DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

May 18, 2011

JudyAnn Bigby, M.D., Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Dear Dr. Bigby:

We have reviewed Massachusetts' State Plan Amendment (SPA) No. 10-005, received in the Boston Regional Office on September 29, 2010. This amendment increases the member pharmacy copayment from $2.00 to $3.00 for certain generic drugs and over-the-counter drugs.

Based on the information provided, we are pleased to inform you that Massachusetts SPA 10-005 is approved, effective July 1, 2010. Enclosed is a copy of the CMS-179 form, as well as the approved pages for incorporation in the Massachusetts Medicaid State Plan.

If you have any questions, please contact Aaron Wesolowski of my staff. Aaron Wesolowski can be reached at (617) 565-1325 or by email at aaron.wesolowski@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Terry Dougherty, Medicaid Director
Michael Coleman, State Plan Coordinator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **10-005**	2. STATE **MA**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **07/01/10**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 USC §1396a(a)(14), 42 USC §1396o and 42 CFR §§447.53 through 447.55	**a. FFY10 $ (774,991)** **b. FFY11 $ (2, 902, 265)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.18-A, page 1** **Attachment 4.18-C, Page 1**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Same**

10. SUBJECT OF AMENDMENT:

Pharmacy Copayments

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: **Not required under 42 CMR 430.12(b)(2)(ii)**

12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME **Judy Ann Bigb** 14. TITLE: **Secretary** 15. DATE SUBMITTED: **09/29/10**	16. RETURN TO: **Michael P. Coleman** **State Plan Coordinator** **Executive Office of Health and Human Services** **Office of Medicaid** **One Ashburton Place, 11th Floor** **Boston, MA 02108**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2011	18. DATE APPROVED: May 18, 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2010	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations

23. REMARKS:
The following change was mutually agreed to by CMS and EOHHS:
-Box 8 is modified to include the following State plan page: "Section 4, page 56d"

FORM CMS-179 (07-92)

Citation	4.18 Recipient Cost Sharing and Similar Charges (cont.)
42 CFR 447.51 through 447.58	(c) (2) (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.
	(iii) All services furnished to pregnant women.
	☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
	(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.
	(v) Emergency services if the services meet the requirements in 42 CFR 447.53 (b) (4).
	(vi) Family planning services and supplies furnished to individuals of childbearing age.
1916 of the Act, P.L. 99-272 (Section 9505)	(vii) Services furnished to an individual receiving hospice care, as defined in section 1905 (o) of the Act.
447.51 through 447.58	(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.
	☐ Not applicable.
	Charges are imposed on services provided by a Managed Care Organization under a contract authorized by the Commonwealth's demonstration project pursuant to 1115 of the Act.
	Charges are not imposed on services provided by a Senior Care Organization (SCO) under a contract pursuant to Section 1915(a) of the Act.

(A) Services for which a charge is applied include those Medicaid-reimbursable prescribed drugs and non-psychiatric acute inpatient hospital stays that are not excluded from cost sharing under federal law.

(B) Nature of the charge imposed on each service is a copayment.

(C) Amount and basis for determining the charge is:

1. $3.00 for each non-psychiatric acute inpatient hospital stay;

2. $1.00 for each prescription and refill for generic drugs and over-the-counter drugs covered by MassHealth in the following classes: antihyperglycemics, antihypertensives, and antihyperlipidemics;

3. $3.00 for each prescription and refill for all other generic, brand-name, and over-the-counter drugs covered by MassHealth.

4. Copayment amounts are set no higher than the amounts permissible according to the chart set forth at 42 CFR §447.54(a)(3). The copayment amounts are fixed, and based on the average or typical payment for services according to 42 CFR §447.55.

(D) Method used to collect the charge is edits in the claims processing system which automatically deducts the copayment amount unless the provider codes the claim indicating that the recipient or service meets the criteria contained in 42 CFR §447.53 (b).

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers is the individual's statement to the provider that he or she does not have the money to pay for the service at the time the service or prescription is provided.

(F) Procedures for implementing and enforcing the exclusions from cost sharing include notices to recipients and providers regarding the copayment requirements, edits to the claims processing system.

To enforce the premiums and cost sharing protections for American Indians/Alaska Natives (AI/AN) contained in Section 5006 of the American Recovery and Reinvestment Act of 2009, the state uses MA-21 eligibility flags and MMIS ethnicity codes to identify individuals eligible for these protections (including those who present an Active/Previous User Letter). The state's MA-21 program will suppress their premiums and the state's MMIS and POPS systems will suppress their copayments. The state will ensure that provider payments may not be reduced by any coinsurance, copayment or deductible that has been exempted for the AI/AN patient.

If an AI/AN has been furnished a service by an Indian health care provider operated by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or by non-Indian health care providers through referral, or if he or she is eligible to receive such services, the state's MA-21 program will suppress their premiums.

If an AI/AN has ever been furnished a service by an Indian Health care provider operated by the Indian Health Service (HIS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or by non-Indian health care providers through referral, the state's MMIS and POPS systems will not charge that individual a copayment for services received from any Medicaid provider and the state will ensure that provider payments may not be reduced by any coinsurance, copayment or deductible that has been exempted for the AI/AN patient.

(G) Cumulative maximum that applies to copayment requirements:
- (1) $200 per year per person for pharmacy services, and
- (2) $36 per year per person for non-pharmacy services.

(A) Services for which a charge is applied include those Medicaid-reimbursable prescribed drugs and non-psychiatric acute inpatient hospital stays that are not excluded from cost sharing under federal law.

(B) Nature of the charge imposed on each service is a copayment.

(C) Amount and basis for determining the charge is:

1. $3.00 for each non-psychiatric acute inpatient hospital stay;

2. $1.00 for each prescription and refill for generic drugs and over-the-counter drugs covered by MassHealth in the following classes: antihyperglycemics, antihypertensives, and antihyperlipidemics;

3. $3.00 for each prescription and refill for all other generic, brand-name, and over-the-counter drugs covered by MassHealth.

4. Copayment amounts are set no higher than the amounts permissible according to the chart set forth at 42 CFR §447.54(a)(3). The copayment amounts are fixed, and based on the average or typical payment for services according to 42 CFR §447.55.

(D) Method used to collect the charge is edits in the claims processing system which automatically deducts the copayment amount unless the provider codes the claim indicating that the recipient or service meets the criteria contained in 42 CFR §447.53 (b).

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers is the individual's statement to the provider that he or she does not have the money to pay for the service at the time the service or prescription is provided.

(F) Procedures for implementing and enforcing the exclusions from cost sharing include notices to recipients and providers regarding the copayment requirements, edits to the claims processing system.

To enforce the premiums and cost sharing protections for American Indians/Alaska Natives (AI/AN) contained in Section 5006 of the American Recovery and Reinvestment Act of 2009, the state uses MA-21 eligibility flags and MMIS ethnicity codes to identify individuals eligible for these protections (including those who present an Active/Previous User Letter). The state's MA-21 program will suppress their premiums and the state's MMIS and POPS systems will suppress their copayments. The state will ensure that provider payments may not be reduced by any coinsurance, copayment or deductible that has been exempted for the AI/AN patient.

If an AI/AN has been furnished a service by an Indian health care provider operated by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or by non-Indian health care providers through referral, or if he or she is eligible to receive such services, the state's MA-21 program will suppress their premiums.

If an AI/AN has ever been furnished a service by an Indian Health care provider operated by the Indian Health Service (HIS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or by non-Indian health care providers through referral, the state's MMIS and POPS systems will not charge that individual a copayment for services received from any Medicaid provider and the state will ensure that provider payments may not be reduced by any coinsurance, copayment or deductible that has been exempted for the AI/AN patient.

(G) Cumulative maximum that applies to copayment requirements:
- (1) $200 per year per person for pharmacy services, and
- (2) $36 per year per person for non-pharmacy services.