

Ka 'Upena Kokua



MED-QUEST MEDICAL ASSISTANCE Questions and Answers

This information is intended to give you a summary of the important items to consider if/when you leave State government employment.

Q1: What is Medicaid?

Medicaid is the federal and state medical programs established and administered by the State that provide medical care and long-term care services to eligible individuals in the State under Title XIX, Title XXI and section 1115 demonstration project under Title XVI of the Social Security Act.

Q2: Is Medicaid different from Medicare?

Yes. Medicare is the health insurance program for the aged and disabled administered by the Social Security Administration under Title XVIII of the Social Security Act.

Q3: Who can apply for Medicaid assistance?

Any Hawaii resident who needs medical assistance can apply for medical care and long-term care services with the Medicaid program. However, the individual must be determined eligible for the medical program he or she is applying for in order to receive Medicaid assistance.

Q4: Who is eligible for coverage?

An individual applying for medical assistance must:

- Be a Hawaii resident
- Be a citizen or national of the U.S. or a qualified non-citizen
- Have a social security number
- Not be living in a public institution
- Meet applicable financial eligibility requirements

Q5: What is QUEST and QExA?

Prior to the Affordable Care Act of 2010, also known as “ACA” or “Obamacare”, QUEST was the managed care health coverage program for individuals who were *not* aged, blind or disabled while QExA was the managed care health coverage program for individuals who *were* aged, blind or disabled.

Under ACA, eligible individuals are now placed in their appropriate eligibility group, and will receive medical services based on their specific needs through the health plan they are enrolled in.

Q6: What is the ACA? How do I know what coverage group I am in?

The ACA simplified Medicaid by creating five new groups: Parent and Caretaker Relatives, Adults, Pregnant Women, Children, and Former Foster Care Children. Except for the Former Foster Care Children group, income eligibility for these groups is determined using Modified Adjusted Gross Income (MAGI) methodology, which is the same methodology the Internal Revenue Service (IRS) uses to determine your taxable income. The new groups are called the MAGI groups,

However, if you are applying for assistance on the basis of age (over 65 years), blindness, disability, Medicare cost sharing assistance, or if you receive SSI, you are considered a MAGI-excepted individual and the department will determine your income eligibility for assistance.

You will automatically be placed in the appropriate eligibility group based on the information from your application for medical assistance.

Q7: What are the income limits for medical assistance?

MAGI Groups (except for the Former Foster Care Children group):

- Parent Caretaker Relatives: not more than 100% of the Federal Poverty Level (FPL)
- Adults: not more than 133% of the FPL
- Pregnant Women: not more than 191% FPL
- Children: not more than 308% of the FPL if uninsured.
(If insured, under age 1 year, not more than 185% of the FPL and for age 1-19 years, not more than 133% of the FPL)
- Former Foster Care Children Group has no income or asset limit.

MAGI-Excepted Individuals:

- Not more than 100% of the FPL
- If income exceeds 100% of the FPL, you may qualify with a spenddown if you have enough qualifying medical costs. (i.e. hospital bills, long-term care bills, etc.)
- Individuals applying for long-term care assistance with excess income may contribute up to \$2931(2015 amount) per month as a voluntary contribution to their spouse to help meet their monthly spenddown requirement.

Q8: What are the asset limits for medical assistance?

For MAGI groups:

No asset limits.

For MAGI-Excepted groups:

HH of 1= \$2,000

HH of 2= \$3,000

Additional HH member=\$250

Q9: *How many health plans are available?*

The current health plans are:

- Aloha Care
- HMSA
- Kaiser
- ‘Ohana Health Plan
- UnitedHealthcare Community Plan

Q10: *Do I get to choose the health plan I want?*

If you are determined eligible for medical assistance, you and each family member will be auto-assigned to a health plan to help ensure quick access to services. You will then be given 15 days to choose another health plan if you do not wish to remain in the plan you were assigned to.

Q11: *What types of benefits are covered by the health plans?*

The basic health care benefits covered include necessary medical services, prescription drugs, behavioral health services, vision and dental services that are medically necessary. For qualified individuals, long-term care services in a nursing facility or home and community based care in your own home or in a Community Care Foster Family Home are also provided.

Q12: *Can I choose my own doctor?*

If you have a primary care physician, you will need to check with him/her first to see if he/she is a participating Medicaid provider. If he/she is participating, you will need to find out which plans he/she is participating in, and select the appropriate plan.

Q13: *What happens when I apply for medical assistance?*

After you submit an application for medical assistance, it will be processed. If you have not provided all the information and materials needed to determine your eligibility, you will be contacted. Generally, an interview is not required, unless you are requesting long-term care services, to provide you with the opportunity to ask about the requirements for these services.

Q14: *Once I am enrolled in a health plan, will my eligibility and coverage remain the same throughout my enrollment?*

The State strives to enable beneficiaries to remain in their chosen health plans. However, due to the uncertainties and cuts associated with the State and Federal budgets, there is no guarantee that you will continue to be eligible for the same health plan you are enrolled in or that your coverage will remain the same throughout.

Q15: *How do I apply for medical assistance?*

If you are interested in applying for medical assistance, you can apply on-line at mybenefits.hawaii.gov or you can call or visit the Med-QUEST office nearest you and request an application.

Once you have completed the application, attach the required documents, and mail or fax the application to the Med-QUEST office in your area. If you need assistance to complete your application, call the Enrollment Call Center at 1-888-764-7586.

	<u>PHONE</u>	<u>FAX</u>
<u>Oahu</u>		
Oahu Section	587-3521	587-3543
Kapolei	692-7364	692-7379
<u>Hawaii</u>		
Hilo (East Hawaii Section)	933-0339	933-0344
Kona (West Hawaii Section)	327-4970	327-4975
Maui Section	243-5780	243-5788
Kauai Section	241-3575	241-3583
Molokai Unit	553-1758	553-3833
Toll free number	1-800-894-5755	
Lanai Unit	565-7102	565-6460
Toll free number	1-800-894-5755	

Q16: *What if I don't qualify for medical assistance under Medicaid?*

If your application for Medicaid assistance is denied, your information will automatically be sent for other insurance affordability programs, including advance tax credits and premium assistance. Go to Healthcare.gov or call 1-877-935-9291, Mon-Fri: 4am-5pm, Sat-Sun: 5am-1pm for more information.

NOTE: *This is a brief summary. It is not a legal document or contract, and is subject to change.*

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