DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and State Operations**

SMD# 09-004
ARRA # 4

July 30, 2009

Dear State Medicaid Director:

This letter provides guidance with respect to the "prompt pay" requirements contained in section 5001(f)(2) of the American Recovery and Reinvestment Act of 2009 (ARRA, Public Law 111-5), under which States must comply with timely claims processing requirements in the Medicaid program, or potentially lose their eligibility for the increased Federal medical assistance percentage (FMAP) for certain expenditures. More detailed technical guidance is attached to this letter.

On February 17, 2009, President Obama signed ARRA into law. Section 5001 of ARRA provides eligible States with significant increases in their respective FMAPs, which are used for the purpose of determining the amounts of Federal funds available to States for their medical assistance expenditures under the Medicaid program. These increases will be effective for a period of 9 calendar quarters between October 1, 2008, and December 31, 2010. Under the ARRA increased FMAP provision, there are a number of requirements and conditions that States must meet in order to continue to be eligible under ARRA for the increase in their FMAPs or for the increase in the FMAPs to be applicable to certain expenditures in their Medicaid programs during this period.

Section 5001(f)(2) of ARRA provides that the increased FMAP is <u>not</u> available "for any claim received by a State from a practitioner . . . for such <u>days</u> during any period in which the State has failed to pay claims in accordance with" the timely processing of claims standards as referenced at section 1902(a)(37) of the Social Security Act (the Act), and in implementing Federal Medicaid regulations (at 42 CFR 447.45(d)). Under ARRA, with respect to <u>practitioners</u> the prompt pay provision only applies "to claims made for covered services <u>after</u> the date of enactment." Since ARRA was enacted on February 17, 2009, the increased FMAP is not available for any practitioner claims received by a State on such day(s), beginning with February 18, 2009, that the State is not in compliance with the prompt pay provision. As described below and in the Appendix to this letter, in accordance with the applicable timely processing standards, claims received prior to February 18, 2009, will be considered in determining compliance with these standards, beginning on February 18, 2009.

Furthermore, ARRA also requires that beginning <u>after a grace period</u> ending May 31, 2009, the prompt pay standards as applicable to practitioner claims will also be applicable with respect to <u>hospital and nursing facility</u> provider claims, insofar as such claims are paid on the basis of submission of claims from such providers.

Under title XIX of the Act and Federal Medicaid regulations at 42 CFR 447.45(d) in effect prior to the enactment of ARRA, and which continue to be in effect, there are two prompt pay standards referenced by the ARRA prompt pay provisions which are applicable to claims (as specified in the regulation) that are received from practitioners on or after February 18, 2009:

- 90 percent of clean claims received by the State must be paid within 30 days of receipt.
- 99 percent of clean claims received by the State must be paid within 90 days of receipt.

Note, that, under the ARRA legislation, the provider claims which are used to determine compliance with the prompt pay standards are separate and distinct from the provider claims that are received on days of non-compliance with the prompt pay standards. The claims received on the days of non-compliance are not eligible for the increased FMAP. These are not the claims that are reviewed to determine compliance. This is discussed in the technical appendix.

Under section 5001(f)(2)(a)(ii) of ARRA, States are required to report their compliance with the prompt payment provisions on a quarterly basis to the Centers for Medicare & Medicaid Services (CMS). CMS will develop and provide guidance for an expenditure report format such that States will be able to identify and report to CMS on the quarterly expenditure report Form CMS-64 the amounts of expenditures for those provider claims received on days of non-compliance with the prompt pay standards. Although reporting will be on a quarterly basis, the State will need to be able to identify relevant provider claims on a daily basis so as to be able to report them quarterly to CMS.

If you have questions regarding this guidance, please contact Mr. Richard Strauss, Acting Deputy Director, Financial Management Group, who may be reached at (410) 786-2019.

Sincerely,

/S/

Cindy Mann
Director

Enclosure

cc:
CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Barbara W. Levine
Chief, Government Relations & Legal Affairs
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State health Policy