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)