

beneficiary could reasonably benefit from them.

(7) The cost of the items or services must not be shifted to another federal health care program, as defined at section 1128B(f) of the Act.

(b) *Technology provided to an EPM beneficiary.* Beneficiary engagement incentives involving technology are subject to the following additional conditions:

(1) Items or services involving technology provided to a beneficiary may not exceed \$1,000 in retail value for any one beneficiary in any one EPM episode.

(2) Items or services involving technology provided to a beneficiary must be the minimum necessary to advance a clinical goal, as listed in paragraph (c) of this section, for a beneficiary in an EPM episode.

(3) Items of technology exceeding \$100 in retail value must—

(i) Remain the property of the EPM participant; and

(ii) Be retrieved from the beneficiary at the end of the EPM episode. The EPM participant must document all retrieval attempts, including the ultimate date of retrieval. Documented, diligent, good faith attempts to retrieve items of technology will be deemed to meet the retrieval requirement.

(c) *Clinical goals of the EPM.* The following are the clinical goals of the EPM, which may be advanced through beneficiary incentives:

(1) Beneficiary adherence to drug regimens.

(2) Beneficiary adherence to a care plan.

(3) Reduction of readmissions and complications resulting from treatment for the EPM clinical condition.

(4) Management of chronic diseases and conditions that may be affected by treatment for the EPM clinical condition.

(d) *Documentation of beneficiary engagement incentives.* (1) EPM participants must maintain documentation of items and services furnished as beneficiary engagement incentives that exceed \$25 in retail value.

(2) The documentation established contemporaneously with the provision

of the items and services must include at least the following:

(i) The date the incentive is provided.

(ii) The identity of the beneficiary to whom the item or service was provided.

(3) The documentation regarding items of technology exceeding \$100 in retail value must also include contemporaneous documentation of any attempt to retrieve technology at the end of an EPM episode as described in paragraph (b)(3) of this section.

(4) The EPM participant must retain and provide access to the required documentation in accordance with § 512.110.

Subpart G—Waivers

§ 512.600 Waiver of direct supervision requirement for certain post-discharge home visits.

(a) *General.* CMS waives the requirement in § 410.26(b)(5) of this chapter that services and supplies furnished incident to a physician's service must be furnished under the direct supervision of the physician (or other practitioner) to permit home visits as specified in this section. The services furnished under this waiver are not considered to be "hospital services," even when furnished by the clinical staff of the hospital.

(b) *General supervision of qualified personnel.* The waiver of the direct supervision requirement in § 410.26(b)(5) of this chapter applies only in the following circumstances:

(1) The home visit is furnished during the episode to a beneficiary who has been discharged from an anchor hospitalization.

(2) The home visit is furnished at the beneficiary's home or place of residence.

(3) The beneficiary does not qualify for home health services under sections 1835(a) and 1814(a) of the Act at the time of any such home visit.

(4) The visit is furnished by clinical staff under the general supervision of a physician or non-physician practitioner. Clinical staff are individuals who work under the supervision of a physician or other qualified health care professional, and who are allowed by law, regulation, and facility policy to perform or assist in the performance of

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a specific professional service, but do not individually report that professional service.

(5) The number of visits that are furnished to the beneficiary during—

(i) An AMI episode, is up to 13 post-discharge home visits;

(ii) A CABG episode, is up to 9 post-discharge home visits; and

(iii) A SHFFT episode, is up to 9 post-discharge home visits.

(c) *Payment.* Up to the maximum post-discharge home visits for a specific EPM episode, as described in paragraph (b)(5) of this section, may be billed under Part B by the physician or non-physician practitioner or by the participant hospital to which the supervising physician has reassigned his or her billing rights.

(d) *Other requirements.* All other Medicare rules for coverage and payment of services incident to a physician's service continue to apply.

§ 512.605 Waiver of certain telehealth requirements.

(a) *Waiver of the geographic site requirements.* Except for the geographic site requirements for a face-to-face encounter for home health certification, CMS waives the geographic site requirements of section 1834(m)(4)(C)(i)(I) through (III) of the Act for episodes being tested in an EPM, but only for services that—

(1) May be furnished via telehealth under existing requirements; and

(2) Are included in the episode in accordance with § 512.210.

(b) *Waiver of the originating site requirements.* Except for the originating site requirements for a face-to-face encounter for home health certification, CMS waives the originating site requirements under section 1834(m)(4)(C)(ii)(I) through (VIII) of the Act for episodes being tested in an EPM to permit a telehealth visit to originate in the beneficiary's home or place of residence, but only for services that—

(1) May be furnished via telehealth under existing requirements; and

(2) Are included in an EPM episode in accordance with § 512.210.

(c) *Waiver of selected payment provisions.* (1) CMS waives the payment requirements under section 1834(m)(2)(A)

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so that the facility fee normally paid by Medicare to an originating site for a telehealth service is not paid if the service is originated in the beneficiary's home or place of residence.

(2) CMS waives the payment requirements under section 1834(m)(2)(B) to allow the distant site payment for telehealth home visit HCPCS codes unique to this model to more accurately reflect the resources involved in furnishing these services in the home by basing payment upon the comparable office visit relative value units for work and malpractice under the Physician Fee Schedule.

(d) *Other requirements.* All other requirements for Medicare coverage and payment of telehealth services continue to apply, including the list of specific services approved to be furnished by telehealth.

§ 512.610 Waiver of SNF 3-day rule.

(a) *Applicability of the SNF 3-day rule waiver.* CMS determines that the SNF 3-day rule is—

(1) Waived for the AMI model;

(2) Not waived for the CABG model; and

(3) Not waived for the SHFFT model.

(b) *Waiver of the SNF 3-day rule.* For episodes being tested in those EPMs where the SNF 3-day rule is waived under paragraph (a) of this section, CMS waives the SNF 3-day rule for coverage of a SNF stay for a beneficiary who is an EPM beneficiary on the date of discharge from the anchor hospitalization on or after October 4, 2018, but only if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of EPM beneficiary admission to the SNF.

(1) CMS determines the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the Five-Star Quality Rating System for SNFs on the Nursing Home Compare Web site. Qualified SNFs are rated an overall of 3 stars or better for at least 7 of the 12 months.

(2) CMS posts to the CMS Web site the list of qualified SNFs in advance of the calendar quarter and the waiver only applies for a beneficiary who has been discharged from an anchor hospitalization if the SNF is included on