Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

STATE REFERRAL OF NURSING HOME ENFORCEMENT CASES

Daniel R. Levinson
Inspector General

December 2005
OEI-06-03-00400

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid Fraud Control Units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which State survey agencies refer nursing home enforcement cases, as required, to the Centers for Medicare & Medicaid Services (CMS).

BACKGROUND

The Omnibus Budget Reconciliation Act of 1987 established a survey and certification process to maintain Federal standards in nursing homes certified for participation in the Medicare and/or Medicaid programs. CMS has the responsibility for enforcement at the Federal level and contracts with States to survey facilities to certify compliance. Deficiencies in patient care are considered in conjunction with facility history to determine any CMS enforcement action.

For CMS to enforce standards, States are required to refer three types of cases to CMS: immediate jeopardy cases, which involve actual (or potential for) death or serious injury; double G cases, which identify facilities with a historical pattern of high-level noncompliance; and opportunity to correct cases, which involve facilities failing to correct less severe problems within a given timeframe.

For this inspection, we identified cases between July 2002 and June 2003 that were not referred, reviewed documentation for these cases from CMS and States, and interviewed CMS and State staff.

FINDINGS

States failed to refer almost 8 percent of required nursing home enforcement cases. Although States referred most nursing home cases warranting enforcement during the study period, we estimate that 7.6 percent of cases were not referred. Two problems accounted for 78 percent of nonreferrals: difficulty identifying double G cases and attempted referrals that were not recognized as such by CMS. The remaining nonreferrals were caused by random human error and a variety of other, less common policy and procedural problems.

Difficulty identifying double G cases, resulting from problems with reviews of facility history, caused 47 percent of nonreferrals. Double G cases require that State staff review facility history to establish a pattern of noncompliance. We found two primary difficulties in properly identifying double G cases during these reviews: State staff did not

conduct a thorough review to detect all prior high-level deficiencies, and State staff misunderstood the fairly complex double G criteria. There is also evidence that these criteria are not completely clear to some CMS regional office staff. In 21 percent of double G cases that were not referred, State staff received incorrect or insufficient guidance from CMS.

Unsuccessful referrals, resulting in 31 percent of nonreferrals, were those attempted by States but not recognized as referrals by CMS. For these cases, States documented that they provided a referral to CMS, but CMS staff reported they never received the referral. When we pursued these cases further, we found that either the methods States used to refer the cases were inadequate to alert CMS staff that a referral had been made, or that States sent sufficient documentation but the referrals were still missed. Neither States nor CMS reported having a routine process for verifying whether CMS received referrals.

RECOMMENDATIONS

CMS should address the failure to identify double G cases. CMS should clarify and communicate specific criteria for identifying double G cases to both State and CMS regional office staff, focusing on common areas of misunderstanding. CMS should also provide technical assistance to States to assist in improving State reviews of facility history which would identify double G cases.

CMS should address the incidence of attempted but unsuccessful referrals by developing a uniform referral process. To ensure that all State referrals are received, CMS should implement a uniform referral process that could include a standard referral document or an automated referral mechanism within the enforcement data system shared by States and CMS. CMS should also develop a method for verifying that cases referred by States are received by CMS.

AGENCY COMMENTS

CMS concurred with our recommendations. The agency further commented that it has recently or will soon implement all of the Office of Inspector General's recommendations.

TABLE OF CONTENTS

OBJECTIVE

To determine the extent to which State survey agencies refer nursing home enforcement cases, as required, to the Centers for Medicare & Medicaid Services (CMS).

BACKGROUND

Enforcement Process

The Social Security Act (the Act) establishes requirements for nursing home participation in the Medicare and Medicaid programs. The Secretary is responsible for ensuring that these requirements and their enforcement "are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys."[1] The Omnibus Budget Reconciliation Act of 1987 establishes a survey and certification process for CMS and States to use to verify that Federal standards are maintained in nursing homes certified for participation in the Medicare and/or Medicaid programs.

CMS has primary responsibility for enforcement of these standards, and contracts with State survey and certification agencies to survey each facility no less than once every 15 months to certify compliance with Federal standards.[2] Surveyors revisit noncompliant facilities to determine whether deficiencies have been corrected and to investigate complaints. These surveys are abbreviated versions of the standard surveys. Any deficiency in quality of care, safety, or patient rights, as determined through these surveys, may lead to CMS enforcement actions.

Deficiencies identified during any facility survey are evaluated against a set of factors to determine a scope and severity rating.[3] The Scope and Severity Grid (Table 1) ranks deficiencies according to how widespread they are and their outcomes, such as harm to residents.[4] The scope and severity levels of the deficiencies are considered in conjunction with the facility's compliance history to determine the enforcement actions taken by CMS, including imposing remedies such as denial of payment and civil money penalties.[5] Successful referral of nursing home enforcement cases by States is essential to CMS's efforts to enforce Federal standards of care.

Table 1: Scope and Severity Grid for Deficiencies

Deficiency Severity	Deficiency Scope		
	Isolated	Pattern	Widespread
Actual or potential for death or serious injury (immediate jeopardy)	J	K	L
Actual harm that is not immediate jeopardy	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm; substantial compliance exists	A	B	C

Source: CMS State Operations Manual, Chapter 7.

Case Referral Requirements

States are required by CMS to refer three types of enforcement cases to CMS regional offices, as described below. When CMS receives such a referral, case information is entered into the Long Term Care Enforcement Tracking System (LTC), a compilation of each region's nursing home enforcement case files. Once a case is referred, CMS considers the State recommendations and imposes remedies on the facility. An enforcement case includes all enforcement activity with respect to a particular facility during a continuous period of noncompliance, which enforcement staff refer to as a cycle.[6] The three types of cases requiring referral are:

Immediate Jeopardy Cases. These are cases in which there is actual (or potential for) death or serious injury. They involve the highest level of noncompliance by a facility, i.e., scope and severity ratings of J, K, and L. States must refer these facilities to CMS within 2 calendar days of finding the deficiency so that CMS can initiate required enforcement activities.[7] Because of the severity of noncompliance, CMS will terminate the Medicare contract of facilities with immediate jeopardy citations lasting 23 days or more.

Double G Cases.[8] The Poor Performer Rule was developed in 1998 as a method for identifying historical patterns of high-level noncompliance by facilities and expanded in 1999 to the Double G Rule.[9] The expanded rule

requires States to establish a double G case when a facility is cited for G-level or higher deficiencies on two surveys, hence the term double G.[10] When a G-level deficiency is cited on a current survey, State staff must review facility history to determine whether the facility was previously cited with a G-level deficiency. However, not all G-level deficiencies found in facility histories count toward a double G. Therefore, establishing a double G case hinges on correct identification of the "prior G."

Double G criteria are defined as follows: double G cases are established when G-level deficiencies are cited on a current survey and on a prior survey. These surveys can be standard, complaint, or revisit surveys. Prior G-level deficiencies count toward establishing a case if they were cited on the most recent completed standard survey (completed indicating that compliance was eventually achieved). Prior G-level deficiencies also count if they were cited on any intervening survey between the most recently completed standard survey and the current survey, as long as they are not in the same period of noncompliance as the current survey. (A pattern of noncompliance is indicated when the two G-level deficiencies occur in separate periods of noncompliance.)

Opportunity to Correct Cases. For most cases that are not rated as immediate jeopardy or double G, facilities are provided an opportunity to correct problems. In these cases, facilities are allowed a period during which they can come into compliance without the involvement of CMS. Upon revisit by State surveyors, if deficiencies at a scope and severity level of D or above are not corrected, States are required to refer the case to CMS. Generally, States are expected to conduct the revisit within 60 days of the initial finding of noncompliance. Then, if referral is needed, States are required to refer the case to CMS within 70 days of the initial finding of noncompliance. Adherence to this timeframe is important because it provides CMS time to impose a denial of payment for new admissions by the 90th day of noncompliance, as required in the Act.[11]

The Referral Process

The term "referral" describes the process by which State survey agencies notify CMS about cases of noncompliance and recommend enforcement actions. Without a successful referral, CMS cannot fulfill its obligation to enforce Medicare standards for nursing homes. For the purposes of this report, a succesful referral indicates that the State agency appropriately identified the case as requiring CMS involvement and provided CMS with sufficient information to alert them to begin the enforcement process. To assist in determining case referrals, CMS provides guidance to States through written instructions provided in the "State Operations Manual"

(SOM) and ongoing dialogue between State and CMS regional office staff. Once the case is referred, CMS determines what enforcement action to take and imposes remedies.

Shared Data Systems

After referral, case information is maintained through data systems shared by CMS and States. Traditionally, CMS has used the Online Survey, Certification and Reporting System (OSCAR) to record the results of standard, complaint, and revisit surveys. In October 2004, CMS completed national implementation of the new Automated Survey Processing Environment (ASPEN) Enforcement Manager (AEM). The ASPEN is used by CMS and States to record and access both survey results and enforcement data. State surveyors enter survey findings into a local ASPEN database, then upload the data into a central ASPEN system and also into OSCAR.

CMS Oversight

Although there is no explicit requirement that CMS oversee State referral of nursing home enforcement cases, the Act gives CMS responsibility for enforcing Federal requirements regarding the health and safety of nursing home residents.[12] The Act also specifies that States must assist in enforcement procedures as part of the survey process.[13] State performance in survey and certification is evaluated annually through State Performance Reviews (SPR), which are conducted by CMS regional offices and include general performance standards. One of the SPR standards addresses the referral process, but only with regard to the timeliness of referrals.

METHODOLOGY

To determine the extent to which States refer required nursing home enforcement cases to CMS, we analyzed available administrative data and reviewed case documents obtained from CMS regional offices and State agencies. Based on our initial review of OSCAR data, we identified 3,663 cases believed to require referral as the result of Medicare certification surveys conducted between July 1, 2002, and June 30, 2003. A review of the regionally based LTC revealed evidence of referral for 3,106 of those cases. Timeliness of those referrals was not assessed.

For the remaining 557 cases, we selected a stratified random sample consisting of 200 records for further investigation. Stratification was based on the case type (i.e., immediate jeopardy, double G, or opportunity to correct) initially identified through analysis of the OSCAR data. For

each sample case, we requested case information and documentation of referral from State agencies and CMS regional offices. Their combined responses were used to categorize each sample case into one of three categories: successful referral, nonreferral (referral error), or did not require referral. Referral errors were further evaluated to determine a primary cause of nonreferral and those causes were then explored during interviews with CMS and State staff.

Our overall estimate reflects necessary adjustments to the population to remove cases found not to require referral. Adjustments to the population had minimal impact on our estimates. Additional information on adjustments and the specifics of our methodology are presented in Appendix A. Confidence intervals for point estimates are provided in Appendix B.

Quality Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency.

FINDINGS

States failed to refer almost 8 percent of cases warranting enforcement, thereby limiting CMS's ability to address poor care at some facilities

While States referred most of the cases requiring referral to CMS during the study period, we found that 7.6 percent of enforcement cases (estimated 253 of 3,323) were never referred or the attempted referral did not adequately alert CMS regional office staff that a referral was made. Because CMS was not aware of these cases, the agency had no opportunity to address noncompliance. The potential result of not enforcing Federal standards is continued poor-quality care of residents in the facilities involved in these cases.

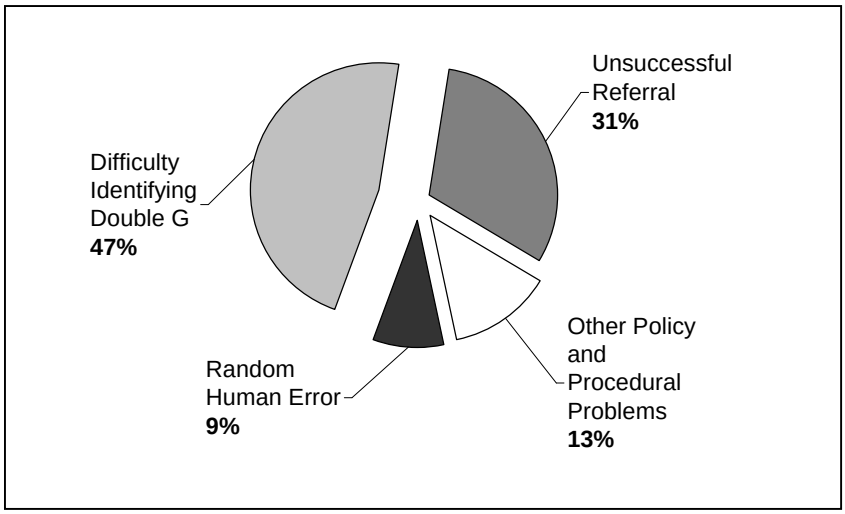
States are required to refer three types of cases: immediate jeopardy, double G, and opportunity to correct. Immediate jeopardy cases—often the most serious cases, involving actual or the potential for death or serious injury—that were not referred included a case of a resident who sustained a bone-breaking fall as the result of a building hazard. Double G cases—those with a pattern of noncompliance—that were not referred included citations for improper treatment of pressure sores and employment of staff previously found guilty of abuse. Opportunity to correct cases—those involving deficiencies of a lower scope and severity that were not corrected over time—that were not referred included a case of inappropriate use of physical restraints.

Two causes accounted for 78 percent of nonreferrals: difficulty identifying double G cases and attempted referrals that were not recognized as such by CMS staff

For the 7.6 percent of enforcement cases not referred, two problems emerged as the primary causes of nonreferrals (see Chart 1 on page 7). Difficulty identifying double G cases was the most prominent cause, accounting for 47 percent of total nonreferrals. Unsuccessful referrals accounted for 31 percent of total nonreferrals and occurred when States attempted to refer a case but the referral was not recognized as such by CMS regional office staff.

An additional 9 percent of total nonreferrals were due to random human error. We found no patterns indicating systemic problems in these cases and we do not discuss them further. The remaining 13 percent of nonreferrals were the result of less-common policy and procedural problems, primarily involving incorrect decisions to not refer cases or to delay referral. Detailed descriptions of these problems are included in Appendix C.

CHART 1
CAUSES OF NONREFERRALS OF NURSING HOME ENFORCEMENT CASES



Source: OIG analysis of 125 cases requiring referral, July 2002–June 2003.

Double G Cases

Difficulty identifying double G cases, which account for 47 percent of nonreferrals, resulted from problems with reviews of facility history. Because double G cases are based on establishing a pattern of high-level noncompliance, identifying double G cases requires that State staff review facility survey history to determine if a prior G-level deficiency has been cited and whether the case should be referred. State staff must follow specific criteria for determining whether G-level deficiencies previously cited for the facility count toward a double G designation. We found two difficulties in identifying double G cases: staff did not conduct a thorough review of facility history (34 percent), and staff misunderstood Federal double G criteria (13 percent).

State staff missed prior G-level deficiencies when conducting reviews of facility history

In our case reviews, we found that 34 percent of nonreferrals resulted from State staff failing to identify a G-level deficiency from a prior survey. When staff offered an explanation, they either reported that they neglected to review the facility survey history, or that they reviewed the history but missed the prior deficiency. CMS staff confirmed in interviews that it can be difficult to find prior G-level deficiencies in survey records.

Based on case reviews and interviews with CMS and State staff, the following two factors contribute to staff missing prior G-level deficiencies during reviews of facility survey history:

Facilities with many surveys can have complicated histories. Cases in our sample had as many as 12 surveys for State staff to review for a single facility (including standard and complaint surveys, as well as revisits), each with varying levels of deficiencies and encompassing multiple periods of noncompliance. In these cases, determining whether a prior G-level deficiency meets Federal double G criteria requires substantial and careful scrutiny of survey records.

OSCAR and ASPEN data can be inaccurate. State staff reported that they often rely on data in OSCAR and ASPEN to review facility histories, yet prior G-level deficiencies were not always included in database records of cases in our sample. In interviews, State and CMS staff identified the following potential causes of inaccurate data: State staff not entering survey data timely due to workload, neglecting to upload data into the national ASPEN and OSCAR databases after entering the data in their local ASPEN system, failing to correct and resubmit data that were rejected in the uploading process as the result of errors, and failing to upload deficiencies retained after an informal dispute resolution.[14]

State staff failed to identify double G cases due to misinterpretation of Federal double G criteria

In some cases, we found that State staff misinterpreted Federal criteria for identifying double G cases. Such errors accounted for 13 percent of total nonreferrals. Both CMS and State staff reported that this misunderstanding is caused in part by the complexity of the double G criteria. Correctly identifying a double G case requires that State staff fully understand which prior G-level deficiencies count toward a double G and correctly apply the criteria to individual cases.

State staff responses in case reviews and interviews indicated a number of misunderstandings regarding double G criteria. For example, staff in eight sample cases did not understand that the prior standard survey that creates the timeframe for review has to be the most recent completed standard survey—meaning the last one for which compliance was eventually achieved (see example in Appendix D).[15] Other examples include the misperception that only deficiencies cited on standard surveys (not complaint or revisit surveys) should count toward a double G, and that the two G-level deficiency findings must involve the same specific deficiency (even though the nature of the deficiency does not matter).

Other State staff reported they believed (incorrectly) that they should review all surveys in the same period of noncompliance as the most recent completed standard survey to find the prior G-level deficiency, rather

than just looking to the most recent completed standard survey and any intervening surveys. This misunderstanding could cause staff to count "prior G" deficiencies that were cited before the most recent completed standard survey but in the same period of noncompliance, inappropriately designating a double G to facilities that did not meet the criteria.

Insufficient or incorrect guidance from CMS contributed to State staff misunderstanding of double G criteria

Our case reviews and staff interviews revealed difficulties with CMS guidance to States. We found that State staff involved in our sample cases had difficulty applying the written instructions in the SOM to the actual cases that they were reviewing. The SOM provides only a brief description of double G criteria and does not provide examples of its application.[16] A clarification was added to the manual in May 2004, but it addresses just one aspect of the criteria (that double G cases must involve two distinct cycles of noncompliance).[17]

In addition to guidance provided in the SOM, State staff frequently contacted CMS regional offices for additional clarification when making double G determinations. However, this guidance sometimes contributed to the misunderstanding of double G criteria. Specifically, we found that in 21 percent of nonreferred double G cases, State staff received incorrect or incomplete guidance from CMS. Further, interviews with CMS regional office staff confirmed that they sometimes have the same difficulties as State staff in fully understanding and applying double G criteria. For example, staff from 5 of the 10 CMS regional offices gave descriptions of double G criteria that were inconsistent with the criteria developed by the CMS central office and included in the SOM.[18]

Attempted but Unsuccessful Referrals

Thirty-one percent of nonreferrals were attempted by States but not recognized as referrals by CMS regional offices

For these cases, States documented or attested that they provided some type of notice to CMS, but CMS regional office staff reported they never received the referral. Unsuccessful referrals in our sample included all 3 case types and 7 of the 10 CMS regions. When we pursued these cases further, we found that either the methods States used to refer the cases were insufficient to alert CMS staff that a referral had been made, or that States sent sufficient documentation but CMS still missed the referrals. Neither States nor CMS reported having a routine process for verifying whether referrals are actually received.

In 15 percent of nonreferrals, States only sent CMS a copy of the noncompliance letter that the State sent to the facility as notice of an enforcement action. Forwarding copies of these letters might appear to be an efficient way to alert CMS of the enforcement case because these letters include the deficiencies cited and the recommended remedies. However, CMS regional office staff reported they might miss these referrals because there is no clear request that action be taken by CMS, regional offices receive large volumes of mail, and letters may be intermingled with communication regarding other business.

The remaining 16 percent of nonreferrals in this group were unsuccessful because, although States sent what appeared to be sufficient referrals, CMS staff still did not recognize them. While it is difficult to determine why this happened in specific cases, both CMS and State staff reported occasional careless practices that could cause missed referrals. Examples include a report of staff in one State mailing all referral documents in a large box at the end of each week with no cover letter or list of contents, and staff in one CMS regional office reporting that documents received on a shared fax machine are not always routed to the appropriate person to initiate enforcement.

An underlying cause of unsuccessful referrals may be that CMS does not require States to use a uniform referral process or a standard referral document. Staff in four CMS regional offices reported that they do not specify any method or content for State referrals and that they will accept as sufficient a copy of the facility noncompliance letter or a brief e-mail message. However, even though these are considered acceptable referral methods, we documented cases sent to the regions by these methods that were not recognized by CMS staff as referrals.

Although successful referrals occurred in most cases, improvements could be made to the process to better ensure that all cases are referred. Our recommendations speak to reinforcement of procedures or policies already in place that States and CMS staff do not always practice. They address the following problems: difficulty identifying double G cases and attempted referrals that are unsuccessful because they are not recognized as such by CMS staff.

CMS should address the failure to identify double G cases by ensuring that CMS and State staff apply double G criteria correctly and by working with States to improve reviews of facility history

CMS should clarify and communicate specific criteria for identifying double G cases. Misunderstanding of the criteria for determining double G cases was a primary cause of nonreferral and was found among both State and CMS regional office staff. CMS should clarify and communicate these criteria to staff, including ensuring that the SOM serves as a clear and practical guide to determining double G cases.

Owing to the complexity of the double G criteria, clearer instruction may not completely alleviate problems. CMS might also wish to consider simplifying the double G criteria while still preserving their purpose of identifying facilities with a pattern of noncompliance.

CMS should provide technical assistance to States to address inaccurate data. CMS and State staffs reported that inaccurate data in OSCAR and ASPEN contributed to staff's missing double G cases when reviewing facility histories. CMS should ensure that States properly enter survey results in these databases and target specific problems raised by staff, such as not entering survey data timely, neglecting to upload data to the national ASPEN and OSCAR databases, failing to correct and resubmit data that were rejected as the result of errors, and failing to upload deficiencies retained after an informal dispute resolution.

CMS should address the incidence of attempted but unsuccessful referrals by developing a uniform referral process and verifying that referrals are received

Twenty-nine percent of State referrals were unsuccessful in alerting CMS that a referral was made. To ensure that all State referrals are received, CMS should implement a uniform referral process. This process could include a standard referral document that could be adapted to various State transmittal methods, such as mail, fax, or e-mail, yet still be easily recognized by CMS staff. Alternatively, CMS could create an automated

referral process in ASPEN that would notify regional offices of any enforcement case entered by State staff. Regardless of the uniform process chosen, CMS should also develop a method for verifying that cases referred by States are received by CMS.

AGENCY COMMENTS

CMS concurred with each of our recommendations, and commented that it has recently or will soon take action related to each of them. We agree that these actions will be useful in addressing the problems identified. However, based on our report findings, we are concerned that CMS's comments to the draft report may not fully address each recommendation. The areas that we continue to believe require additional attention by CMS are listed below:

Double G Criteria

In response to our recommendation that CMS should clarify and communicate specific criteria for identifying double G cases, CMS cited its May 2004 addition to the SOM, discussed on page 9 of this report. This addition instructed State staff to ensure that the two G-level deficiencies that constitute a double G case are found in separate periods of noncompliance. While it is an important clarification, it addresses only one of several problems with interpretation of the double G criteria by State and CMS regional office staff. In conducting this study, we found it clear from our discussions with State and CMS staff that specific technical assistance or training, beyond the issuance of the SOM clarification, is needed to encourage proper application of the criteria and to address common areas of misunderstanding.

We continue to recommend that the guidance provided to States, in the form of the language used in the SOM and the ongoing dialogue between State and CMS regional office staff, be improved to better clarify and communicate double G criteria.

Inaccurate Data

In response to the recommendation that CMS should provide technical assistance to States to address inaccurate data, CMS articulated steps taken to address data problems through full implementation of enforcement-related components of the ASPEN data system. We agree that the newly implemented data systems have the potential to help ensure that survey and enforcement case information is accurate, but CMS should specifically and proactively address problems with data accuracy to more fully alleviate them.

CMS also addressed in its comments our finding that failing to upload case and survey information was a barrier to data accuracy, citing recently issued guidance to States regarding requirements for uploading data timely. We agree that this may improve State accountability in this area; however, other problems with data accuracy remain, including coordination among multiple points of data entry and problems with uploading data that are initially rejected by the data system.

Attempted but Unsuccessful Referrals

Regarding our recommendation that CMS should address the incidence of attempted but unsuccessful referrals, CMS referenced a specific field in the AEM that will allow regional office staff to identify cases that have been referred by States and anticipate their arrival. If used routinely, this would address the incidence of cases wherein States sent sufficient case information and the referral was not recognized as such by CMS, but it would not address cases that were not referred by States at all. CMS believes these nonreferred cases can be detected as regional office staff monitor key dates in the AEM. However, our understanding is that regional offices are not specifically tasked with such monitoring and are likely to do so only on an ad hoc basis, if at all. Therefore, CMS should direct regional offices to make full use of these promising tools.

Technical Comments

CMS submitted technical comments, and we have made changes where appropriate (which caused slight changes to some of the percentages CMS referenced in its comments).

The full text of CMS's comments is presented in Appendix E.

ENDNOTES

[1] Section 1819 (f)(1) of the Social Security Act (SSA).

[2] 42 CFR § 488.330.

[3] 42 CFR §§ 488.404, 488.406, and 488.408; and the State Operations Manual (SOM), Chapter 7, § 7400 (E)(3) (2003).

[4] SOM, Chapter 7, § 7400 (E)(1) (2003).

[5] 42 CFR §§ 488.404 and 488.406.

[6] When the results of a survey indicate that a facility is not in substantial compliance with Federal regulations, it is considered to be noncompliant until it returns to substantial compliance. If the facility requires further enforcement action as a result of new deficiencies without first reaching compliance on the original deficiencies, all enforcement activity is considered to be in the same cycle of noncompliance and a part of the same enforcement case.

[7] Although findings of immediate jeopardy must be included in the initial 2-day notice, the State has 5 calendar days to forward all documentation (notice letter, contact reports, and Form HCFA-1539 Statement of Deficiencies, if completed) to the CMS regional office. 42 CFR § 488.410, as well as SOM, Chapter 7, § 7309(A) (2003).

[8] CMS requires referral of cases in which facilities are not given an opportunity to correct, but which do not involve immediate jeopardy. Nearly all of the cases in this category are double G cases, but in a small number of cases States may have chosen not to give the facility an opportunity to correct due to other circumstances. Because we are only able to identify double G cases in OSCAR and they represent nearly all of the cases in this category, we will use double G cases to represent the group of cases not given an opportunity to correct deficiencies.

[9] In 1998, CMS issued a memorandum to State survey agencies instructing them to include nursing homes cited with repeated patterns of actual harm (H-level or above) deficiencies in the category of poor-performing facilities that are denied an opportunity to correct, which became known

as the Poor Performer Rule. In 1999, CMS issued a second memorandum that expanded this provision to include facilities cited with G-level (isolated actual harm) deficiencies.

[10] Double G criteria apply to any G-level or higher deficiencies. For this report, when we refer to a G-level deficiency it should be assumed that we refer to any deficiency at a G level or higher.

[11] SSA § 1864 and SOM, Chapter 8, § 8000(D)(7) (2003).

[12] SSA § 1819 (f)(1) (2003).

[13] SSA § 1864 and SOM, Chapter 8, § 8000(D)(7) (2003).

[14] When an IDR is pending, State staff are instructed by CMS to delay uploading deficiencies into the ASPEN system until the IDR is resolved. Because ASPEN data are uploaded to OSCAR, the objective behind this is to avoid displaying deficiencies in the Nursing Home Compare directory while they are in dispute.

[15] A recent addition to the SOM addresses this issue, stating "If the most recent standard survey is within the currently running noncompliance cycle, then look back to the most recent standard survey that is not in the currently running noncompliance cycle in making double G determinations." SOM, Chapter 7, § 7304 (B)(1) (2004).

[16] The SOM guidance states "A double G facility is one that has been identified as noncompliant with a scope and severity level of 'G' or higher on a current survey and on the previous standard survey or any intervening survey (i.e., any survey between the current survey and the last standard survey)." SOM, Chapter 7, § 7304 (B) (2003).

[17] See endnote 16 for text. SOM, Chapter 7, § 7304 (B)(1) (2004).

[18] As indicated in Appendix A (Detailed Methodology), to ensure that this inspection relied on the correct interpretation of double G criteria to make case type and referral determinations, we consulted with CMS central office staff via telephone interviews and other correspondence.

Detailed Methodology

For this inspection, we examined nursing home enforcement cases that required State referral to CMS regional offices. Cases requiring referral include immediate jeopardy cases, double G cases, and opportunity to correct cases that failed to achieve subsequent compliance in the required time period. Our sampling frame was limited to cases resulting from surveys conducted during the 12-month period between July 1, 2002, and June 30, 2003. We used a combination of case reviews and interviews to determine the extent to which States refer required nursing home enforcement cases and to reveal any problems affecting the referral process. This study does not address the timeliness of referrals, but rather whether cases were referred at all.

Sampling Design

Initial identification of cases requiring referral was based on CMS's Online Survey, Certification and Reporting System (OSCAR) data. Immediate jeopardy cases included all surveys containing a scope and severity rating of J, K, or L. Opportunity to correct cases that required referral included surveys and complaints with two or more associated revisits. Because of the complexities involved in identifying double G cases, a listing of those cases was provided by CMS central office staff who had previously developed an algorithm to extract such cases using OSCAR data.

We compared the cases identified in the OSCAR data as requiring referral to case information in CMS's Long Term Care Enforcement Tracking System (LTC). If case information was present in the LTC, we considered the case to have been successfully referred. From our population of cases (those that appeared to require referral based on our analysis of OSCAR) we identified two groups: those with evidence of referral in the LTC and those with no evidence of referral. Only cases in the second group (no evidence of referral in LTC) were included in our sampling frame, and then the two groups of cases were ultimately combined to calculate an overall rate of nonreferral.

We selected a stratified random sample of 200 cases from the group that did not have evidence of referral in the LTC. Forty-two States and all 10 regional offices were represented in this sample. Cases were stratified based on case type; i.e., immediate jeopardy, double G, and opportunity to correct, as determined through our initial review of OSCAR data. The breakdown of our sample by case type is presented in Table 2.

Table 2: Sample Design for Cases With No Evidence of Referral		
Strata	**Population**	**Sample**
Double G	254	75
Opportunity to Correct	234	70
Immediate Jeopardy	69	55
Total	**557**	**200**

Source: OIG analysis of 3,323 cases requiring referral, July 2002–June 2003.

Case Type Identification

The three strata are based on our determination of case type using OSCAR data. The case types are, by definition, the reason referral is required. We opted to stratify our sample based on this designation for two reasons: to ensure our ability to include issues involving the most egregious deficiencies (immediate jeopardy) and to be able to identify differences between the case types. Some enforcement cases have multiple reasons for referral, meaning that the case may meet the definition of more than one case type.

In our initial determination, we prioritized these reasons by severity of the situation: immediate jeopardy, double G, and opportunity to correct. In reviewing the cases, however, we found the order of events to be more indicative of the reason for referral and adjusted the case types from our initial determinations. For example, if an initial survey meets the definition of a double G and a subsequent revisit meets the definition of an immediate jeopardy, then our case type classification would have switched from immediate jeopardy to double G. We did not, however, change the strata from which they were selected. Because of these changes, we are not providing error estimates for individual case types.

Document Requests

For cases in the sample, we requested case documentation pertaining to referral from both the State and the CMS regional office responsible for oversight of the facility. From the States, we asked for documentary evidence that a referral had taken place or an explanation of why the case had not been referred.[1] We also allowed State staff who could not produce

[1] Acceptable forms of documentation included electronic mail, facsimile transmission reports, or any other documentation that included case-specific information and a date the information was sent.

documentation to attest that a referral to CMS had been made. From the CMS regional offices, we requested verification of whether the case was received and for additional comments pertaining to its referral. We followed up with individual States and regional offices to resolve inconsistencies and unclear responses.

Criteria

Case reviews were used to determine nonreferrals, as well as to catalogue the causes of nonreferral. Cases were categorized as successfully referred, referred in error, or did not require referral. The projected numbers, including the error rate, were calculated so that cases that did not require a referral were excluded. We determined a successful referral to include:

- cases with evidence of referral in the LTC system,
- cases that CMS acknowledged receiving, and
- cases for which States provided clear documentation of referral.

State and regional office responses to our requests yielded numerous explanations of why specific referrals were not believed to be required. We carefully considered these comments, but our decision for assessing whether a case required referral was based on clarifications sought from the CMS central office.

We identified 75 cases in our sample that did not require referral. Reasons for not requiring referral include inaccurate OSCAR data and Medicaid-only facilities, among others. Cases that did not meet the criteria for successful referral or were exempt from referral were determined to be referral errors. As stated previously, we did not always accept CMS regional office or State responses that a case did not require referral. Some of these cases were classified as referral errors and are a source of our data to identify policy misinterpretations by CMS and/or State staff.

After identifying referral errors, we determined a cause for each. When there were multiple causes for a single case, we selected a primary cause which appeared to be most responsible for the error.

Population Adjustments

Our review identified 75 cases that did not ultimately require referral (see Table 3). These cases were excluded from our projected numbers. Adjustments to the population had minimal impact on our estimates, changing our overall error rate from 7.4 percent to 7.6 percent.

Table 3: Ineligible Cases			
Strata	Initial Sample	Referral Not Required	Final Sample
Double G	75	16	59
Opportunity to Correct	70	46	24
Immediate Jeopardy	55	13	42
Total	**200**	**75**	**125**

Source: OIG analysis of 3,323 cases requiring referral, July 2002–June 2003.

Opportunity to correct. Two-thirds of the opportunity to correct cases in the initial sample were found not to require referral. The number in this stratum was reduced from 70 to 24. The cause of this significant change was the data proxy used to identify opportunity to correct cases. To create our proxy, we identified any case in OSCAR with more than one revisit (not including a superceding immediate jeopardy or double G designation) as having had an opportunity to correct. However, our proxy did not distinguish between documentation-only desk reviews and onsite revisits. Many cases with desk reviews (34 of 46) met the definition of substantial compliance and did not require referral. A second, but less frequent, problem was the result of the proxy being based on the number of revisits rather than the timeframe for referral (we subsequently determined that the 70th day of noncompliance is the critical point for requiring referral). The remaining opportunity to correct cases found not to require referral were the result of various data inconsistencies.

Cases with evidence of referral in LTC. Because cases not requiring referral were prevalent in our sample, we took an additional sample of 300 cases from those deemed as successful referrals based on their presence in the LTC system. We randomly selected 100 cases from each stratum: double G, immediate jeopardy, and opportunity to correct. We reviewed case-specific data in OSCAR and LTC to ascertain that the case (1) was correctly identified as a referral, (2) had the appropriate case type designation, and (3) was eligible for review. Eleven of the 300 cases reviewed in this group were determined to be ineligible. Of these cases, three were from the immediate jeopardy stratum, four were from the double G stratum, and four were from the opportunity to correct stratum. All 11 were the result of the enforcement cycle being represented more than once.

Table 4: Subpopulation Adjustments				
	Evidence in LTC		Record Review	
Stratum	Original Population	Adjusted Population	Original Population	Adjusted Population
Double G	1,382	1,327	254	200
Opportunity to Correct	908	872	234	80
Immediate Jeopardy	816	792	69	53
Total	**3,106**	**2,990**	**557**	**333**

Source: OIG analysis of 3,323 cases requiring referral, July 2002–June 2003.

Adjustment calculations. Population estimates were created by removing ineligible cases from the sample but retaining the original population weights (see Table 4). These estimates were used in the calculation of an overall error rate. Adjustments reduced the total population only slightly, from 3,663 to 3,323, with a confidence interval of plus or minus 3.0 percent (see Table 5). Further analysis confirmed that the impact on our overall estimate was minimal, changing our error rate from 7.4 percent to 7.6 percent.

Table 5: Overall Population Adjustments		
	Adjusted Population	Confidence Interval
In LTC	2,990	2,922 to 3,058
Record Request	333	301 to 364
Total	**3,323**	**3,223 to 3,422**

Source: OIG analysis of 3,323 cases requiring referral, July 2002–June 2003.

Statistics

The SUDAAN statistical software was used to obtain population estimates for each group. The estimates for each group were combined to provide an estimate of the nonreferral rate overall. The estimates are reflective of population adjustments described above. Analysis of these adjustments was conducted by our mathematical statistician.[2]

Our response rate was 100 percent. Confidence intervals were calculated at the 95-percent level and are presented in Appendix B.

[2] RAT-STATS is a statistical program developed by the Office of Audit Services, Office of Inspector General, Department of Health and Human Services.

Interviews/Focus Groups

During the course of this inspection, two sets of interviews were conducted to help us better understand the causes of nonreferral and CMS's oversight of this process. Prior to reviewing specific case data, we conducted interviews with CMS regional and central office staff. The purpose of these interviews was to improve our understanding of the causes of nonreferral and to assess CMS guidance and oversight. Interviews were conducted in person by OEI analysts using a structured protocol. Additionally, we conducted follow-up telephone interviews with all CMS regions and 10 State agencies. States were selected for interviews to represent a broad range of case experiences. In these follow-up interviews, we raised issues that were identified during the individual case reviews. We asked respondents to provide us with additional context and plausible explanations or causes of nonreferral. Although many of the questions were related to specific cases, we provided the same scenarios in each interview to assess the potential for problems in other States and regions.

After transcribing the interviews, analysts reviewed the material from all interviews collectively, identifying similarities and differences among the responses of different offices and gauging the impact of the information on the referrals process.

Limitation

Because we used the OSCAR database to identify sample cases, our analysis does not include any cases that States may have inappropriately omitted from OSCAR. To the extent that State survey agencies did not enter cases requiring referrals into ASPEN (and therefore OSCAR), our results would underestimate the extent of nonreferrals. However, because payments are based on these data (creating an incentive for States to enter the information) and because the annual State Performance Review includes components on survey conduct and data entry, we do not expect this limitation to substantively affect our estimates.

APPENDIX ~ B

CONFIDENCE INTERVALS

POPULATION

	Estimate	95% Confidence Interval	
		Low	High
Error Rate*	7.6%	6.81%	8.30%
Error Cases	253	228	278

SUBSET OF NONREFERRAL ERRORS

	Estimate	95% Confidence Interval	
		Low	High
Difficulty Identifying Double G	47.0%	38.24%	55.76%
- Staff Missed Double G	*34.4%*	*25.60%*	*43.28%*
- Staff Misinterpreted Double G Policy	*12.6%*	*5.94%*	*19.16%*
Unsuccessful Referral	31.1%	22.12%	40.08%
- State Sent Only Copy of Facility Letter	*14.8%*	*7.63%*	*21.97%*
- Referral Documented but Never Received	*16.3%*	*9.68%*	*22.92%*
Random Human Error	8.5%	2.80%	14.20%
Other Policy and Procedural Problems	13.4%	6.68%	20.12%

SUBSET OF DOUBLE G ERRORS

	Estimate	95% Confidence Interval	
		Low	High
Incorrect CMS Guidance Given to State	31.40%	18.97%	43.83%

Source: OIG analysis of 3,323 cases requiring referral, July 2002–June 2003.

*The majority of cases were considered successful referrals based on their presence in the LTC data. Only errors in the remaining portion required estimation.

Other Policy and Procedural Problems

An additional 13 percent of nonreferrals were attributable to specific Federal policies which are unclear or not routinely followed by state staff

Although most nonreferrals were caused by problems with identifying double G cases and insufficient notice to CMS, a smaller number of nonreferrals (20 sample cases) were caused by a variety of other policy and procedural problems. We identified four specific problems within these cases that, although the cause of few nonreferrals, reflect either unclear Federal policies or incorrect State practices.

Staff may restart correction period upon finding new deficiencies. Nonreferral of 11 cases in our sample was the result of State staff not fully understanding Federal referral policy regarding opportunity to correct cases. Opportunity to correct cases which fail subsequent compliance should be referred within 70 days of the initial finding of noncompliance. In the case of these nonreferrals, the facilities were cited with new deficiencies when surveyors revisited them. Mistakenly thinking they must provide the maximum time for correction of the new deficiency, the States restarted the 70-day referral period at the time of the revisit. This allowed the facilities to be out of compliance for longer than 70 days without referral.

State staff may determine not to refer. For four cases in our sample, States chose not to follow Federal referral policy at their own discretion. In these cases, State staff decided to delay referral pending the outcome of a second revisit. As a result, these cases were out of compliance past the date that CMS is required to impose a mandatory remedy for noncompliance. State staff reported that they did not refer these cases because they believed the facility would achieve compliance soon without imposition of a remedy.

Informal Dispute Resolutions may delay referral. All respondents in our State and CMS interviews reported correctly that an Informal Dispute Resolution (IDR) would not delay enforcement action. However, our case reviews revealed three examples in which the State held referral of cases for a pending IDR, then never ultimately referred the cases because the IDR overturned the deficiency that warranted referral. This indicates that all State staff may not be clear regarding the required referral of enforcement cases regardless of whether the facility has initiated an IDR.

Abated immediate jeopardy. According to CMS central and regional office staff, immediate jeopardy cases must be referred by States to CMS, even when the deficiency constituting the immediate jeopardy is removed (abated) while the survey is still in progress. In four CMS regions, staff reported that States are allowed more time to refer these cases than the required 2-day referral period for an immediate jeopardy case. For example, one CMS region requires States to refer abated immediate jeopardy cases within the time period expected for double G cases (10 days). However, in two cases in our sample, surveyors did not refer immediate jeopardy cases that were abated and gave the abatement as their reason for not referring them.

APPENDIX ~ D

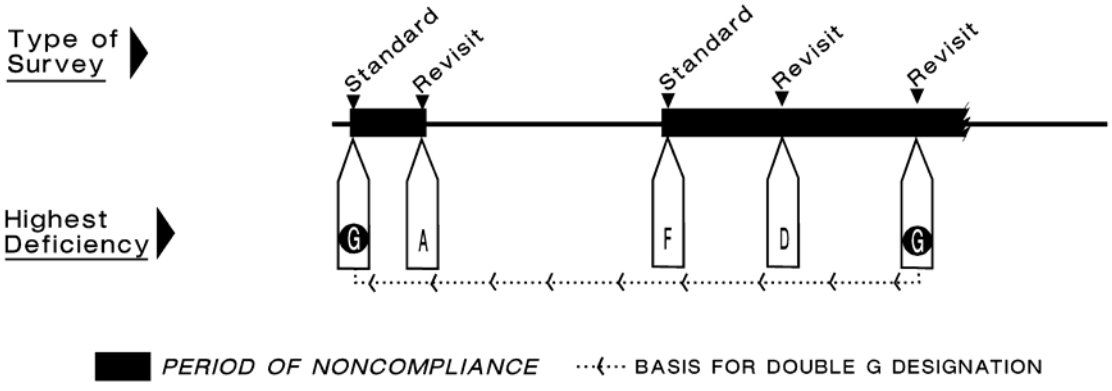
Double G Case Example

Illustrating Federal criteria which require that States use the most recent completed standard survey in establishing a timeframe for review of facility survey history

This example illustrates a potential problem in identifying double G cases (see Figure 1). In this case, a G-level deficiency is cited during a revisit. If State staff reviewed history only back to the most recent standard survey (following which the facility has not yet acheived compliance), the staff would incorrectly determine that this is not a double G case because the highest deficiency cited on that survey was an F-level. Rather, State staff should review history back to the most recent completed standard survey, meaning the most recent for which compliance was eventually achieved.

The double G criteria are designed to identify a historical pattern of noncompliance. Counting deficiencies within the current period of noncompliance can limit the timeframe for review to as little as a few days or weeks. If State staff followed the incorrect policy of reviewing facility history only to the most recent standard survey, they would overlook a pattern of noncompliance.

Figure 1: A DOUBLE G



Source: Example drawn from OIG 2004 analysis of 3,323 cases requiring referral, July 2002–June 2003.

Agency Comments to Draft Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

JUN 21 2005

Administrator
Washington, DC 20201

TO: Daniel R. Levinson
Acting Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: OIG Draft Report: "State Referral of Nursing Home Enforcement Cases", (OEI-06-03-00400)

Thank you for the opportunity to review and comment on the subject OIG draft report. The report's objective was to determine the extent to which states appropriately referred nursing home enforcement cases to Centers for Medicare & Medicaid Services (CMS) using data and documentation from a sample of cases from July 2002 through June 2003. Such referrals are important in order to ensure appropriate enforcement and remedy when serious problems are found in nursing home care.

The CMS policy requires states to refer to CMS, for enforcement purposes, three types of cases:

- Cases involving actual (or potential for) death or serious injury, otherwise known as "immediate jeopardy" cases;
- Cases involving a certain pattern of findings for serious deficiencies in a nursing home, otherwise known as the "double G" policy (in reference to the CMS method of scoring the seriousness and extent of a deficiency),
- Cases in which a nursing home fails to correct other types of problems within the timeframe required.

The OIG found that states appropriately referred the vast preponderance (92 percent) of nursing home cases that warranted enforcement. The OIG also found that an estimated 8 percent of such cases either were not referred, or were referred but the referral was not recognized as a referral by the CMS regional office.

We are pleased to report that we have implemented system improvements that remove the main causes of the above problems. These actions occurred after the June 2003 ending date of the OIG information collection period, so they are not reflected in the findings of the OIG report. We are confident that current and future data collection periods will reveal an even higher rate of conformance with CMS policy than the 92 percent reflected in the June 2002 – June 2003 time period.

Two problems accounted for 80 percent of the 8 percent of cases that should have been referred but were not: 1) difficulty on the part of states in identifying cases with a history of

noncompliance (the "double G cases"); and 2) cases referred to CMS by the states but not recognized as such by CMS regional offices.

With regard to the "double G" policy, we issued clarifications to states on May 21, 2004, that remove some of the most troublesome areas of confusion.

With regard to the problem of referrals being made but not recognized as such by CMS regional offices, we made significant improvements in our information system to improve enforcement and eliminate this problem. In October 2004 we implemented a new subsystem, the ASPEN Enforcement Manager (AEM) that ensures that regional offices do not miss any cases in which a state makes a referral to CMS.

Enforcement and prompt remedy of identified problems in nursing homes is vital. We have implemented a number of improvements to promote fulfillment of that goal, and are committed to taking further such actions. We expect that, in future data collection periods, these actions will indicate that the problems of an earlier period that were identified in the OIG report have, in fact, been addressed.

In the comments below we provide more specific information on the improvements we have made, and also describe some additional steps that are being developed.

OIG Recommendation

1. The CMS should address the failure to identify double G cases by ensuring that CMS and State staff apply double G criteria correctly and by working with States to improve reviews of facility history.

   a. The CMS should clarify and communicate specific criteria.

CMS Response

The CMS certainly concurs with the OIG recommendation and provided the clarifications last year. We made revisions to section 7304-B1 of Chapter 7 of the State Operations Manual (SOM) that clarify and enhance guidance about making double G determinations. This additional guidance, which was issued on May 21, 2004, is detailed and comprehensive and was developed with direct input from our regional offices and the states.

The CMS believe that the current guidance, available on the CMS Websites, now adequately addresses the concerns raised in your report as well as those that had been raised by SOM users.

Your report suggests that it might be helpful to provide examples of double G determinations with our manual guidance criteria. We had proposed to use such examples in our 2001 draft rewrite of Chapter 7, but state and regional office commenters recommended overwhelmingly that examples not be included because they found them more confusing than helpful. In the case of the double G policy, questions and answers and examples had previously been issued on February 14, 2000. The

confusion over the examples was caused by the complicated nature of most survey cycles since they can be comprised of many, many individual surveys.

A slight variation between an example and a specific "real life" scenario could cause an incorrect double G determination to be made. Therefore, after receiving the regional office and state comments, we concluded that our examples were generating more questions than answers due to the reality of the multiple survey issue. The majority of commenters preferred that the criteria be specifically and carefully communicated in explanatory rather than example format.

The OIG report also suggests simplifying the double G criteria. We concur and welcome the support of this recommendation. We will proceed with discussions with our regional offices, states, and other stakeholders to develop a reasonable and understandable approach to identifying facilities having a pattern of serious noncompliance.

At the same time, we are aware that the double G policy is to some extent inherently complicated and may also have unintended consequences that diminish rather than enhance enforcement. We are therefore re-evaluating the wisdom of the policy itself, while we are simultaneously redoubling efforts to make it work. The policy question is whether there are alternative approaches that would involve less confusion and be more effective.

OIG Recommendation

b. The CMS should provide technical assistance to States to address inaccurate data.

CMS Response

The CMS concurs and have already taken steps to achieve this goal. With recent national implementation of two major data systems to manage survey and enforcement actions (the ASPEN Enforcement Manager (AEM)) and complaint and incident-related activities (the ASPEN Complaints/Incidents Tracking System (ACTS)), we now have greater ability to assure that data is as current, accurate, and complete as possible. Increased dependence on these systems to manage and track survey, enforcement, and complaint actions as well as increased national reporting capabilities of the two systems is dependent upon timely data entry.

With the help of our regional offices and states, we developed interim policy instructions that provide specific timeframes in which survey and enforcement data must be entered into ASPEN Central Office (ACO) as well as complaint/incident data into ACTS. This guidance was released to our regional offices and states on May 12, 2005, in Survey and Certification letter S&C-05-27. We will finalize the timeframes once they have been in place for a period of time sufficient for us to evaluate their reasonableness and value.

Your report notes three examples of state failure to upload deficiencies once they were upheld in the Informal Dispute Resolution process. While we do not believe that three cases signal a significant problem, we believe that reiteration of the upload policy would be useful and we have included it in the data entry timeline instructions letter mentioned in the preceding paragraph.

Page 4 – Daniel R. Levinson

OIG Recommendation

2. The CMS should address the incidence of attempted but unsuccessful referrals by developing a uniform referral process and verifying that referrals are received.

CMS Response

The CMS strongly concurs and are exceeding this recommendation. Not only have we clarified the referral process, but we have implemented a system fix that provides assurance that referrals are not missed.

With national implementation of AEM on October 1, 2004, we now have a system that provides data entry and reporting in an electronic environment.

Most significantly, AEM has a specific field in the Case Basics Tab labeled "Refer case to RO" where states must enter the date of the transfer of the case to the regional office. Entering this date will automatically create an action item in AEM for the regional office case worker(s). As soon as the regional office workers access AEM, they are notified of the referral action. Additionally, using the reporting feature of AEM, CMS can monitor and track key dates and key activities in process, including the fact that a case has been, or will shortly be, referred to the regional office by the state for Federal action.

Additional technical comments are attached.

ACKNOWLEDGMENTS

This report was prepared under the direction of Judith V. Tyler, Regional Inspector General for Evaluation and Inspections of the Dallas Regional Office, and Kevin Golladay, Assistant Regional Inspector General of the Dallas Regional Office. Other principal Office of Evaluation and Inspections staff who contributed include:

Amy Ashcraft, *Team Leader*

Ruth Ann Dorrill, *Project Leader*

Blaine Collins, *Program Analyst*

Sarah Craren, *Program Analyst*

Clark Thomas, *Program Analyst*

Susan Wolfe, *Program Analyst*

Sandy Khoury, *Program Specialist*

Technical Assistance

Barbara Tedesco, *Mathematical Statistician*

Kevin Farber, *Mathematical Statistician*

David Graf, *Program Analyst*

Scott Horning, *Program Analyst*

Linda Moscoe, *Program Analyst*

Field Assistance

Tara Bernabe, *Program Analyst, Philadelphia*

Sylvia Chin, *Program Analyst, San Francisco*

Tricia Fields, *Program Analyst, Kansas City*

Graham Rawsthorn, *Assistant Regional Inspector General, Atlanta*

David Rudich, *Program Analyst, New York*

Marco Villagrana, *Program Analyst, Chicago*