General Assembly

Raised Bill No. 1110

January Session, 2023

LCO No. **4248**

Referred to Committee on HUMAN SERVICES

Introduced by:
(HS)

AN ACT CONCERNING VARIOUS REVISIONS TO THE DEPARTMENT OF SOCIAL SERVICES STATUTES.

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

Section 1. Section 17b-8 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services shall submit an application for a federal waiver or renewal of such waiver of any assistance program requirements, except such application pertaining to routine operational issues, and any proposed amendment to the Medicaid state plan to make a change in program requirements that would have required a waiver were it not for the passage of the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies, and, for the waiver application required under section 17b-312, the joint standing committee of the General Assembly having cognizance of matters relating to insurance, prior to the submission of such application

or proposed amendment to the federal government. Not later than thirty days after the date of their receipt of such application or proposed amendment, the joint standing committees shall: (1) Hold a public hearing on the waiver application, or (2) in the case of a proposed amendment to the Medicaid state plan, notify the Commissioner of Social Services whether or not said joint standing committees intend to hold a public hearing. Any notice to the commissioner indicating that the joint standing committees intend to hold a public hearing on a proposed amendment to the Medicaid state plan shall state the date on which the joint standing committees intend to hold such public hearing, which shall not be later than sixty days after the joint standing committees' receipt of the proposed amendment. At the conclusion of a public hearing held in accordance with the provisions of this section, the joint standing committees shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's waiver application or proposed amendment. If the joint standing committees advise the commissioner of their denial of the commissioner's waiver application or proposed amendment, the commissioner shall not submit the application for a federal waiver or proposed amendment to the federal government. If such committees do not concur, the committee chairpersons shall appoint a committee of conference which shall be composed of three members from each joint standing committee. At least one member appointed from each joint standing committee shall be a member of the minority party. The report of the committee of conference shall be made to each joint standing committee, which shall vote to accept or reject the report. The report of the committee of conference may not be amended. If a joint standing committee rejects the report of the committee of conference, that joint standing committee shall notify the commissioner of the rejection and the commissioner's waiver application or proposed amendment shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's waiver application or proposed amendment. If the joint standing committees do not so advise

the commissioner during the thirty-day period, the waiver application or proposed amendment shall be deemed approved. Any application for a federal waiver, waiver renewal or proposed amendment submitted to the federal government by the commissioner, pursuant to this section, shall be in accordance with the approval or modifications, if any, of the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies, and, for the waiver application required under section 17b-312, the joint standing committee of the General Assembly having cognizance of matters relating to insurance.

[(b) The Commissioner of Social Services shall annually, not later than December fifteenth, notify the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and the joint standing committee of the General Assembly having cognizance of matters relating to human services of potential Medicaid waivers and amendments to the Medicaid state plan that may result in a cost savings for the state. The commissioner shall notify the committees of the possibility of any Medicaid waiver application or proposed amendment to the Medicaid state plan that the commissioner is considering in developing a budget for the next fiscal year before the commissioner submits such budget for legislative approval.**]**

[(c)**]** (b) Thirty days prior to submission of an application for a waiver from federal law, renewal of such waiver or proposed amendment to the joint standing committees of the General Assembly under subsection (a) of this section, the Commissioner of Social Services shall publish a notice that the commissioner intends to seek such a waiver or waiver renewal, or submit a proposed amendment to the federal government in the Connecticut Law Journal and on the Department of Social Services' Internet web site, along with a summary of the provisions of the waiver application or the proposed amendment and the manner in which individuals may submit comments. The commissioner shall allow thirty days for written comments on the waiver application or proposed amendment prior to submission of the application for a

waiver, waiver renewal or proposed amendment to the General Assembly under subsection (a) of this section and shall include all written comments with the waiver, waiver renewal application or proposed amendment in the submission to the General Assembly.

[(d)**]** (c) The commissioner shall include with any waiver application or proposed amendment submitted to the federal government pursuant to this section: (1) Any written comments received pursuant to subsection **[**(c)**]** (b) of this section; and (2) any additional written comments submitted to the joint standing committees at such proceedings. The joint standing committees shall transmit any such materials to the commissioner for inclusion with any such waiver application or proposed amendment.

Sec. 2. Section 17b-265 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) In accordance with 42 USC 1396k, the Department of Social Services shall be subrogated to any right of recovery or indemnification that an applicant or recipient of medical assistance or any legally liable relative of such applicant or recipient has against an insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, for the cost of all health care items or services furnished to the applicant or recipient, including, but not limited to, hospitalization, pharmaceutical services, physician services, nursing services, behavioral health services, long-term care services and other medical services, not to exceed the amount expended by the department for such care and treatment of the applicant or recipient. In the case of such a recipient who is an enrollee in a care management organization under a Medicaid care management contract with the state or a legally liable relative of such an enrollee, the department shall be

subrogated to any right of recovery or indemnification which the enrollee or legally liable relative has against such a private insurer or other third party for the medical costs incurred by the care management organization on behalf of an enrollee. Whenever funds owed to a person are collected pursuant to this section and the person who otherwise would have been entitled to such funds is subject to a court-ordered current or arrearage child support payment obligation in an IV-D support case, such funds shall first be paid to the state for reimbursement of Medicaid funds paid on behalf of such person for medical expenses incurred for injuries related to a legal claim by such person that was the subject of the state's right of subrogation, and remaining funds, if any, shall then be paid to the Office of Child Support Services for distribution pursuant to the federally mandated child support distribution system implemented pursuant to subsection (j) of section 17b-179. Any additional claim of the state to the remainder of such funds, if any, shall be paid in accordance with state law.

(b) An applicant or recipient or legally liable relative, by the act of the applicant's or recipient's receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the department. The department shall inform an applicant of such assignments at the time of application. Any entitlements from a contractual agreement with an applicant or recipient, legally liable relative or a state or federal program for such medical services, not to exceed the amount expended by the department, shall be so assigned. Such entitlements shall be directly reimbursable to the department by third party payors. The Department of Social Services may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the Medicaid program and providing services to an applicant or recipient, in order to assist the provider in obtaining payment for such services. In accordance with subsection (b) of section 38a-472, a provider that has received an assignment from the department shall notify the recipient's health insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(1) of the

Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, of the assignment upon rendition of services to the applicant or recipient. Failure to so notify the health insurer or other legally liable third party shall render the provider ineligible for payment from the department. The provider shall notify the department of any request by the applicant or recipient or legally liable relative or representative of such applicant or recipient for billing information. This subsection shall not be construed to affect the right of an applicant or recipient to maintain an independent cause of action against such third party tortfeasor.

(c) Claims for recovery or indemnification submitted by the department, or the department's designee, shall not be denied solely on the basis of the date of the submission of the claim, the type or format of the claim, the lack of prior authorization or the failure to present proper documentation at the point-of-service that is the basis of the claim, if (1) the claim is submitted by the state within the three-year period beginning on the date on which the item or service was furnished; and (2) any action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of the claim.

(d) (1) A party to whom a claim for recovery or indemnification is submitted for an item or service furnished under the Medicaid state plan, or a waiver of such plan, who requires prior authorization for such item or service shall accept authorization provided by the Department of Social Services that the item or service is covered under such plan or waiver as if such authorization were the prior authorization made by such party for the item or service.

(2) The provisions of subdivision (1) of this subsection shall not apply with respect to a claim for recovery or indemnification submitted to Medicare, a Medicare Advantage plan or a Medicare Part D plan.

[(d)**]** (e) When a recipient of medical assistance has personal health insurance in force covering care or other benefits provided under such program, payment or part-payment of the premium for such insurance may be made when deemed appropriate by the Commissioner of Social Services. The commissioner shall limit reimbursement to medical assistance providers for coinsurance and deductible payments under Title XVIII of the Social Security Act to assure that the combined Medicare and Medicaid payment to the provider shall not exceed the maximum allowable under the Medicaid program fee schedules.

[(e)**]** (f) No self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care plan, or any plan offered or administered by a health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, shall contain any provision that has the effect of denying or limiting enrollment benefits or excluding coverage because services are rendered to an insured or beneficiary who is eligible for or who received medical assistance under this chapter. No insurer, as defined in section 38a-497a, shall impose requirements on the state Medicaid agency, which has been assigned the rights of an individual eligible for Medicaid and covered for health benefits from an insurer, that differ from requirements applicable to an agent or assignee of another individual so covered.

[(f)**]** (g) The Commissioner of Social Services shall not pay for any services provided under this chapter if the individual eligible for medical assistance has coverage for the services under an accident or health insurance policy.

[(g)**]** (h) An insurer or other legally liable third party, upon receipt of a claim submitted by the department or the department's designee, in accordance with the requirements of subsection (c) of this section, for payment of a health care item or service covered under a state medical assistance program administered by the department, shall, not later

than [ninety] sixty days after receipt of the claim or not later than [ninety] sixty days after the effective date of this section, whichever is later, (1) make payment on the claim, (2) request information necessary to determine its legal obligation to pay the claim, or (3) issue a written reason for denial of the claim. Failure to pay, request information necessary to determine legal obligation to pay or issue a written reason for denial of a claim not later than one hundred twenty days after receipt of the claim, or not later than one hundred twenty days after the effective date of this section, whichever is later, creates an uncontestable obligation to pay the claim. The provisions of this subsection shall apply to all claims, including claims submitted by the department or the department's designee prior to July 1, 2021.

[(h)] (i) On and after July 1, 2021, an insurer or other legally liable third party who has reimbursed the department for a health care item or service paid for and covered under a state medical assistance program administered by the department shall, upon determining it is not liable and at risk for cost of the health care item or service, request any refund from the department not later than twelve months from the date of its reimbursement to the department.

Sec. 3. Section 17b-265g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

Any health insurer, including a self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, and which may or may not be financially at risk for the cost of a health care item or service, shall, as a condition of doing business in the state, be required to:

(1) Provide, with respect to an individual who is eligible for, or is provided, medical assistance under the Medicaid state plan, to all third-party administrators, pharmacy benefit managers, dental benefit

managers or other entities with which the health insurer has a contract or arrangement to adjudicate claims for a health care item or service, and to the Commissioner of Social Services, or the commissioner's designee, any and all information in a manner and format prescribed by the commissioner, or commissioner's designee, necessary to determine when the individual, his or her spouse or the individual's dependents may be or have been covered by a health insurer and the nature of the coverage that is or was provided by such health insurer including the name, address and identifying number of the plan;

(2) **[**accept**]** Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the health insurer for an item or service for which payment has been made under the Medicaid state plan;

(3) **[**respond to**]** Respond not later than sixty days after receiving any inquiry **[**by**]** from the commissioner, or the commissioner's designee, regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the item or service; and

(4) **[**agree**]** Agree (A) to accept authorization provided by the Department of Social Services that an item or service is covered under the Medicaid state plan, or a waiver of such plan, as if such authorization were the prior authorization made by said health insurer for such item or service, and (B) not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if **[**(A)**]** (i) the claim is submitted by the state or its agent within the three-year period beginning on the date on which the item or service was furnished; and **[**(B)**]** (ii) any legal action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of such claim.

Sec. 4. Subsection (e) of section 12-746 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) Amounts rebated pursuant to this section shall not be considered income for purposes of sections 8-119*l*, 8-345, 12-170d, 12-170aa, **[**17b-550,**]** 47-88d and 47-287.

Sec. 5. Section 16a-41a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(a) The Commissioner of Social Services shall submit to the joint standing committees of the General Assembly having cognizance of energy planning and activities, appropriations, and human services the following on the implementation of the block grant program authorized under the Low-Income Home Energy Assistance Act of 1981, as amended:

(1) Not later than August first, annually, a Connecticut energy assistance program annual plan which establishes guidelines for the use of funds authorized under the Low-Income Home Energy Assistance Act of 1981, as amended, and includes the following:

(A) Criteria for determining which households are to receive emergency assistance;

(B) A description of systems used to ensure referrals to other energy assistance programs and the taking of simultaneous applications, as required under section 16a-41;

(C) A description of outreach efforts;

(D) Estimates of the total number of households eligible for assistance under the program and the number of households in which one or more elderly or physically disabled individuals eligible for assistance reside;

(E) Design of a basic grant for eligible households that does not discriminate against such households based on the type of energy used for heating; and

(F) A payment plan for fuel deliveries beginning November 1, **[**2018**]** 2023, that ensures a vendor of deliverable fuel who completes deliveries authorized by a community action agency that contracts with the commissioner to administer a fuel assistance program is paid by the community action agency not later than **[**thirty**]** ten business days after the date the community action agency receives an authorized fuel slip or invoice for payment from the vendor;

(2) Not later than January thirtieth, annually, a report covering the preceding months of the program year, including:

(A) In each community action agency geographic area, the number of fuel assistance applications filed, approved and denied, and the number of emergency assistance requests made, approved and denied;

(B) In each such area, the total amount of fuel and emergency assistance, itemized by such type of assistance, and total expenditures to date;

(C) For each state-wide office of each state agency administering the program and each community action agency, administrative expenses under the program, by line item, and an estimate of outreach expenditures; and

(D) A list of community action agencies that failed to make timely payments to vendors of deliverable fuel in the Connecticut energy assistance program and the steps taken by the commissioner to ensure future timely payments by such agencies; and

(3) Not later than November first, annually, a report covering the preceding twelve calendar months, including:

(A) In each community action agency geographic area, (i) seasonal totals for the categories of data submitted under subdivision (1) of this subsection, (ii) the number of households receiving fuel assistance in which elderly or physically disabled individuals reside, and (iii) the average combined benefit level of fuel, emergency and renter assistance;

(B) The number of homeowners and tenants whose heat or total energy costs are not included in their rent receiving fuel and emergency assistance under the program by benefit level;

(C) The number of homeowners and tenants whose heat is included in their rent and who are receiving assistance, by benefit level; and

(D) The number of households receiving assistance, by energy type and total expenditures for each energy type.

(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 that no fuel vendor discriminates against fuel assistance program recipients who are under the vendor's standard payment, delivery, service or other similar plans. The commissioner may take advantage of programs offered by fuel vendors that reduce the cost of the fuel purchased, including, but not limited to, fixed price, capped price, prepurchase or summer-fill programs that reduce program cost and that make the maximum use of program revenues. As funding allows, the commissioner shall ensure that all agencies administering the fuel assistance program shall make payments to program fuel vendors in advance of the delivery of energy where vendor provided price-management strategies require payments in advance.

(c) Each community action agency administering a fuel assistance program shall submit reports, as requested by the Commissioner of Social Services, concerning pricing information from vendors of deliverable fuel participating in the program. Such information shall include, but not be limited to, the state-wide or regional retail price per unit of deliverable fuel, the reduced price per unit paid by the state for the deliverable fuel in utilizing price management strategies offered by program vendors for all consumers, the number of units delivered to the state under the program and the total savings under the program due to the purchase of deliverable fuel utilizing price-management

strategies offered by program vendors for all consumers.

(d) If funding allows, the Commissioner of Social Services, in consultation with the Secretary of the Office of Policy and Management, shall require that, each community action agency administering a fuel assistance program begin accepting applications for the program not later than September first of each year.

(e) Not later than November 1, **[**2018**]** 2023, the Commissioner of Social Services shall require each community action agency administering a fuel assistance program to make payment to a vendor of deliverable fuel not later than **[**thirty**]** ten days after the community action agency receives an authorized fuel slip or invoice for payment from the vendor.

(f) The Commissioner of Social Services shall submit each plan or report described in subsection (a) of this section to the Low-Income Energy Advisory Board, established pursuant to section 16a-41b, not later than seven days prior to submitting such plan or report to the joint standing committee of the General Assembly having cognizance of matters relating to energy and technology, appropriations and human services.

Sec. 6. (NEW) (*Effective July 1, 2023*) To the extent permissible under federal law and within available appropriations, as the single state Medicaid agency designated under sections 17b-2 and 17b-260 of the general statutes, the Commissioner of Social Services may implement a bundled payment for maternity services and any other alternative payment methodology or combination of methodologies that the commissioner determines are designed to improve health quality, equity, member experience, cost containment and coordination of care. The commissioner may implement policies and procedures to the extent that regulations may be required to carry out any of the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the commissioner publishes notice of intent to adopt regulations on the eRegulations System not later than

twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 7. Section 53a-290 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

A person commits vendor fraud when, with intent to defraud and acting on such person's own behalf or on behalf of an entity, such person provides goods or services to a beneficiary under sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-103, inclusive, 17b-180a, 17b-183, 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, 17b-357 to 17b-361, inclusive, 17b-600 to 17b-604, inclusive, 17b-749 **[**, 17b-807**]** and 17b-808 or provides services to a recipient under Title XIX of the Social Security Act, as amended, and, (1) presents for payment any false claim for goods or services performed; (2) accepts payment for goods or services performed, which exceeds either the amounts due for goods or services performed, or the amounts authorized by law for the cost of such goods or services; (3) solicits to perform services for or sell goods to any such beneficiary, knowing that such beneficiary is not in need of such goods or services; (4) sells goods to or performs services for any such beneficiary without prior authorization by the Department of Social Services, when prior authorization is required by said department for the buying of such goods or the performance of any service; (5) accepts from any person or source other than the state an additional compensation in excess of the amount authorized by law; or (6) having knowledge of the occurrence of any event affecting (A) his or her initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he or she has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent to fraudulently secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.

Sec. 8. Subsection (l) of section 17b-261 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective from passage*):

(l) On and after January 1, 2023, the Commissioner of Social Services shall, within available appropriations, provide state-funded medical assistance to any child twelve years of age and younger, regardless of immigration status, (1) whose household income does not exceed two hundred one per cent of the federal poverty level without an asset limit, and (2) who does not otherwise qualify for Medicaid, the Children's Health Insurance Program, or an offer of affordable, employer-sponsored insurance, as defined in the Affordable Care Act, as an employee or a dependent of an employee. A child eligible for such assistance under this subsection shall continue to receive such assistance until such child is nineteen years of age, provided the child continues to meet the eligibility requirements prescribed in subdivisions (1) and (2) of this subsection. The provisions of section 17b-265, as amended by this act, shall apply with respect to any medical assistance provided pursuant to this subsection.

Sec. 9. Subsection (a) of section 17b-292 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) A child who resides in a household with household income that exceeds one hundred ninety-six per cent of the federal poverty level but does not exceed three hundred eighteen per cent of the federal poverty level may be eligible for benefits under HUSKY B. Not later than January 1, 2023, the Commissioner of Social Services shall, within available appropriations, provide state-funded medical assistance to any child twelve years of age and younger, regardless of immigration status, (1) with a household income that exceeds two hundred one per cent of the federal poverty level but does not exceed three hundred twenty-three per cent of the federal poverty level, and (2) who does not otherwise qualify for Medicaid, the Children's Health Insurance Program, or an offer of affordable, employer-sponsored insurance, as defined in the Affordable Care Act, as an employee or a dependent of

an employee. A child eligible for such assistance under this subsection shall continue to receive such assistance until such child is nineteen years of age, provided the child continues to meet the eligibility requirements prescribed in subdivisions (1) and (2) of this subsection. The provisions of section 17b-265, as amended by this act, shall apply with respect to any medical assistance provided pursuant to this subsection.

Sec. 10. Sections 17b-306a, 17b-550 to 17b-554, inclusive, and 17b-807 of the general statutes are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	17b-8
Sec. 2	*October 1, 2023*	17b-265
Sec. 3	*October 1, 2023*	17b-265g
Sec. 4	*from passage*	12-746(e)
Sec. 5	*July 1, 2023*	16a-41a
Sec. 6	*July 1, 2023*	New section
Sec. 7	*from passage*	53a-290
Sec. 8	*from passage*	17b-261(l)
Sec. 9	*from passage*	17b-292(a)
Sec. 10	*from passage*	Repealer section

Statement of Purpose:

To (1) delete obsolete reporting requirements, (2) clarify liability of third-party private insurers and other obligors for the costs of certain medical assistance, (3) reduce from thirty to ten days the amount of time a fuel vendor participating in the Low-Income Home Energy Assistance Program shall be paid, and (4) establish bundled Medicaid payments for maternity services.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]