October 29, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
Washington, DC 20201

Dear Secretary Azar:

On behalf of the 121,000 members and affiliates of the American Psychological Association (APA), I write to ask you to stop recent actions taken by the U.S. Department of Health and Human Services (HHS) that appear to bypass the Centers for Disease Control and Prevention (CDC) in the COVID-19 patient data reporting procedures that hospitals must follow. The United States leads the world, with 8.7 million confirmed COVID-19 cases and more than 225,000 lives lost. Accurate and complete data made promptly available to the public is essential to the success of our national response to the COVID-19 pandemic. Yet compliance with regulations concerning reporting of data on race/ethnicity for U.S. COVID-19 cases remains inadequate, with 50 percent of reported cases missing racial and ethnic demographic information as of September 16, 2020.

**Proposed COVID-19 Data Collection Policy Changes**

Public Law 116-136, § 18115(a), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, requires “every laboratory that performs or analyzes a test that is intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19” to report the results from each such test to the HHS Secretary. Further, guidance issued by the Department required “all data be reported through existing public health data reporting methods.” However, the Department did follow its own guidance by requiring hospitals to report COVID-19 admissions data to a federal contractor instead of to the CDC as required under protocols in place at the time.

CDC’s National Healthcare Safety Network (NHSN), the most widely used healthcare-associated infection tracking system, supports the nation’s coronavirus response with COVID-19 reporting protocols in healthcare facilities. Many federal stakeholders, including CDC, the Centers for Medicare and Medicaid Services (CMS), the Federal Emergency Management Agency (FEMA), the Office of the Assistant Secretary for Preparedness and Response and the White House Coronavirus Task Force, use this data for their COVID-19 public health emergency response activities. Until July 15, 2020, hospitals were reporting COVID-19 admissions to the NHSN when suddenly the Administration announced in July a significant change in policy to bypass the CDC as the first recipient of data on patients hospitalized with COVID-19 beginning in July. HHS instructed hospitals to instead report patient admissions data directly to an HHS contractor, or to their state or local health official, who would, in turn, submit the data to the contractor. In August 2020, HHS indicated the new hospital reporting requirements were only interim until CDC’s infrastructure could be strengthened. CMS,
however, released guidance on October 6, 2020, that laid out enforcement provisions to penalize hospitals for non-compliance by cutting off their Medicare and Medicaid reimbursements.\textsuperscript{vii}

More rapid data collection and dissemination are important national goals. However, placing coronavirus surveillance and medical data collection outside of the CDC puts the quality and integrity of the data at risk, thereby threatening to seriously undermine our country’s response to COVID-19. Despite assurances that the CDC and public would continue to have access to the data, APA joined 350 national public health organizations in calling on the Administration to reverse the decision to bypass CDC data collection.\textsuperscript{viii} In addition, 22 state attorneys general asked you to “…withdraw [the] directive that hospitals stop reporting COVID-19 data to the CDC and to restore the CDC to its rightful role as the primary repository for information about the nation’s public health data.”\textsuperscript{ix} Further, by increasing oversight by an agency led by political appointees, the new policy opens the door to inappropriate politicization of data collection efforts during a national public health emergency.

Recommendations
The CARES Act provided $500 million to CDC for modernization of its surveillance and analytics infrastructure\textsuperscript{x}. Any shortcomings in the agency’s COVID-19 data collection should be addressed with these resources, along with sustained investments in CDC’s world class public health surveillance leaders and protocols. Now is not the time to change established and functional processes that laboratories and health systems understand, but rather the time to focus on enhancing federal cooperation with state, local and tribal partners. Our recommendations for immediate action are as follows:

1. **Protect Covid-19 Data Integrity.** We urge the Administration to stop any plans to transfer COVID-19 surveillance, data collection and dissemination from the CDC to Teletracking or any other third-party contractor. Further, HHS should ensure prompt, unrestricted access to any data housed at HHS by the CDC, media hospitals, academic institutions, professional associations and the public.

2. **Sustain Enhanced Investment in Public Health Surveillance.** APA calls upon the Administration to affirm support for CDC’s existing surveillance and disease reporting platforms; invest more in building capacity of state, local and tribal jurisdictions; and rely on data and science to drive decision-making Further, CDC should continue to strengthen coordination with state and local public health authorities to collect, disaggregate and report on data related to COVID-19, specifically as it relates to the hardest-hit populations, to address this current pandemic and eliminate disparities more effectively. This includes authorizing grants to state, local and territorial health departments to support the modernization of data collection methods and infrastructure and disseminating that data to all relevant stakeholders.

3. **Ensure Transparency.** The consequences of this pandemic for American families and communities, as well as its devastating impact on the economy, demand transparency in federal efforts to track and monitor COVID-19 in the U.S. HHS and CDC can enhance transparency by issuing congressionally required reports by the statutory deadlines and articulating new resource needs when found. Meaningful engagement of external stakeholders and members of vulnerable populations must be a priority of both agencies. We urge you to consult with these groups on effective strategies for ensuring the availability of data that all agree is crucially needed to bring the pandemic under control in the nation.
4. **Improve Planning and Cross-Agency Collaboration.** Cross-agency data-sharing, analysis and reporting are essential public health functions that are currently falling short around COVID-19. Information will guide the actions federal agencies can implement to address social determinants of health leading to poorer health outcomes among certain populations. To promote synergies within HHS and with other federal agencies. APA recommends the following steps: 1) integrate more behavioral analysis into national response efforts, including consideration of findings from the Behavioral Risk Factor Surveillance Survey, the Youth Risk Behavior Survey and other population-based survey findings, and 2) foster collaboration with health equity offices across HHS, along with federal agencies responsible for safety net programs, to mitigate underlying social determinants of health responsible for COVID-19 health inequities and improve population health.

In conclusion, recent HHS policy changes jeopardize robust data collection that healthcare providers, researchers and policymakers rely on to understand and best address the factors leading to the disproportionate impact of diseases, such as COVID-19, on different populations. We urge the Administration to return to core public health strategies that have improved state and local data reporting in recent months.

Thank you for considering APA’s views. If you have any questions, you can contact my office or Katherine McGuire, Chief Advocacy Officer, at KBMcguire@apa.org.

Sincerely,

Arthur C. Evans, Jr., PhD
Chief Executive Officer

c: Brett P. Giroir, M.D.
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