Centers for Medicare
& Medicaid Services

August 18, 2021 – Administrative Simplification Enforcement Webinar Questions and Answers

Introduction

The questions below were received during the August 18, 2021, Administrative Simplification Enforcement Webinar. Questions were submitted to the Centers for Medicare & Medicaid Services (CMS) via the chat box. Both questions answered during the webinar and those that could not be answered at that time are included in this document.

Please note that this webinar was an educational opportunity and was not a forum for discussion of specific complaints. Any questions related to specific complaints will be addressed through the complaint process.

Questions and Answers

Question: Health plans are increasingly forcing fees for electronic payments to providers in clear violation of the intent of the HIPAA standards. They often pay providers using virtual credit cards which charge a transaction fee on the provider. The only alternative to these VCCs is to enroll with the plan's EFT vendor which charges a comparable transaction fee. Providers should not have to pay a fee for electronic payments. Today's webinar shared that CMS conducts proactive compliance reviews. Can you provide information about compliance reviews CMS conducted on health plans and their vendors charging fees for standardized EFT transactions?

Response: The compliance reviews consist of testing an entity's transactions for compliance with adopted HIPAA standards. The compliance review program does not review fees, since there is no specific standard adopted for fees charged in association with various business transactions. Note that the use of virtual credit cards is permitted, but providers have the ability to opt-out from receiving them.

We have learned that there are a number of fees that support various services and business arrangements among covered entities. We have also learned that many providers are unable to specify what fees/services they have voluntarily agreed to, and which fees are being assessed without their consent for which transactions. Likewise, plans and clearinghouses often fail to clearly identify the fees being assessed, and how providers can receive a compliant EFT without incurring such fees.

We are aware that this issue is of significant concern to the industry, and we continue to work with individual complainants and filed against entities to resolve individual complaints. We are

also continuing to investigate and analyze common business practices to determine if they fall within the purview of HIPAA Administrative Simplification, and if so, if they constitute a violation.

Any proposed regulation that results from this effort will be published for notice and comment in the Federal Register. Any guidance that is developed will be published on the Administrative Simplification website and will be publicized via our listserv and other social media.

Question: Is CMS levying fines on noncompliant entities?

Response: CMS has not assessed any civil money penalties against covered entities for violations of HIPAA Administrative Simplification rules, but is authorized by the statute to do so. Imposition of civil money penalties is a legal action that requires carefully constructed policies and procedures, mature business processes and systems, and appropriate staff to implement the actions. We are considering means of bringing together all of these elements to ensure any civil money penalties are appropriate and fully enforceable.

Question: Why do so many invalid complaints (85%) end up at CMS? Why are so many entities ill-informed?

Response: Many of the complaints that we receive are unrelated to HIPAA transactions, code sets, unique identifiers, and operating rules. For our record-keeping we categorize these as "Invalid". These complaints often relate to one of the following subject areas:

- Reimbursement disputes
- Coverage disputes
- Medicare beneficiary complaints
- Medicare managed care
- Quality of care

When we receive invalid complaints, we re-route them to the appropriate component or expert at CMS and notify the complainant the reasons why the complaint is invalid for HIPAA Administrative Simplification and advise that their complaint has been forwarded to the appropriate contact.

We also receive complaints that are filed with missing or incorrect contact information, so we are unable to contact the complainant and proceed with the complaint process. We categorize these complaints as "invalid" as well.

CMS is considering how to make clearer the types of complaints we handle and how to use the ASETT system to properly file a HIPAA Administrative Simplification complaint.

Question: If a payer doesn't read the COB portion of the HIPAA transaction and requires paper EOBs, is that a violation of HIPAA transactions?

Response: This may be a HIPAA violation, but additional information is needed. We suggest filing a complaint so that the issue can be investigated. For more details visit: https://www.cms.gov/regulations-and-guidance/administrative-simplification/enforcements

Question: What is the average length of time entities are taking to correct deficiencies?

Response: That time can vary depending upon what the issue is. It can vary anywhere from a few weeks to a few months. It's just dependent upon what the issue is and what the solution is to fix that issue.

Question: Are we able to file a complaint if a trading party attempts to charge fees for these standard transactions? Also, if CMS can't make a ruling about fees - who else can we turn to? Is there another government entity that can make this determination?

Response: This transaction fee issue concerns language in the August 2000 Transactions and Code Sets regulation (45 CFR Parts 160 and 162). CMS has been delegated authority to render any determination or policy related to this issue. You may file a complaint on this topic, and such a complaint should include adequate documentation regarding the fees charged, the reason for each fee, and any agreements, in full, that have been entered into by the entities involved.

Question: If a health plan only provides member eligibility on their portal and not via a 270 transaction, are they considered non-compliant?

Response: According to regulation, if a provider requests that a health plan conduct the standard transaction, which is the 270, the health plan is not in compliance if they do not conduct the standard transaction. Health plans may provide the use of a portal, but are required to conduct the standard transaction when requested to do so (45 CFR 162.925).

Question: If a state Medicaid agency needs to provide appeal rights with a RA, what would be your suggestion on doing that? Would they need to try to get a unique code?

Response: This question requires clarification. Please visit the Enforcement section on the CMS Administrative Simplification website at*:* https://www.cms.gov/regulations-and-guidance/administrative-simplification/enforcements

Question: Does CMS analyze recurrent themes in ASETT complaints to identify areas that may warrant additional guidance/enforcement? For example, numerous providers have filed complaints regarding assessment of percentage-based fees for ACH EFT payments.

Response: As part of our policy, we monitor all the complaints and violations that we receive. When we see that there is a recurring issue, we typically include clarification of the issue and resolution in our Outreach and Education Program. This may consist of publishing sub-regulatory guidance in the way of an FAQ or a guidance letter or informational bulletin to inform the industry.

Question: Even though Unique Patient Identifier does not have a "Standard", it is still a mandate that EDI trading partners must use one, is that correct?

Response: It's not an adopted standard, so it's not required. We have not adopted a patient or individual identifier at this time.

Question: Are entities required to submit an annual attestation of compliance? To whom is this submitted?

Response: No, they are not. They are not required to submit any kind of certification or attestation that they are compliant.

Question: When there is a disagreement on the interpretation of a TR3 requirement, how does that get handled?

Response: The TR3 reports are owned by the ASC X12, the standards development organization. Normally when there is a discrepancy about an area in the TR3 that may not be clear or may be interpreted differently by the entities, we defer to X12. We submit a Request for Information (RFI) to X12. We request interpretation of the specific data element or area in question. Once we receive X12's interpretation, we negotiate potential solutions with the entities.

Question: In follow up to that question about interpretation, are the interpretations posted on CMS sites anywhere if complaints then result in the need to go to X12?

Response: Currently, they are not posted on the CMS website, but if we request an interpretation from X12, we communicate the results with the complaint entities, such as the filed-against entity and the complainant. It is posted and stored in our ASETT system with that particular complaint.

Question: Can you provide an update on the timing for when CMS will reissue guidance that clarifies health plans and their vendors cannot charge fees for EFT transactions?

Response: At this time CMS does not have sufficient data from the industry to perform a thorough analysis regarding the fees related to standard transactions. As we receive additional, complete and reliable information, we continue to analyze that information and, if necessary, will issue guidance when appropriate.

Question: As a provider, we submitted a complaint about the fees 4+ years ago. How long should providers expect to wait for CMS to make a ruling? If fees are allowed for payments - can providers charge payers for all other transactions they request/require?

Response: As stated earlier, analysis of this topic is on-going. We are keeping all related complaints in a pending status until sufficient information is obtained, and analysis is completed.

Question: Also, if CMS can't make a ruling about fees - who else can we turn to? Is there another government entity that can make this determination?

Response: This issue concerns language in the August 2000 Transactions and Code Sets regulation (45 CFR Parts 160 and 162). CMS has delegated authority to render any determination or policy related to this issue.

Question: Are trading partners considered covered entities and if so, the requirements apply to them as well, correct?

Response: If the trading partner meets the definition of a business associate (45 CFR, 162.103), they are required to comply with the HIPAA requirements.

Question: Can you give guidance on future rules that will be coming out (e.g., when any rules are expected to come out, what is expected to be covered in new rules)?

Response: Please consult the Unified Agenda – the Federal Unified Agenda for the Federal Register – which will announce the scheduled publication for future rule making.