Centers for Medicare & Medicaid Services
Open Door Forum: Physicians, Nurses and Allied Health Professionals
Moderator: Jill Darling
April 27, 2022
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press star 1 on your phone to ask a question. I would like to inform all parties that today's call is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to Ms. Jill Darling. Thank you. You may begin.

Jill Darling: Great, thank you, (Chelsea).

Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications, and welcome to today's Physician, Nurses and Allied Health Professionals Open Door Forum.

Before we get into the agenda today, I have one brief announcement. This open door forum is open to everyone. But if you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call.

If you have any inquiries, please contact CMS at Press@cms.hhs.gov.

And I will hand the call off to our co-chair, Dr. Gene Freund.

Dr. Eugene Freund: Hi, this is Gene Freund, and I want to welcome you to this open door forum on behalf of myself and Mr. Gift Tee, my co-chair. And I'm looking forward to the call and the topics. And I'll just turn it back over to Ms. Darling who can run us through the agenda.

Go ahead, Jill.

Jill Darling: Okay. Thanks, Gene. A pretty short agenda today, so we'll get right in. We have (Amy Bedsaul) who will give an update on the - excuse me, Open Payments Review and Dispute.

(Amy Bedsaul): Thanks, Jill, and hi everyone. I just wanted to check in quickly to talk about the review and dispute period for Open Payments since we are in that time frame right now.

If you're new to hearing about Open Payments, our program is a national disclosure program that promotes a more transparent and accountable healthcare system. We publish the financial relationships between applicable manufacturers and group purchasing organizations and healthcare providers. Collectively, we refer to the healthcare providers as "covered recipients." So, if you hear me use that term during this brief update, that's who I'm talking about.

So right now, we are in the review and dispute period, ahead of our annual data publication. And I would also just like to put out another reminder that the upcoming program year 2021 data publication that's set for this June will be the first to include the program expansion, which added five additional

provider types to the Open Payments Program. Those five additional provider types are physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and anesthesiologist assistants, and certified nurse-midwives.

So, the pre-publication review and dispute period opened on April 1st and it will run through May 15th. This is the covered recipient's opportunities to go into the Open Payments system and review any data that's been attributed to them. And they can affirm that it's correct or, if needed, they may initiate a dispute and work with the reporting entities to resolve the dispute ahead of our June publication.

So again, that runs now through May 15th. I do just want to put out the other note that CMS does not mediate disputes. So, it is up to the covered recipients to work directly with the reporting entities to reach a dispute resolution.

Also, any disputes that are initiated by the May 15th deadline will be reflected in our upcoming June publication. But disputes that are initiated after that pre-publication review and dispute period will be reflected in a later data refresh.

Also, the review of the data is voluntary. But we do encourage it as it helps assure that the data reported is accurate.

If you are interested in participating in review and dispute ahead of the publication, you will need to be registered in the CMS Identity Management System, as well as the Open Payments System. So, if you haven't previously

registered, you will need to do that and gain access to the Open Payments System.

If you registered during a prior year, the good news is you don't have to re-register. You'll just have to log in and make sure that your account is still active. On the chance that it's been 180 or more days since you accessed your Open Payments account, you will need to call the help desk to get your account reactivated. But no re-registration is required.

Also, our help desk is operating on extended hours right now. So, they're available 8:30 a.m. until 7:30 p.m. Eastern Standard Time. They will continue those extended hours through the end of the review and dispute period. And they are accessible via e-mail. The e-mail is openpayments@cms.hhs.gov. Or you can give them a call at 1-855-326-8366. And all of their contact information is also available on our Web site.

In addition, there were a few links included in today's agenda. Two are some new videos that we put out, one is an overview about the programs and the other is about our nature as a payment that talks about what type of data is collected and reported for the purposes of our program.

So, if you have any questions, happy to answer them. And also, we have a lot of resources on our Open Payments Web site should you need those.

And that is all of the updates from me today. Thank you.

Jill Darling: Thanks, (Amy).

And our next and last speaker is Beth Karpiak.

Beth Karpiak: Hello, and thank you for having me here today, Jill. I'm excited to speak to this group about two new guidance letters that the National Standards Group, or NSG, within the CMS Office of Burden Reduction & Health Informatics issued last month related to payment of healthcare claims using electronic funds transfers.

First, some brief background. NSG, on behalf of the Secretary of HHS, administers HIPAA Administrative Simplification Provisions that are related to adopting standards for administrative electronic healthcare transactions.

Several of you may be well-versed in HIPAA standard transactions but for those of you that are new to this world, as I am currently new, I'll break it down just a little bit.

Essentially, the transaction standards the Secretary adopts under HIPAA dictate the content and format of particular electronic administrative healthcare transactions. If a covered entity, meaning a healthcare provider, health plan or clearinghouse, conducts an electronic transaction for which the Secretary has adopted a standard, that covered entity must conduct the transaction using the content and format prescribed as a standard.

NSG is the agency within CMS that adopts, administers and enforces compliance with those standards. Thus far, NSG has adopted standards for nine different administrative healthcare transactions. But the one I'm going to

be talking about in detail today is healthcare electronic funds transfer and remittance advice transaction, which I'll refer to from here on out as EFT and ERA.

With that background out of the way, what I hope to do for the remainder of my time is walk through the guidance letters and summarize some of the major clarifications and conclusions that we've made. So, if you are at your computer, now would be a great time to pull up those guidance letters and follow along.

Jill provided links to those guidance letters in your agenda under the bullet titled, "Links to Individual Guidance Letters."

So, I'm going to start with the letter titled, "Guidance on Health Plans' Payment of Healthcare Claims Using Virtual Credit Cards and Adopted HIPAA Standards for EFT and ERA Transactions."

The document opens with an issue statement. And the issue statement explains what prompted NSG to publish this letter. Generally, the industry has shared with CMS that health plans will sometimes pay claims by way of virtual credit card, or VCC. And they'll typically send a VCC number through the mail or fax and then the provider has to enter that number into their point-of-sale system to be paid.

When using that VCC payment, just like with a physical credit card payment, the credit card network charges the provider a percentage-based fee. And providers might find that percentage-based fee charged by credit card

networks for things like copayments or other relatively small payments that provider accepts in office is offset by the convenience of allowing patients to pay by credit card. But when that fee is taken on all of the provider's claims payments from health plans, it really adds up and can account for a significant amount of money.

Many providers that don't wish to be paid by VCC have asked health plans to pay them using EFT through the Automated Clearing House, or ACH, network. This is a method for which NSG, on behalf of HHS, has adopted HIPAA transaction standards. However, what we've heard from the industry is that health plans or, more frequently, entities acting on those health plans' behalf, are requiring providers to pay for services related to receiving EFT payments in order to be paid with EFT through the ACH network using those adopted HIPAA standards.

Groups representing providers have come to CMS asking what we can do as the agency that administers the HIPAA Administrative Simplification Provision related to transaction standards to address their concerns about these practices. So, what we've done with this guidance letter is essentially boiled down the information on what the scope of our authority, our statutory and regulatory authority, does say about this topic into three questions.

Those questions are, "Do the adopted HIPAA EFT and ERA standards permit health plans to pay claims by VCCs?" "If the healthcare" - that's the first question. Number two, "If the healthcare provider requests that a health plan pay the provider's claims using the adopted HIPAA EFT and ERA standards, must the health plan comply?" And then the third and final question in this

letter is, "Can a health plan require a provider to agree to receive payment or reassociation services from a vendor of the health plan's choosing as a condition of receiving EFT or ERA using the adopted standards?"

So, to answer those questions, we start by giving some brief background into EFT and ERA. We have the definitions from our regulations, as well as the adopted standards that are also incorporated by reference into our regulations.

What I hope will be most helpful to the industry is the diagram we've added at the end of this document. If you're following along, I'll give you a second to scroll down to that diagram at the very end. I'm going to do the same.

So, you'll see that it shows unlike most HIPAA transactions that go directly between provider and health plan, EFT through the ACH network goes through three stages. And we've got those three stages on the left of the diagram.

Stage 1, called Payment Initiation, is where the health plan authorizes its bank to send payments to the provider's bank.

Stage 2 is where the plan's bank actually sends the money to the provider's bank. We call that Transfer of Funds.

And then Stage 3, called the Deposit Notification, is where the provider's financial institution, so the provider's bank, notifies the provider, "Hey, you've gotten the payment." So, we call that the Deposit Notification.

Then on a separate track to the right of the diagram, we have the ERA, the electronic remittance advice transmission. You can see that that goes directly between the plan and the provider. And that - the content of that transaction tells the provider why the plan paid the amount that they paid.

You can see that because they're on two separate tracks, in order to balance the books and bill patients' accounts, providers need to be able to match or reassociate each EFT to each ERA because they might come at separate times. So, the standards that HHS has adopted, those HIPAA standards, facilitate that reassociation process by requiring a matching unique trace number to be included in the EFT and its corresponding ERA. So once those both come in, they can be matched up.

All that said, back to the questions in this document.

In answering, "Do the adopted HIPAA EFT and ERA standards permit health plans to pay claims by VCCs?," we explain, yes, they do. With most HIPAA transactions, any time covered entities are conducting a transaction that meets the regulatory definition of that transaction, the standard must be used and nothing else is permitted. But with EFT, we built in an exception. The only time the standard must be used is when a transaction that meets the definition is being conducted through the ACH network. So, this exception permits other forms of EFT, like VCC or wire transfer is another example.

So, although it is permitted that health plans pay by VCC, in Question 2, we explain that our regulations are clear, that even though the plan can pay by check, VCC, other EFT method, when asked to do so, the health plan must

pay by EFT through the ACH network using those HIPAA standards. And we go onto some detail about what compliance with such a request would look like.

And then finally in Question 3, we're at the point where the provider has asked the health plan for EFT and ERA through the ACH network and the health plan complies. But the health plan, or as I mentioned previously, most commonly their business associate, which generally is an entity that performs functions related to HIPAA transactions on behalf of the health plan, will charge the provider for services related to Stage 3 transmissions. Again, that deposit notification and reassociation phase.

So, the health plan may comply with the request to pay using the adopted EFT and ERA standards through the ACH network but they may also say that as a condition of receiving those payments, you, the provider, are going to have to contract with our business associate that provides great services like an online portal to view the ERA information and they also provide an automatic reassociation service.

And if the provider wants those services, then that's great and they can move forward. However, looking at the diagram again, you can see that the health plan really has no role in that Stage 3 deposit notification or reassociation process. Compliance with the request to use the adopted standards really only involves the health plan sending that Stage 1 transmission and sending that ERA.

So, who receives those transactions on the provider's behalf and how the provider conducts reassociation is up to the provider. So, what we say here in the guidance letter in Question 3 is that if payment using the standard EFT through the ACH network is conditioned on payment for those additional services, that may be construed as adversely affecting a transaction because it's a standard transaction. And that's a clear HIPAA violation *(Adversely affecting a transaction because it is a standard transaction is a clear HIPAA violation)*.

So, while charging for these services in and of themselves is not inherently a violation of HIPAA requirements, we've identified this type of conditioning use of the standards on payment for unwanted services as a scenario that could fall into that regulatory authority related to adversely affecting a transaction.

Then very quickly, as a supplement of sorts, although it stands on its own, we also released a guidance letter on business associates, which Jill has linked in the agenda as well. And what that letter does is clarify that NSG does not have the authority to hold business associates directly accountable for compliance with HIPAA standards. Our authority is limited to covered entities -- again, the - those providers, health plans and clearinghouses.

But we do have the authority to take action against covered entities that do not require their business associates to comply. So, kind of a roundabout authority there. So, what we hope this letter does is put health plans on notice that they need to ensure their business associates conducting these EFT and ERA transactions on their behalf are compliant, and if they're not, NSG will hold those health plans directly accountable.

Following similar logic, should a provider wish to file a complaint with our office related to EFT and ERA, in order for NSG to move that complaint through our complaint management process, we'll need the provider to identify and file the complaint against the health plan rather than their business associate which could be maybe a third-party administrator or payment solutions vendor, because our authority is to enforce compliance against the health plans.

If you're interested in filing a complaint, there are instructions in the EFT guidance letter for how to do so. Also, if you have questions, there's an e-mail box at the end of the guidance letter where you can submit those.

And that is all I have. So, I'll turn it over back to Jill.

Jill Darling: Great. Thank you, Beth, and thank you to (Amy).

(Chelsea), we will open the lines for Q&A, please.

Coordinator: If you'd like to ask a question, please press star 1. Unmute your phone and record your name clearly when prompted. Again, if you'd like to ask a question, please press star 1. Unmute your phone and record your name clearly when prompted. One moment while we wait on our first question. The first question is from (Theresa Wilson). Your line is now open.

(Theresa Wilson): Hi. Thanks for having this call today.

I had submitted a question to the HIPAA EFT-ERA committee, I guess it is, based on this guidance letter and I have not - I've yet to receive a response. What is the permissible fee that a payor can charge a provider for EFT transactions?

Beth Karpiak: Hi, (Theresa). This is Beth. And your name does sound familiar and we have received your question and are working to put together a response. But I can talk about that a little bit now.

So, what we discussed in this guidance letter is the HIPAA prohibition on health plans adversely affecting a transaction because it's a standard transaction. We've identified that, you know, if the health plan conditions sending the EFT and ERA transaction using the adopted standards on provider's acceptance of, which may include payment for, unwanted payment or reassociation services that may be construed as adversely affecting the transaction because it's a standard transaction.

So, while there may be circumstances in which fees adversely affect the transaction because it's a standard transaction, the guidance letter does not speak to whether charging fees to conduct transaction is in and of itself a violation of the HIPAA requirement. So, we're not, you know, releasing any kind of fee amount that's acceptable or not. That issue is still pending additional investigation as of this writing - or I'm sorry, as of when we issued the guidance letter.

(Theresa Wilson): So, let me give you an example. So, for instance, we are trying to enroll for ERA with UMR, which is a plan that's under the UnitedHealthcare umbrella.

UMR requires enrollment with Zelis. Zelis has no free ACH - EFT or ERA enrollment. In order to get ERA, you have to have EFT. EFT costs through Zelis 2-1/2%.

So now my question is we've already reached out to the payor, UMR. We're waiting - they're telling us that there's another option that we have to do on our own. We can't do it apparently through our own clearinghouse, which is - I guess is that a violation itself of the HIPAA standard? I mean, you should be able to obtain your ERA and EFT via the normal channels, correct? Or do you have to go through leaps and bounds and go to portals and things of that nature that the payor directs you to in order to get your ERA?

Beth Karpiak: So, I heard two questions there and I think, you know, one is about the fees. And I think that the answer that we give based on the guidance letter today is, you know, it depends. And so, I'd encourage you to, based on the facts of this - of a particular situation that, you know, we wouldn't be able to discuss on this call.

So, if that is something you're interested in pursuing further, I encourage you to file a complaint with our office through that asset system that's indicated in the guidance letter.

And then the second question I heard you asked is about sending to your clearinghouse - sending that ERA directly to your clearinghouse versus to a Web portal. And you're asking, you know, is it compliant to send it to the Web portal or must I send it to your clearinghouse?

Is that the correct question?

(Theresa Wilson): Correct. Yes.

Beth Karpiak: Right. So, what we say in this guidance letter is that if a provider requests that a health plan transmit remittance advice information to that ERA transmission using the adopted standard, the HIPAA regulations do require the health plan to comply with that request…

(Theresa Wilson): Okay.

Beth Karpiak: …of which includes transmitting the data in the standard format to the requesting healthcare provider or the business associate that is acting on behalf of the healthcare provider, which might include a clearinghouse.

(Theresa Wilson): A clearinghouse.

Beth Karpiak: So, there's nothing that prevents a health plan or the business associate that's acting on behalf of the health plan from offering to process that standard transaction into the nonstandard format by posting it into a Web portal for viewing. But the provider may choose to reject that service and request delivery in the standard format to a business associate of the provider's choice.

(Theresa Wilson): Okay. So, if I'm hearing you correctly, if a payor does not provide you with the option to receive it via the standard, then we have the right to submit a complaint against the payor with regard to not complying.

Beth Karpiak: And anyone always has the right to submit a complaint. And we look at all complaints that come in. But what I am saying is the provider - compliance with the standards includes sending that ERA in the standard format directly to the provider or to the business associate of the provider's choice.

(Theresa Wilson): Now does CMS looking for us to do due diligence with the payor like trying to do a reach-out? So, in other words, when we submit a complaint, are we required or CMS requiring that we provide proof that we've reached out and we've, you know, attempted to obtain a response from the payor with regard to, you know, the standards that they have not complied? Do we need to give that to you when we submit a complaint?

Beth Karpiak: It is information that we ask for when someone submits a complaint but it is not a requirement. You know, it's often effective and can…

(Theresa Wilson): Okay.

Beth Karpiak: …go a long way but not a requirement.

(Theresa Wilson): Okay. Thank you so much. I appreciate it.

Beth Karpiak: Yes. Thank you, (Theresa).

Coordinator: The next question is from (Claire).

Your line is now open.

(Claire): Hi, and thank you for having this call. I'm calling on behalf of MGMA. I'm wondering, you did mention that the issue of these and what was permissible is still pending. Do you plan on issuing any further guidance on this in the future?

Beth Karpiak: I'm going to turn over to my Deputy Director, Dan Kalwa that's on the line.

Dan, did you have any thoughts on this question from MGMA?

Daniel Kalwa: Hi, this is Dan. And although Beth was the primary author, I am the Deputy Director of the National Standards Group.

I think the best way to talk about that is to say even though fees is usually at the forefront of everybody's discussion, it's still not clear to us what our authority actually is under the law. So, we're hesitant to really make any pronouncements at this time.

I think we may have more to say in the future but I really can't commit to that over this time.

(Claire): Okay, thank you. I appreciate that.

Coordinator: I'm showing no further questions.

Jill Darling: All right. Well, thank you everyone for joining us. And also, please utilize all the helpful links that are on today's agenda.

If Gene does not have any closing remarks, we can end today's call.

Dr. Eugene Freund: That's fine with me. Thank you all very much for attending.

Jill Darling: All right. Thanks everyone. Enjoy your day.

Coordinator: This concludes today's conference. All participants may disconnect at this time.

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