

MGMA GOVERNMENT AFFAIRS

Tips on Automating your Revenue Cycle and Avoiding EFT Fees

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As part of the Affordable Care Act of 2010 (ACA), health plans as of Jan. 1, 2014 are required to offer physician practices the option of receiving their payment via electronic funds transfer (EFT) using the established national standard. This standard is combined with a set of ACA-mandated EFT business conventions known as “operating rules.” In concert with the existing HIPAA standard for electronic remittance advice (ERA) and new ERA operating rules, also required by the ACA, these important components of the practice revenue cycle have been significantly streamlined.

However, as practices have transitioned away from paper checks to EFT in an effort to gain efficiencies, some health plans either charge a fee for EFT, or route their reimbursements through a third-party payment vendor, who then charge the practice a fee for this service.

In an August 2020 MGMA *Stat* Poll, 26% of respondents indicated that they were being charged a fee for their EFT payments, with 51% responding that they were not charged a fee and a further 23% stating that they were unsure. Of those charged a fee for EFT, 16% reported being charged 1%, 42% indicated their fee was 2%, 33% percent stated that they were charged 3%, and a further 8% responded that they were charged 4% or more.

As well, health plans or their payment vendors can offer payment via a “virtual” credit card (VCC) in lieu of a paper check or offer this as an alternative payment method if the practice opts not to receive payment via EFT with fees. The VCC is typically a 16-digit one-time use credit card that is mailed, emailed, or faxed to the practice for payment of medical services. Practices, of course, are required to pay merchant credit card fees (typically 3-5%) for each VCC transaction.

Despite the advocacy efforts of MGMA and other provider organizations to prohibit these unfair business practices, the government has still not issued guidance prohibiting these actions.

This toolkit is designed to provide assistance to practices that are making the decision to move to EFT by offering action tips to push back against fees charged by health plans or their payment vendors.

THE BENEFITS OF EFT PAYMENTS

There are a number of benefits that practices can realize from moving to EFTs and away from paper checks. These include:

- No check handling costs incurred (staff opening mail, posting amount, going to the bank to deposit paper checks or via bank apps)
- Speedy, near-instant processing time
- Fully encrypted with SSL 128-bit data
- Easy to track payments
- Reduced days in accounts receivable
- Payments are less prone to misplacement or theft
- Supports automated payment posting via the practice management system software
- Facilitates automated reassociation with the ERA transaction

Even health plans realize significant benefits by issuing payments via EFT as they can eliminate all costs associated with check production and mailing.

Adoption of EFT by providers is growing. The new [2019 CAQH Index](#), released Jan. 21, 2020, estimates that 70% of medical claim payments were made electronically. That is an increase of seven percentage points from the 2018 Index. As the Index states, “Electronic adoption for claim payment showed the greatest increase from the prior report compared to the other reported transactions for the medical industry.”

THE CHALLENGE OF EFT FEES

Practices report incurring percentage-based fees by health plans or their designated third-party payment vendors processing the standard EFT transaction. (Note that there are also reports from practices that fees are being imposed on ERA transactions.) Many large commercial health plans are in the process of eliminating paper checks and require their contracted practices to accept EFT or VCCs. As the healthcare industry increasingly phases out paper checks for claims payment, practices in certain plan networks find themselves left with no other option but to “pay to get paid.”

While use of the standard EFT/ERA transaction promotes efficiency and should be encouraged, MGMA believes health plan policies requiring network providers to contract with vendors who charge percentage-based fees to process the EFT/ERA transaction

are inappropriate. While it is within the right of any payment vendor to offer “value-added” services, these should be optional and the practice given the choice of receiving the EFT without any fees. Health plans or their contracted payment vendors should not require providers to incur such fees as the only method to receive EFT payments.

EFT ENROLLMENT TIPS

1. **Review your current payment environment and determine EFT workflow.** The first step in moving forward with EFT is reviewing how you are currently paid by your health plans. Depending on your practice and plan mix, you may be paid now using different formats (i.e., some checks, some VCCs). For low volume health plans, you may decide that it is cost-effective to continue being paid via paper check or even VCC. For larger volume plans, EFT typically will be beneficial.
2. **Discuss EFT with your bank.** When communicating with your bank, determine how they will notify you when a health plan EFT has been received. The bank can also assist you in identifying the “Trace Number” used to reassociate the EFT payment with the ERA. As well, discuss bank account options. For example, some practices are concerned that providing a health plan their ABA routing and account numbers could lead in plans debiting the account for a perceived overpayment without practice authorization. While plans typically do not debit accounts without practice authorization, the practice can open a “sweep” account that immediately transfers EFT deposits into a separate account.
3. **Review the [CAQH EnrollHub website](#) to determine if your health plans are enrolled.** EnrollHub is a CAQH solution that simplifies and streamlines the EFT and ERA enrollment processes by allowing providers to upload their EFT information one time and permit their designated health plans to access it. There is no cost for providers to submit their EFT enrollment information.
4. **Complete and submit all enrollment information.** While the ACA operating rules require that health plans support an online EFT enrollment process and standardize many of the EFT enrollment data elements, individual health plan processes may vary. Ensure that you complete the EFT enrollment process accurately to speed up the approval process.

ACTION STEPS FOR HEALTH PLAN IMPOSED AND VENDOR “VALUE-ADDED” EFT SERVICE FEES

1. **Determine the EFT policies of your contracted health plans and those plans you are considering contracting with.** Do they, for example, stipulate any fees associated with their EFT payments? Do they route payments through a third-party payment vendor, and if they do, does this vendor impose fees on EFT transactions?
2. **Review each plan’s EFT agreement.** Review each plan or plan-designated payment vendor’s agreement. Do they stipulate fees for value-added services (such as a “800” help line)? What, if any, payment options does the agreement offer? For example, some contracts permit the practice to select paper checks in lieu of EFT payments with fees. Others require the practice to accept a VCC if you refuse the EFT option.
3. **Complain to your health plan if they are imposing EFT fees.** There are reports that some practices have been successfully removing EFT fees by simply calling and complaining about these fees to their health plans.
4. **Consider inserting a no EFT provision in your health plan contract.** If you have ability to offer contractual language during your negotiation process with your health plan, consider inserting the following language:

Compensation and Payment. *The compensation due Provider for Covered Services provided to a Covered Person (“Compensation Amount”) will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the plan in which the Covered Person is enrolled or otherwise participates. Subject to the terms of this Agreement, Payor agrees to pay, and Provider agrees to accept, the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less only applicable copayments, cost-sharing or other amounts that are the Covered Person’s financial responsibility under the applicable plan. Provider agrees to receive payment through utilization of standard automated clearing house network electronic funds transfer (ACH-EFT) transactions. Payor agrees to pay Provider directly through ACH-EFT) or to route the payment through a payor-designated payment vendor. To ensure compliance with applicable laws and regulations, including but not limited to 42 CFR 169.925, the parties expressly agree that Payor*

*shall bear all costs, if any, associated with making such ACH-EFT payments either directly or via a payor-designated payment vendor to ensure that the net amount received by Provider is not less than the Compensation Amount determined under the applicable Compensation Schedule.**

(Note: this is sample contract language and may need to be modified to meet the specific needs of your organization and your relationship with your health plan.)

Lodging a complaint to the government

Experiencing unlawful or unfair actions from health plans? Consider lodging an official complaint to CMS. If you believe your health plan (or its designated payment vendor) is acting in an unlawful way (i.e., refusing to support EFT) or imposing unfair fees, you can lodge a complaint directly to CMS using its [**Administrative Simplification Enforcement and Testing Tool**](#). Note: complaints can be submitted anonymously.

Legal Disclaimer

** This sample EFT payment provision is provided to MGMA members for their individual use in evaluating and negotiating fair payment terms in contracts with commercial payors. It is not intended to be used collectively by providers in payor negotiations, and MGMA disclaims any liability in connection with its unauthorized use. Payor contracts with providers are subject to a variety of state and federal laws and regulations, and MGMA does not warrant or represent that this sample provision would be compliant in every instance.*

The background of the entire page is a grayscale image of a hand holding a smartphone. Overlaid on the phone's screen and extending into the background is a digital globe. A network of white dots connected by thin lines surrounds the globe. Scattered throughout this network are several white dollar signs (\$) and small white icons of people. The background is divided into three horizontal bands: a dark gray top band, a teal middle band, and a dark gray bottom band. The teal band contains the contact information. The bottom right corner features the MGMA logo and name.

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