INSTITUTIONAL COST REPORT (NYSICR)

Frequently Asked Questions

(for 2020 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 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 determination should occur approximately 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.
5	**Why will the ICR require separate Essential Plan utilization reporting for the 2022 ICR Report Year?**	Essential Plan utilization reporting will be added to primary payor categories in order to be able to provide future analysis on the Essential Plans. The Essential Plan is a New York health insurance program for state residents that don't qualify for Medicaid or Child Health Plus programs. Note: The change was announced before ICR Year 2022 in order to allow hospitals to update their accounting systems to support the change.
6	**What are the Essential Plans?**	Please refer to the Basic Health Plan Annual Reports for information about the Essential Plans: https://www.health.ny.gov/health_care/managed_care/essential/index.htm
7	**Does line 24.50 include PPP amounts received?**	The published instructions state "Enter the aggregate revenue received for COVID-19 PHE funding including both provider relief fund (PRF) and Small Business ~~Association~~ Administration Loan Forgiveness amounts."

	Question	Answer
8	**How is the primary payor reported for claims made to the HRSA COVID-19 Uninsured Program?**	Claims filed with the HRSA Uninsured Program for COVID-19 services are to be included in the Government Primary Payor Category.
9	**How should amounts remaining on HRSA Uninsured Program COVID-19 claims after HRSA payment be reported in the ICR?**	Report the amounts written off on HRSA Uninsured Program COVID-19 claims as Government Allowances (Exhibit 46, Line 354) since the provider is not being allowed to bill the patient.
10	**What is the treatment of interest earned on PRF [CARES Act Provider Relief Fund] amounts?**	The US Department of Health and Human Services (HHS) stipulates that providers earning interest on PRF funds may either return the interest or may use the interest earned in a manner that would be compliant with the purposes of the PRF principal. For those that returned interest, the amount reported in the ICR as PRF funding would not include the returned interest or would be net of interest yet to be returned. Where PRF reporting allows the provider to retain the interest as used for the principal purpose, no interest offset would be made because this amount is to be treated as interest earned under a restricted grant.
11	**For Exhibit 30, Line 60, Dual-eligible, what meant by "A payor on the account"--are these Medicaid paids or Eligible for payment?**	Hospitals should identify encounters with Medicaid coverage in addition to other coverage in a manner consistent with their Medicaid DSH reporting.
12	**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?**	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 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 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 Line 382, 383 or 386. Use the primary payor category and do not split among lines.
13	**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.
14	**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.
15	**How can I view Exhibit 53 or the ICR Schedules while preparing the ICR?**	To view Exhibit 53, ICR Schedules 1, 1A, 1B, 2, 2A 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 exhibit, stepdown, or schedule within the Software.
16	**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.

	Question	Answer
17	**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 service's 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.
18	**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 patients' outpatient chemotherapy drug costs in Exhibit 11 (Instructions page 20) and charges in Exhibit 51 (Instructions page 64).
19	**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. (Services paid under the FQHC and RHC fee schedules are generally exceptions because the professional component cannot be separately billed for providers that receive the full FQHC/PPS rate.)
20	**Since Rural Health Clinics (RHCs) that are paid under the all inclusive rate and professional cost is left in allowable expenses, do professional charges need to be backed out on Exhibit 51?**	If the provider has elected to be reimbursed the NYS Medicaid FQHC rate for their RHC(s) (reported on CMS line 88 and subscripts thereof) and the provider has included the professional charges on Exhibit 46 then no adjustment is required on Exhibit 51.
21	**If the 2020 Software indicates that, for a service area (Emergency, CPEP Emergency Service or Clinic), "Charges" was the prior-year allocation basis, what options are available?**	ICR Schedules 1B compute the amount of routine and capital costs transferred to and from four outpatient service areas. The three historical service areas (Emergency, CPEP Emergency Service and Clinic) computed in ICR Schedules 1B are based on either the Exhibit 31A visits or Exhibit 46 charges reported in the ICR. —Part of transition of CPEP Observation Beds to Exhibit 33 outpatient reporting was establishing an ICR Schedule 1B for which all hospitals' bases are charges. If the previous year basis was charges, then for that service area in the 2020 ICR: Exhibit 31A will not be available; ICR Schedule 1B will only present transfer based on charges; and the "what if" ability to compare visits-based and charges-based is disabled.
22	**What approval is needed to change the ICR Schedule 1B basis from visits to charges?**	If a provider has utilized visits as a transfer basis statistic in the prior year they may change to charges in the current year with no prior approval. Once an ICR has been submitted with charges used as the basis to determine transfer costs the provider will no longer be permitted to change back to visits. The change is made for the service area on Exhibit 31A.
23	**Where should Hospice days reported on S-3 part I line 24.10 be reported as it relates to Exhibit 32?**	The hospice benefit is not an Inpatient Hospital Service unless the patient is admitted as a hospital (not Hospice) inpatient. Therefore, Exhibit 32 should not include days paid under Hospice rate codes.
24	**What basis should be used to split the real estate tax and insurance expense on Exhibit 40 between 'Buildings and Fixtures' and 'Major Moveable Equipment'?** **Should a similar allocation be done on Exhibit 13?**	Generally, insurance documents provide detail of elemental premiums which should be followed. Where a policy does not provide details of premiums for Buildings and Fixtures (including Land) versus Moveable Equipment, the hospital may make a reasonable allocation and must make that supporting documentation available for ICR Audit review. The Exhibit 13 and Exhibit 40 entries are not linked, but are expected to be similar or the same. As Worksheet A-7, Exhibit 13 is required for Medicare cost reporting.
25	**Will the 2020 ICR filing deadline be extended beyond August 2, 2021**	Should CMS provide any additional filing extensions to the 2552-10 cost report, the Department will also consider an additional extension of the NYS Institutional Cost Report (ICR).
26	**Is the RHCF-2/4 report due date still 7/20/21?**	The Bureau of Residential Health Care Reimbursement has extended the deadline of the RHCF-II filing to August 20, 2021.

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B. Software Questions		
27	**What is the username and password?**	The 2020 ICR Software is available, its link/URL and password are on HCS.
28	**Is Worksheet E part A, line 35, Total Uncompensated Care Amount, updated for the reporting year?**	Yes, when the HIPPS Final Rule for a particular Federal fiscal year is issued, the Medicare cost reporting software is updated with the new UCC amounts and tables.
29	**We have already started entering 2020 data. Will we have any problems saving our work once the updated software is installed?**	There should not be any problems with saving of work once the 2020 software updates have been applied. (Especially where entry or Exhibit definitions have been modified, the hospital should verify that previously entered amounts are accurate and reflect the revised ICR.)
30	**With the purchase of KPMG's cost report service by HFS, will the ICR components be incorporated into the HFS software?**	The ICR components of the software continue to be maintained with the Compu-max utility.
C. Audit Fee Questions		
31	**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 2020 ICR audits.
D. ICR Audit Questions		
32	**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 are used during the ICR desk audit process. Hospitals selected for ICR field audits have additional procedures performed to complete the HFAL compliance determination.
33	**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		
34	**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.
35	**Will the DOH accept an electronic CEO signature page at some point like the Medicare Report does?**	There are internal discussions on the possibility of moving to an electronic certification however at this time we will continue to collect signed CFO certifications and Edits in pdf format.
36	**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