Senate

General Assembly

File No. 165

January Session, 2025

Substitute Senate Bill No. 985

Senate, March 20, 2025

The Committee on Human Services reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING LEGISLATIVE APPROVAL FOR CHANGES TO THE HUSKY HEALTH PROGRAM REIMBURSEMENT AND CARE DELIVERY MODEL.

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

Section 1. (NEW) (*Effective July 1, 2025*) (a) The Commissioner of Social Services shall submit any proposal to change the fee-for-service Medicaid payment model to a managed care payment model 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 for approval, denial or modification before implementing such change or seeking any necessary federal approval to implement such change. Not later than thirty days after the date of their receipt of such proposal, such joint standing committees shall hold a public hearing on the proposal. Not later than thirty days before such hearing, such joint standing committees shall inform the commissioner, in writing, of the date and time of such hearing and invite the commissioner to testify on the reasons for such proposal, including, but not limited to, (1) any costs or benefits to the state, (2) the expected

impact on care provided to Medicaid recipients, and (3) the expected impact on Medicaid reimbursements to providers of such care. At the conclusion of such hearing, such joint standing committees shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's proposal. If such joint standing committees advise the commissioner of their denial, the commissioner shall not implement the proposal or seek any necessary federal approval to implement the proposal.

(b) If such joint standing 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 one joint standing committee rejects the report of the committee of conference, the proposal shall be deemed denied. If such 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 proposal. If such joint standing committees do not so advise the commissioner during the thirty-day period, the proposal shall be deemed denied.

(c) Any application for a federal waiver, waiver renewal or proposed Medicaid state plan amendment submitted to the federal government by the commissioner to implement a proposal under subsection (a) of 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.

(d) Thirty days prior to submission of such proposal to such joint standing committees pursuant to subsection (a) of this section, the

Commissioner of Social Services shall post a notice that the commissioner intends to seek approval for such proposal on the Department of Social Services' Internet web site, along with a summary of the provisions of such proposal and the manner in which individuals may submit comments. The commissioner shall allow thirty days for written comments on such proposal and shall include all written comments with the submission of such proposal to such joint standing committees.

(e) The commissioner shall include with any application for federal approval of such proposal: (1) Any written comments received pursuant to subsection (d) of this section; and (2) any additional written comments submitted to such joint standing committees at such proceedings. Such joint standing committees shall transmit any such materials to the commissioner for inclusion with any such application for federal approval.

Sec. 2. (NEW) (*Effective July 1, 2025*) Not later than December 1, 2025, and annually thereafter, the Commissioner of Social Services shall file reports with the Council on Medical Assistance Program Oversight, established pursuant to section 17b-28 of the general statutes, as amended by this act, concerning (1) the financial performance of the Medicaid program, and (2) access to and quality of care for Medicaid members. The financial performance report shall minimally include updated data similar to the data in the report on financial trends in the HUSKY Health program filed with the council by the commissioner in February 2023, and the report concerning access to and quality of care shall minimally include updated data similar to the data included in the reports filed with the council by the commissioner on physical health measures in January 2023 and behavioral health quality indicators in April 2023 in the HUSKY Health program.

Sec. 3. Subsection (a) of section 17a-460c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

(a) The center, when authorized by the commissioner, may enter into

provider agreements and other contractual arrangements with the Medicaid fee-for-service program and Medicare managed care plans, governmental health plans, health maintenance organizations, health insurance plans, employer and union health plans, preferred provider organizations, physician-hospital organizations, managed care plans, networks and other similar arrangements or plans offered by insurers, third-party payers or other entities offering health care plans to their members or employees and their dependents.

Sec. 4. Section 17b-28 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

(a) There is established a Council on Medical Assistance Program Oversight which shall advise the Commissioner of Social Services on the planning and implementation of the health care delivery system for the HUSKY Health program. The council shall monitor planning and implementation of matters related to Medicaid care management initiatives including, but not limited to, (1) eligibility standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome measures, and (6) the issuance of any request for proposal by the Department of Social Services for utilization of an administrative services organization in connection with such initiatives.

[(b) On or before June 30, 2011, the council shall be composed of the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies, or their designees; two members of the General Assembly, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; the director of the Commission on Aging, or a designee; the director of the Commission on Children, or a designee; a representative of each organization that has been selected by the state to provide managed care and a representative of a primary care case management provider, to be appointed by the president pro tempore of the Senate; two representatives of the insurance industry, to be appointed by the

speaker of the House of Representatives; two advocates for persons receiving Medicaid, one to be appointed by the majority leader of the Senate and one to be appointed by the minority leader of the Senate; one advocate for persons with substance use disorders, to be appointed by the majority leader of the House of Representatives; one advocate for persons with psychiatric disabilities, to be appointed by the minority leader of the House of Representatives; two advocates for the Department of Children and Families foster families, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; two members of the public who are currently recipients of Medicaid, one to be appointed by the majority leader of the House of Representatives and one to be appointed by the minority leader of the House of Representatives; two representatives of the Department of Social Services, to be appointed by the Commissioner of Social Services; two representatives of the Department of Public Health, to be appointed by the Commissioner of Public Health; two representatives of the Department of Mental Health and Addiction Services, to be appointed by the Commissioner of Mental Health and Addiction Services; two representatives of the Department of Children and Families, to be appointed by the Commissioner of Children and Families; two representatives of the Office of Policy and Management, to be appointed by the Secretary of the Office of Policy and Management; and one representative of the office of the State Comptroller, to be appointed by the State Comptroller.**]**

[(c) On and after October 31, 2017, the**]** (b) The council shall be composed of the following members:

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services, public health and appropriations and the budgets of state agencies, or their designees;

(2) Five appointed by the speaker of the House of Representatives, one of whom shall be a member of the General Assembly, one of whom

shall be a community provider of adult Medicaid health services, one of whom shall be a recipient of Medicaid benefits for the aged, blind and disabled or an advocate for such a recipient, one of whom shall be a representative of the state's federally qualified health clinics and one of whom shall be a member of the Connecticut Hospital Association;

(3) Five appointed by the president pro tempore of the Senate, one of whom shall be a member of the General Assembly, one of whom shall be a representative of the home health care industry, one of whom shall be a primary care medical home provider, one of whom shall be an advocate for Department of Children and Families foster families and one of whom shall be a representative of the business community with experience in cost efficiency management;

(4) Three appointed by the majority leader of the House of Representatives, one of whom shall be an advocate for persons with substance abuse disabilities, one of whom shall be a Medicaid dental provider and one of whom shall be a representative of the for-profit nursing home industry;

(5) Three appointed by the majority leader of the Senate, one of whom shall be a representative of school-based health centers, one of whom shall be a recipient of benefits under the HUSKY Health program and one of whom shall be a physician who serves Medicaid clients;

(6) Three appointed by the minority leader of the House of Representatives, one of whom shall be an advocate for persons with disabilities, one of whom shall be a dually eligible Medicaid-Medicare beneficiary or an advocate for such a beneficiary and one of whom shall be a representative of the not-for-profit nursing home industry;

(7) Three appointed by the minority leader of the Senate, one of whom shall be a low-income adult recipient of Medicaid benefits or an advocate for such a recipient, one of whom shall be a representative of hospitals and one of whom shall be a representative of the business community with experience in cost efficiency management;

(8) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee;

(9) A member of the Commission on Women, Children, Seniors, Equity and Opportunity, designated by the executive director of said commission;

(10) A representative of the Long-Term Care Advisory Council;

(11) The Commissioners of Social Services, Children and Families, Public Health, Developmental Services, Aging and Disability Services and Mental Health and Addiction Services, or their designees, who shall be ex-officio nonvoting members;

(12) The Comptroller, or the Comptroller's designee, who shall be an ex-officio nonvoting member;

(13) The Secretary of the Office of Policy and Management, or the secretary's designee, who shall be an ex-officio nonvoting member; and

(14) One representative of an administrative services organization which contracts with the Department of Social Services in the administration of the Medicaid program, who shall be a nonvoting member.

[(d)**]** (c) The council shall choose a chairperson from among its members. The Joint Committee on Legislative Management shall provide administrative support to such chairperson.

[(e)**]** (d) The council shall monitor and make recommendations concerning: (1) An enrollment process that ensures access for the HUSKY Health program and effective outreach and client education for said program; (2) available services comparable to those already in the Medicaid state plan, including those guaranteed under the federal Early and Periodic Screening, Diagnostic and Treatment Services Program under 42 USC 1396d; (3) the sufficiency of accessible adult and child primary care providers, specialty providers and hospitals in Medicaid provider networks; (4) the sufficiency of provider rates to maintain the

Medicaid network of providers and service access; (5) funding and agency personnel resources to guarantee timely access to services and effective management of the Medicaid program; (6) participation in care management programs including, but not limited to, medical home and health home models by existing community Medicaid providers; (7) the linguistic and cultural competency of providers and other program facilitators and data on the provision of Medicaid linguistic translation services; (8) program quality, including outcome measures and continuous quality improvement initiatives that may include provider quality performance incentives and performance targets for administrative services organizations; (9) timely, accessible and effective client grievance procedures; (10) coordination of the Medicaid care management programs with state and federal health care reforms; (11) eligibility levels for inclusion in the programs; (12) enrollee cost-sharing provisions; (13) a benefit package for the HUSKY Health program; (14) coordination of coverage continuity among Medicaid programs and integration of care, including, but not limited to, behavioral health, dental and pharmacy care provided through programs administered by the Department of Social Services; and (15) the need for program quality studies within the areas identified in this section and the department's application for available grant funds for such studies. The chairperson of the council shall ensure that sufficient members of the council participate in the review of any contract entered into by the Department of Social Services and an administrative services organization.

[(f)**]** (e) The Commissioner of Social Services may, in consultation with an educational institution, apply for any available funding, including federal funding, to support Medicaid care management programs.

[(g)**]** (f) The Commissioner of Social Services shall provide monthly reports to the council on the matters described in subsection **[**(e)**]** (d) of this section, including, but not limited to, policy changes and proposed regulations that affect Medicaid health services. The commissioner shall also provide the council with quarterly financial reports for each

covered Medicaid population which reports shall include a breakdown of sums expended for each covered population.

[(h)**]** (g) The council shall biannually report on its activities and progress to the General Assembly.

[(i)**]** (h) There is established, within the Council on Medical Assistance Program Oversight, a standing subcommittee to study and make recommendations to the council on children and adults who have complex health care needs. The subcommittee shall consist of council members appointed by the chairpersons of the council and other individuals who shall serve for terms prescribed by the cochairpersons to advise the council on specific needs of children and adults with complex health care needs. For the purposes of completing the reports required pursuant to subparagraphs (A) and (B) of this subsection, such individuals shall include, but need not be limited to: (1) The Child Advocate, or the Child Advocate's designee; (2) a family or child advocate; (3) the executive director of the Council on Developmental Disabilities, or the executive director's designee; (4) the executive director of the Connecticut Association of Public School Superintendents, or the executive director's designee; (5) an expert in the diagnosis, evaluation, education and treatment of children and young adults with developmental disabilities; and (6) the Healthcare Advocate, or the Healthcare Advocate's designee. The subcommittee shall submit the following reports, in accordance with section 11-4a to the council, the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to children, human services and public health regarding the efficacy of support systems for children and young adults, not older than twenty-one years of age, with developmental disabilities and with or without co-occurring mental health conditions:

(A) Not later than July 1, 2017, recommendations including, but not limited to: (i) Metrics for evaluating the quality of state-funded services to such children and young adults that can be utilized by state agencies that fund such services; (ii) statutory changes needed to promote

effective service delivery for such children and young adults and their families; and (iii) any other changes needed to address gaps in services identified by the subcommittee or council with respect to such children, young adults and their families; and

(B) Not later than January 1, 2018, an assessment of: (i) Early intervention services available to such children and young adults in this state; (ii) the system of community-based services for such children and young adults; (iii) the treatment provided by congregate care settings that are operated privately or by the state and provide residential supports and services to such children and young adults and how the quality of care is measured; and (iv) how the state Department of Education, local boards of education, the Department of Children and Families, the Department of Developmental Services and other appropriate agencies can work collaboratively to improve educational, developmental, medical and behavioral health outcomes for such children and young adults and reduce the number at risk of entering institutional care. As used in this subsection, "developmental disability" means a severe, chronic disability of an individual, as defined in 42 USC 15002, as amended from time to time.

Sec. 5. Section 17b-28h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

The Commissioner of Social Services may, to the extent permitted by federal law, amend the Medicaid state plan to establish a pilot program that serves not more than five hundred persons served by Oak Hill - The Connecticut Institute for the Blind, Inc. who are eligible for Medicare and who voluntarily agree to participate in the program. Such program shall be designed to demonstrate the feasibility and cost effectiveness of delivering comprehensive health insurance coverage **[**in a managed care setting**]** to such persons. The commissioner may include medical assistance services in the program not covered on October 5, 2009, in the state medical assistance program or other modifications to the state medical assistance program to encourage voluntary participation in the pilot program.

Sec. 6. Subsection (b) of section 17b-90 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

(b) No person shall, except for purposes directly connected with the administration of programs of the Department of Social Services and in accordance with the regulations of the commissioner, solicit, disclose, receive or make use of, or authorize, knowingly permit, participate in or acquiesce in the use of, any list of the names of, or any information concerning, persons applying for or receiving assistance from the Department of Social Services or persons participating in a program administered by said department, directly or indirectly derived from the records, papers, files or communications of the state or its subdivisions or agencies, or acquired in the course of the performance of official duties. The Commissioner of Social Services shall disclose (1) to any authorized representative of the Labor Commissioner such information directly related to unemployment compensation, administered pursuant to chapter 567 or information necessary for implementation of sections 17b-112*l*, 17b-688b, 17b-688c and 17b-688h and section 122 of public act 97-2 of the June 18 special session, (2) to any authorized representative of the Commissioner of Mental Health and Addiction Services any information necessary for the implementation and operation of the basic needs supplement program, (3) to any authorized representative of the Commissioner of Administrative Services or the Commissioner of Emergency Services and Public Protection such information as the Commissioner of Social Services determines is directly related to and necessary for the Department of Administrative Services or the Department of Emergency Services and Public Protection for purposes of performing their functions of collecting social services recoveries and overpayments or amounts due as support in social services cases, investigating social services fraud or locating absent parents of public assistance recipients, (4) to any authorized representative of the Commissioner of Children and Families necessary information concerning a child or the immediate family of a child receiving services from the Department of Social Services, including safety net services, if (A) the Commissioner of

Children and Families or the Commissioner of Social Services has determined that imminent danger to such child's health, safety or welfare exists to target the services of the family services programs administered by the Department of Children and Families, or (B) the Commissioner of Children and Families requires access to the federal Parent Locator Service established pursuant to 42 USC 653 in order to identify a parent or putative parent of a child, (5) to a town official or other contractor or authorized representative of the Labor Commissioner such information concerning an applicant for or a recipient of assistance under state-administered general assistance deemed necessary by the Commissioner of Social Services and the Labor Commissioner to carry out their respective responsibilities to serve such persons under the programs administered by the Labor Department that are designed to serve applicants for or recipients of state-administered general assistance, (6) to any authorized representative of the Commissioner of Mental Health and Addiction Services for the purposes of the behavioral health **[**managed care**]** program established by section 17a-453, (7) to any authorized representative of the Commissioner of Early Childhood to carry out his or her respective responsibilities under the two-generational academic achievement and workforce readiness initiative established pursuant to section 17b-112*l* and programs that regulate child care services or youth camps, (8) to a health insurance provider, in IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231, information concerning a child and the custodial parent of such child that is necessary to enroll such child in a health insurance plan available through such provider when the noncustodial parent of such child is under court order to provide health insurance coverage but is unable to provide such information, provided the Commissioner of Social Services determines, after providing prior notice of the disclosure to such custodial parent and an opportunity for such parent to object, that such disclosure is in the best interests of the child, (9) to any authorized representative of the Department of Correction, in IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231, information concerning noncustodial parents that is necessary to

identify inmates or parolees with IV-D support cases who may benefit from Department of Correction educational, training, skill building, work or rehabilitation programming that will significantly increase an inmate's or parolee's ability to fulfill such inmate's support obligation, (10) to any authorized representative of the Judicial Branch, in IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231, information concerning noncustodial parents that is necessary to: (A) Identify noncustodial parents with IV-D support cases who may benefit from educational, training, skill building, work or rehabilitation programming that will significantly increase such parent's ability to fulfill such parent's support obligation, (B) assist in the administration of the Title IV-D child support program, or (C) assist in the identification of cases involving family violence, (11) to any authorized representative of the State Treasurer, in IV-D support cases, as defined in subdivision (13) of subsection (b) of section 46b-231, information that is necessary to identify child support obligors who owe overdue child support prior to the Treasurer's payment of such obligors' claim for any property unclaimed or presumed abandoned under part III of chapter 32, (12) to any authorized representative of the Secretary of the Office of Policy and Management any information necessary for the implementation and operation of the renters rebate program established by section 12-170d, or (13) to any authorized representative of the Department of Aging and Disability Services, or to an area agency on aging contracting with said department to provide services under the elderly nutrition program, information on persons enrolled in the supplemental nutrition assistance program who have requested or been recommended to receive elderly nutrition program services. No such representative shall disclose any information obtained pursuant to this section, except as specified in this section. Any applicant for assistance provided through the Department of Social Services shall be notified that, if and when such applicant receives benefits, the department will be providing law enforcement officials with the address of such applicant upon the request of any such official pursuant to section 17b-16a.

Sec. 7. Section 17b-265c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

The Commissioner of Social Services, to the extent permitted by federal law, shall amend the Medicaid state plan to establish a pilot program serving not more than five hundred elderly or disabled state medical assistance recipients who are also eligible for Medicare and who voluntarily opt to participate in the program. Such program shall demonstrate the feasibility and cost effectiveness of delivering comprehensive health insurance coverage **[**in a managed care setting**]** to such recipients. The commissioner may include medical assistance services in the pilot program not presently covered in the state medical assistance program or other modifications to the state medical assistance program to encourage voluntary participation in the pilot program.

Sec. 8. Section 17b-10a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2025*):

The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures necessary to administer **[**section 17b-197, subsection (d) of section 17b-266, section**]** sections 17b-197, 17b-280a and subsection (a) of section 17b-295, while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of intent to adopt regulations on the department's Internet web site and 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. 9. Sections 17b-28b and 17b-266 of the general statutes are repealed. (*Effective July 1, 2025*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2025*	New section
Sec. 2	*July 1, 2025*	New section
Sec. 3	*July 1, 2025*	17a-460c(a)
Sec. 4	*July 1, 2025*	17b-28
Sec. 5	*July 1, 2025*	17b-28h
Sec. 6	*July 1, 2025*	17b-90(b)

Sec. 7	*July 1, 2025*	17b-265c
Sec. 8	*July 1, 2025*	17b-10a
Sec. 9	*July 1, 2025*	Repealer section

Statement of Legislative Commissioners:
In Section 1, "Not later than sixty days after" was changed to "Not later than thirty days after" for accuracy and internal consistency. In Section 2, in the first sentence, "on financial trends in the HUSKY Health program", "on physical health measures", "behavioral health quality indicators in" and "in the HUSKY Health program" were added for clarity; and in the second sentence, provisions concerning the reporting of data similar to data previously reported were redrafted for clarity.

HS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 $	FY 27 $
Social Services, Dept.	GF - Potential	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill requires the Department of Social Services (DSS) to submit any proposal to change the fee-for-service Medicaid payment model to a managed care payment model to the Appropriations and Human Services committees before implementing or seeking any necessary federal approval to implement such change. To the extent this delays or prevents a change that otherwise would have occurred, the state could experience a fiscal impact that cannot be determined at this time.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to changes in the Medicaid payment model.

OLR Bill Analysis

sSB 985

AN ACT CONCERNING LEGISLATIVE APPROVAL FOR CHANGES TO THE HUSKY HEALTH PROGRAM REIMBURSEMENT AND CARE DELIVERY MODEL.

SUMMARY

This bill requires the Department of Social Services (DSS) to submit any proposal to change the fee-for-service Medicaid payment model to a managed care payment model (see BACKGROUND) to the Appropriations and Human Services committees for approval before implementing this payment model change or seeking federal approval to implement it. It repeals laws that authorize DSS to (1) award contracts for Medicaid managed care health plans, (2) fund medical assistance benefits by purchasing insurance, and (3) require medical assistance recipients to receive medical care on a prepayment or per capita basis.

The bill also requires the DSS commissioner to report annually, starting by December 1, 2025, to the Council on Medical Assistance Program Oversight (MAPOC) on (1) the Medicaid program's financial performance and (2) Medicaid members' access to, and quality of, care. The bill requires these reports to include information from three specific reports the department previously submitted to MAPOC (see BACKGROUND). DSS's annual report on financial performance under the bill must include updated data similar to the data in its February 2023 report on financial trends in the HUSKY Health program. The annual report on access to and quality of care must include data similar to the data in the department's (1) January 2023 report on physical health measures and (2) April 2023 report on behavioral health quality indicators in the HUSKY Health program.

It also makes minor and conforming changes to remove references to managed care in Medicaid in current laws that:

1. allow the Connecticut Mental Health Center to enter into contracts with the Medicaid program (§ 3);

2. allow DSS to amend the Medicaid state plan to establish a pilot program for up to 500 Medicare-eligible people served by Oak Hill – The Connecticut Institute for the Blind, Inc. to deliver comprehensive health insurance coverage in a managed care setting (§ 5);

3. allow DSS to disclose information to a Department of Mental Health and Addiction Services representative for a behavioral health managed care program (§ 6); and

4. require DSS to amend the Medicaid state plan to establish a pilot program for up to 500 Medicaid recipients who are elderly or living with a disability to deliver comprehensive health insurance coverage in a managed care setting (§ 7).

Lastly, the bill makes technical changes to remove obsolete provisions (§ 4).

EFFECTIVE DATE: July 1, 2025

LEGISLATIVE APPROVAL PROCESS FOR MANAGED CARE PAYMENT MODELS IN MEDICAID

The bill establishes a legislative approval process for proposals to change the Medicaid payment model from fee-for-service to managed care.

Comment Period and Hearing

Under the bill, DSS must submit the proposal, including any written comments the department receives on it, to the Appropriations and Human Services committees. The bill requires DSS to accept written comments on the proposal before submitting it to the committees. The department must post notice of the proposal, with a summary of its provisions and the method for submitting written comments, 30 days before submitting it to the committees. The committees must:

1. hold a public hearing within 30 days after they receive the proposal;

2. notify the DSS commissioner about the hearing's date and time at least 30 days before the hearing; and

3. invite her to testify on the proposal, including any costs or benefits to the state and expected impacts on care provided to Medicaid recipients and Medicaid provider payments.

At the end of the hearing, the committees must advise the commissioner of their approval, denial, or modifications to the proposal. The bill prohibits the commissioner from implementing or seeking federal approval to implement any proposal the committees deny.

Conference Committee

If the Appropriations and Human Services committees do not concur on a proposal, the bill requires committee chairpersons to appoint a conference committee, composed of three members of each committee, including one member from the minority party from each committee. The conference committee must report to each committee, which must vote to accept or reject the conference committee's report without amendment. If either committee rejects the conference committee's report, the proposal is deemed denied. If they both accept the report, the Appropriations Committee must advise the DSS commissioner of the approval, denial, or modifications to the proposal. If the committees do not advise the commissioner during the 30-day period, the proposal is deemed denied.

Implementation Application

The bill requires any application for a Medicaid state plan, federal waiver, or waiver renewal to implement a proposal to be in accordance with the Appropriations and Human Services committees' approval or modifications. The bill also requires DSS to include with the application any written comments it received during the comment period and at the hearing. The bill requires the Appropriations and Human Services

committees to transmit these materials to DSS.

BACKGROUND

Managed Care and Fee-for-Service Payment Models

Medicaid programs may deliver benefits through a managed care entity or on a fee-for-service basis. Generally, under a managed care delivery system, the Medicaid program contracts with managed care plans to cover all or most Medicaid-covered services for Medicaid enrollees. States pay the entity administering the plan (typically a managed care organization) a per-member, per-month amount to cover a defined set of services. Under a fee-for-service model, the state pays providers directly for each covered service delivered to a Medicaid enrollee.

DSS Reports Filed With MAPOC

February 2023 Report. This report included data on the following topics:

1. spending by service category;
2. Medicaid growth trends, including per-member per-month trends;
3. Medicaid as a percentage of the state budget; and
4. Medicaid administrative cost ratio.

January 2023 Report. This report included data on the following topics:

1. core measures, developed by the federal Centers for Medicare and Medicaid Services (CMS), to evaluate health care quality;
2. Healthcare Effectiveness Data and Information Set (HEDIS) measures;
3. a health equity analysis; and
4. DSS actions to improve outcomes.

April 2023 Report. This report on behavioral health quality indicators similarly included data on CMS core and HEDIS measures on behavioral health.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 16 Nay 6 (03/04/2025)