

Presumptive Eligibility

Medicaid Only

Presumptive eligibility is temporary Medicaid eligibility as determined by a trained qualified entity. This allows individuals to receive needed health coverage and providers to receive payment for services provided before a full Medicaid determination is completed.

Qualified entities include but are not limited to local health departments, hospitals, and tribal health facilities operated by the Indian Health Services. These entities are trained and authorized by the Michigan Department of Health and Human Services (MDHHS).

To be considered a qualified entity, under the regulation at 42 CFR 435.1110(b) (1), the provider must agree to make presumptive eligibility determinations consistent with state policies and procedures.

Application

A streamlined application is used to determine eligibility. Information on the presumptive eligibility application will be self-attested, without the need for verification.

The application consists of a few simple questions such as name, household size and estimated monthly income.

Presumptive eligibility is determined based on gross income reported at the time of the application. Eligibility is determined for an individual whose application is filed online, by a trained qualified entity.

Eligibility Groups

The eligibility groups for which qualified entities determine eligibility presumptively are:

- Pregnant Women
- Infants and children under age 19
- Parents and caretaker relatives
- Adult Group age 19-64

- Former Foster Care Children
- Certain individuals needing treatment for breast and cervical cancer.

Eligibility Period

The presumptive eligibility period begins on the date the determination is made by the qualified entity. The end date of the presumptive period is the earlier of:

- The date the eligibility determination for ongoing Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made: or
- The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

The beneficiary must complete a health care coverage application and receive a determination to avoid losing coverage when the temporary eligibility period ends. This must be completed within 60 days of the date of the presumptive eligibility determination.

Presumptive eligibility is limited to one period of eligibility during any consecutive 12 month period. Pregnant women are limited to one presumptive eligibility period per pregnancy.

Covered Services

Presumptive eligibility benefits for infants, children and adults are the same as those provided under the Medicaid category for which the individual is determined to be presumptively eligible.

Coverage for a pregnant woman is limited to ambulatory prenatal care services only. Covered services include physician visits for prenatal care, prescription drugs related to pregnancy and prenatal laboratory tests.

Legal Base

The Affordable Care Act of 2010 is the collective term for the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act (P. L. 111-152).

42 CFR 435.1110(b) (1).