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June 8, 2020

The Honorable Maura Healey, Attorney General
1 Ashburton Place
20th Floor
Boston, MA 02108

Dear Attorney General Healey,

We write today to both acknowledge the improvements made to the Crisis Standards of Care Planning Guidance for the COVID-19 Pandemic and identify the remaining discriminatory policies that harm older adults and violate federal civil rights laws. On April 14th, we copied you on our letter to Governor Baker where we shared our concerns related to age-based bias in the original Crisis Care Standards. Another letter addressing our concerns about the discriminatory policies in the revised version was delivered via email to Secretary Sudders on June 5, 2020. The revisions issued on April 20, 2020 continue to use age as a determinative factor in whether to provide scarce resources such as ventilators. Under federal nondiscrimination laws, Massachusetts is obligated to enact policies that do not discriminate on the basis of age or disability.

The revised standards violate the antidiscrimination provisions of the Age Discrimination Act of 1975 ("the Age Act"), and Section 1557 of the Affordable Care Act. By emphasizing an allocation framework that maximizes the number of life-years saved, the policy discriminates against older adults in the prioritization of the provision of life-saving treatment. The use of certain factors correlated with age, such as estimates of number of years remaining and prognosis for long-term survival, discriminate against older adults for receiving life-saving treatment when supply is limited. Bias against older adults in the provision of health care violates federal law. We request immediate amendment of the policy in favor of an unbiased process that relies solely on the individual's likelihood of recovering from coronavirus.

Ageism in Prioritizing "Saving Life Years"

The revised standards allow clinicians to make individualized patient assessments when allocating scare resources. However, the allocation framework is expressly based on "1) saving lives; and 2) saving life-years." (pg. 10). A policy which maximizes life years saved consistently discriminates against older adults.[1] Factors correlated with age, like long term survival and number of anticipated years remaining, violate federal civil right law by limiting the ability of older adults to access life-saving treatment. To comply with federal law, we request that the standard be modified to eliminate "saving life years" as a principle in the allocation framework and solely focus on saving lives and immediate or near-term survivability. Further, the policy should expressly include age along with other factors, like race and ethnicity, that cannot be considered in resource allocation.[2]

Five Year Survivability is Unreliable and Biased

Patients with underlying conditions are subject to priority scoring using the Sequential Organ Failure Assessment (SOFA) score. Persons with comorbidities will get a less favorable score if they have underlying conditions that "significantly limit near term prognosis" defined as death likely within five years. (pg. 16). The use of near-term prognosis in a patient's SOFA score greatly improves on the language in prior standards which accounted for the patient's long-term survival. However, a five-year survivability standard introduces bias against older adults and people with disabilities. The use of such a standard is particularly concerning since many providers have difficulty accurately determining a patient's prognosis for an extended period.[3] Using five-years as a benchmark for survivability can exacerbate inherent biases about a person's life expectancy and will have disproportionate impact on older adults of color, who are more likely to experience severe comorbidities due to systemic health inequities. Thus, arbitrarily assigning a five-year survivability standard in the administration of life-saving treatment will lead to the discriminatory allocation of medical resources. We recommend the framework adopt a shorter time frame for determining prognosis, based on objective medical criteria that is widely accepted in medical practice, like hospice criteria of six-month survivability.

Life Cycle Consideration and Categorical Age Cut-Offs

The revised standards expressly discriminate against older adults by prioritizing younger adults in situations where "tie-breakers" are needed, should multiple patients receive the same priority score, incorporating "life-cycle considerations". (pg. 21). The life-cycle consideration is

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[1] Joint letter from Justice in Aging and partner organizations to MA, April 14, 2020.

[2] *See* Annals of Internal Medicine (discussing physician's duty not to discriminate against a category of patients including discrimination based on age and disability); *see also* AGS Position Statement on Allocating Scarce Resources in the COVID-19 Era (explaining use of "life-years saved" and "long-term predicted life expectancy" shows bias against older adults).

[3] *See* pgs. 2-3 Inequity in Crisis Standards of Care (explaining use of SOFA scores may not accurately predict short-term survivability particularly for people of color with comorbidities); *see also* Clinical Accuracy When Estimating Survival Duration (identifying greater inaccuracy in predicting survivability beyond three months)

based on the assumption that the preventable death of an older individual is less tragic, more desirable, and always cuts against older adults. The guidelines cite to the U.S. Department of Health and Human Services' plan to prioritize pediatric patients over adults when allocating vaccines and antivirals during an influenza pandemic. However, that same article also notes the life cycle principle unjustly discriminates against older adults.[4] A recent opinion in the Annals of Internal Medicine eloquently framed the issue: "Sometimes called a "life-cycle" or "fair innings" approach, it is far from fair, systematically disfavoring older patients, disabled persons, and potentially other groups. Fair approaches evaluate medical need, prognosis, and the effectiveness of treatment for the individual. In a pandemic, the critical question is the ability to survive the acute event, not long-term survival."[5]

Massachusetts' revised standards violate federal anti-discrimination requirements

Federal civil rights laws prohibit the use of categorical age cutoffs in policies and practices of healthcare providers.

The Affordable Care Act's anti-discrimination provision, also referred to as Section 1557, prohibits discrimination based on age, disability, sex, race, color, national origin by incorporating protections from several key civil rights statutes, including the Age Act. 42 U.S.C. § 6102; 42 U.S.C. § 6102. The Age Act establishes that "no person ... shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance." 42 U.S.C. § 6102. The purpose of the Age Act is to prohibit age discrimination in "programs or activities receiving federal financial assistance." Section 1557's incorporation of the Age Act expands those protections to all health programs and activities who receive federal financial assistance. 45 C.F.R. § 92.4.

The revised standard's bias against older adults and the use of categorical age cutoffs are contrary to Section 1557, the Age Act, and OCR guidance. These age-based considerations are impermissibly biased against older adults on their face because they are anticipated to have fewer years of life remaining. The use of categorical age cut-offs is not only ageist and discriminatory, but also highlights the arbitrary nature of the life cycle principle. The revised crisis standards prioritize younger adults over older adults to the point where an insignificant age difference could significantly impact a patient's ability to access life-saving treatment. For example, a patient between the ages of 50 and 65 is granted higher priority over another patient aged 65-80. (p. 21). There is little clinical difference between patients aged 65 and 66,

[4] *See* p. 15, Ethical Considerations for Decision Making Regarding Allocation of Mechanical Ventilators during a Severe Influenza Pandemic or Other Public Health Emergency.

[5] "Universal Do-Not-Resuscitate Orders, Social Worth, and Life-Years: Opposing Discriminatory Approaches to the Allocation of Resources During the COVID-19 Pandemic and Other Health System Catastrophes Free", Annals of Internal Medicine, Ideas and Opinions, Thomas A. Bledsoe, MD; Janet A. Jokela, MD, MPH; Noel N. Deep, MD; Lois Snyder Sulmasy, JD, April 24, 2020.

yet placement in a "50-65" category immediately gives that patient higher preference for life-saving treatment.

More importantly, federal authority does not allow discrimination against older adults in the provision of healthcare. On April 8, 2020, the Department of Health and Human Services Office for Civil Rights ("OCR") resolved a complaint filed by disability advocates regarding Alabama's ventilator triaging guidelines. As a result of the OCR intervention, Alabama agreed to ensure that the prior discriminatory criteria are not in effect and will not include similar provisions singling out certain disabilities for unfavorable treatment or use categorical age cutoffs in future guidelines.[6] In resolving the complaint, OCR expressed concern with the use of "blunt age categorizations, such that older persons might automatically be deemed ineligible for life-saving care without any individualized assessment or examination and based solely on missing a strict age cutoff." Id. The life-cycle considerations and other age-related criteria in the revised standards are similar to the discriminatory policies in the Alabama policy that OCR resolved and must be changed.

In lieu of these discriminatory and arbitrary considerations, we propose Massachusetts adopt a resource allocation policy that only factors the individual's likelihood to survive the immediate episode based on individualized clinical assessments irrespective of how many years of life they may expect to have remaining, and without regard to the patient's age. We encourage Massachusetts to consider the University of California Crisis Standards of Care[7] ("UC Policy"), developed by an interdisciplinary team of professionals. The UC policy does not factor long-term survivability, life cycle considerations or any other provision that discriminates against older adults.[8] California recently engaged with advocates for older adults and persons with disabilities in developing its statewide crisis standard. Although the final policy has not been posted, this collaboration produced a methodology for allocating scarce resources that all but eliminates bias, and highlights the need for Massachusetts to employ a stakeholder-based approach to revising its standards.

We urge the State to take immediate action to rectify the revised standards so they comply with the anti-discrimination requirements under Section 1557 of the Affordable Care Act and the Age Act. We are working with a coalition of advocates impacted by these revised standards and have a scheduled meeting with Secretary Sudders on July 8th. We look forward to working with you to address the issues we have raised in this letter. Please feel free to contact Robert Greenwald at rgreenwa@law.harvard.edu or Regan Bailey at rbailey@justiceinaging.org if you would like to discuss before that meeting.

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[6] https://www.hhs.gov/about/news/2020/04/08/ocr-reaches-early-case-resolution-alabama-after-it-removes-discriminatory-ventilator-triaging.html.

[7] *See* "Allocation of Scarce Critical Resources under Crisis Standards of Care," University of California Bioethics Working Group, April 16, 2020.

[8] *See* UC Policy pg. 57- explaining the policy only favors which patient has a higher chance of survival, irrespective of age. Page 28 of the policy also discusses the goal of maximizing the most lives saved and only factoring short-term survival when allocating resources.

Sincerely,

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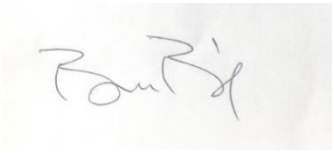

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