



August 11, 2021

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW Washington, DC 20201

Re: CMS' authority to prohibit EFT fees in healthcare

Dear Administrator Brooks-LaSure,

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) writes today regarding the growing incidence of fees being levied upon medical groups by health plans and their payment processing vendors to receive electronic reimbursements through electronic funds transfer (EFT). We believe this increase is partially a result of the void created by CMS beginning in 2017 when it removed clear and unambiguous guidance from its website prohibiting health plans and their payment processing vendors from engaging in abusive business practices that run counter to an efficient healthcare system. Sections 1172 (b) and 1173 (a)(1) of the Social Security Act direct the Secretary to establish standards for certain transactions to, among other goals, improve the operation of the health care system and *reduce administrative costs of providing and paying for health care*. **Given that CMS has a both a statutory requirement and the authority to prohibit EFT fees, the industry guidance removed by the prior administration in 2017 should be reposted or clearly restated by CMS in a definitive manner.¹ If CMS will not provide clear guidance, we ask the agency to expeditiously and clearly state why it is not using its legal authority to prohibit these abuses.**

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties. In our August 10, 2021, *Stat* poll, we surveyed medical groups asking, "Are insurers charging your practice fees you didn't agree to when sending payments via EFT?" A staggering 57% answered "yes," that they were being forced to pay fees.

As part of the Affordable Care Act (ACA), health plans since 2014 have been required to offer physician practices the option of receiving their reimbursement via a standardized EFT method. This standard uses a set of ACA-mandated EFT business operating rules which joined with existing HIPAA-directed electronic remittance advice (ERA) operating rules. In concert together, these standards and operating rules streamline the flow of reimbursement and revenue cycle management, a bedrock healthcare administration process vital to the efficient management of patient care.

CMS issued industry guidance in the form of FAQs in fall 2017 to address several important payment issues. **FAQ 22297**, *now removed from the agency's website*, provided critical industry guidance prohibiting unfair business practices and encouraged the widespread adoption of cost-saving EFT payments. This FAQ guidance instructed the industry that only the provider's financial institution may

¹Administrative Simplification provisions of HIPAA; sections 1171-1178 of the Social Security Act (42 U.S.C. 1320d through d-7)

impose a fee to process EFT payments through the Automated Clearinghouse (ACH) Network. The guidance went on to specify that providers are not required to contract with payment vendors for “value-added services.” 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 not be assessed a fee for EFT transactions from health plans or their payment processing vendors.

The drive toward industry cost savings was the primary motivation for adopting the EFT standard and it is disappointing that a growing number of health plans and payment processing vendors are abusing this mechanism of efficiency by charging providers a percentage-based fee (typically 2-5%) on every EFT transaction. MGMA has been closely tracking a growing number of EFT fee abuses being reported by our members this year. Through our polling data, between 2017 and 2020 we have found the number of practices who report being charged a fee for EFT reimbursements from health plans or their vendors is trending alarmingly upward.

The lack of clarity created by CMS in removing this guidance has created an abusive and unstable situation that is quickly growing out of control as more health plans and commercial payment vendors take advantage of providers because of an unclear regulatory landscape. This FAQ guidance provided clear rules to the industry regarding EFT payments and served as an incentive for plans and providers to embrace EFT and ERA, and further move toward full implementation of the suite of cost-saving administrative simplification transactions. This industry guidance directed health plans and third-party payment vendors in their legal obligations, barred unfair business practices, and educated providers about their rights under the law. This guidance is critical if the healthcare industry is to successfully drive out needless administrative waste and protect the viability of medical groups that equitably serve the diverse population of American patients. **Given that CMS has a both a statutory requirement and the authority to prohibit EFT fees, the industry guidance removed by the prior administration in 2017 should be reposted or clearly restated by CMS in a definitive manner. If CMS will not provide clear guidance, we ask the agency to expeditiously and clearly state why it is not using its legal authority to prohibit these abuses.**

This action would bring clarity to the issue as medical practices struggle with the growing burden and financial costs being pressed upon them by health plans and vendors. Thank you for your consideration of this request and we would welcome the opportunity to meet with you to discuss this matter in greater detail. Please contact Drew Voytal at dvoytal@mgma.org or 202-293-3450 should you have any questions.

Sincerely,

/s/

Anders Gilberg, Senior Vice President, Government Affairs.