This line is the sum of Lines 5(a) through 5(c).

Line 7 - Total Assessable Revenue Received from Non-Direct Pay Payors, including surcharges: Line 4 minus Line 6. The amount reported in Column D, Line 7 must be segregated into the categories listed in Column A, Lines 8 through 12 of the corresponding service period report.

COLUMNAR DESCRIPTIONS

Lines 8 through 12

Column A - Non-Direct Pay Payors: Provides specific line descriptions of non-direct pay payors.

Column B - Total Assessable Revenue, including surcharges: This column is to be used to report total net patient services revenue received from non-direct pay payors during the report month (Column D, Line 7 of the corresponding service period report). However, where a provider erroneously reported non-direct payor payments under the wrong surcharge factor (Column B, Lines 8 through 12) on a prior month's report, then equivalent positive and negative adjustments should be netted from the affected line totals and adjusted amounts reported on the appropriate line in Column B.

Column C - Surcharge Factor: This column provides the appropriate surcharge factor for each class of non-direct pay payors shown in Column A, Lines 8 through 12.

Column D - Assessable Base: Column B divided by Column C.

Column E - Surcharge Payable: Column B minus Column D.

LINEAR DESCRIPTIONS - FOR ASSESSABLE REVENUE

COLUMN B

Note: Refer to Report for applicable surcharge percentage.

Line 8 - Medicaid-HMO/PHSP/Non-Specified Payors: Report payments received from non-electing HMOs or PHSPs and any payor not specifically listed in PHL Section 2807-j(1) (non-specified payor), for services provided to subscribers eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law. See Line 11 for non-specified payor example. Also report payments received from non-electing 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 9 - Other Payors: Report payments received from non-electing agencies of the State of New York (i.e., Office of Mental Health payments for services provided to individuals residing in State operated developmental centers) which have as a program component direct reimbursement to hospitals for rendered inpatient services and payments received directly from non-electing local governments (in New York State) **ONLY** for services provided to correctional facility inmates.

Line 10 - Self-Pay Uninsured, and Patient/Secondary Payor Co-pay, Deductible and Coinsurance Amounts (where primary payor is an electing payor and the secondary payor is a non-electing payor): Self-Pay Uninsured - Report revenue received from patients who do not have any third party health insurance coverage in whole or in part, and also revenue from insured patients who have exhausted their health care benefits or are making payments for an uncovered service except certain HMO patients described on Line 2(d).

In addition, report co-pay or deductible patient payment amounts on this line that are **NOT** reportable on Line 17. Please see instructions for Line 17. Line 10 would also include secondary payor co-pays, deductibles, and coinsurance amounts where the primary payor is an electing payor but the secondary payor is a non-electing payor.

Line 11 - Non-Specified Payors: Enter total net patient services revenue received from any payor not specifically listed in PHL Section 2807-j(1). Example: A freestanding Article 28 comprehensive clinic has a contractual agreement with a nursing facility to perform certain x-ray services for the nursing facility's patients. The freestanding Article 28 comprehensive clinic is providing a surchargeable service for the nursing facility (non-specified payor). The HCRA surcharges apply to the bill the comprehensive clinic submits to the nursing facility. Since the nursing facility is not a specified payor pursuant to Public Health Law and is therefore not required to make an election to make pool payments directly, only the surcharge(s) applies.

Line 12 - All Other Non-Direct Payors: Report on this line payors subject to the non-direct payor surcharge. This would include any payor specified under Public Health Law as being allowed to remit pool payments directly which has not made such election. Note also that this would include patient and secondary payor co-payment, deductible and coinsurance amounts where the primary payor is a non-electing payor.

SUMMARY LINES

Line 13 - Total Assessable Revenue, including surcharges: Sum Column B, Lines 8 through 12. This amount must equal the amount reported in Column D, Line 7 of the corresponding service period report.

Line 14 - Gross Surcharges Payable: Sum Column E, Lines 8 through 12.

Line 15 - Less: Administrative Fee: This line is the product of 2% of the amount reported in Column D, Line 12.

Line 16 - Net Surcharges Payable for the Month: Line 14 minus Line 15.

Line 17 - Co-pay or Deductible Patient Payments: Enter total co-pay and deductible patient payments received during the report month for which the patient's electing third-party payor has provided written notification that they are paying the associated surcharge on the patient's co-pay or deductible amounts directly to the Public Goods Pool via their payor report. All other co-pay and deductible patient payments for which written notification has **NOT** been provided, must be reported on Line 10.