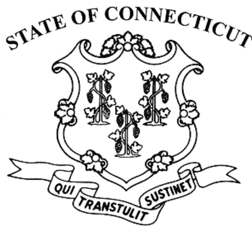

Senate

General Assembly **File No. 79**

February Session, 2026

Substitute Senate Bill No. 289

Senate, March 19, 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 FUNDING OF THE QUALITY METRICS PROGRAM FOR NURSING HOMES.

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

1 Section 1. Subdivision (2) of subsection (a) of section 17b-340d of the
2 2026 supplement to the general statutes is repealed and the following is
3 substituted in lieu thereof (*Effective from passage*):

4 (2) (A) Beginning July 1, 2022, facilities will be required to comply
5 with collection and reporting of quality metrics as specified by the
6 Department of Social Services, after consultation with the nursing home
7 industry, consumers, employees and the Department of Public Health.
8 Rate adjustments based on performance on quality metrics will be
9 phased in, beginning July 1, 2022, with a period of reporting only.
10 Effective July 1, 2023, the Department of Social Services shall issue
11 individualized reports annually to each nursing home facility showing
12 the impact to the Medicaid rate for such home based on the quality
13 metrics program. A nursing home facility receiving an individualized
14 quality metrics report may use such report to evaluate the impact of the

15 quality metrics program on said facility's Medicaid reimbursement. On
16 or after October 1, 2026, the Department of Social Services may establish
17 a quality metrics program, within available appropriations designated
18 for such purpose, to provide payments to nursing home facilities **[**(A)**]**
19 (i) for high-quality outcomes based on performance in the quality
20 metrics program, and **[**(B)**]** (ii) designed to incentivize the provision of
21 high-quality services to nursing home residents who are Medicaid
22 beneficiaries, as indicated in the individualized report issued to each
23 nursing home facility pursuant to the provisions of this subdivision.
24 Such quality metrics program shall evaluate nursing home facilities
25 based on national quality measures for nursing home facilities issued by
26 the Centers for Medicare and Medicaid Services and state-administered
27 consumer satisfaction measures. Such quality measures may be
28 weighted higher for desired outcomes, as determined by the
29 department. Not later than February 1, 2027, the department shall
30 submit a report, in accordance with the provisions of section 11-4a, to
31 the joint standing committees of the General Assembly having
32 cognizance of matters relating to appropriations and the budgets of state
33 agencies and human services on the implementation of the quality
34 metrics program.

35 (B) For the fiscal year ending June 30, 2029, and each fiscal year
36 thereafter, the Department of Social Services shall make distributions,
37 from an annual pool of ten million dollars of enhanced Medicaid quality
38 performance payments, to eligible nursing home facilities based on each
39 nursing home facility's performance in the quality metrics program.
40 Payments will be determined based on the maximum quality score
41 points a nursing home facility may be awarded for its performance in
42 improving its quality metrics. In determining a nursing home facility's
43 maximum quality score points, the department may use the Centers for
44 Medicare and Medicaid Services' nursing home quarterly metrics for
45 patients with stays of one hundred one days or longer, a consumer
46 satisfaction survey and Department of Public Health data. Nursing
47 home facilities that have been identified by the Centers for Medicare and
48 Medicaid Services as special focus facilities for serious quality of care
49 issues, special focus facility candidates or with an abuse icon on the

50 centers' Nursing Home Compare Internet web site shall not be eligible
51 for participation in the quality metrics program and shall not receive
52 payment. Enhanced Medicaid quality performance payments may be
53 prorated to stay within available appropriations.

54 (C) On and after July 1, 2026, the Department of Social Services shall
55 utilize the nursing component of the Patient Driven Payment Model
56 resident assessment to calculate quarterly adjustments to the Medicaid
57 nursing home facility reimbursement case-mix index scores. To align
58 Medicaid cost data with the Patient Driven Payment Model resident
59 assessment data, the department shall rebase nursing home facility
60 Medicaid per diem rates using the cost year ending September 30, 2024,
61 for rates effective July 1, 2026. To incorporate Patient Driven Payment
62 Model data into the Medicaid per diem payment calculation, the
63 department shall adjust Medicaid rates over a three-year phase-in
64 period. The three-year phase-in period shall use phase-in parameters,
65 including, but not limited to, budget adjustment factors, case-mix
66 neutrality factors and stop loss and stop gain corridors, as necessary, to
67 stay within available appropriations.

68 (D) Not later than July 1, 2026, the Department of Social Services shall
69 implement a Medicaid utilization pool that provides enhanced
70 Medicaid payments to nursing home facilities that have a resident payor
71 mix that comprises more than seventy-five per cent Medicaid members.
72 Utilizing annual Medicaid cost reports, the department shall determine
73 each nursing home facility's payor mix to identify nursing home
74 facilities eligible to receive enhanced Medicaid payments on an annual
75 basis. Payments shall be for the purpose of supporting increased
76 Medicaid utilization and enhanced access and services for Medicaid
77 members. Eligible nursing home facilities shall receive enhanced
78 Medicaid funding from a funding pool limited to two million five
79 hundred thousand dollars for the fiscal year ending June 30, 2027, and
80 five million dollars for subsequent fiscal years. The Commissioner of
81 Social Services may prorate enhanced Medicaid utilization payments to
82 stay within available appropriations.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	17b-340d(a)(2)

AGE *Joint Favorable Subst.*

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 - Cost	at least $1.25 million	at least $2.5 million

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill requires Department of Social Services (DSS) to adjust Medicaid rates over a three-year phase-in period to offset reductions due to implementation of the federal patient driven payment model for nursing homes. The extent of the phase-in and related costs are not specified by the bill.

The bill also requires DSS to implement a Medicaid utilization pool of $2.5 million in FY 27 and $5 million in FY 28 (state share of $1.25 million and $2.5 million, respectively) to provide enhanced payments to certain nursing homes. Payments may be prorated to stay within available appropriations.

The bill makes other clarifying and conforming changes that have no fiscal impact.

The Out Years

Beginning in FY 29, the bill requires DSS to make enhanced Medicaid quality performance payments, from an annual pool of $10 million ($5 million state share), to eligible nursing home facilities.

OLR Bill Analysis
sSB 289

AN ACT CONCERNING FUNDING OF THE QUALITY METRICS PROGRAM FOR NURSING HOMES.

SUMMARY

This bill makes several changes in laws on Medicaid reimbursement for nursing homes. Primarily, it:

1. establishes an enhanced Medicaid performance payment for nursing homes that improve their quality-based metrics and requires the Department of Social Services (DSS), beginning in FY 29, to pay it from an annual pool of $10 million;

2. beginning July 1, 2026, requires DSS to phase in the federal Patient Driven Payment Model (PDPM) for nursing home resident assessments; and

3. establishes an enhanced payment for nursing homes whose payor mix is more than 75% Medicaid residents and, beginning in FY 27, requires DSS to pay it from a pool of $2.5 million for the first year and $5 million for each of the following years.

EFFECTIVE DATE: Upon passage

ACUITY-BASED ENHANCED QUALITY PERFORMANCE PAYMENTS

Existing law requires DSS to implement an acuity-based Medicaid reimbursement rate for nursing homes. (Acuity-based rates generally reimburse nursing homes based on the level of care residents need.)

As part of this transition, existing law authorizes DSS, beginning October 1, 2026, to establish a quality metrics program to pay nursing homes (1) for achieving high-quality outcomes based on the program's

quality metrics and (2) to incentivize high-quality services to Medicaid residents based on individualized reports DSS gives the nursing homes.

The bill establishes enhanced Medicaid quality performance payments for eligible nursing homes based on their performance in the quality metrics program. Beginning with FY 29, it requires DSS to make these enhanced payments from an annual pool of $10 million and allows DSS to prorate payments to stay within available funding.

Under the bill, a facility's maximum quality score points determine its payment. Maximum quality score points may be awarded for a facility's improvements in its quality metrics and DSS may use the following to determine a facility's points:

1. the Center for Medicare and Medicaid Services (CMS) nursing home quarterly metrics for patient stays of 101 days or longer,
2. a consumer satisfaction survey, or
3. Department of Public Health data.

A nursing home is ineligible for these enhanced payments under the bill if CMS has (1) identified the home as a special focus facility, due to serious quality of care issues, or special focus facility candidate or (2) given it an abuse icon on CMS' Nursing Home Compare website. The bill also prohibits these homes from participating in the quality metrics program.

REBASING RATES USING THE PATIENT DRIVEN PAYMENT MODEL

Beginning July 1, 2026, the bill requires DSS to calculate quarterly adjustments to the Medicaid nursing home facility reimbursement case-mix index scores using the nursing component of the PDPM (see BACKGROUND) resident assessment. In order to align Medicaid cost data with the PDPM's resident assessment data, it requires DSS to rebase nursing homes' per diem rates using the cost year ending September 30, 2024, for rates that go into effect July 1, 2026.

Additionally, the bill requires DSS to phase in Medicaid rate adjustments over a three-year period. It must use phase-in parameters as needed to stay within available appropriations. These parameters may include, among others, budget adjustment factors, case-mix neutrality factors, and stop loss and stop gain corridors.

MEDICAID UTILIZATION POOL

The bill requires DSS to give an enhanced Medicaid payment to each nursing home where the resident payor mix is more than 75% Medicaid. To identify eligible nursing homes, the bill requires DSS to annually determine each nursing home's payor mix using annual Medicaid cost reports. Nursing homes that receive an enhanced Medicaid payment under the bill must use it to support increased Medicaid utilization and enhance access and services for Medicaid residents.

Under the bill, these enhanced payments must be made from a pool of up to $2.5 million for FY 27 and $5 million for the following fiscal years, and DSS may prorate payments to stay within available funding.

BACKGROUND

PDPM

PDPM is a case-mix classification model developed by CMS to determine payments for patients based on their characteristics and services received. States using a previous model, no longer accepted by CMS, for acuity-based nursing home Medicaid payments may transition to this model.

COMMITTEE ACTION

Aging Committee

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