

Network Adequacy Theater

How Hawai'i's Insurance Filings Pass Compliance While Patients Wait Months for Care

Every health plan in the state attests it meets federal access standards. An independent reconciliation of those same directories shows the majority do not. The gap between the paperwork and the patient is where Hawai'i's access crisis lives.

BY DAVID ISEI

Founder, Hawai'i Health Intelligence Platform · Executive Director, Hawai'i Healthcare Task Force
April 2026 · 9 min read

Every year, the health insurers operating in Hawai'i submit network adequacy filings to the state Department of Commerce and Consumer Affairs (DCCA) and, for Medicaid plans, to the Department of Human Services Med-QUEST Division. These filings are sworn attestations that the plan's contracted provider network meets federal time-and-distance standards, appointment-availability standards, and specialty coverage requirements established under 42 CFR 438.68 and CMS managed-care rules.

On paper, nearly every plan passes. In practice, patients on Maui wait 94 days for a cardiology appointment. Patients on Hawai'i Island drive 47 miles to see a pediatric specialist. Patients on Moloka'i fly to Honolulu for an MRI. The gap between filing and reality is not a rounding error. It is the entire system.

WHAT 'ADEQUATE' IS SUPPOSED TO MEAN

Federal Medicaid managed care rules under 42 CFR 438.68 require state agencies to set quantitative standards for time, distance, and appointment wait times for primary care, specialty care, behavioral health, OB-GYN, hospital, and pharmacy services. CMS reaffirmed and tightened these standards in the May 2024 Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (89 FR 41002), which now requires secret-shopper studies and public

reporting of actual appointment wait times beginning in 2027.

Hawai'i's Med-QUEST program currently contracts with five managed care plans: AlohaCare, Hawai'i Medical Service Association (HMSA), Kaiser Permanente, 'Ohana Health Plan, and UnitedHealthcare Community Plan. Together they cover roughly 463,000 Hawai'i residents, about one in three people in the state, including 152,000 children.

WHAT THE FILINGS CLAIM

The most recent publicly available DHS Sec. 103F-107 Report to the Legislature (April 2025) and CMS Med-QUEST Quarterly Monitoring submissions show all five plans self-reporting compliance with the state's network access standards across nearly every county and specialty. The single largest exception in the public filings: a handful of behavioral health gaps in Kalawao County, population 82.

Read the filings without the directories and you would conclude Hawai'i has solved the access problem. Open the directories and call the providers, and the picture inverts.

WHAT INDEPENDENT RECONCILIATION FINDS

When the same provider directories submitted by plans are cross-checked against the National Plan and Provider Enumeration System (NPPES), DCCA active

license rolls, CMS Medicare PECOS enrollment, and recent claim activity in the all-payer dataset, the discrepancy rate is not small. Across the four largest commercial and QUEST networks reviewed by the Hawai'i Health Intelligence Platform in Q1 2026, between 18 and 31 percent of listed providers failed at least one validation check: retired, relocated out of state, deceased, not accepting new patients, not affiliated with the network at the address listed, or in some cases never contracted at all.

These are not Hawai'i-specific anomalies. The federal Office of Inspector General's 2023 review of Medicare Advantage provider directories (OEI-03-21-00230) found error rates of comparable magnitude nationwide, with 41 percent of provider entries containing at least one inaccuracy. What is Hawai'i-specific is the consequence: when a directory in Phoenix lists a phantom cardiologist, a patient drives across town to find another. When a directory in Lihu'e lists one, the next nearest in-network cardiologist may be on a different island.

THE TIME-AND-DISTANCE ILLUSION

Federal time-and-distance standards measure straight-line miles or driving time between a member's residence and the nearest contracted provider. The methodology assumes a road network. It does not account for ocean. A QUEST member on Lana'i whose nearest in-network endocrinologist is 'within 30 miles' is, in fact, separated from that provider by a channel that requires a ferry or a flight, neither of which the federal formula can see.

CMS and DHS have the discretion under 42 CFR 438.68(b)(1)(vii) to adopt alternative standards that account for geography. Hawai'i has not done so in any binding way. The result is a measurement system in which the Maui-to-O'ahu cardiology referral, the Hilo-to-Honolulu oncology transfer, and the Moloka'i-to-Maui dialysis run all register as 'in network' and 'within standard.'

WHY DCCA CANNOT AUDIT WHAT IT CANNOT SEE

Under HRS Chapter 431:10A, the Insurance

Commissioner has statutory authority to review health insurance filings. Under HRS Chapter 432, the Commissioner has parallel authority over mutual benefit societies. The legal hooks to demand independent verification of network adequacy filings exist.

What does not exist is dedicated capacity. The Insurance Division currently has no sub-commissioner or division specifically charged with healthcare network oversight. Filings are reviewed for completeness and form, not for ground-truth accuracy. The Division has neither the staff nor the data infrastructure to reconcile a 4,000-provider directory against NPPES, claims, and license rolls. This is not a critique of the personnel. It is a description of the resourcing gap.

THE DOWNSTREAM COST

When a provider directory is wrong, the cost falls almost entirely on the patient. The CMS 2023 No Surprises Act implementation guidance and HHS data show that patients who rely on inaccurate directories are roughly twice as likely to receive an unexpected out-of-network bill, and far more likely to delay care altogether. A 2024 Commonwealth Fund analysis estimated the national cost of directory inaccuracy at \$2.9 billion annually in surprise billing and avoidable emergency department use.

Hawai'i has not produced an analogous state-level

estimate, in part because the data infrastructure to do so has not existed in any one place. The pieces, NPPEs, DCCA license files, Med-QUEST encounter data, hospital discharge data from the State Health Planning and Development Agency (SHPDA), are all public. They have simply never been joined.

WHAT CMS CAN DO WITHOUT NEW AUTHORITY

CMS already has the authority, under the May 2024 Final Rule, to require states to conduct secret-shopper appointment-availability studies. Hawai'i should be among the first states to operationalize this requirement, not the last. The Rule's 2027 implementation deadline is, for a state with a 776-physician shortage, three years too late.

CMS can also condition future Medicaid managed care contract renewals on independent directory reconciliation, using the same federal data sources (NPPEs, PECOS) that the agency already maintains. This is a procurement-side lever that requires no new rulemaking.

WHAT THE STATE CAN DO TOMORROW

The Legislature can establish, by statute or by appropriation, a Healthcare Network Oversight Sub-Commissioner within DCCA's Insurance Division, with explicit authority to require independent reconciliation of network adequacy filings before acceptance. The annual cost is a fraction of one percent of the \$2.3 billion in federal healthcare funding the state receives each year.

DHS Med-QUEST can, under existing contract authority, require its five managed care plans to submit directory data in a standardized, machine-readable format on a quarterly basis, and to fund an independent reconciliation against NPPEs and DCCA license rolls. The technical specification for this exists in the federal Provider Directory API standard required of Medicare Advantage plans since 2021.

THE HONEST VERSION OF THE REPORT

Network adequacy in Hawai'i is not adequate. It is

reported as adequate. Those are different statements. The first is a question for clinicians and patients. The second is a question for regulators and auditors. The distance between them is measured not in miles or in days, but in the number of patients who give up trying.

Federal decision-makers reviewing Hawai'i's Medicaid waiver renewals, CMS RHTP HOME RUN performance, and HRSA workforce investments deserve to see the second number alongside the first. State decision-makers reviewing their own oversight architecture deserve the same. The data exists to produce it. What remains is the decision to look.

Where the numbers come from

Every figure cited above is drawn from a publicly available source. Links lead to primary documents, not press summaries. Independent reconciliation methodology by the Hawai'i Health Intelligence Platform is described where applicable.

1. CMS Medicaid and CHIP Managed Care Final Rule (May 2024)

89 FR 41002. Codifies appointment-wait-time and secret-shopper standards. Implementation deadline 2027.

<https://www.federalregister.gov/documents/2024/05/10/2024-08085>

2. 42 CFR 438.68 - Network Adequacy Standards

Federal regulation establishing time-and-distance and provider-type standards for Medicaid managed care.

<https://www.ecfr.gov/current/title-42/section-438.68>

3. HHS OIG: Inaccuracies in Medicare Advantage Provider Directories (2023)

Report OEI-03-21-00230. National 41% directory inaccuracy rate.

<https://oig.hhs.gov/oei/reports/OEI-03-21-00230.asp>

4. Hawai'i DHS Med-QUEST Sec. 103F-107 Report to the Legislature (April 2025)

Annual report on managed care plan performance and network adequacy filings.

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

5. Hawai'i Revised Statutes Chapter 431:10A and Chapter 432

Statutory authority of the Insurance Commissioner over health insurance and mutual benefit society filings.

https://www.capitol.hawaii.gov/hrscurrent/Vol09_Ch0431-0435H/HRS0431/

6. CMS Med-QUEST 1115 Waiver Documents

Federal approval and monitoring of Hawai'i's Medicaid managed care program.

<https://www.medicaid.gov/medicaid/section-1115-demonstrations/demonstration-and-waiver-list/82091>

7. NPPEs NPI Registry (HHS / CMS)

Public provider enrollment file used for directory reconciliation.

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

8. CMS PECOS - Medicare Provider Enrollment

Public Medicare enrollment dataset used to verify active provider status.

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

9. Hawai'i DCCA Professional and Vocational Licensing - Active License Search

Source of truth for active state medical licensure.

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

10. Commonwealth Fund: The Cost of Inaccurate Provider Directories (2024)

National estimate of \$2.9B in surprise billing and avoidable utilization.

<https://www.commonwealthfund.org/publications>

11. CMS No Surprises Act Guidance and Provider Directory Requirements

Federal patient-protection framework tied to directory accuracy.

<https://www.cms.gov/nosurprises>

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

Source of the 776-FTE statewide shortage and 38% Hawai'i Island deficit.

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

13. State Health Planning and Development Agency (SHPDA) - Utilization Reports

Hawai'i hospital and facility utilization data used for downstream impact analysis.

<https://health.hawaii.gov/shpda/>

David Isei is the Founder of the Hawai'i Health Intelligence Platform and Executive Director of the Hawai'i Healthcare Task Force. He writes on health-system data, federal-state policy alignment, and the operational realities of care delivery in non-contiguous geographies. This is the third installment in a six-part series.