

and 425.652(a)(4), and performance year expenditures under §§ 425.604(a)(4), 425.605(a)(3), 425.606(a)(4), and 425.610(a)(4).

(B) Truncating expenditures for assignable beneficiaries in each county for purposes of determining county fee-for-service expenditures according to §§ 425.601(c)(3), 425.603(e)(3), and 425.654(a)(3).

(iii) Determining national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program for assignable beneficiaries for purposes of capping the regional adjustment to the ACO's historical benchmark according to §§ 425.601(a)(8)(ii)(C) and 425.656(c)(3), and capping the prior savings adjustment according to § 425.652(a)(8)(iv).

(iv) Determining the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program for assignable beneficiaries, for purposes of updating the ACO's historical benchmark according to § 425.602(b)(2).

(v) Determining national growth rates that are used as part of the blended growth rates used to trend forward BY1 and BY2 expenditures to BY3 according to §§ 425.601(a)(5)(ii) and 425.652(a)(5)(ii) and as part of the blended growth rates used to trend the benchmark and update the benchmark according to §§ 425.601(b)(2) and 425.652(b)(2)(i).

(3) Calculation of Medicare Parts A and B fee-for-service revenue of ACO participants for purposes of calculating the ACO's loss recoupment limit under the BASIC track as specified in § 425.605(d).

(4) Calculation of total Medicare Parts A and B fee-for-service revenue of ACO participants and total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries for purposes of identifying whether an ACO is a high revenue ACO or low revenue ACO, as defined under § 425.20, determining an ACO's eligibility for participation options according to § 425.600(d), and determining an ACO's eligibility to receive advance investment payments according to § 425.630.

(5) Calculation or recalculation of the amount of the ACO's repayment mechanism arrangement according to § 425.204(f)(4).

[85 FR 27625, May 8, 2020, as amended at 85 FR 85044, Dec. 28, 2020; 87 FR 70241, Nov. 18, 2022]

#### **§ 425.612 Waivers of payment rules or other Medicare requirements.**

(a) *General.* CMS may waive certain payment rules or other Medicare requirements as determined necessary to carry out the Shared Savings Program under this part.

(1) *SNF 3-day rule.* For performance year 2017 and subsequent performance years, CMS waives the requirement in section 1861(i) of the Act for a 3-day inpatient hospital stay prior to a Medicare-covered post-hospital extended care service for eligible beneficiaries assigned to ACOs participating in a two-sided model and as provided in paragraph (a)(1)(iv) of this section during a grace period for beneficiaries excluded from prospective assignment to an ACO in a two-sided model, who receive otherwise covered post-hospital extended care services furnished by an eligible SNF that has entered into a written agreement to partner with the ACO for purposes of this waiver. Eligible SNFs include providers furnishing SNF services under swing bed agreements. All other provisions of the statute and regulations regarding Medicare Part A post-hospital extended care services continue to apply. ACOs identified under paragraph (a)(1)(vi) of this section may request to use the SNF 3-day rule waiver for performance years beginning on July 1, 2019, and in subsequent years.

(i) ACOs must submit to CMS supplemental application information sufficient to demonstrate the ACO has the capacity to identify and manage beneficiaries who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospitalization of fewer than 3-days in the form and manner specified by CMS. Application materials include but are not limited to, the following:

(A) An attestation that it has established and will make available to CMS upon request the following narratives

describing how the ACO plans to implement the waiver:

(1) A communication plan between the ACO and its SNF affiliates.

(2) A care management plan for beneficiaries admitted to a SNF affiliate.

(3) A beneficiary evaluation and admission plan approved by the ACO medical director and the healthcare professional responsible for the ACO's quality improvement and assurance processes under § 425.112.

(B) A list of SNFs with whom the ACO will partner along with executed written SNF affiliate agreements between the ACO and each listed SNF.

(ii) In order to be eligible to receive covered SNF services under the waiver, a beneficiary must meet the following requirements:

(A) In the case of a beneficiary who is assigned to an ACO that has selected preliminary prospective assignment with retrospective reconciliation under § 425.400(a)(2), the beneficiary must appear on the list of preliminarily prospectively assigned beneficiaries at the beginning of the performance year or on the first, second, or third quarterly preliminary prospective assignment list for the performance year in which they are admitted to the eligible SNF, and the SNF services must be provided after the beneficiary first appeared on the preliminary prospective assignment list for the performance year.

(B) In the case of a beneficiary who is assigned to an ACO that has selected prospective assignment under § 425.400(a)(3), the beneficiary must be prospectively assigned to the ACO for the performance year in which they are admitted to the eligible SNF.

(C) Does not reside in a SNF or other long-term care setting.

(D) Is medically stable.

(E) Does not require inpatient or further inpatient hospital evaluation or treatment.

(F) Have certain and confirmed diagnoses.

(G) Have an identified skilled nursing or rehabilitation need that cannot be provided as an outpatient.

(H) Have been evaluated and approved for admission to the SNF within 3 days prior to the SNF admission by an ACO provider/supplier who is a phy-

sician, consistent with the ACO's beneficiary evaluation and admission plan.

(iii) SNFs eligible to partner and enter into written agreements with ACOs for purposes of this waiver must do the following:

(A) Providers eligible to be included in the CMS 5-star Quality Rating System must have and maintain an overall rating of 3 or higher.

(B) Sign a SNF affiliate agreement with the ACO that includes elements determined by CMS including but not limited to the following:

(1) Agreement to comply with the requirements and conditions of this part, including but not limited to those specified in the participation agreement with CMS.

(2) Effective dates of the SNF affiliate agreement.

(3) Agreement to implement and comply with the ACO's beneficiary evaluation and admission plan and the care management plan.

(4) Agreement to validate the eligibility of a beneficiary to receive covered SNF services in accordance with the waiver prior to admission.

(5) Remedial processes and penalties that will apply for non-compliance.

(iv) For a beneficiary who was included on the ACO's prospective assignment list or preliminary prospective assignment list at the beginning of the performance year or on the first, second, or third quarterly preliminary prospective assignment list for the performance year, for an ACO for which a waiver of the SNF 3-day rule has been approved under paragraph (a)(1) of this section, but who was subsequently removed from the assignment list for the performance year, CMS makes payment for SNF services furnished to the beneficiary by a SNF affiliate if the following conditions are met:

(A)(1) The beneficiary was prospectively assigned to an ACO that selected prospective assignment under § 425.400(a)(3) at the beginning of the applicable performance year, but was excluded in the most recent quarterly update to the assignment list under § 425.401(b), and the beneficiary was admitted to a SNF affiliate within 90 days following the date that CMS delivered the quarterly exclusion list to the ACO; or

(2) The beneficiary was identified as preliminarily prospectively assigned to an ACO that has selected preliminary prospective assignment with retrospective reconciliation under § 425.400(a)(2) in the report provided under § 425.702(c)(1)(ii)(A) at the beginning of the performance year or for the first, second, or third quarter of the performance year, the SNF services were provided after the beneficiary first appeared on the preliminary prospective assignment list for the performance year, and the beneficiary meets the criteria to be assigned to an ACO under § 425.401(a)(1) and (2).

(B) But for the beneficiary's removal from the ACO's assignment list, CMS would have made payment to the SNF affiliate for such services under the waiver under paragraph (a)(1) of this section.

(v) The following beneficiary protections apply when a beneficiary receives SNF services without a prior 3-day inpatient hospital stay from a SNF affiliate that intended to provide services under a SNF 3-day rule waiver under paragraph (a)(1) of this section, the SNF affiliate services were non-covered only because the SNF affiliate stay was not preceded by a qualifying hospital stay under section 1861(i) of the Act, and in the case of a beneficiary where the ACO selected one of the following:

(A) Prospective assignment under § 425.400(a)(3), the beneficiary was not prospectively assigned to the ACO for the performance year in which they received the SNF services, or was prospectively assigned but was later excluded and the 90-day grace period, described in paragraph (a)(1)(iv)(A) of this section, has lapsed.

(B) Preliminary prospective assignment with retrospective reconciliation under § 425.400(a)(2), the beneficiary was not identified as preliminarily prospectively assigned to the ACO for the performance year in the report provided under § 425.702(c)(1)(ii)(A) at the beginning of the performance year or for the first, second, or third quarter of the performance year before the SNF services were provided to the beneficiary.

(C) A SNF is presumed to intend to provide services pursuant to the SNF 3-day rule waiver under paragraph (a)(1) of this section if the SNF submitting

the claim is a SNF affiliate of an ACO for which such a waiver has been approved.

(D) CMS makes no payments for SNF services to a SNF affiliate of an ACO for which a waiver of the SNF 3-day rule has been approved when the SNF affiliate admits a FFS beneficiary who was not prospectively or preliminarily prospectively assigned to the ACO prior to the SNF admission or was prospectively assigned but was later excluded and the 90-day grace period under paragraph (a)(1)(iv)(A) of this section has lapsed.

(E) In the event that CMS makes no payment for SNF services furnished by a SNF affiliate as a result of paragraph (a)(1)(v)(D) of this section and the only reason the claim was non-covered is due to the lack of a qualifying inpatient stay, the following beneficiary protections will apply:

(1) The SNF must not charge the beneficiary for the expenses incurred for such services; and

(2) The SNF must return to the beneficiary any monies collected for such services; and

(3) The ACO may be required to submit a corrective action plan under § 425.216(b) for CMS approval. If after being given an opportunity to act upon the corrective action plan the ACO fails to come into compliance with the requirements of paragraph (a)(1), approval for the SNF 3-day rule waiver under this section will be terminated as provided under paragraph (d) of this section.

(vi) The following ACOs may request to use the SNF 3-day rule waiver:

(A) An ACO participating in performance-based risk within the BASIC track under § 425.605.

(B) An ACO participating in the ENHANCED track under § 425.610.

(2) [Reserved]

(b) *Review and determination of request to use waivers.* (1) In order to obtain a determination regarding whether the ACO may use waivers under this section, an ACO must submit a waiver request to CMS in the form and manner and by a deadline specified by CMS.

(2) An ACO executive who has the authority to legally bind the ACO must certify to the best of his or her knowledge, information, and belief that the

information contained in the waiver request submitted under paragraph (b)(1) of this section is accurate, complete, and truthful.

(3) CMS evaluates an ACO's waiver request to determine whether it satisfies the requirements of this part and approves or denies waiver requests accordingly. Waiver requests are approved or denied on the basis of the following:

(i) Information contained in and submitted with the waiver request by a deadline specified by CMS.

(ii) Supplemental information submitted by a deadline specified by CMS in response to a CMS request for information.

(iii) Screening of the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities providing services to Medicare beneficiaries in accordance with the terms of the waiver.

(iv) Other information available to CMS.

(4) CMS may deny a waiver request if an ACO fails to submit requested information by the deadlines established by CMS.

(c) *Effective and termination date of waivers.* (1) Waivers are effective upon CMS notification of approval for the waiver or the start date of the participation agreement, whichever is later.

(2) Waivers do not extend beyond the end of the participation agreement.

(3) If CMS terminates the participation agreement under § 425.218, the waiver ends on the date specified by CMS in the termination notice.

(4) If the ACO terminates the participation agreement, the waiver ends on the effective date of termination as specified in the written notification required under § 425.220.

(d) *Monitoring and termination of waivers.* (1) ACOs with approved waivers are required to post their use of the waiver as part of public reporting under § 425.308.

(2) CMS monitors and audits the use of such waivers in accordance with § 425.316.

(3) CMS reserves the right to deny or revoke a waiver if an ACO, its ACO participants, ACO providers/suppliers or other individuals or entities providing services to Medicare beneficiaries are

not in compliance with the requirements of this part or if any of the following occur:

(i) The waiver is not used as described in the ACO's waiver request under paragraph (b)(1) of this section.

(ii) The ACO does not successfully meet the quality reporting standard under subpart F of this part.

(iii) CMS identifies a program integrity issue affecting the ACO's use of the waiver.

(4) CMS reserves the right to take compliance action, including termination, against an ACO for noncompliance with program rules, including misuse of a waiver under this section, as specified at §§ 425.216 and 425.218.

(e) *Other rules governing use of waivers.* (1) Waivers under this section do not protect financial or other arrangements between or among ACOs, ACO participants, ACO providers/suppliers, or other individual or entities providing services to Medicare beneficiaries from liability under the fraud and abuse laws or any other applicable laws.

(2) Waivers under this section do not protect any person or entity from liability for any violation of law or regulation for any conduct other than the conduct permitted by a waiver under paragraph (a) of this section.

(3) ACOs must ensure compliance with all claims submission requirements, except those expressly waived under paragraph (a) of this section.

(f) *Waiver for payment for telehealth services.* For performance year 2020 and subsequent performance years, CMS waives the originating site requirements in section 1834(m)(4)(C)(i) and (ii) of the Act and makes payment for telehealth services furnished to a beneficiary, if the following conditions are met:

(1) The beneficiary was prospectively assigned to an ACO that is an applicable ACO for purposes of § 425.613 at the beginning of the applicable performance year, but the beneficiary was excluded in the most recent quarterly update to the prospective assignment list under § 425.401(b).

(2) The telehealth services are provided by a physician or practitioner

billing under the TIN of an ACO participant in the ACO within 90 days following the date CMS delivers the quarterly exclusion list to the ACO.

(3) But for the beneficiary's exclusion from the ACO's prospective assignment list, CMS would have made payment to the ACO participant for such services under § 425.613.

[80 FR 32843, June 9, 2015, as amended at 81 FR 80561, Nov. 15, 2016; 82 FR 53371, Nov. 15, 2017; 83 FR 68080, Dec. 31, 2018; 84 FR 63204, Nov. 15, 2019; 87 FR 70242, Nov. 18, 2022]

#### § 425.613 Telehealth services.

(a) *General.* Payment is available for otherwise covered telehealth services furnished on or after January 1, 2020, by a physician or other practitioner billing through the TIN of an ACO participant in an applicable ACO, without regard to the geographic requirements under section 1834(m)(4)(C)(i) of the Act, in accordance with the requirements of this section.

(1) For purposes of this section:

(i) An applicable ACO is an ACO that is participating under a two-sided model under § 425.600 and has elected prospective assignment under § 425.400(a)(3) for the performance year.

(ii) The home of the beneficiary is treated as an originating site under section 1834(m)(4)(C)(ii) of the Act.

(2) For payment to be made under this section, the following requirements must be met:

(i) The beneficiary is prospectively assigned to the ACO for the performance year in which the beneficiary received the telehealth service.

(ii) The physician or practitioner who furnishes the telehealth service must bill under the TIN of an ACO participant that is included on the certified ACO participant list under § 425.118 for the performance year in which the service is rendered.

(iii) The originating site must comply with applicable State licensing requirements.

(iv) When the originating site is the beneficiary's home, the telehealth services must not be inappropriate to furnish in the home setting. Services that are typically furnished in an inpatient setting may not be furnished as a telehealth service when the originating site is the beneficiary's home.

(v) CMS does not pay a facility fee when the originating site is the beneficiary's home.

(b) *Beneficiary protections.* (1) When a beneficiary who is not prospectively assigned to an applicable ACO or in a 90-day grace period under § 425.612(f) receives a telehealth service from a physician or practitioner billing through the TIN of an ACO participant participating in an applicable ACO, CMS makes no payment for the telehealth service to the ACO participant.

(2) In the event that CMS makes no payment for a telehealth service furnished by a physician or practitioner billing through the TIN of an ACO participant, and the only reason the claim was non-covered is because the beneficiary is not prospectively assigned to the ACO or in the 90-day grace period under § 425.612(f), all of the following beneficiary protections apply:

(i) The ACO participant must not charge the beneficiary for the expenses incurred for such service.

(ii) The ACO participant must return to the beneficiary any monies collected for such service.

(iii) The ACO may be required to submit a corrective action plan under § 425.216(b) for CMS approval. If the ACO is required to submit a corrective action plan and, after being given an opportunity to act upon the corrective action plan, the ACO fails to implement the corrective action plan or demonstrate improved performance upon completion of the corrective action plan, CMS may terminate the participation agreement as specified under § 425.216(b)(2).

(c) *Termination date for purposes of payment for telehealth services.* (1) Payment for telehealth services under paragraph (a) of this section does not extend beyond the end of the applicable ACO's participation agreement.

(2) If CMS terminates the participation agreement under § 425.218, payment for telehealth services under paragraph (a) of this section is not made with respect to telehealth services furnished beginning on the date specified by CMS in the termination notice.

(3) If the ACO terminates the participation agreement, payment for telehealth services under paragraph (a) of