



June 5, 2020

Secretary Marylou Sudders  
Executive Office of Health and Human Services  
Commonwealth of Massachusetts  
One Ashburton Place, 11<sup>th</sup> Floor  
Boston, MA 02108

Re: Revised Crisis Standards of Care

Dear Secretary Sudders,

We write today to both acknowledge the improvements made to the Crisis Standards of Care Planning Guidance for the COVID-19 Pandemic as well as note remaining issues that harm older adults. On April 14<sup>th</sup>, we sent a letter to Governor Baker sharing our concerns relating to age-based bias and discriminatory policies in the original Crisis Care Standards. Since that time, the standards have been revised; however, however arbitrary and discriminatory use of age-related factors remain.

The revisions issued on April 20, 2020 improved on a number of provisions impacting older adults and others. However, we remain concerned about language in the policy that continues to use age as a determinative factor in whether to provide scarce resources, such as ventilators. Age is an immutable characteristic and often the subject of bias, much like the factors that the policy correctly notes have no role in triage decisions, including race, disability, and gender. Similarly, age should not be the basis for denial of essential care and services. We invite you to revisit the policy to improve the Crisis Standards of Care and avoid unlawful age discrimination.

#### Problems with the Goal of "Saving Life Years" Rather than Lives Alone

Under the revised standards, clinicians make individualized patient assessments when allocating scarce resources. However, the allocation framework is expressly based on "1) saving lives; and 2) saving life-years." (pg. 10). A policy which maximizes "saving life-years" always

works against older adults. Factors correlated with age, like long term survival and number of anticipated years remaining, violate federal civil right law by limiting access to life-saving treatment to older patients. **We ask 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 (i.e. six months) survivability.**<sup>1</sup>

### Reliance on Five Year Survivability Is Not a Reliable Standard and Invites Bias

Under the revised standards, patients with underlying conditions are subject to priority scoring using the Sequential Organ Failure Assessment (SOFA) score. Many older adults have comorbidities and will get a less favorable score if those conditions “significantly limit near term prognosis”- defined as death likely *within five years*. (pg. 16). The elimination of long-term survival prognosis in a patient's SOFA score improved on the language in prior standards, yet a five-year survivability standard similarly 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.<sup>2</sup> Using five years as a benchmark for survivability will exacerbate inherent biases about an older person's life expectancy and will have a 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.** Other prognosis frameworks adopt shorter time frames for determining prognosis, based on objective medical criteria that is widely accepted in medical practice, such as the hospice criteria of six-month expected survivability.

### Improper Life Cycle Consideration and Categorical Age Cut-Offs

The revised standards also discriminate against older adults by prioritizing younger adults in “tie-breakers” situations by incorporating “life-cycle considerations.” (pg. 21). The life-cycle considerations assume 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.<sup>3</sup> A recent opinion in the *Annals of Internal Medicine* eloquently framed the issue: “Sometimes called a “life-cycle” or “fair innings”

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<sup>1</sup> 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 \(explaining use of “life-years saved” and “long-term predicted life expectancy” shows bias against older adults\)](#).

<sup>2</sup> 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).

<sup>3</sup> See p. 15, [Ethical considerations for decision making regarding allocation of mechanical ventilators during a severe influenza pandemic or other public health emergency \(2011\)](#).

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.”<sup>4</sup> The life-cycles consideration harms older adults and introduces nonclinical considerations and personal bias into the allocation of scarce resources.

Federal civil rights laws protect older adults from this type of bias. Notably, on April 8, 2020, the Department of Health and Human Services Office of 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.<sup>5</sup> In resolving the complaint, OCR *sua sponte* cited its 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.*

Massachusetts’ revised standards include categorical age cut-offs as part of the life-cycle consideration. 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, yet placement in a “50-65” category immediately gives that patient higher preference for life-saving treatment.

#### Criteria to Access to Life Saving Care Cannot Include Age Based Bias

To avoid the introduction of bias into the allocation of scarce resources, **we ask that Massachusetts adopt a resource allocation policy that only factors the individual’s likelihood to survive the immediate episode based on individualized clinical assessments.** We encourage Massachusetts to consider the process and model of the University of California Crisis Standards of Care<sup>6</sup> (“UC Policy”), developed by an interdisciplinary team of professionals. The UC Policy does not factor long-term survivability, life-cycle considerations or any other

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<sup>4</sup> “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.

<sup>5</sup> <https://www.hhs.gov/about/news/2020/04/08/ocr-reaches-early-case-resolution-alabama-after-it-removes-discriminatory-ventilator-triaging.html>.

<sup>6</sup> see “Allocation of Scarce Critical Resources under Crisis Standards of Care,” University of California Bioethics Working Group, April 16, 2020. (available upon request).

provision that discriminates against older adults.<sup>7</sup> The multidisciplinary approach included medical professionals from across relevant health practices and included the diversity and outreach chair of a state health program. We recommend including similar expertise, and specifically including a gerontologist to ensure that considerations relevant to the population most impacted by COVID-19 are addressed. The State of California engaged with advocates for older adults and persons with disabilities in revising its statewide crisis standard, and this collaboration contributed to the development of a methodology for allocating scarce resources that all but eliminates bias. California’s standard is expected to be released publicly in the near future. It will be a useful example for Massachusetts to consider.

We appreciate the work done to date to improve the Crisis Standard of Care and recommend that Massachusetts look to the recent posting of the HHS Office for Civil Rights directing people to the April 14, 2020 guidance of the Health Care Resilience Taskforce (composed of HHS, FEMA, and the Army Corps of Engineers)<sup>8</sup>. This summary guidance of civil rights protections states:

“Treatment decisions, including denials of care under CSCs, must be made after nondiscriminatory consideration of each person, free from stereotypes and biases based on disability or age—including generalizations and judgments about the quality of life, or relative value to society, concerning disabilities or age. This individualized consideration should be based on current objective medical evidence and the views of the patients themselves as opposed to unfounded assumptions.”

We urge Massachusetts to modify the revised standards currently in place to protect older adults who may face a denial of care in a subsequent surge and to ensure compliance with the anti-discrimination requirements of federal law. We appreciate your efforts on the standards thus far, and we are more than happy to work with you to continue to improve the guidelines to best protect older adults in Massachusetts. The undersigned have been working with other advocates as part of a coalition to address these issues and have a scheduled meeting with you on July 8, 2020. We look forward to meeting with you and working with you to improve the standards. In the meanwhile, please feel free to contact Robert Greenwald at [rgreenwa@law.harvard.edu](mailto:rgreenwa@law.harvard.edu) or Regan Bailey at [rbailey@justiceinaging.org](mailto:rbailey@justiceinaging.org) if you have any questions.

Sincerely,



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<sup>7</sup> 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.

<sup>8</sup> “Crisis Standards of Care and Civil Rights Laws,” page 2, <https://files.asprtracie.hhs.gov/documents/crisis-standards-of-care-and-civil-rights-laws-covid-19.pdf>

Robert Greenwald  
Faculty Director and Clinical Professor of Law  
Center for Health Law and Policy Innovation  
Harvard Law School

A rectangular box containing a handwritten signature in black ink. The signature appears to be 'Regan Bailey' written in a cursive style.

Regan Bailey  
Litigation Director  
Justice in Aging

*/s/ Alice Bers*  
Alice Bers  
Litigation Director  
Center for Medicare Advocacy

*/s/ Radhika Bhattacharya*  
Radhika Bhattacharya  
Managing Attorney  
Elder, Health & Disability Unit  
Greater Boston Legal Services