Health Plans Payment of Health Claims

In March 2022 the Department of Health and Human Services released guidance regarding health plans payments of health care claims using virtual credit cards and adopted HIPAA standards in accordance with 45 Code of Federal Regulations (C.F.R.) §§ 162.1601 and 162.1602(d).

There are several key take aways to include:

- The health plan cannot force a provider to accept a credit card if the provider requests the health plan to pay via the adopted EFT and ERA standards. This applies regardless of whether the Provider is in the plans network or otherwise affiliated with the plan.

- If a health plan uses a business associate to conduct all or part of a HIPAA transaction on its behalf, the health plan must require its business associate to comply with all applicable requirements to include the payment through the ACH processing and sending an electronic 835.

- The health plan is required to issue an ERA that matches the dollar amount of the ACH along with including a "trace number" that allows the provider to match the ACH to the ERA.

- A health plan may not require that a provider agree to receive payment or reassociation services from its business associate (nor may the business associate otherwise require this) as a condition of receiving health care payments using the adopted EFT and ERA standards.

- The provider may choose a business associate of its choice from who to receive ERAs from the health plan.

- If the provider believes the health plan is not in compliance with applicable guidance the provider may file a grievance with CMS NSG through the Administrative Simplification Enforcement Testing Tool (ASETT).

Question: If a provider requests that a health plan pay the provider's claims using the adopted HIPAA health care EFT and ERA transaction standards, must the health plan comply?

Answer: Yes, the health plan must comply. 45 C.F.R. § 162.925(a)(1) dictates that if an entity requests that a health plan conduct a transaction as a standard transaction, the health plan must do so. A provider's request that a health plan make claims payments using the adopted standards may include, for example, requests to: (1) use the adopted NACHA CCD+ Addenda standard to send payment initiation transmissions, (2) include the data content and format identified in the ASC X12 835 TRN Segment Specification in the payment initiation transmissions, and (3) use the adopted ASC X12 TR3 835 standard to transmit ERA information.

Section 45 C.F.R. § 162.925(a)(1) provides no exceptions to the requirement that health plans must comply with a request to use the adopted standards. When a provider makes such request, a health

plan must comply with all three standards regardless of whether a provider is in the plan's network or otherwise affiliated with the plan.

Question: Have standard transactions sets been adopted that apply to payment and remittance?

Answer: HHS adopted the following standards for electronic health care EFT and ERA transactions conducted on and after January 1, 2014.

For Stage 1 Payment Initiation transmissions: The National Automated Clearing House Association (NACHA) Corporate Credit or Deposit Entry with Addenda Record implementation specifications (NACHA CCD+Addenda).

For the data content of the Addenda Record in the NACHA CCD+ Addenda: The 835, Accredited Standards Committee (ASC) X12 Technical Report Type 3, 835 Segment Detail: "TRN Reassociation Trace Number" (ASC X12 835 TRN Segment Specification).

For ERA transmissions: The ASC X12 Technical Report Type 835 (ASC X12 TR3 835).

Question: Can the health plan circumvent the requirement to issue standard payment transactions through the national automated clearing house [HACHA]?

ANSWER: Note that this requirement applies specifically to health plans. Furthermore, if a health plan uses a business associate to conduct all or part of a HIPAA transaction on its behalf, the health plan must require its business associate to comply with all applicable requirements. This means that any agreement a health plan has with a business associate to make, or assist with making, claim payments on behalf of the health plan does not relieve a health plan of its responsibility to comply with a request to make claims payments using the adopted standards. If a health plan directs providers to work with the health plan's business associate to receive payments from that health plan, and the health plan's business associate is not able to make health care claims payments using the adopted EFT and ERA standards, or is not compliant with the adopted standards, the health plan may be held accountable for its business associate's noncompliance.

Question: Is the health plan required to issue an ERA for each EFT?

Answer: Under the adopted standards, health plans must also maintain a one-to-one relationship between each ERA and its related EFT. This means that if a health plan sends a Stage 1 payment initiation to its financial institution authorizing payment for one health care claim, the health plan must send an ERA transaction to the provider containing explanation of benefits and remittance information only for that one claim. Similarly, if a health plan sends a Stage 1 payment initiation to its financial institution authorizing payment of several health care claims through one ACH funds transfer, the health plan must send remittance information for all of the claims covered in that Stage 1 payment initiation in one ERA transaction. To facilitate this one-to-one relationship, once a health plan transmits a Stage 1 payment initiation using the NACHA CCD+Addenda standard with the appropriate ASC X12 835 TRN Segment Specification, intermediaries acting on behalf of the health plan, including health care clearinghouses, financial institutions, and payment vendors, should not alter or omit any information included in the NACHA CCD+Adenda.

Question: 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 health care EFT payments or ERA using the adopted standards?

Answer: No, while it may be necessary for a provider to work with a business associate that operates on behalf of a health plan, a health plan may not require that a provider agree to receive payment or reassociation services from its business associate (nor may the business associate otherwise require this) as a condition of receiving health care payments using the adopted EFT and ERA standards.

Section 45 C.F.R. § 162.923(c) permits a health plan to use a business associate to conduct all or part of a HIPAA transaction. In the context of EFT and ERA transmission through the ACH network, this could include transmitting a Stage 1 payment initiation to the health plan's financial institution, transmitting ERAs to providers, managing EFT and ERA enrollment processes, and managing late/missing EFT and ERA resolution procedures.

Question: Can a provider engage a business associate of its choice for the purpose of receiving ERAs from the health plan?

Answer: A health plan may not dictate the specific business associate through which a provider must receive ERAs or dictate how a provider conducts reassociation. A provider may engage a business associate or vendor of its choice to receive ERAs from health plans and provide any services the provider may require related to payment and reassociation.

Question: What should the provider do if the health plan does not comply with the provider's request for ACH and or ERAs?

Answer: If after submitting a request to a health plan to conduct health care EFT and ERA transactions using the adopted standards, a provider believes the health plan has failed to use or comply with any of the adopted standards or operating rules, the provider may file a complaint against the health plan with the CMS NSG through the Administrative Simplification Enforcement Testing Tool (ASETT).

Question: Where do I reach out with questions?

Answer: Send inquiries to AdministrativeSimplification@cms.hhs.gov with the subject line: EFT ERA Guidance Question. Questions on other topics related to the adopted standards or operating rules may be sent to this same e-mail address. For more information, visit the CMS Administrative Simplification website at go.cms.gov/AdminSimp. For the latest news about Administrative Simplification, sign up for Email Updates at https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_7834.

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Date: March 22, 2022 GL-2022-04

Subject: **Guidance on health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted HIPAA standards for Health Care Electronic Funds Transfers (EFT) and Remittance Advice (ERA) transactions; 45 Code of Federal Regulations (C.F.R.) §§ 162.1601 and 162.1602(d)**

The Department of Health and Human Services (HHS) is issuing this guidance to clarify requirements for covered entities in conducting electronic transactions using the EFT and ERA standards adopted at 45 C.F.R. § 162.1602(d).

Issues: In lieu of sending paper checks or paying health care claims using adopted EFT and ERA standards, some health plans pay health care claims by sending health care providers a single use credit card number. Providers must manually enter VCC numbers into their Point-of-Sale (POS) processing terminals to receive payments from the card processing networks. Card processing networks typically charge providers fees of a percent value of each payment. When processing various electronic payment methods, health plans often engage with business associates and/or vendors to conduct transactions, or parts thereof, on their behalf. HIPAA covered health care providers have asked:

1. **Do the adopted HIPAA EFT and ERA standards permit health plans to pay claims by VCCs?**
2. **If a health care provider requests that a health plan pay the provider's claims using the adopted HIPAA EFT and ERA standards, must the health plan comply?**
3. **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 condition of receiving EFT or ERA using the adopted standards?**

Background and Key Regulatory Provisions:

45 C.F.R § 162.1601 defines a health care EFT and ERA transaction as the transmission of either of the following for health care:

EFT: The transmission of any of the following from a health plan to a health care provider:
1. Payment.
2. Information about the transfer of funds.
3. Payment processing information.

ERA: The transmission of either of the following from a health plan to a health care provider:
1. Explanation of benefits.
2. Remittance advice.

Several types of electronic payment delivery methods meet the regulatory definition of the EFT transmission, including the transmission of payment through wire transfer, VCC, or the Automated Clearing House (ACH) Network. HHS has only adopted standards that apply to EFT transmissions through the ACH Network. EFT through the ACH Network includes three stages, outlined in the illustration at the end of this guidance letter.

When health plans initiate payment through the ACH Network, the ERA is generally transmitted separately from the

health care payment and processing information.[1] While EFT through the ACH network involves transmission through financial institutions, ERA can be transmitted directly from a health plan to a provider.

HHS adopted the following standards for electronic health care EFT and ERA transactions conducted on and after January 1, 2014:

1. For Stage 1 Payment Initiation[2] transmissions: The National Automated Clearing House Association (NACHA) Corporate Credit or Deposit Entry with Addenda Record implementation specifications (NACHA CCD+Addenda).[3]
2. For the data content of the Addenda Record in the NACHA CCD+ Addenda: The 835, Accredited Standards Committee (ASC) X12 Technical Report Type 3, 835 Segment Detail: "TRN Reassociation Trace Number" (ASC X12 835 TRN Segment Specification).[4]
3. For ERA transmissions: The ASC X12 Technical Report Type 835 (ASC X12 TR3 835).[5]

Together, these standards facilitate "reassociation." Reassociation is the process by which a provider associates the ERA with the EFT payment it describes, and is necessary for posting payments to a provider's accounts receivable system. The ASC X12 TR3 835 standard includes required data content and format for a Reassociation Trace Number (TRN) that health plans must include in all ERA transmissions. The adopted standards for EFT transmissions require health plans to use the same TRN in Stage 1 for payment initiation as they are required to use in the associated ERA transmission.

Although HHS has not adopted standards for Stage 2 transfers of funds or Stage 3 deposit notifications, by mandating consistent format and data elements for health plans to use in Stage 1 payment initiation transmissions, health care providers should receive a TRN in the Stage 3 deposit notification from their financial institution, and that TRN should match the TRN sent with the associated ERA, allowing the provider to reassociate the EFT to the correct ERA.[6]

Analysis:

1. Do the adopted HIPAA EFT and ERA standards permit health plans to pay claims by VCC?

Yes, the adopted HIPAA EFT and ERA standards permit health plans to pay claims by VCC.

When health plans make claims payments through the ACH network, they must do so using the adopted NACHA CCD+Addenda and the ASC X12 835 TRN Segment Specification standards.[7] However, the preamble to the interim final rule with comment period (IFC) adopting the standards required for Stage 1 payment initiation of EFT

[1] While it is technically possible for a health plan to send EFT and ERA combined through the ACH network, the preamble to the interim final rule with comment period adopting health care EFT and ERA standards notes that this infrequently, if ever, occurs. 77 FR 1561.
[2] Stage 1 payment initiation is defined at 45 C.F.R. § 162.103 as "a health plan's order, instruction or authorization to its financial institution to make a health care claims payment using an [EFT] through the ACH Network."
[3] 45 C.F.R. § 162.1602(d)(1)(i)
[4] 45 C.F.R. § 162.1602(d)(1)(ii)
[5] 45 C.F.R. § 162.1602(d)(2)
[6] 77 FR 1565; Although the NACHA Operating Rules for Stage 2 Transfer of funds require the financial institution to deliver the TRN to the provider in a Stage 3 deposit notification, the provider must first request such delivery from their financial institution.
[7] 77 FR 1567

transmissions states, "The health care EFT standards adopted in this [IFC] do not apply to health care claim payments made via EFT outside of the ACH Network. Health plans are not required to send health care EFT through the ACH Network. They may, for instance, decide to transmit a health care EFT via Fedwire or via a payment card network."[8]

HHS has not promulgated HIPAA regulations governing claims payments made with VCCs. Therefore, HHS does not regulate common business practices associated with VCC payments, including fees assessed by health plans or credit card networks for VCC payments.

2. If a provider requests that a health plan pay the provider's claims using the adopted HIPAA health care EFT and ERA transaction standards, must the health plan comply?

Yes, the health plan must comply. 45 C.F.R. § 162.925(a)(1) dictates that if an entity requests that a health plan conduct a transaction as a standard transaction, the health plan must do so.

A provider's request that a health plan make claims payments using the adopted standards may include, for example, requests to: (1) use the adopted NACHA CCD+ Addenda standard to send payment initiation transmissions, (2) include the data content and format identified in the ASC X12 835 TRN Segment Specification in the payment initiation transmissions, and (3) use the adopted ASC X12 TR3 835 standard to transmit ERA information. Section 45 C.F.R. § 162.925(a)(1) provides no exceptions to the requirement that health plans must comply with a request to use the adopted standards. When a provider makes such request, a health plan must comply with all three standards regardless of whether a provider is in the plan's network or otherwise affiliated with the plan.

Note that this requirement applies specifically to ***health plans***. Furthermore, if a health plan uses a business associate to conduct all or part of a HIPAA transaction on its behalf, the health plan must require its business associate to comply with all applicable requirements.[9] This means that any agreement a health plan has with a business associate to make, or assist with making, claim payments on behalf of the health plan does not relieve a health plan of its responsibility to comply with a request to make claims payments using the adopted standards. If a health plan directs providers to work with the health plan's business associate to receive payments from that health plan, and the health plan's business associate is not able to make health care claims payments using the adopted EFT and ERA standards, or is not compliant with the adopted standards, the ***health plan*** may be held accountable for its business associate's noncompliance.[10]

In order to receive EFT payments through the ACH network and receive ERAs, a provider must enroll with each health plan that it bills to conduct EFT and ERA transactions.[11] All EFT and ERA enrollment processes must comply with the adopted operating rules, the Phase III CORE 380 EFT Enrollment Data Rule and the Phase III CORE 283 ERA Enrollment Data Rule.[12] If a provider does not request that the health plan use the adopted standards for EFT and ERA transactions, or requests to use the adopted standards but does not successfully complete a health plan's

[8] Id.; The flexibility extended in the IFC that allows health plans to transmit health care EFT outside the ACH network, without using an adopted standard, does not extend to the ERA portion of the transaction. A health plan must use the adopted ASC X12 TR3 835 standard when electronically transmitting an explanation of benefits or remittance advice regardless of how the EFT is transmitted.
[9] 45 C.F.R. § 162.923(c)
[10] *See* [link to business associates guidance document]
[11] 77 FR 1562
[12] 45 C.F.R. § 162.1603

EFT and ERA enrollment process, the health plan may pay the provider via alternate methods and may send manual explanations of benefits and remittance advice.

Compliance with a provider's request to use the adopted standards for the EFT and ERA transmissions includes the health plan sending Stage 1 payment initiation transmissions that authorize the health plan's financial institution to transmit payment through the ACH network directly to the provider's financial institution, and sending ERA transactions directly to the provider or the provider's business associate.

Under the adopted standards, health plans must also maintain a one-to-one relationship between each ERA and its related EFT.[13] This means that if a health plan sends a Stage 1 payment initiation to its financial institution authorizing payment for one health care claim, the health plan must send an ERA transaction to the provider containing explanation of benefits and remittance information only for that one claim. Similarly, if a health plan sends a Stage 1 payment initiation to its financial institution authorizing payment of several health care claims through one ACH funds transfer, the health plan must send remittance information for all of the claims covered in that Stage 1 payment initiation in one ERA transaction. To facilitate this one-to-one relationship, once a health plan transmits a Stage 1 payment initiation using the NACHA CCD+Addenda standard with the appropriate ASC X12 835 TRN Segment Specification, intermediaries acting on behalf of the health plan, including health care clearinghouses, financial institutions, and payment vendors, should not alter or omit any information included in the NACHA CCD+Adenda.[14]

3. ***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 health care EFT payments or ERA using the adopted standards?***

No, while it may be necessary for a provider to work with a business associate that operates on behalf of a health plan, a health plan may not require that a provider agree to receive payment or reassociation services from its business associate (nor may the business associate otherwise require this) as a condition of receiving health care payments using the adopted EFT and ERA standards.

Section 45 C.F.R. § 162.923(c) permits a health plan to use a business associate to conduct all or part of a HIPAA transaction. In the context of EFT and ERA transmission through the ACH network, this could include transmitting a Stage 1 payment initiation to the health plan's financial institution, transmitting ERAs to providers, managing EFT and ERA enrollment processes, and managing late/missing EFT and ERA resolution procedures.[15] Should a health plan engage a business associate to conduct any of these processes, the health plan may require a provider to work with the health plan's business associate to do so. A health plan cannot dictate from whom or how a provider receives Stage 3 deposit notifications. The content and format of Stage 3 deposit notifications are dependent on the business agreements in place between the provider and the provider's financial institution.[16] A provider may choose to receive deposit notifications directly from its financial institution, or the provider may engage a business associate of its

[13] The Accredited Standards Committee (ASC) X12 Standards for Electronic Data Interchange Technical Report Type 3, "Health Care Claim Payment/Advice (835), April 2006, Washington Publishing Company, 005010X221 , Sections 1.7.1 and 1.10.2.2
[14] 77 FR 1576
[15] EFT and ERA enrollment and late/missing EFT and ERA resolution procedures are governed by the operating rules adopted at 45 C.F.R. § 162.1603
[16] 77 FR 1566

choice to receive deposit notifications from the provider's financial institution.[17] Similarly, a health plan may not dictate the specific business associate through which a provider must receive ERAs or dictate how a provider conducts reassociation. A provider may engage a business associate or vendor of its choice to receive ERAs from health plans and provide any services the provider may require related to payment and reassociation.

Nothing prevents a business associate that operates on behalf of a health plan in conducting Stage 1 payment initiation transmissions from ***offering*** services to a provider related to Stage 3 transmissions or other payment/and or reassociation processes. However, a health plan may not require a provider to accept those services, and parties should be cognizant that any health plan attempt to require a provider to agree to receive unwanted payment or reassociation services from a specific vendor designated by a health plan as a condition of receiving EFT and ERA using the adopted standards may be construed as the health plan adversely affecting the transaction or the provider on the basis that the transaction is a standard transaction. Should a provider desire to receive EFT and ERA using the adopted standards, under 45 C.F.R. 162.925(a)(2), a health plan may not adversely affect, or attempt to adversely affect the provider or the transaction, because the transaction is a standard transaction.[18]

Additional Information

Providers should be aware of any agreements they have in place with each of the health plans they work with related to claims payment terms. If after submitting a request to a **health plan** to conduct health care EFT and ERA transactions using the adopted standards, a provider believes the **health plan** has failed to use or comply with any of the adopted standards or operating rules, the provider may file a complaint against the **health plan** with the CMS NSG through the Administrative Simplification Enforcement Testing Tool (ASETT).

Should you have questions about this guidance, send inquiries to AdministrativeSimplification@cms.hhs.gov with the subject line: EFT ERA Guidance Question. Questions on other topics related to the adopted standards or operating rules may be sent to this same e-mail address. For more information, visit the CMS Administrative Simplification website at go.cms.gov/AdminSimp. For the latest news about Administrative Simplification, sign up for Email Updates at https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_7834.

Sincerely,

Christine Gerhardt
Director, National Standards Group

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[17] HHS did not adopt a standard for the Stage 3 deposit notification, and the NACHA Operating Rules & Guidelines do not require a provider's financial institution to send the provider a deposit notification at the time funds are received. Providers are responsible for ensuring that their financial institution includes all necessary data content and transmit Stage 3 deposit notifications in a format and timeframe that supports the provider's reassociation process.

[18] 42 U.S.C. 1320d–4(a)(1)(B); 45 C.F.R. § 162.925(a)(2)

Illustration