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United States Senate
COMMITTEE ON SMALL BUSINESS
WASHINGTON, DC 20510-6350

June 21, 2000

VIA FACSIMILE: (202) 690-6262
ORIGINAL BY U.S. MAIL

The Honorable Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Dear Administrator DeParle:

The purpose of this letter is to reiterate my dismay that the Health Care Financing Administration (HCFA) was frightfully unaware of "serious problems" with the Missouri Division of Aging's (MoDA) monitoring of nursing homes and handling of complaint investigations. I appreciate that you share my deep concern, and I recognize that the audit released by Missouri State Auditor Claire McCaskill (McCaskill Audit) primarily focused on the MoDA's compliance with state statutes and regulations. Nevertheless, I am concerned about the adequacy of your response to my inquiries in your letter dated April 21, 2000.

First, you answered my question about the MoDA's ability to complete complaint investigations within the statutory deadline, by stating that HCFA's OSCAR data showed "MoDA initiated complaint investigations within 2 working days after the complaint was filed *on over 64 percent* of the 2,128 complaints received . . . " (emphasis added). If my calculations are correct, approximately 766 complaints were not investigated within the *federally* mandated period — a rate of compliance that is disturbing and should have raised some alarm about the MoDA's performance. It is even more disturbing if considered from the perspective of the family members and/or residents whose 766 complaints fell on deaf ears. Please provide more detailed information regarding these delinquent complaint investigations; specifically, determine how many investigations out of 766 were investigated within 10 days, 30 days, 60 days, and so on until all investigations were initiated.

Second, my letter addressed the status of HCFA's review of its 1864 Agreement with the State of Missouri. You answered that in December 1999 HCFA released a revised State Operations Manual (Manual) and that you expected to issue "shortly" the first program memoranda listing specific performance standards that states must achieve. In addition, you stated that "[t]he Kansas City Regional Office will use these standards to evaluate state performance during FY2000." While this *prospective* plan to ensure state compliance is laudable, I was advised by the Kansas City Regional Office in November 1999, prior to release of the new Manual, that Missouri's contractual agreement was under review to determine

whether the MoDA was meeting the terms and conditions of its contract. Since the Kansas City Regional Office said that the contractual review was already underway, HCFA should have been aware of all the failures identified in the McCaskill audit which affected the MoDA's ability to achieve *federal* performance standards established prior to December 1999. Your response failed to address, in light of the findings in the McCaskill audit *and* HCFA's own contractual review, whether the MoDA failed to meet its contractual obligations.

Please state if HCFA is reviewing whether the MoDA violated its 1864 Agreement prior to FY2000 and whether HCFA was aware of the failures identified in the McCaskill Audit prior to its release — if not, please state why not. In addition, if the first program memorandum has indeed been issued, please forward a copy to my staff. I expect that subsequent program memoranda will be forwarded in the monthly reports you prepare for me.

Third, you answered my question about what action HCFA will take in response to the McCaskill Audit, by stating "the Regional office will work with the MoDA to ensure full implementation of all recommendations that affect its ability to achieve performance standards . . . ." Specifically, you cited the standard that at least 10% of nursing home inspections start in the evening, early morning or on weekends, stating "[w]e will ensure that MoDA does, in fact, meet this standard." I noticed with interest that the MoDA conducted 17 surveys during the first quarter of 2000 and that none were conducted during the evening or on a weekend. Please state what specific actions HCFA is taking to "ensure full implementation" of HCFA's performance standards.

I do not believe that the failures identified in the McCaskill Audit are limited to requirements mandated by Missouri state law and regulations. For example, it is my understanding that although there are currently no federal minimum staffing standards for nursing facilities, under 42 C.F.R. § 483.30, a "facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident" — a standard that appears to be intentionally quite broad. In my letter, I noted that the McCaskill audit found that the MoDA cited 47% of facilities for staffing or for staff qualifications and training issues. You responded, stating "[t]he State Auditor's finding on inadequate staffing relates to the MoDA's failure to meet the [Missouri's] minimum staffing requirements . . . ." This response leads me to conclude, as does the general theme of your letter, that it is your contention that no nexus exists between the MoDA's failures with respect to Missouri's state statutes and regulations and any failure to meet federal survey and certification standards. I submit to you that the McCaskill audit undeniably reveals serious problems that should have been recognized by HCFA and should not be dismissed simply as failures to meet Missouri's standards.

Finally, there is currently a civil lawsuit in Missouri brought by the family of a resident who was brutally and fatally beaten by a nursing-home aide. A certified nurse's assistant

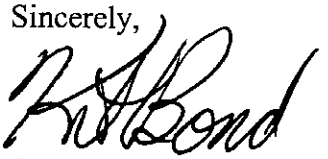
formerly employed by the nursing home provided the following deposition testimony under oath about the nursing home's hiring and training practices:

> [T]he [facility] began hiring people straight off the street . . . [who] [h]ad never done the job, didn't know the job, were put on halls by themselves, left to train each other . . . . We had one guy there . . . [who] was finally fired when he was caught sneaking back into the building and hiding in places to sleep during the day because he was one of the ten people they had from the Salvation Army . . . . They had ten people working from the Salvation Army at one time. . . . [W]hen they couldn't find any staff, they'd go wherever they could to get a body . . . . As far as the homeless people, there was [one] that they went out to pick up . . . he would miss work weeks at a time . . . [h]e failed to come in because he was in jail . . . [h]e also wanted to come in with alcohol on his breath, but he was never sent home for it . . . . I personally smelled alcohol on his breath a couple times . . . . [T]here were a lot of nights that he worked that he would work 48 to 50 residents to himself.

It defies reasonable explanation that an oversight system, whether it be state or federal, can so utterly fail to protect resident safety. We simply cannot turn a blind eye to life-threatening training and staffing failures. I firmly believe that the systemic problems in the MoDA are symptoms of inexcusable lapses by the federal as well as the state oversight program. Moreover, I am troubled that HCFA has yet to determine how such systemic problems developed under its watch. I hope that we can take a constructive approach to addressing these issues so that our nation's elderly receive the quality of care they justly deserve.

I would appreciate receiving a response to my concerns and inquiries no later than July 7, 2000. If you or your staff have any questions regarding this matter contact Dan Donovan at (202) 224-5175.

Sincerely,



Christopher S. Bond
Chairman

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