

**BUDGET REVIEW AND ANALYSIS:
COUNTY/STATE HOSPITAL PROGRAM
AND THE
HEALTH CARE PAYMENTS PROGRAM**

A Report to the Legislature of the State of Hawaii

**Submitted by the
Legislative Auditor of the State of Hawaii**

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FOREWORD

In response to legislative direction, the Office of the Legislative Auditor maintains a budget review and analysis program to provide the Legislature with additional information and perspectives regarding program and budget requests.

In this report, the focus is upon two closely interrelated administrative programs—the county/state hospital program carried out through the Department of Health and the health care payments program (Medicaid) administered by the Department of Social Services and Housing. Besides being interrelated, the two programs are quite large; their annual expenditures are approaching \$75 million and \$200 million, respectively.

This report presents the results of our examination of selected aspects of the two programs.

We wish to acknowledge the cooperation and assistance extended to our staff by officials and personnel of the Department of Health, the Department of Social Services and Housing, the Department of Budget and Finance, the Department of Accounting and General Services, the Department of the Attorney General, the Hawaii Medical Services Association, and the Hawaii Office of the Health Care Financing Administration, U.S. Department of Health and Human Services.

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Chapter 1

INTRODUCTION

Purpose and Focus of Budget Review

This budget review and analysis effort was undertaken in response to provisions contained in the legislative appropriation acts of 1981 and 1982, which directed the Legislative Auditor to initiate a program of budget review and analysis. The overall purpose of this effort is to assist the Legislature in gaining a better understanding of the program and budget requests coming before it for consideration.

More specifically, the objectives of budget review and analysis are:

1. To assess the processes by which budgets are developed and executed, with emphasis on quality of review and analysis at key decision points.
2. To identify and assess significant internal and external factors which influence or constrain budget preparation and execution.
3. To identify areas where the Legislature has expressed specific interest or concern and determine and assess the adequacy of the executive's responses.
4. To identify significant budget changes and evaluate the justifications or explanations provided to support those changes.
5. To examine and evaluate the content and presentation of existing budget information, provide additional or supplemental information, or suggest alternative means of presentation.

In the budget review cycle for 1984, we focused upon selected aspects of the major program areas of health and social services. In this budget review cycle, we continue to direct our attention to these two areas of concern. However, this time our specific focus is upon: (1) the county/state hospital program administered by the Department of Health, and (2) a follow-up review of the health care payments program (Medicaid) administered by the Department of Social Services and Housing.

Organization of the Report

This report consists of six chapters. Chapter 1 is this introductory chapter. Chapter 2 provides some background information on the origins and present status of the county/state hospital program, on major trends affecting hospital care in the United States and in Hawaii, and on Hawaii's Medicaid program and its relationship to the county/state hospital program. Chapter 3 discusses the general framework and planning basis of the budgeting process for the county/state hospital program. Chapters 4 and 5 then examine more fully the revenues and expenditures of the county/state hospital program. Finally, Chapter 6 reviews developments affecting Hawaii's Medicaid program since our budget review of that program for the 1984 session of the Legislature.

Chapter 2

BACKGROUND

Health is one of the larger and more complex of the dozen major programs set forth in Hawaii's state budget. In our first look at this major program area in 1984, we confined our budget review and analysis to two of its larger segments—the mental retardation and mental health programs. In this report, we continue our examination of this major program area by focusing upon its largest single component, the county/state hospital program. To understand this program adequately, however, it is necessary to view it within the context in which it originated and in which it presently functions. The purpose of this chapter is to provide such a context.

Origins and Present Status of the County/State Hospital Program

Unlike most state budget programs in Hawaii, the county/state hospital program is not one which originated at the state level or developed in response to clearly identified statewide needs. Instead, it represents activities which originally were performed at the county level and were gradually taken over by the State, primarily because the counties were unable to finance the cost of these activities. This heritage is significant because it continues to influence how the program is organized and how it operates.

State entry into the hospital field in Hawaii began rather modestly in the form of relatively small subsidies to county operated hospitals. However, under a series of legislative enactments in 1965 (Act 97), 1967 (Act 203), and 1969 (Act 265), the State assumed full responsibility for what then constituted a varied collection of county operated institutions. These institutions were placed under the Department of Health.

From this inception, the county/state hospital program has evolved slowly into what it is today. Headed by a separate deputy director of health, the program presently consists of a small, central administrative staff in Honolulu and a conglomeration of small clinics and hospitals providing acute care, long-term care, and other care on the islands of Kauai, Oahu, Lanai, Maui, and Hawaii. Although the program has been under state control for almost 20 years now, the individual hospitals still enjoy a high degree of autonomy.

The county/state hospital program is larger than the mental retardation and mental health programs combined and accounts for approximately 41 percent of the total Department of Health budget (including all sources of funding). The hospital program's place within the overall health budget can be seen more clearly in Table 2.1 which summarizes the department's total authorized positions and expenditures for FY 1984-85 by major programs.

Table 2.1
Department of Health
Authorized Positions and Expenditures for FY 1984-85
by Major Programs--All Sources of Funding

<i>Program</i>	<i>Authorized</i>		<i>Percent of Total Expenditures</i>
	<i>Positions</i>	<i>Expenditures (in millions)</i>	
Hospital Care	2,230	\$ 71.5	41
Physical Health	536	33.9	19
Mental Retardation	658	25.3	14
Mental Health	761	24.8	14
Overall Program Support	411	13.2	8
Community Health Services	273	7.9	4
TOTAL	4,869	\$176.6	100

Source: Act 285, Session Laws of Hawaii, Regular and First Special Session, 1984.

Table 2.2 provides a more detailed picture of the size and scope of the program and its component units. It lists the hospitals by county and shows the number of beds, types of beds, and authorized positions and expenditures for FY 1984-85. As can be seen from this table, the county/state hospital program is a large and sprawling operation.

Table 2.2

**Size and Scope of the County/State Hospital Program for FY 1984-85
by County and Hospital in Terms of Beds, Types of Beds,
Authorized Positions, and Authorized Expenditures**

<i>Hospital</i>	<i>Total Number of Beds</i>	<i>Types of Beds</i>			<i>Authorized</i>	
		<i>Acute</i>	<i>Long-Term</i>	<i>Other</i>	<i>Positions</i>	<i>Expenditures</i>
Hawaii						
Hilo	276	168	108	—	541.20	\$17,574,421
Honokaa	35	27	8	—	46.00	1,664,982
Ka'u	15	7	8	—	32.00	1,044,037
Kohala	26	10	16	—	36.50	1,220,598
Kona	<u>75</u>	<u>53</u>	<u>22</u>	<u>—</u>	<u>188.00</u>	<u>6,338,336</u>
Total—Hawaii	<u>427</u>	<u>265</u>	<u>162</u>	<u>—</u>	<u>843.70</u>	<u>\$27,842,374</u>
Maui						
Maui Memorial	145	145	—	—	420.00	\$15,819,321
Hana Medical Center	4	4*	—	—	7.00	432,938
Kula	105	4	93	8	177.00	4,617,112
Lanai	<u>14</u>	<u>6</u>	<u>8</u>	<u>—</u>	<u>21.00</u>	<u>682,006</u>
Total—Maui	<u>268</u>	<u>159</u>	<u>101</u>	<u>8</u>	<u>625.00</u>	<u>\$21,551,377</u>
Kauai						
Kauai Veterans Memorial	44	38	6	—	138.00	\$ 4,629,824
Samuel Mahelona Memorial	<u>76</u>	<u>20</u>	<u>56</u>	<u>—</u>	<u>146.00</u>	<u>3,849,715</u>
Total—Kauai	<u>120</u>	<u>58</u>	<u>62</u>	<u>—</u>	<u>284.00</u>	<u>\$ 8,479,539</u>
Honolulu						
Maluhia	150	—	150	—	182.00	\$ 5,092,301
Leahi	<u>242</u>	<u>25**</u>	<u>184</u>	<u>33</u>	<u>295.00</u>	<u>8,503,114</u>
Total—Honolulu	<u>392</u>	<u>25</u>	<u>334</u>	<u>33</u>	<u>477.00</u>	<u>\$13,595,415</u>
TOTAL—Statewide	1,207	507	659	41	2,229.70	\$71,468,702

*Emergency only.

**Reserved for tuberculosis patients.

Source: Department of Health, County/State Hospitals Division.

As large as it is, however, the county/state hospital program still forms only a relatively small portion of the total acute and long-term care services provided in Hawaii. In addition to this state program, the private sector in Hawaii offers a wide range of facilities and services on a rather large scale. This is especially true on the island of Oahu where about 80 percent of the State's population is concentrated. Table 2.3 shows in terms of beds available how the county/state hospital program compares with the private sector in Hawaii.

Table 2.3
Comparison Between State Provided and Private Provided Hospital Beds in Hawaii
by County for 1983

County	Acute			Long-Term			Total		
	State	Private	Total	State	Private	Total	State	Private	Total
Hawaii	254 (100%)	—	254	166 (40%)	244 (60%)	410	420 (63%)	244 (37%)	664
Maui	152 (91%)	15 (9%)	167	102 (28%)	256 (72%)	358	254 (48%)	271 (52%)	525
Kauai	47 (33%)	96 (67%)	143	62 (46%)	74 (54%)	136	109 (39%)	170 (61%)	279
Honolulu	—*	1,775 (100%)	1,775	290 (17%)	1,446 (83%)	1,736	290 (8%)	3,221 (92%)	3,511
TOTAL	453 (19%)	1,886 (81%)	2,339	620 (23%)	2,020 (77%)	2,640	1,073 (22%)	3,906 (78%)	4,979

*On Oahu, there are 25 acute care beds at Leahi Hospital, but these are reserved for tuberculosis patients.

Source: Department of Health, State Health Planning and Development Agency.

From Table 2.3, it can be seen that while the county/state hospital program is the dominant provider of services in the neighbor island counties, it provides only a minuscule proportion—8 percent—of the services provided on Oahu. As a consequence, on a statewide basis its services amount to only 22 percent of the total services available as measured by number of beds. Even on the neighbor islands, the county/state hospital program's position with regard to acute care services is not quite as dominant as it may appear in Table 2.3 because many neighbor island residents go to private hospitals on Oahu for the more serious types of operations or for specialized services available only on Oahu. In a very real sense, then, the county/state hospital program is in direct competition with the private sector in the services it offers to the public.

This competitive nature of county/state hospital operations provides the program with another characteristic which sets it apart from many of the State's

other programs. Instead of being run as regular government activities where legislative appropriations set the limits on expenditures, county/state hospitals are operated on an enterprise basis where fees and charges to customers or clients are expected to cover a substantial portion, if not all, of the expenses incurred.

This means that the hospitals are set up to function as special fund agencies and in their budgeting must concern themselves with revenue raising as well as expenditure control. The individual hospitals vary quite widely in their ability to be self-sufficient. Some of the larger ones, like Hilo and Maui Memorial, come close to covering their expenses with the revenues they receive. Others, however, rely heavily upon subsidies from the state general fund.

When comparing the state operated facilities to similar institutions in the private sector, it should also be noted that county/state hospitals tend to rank among the higher cost institutions. This does not matter so much as long as rates and charges can be set to recover costs, but it becomes crucial when definite limits are set by outside parties (such as Medicare, Medicaid, and private health insurers) on the payments they will make for particular types of services. As we discuss more fully elsewhere in this report, it is high cost services, including those provided by the State, that will likely be affected by cost containment steps being taken or planned by the federal government and others to stem the rapid and large increases in medical care costs.

The General Health Care Environment: Effects Upon the County/State Hospital Program

Over the past several decades and into the foreseeable future, health care has been and promises to continue to be one of the most important and volatile areas of social, political, and economic activity throughout the United States, including Hawaii. Because the county/state hospital program does not and cannot operate in a vacuum, it is not immune to changes taking place in the health care field. It is essential, therefore, to recognize the various influences that will have an effect upon the future course of this program. In this section, we describe briefly the general health care environment that surrounds the county/state hospital program and plays an important role in what the program can do, both now and in the future.

Field undergoing rapid and pervasive technological change. One major factor affecting health care and the county/state hospital program is the rate and extent of technological change. The whole field of medicine has been undergoing radical development in recent years, and all indications are that the rate of change will accelerate. Not only are there new drugs, new diagnostic tools, and new surgical procedures, but there are also such startling advances as organ transplants, artificial organs, and gene splicing.

Although not always readily apparent, the implications of these changes are virtually certain to be significant and diverse. On one hand, they may require large investments in elaborate equipment and specialized training, thereby driving up costs and giving greater impetus to improved utilization of resources and avoidance of unnecessary duplications of facilities and services. On another hand, they may help cost cutting efforts by simplifying procedures, speeding up reaction time, and enabling personnel to be displaced by machines. Similarly, eliminating some diseases and greatly prolonging lives may serve to bring other diseases and ailments to the forefront and present other new or more complicated problems to solve (e.g., meeting the needs of an increasingly aged population or determining when a person should be considered dead for purposes of transplanting organs or terminating life support systems).

In short, any health care or hospital program not only must be aware of technological changes and try to keep abreast of them, but it also must prepare for the long-term implications of these changes.

Field subject to severe economic strains. Another significant factor affecting the county/state hospital program and interacting with technological change is the tremendous economic turmoil that characterizes the whole health care field both nationally and locally. Over the past several decades, the costs of health care have mounted dramatically, outstripping significantly the overall inflation rate—even during periods of general high inflation. Hawaii's Medicaid program well illustrates this inflationary trend. In 1967, when the Medicaid program first began, the total cost of the program amounted to \$6.6 million. Today, the annual costs of the program are approaching \$200 million.

Such costs have finally reached the point where they are meeting stiff resistance and triggering efforts to cut medical costs and reduce health care

expenditures. Not only are governments finding that rising health care costs are contributing mightily to their actual or impending budget deficits, but also many private employers are realizing that the employee health benefits they pay constitute a large personnel cost over which they must exercise control.

Again, this is a trend which has widespread and diverse implications. For one thing, it is changing the whole approach to the financing of health care. Whereas for many years it has been customary both for government programs and private health insurance carriers to pay providers of health care whatever the providers might charge as long as these charges were considered normal and reasonable, the emerging trend now is for payers to determine ahead of time what they will pay according to what is called a prospective payment system. Thus, instead of being able to pass on more or less automatically any cost increases they may experience, health care providers are now facing the prospect of having to live within set limits for each type of service they offer.

This change in financing is, in turn, forcing other types of changes. For instance, health care providers must now pay much more attention to detailed cost accounting for their activities and services so that they will know where expenses are occurring and whether or not they are making or losing money on particular activities and services they perform. Failure to do so cannot help but place an institution at a serious disadvantage.

Identifying where losses are occurring is not sufficient, however. The next step is to take corrective action to cut costs, eliminate losses, and enhance profit margins to the fullest extent possible. It is the taking of this step that has generated a myriad of changes and pilot projects in the health care field. These include the following:

- . Promotion of least-cost forms of care.
- . Utilization of alternative delivery systems.
- . Limitation on reimbursement levels.
- . Reduction of need for care.
- . Improvement of administration and management.
- . Increased emphasis on marketing.

- . Shifting of costs to other payers where possible.
- . Reduction of scope of benefits.
- . Reduction of eligibility for subsidized coverage.
- . Increased utilization of automation and technology.
- . Reduction of hospital days and unnecessary hospital beds.

Field where access to services is considered extremely important. Still another significant factor affecting the county/state hospital program is that it functions in a field where access to services is considered extremely important, in terms of a broad range of health care services being readily available and the cost of such services not being a barrier to receiving the services regardless of one's economic status. In contemporary American society, health service ranks with food, shelter, clothing, and education as a right or entitlement, at least to some minimum degree.

A consequence of this broadly held sentiment has been the establishment of a massive array of public and private programs and institutions to serve and finance the health care needs of the population. Thus, we have extensive federal and state financing of the Medicare and Medicaid programs and heavy subsidization of hospital construction, medical education, and medical research. In the private sector, almost all employed persons are covered by some form of medical insurance financed in whole or in part by their employers.

All of these programs and activities have helped to enhance the quality of health care available to Americans and to make this care more readily accessible to most citizens and residents. At the same time, however, they have contributed to the proliferation of facilities and services—perhaps to the point of excess in many cases—and have done much to fuel the rapid inflationary trend in the health care field.

Only recently, therefore, has it begun to be recognized that some balance must be struck between what is desired in the health care field and what is affordable. Even in the face of such recognition, however, there is still strong underlying support for the concept that quality health care should generally be accessible to all segments of our society and that government has a responsibility for assuring that

this need will be met. The big difference now is a broader acceptance of the idea that there are limits on what the government can and should do in this field.

Field where humanistic and holistic considerations are looming more important. For many years, health care has been a field where improved technology and greater specialization have been dominant themes governing policies and practices. The result in many instances has been the development of large, impersonal institutions which tend to operate in terms of their own convenience and efficiency and to deal with ailments and illnesses rather than with individual human beings who function as members of families and of the broader community in which they live.

More recently, however, there has begun to dawn the recognition that good health is multidimensional and interrelated with and interdependent upon a number of factors. Moreover, in the case of the terminally ill and dying where technology cannot hope to reverse the inevitability of death, it is finally being recognized that humane treatment and close association with loved ones are the primary needs of those affected. As a result of these shifts in attitude and perspective, humanistic and holistic approaches to health care are beginning to loom more important in terms of influencing how health care services are delivered.

One major manifestation of this change is the broad trend toward deinstitutionalization of the handicapped, the mentally retarded, the mentally ill, and those who need long-term care but who can still function as family members or residents in a group or community situation. Thus, we see the use of home care, day care, and respite services for persons who in the past would likely end up simply being "warehoused" in institutions. Similarly, the hospice movement has evolved to bring succor and peace of mind not only to the terminally ill but also to their families and friends. In still more formative stages are other techniques, approaches, and arrangements for treating persons as whole individuals and as members of families and other social groups.

Although they cannot yet be fully and clearly seen, the ramifications of this trend for the county/state hospital program may be quite significant over the long run. In some instances, they may complement other trends quite nicely. For example, day care and home care programs not only may be less costly than full time institutional care, but also may offer a higher quality of care in terms of the welfare

of the persons involved. In any event, any shift from full time institutionalized care to day care, respite, and more personalized care is likely to have a profound impact upon traditional hospital and nursing home facilities.

Medicaid and its Relationship to the County/State Hospital Program

As part of our budget review and analysis of the public welfare financial assistance programs which we reported on to the Legislature in 1984,¹ we examined the health care payments program (Medicaid) which is administered by the Department of Social Services and Housing. Medicaid is a broad-based program that differs from other financial assistance programs in that it does not make payments directly to beneficiaries. Rather, it pays the providers who render hospital, physician, long-term care, and other services to eligible persons.

Medicaid is derived from Title XIX of the Social Security Act. It and Title XVIII (Medicare) were added to the federal law in 1965. Although the two programs are linked together in some respects, they are two quite distinct programs. Medicaid is a state administered program to provide health care assistance to economically and medically needy persons. Funding for the program is shared on a generally equal basis between the federal and state governments. In contrast, Medicare is a health insurance program for the aged that is fully financed and administered by the federal government. One linkage between the two programs occurs when aged persons require long-term care and are usually covered by Medicaid after they exhaust their Medicare benefits.

Probably the greatest area of linkage between the two programs, however, is the body of federal laws and regulations under which they operate. Federal requirements set the parameters for both programs, particularly in relation to making reimbursements to providers. In a number of instances, standards set for Medicare must be met before a state's Medicaid program can qualify for federal matching assistance.

1. State of Hawaii, Legislative Auditor, *Budget Review and Analysis of the Public Welfare Financial Assistance Programs*, Report No. 84-10, January 1984.

Hawaii maintains a liberal Medicaid program. In addition to coverage mandated by the federal government, Hawaii also extends optional coverage which is allowed but not required by the federal government. Such broad coverage is costly, however, and is becoming increasingly expensive as time goes by. The appropriation for FY 1984-85 is in excess of \$188 million. Costs projected for the next biennium as adjusted downward by the Department of Budget and Finance are \$202 million for FY 1985-86 and \$212 million for FY 1986-87.

The county/state hospital program is affected by Medicaid because it is one of the major providers of services covered and financed through Medicaid. For example, of \$78,292,886 in total audited Medicaid payments to institutional providers in FY 1981-82, \$20,378,423, or 26 percent, went to county/state hospitals. By category within this total, the county/state hospitals' share ranged from a low of 12.4 percent for acute care providers to a high of 39.6 percent of those providing intermediate care services. For the past five years, approximately 40 percent of county/state hospitals' revenues has come from Medicaid payments. Another 20 percent has come from Medicare. Medical insurance payments from the Hawaii Medical Service Association have accounted for 16 percent, and payments directly from patients have made up another 10 percent. The remainder was covered by other third parties.

It is quite apparent, therefore, that whatever happens to Medicaid will certainly have some effect upon the county/state hospital program, and whatever happens to the county/state hospital program will likely have an effect upon Medicaid. Complicating relationships between the two programs, however, is the fact that they are separately administered by two different departments. Further compounding the situation is the need to take into consideration both federal and state governments in any matters relating to Medicaid.

Chapter 3

OVERALL PERSPECTIVE OF BUDGETING FOR THE COUNTY/STATE HOSPITAL PROGRAM

As a first step in examining the budget for the county/state hospital program, this chapter presents an overview of the budget situation now facing the program and offers a general assessment of the process through which the program's budget is formulated and executed. Subsequent chapters review in more detail the revenues and expenditures of the program.

Summary of Findings

With regard to the county/state hospital program's overall budget situation and the program's budgeting process, we find as follows:

1. The program is now confronting the problem of a major budgetary squeeze where costs continue to press upward but where limits are beginning to be imposed upon the ability to generate income. Impending cost containment efforts of the federal government are threatening to increase substantially the program's dependence upon subsidies from the state general fund.

2. In the face of this problem, the program has no clearly defined and effective method for formulating and executing its budget on a programwide basis. Instead of a closely integrated process for considering and projecting revenues and expenditures, the component units follow a variety of methods in preparing their separate revenue and expenditure estimates. The net result is a budget which is little more than a loose compilation of disparate parts where modifications can be made only in an arbitrary and inequitable manner.

3. Compounding this situation is the lack of a clear sense of direction or programmatic coherence for the hospital budget. This arises from: (a) a serious lack of systemized planning upon which a meaningful budget might be built; (b) the

lack of an adequate information system; (c) the lack of a systemized process through which to monitor and assess the need for the public hospitals; and (d) the program's underlying uncertainties as to its fundamental purpose and role and its funding responsibilities.

Budget Squeeze Problem Now Facing the County/State Hospital Program

The main legislative problem concerning the county/state hospital program is the program's increasing need for subsidization from the state general fund. This problem is the result of the major budgetary squeeze in which the program now finds itself, where upward pressures on costs are continuing to be experienced but where limits are now being imposed on the program's ability to generate its own income.

The story on the cost side is a familiar one. In recent years, rapidly inflating health care costs have been endemic throughout the United States. Among all these costs, the rise had been greatest for the costs of institutional care, both acute and long term. The county/state hospital program has been very much affected by this nationwide trend.

Until fairly recently, the county/state hospital program was able to offset such cost increases for the most part through its ability to generate more income through rate increases and the cost based payment methods of Medicare and Medicaid. Thus, in recent years, the program reduced proportionately its dependence upon subsidization from the state general fund.

However, the situation is now changing quite significantly. The program currently is reaching the point where it will not only encounter increasing difficulty in trying to increase rates but also face the prospect of reduced payments by some of its major sources of financial support. Even where increases may be allowed, the rates of increase will be lower than in the past and may not be sufficient to cover inflating costs.

One major factor contributing to this situation is the federal government and its efforts to restrain or contain the costs of Medicare and Medicaid. Alarmed at the rapidly increasing financial burden imposed by these two programs, the federal government has begun to bring such expenditures under control. One cost control

method is the prospective payment system under which payments are fixed prospectively rather than determined retrospectively after costs have been incurred. Another approach is to eliminate or reduce the payment differential between expensive hospital based and less expensive freestanding long-term care facilities. These efforts and their impact on the situation affecting the county/state hospital program are discussed more fully later in this report. The main point to recognize here is that they will definitely set limits on the program's ability to generate its own income.

The other major factor in the equation is the fact that the hospitals are concurrently reaching a more or less natural limit on what they will be able to charge other users of its services besides Medicare and Medicaid. For many years, the rates charged to others by county/state hospitals were considerably lower than the rates charged by competitive institutions in the private sector. However, as the result of repeated and substantial rate increases in the past several years, county/state hospital rates are about the same as or in some cases even higher than those charged by private institutions. Public concern over such increases has grown to the point where some patients were actually withdrawn from county/state hospitals when long-term care rates were increased in 1984. Under the normal forces of supply and demand, noncompetitive rates will force county/state hospitals to lose business rather than increase their income.

In view of these financial conditions, therefore, it is important for all affected decision makers, both inside and outside of the program, to recognize the budget squeeze in which the program now finds itself. It is also incumbent upon the program's managers to make sure the program's budgeting process is as effective as possible in identifying where cost savings can be achieved and in maximizing the income producing potential of the program.

Lack of a Consistent and Integrated Budget Methodology

From the foregoing discussion, it is quite apparent that the county/state hospital program should have a strong budgetary process through which both revenues and expenditures can be given close scrutiny and through which fiscal decisions can be meaningfully formulated and effectively implemented. This is

especially true for a far-flung program consisting of many separate and disparate units. We find, however, that despite almost 15 years of direct administration of the program, the Department of Health (DOH) and its County/State Hospitals Division still have not developed an effective systemwide budget process for the program.

Piecemeal evaluation of expenditures. In the face of the impending budgetary squeeze where thorough examination of all expenditures and careful consideration of program alternatives are essential, the approach to budgeting for the 1985-87 fiscal biennium has remained essentially unchanged from what it has been over the years since the State took over the hospitals from the counties. As before, the focus of the program's budget development process has been on incremental inflationary increases over past funding levels rather than on a comprehensive reexamination of the whole program and its component parts.

Moreover, the budgeting process tends to be quite fragmented. This results largely from the practice of considering the historical costs of individual institutions rather than looking at hospital services broadly on a planned and programmatic basis in relation to other aspects of health care.

To further complicate matters for the 1985-87 fiscal biennium, changes in the State's overall approach to the submission of budget requests have dictated the preparation of multiple budgets. Like other programs and units throughout the state government, the county/state hospital program and its component hospitals were given budget ceilings and instructed to develop four budget alternatives: (1) a current approved plan (CAP) budget, which maintains the existing program within the established ceiling; (2) a CAP-nonadd budget, which retains the budget ceiling but allows internal adjustments or tradeoffs within a program; (3) a CAP plus 4 percent budget, which indicates what would be done if an additional 4 percent in funds were made available to a program; and (4) a CAP minus 5 percent budget, which shows what the effects would be of a 5 percent reduction in available funds.

For the county/state hospital program, individual budgets were prepared by the various hospitals. They were then reviewed and consolidated at the division level. After further review by the department's administrative services office, the combined budget was sent to the Department of Budget and Finance for its review and ultimate incorporation in the overall executive budget.

While the process and format have thus been modified for the coming biennium, changes in basic approach have been scant. Historical costs of individual institutions still provide the main foundation. Little or no consideration has been given to such things as comparability studies, efficiency or productivity standards, statewide concerns, or alternative ways of achieving objectives. Without such a broader and more rational basis for judgment, it is hard to arrive at soundly based budget decisions or to avoid arbitrary budget adjustments.

Inadequate revenue projections. Similarly, revenue projections for the 1985-87 fiscal biennium have been little more than the perfunctory exercise they have been over the years despite the changing revenue conditions confronting the program and despite the need for more attention to and greater accuracy in this aspect of budgeting. Again, as with expenditures, there was no systemwide method for projecting revenues. Not even general guidelines were provided. Without any written procedures or instructions, each hospital was given the responsibility of developing its own projections of revenues.

As a consequence, there were many differences in the ways the various hospitals arrived at their individual revenue projections. For example, some of the hospitals considered the impact of the new Medicare prospective payment system and others did not. Some applied the county/state hospital program rates; others used the payers' rates of payment. Projections were made to varying degrees of detail of services, some much more complex than others. Also, such factors as bad debt, charity care, and contractual adjustments were not all consistently defined or derived.

At the division and departmental levels, only cursory attention was given to the revenue projections from the various hospitals. In effect, the projections as originally proposed at the unit level were accepted at face value despite their differences and inconsistencies.

Perhaps most significant of all, the income projections that are included in the executive budget for the 1985-87 fiscal biennium do not consider or make any allowance for the possible impact of cost containment measures scheduled to go into effect under the Medicaid program. Much of this problem lies with the Department of Social Services and Housing, which administers Medicaid, and with the federal government. Both have been slow and less than clear in providing information concerning the timing and effect of impending cost containment measures.

Nevertheless, a part of the problem also lies with the county/state hospital program itself. The likelihood of both the prospective payment system and the reduction of the differential for hospital based long-term care facilities has been known for some time. Yet, the county/state hospital program is still not organized to assess readily the impact of these changes in specific budget terms, much less to come up with responsive actions to alleviate such impact.

Net result. The net result of the current approach to budgeting for the county/state hospital program is a budget that represents little more than a loose compilation of disparate parts where modifications are likely to be made in an arbitrary and inequitable manner. Missing are any programmatic goals or performance standards by which the various units can be judged. Thus, despite the fact that some units may be more effective and efficient than others or may be offering higher priority services, these elements are hard to identify so that resources can be allocated in the most appropriate manner possible.

Recommendations. We recommend that the Department of Health and its County/State Hospitals Division develop a systemwide and integrated budget process for county/state hospitals that will be program based and performance oriented and that will encompass both the expenditure and revenue sides of budgeting for the program. This includes identifying costs by types of services at each hospital and comparing such costs among the various hospitals to establish standards.

We further recommend that the Department of Health and its County/State Hospitals Division develop and submit to the Legislature as early as possible in the 1985 session an updated projection of revenues for the 1985-87 fiscal biennium which will be internally consistent within the county/state hospital program and which will reflect the estimated impact of the third party payers' cost containment measures likely to be implemented during the biennium.

Lack of Overall

Direction for the Budget

By statute, the concept underlying all budgeting for the state government in Hawaii is one embodying the principles of planning and programming. In difficult fiscal times, the need for a cogent program plan to guide budgeting and operations becomes even more urgent. Yet, despite the obvious values of a carefully planned

and soundly based approach to the determination of financial requirements, we have found that the county/state hospital budget for the next biennium not only suffers from budget process shortcomings but also lacks an overall, integrative program and planning framework.

Lack of planning and plans. Most glaringly apparent is the lack of any real program planning or plans for the county/state hospital program. Although some attempts have been made at planning, they generally have been piecemeal and have not been kept abreast of changing conditions. Thus, at present, there is no systemwide program plan. At best, there are a few facility development plans which have been separately developed for only some of the individual hospitals. Having never been coordinated with one another, however, these hardly serve to provide a general framework for the whole program.

Hampering these limited efforts at planning has been the program's lack of a formal and regularized planning process. Past planning has been sporadic and generally performed only in response to outside pressures—e.g., to comply with legislative requests or to justify capital construction at particular institutions. This is not to say, however, that the need for such planning has gone completely unrecognized. In our interviews with them, program personnel acknowledged the value of planning. They have even taken some solid steps toward the development of a planning process. Nevertheless, all such efforts are still very much in the formative stage.

Inadequate information system. Even if the county/state hospital program had a planning process, such a process would be seriously hampered by the program's present lack of a clearly defined and effective management information system. Although a great deal of information is collected and reported by the various hospitals, much of it is duplicative, untimely, and not comparable among the hospitals or from one year to the next. There have been no clear or consistent definitions of the kinds of information to be collected and reported and no comprehensive concept of what information might be needed by program administrators at either the division or unit levels.

Similarly, there has been little regular analysis of data and little effort directed at maintaining consistent historical information. While the county/state hospital program has been in the process of trying to improve its information base through

computerization, such efforts have not been coordinated with the manual collection of substantial amounts of data which is still continuing. Pertinent, accurate, and timely information lies at the heart of planning and programming and should be a matter of prime importance in any effort to improve the management of and budgeting for the county/state hospital program.

Inability to assess need. For the county/state hospital program to plan and budget effectively, it must first have the ability to assess or measure the public problems or needs that it expects to address. However, we find that while some of the problems that originally necessitated the establishment of public hospitals have been alleviated (e.g., tuberculosis), DOH has not taken steps to monitor and assess on a continuing basis the changing environment in which the county/state hospital program is functioning and the implications these changes may have for the program.

DOH not only lacks a process for monitoring and assessing needs, but it also has failed to develop any policies or criteria by which the need for public hospitals can be determined. Except for changes imposed by outside forces or initiated and carried out within a single institution, the basic direction taken so far by the county/state hospital program has been a continuation of the existing configuration of institutions and array of services regardless of shifting demographics and other changes affecting the delivery of health care services in Hawaii. This, in turn, derives from the lack of a clearly defined role for the program as discussed below.

Lack of a clearly defined role. Much of the hospital program's difficulty in planning and in addressing needs springs from the program's underlying uncertainty as to what its role should be in the overall scheme of health care services in Hawaii. This uncertainty extends both to its relationship to the private sector and to its rate setting responsibilities.

Coordination with the private sector. Although state policy as set forth in the State Health Functional Plan calls for coordination with the private sector, it is nowhere made clear how this concept is to be achieved with respect to the county/state hospital program. The program seems to be uncertain whether its primary purpose is to provide services only where the private sector is unable or unwilling to provide services or to compete with the private sector wherever it is

already functioning so as to maintain a statewide hospital care system and perhaps also to help assure the affordability of hospital care services in the affected communities.

If the former is the basic policy, then the county/state hospital program should be considering withdrawal from or phasing out in those areas where private operators are already established or might be enticed to enter. If the latter is the overriding policy, however, then greater emphasis should be directed toward keeping county/state hospitals competitive and enhancing their share of the available market. If some combination of the two is felt to be the best policy, then it might well be that cutbacks in some aspects of the program should go hand in hand with expansions and improvements in other aspects.

Right now, however, program managers at the division and unit levels seem to be unsure as to which direction they should move. Until this policy question is clearly resolved, effective efforts at planning, programming, and budgeting are likely to remain paralyzed.

Rate setting responsibilities. The increasing constraints on revenues require that the county/state hospital program have a definitive approach towards rate setting to allow for effective financial planning and budgeting. However, we find that the program has no coherent policy or consistent method for setting rates. Although it professes to have an identical rate statewide based on average costs, there are many discrepancies among the rates. Moreover, it is not clear that the rates for particular kinds of services relate to the costs for those services.

Most significant is the example of long-term care rates. In 1984, in response to anticipated decreases in federal revenues, neighbor island hospitals increased their long-term care rates by more than 200 percent in an attempt to recover more of their costs from private payers and to standardize rates. Yet, long-term care rates for the program's hospitals on Oahu were not similarly increased and are now less than those for the neighbor island hospitals.

It appears that the program's primary difficulty in establishing a consistent rate policy and method is due to public pressures and a lack of clear guidelines upon which to base its responses. In establishing special funding for the county/state

hospital program, the Legislature generally noted in a committee report that “the special funding accounting . . . is not intended to produce totally self-sufficient public hospitals” but did not then address the extent of self-sufficiency that was expected.¹

Consequently, it is unclear: (1) whether special funds are intended to cover at least certain costs of the program or if general funds are reserved for particular costs; (2) if there should be certain limitations on general funds; or (3) what the objectives of revenue planning should be. And yet, it appears that the program is not entirely free to maximize revenues as part of the State’s overall objective for institutional care because the State Health Functional Plan states that one objective is to provide care at “affordable costs.”

So long as this dilemma persists, it is difficult for the county/state hospital program to do any effective planning, programming, and budgeting as far as rate setting and revenue projecting are concerned.

Recommendations. With respect to overall direction for the county/state hospital program, we recommend as follows:

1. *The Department of Health should develop a planning process to support and guide future budgeting for the county/state hospital program. Such a process should include a regularized means of assessing needs.*

2. *The Legislature should clarify the role of the county/state hospital program relative to the private sector and to setting rates. In so doing, it should include in its consideration the following questions:*

a. *Is it the State’s role to provide hospital services only where the private sector is unable or unwilling to do so?*

b. *What are the intended purposes of special funds and general fund subsidies in meeting the costs of the county/state hospital program?*

c. *How much of the costs of the county/state hospital program is the user of the public hospitals expected to pay, and is it the intention of the Legislature that some users pay more than their costs through a system of charges based on average costs?*

1. House Standing Committee Report No. 45 on House Bill No. 3661, Regular Session of 1971.

3. *The Department of Health should develop a comprehensive program plan for county/state hospitals based upon a clearly defined purpose and role for the program and upon a comprehensive determination of needs for public hospital services in Hawaii. The plan should also set forth the intended means of financing the program, including a clear statement of rate making policies and procedures.*

Chapter 4

REVIEW OF REVENUE ASPECTS OF THE COUNTY/STATE HOSPITAL PROGRAM

In this chapter, we focus specifically on the revenue aspects of the county/state hospital program's budget, and particularly its billing, accounting, and collection procedures.

Summary of Findings

With regard to the revenue side of the budget for the county/state hospital program, we find as follows:

1. Despite the importance of billing and patient accounting as tools for setting and implementing revenue plans, the county/state hospital program has failed to exercise adequate management direction and control in this area. Recent efforts to computerize billing and accounting operations throughout the hospital system have been poorly planned and poorly executed. As a result, the program has increased, rather than decreased, its administrative problems in this aspect of its operations.

2. Management of collections is another area where there is a lack of effective management control. One major consequence is that the program's total receivables have increased by \$7 million over the past two years and stood at \$25 million by June 30, 1984.

3. The county/state hospital program has an obligation to manage effectively all of the resources under its control and to maximize revenues to the extent possible. This includes housing which is not a public service program but for the benefit of hospital employees. Nevertheless, the program has not performed adequately in its management of housing. Practices followed with respect to housing have been inconsistent with state policy, have been inequitable, and have failed to bring in sufficient income to cover even out-of-pocket costs.

Inadequate Management of the Billing and Patient Accounting

Toward late spring of 1984, the county/state hospital program made a sudden decision to automate the billing and patient accounting systems of 10 of the program's hospitals. The two largest were not included as they already had computer capabilities. A time frame of three months was estimated for the project—from May 1, 1984 to July 31, 1984. In reviewing this aspect of revenue administration, we found that the lack of advance preparation and the haste in implementation caused severe and unnecessary disruption to billing, patient accounting, and cash flow at the affected hospitals. Moreover, the long range effectiveness of the resulting systems is now in question.

Lack of planning. Although the program had for some time concluded that automation, i.e., computerization, was desperately needed for its billing and patient accounting, we found that it had done little to actually define its specific needs as a basis for computerization. There was no evidence in the records of any planning for the project; the existing systems were not studied or documented, and there was no determination made as to the program's actual hardware and software requirements. Alternative courses of action, such as partial or incremental computerization, were not examined. The selection of hardware and the software contractor was made by the program without serious consideration of other possible options. Further, there were no cost studies or analyses of benefits, even for the option chosen.

In acknowledging its lack of planning, the county/state hospital program explained that it was caused by the sudden imposition of uniform billing requirements by major payers (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services, and Hawaii Medical Service Association), which could not be accommodated manually and which left little time for response. However, we note that uniform billing does not require computerization, and the county/state hospital program itself did not actually determine that computerization was the necessary response—especially for all of the hospitals, and all at the same time. Moreover, the records show that the county/state hospital program had been notified of the impending requirements as early as July 1983, but for months afterwards had ignored the import of the impending changes.

The records also show that the State's computer review processes failed to assure a minimum of planning and forethought in this project. In June 1984, with the project already under way, the program quickly obtained the approval of the Electronic Data Processing Division of the Department of Budget and Finance without submission of any specific information on its assurance that plans and details of the project would be forthcoming. As of November 1984, the promised plans had not yet been developed.

Failure to define the project and assign responsibility. In view of the substantial costs involved (\$65,000 was projected for the software contractor alone) and the inherent hazards involved in any conversion of accounting systems, it was especially important that the State clearly delineate the scope of the project, the systems that it needed, the work that was to be done and by whom, and the specific objectives that it hoped to accomplish. However, we found that the State essentially left the task of defining the project to the contractor.

According to the County/State Hospitals Division, it did not develop any written specifications for the project. Although it had to rely extensively on the expertise, services, and resources of the contractor, it did not formalize the relationship by written contract. We found nothing in the records that established the State's requirements of the software contractor for this project or the specific results that the program expected from its expenditure of \$65,000.

In response to our concern, the County/State Hospitals Division expressed the position that it was neither necessary nor required to execute written contracts in purchasing such services, and that its verbal agreement with the software contractor was sufficient. The fiscal office of the Department of Health (DOH) and the Department of Accounting and General Services supported the position that only a purchase order was needed for processing payments for services, citing advice from the Department of the Attorney General. However, following our inquiry on the matter, the Department of the Attorney General issued a letter of clarification to the Comptroller on October 31, 1984. Stating that the previous advice "may have been misapplied" the letter went on to point out that the practice of using purchase orders to secure the services of an individual, or consultant limits the protection to the State, and "is ill-advised and not in the State's best interest."¹

1. Letter from Michael Lilly, Attorney General, to Hideo Murakami, Comptroller, October 31, 1984.

Poor project development and implementation. As with planning, many steps in the development and implementation of the new system were also bypassed or compressed, which ultimately contributed to the difficulty of the project. For example, participation by the staffs of the affected hospitals was very limited, involving primarily only two of their accountants. Moreover, despite the lack of prior documentation of the existing systems, none was undertaken at that time. Then, once the new system was developed, there was virtually no testing with actual data or in the field prior to implementation. Additionally, very little time was given to training although it was known from the outset that the hospitals' staffs generally had little or no experience with computers.

The instructions that were prepared for the project were also lacking as they addressed only the operation of the computers and the use of the software. There was no comprehensive instruction on interfacing the new system with the existing systems, or specifying the functions that were to be continued or discontinued with the new systems. The important matter of backup systems was also neglected; there was no direction given to maintain temporarily the old systems alongside the new so as to assure necessary continuity of the accounting and security of data while the new system was being tried.

Once implementation began, the software was also found to be inadequate. There were many instances of programming errors and oversight, including a major failing to accommodate split billing requirements for long-term care charges. Moreover, the implementation of the untried system at all ten hospitals at the same time only served to multiply by tenfold the negative impact of any error or problem that cropped up.

Billing, accounting, and cash flow severely disrupted. Although all of the hospitals were current in billing prior to the start of this project, at mid-October many were backlogged to July bills, and others were not much farther along. Moreover, collections work generally was suspended in favor of billing. While there was no exact count of the billing backlog, it could be seen that the total of unbilled charges was substantial and that cash flow to the hospitals was seriously decreased. A comparison of the receipts of the 10 hospitals for October of 1983 and 1984 showed that despite increased rates, collections for patient services in October 1984 (excluding cost settlements) were almost \$2 million less than in 1983. Many of the hospitals were hard-pressed for cash in the first and second quarters, and Lanai Hospital went into deficit.

We also found that patient accounting was in disarray as a result of the unexpected delays in computerization of that part of the new system. Although initial plans called for the simultaneous implementation of billing and patient accounting, the problems in billing soon took precedence over all other functions. Consequently, patient accounting became fragmented, and was only partly computerized. To compound this problem, the manual processes in many cases had already been discontinued. The net result was that patient accounts became separated among computer files, manual accounts, and numerous unbilled records. Most of the hospitals stated at that time that they could not readily ascertain the status of their receivables or of individual patient accounts.

Adequacy of the hardware is in question. The county/state hospital program purchased 11 microcomputers for this project. At the time of our study, all of the hospitals were extremely concerned with the unexpected slowness of the newly installed systems and the amount of staff hours required for the new systems. Backlogs continued to build despite much overtime and the use of additional staff. Although all of the systems were not yet implemented, most of the computers were already in use continuously throughout the workday, and often even longer. For example, at Kona Hospital, the capacity of the computer was already strained by only a portion of the regular billing workload, and it appeared doubtful that the present staff and hardware would even accommodate Kona's full billing workload.

Recommendations. With respect to the computerization of the billing and patient accounting systems, we recommend that the Department of Health:

1. *Conduct a comprehensive study of its billing and patient accounting systems to determine the effectiveness and efficiency of its computer systems. Specifically, that it:*
 - a. *determine the impact computerization has had on the billing and collections workload, patient accounting, revenues, and cash flow of each hospital; and*
 - b. *assess the adequacy of the hardware, software, and workforce to accommodate the present billing and accounting workloads at each hospital.*
2. *Develop comprehensive instructions for the interface and integration of the new computer systems into the total operating systems of each hospital and the program as a whole.*

3. *Study and assess the program's overall needs for computerization and develop a comprehensive plan for computerization.*

With respect to the broader issue of purchasing services, we recommend that the Department of Health clarify with the Department of Accounting and General Services and the Department of the Attorney General the proper procedures for contracting and instruct all of its units accordingly.

Need to improve collections. The county/state hospital program has had continuous difficulties in managing patient receivables. Receivables have increased through the years to where they totalled over \$25 million as of June 30, 1984. (See Table 4.1, which compares 1984 to 1982.) This represents an increase in active as well as inactive accounts and in days and dollars of uncollected revenue for most of the hospitals. By maintaining such a sizable and growing amount of receivables, the State continues to forego sizeable earnings that could be realized if its receivables were converted into collections.

Table 4.1

Patient Account Receivables for
County/State Hospitals--June 30, 1984
With Comparative Figures for June 30, 1982

Hospital	1984	1982	Increase	
			Amount	Percent
Hilo	\$ 9,570,400	\$ 6,167,957	\$3,402,443	55
Honokaa	420,226	240,983	179,243	74
Ka'u	192,919	110,533	82,386	75
Kohala	162,029	139,997	22,032	16
Kona	2,350,137	1,572,788	777,349	49
Maui Memorial and Hana Medical Center	7,394,812	6,160,178	1,234,634	20
Kula	332,967	332,183	784	0
Lanai	157,047	39,384	117,663	299
Kauai Veterans Memorial	791,930	656,774	135,156	21
Samuel Mahelona Memorial	1,122,343	640,068	482,275	75
Maluhia	1,271,023	1,128,536	142,487	13
Leahi	1,294,756	790,336	504,420	64
TOTAL	\$25,060,589	\$17,979,717	\$7,080,872	39

Source: The audited financial statements of the hospitals as of June 30, 1982 and June 30, 1984.

Although the county/state hospital program has long believed that a lack of computerization was the cause of its growing receivables, it appears that a lack of policy and effective procedures also contributes substantially to this problem.

Lack of a consistent credit and collection policy. While it has become increasingly important for hospitals to maximize their collections from patients as well as other payers, we find that the county/state hospital program has as yet no systemwide policies for either patient credit or collections. Consequently, the hospitals are continuing to apply their lenient practices of past years. At most of the hospitals, essentially unlimited credit is allowed, and there is no set minimum for payments, regardless of the size of an outstanding account.

However, Maui Memorial, in contrast to the others, was planning to implement firmer collection and credit policies. Among its proposed revisions were: the preregistration of nonemergency patients to allow for the early arrangement of financial matters, the collection of deposits prior to hospitalization for elective and maternity cases, and the requirement of full payment for outpatient laboratory and X-ray services on the date of service for charges less than \$50.

Inconsistent and burdensome procedures. Despite the adoption of systemwide collection procedures in 1976, we found that actual collection practices were inconsistent. Our concern in this regard is primarily for those procedures which make collections more burdensome and time consuming and less effective. Specifically, the hospitals find the procedures unclear on the matter of minimal accounts with the result that there is no consistent approach towards handling these accounts. Many of the hospitals make no exception for minimal amounts and pursue all accounts (even as small as \$1.50) through the entire collection process. Others have arbitrarily established minimum amounts that they write off on their own, and one administrator exercises personal authority to write off amounts up to \$500 without the involvement of either a collection agency or the attorney general. Additionally, although the law and procedures require a two-year wait prior to write-off, the measure for the two years is not clear. Consequently, different dates are used; e.g., the first date of service, the last date of service, the date of referral to a collection agency, or the date of return from a collection agency.

Moreover, the procedures require that referral be made twice to a collection agency before a request for write-off can be made although it appears that most of

the hospitals make only one referral. Finally, the approval of the Department of the Attorney General is required for all write-offs, in accordance with Section 40-82, Hawaii Revised Statutes, a process that has generally added months and even years to the process, despite the fact that most cases are routine.

Recommendations. With respect to the collection process, we recommend that the Department of Health:

1. Develop systemwide policies for patient credit and collections, including payment requirements, and assure that policies are uniformly implemented.

2. Develop systemwide criteria and procedures for determining a patient's ability to pay and establishing payment requirements.

3. Review and assess the adequacy and effectiveness of its present collection procedures, and clarify and revise as necessary. Specifically, the following should be considered.

a. The establishment of a minimum amount for referral to a collection agency and separate processes to facilitate the processing of minimal accounts.

b. The deletion of the requirement for a second referral to a collection agency.

c. Seeking a revision to Section 40-82, Hawaii Revised Statutes, that would allow directors of departments or agencies to write-off routine uncollectible accounts of reasonable amounts according to conditions and criteria established by the Attorney General.

Management of Housing Programs Is Inadequate

Although some revenues are derived from housing rentals, housing is primarily an employee benefit program rather than a source of revenue. The county/state hospitals' practice of providing living quarters to employees is a carryover from times when it was considered necessary due to the isolation of the hospitals, a lack of housing, or work requirements. While some of the conditions that necessitated housing in the past have changed, it can be seen from Table 4.2 that most of the hospitals still maintain housing programs. We found that the administration of housing is inadequate, and there are no systemwide policies or practices in place.

Table 4.2
Summary of Housing
County/State Hospitals

<i>Hospital</i>	<i>Houses</i>	<i>Dormitory Rooms</i>
Hilo	5	30
Honokaa	4	
Ka'u	1	
Kohala	2	
Kona	2	11*
Maui Memorial		14
Hana Medical Center	3	
Kula	10	30
Lanai	1	4
Samuel Mahelona Memorial	3	15
Leahi	8	13
TOTAL	39	117

*Apartments.

Source: Department of Health, County/State Hospitals Division,
Summary of Housing Accommodations, August 8, 1984.

Noncompliance with state policy. Administrative Directive No. 7, issued by the Governor on October 7, 1963, states that it is the policy of the state government to administer employee perquisites in a uniform and equitable manner, to provide housing only where and when necessary, and to charge a reasonable value for housing unless conditions are met that justify the provision of free housing. Despite these instructions and similar policies and procedures issued by the director of health in 1964, there is still no process to assure that housing is provided only where needed and that charges are made, or free housing is provided, on a uniform and equitable basis. We found that eligibility requirements for housing, rent amounts, and the awarding of free housing differ from hospital to hospital.

For example, housing is provided in urban as well as rural areas and in communities where rentals are available as well as in those where rentals are scarce. Employees with regular hours as well as those on call have housing, including a variety of employees, i.e. administrative, nursing, clerical, laundry,

kitchen, and general maintenance. Rentals range from \$50 to \$148 for single rooms, \$50 to \$75 for one-bedroom houses, \$25 to \$231 for two-bedroom houses, and \$75 to \$350 for three-bedroom houses. Fourteen houses were being provided free, including five each of three-bedroom and four-bedroom size. At most of the hospitals, there was either no free housing or housing only for the administrator but at Leahi Hospital, eight persons had houses at no cost, including the administrator, the assistant administrator, the medical director, the director of nursing, the housekeeping superintendent, and three staff physicians. By comparison, Maluhia, which is also located in urban Honolulu and offers essentially the same kinds of services as Leahi, provides no free housing and discontinued housing altogether at the end of 1984.

Costs not covered. Where housing is provided, it is not unreasonable to expect that the rentals charged will at least cover the direct expenses incurred in maintaining such facilities, such as for utilities and repairs. Based on the limited information readily available, however, it appears that the county/state hospital program's out-of-pocket expenses for housing exceed the income generated from rentals. For example, for FY 1983-84, Kula and Leahi Hospitals expended \$26,000 and \$18,981, respectively, for repairs, maintenance, and utilities while generating only \$18,477 and \$8,609, respectively, in rental income. In the case of Leahi, it did not even recover the full costs of the electricity provided.

Recommendations. With respect to housing, we recommend that the Department of Health take the necessary steps to assure conformance with Administrative Directive No. 7. Specifically, it should:

1. *Establish department-wide procedures for determining the need for housing programs and maintaining programs based only on a defined need;*
2. *Establish department-wide procedures for determining the eligibility of employees for housing and for free housing based on a clearly defined need;*
3. *Establish department-wide procedures for setting rentals of reasonable value that at least recover the program's direct costs; and*
4. *Conduct a review of the hospital program's housing practices to identify and resolve discrepancies.*

Chapter 5

REVIEW OF EXPENDITURE ASPECTS OF THE COUNTY/STATE HOSPITAL PROGRAM

In this chapter, we focus on the expenditure side of the county/state hospital program. Inasmuch as personnel costs constitute approximately 70 percent of total expenditures for the program, they were the costs which we first considered in our review. Other current expenses is the next largest budget category. Within this category, we looked at the two largest items—services on a fee basis and hospital and medical supplies—which account for approximately half of the other current expenses. Set forth below are our findings and recommendations relating to personnel services, services on a fee basis, and hospital and medical supply purchases.

Summary of Findings

We make the following findings regarding the expenditure side of the county/state hospital program:

1. In the important area of personnel costs, we find that the program has failed to develop an adequate systemwide approach to assessing staffing needs, maximizing the utilization of personnel resources, and controlling personnel costs. As a result, the following problems are occurring:

a. In the face of low demand for services—especially acute care services in rural areas—very low utilization of staff services is being experienced in some areas. Yet, no overall policies or plans exist for improving the utilization of staff resources.

b. The need for and utilization of personnel are being distorted in a number of instances by the heavy use of temporary hires and the extended retention of vacant positions. Such broad reliance upon these expediciencies makes it difficult to know, control, and budget for staffing requirements for the county/state hospital program and its individual units.

2. With respect to contracting for services on a fee basis, the program lacks an overall system of firm administrative control over this important area of activity. This has led to problems such as the following:

a. Considerable uncertainty and extended delays in the granting and payment of contracts for medical services.

b. A confusion of relationships between the county/state hospital program and a provider of pathology services on the island of Hawaii arising out of the use of revocable permits to contract for services from the provider as well as to lease facilities to the provider. Not only does this make it difficult to fix responsibility and fiscal accountability, but it also has resulted in the violation of the terms of the agreement.

3. Regarding the purchasing of hospital and medical supplies, the county/state hospital program in cooperation with the Department of Accounting and General Services (DAGS) has undertaken a commendable effort to reduce costs through bulk buying and competitive bids. However, due to inadequate administrative control, the overall effects of the efforts cannot be readily determined and are not being reflected in the hospital program's budget requests for the 1985-87 fiscal biennium.

Lack of Overall Approach to Assess and Manage Personnel Resources

As already noted, personnel costs constitute 70 percent or more of the county/state hospital program's annual expenditures. It should thus be the area of prime concern in any effort to plan for or control the allocation of resources to the program. One important way of doing this is to look at staffing patterns within and among the different institutions that make up the hospital program and see how they compare with each other and with any available standards or measures of productivity and efficiency from outside of the program. Once this has been done, it is then possible to determine where personnel costs may be excessive and to consider alternative ways of bringing such costs into line.

We have found in our examination, however, that the Department of Health (DOH) has not yet undertaken this very elemental and fundamental first step. Indeed, there is still lacking any overall perspective of or integrated approach to personnel as a basic resource of the program as a whole and as an area of major management attention. For the most part, when personnel matters have been considered, it has been on an institution by institution basis or with respect to a particular category of employee—such as nurses, when they were in short supply both nationally and locally.

Thus, at the present time when plans are being formulated to hire a consultant to study patient classifications and staffing, the focus is being restricted to nurses, and only the directors of nursing at the larger institutions are participating with division personnel in the development of the project. Whatever results come out of the study, therefore, are likely to deal only partially with the questions of staff utilization and staff productivity which now face all hospitals and are likely to become more acute as major payers of health care services move to contain costs.

Problem of Low Patient Census and Low Staff Utilization

The general problem confronting private as well as public hospitals both nationally and locally becomes glaringly apparent for the county/state hospital program when one looks at the patient census at the individual hospitals within the program—especially the acute care facilities located in rural areas. Probably in response to cost containment efforts by major payers of hospital care services but perhaps due also to other factors, there has been a recent national downward trend in the utilization of acute care facilities. In the case of Hawaii's rural hospitals, however, utilization of acute care facilities began dropping even before cost containment became a national concern. This is probably the result of: (1) the changing demographics of the plantation communities where the hospitals are located, and (2) the improved transportation options now available to rural residents which enable them to go to the larger urban centers for major surgical and related services.

Indications of the problem. Table 5.1 depicts this situation quite starkly. For calendar year 1983, it shows that occupancy rates at the acute care sections of the six affected hospitals ranged from a low of 8.6 percent to a high of 48.4 percent. At two of the hospitals, the number of patients per day averages less than one. This means that on a number of occasions there are no acute care patients at all in some of the hospitals. At one hospital, the census of patients has been between 20 and 30 percent of capacity for approximately one year. For the three smallest hospitals on the island of Hawaii combined, the average daily census in 1983 was less than 10.

Table 5.1

Acute Care Occupancy Rates
Rural and Community Hospitals
Calendar Year 1983

<i>Hospital</i>	<i>Number of Acute Beds</i>	<i>Average Daily Census of Patients</i>	<i>Occupancy Rate Percentage</i>
Honokaa	27	6.2	23.0
Ka'u	7	0.6	8.6
Kohala	10	2.8	28.0
Kona	45	21.8	48.4
Lanai	6	0.8	13.3
Kauai Veterans Memorial	38	16.7	43.9

Source: Department of Health, State Health Planning and Development Agency.

Offsetting this situation to some extent are the census of long-term patients that are cared for at these six rural hospitals. Table 5.2 shows the long-term occupancy rates for calendar year 1983 for these hospitals. Except for the Kona and Lanai Hospitals, the occupancy rates were fairly close to capacity. Where staff can be shifted from acute care to long-term care, it is possible to alleviate underutilization of staff to some extent by making this shift. However, not all of the hospitals are organized to enable or facilitate such sharing of staff. In such instances, part of a hospital's staff may be very busy while another part may have little or nothing to do.

Table 5.2

Long-Term Occupancy Rates*
Rural and Community Hospitals
Calendar Year 1983

<i>Hospital</i>	<i>Number of Long-Term Beds</i>	<i>Average Daily Census of Patients</i>	<i>Occupancy Rate Percentage</i>
Honokaa	8	6.6	82.2
Ka'u	8	7.4	92.5
Kohala	16	14.2	88.6
Kona	26	12.5	48.3
Lanai	8	5.3	66.6
Kauai Veterans Memorial	6	5.2	86.6

*The figures shown above include all types of long-term care beds, skilled nursing beds, intermediate care beds, and a combination of both.

Source: Department of Health, State Health Planning and Development Agency.

Complicating the staffing situation are outside influences which affect and interact with the hospital program—such as employee bargaining agreement provisions, accreditation demands, and regulatory requirements. For example, many of the rural hospitals are tied into the State's system of emergency ambulance services. This means their staffs fulfill dual functions—providing hospital care services and serving as secondary emergency care personnel—which, in turn, means they must comply with DOH's Rule No. 48 governing emergency services as well as general accreditation requirements covering such services. These requirements stipulate the numbers and types of personnel who must be on duty at all times when emergency services are offered. Labor union contracts place similar restrictions on the use of personnel.

Nevertheless, such restrictions do not mean that no changes can be made or no improvements can be inaugurated. They simply mean that careful, concerted attention must be given to personnel management within the county/state hospital program if the program is to function effectively and if resources are to be maximized. Our finding is, however, that such careful, concerted attention has not yet been evidenced within the department. Instead, to the extent corrective efforts have been undertaken, they have been initiated and carried out on a fragmented and uncoordinated basis as indicated below.

Fragmented and uncoordinated efforts directed at dealing with problem of low utilization. Up to now, all matters relating to staff utilization generally have been handled at the level of the individual hospital. Even within the separate hospitals, the tendency has been to delegate downward the responsibility for fixing staffing patterns. Thus, the director of nurses in each institution—whether the nursing staff consists of 20 or 200 nurses—is the one primarily responsible for determining how the nursing staff in that hospital will be deployed.

In the small rural hospitals, the prevailing practice has been to have nurses handle all types of patients whether they be acute care or long-term care recipients. In the larger facilities where acute care predominates, the general approach is to have nurses specialize along type of care lines—such as medical-surgical, obstetrics, intensive care, emergency room, and skilled nursing. The former approach facilitates the movement of staff and enhances the ability to maximize the utilization of personnel, but the latter ensures better compliance with accreditation requirements which vary according to each type of care.

In the face of a varying and changing availability of nurses and other medical personnel and of increasing demands that costs be reduced, the hospitals have resorted to or are considering a number of different alternatives aimed at improving staff utilization or cutting down personnel costs. These include:

- freezing and not filling positions when they become vacant.
- requesting staff to use up accumulated compensatory time and vacation leave during periods of low patient occupancy.
- hiring specialized medical services on a contract basis.
- providing in-service training during slow periods.
- offering laundry and food preparation services to outside organizations, such as other hospitals, the Salvation Army, and the Meals-on-Wheels program.
- providing day care services to the elderly and infirm who may not need long-term care but who may need some attention during working hours when their families cannot care for them.

In the case of two hospitals, there has been a move from the traditional three 8-hour shifts per day for nurses to two 12-hour shifts. At Lanai Hospital, this applies to all the nurses. At Kauai Veterans Hospital, it applies to the contract nurses who work in the intensive care unit. In both instances, such a move has enabled the hospitals involved to reduce the number of nurses needed and thereby cut personnel costs. By allowing them to be off for longer periods of time, the arrangement appears to be acceptable to the affected employees even though it was originally designed to meet a severe shortage of nurses.

For the most part, however, the various steps taken or being considered have been viewed as stopgap measures to be undertaken to meet particular problems at particular institutions. No one has been taking the broader view and the longer perspective to coordinate efforts, to assess successes and failures, and to promote personnel resource utilization and cost cutting on a programwide basis. As a consequence, improvements in one place go unnoticed elsewhere. Moreover, no one is in a position of knowing how well or how poorly individual hospital administrators may be managing their personnel resources.

As a result of legislative impetus, at least one potentially broader and longer range effort in this area is now being undertaken by DOH. This is the \$100,000 study of hospitals on the island of Hawaii mandated under Section 17D of the Supplemental Appropriation Act of 1984 (Act 285). In accordance with this provision, DOH is supposed to make a comprehensive study of hospitals in Hawaii county, consider various alternatives for delivering hospital care services in that county, obtain public input concerning proposed alternatives, and prepare recommendations and cost estimates for making changes in the existing hospital setup.

Even this study is limited in scope, however, inasmuch as only the hospitals on the island of Hawaii were included in it. Moreover, because the study was only getting under way at the time of our budget review and analysis, it is too soon to know what will actually be covered. Closing or curtailing hospital services is an extremely sensitive issue in any community facing such a prospect and thus must be approached as carefully as possible. At the same time, the cost, quality, and availability of alternative means of hospital care services are also important considerations and deserve to be examined.

Therefore, in addition to whatever may be done as part of the hospital study for the island of Hawaii, it would seem to be appropriate for DOH to take an overall view of personnel management for the county/state hospital program and to develop a comprehensive and coordinated approach to assessing staffing needs, maximizing the utilization of personnel resources, and reducing personnel costs to the fullest extent possible without endangering the quality of hospital services provided. A good way to start is to build upon and expand the application of various efforts that have been undertaken by the individual hospitals in the statewide system. The end objective should be to develop standards and measures by which performance throughout the program can be continuously evaluated and improved.

Heavy use of temporary hires and extended retention of vacant positions. In response to budget restrictions, nursing shortages, and other emergency conditions in recent years, the various hospitals have resorted extensively to: (1) creating and filling positions on a temporary basis, and (2) leaving positions vacant or filling them only on an emergency hire basis. Although both of these personnel practices are designed to deal with very temporary conditions, they have become well established and ongoing methods of operation within the county/state hospital program—so much so, in fact, that the program's personnel requirements have become distorted, and it is extremely difficult to know just what the program's staffing needs actually are.

This situation is portrayed in Table 5.3 which summarizes the status of vacant and temporary positions for the various hospitals as of June 30, 1984. As this table indicates, more than 10 percent of the program's positions were vacant at that time, with one-fourth of the vacancies filled on an emergency hire basis. In addition, 166 temporary positions had been authorized, of which 102 were filled. At Hilo Hospital alone, there were 35 vacant positions, with 17 filled on an emergency hire basis, and 50 authorized temporary positions, with 16 filled. In one department in that hospital almost one-half of the staff of 22 were temporary hires. Much the same situation prevailed at Maui Memorial Hospital where there were 40 vacant positions, with 13 filled on an emergency hire basis, and 80 temporary positions, with 64 filled.

Table 5.3
 Vacant and Temporary Positions
 County/State Hospitals
 June 30, 1984

<i>Hospital</i>	<i>Authorized Positions</i>	<i>Vacant</i>	<i>Emergency Hire/ Appointment</i>	<i>Temporary</i>	
				<i>Authorized</i>	<i>Filled</i>
Hilo	541.2	35	17	50	16
Honokaa	46.0	3	0	1	0
Ka'u	32.0	4	0	1	0
Kohala	36.5	4	0	0	0
Kona	188.0	28	7	13	10
Mauui Memorial	420.0	40	13	80	64
Hana Medical Center	7.0	0	0	0	0
Kula	177.0	18	6	6	4
Lanai	21.0	1	0	1	0
Kauai Veterans Memorial	138.0	25	0	1	1
Samuel Mahelona Memorial	146.0	15	3	6	3
Maluhia	182.0	27	9	4	2
Leahi	295.0	44	6	3	2
TOTAL	2,229.7	244	61	166	102

Source: Department of Health, County/State Hospitals Division.

This is not to say, of course, that there should never be any vacant positions or temporary positions. With normal turnover it should be expected that there will always be some vacant positions in a program as large as the hospital program. To achieve temporary payroll savings, it is even acceptable to slow down or temporarily halt the filling of positions as they become vacant. Similarly, creating and filling temporary positions is a very reasonable way of dealing with fluctuating demands for services. However, both practices become highly questionable when extensive and extended use of them becomes the normal method of operation.

For example, when looking at some of the individual positions involved, we found that some of the vacant positions have remained vacant for five years or more and some of the temporary positions have been "temporary" for more than four years. The distorting effect this has on the budget is shown by Table 5.4 which summarizes for selected hospitals: (1) the number of positions left vacant for two years or more or deliberately frozen to achieve turnover savings, and (2) the annual

salary amounts for these long maintained vacant positions. At the seven hospitals involved, the vacancies total 59 at a combined annual salary cost of \$1,026,540.

Table 5.4
Permanent Position Vacancies in the
Personal Services Budget for
FY 1984-85 at Selected Hospitals

<i>Hospital</i>	<i>Number of Vacancies</i>	<i>Type of Vacancies*</i>	<i>Total Cost</i>
Samuel Mahelona Memorial	4	Prolonged	\$ 52,506
Kauai Veterans Memorial	19	Frozen	336,426
Leahi	17	Frozen/Prolonged	289,314
Maluhia	3	Prolonged	52,332
Maui Memorial	8	Prolonged	123,342
Kula	3	Prolonged	79,530
Kona	5	Prolonged	93,090
TOTAL	59		\$1,026,540

*Prolonged vacancies are those which have been vacant for more than two years. Frozen positions are those positions which the administration chooses not to fill as the position becomes vacant so as to achieve turnover savings.

Source: Department of Health, County/State Hospitals Division, Vacancy Reports, September 1984.

In effect, it can be said that the salary account for the program in this respect alone is overstated by more than \$1 million. While this equals only about 2 percent of the county/state hospital program's total annual budget for personal services, it is still a substantial amount. Moreover, the overstatement at some of the hospitals is significantly higher. For example, at Kauai Veterans Memorial Hospital, it amounts to 10 percent of that hospital's total personnel costs, and at Leahi Hospital, it is approximately 5 percent of total personnel costs.

Indeed, even this amount does not represent the full extent to which the budget may be distorted. For example, we found that at Kauai Veterans Memorial Hospital, nursing services for the intensive care unit are contracted out to a private group, with funds included in the budget for this purpose. At the same time, however, 12 vacant positions are retained in the budget for this unit at an annual

salary cost of \$219,108. What this means, in effect, is that the hospital is budgeting in two different places to provide this service.

In defense of these practices, program administrators state that they need to retain the positions they have to meet the situation they would face if suddenly there should be a marked increase in their patient populations. However, with patient census remaining stable or actually decreasing as has been happening in the acute care services area, this does not provide a very strong argument. In the meantime, the budget does not serve the basic purposes of accurately portraying and controlling the costs of the program.

Recommendations. In the area of planning for, managing, and budgeting for personnel resources for the county/state hospital program, we recommend as follows:

1. The Department of Health should commission a staffing study and plan for the county/state hospital program and its component hospitals that will take into consideration the following factors:

a. The different types of hospitals and services within hospitals in the program.

b. Alternative types of staffing patterns based upon the types of patients treated and the acuity of the illnesses affecting those patients.

c. Alternative means of delivering services, especially in areas of low population density (e.g., improved ambulance and medical evacuation services in lieu of numerous small hospitals with limited capabilities and low utilization per unit).

d. Alternative hiring arrangements, such as:

(1) part time and temporary employment;

(2) job sharing;

(3) flexible shifts; and

(4) contracting for nursing and other services.

e. Alternative placement, if needed, of employees who may be found in excess of needs.

f. Alternative services, such as day care and respite services for persons who really do not need full-time institutional care.

2. *In the meantime, program administrators—both at the division and hospital levels—should consult with each other, assess their various experiences to date, and take whatever immediate steps they can to maximize the utilization of existing personnel resources and to reduce personnel costs.*

3. *The Department of Health should closely scrutinize all vacant and temporary positions within the program to determine how long they have been in their present status and whether or not their continued retention can be justified. Steps should then be taken to eliminate all those positions for which a strong justification cannot be made.*

Weaknesses Relating to Contracting for Services on a Fee Basis

Upon reviewing expenditures for contracts for services on a fee basis by the county/state hospital program, we found two procedural or administrative control problems, which are discussed below.

Delay and uncertainties surrounding contracts for medical services. For certain types of medical specialization—pathology, radiology, emergency room, and nursing—the hospital program often contracts for services on a fee basis with private individuals or groups rather than always employ such personnel on a regular full-time basis. The standard practice in these cases has been to negotiate such contracts directly without going through competitive bidding. The department has based this approach on a 1980 memorandum from the State Comptroller to DOH in which it was indicated that the bidding procedures prescribed under Chapter 103, Hawaii Revised Statutes, did not have to be followed when contracting for nursing personnel for the Hawaii State Hospital at Kaneohe.

However, during the current biennium, the Comptroller has questioned all such contracts for medical services for the county/state hospital program and has held up payment under many of the contracts. The Comptroller's concerns revolved around the sole source nature of the contracts, and whether or not medical services were exempt from the Chapter 103 bidding procedures.

In the case of most of the pathology, radiology, and emergency room contract services, the Comptroller has relented at least temporarily and has allowed the payment of such charges since August 1984. At the same time, however, the

Comptroller cautioned DOH that: "... if there is a potential question as to whether the services are subject to competitive bidding, a determination by the Comptroller should be requested by your department in advance, and in writing, before any obligation of State funds for the services is incurred."¹ This suggests the same problem is likely to recur when new contracts are negotiated unless prior clearance is received or the contracts are put out to bid under Chapter 103 procedures.

With regard to the nursing contracts, their status remained similarly tangled at the time of our review. When the contracts for Kona and Kauai Veterans Memorial Hospitals for 1984 were being negotiated in December 1983, the Comptroller granted an exemption from Chapter 103, but went on to warn DOH that any such contracts for 1985 would require "full justification as to why it is a purpose that does not admit of competition."²

Thus, this still seems to be a serious point at issue between DOH and the Comptroller. No general guidelines seem to be available concerning this matter. The closest thing is a Governor's Administrative Directive issued in 1974 which exempts medical services, legal services, and engineering and architectural services (exclusive of master planning and development planning) from procedures of the Department of Budget and Finance covering requests for permission to engage the services of a consultant.³ However, this directive is not aimed at the specific question of Chapter 103 bidding requirements. Moreover, it does not define medical services so as to make clear whether it extends to contracts for nursing and similar services.

It appears, then, that DOH and the Comptroller—and perhaps other agencies—should get together and resolve this issue before any more contracts are negotiated or payments are delayed. If interpretation or clarification by the Attorney General is needed, then this should be obtained. Similarly, if clearance from the Department of Personnel Services appears necessary so that personal

1. Memorandum to the Director of Health from the Comptroller, Subject: Payments to Pathology Laboratory and Emergency Room Services, August 10, 1984.

2. Memorandum to the Director of Health from the Comptroller, Subject: DOH's Request for Exemption from Bidding for Nursing Services, December 6, 1983.

3. Administrative Directive No. 1974-1 to All Department Heads and Agencies from George R. Ariyoshi, Acting Governor, Subject: Approval of Consultant Contracts, July 29, 1974.

services of this type can be procured through contract, then this approval should also be secured.

Recommendation. We recommend that the Department of Health get together with other affected agencies forthwith to clarify and firmly establish the conditions and procedures under which medical services can be obtained on a fee basis. Department of Health should then adopt and implement the necessary procedures to insure proper compliance with all applicable requirements and timely payment of its bills.

Confusion arising out of use of revocable permits to contract for services. In the hospital program's contracting for medical services, we found that it does not always rely upon standard contracts for this purpose. Instead, on the island of Hawaii, it secures pathology services for two of the hospitals by means of revocable permits. Revocable permits are short-term leases (usually cancellable on 30 days notice by either party) under which county/state hospital land or facilities are made available for use by an outside party. In addition to requiring DOH approval, they must also be approved by the Department of Land and Natural Resources because that department has general jurisdiction over most state real property.

In the case of the private provider of pathology services on the island of Hawaii, the affected revocable permits not only make space, facilities, and equipment available to the private party but also provide for that party to supply pathology services to the county/state hospital program and even to exercise management control over a number of state employees. To further complicate matters, the private party has "donated" a computer and the part-time services of a computer programmer to one of the hospitals for its use in return for various financial concessions from the program.

The net effect of this arrangement is that the private provider operates pathology laboratories at three hospitals—those at Hilo, Kona, and Honokaa,⁴ and offers pathology services for the remaining hospitals on the island. The Kona and Honokaa laboratories are staffed respectively by 15 and 2.5 employees of the private provider. At Hilo, there are 27 employees in the laboratory—20 regular state civil

4. Until recently, the provider had a negotiated contract with Honokaa Hospital. Supervisory laboratory services continue to be provided but at no fee to the hospital. The supervisory services are also provided at no fee to Ka'u and Kohala Hospitals by this private provider under the umbrella of the Hilo and Kona permits.

service employees assigned to Hilo Hospital and seven employees of the private provider. In addition, the private provider has nine other employees located at the hospital who work primarily on billing and data processing matters. Besides the computer which has been "donated" to the State, the private provider has another computer on the premises to handle his private business operations.

As a result of this complex web of agreements and understandings, relationships between the county/state hospital program and the private provider are thoroughly confused and it is difficult to determine who is paying how much for what and who is actually in control. For example, there are the score of workers at Hilo Hospital who are state employees for payroll purposes but who actually function as virtual employees of the private provider. Moreover, when the county/state hospital program wants programming services for the computer that has been "donated" to it, it must request the services from the private provider. Perhaps even more serious, the terms of the revocable permit at Hilo Hospital are currently being grossly violated as a result of an alleged verbal agreement between the private provider and the former administrator of the hospital. In addition to the 6,868 square feet of space covered by the permit, the private provider is occupying another 7,376 square feet of space.

Apart from these problems, there is also the question touched upon in the preceding discussion concerning contract letting procedures for contracted medical services. As long as the revocable permit procedure is followed to contract for such services, then the whole matter of the possible application of Chapter 103 and its competitive bidding requirements is completely circumvented.

Not to be overlooked either is the fact that the revocable permit arrangement does not provide much protection to the private provider. With the 30-day cancellation provision in the permits, the private provider is vulnerable to being terminated on very short notice. Further, if no new arrangements (contract or permit) are made with this provider prior to the move to the new Hilo Hospital facility, the hospital could conceivably be without the services of the provider since the present permit confines his work to the laboratory facilities in the present facility. Any move to the new hospital without a new contract or permit would not comply with legal requirements.

What this situation and the preceding situation regarding the medical services contracts both indicate is a lack of an overall system of firm administrative control over this activity. For the most part, the department has failed to develop any general policies and procedures in this area and the separate hospital administrators are left much on their own as to how to deal with contract services. While it may be desirable to provide a degree of administrative flexibility to the unit administrators, it is also important to establish a meaningful framework within which the local units can operate and then to monitor them to insure compliance with defined policies and procedures. These elements are lacking at the present time.

Recommendations. We recommend that the Department of Health thoroughly review the present situation regarding the contracting of pathology services on the island of Hawaii and develop a clearer basis of interrelationships which will place the county/state hospital program firmly in control and will define who is in charge of what activities and who is paying how much for what services or use of facilities.

We further recommend that the Department of Health reexamine its whole approach to contracting for services on a fee basis with the objective of developing and implementing a set of policies and procedures that will enable the county/state hospital program to exercise firm administrative control over this activity.

Shortcoming Relating to the Purchasing of Hospital and Medical Supplies

As might be expected, hospital and medical supplies constitute major items in the budgets of the county/state hospitals. In recent years, DOH has given some recognition to the importance of this area of expenditure and has taken steps to maximize resources devoted to this purpose. This has taken the form of a purchasing committee which was created in 1978 and which includes a purchasing agent from DAGS as well as purchasing and central supply personnel from the various county/state hospitals. Representation of DAGS on the committee is significant because that department has general responsibility for central purchasing for the state government and has developed a degree of expertise in volume purchasing.

Prior to the formation of this committee, each hospital largely handled its own purchasing. Even within single hospitals, there often was a lack of standardization for widely used items because individual doctors were allowed to specify the particular products they wanted. Since its inception, the committee has had the goal

of lowering the costs of such supplies through standardization and bulk purchasing while at the same time avoiding any compromise that would undermine the desired level of quality in the affected products.

To this end, the committee has proven reasonably effective. For example, it reports saving \$75,000 on surgical packs and sterile/disposable drapes through a bid covering the period of August 1, 1984, through November 30, 1984, and for which an extension has been requested from December 1, 1984, through February 25, 1985. On one item alone—the laparotomy surgical pack—the bid price was \$12.30 per pack compared with the previous price paid by the hospitals of \$23.89 per pack. Similarly, whenever price increases are announced, the committee has a review process for checking vendor prices to make sure they appear reasonable and remain competitive.

Despite these efforts of the committee, no steps have been taken to translate committee accomplishments into budgetary terms and budgetary decisions. As a consequence, there appears to be considerable excess funds for hospital and medical supplies in the budget. An indication of this is the fact that \$0.5 million was restricted in this category during the 1983-84 fiscal year with no apparent adverse effect on the availability of needed supplies.

Considering that the purpose of a budget is to reflect accurately and control the resources needed to carry out programs and activities, cost containment results like those achieved by the purchasing committee need to be translated into the budgetary process. It is important, therefore, that the work of the purchasing committee become an integral part of the county/state hospital program's approach to internal budget management.

Recommendations. We recommend that the county/state hospital program develop a procedure whereby the savings or related cost containment benefits accruing to the State through volume purchasing and competitive bidding be quantified and documented for use by personnel at both the unit and division levels in formulating budget requests and controlling expenditures for the program and for the individual hospitals.

We further recommend that the scope and membership of the purchasing committee be expanded so that quantity purchasing and bidding procedures can be further improved and the benefits obtained thereby can be extended to other institutions within the state government, particularly the other hospitals under the jurisdiction of the Department of Health.

Chapter 6

FOLLOW-UP REVIEW OF THE HEALTH CARE PAYMENTS PROGRAM (MEDICAID) AND REVIEW OF ITS RELATIONSHIP TO THE COUNTY/STATE HOSPITAL PROGRAM

In a budget review and analysis report to the Legislature in 1984, we examined the health care payments program (Medicaid) administered by the Department of Social Services and Housing (DSSH).¹ Out of this examination came various findings and recommendations calling for changes and improvements to be made in the State's budgeting for Medicaid. Although the close interrelationship between Medicaid and the county/state hospital program was recognized then, we did not at that time focus specifically upon this relationship.

However, now that we have been directing attention to the county/state hospital program, it would be appropriate and timely to review what has been happening to Medicaid since the 1984 legislative session and to examine more fully the interrelationship between Medicaid and the hospital program. This chapter sets forth the results of our review of these two overlapping areas of concern.

Summary of Findings

With respect to Medicaid follow-up action and Medicaid's interrelationship with the county/state hospital program, we find as follows:

1. Although DSSH has taken a number of steps to correct deficiencies and make improvements in its administration of and budgeting for Medicaid as

1. State of Hawaii, Legislative Auditor, *Budget Review and Analysis of the Public Welfare Financial Assistance Programs*, Report No. 84-10, January 1984, pp. 15-26.

recommended in our 1984 report, much more still needs to be done to assure continuing and fully effective management and budget control over the program. More specifically, the program continues to suffer the following shortcomings:

a. A questionable expenditure base is being used for making future budget projections. The base used exceeds by millions of dollars the amount reported by DSSH's fiscal unit.

b. DSSH has not developed an analytic capability to understand *why* changes are occurring as well as the fact that they are. No one seems to know why sudden drops in some categories are taking place and whether or not they are likely to continue.

c. There has not been consideration and weighing of alternative cost containment efforts on a comprehensive and integrated basis. It is difficult to know which efforts or combination of efforts should be pursued as long as they are considered on a piecemeal and limited basis.

d. There is an absence of a concerted approach to the development of community based alternatives to institutionalized care. Although such alternatives appear to offer both therapeutic and cost advantages, no coordinated push is being exerted to enlarge the role of such alternatives in Hawaii.

e. DSSH has been slow in implementing corrective action where additional resources have been authorized by the Legislature. No concrete action has been taken yet to follow up on the collection of several million dollars of third party liabilities despite the authorization of additional positions by the 1984 Legislature to handle this task.

2. Despite the profound impact the imposition of limits on Medicaid payments (through such measures as a prospective payment system) is almost certain to have on the county/state hospital program, state response has been characterized by: (a) the tendency of the affected agencies to approach the matter almost entirely within the narrow view of their individual perspectives, and (b) the failure of any agency to exert leadership in this area, provide overall coordination, and direct

efforts towards optimizing the effects of required changes upon the State as a whole, including the users of services as well as the State as a provider.

Follow Up on Previous Budget

Review and Analysis of Medicaid

Based upon our earlier budget review and analysis of public welfare financial assistance programs, including Medicaid, we reported various findings and recommendations to the 1984 session of the Legislature. When we shifted the focus of our attention to the county/state hospital program, which is closely intertwined with Medicaid, these previous findings and recommendations became appropriate subjects for follow-up review. The results of this follow-up review are set forth below.

Lack of adequate data base for budget projections. One of our previous findings affecting all of the public welfare financial assistance programs was that DSSH had not developed adequate information bases and related capacities to provide reasonable projections of future budgetary requirements. Different and irreconcilable compilations of fiscal data came from different units within the department. To remedy this situation, we recommended that DSSH coordinate its efforts and refine and standardize its budget data base and projection methodology so as to provide an adequate basis for preparing the 1985-87 biennium budget.

Our follow-up review reveals, however, that not much has been accomplished toward achieving this objective. Although a coordinating committee has been set up and somewhat different procedures are being followed, the net result does not represent much of an improvement. Serious discrepancies are still occurring in data base information.

An example is provided by total actual Medicaid expenditures for fiscal years 1981-82, 1982-83, and 1983-84 as reported by DSSH fiscal office and as used by the Medical Care Administration Services (MCAS) for making its budget projections for the 1985-87 biennium. As can be seen in Table 6.1, variances between the two amounting to millions of dollars each year occur for all three years.

Table 6.1

Comparison of Actual Medicaid Expenditures
for Fiscal Years 1981-82, 1982-83, and 1983-84
as Reported by MCAS and by DSSH Fiscal Office

<i>Year</i>	<i>MCAS</i>	<i>DSSH Fiscal Office</i>	<i>Variance</i>
1981-82	\$153,161,558	\$150,679,578	\$ 2,481,980
1982-83	175,261,393	163,292,116	11,969,277
1983-84	178,628,807*	174,772,928	3,855,879

*Includes transfer funds.

Sources: Department of Social Services and Housing, Medical Care Administration Services, Worksheet A--Benefit Payments: Actual and Projected, August 20, 1984 (Revised) and Department of Social Services and Housing, Fiscal Office, Medical Assistance Payments--Soc 230, Fiscal Years 1977 Through 1984, September 1984.

Considering that inflation factors are usually applied to such past costs to project future costs, it is important that this data base be as accurate as possible. Otherwise, the future projections will be proportionately distorted.

Despite our efforts, we were unable to reconcile these two sets of figures. Presumably MCAS' figures came from the budget projection committee. However, no records are kept of the committee's activities and no documentation could be located to substantiate the reported end result. It is noteworthy that MCAS' figures are consistently higher than those reported by the fiscal office. To the extent they may be inflated, they may also be causing an upward distortion in the Medicaid budget requirements for the 1985-87 biennium.

Recommendation. We again recommend that the Department of Social Services and Housing coordinate internally and develop a base of data for its financial assistance programs that will be accurate, consistent, and verifiable.

Lack of analytic effort and capability. Another shortcoming we found in our previous review of Medicaid--and one closely allied to the failure to develop an adequate data base--was DSSH's failure to refine its analytic capabilities sufficiently to be able to avoid, or at least minimize, large unexpected and unexplainable fluctuations in program expenditures. To cope with this problem, we

recommended that the department analyze its budget preparation process and methods and then devise a better method to derive budget projections. Implicit in this recommendation is the need to be able to detect early when changes seem to be occurring and the need to be able to analyze the possible causes and future implications of such changes. In our follow-up review, however, we discovered that little progress has been made toward developing a capability to analyze changes and the future implications of these changes.

That some sort of significant changes have been occurring recently is fairly apparent. Overall program costs have been running substantially below what had been anticipated. These changes can be seen in Tables 6.2 and 6.3.

Table 6.2 compares projections and actual expenditures for FY 1983-84, both on an individual basis and on a total basis for the six major categories of vendor provided services. As this table clearly shows, actual expenditures have run substantially below projections overall and in five of the six categories of vendor provided services—ranging from a high of 92 percent of projections for intermediate care services to a low of 79 percent of projections for skilled nursing services. Only the expenditures for the drug category exceeded projections by 11 percent.

Table 6.2
Comparison of Projections to Actual Expenditures*
for Six Major Vendor Provided Services
(FY 1983-84)

<i>Services</i>	<i>Projections</i>	<i>Actual Expenditures</i>	
		<i>Amount</i>	<i>Percent of Projection</i>
Hospital In-Patient	\$ 47,592,000	\$ 41,278,423	86
Skilled Nursing Facility	28,096,000	22,226,981	79
Intermediate Care Facility	48,096,000	44,418,613	92
Physician	25,312,000	22,652,794	89
Dental	8,856,000	7,303,683	82
Drug	7,572,000	8,424,383	111
TOTAL	\$165,524,000	\$146,304,877	88

Sources: Projections are from the Department of Social Services and Housing; actual expenditures are from the Hawaii Medical Service Association, Hawaii Medicaid Program, Benefit Projection Worksheet, August 3, 1984 (Revised).

Table 6.3 provides a more detailed comparison of cost data extended over four fiscal years (1980-81 through 1983-84) instead of just one. For each of the six major categories of vendor provided services, it shows for each year total expenditures, total number of recipients, total number of patient (recipient) services, the average services per recipient, and the average payment per service. Shown also are the percent change from one year to the next in the services per patient and the payment per service.

Although no single or clear pattern is indicated in Table 6.3, the table does show some perceptible changes between FY 1983-84 and the preceding years. For example, total costs in almost every category showed steady increases during the first three years. However, for FY 1983-84, total expenditures decreased in four of the six categories; only for intermediate care services and drugs did there continue to be increases.

Basically, three variables determine the total costs of services provided under this program—the number of recipients, usage (days of care received or services consumed), and the cost per unit of type of service received. As can be seen from Table 6.3, information concerning these variables is generated and reportable. However, to be useful, such information needs to be reviewed and analyzed to detect trends, uncover their possible causes, and identify their likely consequences. On this basis, future plans can be laid and future budget projections can be made which should be more reliable and realistic.

So far, however, DSSH has not developed any systematized approach to this matter. When asked for an explanation for the recent changes noted above, the best that MCAS personnel could offer was the suggestion that the cost reductions are probably due in part to cost containment efforts undertaken and may be due in part to anticipation by providers of impending limitations on payments to be imposed by federal regulations. The latter is purely speculation, however, as no evidence or supporting data have been offered to substantiate this contention. In any event, MCAS personnel seem to be treating the recent reductions as a temporary aberration in long-term trends. They have made no separate analysis of their own of what has been happening. Accordingly, they are projecting a continued upward surge in the demand for resources to sustain this program.

Table 6.3

Comparison of Medicaid Cost Data for Six Major Vendor Payment Services
Fiscal Years 1980-81 Through 1983-84

<i>Year</i>	<i>Costs</i>	<i>Recipients</i>	<i>Services*</i>	<i>Services Per Recipient*</i>	<i>Percent Increase [Decrease] From Prior Year</i>	<i>Per Service*</i>	<i>Percent Increase [Decrease] From Prior Year</i>
In-Patient Hospital							
1981	\$28,978,252	16,462	119,313	7.25	3.29	\$242.88	19.63
1982	34,249,765	16,754	124,623	7.44	2.63	274.83	13.16
1983	42,563,252	17,438	132,997	7.63	2.53	320.03	16.45
1984	41,278,423	16,670	112,865	6.77	[11.23]	365.73	14.28
Skilled Nursing Facility							
1981	\$18,736,621	2,370	312,659	131.92	[16.00]	\$ 59.93	15.09
1982	22,874,683	2,227	309,280	138.88	5.27	73.96	23.42
1983	25,261,349	2,556	316,872	123.97	[10.73]	79.72	7.79
1984	22,266,981	2,322	278,731	120.04	[3.17]	79.89	0.21
Intermediate Care Facility							
1981	\$26,664,528	2,314	560,391	242.17	[1.31]	\$ 47.58	13.97
1982	33,598,856	2,444	569,513	233.02	[3.78]	59.00	23.99
1983	41,940,198	2,749	608,356	221.30	[5.03]	68.94	16.86
1984	44,418,631	2,727	620,617	227.58	2.84	71.57	3.82
Physicians							
1981	\$21,055,000	105,918	773,528	7.30	4.44	\$ 27.22	13.13
1982	21,411,058	103,614	747,132	7.21	[1.26]	28.66	5.28
1983	23,767,721	105,812	811,895	7.67	6.41	29.27	2.15
1984	22,652,794	101,755	819,473	8.05	7.96	27.64	[5.57]
Dental							
1981	\$ 8,877,021	50,587	440,968	8.72	[2.37]	\$ 20.13	7.39
1982	8,792,498	50,542	428,628	8.48	[2.71]	20.51	1.90
1983	8,927,404	50,853	438,253	8.62	1.62	20.37	[0.70]
1984	7,303,683	47,598	397,153	8.34	[3.18]	18.39	[9.72]
Drugs							
1981	\$ 6,066,917	94,044	926,027	9.85	[0.90]	\$ 6.55	4.85
1982	6,538,656	93,223	910,758	9.77	[0.78]	7.18	9.58
1983	8,056,493	95,973	993,674	10.35	5.98	8.11	12.93
1984	8,424,383	89,354	938,370	10.50	1.43	8.98	10.73

*For in-patient hospital, skilled nursing facility, and intermediate care facility, these columns refer to number of patient days, days per recipient, and payment per day; for physicians and dentists, these columns refer to number of patient visits, visits per recipient, and payment per visit; for drugs, these columns refer to number of prescriptions, prescriptions per recipient, and payment per prescription.

Source: Hawaii Medical Service Association, Hawaii Medicaid Program, Benefit Projection Worksheet, August 3, 1984 (Revised).

Thus, for FY 1984-85, they are assuming total expenditures will reach \$187,830,703 or 100 percent of the total appropriation² for this year. [For FY 1983-84, expenditures amounted to only \$174,772,928 (including carryover expenditures from prior year), or 92 percent of the \$190,317,124 appropriation for that year.] Then, for FY 1985-86 and FY 1986-87, MCAS has projected requirements of \$211,392,981 and \$234,779,552, or increases of 13 percent and 11 percent over the preceding years. The Department of Budget and Finance has scaled these totals back to \$202,171,005 for FY 1985-86 and \$214,350,005 for FY 1986-87, but even so, the executive budget is contemplating increases for Medicaid of 8 percent for FY 1985-86 and 6 percent for FY 1986-87.

If FY 1983-84 represents a beginning of a reining in of health care costs, however, then the projections by MCAS are quite likely to be major overstatements of program requirements. To the extent unneeded funds are committed to Medicaid, other deserving programs may be deprived of badly needed support. For this reason, it is important that the projections for Medicaid be as soundly based as possible.

Recommendation. In this case, too, we again recommend that the Department of Social Services and Housing and the Medical Care Administration Services analyze their budget preparation process and methods and devise a better way of deriving their budget projections for Medicaid. The end objective should be to minimize differences between projections and actual needs and to avoid excess balances or shortfalls at the end of each year.

Failure to take adequate approach to weighing cost containment alternatives. Another finding that came out of our previous review of Medicaid was that in its efforts to contain costs in the face of escalating Medicaid expenditures, DSSH had not systematically analyzed the alternatives available to it in terms of their weighed impacts and had not presented the Legislature with a consistent plan of action. To deal with this problem, we recommended that DSSH should: (1) systematically analyze alternatives in terms of cost savings, short-term and long-term effects on recipients, and effects upon providers of services and upon other state programs, and (2) rate alternatives according to the degree they threaten recipients, their feasibility, and their fiscal results (not only on Medicaid but upon the State as a whole).

2. Including the appropriation for personal care services and federal matching funds.

In the period since our previous review, we find that DSSH and MCAS have continued to pursue or have initiated numerous cost containment efforts. In so doing, however, we also find that they still are not taking a comprehensive and integrated approach where all factors can be weighed and the individual and cumulative effects of the different alternatives can be determined. Still lacking is any systematized means of analyzing and rating the many alternatives and knowing what their total impacts will be—on recipients, on providers of services, and on the state budget as a whole.

Rapidly increasing health care costs have forced federal and state governments alike to confront the need for cost containment with respect to Medicaid. Initiatives to contain costs cover a wide range of actions, but can be grouped into eight broad categories: (1) constrain reimbursement levels, (2) promote the least costly forms of care, (3) reduce the need for care (prevention), (4) improve administration and management, (5) maximize third party collections, (6) reduce the scope of benefits, (7) reduce the number of eligibles, and (8) utilize alternative delivery systems.

Under these various categories, DSSH has considered a large number of options since 1983. In a letter to the Director of DSSH, MCAS listed 20 that were under consideration or had been adopted. Of these, 13 were reported to have been implemented, six were currently under development, and one was being considered for possible development. Among these were several which were the result of legislative, rather than departmental, initiatives. Not listed were several that had been considered, but dropped due to opposition from recipients, providers of services, or the Legislature.

Despite all this activity, however, it is virtually impossible to obtain a clear picture of what is happening or potentially can happen to the programs, to recipients, or to providers of services, or to assess the budgetary impact of the various measures already undertaken or being contemplated—either individually or cumulatively. DSSH simply has not devised any regular mechanism for evaluating and costing out different alternatives as they come up for consideration. Without such a mechanism, decision makers are placed in an almost impossible position of knowing in which direction to move. Moreover, as brought out in the previous section regarding the lack of explanation for the sudden drop in Medicaid costs, they do not know how to assess events after they have happened.

Among the various alternatives, the prospective payment system (PPS) is likely to have the most significant impact, not only on program costs but also on program operations. Under PPS, services are paid for on a predetermined basis without regard to the costs in any particular case. This is in contrast to the long established practice of covering reasonable costs as determined after the fact in each case. The objective of PPS is to cut costs by providing an incentive to do so which is lacking under the traditional approach.

The steps taken to install PPS in Hawaii's Medicaid program well illustrate the general weaknesses in DSSH's overall approach to cost containment for Medicaid. The whole effort has been engulfed in uncertainty and confusion as the department has plunged headlong into trying to meet a January 1985 deadline for converting to this new system. Due to the importance of this particular effort and its direct and extensive impact upon the county/state hospital program, it is discussed more fully in a subsequent section in this chapter.

Recommendation. We reiterate our previous recommendation that the Department of Social Services and Housing develop a systematic approach to analyzing cost containment alternatives, giving due consideration to cost savings and short-term and long-term effects on recipients, on providers of services, and on all affected state programs. Alternatives should be rated according to the extent they impact upon recipients, their feasibility, and their fiscal results.

Lack of concerted approach to community-based alternatives to institutionalized long-term care. For many years, Hawaii's Medicaid program has been heavily oriented toward meeting long-term care needs through institutionalized services—skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and intermediate care facilities for the mentally retarded (ICF-MRs). Some of these services have been hospital-based; others have been provided through free-standing institutions (nursing homes). Although the hospital-based services are the most expensive, any type of institutionalized service tends to be quite costly. Moreover, these costs have been rising rapidly in recent years. For this reason alone, finding less expensive alternative means of delivering services would be highly attractive.

In addition, there is another reason for seeking such alternatives. As brought out in Chapter 2 above, there is a trend in the health care field toward a more

humanistic and holistic approach; a recognition that besides physical and medical needs, psychological and social considerations are important—not only for the patients but also for their families and friends.

Cost and therapeutic considerations, therefore, have given strong impetus to the concept of community-based services, or a movement sometimes referred to as “deinstitutionalization.” To the extent possible, its aim is to get away from costly around-the-clock “warehousing” of the aged and infirm and to draw upon the resources of individuals, their families and friends, and the community in providing care for those who cannot care completely for themselves.

Community-based services can take a variety of forms—in-the-home, part-time nursing and personal care and housekeeping assistance, group living arrangements where individuals can help each other, respite (temporary relief) care, day care services, and hospice services for the terminally ill.

The need to do more to come to grips with long-term care needs in Hawaii is glaringly apparent. The State formed a Long Term Care Planning Group to look at the problem. Making an assumption based upon previous experience nationwide that 4.5 percent of the population would require some type of long-term institutionalization, it projected that Hawaii would require 3,316 certified beds in 1980 and 6,345 certified beds by the year 2000. The actual count of such beds in 1984 is only 2,648.

Meanwhile, usage of long-term facilities has been increasing quite sharply, and the demand for some type of relief has been becoming more acute. In FY 1978-79, there were 4,363 SNF and ICF patients who required 800,610 patient days of care. By FY 1983-84, these totals had increased to 5,049 patients and 899,348 patient days. To make matters worse, the lids on payments imposed or proposed under various Medicare and Medicaid cost containment measures have caused the threatened termination of at least some hospital-based long-term care programs.

Additional beds will help some to relieve this problem. However, the consideration of more beds is likely to be adversely affected by uncertainty over the level of payments for care that will be available under Medicare, Medicaid, and other programs. Moreover, such institutional care will continue to be very expensive and will not provide the benefits available under the community-based approach. Also

unknown is the number of persons who need care or are receiving care, but who for one reason or another have not sought admission into a long-term care facility. These constitute another source of participants in any community-based long-term care program.

DSSH and the Legislature have accorded some recognition and support to community-based programs, including the Queen's Home and Community Based Service Project, the Nursing Home Without Walls Demonstration Project, and the Personal Care Services Project. At the time of our examination, these programs were still in the development stages and were of limited scope. However, the DSSH evaluation of the Nursing Home Without Walls Demonstration Project indicates that the project has shown considerable cost savings and patient benefits. Consequently, DSSH is requesting the Legislature to extend the project for another two years through the 1985-87 biennium. In the meanwhile, DSSH should be preparing a program design which details how Nursing Home Without Walls will move from project status to full program implementation.

In addition to DSSH's efforts, the Department of Health (DOH) also provides similar services—sometimes with Medicaid support—through its various programs, such as public health nurse outreach activities, community programs for the developmentally disabled, and day hospital care.

Although these numerous community-based efforts appear to be more cost effective than institutional care, it is difficult to assess their actual savings potential as the separate developments have generally been uncoordinated with each other, with the budgeting and planning of the Medicaid program, and with other state long-term care programs.

At the same time, the State has recognized the need for comprehensive planning for long-term care as evidenced by its establishment of the Long Term Planning Group in 1981. Composed of representatives from affected state and federal agencies, the Long Term Planning Group has laid the groundwork for planning in this area by describing existing activities and sources of information, identifying problems in the State's present approach to long-term care, and formulating a general planning framework. However, during its three year existence, it apparently has not been able to overcome jurisdictional barriers to develop a functioning planning system, or to formulate any definite action plans to resolve the

basic problems of fragmentation and lack of coordination. The ultimate result is a recent recommendation that the Executive Office on Aging assume the function of comprehensive long-term care planning for the State.

Concerning the role community-based services might play in this area, it should be noted that the State of Texas has made expansion of community-based long-term care services a major part of its efforts to reduce Medicaid costs. As a result, the nursing home population is reported to have decreased by 11.8 percent between 1979 and 1983 and that the nursing home share of Medicaid funds was reduced from 46.5 percent in 1976 to a projected 27.5 percent in 1985.

Recommendation. We recommend that an appropriate high level and coordinated effort be undertaken forthwith to develop and recommend to the Legislature an action oriented state plan for community-based long-term care services in Hawaii. Leadership to develop the plan might well be assigned to the Executive Office on Aging, as is currently being proposed by the state administration. Such a plan should include the following elements:

1. Recommendations regarding the kinds of services and the extent to which the State should provide long-term community-based services;
2. Recommendations concerning the role of the Medicaid program and of regulatory activities, such as the certificate of need process, in the State's overall efforts to achieve a coordinated, cohesive, and efficient approach to the provision of services in this area; and
3. Definite implementation plans, cost estimates, and timetables to carry out the recommended changes.

We further recommend that the Department of Social Services and Housing develop and submit to the Legislature a program design for Nursing Homes Without Walls which outlines the steps necessary, the resources required, and the timetable for full program implementation.

Slowness in implementing corrective actions to collect from liable third parties. In our previous review of Medicaid, we found that financing of the program from other than state sources was jeopardized to some extent by an inability to meet federal standards and by the lack of an adequate system of collection from liable

third parties. To correct this dual problem, we recommended that DSSH make every effort to: (a) reduce errors so as to avoid federal government sanctions, and (b) resolve internal differences so as to expedite collection from liable third parties.

In our follow-up review of actions taken in response to those recommendations, we find that DSSH has moved quite expeditiously to deal with the problem of errors causing the federal government to threaten to exercise sanctions against the State. With regard to improving collections from liable third parties, however, DSSH has not been so diligent. As a consequence, there are several millions of dollars in collections that remain essentially untouched.

Corrective actions to avoid the imposition of federal sanctions include:

- . Retention of an additional two-member utilization review team to enable timely independent professional reviews to be made of long-term care facilities.
- . Amendment of regulations to permit physician aides and nurse practitioners, as well as physicians, to certify and re-certify patient eligibility so as to remove a bottleneck in the certification and re-certification process.
- . Reduction of the error rate to 1.33 percent during the first three quarters of 1984 (compared to the federal tolerance rate of 3 percent) by hiring two quality maintenance workers to review error prone cases, employing a trainer on a temporary basis, and implementing a staff training program.

The main job remaining to be done in this area, therefore, is to maintain the current level of effort so as to keep errors within the tolerance rates allowed by the federal government.

“Third party liability” refers to those obligations payable by parties other than Medicaid or the recipients of financial assistance, such as private health and accident insurance carriers, Medicare, and workers’ compensation. As the payer of last resort, Medicaid has the responsibility of pursuing and collecting third party liability payments. Nationally, this activity has been an important part of cost containment strategies aimed at reducing expenditures for Medicaid. Some states have recovered as much as 20 percent of their Medicaid expenditures through such

efforts, and 25 states in a recent poll indicated they were expanding their third party recovery staffs and budgets over the next two years.

During its 1984 session, the Legislature authorized eight additional temporary positions to DSSH to push third party recovery efforts which up to then had been stymied by a lack of resources and a lack of agreement among affected state agencies as to which one should pursue this activity. With this authorization, however, the question still had not been decided as to how the additional positions should be organized. After weighing whether they should be located within a single specialized unit or spread through the several affected existing units, it has apparently been decided to adopt the second of these options.

Accordingly, three positions—the third party liability coordinator, a clerk steno, and an investigator—have been assigned to MCAS; three pre-audit clerk positions have been placed in DSSH's administrative services office, and one legal assistant position has been assigned to the Department of the Attorney General. Placement of the eighth and remaining position reportedly has not yet been determined. This is only the first step, however. Most of these positions still have to be established and filled. This can be quite time consuming. Then it will still be necessary to take this group spread out over at least three administrative units in two separate departments and weld it into a cohesive and smoothly running operation.

There is no telling how long it will be before any concrete steps can be taken to accelerate the collection of outstanding third party obligations. A key to these efforts is the newly authorized coordinator's position. Early appointment of the right kind of person can do much to move things along. Delay of such action, however, will cause the collection activity to continue to lag. Meanwhile, the outstanding uncollected amount continues to increase. From June 1983 to June 1984, it rose from \$2,559,517 to \$3,188,265. Such a situation deserves more urgent attention than it has received up to now.

Recommendation. We recommend that the Department of Social Services and Housing move forthwith to establish and fill the positions authorized by the 1984 Legislature to accelerate third party liability recovery efforts and charge the persons who fill these positions to pursue as expeditiously as possible all outstanding third party obligations. Due to the key importance of the coordinator's position, we further recommend special attention be given to filling this position.

**Problems Related to the Interaction Between
Medicaid and the County/State Hospital Program:
The Current Prospective Payment System Situation**

As brought out in Chapter 2, Medicaid and the county/state hospital program are closely intertwined with one another, especially in the area of long-term care. County/state hospitals constitute a major provider of services to Medicaid recipients, and Medicaid is a major source of revenue for the hospitals. It is quite obvious, therefore, that any major action contemplated for one should not actually be taken without careful consideration of the likely impact on the other.

However, we find that this close interrelationship is not given much attention—at least in terms of developing and carrying out comprehensive and integrated policies and courses of action. This is glaringly apparent in the events associated with DSSH's recent moves to adopt a PPS for its Medicaid program. The department is proceeding headlong to install a form of PPS although it is by no means clear what the net effects of this action on the State will be or whether other alternatives may be feasible and more attractive. In this section, we review the situation surrounding this move to PPS.

Important impact of federal requirements. As a program financed 50 percent by federal funds, Medicaid is directly and significantly affected by requirements and limitations imposed upon the program by federal laws and regulations. In recent years, the federal government has inaugurated a number of measures aimed at curbing the rapidly rising costs of Medicaid. It is important to understand these when looking at Hawaii's recent actions relating to Medicaid. The most significant of these federal requirements and limitations are summarized below.

1. *Federal provisions of 1981.* In 1981, Congress passed the Omnibus Budget Reconciliation Act which gave states flexibility to set their own Medicaid payments for acute care and long-term care services so long as: (a) these payments were adequate to meet the costs of institutions which were efficiently and economically operated and which were also run in conformance with applicable federal and state laws, and (b) the payments, in the aggregate, did not exceed what would be paid under Medicare principles of reimbursement. This latter provision was significant because the federal government was moving toward a PPS approach to Medicare based upon diagnostically related groups for acute care services. The 1981 budget act also authorized the federal government to waive certain

requirements in the Medicaid law to enable states to investigate and utilize alternative delivery systems which were cost effective, efficient, and consistent with the objectives of the Medicaid program. In effect, this law served notice to the states that they should start containing Medicaid costs, but also gave them latitude to devise the best ways to do this.

2. *Federal provisions of 1982.* In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act which initiated the first steps toward setting definite and lower limits on payments to be made to providers of long-term care services under Medicare (and indirectly under Medicaid). It called for shifting from a dual standard of payments for freestanding and hospital-based facilities to a single standard of payments for all facilities based upon the cost experiences of the less expensive freestanding facilities. In short, the hospital-based facilities would have to match the costs of freestanding facilities or suffer the consequences (such as by dropping out of the long-term care business or by absorbing the losses incurred because Medicare payments did not cover their full costs). This provision was originally scheduled to be implemented in October 1982, but this deadline was extended by an amendment included in the Social Security Act of 1983. Under this amendment, the Secretary of Health and Human Resources was supposed to submit a report to Congress by December 1983 showing what the impact of the single rate payment system and PPS would be on hospital-based long-term care facilities. Subsequent legislation has altered this change by retaining the dual system of payments on a modified basis.

3. *Social Security Amendments of 1982.* Among the provisions included by Congress in the Social Security Amendments of 1982 was one which requires Medicare payments for acute care services to be placed on a PPS basis and that this be phased in over four years.

4. *Federal provisions of 1984.* In 1984, Congress adopted the Deficit Reduction Act which among other things retained the dual system of payments for providers of long-term care services, but modified the method of computing reimbursements for hospital-based facilities. Basically, the new limit set on hospital-based facilities would be an amount equal to that paid to freestanding facilities plus 50 percent of the difference between the rate for freestanding facilities and what the cost based rate would be for hospital-based facilities if such a rate were still allowed. While imposing a reduced rate on the hospital-based facilities, the reduction would not be as drastic as that provided for under the Tax

Equity and Fiscal Responsibility Act. This legislation also extended to December 1, 1984, the deadline for the Secretary of Health and Human Services to report on the impact of PPS on hospital-based, long-term care facilities. As of mid-December 1984, no federal rules and regulations relating to the Deficit Reduction Act had been adopted. Nevertheless, under the provisions of the act, implementation took effect July 1, 1984, and its impact will soon be felt by providers in Hawaii who serve Medicare and Medicaid covered patients.

State actions to date on contain Medicaid costs. As reported in our 1984 budget review and analysis of Medicaid and reiterated earlier in this chapter, DSSH has taken a number of steps to contain costs within the Medicaid program but has done this on a piecemeal, inconsistent, and uncoordinated basis. As a result, there has been no clear picture of what the cumulative effects of the various actions might be, how much more has to be done to meet federal requirements that are still somewhat uncertain, or what alternatives might be available with some evaluation of their relative advantages and disadvantages. Complicating this situation, of course, is the fact that the State is a major provider of services through county/state hospitals as well as the payer of last resort through Medicaid.

Lacking such an overall perspective upon which to guide its actions, the Legislature made its own decision on the matter. This took the form of a proviso (Section 18B) to the Supplemental Appropriation Act of 1984 (Act 285) which required DSSH to develop and implement not later than January 1, 1985, a prospective payment system for institutional providers of service under the Medicaid program. Payments under this PPS were to be based upon a reasonable cost method or other reasonable method as deemed appropriate by DSSH.

In response to this legislative directive, DSSH has retained a consultant to develop the revised method of reimbursement for institutional providers. With first priority given to the long-term care providers, DSSH expected to be able to implement PPS for those providers by January 1985 and for the acute care providers by April 1985.³

3. Although the rules to bring about implementation for long-term care providers have been signed by the Governor to go into effect in February 1985, a suit has been filed by a group of private providers to prevent such implementation. This suit will probably at least delay, if not permanently halt, the implementation of the recently approved rules. According to the latest word we have received, implementation of PPS for acute care providers is still scheduled for April 1985.

The revised reimbursement method for long-term care providers has just recently been completed and the rules to implement it were approved by the Governor in mid-January of 1985. The PPS for these providers is based on the facility specific approach—one where a separate prospective per diem rate is set for each facility based upon a comparison of previous cost experiences between that institution and other institutions in the same category, with the historical costs broken down into four components: (1) direct nursing, (2) general and administrative, (3) capital, and (4) ancillary. The institutions, in turn, are classified into five categories: (1) SNF hospital-based, (2) ICF hospital-based, (3) SNF freestanding, (4) ICF freestanding, and (5) ICF-MR. Component cost ceilings are calculated for each classification of institution. The allowable component rate for each institution is the lesser of the facility's historical cost or the component ceiling for that classification of institution. For institutions with more than one level of care, separate rates are set for each level of care. Special consideration in the form of higher allowed rates are accorded to neighbor island facilities for the first two years.

Based upon this methodology, component rate ceilings for each classification were calculated, and proposed payment levels and draft rules were disseminated to the affected providers, both private and those under DOH (including county/state hospitals) for their review and reaction. After it received feedback and made adjustments, DSSH finalized its rules and rates for each institution and revised its targeted date for implementation to February 1, 1985.

The response of the providers to the proposed payment system and rates has been strongly negative because of the anticipated adverse impact they were expected to have on institutional revenues. Complicating this whole picture is the fact that DSSH plans to incorporate the Deficit Reduction Act's modified dual rate system at the same time. Hence, the effects of both cost containment efforts will be felt by providers simultaneously. At the time of the writing of this report, a group of providers had filed suit against DSSH on January 18, 1985 in the U.S. District Court seeking an injunction to halt the implementation of the new payment system.⁴

4. *Hospital Association of Hawaii et al. v. Department of Social Services and Housing, State of Hawaii et al.*, Civil No. 85 0051, January 18, 1985.

Offsetting this negative impact on private providers and on DOH's budget, however, would be the positive impact on the Medicaid budget. The Medicaid budget for both the remaining six months of the current biennium and for the 1985-87 biennium is based upon the traditional reasonable cost basis for reimbursing providers. To the extent that the Deficit Reduction Act and the proposed PPS reduce the need to make outlays, the Medicaid budget may be said to be excessive.

From the perspective of the State's overall interest, all of these factors need to be examined together so that their net effect on the State can be determined. By this means, various alternatives can be considered and the optimum one can be identified and adopted.

Present situation. The trouble at the present time, however, is that apparently no one is looking at the overall impact of these cost containment efforts. The two principal agencies—DSSH and DOH—have both tended to approach the whole matter almost entirely within the narrow view of their individual perspectives. As a consequence, no one knows with any degree of assurance what the net effects of the Deficit Reduction Act's dual rate system and of the proposed PPS for Medicaid will be. Unknown, for example, are: (1) the extent to which county/state hospitals can actually achieve cost reductions or revenue increases from other sources so as to offset the projected reductions in Medicaid income, and (2) the extent to which the hospitals will be forced to seek additional subsidization from the state general fund. Unknown, too, is whether or not, or the extent to which, reduced rates may adversely affect existing private providers, may deter the development of additional facilities, and, overall, may affect the supply of long-term care institutional services relative to the need in the community. As already noted, a group of private providers feels strongly enough about the PPS adopted for long-term care providers that it has gone to court to halt its implementation.

As previously mentioned, the provision of services through alternative means of delivery (e.g., community based services) remains largely unexplored and therefore underdeveloped. Even the U.S. Department of Health and Human Services has not yet come out with its long awaited report on the impact of PPS on skilled nursing facilities.

The danger, then, is that precipitous and inadequately considered action may be taken that will cause problems that might be avoidable ahead of time, but not easily

solvable once they have been created. For example, if some of the present private providers should decide to withdraw from the business, the county/state hospitals might be forced to take on additional patients simply because they have no other place to go and despite the fact that such action would serve to push county/state hospitals into an even greater deficit position.

Recommendations. We recommend, first of all, that Hawaii not act precipitously to change its approach to funding Medicaid, but that it move cautiously to comply with federal requirements in this area. While proper emphasis should be given to cost containment, appropriate consideration should also be given to avoiding unnecessary disruptions and upheavals in the program and to maintaining services to recipients at the highest level possible. This requires a systematic approach to gathering information and weighing carefully the possible alternative courses of action.

Regarding the proposed prospective payment system (PPS) for long-term care and acute care institutional services, we recommend that prior to implementation, the Department of Social Services and Housing take steps to further assess the impact of its proposed changes by:

a. determining the overall net financial impact on the State that would occur as a result of the proposed PPS, considering the benefits or losses to the State's own institutional programs, and also the concurrent effects of expected federal reductions (e.g., Medicare's PPS for acute care and the Deficit Reduction Act for long-term care); and

b. comprehensively examining the broader implications of the proposed PPS on Hawaii's institutional providers generally, and on the overall delivery of long-term and acute care institutional services in the State, especially in view of expected federal reductions.

We also recommend that the Department of Social Services and Housing and the Department of Health give clearer recognition to their joint and intertwined interests in the whole area of health care (acute care as well as long-term care) and that they develop a more effective approach to cooperation and coordination of efforts in this field. Perhaps the best way to do this is to form a joint working group under the direct supervision of high level officials in the two departments.