

Medicaid Standards of Promptness Report 1

(FY2019 Appropriation Act - Public Act 207 of 2018)

February 1, 2019

Sec. 620. (1) *The department shall make a determination of Medicaid eligibility not later than 90 days if disability is an eligibility factor. For all other Medicaid applicants, including patients of a nursing home, the department shall make a determination of Medicaid eligibility within 45 days of application.*

(2) *The department shall provide quarterly reports to the senate and house appropriations subcommittees on the department budget, the senate and house standing committees on families and human services, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the average Medicaid eligibility standard of promptness for each of the required standards of promptness under subsection (1) and for medical review team reviews achieved statewide and at each local office.*



Section 620(2) Report #1
(FY2019 Boilerplate - Public Act 207 of 2018)

Section 620(2) of Public Act 207 of 2018 Report #1 (October 1, 2018 – December 31, 2018) Medicaid Standard of Promptness	
Average Medicaid eligibility standard of promptness when disability is an eligibility factor	91.26%
Average Medicaid eligibility standard of promptness for all other Medicaid applications	96.60%

Section 620(2) of Public Act 207 of 2018 Report #1 (October 1, 2018 – December 31, 2018) Medical Review Team Reviews Processing Time	
Average processing time for medical review team reviews Statewide*	83.01 days
Average processing time for medical review team reviews Central Service Area (Lansing office)	78.00 days
Average processing time for medical review team reviews Detroit Service Area (Detroit office)	91.04 days

*The statewide average is a weighted average based on the caseload of each DDS office.