JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Robinsue Frohboese
Acting Director, Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington DC 20201

September 22, 2021

Re: Age Discrimination in Idaho's Crisis Standards of Care

Dear Acting Director Frohboese,

We write today to express our concern regarding Idaho's Crisis Standards of Care (CSC) criteria for allocating scarce resources. Justice in Aging is a nationwide advocacy organization for low income older adults. We regularly engage in legislative, policy and litigation based advocacy to improve access to health care services for our constituents. We have recently learned that the Governor of Idaho activated the Crisis Standards of Care in response to the surge in hospitalized COVID-19 patients. This CSC discriminates against older adults, and particularly Black older adults in violation of the Age Discrimination Act of 1975 (Age Act) and Section 1557 of the Affordable Care Act (Section 1557). We request that the Office for Civil Rights (OCR) open an investigation into the State's resource allocation protocols to identify and eliminate discriminatory policy and practice.

1. Idaho's Policy for Allocating Scarce Resources

In January 2021, Idaho adopted *Patient Care: Strategies for Scarce Resources* as the criteria to guide decision making under their Crisis Standards of Care. This policy was the third revision of the State's criteria. While the Ethical Framework prefacing the criteria includes a commitment that "no patients will be discriminated against on the basis of disability, race, color, national origin, age, sex, gender or exercise of conscience and religion," the policy goes on to do just that. Its Ethical Framework states that "the focus is on saving the most lives and life years" and correctly notes that assessments should be in the "context of ensuring meaningful access for all patients, ensuring individualized patient assessments, and diminishing the negative effects of social inequalities that lessen some patients long term life expectancy." *Id* at p. 3. However, when the policy shifts to the difficult task of resolving ties (where two similarly situated persons need a scarce resource), facially discriminatory criteria gives preference to younger patients over older ones, including a criterion based on the theory that older persons have enjoyed more "life cycles" and, essentially, had their opportunity to live:

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Resolving "Ties"

> In the event that there are more patients in a Priority Category than there are critical care resources/ventilators, several "tiebreakers" should be used. (1) Priority should first be given to children ages 0-17. (2) Priority should next go to pregnant women with a viable pregnancy ≥ 28 weeks of gestation. (3) Priority should then go to patients based on lifecycle, prioritizing those patients who have lived through fewer lifecycles (lifecycle categories: age 18-40, age 41-60; age 61-75; older than age 75). (4) Priority should next go to individuals who perform tasks that are vital to the public health response of the crisis at hand, including, but not limited to, those whose work directly supports the provision of acute care to others. (5) Finally, if a "tie" still remains, a lottery (i.e. random allocation) should be used to determine priority for ventilator access.

Id at p. 8.

The tiebreaker language is only mentioned in one section of the document – Mechanical Ventilation. However, elsewhere in the document healthcare providers are instructed to apply the prioritization in the Mechanical Ventilation protocol if resources are insufficient to meet the demand, *see* Renal Replacement Therapy/Triage, p. 17. Because the *Strategies for Scarce Resources* provides one just standard for breaking a tie, the Mechanical Ventilation protocol is the standard that will likely be relied upon by hospital staff responding to other areas of shortage as well, including decisions relating to scarce staffing (impacting the availability of ICU beds), ECMO treatment, oxygen or medication.

2. The Age Act and Sec. 1557 of the Affordable Care Act Prohibit Age Based Discrimination in Healthcare

The Age Act was incorporated into the Affordable Care Act in Section 1557, prohibiting discrimination on the basis of age in healthcare settings, including hospitals. The Office for Civil Rights has made clear that federal civil rights protections remain in effect during the COVID 19 pandemic[1], and there is no carve out for Crisis Standards of Care. 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. While the Age Act has certain exceptions, they do not support the use of age as a tiebreaker or the categorical denial based on age. The regulation's four-part test necessitates that all criteria must be met for an exception to apply:

> (a) age used to measure or approximate another characteristic;
>
> (b) other characteristic must be measured or approximated for the normal operation of the program or activity to continue;

[1] HHS, Office for Civil Rights, BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19) March 28, 2020. https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf

(c) other characteristic can be reasonably measured or approximated by use of age; and

(d) other characteristic is impractical to measure directly on an individual basis.

42 C.F.R. § 91.13

Regulations governing the Age Act make clear that age can legally be used in public benefits only when providing special benefits to older adults and children, not to deny care based on age:

Special benefits for children and the elderly.

If a recipient operating a program or activity provides special benefits to the elderly or to children, such use of age distinctions shall be presumed to be necessary to the normal operation of the program or activity, notwithstanding the provisions of § 91.13.

42 C.F.R. § 91.17. This provision allows for extension of benefits to children or the elderly, but not the withholding of benefits based on age.

3. Lifecycle or Fair Innings Criteria are Inherently Discriminatory Against Older People

The *Strategies for Scarce Resources* categorically favor younger patients. In the tie resolution protocol relating to Mechanical Ventilation, priority, after children and pregnant women, goes to "patients based on **lifecycle**, prioritizing those patients who have lived through fewer lifecycles," which are defined as 18-40, 41-60, 61-75 and older than age 75. *Id* at 8.

The age-based life-cycle or fair-innings approach assumes that the preventable death of an older individual is less tragic or more desirable, and "systematically disfavor[s] older patients, disabled persons, and potentially other groups."[2] The fair allocation of resources should rely on "the ability to survive the acute event, not long-term survival."[3] The Idaho life-cycle criteria is in conflict with OCR's guidance that medical care cannot be denied "on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative 'worth' based on the presence or absence of disabilities or age." *see* OCR Bulletin, Civil Rights, HIPAA, and the Coronavirus Disease 2019.[4]

The tiebreaker language in Idaho is not limited to situations where there are large age differences between the two people needing care. By its terms, it would be applied in situations where there may be very little difference, such as a 60-year-old man and a 61-year-old man. When they are

[2] "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.); *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] *Id*.

[4] HHS, Office for Civil Rights, BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19) March 28, 2020. https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf

so clinically similar as to require a tiebreaker, this would lead to absurd and ageist result of denying care to the 61-year-old man simply because he is as little as one year older.

Older adults are facing serious risk of discrimination, resulting in death, now that the *Scare Resource Strategy* is operational. COVID-19 has disproportionately targeted older adults, and older adults need the treatment necessary to fight back. The landscape in Idaho is dire.[5] Idaho reports 45,154 COVID 19 cases in persons over the age of 60, out of a total of 243,565[6]. There have been 2,398 deaths of person over age 60 out of a total of 2,649 deaths in the state – over 90% of all deaths occurred in the over 60 population. Currently, Idaho is in a surge, with a 60% increase in cases and a 245% increase in deaths the past 14 days.[7]

Idaho has become the first state to activate its Crisis Standards of Care in response to overwhelmed hospitals. Because older adults face a high risk of death and complications from COVID-19, self-isolation and social distancing measures have been undertaken across the country to save lives. Yet, Idaho's policy inexplicably denies critical care to the very people these public health efforts were meant to protect – those most at risk of dying from COVID-19 complications.[8] By design, the *Scarce Resource Strategy* denies support to the very population most impacted by COVID 19, and as such, is discriminatory.

4. Age-Based Criteria Categorically Deny Life Saving Care

The *Strategies for Scarce Resources'* tiebreaker language includes draconian categorical age-based criteria and relies on age as the sole reason for denial of healthcare. The policy places people in need of scarce health care services into age based categories and ranks them to determine who will get treatment: "Priority should then go to patients based on lifecycle, prioritizing those patients who have lived through fewer lifecycles (lifecycle **categories: age 18-40, age 41-60; age 61-75; older than age 75**)." *Strategies for Scarce Resources* at p. 8.

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[5] Many Older Americans Still Aren't Vaccinated, Making the Delta Wave Deadlier. New York Times, Aug. 24, 2021, https://www.nytimes.com/interactive/2021/08/24/world/vaccines-seniors.html
"While older Americans are more likely to be vaccinated than younger Americans, seniors without full vaccine protection are at much higher risk of dying from Covid-19. The Delta variant has hit many areas with clusters of vulnerable seniors particularly hard. Low elderly vaccination rates in Arkansas, Florida, Idaho, Louisiana and Nevada have coincided with surging rates of hospitalization and death." *See also* Idaho data Feb 17, 2021 to Sept 16, 2021:
Deaths stats: The Idaho Department of Health and Welfare has reported 828 deaths tied to long-term care facilities (updated Fridays). Here's how Idaho's deaths break down by age group, according to IDHW: 80+: 1,213; 70s: 726; 60s: 387; 50s: 145; 40s: 59; 30s: 21; 18-29: 9.
https://www.idahostatesman.com/news/coronavirus/article252139258.html#storylink=cpy

[6] https://public.tableau.com/app/profile/idaho.division.of.public.health/viz/DPHIdahoCOVID-19Dashboard/Home (visited September 21, 2021)

[7] https://www.nytimes.com/interactive/2021/us/idaho-covid-cases.html

[8] The explicit reliance on age in triage protocols either as a categorical exclusion, or as a secondary tiebreaker further frustrates the ability to assess the extent to which the physiology of advanced age impacts the lethality of the COVID-19 pandemic.

Categorical exclusions deny care based on whether the person falls into a favored category – here based on youth. OCR's resolution of the complaint regarding Arizona's Crisis Standards of Care (Arizona Resolution)[9] made clear that federal civil rights laws prohibit "the use of categorical exclusion criteria, instead requiring an individualized assessment based on the best available objective medical evidence."

In a tiebreak situation, all persons under review are essentially clinically the same or very similar, and the policy turns to age based categories to break the tie. The categorical age is considered alone, unrelated to clinical findings, making age the singular basis for denial of care.

5. Goal of Saving "Life Years" Discriminates on the Basis of Age

The Idaho *Strategies for Scarce Resources* includes the stated goal of saving "life years," and explicitly invokes age as a basis for the allocation of scare medical resources if two individuals have the same SOFA scores. A "life years" focus looks to longevity as a factor in the allocation of scarce resources. However, OCR's Arizona Resolution found that "the use of a patient's long-term life expectancy as a factor in the allocation and re-allocation of scarce medical resources" was prohibited under federal civil rights laws. Yet the "life years" language is found in both the Ethical Framework and the "tiebreaker" provisions in the document. Reliance on "life years" or similar longevity criteria violates the Affordable Care Act's anti-discrimination provisions, as well as the Age Act.

The American College of Physicians has rejected the use of "number of life years," instead recommending that hospitals make resource allocation decisions based on patient need, prognosis (determined by objective scientific measures and informed clinical judgment), and effectiveness (i.e., the likelihood that the therapy will help the patient recover). Allocation of treatments must maximize the number of patients who will recover, not the number of "life-years," which is inherently biased against older adults and people with disabilities.[10] The focus on "life years" disproportionately jeopardizes older adults of color, such as those in Black[11] and Native American[12] communities, who suffer from lower life expectancies due to systemic discrimination in healthcare and social services.[13] Idaho's preamble Ethical Framework expressly calls for consideration of these lifelong disparities, but the application of the Priority Score process explicitly contradicts this intention. *Strategies for Scarce Resources* p. 7.

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[9] https://www.hhs.gov/about/news/2021/05/25/ocr-provides-technical-assistance-state-arizona-ensure-crisis-standards-care-protect-against-age-disability-discrimination.html

[10] Available at https://www.acponline.org/acp-newsroom/internists-say-prioritization-allocation-of-resources-must-not-result-in-discrimination.

[11] *See*, Allan S. Noonan, et al., Improving the Health of African Americans in the USA: An Overdue Opportunity to for Social Justice, 37 Oub. Health Rev. 12 (2016) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5810013/.

[12] Indian Health Service, Fact Sheet: Disparities, at https://www.ihs.gov/newsroom/factsheets/disparities/.

[13] The impact of COVID-19 in non-white communities has only exacerbated that divide. *See* CDC National Vital Statistics System, Provisional Life Expectancy Estimates for January through June, 2020, p 3, February 2021, https://www.cdc.gov/nchs/data/vsrr/VSRR10-508.pdf

If the *Strategies for Scarce Resources* is attempting to use age as a proxy for survival, individualized clinical considerations of survival - which already reflect the impact of age on the person's body and related assessments - have already been considered. The addition of age here double counts that impact and is discriminatory against older adults and violative of Section 1557 of the ACA and the Age Act

6. SOFA Criteria Disadvantages Older Black Adults

Reliance on SOFA scoring in Crisis Standards of Care has been problematic.[14] The SOFA score is a composite measure of organ dysfunction. It is the foundational assessment for ranking patients for access to scarce resources. In addition to the disability bias inherent in SOFA scoring, which the State resolved with appropriate modifications, Idaho's reliance on SOFA scoring for assessing likelihood of survival disproportionately disadvantages older Black adults, *see Scarce Resource Strategy*, p. 6. SOFA scores have been shown to be inaccurate in assessing likelihood of survival of Black patients, and instead indicate that Black patients are less likely to survive than has proven to be the case.[15] "SOFA scores were associated with overestimated mortality among Black patients compared with white patients, and this was associated with a structural disadvantage for Black patients in CSC allocation systems. These findings suggest that guidelines should be revised to correct this inequity and alternative methods should be developed for more equitable triage."[16]

Black older adults face intersectional discrimination written into the *Scarce Resource Strategy* currently activated throughout Idaho. The age-based factors detailed in above work concurrently with the race-based bias in the SOFA scoring system to underestimate the likelihood of survival of older Black patients and unfairly exclude them from receiving scarce resources. In Idaho, the Black community is small and the state's overall population is predominately white. In this environment disparities can be less obvious because of the lower numbers of Black Idahoans, but smaller populations often acutely experience the impacts of discrimination. According to Idaho's data, out of 170,401 cases with a known race, 0.88% were identified as Black people.[17] The SOFA score would apply to approximately 1,500 Black Idahoans and would systemically

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[14] See *Discriminant Accuracy of the SOFA Score for Determining the Probable Mortality of Patients With COVID-19 Pneumonia Requiring Mechanical Ventilation*, February 17, 2021; https://jamanetwork.com/journals/jama/fullarticle/2776737
"The SOFA score possesses inadequate discriminant accuracy to be used for ventilator triage of COVID-19 patients. A better option is needed that incorporates variables specifically related to mortality in patients with COVID-19 pneumonia requiring mechanical ventilation."

[15] See *Accuracy of the Sequential Organ Failure Assessment Score for In-Hospital Mortality by Race and Relevance to Crisis Standards of Care,* Miller DM et al, June 18, 2021, *JAMA Network Open.* 2021;4(6):e2113891. doi:10.1001/jamanetworkopen.2021.13891; *see also* "Covid Triage Standards Worsen Racial Disparities in Treatment," Medical Xpress, September 21, 2021, https://medicalxpress.com/news/2021-09-covid-triage-standards-worsen-racial.html

[16] *Id.* at p. 8 ("Increasing the SOFA thresholds for Black patients by 2 points equalized the adjusted odds of death for Black and White individuals who qualified for high priority broadly across the 3 systems and under all shortage conditions.")

[17] Idaho COVID 19 Dashboard – Case Characteristics (visited September 21, 2021) https://public.tableau.com/app/profile/idaho.division.of.public.health/viz/DPHIdahoCOVID-19Dashboard/Home

disfavor them for life saving care. The same is likely true for other minority populations in the state.

The reliance on SOFA scoring in Crisis Standards of Care is a largely untried endeavor. It has been rare for these protocols to be activated. The COVID-19 pandemic has made clear the racial disparities in access to health and the dire need to cull bias from any tools used to allocate scarce resources. Scoring that disfavors some racial groups for life saving care contain impermissible bias that harms people of color in their hour of greatest need, and coupled with the age-based factors in the CSC, work to uniquely harm older Black adults.

Conclusion

Justice in Aging request a meeting with the Office for Civil Rights to discuss a potential investigation the *Scarce Resource Strategy* currently in operation in Idaho. We also request that OCR take appropriate and necessary action to protect the right of older adults to non-discrimination in healthcare settings, including and especially in life-saving situations. Such action would include the removal of the lifecycle considerations, the goal of saving life years and categorical denials; and would require the modification or removal of SOFA as a tool for assessing likelihood of survival. We also seek an affirmative declaration regarding the related prohibition on considering the long term survival of patients in making resource allocation decisions. While Idaho's current policy does not explicitly limit treatment based on considerations of an individual's heightened need for medical resources, any replacement language should prohibit such considerations given the disparate impact it would have on older adults, especially and including older Black Idahoans. Please contact Regan Bailey at Justice in Aging at rbailey@justiceinaging.org.

Sincerely,



Regan Bailey
Director of Litigation
202-683-1990

Denny Chan
Directing Attorney, Equity Advocacy
213-375-3559

Gelila Selassie
Staff Attorney
843-813-7521

CC: Pamela O. Barron, J.D, Deputy Director, Office for Civil Rights, DHHS
Ari Ne'eman, Senior Disability Advisor, Office for Civil Rights