the funds are immediately available to the HHA. In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For the purpose of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial three month period for which the initial reserve operating funds are required does not qualify in meeting the initial reserve operating funds requirement. Examples of cash equivalents for the purpose of this section are Treasury bills, commercial paper, and money market funds. As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS later may require the HHA to furnish another attestation from the financial institution that the funds remain available, or, if applicable, documentation from the HHA that any cash equivalents remain available, until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA’s cost report must certify what portion of the required initial reserve operating funds is non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

(e) Borrowed funds. If borrowed funds are not in the same account(s) as the HHA’s own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA’s savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA’s own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds, including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

(f) Line of credit. If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

(g) Billing Privileges. (1) CMS may deny Medicare billing privileges to an HHA unless the HHA meets the initial reserve operating funds requirements of this section.

(2) CMS may revoke the Medicare billing privileges of an HHA that fails to maintain and comply with the initial reserve operating funds requirements of this section for the three-month period after it receives its Medicare billing privileges.

§ 489.29 Special requirements concerning beneficiaries served by the Indian Health Service, Tribal health programs, and urban Indian organization health programs.

(a) Hospitals (as defined in sections 1861(e) and (f) of the Social Security Act) and critical access hospitals (as defined in section 1861(mm)(1) of the Social Security Act) that participate in the Medicare program and furnish inpatient hospital services must accept the payment methodology and no more than the rates of payment established under 42 CFR part 136, subpart D as payment in full for the following programs:

(1) A contract health service (CHS) program under 42 CFR part 136, subpart C, of the Indian Health Service (IHS);
(2) A CHS program under 42 CFR part 136, subpart C, carried out by an Indian Tribe or Tribal organization pursuant to the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93–638, 25 U.S.C. 450 et seq.; and

(3) A program funded through a grant or contract by the IHS and operated by an urban Indian organization under which items and services are purchased for an eligible urban Indian (as those terms are defined in 25 U.S.C. 1603 (f) and (h)).

(b) Hospitals and critical access hospitals may not refuse service to an individual on the basis that the payment for such service is authorized under programs described in paragraph (a) of this section.

[72 FR 30711, June 4, 2007]

Subpart C—Allowable Charges

§ 489.30 Allowable charges: Deductibles and coinsurance.

(a) Part A deductible and coinsurance. The provider may charge the beneficiary or other person on his or her behalf:

(1) The amount of the inpatient hospital deductible or, if less, the actual charges for the services;

(2) The amount of inpatient hospital coinsurance applicable for each day the individual is furnished inpatient hospital services after the 60th day, during a benefit period; and

(3) The posthospital SNF care coinsurance amount.

(4) In the case of durable medical equipment (DME) furnished as a home health service, 20 percent of the customary (insofar as reasonable) charge for the service.

(b) Part B deductible and coinsurance.

(1) The basic allowable charges are the $75 deductible and 20 percent of the customary (insofar as reasonable) charges in excess of that deductible.

(2) For hospital outpatient services, the allowable deductible charges depend on whether the hospital can determine the beneficiary’s deductible status.

(i) If the hospital is unable to determine the deductible status, it may charge the beneficiary its full customary charges up to $75.

(ii) If the beneficiary provides official information as to deductible status, the hospital may charge only the unmet portion of the deductible.

(3) In either of the cases discussed in paragraph (b)(2) of this section, the hospital is required to file with the intermediary, on a form prescribed by CMS, information as to the services, charges, and amounts collected.

(4) The intermediary must reimburse the beneficiary if reimbursement is authorized and credit the expenses to the beneficiary’s deductible if the deductible has not yet been met.

(5) In the case of DME furnished as a home health service under Medicare Part B, the coinsurance is 20 percent of the customary (insofar as reasonable) charge for the services, with the following exception: If the DME is used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment, no coinsurance is required.


§ 489.31 Allowable charges: Blood.

(a) Limitations on charges. (1) A provider may charge the beneficiary (or other person on his or her behalf) only for the first three pints of blood or units of packed red cells furnished under Medicare Part A during a calendar year, or furnished under Medicare Part B during a calendar year.

(2) The charges may not exceed the provider’s customary charges.

(b) Offset for excessive charges. If the charge exceeds the cost to the provider, that excess will be deducted from any Medicare payments due the provider.


§ 489.32 Allowable charges: Non-covered and partially covered services.

(a) Services requested by beneficiary. If services furnished at the request of a