

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 effective oversight
2 of managed care organizations contracted under the State's
3 medicaid managed care program is essential to ensure the proper
4 use of public funds and the delivery of quality health care
5 services to medicaid beneficiaries. The legislature further
6 finds that independent oversight of the department of human
7 services is necessary to verify the department's reporting, data
8 governance, internal reconciliation processes, and its execution
9 of federal program integrity obligations.

10 The legislature believes that transparency, accountability,
11 and program integrity can be strengthened through two distinct,
12 biennial audit tracks conducted by the auditor, consisting of a
13 contractor and provider audit and a department audit.

14 The legislature finds that the contractor and provider
15 audit could examine managed care contractors, their
16 subcontractors, provider networks, encounter and claims data,
17 and external quality review work products. The legislature



1 further finds that the department audit would examine the
2 department of human services and its med-QUEST division's
3 reporting, data governance, internal reconciliation processes,
4 secret shopper implementation, advisory council functioning, and
5 compliance with federal program integrity and reporting
6 obligations. The legislature also finds that each audit track
7 would have a tailored scope, methodology, access, and reporting
8 requirements and that where audits overlap, the auditor would
9 require cross-track reconciliation and coordinated findings.

10 The legislature additionally finds that although the
11 auditor has held statutory authority since 1975 to audit
12 medicaid health care insurance contractors, this authority has
13 not been exercised in a regular, scheduled way. The absence of
14 systematic, periodic audits of the State's medicaid program has
15 left the State vulnerable to undetected mismanagement,
16 diminished quality of care, and erosion of public trust. The
17 legislature further finds that the auditor is authorized to
18 audit state departments, divisions, and offices that administer,
19 oversee, or receive federal or state funds for medicaid
20 programs, including the department of human services and its
21 med-QUEST division. The legislature also finds that for the



1 purposes of this measure's proposed audits, the auditor should
2 have authority to access and examine records, working papers,
3 contracts, data submissions, reporting templates, and supporting
4 documentation, to interview relevant personnel, and to
5 coordinate audit activities with federal and other state
6 auditors.

7 The legislature finds that the department of human services
8 documented multiple cases of medicaid overpayments in 2021 and
9 2022 attributable to provider ineligibility, payment for
10 noncovered services, and failures of prior authorization
11 controls, resulting in recoupment actions, tax offsets, and
12 court judgments. The legislature further finds that additional
13 examples of medicaid overpayment include payments continued
14 after provider enrollment lapses, claims paid without required
15 prior authorization, and duplicate payments later identified
16 through administrative review, each requiring recovery efforts
17 and, in some instances, civil collection activity.

18 The legislature additionally finds that state-level
19 procurement and contract oversight reviews identified
20 inconsistent encounter data reconciliation practices between
21 contractors and the State, with a memoranda of understanding and



1 interagency correspondence documenting delays and gaps in data
2 exchange and reconciliation protocols. These financial
3 oversight gaps increased the risk of payment errors and hindered
4 timely corrective action.

5 The legislature further finds that a Centers for Medicare
6 and Medicaid Services program integrity review of the State in
7 2023 identified operational weaknesses, including inaccurate
8 encounter reporting, insufficient provider screening, and
9 inadequate reconciliation of capitation versus fee-for-service
10 payments. The legislature believes that these weaknesses create
11 ongoing fiscal and programmatic risk if left unaddressed.

12 The legislature additionally finds that the contracted
13 external quality review report (EQR) states that med-QUEST plans
14 meet the State primary care provider standard and supplies plan-
15 level provider-to-enrollee metrics. State workforce and
16 physician shortage reports identify persistent provider
17 shortages in multiple counties and specialties. The legislature
18 finds that the EQR work product, med-QUEST division reporting
19 templates used to collect contractor data, and related
20 verification activities contain item gaps and procedural
21 interruptions that may materially affect provider capacity



1 conclusions. Because the EQR findings and independent workforce
2 assessments present materially inconsistent representations of
3 provider capacity, and because data collection instruments and
4 verification activities appear to be misaligned or incomplete,
5 the EQR report alone is insufficient to establish reliable
6 provider capacity conclusions for policy or payment
7 determinations. The legislature finds that the department of
8 human services may be reporting incomplete or inaccurate data to
9 federal oversight entities, which could compromise program
10 integrity and hinder effective oversight.

11 The legislature believes that the auditor should prepare
12 and report on the performance of the department of human
13 services with respect to federal and state medicaid
14 requirements, including compliance with reporting requirements;
15 the functioning of required advisory councils; secret shopper
16 surveys; and the existence of a qualified external quality
17 review as required under federal law.

18 The legislature finds that the department of human services
19 has demonstrated recurring failures that warrant an independent
20 auditor review, including documented medicaid overpayments and



1 uneven recovery actions that have not fully protected public
2 funds.

3 The legislature further finds that State and contract
4 oversight materials reveal inconsistent and delayed encounter
5 data reconciliation between contractors and the State, creating
6 risks of payment errors and undermining timely corrective
7 action. Med-QUEST division reporting templates and verification
8 activities contain procedural gaps and interruptions that
9 materially impair conclusions about provider capacity and
10 network adequacy. In addition, there is evidence of incomplete
11 or inaccurate reporting to federal oversight entities, suspended
12 or inadequately executed timely access and secret shopper
13 verification activities, and insufficient provider screening
14 that allows duplicate, inactive, or misclassified provider
15 records. These weaknesses increase the likelihood of improper
16 payments and compromised beneficiary access.

17 The legislature finds that contract oversight shortcomings
18 and data governance failures prevent reliable assessment of
19 managed care performance and obstruct effective remediation.
20 The legislature believes that an impartial, statutorily
21 empowered audit is necessary to identify root causes, reconcile



1 contractor and department records, and recommend remedies to
2 protect program integrity and ensure timely, high-quality care
3 for medicaid beneficiaries.

4 The legislature further finds that multiple states have
5 codified or institutionalized biennial or recurring medicaid
6 audit requirements for contractors and that numerous additional
7 states conduct recurring audits or targeted reviews through
8 their state auditors, medicaid agencies, or inspector general
9 offices. The legislature additionally finds that state auditors
10 in multiple jurisdictions conduct audits of the departments that
11 administer the medicaid program, examining program
12 administration, eligibility and enrollment controls, data
13 governance, federal reporting, and internal recovery and program
14 integrity functions. These departmental audits complement
15 contractor focused audits by validating state processes,
16 reconciling contractor submissions with state reporting, and
17 identifying systemic control weaknesses that require statutory,
18 administrative, or funding remedies.

19 The legislature also finds that state auditors nationwide
20 report hundreds of medicaid audit findings annually, with a
21 substantial percentage being repeat findings, indicating



1 persistent control weaknesses that risk ongoing improper
2 payments and underscoring the value of sustained independent
3 auditing to achieve durable remediation.

4 The legislature further finds that federal payment accuracy
5 reporting estimates medicaid improper payments in the tens of
6 billions of dollars annually, reflecting documentation,
7 eligibility, and payment processing vulnerabilities that audits
8 can help detect and correct. The legislature believes that
9 enforcement and recovery activity by medicaid fraud control
10 units demonstrates that a portion of improper payments is the
11 result of prosecutable provider fraud. Strengthened state
12 auditing and program integrity controls would materially support
13 recoveries, exclusions, and deterrence of medicaid fraud.

14 The legislature further finds that the Medicaid Program
15 Integrity Manual, published by the Centers for Medicare and
16 Medicaid Services, underscores the importance of audits in
17 identifying fraud, waste, and abuse and calls for proactive
18 collaboration between auditors and state agencies to ensure
19 program integrity. Regular, risk informed audits are a
20 recognized control that supports accurate payments, eligibility



1 determinations, appropriate utilization management, and timely
2 corrective action.

3 The legislature believes that the aforementioned two
4 distinct biennial medical program audits--a contractor and
5 provider audit and a department audit--conducted by the auditor
6 are necessary to ensure financial integrity, compliance with
7 federal and state regulations, appropriate utilization and
8 delivery of services, and the delivery of high-quality health
9 care. These audits will restore transparency, reinforce public
10 trust, and strengthen the efficacy of the State's medicaid
11 managed care program.

12 Accordingly, the purpose of this Act is to require the
13 auditor to conduct a separate biennial audit for all medicaid
14 health care insurance contractors and the department of human
15 services and its med-QUEST division.

16 SECTION 2. Chapter 23, Hawaii Revised Statutes, is amended
17 by adding a new part to be appropriately designated and to read
18 as follows:

19 **"PART . REVIEW OF THE STATE MEDICAID PROGRAM**

20 **§23-A Definitions.** As used in this part:



1 "Audit track" means one of the audits established under
2 sections 23-B or 23-C.

3 "Department" means the department of human services.

4 "Encounter data" means data submitted by a medicaid health
5 care insurance contractor to the State that describes services
6 provided to members, including but not limited to dates of
7 service, procedure codes, diagnosis codes, service provider
8 identifiers, units of service, and billed and allowed amounts.

9 "External quality review work product" means the external
10 quality review deliverables produced or retained by contractors
11 or their external quality review vendors.

12 "Medicaid health care insurance contractor" means any
13 managed care organization, prepaid health plan, or other entity
14 under contract with the department of human services to provide
15 medicaid managed care services, whether directly or through
16 subcontract, including wholly-owned subsidiaries, related
17 parties, or third-party administrators that perform claims
18 adjudication, care management, or network administration
19 functions.

20 "Overpayment" means any funds disbursed or paid by the
21 State that are in excess of the amount due and payable under



1 program rules, contract terms, or applicable law, including
2 payments made to ineligible providers, for noncovered services,
3 for duplicate claims, or due to calculation errors.

4 "Program integrity" means the processes, controls, and
5 systems used to detect, prevent, and recover improper payments,
6 fraud, waste, and abuse.

7 "Protected health information" has the same meaning as
8 defined in title 45 Code of Federal Regulations section 160.103,
9 as may be amended.

10 "Reconciliation" means the State's enrollment, payment, and
11 licensure records used to validate contractor encounter
12 submissions.

13 "Risk-based methodology" means a documented approach used
14 by the auditor to prioritize audits based on objective risk
15 indicators including financial exposure, prior findings,
16 complaint and hotline data, contract changes, or other
17 indicators the auditor determines relevant.

18 "Subcontractor" means any entity that has been delegated
19 contractual authority by a medicaid health care insurance
20 contractor to perform services or functions, including but not
21 limited to utilization management, prior authorization, claims



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1 processing, pharmacy benefit management, behavioral health
2 services, long term services and supports, or provider network
3 management.

4 **§23-B Medicaid contractor and provider audit.** (a) The
5 auditor shall conduct at least once every two years a
6 management, financial, performance, and data audit of each
7 medicaid health care insurance contractor, their subcontractors,
8 and provider networks under contract with the department. The
9 first audit shall be conducted no later than January 1, 2027,
10 with the first audit report to be submitted to the governor,
11 legislature, and director of human services no later than twenty
12 days prior to the regular session of 2027.

13 (b) The audits shall:

14 (1) Examine claims and encounter data, provider enrollment
15 and credentialing practices, network adequacy and
16 provider-to-enrollee metrics, external quality review
17 reports and processes, contract compliance, and
18 program integrity safeguards applied by contractors;

19 (2) Review financial management, claims adjudication, and
20 contract compliance by the contractor and its
21 subcontractors;



- 1 (3) Reconcile contractor enrollee rosters and provider
2 lists with med-QUEST enrollment files and state
3 licensure and credentialing records to identify
4 mismatches, duplicates, inactive records, and
5 misclassified providers;
- 6 (4) Reproduce and validate provider-to-enrollee ratio
7 calculations, including sampling frames, weighting
8 methods, and any formulae used to generate plan-level
9 metrics;
- 10 (5) Verify encounter data completeness and accuracy and
11 document data sources, reconciliation steps, provider
12 definitions, and inclusion and exclusion criteria;
- 13 (6) Conduct an independent performance and data audit of
14 the contractor's external quality review work product,
15 including methodological critique and reconciliation
16 with independent workforce data; and
- 17 (7) Produce a public audit report for each contractor and
18 provider audit containing itemized reconciliations,
19 methodological critiques, corrective recommendations,
20 and suggested contractual or statutory remedies.



1 (c) All medicaid health care insurance contractors and
2 their subcontractors shall cooperate with and assist the auditor
3 as needed in conducting the audit, including promptly providing
4 all records, documents, and any other information requested by
5 the auditor in the course of the audit.

6 (d) The auditor shall submit a report of its findings and
7 recommendations to the governor, legislature, and director of
8 human services no later than twenty days prior to the convening
9 of the regular session following the year in which the audit is
10 conducted.

11 Each contractor and provider audit report shall be at the
12 plan level, clearly identify contractor responsibilities, and be
13 made publicly available with redactions only as required by law.
14 Each report shall include an executive summary that identifies
15 which entity or entities are subject to the auditor's
16 recommendations, cross referenced reconciliations where
17 applicable, office of the auditor budget utilization, and a
18 timetable for recommended corrective actions. The auditor shall
19 provide notice to any affected contractor of major findings no
20 later than thirty days before public release.



1 (e) The auditor may conduct additional audits as deemed
2 necessary based on risk assessments or at the request of the
3 governor, legislature, or director of human services. The
4 auditor may initiate expedited audits for credible allegations
5 of fraud, waste, or abuse. Initiation criteria, scope, and
6 timelines for expedited reviews shall be documented in the
7 auditor's published audit schedule.

8 **§23-C Medicaid department audit.** (a) The auditor shall
9 conduct at least once every two years a management and
10 performance audit of the department and its med-QUEST division.
11 The first audit shall be conducted no later than January 1,
12 2027, with the first audit report to be submitted to the
13 governor, legislature, and director of human services no later
14 than twenty days prior to the regular session of 2027.

15 (b) The audits shall:

16 (1) Examine the department's data governance, internal
17 reconciliation processes, functioning of required
18 advisory councils, contracting oversight practices,
19 and actions taken by the department to detect,
20 recover, and prevent improper payments;



- 1 (2) Review the department's reporting accuracy to federal
2 and state oversight entities, timeliness of
3 submissions, and evidence of internal validation and
4 reconciliation;
- 5 (3) Evaluate med-QUEST division reporting templates, their
6 implementation, and alignment with contractual network
7 adequacy standards;
- 8 (4) Review secret shopper survey design, sampling
9 methodology, implementation protocols, data collection
10 instruments, timeliness of execution, result
11 validation and reconciliation, and documentation of
12 corrective actions;
- 13 (5) Reproduce, where feasible, a statistically valid
14 sample of secret shopper calls or visits and assess
15 whether secret shopper findings were incorporated into
16 contractor oversight and corrective action;
- 17 (6) Assess timely access verification activities,
18 including identification of periods when verification
19 was suspended or materially limited, quantification of
20 verification gaps, and evaluation of their effect on
21 access conclusions;



1 (7) Review departmental contract oversight practices,
2 provider screening procedures, overpayment detection
3 and recovery processes, and data governance controls;
4 and

5 (8) Produce a public audit report for the department audit
6 containing itemized reconciliations, methodological
7 critiques, corrective recommendations, and suggested
8 statutory, administrative, or funding remedies.

9 (c) The department and its med-QUEST division shall
10 cooperate with and assist the auditor as needed in conducting
11 the audit, including promptly providing all records, documents,
12 and any other information requested by the auditor in the course
13 of the audit.

14 (d) The auditor shall submit a report of its findings and
15 recommendations to the governor, legislature, and director of
16 human services no later than twenty days prior to the convening
17 of the regular session following the year in which the audit is
18 conducted.

19 Each department audit report shall be at the state level,
20 clearly identify department responsibilities, and be made
21 publicly available with redactions only as required by law.



1 Each report shall include an executive summary that identifies
2 which entity or entities are subject to the auditor's
3 recommendations, cross referenced reconciliations where
4 applicable, office of the auditor budget utilization, and a
5 timetable for recommended corrective actions. The auditor shall
6 provide notice to the department of major findings no later than
7 thirty days before public release.

8 (e) The auditor may conduct additional audits as deemed
9 necessary based on risk assessments or at the request of the
10 governor, legislature, or director of human services. The
11 auditor may initiate expedited audits for systemic reporting
12 failures. Initiation criteria, scope, and timelines for
13 expedited review shall be documented in the auditor's published
14 audit schedule.

15 **§23-D Audit methodology; access and evidence; cross-track**
16 **reconciliation; multi-year audit schedule.** (a) The auditor
17 shall perform audits in accordance with generally accepted
18 government auditing standards and shall have authority to review
19 and test contractor and department policies, examine records,
20 interview personnel, use sampling and analytics, and coordinate
21 with federal and state auditors.



1 (b) For contractor and provider audits under section 23-B,
2 the auditor's access shall include, where applicable and subject
3 to lawful protections, contractor claims systems, adjudication
4 logs, subcontractor agreements, pharmacy benefit management
5 records, external quality review vendor working papers, and
6 other contractor evidence necessary to validate contractor
7 submissions.

8 (c) For department audits under section 23-C, the
9 auditor's access shall include department enrollment files, med-
10 QUEST division reporting templates and submission logs, internal
11 reconciliation logs, secret shopper instruments and results,
12 interagency correspondence, and other state records necessary to
13 validate departmental reporting and reconciliation activities.

14 (d) When requested evidence contains protected health
15 information or proprietary contractor materials, the auditor
16 shall obtain appropriate data use agreements and handle the
17 information and materials in accordance with federal and state
18 privacy laws. The auditor shall apply uniform redaction
19 standards and publish a redaction matrix with each public report
20 identifying legal bases for redactions.



1 (e) The Auditor shall develop and publish a multi-year
2 audit schedule no later than , 2026. The schedule
3 shall identify sequencing, projected audit periods, and
4 estimated completion windows for each audit track. The auditor
5 shall use a risk-based methodology to prioritize audits and
6 shall structure the schedule to include coordination windows
7 that require cross track reconciliation for audits addressing
8 the same reporting periods. For matters that overlap both audit
9 tracks, including reconciliation between contractor encounter
10 submissions and department reporting, the auditor shall
11 coordinate findings across tracks, require joint reconciliation
12 workpapers where necessary, and include cross referenced
13 reconciliations in each relevant report.

14 **§23-E Confidentiality; data protection; redaction**
15 **protocol.** (a) The auditor shall handle protected health
16 information in accordance with federal and state privacy laws
17 and obtain necessary data use agreements for secure handling and
18 limited disclosure for both audit tracks.

19 (b) The auditor shall adopt and publish a redaction matrix
20 accompanying each public report that documents the legal
21 authority for each redaction and identifies the supplying party.



1 (c) Where contractor proprietary information is necessary
2 for audit validation but is lawfully protected, the auditor
3 shall require contractors to provide summaries or independent
4 attestations where feasible to preserve audit transparency
5 without disclosing confidential trade secrets.

6 **§23-F Coordination authorization.** (a) The auditor may
7 coordinate audit activities and share nonconfidential findings
8 with federal oversight entities and other state auditors when
9 relevant.

10 (b) For contractor billing practices or claims integrity
11 matters, the auditor shall note federal coordination actions in
12 the contractor audit report under section 23-B. For state
13 reporting, reconciliation, or compliance matters, the auditor
14 shall note federal coordination actions in the department audit
15 report under section 23-C. All coordination actions shall be
16 recorded in the public audit record to the extent permitted by
17 law.

18 **§23-G Response to audit report; follow up reviews.** (a)
19 For department audits pursuant to section 23-C, the director of
20 human services shall provide a written response and corrective
21 action plan within sixty days of report issuance. For



1 contractor and provider audits pursuant to section 23-B,
2 contractors shall provide written responses and corrective
3 action plans within sixty days of report issuance and shall
4 deliver remediation certifications to both the auditor and the
5 department where remediation affects State reporting.

6 (b) Where contractor remediation affects department
7 reporting or federal submissions, the department and contractor
8 shall jointly certify reconciliations and corrective steps
9 within specified timelines established in the auditor's report.

10 (c) The auditor shall include follow up reviews of prior
11 audit recommendations for both audit tracks to verify
12 implementation. Repeat findings of noncompliance or areas of
13 concerns shall be classified and systemic weaknesses
14 highlighted.

15 **§23-H Rules; guidance.** (a) The auditor shall adopt rules
16 pursuant to chapter 91 necessary for the purposes of this part.

17 (b) The auditor shall publish separate guidance annexes
18 for contractor evidence submissions and for department med-QUEST
19 division templates and reconciliation protocols.

20 (c) The auditor, in consultation with the department, may
21 issue guidance on documentation standards, secure data transfer



1 protocols, evidence submission formats, and analytic
2 specifications. The guidance shall not alter statutory or
3 contractual obligations."

4 SECTION 3. There is appropriated out of the general
5 revenues of the State of Hawaii the sum of \$ or so
6 much thereof as may be necessary for fiscal year 2026-2027 for
7 the auditor to:

- 8 (1) Implement a multi-year audit schedule;
- 9 (2) Conduct the provider and contactor audit and
10 department audit under sections 23-B and 23-C, Hawaii
11 Revised Statutes, respectively;
- 12 (3) Procure necessary expertise or consulting services;
- 13 (4) Acquire data analytic tools; and
- 14 (5) Support secure data handling.

15 The sum appropriated shall be expended by the office of the
16 auditor for the purposes of this Act.

17 SECTION 4. If any provision of this Act, or the
18 application thereof to any person or circumstance, is held
19 invalid, the invalidity does not affect other provisions or
20 applications of the Act that can be given effect without the



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Report Title:

Auditor; DHS; Med-QUEST Division; Medicaid; Managed Care Organizations; Medicaid Health Care Insurance Contracts; Management and Financial Audits; Biennial Audit Schedule; Reports; Rules; Guidance; Appropriation

Description:

Requires the State Auditor to conduct audits of Medicaid health care insurance contractors and the Department of Human Services and its Med-QUEST division at least once every two years, with the first audits to be conducted by 1/1/2027, and the reports to be submitted no later than twenty days prior to the Regular Session of 2027. Requires the Auditor to conduct audits. Appropriates funds.

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

