

The Neighbor Island Surcharge

Why a ZIP Code Outside Honolulu Is the Single Strongest Predictor of Delayed Care in Hawai'i

Federal shortage designations cover most of Hawai'i, yet the state continues to allocate workforce, capital, and reimbursement as if the islands were one market. They are not. The data shows a measurable surcharge, in dollars, in days, and in lives, paid by anyone who lives off O'ahu.

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Ask a federal analyst what Hawai'i looks like, and the answer is almost always the same: a small, high-income, high-life-expectancy state with an oversupplied capital and a few rural pockets. The first half is true on O'ahu. The second half is, statistically, the rest of the state. Hawai'i Island, Maui County, and Kaua'i together hold roughly 30 percent of the state's population and produce the great majority of its access failures.

The Health Resources and Services Administration (HRSA) currently designates 100 percent of Hawai'i Island, Maui County, Moloka'i, Lana'i, and Kaua'i as either a Health Professional Shortage Area (HPSA), a Medically Underserved Area (MUA), or both. The University of Hawai'i John A. Burns School of Medicine 2024 Workforce Assessment puts the neighbor-island physician deficit at 38 percent on Hawai'i Island, 33 percent on Maui, and 27 percent on Kaua'i, against an O'ahu deficit of roughly 13 percent. The shortage is statewide. The distribution is not.

What the cost data shows

Center for Medicare and Medicaid Services (CMS) Geographic Practice Cost Index (GPCI) tables treat Hawai'i as a single locality. Every Hawai'i provider, whether practicing in Waikiki or Hana, is paid on the same geographic adjustment factor. The result is that the cost of operating a clinic on Moloka'i, where

supplies arrive by barge, staff housing is scarce, and call coverage requires inter-island flights, is reimbursed identically to a practice on Beretania Street. Operationally, this is a transfer of about 14 to 22 percent of revenue from the neighbor-island provider to the locality average, by the analysis of Hawai'i Health Intelligence Platform (HHIP) using 2024 CMS Physician Fee Schedule data and county-level cost-of-practice estimates from the American Medical Association.

On the patient side, the All-Payer Claims Database (APCD) shows neighbor-island residents incurring a higher share of out-of-pocket travel and lodging costs for care that would, on O'ahu, be a same-day outpatient visit. The Department of Human Services Med-QUEST non-emergency medical transportation (NEMT) line item, which exists specifically to bridge this gap, has grown by more than 60 percent over the past five years and still does not cover the full demand documented in plan grievance filings.

The single-locality problem

CMS revises GPCI localities periodically. In every revision since the 1990s, Hawai'i has remained a single locality. The agency's stated rationale is administrative simplicity and the relatively small population. The same logic, applied to a contiguous mainland state, would split California into three or

four distinct localities, as the agency in fact does. The geography that produces the strongest case for sub-state localities, ocean separation between major population centers, is the geography Hawai'i has.

Splitting Hawai'i into at least two localities, an Honolulu MSA locality and a Neighbor Islands locality, is within CMS's existing administrative authority under the Social Security Act Section 1848(e). It does not require an Act of Congress. It requires a CMS rulemaking decision and a Hawai'i state submission documenting the cost differential. The submission has, to date, not been made.

What HRSA is missing

HRSA shortage scoring drives the National Health Service Corps (NHSC) loan repayment, the J-1 visa Conrad 30 waiver, the Federally Qualified Health Center (FQHC) New Access Point grants, and a half-dozen other federal pipelines. Hawai'i's neighbor islands are scored as shortage areas, but the scoring formula was not designed for the kind of shortage they have.

HRSA HPSA scores weight population-to-provider ratio, percent of population below 100 percent of the Federal Poverty Level, infant mortality rate, and travel time to the nearest source of care. The travel-time component caps at 40 minutes. A patient on Hana whose nearest specialist is in Honolulu does not score 40 minutes. They score 40, the same as a patient on a mainland highway 40 minutes from a regional hospital. The cap erases the actual access gap.

HRSA has the discretion under 42 CFR Part 5 Appendix A to grant 'special consideration' for unusual geographic circumstances. Hawai'i, like Alaska, qualifies on its face. The state has used this discretion for several specific designations. It has not been used systematically. The result is that in the federal pipeline that exists specifically to subsidize providers practicing in shortage areas, the neighbor islands compete for slots against rural counties that are, in operational terms, far easier to serve.

What the workforce data shows

The HHIP workforce reconciliation, which cross-validates NPPES, DCCA active licenses, and Med-QUEST claims activity, shows a quiet but persistent migration of mid-career physicians from neighbor islands to O'ahu, and from O'ahu to the mainland. The pattern is not new. What is new is the speed: between 2021 and 2025, the active-clinical-FTE counts for primary care on Hawai'i Island and Maui declined by 9 and 7 percent respectively, while O'ahu held roughly flat and the resident population on the affected islands grew.

Replacement supply is structurally constrained. JABSOM produces approximately 77 medical school graduates per year. The Hawai'i Residency Programs and the University of Hawai'i system together fund roughly 250 GME positions, the majority on O'ahu. The neighbor-island clinical training footprint, the single strongest predictor of where a physician eventually practices, is small. Expanding it is the single most leveraged workforce intervention available, and it is currently funded at a fraction of what the gap requires.

What this looks like to a patient

A 64-year-old retiree on Moloka'i with a new cardiac arrhythmia receives a same-day primary care visit. The referral to electrophysiology is to Honolulu. The

earliest available consultation is in 11 weeks. The procedure, if recommended, requires two inter-island trips, one for pre-op and one for the procedure itself, plus a post-op follow-up. Each trip is a full day off-island, often with a family member as escort. None of this is captured in the HRSA score, the GPCI adjustment, or the network adequacy filing.

Multiply this case by the roughly 350,000 residents of the neighbor islands, weight it by the prevalence of conditions that require sub-specialty care, and the result is a population-level surcharge that does not appear on any line of any federal budget.

What can change in 18 months

Three actions are within reach without new federal legislation. First, a state submission to CMS requesting a sub-state GPCI locality split for Hawai'i, supported by the cost-of-practice data the state already holds. Second, a HRSA-recognized 'special consideration' designation for the neighbor islands that uncaps the travel-time component for inter-island care. Third, a Med-QUEST contract amendment requiring its five managed care plans to report neighbor-island appointment availability and cost separately from statewide aggregates.

None of these steps closes the workforce gap. They make the gap visible to the federal funders and rule-writers whose decisions the state currently absorbs without amendment. Visibility is the precondition for everything else.

The honest version

Hawai'i's healthcare statistics are reported as a state average, and the state average is shaped by O'ahu. The neighbor islands are not an exception to that average. They are the population that pays for it. Federal and state oversight bodies that have made decisions on the strength of the average have, by and large, made decisions that the average does not justify. Disaggregating the data is not a matter of advocacy. It is a matter of accuracy, and the state has the data to do it.

Where the numbers come from

Every figure cited is drawn from publicly available federal or state data. Independent reconciliation by the Hawai'i Health Intelligence Platform cross-validates NPPES, DCCA license rolls, CMS PECOS, and Med-QUEST encounter data.

1. HRSA Health Professional Shortage Area (HPSA) Designations

Federal shortage scoring methodology. 42 CFR Part 5 Appendix A.

<https://data.hrsa.gov/topics/health-workforce/shortage-areas>

2. HRSA Medically Underserved Areas / Populations (MUA/P) Database

County and tract-level designations covering all Hawai'i neighbor islands.

<https://data.hrsa.gov/tools/shortage-area>

3. UH JABSOM Hawai'i Physician Workforce Assessment (2024)

Statewide and county-level FTE deficit measurements. Source of 38% Hawai'i Island and 776-FTE statewide gap.

<https://www.hawaiidatacollaborative.org/healthcare/physician-workforce>

4. CMS Physician Fee Schedule and GPCI Tables (2024)

Geographic Practice Cost Index. Hawai'i is currently a single locality.

<https://www.cms.gov/medicare/payment/fee-schedules/physician/geographic-practice-cost-index>

5. Social Security Act Section 1848(e)

Statutory authority for CMS to designate sub-state Medicare payment localities.

https://www.ssa.gov/OP_Home/ssact/title18/1848.htm

6. Hawai'i DHS Med-QUEST Annual Reports and NEMT Utilization

Non-emergency medical transportation expenditure trends and grievance filings.

<https://medquest.hawaii.gov/en/resources/reports.html>

7. CMS National Plan and Provider Enumeration System (NPPES)

Public NPI registry used to validate active provider counts by county.

<https://npiregistry.cms.hhs.gov/>

8. CMS PECOS Medicare Provider Enrollment

Active Medicare enrollment status by provider.

<https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment>

9. Hawai'i DCCA Professional and Vocational Licensing

Source of truth for active state medical licensure by county.

<https://pvl.ehawaii.gov/pvlsearch/>

10. AMA Physician Practice Cost Index (2024)

County-level cost-of-practice differentials used in GPCI critique.

<https://www.ama-assn.org/practice-management/medicare-medicaid>

11. CMS Medicare Advantage Network Adequacy Standards

Federal access standards including travel-time exceptions for non-contiguous geographies.

<https://www.cms.gov/medicare/health-plans/healthplansgeninfo/medicareadvantageapps>

12. National Health Service Corps and Conrad 30 J-1 Visa Waiver Program

Federal workforce pipelines tied to HPSA designation.

<https://nhsc.hrsa.gov/>

13. Hawai'i Residency Programs (HRP) and UH GME

Source for statewide GME slot counts and neighbor-island training footprint.

<https://www.hawaiiresidency.org/>

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