Subject: Discrimination against Patients in Medicare Advantage Organizations

Introduced by: New York County Medical Society

Referred to: Reference Committee on Socio-Medical Economics

Whereas, Certain laws are designed to protect patients (and sometimes physicians) against managed-care contract clauses favoring the insurer, and

Whereas, Examples exist in which a contract clause, such as one favoring a managed care company, have negated the dictates of a federal regulation protecting patients and physicians; and

Whereas, Many Medicare Advantage Plans (MAOs — Medicare Advantage Organizations) have denied claims for visits and diagnostic tests that would have been covered under fee-for-service Medicare, and

Whereas, Staff of CMS (the Centers for Medicare and Medicaid Services) have refused to deal with these coverage discrepancies, saying the issues were strictly contractual and physicians could only challenge the denials through arbitration or legal action; and

Whereas, The CMS position calling coverage discrepancies contractual contradicts federal law (42 C.F.R.422.101(a)), which states that:

1. MAOs are required to provide to their Medicare enrollees, those services that are covered under Medicare and are available to other fee-for-service Medicare beneficiaries in the geographic area covered by the plan; and

2. MAOs are required to abide by CMS regulations, national coverage decisions (NCDs), and the local coverage determinations (LCDs) made by the Medicare Administrative Contractors (MACs) that have claims jurisdiction in the MAO’s geographic area; and

Whereas, Because CMS is abrogating its responsibility to regulate and monitor the MAOs, the CMS position has the effect of blatantly discriminating against the MAO enrollees as a beneficiary class; and

Whereas, An investigation of this question by the legal counsel of the Medical Society of the State of New York (MSSNY) would benefit patients and physicians; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) examine the legality of the position taken by the Centers for Medicare and Medicaid Services (CMS), that if a Medicare Advantage Organization (MAO) has denied payment for services that would have been covered by fee-for-service Medicare, a physician’s only recourse is arbitration or legal action despite the provisions in 42 C.F.R.422.101(a), which state that:

1. MAOs are required to provide to their Medicare enrollees, those services that are covered under Medicare and are available to other fee-for-service Medicare beneficiaries in the geographic area covered by the plan; and
2. MAOs (both risk and cost plans) are required to abide by CMS regulations, national
coverage decisions (NCDs), and local coverage determinations (LCDs) made by the
Medicare Administrative Contractors (MACs) that have claims jurisdiction in the MAO's
geographic area;

and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) seek case law or
precedent requiring MAOs to fully adhere to 42 C.F.R 422.101(a) regardless of contract terms
or in-house claims processing policies and bring such findings to the attention of the Centers for
Medicaid & Medicare Services; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) bring this resolution
to the American Medical Association and ask it to seek recourse from the Centers for Medicaid
and Medicare Services to resolve discrimination against Medicare Advantage patients and the
physicians who care for them.