part 199 concerning program benefits under the Department of Defense. This section applies to inpatient services furnished to beneficiaries admitted on or after January 1, 1987.

[59 FR 32123, June 22, 1994]

§ 489.26 Special requirements concerning veterans.

For inpatient services, a hospital that participates in the Medicare program must admit any veteran whose admission is authorized by the Department of Veterans Affairs under 38 U.S.C. 603 and must meet the requirements of 38 CFR part 17 concerning admissions practices and payment methodology and amounts. This section applies to services furnished to veterans admitted on and after July 1, 1987.

[59 FR 32123, June 22, 1994]

§ 489.27 Beneficiary notice of discharge rights.

(a) A hospital that participates in the Medicare program must furnish each Medicare beneficiary, or an individual acting on his or her behalf, the notice of discharge rights required under section 1866(a)(1)(M) of the Act. The hospital must provide timely notice during the course of the hospital stay. For purposes of this paragraph, the course of the hospital stay begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission. The hospital must be able to demonstrate compliance with this requirement.

(b) *Notification by other providers.* Other providers that participate in the Medicare program must furnish each Medicare beneficiary, or authorized representative, applicable CMS notices in advance of the termination of Medicare services, including the notices required under §§ 405.1202 and 422.624 of this chapter.

[68 FR 16669, Apr. 4, 2003, as amended at 69 FR 69268, Nov. 26, 2004]

§ 489.28 Special capitalization requirements for HHAs.

(a) *Basic rule.* An HHA entering the Medicare program on or after January 1, 1998, including a new HHA as a result of a change of ownership, if the change of ownership results in a new provider number being issued, must have available sufficient funds, which we term ''initial reserve operating funds,'' to operate the HHA for the three month period after its Medicare provider agreement becomes effective, exclusive of actual or projected accounts receivable from Medicare or other health care insurers.

(b) *Standard.* Initial reserve operating funds are sufficient to meet the requirement of this section if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of three or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first three months of operation—or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs—whichever is greater.

(c) *Method.* CMS, through the intermediary, will determine the amount of the initial reserve operating funds using reported cost and visit data from submitted cost reports for the first full year of operation from at least three HHAs that the intermediary serves that are comparable to the HHA that is seeking to enter the Medicare program, considering such factors as geographic location and urban/rural status, number of visits, provider-based versus free-standing, and proprietary versus non-proprietary status. The determination of the adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first three months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a three month period for the HHAs used in determining the average cost per visit.

(d) *Required proof of availability of initial reserve operating funds.* The HHA must provide CMS with adequate proof