

E. Executive Order 13132 (Federalism)

This action does not have federalism implications. It will not have substantial direct effects on the states, on the relationship between the National Government and the states, or on the distribution of power and responsibilities among the various levels of government.

F. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This action does not have tribal implications as specified in Executive Order 13175. Thus, Executive Order 13175 does not apply to this action.

G. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

The EPA interprets Executive Order 13045 as applying only to those regulatory actions that concern environmental health or safety risks that the EPA has reason to believe may disproportionately affect children, per the definition of “covered regulatory action” in section 2–202 of the Executive order. This action is not subject to Executive Order 13045 because it does not concern an environmental health risk or safety risk.

H. Executive Order 13211: Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use

This action is not subject to Executive Order 13211, because it is not a significant regulatory action under Executive Order 12866.

I. National Technology Transfer and Advancement Act

This rulemaking does not involve technical standards.

J. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

The EPA believes that this action does not have disproportionately high and adverse human health or environmental effects on minority populations, low-income populations and/or indigenous peoples, as specified in Executive Order 12898 (59 FR 7629, February 16, 1994).

K. The Congressional Review Act

This rule is exempt from the Congressional Review Act (CRA) because it is a rule of agency organization, procedure or practice that does not substantially affect the rights or obligations of non-agency parties.

List of Subjects in 40 CFR Part 16

Environmental protection, Administrative practice and procedure, Confidential business information, Government employees, Privacy.

Kimberly Y. Patrick,

Principal Deputy Assistant Administrator, Office of Mission Support.

For the reasons stated in the preamble, title 40, chapter I, part 16 of the Code of Federal Regulations is amended as follows:

PART 16—IMPLEMENTATION OF PRIVACY ACT OF 1974

■ 1. The authority citation for part 16 continues to read as follows:

Authority: 5 U.S.C. 301, 552a (as revised).

■ 2. Amend § 16.12 by:

■ a. Revising paragraphs (a)(1), (a)(4)(i) and (iii), (a)(5) introductory text, and (b)(1);

■ b. Adding paragraph (b)(4)(iii); and

■ c. Revising paragraph (b)(5) introductory text.

The revisions and additions read as follows:

§ 16.12 Specific exemptions.

(a) * * *

(1) *Systems of records affected.* (i) EPA–17 Online Criminal Enforcement Activities Network (OCEAN).

(ii) EPA–21 External Compliance Case Tracking System (EXCATS).

(iii) EPA–30 Inspector General Enterprise Management System (IGEMS) Hotline Module.

(iv) EPA–40 Inspector General Enterprise Management System (IGEMS) Investigative Module.

(v) EPA–63 eDiscovery Enterprise Tool Suite.

(vi) EPA–79 NEIC Master Tracking System.

(vii) EPA–83 Personnel Security System (PSS) 2.0.

* * * * *

(4) * * *

(i) EPA systems of records 17, 30, 40, 63, and 79 are exempted from the following provisions of the PA, subject to the limitations set forth in 5 U.S.C. 552a(k)(2): 5 U.S.C. 552a(c)(3); (d); (e)(1), (4)(G) and (4)(H); and (f)(2) through (5). EPA system of records 21 is exempt from the following provisions of the PA, subject to limitations set forth in 5 U.S.C. 552a(k)(2): 5 U.S.C. 552a(c)(3), (d), and (e)(1). EPA system of records 83 is exempt from the following provisions of the PA, subject to the limitations set forth in 5 U.S.C. 552a(k)(2): 5 U.S.C. 552a(d); (e)(1); (e)(4)(G), (4)(H) and (4)(I); and (f)(2) through (5).

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(iii) EPA–83 Personnel Security System (PSS) 2.0 is exempted under 5 U.S.C. 552a(k)(2).

(5) *Reasons for exemption.* EPA systems of records 17, 21, 30, 40, 63, 79, and 83 are exempted from the provisions of the PA in paragraph (a)(4) of this section for the following reasons:

* * * * *

(b) * * *

(1) *Systems of records affected.* (i) EPA 36 Research Grant, Cooperative Agreement, and Fellowship Application Files.

(ii) EPA 40 Inspector General’s Operation and Reporting (IGOR) System Personnel Security Files.

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(4) * * *

(iii) EPA 83 is exempted from the following provisions of the PA, subject to the limitations of 5 U.S.C. 552(a)(k)(5): 5 U.S.C. 552a(d); (e)(1); (e)(4)(G), (4)(H) and (4)(I); and (f)(2) through (5).

(5) *Reasons for exemption.* EPA 36, 40, 83, and 100 are exempted from the above provisions of the PA for the following reasons:

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[FR Doc. 2023–24669 Filed 11–16–23; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 424 and 455

[CMS–6084–F]

RIN 0938–AU90

Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities; Medicare Providers’ and Suppliers’ Disclosure of Private Equity Companies and Real Estate Investment Trusts

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

ACTION: Final rule.

SUMMARY: This final rule will 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. It will also finalize definitions of private equity company and real estate investment trust for Medicare provider enrollment purposes.

DATES: These regulations are effective on January 16, 2024.

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

SUPPLEMENTARY INFORMATION:

I. Executive Summary and Background

A. Executive Summary

1. Background and 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 and occasionally referenced as “nursing facilities,” “nursing homes,” or simply “facilities” or “providers”).

In a proposed rule published in the **Federal Register** on February 15, 2023 titled “Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities” (88 FR 9820), we proposed to implement portions of section 1124(c) of the Act. As we explained in detail in the February 15, 2023 proposed rule, we are engaging in rulemaking that is required under section 1124(c) of the Act. Furthermore, we have recently received information regarding particular categories of nursing facility owners (including, but not limited to, private equity companies (PECs) and real estate investment trusts (REITs)) that has generated concerns about the quality of care that nursing facility residents receive. We stated that having sufficient data on these owners could help CMS better monitor and hold accountable their nursing facilities. We accordingly believed that implementing the data collection requirements in section 1124(c) of the Act (albeit with isolated exceptions) would assist us in achieving this aim.

We also proposed in the February 15, 2023 proposed rule to establish definitions of PEC and REIT in 42 CFR 424.502. The purpose was to assist SNFs in identifying on their Form CMS–855A enrollment applications (Medicare Enrollment Application—Institutional Providers; OMB Control No.: 0938–0685) which entities listed in Section 5

of said application are PECs or REITs.¹ In addition, in the Fiscal Year 2024 Inpatient Prospective Payment System Long-Term Care Hospital Prospective Payment System proposed rule that appeared in the May 1, 2023 **Federal Register** (88 FR 26658) (hereinafter referred to as the FY 2024 IPPS/LTCH PPS proposed rule), we proposed to apply the aforementioned PEC and REIT definitions to all providers and suppliers that complete the Form CMS–855A, not merely SNFs.²

2. Summary of the Major Finalized Provisions

There are three principal categories of provisions that we are finalizing in this rule.

a. Data To Be Reported

We are finalizing our proposals that nursing homes must disclose the following information to CMS or, for Medicaid nursing facilities, the applicable state Medicaid agency (hereafter occasionally referenced as “state” or “state agency”):

- Each member of the facility’s governing body, 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, we are finalizing our proposal that the SNF need not report the same data required under section 1124(c) of the Act more than once on the same application

¹ We proposed on December 15, 2022 to revise the Form CMS–855A application in a Paperwork Reduction Act submission (87 FR 76626) to require all owning and managing entities listed on any provider’s or supplier’s Form CMS–855A submission to disclose whether they are a PEC or a REIT.

² “Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership.”

submission. (States will have the option of adopting a similar policy with respect to the required Medicaid nursing facility data.) In general, this rule should be construed towards disclosure and, if in doubt about whether additional information should be released, SNFs should disclose it.

We will also make the information provided per section 1124(c) of the Act publicly available within 1 year as required under section 6101(b) of the Affordable Care Act.

b. Timing of Reporting

We are finalizing our proposal that the nursing facility must report the foregoing information upon initially enrolling in Medicare or Medicaid (which, for purposes of this requirement, includes changes of ownership under 42 CFR 489.18) and when revalidating their Medicare or Medicaid enrollment. Moreover, a Medicare SNF, once enrolled, must 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 must 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 the provider’s or supplier’s 5-year revalidation cycle. As finalized, CMS will accordingly reserve the right and indeed plans to conduct off-cycle revalidations of SNFs to collect the data required under section 1124(c) of the Act beginning when the revisions to the Form CMS–855A are finalized. .

c. Definitions

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

Concerning the PEC and REIT definitions we proposed in the February 15, 2023 and FY 2024 IPPS/LTCH PPS proposed rules, we are finalizing the PEC definition with one minor clarification, as discussed in section III. of this final rule. Due to concerns raised by commenters, we are not finalizing our proposed REIT definition. However, we are finalizing a definition of REIT that commenters recommended that: (1) we believe is more consistent with current federal law and industry practice; and (2) will still enable us to collect the information we need

regarding REIT ownership of nursing homes.

We are also finalizing without modification: (1) all other definitions we proposed in the February 15, 2023 proposed rule; and (2) our proposal in the FY 2024 IPPS/LTCH PPS proposed rule to apply the PEC and REIT definitions (though as modified in this final rule) to all providers and suppliers that complete the Form CMS–855A.

d. Effective Date

This final rule will become effective 60 days after the date it is published in the **Federal Register**. Yet Medicare SNFs will not have to disclose the data required under section 1124(c) of the Act until the Form CMS–855A is: (1) revised to collect this data; and (2) publicly available for use. For Medicaid nursing facilities, the required data will not need to be reported until the applicable state Medicaid agency has established means to collect it. CMS expects state Medicaid agencies to promptly: (1) establish such data collection mechanisms; and (2) begin requiring Medicaid nursing facilities to provide this data once these collection means are established.

3. Summary of Costs and Benefits

Sections IV. and V. of this final rule outline the impacts that our proposals will have on affected entities and beneficiaries. The principal impact will involve the disclosure of the required data by nursing facilities. As explained in section IV. of this final rule, we project a total annual information collection burden on Medicare and Medicaid nursing facilities in reporting this data of 26,974 hours at a cost of \$2,216,128.

We have determined that this final rule is not 3(f)(1) significant. See section IV. of this final rule for a detailed discussion.

B. Legislative and Regulatory Authority

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

- 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.

D. Publication of the Proposed Rules

We received approximately 75 timely pieces of correspondence in response to the February 15, 2023 proposed rule. We received approximately 10 timely pieces of correspondence in response to our PEC and REIT proposals in the FY 2024 IPPS/LTCH PPS proposed rule (88 FR 27190). This final rule will summarize and respond to all of these comments and address our finalized provisions stemming from both the February 15, 2023 proposed rule and our PEC and REIT proposals from the FY 2024 IPPS/LTCH PPS proposed rule.

II. Provisions of the February 15, 2023 and FY 2024 IPPS/LTCH PPS Proposed Rules

A. February 15, 2023 Proposed Rule

1. Background

a. 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 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. Section 1124(c)(5)(D) of the Act defines "organizational structure" as meaning, in the case of—

- 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;
- 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);
- A general partnership—The partners of the general partnership;
- 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;
- A trust—The trustees of the trust;
- An individual—Contact information for the individual; and
- Any other person or entity, such information as the Secretary determines appropriate.

2. Concerns About Nursing Facility Ownership

We initially 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 those proposed disclosure provisions in the subsequent final rule, published on August 8, 2011,³ however, 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. Yet 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 and we thus released a new proposed rule in February 2023. We addressed these concerns in detail in the proposed rule and restate them here.

As of 2021, roughly 70 percent of nursing homes were for-profit facilities; this includes those owned by PECs, which comprised approximately 11

percent of all nursing homes (although estimates vary).⁴ Reports have circulated that nursing facility quality has declined under private equity and similar owners. For example, 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%."⁵ A November 2021 analysis published in the *Journal of the American Medical Association* contained similar findings concerning PEC-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 PECs 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.⁶ 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.⁷ The previously mentioned concerns about nursing home ownership are not limited to PECs. Other types of private ownership, such as REITs, have generated similar concerns.⁸

⁴ Medicare Payment Advisory Commission, "Congressional Request: Private Equity and Medicare," June 2021. [jun21_ch3_medpac_report_to_congress_sec.pdf](#).

⁵ 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.

⁶ Robert Tyler Braun, Hye-Young Jung, Lawrence Casalino, et al., *JAMA Health Forum*, November 19, 2021.

⁷ *Ibid.*

⁸ Robert Tyler Braun et al., *The Role Of Real Estate Investment Trusts In Staffing US Nursing Homes*, Health Affairs, January 25, 2023, *The Role Of Real Estate Investment Trusts In Staffing US Nursing Homes | Health Affairs The Role Of Real Estate Investment Trusts In Staffing US Nursing Homes | Health Affairs*.

³ "Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012; Final Rule" (76 FR 48485).

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."⁹ 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."¹⁰

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" (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 included infection prevention and control, ensuring that the nursing home environment is free from accidents, and food safety.¹¹ 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 and 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.¹² The OIG added that such background checks can help protect long-term care beneficiaries.¹³

⁹ <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/>.

¹⁰ *Ibid.*

¹¹ GAO-22-105422, p. 1.

¹² OEI-07-20-00180, p. 1.

¹³ *Ibid.*

All of the foregoing emphasizes 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 PECs, REITs, or otherwise. We believe nursing homeowners 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 and the data publication under section 6101(b) of the Affordable Care Act will: (1) provide additional transparency that may assist CMS and other regulators in holding nursing facilities accountable; and (2) create increased competition between nursing homes to improve quality by allowing consumers to select facilities with better knowledge of their owners and operators.

3. Proposed Provisions

To this end, we proposed the following provisions in the February 15, 2023 proposed rule:

a. Medicare

(1) Update to § 424.516

We proposed to 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 (including off-cycle revalidation applications). 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 part 424 subpart P:

- Each member of the facility's governing body, 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 also proposed 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 help ensure 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. Some of this information is already captured on the Form CMS-855A application. To avoid duplicate reporting and thus ease the burden on SNFs, we proposed 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 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 section 1124(a) 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.

(2) Definitions

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

First, we proposed to define "additional disclosable party" consistent with 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) of the Act definition for nursing facilities. Accordingly, we proposed 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 proposed to define "organizational structure" as the term is defined in section 1124(c)(5)(D) of the Act.

Fourth, we have added data elements to the Form CMS-855A via which all providers and suppliers must identify whether an entity it has disclosed on its application is a PEC or a REIT. To assist stakeholders in understanding the meaning of these terms for provider enrollment purposes, we proposed to add definitions thereof to § 424.502. We proposed to define a PEC 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 proposed to 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 solicited comment on the propriety of our proposed definitions and welcomed any suggested revisions thereto; we particularly solicited comment on whether our proposed definition of PEC should include publicly traded PECs. We also welcomed public feedback regarding any other types of private ownership besides PECs and REITs about which CMS should consider collecting information from SNFs as part of the enrollment process.

b. Medicaid

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

In § 455.101, we proposed to add the same definitions of "additional disclosable party" and "organizational structure" that we proposed 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 proposed 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. Second, and similar to our proposed revision to the definition of "managing employee" in § 424.502, we proposed 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 proposed 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 proposed 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 proposed 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. Consistent with the general deference we have long afforded states regarding the operation of their Medicaid provider enrollment programs, we did not seek to overly restrict the logistical means by which states collect the information in question.

In a similar vein regarding state deference, we did not propose that states require nursing homes to report changes to their existing section 1124(c) information within certain timeframes. However, we did encourage states to establish such reporting requirements, including when the provider changes its ownership. Likewise, we suggested (but did not propose to require) that states collect data signifying whether a particular organization reported under section 1124(c) of the Act is a PEC 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 the Affordable Care Act, we outlined in the proposed rule our intention to make data reported per section 1124(c) of the Act publicly available within 1 year after the final rule is published in the **Federal Register**.

(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”) is beneficial for ensuring that the provider and its signatory fully understand the need to submit accurate data.

We expressed concern in the proposed rule 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 noted 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 did not propose to implement this provision but stated that we may pursue implementation via future rulemaking. Regardless, providers should submit accurate information, and we may take enforcement action if the information furnished is inaccurate.

(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 stated in the proposed rule that we needed additional time to examine this matter but would consider addressing section 1124(c)(2)(B) of the Act in future rulemaking.

B. FY 2024 IPPS/LTCH PPS Proposed Rule

In addition, in the FY IPPS/LTCH PPS proposed rule (88 FR 27190), we proposed to apply the aforementioned PEC and REIT definitions to all providers and suppliers that complete the Form CMS–855A, not merely SNFs.¹⁴ We explained therein that the reason for this proposal was to help us better understand the scope of PEC and REIT involvement in the health care field as a whole. In our view, limiting the collection of PEC and REIT data to SNFs would give us an incomplete picture of PEC and REIT impact on patient care.

We explained in the FY 2024 IPPS/LTCH PPS final rule (88 FR 59309) that we would address the comments we received on our proposal in the present final rule.

III. Analysis of and Responses to Public Comments and Final Provisions

As noted in section I.D. of this final rule, we received approximately 75 timely pieces of correspondence in response to the February 15, 2023 proposed rule. We received approximately 10 timely pieces of correspondence in response to our PEC and REIT proposals in the aforementioned FY 2024 IPPS/LTCH PPS proposed rule. This section summarizes and responds to all the public comments and addresses our finalized provisions stemming from the February 15, 2023 proposed rule and our PEC and REIT proposals from the FY 2024 IPPS/LTCH PPS proposed rule.

Although the comments and responses regarding the February 15, 2023 proposed rule are categorized by specific subject matter, we note that there is topical overlap between some of them; for instance, certain comments can fall within multiple subcategories. Readers are therefore encouraged to review all of the comments and responses following to ensure that their specific areas of interest are addressed.

A. Comments and Responses—February 15, 2023 Proposed Rule

1. General Comments

Comment: Numerous commenters supported our proposal to implement section 1124(c) of the Act and the

reporting requirements therein. They noted that nursing facilities are often owned by large corporations or investment funds with complex ownership structures that can be difficult to understand. Transparency in ownership, they stated, is necessary to: (1) provide accountability and oversight of these facilities; (2) identify potential risks and weaknesses in the facility’s operations, such as financial instability or inadequate staffing; and (3) help ensure that nursing facilities are operated with their patients’ best interests in mind.

Response: We appreciate the commenters’ support.

Comment: Several commenters believed the proposed rule lacked evidence of a direct connection between disclosure of the proposed information and nursing home quality of care. A commenter stated that some states already have similar disclosure requirements, but this data has neither predicted nor prevented instances of poor quality, which, the commenter stated, are infrequent. Another commenter questioned whether the significant effort they believed nursing homes will have to make to comply with the rule’s requirements will achieve CMS’ goal of providing the public with an understanding of nursing homes’ organizational relationships.

Response: We respectfully disagree with the commenters on several grounds.

First, section 1124(a)(1) of the Act required us to undertake this rulemaking consistent with section 6101 of the Affordable Care Act. We proposed the February 15, 2023 proposed rule in part to help satisfy this requirement.

Second, part of the challenge CMS faces in ensuring quality care at nursing homes is our lack of sufficient knowledge of all the parties associated with the nursing home’s ownership, operations, and management. Without a complete understanding of the full scope of the facility’s operations and its relationship with other persons and entities, it can be challenging to pinpoint the origin within the organization’s overall structure of any quality-of-care problems, as well as whether taxpayer funding is being appropriately spent on care. This, in turn, can hinder CMS’ ability to take remedial action as warranted and applicable. While we currently collect some ownership and management data per section 1124(a) of the Act, this data has proven insufficient to furnish the complete picture we need to detect nursing home care problems from an organizational standpoint.

Third, we agree that CMS in the proposed rule does not cite evidence beyond all possible doubt of a correlation between the section 1124(c) data and improved care. This is because we have not collected some of this data before. A principal motivation for this proposal is to accumulate more information to better understand the relationship between nursing facility ownership and management structures and quality of care.

Fourth, while the commenter contends that some states already collect similar data but that there is no proof it has positively impacted patient care, CMS will be obtaining and publishing this information on a national scale and not on a statewide basis. This will better enable CMS and stakeholders to view ownership trends, especially involving nationwide chains and organizations, to a truly robust degree and to gauge the impact on patient care. In other words, we believe a nationwide and uniform data collection could go further towards favorably affecting nursing home services than the more limited, piecemeal data submission that currently exists.

Fifth, we recognize that nursing facilities may incur some burden in accumulating and submitting the section 1124(c) data (see section IV. of this final rule for more information). As we have indicated, though, the importance of quality care and the potential saving of lives justifies additional burden on the part of the nursing facilities. It is imperative that beneficiaries and their families are aware of the persons and entities that own and operate nursing facilities so they can make the best decisions regarding care.

Comment: Commenters expressed concern about the increase in administrative burden and the allocation of resources that nursing facilities will need to fulfill these reporting requirements, particularly for multi-facility and multi-state organizations. A commenter cited, as an example, the requirement to report changes within 30 or 90 days, which the commenter stated could be frequently necessary and will require constant monitoring by dedicated staff. This commenter, as well as others, stated that assigning staff to address the proposed reporting requirements could: (1) inhibit the facility's ability to hire staff in other positions; and (2) negatively impact patients by taking personnel away from the provision of care. Another commenter contended that the proposed disclosure requirements far exceed what most other Medicare and Medicaid

enrolled healthcare organizations are currently required to report to CMS. Other commenters generally stated that some data (for instance, regarding additional disclosable parties (ADPs)) could be difficult to secure, in some cases due to confidentiality agreements.

Response: We again acknowledge the burden that nursing facilities may incur in complying with our proposal's requirements. Yet we also reiterate that, per section 1124(a) of the Act, nursing homes already furnish to CMS some of the information referenced in section 1124(c) of the Act via initial enrollments, revalidations, changes of ownership, and other changes to this information within 30 or 90 days (as applicable). This final rule would thus not increase the burden associated with disclosing such information. As for data elements not currently collected, and as a prior commenter noted, some states may presently require the disclosure of some of this information, meaning that: (1) the affected nursing homes may currently maintain this data for Medicaid reporting purposes; and (2) these facilities would not incur additional reporting burden under this final rule. In fact, some facilities not in these states may nonetheless have this information on hand as part of their normal business operations. We accordingly believe—and based partly on our longstanding experience in requiring section 1124(a) data submission—that the reporting burden on nursing homes may be less than the commenters surmise. We note further that while some section 1124(a) information, per provider feedback over the years, can be challenging to secure, providers have generally been able to obtain and report it. We are similarly confident that SNFs will be able to obtain section 1124(c) data that is not currently required to be disclosed.

Comment: A commenter stated that our provisions will lead to the submission of vague and inaccurate data from various categories of investors. This will undermine CMS' goal of collecting clear and useful information regarding parties that exercise operational, financial, or managerial control (OFMC) over nursing facilities.

Response: We respectfully disagree. We believe the data reporting standards in the rule are clear as articulated. However, to avoid provider uncertainty and to facilitate the clarity of the furnished data, we will: (1) ensure that the data elements to be reported are specifically identified and labeled on the Form CMS-855A; and (2) issue sub-regulatory guidance and perform outreach to the nursing home community regarding our data

submission expectations. Moreover, we will verify this data as fully as possible for correctness.

2. Revalidation

Comment: A commenter requested that CMS give nursing facilities at least 90 days' advance notice if CMS intends to perform an off-cycle revalidation of their enrollment.

Response: We typically do not furnish advance notice of our intent to perform an off-cycle revalidation beyond the standard notification letter sent to the provider requesting its submission of a revalidation application within 60 days of the date of the letter. We believe 60 days is sufficient time for a provider to submit the required revalidation information.

Comment: Several commenters stated that CMS should require Medicare and Medicaid nursing facilities to report the section 1124(c) data on an annual basis, rather than upon revalidation every 5 years. A commenter stated, as an example, that a PEC that controls a nursing home might make substantial changes to the facility's staffing, patient care, and asset/debt ratio during its period of control that could harm patients; requiring annual disclosures of PEC data would allow CMS to have up-to-date information on such owners.

Response: Though we appreciate this suggestion, we are concerned about the burden on nursing homes of what would amount to annual revalidations of the section 1124(c) data as opposed to a 5-year schedule. No other data on the Form CMS-855 is subject to annual revalidations, and we do not believe we should establish an exception for certain types of information on the application. However, and as already mentioned, we reserve the right and plan to commence off-cycle revalidations of SNFs to secure the section 1124(c) data once the Form CMS 855A application is revised to collect it. Additionally, we will continue to enforce our longstanding policy, codified in 42 CFR 424.516, that requires providers to report any changes to their enrollment data (including, with this rule, the section 1124(c) information) within the timeframes specified therein.

Comment: Several commenters were concerned that currently enrolled nursing homes might not need to furnish the section 1124(c) data for several years after the Form CMS-855A is revised. This is because the rule only requires full disclosure upon initial enrollment, a 42 CFR 489.18 change of ownership, or revalidation, none of which might apply to the facility for some time following the form's revision.

Response: We appreciate the commenters' concerns but emphasize again that CMS can perform off-cycle revalidations. Accordingly, once the Form CMS-855A application is revised to collect the section 1124(c) data, we plan to commence off-cycle revalidations of SNFs to obtain it.

3. Medicaid

Comment: A commenter recommended that the final rule outline specific requirements for state Medicaid programs to use in operationalizing the Medicaid disclosure provisions. The commenter believed this would: (1) minimize inconsistencies among states, particularly with respect to multi-state providers; and (2) enable CMS to monitor states' implementation of this rule.

Response: We previously noted that states have considerable flexibility when administering their Medicaid programs within a broad federal framework, and programs vary by state. While all states must comply with federal Medicaid and CHIP provider enrollment requirements, states have substantial discretion to establish: (1) additional provider enrollment requirements; and (2) their own operational procedures in implementing provider enrollment requirements. Consistent with this, we believe each state should have the ability (and is in the best position) to determine the most appropriate logistical means of implementing this final rule's provisions.

Comment: A commenter stated that to ensure standardized data reporting, CMS should: (1) require Medicaid nursing facilities to report the section 1124(c) data via the Provider Enrollment, Chain, and Ownership System (PECOS); (2) have states work with CMS to develop a common dataset that would enable analyses of all Medicare and Medicaid nursing facility ownership; and (3) build on existing processes to reduce reporting burden and make the data more useable.

Response: We appreciate this comment. We intend to work with the states regarding the coordination and publication of the submitted data. This includes ensuring that consistent, organized, and thorough information regarding Medicare and Medicaid nursing homes is published. However, we believe each state should, consistent with states' existing discretion regarding their enrollment processes, be able to determine their own means of collecting the section 1124(c) data. We do not believe the Medicare and Medicaid enrollment processes must be combined for purposes of section 1124(c) data

when they have remained largely separate for all other enrollment information; this includes not having Medicaid nursing homes report their section 1124(c) data via PECOS, to which Medicaid providers do not currently have access or utilize for Medicaid enrollment.

Comment: Noting the proposed rule stated that (per redesignated 42 CFR 455.104(f)) federal financial participation would be unavailable in payments for nursing facilities that do not report required ownership or control data, a commenter requested that CMS explain how this oversight will occur, including any enforcement authorities given to the Medicaid program.

Response: We routinely conduct oversight of Medicaid provider enrollment requirements, such as through various audits, reviews, and technical assistance efforts. In addition, states will continue to have responsibility for establishing their own oversight and enforcement mechanisms regarding the reporting of section 1124(c) data. If a state's non-compliance is identified, we would follow our normal processes related to the recovery of FFP associated with any identified overpayments.

Comment: Commenters stated that CMS should share section 1124(c) data gathered during Medicare enrollment with Medicaid agencies or otherwise align the disclosure processes.

Response: As noted previously, we plan to work with the states regarding the coordination and publication of the submitted data. States will also be required to submit to CMS the section 1124(c) data they receive. With respect to the collection of this information, though, states will utilize their own means for this purpose. Indeed, the Medicare and Medicaid programs and enrollment processes are separate and often collect different types and quantities of data.

Comment: A commenter suggested that CMS consider expanding Medicaid agencies' authority to require reporting on ownership structures to include other types of long-term services and entities, such as assisted-living facilities, adult day health programs, and senior living communities.

Response: States currently have the authority to collect ownership and control enrollment data above and beyond the minimum ownership and control information outlined in 42 CFR part 455. This includes, but is not limited to, obtaining section 1124(c)-type information from enrollment-eligible provider types other than nursing facilities (to the extent a state's

particular laws and regulations require or permit such collection).

Comment: A commenter stated that there are significant differences between the proposed Medicare and Medicaid definitions. The commenter, as well as others, stated that CMS should ensure in the final rule that: (1) the definitions are the same; and (2) the proposed PEC and REIT definitions are applied to Medicaid. Additional commenters also recommended that CMS require (and not merely encourage) states to collect PEC and REIT data from Medicaid nursing homes, with a commenter stating that the final rule should: (1) outline a timeframe within which states must begin collecting this data; and (2) describe how states should consider this information in assessing the provider's enrollment application. Other commenters stated that the proposed Medicaid disclosure regulations should mirror the proposed Medicare disclosure provisions in all aspects.

Response: We respectfully disagree that the Medicare and Medicaid definitions are materially different. The definitions of, for instance, organizational structure and ADP are similar and reflect the language of section 1124(c) of the Act. In fact, the preponderance of Medicare and Medicaid provisions we proposed are virtually identical. Any variations in definition language or data collection policies are largely attributable to differences in each program's unique terminology, the structure of their respective regulatory sections, and basic differences in program requirements. As we explained in the proposed rule, we wish to maintain the deference generally afforded to states in the operation of their Medicaid programs, including with respect to provider enrollment; this includes the timeframes by which they must implement section 1124(c) of the Act and how they assess this information in their enrollment determinations. It is for this reason that we did not propose to require states to, for example, collect PEC and REIT data, though we encouraged them in the proposed rule to do so and we reiterate this recommendation here. We also strongly encourage states to use the same definitions for PEC and REIT as finalized in this rule for the sake of consistent data collection.

Comment: Commenters stated that CMS should use the same reporting timeframes for Medicaid nursing homes that it proposed in the 2011 proposed rule. Specifically, they contended that Medicaid nursing facilities should furnish all the required disclosures upon enrollment, on an annual basis to be determined by the state, and within

30 days after any change to any of the previous disclosures.

Response: Consistent with our proposed provisions, Medicaid nursing homes will have to report the section 1124(c) data upon initial enrollment and revalidation. In terms of the latter, the revalidation periods are left to the states' discretion so long as revalidation is performed at least as frequently as prescribed in 42 CFR part 455. Hence, we are not requiring states to conduct annual revalidation of the section 1124(c) information. Likewise, the establishment of timeframes for reporting changes in Medicaid enrollment information (which would include the section 1124(c) data) is a matter within the states' purview.

4. Public Availability of Data

Comment: Many commenters urged CMS to furnish more specificity (preferably in the final rule) concerning: (1) when, where, how, and via which vehicle the section 1124(c) data will be publicly released; and (2) the exact data that will be included. They added that it was important that the information be published in full as soon as possible but no later than the 1-year deadline referenced in section 6101(b) of the Affordable Care Act.

Response: As we indicated in the proposed rule, we will issue sub-regulatory guidance regarding the publication of the section 1124(c) data. This guidance will outline the timing, content, and means of the data publication, as well as other related information. We agree with the commenters regarding the importance of publishing the section 1124(c) data as soon as possible, and we intend to do so within the aforementioned 1-year timeframe.

Comment: Many commenters recommended that CMS publish the section 1124(c) data: (1) on the Care Compare website, *cms.data.gov*, and/or other easily accessible and searchable/sortable website; (2) using plain language; and (3) to allow consumers to identify and examine quality ratings for multiple nursing facilities that may be owned or controlled by the same PEC. Several commenters more specifically urged CMS to make parent company and related party data for each nursing home available on its Care Compare website, including information indicating whether a facility is part of a chain. They added that the data must be organized to enable stakeholders to detect patterns in quality, ownership, management, etc.

Response: We appreciate these suggestions and will consider them as we develop our sub-regulatory guidance

and prepare to publish the section 1124(c) data. We concur with the commenters concerning the need to disseminate the section 1124(c) information in an easy-to-read-manner: (1) via an accessible, navigable, and searchable website that users can understand; and (2) in a manner that enables users to search for trends, relationships, and connections in nursing homes' ownership structures.

Comment: A commenter stated that CMS should make the section 1124(c) data publicly available using common identifiers (for example, CMS Certification Number (CCNs)) that are linked to existing CMS data, such as nursing facility quality measures, staffing rates, survey deficiencies, and nursing facility resident demographics.

Response: We appreciate these recommendations and agree that identifiers such as CCNs could help users locate nursing homes and their section 1124(c) information. Future sub-regulatory guidance will address whether (and, if applicable, the extent to which) the section 1124(c) data will link to other CMS information like nursing home quality measures or to cost reports.

Comment: Several commenters recommended that CMS post section 1124(c) information on the Care Compare website in lieu of publishing it only on *cms.data.gov*. A commenter stated that many nursing home residents and their families are unfamiliar with the *cms.data.gov* website and that said website can be challenging to use.

Response: We appreciate and will consider these comments as we prepare our sub-regulatory guidance and determine the best vehicle by which to publish the section 1124(c) data.

Comment: A commenter stated that CMS should make available for public review data regarding the facility's ownership, budgets, expenditures, and payments. The location of this data, the commenter added, should be furnished to residents and other interested parties, and the information should be provided on facility websites, Care Compare, and in admissions and marketing materials.

Response: Certain ownership data reported per section 1124(a), such as the names of SNF owners and their percentages of ownership, is already public via Care Compare. Additional ownership information under section 1124(c) of the Act will, as previously noted, be published publicly. Regarding budgets, expenditures, and payments, however, this information has never been collected as part of the enrollment process, we did not propose to do so in the proposed rule, and section 1124(c)

of the Act does not require its acquisition.

Comment: A commenter stated that Care Compare: (1) should include information from the data file on nursing home ownership posted to *data.cms.gov* in September 2022 and not simply a link thereto; and (2) must be made easily searchable by chain, common ownership and operators, and across multiple states given the significant number of for-profit nursing homes operated and/or owned by multi-state or national chains or private equity firms.

Response: We thank the commenter for their suggestions and will consider them as we prepare our sub-regulatory guidance and determine the best vehicle by which to publish the section 1124(c) information. We further appreciate the request that this information be provided on Care Compare and will consider publishing the section 1124(c) data via that vehicle. We will also ensure that the ownership data already in Care Compare is included in the section 1124(c) data release if we determine the best vehicle for the latter is something other than Care Compare.

Comment: Several commenters stated that the section 1124(c) data posting should include documentation verifying the accuracy of the facility's information submission.

Response: We will, as needed, request supporting documentation to validate the disclosed data. However, verification documentation that is submitted as part of the current enrollment process is generally not made public, and we do not intend to do so with the section 1124(c) data.

Comment: A commenter stated that CMS should incorporate into the final rule the current requirements on the Form CMS-855A that: (1) the provider submit an organizational diagram identifying all entities identified in Section 5 of the Form CMS-855A and their relationship with the provider and each other; and (2) nursing homes submit a chart identifying the organizational structures of all its owners. Additional commenters recommended that CMS publish all organizational diagrams submitted by providers.

Response: The requirement to submit these diagrams is consistent with our authority under 42 CFR 424.510(d)(2)(ii) to collect documentation that helps verify details regarding the provider's ownership (for example, whether a particular owner is direct or indirect). This is akin to other existing Form CMS-855A documentation submission requirements per § 424.510(d)(2)(ii), such as sales agreements, adverse legal

action documentation, and documentation verifying non-profit status, none of which are explicitly identified in 42 CFR part 424, subpart P. Since these and other documents are requested under our authority in § 424.510(d)(2)(ii), we deem it unnecessary to articulate all of them in regulation.

Concerning the publication of organizational diagrams, we previously noted that we presently publish certain ownership data submitted by providers on the enrollment application, some of which mirrors the information that providers furnish on the organizational charts. We will release, in a yet-to-be-determined manner and form, those portions of the SNF organizational charts containing data that must be published under section 1124(c).

Comment: A commenter stated that CMS should make available a public database that identifies and tracks entities that have common ownership of nursing homes or exercise managing control over them.

Response: We appreciate and will consider this comment as we prepare our sub-regulatory guidance and determine the best vehicle by which to publish the section 1124(c) information.

Comment: A commenter opposed our intention to publicly post section 1124(c) data because it would involve releasing the names of the nursing facility's employees. The commenter believed this could discourage persons from seeking employment with nursing facilities, hence harming the nursing facility industry.

Response: While we recognize the commenter's concern, we emphasize that section 6101(b) of the Affordable Care Act requires the public disclosure of the section 1124(c) data. We further note that not every employee of a nursing facility will have to be reported on the Form CMS-855A and, consequently, be included in the public data posting. Only those parties that must be disclosed under section 1124(c) of the Act will be part of said posting.

5. Timeframes for Reporting Changes of Information

Comment: Several commenters supported our proposal to require changes to the section 1124(c) data to be reported within, as applicable, 30 days or 90 days of the change.

Response: We appreciate the commenters' support.

Comment: A commenter recommended that CMS increase the reporting timeframe for changes in ADPs from within 90 days of the change to 120 days.

Response: We first reiterate that the timeframe for any such change in an ADP depends, as we proposed and consistent with existing § 424.516(e)(1) and (2), on whether it involves a change in ownership or control. If it does, the reporting period is within 30 days of the change; if it does not, the period is 90 days. Regardless, we do not believe the 90-day timeframe should be increased to 120 days. It is important that CMS receive updated enrollment data as soon as possible, and we consider 90 days to be an adequate amount of time for SNFs to report non-ownership/control changes to us. CMS will identify in future sub-regulatory guidance those changes in section 1124(c) data that qualify as ownership/control changes and those that do not.

Comment: Several commenters suggested timeframes for reporting changes in section 1124(c) data that are stricter than what we proposed. These included requiring: (1) any change in direct or indirect ownership of a parent company, parent organization, or ADP to be disclosed at least 30 days before the change takes effect; (2) all other changes to data concerning the parties referenced in (1) to be reported within 30 days of the change; and (3) any change in nursing home ownership or management to be reported at least 90 or 120 days prior to the change.

Response: We do not currently require changes in provider enrollment data to be reported before their occurrence because providers and suppliers often do not and cannot know when a change will happen. To illustrate, the voluntary or involuntary departure of a managing employee can be sudden, making prior notice thereof to CMS impossible. We thus believe that applying to section 1124(c) data our proposed timeframes of 30/90 days post-change is appropriate. As for the suggestion in (2) earlier, some of these changes could qualify as a change in ownership/control (for example, a change in managing employees) and thus have to be disclosed within 30 days consistent with the commenters' recommendation.

6. Certification and Accuracy of Data, Including Penalties for Non-Compliance

Comment: Several commenters supported our proposal that SNFs certify on the Form CMS-855A that the section 1124(c) data is "true, correct, and complete" without a "to the best of my knowledge" qualifier while we continue to review the potential operational implications of section 1124(c)(3)(A) of the Act.

Response: We appreciate the commenters' support.

Comment: Several commenters stated that the SNF's parent company's or sole owner's chief executive officer (CEO) (and not simply any representative of the nursing facility) should be required to certify (under penalty of perjury) the accuracy of all section 1124(c) disclosures. If the CEO is unavailable, a designee of the CEO who has full knowledge of the SNF's ownership should certify the information's accuracy.

Response: We have specific and strict regulatory requirements regarding who can sign the Form CMS-855A on behalf of a provider. To illustrate, an initial Form CMS-855A application must be signed by an authorized official. Existing § 424.502 defines an authorized official as an appointed official to whom the organization has granted the legal authority to enroll it in Medicare, to make changes or updates to the organization's Medicare status, and to commit the organization to fully abide by Medicare's statutes, regulations, and program instructions. Examples of such high-ranking persons, as outlined in the § 424.502 definition, include a chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner. Therefore, it is not as though any person, regardless of status, can serve as a provider's authorized official. Only those that meet the aforementioned definition may do so. This requirement helps ensure the correctness and thoroughness of the furnished data without a need to require the commenter's recommended signatories to sign the Form CMS-855A.

Comment: Several commenters suggested that, along with denial or revocation/termination of Medicare/Medicaid enrollment, CMS should consider imposing the following penalties should the nursing home fail to completely, truthfully, and accurately report the required section 1124(c) data: (1) withholding of payments; (2) assessment of a \$10,000 civil money penalty; (3) fines; and (4) immediate suspension, in whole or in part, of payments to providers that submit materially false information. Repeated failures should warrant increased sanctions. They and other commenters stated that any penalty must be significant enough to ensure compliance with the reporting requirements, though some commenters added that the sanction should be commensurate with the reporting failure in question (for example, material failures warrant more significant penalties) and/or proportional to the parent company's revenue. Additional commenters suggested criminal penalties for owners

and operators who knowingly submit false information.

Response: As the commenters noted, CMS has the authority to deny or revoke enrollment under §§ 424.530(a)(4) and 424.535(a)(4), respectively, if the provider certified as “true” misleading or false information on the enrollment application to enroll or maintain enrollment in Medicare. A provider that is denied enrollment on this basis is subject to a reapplication bar of up to 3 years per § 424.530(f),¹⁵ and a provider revoked under § 424.535(a)(4) is subject to (with certain exceptions) a maximum 10-year reenrollment bar under per § 424.535(c). We further state in §§ 424.530(a)(4) and 424.535(a)(4) that offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations. Moreover, we can, as applicable, deny, revoke, or deactivate enrollment (or reject an enrollment application) in certain instances where the provider does not submit complete information to us. We take very seriously the provider’s obligation to furnish full and accurate data, will do so with respect to the section 1124(c) information, and will stand ready to take the applicable administrative measures we have just outlined, including, as needed, referrals to law enforcement. We are confident that the mechanisms we presently possess to enforce compliance will help ensure the submission of correct and thorough data.

Comment: Several commenters suggested that CMS establish a “reward system” for finding and reporting errors in a facility’s disclosure of the section 1124(c) data. To illustrate, if an individual notifies CMS that a facility furnished inaccurate information and CMS confirms that the facility indeed did, the individual could be paid a modest fee (though without supplanting existing whistleblower laws).

Response: We appreciate this suggestion, though we believe there is no statutory authority for such a system as it relates to section 1124(c) information.

Comment: A number of commenters stated that CMS and the states should:

¹⁵ CMS recently finalized an expansion of the maximum reapplication bar to 10 years in a final rule placed on display at the **Federal Register** on November 1, 2023, titled Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements.”

(1) perform auditing to verify the accuracy of reported section 1124(c) data; (2) analyze this data alongside cost reports, staffing information, survey inspection results, and other relevant information; (3) use the section 1124(c) data in determining who can participate in Medicare and/or Medicaid and ensuring that high quality care is provided; and (4) explain in the final rule how the auditing process will work. They added that merely relying on the provider’s attestation (for example, the authorized official’s signature on the Form CMS–855A) that the submitted data are correct is insufficient to guarantee its accuracy and that actual verification is required.

Response: We validate submitted enrollment information notwithstanding the signing official’s attestation that it is accurate and complete, and we intend to take steps to verify the submitted section 1124(c) data, too. The specific means of validation will be clarified during the implementation process.

Comment: Commenters urged CMS to outline a definite timeframe for completing its revisions to the Form CMS–855A to capture the section 1124(c) data. They stressed the importance of collecting this data as soon as possible.

Response: Although we will furnish more information about the timing of our planned Form CMS–855A revisions after the final rule is published, we agree with the commenters regarding the importance of revising the application and collecting the section 1124(c) information as soon as feasible. This is indeed our aim.

8. Definitions/Terminology in Section 1124(c) of the Act

a. General Comment

Comment: Numerous commenters requested that CMS in the final rule: (1) add definitions of certain terms used in section 1124(c) of the Act, such as “financial control;” (2) include more specificity in some of the proposed definitions; and (3) expand the scope of several proposed definitions to include additional parties. Regarding the first two requests, commenters stated that nursing facilities need more clarification (via additional or revised definitions) to understand what data must be disclosed; without this clarification, CMS might receive superfluous and unnecessary information. Concerning the third request, commenters expressed concern that some of the proposed definitions (such as organizational structure) are too narrow and would not capture enough data to clarify a nursing

facility’s ownership, managerial, and operational structure.

Response: We appreciate these comments and note two things.

First, some of the more specific comments that follow identify various terms that commenters wish to see defined in the final rule. We believe the ordinary meanings of these terms are clear and that formal definitions are unnecessary. However, we will provide clear examples of their meaning, as well as factual situations that could fall within the scope of a particular term, via sub-regulatory guidance to ensure that all interested parties understand the new disclosure requirements. There are, of course, parties that would clearly fall within some of these definitions, such as a: (1) management company that runs the day-to-day operations of the SNF (managing control); and (2) an organization the SNF hires to manage all of its financial matters (financial control). Yet we believe that sub-regulatory guidance allows CMS to modify our planned sub-regulatory examples to provide greater specificity in response to stakeholder questions and feedback and to address the variety of factual scenarios that may arise. We stress further that the two examples cited previously should not be construed as establishing a minimum reporting threshold of control and influence; the first example, for instance, is not meant to imply that any entity with less managing control over the SNF need not be disclosed under section 1124(c) or (a) of the Act.

Second, and regarding revisions of (and expansions to) some of our proposed definitions, we are generally satisfied with these definitions’ scope and clarity. Although we are finalizing two modifications to these definitions, most of the commenters’ recommended revisions involve changes that would collect data well beyond the scope of what we proposed. Nonetheless, we will keep these comments in mind and, if we determine in the future that collecting some of this additional data is appropriate, we will take appropriate steps.

b. Additional Disclosable Party

Comment: A commenter recommended that CMS amend its proposed definition of ADP to clarify that a party can have OFMC of a nursing facility regardless of whether it has an ownership interest.

Response: We agree that a party can have OFMC without having an ownership interest. Indeed, this has long been our position with respect to our section 1124(a) reporting requirements. While we believe this

interpretation is clear based on the statutory language and thus the ADP definition need not be revised, we will restate this point in our forthcoming sub-regulatory guidance.

Comment: Commenters suggested additions to the ADP definition to ensure that CMS has a full understanding of the nursing facility's ownership and managerial structure. The first addition would include any party with an ownership or control interest (as that term is defined in 42 CFR 420.201) in the nursing facility. The second would include any party that directly or indirectly owns or controls an equity interest in the nursing facility, its business, its parent company or chain, or any other subsidiaries (including properties) that equals or exceeds 5 percent of the total outstanding equity interest of all equity owners in the nursing facility, its business, its parent company or chain, or other subsidiaries. This could include an individual or organization that receives or is entitled to receive (directly or indirectly) 5 percent or more of the profits or revenues of the nursing home, parent company, etc. The third would include any person or entity who: (1) exercises any level of OFMC over the facility or a part thereof; (2) provides any level of financial or cash management services to the facility; or (3) provides any level of management or administrative services, management or clinical consulting services, or accounting or financial services to the facility. The fourth would include all: (1) the nursing facility's parent organizations and related parties (as the term "related" is defined in 42 CFR 413.17(b)(1)), for purposes of cost reporting; and (2) the owners and related entities of the parties described in (1).

Response: We do not believe section 1124(c) of the Act gives the Secretary the authority to add persons and entities to the ADP definition in section 1124(c)(5)(A) of the Act. As previously noted, there is no provision in section 1124(c)(5)(A) of the Act akin to section 1124(c)(5)(D)(vii) of the Act regarding the organizational structure definition. Nonetheless, we believe much of the data the commenters reference will still be captured under our proposal and, in some cases, is collected today. For example, regarding the commenters' first recommended addition, CMS currently collects information on all parties with a 5 percent or greater direct or indirect ownership interest in a nursing facility. (Section 1124(a) of the Act has no minimum percentage threshold for reporting partnership interests.) In many instances, this

involves the disclosure of multiple layers of the facility's ownership. (As a further illustration, suppose the nursing facility is 100 percent owned by Entity W, which is 75 percent owned by Entity X, which is 90 percent owned by Entity Y, and which is 90 percent owned by Entity Z. Since all these owners—representing four layers of ownership—hold a 5 percent or greater direct or indirect ownership interest in the nursing home, they must be reported.) Concerning the third recommendation, these parties already fall within the proposed ADP definition and may include parent companies and other owners (for instance, the owning parent exercises managerial control over the facility).

As for the fourth suggestion, parties that are "related" to the nursing facility must be disclosed to the extent required under section 1124(a) or 1124(c) of the Act, though the organizational charts referenced on the Form CMS-855A application will also capture data regarding related entities.

Comment: A commenter expressed concern that it could prove difficult for nursing facilities to obtain and furnish data on ADPs and the relationships between them. The commenter stated that the facility may not know or be able to ascertain the organizational structures of all ADPs (for example, consulting or professional services firms) and related parties. The commenter requested that CMS: (1) outline the efforts that facilities must make to secure ADP data; (2) explain how the facility would demonstrate such efforts; and (3) state that facilities will not be held accountable for failing to disclose data it could not reasonably be expected to secure.

Response: We previously acknowledged that securing data regarding owning or managing organizations can prove challenging. Yet we have found with respect to section 1124(a) data that nursing facilities have typically been able to obtain it and to also furnish the required organizational charts. We believe this will also be true with section 1124(c) data, such as ADP information. Given the importance of the section 1124(c) data, we do not believe any exemptions to its reporting, such as the commenter suggests, should be granted. The information must be disclosed without exception, and this will be demonstrated via the submission of full, complete, and accurate data. Our position is that if a nursing facility wishes to receive Medicare or Medicaid payment, it must comply with all requirements for doing so, one of which is the disclosure of the information in question.

Comment: Regarding the disclosure of parties that furnish the services outlined in the ADP definition (for example, consulting, financial), a commenter questioned whether this would include, for instance: (1) all corporate office staff who support individual facilities within a multi-site organization; (2) an external nurse consultant who offers brief assistance with preparing a plan of correction following an annual nursing home survey but otherwise does not provide services to the facility; (3) all staff who work in the billing department; (4) a nursing staff member who supervises one unit within the facility (since the ADP definition references "part(s)" of a facility); (5) unaffiliated, independent auditors; and (6) an independent, unaffiliated organization that provides template policies and procedures. The commenter believed that disclosing this sixth party would seem unnecessary, since nursing home leadership must separately tailor, adopt, and implement those policies.

Response: We believe the ADP definition is clear on its face. However, CMS' forthcoming sub-regulatory guidance will include examples (some of which may mirror those the commenter presents) to help nursing facilities understand which ADP data must be reported.

Comment: Several commenters requested greater specificity as to the exact types of services that fall within the categories of management or administrative services, management or clinical consulting services, or accounting or financial services to the facility under section 1124(c)(5)(A)(iii) of the Act.

Response: Again, we believe the ordinary meanings of the terms used in the ADP definition, including those in section 1124(c)(5)(A)(iii) of the Act (for example, financial services), are clear. Our sub-regulatory guidance will nevertheless furnish examples of the types of services that can fall within these categories.

Comment: A commenter stated that management entities under the ADP definition should include any organization that is paid for furnishing management services (or is paid management fees) regardless of that organization's level of involvement in the facility's day-to-day operations.

Response: We concur with the commenter's statement. We note that the references to management in sections 1124(c)(5)(A)(i) and (iii) of the Act contain no minimum threshold regarding the level of management services or day-to-day involvement a party must furnish to qualify as an ADP.

Comment: A commenter stated that CMS should, for each ADP, require a detailed statement of the functions the ADP performs as part of any contract or other arrangement with the nursing facility; this could include, for example, identifying the specific type of administrative services performed, such as payroll, accounting services, or insurance billing.

Response: We appreciate this recommendation. We agree that the facility must identify the types of services, control, etc., the ADP provides to or has over the nursing facility so that CMS can evaluate compliance with the statutory and regulatory requirements. This will also enable CMS to better understand the ADP's precise relationship to the nursing home. We will keep this comment in mind when considering revisions to the Form CMS-855A.

Comment: A commenter recommended that nursing homes submit an explanation of how each ADP is related to it (for example, shared ownership, familial relationship, officer/director). This explanation, the commenter added, should list all persons who are employed or paid a salary by each ADP. It should also identify whether any entity involved in leasing, subleasing, or owning the property (including any direct or indirect property owners) is a REIT or affiliated with a REIT; this should include the REIT's identity and a description of the arrangement/agreement between the nursing facility and its REIT landlord.

Response: For reasons similar to those in our previous response, we concur that each ADP should identify on the Form CMS-855A its relationship with the facility, which could include lease and sub-lease arrangements. Yet we do not believe a list of all the ADP's employees and paid personnel is warranted for several reasons. First, section 1124(c) does not contemplate the collection of all such persons. Second, some ADPs may have thousands of employees. Reporting all of them could pose an undue burden on the nursing facility, particularly since some persons might, for instance, have no involvement with the ADP's contractual relationship with the facility. Insofar as the commenter's recommendations regarding REITs, and for each entity disclosed under section 1124(a) or (c) of the Act, the nursing facility will have to identify whether that organization is a REIT. Furthermore, and as already noted, Medicare nursing facilities are currently required per the Form CMS-855A to furnish: (1) a diagram identifying the

organizational structures of all its owners, which can include REITs; and (2) an organizational chart identifying all entities listed in Section 5 of the Form CMS-855A (including REITs) and their relationships with the provider and with each other. We believe our current and proposed disclosure requirements will encompass much of the data the commenter suggested that we collect.

Comment: A commenter urged CMS to clarify the proposed ADP definition. Without this elucidation, the commenter believed that facilities will interpret the definition too broadly, resulting in the disclosure of persons (for example, consultants that do not own, control or manage the facility's operations) who need not have been reported.

Response: We reiterate our view that the ADP definition is clear. Yet we will ensure our forthcoming sub-regulatory guidance furnishes examples regarding the ADP definition to help nursing homes understand the scope of the reporting requirements.

Comment: A commenter recommended that PECs and REITs be included as ADPs.

Response: Although, as stated, we do not believe section 1124(c) of the Act permits us to add parties to the ADP definition, we believe that some PECs and REITs will fall within one of the ADP categories in section 1124(c) of the Act regardless. A REIT might qualify as an ADP by, for example, exercising financial control over the nursing facility, leasing or subleasing real property thereto, or owning at least 5 percent of said real property. PECs, meanwhile, could meet the ADP definition by having operational, managerial, or financial control over the nursing home. Even if the PEC or REIT does not qualify as an ADP, it would have to be identified as a PEC or REIT per our Form CMS-855A revisions if the organization must otherwise be reported under section 1124(a) or (c) of the Act. Consequently, considerable information about owning, managing, and leasing PECs and REITs will be reported irrespective of whether these entities are explicitly referenced in the ADP definition.

c. Managing Employee

Comment: Several commenters recommended that CMS specifically include medical directors within the definition of managing employee. A commenter further suggested that the definition include persons, such as consultants, who influence the finances and operations of a facility but may not be permanent staff; the commenter

believed this would recognize the involvement of private-equity-backed management services companies in health care.

Response: In the Calendar Year 2024 Home Health Prospective Payment System final rule, which was published in the **Federal Register** on November 13, 2023 (88 FR 77676), we revised our current managing employee definition in § 424.502 to explicitly include SNF and hospice medical directors and administrators.¹⁶ Specifically, we added the following language to the end of the current managing employee definition: For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director. We believe this change will make clear that SNF medical directors are managing employees, a stance we have held for many years.

We note that our February 15, 2023, proposed change to this definition did not include the previously noted language. With the finalization of the managing employee definitions in both the November 1, 2023, final rule and the present nursing home disclosure final rule, paragraph (1) of the managing employee definition will incorporate the definition we finalized in the November 1, 2023, final rule. Paragraph (2) will include the second paragraph of the definition we are finalizing in this final rule.

Concerning the remaining comment, it is unnecessary for someone to be an employee or permanent staff member to qualify as a managing employee. This is consistent with our existing managing employee definition in § 424.502, which states that a person can be a managing employee "whether or not the individual is a W-2 employee of the provider or supplier."

Comment: A commenter stated that the facility's medical director should not be identified as management when the nursing home data is published.

Response: We respectfully disagree. As already mentioned, we have long taken the stance that SNF medical directors qualify as managing employees. Each medical director will hence be designated as such when we publish the section 1124(c) data.

¹⁶ Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements.

d. Operational, Financial, or Managerial Control (OFMC)

Comment: A commenter recommended that CMS in the final rule discuss and clearly define (with accompanying examples) a party that exercises OFMC over the facility or a part thereof.

Response: We did not propose to define “operational, financial, or managerial control” because we believe the ordinary meanings of these terms are clear. Nevertheless, we plan to outline examples of possible OFMC in our sub-regulatory guidance and will, as needed, consider proposing an OFMC definition in future rulemaking.

Comment: A commenter stated that the definition of “managerial control” should include any entity that: (1) receives and approves facility budgets; or (2) approves or has the right to approve any nursing home operational expenditure. Several other commenters suggested defining managerial control as having the power (directly or indirectly) to influence or direct the day-to-day operation of an institution, organization, or agency, either under contract or through some other arrangement. This would include any party that is a related organization under § 413.17.

Response: We believe the meaning of “managerial control” is plain. As already noted, however, we intend to provide examples in sub-regulatory guidance to help ensure that nursing homes understand these reporting requirements.

Comment: A commenter suggested that CMS define “control” as the ability to direct the operation or management of the nursing facility, including through intermediary or subsidiary entities. Another commenter recommended defining “control” as direct or indirect exercise of substantial control. Substantial control, according to the commenter, would involve: (1) board representation; (2) ownership or control of a majority of the voting power or voting rights of the reporting company; (3) rights associated with any financing arrangement or interest in a company; (4) control over one or more intermediary entities that separately or collectively exercise substantial control over a reporting company; (5) arrangements or financial or business relationships (whether formal or informal) with other individuals or entities acting as nominees; or (6) any other contract, arrangement, understanding, or relationship. Another commenter suggested defining control consistent with the same definition of the term in § 413.17. It could include, the commenter stated, language from the

Medicare Provider Reimbursement Manual stating that the § 413.17 definition includes “any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised; it is the reality of the control which is decisive, not its form or the mode of its exercise.” An additional commenter stated that CMS should explicitly state that control includes chain or parent company activity.

Response: We appreciate these suggestions but believe the meaning of “control” is clear.

Comment: Several commenters sought clarification of the meaning of “or a part thereof” (cited in section 1124(c)(5)(A)(i) of the Act) in the context of OFMC over the facility.

Response: We believe the meaning of “or a part thereof” is clear. Nonetheless, we will provide examples of the term “part” in our sub-regulatory guidance to assist nursing homes in reporting the section 1124(c) data.

Comment: Several commenters recommended that CMS define “operational control” (with minor variations among the commenters’ suggested definitions) as an individual or entity that has the power (directly or indirectly) to: (1) to influence or direct the actions or policies of any part of either the nursing facility or any ADP; or (2) choose, appoint, or terminate: (i) any member of the board of directors or management committee; (ii) any manager or managing member; (iii) any member of senior management of the nursing facility or its business, including its chain or parent company; or (iv) any other person or entity that participates in the operational or financial oversight of the facility or its business. Another commenter stated that operational control should include parties that guide the overall operation of the nursing home, including setting policies and budgets.

Response: Our sub-regulatory guidance will include examples of potential operational control, though we believe the term’s meaning is plain. Yet we note that section 1124(c)(5)(A)(i) of the Act only references OFMC over the facility itself or a part thereof. It does not include OFMC over the facility’s parent or another ADP. Hence, our sub-regulatory examples will address OFMC over the facility rather than over other organizations.

Comment: Additional commenters recommended that CMS define “financial control” as a party that directly or indirectly: (1) has the power to influence, direct, or manage the finances of the facility or an ADP; (2) receives or is entitled to receive 5 percent or more of any of the profits or

revenues of the facility, its business, or its properties during any time period; or (3) owns or controls an equity interest in the facility, its business, or its properties that is equal to or exceeds 5 percent of the total outstanding equity interest of all equity owners in the facility, its business, or its properties. Another commenter stated that the financial control concept should take into account complex ownership structures.

Response: We believe the phrase “financial control” is plain on its face, though our sub-regulatory guidance will furnish examples so that nursing homes understand the reporting requirements.

e. Ownership Interests

Comment: Several commenters expressed concern about limiting the ownership interest for financial control to 5 percent, with a commenter stating that the 5 percent threshold inaccurately reflects the complex ways that certain owners (including PECs) operate and hide connections to other entities and individuals. Commenters suggested that: (1) 5 percent ownership be an aggregate across all nursing homes in which a party holds an interest (and not simply a 5 percent interest in a single facility); or (2) change the 5 percent standard to any ownership interest regardless of the percentage involved. A commenter stated that the first suggestion regarding aggregation would prevent individuals from avoiding disclosure by holding several investments in nursing homes slightly below the percentage threshold. Another commenter stated that CMS should at least acknowledge that ownership interests can be shielded from disclosure by having the interest be, for example, 4.9 percent.

Response: Section 1124(a) of the Act requires disclosure of the provider’s 5 percent or greater direct or indirect owners (excluding partnerships, which have no minimum threshold). Too, sections 1124(c)(5)(A)(ii) and (c)(5)(D)(i) of the Act, which discuss ADPs, explicitly reference a 5 percent standard. Although, under sections 1124(c)(5)(D)(ii) and (iii) of the Act, general partnership and limited liability company ownership interests have no minimum percentage for disclosure, limited partnerships have a 10 percent threshold. There are, accordingly, clear parameters in section 1124 of the Act regarding the reporting of certain types of ownership interests. While we recognize the commenters’ concerns about potential circumvention of the aforementioned 5-percent limit, we do not believe we have the statutory authority to: (1) collect ownership interests below the current specified

thresholds; and (2) interpret the 5 percent threshold as meaning ownership interests across multiple providers that together total 5 percent. To illustrate the latter situation in the context of section 1124(a) of the Act, suppose Entity W has a 2 percent ownership interest in Provider X, 2 percent in Provider Y, and 2 percent in Provider Z. (None of the entities are partnerships.) The 5 percent standard applies to an ownership interest in a single provider, not a combined 5 percent across several providers. In our example, therefore, since Entity W does not own at least 5 percent of X, Y, or Z, Entity W need not be reported as an owner on X's, Y's, or Z's enrollment application.

Comment: A commenter stated that CMS should adopt a broad definition of "ownership interest" so that facilities cannot use shell companies, affiliates, and financial instruments to evade reporting requirements.

Response: As explained previously, many of the entities the commenter references must already be reported per section 1124(a) of the Act; this includes indirect owners of at least 5 percent of the provider, such as holding companies. We also noted the organizational charts that must be furnished which identify, for instance, some of the provider's affiliates and the relationships between them.

Comment: A commenter recommended that CMS define "ownership interest" such that it includes, for instance, equity, stock, preorganization certificates, voting trust certificates, certificates of deposit for an equity security, interest in a joint venture, any capital or profit interest in an entity, or any other instrument, contract, arrangement, understanding, relationship, or mechanism used to establish ownership.

Response: Section 420.201 currently defines an "ownership interest" as "possession of equity in the capital, the stock, or the profits of the disclosing entity." (The term "disclosing entity" includes providers and suppliers per § 420.201.) We believe this definition broadly captures many of the matters the commenter cites.

Comment: Several commenters recommended that CMS insert "direct or indirect" before the word "ownership" in paragraph (1) (which addresses corporations) of the proposed ownership structure definition in §§ 424.502 and 455.101. Other commenters stated that this paragraph (1) should also clarify that a corporation can be owned by another corporation.

Response: While we did not include "direct or indirect" in paragraph (1), our

longstanding definition of owner in § 424.502 references direct and indirect owners. This is consistent with section 1124(a)'s requirement that all 5 percent or greater direct or indirect owners be disclosed. We interpret the "ownership" reference in paragraph (1) in the same manner and do not believe the regulatory text needs to be updated in the final rule to reflect this. Concerning corporate ownership, we often see providers and suppliers that are corporations under the ownership of other corporations.

Comment: A commenter recommended that CMS limit the meaning of "ownership interest" to those parties that can remove or replace a general partner or managing member without cause. The commenter believed this modification would better reflect an owner's actual level of influence and be consistent with the definition of "voting security" in 15 U.S.C. 80a-2(a)(42).

Response: We believe the commenter is referencing ownership in the context of disclosure thereof (for instance, under section 1124(a) or (c) of the Act) rather than the "ownership interest" definition in § 420.201. To this extent, we respectfully disagree with the commenter. There is no reporting exception in section 1124(a) or (c) of the Act for owners that otherwise meet the requirements for disclosure but do not have the type of authority or influence the commenter cites. Indeed, if we were to limit ownership disclosures only to those parties with such influence, many indirect owners, including holding companies, might not be reported. This would be contrary to both the statute and our need to have as full a picture as possible of a provider's or supplier's ownership structure.

Comment: A commenter stated that CMS should not require nursing facilities to disclose indirect owners because such parties generally lack the ability to control and operate a nursing facility.

Response: We respectfully disagree. Again, section 1124(a) of the Act is clear that persons and entities with at least a 5 percent direct or indirect ownership in the nursing facility must be disclosed. Capturing indirect ownership data also helps CMS understand the scope of the provider's organizational framework.

f. Organizational Structure

Comment: Several commenters recommended that the term "trust" in the organizational structure definition: (1) require identification of the trustees and beneficiaries of the trust; and (2) specifically reference REITs.

Response: Section 1124(c)(5)(D)(v) of the Act includes the trust's trustees within the definition of organizational structure. However, beneficiaries are not included. Although section 1124(c)(5)(D)(vii) of the Act permits the Secretary to include within the organizational structure definition any other person or entity as deemed appropriate, the addition of trust beneficiaries would require rulemaking. We may consider the commenters' suggestions regarding the term "trust" (including that pertaining to REITs) for future rulemaking.

Comment: A commenter stated that our proposed definition of organizational structure (which mirrors that in section 1124(c)(5)(D) of the Act) is overbroad and should be restricted to ease the burden on disclosing facilities. In this vein, the commenter stated that a minimum 25 percent ownership threshold for reporting should apply to interests in limited partnerships and limited liability companies. The commenter contended that this modification, besides reducing burden, would clarify that certain owners do not have managerial or decision-making authority over the business.

Response: We respectfully disagree with the commenter on several grounds. First, section 1124(c) of the Act clearly outlines the interests and parties that fall within the definition of organizational structure. While, as mentioned, the Secretary has the authority under section 1124(c)(5)(vii) of the Act to add persons and entities to the scope of this definition, there is no authority in section 1124(c) of the Act to restrict the definition, such as by applying a higher threshold percentage (for example, 25 percent) for reporting ownership interests. Second, and as already noted, it is critical that CMS obtain as much background as possible about the nursing facility's ownership structure, even if certain owners may not exercise day-to-day control over the provider. Only in this manner can we truly ascertain the scope of parties that own and operate the nursing facility.

Comment: Several commenters stated that the organizational structure definition should include the following phrase from section 1124(c)(5)(D)(vii) of the Act: "any other person or entity, such information as the Secretary determines appropriate." The commenters believed this would give CMS the authority to require additional parties and interests to be disclosed.

Response: The quoted language in section 1124(c)(5)(D)(vii) of the Act, as already mentioned, gives the Secretary the authority to include additional parties and interests within the

organizational structure definition. We do not need to include this language within our proposed organizational structure definition to retain such authority. However, any addition of parties and interests to this definition would require future rulemaking.

Comment: Several commenters suggested that the proposed organizational structure definition in § 424.502 include the following categories, which would be codified respectively as paragraphs (7), (8), and (9) within the definition: (i) a financial investment entity (including a private equity investment company) and any partner, limited partner, or investor that has a 5 percent or greater ownership or equity interest in the entity; (ii) if an ADP does not meet any of the definitions contained in paragraphs (1) through (7), the name and contact information of the person or entity and any other information the Secretary determines appropriate; or (iii) if an entity listed in sections (1) through (8) is not the parent organization, the corresponding organizational structure for all direct or indirect owners of that entity back to the parent organization of the initial disclosing entity.

Response: We appreciate these suggestions and may consider them for future rulemaking.

Comment: A commenter recommended that the organizational structure definition include investment firms (such as private equity firms or funds) and any partner or limited partner with an ownership interest in the firm or fund that exceeds 5 percent.

Response: We appreciate this suggestion and may consider it for future rulemaking. We note that with our previously referenced revision to the Form CMS-855A, the provider or supplier (including nursing homes) will have to disclose whether an entity reported in Section 5 (or its successor or supplementary section) of the application is a PEC or REIT. With this, some of the entities to which the commenter refers will ultimately be disclosed irrespective of whether we pursue the rulemaking the commenter recommends.

Comment: A commenter stated that CMS should strike the proposed language “with respect to a skilled nursing facility defined at section 1819(a) of the Act” from proposed § 424.516(g)(1). The commenter contended that this language: (1) is not in the original statute; and (2) appears to apply the organizational structure definition only to nursing facilities and not to all ADPs, which would defeat section 1124(c)’s purpose.

Response: We respectfully disagree. The language the commenter cites is referenced in section 1124(c)(5)(B) of the Act, which defines a facility as a skilled nursing facility “as defined in section 1819(a)” or a nursing facility “as defined in section 1919(a).” To clarify which types of facilities are the subject of our provisions—specifically, SNFs and nursing facilities—we believe that referencing the applicable statutory provisions is necessary. In other words, the language in the opening of our proposed organizational structure definition that reads “Organizational structure means, with respect to a skilled nursing facility defined at section 1819(a)” simply confirms that the definition applies to SNFs as opposed to, for example, a hospital or home health agency. Moreover, the reference to section 1819(a) of the Act does not restrict the proposed reporting requirements in any way. The organizational structure of each ADP will still have to be reported per § 424.516(g)(1)(iv).

Comment: A commenter suggested including non-profit entities within the organizational structure definition.

Response: The business types described in this definition include all for-profit and non-profit entities. Section 1124(c)(5)(D) of the Act makes no distinction between the two and contains no exemption for non-profit entities. We have long interpreted section 1124(a) of the Act in a similar manner when requiring the disclosures mentioned therein. We hence do not believe a specific addition of non-profit entities to the organizational structure definition is needed because, in our view, said definition already includes such organizations.

g. Additional Suggested Definitions and Disclosures (Excluding PECs and REITs)

Comment: Several commenters recommended that CMS require the nursing facility to report its status as a “chain provider” in any nursing home chain. For this purpose, some commenters suggested utilizing the definition of “chain provider” in § 421.404(a). Others recommended defining “chain” consistent with this term’s definition in the Medicare Provider Reimbursement Manual; specifically, as a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or, through any other device, controlled by one organization. These latter commenters added that chain organizations: (1) should include, but not be limited to, chains operated by proprietary, religious, charitable, or

governmental organizations; and (2) may include business organizations engaged in activities not directly related to health care. Additional commenters recommended that if the nursing facility is part of a chain, CMS should require the disclosure of the names and identifying information of: (1) all facilities within that chain; and (2) the parent organization. Too, commenters stated that the facility should include a detailed explanation of its relationship to the chain (wholly owned, managed, etc.) and to the other facilities in the chain. They further added that this explanation should address how the ownership is structured between the facility and the chain level, whether the provider is under contract to pay the chain (chain home office) any fees, revenues or profits, and what type of support (financial or otherwise) the chain provides the facility. The commenters believed that requiring all of this chain-related data would give CMS a clearer understanding of nursing home chain structures in a manner that existing Section 7 of the Form CMS-855A does not.

Response: Like all certified providers, a nursing home currently must disclose in Section 7 of the Form CMS-855A if they are part of a chain. If it is, it must disclose: (1) identifying information about the chain home office; (2) the chain home office administrator; (3) the chain home office’s business structure (for example, corporation, non-profit religious organization, government-owned); and (4) the chain home office’s affiliation to the nursing facility (for instance, owned, managed). Section 7 also specifically references the chain provider regulations in § 421.404. The aforementioned required organizational charts also help CMS ascertain the ownership structure between the provider and the chain. In sum, much of the chain data the commenters cite is already reported via the Form CMS-855A. To the extent information on nursing home chain data is collected under this rule and falls within the scope of data referenced in section 1124(c), it will be made publicly available.

CMS does not presently collect data in Section 7 regarding whether the provider is contractually obligated to pay the chain home office any fees, revenues, or profits, or what kind of financial or other support the chain provides the facility. We appreciate the commenters’ recommendation that we do so, however, and may consider them as future enhancements to the Form CMS-855A to the extent necessary.

Insofar as having individual facilities report reporting identifying data on all

other providers in the chain, this is not currently required. We are not seeking at this time to establish such a requirement, for some chains may have many entities. Asking each facility to report all of them could pose an excessive burden on each provider and lead to the submission of duplicative information. We note, though, that CMS assigns each chain a unique identifier known as a “chain home office number.” When each certified provider in the chain enrolls, it must report the chain data in Section 7, including the chain home office number. This allows PECOS to identify all enrolled providers within the chain. Consequently, although each provider is not required to disclose all providers in its chain, much of this data is already furnished to CMS via the individual enrollments of the providers in the chain.

Comment: Several commenters suggested that CMS define “parent corporation or parent organization.” The term should mean, the commenters stated, the legal entity that owns a controlling interest in a nursing facility. The definition should further clarify that: (1) the parent organization is the “ultimate” parent, or the top entity in a hierarchy (which may include other parent organizations) of subsidiary organizations that is not itself a subsidiary of any corporation; and (2) a legal entity may be its own parent organization if it is not a subsidiary of any other organization. Another commenter stated that “parent organization” and/or “parent company” should be defined as an organization in control of another organization either directly or indirectly through one or more intermediaries.

Response: While we appreciate this comment, neither section 1124(a) or 1124(c) of the Act nor our proposed rule contains the term “parent.” Therefore, we believe this comment is outside the scope of this rule. However, we do use this term sporadically in our sub-regulatory provider enrollment manual instructions in CMS Publication (Pub.) 100–08, Medicare Program Integrity Manual, Chapter 15. Should we deem it necessary, we will consider clarifying this term in our manual instructions.

Comment: Several commenters suggested that proposed § 424.516(g) require a description (and accompanying diagram) of each ADP’s relationship with the nursing facility, with other ADPs, and all parties identified in section 1124(a) of the Act. Another commenter stated that the diagram should include all persons or entities that are intermediaries between the facility and the parent company.

Response: The diagrams we currently require, which will capture additional nursing home data per section 1124(c) of the Act, already secure or will secure much of the data the commenters reference. We may combine the currently required nursing home charts with the ADP organizational data description requirement referenced in § 424.516(g)(1)(iv) such that only one chart encompassing all this information will be required.

Comment: Several commenters stated that CMS should require the nursing facility to disclose organizations in which it has an ownership or managerial interest.

Response: Neither section 1124(a) nor 1124(c) of the Act require a nursing home to disclose entities in which it has an ownership or managerial interest. However, some of this data may be reported via the organizational charts or through more indirect means. To illustrate the latter, suppose Provider X owns 50 percent of Provider Y. Provider Z owns the other 50 percent of Provider Y as well as 75 percent of Provider X. All three providers are enrolling in Medicare. Here—

- Z would not have to report on its Form CMS–855A that it owns X and Y. Yet CMS would still receive this data when X and Y report that they are owned by Z.

- Neither X nor Y would need to disclose that their owner, Z, also owns another Medicare provider. Again, however, X and Y will report that they are owned by Provider Z.

With this data, PECOS can ascertain the providers that Z owns and how X and Y are related through this common ownership (for example, what percentage of X and Y that Z owns). In sum, even though certain information the commenters identify is not directly reported on a particular facility’s application, the facility’s relationships with other providers can be ascertained in PECOS due to the submission of applications by these other providers. We therefore believe that much of the data the commenters are requesting be submitted is already being furnished. To the extent it is not, we believe that the requirement to furnish data (including organizational structures) on ADPs will help close some gaps in nursing home information. CMS will make information collected on facility relationships per section 1124(c) accessible to the public in a clear manner.

Comment: A commenter stated that the description of relationships between ADPs and facilities: (1) must include information that clearly outlines the ownership structure of each disclosed

entity, the exchange of any goods or services between each entity and the facility, the flow of payments between each entity and the facility, and any and all related party relationships; and (2) should be provided via a graphical diagram that allows stakeholders to easily understand each ADP’s organizational structure and the various relationships among the disclosed parties and the facility (including the parent/subsidiary hierarchy of all direct and indirect owners, any related party relationships, and any private equity involvement). The commenter added that the facility should regularly update these diagrams and post them on a public website. Another commenter stated that for disclosed related organizations, the facility should also have to report (1) total payments to the related organization; and (2) costs incurred by the related organization to provide services to the nursing facility. An additional commenter stated that CMS should require nursing facilities to disclose their debt in comparison to the total market value of their property and assets.

Response: We agree that: (1) the ownership structure of each disclosed entity must be clearly outlined; (2) this data would be ideally via a comprehensive and understandable diagram; and (3) the data must be updated within the applicable timeframes specified in § 424.516. However, we do not believe that data regarding debt, the exchange of goods/services, payment flow, and payments to or costs incurred by related organizations must be reported as part of the section 1124(c) of the Act disclosure process. We do not believe sections 1124(a) and (c) of the Act authorize the collection of this information, we did not propose to require its reporting, and we are concerned in any event about the burden this data submission could pose on the nursing homes.

Comment: Several commenters recommended that CMS require the disclosure of individuals and entities with 5 percent or greater ownership in the parent company.

Response: As noted, section 1124(a) of the Act requires the reporting of the provider’s direct or indirect owners as opposed to 5 percent owners of the nursing facility’s parent company. Thus, we do not believe section 1124(a) of the Act (or, for that matter, section 1124(c) of the Act) permits us to collect all of a parent company’s owners regardless of whether they have a 5 percent or greater indirect ownership interest in the facility. However, depending on the number of ownership layers and

indirect owners the facility has, there are situations where the parent company's owners are indeed reported because they meet the aforementioned 5 percent indirect ownership threshold.

Comment: Several commenters recommended that CMS require the submission of an organizational diagram: (1) identifying all the companies the nursing facility's parent organization controls; and (2) that explains how these entities are related to each other.

Response: Neither section 1124(a) nor 1124(c) of the Act explicitly requires the disclosure of all entities the provider's parent company controls, owns, manages, or is related to. Nonetheless, and as already explained, some of this data is already captured via the Form CMS-855A data and the organizational charts. (For example, if the provider lists all its 5 percent direct and indirect owners up to the parent company on the Form CMS-855A, the intermediate organizations between the parent and the provider—and in which the parent has an ownership interest—will be reflected.)

Comment: Many commenters stated that facilities should include supporting documentation with their disclosures to verify said data, such as documents that confirm financial or managing control. To this end, several commenters requested that CMS require the facility to submit: (1) copies of articles of incorporation and bylaws; (2) management, property, loan, mortgage, organizational, employment, and other types of agreements, contracts, etc.; and (3) copies of documents that clarify the relationship between the facility and any disclosed person or entity. The commenters believed such documents will help CMS confirm the submitted data's accuracy.

Response: We intend to validate section 1124(c) data to the fullest extent feasible. As already mentioned, CMS under 42 CFR 424.510(d)(2)(ii) is authorized to require the submission of documentation that helps confirm details regarding the provider's ownership. Our sub-regulatory guidance will identify the types of supporting documents that nursing homes may be required to submit, some of which may fall within the categories the commenters suggested.

Comment: Several commenters stated that CMS should require the nursing facility to disclose details of any lease agreement it has with its lessor/landlord. This should include: (1) how many and which other nursing homes are included under the lease; and (2) other lease terms that may have

substantial financial implications for the nursing facility.

Response: We appreciate this suggestion. To the extent necessary to validate data the facility has submitted (for example, ADP lessor information under section 1124(c)(5)(A)(ii) of the Act), we may consider requiring a copy of the lease agreement.

9. PECs and REITs

Comment: Many commenters supported: (1) the disclosure of PEC and REIT data on the Form CMS-855A application; and (2) the inclusion of publicly traded firms within the PEC definition.

Response: We appreciate the commenters' support.

Comment: Several commenters opposed the collection of PEC and REIT data. A commenter stated that, according to some reports, there are no statistically significant differences between PEC-owned nursing facilities and non-PEC-owned nursing facilities in the areas of: (1) staffing levels; (2) COVID-19 cases or deaths; or (3) deaths from any cause.

Response: We respectfully disagree with these commenters. We noted in the proposed rule and this final rule that we have seen reports that raise concerns about the quality of care in PEC-owned and REIT-owned nursing homes. One such report, issued by the National Bureau of Economic Research, estimated that PEC ownership “increases the short-term mortality of Medicare patients by 10%.”¹⁷ We believe these and other studies, combined with our obligation to protect Medicare beneficiaries, justify our efforts to gather PEC and REIT data so that we can examine the extent to which these entities' ownership of facilities impacts patient care.

Comment: A commenter stated that the PEC definition should include any PEC with any ownership interest in a nursing facility no matter how the PEC has titled itself.

Response: We concur with this commenter. It is important that any such entity—irrespective of whether it owns a majority or minority interest in the nursing home—be disclosed if the applicable ownership reporting thresholds (for example, 5 percent) are met so that CMS and stakeholders can understand the full scope of the nursing home's ownership structure. We also do not believe the question of whether an organization qualifies as a PEC for

disclosure purposes should be determined by its title; the test, rather, is whether the entity meets the PEC definition.

Comment: A commenter stated that CMS should not create its own PEC definition (which the commenter believed was inaccurate and too broad) but should instead use the existing definition of “private equity fund” utilized by other regulatory agencies, including the Securities and Exchange Commission (SEC).

Response: We respectfully disagree. In establishing our PEC definition, we considered several regulatory and non-regulatory descriptions of such companies. The definition was intended to be sufficiently expansive so as to collect a wide volume of these entities. In our view, only by promulgating a broad definition, rather than a restrictive one, can we capture the universe of organizations needed to help us assess the extent of private equity involvement among nursing homes.

Comment: Commenters contended that our PEC definition improperly includes entities that are not private companies. A commenter did not believe that information about public entities aligns with CMS' intent and that CMS' main interest was in private organizations. The commenter recommended that the PEC definition be revised to read, “for purposes of this subpart only, a publicly-traded or non-publicly-traded company that collects capital investments from individuals or entities and purchased [a majority ownership share of]/[a controlling interest in] a provider.”

Response: While we appreciate this comment, we do not believe our proposed PEC definition can be interpreted to include governmental entities (which we believe the commenter was referencing when discussing “public entities”). In our view, the definition clearly only includes private entities, whether publicly traded or not. We also respectfully do not favor limiting PEC disclosure to those PECs with majority ownership of the nursing facility. We cannot obtain a full understanding of the prevalence of PECs in the nursing home sector without collecting data on all PECs that meet our definition thereof, regardless of whether the ownership interest is majority or minority.

Comment: A commenter stated that the proposed PEC definition: (1) does not fully capture private equity involvement in facilities and their chain organizations and parent companies; and (2) applies only to owners or managers of the facility, which is not

¹⁷ 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.

necessarily how private equity structures its involvement in facilities. To secure more thorough PEC data, the commenter (as well as others) stated that CMS should expand the ADP definition to include private equity ownership and control of nursing homes.

Response: We note several things. First, and as previously explained, data regarding a nursing home's chain home office and parent companies, will, with isolated exceptions, be reported to CMS. (Exceptions could include parent companies with less than 5 percent indirect ownership of the provider.) For each of these reported entities, the facility will have to disclose whether that organization is a PEC. To illustrate, assume 6 nursing homes are in a chain. All are enrolling in Medicare and must disclose whether a reported entity is a PEC. PECOS will be able to identify these 6 as part of a chain and, equally important, indicate whether a PEC owns these facilities. Therefore, we believe this will alleviate concerns that PEC involvement in a chain (and the degree of said involvement) will not be revealed. Second, the PEC disclosure requirement is not limited to owning and managing entities of the provider. It includes all entities reported per section 1124(a) and (c) of the Act, some of which may be, for example, lessors of real property per section 1124(c)(5)(A)(ii) of the Act. Third, and as mentioned, section 1124(c) of the Act contains no provision authorizing the Secretary to include additional parties within the ADP definition. Nevertheless, nursing facilities will still have to submit the organizational charts currently required per the Form CMS-855A, which will help identify the ownership relationships of entities that are PECs.

Comment: Commenters suggested that CMS revise its proposed PEC definition. A PEC, according to the commenters, should be defined as a publicly-traded or non-publicly traded company that collects capital investments from individuals or entities and purchases an ownership share of: (1) a provider; (2) the real estate or buildings on or in which a provider operates; (3) a company with an ownership or control interest in a provider; or (4) an ADP. They further stated that CMS' proposed definition has two drawbacks. One is that it lacks adequate specificity to capture actual private equity investment, partly because there is no legal term for private equity. The second is that it is too narrow and focuses only on the provider rather than taking into account complex ownership structures.

Response: We believe our definition is clear enough to alert nursing homes of the types of entities that must be disclosed as PECs. We disagree that the definition is too narrow. As previously explained, we consider it to be reasonably broad in terms of the companies that fall within its purview.

On the other hand, we recognize the commenters' concerns that the proposed definition could be read to only apply to PEC interests in the provider rather than, for instance, PEC interests in one of the provider's indirect owners. As an illustration, assume Nursing Home W is 75 percent owned by Entity X, which is 75 percent owned by Entity Y. Entity Z, a PEC, owns 90 percent of Entity Y. Although Entity Z would have to be disclosed as a 5 percent or greater indirect owner of the nursing facility, it would not qualify as a PEC for Form CMS-855A reporting purposes because its capital investment is in Entity Y instead of the provider/nursing home. This could inhibit our ability to assess the amount of PEC involvement among a provider's indirect owners. We emphasize that we proposed our PEC definition with the intention of collecting both direct and indirect PEC ownership interests in the provider. We never meant to exclude indirect interests. To clarify this for the public, we will insert "direct or interest" before "ownership share" in our final PEC definition. We do not view this as an expansion of the data we proposed because we had always intended to require PEC data from indirect owners. We appreciate the commenters' other suggested revisions, and we will consider them for future rulemaking.

Comment: Commenters recommended changing our proposed REIT definition to that of an entity that meets the definition of REIT in 26 U.S.C. 856 or that claims REIT status when filing taxes with the Internal Revenue Service (IRS). The commenters stated that: (1) REIT is a legal term recognized by the IRS; and (2) CMS' proposed definition does not reference this legal definition but instead captures many companies that own the real estate or building in or on which a provider operates (or owns or operates the provider itself) but are not REITs. With so all-encompassing a definition, CMS will be unable to identify actual REITs. Commenters also recommended establishing definitions that differentiate between publicly offered and non-publicly offered REITs.

Response: The commenters' recommendation to adopt an alternative REIT definition of REIT differs from the earlier recommendation to adopt a different PEC definition in two ways. First, some of the suggested PEC

definition revisions could entail a significant increase in the number of entities that would qualify as PECs and, in turn, would have to be reported as such. The section 856 definition, on the other hand, would be narrower than the REIT definition we proposed, as the commenters indicated when noting that the proposed definition would capture numerous entities that are not REITs. This means that fewer organizations would be reported as REITs, hence potentially reducing the burden on nursing homes, although this definition will still capture entities that should appropriately be reported as REITs. Second, there is no uniform, standard, widely accepted definition of "private equity company" in our federal regulations. Such is not so with the section 856 REIT definition, which is broadly acknowledged throughout the public and private sectors and, accordingly, could help facilitate the reporting of consistent REIT data. For these two reasons (as well as for the reasons the commenters outlined), we concur with the recommendation that the section 856 definition should be utilized instead of the proposed REIT definition. We will update this final rule to include the former.

As for the recommendation to establish definitions to distinguish between publicly-offered and non-publicly offered REITs, we are not at this time focused on such differences for Medicare provider enrollment purposes.

Comment: A commenter offered several recommendations regarding our REIT proposal. First, the commenter stated that CMS should adopt the definition of "publicly offered REIT" in 26 U.S.C. 562 and require said entity to designate whether it is a publicly offered REIT. Second, the commenter suggested that our proposed REIT definition be revised to mean an entity that: (1) reported itself as a REIT for its last tax return and continues to qualify as such under section 856; or (2) has not filed its first tax return but has stated its intention to identify itself as a REIT on its tax return to its owners and effectuates it stated intention. Third, the commenter urged CMS to clarify that an entity that has elected to be taxed as a REIT should continue to be categorized as such for "organizational structure" purposes.

Response: As stated, we are including within this final rule the REIT definition used in section 856, which we believe addresses the commenter's second suggestion. We also previously noted section 562's definition of publicly offered REIT, which is referenced in 26 U.S.C. 856(c)(5)(L)(i). If the commenter is suggesting that we include

checkboxes on the Form CMS–855A to distinguish between publicly offered REITs and non-publicly offered REITs, we may consider this as a future enhancement to the application. Regarding the commenter's third recommendation, we interpret this as a request to add REITs to our organizational structure definition. We appreciate this suggestion and may contemplate it for future rulemaking.

Comment: While recommending adoption of the section 856 REIT definition, a commenter stated that REIT disclosure should only be required if the REIT: (1) leases or subleases real property to the provider in the ordinary course of its business; and (2) has the power to exert OFMC over the provider or a part thereof. Another commenter agreed that the second criterion regarding OFMC should be a prerequisite for REIT disclosure.

Response: While we concur that the REIT definition should mirror that in section 856, we respectfully disagree that disclosure should be restricted to REITs that meet the two recommended criteria. The central issue is not whether a particular transaction was done in the ordinary business course or the degree of the REIT's control over the provider. The main issue is whether it meets the section 856 definition. Indeed, REITs often merely own or lease the land on which the provider is located and do not own or operate the facility.

Comment: A commenter stated that, in addition to REIT data, CMS should collect information on non-profit or public entities that purchase nursing facility real estate but may not qualify as REITs. The commenter stated that these entities, like for-profit organizations, engage in such practices.

Response: We appreciate this suggestion and may consider it for future policy development.

Comment: A commenter stated that CMS should exempt non-profit, hospital-based providers (NPHBPs) that operate nursing facilities from the PEC disclosure requirements (or, at a minimum, add a checkbox to the Form CMS–855A to capture NPHBP ownership to distinguish NPHBPs from PECs). The commenter stated that NPHBPs (being hospital-based) are subject to stricter oversight and regulations than private equity firms. Excluding NPHBPs as described would reduce the reporting burden on these entities.

Response: We respectfully disagree. Exempting certain types of nursing facilities from PEC disclosure could leave CMS, stakeholders, and beneficiaries with an incomplete understanding of the scope of PEC

prevalence in the nursing home sector. Concerning the suggested checkbox, an enrolling nursing home must already disclose any non-profit status in Section 2 of the Form CMS–855A; furthermore, any association with a hospital (such as ownership or management) is reported in Section 5 of the Form CMS–855A. We thus do not believe the recommended checkbox is necessary.

Comment: Several commenters recommended that CMS continue investigating private equity's involvement in health care facilities.

Response: We agree with this commenter and intend to continue our efforts to examine the role and scope of PEC involvement in the health care sector.

10. Miscellaneous Comments

Comment: A commenter stated that CMS should: (1) require nursing homes to place signs at their entrances stating their ownership type and for-profit/non-profit status; and (2) create a registry outlining each nursing home's status concerning national nurse and doctor staffing standards.

Response: Although we respectfully believe these comments are outside the scope of this rule, we appreciate all suggestions from stakeholders regarding means of (1) facilitating transparency concerning nursing home ownership and operations and (2) improving the quality of nursing home care.

Comment: A commenter encouraged CMS to consult with industry experts regarding the proposed rule. These parties should include: (1) unions representing nursing home employees; (2) academics who research nursing homes; and (3) organizations that advocate for the elderly. Other commenters stated that CMS should seek input from stakeholders when developing plans for publishing the section 1124(c) data and when crafting the sub-regulatory guidance related to this rule.

Response: We received feedback from some of the parties the commenter references during the 60-day notice-and-comment period and, as with all the comments we received, both appreciated and considered them. After the final rule is issued, CMS will remain open to feedback from stakeholders regarding section 1124(c)'s implementation, the publication of the section 1124(c) data, and our sub-regulatory guidance.

Comment: A commenter urged CMS to expand the section 1124(c) reporting requirements to include additional provider/supplier types, such as physician practices, hospitals, and dialysis facilities.

Response: While we appreciate this comment, section 1124(c) of the Act is limited to nursing homes. Therefore, we believe we lack the statutory authority to include other provider/supplier types within section 1124(c)'s purview.

Comment: Several commenters expressed concern that CMS and certain states allow nursing home ownership changes a— with Medicare changes of ownership under § 489.— transfer of a provider agreement with little scrutiny of the new owner. They recommended that CMS: (1) establish or strengthen requirements for changes of ownership or management of nursing homes; and (2) identify owners with a potential for (or actual history of) furnishing poor care or participating in fraud and disqualify them from Medicare or Medicaid participation. They added that these requirements should extend to current owners and managers of nursing homes (not simply new ones) and that these parties should be removed or suspended from Medicare if they engage in such conduct.

Response: We appreciate these comments but believe they are outside the scope of this rule.

Comment: A commenter recommended that a centralized Medicaid provider enrollment application system be created to better coordinate information across states and reduce duplication.

Response: We appreciate this recommendation but believe it is outside the scope of this rule.

Comment: Several commenters requested clarification as to how the section 1124(c) data collection will help improve the quality of nursing home care.

Response: We believe the section 1124(c) information will help enhance nursing home quality by enabling CMS, states, and stakeholders to examine the entire scope of the facility's organizational, operational, and managerial structure, including its relationships with other entities (for instance, consulting firms). With this more complete picture—and in conjunction with quality-of-care data such as survey results—CMS, states, and stakeholders will be better positioned to ascertain areas of the facility's operations that could be sources of sub-standard quality and, to the extent applicable, undertake remedial measures or otherwise hold the facilities accountable. Furthermore, public disclosure of the section 1124(c) data will allow beneficiaries, their families, and other parties to identify which nursing homes may be best suited to provide quality care. This, in turn, could spur nursing homes to improve

the quality of their services so as to become a more desirable choice for beneficiaries.

Comment: Several commenters stated that CMS should assign a personal identification number to an individual with an ownership or management interest in a nursing home.

Response: We appreciate this suggestion, but we do not believe the personal identification numbers the commenters cite are necessary. Providers must currently report identifying data about their owners and managers, such as their legal business name, doing business name, address, etc. This allows us to track such parties in PECOS, including their ownership or management of other enrolled providers and suppliers. (We will also require identifying information regarding the parties reported per section 1124(c) of the Act.) We believe this identifying data largely serve the same purpose as a personal identification number.

Comment: Several commenters requested that CMS explain how it will use section 1124(c) data disclosures in: (1) its Medicare enrollment decisions; and (2) determining whether a potential owner requires further investigation.

Response: Nursing homes will have to submit full and accurate section 1124(c) data. If the facility does not, its enrollment may, as applicable, be denied, revoked, or deactivated, or its application rejected. Reported parties will be reviewed against the OIG exclusion list, too. Newly reported SNF owners will be scrutinized (and, as applicable, subject to further review) consistent with our current procedures, such as requiring the submission of fingerprints.

Comment: Several commenters stated that CMS should implement in the final rule section 1124(c)(2)(B) of the Act, which permits non-profit nursing homes to submit the IRS Form 990 to the extent that the information thereon meets the section 1124(c) disclosure requirements. A commenter explained that the Form 990 discloses governance and operational leadership, related parties and affiliates, level of control and ownership, key employees and independent contractors, and other detailed information. The commenter stated CMS should promptly establish procedures for submitting Form 990 data in lieu of its duplicate disclosure via the Form CMS–855A.

Response: As we noted in the proposed rule, CMS is exploring the operational complexities involved in implementing section 1124(c)(5) of the Act. We may address this matter in future rulemaking.

Comment: Several commenters recommended that CMS prohibit a party from: (1) acquiring 5 percent or more ownership of a nursing facility (or management company under contract therewith); or (2) becoming an officer, director, or general partner in a SNF or contracted management company without written CMS approval at least 90 days before the transaction.

Response: We appreciate this recommendation but believe it is outside the scope of this rule.

Comment: A commenter stated that CMS should: (1) collect data that assesses the labor-related impacts of consolidation in health care and how changes to the labor market affect patient care; and (2) release data to help stakeholders better understand how mergers and acquisitions can lead to anti-competitive and harmful practices (for example, reduced wages and/or non-cash benefits).

Response: We appreciate this comment but believe it is outside the scope of this final rule. However, with the additional information collected as part of this rule, we hope to better elucidate how consolidation and certain ownership structures may be affecting the health care labor market and quality of care.

Comment: A commenter stated that CMS should prohibit “squatting”, which the commenter described as when a party acquires, operates, establishes, manages, conducts, or maintains a nursing facility before CMS has approved its enrollment application. The commenter contended that should a party obtain such an interest in a nursing facility without first obtaining a state license, CMS should take immediate action, including a: (1) ban on new admissions; and (2) suspension of all Medicare and Medicaid payments to the facility.

Response: We appreciate this comment but believe it is outside the scope of this final rule.

Comment: Several commenters noted that section 1124(c)(1) of the Act requires the “identity of and information on” the parties disclosed under section 1124(c)(2)(A)(ii) of the Act. They stated that CMS should use this authority to collect data other than names, titles, and dates of service. A commenter explained that disclosure of a person’s name by itself may not adequately identify that individual.

Response: We recognize that requiring data beyond the party’s name and title (such as an address) may be necessary to confirm identification. Any such data elements will, if required, be added to the Form CMS–855A via the Paperwork

Reduction Act process and be subject to prior public notice-and-comment.

Comment: Several commenters recommended the creation of an interagency task force to identify trends in nursing home transparency and monitor nursing homes that require particular scrutiny. This group, the commenters stated, should include Justice Department and Labor Department staff to provide guidance on mechanisms for: (1) enforcing the final rule’s provisions; and (2) improving patient care.

Response: We appreciate this suggestion and note that we communicate with other government agencies regarding nursing home program integrity, quality, and transparency issues. We will continue to do so during and after section 1124(c)’s implementation.

Comment: Several commenters urged CMS to implement the GAO’s recommendations in its January 2023 report titled, “CMS Should Make Ownership Information More Transparent for Consumers.”¹⁸ In that report, the GAO found that ownership information on Care Compare was insufficiently transparent for consumers.¹⁹ Its recommendations included but were not limited to: (1) using plain language to define key terms in Care Compare’s ownership section; and (2) organizing ownership information by providing consumers easy access to a list of all facilities under common ownership.²⁰

Response: We believe these comments are outside the scope of this final rule because our proposals were unrelated to the format of the current Care Compare website. However, as announced on June 28, 2023, ownership and operatorship affiliation information is now available on the Nursing Home Care Compare website in a clear, accessible, and easily readable format for consumers (<https://www.cms.gov/files/document/qso-23-18-nh.pdf>).

B. Public Comments Received on the FY 2024 IPPS/LTCH PPS Proposed Rule

Comment: Several commenters supported our proposed PEC and REIT definitions, the collection of PEC and REIT data, and the application of these definitions to all providers and suppliers that complete the Form CMS–855A.

Response: We appreciate the commenters’ support.

Comment: Several commenters recommended that CMS furnish

¹⁸ GAO–23–104813.

¹⁹ *Ibid.*, p. 18.

²⁰ *Ibid.*, p. 25.

scenarios regarding when and how PEC and REIT ownership and relationships would be reported. They cited an example of a provider with a long-term building lease with a county to operate a hospital and questioned whether this would qualify as a REIT relationship.

Response: CMS in its sub-regulatory guidance will provide guidance on the requirements for reporting PEC and REIT data, including situations similar to the commenter's example.

Comment: Several commenters opposed the collection of PEC data from providers and suppliers other than SNFs. A commenter stated that PEC ownership does not inherently indicate lesser levels of care than other types of ownership, while another commenter stated that the proposed rule cited no evidence that PEC-owned hospitals needed closer monitoring. At a minimum, a commenter recommended that CMS explain how: (1) it will determine if a connection exists between quality and ownership type for non-SNF providers and suppliers; and (2) quality is impacted if the requested data show that such a connection exists. Another commenter stated that the request for PEC data impugns private equity owners.

Response: We cited in the aforementioned February 15, 2023 proposed rule several studies that expressed concern regarding the quality of care furnished at PEC-owned SNFs. Although those studies were restricted to SNFs, we explained in the FY 2024 IPPS/LTCH PPS proposed rule that the studies raised legitimate concerns that similar problems might exist with PEC ownership of other provider and supplier types, hence the need to collect PEC data on the latter across the healthcare industry. Concerning the commenter's recommendation, and as previously explained, the furnishing of PEC data will help CMS determine: (1) the prevalence of PEC involvement within the Medicare provider or supplier universe; and (2) the extent to which (and in what aspects) patient care is deleteriously impacted. That is, our objective is not to disparage PECs but to ascertain the degree and impact of PEC ownership of providers and suppliers.

Regarding our proposed PEC definition, we previously noted that we considered several other regulatory and non-regulatory descriptions of PECs with the goal of establishing a definition that could capture a wide volume of such organizations; this will help us ascertain the degree of PEC involvement among Medicare providers and suppliers. We believe our proposed definition (aside from the aforementioned minor clarification

thereto that we are finalizing) fulfills this objective.

Comment: Several commenters opposed the collection of REIT data. They stated that: (1) CMS furnished no proof that REIT ownership leads to substandard care; and (2) REITs have only limited involvement in the health care arena.

Response: We noted in the February 15, 2023 proposed rule that REIT ownership of nursing homes has generated concerns akin to those involving PEC-owned nursing facilities. We acknowledge that these concerns pertained to REIT-owned nursing homes as opposed to, for example, hospices that are owned by REITs. Yet it is precisely for this reason that we need to know the prevalence of REIT involvement with other Medicare provider and supplier types. Indeed, any quality-of-care issues regarding REIT-owned nursing homes might also exist with respect to non-SNF providers. Given our obligation to protect Medicare beneficiaries, it is imperative to collect information that can assist us in stemming any problems associated with certain types of ownership, no matter the amount of involvement a particular ownership type may have in the health care field.

Comment: Several commenters recommended that CMS not finalize its proposed definition of REIT and instead adopt the REIT definition in 26 U.S.C. 856.

Response: As stated in our response to a similar comment on the February 15, 2023 proposed rule, we agree with this suggestion and will finalize the section 856 definition.

C. Final Provisions

We are finalizing all of our provisions from both the February 15, 2023 and FY 2024 IPPS/LTCH PPS final rules as proposed except as follows:

- We are inserting "direct or indirect" before the term "ownership share" in our PEC definition in 42 CFR 424.502.
- We are redefining REIT in 42 CFR 424.502 as a real estate investment trust as that term is described in 26 U.S.C. 856.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-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 sought 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 final rule, we proposed 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 include, 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. Nursing Home Submission of Section 1124(c) Data

1. Medicare

We noted in section II. of this final 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 the previously referenced organizational charts. However, certain data is not collected via the existing Form CMS-855A process, 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”) will constitute additional ICR burden to the SNF community.

There will be three principal types of Form CMS–855A transactions via which SNFs will report supplemental data: (1) applications to initially enroll in Medicare (which, for purposes of the reporting requirements in proposed

§ 424.516(g), will 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 will 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 2022 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	20.75	20.75	41.50
Lawyers	23–1011	78.74	78.74	157.48

Based on our internal data, and as stated in the proposed rule, we estimate that each year approximately: (1) 1,055 SNFs will submit an initial Form CMS–855A enrollment application (excluding Form CMS–855A change of ownership applications under § 489.18); (2) 1,672 will submit a Form CMS–855A revalidation application; (3) 951 will submit a Form CMS–855A change of ownership application; and (4) 4,500 will report new or changed supplemental data via a Form CMS–855A change of information application. Furthermore, we project that it will 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 will 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 will be \$99.49 (((\$41.50 + \$157.48)/2). (The figure in the proposed rule was \$91.64 (((\$40.94 + \$142.34)/2), which was based on the

May 2021 BLS wage figures.) As outlined in more detail in Table 2, this results in a projected annual ICR burden of our Medicare SNF disclosure provisions of 12,776 hours at a cost of \$1,271,084. (Using the May 2021 BLS wage figures, our estimate in the proposed rule was \$1,170,793.)

2. Medicaid

We mentioned in section II. of this final rule that states have considerable discretion in the operational aspects of their Medicaid programs, including with respect to provider enrollment. Concerning our 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 newly reporting this information, as well as the time it takes the facility to disclose the data, will 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. 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 final rule for initial and revalidation applications can also be used for our proposed Medicaid provisions. (We took a similar approach when establishing our Medicaid application projections in the proposed rule.) Consequently, and as indicated in Table 2, we estimate an annual ICR burden for these provisions of 6,136 hours and \$610,470. (Using the May 2021 BLS wage figures, our estimate in the proposed rule was \$562,303. We solicited public comments on the accuracy of this projection.)

3. Total

Given the foregoing, and as outlined in the following table, we project an annual total ICR burden associated with our SNF disclosure provisions of 18,912 hours and \$1,881,554. (Our estimate in the proposed rule was \$1,733,096, which, again, was due to our use therein of the May 2021 BLS wage figures.)

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	99.49	236,189

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

	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 (\$)
Form CMS–855A Revalidation Applications	0938–0685	1,672	1,672	2.25	3,762	99.49	374,281
Form CMS–855A Change of Ownership Applications	0938–0685	951	951	2.25	2,140	99.49	212,909
Form CMS–855A Change of Information Applications	0938–0685	4,500	4,500	1	4,500	99.49	447,705
Medicare Totals	N/A	8,178	8,178	N/A	12,776	N/A	1,271,084
Medicaid							
Initial Application	N/A	1,055	1,055	2.25	2,374	99.49	236,189
Revalidation Application	N/A	1,672	1,672	2.25	3,762	99.49	374,281
Medicaid Totals	N/A	2,727	2,727	N/A	6,136	N/A	610,470
Totals	N/A	10,905	10,905	N/A	18,912	N/A	1,881,554

C. ICRs for Reporting of PEC and REIT Data

As previously explained in this final rule, we proposed in the FY 2024 IPPS/LTCH proposed rule that the PEC and REIT definitions we proposed in the February 15, 2023 proposed rule apply to all providers and suppliers completing the Form CMS–855A enrollment application (OMB Control No. 0938–0685), not merely SNFs. This was consistent with our proposal on

December 15, 2022 to revise the Form CMS–855A application in a Paperwork Reduction Act submission (87 FR 76626) to require all owning and managing entities listed on any provider’s or supplier’s Form CMS–855A submission to disclose whether they are a PEC or a REIT.²¹

There will be five types of Form CMS–855A transactions via which we believe providers and suppliers (including SNFs) would report PEC and

REIT data: (1) initial enrollment applications; (2) change of ownership applications; (3) revalidation applications; (4) reactivation applications; and (5) change of information applications. Form CMS–855A applications are typically completed by the provider’s or supplier’s office staff. Therefore, we will use the previously referenced BLS wage estimate for “Office and Administrative Support Workers, All Other.”

TABLE 3—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	20.75	20.75	41.50

Based on our internal data, and as we did in the FY 2024 IPPS/LTCH PPS proposed rule, we estimate that the following number of Form CMS–855A applications will be submitted reporting PEC or REIT data: (1) 6,462 initial

applications; (2) 3,105 changes of ownership; (3) 3,133 revalidations; (4) 610 reactivations; and (5) 27,000 changes of information. Furthermore, we project that it would take an average of 12 minutes to furnish the PEC and

REIT data, though we recognize that this will vary by Form CMS–855A transaction type and the amount of the data the particular provider or supplier must disclose.

²¹ <https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pralisting/cms-855a>.

TABLE 4—HOURLY AND BURDEN ESTIMATES FOR PEC AND REIT 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 (\$)
Initial Form CMS–855A Applications	0938–0685	6,462	6,462	0.2	1,292	41.50	53,618
Form CMS–855A Change of Ownership	0938–0685	3,105	3,105	0.2	621	41.50	25,772
Form CMS–855A Revalidation Applications	0938–0685	3,133	3,133	0.2	627	41.50	26,021
Form CMS–855A Reactivation Applications ..	0938–0685	610	610	0.2	122	41.50	5,063
Form CMS–855A Change of Information Applications	0938–0685	27,000	27,000	0.2	5,400	41.50	224,100
Totals	N/A	40,310	40,310	N/A	8,062	41.50	334,574

D. Totals

Given the foregoing, we estimate that the combined burden of our section 1124(c) of the Act and PEC/REIT disclosure requirements is 26,974 hours and \$2,216,128.

We received no comments on our proposed ICR estimates for either rule and are finalizing them as proposed with the exception of the increased costs (described in the succeeding paragraphs) associated with our use of the May 2022 BLS wage estimates.

V. Regulatory Impact Analysis

A. Statement of Need

This final 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 PECs. This rule is an important component of the Biden-Harris Administration’s initiative to improve nursing home safety, quality, and accountability.²²

B. Overall Impact of Provisions of This Final Rule

1. Background

We have examined the impacts of this final 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 Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (commonly known as the Congressional Review Act) (5 U.S.C. 804(2)). This section of this final 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, as amended by Executive Order 14094 (Modernizing Regulatory Review), 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 \$200 million or more in any 1 year (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (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 legal or policy issues for which centralized review would meaningfully further the President’s priorities or the principles set forth in Executive Order 12866, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) of \$200 million or more in any 1 year. Based on our estimates, OIRA has determined this rulemaking is not significant per section 3(f)(1) of Executive Order 12866 and does not meet the definition in 5 U.S.C. 804(2) (Congressional Review Act). Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

1. Benefits

As discussed in section II. of this final rule, we believe the data furnished in accordance with this rule will 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 costs associated with the requirements of this final rule involves nursing facilities’ submission of the required information and the regulatory review costs. We projected in section IV.

²² <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/>.

of this final rule that the annual burden on nursing facilities of furnishing this data would be 26,974 hours and \$2,216,128. Meanwhile, the total cost of reviewing this final rule is \$4,160,189.

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will be directly impacted and will review this final rule, we will assume that roughly half the number of SNFs (or 7,770 out of the aforementioned universe of 15,500) will review this rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule.

For purposes of our estimate, we assume that the SNF's legal counsel and the medical and health service manager will read the rule. Using the BLS May 2022 mean wage information for medical and health service managers

(Code 11–9111) we estimate that the cost of reviewing this final rule is \$123.06 per hour, including overhead and fringe benefits (<https://www.bls.gov/oes/current/oes119111.htm>). The mean hourly wage for the SNF's lawyer (Code 23–1011) is \$157.48. Assuming an average reading speed of 250 words per minute, we estimate that it will take approximately 114 minutes (1.91 hours) for the staff to review all of this final rule, which contains a total of approximately 28,600 words. For each SNF that reviews the final rule, the estimated cost is $(1.91 \times \$123.06) + (1.91 \times \$157.48)$ or \$545.42. Therefore, we estimate that the total cost of reviewing this final rule is \$4,160,189 ($\$535.42 \times 7,770$ SNFs).

3. Savings or Transfers

We do not anticipate any direct savings or transfers from our provisions. This is principally because the provisions merely involve 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 section 1124(a) 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 5 showing the classification of the impact associated with the provisions of this final rule.

TABLE 5—ACCOUNTING STATEMENT: ESTIMATED ANNUAL BURDEN OF NURSING FACILITY DISCLOSURE FINAL RULE

Category	Primary estimate	Year dollar	Period covered
Annualized Monetized ICR Burden	\$2.22	2022	2022–2032

We did not receive comments on our regulatory impact analysis and are finalizing the estimates described therein with the exception of the increased costs (described in the succeeding paragraphs) associated with our use of the May 2022 BLS wage estimates.

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 final rule. Therefore, the Secretary has certified that this final 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 604 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 final rule will only affect nursing facilities, it will 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 2023, that threshold level is currently approximately \$177 million. Given the aforementioned estimated costs, this final 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 final rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has federalism implications. We have

examined our final 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.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on November 8, 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 amends 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:

- (i) Exercises operational, financial, or managerial control over the facility or a part thereof;
(ii) Provides policies or procedures for any of the operations of the facility; or
(iii) Provides financial or cash management services to the facility.

(2)(i) Leases or subleases real property to the facility; or

(ii) Owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property.

(3) Provides—

- (i) Management or administrative services;
(ii) Management or clinical consulting services; or
(iii) 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. For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.

(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 a

direct or indirect ownership share of a provider.

Real estate investment trust means, for purposes of this subpart only, a real estate investment trust as defined in 26 U.S.C. 856.

* * * * *

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 a 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.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2023–25408 Filed 11–15–23; 8:45 am]

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DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Chapter III

[Docket No. FMCSA–2023–0174]

RIN 2126–AC60

General Technical, Organizational, Conforming, and Correcting Amendments to the Federal Motor Carrier Safety Regulations

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: FMCSA amends its regulations by making technical corrections throughout the Federal Motor Carrier Safety Regulations (FMCSRs). The Agency makes minor changes to correct inadvertent errors and omissions, remove or update obsolete references, and improve the clarity and consistency of certain regulatory provisions. The Agency also makes a change to its rules of organization, procedures, and practice.

DATES: This final rule is effective November 17, 2023, except for amendatory instruction 88, which is effective January 16, 2024.

FOR FURTHER INFORMATION CONTACT: Mr. Nicholas Warren, Regulatory Development Division, Office of Policy, FMCSA, 1200 New Jersey Avenue SE, Washington, DC 20590–0001; (202) 366–6124; nicholas.warren@dot.gov.

SUPPLEMENTARY INFORMATION:

I. Legal Basis for the Rulemaking

Congress delegated certain powers to regulate interstate commerce to DOT in numerous pieces of legislation, most notably in section 6 of the Department of Transportation Act (DOT Act) (Pub. L. 89–670, 80 Stat. 931, 937, Oct. 15, 1966). Section 6 of the DOT Act transferred to DOT the authority of the former Interstate Commerce Commission (ICC) to regulate the qualifications and maximum hours of service of employees, the safety of operations, and the equipment, of motor carriers in interstate commerce (80 Stat. 939). This authority, first granted to the ICC in the Motor Carrier Act of 1935 (Pub. L. 74–255, 49 Stat. 543, Aug. 9, 1935), now appears in 49 U.S.C. chapter 315. The regulations issued under this authority, as well as subsequently enacted laws, became known as the FMCSRs, codified at 49 Code of Federal Regulations (CFR) parts 350 through 399. The administrative powers to