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State/Territory Name: Connecticut

State Plan Amendment (SPA) #: 21-0037

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

June 30, 2022

Dr. Deidre Gifford, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Re: Connecticut State Plan Amendment (SPA) 21-0037

Dear Commissioner Gifford:

We reviewed your proposed Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 21-0037. This amendment updates the state plan to remove federally optional liens and recoveries; update third-party liability section to reflect current law and practice with respect to the BBA of 2018; and remove the language regarding the cost effectiveness premium purchase program for group health insurance that is authorized under section 1906 of the SSA.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 1902(a)(18), (25), 1906, 1912, 1917(a) and (b). This letter is to inform you that Connecticut Medicaid SPA Transmittal Number 21-0037 was approved on June 28, 2022 with an effective date of October 1, 2021.

If you have any questions, please contact Marie DiMartino at 617-565-9157 or via email at Marie.DiMartino@cms.hhs.gov.

Sincerely,



James G. Scott, Director
Division of Program Operations

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>2 1 - 0 0 3 7</u>	2. STATE <u>CT</u>
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
5. FEDERAL STATUTE/REGULATION CITATION Social Sec. Act Sec. 1902(a)(18), (25), 1906, 1912, 1917(a) and (b)		4. PROPOSED EFFECTIVE DATE <p style="text-align: center; font-weight: bold;">October 1, 2021</p>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Pages 53, 53a, 53c, 70 Attachment 4.17-A, Page 1 Attachment 4.22-A, Page 1 Attachment 4.22-A, Pages 2 through 6 (NEW) Attachment 4.22-B, Pages 1; Attachment 4.22 B Pages 2-3 (NEW) Attachment 4.22-C, Pages 1 and 2 - (intentionally deleted)		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2022</u> \$ <u>10,000,000</u> b. FFY <u>2023</u> \$ <u>10,000,000</u>	
9. SUBJECT OF AMENDMENT 1. Removes federally optional liens and recoveries. 2. Updates third-party liability section to reflect current law and practice. 3. Removes the language regarding the cost effectiveness premium purchase program for group health insurance that is authorized under section 1906 of the SSA.		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Pages 53, 53a, 53c, 70 Attachment 4.17-A, Page 1 Attachment 4.22-A, Page 1 Attachment 4.22-B, Page 1 Attachment 4.22-C, Pages 1 and 2 (intentionally deleted)	
10. GOVERNOR'S REVIEW (Check One) <input checked="" type="radio"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="radio"/> OTHER, AS SPECIFIED: <input type="radio"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="radio"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO State of Connecticut Department of Social Services 55 Farmington Avenue - 9th floor Hartford, CT 06105 Attention: Ginny Mahoney		
12. TYPED NAME Deidre S. Gifford, MD, MPH	14. DATE SUBMITTED December 29, 2021		
13. TITLE Commissioner	FOR CMS USE ONLY		
16. DATE RECEIVED December 29, 2021	17. DATE APPROVED June 28, 2022		
PLAN APPROVED - ONE COPY ATTACHED			
18. EFFECTIVE DATE OF APPROVED MATERIAL October 1, 2021	19. SIGNATURE OF APPROVING OFFICIAL 		
20. TYPED NAME OF APPROVING OFFICIAL James G. Scott	21. TITLE OF APPROVING OFFICIAL Director Division of Program Operations		
22. REMARKS			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Connecticut

Citation 42 CFR 433.36(c) 1902 (18) and 1917 (a) and (b) of the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

- The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

- The State complies with the requirement of section 1917 (a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

- X The State imposes liens on real property on account of benefits incorrectly paid.

- The State imposes TEFRA liens 1917 (a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/IID, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

- The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

- The State imposes liens on both real and personal property of an individual after the individual's death.

TN #: 21-0037

Approval Date: 06/28/22

Effective Date: 10/01/2021

Supersedes

TN #: 04-002

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Connecticut

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/IID, or other medical institution.

_____ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

- (2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under § 1917(a)(1)(B) (even if it does not impose those liens).
- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

_____ In addition to adjustment or recovery of payments for services listed above, except for individuals covered pursuant to Section 1902(a)(10)(A)(i)(VIII), payments are adjusted or recovered for other services under the State Plan as listed below:

All services after age 55 except for Medicare cost sharing as specified in 4.17(b)(3).

TN #: 21-0037

Supersedes

TN #: 14-022

Approval Date: 06/28/22

Effective Date: 10/01/2021

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**State/Territory: Connecticut****(c) Adjustments or Recoveries: Limitations**

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR 433.36 (h) – (i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either disabled under age 21, blind or disabled.
- (2) With respect to liens on the house of any individual who the State determine is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment of recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home
 - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized),
or
 - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

TN #: 21-0037

Supersedes

TN #: 04-002Approval Date: 06/28/22Effective Date: 10/01/2021

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Connecticut

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State agency(s)--

Other appropriate agency(s) of another State--

Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

TN #: 21-0037

Supersedes

TN #: 94-001

Approval Date: 06/28/22

Effective Date: 10/01/2021

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**STATE: CONNECTICUT****Liens and Adjustments or Recoveries****1. The State uses the following procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:**

a. The process for determining whether an institutionalized individual cannot be reasonably expected to be discharged from the long-term care facility to return home is based on the following:

- (1) diagnosis of the individual's medical condition as documented by the long-term care facility's authorizing physician; and
- (2) the physician's prognosis for the individual's recovery; and
- (3) availability of private care which the individual could receive at home as an alternative to institutionalization; and
- (4) statement from the individual if he or she is competent regarding the intent to return home; and
- (5) financial ability of the individual to maintain the home.

b. If there is no reasonable expectation that the institutionalized individual can return home the Department sends a written notice to the individual or conservator which includes:

- (1) a statement of the Department's intent to recover from the individual's estate the cost of medical assistance paid on behalf of the individual; and
- (2) the reason for the intended action; and
- (3) the specific regulation and/or statute supporting such action; and
- (4) an explanation of the assistance unit's right to request a Fair Hearing and the Fair Hearing procedures.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR § 433.36(f):

- a. the individual's medical condition warrants institutionalization, as verified by a physician; and
- b. the son or daughter claims and verifies rendering or paying for homemaker or home health aide services for a specific number of hours per day in order to avoid the individual's institutionalization.

3. The State defines the terms below as follows:

- Estate – a decedent estate is the asset and liabilities which a deceased person has at the time of his or her death.
- Individual's home – real property which someone owns and is using as a principal residence.
- Equity interest in the home – the amount of equity which the legal owner has in an asset.
- Residing in the home for at least one or two years – the sibling or son or daughter of the individual resided in the home for one or two years respectively immediately before the date of the individual's admission to the medical institution and they provided care to the individual which permitted the individual to reside at home rather than in an institution.
- Discharged from a Medical Institution – the individual no longer requires institutional care and leaves the facility for an indefinite period of time with the intention of remaining home.
- Lawfully residing – actually residing at a certain address and publicly affirming this address as one's residence to local Post Offices, Voters Registration Office, or other governmental agencies.

TN #: 21-0037Approval Date: 06/28/22Effective Date: 10/01/2021

Supersedes

TN #: 04-002

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CONNECTICUT

Requirements for Third Party Liability - Identifying Liable Resources

42 C.F.R. § 433.138 Identifying liable third parties

(b) Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility:

(b) (1) The Connecticut Department of Social Services (CTDSS) determines Medicaid eligibility. CTDSS obtains commercial health insurance information from the applicant or client during the respective initial application and redetermination of Medicaid benefits. CTDSS utilizes a Third-Party Liability (TPL) Contractor to verify and validate the health insurance information and transmit it to CTDSS. Also, CTDSS utilizes a TPL Contractor to identify client commercial health insurance coverage not identified through the initial application or redetermination of Medicaid benefits.

(b) (2) Not applicable

(b) (3) Not applicable

(c) Obtaining Other Information: The CTDSS ImpaCT System captures non-custodial parent name, social security number, and employer information.

(d) Exchange of Data:

(d) (1) CTDSS utilizes alternative sources of information than the SWICA and SSA wage and earnings files in determining the legal liability of third parties.

(d) (2) CTDSS utilizes a TPL Contractor who conducts data exchanges with commercial health insurance companies on a daily and bi-weekly basis to identify new client health insurance coverage or changes to be made to existing client TPL. The TPL Contractor utilizes its proprietary national eligibility platform that contains subscriber enrollment information for over one thousand (1,000) health insurance companies in which the TPL Contractor has agreements to perform electronic data matches to identify CTDSS Medicaid clients with health insurance coverage. The TPL Contractor transmits to CTDSS new client health insurance, or changes to be made to existing client health insurance. Also, CTDSS provides the TPL Contractor with a monthly child support enforcement file that contains the names of Medicaid and non-Medicaid children, and their absent parents' names and social security numbers that have medical support enforcement orders to provide health insurance to the child. The TPL contractor conducts data exchanges with commercial health insurance companies to identify if the children have health insurance coverage and reports this information to CTDSS.

TN #: 21-0037

Approval Date: 06/28/22

Effective Date: 10/01/2021

Supersedes

TN #: 87-61

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**STATE: CONNECTICUT***Requirements for Third Party Liability - Identifying Liable Resources, Cont'd*

(d) (3) CTDSS is the State IV-A agency and receives financial information from federal and state agencies to determine Supplemental Nutrition Assistance Program eligibility and enrollment. This information includes client employment information, which is maintained on the CTDSS ImpaCT eligibility system.

(d) (4) CTDSS will attempt to secure agreements from the State of Connecticut Workers' Compensation Commission, to obtain information that identifies Medicaid clients and absent or custodial parents of Medicaid clients with employment-related injuries or illnesses. CTDSS will attempt to secure agreements from the State of Connecticut Department of Motor Vehicle accident report files, to obtain information that identifies those Medicaid clients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(d) (5) If CTDSS is unable to secure the agreements specified in (d) (4) of this section, CTDSS will submit documentation to the CMS regional office that demonstrates the agency made a reasonable attempt to do so.

(e) Diagnosis and trauma code edits. The CTDSS TPL Contractor and MMIS Contractor perform trauma diagnosis claim reviews. The TPL Contractor selects claims that have diagnosis codes within the range defined for accident/trauma (800.00-999.9), or where the diagnosis codes are within the range defined as the supplementary classification of external causes of injury and poisoning found in diagnosis code range E800-E999, inclusive. A trauma case is established when selected claim(s) meet a \$250 threshold. For trauma case reviews that result in the identification of a client lawsuit, the case is referred to the State of Connecticut Department of Administrative Services (DAS). DAS recovers Medicaid claim costs from the client's lawsuit. For trauma case reviews that result in the identification of a client workers' compensation case, the TPL Contractor recovers the Medicaid claim costs from the workers' compensation carrier. The MMIS Contractor establishes a trauma case by selecting hospital claims that have an accident indicator, or a primary or secondary diagnosis code within the range defined for accident/trauma or supplementary classification of external causes of injury, and the client's claim(s) payments have accumulated to meet a \$500 threshold. When a trauma case is established, the MMIS Contractor sends the hospital an accident questionnaire to obtain information to determine if the case is the result of an accident and third-party liability may exist. If a hospital response is received indicating third party liability may be available, the hospital accident questionnaire and any other hospital-provided information are scanned into the interChange OnBase reporting system.

TN #: 21-0037Approval Date: 06/28/22Effective Date: 10/01/2021

Supersedes

TN #: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**STATE: CONNECTICUT***Requirements for Third Party Liability - Identifying Liable Resources, Cont'd*

(f) Data exchanges and trauma code edits: Frequency. The CTDSS TPL Contractor performs health insurance data exchanges daily for new enrolled Medicaid clients, and on a bi-weekly basis for existing Medicaid clients. The CTDSS TPL and MMIS Contractor perform trauma diagnosis claim reviews monthly.

(g) Follow up procedures for identifying legally liable third party resources:

(g) (1) SWICA, SSA wage and earnings files, and title IV-A data exchanges.

(i) CTDSS utilizes alternative sources of information than the SWICA and SSA wage and earnings files in determining the legal liability of third parties. CTDSS utilizes a TPL Contractor who conducts data exchanges with commercial health insurance companies on a daily and bi-weekly basis to identify new client health insurance coverage or changes to be made to existing client health insurance coverage. From commercial health insurance data exchanges performed daily, the TPL Contractor will identify active client health insurance and transmit the health insurance policy information to CTDSS within one (1) day of performing the data exchange. From commercial health insurance data exchanges performed bi-weekly, the TPL Contractor will identify active client health insurance, or changes that need to be made to existing client health insurance and transmit this information to CTDSS within fourteen (14) days of performing the data exchange.

Also, the CTDSS TPL Contractor utilizes proprietary data exchange technology to identify previously unknown health insurance coverage for existing CTDSS clients, or changes that need to be made to existing clients' currently known health insurance coverage. CTDSS sends the TPL Contractor a weekly file of active Medicaid clients. The TPL Contractor uses this file to perform bi-weekly commercial health insurance data exchanges for these clients. The TPL Contractor will identify within fourteen (14) days of receiving a weekly enrollment file those clients that have active health insurance coverage, or changes that need to be made to a client's existing health insurance. This health insurance information is immediately integrated with the CTDSS interChange system, resulting in CTDSS meeting the requirements specified under § 433.139 Payment of claims, (b).

TN #: 21-0037

Approval Date: 06/28/22

Effective Date: 10/01/2021

Supersedes

TN #: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CONNECTICUT

Requirements for Third Party Liability - Identifying Liable Resources, Cont'd

(ii) The CTDSS TPL Contractor utilizes proprietary data exchange technology to provide CTDSS with daily health insurance information at the point of client enrollment into the Connecticut Medicaid Program. CTDSS sends the TPL Contractor a daily file of new Medicaid clients enrolled in the HUSKY A, C, and D, Q01 ((dual eligible clients with full and partial Medicaid benefits) and N03 (CT Home Care Program for Elders) coverage groups. The TPL Contractor uses this file to perform daily commercial health insurance data exchanges for these newly enrolled clients. The TPL Contractor will identify within one (1) day of receiving a daily enrollment file those clients that have active health insurance coverage and transmit this information to the CTDSS ImpaCT eligibility system. The new ImpaCT health insurance information is immediately integrated with the CTDSS interChange System resulting in CTDSS meeting the requirements specified under § 433.139 Payment of claims, (b).

Also, the TPL Contractor utilizes proprietary data exchange technology to identify previously unknown health insurance coverage for existing CTDSS clients, or changes that need to be made to existing clients' currently known health insurance coverage. CTDSS sends the TPL Contractor a weekly file of active Medicaid clients. The TPL Contractor uses this file to perform bi-weekly commercial health insurance data exchanges for these clients. The TPL Contractor will identify within fourteen (14) days of receiving a weekly enrollment file those clients that have active health insurance coverage, or changes that need to be made to a client's existing health insurance. This health insurance information is immediately integrated with the CTDSS interChange system, resulting in CTDSS meeting the requirements specified under § 433.139 Payment of claims, (b).

(g) (2) Health insurance information and workers' compensation data exchanges.

(i) CTDSS uses the procedures described above in 433.138 (g) (1), (i), (ii) to identify legally liable third party resources so the state agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f).

(g) (3) State motor vehicle accident report file data exchanges. CTDSS does not perform State motor vehicle accident report file data exchanges currently.

TN #: 21-0037

Approval Date: 06/28/22

Effective Date: 10/01/2021

Supersedes

TN #: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**STATE: CONNECTICUT***Requirements for Third Party Liability - Identifying Liable Resources, Cont'd*

(g) (4) Diagnosis and trauma code edits.

(i) The CTDSS TPL Contractor performs trauma diagnosis claim reviews. The TPL Contractor selects Medicaid claims using the following criteria: claims with diagnosis codes within the range defined for accident/trauma (800.00-999.9), or within the range defined as the supplementary classification of external causes of injury and poisoning found in diagnosis code range E800-E999, inclusive; claim service periods are within one (1) year from selection date; a claim(s) meets a \$250 threshold. Claims that meet this criterion establishes a trauma case. The TPL Contractor sends the client associated with the trauma case an accident questionnaire to obtain information about the person's injury or illness. For trauma case reviews that result in the identification of a client lawsuit, the case is referred to the State of Connecticut Department of Administrative Services (DAS). DAS recovers Medicaid claim costs from the client lawsuits. For trauma case reviews that result in the identification of a client workers' compensation case, the TPL Contractor recovers the Medicaid claim costs from the workers' compensation carrier.

(ii) CTDSS incorporates client lawsuit or workers' compensation information into the client eligibility case file.

(h) Obtaining other information and data exchanges: Safeguarding information.

(h) (1) The CTDSS ImpaCT and interchange (MMIS) systems which process, store, and store electronic protected health information (ePHI) have been certified to a "Moderate" data classification using the NIST 800-53 version 4 Data Security Control set. This classification has been accredited by federal regulatory bodies such as IRS, SSA, and CMS through multiple risk assessments and onsite audits.

(h) (2) The CTDSS TPL Contractor maintains Data Use Agreements (DUAs) with the health insurance companies in which it performs data exchanges to identify CTDSS clients who have health insurance coverage. The DUAs specify the information to be exchanged, the names and titles of the TPL Contractor officials with the authority to request third party information, the methods, including the formats to be used, and the timing for requesting and providing the information, the safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations, and the method the TPL Contractor will use to reimburse reasonable costs of furnishing the information if payment is requested.

TN #: 21-0037

Approval Date: 06/28/22

Effective Date: 10/01/2021

Supersedes

TN #: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**STATE: CONNECTICUT***Requirements for Third Party Liability - Identifying Liable Resources, Cont'd*

(i) Reimbursement. Connecticut General Statute 17b-137 requires health insurance companies to conduct data exchanges with CTDSS or its TPL Contractor. The statute does not require CTDSS nor its TPL Contractor to reimburse health insurance companies for reasonable costs in conducting data exchanges.

(j) Reports. CTDSS will provide reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under § 433.138 and evaluating the effectiveness of the third party liability identification system.

(k) Integration with the State mechanized claims processing and information retrieval system. Basic requirement - Development of an action plan. CTDSS has a mechanized claims processing and information retrieval system (interChange) approved by CMS under Subpart C of this section on April 10, 2010. The interChange TPL Subsystem documentation describes the system's actions and methodologies for maintaining client third party liability information, and avoiding payment of claims as required in § 433.139.

(l) Waiver of Requirements. CTDSS currently has no waiver of third party liability requirements.

TN #: 21-0037Approval Date: 06/28/22Effective Date: 10/01/2021

Supersedes

TN #: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CONNECTICUT

Requirements for Third Party Liability – Payment of Claims

42 C.F.R. § 433.139 Payment of claims.

(a) Basic provisions. CTDSS utilizes the procedures specified in paragraphs (b) through (f) of this section. The CTDSS Medicaid provider participation manual advises providers that the Connecticut Medical Assistance Program (CMAP) is the payer of last resort and client third party liability should be utilized prior to seeking payment from CMAP.

(b) Probable liability is established at the time claim is filed.

(b) (1) The Bipartisan Budget Act of 2018 amended section 1902(a)(25)(E) of the Act to require a state to use standard coordination of benefits cost avoidance instead of “pay and chase” when processing claims for prenatal services, including labor and delivery and postpartum care. CTDSS began processing prenatal services, including labor and delivery and postpartum care using cost avoidance on January 1, 2020.

(b) (3)

(i) Section 1902(a)(25)(E) of the Act provides that in the case of preventive pediatric care (including EPSDT services) covered under the state plan, the state shall make payment under the usual payment schedule without regard to liability of a third party for payment for such services, except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services. The state has elected to choose the option to make payment under the usual schedule without regard to liability of a third party and the state, as required, seeks reimbursement from such third party.

TN #: 21-0037

Approval Date: 06/28/22

Effective Date: 10/01/2021

Supersedes

TN #: 90-8

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**STATE: CONNECTICUT***Requirements for Third Party Liability – Payment of Claims, Cont'd*

(B) Section 1902(a)(25)(F) provides that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency, the state shall make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 100 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care. The state has determined that paying within 30 days after such date is cost-effective and necessary ensure access to care and the state, as required, seeks reimbursement from such third party.

(C) CTDSS Utilizes a mechanized claims processing and information retrieval system - "interChange or "iC" to process Medicaid claims. The iC will cost avoid and reject the claim if the provider has not demonstrated that client third party liability has first been utilized. The CTDSS Medicaid provider participation manual advises providers how to submit claims to the iC system that demonstrates the provider first utilized client third party liability. Providers' claims that fail to show proof that the third party either denied or partially paid a claim are rejected on the provider's Medicaid remittance. When the provider correctly submits a claim showing proof client third party liability was first utilized, the iC system will adjudicate and pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

(c) Probable liability is not established, or benefits are not available at the time claim is filed. CTDSS will adjudicate and pay the full amount under the agency's payment schedule at the time the claim is filed if the existence of client third party liability is not known.

(d) Recovery of Reimbursement

(1) CTDSS does not currently have any waivers to not cost avoid claims and instead seek recovery of reimbursement from client third party.

TN #: 21-0037

Approval Date: 06/28/22

Effective Date: 10/01/2021

Supersedes

TN #: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CONNECTICUT

Requirements for Third Party Liability – Payment of Claims, Cont'd

(2) The CTDSS TPL Contractor will seek to recover Medicaid costs from commercial health insurance or Medicare within 60 days after the end of the month in which the client third party liability is identified.

(e) Waiver of requirements. CTDSS does not currently have any waivers to not cost avoid claims and instead seek recovery of reimbursement from client third party, or to not seek Medicaid recovery from legally liable third parties.

(f) Suspension or termination of recovery of reimbursement.

Non-Hospital Claims for Commercial Insurance: The CTDSS TPL Contractor uses a minimum threshold of \$0 for Medicaid claim amount to select and bill Medicaid claims that are directly billed to commercial health insurance.

Hospital Claims for Commercial Insurance: The CTDSS TPL Contractor uses a minimum Medicaid claim dollar threshold amount of \$50 for selecting Medicaid hospital claims to be recovered through the commercial health insurance disallowance process; CTDSS recoups the Medicaid claim from the provider and the provider pursues health insurance reimbursement.

Claims for Medicare Part A: The CTDSS TPL Contractor uses a minimum Medicaid claim dollar threshold amount of \$200 for selecting Medicaid claims to be recovered through the Medicare Part A disallowance process; CTDSS recoups the Medicaid claim from the provider and the provider pursues Medicare Part A reimbursement.

Claims for Medicare Part B: The CTDSS TPL Contractor uses a minimum Medicaid claim dollar threshold amount of \$50 for selecting Medicaid claims to be recovered through the Medicare Part B disallowance process; CTDSS recoups the Medicaid claim from the provider and the provider pursues Medicare Part B reimbursement.

TN #: 21-0037

Approval Date: 06/28/22

Effective Date: 10/01/2021

Supersedes

TN #: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CONNECTICUT

1906 of the Act

State Method on Cost Effectiveness of Employer-Based Group Health Plans.

[Intentionally Deleted]

TN #: 21-0037

Supersedes

TN #: 92-3

Approval Date: 06/28/22

Effective Date: 10/01/2021

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CONNECTICUT

State Method on Cost Effectiveness of Employer-Based Group Health Plans, Cont'd

[Intentionally Deleted]

TN #: 21-0037

Supersedes

TN #: 92-3

Approval Date: 06/28/22

Effective Date: 10/01/2021