April 2, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Reinstatement of Electronic Payments Guidance on the CMS Website

Dear Administrator Verma:

We write today to convey our great concern regarding the recent removal from the Centers for Medicare & Medicaid Services (CMS) website several frequently asked questions (FAQs) instructing providers of their rights and prohibiting unfair business practices regarding electronic payments (e-payments) from health plans to providers. We urge you to expeditiously re-post these FAQs.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, advocacy and education, MGMA empowers medical group practices to create meaningful change in healthcare. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

At issue are the unfair business practices related to two forms of payments made from health plans to providers, “virtual” credit cards (VCCs) and electronic funds transfer (EFT), and the various impediments health plans and third-party payment vendors have implemented that discourage provider adoption of EFT. Health plan use of third-party payment vendors has become a significant issue in the payment environment. A March 20, 2018 MGMA poll with over 850 responses found that nearly 3 in 10 respondents (29%) report that their payment from the health plan is routed through a third-party payment vendor. Of these, 58% reported being charged a fee by the vendor to receive their payment. Less than one quarter of respondents (24%) stated that no fee was attached to their payment and an additional 18% were unsure.

In a VCC payment, a health plan or its payment vendor sends a single-use credit card number to a provider by mail, fax, or email which the provider must then manually enter. This is known as a “virtual” card because a physical credit card is never created or presented to the provider. For these authorizations, providers are required to pay credit card interchange fees, typically ranging from 3 to 5% of the value of the payment.

Not only are these fees unwarranted and unfair, but in the vast majority of cases, the practice did not choose this payment method. Opting out of VCCs and receiving payments via EFT from a reluctant payer or vendor is a manual, burdensome process that further delays payment. Even more disconcerting, the use of VCCs is contrary to the agency's stated priority of putting "patients over paperwork" and reducing physician administrative burden and cost. Importantly, VCCs do not meet the national EFT standard established by the Department of Health and Human Services (HHS) in the 2012 interim final regulation, nor do they support the Health Information Portability and Accountability Act (HIPAA) standard transaction for Electronic Remittance Advice (ERA), resulting in additional manual processing for practices along with significant associated costs.

The Automated Clearinghouse "CCD+Addenda" standard was adopted as the HIPAA standard transaction for EFT and took effect January 1, 2014. The regulation specified that "if a covered entity conducts with another covered entity (or within the same covered entity), using electronic media, a transaction for which the Secretary has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction." In requiring the adoption of a standard for EFT, the 2012 rule clearly states a cost savings intent when utilizing EFT over traditional paper payments. The Impact Analysis from the rule, for example, states that the issuance of an EFT standard: "is based on the assumption that the health care EFT standards will make health care claim payments via EFT more cost effective and will therefore incentivize increased usage of EFT by physician practices and hospitals" (77 FR 1575). The final rule goes on to say "[e]ach move from a non-electronic, manual exchange of information to an electronic transaction brings with it material savings in terms of less money spent on paper, postage, and equipment required for paper-based transactions, as well as cost avoidance in terms of time savings for staff. For health plans, we expect direct savings from the transition from a paper-based payment system (for example, paper checks) to EFT. These savings are found in the amount of staff time saved, as well as material savings such postage, paper, and printing" (77 FR 1582-83).

With industry cost savings as the primary motivation for adopting the EFT standard, it is very disappointing that some unscrupulous health plans and payment vendors have begun to take advantage of providers by charging them a percentage-based fee (typically 2-5%) on every EFT transaction. Providers unwilling to pay these fees are typically offered a VCC as the only other payment option, forcing them to incur fees no matter which option they choose.

Other unfair practices employed by health plans and payment vendors to discourage adoption of EFT by providers include:

- Automatic opt-in for virtual card payments, forcing the provider to opt out to receive payment by another method, including EFT;
- Informing providers wanting to opt out of VCC payments that it takes 60 days or more to reissue the claims payment as either a check or ACH EFT payment, thus negatively impacting business cash flow;
- Creating unnecessarily burdensome processes for opting out of VCC payments, such as not including payer contact information when issuing the VCC number;

- Creating unnecessarily burdensome EFT enrollment processes, such as refusing to permit enrolling all physicians in a group at the same time, to deter use of the EFT standard transaction;
- Communicating inaccuracies about the lack of safety of banking information used in EFT transactions;
- Misrepresenting card system rules such as informing providers that they must accept VCCs for claims payment if they accept patient credit cards; and
- Requiring VCC payments as part of provider contracts by telling providers they are exempt from the requirement or that a VCC payment meets the definition of "electronic payment.".

The National Committee on Vital and Health statistics (NCVHS), the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the HHS Secretary, has weighed in on the need for e-payments guidance. In its 2014 letter to the Secretary, NCVHS made the following recommendations:

"*HHS should issue guidance that:*

- *Defines whether, when, and how VCCs and CCs comply with national HIPAA-adopted standards for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA), and are valid options for health care claim payments.*
- *Clarifies and emphasizes the current provisions that prohibit practices that discourage or prevent the use of a national HIPAA adopted standard, in lieu of other transaction methods.*

HHS should work with the health care industry and other appropriate agencies to:

- *Encourage the increased adoption of EFT and ERA by identifying and disseminating best practices.*
- *Ensure there is full transparency, disclosure, and informed optionality between trading partners regarding the use of VCCs and CCs.*
- *Identify and encourage the use of nationally accepted good business practices in the financial sector with respect to the use of VCCs and CCs.*
- *Ensure that health care providers understand their rights with respect to acceptance or declining to accept VCCs and CCs as payment methods for their services.*

HHS should work with the health care industry and other appropriate agencies to identify market-driven solutions that support the industry as it:

- *Continues to innovate and improve administrative efficiency.*
- *Educates itself on the use of health care administrative transaction standards as it relates to VCCs and CCs.*
- *Identifies and emphasizes generally accepted best practices of electronic payment and VCC and CC use.*
- *Seeks to eliminate coercive business practices in the use of VCCs and CCs.*
- *Develops mechanisms to monitor and resolve inappropriate and unfair payment practices."*

Based in part on the NCVHS recommendations, CMS issued FAQs in fall 2017 to address several important payment issues. The following FAQs, now removed from the agency's website, provided critical industry guidance prohibiting unfair business practices and encouraging the widespread adoption of cost-saving EFT payments.

FAQ 22285 made it clear that providers were not required to accept VCCs from health plans and that they had "…the right to request that a health plan use the EFT transaction." This was important guidance, as many of our members have told us that health plans and their business associates send a VCC to the provider for payment of a claim (i) without prior notice of this method of payment; (ii) without offering that the payment be sent via EFT; (iii) using language that suggests that this VCCs qualify as e-payments; and (iv) that the provider has no choice but to accept this payment method.

FAQ 22281 definitively stated that a VCC is not considered a HIPAA standard transaction because the payment is made outside the ACH network and that health plans "must comply" with requests to receive claims payments via EFT. Most importantly, FAQ 22281 stated explicitly that fees may not be imposed on a provider for this transaction by either the health plan or their payment vendor. "Health plans should not charge providers communications fees for the use of the HIPAA EFT transaction, nor should health plans' payment vendors, which are business associates of the health plans, do so." The FAQ went on to state that "[a]ny fees charged to a provider for an EFT transaction are banking transaction fees, which should be applied only by the provider's financial institution…[and] are typically around $.034 per transaction nationally."

FAQ 22297 addressed four important and related issues. First, the FAQ reminded the industry that non-banking fees cannot be assigned to EFT transactions. Second, it stipulated that providers are not required to contract with payment vendors for "value-added services." Third, providers were reminded that they should closely review all vendor contracts and agreements. Finally, health plans functioning as clearinghouses were instructed not to charge fees or costs for normal telecommunications that exceed the fees they incur when they directly transmit or receive a standard transaction.

Most importantly, the guidance clarifying value-added fees was critical, as providers are often instructed by their health plans that they are required to receive their payment via the plan's designated third-party vendor, who in turn charges the provider a percentage fee on the EFT transaction. These "value-added" services are typically not offered as an option, but rather a requirement of payment, regardless of whether the provider wishes to take advantage of these services or not. While we do not oppose the ability of a payment vendor to offer these services, we contend that there needs to be full transparency regarding the specifics of these services and any associated fees. Further, these fees should be optional, and providers must be given the option of free EFT transactions.

FAQ 22385 provided important guidance to providers regarding updating, renewing, or signing e-payments-related contracts. We were pleased to see CMS reference the Workgroup for Electronic Data Interchange's (WEDI's) Electronic Payments: Guiding

Principles white paper in the FAQ. MGMA served as co-chair of the broad industry coalition that developed this white paper, an effort that included health plans, payment vendors, credit card companies, clearinghouses, hospitals, physicians, and CMS itself. This set of core principles were developed with the goal of advancing the adoption and use of the EFT transaction, and many of the principles mirrored the four CMS FAQs referenced above.

In concert, these FAQs provided clear guidance to the industry regarding e-payments, served as an incentive for providers to embrace EFT and ERA, and further encouraged implementation of the full suite of cost-saving administrative simplification transactions. They informed health plans and third-party payment vendors of their legal obligations, barred unfair business practices, and educated providers about their rights under the law. They are critical if the healthcare industry is to successfully drive out needless administrative waste.

We appreciate the opportunity to share our concerns regarding the removal of this important industry guidance and urge you to expeditiously re-post these critical FAQs. This action would communicate your commitment to simplifying the nation's healthcare system and prohibiting VCC abuses and unjust EFT fees imposed on physician practices. Thank you for your consideration of this request and please contact Robert Tennant at rtennant@mgma.org or 202-293-3450 should you have any questions.

Sincerely,

/s/

Anders Gilberg, MGA, Senior Vice President, Government Affairs

CC: Madhusudhan Annadata, Director, Division of National Standards, CMS