**OLR Bill Analysis**

**sSB 1110**

***AN ACT CONCERNING REQUIREMENTS FOR THIRD-PARTY MEDICAID PAYMENT REIMBURSEMENTS, VENDOR PAYMENT STANDARDS IN THE LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM AND MEDICAID PAYMENTS FOR MATERNITY SERVICES.***

## SUMMARY

This bill codifies two new third-party liability (TPL) requirements under federal law for the state's Medicaid program (§§ 1 & 2). The first requires liable third-party payers to accept the Department of Social Services (DSS) authorization as the TPL's prior authorization for Medicaid claims for payment. The second change shortens, from 90 to 60 days, the timeframe in which a third party must respond to the state about a Medicaid reimbursement claim. The bill also applies TPL provisions to state-funded medical assistance given to certain children under age 12 regardless of their immigration status (§§ 7 & 8).

The bill requires the DSS commissioner to ensure fuel vendors for the Low-Income Home Energy Assistance Program (LIHEAP) are given the option to electronically submit their invoices and receive payments. Among other changes, it also requires payment to a fuel vendor within ten days, rather than 30 days as under current law, after receiving an authorized fuel slip or invoice (§ 4).

The bill allows the DSS commissioner to implement a bundled Medicaid payment for maternity services, to the extent allowed under federal law and within available appropriations (§ 5).

The bill also expands the situations in which DSS may use state funds to pay for certain emergency housing, conforming with current practice. Current law limits the use of state funds to pay for emergency housing for recipients of Temporary Family Assistance and State Administered

General Assistance in hotels or motels to only during natural or man-made disasters or other catastrophic events (CGS § 17b-807). The bill repeals this limitation (§§ 6 & 9).

Lastly, the bill repeals additional provisions in statute, including the now defunct Connecticut Medicare Assignment Program (§§ 3, 6 & 9) and makes numerous technical changes.

EFFECTIVE DATE: Upon passage unless otherwise noted below.

**§§ 1 & 2 — THIRD PARTY LIABILITY FOR MEDICAID PAYMENTS**

Under federal law, Medicaid is generally the "payer of last resort," which means that health insurers and other third parties legally liable for health care services received by Medicaid beneficiaries must pay for them. Federal law also requires states to have laws enhancing the states' ability to identify and get payment for Medicaid claims from legally liable third-party sources.

Under existing Connecticut law, claims for recovery or indemnification submitted by DSS, or its designee, cannot be denied solely on the lack of prior authorization, among other reasons, if (1) the claim is submitted within three years and (2) any action by the state to enforce its rights to the claim begins within six years of the claim submission.

The bill codifies two new requirements under section 202 of the Consolidated Appropriations Act of 2022, Public Law 117-103. First, when claims are submitted to a TPL for recovery or indemnification for a service provided under the state's Medicaid plan or a Medicaid waiver, and the TPL requires prior authorization for that service, it must accept DSS's prior authorization as its own. This requirement does not apply to Medicare, Medicare Advantage, or Medicare Part D plans.

Second, the bill shortens the required response time from TPLs, including health insurers. Under current law, an insurer or TPL, upon receipt of a claim submitted by DSS or the department's designee must respond within 90 days after (1) receiving the claim or (2) the effective date of the law, whichever is later. The bill instead requires an insurer

or TPL to respond to a DSS inquiry about a claim for reimbursement within 60 days after receiving the claim.

Under existing law, failure to pay the claim, issue a written reason for denying it, or requesting information necessary to determine its legal obligation to pay it within 120 days after receiving the claim creates an uncontestable obligation to pay it.

The bill makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2023

## §§ 7 & 8 — TPL PROVISIONS FOR STATE-FUNDED MEDICAL ASSISTANCE

By January 1, 2023, existing law requires the DSS commissioner to provide state-funded medical assistance, within available appropriations, to certain children ages 12 and under regardless of their immigration status. Under the law, DSS must provide the assistance to children who are not eligible for Medicaid, the Children's Health Insurance Program (CHIP, also known as HUSKY B), or affordable employer-sponsored insurance, and have household incomes (1) up to 201% of the federal poverty limit (FPL) without an asset limit (aligning with HUSKY A limits under Medicaid) or (2) over 201% and up to 323% of FPL (generally aligning with HUSKY B limits under CHIP).

The bill applies third party liability provisions in existing law and those under the bill to the state-funded medical assistance (equivalent coverage to HUSKY and the state's children's health insurance program) provided to these children. By law, unchanged by the bill, a child who is eligible for assistance under these provisions must continue to receive it until he or she is 19 years old, so long as he or she continues to (1) meet income requirements and (2) be ineligible for Medicaid, CHIP, or affordable employer-sponsored insurance.

## § 4 — ENERGY ASSISTANCE VENDOR PAYMENT STANDARDS

The bill requires the DSS commissioner to ensure an adequate supply of fuel vendors for LIHEAP by:

1. establishing (a) county and regional pricing standards for deliverable fuel and (b) a discount on the vendor's retail price,

2. reimbursing fuel providers based on the price of the fuel on the delivery date, and

3. allowing a vendor to electronically submit an authorized fuel slip or invoice for payment.

By November 1, 2023, the commissioner must require each community action agency (CAA) administering a fuel assistance program to make payment to a fuel vendor within 10 days, rather than 30 days as under current law, after receiving an authorized fuel slip or invoice for payment from the vendor. She must also require these CAAs to offer vendors the options of electronic (1) payments and (2) submission of their authorized fuel slips or invoices for payment.

By law, the commissioner must submit the LIHEAP annual plan by August 1 of each year to the Appropriations, Energy, and Human Services Committees. Under current law, the plan must include a payment plan for fuel deliveries that ensures fuel vendors who complete CAA-authorized deliveries are paid by the CAA within 30 days of receiving the vendor's fuel slip or invoice. Under the bill, these payment plans must ensure vendors are paid by the CAA within 10 days of fuel slip or invoice receipt and are given the option to be paid electronically.

EFFECTIVE DATE: July 1, 2023

## § 5 — BUNDLED MEDICAID PAYMENT FOR MATERNITY SERVICES

The bill authorizes the DSS commissioner, to the extent allowed under federal law and within available appropriations, to implement a bundled Medicaid payment for maternity services and any other alternative payment methodology or combination of methodologies for these services that she determines are designed to improve health quality, equity, member experience, cost containment, and coordination of care.

By law, for certain programs including Medicaid, DSS may implement policies and procedures while in the process of adopting them as regulations (CGS § 17b-10(b)). The bill explicitly allows the DSS commissioner to implement policies and procedures this way under the bill and requires her to post notice of her intent to adopt regulations on the eRegulations System within 20 days of implementing the policies and procedures, which are valid until final regulations are adopted.

EFFECTIVE DATE: July 1, 2023

**§ 3, 6 & 9 — REPEALER**

The bill eliminates the Connecticut Medicare Assignment Program (ConnMAP), a state program that limits participating providers to billing Medicare Part B enrollees only up to the 20% co-payment for the service (Medicare pays the remaining 80%) (CGS §§ 17b-550 to -554). This program is effectively obsolete, as federal law requires Medicare-participating providers to accept the Medicare-determined reasonable charge as payment in full for services rendered to Medicare beneficiaries.

The bill eliminates the requirement for DSS, in collaboration with the Departments of Children and Families and Public Health, to establish a child health quality improvement program to promote the implementation of evidence-based strategies by providers participating in HUSKY to improve delivery and access of children's services and annually report on its efficacy (CGS § 17b-306a).

It also makes conforming changes to eliminate references to these provisions elsewhere in statute (§ 3).

**COMMITTEE ACTION**

Human Services Committee

Joint Favorable Substitute
Yea 21 Nay 0 (03/21/2023)