



Tulare Local Healthcare District

Past Poor Decisions Contributed to the Closure of the Medical Center, and Licensing Issues May Delay Its Reopening

Report 2018-102





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October 9, 2018

2018-102

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the Tulare Local Healthcare District (district) and its oversight of the Tulare Regional Medical Center (medical center) and Healthcare Conglomerate Associates (HCCA). This report concludes that poor decisions by the district's previous board of directors (previous board) contributed to the closure of the medical center, and that licensing issues may delay its reopening.

In September 2017, after nearly four years of medical center management by HCCA, the district filed for bankruptcy and in October 2017 voted to suspend the medical center's license, and the medical center closed. The previous board did not act in the best interest of the district and the community it serves when it selected HCCA to manage the medical center in 2013. The documentation shows that the previous board selected HCCA against the advice of the consulting firm it had engaged to assist in the selection process and evidence that HCCA might not be the most qualified. The same board also negotiated contract terms with HCCA that were expensive and unfavorable, including a monthly management fee of \$225,000 or \$2.7 million a year, and provisions to become the exclusive employer of the medical center personnel, which required the district to lease the employees at a cost of 130 percent of their salaries and wages. This provision resulted in HCCA earning an additional \$2.5 million in fiscal year 2015–16. Operating revenue fell under HCCA management, caused in part by the previous board's removal of the medical center's medical executive committee—the body that governs the medical staff—and the subsequent reduction in the number of physicians choosing not to renew their privileges or resigning from the medical center, and an accompanying reduction in patient service revenue. The district's cash position also decreased under HCCA as it failed to pay vendors that provided billing services and to collect on services billed.

The district plans to reopen the medical center in mid-October 2018. Its new board of directors contracted with an interim management consultant in November 2017 to work toward the reopening. Additionally, in September 2018, the district signed a management services agreement with a new affiliate partner to manage the medical center. Although the district has made progress toward reopening the medical center, it faces licensing issues that make it unclear whether the medical center will reopen in mid-October as planned. Finally, the district could have been more effective in its oversight of its use of \$85 million in bond proceeds for its expansion of the medical center.

Respectfully submitted,



ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CMS	Centers for Medicare and Medicaid Services
EHR	electronic health record
HCCA	Healthcare Conglomerate Associates
MEC	medical executive committee
OSHPD	Office of Statewide Health Planning and Development
PRIME program	Public Hospital Redesign and Incentives in Medi-Cal program

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Summary

Results in Brief

After the September 2017 bankruptcy filing by the Tulare Local Healthcare District (district) and the district's subsequent decision to suspend its medical center license, the Tulare Regional Medical Center (medical center) closed its doors, having served as one of the region's acute care hospitals for more than 60 years. The October 2017 closure followed a nearly four-year period during which the district had contracted the medical center's operational management to an affiliate partner, Healthcare Conglomerate Associates (HCCA). Among the factors contributing to the medical center's closure were the high cost of HCCA's services and a decline in patient volume and resulting drop in patient revenue, caused at least in part by a decision by the district's previous board of directors (previous board) to replace the committee overseeing the medical center's medical staff.

Moreover, available documentation does not demonstrate that the previous board acted in the best interest of the district and the community it serves when it selected HCCA in 2013 to manage the medical center. According to existing documentation, the board unanimously voted to choose HCCA despite the advice of the consulting firm it had engaged to assist in the selection process and evidence that HCCA might not be the most qualified management partner. Furthermore, HCCA's management contract contained some terms that created obstacles to the medical center's future success, including provisions that limited the board's ability to adequately monitor the operations and finances of the medical center. Other expensive and unfavorable contract provisions included HCCA's monthly management services fee of \$225,000—or \$2.7 million a year—and a provision under which HCCA became the exclusive employer of the medical center personnel, an arrangement that required the district to lease employees from HCCA at a cost of 130 percent of their salaries and wages. This contract term resulted in HCCA earning an additional \$2.5 million in compensation in fiscal year 2015–16.

In addition to these unfavorable contract provisions, the medical center experienced a decline in operating revenue under HCCA. Although the reliability of the financial records for the final 16 months of HCCA's operation of the medical center is poor, it is clear that patient service revenue decreased over this period. This decline was due, at least in part, to the previous board's decision to replace the medical center's medical executive committee (MEC). The MEC governed the medical staff and was responsible for monitoring and supervising the medical staff's compliance with generally accepted medical standards and for ensuring the

Audit Highlights . . .

Our audit of the district and its oversight of the medical center and HCCA highlighted the following:

- » *The high cost of HCCA's services and decline in patient volume and resulting drop in patient revenue contributed to the closure of the medical center.*
- » *Available documentation fails to support the previous board's decision to select HCCA in 2013 to manage the medical center.*
 - *It was advised not to choose HCCA.*
 - *HCCA's management contract limited the board's ability to adequately monitor the operations and finances of the medical center and cost \$2.7 million a year for management services and an additional \$2.5 million in compensation in fiscal year 2015–16.*
- » *Patient service revenue decreased after the previous board replaced the medical center's medical executive committee.*
 - *Many physicians left the medical center.*
- » *Cash decreased when the district stopped paying its billing vendors and collecting on services billed.*
- » *Although the district is planning to reopen the medical center in mid-October 2018, it is unclear whether it can.*
 - *The interim management consultant has not included some costs in its budget.*
 - *Work remains for the district to meet all licensing requirements in federal and state regulations.*

accountability of the medical staff to the district's board. After the previous board removed the MEC, many physicians chose not to renew their privileges or resigned from the medical center, according to the medical center's chief nursing officer. This reduction in the number of physicians available to provide services explains, at least in part, the subsequent drop in patient volume and patient revenue. The board's decision to replace the MEC also resulted in a February 2016 lawsuit against the board, alleging that the board had violated the medical staff's right to self-governance.

The district's cash also decreased during the final 16 months of HCCA's operation because of the district's failure to pay its billing vendors and to collect on services billed. Available financial records show that the district's accounts payable balance increased by more than \$11 million between June and October 2017, resulting in vendors placing holds on the medical center accounts, and district staff explained that the nonpayment impeded some departments' ability to obtain necessary medical supplies and services for operation. Finally, in a September 2017 letter to the district's legal counsel, HCCA announced that the district was completely out of cash.

Despite all of the issues that led to the closure of the medical center, the district is planning to reopen the center in mid-October 2018. Its new board of directors has contracted with an interim management consultant to work toward the reopening, and after the bankruptcy court approved transactions facilitating affiliation with a new partner in August 2018, the district signed a management services agreement with its new affiliate partner (new manager) in early September 2018 to manage the medical center. Nevertheless, the district faces licensing issues that make it unclear whether the medical center will be able to reopen as currently scheduled.

Even though the new manager is providing the district with a \$10 million line of credit to assist with reopening expenses, the interim management consultant has not included in its budget for reopening the payment of *pre-petition debt*—costs incurred before the district filed for bankruptcy. Without budgeting for costs to reestablish relationships with vendors from which it needs to obtain required supplies and services, the district risks delaying the reopening of the medical center.

The district also faces licensing issues. Specifically, although the district has made progress in meeting licensing requirements in federal and state regulations, more work remains. In addition, the temporary suspension of its license expires in October 2018, and the district risks incurring additional costs required to meet current building standards if it lets the license expire and then has to apply for a new license. When a health care facility chooses to suspend its license with the California Department of Public Health, as the

district's medical center did in late 2017, it has the ability to request an extension of the license suspension, but the district has not done so. If the temporary suspension expires, the additional costs of meeting current building standards could further compromise the district's ability to reopen the medical center as planned.¹

Finally, the district could have been more effective in its oversight of its use of bond proceeds. Although the district established a bond oversight committee to oversee its spending of proceeds from \$85 million in general obligation bonds to fund the expansion of the medical center, it did not have the committee review key information necessary to allow the committee to do its job effectively. The district also had four external audits of its bond expenditures, three of which identified that the district had spent some bond proceeds for unallowable purposes. However, the district did not address all of the findings and recommendations that its external bond auditors made in those audits.

Selected Recommendations

To ensure that the district can demonstrate that its decisions for selecting contractors are justified and are in the best interest of the district's residents, by April 2019 the district should establish formal procedures designed to ensure that it follows and documents a rigorous and appropriate evaluation and contract awarding process.

To ensure that the district pays only reasonable and appropriate contract administrative costs, before the district signs any future management contract, it should prepare estimates of the costs for all proposed contract terms related to compensation.

To ensure that the district is able to reopen by mid-October 2018, it should continue to address the necessary licensing requirements.

To ensure that it uses bond proceeds for allowable purposes, by April 2019 the district should formalize and document policies and procedures for verifying that it uses bond proceeds for allowable purposes and for approving expenditures paid from general obligation bond proceeds.

To increase the effectiveness of its monitoring to ensure that bond proceeds are used only for the purposes that the voters intended, by April 2019 the district should establish a written process to document the steps it will take to address findings and recommendations identified in any future external audits of the bond proceeds.

¹ Shortly before our report was to be published, we learned that the district had requested an extension of its license suspension on September 7, 2018. Public Health approved the district's request on September 19, 2018. Refer to comment 8 on page 56 for additional detail.

Agency Comments

The district disagreed with the tone and conclusions we reached in Chapter 2. The district's response was silent on chapters 1 and 3 and did not address any of our recommendations.

Introduction

Background

Until its closure in October 2017, the Tulare Local Healthcare District (district) operated the Tulare Regional Medical Center (medical center), an acute care hospital that had served approximately 170,000 residents of the city of Tulare and the surrounding areas of Tulare County for more than 60 years. While the medical center is closed, residents are being referred to three neighboring medical centers, the nearest of which is 15 miles from the district's medical center.

The district—and its medical center—are governed by a board of directors (board), the members of which are elected by district voters on a rotating schedule to serve four-year terms. Each director represents one of five geographic areas of the district. Although historically the board had hired a chief executive officer (CEO) to manage its medical center operations, in early 2013, a year after the district suffered an operating loss of \$10.6 million, the board began exploring the possibility of aligning with a strategic partner that had the financial strength and organizational expertise to promote the long-term financial and operational viability of the medical center. In February 2013, the district's then-CEO gave a presentation to the board about the impact of upcoming changes resulting from health care reform, the challenges rural hospitals would face as a result of the reform, and the benefits of aligning with another entity or hospital network (affiliate partner). After three board meetings on this topic, in April 2013 the board adopted a resolution to start a formal process to explore the viability of such an affiliation and to seek a potential affiliate partner. The resolution cites key guiding principles that the district indicated would guide it in selecting an appropriate affiliate partner, as shown in the text box. In April 2013, with the assistance of a consulting firm, the district issued a request for proposal (RFP) for parties interested in managing the hospital. In December 2013, the district selected Healthcare Conglomerate Associates (HCCA) over five other firms as its affiliate partner.

Key Guiding Principles for Selecting an Affiliate Partner

- Financial strength and operational expertise
- Access and willingness to provide capital to the district
- Commitment to ensuring completion of the medical tower expansion
- Commitment to maintaining key hospital services

Source: The district's board resolution 832, adopted April 17, 2013.

HCCA began managing the medical center in January 2014 and continued to do so until November 2017. In September 2017, the district filed for Chapter 9 (municipal) bankruptcy and the following month asked the bankruptcy court to rescind its management contract with HCCA, which the court granted. In response to these actions, HCCA issued a notice to employees in October 2017 that it planned to temporarily suspend operations

at the medical center. The same day, the district's board voted to suspend its medical center license, and the medical center closed the following day. In November 2017, the district contracted with a consulting firm to assist in reopening the medical center. The consulting firm is providing the district with a CEO, chief financial officer (CFO), chief administrative officer, and controller to assist in its bankruptcy process and in improving its current financial situation. In this report, we refer to this consulting firm as the *interim management consultant*.

In the bankruptcy filing, the district declared a fiscal emergency, citing HCCA's inability to make payroll for the medical center and the district's inability to pay vendors critical to the operation of the medical center, which had caused vendors to discontinue service to the medical center. The district estimated that it had accumulated claims totaling \$27.5 million when it filed for bankruptcy; it estimates that it has generated another \$9 million in debt subsequent to the filing. As part of its bankruptcy proceedings, the district must file a plan for an adjustment of its debts, but as of August 2018 it had not done so. The district requested that the bankruptcy court set another status conference for January 2019 to discuss progress.

Legal Issues With the Hospital's Medical Executive Committee

State law establishes a right of self-governance for medical staff, and the district's medical staff operated independently from the medical center's administration. The medical staff bylaws established a medical executive committee (MEC), which governed the medical staff and was responsible for monitoring and supervising the medical staff to ensure that all patients admitted to the hospital received services and care at a level of quality that was consistent with generally accepted medical standards. The MEC was also responsible for ensuring the accountability of the medical staff to the district's board.

In January 2016, the California Department of Public Health (Public Health) conducted a validation survey—an inspection of the medical center to determine compliance with Medicare participation requirements—and reported to the federal Centers for Medicare and Medicaid Services (CMS) serious deficiencies, including some related to duties involving the board and some related to the medical center's MEC. For example, Public Health reported that the medical center did not have a system in place to ensure that it was following medical staff bylaws, rules, and regulations, and to ensure that medical staff were regularly evaluated. It also reported that there were no means to ensure that medical staff were professionally qualified for the positions to which they were appointed and for the privileges they were granted.

In January 2016, the board voted to replace the MEC and the medical staff bylaws with another medical staff organization (and thus a new MEC) and a new set of bylaws. After the board removed the MEC, the medical staff filed a lawsuit. In July 2018, the district settled the lawsuit with the medical staff and agreed to reinstate the MEC.

Licensing and Other State and Federal Requirements for Hospitals

Public Health assesses whether a hospital meets state regulations before issuing a license for it to operate in California. In broad terms, a hospital must have a governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the eight basic services shown in the text box. Most service areas have requirements related to staffing, space, equipment and supplies, and policies and procedures, and the requirements range in specificity, such as maintaining set staffing-to-patient ratios or maintaining adequate supplies. In addition, all licensed hospitals must meet requirements pertaining to administration and the physical plant.

Eight Required Basic Service Areas

- Medical
- Surgical
- Laboratory
- Pharmacy
- Nursing
- Anesthesia
- Radiology
- Dietary

Source: California Code of Regulations, title 22, section 70005.

State requirements largely mirror federal requirements, which are administered by CMS. By following federal and state requirements, hospitals can receive payment for services rendered to patients who are covered by Medicare and Medi-Cal, the term used to refer to Medicaid in California. Patient service revenue from Medicare and Medi-Cal patients was approximately 80 percent of the medical center's net revenue for fiscal year 2015–16, so compliance with federal and state requirements is crucial to the reopening of the medical center and to its financial viability.

Three of the basic services that state and federal regulations require hospitals to provide to receive a hospital license—pharmacy, laboratory, and radiology services—require additional licenses from separate oversight entities. The California State Board of Pharmacy enforces regulations that pharmacies must comply with in order to operate in California, while Public Health's Laboratory Field Services and Radiologic Health branches enforce regulations that laboratories and public health functions associated with administering radiology services must comply with in order to operate in California. The medical center needs licenses from all three of these entities.

In addition, a medical center must comply with state regulations on seismic safety before Public Health will issue it a license to operate in California. California's Office of Statewide Health Planning and

Development (OSHPD) monitors the construction, renovation, and seismic safety of hospitals in California. The Seismic Compliance Unit within OSHPD enforces seismic compliance requirements.

After closing the medical center in October 2017, the district voluntarily suspended its medical center license, providing a period of one year for the district to relicense the medical center. The medical center may seek to either reinstate its license during this one-year period, allow the license to expire, or request an extension of the suspension period.

Bond Measure and Hospital Expansion

In 2005 district voters approved a measure that increased the property tax rate so that the district could issue \$85 million in general obligation bonds to expand and renovate the medical center, including a new tower project. Initial estimates for the tower project were approximately \$120 million. The district issued the first \$15 million in bonds in 2007 and the remaining \$70 million in 2009. It used part of the bond proceeds to reimburse itself for nearly \$1.6 million in construction expenditures that it had paid before receiving the first bond proceeds in 2007, and then it spent the remaining bond proceeds through September 2014. According to the most recent audited financial statements, as of the end of fiscal year 2015–16, the district had spent \$138 million, including the \$85 million in general obligation bonds, on its tower expansion and other smaller renovation projects. However, these projects remain incomplete. The fiscal year 2015–16 financial statement audit stated that the remaining costs would be approximately \$55 million, for a total of \$193 million, with an estimated completion date of 14 to 16 months after the district secures additional financing. The district attempted to obtain voter approval for \$55 million in additional general obligation bonds in August 2016, but the measure failed.

Scope and Methodology

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor's Office to examine the district and its oversight of the medical center and HCCA. The Audit Committee requested that we examine five specific audit objectives to accomplish this task. Table 1 describes the Audit Committee's objectives and our methodology for addressing each one.

Table 1
Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
<p>1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.</p>	<p>Reviewed relevant laws and regulations.</p>
<p>2 Review and evaluate the district’s spending and monitoring of its bond proceeds. At a minimum, perform the following:</p> <p>a. Assess the district’s process for spending bond proceeds related to the medical center, including HCCA’s role in spending these funds.</p> <p>b. Identify the oversight structure in place for monitoring bond proceeds and assess the adequacy of this oversight.</p> <p>c. Determine whether expenditures related to bond proceeds were for allowable activities and were reasonable.</p>	<p>Our access to and review of documentation for this objective was limited to what we, in conjunction with current district staff, were able to locate in the district’s archived files. Key staff who were involved in the spending and oversight of the bond proceeds are no longer employed at the district.</p> <ul style="list-style-type: none"> • Interviewed district staff to understand their process for spending bond proceeds. • Judgmentally selected 30 invoices from between 2007 and 2014 paid for using bond proceeds. • Obtained invoices and other supporting documentation to determine district adherence to bond spending restrictions and the district’s invoice approval process. • Interviewed district staff and reviewed invoices to identify HCCA’s role in spending bond proceeds. • In 2015 the district, under HCCA management, canceled an equipment contract the district had entered into and paid for with bond proceeds and received a refund for \$4.6 million. The refund was used to offset construction costs paid for using other district funds. We selected five invoices that were included in the offset expenditures for review, and did not identify issues with the transactions. • Interviewed district staff and reviewed key documentation to determine the entities performing oversight of bond expenditures. • Interviewed district staff and reviewed invoices to determine if the district management appropriately approved invoices for payment. • Reviewed bond oversight committee (committee) meeting minutes to determine if the committee fulfilled its oversight and reporting duty, as defined in its charter. • Interviewed former district staff to determine the extent to which the district used the information generated from its external bond audits. • Identified and reviewed documentation from the district’s \$85 million in general obligation bonds, including legal documents and board resolutions, to determine the allowable purposes of the proceeds as approved by the voters. • Reviewed invoices to determine whether bond proceeds paid for allowable uses.
<p>3 Assess the district’s oversight of HCCA’s management of the medical center from fiscal year 2014–15 through October 2017 including the following:</p> <p>a. Identify and evaluate the district’s revenues and expenditures related to its operation of the medical center, including identifying significant trends and their causes.</p>	<ul style="list-style-type: none"> • Used audited financial statements and other relevant documents and performed an analysis of operating revenue and expenditures and identified causes for significant revenue and expenditure trends. • Identified categories of revenues and expenditures contributing to the closure of the medical center and obtained documentation supporting trends in those categories. • Interviewed current and former district employees for perspective and explanations regarding identified trends.

continued on next page . . .

AUDIT OBJECTIVE	METHOD
<p>b. Examine the management structure of the district and the medical center. Determine whether the structures and changes within them, including management and executive turnover, affected sound operational and financial practices.</p>	<ul style="list-style-type: none"> • Obtained and reviewed available district organizational charts from 2015 through 2017. • Obtained and reviewed the MEC’s charge and responsibilities. • Reviewed district election results and board meeting minutes to document changes in key positions—CEO, CFO, and board members—from 2014 through 2017. • Documented changes in physician levels. • Reviewed board meeting minutes to identify the board’s decision to seek an affiliate partner for managing the medical center. • Interviewed former board members to understand their rationale for change to the management structure. • Reviewed audited financial statements for fiscal years 2012–13 through 2015–16.
<p>c. Identify the key events leading to the closure of the medical center, including the rationale behind key district actions.</p>	<ul style="list-style-type: none"> • Reviewed board meeting minutes from 2014 through 2017, identifying key events and when possible, the rationale behind key decisions. • Obtained and reviewed the district’s RFP for a strategic partner, and requested the proposals the RFP generated. Only two proposals were available for our review. • Reviewed HCCA’s contract with Southern Inyo Healthcare District (Inyo) to identify key differences between its contract with the district and with Inyo. • Reviewed the January 2016 CMS report, board minutes, and additional documentation to identify circumstances leading to the district’s replacement of the MEC. • Interviewed three former board members who took part in selecting HCCA to ascertain their rationale for certain decisions.
<p>4 To the extent possible, identify steps the district could take to reopen the medical center.</p>	<ul style="list-style-type: none"> • Reviewed federal and state regulations regarding requirements to obtain a hospital license. • Reviewed other requirements to reopen the medical center. • Obtained and assessed the adequacy of the district’s plans to address requirements to obtain a hospital license and address other requirements to reopen the medical center. • Documented relevant district perspective on its time frames and plans for meeting hospital license requirements and other requirements the district needs to address before reopening the medical center.
<p>5 Review and assess other issues that are significant to the audit.</p>	
<p>a. Determine whether HCCA management had conflicts of interest in their roles between the district and Inyo.</p>	<ul style="list-style-type: none"> • Reviewed Inyo’s board minutes from 2016 and 2017 to identify and document any substantive input by district board members and HCCA management. • Reviewed the district interim controller’s analysis and estimates of the cost of management and staff paid for by the district but working at Inyo. • Obtained job descriptions and other relevant documents for key positions to determine if concurrent employment at the district and Inyo was allowable.
<p>b. Identify potential conflicts of interest by the district board members and HCCA management.</p>	<ul style="list-style-type: none"> • Obtained the district’s conflict-of-interest policy. • For 2014 through 2017, reviewed district board members’ statements of economic interests to determine whether any had disclosed potential conflicts. • The district could not provide any statements of economic interests for HCCA employees, and we were unable to successfully contact HCCA to address our requests.

Source: Analysis of the Audit Committee’s audit request number 2018-102, as well as information and documentation identified in the column titled *Method*.

Assessment of Data Reliability

In performing this audit, we relied on various electronic data files that we obtained from the district. The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support findings, conclusions, or recommendations. In performing this audit, we obtained the district's accounting data to identify trends in revenue and expenditures. To evaluate this data, we performed electronic testing of the data, reviewed existing information about the data and systems, and interviewed district officials knowledgeable about the data. However, because of issues discussed in Chapter 1, we found the data to be of undetermined reliability. Although this determination may affect the precision of the numbers we present, there is evidence in total to support our audit findings, conclusions, and recommendations.

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Chapter 1

POOR DECISIONS BY THE DISTRICT'S PREVIOUS BOARD MEMBERS HAMPERED OVERSIGHT AND CONTRIBUTED TO FINANCIAL DIFFICULTIES AT THE MEDICAL CENTER, RESULTING IN ITS CLOSURE

Chapter Summary

The decision of previous district board members in December 2013 to award an affiliate partner management contract to HCCA to manage the district's medical center contributed to serious financial difficulties, which led to bankruptcy and the closing of the medical center. According to existing documentation, this decision was neither justified nor in the best interest of the district or the community. Further, the contract and subsequent amendment with HCCA limited the board's ability to oversee the medical center's operations and finances adequately because they contained provisions restricting direct access to the medical center and its data systems. Previous board members also voted to replace the medical center's MEC, an act that had lasting consequences, including a significant decline in the number of its physicians, which led to, at least in part, its decrease in patient service revenue. Other key factors contributing to the decline in patient service revenue included a drop in patient volume and a decline in supplemental funds.² Further, professional fees and labor expenses increased, mainly because of the compensation terms in the contract with HCCA. As revenues decreased, the district struggled to pay its vendors, resulting in some of its vendors canceling services with the district. The previous board's decisions and the deteriorating financial condition during the last 16 months of its operations—July 2016 to October 2017—under HCCA's management resulted in the district filing bankruptcy and the closing of the medical center. Figure 1 on the following page shows a timeline of key relevant events discussed in this report.

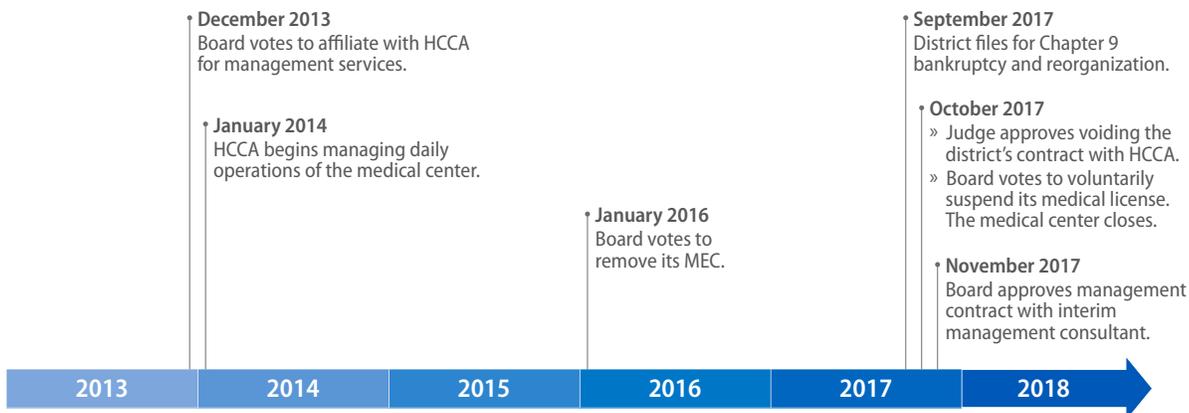
Existing Documentation Does Not Demonstrate Justification for the Board's Choice of HCCA

Although previous members of the district's board voted unanimously in 2013 to select HCCA to manage the medical center, documentation from the district's consulting firm that reviewed the proposals received indicates that HCCA was not

² Supplemental funds are funds available from state programs to offset low reimbursement rates for Medi-Cal patient services.

the most qualified choice. As discussed in the Introduction, the district engaged a consulting firm to assist it in developing and issuing the RFP seeking an affiliate partner and to advise the district in evaluating strategic partnership options, which included reviewing the proposals. The district could not provide copies of the proposals received from the prospective affiliate partners, and the consulting firm was able to provide only two of the proposals. The consulting firm completed an evaluation summary, dated in early December 2013, comparing the prospective affiliate partners and including a scorecard.³ Table 2 shows the consulting firm's scorecard for the prospective affiliate partners.

Figure 1
Timeline of Key Relevant Events



Source: Board meeting minutes; district's contract with HCCA; various legal documents concerning the district's filing for bankruptcy.

The scorecard shows that HCCA was scored as "unknown" for all of the criteria categories in the consulting firm's evaluation summary. Each of the prospective affiliates, including HCCA, made public presentations to the board in November or December 2013.⁴ Our examination of the board meeting minutes documenting the oral presentations with corresponding PowerPoint slides did not find a level of detail that would enable the board to determine which candidate was the most qualified. For example, the RFP requested that each of the prospective affiliates state its commitment to providing the district with capital or a line of credit

³ In 2015 another firm acquired the assets of this consulting firm. The successor firm stated that the employees who worked directly with the district during the firm's engagement were no longer employed at the firm. The successor firm also indicated that it had provided us with all documents in its possession regarding the original firm's 2013 engagement with the district.

⁴ The board meeting minutes reflect that one of the public presentations to the board included two parties: Community Medical Centers and Strategic Global Management, Inc.

upon entering into a management contract. The consulting firm’s evaluation contained detailed information regarding each affiliate’s willingness to provide capital, but no details were identified for HCCA. The presentations to the board also did not contain these details, and the meeting minutes did not reflect that HCCA was willing to provide capital.

Table 2
The Consulting Firm’s Scorecard of Affiliate Partner Proposals Did Not Support the Selection of HCCA

CRITERIA	PROPOSALS RECEIVED					
	ADVENTIST HEALTH*	ALECTO HEALTHCARE SERVICES, LLC*	BRIDGEWATER HEALTHCARE GROUP*	COMMUNITY MEDICAL CENTERS	HCCA†	STRATEGIC GLOBAL MANAGEMENT, INC.*
Financial strength	Strong	Unknown	Unknown	Strong	Unknown	Strong
Position in marketplace	Strong	Weak	Weak	Strong	Unknown	Moderate
Company history and experience	Strong	Moderate	Moderate	Strong	Unknown	Strong
Executive experience	Unknown	Strong	Strong	Strong	Unknown	Strong
Willingness to provide capital	Moderate	Moderate	Moderate	Weak	Unknown	Moderate
Commitment to continue hospital services	Strong	Strong	Strong	Strong	Unknown	Strong
Strategic advantages	Strong	Unknown	Moderate	Strong	Unknown	Unknown
Opportunity to provide corporate synergy	Strong	Moderate	Unknown	Strong	Unknown	Unknown

Source: Strategic Partner Evaluation Summary prepared in December 2013 by the consulting firm assisting the district in assessing the proposals.

* For Adventist Health, Alecto Healthcare Services, LLC, Bridgewater Healthcare Group, and Strategic Global Management, Inc., the consultant used “Unknown” for reasons such as that the prospective affiliate partner was a newly formed company and its financial strength was somewhat unknown, or the prospective affiliate partner’s strategic advantages were dependent on a relationship with a third-party health system.

† The consulting firm’s summary generally indicated that HCCA’s proposal either needed clarification or did not address the criteria contained in the RFP.

We expected the board to have considered carefully the analysis of the written proposals and the scorecard from its consulting firm as well as the presentations when it made its selection of the best affiliate partner. The meeting minutes do reflect that one board member raised concerns regarding the two prospective affiliates that the consulting firm rated as the strongest. She stated that she did not believe it was right to align with a religious institution because the medical center was a government entity. She also expressed concern that the consulting firm reviewing the proposals had not identified that one affiliate had questionable legal charges,

and she indicated her support for choosing HCCA. The minutes do not reflect any further discussion among the board members about those concerns.

Despite the consulting firm's analysis and scorecard of the prospective affiliates, as shown in Table 2, in December 2013 the board's two-member subcommittee assigned to work with the consulting firm in reviewing the proposals recommended that the board award the management contract to HCCA, and the board unanimously voted to do so. The former board chair, who was on that subcommittee, told us that the board members did not review the written proposals and that, from her perspective, the consulting firm did not provide a lot of information on the proposals. However, she confirmed that the consulting firm had provided the scorecard on the proposals. Further, she stated that as a newly elected board member in 2013, she relied on the counsel of trusted individuals in the community, such as a former city manager for Tulare, a former council member, and some doctors that practiced in Tulare, to assist her in deciding which prospective affiliate to select. She also stated that she and the other subcommittee member discussed whom to recommend as the affiliate, but they did not provide any written or verbal analysis to the board to support their recommendation of HCCA. The board meeting minutes state the chair's desire to have a facility where physicians would not be ridiculed for bringing patients to the medical center and to complete the tower, and that she believed the only candidate that would accomplish those two goals was HCCA.

When we spoke to the former board vice chair about why he voted to select HCCA, he stated that HCCA gave the best presentation and was the most honest. He also stated that the district was losing approximately \$1 million a month and was on the brink of bankruptcy; therefore, he believed there was no other choice. Another former board member echoed this same sense of urgency over the need to make a decision to address the district's deteriorating financial position. The board selected HCCA even though the consulting firm's written analysis indicated that HCCA was not the most qualified. In addition, the board did not prepare an alternate analysis showing that its selection aligned with the intent of the RFP. Therefore, the board did not demonstrate that its decision to select HCCA met its goals and intent of aligning with an affiliate partner, nor that its decision was in the best interest of the district and the community that it serves. In fact, in response to the subcommittee's decision to recommend HCCA, the consulting firm resigned from further work in advising the district, stating that the subcommittee had chosen to disregard its advice in carrying out the selection process.

The board selected HCCA even though the consulting firm's written analysis indicated that HCCA was not the most qualified.

The Previous Board Members Approved Contract Terms That Did Not Adequately Protect the District's Interests

The contract with HCCA and a subsequent amendment, both approved by the previous board, limited the board's ability to oversee the medical center's operations and finances adequately. State law specifies that a hospital board is responsible for operating its health care facilities in a way that best serves the public health interests of its community. However, the restrictive provisions in the contract prevented the previous board from fulfilling this responsibility. The contract specified that district representatives could not access the medical center, its clinics, and other facilities without prior arrangement with HCCA. The district also could not access data systems used in connection with the operations of the medical center unless specifically authorized by HCCA in each instance.

When we spoke about these contract terms with former board members, the chair and two other former board members stated that HCCA never denied them access to the hospital facilities. According to the former board chair, the requirement for approval to access the facilities was for HCCA's protection, a precaution to prevent future board members from potentially disrupting hospital operations. She also stated that she never asked for direct access to review the medical center's financial records, but that she did receive basic financial statements, profit and loss statements, and reports on patient volume. Further, she stated there was no reason to doubt the financial statements as they were audited annually and she believes it was not the board's place to perform a detailed review of the financial records unless something was amiss.

Nonetheless, these contract provisions hampered the current board. The current chair stated that while he did not attempt to enter the medical center to access its data systems, HCCA was not responsive to some of the board's requests for data. In particular, he stated that in January 2017 the board requested data from the medical center's accounting records, and although HCCA initially indicated that it would provide those reports at the February 2017 board meeting, from his perspective, it was later unresponsive to that request. Board agenda materials for a special meeting in September 2017 included correspondence between the legal counsels of the district and HCCA regarding a request for detailed financial information related to the medical center's financial performance. The correspondence shows a disagreement about the level of detail HCCA needed to provide. HCCA's counsel claimed that the list of requested items was burdensome because of the number of items requested and because some information requested went back two to four years. He further explained that it would cause great expense to HCCA to provide the information

The contract with HCCA and a subsequent amendment limited the board's ability to oversee the medical center's operations and finances adequately.

and would interfere with HCCA's ability to operate the medical center. However, the district's counsel claimed that the information requested was necessary for the board to be able to make informed decisions. Board meeting minutes do not indicate whether HCCA fully complied with the board's requests for information before the board terminated HCCA's management contract in October 2017.

As previously stated, the board has a statutory responsibility to operate its health care facilities in a way that best serves the public health interests of the community, and the board members hold office as a public trust created in the interest and for the benefit of district residents. The fact that HCCA could deny the board information that it thought it needed to govern the district, points out the inappropriate nature of the contract terms, which hindered the board from fulfilling its legal responsibility to operate its health care facilities in a way that best served the interests of the community. The current board chair further stated that HCCA management ordered him off the premises when he entered the medical center to post notices announcing the board's suspension of the medical center's license.

The contract also contained provisions that made HCCA the exclusive employer of the medical center's staff and required the district to "lease" the employees from HCCA at a cost of 130 percent of the employees' salaries or other base compensation. Financial records indicate that HCCA recorded a portion of the 30 percent as a "compensation premium" after deducting the costs of benefits, taxes, and other expenses. For fiscal year 2014-15, the premium was \$1.7 million, and for fiscal year 2015-16 it was \$2.5 million. This premium was in addition to HCCA's annual management fee of \$2.7 million, a considerable amount, given that the district's operating income was more than the annual management fee in just two of the five fiscal years leading up to the contract with HCCA—\$4.2 million in fiscal year 2009-10 and \$5.5 million in fiscal year 2010-11. The district had a net loss in the two fiscal years that immediately preceded the start of the contract.

We question how the board members could have found the costs associated with these contract terms reasonable. Adding such a significant cost to the medical center's already slim margins further contributed to the financial strain of the medical center. The former board chair could not explain why she agreed to the contract provisions transferring the district's employees to HCCA, nor how doing so was in the best interest of the district, although she believed the 30 percent was to pay for employee benefits.

Adding such a significant cost to the medical center's already slim margins further contributed to the financial strain of the medical center.

In January 2016, two years after it began managing operations at the medical center, HCCA entered into a contract with Southern Inyo Healthcare District (Inyo) to manage its medical center. However, as Table 3 shows, HCCA’s contract with Inyo did not contain contract terms as restrictive as those with the Tulare district.

Table 3
Key Terms in HCCA’s Contracts With the District Were More Restrictive Than Those for Inyo

	DISTRICT	INYO
Number of licensed beds	112	39
Contract duration	2014–2017	2016–2017
Key terms		
Healthcare district oversight	District representatives restricted from entering the medical center, its clinics, and other sites without prior arrangement with HCCA. The district shall also not access data systems utilized in connection with the operations of the medical center, unless specifically authorized by HCCA in each instance.	No restrictions as to when or where Inyo representatives may enter medical center facilities or access data systems.
Employment agreement	District transitioned its employees to HCCA; HCCA is the exclusive employer of the employees and leased them to the district. The district cannot solicit for employment any leased employee for a period of two years after the term of the contract. The district pays HCCA 130 percent of each leased employee’s salary or other base compensation, excluding items such as benefits, insurance, and taxes.	Employees remained employees of Inyo.
Contractor relationship	District representatives cannot disclose any negative information or make any disparaging statements regarding HCCA. (No such provision prevents HCCA from speaking negatively about district representatives.)	Inyo representatives cannot disclose any negative information or make any disparaging statements regarding HCCA, and the same prohibitions apply to HCCA representatives regarding Inyo.

Source: HCCA’s contracts with the district and Inyo.

The Board Members Removed the Medical Center’s MEC in January 2016 Without First Discussing Their Concerns

The previous board’s decision to replace the medical center’s MEC has had lasting repercussions. We spoke with two of the former board members who voted to replace the MEC to understand their reasons for doing so. The former board chair stated that several individuals, including HCCA’s CEO, told her that a representative from Public Health’s team that conducted the 2016 inspection had stated that the medical center would be closed unless the board took action to replace the MEC. Another former board member we spoke with stated that HCCA management told her that CMS was

The former board chair explained that a group of doctors came to the January 2016 board meeting and agreed to be the new MEC, so the board voted to replace the MEC with this second group of doctors.

going to stop allowing Medicare and Medi-Cal patients to seek care at the medical center because of many things that the MEC was not doing or was not doing properly.

Our review of the January 2016 Public Health inspection report of the medical center, its May 2016 reinspection report, and a February 2016 letter from CMS, which receives inspection reports from Public Health, showed deficiencies, including some related to the duties of the MEC, such as not ensuring that medical staff were regularly evaluated, and not having a means to ensure that medical staff were professionally qualified for the positions to which they were appointed and for the privileges they were granted. However, none of these documents specified that the medical center had to replace its MEC. Instead, the letter specifies that the medical center must address the deficiencies identified to avoid termination of its Medicare provider agreement. We asked the former board chair whether she had talked with the MEC about the inspection concerns and she said she had not, and that the MEC had been uncooperative and had refused to meet with her in the past. She also understood that the board was responsible for mitigating the deficiencies and did not want the medical center to close. The former board chair explained that a group of doctors, including a former vice chair, came to the January 2016 board meeting and agreed to be the new MEC, so the board voted to replace the MEC with this second group of doctors.

It is clear from the Public Health inspection report that there were issues involving medical staff that the board needed to address. It is also evident from our discussions with the two former board members that each did not want the medical center to close and that they believed the situation was urgent and required action. However, it is not clear that replacing the MEC was the only option. We also question why the board took action to replace the MEC before it received any official correspondence from CMS or Public Health. The earliest letter from CMS provided to us by the district notifying the hospital that it was out of compliance because of issues concerning the MEC was dated February 2, 2016, five business days after the board voted to replace the MEC. We also expected the board to have discussed with the MEC the serious concerns from CMS before it took such a significant action, but we did not see evidence of any efforts to do so. Had the board waited until it received CMS's official letter notifying it of the report findings, it could have better considered its response.

The first consequence of the MEC replacement was the departure of a significant number of the medical staff. According to the district's chief nursing officer, when the MEC was replaced, many physicians either did not renew their privileges to practice in the medical center or resigned from it. The district provided a

summary document showing a decline from 79 active physicians on June 30, 2015, to 49 on June 30, 2016—roughly six months after the board replaced the MEC. The medical center’s drop in patient service revenue, which we discuss further in the next section, was due in part to the reduced number of physicians. However, available internal reports show that patient volume had already been declining for several years. Specifically, the average daily patient census dropped from 61 patients in fiscal year 2010–11 to 40 patients in fiscal year 2013–14. Although the average census was 41 per day in fiscal year 2015–16, it fell to 37 in fiscal year 2016–17, a decline on average of four per day. The average daily census dropped to 25 for July to October 2017, when the district suspended its license. The second consequence of the MEC replacement was litigation. In February 2016, members of the former medical staff, including the replaced MEC, filed a lawsuit alleging that the board had violated the medical staff’s right to self-governance, and it requested the reinstatement of the original MEC and the original medical staff bylaws.

Several Factors Contributed to Declining Revenue and Increasing Costs During HCCA’s Management of the Medical Center

The deteriorating financial condition after fiscal year 2015–16 resulted in the district filing bankruptcy and closing the medical center. One key factor was the drop in patient volume, resulting in lower patient revenue. Others included a decrease in supplemental funds; increased administrative costs because of HCCA’s management fee, and its CFO’s salary and his expense reimbursements; and an increase in the cost of purchased labor—salaries and wages and benefits for HCCA employees.

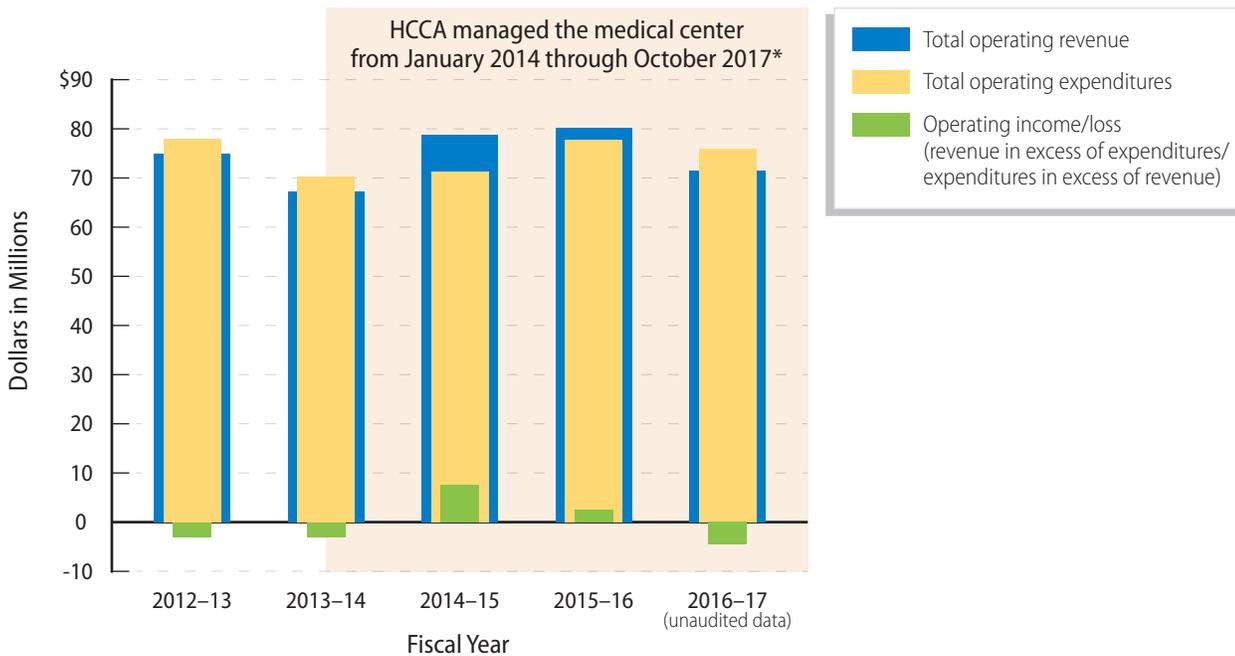
When we reviewed the available financial records for the last 16 months of the district’s operations, multiple factors prevented us from determining whether these financial records are accurate. The district has a history of accounting errors related to financial reporting, including \$6.5 million in errors related to the district’s fiscal year 2014–15 financial statements. Further, the fiscal year 2015–16 financial audit report also noted findings related to the district’s financial reporting, including its processes for identifying and adjusting accounting errors. When we followed up with the district’s interim controller regarding discrepancies we identified in our preliminary analysis of the district’s accounting records, she stated that the district is continuing to correct errors. Compounding the difficulty in understanding this chain of events is the fact that the district’s financial statements for the last 16 months of the medical center’s operations remain unaudited, as the district cannot presently afford to hire independent financial auditors and sufficient internal financial staff to prepare for and perform an

The district has a history of accounting errors related to financial reporting, including \$6.5 million in errors related to the district’s fiscal year 2014–15 financial statements.

audit. As a result, we present the available unaudited operating revenue and expenditure information for the last full fiscal year of operations only as an indicator of overall trends in revenue and expenditures.

Our review of the district’s audited financial statements for fiscal years 2012–13 through 2015–16 and available financial information for fiscal year 2016–17 showed that operating revenue and income initially rose in fiscal year 2014–15, the first full fiscal year after HCCA began managing the medical center. Then, between fiscal years 2014–15 and 2015–16, operating expenditures increased more than revenues, as shown in Figure 2. Finally, the financial position of the medical center declined after fiscal year 2015–16 and resulted in the district filing for bankruptcy in September 2017.

Figure 2
The Medical Center’s Operating Income Initially Improved Under HCCA, Until Expenditures Increased More Than Revenues



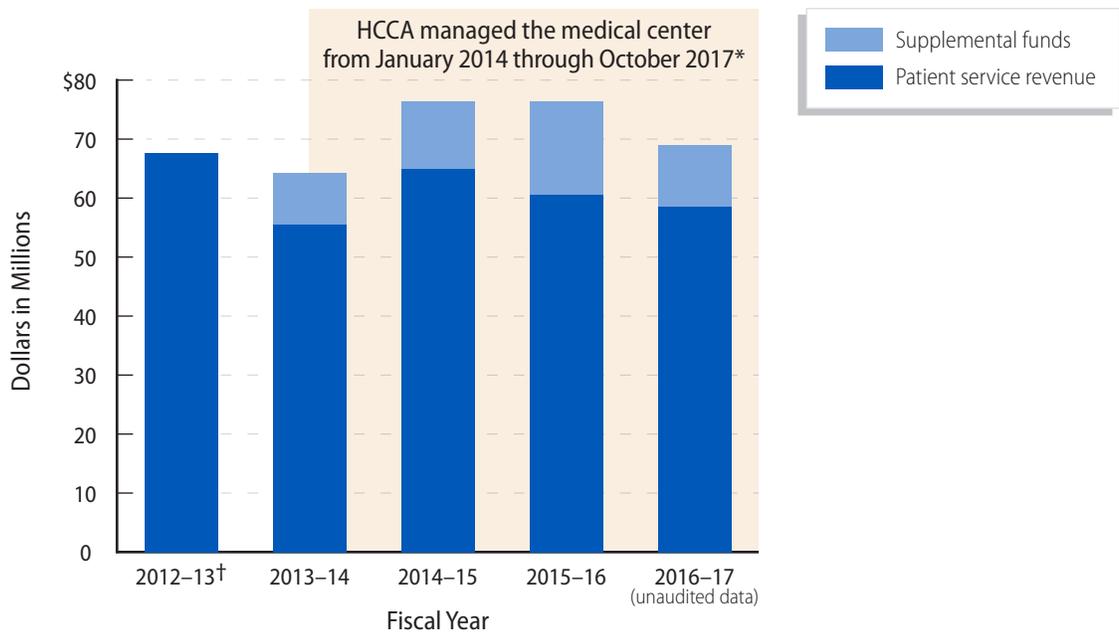
Source: Medical center’s audited financial statements for fiscal years 2012–13 through 2015–16 and unaudited available financial statements for fiscal year 2016–17.

* The district filed for bankruptcy in September 2017 and in October 2017 filed a motion with the bankruptcy court to reject HCCA’s management services agreement.

Historically, patient visits drove revenue for the medical center, and that revenue, along with supplemental funds, accounted for 90 percent or more of the medical center’s operating revenue, according to audited financial statements for fiscal years 2012–13 through 2015–16. Using earlier audited financial statements and other

available financial records, we identified two categories of operating revenue that had significant changes leading to the decline in the medical center’s financial situation: patient service revenue and supplemental funds within revenue. Patient service revenue increased in fiscal year 2014–15 before declining in fiscal year 2015–16, while revenue from supplemental funds rose in both fiscal years. Available financial statements indicate that both had declined by June 2017, as shown in Figure 3. Although total patient service revenue and supplemental funds were slightly higher in fiscal year 2015–16, increases in operating expenditures outpaced operating revenue growth beginning in that fiscal year, as shown in Figure 2, reducing the improvements seen in fiscal year 2014–15.

Figure 3
Patient Service Revenue and Supplemental Funds Fluctuated Under HCCA



Source: Medical center’s audited financial statements for fiscal years 2012–13 through 2015–16 and unaudited available financial statements for fiscal year 2016–17.

* The district filed for bankruptcy in September 2017 and in October 2017 filed a motion with the bankruptcy court to reject HCCA’s management services agreement.

† The audited financial statements for fiscal year 2012–13 do not provide a breakdown of the portion of overall patient service revenue into patient service revenue and supplemental funds.

The medical center saw a drop in patient volume and subsequent patient service revenue during the last two fiscal years. The audited financial statements for fiscal year 2015–16 show that net patient service revenue—which consists of both charges associated with patient visits and supplemental funds—remained relatively flat between fiscal years 2014–15 and 2015–16, decreasing by only \$225,000.

Although revenue from supplemental funds increased through fiscal year 2015–16, the district under HCCA management lost several opportunities to receive additional supplemental funds from Health Care Services.

The decrease was small overall because increases in supplemental funding offset lower service volumes and the subsequent lower patient revenue. Specifically, patient service revenue fell from \$65.1 million in fiscal year 2014–15 to \$60.6 million in fiscal year 2015–16, and available financial records indicate that it continued to decline in fiscal year 2016–17. Supplemental funds accounted for between 13 percent and 20 percent of the medical center’s operating revenue in fiscal years 2013–14 through 2015–16. In fiscal year 2016–17, supplemental funds revenue decreased slightly, falling below the amount received in fiscal year 2014–15.

Although revenue from supplemental funds increased through fiscal year 2015–16 as shown in Figure 3 on page 23, the district under HCCA management lost several opportunities to receive additional supplemental funds from the Department of Health Care Services (Health Care Services). The interim CFO explained that agreements with Health Care Services required the district to advance funds to Health Care Services for rate increases. Health Care Services would then seek federal funding for the rate increases covered by the agreements, and would return to the district up to twice the amount of the advance. The two agreements covered capitation rate increases for two health plans for fiscal years 2015–16 and 2016–17.⁵ However, according to an email from the former controller to Health Care Services, the district was unable to provide \$2.8 million as required by the transfer agreements because it lacked the funds, and thus it missed out on up to an additional \$2.8 million in supplemental funds, less administrative costs. As a result, Health Care Services rescinded the two agreements.

Another potential source of supplemental funds was California’s Public Hospital Redesign and Incentives in Medi-Cal program (PRIME program), which is administered by Health Care Services to improve the delivery of care through California’s safety net hospitals—those that serve a higher share of patients covered by Medi-Cal and the uninsured. The PRIME program spans from January 1, 2016, to June 30, 2020, and provides incentive payments for quality improvement, which concerns maximizing health care value. Similar to the Health Care Services agreements, participants must advance the State’s share of financing, and then the federal government matches the funds and returns them to the State. Participants receive a return of twice the amount of the advanced funds. The district received \$2.3 million from the PRIME program during fiscal year 2015–16. However, Health Care Services informed the district in March 2018 that its participation in the PRIME program was terminated as of October 2017 because of

⁵ A capitation rate is a fixed amount of money per patient per unit of time paid in advance to a physician for the delivery of health care services.

the closure of the medical center. Health Care Services also noted that the district was ineligible for funds from the program for fiscal year 2016–17 because it submitted a required report that had been due September 30, 2017, on January 17, 2018, six weeks after the 60-day extended time period. According to the interim CFO, the PRIME program grants lost for the period from October 2016 to September 2017 totaled \$2.5 million. The district filed an appeal with Health Care Services in March 2018 requesting that it reconsider the district's termination from the PRIME program; however, according to the interim CFO, it has not received a response from Health Care Services.

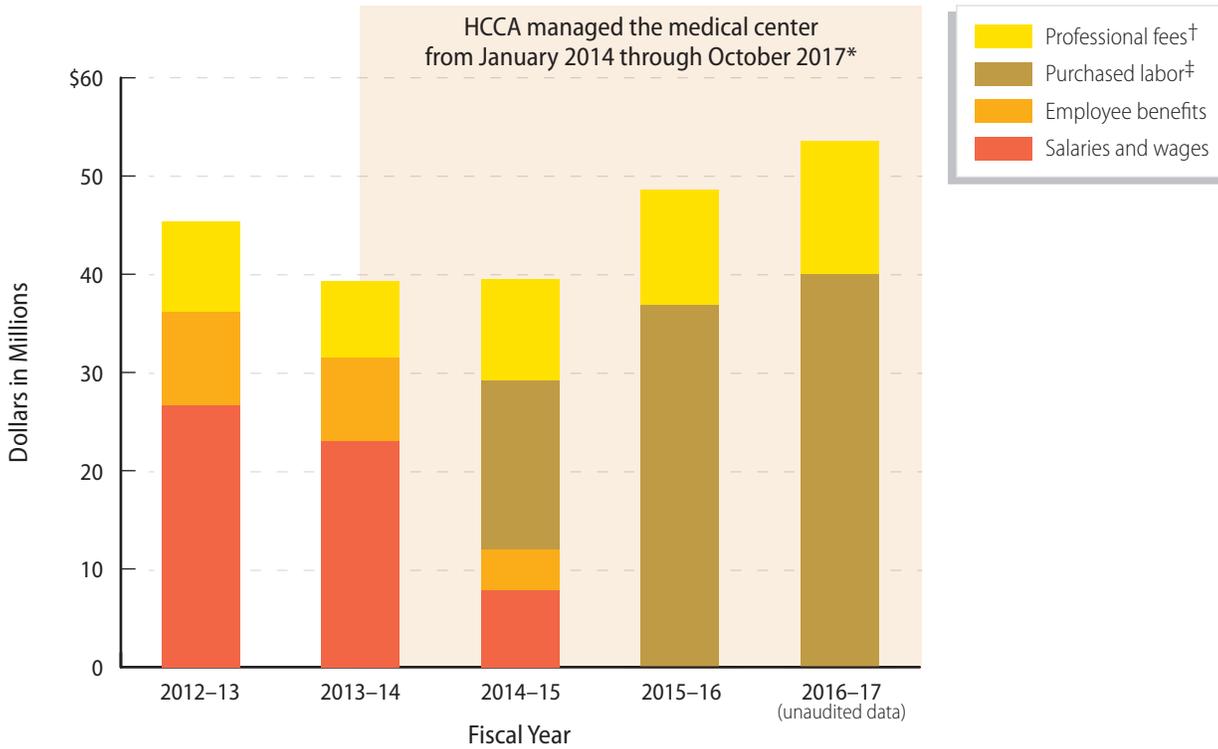
Operating expenditures increased while HCCA was managing the medical center, beginning in fiscal year 2013–14. The medical center's operating expenditures included costs for supplies and services to operate the hospital plus the salaries and benefits of staff working at the hospital, which accounted for between 41 percent and 47 percent of its operating expenditures each year. Our review of these expenditures identified two categories that contributed substantially to the increase: professional fees, such as fees for physicians; legal and consulting services; and purchased labor—the cost for payroll and benefits for the employees leased from HCCA per the contract—as shown in Figure 4 on the following page.

HCCA's management fee contributed to the increase in professional fees for the medical center. The district's 15-year contract with HCCA, effective in May 2014, required the district to pay HCCA a monthly fee of \$225,000 for management services, a total of \$2.7 million per year.⁶ The contract also specified that HCCA would provide a CEO as a part of its performance under the agreement, but the contract did not specify any other positions that HCCA would provide, such as the CFO, as we discuss in more detail later. We did not see any evidence that the district conducted a cost-benefit analysis of the impact of the costs associated with these contract terms. When we discussed the management fee with some of the former board members who had approved the contract, the former vice chair stated that he believed that the management fee was reasonable given that the district was losing more than \$1 million per month. However, we expected the district to have conducted a cost-benefit analysis before approving a costly long-term contract and to have considered whether the medical center could reasonably sustain the increased costs of the management fee. Such analysis would have been of particular importance given the operating losses the district had sustained in the two fiscal years before it entered into the agreement with HCCA, as shown in Figure 5 on page 27.

Operating expenditures increased while HCCA was managing the medical center, beginning in fiscal year 2013–14.

⁶ The district signed an initial, short-term contract with HCCA that was effective January 2014. Before the conclusion of the initial contract, the district decided to enter into a 15-year contract with HCCA in May 2014.

Figure 4
Professional Fees and Purchased Labor Initially Declined Before Rising Under HCCA



Source: Medical center’s audited financial statements for fiscal years 2012–13 through 2015–16 and unaudited available financial statements for fiscal year 2016–17.

* The district filed for bankruptcy in September 2017 and in October 2017 filed a motion with the bankruptcy court to reject HCCA’s management services agreement.

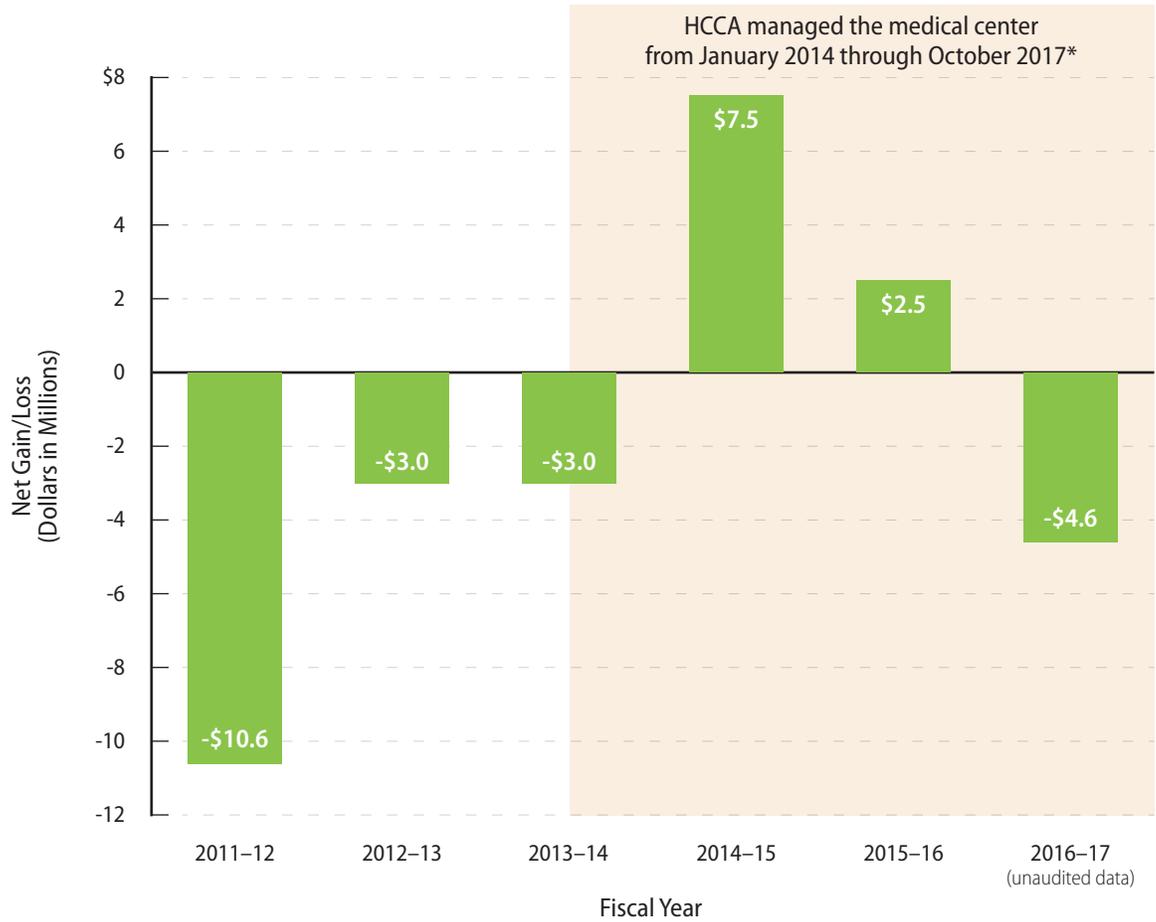
† Professional fees include costs to support operations, such as physicians, legal, and consulting fees.

‡ The medical center’s staff became HCCA staff in November 2014. The *purchased labor* category reflects both salaries and benefits from November 2014 through the end of fiscal year 2016–17.

Purchased labor costs increased while HCCA managed the medical center. Purchased labor includes salaries and wages and benefits, which were a part of the employee lease payment. As discussed previously, under its contract with the district, HCCA became the exclusive employer of the medical center personnel and leased the employees to the district at 130 percent of employee salaries and wages, excluding benefits and certain costs (referred to here as the *employee lease payment*).⁷

⁷ The employee lease payment is equal to 130 percent of salary or other base compensation, excluding, without limitation, costs such as employment benefits, taxes, retirement, and workers’ compensation premiums.

Figure 5
HCCA Did Not Sustain Its Initial Improvement of the Financial Performance of the Medical Center



Source: Medical center's audited financial statements for fiscal years 2011-12 through 2015-16 and unaudited available financial statements for fiscal year 2016-17.

* The district filed for bankruptcy in September 2017 and in October 2017 filed a motion with the bankruptcy court to reject HCCA's management services agreement.

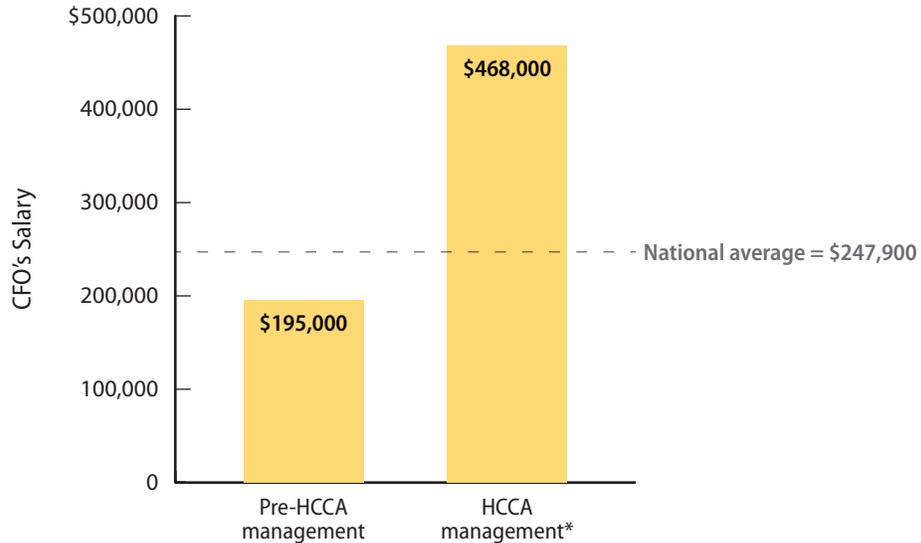
HCCA became the exclusive employer of the medical center's employees in November 2014. The medical center's accounting records show that HCCA recorded a compensation premium, which we define on page 18, in fiscal year 2014-15 of \$1.7 million and in fiscal year 2015-16 of \$2.5 million. This premium was included in the purchased labor category of the financial statements. As discussed earlier, multiple factors prevented us from determining whether the financial records from the last 16 months of operation are accurate, and thus it is unclear what HCCA recorded as its compensation premium during the last 16 months of operations.

The district and HCCA also contracted for a CFO . . . the district's monthly management fee of \$225,000, or \$2.7 million per year, evidently did not include CFO services. As a result, the district hired an independent contractor to serve as the interim CFO and agreed to pay him \$468,000 annually, plus up to \$8,000 a month in travel expenses.

Another factor contributing to the increase in purchased labor was an increase in salaries and wages and benefits, although it is not clear, based on the financial statements, which of the two categories increased. Before HCCA began managing the medical center, financial statements prepared for the district presented salaries and wages as a component separate from benefits. However, after district employees became HCCA employees in November 2014, salaries and wages and benefits were shown in one category, purchased labor, along with the compensation premium. Thus, it is not clear whether both salaries and wages and benefits increased, or if one category increased more than the other.

The district and HCCA also contracted for a CFO, further increasing the district's costs. As mentioned previously, the district's monthly management fee of \$225,000, or \$2.7 million per year, evidently did not include CFO services. As a result, following the resignation in July 2014 of the district's then-CFO, the district entered into a six-month contract with an independent contractor to serve as the interim CFO. The district agreed to pay him \$39,000 monthly, or \$468,000 annually, plus travel expenses of up to \$8,000 per month because he lived in Arizona. In February 2015, HCCA entered into a subsequent contract with the same contractor to serve as the CFO and chief operating officer for the medical center. The contract specified a monthly rate of \$46,800 for his services, or \$561,600 annually, plus up to \$8,000 per month in travel expenditures. The amount invoiced by the CFO monthly and paid by the district rose to \$56,800 in January 2016, or \$681,600 annually, but we did not find any documentation of a contract amendment associated with the January change, nor any documentation showing that the district's board was aware of this increase. As shown in Figure 6, the salary paid to the CFO was significantly higher than both the national average and the amount the district had paid the medical center's former CFO. Further, available documentation shows that the CFO's travel reimbursement claims totaled \$249,000 for August 2014 through June 2017. Again, we expected the district to have considered the impact of these high costs before approving the agreement, and we saw no evidence that the district performed a cost-benefit analysis. Without a cost-benefit analysis to determine whether the costs it would incur are reasonable, the district could not ensure that it was spending its funds prudently.

Figure 6
 The CFO's Salary Exceeded Both the National Average and the Previous CFO's Salary



Source: Medical center's payroll documentation and contracts as well as *100 Statistics for CEOs and CFOs* report from Becker's Hospital Review regarding hospital statistics for an independent hospital in 2014.

* We compared only the initial salary for the CFO under HCCA management, a rate he was paid for August 2014 through January 2015, to the national average and to the former CFO because he entered into a contract to serve as the chief operating officer in addition to the CFO in February 2015.

Declining Cash Flow Led to Reduced Payments to Vendors

In addition to the declining revenue and increasing expenditures discussed earlier, two other factors contributed to a decrease in cash at the medical center. According to a district information technology consultant, the district, under HCCA's management, failed to pay certain billing services vendors for several months. He also stated that the district converted to another electronic health record (EHR) system. Because of discrepancies in the available financial records for the last 16 months of operations, as mentioned earlier, we are able to determine only in general terms how these events affected the operations of the medical center.

Under HCCA management, the district contracted with a vendor in April 2015 to perform emergency department billing and coding services for the medical center, processes necessary to receive payment for services provided in that department. However, according to a letter from the vendor's legal counsel in February 2017, the district stopped providing billing information to the vendor in October 2016, and the vendor discontinued services to the district two months later because it did not receive payment of nearly \$274,000. As discussed later in this section, the lack of payment to these and other vendors continues to cause operational and legal difficulties for the district.

The district experienced a decrease in cash following the implementation of a new EHR system between July and October 2016.

After the first billing vendor discontinued services, the district entered into a billing services agreement in April 2017 with a second vendor to perform billing and coding services for the emergency department. However, a letter from the second vendor in August 2017 shows that the district also did not pay that vendor for its services.

The district also experienced a decrease in cash following the implementation of a new EHR system between July and October 2016. According to the former controller, the implementation caused a decrease in cash receipts for the first couple of months due to delays in billing, and while cash receipts eventually increased, they did not return to the level before the conversion. According to an April 2017 presentation by a district vendor providing revenue cycle services to the medical center, average cash after the implementation of the new EHR system was \$1 million less per month, with a shortfall between implementation and April 2017 of approximately \$6 million.⁸ As discussed previously, the discrepancies in the available financial records for the last 16 months of operation make it difficult to determine precisely how the lack of payment to these vendors and the EHR system conversion affected the operations of the medical center and whether the money owed as recorded by the district is accurate. However, it is clear that the amount of cash available to the medical center dropped significantly during the last 16 months of operation, and its failure to pay the billing vendors and the EHR system conversion were likely contributing factors.

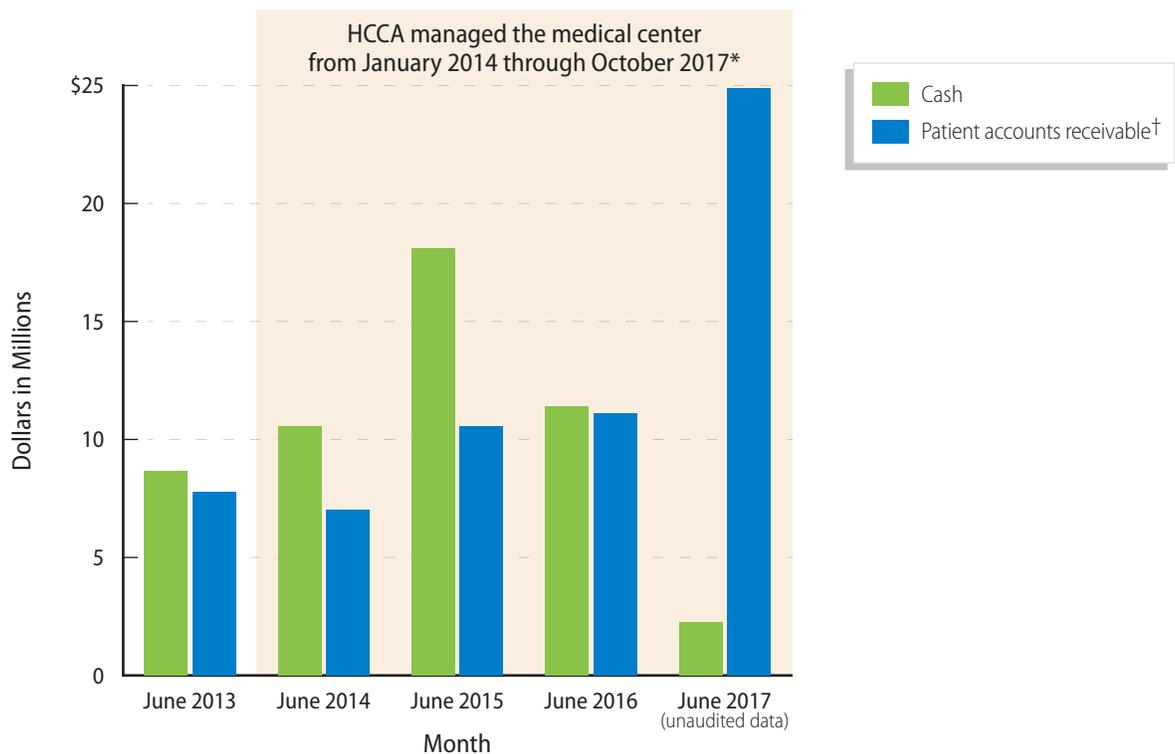
The medical center's cash balance rose from June 2014 to June 2015 under HCCA but then fell considerably by June 2016, as shown in Figure 7. Further, bank statements provided by the district show that the medical center had \$2.3 million in cash as of June 2017 but only \$144,000 four months later. This decrease in cash significantly hindered the medical center's ability to pay for supplies, staff, and other operating expenses. Accounts receivable (money due to the district) increased from June 2014 to June 2017, before the district's interim controller adjusted the balance to \$6.5 million in October 2017, based on historical collection rates. In January 2018, the district contracted with a billing and collection services vendor, which has collected \$5.5 million to date.

The medical center struggled as well with bills that it owed. Available unaudited financial statements show that the accounts payable balance rose from \$19.6 million in June 2017 to \$31 million in October 2017, which resulted in vendors placing credit holds with the medical center. Accounting staff provided accounting records from 2017 showing that comments documented which

⁸ The revenue cycle consists of all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.

vendors were complaining about lack of payment and making demands for payment, and that the amounts available for payment were often prioritized to complaining vendors. According to the current laboratory operations manager, medical center department heads were meeting daily with the chief nursing officer in August 2017 to inform her of the supplies and services each department needed to maintain the ability to function, as many vendors were placing credit holds because of a lack of payment. He stated that the chief nursing officer took the requests for payments to vendors to the CFO, but in most cases he denied the requests. In a September 2017 letter to the district’s legal counsel, HCCA stated that the district was completely out of cash, that many vendors were threatening to cease providing goods and services, and that there was insufficient cash to fund payroll.

Figure 7
Under HCCA Management, Cash Was Depleted While Net Patient Accounts Receivable Increased



Source: Medical center’s audited financial statements for fiscal years 2013–14 through 2015–16 and unaudited available financial statements for fiscal year 2016–17.

* The district filed for bankruptcy in September 2017 and in October 2017 filed a motion with the bankruptcy court to reject HCCA’s management services agreement.

† Patient accounts receivable is shown without accounts that are likely uncollectible.

The District Did Not Follow State Conflict-of-Interest Laws Requiring Disclosure Forms

The Political Reform Act of 1974 requires that each local government agency, such as the district, adopt a conflict-of-interest code. The act seeks to bar public officials from using their positions to influence government actions in which they may have a financial interest and establishes several requirements related to conflicts of interest. For example, it requires those holding certain positions to disclose their reportable economic interests both annually and when assuming or leaving office. The principles related to conflicts of interest as outlined in the district's 2014 policy manual specify that all persons holding designated positions must file statements of economic interests each year. The policy identifies, among others, the board members, CEO, CFO, and consultants acting on the district's behalf.

The district did not ensure that designated individuals consistently filed statements of economic interests. Specifically, the district could not provide an annual statement of economic interests for one board member for 2014, and was also unable to provide four leaving-office statements—one for 2016 and three for 2017—that the exiting board members were required to file. When designated individuals from the district do not file statements of economic interests, the public has no assurance that potential conflicts are identified and that those designated individuals are not making or influencing decisions that could benefit them financially.

The district could not provide the statements of economic interests for the individuals who functioned as its CEO and CFO for 2014 through 2017.

Additionally, the district could not provide the statements of economic interests for the individuals who functioned as its CEO and CFO for 2014 through 2017. Although state law requires that these forms be available for public inspection, the district's conflict-of-interest policy does not identify how it will maintain the forms to ensure that they are available for such an inspection. When we asked for the CEO's and CFO's statements of economic interests, the district could not provide these for any HCCA staff, stating that HCCA could have taken the forms with it when the district terminated its contract. We attempted to contact HCCA to request these statements, but our attempts were unsuccessful. Further, although the district's interim CEO should have submitted his assuming-office statement in December 2017, he did not do so until August 2018. Without having a policy and procedures to ensure that it obtains the forms and maintains them as required, the district cannot demonstrate that it has appropriately considered potential conflicts of interest and it cannot provide the statements for public inspection when requested.

HCCA also may have misappropriated public funds when it inappropriately used district funds to pay some of the medical center's employees to work at Inyo's medical center, which HCCA also managed. The district's interim controller performed an analysis using payroll and accounting data for hourly employees and conducted interviews with staff to estimate the percentage of time salaried staff spent at Inyo. She estimated that between January 2016 and November 2017, 31 individuals paid with district funds worked nearly 4,500 hours at Inyo, with roughly 1,200 of those hours attributed to the CFO.

While other district staff may have been able to perform work outside the district—as long as that work was not paid for with district funds—the CFO should have been working full time on the district's activities. According to HCCA's February 2015 contract with the individual who was serving as the CFO and chief operating officer at the district, he was to devote his time, attention, and efforts as needed to properly render the services and perform the duties required within the district's contract, but in no event were those services to be less than full time. Further, HCCA's job description lists numerous responsibilities, such as developing, coordinating, and administering medical center policies on finance; assisting in day-to-day operational decision making; directing the financial management functions; interpreting financial and statistical trends, as well as projecting capital and operating financial needs; and regularly attending district board meetings. These duties would be difficult, if not impossible, to adequately fulfill without working full time at the district's medical center. Nevertheless, meeting minutes from Inyo's board of directors reveal that this individual was the chief restructuring officer at Inyo in 2016 and attended a number of board meetings in person. We question how he could have effectively fulfilled his duties as the district's CFO while simultaneously holding a high-level management position at another district.

The interim controller estimated that the value of employee time misdirected from the district was substantial. Based on her estimate of nearly 4,500 employee hours paid for by the district but spent on HCCA's directed activities at Inyo, the district had paid more than \$400,000 as of November 2017 for which it had received no services. Based on the interim controller's assessment, HCCA's payments could constitute a misappropriation of public funds, which is a violation of state law. Pursuant to government auditing standards applicable to our office, we are forwarding this information to the Tulare County District Attorney.

Based on the interim controller's estimate, the district had paid HCCA more than \$400,000 as of November 2017 for which it had received no services.

Recommendations

To ensure that the district can demonstrate that its decisions for selecting contractors are justified and are in the best interest of the district's residents, by April 2019 the district should establish formal procedures designed to ensure that it follows a rigorous and appropriate evaluation and contract awarding process.

To ensure that the district pays only reasonable and appropriate contract administrative costs, before the district signs any future management contract, it should prepare estimates of the costs for all proposed contract terms related to compensation.

To ensure that it complies with state law, by April 2019 the district should update its policy related to conflicts of interest to include procedures requiring the district to obtain and maintain copies of all designated individuals' statements of economic interests at the medical center.

To ensure that the district recovers funds inappropriately used to pay for work outside the district, it should immediately take steps to seek reimbursement from HCCA for payments the district made to HCCA for time the former CFO and other employees spent working at Inyo.

Chapter 2

IT IS UNCERTAIN IF THE DISTRICT WILL REOPEN THE MEDICAL CENTER BY MID-OCTOBER 2018 AS IT PLANS

Chapter Summary

The district has made progress in meeting licensing requirements in state and federal regulations, but work remains. The district currently plans to reopen the medical center by October 15, 2018; however, it is not clear whether it will address all requirements to reopen by then. In late June 2018, the district's board chose an affiliate partner (new manager) to operate the medical center and provide funding necessary to resume operations by mid-October 2018 through a long-term lease agreement. The district provided some documentation demonstrating that it is meeting with its new manager to address requirements to reopen by service area, such as laboratory, surgical, and pharmacy. However, it is still in the process of fulfilling those requirements and, in some cases, is still identifying items it must address. The new manager extended a line of credit to the district to reopen the medical center, but the district did not include in its budget some of the costs to reestablish relationships with vendors, which may prevent it from obtaining the supplies and services necessary to reopen the medical center. Although the district currently plans to reopen the medical center before its suspended license expires in late October 2018, it can request an extension of its suspension from Public Health if it is not able to open by the planned timeline. However, the district has not yet requested an extension.⁹ Without an extension in place before its temporary suspension expires, the district risks incurring additional costs to meet current building standards if it has to apply for a new license. These additional costs could compromise its ability to reopen.

The District Is Working Toward Reopening the Medical Center, but It Is Unclear Whether It Is Addressing All of the Necessary Requirements

The district and its interim management consultant began working toward relicensing and reopening the medical center in October 2017, and the district plans to reopen the medical center by mid-October 2018. In spring 2018, when we initially reviewed the district's progress toward reopening, we noted that although it had a list of various tasks it needed to complete, it did not have a comprehensive plan for reopening. A comprehensive plan is

⁹ Shortly before our report was to be published, we learned that the district had requested an extension of its license suspension on September 7, 2018. Public Health approved the district's request on September 19, 2018. Refer to comment 8 on page 56 for additional detail.

The district has recently engaged in more frequent and structured meetings to identify the remaining activities it needs to complete to reopen, but we are concerned that the district may not meet all requirements to reopen the medical center by mid-October 2018.

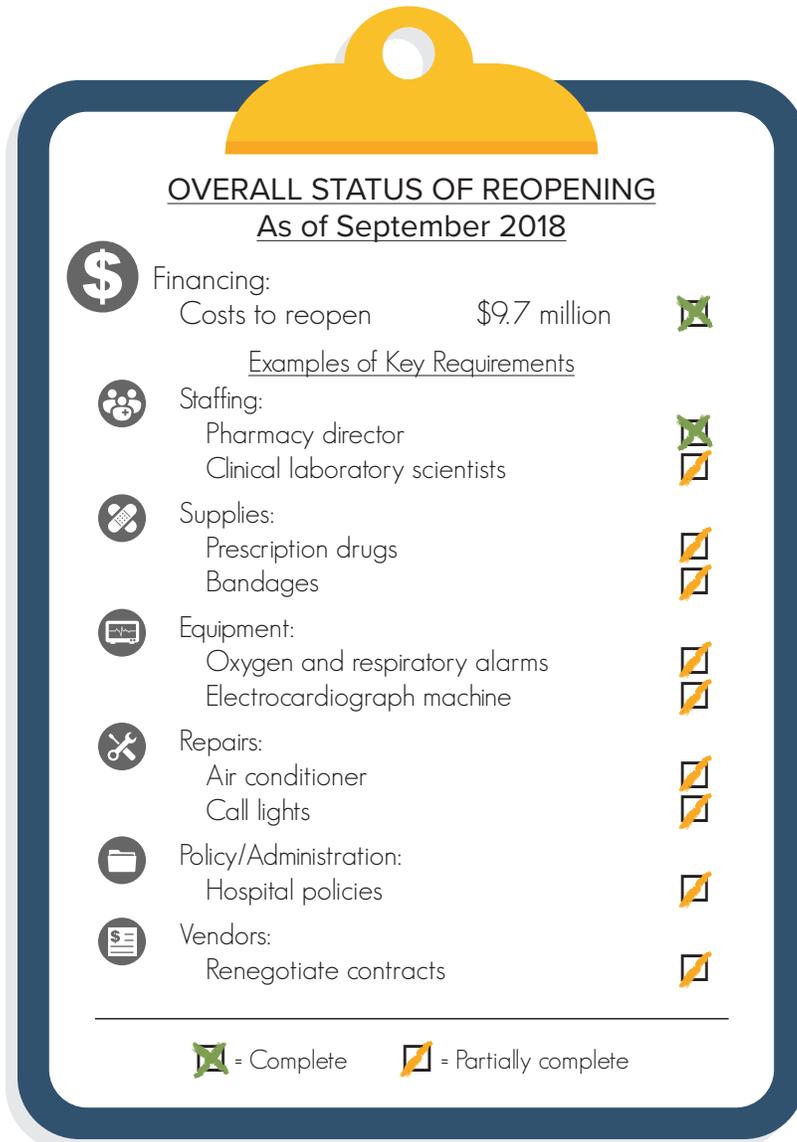
important because it identifies all of the licensing requirements by area, the activities that need to be completed, a time frame for completion, and any associated costs. Instead, the district referred us to department managers to discuss their plans and progress toward reopening. As shown in Figure 8, the district is making some progress toward meeting the requirements to reopen, but it has not completely addressed all of these requirements. Based on our initial review, we were concerned that the district had not fully considered its equipment and supply needs and the length of time associated with the tasks necessary to prepare the medical center to reopen. For example, the district did not provide a list of supplies necessary for the surgery service, nor did it incorporate the length of time associated with testing clinical laboratory equipment into its task list. Without considering these requirements, it was unclear how the district could determine a reopening date.

The district has recently engaged in more frequent and structured meetings to identify the remaining activities it needs to complete to reopen. However, planning documentation demonstrates that the district is still identifying items it must address before reopening. In June 2018, after our initial review in the spring, the district selected a new manager for its medical center. The district obtained approval from the bankruptcy court in early August 2018 to enter into several transactions with the new manager, including an interim management consultant services agreement, lease, and credit agreement. The district then began meeting daily with the new manager to discuss how each of the service areas will meet the requirements to reopen. The district provided us the task lists that its department directors use to identify all tasks they need to perform before reopening. Although the district is making progress, documentation provided by the district regarding its current daily meetings does not demonstrate that the district is fully aware of all it needs to do to reopen.

For example, the daily meeting documentation indicates that the district is presently conducting inventories of equipment. State regulations require service areas to have adequate equipment and supplies, such as oxygen and respiratory rate alarms for the surgery service. These regulations are designed to ensure that the medical center can address the needs of its patients. Because the district is currently conducting an inventory of equipment, it may not be aware of repairs or other actions necessary to ready equipment for use, or whether some equipment needs to be replaced. We asked the district for documentation of the inventory of supplies for the surgery service area, but it did not provide us with any. The daily meeting documentation notes that supply needs for the surgery service area were discussed, but it is unclear whether the district has completed an inventory of supplies and determined what is needed based on this limited information. Given that some tasks

such as inventories of supplies and equipment have not been completed, we are concerned that the district may not meet all requirements to reopen the medical center by mid-October 2018.

Figure 8
 The District Is Making Some Progress Towards Reopening the Medical Center



Source: California Code of Regulations, title 22; 42 Code of Federal Regulations part 482; and documentation provided by medical center staff.

Moreover, it is uncertain whether the district will have its equipment ready in time for the planned reopening. For example, according to the medical center’s current pharmacy director,

Given the short time frame in which the district is attempting to reopen the medical center and the outstanding tasks identified, it is not clear whether it will meet all requirements necessary to reopen by mid-October 2018.

the pharmacy's intravenous (IV) hoods, equipment needed for creating liquid medications without contamination, must undergo testing before the pharmacy can make IV solutions. The results of such testing can take two weeks to process. The daily meeting documentation indicates that a check was sent to the vendor that will perform the testing and, once the check clears, the district is planning to schedule the testing. However, the district has also identified other equipment needs, such as an electrocardiogram machine, a device that measures the electrical activity of the heart. It is not clear whether this equipment needs to be repaired or replaced, but the daily meeting documentation indicates that the district still needs to obtain a quote on the price of repairing or replacing its electrocardiogram machine. In order to reopen by mid-October 2018, the district will need to demonstrate compliance with licensing operational requirements so that it can receive its hospital license from Public Health again. Given the short time frame in which the district is attempting to reopen the medical center and the outstanding tasks identified, it is not clear whether it will meet all requirements necessary to reopen by mid-October 2018. Therefore, it is critical that the district continue working toward addressing these requirements.

The New Manager Is Providing Funding Through a Line of Credit to Assist the District With Reopening

The new manager has extended a \$10 million line of credit to the district to finance the reopening of its medical center. The line of credit is a loan that the district will have to repay. As shown in Figure 8 on page 37, financing is a critical element in reopening the hospital. However, once the medical center is open, the new manager will administer operations for the hospital. The interim management consultant provided a budget demonstrating that the \$10 million would cover some of the costs of reopening, such as salaries and employee benefits, supplies, and repairs. Although the budget will cover some of the costs of reopening, it notes a number of assumptions for its estimates. For example, the budget assumes that repairs will cost the amount budgeted and that the medical center will receive supplemental income—additional funds the State provides to hospitals that serve Medi-Cal and uninsured patients—on time. If repair costs exceed estimates included in the budget and the medical center does not receive supplemental funds on time, the costs to reopen may exceed the amounts included in the budget and the district may not have the funds available to reopen.

Further, the district has not budgeted for some of the costs to reestablish relationships with former vendors so that it can purchase supplies necessary for operating the medical center and obtaining its license. The district owes vendors both *pre*-petition

debt, which is debt incurred before the district filed for bankruptcy, and *post*-petition debt, which is debt incurred after the district filed for bankruptcy, to reopen the medical center. The district's budget includes costs to cover post-petition debt, but it does not cover payment of pre-petition debt. Several vendors have requested payment of some or all of their pre-petition debt before they will do further business with the district. According to the interim CEO, the district is assessing each contract to determine how necessary the vendor is to reopening, and is taking advantage of the new manager's existing contracts with vendors when applicable and desirable. He also indicated that only a few vendor contracts remain to be negotiated. Documentation we were provided shows that as of August 2018 the district is prioritizing negotiations with a few vendors owed \$1.8 million in post-petition debt and \$2.9 million in pre-petition debt. However, the documentation also shows that the district has not yet established contracts with more than 100 additional vendors that are necessary for the medical center to reopen, and those vendors have more than \$200,000 in post-petition debt and \$1.1 million in pre-petition debt. Given the extensive number of vendors that the district still needs, and their associated debt, it is unclear whether the district will have the contracts in place to obtain necessary supplies and purchased services by October 2018, so that it can reopen.

Although the District Can Request to Extend Its License Suspension, It Has Not Done So

When the district voluntarily suspended its license in October 2017, it received a temporary suspension that is valid for one year, as specified in state regulations. Public Health informed us that it could also authorize an extension, if requested. Public Health also informed us that it had notified the interim CEO in March 2018 that it could make this option available, but the district had not requested an extension. Thus, based on Public Health's representation, the district may request an extension of the suspension of its license, submit an application for reinstatement—which first requires relicensing by Public Health—before the end of the suspension, or allow the suspension to expire and lose the medical center's license. If the district allows its license to expire, it will have to apply for a new license, which may require it to incur additional costs to meet current building standards for the medical center, such as requirements for seismic safety, fire and life safety, and environmental impact. Reinstating its suspended license, rather than letting it expire and applying for a new license, is critical to the medical center's ability to reopen cost-effectively and as soon as possible. Any substantial costs would be a large financial challenge for the district to overcome in its efforts to reopen. According to the interim CEO, he has not performed an analysis of the costs

The documentation shows that the district has not yet established contracts with more than 100 additional vendors that are necessary for the medical center to reopen.

associated with the medical center obtaining a new license because there was no need to do so. Given that the district is not yet certain whether it will be able to reopen by mid-October 2018, we are concerned that if it does not request an extension from Public Health, it risks incurring costs that would compromise its ability to reopen the medical center.¹⁰

Recommendations

To ensure that the district is able to reopen by mid-October 2018, it should continue to address requirements to reinstate its license and should arrange for Public Health to verify compliance with licensing operational requirements as soon as it has completed addressing the requirements to reopen.

To ensure that the district budgets for all costs necessary to reopen, it should immediately include in its budget the costs to pay pre-petition debt for vendors with whom it must reestablish relationships before it can resume operations.

To ensure that the district is able to obtain the supplies and purchased services necessary to reopen the medical center, the district should continue its efforts toward reestablishing relationships with vendors so that it can reopen the medical center by mid-October 2018.

¹⁰ Shortly before our report was to be published, we learned that the district had requested an extension of its license suspension on September 7, 2018. Public Health approved the district's request on September 19, 2018. Refer to comment 8 on page 56 for additional detail.

Chapter 3

THE DISTRICT COULD HAVE MORE EFFECTIVELY MONITORED ITS SPENDING OF BOND PROCEEDS

Chapter Summary

The district's oversight structure for monitoring its spending of \$85 million in bond proceeds has included requiring approval of invoices by construction and executive staff, appointing a committee, and initiating external auditor reviews of the bond expenditures. However, we noted weaknesses with each of the components that reduced the effectiveness of the district's monitoring. The district can increase the effectiveness of its monitoring by formalizing its processes for approving expenditures from bond proceeds, establishing policies for periodic committee review of bond expenditures, and establishing a process to verify that it addresses all audit findings from bond audits.

The District Did Not Always Spend Bond Proceeds for Allowable and Reasonable Activities

The 2005 board resolution that ordered the ballot measure for issuing \$85 million in bonds specified that the district would use the proceeds for costs of construction, acquisition, and expansion of the district's medical facilities and specifically prohibited paying for costs unrelated to construction activities, including staff and administrator salaries and other operating expenses. However, our review of 30 expenditures totaling approximately \$3.8 million from bond proceeds in 2007 through 2014 found that the district and HCCA spent more than \$61,000 on four expenditures that did not meet the stated criteria or were an unreasonable use of bond proceeds.

The district used bond proceeds to pay for a software maintenance agreement for existing medical equipment totaling \$48,000. The software was not related to construction or expansion of the medical center and therefore was not an allowable use of bond proceeds. Further, the district used roughly \$450 in bond proceeds to reimburse the project management consultant for the medical center's expansion project for meal costs. However, the district's contract with the consultant did not include meals as reimbursable expenses. Although the dollar amount is small, because the district was not contractually required to pay for meals, this expense was an improper use of bond proceeds. Further, for another bond expenditure we selected for review totaling \$45,000, the district was unable to provide the invoice and supporting documentation. According to the interim controller, the invoice was likely misfiled.

Under the management of HCCA, the district used bond proceeds to pay for expenditures totaling \$13,000 that we also determined to be unreasonable.

HCCA began managing the medical center in January 2014, and according to the financial report presented to the committee, the bond proceeds remaining at the end of January 2014 were approximately \$3.8 million. Under the management of HCCA, the district used bond proceeds to pay for expenditures totaling \$13,000 that we also determined to be unreasonable. In March 2014, HCCA used bond proceeds to pay for a \$12,500 severance payment to the district's director of construction. Although the salaries of district employees hired to work in the district's construction management department, such as the director of construction, were an allowable use of bond proceeds, it is unreasonable to use proceeds for a severance payment because it does not directly contribute to the construction and improvement of the medical center. Further, we expected HCCA to have documented its justification for why a severance payment was necessary; however, the district was unable to provide any justification for this payment. HCCA also used more than \$500 in bond proceeds to reimburse its project management consultant for meal costs, despite meals not being included as reimbursable expenses in its contract.

Former staff who were involved in the spending of the bond proceeds are no longer employed at the district, and current district staff could not explain why previous staff had used bond proceeds for inappropriate purposes. According to accounting staff, the district did not have a formal written policy or procedure for approving expenditures from bond proceeds. Instead, according to the former district controller, the director of construction would review the construction invoices and indicate whether the invoice was for the expansion project. After approving invoices, the construction department sent the invoices to the CEO or CFO for approval. Although the district was not always consistent as to which executives approved invoices, all invoices reviewed had, at a minimum, approval from the CEO, the CFO, or the board chair. However, for the unallowable expenditure for the software maintenance agreement, the district did not follow its informal process for approving bond expenditures because the invoice did not have the director of construction's approval.

The district's external audits, which reviewed all bond expenditures, also found that the district spent bond proceeds on some expenditures that it should not have and that it did not consistently follow its invoice approval process. The district obtained four external audits completed in 2010, 2011, 2013, and 2015 to review its spending of bond proceeds, and three of the audits identified some unallowable expenditures as well as inconsistencies in complying with the district's approval process, which we discuss further in the next section. Given the significant amount of the bond proceeds, we expected the district to have a written process for staff to follow, but it did not, thus weakening its ability to ensure that it spent all bond proceeds exclusively for the purposes it had pledged to the voters.

The district could also benefit from a contract retention policy. As part of our invoice testing, we reviewed the district's vendor contracts to ensure that the district had contracted for the billed services. In addition to the 30 expenditures, we also reviewed five that were included in offset expenditures after HCCA cancelled an equipment contract paid with bond proceeds. We did not identify issues with those transactions. In our selection of 35 expenditures for review, the district could not locate five contracts and two contract amendments for invoices we reviewed. Although we were able to determine that the purchases made with each of these invoices were allowable, the district could not provide a copy of the contracts to demonstrate that it had actually contracted for those services. According to the facilities coordinator, who was the former construction department's administrative assistant, the district does not have a retention policy for its contracts. Further, the district's contract management policy does not indicate how long it is required to maintain copies of its contracts. However, it is important that the district include as part of its contract management policy a retention period to ensure that it is maintaining contracts for an appropriate amount of time. For example, the *State Contracting Manual* requires state departments to maintain such documents for seven years after the last payment.

The District's Monitoring of Its Spending of Bond Proceeds Could Have Been More Effective

Other components of the district's efforts to monitor its spending of bond proceeds included appointing the committee and obtaining independent external reviews of its bond expenditures. We found concerns with each of these components of its monitoring.

The district did not require its committee to perform certain duties that would have improved its effectiveness in monitoring the district's use of the bond proceeds. The committee's roles and responsibilities (charter) required that it review the projects with construction and building staff to assure that the district was meeting the intent of the voters in every aspect of the actual use of the proceeds. The charter also required the committee to report quarterly to the district's board on the progress in the use of the proceeds and the consistency between the bond spending and the assertions made to voters. Committee meeting minutes show that it received frequent reports from staff on construction progress and milestones, and some updates on the construction schedule and budget changes and the remaining balance of bond proceeds. However, these reports from staff failed to provide an overview of *how* the district was spending the bond proceeds, as they did not include any expenditure details. It is unclear how the committee could adequately monitor the district's use of the bond proceeds

Reports from staff failed to provide an overview of how the district was spending the bond proceeds.

The committee did not begin to review expenditure details regularly until mid-2013, by which time the district had already spent approximately \$73 million of the \$85 million in bond proceeds.

and inform the board about compliance with the voter-approved purposes without having reviewed expenditure details in addition to the information it was reviewing.

The committee did not begin to review expenditure details regularly until mid-2013, by which time the district had already spent approximately \$73 million of the \$85 million in bond proceeds. Although it is unclear exactly what prompted the district to begin providing this information to the committee, board meeting minutes from September and October 2012 show that a member of the committee twice expressed that it was not receiving the financial information it had requested from the district. According to the minutes for the committee's July 2013 meeting, the CEO asked the committee what information it would like to have presented at each meeting. The committee requested expenditure reports, among other items, and the CEO directed the director of construction to provide the information for each meeting going forward. Subsequent to this meeting, the committee began reviewing summaries of expenditure information categorized by month and by vendor. These monthly expenditure summaries were beneficial because they improved the committee's understanding of how much was spent per vendor. However, the district should also have required the committee to review expenditure details or a staff analysis of those expenditures to allow it to verify them and thus increase its ability to report quarterly to the board about whether expenditures were allowable.

Further, the committee did not consistently report to the board quarterly. Board meeting minutes show that the committee did report quarterly to the board in 2007 and 2013, but the minutes do not reflect any reports from it in 2008 through 2011 and reflect reports that are less frequent than quarterly in 2012 and 2014. Current district staff could not explain why the committee did not report quarterly to the board as required. Although we question whether the committee could have provided insightful reports to the board without consistently reviewing expenditure details, nonetheless the district should have ensured that the committee was reporting as frequently as was required. In failing to do so, the district was not maximizing its efforts to ensure that it was spending bond proceeds exclusively on allowable activities.

Finally, the district did not ensure that it consistently implemented all recommendations made by the external auditors reviewing the district's use of bond proceeds. The district obtained four independent reviews of the bond expenditures over several years, as shown in Table 4. The first audit report, which covered the district's spending of the first \$16 million in bond proceeds, did not identify any findings, but in each of the other three reports, covering the remaining \$70 million, the external auditors identified

concerns related to compliance with obtaining appropriate approvals. The reports also identified that the district had spent some bond proceeds on items that it should not have, although the amount represented a small percentage of the total bond proceeds. Nonetheless, the district did not always ensure that it addressed the findings and recommendations in the reports.

Table 4
The District’s Bond Expenditures Were Independently Reviewed

REPORT ISSUED	DATE OF EXPENDITURES REVIEWED	AMOUNT REVIEWED* (IN MILLIONS)
February 2010	October 2005–November 2009	\$15.6
June 2011	November 2009–March 2011	19.3
June 2013	April 2011–December 2012	35.7
December 2015	January 2013–December 2014	†

Source: Independent Accountants’ Report on Compliance reports.

* Amounts reviewed include interest earned on bond proceeds.

† This report does not specify the total expenditures reviewed; it specifies review of expenditures for January 2013 through December 2014 and notes that bond proceeds were fully exhausted in September 2014. However, in a January 2013 board meeting, the district’s controller stated that the remaining bond proceeds totaled \$15.8 million.

Specifically, the second report identified invoices totaling \$350,000 for items such as medical center refurbishments that the district should not have paid for with bond proceeds. Although the audit report recommended that the district reimburse the bond fund account for these expenditures, our review of related board and committee meeting minutes did not uncover any discussion regarding addressing that recommendation. Also, for the fourth report, the auditors identified expenditures totaling \$31,500 that were unrelated to the bonds or did not have support. When we spoke to the district’s former controller, he confirmed that the district had not reimbursed its bond proceeds for the unrelated expenditures identified in the second audit report but did not indicate a reason for not doing so. For the fourth report, he stated that the district did not reimburse the bond proceeds because there were other construction expenditures eligible for bond proceeds that had been paid with other funds. We also expected the district to have a written process to address audit findings and recommendations and to document its actions. However, we did not identify any procedures. When the district does not take steps to ensure that it has addressed audit findings, the problems identified in the reports can go uncorrected and bond proceeds may be spent for unallowable purposes.

Recommendations

To ensure that it uses bond proceeds for allowable purposes and improves its consistency and accountability in processing payments from bond proceeds, by April 2019 the district should formalize and document policies and procedures for verifying that it uses bond proceeds for allowable purposes and for approving expenditures paid from general obligation bond proceeds.

To ensure that it maintains adequate oversight of expenditures from any future bond proceeds, by April 2019 the district should establish a formal policy to include, as part of the charter for any future bond oversight committee, a requirement that the committee review bond expenditures quarterly at a minimum. The policy should also require the committee to report the results of its reviews to the board quarterly.

To ensure that any future bond oversight committee meets specified reporting requirements, by April 2019 the district should establish a written process to periodically monitor committee compliance with reporting requirements.

To increase the effectiveness of its monitoring to ensure that bond proceeds are used only for the purposes that the voters intended, by April 2019 the district should establish and follow a written process to document the steps it will take to address findings and recommendations identified in any future external audits of the bond proceeds.

To ensure that it can demonstrate that invoices it pays are for contracted services, by April 2019 the district should update its contract management policy to include a requirement to retain a copy of all contracts similar to the State's requirement of seven years.

We conducted this audit under the authority vested in the California State Auditor by section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
California State Auditor

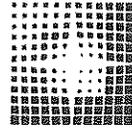
Date: October 9, 2018

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

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Tulare Regional Medical Center

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September 20, 2018

Ms. Elaine M. Howle, CPA*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

RE: Tulare Regional Medical Center Special Legislative Audit

Dear Ms. Howle:

In behalf of the Tulare Local Health Care District Board of Directors, the Board and Management of Tulare Regional Medical Center is submitting our response to your draft report received on September 14, 2018. We appreciate the opportunity to provide response to this draft as this document was discussed at the Board's Special District Board meeting last night, September 19, 2018. We have taken extraordinary steps to secure this draft without any unauthorized review taking place.

First, we wish to thank Supervisor Rick Power for his professional approach to this very challenging project. We realize that many pressures exist from many different sources and Rick kept his team focused and centered. Second, the Board, management, and the Board's legal counsel are very concerned with your team's effort regarding Chapter 2 of the Report. While we understand that your agency has been given the responsibility to assess the processes of reopening the hospital, we are aghast at some of the conclusions and tone of this chapter. While it is not our responsibility to worry about the integrity of your report, major concern is present as to the capability and capacity of your team analyzing a hospital process that is being executed by a health system and professionals that have been performing this function for many years. Many of the conclusions presented in Chapter 2 defy the audit principles that in our thinking is the basis of accurate auditing. Arriving at conclusions at a specific period of time is fine but to assume without any factual basis or understanding of hospital preparedness that the processes that are on-going will not effectuate opening is unconscionable and is misleading to the public.

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* California State Auditor's comments begin on page 55.



Tulare Regional Medical Center

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- ③ Please consider our concerns in the attached Response. It appears to our Team that
① addressing this issue in Chapter 2 based on the evaluation of a specific period of time and a
simple sentence that identifies that this process is ongoing and will be evaluated by CDPH
would be factual and understandable. To conclude that the reopening is “uncertain”
without any factual evidence, is unacceptable to our thinking and practice.

Thank you for your team’s effort and the opportunity to provide our thoughts. Please
contact me if you have any questions.

Sincerely Yours,


Larry A. Blitz
Interim CEO

Response to the Special Legislative Audit Report (9/14/'18)

Summary

- PP. 4 – 1st Paragraph – “Nevertheless, the district faces licensing issues that make it unclear whether the District will be able to reopen as currently scheduled.” (4)

Every hospital or healthcare facility that files for opening under Federal and State regulations, faces licensing issues. The numerous list of regulations governing licensure attempts to ensure that each health care entity conforms to programmatic and safety standards that are compliant with high quality. It is never totally “clear” that standards are met until the licensing survey. The combination of Adventist Health with over 20 hospitals in good standing with Federal and State regulations and Wipfli’s over 40 years of providing management and consulting services to the California Health Industry provides a credible experienced approach to ensuring that TRMC will meet such standards. An ongoing dialogue with CDPH that is maintained by both AH and Wipfli is not designed to meet special audit requirements. The State Legislative Audit Team is unfamiliar with day-to-day hospital operations and its business realities. “Unclear” represents a lack of understanding of hospital protocol and operations. (5) (6) (1)

- Pp. 4 – 2nd Paragraph – “the interim management consultant has not included in its budget for reopening the payment of pre-petition debt.” *It would be impossible at this point to include pre-petition debt as part of the budget as the Bankruptcy Court will decide this debt far into 2019. This debt would become part of the District’s ongoing obligations after the opening. In regards to PP. 38securing necessary vendors, each vendor necessary to supply services to reopen is either settled or in ongoing negotiations. At this point in time, all services necessary for to reopen the hospital will be present. Auditing usually represents an evaluation of what has happened in the past. Ongoing discussions and negotiations are also an important component of the Team’s daily routine. To infer that delays are possible due to pre-petition moneys owed is a false prophesy based on uninformed subjectivity.* (4) (7) (4) (7)

- PP. 4 – 3rd Paragraph – “Without an extension in place before its temporary suspension expires in October 2018, the District risks incurring additional costs required to meet current building standards if it has the apply for new license. These additional costs could further compromise its ability to reopen the medical center.” *During a telephone meeting with CDPH officials from Sacramento, such officials recommended not to extend unless needed. If needed, a 24 hour turnaround would be realized. For example, if a construction project* (4) (8)

- ⑨ *requires more time than previously anticipated, a simple notice to CDPH will extend the license. Also, the Board does not choose to extend the license unless a situation like the above occurs due to political reasons which are also not auditable. Your team has spent an inordinate amount of time on this issue which is beyond our understanding. AH, Wipfli and the Board are bewildered why this has become a focus of your team. Totally in control of this issue.*
- ④ • *PP 38 – “it is not clear whether all requirements to reopen by then.” Reopening is an on-going action plan. AH and Wipfli have 8-10 meetings per day making progress and ensuring that opening will be actualized. While it is always possible that the survey teams may discover issues, it is AH and Wipfli’s expertise that minimizes the chance that issues may occur. Much of the work ongoing is verbal and cannot be audited. Much hospital work is orally conveyed to another worker – some of which is duly documented. It is impossible for an audit team to discover a methodology that can find assurance that survey results will be compliant. To insinuate that because the audit team does not possess this information is simply not realistic in regarding to not having reopening information and - leads our Team to believe that your audit team does not understand the dynamics of hospital compliance and operations.*

⑪ *The District included all of the known costs to reestablish relationships with vendors at the time of submitting such information to the audit team. Each week based on need our team vendors may be identified as to particular issues with credit and shipping. At this point, no known supplies are being withheld due to vendor issues.*

⑧ *The extension issue was discussed above.*

④ *pp. 39 1st paragraph – The Auditor’s comments regarding this paragraph neglects the important fact that at this reading, the hospital is not open, supplies are being purchased and stocked, and a comprehensive plan that evidentially the Auditors do not understand is being exercised with no barriers to opening present. The State Legislative Auditors are attempting to analyze our Team’s efforts in reopening the hospital without management and operation knowledge of hospitals and procedures that are comprehensive and complete. Your team is not at our planning meetings and to assume that because you do not have an audit sheet that in your format provides you with desired answers that our team is not performing is very troubling. The District considers equipment issues every day as equipment is a necessary component of reopening and patient care. To assume that this is not the case is insulting and leads us to believe that the our*

work needs to be designed solely for an audit. Our work is designed to accomplish action plans and is constructed to do so in many different actions.

Paragraph 2 PP. 39 – 40 - *Again, our Team’s process designed for reopening is not constructed as an auditable exercise. We are confident of proven successful processes that will ensure reopening at our desired date. What the Audit does not take into consideration is that this very expedited process to reopen is an ongoing process that may take us up to a few days before the opening. There are thousands of issues that are successfully being handled and it is very troubling that this part of the audit concentrates on processes that are unfamiliar to those who are not a part of our staff. All of the Pharmacy challenges are resolved and reported. Under what experience does the audit team have the right or knowledge to presume that these tasks will not be completed. In addition, if certain tasks are not completed, the Hospital Team will quickly correct and if needed, extend the license until resolution is complete. The implication provided in this report subjective conclusions without the necessary information to arrive at these conclusions. Your team is warning that we may have too many hurdles to clear. This conclusion is without any substantive basis.*

This report is written at a certain time that would discover that all that is necessary tasks needed to be completed are in progress. It is unconscioable that a conclusion can be made that the required tasks will not be concluded. What is the informed basis for this conclusion? This in our view is unsubstiated uniformed conclusions that present very misleading information. We do not believe that is an audit role. especially when the audit team does not have the experience to evaluate this reopening function.

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE TULARE LOCAL HEALTHCARE DISTRICT

To provide clarity and perspective, we are commenting on the district's response to the audit. The numbers below correspond to the numbers we have placed in the margin of its response.

In several of its comments, the district questions our capability and experience to evaluate its processes, and the integrity of our conclusions in Chapter 2. We conducted this audit in accordance with generally accepted government auditing standards. These standards require that we obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions. Therefore, we stand by our conclusions.

①

The district is mischaracterizing our conclusions. We do not state that its processes will not effectuate opening. On pages 35 through 38, we state that the district is making progress in its effort to reopen but note that the district did not have a comprehensive plan, and we describe our concerns with its progress and ability to meet its planned reopening by mid-October 2018.

②

The district's statement that we conclude that the reopening is "uncertain" is taken out of context. We state that it is uncertain if the district will reopen the medical center by mid-October 2018 as it plans.

③

The district's response uses page number references from a draft copy of our report. Since we provided the district the draft copy, page numbers have shifted.

④

In its response, the district refers to Adventist Health System (Adventist) and Wipfli LLP (Wipfli). Adventist is the district's new manager, which it contracted with in early September 2018 to manage the medical center. Wipfli is the interim management consultant the district contracted with in November 2017 to assist in reopening the medical center.

⑤

We do not know what the district means by "special audit requirements." We had numerous discussions with district staff and interim management beginning in spring 2018 regarding its plans for reopening, in which we asked for any documentation that would demonstrate its plans for reopening.

⑥

We are unclear why the district believes it is impossible to include pre-petition debt as part of the budget. The district could include an estimate for each of the vendors it has identified as necessary

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based on the amounts it owes to them. As we discuss on page 39, the district's documentation shows that it has not yet established contracts with more than 100 vendors that are necessary for the medical center to reopen, and those vendors are owed \$1.1 million in pre-petition debt. If the district has not yet determined whether these vendors require payment of pre-petition debt, it would be prudent for the district to include an estimate of such debt in the event that the vendors require payment. The district also contends that all services necessary to reopen the hospital will be present, but as mentioned above, the district's documentation does not support that it has contracts with the vendors who would provide the services. Therefore, we also disagree with the district's assertion that inferring delays are possible is a false prophecy. As we indicate on page 39, the district still has an extensive amount of vendors with which to negotiate contracts and given the limited time remaining before its planned mid-October 2018 reopening date, it may not have the supplies or services necessary to reopen.

- ⑧ The district's disagreement with our recommendation to request an extension of its license suspension is disingenuous. The district's response, dated September 20, 2018, states that the board does not choose to extend the license. However, on October 1, 2018, we learned that the district's interim CEO had sent a letter, dated September 7, 2018, to Public Health requesting an extension of the suspension. Public Health approved the district's request on September 19, 2018. Because these events took place *before* the district provided its response to our audit, we are perplexed as to why the district did not inform us of its request and why it expressed disagreement in its response with our recommendation that it make this request. We are disappointed that the district chose not to be forthright about its request for an extension. Nonetheless, we are pleased that the district obtained the extension, as we had recommended in our draft report to the district, and therefore we removed that recommendation from our final report.
- ⑨ The district's response regarding a situation not being auditable is shortsighted. We reviewed the status of the district's license suspension extension because it is a step that may be necessary to reopen the medical center.
- ⑩ We disagree with the district's assertion that "it is impossible for an audit team to discover a methodology that can find assurance that survey results will be compliant." As we discuss on pages 36 through 38, we reviewed daily meeting documentation provided by the district in late August 2018 and compared it against state and federal regulations to assess the district's progress toward addressing the licensing requirements. The daily meeting documentation indicates some tasks the district has not completed, such as taking an inventory of equipment for many departments.

We based our conclusions on the documentation provided, which indicates that there are still outstanding areas the district must address within the next few weeks if it expects to reopen by mid-October 2018. The district's contention that it is simply not realistic for us to expect that information about the district's efforts to reopen the medical center would be documented is concerning. It is questionable how executive leadership in any organization, let alone a medical center with eight service areas, can have any assurance regarding progress in meeting deadlines for such a major project without written documentation.

The district provided no support for this assertion. In addition, as we state in comment 7 on pages 55 and 56, the district's documentation shows that it still has not contracted with more than 100 vendors it has identified as necessary to reopen the medical center. As we mention in comment 10, the district's daily meeting documentation indicates it is still in the process of taking an inventory of equipment for many of its departments. Therefore, it may not have identified all of the equipment and supplies that it needs. Thus, there may be equipment and supplies the district needs and cannot obtain due to the extensive number of vendors with which it has not yet contracted.

⑪

The district indicates that we do not understand the comprehensive plan it is exercising. However, as we discuss on pages 35 and 36, the district did not have a comprehensive plan for reopening. Rather, the district described its planning as the amount of daily meetings it is conducting and provided daily meeting documentation. We reviewed the documentation provided and discuss our concerns with the information on pages 36 through 38.

⑫

The district's comment regarding an "audit sheet" is incorrect and mischaracterizes our work. We requested any form of documentation demonstrating its efforts to reopen the medical center on numerous occasions and did not limit our requests to a particular format. Further, we do not assume that the district is not considering equipment issues. As we discuss on page 36, the district is taking inventories of equipment. Our concerns with the documentation provided are discussed in our comment 10.

⑬

The district's statements mischaracterize our report conclusions. We do not state that the district will not complete tasks. On page 37, we state that we are concerned that the district may not meet all the requirements to reopen the medical center by mid-October 2018, not whether these requirements will be met or not.

⑭