Superior Medicare Advantage and STAR+PLUS MMP Balance Billing Quick Reference Guide

Members enrolled in Superior HealthPlan Medicare Advantage (HMO and HMO SNP) and STAR+PLUS Medicare-Medicaid Plan (MMP) have certain rights and protections. Among those is a protection against balance billing.

When working with members that are eligible for both Medicare and Medicaid, providers need to avoid balance billing dual-eligible beneficiaries. Dual-eligible beneficiaries are eligible for both Medicaid and Medicare plans and should never be charged any amount for Medicare or Medicaid-covered services, including copayments, co-insurance and deductibles.

Balance billing is illegal under both state and federal law (refer to Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997).

What is Balance Billing?

- Balance billing occurs when a provider bills dual-eligible beneficiaries for Medicare cost-sharing.
- If a provider bills the member for the difference between what MMP pays and the retail price a physician charges for services, this is balance billing.

Helpful Reminders:

- A member should never receive a “balance bill” for any medical services from a provider under either the Advantage or MMP program, this includes covered and non-covered services.
    - **Exception:** If an organizational determination has been made and a prior written agreement has been signed by both the provider and the Superior member for non-covered services.
- If a provider has balance billed a dual-eligible beneficiary, the provider is expected to take prompt action to remedy such situations and avoid these billing practices in the future. The provider must stop the bill collection process and work with credit reporting agencies to correct any resulting issues for the beneficiary.
- A provider must accept payment in full from MMP and should not deny any services to members for non-payment.
- MMP enrollees receive benefits and services from both Medicare and Medicaid programs.
- Medicare provides primary coverage for health-care services and prescription drugs.
- Medicaid covers additional benefits, such as Long-Term Services and Supports.
- Medicaid provides help to pay Medicare premiums and cost sharing.

If it is a Medicare covered service, the provider will file the claim with Superior. Any piece that is not covered by Medicare will cross over to the Medicaid side for additional payments.

Crossover Claims:

- Providers must file the claim with Superior for Medicare covered services. Any part of the service that is not covered by Medicare will cross over to the Medicaid side for additional payments.
- Claims “cross over” to Medicaid for payment of beneficiary cost sharing and for services Medicare does not cover.
- The provider should receive two (2) checks from Superior. Due to the crossover process, these checks may have a three to five (3-5) day delay between them.

- Any payment a provider receives (Medicare or Medicaid claims payment) will be from Superior.
    - **Exception**: If Medicare Advantage Dual Eligible Special Needs (DSNP) members have MMP coverage with another carrier and the service is covered under Medicaid, the provider should bill that carrier for the Medicaid portion after Superior has paid the Medicare portion.
- The state has no liability for Superior members.

Additional Information:

- Access more information about balance billing and dual-eligible beneficiaries on the CMS web site at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244469.html
- If you have questions about a dual-eligible patient enrolled in a Superior STAR+PLUS MMP or Medicare Advantage product, please call the phone number listed on the back of the member's Superior identification card or contact your local Account Manager.