COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

August 4, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Re: Improving COVID-19 nursing home data collection and reliability

Dear Administrator Verma:

As cases of COVID-19 surge across the nation, this deadly virus continues to devastate long-term care (LTC) facilities.[1] Some reports estimate as many as 335,000 nursing home residents and employees have been infected with COVID-19 across 15,000 long-term care facilities, accounting for more than 40 percent of all COVID-19 deaths nationwide.[2] LTC facilities continue to be a perfect storm for COVID-19, with vulnerable residents living in close proximity within these hotspots for infection and disease.[3]

Access to timely, robust, and reliable data is critical in understanding the magnitude of the COVID-19 crisis in nursing homes and appropriately allocating resources to the hardest hit facilities as well as those at greatest risk for outbreaks. The Centers for Medicare & Medicaid Services (CMS) started requiring LTC facilities to report limited COVID-19 data through its May 8, 2020, Interim Final Rule (85 FR 27550).[4] Despite this requirement, reports of insufficient and unreliable nursing home data persist, most notably nursing home COVID-19 staff fatality data.[5] Furthermore, issues of unreliable and insufficient data go beyond lapses in staff data, as the Nursing Home COVID-19 Public File contains large amounts of insufficient, unreliable, and missing data.[6]

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[1] https://www.wsj.com/articles/in-the-u-s-coronavirus-tells-a-tale-of-two-americas-11593797658
[2] https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html
[3] https://www.washingtonpost.com/business/2020/04/17/nursing-home-coronavirus-deaths/?arc404=true
[4] https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory
[5] https://www.cnn.com/2020/07/23/us/nursing-home-worker-death-investigations-osha-invs/index.html
[6] https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

Insufficient Nursing Home COVID-19 Staffing Data

To date, no reliable national data on the number of Long-Term Care facility workers that have died as a result of COVID-19 exist. [7] As of July 28, 2020, CMS estimated approximately 760 workers across 400 facilities had died.[8] These data equate to more than 200 nursing home staff fatalities per 100,000 workers, which is more than double the rate of 2019's deadliest occupations, such as logging workers, fishers, and aircraft engineers. [9] [10] Ways and Means staff analysis of the Nursing Home COVID-19 Public File (see Table 1 at the end of this letter) found that over three percent (about 3,900 data fields) of the data related to COVID-19 cases and deaths of LTC facility workers was completely missing. Even more alarming, Occupational Safety and Health Administration (OSHA) claims to have received reports of only 99 LTC facility worker fatalities related to COVID-19, suggesting there are data and reporting issues for this population across the federal government.[11]

Staffing shortages in LTC facilities continue to pose impediments to the safety of and quality of care delivered to nursing home residents. Studies have found that staffing shortages are associated with higher rates of COVID-19 cases and fatalities in nursing facilities.[12] [13] To sufficiently allocate resources to nursing facilities with staffing shortages, at a minimum, CMS needs reliable information on the number of Registered Nurse (RN), Licensed Practice Nurse/Licensed Vocational Nurse (LPN/LVN), and Certified Nursing Assistant (CNA) hours per resident per week.

As I noted in my July 10, 2020 letter to you, I applaud the agency for reinstating the collection of staffing data through the Payroll-Based Journal (PBJ) system.[14] However, the reporting requirements outlined in the agency's May 8, 2020, Interim Final Rule (85 FR 27550) do not align with existing mandatory and standardized staffing data through the PBJ system, which is reported as staffing hours per resident per week. [15] [16] [17] According to the Nursing Home COVID-19 Public File data dictionary, nursing homes are not required to report any information on staffing hours per resident; rather, they must self-report whether or not the facility is experiencing staffing shortages – a significantly less comprehensive measure of staffing capacity

[7] https://www.cnn.com/2020/07/23/us/nursing-home-worker-death-investigations-osha-invs/index.html
[8] https://www.washingtonpost.com/opinions/2020/07/28/nursing-home-workers-now-have-most-dangerous-jobs-america-they-deserve-better/?hpid=hp_save-opinions-float-right-4-0_opinion-card-a-right%3Ahomepage%2Fstory-ans
[9] https://www.washingtonpost.com/opinions/2020/07/28/nursing-home-workers-now-have-most-dangerous-jobs-america-they-deserve-better/?hpid=hp_save-opinions-float-right-4-0_opinion-card-a-right%3Ahomepage%2Fstory-ans
[10] https://www.cnbc.com/2019/12/27/the-10-most-dangerous-jobs-in-america-according-to-bls-data.html
[11] https://www.cnn.com/2020/07/23/us/nursing-home-worker-death-investigations-osha-invs/index.html
[12] https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.16689
[13] https://journals.sagepub.com/doi/full/10.1177/1527154420938707
[14] https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/07%2010%2020_COVID_SNF_Survey%20and%20Data%20Letter%20to%20CMS_FINAL.pdf
[15] https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory
[16] https://www.cms.gov/files/document/qso-20-34-nh.pdf
[17] https://www.medicare.gov/NursingHomeCompare/Data/Staffing.html

in LTC facilities.[18] [19] Furthermore, the COVID-19 reporting data dictionary does not appear to offer any additional guidance for how nursing homes can define whether or not they are facing a staffing shortage.[20] The misalignment of these two data sources as well as the lack of definitional clarity raise questions as to the reliability of the data writ large and, specifically, how policymakers, public health officials, and other stakeholders should be interpreting these varying sources of staffing data during this crisis.

Insufficient Nursing Home Resident COVID-19 Data

CMS's COVID-19 resident data have similar problems. As shown in Table 1 at the end of this letter, approximately three percent (about 3,900 data fields) of the data related to COVID-19 cases and deaths among facility residents were missing or incomplete. Missing data are slightly worse when reporting the number of total and occupied beds per facility, where over four percent (5,141 data fields) of the data were missing. Approximately 16 percent of the data were missing on the "three or more confirmed and suspected COVID-19 cases" metric and 66 percent of the data were missing for the "total COVID-19 deaths as percentage of confirmed COVID-19 cases among LTC facility residents" metric. Most alarmingly, *96 percent* of the data related to the supply of ventilators in facilities are blank within the datafile.

Improving COVID-19 Data in Nursing Homes

On July 22, 2020, the Department of Health and Human Services (HHS) announced an additional allocation of $4.9 billion from the Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund to Medicare-certified LTC facilities and state veterans' homes.[21] HHS has yet to announce the underlying methodology used to allocate these funds.[22] Given the lack of reliability of both staff and patient COVID-19 nursing home data CMS has publicly reported, I am deeply concerned that the decisions related to the allocation of these funds may be informed by incomprehensive and unreliable data. Given the urgent need for reliable long-term care data, I request that you respond to the following questions by August 21, 2020:

1. Please provide a detailed explanation for how CMS plans to crosswalk the nursing home data reported to the Nursing Home COVID-19 Public File data with the existing staffing data reported through Payroll-Based Journal (PBJ) system. How will the agency reconcile differences and which file will be used to inform decisions around resource allocation to SNFs in the future?

2. Given the lack of clarity in the data dictionary for COVID-19 reporting, what guidance has CMS provided nursing homes to determine whether a specific facility is facing Personal Protective Equipment (PPE) shortages.

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[18] https://data.cms.gov/Special-Programs-Initiatives-COVID-19-Nursing-Home/COVID-19-Nursing-Home-Dataset/s2uc-8wxp
[19] https://www.healthaffairs.org/do/10.1377/hblog20200723.64590/full/
[20] https://data.cms.gov/Special-Programs-Initiatives-COVID-19-Nursing-Home/COVID-19-Nursing-Home-Dataset/s2uc-8wxp
[21] https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html
[22] https://www.washingtonpost.com/business/2020/06/04/nursing-homes-coronavirus-deaths/

      a. Specifically, what guidance did CMS provide facilities so that they can determine whether a facility has a one-week supply of N95 masks, surgical masks, eye protection, gowns, gloves, and hand sanitizer?

      b. What guidance has CMS provided for facilities to determine whether a specific LTC facility is facing staffing shortages of nursing staff, clinical staff, aides, and other staff?

3. As noted in Table 1 at the end of this letter, 12.4 percent of the Nursing Home COVID-19 Public File data fields were missing. Please provide a detailed explanation for why these data were missing. Please also provide a detailed plan on the ways CMS is ensuring facilities are reporting COVID-19 information to the Center for Disease Control's (CDC) National Healthcare Safety Network (NHSN) and how CMS is holding facilities who fail to report this information in accordance with 42 CFR §483.80(g) accountable.

      a. Specifically, how is CMS ensuring that the information submitted to the CDC NHSN is complete and reliable? How is CMS tracking facilities that are not reporting this information and what enforcement steps are being taken to penalize those facilities?

      b. To what extent are there patterns in missing data? For example, do the same facilities fail to report the same data every week? Are there certain types of facilities that have higher rates of missing data fields? Please describe and provide analyses the agency has conducted to ascertain these missing data trends.

      c. Does HHS plan on using these data to inform decisions about allocations from the Provider Relief Fund? How will the Department account for aberrations in the data due to missing fields?

4. As a follow-up to my July 10, 2020, letter to you on increasing nursing home oversight through improved surveys, I am deeply concerned that the "streamlined tool" CMS required in its March 23rd guidance is inadequate to robustly survey facilities.[23] [24] Please provide details on how CMS plans to train surveyors on the new guidance as detailed in the May 6, 2020 memorandum QSO-20-29-NH and in accordance with 42 CFR §483.80(g).

      a. Some studies point to changes in surveyor guidance and new citation tagging methods being associated with a reduction in citations.[25] How has CMS ensured that surveyors are properly trained on the new citation tags *F884: COVID-19 Reporting to CDC* and *F885: COVID-19 Reporting to Residents, their Representatives, and Families* in accordance with 42 CFR §483.80(g)?

      b. Please provide the provider numbers of facilities cited for *F884: COVID-19 Reporting to CDC* and *F885: COVID-19 Reporting to Residents, their Representatives, and Families* citations. Please also provide information on the

[23] https://www.cms.gov/files/document/qso-20-31-all.pdf
[24] https://www.cms.gov/files/document/qso-20-20-all.pdf
[25]https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WMD%20Nursing%20Home%20Report_Final.pdf

citation severity level, grade level, and any associated Civil Monetary Penalties (CMPs).

Thank you for your attention to this important matter. If you have questions, please contact Rachel Dolin with the Ways and Means Committee Majority staff at Rachel.Dolin@mail.house.gov or 202-225-3625.

Sincerely,

Richard E. Neal
Chairman

Table 1. List of Missing Data in Nursing Home COVID-19 Public File (Accessed on July 24, 2020)

Data Field	Missing Entries (Total)	Missing Entries (Percent)
Submitted Data	0	0.0%
Passed Quality Assurance Check	3,444	2.8%
Residents Weekly Admissions COVID-19	3,919	3.2%
Residents Total Admissions COVID-19	3,919	3.2%
Residents Weekly Confirmed COVID-19	3,919	3.2%
Residents Total Confirmed COVID-19	3,919	3.2%
Residents Weekly Suspected COVID-19	3,919	3.2%
Residents Total Suspected COVID-19	3,919	3.2%
Residents Weekly All Deaths	3,919	3.2%
Residents Total All Deaths	3,919	3.2%
Residents Weekly COVID-19 Deaths	3,919	3.2%
Residents Total COVID-19 Deaths	3,919	3.2%
Number of All Beds	5,141	4.2%
Total Number of Occupied Beds	4,170	3.4%
Resident Access to Testing in Facility	5,060	4.1%
Laboratory Type Is State Health Dept	5,060	4.1%
Laboratory Type Is Private Lab	5,060	4.1%
Laboratory Type Is Other	5,060	4.1%
Staff Weekly Confirmed COVID-19	3,919	3.2%
Staff Total Confirmed COVID-19	3,919	3.2%
Staff Weekly Suspected COVID-19	3,919	3.2%
Staff Total Suspected COVID-19	3,919	3.2%
Staff Weekly COVID-19 Deaths	3,919	3.2%
Staff Total COVID-19 Deaths	3,919	3.2%
Shortage of Nursing Staff	5,511	4.5%
Shortage of Clinical Staff	5,513	4.5%
Shortage of Aides	5,510	4.5%
Shortage of Other Staff	5,515	4.5%
Any Current Supply of N95 Masks	5,515	4.5%
One-Week Supply of N95 Masks	5,510	4.5%
Any Current Supply of Surgical Masks	5,602	4.5%
One-Week Supply of Surgical Masks	5,601	4.5%
Any Current Supply of Eye Protection	5,601	4.5%
One-Week Supply of Eye Protection	5,601	4.5%
Any Current Supply of Gowns	5,601	4.5%
One-Week Supply of Gowns	5,602	4.5%
Any Current Supply of Gloves	5,603	4.5%
One-Week Supply of Gloves	5,601	4.5%
Any Current Supply of Hand Sanitizer	5,604	4.6%
One-Week Supply of Hand Sanitizer	5,608	4.6%

Ventilator Dependent Unit	7,588	6.2%
Number of Ventilators in Facility	118,742	96.4%
Number of Ventilators in Use for COVID-19	118,746	96.4%
Any Current Supply of Ventilator Supplies	118,742	96.4%
One-Week Supply of Ventilator Supplies	118,740	96.4%
Total Resident Confirmed COVID-19 Cases Per 1,000 Residents	4,521	3.7%
Total Resident COVID-19 Deaths Per 1,000 Residents	4,521	3.7%
Total Residents COVID-19 Deaths as a Percentage of Confirmed COVID-19 Cases	80,819	65.6%
County	0	0.0%
Three or More Confirmed and Suspected COVID-19 Cases This Week	19,332	15.7%
Initial Confirmed COVID-19 Case This Week	19,333	15.7%
Total	795,881	12.4%