CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 312	Date: November 20, 2009
	Change Request 6732

SUBJECT: Home Health Agency (HHA) Capitalization Requirements

I. SUMMARY OF CHANGES: This change request incorporates all of the provisions of 42 CFR 489.28. No new requirements are being added as a result of this change request, as contractors are already required to apply the provisions of 42 CFR 489.28 to incoming HHAs and to verify that such HHAs are in compliance with said provisions.

NEW / REVISED MATERIAL
EFFECTIVE DATE: December 21, 2009
IMPLEMENTATION DATE: December 21, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/12.1.6/Home Health Agencies (HHAs)
N	10/12.1.6.1/HHA Capitalization

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 312	Date: November 20, 2009	Change Request: 6732

SUBJECT: Home Health Agency (HHA) Capitalization Requirements

Effective Date: December 21, 2009
Implementation Date: December 21, 2009

I. GENERAL INFORMATION

A. Background: This change request incorporates into Pub. 100-08, chapter 10, all of the provisions of 42 CFR §489.28. No new requirements are being added as a result of this change request, as contractors are already mandated to apply the provisions of 42 CFR §489.28 to incoming HHAs and to verify that such HHAs are in full compliance with said provisions.

B. Policy: The purpose of this change request is to furnish to contractors additional background information to further assist them in verifying that incoming HHAs are in compliance with the capitalization requirements in 42 CFR §489.28.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6732.1	The contractor shall note that all of the provisions of 42 CFR §489.28 are being incorporated into Pub. 100-08, chapter 10, per this change request.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact: Frank Whelan, (410) 786-1302.
Post-Implementation Contact: Frank Whelan, (410) 786-1302.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:* No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual

Chapter 10 - Medicare Provider/Supplier Enrollment

Table of Contents
(Rev. 312, 11-20-09)

12.1.6.1 – HHA Capitalization

12.1.6 - Home Health Agencies (HHAs)

(Rev. 312; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. General Background Information

An HHA is an entity that provides skilled nursing services and at least one of the following therapeutic services: speech therapy, physical therapy, occupational therapy, home health aide services, and medical social services. The services must be furnished in a place of residence used as the patient's home.

Like most certified providers, HHAs receive a State survey or survey from an approved accrediting organization to determine compliance with Federal, State, and local laws, and must also sign a provider agreement. All HHA services, moreover, must be part of a plan of care established by a physician, accompanied by a certification from the doctor that the patient needs home health services. HHA services can be covered even if the patient lives with someone who might ordinarily be able to perform such services himself/herself.

B. Capitalization Requirements

See section 12.1.6.1, of this chapter, for more information on HHA capitalization requirements.

C. HHA Components

There are three potential "components" of an HHA organization:

Parent – The parent HHA is the entity that maintains overall administrative control of its location(s).

Sub-unit – A sub-unit is associated with the parent HHA, but services a different geographic area. It is thus considered a semi-autonomous HHA since it is too far away from the parent HHA to share administration/supervision on a day-to-day basis. This means that HHA sub-units must separately enroll in Medicare, obtain a separate State survey, and sign a separate provider agreement. As with parent HHAs, sub-units receive their own 6-digit CCN.

Branch – Is a location or site that services patients in the same geographic area as the parent and shares administration with the parent on a daily basis. Consequently, unlike sub-units, branches need not enroll separately. They can be listed as practice locations on the main provider's (or sub-unit's) Form CMS-855A. Though the branch receives a 10-digit CCN identifier, it bills under the parent HHA's or sub-unit's CCN number.

The question of whether a particular location qualifies as a branch or a sub-unit – and hence requires a separate Form CMS-855A enrollment – is resolved by the RO.

Consider the following scenario:

PARENT HHA

owns owns owns

BRANCH A SUB-UNIT B BRANCH C

operates

BRANCH D

Here, the parent HHA has two branches (A and C) and one sub-unit (B). B also has a branch (D). They will be enrolled as follows:

- The parent HHA must complete a Form CMS-855A, undergo a State survey, and sign a provider agreement;

- Branches A and C would be listed as practice locations on the parent's Form CMS-855A because a branch is sufficiently "attached" to the parent to be considered part of it;

- Sub-unit B would enroll separately from the parent and would complete its own Form CMS-855A, undergo its own survey, and sign its own agreement. For purposes of enrollment, it is considered an entity separate and distinct from the parent, henceforth requiring a separate enrollment. (This also means that Sub-unit B would not have to be listed on the parent's Form CMS 855A as a practice location.)

- Because sub-units can have branches just like parents can, Branch D would be listed as a practice location on Sub-unit B's application.

- See Pub. 100-07, chapter 2, section 2182, for discussion of branches.

D. Out-of-State HHA Branches

In general, an HHA can only have a branch in another State (and treat it as a branch, rather than a separate HHA) if there is a reciprocity agreement between the two States. If none exists, the out-of-state location must enroll as a new provider by submitting a new Form CMS-855A and signing a separate provider agreement. It cannot be treated as a branch/practice location of the main HHA. (See Pub. 100-07, chapter 2, section 2184 for specific provisions regarding HHAs that cross State lines.)

E. Additional Data

For more information on HHAs, refer to:

- Sections 1861(o) and 1891 of the Social Security Act;

- 42 CFR Part *484;*

- 42 CFR §489.28 (capitalization);
- Pub. 100-07, chapter 2, sections 2180 – 2198C (State Operations Manual);
- Pub. 100-04, chapter 10 (Claims Processing Manual); and
- Pub. 100-02, chapter 7 (Benefit Policy Manual).

12.1.6.1 – HHA Capitalization

(Rev. 312; Issued: 11-20-09; Effective/Implementation Date: 12-21-09)

A. General

Prior to enrolling in Medicare as an HHA, the provider must, per 42 CFR §489.28(a), have available sufficient funds (known as "initial reserve operating funds") to operate the HHA for the 3-month period after its Medicare provider agreement becomes effective - exclusive of actual or projected accounts receivable from Medicare or other health care insurers. The capitalization requirement applies to: (1) newly enrolling HHAs, (2) HHAs undergoing a change of ownership that results in the issuance of a new provider number, and (3) HHA subunits undertaking either of the transactions described in (1) and (2).

Initial reserve operating funds are sufficient to meet the requirement of 42 CFR §489.28(a) 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.

B. Determining Initial Reserve Operating Funds

The contractor shall 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 contractor serves that are comparable to the HHA that is seeking to enter the Medicare program. Factors to be used in making this determination shall include:

- *Geographic location and urban/rural status;*
- *Number of visits;*
- *Provider-based versus free-standing status; 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 3 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.

C. Proof of Operating Funds

The HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, must include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that 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 3 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 may later 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 constitutes 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.

D. 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.

E. 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.

F. Documents

As part of ensuring the prospective HHA's compliance with the capitalization requirements, the contractor shall obtain the following from the provider:

- *A document outlining the provider's projected budget – preferably, a full year's budget broken out by month*

- *A document outlining the number of anticipated visits - preferably a full year broken out by month*

- *An attestation statement from an officer of the HHA defining the source of funds*

- *Copies of bank statements, certificates of deposits, etc., supporting that cash is available (must be current)*

- *Letter from officer of the bank attesting that funds are available*

- *If available, audited financial statements*

The contractor shall also ensure that the capitalization information in section 12, of the CMS-855A is provided.