Surprises in No Surprises Regulation:
MGB's Patient-Centric Approach to Compliance

MA/RI HFMA Conference Presentation

May 2023

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Introducing Today's Speakers & Learning Objectives

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Learning Objectives:

- Define the requirements of the No Surprises Act (federal and state considerations).
- Discuss the challenges and opportunities in achieving compliance with the No Surprises Act.
- Explain how MGB took a patient-centric approach to compliance.

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Understanding NSB Requirements by Federal and MA State, Across the Continuum of Care

	Pre-Service	Time of Service	Post-Service
Federal	➢ Provide Good Faith Estimate (GFE) to self-pay patients ➢ Provide estimate to all patients who request one ➢ Provide Notice & Consent form to in-network patients seeing non-contracted provider, where MGB would like to balance bill a patient	➢ Provide Disclosure Notice in service areas	➢ Ensure the bill of an in-network patient who sees a non-contracted provider does not exceed in-network cost sharing, unless a signed Notice & Consent is obtained ➢ Ensure GFE for self-pay patients is not "substantially in excess" (within $400) of expected charges
State	➢ Facility to share network status with all patients at time of scheduling ➢ Provide an insurance estimate for in-network patients **upon request** ➢ Provide estimate to **all** out of network (OON) patients ➢ Redirect patients with non-contracted insurance to the patient financial experience (PFE) team to receive a self-pay estimate	➢ Indicate whether referred to provider is part of the same organization and verified in-network ➢ Provide information to support patient research on referred to provider network status	➢ n/a

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Spotlight on Federal vs. State Considerations: Which Patient Population Should be Addressed?

- Across 2022, MGB implemented NSB Workflows which were built to meet both Federal (in-network patients seeing non-contracted providers) and State (OON/non-contracted) compliance
- Shortly before its implementation date, Massachusetts delayed enforcement of state regulations, directing MGB to focus on NSB requirements from the Federal perspective, which are the only requirements currently in effect today
- Out-of-Network and non-contracted patients are **not** protected by the Federal legislation and will not have protections until Massachusetts enforces state requirements in 2025

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Challenges & Opportunities in Achieving NSB Compliance

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With key stakeholders impacted across enterprise revenue cycle and individual access points across all MGB locations, ***ensuring key stakeholder input and participation in NSB decision making and work efforts was key.*** ➢ MGB both leveraged existing leadership forums across CFO councils, ambulatory leadership, and RCM forums, but also stood up an NSB Operations workgroup and multiple work teams to ensure broad representation and involvement across the enterprise. Leaders of these small groups also convened regularly to maintain coordination. ➢ Workgroups included: • NSB Scheduling • Ambulatory Scheduling • OR Scheduling • Walk-in Scheduling • NSB PFE Clearance • GFE / Notice & Consent • Referrals • Dispute Resolution • Dashboard and Reporting • Billing Optimization 	Despite complexities regarding OON payer variations from site to site, MGB leaders committed to approaching the NSB compliance as a united system, ensuring both consistent internal processes and protocols and delivering a reliable experience. ***Key guiding principles were set by MGB leaders,*** including: ➢ MGB will manage compliance with NSB ***as a system.*** ➢ MGB will institute compliant processes per state and federal regulations. ➢ Given the negative impact on patient experience, provider schedule availability, and front-line staff rework, MGB should design a process to ***ensure OON patients are stopped,*** and NSB compliance items are addressed, ***before they are scheduled.*** 	Though ***not required*** by federal NSB requirements, implementing enhanced processes ***can strengthen MGB patient experience.*** ➢ MGB leaders unanimously agreed that ***achieving compliance should be achieved through ensuring patient-friendly processes.*** ➢ For example, informing all non-contracted patients they are out-of-network with MGB is not required, but improves the patient's understanding of their insurance plan. ➢ MGB received ***significant positive patient feedback regarding communicating OON status to patients*** prior to scheduling and/or rendering care. 

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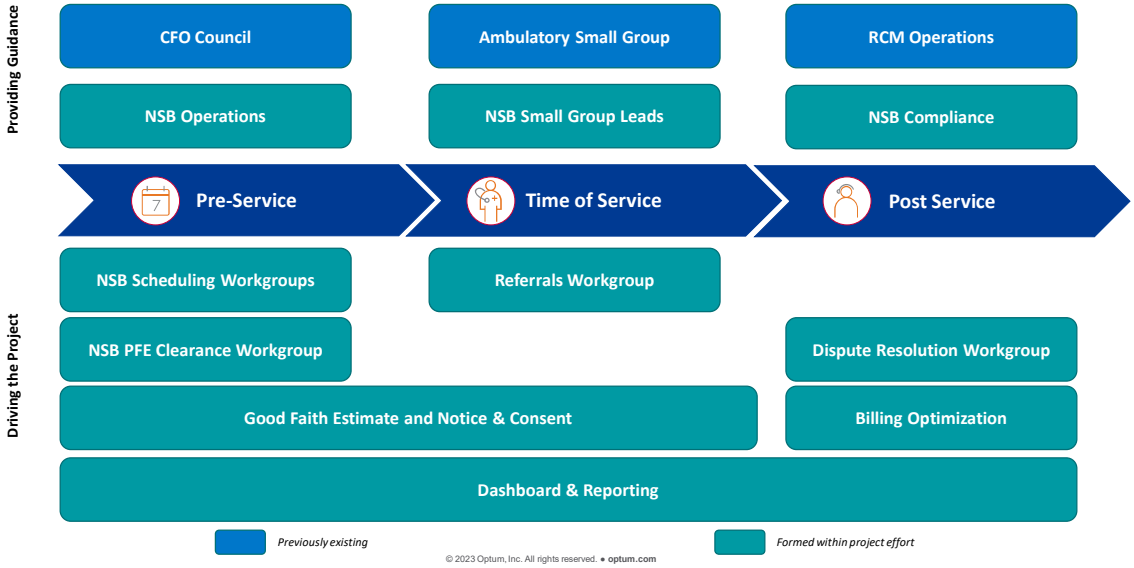
NSB Governance Aligned with the Patient Journey



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MGB Accomplishments & Future Considerations

- ❖ Achieved compliance with federal requirements
- ❖ Designed and implemented internal audit process in Q4 2022
- ❖ Developed and maintaining dashboard to monitor volumes and impact of NSB

Specific accomplishments and future state considerations include:

	Federal Requirements	Implementation Accomplishments	Future Considerations & Recommendations
Disclosure Notice	• Providers must prominently display disclosure notice information in patient service areas (e.g., where individuals schedule care, check-in for appointments, or pay bills) • The disclosure (or link to disclosure) must be searchable on provider's website homepage • Provided before payment request	• Implemented model disclosure notice (provided by CMS) for calendar year 2022 – collaborated with MGB marketing to post in service areas and on website • Updated disclosure notice language in alignment with CMS guidance for calendar year 2023 and beyond	• Monitor CMS guidance for future updates and requirement changes • Ensure disclosure notice verbiage aligns to future state requirement details (if applicable / once enforced)

Good Faith Estimate	• Deliver Good Faith Estimate (GFE) to self-pay and uninsured patients in either written or printable format
	• Provide estimate within defined timeframes – 3 days in advance for services scheduled 10+ days out; 1 day in advance for services scheduled 2-9 days out
	• Ensure GFE provided to patient is not "substantially in excess" of final charges (>$400)
	• Retain GFE as part of medical record
		• Implemented workflow and Epic work queue logic to direct appropriate patients to Patient Financial Experience (PFE) Team for GFE delivery
		• Enhanced work queue logic to support account prioritization based on date of scheduled appointment
		• Aligned GFE template elements with model from CMS
		• Implemented statement hold work queue to capture accounts where charges exceed GFE by $400
		  • Developed tip sheet with scenarios to help staff operationalize workflow
			• Monitor enforcement of Convening & Co-Provider Requirement (delayed indefinitely by CMS)
			  • Continue discussions and optimize efforts to identify and maintain list of external providers
			  • Develop standardized approach for external provider outreach and capturing responses
			  • Evaluate third party technology capabilities to support
			• Optimize workflows and work queue logic to direct self-pay patients for GFE and reduce workload of inaccurate estimates

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MGB Accomplishments & Future Considerations (continued)

	Federal Requirements	Implementation Accomplishments	Future Considerations & Recommendations
Notice & Consent (N&C)	• Provide N&C to patients where MGB is allowed to balance bill greater than the in-network cost sharing amount in alignment with federal regulations • Provide N&C within defined timeframes – 72 hours in advance if scheduled 3 days out; 3 hours in advance if scheduled < 3 days out • Include all CMS model elements and meet accessible language requirements	• Analyzed patient volume and dollars impacted by federal NSB regulations and evaluated potential return against resource requirements to implement and patient experience implications • MGB leadership decision to not pursue balance billing based on operational lift to implement and patient satisfaction considerations • Developed NSB denial dashboard with NSB remittance information to monitor volumes moving forward	• Monitor volume / revenue impact on monthly basis to determine if balance billing is worth pursuing in future • Optimize NSB dashboard as appropriate to inform decision making and evaluate approaches to mitigate write-off impact • Explore technology to support identification and management of external provider list and automation capabilities for N&C delivery

Balance Billing	• Ensure bill does not exceed in-network cost sharing for:
	  ➢ Out-of-network emergency care
	  ➢ Ancillary services delivered by out-of-network provider at an in-network facility
	  ➢ Non-emergent care delivered by out-of-network provider at an in-network facility (unless patient signs N&C)
		• Implemented back-end workflow and developed HB & PB statement hold work queues to capture federally protected accounts and prevent balance billing patients – including enhanced logic to capture payor NSB remit codes
		• Analyzed volume and dollar impact based on NSB remittance codes o inform leadership decision on Independent Dispute Resolution (IDR)
		• MGB leadership decided to not pursue IDR process, and will re-visit in future based on volume trends
		• Developed denial governance plan to support back-end operational team working accounts
			• Track NSB statement hold work queue volume trends to identify potential logic improvements and automation opportunities for improved efficiency
			• Leverage work queues to identify and address payor NSB concerns
			• Evaluate options to enhance external provider identification and management in alignment with credentialling / enrollment process
			• Continue to monitor impact of NSB payments and write-offs to determine if implementing IDR process is warranted

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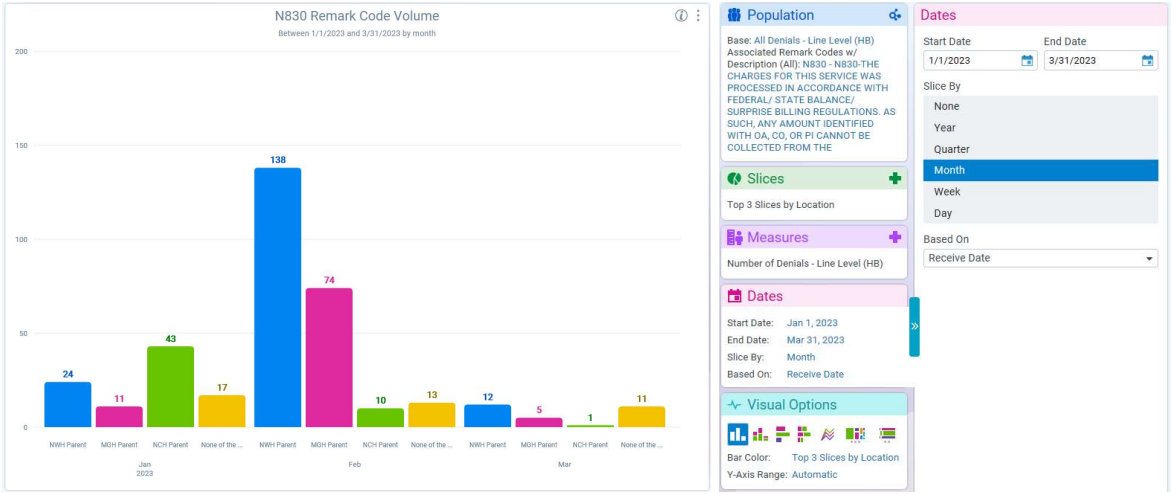
NSB Remittance Tracking with SlicerDicer



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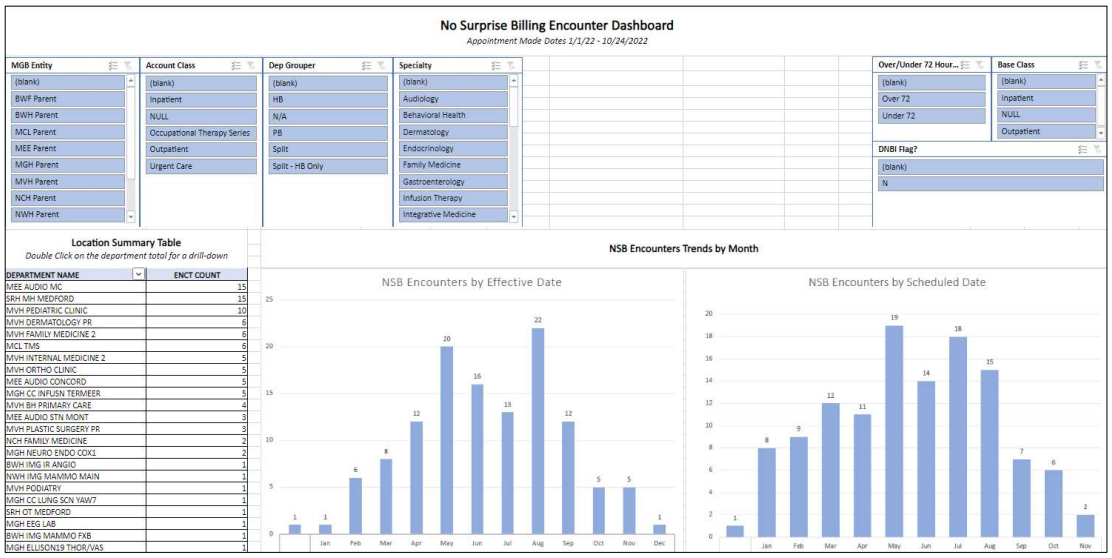
NSB Remark Pivots & Trends Dashboard



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Good Faith Estimate & Statement Discrepancy Scenarios

Estimate Scenario	Resolution Steps
The contrast was not included in the radiology estimate	• Write off contrast charges • Contrast will be built into templates late Nov. / early Dec.
An automated radiology estimate excluded other same day services (Additional visits, etc.)	• Hold patient liable
The patient provides the CPT for the estimate (Based on estimate documentation)	• Discussion required • Handled on a case-by-case basis
The estimates service is always rendered with another service (Ultrasound done with lab work, etc.)	• Write off charges • Identify estimate trends and update corresponding template
An OR case has the correct CPT code but additional time and supplies are incurred (Includes same day add on levels for other visits, etc.)	• Write off additional charges
An OR case has a different, unforeseen procedure completed	• Hold patient liable
Estimate error (Drug not added to infusion estimate when one was documented, etc.)	• Write off additional charges
The procedure completed in the OR differs from the OpTime system-generated estimate that the surgical case was originally booked with. (The surgeon completed a different procedure than was booked)	• Write off additional charges

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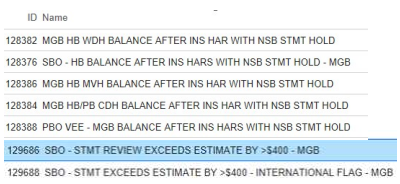
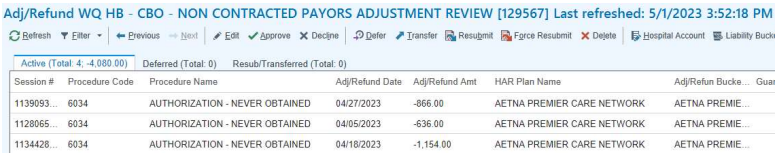
Epic Work Queues

Statement Holds



MGB proactively reviews statements in these WQs for patients that received estimates or have non-contracted coverage to ensure compliance prior to releasing.

Adjustment Accuracy



Created an adjustment review WQ to ensure appropriate write offs take place on accounts where the payer is non-contracted. Historically, auth not obtained would be used instead of non-contracted which skews department figures and doesn't fully represent our OON population.

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FYTD 2023 Write Offs

SOURCE	HB
Entities	**Sum of AMOUNT**
BWF Parent	$ (24,672.72)
BWH Parent	$ (48,985.54)
CDH Parent	$ (280.73)
MCL Parent	$ (2,971.96)
MEE Parent	$ (25,673.52)
MGH Parent	$ (293,507.49)
MVH Parent	$ (312.00)
NCH Parent	$ (5,325.35)
NWH Parent	$ (40,761.80)
SLM Parent	$ (38,592.23)
SRH Parent	$ (2,664.10)
WDH Parent	$ (208,657.04)
Grand Total	**$ (692,404.48)**

SOURCE	PB
Entities	**Sum of AMOUNT**
BWF Parent	$ (20,907.79)
BWH Parent	$ (238,039.47)
CDH Parent	$ (473.50)
Community Physicians	$ (21,834.67)
Mass General Brigham Urgent Care	$ (9,096.11)
MCL Parent	$ (9,643.64)
MEE Parent	$ (32,517.59)
MGH Parent	$ (241,693.14)
MVH Parent	$ (7.51)
NCH Parent	$ (2,299.34)
NWH Parent	$ (18,451.11)
SCC Parent	$ (32.41)
SLM Parent	$ (17,101.64)
SRH Parent	$ (1,562.31)
WDH Parent	$ (11,473.37)
Grand Total	**$ (625,133.60)**

Payer	Sum of AMOUNT
AETNA	$ (56,402.12)
BLUE CROSS BLUE SHIELD	$ (241,727.69)
CIGNA	$ (41,848.59)
FALLON HEALTH	$ (7,198.91)
GENERIC COMMERCIAL	$ (42,614.95)
HARVARD PILGRIM	$ (111,184.49)
HEALTH NEW ENGLAND	$ (21,667.01)
HUMANA	$ (1,696.68)
SELF-PAY	$ (416,092.93)
TUFTS HEALTH PLAN	$ (124,476.65)
TUFTS HEALTH PUBLIC PLANS	$ (158,963.68)
UNICARE GIC	$ (2,767.70)
UNITED HEALTHCARE	$ (24,663.08)
WELLSENSE	$ (66,233.60)
Grand Total	**$ (1,317,538.08)**

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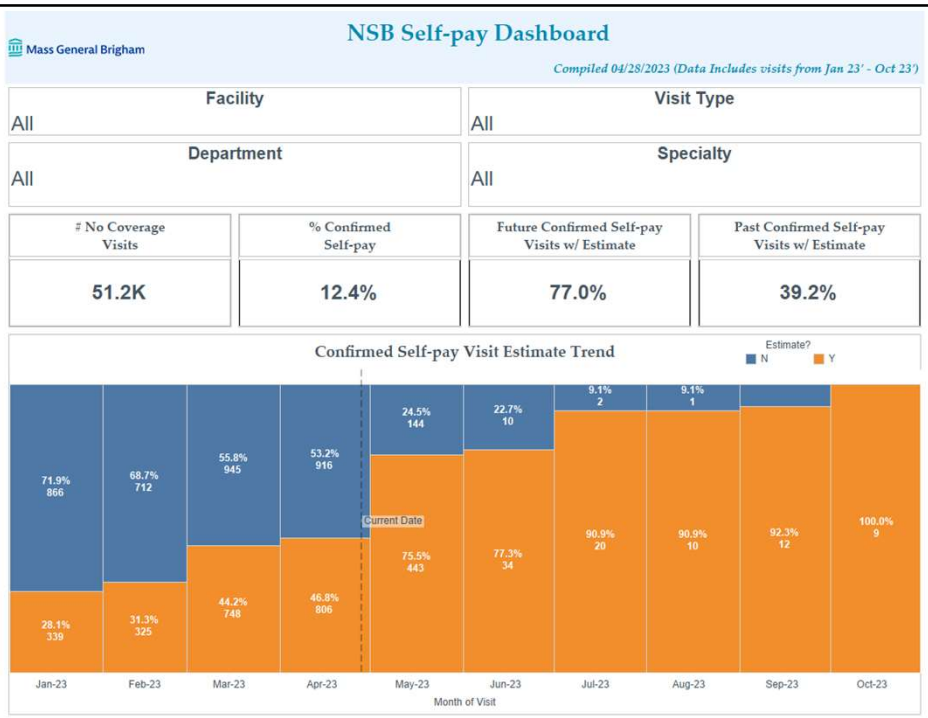

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Thank You for Your Time and Participation Today

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MGB Accomplishments & Future Considerations

Project Updates
➢ Implemented NSB Workflows were built to meet both Federal (in-network patients seeing non-contracted providers) and State (OON/non-contracted) compliance
➢ Shortly before implementation date, Massachusetts delayed enforcement of state regulations, and follow-up with Husch Blackwell provided guidance on NSB requirements from the Federal perspective, which are the only requirements currently in effect
➢ Out-of-Network and non-contracted patients, for whom workflows were built to meet compliance, are ***not*** protected by the Federal legislation and will not have protections until Massachusetts enforces state requirements in 2025

Recent developments necessitated updated leadership direction

	Leadership Direction
1)	***Start*** identification of all ***non-contracted providers who see patients in-network with MGB*** to manage risk of exceeding in-network cost sharing, unless a signed Notice & Consent is obtained
2)	***Stop*** requirement of signature for Notice & Consent form when both facility and provider are non-contracted/OON for a patient's insurance
3)	***Start*** developing a methodology to ***release statement holds for non-contracted/OON patients*** a) Pending identification of non-contracted providers who see in-network patients, develop statement hold for in-network patient population
4)	***Defer*** to 2024 work on sharing network status with all patients at time of scheduling
5)	***Defer*** to 2024 work on informing referred patient whether referred to provider is part of the same organization and verified in-network

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