

Public Health Emergency as defined in § 400.200 of this chapter.

(2) CMS defines the episode of care as starting in the month in which the inpatient stay begins as identified by the admission date, all months during the inpatient stay, and the month following the end of the inpatient stay as indicated by the discharge date.

(c) *Applicability of adjustments.* Notwithstanding any other provision in this part, CMS adjusts the following Shared Savings Program calculations to exclude all Parts A and B fee-for-service payment amounts for a beneficiary's episode of care for treatment of COVID-19 as described in paragraph (b) of this section:

(1) Calculation of Medicare Parts A and B fee-for-service expenditures for an ACO's assigned beneficiaries for all purposes including the following: Establishing, adjusting, updating, and resetting the ACO's historical benchmark and determining performance year expenditures.

(2) Calculation of fee-for-service expenditures for assignable beneficiaries as used in determining county-level fee-for-service expenditures and national Medicare fee-for-service expenditures, including the following calculations:

(i) Determining average county fee-for-service expenditures based on expenditures for the assignable population of beneficiaries in each county in the ACO's regional service area according to §§ 425.601(c), 425.603(e), and 425.654(a) for purposes of calculating the ACO's regional fee-for-service expenditures.

(ii) Determining the 99th percentile of national Medicare fee-for-service expenditures for assignable beneficiaries for purposes of the following:

(A) Truncating assigned beneficiary expenditures used in calculating benchmark expenditures under §§ 425.601(a)(4), 425.602(a)(4), 425.603(c)(4), 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 § 425.658(c)(1)(ii).

(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).

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§ 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 physician, 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 pro-

vided 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 ap-

proved 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.