H.B. NO.

Report Title:
DHS; Med-QUEST Division; Medicaid; Financial Risk-Bearing Entity; Prohibition; Administrative Services Organization; Medicaid; Care Coordination Program; Regional Health Hub; Medicaid Stakeholder Advisory Group; Reports; Appropriation

Description:
Prohibits a financial risk-bearing entity from administering Medicaid services. Requires the Department of Human Services to contract with one or more administrative services organizations to perform non-risk administrative functions for the operation of the State's Medicaid program. Requires the Department to establish a Medicaid Care Coordination Program to contract with community-based programs to provide care coordination services. Requires physicians, other independent practitioners, hospitals, and other institutional providers to be paid or reimbursed directly by the State's medicaid agency. Requires the Department to establish regional health hubs in each county to serve as localized oversight bodies. Requires the Department to convene a Medicaid Stakeholder Advisory Group to support continuous improvement throughout the transition period. Requires reports to the Legislature. Appropriate funds.

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HOUSE OF REPRESENTATIVES
THIRTY-THIRD LEGISLATURE, 2026
STATE OF HAWAII

H.B. NO.

A BILL FOR AN ACT

RELATING TO MEDICAID.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that the administration of medicaid through managed care organizations has contributed to excessive administrative costs, reduced transparency in financial and clinical decision-making, and barriers to timely access to medically necessary care. These outcomes have disproportionately impacted Native Hawaiian communities, rural residents, individuals with complex health needs, and those navigating behavioral health and disability services.

The legislature further finds that a managed fee-for-service model, under which providers are paid directly by the State and care coordination is funded separately, will promote transparency, accountability, and equity. This model will reduce administrative overhead, restore public ownership of medicaid data, and ensure that care decisions are made in the best interest of patients, rather than corporate shareholders.

Accordingly, the purpose of this Act is to:

(1) Prohibit a financial risk-bearing entity from administering medicaid services;

(2) Require the department of human services to contract with one or more administrative services organizations to perform non-risk administrative functions for the operation of the State's medicaid program;

(3) Require the department of human services to establish a medicaid care coordination program to contract with community-based programs to provide care coordination services;

(4) Require physicians, other independent practitioners, hospitals, and other institutional health care providers to be paid or reimbursed directly by the State's medicaid agency;

(5) Require the department of human services to establish regional health hubs in each county to serve as localized oversight bodies; and

(6) Require the department of human services to convene a medicaid stakeholder advisory group to support continuous improvement throughout the transition period.

(7) Appropriate funds.

SECTION 2. Prohibition of risk-based medicare contracts. (a) Beginning July 1, 2026, the department of human services shall not initiate, renew, or extend any contract with a financial risk-bearing entity for the administration of medicaid services. This prohibition shall apply to all programs administered under the State's medicaid agency, including med-QUEST and any successor programs.

(b) All existing contracts with managed care organizations shall terminate no later than December 31, 2026. The department shall support the smooth and orderly transition for enrollees, providers, and administrative systems.

(c) A fiscal intermediary entity shall not receive capitated payments or assume financial risk for medicaid enrollees under any program administered by the State. Medicaid payments for health care services shall be made directly from the State to providers of care on a fee-for-service basis, with care coordination funded separately. Providers of direct care shall not be paid with capitation except for a fixed, predetermined monthly care coordination fee paid to practices designated by a beneficiary as the coordinator of their care.

SECTION 3. Performance of non-risk administrative functions by an administrative services organization. (a) The department shall contract with one or more administrative services organizations to perform non-risk administrative functions necessary for the operation of the medicaid program. These functions shall include but are not limited to:

(1) Prior authorization review to ensure that medically necessary services are approved in a timely and equitable manner. Prior authorization shall be used as judiciously as possible and only for services with a demonstrated risk of non-medically necessary use. As a non-risk contractor, the administrative services organization shall have no financial stake in medical necessity determinations;

(2) Administration of provider credentialing and recruitment to support a robust, culturally competent, and geographically distributed provider network; provided that the state medicaid agency shall retain authority over participation status of individual practitioners with a goal of maintaining as broad a network as possible, excluding only practitioners

found to have engaged in material professional misconduct, including fraud, felony, gross or hazardous negligence, incompetence, or multiple instances of negligence;

(3) Customer service and grievance resolution to assist enrollees in navigating benefits, resolving disputes, and accessing care;

(4) Data analytics and utilization monitoring to evaluate service patterns, identify gaps in care, and support continuous quality improvement;

(5) Claims processing to ensure accurate and timely reimbursement for covered services; and

(6) Administrative support for care coordination programs, including scheduling assistance, documentation infrastructure, and technical support for interdisciplinary teams engaged in patient-centered care and community-based specialist consultations to primary care.

(b) The department shall retain primary responsibility for medicaid administration, provider payment, and oversight of administrative services organizations. The department of health

shall retain authority over public health functions pursuant to section 8 of this Act.

(c) An administrative services organization shall not establish or maintain separate provider networks. Each medicaid enrollee shall access care through a unified statewide provider network that is publicly managed and inclusive of safety-net providers, culturally competent practitioners, and geographically distributed services.

(d) An administrative services organization shall comply with all transparency and data-sharing requirements established by the department, including public reporting of performance metrics, audit results, and stakeholder feedback.

SECTION 4. Medicaid care coordination program. (a) The department shall establish a medicaid care coordination program to contract with community-based programs with interdisciplinary teams to provide care coordination services that can improve health outcomes, reduce unnecessary utilization, and promote culturally responsive care. These services shall include, but are not limited to, patient navigation, transportation services for health care, interdisciplinary care planning, chronic disease management, specialist consultations to primary care,

programs for patients with specialized care needs including for those with serious mental illness and substance abuse disorders, specialized programs for geriatric care needs, behavioral health integration, and culturally competent outreach.

(b) The department shall provide fixed, predetermined care coordination payments to any primary care practice formally designated by a medicaid enrollee as their source of coordinated care. The department shall prioritize models that allow lean primary care practices to collaborate with community-based care coordination teams, ensuring flexibility, cost-effectiveness, and responsiveness to patient needs. Community-based care coordination services shall be funded with budgets from the care coordination program based on cost of operations and community need, and not with capitation based on defined members that would shift insurance risk onto care providers, require risk adjustment, or impose undue administrative burden.

(c) The department shall develop and publish performance metrics to evaluate the effectiveness of care coordination services. These metrics shall include, but shall not be limited to, patient satisfaction, reduction in avoidable

hospitalizations, improved chronic disease management, and culturally appropriate service delivery.

SECTION 5. Provider compensation. (a) Physicians and other independent practitioners shall be paid directly by the state medicaid agency for clinical services provided to medicaid enrollees. Payments shall be made on a fee-for-service basis and shall be equal to at least one hundred per cent of the applicable medicare rates for the same services, adjusted for geographic and practice-specific factors as determined by the department.

(b) In addition to standard fee-for-service payments, the department shall provide a fixed, predetermined care coordination fee to eligible providers for each medicaid enrollee who formally designates that provider or practice as their primary source of coordinated care. This fixed, predetermined care coordination fee shall be drawn from the medicaid care coordination program established under section 4 of this Act.

(c) Hospitals and other institutional providers shall be reimbursed directly by the state medicaid agency through fee-for-service payments. Payment methodologies shall be

designed to promote financial stability, access to essential services, and alignment with the goals of this Act.

(d) All care coordination services, whether provided by independent practitioners, institutional providers, or community-based entities, shall be funded through budgets drawn from the care coordination program. The department shall establish clear guidelines for performance evaluation to ensure that care coordination payments support high-quality, patient-centered, and culturally competent care.

SECTION 6. Regional health hubs. (a) The department of human services shall establish regional health hubs in each county to serve as localized oversight bodies that monitor community health needs, assess disparities in access and outcomes, and facilitate continuous feedback between providers, patients, and the department. Each hub shall be tasked with identifying gaps in service delivery, recommending culturally responsive best practices, and supporting the implementation of care coordination strategies aligned with the goals of this Act.

(b) Each regional health hub shall convene not less than once per calendar quarter and shall include representation from primary care providers, community health workers, behavioral

health specialists, patient advocates, and local public health officials. The department shall ensure that hub membership reflects the geographic, cultural, and linguistic diversity of the region served.

(c) The department shall provide operational funding, technical assistance, and administrative support to each regional health hub. Each hub shall submit an annual report to the department and the legislature summarizing its findings, recommendations, and stakeholder engagement activities.

SECTION 7. Transparency and ownership of data. (a) All contracts entered into by the department with administrative services organizations shall include provisions requiring full compliance with chapter 92F, Hawaii Revised Statutes, the State's Uniform Information Practices Act, and any other applicable laws governing public access to government records and data.

(b) The State shall retain full and exclusive ownership of all medicaid-related data, including but not limited to utilization records, cost reports, provider directories, and enrollee demographics. A private entity shall not assert

proprietary rights over data generated through publicly funded programs.

(c) The department shall develop and maintain a publicly accessible data dashboard that includes de-identified medicaid data for research, oversight, and community engagement. The dashboard shall be updated quarterly and shall include metrics related to access, quality, equity, and cost. The department shall also publish an annual data report summarizing trends, disparities, and recommendations for improvement.

SECTION 8. Department of health public health functions. (a) Public health functions, including vaccination programs, disease surveillance, emergency response coordination, and health education initiatives, shall remain under the direct administration of the department of health. These functions shall not be delegated to any administrative services organization, contractor, or third-party entity.

(b) The department of health shall ensure that public health operations are integrated with medicaid services where appropriate, and that coordination between agencies supports continuity of care, emergency preparedness, and population health management. The department of health shall maintain

staffing, infrastructure, and funding necessary to fulfill its public health responsibilities without reliance on privatized intermediaries.

SECTION 9. The department shall convene a medicaid stakeholder advisory group composed of providers, patient advocates, public health officials, and community leaders to monitor implementation, provide feedback, and support continuous improvement throughout the transition period.

SECTION 10. Annual Reports; budget. (a) The department shall submit a report to the legislature no later than forty days prior to the convening of each regular session beginning with the regular session of 2027. The report shall include detailed information regarding:

(1) Income and expenditures related to medicaid program administration and service delivery, including disbursements from appropriations made to the department for the medicaid care coordination program, including general funds and federal fund, as applicable;

(2) Provider participation and the quality of care provided to medicaid program beneficiaries, including performance metrics and patient outcomes;

(3) Challenges encountered by providers, including physicians, hospitals, and community-based organizations; and

(4) Recommendations for medicaid program improvement, policy adjustments, and legislative support;

provided that the department shall consult with regional health hubs, provider networks, and patient advocacy groups in preparing the report. The report shall be made publicly available and shall serve as a primary tool for legislative oversight and continuous improvement of the medicaid program.

(b) The department shall submit a detailed budget and implementation timeline to the legislature no later than December 1, . The budget shall include projected costs, staffing requirements, technology upgrades, stakeholder engagement plans, and contingency strategies to ensure uninterrupted service delivery during the transition period.

SECTION 11. The department of human services shall apply to the United States Department of Health and Human Services for

any amendment to the state medicaid plan or for any medicaid waiver necessary to implement sections 2 through 7 of this Act.

SECTION 12. As used in this Act:

"Administrative services organization" means an entity contracted by the State to perform administrative functions related to medicaid, including but not limited to claims processing, prior authorization review, provider credentialing and recruitment, customer service and grievance resolution, and data analytics and utilization monitoring, and does not assume financial risk for the cost of medicaid services.

"Care coordination" means a set of services provided by a physician, nurse, community health worker, behavioral health professional, or other licensed provider to ensure that patients receive appropriate, timely, and culturally responsive care across the continuum of health services.

"Department" means the department of human services.

"Financial risk-bearing entity" means any organization that receives capitated payments or assumes financial liability for the costs of medicaid services, including managed care organizations, health maintenance organizations, and other entities operating under risk-based contracts.

"Managed fee-for-service" means a medicaid delivery model in which providers are paid directly by the State through fee-for-service for clinical services, and care coordination is funded through a separate mechanism that does not involve capitation of a risk-bearing fiscal intermediary.

"Medicaid" or "medicaid program" means the joint federal-state program enacted under Title XIX of the Social Security Act of 1935, as amended, that provides medical assistance for adults and children with limited income and resources.

"Regional health hub" means a geographically designated body convened by the department of human services to monitor community health needs, assess equity outcomes, facilitate provider and patient feedback, and recommend best practices for care delivery and access.

"State medicaid agency" means the department of human services, designated as the single state agency responsible for administration of the medicaid program pursuant to Title XIX of the Social Security Act of 1935, as amended, acting directly or through its med-QUEST division.

SECTION 13. There is appropriated out of the general revenues of the State of Hawaii the sum of $ or so much thereof as may be necessary for fiscal year 2026-2027 for:

(1) Transitioning infrastructure and administrative systems from risk-bearing managed care organizations to non-risk administrative services organizations;

(2) Establishing and maintaining the care coordination fund, including provider outreach, enrollment, and performance monitoring;

(3) Developing and supporting regional health hubs, including staffing, meeting facilitation, and reporting functions; and

(4) Expanding provider recruitment, training, and retention programs, with emphasis on culturally competent care and service to underserved populations.

The sum appropriated shall be expended by the department of human services for the purposes of this Act.

SECTION 14. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the

invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 15. This Act shall take effect on July 1, 2026; provided that sections 2 through 7 of this Act shall take effect upon approval of the Hawaii medicaid state plan by the Centers for Medicare and Medicaid Services.

INTRODUCED BY: _____