

February 20, 2015

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) were intended to reduce costs, paperwork and manual tasks through standardization of the transactions and code sets used in the electronic exchange of administrative health care information. With the adoption of the HIPAA standard electronic transactions and operating rules, the health care industry has begun to achieve these improved efficiencies and savings. However, in some instances, the implementation of administrative simplification provisions has led to unintended consequences, including additional stakeholder burdens and confusion.

The undersigned provider groups would like to draw your attention to implementation concerns regarding two administrative simplification issues:

- The payment of claims using virtual credit cards and
- The inclusion of the health plan identifier (HPID) and other entity identifier (OEID) in standard electronic transactions.

Each of these areas is associated with significant costs, time burden and administrative hassles for providers—outcomes that directly counter the stated goals of administrative simplification. More importantly, these additional provider burdens reduce the time and attention available for direct patient care. We urge you to consider our recommendations on these two issues, as we firmly believe that they will not only reduce administrative waste in our health care system, but will also ultimately improve patient care.

Virtual Credit Cards

The Centers for Medicare & Medicaid Services (CMS) recently issued frequently asked question (FAQ) #6343 regarding providers' options for receiving health care payments. We appreciate CMS's effort to provide guidance to the industry on electronic funds transfer (EFT) and virtual credit cards and fully agree that, as stated in the FAQ, providers should analyze their payment options and carefully review trading partner agreements for any associated fees. However, we are disappointed that the FAQ did not provide much-needed clarification on other serious issues

related to electronic health care payments. We would like to draw your attention to systemic concerns with virtual credit card and EFT payments and urge you to address these remaining problems by promptly providing additional guidance.

In a virtual credit card payment (a nonstandard type of EFT), a health plan or its payment vendor issues single-use credit card information to a provider via mail, fax or email; the payment is “virtual” in that there is not a physical credit card. Providers then manually enter the virtual credit card number into their point-of-sale (POS) processing terminal, and the card processing network authorizes the payment.

While the process described above may sound benign and similar to provider processing of patient credit cards, virtual credit card payments can have a significant negative financial impact on a provider. Interchange fees of up to five percent are imposed on virtual credit card payments; these fees essentially reduce the contracted fee rate negotiated between the health plan and the provider for a particular service or services. For example, if the payment to the provider was \$100, the provider will actually receive \$95. These fees quickly add up to thousands of dollars, all representing lost income for the provider. Unfortunately, many providers are unaware of these fees when accepting virtual credit card payments. Yet while providers are losing income from this payment method, health plans and intermediaries can profit from virtual credit cards, as they often receive cash-back incentives from credit card companies.

Virtual credit card payments also pose major administrative challenges for providers. Providers must manually enter the virtual credit card information into their POS systems, and any keying errors require the health plan to reissue a new virtual credit card, causing further delays in payment. Additionally, virtual credit card payments are not supported by the current version of the HIPAA standard electronic remittance advice (ERA) transaction (Accredited Standards Committee [ASC] X12 835). As a result, virtual credit card payments must be manually processed and reconciled, which increases administrative burdens and expenses on the provider. More importantly, the negative impact of virtual credit cards on providers runs contrary to the intent of the HIPAA and Affordable Care Act (ACA) administrative simplification provisions. While some stakeholders may claim that virtual credit cards align with the ACA’s goal of health care innovation, any new processes must benefit **all** stakeholders to be of any value to the industry as a whole. Virtual credit cards, which offer a one-sided value proposition to the detriment of providers, clearly do not meet the criteria for true innovation.

Finally, we are extremely concerned about the manner in which virtual credit card payments are currently being implemented. Almost without exception, virtual credit card programs are rolled out to providers in an opt-out fashion, meaning that providers begin receiving virtual credit card payments without receiving prior notification or consenting to the change in payment method. As mentioned earlier, this is particularly troubling because many providers are unaware of the interchange fees associated with credit card payments. In addition to the coercive nature of the opt-out paradigm, it also further increases the administrative hassles for providers, as they must waste valuable time contacting each health plan or vendor to stop receiving virtual credit card payments.

Many in the provider community had hoped that the requirement for all health plans to offer Automated Clearing House (ACH) EFT effective January 1, 2014, as required under the HIPAA regulation, would provide a viable electronic payment alternative to virtual credit cards. As the HIPAA standard method of electronic payment, ACH EFT offers many advantages to providers. In addition to the obvious gains in efficiency with electronic payment as compared with paper checks, ACH EFT works synergistically with the HIPAA-standard ERA transaction to facilitate payment reconciliation. Moreover, the cost of ACH EFT to providers is minimal—just a nominal banking fee of approximately \$0.34, which is assessed by the provider’s bank for EFT processing. Likewise, the cost of ACH EFT to health plans is approximately \$0.14, representing a significant savings from the expense of sending paper checks and making the standard ACH EFT process financially beneficial to both providers and health plans.

Given the expectation that ACH EFT implementation would offer a cost-effective alternative for providers wishing to avoid virtual credit card fees, we have been alarmed to receive reports of health plans or their vendors assessing percentage-based fees (usually 1.5–2 percent) for delivering ACH EFT payments to providers. Health plans or vendors often claim these fees are for “value-added services.” However, providers are generally not making active, informed decisions to receive these value-added services, as there is no indication in communications to providers that the basic ACH EFT option is available at no cost from the health plan or payment vendor. As with virtual credit cards, providers are again losing income from their contracted rates due to unnecessary fees.

CMS provided some initial guidance on the issue of ACH EFT fees. CMS FAQ #9778, issued in March 2014, states that a “health plan cannot . . . adversely affect the provider for using the standard transaction (i.e. charging excessive fees).” However, it appears that FAQ #9778 was recently removed from the CMS website. We are concerned about the removal of this FAQ, as it provided essential guidance to the industry regarding ACH EFT fees. Since the newly issued FAQ #6343 fails to address the topic of fees, we believe FAQ #9778 should be reposted. Additionally, we urge CMS to define “excessive fees,” as this phrase is open to interpretation. We strongly believe that any ACH EFT fee other than the nominal charge assessed by the provider’s financial institution is inappropriate and therefore “excessive.”

Our Recommendations

The payment practices described above are having significant negative consequences on the provider community. Thousands of dollars that providers could be investing in health information technology, new medical equipment or additional staff are instead being lost to unnecessary fees. To address these issues, we recommend that CMS provide the following direction to the health care industry regarding virtual credit card and ACH EFT payments:

- Require that a provider explicitly opt-in to virtual credit card payments prior to the issuance of any payments via this method;
- Require that prior to opting in to virtual credit card payments, the provider must receive a complete disclosure of all fees associated with this payment option;

- Require that virtual credit card programs provide clear and hassle-free instructions to providers on how to opt-out of these payments, should they later decide to choose another payment method;
- Prohibit health plans from requiring acceptance of virtual credit card payments as part of their provider contracts;
- Reissue CMS FAQ #9778 and clarify the definition of “excessive fees” in the context of ACH EFT payments to prohibit health plans and their vendors from charging fees for ACH EFT payments in excess of the nominal charge assessed by the providers’ financial institution; and
- Require that any services designed to supplement the standard ACH EFT process be independently selected at the provider’s discretion and be unambiguously separate from ACH EFT enrollment forms.

HPID/OEID

Under CMS’s final rule pertaining to HPIDs/OEIDs, health plans are required to obtain an HPID, a unique identifier, and use this identifier in standard electronic transactions. The original goal of HPID implementation was to standardize payer identification to support proper transactional routing. Providers initially were strong advocates of HPID and OEID implementation, as they believed that these identifiers would offer additional granularity in health plan identification in electronic transactions.

However, as the industry has moved toward implementation of the final rule, it has become clear that adding HPIDs and OEIDs to standard electronic transactions will create large-scale administrative problems across stakeholders without any offsetting benefit. Since the initial HIPAA legislation was drafted in 1996, the industry has collectively addressed the need for standardized payer identification to ensure proper routing of claims information. As a result, HPID implementation would disrupt today’s functional routing systems, essentially breaking something that has already been fixed. HPID adoption could lead to misrouted transactions, privacy breaches and payment interruptions. Additionally, some health plans have indicated that they will be obtaining upwards of sixty HPIDs based upon advice from their legal departments. This level of enumeration will complicate provider mapping of current payer identifiers to HPIDs without providing any useful information to providers. Finally, CMS has indicated that there will not be a publicly available look-up database for HPIDs/OEIDs for at least the initial implementation period. Without such a tool, providers will have no way of validating HPIDs, which will create further administrative burdens and confusion.

Despite the initial promise of the HPID/OEID concept, we strongly believe that HPIDs/OEIDs should not be used in standard electronic transactions due to the substantial costs and disruptions associated with implementation. HPID/OEID use in transactions would no longer address the problem for which it was mandated and would instead create significant administrative burdens and complexities in the claims process, which is in direct contrast to the intent of the HIPAA administrative simplification provisions. If CMS is requiring HPID/OEID enumeration for purposes other than electronic transaction routing, such as for health plan certification tracking, this should be clearly communicated to the industry.

Our Recommendation

On October 31, 2014, the Office of e-Health Standards and Services (OEES) announced a delay until further notice in the enforcement of the regulations pertaining to health plan enumeration and use of the HPID in HIPAA transactions. We applaud this move and request that CMS overturn the previous regulation by issuing a new rule that would prohibit the use of HPIDs/OEIDs in standard transactions. We understand that CMS may still wish to use HPIDs for health plan certification purposes, and we do not object to this particular use of HPIDs—as long as the identifier is not used in electronic transactions.

Conclusion

We appreciate your time and attention to our recommendations. Reducing administrative burdens and associated costs is a key concern across industry stakeholders, and we are eager to continue working with you to achieve our mutual goals. We truly believe that change is needed on the issues identified above to ensure that providers can focus on what we believe is most important to all of us—providing quality patient care.

Should you have any further questions or wish to arrange a meeting with our organizations, please contact Mari Savickis, Assistant Director, American Medical Association Federal Affairs, at mari.savickis@ama-assn.org or 202-789-7414.

Sincerely,

American Dental Association
American Hospital Association
American Medical Association
American Society of Anesthesiologists
Colorado Medical Society
The Everett Clinic
Johns Hopkins Health System
LabCorp
Mayo Clinic
Medical Group Management Association
Montefiore Health System
Physicians Advocacy Institute
Tampa General Hospital
Wake Forest Baptist Medical Center