

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.

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(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

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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-