OLR Bill Analysis

sSB 985 (File 165, as amended by Senate "A")*

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

SUMMARY

By law, the Department of Social Services (DSS) commissioner must seek legislative approval when applying to the federal government to (1) waive Medicaid requirements or (2) amend the Medicaid state plan to change program requirements that would have otherwise required a waiver but for the passage of the federal Affordable Care Act.

This bill (1) extends the requirement for legislative approval to any executive branch agency or office planning to implement such a waiver or amendment and (2) requires legislative approval for state plan amendments to provide assistance through a Medicaid managed care organization (MCO) (currently, the state administers the program using a fee-for-service model).

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.

The bill 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 (§ 4);

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 (§ 6);

3. allow DSS to disclose information to a Department of Mental Health and Addiction Services representative for a behavioral health managed care program (§ 7); 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 (§ 8).

Lastly, the bill makes technical changes to remove obsolete provisions (§ 5).

*Senate Amendment "A" replaces the original bill. It modifies the process for seeking legislative approval to change the Medicaid payment model from fee-for-service to managed care. It also adds provisions (1) requiring state agencies and offices to submit waiver and state plan amendment applications for legislative approval and (2) requires the Office of Policy and Management (OPM), instead of DSS, to notify the legislature about potential waivers and state plan amendments.

EFFECTIVE DATE: July 1, 2025

LEGISLATIVE APPROVAL PROCESS FOR MCO STATE PLAN AMENDMENTS

By law, the DSS commissioner must submit to the Human Services and Appropriations committees applications DSS is submitting to the federal Centers for Medicare and Medicaid (CMS) to (1) waive any Medicaid requirements, unless the waiver pertains to routine operational issues, or (2) amend the state Medicaid plan to change program requirements that would have otherwise required a waiver but for the passage of the federal Affordable Care Act. Existing law establishes a process for the legislature to review these applications.

The bill extends this requirement for legislative approval to any executive branch agencies or offices planning to implement such a waiver or state plan amendment. It also requires the DSS commissioner and these agencies and offices to follow a similar process when seeking a state plan amendment to provide medical assistance through a Medicaid MCO.

The bill makes related technical and conforming changes.

Public Hearing

As under current law, the bill requires the DSS commissioner and these agencies and offices to submit to the Appropriations and Human Services committees applications they are submitting to CMS for a Medicaid MCO state plan amendment. The committee chairpersons must notify the DSS commissioner if they intend to hold a public hearing on the application and if so, the date that it will be held, which cannot be more than 60 days after they receive the amendment.

Committee Recommendations

Once the hearing is concluded, the bill requires the Appropriations and Human Services committees to forward their recommendations to approve, deny, or modify the proposed Medicaid MCO state plan amendment to the legislature for advice and consent. If the legislature denies the amendment, the commissioner may not submit to CMS.

Under the bill, if the Appropriations and Human Services committees

do not agree, the chairpersons must appoint a conference committee with three members from each committee. At least one member from each committee must be from the minority party. The conference committee must report to both standing committees, which must vote to accept or reject the report. The report may not be amended.

Any proposed Medicaid MCO state plan amendment submitted to the federal government must be in accordance with the legislature's approval or modifications.

Waiver and Amendment Notification

Current law requires the DSS commissioner, annually by December 15, to notify the Appropriations and Human Services committees of potential Medicaid waivers and state plan amendments that may result in state cost savings.

The bill instead requires the OPM secretary to annually notify the committees of potential Medicaid waivers and state plan amendments, or other proposals of executive branch agencies or offices, that (1) result in Medicaid state cost savings or expenses or (2) DSS or the agencies or offices are considering in developing the next fiscal year's budget, before submitting it for legislative approval.

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 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)