PUBLIC GOODS POOL
GENERAL INSTRUCTIONS FOR COMPLETING
PAYOR MONTHLY REPORTING FORMS

Payors that have elected to remit their public goods liability directly to the Office of Pool Administration are required to file electronically to calculate and remit monthly payments to the Public Goods Pools.

Generally, monthly 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 monthly 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. Such 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 Pools do not become effective until January 1st of the current year must not submit the previous service year portion of the report since they are required to continue to remit any applicable surcharges/assessments for such service periods 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 periods on the Public Goods Pool report forms since they are required to remit any applicable surcharges/assessments for such service periods to designated providers of services.

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was an electing payor, will continue for a period of one year following the end of the year in which the election was rescinded or until all claims for such service period have been adjudicated.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

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 payors must segregate patient services payments and the related surcharges into service period 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 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 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.

COLUMN 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 report month 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 the surcharge requirements are:

- payments for physician practice or faculty practice plan 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 an 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, VA;
- laboratory tests performed on laboratory specimens collected outside New York State and;
- 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 and clinic 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, 2000 [1] 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.

LINEAR DESCRIPTIONS

Line 1(a) - Current Month: This line is to be used for reporting patient services payments made during the report month that are subject to this surcharge rate (refer to report for applicable surcharge rate). Payments must be reported according to the categories listed in Columns B through E.

[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.

Patient services payments subject to this surcharge rate 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 in a prior month 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. As a result, previous overpayments may have to be spread out over a number of months. Detailed records are to be maintained since all data is subject to audit. To report an underpayment made for a prior period, an additional certified report for the reporting period in which the underpayment originally occurred is required.

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 Month: This line is to be used for reporting patient services payments made during the report month that are subject to this surcharge (refer to report for applicable surcharge rate). 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;
- 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 in a prior month 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. As a result, previous overpayments may have to be spread out over a number of months. Detailed records are to be maintained since all data is subject to audit. To report an underpayment made for a prior period, an additional certified report for the reporting period in which the underpayment originally occurred is required.

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/nysdoh/hcra/examples.htm.

Payors directly remitting 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 individual covered lives and family unit covered lives residing in New York State during the report month, 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 the reporting month, by region.

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

These numbers should include any members on your rolls on the first day of the month plus any additions during the month.

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 submitted as part of the payor's election application.

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: Line (C) x Line (D).
Line (H) Apportioned # of Family Unit Covered Lives: Line (F) x 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): For the January monthly report only, make no entry on Lines (K) and (L) since prior period adjustments do not apply to the current service year portion of the January monthly report. For the February through December monthly reports, enter the net number of individual and family unit covered lives over reported for prior periods (Prior Period Adjustments) by region on Lines (K) and (L), respectively. The net number of covered lives over reported for prior periods must reflect any apportionments if the lives being adjusted were previously subject to apportionment. The adjustment(s) may not result in the Total Public Goods Pool Liability Payable to be less than zero. As a result, previous overpayments may have to be spread out over a number of months. To report an underpayment made for a prior period, an additional certified report for the reporting period in which the underpayment originally occurred is required.

For example, if 10 covered lives were being retroactively deleted for a month and pursuant to an apportionment agreement, this payor shared costs at a 50 percent level, only 5 lives would be shown on this section of the report. Prior period adjustments include retroactive additions and deletions to membership.

Note that retroactive deletions apply only when the individual or family unit is being retroactively deleted for full monthly periods. For example, if a covered life was originally included in the January 2002 through June 2002 monthly reports and was retroactively deleted effective January 5, 2002 the prior period adjustment would only reflect the deletion for the months of February through June 2002 since covered lives payments are due for any plan participant on the membership rolls for all or any part of a month.

Total Covered Lives – Lines (M) and (N): For the January monthly report only, carry the amounts forward from Lines (I) and (J) to Lines (M) and (N), respectively. For the February through December monthly reports, 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) Monthly Payment Liability: Line (S) divided by 12.

Total Covered Lives Liability for the Month – Line VIII: The total covered lives liability for the month 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 net number of covered lives over reported for prior periods (Prior Period Adjustments), by region. The net number of covered lives over reported for prior periods must reflect any apportionments if the lives being adjusted were previously subject to apportionment. The adjustment(s) may not result in the Total Public Goods Pool Liability Payable to be less than zero. As a result, previous overpayments may have to be spread out over a number of months.

For an example, please refer to page 7 of instructions under "Net Covered Lives - Prior Periods – Lines (K) and (L)".

Line (M) # Individuals (Prior Period Adjustment): Enter the number of individual covered lives over reported during a prior reporting period(s).
Line (N) # Family Units (Prior Period Adjustment): Enter the number of family unit covered lives over reported during a prior reporting period(s).

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) Monthly Payment Liability: Line (S) divided by 12.

Total Covered Lives Liability for the Month – Line VIII: The total covered lives liability for the month 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

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