



Policy Title: Benefit Enhancement 3-Day SNF Rule Waiver			
Department Responsible: Operations	Policy Number: BE - 101	THN's Effective Date: April 10, 2017	Next Review/Revision Date: September 30, 2026
Title of Person Responsible: Director of Operations	THN Approval Council: Operating Committee	Date Approved: August 14, 2025	

PURPOSE:

The purpose of this policy is to provide guidance on the 3-Day Skilled Nursing Facility (SNF) Wavier Benefit Enhancement and to outline the requirements and ensure compliance with Section 10.02 and Appendix I of the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Centers for Medicare and Medicaid Services (CMS) Participation Agreement (PA) for Triad HealthCare Network (THN), and all ACO Related Individuals.

DEFINITIONS:

Term	Definition
Benefit Enhancements	<p>Additional benefits THN chooses to make available to ACO REACH Beneficiaries through ACO REACH Participants and Preferred Providers to support high-value services and allow THN to effectively manage the care of ACO REACH Beneficiaries:</p> <p>A. 3-Day SNF Rule Waiver (as described in the ACO REACH Triad HealthCare Network (CMS ACO REACH) Participation Agreement, Section 10.02 and Appendix I).</p>



Eligible SNFs	<p>For this waiver, is a Skilled Nursing Facility (“SNF”) or a Swing-Bed Hospital that is an ACO REACH Participant or Preferred Provider that has:</p> <ul style="list-style-type: none"> A. Entered into a written agreement with THN to provide SNF services in accordance with the SNF 3-Day Rule Waiver Benefit Enhancement under Section II of Appendix I; B. Identified by THN as having agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement in accordance with Section I.B of this Appendix I; and C. Approved by CMS to participate under the 3-Day SNF Rule Waiver Benefit Enhancement following a review of the qualifications of the SNF or Swing-Bed Hospital to accept admissions without a prior inpatient hospital stay (“Direct SNF Admissions”) and admissions after an inpatient stay of fewer than three days.
ACO REACH Participant Provider	<p>An individual or entity that:</p> <ul style="list-style-type: none"> A. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202); B. Is identified on the Participant List in accordance with Article IV; C. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a Tax Identification Number (TIN) in accordance with applicable Medicare regulations; D. Is not a Preferred Provider; E. Is not a Prohibited Participant; and F. Pursuant to a written agreement with THN, has agreed to participate in the Model, to report quality data through THN, and to comply with care improvement objectives and Model quality performance standards.
ACO REACH Preferred Provider	<p>An individual or entity that:</p> <ul style="list-style-type: none"> A. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202); B. Is identified on the Preferred Provider List in accordance with Article IV; C. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations; D. Is not an ACO REACH Participant; E. Is not a Prohibited Participant; and F. Has agreed to participate in the Model pursuant to a written agreement with THN.
ACO Related Individual	<p>Any THN officer, director, employee, ACO Participant, ACO Preferred Provider, ACO Professional, or any other individual or entity providing functions or services related to THN ACO Activities.</p>



ACO Activities	Activities related to promoting accountability for the quality, cost, and overall care for a population of THN Beneficiaries, including managing and coordinating care, encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery or carrying out any other obligation or duty of THN under the <u>ACO REACH Model</u> .
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POLICY:

CMS waives the requirement in section 1861(i) of the Social Security Act for a three-day inpatient hospital stay prior to the provision of an otherwise covered Medicare post-hospital extended care services (“SNF Services”) furnished under the terms and conditions set forth in this policy.

PROCEDURE:

Appendix I shall apply for any Performance Year for which THN has selected the 3-Day SNF Rule Waiver Benefit Enhancement as described in Section 8.01 and for which THN has submitted an Implementation Plan under Section 10.01.B for the 3-Day SNF Rule Waiver Benefit Enhancement and CMS has not rejected THN’s selection pursuant to Section 8.02 or Section 10.01.E.

- I. For THN to offer the 3-Day SNF Rule Waiver Benefit Enhancement during a Performance Year, THN must:
 - A. Timely submit to CMS its selection of the 3-Day SNF Rule Waiver Benefit Enhancement as described in Section 8.01 of the Agreement and an Implementation Plan in accordance with Article X of the Agreement for the 3- Day SNF Rule Waiver Benefit Enhancement; and
 - B. Timely submit in accordance with Article IV of the Agreement a true, accurate, and complete list of Participant Providers that have agreed to participate in the 3- Day SNF Rule Waiver Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement.

II. *Eligible SNFs*

- A. For purposes of this waiver, an “Eligible SNF” is a SNF or a Swing-Bed Hospital that is a Participant Provider or Preferred Provider that has:
 - i. entered into a written arrangement with THN to provide SNF Services in accordance with the SNF 3-Day Rule Waiver Benefit Enhancement under Section II of Appendix I
 - ii. been identified on the Participant List or Preferred Provider List by THN as having agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement in accordance with Section I.B of Appendix I; and
 - iii. been approved by CMS to participate under the 3-Day SNF Rule Waiver Benefit Enhancement following a review of the qualifications of the SNF or Swing-Bed Hospital to accept admissions without a prior inpatient hospital stay (“Direct SNF Admissions”) and admissions after an inpatient stay of fewer than three Days.
- B. Additionally, at the time of CMS review and approval of the SNF to participate under the 3-Day SNF Rule Waiver, the SNF must have an overall rating of three or more stars under the CMS 5-

Star Quality Rating System in the applicable number of months listed in Table A of Appendix I in the ACO participation agreement.

- C. Eligibility of SNFs and swing bed hospitals to provide services under this 3-Day SNF Rule Waiver will be reassessed annually, prior to the start of each Performance Year by THN or its Designated Representatives.
- D. THN shall maintain and provide to its ACO REACH Participants and Preferred Providers an accurate and complete list of eligible SNFs and shall furnish updated lists as necessary to reflect any changes in SNF eligibility. THN or its designated representative shall also furnish these lists to an ACO REACH Beneficiary, upon request.
- E. Designated Representative must notify THN regarding any changes to the list of eligible SNFs.
- F. THN must provide written notification to CMS within 10 days of any changes to the list of eligible SNFs. Within 10 days following the removal of any eligible SNF from the list of eligible SNFs, THN or its Designated Representative must also provide written notification to the SNF or swing-bed hospital that it has been removed from the list and that it no longer qualifies to use this 3-Day SNF Rule Waiver.
- G. THN or Designated Representative shall provide a copy of Appendix I 3-Day SNF Rule Waiver to each eligible SNF to which ACO REACH Beneficiaries are referred.
- H. If CMS notifies THN that a SNF or Swing-Bed Hospital has not been approved for participation in the 3-Day SNF Rule Waiver Benefit Enhancement under Section 10.02, but the SNF or Swing-Bed Hospital is otherwise eligible to be a Participant Provider or Preferred Provider, THN may either remove the SNF or Swing-Bed Hospital from the Participant Provider or Preferred Provider List, or amend the relevant list to reflect that the SNF or Swing-Bed Hospital will not participate in the 3-Day SNF Rule Waiver Benefit Enhancement. THN shall amend the relevant list no later than 30 Days after the date of the notice from CMS.

III. *Beneficiary Eligibility Requirements*

- A. The referring Participant Provider is responsible to determine whether the Beneficiary is eligible under the terms of the 3-Day SNF Rule Waiver, which states the Beneficiary must be:
 - 1. ACO REACH Beneficiary at the time of SNF admission under this waiver or within the grace period under Section VI of this Appendix; and
 - 2. Not reside in a SNF or long-term care facility at the time of SNF admission under this waiver. For purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long-term care facilities.
- B. A Direct SNF Admission will be covered under the terms of the waiver in Appendix I only if, at the time of admission, in addition to the meeting the eligibility requirements under Section IV.A of Appendix I, the Beneficiary:
 - i. Is medically stable;
 - ii. Has confirmed diagnoses;
 - iii. Has been evaluated by a physician or other practitioner licensed to perform the evaluation within three days prior to admission to the eligible SNF;
 - iv. Does not require inpatient hospital evaluation or treatment; and
 - v. Has a skilled nursing or rehabilitation need that is identified by the evaluating physician and cannot be provided as an outpatient.

- C. A SNF or Swing Bed-Hospital admission will be covered for a Beneficiary who is discharged to an eligible SNF after fewer than three days of inpatient hospitalization only if, at the time of the referral or admission, the Beneficiary:
- i Is medically stable;
 - ii Has confirmed diagnoses;
 - iii Does not require further inpatient hospital evaluation or treatment; and
 - iv Has a skilled nursing or rehabilitation need that has been identified by a physician during the inpatient hospitalization and that cannot be provided on an outpatient basis.

IV. *Grace Period for Excluded Beneficiaries*

- A. In the case of a former ACO REACH Beneficiary, that is, a Beneficiary who was aligned to THN at the start of the applicable Performance Year but who is later excluded from alignment to THN, CMS shall make payment for SNF Services furnished to such a Beneficiary without a prior 3 day inpatient hospitalization by an eligible SNF under the 3-Day SNF Rule Waiver, applying the terms of the waiver in Section II of this Appendix, as if the Beneficiary were still aligned to THN when the admission to the eligible SNF occurs within 90 days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

V. *SNF Services Provided to Non-Eligible Beneficiaries:*

- A. If an eligible SNF provides SNF Services under this 3-Day SNF Rule Waiver to an ACO REACH Beneficiary who does not meet the Beneficiary Eligibility Requirements in Section IV of this Appendix, the following rules shall apply:
1. CMS shall make no payment to the eligible SNF for such services.
 2. THN or its Designated Representative shall ensure that the eligible SNF that provided the SNF Services does not charge the ACO REACH Beneficiary for the expenses incurred for such services.
 3. THN or its Designated Representative shall ensure that the eligible SNF that provided the SNF Services returns to the ACO REACH Beneficiary any monies collected from the ACO REACH Beneficiary.

VI. *Responsibility for Denied Claims*

- A. If a claim for any SNF Services furnished to a Beneficiary by an eligible SNF is denied as a result of a CMS error and the eligible SNF did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such SNF Services under the terms of the waiver in Section II of this Appendix as though the coverage denial had not occurred.
- B. If a claim for any SNF Services furnished to a Beneficiary by an eligible SNF is denied for any reason other than a CMS error and CMS determines that that the eligible SNF did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall, notwithstanding such determination, pay for such SNF Services under the terms of the waiver in Section II of this Appendix as though the coverage denial had not occurred, but

- CMS will recoup these payments from THN. THN shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
2. THN or its Designated Representative shall ensure that the eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred by such services; and
 3. THN or its Designated Representative shall ensure that the eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary.
- C. If a claim for any SNF Services furnished to a Beneficiary by an eligible SNF is denied and the eligible SNF knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall not make payment to the eligible SNF for such services;
 2. THN or its Designated Representative shall ensure that the eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred by such services; and
 3. THN or its Designated Representative shall ensure that the eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary.
- D. If an ACO REACH Participant or Preferred Provider that is not an eligible SNF submits a claim for SNF Services under this 3-Day SNF Rule Waiver, furnishes services to a Beneficiary for which CMS only would have made payment if the ACO REACH Participant or Preferred Provider was an eligible SNF participating in the 3-Day SNF Rule Waiver in Section II of this Appendix at the time of service:
1. CMS shall not make payment to the ACO REACH Participant or Preferred Provider for such services;
THN or its Designated Representative shall ensure that the ACO REACH Participant or Preferred Provider that provided the SNF Services does not charge the Beneficiary for the expenses incurred by such services; and
 2. THN or its Designated Representative shall ensure that the ACO REACH Participant or Preferred Provider that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary.

VII. *Monitoring*

- A. THN or its Designated Representative will conduct the following monitoring activities:
1. Verify and document the SNF is a contracted ACO REACH Preferred Provider
 2. Verify and document the referred Beneficiary is an active ACO REACH patient
 3. THN or Designated Representative Liaison to follow patient at SNF
 4. THN or Designated Representative Liaison to track and report discharge disposition from SNF
 5. Produce quarterly reports to Compliance and Privacy for compliance auditing purposes
 6. Produce monthly reports for THN Medical Director(s) for quality control review.

VIII. *Compliance and Enforcement*

- A. CMS may revoke its approval of an ACO REACH Participant or Preferred Provider to participate as an eligible SNF under the 3-Day SNF Rule Waiver Benefit Enhancement at any time if the ACO REACH Participant or Preferred Provider's continued participation in this 3-Day SNF Rule Waiver Benefit Enhancement might compromise the integrity of the Model.



- B. THN must have appropriate procedures in place to ensure that ACO REACH Participants and Preferred Providers have access to the most up-to-date information regarding ACO REACH Beneficiary alignment to THN.
- C. THN shall provide CMS with information upon request regarding its use of the 3-Day SNF Rule Waiver.

IX. Record Retention

- A. THN and its Designated Representative shall maintain, and shall require all Participant Providers, Preferred Providers, and individuals and entities performing functions or services related to ACO Activities or Marketing Activities to maintain contracts, records, documents, and other evidence for a period of 10 years from the expiration or termination of the Agreement.

REFERENCE DOCUMENTS/LINKS:

- ACO REACH Model Participation Agreement (Second Amended and Restated Participation Agreement for 2022 Starters) Section 10.02 and Appendix I
- SEC. 1861 [42 U.S.C. 1395m] (i) Post-Hospital Extended Care Services
- FWA Compliance: Beneficiary Enhancements and Beneficiary Engagement Incentives (FWA-002)

PREVIOUS REVISION/REVIEW DATES:

Date	Reviewed	Revised	Notes
May 23, 2017	N/A	N/A	New Policy
July 24, 2017	Yes	Yes	Includes new procedures
September 14, 2021	Yes	No	Formatting changes
January 2024		Yes	Updated to ACO REACH
December 2024		Yes	Revised section II. E
September 2025	Yes		No changes