Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Social Services**
Proposal Name	An Act Concerning Nursing Homes
Legislative Liaison	David Seifel, Jalmar De Dios, Matt Festa
Division Requesting Proposal	Reimbursement & CON
Drafter	Nicole Godburn, Nick Mazzatto, Betsy Bujwid

Overview

Brief Summary of Proposal

Sections 1 and 2 of the proposed statutory language allow for the addition of new nursing home beds into a geographic area to address access concerns for those needing nursing home level of care. State right-sizing and rebalancing goals were implemented years ago to assist the state with excess bed capacity. What was not predicted when right-sizing goals were implemented was the impact of a global pandemic or the increased number of nursing home closures. The proposed language would allow the department to look at the state from geographic criteria versus a statewide view and to identify geographic need before the state has an access concern. This language allows DSS to be proactive in developing criteria to look at geographic need and to allow a process for expansion of nursing home beds should a region of the state experience access issues. **Section 3** of the proposal also contains language that will ensure nursing homes are properly submitting client records to DSS to inform reimbursement for the acuity level of residents. **Section 4** of the proposal restricts Medicaid payments to the related party of a nursing home owner to the related party cap for that job classification.

What problem is this proposal looking to solve?

Sections 1 and 2: Between 2021 to 2024, 15 nursing homes have closed and over 3,000 beds have been delicensed and closures continue. In accordance with statute, DSS defines nursing home access as bed need in the towns within a fifteen-mile radius of the town in which the proposed beds are located and availability of beds in the service

area; bed need is defined in statute as at 97.5% occupancy in the area. The department proposes that area need be defined as 96% occupancy during a minimum of two consecutive quarters. While statewide occupancy is 88% as of June 2025, and DSS continues to support right-sizing efforts and continues to encourage nursing homes to delicense beds, the department is being proactive should an area of the state experience too great of a contraction in available beds. For example, using the 15-mile criteria, Stratford area beds are 92% occupied and Torrington area occupancy is 90% occupied, which is greater than the statewide percentage of 88.6%. **Section 3**: Medicaid nursing home payment is based on the MDS data reported by nursing homes. The department audits this information to ensure Medicaid payment is accurate and used in accordance with its intended purpose – resident care. The department has been auditing MDS data for the past year since acuity reimbursement was fully launched in July 2024. During this time, the department has discovered that about 30% of the documentation received during the course of the MDS audit has been deemed questionable. Because nursing homes are federally required to complete MDS assessments in accordance with timeframes specified by CMS, when the department audits, the nursing home should have that documentation immediately available upon the department's request. Why is this bill important? To ensure that Medicaid payment is accurate and used for resident care. Since the launch of acuity reimbursement, the department has seen "upcoding" in MDS data of 7% whereas mature acuity systems typically see a 1% to 2% increase. Resident acuity has not increased by 7% yet nursing homes are coding residents as such and thus increasing the Medicaid payment. The MDS audit is an important tool to control upcoding and ensure accurate Medicaid payment. **Section 4.** Prevents the state from paying inflated costs or paying for costs that are not considered reasonable for Medicaid reimbursement purposes.

How does the proposal solve the problem?

Sections 1 and 2: Allows for the addition of new nursing home beds into a geographic area to address access concerns for those needing nursing home level of care. **Section 3**: Allows for the department to ensure accurate information is presented to the department during MDS audit of resident assessments. Audits ensure correct Medicaid payments made to nursing homes for appropriate care based on the MDS resident needs. **Section 4**: Related party includes, but is not limited to, any company related to a chronic and convalescent nursing home through family association, common ownership, control or business association with any of the owners, operators or officials of such nursing home. The state evaluates such arrangements to ensure compliance with the prudent buyer principal where state reimbursement for related party transactions is limited to the reasonableness of a cost, requiring that the amount paid is

what a prudent person would pay under similar circumstances. This prevents the state from paying inflated costs or paying for costs that are not considered reasonable for Medicaid reimbursement purposes.

Section by section summary:

Section #(s)	Section Summary
1 and 2	Outlines that new beds added to a facility, or the development of a new facility, will give preference to nontraditional, small-house style facilities to address priority need reflected by area census trends. Details the specific requirements needed for DSS to consider allowing the exception to the moratorium, specifically, bed need shall be based on occupancy above 96% for a minimum of two consecutive quarters.
3	Audits of long-term care facilities
4	Related party revision

Statutory Reference (if any): CGS 17b-354, 17b-99a, 17b-340

Background

☒ New Proposal ☒ Resubmission

If resubmission, please provide details below. Please also note any changes made since the last submission:

Bill #(s)	Reason bill(s) did not move forward
House Bill No. 7026	Sections 1 and 2 of this proposal were a standalone bill in 2025 that had unanimous support and was overwhelmingly voted out of committee. The bill passed in the House, but time ran out in the Senate before a final vote. The language DSS is submitting this year for Section 1 is the version passed out of the Aging Committee in 2025. Section two is the same language as House Schedule A, LCO 9720. The remaining sections of this proposal are new for 2026

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No	No. Skilled Nursing Facilities ("SNF") are handled differently in every state.

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	N/A
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

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

(a) The Department of Social Services shall not accept or approve any requests for additional nursing home beds, except (1) beds restricted to use by patients with acquired immune deficiency syndrome or by patients requiring neurological rehabilitation; (2) beds associated with a continuing care facility, as described in section 17b-520, provided such beds are not used in the Medicaid program; [. For the purpose of this subsection, beds associated with a continuing care facility are not subject to the certificate of need provisions pursuant to sections 17b-352 and 17b-353;] (3) Medicaid certified beds either to be relocated from one licensed nursing facility to another licensed nursing facility to meet a priority need identified in the strategic plan developed pursuant to subsection (c) of section 17b-369 or new beds added to an existing facility or a new facility with preference given to a nontraditional, small-house style nursing home facility that incorporates the goals for nursing facilities referenced in the department's strategic plan for long-term care, as outlined in section 17b-355, to address priority needs reflected by area census trends; (4) licensed Medicaid nursing facility beds to be relocated from one or more existing nursing facilities to a new nursing facility, including a replacement facility, provided (A) no new Medicaid certified beds are added, (B) at least one currently licensed facility is closed in the transaction as a result of the relocation, (C) the relocation is done within available appropriations, (D) the facility participates in the Money Follows the Person demonstration project pursuant to section 17b-369, (E) the availability of beds in the area of need will not be adversely affected, (F) the certificate of need approval for such new facility or facility relocation and the associated capital expenditures are obtained pursuant to sections 17b-352 and 17b-353, and (G) the facilities included in the bed relocation and closure shall be in accordance with the strategic plan developed pursuant to subsection (c) of section 17b-369; and (5) proposals to build a nontraditional, small-house style nursing home designed to enhance the quality of life for nursing facility residents, provided that the nursing facility agrees to reduce its total number of licensed beds by a percentage determined by the Commissioner of Social Services in accordance

with the department's strategic plan for long-term care. For the purposes of this subsection, beds associated with a continuing care facility are not subject to the certificate of need provisions pursuant to sections 17b-352 and 17b-353.

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

(a) In determining whether a request submitted pursuant to sections 17b-352 to 17b-354, inclusive, as amended by this act, will be granted, modified or denied, the Commissioner of Social Services shall consider the following: (1) The financial feasibility of the request and its impact on the applicant's rates and financial condition, (2) the contribution of the request to the quality, accessibility and cost-effectiveness of the delivery of long-term care in the region, including consideration of the nursing home's star rating on the five-star quality rating system for nursing homes published by the Centers for Medicare and Medicaid Services, (3) whether there is clear public need for the request, (4) the relationship of any proposed change to the applicant's current utilization statistics and the effect of the proposal on the utilization statistics of other facilities in the applicant's service area, (5) the business interests of all owners, partners, associates, incorporators, directors, sponsors, stockholders and operators and the personal background of such persons, and (6) any other factor which the Department of Social Services deems relevant. In considering whether there is clear public need for any request for the relocation of beds to a replacement facility or for new beds added to an existing facility or a new facility, the commissioner shall consider whether there is a demonstrated bed need in the towns within a fifteen-mile radius of the town in which the beds are proposed to be located and whether the availability of beds in the applicant's service area will be adversely affected.

(b) Any proposal to relocate nursing home beds from an existing facility to a new facility shall not increase the number of Medicaid certified beds and shall result in the closure of at least one currently licensed facility. The commissioner may request that any applicant seeking to replace an existing facility reduce the number of beds in the new facility by a percentage that is consistent with the department's strategic state-wide long-term

rebalancing plan for long-term care. If an applicant seeking to replace an existing facility with a new facility owns or operates more than one nursing facility, the commissioner may request that the applicant close two or more facilities before approving the proposal to build a new facility. The commissioner shall also consider whether an application to establish a new or replacement nursing facility proposes a nontraditional, small-house style nursing facility and incorporates goals for nursing facilities referenced in the department's strategic state-wide long-term rebalancing plan for long-term care, including, but not limited to, (1) promoting person-centered care, (2) providing enhanced quality of care, (3) creating community space for all nursing facility residents, and (4) developing stronger connections between the nursing facility residents and the surrounding community.

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

Section 3: **Sec. 17b-99a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*).** (a)(1) For purposes of this section, (A) "extrapolation" means the determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn, (B) "facility" means any facility described in this subsection and for which rates are established pursuant to section 17b-340, [and] (C) "universe" means a defined population of claims submitted by a facility during a specific time period, and (D) "minimum data set" means the federal resident assessment tool required by the Centers for Medicare and Medicaid Services.

(2) The Commissioner of Social Services shall conduct any audit of a licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, a rest home with nursing supervision, a licensed residential care home, as defined in section 19a-490, and a residential facility for persons with intellectual disability which is licensed pursuant to section 17a-227 and certified to participate in the Medicaid program as an intermediate care facility for individuals with intellectual disabilities in accordance with the provisions of this section.

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

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

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

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

(f) The commissioner shall produce a preliminary written report concerning any audit conducted pursuant to this section and such preliminary report shall be provided to the

facility that was the subject of the audit not later than sixty days after the conclusion of such audit.

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

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

(i) Any facility aggrieved by a final report issued pursuant to subsection (h) of this section may request a rehearing. A rehearing shall be held by the commissioner or the commissioner's designee, provided a detailed written description of all items of aggrievement in the final report is filed by the facility not later than ninety days following the date of written notice of the commissioner's decision. The rehearing shall be held not later than thirty days following the date of filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision not later than sixty days following the close of evidence or the date on which final briefs are filed, whichever occurs later. Any items not resolved at such rehearing to the satisfaction of the facility or the commissioner shall be submitted to binding arbitration by an arbitration board consisting of one member appointed by the facility, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434. The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 42 USC 1396, as amended from time to time, and chapter 54.

(j) The commissioner shall conduct audits of minimum data set information used in the calculation of Medicaid acuity based per diem rates paid to licensed nursing homes. The audit process of minimum data set information shall be conducted in accordance with the provisions of this section except for documentation required from the nursing facility to support the minimum data set audit. Nursing facilities must provide all documentation requested pursuant to the minimum data set audit within ten business days. No documentation will be accepted after completion of the audit which concludes at the exit conference unless the commissioner and the facility agree to a later date.

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

[(k)] (l) The commissioner, or any agent authorized by the commissioner to conduct any inquiry, investigation or hearing under the provisions of this section, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the commissioner, the commissioner or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to the person by the commissioner or the commissioner's authorized agent or to produce any records and papers pursuant thereto, the commissioner or the commissioner's agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, or to any judge of such court if the same is not in session, setting forth such disobedience to process or refusal to answer, and such court or judge shall cite such person to appear before such court or judge to answer such question or to produce such records and papers.

[(l)] (m) The commissioner shall provide free training to facilities on the preparation of cost reports to avoid clerical errors and shall post information on the department's

Internet web site concerning the auditing process and methods to avoid clerical errors. Not later than April 1, 2015, the commissioner shall establish audit protocols to assist facilities subject to audit pursuant to this section in developing programs to improve compliance with Medicaid requirements under state and federal laws and regulations, provided audit protocols may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by any person, including a corporation. The commissioner shall establish and publish on the department's Internet web site audit protocols for: (1) Licensed chronic and convalescent nursing homes, (2) chronic disease hospitals associated with chronic and convalescent nursing homes, (3) rest homes with nursing supervision, (4) licensed residential care homes, as defined in section 19a-490, and (5) residential facilities for persons with intellectual disability that are licensed pursuant to section 17a-227 and certified to participate in the Medicaid program as intermediate care facilities for individuals with intellectual disabilities. The commissioner shall ensure that the Department of Social Services, or any entity with which the commissioner contracts to conduct an audit pursuant to this section, has on staff or consults with, as needed, licensed health professionals with experience in treatment, billing and coding procedures used by the facilities being audited pursuant to this section.

Section 4: **Subsection (a) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*).** (a) For purposes of this subsection, (1) a "related party" includes, but is not limited to, any company related to a chronic and convalescent nursing home through family association, common ownership, control or business association with any of the owners, operators or officials of such nursing home; (2) "company" means any person, partnership, association, holding company, limited liability company or corporation; (3) "family association" means a relationship by birth, marriage or domestic partnership; and (4) "profit and loss statement" means the most recent annual statement on profits and losses finalized by a related party before the annual report mandated under this subsection. The rates to be paid by or for persons aided or cared for by the state or any town in this state to licensed chronic and convalescent nursing homes, to chronic disease hospitals associated with chronic and convalescent nursing homes, to rest homes with nursing supervision, to licensed residential care homes, as defined by section 19a-490, and to residential

facilities for persons with intellectual disability that are licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as intermediate care facilities for individuals with intellectual disabilities, for room, board and services specified in licensing regulations issued by the licensing agency shall be determined annually, except as otherwise provided in this subsection by the Commissioner of Social Services, to be effective July first of each year except as otherwise provided in this subsection. Such rates shall be determined on a basis of a reasonable payment for such necessary services, which basis shall take into account as a factor the costs of such services. Cost of such services shall include reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons who are a related party or employed as managers or chief administrators or required to be licensed as nursing home administrators, and compensation for services rendered by proprietors at prevailing wage rates, as determined by application of principles of accounting as prescribed by said commissioner. Cost of such services shall not include amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys, or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit inclusion of amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations. The commissioner may, in the commissioner's discretion, allow the inclusion of extraordinary and unanticipated costs of providing services that were incurred to avoid an immediate negative impact on the health and safety of patients. The commissioner may, in the commissioner's discretion, based upon review of a facility's costs, direct care staff to patient ratio and any other related information, revise a facility's rate for any increases or decreases to total licensed capacity of more than ten beds or changes to its number of licensed rest home with nursing supervision beds and chronic and convalescent nursing home beds. The commissioner may, in the commissioner's discretion, revise the rate of a facility that is closing. An interim rate issued for the period during which a facility is closing shall be based on a review of facility costs, the expected duration of the close-down period, the anticipated impact on Medicaid costs, available appropriations and the relationship of the rate requested by the facility to the average Medicaid rate for a close-down period. The commissioner may so revise a

facility's rate established for the fiscal year ending June 30, 1993, and thereafter for any bed increases, decreases or changes in licensure effective after October 1, 1989. Effective July 1, 1991, in facilities that have both a chronic and convalescent nursing home and a rest home with nursing supervision, the rate for the rest home with nursing supervision shall not exceed such facility's rate for its chronic and convalescent nursing home. All such facilities for which rates are determined under this subsection shall report on a fiscal year basis ending on September thirtieth. Such report shall be submitted to the commissioner by February fifteenth. Each chronic and convalescent nursing home that receives state funding pursuant to this section shall include in such annual report a profit and loss statement from each related party that receives from such chronic and convalescent nursing home thirty thousand dollars or more per year for goods, fees and services. No cause of action or liability shall arise against the state, the Department of Social Services, any state official or agent for failure to take action based on the information required to be reported under this subsection. The commissioner may reduce the rate in effect for a facility that fails to submit a complete and accurate report on or before February fifteenth by an amount not to exceed ten per cent of such rate. If a licensed residential care home fails to submit a complete and accurate report, the department shall notify such home of the failure and the home shall have thirty days from the date the notice was issued to submit a complete and accurate report. If a licensed residential care home fails to submit a complete and accurate report not later than thirty days after the date of notice, such home may not receive a retroactive rate increase, in the commissioner's discretion. The commissioner shall, annually, on or before April first, report the data contained in the reports of such facilities on the department's Internet web site. For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the services of any nursing personnel supplied by a temporary nursing services agency by separating said cost into two categories, the portion of the cost equal to the salary of the employee for whom the nursing personnel supplied by a temporary nursing services agency is substituting shall be considered a nursing cost and any cost in excess of such salary shall be further divided so that seventy-five per cent of the excess cost shall be considered an administrative or general cost and twenty-five per cent of the excess cost shall be considered a nursing cost, provided if the total costs of a facility for nursing personnel supplied by a temporary nursing services agency in any cost year are equal to or exceed

fifteen per cent of the total nursing expenditures of the facility for such cost year, no portion of such costs in excess of fifteen per cent shall be classified as administrative or general costs. The commissioner, in determining such rates, shall also take into account the classification of patients or boarders according to special care requirements or classification of the facility according to such factors as facilities and services and such other factors as the commissioner deems reasonable, including anticipated fluctuations in the cost of providing such services. The commissioner may establish a separate rate for a facility or a portion of a facility for traumatic brain injury patients who require extensive care but not acute general hospital care. Such separate rate shall reflect the special care requirements of such patients. If changes in federal or state laws, regulations or standards adopted subsequent to June 30, 1985, result in increased costs or expenditures in an amount exceeding one-half of one per cent of allowable costs for the most recent cost reporting year, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this section shall be construed to require the Department of Social Services to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the Department of Public Health. Such assistance as the commissioner requires from other state agencies or departments in determining rates shall be made available to the commissioner at the commissioner's request. Payment of the rates established pursuant to this section shall be conditioned on the establishment by such facilities of admissions procedures that conform with this section, section 19a-533 and all other applicable provisions of the law and the provision of equality of treatment to all persons in such facilities. The established rates shall be the maximum amount chargeable by such facilities for care of such beneficiaries, and the acceptance by or on behalf of any such facility of any additional compensation for care of any such beneficiary from any other person or source shall constitute the offense of aiding a beneficiary to obtain aid to which the beneficiary is not entitled and shall be punishable in the same manner as is provided in subsection (b) of section 17b-97. Notwithstanding any provision of this section, the Commissioner of Social Services may, within available appropriations, provide an interim rate increase for a licensed chronic and convalescent nursing home or a rest home with nursing supervision for rate periods no earlier than April 1, 2004, only if the commissioner determines that the increase is necessary to avoid the filing of a petition for relief under

Title 11 of the United States Code; imposition of receivership pursuant to sections 19a-542 and 19a-543; or substantial deterioration of the facility's financial condition that may be expected to adversely affect resident care and the continued operation of the facility, and the commissioner determines that the continued operation of the facility is in the best interest of the state. The commissioner shall consider any requests for interim rate increases on file with the department from March 30, 2004, and those submitted subsequently for rate periods no earlier than April 1, 2004. When reviewing an interim rate increase request the commissioner shall, at a minimum, consider: (A) Existing chronic and convalescent nursing home or rest home with nursing supervision utilization in the area and projected bed need; (B) physical plant long-term viability and the ability of the owner or purchaser to implement any necessary property improvements; (C) licensure and certification compliance history; (D) reasonableness of actual and projected expenses; and (E) the ability of the facility to meet wage and benefit costs. No interim rate shall be increased pursuant to this subsection in excess of one hundred fifteen per cent of the median rate for the facility's peer grouping, established pursuant to subdivision (3) of subsection (a) of section 17b-340d, unless recommended by the commissioner and approved by the Secretary of the Office of Policy and Management after consultation with the commissioner. Such median rates shall be published by the Department of Social Services not later than April first of each year. In the event that a facility granted an interim rate increase pursuant to this section is sold or otherwise conveyed for value to an unrelated entity less than five years after the effective date of such rate increase, the rate increase shall be deemed rescinded and the department shall recover an amount equal to the difference between payments made for all affected rate periods and payments that would have been made if the interim rate increase was not granted. The commissioner may seek recovery of such payments from any facility with common ownership. With the approval of the Secretary of the Office of Policy and Management, the commissioner may waive recovery and rescission of the interim rate for good cause shown that is not inconsistent with this section, including, but not limited to, transfers to family members that were made for no value. The commissioner shall provide written quarterly reports to the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services and appropriations and the budgets of state agencies, that identify each facility requesting an interim rate increase, the amount of the requested rate increase for each facility, the action taken by the

commissioner and the secretary pursuant to this subsection, and estimates of the additional cost to the state for each approved interim rate increase. Nothing in this subsection shall prohibit the commissioner from increasing the rate of a licensed chronic and convalescent nursing home or a rest home with nursing supervision for allowable costs associated with facility capital improvements or increasing the rate in case of a sale of a licensed chronic and convalescent nursing home or a rest home with nursing supervision if receivership has been imposed on such home. For purposes of this section, “temporary nursing services agency” and “nursing personnel” have the same meaning as provided in section 19a-118.

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Social Services**
Proposal Name	Aligning LIHEAP deliverable fuel pricing standards to findings of working group and current practices.
Legislative Liaison	David Seifel;
Division Requesting Proposal	POGA, OCS
Drafter	Princess O'Reggio

Overview

Brief Summary of Proposal

The Department of Social Services convened a working group of stakeholders and legislators, as required in Public Act 24-145, to study best practices in other states for reimbursing deliverable fuel vendors while protecting maximum funding for benefit recipients. Through the collaborative effort, the working group identified new pricing standards no longer tied to county (no other state utilizes county pricing). The Department of Social Services, as approved by the legislature, has moved to regional pricing standards for deliverable fuel. We are requesting that the wording "county and" be removed to align statute with current practice. The department is also clarifying how the daily price for reimbursement is determined.

What problem is this proposal looking to solve?

The proposal recommends removing references to county pricing standards for deliverable fuel from CGS 16a-41a. This term is not aligned with the pricing structure best practices identified by the working group and current legislatively approved LIHEAP Allocation Plan. Additionally, there have been varying interpretations of the language in subparagraph (b)(2) for how the daily price for reimbursement is determined, this language is being clarified.

How does the proposal solve the problem?

By removing references to county pricing standards, it ensures the statute aligns to CEAP's current practices and the recommendations of the working group. Clarifying language inserted in subparagraph (b)(2).

Section by section summary:

Section #(s)	Section Summary
1	(b) The Commissioner of Social Services shall implement a program to purchase deliverable fuel for low-income households participating in the Connecticut energy assistance program and the state-appropriated fuel assistance program. The commissioner shall ensure an adequate supply of vendors for the program by (1) establishing regional pricing standards for deliverable fuel, (2) reimbursing fuel providers based on the price of the fuel publicly posted by the commissioner on the date of delivery, and (3) allowing a vendor to electronically submit an authorized fuel slip or invoice for payment.

Statutory Reference (if any): CGS 16a-41a (b)

Background

☒ New Proposal ☐ Resubmission

If resubmission, please provide details below. Please also note any changes made since the last submission:

Bill #(s)	Reason bill(s) did not move forward

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

Yes — Public Act 24-145 required the creation of a working group to review CEAP vendor reimbursement best practices. Based on the group's findings, the county pricing language introduced in Public Act 23-204 no longer aligns to CEAP pricing practices. The group recommended moving away from county pricing, making it necessary to update the statute and remove this wording.

Has this proposal or a similar proposal been implemented in other states?

No

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	N/A
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Subsection (b) of section 16a-41a of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*effective from passage*):

(b) The Commissioner of Social Services shall implement a program to purchase deliverable fuel for low-income households participating in the Connecticut energy assistance program and the state-appropriated fuel assistance program. The commissioner shall ensure an adequate supply of vendors for the program by (1) establishing **[**county and**]** regional pricing standards for deliverable fuel, (2) reimbursing fuel providers based on the price of the fuel publicly posted by the commissioner on the date of delivery, and (3) allowing a vendor to electronically submit an authorized fuel slip or invoice for payment. Commencing with the energy assistance program period beginning November 1, 2025, the commissioner shall ensure an adequate supply of vendors for the program by establishing new pricing standards for deliverable fuel that fairly compensate fuel vendors for costs incurred on fuel purchase and delivery while maintaining the maximum amount of funding to benefit recipients of the program. Not later than August 1, 2025, the commissioner shall include such pricing standards in the annual plan for the program required pursuant to subsection (a) of this section.

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Social Services**
Proposal Name	An Act Concerning Various Revisions to DSS Statutes
Legislative Liaison	David Seifel, Jalmar De Dios, Matt Festa
Division Requesting Proposal	Various
Drafter	Various

Overview

Brief Summary of Proposal

This proposal contains various technical changes, as well as corrections to legislative oversight, to create more uniformity and clarity in DSS statutes and compliance with federal law.

What problem is this proposal looking to solve?

This proposal seeks to 'clean up' statute.

How does the proposal solve the problem?

These proposed changes will more accurately reflect the intent of the legislature and the agency in implementing state statute.

Section by section summary:

Section #(s)	Section Summary
1	Update statute to allow DSS to develop a child support enforcement system that supports administrative enforcement in interstate cases (AEI).
2	Update statute to conform with federal law related to modification of child support orders.

3	Currently, managed residential communities are required to post in their facility the patient bill of rights. DSS believes that as a part of that posting, they should also be required to post the contact information for the department's Protective Services for the Elderly division**.**
4	Legislation passed in 2024 requires DSS to stagger SNAP benefits beginning in March, 2026. As part of that statute, DSS is required to submit an annual report regarding the staggering of benefits, beginning in April 2026. Once DSS implements the staggering of benefits, there will be minimal information to report. As such, DSS requests repealing the 'annual' requirement and reporting just one time immediately after the staggering is implemented.
5	This will allow providers for the autism waiver to access the DDS Neglect and Abuse Registry so that they may consult the registry prior to hiring staff, which was the intent when the autism waiver was transferred from DDS to DSS.

Statutory Reference (if any):	CGS 19a-697; PA 24-82; CGS 17a-247b(c); 17b-340(h)

Background

☐ New Proposal ☒ Resubmission

If resubmission, please provide details below. Please also note any changes made since the last submission:

Bill #(s)	Reason bill(s) did not move forward
	Sections 1-5, of this proposal were part of the department's 2025 "various revisions" bill, which passed in the Senate on the consent calendar, but time ran out before it could pass in the House.

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	N/A
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Section 1:

Subsection (d) of section 52-362d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) Whenever an order of the Superior Court or a family support magistrate of this state, or an order of another state that has been registered in this state, for support of a minor child or children is issued and such payments have been ordered through the IV-D agency, or when a request from another state for assistance enforcing an order that has not been registered in this state is received by the IV-D agency and such request meets the requirements of 42 USC 666(a)(14), and the obligor against whom such support order was issued owes overdue support under such order in the amount of five hundred dollars or more, the IV-D agency, as defined in subdivision (12) of subsection (b) of section 46b-231, or Support Enforcement Services of the Superior Court may notify (1) any state or local agency or officer with authority (A) to hold assets or property for such obligor including, but not limited to, any property unclaimed or presumed abandoned under part III of chapter 32, or (B) to distribute benefits to such obligor including, but not limited to, unemployment compensation and workers' compensation, (2) any person having or expecting to have custody or control of or authority to distribute any amounts due such obligor under any judgment or settlement, (3) any financial institution holding assets of such obligor, and (4) any public or private entity administering a public or private retirement fund in which such obligor has an interest that such obligor owes overdue support in a IV-D support case. Upon receipt of such notice, such agency, officer, person, institution or entity shall withhold delivery or distribution of any such property, benefits, amounts, assets or funds until receipt of further notice from the IV-D agency.

Section 2:

Subsections (a) to (c), inclusive, of Section 46b-215e of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Initial or modified support order when child support obligor is institutionalized or incarcerated. Procedure in IV-D support cases when child support obligor is incarcerated for more than ninety days. (a) Notwithstanding any provision of the general statutes,

whenever a child support obligor is institutionalized or incarcerated, the Superior Court or a family support magistrate shall establish an initial order for current support, or modify an existing order for current support, upon proper motion, based upon the obligor's present income and substantial assets, if any, in accordance with the child support guidelines established pursuant to section 46b-215a. [Downward modification of an existing support order based solely on a loss of income due to incarceration or institutionalization shall not be granted in the case of a child support obligor who is incarcerated or institutionalized for an offense against the custodial party or the child subject to such support order].

(b) In IV-D support cases, as defined in section 46b-231, when the child support obligor is institutionalized or incarcerated for more than ninety days, any existing support order, as defined in section 46b-231, shall be modified to zero dollars effective upon the date that a support enforcement officer files an affidavit in the Family Support Magistrate Division. The affidavit shall include: (1) The beginning and expected end dates of such obligor's institutionalization or incarceration; and (2) a statement by such officer that (A) a diligent search failed to identify any income or assets that could be used to satisfy the child support order while the obligor is incarcerated or institutionalized, and (B) **[**the offense for which the obligor is institutionalized or incarcerated was not an offense against the custodial party or the child subject to such support order, and (C)**]** a notice in accordance with subsection (c) of this section was provided to the custodial party and an objection form was not received from such party.

(c) Prior to filing an affidavit under subsection (b) of this section, the support enforcement officer shall provide notice to the custodial party in accordance with section 52-57 or by certified mail, return receipt requested. The notice shall state in clear and simple language that: (1) Such child support order shall be modified unless the custodial party objects not later than fifteen calendar days after receipt of such notice on the grounds that **[**(A)**]** the obligor has sufficient income or assets to comply with the support order, **[**or (B) the obligor is incarcerated or institutionalized for an offense against the custodial party or the child subject to such support order;**]** and (2) the custodial party may object to the proposed modification by delivering a signed objection form, or other written notice or motion, indicating the nature of the objection or grounds of the motion, to the support enforcement officer not later than fifteen calendar days after receipt of such notice. Upon receipt of any objection or motion, the support enforcement officer shall promptly arrange with the clerk of the Family Support Magistrate Division to enter the appearance of the custodial party, set the matter for a hearing, send a file-stamped copy of the objection or motion to the IV-D agency of the state to whom the support order is payable,

and notify all parties of the hearing date set. The court or family support magistrate shall promptly hear the objection or motion and determine whether the child support order should be modified in accordance with subsection (b) of this section.

Section 3.

Subsection (b) of section 19a-697 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2026*):

(b) A managed residential community shall post in a prominent place in the managed residential community the resident's bill of rights, including those rights set forth in subsection (a) of this section. The posting of the resident's bill of rights shall include contact information for (1) the Department of Public Health and the Office of the State Long-Term Care Ombudsman, including the names, addresses and telephone numbers of persons within such agencies who handle questions, comments or complaints concerning managed residential community, and (2) the Department of Social Services to report the suspected abuse, neglect, exploitation or abandonment of an elderly person, or that an
elderly person may be in need of protective services

Section 4.

Subsection (d) of Section 17b-105a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective Upon passage).*

(d) The Commissioner of Social Services shall enter into a contract with an outside vendor to update the system utilized by the Department of Social Services to administer the supplemental nutrition assistance program for the purpose of enabling the department to stagger the distribution of program benefits so that benefits are distributed, in accordance with federal law, to cohorts of program beneficiaries designated by the commissioner at multiple intervals during each month. Not later than March 1, 2026, the commissioner shall commence staggering the distribution of such benefits to such cohorts of beneficiaries each month, in accordance with federal law. Not later than April 1, 2026, **[**and annually thereafter,**]** the commissioner shall report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly

having cognizance of matters relating to human services regarding the staggering of distribution benefits pursuant to this subsection.

Section 5.

Subsection (c) of Section 17a-247b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The department shall make information in the registry available only to: (1) Authorized agencies, for the purpose of protective service determinations; (2) employers who employ employees to provide services to an individual who receives services or funding from the department or the Medicaid waiver program for autism spectrum disorder administered by the Department of Social Services, as described in section 17a-215c; (3) the Departments of Children and Families, Mental Health and Addiction Services, Social Services and Administrative Services and the Office of Labor Relations, for the purpose of determining whether an applicant for employment with the Departments of Children and Families, Developmental Services, Mental Health and Addiction Services and Social Services appears on the registry; or (4) charitable organizations that recruit volunteers to support programs for persons with intellectual disability or autism spectrum disorder, upon application to and approval by the commissioner, for purposes of conducting background checks on such volunteers.