

BENEFITS PACKAGE DOCUMENTATION

SPD FINANCIAL ELIGIBILITY DETERMINATION PROCESS PRESUMPTIVE MEDICAID DISABILITY DETERMINATION TEAM

**Event Id: SPD-05 1.1
VERSION 1.0**

EXECUTIVE SUMMARY OF THE INITIATIVE

SPD Initiative O5 focuses on streamlining the financial eligibility process, which includes presumptive Medicaid determinations. A presumptive Medicaid determination is required when an individual applies for medical assistance (Medicaid) stating they have a disability, no medical coverage and will be unable to generate income by way of working for twelve months or longer. Referrals for a determination are sent by local offices. Because of the need to interpret extensive medical information, these determinations are completed by Disability Analysts within the Presumptive Medicaid Disability Determination Team (PMDDT). PMDDT reviews all available documentation, requests further information or medical exams and determines if the person is eligible for Medicaid coverage due to a disabling condition. Since the individual needs continuing medical care, the sooner a decision can be made the sooner a person will receive, or not receive, medical coverage. Cost savings from this event are from the timeliness of clients obtaining medical coverage or care and are not tracked at this time.

IMPROVEMENT SUMMARY

The Rapid Process Improvement event identified a number of improvement opportunities that are implemented including:

- Revising case assignments made to the first available disability analyst, thus reducing the time from receipt of the application to the time of initial review and to identify if additional medical documentation or exams are needed.
- Revising workspace layout improving communications and access to documents and printers.
- Education of field office staff submitting applications on documents required to support more timely decisions (See Informational Memorandum attached).
- Tracking the three major types of determination processes including those arriving with all required information, those needing additional medical documentation, and those needing additional medical exams.

Prior to the Rapid Process Improvement (RPI) event PMDDT averaged 83 days to make a disability determination¹ with 38% of those taking over 90 days to complete.

Implementation of the action steps from the RPI is increasing the number of completed determinations made within 90 days. As of April, 2009 the average has risen from 62% to 65% and expected to continue to improve with more training being provided in field offices and the April release of the Informational Memorandum.

BENEFIT/OUTCOME DESCRIPTION

Cost/Productivity Savings:

While Federal regulations allow PMDDT to make disability determinations within a 90 day period, applicants dependent upon a Medicaid eligibility decision frequently attempt to delay medical care and treatments to avoid out-of-pocket costs. Additionally, delays in determinations cause increased medical cost to the client and department even after a decision is made in a number of ways²:

- Clients access emergency room care instead of in-office doctor care.
- Clients tend to access the higher cost “fee-for-service” care, while waiting for the determination.
- Untimely determinations results in delayed payment to providers.

Service:

- Reduced cycle time for clients with medical documentation. Goal = 14 days. Actual = 11 days.
- Reduced cycle time for referrals with medical documentation needed. Goal = 45 days. Actual = 45 days.
- Reduced number of steps by 55% from 36 to 20.
- As of April 2009, 65% of all referrals were completed within the 90 days, an increase of 3%.

Quality:

- Anticipated increases in complete applications with the recent release of the first Informational Memorandum with additional follow-up IM’s and training, but not realized yet. As noted above in Service, the time necessary to process an application with full medical documentation is substantially less than when medical documentation or medical assessments are necessary (11 days as compared to 45 or more days).

¹ Client referrals fall into three categories: 1. Clients that bring medical documentation with them, 2. Those that a current treating medical practitioner and the medical record is can be requested, and 3. Those that have not seen a medical practitioner for two or more years.

² These costs are widely recognized but not currently tracked.

People:

- An employee satisfaction survey was conducted 6 months after the RPI reflecting satisfaction levels. Results are still pending.

LOGIC DESCRIPTION

ATTACHMENTS:

Data Spreadsheet

Reinvestment Plan

Informational Memorandum 09-034 released April 8, 2009

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