FOR DELIVERY & PAYMENT TRANSFORMATION

April 23, 2020

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
United States House of Representatives
Washington, DC 20515

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
Washington, DC 20515

Dear Speaker Pelosi and Leaders McConnell, McCarthy, and Schumer:

The undersigned members of the *Health Equity Task Force for Delivery and Payment Transformation* (Task Force), a Families USA coalition of national and state health equity advocates, strongly urge you to advance policies that ensure all children and families have a fair and just opportunity to be as healthy as possible during the novel coronavirus (COVID-19) pandemic.

This public health emergency presents a moment in our nation ripe for addressing the social and structural drivers of health inequities. The pandemic illuminates existing racial, ethnic, geographic, and other health and health care disparities. Across the country we are witnessing communities of color, particularly Black Americans, hit the hardest by COVID-19. Preliminary findings across states that have released disaggregated data show higher contraction and death rates in Black and Latinx communities.[i] Language access barriers have prevented patients from receiving proper diagnosis and treatment, in addition to unjust immigration laws that stoke fears among undocumented individuals of being deported and detained in the process of seeking care.[ii] In addition, civil and human rights of individuals with disabilities are threatened with reports of rationing critical care resources such as ventilators.[iii] These injustices are unacceptable.

The following recommendations reflect the immediate needs of our most vulnerable populations, many of whom are serving on the frontlines of the pandemic. It is critical that Congress address the following issues in the next response package:

Ensure public health and safety of all people. Congress must ensure that all people, including health care workers, store clerks, janitors, agricultural workers, mail carriers, domestic workers and other essential workers on the frontlines, many of whom face the aforementioned health disparities, have the ability to be safe as they do their jobs. This not only protects their health but also protects the health of all families by maintaining essential services and maximum surge-capacity in the health care system. Employers should implement effective workplace controls, such as the kinds of work practices and protective equipment or shields outlined in the employer guidance from the Centers of Disease Control (CDC) and Occupational Safety and Health Administration (OSHA). The most important measure to keep workers safe is increased physical distance between workers, and between workers and customers, to six feet.

Recommendation: Congress should require the Occupational Safety and Health Administration (OSHA) to issue an emergency temporary standard on infectious disease that would provide protections to all workers for the duration of the pandemic. OSHA should be required to include four levels of workplace controls: engineering controls (such as improving ventilation, installing plastic shields and other physical barriers, and instituting drive-through services); work practices designed to prevent exposure (including frequent handwashing, practices to increase physical distancing, staggering shifts, and regularly cleaning and disinfecting commonly touched surfaces in the workplace); administrative policies (including providing sick leave that allows workers to stay home when they are sick without loss of pay, encouraging working from home whenever possible, and training employees on the disease response plan and workplace controls); and finally, full transparency and national coordination around the production and distribution of personal protective equipment (PPE), which should be provided at no cost to the employee and in conjunction with employee training, medical evaluation and fit testing. Congress also should dramatically improve paid sick leave for workers affected by the pandemic by removing exemptions for certain employers, increasing the level of support, including hazard pay, for lower-wage workers, and expanding access to the benefit.

Ensure equitable access to affordable health insurance coverage. This pandemic has revealed that our collective health as a nation depends on high-quality, affordable health care and improved health for all. Many of the essential workers and newly uninsured are people of color. Any federal approach to flattening the curve must integrate equitable access to insurance coverage, whether through the private market or public programs such as Medicaid and the Children's Health Insurance Program (CHIP).

Recommendation: To ensure that those who have lost their jobs due to COVID-19 can access testing and treatment and medical, mental, oral, and other health needs, it is critical that Congress open and strengthen the individual and work-based health insurance market to the uninsured by providing enhanced premium tax credits and COBRA subsidies; opening a national special enrollment period; and providing financial assistance for low-income, uninsured patients in the health insurance exchange in non-Medicaid expansion states.

Ensure health care inclusion for immigrant communities. We cannot fully address this public health crisis if we leave out large segments of our population: immigrant families, including mixed immigration status families. Federal Medicaid rules exclude many lawfully residing people from coverage – including people granted Deferred Action for Childhood Arrivals (DACA), most lawful permanent residents during their first five years in that status, survivors of crime-granted U visas, Pacific Islanders who entered the US under the Compacts of Free Association (COFA), and people with Temporary Protected Status – along with those without status.

Recommendation: Congress should ensure that the Department of Homeland Security (DHS) and Immigration and Customs Enforcement (ICE) follow the announcement regarding enforcement and detention on public safety risks, and that no immigration enforcement actions take place at or near health care facilities. Congress should enact the *Federal Immigrant Release for Safety and Security Together (FIRST) Act* that would move immigrants out of detention and halt immigration enforcement against individuals not deemed a significant public safety risk during this coronavirus public health emergency and future health emergencies. Congress should halt the implementation of the DHS and Department of State (DOS) public charge rules retroactive to February 24.

Recommendation: We urge Congress to leverage Medicaid coverage by offering a state option for 100% Federal Medical Assistance Percentages (FMAP) for all uninsured individuals for COVID-19 testing, prevention, and treatment (including a vaccine when available), regardless of immigration status, citizenship, income, or categorical eligibility, and by replicating the 100% FMAP and phasedown for states newly expanding Medicaid. We also urge you to lift the five-year waiting period and other restrictions

currently in place for lawful permanent residents and other lawfully residing immigrants to access Medicaid and CHIP. In addition, we urge Congress to restore Medicaid eligibility for COFA migrants and recommend inclusion of the bipartisan *Covering our FAS Allies Act* (H.R. 4821 and S. 2218).

Require Comprehensive COVID-19 Data Collection, Reporting and Analysis. COVID-19 health disparities are stark, disproportionately impacting Black Americans. A multi-state analysis shows that predominantly Black counties have three times the rate of COVID-19 infections and approximately six times the rate of COVID-19 related deaths.[iv] Given this preliminary data, we echo the call for immediate action by your colleagues in the Congressional Tri-Caucus to ensure there are no racial or ethnic health disparities regarding the testing and treatment of COVID-19. Section 4302 of the Affordable Care Act (ACA) also requires the U.S. Department of Health and Human Services (HHS) to collect, analyze, and report disaggregated data for health care programs. And, the bipartisan *Saving Lives Through Better Data Act* (S. 1793) calls for the CDC to develop a strategy and implementation plan to update and improve the CDC's public health data systems as well as support improvement of state, local, tribal, and territorial public health data systems.

Recommendation: Direct the Secretary of HHS, acting through the CDC to collect, report and analyze disaggregated data on race, ethnicity, geographic location, primary language, socioeconomic status, gender identity, sexual orientation, age, and disability status of patients being tested, the rate of positive test results for each group, insurance coverage status and outcomes for those diagnosed with COVID-19. The Secretary should release the aforementioned disaggregated demographic data daily through CDC surveillance systems. Reporting of data should include analysis by state, county, and metropolitan statistical area. Furthermore, the Secretary should submit, no later than six months after the end of the public health emergency, a comprehensive report to the relevant health committees, not limited to the Committee on Health, Education, Labor, and Pensions of the Senate; Finance Committee of the Senate; Committee on Ways and Means of the House of Representatives; Committee on Education and Workforce of the House of Representatives; and the Committee on Energy and Commerce of the House of Representatives. In order to carry out these efforts, we must strengthen our public health capacity and fund the CDC to lead state efforts to oversee the monitoring and reporting of outbreaks as well as implement testing, tracing, and quarantine plans. An equitable approach to the surveillance of COVID-19 should also recognize assets within vulnerable communities such as community health workers (CHWs). The entire public health workforce, including CHWs, should be brought to bear to create innovative community centered solutions that protect and strengthen communities experiencing vulnerability.

Include Resources for Language Access for COVID-19 Outreach and Treatment. We know that the novel coronavirus does not discriminate on the basis of language; therefore, it is imperative to bolster resources to address unnecessary gaps in outreach and treatment for individuals whose primary language is not English. And while we know that language barriers far too often keep individuals from accessing critical care and health services, our nation's immigration laws further compound challenges individuals are facing during this global pandemic. Title VI of the Civil Rights Act requires entities that receive federal funds to ensure meaningful language access already, including translation and interpretation services. Compliance and enforcement of these regulations are compounded by lack of resources. We encourage you to consider provisions of the *Health Equity and Accountability Act of 2018 (S. 3660), Sec. 207(b) and Sec. 207(d) Federal Reimbursement for Culturally and Linguistically Appropriate Services Under the Medicare, Medicaid and State Children's Health Insurance Programs.*

Recommendation: Provide for enhanced reimbursement by Medicaid and CHIP for interpretation services during the COVID-19 outbreak. Provide resources to the CDC for the translation of public health materials into multiple languages and for outreach to linguistically diverse communities.

Prohibit Rationing of COVID-19 Treatment and Critical Care Resources. People with disabilities report discrimination related to COVID-19 treatment.[v] Older adults and people with disabilities are most at risk from both the virus and the range of harms caused by isolation during strict physical distancing. Risk is particularly high in nursing homes where in the first two weeks of April more than 3,000 deaths from COVID-19 have been reported across the United States. Longstanding nondiscrimination laws, such as the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act and Section 1557 of the ACA prevent discrimination on the basis of disability status. Entities covered by civil rights authorities must adhere to their obligations even in a time of strained health care capacity. We applaud the HHS Office of Civil Rights (OCR) in the release of a bulletin[vi] outlining civil rights and Health Insurance Portability and Accountability Act (HIPAA) implications related to COVID-19; however, the guidance does not go far enough. In addition, without additional resources to support access to Home and Community-Based Services (HCBS) and the workforce that provides them, aging adults and people with disabilities risk being forced into congregate settings, at grave risk to their health.

Recommendation: HHS OCR should update guidance to include recommendations on best practices related to the triage of critically ill patients and ethical allocation of critical care resources (e.g. critical care beds, ventilators). Guidance should also include reassessment criteria to determine whether ongoing provision of scarce critical care resources are needed for individual patients.[vii] Timing of assessments, to be conducted by a triage team, should be based on disease trajectory and severity of the crisis. In addition, HHS should prohibit use of categorical exclusion criteria (e.g. age, disability) related to COVID-19 treatment. We urge Congress to also consider targeted financial resources for nonprofit frontline and human services providers who are currently providing additional support to individuals with disabilities during this outbreak.

Recommendation: Targeted grants must be provided to states to increase HCBS to ensure older adults and people with disabilities can receive the services they need in their homes and communities rather than nursing facilities. Second, states need additional flexibility to make retainer payments to HCBS providers to protect the fragile network of entities that provide services to beneficiaries. Third, we request Congressional authority for states to make retainer payments to any Medicaid-enrolled provider for both the duration of the pandemic and the recovery period following the pandemic.

We stand ready to provide detailed specifications and technical assistance regarding each recommendation above. We are at a critical moment that calls for the need to prioritize communities disproportionally impacted due to structural, political and social determinants of health. How Congress responds during this moment of crisis will directly impact the health equity movement for decades to come. We envision a nation where no one faces barriers to a healthy life because of who they are or where they live. Please reach out to Amber Hewitt, Director of Health Equity at Families USA, ahewitt@familiesusa.org to discuss any of these recommendations.

Sincerely,

Asian & Pacific Islander American Health Forum
California Pan-Ethnic Health Network (CPEHN)
Coalition for Disability Health Equity
Community Catalyst
Daniel Dawes, JD; Health Equity Leadership & Exchange Network (HELEN)
Disparities Solution Center
Families USA
Health Equity Solutions

HealthConnect One
Ignatius Bau, JD; Consultant
National Urban League
Marshall Chin, MD, MPH; University of Chicago Medicine
National Association for the Advancement of Colored People
National Birth Equity Collaborative
National Council on Urban Indian Health
National Urban League
Oregon Nurses Association
The Center for Health Innovation
UnidosUS

---

[i] Rashawn Ray. "Why are Blacks dying at higher rates from COVID-19?" The Brookings Institution, April 9, 2020. https://www.brookings.edu/blog/fixgov/2020/04/09/why-are-blacks-dying-at-higher-rates-from-covid-19/

[ii] Joshua Kaplan. "Hospitals Have Left Many COVID-19 Patients Who Don't Speak English Alone, Confused and Without Proper Care." ProPublica. March 31, 2020. https://www.propublica.org/article/hospitals-have-left-many-covid19-patients-who-dont-speak-english-alone-confused-and-without-proper-care

[iii] Disability Rights Education and Defense Fund. "Preventing Discrimination in the Treatment of COVID-19 Patients: The Illegality of Medical Rationing on the Basis of Disability." March 25, 2020. https://dredf.org/the-illegality-of-medical-rationing-on-the-basis-of-disability/

[iv] Reis Thibault, Andrew Ba Tran, Vanessa Williams. "The coronavirus is infecting and killing black Americans at an alarmingly high rate." April 7, 2020. https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows/?arc404=true

[v] Joseph Shapiro. "Disability Groups File Federal Complaint About COVID-19 Care Rationing Plans." March 23, 2020. https://www.npr.org/2020/03/23/820303309/disability-groups-file-federal-complaint-about-covid-19-care-rationing-plans

[vi] Health and Human Services. "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

[vii] University of Pittsburgh Department of Critical Care Medicine. "Allocation of Scarce Critical Care Resources During a Public Health Emergency." April 3, 2020. https://ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy.pdf