



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 not available “for any claim received by a State from a practitioner . . . for such days 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 practitioners the prompt pay provision only applies “to claims made for covered services after 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 after a grace period ending May 31, 2009, the prompt pay standards as applicable to practitioner claims will also be applicable with respect to hospital and nursing facility 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:

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PROMPT PAYMENT IMPLEMENTATION GUIDANCE**A. Determining Compliance Under the ARRA Prompt Pay Provisions: Definitions**

1. Compliance Determined for a Day. Section 5001(f)(2) of ARRA requires compliance with respect to the two prompt pay claims processing standards which are applicable for determining the days that the “State has failed to pay claims” in accordance with such standards. If compliance with either standard is not met by a State for a day, the increased FMAP is not available for matching any of the State’s expenditures for such provider claims (related to the applicable practitioner, hospital, or nursing facility providers) received by the State on the day (of noncompliance) for which the increased FMAP would otherwise have been available.
2. Compliance Standard is a Percentage. The two prompt pay standards are generally applicable to the relevant universe of “clean” provider claims. The two prompt pay standards are expressed as percentages (90% and 99% as noted previously); accordingly, the basic compliance determination under such standards involves identifying and counting the number of claims within the universe of claims for which a “denominator” and “numerator” is determined. The determining percentages for a State is calculated by dividing the respective numerators associated with each prompt pay standard (that is, the 30 day standard and the 90 day standard) by the denominator related to the universe of clean claims received by the State.
3. Compliance is With Respect to Two Payment Periods. Section 5001(f)(2) of ARRA, the Medicaid statute at section 1902(a)(37) of the Act, and the Medicaid regulations at 42 CFR 447.45(d) characterize compliance with the prompt pay standards on the basis of payment of Medicaid claims within certain timeframes. From that perspective, the prompt pay standards, are defined by two percentages (90 percent and 99 percent) of claims paid within the two respective time periods (30 days and 90 days). The ARRA provision further characterizes compliance with the standards for purposes of the availability of the increased FMAP with respect to the “days” for which the State has failed to pay claims in accordance with the standards. In this regard, compliance with each prompt pay standard is determined with respect to the percentage of claims paid by the end (the last day) of the respective period associated with each standard (day-30 or day-90).

Note, as discussed under Implementation Guidance Item F below, for purposes of determining compliance with the prompt pay provisions, (clean) denied claims are also included; that is, (clean) denied claims are considered and counted in the same way as paid claims in determining whether the compliance standards are met with respect to a particular compliance day.

4. Compliance is With Respect to Claims Received by the State. In accordance with the ARRA prompt pay provision requirements and the existing statutory and regulatory claims processing standards, compliance with the standards is determined with respect to clean claims received by a State, and whether such claims were paid by the State by a particular day in accordance with such standards. In this regard, the date the services are furnished by the provider is not relevant. Some States provide “advance” payments to certain providers such as

hospitals and nursing facilities prior to the actual submission of the associated claims. Such payments should not be considered under the prompt pay provisions as they do not represent claims for purposes of the provision of Federal funds under Medicaid.

5. Compliance is With Respect to the Last Day of the Prompt Pay Period. The compliance/non-compliance day is the day by which payment should have been made in accordance with the respective prompt pay standard(s) applicable to that day as determined under the ARRA and other applicable timely claims processing requirements. In effect, the compliance/non-compliance day is the last day of each of the applicable prompt pay periods; that is, the compliance day is the last day of the 30-day and 90-day periods, respectively.

6. Compliance is with Respect to Medicaid Claims. Determining compliance with section 5001(f)(2) of ARRA should only be with respect to the applicable provider Medicaid claims under title XIX of the Act. Although a State may use the same system to process non-title XIX claims, such as under title V of the Act related to Maternal and Child Health Services or State only Medicaid claims, such claims would not be counted in determining compliance with the ARRA provisions.

B. Determining Compliance Under (Application of) the Prompt Pay Provision

1. Application of the Prompt Pay Standards. In summary, determining compliance with each of the prompt pay standards involves the following factors:

- i. Universe of claims (“clean claims”) are those claims received from the applicable providers (practitioners, nursing facilities, hospitals) on the first day of the 30-day or 90-days period ending with the Compliance Date, for which no additional information from the provider or a third party was required to make payment. “Clean claim” includes a claim with errors originating in a State’s claims system. It does not include a claim from a provider that is under investigation for fraud, abuse, or a claim under review for medical necessity.
- ii. Date of receipt by the State of the provider claim (day-1); generally, this is the actual date on which the claim was received by the State or its fiscal agent.
- iii. Date of payment or denial by the State of the provider claim is the day on which a claim was paid or denied, for example: the date of the check for payment, the date of the payment for such claim is made through an electronic funds transfer (EFT) or that the payment is mailed or otherwise transferred to the provider, or the date on the Explanation of Benefits or denial notice denying the claim.
- iv. Compliance Date for Application of the Timely Processing Standards:
 - Last day of the 30-Day Period (day-30)
 - Last day of the 90-Day Period (day-90)
- v. Percentage for the Timely Processing Standard:
 - 90 Percent (for the 30 Day Period)
 - 99 Percent (for the 90 Day Period)
- vi. Compliance Calculation:

- Denominator is the total number in the universe of claims (clean claims received on day-1 of the applicable compliance period).
- Numerator(s) is the number of claims in the universe of clean claims which are paid (or denied) by the end of the 30-day or 90-day period related to the date of receipt (that is, day-1) for such claims; the end of this period is the Compliance Date (that is, day-30 or day-90). The determination of the numerator would necessarily exclude (not count) claims that were received at the beginning (day-1) of the 30- or 90-day compliance period, but which were still pending (not paid or not determined as denied) by day-30 or day-90.

2. **30 Day/90 Percent Standard.** This is the traditional standard under which 90 percent of the appropriate universe of clean claims received by a State on a day (day-1) from the applicable provider(s) should be paid (or denied) by the State by the end of the 30-day period related to the day-1 date of receipt; compliance is determined with respect to the day that is the end (last day) of the 30-day period related to the date of receipt of the claims (day-30).

Determining Compliance for Day-30. Under this “30 day/90 percent standard”, the day-1 denominator is the total number of clean claims received by a State on day-1 of the 30-day period ending with the (day-30) compliance date. With respect to the universe of claims received by the State on day-1, the total number of those claims paid (or denied) by the end of the 30-day period ending with the compliance date (day-30) is counted; this total number is the “30-day numerator.” If the percentage determined by dividing such day-30 numerator by such day-1 denominator is greater than or equal to 90 percent, the State is in compliance with prompt pay standards on the compliance date (day-30) of the 30-day period. If the 30-day numerator divided by the denominator is less than 90 percent, the State would not be in compliance with the 30-day/90 percent prompt pay standard as of such date. With respect to nursing facility and hospital claims, the first day for which compliance would need to be determined for the 30 day/90 percent standard, is June 30, 2009. (See Item H below for further detail on the first day for which compliance will be determined.)

Example 1. On January 20, 2009, the State received 1,000 clean practitioner claims; in this regard, the 30-day period would start on January 20 (day-1) and end on February 18, 2009 (day-30). In this case, the compliance day is February 18, 2009 (day-30). With respect to this universe of 1,000 clean claims received on January 20, 2009, 910 claims were paid by the State by (no later than) February 18, 2009. In this case, the numerator is 910, the denominator is 1,000, and the compliance percentage is 91 percent (910/1,000). Accordingly, in this example, the State is considered in compliance on the February 18, 2009, compliance date related to the 30 day/90 percent prompt pay standard. February 18, 2009, is the first date for which compliance under the ARRA provisions must be determined.

Example 2. Same facts as presented in Example 1, except that 890 of the 1,000 clean claims received on January 20, were paid by February 18, 2009. In this case, the numerator is 890, the denominator is 1,000 and the percentage is 89 percent (890/1,000). Accordingly, in this example, the State is not in compliance with the 30-day prompt pay

standard on the February 18, 2009, compliance date. Because the State was not in compliance with the prompt pay standard on such date, the increased FMAP would not be available for any practitioner claims received on February 18, 2009 (refer to Section N for details on availability of increased FMAP on non-compliance days). Again, February 18, 2009, is the first potential date that a State may not be in compliance with the prompt pay provisions under the ARRA.

Example 3. On June 1, 2009, the State received 1,500 clean provider claims (comprised of 1,000 practitioner, 200 nursing facility and 300 hospital claims); in this regard, the 30-day period would start on June 1, 2009 (which is day-1, the first date after the “grace period” on which the prompt pay standards apply for nursing facility and hospital claims) and end on June 30, 2009 (day-30). In this case, June 30, 2009, is the first potential compliance date for which compliance is determined for the combined provider claims which include practitioner, nursing facility, and hospital claims (refer to Item H relating to combined provider claims). With respect to this universe of 1,500 clean claims, 1,365 (950 practitioner, 150 nursing facility, and 265 hospital claims) were paid by the State by (no later than) June 30, 2009. In this case, the day-30 numerator is 1,365, the day-1 denominator is 1,500, and the overall paid claim percentage is 91 percent (1,365/1,500). Accordingly, in this example, the State is considered in compliance with the 30 day/90 percent prompt pay standard on June 30, 2009.

Note, in this example, even though by day-30 the State had only paid 75 percent (150/200) of the nursing facility claims, and only 88.3 percent (265/300) of the hospital claims received on day-1 June 1, 2009, when all of these claims are combined with the practitioner claims received on that date and paid by (no later than) June 30, 2009, the State is in compliance on the day-30 June 30, 2009, compliance date.

Example 4. Same facts as presented in Example 3, except that 1,335 (comprised of 885 practitioner, 180 nursing facility, and 270 hospital claims) of the 1,500 clean provider claims received on June 1, 2009, were paid by the day-30 June 30, 2009, compliance date. In this case, the day-30 numerator is 1,335, the day-1 denominator is 1,500, and the percentage is 89 percent (1,335/1,500). Accordingly, in this example, the State is considered not in compliance with the prompt pay standards on the day-30 June 30, 2009, compliance date related to the 30 day/90 percent prompt pay standard.

June 30, 2009, is the first potential day-30 compliance date for which compliance is determined for the combined provider claims which include practitioner, nursing facility, and hospital claims (refer to Item I relating to combined provider claims). In this example, because the State was not in compliance with the 30 day/90 percent prompt pay standard on June 30, 2009, the increased FMAP would not be available for any affected provider claims received on June 30, 2009. This is the first day on which compliance under the ARRA provisions must be met for all providers referenced under ARRA, that is, including practitioner, nursing facility, and hospital claims. Note, that even though the State paid 90 percent (180/200) of the nursing facility claims and 90 percent (270/300) of the hospital claims received on June 1, 2009, by the day-30 compliance date, when all of these claims were combined with the practitioner claims received on

June 1, 2009, and paid by (no later than) June 30, 2009, the State would not be in compliance on the June 30, 2009, compliance date.

3. **90 Day/99 Percent Standard.** This is the traditional standard under which 99 percent of the appropriate universe of clean claims received by a State on a day (day-1) from the applicable provider(s) should be paid (or denied) by the State by the end of the 90-day period related to the day-1 date of receipt; compliance is determined with respect to the day that is the end (last day) of the 90-day period related to the date of receipt of the claims (day-90).

Determining Compliance for Day-90. Under this “90 day/99 percent standard”, the day-1 denominator is the total number of clean claims received by a State on day-1 of the 90-day period ending with the compliance date (day-90). With respect to the universe of claims received by the State on day-1, the total number of those claims paid (or denied) by the end of the 90-day period ending with the (day-90) compliance date is counted; this total number is the “90-day numerator.” If the percentage determined by dividing such numerator by such denominator is greater than or equal to 99 percent, the State is in compliance with prompt pay standards on the compliance date (day-90) of the 90-day period. If the 90-day numerator divided by the denominator is less than 99 percent, the State would not be in compliance with the 90-day 99 percent prompt pay standard as of such date. With respect to nursing facility and hospital claims, the first day for which compliance would need to be determined for the 90 day/99 percent standard is August 29, 2009. (See Item H in this letter for further detail on the first day for which compliance will be determined.)

Both the 30 day/90 percent standard and the 90 day/99percent standard must be met by the State with respect to the end of the 30 day (day-30) and 90 day (day-90) periods, respectively, in order to be considered in compliance with the prompt pay standards on such days (day-30 and day-90).

C. Definition of Applicable Provider Types: Practitioner, Nursing Facility, and Hospital.

None of the Federal requirements at section 5001(f) of ARRA, existing statute under title XIX of the Act, or existing regulations at 42 CFR 447.45 contain an explicit definition for the term “practitioner” or other types of providers for which the prompt pay provisions apply. States have traditionally applied their own definitions and we will continue that policy for purposes of the ARRA prompt pay provision.

Accordingly, each State should apply its existing operational definition(s) of what is (and is not) considered to be a practitioner, nursing facility, and hospital applicable to timely processing of claims, as in effect, and under the conditions for how such definition were applied in the State for purposes of the prompt pay provision as of February 17, 2009, the date of enactment of ARRA.

There are some States, which prior to enactment of ARRA, had not applied an explicit definition of “practitioner” claims; rather such States may have applied the timely processing standards to all provider claims. In such cases, CMS will work with the State to identify an appropriate operational definition of practitioner claims for purposes of the prompt pay provision.

D. Treatment of Claims from Managed Care Organization Subcontractors.

Providers having subcontractual relationships with managed care organizations (MCOs) in a State (which receive a capitated payment under the State Medicaid program, such as Health Maintenance Organizations (HMOs)) do not submit claims to the State; rather, providers which are subcontracted to MCOs forward their claims to the MCOs. Such MCO claims are not submitted to the State, nor are such claims processed by the State. Since the prompt pay provisions only apply to claims received by the State, such MCO claims would not be subject to the prompt pay requirements as such claims are processed by the MCO in accordance with the terms of the contract between the MCO and the subcontracted provider.

E. Compliance Based on Date Claims are Paid, Not Date Claims are Adjudicated.

Date of Adjudication v. Date of Payment. The ARRA prompt pay provision requires that the determination of compliance with such provision be done with respect to the days that the “State has failed to pay claims” in accordance with the prompt pay standards. Typically for many if not all States under the payment system/process, claims are “adjudicated.” In general, this refers to a determination by the State of the disposition of the claim (approved, denied, or otherwise processed), for payment. The adjudication of a claim is distinct from the payment (or denial) of the claim, and in particular, there may be a time lag between when a claim is adjudicated and when payment or (notification of) denial for such claim is actually made by the State for the claim.

The day a claim is adjudicated may be different from the day the claim is actually paid or denied. In particular, the day on which a claim from a practitioner is adjudicated/processed for payment (or denial) by the State may be within the 30-day and/or 90-day period related to the date of receipt from the practitioner, and by which the claim should be paid. However, the day on which the actual payment is made (such as the date on the check, the date of the electronic funds transfer (EFT), the date the payment is mailed or otherwise transferred to the provider, or the date of the Explanation of Benefits/remittance, or denial notice which notifies the provider of the denial of the claims) by the State, may be after the end of the 30/90 day period.

Compliance is Determined Based Only With Respect to the Day the Claim is Paid. The ARRA statute is clear in characterizing compliance with the prompt pay standards with respect to the days claims are paid; it does not refer to the day a claim is adjudicated; rather, it refers to the date of payment. Therefore, only the date of payment for the claim may be used for the purpose of determining the State’s compliance for a particular day; the date of adjudication should not be used for determining compliance with the prompt pay standards. If claims have been adjudicated but not actually paid, they are still considered as unpaid.

Note, for this purpose refer to the treatment of denied claims, as discussed under Item E below.

Because of the way States pay claims, the following are recognized as the day the claim is paid:

- Date on the Check

- Date of the Explanation of Benefits
- Date of Remittance
- For electronic fund transfers, the date the funds are actually deposited in the providers account

For a particular claim, one of these dates may be earlier than another; the State may use the earliest date in that case, as long as there is documentation to support that date. For example, the date that an EFT is actually deposited in a providers account may be earlier than the date of the Explanation of Benefits for such payment; in that case, the State could use the earlier date of deposit which is documented (by the actual deposit).

F. Treatment of Denied Claims.

Many claims are not actually “paid” because such claims are ultimately denied by the State. However, all claims that have been received by the State should be promptly acted upon, including claims that are ultimately denied by the State. In this regard, with respect to the application of the prompt pay standards whether ultimately denied or paid, only “clean” claims (as defined in regulations at 42 CFR 445.47(b)) are considered/counted in determining compliance with the prompt pay standards, since non-clean claims are not considered/counted for purposes of the prompt pay provisions. If the ultimately denied claim is not clean, it would not be counted or considered under this determination. Similarly, if an ultimately paid claim is not clean, it too would not be counted or considered under this determination.

1. Ultimately Denied Claims Should be Considered In Determining Compliance with the Prompt Pay Standards. The ARRA statute explicitly references compliance in the context of when the State “has failed to pay claims.” Because all claims must be acted upon by the State in a timely manner, we do not believe that (clean) denied (or ultimately denied) claims should be excluded from consideration under the prompt pay provisions; rather, all clean claims including denied (or ultimately denied) claims will be considered. Furthermore, this accounts for State resources that have been used to process these (denied) claims on a timely basis.

The following example illustrates the treatment of denied claims:

Example 1. A State receives 1,000 practitioner claims on (day-1) May 1, 2009. On (day-30) May 30, 2009, there are 10 (“clean”) unpaid claims which may ultimately be denied, but which as of such date were not yet adjudicated (denied or otherwise). At that point in time (May 30) these 10 potentially deniable claims which remain unpaid would not be counted or included in the (day-30) numerator as “paid” in determining whether the State was in compliance with the 30 day/90 percent standard; however, such claims would be counted as received by the State on May 1, 2009, and are included in the (day-1) denominator for purposes of determining the paid claim percentage. That is, the compliance test is whether 90 percent of the claims received by the State on May 1 (including the 10 potentially deniable claims) have been paid by the day-30 (May 30).

Note, clean denied claims that had been adjudicated and for which notice was given by (no later than) May 30 are included (and counted as “paid”) in the (day-30) numerator in determining whether 90 percent of the claims received on May 1 were paid by May 30.

As illustrated in the above example, denied claims are considered and counted in the received and “paid” count of claims in determining compliance with the prompt pay standards, and as long as such claims were considered as clean claims.

2. Use the Notification Date For Denied Claims in Determining Compliance. Similar to the process for claims that are ultimately paid, with respect to denied claims there is an adjudication date (when the decision about denying the claim is made) and a notification date. In this case, the date on the official notice of the denial to the provider (including electronic notices) is determinative, not the adjudication date (although, such dates could coincide). In this regard, a denied claim that had only been adjudicated, but for which no notification of denial had been made, would still be considered as unpaid for purposes of counting the total number of paid claims. A denied claim that had been adjudicated as denied and for which notification had been provided is considered as “paid.”

Example 2. Same facts as in Example 1 above except that by May 30, 2009 the 10 potentially deniable claims were actually determined as denied and the providers had received notice of that determination. In that case, the provider notification of denial has occurred and such claims are considered under the 30 day/90 percent standard for paid claims. In that case, the 10 denied or notified claims are counted/included along with the numbers of other claims paid by May 30, 2009, to determine if 90 percent of the claims received on May 1, 2009 were paid by May 30, 2009.

In conclusion, although by definition, a provider will not receive an actual payment for a claim that is “denied” by the State, such claim must still be disposed of, that is, processed, by the State. For denied claims that final disposition of the claim constitutes a determination by the State as to the acceptability for payment of the claims (denial), although the effect is that the payment is \$0. The practitioner/provider would then be notified of the denial determination (decision of no payment). As is the case for claims that are paid by the State, for claims that are denied by the State, there is an adjudication date (when the determination to deny the claim is made) and a notification date (when the provider is provided a notice of the denial decision). Denied claims for which notification has been provided are considered and counted in the same way as claims for which an actual payment is made.

For purposes of determining compliance with the prompt pay standards, the following would be considered as the date of notice of the denial:

- Date on the official notice of denial
- Date on the Explanation of Benefits
- Date on an electronic notice of denial

G. Effective Date for Practitioner Claims v. Effective Date for Nursing Facility and Hospital Claims.

During the “grace period,” the effective date for determining compliance with the prompt pay requirements for a day is different for practitioner claims as compared to nursing facility and hospital claims. Prior to the enactment of ARRA, States were already required to process practitioner claims on a timely basis in accordance with the prompt pay standards already in existence and referenced by ARRA. In contrast, prior to the enactment of ARRA nursing facility and hospital claims were not subject to such prompt pay standards.

Practitioner Claims. Under section 5001(f)(2)(A)(iv) of ARRA, compliance with the prompt pay provision standards applies with respect to practitioner “claims made for covered services after the date of enactment.” Since ARRA was enacted on February 17, 2009, the first compliance day with respect to the prompt pay standards for practitioner claims, begins with February 18, 2009. Therefore, for practitioner claims, February 18, 2009, is the first “day-30” and also the first “day-90” compliance day, which is the end of the 30-day and 90-day periods, respectively, that began prior to February 18, 2009. That is, with respect to the 30-day period, day-1 is January 20, 2009, and day-30 is February 18, 2009; with respect to the 90-day period, day-1 is November 21, 2008, and day-90 is February 18, 2009.

Nursing Facility and Hospital Claims. Under section 5001(f)(2)(B)(ii) of ARRA, with respect to nursing facility and hospital claims, “no period of ineligibility shall be imposed against a State prior to June 1, 2009.” In contrast to practitioner claims, the timely processing statute and regulations in effect prior to the enactment of ARRA and currently, were not applicable for nursing facility and hospital claims. Under the ARRA grace period, States have until June 1, 2009, before compliance would need to be considered for nursing facility and hospital claims. Furthermore, we believe that compliance with the 30-day and 90-day standards is determined with respect to nursing facility and hospital claims that are received on or after June 1, 2009. That is, because of the grace period, compliance for nursing facility and hospital claims would only be determined by counting the number of such claims that were paid by the end of the 30-day period (June 30, 2009) and 90-day period (August 29, 2009) that began on June 1, 2009. This is in contrast with the previously existing (that is, prior to enactment of ARRA) requirement that States should have already been complying with the prompt pay standards for practitioner claims beginning with February 18, 2009.

Effective Compliance Date for Practitioner Claims. With respect to practitioner claims, the first compliance date is February 18, 2009. That is the 30 day/90 percent prompt pay standard is applied with respect to the 30-day period beginning January 20, 2009 (and ending February 18), and the 90 day period beginning November 21, 2008 (and ending February 18, 2009).

Effective Compliance Date for Nursing Facility/Hospital Claims. Because of the “grace period” provision, with respect to nursing facility/hospital claims, the first compliance date is for claims received from such providers beginning on or after June 1, 2009. That is the 30 day/90 percent standard and the 90 day/99 percent standard is applied with respect to the 30- and 90-day periods both beginning June 1, 2009, and ending June 30, 2009, and August 29, 2009, respectively.

H. Date of Receipt of Claims.

Use State’s Operational Protocols For Designation of Date of Receipt. For purposes of determining compliance with the prompt pay provision under ARRA, the “day-1” date of receipt (that is the first day of the 30-day and 90-day periods) for a claim is as designated in accordance with the State’s institutionalized and documented protocols for doing so. In that regard, the designated day-1 date of receipt might differ from the actual day of receipt. For paper claims, the date of receipt should be determined with respect to the date stamp applied to the claim. Some States may designate the day-1 date of receipt of the claim based on the time of day the claim is electronically entered/recognized by the system. The following examples are provided to illustrate various protocols which State may be using for designating the day-1 for the 30- and 90-day period(s):

Example 1. The State employs a 3:00 p.m. cut-off time for claims entered/recognized on a day; claims entered/recognized after that time may be considered received on the following day.

Example 2. A State processes claims on a 24-hour per day basis; under that protocol, claims are date stamped with the exact time and calendar date of receipt, and “day-1” for a claim may be considered by the State to be the calendar day following the calendar day of the date stamp

Example 3. In accordance with the State’s protocol for designating the day-1 date of receipt, if claims are actually received after the end of the workday (and the end of the workday is different and before midnight of the calendar day), the day-1 date of receipt for the claim may be designated or considered as being received on the following calendar day. That is, under the State’s protocol the end of the workday is 6:00 p.m., and claims received after that time are assigned a day-1 date of receipt as the next (calendar) workday.

Example 4. Under the State’s protocol, for claims received on a non-workday (such as a holiday or weekend), the day-1 date of receipt may be designated as the next (calendar) work day.

The State’s protocol for designating dates of receipt must be followed consistently by the State and should not result in more than a single business day difference between the designated date and the actual calendar day of receipt.

I. Combining Practitioner, Nursing Facility, and Hospital Claims in Determining Compliance with Prompt Pay Standards.

As discussed below, in the determination of compliance with the prompt pay standard(s), all practitioner, nursing facility, and hospital clean claims should be combined depending on the date.

Prior to June 1, 2009, the only providers subject to the prompt pay standards are practitioners. Therefore, the relevant question is how should nursing facility and hospital claims as distinct from practitioner claims be treated in the compliance determination. This issue is relevant only to prompt pay provision compliance determinations that are made for days after May 31, 2009, which is the end of the grace period under ARRA.

Furthermore, as indicated above under the effective date discussion (Item G), determining compliance for nursing facility and hospital claims received on or after June 1, 2009, under the 30-day standard would effectively begin on June 30, 2009, (the end of the 30-day period beginning June 1, 2009). With respect to the 90-day prompt pay standard, compliance days begin for nursing facility and hospital claims received on or after August 29, 2009 (the end of the 90-day period beginning June 1, 2009).

With respect to determining compliance with the 30-day prompt pay standard, only practitioner claims that were paid (or denied) by June 29, 2009, must be counted (the next day, June 30, 2009, is the first day by which all claims including nursing facility and hospital claims must be paid in accordance with the 30-day standard). For days prior to June 30, 2009 for the 30 day/90 percent standard, the issue of combining claims for the purpose of determining compliance is inapplicable.

With respect to determining compliance with the 90-day prompt pay standard, only practitioner claims that were paid (or denied) by August 28, 2009, must be counted (the next day, August 29, 2009 is the first day by which all claims including nursing facility and hospital claims must be paid in accordance with the 90-day standard). For days prior to August 29, 2009, for the 90 day/99 percent standard, the issue of combining claims for the purpose of determining compliance is inapplicable.

In summary, beginning June 30, 2009, (for the 30-day standard) and August 29, 2009, (for the 90-day standard), States should combine the numbers of all provider types (practitioners, nursing facility, and hospital) claims in determining compliance with prompt pay standards. With respect to the 30-day prompt pay standard, beginning on June 30, 2009 (the end of the 30 day period beginning June 1, 2009) the numbers of all practitioner, nursing facility, and hospital claims that were paid must be combined in determining compliance with the 30-day prompt pay standard. With respect to the 90-day prompt pay standard, beginning with August 29, 2009 (the end of the 90-day period beginning June 1, 2009) the numbers of all practitioner, nursing facility, and hospital claims that were paid must be combined in determining compliance with the 90-day prompt pay standard.

J. Determining the Claims that are Counted for Purposes of Determining Compliance

1. Limited to Practitioner, Nursing Facility, or Hospital Claims.

With respect to determining compliance with the prompt pay standards, claims that are not from practitioners, nursing facilities, or hospitals are not considered. “Expenditures” which are not paid on the basis of a claim to the State are not considered. These may include:

- As noted above, hospital or nursing facility expenditures that are not paid on the basis of submission of claims would not be included in the determination of prompt pay compliance.
- Disproportionate share hospital payments that are not submitted as claims to the State by the provider would not be considered.
- Certified public expenditures submitted to the State from public facilities to support claims for Federal funding are not claims.

2. Counting Claims Not Eligible for Increased FMAP Under the Prompt Pay Provisions.

All Practitioner, Nursing Facility and Hospital Claims Should Be Counted, Regardless of Whether the Claims Are Matchable at the Increased FMAP. Section 5001(f)(2)(A)(i) of ARRA distinguishes the applicable expenditures for which the increased FMAP is available, from the determination of compliance under the prompt pay standards, and the expenditures which are applicable in making such a compliance determination. The compliance criteria under the prompt pay provision are with respect to “days during any period in which that State has failed to pay claims in accordance with” the prompt pay standards. That is, the compliance determination as to whether the State has paid claims promptly is in accordance with the prompt pay standards referenced under section 1902(a)(37) of the Act.

Compliance is determined with respect to all claims from the types of providers for which the prompt pay standards apply (that is, practitioner claims are initially considered in the aggregate, and then practitioner, nursing facility and hospital claims are aggregated). In this regard, the compliance determination is not with respect to whether the increased FMAP is or is not available for those claims. For example, compliance determinations would include claims for practitioner services for individuals who are eligible based on diagnoses of breast and cervical cancer even though expenditures for those services are matched at the “enhanced FMAP” referenced in section 2105(b) of the Act (which is the applicable Federal matching rate for such services in the Medicaid program). Similarly, compliance determinations would include claims for practitioner-furnished family planning services which are matched at a 90-percent Federal matching rate. All clean claims from practitioners, and nursing facilities and hospitals (with respect to nursing facilities and hospitals, beginning with claims after July 1, 2009) are considered in determining compliance with the prompt pay standards, regardless of whether the increased FMAP is available for such claims.

3. Fiscal Intermediary and Batch Processing Payment Mechanisms.

States often use fiscal intermediaries (FIs) for purposes of processing claims. These contractors often batch and pay claims for/on behalf of the State. Under this arrangement, the issue is how to address the bundling process in terms of what the dates of receipt by the State should be if the claims are initially processed by the FI. There are similar questions/issues by service type. For example, with respect to processing prescription drugs, States may use a “Pharmacy Benefit Manager” (PBMs) to bundle the claims submitted by pharmacies and then forward such claims to the Medicaid agency.

The main issue is how should the date received (by the State or FI), and the date paid (by the State or FI) be determined, for purposes of claims that are processed by the FI. In this respect, the use of FIs or similar administrative/operational processing mechanisms should not be considered as relieving States from complying with the prompt pay requirements, or somehow to be considered as relaxing (increasing) the standards which must be met. In particular, the date the FIs or the State receives the claims from the types of provider claims they are responsible for administering/paying, should be considered the date of receipt by the State for purposes of the determining compliance with the prompt pay standards. Similarly, the date such FIs or the State pay such claims is considered as the date the State paid such claims.

Sub-Issue Batch Processing. Many, if not all States, “batch process” claims; that is, the processing of claims is done on a batch basis, rather than on an individual claim basis. In that regard, there can be some delays in processing the claims because of the batching process; and because of the delays there may be time added to the payment process. This may at times result in delays in “paying” such claims by the end of the 30- or 90-day period. However, there is no authority to allow the prompt pay standards to be revised because a State is using batch processing for claims payment. Consequently, States will have to consider this and make whatever appropriate adjustments to the date of the batch processing to ensure that the prompt pay standards are met.

The date the FIs received the clean claims is considered to be the date of receipt for purposes of determining compliance with the prompt pay provisions. Batch processing by State would not change the dates that must be used in determining compliance with the prompt pay standards.

4. Cross-Over Claims.

Cross-over claims, that is, claims for dual (Medicare/Medicaid) eligible individuals received by a Medicare Administrative Contractor (MAC) or the national Medicare Coordination of Benefits Agreement (COBA) contractor, are first received/processed by such entities. Only after the MAC or the national COBA contractor makes its determination as to payment for such claims are the claims forwarded to the Medicaid agency. For “clean” crossover claims, for purposes of determining compliance with the prompt pay standards, the date of receipt by the Medicaid agency should be only when the Medicaid agency receives the claim(s) from the MAC or the national Medicare COBA contractor, as distinct from when such entities received the claim from the practitioner.

Finally, under Medicaid regulations at 42 CFR 447.45(d)(4)(ii), “if a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim.” In effect, such crossover claims should not be counted/considered in determining compliance with the 30-day and 90-day prompt pay standards for the purposes of the availability of the increased FMAP under the ARRA prompt pay provisions, since claims may be paid within the separate 6 month standard, as indicated.

Note, MACs or the national Medicare COBA contractor in this context are distinguished from FIs as previously discussed in 3. above. As distinguished from claims processed by MAC or the

national Medicare COBA contractor, FIs are an administrative/operational mechanism available and chosen by the States for paying claims; they are not third parties to the State.

5. Treatment of Nursing Facility Claims.

Section 5001(f)(2)(B)(i) of ARRA indicates that the prompt payment provision is applicable for a nursing facility and hospital claim only “insofar as it is paid under title XIX of the Social Security Act on the basis of submission of claims”

We understand that State payment mechanisms for nursing facilities vary widely and there may be questions as to whether they are based on “submission of claims.” CMS will address these questions on a case-by-case basis after analysis of each State’s circumstances.

K. Waiver of Prompt Pay.

Under section 5001(f)(2)(A)(iii) of ARRA, for purposes of determining the availability of the increased FMAP, the Secretary has discretion to waive the prompt pay claims processing and reporting requirements for a State for periods “in which there are exigent circumstances, including natural disasters, that prevent the timely processing of claims or the submission of such a report.” The ARRA statute does not provide any further definition of the term “exigent circumstances,” and only refers to natural disasters as an example.

Furthermore, the prompt pay regulatory requirements which implement section 1902(a)(37) of the Act also contain provisions related to waiving such requirements. In particular, 42 CFR 447.45(e) permits the CMS Administrator to waive the 30- and 90-day timely processing standards if it is determined that a State “has shown good faith in trying to meet” such standards. This citation indicates that “the Administrator will consider whether the agency has received an unusually high volume of claims which are not clean claims, and whether the agency is making diligent efforts to implement an automated claims processing and information retrieval system.” Under the regulation, a written plan of correction would also be required.

Any waivers of the ARRA prompt pay provisions under ARRA will be considered on a case-by-case basis in accordance with the indicated applicable statute and regulation and the particular facts for each State. Even if a waiver under section 5001(f)(2) of ARRA were granted to a State, CMS would expect the State to work in good faith to pay claims in accordance with the prompt pay requirements under section 1902(a)(37) of the Act and implementing regulations at 42 CFR 447.45. To justify a waiver, CMS may request that the State provide a quarterly report on its ongoing efforts, and degree of success, in complying with the prompt pay requirements.

L. State Reporting.

Section 5001(f)(2)(A)(ii) of ARRA requires States to report compliance with the prompt pay provisions on a quarterly basis with respect to claims received during each month of the preceding quarter. CMS will provide instructions on the reporting of expenditures related to this

provision in a separate communication for purposes of identifying expenditures for claims received on days of non-compliance with the prompt pay provision for which the increased FMAP is not available.

M. Application of “12-Month” Regulatory Requirement Under ARRA Prompt Pay Provisions.

For purposes of the application of the prompt pay provisions under section 5001(f)(2) of ARRA, the regulatory requirement at 42 CFR 447.45(d)(4) does not apply. Under Medicaid regulations at 42 CFR 447.45(d)(4) the “agency must pay all other claims within 12 months of the date of receipt” with certain exceptions. Although States must still comply with this regulatory provision, for example, to ensure that “non-clean” claims must still be processed by the State, within 12 months from the date of receipt (subject to the exceptions indicated in the regulation), such claims would not be included in determining compliance under the ARRA prompt pay provision.

In particular, section 5002(f)(2)(A)(i) of ARRA indicates that a State is not eligible for the increased FMAP rate “subject to the terms of section 1902(a)(37)(A) of the Social Security Act.” In this regard, section 1902(a)(37) of the Act contains reference only to the two timely processing standards discussed above, that is, the “30-day/90 percent standard” and the “90-day/99 percent standard.” Section 1902(a)(37)(A) of the Act does not include reference to the “12-month” regulatory timely processing provision; accordingly, such 12-month requirement is not applicable in determining compliance with the ARRA prompt pay requirement for purposes of the availability of the increased FMAP. That is, the availability of the increased FMAP is not affected by claims processed under the 12-month requirement.

N. Availability of Increased FMAP for Claims Received on Days of Non-Compliance.

Section 5001(f)(2)(A)(i) of ARRA provides that States are not eligible for the increased FMAP for “any claim received by a State from a practitioner subject to the terms of section 1902(a)(37)(A)” of the Act (which contains the prompt pay requirements) on days when the State is not in compliance with those prompt pay standards. As noted above, section 5001(f)(2)(B) applies this same rule to certain hospital and nursing facility claims received after May 31, 2009. Once the day(s) of non-compliance are determined, as described in previous sections, the State must identify/determine the claims received on such day(s) for which the increased FMAP is not available, as well as the claims received on such day(s) for which the increased FMAP is available, in order to ensure that the claims are claimed appropriately at the correct FMAP rate.

Claims for which the increased FMAP would not be available under section 5001(f)(2) are those to which the prompt pay requirements under section 1902(a)(37)(A) apply. Section 1902(a)(37)(A) of the Act establishes requirements for payment of claims “for which no further written information or substantiation is required in order to make payment,” which we refer to as “clean claims” under implementing regulations at 42 CFR section 447.45(b). The increased

FMAP would not be available for such clean claims. The increased FMAP is available for claims received on days of non-compliance with the prompt pay standards that:

- Require further written information or substantiation (are not clean claims).
- Are received from providers for which the ARRA provisions are not applicable, that is, providers other than those meeting the State’s definition of practitioners, nursing facilities, and hospitals.

O. Operational Issues

Treatment of State Claims During Implementation.

Following the enactment of ARRA, some if not all States may need to make changes to their claims processing systems in order to ensure compliance with the ARRA prompt pay provisions. In particular, States’ systems will need to be able to determine compliance on a “by day” basis for the 30-day and 90-day standards for the appropriate provider types/definitions. On days of non-compliance with such standards, States will need to be able to identify the expenditures for all claims received by the State on such days which would be claimable to the Federal Government at the increased FMAP, in order to ensure that such claims would not be claimed at the increased FMAP. For purposes of State claims to the Federal Government for expenditures at the increased FMAP, claims that are not claimable at the increased FMAP would not necessarily need to be identified (this does not address whether such claims should be identified for other purposes).

The ARRA indicates that the increased FMAP is not available for the applicable expenditures in accordance with the applicable effective dates: February 18, 2009, is the first compliance day for the 30-day and 90-day standard for practitioner claims; June 30, 2009, is the first compliance day for the 30-day standard, and August 29, 2009, is the first compliance day for the 90-day standard with respect to nursing facility and hospital claims.

We understand there may be a lag for States in operationalizing this provision, and that the amount of Federal funds for some expenditures may be inappropriately claimed by States at the increased FMAP while the States’ systems are being modified to correctly identify days that they are non-compliant with the prompt pay standard. When a State implements its tracking system after February 18, 2009, it will need to run the system retrospectively back to that date to document and verify prior period claims. We expect that States will make correcting prior period adjustments as appropriate to ensure that all expenditures are claimed correctly in accordance with all ARRA and other Federal requirements.

Relationship to Passive Attestation. All States have been made aware through the “passive attestation” included on the ARRA grant award letters that the Federal funds associated with the increased FMAP provision is not available for the indicated conditions and expenditures provided under ARRA. Under the passive attestation, States understand that their drawing of ARRA increased FMAP funds represents their agreement that they meet such conditions and the expenditures (in this case explicitly related to the prompt pay provisions) for which they are

drawing funds are those for which such funds are available. In this regard, if States were to draw funds at the increased FMAP for which such funds were not available, such funds would need to be returned on a retroactive basis, and any interest or other penalties would apply.

The following example illustrates the reporting of the expenditures with respect to the ARRA prompt pay provisions:

Example. For the quarter ending March 31, 2009, the State was not in compliance with the prompt pay provisions with respect to one day, February 20, 2009. The State received 300 practitioner claims on February 20, 2009, with respect to which it paid the providers for 100 of the claims on or before March 31, 2009, a total computable amount of \$15,000. The States' regular FY 2009 FMAP is 50.00 percent, and its increased FMAP for the second quarter of FY 2009 is 60.00 percent. Because the State was not in compliance with the prompt pay provisions for February 20, 2009, it is not eligible to claim the 300 practitioner claims received on such date at the increased FMAP. With respect to the particulars of this Example, the following scenarios illustrate how the State may report the Federal claim for these expenditures:

- Scenario 1. Under this scenario, the State has put in place a system which has identified and tracked all practitioner claims received on days of non-compliance with the prompt pay provisions and paid during the second quarter of FY 2009. Under the particulars of this example, the State is only eligible to claim the total computable amount of expenditures for claims it received on February 20, 2009, and paid during the second quarter of FY 2009 (\$15,000), at the regular FMAP (50.00 percent). That is, the State is only eligible to claim \$7,500 (\$15,000 x 50.00 percent regular FMAP) for the claims received on February 20, 2009, and paid during the second quarter. Therefore, under this Scenario, in submitting its second quarter FY 2009 expenditure report to CMS, the State would report and claim \$7500 in Federal funds for the \$15,000 in total computable expenditures for the practitioner claims received and paid during the second quarter of FY 2009.
- Scenario 2. Under scenario 2, using the same facts with respect to the available FMAPs as in Scenario 1, the State did NOT have a system in place to identify and track claims received on days of non-compliance with the prompt pay provisions during the second quarter of FY 2009. In the absence of a tracking system, the State claimed the increased FMAP for all expenditures during the quarter. When the State was able to put such a system in place during the third quarter of FY 2009, it used the system to review compliance with prompt pay standards for the prior quarter and determined that it was not in compliance on February 20. Accordingly, under this scenario, with respect to the \$15,000 in total computable expenditures which it had received on February 20, 2009, (the non-compliant prompt pay day) and paid during the second quarter of FY 2009, the State had erroneously reported and claimed such expenditures on the second quarter expenditure report at the increased FMAP, rather than correctly claiming such expenditures at the regular FMAP. That is, the State had erroneously reported the \$15,000 expenditures at the increased FMAP of 60.00 percent and claimed \$9,000

(\$15,000 x 60.00 percent) in Federal share, instead of properly reporting such expenditures at the regular FMAP of 50.00 percent and claimed \$7,500 (\$15,000 x 50.00 percent). Under this scenario, on a retroactive basis the State would need to identify the expenditures it had erroneously claimed at the increased FMAP for practitioner claims received on days of non-compliance with the prompt pay provisions. Under Scenario 2, in submitting its third quarter FY 2009 expenditure report to CMS, the State would need to submit a prior period negative adjustment for the \$9,000 increased FMAP claim that it had previously incorrectly reported on the second quarter FY 2009 expenditure report, and resubmit those expenditures as a prior period (related to the second quarter FY 2009) claim at the regular FMAP for \$7,500.

Further instructions on the proper reporting of expenditures related to the prompt pay provision will be provided in a separate communication.