Report of the Working Group on Managed Care
For Action (3 Recommendations)

On June 17, 2015, the CMS Committee on Physician Practice Evolution convened as the multi-specialty Working Group on Managed Care to develop policy and to engage and educate physicians on aspects of managed care narrow networks at the request of the BOD in May. The BOD should anticipate that the following recommendations are the first in a series that will be presented over the remainder of the year and beyond.

The questions before the BOD:

1. The Working Group on Managed Care respectfully recommends that the BOD approve the following new CMS policies (1) Physician freedom to establish their fees (usual and customary rates), and (2) Avoidance of excessive fees, and
2. Educate members about the need to notify and assist patients when care is rendered out-of-network.

A. Physicians' freedom to establish their fees[i] - Our CMS:

1. Affirms that it is the basic right and privilege of each physician to set fees for services that are reasonable and appropriate, while always remaining sensitive to the varying resources of patients and retaining the freedom to choose instances where courtesy or charity could be extended in a dignified, ethical and lawful manner;
2. Supports the concept, when the physician does not have a contract with the health insurance plan, that health insurance should be treated like any other insurance (i.e., a contract between a patient and a third party for indemnification for expense or loss incurred by virtue of obtaining medical or other heath care services); and
3. Believes that the contract for care and payment is between the physician and patient.

B. Fees for medical services[ii] - A physician should not charge or collect an illegal or excessive fee. For example, an illegal fee occurs when a physician accepts an assignment as full payment for services rendered to a Medicare patient and then bills the patient for an additional amount. A fee is excessive when after a review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee. Factors to be considered as guides in determining the reasonableness of a fee include the following:

1. The level of training, education and experience of the physician;
2. The circumstances and complexity of the particular case, including time and place of the service;
3. Individual patient characteristics;
4. Unusual circumstances;
5. The physicians usual professional fees charged;
6. The professional fee customarily charged in the locality for similar physician services; and
7. Other relevant aspects of the economics of the physician's practice.

C. Out-of- network charges – Notification of patient rights - CMS encourages physicians to assist consumers facing out-of-network charges by informing them of their rights

under this statute. CMS recommends that when a physician is unable to accept the insurer's payment as payment in full, then the physician should:

a. Advise the consumer to contact their insurance plan directly for assistance; and
b. Include the following message on the billing statement:

"I do not participate with the your health insurance plan. If you received emergency services or services rendered by me at an in-network facility, then you may be entitled to certain out-of-network protections according to Colorado law. I have submitted a claim to your insurance plan on your behalf *[if this is your normal procedure]*. If there are questions concerning payment for the services please contact your insurance plan directly."

Background: The underlined language below represents amendments made by the BOD in May to the 2014-2015 fiscal year work plan on regulation of Health Plan Networks. The motion to amend the work plan included designation of this portion of the plan as a high priority with referral to CPPE for action and a report back.

1. Regulation of Health Plan Networks

Goal: Achieve enhanced patient and provider protections for network adequacy of health insurance plans

Objective: Focus support specifically on protections related to transparency and quantitative standards for network adequacy of health insurance plans, and develop recommendations for BOD and HOD consideration, as appropriate, relating to consumer protections and potential excessive charges specific to situations where a provider is out-of-network in an in-network facility.

Strategy: Lobby public officials at the state and national level, inform and enlist other stakeholders as needed, and take full advantage of any state-sponsored interim study on OON and related matters and DOI rulemaking

[i] Adapted from AMA policy H-380.994 Physicians' Freedom to Establish Their Fees

[ii] Policy adapted from AMA Code of medical ethics: Opinion 6.05 – Fees for Medical Services and modified to include "reasonableness" language from recent New York legislation and California HMO regulations.