



Skilled Nursing Facility 3-Day Rule Waiver Application | Phase 1 | Agreement Period or Performance Year Beginning on January 1, 2023

Please refer to the [Application Toolkit](#) for instructions and eligibility requirements for completing this application.

PAPER APPLICATIONS ARE NOT ACCEPTED. USE THIS DOCUMENT TO PREPARE YOUR RESPONSES. SUBMIT YOUR APPLICATION ONLINE VIA THE [ACO MANAGEMENT SYSTEM](#) (ACO-MS).

*This application is only applicable to Accountable Care Organization (ACO) applicants applying to participate in the Medicare Shared Savings Program (Shared Savings Program) Levels C, D, or E of the BASIC track or the ENHANCED track, or existing Shared Savings Program ACOs currently participating in the ENHANCED track, Levels C, D, or E of the BASIC Track, or entering Levels C, D, or E of the BASIC track.

SECTION 1 – COMMUNICATION, CARE MANAGEMENT, AND BENEFICIARY EVALUATION AND ADMISSION PLANS

1. Submit the following:
 - a. Your ACO's communication plan between your ACO and your Skilled Nursing Facility (SNF) affiliates.
 - b. Your ACO's care management plan for beneficiaries admitted to a SNF affiliate pursuant to the SNF 3-Day Rule Waiver.
 - c. Your ACO's beneficiary evaluation and admission plan approved by your ACO medical director and the healthcare professional responsible for your ACO's quality improvement and assurance processes under 42 CFR § 425.112.

SECTION 2 – SNF AFFILIATES

2. Submit the first page and signature page of the signed SNF Affiliate Agreement for each SNF affiliate included on your SNF Affiliate List. The SNF Affiliate Agreement must be signed by both an individual authorized to sign on behalf of the ACO and an individual authorized to sign on behalf of the SNF affiliate. If you do not have an executed SNF Affiliate Agreement with a SNF affiliate, the SNF affiliate cannot be included on your SNF Affiliate List. Please note, per 42 CFR § 425.612(b)(3)(iii), an ACO must have at least one approved SNF affiliate to be approved for use of the SNF 3-Day Rule Waiver.

SECTION 3 – CERTIFICATIONS

3. I certify to the best of my knowledge, information, and belief that my ACO has the capacity to identify and manage beneficiaries who are either directly admitted to a SNF or are admitted to a SNF after an inpatient hospitalization of fewer than 3 days.

Yes

Disclaimers: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

This communication material was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of its contents.

4. I certify that a beneficiary eligibility review process will be implemented in order to ensure that each beneficiary who will receive covered SNF services under the waiver meets the following requirements:
- a. If my ACO has selected preliminary prospective assignment with retrospective reconciliation under 42 CFR § 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. If my ACO has selected prospective assignment under 42 CFR § 425.400(a)(3), the beneficiary must be prospectively assigned to my 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. Has certain and confirmed diagnoses.
 - g. Has an identified skilled nursing or rehabilitation need that cannot be provided as an outpatient.
 - h. Has 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.
- Yes
5. I certify to the best of my knowledge, information, and belief that my ACO has executed SNF Affiliate Agreements that meet the requirements of 42 CFR § 425.612(a)(1)(iii) with all SNF affiliates identified on the list submitted pursuant to 42 CFR § 425.612(a)(1)(i)(B). I understand, acknowledge, and agree that 42 CFR § 425.612(d)(2) authorizes CMS to monitor and audit the use of the SNF 3-Day Rule Waiver in accordance with 42 CFR § 425.316. Such monitoring may include review of any and/or all SNF Affiliate Agreement(s) at any time to determine compliance with Shared Savings Program requirements. Finally, I understand, acknowledge, and agree that if my ACO's executed SNF Affiliate Agreements do not satisfy all applicable requirements, including those set forth in 42 CFR § 425.612, CMS may take one or more of the compliance actions listed under 42 CFR §§ 425.216 and 425.218 against my ACO.
- Yes

SECTION 4 – CERTIFY YOUR APPLICATION

*CMS will not process your application if you do not complete this certification in ACO-MS. This page will appear at the end of your application. You certify your application when you select "I agree."

I have read the contents of this application. I certify that I am legally authorized to execute this document and to bind my ACO to comply with all applicable laws and regulations. By my signature, I certify to the best of my knowledge, information, and belief that the information contained herein is true, accurate, and complete, and I authorize CMS to verify this information. If I become aware that any information in this application is not true, accurate, or complete, I agree to notify CMS of this fact immediately and to provide the correct and/or complete information.

I agree