Follow-Up Study of the Hawaii Health Systems Corporation

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 02-09
April 2002

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds are existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

THE AUDITOR
STATE OF HAWAII
Kekuanaoʻa Building
465 S. King Street, Room 500
Honolulu, Hawaii 96813

OVERVIEW

Follow-Up Study of the Hawaii Health Systems Corporation

Report No. 02-09, April 2002

Summary

In 1996, the Hawaii Health Systems Corporation took over the management, assets, and property rights of the State's community hospitals system from the Division of Community Hospitals in the Department of Health. Act 262, Session Laws of Hawaii 1996, established the Hawaii Health Systems Corporation as a "public body corporate and politic and an instrumentality and agency of the State." The purpose of Act 262 was to provide better health care to people, including those served by small rural facilities, by freeing the corporation's facilities from unwarranted bureaucratic oversight.

Placed within the Department of Health for administrative purposes only, the corporation is organized into five regions based on the counties of Honolulu, Kauai, and Maui, and the eastern and western sections of the county of Hawaii. Governed by a 13-member Board of Directors, which appoints the corporation's president/chief executive officer, the corporation oversees the operations of 12 community hospitals, classified as acute care, long-term care, or rural. The corporation operates over 1,200 licensed beds and employs over 3,000 state workers. In FY1998-99, the corporation's facilities admitted 21,754 inpatients.

The corporation's revenues consist primarily of third party payments, which along with patient copayments are deposited into the Health Systems Special Fund. For FY1999-2000, the Legislature authorized about $235.4 million to be spent from the special fund, and made an additional $7.75 million in general fund appropriations and $20.5 million in emergency general fund appropriations to the corporation.

In our study, we found that the corporation's control over its procurement and contract spending has worsened since our 1999 audit of the corporation and may be costing millions of dollars. Substandard procurement practices, questionable discretionary purchases, and other serious deficiencies reflect laxity at the corporate level.

We also found that the corporation is now managing its information systems more effectively. In addition, the corporation has made progress by developing action plans for its personnel system and is moving to take advantage of recent Hawaii state legislation on personnel flexibility. However, an "independent contractor" arrangement with a top executive of the corporation was questionable.

Some of the corporation's key financial operations need tighter control. We found weaknesses in its billings and collections for services to its patients. Also, the corporation lacks control over the invoices (bills) it receives from others. Deficiencies in financial operations can have wide-ranging impact. Excessive

funds may be expended. Revenues may not be maximized and expenditures minimized. In addition, without adequate controls, the corporation is at greater risk of loss, including waste or possible fraud and abuse.

In addition, we found that potential conflicts relating to officials of the corporation serving as directors and officers of Ali'i Community Care, Inc. were not adequately addressed.

We retained consultants to assess the corporation's organizational structure and to perform some other tasks. The consultants concluded that the corporation is working with an organizational structure that approaches efficiency and effectiveness given the political constraints it operates under. The corporation's operating performance is mixed when viewed as an entire system and compared against other health facilities in Hawaii. The consultants also concluded that the corporation's executives are underpaid when compared to national industry standards. We found that the corporation's executive salaries sometimes fell below and sometimes exceeded the salaries paid to top officials of Hawaii state government.

Our consultants found that the corporation in its current configuration will not become self-sufficient. However, they observed that the corporation might make progress toward self-sufficiency through outsourcing, consolidation, staff incentives, and adjustments in service delivery levels. The consultants also found that the corporation has not substantially reduced or eliminated direct care services since its inception and that board members and senior executives were very aware of the legislative intent to maintain services.

Recommendations and Response

We made a number of recommendations to the corporation to correct problems that we identified.

In written comments on a draft of our report, the corporation's president/chief executive officer acknowledged that many of our findings are accurate and our recommendations are reasonable. He also disagreed on some points and clarified others.

Marion M. Higa
State Auditor
State of Hawaii

Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813
(808) 587-0800
FAX (808) 587-0830

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A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 02-09
April 2002

Foreword

This follow-up study of the Hawaii Health Systems Corporation was conducted pursuant to Section 4(13) of Act 281, Regular Session of 2000.

We wish to express our appreciation for the cooperation and assistance extended to us by the Hawaii Health Systems Corporation, the Department of Health, and others whom we contacted during the study. We also wish to acknowledge the assistance of Meaghan Jared Partners, Inc., with certain aspects of the study.

Marion M. Higa
State Auditor

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Chapter 1

Introduction and Background

The Hawaii State Legislature, through Section 4(13) of Act 281, Regular Session of 2000, required the State Auditor to conduct a follow-up study of the Hawaii Health Systems Corporation (the corporation). Section 4(13) directed us to include, but not be limited to, an analysis of information systems operation, procurement practices, cash collections, the maximization of accounts receivable, and the effect of Act 229, Session Laws of Hawaii (SLH) 1998, on personnel management.

Background on the Corporation

In 1996, the Hawaii Health Systems Corporation took over the management, assets, and property rights of the State's community hospital system from the Division of Community Hospitals in the Department of Health.

Act 262, SLH 1996, established the corporation as a "public body corporate and politic and an instrumentality and agency of the State." The purpose of Act 262 was to provide better health care to people, including those served by small rural facilities, by freeing the corporation's facilities from unwarranted bureaucratic oversight. The key laws concerning the corporation are now found in Chapter 323F, Hawaii Revised Statutes (HRS).

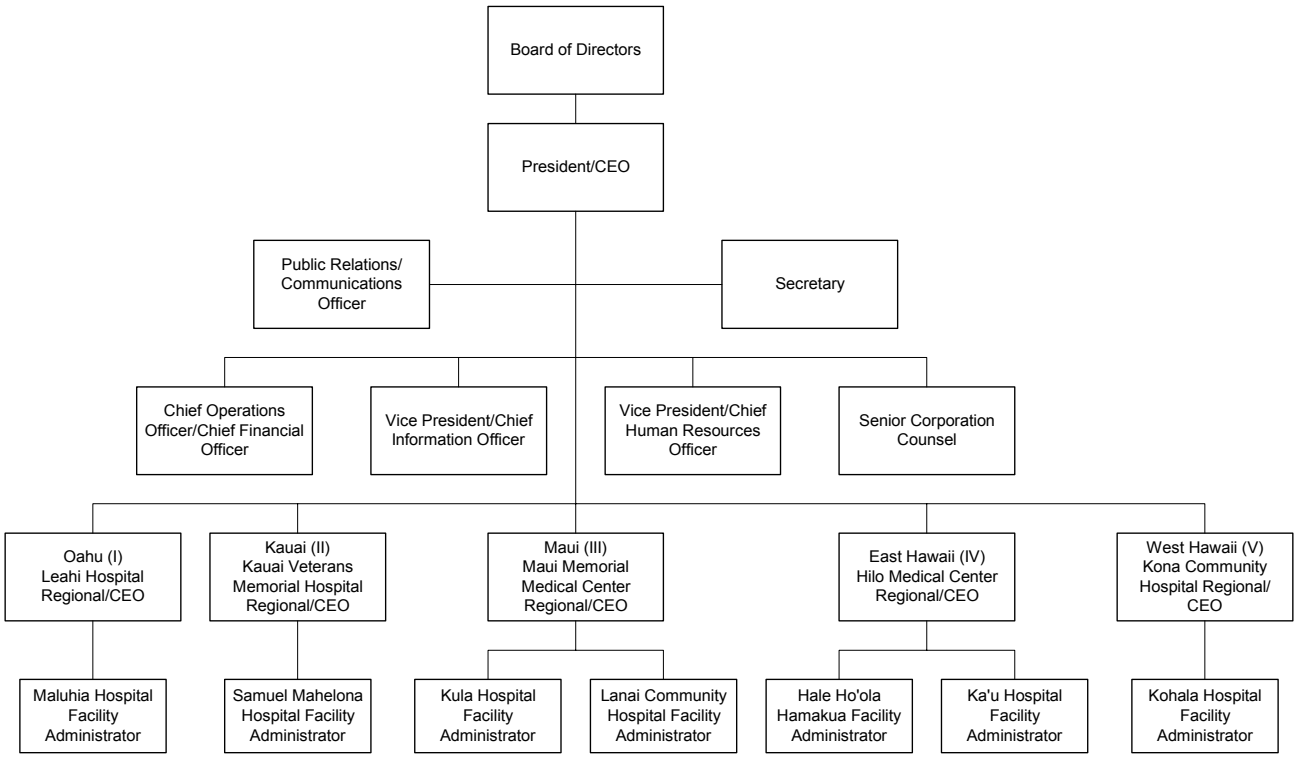
Organization

Chapter 323F places the corporation within the Department of Health for administrative purposes only. Exhibit 1.1 shows the corporation's organization.

The law organizes the corporation into five regions: (I) the City and County of Honolulu; (II) the County of Kauai; (III) the County of Maui, except the County of Kalawao; (IV) the eastern section of the County of Hawaii (the Puna, north Hilo, south Hilo, Hamakua, and Kau districts); and (V) the western section of the County of Hawaii (the north Kohala, south Kohala, north Kona, and south Kona districts).

A 13-member Board of Directors governs the corporation. Each member has a vote. The governor of the state appoints ten members: one from each of the five regions; a sixth from Kauai County, the island of Lanai, or Hana, Maui; and four at large. The eleventh member is the chairperson of the Executive Public Health Facility Management Advisory Committee. The twelfth member must be a physician with staff privileges at one of the corporation's facilities. This slot rotates among all the regions except the City and County of Honolulu; the

Exhibit 1.1
Organization of the Hawaii Health Systems Corporation



Source: Hawaii Health Systems Corporation information.

member is appointed by majority vote of the Executive Public Health Facility Management Advisory Committee from a list of qualified nominees submitted by the Public Health Facility Management Advisory Committee for the appropriate region. The thirteenth board member is the state director of health or a designee.

The board appoints the president/chief executive officer of the corporation. The law establishes within the corporation a Public Health Facility Management Advisory Committee for each region to provide input to the corporation's president/chief executive officer and staff about community needs. The chairs of the advisory committees sit on the Executive Public Health Facility Management Advisory Committee, which meets monthly with the president/chief executive officer and plays a role in policy decisions at the facility and regional level. The chair of the executive advisory committee serves as a member of the corporation's Board of Directors.

Duties, powers, and oversight

Chapter 323F authorizes the Board of Directors to carry out the duties and responsibilities of the corporation. The board's bylaws reiterate these responsibilities.

The laws gave the corporation greater flexibility and autonomy than that of the former Division of Community Hospitals in order to compete with the private sector and remain viable. Among other things, the corporation has the power to:

- Develop its own policies, procedures, and rules necessary to plan, operate, manage, and control the system of public health facilities and services, without regard to the State's administrative procedure statute;
- Evaluate the need for health facilities and services;
- Enter into leases, contracts, and cooperative agreements;
- Enter into business relationships;
- Set rates and charges for its services without regard to the administrative procedure statute;
- Develop a corporation-wide personnel system subject to state government's civil service, compensation, and collective bargaining laws; and

- Develop internal policies and procedures for the procurement of goods and services consistent with the goals of public accountability and public procurement practices, but not subject to the State's public procurement code.

Chapter 323F also provides that the governor and executive branch agencies limit their responsibility to review and oversight when the corporation receives general funds from the State to subsidize the operating budgets of deficit facilities.

The corporation's operating and capital improvement budgets are not subject to approval by the governor or any state agency, except where state general funds or capital improvement moneys are requested. The law prohibits the governor and executive branch agencies from interfering with the "systemic change, capacity building, advocacy, budget, personnel, system plan development, or plan implementation activities of the corporation" and from "interfering with the ability of the corporation to function as a multiple facility hospital system delivering health care services to the residents of the state."

Despite this flexibility, the law:

- Requires the Legislature to maintain review and oversight authority over the provision of direct patient care services at each facility;

- Requires the corporation to notify the Legislature of any planned substantial reduction or elimination of direct patient care services;

- Authorizes the Legislature to counter or restrict any substantial reduction or elimination of patient care services;

- Requires the Legislature's approval before the corporation substantially reduces or eliminates direct patient care services.

The law prohibits the corporation from entering into any contractual or business relationships that allow private sector counterparts to replace existing employee positions or responsibilities within the corporation or its facilities (except as the corporation could have done under collective bargaining contracts in effect for FY1995-96).

Community hospitals

The corporation oversees the operations of 12 community hospitals. As Exhibit 1.2 shows, the hospitals are classified as acute care, long-term care, or rural. Acute care facilities provide full medical services such as medical, surgical, and critical care; obstetrics; pediatrics; psychiatric treatment; and physical and occupational therapy. Long-term care

facilities consist of intermediate care and skilled nursing facilities that provide differing levels of medical and therapeutic care for the elderly or the chronically ill. Rural centers are primarily skilled nursing facilities that provide limited acute care, long-term care, or both to the elderly or the chronically ill.

Exhibit 1.2
Community Hospitals by Location and Type

Location	Type of Care
Oahu	
• Maluhia Hospital	Long-term care
• Leahi Hospital	Long-term care
Maui	
• Maui Memorial Medical Center	Acute care
• Kula Hospital	Long-term care
Kauai	
• Kauai Veterans Memorial	Acute care
• Samuel Mahelona Memorial	Long-term care
Hawaii	
• Hale Hoʻola Hamakua	Rural
• Kaʻu Hospital	Rural
• Kohala Hospital	Rural
• Hilo Medical Center	Acute care
• Kona Community Hospital	Acute care
Lanai	
• Lanai Community Hospital	Rural

The corporation is one of the largest public hospital systems in the nation, operating over 1,200 licensed beds and employing over 3,000 state workers. In FY1998-99, the corporation's facilities admitted 21,754 inpatients.

Mission and issues

The corporation's stated mission is to provide and enhance accessible, comprehensive health care services that are quality-driven, customer-focused, and cost-effective. The corporation's "vision" is to be the provider of choice for the communities it serves, the employer of choice for its staff, and the system of choice for its physicians.

Expectations existed that the corporation would be a more efficient and cost-effective system than the community hospital system under the Department of Health. However, questions have been raised about the efficiency of the corporation, in part because the corporation has required emergency appropriations from the State to maintain operations. Other concerns included the questionable practice of giving bonuses to corporation officials, the efficiency of cash collection activities, and whether all the islands have adequate services.

At the time of our fieldwork on this study, the corporation was working to convert some of its hospitals to "critical access" hospitals, a designation created by the federal Medicare Rural Hospital Flexibility Program established by Congress as part of the Balanced Budget Act of 1997. According to corporation officials, Kauai, Kohala, and Ka'u are now established as critical access hospitals and Lanai will receive the designation shortly. A critical access hospital is an acute care facility that provides outpatient, emergency, and limited inpatient services. Such hospitals receive "reasonable-cost" reimbursement for services to Medicare beneficiaries, an approach designed to help alleviate the financial crisis faced by many rural hospitals.

Revenues

The corporation's revenues consist primarily of third party payments. These and patient copayments are deposited into the Health Systems Special Fund, which is located in the state treasury. The Legislature appropriates (authorizes) amounts that can be spent from the special fund. The Legislature also appropriates revenues to the corporation from the state general fund. Exhibit 1.3 shows program appropriations to the corporation since its inception. In three of the four years reported below, the corporation has received emergency general fund appropriations in addition to ordinary general fund moneys. The total emergency funding has exceeded the ordinary general fund support by more than 50 percent.

Exhibit 1.3
Program Appropriations to the Corporation, FY1996-97 through FY1999-00

Fiscal Year	Special Fund Appropriations	General Fund Appropriations	Emergency General Fund Appropriations	Total
1996-97	$275,997,224	$332,088	$12,000,000	$288,329,312
1997-98	$218,431,089	$8,000,000	$5,000,000	$231,431,089
1998-99	$225,552,744	$8,000,000	-	$233,552,744
1999-00	$235,409,397	$7,750,000	$20,500,000	$263,659,397

Source: Session Laws of Hawaii, 1997 through 2000.

Previous Audits and Related Reports

Our 1988 study of the county/state hospital program found many operational and financial problems at the hospitals. That report also summarized several alternative organizational structures, which included creating a new department, creating a state hospital authority, establishing an independent nonprofit corporation, and contracting with a private management firm. It concluded that the most practical course at that time would be to seek improvements within the then existing organizational structure.

Our 1992 study of the Division of Community Hospitals found delays in billings and collections, large accounts receivable balances, and pointed out that state policies on personnel had hampered timely recruitment and hiring of appropriately trained personnel. Our report recommended the establishment of a public corporation, attached to the Department of Health for administrative purposes only. The corporation would be authorized to make personnel decisions, budget, set rates, procure materials and services, obtain short-term loans, and hold title to real property interests. A special legislative task force produced a preliminary report in December 1994 and a supplemental report in January 1995 that also recommended transforming the community hospital system into a public benefit corporation and identified specific issues to address. These issues included the State's inflexible budget process, stringent procurement requirements, and an unresponsive personnel system as hindrances to hospital efficiency and productivity.

Our 1995 audit of the information system of the Division of Community Hospitals cited the ineffective management of information systems development, which had resulted in fragmented systems and inefficiencies.

Subsequent to the corporation's establishment in 1996, we conducted an audit of the corporation in 1999. The resulting report, *Audit of the Hawaii Health Systems Corporation* (Report No. 99-9) identified problems with the corporation's ability to establish a viable public hospital system because of inadequate planning and implementation of policies, an inadequate financial system, and restrictive personnel rules. The report also identified problems with poor management controls over procurement and contracting, and the corporation's failure to effectively plan and control its computer system, which lacked statewide integration.

According to our 1999 report, state civil service rules and collective bargaining requirements continued to limit the corporation's ability to effectively use personnel resources. Act 262, SLH 1996, which created the corporation, had provided little relief from the State's inflexible

personnel system. Our report also found that a new law, Act 229, SLH 1998, might provide increased flexibility for the corporation to manage personnel, but that it was premature to fully evaluate the effects of the legislation.

Our 1999 audit recommended that the corporation's Board of Directors develop a transition plan with several elements, including an implementation plan for the corporation's personnel system, and justification for additional legislation that may be necessary to achieve goals. We also recommended that the board amend its procurement policies, for example by requiring formal analysis of expected benefits and outcomes of contracts; requiring contract provisions with objectives and deliverables that can be measured and evaluated; and developing clear monitoring procedures.

We recommended that the corporation's administrators establish formal policies and procedures for accounting practices, develop a strategic plan to define long-term information system needs, establish policies and procedures for information system acquisitions, and ensure Y2K-compliant computer and medical equipment.

Objectives of the Study

1. Assess actions taken by the Hawaii Health Systems Corporation to address findings and recommendations concerning procurement practices and information systems in our 1999 *Audit of the Hawaii Health Systems Corporation* (Report No. 99-9).

2. Evaluate the effect of Act 229, SLH 1998, and subsequent related legislation, on the corporation's personnel management.

3. Assess the effectiveness of the corporation's management of cash collections and accounts receivable.

4. Determine whether the corporation's organizational structure is conducive to ensuring its efficient and effective performance as a public hospital system.

5. Make recommendations as appropriate.

Scope and Methodology

We assessed procurement practices and information systems existing during the period following the issuance of our previous audit of the corporation, Report No. 99-9 (February 1999) to April 2001.

We evaluated the effect of Act 229, SLH 1998 (and subsequent legislation) on the corporation's personnel management from the act's effective date (June 1, 1998) to April 2001. Our scope included legislation designed to modernize the civil service.

In assessing the management of cash collections and accounts receivable, we focused on July 1999 through April 2001, and as necessary included the period since the corporation's establishment in November 1996 to obtain a complete picture and identify trends.

We conducted our work at the corporate headquarters and at certain facilities.

We used criteria and recommendations of our previous audits as criteria for the present study. Our criteria also included the corporation's own policies, applicable state and federal requirements, and the text *State and Local Government Purchasing Principles and Practices*, published by the National Association of State Procurement Officials in 1997.

Our consultants, Meaghan Jared Partners, Inc., a firm with expertise in health care systems, assessed whether the corporation's organizational structure is conducive to ensuring its efficient and effective performance as a public hospital system. Focusing on the period from November 1996 to February 2001, the consultants measured the corporation's financial performance, cost-effectiveness, and efficiency. This included comparing the corporation's organization and performance with that of similar hospital systems. The consultants also determined whether the corporation has substantially reduced or eliminated direct patient care services at any of the corporation's facilities (hospitals) since the corporation's inception. In addition, the consultant assessed whether the compensation packages of the corporation's executive management team are in line with industry standards.

The consultants also determined whether the corporation's allowances for contractual adjustments and bad debt were reasonable and were calculated correctly. This aspect of the consultant's work addressed only Hilo Medical Center, Maui Memorial Medical Center, and Kona Community Hospital.

Our work was performed from June 2000 through February 2002 in accordance with generally accepted government auditing standards.

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Chapter 2

The Corporation Does Not Manage Its Contract Spending and Financial Operations Effectively

This chapter contains the findings and recommendations of the Office of the Auditor concerning the Hawaii Health Systems Corporation's management of its procurement practices, information systems, personnel system, cash collections, and accounts receivable. While the corporation has made progress in its information and personnel systems, we found weak management of its contract spending and financial operations. We also found insufficient corporate concern about a potential conflict of interest.

Throughout this chapter, the word "hospital" includes any of the corporation's health care facilities, whether acute care, long-term care, or rural.

Summary of Findings

1. The corporation's worsening control of its procurement and contracting may be costing millions of dollars.

2. The corporation's management of its information systems has improved. However, further improvements are needed.

3. The corporation's personnel system is in transition. The corporation has begun to make use of the personnel flexibility provided by recent state legislation. However, an "independent contractor" arrangement with a corporate executive was questionable.

4. The corporation's financial operations need tighter control. The corporation needs an internal audit function.

5. The corporation and some of its top management employees have not been sufficiently careful to avoid potential conflicts from the formation of Ali'i Community Care, Inc., a wholly owned subordinate corporation.

The Corporation's Weak Controls Over Procurement and Contract Spending Have Further Declined

The corporation's control over its procurement and contracting has worsened since our previous audit. Substandard procurement practices, questionable discretionary purchases, and other serious deficiencies reflect laxity at the corporate level.

Past procurement problems were serious

The Legislature authorized the corporation to set its own procurement policies when it was established, but also required accountability. Section 323F-7, Hawaii Revised Statutes (HRS), requires the corporation to develop "internal policies and procedures for the procurement of goods and services, consistent with the goals of public accountability and public procurement practices . . . ." Therefore, while the corporation is not subject to the Hawaii Public Procurement Code, it must develop policies consistent with those goals.

The publication *State and Local Government Purchasing Principles and Practices,* issued by the National Association of State Procurement Officials in 1997, says policy goals and objectives of procurement should include a commitment to enhance competition on the basis of opportunity and fair treatment. Furthermore, all procurements above a certain dollar amount should be conducted through formal competition or through some competitive process "because competition is beneficial and leaves a good audit trail of how a contractor is selected."

Contracting should also be guided by management controls that safeguard against waste, fraud, and inefficient use; encourage and measure compliance with agency policies; and evaluate the efficiency of operations. Good control procedures provide properly authorized transactions and activities, appropriately segregated duties, and adequately documented and recorded transactions and events.

Allowing contractors to render services without a fully and properly executed contract is not a sound contracting practice. An executed contract ensures agreement on the type and scope of services and the responsibilities of the contracting agency and the provider. Providing services without an executed contract can put the State and the provider in legal jeopardy.

Our *Audit of the Hawaii Health Systems Corporation* (Report No. 99-9) found that poor management controls over procurement and contracting had created opportunities for unauthorized purchases and resulted in waste. The corporation's procurement policies and procedures lacked fundamental elements for internal control, created confusion, and

resulted in noncompliance with procurement rules. One provision gave the corporation's chief executive officer broad and arbitrary authority over discretionary purchases. Requirements for discretionary purchases needed clarification to ensure that vendors are given a fair opportunity to compete and that purchases serve the best interests of the corporation.

Furthermore, the corporation was not maintaining proper audit trails and could not ensure that purchases were properly authorized; one hospital did not properly segregate accounts payable and purchasing duties; and some hospital administrators did not have adequate oversight over daily purchasing.

Our Report No. 99-9 also said that contract management was inadequate: contracts were poorly written resulting in disadvantageous or questionable contracts; contracts were sometimes duplicative; and contract monitoring was insufficient.

Report No. 99-9 recommended that the corporation's Board of Directors amend its procurement policies. Specifically, we recommended that the board:

- Require a formal analysis of the expected benefits and outcomes for all contracts, an assessment of alternatives, and any recommendations by inhouse staff which relate to the objectives of the contracts;
- Require that the scope of services specified in contracts contain specific objectives and deliverables which can be measured and evaluated;
- Develop clearly defined monitoring procedures;
- Require an evaluation of each contract upon its completion to determine if objectives have been achieved;
- Require complete contract documentation for personal services contracts; and
- Ensure hospitals follow contracting procedures.

Current procurement practices continue to raise serious concerns

Although the corporation revised its procurement policies after our previous audit, the policies did not address the weak procurement practices that we had identified. Moreover, the corporation does not follow its own policies, and in many cases engages in questionable procurement practices that violate the intent of public procurement.

Corporation's procurement policies fall short of accepted standards

The corporation's policies undermine the intent of fair competition by making it too easy to avoid the competitive process and accountability. While the policies provide for some competitive procurement, they also provide for discretionary contracts. As a result, the corporation may be paying more than the fair value for its purchases. For example, the decision to use the discretionary, not competitive process, for a $40 million contract for laboratory services lacked justification. The corporation does not know whether significant savings could have been realized had this contract been put out for competitive bid.

The corporation's policies are also remiss in not addressing the approval of contract amendments that change the total cost of a contract. The policies establish certain dollar ceilings and purchase review procedures. A hospital's purchases up to $50,000 must be approved by the hospital's administrator. A hospital's purchases over $50,000 and up to $100,000 must be approved by the appropriate regional chief executive officer, and purchases over $100,000 and up to $200,000 must be approved by the corporation's chief executive officer. Purchases over $200,000 must be approved by the corporation's Board of Directors.

However, contract amendments that move the total contract amount into a higher cost category do not automatically require a higher level of review approval. For example, if an original contract of $40,000 approved by the hospital administrator is later amended to total $80,000, the amended purchase does not have to be reviewed by the higher level regional administrator. As another example, if an original contract for under $100,000 is amended to total over $2 million, board review is not necessary because the original contract did not exceed $200,000. According to the corporation's purchasing personnel, it is an unwritten policy that amended amounts which increase the contract's dollar amount to a new level do not trigger the higher review. However, this "policy" creates a loophole through which major expenditures can escape appropriate review.

Discretionary purchases circumvent effective procurement and lack controls

A discretionary contract is one in which the normal bid requirements are bypassed. The corporation's policies allow for discretionary purchases of goods or services under $100,000 when time is of the essence, when only one vendor can furnish goods or services, when technical characteristics are so complex that only one vendor has that expertise, or when price and other factors for existing contracts can be improved through renegotiation.

Our concern with the corporation's discretionary policy is twofold. First, the policy circumvents accountability and effective procurement practices. Second, the corporation's misuse of discretionary purchases has resulted from weak oversight and control. Discretionary purchasing is overused by the corporation, rarely meets the policy's intent of special circumstances, and has become an open door for lax procurement practices.

The corporation has increased its use of discretionary purchases since our previous audit, when we conservatively estimated that the corporation spent approximately $1.1 million on these contracts for about a two-year period beginning in June 1996. We now conservatively estimate that the corporation spent more than $48 million on discretionary contracts from December 1998 through August 2000. Because of the corporation's lack of documentation, we are probably understating our estimate. We note that $40 million of this amount is attributable to the contract for laboratory services mentioned above. The corporation recently informed us that since August 2000, it has added nearly $12.9 million in discretionary contracts.

The corporation has not followed its own procurement policies on justifications for discretionary purchases. The policies require completion and approval of a form justifying the discretionary method on the basis that time is of the essence or only one vendor can supply the services. Of the 33 discretionary contracts we tested, 24 (73 percent), either had no justification or did not have adequate justification that met the corporation's own criteria.

For example, a discretionary one-year contract for the services of the corporate controller did not meet the corporation's justification criteria. The justification that it would take six months to fill the position was not submitted until a month before the contract period ended. Furthermore, the same weak justification was used for a subsequent two-year contract with the same person.

Another example of poor use of discretionary purchases was an engineering services contract for over $1 million for which the justification for a discretionary purchase was not submitted until three months after the start of the contract period. Untimely justification of a discretionary purchase defeats the intent of the corporation's policy. The contract file included a note from a corporation official saying that future engineering services would be handled through requests for proposals because the official thought that the corporation would come under scrutiny in the future. This led us to question why a competitive process was not used in the first place. According to the corporation's own policies, this contract should have been awarded competitively through sealed proposals because it involved professional services greater than $100,000.

We found several other contracts for professional services over $100,000 that should have been handled through sealed proposals according to corporation policies, but were instead handled through discretionary purchases. The corporation has misused its discretionary procurement policy, and as a result may have spent more on the contracts than if they had been handled competitively. The lack of proper justification for these questionable discretionary awards resulted from the corporation's lack of management controls.

Other serious procurement deficiencies exist

We tested a total of 55 contract files from the corporate office and the three largest hospitals, Maui Memorial Medical Center, Kona Hospital, and Hilo Medical Center, and found serious procurement deficiencies.

We reviewed 18 contract files at the corporate office and found circumvented or ignored policies and procedures, resulting in no accountability, higher priced contracts, and loss of effective control over contractors.

Some contracts were not signed until after the contract period began, and sometimes even when the services were almost completed. One contract was not signed until after the contract period ended. Contract payments were made before contracts were finalized and even before work started. For example, a contractor for accounting services was paid $385,850 before the contract period officially started. In one contract of over $2 million, payment was made to a contractor who had installed wrong equipment. Still another contract was amended to pay a higher amount to a consultant despite the objections of the procurement staff and the president/chief executive officer.

As in our previous audit, we continued to find contracts with vague or unclear scopes, performance expectations, or compensation terms. A contract for legal services stated "HHSC and the contractor acknowledge that the complete scope of services for the initial project under this agreement are unknown on the date of this execution." This contract, originally at $50,000, was increased to $240,000 through unsigned amendments. A contract for engineering, consulting, and design services exceeding $1 million stated: "Perform other engineering professional services as requested." All contracts, and certainly one with such a significant contract amount, should more clearly describe the scope of services and tie the contractor's remuneration to the measurable deliverables. Not doing so prevents the corporation from monitoring its contracts for the quality and timeliness of services.

The corporation is paying more for contracts than necessary and is not making efficient use of its resources. One discretionary-contract file documented the availability of services at a lower cost, but the

corporation selected the higher-cost services. The $195,000 contract was for reviewing of records for unbilled services on a contingency fee basis. The contractor would be paid a percentage of what the company recovers. The contract file included a memo by a corporation official stating that the 45 percent contingency fee was too high. Another official wrote that other firms were quoting 38 percent contingency fees and that this contract should be put out for bid. Yet the contract was not let competitively but was a discretionary contract awarded to the company with the higher contingency fee of 45 percent. Another contract that was competitively let also went to a high bidder. This contract file showed two bids—one for $92,000 and the other for $75,000 with the contract awarded to the high bidder and with no documented justification for the higher cost.

Files for contracts awarded through competitive sealed proposals should include documentation of the list of vendors, a copy of the request for proposal, the basis for the award, the name and dollar amount of the successful offeror, and a copy of all proposals. Of seven contracts awarded through a competitive process, only one contained all of the required documentation.

In another contract, the corporation waived its actual or potential conflicts of interest with the contractor. The $50,000 contract for legal services was with a law firm, a partner of which was going to be a director of the corporation's board. A letter from the law firm to the corporation stated:

> By signing this letter and engaging our firm, you are agreeing to this arrangement and to waive the actual or potential conflicts of interest that may arise in the future . . .

This waiver as a condition of retention of the law firm is highly questionable. The broad and sweeping waiver only favors the law firm and allows the partner/director to determine on his own without disclosure what may or may not be a conflict of interest.

In several contract files, we found that the corporation's procurement staff had raised legitimate concerns that policies were being violated and overridden by management. The corporation's lax control environment allowed top management to ignore established policies, such as requiring justification of contract awards, legal review of contracts, and tax clearances for contractors.

We also reviewed 37 procurement files at the three large hospitals: Maui Memorial Medical Center (13), Kona Hospital (12), Hilo Medical Center (12). In general, the three hospitals' procurement practices had similar procurement problems, such as purchases made without contracts; untimely, nonexistent, or inadequate requests for contracts; discretionary

contracts that should have been awarded through a competitive process; unclear terms or scopes; and contracts remaining unsigned after services had already begun.

For example, Hilo Medical Center paid more than $95,000 over a three-year period for housekeeping services without a contract because the housekeeping manager did not want one. Hilo Medical Center personnel also told us that they do not have the expertise to issue contracts. The corporation has been derelict in its oversight of providing procurement training for this facility.

Corporation pays many millions of dollars for laboratory services not reconciled to contract

The corporation pays millions for laboratory services that are not reconciled to the service contract.

The corporation's $40 million discretionary contract for laboratory services ran from July 1, 1997 through June 30, 2001, consisting of a $20 million, two-year contract that was extended for another two years and $20 million.

The hospitals do not conduct a full reconciliation to determine whether the bills received from the laboratory were within the contracted scope of services. We reviewed the bills for two hospitals for one month and found that about half of the hospitals' bills (54 percent at one hospital, 48 percent at the other) were for noncontracted services. We could not review the laboratory bills for the third hospital because it did not even keep its bills, instead discarding them without any reconciliation. In summary, these hospitals may be paying as much as half of the contract amount, or $20 million, for services that were not contracted. The unaccounted payments are a blatant disregard of fiduciary responsibility. The corporation again is responsible for the unacceptable management of its contract payments at its three major hospitals.

Corporation's procurement policies are circumvented through parceling, purchase order abuse, and a questionable award

The corporation's procurement policies are easily circumvented, allowing abuses. We found a purchase order at the corporation for over twice the limit of $100,000 set by the corporation's own policies, and several other purchase orders over $150,000. We also found purchase orders of individual hospitals that exceeded the allowed limit. We found instances of parceling, whereby using multiple small amount purchases circumvents the competitive procurement requirements that would apply to a single large amount contract. For example, the corporation paid almost $300,000 to SCI Healthcare Group in three days through a series of four parceled purchase orders.

In addition, the corporation's award to a vendor for a telemedicine project is questionable and could be subject to legal protest by other contractors who believe they were unfairly disadvantaged. The corporation awarded a contract for a feasibility and needs assessment study for the telemedicine project. The corporation later awarded that same contractor an $840,856 contract to implement the very plan it had developed. The contractor's prior knowledge of the corporation's operations, hospital facilities, and telemedicine needs is an unfair advantage over other vendors. Furthermore, during the evaluation of proposals, the contract selection committee changed the evaluation criteria that were set forth in the request for proposals, for example by eliminating cost as a factor. The corporation's procurement practices in these examples defy the intent of the procurement law and allow abuses not acceptable in state government.

The corporation does not adequately oversee procurement and contracting practices

The corporation's lax oversight of procurement and contracting practices includes areas of contract monitoring, audit trails, and monitoring of expenditures.

Contract monitoring is lacking

Contract monitoring includes keeping track of contracts, assigning a contract monitor, receiving timely and measurable contract feedback, and establishing procedures for the expedient resolution of contract disputes and claims. The corporation's policies do not address these areas. We found no evidence of contract monitoring.

Corporation's audit trails have worsened

The corporate office maintains no audit trail for its processed checks. There is no way to trace the purpose of checks, the receipt of goods or services, or their approvals or justifications. This financial management condition is even more serious than reported in our previous audit where we found the corporation's payment system not always matching invoices of received items to corresponding purchase orders. Now it is impossible for us to trace any payment accurately back to an invoice, purchase order, or contract at the corporate headquarters. It is difficult to audit money spent for legitimate purchases or determine whether purchases were even received. This serious management deficiency can result in misspending, misallocations, and undetected illegal acts.

We noted this serious problem primarily at the corporate office. Adequate audit trails were in place at Hilo Medical Center, Maui Memorial Medical Center, and Kona Community Hospital, where we could trace purchases back to the goods or services received.

Contract expenditures are not reliably identified

Corporation officials could not accurately identify how much was being spent on purchases or even how many contracts were in effect. We estimate contract spending of at least $70 million since our previous audit, but an accurate figure is not known because the corporation was never able to provide us with a reliable list of contracts. Our estimated figure represents about 27 percent of the corporation's total appropriations for FY1999-00. According to corporation officials, they do not monitor overall contract expenditures.

Corporation has not made procurement and contracting controls a priority

The corporation's lack of guidance and the failure to address our previous findings and recommendations indicate that the corporation has not made sound procurement and contracting practices a priority. The corporation's lack of guidance, communication, and adherence to its policies and procedures all increase the system's inefficiencies. Inadequate audit trails cannot detect the misuse of corporate funds. Weak controls result in weak cash flow management, which affects fiscal planning.

Inadequate contract monitoring carries the potential for noncompliance with contract provisions, poor fiscal controls, fraud, waste, and inefficient use of public resources. If they do not give spending controls high priority, corporation officials are unable to plan and budget for maximum efficiency of their dollars. This could increase the need for general fund appropriations, in the form of both regular budget requests as well as emergency requests for additional money.

Information Systems Are Better Managed But Challenges Remain

Our previous audit found that the corporation's failure to effectively plan and control its information systems had created an inefficient health care information system that lacked statewide integration and would encounter problems in the year 2000.

In the present study, we found that the corporation is now managing its information systems more effectively. The planning, organization, staffing, and functioning of information technology have improved. Problems with the long-term care information system are being resolved, but the costs were excessive. Further improvements in information systems are needed.

Planning, organization, and staffing have improved

Cost-effective information systems require systematic planning, organization, and staffing. We previously found that the corporation lacked a long-range plan guiding the implementation of its information systems to meet corporate goals and objectives.

Subsequently, the corporation created an Information Technology Steering Committee responsible for establishing the one- to five-year direction. The committee consists of the corporation's president/chief executive officer, chief information officer, chief financial officer, chief human resources officer, and general counsel; a representative of the Physicians Advisory Group; and the regional chief executive officers. The committee's primary objective is to maximize the corporation's business goals to provide high-quality patient care services. Meeting quarterly, the committee reviews long-range information technology plans, overall communication strategy, usage standards, specific direction, use of capital, vendors to provide information systems, and policies regarding corporate and physician staff.

In 1999, the corporation reorganized its information technology structure by requiring information technology personnel placed in the hospitals to report directly to the corporation's chief information officer. The objective of the reorganization was to allow for a coordinated system-wide development of projects, maximization of information systems resources, standardized hardware and software systems, and consistent policies and procedures. Also, the number of information technology staff at the corporate office and the individual facilities has doubled since our previous audit. The reorganization and staff increases have resulted in more information systems and better support for the hospital facilities.

The corporation's long-range information technology plan dated January 2000 set directions toward specific goals. To be dynamic, the plan should be periodically reviewed and updated for consistency with corporate goals.

Information systems are functioning more effectively

Our previous audit found that the corporation had hired full-time employees to manually reenter data from one automated system to the main information system. This inefficient practice at two hospitals was costing the corporation over $170,000 annually in salaries and benefits. Subsequent to our previous audit, the corporation installed electronic interface devices to allow for automated transfer of data between systems thus avoiding unnecessary personnel costs.

Report No. 99-9 stated that the corporation was still in the early phases of addressing the Year 2000 (Y2K) problem and it was questionable whether the problem would be corrected in time. The Y2K problem

resulted from the way dates were stored and processed in the corporation's computer systems and medical equipment.

During the present study, we found that the corporation met the time schedule for Y2K compliance with no major problems. The corporation reported that it took approximately 70 personnel and four consulting firms to meet this objective. The project reportedly required 21 months to assess 6,000 items in the information systems as well as to assess medical equipment that needed to be replaced or upgraded at an estimated cost of $5.9 million.

The corporation has taken other steps to reduce health care costs through technology. These steps include increasing the use of its video teleconferencing system and implementing a new telemedicine project. Video teleconferencing allows two or more individuals in different geographic locations to conduct educational, administrative, or collaborative meetings without spending time and money for travel. During calendar year 2000, the corporation reported a cost avoidance of more than $100,000 in airfare and over 4,000 hours in travel time. Video teleconferencing can be especially cost-effective with a 12-hospital, five-island corporation.

Problems with long-term care system were resolved, but costs were excessive

The State requires its agencies to use the System Development Methodology when developing or acquiring information systems. The methodology provides detailed guidelines and step-by-step descriptions of tasks that help ensure that the system meets user needs. One of the most important tasks is to develop a system plan that describes what the system will do for users and how.

In our previous audit, we found that the corporation had failed to follow these guidelines, resulting in a long-term care information system that was poorly planned and implemented. The corporation had procured the system to meet a federal mandate to implement a billing reimbursement system by July 1, 1998. Failure to meet this requirement would result in a lower reimbursement rate for patient care and a loss of revenue for the corporation. In June 1997, the corporation contracted for a software system to meet the federal mandate and long-term care hospitals' requirements.

Although the federal requirement was met, the corporation later reported that management became aware that the system was not sufficient to meet both the clinical and financial components of the hospitals' needs. Without the financial component, the long-term care hospitals were without general ledger, automated billing, and accounts receivable capabilities. As a result, five of the corporation's long-term care facilities had to bill patients manually. This caused an increase in accounts receivable days, which delayed revenue collections. The

system failed to meet the hospitals' long-term care needs and cost taxpayers approximately $680,000 for software, hardware, and professional services.

We also found in our previous audit that the information system had other deficiencies that raised questions about its effectiveness. For example, users reported that the system took over 30 minutes to allow them to log on. Also, we noted that the financial component of the system was being implemented but was not yet operational.

In the present study, we found that the corporation subsequently determined that the financial component could not be made operational. In June 1999, only two years after awarding the initial contract for the long-term care system, the corporation awarded another contract to replace the software initially selected. The replacement system was properly planned and implemented, resulting in users being satisfied with its performance. However, the replacement system cost the corporation an additional $600,000, raising total costs for the long-term care information system to over $1.2 million. If the long-term care system had been properly planned and implemented initially, the time and costs to meet the federal mandate and user requirements might have been avoided.

Further improvements are needed

To meet organizational needs and goals, an effective and efficient information system must be user-friendly and responsive. Without automated systems, management must rely on manual tracking and reporting of information to support its decision-making process. In this study, we found that some of the corporation's information systems are outdated and require replacement, while other systems are still not operational.

For example, the corporation's materials management system was outdated and did not meet the hospitals' requirements. This system was installed in 1997 and 1998 at two of the hospitals to automate the purchase order, requisitioning, and inventory functions. However, hospital officials reported to us that the system was unfriendly and needed replacement. At the time of our fieldwork, we found that some of the corporation's functions lacked information systems to assist in daily operations. Although information systems were being planned, human resource, payroll, contracting, time-and-attendance, and other functions were without an operational information system.

We interviewed 21 hospital personnel by telephone for their views on how well the information systems supported them. While most of these system users responded positively, some still had concerns, primarily

with the systems for materials management and for human resources. Several users said that training was inadequate and that the overall support needed improvement.

Corporation officials recently informed us that as of January 2002, they had fully implemented an information system for human resources and were in the process of implementing an information system for a time-and-attendance program and eventual payroll system.

We also found that the corporation failed to prepare committee minutes on information technology decisions as required in the System Development Methodology. The methodology requires all state agencies to prepare and publish minutes for all formal and prescheduled meetings of executive review committees. These minutes provide a permanent record of committee deliberations and actions. Management has a general duty to develop and maintain internal controls including adequate documentation and records of transactions and events to provide an adequate audit trail. Records should be maintained documenting information technology decisions.

However, we found the corporation does not document and maintain minutes of the Information Technology Steering Committee to allow for accountability and management oversight of information technology decisions. This committee is a decision-making body with the objectives of recommending and approving information systems for the corporation. The committee has the authority to commit resources and determine the future of the corporation's information technology. However, since April 1999, these key decisions have been undocumented due to the lack of committee minutes.

The Corporation's Personnel System Is Still in Transition

The corporation has made progress by developing action plans for its personnel system and is moving to take advantage of recent Hawaii state legislation on personnel flexibility. However, an "independent contractor" arrangement with a top executive of the corporation was questionable.

Previous personnel findings

Our Report No. 99-9 noted that hospitals require flexible labor and compensation arrangements to remain competitive and meet the unique needs of a health care system. Act 262, Session Laws of Hawaii (SLH) 1996, which created the Hawaii Health Systems Corporation, authorized the corporation to develop its own personnel system. We found that the act had provided little relief from the State's inflexible personnel system. State civil service rules and collective bargaining requirements were still limiting the corporation's ability to effectively use personnel resources.

State rules and requirements imposed restrictive procedures and noncompetitive compensation levels that further hindered the corporation's ability to attract needed personnel. The corporation's ability to negotiate collective bargaining agreements was constrained because any negotiated agreement was subject to the approval of other state parties (the state Office of Collective Bargaining and other relevant public employers). State collective bargaining laws limited the corporation's ability to manage its personnel and address pay issues. For example, collective bargaining agreements were negotiated without the corporation's involvement. Uniform compensation programs negotiated through collective bargaining made it difficult for the hospitals to recruit skilled and experienced staff competitively.

The corporation used Act 229, SLH 1998, to facilitate labor agreements, additional positions, and key appointments

At the time of our previous audit, Act 229, SLH 1998, had only recently been signed into law, so our Report No. 99-9 noted that it would be premature to assess its full impact. However, our report did note that the act provided the corporation with position control management and the authority to negotiate specific terms and conditions of employment with collective bargaining units through memorandums of agreement. Administrators of the corporation's hospitals believed that position control management would give the corporation the authority and flexibility to manage positions and to authorize and establish positions without legislative approval. The corporation anticipated that Act 229 would save considerable time and effort by allowing the corporation to create or abolish positions without legislative approval. Furthermore, the law authorized the corporation to appoint hospital administrators, assistant administrators, directors of nursing, medical directors, and staff physicians. Directors of nursing had the option of remaining in civil service or accepting exempt status, while the other positions were all exempt from civil service.

Subsequent to our previous audit, the corporation took advantage of the added flexibility provided by Act 229. At the time of this study, the corporation had executed or was negotiating a total of 23 memorandums of agreement. The agreements address floating nurse pools, sick leave abuse, flexible work hours, overtime, dress codes, an annual recognition program, and other issues. In addition, the law made it possible for the corporation to establish 616 new positions covering all facilities and job descriptions without legislative approval.

The corporation plans to implement civil service reforms under Act 253, SLH 2000

Act 253, the State's civil service modernization law, takes effect on July 1, 2002. The act significantly affected public employment in the State of Hawaii. Conference Committee Report No. 115 on Senate Bill 2859, C.D. 1 (which became Act 253) stated:

> This measure amends public employment laws that have evolved over decades and procedures constricted by layers of well-intended rules and ordinances. Your Committee believes that the principles, innovations, and additional flexibility contained in this measure, as amended, will provide a more responsive base for the continuing evolution of public employment.

Act 253 should benefit the Hawaii Health Systems Corporation. The law will give the corporation, as a recognized public employer, a vote in collective bargaining negotiations and the ability to negotiate supplemental agreements with its unions outside collective bargaining. In addition, the corporation will have the flexibility to adjust wages, work hours, benefits, and other terms and conditions of employment. Also, the corporation will be able to create its own, independent classification, compensation, and recruitment structures. Currently, the corporation is allowed to negotiate changes in those structures, but is hampered by civil service rules that require changes to be adopted across the entire state classification system. Under the new law, the corporation will be able to negotiate changes affecting only its own employees.

In response to Act 253, the corporation has developed an action plan for its personnel system. In July 2000, the corporation held a human resources planning conference to design a new human resources system. As a result of the conference, action plans and action teams were formed to focus on five key areas: civil service, recruitment, classification, labor, and other issues. Teams have met regularly to develop these action plans.

"Independent contractor" arrangement with a top executive was questionable

The corporation retained a person as an "independent contractor" to serve as corporate controller from May 1, 1998 through June 30, 2002. The person left the corporation in mid-2001 and was replaced by a permanent employee.

We question why the contracted controller was not hired as an employee since his work was ongoing. We also question whether he was actually an independent contractor. The Internal Revenue Service (IRS) established 20 factors for determining whether a worker is an "employee" or an "independent contractor." The IRS factors include, for example, assessing an individual's continuing relationship, set hours of work, set payment schedule, and realization of a profit or loss. The distinction between independent contractor and employee can affect whether income taxes are withheld and social security payments made. In applying the 20 factors, we found that the contracted controller qualified as an "employee" on 13 of the criteria. Only one criterion, the lack of specific sequence of tasks, qualified the person as an "independent contractor." We were unable to accurately evaluate the

person's work status on the six other criteria, including full-time work requirement, work performed on the employer's premises, and working for more than one firm.

The continued practice of using an "independent contractor" to perform what appears to be an "employee" function could have negative tax implications for the corporation and may violate state law. Section 323F-7, HRS, states:

> The duties and powers granted to the corporation may not be used to enter into contractual or business relationships which have the practical effect of allowing or are intended to allow the private sector counterparts to replace existing employee positions or responsibilities within the corporation or its facilities; provided the corporation shall be allowed to enter into such relationships to the extent and for the purposes that the division of community hospitals could have done under collective bargaining contracts which were in effect for the 1995-1996 fiscal year.

Furthermore, if the controller was indeed an employee, he was hired in violation of Section 78-1(c), HRS, which requires state employees to be state residents at the time of their employment application.

Finally, we found that the controller's contract was exceedingly unfavorable to the corporation, lacking the usual provisions of indemnification, obligation to defend, cost of litigation, and liability for excess costs on the default of the contractor, which would protect the corporation from the contractor's intentional or negligent acts. The contract also provided for an automatic severance payment of six months' salary if the corporation terminated the controller. This generous provision is unusual for a state contract.

Key Financial Operations Need Tighter Control

Some of the corporation's key financial operations need tighter control. We found weaknesses in its billings and collections for services to its patients. Also, the corporation lacks control over the invoices (bills) it receives from others. The corporation needs to make financial controls a priority and consider establishing an internal audit function.

Billing problems can affect revenues and accounts receivable

Effective billing for patient services includes (1) capturing the correct demographic and financial information about the patient during admission/registration, (2) capturing and coding patient charges, and (3) transmitting timely, accurate bills. The corporation has problems in each of these areas, which can result in delayed or lost revenues. The problems could also affect the corporation's estimate (valuation) of accounts receivable.

Our review of monthly reports of unbilled accounts at the three hospitals we visited found that 17 percent (worth over $1 million) at two hospitals were waiting for verification of insurance, which is a failure of the admission/registration process. At the third hospital, no unbilled accounts were awaiting verification of insurance. However, that hospital pays a consultant a percentage of patients' bills to verify insurance prior to billing. The question remains why none of the three hospitals is adequately performing insurance verification inhouse using its own personnel.

We also found numerous capture and coding problems. In one instance at Maui Memorial Medical Center, over $98,000 in potential revenue was not captured for billing for 11 months. Hospital personnel informed us that a portion of the money was eventually recouped, but they could not determine how much. Hilo Medical Center's records included more than $229,000 in unbilled late charges (charges that were not captured because they were processed after the account had been final-billed). This may be lost revenue.

Patients are frequently not billed on time or accurately. Monthly reports of unbilled accounts attributed an average of 71 percent of the unbilled accounts to doctors' failure to provide final diagnoses, which held up the billing process. Our review of monthly reports of the total accounts that were rejected from billing at the three largest hospitals found as many as 3,112 unbilled accounts totaling more than $10 million in October and December 2000. As of June 2000, unbilled accounts at seven hospitals totaled $22,074,962.

Other revenue may be lost because some of the corporation's hospitals write off the portion of a patient's charges not paid by the insurer without verifying the contractual allowance. Contractual allowances are the amounts that the patient's insurance contract allows the insurer not to pay on patients' bills. For example, if the insurer contracted to pay 60 percent of the total charges billed, the contractual allowance is 40 percent. Hospitals that fail to verify a patient's contractual allowance may be accepting insurance payments that are too low. Some hospitals do not even have copies of the contracts and therefore have no way of knowing the allowances. Chapter 3 of the present report contains additional information concerning some inconsistencies in the process for determining allowances for contractual adjustments and bad debt.

Flaws in collection process increase risk of waste, theft, and fraud

The corporation's cash collection process has several flaws.

Two of the three facilities we tested do not document who is responsible for certain parts of the collection process. This failure results in an inadequate audit trail in the event of loss or theft, and no assurance that unauthorized transactions are not occurring.

Furthermore, segregation (sometimes called separation) of duties in cash collections is often weak or nonexistent. The corporation's external auditors have repeatedly identified this type of problem as a "reportable condition" since at least 1997. Segregated duties provide reasonable assurance of preventing or timely detecting unauthorized use of the assets. However, the corporation often fails to segregate duties. At the corporate office and at Leahi Hospital, the same person who receives cash also has authority to account for it, prepare the cash deposit, record the deposit into the accounting records, and reconcile the bank statements to the general ledger. At Maui Memorial Medical Center, one person receives and accounts for the cash.

Moreover, the Maui Memorial Medical Center does not always adhere to its controls for cash deposits. The medical center's normal procedure is to make deposits daily using the bank's lockbox services. However, on the last day of the month, a messenger sometimes carries an unlocked cash bag to the bank and waits for the teller to complete the transaction. The medical center justifies this departure from normal procedures as enabling inclusion of the deposit in the month-end reporting period. While this practice occurs infrequently, the justification does not outweigh the risk to the employee and the cash.

To pursue unpaid bills, the corporation has contracts with private collection agencies and the Collections Unit of the Civil Recoveries Division of the Department of the Attorney General. However, except for the Maui Memorial Medical Center, neither the corporate office nor the hospitals review or reconcile collection reports from those agencies. They do not verify the agencies' bills to the corporation for payment against the agencies' reports of collections. In addition, at the corporate office we found multiple reports by the attorney general's Collections Unit for the same month with large discrepancies between reports in the number of accounts and the moneys collected. We found no record of the corporation following up on the discrepancies.

Lack of invoice control causes additional risk

The corporate office lacks control over invoices it receives from others, from initiation to completion. The staff do not log or otherwise track invoices from receipt. This failure prevented us from verifying the accounts payable to the general ledger. Invoices were sometimes paid with no supporting documentation. According to a corporation official, no official policies and procedures are in place for accounts payable. Another official also stated that there is no internal review process for accounts payable.

We also found a systemic failure to timely record payments made by the corporation. We found 148 manual checks that were recorded as late as

four to nine weeks after the check was issued. We also found that lease payments of $49,879 were made almost four months earlier than required.

In addition, accounts payable duties were not segregated. The payables clerk receives invoices, cuts checks, posts the payments, creates and records adjusting entries, and reconciles to the general ledger, all without direct review or supervision. The impact of failing to segregate duties was demonstrated by reports showing that sometimes the same check was voided multiple times without being discovered. Both human and computer controls failed to detect the problem. If the situation had involved fraud, a loss of over $100,000 would have remained undetected for months.

Deficiencies in financial management are longstanding and reflect lack of management controls

Our Report No. 99-9 said that the internal control structure of the corporation did not ensure accountability, and accounting policies and procedures were nonexistent. For example, we found lack of a proper audit trail at the corporation; improper segregation of duties; and inadequate oversight by hospital administrators, which are similar findings to those reported earlier in this chapter.

Internal controls are adopted within a business to safeguard its assets, check the accuracy and reliability of its accounting data, promote organizational efficiency, and encourage adherence to prescribed managerial policies. Controls are normally communicated by way of policies and procedures. In the present study we found that the corporation lacks systematic internal controls for its business management and financial reporting practices. Existing controls are not reviewed for compliance, or assessed and modified as needed.

There is also no internal audit function, nor is there a separate audit committee of the Board of Directors. The corporation's reliance on external auditors to alert it to problems is inappropriate. External auditors do not and cannot identify the wide range of control issues and resultant problems that an internal audit function would. Even when external auditors find problems, the discovery can be months after the fact, with reporting and requisite corrective action taking even longer. Establishing an internal audit function and audit committee would help ensure that the corporation's board and administration perform their fiduciary duties to assure accountability for public funds.

Deficiencies in financial operations have serious effects

The deficiencies in financial operations described above can have wide-ranging impact. Excessive funds may be expended. Revenues may not be maximized and expenditures minimized. In addition, without adequate controls, the corporation is at a greater risk of loss, including

waste or possible fraud and abuse. Processes must be in place to ensure systems are working appropriately, such as timely, accurate, credible billing and collections.

An internal audit function is needed

The corporation's lack of an internal audit function, in particular for cash handling and payables, creates classic textbook opportunities for fraud, misuse, and loss. By identifying corporate inefficiencies, an internal audit function would provide management with the information to guide future policy and procedure development. An internal audit function would hold all staff, from senior executives to line employees, accountable for adhering to policies and procedures. The internal audit function would also expedite external audits. By reducing risk, effective internal controls reduce the need for extensive testing during audits.

Establishing an internal audit position within the corporation's administration and a corresponding audit committee within the corporation's Board of Directors would make improvements a priority and establish oversight. While the board's finance and information technology committee currently is presented with the corporation's external audits, the duties of an audit committee are typically more extensive. Audit committees can oversee the reliability of financial reporting and the effectiveness of internal control over financial reporting. They can conduct special investigations when needed.

Potential Conflicts Involving Ali‘i Community Care, Inc. Were Not Adequately Addressed

We question certain aspects of an arrangement in which the president/chief executive officer, vice president/general counsel, chief financial officer, and chief information officer of the Hawaii Health Systems Corporation serve as directors of Ali‘i Community Care, Inc. (Ali‘i). All these officials of the health systems corporation served as officers of Ali‘i at the time of Ali‘i's incorporation. The health systems corporation and some of its top management employees have not been sufficiently careful to avoid potential conflicts from this arrangement.

Ali‘i is a Hawaii nonprofit corporation, established in June 2000, whose purpose is to own, manage, and operate assisted-living facilities in the state. According to a top official of the health systems corporation, assisted living is a new enterprise for the health systems corporation, so a separate entity was needed. The official also commented that Ali‘i was created to isolate liability in order to protect the health systems corporation.

Advisory Opinion 86-1 (January 31, 1986) of the State Ethics Commission outlines several considerations to determine whether a state

employee may serve in a state capacity as a director or officer of a private corporation. Factors in favor of the acceptability of such an arrangement include, for example, that:

- There is a valid state purpose that justifies a state agency's having one of its employees serve in a state capacity as a director or officer of the private corporation;
- That the state employee serving as a director or officer serves or acts solely on behalf of the State's interests;
- That the state employee receives no compensation from the private corporation; and
- That the state employee has no financial interest in the private corporation.

Another factor mentioned in the Ethics Commission advisory is that the question of whether the employee may serve as a director or officer of the corporation has been presented to the Ethics Commission, and the commission has granted its approval. A key official of the health systems corporation acknowledged to us that the corporation did not seek or obtain such approval and that perhaps it should have done so. However, the official viewed this is as only a possible technical violation and indicated that the omission may have reflected that Ali‘i is "wholly owned" by the health systems corporation and would be acting only in the corporation's interests.

We do not question the authority of the Hawaii Health Systems Corporation to create and wholly control a nonprofit corporation; Section 323F-7(4), HRS, provides this authority.

Nevertheless, we believe that Ethics Commission approval should have been obtained. Doing so would have helped assure in advance that the arrangement with Ali‘i was ethically sound and did not put the corporation, the State, and the involved persons in a situation that could involve conflict of interest or personal gain. Such an assurance is especially important in light of provisions in Ali‘i's articles of incorporation and bylaws allowing reasonable compensation for services to or for Ali‘i relating to its objects and purposes. The official of the health systems corporation informed us that Ali‘i's directors and officers do not receive any compensation and was not aware that they will ever receive moneys from Roselani Place, Ali‘i's first project, which is an assisted-living facility being developed on Maui. Nevertheless, the compensation provisions in the articles and bylaws appear to open the door for compensation, which underscores the importance of Ethics Commission approval.

Recommendations

1. The Board of Directors of the Hawaii Health Systems Corporation should make it a priority to establish procurement policies that are consistent with the goals of public accountability and public procurement practices.

2. Corporate management should improve its control of contract spending by the following:

   a. More effectively monitoring contract expenditures;

   b. Ensuring compliance with procurement and contracting policies. Those policies should include the process for selecting vendors and for establishing, administering, monitoring, and evaluating contracts; and

   c. Ensuring that there is an adequate audit trail for all purchases.

3. Corporate management should systematically address the concerns of information technology users and should require the Information Technology Steering Committee to prepare committee minutes that document its decisions.

4. Corporate management should continue its efforts to redevelop the corporation's personnel system and to take full advantage of recent legislation providing flexibility. The corporation should reexamine its practice of maintaining certain corporate executives as "independent contractors."

5. Corporate management should improve financial management by developing, implementing, and enforcing the following:

   a. An internal audit function and a board audit committee; and

   b. Policies and procedures that ensure adequate controls for major programs such as billing, collections, and payables.

6. The corporation should obtain the State Ethics Commission's review and approval of the involvement of some key corporation executives as directors and officers of Ali'i Community Care, Inc. In the future, the corporation and its top officials should take greater care before becoming involved in arrangements that could put them in actual or perceived conflicts of interest.

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Chapter 3

Our Consultants Provided Additional Perspectives on the Corporation's Organization and Performance

This chapter summarizes the results of our consultants' work and some of our own observations on the issues they studied. We asked our consultants, Meaghan Jared Partners, Inc., to assess whether the organizational structure of the Hawaii Health Systems Corporation is conducive to ensuring its efficient and effective performance as a public hospital system, and to perform some other tasks. Their specialty in health care provided perspectives on the corporation's organization and performance that would not otherwise have been available to us.

The consultants conducted fieldwork in January and February 2001. Any changes that may have occurred at the corporation (or in the environment in which it operates) subsequent to that time were beyond the scope of work for which the consultants were responsible and were not considered in preparing this chapter.

The consultants concluded that the corporation is working with an organizational structure that approaches efficiency and effectiveness given the political constraints it operates under. We believe that a full assessment of the impact of the new corporate structure of Hawaii's state system of public hospitals will require more time. However, the corporation needs to address immediately the operational problems that we described in Chapter 2.

Summary of Findings

1. Our consultants found that the corporation's operating structure—a "matrix" approach designed to foster local input and autonomy—is realistic in light of the circumstances. The structure has strengths and weaknesses. In our view, the consultants' analysis raises questions about the corporation's regionalization.

2. Our consultants found that the corporation's operating performance is mixed when viewed as an entire system and compared against other health facilities in Hawaii. The larger facilities perform better than the smaller facilities that are responsible for rural services.

3. Our consultants found that the corporation's executives are underpaid when compared to national industry standards. We found that the corporation's executive salaries sometimes fell below and

sometimes exceeded the salaries paid to top officials of Hawaii state government. Executive compensation remains a key policy issue.

4. Our consultants found that the corporation in its current configuration will not become self-sufficient; however, they observed that the corporation might make progress toward self-sufficiency through outsourcing, consolidation, staff incentives, and adjustments in service delivery levels.

5. Our consultants had a favorable finding on the corporation's maintenance of services. They also found that the corporation's overall methodology for calculating contractual adjustments (reserves) and bad debt is technically accurate and leads to a reasonable estimate of the value of accounts receivable. However, the consultants also concluded that the corporation should consider selected adjustments to further refine the process.

The Corporation's Operating Structure Is Realistic But Raises Questions About Regionalization

Our consultants found that the corporation's operating structure—a "matrix" approach designed to foster local input and autonomy—is realistic in light of the circumstances. The structure has strengths and weaknesses. In our view, the consultant's analysis raises questions about the corporation's regionalization.

Operational structure is "matrix" in nature

Our consultants began by observing that the corporation consists of 12 facilities providing services in five regions, set by law, encompassing the entire geography of the state. The scope of the corporation's service delivery is broad and complex, ranging from an acute care facility, Maui Memorial Medical Center, with nearly 10,000 admissions in FY1999-00 to a much smaller facility, Ka'u Hospital, with 41 admissions in that year. The corporation's headquarters are on Oahu, located at the Leahi long-term care facility.

At first glance, said our consultants, the corporation appeared to be a classic hierarchy, a common model among health care systems across the nation. In such a model, strategic planning, goal setting, policies and procedures, and performance monitoring are approved by a board of directors and implemented by the management team in a top-down, adherence-to-policy approach. The organizational chart in Exhibit 1.1 of Chapter 1 of this report suggests such a framework.

However, on closer scrutiny our consultants found that in its day-to-day operations, the corporation's decision-making framework depends more on informational and advisory input from the levels and regions of the organization than does a classic hierarchy. While the Board of Directors retains full approval authority and overall accountability for the organization's success, the board and corporate management have implemented an operating structure that is heavily oriented to input from "below." This structure more closely resembles another common model in the health care industry, the highly decentralized model.

According to our consultants, four main considerations drive the organizational philosophy and culture of the Hawaii Health Systems Corporation:

- Governance, policy, and financial decision making at the Board of Directors level;

- Autonomy, to the maximum extent possible, at the operating-facility level;

- Integration of ideas, required action, and initiatives derived from the efforts of corporate and facility staff;

- The political reality of the history and culture inherited at the creation of the corporation in which local autonomy was substantial, local pride in the facilities is retained, and political support for the local facilities is strong.

Our consultants viewed the operating structure as based on the regional approach and on the corporation's philosophy of local autonomy. The decision-making process includes the following resources:

- *Board subcommittees.* The board completes its work in preparation for meetings and decision making through a series of subcommittees. These working committees meet regularly in advance of the scheduled monthly board meetings and review materials pertinent to their domain of authority. They also determine if an issue has been sufficiently examined to warrant presentation to the full board. If so, the initiative is forwarded to the board, where additional debate may ensue. While a subcommittee may recommend an item for approval, only the full board can approve actions for implementation.

- *Public Health Facility Management Advisory Committees.* Created by law, these regional advisory committees give input to the president/chief executive officer and/or delegated staff on the needs of the communities. The chairs of the advisory committees sit on the Executive Management Advisory

Committee, which meets monthly with the president/chief executive officer, and play an important role in policy decisions at the facility and regional level. The chair of the Executive Management Advisory Committee serves as a member of the corporation's Board of Directors.

- *The Physicians Advisory Group.* This body comprises physicians throughout the islands who volunteer their time and talents to meet on a monthly basis with the president/chief executive officer to discuss clinical and medical staff issues facing the corporation's facilities. The Physicians Advisory Group represents the 800 physician staff members who are essential to the daily operations and success of the corporation.

- *Executive Management Team.* This group comprises the president/chief executive officer and the senior corporate and regional executive staff. Besides their own working group deliberations, these members, either individually or in groups, staff the board subcommittees, the Management Advisory Committees, and the Physicians Advisory Group. In addition, they may provide leadership to ongoing work groups.

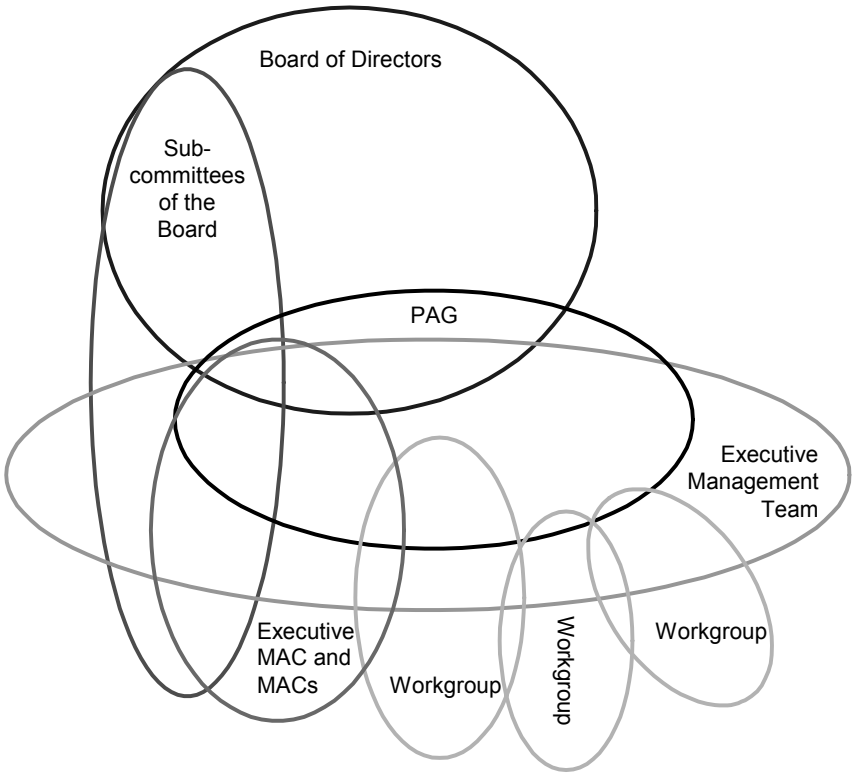
- *Selected work groups.* These groups may comprise individuals at all levels of the organization and from all regions and facilities. Projects are originated at the state or local level; work groups are then formed around topics. Examples of such groups might include the following: chief financial officer(s); information systems; patient accounts; and purchasing.

Our consultants observed that through these work groups, the corporation encourages efforts at standardization across the entire hospital system. In addition to process and procedure improvement, these teams foster the cultural development goal that the corporation is one organization rather than a group of independent ones.

Individually and collectively, the various committees and work groups staff projects and initiatives, eventually coming to agreement on actions to recommend for implementation. The results of analysis and review are presented to the appropriate board subcommittee. After deliberating, the subcommittees may refer them to the full board for further review and debate. Again, only at the full board meeting can an item be approved for implementation.

According to our consultants, the organization is a "matrix" in its actual operations, not the simple hierarchy that it may appear to be. The matrix approach to management fosters a bottom-up flow of facts and information rather than a top-down flow of dictates. Exhibit 3.1 illustrates our consultants' view of the matrix structure.

Exhibit 3.1
Matrix Operating Structure



"PAG" - The Physicians Advisory Group
"MAC" - Management Advisory Committee

Source: Meaghan Jared analysis.

Matrix approach to management has strengths and weaknesses but is realistic

As Exhibit 3.1 suggests, actions in the "matrix" are interlocking, and communication across constituencies and parties involved is a key to success. In Exhibit 3.2, our consultants summarize the strengths and weaknesses of this structure.

Exhibit 3.2
Strengths and Weaknesses of the Matrix Organizational Model

Strengths	*Weaknesses*
• Follows regionalization and locale of facilities • Fosters local input • Strengthens desire of all parties to participate • Reduces risk of making decisions contrary to local political considerations • Builds consensus around required actions • Enhances development of corporate culture	• More difficult to manage due to consensus nature of decision making • Reduces opportunity for consolidation and cost containment • Takes longer to complete decision-making and implementation processes

Source: Meaghan Jared analysis.

Our consultants view the matrix approach as sound in the environment in which the corporation must operate and as conducive to managing operations effectively. The consultants observed that the corporation's governing body and senior management are acutely aware of the complexity, political reality, and geographic dynamics of leading the corporation; the input-oriented management structure is designed to foster participation at all levels and in each community where facilities are located. The organizational model follows the regional nature of the corporation's service delivery locations.

While our consultants' organizational analysis concluded that input is the corporation's model, our own fieldwork found instances where facility staff had significant complaints about the corporation's lack of effective communication with them and its unwillingness to utilize their input.

Regionalization becomes a key policy issue

Our consultants' analysis led us to question whether the regional structure of the corporation should continue, particularly in light of the recommendations and suggestions made in this report.

In Chapter 2, we recommended tighter central control over key corporation operations such as contracting and financial management. Later in this Chapter 3, our consultants suggest an economic assessment of the benefits of outsourcing selected services; a similar analysis of

consolidating a wide range of business functions on Oahu; and a physician-driven analysis of service models and requirements at various geographic points in the state to define the optimum model for delivering care. At the same time, the consultants see the matrix approach as (1) more difficult to manage due to the consensus nature of decision making, (2) reducing opportunity for consolidation and cost containment, and (3) taking longer to complete decision-making and implementation processes. The consultants also say the matrix approach is based largely on regionalization.

Under these circumstances, we believe it is reasonable to ask whether the five geographic regions of the corporation, and the regional level of the corporation's administration, are necessary and appropriate. While our consultants observed that even the nation's decentralized hospital systems have strong linkages between the autonomous units and the corporate entity, we believe regionalization may make it more difficult to strengthen those linkages and implement the controls and initiatives that could improve the corporation's operations.

The Corporation's Performance on Standard Efficiency Indicators Is Mixed

Our consultants found that the corporation's operating performance is mixed. The larger facilities perform better than the smaller facilities.

Our consultants concluded that it would be difficult to compare the corporation's performance with other public hospital systems nationwide because other "comparable" entities are generally larger urban-oriented systems. Instead, they compared the corporation's performance on industry standard indicators to the performance of other facilities in Hawaii. They obtained the indicators from *The Comparative Performance of U.S. Hospitals: The Sourcebook*, HCIA-Sachs, 2001, which is organized around 58 individual measures of hospital performance, classified into seven major categories:

- Capacity and utilization;
- Patient and payer mix;
- Capital structure;
- Liquidity;
- Revenue, expenses, and profitability;
- Productivity and efficiency; and
- Pricing strategies.

When applying the standard indicators, the consultants first looked at the aggregate level (the corporation as a whole) and then divided the corporation's hospitals into two subgroups (large hospitals and small hospitals). It should be noted that 14 of the indicators are neutral, that is, there was no measure of efficiency, so the comparison was made using only 44 of the 58 characteristics.

When reviewing the corporation's aggregate performance, the corporation's hospitals compared favorably on 13 of the indicators and unfavorably on 31 of the indicators.

The more detailed comparison broke out the standards by subcategory and by large and small facilities, as well as in the aggregate. Exhibit 3.3 illustrates the comparison.

This comparison indicates that the corporation in the aggregate is operating below a favorable level. It also shows that the large facilities fare better overall than the small facilities.

Our consultants also chose three key characteristics to highlight the corporation's comparative performance: (1) percentage of operating expense incurred by overhead categories; (2) case flow; and (3) total asset turnover ratio. The results of these indicators also show a mixed performance.

The first characteristic was the percentage of operating expense incurred by overhead categories and the result was not favorable for the corporation's aggregate performance. This ratio measures how much of the corporation's overhead (administrative and general) accounts for its total expenses. The percentage of operating expense incurred by overhead categories was higher for the corporation than national and state medians. The corporation's aggregate ratio was 45 percent, where

Exhibit 3.3
Comparative Analysis on 44 Sourcebook Indicators

		Hawaii Health Systems Corporation Overall		Large Hospitals		Small Hospitals	
Category	Number of Indicators per Category	Number of Favorable Indicators	Number of Unfavorable Indicators	Number of Favorable Indicators	Number of Unfavorable Indicators	Number of Favorable Indicators	Number of Unfavorable Indicators
Capacity and Utilization	5	4	1	3	2	4	1
Patient and Payer Mix	1	0	1	0	1	0	1
Capital Structure	10	4	6	8	2	4	6
Liquidity	5	2	3	2	3	2	3
Revenue and Expenses	11	1	10	5	6	1	10
Production and Efficiency	7	2	5	5	2	2	5
Pricing Strategies	5	0	5	1	4	0	5
Total Indicators	44	13	31	24	20	13	31

Source: Meaghan Jared analysis.

the national and state medians approximate 32 percent. Typically, high values for this characteristic suggest high fixed costs and less flexibility to change operating cost structure, as well as a need to examine specific categories where administration and general costs are incurred.

The corporation's aggregate results were also less favorable with regard to case flow, another important indicator of a hospital's production and efficiency. This characteristic, measured as acute care discharges per acute care bed, is an indicator of both the average length of stay and occupancy rate. Typically, lower values indicate unfavorable levels of occupancy, utilization, or both.

The corporation's hospitals came out favorably, however, when the consultants looked at total asset turnover ratio. This production and efficiency characteristic is the net patient revenue divided by total assets. The corporation's hospitals came out high on this indicator, indicating relatively efficient hospital operations, given their material assets, a factor that can correlate with opportunities for profitability.

In sum, at the corporation-wide level, labor and overhead costs are both higher than the relative standards for the other Hawaii hospitals. The corporation's hospitals were underperforming in three key predictors of efficiency:

- FTE (full time equivalent) personnel per average daily census and per discharge;
- Overhead expense, as a percentage of total operating expense; and
- Number of discharges per bed.

While an initial reaction to the results of these indicators might be that facilities are overstaffed or employees overpaid, the actual root causes according to our consultants are the rural nature of the facilities, low volume of acute care patients, and comparison of the corporation's predominantly long-term care facilities, which may be licensed as hospitals, with traditional acute care facilities.

In order to more definitively assess the performance of the corporation against the other Hawaii hospitals, the consultants then reviewed the "production and efficiency" subcategory of characteristics. *The Sourcebook* states "Hospital operations and productivity analyses identify specific opportunities for revenue enhancement and cost containment, as well as ways to improve the effectiveness and efficiency of operations." The consultants then analyzed the data by dividing the corporation's facilities into the two subgroups of large and small facilities:

- Large facilities (Maui Memorial Medical Center, Hilo Medical Center, Kona Community Hospital)
- Small facilities (all other facilities)

The designation "large" or "small" depended primarily on the number of admissions. The consultants then used this analysis to make a more detailed and informed quantitative assessment of the corporation's operations and efficacy of performance. Exhibit 3.4 shows the comparisons for the large and small facilities.

Overall, the larger hospitals compare more favorably with the Hawaii comparison facilities than do (1) the corporation in the aggregate and (2) the smaller-facility group. In some cases, the larger facilities outperform the comparison facilities. Exhibit 3.5 illustrates the comparative analysis. We underlined the results that show a positive comparison.

Exhibit 3.4
Differentiation of Facility Characteristics

	Type of Facility	Beds	Staff	Physical Plant Square Feet	Admissions
Large					
Maui Memorial Medical Center	Acute	204	700	305,000	10,054
Hilo Medical Center	Acute	275	800	550,000	7,519
Kona Community Hospital	Acute	75	380	100,000	3,142
Small					
Kauai Veterans Memorial Hospital	Acute	49	140	75,000	850
Maluhia Hospital	LT Care	158	230	110,000	163
Leahi Hospital	LT Care	192	300	305,000	44
Kula Hospital	LT Care	105	200	165,000	35
Samuel Mahelona Memorial Hospital	LT Care	81	150	78,000	154
Hale Hoʻola Hamakua	Rural	50	80	120,000	166
Kaʻu Hospital	Rural	21	30	21,000	41
Kohala Hospital	Rural	26	45	35,000	44
Lanai Community Hospital	Rural	14	40	24,000	84

"LT" - Long-term

Source: Hawaii Health Systems Corporation data.

Exhibit 3.5
Comparative Analysis
Selected Operating Characteristics (1999 Data)

		50th Percentile	Hawaii Health Systems Corporation		
Characteristic	**Favorable Value/Median Relationship**	**State of Hawaii**	**Large**	**Aggregate**	**Small**
1. FTE Personnel Per Adjusted Average Daily Census	Below	5.03	4.25 (Favorable)	12.95	56.82
2. FTE Personnel Per 100 Adjusted Discharges	Below	8.50	6.25 (Favorable)	27.92	38.44
3. FTE Personnel Per 100 Adjusted Discharges, Case Mix-Adjusted	Below	6.08	4.86 (Favorable)	19.65	48.07
4. Salary and Benefits Expense Per FTE Personnel	Below	$49,115	$51,937	$45,808 (Favorable)	$45,352 (Favorable)
5. Salary and Benefits Expense, as a Percentage of Total Operating Expense	Below	46.93%	43.21% (Favorable)	59.54%	66.47%
6. Overhead Expense, as a Percentage of Total Operating Expense	Below	31.67%	35.26%	46.48%	48.03%
7. Discharges Per Bed, Acute Care	Above	38.59	37.64	1.62	1.18
8. Total Asset Turnover Ratio	Above	0.91	1.22 (Favorable)	1.22 (Favorable)	1.29 (Favorable)

Source: Meaghan Jared analysis.

The first three characteristics show staffing comparisons. As noted, the large facilities show favorable and more efficient ratios than the state median, while the small hospitals show higher staffing levels and compare less favorably.

The fourth characteristic shows median labor costs. National data indicate that these costs do not vary significantly among large and small hospitals or between rural or urban locations. Therefore the results are in line with expectations that show both small and large corporation hospitals with salaries and benefits that approximate the state median of $49,115, which is in the 85th percentile nationally.

The fifth characteristic shows that isolating the larger hospitals reveals reasonable performance relative to both state and national benchmarks, with less than 45 percent of total operating expense composed of salaries and benefits.

Characteristics 6, 7, and 8 are the same characteristics discussed earlier and now broken out by small and large facilities. Number 6, the percentage of operating expense incurred by overhead categories, shows that large facilities have a lower percentage of the overhead going to total operating expenses than do the smaller facilities.

The largest discrepancy between the small and large hospitals is seen in the seventh characteristic. This characteristic, known as case flow, is measured as acute care discharges per acute care bed, and, as discussed earlier, is an indicator of both the average length of stay and occupancy rate. The corporation's large hospitals approximate both state and national medians with over 37 discharges per bed, while the small hospitals have only 1.18 discharges per bed.

A final production and efficiency characteristic is the total asset turnover ratio, or the net patient revenue divided by total assets, which is seen in characteristic number ten. Both large and small corporation hospital groups outperform benchmarked data. This indicates relatively efficient hospital operations.

The disparity in the results is due in part to the fact that the larger corporation facilities are acute care organizations. Therefore, they are more directly comparable with other facilities in Hawaii using the data in *The Sourcebook*. Volume is also a significant factor in defining why the corporation's larger facilities perform better than the smaller facilities. The larger facilities have sufficient capacity and patient volume to allow effective patient care delivery programs to be developed. This results in favorable comparison with peer entities in Hawaii.

Our consultants also compared the small hospitals against a more detailed subset of like facilities. They compared available benchmarked data for rural hospitals with 25 to 100 beds both nationally, and where available, the Pacific Region, which includes Hawaii.

The corporation's small hospitals also compared unfavorably in this analysis. Their production and efficiency characteristics continued to trail national benchmarks for rural hospitals in seven of the eight available characteristics. However, similar to results described above, the corporation's small hospitals showed a better total assets turnover ratio than other rural hospitals nationally. Exhibit 3.6 shows the results:

Exhibit 3.6
Small Facilities—Comparative Analysis

	50th Percentile			
Characteristic	**All Rural Hospitals 24 to 99 Beds**	**Pacific Rural Hospitals 25 to 99 Beds**	**Hawaii Health Systems Corporation-Small**	**Hawaii Health Systems Corporation-Small Average**
FTE Personnel Per Adjusted Average Daily Census	5.57	6.65	56.82	28.51
FTE Personnel Per 100 Adjusted Discharges	5.35	Not available	38.44	27.98
FTE Personnel Per 100 Adjusted Discharges, Case Mix-Adjusted	4.86	Not available	48.07	29.23
Salary and Benefits Expense Per FTE Personnel	$33,828	Not available	$45,352	$43,416
Salary and Benefits Expense, as a Percentage of Total Operating Expense	50.84%	50.21%	66.47%	65.18%
Overhead Expense, as a Percentage of Total Operating Expense	31.27%	Not available	48.03%	47.51%
Discharges Per Bed, Acute Care	28.39	Not available	1.18	2.57
Total Asset Turnover Ratio	1.00	Not available	1.29	1.89

Source: Meaghan Jared analysis.

The smaller facilities' substandard performance across over two-thirds of the key indicators of efficient production significantly influences the corporation's overall performance and makes it lower than it would otherwise be.

The inefficiency of the corporation's small facilities is made up of a variety of factors. Among the most significant is the rural flavor of the facilities and the inclusion of long-term care facilities in the analysis. Outputs are also low, resulting in higher unit cost.

However, the rural nature of the system creates that perception. In the smaller facilities, the environment is one where staff must be available even when the facilities do not have a large volume of patients, and this results in the appearance of inefficiency. The reality is that provision of these services is typically a safety net provision of public hospitals and usually mandated and sponsored by a governmental agency. Thus the

consultants stated that the data, when disaggregated, indicate that the corporation is reasonably efficient when the large facilities are compared to peer type organizations and the mandated service nature of the smaller rural facilities is considered.

The corporation also inherited physical plants in need of repair. Age of physical plant is another factor in assessing the characteristics of an organization. A hospital's average age of plant, when compared to other hospitals of similar size and location, is one indicator of market competitiveness, particularly in terms of patient perspective. Deteriorating physical plants have an adverse impact on cost, operating efficiency, competitive position, and delivery of patient care services. Using *The Sourcebook*, data in Exhibit 3.7 indicate the following regarding the corporation's physical plant:

The corporation in aggregate has older facilities compared to both national and state norms. The larger hospitals' average plant age is notably younger than the other hospitals at just less than 7.5 years. Meanwhile, the smaller facilities' age, at over 12 years, may be an indication of necessary replacement or renovation of assets in the future.

Our consultants observed that this trend fits with the corporation's recent development of a multi-year (2000 to 2003) capital improvement plan that identified more than $42 million in required renovations.

Exhibit 3.7
Comparative Age of Physical Plant

Characteristics	Favorable Value/Median Relationship	All Facilities	State of Hawaii	Hawaii Health Systems Corporation		
				Large	Small	Aggregate
Average Age of Plant, Total Facility	Below	9.53	9.16	7.38	12.44	11.60

Source: Meaghan Jared analysis.

Executive Compensation Raises Fundamental Policy Issues

Generally, our consultants found that the corporation's executives are underpaid when compared to national industry standards. We found that salaries paid to the corporation's executives are sometimes lower and sometimes higher than salaries of top officials of state government in Hawaii. We believe that determining the appropriateness of compensation paid to executives of a corporation that is a hybrid of state agency and business raises a fundamental policy issue.

Corporation's executives are underpaid in light of industry standards

In establishing the corporation, the Legislature authorized the chief executive officer to appoint up to 18 exempt positions to build an executive management team. The law did not specify job titles, descriptions, or compensation.

In August 1998, the corporation contracted the consulting firm of William M. Mercer, Incorporated, to develop a market-based salary structure for executive and exempt employees. Mercer was to develop a salary structure representative of competitive pay practices in the relevant geographic and health care labor market, and emphasized the ability to recruit and retain a highly qualified staff by providing a compensation package that was competitive with comparable employees. We found that the corporation adopted the salary ranges recommended by the Mercer report and, with few exceptions, is paying its executives within those ranges.

Generally, our consultants found that the corporation's executives are underpaid when compared to national industry standards. In comparing senior management salaries at the corporation to data presented in national compensation surveys, our consultants found that over 80 percent of the management team are paid less than their industry peers. It is important to note that the national figures used in the compensation comparison utilized aggregate data from hospital systems with varying management and operational structures from across the country. The consultants were not able to identify a hospital system comparable to the corporation that was structured as a public-private entity managing multiple facilities in both urban and rural settings.

However, our consultants found that the salary of the corporation's chief information officer is at the maximum salary range point of the Mercer study and, in fact, approaches the 75th percentile of national data. Our consultants also found that the corporate controller's salary at the time of our study exceeded the national median level of compensation by as much as $60,000 to $70,000, and exceeded the maximum Mercer-recommended salary range point by $38,895.

Our consultants suggested that the corporation closely examine the appropriateness of its executive compensation levels. Specifically, the corporation's board should commission a compensation study, reestablish requirements for each executive position and, as appropriate, revise compensation levels. The consultants also suggested that the board fully implement the corporation's executive incentive plan, and earned incentives should be paid at the completion of FY2000-01.

Executive salaries are sometimes higher than those of state officials

To supplement the consultants' work, we examined salary data on Hawaii state officials. We found that salaries paid to the corporation's executives sometimes fell below and sometimes exceeded salaries of other Hawaii state officials (see Exhibit 3.8).

Exhibit 3.8
Comparison of Compensation Between Hawaii Health Systems Corporation Executives and Other State Officials

Hawaii Health Systems Corporation Executives	Hawaii State Officials
Chief Executive Officer - $265,000*	Dean of the University of Hawaii's John A. Burns School of Medicine - $345,720**
Chief Financial Officer - $171,000*	Director, University of Hawaii Institute for Astronomy - $225,264**
Prior Contracted Corporate Controller - $159,895*	Chief Justice, Hawaii Supreme Court - $116,779**
Senior Corporation Counsel - $149,000*	Governor of the State of Hawaii - $94,780**
Chief Human Resources Officer - $112,000*	Comptroller, Department of Accounting and General Services - $85,302**
	Director, Department of Human Resources Development - $85,302**
	Attorney General - $85,302**
	Director of Finance - $85,302**
	Director, Department of Health - $85,302**

*Salaries in effect at the time of our fieldwork.
**Current salaries.

Outsourcing, Consolidation, Incentives, and Alternative Service Models Need Careful Consideration

Our consultants found that the corporation in its current configuration is not likely to become self-sufficient. The enabling legislation had several controls that limit the corporation's ability to be self-sufficient, including limitations on outsourcing.

Our consultants did, however, find that the corporation could make progress toward self-sufficiency through improvements at the detailed operating level and suggested some organizational options, as shown in Exhibit 3.9.

Exhibit 3.9
Comparative Analysis—Organizational Options

Opportunity	*Implication*	*Barrier(s)*
Outsourcing selected services such as: • Laundry • Housekeeping • Others	Reduced cost to the organization; higher quality services	Precluded by statute; potential loss of jobs generating union or political intervention
Consolidating selected operations in a single location. For discussion purposes, assume consolidation of patient accounts operations on Oahu. Such consolidations are typical and the economics of scale generate cost savings for the entity as a whole.	Reduced cost; improved performance; increased cash collections; lower requirements for contractual allowances and bad debts	Potential loss of jobs on neighbor islands; union intervention; political intervention; decreased autonomy of neighbor island facilities
Incentives for staff and/or revised fringe benefits	Potentially lower cost and higher productivity among employees; greater accountability	Precluded by statute; contrary to union policy and conflicts with current state personnel system
Adjusting service delivery levels	Shift levels of services to required levels at various sites, rather than those in place in 1995/1996. Result could be overall higher level of care.	Precluded by statute without legislative approval; imbedded in the politics between and among islands

Source: Meaghan Jared analysis.

The consultants indicated that these alternatives should be considered with an economic assessment, but in each case the political considerations and any considerations based on collective bargaining units should be incorporated.

Specifically, the consultants proposed that the corporation conduct a series of feasibility studies including:

- An economic assessment of the benefits of outsourcing selected services. The analysis should include careful assessment of the actual and any human costs of implementation. Input should be obtained from the communities affected;

- A similar analysis of consolidating a wide range of business functions on Oahu. These might include patient accounts, information systems, general accounting, and others. This second analysis should focus on the same data outputs as the outsourcing analysis; and

- A physician-driven analysis of service models and requirements at various geographic points in the state. The purpose would be to define the optimum model for delivering care. The analysis should be supported with a detailed cost analysis. This could then be compared with the current service model.

Political considerations and considerations based on collective bargaining units should be incorporated into the above analyses. The consultant observed that through the approach outlined above, a body of data to support effective public policy making could be developed.

Certain Other Functions Appear to Be Handled Appropriately

Our consultants had a favorable finding on the corporation's maintenance of services. The consultants also stated that while they believe the corporation's estimates of allowances for contractual adjustments and bad debt are reasonable, the corporation should consider selected adjustments to further refine the process.

Services have been maintained

Our consultants found that the corporation has not substantially reduced or eliminated direct care services since its inception and that board members and senior executives were very aware of the legislative intent to maintain services. The consultants also found that the corporation has implemented several new programs, including an assisted living program.

Allowances for contractual adjustments and bad debt are calculated correctly, but the process could be refined

Our consultants found that the corporation's overall methodology for calculating contractual adjustments (reserves) and bad debt is technically accurate and leads to a reasonable estimate of the value of accounts receivable. However, the consultants also stated that the corporation should consider selected adjustments to further refine the process.

Since the differing facilities have different prices, mix of reserves, and contract arrangements, they should also have differing estimated percentages for contractual allowances.

Two of the three hospitals, Hilo and Maui, adjusted their reserve rates year to year as expected, but Kona did not.

The methods the facilities used also had additional variances. For example:

- Maui uses a far more detailed inventory of payers in developing its reserve percentages than Hilo and Kona.
- Maui also adds back the value of credit balances in calculating its reserves. This adds credibility to the estimate by recognizing that the organization may have liability to these accounts, and thus the net accounts receivable asset value should be reduced.
- The three facilities use differing bad debt percentages at different age groupings of bills (see Exhibit 3.10).

The consultants stated that the corporation's overall accounting policies should incorporate consistency across facilities in calculating and setting reserve values.

While the consultants believe the estimates are reasonable, they also stated that the corporation should consider selected adjustments to further refine the process. The consultants stated that consideration should be given to:

- Incorporating more consistency across organizations as to method. The corporation should develop a policy that standardizes financial classes to be used in the analysis, methods to determine the specific account classification percentage, and the timing of change in bad debt and bad debt percentages used in the calculations. This approach will standardize the process, but the percentages used in each facility for each classification will remain facility-specific. This will foster more efficient corporate review of the local facilities' estimation work and enhance timeliness and consistency of financial statement presentation on a month-to-month basis.

- Re-evaluating the Kona contractual-allowances percentage by payer class. This should be done to ensure the contractual allowances are in line with year-to-year changes in payer and/or patient mix positions, and to take advantage of each year's collections experience.

In each case, the proposed adjustments would result in a more conservative presentation of the value of the accounts receivable. Accordingly, a potential decline in net patient service revenue on an ongoing basis could occur. However, the consultants believe that this change could be offset with continued changes and refinements in the revenue cycle that the corporation has in process and should continue to pursue with extensive vigor.

Exhibit 3.10
Bad Debt Percentages—Variances by Facility

Age of bill (in days)	Medicare	Medicaid	HMSA	Contracts	Self-Pay
Maui:					
Less than 60	5%	5%	5%	25%	50%
61-120	5%	5%	5%	50%	75%
121-150	5%	5%	10%	75%	75%
151-365	75%	75%	75%	75%	75%
More than 365	100%	100%	100%	100%	100%
Hilo:					
Less than 60	5%	5%	5%	5%	50%
61-120	5%	5%	5%	5%	50%
121-150	20%	20%	20%	5%	75%
151-365	75%	75%	75%	75%	100%
More than 365	100%	100%	100%	100%	100%
Kona:					
Less than 60	0%	0%	0%	5%	89%
61-120	0%	0%	0%	5%	89%
121-150	5%	5%	5%	5%	89%
151-365	5%	10%	20%	75%	89%
More than 365	100%	100%	100%	100%	100%

Source: Meaghan Jared Partners Inc. from Hawaii Health Systems Corporation data.

Conclusion

Given the corporation's current structure and mandates, our consultants concluded the corporation will not achieve self-sufficiency. We believe that significantly reducing the corporation's need for general fund appropriations, including emergency appropriations, is a more realistic goal.

Achieving this goal will depend on many factors. Some factors remain outside the corporation's control, such as federal reimbursement levels established in Washington, D.C. However, the corporation's board and administrators can influence other factors. Examples include making improvements in the corporation's contracting and financial operations. Our consultant's suggestions for considering consolidation and outsourcing also bear looking into.

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Responses of the Affected Agencies

Comments on Agency Response

We transmitted drafts of this report to the chairperson of the Board of Directors of the Hawaii Health Systems Corporation, the corporation's president/chief executive officer, and the Department of Health on April 17, 2002. A copy of the transmittal letter to the chairperson is included as Attachment 1. Similar letters were sent to the president/chief executive officer and the Department of Health. The response of the president/chief executive officer is included as Attachment 2. The chairperson and the Department of Health did not submit responses.

In his response, the president/chief executive officer acknowledged that many of our findings are accurate and our recommendations are reasonable. However, he disagreed on some points and clarified others.

The president/chief executive officer expressed concern "that the remarks in [our] report about consistency with public accountability and public procurement practices may reflect a bias toward standard government procurement practices that would be inconsistent with sound business practices that focus on achieving positive financial outcomes rather than focusing on compliance with processes to the possible detriment of outcomes." However, we wish to emphasize, as we do in our report, that it is state law that specifically requires the corporation to develop internal policies and procedures for the procurement of goods and services, "consistent with the goals of public accountability and public procurement practices." Moreover, sound procurement practices, such as adequate review and accountability, do not preclude good business decisions.

In addition, the president/chief executive officer stated that some of the contracts that we identified as discretionary were actually competitive procurements. However, our review of procurement files found no documentation that this was the case.

The president/chief executive officer also questioned a suggestion of our consultants in Chapter 3 of the report that the corporation consider adjusting the bad debt percentages by applying these amounts to the gross receivables. After discussion with our consultants, we deleted the consultants' suggestion as erroneous.

Our final report also contains a few minor, technical editorial changes.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

April 17, 2002

COPY

Ms. Diane J. Plotts, Chairperson
Board of Directors
Hawaii Health Systems Corporation
3675 Kilauea Avenue
Honolulu, Hawaii 96816

Dear Ms. Plotts:

Enclosed for your information are 13 copies, numbered 6 to 18 of our confidential draft report, *Follow-Up Study of the Hawaii Health Systems Corporation*. We ask that you telephone us by Friday, April 19, 2002, on whether or not you intend to comment on our recommendations. Please distribute the copies to the members of the board. If you wish your comments to be included in the report, please submit them no later than Wednesday, April 24, 2002.

The President and Chief Executive Officer of the Hawaii Health Systems Corporation, Department of Health, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this confidential draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Everyday"

April 24, 2002

COO/CFO-02-088

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OFC. OF THE AUDITOR
STATE OF HAWAII

Ms. Marion Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

Thank you for the opportunity to respond to the draft Follow-Up Study of the Hawaii Health Systems Corporation. We appreciate the professionalism of your staff throughout the conduct of the Audit.

We acknowledge that many of the findings are accurate and the recommendations are reasonable, however, we disagree on some points and think it is essential to clarify other points with additional information, thus, our comments on the Audit are as follows:

Recommendation 1 & Recommendation 2, page 31:

The Corporation's centralized negotiation of contracts and control of standardized purchasing practices have resulted in savings of millions of dollars over the past four years. This is reflected in the fact that the Corporation has held the cumulative increase in expenses over the past four years to only $3 million (less than 1 percent) while offering more services and serving more patients, as evidenced by an increase in average daily census from less than 1,000 to almost 1,100 and an increase in cumulative operating revenues by over $130 million (please see attached graphs #1 and #2). Also it is significant to note that in April 2002 HHSC received national recognition as the most controlled and compliant purchaser of healthcare goods and services of all MedAssets Health Services Corporation of America (HSCA) customers in the Western United States (MedAssets HSCA is the third largest group purchasing organization – GPO – in the nation).

While the Corporation has appropriately and successfully focused on outcomes resulting in big dollar savings, we are not satisfied with the current level of control and compliance with overall procurement policies and agree that action must be taken to improve compliance. However, the conclusion that control over procurement and contract spending has declined does not appear to be correct. Since the 1999 Audit, the Corporation has revised procurement policies and procedures and has also implemented a semi-annual review program to identify variances from policies and procedures and to provide on site training to staff members and members of management. This program has been effective in identifying non-compliance opportunities for improvement and has provided a great deal of information for management and auditors on procurement issues that were not available to auditors in 1999. Although compliance with procurement policies and procedures has been improved, the large volume of self-reported information about compliance shortfalls may have led to the impression of even higher non-compliance.

We are concerned that the remarks in the report about consistency with public accountability and public procurement practices may reflect a bias toward standard government procurement practices that would be inconsistent with sound business practices that focus on achieving positive financial outcomes rather than focusing on compliance with processes to the possible detriment of outcomes. We applaud the wisdom of the Legislation that created HHSC and that provided for the establishment of separate procurement policies and procedures and the legislative intent to free the facilities of the corporation "from unwarranted bureaucratic oversight." The ability to make decisions "based upon a prudent business

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person standard" instead of overly rigid adherence to policies and procedures (P&P) has been invaluable to HHSC. The concept that "time equals money" and "loss of timely opportunity equals cost," must be balanced against rigid compliance to come up with a business practice mix that facilitates rapid "outcome focused" decision making with strong accountability. Survival in today's ever changing healthcare environment demands quick decision making and the ability to take advantage of cost savings/-revenue enhancement opportunities at all levels of operation.

A specific example of actual savings compared to potential losses is the $40 million system-wide contract with Clinical Laboratories of Hawaii that was criticized in the audit. This contract re-negotiation has produced $20 million in savings over the past four years. Details on these savings are available later in this letter.

We understand the concern expressed in the draft report about extensive use of discretionary purchases and provide two points for consideration: First, the use of management discretion in the awarding of contracts is frequently the most appropriate course of action that enables administrators to respond appropriately and rapidly to needs and to opportunities. Second, it should be noted that many of the contracts identified as discretionary procurements were actually competitive procurements that for one technicality or another did not strictly qualify as requests for proposals (RFP) or invitations for bid (IFB), the formal competitive procurements as defined by HHSC Procurement P&P. In these cases, although there was often much competition considerations, the corporate staff scrupulously and appropriately processed the procurements as discretionary contracts. A new category of competitive procurements – Request for Oral Presentations (RFOP) has now been established to facilitate rapid processing of competitive procurements and facilitate compliance.

Recommendation 3, page 31:

We fully agree with the on-going need to address the concerns of information technology users and the need to better document committee meetings minutes. We interpret this recommendation to be a validation of current practices because we have now been documenting Information Technology Steering Committee meetings for over a year with e-mail feedback to all participants. We must additionally comment that our work in information technology has brought HHSC from the " dark ages " five years ago where there was no strategic information technology plan and virtually no information technology support to a prominent position of national recognition as a leader in healthcare automation and telemedicine.

Recommendation 4, page 31:

We agree with the recommendation to continue efforts to develop the corporation's personnel system and to take advantage of recent legislation. We have made huge strides in this area and are working closely with both the administration and other jurisdictions to rapidly implement personnel system change. Please recognize that this is a laborious process requiring virtually the full-time dedication of several individuals in the corporate office, tremendous involvement by all hospital personnel offices, and a tremendous amount of sensitive interaction with our union partners.

We also agree that it is preferable to directly employ corporate executives rather than engage independent contractors to perform executive functions. However, some situations require creative action to obtain the desired result. In this case, HHSC had to be particularly innovative to craft a relationship through which we could take advantage of the special skills offered by one very talented individual. Although, HHSC derived tremendous return from this initiative, the "independent contractor" relationship with the Corporate Controller was terminated in May 2001 because the incumbent moved to a higher paying position out-of-state. No "independent contractors" are now being utilized to perform executive functions.

Recommendation 5, page 31:

Management is taking action to establish an internal audit function. It is not fully accurate to characterize the Corporation as not having a board audit committee because the Board Finance and Information Systems Committee performs the basic functions of an audit committee. The Board will discuss the concept of establishing a separate audit committee, but this issue is a challenge for a Board with fiduciary responsibilities serving on a volunteer basis given the volatile legal environment in which we must operate today.

Deloitte & Touche, LLP has rendered a clean audit on HHSC for four consecutive years, meaning that no material weaknesses have been reported. The number of reportable conditions reported each year has decreased from four in 1998 to one in 2001. Some conditions reported in the FY 2000 D&T audit that were included in the Legislative Audit Report (e.g., segregation of duties over cash-related functions) were not repeated in the FY 2001 D&T audit. We can and should do even better and therefore agree with the recommendation to improve and enforce policies and procedures to ensure adequate controls for major programs such as billing, collections, and payables. However, we ask the Legislative Auditor to recognize that in this instance and other instances over the course of the Legislative Audit, some findings are dated because they have already been identified by HHSC and corrected.

The audit report alleges that "the corporate office lacks control over invoices it receives from others," and that accounts payable could not be verified to the general ledger. Since no details were provided to us with the audit report, it is difficult for us to verify or deny these allegations. The corporate office reconciles its accounts payable details to the general ledger on a monthly basis. HHSC's financial auditors (Deloitte & Touche LLP) audited the corporate office financial statements, and has not reported to management any reportable conditions or material weaknesses as a result of a failure to reconcile accounts payable details to the general ledger balances since D&T became HHSC's auditors in FY 98.

The audit report also alleges that "there is no internal review process for accounts payable" and "accounts payable duties were not segregated." Invoices are not put into the accounts payable system without the approval of the department head responsible for the expenditure. Further, the Chief Financial Officer or his designee will not sign a check without supporting documentation, and there have been several instances where the Chief Financial Officer has refused to sign the check until adequate documentation is provided. Finally, the reconciliation of the accounts payable detail to the general ledger balance was being reviewed on a monthly basis during the period in question by the fiscal agent or the corporate controller, and D&T did not report to management any reportable conditions or material weaknesses in this area.

HHSC acknowledges that the Corporation can certainly improve its processing of accounts payable, particularly in the area of policies and procedures. Management currently has a policy pending on invoice processing which should address most, if not all, of the areas of concern mentioned in the audit report.

We appreciate the consultant's conclusion that HHSC's "overall methodology for calculating contractual adjustments (reserves) and bad debt is technically accurate and leads to a reasonable estimate of the value of accounts receivable."

The comment in the draft report that HHSC should consider adjusting bad debt percentages by applying amounts to gross receivables cannot be favorably considered as the recommendation is not in accordance with healthcare industry accounting practice and would misstate values. Standard practice in the industry is to apply bad debt percentages to the net receivables (after contractual allowances). The net receivables (after contractual allowances) represent the true amount that should be collectible from third party payers and patients, and it makes logical sense that any bad debt to be written-off would be at the net amount rather than the gross amount. Further, HHSC's financial auditor (Deloitte & Touche LLP) reviews bad debt percentages on an annual basis and has determined that our methodology does not result in a material misstatement of HHSC's financial statements. Applying the bad debt percentages to

the gross receivables would result in a material misstatement of the allowance for doubtful accounts and the provision for bad debt.

Recommendation 6, page 31:

Per the State Ethics Commission, HHSC executives have proven to be diligent in obtaining the review and approval of the State Ethics Commission when they are considering sitting on outside boards. In fact, an employee of the Commission recently commented that HHSC is one of the most active agencies in seeking advice and approval. We value the Ethics Code so highly that it is largely quoted in our Corporate Bylaws, along with a detailed section on conflicts of interest.

A review of the Ethics Code supports the HHSC decision not to obtain approval of the Ethics Commission prior to appointment of HHSC executives to the Ali'i Community Care, Inc. (Ali'i) Board. Ali'i is a wholly owned subsidiary of HHSC, with the sole member being HHSC. The HHSC executives who serve on the Board of Ali'i are sitting in that capacity with no remittance because it is part of their jobs. Accordingly, they have a duty to ensure that the interests of HHSC are never compromised. The provisions of the Ethics Code are intended to deter employees of the State from sitting on "private" boards that may have a conflict with the interests of the State. There clearly can be no such conflict here, where Ali'i is owned and operated by HHSC.

Additional Comments:

We ask that the Auditor please consider modifying the first statement on page 11, "Summary of Findings," Chapter 2, to read "The corporation's control of its procurement and contracting still needs improvement. Through better control, the corporation may further increase the millions of dollars in savings that have already been achieved since the corporation was formed in 1996," or words to that effect. To substantiate our request for this modification to wording in the Audit Report, please consider that:

> HHSC has actually been able to consolidate and re-negotiate key contracts for our 12 hospitals, contributing in large part to our operational savings of $130 million over the past four years by "holding the line" on expenses and increasing revenue.
>
> In terms of magnitude, much of the concern expressed over HHSC discretionary contracting control revolves around one single contract of over $40 million for laboratory services, suggesting that significant savings could have been realized if this contract had been put out for bid. The report does not mention that this contract was initially awarded in 1997 after a precise and exhausting RFP process between the only two providers capable of offering the service in the State of Hawaii and that the RFP process reduced the recurring laboratory services cost to HHSC from $15 million to $10 million per year. It was the extension of this contract with full Board of Directors review and approval in subsequent years that was discretionary.
>
> Although HHSC's procurement and contracting control can be improved in many ways as appropriately pointed out by the Audit, nonetheless, HHSC has received national recognition in healthcare procurement twice in the past five years (most recently in April 2002) for our demonstrated control and compliance performance.

The Audit under discussion is the second full Audit of HHSC in the past four years. At the start of the first Audit and again at the start of the second Audit, we asked the Audit team to please advise HHSC immediately if they identified any activity or practice that resulted in inefficiency so that HHSC could take immediate corrective action and not have to wait until the Audit was complete. We clearly acknowledged and agreed that any concern raised by the Audit should be written up and included in the final report. Although this process was not agreed to for this audit, we request that this process change be considered for future Audits as a means of facilitating more timely implementation of corrective actions. Many of the

concerns raised over the course of this one and one-half year Audit have already been identified and corrected by HHSC, but if we could have had collaborative information sharing during this Audit, more could have been accomplished faster.

We applaud the wisdom of the State Auditor for contracting with a healthcare consultant to help review, evaluate, and offer "healthcare specific" conclusions about the operations of HHSC over the past five years. We especially appreciate your healthcare consultant's favorable findings on the Corporation's maintenance of services. Quality, accessible, and affordable healthcare for the communities we serve is the reason that HHSC exists. Your highlighting this often overlooked point is tremendously important.

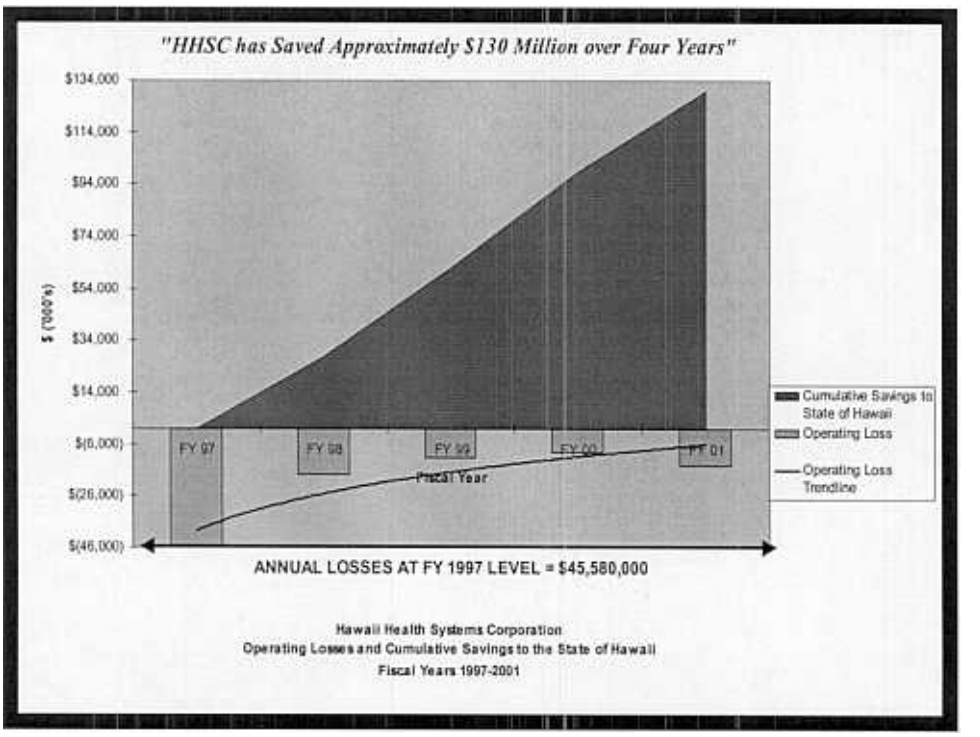
We also appreciate your consultant's review of HHSC executive salaries because this has been, as you point out, a policy issue. Your consultant's conclusion that "The corporation's executives are underpaid compared to national industry standards" underscores the dilemma of our "half-public/ half-private" corporation. Your consultant's recommendations for HHSC organizational change to overcome this "half-public/half-private" status will be fully evaluated by the HHSC Board, community advisors and management in concert with our union partners, employees, and medical staff. Using your consultant's recommendations, we will develop alternatives for consideration in the next legislative session that will improve operations and reduce costs to the State for the services HHSC provides. In this regard, we request you provide HHSC a complete copy of your consultant's final report so we can gain an even better understanding of his conclusions.

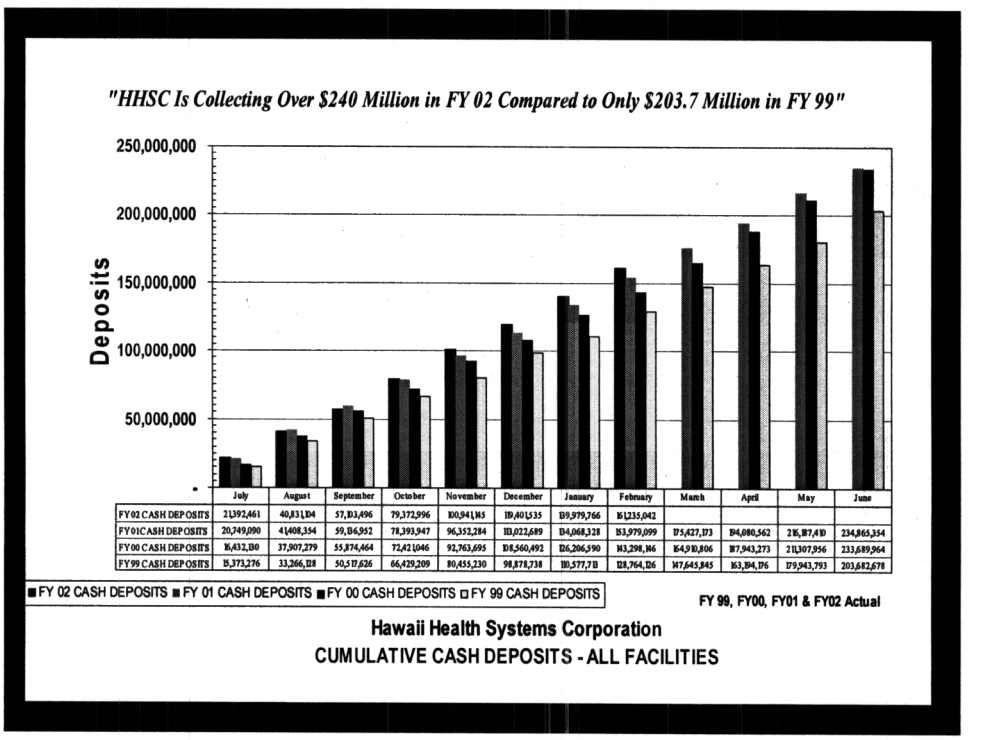
Again, we appreciate the professionalism and courtesy of your staff during this Audit. Please do not hesitate to call me if you have any questions or want to discuss any portion of the Audit or our response.

Most sincerely,

THOMAS M. DRISKILL, JR.
President and Chief Executive Officer

Attachment





	July	August	September	October	November	December	January	February	March	April	May	June
FY 02 CASH DEPOSITS	21,392,461	40,831,104	57,103,496	79,372,996	100,941,185	119,401,535	139,979,766	161,235,042				
FY01CASH DEPOSITS	20,749,090	41,408,354	59,116,952	78,393,947	96,353,284	113,022,689	134,068,328	153,979,099	175,427,173	194,080,562	216,187,410	234,865,354
FY 00 CASH DEPOSITS	16,432,180	37,907,279	55,874,464	72,421,046	92,763,695	108,560,492	126,206,590	143,298,146	164,910,806	187,943,273	211,307,956	233,689,964
FY 99 CASH DEPOSITS	15,373,276	33,266,128	50,517,626	66,429,209	80,455,230	98,878,738	110,577,718	128,764,126	147,645,845	163,194,176	179,943,793	203,682,678