OLR Bill Analysis
sHB 7165

AN ACT CONCERNING MEDICAID COVERAGE FOR DONOR BREAST MILK.

SUMMARY

This bill requires the Department of Social Services (DSS) commissioner to provide Medicaid coverage for medically necessary pasteurized donor breast milk provided at a hospital on an inpatient basis. Under the bill, donor breast milk is eligible for Medicaid reimbursement if a licensed health professional signs a medical order indicating the donor milk is medically necessary (see BACKGROUND) for an infant Medicaid beneficiary (1) who medically or physically cannot breastfeed or receive maternal breast milk or (2) whose mother medically or physically cannot breast feed or produce milk in sufficient quantities despite optimal lactation support.

The bill requires DSS to (1) seek federal approval of a Medicaid state plan amendment or waiver if necessary to provide such coverage, and (2) adopt regulations that include provisions establishing infant health conditions that qualify for medically necessary 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.

The bill applies existing requirements on legislative approval of Medicaid waivers and certain state plan amendments to waivers and amendments under the bill (see BACKGROUND).

EFFECTIVE DATE: July 1, 2019

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 convenience or the 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

Joint Favorable Substitute

Yea 18  Nay 0  (03/21/2019)