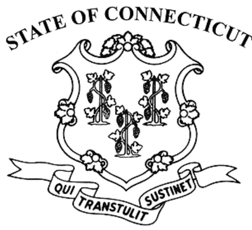

Senate

General Assembly

File No. 124

February Session, 2026

Substitute Senate Bill No. 288

Senate, March 23, 2026

The Committee on Aging reported through SEN. HOCHADEL of the 13th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES' RECOMMENDATIONS REGARDING EXCEPTIONS TO THE NURSING HOME BED MORATORIUM, NURSING HOME RESIDENT DATA AND NURSING HOME REIMBURSEMENT RATE CAPS FOR RELATED PARTY EMPLOYEES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (a) of section 17b-354 of the 2026 supplement to
2 the general statutes is repealed and the following is substituted in lieu
3 thereof (*Effective from passage*):

4 (a) The Department of Social Services shall not accept or approve any
5 requests for additional nursing home beds, except (1) beds restricted to
6 use by patients with acquired immune deficiency syndrome or by
7 patients requiring neurological rehabilitation; (2) beds associated with a
8 continuing care facility, as described in section 17b-520, provided such
9 beds are not used in the Medicaid program; **[**. For the purpose of this
10 subsection, beds associated with a continuing care facility are not subject
11 to the certificate of need provisions pursuant to sections 17b-352 and
12 17b-353;**]** (3) Medicaid certified beds <u>either</u> to be relocated from one

13 licensed nursing facility to another licensed nursing facility to meet a
14 priority need identified in the strategic plan developed pursuant to
15 subsection (c) of section 17b-369 or new beds added to an existing
16 facility or a new facility with preference given to a nontraditional, small-
17 house-style nursing home facility that incorporates the goals for nursing
18 facilities referenced in the department's strategic plan for long-term
19 care, as described in section 17b-355, as amended by this act, to address
20 priority needs reflected by area census trends; (4) licensed Medicaid
21 nursing facility beds to be relocated from one or more existing nursing
22 facilities to a new nursing facility, including a replacement facility,
23 provided (A) no new Medicaid certified beds are added, (B) at least one
24 currently licensed facility is closed in the transaction as a result of the
25 relocation, (C) the relocation is done within available appropriations,
26 (D) the facility participates in the Money Follows the Person
27 demonstration project pursuant to section 17b-369, (E) the availability of
28 beds in the area of need will not be adversely affected, (F) the certificate
29 of need approval for such new facility or facility relocation and the
30 associated capital expenditures are obtained pursuant to sections 17b-
31 352 and 17b-353, and (G) the facilities included in the bed relocation and
32 closure shall be in accordance with the strategic plan developed
33 pursuant to subsection (c) of section 17b-369; and (5) proposals to build
34 a nontraditional, small-house style nursing home designed to enhance
35 the quality of life for nursing facility residents, provided that the
36 nursing facility agrees to reduce its total number of licensed beds by a
37 percentage determined by the Commissioner of Social Services in
38 accordance with the department's strategic plan for long-term care. For
39 the purposes of this subsection, beds associated with a continuing care
40 facility are not subject to the certificate of need provisions pursuant to
41 sections 17b-352 and 17b-353.

42 Sec. 2. Section 17b-355 of the general statutes is repealed and the
43 following is substituted in lieu thereof (*Effective from passage*):

44 (a) In determining whether a request submitted pursuant to sections
45 17b-352 to 17b-354, inclusive, as amended by this act, will be granted,
46 modified or denied, the Commissioner of Social Services shall consider

47 the following: (1) The financial feasibility of the request and its impact
48 on the applicant's rates and financial condition, (2) the contribution of
49 the request to the quality, accessibility and cost-effectiveness of the
50 delivery of long-term care in the region, including consideration of the
51 nursing home's star rating on the five-star quality rating system for
52 nursing homes published by the Centers for Medicare and Medicaid
53 Services, (3) whether there is clear public need for the request, (4) the
54 relationship of any proposed change to the applicant's current
55 utilization statistics and the effect of the proposal on the utilization
56 statistics of other facilities in the applicant's service area, (5) the business
57 interests of all owners, partners, associates, incorporators, directors,
58 sponsors, stockholders and operators and the personal background of
59 such persons, and (6) any other factor which the Department of Social
60 Services deems relevant. In considering whether there is clear public
61 need for any request for the relocation of beds to a replacement facility,
62 or for new beds added to an existing facility or a new facility, the
63 commissioner shall consider whether there is a demonstrated bed need
64 in the towns within a fifteen-mile radius of the town in which the beds
65 are proposed to be located and whether the availability of beds in the
66 applicant's service area will be adversely affected.

67 (b) Any proposal to relocate nursing home beds from an existing
68 facility to a new facility shall not increase the number of Medicaid
69 certified beds and shall result in the closure of at least one currently
70 licensed facility. The commissioner may request that any applicant
71 seeking to replace an existing facility reduce the number of beds in the
72 new facility by a percentage that is consistent with the department's
73 strategic state-wide long-term rebalancing plan for long-term care. If an
74 applicant seeking to replace an existing facility with a new facility owns
75 or operates more than one nursing facility, the commissioner may
76 request that the applicant close two or more facilities before approving
77 the proposal to build a new facility. The commissioner shall also
78 consider whether an application to establish a new or replacement
79 nursing facility proposes a nontraditional, small-house style nursing
80 facility and incorporates goals for nursing facilities referenced in the
81 department's strategic state-wide long-term rebalancing plan for long-

82 term care, including, but not limited to, (1) promoting person-centered
83 care, (2) providing enhanced quality of care, (3) creating community
84 space for all nursing facility residents, and (4) developing stronger
85 connections between the nursing facility residents and the surrounding
86 community. [Bed]

87 (c) Demonstrated bed need shall be based on the recent occupancy
88 percentage of area nursing facilities [and the] with occupancy above
89 ninety-six per cent for a minimum of two consecutive quarters. The
90 department may consider projected bed need [for no more than five
91 years] into the future at [ninety-seven and one-half per cent] occupancy
92 above ninety-six per cent using the latest [official population projections
93 by town and age as published by the Office of Policy and Management
94 and the latest available state-wide nursing facility utilization statistics
95 by age cohort from the Department of Public Health] strategic state-
96 wide long-term rebalancing plan for long-term care as published by the
97 department. The commissioner may also consider area specific
98 utilization and reductions in utilization rates to account for the
99 increased use of less institutional alternatives.

100 Sec. 3. Section 17b-99a of the 2026 supplement to the general statutes
101 is repealed and the following is substituted in lieu thereof (*Effective July*
102 *1, 2026*):

103 (a) (1) For purposes of this section, (A) "extrapolation" means the
104 determination of an unknown value by projecting the results of the
105 review of a sample to the universe from which the sample was drawn,
106 (B) "facility" means any facility described in this subsection and for
107 which rates are established pursuant to section 17b-340, as amended by
108 this act, (C) "minimum data set" means the federal resident assessment
109 tool required by the Centers for Medicare and Medicaid Services, and
110 [(C)] (D) "universe" means a defined population of claims submitted by
111 a facility during a specific time period.

112 (2) The Commissioner of Social Services shall conduct any audit of a
113 licensed chronic and convalescent nursing home, chronic disease
114 hospital associated with a chronic and convalescent nursing home, a rest

115 home with nursing supervision, a licensed residential care home, as
116 defined in section 19a-490, and a residential facility for persons with
117 intellectual disability which is licensed pursuant to section 17a-227 and
118 certified to participate in the Medicaid program as an intermediate care
119 facility for individuals with intellectual disabilities in accordance with
120 the provisions of this section.

121 (b) Not less than thirty days prior to the commencement of any such
122 audit, the commissioner shall provide written notification of the audit
123 to such facility, unless the commissioner makes a good-faith
124 determination that (1) the health or safety of a recipient of services is at
125 risk; or (2) the facility is engaging in vendor fraud under sections 53a-
126 290 to 53a-296, inclusive.

127 (c) Any clerical error, including, but not limited to, recordkeeping,
128 typographical, scrivener's or computer error, discovered in a record or
129 document produced for any such audit, shall not of itself constitute a
130 wilful violation of the rules of a medical assistance program
131 administered by the Department of Social Services unless proof of intent
132 to commit fraud or otherwise violate program rules is established. In
133 determining which facilities shall be subject to audits, the Commissioner
134 of Social Services may give consideration to the history of a facility's
135 compliance in addition to other criteria used to select a facility for an
136 audit.

137 (d) A finding of overpayment or underpayment to such facility shall
138 not be based on extrapolation unless (1) there is a determination of
139 sustained or high level of payment error involving the facility, (2)
140 documented educational intervention has failed to correct the level of
141 payment error, or (3) the value of the claims in aggregate exceeds two
142 hundred thousand dollars on an annual basis.

143 (e) A facility, in complying with the requirements of any such audit,
144 shall be allowed not less than thirty days to provide documentation in
145 connection with any discrepancy discovered and brought to the
146 attention of such facility in the course of any such audit.

147 (f) The commissioner shall produce a preliminary written report
148 concerning any audit conducted pursuant to this section and such
149 preliminary report shall be provided to the facility that was the subject
150 of the audit not later than sixty days after the conclusion of such audit.

151 (g) The commissioner shall, following the issuance of the preliminary
152 report pursuant to subsection (f) of this section, hold an exit conference
153 with any facility that was the subject of any audit pursuant to this
154 subsection for the purpose of discussing the preliminary report. Such
155 facility may present evidence at such exit conference refuting findings
156 in the preliminary report.

157 (h) The commissioner shall produce a final written report concerning
158 any audit conducted pursuant to this subsection. Such final written
159 report shall be provided to the facility that was the subject of the audit
160 not later than sixty days after the date of the exit conference conducted
161 pursuant to subsection (g) of this section, unless the commissioner and
162 the facility agree to a later date or there are other referrals or
163 investigations pending concerning the facility.

164 (i) Any facility aggrieved by a final report issued pursuant to
165 subsection (h) of this section may request a rehearing. A rehearing shall
166 be held by the commissioner or the commissioner's designee, provided
167 a detailed written description of all items of aggrievement in the final
168 report is filed by the facility not later than ninety days following the date
169 of written notice of the commissioner's decision. The rehearing shall be
170 held not later than thirty days following the date of filing of the detailed
171 written description of each specific item of aggrievement. The
172 commissioner shall issue a final decision not later than sixty days
173 following the close of evidence or the date on which final briefs are filed,
174 whichever occurs later. Any items not resolved at such rehearing to the
175 satisfaction of the facility or the commissioner shall be submitted to
176 binding arbitration by an arbitration board consisting of one member
177 appointed by the facility, one member appointed by the commissioner
178 and one member appointed by the Chief Court Administrator from
179 among the retired judges of the Superior Court, which retired judge

180 shall be compensated for his services on such board in the same manner
181 as a state referee is compensated for his services under section 52-434.
182 The proceedings of the arbitration board and any decisions rendered by
183 such board shall be conducted in accordance with the provisions of the
184 Social Security Act, 42 USC 1396, as amended from time to time, and
185 chapter 54.

186 (j) The commissioner shall conduct audits of minimum data set
187 information used in the calculation of Medicaid acuity-based per diem
188 rates paid to licensed nursing homes. The commissioner shall conduct
189 an audit of minimum data set information in accordance with the
190 provisions of this section, except a nursing home shall provide all
191 documentation requested by the commissioner pursuant to the
192 minimum data set audit not later than ten days after the date on which
193 the commissioner requests such documentation. The commissioner
194 shall not accept any documentation submitted by a nursing home after
195 the completion of the exit conference portion of the audit unless the
196 commissioner and the nursing home agree to such submission of
197 documentation.

198 **[**(j)**]** (k) The submission of any false or misleading **[**fiscal**]** information
199 or data to the commissioner shall be grounds for suspension of
200 payments by the state under sections 17b-239 to 17b-246, inclusive, and
201 sections 17b-340, as amended by this act, and 17b-343, in accordance
202 with regulations adopted by the commissioner. In addition, any person,
203 including any corporation, who knowingly makes or causes to be made
204 any false or misleading statement or who knowingly submits false or
205 misleading fiscal information or data on the forms approved by the
206 commissioner shall be guilty of a class D felony.

207 **[**(k)**]** (l) The commissioner, or any agent authorized by the
208 commissioner to conduct any inquiry, investigation or hearing under
209 the provisions of this section, shall have power to administer oaths and
210 take testimony under oath relative to the matter of inquiry or
211 investigation. At any hearing ordered by the commissioner, the
212 commissioner or such agent having authority by law to issue such

213 process may subpoena witnesses and require the production of records,
214 papers and documents pertinent to such inquiry. If any person disobeys
215 such process or, having appeared in obedience thereto, refuses to
216 answer any pertinent question put to the person by the commissioner or
217 the commissioner's authorized agent or to produce any records and
218 papers pursuant thereto, the commissioner or the commissioner's agent
219 may apply to the superior court for the judicial district of Hartford or
220 for the judicial district wherein the person resides or wherein the
221 business has been conducted, or to any judge of such court if the same
222 is not in session, setting forth such disobedience to process or refusal to
223 answer, and such court or judge shall cite such person to appear before
224 such court or judge to answer such question or to produce such records
225 and papers.

226 [(l)] (m) The commissioner shall provide free training to facilities on
227 the preparation of cost reports to avoid clerical errors and shall post
228 information on the department's Internet web site concerning the
229 auditing process and methods to avoid clerical errors. Not later than
230 April 1, 2015, the commissioner shall establish audit protocols to assist
231 facilities subject to audit pursuant to this section in developing
232 programs to improve compliance with Medicaid requirements under
233 state and federal laws and regulations, provided audit protocols may
234 not be relied upon to create a substantive or procedural right or benefit
235 enforceable at law or in equity by any person, including a corporation.
236 The commissioner shall establish and publish on the department's
237 Internet web site audit protocols for: (1) Licensed chronic and
238 convalescent nursing homes, (2) chronic disease hospitals associated
239 with chronic and convalescent nursing homes, (3) rest homes with
240 nursing supervision, (4) licensed residential care homes, as defined in
241 section 19a-490, and (5) residential facilities for persons with intellectual
242 disability that are licensed pursuant to section 17a-227 and certified to
243 participate in the Medicaid program as intermediate care facilities for
244 individuals with intellectual disabilities. The commissioner shall ensure
245 that the Department of Social Services, or any entity with which the
246 commissioner contracts to conduct an audit pursuant to this section, has
247 on staff or consults with, as needed, licensed health professionals with

248 experience in treatment, billing and coding procedures used by the
249 facilities being audited pursuant to this section.

250 Sec. 4. Subsection (a) of section 17b-340 of the 2026 supplement to the
251 general statutes is repealed and the following is substituted in lieu
252 thereof (*Effective July 1, 2026*):

253 (a) For purposes of this subsection, (1) a "related party" includes, but
254 is not limited to, any company related to a chronic and convalescent
255 nursing home through family association, common ownership, control
256 or business association with any of the owners, operators or officials of
257 such nursing home; (2) "company" means any person, partnership,
258 association, holding company, limited liability company or corporation;
259 (3) "family association" means a relationship by birth, marriage or
260 domestic partnership; and (4) "profit and loss statement" means the
261 most recent annual statement on profits and losses finalized by a related
262 party before the annual report mandated under this subsection. The
263 rates to be paid by or for persons aided or cared for by the state or any
264 town in this state to licensed chronic and convalescent nursing homes,
265 to chronic disease hospitals associated with chronic and convalescent
266 nursing homes, to rest homes with nursing supervision, to licensed
267 residential care homes, as defined by section 19a-490, and to residential
268 facilities for persons with intellectual disability that are licensed
269 pursuant to section 17a-227 and certified to participate in the Title XIX
270 Medicaid program as intermediate care facilities for individuals with
271 intellectual disabilities, for room, board and services specified in
272 licensing regulations issued by the licensing agency shall be determined
273 annually, except as otherwise provided in this subsection by the
274 Commissioner of Social Services, to be effective July first of each year
275 except as otherwise provided in this subsection. Such rates shall be
276 determined on a basis of a reasonable payment for such necessary
277 services, which basis shall take into account as a factor the costs of such
278 services. Cost of such services shall include reasonable costs mandated
279 by collective bargaining agreements with certified collective bargaining
280 agents or other agreements between the employer and employees,
281 provided "employees" shall not include persons who are a related party

282 or employed as managers or chief administrators or required to be
283 licensed as nursing home administrators, and compensation for services
284 rendered by proprietors at prevailing wage rates, as determined by
285 application of principles of accounting as prescribed by said
286 commissioner. Cost of such services shall not include amounts paid by
287 the facilities to employees as salary, or to attorneys or consultants as
288 fees, where the responsibility of the employees, attorneys, or consultants
289 is to persuade or seek to persuade the other employees of the facility to
290 support or oppose unionization. Nothing in this subsection shall
291 prohibit inclusion of amounts paid for legal counsel related to the
292 negotiation of collective bargaining agreements, the settlement of
293 grievances or normal administration of labor relations. The
294 commissioner may, in the commissioner's discretion, allow the inclusion
295 of extraordinary and unanticipated costs of providing services that were
296 incurred to avoid an immediate negative impact on the health and safety
297 of patients. The commissioner may, in the commissioner's discretion,
298 based upon review of a facility's costs, direct care staff to patient ratio
299 and any other related information, revise a facility's rate for any
300 increases or decreases to total licensed capacity of more than ten beds or
301 changes to its number of licensed rest home with nursing supervision
302 beds and chronic and convalescent nursing home beds. The
303 commissioner may, in the commissioner's discretion, revise the rate of a
304 facility that is closing. An interim rate issued for the period during
305 which a facility is closing shall be based on a review of facility costs, the
306 expected duration of the close-down period, the anticipated impact on
307 Medicaid costs, available appropriations and the relationship of the rate
308 requested by the facility to the average Medicaid rate for a close-down
309 period. The commissioner may so revise a facility's rate established for
310 the fiscal year ending June 30, 1993, and thereafter for any bed increases,
311 decreases or changes in licensure effective after October 1, 1989.
312 Effective July 1, 1991, in facilities that have both a chronic and
313 convalescent nursing home and a rest home with nursing supervision,
314 the rate for the rest home with nursing supervision shall not exceed such
315 facility's rate for its chronic and convalescent nursing home. All such
316 facilities for which rates are determined under this subsection shall

317 report on a fiscal year basis ending on September thirtieth. Such report
318 shall be submitted to the commissioner by February fifteenth. Each
319 chronic and convalescent nursing home that receives state funding
320 pursuant to this section shall include in such annual report a profit and
321 loss statement from each related party that receives from such chronic
322 and convalescent nursing home thirty thousand dollars or more per
323 year for goods, fees and services. No cause of action or liability shall
324 arise against the state, the Department of Social Services, any state
325 official or agent for failure to take action based on the information
326 required to be reported under this subsection. The commissioner may
327 reduce the rate in effect for a facility that fails to submit a complete and
328 accurate report on or before February fifteenth by an amount not to
329 exceed ten per cent of such rate. If a licensed residential care home fails
330 to submit a complete and accurate report, the department shall notify
331 such home of the failure and the home shall have thirty days from the
332 date the notice was issued to submit a complete and accurate report. If
333 a licensed residential care home fails to submit a complete and accurate
334 report not later than thirty days after the date of notice, such home may
335 not receive a retroactive rate increase, in the commissioner's discretion.
336 The commissioner shall, annually, on or before April first, report the
337 data contained in the reports of such facilities on the department's
338 Internet web site. For the cost reporting year commencing October 1,
339 1985, and for subsequent cost reporting years, facilities shall report the
340 cost of using the services of any nursing personnel supplied by a
341 temporary nursing services agency by separating said cost into two
342 categories, the portion of the cost equal to the salary of the employee for
343 whom the nursing personnel supplied by a temporary nursing services
344 agency is substituting shall be considered a nursing cost and any cost in
345 excess of such salary shall be further divided so that seventy-five per
346 cent of the excess cost shall be considered an administrative or general
347 cost and twenty-five per cent of the excess cost shall be considered a
348 nursing cost, provided if the total costs of a facility for nursing personnel
349 supplied by a temporary nursing services agency in any cost year are
350 equal to or exceed fifteen per cent of the total nursing expenditures of
351 the facility for such cost year, no portion of such costs in excess of fifteen

352 per cent shall be classified as administrative or general costs. The
353 commissioner, in determining such rates, shall also take into account the
354 classification of patients or boarders according to special care
355 requirements or classification of the facility according to such factors as
356 facilities and services and such other factors as the commissioner deems
357 reasonable, including anticipated fluctuations in the cost of providing
358 such services. The commissioner may establish a separate rate for a
359 facility or a portion of a facility for traumatic brain injury patients who
360 require extensive care but not acute general hospital care. Such separate
361 rate shall reflect the special care requirements of such patients. If
362 changes in federal or state laws, regulations or standards adopted
363 subsequent to June 30, 1985, result in increased costs or expenditures in
364 an amount exceeding one-half of one per cent of allowable costs for the
365 most recent cost reporting year, the commissioner shall adjust rates and
366 provide payment for any such increased reasonable costs or
367 expenditures within a reasonable period of time retroactive to the date
368 of enforcement. Nothing in this section shall be construed to require the
369 Department of Social Services to adjust rates and provide payment for
370 any increases in costs resulting from an inspection of a facility by the
371 Department of Public Health. Such assistance as the commissioner
372 requires from other state agencies or departments in determining rates
373 shall be made available to the commissioner at the commissioner's
374 request. Payment of the rates established pursuant to this section shall
375 be conditioned on the establishment by such facilities of admissions
376 procedures that conform with this section, section 19a-533 and all other
377 applicable provisions of the law and the provision of equality of
378 treatment to all persons in such facilities. The established rates shall be
379 the maximum amount chargeable by such facilities for care of such
380 beneficiaries, and the acceptance by or on behalf of any such facility of
381 any additional compensation for care of any such beneficiary from any
382 other person or source shall constitute the offense of aiding a beneficiary
383 to obtain aid to which the beneficiary is not entitled and shall be
384 punishable in the same manner as is provided in subsection (b) of
385 section 17b-97. Notwithstanding any provision of this section, the
386 Commissioner of Social Services may, within available appropriations,

387 provide an interim rate increase for a licensed chronic and convalescent
388 nursing home or a rest home with nursing supervision for rate periods
389 no earlier than April 1, 2004, only if the commissioner determines that
390 the increase is necessary to avoid the filing of a petition for relief under
391 Title 11 of the United States Code; imposition of receivership pursuant
392 to sections 19a-542 and 19a-543; or substantial deterioration of the
393 facility's financial condition that may be expected to adversely affect
394 resident care and the continued operation of the facility, and the
395 commissioner determines that the continued operation of the facility is
396 in the best interest of the state. The commissioner shall consider any
397 requests for interim rate increases on file with the department from
398 March 30, 2004, and those submitted subsequently for rate periods no
399 earlier than April 1, 2004. When reviewing an interim rate increase
400 request the commissioner shall, at a minimum, consider: (A) Existing
401 chronic and convalescent nursing home or rest home with nursing
402 supervision utilization in the area and projected bed need; (B) physical
403 plant long-term viability and the ability of the owner or purchaser to
404 implement any necessary property improvements; (C) licensure and
405 certification compliance history; (D) reasonableness of actual and
406 projected expenses; and (E) the ability of the facility to meet wage and
407 benefit costs. No interim rate shall be increased pursuant to this
408 subsection in excess of one hundred fifteen per cent of the median rate
409 for the facility's peer grouping, established pursuant to subdivision (3)
410 of subsection (a) of section 17b-340d, unless recommended by the
411 commissioner and approved by the Secretary of the Office of Policy and
412 Management after consultation with the commissioner. Such median
413 rates shall be published by the Department of Social Services not later
414 than April first of each year. In the event that a facility granted an
415 interim rate increase pursuant to this section is sold or otherwise
416 conveyed for value to an unrelated entity less than five years after the
417 effective date of such rate increase, the rate increase shall be deemed
418 rescinded and the department shall recover an amount equal to the
419 difference between payments made for all affected rate periods and
420 payments that would have been made if the interim rate increase was
421 not granted. The commissioner may seek recovery of such payments

422 from any facility with common ownership. With the approval of the
423 Secretary of the Office of Policy and Management, the commissioner
424 may waive recovery and rescission of the interim rate for good cause
425 shown that is not inconsistent with this section, including, but not
426 limited to, transfers to family members that were made for no value. The
427 commissioner shall provide written quarterly reports to the joint
428 standing committees of the General Assembly having cognizance of
429 matters relating to aging, human services and appropriations and the
430 budgets of state agencies, that identify each facility requesting an
431 interim rate increase, the amount of the requested rate increase for each
432 facility, the action taken by the commissioner and the secretary pursuant
433 to this subsection, and estimates of the additional cost to the state for
434 each approved interim rate increase. Nothing in this subsection shall
435 prohibit the commissioner from increasing the rate of a licensed chronic
436 and convalescent nursing home or a rest home with nursing supervision
437 for allowable costs associated with facility capital improvements or
438 increasing the rate in case of a sale of a licensed chronic and convalescent
439 nursing home or a rest home with nursing supervision if receivership
440 has been imposed on such home. For purposes of this section,
441 "temporary nursing services agency" and "nursing personnel" have the
442 same meaning as provided in section 19a-118.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	17b-354(a)
Sec. 2	*from passage*	17b-355
Sec. 3	*July 1, 2026*	17b-99a
Sec. 4	*July 1, 2026*	17b-340(a)

Statement of Legislative Commissioners:

In Section 1(a), "outlined in" was changed to "described in" for accuracy and Section 3(j) was redrafted for clarity.

AGE *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 27 $	FY 28 $
Social Services, Dept.	GF - Potential Cost/ Savings	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

Sections 1 and **2** of the bill could result in increased Medicaid costs to the Department of Social Services (DSS) associated with allowing DSS to approve requests to add new Medicaid-certified beds to existing or new nursing homes. To the extent this results in a higher cost per bed than Medicaid would otherwise support, or new costs related to a new facility, the state will incur associated allowable Medicaid expenditures. The actual fiscal impact is dependent on the scope and approval of such requests.

Section 2 also adds to the list of items DSS must consider when determining whether to approve or deny requests for additional nursing home beds. To the extent considering the Center for Medicare and Medicaid Services' (CMS) five-star quality rating system alters the decision DSS would have otherwise made, the agency could experience an impact, which cannot be determined at this time.

Section 3 modifies minimum data set requirements for audit purposes. This could impact nursing home rates to the extent limiting the timeframe in which minimum data set information must be

submitted adjusts the calculation of Medicaid acuity-based per diem rates paid to nursing homes.

Section 4 limits Medicaid reimbursement for union employees who are related to an owner of a nursing home, which will reduce rates to the extent such related parties costs would otherwise be factored into Medicaid rates.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to related adjustments to Medicaid rates for nursing homes.

OLR Bill Analysis
SB 288

AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES' RECOMMENDATIONS REGARDING EXCEPTIONS TO THE NURSING HOME BED MORATORIUM, NURSING HOME RESIDENT DATA AND NURSING HOME REIMBURSEMENT RATE CAPS FOR RELATED PARTY EMPLOYEES.

SUMMARY

This bill makes several unrelated changes to laws on nursing homes. Primarily, it:

1. creates an exception to the state's nursing home bed moratorium, allowing the Department of Social Services (DSS) to approve additional Medicaid-certified beds in existing or new nursing homes under certain circumstances;

2. modifies the factors the DSS commissioner must consider when reviewing certificate of need (CON) applications;

3. establishes a separate process for DSS audits of licensed nursing homes' minimum data set information for acuity-based Medicaid payments; and

4. caps the Medicaid reimbursement rate of pay for union employees who are related to the owner of a nursing home.

The bill also makes minor, technical and conforming changes.

EFFECTIVE DATE: Upon passage, except the provisions on DSS audits and Medicaid reimbursement for related-party pay are effective July 1, 2026.

§ 1— NURSING HOME BED MORATORIUM EXCEPTION

Existing law establishes a nursing home bed moratorium that generally prohibits DSS from accepting or approving CON requests for

more nursing home beds, with certain exceptions (see BACKGROUND).

The bill adds a new exception that allows DSS to approve a request to add new Medicaid-certified beds to existing or new nursing homes. When doing so, the department must give preference to nontraditional, small-house style nursing homes whose goals are in keeping with the department's long-term care strategic plan to address facility needs in priority census tracts.

§ 2 — CON CRITERIA

By law, nursing homes, rest homes, and intermediate care facilities for people with intellectual disabilities must generally receive CON approval from DSS when (1) introducing new services, (2) changing ownership, (3) relocating licensed beds or decreasing bed capacity, (4) terminating a service, or (5) incurring certain capital expenditures.

Under existing law and the bill, the DSS commissioner must consider several factors when reviewing CON requests, such as whether there is clear public need for the proposal. When determining public need for requests to add new Medicaid-certified beds under the bill, the commissioner must consider whether there is a demonstrated bed need in the towns within a 15-mile radius of the town where the new beds will be added. (Existing law also requires the commissioner to do this when considering requests to relocate beds to a replacement nursing home.)

For all CON requests, existing law requires the commissioner to consider how a request contributes to regional long-term care delivery quality, accessibility, and cost-effectiveness. Under the bill, in making this consideration, she must include the requesting nursing home's star rating on the Centers for Medicare and Medicaid Service's (CMS) five-star quality rating system for nursing homes.

The bill also modifies how bed need is determined for CON requests. Under the bill, a service area with a demonstrated bed need is one whose nursing home occupancy is above 96% for at least two consecutive

quarters. The DSS commissioner may also consider the service area's projected future bed need above 96% occupancy using its latest strategic statewide long-term care rebalancing plan. Currently, demonstrated bed need is based on a service area's nursing home occupancy (the law does not specify a percentage) and projected bed need for up to five years at 97.5% occupancy using the (1) Office of Policy and Management's latest population projections by town and age and (2) Department of Public Health's latest available nursing home utilization statistics by age cohort.

§ 3 — NURSING HOME MINIMUM DATA SET AUDITS

Existing law sets procedures and requirements related to DSS audits of long-term care facilities that receive Medicaid or other state payments (for example, nursing homes, residential care homes, and intermediate care facilities for people with intellectual disabilities).

The bill establishes a different process for DSS audits of nursing homes' minimum data set (MDS) information. Federal law requires nursing homes to assess each resident's functional capacity using the MDS assessment tool and DSS then uses the information to calculate nursing homes' acuity-based Medicaid reimbursement rates. (Generally, acuity-based rates refer to rates that vary based on, among other things, the facility's patient casemix.)

Deadline to Provide Information

Under the bill, if DSS requests documentation related to an MDS audit, the nursing home must provide it within 10 days. For other types of audits, existing law grants facilities at least 30 days to provide documentation on any discrepancies found during the audit.

Limitation on Post-Exit Interview Submissions

Under existing law, unchanged by the bill, the commissioner must prepare a preliminary report on an audit's findings. She must then hold an exit conference with the audited facility to discuss the preliminary report, and the facility may present evidence refuting the report's findings. For MDS audits, the bill prohibits nursing homes from giving

the commissioner any more documentation after the exit conference, unless the commissioner and nursing home agree to it.

§ 4 — MEDICAID REIMBURSEMENT FOR RELATIVES' WAGES

Under existing law, the DSS commissioner sets Medicaid reimbursement rates for nursing homes, (as well as certain chronic disease hospitals, residential care homes, and intermediate care facilities for people with intellectual disabilities). These rates take into account the costs of providing necessary services and include expenses required under any collective bargaining agreement, such as union employee compensation, or other agreements.

For union employees who are related to a nursing home's owners, operators, or officials, the bill limits how much of the employee's compensation is eligible for Medicaid reimbursement. The bill appears to limit Medicaid reimbursement for these employees to the allowable salary amount set in law for related parties.

Under existing law, unchanged by the bill, reimbursement for a non-union related party's salary is limited to amounts annually published in a salary limitations schedule.

By law, "related parties" include any company related to a nursing home's owners, operators, or officials through common ownership, control, business association, or family association (a relationship by birth, marriage, or domestic partnership).

BACKGROUND

DSS CON Program

By law, nursing homes, rest homes, and intermediate care facilities for people with intellectual disabilities must generally receive CON approval from DSS when (1) introducing new services, (2) changing ownership, (3) relocating licensed beds or decreasing bed capacity, (4) terminating a service, or (5) incurring certain capital expenditures.

Exceptions to Nursing Home Bed Moratorium

For over 30 years, the state has placed a moratorium on new nursing

home beds, except for those:

1. restricted to use by patients with AIDS or who require neurological rehabilitation;
2. associated with a continuing care facility, if they are not used for Medicaid patients;
3. that are Medicaid-certified and relocated from one licensed nursing home to another or to a new facility, under certain conditions; and
4. in certain nontraditional, small-house style nursing homes.

COMMITTEE ACTION

Aging Committee

Joint Favorable
Yea 14 Nay 0 (03/05/2026)