DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 424 and 455

[CMS–6084–P]

RIN 0938–AU90

Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement portions of section 6101 of the Patient Protection and Affordable Care Act (Affordable Care Act), which require the disclosure of certain ownership, managerial, and other information regarding Medicare skilled nursing facilities (SNFs) and Medicaid nursing facilities.

DATES: *Comment period:* To be assured consideration, comments must be received at one of the addresses provided below, by April 14, 2023.

ADDRESSES: In commenting, please refer to file code CMS–6084–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6084–P, P.O. Box 8010, Baltimore, MD 21244–1810.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6084–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Frank Whelan, (410) 786–1302 or via email at *Frank.Whelan@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Executive Summary and Background

A. Executive Summary

1. Purpose

Section 6101(a) of the Affordable Care Act (Pub. L. 111–148) added a new section 1124(c) to the Social Security Act (the Act). This provision established requirements for the disclosure of information about the owners and operators of Medicare SNFs and Medicaid nursing facilities. (Except as otherwise indicated, these Medicare and Medicaid providers will be collectively referenced as ''nursing facilities,'' ''nursing homes,'' or simply ''facilities''.)

We included provisions to implement section 1124(c) of the Act as part of the May 6, 2011 proposed rule titled ''Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Disclosures of Ownership and Additional Disclosable Parties Information'' (76 FR 26364). We did not finalize these proposed disclosure provisions in the subsequent final rule, published on August 8, 2011,[1] due to the need for more time to consider the comments received, though we stated that we would address our provisions in a separate final rule in early 2012. After reviewing the comments, we did not publish a final rule or finalize our proposals.

As explained in detail in the present proposed rule, however, we have recently received information regarding particular categories of nursing facility owners (including, but not limited to, private equity companies and real estate investment trusts) that has generated concerns about the standard of care that nursing facility residents receive. To help ensure that CMS has sufficient data on these owners and can thus better monitor and hold accountable their nursing facilities, we are again proposing to implement section 1124(c) of the Act, albeit with isolated exceptions as explained in section II.C. of this proposed rule.

2. Summary of the Major Provisions

There are three principal categories of provisions in this proposed rule.

a. Data To Be Reported

We are proposing that nursing facilities would be required to disclose the following information to CMS or, for Medicaid nursing facilities, the applicable state Medicaid agency:

- Each member of the governing body of the facility, including the name, title, and period of service of each member.
- Each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity.
- Each person or entity who is an additional disclosable party of the facility.
- The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

To the extent that a Medicare SNF must already report some of this data via the Form CMS–855A provider enrollment application (Medicare Enrollment Application—Institutional Providers; Office of Management and Budget (OMB) Control No.: 0938–0685), we are proposing that the SNF need not report the same data required under section 1124(c) of Act more than once on the same application submission. (States would have the option of adopting a similar policy with respect to the required Medicaid nursing facility data.) We believe this would help prevent unnecessary burden on the facility.

We also intend to make the information provided per section 1124(c) of the Act publicly available as required under section 6101(b) of the Affordable Care Act.

b. Timing of Reporting

We are proposing that the nursing facility would have to report the

[1] ''Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012; Final Rule'' (76 FR 48485).

aforementioned information upon initially enrolling in Medicare or Medicaid and when revalidating their Medicare or Medicaid enrollment. Moreover, a Medicare SNF, once enrolled, would be required to disclose any changes to this information within the current timeframes specified in § 424.516(e) for reporting changes in enrollment data.

Consistent with 42 CFR 424.515, SNFs are required to revalidate their Medicare enrollment every 5 years. However, CMS under § 424.515(d) can perform off-cycle revalidations; that is, we can revalidate a provider or supplier at any time and need not wait until the arrival of their 5-year revalidation cycle. Should this proposed rule be finalized, CMS would accordingly reserve the right to conduct off-cycle revalidations of SNFs to collect the data required under section 1124(c) of the Act.

c. Definitions

To explain some of the terminology associated with these reporting requirements, we are also proposing several new definitions. These include, but are not limited to, private equity company, real estate investment trust, additional disclosable party, and organizational structure.

d. Effective Date

If finalized, the rule would become effective 60 days after the date the final rule is published in the **Federal Register**. However, Medicare SNFs would not have to disclose the data required under section 1124(c) of the Act until the Form CMS–855A is revised (a process CMS would seek to undertake promptly upon the publication of any final rule) to collect this data and is publicly available for use. For Medicaid nursing facilities, the required data would not have to be reported until the applicable State Medicaid agency has established the means to collect it.

3. Summary of Costs and Benefits

Sections III. and IV. of this proposed rule outline the impacts that our proposals would have on affected entities and beneficiaries. The principal impact would involve the disclosure of the required data by nursing facilities. As explained in section IV. of this proposed rule, we project a total annual information collection burden on Medicare and Medicaid nursing facilities in reporting this data of 18,912 hours at a cost of $1,733,096.

We have determined that this proposed rule is not economically significant. See section IV. of this proposed rule for a detailed discussion.

B. Legislative and Regulatory Authority

There are three principal categories of legal authorities for our proposals:

- Section 1124(c) of the Act requires Medicare and Medicaid nursing facilities to disclose certain information about their ownership and management.
- Section 1866(j) of the Act furnishes specific authority regarding the enrollment process for providers and suppliers.
- Sections 1102 and 1871 of the Act provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program.

C. Overview of Provider Enrollment

1. Medicare

Section 1866(j)(1)(A) of the Act requires the Secretary to establish a process for the enrollment of providers and suppliers into the Medicare program. The overarching purpose of the enrollment process is to confirm that providers and suppliers seeking to bill Medicare for services and items furnished to Medicare beneficiaries meet all applicable Federal and State requirements to do so. The process is, to an extent, a ''gatekeeper'' that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. Since 2006, we have undertaken rulemaking efforts to outline our enrollment procedures. These regulations are generally codified in 42 CFR part 424, subpart P (hereafter occasionally referenced as simply ''subpart P''). They address, among other things, requirements that providers and suppliers must meet to obtain and maintain Medicare billing privileges.

As outlined in § 424.510, one such requirement is that the provider or supplier complete, sign, and submit to its assigned Medicare Administrative Contractor (MAC) the appropriate enrollment form, typically the Form CMS–855 (OMB Control No. 0938–0685). The Form CMS–855 collects important information about the provider or supplier. Such data includes, but is not limited to, general identifying information (for example, legal business name), licensure and/or certification data, and practice locations. The application is used for a variety of provider enrollment transactions, including the following:

- Initial enrollment—The provider or supplier is—(1) enrolling in Medicare for the first time; (2) enrolling in another Medicare contractor's jurisdiction; or (3) seeking to enroll in Medicare after having previously been enrolled.
- Change of ownership—The provider or supplier is reporting a change in its ownership.
- Revalidation—The provider or supplier is revalidating its Medicare enrollment information in accordance with § 424.515.
- Reactivation—The provider or supplier is seeking to reactivate its Medicare billing privileges after it was deactivated in accordance with § 424.540.
- Change of information—The provider or supplier is reporting a change in its existing enrollment information in accordance with § 424.516.

After receiving the provider's or supplier's initial enrollment application, CMS or the MAC reviews and confirms the information thereon and determines whether the provider or supplier meets all applicable Medicare requirements. We believe this screening process has greatly assisted CMS in executing its responsibility to prevent Medicare fraud, waste, and abuse.

As previously mentioned, over the years we have issued various final rules pertaining to provider enrollment. These rules were intended not only to clarify or strengthen certain components of the enrollment process but also to enable us to take further action against providers and suppliers: (1) engaging (or potentially engaging) in fraudulent or abusive behavior; (2) presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Funds; or (3) that are otherwise unqualified to furnish Medicare services or items.

2. Medicaid

States have considerable flexibility in how they administer their Medicaid programs within a broad Federal framework, and programs vary from state to state. In operating Medicaid, states historically have permitted the enrollment of providers who meet the state requirements for program enrollment as well as any applicable Federal requirements. State enrollment requirements must be consistent with section 1902(a)(23) of the Act and implementing regulations at § 431.51.

Part 455 of title 42 includes Federal Medicaid provider enrollment requirements to which states must adhere. These include, but are not limited to, the following:

- Requiring providers to disclose information regarding ownership, business transactions, certain criminal convictions, and affiliations (§§ 455.104 through 455.107).
- Screening providers consistent with the procedures in part 455, subpart E (§ 455.410).

• Revalidating a provider's enrollment at least every 5 years (§ 455.414).

• Performing site visits and criminal background checks in certain circumstances (§§ 455.432 and 455.434).

Although required to comply with the foregoing Federal requirements, states have the discretion to, for instance: (1) undertake stricter screening of providers; and (2) require providers to submit data beyond that identified in §§ 455.104 through 455.107. Except as otherwise noted therein, the provisions in 42 CFR part 455 are thus the minimum requirements for states, not the maximum.

II. Provisions of the Proposed Regulations

A. Background

1. Statutory and Regulatory History

Section 6101(a) of the Affordable Care Act added a new section 1124(c) to the Act. It established requirements for the disclosure of information about nursing facility ownership and oversight. Under section 1124(c)(2)(A)(ii) of the Act, a nursing facility enrolling or enrolled in Medicare or Medicaid must disclose—

• The name, title, and period of service of each member of the facility's governing body;

• The name, title, and period of service of each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility; and

• Each person or entity who is an additional disclosable party of the facility.

Section 1124(c)(5)(A) of the Act defines ''additional disclosable party'' as a person or entity that—

• Exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the facility's operations, or provides financial or cash management services to the facility;

• Leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

• Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

In addition, section 1124(c)(2)(A)(iii) of the Act requires the nursing facility to disclose: (1) the organizational structure (as defined in section 1124(c)(5)(D) of the Act) of each additional disclosable party of the facility; and (2) a description of the relationship of each such additional disclosable party to the facility and to one another.

As noted previously, we proposed regulations to implement section 1124(c) of the Act as part of a proposed rule published on May 6, 2011. We also proposed therein several regulatory definitions of section 1124(c)'s terminology to help nursing facilities understand what must be reported. We did not finalize our proposed provisions in the subsequent August 8, 2011 final rule because we needed more time to consider the comments received, though we stated that we would address our provisions in a separate final rule in early 2012. After reviewing the comments, we decided not to publish a final rule or to finalize our proposals.

2. Concerns About Nursing Facility Ownership

CMS's concerns about the quality of care and operations of nursing facilities, including (though by no means exclusively) those owned by private equity and other types of investment firms, have increased since 2011. As of 2021, roughly 70 percent of nursing homes were for-profit facilities; this includes those owned by private equity companies, which comprised approximately 11 percent of all nursing homes (although estimates vary).[2] Reports have circulated that nursing facility quality has declined under private equity and similar owners. For instance, in February 2021 the National Bureau of Economic Research (NBER) published an analysis titled ''Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes.'' The report stated: ''Our estimates show that private equity (PE) ownership increases the short-term mortality of Medicare patients by 10%, implying 20,150 lives lost due to PE ownership over our twelve-year sample period. This is accompanied by declines in other measures of patient well-being, such as lower mobility, while taxpayer spending per patient episode increases by 11%.'' [3] A November 2021 analysis published in the *Journal of the American Medical Association* contained similar findings concerning private equity-owned nursing facilities. Titled ''Association of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents,'' the report stated that private equity companies seek annual returns of 20% or more; with this pressure to generate high short-term profits, private-equity-owned nursing homes might reduce staffing, services, supplies, or equipment, which could adversely affect quality of care.[4] The analysis concluded that: (1) private equity acquisition of nursing facilities was associated with higher costs and increases in emergency department visits and hospitalizations for ambulatory sensitive conditions; and (2) per the study's findings, more stringent oversight and reporting on private equity ownership of nursing homes may be warranted.[5]

The Biden-Harris Administration's concerns about nursing facility quality of care and private equity-ownership led to its announcement on February 28, 2022, of a series of initiatives designed to improve care and accountability at such facilities. In its fact sheet titled ''Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes,'' the White House stated that ''(f)or too long, corporate owners and operators have not been held to account for poor nursing home performance.'' [6] The fact sheet also stated that CMS would ''implement Affordable Care Act requirements regarding transparency in corporate ownership of'' nursing facilities, including the ''collect[ion] and public reporting [of] more robust corporate ownership and operating data.'' [7]

We stress that the above-mentioned concerns about nursing home ownership are not limited to private equity companies. Other types of private ownership, such as real estate investment trusts (REITs), have generated similar concerns; indeed, REITs, in addition to private equity companies and other investment ownership structures, were specifically referenced in the February 28, 2022 White House fact sheet.

We note that Government oversight bodies, too, have studied the issue of nursing facility quality across the board, regardless of the precise type of ownership involved. The Government Accountability Office (GAO) published an analysis on January 14, 2022 titled ''Health Care Capsule: Improving Nursing Home Quality and Information''

[2] Medicare Payment Advisory Commission, ''Congressional Request: Private Equity and Medicare,'' June 2021. *jun21_ch3_medpac_report_to_congress_sec.pdf.*

[3] Atul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta, *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes,* 2021, p. i.

[4] Robert Tyler Braun, Hye-Young Jung, Lawrence Casalino, et al., JAMA Health Forum, November 19, 2021.

[5] Ibid.

[6] *https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.*

[7] Ibid.

(GAO–22–105422). This document summarized past GAO reports that expressed continued concern about the level of care that SNF beneficiaries receive. Problems that the GAO cited in this analysis and in prior studies (based in part on CMS statistics regarding nursing facility deficiencies) included infection prevention and control, ensuring that the nursing home environment is free from accidents, and food safety.[8] In a September 2020 report titled ''National Background Check Program for Long-Term Care Providers: Assessment of State Programs Concluded in 2019'' (OEI–07–20–00180), the U.S. Department of Health & Human Services Office of Inspector General (OIG) noted that patient abuse, patient neglect, and misappropriation of property have been identified as widespread problems harming beneficiaries receiving long-term care. Of particular significance was the OIG's statement that, per various studies, some nurse aides who were convicted of abuse, neglect, or theft had previous criminal convictions that could have been found through background checks.[9] The OIG added that such background checks can help protect long-term care beneficiaries.[10]

These two reports further emphasize the importance of CMS' efforts to: (1) improve the quality of care provided in nursing facilities; and (2) facilitate greater transparency regarding nursing facilities' owners and operators, whether they be private equity companies, REITs, or otherwise. We believe nursing home owners and operators are in a position to address some of the problems referenced in the aforementioned analyses and reports and make operational improvements. Knowing who these parties are through their disclosures on the Form CMS–855A and to States would: (1) provide additional transparency that may assist CMS and other regulators in holding nursing facilities accountable; and (2) allow consumers to select facilities with better knowledge of their owners and operators.

3. Implementation of Section 1124(c) of the Act

Given all of the foregoing, we propose to implement section 1124(c) of the Act consistent with the statutory mandate. Although, as previously stated, CMS did not finalize its 2011 proposal to implement section 1124(c) of the Act, there are several important differences between 2011 and now.

First, and as already noted, reports linking certain types of ownership with a decline in nursing facility quality of care have become more frequent, definitive, and alarming. As the White House indicated in its February 28, 2022 announcement, this increases the urgency to take wide-ranging measures to address this problem.

Second, our enhancements to the Provider Enrollment, Chain, and Ownership System (PECOS) over the years have made the enrollment process easier and faster for SNFs than was the case in 2011. We believe this would help reduce the operational burden of reporting the requested data.

Third, and as explained further in section II.B. of this proposed rule, our intended revisions to the Form CMS–855A to collect the section 1124(c) data would be structured so that SNFs would not have to disclose this same information twice on the same application submission. That is, ownership and managerial data that must already be reported as part of the enrollment process would not need to be disclosed a second time on the same Form CMS–855A submission if it duplicates the information required under section 1124(c) of the Act. This would further alleviate the burden on nursing facilities.

Fourth, and unlike in 2011, the implementation of section 1124(c) of the Act would not be a comparatively isolated or stand-alone means of addressing nursing home ownership. Indeed, the Administration has implemented or plans to implement initiatives to strengthen its oversight of SNFs. To illustrate, CMS finalized several changes to § 424.518 in the 2023 Physician Fee Schedule final rule (CMS–1770–F), one of which requires 5 percent or greater owners of SNFs to submit fingerprints and be subject to an FBI criminal background check for certain provider enrollment transactions, such as initial enrollment and revalidation.[11] This is based on our concerns about criminal activity involving nursing facility operators and overseers.

With these changed circumstances and the pressing need to address the aforementioned issues, section II.B. of this proposed rule outlines our proposed provisions. These largely mirror what we proposed in the May 6, 2011 proposed rule and, except as otherwise specified, affect both the Medicare and Medicaid programs.

B. Proposed Provisions

1. Medicare

a. Update to § 424.516

We would add new paragraph (g)(1) to § 424.516 outlining the following information to be reported as part of a SNF's Form CMS–855A initial enrollment or revalidation application. These data elements would be designated as paragraphs (g)(1)(i) through (iv), respectively, and would be in addition to (and not in lieu of) all other reporting requirements in subpart P:

- Each member of the governing body of the facility, including the name, title, and period of service of each such member.
- Each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity.
- Each person or entity who is an additional disclosable party of the facility.
- The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

(We would clarify in the introductory paragraph of (g)(1) that initial applications include, strictly for purposes of paragraph (g)'s applicability, changes of ownership under 42 CFR 489.18. This means that the SNF's new owner, like an initially enrolling SNF, would have to disclose on its Form CMS–855A the data required per § 424.516(g). This would assist in ensuring that CMS has sufficient data on the facility's new ownership and operators.)

The four data elements in paragraphs (g)(1)(i) through (iv) are identical to those in section 1124(c)(2)(A)(ii) and (iii) of the Act. Also, and as mentioned previously, much of this information is already captured on the Form CMS–855A application. To avoid duplicate reporting and thus ease the burden on SNFs, we propose in paragraph (g)(2) that the data in paragraphs (g)(1)(i) through (iv) need not be disclosed more than once on the same application submission. To illustrate, and consistent with sections 1124(a) and 1124A of the Act, an organizational provider or supplier (including a SNF) must currently report in Section 5 of the Form

[8] GAO–22–105422, p. 1.

[9] OEI–07–20–00180, p. 1.

[10] Ibid.

[11] ''Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs To Provide Refunds With Respect to Discarded Amounts; and COVID–19 Interim Final Rules'' (87 FR 69404), published in the **Federal Register** on November 18, 2022.

CMS–855A all entities with a partnership interest in the provider or supplier and, in Section 6, all of the provider's or supplier's managing employees. While proposed paragraph (g)(1)(ii) also would require SNFs to disclose this data, the SNF would not have to report it twice on the same Form CMS–855A submission: once per sections 1124(a) and 1124A of the Act and again per section 1124(c) of the Act.

New paragraph (g)(3) would state that the SNF must report any change to any of the information described in paragraphs (g)(1)(i) through (iv) within the current timeframes in § 424.516(e) for reporting changes in enrollment data—specifically, 30 days for changes in ownership or control and 90 days for all other changes. This is to ensure that CMS has accurate and updated information on the SNF.

b. Definitions

To clarify some of the terminology used in § 424.516(g)(1), we propose to add several definitions to § 424.502.

First, we propose to define ''additional disclosable party'' as meaning (with respect to a skilled nursing facility defined at section 1819(a) of the Act) any person or entity who: (1) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility; (2) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or (3) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility. This duplicates the definition of the same term in section 1124(c)(5)(A) of the Act.

Second, § 424.502 currently defines ''managing employee'' consistent with the definition of the same term in section 1126(b) of the Act. Section 1124(c)(5)(C) of the Act, too, defines ''managing employee,'' though only for purposes of nursing facilities under section 1124(c) of the Act. This latter definition is slightly broader and encompasses more individuals than section 1126(b) of the Act. Since the two definitions are not precisely the same, we cannot use the section 1126(b) definition for nursing facilities. Accordingly, we propose to add to the end of § 424.502's definition of ''managing employee'' a separate definition of ''managing employee'' that mirrors section 1124(c)(5)(C) of the Act and applies only to SNFs and the requirements in § 424.516(g). It would mean an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

Third, we propose to define ''organizational structure.'' It would mirror the definition of the same term in section 1124(c)(5)(D) of the Act. With respect to a SNF, it would mean—

- For a corporation—The officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;
- For a limited liability company—The members and managers of the limited liability company including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company;
- For a general partnership—The partners of the general partnership;
- For a limited partnership—The general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;
- For a trust—The trustees of the trust;
- For an individual—Contact information for the individual.

Fourth, we intend to add data elements to the Form CMS–855A through which owning and managing entities of SNFs would have to disclose whether they are either a private equity company or a REIT. To assist stakeholders in understanding the meaning of these terms for provider enrollment purposes, we propose to add definitions thereof to § 424.502. A private equity company would be defined as a publicly traded or non-publicly traded company that collects capital investments from individuals or entities (that is, investors) and purchases an ownership share of a provider (for example, SNF, home health agency, etc.). We would define a REIT as a publicly-traded or non-publicly traded company that owns part or all of the buildings or real estate in or on which the provider operates. We recognize that these definitions may be modestly different from definitions of the same terms used in other settings. We solicit comment on the propriety of our proposed definitions and welcome any suggested revisions thereto; we particularly seek comment on whether our proposed definition of private equity company should include publicly-traded private equity companies. We also welcome public feedback regarding any other types of private ownership besides private equity companies and REITs about which CMS should consider collecting information from SNFs as part of the enrollment process.

As previously mentioned, SNFs would have to report the information required under § 424.516(g) upon revalidation. SNFs are required to revalidate their Medicare enrollment every 5 years consistent with 42 CFR 424.515. Yet CMS under § 424.515(d) can also perform off-cycle revalidations; specifically, CMS can revalidate a provider or supplier at any time and need not wait until the arrival of their 5-year revalidation cycle. Should this proposed rule be finalized, CMS would have the authority to conduct off-cycle revalidations of SNFs to collect the section 1124(c) data.

2. Medicaid

We propose to revise our Medicaid enrollment provisions in 42 CFR part 455, subpart B, to include therein regulatory provisions akin to those we are proposing in part 424, subpart P.

In § 455.101, we propose to add the same definitions of ''additional disclosable party'' and ''organizational structure'' that we are proposing in § 424.502, excluding the reference to skilled nursing facility, a Medicare-only term; we would instead reference nursing facilities as defined in section 1919(a) of the Act.

We also propose to revise § 455.101's definition of ''managing employee'' in two ways. First, we would clarify in the definition's opening sentence that an individual can qualify as a managing employee: (1) even if he or she is acting under contract or through some other arrangement; and (2) whether or not the individual is a W–2 employee of the institution, organization, or agency. This would better conform to the current definition of the same term in § 424.502. Second, and similar to our proposed revision to the definition of ''managing employee'' in § 424.502, we propose to add to the end of the definition of this term in § 455.101 a separate definition of ''managing employee'' that mirrors section 1124(c)(5)(C) of the Act and applies only to nursing facilities. It would mean an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

Current § 455.104 identifies certain ownership and control information that Medicaid providers must disclose to enroll or remain enrolled in Medicaid.

This information includes some of that referenced in section 1124(c) of the Act, but § 455.104 does not currently incorporate all of the section 1124(c) of the Act data elements. To address this, we propose several changes to § 455.104.

First, existing § 455.104(e) states that Federal financial participation is not available in payments made to a disclosing entity that fails to report required ownership or control information. We propose to redesignate this paragraph as § 455.104(f) for organizational purposes and to establish a new § 455.104(e) that would address our proposed additional disclosure provisions.

Second, and for nursing facilities as defined in section 1919(a) of the Act, new § 455.104(e)(1)(i) through (iv) would include the same data elements described in proposed § 424.516(g)(1) through (iv). Paragraph (e)(1) would also specify that this information must be furnished (a) upon initial enrollment and revalidation and (b) in addition to (and not in lieu of) all other required data disclosures in part 455, subpart B.

Third, we propose in § 455.104(e)(2) that the state need not require the provider to report the data described in paragraph (e)(1) more than once on the same enrollment application submission. This provision is similar to that in proposed § 424.516(g)(2) for Medicare but with an important difference, in that § 455.104(e)(2) would be optional for states. That is, the state could, but would not be required to, mandate the reporting of the § 455.104(e)(1) data more than once on the same application submission. As an illustration, a particular state's enrollment application may currently require the corporate directors of each enrolling provider (regardless of type) to be disclosed in one section. Our proposal would permit the state either to use this application section alone to collect such data from nursing facilities per proposed § 455.104(e)(1) or to, for example, require nursing facilities to again submit this data on a separate application attachment exclusive to nursing facilities. Consistent with the general deference we have long afforded states regarding the operation of their Medicaid provider enrollment programs, we do not seek to overly restrict the logistical means by which states collect the information in question.

In a similar vein regarding state deference, we are not proposing that states require nursing homes to report changes to their existing section 1124(c) information within certain timeframes. However, we believe it is critical that states have accurate and updated information regarding nursing facilities' owners and operations. We therefore encourage states to establish reporting requirements regarding changes in the data required under section 1124(c) of the Act, including when the provider changes its ownership. Likewise, we suggest (but are not proposing) that states collect data signifying whether a particular organization reported under section 1124(c) of the Act is a private equity company or REIT.

C. Additional Related Proposed Provisions

1. Public Posting of Data

Section 6101(b) of the Affordable Care Act states that no later than 1 year after final regulations promulgated under section 1124(c)(3)(A) of the Act are published in the **Federal Register**, the Secretary shall make the information reported per such regulations available to the public. Consistent with section 6101(b) of Affordable Care Act, we intend to make data reported in accordance with section 1124(c) of the Act publicly available within 1 year after this rule, if finalized, is published in the **Federal Register**. We would consider making this data available on *data.cms.gov.* Further information regarding the format and scope of the published information would be provided via future sub-regulatory guidance.

2. Section 1124(c)(3)(A) of the Act

Section 1124(c)(3)(A) of the Act states, in part, that regulations implementing the reporting requirements of section 1124(c) of the Act must also require that the facility certifies (as a condition of participation and payment under Medicare and Medicaid) that the information the facility reports ''is, to the best of the facility's knowledge, accurate and current.'' Under our current Medicare regulations at § 424.510(d)(3), an authorized official or delegated official (as those terms are defined in § 424.502) must sign the Form CMS–855A on behalf of the provider. In signing the application, the official attests to the following: ''By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the timeframes established in 42 CFR 424.516(e).'' This ''true, correct, and complete'' standard has been part of Medicare provider enrollment applications for many years, and we believe its lack of associated qualifying language (such as ''to the best of my knowledge'') has helped ensure that the provider and its signatory fully understand the need to submit accurate data.

We are concerned that implementation of section 1124(c)(3)(A) of the Act would result in two knowledge standards for the Form CMS–855A. Specifically, the required nursing facility information would have a ''to the best of my knowledge'' standard, whereas all other data on the application (for instance, practice locations, final adverse actions) would have an unqualified ''true, correct, and complete'' standard. This could cause confusion within the nursing facility community. More importantly, though, it might convey the impression that the provider need not be as careful and thorough about confirming the correctness of the nursing facility data in comparison to the rest of the application's information. This is because the nursing facility data would appear to invoke a lesser knowledge standard. We note that these same issues could arise with Medicaid enrollment, since some state Medicaid provider enrollment applications may have knowledge standards different from that identified in section 1124(c)(3)(A) of the Act. Due to the need to further review the potential operational implications of section 1124(c)(3)(A) of the Act, we are not proposing to implement this provision in this proposed rule but may consider doing so in future rulemaking. For the time being, the certification statement language applicable to the entire Form CMS–855A enrollment application would apply to the information described in proposed § 424.516(g).

3. Section 1124(c)(2)(B) of the Act

Section 1124(c)(2)(B) of the Act states that if a facility reports the data described in section 1124(c)(2)(A) to another Federal agency, the facility may provide the form on which the data was submitted (or other such information submitted) to meet the disclosure requirements of section 1124(c)(1) of the Act. Given the potential operational complexities of incorporating the provisions of section 1124(c)(2)(B) of the Act into § 424.516(g) or 42 CFR part 455 when we already have a vehicle (the Form CMS–855A) for collecting the data referenced in section 1124(c) of the Act, we need additional time to examine this matter. We may address section 1124(c)(2)(B) of the Act in future rulemaking.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. Background

As explained in section II. of this proposed rule, we are proposing to implement most of section 1124(c) of the Act. Section 1124(c) of the Act requires Medicare and Medicaid nursing facilities to report certain information about their ownership and operators. This data includes, but is not limited to: (1) members of the facility's governing body; (2) the facility's officers, directors, members, partners, trustees, and managing employees; (3) parties that exercise operational, financial, or managerial control over the facility or a part thereof; (4) parties who lease or sublease real property to the facility, or own a whole or part interest equal to or exceeding 5 percent of the total value of such real property; and (5) parties that furnish management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

B. Medicare ICR Estimates

We noted in section II. of this proposed rule that the Form CMS–855A (OMB Control No.: 0938–0685), which SNFs must complete to enroll in Medicare, already collects much of the aforementioned information. Examples of this data include the SNF's owners, managing employees, corporate officers, corporate directors, and other parties. As part of the enrollment process, the SNF is also currently required to submit: (1) an organizational diagram identifying all of the owning and managing entities listed on the Form CMS–855A and their relationships with the provider and with each other; and (2) a diagram identifying the organizational structures of all of the SNF's owners. Nonetheless, certain data is not collected on the existing Form CMS–855A, such as parties that perform administrative, financial, or clinical consulting services and do not qualify as another person or entity that is otherwise required to be reported on the application (for example, a managing employee or owner). Disclosure of this heretofore non-mandatory information (hereafter referenced as ''supplemental data'') would constitute additional ICR burden to the SNF community.

There would be three principal types of Form CMS–855A transactions via which SNFs would report supplemental data: (1) applications to initially enroll in Medicare (which, for purposes of the reporting requirements in proposed § 424.516(g), would include changes of ownership under 42 CFR 489.18); (2) applications to revalidate the SNF's current enrollment information per § 424.515; and (3) reporting changes to any of the SNF's previously disclosed supplemental data per proposed § 424.516(g).

Form CMS–855A applications are typically completed by the provider's office staff. However, given the potential complexity of the supplemental data to be reported, it is possible that the SNF's legal counsel would be involved in reviewing this information. Accordingly, we will use the following categories and hourly wage rates from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates for all salary estimates (*https://www.bls.gov/oes/current/oes_nat.htm*):

TABLE 1—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Office and Administrative Support Workers, All Other	43–9199	20.47	20.47	40.94
Lawyers	23–1011	71.17	71.17	142.34

Based on our internal data, we estimate that each year approximately: (1) 1,055 SNFs would submit an initial Form CMS–855A enrollment application (excluding Form CMS–855A change of ownership applications under § 489.18); (2) 1,672 would submit a Form CMS–855A revalidation application; (3) 951 would submit a Form CMS–855A change of ownership application; and (4) 4,500 would report new or changed supplemental data via a Form CMS–855A change of information application. Furthermore, we project that it would take the SNF an average of 2.25 hours to furnish the supplemental data for initial, revalidation, and change of ownership applications and 1 hour for changes of information. (We recognize that the actual time for a particular SNF may be more or less than these figures.) Of these hour estimates, we project that the burden would be split evenly between the SNF's administrative staff and legal counsel (for example, 1.125 hours each for initial and revalidation applications). With this equal division, the per hour wage would be $91.64 (($40.94 + $142.34)/2.) As outlined in more detail in Table 2, this results in a projected annual ICR burden of our proposed Medicare SNF disclosure provisions of 12,776 hours at a cost of $1,170,793.

C. Medicaid ICR Estimates

We mentioned in section II. of this proposed rule that states have considerable discretion in the operational aspects of their Medicaid provider enrollment programs. Concerning our proposed requirements regarding nursing home data, some states may already collect all of this information, the majority of it, or only a modest portion of it. This means that the number of projected initial and revalidation applications reporting this information, as well as the time it takes the facility to disclose the data, would likely vary from state to state. Furthermore, we do not have readily available information on the number of

Medicaid nursing facility initial and revalidation applications that are submitted to each state each year. However, notwithstanding these uncertainties, we believe that reasonable estimates of the hour and cost burdens are possible.

The number of Medicaid-enrolled nursing facilities nationwide is comparable to that for Medicare-enrolled SNFs: roughly between 15,000 and 15,500. In light of this, we believe the Medicare application estimates we used in section III.B. of the proposed rule for initial and revalidation applications can—strictly for purposes of outlining a projection on which stakeholders can submit comments—be used for our proposed Medicaid provisions. Consequently, and as indicated in Table 2, we estimate an annual ICR burden for these provisions of 6,136 hours and $562,303, though, again, we seek public comments on the accuracy of this projection.

D. Total

Given the foregoing, and as outlined in the table below, we project an annual total ICR burden associated with our proposed provisions of 18,912 hours and $1,733,096.

TABLE 2—HOUR AND BURDEN ESTIMATES FOR NURSING HOME DISCLOSURE PROVISIONS

	OMB control No.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting ($) (includes 100% fringe benefits) *	Total cost ($)
Medicare							
Initial Form CMS–855A Applications	0938–0685	1,055	1,055	2.25	2,374	91.64	217,553
Form CMS–855A Revalidation Applications	0938–0685	1,672	1,672	2.25	3,762	91.64	344,750
Form CMS–855A Change of Ownership Applications	0938–0685	951	951	2.25	2,140	91.64	196,110
Form CMS–855A Change of Information Applications	0938–0685	4,500	4,500	1	4,500	91.64	412,380
Medicare Totals	N/A	8,178	8,178	N/A	12,776	N/A	1,170,793
Medicaid							
Initial Application	N/A	1,055	1,055	2.25	2,374	91.64	217,553
Revalidation Application	N/A	1,672	1,672	2.25	3,762	91.64	344,750
Medicaid Totals	N/A	2,727	2,727	N/A	6,136	N/A	562,303
Totals	N/A	10,905	10,905	N/A	18,912	N/A	1,733,096

If you comment on these information collection requirements (that is, reporting, recordkeeping or third-party disclosure requirements), please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

Comments must be received on/by April 14, 2023.

IV. Regulatory Impact Analysis

A. Statement of Need

This proposed rule is necessary so that CMS and states can obtain important data about the owners and operators of nursing facilities. This would better enable CMS and states to monitor the ownership and management of these providers; this is an especially critical consideration given documented quality issues and differences in outcomes in nursing facilities with certain types of owners, such as private equity firms. Our proposal would also serve as an important component of the Biden-Harris Administration's initiative to improve the safety, quality, and accountability of nursing homes.[12]

B. Overall Impact of Provisions of This Proposed Rule

1. Background

We have examined the impacts of this proposed rule, as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)). This section of this proposed rule contains the impact and other economic analyses for our proposed provisions.

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition,

[12] *https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.*

jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory actions and/or with economically significant effects ($100 million or more in any 1 year). Based on our estimates, this proposed rule is not economically significant since it does not meet the $100 million threshold. Nevertheless, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is ''significant'' according to section 3(f) of Executive Order 12866, ''. . . raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order . . .'' Therefore, OMB has reviewed this proposed rule, and the Departments have provided the following assessment of their impact.

C. Detailed Economic Analysis

1. Benefits

As discussed in section II. of this proposed rule, we believe the data furnished under our proposal would help CMS more closely monitor the ownership and management of nursing facilities. This, in conjunction with the Biden-Harris Administration's other initiatives, could help improve beneficiary care, although these potential benefits cannot be monetarily quantified.

2. Costs

The lone category of costs associated with this proposed rule involves nursing facilities' submission of the required information. We projected in section III. of this proposed rule that the annual burden on nursing facilities of furnishing this data would be 18,912 hours at a cost of $1,733,096. (Note that there are no Regulatory Review Costs. Costs to understand and provide the necessary data are included in the ICR costs mentioned above.)

3. Savings or Transfers

We do not anticipate any direct savings or transfers from our proposal. This is principally because the proposal merely involves the submission of data for CMS or state review.

D. Alternatives Considered

The principal alternative we considered and adopted was our proposal that a SNF would not have to report the data referenced in proposed § 424.516(g) twice on the same Form CMS–855A submission: once per sections 1124(a) and 1124A of the Act and again per section 1124(c) of the Act. This was intended to alleviate the burden on the SNF community, though we cannot quantify any resultant savings in monetary terms. We did not consider other alternatives because of the statute's clear mandate concerning the specific data to be reported.

E. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement in Table 3 showing the classification of the impact associated with the provisions of this proposed rule.

TABLE 3—ACCOUNTING STATEMENT: ESTIMATED BURDEN AND REVIEW COSTS OF NURSING FACILITY DISCLOSURE PROPOSED RULE

Category	Primary estimate	Low estimate	High estimate	Units		Period covered
				Year dollar	Discount rate (%)	
Annualized Monetized ICR Burden	$1.73	$1.30	$2.16	2022	7	2022–2032
	1.73	1.30	2.16	2022	3	2022–2032

F. Regulatory Flexibility Act (RFA) Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that SNFs are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers (including nursing facilities) are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business having revenues of less than $14 million to $30 million in any 1 year (for details, see the SBA's website at *https://www.sba.gov/document/support-table-size-standards* for the 62311 SNFs series). For purposes of the RFA, most SNFs are considered small businesses according to the SBA's size standards with total revenues of $30 million or less in any 1 year.

Individuals and states are not included in the definition of a small entity. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. Given the: (1) fairly small number of providers that would be affected by this rule when compared with the over 2 million Medicare providers and suppliers; and (2) projected costs we previously outlined, we do not believe this threshold would be reached by the requirements of this proposed rule. Therefore, the Secretary has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has 100 or fewer beds. As this proposed rule would only affect nursing facilities, it would not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2022, that threshold level is currently approximately $165 million. Given the aforementioned estimated costs, this proposed rule does not mandate any requirements for State, local, or tribal governments, or for the private sector.

H. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has federalism implications. We have examined our proposed provisions in accordance with Executive Order 13132 and have determined that they will not have a substantial direct effect on State, local or tribal governments, preempt State law, or otherwise have a federalism implication.

V. Response to Comments

Because of the large number of public comments, we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on January 24, 2023.

List of Subjects

42 CFR Part 424

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 455

Grant programs—health, Health facilities, Medicaid, Program integrity.

For the reasons stated in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 1. The authority for part 424 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

■ 2. Section 424.502 is amended by—
■ a. Adding the definition of ''Additional disclosable party'' in alphabetical order;
■ b. Revising the definition of ''Managing employee''; and
■ c. Adding the definitions of ''Organizational structure'', ''Private equity company'', and ''Real estate investment trust'' in alphabetical order.

The additions and revision read as follows:

§ 424.502 Definitions.

* * * * *

Additional disclosable party means, with respect to a skilled nursing facility defined at section 1819(a) of the Act, any person or entity who does any of the following:

(1) Exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility.

(2) Leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property.

(3) Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

* * * * *

Managing employee means—

(1) A general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the provider or supplier; or

(2) With respect to the additional requirements at § 424.516(g) for a skilled nursing facility defined at section 1819(a) of the Act, an individual, including a general manager, business manager, administrator, director, or consultant, who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

* * * * *

Organizational structure means, with respect to a skilled nursing facility defined at section 1819(a) of the Act, in the case of any of the following:

(1) *A corporation.* The officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent.

(2) *A limited liability company.* The members and managers of the limited liability company including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company.

(3) *A general partnership.* The partners of the general partnership.

(4) *A limited partnership.* The general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent.

(5) *A trust.* The trustees of the trust.

(6) *An individual.* Contact information for the individual.

* * * * *

Private equity company means, for purposes of this subpart only, a publicly-traded or non-publicly traded company that collects capital investments from individuals or entities and purchases an ownership share of a provider.

Real estate investment trust means, for purposes of this subpart only, a publicly-traded or non-publicly traded company that owns part or all of the buildings or real estate in or on which a provider operates.

* * * * *

■ 3. Section 424.516 is amended by adding paragraph (g) to read as follows:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

* * * * *

(g) *Skilled nursing facilities.* (1) In addition to all other applicable reporting requirements in this subpart, a skilled nursing facility (as defined in section 1819(a) of the Act) must disclose upon initial enrollment (which, for purposes of this paragraph (g), also includes a change of ownership under 42 CFR 489.18) and revalidation the following information:

(i) Each member of the governing body of the facility, including the name, title, and period of service for each such member.

(ii) Each person or entity who is an officer, director, member, partner, trustee, or managing employee (as defined in § 424.502) of the facility,

including the name, title, and period of service of each such person or entity.

(iii) Each person or entity who is an additional disclosable party of the facility (as defined in § 424.502).

(iv) The organizational structure (as defined in § 424.502) of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

(2) The skilled nursing facility need not disclose the same information described in paragraph (g)(1) of this section more than once on the same enrollment application submission.

(3) The skilled nursing facility must report any change to any of the information described in paragraph (g)(1) of this section consistent with the applicable timeframes in paragraph (e) of this section.

PART 455—PROGRAM INTEGRITY: MEDICAID

■ 4. The authority citation for part 455 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 5. Section 455.101 is amended by:
■ a. Adding the definition of ''Additional disclosable party'' in alphabetical order;
■ b. Revising the definition of ''Managing employee''; and
■ c. Adding the definition of ''Organizational structure'' in alphabetical order.

The additions and revision read as follows:

§ 455.101 Definitions.

Additional disclosable party means, with respect to a nursing facility defined in section 1919(a) of the Act, any person or entity who—

(1) Exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

(2) Leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

(3) Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

* * * * *

Managing employee means—

(1) A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of an institution, organization, or agency, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the institution, organization, or agency; or

(2) With respect to the additional requirements at § 455.104(e) for a nursing facility defined in section 1919(a) of the Act, an individual, including a general manager, business manager, administrator, director, or consultant, who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

Organizational structure means, with respect to a nursing facility defined in section 1919(a) of the Act, in the case of any of the following:

(1) *A corporation.* The officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent.

(2) *A limited liability company.* The members and managers of the limited liability company including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company.

(3) *A general partnership.* The partners of the general partnership;

(4) *A limited partnership.* The general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent.

(5) *A trust.* The trustees of the trust.

(6) *An individual.* Contact information for the individual.

* * * * *

■ 6. Section 455.104 is amended by redesignating paragraph (e) as paragraph (f) and adding new paragraph (e) to read as follows:

§ 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

* * * * *

(e) *Nursing facilities.* (1) In addition to all other applicable reporting requirements in this subpart, a nursing facility (as defined in section 1919(a) of the Act) must disclose upon initial enrollment and revalidation the following information:

(i) Each member of the governing body of the facility, including the name, title, and period of service for each such member.

(ii) Each person or entity who is an officer, director, member, partner, trustee, or managing employee (as defined in § 455.101) of the facility, including the name, title, and period of service of each such person or entity.

(iii) Each person or entity who is an additional disclosable party of the facility (as defined in § 455.101).

(iv) The organizational structure (as defined in § 455.101) of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

(2) The State need not require the facility to disclose the same information described in this paragraph (e) more than once on the same enrollment application submission.

* * * * *

Dated: February 8, 2023.

Xavier Becerra

Secretary, Department of Health and Human Services.

[FR Doc. 2023–02993 Filed 2–13–23; 4:15 pm]

BILLING CODE P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS–R4–ES–2022–0099; FF09E22000 FXES1113090FEDR 234]

RIN 1018–BF53

Endangered and Threatened Wildlife and Plants; Removal of the Southeast U.S. Distinct Population Segment of the Wood Stork From the List of Endangered and Threatened Wildlife

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), propose to remove the Southeast U.S. distinct population segment (DPS) of the wood stork (*Mycteria americana*) from the Federal List of Endangered and Threatened Wildlife due to recovery. This determination is based on a thorough review of the best available scientific and commercial data, which indicate that this wood stork DPS has recovered and the threats to it are being adequately managed such that the DPS no longer meets the definition of an endangered species or threatened species under the Endangered Species Act of 1973, as amended (Act). If we finalize this rule as proposed, the prohibitions and conservation measures provided by the Act, particularly through section 7, and our regulations would no longer apply to the wood stork DPS. We are seeking information