THE STATE of ALASKA
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Budget-Delayed Medicaid Payments
Frequently Asked Questions

QUESTION	RESPONSE
Why are you delaying some Medicaid payments?	Alaska Medicaid is currently experiencing a budget shortfall, as we have experienced in prior years. The Department of Health and Social Services is closely analyzing Medicaid funding and reallocating as needed.
Did this happen because of Medicaid expansion?	No, this is not related to Medicaid expansion.
Does this apply to all provider types?	At this time we do not know which provider types will be impacted; however the department will make every effort to avoid or reduce the impact on small providers and providers with 100% Medicaid revenue sources. Any payments delayed due to the budget shortfall will be paid within federal timeliness standards.
How long will I have to wait to receive payment for my claims?	All claims will be paid within federally required timeframes. Delays will range from 0 – 3 weeks.
When payments resume, will they be paid in full, or at a reduced amount?	All claims will be paid in full under standard processing rules. Providers will be notified when payments resume.
Should we continue to submit claims, or should we wait until after the first of the new fiscal year?	Please continue to submit claims so that reimbursement can be expedited, once payments resume. Timely filing requirements remain in effect.
Medicaid is the only revenue for my practice/business, and I won't be able to meet payroll or other financial obligations if my payments are delayed. What do I do?	The department will make every effort to avoid or reduce the impact on small providers and providers with 100% Medicaid revenue sources. Any payments delayed due to the budget shortfall will be paid within federal payment timeliness standards.

The letter stated that Alaska Medicaid will remain in full compliance with federal payment timeliness standards. Where are these standards located?	Federal timeliness standards are defined in the Code of Federal Regulations, 42 CFR 447.45(d). **42 CFR 447.45(d) Timely processing of claims.** (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service. (2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt. (3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt. (4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances: (i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system, as defined in §447.272 of this part. (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. (iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse. (iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it. (5) The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. (6) The date of payment is the date of the check or other form of payment.