

Medicaid Standards of Promptness

(FY2018 Appropriation Act - Public Act 107 of 2017)

April 20, 2018

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 report on a quarterly basis 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 #2
(FY2018 Boilerplate - Public Act 107 of 2017)

Section 620(2) of Public Act 107 of 2017 Report #2 (January 1, 2018 – March 31, 2018) Medicaid Standard of Promptness	
Average Medicaid eligibility standard of promptness when disability is an eligibility factor	95.70%
Average Medicaid eligibility standard of promptness for all other Medicaid applications	98.75%

Section 620(2) of Public Act 107 of 2017 Report #2 (January 1, 2018 – March 31, 2018) Medical Review Team Reviews Processing Time	
Average processing time for medical review team reviews Statewide*	110.10 days
Average processing time for medical review team reviews Central Service Area (Lansing office)	88.70 days
Average processing time for medical review team reviews Detroit Service Area (Detroit office)	137.94 days

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