4110 WORKSHEET S-8 - SNF-BASED HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310, hospice providers of service participating in the Medicare program are required to submit information for health care services rendered to Medicare beneficiaries. 42 CFR 413.20 requires cost reports from providers on an annual basis. The statistics required on this worksheet pertain to a SNF-based hospice. Complete a separate Worksheet S-8 for each SNF-based hospice.

4110.1 Part I - Enrollment Days for Cost Reporting Periods beginning before October 1, 2015.

Lines 1 through 4.--Enter on lines 1 through 4 the enrollment days applicable to each level of care (LOC). Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four levels of care. Where a patient moves from one LOC to another, count only one day of care for that patient for the last type of care rendered. For line 4, an inpatient care day may be reported only where the hospice provides or arranges to provide the inpatient care.

Line 5--Enter the total of columns 1 through 6 for lines 1 through 4.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Hospice Continuous Home Care (HCHC) Day - A HCHC day is a day that the hospice patient is not in an inpatient facility, and receives continuous care during a period of crisis in order to maintain the individual at home. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. For each day a beneficiary received 8 or more hours of predominantly nursing care, count the day as one HCHC day. Note: Do not count days by dividing the total hours by 24.

Hospice Routine Home Care (HRHC) Day - A HRHC day is a day that the hospice patient is at home and not receiving HCHC.

Hospice Inpatient Respite Care (HIRC) Day - An HIRC day is a day that the hospice patient receives care in an approved inpatient facility, to provide respite individual's family or other persons caring for the individual at home.

Hospice General Inpatient Care (HGIP) Day - A HGIP day is a day that the hospice patient receives care in a Medicare certified hospice facility, hospital or SNF for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column Descriptions

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2.--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3.--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4.--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5 the total unduplicated days.

Column 5.--Enter in column 5 only the days applicable to the four types of care for all other non-Medicare or non-Medicaid hospice patients. Enter on line 5 the total unduplicated days.

Column 6.--Enter the total days for each type of care, (i.e., sum of columns 1, 2, and 5). The amount entered in column 6, line 5 represents the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6, line 5, reflects the actual total number of days provided by the SNF-based hospice.

4110.2 Part II --Census Data for Cost Reporting Periods beginning before October 1, 2015.--

Line 6.--Enter on line 6 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line equals the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two cost reporting periods, the stay is counted once in each cost reporting period. The patient, who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a cost reporting period is considered to be a new admission with a new election and is counted twice.

A patient transferring from another hospice is considered to be a new admission and is included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects the Medicare hospice benefit, count the patient once for each pay source.

The difference between line 6 and line 9 is that line 6 equals the actual number of patients served during the cost reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one cost reporting period.

Line 7.--Enter the total Title XVIII unduplicated continuous care hours billable to Medicare. When computing the unduplicated continuous care hours, count only one hour regardless of the number of services or therapies provided simultaneously within that hour.

Line 8.--Enter the average length of stay for the cost reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then re-elects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B). Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

Medicare Days (90 & 45 & 29)	164 days
Patient (A, B & C)	
Medicare Patients	/3

Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92)	92 Days
Medicaid Patient	1
Average LOS Medicaid	92 Days
Other (Insurance) Days (87 & 27)	114 Days
Other Payments (D & E)	2
Average LOS (Other)	57 Days
All Patients (90+45+29+92+87+27)	370 Days
Total number of patients	6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 8.

Line 9.--Enter the unduplicated census count of the SNF-based hospice for all patients initially admitted and filing an election statement with the hospice within a cost reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. 100-02, chapter 9, §10). A beneficiary, who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the cost reporting period is considered a new admission with each new election and is counted twice.

The total under this line equals the unduplicated number of patients served during the cost reporting period for each program. Thus, you do not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

4110.3 Part III – Enrollment Days for Cost Reporting Periods beginning on or after October 1, 2015.--This section collects unduplicated days data.

Lines 10 through 13.--Enter the enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received one of four levels of care -- HCHC, HRHC, HIRC, or HGIP. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Report an HIRC day on line 12 only when the hospice provided or arranged to provide the inpatient respite care.

Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

Line 14.--Enter the total unduplicated days (sum of lines 30 through 33) in each column as applicable

4110.4 Part IV - Contracted Statistical Data for Cost Reporting Periods beginning on or after October 1, 2015.--This section collects unduplicated days data for inpatient services at a contracted facility. The days reported in Part IV are a subset of the days reported in Part III.

Lines 15 and 16.--Enter the contracted inpatient service enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received HIRC or HGIP care at a contracted facility. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.