Medicare
Provider Reimbursement Manual -
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 38, Form CMS-1984-99

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3807.2 - 3810 (Cont.)	38-7 - 38-10 (4 pp.)	38-7 - 38-10 (4 pp.)
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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 38, Hospice Cost Report, (Form CMS-1984-99). The effective dates for instructional changes will be for cost reporting periods ending on or after July 31, 2011.

Significant Revisions:

- Worksheet S-1, Part II, line 11 - Modification to form and instructions to rephrase the inpatient general care costs from general inpatient care costs to be consistent with inpatient respite costs on line 10.

- Worksheet S-1, Part IV, line 19 - Added a new section to the form and corresponding instructions to capture the drug, durable medical equipment/oxygen and medical supply costs relating to inpatient general care services.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after July 31, 2011.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

X Proprietary - A proprietary hospice is owned and operated by an individual business corporation. The organization may be a sole proprietorship (individual), a partnership (including limited partnership and joint stock company) or a corporation. Indicate the type of operation.

X Government - A government hospice is operated by a State, county, city or other local unit government.

3807.2 Part II--Enrollment days based on level of care.

Lines 8-11.--Enter on line 8 through 11 the enrollment days applicable to each type of care. 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 types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 10, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

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:

Continuous Home Care Day - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. **Note: Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.**

Routine Home Care Day - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Inpatient Respite Care Day - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

***Inpatient General* Care Day** - An *inpatient general* care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Line 12.--Enter the total unduplicated days.

COLUMN DESCRIPTIONS

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 12 the total unduplicated Medicare days.

Column 2.--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 12 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 12 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 12 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 Medicaid hospice patients. Enter on line 12 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 12 should represent the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6 line 12 reflects the actual total number of days provided by the hospice.

3807.3 Part III --Census data.

Line 13.--Enter on line 13 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

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

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

The difference between line 13 and line 16 is that line 13 should equal the actual number of patients served during the reporting period for each program, whereas under line 16, patients are counted once, even if their stay overlaps more than one reporting period.

Line 14.--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 number of services or therapies provided simultaneously within that hour.

Line 15.--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 the Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefit for an additional 45 days, under a new benefit period as patient B, then dies. 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, with private insurance, received hospice care for 87 days. Patient E was admitted with private insurance for 27 days, until the private insurance ended, and Medicaid covered an additional 92 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the reporting period) is computed as follow:

Medicare Days (90 & 45 & 29)	164 Days
Patients (A, B & C)	
Medicare Patients	/3
Average LOS Medicare	54.67 Days
Medicaid Days Patient E (92)	92 Days
Medicaid Patients	/1
Average LOS Medicaid	92 Days
Other (Insurance) Days (87 & 27)	114
Other Patients (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 15.

Line 16.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods. (See CMS Pub. 21 §204.) However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and should be counted twice.

The total under this line should equal the unduplicated number of patients served during the reporting period for each program. Thus, you would 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.

Line 17.--If the hospice componentized (or fragmented) its administrative and general service costs, enter "1" for option 1 and "2" for option two. Do not respond if A&G services are not fragmented. (See §3820 for an explanation of the A&G componentization options.)

Line 18.—Are there any related organization or home office costs claimed? Enter "Y" for yes or "N" for no in column 1. If yes, enter the Chain Home Office's provider number in column 2. If yes, complete Worksheet A-8-1.

3807.4 Part IV--Inpatient general care data.

Line 19.—Enter in columns 1, 2, and 3, respectively, the costs of drugs, durable medical equipment/oxygen, and medical supplies that are related to inpatient general care. Report these costs in addition to and not in lieu of the costs that may already be reported on lines 10, 30, 31 and 35 of column 5 on worksheet A.

3810. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner, which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, B-1, the line numbers are consistent, and the total line is set at 100). Not all of the cost centers listed apply to all providers using these forms.

If the cost elements of a cost center are separately maintained on your books, reconcile the costs for the accounting books and records with those on this worksheet. The reconciliation is subject to review by the intermediary.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions may not be changed. If you need to use additional or different cost center descriptions, add additional lines to the

cost report. When an added cost center description bears a logical relationship to a standard line description, insert the added label immediately after the related standard line description. Identify the added line as a numeric (only) subscript of the immediately preceding line, except when subscripting administrative and general (A&G) costs. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02.

But if A&G costs (line 6) are subscripted, eliminate line 6 and begin subscripting with line 6.01. If additional lines are added for general service cost centers to Worksheet A, corresponding columns must be added to Worksheets B and B-1 as well as lines to Worksheet A-1, A-2, A-3, B, and B-1 for cost finding.

Cost center coding is a method for standardizing cost center labels used by health care providers on the Medicare cost reports. Form CMS 1984-99 provides for preprinted cost center descriptions on Worksheet A. The preprinted cost center labels are automatically coded by CMS approved cost reporting software.

These cost center descriptions are hereafter referred to as the standard cost centers. Nonstandard cost center descriptions are identified through analysis of frequently used labels.

Column 1.--Obtain salaries to be reported from Worksheet A-1, col. 9, line 3-100.

Column 2.--Obtain employee benefits to be reported from Worksheet A-2 col. 9 lines 3-100.

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 32.

Column 4.--Obtain the contracted services to be reported from Worksheet A-3, col. 9 lines 3-100.

Column 5.--Enter in the applicable lines in column 5 all costs which have not been reported in columns 1 through 4.

Column 6.--Add the amounts in columns 1 through 5 for each cost center and enter the total in column 6.

Column 7.--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation.

Worksheet A-6 reflects the reclassifications affecting the cost center expenses. This worksheet need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 100.

Column 8.--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 100.

Column 9.--Enter on the appropriate lines in column 9, the amounts from Worksheet A-8. The total on Worksheet A, column 9, line 100 must equal Worksheet A-8, column 2, line 11.

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.