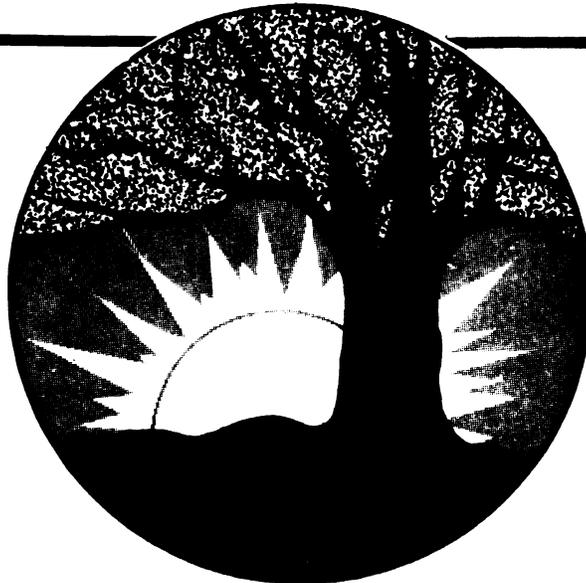


PERFORMANCE AUDIT

Health Services and Development Agency
July 2012



Justin P. Wilson
Comptroller of the Treasury



State of Tennessee
Comptroller of the Treasury
Department of Audit
Division of State Audit

Arthur A. Hayes, Jr., CPA, JD, CFE
Director

Deborah V. Loveless, CPA, CGFM
Assistant Director

Diana L. Jones, CGFM
Audit Manager

Lisa Williams, CGFM, CFE
In-Charge Auditor

Amy Brack
Editor

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-1402
(615) 401-7897

Performance audits are available online at www.comptroller.tn.gov/sa/AuditReportCategories.asp.
For more information about the Comptroller of the Treasury, please visit our website at
www.comptroller.tn.gov.



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT

SUITE 1500
JAMES K. POLK STATE OFFICE BUILDING
NASHVILLE, TENNESSEE 37243-1402
PHONE (615) 401-7897
FAX (615) 532-2765

July 24, 2012

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Jim Cobb, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the sunset performance audit of the Health Services and Development Agency. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the agency should be continued, restructured, or terminated.

Sincerely,

Arthur A. Hayes, Jr., CPA
Director

AAH/dlj
12-026

State of Tennessee

A u d i t H i g h l i g h t s

Comptroller of the Treasury

Division of State Audit

Performance Audit
Health Services and Development Agency
July 2012

AUDIT OBJECTIVES

The objectives of the audit were to determine whether the Health Services and Development Agency followed statutory and rule requirements for Certificate of Need applications heard in fiscal year 2011, and to obtain a detailed description of (1) the data sources the agency relies on to make decisions and (2) the reliability testing conducted on that data.

OBSERVATIONS AND COMMENTS

The audit discusses the following issues: improvements the agency should consider with regard to increasing the level of detail in agency motions; the resolution of problems regarding documentation of determinations for application placement on consent calendars; the Department of Health's report of its review of Certificate of Need applications; data maintained by the Departments of Health and Mental Health; the new All Payer Claims Database; and a review of meeting minutes and related documentation (page 6).

Performance Audit Health Services and Development Agency

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
Purpose and Authority for the Audit	1
Objectives of the Audit	1
Scope and Methodology of the Audit	1
Agency Membership and Staffing	2
Certificate of Need (CON) Application Process	3
Revenues and Expenditures	6
OBSERVATIONS AND COMMENTS	6
The Agency Should Consider Adding More Detail in Its Motions Regarding the Factual and Legal Basis of Its Decisions	6
The Executive Director Resolved Problems with Adequate Documentation of Determinations for Application Placement on Consent Calendars	8
The Department of Health’s Statutorily Required Reports to HSDA of Its Review of CON Applications Should Contain the Minimally Required Elements	9
The CON Process Relies on Data Collected and Maintained by the Departments of Health and Mental Health	12
All Payer Claims Database – Division of Health Planning, Department of Finance and Administration	13
Review of Agency Meeting Minutes and Related Documentation	14
RECOMMENDATION	14
Administrative	14
APPENDICES	15
Appendix 1 - Staff and Board Information	15
Appendix 2 - Performance Measures Information	16

Performance Audit Health Services and Development Agency

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Health Services and Development Agency was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-234, the Health Services and Development Agency is scheduled to terminate June 30, 2013. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the agency should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine whether the Health Services and Development Agency followed statutory and rule requirements for Certificate of Need applications heard in fiscal year 2011, and
2. to obtain a detailed description of (1) the data sources the Health Services and Development Agency relies on to make decisions and (2) the reliability testing conducted on that data.

SCOPE AND METHODOLOGY OF THE AUDIT

The activities of the Health Services and Development Agency were reviewed for the period January 2008 to November 2011. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Methods used included

1. review of applicable legislation and policies and procedures;
2. review of prior performance and financial and compliance audit reports;

3. examination of the entity's records, reports, and information summaries; and
4. interviews with agency members and staff, staff of the Departments of Health and Mental Health, and representatives of concerned advocacy groups.

In addition to audit responsibilities, Tennessee statutes entrust certain other responsibilities to the Comptroller of the Treasury. Those responsibilities include serving as a member of the Health Services and Development Agency. *Government Auditing Standards* specifically permit both the performance of audits and the performance of these other duties when required by state statute. We believe that the Comptroller of the Treasury's membership on the Health Services and Development Agency did not affect our audit conclusions.

AGENCY MEMBERSHIP AND STAFFING

The Health Services and Development Agency was created by Section 68-11-1601 et seq., *Tennessee Code Annotated*, effective July 1, 2002. The agency, which is responsible for administering the Certificate of Need program, assumed the duties of the Health Facilities Commission, which ceased to exist on June 30, 2002.

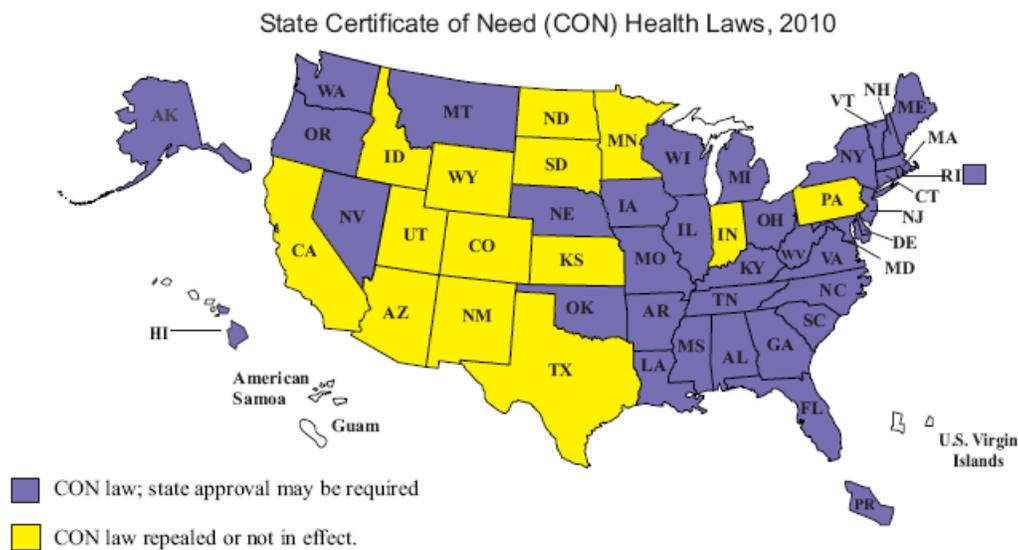
The Health Services and Development Agency has 11 members:

- the Comptroller of the Treasury or designee;
- the Director of TennCare or designee;
- the Commissioner of the Department of Commerce and Insurance or designee;
- one consumer member appointed by the Speaker of the Senate;
- one consumer member appointed by the Speaker of the House of Representatives;
- one consumer member appointed by the Governor;
- one person with recent experience as an executive officer of a hospital or hospital system, appointed by the Governor from a list of three nominees submitted by the Tennessee Hospital Association;
- one licensed physician, appointed by the Governor from a list of three nominees submitted by the Tennessee Medical Association;
- one representative of the nursing home industry, appointed by the Governor from a list of three nominees submitted by the Tennessee Health Care Association;
- one representative of the home care industry, appointed by the Governor from a list of three nominees submitted by the Tennessee Association for Home Care; and
- one representative of the ambulatory surgical treatment center industry appointed by the Governor.

The agency has nine staff, headed by an executive director.

CERTIFICATE OF NEED (CON) APPLICATION PROCESS

Certificate of Need (CON) programs are aimed at restraining health care facility costs and allowing coordinated planning of new services and construction. In 1964, New York became the first state to enact a statute granting the state government power to determine whether there was a need for any new hospital or nursing home before it was approved for construction. By 1975, 20 states had enacted CON laws; by 1978, 36 states had enacted them. The federal Health Planning and Resources Development Act of 1974 required all 50 states to have a structure involving the submission of proposals and obtaining approval from a state health planning agency before beginning any major capital projects such as building expansions or ordering new high-tech devices. Many states implemented CON programs in part because of the incentive of receiving CON federal funds. The federal mandate was repealed in 1987, along with its federal funding. In the decade that followed, 14 states discontinued their CON programs. However, as of 2010, 36 states—including Tennessee’s contiguous states of Alabama, Arkansas, Georgia, Kentucky, Mississippi, Missouri, North Carolina, and Virginia—maintained some form of CON program, and even the 14 that had repealed their state CON laws still retained some mechanisms intended to regulate costs and duplication of services. Puerto Rico and the District of Columbia also had CON programs.



Compiled by NCSL June 2010; based on data from AHPA

Before health-care providers can build facilities, become licensed, or conduct business in Tennessee, they must be granted a Certificate of Need (CON) by the Health Services and Development Agency, the details of which are set out in Section 68-11-1601 et seq., *Tennessee Code Annotated*. In order for a CON to be granted, a provider must establish that the proposed service is needed, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health-care facilities and/or services.

Tennessee’s current CON process has very specific time frames. The process begins when the provider (i.e., the entity applying for a CON) files a Letter of Intent with the agency

within the first ten days of the month. During the same ten days, the provider must publish a notice in the local newspaper(s) where the service will be provided. The notice is paid for by the applicant, and its purpose is to notify anyone in the public who may be affected and may want to comment on the application. Agency staff review the letter to ensure it meets all standards and specifications as set by statute. If the letter does not meet all standards, it is voided, and the process must begin again.

Within five days of publication of the Letter of Intent, the provider must submit the CON application to the agency. Agency staff review the application to determine whether it is complete and contains the necessary information regarding intent. According to agency management, there are usually questions regarding the application, and staff must contact providers for clarification. Staff then send the applications to be reviewed by the department responsible for regulation of the facility/service or within whose respective jurisdiction the subject matter or funding falls (the Department of Health, the Department of Mental Health, or the Department of Intellectual and Developmental Disabilities).

Section 68-11-1608(a), *Tennessee Code Annotated*, requires the review report to include the following at a minimum:

- (1) Verification of applicant-submitted information;
- (2) Documentation or source for data;
- (3) A review of the applicant's participation or nonparticipation in TennCare or its successor;
- (4) Analyses of the impact of a proposed project on the utilization of existing providers and the financial consequences to existing providers from any loss of utilization that would result from the proposed project;
- (5) Specific determinations as to whether a proposed project is consistent with the state health plan; and
- (6) Further studies and inquiries necessary to evaluate the application pursuant to the rules of the agency.

The vast majority of the applications go to the Department of Health for review and verification. (For example, all applications heard in fiscal year 2011 went to the Department of Health for review.) The departments must complete these reviews within 60 days following receipt from the Health Services and Development Agency. After the review is completed, agency staff schedule a public hearing. Generally, hearings occur in the month following completion of the review, two to three months after the Letter of Intent was first received. The applicant makes a presentation offering justification for the CON, followed by any opposition statements to the CON application. In addition, the public can request the opportunity to speak either on behalf of, or in opposition to, a proposal.

Approximately two weeks prior to the date of the hearing, staff provide agency members with an application packet that includes the Letter of Intent, the application, any supplemental information, and the reviewing department's report. When making their decisions, members rely

on the criteria and standards included in *Tennessee's Health Guidelines for Growth, 2000 Edition* and the State Health Plan (first version appeared in 2009) as drawn up by the Department of Finance and Administration's Division of Health Planning. The agency is to consider the following three major criteria in determining whether an application for a CON should be granted:

Need – The health care needed in the area to be served is evaluated on factors including the relationship of the proposal to any existing applicable plans; the population served by the proposal; existing or certified services or institutions in the area; and the extent to which Medicare, TennCare/Medicaid, and low-income groups will be served by the project.

Economic Factors – The probability that the proposal can be economically accomplished and maintained is evaluated based on factors such as whether adequate funds are available to complete the project; the reasonableness of the proposal's costs; anticipated revenue from the proposed project; and the impact on existing patient charges.

Contribution to the Orderly Development of Adequate and Effective Health-care Facilities and/or Services – This criterion is evaluated based on factors including conformance to the goals for quality health care for Tennesseans contained in the State Health Plan to be outlined by the Division of Health Planning in the Department of Finance and Administration; relationship of the proposal to the existing health-care system; and any positive or negative effects attributed to duplication or competition.

**CON Applications Received in a Calendar Year
And Their Dispositions**

	Calendar Year 2009	Calendar Year 2010	Calendar Year 2011(as of 10/12/11)
Total Received	56	59	20
Withdrawn	4	7	0
Voluntarily Surrendered	1	0	0
Voided	0	0	0
Total Heard	51	52	20
Approved	38	48	19
Denied	13	4	1

REVENUES AND EXPENDITURES

The Health Services and Development Agency is funded by a general appropriation as all funds received through CON application fees (\$928,150 in fiscal year 2011) and charges for other miscellaneous CON-related services are deposited into the general fund. For fiscal year 2011, the agency had expenditures of \$1,061,700. For fiscal year 2012, the agency anticipated expenditures of \$1,153,000.

OBSERVATIONS AND COMMENTS

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the Health Services and Development Agency (HSDA) and on the citizens of Tennessee.

The Agency Should Consider Adding More Detail in Its Motions Regarding the Factual and Legal Basis of Its Decisions

In order for a Certificate of Need (CON) to be granted, a provider must establish that the proposed service is needed, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health-care facilities and/or services. A review of all 49 CON applications heard by the agency in fiscal year 2011 determined that the agency referenced the required criteria (need, economic feasibility, and contribution to orderly development) although not always the specific details of how the criteria were met in each of its motions/decisions. Although the total record of the process and decision is contained in the records of the agency, and motions don't need to contain all of the details involved in the final decision, it would be useful for third parties if the formal motions included enough of those details to provide the reader with a more complete understanding of the basis for the decision by referring to specific facts related to each factor required for the decision.

In Tennessee, before certain health-care providers can build facilities, become licensed, or conduct business, they must be granted a CON by the Health Services and Development Agency, the details of which are set out in Section 68-11-1601 et seq., *Tennessee Code Annotated; Guidelines for Growth: Criteria and Standards for Certificate of Need 2000 Edition*; and the 2009 and 2010 State Health Plans as promulgated by the Department of Finance and Administration's Division of Health Planning. Section 68-11-1616, *Tennessee Code Annotated*, states, "Each decision rendered by the health services and development agency shall include written documentation and explanation of the factual and legal basis upon which the agency grants or denies the certificate of need." The auditor's review found that the specific standards for the application CON category (i.e., long-term care hospital beds; the construction, renovation, expansion, and replacement of health-care institutions; or MRI equipment and

services) and how the applicant had proven fulfillment of the three CON criteria were not always clearly explained.

The agency should strive to be more specific in its documented motions to approve or deny CON applications and refer to how the applicant has met the criteria of need, economic feasibility, and contribution to orderly development specific to its proposed service or expansion.

Health Services and Development Agency's Response

We concur that the Agency should strive to provide more details in its documented motions to approve or deny applications and refer to how the applicant has met the criteria of need, economic feasibility and contribution to the orderly development of health care. In the instance of a denied application, the Agency will continue to provide an example of how at least one of the criteria is not met.

-Continuous Improvement Action:

- 1) In order to help Agency members quickly identify which standards had been met during the initial staff review of the application, the staff summary was revised to include the specific criteria and standards applicable to each CON application and the staff determination whether the criteria appear to be met or not during the initial review. Effective 8/11.
- 2) In addition to the "New Member Orientation" a board member receives upon appointment to the board, the agency will also provide ongoing training to ensure that motions provide an adequate explanation for the reason for the Agency's decision. The consideration¹ that goes into the determination of whether an application meets the criteria of need, economic feasibility and contribution to the orderly development of health care is fully documented in the Agency's official record. The Agency will avail itself of State Audit's offer to assist in this regard. Effective 7/12.
- 3) Minutes will reflect that a recording and/or transcript are available upon request that fully document the verbatim discussion of how the agency reached its determination. Effective 5/12.
- 4) The criteria for Certificate of Need from the Agency's rules will be included in each application packet so members may make notations as they review each application and hear the presentation. Effective 7/12.

¹ Each CON application includes a substantial amount of information regarding why the applicant wants to establish a health care institution, institute a health care service or acquire some type of major medical equipment. Applications (staff summary; original application and supplemental responses; reviewing agency report; and support and opposition letters) generally contain around 200 pages of information. Several applications are heard by the board each month. Board members receive these packets of information around 12 days before the meeting. Board members invest a great deal of time prior to the meeting reviewing the information and then sit through several hours of testimony at each meeting. After each application is presented questions and deliberations take place. By this time there usually has been much discussion as to why an application should be approved or denied.

- 5) The Agency will request that reviewing agencies (Health, Mental Health & Intellectual and Developmental Disabilities) determine each applicant's compliance with the applicable criteria during the review of CON applications and provide that documentation in its report along with the other required information as noted in this audit. The agency will make this request effective 7/12; however, please note this Agency has no enforcement authority in this regard.

The Executive Director Resolved Problems with Adequate Documentation of Determinations for Application Placement on Consent Calendars

All four CON applications placed on the consent calendar in fiscal year 2011 did not have documentation of the executive director's initial determination that they met the criteria to be placed on consent. Rule 0720-10-.05(2) states, "In order to be placed on the consent calendar, the application must not be opposed by anyone having legal standing to oppose the application, and the executive director must determine that the application appears to meet the established criteria for granting a certificate of need. Public notice of all applications intended to be placed on the consent calendar will be given." However, the executive director provided auditors with documentation showing that since October 2011, following fieldwork for this audit and before receipt of the draft audit, documentation was now and would continue to be maintained of the executive director's determination of an application's eligibility for placement on a consent calendar.

Health Services and Development Agency's Response

We concur that written documentation should be provided. The executive director did make the initial determination that all four applications appeared to meet the established criteria for granting a certificate of need prior to placing them on the consent calendar. The applications could not have entered the review cycle if opposition had been received. If opposition had been received during the review cycle or at any time including up to the moment the application was to be heard, the application would have been moved to the heel of the agenda as required by Agency rules. (The Chairman did and will continue to ask prior to the application being heard if there is any opposition—either by an Agency board member or by anyone in the audience—to the item being heard on the consent calendar.)

Public notice was and is always given via the Notice of Beginning of Review Cycle, Communique and Meeting Agenda which is posted on the Agency's website and at the www.tn.gov website.

In all four cases the executive director did read her determination into the Agency record as to how each application met the criteria of need, economic feasibility, and contribution to the orderly development of health care. The board adopted the executive director's initial determination and unanimously approved each of the four applications.

-Continuous Improvement Action:

As noted in the auditor's comments above, in October 2011 in addition to existing procedure, the executive director began including a memo to Board members (Executive Director Justification for Consent Calendar) that detailed the determination of need, economic feasibility, and contribution to the orderly development of health care in written format prior to the Agency meeting. Effective 10/11.

The Department of Health's Statutorily Required Reports to HSDA of Its Review of CON Applications Should Contain the Minimally Required Elements

By statute, the Health Services and Development Agency relies upon the Departments of Health, Mental Health, and (as of January 2011) Intellectual and Developmental Disabilities to verify, assess, and analyze CON applications and their information. The statutorily required reports of the Department of Health's review of CON applications to the HSDA do not address most of the statutory and rule requirements.

Section 68-11-1608, *Tennessee Code Annotated*, (created in 2002 and amended in 2010) states that

- (a) The departments of health, mental health, and intellectual and developmental disabilities shall review each application whose subject matter or funding is within their respective jurisdictions, according to the process described in the rules of the health services and development agency. At a minimum, the reports shall provide:
 - (1) Verification of applicant-submitted information;
 - (2) Documentation or source for data;
 - (3) A review of the applicant's participation or nonparticipation in TennCare or its successor;
 - (4) Analyses of the impact of a proposed project on the utilization of existing providers and the financial consequences to existing providers from any loss of utilization that would result from the proposed project;
 - (5) Specific determinations as to whether a proposed project is consistent with the state health plan; and
 - (6) Further studies and inquiries necessary to evaluate the application pursuant to the rules of the agency.

In addition, Rules 0720-10-.03(10)(a) and (b), respectively, state that the Department of Health shall

- address the applicant’s compliance with the general criteria for CONs of need, economic factors, and contribution to the orderly development of adequate and effective healthcare facilities and/or services; and
- verify the methodologies provided by the applicant to meet the applicable criteria (need, economic feasibility, orderly development) and identify any additional methodologies that would further clarify the applicant’s compliance with the criteria.

The auditor reviewed all 49 CON applications (and accompanying paperwork) heard by the agency in fiscal year 2011 (55 applications were received by the agency, but 6 were withdrawn; there were no applications requiring a review by any agency other than the Department of Health). The auditor found that the Department of Health’s report of its review appeared to be only a summary of applicant-provided information, if not a direct cut-and-paste. The reports often stated “according to applicant” or “applicant states” and sometimes lifted wording verbatim without attribution. For all 49 applications reviewed, the Department of Health’s report failed to state and/or document that it (1) verified applicant-submitted data; (2) analyzed the utilization and financial impact of a project on existing providers, or (3) determined the applicant’s compliance with applicable criteria. In 48 of 49 cases, the Department of Health did not specifically state or determine that the application was consistent with the state health plan. In 47 of 49 cases, the department’s report did not state and/or document that it had verified the applicant’s methodologies. In only two cases did the department not state the source of its data. In all 49 cases, though, the Department of Health’s report did state whether the applicant did or did not participate in TennCare.

Department of Health’s Response

The Department of Health (“TDH”) agrees with a portion of the performance audit. We agree that not every response to HSDA regarding CON applications contains a clear statement on each of the required elements. Nevertheless, we have provided all of the required information to HSDA to enable it to make an informed decision regarding each CON application.

We also note that HSDA has not contacted TDH with any concerns about deficiency in the information provided. Our staff has stated its willingness to work with HSDA on future CON applications to ensure compliance in the following areas:

- Provide a written statement that we have verified applicant data and methodologies if applicants cite their data sources.
- Include a paragraph in the report, which more clearly identifies how the proposed project is or is not consistent with the State Health Plan.
- Notify the HSDA in writing (in addition to the current email that is sent monthly) within 7 days of receipt of a completed application.

It should be recognized that since April 1, 2012, TDH’s current staffing for the CON Application Review Process is one full time equivalent. One individual is performing all the statutory and rule requirements. Furthermore, staff in TDH’s Health Statistics division compared

CON reports from 2002 to the reports of 2012 and identified the following additional content that was provided to HSDA:

- Information related to the Joint Annual Report (JAR) Tables and information regarding the applicant's speculations pertaining to its justification of needs related to both patients and physicians.
- Table(s) which outline(s) the TennCare enrollees in the applicant's service area and Tennessee Population Projections 2000-2020.
- Detailed information related to the methodology that the applicant used to rationalize the CON.
- Content related to transfer agreements with hospitals closest to the project site. Further details to support the applicant's claims are also provided.

Additionally, our staff reviewed all CON applications from July 2010 through June 2011, which total 55 instead of the 49 identified in the audit. The identified applications totaled 55, but three were withdrawn and two applications were deferred to the next fiscal year. Our findings reveal the following:

- Applicant-submitted information is verified when the applicant cites its source(s) of information.
- Data sources for table/illustration were not provided in 2 of the 49 applications.
- All 55 of the reviewed applications included the applicant's intent to participate in TennCare.
- The impact of the proposed projects could only be determined by the information provided by the applicants. TDH is unable to determine the extent or financial impact that the proposed project may cause on other providers.
- All CON proposed projects are consistent with the State Health Plan (SHP) unless otherwise noted by TDH.

For all applications, TDH provided additional information and/or performed inquiries when HSDA made such a request.

Lastly, should the Comptroller interpret the current statutory requirements such that TDH is required to perform additional tasks, it may be necessary for the Department to seek new legislation to facilitate the CON process.

The CON Process Relies on Data Collected and Maintained by the Departments of Health and Mental Health

CON applicants rely on data collected and compiled by the Departments of Health and Mental Health to help them establish that their application's proposed service is needed, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health-care facilities and/or services.

Department of Health

The Department of Health's Division of Health Statistics collects required annual self-reported data from licensed facilities for the Joint Annual Review (JAR) process: hospitals, nursing homes, ambulatory surgical treatment centers, assisted-care living facilities, home health organizations, hospice organizations, and outpatient diagnostic centers.

As of December 2011, the only summary 2010 JAR data available were for hospitals and home health agencies. Because only the hospital summary is required of the Department of Health, the division directs its limited resources toward that priority first. However, individual facility data for all categories of providers were available (provisional and/or final) for 2010.

The Summary Hospital JAR information is not as of a specific year's beginning and ending date but represents 12 months' operation at a facility. Tennessee hospitals operate under four different fiscal years and report based on their fiscal year. The Department of Health does not require all hospitals to report data for a standard time frame. The self-reported data are collected electronically from providers. Hospital data also go simultaneously to the Tennessee Hospital Association, which reviews the data with its members.

According to Department of Health staff, all units of the Division of Health Statistics are involved to some degree in reviewing data for accuracy and reliability.

The Facilities Unit gathers the data and checks it first. The Department of Health performs both manual and automated edit checks of the data submitted. The data submitted in department-provided Excel forms have some automated edit checks built in, such as drop-down menus. However, the hospital data must primarily be manually checked. Staff in the Facilities Unit look first for completeness, then for significant changes from prior years, and then check certain entries where acceptable ranges have been established for the data.

The Statistical Services Unit does calculations and projections (for example, population-based need versus actual utilization) and reviews data for accuracy and to make sure the CON calculations work properly. Occasionally, staff will check the reliability of the data and calculations from the information system by manually doing the calculations for comparison against computer-generated results.

The Publications Unit is responsible for the last check of the data and publication in print and on the department's website.

Department of Mental Health

The Department of Mental Health collects and compiles data for the federally required methadone clinic registry that every state must have. The purpose of the registry is to keep patients from double-dosing at multiple clinics. In Tennessee, to establish a methadone clinic, a CON is required; to be licensed, a clinic must become part of the registry. There are 12 clinics at present in Tennessee, with roughly 6,000 patients actively enrolled.

Methadone clinic information is not part of the JAR process, was never intended to be, and the department and federal government do not want it to be. According to management at the registry, the federal government states that registry data are not public. Even the licensing authority for methadone clinics does not have access to registry data. However, as the CON process for methadone clinics requires data and the registry was never intended for this, a compromise has been reached that, upon request, the registry would provide CON applicants with applicant-specific/limited aggregate numbers by residents in counties.

Methadone clinics are required to notify the registry of admissions and releases within 72 hours. Data collection is currently paper-based and data must be manually entered by a staff person into the database, but management hopes to operate electronically in the future. Three to four people (registry head, one staff person, and the department's chief pharmacist/state opioid treatment authority) have full edit access to registry data that are maintained in a department-created SQL server database. The registry can generate a report for any point in time. According to Department of Mental Health management, the registry will periodically (once or twice a year) send clinics a list for them to confirm that the information on file with the registry is correct. Also, occasionally during the course of performing field surveys on clinics, a physical copy of the clinic's census might be brought back to the registry's main office and checked against the registry.

All Payer Claims Database – Division of Health Planning, Department of Finance and Administration

By the end of calendar year 2011, the Department of Finance and Administration's Division of Health Planning was expecting the All Payer Claims Database to be online and available to the Health Services and Development Agency and Certificate of Need applicants, as well as the Department of Commerce and Insurance, to assist in researching insurance rates. Information is to come from TennCare and commercial insurance companies (though not Medicare). It was anticipated that this database would be the most up-to-date source of data. Until November 30, 2011, data gathering and data reliability testing were contracted out to two third-party contractors. As of February 24, 2012, the director of the Division of Health Planning stated that

- the database is in place for data for the calendar years 2009 and 2010, and its data accuracy is currently being tested against TennCare Managed Care Organization data;

- draft reports from the database are currently being developed for eventual review and approval for publication by the Tennessee Health Information Committee;
- issuance of a Request for Proposal (RFP) to bring data-gathering in-house (by contracting for the development of a software program to be owned by the state that will perform the functions of the software program used by the outside third party) is in the final stages; and
- industry-standard data checks previously used by the third-party contractor will be incorporated into the software program acquired by RFP.

According to the director of the Division of Health Planning, Tennessee is the ninth state, and the only southern state, to have such a database.

Review of Agency Meeting Minutes and Related Documentation

The auditor reviewed agency meeting minutes for January 2009 through July 2011 and agency member files to determine whether there were any issues regarding member attendance, meeting quorums, members recusing/abstaining from votes, and the filing of annual conflict-of-interest forms. No problems were found (as of October 2011) with the exception that eight members were missing 2010 conflict-of-interest forms and two were missing 2011 forms. The forms were subsequently discovered in another folder where they were not regularly kept.

RECOMMENDATION

ADMINISTRATIVE

The Health Services and Development Agency should address the following area to improve the efficiency and effectiveness of its operations.

1. The agency should strive to be more specific in its documented motions to approve or deny CON applications and refer to how the applicant has met the criteria of need, economic feasibility, and contribution to orderly development specific to its proposed service or expansion.

Appendix 1

**Health Services and Development Agency
Staff by Job Title
November 2011**

Title	Gender		Ethnicity	
	<i>Male</i>	<i>Female</i>	<i>White</i>	<i>Black</i>
Executive Director		1	1	
Assistant Executive Director	1		1	
General Counsel	1		1	
Health Planner 3	1		1	
Director of Administrative Services		1	1	
Statistical Analyst 3		1	1	
Administrative Services Assistant 3		1	1	
Administrative Assistant 1		2	1	1
Total	3	6	8	1

**Health Services and Development Agency
Board Members
November 2011**

Title	Gender		Ethnicity	
	<i>Male</i>	<i>Female</i>	<i>White</i>	<i>Black</i>
Appointed Members	7	1	8	0
Ex Officio Members	1	2	2	1
Total	8	3	10	1

Appendix 2

Performance Measures Information

As stated in the Tennessee Governmental Accountability Act of 2002, “accountability in program performance is vital to effective and efficient delivery of governmental services, and to maintain public confidence and trust in government.” In accordance with this act, all executive branch agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The department publishes the resulting information in two volumes of *Agency Strategic Plans: Volume 1 - Five-Year Strategic Plans* and *Volume 2 - Program Performance Measures*. Agencies were required to begin submitting performance-based budget requests according to a schedule developed by the department, beginning with three agencies in fiscal year 2005, with all executive-branch agencies included no later than fiscal year 2012. The Health Services and Development Agency began submitting performance-based budget requests effective for fiscal year 2011.

Detailed below are Health Services and Development’s performance standards and performance measures, as reported in the September 2011 *Volume 2 - Program Performance Measures*. Also reported below is a description of the agency’s processes for (1) identifying/developing the standards and measures; (2) collecting the data used in the measures; and (3) ensuring that the standards and measures reported are appropriate and that the data are accurate.

Performance Standards and Measures

Performance Standard 1 – Medical equipment registrations will be current.

Performance Standard 2 – Medical equipment utilizations will be reported.

Performance Measure 1 – The percent of current registrations.

Actual (FY 2010-2011)	Estimate (FY 2011-2012)	Target (FY 2012-2013)
97.8%	97.8%	97.9%

Performance Measure 2 – The percent of equipment utilizations reported.

Actual (FY 2010-2011)	Estimate (FY 2011-2012)	Target (FY 2012-2013)
97.4%	97.6%	97.8%

The Health Services and Development Agency was mandated by Section 68-11-1607, *Tennessee Code Annotated*, to maintain a medical equipment registry. The registry contains, but is not limited to, registrations and utilizations of major medical equipment: Computed Tomography (CT) scanners, Linear Accelerators, Lithotripters, Magnetic Resonance Imagers (MRI), and Positron Emission Tomography (PET) scanners. Since the initial implementation of the registry, the data collected include general information about the provider (e.g., provider name, provider address), the name brand of the equipment and general information (e.g., serial number, MRI

magnet type), utilization – by each type of equipment, and historical information on the provider or equipment (e.g., provider name changes, owner changes, replacement of equipment).

The medical equipment registry is the sole source of medical equipment data from all provider types (e.g., hospitals, outpatient diagnostic centers, physicians' offices). Having a comprehensive registry is valuable in evaluating a Certificate of Need (CON) application, which assists in determining whether a proposed project is needed, is financially feasible, and contributes to the orderly development of adequate and effective healthcare. These three items are the criteria the agency must evaluate prior to a decision on a CON application.

According to agency staff, the data collected help them measure the following aspects of the program:

Inputs: During the annual update, providers are asked to submit information on their registered major medical equipment and utilization of that equipment. The measured response shows how many of the registered providers responded so it can be determined how complete the data are.

Outputs: The submitted registrations are used to help ascertain the percentage of current inventory of each equipment type in the market place. Agency staff's analysis of the submitted utilization data assists the agency in determining the need for the medical equipment being reviewed. Knowing the percent of submitted reports helps in determining the validity of the data.

Outcomes: Data presented by applicants and subsequently analyzed by agency staff assist the agency in its deliberations about whether to grant a CON. The higher the percentage of completed registrations, the more accurate the data available for assessment by the agency and staff.

In summary, according to agency staff, the percent of new or updated registrations submitted helps determine the completeness of the data, and the percent of utilizations submitted helps determine the validity of the data. With a high percentage of completion, the agency can be confident in data elements such as utilization by payor source (Medicare, TennCare/Medicaid, Managed Care/Commercial, Self Pay/Other), patient origin (number of procedures by patients' county of residence), and utilization trends (increasing/decreasing volumes over several years).

The statistical analyst collects the data. The measure is the percent of registrations and utilizations received by the end of the fiscal year. An annual update, by use of a survey instrument, usually starts around January 6 (or sooner). The requested date for all the reports to be submitted is March 31st. Not all providers will submit by the deadline; however, every effort is made to have the providers submit the required reports prior to the end of the fiscal year. The registrations submitted either report that their current registration is still correct or corrections are reported. The corrections will range from changing misreported information (e.g., a character in a serial number) to adding/replacing/deleting medical equipment. During the update, health care providers are also asked to submit calendar year utilizations for each of their registered medical

equipment types. The utilizations submitted are by payor and by patient origin. All data collected are placed in an Access database.

Prior to the update, a list of current providers with active medical equipment is compiled. Along with the list of providers, a chart is created which lists the providers and eight blank columns. Those columns are used to log in the reports as they are received. The columns are Complete (all reports submitted), Registration, Question, Registration Correct, Registration Changed, Registration New, Utilization, Utilization by County, and Status. At the bottom of the chart are formulas that calculate how many reports have been received and the percent (based on total number of providers). As the reports are received, they are logged onto the chart. If it has been determined that providers stopped using their registered equipment or closed their business, those providers are not counted toward the final measure and are deleted from the chart. This chart is an Excel file so the column calculations can be automatically made as entries are entered. The calculations on the chart are used to determine if the target measure has been met or not. Two of the calculations used for the columns are total received and percent received.

The calculation is the number of reports submitted divided by the number of registered providers. Some providers have multiple locations and report under one location. In that case, the one provider with data is logged in as submitted while the others are "N/A." Since they have all technically reported, they are included in the percent calculations.

The Strategic Planning Group (selected members of the staff including the Executive Director, the Assistant Executive Director, the Statistical Analyst, the Director of Administrative Services, and the Administrative Services Assistant) meet toward the end of the fiscal year to determine if the targeted measure for the year is met. At that time, the measure is adjusted based on actual results and issues encountered during the year. A target of 100 percent will never be achieved because of uncontrollable factors such as providers closing without notice and contacts leaving without forwarding the update request to their replacement.

According to staff, the registry has grown over the years and has become very reliable. All Certificate of Need reviewable medical equipment has been registered. Only the CT scanners are not as complete. There are many CT scanners registered, but there are likely some not registered in physician offices that have no other services requiring a CON. These physicians' offices usually come to staff's attention by sources such as word of mouth or advertisement. CT scanners only require a CON if the capital expenditure for the unit is in excess of \$2 million.