Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

All Provider Bulletin 386

DATE: January 2024

TO: All Providers Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: **MassHealth Medicare Savings Programs**

Provider Reminder: Illegal Billing of Qualified Medicare Beneficiary Members

Under federal law, it is illegal for Medicare providers and suppliers—even those that do not accept Medicaid—to bill Qualified Medicare Beneficiary (QMB) beneficiaries for Medicare cost sharing for any Medicare Part A and B covered services.[1]

The Centers for Medicare & Medicaid Services (CMS) advises providers and suppliers to establish processes to routinely identify the QMB status of their patients before billing, including those enrolled in Original Medicare and Medicare Advantage plans. See cms.gov/outreach-and-education/outreach/npc/downloads/2018-06-06-qmb-call-faqs.pdf.

CMS also says that providers and suppliers that have mistakenly billed a person who is enrolled in the QMB program must recall the charges (including referrals to collection agencies) and refund the charges paid.

Providers that violate these requirements may be subject to state or federal prosecution, including by the Massachusetts Attorney General and the US Attorney.

Facts about Medicare Savings Programs

The QMB program is one of three federally mandated Medicare Savings Programs (MSPs) run by MassHealth to help lower the cost of Medicare for eligible beneficiaries. Formerly known as MassHealth Senior Buy-In, the Medicare Savings QMB program pays Medicare Part A and B premiums, deductibles, copays, and coinsurance. This protects individuals in the QMB program from cost sharing for Medicare covered services or items.

MSPs are not insurance plans. They are programs designed to help lower the costs of Medicare insurance coverage. MSPs are always combined with Medicare and do not offer any additional

1. See also Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.

coverage or services that Medicare does not provide. Full MassHealth programs like MassHealth Standard and CommonHealth count as health insurance programs and can be used alone or combined with Medicare coverage. Unlike MSPs, MassHealth provides additional coverage and services not offered by Medicare. Some people may qualify for Medicare, MSPs, and full MassHealth coverage.

In January 2023, Massachusetts expanded eligibility of the Medicare Savings Programs including the QMB program. This has increased the number of individuals in the QMB program, particularly those that do not also have full MassHealth benefits.

- QMB: MassHealth pays for the Medicare Part A premium, for people who have one (most people will not) and the Medicare Part B premium and cost sharing. Medical providers must not bill Medicare beneficiaries with QMB for Medicare copays and deductibles. This includes Medicare Advantage plan providers. However, QMB beneficiaries can still be charged a pharmacy copay. (QMB is the same program as MassHealth Senior Buy-In.)
- Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI): MassHealth pays for the Medicare Part B premium. (This is the same program as MassHealth Buy-In.)

People enrolled in any of the MSPs also automatically receive drug coverage with low copays. MSP enrollment also allows Medicare beneficiaries to sign up for Medicare Part B at any point in the year, without any financial penalties for signing up late.

Important Reminder for Providers

Please review this bulletin carefully to ensure that you do not violate federal QMB protections.

Under federal law, all Medicare suppliers and providers—even those that do not accept Medicaid—may not bill QMB beneficiaries for Medicare copays for Part A and B covered services.

QMB program billing protections apply regardless of whether a person is enrolled in Medicare fee-for-service or a Medicare Advantage Plan.

Medicare Advantage providers cannot refuse to serve QMBs. Medicare Advantage plans and their contracted providers are prohibited from discriminating against plan members based on the source of payment. Massachusetts law also prohibits providers from discriminating against any person who is a recipient of federal, state, or local public assistance because the person is such a recipient or because of any requirement of such an assistance program. See M.G.L. c. 151B, § 4 and 130 CMR 450.202.

Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, co-insurance, or copays for any Medicare-covered items and services. QMB beneficiaries cannot choose to pay Medicare deductibles, coinsurance, and copays.

Billing MassHealth

Providers who serve QMB beneficiaries are responsible for billing the state Medicaid agency for any Medicare cost sharing amounts the state is responsible for covering.

Providers should check the eligibility verification system (EVS) through the Provider Online Service Center, the Medicare Provider Remittance Advice, and other sources for MSP eligibility, to determine whether a patient had MSP on the date a service was provided.

Providers who participate in MassHealth must accept payment from MassHealth as payment in full. Under state and federal law, providers may not solicit, charge, receive, or accept payment from MassHealth members for any services payable by MassHealth.

As soon as a provider learns an individual was a QMB program member at the time a service was provided, the provider must immediately return any sums solicited, charged, received, or accepted from the member and must bill MassHealth. Please see 130 CMR 450.203, M.G.L. c. 118E, § 36(3), and 42 CFR § 447.15 for more information.

MassHealth must receive claims within 90 days from the date of service (130 CMR 450.309(A); M.G.L. c. 118E, § 38).

- If a member's eligibility is reinstated more than 90 days after a date of service, and the provider already billed the member or sent the bill to collections, the provider is still obligated to bill MassHealth for the service and may not solicit, charge, receive, or accept payment from the member. In this situation, the provider must check EVS to confirm that the member had MassHealth coverage on the date of service, and if so, the provider must void any bill sent to the member or work with the collection agency to remove the member's account from collections. Providers may then bill MassHealth for the service but will need to request a waiver of the 90-day deadline to submit a claim. Providers can request this waiver in order to submit a claim for medical services "provided to a person who was not a member on the date of service but was later enrolled as a member for a period that includes the date of service" (130 CMR 450.309(B)(1)). Providers must include a copy of the bill sent to the member to support the 90-day waiver request. For more information, please see All Provider Bulletin 233 on how to request a 90-day waiver or All Provider Bulletin 232 on final deadline appeal procedures, or contact MassHealth.

MassHealth Website

This bulletin is available on the MassHealth Provider Bulletins web page.

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Questions

If you have questions about the information in this bulletin, please contact:

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Massachusetts Attorney General's Consumer Protection Office

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