Member Call Summary

June 20, 2025

Senate Finance Committee Releases Draft Reconciliation Bill: Health Issues

On June 16, the Senate Finance Committee (SFC) released draft text of its proposals for the Senate's version of the One Big Beautiful Bill (OBBB). SFC has jurisdiction over tax as well as Medicare, Medicaid, and the Affordable Care Act. LeadingAge is still evaluating the new text as it compares to the House version of the bill. Some topline changes of note:

- Retroactive payments: In the House bill, retroactive eligibility for Medicaid was changed from 90 days to 30 days. In the SFC draft, they propose 30 days of retroactive coverage for the ACA population and 60 days for traditional Medicaid populations. LeadingAge had asked for 90 days particularly for those who are getting Medicaid due to age or disability. Ideally this would include those who are disabled getting coverage through the ACA expansion pathway. This change is a partial victory in that it gives more leeway for retroactive coverage for the populations that are mostly likely to need it; but we would prefer the changes go further.
- Provider Taxes: The House policy froze provider taxes where they are across all classes of taxes. The Senate bill goes further.
    - The moratorium on new taxes remains for both expansion and non-expansion states. There is new language about when states can make changes relative to the date of enactment that we will analyze in the coming days.
    - Starting in 2027, for expansion states, the hold harmless threshold decreases by 0.5% a year until 2031 when the hold harmless threshold would be 3.5%. Nursing homes and intermediate care facilities are excluded from this provision. However, LeadingAge knows that nursing homes receive money from provider taxes that are levied on classes besides nursing homes (such as hospitals and managed care organizations). The drop in the hold harmless threshold for other classes also means that expansion states will be receiving fewer federal dollars (in some cases, significantly fewer), which will have a negative impact on home- and community-based services as well as nursing homes.
- State directed payments: The House bill revised the payment limit for state directed payments (SDPs) to the Medicare rate for expansion states and 110% of Medicare for non-expansion states. The Senate version keeps this policy. It also

adds a policy that existing SDPS would be reduced by 10% annually until the allowable Medicare-related payment rate is achieved. The House bill grandfathered in current SDPs without reductions.

- Nursing home staffing mandate: Like the House version, the nursing home staffing standard elimination is in the Senate bill. However, the Senate's language says that the rule can never be enforced, as opposed to the House bill which put a moratorium on enforcement until 2035.
- The work requirements were adjusted to: 1) cap the look-back for demonstrating community engagement at 3 months; the House bill would have allowed an indefinite lookback; 2) limits the exemption for parents of children 14 and under. It also adds family caregivers to the definition based on the definition in the RAISE Family Caregiver's Act; and 3) allows the Secretary to exempt states from the requirements until Dec 31, 2028 if a state is demonstrating a good faith effort to comply.

Overall, the SFC bill takes an even harder swing at states that chose to expand Medicaid and uses what will likely be increased federal cuts to Medicaid, compared to the House bill, to fund priorities like tax increases for the wealthiest Americans. We will continue to analyze the bill but the SFC's attempts to protect long-term care, we believe, do not do nearly enough to counterbalance the devastating impacts of such large cuts. We will provide a more detailed summary in the coming days along with action items.

Read the SFC text here.

Follow all related information via our Budget Reconciliation 2025 serial post.

House Removes Employee Retention Tax Credit Provision from Budget Reconciliation Bill

During a June 11 floor session, the House of Representatives approved an amendment to the One Big Beautiful Bill Act (OBBB), the tax and spending package passed by the House on May 22, that makes certain changes needed to ensure compliance with Senate rules and preserve the Senate's ability to bypass the filibuster when the body brings its own budget reconciliation bill to the floor. Among other changes, the House amendment removes a section from the OBBB relating to the Employee Retention Tax Credit (ERTC). Current law allows employers to claim COVID-related ERTC through April 15, 2025. Section 112205 of the OBBB would have barred the Internal Revenue Service (IRS) from issuing any additional unpaid claims, unless a claim was filed on or before January 31, 2024, and it would have established certain program integrity requirements and penalties aimed at COVID-ERTC promoters.

The removal of this provision, which was intended to generate budget savings that helped offset the cost of the overall bill, means that employers who submitted claims through April 15, 2025, can still get paid. Senate Republicans will make their own changes to the House bill, but the ERTC issue and others needed to be addressed

before the House official sent their bill to the other chamber. You can stay up to date with all budget reconciliation news in this serial post.

June 30, 2025 – Applications to Iowa Medicaid for NFIF funding due.

Reminder: Member Engagement Opportunities

- Staff Shoutout Form
- Member News Form
- Member Call Discussion Topic Form
- Member Feedback Form

Federal Judge Rules in Favor of LeadingAge State Affiliates

On June 18, federal judge Leonard T. Strand issued a ruling in favor of the plaintiffs to vacate the Centers for Medicare & Medicaid Services (CMS) staffing standards included in the final rule. The plaintiffs, including 17 LeadingAge State affiliates, two Kansas nursing home providers, and 20 states attorneys general filed to vacate the staffing mandate final rule in its entirety. Similar to the case in Texas filed by LeadingAge and American Health Care Association (AHCA), the plaintiffs argued that CMS lacks the statutory authority to issue such a rule, that the rule is contrary to law, and the provisions are arbitrary and capricious. Judge Strand ruled in favor of the plaintiffs as it relates to the minimum staffing hours and the 24/7 RN requirements. However, Judge Strand ruled in favor of HHS/CMS regarding the facility assessment and state Medicaid reporting requirements.

LeadingAge Iowa staff Samantha Heibel, Director of Advocacy & Engagement stated "This ruling marks a significant victory for mission-driven aging services providers across Iowa and the nation. This mandate, while well-intentioned, would have imposed rigid staffing ratios without addressing the underlying issues of funding and workforce scarcity, placing undue financial strain on providers and jeopardizing access to essential care for older Iowans. We are grateful to the courts for recognizing the importance of sustaining mission-driven, community-oriented care, and we thank our members whose voices, experiences, and stories brought this fight to the forefront. We will continue to advocate for meaningful, durable actions that will truly protect the health, dignity, and well-being of older Iowans."

"LeadingAge Iowa is beyond relieved with Judge Strand's ruling even if it doesn't vacate the rule in its entirety. The staffing provisions in the final rule were unattainable for several of our members given the workforce. At baseline, many of our members staff well above average levels and provide exceptional care to those they serve but the burden of this rule left many wondering about the sustainability of nursing home care nationwide" stated LeadingAge Iowa Director of Clinical Services, Kellie Van Ree.

CMS Releases QSO Memo on Changes to 5-Star Report and Care Compare

On June 18, the Centers for Medicare & Medicaid Services (CMS) released QSO-25-20-NH related to 5-Star reports and updates to the Care Compare website. The changes are outlined below.

Nursing Home Chains

Beginning September 26, 2022, CMS began publishing ownership data on data.cms.gov. As part of that release, CMS linked together nursing homes that had common owners and control as “affiliated entities” or “chains”. Additionally, in June 2023, CMS posted average ratings and performance measures by affiliated entities or chains on the cms.data.gov website. The next phase of this transparency effort will be implemented on July 30, including publishing performance information including average overall 5-star ratings, health inspection, staffing, and quality measure ratings for each chain directly on the Nursing Home Care Compare website. This will allow a more consumer-friendly format to allow individuals to make more informed decisions on their care.

Health Inspection Star Rating

Previously, the nursing home health inspection star rating was calculated based on an allocated point value weighed over three survey cycles. CMS notes due to a backlog of surveys with the COVID-19 pandemic surveys may be more than 45 months old and still used to calculate the health inspection star rating. Beginning with the July 2025 refresh, CMS will no longer use the three-survey cycle period for recertification surveys but will calculate the score based on the two most recent survey cycles. The weights will be measured based on 75% of the value from Cycle one including the most recent standard survey and any complaint and infection control surveys completed in the past 12 months. The second cycle will be weighed at 25% and include the second most recent standard survey along with any complaint and infection control surveys from the last three years. CMS notes that this will likely not impact many providers but will emphasize the most recent survey performance.

Updated Long Stay Antipsychotic Quality Measure Calculation

The Office of Inspector General (OIG) issued a report in 2021 identifying that the Minimum Data Set (MDS) which is currently being used to calculate the percentage of antipsychotics used in the nursing home was not accurately reflecting the number of residents who were currently prescribed antipsychotic medications. Based on knowledge of how the measure is calculated, this could include nursing homes not coding an antipsychotic on the MDS or inaccurately coding a diagnosis of schizophrenia. To mitigate this, CMS is updating the measure to include both MDS and claims data to calculate the percentage of residents using antipsychotic medications.

For example, if a resident does not have an antipsychotic medication coded on the MDS, but based on claims data, Medicare is billed for an antipsychotic medication, then the resident will be included in the numerator for the measure. Additionally, if the resident receives an antipsychotic medication and is excluded based on the MDS coding of a schizophrenia diagnosis, but the claim data does not support ongoing care for schizophrenia, the resident will not be excluded from the numerator as they would have been previously.

Removal of the COVID-19 Vaccine Percentages

CMS began displaying the resident and staff vaccination percentages for the COVID-19 vaccine in 2021 on each nursing home's Care Compare page. However, beginning July 30, 2025, CMS will no longer post this metric on the main profile page of each nursing home.

CMS Releases QSO Memo on 2567 Transparency

On June 18, the Centers for Medicare & Medicaid Services released QSO-25-19-All related to procedural changes for survey agencies releasing the CMS-2567 form upon completion of a survey for all provider types. Previously, survey agencies had up to 90 days after the completion of the survey to publicly release the CMS-2567 or until the plan of correction (POC) or Allegation of Compliance (AOC) was approved. CMS notes that this also delayed the release of important quality and safety findings to the public.

CMS is updating the practice to allow the release of the CMS-2567 immediately upon receipt by the provider, supplier, or lab. While the release timeframe for the CMS-2567 is being shortened, the review period is not changing.

CMS Implements Permanent Approach to Fraud, Waste & Abuse

The Centers for Medicare & Medicaid Services announced on June 17 the intention of making the Fraud Defense Operations Center (FDOC) pilot a permanent approach to crushing Medicare & Medicaid fraud, waste, and abuse. According to the announcement, the FDOC pilot from March 31 – May 1, 2025, saved $105 million by detecting, stopping, and preventing fraud waste and abuse. You can read the fact sheet on the pilot's achievements along with visiting the Crushing Fraud, Waste, & Abuse website.

Assisted Living Rule Review – 481-69.21 Occupancy Agreement

There are rules related to the program's occupancy agreement in 481-69.21 and 231C.5. In Chapter 69.21, the Department of Inspections, Appeals, & Licensing (DIAL) requires the following:

- The occupancy agreement must be in 12-point font (or larger).

- Written in plain language, using commonly understood terms. This means that the tenant or their legal representative should be able to easily understand the agreement.
- Include the following:
    - The telephone number for filing a complaint with the department (877) 686-0027.
    - The telephone number for the office of the long-term care ombudsman (515) 725-3308 or (866) 236-1430.
    - The telephone number for reporting dependent adult abuse (DIAL Complaint number indicated above).
    - A copy of the program's statement on tenants' rights.
    - A statement that the tenant landlord law applies to assisted living programs.
    - A statement providing at least 90-days advance notice of any planned program cessation, except in cases of emergencies.

Additionally, the agreement must be reviewed and updated as necessary to reflect changes in services or financial arrangements. Copies of the agreement shall be provided to the tenant or their legal representative and maintained by the program. A blank copy of the agreement shall be available for review from the general public upon request. Finally, any marketing materials shall include a statement that a copy of the occupancy agreement is available to everyone upon request.

This rule is periodically cited for various reasons including that the agreement did not include the appropriate contact information or if the program did not have a copy of specific tenant's signed agreements.

Regulatory Review – F567 Protection of Resident Funds

Continuing in the residents' right section of Appendix PP includes F567 which tells nursing home providers that residents have the right to manage their own financial affairs. This includes what charges the nursing home may impose against their personal funds (such as transportation services). You cannot require that residents deposit any personal funds into an account with the nursing home (such as if you feel like this would be the safer option). If they choose to deposit funds within your trust account, they must agree to this in writing, and the nursing home is expected to hold, safeguard, and manage for those funds including providing an accounting of fund usage and availability. These funds must be separated from business accounts.

The resident must have access to their funds in a timely manner. While a timely manner is not immediately, it is expected that the resident can access their funds whenever they desire to do so, including evenings, weekends, and holidays. The interpretative guidance indicates that residents must be able to access requested funds of less than

$100 (or $50 for Medicaid residents) the same day of the request and three banking days for amounts of $100 (or $50 for Medicaid residents) or more.

If the resident's money is in excess of $100 (or $50 for Medicaid residents), the nursing home must place this in an interest-bearing account and provide separate accounting of these funds. The interest must be appropriately divided among the accounts and provided at least a quarterly statement. If the money is in a pooled account (such as all resident's funds are deposited into one account), there must be a system for providing individual accounting records.

If the bank charges a fee for handling funds, the nursing home may pass this fee along to the resident(s). However, the nursing home cannot charge a fee to handle the resident's money.

This regulation is not frequently cited, but when it is, the noncompliance generally relates to the resident not having access to their funds as outlined and/or the nursing home not providing statements for the resident's account including what transactions occurred and if interest is added to the account, the amount of interest accrued. While the regulation requires that this is completed on a quarterly basis, you may provide a statement of accounting more frequently if desired.

New Member Resources Available

LeadingAge Iowa is pleased to offer new member resources including a Past Noncompliance Template for nursing homes to use as a tool to document their efforts to correct self-identified deficiencies prior to the current survey. When cited, past noncompliance does not require submission of a new plan of correction and can be taken into account with enforcement action. This tool will be an excellent resource as part of your quality assurance program.

Library of Free Member Webinar Recordings

Upcoming Events

Leveraging Rehab Outcomes for Managed Care: Section GG Isn't Enough (virtual)
July 10 from 1:30-2:30 p.m.

Regional Networking Meeting (in-person)
July 15 from 1-3 p.m.
Location: Friendship Haven, Fort Dodge

CAA Virtual Program (virtual)
July 17 from 11 a.m.-3 p.m.