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116TH CONGRESS
2D SESSION

H. R. 8073

To require the Director of the Centers for Disease Control and Prevention to create a standardized method for State, Tribal, and local health departments to report to the Centers with respect to COVID–19, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 21, 2020

Mr. BEYER (for himself, Ms. SEWELL of Alabama, Mr. CONNOLLY, Mr. VARGAS, Ms. PORTER, Mr. TAKANO, Mr. SABLAN, Ms. SHERRILL, Mr. PASCRELL, Mr. DEUTCH, and Ms. GABBARD) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To require the Director of the Centers for Disease Control and Prevention to create a standardized method for State, Tribal, and local health departments to report to the Centers with respect to COVID–19, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving COVID–19 Data Transparency Act''.

SEC. 2. STANDARDIZED METHOD FOR HEALTH DEPARTMENT REPORTING .

(a) IN GENERAL.—Not later than 30 days after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention shall create a standardized method for State, Tribal, and local health departments to report to the Centers with respect to COVID–19 the following:

(1) New confirmed and probable cases in the respective jurisdiction, including—

(A) per capita rates by date;

(B) the 7-day moving average;

(C) disaggregation of the new cases, if known, by whether the cases are part of an identifiable outbreak versus community spread; and

(D) the percentage of new cases epidemiologically linked to at least one other case.

(2) Daily hospitalizations of patients in the respective jurisdiction with a confirmed or presumed case of COVID–19, including—

(A) per capita rates by date; and

(B) the 7-day moving average.

(3) The percentage of hospital beds occupied by such patients.

(4) Daily numbers of such patients in the intensive care unit.

(5) Daily numbers of such patients on ventilators.

(6) How long such patients have been in the hospital.

(7) Trends in emergency departments of patients with COVID-like illness and influenza-like illness.

(8) Daily numbers of diagnostic and serological tests administered for SARS–CoV–2 with respect to patients in the respective jurisdiction, disaggregated by—

(A) the type of test;

(B) the testing positivity rate of each type of test, including a 7-day moving average; and

(C) testing per capita rates by date for each type of test, including a 7-day moving average.

(9) The sensitivity and specificity of each such type of test.

(10) Daily numbers and percentages of contacts traced with respect to patients in the respective jurisdiction and the percentages of such contacts who know each other.

(11) The rate of transmission of SARS–CoV–2 in the respective jurisdiction.

(12) Daily numbers of deaths of individuals with a confirmed or probable case of COVID–19 and per capita rates of such deaths, with a 7-day moving average.

(13) Daily averages, and 7-day moving averages, of turnaround time for diagnostic tests for COVID–19—

(A) from the time of specimen collection to reporting; and

(B) from the time of specimen collection to isolation of confirmed cases.

(14) Institutions in the respective jurisdiction with major outbreaks of COVID–19, including any such nursing homes, prisons, schools, and meatpacking plants.

(15) A list of—

(A) long-term care and other congregate facilities (including homeless shelters and correctional facilities) and essential workplaces (including meatpacking plants) with outbreaks of COVID–19 cases; and

(B) the numbers of deaths of residents (as applicable) and staff of such facilities and workplaces.

(16) A weekly percentage of residents in the respective jurisdiction wearing masks correctly in public indoor settings, based on direct observation or security camera analysis, by a standard, consistent method.

(17) The weekly percentage of new confirmed and probable cases among quarantined contacts.

(18) Daily numbers of new confirmed and probable cases of COVID–19 among health care workers that are not confirmed to have been contracted outside of the workplace.

(b) DISAGGREGATION REQUIRED.—The Director of the Centers for Disease Control and Prevention shall ensure that the standardized method of reporting under subsection (a) requires the disaggregation of data by gender, age, cohort, race, and ethnicity.

(c) POSTING BY CDC.—The Director of the Centers for Disease Control and Prevention shall—

(1) post the information described in paragraphs (1) through (19) of subsection (a), to the extent such information is in the possession of the Centers, on the public website of the Centers, except

that such posting shall exclude any individually identifiable information; and

(2) to the extent feasible disaggregate such information by State, Tribal, and local jurisdiction.

(d) UPDATES.—The Director of the Centers for Disease Control and Prevention—

(1) shall, as appropriate, periodically update the method posted under subsection (a); and

(2) may revise and expand the reporting categories listed in such subsection.

(e) STATE.—In this section, the term ''State'' includes the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, and American Samoa.

SEC. 3. TELEVISED REPORTING OF MORBIDITY AND MORTALITY WEEKLY REPORT.

Each week, the Director of the Centers for Disease Control and Prevention shall—

(1) deliver a televised presentation of its Morbidity and Mortality Weekly Report;

(2) make the presentation open to the media; and

(3) assign a career civil servant to deliver the presentation.

SEC. 4. MODELING TRANSPARENCY.

(a) ENSURING REPRODUCIBILITY.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall ensure that any COVID–19 modeling that is conducted or supported by the Centers is fully reproducible by sharing, to the extent permissible and appropriate, the information needed to reproduce such modeling, including any modeling code.

(b) REPORT.—The Secretary of Health and Human Services shall enter into an arrangement with the National Academies of Sciences, Engineering, and Medicine to prepare, not later than 6 months after the date of enactment of this Act, and publish a report on—

(1) the sources of data and information relied on by entities for COVID–19 modeling;

(2) the reasons why the Institute for Health Metrics, Johns Hopkins University, The COVID Tracking Project, and 1Point3Acres decided to start COVID–19 modeling;

(3) the coordination and financial support that has been provided by the Federal Government for COVID–19 modeling to entites conducting COVID–19 modeling that have been widely relied upon; and

(4) what can be done to ensure the continuation and availability of reliable COVID–19 modeling.

SEC. 5. IMPROVED CASE REPORTING.

Section 3001(c)(5) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(5)) is amended—

(1) by redesignating subparagraph (E) as subparagraph (F);

(2) in subparagraph (F), as redesignated, after ''subparagraph (D)'' by inserting ''or (E)''; and

(3) after executing the redesignation made by paragraph (1), by inserting after subparagraph (D) the following:

''(E) ADDITIONAL CONDITIONS OF CERTIFICATION.—Not later than 1 year after the date of enactment of the COVID–19 Data Transparency Act, the Secretary, through notice and comment rulemaking, shall require, as a condition of certification and maintenance of certification for programs maintained or recognized under this paragraph, consistent with other conditions and requirements under this title, that the health information technology developer or entity provides assurances satisfactory to the Secretary that the health information technology is designed to effectuate the automated generation and transmission of reports of possible reportable conditions from

electronic health records to public health agencies for review and action.''.

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