October 9, 2012

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW Washington, DC  20201

45 CFR Part 162 RIN 0938-AR01

Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions

Dear Secretary Sebelius:

The Medical Group Management Association (MGMA) is pleased to provide comments on the interim final rule with comment “Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice transactions” as issued in the Federal Register on August 10, 2012.

MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices. Since 1926, the Association has delivered networking, professional education and resources, political advocacy and certification for medical practice professionals. The Association represents 22,500 members who lead 13,200 organizations nationwide in which some 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States. MGMA’s core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. Individual members, including practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so that patient care remains the focus of physicians’ time and resources.

Background

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in an effort to standardize the electronic exchange of information between practices and health plans. The ASC X12N 835 Health Care Payment/Advice (Remittance Advice) transaction was adopted by HIPAA to be the standard communication instrument for reporting payments, adjustments, and patient financial responsibility. Originally, it was hoped that practices would be able to program their practice management systems one time to process payments from all health plans from whom they receive electronic files.
Effective utilization of the ASC X12 835 transaction, however, have been hindered by health plan variations in the association of Claims Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs) and Claim Adjustment Group Codes (CAGCs). Non-uniform or incorrect coding typically leads to unnecessary manual follow-up, faulty electronic secondary billing, inappropriate write-offs of billable charges, and incorrect billing of patients for co-pays and deductibles, all of which cost practices time and money. As a consequence, practices are often reluctant to implement the 835 transaction, reducing the return on investment for both practices and payers. This is clearly an example of the promise of HIPAA not being fulfilled.

MGMA strongly supports the adoption of operating rules for health care electronic funds transfers (EFTs) and remittance advice transactions (ERAs) as an important means to promote further achievement of administrative simplification. We concur with the Dec. 7, 2011 recommendations of the National Committee on Vital and Health Statistics (NCVHS) to adopt the EFT and ERA operating rule set from the Council for Affordable Quality Healthcare, Committee on Operating Rules for Information Exchange (CAQH CORE), which were developed in collaboration with NACHA – The Electronic Payments Association. As a long-time supporter, participant and official endorser of CAQH CORE, MGMA applauds HHS for naming the CORE EFT and ERA operating rules in the IFC.

**MGMA Comments and Recommendations**

MGMA offers the following comments and recommendations to improve the effectiveness and further encourage the adoption of the EFT and ERA transactions:

MGMA supports the adoption of the Phase III CORE EFT and ERA Operating Rule Set, approved June 2012. The EFT and ERA operating rule set includes the following rules: (1) Phase III CORE 380 RFT Enrollment Data Rule; (2) Phase III CORE 382 ERA Enrollment Data Rule; (3) Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule; (4) CORE required Code Combinations for CORE defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule; (5) Phase III CORE 370 EFT and ERA Reassociation (CCD+/835) Rule; and (6) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

The six operating rules identified in the IFC are interdependent with each other and we agree with the Department that they must be adopted together to achieve optimum efficiency. As noted in the IFC, EFT and ERA suffer from a very low adoption rate among practices because of issues throughout the entire workflow of managing remittance processes, from cumbersome enrollment in EFT and ERA, to variability in information supplied explaining claim adjustment reasons, and inability to reassociate data to dollars. We anticipate that implementation of the full set of operating rules will help realize the efficiencies called for in section 1104 of the ACA.
The operating rules within the named EFT and ERA Operating Rule Set will provide important simplification of a provider’s revenue cycle operation. The following are comments specific to the operating rules named in the IFC.

- **EFT Enrollment Data Rule and ERA Enrollment Data Rule.** In order to achieve the highest possible penetration level for provider utilization of the EFT and ERA transaction, we believe that it is critical that the enrollment process adopted by health plans be standardized to the greatest extent possible. Therefore, we support the Phase III CORE 380 and 382 operating rules. These rules specify a maximum set of enrollment data and standardized enrollment terms, definitions, and processes, consistent with section 1104(b)(2) of the ACA which states that “in adopting standards and operating rules for the transactions…the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and practices.” With the interdependencies in the EFT and ERA Operating Rule Set in mind, it is important that these rules drive the efficiencies and economies of scale called for in the ACA and contribute directly to the data elements required in the Reassociation Rule.

We are also strongly supportive of requiring health plans, even those currently with paper-based enrollment systems, to offer an ERA electronic enrollment process to those practices that request it. We encourage HHS to monitor this health plan requirement to ensure that appropriate notice is offered to practices regarding their options.

- **CARCs and RARCs Rule and Code Combination Rule.** Practices have been burdened by a lack of consistency in health plan Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) definitions and approaches. We support the adoption of operating rules that require consistent definitions of these codes, elimination of health plan proprietary codes, and clear delimitation of how codes may be used together. These would address section 1104(b)(2) of the ACA which requires standards and operating rules to “describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions …”

The IFC recognizes the importance of analysis and ongoing maintenance and alignment with the various code committees that author the codes. Without these definitions and maintenance approach for the business scenarios the entire reassociation process will continue to impose significant administrative burdens on physician practices.

We encourage the Department to work with CORE to convene the appropriate stakeholders to ensure that the appropriate business scenarios are identified and incorporated in an expeditious manner into the operating rules.

- **Reassociation Rule.** As the IFC outlines, the process of reassociation of payments from banks with remittance advice data from health plans is a slow and burdensome
task, especially when the two cannot be reassigned by matching identical data elements. We support the naming of the Phase III CORE operating rule 370 as part of the EFT and ERA Operating Rule Set as it enables end-to-end automation of the matching process. We agree that the following five required and one situational data elements should be included in the required operating rules:

a. Effective Entry Date - Required
b. Amount - Required
c. TRN01 Trace Type Code - Required
d. TRN02 Reference Identification (EFT Trace Number) – Required
e. TRN03 Originating Company Identifier (Payer Identifier) – Required
f. TRN04 Reference Identification (Originating Company Supplemental Code) – Situational

We recognize that the IFC issued in January 2012 on the EFT and ERA standards addressed two of the needed data elements, while at the same time specifying that the remaining needed data elements associated with Payment Related Information (TRN Reassociation Trace Number Segment) be adopted under the operating rules requirement. As such, this IFC on the EFT and ERA Operating Rule Set specifies that the payment related information include three required data elements and one situational data element.

We also strongly support the requirement that a health plan transmit the EFT within three business days of the transmission of the ERA. However, to better align these operating rules with those developed by NACHA, we recommend that “business days” be changed to “banking days.”

The Phase III CORE 370 Reassociation Rule requires that practices proactively contact their banks to arrange for the delivery of the CORE-required minimum CCD+ data elements necessary for successful reassocation of the EFT with the ERA. We are concerned that banks will not adequately inform clients of this requirement and we urge the Department to take the necessary steps to educate physician practices regarding this important step.

- **Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.** We support requiring all covered entities to implement HTTP/S Version 1.1 over the public Internet as a transport method for the health care electronic funds transfers (EFT) and remittance advice transaction. We concur that these requirements are designed to provide a “safe harbor” that application vendors, providers, and health plans (or other information sources) can be assured will be supported by all covered entities.

We also support requiring health plans that issue proprietary paper claim remittance advice to continue to offer this paper remittance advice for a minimum amount of time after requiring practices to accept an ERA. While we concur with the IFCs minimum of 31 days, we urge the health plans to communicate the nature and timing
of the change to its ERA enrollment process. At the same time, we urge the Department to proactively monitor health plans to ensure that these modifications are taking place in a timely manner. In addition, we support the requirement that health plans use the CORE Master Companion Guide Template for the flow and format of companion guides.

**Additional Issues**

- **Standardized EFT Enrollment.** Proprietary EFT enrollment programs instituted by health plans have also proven themselves to be a barrier to adoption for practices. Health plans adopting their own enrollment process adds needless administrative burden. Further, some practices do not wish to share their banking information with multiple health plans. As a result, we urge the Department to encourage and support where appropriate the development of a single electronic EFT enrollment process to decrease administrative burden and increase EFT adoption rates. This process could leverage the existing CAQH Universal Provider Datasource as both the conduit for the information flow between physician practices and health plans and the steward of EFT data.

- **The need to adopt a standard and operating rules for electronic acknowledgments.** Since 2005, the CAQH CORE operating rules have always included use of acknowledgments and both government and private sector entities have adopted these operating rules on acknowledgments as part of their voluntary CORE certification. While the IFC outlines the importance of acknowledgments and highlights recent recommendations from the NCVHS to adopt a standard for acknowledgments, the Department falls short of requiring them.

  Electronic acknowledgement transactions are responses that notify transaction senders whether or not their transaction has been received or if there are problems with the transaction. The use of these transactions adds significant value to the underlying transactions for which they are sent by informing the practice that a transaction has been received by a health plan or has been rejected. For practices, it is difficult to know if the intended health plan actually received the transaction. In many cases, practices will be forced to contact the health plan via telephone as to the status of the transmission, costing both the practice and health plan time and money.

  It is important to note that nothing in the ACA prohibits HHS from adopting operating rules for acknowledgements prior to the adoption of a standard for acknowledgements for the limited purpose of supporting specified HIPAA transactions. In addition, we are concerned that although section 10109 of the ACA enables additional transaction standards and operating rules adoption through a new review process, HHS has been made no movement to adopt these important acknowledgment standards. Voluntary adoption through contractual obligation would follow Medicare’s lead, where Medicare’s Fee for Service program utilizes the 999 Implementation Acknowledgement for Health Care Insurance (005010X231A1) and
the 277CA Claim Acknowledgment (005010X214).

It is clear that the Department and many health care stakeholders attach great importance to electronic acknowledgments. Unfortunately, the reality is that the health care industry is reluctant to adopt voluntary electronic transactions and, absent a federal mandate, we are not likely to see wide-scale use of acknowledgement transactions. Therefore, we urge HHS to follow the guidance of the ACA, adhere to the recommendations of the NCVHS and numerous private sector stakeholders, and move expeditiously to adopt standards and operating rules for electronic acknowledgment transactions.

- **Do not require EFT with ERA.** Currently, physician practices enrolled in EFT programs with health plans and receiving payments electronically are not required to accept an 835 transaction. Some practices simply do not have the technical capability to accept 835 transactions and we encourage the Department to stipulate in the final rule that enrollment of EFT does not require enrollment in the ERA. We believe that the move toward more automated administrative processes will be gradual and requiring the purchase of expensive new software to accommodate the 835 will be a discouragement for practices to adopt EFT.

- **Conduct a comprehensive campaign to assess industry adoption, and educate and encourage physician practices to adopt EFT, ERA and the other HIPAA transactions standards.** Administrative simplification is best served when all parties use standard transactions. While practices are required to utilize the standard transactions when they choose to conduct electronic transactions, many do not because of health plan variability and the lack of appropriate and affordable software. We strongly encourage HHS to closely monitor the readiness levels of all key stakeholder groups, including vendors to ensure that they have fully adopted the standards and operating rules and are engaging providers.

HHS should continue to serve as a role model in incentivizing practices to use electronic transactions. In addition, we strongly encourage HHS to work in tandem with MGMA and other provider trade associations to develop and deploy comprehensive educational programs aimed at encouraging physician practices to adopt the technology necessary to fully achieve administrative simplification.

**Conclusion**

MGMA strongly supports the development and use of national standards for the health care industry. Standards for the collection and transmission of electronic health data will improve the quality of health care and lower the cost of providing it. It is clear that EFT payments and electronic remittance advice are more convenient and efficient for physician practices. They reduce paper handling, streamline lockbox services, decrease the risk of lost payments and dramatically improve the reassociation process. While the set of operating rules included in this IFC will serve to significantly improve the EFT and ERA transactions, we strongly
encourage the agency to expand the scope of these operating rules to even further enhance the administrative simplification opportunities.

While MGMA is confident that full implementation of EFT and ERA operating rules will ease administrative burdens and facilitate improved data interchange within the health care community, roadblocks must be addressed before full implementation and improved efficiency can be achieved. We look forward to working with the Department to overcome these roadblocks and appreciate the opportunity to offer our comments to this interim final rule. Should you have any questions, please contact Robert Tennant at rtennant@mgma.org or 202-293-3450.

Sincerely,

Susan Turney, MD, MS, FACP, FACMPE
MGMA president and CEO