**Medicaid Suggestions: February, 14, 2011, Videoconference**

**Oahu**

Disagree with termination of passive renewal.
Implement online renewal process and application process if passive renewal is terminated.
Increase primary and acute care services to decrease ER services.
Decrease in reimbursement rates will erode number of doctors willing to take patients with Medicaid.
Disagree with limited decrease of medical benefits.
Increase partnership with providers. (i.e. less harassment from health plans).
Maintain services that would most likely reduce costs.
Re-bid the QUEST programs.
Maintain outpatient services and generic drugs.
Find all Third Party Liabilities.
Increase access to home and community-based services to decrease use of more expensive programs.
Support through medical homes.
Focus on primary care to decrease use of more expensive programs.
Social issues – social determinants of health and personal accountability.
More primary care.
ER diversion to increase primary care.
Grow primary care and incentivize plans.
More information about where costs are coming from.
Re-bid QExA contract.
Additional revenue – apply for grants through health care reform.
State bureaucracies should cooperate with one another more.
Coordinate services at the grassroots level.
Decrease interference with services due to multiple audits.
Adding requirements that State law does not require.
Higher credentialing not meeting the community needs.
Service provision using case managers.
Empower communities to address their problems at the community level.
Centralization of care provision for high-needs children.
Empty schools to be utilized for high-needs children (magnet schools) and empower parents to be part of program and not adversaries with the State.
Addictive pain therapy should be more closely examined.
Better handle on pharmaceutical companies.
Reconsider residency requirements.
Medicaid buy-in allowing people to go back to work.
Access to care for those in QUEST-ACE and QUEST-Net.
Improve doctor-patient relationship to access care.
Better family planning in QUEST-ACE and QUEST-Net.
Dedicated and coordinated staff to focus on health reform.
Maximize federal funds and look into presumptive eligibility.
Increase incentives to bring more physicians to Hawaii.
Improve the health of the population.
Enhance the patient experience of care.
Reduce or control the per capita cost of care.
The Department continues its role as a safety net for those who do not qualify for prepaid healthcare.
Institute a pay-for-prevention model, incentivizing use of primary care and recommended preventive services.
Continue to coordinate benefits for dual-eligibles.
Hold health plans accountable for the health of their members.

Everything should be on the table. Medicaid can't be a sustainable program by addressing costs and benefits only for a subset of the programs, especially when it is not the most costly part of the system.
Medicaid changes must not result in more people becoming uninsured.
Medicaid changes must not be contrary to tenets of successful health care reform and longer-term strategies.
Changes in Medicaid must not shift the burden of care to essential providers, including FQHCs, hospitals and long-term care facilities.
Recommendation to convene a working group to work on short-, mid- and long-term solutions.
Maintain the services most likely to reduce more costly utilization, such as ER visits and hospitalizations.
Encourage the development of ER diversion programs.
Explore less costly community-based care models for the elderly and disabled.
Explore patient-centered health care homes.
Change the law where EVERY school must provide EVERY service.
Change laws that require people to accept Med-QUEST when they already have private medical insurance, just to receive other assistance help requires insurance to provide needed services that they do not recognize.
If a child is born with a disability, they do not qualify for certain help. – Speech
Need to decrease eligibility – reduce QUEST Expanded population.
Creation of a data registry that tracks patients and their conditions (i.e. diabetes, COPD, CHF, renal failure/CKD) to determine access issues.
DHS to work with DLIR to better enforce the Hawaii Prepaid Healthcare Act and crack down on illegal practices.
Recommend to have additional workers who speak various languages to educate those in the workforce relating their right to healthcare benefits.
Ensure that those most vulnerable (especially in the LEP communities) have access to appropriate services.

**Kauai**
Decreasing reimbursement rates – difficulty in accessing medical care.
Automate or electronic enrollment or phone notices to increase sufficiency/lower costs.

**Maui**
Doctors not participating in certain health plans.
Support pregnancy education.
Co-payments for Med-QUEST patients.
Revisit hiring of out-of-state staff.
Promote businesses to hire individuals with disabilities, enabling them to receive health benefits.
Cover full-time employees with medical benefits for their families.
Mid-level practitioners find it difficult to practice in Hawaii.
No assisted living facilities.
Difficulty getting State approvals.
Permissive residency requirements.
Cost-saving measures: home modifications, tele-health, incentivize, who is at the table (increase participation besides stakeholders) with no conflict of interest.
Focus on prevention.
Need to implement commission on mental health (for planning purposes).
Better coordination among programs for federal grants.
Incentivizing, i.e. QExA recipients.
Chronic disease – self management.
Consider eliminating Evercare and Ohana; use savings to incentivize local insurers (State spent lots of money upfront on Evercare and Ohana; no transition plan in place before the switch to managed care).
Consider increasing taxes an additional 5 percent.
Ensure there are transition plans in place for all DHS programs – especially for major transition events (i.e. youths aging out of system, youths transitioning to adult health and social services).

Consider a shared statewide database system with DHS and DOH.
Improve collaborative partnerships between all departments providing education, health and social services (this can be done through an MOU or Business Partnerships Agreement).
Vulnerable populations assured access to dental and medical homes (especially on Neighbor Islands).
Ensure that purchase of service providers for Executive and Judicial branches have "collaborative partnerships" clause in their contracts (these branches must work together and communicate).

**Kona**

Formulate a single statewide drug formulary.
Co-payments.
Alternative to written correspondence for eligibility renewal.
Less bureaucratic Med-QUEST providers, re-bid health plans.

**Honokaa**

Evaluate impact of cuts and services on families.
Use tele-health for remote care.
Are the QExA plans meeting requirements? Are they audited? Re-bid contracts.

**Hilo**

Need for transportation.
Passive renewal is an issue in the Compacts of Free Association (COFA) population unless assistance is available to help understand the document.
Need mid-level practitioners.
Flat statewide formulary needed.