Study of the Division of Community Hospitals

A Report to the Governor and the Legislature of the State of Hawai‘i

Report No. 92-6
January 1992

THE AUDITOR
STATE OF HAWAI‘I

Office of the Auditor

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

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

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

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

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

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

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

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

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

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

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

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

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OVERVIEW

THE AUDITOR
STATE OF HAWAII

Study of the Division of Community Hospitals

Summary

The State's community hospitals have been continously plagued with financial problems. These have become particularly serious in recent years. In 1991, the Legislature had to appropriate $15 million in immediate emergency funds to pay for the hospitals' operating deficits. The Legislature also appropriated an additional $309 million, including $56 million in general funds, to the community hospitals for the 1991-1993 fiscal biennium. By September 1991, however, the community hospitals were projecting another operating deficit of $19.2 million for fiscal year 1991-1992.

The community hospitals are administered by the Division of Community Hospitals, one of 14 divisions of the state Department of Health. It consists of a central office located in Honolulu and 13 medical facilities located primarily on the neighbor islands. Three islands, Maui, Lanai, and Hawaii, depend entirely on community hospitals for acute care.

Concerns about the division's collections of accounts receivable and the ability of the Community Hospitals Information Processing System (CHIPS) to provide administrators with adequate financial and operational information led to this request for the Auditor to conduct a management and financial study of the Division of Community Hospitals.

Despite expenditures of over $11 million, CHIPS is problem-ridden. We found that it is not generating the financial and operational information that division and hospital administrators need to manage the facilities in a businesslike way. We also found that the system was implemented without the appropriate staff to manage or operate it or an adequate budget to give it support.

We found that the source of the community hospitals' financial and operational problems goes much deeper. State laws and policies have resulted in unrealistic budgets, cash flow problems, recurrent deficits, and poor financial management. Delays in billings and collections fall below industry standards and have resulted in millions of dollars in lost revenues. In the year ended 1990, the hospitals had a combined accounts receivable balance of $56 million. State practices on paying vendors have resulted in delays that threaten hospital services. State policies on personnel also have hampered timely recruitment and hiring of appropriately trained personnel. A pilot project giving Maui Memorial and Hilo

hospitals greater autonomy and authority to make decisions has not resulted in significant operational changes or financial improvement.

We believe the community hospitals could be managed much more efficiently and effectively as business entities free of the policies governing state agencies. A new legal structure is needed—a public corporation—to effect these changes and improve management of Hawaii's community hospital system.

Recommendations and Response

We recommend that the Legislature establish a Community Hospitals Public Corporation attached to the Department of Health for administrative purposes only. The governing body of this corporation will be a board of directors consisting of eight members nominated by the counties and appointed by the governor with the advice and consent of the Senate. Also, the director of health will serve as a voting, ex-officio member of the board. The chief executive officer of the corporation be hired by the board to manage the hospital system. The corporation will have the authority to make personnel decisions, budget, set rates, procure materials and services, obtain short-term loans, and hold title to real property interests. The corporation will report annually to the Legislature on its financial viability and the quality and access to care it provides and be held accountable for its decisions..

We recommend the corporation be established by legislation in the 1992 Regular Session of the Legislature with preliminary implementation by a special master and transition team. The special master and transition team will plan for the transfer of functions from the Division of Community Hospitals to the community hospitals public corporation and will propose necessary amendments to the 1992 legislation at the 1993 Regular Session.

The Department of Health responded that it found our approach to be refreshing and constructive. The director of health says that the department has also made declarations about the incompatibility between state bureaucracy and hospital operations.

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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 92-6
January 1992

Foreword

Section 35, Act 296, the 1991 general appropriations act, requested the Auditor to conduct a management and financial study of the Division of Community Hospitals. The request said that the study should review budget planning, revenues, special fund expenditures, and accounts maintained by the division. It specifically asked the Auditor to suggest budgeting and financial record-keeping practices that would support the development and operation of a hospital authority.

We wish to acknowledge the technical assistance provided by the firm of Meaghan Jared Partners as well as the cooperation of the Department of Health—particularly the administrators and staff of the Division of Community Hospitals and Hilo, Kona, Maui Memorial, Kula, and Kauai Veterans Memorial hospitals—the Department of Personnel Services, the Department of Budget and Finance, and the Department of Accounting and General Services.

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Chapter 1
Introduction

This study was conducted in response to Section 35 of Act 296, the 1991 General Appropriations Act, which requests the Auditor to conduct a management and financial study of the Division of Community Hospitals. The budget proviso states that the study shall review budget planning, revenues, special fund expenditures, and accounts maintained by the division.

The proviso and others like it reflect the Legislature's continuing concern about the management of community hospitals. It specifically requests the Auditor to suggest budgeting and financial record-keeping practices that would support the development and operation of a hospital authority. Committee reports indicate that the Legislature is also concerned about the status and management of the Community Hospital Information Processing System (CHIPS).

Background

The Division of Community Hospitals is one of 14 divisions of the state Department of Health. It consists of a central office located in Honolulu and 13 medical facilities located primarily on the neighbor islands.

The central office oversees the activities of all facilities and maintains contact with state government agencies responsible for budgeting, accounting, purchasing, and personnel. The facilities consist of 12 hospitals and one medical center. Four of them offer long term care. The larger hospitals—Maui Memorial, Hilo, Kauai Veterans Memorial, and Kona hospitals provide acute care and more extensive services. Three islands—Maui, Lanai, and Hawaii—depend entirely on community hospitals for acute care.

State involvement began in the 1950s and 1960s with small annual subsidies to county hospitals. In 1967, Act 203 transferred several hospital management functions from the counties to the State, and hospital employees became part of the state civil service system. State takeover of hospitals was completed in 1969 when the state director of health was made the sole "governing authority" over all county/state hospitals.

To the extent possible, the community hospitals are expected to generate enough income through fees to pay their operating costs. But over the years, state support has been increasingly necessary. The

Legislature has tried different ways to control the hospitals' growing need for state funds.

After a 1971 audit of the County/State Hospital Program by the Auditor, the Legislature set up special funds for all the hospitals so that their fees could be clearly linked to operating costs. It expected fees to offset most, if not all, the costs of service. The special funds also were intended to provide the Legislature with information about how much revenue each hospital generated from fees.

In 1987, the Legislature again asked the Auditor to study the county/state hospital program. The study found many operational and financial problems. To correct some of the problems, in 1989 the Legislature reorganized the hospitals into a Division of Community Hospitals. It gave the division the flexibility to manage and operate the hospitals and the power to establish budget and management policies systemwide. The division's central office was required to monitor the performance of hospitals and to report annually to the Legislature on the financial status of each facility.

Despite increasing state support, serious fiscal problems persisted. During the 1991 Regular Session, the division requested $15 million in immediate emergency funds to pay for hospital operating costs. It attributed this deficit to high inflation rates in the industry, decreasing Medicaid and Medicare reimbursements, and the high cost of nursing care. During hearings, legislators questioned the division's policies for collecting accounts receivable and bad debts. They voiced concern about the ability of the information processing system to provide administrators with adequate information about a patient's ability to repay an outstanding hospital debt.

The Legislature appropriated $309 million in operating expenses for fiscal biennium 1991-1993, of which 18 percent or $56 million was in general funds. It approved 2,843 employee positions, together with 39 positions for the division's central office. Except for Maui Memorial and Hilo, all hospitals received general fund appropriations. Excess special funds for Maui Memorial and Hilo hospitals will be used to replace part of the general fund appropriations for the other community hospitals.

Objectives

The purpose of this study is to provide the Legislature with information about the current status and structure of the Division of Community Hospitals and to make recommendations on improvements. Our objectives were threefold:

1. Assess the administrative structure and the management policies and procedures of the Division of Community Hospitals—specifically in the areas of personnel, fiscal services and management, program planning, and budget planning.

2. Assess the division's policies and procedures in financial management, including policies to generate revenues, control costs, and reduce accounts receivable.

3. Explore similar multi-hospital systems and suggest cost efficient models that have improved management, accountability, and responsiveness to community needs.

Scope and Methodology

Focusing primarily on the years between 1988 and the present, the study examined how the division developed and implemented management and budget policies and procedures. We reviewed the extent to which policies and procedures helped hospital administrators manage their resources. We visited hospitals in the system and interviewed staff to determine whether division policies and procedures enabled hospitals to achieve objectives.

Our literature review encompassed several topics: the health care industry, multi-hospital systems, hospital management systems, and financial management practices. We contacted national health care associations, such as the American Hospital Association, and we interviewed local members of the hospital and health care industry, including officials of the Department of Health, administrators of the division and the community hospitals, and other key staff.

To gain a perspective on future activities, we reviewed state health plans and the plans of the division and individual hospitals. We also examined records and files of the division and some of its hospitals, as well as minutes of meetings, letters, internal newsletters, and other means of communication used within the division.

The firm of Meaghan Jared Partners contributed technical assistance. The firm examined the division's policies and procedures for containing costs, generating revenues, collecting accounts receivable, and planning budgets, and it evaluated these against industry standards. The firm compiled and analyzed financial data from the community hospitals.

A legal compliance assessment was part of this study because many laws governing the community hospitals were passed in response to our 1985 and 1988 reports. Because the statutes require the division

to develop monitoring procedures, we also assessed management controls.

The study was conducted between May and November 1991. We did not test the data provided by the division, but in all other respects, our work was carried out in accordance with generally accepted government auditing standards.

Chapter 2

Information Processing System

In 1986, the County/State Hospitals Division, now the Division of Community Hospitals, initiated the Community Hospitals Information Processing System, known as CHIPS. Intended to provide managers with timely and accurate information on hospital activities and finances, the system has instead proven to be costly, poorly managed, and deficient in producing the hoped-for results. The problems of implementation and the weaknesses inherent in the system today demonstrate what happens when an organization directs its efforts into complying with rules, when it fails to make fiscal responsibility a critical concern, and when it cannot hold its managers accountable for results.

In not living up to its purpose, CHIPS epitomizes, we believe, the difficulty of operating the community hospitals as part of state government.

Summary of Findings

1. The hospital division has implemented CHIPS without sufficient management oversight. The project lacked a guiding organization responsible for its progress and accountable for results. The system did not have appropriate staff to manage and operate it, or an adequate budget to give it support.

2. Though costly, the system does not give the division office or the hospitals the financial information they need to manage the facilities in a businesslike way.

Effective Automated Systems Are Essential

To survive in today's complex health care environment, hospitals must have up-to-date, accessible, accurate information about costs and revenues. Information about such matters as monthly profits and losses, accounts receivable, collections, and employee productivity is vital to guide the decisions of hospital administrators. Today, most hospitals rely on automated information systems to determine the resources they need. With these systems, managers can assess operations by comparing, for example, budgeted versus actual receipts and expenditures.

Our audit two decades ago found that the State's hospitals needed a better information system. Program administrators, we reported, did

not understand how to best use technology to support hospital management. Hospitals lacked control over patient accounting and other financial operations and had large accounts receivable balances.

In 1985, we repeated our concern for an improved statewide automated system. A year later, the division initiated CHIPS. But despite an investment of over $11 million through June 1990, the system is problem-ridden, and it is not generating the financial and operational information so necessary for management decision making.

Division Has Not Managed Its System

Deficits, large accounts receivable, and insufficient cash to pay bills are problems that typically beset the community hospitals. An automated information system to alleviate these problems should be a high priority to division and hospital administrators. However, the division has not paid sufficient attention to the system ostensibly established for this purpose. We found no formal organization to support this important effort, and no permanent qualified leaders or staff. Costs for its development and implementation, though substantial, were left unbudgeted.

No formal organization

The division has never created a formal organization to support the system. Without it, the project has proceeded on an ad hoc basis, headed at times by committees, at other times by individuals. Because responsibility has not been clearly assigned, no one is accountable for the project.

The director of a department, with the approval of the governor, may establish any division or administrative segment to achieve economy and efficiency in accordance with sound administrative principles. Such principles would include identifying functions and responsibilities, the number of persons needed to carry out those functions, their qualifications, and an organizational structure. The structure formalizes the chain of command so that implementation can proceed smoothly and accountability can be assigned.

Administrative directives 78-04 and 90-01 require department heads to submit organizational changes—whether additions, deletions, or adjustments—to the Department of Budget and Finance. Until the governor approves the organization, the Department of Personnel Services will not process positions for it. Several times between 1987 and 1989 the governor requested the division to submit organizational changes as required by the administrative directives. The division has not done so. As a result the project has had no permanent leadership and has been unable to hire permanent staff.

Changing leadership

There is no overall management or control of the project. Several people now give direction, clarification, and approval—the systems analyst at the Honolulu site, the deputy director for community hospitals, the staff coordinator, and any of several consultants contracted by the hospitals.

The system is not synchronized. Three data centers—at Honolulu, Wailuku, and Hilo—now operate, each with its own modifications. The supplier noted the problems as follows:

> Three facilities are expending tremendous amount of resource hours to produce the required statistics and logs. The various facilities cannot agree on common requirements to automate this process. Lack of central control and project management is a primary concern. No one is directing the overall project, setting clear project objectives and milestones to be achieved.[1]

During its short history, leadership of CHIPS has shifted from a steering committee to the hospital system executive officer, to another committee where leadership changed three times, to the deputy director, and to his staff coordinator. Consultants contracted by the division have also led the project at different times.

At the project's inception in 1986, the division office established a steering committee chaired by the division's executive officer to oversee the work. On the advice of the consultants, the committee awarded several software and hardware contracts.

In 1987, the division appointed its executive officer to be the project director and charged him with implementing the computerization project over the next three years. He assembled a temporary CHIPS team comprising division staff, hospital personnel loaned fulltime to the project, and consultants. The team was to assist the executive officer by developing policies, procedures, and standards; installing hardware and software; training users; and evaluating the system. Each hospital was to have a similar project team help with installation and report back to the CHIPS team. In 1989, when the hardware was installed, the CHIPS team was disbanded.

Shortly thereafter, in February 1989, the deputy director for hospitals reassigned the executive officer and appointed a new steering committee. The new committee, chaired by the Kula hospital administrator, was to prepare a long-term plan and budget, monitor implementation, and promote the system statewide. Members of the committee, including its chair, continued with their regular jobs since there were still no permanent positions authorized to staff the project.

Committee leadership underwent three changes within two years. Before leaving in 1990, the second chair noted the many basic but still unresolved questions, such as when CHIPS would be budgeted, who would oversee contracts, and how the project would be implemented. The committee has not met for the last nine months.

In the absence of permanent, qualified leadership, the division has relied on a consultant to help manage the project. Contracted services have included monitoring, quality assurance, training, and evaluation. In 1988, these services cost $165,000. In the next two years, the division amended the contract four times and expenditures have totaled more than $1.1 million. The current contract expands the consultant's scope of services to include assessing data processing requirements for long-term care and fee-for-service programs. The consultant staff has also turned over numerous times—since 1986, five different persons in the firm have been assigned to CHIPS.

To be properly managed, CHIPS needs a permanent chief information officer with clear authority to make decisions and be accountable for them. The officer would supervise analysts and operators at each site to make sure that standard procedures are applied. The officer also would have broader responsibilities, such as developing a tactical plan for system implementation, setting priorities for phasing it in, budgeting and monitoring the costs, establishing management controls, and establishing procedures for evaluating commercial software packages.

Inadequate staffing

Entering data, troubleshooting, maintaining the system, and supervising automated operations require technical skills that only qualified personnel can provide. CHIPS lacks permanent positions for technically skilled personnel, an appropriate salary schedule, and a career ladder to encourage recruitment and retention.

Although the 1991 Legislature authorized positions for CHIPS, the Department of Personnel Services could not establish permanent positions without an approved division reorganization plan. The authorized positions include ten computer operators for the Hilo and Wailuku data centers.

For five years, CHIPS has used emergency and temporary positions and also positions borrowed from the hospitals or the division office. The use of borrowed positions has resulted in salaries for data systems personnel that are not commensurate with the job. Some persons are paid too much, some too little. For example, a registered professional nurse III position which is salaried at $36,288 is being used to pay for

a systems analyst normally salaried at $29,000. Clerk typist positions salaried at $17,000 were used to hire computer operators who are normally paid around $22,500.

The division is aware that an automated system needs appropriately trained staff. The hospitals have alerted the division office to the problems resulting from not having permanent staff. The administrator at Maui Memorial Hospital has repeatedly requested positions for a systems analyst and computer operators. He has suggested deferring further installations at other hospitals until the problems at Maui Memorial and Hilo Hospital were corrected and permanent staff hired.

In 1989, the Maui administrator expressed concern about a possible "sick out" among the data processing staff because permanent positions with leave benefits had not been established. Kula Hospital reported that the recruiting process for data processing positions was slow. The administrator of Samuel Mahelona Memorial Hospital could not upgrade his account clerks to more appropriate levels when they assumed additional data processing responsibilities.

Without a defined career path in the data processing program, recruitment and retention of personnel have been difficult. After gaining experience, operators leave for better opportunities. High turnover results in inadequately trained personnel which slows down billings and collection operations and costs months of revenues. One source noted that consultants brought in to provide vital services result in additional costs. One hospital staff member called for inhouse expertise: "Contracting out is not realistic for an ongoing operation. It has not worked in the past, and it is too expensive."[2] As of August 1991, Maui Memorial and Hilo hospitals, the first two sites where CHIPS was installed, hired consultants to improve their billing operations and reduce their accounts receivable. These contract services are costing $645,248.

No budget

The division has expended several million dollars on CHIPS without a year-to-year budget showing an identifiable means of financing. Unlike private hospitals that have to watch their costs and manage their finances, the division has accommodated CHIPS expenses by getting the governor's approval to raise its spending ceiling. With the governor's approval, the division can use moneys in excess of its allocations from division and hospital special funds.

In 1987 when CHIPS was initiated, the division's fiscal services unit was responsible for electronic data processing. But the CHIPS project team did not use the fiscal services unit to develop appropriate

accounting procedures. It did not plan, for example, how to reimburse overtime and travel costs.

In early 1989, the division's fiscal services officer informed the chair of the new steering committee that CHIPS had no accounting plan and no budget. In late 1989, the deputy director charged the steering committee to develop a CHIPS budget. One year later, CHIPS funding still had not gone through a legislative appropriations process, and the committee acknowledged that there should be some planning in this area.

In March 1991, the division asked the Legislature for a projected $10.4 million in funding for CHIPS for 1991-93. The request categorized costs by personnel, operations, equipment, and consultant fees, but the division supplied little additional information about program costs, comparative data, revenue estimates, program size, program indicators of effectiveness, or the full cost implications such as five-year cost projections and the total number of positions.

Costs not tracked

There can be no doubt that CHIPS has been costly, but no one is tracking and reporting what those costs in fact are. Various figures have been given. Our conservative estimate, based on financial reports of the division's independent auditors, is $11 million from its inception through June 1990. The division paid for some of these costs through accumulated special funds; they assigned other costs to the community hospitals that use CHIPS, often without prior notice.

The division has yet to identify these costs and to establish a clear basis for allocating them. At a July 1990 steering committee meeting, the division's budget officer noted that CHIPS budget allocations were not clearly determined. The division did not know whether the allocated costs should be based on individual transactions or user processing time. In 1991, the division asked its independent financial auditors to determine year-end costs that should be allocated to hospitals.

Hospitals without budgets for CHIPS costs

Because they do not budget for them, hospitals are not financially prepared to assume allocated costs for CHIPS. In March 1990, Maui Memorial cautioned that it was ill-prepared to meet the unbudgeted expenses it was expected to bear. The administrator wrote the deputy director that the hospital was in a critical financial position due in part to unanticipated and unbudgeted expenses for CHIPS, Compulab, insurance, and others.[3] Maui's June 30, 1990, financial statement reported operating losses of $8.7 million.[4]

The administrator of Kauai Veterans' Memorial Hospital reported that its CHIPS costs for the fiscal biennium 1991-93 will be $627,000 and will be deducted from the hospital's special fund.[5] The June 30, 1990, financial statement reported operating losses of $3.5 million.[6]

CHIPS Falls Short of Its Mission

The mission of CHIPS was straightforward—to provide greater managerial control and operational efficiency of hospitals. The system was to attain this by generating standardized data so comparisons between planned and actual performance could be made. It was supposed to force some uniformity on selected hospital procedures, generate timely and accurate financial data, and integrate several financial and clinical information systems. Hospitals were supposed to benefit in the following ways:

- reduce the costs of operation;
- increase revenue opportunities;
- minimize lost charges;
- improve the capture of receivables at billing and collection points;
- improve the delivery of patient care;
- increase the satisfaction of physicians; and
- enhance the image of community hospitals.

After almost six years and expenditures in excess of $11 million, this mission and the desired benefits remain out of reach. CHIPS is marked by many shortcomings. The hardware and software are inadequate, and the system does not generate the information needed by managers.

Inadequate hardware and software

The System 38 hardware and software purchased for seven hospitals need to be upgraded. Expensive changes have had to be made to keep it functioning. The original purchase agreement between the division and the supplier said that no modifications were to be made to the software. But the three data centers have each made their own modifications, and the software must now be synchronized.

A larger capacity AS/400 system is needed to avoid a system failure, although debate continues as to whether the problems are due to poor management or to a system capacity that was not accurately estimated. Since June 1988, the Hilo system has failed three times. In May 1990, Hilo Hospital reported being at 90 percent of its capacity and in jeopardy of another system failure.[7] Such a failure would result in loss of historic data and possibly all records of accounts receivable. Weekly printouts to measure ongoing capacity—a standard practice in

data processing systems—have not been produced by the hospital for the past two years.

Lack of timely, useful financial information

CHIPS is not generating the information that hospitals need for managing, monitoring, and controlling operations. Due to technical deficiencies and poor staffing, the division and hospitals lack timely, useful, accurate information for managing their financial operations. Staff are handicapped when billing patients and when trying to capture as much revenue as possible.

The division receives CHIPS accounts receivable (a/r) printouts from hospitals once a month. The a/r printout tells administrators the total amounts due each month but does not report what has been collected and deposited each day. Since the a/r printout is done only monthly, it has limited value for administrators and cannot be used for daily cash management.

CHIPS has not functioned according to industry standards for management information systems. The general ledger system at Maui Memorial Hospital has been down since June 1991. Final billings cannot be processed because new diagnostic charges reimbursed by Medicare and Medicaid into "groupers" have not been entered in the system. The contractor cannot enter these new charges because past changes that had to be entered sequentially were never made.

A good information system should encompass various subsystems covering personnel, accounting, inventory, and other data. It should provide information managers need to run a hospital with profitability. Managers should have a complete view of the financial and operational status of the organization. Data such as costs, revenues, personnel utilization and scheduling, purchasing and inventories, construction, planning, and other institutional needs and activities should be readily accessible for budgeting and decision making.

Recommendations

1. The deputy director of the Division of Community Hospitals should appoint a permanent, qualified person to manage CHIPS, its personnel, program, and costs.

2. This manager should ensure that appropriate management controls and reporting procedures are in place to monitor CHIPS' financial status, expenditures, budget assessment and projections, and usefulness for managing the community hospitals.

Chapter 3
State Policies Constrain Hospital Management

Although the Division of Community Hospitals has implemented many legislative directives as well as a number of our own recommendations, these actions have had little impact on improving management of the community hospitals. The source of the problem goes much deeper. In this chapter, we examine how state policies inhibit practices that encourage fiscal responsibility.

Summary of Findings

1. State laws and policies on budgeting and expenditures create financial problems. For the community hospitals, they have resulted in unrealistic budgets, cash flow problems, deficits, and poor financial management.

2. State policies and practices on procuring and paying vendors are not suited to the community hospitals. They have resulted in delays that threaten hospital services.

3. Many state policies and practices on personnel are not appropriate for community hospitals. They hamper timely recruitment and hiring of appropriately trained personnel.

Autonomy May Be Necessary

Hospitals throughout the United States have suffered under pressures brought on by the increasing cost of labor, equipment, and insurance; by shortages of qualified personnel; and by reductions in Medicaid and Medicare reimbursements. These pressures contributed to the closure of 387 hospitals in the United States between 1980 and 1987.

To survive in this difficult environment, private hospitals operate like businesses. They set policy internally and they control their operating units. Administrators have the authority to allocate resources and coordinate activities. They continuously scrutinize their revenues and expenditures, monitor their operations, review the cost and benefits of the services they offer, recruit technically proficient staff, and pay them competitively.

Hawaii's community hospitals are faced with the same industry pressures. But as part of a state department, they have not responded effectively to them. Governed by state policies on budget planning,

cash management, purchasing, and personnel, the division spends much of its effort and attention on complying with requirements.

State policies create additional work for division and hospital administrators and deny them the authority to make final decisions about budgets, cash management, purchases, bill payments, organization, or personnel. Administrators must hurdle numerous levels of review and approval before their decisions can be implemented. Their inability to control the most basic financial and management functions adds to their operational and financial difficulties. More important, under the state system administrators cannot be held accountable for results.

State Policies Worsen Financial Problems

Community hospitals are caught in a cycle of financial problems for several reasons. They do not have budgets that realistically meet their need, and they do not generate the revenues that they should. They do not control the rates they charge; most do not control their own special funds. They generally do not know how much cash they have on hand and often find that they are unable to pay their bills.

Unrealistic budgets

The division and the community hospitals have little control over their budgets. Their budgets are prepared according to Chapter 37, HRS, and other policies developed by the Department of Budget and Finance (B&F). Most procedures on budget planning and financial management outlined in the division's *Budget and Finance Policies and Procedures Manual* merely reiterate policies of B&F.

Community hospital budgets must be approved by the division, the Department of Health, B&F, the governor, and finally, the Legislature. Hospital administrators have had difficulty in getting funding for essential needs since their budgets are frequently changed during the review process. Funds for repair and maintenance, medical equipment, and personnel are often cut. Because budgets are inadequate, administrators are faced constantly with cash flow problems and deficits.

Instead of focusing administrative attention on financial management, the methods of budget preparation and financial management focus attention on appropriation and allotment processes. In the private sector, budgeting is not a once-a-year process. Budget planning and revision continue throughout the year as new information about a facility's financial status becomes available. Budget analyses usually focus on making sure the facility has adequate income to pay its operating expenses.

As a rule, these hospitals generate and compare statements of revenues, expenses, and gains or losses on monthly and year-to-date bases. Throughout the fiscal year, they compare key statistical indicators such as patient days and discharges to budget expectations to determine if revenue and expenses are in line with estimations. They also examine balance sheets detailing a facility's total assets, liabilities, and fund balances at given times.

State budget planning processes are not set up along this model. Community hospitals must follow the same procedures as other state agencies. Hospital administrators also are advised to conservatively estimate their revenues and to recognize the risks of not achieving their projections. Evaluations of budget requests by the Department of Health and B&F are based on state plans and funding priorities, not on the needs of individual hospitals.

According to a B&F memorandum dated August 29, 1990, guidelines for developing base budget levels for each department have been centrally established by B&F.[1] The base budget is intended to be the foundation upon which all additional funds will be considered. Special and other non-general funded programs must conform to the budget requirements. B&F guidelines also require that department budgets conform to the functional plans approved by the governor. A subsequent B&F memo states that budgets submitted by departments may change depending on the level of funding available and the governor's priorities.[2]

These requirements are often not appropriate for the community hospitals. For example, B&F requires community hospitals to use the same percentage for inflation as that used by all state agencies. Since hospital inflation rates have been much higher than the rate allowed by B&F, the community hospitals fall behind. In 1991, B&F guidelines allowed the hospitals to add 5 percent to their appropriations from fiscal year 1990-1991[3] when the actual inflation rate for the hospital industry was 11 percent.[4]

Recurrent deficits

Caught between inadequate budgets and insufficient revenues, community hospitals frequently find themselves short of cash. Bills often go unpaid and deficits are carried over from quarter to quarter.

Between 1988 and 1991, community hospitals used up an entire year's general and special fund appropriations in the first three quarters of the year. Problems occurred in the fourth quarter when the community hospitals did not generate enough revenue to cover their operating costs. To cover these costs, they either received loans from the general fund or carried expenses over to the following year.

Part of the reason the hospitals needed $15 million in immediate emergency funds during the 1990-1991 fiscal year was to repay these general fund loans. The division did not have sufficient funds to repay the loans or to cover current operating expenses. It, therefore, requested $15 million in emergency appropriations—$14 million to repay the loans and $1 million to pay for operating costs.

Unrealistic rate-setting

Community hospitals do not control the rates they charge. The division and the Department of Health first approve all increases. Then public hearings must be held in accordance with Chapter 91 before the administrative rules setting the rates can be changed. Any rule changes must be approved by the department, B&F, and the governor.

The division has not set rates that allow the community hospitals to recover the full costs of providing care. Until 1991, the Department of Health urged the community hospitals to keep patient fees as low as possible. This policy led to an increasing gap between operating expenses and revenues and between rates charged by private hospitals and those charged by community hospitals. By 1990, the rates charged at the community hospitals were approximately 60 percent lower than rates for the same services at private facilities.

Until April 1991, the community hospitals charged patients a set rate per day regardless of the services they received. Patients who had surgical procedures or treatment for an illness were all charged the same amount. Hospitals set specific rates for other selected services, but generally the all-inclusive rate structure meant that hospitals did not establish rates based on the actual costs of care. Hospitals also did not clearly identify the costs of care to indigent patients.

Low rates and inattention to costs contributed to operating losses of approximately $23.9 million at the four largest acute facilities—Hilo, Maui Memorial, Kona, and Kauai Veterans Memorial hospitals—in FY1990-91.[5]

Recently in April 1991, the division raised rates by 40 percent at all facilities. This increase is expected to produce $4 million in additional income in FY1991-92 and $16 million in FY1992-93. In the meantime, the division estimates that the hospitals will have a total deficit of $19.2 million for FY1991-92.[6]

No knowledge of daily financial status

Community hospital administrators often do not know the financial status of their facilities, circumscribing their ability to control their financial activities.

The community hospitals each have a special fund into which they deposit patient fees and third-party reimbursements daily. But because the division continually shifts money among these funds, hospital administrators do not know the status of their funds at any given time.

In their weekly reports to the division, hospital administrators frequently beg for money to cover such essentials as payroll and supplies so that they can continue to deliver care. In one extreme case, an administrator noted: "This problem is getting ridiculous. We can't even purchase stamps so that we can send our bills out!"[7] Division officials, in turn, try to satisfy the needs of these facilities by shuffling funds from one special fund to another. The result, however, as chronicled in weekly reports, is a vicious circle of insufficient cash and resulting transfers.

Recently, the division changed its policies to allow Maui and Hilo administrators the authority to approve transfers out of their funds. But other hospitals have virtually no control over this practice.

Billings and collections below industry standards

Delays in billings and collections have resulted in millions of dollars in lost revenues. Insufficient staff and inadequate information processing systems are contributory causes. These deficiencies lead to the conclusion that hospitals lack the guidance and support to improve the way they bill clients and collect accounts receivable.

The community hospitals typically hold bills for *15 to 25* days before sending them to patients or third-party payers. The national average for processing and sending out bills is *13* days. Truly efficient hospitals produce billings within 3 to 5 days. Billings from the community hospitals frequently take longer than 15 to 25 days because of such tasks as coding charges for diagnosis and treatment and getting authorizations (called attestations) from physicians. In one instance, the Lanai Community Hospital administrator advised the division office that his facility had approximately $81,000 in billings that were delayed because the facility's physician had not completed his attestation forms.[8]

The community hospitals also are not analyzing their accounts receivable on a regular and timely basis. Using one measure, we found that the community hospitals are taking almost twice the national average to complete the bill generation and payment cycle.

Most hospitals categorize accounts receivable in ways that help them determine the steps needed to complete the billing process. These categories might include (1) *in-house* receivables for patients who have not yet been discharged; (2) *discharged, but not finally billed* receivables for patients who have left the facility, but whose bills or insurance claims have not been sent; and (3) *billed* receivables sent to patients or third-party payers. In addition, hospitals typically segregate their receivables by age, types of payers, and a measure called days-revenue-outstanding, or DRO. The DRO is a measure of the average length of time it takes a facility to generate, process, and receive payment for a bill. It is a useful measure because it is easily compared with industry standards and can be monitored to identify trends.

The national average for completing the bill generation and payment cycle is 76.6 days. Using this measure, we found that in FY1990-91, the community hospitals took 177 days to complete the same cycle, nearly double the national average. The additional days mean that revenues will be lost.

The community hospitals now have a combined accounts receivable balance of $56 million (See Appendix A).[9] If the facilities had collected their receivables within the 77-day industry standard, we estimate that they could have collected $31 million and their total accounts receivable would have been reduced from $56 million to $25 million.

Some accounts are so old there is little likelihood of collecting them. (Generally, the longer an account remains unpaid, the less the likelihood it will be collected.) In 1990, over $26 million in accounts receivables were over 121 days old. The hospitals had allowances for uncollectable accounts of over $30 million. Of this $30 million, Hilo Hospital's allowance was over $12 million and Maui Memorial Hospital's allowance was over $10 million. In both cases, the allowance for uncollectibles constituted over 62 percent of the total accounts receivable.

However, we estimate that about 10 to 20 percent of the excess receivables are collectible. If the hospitals capture the collectible portions of the excess accounts receivable, they could realize a one-time cash infusion of between $3.2 and $6.4 million.

Procurement and Vendor Payment Policies Are Counterproductive

State purchasing policies are not helpful to hospitals. Delays in vendor payments have created critical problems that threaten services.

Unsuitable purchasing policies and procedures

State purchasing policies of the Department of Accounting and General Services (DAGS) add to hospital costs and limit savings that hospitals could realize. Hospitals cannot purchase or replace diagnostic or therapeutic equipment costing $8,000 or more without first advertising for sealed bids. Since the cost of most medical equipment exceeds this limit, purchases are usually delayed.

Hospitals generally must buy items from state-approved bid lists that are intended to save state agencies money through volume discounts. But items on the bid lists are often not appropriate or sufficient for the hospitals' unique supply needs. According to the administrator at Kauai Veterans Memorial Hospital, for example, the facility did not need the expensive $3,000 modems approved for purchase on the state bid list. The facility could have purchased another model more cheaply on its own.

Moreover, community hospitals do not always get the benefit of volume discounts. The Purchasing Advisory Committee established by the division has had little impact in expediting purchases and payments. The division does not require centralized purchasing, so hospitals lose volume discounts for specific purchases.

State policies are designed to act as controlling mechanisms, but they force the division to focus on paperwork. Officials spend much of their time making sure the hospitals conform to state policies, leaving them little time to develop alternate means of procurement.

Delays in vendor payments

Unlike most private and not-for-profit hospitals, the state community hospitals do not pay their vendors directly. Community hospitals must submit copies of their bills and vouchers to the division, which in turn sends them to DAGS. The agency processes these through the state Financial Accounting Management Information System (FAMIS) before making payment. The process can take more than four weeks (from the time the voucher is submitted to the time payment is confirmed). Slow payments have resulted in deteriorating relations with vendors.

Several incidents illustrate poor relationships with vendors, the limited range of options available to the hospitals, and the significant amount of staff time taken up by what were minor payment problems.

In two examples, surgical units were threatened with closure. In the first incident, Maui Memorial Hospital was nearly forced to shut its surgical unit because a vendor threatened to cancel a delivery of a $220 shipment of benedyne, a sterilizing agent used prior to surgery, unless the facility paid cash upon delivery. The problem stemmed from another outstanding bill Maui Memorial Hospital had with the vendor for $6,000. The Maui Memorial administrator contacted the division office for possible solutions to the dilemma. The deputy director, medical director, division chief budget officer, division staff coordinator, and the hospital administrator conferred to review options.

Physicians at Maui Memorial immediately rejected as too risky the group's suggestion of using an alternative sterilizing agent. An option of paying from petty cash was discarded because the $220 bill exceeded the hospital's $100 petty cash limit. A third option of hand-carrying the voucher through DAGS also failed to resolve the problem since a minimum of four days would be required to process the bill, and Maui Memorial had only four days' supply of the substance left. The administrators finally decided that Maui Memorial should borrow enough benedyne from Hilo Hospital to cover the emergency until the voucher could be hand-carried through DAGS and funds could be released to pay the vendor.

A similar situation occurred when a $46 bill for blood reagents threatened to close the surgical unit at Kauai Veterans Memorial Hospital. Lanai Community Hospital also has reported frequent credit holds and vendor supply problems because of inadequate funds to pay overdue bills. Division and hospital administrators frequently have to negotiate with vendors to keep their facilities supplied with items critical to providing care.

Personnel Procedures Hamper Hiring Efforts

State personnel policies have contributed to difficulties community hospitals have had in getting skilled technical personnel. Delays in filling positions have contributed to higher costs and reduced revenues.

As state agencies, the community hospitals must comply with civil service laws and collective bargaining agreements and must follow a series of requirements to obtain new positions. Needed positions must (1) be authorized by the Legislature, (2) fit into an organization plan reviewed by B&F and approved by the governor, (3) be classified by the Department of Personnel Services (DPS), and (4) follow the department's compensation plans and recruitment and hiring procedures.

To a great extent, the division's personnel unit acts as an extension of other state agencies, particularly DPS. The division makes sure the hospitals comply with various state policies governing the hiring and compensation of personnel. Much of the division's time is spent processing reorganization requests to comply with the governor's administrative directive 90-01.

We estimate that it can take up to two years or more for a hospital to fill a position. The process starts when the hospital decides that a position is needed and requests one in its budget. This request is forwarded first to the division and then the Department of Health for their assessment of the need for the position and the availability of funds for it. The request is then submitted to B&F for its review and for inclusion in the executive budget. Finally, the Legislature must approve it.

From the time the request is initiated to the time it is approved by the Legislature, about nine months will have passed. If an appropriated position falls within an approved position classification, the division can begin to recruit. A new position, however, may require a reorganization or the creation of a new position classification. In these instances, additional approvals and processing must be received from B&F and the DPS. These can delay filling of positions for up to two years.

Delays from policies on reorganization

Because of state policies on reorganization, hospitals have lost income and have been forced to reduce services. Since 1989, the division has been given 481 authorized positions. Over 140 of these were temporary positions that are now being converted to permanent status. All of these positions are pending classification, but 60 of them will require division or hospital reorganizations that first must be reviewed by B&F and approved by the governor. DPS must then classify positions before they can be filled.

The reorganization process has delayed the hiring of a medical director at Kauai Veterans Memorial Hospital for a year and a half. The medical director is responsible for monitoring the facility's compliance with Medicare policies. Without a director, the facility has been unable to offer certain kinds of long-term care or to maximize Medicare reimbursements.

Kona Hospital has also had problems because of delays in the reorganization and position approval process. Kona Hospital has sought to add a business manager position to its business office to help improve billing and collection procedures. But because this

position creates an additional supervisory layer, a reorganization must first be reviewed by B&F and approved by the governor before the facility can fill the position.

Unfilled critical positions

Community hospitals have had difficulty hiring trained billing clerks and technical specialists like respiratory therapists, occupational therapists, and X-ray technicians. Weekly reports from the community hospitals note chronic shortages of radiologists, ward clerks, paramedic assistants, social workers, and registered nurses. Positions for office personnel critical to generating and collecting billings have remained vacant for long periods of time. Hospitals also have not filled positions for food service workers and janitors—positions required by national and state hospital standards.

The division has not actively recruited physicians and other medical personnel for hospitals needing them. At Kauai Veterans Memorial Hospital, for example, the obstetrics unit has remained closed for 18 months, at an estimated loss of $500,000 in annual revenues, because there is no obstetrician in the community.

In some other states, the hospital system strongly supports hospitals located in remote areas. For example, North Carolina aggressively seeks physicians willing to practice in remote areas and supplements their income, if necessary, to ensure they will practice for given lengths of time.

Some hospital systems create pools of workers in hard-to-fill specialty areas and share these workers among facilities. The pooling of employees minimizes costs for facilities in remote areas by centralizing services such as data processing and medical coding, and by providing on-site services by groups of "circuit-riding" workers.

Inadequate state classifications

Some positions remain vacant because state position classifications are either not established or not appropriate. Compensation rates are frequently not competitive with those in private industry. As part of state government, the community hospitals are required to hire people in existing position classifications and pay them within designated salary ranges.

The state classification system does not yet include certain needed hospital positions. For example, it has no position classification for pharmacy technologists, although this position is recognized and defined by the American Hospital Association. Division personnel officers have been working with DPS to create such a classification so that individuals with appropriate training and capabilities can be hired

and compensated at market rates. So far, the classification process for this position has not been completed.

Below-market compensation hinders hiring to fill existing positions. To keep adequate levels of professional nurses, hospitals spend unduly large sums of money contracting with private agencies who provide part-time and "fill-in" nursing services. These agencies pay salaries far higher than those paid by the State. Unable to compete at market rates, hospitals are unable to hire nurses and other professionals on a permanent full-time basis.

State-employed staff nurses are paid an average of $17 an hour; private agency nurses receive as much as $31 an hour. State compensation policies also limit pay rates for nurses, requiring new nurses to start at entry level pay grades regardless of experience. Agency nurses hired as part-time workers receive overtime when they work more than 20 hours per week, as most do. In FY1990-91, Maui Memorial reported paying $1.9 million for contract nursing, laboratory, and radiology services.[10] The Maui Memorial Hospital attributed $1 million of these costs to contract nursing services.

Inappropriately classified business office personnel

The business offices at the community hospitals are not staffed with enough appropriately trained personnel. They lack persons with backgrounds in financial management and analysis, persons familiar with practices specific to the hospital industry. Instead of patient account personnel typically used within the industry, offices are staffed by positions classified as "accountants."

There are important differences between patient accounts personnel and accountants. The position of state accountant is described as supervising the maintenance and control of accounting records and state fund reports. They collect, compile, and evaluate fiscal data and verify that the use of funds is in accordance with state requirements. In contrast, patient account managers review and implement financial planning and management control. The focus of this position is on increasing cash receipts, ensuring timely completion of billings, and reducing accounts receivable.

DPS has approved a position classification for a hospital billing and collection supervisor with responsibilities similar to those usually ascribed to patient account managers. However, no such positions have yet been filled.

Hospitals also suffer from vacant positions in their collection units. Only Maui Memorial has a chief financial officer on staff. Hilo

Hospital has approval to hire a chief financial officer, but the position is still vacant after two years. Kona Hospital is in the process of receiving approval to recruit a business manager.

Concluding Remarks

State policies and procedures for budgeting, managing cash, purchasing supplies and paying vendors, and recruiting and hiring personnel are all intended to manage the spending of taxpayer dollars. Designed for the control of state funds and resources and not for the efficiency of management, they are ill-suited to the operations of hospitals.

Hospitals must operate as business entities if they are to survive. They must be able to set their own policies, control their rates, and allocate resources as befits their unique circumstances. They must have the capability to analyze their revenues and expenditures, review the cost benefits of their services, recruit the staff they need, and pay them competitively.

Instead of running hospitals as businesses that together generated more than $115 million in revenues in FY1990-91, Hawaii's Division of Community Hospitals has spent the bulk of its time and effort on processing the paperwork required by state policies and procedures.

Community hospitals, we believe, could be managed much more efficiently and effectively as business entities free of the policies governing other state agencies. In the next chapter, we discuss alternatives for the community hospitals and propose some long-term recommendations for improving the system.

Chapter 4

Proposal For a Hospitals Public Corporation

The continuing problems of the community hospitals point to an urgent need to change the method of administering them. Many hospitals across the country are able to provide quality care and maintain fiscal stability despite rising costs and diminishing funds. In this chapter, we describe two health care facilities that have survived these challenges and which could serve as models for the community hospitals. We also discuss alternate strategies for rural hospitals. We then propose another form of governance for the community hospitals.

Examples of Viable Hospitals

Effective health care organizations employ hospital administrators who have the power to make timely, businesslike decisions in the best interests of their facility and who can be held accountable for quality of care and health of finances. These persons have the authority to plan and expend their budgets and to monitor and evaluate their fiscal needs. They are responsible for ensuring that funding is adequate. Hospital administrators work with their boards of directors or system headquarters to set rates at levels that allow the hospital to recover the full costs of providing care.

Because many of these facilities also offer care to indigent patients as a primary part of their mission, reductions in Medicaid and Medicare reimbursements have had a significant impact on their rates of uncompensated care. Unlike Hawaii's community hospitals, these successful facilities have developed alternative sources of funding or have sought creative ways to reduce the costs of care without limiting the quality and extent of services. Flexible management and effective planning have allowed some facilities to explore innovative ways to increase revenues and control costs.

The two systems we describe here have provided care to all people, regardless of their ability to pay, and have achieved fiscal solvency using approaches that the community hospitals might find useful. We also profile several strategies by some other states to maintain care for rural and geographically isolated areas.

Sisters of Providence

The Sisters of Providence system provides universal health care through 23 hospitals and managed health care plans in four northwestern states—Alaska, Washington, Oregon, and California. In 1990, the integrated health care system operated 3,704

licensed acute care beds and 883 long-term care beds, with 14,624 full-time employees. Gross revenues for the system in 1990 were more than $1 billion, of which $52.2 million was for indigent care.[1] The system provided nonbilled services to approximately 136,500 people in 1990.[2]

Three separate corporations—serving Alaska and Washington, Oregon, and California—comprise the Sisters of Providence health care system. Each hospital within the system is an independently run, nonprofit entity. Income in excess of expenses is reinvested in the facility and its programs.

The health care system owns all facilities and provides central management, including finances, operations, legal advice, public relations, planning and development, group purchases, mission direction, and monitoring. Central headquarters also oversees the John Gabriel Ryan Corporation, a taxable, not-for-profit entity for joint ventures.

Sisters of Providence hospitals have been able to meet their mission of universal care by supplementing their income with foundation support and with fees for their educational programs. The system has obtained grants from the Robert Wood Johnson Foundation and the Pew Charitable Trust. System purchasing and shared services also reduce costs, as does the use of medical students who can provide some kinds of care. (The Sisters of Providence hospitals serve as teaching hospitals in many communities.)

St. Francis Health Care System

Another example is the St. Francis Health Care System, located in Hawaii. The St. Francis Health Care System originally began as one hospital in Liliha. The hospital was owned and run by the Sisters of St. Francis of Syracuse, New York, which run the St. Francis and St. Joseph high schools in Hawaii and other hospitals and schools in New York.

St. Francis Medical Center recently expanded into a health care system which includes four separate entities: St. Francis Medical Center, St. Francis—West, St. Francis Health Care Enterprises, and St. Francis Health Care Foundation. Like the Sisters of Providence and the community hospitals, the St. Francis Health Care System serves patients regardless of their ability to pay. Like the Sisters of Providence system, the St. Francis hospitals function as independent, nonprofit entities.

The Liliha hospital and the Health Care System Foundation provide St. Francis-West with some ancillary services. St. Francis-West does

not pay for all of these services, but the donated hours are invoiced so that administrators can determine the actual costs of providing care at the new facility.

The St. Francis Health Care Foundation was created to centralize some functions. One of the foundation's primary responsibilities will be to raise funds for capital improvements and to supplement services for indigent health care. It will also provide cost savings by centralizing administrative services, grant writing, and grant monitoring. In 1990, approximately 33 percent of the medical center's expenses involved charity care, uncollected bills, and unreimbursed Medicaid and Medicare costs.

The St. Francis Health Care Enterprises will raise funds partially by providing for-profit services such as laundry and data processing.

Strategies for rural hospitals

Many rural communities are too small to support the staffing and service needs of a fully accredited licensed hospital. Rising costs have forced hospitals in these communities to either reduce their services or close altogether.

In an effort to cut services but still qualify for funding from the federal Health Care Financing Agency, many opt to provide only emergency treatment, stabilization care, and basic surgery. These "alternative rural health care facilities"—also termed medical assistance facilities, essential access community hospitals, and rural primary care hospitals—can give basic care at a much lower cost than full-fledged hospitals. They focus on first stabilizing patients and then transporting them to hospitals that offer secondary or tertiary care. Most provide this care at all hours, though some offer services only during certain hours. These facilities can be staffed by a physician's assistant or nurse practitioner and still retain accreditation. Radiology and laboratory personnel are usually trained in other specialties as well, thereby maximizing the facility's diagnostic capability without increasing personnel costs.

Some communities, however, fear losing hospitals that provide a full spectrum of services. Some of these communities are so isolated that patients cannot be transported easily to metropolitan hospitals. Rather than drastically cut services, some independent hospitals have instead banded together in consortia. These loosely affiliated groups seek to reduce costs among member hospitals by sharing services, personnel, and even purchases. Consortia offer small hospitals the benefits of a larger system without the loss of administrative or operational control.

The Health Service Consortium based in Seattle, Washington, provides continuing education to professional and technical staffs at geographically isolated hospitals. It also sponsors circuit-riding specialists to provide infrequently needed diagnostic and therapeutic services. Participating facilities share the costs and benefits of the specialists and their services. A central office, funded through fees assessed of participating hospitals, schedules and coordinates visits. This consortium also provides centralized billings, data processing, and medical coding for its participating facilities on request.

Case for a Hospitals Public Corporation

A pilot project giving Maui Memorial and Hilo hospitals greater autonomy and authority to make decisions has not resulted in significant changes in operation. We believe a new legal structure is needed—a public corporation—to improve the management of Hawaii's community hospital system.

Public corporations, which include entities such as authorities, are created to serve the public good. They are distinguished from private corporations created for purposes other than those of government. Public corporations are instruments of the state. They are owned by the state and its citizens and supported, in whole or part, by public funds.

The Council of State Governments, in a study of public authorities, characterized them as follows:

> Public Authorities generally are corporate bodies authorized by legislative action to function outside of the regular structure of state government in order to finance and construct and usually to operate revenue-producing public enterprises. . . . Public authorities are authorized to issue their own revenue bonds, which ordinarily do not constitute debt within the meaning of constitutional debt limitations, since they are required to meet their obligations from their own resources. They lack the power to levy taxes, but are empowered to collect fees or other charges for use of their facilities, devoting the resulting revenue to payments of operational expenses and to interest and principal on their debts.[3]

The intent in establishing a hospitals public corporation is to retain hospitals as part of state government, but to give them sufficient autonomy to operate as ongoing businesses. The corporation would have three kinds of autonomy: legal, administrative, and fiscal. Legal autonomy would give it separate corporate status in law. Administrative autonomy would give it freedom from such state controls as civil service and pay scales, budgeting and audit controls,

and procurement regulations. Fiscal autonomy means that it would support itself from revenues derived from sources other than taxes.[4]

Establishment of a Community Hospitals Public Corporation

This study proposes that the Legislature establish a community hospitals public corporation attached to the Department of Health for administrative purposes only.

The governing body of this corporation will be a board of directors consisting of nine voting members and one ex officio, nonvoting member. To ensure county representation, each of the four counties will be represented by two members. The director of health will be an ex officio, voting member to provide for overall health care coordination in the State. The chief executive officer of the corporation will be an ex officio, nonvoting member.

Each county will nominate two people for each of its members on the board through its county advisory committee. The governor will make the appointments with the advice and consent of the Senate. Each county board member will serve a four-year term; except that, for the purpose of staggering terms and creating county continuity on the board, one of the initial members will serve a two-year term and the other member will serve a four-year term. Thereafter, each newly appointed member will serve a four-year term.

The chairperson and vice chairperson of the board will be elected by the majority of the board. The members will serve without compensation, but will be allowed their actual and necessary expenses incurred in the performance of their duties.

The board will appoint the chief executive officer of the corporation who will be responsible for implementing the decisions and policies of the board. The board will supervise and periodically evaluate the performance of the chief executive officer.

The corporation, through the chief executive officer, will hire both civil service and civil service exempt employees as needed. The chief executive officer will hire an administrator for each hospital with the advice of the county advisory committee. The administrators will be supervised by the chief executive officer.

Each county will have an advisory committee of nine members to advise administrators of the facilities in the county. The advisory committees may engage in public education and fund raising. The advisory committee will nominate members who will be appointed by the chief executive officer. Members will serve a four-year term,

except for the initial members who will serve staggered terms. The members will serve without compensation, but will be allowed their actual and necessary expenses incurred in the performance of their duties.

Additionally, each hospital administrator may organize voluntary committees to advise the administrator on matters of particular concern to the administrator's hospital and the community it serves.

To give the corporation sufficient flexibility and powers to manage the hospitals, the corporation will have the authority to make personnel decisions; to budget; to set rates and charges for services; to procure materials and supplies; to obtain short-term loans; to establish rules, procedures, and policies; to hold title to real property or interests in real property sufficient to decide on the uses and dispositions of the property; to seek, accept, and use gifts or grants of money or property; to engage in private business activities for the purpose of increasing income; to make decisions regarding capital improvements; and to issue revenue bonds.

The corporation will report annually to the Legislature on its financial viability and the quality of care and access to such care it provides.

Preliminary implementation

The Hawaii Community Hospitals Public Corporation should be established by legislation at the 1992 Regular Session of the Legislature, with the provision for it to go into effect on July 1, 1993. (The Division of Community Hospitals statutes would be repealed on July 1, 1993.) Legislation for establishing such a corporation is included in Appendix B.

The 1992 legislation will provide that the governor appoint a special master who will hire technical staff and head a transition team. The special master and transition team will study and plan for the transfer of functions from the Division of Community Hospitals, Department of Health, to the Hawaii Community Hospitals Public Corporation, and propose appropriate and necessary amendments to the 1992 legislation at the 1993 Regular Session so that the corporation can be fully functional on July 1, 1993. An appropriation for FY1992-93 will be necessary to fund the work of the special master and transition team.

The governor will appoint the members of the transition team, which will include representatives from the departments of Accounting and General Services, Attorney General, Budget and Finance, Health, Labor and Industrial Relations, Land and Natural Resources, and Personnel Services, the Office of State Planning, the State Health

Planning and Development Agency, and county hospital management advisory committees. Additionally, the governor will request that representatives of collective bargaining units whose members are affected by the transition serve as appointed members of the transition team.

As the leader of the transition team who will hire technical staff, coordinate the activities of the team, and set the direction and pace of the work, the special master must bring to this project superior experience, training, education, skills, and leadership. This will be a critical planning and implementation stage of the public corporation.

The special master will be expected to be a reputable executive with extensive background in the administration of financially sound, private hospital systems. Familiarity with the administration of public corporations would be a valuable asset. The special master would be expected to bring unquestionable integrity and objectivity to the task, an expectation reinforced with a provision in the bill prohibiting the special master from being appointed as chief executive officer of the corporation.

Amendments to the 1992 legislation (creating the hospitals public corporation), as proposed by the special master and transition team, should be enacted at the 1993 Regular Session of the Legislature and become effective upon approval by the governor. On July 1, 1993, the Hawaii Community Hospitals Public Corporation should begin its existence as a fully functioning governing entity of the community hospitals, sufficiently planned and empowered to successfully carry out the purposes for which it was created.

Matters to be addressed

In planning the transition, the special master and transition team must consider among other matters (1) requirements of personnel, civil service, and collective bargaining; (2) transfer of real property; (3) bond financing; (4) transfer of personal property; (5) revenues, subsidies, and other sources of funding; (6) malpractice and other tort liability; (7) allocation of debts and other contractual agreements of the Division of Community Hospitals; (8) contractual agreements between the corporation and other state agencies, other governmental agencies, or private entities; (9) taxation; and (10) any other matters relevant to the establishment of the public corporation.

Personnel, civil service, and collective bargaining requirements

A workable, effective, personnel plan for the corporation is of particular importance. As of October 1991, the records of the Department of Health show 2,958 civil service positions in the

Division of Community Hospitals. The vacancy rate runs from 20 to 25 percent of the positions. Therefore, there are approximately 2,218 to 2,366 employees filling these positions.

Planning for the personnel to carry out the functions of the public corporation will be a complex task because of the numerous civil service employees who are either subject to collective bargaining or are affected by collective bargaining. The special master and transition team will have to negotiate the future status of these employees with collective bargaining representatives and affected state departments.

In recent years, transfers of personnel have been made from established state agencies to newly created state agencies. When the Housing Finance and Development Corporation, Office of State Planning, and Department of Public Safety were created, civil service employees were transferred without loss of their civil service status and employee benefits and privileges.

The corporation will need flexibility for specialized personnel but retaining as civil service employees those who currently serve in generalized state positions, such as clerical and janitorial employees, should not hinder operations of the public corporation. To meet the specialized personnel and technical needs of hospitals, however, exemption from civil service must be provided. It may be necessary also to exempt these positions from collective bargaining. Discord may arise should there be a difference in pay for similar work between civil service exempt and civil service employees in the same bargaining unit.

Current specialized or technical employees of the division may be given the options of (1) accepting a civil service- and collective bargaining-exempt position with the corporation (made very attractive in terms of compensation and benefits), or (2) transferring to another civil service position within the State.

Alternatively, the transition team may explore the creation of a personnel merit system particularly tailored to the needs of the hospitals.

Transfer of real property

A title search of the lands and physical facilities of the community hospitals must be done to determine which properties currently fall under the jurisdiction of the Department of Health and which properties do not, but should, fall under its jurisdiction. A title search of the real properties of the county hospitals which were to be

conveyed to the State in accordance with Section 27-21.4, Hawaii Revised Statutes, should be conducted to determine the extent to which there has been compliance with the statute.

When an inventory is completed, the special master and transition team must determine which properties have to be placed under the jurisdiction of the hospitals public corporation. The special master and transition team should work to resolve any title discrepancies or any other asserted interests in the properties which may hamper the successful functioning of the corporation.

The special master and transition team should also recommend to the Legislature how the properties should be brought under the jurisdiction of the public corporation. Options include (1) obtaining an executive order from the governor setting aside the lands and improvements to the public corporation, or (2) having the corporation hold title to the lands and improvements in its corporate capacity.

Bond financing

The special master and transition team should study the feasibility of issuing revenue bonds for capital improvements. If this is not feasible, they should propose an alternate plan regarding the financing of capital improvements.

Transfer of personal property

An inventory of the personal property of the Division of Community Hospitals must be obtained in order to determine how much should be transferred to the corporation.

Revenues, subsidies, and other sources of funding

The special master and transition team should prepare a plan to maximize financial self-sufficiency for the hospitals public corporation. All possible ways of obtaining income, including the establishment of nonprofit or for-profit organizations by the public corporation, should be considered.

Malpractice and other tort liability

How best to protect the hospitals public corporation, its employees, and the State from malpractice and other tort liability is another task.

Allocation of debts and other contractual agreements

A determination must be made of the debts and other contractual obligations of the division so that the public corporation can begin

functioning with a "clean slate." A plan must be devised to resolve any existing debts or other obligations of the hospitals.

New contractual agreements

It may be more efficient or cost effective for the hospitals public corporation to use or purchase services from other state agencies, governmental agencies, or private entities. The corporation may also want to provide services for a fee to such entities for additional income. The special master and transition team should explore these possibilities in planning for the transition of functions and, if necessary, make recommendations to the Legislature for appropriate amendments to the 1992 legislation.

Taxation

The special master and transition team should address any taxation issue which might arise in the course of their planning and formulate recommendations to the Legislature.

Concluding Remarks

The creation of the hospitals public corporation by the Legislature in 1992 will commit the State to a new form of governance for the community hospitals. The purpose is to create a form of governance more appropriately tailored to the needs of the hospitals and the communities which they serve.

The creation of the hospitals public corporation will not break unproven ground in the administration of state government. Several public corporations are already in existence: the Hawaii Housing Authority, the Research Corporation of the University of Hawaii, and the Aloha Tower Development Corporation, to name a few.

The time now appears ripe to establish this new organization. Any delay will merely allow the problems of the community hospitals to continue.

Recommendations

1. The Legislature should establish the Hawaii Community Hospitals Public Corporation to operate the community hospitals as proposed in the legislation in Appendix B of this report.

2. The Legislature should enact interim measures to improve hospital management before the corporation becomes effective in July 1993 by exempting the Division of Community Hospitals from state

laws and requirements on budgeting, procurement and vendor payments, and personnel.

3. The Division of Community Hospitals should immediately improve overall management of accounts receivable at each of the community hospitals and report its progress to the 1993 Legislature.

4. The Division of Community Hospitals should improve its financial management system so that it can identify the cost of services, including the cost of indigent care. The division should report to the 1993 Legislature how much general fund support is needed for indigent care.

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Notes

Chapter 2

1. Letter to Jerry Walker, Deputy Director of Health, from Anan Khaldi, Area Manager, Spectrum Healthcare Solutions, March 2, 1990.

2. Minutes of the Division of Community Hospitals Credit and Collections Policy Committee Meeting, August 12, 1991.

3. Letter to Jerry Walker, Deputy Director of Health, from A.B. Carr, Jr., Maui Memorial Hospital Administrator, March 27, 1990.

4. Financial Audit, Maui Memorial Hospital, Years Ended June 30, 1990 and 1989, p. 5.

5. Biennium Budget Request to Jerry Walker, Deputy Director of Health, from Keith Horinouchi, Kauai Veterans Memorial Hospital Administrator, February 4, 1991.

6. Financial Audit, Kauai Veterans Memorial Hospital, Years Ended June 30, 1990 and 1989, p. 6.

7. Memorandum to Jerry Walker, Deputy Director of Health, from Fred Horwitz, Hilo Hospital Administrator, May 7, 1990.

Chapter 3

1. Memorandum from Yukio Takemoto, Director of Finance, to all department heads, August 29, 1990.

2. Memorandum from Yukio Takemoto, Director of Finance, to John C. Lewin, Director of Health, November 30, 1990.

3. Memorandum from the Department of Budget and Finance, "General Operating Budget Guidelines for FB1991-93 and Out Years, attachment to November 30, 1990 memorandum.

4. Biennium Budget Testimony, Department of Health, FB1991-93, for HTH 295 Community Hospitals Administration.

5. Financial Audit of Hilo, Maui Memorial, Kona, and Kauai Veterans Memorial hospitals, Years Ended June 30, 1990 and 1989.

6. Division of Community Hospitals, spreadsheet of projected revenues and expenditures for FY1991-92.

7. Kauai Veterans Memorial Hospital Weekly Report, August 18, 1991.

8. Lanai Community Hospital Weekly Report, August 18, 1991.

9. Meaghan Jared Partners, Inc., "An Analysis of the Financial Operations of Division of Community Hospitals Facilities," October 15, 1991, Exhibit I, p. 6.

10. Memorandum from John C. Lewin, Director of Health, to Governor John Waihee, May 14, 1991.

Chapter 4

1. Sisters of Providence 1991 Fact Sheet, p. 3.

2. Sisters of Providence 1990 Annual Report, p. 30.

3. Council of State Governments, *State Public Authorities*, Lexington, Kentucky, July 1970, p. 2.

4. Eugene McQuillan, *The Law of Municipal Corporations*, 3d ed., rev., vol. 1, Callaghan and Co., Wilmette, Illinois, 1987, sect. 2.29a, p. 198.

State of Hawaii
Division of Community Hospitals
Selected Hospital Data, Fiscal Year Ended June 30, 1990

	Hilo	Honoka'a	Kohala	Kona	Ka'u	Le'ahi	Maluhia	Kula	Maui Mem/ Hana	Lana'i	Kaua'i Veterans	Samuel Mahelona	Total
Patient Revenue	$36,871,978	$ 2,541,661	$ 1,261,535	$11,715,193	$ 1,034,138	$ 9,972,699	$ 5,956,548	$ 5,826,506	$ 31,965,200	$ 707,422	$ 3,565,454	$ 4,424,839	$115,843,173
Adjustments (Deductions)	(7,784,675)	(1,115,382)	(149,185)	(1,688,362)	(219,552)	(1,443,626)	(35,272)	(2,072,072)	(6,195,781)	(89,902)	23,206	(262,524)	(21,033,127)
Net Patient Revenue	29,087,303	1,426,279	1,112,350	10,026,831	814,586	8,529,073	5,921,276	3,754,434	25,769,419	617,520	3,588,660	4,162,315	94,810,046
Other Operating Revenue	655,396	23,443	7,987	142,990	22,212	89,321	304,566	44,923	1,545,868	6,723	60,429	103,028	3,006,886
Total Operating Revenue	29,742,699	1,449,722	1,120,337	10,169,821	836,798	8,618,394	6,225,842	3,799,357	27,315,287	624,243	3,649,089	4,265,343	97,816,932
Total Operating Expenses	(36,893,429)	(2,742,242)	(1,912,940)	(14,709,110)	(1,707,236)	(11,317,852)	(7,211,372)	(6,424,561)	(36,080,003)	(1,295,271)	(7,170,566)	(5,967,004)	(133,431,586)
Total Non-Operating Revenue (Expenses)	(1,089,205)	530,764	496,569	3,273,677	636,095	1,658,361	265,833	790,374	350,644	441,443	2,194,631	817,919	10,367,105
Excess of Expenses over Revenues	$ (8,239,935)	$ (761,756)	$ (296,034)	$ (1,265,612)	$ (234,343)	$ (1,041,097)	$ (719,697)	$ (1,834,830)	$ (8,414,072)	$ (229,585)	$ (1,326,846)	$ (883,742)	$ (25,247,549)
Aging of Accounts Receivables													
Not yet billed	$ 3,832,269	$ NR	$ NR	$ 1,505,564	$ 65,518	$ NR	$ 882,385	$ 472,901	$ 2,945,338	$ NR	$ 156,125	$ NR	$ 9,860,100
0-30 days	3,131,191	CMB	CMB	1,390,273	147,535	670,669	CMB	CMB	CMB	64,128	203,647	NR	5,607,443
31-60 days	1,455,021	452,046*	191,655*	536,738	16,275	717,912	538,788	1,418,384	4,576,176	67,501	152,804	NR	10,123,300
61-90 days	656,550	149,653	17,741	296,863	16,932	CMB	3,600	227,912	997,912	12,332	32,041	NR	2,411,536
91-120 days	464,101	80,578	9,688	297,644	CMB	CMB	9,284	7,539	1,261,692	8,196	95,842	NR	2,234,584
over 121 days	10,184,067	908,830	233,557	2,865,103	231,971	1,467,031	935,788	1,292,830	6,860,283	462,691	561,563	NR	26,003,714
Total Accounts Receivable	19,723,199	1,591,107	452,641	6,892,205	478,231	2,855,612	2,369,845	3,419,566	16,641,401	614,848	1,202,022	968,832	56,240,677
Less Allowance for Uncollectables	(12,290,000)	(837,000)	(189,364)	(2,661,995)	(212,000)	(109,058)	(747,000)	(2,326,845)	(10,407,000)	(385,600)	(46,000)	(89,000)	(30,300,862)
Net Accounts Receivable	$ 7,433,199	$ 754,107	$ 263,277	$ 4,230,210	$ 266,231	$ 2,746,554	$ 1,622,845	$ 1,092,721	$ 6,234,401	$ 229,248	$ 1,156,022	$ 879,832	$ 25,993,815

Source: Individual Audited Financial Statements, as of June 30, 1990.

Legend: NR - Not Reported in Financial Statements
CMB - Combined with Data in Subsequent Aging Catagory
*Includes Medicare/Medicaid Receivables

APPENDIX A

PROPOSED LEGISLATION

RELATING TO HOSPITALS

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"Chapter

HAWAII COMMUNITY HOSPITALS PUBLIC CORPORATION

Section -1. Purpose and intent. The legislature finds and declares that the creation of a Hawaii community hospitals public corporation to govern those public health facilities currently administered by the division of community hospitals of the department of health, pursuant to chapter 323, is necessary to increase efficiency, cost-effectiveness, and quality in the delivery of acute and long-term care services in the State's public hospitals. The purpose of this Act is to establish the Hawaii community hospitals public corporation to provide quality health care to the general public, with a particular commitment to the indigent population.

It is the legislature's intent to create a public, but autonomous, form of governance for these health care facilities that will promote financial self-sufficiency, while upholding the State's commitment to serve the indigent population. It is also the intent of this legislature to authorize the public corporation to grant operational autonomy to each facility to the greatest extent possible within the structure of the public corporation.

Section -2. Definitions. The following terms, whenever used or referred to in this chapter, shall have the following meanings, unless the context clearly requires a different meaning:

"Administrator" means the administrator of a public health facility.

"Board" means the board of directors of the Hawaii community hospitals public corporation.

"Corporation" means the Hawaii community hospitals public corporation created by this chapter.

"Public health facility" means any of the following health care facilities and all other health care facilities that may hereafter be placed within the jurisdiction of the corporation:

(1) Hana Medical Center, Hana, Maui;

(2) Hilo Hospital, Hilo, Hawaii;

(3) Honokaa Hospital, Honokaa, Hawaii;

(4) Kau Hospital, Pahala, Hawaii;

(5) Kauai Veterans Memorial Hospital, Waimea, Hawaii;

(6) Kohala Hospital, Kohala, Hawaii;

(7) Kona Hospital, Kealakekua, Hawaii;

(8) Kula Hospital, Keokea, Maui;

(9) Lanai Community Hospital, Lanai City, Lanai;

(10) Leahi Hospital, Honolulu, Oahu;

(11) Maluhia Hospital, Honolulu, Oahu;

(12) Maui Memorial Hospital, Wailuku, Maui; and

(13) Samuel Mahelona Memorial Hospital, Kapaa, Kauai.

Section -3. Hawaii community hospitals public corporation; establishment; board; staff. (a) There is established the Hawaii community hospitals public corporation, which shall be a public body corporate and politic and an instrumentality of the State, for the purposes of operating, managing, maintaining, and controlling public health facilities and providing health care services to the public, including the indigent, at and through the public health facilities. The corporation shall be placed within the department of health for administrative purposes only.

(b) The governing body of the corporation shall consist of a board of directors having nine voting members, and one ex officio nonvoting member who shall be the chief executive officer of the corporation. Two voting members shall be
residents and representatives of the city and county of Honolulu, and each of the counties of Hawaii, Kauai, and Maui shall have two residents representing their respective county as voting members of the board. Additionally, the director of health shall be an ex officio voting member.

The members representing the counties shall be appointed by the governor in the manner provided in section 26-34 and serve four-year terms, except that the initial members shall serve terms determined by having each county represented by one member serving a two-year term and the other member serving a four-year term. Thereafter, each newly appointed member shall serve a four-year term. For each of its representative members, each county shall nominate two people through its county advisory committee.

The chairperson and vice chairperson of the board shall be elected by the majority of the board.

The members of the board shall serve without compensation, but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

(c) The board shall appoint a chief executive officer for the corporation. The chief executive officer shall be directly supervised by the board. Each of the public health facilities shall have one administrator who shall be hired by the chief executive officer with the advice of the county advisory committee serving the public health facility, and who shall be compensated in accordance with the extent and nature of the responsibilities required of the administrator. Each administrator shall be directly supervised by the chief executive officer.

Section -4. County advisory committees. (a) There is established within the corporation an advisory committee for each county consisting of nine members appointed by the chief executive

officer. The members shall serve for a term of four years; provided that upon the initial appointment of members, two members shall serve a one-year term, two members shall serve a two-year term, two members shall serve a three-year term, and three members shall serve a four-year term. Thereafter, each newly appointed member shall serve a four-year term. Except for the initial appointments, the chief executive officer shall make all appointments from nominations submitted by the county advisory committee to which the appointments are to be made.

Each committee shall select its own chairperson and vice chairperson and may adopt such rules as it may consider necessary for the conduct of its business.

The members of the committees shall serve without compensation, but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

(b) Each committee shall sit in an advisory capacity to the administrators of the public health facilities located within its county on matters concerning policy, strategic plans, budgeting, procurement, personnel, setting of rates or charges for services, medical quality assurance, hospital accreditation, construction, improvements, maintenance, and any other matter of concern to the public health facilities. The committees may also participate in public education and fund-raising activities. Nothing in this section shall be construed as precluding or preventing the committees from coordinating their efforts and activities between committees.

Section -5. Facility committees. Each administrator may organize facility committees to advise the administrator on matters of particular concern to the administrator's public health facility or the community it serves. The administrator shall determine the composition of the committees and solicit and select persons to serve, and may also direct employees of the public health facility to serve in their official capacities.

Section -6. Powers; generally. (a) The corporation shall have all the powers necessary to carry out its purposes, including the following powers:

(1) To operate, manage, maintain, and control the system of public health facilities;

(2) To sue and be sued;

(3) To have a seal and alter the same at pleasure;

(4) To hold title and other legal interests in real, personal, or mixed property;

(5) To make and execute contracts, leases, and other instruments necessary or convenient for the exercise of its powers or functions under this chapter;

(6) To make and alter bylaws for its organization and internal management;

(7) To adopt rules under chapter 91 necessary to effectuate this chapter;

(8) To establish corporate budgets, policies, and procedures;

(9) To execute short-term loan agreements;

(10) To set and collect all rates or charges for the services provided at or through the public health facilities as determined by the board to be necessary to carry out the purposes of this chapter, and to delegate this authority to the individual administrators of the public health facilities at the board's discretion;

(11) To procure all necessary supplies, equipment, and services;

(12) To construct, repair, and maintain all premises necessary for the operations of the public health facilities;

(13) Through the chief executive officer, to employ administrators and create and fill administrative, technical, or specialized positions, or other positions determined to be necessary by the chief executive officer, without reference to chapters 76 and 77, and to set salaries for the chief executive officer and such described employees without reference to chapters 76 and 77; and to employ persons subject to chapters 76 and 77;

(14) To contract for or receive or accept gifts or grants of any kind from any public agency or any other source, and to use, manage, or invest any gift of money or property, whether real, personal, or mixed, in carrying out the purposes of this chapter;

(15) To issue bonds of the corporation for the purpose of providing funds for any of its corporate purposes; and

(16) To enter into business relationships, including but not limited to creating nonprofit corporations; establishing, subscribing to, and owning stock in for-profit corporations individually or jointly with others; and entering into partnerships and other joint venture relationships.

(b) In addition to any other powers conferred upon the corporation, the corporation may do all things necessary and convenient to carry out the powers expressly given in this chapter.

Section -7. Annual report. The corporation shall report annually to the legislature, twenty days prior to the convening of the session, on the status of its finances, operations, quality of care, care to the indigent, and other significant matters."

SECTION 2. The governor shall appoint a special master who shall hire technical staff, without reference to chapters 76 and 77, Hawaii Revised Statutes, and who shall head a transition team which shall be appointed by the governor from, but not limited to, the departments of accounting and general services, attorney general, budget and finance, health, labor and industrial relations, land and natural resources, and personnel services; and the office of state planning, state health planning and development agency, and county public health facility management advisory committees. In addition, the governor shall make requests to the exclusive representatives of appropriate collective bargaining units for nominations for appointment by the governor to the transition team as collective bargaining representatives. The special master and transition team shall plan the orderly transition of authority and functions from the division of community hospitals, department of health, to the Hawaii community hospitals public corporation, and shall submit proposed amendments to section 1 of this Act to the legislature for the 1993 Regular Session for the purpose of implementing an appropriate and effective system of operating, managing, funding, constructing and maintaining, and controlling the public health facilities and their services under the public corporation governance structure.

The subjects to be addressed by the special master and transition team shall include but not be limited to the following: (1) personnel, civil service, and collective bargaining requirements;

(2) transfer of real property; (3) bond financing; (4) transfer of personal property; (5) revenues, subsidies, and other sources of funding; (6) malpractice and other tort liability; (7) allocation of division of community hospitals' debts and other contractual agreements; (8) contractual agreements between the public corporation and other state agencies, other governmental agencies, or private entities; and (9) taxation. The special master and transition team shall be available to meet with individuals and entities who wish to convey their comments and concerns to the special master and transition team.

The special master shall not be nominated for or appointed to the position of chief executive officer of the public corporation.

SECTION 3. Effective July 1, 1993, part V, chapter 323, Hawaii Revised Statutes, is repealed.

SECTION 4. There is appropriated out of the general revenues of the State of Hawaii the sum of $_____, or so much thereof as may be necessary for fiscal year 1992-1993, to carry out the purposes of section 2 of this Act. The sum appropriated shall be expended by the office of the governor.

SECTION 5. This Act shall take effect upon its approval; provided that section 1 of this Act shall take effect on July 1, 1993.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this study to the Department of Health on January 14, 1992. A copy of the transmittal letter to the director of health is included as Attachment 1. The director's response is included as Attachment 2.

The Department of Health responded that it found our approach refreshing and constructive. It said that many of our findings echo similar declarations by the department about the incompatibility between state bureaucracy and hospital operations. The department suggested some technical changes which we have incorporated in our report.

We are pleased that the department believes the report to be constructive and we look forward to its support in carrying out the improvements needed.

ATTACHMENT 1

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

(808) 548-2450
FAX: (808) 548-2693

New numbers as of 12-01-91
(808) 587-0800
FAX: (808) 587-0830

January 14, 1992

C O P Y

The Honorable John C. Lewin, M.D.
Director of Health
Department of Health
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Lewin:

Enclosed are three copies, numbered 6 through 8, of our draft report, *Study of the Division of Community Hospitals.* We ask that you telephone us by Thursday, January 16, 1992, on whether you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Friday, January 24, 1992.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

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

Sincerely,

Marion M. Higa

Marion M. Higa
Acting Auditor

Enclosures

JOHN WAIHEE
GOVERNOR OF HAWAII

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

JERRY WALKER
DEPUTY DIRECTOR FOR HOSPITALS

January 23, 1991

In reply, please refer to:
File: C/S Hosp. _____

RECEIVED
JAN 27 10 39 AM '92
OFC. OF THE AUDITOR
STATE OF HAWAII

Ms. Marion M. Higa
Acting Auditor
Office of the Legislative Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813

Dear Ms. Higa:

Thank you for the opportunity to respond to your draft report entitled, "Study of the Division of Community Hospitals." As you requested, we have controlled access to this report and have not released the contents.

In general, we find your approach refreshing and constructive. In large measure, your findings echo declarations previously made by the Department of Health, such as the incompatibility betweem State bureaucracy and hospital operations.

Please find attached a list of corrections and clarifications related to content. In addition, you will note the inclusion of a number of initial responses to your recommendations. We hope that this input will contribute positively to your final report.

Sincerely,

John C. Lewin, M.D.
Director of Health

Attachments

STATE DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HOSPITALS

RESPONSE
to the
STUDY OF THE DIVISION OF COMMUNITY HOSPITALS

JANUARY 23, 1992

CHAPTER ONE -- INTRODUCTION

Corrections and Clarifications

PAGE 1

* The Department of Health is actually made up of fourteen (14) divisions and not six "major" administrations.

* Actually, three (3) islands depend entirely on community hospitals for acute care. These are: Maui, Hawaii, and Lanai.

CHAPTER TWO -- INFORMATION PROCESSING SYSTEM

Response to Recommendations

The Division of Community Hospitals concurs with the recommendation to establish a permanent, qualified person to manage CHIPS, its personnel,program, and costs. A position to perform these functions was identified in the biennium budget request for FY 91-93, was approved by the Legislature, and was included in the reorganization concept approved by Budget and Finance. The Division is continuing to process this reorganization as a top priority.

Further, the Division concurs with the recommendation that the CHIPS manager establish appropriate management controls and reporting procedures to monitor CHIPS' financial status, expenditures, budget assessment and projections, and usefulness for managing the community hospitals.

Corrections and Clarifications

PAGE 6

* Administrative Directive 90-1 actually replaced Administrative Directive 74-04.

* While the report states that "Several times between 1987 and 1989 the governor requested the division to submit organizational changes as require by the administrative directives. The Division has not done so." A reorganization proposal was submitted to the governor in January 1989, but the reorganization proposal was returned pending a response from the Department of Health to the Director of Finance regarding certain funding concerns. As of the close of 1991, the Director of Finance had been notified by the Director of Heal of his desire to organizationally establish a data processing section at the

Division of Community Hospitals (Administrative level), Maui Memorial Hospital, and Hilo Hospital. The Director of Finance has authorized the Director of Health to proceed with the preparation of the reorganization for the Division, and it is expected that authorization to proceed with the reorganizations for the two hospitals will be received in the near future.

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* The issue of system synchronization is of particular interest to the software vendor for the CHIPS system, but it has relatively little impact to the Division. The question is really whether the three data centers should run exactly the same software (the vendor calls this "synchronization") or whether instead, modifications should be allowed to meet local needs.

* The division is currently planning to upgrade the software at all three data centers, one site at a time, over approximately 2.5 years. During that time, the system will not be synchronized, because certain sites will still have the old software while others have the upgraded software. Since the sites run independently, the Division does not foresee any negative impact to operations in running different software at the various sites.

* A quote from Anan Khaldi of Spectrum actually refers to reports that are required by Medicare that the CHIPS system currently does not prepare them properly. The problems are not related to synchronization of the system. Spectrum was suggesting that the Division contract with their firm to modify the CHIPS system to correct the problem with statistics and logs. The Division estimated that the total cost of such a contract would be in excess of $100,000. The Division decided that fixing the problem at that time was not worth the expense, because any modifications to the system would have to be reimplemented when the software upgrade was made.

PAGE 8

* Contrary to report claims that the CHIPS Committee had not met for the last nine months, the CHIPS Steering Committee met on December 13, 1991, and again on January 15, 1992. Minutes of those meetings are available upon request.

* During 1990 and 1991, Data House, Inc. performed several tasks under contract to the Division. These included support in preparing the biennium budget and preparation of the five-year DIPIRM date processing plan to State of Hawaii standards, in addition to the long-term care and fee-for-service tasks cited.

* The DIPIRM data processing plan was a major effort, requiring five months, involving all twelve facilities and the Division Office. It was not limited to CHIPS, but covered all data processing activities planned for the Division. The project resulted in a 400 page document that was approved by the Department of Budget and Finance, and that will guide data processing in the Division for years to come.

* These contracts were all evaluation, planning, or analysis of future needs related. They did not include any provision for Data House to operate or modify the current CHIPS system.

* The legislature authorized a total of 21 positions: one systems manager, four senior data processing systems analysts, six computer operators at Oahu, five computer operators at Maui, and five computer operators at Hilo.

PAGE 9

* The Division supports the request of the Maui Memorial Hospital administrator for additional data processing positions. These positions were included in the biennium data processing budget request for FY 91-93, along with similar positions for Hilo Hospital and for the Oahu data center.

* It is currently planned that Division resources will be devoted to upgrading the CHIPS hardware and software during calendar 1992. As a consequence, resources will probably not be available to add additional hospitals onto CHIPS for the next 12 months. Further installations at other hospitals will therefore be deferred as suggested until the permanent staff is in place.

* The report claims that high turnover of computer operators results in billing and collection delays that cause significant revenue loss. In fact, this is not the case. The computer operators perform largely routine tasks that ordinarily have no effect on billing or collection operations.

* The $645,248. cited appears to be the total of two contracts, one to Data House to improve accounts receivable at Maui, and one to Deloitte and Touche to improve accounts receivable at Hilo. These contracts included analysis of existing policies and procedures, including data processing procedures, and providing supplemental staff to the billing office to process bills. Neither contract included operating or modifying the CHIPS system.

* In 1987, it was the Hospital System Executive Officer, and not the Division's fiscal services unit, which was responsible for electronic data processing.

* While Chapter 2 cites Kula Hospital as reporting the recruiting of data processing positions as "slow", Kula Hospital has not been authorized any data processing positions and has never recruited for any such positions.

PAGE 10

* CHIPS costs are determined annually at each the end of each fiscal year for financial and cost reporting purposes. Ernst & Young, our cost report consultants, have assisted us in determining an accrual allocation to CHIPS users since these allocated costs will be recognized in audited financial statements to meet State of Hawaii reporting and Medicare/Medicaid reporting purposes.

* For FAMIS, the State's modified cash accounting system, a cost center code was created several years ago for use in accumulating CHIPS costs within the State of Hawaii accounting system.

* The report indicates that CHIPS funding had not gone through a legislative appropriations process in the year following late 1989. Perhaps there is some confusion concerning the dates since 1990 was not a budgeting year under the biennium budget process.

* The Division did contract with Data House to prepare a detailed CHIPS budget for FY 91-93. The Data House report was completed November 5, 1990, and was used as detailed backup to the biennium budget request in the 1991 legislative session.

PAGE 11

* The budget request for data processing includes $345,000. for FY 91-92 and $282,000. for FY 92-93 for Kauai Veterans' Memorial Hospital, for a total of $627,000. for the biennium, not for FY 92-93 as cited in the report. This budget requested included all data processing costs, not just CHIPS.

* The mission cited, "to provide greater managerial control and operational efficiency of hospitals", is only part of what CHIPS was intended to do. CHIPS, today, maintains the admitting, transfer, and discharge records, the general ledger, the accounts receivables, and produces bills for seven hospitals and captures all critical statistics. At the four large acute care hospitals, CHIPS also provides order communications between the nursing stations and ancillary departments as well as staff scheduling. These functions are better characterized as direct automation of hospital operations than as support to hospital management.

* Although the Division would agree that CHIPS has not delivered fully on its expectations, we believe that the benefits cited have been achieved in part, and that the mission and desired benefits are not "out of reach" as the report indicates. CHIPS has improved the efficiency of admitting clerks, nurses, billing clerks, and accounting staff, by putting much of the data that they use most often in automated form. It has improved billing operations, by providing an automated record of charges, and by making data instantly accessible to billing and collections staff. It has also improved the delivery of patient care and the image of the community hospitals, by providing patients with a thorough and professional record of charges on their bill, and by allowing hospital staff electronic access to patient records. All of these items are significant improvements to the prior manual process.

* The Division concurs that the CHIPS hardware and software need to be upgraded. However, as previously discussed, the Division feels that synchronizing the software would not be a wise investment at this time.

* The report indicates that a failure at Hilo "...would result in loss of historic data and possibly all records of accounts receivable." A failure of this magnitude is possible, but because backup tapes are made regularly, the system could be restored with at most a few days' loss of data.

* Hilo Hospital has installed new disk drives and has purged the system of unused historical data since May 1990, and disk utilization is now 70%.

* The relative value of weekly printouts is exaggerated in the report, and does not relate to the adequacy of the CHIPS hardware and software.

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* The Division concurs that more data processing functions are needed than those currently provided by CHIPS. One of the objectives of the planned AS/400 upgrade is to provide capacity for additional functions. Patient care plans, electronic billing, enhanced processing of the "groupers" cited in the third paragraph, purchasing, inventory control, pharmacy, dietary, radiology, and personnel systems are all included in the Division's FY 91-96 DIPIRM data processing plan.

CHAPTER THREE -- STATE POLICIES CONSTRAIN HOSPITAL MANAGEMENT

Corrections and Clarifications

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* The State's accounts receivable write-off process requires the exhaustion of collection efforts, two consecutive years of delinquency, and formal approval from the Attorney General's Office before an account can be written off. Therefore, the net account receivable, not gross accounts receivable, should be used for any analysis or comparison with private hospitals.

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* The sole reason for poor vendor relations has been the lack of adequate cash flow.

* The Division's Purchasing Committee has in fact achieved a long-list of price reductions and volume discounts contrary to what is suggested in the report.

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* Contrary to the report, only after the creation and establishment of a position can the Division begin to recruit.

CHAPTER 4 -- PROPOSAL FOR A HOSPITALS PUBLIC CORPORATION

* The community hospitals of Maui and Hawaii have participated extensively with medical staffs, community groups, the State Health Planning and Development Agency, and various legislative members during the last year in preparing island-specific legislation which will be introduced by those communities .

* The Department of Health continues to participate in the planning and preparation for transition to more independent and financially successful community hospitals.