OLR Bill Analysis
sHB 7165 (as amended by House "A")*

**AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK.**

**SUMMARY**

This bill requires the Department of Social Services (DSS) commissioner, to the extent permissible under federal law, to provide Medicaid coverage for medically necessary pasteurized donor breast milk. Under the bill, donor breast milk is eligible for Medicaid reimbursement if a licensed physician, physician’s assistant, or advanced practice registered nurse (APRN), signs an order stating that donor milk is medically necessary (see BACKGROUND) for an infant Medicaid beneficiary (1) who medically or physically cannot receive maternal breast milk or participate in breastfeeding or (2) whose mother medically or physically cannot produce milk in sufficient quantities.

The bill requires DSS to seek federal approval of a Medicaid state plan amendment or waiver if necessary to provide such coverage. It applies existing requirements on legislative approval of Medicaid waivers and certain state plan amendments to waivers and amendments under the bill (see BACKGROUND).

The bill also requires DSS to adopt or amend regulations that include provisions establishing (1) infant birth weight and health conditions that qualify for medically necessary donor breast milk and (2) time limits for Medicaid coverage of donor breast milk. The bill allows DSS to adopt policies or procedures to implement the bill’s provisions while adopting regulations as long as the department posts them on its website and in the eRegulations System.

**EFFECTIVE DATE: July 1, 2019**

*House Amendment “A” replaces the underlying bill with similar
provisions; requires a physician, physician’s assistant, or APRN to sign the order, rather than any licensed health professional; requires that DSS’s regulations establish infant birth weights that would qualify for the benefit; and makes other minor changes to the underlying bill.

BACKGROUND

**Medically Necessary Services**

By law, medically necessary services are those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate an individual’s medical condition, including mental illness, or its effects, to attain or maintain the individual’s achievable health and independent functioning (CGS § 17b-259b). Medically necessary services must also be:

1. consistent with generally accepted standards of medical practice;
2. clinically appropriate in terms of type, frequency, timing, site, extent, and duration and considered effective for the individual’s illness, injury, or disease;
3. not primarily for the individual’s or provider’s convenience;
4. not more costly than an alternative service likely to produce equivalent therapeutic or diagnostic results; and
5. based on an assessment of the individual and his or her medical condition.

**Waiver and Amendment Approval Process**

By law, before submitting a waiver application or certain state plan amendments to the federal Centers for Medicare and Medicaid Services (CMS), DSS must (1) publish a notice of intention to seek a waiver in the Connecticut Law Journal and on the department’s website and (2) submit the waiver application to the Appropriations and Human Services committees. The committees must hold a public hearing (for waivers) or notify DSS whether they intend to hold a public hearing (for state plan amendments) and advise the DSS commissioner of their approval, disapproval, or modifications of the
waiver application or state plan amendment (CGS § 17b-8).

**COMMITTEE ACTION**

Human Services Committee

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(03/21/2019)