

The 776-Physician Gap: Why Hawai'i's Doctor Shortage Is a Federal Math Problem

Federal formulas treat the Pacific Ocean like a county line. The result: a 776-FTE shortage, a tax penalty no other state pays, and a network adequacy system built on paperwork instead of access.

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Hawai'i has 3,672 practicing physicians serving 1.4 million residents across six inhabited islands. According to the University of Hawai'i John A. Burns School of Medicine (JABSOM) 2024 Physician Workforce Assessment, the state is short 776 full-time-equivalent physicians. That number is not an estimate from an advocacy group. It is the official count produced by the medical school the state funds to train its workforce.

To put that in perspective, the shortage equals more than 21 percent of the entire practicing physician workforce. No other state, no matter how rural, faces a structural gap of this magnitude. And yet, federal Health Professional Shortage Area (HPSA) designations and Medicare payment formulas continue to treat Hawai'i as if it were a mid-sized mainland market with a mild access problem.

Why Federal Math Fails an Island State

HRSA's HPSA scoring system was designed for contiguous geography. It measures provider-to-population ratios, travel time by road, and population-weighted distances. None of those variables capture what a patient on Lana'i, Moloka'i, or Hana actually experiences: there is no road to the specialist. There is a Cessna, a co-pay, and a day off work.

The result is that islands with single-digit specialist counts, or in some cases zero, do not consistently trigger the federal shortage designations that unlock loan repayment, J-1 visa waivers, and enhanced Medicare reimbursement. The formula does not see what the ocean

does to access.

The GPCI and GET Double Penalty

Medicare's Geographic Practice Cost Index (GPCI) is supposed to adjust physician payments for local cost of practice. Hawai'i's GPCI consistently underweights the true cost of operating a clinic in Honolulu, Hilo, or Kahului, where commercial rent, utilities, and staffing costs rival or exceed San Francisco. CMS public files confirm Hawai'i physicians are reimbursed at rates that do not reflect on-the-ground operating costs.

Layered on top is the Hawai'i General Excise Tax (GET) of 4.712 percent in Honolulu County, applied to gross medical receipts. Unlike a sales tax, the GET is paid by the provider, not the patient, and Medicare does not reimburse for it. Independent analyses estimate the annual statewide GET burden on physician practices exceeds \$200 million. No mainland physician faces this combination.

Network Adequacy Theater

Hawai'i's Medicaid managed care program (QUEST Integration) and commercial insurers file network adequacy attestations with the state Department of Commerce and Consumer Affairs (DCCA) and CMS. On paper, the networks meet standards. In practice, patients wait six to twelve months for a new-patient appointment with a primary care physician on most islands, and longer for behavioral health, dermatology, and rheumatology.

The gap between filed networks and functional access is

the single most actionable transparency problem in the state. CMS-10949 Checkpoint 2.3, the Rural Health Transformation Program metric reporting standard, explicitly requires evidence-based network validation, not self-attestation.

What Decision-Makers Are Not Seeing

Federal and state policymakers receive aggregated reports that flatten island-level reality into statewide averages. A statewide average hides that Moloka'i has zero practicing endocrinologists, that Lana'i has no obstetric services, and that Hana families drive three hours each way for a pediatric specialist visit on Maui. The averages also hide that the practicing physician workforce is aging faster than it is being replaced, with JABSOM projecting accelerating retirements through 2030.

Hawai'i does not need more reports. It needs federal formulas that recognize island geography, a Medicare payment correction that accounts for the GET, and a network adequacy regime that measures actual patient access instead of paperwork compliance.

The Path Forward

Three concrete federal actions would change the trajectory: (1) reclassify Moloka'i, Lana'i, and Hana as Insular Frontier areas to unlock targeted HRSA funding; (2) adjust the GPCI methodology to incorporate the GET as a reimbursable cost of practice; and (3) require independent, claims-based network adequacy validation under CMS-10949 rather than insurer self-attestation.

None of these require new appropriations. They require federal agencies to update formulas that were written for a country that ends at the Pacific coastline.

Sources & Methodology

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