

## **Table of Contents**

**State/Territory Name: Massachusetts**

**State Plan Amendment (SPA) #: 11-006**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form
- 3) Approved SPA Pages

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



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

February 3, 2012

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. 11-006, received in the Boston Regional Office on June 30, 2011. This amendment inserts language into the State plan concerning a nursing home patient paid amount deduction for non-covered, necessary remedial care expenses in the three months prior to eligibility.

Based on the information provided, we are pleased to inform you that Massachusetts SPA No. 11-006 is approved, effective April 1, 2011. Enclosed is a copy of the CMS-179 form, as well as the approved page for incorporation in the Massachusetts Medicaid State plan.

If you have any questions, please contact Robert Cruz of my staff. Robert Cruz can be reached at 617-565-1257 or by email at [robert.cruz@cms.hhs.gov](mailto:robert.cruz@cms.hhs.gov).

Sincerely,

/s/

Richard R. McGreal  
Associate Regional Administrator

Enclosures

cc: Julian Harris, M.D., M.B.A., M.Sc., Medicaid Director  
Michael Coleman, State Plan Coordinator

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER:  <p style="text-align:center;"><b>011-006</b></p>	2. STATE  <p style="text-align:center;"><b>MA</b></p>				
	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  <p style="text-align:right;"><b>04/01/11</b></p>					
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )						
6. FEDERAL STATUTE/REGULATION CITATION:  <p style="text-align:center;"><b>42 CFR 435.832 (C)</b> <b>42 CFR 435.725 (C)</b></p>	7. FEDERAL BUDGET IMPACT:  <table style="width:100%; border:none;"> <tr> <td style="width:50%;">a. FFY11</td> <td style="width:50%; text-align:right;">\$ 00.00</td> </tr> <tr> <td>b. FFY12</td> <td style="text-align:right;">\$ 00.00</td> </tr> </table>		a. FFY11	\$ 00.00	b. FFY12	\$ 00.00
a. FFY11	\$ 00.00					
b. FFY12	\$ 00.00					
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <p style="text-align:center;"><b>Supplement 3 to Attachment 2.6-A, page 4</b></p>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <p style="text-align:center;">N/A</p>					

10. SUBJECT OF AMENDMENT:

**Deductions for Health-Care Coverage and Other Incurred Expenses**

11. GOVERNOR'S REVIEW (*Check One*):

<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Not required under <b>42 CFR 430.12(b)(2)(ii)</b>
---	--

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/	16. RETURN TO:  <p style="text-align:center;"><b>Michael P. Coleman</b> <b>State Plan Coordinator</b> <b>Office of Medicaid</b> <b>Executive Office of Health and Human Services</b> <b>One Ashburton Place, 11<sup>th</sup> Floor</b> <b>Boston, MA 02108</b></p>
13. TYPED NAME: <b>JudyAnn Bigby, M. D.</b>	
14. TITLE: <b>Secretary</b>	
15. DATE SUBMITTED: <b>06/30/11</b>	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: <b>June 30, 2011</b>	18. DATE APPROVED: <b>February 3, 2012</b>
---	--

**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL: <p style="text-align:center;"><b>April 1, 2011</b></p>	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: <p style="text-align:center;"><b>Richard R. McGreal</b></p>	22. TITLE: <b>Associate Regional Administrator, Division of Medicaid &amp; Children's Health Operations</b>

23. REMARKS: The following modifications were mutually agreed upon by the Centers for Medicare & Medicaid Services and the Massachusetts Executive Office of Health & Human Services:

- \*Box 6 revised to cite the following regulations: "42 CFR 435.832(c)" and "42 CFR 438.725(c)"
- \*Box 7 revised with the following Federal budget impact figures: "FFY 11: \$9,987,300" and "FFY 12: \$19,974,600"
- \*Box 11 revised to cite the following regulation: "42 CFR 430.12(b)(2)(i)"

**Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid**

---

Reasonable and necessary medical and remedial care expenses recognized under State law that are not covered by Medicaid or payable by a third party which are incurred in the three month period prior to the month of application may be allowable deductions. Expenses incurred prior to this three month period are not allowable deductions.

For medically necessary services and items not covered by the Medicaid State Plan, the actual paid amount will be used as the deduction, subject to the following limit: the highest of a payment/fee recognized by Medicaid, Medicare, or any commercial payers in the Commonwealth.

No deduction shall be allowed for medical and remedial care expenses that were incurred as a result of the imposition of a transfer of resources penalty.