SPECIAL COMMITTEE REPORTS

Spec. Com. Rep. No. 1

Your Joint Senate-House Investigative Committee established under S.C.R. No. 65, S.D.1, H.D.1, entitled:

"SENATE CONCURRENT RESOLUTION ESTABLISHING A JOINT SENATE-HOUSE INVESTIGATIVE COMMITTEE TO INVESTIGATE THE STATE'S EFFORTS TO COMPLY WITH THE FELIX CONSENT DECREE,"

begs leave to report as follows:

The purpose of the committee was to investigate the State's efforts to comply with the Felix consent decree and submit a report to the Legislature no later than twenty days before the 2002 Regular Session.

Your committee notes that during six months of hearings and intense investigative work, this Committee was troubled by much of what it uncovered about the impact of the Felix consent decree. Despite good intentions and improved services to some children with mental disabilities, the decree resulted in a Pandora's box of unintended consequences. Specifically, your committee notes the following factors:

(1) The unclear requirements for compliance concurrent with departmental exploitation of the court's "money is no object" expectations;

(2) The generally poor oversight and accountability of the two departments responsible for implementing the Felix consent decree and the curtailment of the federal court of oversight by the Legislature; and

(3) The "superpowers" granted to the superintendent of education and the director of health that allowed them to waive the requirements of the state procurement law and to bypass personnel laws.

However, your committee notes that it faced a number of obstacles that prevented it from obtaining full access to records and key individuals, blocking an in-depth investigation of certain matters. The federal court quashed the subpoenas of key individuals appointed by the court to oversee implementation of the Felix consent decree. The DOE and DOH cited federal privacy laws to deny the Committee access to files. Despite the Committee's respect for privacy protections and assurances that the identities of the students could be redacted or substituted with non-descript numbers, access was continually denied. The Committee emphasizes that the scope of the inquiry was aimed at the service and provider, not at the student. Access to files to determine effectiveness of services will be a central issue should the work of the Committee continue.

Your committee presents its conclusions and recommendations in the attached report.

Signed by Representative Scott Saiki, Co-Chair.
Signed by Senator Colleen Hanabusa, Co-Chair.

Members appointed pursuant to S.C.R. No. 65, S.D. 1, H.D. 1 by the presiding officer of the respective Chamber:
Representatives Ito, Kawakami, B. Oshiro, Leong and Marumoto.
Senators Buen, Kokubun, Matsuura, Sakamoto and Slom.

Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance With the *Felix* Consent Decree

December 26, 2001

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Chapter 1

Introduction

The *Joint Senate-House Investigative Committee To Investigate the State's Compliance With the* Felix *Consent Decree* presents its conclusions to the Legislature in this report. The Committee was established under Senate Concurrent Resolution No. 65, S.D.1, H.D.1, pursuant to Chapter 21, Hawaii Revised Statutes (HRS), which authorizes the Committee to subpoena records and the attendance of witnesses, and take testimony of witnesses under oath. The Committee held a series of public hearings from June to November 2001. This report contains information obtained from those hearings, related additional work by committee staff, and the Committee's conclusions.

Senator Colleen Hanabusa and Representative Scott Saiki served as co-chairs of the Committee. They presided over the hearings. In addition to the two co-chairs, ten committee members represented both houses of the Legislature. Members from the Senate were Vice-Chair Russell Kokubun and Senators Jan Yagi Buen, David Matsuura, Norman Sakamoto, and Sam Slom. Members from the House of Representatives were Vice-Chair Blake Oshiro and Representatives Ken Ito, Bertha Kawakami, Bertha Leong, and Barbara Marumoto. James Kawashima of Watanabe, Ing, and Kawashima served as Special Counsel to the committee. Law firm staff and staff from the Office of the Auditor assisted the Committee in collecting and analyzing information.

Impetus for the Investigative Committee

The State's educational system and the state budget have been gripped by the *Felix* consent decree since its inception in October 1994. Both legislators and the general public have become concerned about the unclear requirements set by the federal court and exponentially increasing costs. The parents of regular education students have also expressed concerns about the effect of those expenditures on funds available for regular education. The *Felix* consent decree is the outcome of a 1993 lawsuit filed against the State in U.S. District Court on behalf of seven children, their parents (guardians), and mental health advocates. The lawsuit alleged that qualified handicapped children were not receiving the educational and mental health services they needed and that the State was in violation of two federal laws — the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973.

First enacted by Congress in 1975 as the Education for All Handicapped Children Act, the Individuals with Disabilities Education Act (IDEA) requires states to provide children with disabilities a "free and appropriate education" that emphasizes special education and related services to meet their unique needs. The IDEA applies to students with the following disabling conditions: autism, deaf-blindness, deafness, emotional impairment, hearing loss, learning impairment, mental retardation, orthopedic impairment, other health impairment, speech or language impairment or both, traumatic brain injury, severe multiple impairments, specific learning disabilities, or visual impairment.

Section 504 of the Rehabilitation Act of 1973 (Section 504) applies to children in regular and special education programs that receive federal funding. It stipulates that a qualified person with a disability cannot be excluded from any program receiving federal financial assistance. Section 504 covers a much broader category of students who may have a physical or mental impairment. Physical or mental impairment includes, but is not limited to the following: infectious diseases such as HIV or AIDS, tuberculosis, and Hepatitis B; medical conditions such as juvenile rheumatoid arthritis, chronic asthma, severe allergies, epilepsy, heart disease and cancer; drug addiction; alcohol addiction; attention deficit

disorder or attention deficit with hyperactivity disorder; and mental or psychological disorders such as depression, school phobia, and post-traumatic stress disorder.

The *Felix* lawsuit was patterned after those that had met with success on the mainland with one significant difference. Because Hawaii's school system is the only statewide system in the country, the State is accountable for its most rural and most isolated communities. In essence, this makes the *Felix* consent decree more far-reaching and difficult to comply with.

The federal court granted summary judgment against the State and in favor of the *Felix* plaintiffs on liability. This gave the *Felix* plaintiffs considerable leverage and threatened the State's control over Hawaii's statewide school system. Rather than face a federal takeover or be placed into receivership, the State entered into the consent decree, where it waived all rights to appeal and agreed to fully implement a statewide system of care by June 30, 2000. The State agreed to the consent decree in an attempt to preserve its autonomy and maintain control in the design and implementation of a system of care.

In May 2000, the federal court found the State in contempt for failing to comply with the consent decree and threatened the State with a federal takeover. However, the federal court gave the State a reprieve and set up 56 specific benchmarks for it to meet. For example, all school complexes were to receive "recommendations for compliance" status from the court monitor by October 31, 2001. The federal court ultimately gave the State a final deadline of March 31, 2002, when it must meet all 56 benchmarks or face federal receivership of the educational system.

To meet these benchmarks, the federal court granted the superintendent of education and the director of health extraordinary powers. These so-called "super powers" were issued by the federal court on June 27, 2000, and authorized the two department heads to waive the state procurement laws (Chapters 103D, HRS and 103F), which required that services be purchased by competitive bidding. The federal court's grant of superpowers also permitted department heads to bypass state collective bargaining laws and to pay newly recruited teachers far more than those who were already working for the State. There was even an interpretation of the superpowers that the Board of Education had no role in oversight. The federal court expects all benchmarks to be met without consideration of cost.

Even prior to the granting of extraordinary powers, the Department of Health (DOH) and Department of Education (DOE) had demanded large amounts of funding for *Felix*, claiming that they were needed to meet the requirements of the *Felix* consent decree. Since FY1994-95, expenditures have increased from $181,071,352 to $301,863,705 in FY1999-00, and the number of children in the *Felix* class has grown from an estimated 2,894 to 11,842 in FY1999-00.

The Legislature grew increasingly concerned with the rising *Felix* costs. It requested the State Auditor to review expenditures and factors related to the increasing cost. The State Auditor issued an assessment in 1998 (*Assessment of the State's Efforts Related to the* Felix *Consent Decree,* Report No. 98-20) and a consultant's follow-up report in 2001 (*Follow-Up Review of the State's Efforts to Comply with the* Felix *Consent Decree).* The DOH and DOE disputed the findings in both reports.

The 1998 Auditor's report found that the State's failure to ensure that the *Felix* consent decree requirements were clear, made the goal of compliance a moving target. Additionally, the State did not clearly and accurately identify funding related to the consent decree. Furthermore, the State's efforts to comply with the *Felix* consent decree were characterized by a lack of leadership, resulting in inefficient delivery of educationally related mental health services.

In response to these findings, the Legislature took steps to establish better accounting of the monies that it appropriated for the *Felix* consent decree. Starting in 1999, the Legislature created a new budget program designation, EDN 150, Comprehensive School Support Services, which it thought would correct unclear and inaccurate identification of funding related to the consent decree. In the same year, Act 91, Session Laws of Hawaii (SLH) 1999, required the DOE to submit a detailed report to both 2000 and 2001 legislative sessions on EDN 150 allocations and expenditures for special education, the decree, and comprehensive student support services. Act 91 also required the DOE and DOH to develop procedures to transfer the delivery of mental health services from the DOH to the DOE.

Despite legislative efforts to clarify the reporting of *Felix*-related expenditures, problems remained. In the Auditor's 2001 follow-up report, consultants from the University of Pennsylvania found that *Felix*-related costs and services continued to be inconsistently reported. The DOE continued to combine *Felix*-related administrative and service costs with other special education costs. The DOH combined costs for compliance with costs for the delivery of services and combined costs for new and experimental services such as Multisystemic Therapy with costs for traditional mental health services. The consultants concluded that it was impossible to determine the cost of core and essential services versus the cost of new, experimental, and non-essential services.

Both the DOE and DOH would blame the Legislature for not giving them enough money whenever the State received a setback in federal court. The DOE and DOH felt that the more money put into *Felix* the greater their chances of achieving compliance. The Legislature suspected the departments were not making the best use of the funding they had received. "The *Felix* consent decree had become a blank check or black hole," became the common legislative perception. However, the federal court repeatedly threatened federal takeover and the Legislature was told not to question, but simply to find more funds for *Felix*. And while the Legislature did provide such funding, questions have surfaced as to whether there is a surplus of the emergency funds, emphasizing whether the requests were truly exigent in nature.

This conflict led to the creation of the Joint Senate-House Investigative Committee. The Legislature noted that it had relied on the State Auditor to monitor the expenditure of state funds for the *Felix* consent decree on its behalf. However, parties involved in the decree did not cooperate and refused access to certain key information. The Legislature concluded that an investigative setting was the only way it could get its questions answered.

Focus of the Investigative Committee

Senate Concurrent Resolution No. 65, S.D. 1, H.D. 1 called for the Committee's investigation to include:

- A review of the recommendations and implementation of the findings of the 1998 and 2001 *Felix* consent decree reports issued by the Office of the Auditor.

- An assessment of changes that resulted from Act 91, SLH 1999 – the act that shifted fiscal and decision-making authority and accountability from a primarily off campus, medically-based service delivery system to a primarily education-based service delivery system focused on providing services in classroom environments.

- A consideration of how best to transition from a special education service delivery system based on compliance to a more permanent one that is cost-effective, efficient, based on measures and outcomes, and compliant with IDEA and Section 504.

- An examination of federal and other sources of funding for special education in the public school system of Hawaii.

The Committee reviewed the above issues, but its short time frame forced it to focus on three areas. These areas were the possible misidentification of *Felix* class members, questionable *Felix*-related expenditures, and potential conflicts of interest by individuals and entities involved with the consent decree. As will be discussed later, the Committee was unable to properly investigate the misidentification issue in large part because committee staff was denied access to client files. The Department of the Attorney General cited several federal laws, including the Family Educational Rights and Privacy Act or FERPA, to prevent access. Nevertheless, the Committee uncovered much information related to questionable *Felix*-related expenditures and potential conflicts of interest.

Rules of the Investigative Committee

The Committee adopted rules of procedure in accordance with Chapter 21, HRS and SCR 65, S.D. 1, H.D.1. In summary, the proceedings were conducted in a formal setting. Subpoenas were served and witnesses were given ten days' notice to appear. Unlike other hearings of the Legislature, only those subpoenaed or invited by the Committee testified. Members of the public were not allowed to testify.

Witnesses were questioned under oath. They were allowed to bring an attorney, and a court reporter recorded the proceedings. The Clerk of the House of Representatives served as the official repository of the committee's records. The proceedings were open to the public, unless it was necessary for the committee to meet in executive session to confer with counsel. Olelo, the community access station, telecast most of the hearings live; some hearings were shown on a delayed basis. The written transcripts of the proceedings were placed on the Internet.

Appendix A lists the dates of the hearings, the witnesses, and the subject of their testimony.

Obstacles

The Committee was faced with a number of obstacles that prevented it from obtaining full access to records and key individuals, blocking an in-depth investigation of certain matters. The federal court quashed the subpoenas of Court Monitor Ivor Groves; the administrator of the Felix Monitoring Project, Juanita Iwamoto; and Judith Schrag, who was a member of the Technical Assistance Panel, a court-mandated entity.

The DOE and DOH cited federal laws, such as the Family Education Rights and Privacy Act (FERPA) to deny the Committee's access to files. Private providers of mental health services also denied access to files for allegedly the same reason. However, it is important to note the Committee recognizes the need for privacy protections. It provided several assurances that the identities of the students could be redacted or substituted with non-descript numbers. The scope of the inquiry was aimed at the service and provider, not at the student. Despite its attempts to make accommodations, access was continually denied.

Without this access, committee staff were hampered in their efforts to tie allegations of questionable billings to the services ordered for each student. Nor could staff verify whether the State was being accurately billed for services for specific clients at specific times. Moreover, the DOE and DOH

responded to requests on *Felix* expenditures by saying that several months would be required to produce some of the required information.

Many people were reluctant to publicly share information on specific incidences of abuse and waste for fear of possible retaliation. The Committee received reports of threats to witnesses and potential testifiers. The Committee gratefully acknowledges those who came forward with their concerns despite this climate of fear.

Despite obstructions, the Committee was able to review some matters in detail. Conclusions and recommendations related to these issues are presented in the following chapter.

Chapter 2

Conclusions

During six months of hearings and intense investigative work, this Committee was troubled by much of what it uncovered about the impact of the *Felix* consent decree. The decree has been a double-edged sword. Despite good intentions and improved services to some children with mental disabilities, the decree has also unleashed a Pandora's box of unintended consequences. The unclear requirements for compliance, the extraordinary powers granted by the federal court to certain administrators without any apparent oversight, and the court's curtailment of the Legislature's access to information have exacerbated troubled governmental programs already mired in fiscal mismanagement.

The Committee heard testimony about apparent conflicts of interest, profiteering, and wasteful spending. Such practices erode public confidence in government and erode the morale of those public servants committed to doing a good job. The Committee believes that it is important to bring these practices to light—to understand how and why they occurred and to prevent them in the future.

The Committee has concluded that the implementation of the *Felix* consent decree has been problematic due to several factors. They are:

1. The unclear requirements for compliance concurrent with departmental exploitation of the court's "money is no object" expectations.

2. The generally poor oversight and accountability of the two departments responsible for implementing the *Felix* consent decree and the curtailment by the federal court of oversight by the Legislature.

3. The "superpowers" granted to the superintendent of education and the director of health that allowed them to waive the requirements of the state procurement law and to bypass personnel laws.

We discuss below these three aspects and the environment of waste and profiteering that they fostered.

Problems Stemming from Undefined, Unclear, and Costly *Felix* "Compliance" Requirements

Federal laws have never clearly defined criteria for compliance, leaving the State at the mercy of the federal court. The *Felix* consent decree, issued in October 1994, mandated that the State design and implement a system of care for the *Felix* class by June 30, 2000. The State was also required to maintain specific levels of service and spending. However, a precise definition of compliance was never formally established.

Although it might appear that there are specific benchmarks and objective standards for whether schools are in compliance, many of the requirements were introduced at various times since the decree was issued, and many of the standards are arbitrary. Over the years, this has created a "moving target" that makes it difficult to plan sensibly for accomplishing compliance. The Court Monitor sometimes made unexplained changes in the benchmarks that left the State even more uncertain about its targets.

The State and other parties to the 1993 lawsuit had no clear definitions and measures when the consent decree was issued. Currently, an unproven and untested protocol is used to assess compliance. Compliance measures include "written" and "oral" components, but are without clear explanations of how requirements for the "written" service testing portion are to be met or what would constitute "passing" activity levels or satisfactory performance in the oral presentations made to the court monitor and the plaintiffs' attorneys. The lack of clarity relating to compliance could extend the life of the decree indefinitely.

Compliance measures appear arbitrary and unscientific

The primary measure used to determine whether or not services have been adequate, i.e., whether the State is in compliance, is called "service testing." Court Monitor Ivor Groves and his business partner, Ray Foster, under their company Human Systems and Outcomes, Inc., designed the measure. Service testing consists of a qualitative measure (similar to a case study) that was developed during the initial stages of the consent decree. The tool had not been previously used, and in fact, had to be refined and structured with significant input from DOE administrators. Copyrighted in 1998 by Human Systems and Outcomes, Inc., the service testing instrument is comprised of two protocols: the *School-Based Services Review* for those with less intensive needs and the *Coordinated Services Review*, which is used to measure results and performance for those *Felix* class members with more intensive needs or complex life situations.

The *School-Based Services Review* is defined as a "Case-Based Protocol of School-Based Services Provided for Students with Special Needs." The review measures short-term results for children with special needs and those who provide services to these children. These results are intended for use by student services teams to improve "front-line practices." The protocol asks the reviewer to first assess the case on the basis of level of functioning on a scale of 1 to 10, with "1" as needing constant supervision and "10" as superior functioning. The reviewer's scores are based on status and service examinations, which include school attendance and learning progress. This information is then presented in report outline form under such headings as "Characteristics of the Student and Family," "School-Based Services Involvement," and "Suggestions for Improvement."

The *Coordinated Services Review* is a more detailed review. It uses a "spot-checking method" for "appraising the current status of persons receiving combinations of public services (e.g., special education, behavioral health, child protection/foster care, juvenile justice, vocational rehabilitation services)." This instrument also looks at short-term results for children with special needs and those providing services to them. This particular protocol states that it is used for "monitoring *Felix* class members and tracking improvements in local interagency practices." The *Coordinated Services Review* uses narratives, rather than outlines, to tell the story of the child's background and his family situation. Narrative headings include family situation, school situation, involvement with other child-serving agencies, and other special factors or circumstances. Also, an appraisal is made of system performance covering such areas as "What's Working" and "Practical Steps to Overcome Problems."

Each school complex (a high school and its feeder schools) must pass with an 85 percent score on both the School-Based Services Review and the Coordinated Services Review. The basis for this 85 percent "passing" score appears arbitrary. A former DOE official testified that at the start of the compliance reviews the passing score was 70 percent, but too many schools were easily meeting that goal, so the bar was raised. Evidently, many schools did not pass once the higher standard was implemented.

After these two protocols were established, Court Monitor Groves, using his administrative office, Felix Monitoring Project Inc., and his private business partner, Ray Foster, trained and hired a number of independent contractors to collect baseline data for service testing. These service testers then reviewed cases supposedly randomly selected by staff of the Felix Monitoring Project, Inc.

Random samples are a prerequisite for statistical inferences. Although the samples are reportedly randomly selected, the results may not be representative of the larger population. On average, the sample sizes for service testing have been 20 students or less. Statistically, these sample sizes would be too small to permit a valid conclusion on compliance, as sampling bias might influence the results. Also, a disproportionate number of autism cases were included in the samples. This overrepresentation may be an indication that sample selection was not random but biased toward such cases. The committee could not verify the validity of the sample selection because the subpoenas quashed by the federal court prohibited access to case files by committee staff.

Given the numerical target of an 85 percent passing score and the use of a random sample, the general public might be led to believe that the results are somehow "scientific." However, even Court Monitor Dr. Groves and his partner, Dr. Foster, acknowledge that the service testing protocols were not developed with psychometric properties, that is, the protocols were not tested for reliability and validity as standardized testing measures should be. Furthermore, they stress that the protocol supports a "professional appraisal" of child status and service system performance at a given point in time and the instrument should not be used without proper training and supervision.

Meaning of compliance differs

Dr. Douglas Houck, DOE's Director of Program Support and Development, testified to the Committee that, in his estimation, the State, overall, was in compliance. Dr. Houck, in a memo dated July 20, 2001, to the superintendent, stated the following:

> The fifteen (15) complexes tested during the 2001 calendar year achieved an overall score of 87% on school-based services and 85% on Coordinated Services. This indicates that the State has now achieved overall substantial compliance with the principles and standards established by the Consent Decree. The Monitor previously established the 85% score as his criteria for meeting substantial compliance. We also need to keep in mind that the Consent Decree speaks only in general terms regarding State wide compliance. It does not address the matter of achieving compliance on a complex-by-complex basis.[1]

When this was brought to the attention of the plaintiffs' attorneys during a federal court hearing in August 2001, they vehemently argued that compliance was supposed to be by individual complex, regardless of whether the State, as a whole, had essentially met the requirements of the consent decree.

School complexes are unclear about compliance

School complexes are unclear about how to "pass" compliance testing. The DOE has issued two main guidelines, but they are inadequate. The first is a one-page document labeled: "Achieving Compliance with Service Testing: Eleven Essential Elements." The document primarily reminds schools to keep accurate and up-to-date files and records to ensure efficient processing of paperwork and provision of services. The second, more detailed document, the product of a collaboration with DOH, is the "Procedural Manual for Service Testing Reviews." It provides a planning guide to prepare for the different steps involved in a compliance presentation review.

In addition, DOE and DOH staff offer basic training on the service testing protocol. Preparation for service testing and compliance presentations is informal and voluntary. For compliance presentations, DOE staff is available to meet with schools and provide informal advice during practice sessions. Even with the training and the internal guidelines, schools reported that they were unsure about how to pass compliance.

Furthermore, the DOE has spent $2.3 million on targeted technical assistance for those schools facing the most difficulty in passing compliance. However, even today, with compliance appearing more likely, the extent of assistance provided by this program is not demonstrated and is speculative.

Compliance is a moving target

The entire issue of compliance has been a problem from the beginning of the consent decree. The monitor's standards for compliance have changed constantly with the addition of new initiatives, such as reading assessments, which appear to go beyond the requirements of the decree, according to DOE officials who served as point persons for *Felix*.

Currently, Court Monitor Groves distinguishes three levels of compliance. He awards *Partial compliance* when a school complex is able to reach a passing score (85 percent) on only one of the two service testing protocols. He awards *Provisional compliance* when a school complex has passing scores on both protocols, but has yet to schedule a compliance presentation to him and the plaintiff attorneys. *Full compliance* is awarded when the monitor makes a recommendation to the federal court that the complex has demonstrated its compliance with the Individuals with Disabilities Education Act and the consent decree. As of November 1, 2001, 20 of 41 school complexes are in full compliance, eight complexes are in provisional compliance, three are in partial compliance, and the remaining 10 are not in compliance.

The DOE and DOH exploit the "money is no object" expectations

The federal court has made it clear that compliance is necessary without regard to cost. This, together with the unclear requirements of the consent decree, made it inevitable that the costs of compliance would escalate. The DOE's expenditures for *Felix* grew from $77.5 million in 1994 to $179.8 million in 2001, an increase of 132 percent. The DOH's general fund expenditures for *Felix* grew from $48 million in 1995 to $148.2 million in 2001, an increase of 209 percent. Since 1994, the State has spent almost **$1.5 billion** on *Felix* related programs. Even so, these numbers are understated. They do not include federal funds expended by DOH and expenditures by other agencies, such as the costs for attorneys' fees by the Department of the Attorney General and *Felix* costs for the Department of Human Services.

The Committee finds most disturbing the fact that no one knows how much *Felix* is costing the State. Neither the DOE nor DOH has held itself accountable for using public monies in a responsible and prudent manner. They are unable to accurately identify the costs of *Felix*.

Exhibits 2.1 and 2.2 show the information provided by the DOE and DOH on *Felix* expenditures, respectively.

In FY2000-01, DOE and DOH reported total *Felix* costs of $328 million. The DOH provided only general fund information of $148.2 million while the DOE reported expenditures of $179.8 million from all sources of funding. The DOH claimed that information on non-general fund *Felix* expenditures was not readily available. In addition to the missing non-general fund information from DOH, the DOE may not have included all *Felix*-related costs since it claims that it could not accurately separate *Felix* costs from non-*Felix* special education costs.

Exhibit 2.1 Estimated DOE *Felix* Expenditures by Source of Funding for FY1993-94 to FY2000-01

	1994	1995	1996	1997	1998	1999	2000	2001	TOTAL
General Fund	71,468,776	75,849,984	76,593,555	79,591,409	92,050,860	104,162,667	129,122,624	160,618,775	789,458,650
Other Funds	6,005,410	7,702,779	7,351,428	8,047,446	10,633,527	12,788,898	19,413,448	19,146,885	91,089,821
Total *Felix* expenditures	77,474,186	83,552,763	83,944,983	87,638,855	102,684,387	116,951,565	148,536,072	179,765,660	880,548,471
Percent increase from prior year		7.85%	0.47%	4.40%	17.17%	13.89%	27.01%	21.02%	
Percent increase since 1994		7.85%	8.35%	13.12%	32.54%	50.96%	91.72%	132.03%	

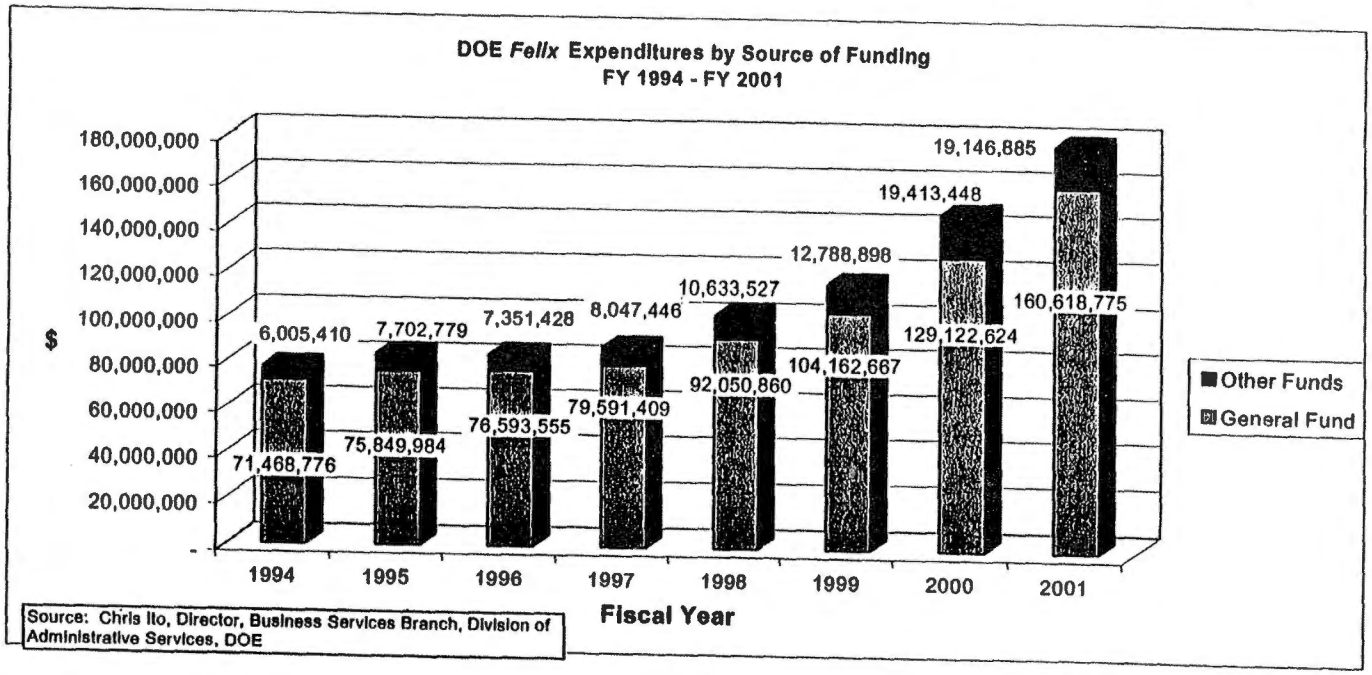
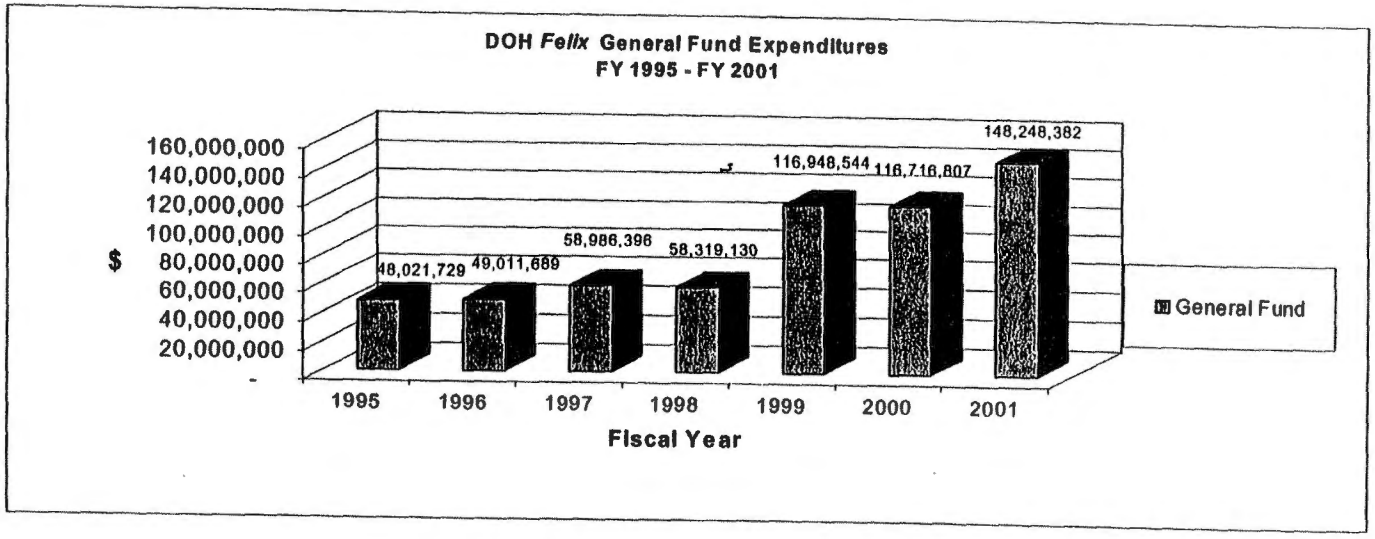


Exhibit 2.2 Estimated DOH *Felix* General Fund Expenditures from FY1994-95 to FY2000-01

Prog ID	Title	1995	1996	1997	1998	1999	2000	2001	TOTAL
HTH 460	Child and Adolescent Mental Health	29,554,797	34,585,260	45,237,143	44,652,576	102,930,932	99,580,600	123,273,302	479,814,610
HTH 495	Behavioral Health Services Administration	1,697,930	2,092,265	3,340,572	3,322,937	3,623,221	4,855,089	5,504,858	24,436,872
HTH 530	Children with Special Health Needs Services	4,766,542	2,849,514	2,571,203	3,227,941	3,194,614	5,122,741	6,978,269	28,710,824
HTH 550	Maternal and Child Health Services	10,935,203	8,305,271	6,746,929	6,030,276	6,098,159	6,070,170	11,403,746	55,679,754
HTH 501	Developmental Disabilities	1,067,257	1,089,379	1,090,549	1,085,400	1,101,618	1,088,207	1,088,207	7,610,617
Total *Felix* general fund expenditures		48,021,729	49,011,689	58,986,396	58,319,130	116,948,544	116,716,807	148,248,382	596,252,677
Percent increase from prior year			2.06%	20.35%	-1.13%	100.53%	-0.20%	27.02%	
Percent increase from 1994			2.06%	22.83%	21.44%	143.53%	143.05%	208.71%	



Source: Valerie Ako, Chief, Administrative Services Office, DOH

Poor cost data reflect poor fiscal management at the DOE

The DOE has long been characterized by a management structure with poor fiscal accountability, leaving the department unable to accurately assess its needs. Divisions and programs within the DOE do not communicate with each other. For example, budget and accounting functions do not share information and budget requests are not based on expenditure data. DOE continually miscalculates its budget requests, which has led to unnecessary spending and abundant leftover funds. Yet, the DOE has repeatedly requested emergency appropriations from the Legislature. In turn, the Legislature questions whether appropriations based on inaccurate numbers are really warranted.

Legislators have long been frustrated with the DOE's inability to provide adequate information. In testimony, DOE staff continually deferred questions to others or provided inconclusive information. The information was not responsive to the committee's requests.

It is not only the Legislature that is frustrated, the current and former chairs of the Board of Education testified to the Committee that they too had not received adequate answers from the DOE on fiscal matters. Given DOE's fiscal practices, neither the Legislature nor the Board of Education can determine whether public monies have been spent wisely.

The DOE has inept fiscal management

The DOE's internal auditor reported on the difficulty of compiling simple *Felix*-related financial information when he conducted his fiscal review of the *Felix* Response Plan or FRP. The plan consists of 12 items identified by the department as necessary for meeting the requirements of the decree. The audit was initiated by former Deputy Superintendent Pat Hamamoto to determine whether the funds appropriated for the *Felix* Response Plan were being spent appropriately. This was the first ever internal audit of *Felix* expenditures.

The internal auditor spent the majority of his time simply attempting to compile data into an understandable financial format. He identified 38 separate problems that needed correction, such as improper purchases of equipment and misspent funds. The majority of these problems were due to poor communications within the department, lack of effective fiscal management tools and reports, and a lack of general fiscal oversight. Full circle communication was not evident, as individuals in the field were often not given sufficient opportunity to provide input as to budgetary needs for implementing *Felix* programs, neither did program managers clearly communicate budget objectives to those in the field.

The internal auditor found financial data to be seriously fragmented among units such as budget, personnel, accounting, programs, districts, and schools. Program managers did not readily have the information they needed to manage operations. There was no specific official or unit in the department that analyzed *Felix* Response Plan funds in a budget-to-actual expenditure comparison, to determine variances, obtain explanations, or evaluate performance. The internal auditor recommended that the DOE improve its budget communication process; develop a comprehensive *Felix* financial report that extracts and compiles data from programs, budget, personnel, payroll, accounting, districts and schools in an understandable format; and perform complete, on-going financial analysis and audits of *Felix* Response Plan transactions.

The DOE purchased laptop computers for vacant positions

One blatant example of wasted funds is the DOE's unnecessary purchase of equipment for vacant positions. The DOE had requested funding for laptops for *Felix* student services coordinators and special education teachers. The laptops allegedly would give these staff "additional flexibility." However, the

DOE purchased laptop computers for *all* student services coordinator and special education teacher *positions*, even vacant positions.

A total of 140 laptops were purchased for vacant positions at a cost of $294,000. A number of special education positions will remain vacant due to ordinary staff turnover and to the department's inability to fill all positions. The excess laptop computers are either sitting idle or used for purposes other than compliance with the *Felix* consent decree—the purpose the DOE gave the Legislature when it sought the funding.

The DOE uses budget program EDN 150 to obscure *Felix* and special education costs

To obtain a handle on *Felix* costs, the Legislature created a separate budget program designation, EDN 150, Comprehensive School Support Services. However, the new program designation provides false comfort for the Legislature because the DOE still manages to obscure *Felix*-related costs. Even after the creation of EDN 150, *Felix* costs have still been found in other budget program designations. For example, for FY2000-01, the DOE reported to committee staff that over $100,000 for *Felix*-related expenditures are in EDN 200, which is the program designation for instructional support.

The DOE argues that a special education teacher may be responsible for both *Felix* and non-*Felix* students and calculating a percentage of time spent with the *Felix* child would be nearly impossible. It argues similarly that both *Felix* and non-*Felix* students and related school personnel may use supplies and equipment.

Currently, EDN 150 consists of *Felix* costs, special education costs for non-*Felix* students, and costs related to the education department's school reform effort, Comprehensive Student Support System or CSSS. Combining these three categories under EDN 150 makes it very difficult to separate out *Felix* costs.

The DOE has unspent funds yet asks for more

Due to the dysfunctional management structure and poor fiscal management, the DOE's budget requests are often inaccurate and overestimated. The department is itself unable to reach a consensus on its official numbers.

The committee staff found discrepancies in the amounts of surplus funds, carry over funds, and lapsed funds. The amount of carry over funds reported by the DOE's budget office differed significantly from the information provided by the DOE accounting office. The DOE accounting director, Chris Ito, attributed the surplus differences to reconciling adjustments and timing issues, while the head of DOE's planning, budget, and resource development, Laurel Johnston, stated that there had been internal "quibbling" regarding the accuracy of the numbers. She suggested utilizing the numbers obtained from the accounting office as the "official" numbers.

Each year since the inception of the *Felix* consent decree, the DOE has requested additional funding from the Legislature to comply with the decree. In the 2001 legislative session, the department requested an emergency appropriation for FY2000-01 of $41.3 million. This amount appears to be arbitrary because the DOE later reduced the request to $33.4 million and then reduced it again to $27.9 million.

The Legislature grew more concerned and skeptical at the end of FY2000-01 when the DOE had $62.5 million in surplus funds of which $17.4 million were from EDN 150, which includes *Felix* costs. The DOE retained and carried over $48.2 million from FY2000-01, the same fiscal year that it requested an emergency appropriation for $27.9 million. In addition to the amount it retained, the DOE lapsed or returned $14.3 million to the State.

The Committee believes that the DOE may also be inappropriately increasing the amounts of authorized carry over funds by transferring surplus funds from one budget program category to another. Section 37-41, HRS states that, unless otherwise provided by Section 37-41.5 or any other law, every appropriation remaining unexpended and unencumbered at the close of any fiscal year shall lapse and be returned to the general fund. Section 37-41.5 authorizes the department to carry over funds remaining in budget program identification numbers EDN 100 and EDN 150 to the next fiscal year; however, the department has also transferred surplus funds of $14.3 million from several other program budget identification numbers to EDN 100. By placing surplus funds into EDN 100, the regular education program budget, DOE retains funds that must lapse and become available for other state needs.

In response to legislative inquiries, DOE officials claimed that the large surplus resulted from salary savings from vacant positions. However, the committee's staff found that only 56 percent of the surplus was tied to personal services, while the remaining 44 percent was tied to other current expenses such as supplies, equipment, motor vehicles, and contracted personal services.

DOE misuses excess federal impact aid

The Committee is also concerned that the DOE has mismanaged millions of federal impact aid dollars. The State receives annual reimbursement from the federal government in the form of impact aid funds for federally connected students. The parents of these students are either active duty military or civilians working or living on federal property. The Legislature appropriates impact aid at a specific dollar amount to the department. The impact aid receipts for any given year can vary widely from the appropriation based on such factors as the success of Hawaii's congressional delegation, the actual numbers of federally connected students, and back payments.

Although the number of active duty dependents has been declining and the number of civilian dependents has remained relatively stable since FY1993-94, the amount of federal impact aid received by the State over that period increased from $23,994,289 in FY1993-94 to $37,953,371 in FY2000-01. At the same time, the appropriation amount remained at $19 million until FY1999-00.

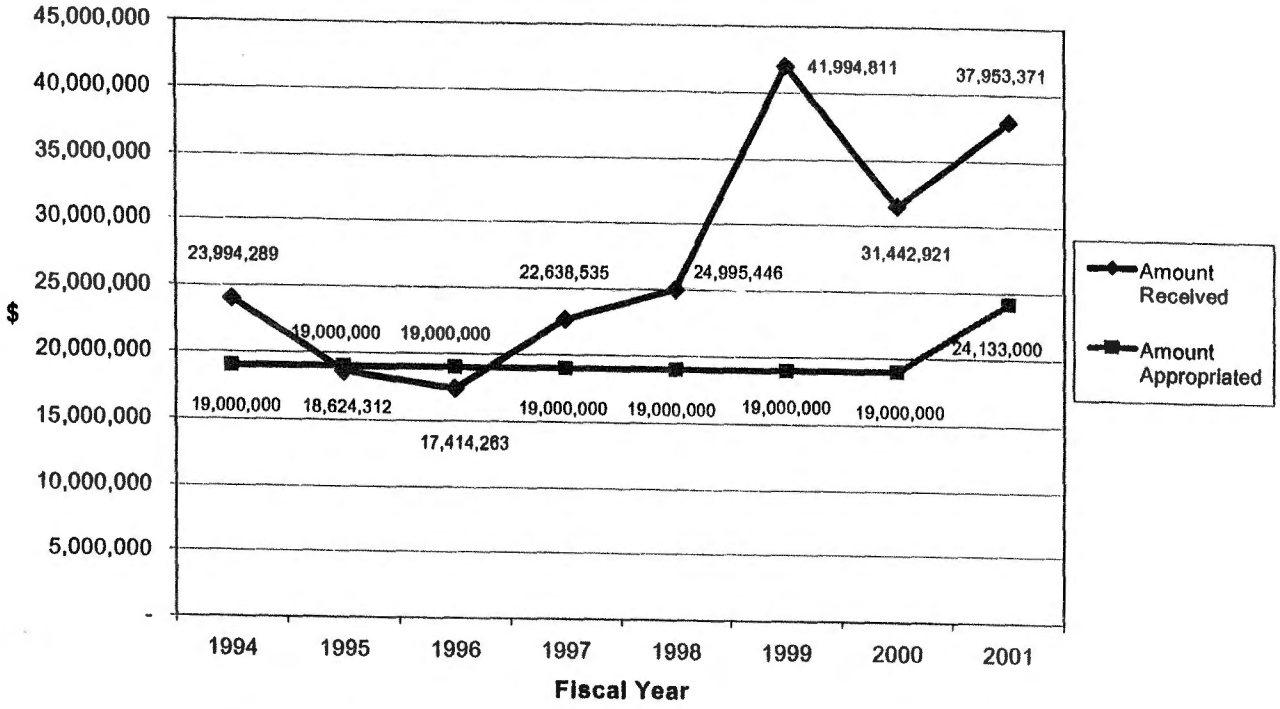
In view of the higher federal reimbursements, the Legislature raised the impact aid appropriation to $24,133,000 in FY2000-01 and to $25,978,520 in FY2001-02. Despite this higher appropriation, the department has been able to retain a total of $26,263,292 ($12,442,921 in FY1999-00 and $13,820,371 in FY2000-01) in surplus impact aid funds. Exhibit 2.3 displays the history of impact aid appropriations and reimbursements from FY1993-94 to FY2000-01.

Prior to July 1, 2000, any federal impact aid reimbursements in excess of the Legislature's appropriation were lapsed and deposited into the general fund to be available to all other state programs. The 2000 Legislature through Act 234, authorized the DOE to retain the excess funds and spend them at its discretion, albeit within certain parameters as discussed below. Prior to Act 234, the DOE lapsed $37,623,081 between FY1993-94 and FY1998-99.

DOE has misused Act 234

The Legislature set out certain parameters in Act 234, SLH 2000 that the DOE has ignored. On June 6, 2000, the governor gave the DOE approval to spend over $12 million in excess impact aid. The law requires the DOE to allocate the excess funds among all program identification numbers, by an amount proportionate to the total general fund appropriation made by the Legislature. However, during a committee hearing, the DOE budget and planning head conceded that the DOE allotted all surplus impact aid received in FY1999-00 into only one budget program identification number – EDN 100. By doing so, the DOE inappropriately allocated *Felix* funding within a non-*Felix* program identification number, confusing the amounts available for *Felix* programs.

Exhibit 2.3 Amount of Federal Impact Aid Received and Amount Appropriated to the DOE, FY1993-94 to FY2000-01



Source: Linda Unten, Budget Specialist, Planning, Budget and Resource Development Office, Office of the Superintendent, DOE

More importantly, EDN 100 comprises approximately 78 percent of the total, overall DOE appropriation, and EDN 150 comprises about 15 percent. But, the *Felix*-related items to be funded by the $12 million in excess impact aid totaled 30 percent. The DOE, in essence, doubled the EDN 150 share of excess impact aid, a flaunting of the proportionality requirement of Act 234.

Furthermore, Act 234 also prohibits the DOE from using excess impact aid to create new programs or expand existing ones. Yet, the DOE used $2.3 million in surplus federal impact aid for "School Based Technical Services Assistance – *Felix*," a targeted technical assistance program. This resulted in a highly controversial targeted technical assistance contract with Pacific Resources for Education and Learning (PREL) and subcontractor Na Laukoa.

This was a new program that was not eligible for federal impact aid. The concept emerged in May 2000 from discussions between Court Monitor Groves and the former superintendent. Moreover, targeted technical assistance was originally to be funded with emergency general funds requested in the 2001 legislative session.

Act 234 has given the DOE full discretion over surplus federal impact aid, eliminating the checks and balances embedded within the State's budgeting process. The larger the difference between the level appropriated and the level received, the greater the risk of mismanagement and lack of accountability. The excess funds create a budgetary cushion for the department. Its use could have negative consequences for the Legislature, such as new programs that the Legislature did not authorize but would have little choice but to continue.

The Committee strongly believes that Act 234, SLH 2000 should be reevaluated.

Problems Stemming From Inadequate Oversight and Accountability

Many of the problems that the Committee uncovered could have been prevented had meaningful oversight been maintained over the DOE and DOH. Oversight and monitoring helps to ensure that officials are responsible and accountable for their actions. The Committee believes that access to better information leads to better oversight and accountability. We found numerous instances of questionable practices, mismanagement, waste and potential fraud that could have been prevented had information about them been made public. Unfortunately, this Committee's work has been obstructed by the federal court and interpretation of federal laws that have curtailed access to the information we need.

In addition, the DOE and DOH cited federal laws, such as the Family Education Rights and Privacy Act (FERPA) for denying access to files. Private providers of mental health services also denied legislative staff access to files for allegedly the same reason. These obstructionist tactics prevented Committee staff from verifying allegations of questionable billings and from verifying whether services the State was billed for had actually been provided to specific clients at specific times. Also, the DOE and DOH told the Committee that it would take several months before they could produce the required information on *Felix* expenditures.

Court curtails legislative oversight

The Committee faced a number of obstacles that prevented it from obtaining full access to records and key individuals, thereby blocking an in-depth investigation of certain matters. The federal court quashed the subpoenas for Court Monitor Groves; for the administrator of the Felix Monitoring Project, Juanita

Iwamoto; and for Judith Schrag, a former member of the Technical Assistance Panel, a court-mandated entity.

The Committee issued subpoenas for Court Monitor Groves and Juanita Iwamoto, an official and employee of the Felix Monitoring Project, to provide testimony on July 13, 2001. The Committee needed information from them on many issues, including:

- The numerous changes made to the testing method used to assess compliance,
- Their use of the Hawaii testing instrument in states other than Hawaii,
- The switch from a private provider model to a school based model for mental health services,
- The compensation and benefits package paid to Court Monitor Groves and Ms. Iwamoto,
- The expenses of the Felix Monitoring Project, and
- Their use of business associates to conduct all expense paid seminars and training sessions in Hawaii.

The plaintiffs' attorneys filed a motion to block the Committee's subpoenas for information. Although the Committee's subpoenas were Hawaii State subpoenas, the plaintiffs' attorneys filed their motion in federal court before the same federal judge who had appointed Court Monitor Groves, and who had approved the salaries and expenses incurred by Dr. Groves, Ms. Iwamoto, and the Felix Monitoring Project.

Court Monitor Groves and Ms. Iwamoto, through their own attorney, also joined in the request to block the disclosure of information and asked the federal judge to quash the subpoenas. They asserted that they were entitled to the same immunity that applied to the federal court and cited authority indicating that their actions could not be discovered "however erroneous the act may have been, and however injurious its consequences may have proved to plaintiff."

Judge Ezra, who had created and has filled the *Felix* Monitor position, and who has presided over the *Felix* v. *Cayetano* litigation, also presided over the motion to block the disclosure of information. He agreed with the position taken by his appointee and the plaintiffs and quashed the subpoenas issued by the Committee. In making his ruling, Judge Ezra stated that he would find in contempt the Committee and the State Auditor if they made any additional requests for information from those whom he had appointed. Judge Ezra also indicated any appeal of his ruling would be unsuccessful because the Committee was not a party to the *Felix* litigation.

The Committee continues to believe that testimony from Court Monitor Groves and other members of the Felix Monitoring Project is essential for examining the impact of the decree and its costs. Although Judge Ezra blocked the Committee's access to information from his appointees, the Committee has persevered and received sworn testimony from other witnesses that question the scientific validity of the testing methodology used by the court appointed monitor. Witnesses also criticized the court monitor's administration of the testing instrument. In addition, the Committee received sworn testimony that the testing instrument developed in Hawaii is being used by Court Monitor Groves in other states.

Approximately two months after the federal court quashed the subpoenas for Court Monitor Groves and Juanita Iwamoto, the Committee issued a subpoena to Judith Schrag. Dr. Schrag was a former member of the *Felix* Technical Assistance Panel. She was also a consultant to the DOE as well as to Court Monitor Groves. In a separate case involving DOE officials, Dr. Schrag had testified about her work with the DOE and the requirements set by Court Monitor Groves. The Committee needed information from Dr. Schrag on such matters as her role as a consultant to the DOE, her relationship with private companies that had contracts with the DOE, her compensation and benefits, and her collaborations with Court Monitor Groves and others. Shortly after she received the subpoena, Dr. Schrag requested a change in the date and time of her appearance before the Committee. The Committee agreed.

Prior to the scheduled appearance of Dr. Schrag, the attorney for Court Monitor Groves and Ms. Iwamoto filed a motion in federal court to quash the subpoena served on Dr. Schrag. Judge Ezra again quashed the subpoena thereby denying the Committee the opportunity to question Dr. Schrag.

Judge Ezra ruled that Dr. Schrag had quasi judicial immunity because she was an advisor who reported to Court Monitor Groves, Judge Ezra's appointee. The judge did not consider Dr. Schrag's work as a consultant for the DOE and her prior deposition testimony in a separate lawsuit brought by a DOE official. Even though the Committee had agreed to accommodate Dr. Schrag by rescheduling the date and time of her appearance, Judge Ezra accused the Committee of harassing her. Without any supporting evidence in the record before him, Judge Ezra reportedly compared the Committee's investigation to the McCarthy hearings on communist activity in the 1950s. Although the federal court has repeatedly threatened to take over the State's school system if the Legislature did not fund *Felix*-related requests, it has effectively denied access to information on how that appropriated money is being used.

The Committee has authorized taking court action to reverse Judge Ezra's rulings. The Committee seeks to have him disqualified based on his conflict of interest in ruling on his own appointees and in making statements intended to bolster his own credibility and that of his appointees. His public comments have raised questions about his impartiality.

Upon learning of the Committee's intent to challenge his rulings and his impartiality, Judge Ezra called an immediate public status conference in open court. The Committee's lead counsel could not be in attendance, but Judge Ezra ordered the Committee's co-counsel to be in attendance at the status conference. This contradicted his earlier position that the Committee was not a party and any appeal of his rulings would therefore be unsuccessful. At the status conference, Judge Ezra refused to permit the reading of a letter from the Committee's lead counsel who could not attend and disallowed the letter from becoming a part of the record of the proceeding. The letter questioned the propriety of the Judge's actions and indicated that the Committee would request his disqualification.

Judge Ezra's actions were all highly unusual. He scheduled his own status conference. He ordered the attendance of the Committee's co-counsel by a telephone call that the judge placed himself when the Committee was not a party. He refused to permit lead counsel's letter to become part of the record. These actions, together with the judge's highly critical and unsupported comments about the Committee, create the appearance that the judge, instead of remaining a detached and neutral adjudicator, has, perhaps unwittingly, become an interested participant, attempting to protect his appointees and himself.

The Committee, after consulting with counsel, intends to move ahead with legal action to reverse Judge Ezra's actions and disqualify him. Unless the Committee can obtain testimony from Court Monitor Groves, Juanita Iwamoto, and Judith Schrag, it will have many unanswered questions about their roles, those they hired, their compensation and expenditures, and the overall effectiveness of their efforts. The

committee's work is incomplete unless it learns more about the benchmarks and how they came about. It needs information on the numerous consultants who were brought to Hawaii to assist in the development of a system of care and other topics on which only the federally-appointed officials can shed light.

The committee still desires to speak with Lenore Behar, another former member of the Technical Assistance Panel. Dr. Behar is under indictment on 46 counts in North Carolina for allegedly misusing foster care and Medicaid monies. She had a large role in designing Hawaii's system of care that is patterned after her philosophy of a comprehensive continuum of care.

The Board of Education exercises minimal oversight over* Felix *spending

The Committee found that the Board of Education also has not received a clear accounting of *Felix*-related costs. The former board chair, Mitsugi Nakashima, and the current board chair, Herbert Watanabe, testified to the Committee about the shrinking role of the board. They described the board's responsibilities as primarily establishing policies and hiring the superintendent who manages the system.

With respect to the budget process, the board reviews and approves the operating and capital improvement project budgets that DOE staff prepares. These are submitted to the governor through the Department of Budget and Finance, to become part of the executive budget requests. Once the appropriations act is signed, the board's role is limited to approving the department's distribution of the governor's budget restrictions.

The board does not receive expenditure information automatically or regularly from the DOE. Additionally, according to the board chairs, the board sometimes receives information that is not useful because of insufficient detail. For example, the board raised questions and did not receive adequate answers about two *Felix*-related contracts. Unresponsive replies to board requests appear typical—when the DOE does not respond to board questions, the chairs stated their only recourse was to maintain a list of IOUs and to remind the superintendent of them.

The board's minimal role has been further diminished by the federal court's granting of "superpowers" to the superintendent. The "superpowers" exempted the superintendent from state procurement and civil service laws. In fact, the Department of the Attorney General emphasized to the board that while it should be kept informed of *Felix* matters, it should not interfere with compliance efforts.

The DOE bypasses the board on numerous *Felix*-related matters. For example, the board had no opportunity to review two controversial contracts: a $100 million special education teacher recruitment and leasing contract and a $2.3 million contract for targeted technical assistance (both discussed in later sections of the report). In addition, although the board normally reviews items related to federal funds, it was not given that opportunity when excess federal impact aid was used instead of general funds for a targeted technical assistance contract.

Surprisingly, the board also did not have any role in the request for emergency appropriations. When the budget administrator was asked why that would be, the only answer was that it would require an emergency meeting, but the DOE had no idea if the board had any resistance toward scheduling one. This only further demonstrates that the DOE does not consider the BOE to have any meaningful role in *Felix* matters.

The Board of Education recently took a more assertive role in *Felix* matters

The board chairs revealed to the Committee that over the past year and a half, they have responded to growing concerns from DOE staff about potential problems related to *Felix*. For example, the board

instructed the former superintendent to resign from his membership on the Board of Directors of Pacific Resources for Education and Learning (PREL), a federally funded agency that provides assistance to school systems in the Pacific Region.

In August 2000, without board approval, former superintendent LeMahieu awarded PREL a $2.3 million contract to assist the DOE in achieving compliance with the *Felix* consent decree. Embedded in that contract was a subcontract to Na Laukoa that DOE staff had opposed because of the contractor's lack of qualifications. When questions arose about a conflict of interest, the former superintendent argued that his membership on PREL's board did not pose a conflict of interest. However, upon review of the information submitted and the $2.3 million PREL contract, the board asked the former superintendent to resign from his position on PREL's board of directors, which he did.

The Committee believes that the Board of Education should be more knowledgeable and involved in the review of *Felix* matters. The board should demand that DOE develop a more accurate and efficient way to explain its budget and expenditure information. Most importantly, regardless of any superpowers granted by the federal court, the board should require the department to justify its spending decisions on *Felix*-related items just as it should for all other expenditures of the department. As will be seen throughout this report, the department's lack of controls in the *Felix* system of care has allowed accountability for spending and effectiveness of services to fall by the wayside. The Board of Education should lead corrective actions.

The DOH has used confidentiality to limit legislative oversight

The Committee found the DOH to be uncooperative in providing committee staff access to client files and related documentation. The DOH cited its deputy attorney general's interpretation of FERPA, which made the investigation of specific alleged improprieties, waste, or lack of oversight difficult. The DOH first limited its concerns on the confidentiality issue to the revelation of client names. The committee's staff reassured DOH that it was not interested in client names—just in some method of matching billing records, which contained client registration numbers. However, once questions of potential fraud arose and committee staff requested billing records, the DOH also denied access to client numbers. This made it impossible for the Committee to carry out its oversight role and verify allegations of abuse.

Internal monitoring at the DOH is deficient

In FY1999-00, the DOH Child and Adolescent Mental Health Division had 91 contracts worth approximately $92.4 million. Most of the contracts are for direct services to children. The DOH has in-house and contracted staff that are supposed to assist the division in monitoring mental health services under the *Felix* consent decree and to ensure that they are cost-efficient.

Despite having established monitoring processes and a certain degree of oversight, the division has not adequately monitored the effectiveness or cost-efficiency of the services it funds. Instead, the division and the department have ignored telltale signs of abuse that foster a culture of profiteering at the State's expense.

The DOH administration exercises minimal oversight over the division's contracts and operations. In fact, Valerie Ako, chief of the department's Administrative Services Office, told the Committee that as of July 2001, her office is no longer involved in the division's contract administration. Instead, the division acts on its own. It bypasses the Administrative Services Office and works directly with the Department of the Attorney General in processing contracts. It has its own staff that outnumbers staff in Ms. Ako's office. Yet the division has failed to prevent abuse and waste on the part of its contractors. The committee found that some private provider agencies have made excessive profits by retaining a large

portion of payments they receive from the State for overhead or administrative costs. The division excused these disadvantageous contracts with the rationale that it had little choice, with the threat of federal takeover. The division also argues that it was focused on building system capacity with a network of providers.

The division's contract monitoring focuses on procedural compliance and not on whether services ordered in the student's Individual Education Program (IEP) were actually authorized, delivered, and in conformance with clinical standards. The division relies heavily on computerized verification to validate billings and expends little effort in analyzing anomalies in those billings. Therefore, the division has failed to identify incidences of false billing.

Flex and respite services are not monitored

The DOH pays for flex services or services other than those under contract. They include payments for such things as medication, mental health services not defined in the Clinical Standards Manual, and recreational activities. Respite services provide a paid caregiver for parents so that they can have a reprieve from the stress that often accompanies caring for a seriously mentally ill or disabled child. Payments for both flex and respite services are tracked manually and entered in summary form into the division's computer system.

Because flex and respite services are highly discretionary, they are highly subject to abuse. For example, the Committee heard complaints of boyfriends and relatives receiving payments and of payments for horseback riding lessons. Despite these pitfalls, the division chief recently rescinded her oversight over the use of these funds and delegated it to the branch chiefs.

The delegation of responsibility and the manual—rather than computerized—tracking of flex and respite service payments has resulted in even less effective controls and accountability over these payments. For example, as long as four months after the end of the fiscal year, the division was still unable to provide any reports on flex and respite expenditures for FY2000-01. The division has not monitored these expenditures to determine whether patterns of waste, abuse, or fraud have occurred. The DOH's lack of controls over these expenditures and the seeming lack of common-sense justification for such services are of concern to the Committee.

Problems Stemming from Court-Granted Extraordinary Powers

In June 2000, the U. S. District Court granted the superintendent of education and the director of health extraordinary powers to make changes needed to achieve compliance. Under these powers, the two department heads could waive requirements of the procurement law and bypass personnel laws for creating and hiring *Felix*-related positions.

The former superintendent of education appears to have abused superpowers

The former superintendent used the court-granted "superpowers" to enter into a contract with an unqualified provider. These powers allowed him to circumvent the seeking of competitive bids and the approval of the Board of Education and the attorney general.

The federal court has been concerned with those school complexes that have had the most difficulty in passing service testing. This concern resulted in court-approved benchmarks requiring the DOE to identify the 14 complexes with the greatest needs, and to contract with private agencies to coordinate, direct, and provide targeted technical assistance to these complexes. Targeted technical assistance

involves working with the schools in each identified complex to develop a Service Design Plan that would enable the DOE to deliver those services that would help schools meet the requirements of the *Felix* consent decree.

Serious ethical concerns arose when the former superintendent personally selected the company of a friend, Kaniu Kinimaka-Stocksdale, for a contract even though DOE staff objected that her company, Na Laukoa, was not qualified. Ms. Kinimaka-Stocksdale does not have any educational or professional background in mental health. She was previously employed as a hula dancer and operated a modeling and talent agency. She admitted to an intimate relationship with the former superintendent.

The former superintendent and Ms. Kinimaka-Stocksdale deny that the contract was awarded because of their personal relationship, but the former superintendent took a number of steps to ensure that the contract would be granted to Na Laukoa. He altered the funding for the contract from state general funds to excess federal impact aid funds, which are not subject to legislative review. Also, because staff expressed serious concerns with Na Laukoa's qualifications, he created an umbrella contract with Pacific Resources for Learning in Education (PREL). PREL is a nonprofit organization that holds a federal contract with the U.S. Department of Education and grants awards primarily through a competitive process. The contract with PREL stipulated that Na Laukoa be subcontracted for the targeted technical assistance function and specified that Na Laukoa would receive $688,000 of the over $2.3 million contract. The DOE apparently circumvented a competitive search for other possible competitors by designating Na Laukoa as the subcontractor in the PREL contract.

DOE staff objected to the contract

The former director of the DOE's Student Support Services Branch, Robert Golden, found a presentation conducted by Na Laukoa to be unsatisfactory. The presentation was made two months prior to the PREL contract. Mr. Golden had been directed to attend the presentation by the former superintendent with no explanation as to its purpose. There were no other presenters. Mr. Golden expressed his disapproval to the former superintendent both verbally and in writing. Mr. Golden felt that Na Laukoa had no understanding of school-based services locally or awareness of nationally recognized models on school-based mental health. Failing to persuade the former superintendent, Mr. Golden took his concerns to the Court Monitor, who did nothing.

Additionally, Na Laukoa required considerable "catch up" to fully grasp the DOE's school reform initiative, Comprehensive Student Support System (CSSS). The head of the DOE's Special Education Section, Debra Farmer, stated in her testimony that she spent a significant amount of time training Na Laukoa staff on such basic topics as state and federal special education regulations and service testing – topics in which any qualified agency providing school-based services should already have had expertise.

Health department staff received complaints that some of the therapeutic aides employed by Na Laukoa were abrasive and unprofessional with both DOH and DOE personnel. Furthermore, DOH questioned Na Laukoa's ability to administer a statewide contract.

The more important questions are whether Na Laukoa's services were necessary or worthwhile. The commonly held opinion is that the value of this targeted technical assistance is highly questionable. The technical assistance coordinators, hired by PREL, worked with each complex to help them complete and implement its Service Design Plan, a document required by the court for compliance. When questioned about exactly what type of assistance Na Laukoa provided, the owner of Na Laukoa could not provide an adequate or coherent explanation.

Because of the former superintendent's abuse of his extraordinary powers, the DOE issued a costly contract for Na Laukoa to perform a function that may not have been necessary. The DOE could have sought other more cost-efficient alternatives, including the use of existing staff in the DOE's Special Education Section. The $2.3 million was a wasteful endeavor that reduced funds that could have been used for direct services to children.

Superpowers used for a questionable $100 million contract recommended by a federal court-appointed official

The DOE used the superpowers again to enter into a controversial contract with a mainland firm to recruit special education teachers. The DOE awarded the contract without competitive bidding and without any review by the Department of the Attorney General.

The federal court has an ongoing concern with the shortage of certified or fully qualified special education teachers and other professionals. On August 3, 2000, Court Monitor Groves set a benchmark for the DOE stating that "national recruitment firm(s) will be retained to recruit qualified professional manpower for difficult-to-serve areas of Hawaii as soon as possible and no later than August 15, 2000." A specific benchmark required that the percentage of licensed and/or trained special education teachers in the classroom would not fall below 85 percent of the total special education teacher positions by September 2000.

According to the former Assistant Superintendent of Administrative Services, Paula Yoshioka, the DOE felt extremely pressured because it had only two weeks to retain a mainland recruitment firm. Since DOE staff had little experience with contracted mainland recruiting for special education teachers, the deputy superintendent at the time contacted Court Monitor Groves for advice. He suggested Columbus Educational Services upon the referral of Judith Schrag, another Technical Assistance Panel member. This Committee finds Dr. Schrag's referral questionable since Columbus had very little experience with hiring special education teachers.

Ms. Yoshioka testified that she contacted Columbus Educational Services and requested submission of a proposal. After reviewing several drafts of the proposal, and apparently without much negotiation, a three-year contract for $100 million, to be paid through state general funds, was signed. The Columbus contract has been in effect since September 1, 2000 and was exempt from the public bidding process pursuant to the federal court's grant of "super powers" to the superintendent.

Under the contract, Columbus is required to conduct an "extensive search" for candidates who are qualified, licensed, and certified in special education, which includes masters-level counselors (41 FTEs) and special education teachers (332 FTEs). The work is to focus on referring candidates to serve Hawaii's rural areas such as Molokai, Lanai, Kau, and Kohala. Those hired become employees of Columbus for up to three years, subject to the availability of DOE funding. Therefore, special education teachers coming to Hawaii are not state employees, but are merely leased to the department. This arrangement caused much controversy among DOE teachers who discovered that teachers hired by Columbus could be paid upwards of $102,000, which includes salary, benefits, and incentives, plus a one-time relocation bonus of $10,000. In fact, by the end of the contract period in August 2003, a special education teacher leased by the State from Columbus would cost the State $335,250 over three fiscal years.

The State covers virtually all contract costs

The State covered virtually all costs for the Columbus contract. In addition to paying the teachers' salaries and Columbus' profit, the State pays for Columbus' candidate recruitment travel costs, including:

1) Mainland travel (within the continental U.S.) at $1,430 per trip; 2) Mainland to Hawaii travel at $4,505 per trip; and 3) Hawaii inter-island travel at $845 per trip. The projected travel costs include roundtrip airfare, lodging, meals, auto rental, parking, and taxis. Over a three-year period, Columbus projected that the cost for recruitment travel would be approximately $2.1 million.

The State also paid for staff support services so that Columbus could set up an office in Honolulu. The start-up included five Columbus employees who would accompany candidates on interviews, facilitate relocation, and support their final decision-making process. The projected total for these staff support services costs are approximately $3.3 million.

The contract also allows Columbus to retain all of the equipment and furniture it purchases. Normally, such items become the property of the State. Committee staff attempted to determine how much the State has paid Columbus for furniture and equipment. However, the DOE reported that it did not have this information, but that Columbus reportedly purchased furniture at local auctions and that some of the furniture includes personal items of the Honolulu office head.

Columbus Educational Services clearly benefits from the contract since it does not have any liability. Even if Columbus failed to hire a single teacher or if a teacher terminated his or her contract prematurely, Columbus would not have breached its contract with the State.

Contract amount fluctuates dramatically

During one of the investigative hearings, an allegation was made that the Columbus contract started out as high as $120 million and then was reduced to $100 million, which became the initial contract amount. Since then, the contract has been amended twice and the total contract amount has fluctuated widely as shown in Exhibit 2.4. It varied from $100 million to $40 million to $63 million.

Exhibit 2.4
Columbus Educational Services Contract Amounts, FY1999-00 to FY2003-04

FISCAL YEAR	ORIGINAL CONTRACT (September 1, 2000)	1st AMENDMENT (January 28, 2001)	2nd AMENDMENT (September 1, 2001)
FY2000-01	$16,401,025	$7,201,983	$4,812,732
FY2001-02	$41,537,419	$16,341,604	$25,248,135
FY2002-03	$42,172,496	$16,538,047	$28,546,588
FY2003-04 (for July and August only)	Not applicable	Not applicable	$4,739,317
TOTAL	$100,110,940	$40,081,634	$63,346,772

Ms. Yoshioka testified that the reasons for the amendments were (1) the lack of accurate, updated DOE information on special education teacher vacancies and (2) a decision to focus on hard-to-fill areas. Therefore, the contract amount was reduced to $40 million on January 28, 2001 to reflect the adjusted amount. The number of recruits needed decreased to 15 masters' level school counselors and 123 special education teachers. The Committee questions whether the true reason might have been Columbus' inability to hire enough teachers to meet the terms of the original contract.

Another amendment to the Columbus contract was executed on September 1, 2001, which increased the contract amount by $23 million to $63.3 million. By June 30, 2002, Columbus is to provide qualified

referrals for 14 high-risk counselors and 241 special education teachers for a total of 255 positions. All of these employees will be terminated on August 31, 2003.

The Committee was surprised to find the DOE increasing its contract with Columbus by $23 million, given its past problems with Columbus. The DOE staff reported that they have been unable to obtain detailed information from Columbus on the actual cost of leasing a special education teacher from Columbus and administrative costs and profit. Columbus reportedly told the DOE that the approximately $100,000 paid to Columbus for each teacher per year, could be broken down as follows:

- 1/3 base salary ($33,000 to $42,000);
- 1/3 employee benefits and taxes (medical, dental, life insurance, disability insurance, pension (401K), payroll taxes; and
- 1/3 additional allowances or incentives (temporary living expenses, travel, housing, technical support, sign-on and retention bonuses).

The DOE staff currently responsible for the administration of the Columbus contract claims that Columbus does not make any profit from the approximately $100,000 it charges per teacher. However, Ms. Yoshioka's testimony confirmed that Columbus could indeed retain any remaining balance after salary, benefits, and incentives are paid to the teacher. She also agreed with a Committee member's suggestion that out of a potential balance of close to $47,000 after salary and benefits are paid, Columbus would profit on whatever remained. Committee staff estimated that Columbus' profit could be as high as $20,000 per teacher per year. And despite this enormous amount of profit that Columbus could reap, there was nothing to require Columbus to document the breakdown of payment for any meaningful oversight.

Committee staff reviewed correspondence provided by DOE staff and noted its repeated and futile attempts to obtain accurate cost information from Columbus. Some of the correspondence clearly indicated frustration with Columbus and a desire to seek alternatives to the contract. Therefore, the Committee questions why the DOE would increase Columbus' contract amount without adequate cost information.

The DOE created questionable Felix *positions*

The DOE has also created a number of *Felix*-related positions. This Committee has yet to receive the information it requested from DOE on position descriptions and justifications for these positions. At first glance, responsibilities for these positions are unclear and compensation appears to be arbitrary. For example, the superintendent's office has three new *Felix* "assistant" positions. One supervisor is supposed to oversee the other two staff, but one subordinate is paid the same salary as the supervisor and the other subordinate is at a much higher rate than the supervisor. The DOE should be focusing its staffing efforts on school-level positions, not on the state and district levels.

The *Felix* Consent Decree Had Unfortunate Consequences: Conflicts of Interest and Self-Serving Practices

From the court monitoring personnel through the plaintiffs' attorneys down to the former superintendent of education and staffs at the DOE and DOH, instances of apparent conflicts of interest and self-serving

profiteering are easily found. We believe that this climate of profiteering is a byproduct of the federal court's protection of court appointed personnel, the superpowers given to the heads of the DOE and DOH, the curtailment of the Legislature's investigative powers, and lackadaisical monitoring, particularly by the DOH. Those who profit while violating state ethics law appear to suffer no consequences.

The plaintiffs' attorneys fees have increased ever since the consent decree was issued in 1994. Many providers who received contracts appear to have had an unfair advantage. One issue that was raised throughout the investigative hearings was the conflicts of interest that allegedly exist between some DOH employees and some of the private provider agencies.

Court monitor was self-serving

In the prior section, the Committee discussed the service-testing instrument used to measure compliance with the *Felix* decree. Court Monitor Groves and his business partner, Ray Foster, designed the instrument shortly after the decree was issued. Although they apparently did not charge the State for use of the instrument, the State basically paid for its development because anything the Court Monitor worked on related to *Felix* could be charged to the State. Committee witnesses testified that modified versions of the protocol developed in Hawaii have been used in other states, possibly for a fee. Furthermore, Dr. Foster was paid for providing service testing training. For FY2000-01 alone, the budget for service testing costs was $412,000, with $50,000 for Dr. Foster to provide training.

The extent to which either the Court Monitor or his business partner might have benefited from the service testing instrument could not be determined. Committee staff were denied copies of federally-required tax documents that should be readily provided upon request.

One committee witness claimed that DOE staff worked on some of the components of the protocol, but were not credited for their efforts. Furthermore, DOE staff was not informed that Court Monitor Groves and Dr. Foster were planning to copyright the document for marketing and distribution in other states. Interim superintendent Hamamoto testified that she did not know that the service testing instrument was owned by Court Monitor Groves and his partner—yet, she was the designated primary *Felix* compliance official when she was deputy superintendent.

The State has paid over $1.5 million to plaintiffs' attorneys

The consent decree requires the State of Hawaii to pay fees and costs to attorneys representing the *Felix* plaintiffs. The State has paid over $1.5 million in fees and costs so far. As part of its investigation, the Committee subpoenaed all documents relating to legal services and costs of private attorneys involved in the *Felix* consent decree. In reviewing the information, we found fees charged by the plaintiffs' attorneys have increased.

In 1994, after the decree was filed, the State paid $347,638 in attorneys' fees and costs to four law firms for the work they did from 1991 to 1994. They were: (1) Alston Hunt Floyd & Ing; (2) Eric Seitz, Esq.; (3) Protection & Advocacy/Schember-Lang, Esq. and (4) Disabled Legal Rights Project/Cooper, Esq. The decree allows the attorneys to recover:

- Reasonable attorneys fees and expenses, and
- Fees and expenses of expert witnesses.

Fees continue to increase

The State is paying increasing fees to plaintiffs' attorneys, even though the decree is largely silent on their role once the decree was filed. The only specific reference in the original decree required the plaintiffs to review and approve an Implementation Plan. As seen in Exhibit 2.5 below, in the six years since the decree was issued, attorneys' fees have generally increased, from $93,822 in 1995, the year after the decree was issued, to $271,841 in 2000.

Based on the information that was provided, from 1991 to approximately April 2001 the State paid $1,559,535 in attorneys' fees and costs to plaintiffs' attorneys.

The plaintiffs' attorneys' role is not clearly defined

The deputy attorney general representing the State in the *Felix* lawsuit conceded that legal activity by plaintiffs, instead of decreasing, has increased over the years. He testified that Court Monitor Groves

Exhibit 2.5
Fees Paid to Felix Plaintiffs' Attorneys, 1991 to 2001*

YEAR	AMOUNT
Prior to 1995	$373,949
1995	$93,822
1996	$153,159
1997	$148,205
1998	$204,539
1999	$200,782
2000	$271,841
2001**	$113,238
TOTAL:	$1,559,535

* Excludes fees paid for individual claims.

** In addition, plaintiffs' attorneys have submitted $102,927 in requests for payment for services rendered through approximately August 2001. These requests are apparently pending with the Department of the Attorney General.

proposed that the plaintiffs' attorneys increase their involvement in the process, which began two or three years after the decree had been issued. On more than one occasion, even the federal court has expressed concerns about the over-participation by plaintiffs' attorneys in consent decree activities and the amount of attorneys' fees being charged to the State.

Plaintiffs' attorneys appear to be overly involved in a number of compliance activities. For example, they appear to have taken an active role in reviewing whether or not individual school complexes are in compliance with the terms of the decree. They attend school complex compliance presentations, sit alongside the court monitor and appear to provide input as to whether a school complex has achieved compliance. Even the interim superintendent has affirmed to the committee that the plaintiffs' attorneys' over-involvement affected morale in the schools and affected the compliance efforts. The Committee has been unable to determine why the plaintiffs' attorneys have assumed this role since it was prohibited from questioning Court Monitor Groves about this as well as other types of issues.

Attorneys' fees lack careful scrutiny

Plaintiffs' attorneys submit their invoices to the Department of the Attorney General for review and payment. Once the parties agree on the amount of fees owed, they submit a stipulation for payment for

the court's approval. Upon approval by the court, the attorney general directs the DOE to remit a check to the respective attorneys. Exhibit 2.6 shows the attorneys' fees that have been paid to individual law firms from 1991 to approximately mid 2001. (The exhibit excludes recent payment requests of $102,927 that appear to be pending with the Department of the Attorney General.)

Generally, a review of the reasonableness of attorney's fees is based on the following guidelines: (1) time and labor required, difficulty of the questions involved and requisite skill required; (2) customary charges for similar services; (3) the amount in controversy and the benefits resulting to the client from the services; (4) certainty of the compensation; and (5) whether the acceptance of the particular case will preclude the lawyer's appearance for others or the loss of other employment. Courts note that the legal profession is a branch of the administration of justice and not a mere money-getting trade.

Exhibit 2.6 Fees Paid to Law Firms, 1991 to 2001

YEAR	ATTORNEY	AMOUNT
Prior to 1995	Alston Hunt	$263,524
	Eric Seitz	$59,505
	Susan Cooper	$19,475
	Suzanne Young	$31,445
	Total	**$373,949**
1995	Alston Hunt	$58,369
	Eric Seitz	$23,197
	Susan Cooper	$4,950
	Suzanne Young	$7,306
	Total	**$93,822**
1996	Alston Hunt	$95,758
	Eric Seitz	$46,759
	Susan Cooper	$1,350
	Suzanne Young	$9,292
	Total	**$153,159**
1997	Alston Hunt	$91,005
	Eric Seitz	$53,507
	Susan Cooper	$1,050
	Suzanne Young	$2,643
	Total	**$148,205**
1998	Alston Hunt	$125,852
	Eric Seitz	$77,237
	Susan Cooper	$1,450
	Total	**$204,539**
1999	Alston Hunt	$138,721
	Eric Seitz	$60,499
	Susan Cooper	$1,562
	Total	**$200,782**
2000	Alston Hunt	$214,470
	Eric Seitz	$54,949
	Susan Cooper	$2,422
	Total	**$271,841**
2001*	Alston Hunt (through April 30)	$72,591
	Eric Seitz (through July 9)	$39,762
	Susan Cooper (through March 31)	$885
	Total	**$113,238**

* partial amount

The Committee found that the Department of the Attorney General paid in full almost all of the fees requested by the plaintiffs' attorneys. The office appears not to have scrutinized the billings in any meaningful way. When the Committee questioned the deputy attorney general about the appropriateness of certain time entries, he indicated that, to some extent, the attorney general's department was trying to accommodate the plaintiffs by gathering "the consent or the support of the Plaintiffs and not have a very adversarial situation where we would have to not only confront them on the attorney's fees issues but also on the compliance issues."

The Committee questions whether the attorney general's department followed any guidelines or standards in determining whether the fees and costs requested were reasonable. For example, the Committee found billings for:

- Charge of 0.4 hours to "work on political issues";
- Attendance at three different meetings on educational plans for individual *Felix* students on the Big Island, including payment of airfare and travel expenses to attend the meetings;
- Partial attendance at MST (presumably Multisystemic Therapy) training;
- Monitoring *Felix*-related legislative bills and speaking with legislators during the 2001 session by Alston Hunt;
- Multiple vague references in Alston Hunt legal invoices to conversations with various individuals such as "Kauai mom," "Konawaena mom," or "Big Island grandmother";
- Airfare and related travel expenses for a plaintiff's attorney on a neighbor island to fly to Honolulu to attend compliance presentations, meetings, and court hearings despite the fact that the attorney moved from Honolulu after the consent decree; and
- Airfare and related travel expenses for plaintiffs' attorneys to travel to the neighbor islands to attend school complex compliance presentations.
- Alston Hunt staff to prepare for and attend a legislative investigative committee hearing on July 13, 2001;
- A plaintiff attorney's attendance at a legislative investigative committee hearing on August 20, 2001;
- Quashing the Committee's subpoenas of the court monitor and Juanita Iwamoto, executive director of the Felix Monitoring Project, Inc., including multiple communications with the monitor and Iwamoto regarding the subpoenas;
- Meeting with the Court regarding "legislative activity" on June 15, 2001;
- Costs of various meals for lunch/dinner meetings with plaintiffs' attorney, court monitor or others, totaling approximately $400;

- Conversations and meetings with members of the investigative committee;
- Time to pull articles re: "Legislative attacks on *Felix*".

Disparity in billing rates and amounts
The plaintiffs' attorneys charge different fees. It is unclear why the Alston Hunt law firm billed twice as much in legal fees and costs as Mr. Seitz's law firm, when presumably Mr. Seitz is also representing *Felix* plaintiffs and rendering services that he deems necessary to adequately represent his clients. In addition, the lead Alston attorney's present billing rate is $250/hour compared to Mr. Seitz's $200/hour rate. Mr. Seitz's rate has remained the same since the inception of the case, while the Alston attorneys' rates have steadily increased since 1994.

Total legal fees and costs are not known
The State also pays attorneys' fees in addition to those paid in the *Felix* litigation. These claims are outside the *Felix* consent decree but relate to special education. Parents often file individual claims on behalf of their children for violations of the IDEA or Section 504. Individuals who prevail at an administrative hearing are entitled to attorneys' fees. The Committee was not able to obtain information from the attorney general's department about the amount of attorneys' fees and amount the State paid for individual claims. They have been described as a "formidable amount." Sometimes the attorneys' fees exceed the cost of the services that the plaintiffs are requesting.

The DOH staff have many apparent conflicts of interest

The Committee found numerous instances where DOH staff appear to have conflicts of interest. Often, DOH staff responsible for preparing proposals ended up receiving a contract for the services ordered under the proposals. Personal relationships were often involved in service programs. We give some examples below.

Personal relationships were involved in the implementation of MST
In a later section, we discuss the MST, a home-based experimental program. The program coordinator was John Donkervoet, the husband of Tina Donkervoet, the chief of the DOH Child and Adolescent Mental Health Division. Although Dr. Donkervoet did not report directly to his wife, his supervisor, head of clinical services, Mary Brogan, reported directly to Ms. Donkervoet.

Both Dr. and Ms. Donkervoet acknowledged the Committee's concerns over an appearance of a conflict of interest. In fact, Ms. Donkervoet had asked the State Ethics Commission to determine whether there were any ethical considerations. Dr. Donkervoet said the issue of conflict of interest was one of the reasons why he resigned from his MST coordinator position in October 2001. This was, however, more than one and a half years after he had been appointed and just before he was scheduled to testify to the Committee.

Furthermore, in the mid-1990s, John Donkervoet had worked with the developer of MST, Scott Henggeler, at the Medical University of South Carolina. Both Dr. Donkervoet and Dr. Henggeler stood to gain from the implementation of MST. Dr. Henggeler charges a licensing fee for the use of MST and also charges for consultation and training. Committee staff could not get information on the amount of the licensing fee, but found that in FY2000-01 the DOH spent $522,000 on MST Clinical Consultation and Training.

Former DOH employees may have violated ethics laws

Two former employees of the DOH Child and Adolescent Mental Health Division are owners of Hoahana Institute, a for-profit provider agency that obtained a contract with the division to provide outpatient and intensive support services to *Felix* children. Linda Hufano, Hoahana vice president, was formerly head of the DOH Child and Adolescent Mental Health Division's Children's Mental Health Services Team. Her husband, Dr. Richard Kravetz, Hoahana Institute's president, was still employed as head of the division's Diamond Head Adolescent Day Treatment Program when he began providing services for the division under the Hoahana contract. The contract became effective on July 1, 1997—only nine months after Dr. Hufano had left the division and two weeks before Dr. Kravetz's resignation.

Doctors Hufano and Kravetz appear to have violated several sections of the State Ethics Code. Section 84-18(c), HRS prohibits a former state employee from receiving compensation to represent a business on matters in which he participated or on matters involving official action by the particular agency with which he had served for a period of *12 months* after his termination. Section 84-14(d), HRS prohibits a state employee from being compensated to assist or represent a business on a matter in which he has or will participate and on a matter before his own agency. Both sections are intended to prevent a third party from obtaining an inside track or unfair advantage with a state agency through either a current or former employee.

The nature of Dr. Hufano's duties at Hoahana Institute during her 12-month "cooling off period" appear to violate the second part of Section 84-18(c). She established Hoahana Institute along with some others a month before she left the DOH. Dr. Hufano ended her position with the Child and Adolescent Mental Health Division on September 30, 1996. However, she assisted in preparing Hoahana Institute's contract proposal during the early part of 1997 and signed the proposal on March 12, 1997. By addressing a fax to Dr. Hufano regarding Hoahana's submission of its best and final offer on May 13, 1997, the division recognized her as the agency's contact person on matters involving official action by the division. The division also addressed a fax to Dr. Hufano regarding Hoahana's award notice on May 22, 1997.

The nature of Dr. Kravetz's duties at Hoahana Institute appear to violate the second part of Section 84-18(c), as well as Section 84-14(d). He resigned from the Child and Adolescent Mental Health Division on July 15, 1997. However, he signed Hoahana's contract on July 17, 1997—just two days after his date of termination. Possibly a more serious ethics violation is the fact that Dr. Kravetz also assisted in preparing Hoahana Institute's contract proposal while still employed at the division.

The DOH Child and Adolescent Mental Health Division is remiss about ethical considerations

The DOH's Child and Adolescent Mental Health Division appeared to disregard the State Ethics Code. According to a July 10, 1997 memo from former division chief Rich Munger, employees could work with private provider agencies as long as their involvement did not constitute a conflict of interest. However, the example used to describe a conflict of interest was that of an employee authorizing services that he would also provide. The division failed to warn against potential conflicts of interest that may arise when it directly contracts with a former or current division employee's private business.

Furthermore, the division has no measures to ensure that private provider agencies abide by the State Ethics Code. The division does not adequately review private provider agencies' responses to proposals. For example, if it had carefully reviewed Hoahana Institute's proposal, the division would have discovered that Dr. Kravetz was still employed at the division. This should have raised a red flag during the review process.

Also, although private providers are required to sign a Standards of Conduct Declaration, which covers the State Ethics Code, the division does not verify whether statements are accurate. The division's actions are reactive, and it investigates potential violations only when brought to its attention by an outside party.

In a belated response to the allegations against Doctors Hufano and Kravetz, the Child and Adolescent Mental Health Division contacted both the Department of the Attorney General and the State Ethics Commission. At one point, the division considered ending its contract with the Hoahana Institute, but, instead, chose to wait for close to three years for a response from the State Ethics Commission. In the meantime, the division extended Hoahana's contract even though, in November 1997, it had sent a memo to the Department of the Attorney General stating that the contract should be terminated immediately.

The *Felix* Consent Decree Has Fostered an Environment of Waste and Profiteering

In an environment where money is no object, questionable practices are often not scrutinized carefully. Violations have occurred without sanctions or other consequences. Both the DOE and DOH were profligate with public monies. The departments sometimes spent wastefully and imprudently.

The DOH allows providers to overcharge for services

The Committee has found numerous instances where private provider agencies have overcharged the State for services. Inadequate controls impair the DOH's ability to ensure that children actually receive the services the State is paying for. The DOH Child and Adolescent Mental Health Division has only recently become concerned about this.

We note some examples of apparent overcharges below.

- A private provider billed the State for more hours worked by some employees than the number of hours it was paying them for according to the provider's payroll register.

- A therapist was paid for 1765.8 hours worked during August 1999 amounting to $59,987.69. The billing included 7 hours of individual therapy, 5 hours of group therapy, 9 hours of therapeutic aide services, and 106 hours of Biopsychosocial Rehabilitation (BPSR) for a total of ***127 hours for one day.*** BPSR billings may combine services by more than one clinician under one clinician's name, however, the lead clinician under whose name the billing is made is expected to be substantially involved. The DOH is still using and paying the therapist for services.

- A therapist billed for services for two sequential hours of billing—the first hour on the Big Island and the second hour on Oahu.

- Some providers appear to bill for individual services when they actually serviced clients in groups. This is not appropriate except for services designated and priced as group sessions.

- Committee staff also identified patterns of multiple billings being submitted for the same client on the same day.

- Often providers offer services that do not adhere to the DOH's clinical standards. For example, services limited to 12 weeks except in exceptional cases are routinely exceeded. One private provider agency provided services to 77 clinical clients (72 percent) for periods exceeding 12 weeks, 18 (17 percent) for at least a year. The State pays for these services at $70 per hour and annual billings for a single client can exceed $30,000.

Providers profit from excessive markups for therapeutic aide services

The DOH Child and Adolescent Mental Health Division has a standard rate schedule attached to its request for proposals for mental health services. Private provider agencies bidding on these proposals must stay within the standard rate schedule. For example, the State reimburses private provider agencies a maximum of $29 an hour for therapeutic aide services. This arrangement may encourage some private provider agencies to "underpay" its employees and contractors so that it can keep a larger amount in profit. We found markups of up to 250 percent for some services.

Therapeutic aides are used quite extensively to provide mental health services and may have only a high school diploma. According to the division's clinical standards manual, a therapeutic aide must have two years of work with children and/or adolescents. They must also be trained by someone trained or certified through the *Felix* Staff/Service Development Institute. Whether these standards ensure effective services is not known.

The Committee found that some private provider agencies have excessive markups. A private provider testified to the Committee that therapeutic aides are paid between $11 to $20 per hour. The records available to the Committee indicate an actual range of $10 to $17 per hour, with an average hourly pay of around $13.

One provider's bill during FY2000-01 for therapeutic aides totaled 18,835 hours and $749,885. Assuming that the employees were paid between $13 and $15.50 an hour, the payroll for 18,835 hours would be between $245,000 and $292,000, leaving the employer with a markup of between $458,000 and $505,000 or 157 percent to 200 percent. This differential is far greater than can be explained by the cost of employee benefits, training and supervision, and a reasonable profit.

A private provider maximized its profit by billing 3,425 hours and $240,000 for one therapeutic aide for FY2000-01, or up to $805 per client per day. If the aide were paid at the reported top rate of $20 an hour, the payroll cost to the employing private provider agency would be $68,500, leaving the provider with $171,500 to cover costs and profit, a markup of almost 250 percent.

Another private provider charged the State $70 an hour for up to 11.5 hours a day for intensive in-home services by a therapeutic aide. Intensive in-home services are supposed to pair a mental health professional with a paraprofessional to provide therapeutic and systematic support to a client and family. However, the Committee found providers frequently billing this service under the credentials of therapeutic aides who are not necessarily mental health professionals. The division has confirmed that, in at least one instance, a therapeutic aide worked alone without a mental health professional.

The DOH Child and Adolescent Mental Health Division is unconcerned about potential fraud

Conceptually, the Child and Adolescent Mental Health's billing system is simple and effective. Mental health services are specified by a group of professionals and are documented in a child's Individual Education Program (IEP). A care coordinator or an equivalent person at a school identifies a suitable private provider agency and issues a service authorization. The service authorization data is entered into the division's computer system.

The private provider agency assigns a clinician who is an employee or independent contractor. As services are provided, the clinician submits the billing to the contracted provider, who in turn submits the billing data in electronic form to the division. The electronic billing data is automatically checked by the computer to ensure that the billing data corresponds with the service authorization. A rejected bill is returned to the provider for resolution. According to division personnel, the most frequent problems that occur with automatic verification of billings are data mismatches, such as misspellings or inputting errors.

The Child and Adolescent Mental Health Division relies extensively on the automated check for ensuring that billings are accurate. Since the division has not assigned any fiscal staff to identify cases of false billings, abuse and possibly fraud have resulted. Additionally, audits conducted by the division are not designed to discover billing abuse, but merely focus on documentation and adherence to clinical standards. Division personnel directly involved with service authorizations informed the Committee in testimony and informally that providers have found ways to "beat the system" that can only be detected by critically analyzing billing data and targeting questionable patterns.

For example, committee staff identified service providers whose billing patterns appear potentially abusive. Some of these problems date back at least two years and some of these same clinicians are known chronic abusers. These clinicians have been brought to the attention of superiors but no action has been taken.

Computer problems continue

In the *Study on the Privatization of the Child and Adolescent Mental Health Program (Report No. 99-12)*, the Auditor found several problems with the Department of Health's Child and Adolescent Mental Health Management Information System or CAMHMIS. At the time, the division had not adequately planned for the inclusion of private providers in the system. Without additional training or support from the division, private providers had submitted the following types of data errors: invalid service authorization codes, total service units billed in excess of units authorized, unauthorized service codes, and services provided prior to their authorization. The division acknowledged at the time of the study that it had problems with its management information system.

According to Child and Adolescent Mental Health staff, all of these problems have been resolved. However, during the course of the hearings, the Committee heard the same concerns regarding invalid codes, improper billings, and excess units or hours billed. For example, the computer system does not have a proper coding for day treatment services. Therefore, all day treatment hours are billed under one service provider's name, resulting in an unusually high number of hours. Although those large numbers of hours may well include a number of different service providers, verifying their accuracy is difficult. Another problem is presented by billings for group therapy that may actually be providers billing for more than one client during the same period of time. Of significant concern is circumstantial evidence that progress notes to document and substantiate billings may have been falsified or merely produced with any service being provided. This is especially disconcerting since it not only undermines the prognosis and development, if any, of the student, but also questions the accuracy of DOH's billing protocol.

The DOH has largely taken a reactive stance to these concerns and the Deputy Director of Behavioral Health constantly reiterated during her testimony to the Committee she would initiate an investigation if the Committee pointed out specific incidences of abuse. The DOH is missing the point – it needs to take preventive action.

MST was a costly, wasteful experiment

The DOH has wasted state funds on an expensive, experimental form of treatment called Multisystemic Therapy or MST. During the 2000 legislative session, the department requested $1.2 million for MST as part of its emergency appropriation request. The DOH had issued a Request for Proposal in October 1999 for MST Services and awarded contracts in January 2000 with the knowledge that it did not have adequate funding for MST's implementation.

Furthermore, the consultants who worked on the *Felix* follow-up study for the Office of the Auditor found that using MST for the *Felix* class was questionable. MST had never been used with the same category of special education or mental health needs as *Felix* class children. MST was viewed as an experimental service that had not been used by other school districts and should not have been considered an "essential" service.

Concern with the DOH's questionable use of MST for the *Felix* class was confirmed by Len Bickman who was the lead researcher for the Fort Bragg Study in North Carolina that concluded that treatment outcomes for children with mental health needs were no different from the control group in the study. Reviewing a videotape of John Donkervoet's testimony to the Committee, Dr. Bickman stated that the research citing the effectiveness of MST to treat mental health problems of non-delinquent children and adolescents is weak to non-existent. Moreover, the only research that studied this type of children was conducted by Scott Henggeler, the founder of MST, and not an independent party – subjecting the studies to a potential bias toward favorable outcomes.

The budget for MST in FY1999-00 was $1.25 million and $2.5 million for FY2000-01. The Child and Adolescent Mental Health Division, which is responsible for MST, estimated during the 2001 legislative session that it would have a shortfall of $1.9 million for MST and would need $4.3 million. In one year, based on actual expenditures, the cost of MST increased by approximately $4.8 million–from $744,733 in FY1999-00 to $5,519,837 in FY2000-01. Approximately $1.4 million or one-fourth of this increase in cost was due to the addition of a second component of the MST initiative called the MST Continuum research project. The project was terminated well before completion and without any perceivable benefit to the children and families who participated.

MST was mandated by the consent decree despite its experimental nature

The Committee questioned DOH administrators about the circumstances that led to the federal court mandating MST as a part of the consent decree. To the Committee's knowledge, other types of treatment are not specifically named in the decree. In its *Stipulation Regarding the Plans for Strengthening and Improving the System of Care* dated July 21, 2000, the federal court required the inclusion of MST and described it as a necessary component of the development of a system of care in Hawaii. A specific court benchmark required that at least 56 youth be receiving services by July 2001.

It was clear that Court Monitor Groves was familiar with the research project. The DOH notified him in April 2001 that the MST Continuum was failing. In the court monitor's second quarterly report for 2001, he noted that the department could not reach the benchmark and that he had no additional recommendations for how to improve the enrollment process for the MST Continuum study. He then simply replaced MST with a vague benchmark stating that both the departments of health and education must address the continued expansion and development of evidence-based interventions.

While the Committee recognizes the apparent improvement of the potential MST students, in that the number being sent to the mainland for treatment are at an all-time low, it in no way deflects the basic question as to why an experimental program was a benchmark.

MST was a failure

After a little over a year, the MST Continuum study was shut down for lack of participants. The DOH had promised families who had agreed to participate in the research project that they would receive MST Continuum services for two years. However, since the study was terminated abruptly, the DOH reneged on its agreement.

Families were informed of the termination of the study in a hasty manner. The DOH told parents that the transition would occur over the next few weeks to several months with care taken to ensure that youths and families would experience no gap in services. An MST team member testified to the Committee that she was given only two and a half days to transition the families she was working with and inform them that they would no longer be able to contact her for assistance.

Families who participated in the MST Continuum were supposed to be transitioned into alternative treatments. How this disruption in service impacted the youth and the families is not known.

The MST Continuum study has closed, but the DOH plans to continue home-based MST services. But home-based MST is also plagued with problems. A Therapist Adherence Measure or TAM was used to assess whether therapists were adhering to the MST treatment model by taking six factors into consideration. Three of the six factors were supposed to be positively correlated with positive outcomes for families who received home-based MST treatment.

The TAM scores of the therapists have not improved over the past year. The DOH acknowledged the negative scores and noted that the MST therapists are doing worse this year than last year on specific factors, including lack of adherence to the MST model.

The DOH attributed the decline in performance by MST therapists to high staff turnover and the lack of qualified candidates for MST therapist positions. Given the concerns with properly implementing the MST model and the health department's inability to determine cost-effectiveness, the Legislature should proceed cautiously before approving more spending for MST.

A DOH employee has a private business on the grounds of a private provider

Dr. David Drews, chief of the Diamond Head Family Guidance Center[2], appears to have a conflict of interest. Dr. Drews was involved in a business relationship with a state-contracted private provider agency, Loveland Academy. Dr. Drews' relationship with Loveland Academy appears to be a conflict of interest because he oversaw authorization of services and payments to private provider agencies including Loveland Academy. Although he was not directly involved on a daily basis with service authorizations, he had the authority to override decisions made by subordinate staff, including care coordinators.

Since July 1, 1999, Loveland Academy has been under contract with the DOH Child and Adolescent Mental Health Division for assessment and diagnostic, outpatient, and intensive support and day treatment services to *Felix* class children between the ages of 3 to 20. Many of Loveland's clients are within the caseload of the Diamond Head Family Guidance Center. When testifying to the Committee, Dr. Drews acknowledged that, on occasion, he has reviewed Loveland's billings and has been contacted directly by Loveland's staff regarding billing concerns.

Dr. Drews also established Central Pacific University, a distance education institution located on Loveland's campus. Dr. Drews established the university on August 17, 1999, one month after Loveland

opened its doors. The university stemmed from Dr. Drews' previous association with Honolulu University, another distance education institution. Both Central Pacific University and Honolulu University lack accreditation from an agency recognized by the U.S. Secretary of Education. In addition to lacking accreditation, they charge tuition on a degree basis rather than on a per-semester or per-credit basis. For $3,000, a student can receive a bachelor's degree, for $3,500, a master's degree, and for $4,000, a doctorate.

Central Pacific University and Loveland have a formal relationship. According to an October 1, 1999 Memorandum of Agreement, Dr. Drews renovated several classrooms in exchange for use of classroom space at Loveland. Until October 2001, Central Pacific University prominently displayed its banner on one of Loveland's buildings. The university advertises itself as having an innovative practicum program at Loveland for its psychology students, and Dr. Dukes claimed to be a member of the university's advisory board.

Dr. Drews appears to have violated the DOH Child and Adolescent Mental Health Division's policy and procedure manual relating to outside employment and relevant business interests. The manual states that employees are prohibited from engaging in any practice, outside employment, or relevant business interest that creates a conflict of interest or the appearance of a conflict of interest. Although Dr. Drews disclosed his interest in Central Pacific University in September 1999, he listed only the university's office address located on Kapiolani Boulevard and omitted Central Pacific University's campus address, which is located on the grounds of Loveland Academy. Therefore, on paper, the connection between Loveland and Central Pacific University is hard to discern.

Allegations of preferential treatment for Loveland have been raised

Family guidance centers refer clients and authorize treatment services. Dr. Drews apparently gave Loveland Academy preferential treatment. During the first three months of Loveland's contract, Dr. Drews was allegedly at odds with the Leeward and Central Oahu Family Guidance Center chiefs regarding the appropriate level of Biopsychosocial Rehabilitation (BPSR) service authorizations that Loveland was to receive. Both Loveland and Dr. Drews insisted that BPSR Level III services, at a rate of $40 an hour, was necessary to treat children with Autism Spectrum Disorders and Pervasive Developmental Disorders (PDD). However, the other chiefs believed that BPSR Level II services, at a much lower rate of $15 an hour, was equally appropriate. The division's clinical services director and contracts management supervisor agreed, stating in a letter that the division had advised Loveland both prior to the contract signing and at a Clinical Standards training workshop that BPSR Level II was designed specifically for the autistic population.

This dispute was finally resolved in October 1999, when the family guidance centers agreed to (1) authorize BPSR Level III when making initial referrals for autistic and PDD children and (2) to review each case after six weeks to determine if BPSR Level II was appropriate. The Committee, however, has not yet determined if any of Loveland's cases were actually reduced to BPSR Level II.

Apparently, the Committee's concerns have caused Dr. Drews to rethink his relationship with Loveland. As a direct result of the Committee's inquiries, Dr. Drews formally terminated his business relationship with Loveland Academy in a memo dated October 15, 2001.

Recommendations

1. The Committee should continue its work during the 2002 legislative session in order to address the matters it could not complete in the interim as well as to prepare for the post decree continuum of care. The Legislature will need to address such issues as:

   - the transfer of a significant portion of the *Felix* population to school-based services;
   - gap groups that may result;
   - the continued participation and support of communities and whether best practices serve as the basis for service delivery.

   The Committee should continue to build on the contributions and efforts of all those individuals who have brought the system of care to the point of compliance.

2. The Legislature should closely scrutinize the extraordinary or "super powers" granted by the federal court.

3. The amount of federal impact aid that exceeds the authorized appropriation in the general appropriations act or the supplemental appropriations act should be subject to legislative oversight. The appropriation of anticipated impact aid should be raised to be closer to actual receipts.

4. The DOE should improve its fiscal management by:

   - Developing a means of reconciling budget and expenditure information.
   - Developing functional reports, such as an analysis of budgeted to actual expenditures.

   These reports should be routinely shared with the Board of Education, the governor, and the Legislature.

5. The DOE should provide a further breakdown of EDN 150 by separating *Felix* costs from overall special education and CSSS costs.

6. The Board of Education should require the DOE to strengthen its accountability for compliance with the *Felix* consent decree. The board should routinely share any accountability reports with the Legislature and the governor.

7. The DOH should ensure that it has proper and adequate oversight over *Felix*-related contract and expenditures by establishing a formal review system for all private provider agencies contracted by its Child and Adolescent Mental Health Division.

8. The Child and Adolescent Mental Health Division should abide by its policy and procedure manual and take appropriate actions to guard against conflicts of interest.

9. The Child and Adolescent Mental Health Division should take additional steps to ensure that provider agencies are not in violation of the State law, including but not limited to the State Ethics Code and procurement law. Such steps should include:

a. Reviewing an agency's proposal for possible ethical violations.

b. Addressing any concerns arising from the proposal (i.e. requiring the agency to provide a written explanation of how it would ensure the State that an employee's position will not present an ethical conflict).

10. The Department of the Attorney General should review all of the concerns raised in the report such as private provider contracts, billings and fees, and alleged conflicts of interest.

Notes

[1] Memorandum to Paul LeMahieu, Ph.D., Superintendent of Education from Douglas Houck, Ed.D., Director of Program Support and Development, Subject: Profile of Overall System Performance on *Felix* Service Testing, July 20, 2001.

[2] According to staff at the Child and Adolescent Mental Health Division, there is no official date when the Diamond Head Family Guidance Center "merged" with the Kalihi-Palama Family Guidance center to form the Honolulu Family Guidance Center. Staff indicate that the change occurred some time in early 2000. The "merger" occurred so the Department of Health could have the same point of reference as the Department of Education's Honolulu District.

Chapter 3

Much Work Remains

The work of the Joint Investigative Committee is not complete. Issues remain despite the overarching conclusions we have reached, as described in the previous chapter. Some issues were on our menu of issues when we started, others emerged as our work proceeded. Some issues are specific, others are broad. They cross departments, budget programs, and branches of government. Above all, on behalf of the entire Legislature, the Committee needs to continue to insist on accountability for an effective and cost-efficient system of care for *Felix* children. In this chapter we discuss the unfinished business and argue for continued scrutiny by the Committee.

Preparation for the Day the Consent Decree Is Lifted

The day will come that the *Felix* consent decree is lifted. The federal court will have deemed the State in full compliance, the transitional 18-month period of stepped-down federal oversight will have been satisfactorily completed, and the system of care will be fully the State's. The Legislature's interest in that system of care is that it be one that delivers effective services to the right children in the right way at the right cost—and that the system be of the State's own design. With what the Investigative Committee has concluded, however, the Legislature will have no assurance that the State is prepared for that day.

There must be an immediate stop to the egregious actions of those who have taken advantage of the State at the same time measures are initiated for longer-term correction. State officials who are aware of misdeeds should be held to account just as perpetrators should be punished. Those who threaten retaliation against those who come forth with the truth should be held to account as well. Everyone should be encouraged to use the state and federal whistleblower and false claim laws. These laws protect those who assist in investigation, prosecution, and conviction, and award to the truth tellers up to 25 percent of any money recovered.

State agencies should be preparing already for the post-*Felix* system of care. They need to identify what aspects of the consent decree were dysfunctional and how they would design a system of the State's own choosing. The Legislature should demand a plan and compare any budget or program requests against that plan. Even more basically, the Legislature may have to examine whether a roadblock to an effective system of care is the governance of education. In light of the minimal role that the Committee found that the Board of Education has played, perhaps this is also the time to examine whether accountability for results can be assigned in some other way.

The Legislature needs to rethink the authority it has given away over the years. In addition to the points raised in chapter 2 regarding impact aid and the EDN 150 program budget, the Legislature needs to toughen its approach to budgeting. Budget requests should be scrutinized and agencies made to justify all their personnel positions, even the positions they already have. The days of expecting automatic legislative approval of budget demands, in the name of the consent decree and its benchmarks, should be over. Instead, the Legislature should demand answers to questions about effectiveness of services and efficiency of spending. Any roadblocks to the Legislature's ability to secure such information should be removed, including the enactment of legislation to clarify that the State Auditor is in fact Hawaii's designated audit authority where educational and health issues are concerned.

Misidentification of Felix Students

The Legislature still needs to be sure that the right children are served. The Legislature has received reports over the years that students have been placed into the *Felix* class under vague definitions of mental disability and correspondingly vague services. Sometimes, we have been told, children have been *Felix*-certified or have had services ordered in IEPs at the insistence of parents, with school personnel acceding despite their professional misgivings. Information on desired outcomes has been elusive. We could not determine whether IEPs provide for appropriate exiting of students from the *Felix* class and whether any students are ever in fact properly decertified or just age out of the class. The Committee and the Legislature need access and time to confer with experts who are independent of the federal court and the executive departments.

Federal Funds

The Investigative Committee needs to continue to bring attention to the federal funding issues it learned about during the past six months.

Federal funds in the Department of Human Services

The Investigative Committee focused on the two primary departments in the *Felix* system of care. That it did not focus on a third, albeit less involved department, is a function of the time that was available to the Committee. The Department of Human Services is part of the picture in at least two ways: (1) in placing Felix children in foster homes and (2) in paying for mental health services through Medicaid. In both these areas, federal funds are involved. The Committee needs to explore further whether any action or inaction by the DHS viz. federal funds in those programs puts the State at risk.

The Committee comes to this conclusion as the result of the recent conviction of a member of the *Felix* Technical Assistance Panel. Dr. Lenore Behar pled guilty in North Carolina to a federal charge of obstruction of justice in misusing federal foster care moneys. She had been indicted on 46 charges that included allegations of misuse of Medicaid moneys as well. She had a large role in designing Hawaii's system of care both as a member of the TAP and as the State's expert witness at the inception of the Felix case. She agreed to pay $274,000 in restitution. She could be sentenced to as much as 10 years in prison, a fine of up to $250,000, and three years of probation, but the plea agreement indicates that she will likely be sentenced to six to 12 months in prison or house arrest.

IDEA moneys

The federal government, by various accounts, indicated when IDEA was enacted that the new mandate on the states would be federally supported up to 40 percent of the additional cost. In fact, however, the level of federal support is closer to 12 percent. IDEA is will be before Congress for reenactment in 2002. States are becoming increasingly restive over what they consider to be a virtual unfunded mandate and it behooves Hawaii to maintain an active legislative presence on this issue.

Moreover, although the majority of federal impact aid money is unrestricted, a portion does derive from IDEA. The Investigative Committee did not receive complete answers as to the use of these funds and whether any restrictions accompany them.

Open Issues with the Federal Court

The Investigative Committee's subpoenas for the testimony of the court monitor, his executive assistant, and a member of the Technical Assistance Panel remain open issues. The Committee's decision to challenge the quashing of at least one subpoena and to seek the disqualification of the federal district judge continues to make its way through the legal process. The Committee is committed to maintaining its momentum to restore the dignity of the Legislature that was damaged by insult and abuse from the federal district bench.

Open Issues with Compliance

The Committee continues to receive information, oftentimes daily, from individuals finally emboldened to tell us or our Committee staff about what is really going on or has gone on with *Felix* compliance efforts. Even as we submit this report, we realize that our information is incomplete; data is still trickling in, documents are being transmitted, pieces of the picture are still being assembled. The conclusions of this report may change as the additional information is gathered.

We need to monitor the progress being made with the school complexes yet to come into compliance. These are the last few, but they are admittedly perhaps the most difficult ones—partly by geography, partly by demographics. We need to be sure that the definition of compliance will be consistent, despite what we have learned in the past six months.

We need to monitor ISPED—Interactive Special Education—the DOE computer system that will replace three unlinked systems and reduce the massive paperwork requirements in special education. The Committee did not have sufficient time to examine why the system is so far behind schedule and has cost more than planned, whether the system truly will work for its users, and whether the system will enable the Legislature and anyone else to obtain the necessary reports that managers need. The Committee would like to be sure that the benefits that it has gained from the Department of Health computer system will not be lost as the DOE takes jurisdiction over most of the students formerly served and tracked by DOH.

We need to monitor the Columbus Educational Services contract—not just in terms of the amounts of money involved, but for its longer term consequences for the State's public servants. The effect of having so many leased personnel in the schools requires careful watching.

Comments on Responses

The Investigative Committee solicited comments to our preliminary draft of this report from all who testified, were subpoenaed, were the subjects of the committee's hearings, or were interested parties. They were given 14 days to respond. They were requested to limit their comments to three pages, single spaced. They were informed their comments would be attached to this report. If they wished to submit more material than that, they could do so, but only a three-page, single spaced executive summary would be attached to the report and the remainder of the material would be placed with the Committee's official repository (the Clerk of the House of Representatives). By the deadline of 4:30 p.m. Tuesday, December 18, 2001, the Committee received eight responses. They are Attachments 1 through 8.

The Investigative Committee notes the following:

1. Before the Committee could subpoena former superintendent Dr. Paul LeMahieu, he resigned. So the Committee subpoenaed the interim, now permanent, superintendent. After his resignation, Dr. LeMahieu was given the option to testify before the Committee and not be subpoenaed. The Committee believed that giving him the opportunity to decide was the more humane thing to do. However, had he appeared before the Committee, he would have had to testify under oath and answer all questions put to him by Committee counsel and Committee members. This was explained to him. He chose not to appear. Instead, he asked to "meet" with the co-chairs. And he submitted a comment and a supplement to this report. Both of his actions avoided confronting the Committee and the requirement that he tell the truth under examination. The Committee believes his submittals should be viewed in light of the above facts.

2. There is a striking contrast between the responses of the superintendent of education and the director of health. The superintendent acknowledges the DOE's need to make major improvements, takes responsibility, and describes several corrective initiatives. The director of health, on the other hand, disputes most of the Committee's conclusions and offers "facts" that were already considered and discounted by the Committee. The director of health recommends that the Investigative Committee not be continued by the Legislature while the superintendent promises corrective actions as recommended by the Committee.

3. There are contradictions among the responses of Dr. LeMahieu, PREL, and Na Laukoa regarding the technical assistance contract with PREL and subcontract with Na Laukoa. Dr. LeMahieu states that it was Dr. Douglas Houck, and not himself, who was the individual most responsible for representing DOE in "defining the initiative and coordinating it once the effort got underway." Dr. LeMahieu asserts that others were involved in decision making regarding the contract, that he introduced Na Laukoa to PREL as "the firm that had developed the initiative," and that PREL was not required to subcontract with Na Laukoa. PREL states that the State asked for PREL's assistance and PREL "accepted the contract in good faith." The contract indeed required PREL to subcontract with Na Laukoa. Na Laukoa states that it was recruited by the (former) superintendent for the contract.

Final Conclusion

For all the pending issues that remain and because of the knowledge we have gained since June 2001, this Committee believes it needs to continue beyond its scheduled expiration date of the convening of the 2002 Regular Session.

Appendix A
Brief Synopsis of Hearings

Date of Hearing	Name and Title of Testifier	Subject of Testimony
June 19, 2001	No witnesses.	The Committee met to adopt rules for the conduct of the investigation and to discuss organizational and procedural matters for future hearings including securing attendance of witnesses by subpoena.
July 13, 2001	• Ivor Groves, *Felix* Court Monitor • Juanita Iwamoto, Executive Director, Felix Monitoring Project	Subpoena quashed by federal court.
	Marion Higa, State Auditor	Discussed findings of her office's prior *Felix* reports and obstacles her staff encountered during the course of their work.
August 20, 2001	Douglas Houck, retired Director of Program Support and Development, Department of Education	Compliance issues and efforts related to the consent decree.
	• Bruce Anderson, Director of Health • Paul LeMahieu, former Superintendent	Presented documents to the Committee pursuant to subpoena.
September 17, 2001	• Robert Golden, retired Director of the Student Support Services Branch, Department of Education • Debra Farmer, Administrator, Special Education Section, Department of Education	Targeted technical assistance and the Department of Education's contract with Na Laukoa.
	Russell Suzuki, Deputy Attorney General	Plaintiff attorney fees.

October 3, 2001	Judith Schrag, *Felix* Technical Assistance Panel member	Rescheduled
	Margaret Pereira, mental health worker for various private provider agencies	Questionable billing practices and Multisystemic Therapy or MST Continuum projects.
	• Kenneth Gardiner, Mental Health Supervisor, Department of Health • Michael Stewart, Care Coordinator, Department of Health	Questionable billing practices and potential conflicts of interest by private providers contracting with the State.
October 5, 2001	Karen Ehrhorn, Chief Financial Officer of Pacific Resources for Education and Learning (PREL)	PREL's subcontract with Na Laukoa.
October 6, 2001	Danford Sakai, former Hawaii District Superintendent	PREL's subcontract with Na Laukoa.
	Albert Yoshii, former Personnel Director, and now *Felix* DOE Contract Compliance Director	Columbus Educational Services and PREL/Na Laukoa contracts.
October 12, 2001	Richard Kravetz, President of Alakai Na Keiki	Alakai Na Keiki's billing practices.
	Ronald Higashi, Executive Director of the Susannah Wesley Community Center	Produced and authenticated documents requested by subpoena.
	Don Burger, Program Director, PREL	PREL's subcontract with Na Laukoa.
October 13, 2001	• Patricia Jean Dukes, President, Loveland Academy • Margaret Koven, Clinical Director, Loveland Academy	Allegations of questionable billing practices at Loveland Academy.
	David Drews, Branch Chief, Honolulu Family Guidance Center	Alleged conflict of interest of his duties as a state employee, his establishment and presidency of Central Pacific University, and his alleged business relationship with Loveland Academy.

October 17, 2001	Judith Schrag	Rescheduled
	• Dennis McLaughlin, President, CARE • Tina McLaughlin, Vice-President, CARE	Billing practices at CARE.
	• Sharon Nobriga, Co-Executive Director, Hawaii Families as Allies • Vicky Followell, Co-Executive Director, Hawaii Families as Allies	Purpose of Hawaii Families as Allies and its involvement with the *Felix* consent decree.
	Kate Pahinui, former Director of Hawaii Ohana Project	Project's involvement with the Court Monitor and his associates as well as the service testing instrument.
October 20, 2001	Kenneth Omura, point person for *Felix* in the Department of Education	Compliance issues and service testing.
	Kaniu Kinimaka-Stocksdale, owner of Na Laukoa	Subcontract with PREL to provide targeted technical assistance to the Department of Education. Her relationship with former Superintendent LeMahieu
October 27, 2001	John Donkervoet, former MST Coordinator, Department of Health	Concerns with MST and particularly the MST Continuum research project; responded to Ms. Pereira's allegations.
	Edwin Koyama, Internal Auditor, Department of Education	Internal audit he conducted on the *Felix* Response Plan earlier this year.
October 31, 2001	• Mitsugi Nakashima, former Chair, Board of Education • Herbert Watanabe, Chair, Board of Education	Board's involvement with the *Felix* consent decree. Specific emphasis was placed on the Na Laukoa subcontract with PREL and the Columbus Educational Services contract.
	Paula Yoshioka, former Assistant Superintendent, Division of Administrative Services	Columbus Educational Services contract.
November 2, 2001	Judy Schrag	Subpoena quashed by federal court.
	Mary Brogan, former Clinical Director, Child and Adolescent Mental Health Division, Department of Health	Division's contract monitoring, questionable billings, and service testing.

November 3, 2001	Chris Ito, Director, Business Services Branch, Department of Education	Department of Education's expenditures for the *Felix* consent decree.
	Valerie Ako, Chief, Administrative Services Office, Department of Health	Contract monitoring and budgeting for the consent decree.
	Christina Donkervoet, Chief, Child and Adolescent Mental Health Division	Contract monitoring, questionable billings, and MST.
November 7, 2001	• Bruce Anderson, Director of Health • Anita Swanson, Deputy Director, Behavioral Health Administration	Departmental efforts to comply with the *Felix* consent decree.
November 9, 2001	Laurel Johnston, Assistant Superintendent, Planning, Budget, and Resource Development	Department of Education's budgeting practices and accountability over *Felix*-related funds.
November 10, 2001	Patricia Hamamoto, Interim Superintendent	Department of Education's efforts to comply with the *Felix* consent decree.
November 16, 2001	Marion Higa, State Auditor	General overview of the Committee's conclusions and discussed obstacles her staff and the Committee faced while attempting to gather information.

Attachment 1

TORKILDSON, KATZ, FONSECA, JAFFE,
MOORE & HETHERINGTON

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PERRY W. CONFALONE
E-MAIL: PWC@TORKILDSON.COM

December 18, 2001

RECEIVED
Dec 18 2 52 PM '01
OFC. OF THE AUDITOR
STATE OF HAWAII

By Hand Delivery

Joint Investigative Committee Staff
Office of the Auditor
465 South King Street, Room 500
Honolulu, HI 96813

Re: Preliminary Draft Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance with the Felix Consent Decree

Dear Sir:

Pursuant to the correspondence from Co-Chairs Hanabusa and Sakai we hereby transmit our comments with respect to the preliminary draft of the Joint Committee Report.

We will withdraw these comments for publication in the event that the Joint Committee deletes from the final draft the references to Dr. Hufano and Dr. Kravetz with respect to alleged ethical violations consistent with the confidentiality requirements of Haw. Rev. Stat. Chapters 84 and 92F.

Please call if you have any questions.

Yours truly,

TORKILDSON, KATZ, FONSECA
JAFFE, MOORE & HETHERINGTON
Attorneys at Law, A Law Corporation

Perry W. Confalone

PWC/cyn
Enclosure
cc: Dr. Linda Hufano
Dr. Richard Kravetz

52744/0003/517598.V1

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December 18, 2001

By Hand Delivery
Joint Investigative Committee Staff
Office of the Auditor
465 South King Street, Room 500
Honolulu, HI 96813

Re: Comments of Dr. Kravetz and Dr. Hufano on Preliminary Draft Report

Dear Sir:

Dr. Richard Kravetz and Dr. Linda Hufano are obliged to respond to the Joint Committee's assertions that they may have violated ethics laws in obtaining a contract to deliver mental health services for children in 1997.

Beginning in 1998 the State Ethics Commission thoroughly investigated the alleged ethics violations referenced in the Joint Committee Report. Dr. Hufano and Dr. Kravetz fully cooperated with the Ethics Commission. The Commission investigation included interviews with DOH officials. In August 2000, Drs. Hufano and Kravetz received confidential letters from the Ethics Commission informing them that the case was closed and thanking them for their cooperation. The Commission determined not to issue an ethics violation charge. Because a charge did not issue, the investigation was required to be confidential by statute and was not a matter of public record. Since the Joint Commission published these assertions, the public should know that the Ethics Commission concluded the following: 1) There was no evidence indicating an intent to circumvent ethics requirements in the contracting process. Indeed Drs. Hufano and Kravetz submitted their resumes detailing their employment histories with the State as part of the contracting process; 2) There was no evidence indicating that Drs. Kravetz or Hufano used their state employment to benefit Hoahana; and 3) There was no evidence that Hoahana received preferential treatment.

Respectfully submitted,

Perry W. Confalone, Esq.
Counsel for Dr. Richard Kravetz and
Dr. Linda Hufano

PWC/cyn
52744/0003/517591.V1

Attachment 2

Child and Adolescent Resources for Education, Inc.

CARE-HAWAII

677 Ala Moana Blvd., Suite 1003
Honolulu, HI 96813

Phone: 808-533-3936
Fax: 808-533-3966
Email: tina@care-hi.net

December 17, 2001

Senator Colleen Hanabusa, Co-Chair
Representative Scott K. Saiki, Co-Chair
Joint Investigative Committee Staff
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813

Dear Senator Hanabusa and Representative Saiki:

Thank you for allowing me this opportunity to comment on the preliminary draft of the Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance With the *Felix* Consent Decree.

As the Report notes, costs for compliance with the Felix Consent Decree have increased, however, it should be noted that overall costs per student have significantly dropped. Currently, Hawaii is serving the number of students under this decree that could be expected to be served for the population size.

Although provider agencies are singled out by the auditor as profiting from the Decree, these agencies have been a positive force, along with DOE and DOH efforts, in bringing the majority of DOE Complexes into compliance with the Decree.

Page 5 of the Report notes that the delivery system was previously primarily off campus, and medically-based. For the past four years, all provider agencies have provided well over 90% of services on-campus and in the student's homes and community settings. Additionally, treatment plans and services delivered focused on assisting the student to benefit from educational opportunities and were not based on medical need as the criteria for treatment.

The Report comments in several places on the Committee being denied access to student treatment records based on confidentiality issues. Even though the auditor sought to insure privacy by having the student's name removed from the record, records almost always contain other identifying information, such that the student could be easily

identified. Confidentiality laws and professional ethics prohibit the release of records if any such information can be used to identify the student without the legal parent/guardian's consent. Thus, not releasing records is merely complying with the law, not obstructing inquiry.

The Report comments on the DOH and DOE fostering a culture of profiteering at the State's expense through inadequate monitoring of services. Yet agencies typically experience several audits a year, including audits for fiscal, clinical, and personnel practices. The Report comments on excessive administrative costs, yet agencies are held to high standards of performance both in the delivery of clinical services with intense supervision and training requirements, and extremely thorough credentialing processes to ensure that the State is able to collect funds from the Med-Quest program. These efforts all inflate administrative costs. Also, the Report does not define what "excessive" profit is and how the determination of "excessive" was made. The agencies that I am aware of are all expressing concern for their financial survival. Additionally, individual providers that I know are not living grand lifestyles, and are just generally getting by from month to month. Thus, it is disturbing to be branded as participating in a "culture of excessive profit".

On page 31, the Report notes that boyfriends and relatives receive payments for services and that payments for horseback riding lessons have been provided. Good practice suggests that if a relative, who would be otherwise employed, could be employed to assist a student, that often such an individual will help the student achieve the most success. In terms of horseback riding lessons, the choice of that technique is again driven by the IEP team, and there is significant literature that addresses the effectiveness of that technique, along with others, to assist students in developing focus, concentration, the ability to follow directions, and, in some cases, the ability to begin to relate to another living organism.

On page 48, the Report describes a therapist billing for 127 hours in one day. This situation has been previously explained to the Legislative Investigative Committee so it is a bit surprising to see it resurfacing in the Report. The 106 hours of Biopsychosocial Rehabilitation (BPSR) represent multiple students receiving services in a group format. CAMHD mandated that billing be done under the name of a lead, or supervising therapist, even though other M.A. and doctoral level therapists were involved in the provision of care for the students on a particular day in the program. Given this scenario, the case cited in the Report likely represents 8-10 hours of work for that day on the provider's part. The provider would have been paid for those hours worked, and the other participating providers paid for their portion of the work.

On Page 49 the Report notes that providers offer services that do not adhere to the DOH's clinical standards, and that services may exceed recommended DOH limits. It should be noted that DOH's limits are not firmly linked to evidence based practices but were set to provide guidelines for review of services. In any case, all services are recommended by the IEP team, and approved by the DOH because the services are believed to have merit in assisting the student to benefit from educational services. Additionally, for some

diagnostic categories, such as autism, it is the national norm that services run in the range of $30,000 per year. However, when these services are provided early and in a timely manner to the student, it is unlikely that the student will continue to require services anywhere close to that level after a 3-4 year time period. Many students receiving that level of service at an early stage go on to be fully integrated into regular education classroom settings and become productive members of society in adulthood. Without such services, the picture for these students usually includes prolonged services that are not highly effective during childhood and adolescence, and possible institutionalization or ongoing care in adulthood.

Also, on page 49, the Report makes assumptions regarding the mark-up on billing for therapeutic aide services. What the Report does not capture is the fact that therapeutic aides are paid not only for direct hours of service to students, but for time spent in training, supervision, documentation and other such activities. The Report does not note that agencies typically carry health insurance for these part-time employees, and that recruitment and retention efforts for this level of employee are considerable. Most of these employees are pursuing their own education and terminate service after a few months, necessitating the recruitment and training of a new employee. It is not uncommon to have to recruit, orient, fully train and supervise 3-4 employees during a given year to provide service for one child. These activities can rapidly vaporize any remaining "mark-up". Thus, the assumptions made in the Report about the markup are erroneous. It is also interesting that the Report makes no mention of services such as psychiatry and psychology on which provider agencies typically lose money – yet these services for many agencies make up the majority of services offered.

On page 51 the Report states that audits conducted by CAMHD merely focus on documentation and adherence to clinical standards. Our experience is that each of our audits by CAMHD was linked to the billing record. In addition, CAMHD regularly surveys student families, providing them a Report of all services for which the state is paying for the family's student. Thus, this mechanism serves as a check of the accuracy of provider billings. In addition, agencies maintain their own mechanisms for detecting fraud and abuse and frequently self-report findings and return funds the agency determines were not appropriately billed.

Hopefully these comments provide the Committee with more information to round out some of the statements in the Report. As an agency providing services to students we strive to provide effective and accountable services, meeting accreditation, credentialing and audit standards. It is important to us that our work be presented fairly and accurately, and that global statements that may not represent the whole picture not be used to mischaracterize our work.

Sincerely,

Tina L. McLaughlin, Psy. D.

Tina L. McLaughlin, Psy.D.
Chief Executive Officer

Attachment 3

December 18, 2001

Joint Investigative Committee Staff
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawai`i 96813

To Whom It May Concern:

Aloha, my name is Kaniu Kinimaka-Stocksdale, principal owner of Kaniu I, LLC dba Nā Laukoa, a private for profit company. Our company was created in September 1997 to provide behavioral and mental health services to the children and families of the Big Island. Mahalo to the Senate-House Committee for this opportunity to respond to the Joint Senate-House Investigative Committee report.

As stated in the cover letter dated December 4, the three pages of my response will be a part of the final Joint Senate-House Investigative report.

The committee report questions Nā Laukoa's qualifications to perform the Nā Kāko`o Technical Assistance project. For the record, only a few of Nā Laukoa's employees and professional staff were involved in this particular project. The names, resumes' and credentials of the professionals who were involved are shown in the report submitted to the committee by PREL. To the best of my recollection, all of the professional employees or subcontractors who worked for Nā Laukoa, or who were subcontracted by PREL, were approved by DOE representatives prior to their employment.

As clarification, I would like to point out that Nā Laukoa was recruited by the Superintendent for this contract. Further, the more complete story is that the task was to be so different from what had gone on before, that nobody had a complete grasp of the qualifications that would be necessary for the success of this project. As a result of the unique professional qualifications of our professional employees, Nā Laukoa did an excellent job in performing this contract.

The report cites my lack of a "formal education" as further criticism of Nā Laukoa's involvement. This criticism misses the point. It was not my job to provide direct services to the children in the complexes that had been selected. Further, it was not my job to interact directly with the complexes. It was my job to hire or subcontract professionals who not only had the necessary professional credentials but who also had the ability to work within the system at each of the complexes.

Nā Laukoa
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Telephone (808) 961-0031 Fax (808) 969-9936

The report raised an ethical concern about a personal relationship entering into a professional decision. It is true that the professional relationship had changed over time into a personal one. This change occurred after the contract was awarded. The focus on this incident has clouded the important issue of whether or not Nā Laukoa helped the identified complexes make important changes in their systems; which we accomplished, as evidenced by the informal and formal data submitted by PREL.

It should be recognized that Nā Kāko`o Technical Assistance project was awarded to Nā Laukoa based on what the professionals employed by Nā Laukoa had to offer in connection with facilitating systemic changes within the school complexes. It was a DOE team decision that Nā Laukoa be awarded the contract. It is my firm believe that there was no other agency that had the access to the professional expertise which we enjoyed, and which would have been willing to go to the extent we did to assist the identified schools and the DOH Family Guidance Centers.

The lead coordinator for Nā Kāko`o Technical Assistance project was Dr. Kimo Alameda. Upon his resignation to join the Department of Health as Transitional Specialist for CAMHD, Ms. Carol Plummer held the position as lead coordinator until the contract terminated October 31, 2001. Dr. Alameda, as lead coordinator, set up the guidelines, rules, policies and directives for the project. Dr. Alameda was uniquely qualified since he was a health professional and also had worked as a counselor in the DOE school system. PREL became a partner to enhance and strengthen the project after questions were raised concerning Nā Laukoa's ability to handle the necessary fiscal and data collecting aspects of the program. The ground work was to be directed and coordinated by Dr. Alameda, and Carol Plummer. The primary work had to be done at the schools and the DOH Family Guidance Centers. Dr. Alameda and Carol Plummer helped build the communication bridge between the two departments so that collaboration was the rule rather than the exception. It was crucial that, although having experiences in both DOE and DOH systems, Dr. Alameda and Ms. Plummer were not employed by either system. This made it possible for them to challenge the status quo by providing honest and direct feedback without fearing job loss or the "good old boy" network. This is the key if systems, such as DOE and DOH, are serious about making genuine and lasting change.

The report cites Debra Framer's concerns. If you review the resumes of the professionals hired to do the work, you will find that many of them had already extensive experience in the Department of Education (e.g.; special education, teacher, principal, vice principal, school counselor, resource teacher). A detailed list submitted to the committee by Dr. Don Burger of PREL shows exactly what was provided by Debra Farmer. In a conversation with the present Superintendent, Debra Farmer's training was described more as an orientation rather than training.

The report concludes by asking whether the contract was necessary and whether the funds could have been put to better use providing services to our school children. Services to children come in different forms. The services referred to by the committee are "direct service" such as those a teacher or counselor would provide. Other types of

services are called "indirect services", such as those a school consultant would provide. Both types of service are crucial elements in the overall servicing of children. A functional system can't have one without the other. The purpose of Nā Kāko`o contract was to provide "indirect consultation services", with the goal of helping those fifteen identified complexes help themselves; which in turn would help the children receive the services they deserve in those complexes.

Attachment 4

A Response to the *Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance with the Felix Consent Decree*
Prepared by Paul LeMahieu

I write to respond to the Committee's preliminary draft report, *Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance with the Felix Consent Decree*, dated December 4, 2001. I want to express my appreciation to the Committee for this opportunity. I hope that nothing contained herein gives offense, either in its particulars or in the manner expressed. However, there are points at which challenge is issued. Pleased know that the sole purpose in doing so is to assist the Committee in making fair and well informed judgments, leading to appropriate conclusions and actions that will help this state successfully address its problems.

This response is organized into three sections: ***General Observations***, ***Targeted Technical Assistance Project***, and ***Summary and Challenges to the Committee***.

General Observations

The tone throughout the report ascribes sinister intentions on the part of agencies and individuals that are most improbable and, more important, fly in the face of volumes of contrary evidence. For example, much is made of purported efforts to use federal funds to avoid legislative oversight in spending for Felix related costs. Federal funds, specifically Impact Aid monies were used to defray Felix related costs -- for technical assistance and a number of other costs as well. The reason for doing so was quite simple and far less sinister than suggested in the report: the DoE made every effort to reallocate funds so as to minimize impact on local tax revenues.

Evidence overwhelmingly suggests that the malevolent interpretation offered in the report is unreasonable. DoE staff met with the Finance Committee of the House and the Ways and Means Committee (WAM) of the Senate on Jan. 4, 2001 to discuss the Felix costs and a likely emergency funding request. Follow-ups for similar purposes were held on Jan 8 with WAM, and with Senator Hanabusa and staff on Jan 28. These meetings led to summits (including leadership of education and money committees and the President or Speaker as appropriate along with staffs) with the House on Feb 5 and the Senate on Feb 8. Legislators concerns about the budget were vigorously voiced, and at these meetings it was determined that the Department would do everything in its power to minimize the emergency request: including measures to minimize costs, updating projected budget figures, reallocating resources (including federal funds), so as to minimize costs to local taxpayers. There were many legislators at these summits, including Sens. Hanabusa and Sakamoto as well as Reps. Saiki and Ito of this Committee amongst others.

The use of these moneys to support Felix compliance was approved by the Board of Education, and the use of federal funds was explicit from that point forward in documentation provided to the Education and Budgetary Committees of both houses. These efforts proved successful as the need for the emergency request was reduced by 34% during the session and nearly eliminated after its close.

Even as I promised that we would reduce the burden on the General Fund, I saw a trap. I predicted that the DoE would be cited as being either incompetent in its budgeting or dishonest. In this report, my prediction seems to be proved correct despite evidence of more responsible motives and documentation of efforts to be forthcoming,.

Targeted Technical Assistance

The targeted technical assistance initiative was a complex undertaking. Space does not permit a detailed treatment of its design or rationale (a more complete Overview is appended as Attachment A) but it is important to know that its purpose was to provide external technical assistance to complexes to plan for the transition to school based services as well as service testing and compliance. The Federal Court's orders of June, 2000 required that the State enter into a contract with an external agency to provide this TA, and to do so within a timeframe that simply did not permit the usual procurement practices.

Given that circumstances did not permit things to be done in "the usual way" (and that there is nothing wrong in that alone), the public's interest and the Committee's concerns should most properly be focused on three primary questions: 1. Were those who provided TA qualified to do so? 2. Was the contract let in a manner that protected the public's interests? 3. How did the contractors perform and what was the impact of the effort?

Were those who provided TA qualified to do so? The report's treatment of this matter raises questions of analytic rigor, balance and fairness. The suggestion that the technical assistance coordinators (TAC's) were not qualified is based on Mr. Albert Yoshii's testimony who makes it amply clear (Committee Testimony, pp. 119-122) that he knows nothing about the TAC's except what he learned from Mr. Robert Golden. Mr. Golden, in turn, testified that he knows nothing about them other than what he heard from two calls from the Big Island (Committee Testimony, pp. 36-40). One of those who made the calls (Mr. Danford Sakai) testified that he informed me that the major concern was that NLK had on occasion been perceived as "too critical and challenging of DoE staff in the

schools." When asked if he had been told by staff that NLK was not qualified to provide that type of service, he replied "No." (Committee Testimony, p. 24) and that to his knowledge staff was not opposed "to NLK being one of the organizations to provide technical assistance." (Committee Testimony, pp. 23-24)

Just what were the TAC's qualifications for this effort? The qualifications of the TAC's are presented in documentation provided by PREL. I will summarize them here: 1) Of the total complement of TAC's 26% had Doctorates; 58% had Master's Degrees -- a combined total of 84% with advanced degrees in education, special, education, counseling or related fields; 2) Over half of the TAC's have since been hired by the University of Hawai'i, the Department of Health, or the DoE -- further validation of their qualifications; 3) PREL has extensive qualified staff in education program design and management and over ten years experience in technical assistance focusing on underserved and rural locales much like those of this initiative; 4) NLK had 45-50 employees, national accreditation by the mainland based Commission on Accreditation of Rehabilitation Facilities, experience providing mental health services to over 200 children in 28 schools with annual billings averaging $2-2.5 million.

Was the contract let in a manner that protected the public's interests? The Committee is rightfully concerned to question whether a rumored (and later admitted) personal indiscretion compromised the public's interest in the award of this contract. In fact, the public's interest was not compromised and there are a number of reasons why it could not have been. First, the relationship grew to become personal *after* the contract was executed. Second and even more to the point, there is ample documentation of the involvement of others in decision making regarding the contract. Knowing that the contract was to be defined and pursued outside the usual procurement procedures we were concerned that prudent judgments be made.

1. Dr. Douglas Houck, not I, was the individual most responsible for representing the DoE in defining the initiative and coordinating it once the effort got underway. Despite the fact this contract was of singular concern to the Committee and that he was in charge of the contract, the Committee did not ask him anything about it in approximately four hours of testimony.

2. As the time for contract execution approached, a three person panel was formed to hear a presentation from the proposed coordinators, ask tough questions, and examine credentials and background. Two of the three panelists recommended approval and voted in favor of the contract, offering on their reaction forms comments such as "strong clinical team," "expertise in bridging mental health to education," "can provide the necessary team approach (if properly supported by DoE) to bring the identified complexes into compliance," "staff has an understanding . . . and commitment to school based services," and "I believe that they will be able to do the job in an appropriate manner." The Investigative Committee heard from and incorporated the views of the lone dissenter into its deliberations. It chose not to hear from the two others present who were in favor of the contract.

3. As the initiative was restructured in response to those concerns that were legitimate, I introduced NLK to PREL as the firm that had developed the initiative. I made it clear that they were not required to subcontract to NLK, that it was not a requirement of the contract. This fact has been confirmed by Mr. John Kofel, president of PREL. He was quoted in the press as saying that "Dr. LeMahieu did not insist on their [NLK] involvement. That was our decision." (Honolulu Advertiser, May, 2001 and confirmed on Oct, 20, 2001) The reporter who wrote that story has since checked her notes and corroborates that as correct and accurate. It was correct when the contract was being set up, it was correct when reported in May and in October, 2001, it is correct today. That the contract includes NLK as a subcontractor does not necessarily mean that it was a precondition of the contract any more than a construction contract that identifies the general contractor's choice of electricians necessarily required those subcontractors as a precondition. To suggest otherwise is disingenuous.

How did the contractors perform and what was the impact of the effort? Those who provided TA performed extremely well in the main and far better than might be expected under the circumstances. This is not to suggest that there were no problems, but perfection is hardly the appropriate standard of judgment. Questions about performance come form two sources. Ms. Debra Farmer expressed concern that the TAC's had to be trained regarding DoE Programs including local regulations and administrative rules. This was to be expected as they were external contractors. It in no way suggests that they were unqualified as it is to be expected that external contractors will have to be oriented to local rules in order to best communicate and apply their expertise. In addition, Mr. Sakai was questioned about some early difficulties that he was aware of. He testified that as soon as the problems were brought to the attention of the Project Director Dr. Kimo Alameda they were resolved at the [school and complex] level (Committee Testimony pp. 84-85) and that problems were resolved such that the communications "met the needs . . . and it was satisfactory." (Committee Testimony, pp. 53-54)

Much more important is the performance of those complexes served by the Technical Assistance Initiative. (Detailed data has been provided to the Committee by PREL; they are summarized on Attachment B.) The TTA

focused on the 15 complexes deemed by the Court to be having the greatest difficulty coming into compliance. Of those 15, ten have undergone service testing. Of those ten, seven passed service testing completely and three others passed one of the two portions, falling close on the other. In other words, the ten complexes tested have yielded seven complete successes and three partial successes. An examination of the numbers quantifies the gains in those complexes. When compared to previous testing done (most of it in the 1994-95 timeframe), the TTA complexes that were service tested increased their performance by 28.8 percentage points. A comparison to all other complexes not receiving TTA support but service tested twice within the same timeframe shows that the comparison group increased their performance by 19 percentage points. The comparison again is 28.8 percentage points improvement in the TTA complexes compared to 19 percentage points in all others. In other words, the TTA complexes not only dramatically increased their performance, they did so significantly better than complexes not receiving TTA support. While honesty compels one to admit that the TAC's were not the only reason for this tremendous success (much credit goes to the folks in the schools) it would be equally unfair to discount them, especially given the superiority over the comparison group without TAC support. As Superintendent Hamamoto has said the success is due to all pulling together.

Summary and Challenges to the Committee

In summary, this response speaks to allegations and insinuations of possible impropriety in the award of a contract and possible efforts to subvert the Legislature's oversight and appropriate funds for inappropriate purposes. As demonstrated here and corroborated by evidence, none of this occurred. Those who provided technical assistance under the contract were well qualified to do so; the plans were independently reviewed by a number of senior staff in the DoE, and they recommended 2 to 1 to proceed with the award. Ultimately the decision to subcontract with NLK was left to the prime contractor, as their president has stated repeatedly to the press and reporters have corroborated. Most important, the TAC's were of great benefit to a number of complexes and the success was remarkable for an undertaking so complex and so quickly assembled. There was no effort to dodge legislative oversight. We committed to control costs and shift funding sources (including federal monies which the legislature has repeatedly advocated) in meetings as far back as January and February of 2001, meetings at which at least four members of the investigative committee were present. Relevant documentation was then provided at each of the many relevant hearings before House and Senate committees.

This leaves the Committee with three very great challenges: 1) to distinguish real problems from unpopular decisions; 2) based on #1, to fashion solutions that do not impede effective management of public affairs; and 3) to carefully manage the lessons of this investigation such that they are not again prohibitive of efforts to innovate or to take action in the interest of solving our State's problems.

We do have real problems, and the work of the Committee has uncovered a number of them. It is important, however, to distinguish real and enduring problems from matters that are not or that are unique to this circumstance or time. For example, the Columbus contract and the PREL contract, whatever one might think of them substantively, are unique to the current situation. They would not be needed at any other time and they would not have been possible at any other time. It is not clear that they constitute situations that need legislative remedy.

The whole of the investigation has uncovered a number of legitimate problems. Inability to monitor billings under contracts or analyze and report expenditures has been a concern for some time. We see now the problems that this can create. There are two possible approaches to addressing such issues. One may impose (legislative) controls and constraints or one may invest in the systems necessary to monitor, analyze and report effectively. The record is clear that the latter solution leads to a healthy and effective system. The record is equally clear that no set of controls will ever be able to anticipate all possible problems and instead they will perpetuate the inefficiency and inability to act decisively for which our government is well known. When faced with the most serious economic crisis ever to face our State, the very first thing that the Governor sought was relief from such constraints. He was right to do so; we should learn from that.

Finally, there is the matter of the lessons learned by our system from this experience. The Committee must consider them carefully in order to help us create the system we want and need. Not all decisions with which we might disagree constitute wrongdoing. Similarly, not every action taken in an unusual manner is mismanagement. Not even every mistake is an error deserving of the severest punishment. To treat them as such teaches the Department to never put accomplishment ahead of time served, performance ahead of procedures, and never seek to innovate or advocate the unusual. That sort of risk taking is what is most needed in a system struggling to reform itself. We must not teach that the way things have always been done is the only acceptable way. If the work of this Committee substantiates past practice as the standard for judging action, our system will take a dangerous turn in exactly the wrong direction..

Attachment 5

BENJAMIN J. CAYETANO
GOVERNOR

PATRICIA HAMAMOTO
INTERIM SUPERINTENDENT

STATE OF HAWAI'I
DEPARTMENT OF EDUCATION
P.O. BOX 2360
HONOLULU, HAWAI'I 96804

OFFICE OF THE SUPERINTENDENT

December 18, 2001

The Honorable Colleen Hanabusa, Senator
The Honorable Scott K. Saiki, Representative
Co-Chairs, Joint Senate-House Felix Investigative Committee
Hawaii State Legislature
State Capitol
Honolulu, Hawaii 96813

Dear Senator Hanabusa and Representative Saiki:

The Department of Education appreciates the opportunity to comment on the *Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance With the Felix Consent Decree.*

The Department has made significant progress towards complying with the federal court's requirements of the Felix Consent Decree and Contempt Order. This is a result of the diligent efforts of all the leadership and staff at state, district offices, complexes and schools who have focused on identifying and serving those students in need of mental health services. We therefore would like to recognize all of those individuals who have helped the Department achieve its significant progress towards compliance.

We also acknowledge the efforts of the Joint Senate-House Investigative Committee over the past several months. The Committee's Report has listed several recommendations. The Department recognizes that major improvements must be made in various areas, including fiscal management of Felix-related expenditures. The Department is taking corrective action regarding the Committee's recommendations.

The Department recognizes that its existing fiscal organization structure, management information and internal processes have not been satisfactory. Therefore, I have begun several initiatives to revamp the Department's fiscal management:

a. Establishing an organization structure that will be conducive to effective and efficient fiscal management, including the coordination of budget and accounting functions, with the objective of producing consistent and accurate financial and statistical information.
b. Defining relevant and useful management information data.

c. Implementing a financial analysis process, to include financial projections and effective use of unexpended resources.

d. Developing a system of accountability that will link program outcomes with fiscal results. As part of this initiative, we will research the development of an activity-based or performance-measurement costing method. This approach could result in more detailed cost analyses and more specific identification of services provided to Felix-class students. We anticipate that data from the ISPED system may provide valuable data in such analyses.

Some these initiatives will include both short-term and long-term solutions. In the short-term, there are a number of tasks that can be completed and implemented within a reasonably short period of time. Long-term plans would involve operational and computer system changes that may take longer than one year. Whether short-term or long-term, our consistent goal will be to achieve effective and efficient fiscal management of the Department.

Very truly yours,

Patricia Hamamoto
Superintendent

PH:EK

Attachment 6

BENJAMIN J. CAYETANO
GOVERNOR

PATRICIA HAMAMOTO
INTERIM SUPERINTENDENT

STATE OF HAWAI'I
DEPARTMENT OF EDUCATION
P.O. BOX 2360
HONOLULU, HAWAI'I 96804

OFFICE OF THE SUPERINTENDENT

December 18, 2001

The Honorable Colleen Hanabusa, Senator
The Honorable Scott K. Saiki, Representative
Co-Chairs, Joint Senate-House Felix Investigative Committee
Hawaii State Legislature
Honolulu, Hawaii 96813

Dear Senator Hanabusa and Representative Saiki:

Thank you for the opportunity to comment on the *Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance With the Felix Consent Decree.*

I would like to clarify your finding that *"the DOE purchased laptop computers for vacant positions." [page 18]* This issue was raised in my internal audit report *("fiscal review")* of the Felix Response Plan.

As I testified to the Committee on October 27, 2001, the definition of "vacant position" requires further explanation. A "vacancy" in a special education teacher position, for example, indicates that there is no certified Department employee in that position. However, subsequent to the issuance of my report, I was informed that vacant positions most likely were filled with substitute teachers, or a contracted employees. Therefore, in most cases, there may have been persons assigned to teach the special education students. The laptop computers would have been used by persons assigned to teach the special education students, and would not be *"sitting idle or used for purposes other than compliance with the Felix consent decree."* Accordingly, as mentioned in my testimony on October 27, 2001, the dollar impact of 140 laptops for the "vacant" positions costing $294,000 *[page 19]*, as originally reported, may be substantially reduced.

I have not yet been able to verify the exact number of "vacant" positions occupied by substitutes or contract employees, and have not yet been able to recalculate the dollar impact. I expect to complete the verification of those statistics in time for the upcoming Legislative session.

Sincerely,

Edwin Koyama
DOE Internal Auditor

Attachment 7

Pacific
Resources for
Education and
Learning

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An Equal Opportunity Employer

December 18, 2001

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OFC. OF THE AUDITOR
STATE OF HAWAII

Joint Investigative Committee Staff
Office of the Auditor
465 S. King Street, Room 500
Honolulu, HI 96813

Dear Committee:

RE: Preliminary Draft Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance with the *Felix* Consent Decree

On behalf of Pacific Resources for Education and Learning (PREL), I would like to thank you for the opportunity to respond to the Committee's draft report. In the spirit of fairness, objectivity, and accuracy, I would like to share a few additional pieces of information regarding PREL's involvement in the Felix Consent Decree work.

It is important to know that the State asked for PREL's assistance in meeting an impending Federal benchmark. Knowing the importance of providing services to children, the potential impact of not meeting the court mandated benchmarks, and PREL's demonstrated ability to successfully manage, implement, and monitor targeted, complex technical assistance, PREL accepted the contract in good faith. We considered the potential of political implications arising from Felix work, but felt that these implications were more than offset by the opportunity to help others meet the needs of children in our state. Consequently, we accepted the legally executed contract and from that point to the present have done everything humanly possible to deliver the services needed.

Regrettably, the Committee's report does not include the most important part of this work – the service testing results. Attached, please find an updated summary of service testing outcomes for those school complexes that received targeted PREL technical assistance. The improvement is dramatic, particularly when contrasted to the previous seven years of non-compliance. PREL is not suggesting that our assistance alone is responsible for the improvements realized; we made that clear in our testimony before the Committee. Appropriately, recognition and congratulations should go to the individual schools, the parents, PREL's partners, and others.

PREL is proud of its work, the compliance achievements realized, and the services to deserving children and families.

Respectfully,

John W. Kofel
President & CEO

Attachment
Cc: Gary Slovin, Esq.
Goodsill Anderson Quinn & Stifel

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Nā Kāko'o
Felix Technical Assistance Project

SUMMARY OF RESULTS

Pacific Resources for Education and Learning (PREL) was contracted to provide technical assistance to develop and implement a Service Design Plan for 15 designated Hawaii Department of Education school complexes, so as to enable the DOE to provide school based delivery services to meet the requirements of the Felix v. Cayetano Consent Decree. The designated school complexes were those with the lowest compliance scores.

The contract was initiated in August 2000 with an end date of September 1, 2001. The contract was extended to October 31, 2001, primarily due to rescheduling of service testing as a result of the teachers' strike in Spring 2001. With the extension, new complexes were designated for targeted technical assistance.

Following is a summary of Service Testing reviews and compliance status for complexes that received assistance under the contract:

Results of Service Testing Reviews and Compliance Status by Complex

	Complex	Test Date	Compliance Status **Before** Targeted Technical Assistance	Compliance Status **After** Targeted Technical Assistance
1	'Aiea	February 2001	Not in compliance	Full
2	Kaiser	January 2001	Not in compliance	Full
3	Leilehua	January 2001	Not in compliance	Full
4	Kahuku	October 2001	Not in compliance	Provisional
5	Kealakehe	November 2001	Not in compliance	Provisional
6	Lahainaluna	October 2001 November 2000 May 1999	Not in compliance	Provisional
7	Maui	October 2001	Not in compliance	Provisional
8	Mililani	September 2001	Not in compliance	Provisional
9	Roosevelt	October 2001 October 2000 November 1999	Not in compliance	Provisional
10	Waialua	September 2001	Not in compliance	Provisional
11	Kapolei	February 2001	Not in compliance	Partial
12	Konawaena	October 2001	Not in compliance	Partial
13	Wai'anae	March 2001	Not in compliance	Partial
14	Ka'ū	March 2000	Not in compliance	Revisit February 2002
15	Lāna'i	December 2000	Not in compliance	Revisit February 2002
16	Moloka'i	October 1999	Not in compliance	Revisit February 2002
17	Pāhoa	January 2000	Not in compliance	Revisit February 2002
18	Hāna	March 2001	Not in compliance	Revisit January 2002
19	Kohala	February 2000	Not in compliance	Revisit January 2002
20	Baldwin	October 1999	Not in compliance	Revisit November 2001

[a]School Based Service Report. [b]Number of cases reviewed. [c]Coordinated Service Report.

Attachment 8

BENJAMIN J. CAYETANO
GOVERNOR

BRUCE S. ANDERSON, Ph.D., M.P.H.
DIRECTOR OF HEALTH

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

In reply, please refer to:
File:

December 18, 2001

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OFC. OF THE AUDITOR
STATE OF HAWAII

Joint Investigative Committee Staff
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813

Dear Joint Investigative Committee Staff:

Enclosed you will find the Department of Health's response to the draft Report of the Joint Senate-House Investigative Committee to investigate to the State's Compliance with the Felix Consent Decree.

If you have any questions, please call me or Anita Swanson, Deputy Director for Behavioral Health, at 586-4416.

Sincerely,

Bruce S. Anderson, Ph.D., M.P.H.
Director of Health

Enclosures

State of Hawaii
Department of Health
Executive Summary

Thank you for this opportunity to respond to the **Report of the Joint Senate-House Investigative Committee to Investigate the State's Compliance with the Felix Consent Decree.** The Department of Health (DOH) continues to support the information needs of Joint Senate-House Investigative Committee To Investigate the State's Compliance With the Felix Consent Decree (hereafter referred to as the Committee).

General Comments
While the Department supports the objectives of the Committee, there is concern that information and data previously submitted to the Committee is not evident in this report. It is understandable that the Committee received a great deal of information and committee members may not have been able to review all of the information in the time available. Given that situation, we would ask the Committee to use caution when coming to conclusions and making recommendations. Specific feedback to the report is offered below.

"Compliance Measures Arbitrary and Unscientific," "Compliance is a Moving Target," "School Complexes Unclear About Compliance" (pages 10 – 14)
This is an inaccurate statement. The Department has consistently been aware of the requirements for compliance with the Consent Decree. The selection of youth for service testing utilizes a stratified sampling procedure. This method is used to ensure that youth are selected from each school. The Department of Health employees are clear on the expectations of compliance presentations. Family Guidance Center Chiefs have consistently participated in these presentations to the Court Monitor. If there is any perception within the Department of the "monitors standards changing," it relates to additional commitments made by the State when the State was held in contempt.

"The DOE and DOH exploit 'the money is no object' expectations" (page 14)
The Department provided testimony that this is not the case. The Department has provided information to Legislature accounting for departmental Felix costs. Also, the Department offered in testimony that the Legislature has been supportive of the Department's efforts to comply.

"The DOH has used confidentiality to limit legislative oversight" (page 30)
The Department has no intention of inappropriately withholding documentation from the Committee. Indeed we have made every effort to provide information requested by the Committee in a timely manner. The AG's Office continues to advise the Department of the need to redact any information shared, in order to protect student's rights under the Family Educational Rights & Privacy Act (FERPA). The Department follows the advice of the Attorney General's (AG) Office regarding this matter.

"Internal Monitoring at the DOH is deficient (pages 30-31)
The Department's system for monitoring the quality and effectiveness of mental health services is extensive as mandated by the Consent Decree. The system has received national accolades, and is considered by experts in the field to be a model for other mental health systems. The Department's monitoring system has received national accolades, and is considered by experts in the field to be comprehensive and a model for other mental health systems. Oversight and review is consistent and intensive, and includes monitoring of compliance with standards and expenditures. Areas monitored include programmatic compliance with licensing rules, quality of treatment processes, performance on case-based reviews (child status and program functioning), quality of supervision and training, status of

sentinel events and complaints, quality of family engagement, and many other dimensions of performance. Attached are documents that provide an overview of the CAMHD provider monitoring system.

"Personal Relationships were involved in the implementation of MST" (page 45)
The Department took great care to ensure that all state personnel requirements in this area were followed. In the early summer 2000, John Donkervoet, a licensed clinical psychologist, was interviewed for the MST Administrator position by a DOH panel in accordance with Department recruitment policies. At the time of his interview Dr. Donkervoet was employed by the Adult Mental Health Division. Ms. Anita Swanson, Dr. Al Arensdorf and Ms. Carol Matsuoka conducted the interview. Dr. Donkervoet was selected for the position as Clinical Director of the MST Continuum of Care Project and began employment on July 3, 2000. His supervisor was Carol Matsuoka, MST Administrator. Ms. Mary Brogan, CAMHD Clinical Services Manager, directly supervised Ms. Matsuoka. The MST Home Based Programs and the MST Continuum were under the supervision of the Clinical Services Offices, headed by Ms. Mary Brogan.

Ms. Tina Donkervoet contacted the State Ethics Commission to verify that there would be no violations if Dr. Donkervoet worked for CAMHD. State Ethics Commission verified that as long as Dr. Donkervoet met the position's qualification requirements, was hired in accordance with departmental recruitment polices, and was not directly supervised by Ms. Donkervoet; there would be no violations.

"The DOH allows provider to overcharge for services" (pages 48-50)
The DOH takes strong exception to any implication that we allow (which implies permission) for providers to over bill. For the past two fiscal years, CAMHD has conducted fiscal claims reviews involving the audit of provider records for adequate claims documentation. CAMHD has required annual fiscal reports, and provided quarterly explanation of benefits to the parent/guardian and care coordinator to allow for verification of service delivery. The examples identified in the report have already been addressed with the Auditor's Office. The report, as previously provided to the Auditor's Office, is attached.

Computer Problems Continue (page 51)
The Department strongly disagrees with the statements criticizing CAMHD's computer problems. While large provider systems, such as CAMHD, might always expect some level of billing disputes between payer and payee, the CAMH management information system (CAMHMIS) has greatly increased the Department's ability to complete timely fiscal reports and data evaluation. The CAMHMIS system has been reviewed by the Auditor's Office on several occasions. We recommend that the committee reference the most recent Auditor's report for comments regarding the strengths of the information system.

"MST was costly, wasteful experiment"/"MST was a failure" (page 52 - 53)
The Department elected to implement the Continuum of Care (COC) research project after great consideration of the issues impacting the state. The Department was faced with criticism and concern about the high number of youth being placed on the mainland, escalating costs of out of home residential care, and criticisms from stakeholders for not applying evidenced based treatments. The COC program was initiated to serve complex, severely challenged youth in a community based setting. The funds used in the MST COC project were funds already being expended on the participating youth. These youth and the corresponding expenditures were diverted from higher cost residential treatment and mainland placement into the COC program.

MST is one of the most intensely researched treatment model in children's services. It is accurate that most of this research has involved youth with willful misconduct issues. And it is also true that the developer of the treatment model, has completed the research. We agree that there are limitations to the interpretations of the research when the developer participates in the study, however, there are tremendous gaps in the research knowledge in children's mental health at this time. At the present time, there are not

sufficient numbers of treatment modalities that have been empirically validated with high-end, complex, emotionally disturbed youth with co-occurring disorders. Given this, the Department presented to the legislature that MST was one of the most promising treatments, and recommended that we implement a study on a small scale to evaluate it's effectiveness. We have an obligation to serve this population, and applying MST COC study was an attempt at implementing a promising treatment in a controlled manner and evaluating the results.

The Department agrees with the Office of the Auditor Report of January 2001, that all treatments and services should be reviewed for outcomes and effectiveness. Currently, University of California San Francisco (UCSF) is conducting review of the model. This report is due to the legislature 20 days prior to session. Any decisions or conclusions about the effectiveness of MST should be deferred to this evaluation.

A DOH employee has a private business on the grounds of a private provider (page 55)
Dr. David Drews, a CAMHD Branch Chief, is also the President of Central Pacific University. As submitted in Dr. Drews' testimony, CPU's private office space has never been on the grounds of a private provider. As stated in his testimony, normal business operations were never transacted at the identified private provider location. An arrangement was made to use some classroom space for future seminars and workshops, in exchange for cleaning and renovating the space. An internal comprehensive investigation conducted by CAMHD concluded that this relationship did not constitute a conflict of interest and minor Website modifications and sign placement issues were recommended. The DOH CAMHD policy regarding outside employment was followed by Dr. Drews and CAMHD. A copy of this investigation was previously provided to this Committee and is again attached for reference.

The issue of preferential treatment being given to the agency was also examined, and it was found that the allegation of increasing services during intercession was not only false, but it was shown that services were actually cut back during the period when it was alleged they were increased. There is no evidence that any preferential treatment has ever existed. There have been no substantiated problems with the arrangement. However, due to the Legislative committee's concerns, Dr. Drews chose to terminate any arrangement with this private agency.

It is important to emphasize that during Dr. Drews' tenure and under his leadership, all six Honolulu complexes have passed service testing and been deemed in full compliance with the requirements of the Consent Decree. Honolulu district has reduced the number of Mainland placed youth from 19 to one by implementing sound clinical transition plans. Dr. Drews and the Honolulu Family Guidance Center staff have demonstrated consistent professionalism and competence in representing the State with respect to a variety of compliance issues, performance outcomes, and school complex compliance presentations

Comments on Recommendations

The first recommendation offered in this report is that the Investigative Committee be given the authority to continue this process. The Legislature already has many committee resources available, including the Education and Health Subject Committees of both Houses, the Joint Felix Task Force, and the money committees of both Houses. This committee has invested significant resources looking from a historical perspective at the Department's role in the Felix Consent Decree. We encourage the Legislature through the Joint Felix Task Force to work with the Department to evaluate how we can sustain our efforts to meet children's needs in the future.

Spec. Com. Rep. No. 4

Your Special Joint Legislative Committee on Long-Term Care Financing, to which was referred S.C.R. No. 23, S.D. 1, H.D. 1, C.D. 1, entitled:

"REQUESTING THE DEVELOPMENT AND IMPLEMENTATION OF A LONG-TERM CARE FINANCING PLAN AND A STATEWIDE LONG-TERM CARE PROVIDED CERTIFICATION PROGRAM",

begs leave to report as follows:

Introduction

The Congressional Budget Office expects the national expenditures for long-term care services for the elderly (people age sixty-five and older) to grow through the year 2040 ("Projections of Expenditures for Long-Term Care Services for the Elderly", March 1999, Congressional Budget Office). The main reason for that growth is that the U.S. population is aging, and elderly people receive the most long-term care services because they are more likely than younger people to have some kind of functional limitation. Many baby boomers will begin to reach age sixty-five in 2011. In addition, more elderly people will reach advanced ages (eighty-five and older) than in the past because of declining mortality rates. These trends will cause the proportion of the population that is elderly, which was just under thirteen per cent in 1995, to rise to twenty per cent in 2040. More importantly, the population over age eighty-five, the segment most likely to require long-term care, will grow over three times its current size by 2040.

In Hawaii, according to a report by the Hawaii Health Information Corporation and the Hawaii Medical Service (HMSA) Foundation ("Health Trends in Hawaii", Fifth Ed., 2001), the State's population growth was greatest among the elderly between 1990 and 1999. The number of residents ages sixty-five to seventy-four increased thirteen per cent (one per cent was the national average), while the number of those ages seventy-five and older increased by sixty-two per cent (twenty-four per cent was the national average). On a county level, all counties experienced significant growth in their elderly populations, with Honolulu experiencing the greatest increase from five per cent in 1970 to fourteen per cent in 1999. Overall since statehood, the proportion of elderly to total population has increased roughly five per cent in 1960 to fourteen per cent in 1999, when the proportion of elderly in Hawaii's population just exceeded that of the U.S. population.

As the baby boom generation ages, these figures are projected to increase causing a host of social and economic demands. Aging brings concomitant chronic health diseases such as cancer, cardiovascular disease, and stroke, all of which necessitate intense daily care in the latter years of life.

People in Hawaii are simply living longer, due in large measure to the State's excellent health care. However, the irony would be if the State could not also care for the elderly who have benefited from the enhanced health care in their younger years. The implication, according to the HMSA report, is that "The increasing proportion of elderly in Hawaii's population signals the need to monitor the ability of health care resources to meet the elderly's greater need for services, including the distribution of those services to the Neighbor Islands." Furthermore, according to the HMSA report, "The proportion of the population deemed 'work age' (19-65) is decreasing relative to the elderly, raising questions abut the social burdens this decreasing cohort must bear." These factors pose important questions for health care and public policy.

The whole dynamic of the extended family in Hawaii will radically change to place impossible financial and social hardship on Hawaii families. As people age or become disabled, they need services to help them with activities of daily living. The approach to helping Hawaii's elderly and disabled should be prompted by compassion and caring, although the problem is inextricably one of economics.

Because increasing numbers of Hawaii's residents will need long-term care services, there is a compelling need to create an affordable method of financing those services. What Hawaii needs is a method of financing that is affordable and suitable for the majority of residents. Current methods of financing long-term care in Hawaii involve predominantly Medicaid, private insurance, and personal assets. Medicaid eligibility is qualified by income limits. Private insurance is not widespread, and most people do not have sufficient personal assets. Contrary to popular belief, Medicare pays for only the initial hospitalization stay (acute care) of a patient for a limited number of days.

Legislative Mandate

Pursuant to Senate Concurrent Resolution No. 23, C.D. 1, the Legislature formed a Special Joint Legislative Committee on Long-Term Care Financing (Joint Committee) composed of Representative Dennis A. Arakaki, Chair; Representative Michael P. Kahikina and Senator David M. Matsuura, Vice-Chairs; Senators Jan Yagi Buen, Russell Kokubun, Colleen Hanabusa, and Bob Hogue, and Representatives Marilyn Lee, Bob Nakasone, and Mindy Jaffe, members. The Joint Committee undertook to:

(1) Develop and implement a plan for a dedicated source of revenue that will:

(a) Assure a comprehensive long-term care infrastructure;

(b) Support the long-term care needs of all citizens in the State regardless of their income; and

(c) Control the escalating costs of long-term care and the burden on the State; and

(2) Develop a statewide certification program for long-term care providers.

Approach of the Joint Committee

The Joint Committee, with Representative Arakaki as the designated chair by agreement, held a series of informational briefings with community members interested in long-term care, including representatives of consumers, providers, government agencies, non-profit organizations, and the federal government. Their input and the discussions enabled the Committee to craft meaningful proposed legislation for the 2002 Regular Session. Meetings were held at the State Capitol on October 1, 2001; October 15, 2001; October 24, 2001; November 20, 2001; December 4, 2001; December 18, 2001; January 8, 2002, and January 22, 2002. The January 8 meeting featured First Lady Vicky Cayetano, whose presentation was in support of a long-term care financing system.

The Executive Office on Aging (EOA) assisted the Joint Committee by making available the results of its long-term care actuarial study, financed from the EOA's own funds.

The Auditor also stood ready to assist the Joint Committee with any supplemental studies deemed appropriate by the Co-Chairs of the Joint Committee.

The Joint Committee examined and discussed (1) the report of the Joint Legislative Committee on Long-Term Care, Regular Session of 1999, Misc. Comm. No. 9, pursuant to Act 339, Session Laws of Hawaii 1997; (2) *Financing Long-Term Care: A Report to the Hawaii State Legislature*, Executive Office on Aging, 1991; (3) *Report to the Hawaii State Legislature*, Long-Term Care Financing Advisory Board, 1992; and (4) *Actuarial Report on the Proposed Family Hope Program*, Actuarial Research Corporation, 1992. The Joint Committee took the findings and recommendations of the reports into consideration in its deliberations. The Joint Committee also discussed the Hawaii Family Hope Program, proposed by H.B. No. 31, 1993.

Pursuant to the legislative mandate, the Joint Committee has prepared three Senate and House companion bills for introduction in the 2002 Regular Session:

(1) Relating to the Hawaii long-term care financing Act;

(2) Relating to long-term care (single entry point); and

(3) Relating to Aging (caregiver support).

The substance of these three bills are discussed below.

Caregiver Support

No state has a caregiver certification program, according to the National Conference of State Legislatures. The issue has not generated much research material nationally. In Hawaii, the discussion among the Department of Health (DOH), Department of Human Services (DHS), and provider groups has been somewhat minimal in terms of identifying problems and recommending solutions. In fact, most of the representatives of consumers, providers, government agencies, and nonprofit organizations are not familiar with the issue or the problem.

The Joint Committee found that the Hawaii Revised Statutes currently regulates adult residential care homes, nurses aides, and home health care agencies.

The Joint Committee discussed the establishment of a certification program for caregivers. After much consideration and deliberation, the Joint Committee recommends against certification for the following reasons:

(1) No existing entity is capable of doing the certification;

(2) There are no certification standards;

(3) Certification means more governmental regulation;

(4) Family caregivers would be discouraged from providing caregiver services to a loved one, if they are required to be certified;

(5) If the State were to do the certification, the State would be exposed to liability if a patient is injured or has died because of fault of the certified caregiver; and

(6) The DHS is skeptical that it could afford to hire certified caregivers for Medicaid long-term care recipients.

The Joint Committee determined that the real problem is not certification, but rather the lack of adequate training. Certification is only a means to assure adequate training.

The Joint Committee appointed a Subcommittee on Certification which filed a report to the Joint Committee on November 1, 2001, recommending:

(1) No certification program for family and friends who care for individuals on a daily basis;

(2) The State appropriate funds to provide training for caregivers;

(3) No certification for government programs such as Medicare and Medicaid because adequate regulations are currently in place to address licensing and skills competency for quality assurance;

(4) No certification program for professional caregivers (private pay) at this time, in reference to insurance companies paying for or being responsible for the certification, because the Joint Committee has no information on insurance company coverage requirements for caregivers; and

(5) A registry system would escalate the cost of providing caregiver services because of the magnitude of administrative expenses entailed with providing a registry. Because a caregiver registry would be the practical equivalent of ensuring competency, the entity responsible for registration would have to assess the care provider's skills; issue the certificate; monitor for continued quality assurance; maintain an up-to-date data base; and ensure against liability. The fiscal and human resources required to implement and ensure a proper registry system is unfeasible at the state level.

The Joint Committee has prepared a bill for introduction in the 2002 Regular Session to allow the EOA to use available state funds to supplement federal grants to provide support services and training for family caregivers. The EOA receives grant moneys under the National Caregiver Support Program, Public Law 106-501, to provide basic services for family caregivers. These services include information to caregivers about available resources; assistance to caregivers to gain access to the services; individual counseling; organization of support groups; caregiver training to assist caregivers to make decisions and solve problems relating to their caregiver roles; respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and supplemental services to complement the care provided by caregivers. Priority is given to caregivers that care for persons having the greatest social and economic need, particularly low-income individuals, and persons with mental retardation and developmental disabilities.

The Joint Committee encourages Kapiolani Community College (KCC) to provide training courses and support services for professional caregivers, including issuing a certificate of completion or issuing a certification, and maintaining a registry for those professional caregivers who complete the program or attain a certification. The KCC is particularly well suited for this endeavor inasmuch as it offers nursing courses related to long-term care. A certificate of completion or a certification could provide an incentive for professional caregivers to attend KCC, and may lead to economic growth for Hawaii in establishing a new industry. The other state community colleges are encouraged to follow the lead of KCC or initiate their own programs.

Single Entry Point System

The Joint Committee referred to the briefing paper "Single Entry Point System", prepared by the Senate Majority Office in conjunction with the Committee's work. The issue has been discussed in the Legislature since 1995, with the Legislative Reference Bureau's "Long-Term Care: A Single Entry Point for Three Populations", Report No. 8, and the report of the DHS, "Single Entry Point System", 1996. No consensus resulted from these discussions.

The Joint Committee seeks to expediently implement an effective, cohesive, coordinated, and affordable single entry point system, without doing violence to the organizational structure of the DOH and DHS. The Joint Committee has prepared a bill for introduction in the 2002 Session that vests the EOA with responsibility for establishing and administering a single entry point system of long-term care coordination that provides:

(1) A unified system of multiple entry points;

(2) Information and referral services;

(3) Needs assessment at the time of intake;

(4) Preadmission social and medical screening for institutional care;

(5) Placement of the individual into the appropriate setting; and

(6) A tentative comprehensive service plan.

The EOA may contract out for the services to a private, nonprofit entity for $1 per year. The Joint Committee has been informed that there is a reputable, experienced entity that is willing to be paid $1 per year to provide the program.

The Joint Committee believes that this approach to creating a single entry point system is the most workable, and should be given an opportunity to succeed where most proposals to date call for planning only. This measure goes beyond planning and actually establishes the system.

Financing

Current methods of financing long-term care involve predominantly Medicaid, private insurance, and personal assets. Medicaid, which is limited to financially qualified persons of low income, pays for institutional care (about eighty per cent of all nursing home residents are dependent on Medicaid) and home- and community-based services. Medicare benefits for long-term care are limited. It has been unofficially estimated that Medicaid represents only about ten per cent of the total number of long-term care eligible persons, and only five per cent of the population has private long-term care insurance. Therefore, approximately eighty-five per cent of the population must depend upon their personal assets to pay for long-term care services.

This is the large population that needs an affordable long-term care program.

Hawaii's citizens are faced with an overwhelming financial burden of caring for their elderly and disabled citizens. The elderly and disabled population needing long-term care will continue to grow as the population ages. Nursing home costs often exceed a family's

ability to pay, threatening a family's financial self-sufficiency. However, nursing home care is but one component of an array of long-term care services options, including home-based services and community-based facilities.

Since increasing numbers of Hawaii's population will need long-term care services, there is a compelling need to create an affordable and universal method of financing those services. Unlike the past, federal and state moneys cannot be relied upon in the future. What Hawaii needs is another method of financing that is affordable and suitable for the vast majority of residents.

The Joint Committee recommends the enactment of the Hawaii Long-Term Care Financing Act, the bill it has prepared for introduction in the 2002 Regular Session. The main characteristics of the Act are discussed below.

Scope of Benefits

Benefits would be paid for "long-term care services", defined as a broad range of supportive services needed by individuals who are age twenty-five or older with physical or mental impairments and who have lost or never acquired the ability to function independently. Long-term care services include a range of home- and community-based services, including home health services, adult day care, adult residential care homes, extended care adult residential care homes, hospices, personal care, respite care, care at home by a relative of the caregiver, and products and implements used in the care of the individual. The benefit amount would start at $70 per day up to a period of three hundred sixty-five days. The covered services and the benefit amount were deemed to be actuarially sound for the system to sustain solvency.

Mandatory Premium

A viable and actuarially sound program must have mandatory contributions. A voluntary program would:

(1) Be impossible to accurately predict the number of participants and the potential amount of benefits to be paid;

(2) Make the premium too expensive to be affordable because only a small percentage of the population could be depended upon to contribute;

(3) Not be universal because it would not cover everyone;

(4) Compete with private insurance, but probably at a higher price than private insurance (the proposal does not compete, but is supplemental to private insurance); and

(5) Make it difficult for the State to collect.

Payroll Deduction

Because the system is mandatory, the most efficient and universal means of collection is to tie the contributions with payroll deduction. The mechanisms for collection and identification are built into the payroll tax withholding system. Those persons without a payroll, such as the self-employed, would contribute in the same manner as paying their income taxes. The term "premium" is used because it is not a tax, although the manner of collection is similar to a tax withholding or other collection.

The Department of Taxation expressed opposition to designating it as the agency of collection. Therefore, the proposed legislation deletes reference to the Department of Taxation and to a payroll withholding. As the bill moves through the legislative process in 2003, the respective Senate and House committees hearing the measure must designate the appropriate collection entity or create a new entity for this function.

Payment of Benefits

The system would pay long-term care benefits directly to qualified recipients of the long-term care services. The payment is intended as a reimbursement to the recipient rather than compensation to the provider of the service. This allows the recipient to choose whichever long-term care service is deemed appropriate. The concept is not to create a long-term care system, as would occur if payments were made to the providers, but to expand the provision of long-term care services, as would occur if the recipient exercises choice in selecting a long-term care service. According to the Executive Office on Aging, the scarcity of long-term care services is attributable to the lack of a payment stream for those services. It is anticipated that a reimbursement system would stimulate competition in the economic marketplace by enticing more providers to enter the market, and ultimately leading to a new growth industry for Hawaii, resulting in more tax revenue for the State.

Covered Population

There is no definitive age at which a person could be diagnosed with a condition or disease needing long-term care services. However, an age range must be specified for actuarial purposes and to keep the system solvent. Accordingly, under the proposed system, persons who are age twenty-five or older would be eligible to receive benefits. Those younger than eighteen who are disabled are generally eligible for lifetime government programs such as Social Security or Medicaid. Others who are age eighteen to twenty-four generally are healthy (except for the occasional critical motor vehicle accident).

Premium Contribution Amount

The amount of $10 per month is recommended as affordable. This amount is very inexpensive when compared to private insurance premiums. The public should bear in mind that their contribution will someday be returned to them in the way of benefit payments. Each person's premium will be duly and accurately identified and a running total will be maintained for that person.

Interrelationship with Other Long-Term Care Payments

The proposed system would pay primary to Medicaid and private insurance. A recipient of long-term care services would exhaust benefits under the proposed system before resorting to Medicaid and private insurance. In this manner, the State would be relieved of the Medicaid burden at least for the period of time that the recipient receives benefits under the proposed system. In addition, the recipient who is not yet on Medicaid, would have time to transition into Medicaid if necessary.

The recipient with private insurance could preserve those insurance benefits until a later time in life, particularly advantageous because insurance benefits tend to be limited in duration. Because the proposed system would be the primary payor, people may not need as much long-term care private insurance coverage.

Administration

A plan for the administration of the proposed system will be addressed in the 2003 Regular Session. The administration is viewed as secondary at this time to the passage of the substance of the Hawaii Long-Term Care Financing Act. Furthermore, the administration is predominantly germane to paying of the benefits, which will occur after several years as the system would require enough time to build up reserves to meet anticipated liabilities.

Recommendations

The Joint Committee's recommendations for legislative action are embodied in the three bills drafted by the Joint Committee. The Co-Chairs of the Special Joint Legislative Committee on Long-Term Care Financing, Senator David M. Matsuura and Representatives Dennis A. Arakaki and Michael P. Kahikina, will jointly sponsor the introduction of three bills as identified herein, for the consideration by the 2002 Regular Session.

Signed by Senator Matsuura, Co-Chair.
Signed by Representatives Arakaki and Kahikina, Co-Chairs.

Members appointed pursuant to S.C.R. No. 23, S.D. 1, H.D. 1, C.D. 1 by the presiding officer of the respective Chamber:
Senators Buen, Kokubun, Hanabusa and Hogue.
Representatives Lee, Nakasone and Jaffe.