Medicaid Deprivatization Act of 2026

RELATING TO HEALTH

Be it enacted by the Legislature of the State of Hawai‘i:

SECTION 1. Purpose.

The Legislature finds that the administration of Medicaid through managed care organizations (MCOs) has resulted in 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, in 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.

The purpose of this act is to eliminate financial risk-bearing intermediaries from the state's Medicaid program and to establish a publicly accountable, managed fee-for-service system that centers care coordination, community oversight, and health equity.

SECTION 2. Definitions.

As used in this act:

(a) "Administrative Services Organization" or "ASO" 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. An ASO shall not assume financial risk for the cost of Medicaid services.

(b) "Care Coordination" means a set of services provided by physicians, nurses, community health workers, behavioral health professionals, and other licensed providers to ensure that patients receive appropriate, timely, and culturally responsive care across the continuum of health services.

(c) "Department" means the Department of Human Services, unless otherwise specified in this Act. 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 as defined in Section 9 of this Act.

(d) "Financial Risk-Bearing Entity" means any organization that receives capitated payments or assumes financial liability for the cost of Medicaid services, including managed care organizations, health maintenance organizations, and other entities operating under risk-based contracts.

(e) "**Managed Fee-for-Service"** means a Medicaid delivery model in which providers are paid directly by the State for clinical services, and care coordination is funded through a separate mechanism that does not involve capitation or financial risk.

(f) "Medicaid," sometimes referred to in Hawai‘i as "Med-QUEST," means the joint federal-state program enacted under Title XIX of the Social Security Act that provides health insurance coverage for adults and children with limited income and resources. In Hawai‘i, Medicaid is administered by the Department of Human Services through the Med-QUEST Division

(g) "Regional Health Hub" means a geographically designated body convened by the Department to monitor community health needs, assess equity outcomes, facilitate provider and patient feedback, and recommend best practices for care delivery and access.

SECTION 3. Prohibition on Risk-Based Medicaid 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 authority, 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 ensure a smooth and orderly transition for enrollees, providers, and administrative systems.

(c) No entity shall be authorized to receive capitated payments or assume financial risk for Medicaid enrollees under any program administered by the state. All Medicaid payments shall be made on a fee-for-service basis, with care coordination funded separately.

SECTION 4. Establishment of Administrative Services Organization Model.

(a) The department shall contract with one or more administrative services organizations (ASOs) 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;

(2) Provider credentialing and recruitment to support a robust, culturally competent, and geographically distributed provider network;

(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;

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

(b) Administrative services organizations shall not establish or maintain separate provider networks. All Medicaid enrollees 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.

(c) Administrative services organizations 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 5. Care Coordination Program.

(a) The department of human services shall establish a care coordination fund to compensate approved providers for documented care coordination services that improve health outcomes, reduce unnecessary utilization, and promote culturally responsive care. These services shall include, but are not limited to, patient navigation, interdisciplinary care planning, chronic disease management, behavioral health integration, and culturally competent outreach.

(b) The department shall provide flat 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. Payment levels shall be structured to support meaningful coordination without requiring risk adjustment or imposing 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 are not limited to, patient satisfaction, reduction in avoidable hospitalizations, improved chronic disease management, and culturally appropriate service delivery. The department shall report annually to the legislature on fund disbursement, provider participation, patient outcomes, and recommendations for improvement.

SECTION 6. 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 percent (100%) 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 flat 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 flat care coordination fee shall be drawn from the care coordination fund established under Section 6 of this Act.

(c) Hospitals and other institutional providers may be reimbursed through fee-for-service payments, global budgets, or a combination of the two, as determined by the department in consultation with stakeholders. 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 Fund. The department shall establish clear guidelines for eligibility, documentation, and performance evaluation to ensure that care coordination payments support high-quality, patient-centered, and culturally competent care.

SECTION 7. 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 no 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 8. Transparency and Data Ownership.

(a) All contracts entered into by the department with administrative services organizations shall include provisions requiring full compliance with Hawai‘i’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. No private entity shall 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 9. Public Health Continuity.

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.

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

SECTION 10. Appropriations.

(a) The legislature shall appropriate funds necessary to implement the provisions of this Act, including but not limited to:

(1) Transitioning infrastructure and administrative systems from managed care organizations to 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;

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

(b) The department shall submit a detailed budget and implementation timeline to the Legislature no later than December 1, 2025. 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. Annual Reporting and Legislative Oversight.

(a) The department shall submit an annual report to the Legislature no later than December 1 of each year preceding the Regular Session. The report shall include detailed information regarding:

(1) Income and expenditures related to Medicaid administration and service delivery;

(2) The quality of care provided to Medicaid beneficiaries, including performance metrics and patient outcomes;

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

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

(b) 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.

SECTION 12. Effective Date.

This Act shall take effect upon its approval. Full implementation of all provisions shall be completed by January 1, 2027. The department shall submit quarterly progress reports to the Legislature beginning March 1, 2026, detailing milestones achieved, challenges encountered, and adjustments made to ensure fidelity to the goals of this Act.

The department shall also convene a 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.