September 27, 2022

VIA EMAIL

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Re: *CDC COVID-19 Community Level Data Calculations*

Dear Director Bialek and Deputy Director Clark:

On behalf of our client, Informed Consent Action Network ("**ICAN**"), we write to address the Center for Disease Control and Prevention's ("**CDC**") COVID-19 Community Level indicators[1] and request that the definition of "New COVID-19 admissions" and "COVID-19 patients" be revised to account only for those cases hospitalized *for* COVID-19, rather than those incidental to admission for alternate reasons (or, hospitalized *with* COVID-19). The current CDC indicators vastly inflate the present risk to communities because they include all patients with positive COVID-19 cases, regardless of whether the hospitalization relates to or is caused by COVID-19. These metrics have resulted in, and will continue to result in, misinformed policy decisions at the state and local level; these policy decisions greatly affect individuals' everyday lives. We urge the CDC to reconsider and modify the present indicators to better reflect the actual risk posed to communities across the country.

A. CDC COVID-19 Community Level Indicators

In calculating the COVID-19 Community Level for a particular Health Service Area ("**HSA**"), there are three key datapoints: (1) the number of new cases in the county in the past 7 days divided by the population in the county (or other administrative level) multiplied by 100,000; (2) the total number of new admissions of patients with confirmed COVID-19 in the past 7 days divided by the total population in the HSA, multiplied by 100,000; and (3) the percentage of staffed

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[1]   *See*   https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=CommunityLevels&null=CommunityLevels.

inpatient beds in use by patients with confirmed COVID-19 within the entire HAS (7-day average).[2] The COVID-19 Community Level is determined by first establishing whether the number of new cases per 100,000 people is less than or greater than 200.[3] Next, the CDC takes the higher of the two indicators as depicted in the chart below. For example, if an HSA returns a rate of 199 "New Cases" and a rate of 9.0 "New COVID-19 admissions per 100,000" and a 11.0 "Percent of staffed inpatient beds in use by COVID-19 patients," the HSA would be classified as a Medium COVID-19 Community Level, as depicted in the chart below.[4]

New Cases[1] (per 100,000 population in the last 7 days)	Indicator	Low	Medium	High
<200 cases	New COVID-19 admissions per 100,000 population (7-day total)[2]	<10.0	10.0-19.9	≥20.0
	Percent of staffed inpatient beds in use by COVID-19 patients (7-day average)[3]	<10.0%	10.0-14.9%	≥15.0%
≥200 cases	New COVID-19 admissions per 100,000 population (7-day total)	NA	<10.0	≥10.0
	Percent of staffed inpatient beds in use by COVID-19 patients (7-day average)	NA	<10.0%	≥10.0%

B. "With COVID-19" Versus "For COVID-19"

At issue in this calculation is the way in which the CDC has chosen to define what constitutes a "New COVID-19 Admission" and "COVID-19 patients."[5] Rather than calculate the number of individuals hospitalized *because of COVID-19*, the calculation includes *all COVID-19 positive patients* regardless of what prompted their visit to the hospital. There is a clear distinction between these two types of patients. The failure to distinguish between them greatly biases the hospitalization data (skews it higher) reported to the CDC and, as a result, provides an inaccurate depiction of the overall contagion risk. Patients brought to the hospital as a result of severe COVID-19 infection should be calculated as a factor in the overall risk to the community and the impact on the hospital system; however, a person taken to the hospital for a car accident that incidentally tests positive upon arrival for COVID-19 erroneously skews the data.

Several states have already acknowledged the problem in conflating these two types of cases. For example, in January 2022, NYU Langone Health reported about 65% of its COVID-19

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[2] COVID Data Tracker, Centers for Disease Control and Prevention (Sep. 15, 2022), https://covid.cdc.gov/covid-data-tracker [https://perma.cc/7TSM-86GB].

[3] *Id.*

[4] *Id.*

[5] *Id.*

patients had incidental infections, meaning only about 35% of the patients listed as being hospitalized with COVID-19 were hospitalized *because of* their infection.[6] This prompted New York Governor Kathy Hochul to require hospitals in New York, when reporting hospitalizations, to begin distinguishing between patients admitted for COVID-19 as their primary condition from those who are hospitalized for other reasons and had incidental COVID-19.[7] In addition to New York, New Hampshire, Massachusetts, and Maine have likewise chosen to modify their reporting of COVID-19 cases by either excluding incidental COVID-19 cases entirely, or separating them into distinct categories.[8]

Furthermore, the CDC indicators do not account for the severity of reported COVID-19 infections, which is an important metric when accessing actual risk to the community. Given the reduced severity of the Omicron variant,[9] the exclusion of severity data further biases the perception of COVID-19 risk. Despite failing to include case severity in its Community Level analysis, the CDC currently recommends that data on disease severity and healthcare system strain be used in addition to community transmission rates:

> Despite high volume of hospitalizations due to high caseloads, **the emergence of Omicron as the dominant variant reflected lower virulence and disease severity.** These changes make it more feasible to minimize medically significant disease and prevent excessive strain on the healthcare sector, even in the occurrence of SARS-CoV-2 transmission. [] Accordingly, at this stage of the pandemic, **data on disease severity and healthcare system strain to complement case rates are more informative for public health recommendations** for individual, organizational, and jurisdictional decisions than data on community transmission rates alone.[10]

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[6] *In Omicron Hot Spots, Hospitals Fill Up, but I.C.U.s May Not,* New York Times (Jan. 4, 2022), https://www. nytimes.com/2022/01/04/health/covid-omicron-hospitalizations.html.

[7] *Governor asks New York hospitals for greater detail in COVID-19 inpatient reports*, Beckers Hospital Review (Jan. 4, 2022), https://www.beckershospitalreview.com/public-health/governor-asks-new-york-hospitals-for-greater-detail-in-covid-19-inpatient-reports.html.

[8] *See, e.g.*, *State and hospitals don't see eye to eye on counting COVID hospitalizations,* New Hampshire Bulletin (Mar. 31, 2022)*,* https://newhampshirebulletin.com/2022/03/31/state-and-hospitals-dont-see-eye-to-eye-on-counting-covid-hospitalizations/ (redefining "COVID-19 hospitalization to include only patients being treated with remdesivir or dexamethasone, drugs used for hospitalized patients with moderate to severe illness. Those hospitalized with milder symptoms or primarily for another cause are no longer included – even if they continue to take up a hospital bed because they are too ill to be discharged."); *Changes to Mass. COVID-19 Hospitalization Reporting Taking Effect*, NBC Boston (updated Jan. 10, 2022), https://www.nbcboston.com/news/local/changes-to-mass-covid-19-hospitalization-reporting-takes-effect/2609127/ ("Starting Monday, Massachusetts hospitals will differentiate between patients they admit primarily for COVID-19 and those admitted to be treated for something else who end up testing positive."); *COVID-19: Maine Data;* Maine Center for Disease Control and Prevention (Sep. 19, 2022)*,* https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus/data.shtml.

[9] *Variants of the Virus*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/variants/index.html.

[10] *Science Brief: Indicators for Monitoring COVID-19 Community Levels and Making Public Health Recommendations*, CDC, https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/indicators-monitoring-community-levels.html#anchor_1646354066920.

Despite this acknowledgment, the CDC has not revised its Community Level indicators to accurately reflect the risk to the community, ultimately leading to the implementation of misinformed public health policy at the state and local level.

C. Overinflated Community Levels Lead to Misinformed State and Local Policy

Public health and other governmental authorities across the country continue to rely upon the CDC's Community Level numbers in making COVID-19 safety policies. This includes school districts, like the School District of Philadelphia ("**SDP**"), whose General COVID-19 Protocol for the 2022-2023 School Year relies directly on the COVID-19 Community Level indicators in imposing mask requirements on children.[11] There, SDP requires masking if the CDC Community Level reaches high, and strongly recommends masking if the level reaches medium. [12] Consequently, including the number of incidental COVID-19 hospitalizations in the Community Level indicators will result in school districts, like Philadelphia's, imposing unnecessary mask requirements on children due to the misperceived risk of contagion.

As the country moves forward from the COVID-19 pandemic, maintaining adequate benchmarks for local officials to base their public health decisions is critical. Restrictions should be no more onerous than necessary and based on the true risk of contagion to a particular community. For all of the aforesaid reasons, we respectfully urge the CDC to revise its indicators in determining COVID-19 Community Levels to only include those hospitalizations *because of* COVID-19, rather than those positive cases incidental to the patient's hospitalization. We look forward to your prompt response.

Sincerely Yours,

ABrehm

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[11] General COVID-19 Protocol for the 2022-2023 School Year, School District of Philadelphia, https://www.philasd.org/studenthealth/covid19protocols/.

[12] *Id.*