INSTITUTIONAL COST REPORT (NYSICR)

Frequently Asked Questions

(for 2019 ICR)

	Question	Answer
A. Reporting Questions		
1	**What is causing a data error on Exhibit 17 - (Worksheet A-8-2) - Provider Based Physicians Adjustment after all data is entered?**	If providers try to use more than 100 Exhibit 17 lines, there will be a data issue because of our system limitations. We would advise you to stay within the 100-line limit, entering nothing on Lines 101-199. This may mean you have to roll certain lines together.
2	**What can be reported on the cost report in order to obtain/maintain a clinic rate code 1432. If the hospital has an extension clinic reported on the Operating Certificate, should those services be reported under the clinic cost centers on the ICR?**	If an extension site is certified by NYS as a "Hospital Extension Clinic", the hospital would report the services provided by that site in the clinic cost center and step down all costs applicable to that site in order to receive a clinic rate. Regarding payment for the claims submitted for that site, billing rules will determine if the APG rate can be used for the service(s) provided. For example, if the only service that was provided in the visit was a diagnostic test and the patient was referred to that clinic, a claim with only a radiology CPT code will not pay under APGs and must be fee-billed. So, as the clinic rate will be available for the provider to bill, it should be utilized based on appropriate billing policies.
3, Pt I	**How should payments distributed as a result of Medical Liability Mutual Insurance Company's (MLMIC) 2018 acquisition by Berkshire Hathaway be reported? Part 1 of 2 (revised 05/25/2021)**	These payments from MLMIC to eligible policyholders (or designees) are to be reported in the ICR for the period(s) during which they are received as Other Revenue and treated as investment income. The New York State Department of Financial Services (DFS), when it approved the MLMIC demutualization transaction, determined that the cash consideration received by MLMIC's policyholders in return for their equity interest in the mutual insurance company was investment income. Further, the equity interest in the demutualized company is considered investment income by the Internal Revenue Service. In addition, because the transaction did not change existing insurance policies, payments are not to be ICR-reported as returns or refunds of insurance premiums or insurance settlement payments unless documentation from MLMIC (or its representatives or successors) explicitly state that they are returns or refunds.
3, Pt II	**How should payments distributed as a result of Medical Liability Mutual Insurance Company's (MLMIC) 2018 acquisition by Berkshire Hathaway be reported? Part 2 of 2 (revised 05/25/2021)**	Title 10 New York Codes, Rules and Regulations section 86-1.25(g)(3) states that "Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses." The payments for the end of MLMIC demutualization membership interests meet this definition on investment income. The regulations further require that "Interest expense shall be reduced (offset) by investment income with the exception of income from funded depreciation, qualified pension funds, trusteed malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors." The description for financial statement presented amounts may differ from the ICR description. The Berkshire Hathaway acquisition resulted in MLMIC's conversion from a property and casualty mutual insurance company to a property and casualty stock insurance company with, per the DFS September 6, 2018 Decision, cash consideration was paid for extinguished members' equity according to an approved formula. The offsetable ICR investment income value is the difference in the cash consideration received from MLMIC and the hospital-specific net premiums paid during the three-year period that was used by MLMIC to calculate the hospital's share of the cash consideration pool.
4	**What is the proper ICR reporting of gains on disposal? (added 05/11/2020)**	When disposal of an asset which had its costs included as allowable in any reported period results in a gain on disposal in the current reporting period, then either: 1. For the **most frequent disposals**, a **bona fide sale** or a **scrapping**, the gain is disregarded and no adjustment made. 2. For a sale that is **not bona fid**e, the pre-December 1, 1997 rules apply and the allowable gain is limited to the asset's accumulated depreciation at disposal and may require an adjustment; or 3. For other types of disposition (like involuntary conversions), the CMS Provider Manual paragraphs 132-136 explains the treatment of gains. (These types of dispositions result in losses in most cases.) **Bona fide sale** - Arm's length transaction between a willing and well-informed buyer and seller, neither being under coercion, for reasonable consideration. An arm's-length transaction is a transaction negotiated by unrelated parties, each acting in its own self-interest. (CMS Manual 15-1 paragraph 104.24) **Scrapping** - Tangible personal property only that is: able to be removed from the premises; no longer useful for its intended purposes; AND only salable for scrap or junk value. (CMS Manual 15-1 paragraph 132.A.1)
5	**What are the primary payor categories?**	Definitions relating to primary payor categories for reporting of Exhibits 32, 33, 34 and 46 may be found within the ICR instructions. Further clarification on specific primary payors as it relates to Exhibit 46 HFAL reductions are provided below: **Insured** means at least one provided service is covered by at least one of the patient's third-party payors. It is not necessary to collect from the third-party. HFAL reductions for these accounts are reported in the primary payor's charity line. **Uninsured** means the hospital expects a patient with NO third-party coverage for ANY service provided in the account to pay at least a portion of the charges. **Free, Charity** is for patients for whom application of the hospital financial aid policy (HFAL) results in reduction (write-off) of charges to zero. They should initially be recorded at the same value as other patients. (This should approximate when service begins, but often the determination happens during or after service—such as after receiving a charity care application.) Charity care determination or documented presumptive eligibility per HFAL Policy.

	Question	Answer
6	**Are we to carve the amounts on Exhibit 46 lines 382, 386, 383 and 391 out of the allowances where they would normally be reported under primary insurance?**	Yes, the 2019 ICR is treating these amounts as not allowances. Several hospitals, with acceptance by the healthcare associations, have put forth the viewpoint that allowances are adjustments (usually reductions) from charges because of third-party payor rules or by agreement between the third-party payor and the provider. Reductions to patient-responsible amounts including those set under third-party payor rules by the provider do not meet this description of allowances. **(The patient-responsible amount is often a "covered" amount less insurer payment.)** Use these lines to align reporting of **Financial Aid Policy charge** reductions with the rest of Exhibit 46.
7	**How are charges written-off (reduced) because of the hospital Financial Aid Law (HFAL) Policy to be reported in Exhibit 46?**	Because of the Report Year 2019 change in reporting HFAL reduction, an example using Third-Party is as follows: • If application of the HFAL results in write-off of ALL charges for an account with NO services covered by ANY third-party payor, report full charges under Primary Payor Free (Charity, Hill-Burton) on Line 313 and NEW Line 391. (Line 355, Allowances for the Free Primary Payor, would rarely be used, but, if used, the Line 355 amount would not also be reported in Line 391.) • For an account with NO services covered by ANY third-party payor where some payment is expected from/for the patient, report full charges under Primary Payor Uninsured/Self-Pay on Line 311 and HFAL write-off on NEW Line 391. • For accounts with at least one service covered by a third-party payor, report full charges under the applicable primary payor category and HFAL write-offs on NEW Line 382, 383 or 386. Use the primary payor category and do not split among lines.
8	**Are we to report lines 382, 383, 386 and 391 based on accrual or actual write-offs?**	The Department expects the accounting basis of amounts reported on lines 382, 383, 386 and 391 to be consistent with that for the remainder of Exhibit 46.
9	**How can I view Exhibit 53 or the ICR Schedules while preparing the ICR?**	To view Exhibit 53, ICR Schedules 1, 1A, 1B, 2 or 3, within the ICR Software, select the Print Cost Report Icon, then select from the ICR Exhibits Menu, the exhibit or ICR schedule (use the Control key to select multiple items). To display, select Preview/Print or to create a pdf select Print to PDF. This option will allow you to save a pdf copy which can then be stored and/or printed outside of the software. These steps will work for any exhibits, stepdown, or schedules within the Software.
10	**Where should utilization for services provided only outside of the Medicaid Program without any rate codes listed in Table I be reported?**	When a hospital offers a service outside of the Medicaid Program, the costs, charges, visits, etc. need to be adjusted in the ICR so that remaining amounts used for rate-setting are correctly stated. Utilization for such a service provided outside the Medicaid Program should be reported in the same service area and MSC as similar services (see next response). If reporting these services results in an Edit for Exhibit 53 because the MSC 959 costs and charges were not associated with utilization reportable for Exhibit 33, then the Edit Report would briefly explain the service as not having a billable rate code, etc.
11	**How is the MSC identified when a service described in the ICR Instructions is provided outside of the Medicaid Program, for example before approval to use rate codes or funded only from grants?**	When the hospital provides a service to Medicaid FFS or PHSP/HMO Medicaid patients, use the rate code(s) to identify the MSC from the Medicaid Service Code Mapping to Rate Codes Table, Appendix I to that Report Year's ICR Instructions. (1) If the hospital has not provided these services to Medicaid patients but the rate code established in Table I is associated with the hospital, use the MSC. (2) If the services rate code is not listed in Table I but services are provided in the Medicaid Program, contact the ICR mailbox to ask whether the rate code should be included in the Table. There are some instances where the costs and utilization may be reimbursed by Medicaid, however, they are not used in hospital rate-setting by the Bureau of Hospital & Clinic Rate Setting and there is no MSC specifically assigned for the service. In this instance, MSC 959 would be used. (3) If the service is not billable to Medicaid, there should not be a rate code available for the service and the hospital would use MSC 959.
12	**What changes are required for drugs paid outside the rate code?**	At this time, for ratio-of-cost-to-charges (RCC) development, ICR Instructions require adjustment as paid outside the rate only of the amounts of all patient's outpatient chemotherapy drug costs in Exhibit 11 (Instructions page 20) and charges in Exhibit 51 (Instructions pages 20 and 61).
13, Pt I	**Can the Instructions' regarding Interest Rate Swap Reporting be expanded? Part 1 of 2**	Variable-rate interest mortgages and loans (agreements) are often the vehicle available to and used by hospitals for funding. Usually, an initial low rate adjusts upward in increments stated in the agreement until the rate reaches a level that is based on an index. From that point, the rate changes up or down based on the index change with the maximum rate change as specified. Because these agreements may not include or include a prohibitive maximum rate, hospitals hedge the interest-rate risk with an interest rate swap (swap) at a fixed level somewhat less than the maximum rate. To establish the swap, a financial institution usually charges a fee. In addition to the fixed-rate interest expense, fees or costs are charged for maintaining the swap arrangement. When a swap is offered for "free" or at a reduced cost by a supplier (for example, a banking partner of the hospital), Statutes and Regulations require the value of the swap to be reported if any of the supplier's payments are included in Program costs.

	Question	Answer
13, Pt II	**Can the Instructions' regarding Interest Rate Swap Reporting be expanded? Part 2 of 2**	New York Codes, Rules and Regulations requires that hospital costs be adjusted to not include interest rate swap costs and fees. Although more complicated swaps may require additional analysis, for each swap and its agreement, the hospital should determine current year costs and fees to establish and maintain the swap. Where these costs and fees are built into the loan agreement (potentially included in the interest rate or otherwise unstated built-in costs) they will need to be computed and excluded from reported costs. Support for this calculation should be available for the ICR Auditor's inspection. The interest expense that is allowable is the lesser of: · Current period swap (fixed-rate) interest expense (without built-in swap costs or fees), or · The agreement's current period interest that would have been paid if the swap was not in effect.
14	**What professional services may be reported within the Exhibit 50 HFAL costs (charges) and payments?**	Professional services that are discretely billed are to be excluded from Exhibit 50 costs/charges and payments. If the hospital billed a global charge and it could have billed the professional and technical components separately, then the charges (costs) and payments for the professional component are to be excluded from Exhibit 50. (FQHC and RHC are exceptions because the professional component cannot be separately billed.)
15	**If the 2019 Software indicates that, for a service area (Emergency, CPEP or Clinic), "Charges" was the prior-year allocation basis, what options are available?**	Historically, the Department of Health (Department) has included Schedules 1 through 3 in the Department's database system which computes on Schedule 1B the amount of routine and capital costs transferred to and from four outpatient service areas. These schedules have also historically been provided to hospital users through the Health Commerce System (HCS). For Schedule 1B and the three service areas for which cost transfers are still used (Emergency, CPEP and Clinic), the transfers computed in Schedules 1B are based on either the Exhibit 31A visits or Exhibit 46 charges reported in the ICR. The flag established for the 2019 ICR report year was based on each service area's long-standing historical basis. Except for hospitals moving off of flat-rate reporting, the basis has not changed from what has been historically used for these schedules for each hospital. For 2019, ICR Schedule 1B was added to the ICR Software presenting the computed transfer costs and historical transfer basis. For information and convenience, ICR Schedule 1B currently will present what the transferred costs would be using both the charges and visit basis. This was to assist the hospital in identifying inconsistencies in visit and charge reporting. For this review, the change from the historical transfer basis is a temporary change to the other basis in order for the hospital to visualize the impact of the other basis.
16	**If the 2019 Software indicates that, for a service area (Emergency, CPEP or Clinic), "Charges" was the prior-year allocation basis, what options are available?**	Please note: 1. A temporary change from charges to visits may be viewed, but CANNOT be retained or submitted. 2. A temporary change from visits to charges may be viewed and also retained and submitted and made permanent for future ICRs. However, the basis can also be reset to visits before submission. Please note that, once the basis is changed from visits to charges in an ICR submission, the hospital cannot revert back to visits for future cost reporting. This is due to the preference for the Department being charges as it is a better reflection of costs than a visit count. If a hospital's Schedule 1B transfer costs have historically been calculated using charges as the basis, the 2019 ICR software will reflect and require charges be used upon submission (1 above). However, if a hospital's Schedule 1B transfer costs have historically been calculated using visits as the basis, the 2019 software will reflect visits but will allow a temporary or permanent change to charges upon submission (2 above).
B. Software Questions		
17	**What is the username and password?**	The 2019 ICR Software is available, its link/URL and password are on HCS.
C. Audit Fee Questions		
18	**What are the fees associated with submitting an ICR?**	The ICR audit fees are based on Exhibit 11, column 3, line 960 **total expenses** at Class code 00042, line 960 of the previous year's report. The audit fee levels are posted on the DOH website at: http://www.health.ny.gov/facilities/hospital/audit_fee/ For cost report audits for years 2015 and prior, the audit fee payments have been based on the above costs at these fee amounts: <$50 million = $ 5,000 fee $50 - $100 million = $ 7,500 $100 - $300 million = $10,000 $300 - $700 million = $15,000 $700 - $1 billion = $20,000 $1 - $1.5 billion = $30,000 >$1.5 billion = $40,000 This fee applies to 2018 ICR audits.
D. ICR Audit Questions		
19	**Is the Hospital Financial Assistance Law (HFAL) questionnaire used solely to determine compliance? Are hospitals field audited on HFAL compliance?**	All hospitals' questionnaire responses are used to determine HFAL compliance and is used during the ICR desk audit process. Hospitals selected for ICR field audits have additional procedures performed to complete the HFAL compliance determination.

	Question	Answer
20	**If a hospital is not found to be in substantial compliance with the HFAL, how long does it have to correct the issue?**	As with any ICR Audit finding, for an HFAL non-compliance finding, the hospital is to provide a corrective action plan (CAP) with a "completed-by" date for the Final Audit Dashboard. The Department has the final determination in whether this CAP results in compliance and its timing is appropriate.
E. General Questions		
21	**How is the information in cost reports used by the Department?**	The data in the report is used by the Department for data analysis, rate development, the Upper Payment Limit calculation, Disproportionate Share calculation and development of fund distributions. Certain data elements in the ICR is used by other Agencies.
22	**Who should I contact with ICR related questions?**	**ICR questions can be answered using the following emails:** General ICR Questions**:** Hospital.ICR@health.ny.gov KPMG ICR Audit Contact: us-albadvnysdhicr@kpmg.com. Audited Financial Statements must be emailed in pdf format to: AFS@health.ny.gov **Other resources include:** Hospital Inpatient or Outpatient Article 28 rates: HospFFSUnit@health.ny.gov Hospital Outpatient Services for Article 32 (OASAS), Article 31 (OMH) & Article 16 (OPWDD) providers or rates: https://www.health.ny.gov/health_care/medicaid/rates/contacts/ Medicaid Managed Care Rates: bmcr@health.ny.gov Accounts Receivables and Recoupment: bimamail@health.ny.gov. The payoff or collection process for a liability balance: mfm@health.ny.gov HCRA and Cash Assessment: hcraprov@health.ny.gov DSRIP: DSRIP@health.ny.gov VBP QIP: vbp_qip@health.ny.gov VAPAP: vapap@health.ny.gov Establishment of locations on eMedNY: providerenrollment@health.ny.gov Billing questions: eMedNY Helpline Number: 1-800-343-9000