Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER PHM-56
July 2006

TO: Pharmacies Participating in MassHealth

FROM: Beth Waldman, Medicaid Director

RE: *Pharmacy Manual* (Revision to Regulations about Medicare Part D)

This letter transmits clarifications to the pharmacy regulations about Medicare Part D.

Except for prior authorization, all other MassHealth pharmacy limits will apply to one-time supplies.

For Medicare Part D cost-sharing assistance for dually eligible MassHealth members, the member will pay the applicable MassHealth copayment and MassHealth will pay the difference to the pharmacy, up to the amount that the Medicare Part D plan is permitted to charge a dually eligible person.

These emergency regulations were effective January 1, 2006.

If you have any questions about the information in this transmittal letter please contact Affiliated Computer Systems (ACS) at 1-866-246-8503.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Pharmacy Manual

Pages 4-9 and 4-10

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Pharmacy Manual

Pages 4-9 and 4-10 — transmitted by Transmittal Letter PHM-54

(2) The MassHealth agency does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs; and

(c) drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The MassHealth agency, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(3) The MassHealth agency does not pay any additional fees for dispensing drugs in a unit-dose distribution system. The MassHealth agency does, however, pay a unit-dose return fee in accordance with 130 CMR 406.446.

(4) The MassHealth agency does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the MassHealth agency determines to be consistent with current medical evidence.

(5) The MassHealth agency does not pay for drugs that are provided as a component of a more comprehensive service for which a single rate of pay is established in accordance with 130 CMR 450.307.

406.414: Insurance Coverage

(A) Managed Care Organizations. The MassHealth agency does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth Standard MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107 and 450.117.

(B) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the MassHealth agency for the primary insurer's member copayment for the primary carrier's preferred drug without regard to whether the MassHealth agency generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 406.413(C)(2)(a) and (c). In such cases, the prescriber must obtain prior authorization from the MassHealth agency in order for the pharmacy to bill the MassHealth agency for the primary insurer's member copayment. For additional information about third party liability, see 130 CMR 450.101 et seq.

(C) Medicare Part D.

(1) Overview. Except as otherwise required in 130 CMR 406.414(C)(2) and (3), for MassHealth members who have Medicare, the MassHealth agency does not pay for any Medicare Part D drugs, or for any cost-sharing obligations (including premiums, copayments, and deductibles) for Medicare Part D drugs, whether or not the member has actually enrolled in a Medicare Part D drug plan. Medications excluded from the Medicare Part D drug program continue to be covered for MassHealth members eligible for Medicare, if they are MassHealth-covered medications.

(2) Medicare Part D Transitional Coverage. MassHealth pays for one-time supplies of prescribed medications, as described in 130 CMR 406.414(C)(2)(a) and (b). These payments will be authorized only if the MassHealth member's Medicare prescription drug plan will not cover the prescribed medication at the time the prescription is presented, if the medication is a MassHealth-covered medication, and for MassHealth members who would otherwise be entitled to MassHealth pharmacy benefits but for being eligible for Medicare prescription drug coverage. MassHealth prior authorization does not apply to such one-time supplies.

(a) Between January 1 and June 30, 2006, MassHealth pays for a one-time 30-day supply of prescribed medications. After this supply of the prescribed medication, MassHealth pays for a one-time 72-hour supply of the same prescribed medication.

(b) Effective July 1, 2006, MassHealth pays for a one-time 72-hour supply of prescribed medications.

(3) Cost-Sharing Assistance for Dually Eligible MassHealth Members. Effective January 1, 2006, for dually eligible MassHealth members who are enrolled in a Medicare Part D plan and are charged a copayment in excess of the member's applicable MassHealth copayment, the member pays the applicable MassHealth copayment and MassHealth pays the difference to the pharmacy, up to the amount that the Medicare Part D plan is permitted to charge a dually eligible enrollee.

(130 CMR 406.415 through 406.419 Reserved)