IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI SOUTHERN DIVISION

STATE OF MISSISSIPPI, *et al.*,

Plaintiffs,

v. Civil Action No. 1:22-cv-00113-HSO-RPM

XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services, *et al.*,

Defendants.

BRIEF OF ROBERT WOOD JOHNSON FOUNDATION AS *AMICUS CURIAE*

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The Robert Wood Johnson Foundation ("RWJF") is a leading national philanthropy dedicated to taking bold leaps to transform health in our lifetime. It works side-by-side with partners to pave the way to a future where health is no longer a privilege, but a right. A core feature of RWJF's philanthropic approach is funding research to identify evidence-based methods of improving health outcomes for all and supporting implementation and dissemination of such strategies. As a result, RWJF is deeply familiar with the evidence regarding efforts to reduce racial disparities in health outcomes and seeks to present that evidence to this Court.

INTRODUCTION

The anti-racism plans described in the challenged rule—Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes, 86 Fed. Reg. 64,996, 65,969 (Nov. 19, 2021) ("the Rule")—ask clinicians to look for racial disparities among their patient populations and take practical, concrete steps to measurably reduce those disparities. Anti-racism plans in medicine are not new. In fact, many of the country's largest and leading hospital systems have adopted various interventions seeking to reduce and eliminate racial disparities as part of broader health equity efforts. As a result, there is an existing body of literature that examines the effects of clinical changes that seek to reduce racial disparities. What this literature shows is that interventions targeting a particular racial disparity routinely have positive effects for White and other racial groups as well. That is because the interventions offered, even when motivated by efforts to reduce racial disparities, consistently result in identifying ways to standardize and improve care for all patients. As described in detail below, this phenomenon has been observed in

[1] No counsel for a party authored this brief in whole or in part, and no entity or person other than *amicus curiae* and its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

a wide range of medical fields including pre- and post-natal care, cancer screening, and even organ transplants. Similarly, efforts to improve language access for individuals with limited English proficiency ("LEP") result in lower costs for healthcare systems overall, expanding the resources available for all patients.

The same results can be expected following the anti-racism plans implemented under the Rule, which directs clinicians towards its Disparities Impact Statement tool. *Id.* at 65,970 (referencing the tool). Critically, that tool emphasizes that "any interventions" offered must be "available to individuals without regard to a person's race," or other protected status.[2] Thus, while particular interventions may be motivated by a desire to reduce racial disparities, the likely result is improvements in patient care and safety across the board.

ARGUMENT

I. ANTI-RACISM PLANS IN MEDICINE EMPHASIZE PATIENT QUALITY OF CARE AND ENCOURAGE PROVIDERS TO TAKE CONCRETE ACTIONS THAT REDUCE SPECIFIC, TARGETED RACIAL HEALTH DISPARITIES.

As described in the Rule, anti-racism plans ask clinicians to look for racial disparities among their patient populations and take practical, concrete steps to measurably reduce those disparities. The concrete steps a given clinician or medical institution adopts can vary widely. They may include healthcare provider training and education on the existence of racial disparities and the need for action to address those disparities, changes to clinical practice guidelines to address root causes of racial disparities, ongoing monitoring of the disparities to ensure interventions are working, and community interventions to address the social determinants of health. The plans can be system-wide or focused on a particular practice; they can address the needs of multiple patient

[2] CMS, *Disparities Impact Statement* at 2 (Mar. 2021), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.

populations or a single one. One essential feature of any anti-racism plan, however, is that it must define clear goals and measurable objectives and result in specific, tangible interventions to achieve those goals.[3] As such, anti-racism plans are consistent with a longstanding—though not fully realized—effort to redress racial disparities in healthcare and move toward health equity: a state in which *all* patients, regardless of their race gender, or income, experience optimal health.[4]

The Rule reflects the importance of measurable goals and overall patient care. In order to satisfy the Rule, the plan must begin with "a clinic-wide review of existing tools and policies," including "clinical practice guidelines" to identify "target goals and milestones" that address the "issues and gaps" uncovered by the review. 86 Fed. Reg. 65,970. CMS emphasized that "clinicians [must] move beyond analyzing data to taking real steps to naming and eliminating the causes of the disparities identified." *Id.*

The Rule further directs clinicians to use CMS's Disparities Impact Statement tool. *See id.* (referencing the tool). Like the Rule itself, the tool emphasizes the importance of using "available data" to target a particular disparity and "monitor[ing] and evaluat[ing] progress using specific

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[3] Nadha Hassen et al., *Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review*, 18 Int. J. Env't Rsch. & Pub. Health 2993 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8000324/; Inst. Antiracism & Accountability Project, Harvard Univ., *Antiracist Institutional Change in Healthcare* (Mar. 2023), https://ash.harvard.edu/wp-content/uploads/2024/02/330395_hks_policy_brief_antiracism_web.pdf; J. Nwando Olayiwola et al., *Making Anti-Racism A Core Value In Academic Medicine*, Health Affs. Forefront (2020), https://www.healthaffairs.org/content/forefront/making-anti-racism-core-value-academic-medicine ("Rigorous, regular evaluation" must accompany the implementation of anti-racism plans); Camara Phyllis Jones, *Toward the Science and Practice of Anti-Racism: Launching a National Campaign Against Racism*, 28 Ethnicity & Disease 231 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6092166/.

[4] National Academy of Sciences, *Ending Unequal Treatment: Strategies to Achieve Equitable Health Care and Optimal Health for All*, 20 (2024), available at https://nap.nationalacademies.org/download/27820 (hereinafter "Unequal Treatment").

measures."[5] Critically, the tool also directs that "any interventions" must be "available to individuals without regard to a person's race," or other protected status, ensuring that interventions will have a positive effect on *all* patient care.[6]

Examples from healthcare providers themselves underscore how these principles operate in practice: namely that the adoption of an anti-racism or health equity plan results in concrete, practical clinical interventions that improve patient quality and safety overall. As previously described to this Court, *see* Dkt. No. 98-1 at 16-17, health systems such as Ohio State University's Wexner Medical Center and Health Sciences Colleges and HealthPartners have changed clinical practices in areas such as vaccine outreach, pre- and post-natal education, and cancer screening.[7]

Penn Medicine has likewise adopted a Diversity, Equity, and Inclusion and Healthcare Quality plan that strives to ensure that *all* patients have "access to high-quality medical care."[8] As part of that commitment, Penn Medicine set a goal to reduce racial disparities in Black maternal

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[5] CMS, *Disparities Impact Statement, supra* n.2 at 2, 3, 5.

[6] *Id.* at 2.

[7] *See also* Beth Harvilla, Ohio St. Wexner Med. Ctr., *Closing disparity gaps in vaccinations, infant mortality and overdose deaths* (June 21, 2022), https://health.osu.edu/community-health/equity-and-race/hear-closing-disparity-gaps-vaccinations-infant-mortality-overdose?utm_campaign=med_general-awareness_fy22_corp-contentengine-2022-health-equity-and-antiracism-report&utm_medium=print&utm_source=hear_report (describing Wexner Center's clinical changes that resulted in in measurable reductions in Black infant mortality and the rates of flu vaccinations among Black patients); Ohio St. Wexner Med. Ctr., *Health Equity and Anti-Racism Report* 2 (2022) https://wexnermedical.osu.edu/-/media/files/wexnermedical/about-us/anti-racism/hear-report-2022.pdf; HealthPartners, *Equity, inclusion and anti-racism Report to the community*, 2, 9-13 (2023), https://www.healthpartners.com/content/dam/corporate/diversity-inclusion/23-2303009-2305454-dei-report-booklet-final.pdf (following adoption of Equity, Inclusion and Anti-Racism Cabinet in 2020, HealthPartners has implemented numerous clinical changes including changes in the provision of care related to pre- and post-natal care, vaccine accessibility, and breast and colorectal cancer screening protocols, including offering same-day and mobile mammogram options to reach communities that do not routinely make it to a doctor's office for screening).

[8] Penn Medicine, *Diversity, Equity and Inclusion and Healthcare Quality* https://www.pennmedicine.org/about/transforming-patient-care/our-commitment-to-quality-and-patient-safety/patient-safety/dei (last visited Nov. 11, 2024).

health outcomes.[9] While motivated by reducing a specific racial disparity, the interventions adopted have been offered more broadly. For instance, Penn Medicine has conducted community engagement and education and "standardiz[ed] patient care during key moments in pregnancy and childbirth to reduce opportunities for racial bias," including adopting a "system-wide standard procedure for postpartum hemorrhage care" applicable to all postpartum patients.[10] After just one year of implementing these interventions, health problems for Black women resulting from pregnancy and childbirth dropped nearly 30 percent at Penn Medicine hospitals,[11] and experiences from other health systems show that after these types of global changes to hemorrhage care, "[b]oth black and white mothers benefited from the intervention."[12]

These are not isolated examples. Anti-racism interventions are part of a broader and widespread effort to achieve health equity and eliminate health disparities by improving overall patient quality of care and safety.[13] Indeed, the Joint Commission, the principal accrediting body that ensures quality and safety in U.S. hospitals, has emphasized that

> although health care equity is often viewed through a social justice lens, we understand it to be first and foremost a quality-of-care problem. Which means to achieve sustainable improvement we need to approach health care equity in the same way we

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[9] *See* Christina Hernandez Sherwood, Penn Medicine Obstetrics & Gynecology, *Helping Black Families to Grow and Thrive* (Nov. 20, 2023) https://communityimpact.pennmedicine.org/maternal-health-equity/; Christina Hernandez Sherwood, Penn Medicine Obstetrics & Gynecology, *Health Equity Efforts Help Moms Newly Home from the Hospital* (Dec. 6, 2023) https://communityimpact.pennmedicine.org/health-equity-postpartum/.

[10] Sherwood, "Helping Black Families," *supra* n. 9.

[11] Rebecca Feldman Ham et al., *Implementation and outcomes of a system-wide women's health 'team goal' to reduce maternal morbidity for black women: a prospective quality improvement study*, 11 BMJ Open Qual. e002061 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9670954/.

[12] Elliot K. Main et al., *Reduction in racial disparities in severe maternal morbidity from hemorrhage in a large-scale quality improvement collaborative,* 223 Am. J. Obstetrics & Gynecology 123.e1-123.e14 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8923030/.

[13] *See generally,* Unequal Treatment *supra* n. 4.

> approach other crucial patient safety priorities — by understanding the root causes and implementing targeted standards of care.[14]

The Joint Commission specifically accredits and certifies hospitals for health equity, applying criteria consistent with the Rule's anti-racism plans.[15] The Hospital Corporation for America (HCA)—the single largest health system in the country—utilizes the Joint Commission's health equity standards in its ongoing Diversity, Equity, and Inclusion initiatives.[16] One of HCA's core equity initiatives is data collection, which brings together staff to "analyze data related to patient outcomes [and] explore opportunities to address disparities within the walls of our hospitals."[17] As a result of these efforts, HCA is targeting racial disparities by "pursuing partnerships with outside organizations to address inequities related to maternal health, cardiovascular outcomes and cancer screenings for communities of color."[18] In fact, approximately 80 percent of all U.S. hospitals have reported adopting "community engagement" and "culturally appropriate patient care" as health equity initiatives as part of their strategic plans and 67 percent "collect[] and use . . . segmented data to drive action."[19]

In sum, anti-racism plans and closely related health equity strategies are well-established in U.S. healthcare, encouraging healthcare providers to adopt concrete, evidence-based interventions to address race-based health disparities and improve patient safety and quality of care for all.

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[14] Joint Commission, *Our Priorities: Health Care Equity*, https://www.jointcommission.org/our-priorities/health-care-equity/ (last visited Nov. 11, 2024).
[15] *Id.*
[16] HCA Healthcare, *Diversity, Equity and Inclusion Snapshot* (2023), https://hcahealthcare.com/util/documents/2023/2023-HCAH-DEI-Year-in-Review-a.pdf.
[17] HCA Healthcare, *Patients: Providing equitable access to high-quality, culturally competent patient care* https://hcahealthcare.com/about/diversity-equity-and-inclusion/patients.dot (last visited Nov. 11, 2024) ("Data collection" tab).
[18] *Id.*
[19] Simone R. Singh & Cherie Conley, *Inclusion of Health Equity Initiatives in Hospitals' Strategic Plans* 7 Health Equity 753-760 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10698784/.

II. RESEARCH SHOWS THAT INTERVENTIONS THAT REDUCE RACIAL HEALTH DISPARITIES DO SO BY IMPROVING OUTCOMES FOR RACIAL MINORITIES WITHOUT HARMING OUTCOMES FOR WHITE PATIENTS AND OFTEN IMPROVING OUTCOMES FOR ALL PATIENTS.

As described above, interventions to reduce racial disparities are rooted in concerns about improving patient safety and quality of care. Thus, any intervention adopted seeks to improve upon the quality of care already provided. In fact, while targeted to address disparities among a particular racial group, the clinical interventions adopted regularly result in improvements in patient safety and quality of care for *all* patients. As described below, positive spillover effects from targeted interventions have been documented in several clinical areas including maternal and infant health, cancer screening and detection, and even organ transplants. Improving communication with individuals with limited English proficiency likewise improves quality of care, reduces costly mistakes, and frees up resources for all patients. In short, the existing evidence shows that efforts to reduce racial disparities in healthcare do not harm the care currently provided and frequently lead to improvements in health outcomes for all patients.

A. Interventions to address racial disparities in maternal and infant mortality can help all pregnant and postpartum patients and infants.

Disparities in maternal and infant mortality between Black and other racial groups are well-documented.[20] As a result, there are several studies that evaluate the efficacy of targeted interventions designed to reduce these disparities. These studies show that interventions designed

[20] *See, e.g.*, Donna Hoyert, Ctrs. for Disease Control, *Maternal Mortality Rates in the United States, 2021* (2023) https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm; Latoya Hill et al., Kaiser Fam. Found., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them* (Nov. 1, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/#:~:text=Infants%20born%20to%20Black%2C%20AIAN,disparities%20widened%20for%20Black%20women.

to reduce racial disparities among Black patients not only reduce disparities but actually result in changes that benefit all postpartum patients.

For instance, a study evaluating the efficacy of providing doula care to birthing women—an increasingly common strategy to address racial disparities in maternal health—found that women who received such care had 52.9 percent lower odds of cesarean delivery and 57.5 percent lower odds of postpartum depression and anxiety.[21] The study demonstrated that Black and White expectant mothers experienced health benefits from doula care and both groups showed lower risks compared to those who did not receive doula support. Thus, while provision of doula care may be motivated by an anti-racism plan targeting racial disparities in maternal health outcomes, the results are likely to benefit the outcomes of all birthing patients.

Studies of postpartum interventions show similar spillover results. For instance, in 2021, as part of its comprehensive efforts to eliminate racial inequities in maternal morbidity and mortality, Penn Medicine implemented a "fourth trimester" program, which set a goal for all patients to receive a postpartum visit within three weeks of delivery (as opposed to the standard visit at six weeks postpartum) either in person or via telehealth.[22] An evaluation of that program showed that the proportion of patients with a visit in the first three weeks jumped from 15 percent to 64 percent with positive benefits for Black and non-Black patients.[23] Notably, however, the option to have telehealth postpartum visits decreased pre-existing racial disparities in both visit attendance and postpartum depression screening.[24]

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[21] April M. Falconi et al., *Doula Care Across the Maternity Care Continuum and Impact on Maternal Health: Evaluation of Doula Programs Across Three Status Using Propensity Score Matching*, 50 The Lancet (2022), https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(22)00261-9/fulltext.

[22] Sherwood, "Health Equity Efforts," *supra* n.9.

[23] *Id.*

[24] Natasha R. Kumar et al., *Assessing the impact of telehealth implementation on postpartum*

Another study evaluated the efficacy of a program called Heart Safe Motherhood, which provides postpartum patients with a blood pressure cuff and educates them on how to use it—in an effort to reduce hypertension-related morbidity and mortality, especially among Black patients.[25] For 10 days following discharge from the hospital, postpartum patients participating in the program receive text-message reminders to conduct twice-daily blood pressure readings at home and report the readings to their providers via reply message. Absent this program, blood pressure was monitored solely through an office visit. A 2019 study of the Heart Safe Motherhood program documented increases in blood pressure readings among all patients: rising from 70 percent to 91 percent in non-Black patients and from 33 percent to 93 percent among Black patients. Both groups experienced better quality of care and improved patient safety, and racial disparities were eliminated.[26]

Other interventions have focused on clinical and social supports provided by community health workers (CHWs). There is evidence that making Community Health Workers available—for all kinds of care—can help reduce racial disparities, in particular by improving access to care for patients who may not otherwise receive care.[27] CHW "interventions are usually focused on improving health and well-being among those communities and individuals who are members of minority groups, socially or economically marginalized, or who face geographic, language, or

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outcomes for Black birthing people 5 Am. J. Obstet. Gynecol MFM 100831 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9726646/.

[25] Heart Safe Motherhood, Home Page, https://heartsafemotherhood.org/ (last visited Nov. 11, 2024).

[26] Adi Hirshberg et al., *Text message remote monitoring reduced racial disparities in postpartum blood pressure ascertainment*, 221 Am. J. of Obstet. & Gynecol. 283, 284-85 (Sept. 2019), https://www.ajog.org/action/showPdf?pii=S0002-9378%2819%2930669-6.

[27] County Health Rankings & Roadmaps, *Community health workers* (2023), https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/community-health-workers (collecting citations).

other barriers to accessing care," and "have been shown to be effective among Blacks, Hispanics, Asian Americans, Native Hawaiians, and Pacific Islanders."[28] Through both pre- and post-natal supports, CHWs can contribute to improvements in maternal and infant health outcomes among a wide range of patient groups, including increased breastfeeding among Black women and among women of all races with lower incomes; and increased breastfeeding initiation and exclusivity as well as improved childhood immunization rates among all groups.[29]

In sum, although many of these interventions are motivated by an effort to reduce racial disparities in maternal health, the resulting changes in clinical practice routinely benefit all birthing and postpartum patients and their children.

B. Efforts to reduce disparities in cancer screenings can improve outcomes for all patients.

Early cancer detection has significant impacts on health outcomes. Thus, several studies have aimed to improve cancer screening rates and reduce racial disparities in screening. One well-studied example, the Accountability for Cancer Care Through Undoing Racism and Equity ("ACCURE") study, was designed specifically to address racial disparities between Black and White patients with breast and lung cancer. After conducting research regarding the causes of the disparities, including focus groups among patients, the participating health systems adopted multiple strategies to change how they were providing cancer care.[30] These interventions included introducing health equity training at the medical institutions, adding real-time data tracking on care quality disaggregated by patient race, collecting race-specific feedback for providers regarding treatments, and incorporating nurse navigators who worked to improve communication between

[28] *Id.*
[29] *Id.*
[30] Bridgespan Grp., *A Case Study in Anti-Racist Organizing: Closing Healthcare Disparities in Greensboro by Focusing on Structural Racism* (June 2022), https://sph.unc.edu/wp-content/uploads/sites/112/2022/07/GHDC-case-study-June-2022.pdf.

the medical center and the patients.[31] Though aimed at reducing racial disparities for Black patients, the results were significant for both Black and White patients. For instance, both groups saw measurable improvements in treatment completion for breast and lung cancer[32] and in the timeliness of lung cancer surgery due to the interventions, averaging surgery nearly two weeks sooner. Without the interventions, only 58.7 percent of Black patients and 75 percent of White patients received timely surgery, [33] but with the intervention, both groups saw improvement; 87.1 percent of Black patients and 85.4 percent of White patients received timely surgery.

Similar positive spillover effects were observed following interventions in Delaware to screen for colorectal cancer. In 2003, at the direction of the Delaware Governor and with funding from the Delaware state legislature, the Delaware Cancer Consortium initiated a statewide program aimed at reducing colorectal cancer mortality.[34] The initiative included three key components: (1) a screening program for colorectal cancer; (2) a cancer treatment program for the uninsured; and (3) an emphasis on reducing disparities in outcomes among African American patients, including through outreach programs tailored specifically to ensure that nurse navigators reach these communities. A study of that program showed that it was effective at reducing disparities in mortality rates, by bringing the African American mortality rate down to 42 percent, equal to the mortality rates for White patients. There were additional benefits for both African Americans and

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[31] *Id.*

[32] Samuel Cykert et al., *A Multi-faceted Intervention Aimed at Black-White Disparities in the Treatment of Early Stage Cancers: The ACCURE Pragmatic Quality Improvement trial*, 112 J. Nat'l Med. Ass'n. 468 (2020), https://pubmed.ncbi.nlm.nih.gov/30928088/.

[33] Marjory Charlot et al., *Effect of an Antiracism Intervention on Racial Disparities In Time to Lung Cancer Surgery*, 40 J. Clinical Oncology 1755 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9148687/.

[34] Stephen S. Grubbs et al., *Eliminating Racial Disparities in Colorectal Cancer in the Real World: It Took a Village*, 31 J. Clinical Oncology 1928 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3661932/.

White patients, including that between 2002 and 2009 the overall colorectal screening rates for *all* Delawareans age 50 and up increased from 57 percent to 74 percent. Moreover, incidence rates of colorectal cancer declined for both African American and White patients, decreasing from 67 percent to 45 percent for African Americans and from 58 percent to 45 percent for White patients. Another effort to reduce colorectal cancer screening rates by the healthcare organization HealthPartners in Minnesota saw similar results: between 2009 and 2022 the rates of screening for patients of color increased from 43 percent to 61.7 percent and during that same time period the rates of screening for White patients increased from over 60 percent to nearly 80 percent.[35]

C. Anti-racism plans can reduce the use of racially biased algorithms in healthcare in ways that improve quality of care for all patients.

There has been increasing evidence that certain tools and algorithms used in healthcare can exacerbate existing racial disparities, resulting in research into the efficacy and safety of these tools.[36] For example, studies of pulse oximeters have shown that they are less effective at identifying when Black and other patients with darker skin experience a drop in oxygen compared to White patients. One study, for instance, found that the pulse oximeter missed 17 percent of low oxygen episodes in Black patients compared to 6.2 percent of those in White patients.[37] While the study certainly reveals a racial disparity, it also demonstrates that oxygen monitoring could be improved for all patients. Thus, efforts like these to identify and reduce racial disparities may lead to changes that improve the accuracy of oxygen measurements that benefit all racial groups.

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[35] HealthPartners, *supra* n. 7, at 13.
[36] *See generally* Kelley Tipton et al., Agency for Healthcare Research and Quality, *Impact of Healthcare Algorithms on Racial and Ethnic Disparities in Health and Healthcare* (Dec. 2023), https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/cer-268-racial-disparities-health-healthcare-addendum.pdf (hereinafter "AHRQ, Impact of Healthcare Algorithms").
[37] Michael W. Sjoding et al., *Racial Bias in Pulse Oximetry Measurement,* 383 NEJM 2477 (2020), https://www.nejm.org/doi/full/10.1056/NEJMc2029240.

Similar spillover effects have been observed following efforts to reduce racially biased algorithms in kidney care.[38] Historically, calculations estimating the "glomerular filtration rate"—a measure of kidney function used to diagnose and monitor kidney disease—have explicitly included adjustments for race.[39] The algorithm widely used assumed that Black patients had higher levels of creatinine (a waste product that is an indicator of glomerular filtration rate) than White patients with the same kidney function.[40] This assumption was based on observational studies that found differences in creatinine levels between racial groups but did not account for other factors, such as diet.[41] To address concerns that this algorithm has resulted in significantly delayed diagnosis and care for Black patients, the National Kidney Foundation and American Society of Nephrology convened a task force that removed race from the estimated glomerular filtration rate calculation in September 2021, replacing it with overall more accurate measures based on observable, biological factors.[42]

Similar improvements have even been documented in changes to two different transplant allocation algorithms—even though transplant allocation necessarily involves distributing a finite resource (*i.e.*, organs available for transplants). First, the system for allocating kidneys for

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[38] *See* Tina Hernandez-Boussard, *Promoting Equity in Clinical Decision Making: Dismantling Race-Based Medicine*, 42 Health Aff. 1369, 1370 (2023), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2023.00545.

[39] *Id. See also* Lesley Inker et al., *A New Panel Estimated GFR, Including β_2-Microglobulin and β-Trace Protein and Not Including Race, Developed in a Diverse Population*, 77 Am. J. Kidney Dis. 673 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8102017/.

[40] Hernandez-Boussard, *supra* n. 38.

[41] *Id.*

[42] *Id.* Cynthia Delgado et al., *A Unifying Approach for GFR Estimation: Recommendations of the NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Disease* 79 Am. J. Kidney Dis. 268 (2022), https://www.ajkd.org/action/showPdf?pii=S0272-6386%2821%2900828-3; *see also* National Kidney Foundation, *NFK and ASN Release New Way to Diagnose Kidney Disease* (Sept. 23, 2021), https://www.kidney.org/press-room/nkf-and-asn-release-new-way-to-diagnose-kidney-diseases.

transplants historically had been an algorithm that prioritizes patients based on the time they had spent waiting on the waitlist.[43] In 2014, the system was recalculated to consider either the date on which patients were added to the waitlist or the date of first regular dialysis, whichever came first.[44] This change was intended to address the fact that racial and ethnic minority populations often spend more time on dialysis than White patients before being placed on the waitlist.[45] Yet, the result was that the overall waitlist rate decreased for all racial and ethnic groups. The study authors explained that this was caused by reducing a practice called "inactive waitlisting" in which providers placed patients on the waitlist who were not in fact eligible for transplant for various reasons.[46] Second, a study of the "Lung Allocation Score" showed that this tool—which does not include race as a factor—reduced the number of patients who died or became too sick for lung transplantation among both Black and White patients, while also eliminating the pre-existing racial disparity.[47]

D. The Rule encourages better language access, which research demonstrates reduces health disparities without harming care for English-speaking patients.

The Rule also explicitly encourages clinicians to use the anti-racism plans to "improve language access and accessibility to ensure services are accessible and understandable for those

[43] Hernandez-Boussard, *supra* n. 38.
[44] *Id.*
[45] *Id.*; Hannah Wesselman et al., *Social Determinants of Health and Race Disparities in Kidney Transplant*, 16 Clin. J. of the Am. Society of Nephrology 262 (2021), https://journals.lww.com/CJASN/fulltext/2021/02000/Social_Determinants_of_Health_and_Race_Disparities.14.aspx (study documenting racial disparity in prior allocation system).
[46] Xinguy Zang et al., *Racial/Ethnic Disparities in Waitlisting for Deceased Donor Kidney Transplantation One Year after Implementation of the New National Kidney Allocation System*, 18 Am. J. Transplant 1936 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6105401/; *see also* AHRQ, Impact of Healthcare Algorithms, *supra* n. 36, at 59 (summarizing study).
[47] Keith M. Wille et al., *Disparities in Lung Transplantation Before and After Introduction of the Lung Allocation Score*, 32 J. Heart Lung Transplant. 684 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3714222/; *See also* AHRQ, Impact of Healthcare Algorithms *supra* n. 36, at 59 (summarizing study).

seeking care." 86 Fed. Reg. 65,970. This approach to improving patient safety and quality of care is amply supported by the literature. Language barriers have been identified as a patient safety issue since at least 2003,[48] and are currently recognized as "one of the underlying drivers of racial/ethnic disparities" in healthcare.[49] Indeed, the National Academies of Sciences recently explained that "minoritized patients frequently report worse patient–provider communication and the prevalence of culturally and linguistically misaligned care is a well-established barrier to health equity."[50] Thus, the provision of language access services—targeted to reduce those barriers—is an evidence-based approach to reduce racial disparities.[51] Nonetheless, language access services benefit patients across racial groups: 11 percent of people in the U.S. with limited English proficiency (LEP) are White, 22 percent are Asian, and 64 percent are Hispanic.[52] Notably, language access services are defined as "any service that helps a [patient with] LEP . . . obtain the same access to and understanding of health care as a native English speaker. This includes oral interpretation, written translations, signage, and the provision of services in non-English languages by bilingual clinicians."[53]

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[48] Glenn Flores, Agency for Healthcare Research & Quality, Patient Safety Network, *Language Barrier* (2006), https://psnet.ahrq.gov/web-mm/language-barrier.

[49] Michelle Ko et al., *Managing Diversity to Eliminate Disparities: A Framework for Health*, Health Aff. (Sept. 2018), https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0438.

[50] Unequal Treatment, *supra* n. 4, at 171 (internal citations omitted).

[51] *Id.* at 176 ("The use of bilingual clinicians and professional interpreters, rather than family or untrained interpreters, has been shown to improve healthcare quality, use of preventive care, and patient satisfaction.").

[52] Sweta Haldar et al., Kaiser Fam. Found., *Overview of Health Coverage and Care for Individuals with Limited English Proficiency (LEP)* (July 7, 2023), https://www.kff.org/racial-equity-and-health-policy/issue-brief/overview-of-health-coverage-and-care-for-individuals-with-limited-english-proficiency/.

[53] Sharon E. Barrett et al., *Language Access: Understanding the Barriers and Challenges in Primary Care Settings* (2008), https://healthlaw.org/resource/language-access-understanding-the-barriers-and-challenges-in-primary-care-sett/.

In the last two decades, a robust body of research has repeatedly demonstrated both the harm from the absence of language services and the positive effects that providing language services has on quality of care, patient safety, and overall financial and administrative costs to healthcare institutions.[54] For instance, one systematic review of peer-reviewed articles on professional medical interpreters showed that the use of professional interpreters is associated with improved clinical care and can raise the quality of clinical care for LEP patients to approach or equal that for patients who have no language barriers.[55] A case study of eight hospitals likewise concluded that "using qualified interpreters means they provide better-quality care, order fewer unnecessary tests, and quite likely decrease medical errors."[56] Furthermore, language barriers are a significant source of medical malpractice lawsuits, which can impose significant costs on clinicians and medical institutions.[57]

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[54] Unequal Treatment, *supra* n. 4, at 175-76 ("A large evidence base documents the potential harms to patients with LEP who face language barriers in health care settings, including inequitable health care delivery, lower patient satisfaction, and worse health outcomes."); *see also* Shail Rawal et al., *Association between limited English proficiency and revisits and readmissions after hospitalization for patients with acute and chronic conditions in Toronto, Ontario, Canada* 322 JAMA 1605 (2019), https://jamanetwork.com/journals/jama/fullarticle/2753354; Timothy S. Anderson et al., *Association of Primary Language and Hospitalization for Ambulatory Care Sensitive Conditions*, 58 Med. Care 45 (2020), https://journals.lww.com/lww-medicalcare/abstract/2020/01000/association_of_primary_language_and.8.aspx; Ninez Ponce et al., *Linguistic Disparities in Health Care Access and Health Status Among Older Adults*, 21 J. Gen. Intern. Med 786 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924691/; Ava John-Baptiste, *The Effect of English Language Proficiency on Length of Stay and In-hospital Mortality*, 19 J. Gen. Intern. Med 221 (2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1492154/.

[55] Leah S. Karliner et al., *Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature*, 42 Health Servs. Rsch. 727 (2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955368/.

[56] Mathew Wynia & Jennifer Matiasek, Commonwealth Fund, *Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals* (2006), https://www.commonwealthfund.org/publications/fund-reports/2006/aug/promising-practices-patient-centered-communication-vulnerable.

[57] Mara Youdelman, Nat'l Health L. Program, *The High Costs of Language Barriers in Medical Malpractice* (2013),

Another example that has been repeatedly studied is the relationship between hospital lengths of stay and readmission rates and the availability of language services.[58] Language barriers can adversely affect a patient's ability to explain their symptoms, and among hospitalized patients, these barriers lead to longer hospitalizations for patients with LEP. For example, one study found that—before any intervention— individuals with LEP not receiving language services had lengths of stay that were 0.7 to 4.3 days longer than English-speaking patients with similar conditions, but that interventions that provided professional interpretation services reduced the length of hospital stays for individuals with LEP by an average of 1.5 days.[59] A recent systemic literature review concluded that, with respect to hospital readmission, "30-day readmission was clearly higher for LEP populations."[60]

Of course, reducing hospital readmissions and the lengths of hospital stays can not only improve health outcomes, but it can also reduce healthcare costs and free up hospital rooms for other patients' use.[61] In short, the evidence base shows that the provision of language services

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https://healthlaw.org/resource/the-high-costs-of-language-barriers-in-medical-malpractice/.

[58] John-Baptiste et al., *supra* n. 54; Anderson et al., *supra* n. 54; Rawal et al., *supra* n. 54; Melody K. Schiaffino et al., *Culturally and Linguistically Appropriate Hospital Services Reduce Medicare Length of Stay*, 30 Ethn. Dis. 603 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7518542/.

[59] Mary Lindholm et al., *Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates*, 27 J. Gen. Int. Med 1294 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445680/.

[60] Sylvia E. Twersky, *The Impact of Limited English Proficiency on Healthcare Access and Outcomes in the U.S.: A Scoping Review*, 12 Healthcare 364 (2024), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10855368/.

[61] *See generally*, Shazia Mehmood Siddique et al., *Interventions to Reduce Hospital Length of Stay in High-risk Populations: A Systematic Review*, JAMA Network Open, e2125846 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784338; William J. Freeman et al., Agency for HealthCare Research and Quality, *Overview of U.S. Hospital Stays in 2016: Variation by Geographic Region* (2018), https://hcup-us.ahrq.gov/reports/statbriefs/sb246-Geographic-Variation-Hospital-Stays.pdf; Kaiser Fam. Found, Hospital Adjusted Expenses per Inpatient Day (2022), https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-

improves quality of care for patients with LEP without impacting the care of English-speaking patients.

Despite the well-documented benefits of language services, many hospitals and healthcare providers do not reliably provide them. One national study of hospitals found that hospitals frequently provided notice about a patient's right to receive language services in English only. And many hospitals opted to use family members or untrained staff as interpreters.[62] Thus, interventions, such as the Rule, which encourage clinicians to adopt plans to improve language access, can have meaningful impacts on patient safety and healthcare quality.

CONCLUSION

For the reasons stated above and in Defendants' brief, *Amicus* Robert Wood Johnson Foundation respectfully urges this Court to deny Plaintiffs' motion for summary judgment and grant Defendants' cross-motion.

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[62] Unequal Treatment, *supra* n. 4, at 205.