

JAN 30 2026

A BILL FOR AN ACT

RELATING TO MEDICAID.

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

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

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

16 Accordingly, the purpose of this Act is to:



- 1 (1) Prohibit a financial risk-bearing entity from
2 administering medicaid services;
- 3 (2) Require the department of human services to contract
4 with one or more administrative services organizations
5 to perform non-risk administrative functions for the
6 operation of the State's medicaid program;
- 7 (3) Require the department of human services to establish
8 a medicaid care coordination program to contract with
9 community-based programs to provide care coordination
10 services;
- 11 (4) Require physicians, other independent practitioners,
12 hospitals, and other institutional health care
13 providers to be paid or reimbursed directly by the
14 State's medicaid agency;
- 15 (5) Require the department of human services to establish
16 regional health hubs in each county to serve as
17 localized oversight bodies; and
- 18 (6) Require the department of human services to convene a
19 medicaid stakeholder advisory group to support
20 continuous improvement throughout the transition
21 period.



1 (7) Appropriate funds.

2 SECTION 2. Prohibition of risk-based medicare contracts.

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

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

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



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

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

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





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

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

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

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



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

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

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



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

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

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

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



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

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

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

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



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

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

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

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



1 proprietary rights over data generated through publicly funded
2 programs.

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

10 SECTION 8. Department of health public health functions.

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

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



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

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

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

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



1 (2) Provider participation and the quality of care
2 provided to medicaid program beneficiaries, including
3 performance metrics and patient outcomes;
4 (3) Challenges encountered by providers, including
5 physicians, hospitals, and community-based
6 organizations; and
7 (4) Recommendations for medicaid program improvement,
8 policy adjustments, and legislative support;
9 provided that the department shall consult with regional health
10 hubs, provider networks, and patient advocacy groups in
11 preparing the report. The report shall be made publicly
12 available and shall serve as a primary tool for legislative
13 oversight and continuous improvement of the medicaid program.

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



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

3 SECTION 12. As used in this Act:

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

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

16 "Department" means the department of human services.

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



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

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

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

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



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

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

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

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

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

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

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



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

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

7

INTRODUCED BY: 



S.B. NO. 3306

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.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

