FRANK PALLONE, JR., NEW JERSEY
CHAIRMAN

GREG WALDEN, OREGON
RANKING MEMBER

ONE HUNDRED SIXTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

August 19, 2020

The Honorable Gene Dodaro
Comptroller General of the United States
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dodaro:

As our nation continues to face the coronavirus disease of 2019 (COVID-19) pandemic, it is crucial that we rely on science, public health expertise, and quality data to inform the nation's actions. Unfortunately, the Trump Administration continues to undermine COVID-19 response efforts by sidelining scientific and public health experts and threatening the quality of COVID-19-related data. The U.S. Department of Health and Human Services's (HHS) introduction of new and potentially duplicative hospital capacity reporting requirements is yet another example of this concerning trend. Not only have HHS's actions seemingly sidelined the nation's top public health officials, but they have also reportedly led to unnecessary confusion, additional burden on critical COVID-19 response professionals, and the loss of timely and reliable data, all in the midst of the pandemic when people's lives are at stake. We are concerned that these reporting changes undermine the nation's COVID-19 response efforts, and therefore request that the Government Accountability Office (GAO) review the process and impacts of these changes.

Throughout the response to the pandemic, the Trump Administration's guidance and hospital capacity reporting requirements and systems for key COVID-19 metrics have frequently shifted, requiring hospitals, and in some cases states, to collect and submit new information through different platforms with little to no advanced notice. On March 29, Vice President Pence requested hospitals report daily through the Centers for Disease Control and Prevention's (CDC) new National Healthcare Safety Network (NHSN) COVID-19 hospital module.[1] The following week, HHS Secretary Azar sent a letter to hospital administrators introducing a new third-party reporting mechanism through TeleTracking Technologies, Inc. (TeleTracking), which

---

[1] Letter from the Honorable Michael R. Pence, Vice President of the United States, to Hospital Administrators (Mar. 29, 2020).

had been awarded a $10 million, six-month contract on April 6.[2] In addition to introducing these new mechanisms, HHS also continued to issue new reporting requests—including an abrupt reversal of new requirements—tying hospital eligibility for access to certain COVID-19 treatments in the subsequent weeks and months to data submission.[3]

On July 10, HHS released new guidance removing CDC's NHSN from the reporting process and requiring hospitals to instead submit data daily either through the TeleTracking platform or state health agencies authorized by HHS.[4] In testimony before Congress on July 31, 2020, CDC Director Redfield stated that CDC was not involved in this decision and that he was informed of the change only after it was made.[5] We are concerned these repeated changes to reporting efforts represent yet another attempt by the Trump Administration to sideline CDC during the national public health emergency.

These reporting changes raise a number of further concerns. When HHS issued its July 10 guidance removing NHSN as a reporting option, HHS noted that 85 percent of hospitals had been submitting COVID-19 data through NHSN,[6] and therefore the vast majority of hospitals had to change reporting platforms. In addition, the guidance required that entities report additional detailed data variables that were not previously requested.[7] After this guidance was issued, several state health officials raised concerns about the "additional burden placed on

---

[2] Letter from the Honorable Alex M. Azar, Secretary, Department of Health and Human Services, to Hospital Administrators (Apr. 9, 2020); *'Sole Source' Contract for Covid-19 Database Draws Scrutiny from Democrats*, New York Times (July 15, 2020).

[3] *See* American Hospital Association, *HHS Requests Weekly Data from Hospitals to Inform Remdesivir Distribution* (May 11, 2020) (special bulletin); American Hospital Association, *Next Deadline for HHS-requested Data to Inform Remdesivir Distribution is Monday, May 18* (May 15, 2020) (special bulletin); American Hospital Association, *HHS Cancels its Data Collection Deadline Scheduled for Today, May 18, to Inform Remdesivir Distribution* (May 18, 2020) (special bulletin).

[4] Department of Health and Human Services, *COVID-19 Guidance for Hospital Reporting and FAQs for Hospitals, Hospital Laboratory, and Acute Care Facility Data Reporting* (July 10, 2020).

[5] House Select Committee on the Coronavirus Crisis, Testimony of Robert R. Redfield, Director, Centers for Disease Control and Prevention, *Hearing on The Urgent Need for a National Plan to Contain the Coronavirus*, 116th Cong. (July 31, 2020).

[6] *Trump administration shifts control of coronavirus hospital data from CDC to HHS*, CNBC (July 15, 2020).

[7] Department of Health and Human Services, *COVID-19 Guidance for Hospital Reporting and FAQs for Hospitals, Hospital Laboratory, and Acute Care Facility Data Reporting* (July 10, 2020).

hospitals" and that the short turnaround to comply "'could very easily impede patient care and patient flow.'"[8]

In briefings with Committee staff, experts have also suggested that the new data reporting process may erode the quality of data, in part because the system is overly cumbersome and was developed without input from end users, including public health experts. It also remains unknown if or how data are being validated, with reports indicating that "there is a data consistency and quality problem."[9] Past and current members of the Healthcare Infection Control Practices Advisory Committee recently echoed these concerns, warning that retiring NHSN—a system that ensures national standardization and data integrity—"will have serious consequences on data integrity."[10]

Additionally, stakeholders have suggested that the new federal process may come at the expense of state and local planning efforts. Reports indicate that access to key indicators has been delayed by the transition.[11] Further, states no longer receive CDC analyses of the data, nor have consistent access to data submitted to the federal government, both of which they previously relied on to inform their pandemic response planning.[12] While HHS has stated CDC will have access to the data that is made available in HHS Protect, in bypassing CDC, the new reporting processes raise transparency concerns around how the data may be reviewed and its vulnerability to manipulation to hide the severity of the pandemic.[13]

In light of these concerns, to the extent relevant information and data are available in a timely manner, we request that GAO review the following:

1. What benefits or challenges did changes to the COVID-19 hospital capacity reporting guidance and systems have on the nation's COVID-19 pandemic response including the health care system, public health stakeholders, patient care, and access to treatment? In particular, please address:

---

[8] *Hospital officials, experts say new federal rules for covid-19 reporting will add burdens during pandemic*, Washington Post (July 15, 2020).

[9] *Covid-19 Data Reporting System Gets Off to Rocky Start*, Wall Street Journal (Aug. 11, 2020).

[10] Statement from Past and Present CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) Members, *Diverting COVID-19 Information from the CDC to DHHS: Another Strike Against Science* (July 31, 2020).

[11] *Id.*

[12] *Hospital officials, experts say new federal rules for covid-19 reporting will add burdens during pandemic*, Washington Post (July 15, 2020); The COVID Tracking Project *Erratic Hospital Numbers, Deaths Still Rising: This Week in COVID-19 Data, July 23*, (July 23, 2020) (weekly update blog).

[13] *How HHS's new hospital data reporting system will actually affect the U.S. COVID-19 response*, Stat News (July 16, 2020).

a. What effect, if any, did reporting changes have on the ability of federal, state, and local health departments as well as hospital systems to access data and conduct planning and analysis?

b. What, if any, burdens did the reporting changes place on hospital staff and networks, including but not limited to smaller, rural, and tribal hospital systems?

c. What, if any, communication or assistance was provided to hospital staff during the transition to the new reporting system and what ongoing support, if any, remains?

d. How, if at all, was ongoing work of public health epidemiologists and researchers impacted by the guidance and system changes?

e. How, if at all, did reporting changes affect patient and community care and treatment?

f. How, if at all, did the reporting changes impact the distribution of authorized drug products for COVID-19 and medical supplies, including personal protective equipment and ventilators?

g. How, if at all, has HHS addressed any of these challenges or adapted based on these impacts?

2. How has the Administration monitored, tracked, and aggregated data collected and compiled through various mechanisms including NHSN, TeleTracking, state-based reporting, and the HHS Protect platform, and further ensured quality control, utility, and transparency of data collected from hospitals and others on COVID-19 cases and hospital resources? Please incorporate the following questions into the review:

   a. For which federal programs or activities are these data being used? For example, how are these data being used to determine federal funding or medical supply allocations for hospitals, state, and local jurisdictions?

   b. How, and to what extent, are these data shared, if at all, among various federal agencies and with state and local public health authorities?

   c. What plans, if any, does HHS have to make the data available to the public and researchers and in what formats or platforms?

   d. How, and to what extent, is HHS overseeing these data collection mechanisms and the HHS Protect platform to ensure data quality? For example, what analyses, if any, is being conducted to determine the uniformity, completeness, and accuracy of the data being collected through TeleTracking and states, and are these analyses being conducted internally or externally?

e. What is known about any differences in data quality between the hospital data collected by NHSN prior to July 10, 2020, the data collected through the TeleTracking system, and the data within HHS Protect thereafter, including any analyses to determine the uniformity, completeness, and accuracy of such data?

3. What was the timeline and process for the decisions that led to removing NHSN as a reporting option and limiting future reporting options to TeleTracking and authorized state-based reporting in July 2020? As part of this review, please address:

    a. How have reporting mechanisms and any reporting instructions or guidance evolved over time since Vice President Pence requested data from hospitals on March 29, 2020?

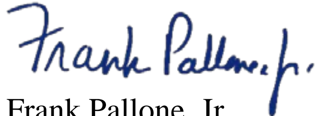
    b. Who was consulted, both internally within the Administration and externally, for input into changes to the reporting mechanisms and guidance and what were their recommendations? In particular, who was involved in the TeleTracking award decision?

    c. What Paperwork Reduction Act approval was sought and granted by the Office of Management and Budget for the new NHSN COVID-19 module, TeleTracking, or the state-based reporting mechanism, as applicable? Please explore if any exemptions or irregularity in the approval process occurred. If so, who was involved in the process or determination?

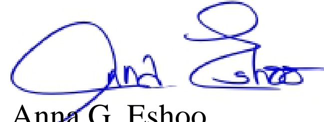
    d. What analyses, if any, were done to justify transitioning reporting from NHSN to TeleTracking and authorized state-based reporting? Further, what assessment, if any, was done to analyze the financial and resource impact of such transition on hospitals systems and state and local health departments?

Thank you for the timely attention to this request. Understanding that this evaluation may need to be completed in a series of briefings and reports, we request that GAO provide a projected timeline as soon as possible of what questions are likely to be addressed within 90, 180, and 365 days. For any questions regarding this request, please contact Jesseca Boyer, Manmeet Dhindsa, Kimberly Espinosa, and Jon Monger of the Majority Staff at (202) 225-2927.

Sincerely,



Frank Pallone, Jr.
Chairman



Anna G. Eshoo
Chairwoman
Subcommittee on Health

Diana DeGette
Chair
Subcommittee on Oversight
and Investigations