

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

STATE OF MISSISSIPPI, *et al.*,

Plaintiffs,

v.

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

Defendants.

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

**BRIEF OF THE AMERICAN MEDICAL ASSOCIATION,
THE NATIONAL MEDICAL ASSOCIATION, AND
THE AMERICAN COLLEGE OF PHYSICIANS AS *AMICI CURIAE*
IN SUPPORT OF DEFENDANTS**

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INTERESTS OF *AMICI CURIAE*¹

The American Medical Association (“AMA”), founded in 1847, is the largest professional association of physicians, residents, and medical students in the United States. The National Medical Association (“NMA”), established in 1895, is the nation’s largest professional and scientific organization of African American physicians. It represents more than 50,000 African American physicians and their patients. American College of Physicians (“ACP”) is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Together, *Amici* have long recognized that health is a foundational element of well-being and have committed to promoting health equity. *Amici* support CMS’s definition of “health equity” to mean (among other things) “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health.”² *Amici* have a strong interest in supporting health care regulation and guidance, including anti-racism plans, to address racial inequities in health care and health outcomes evident in medical and social science data. *Amici* are uniquely qualified by their expertise and perspective as large membership organizations to present the views of the professional health care community and the relevant medical and scientific data to this Court regarding the incentive for anti-racism plans that Plaintiffs challenge in this lawsuit.

INTRODUCTION

In 2015, Congress authorized the Centers for Medicare & Medicaid Services (“CMS”) to establish a Merit-based Incentive Payment System (“MIPS”) that scores providers of health care

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

² CMS, *Health Equity*, <https://bit.ly/47bGQOu> (modified Feb. 4, 2024); *see also* AMA, *Advancing Health Equity: A Guide to Language, Narrative and Concepts* 36 (2021), <https://bit.ly/3Oxpwv1>.

services to Medicare beneficiaries along several performance measures, including “clinical practice improvement activities.” Congress defined such an activity as one that “relevant eligible professional organizations and other relevant stakeholders”—like *Amici*—“identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.”³ Such “improvement activities” are one of four MIPS categories. In 2024, to earn full credit for this category, clinicians need only complete 2 to 4 of 106 available activities. In counting anti-racism plans as one option, CMS acknowledged the need to move beyond simply documenting racial disparities and address root causes. Plaintiffs’ challenge to that decision rests on their notion that anti-racism plans “encourage[] doctors to see patients not as individuals but as sub-components of racial groups” and “to elevate faddish theories about race above patient care.” Am. Compl. [28] ¶ 6. The experience of *Amici* and the scientific literature refute that notion and support CMS’s decision.

Although race is well understood as a social construct distinct from ethnicity, genetic ancestry, or biology, there is public health consensus that longstanding systemic and social factors have led to disproportionately adverse health outcomes, including severe illness and death, among individuals identifying with historically minoritized and marginalized races and ethnicities, including Black, Native American, Indigenous, Latino, Asian American, Pacific Islander American, and others identifying as people of color. The medical and public health community widely recognizes the health harms of racism, including clinical care quality inequities for minoritized and marginalized individuals, and the efficacy of anti-racism plans to close gaps and improve clinical practice and health outcomes for *all* individuals.

³ 42 U.S.C. § 1395w-4(q)(2)(C)(v)(III).

ARGUMENT

I. *AMICI* PROMOTE ANTI-RACISM PLANS IN ORDER TO IMPROVE CLINICAL PRACTICE AND HEALTH OUTCOMES FOR ALL AMERICANS

Plaintiffs’ suit is premised on the view that anti-racism is itself discriminatory. In equating anti-racism plans with racial discrimination, Plaintiffs rely on quotations taken out of context from the work of one author (Ibram X. Kendi, Ph.D.) that “[t]he only remedy to past discrimination is present discrimination” and that such discrimination is acceptable so long as it is “antiracist” and “promotes ‘equity.’” Am. Compl. [28] ¶ 2. But Plaintiffs set up a false equivalence between race-based policies that benefit one group and deprive another, and race-conscious policies that aim to address this historical injustice by restoring or creating equal opportunity or access for all. Plaintiffs also claim that the AMA in particular “is pushing clinicians to adopt anti-racism plans” to maximize MIPS compensation. *Id.* ¶ 56. *Amici* are compelled to correct Plaintiffs’ mischaracterization both of anti-racism plans generally and of *Amici*’s own position.

Amici define anti-racism as “the active process of naming and confronting racism by changing systems, organizational structures, policies and practices and attitudes, so that power is [fairly distributed] and shared equitably.”⁴ In medicine, changing systems is a hallmark of quality improvement and patient safety,⁵ and addressing power relations has been enshrined in “shared decisionmaking” since the 1980s,⁶ to improve quality and cost⁷ through ethical practice. In *Amici*’s view, an anti-racism plan is one that remedies or prevents past, current, or future harm, whether witting or unwitting. In contrast to Plaintiffs’ views, the views of *Amici*—as “relevant eligible professional organizations and other relevant stakeholders”—are what Congress pointed to in

⁴ AMA, *Advancing Health Equity*, *supra* note 2, at 28.

⁵ Inst. for Healthcare Improvement, *Improvement Areas*, <https://bit.ly/44NFvfd> (visited Nov. 12, 2024).

⁶ Agency for Healthcare Research and Quality, Dep’t of Health & Hum. Servs., *Strategy 6I: Shared Decisionmaking*, <https://bit.ly/3Z6KR3J> (updated Apr. 2023).

⁷ Greenfield et al., *Expanding Patient Involvement In Care: Effects on Patient Outcomes*, 102 *Ann. Internal Med.* 520 (1985), <https://bit.ly/40H2w44>.

defining the term “clinical improvement activities” at issue here.⁸ *Amici* recognize that anti-racism plans are widely accepted as effective tools to “improv[e] clinical practice or care delivery,” and based on health equity research detailed in Part III, *Amici* agree with CMS that, “when effectively executed,” anti-racism plans are “likely to result in improved outcomes.”⁹ Plaintiffs may disagree with the need for or use of such plans to improve clinical practice. But the evidence shows, and *Amici* and other relevant professional organizations recognize, that such plans are designed to—and do—improve clinical practice and thus fall well within the “improvement activities” Congress authorized CMS to consider for MIPS purposes.¹⁰

Amici are committed to improving health care practice in the United States, including addressing inequities disproportionately leading to adverse health outcomes in marginalized populations. The AMA has called for “acknowledging the harm caused by racism and unconscious bias within medical research and health care” and “identifying tactics to counter racism and mitigate its health effects.”¹¹ The NMA has been a leading force in advocating for equity and the elimination of disparities in health care since its founding in 1895, by addressing the health care needs of marginalized populations, increasing the number of minority physicians, and improving the overall health of the Black community. The ACP has long fought against racial disparities in health care, examining the role of racism and discrimination “as a social determinant of health while calling attention to ... the harmful consequences of racial, ethnic

⁸ 42 U.S.C. § 1395w-4(q)(2)(C)(v)(III).

⁹ *Id.*

¹⁰ *Amici* are “relevant eligible professional organizations” under the applicable statute, 42 U.S.C. § 1395w-4(q)(2)(C)(v)(III), and their support of anti-racism efforts in the provision of medical care, including anti-racism plans, long predates CMS’s inclusion of anti-racism plans as an optional clinical practice improvement activity.

¹¹ AMA, Press Release, *New AMA Policy Recognizes Racism as a Public Health Threat* (Nov. 16, 2020), <https://bit.ly/3OB8BZH>.

and gender disparities in health and health care.”¹² *Amici* have worked together in recent decades on their shared goal of advancing equity in medicine, pursuing joint statements, amicus briefs, educational programming, and other advocacy efforts to improve access to health care, promote diversity in the medical profession, and address social drivers of health. Their Commission to End Health Care Disparities, joined by 37 public health, state, and medical specialty societies and other organizations, is committed to tackling health disparities.¹³ Ongoing collaboration offers hope for a more equitable and inclusive health care system for all.

Contrary to Plaintiffs’ assertion, *Amici* are not “pushing” (Am. Compl. [28] ¶ 56) or otherwise coercing medical practitioners to adopt anti-racism plans, but rather providing evidence-based recommendations. To that end, *Amici* encourage clinicians to *voluntarily* create and implement anti-racism plans, because such plans have been shown to improve clinical practice and health outcomes broadly in society, and close gaps for minoritized and marginalized populations.

II. MARGINALIZED POPULATIONS ARE AT INCREASED RISK FOR ADVERSE HEALTH OUTCOMES

Plaintiffs ignore an odious reality: Racism is a threat to public health.¹⁴ Racial and ethnic inequities in health outcomes are well documented, and persist “even when access-related factors, such as patients’ insurance status and income, are controlled.”¹⁵ To better understand these health disparities, Congress commissioned a study by the Institute of Medicine (renamed the National

¹² ACP, *Commitment to Being an Anti-Racist, Diverse, Equitable, and Inclusive Organization* (Sept. 28, 2020), <https://bit.ly/4hLK9RG>.

¹³ AMA, *The History of African Americans and Organized Medicine*, <https://bit.ly/3Oy8TAd> (updated Feb. 2, 2024).

¹⁴ CDC, *Impact of Racism on our Nation’s Health* (updated June 20, 2024) (“Racism, both structural and interpersonal, are fundamental causes of health inequities, health disparities and disease. The impact of these inequities on the health of Americans is severe, far-reaching, and unacceptable.”), <https://bit.ly/4f7O49E>; Jones, 2020 Bray Health Leadership Lecture, *Racism is a Public Health Crisis: Now That We See, What Do We Do?* (Oct. 5, 2020), <https://bit.ly/3YeOKCP>; CDC, *Media Statement from CDC Director Rochelle P. Walensky, MD, MPH, on Racism and Health* (Apr. 8, 2021), <https://bit.ly/4f10A5Z>.

¹⁵ Inst. of Med., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care 1* (Smedley et al. eds., 2003) (“*Unequal Treatment*”); see also Hill, *Inequality and African-American Health* 11, 22 (2016).

Academy of Medicine in 2015) to “[a]ssess the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care (*e.g.*, ability to pay or insurance coverage)” and “[e]valuate potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels.”¹⁶ Building on the 1985 “Heckler” Report of the Secretary’s Task Force on Black and Minority Health that brought wide attention to disparities in health outcomes,¹⁷ the Institute of Medicine’s findings marked a turning point in awareness among the medical community of the adverse impact of racism on quality of clinical care.

Extensive medical and scientific literature on social drivers of health explains the racial and ethnic inequities in health care in the United States.¹⁸ First, the legacy of this country’s long history of racist policies—such as segregation and persistent inequities in housing, employment, access to health care, and other life opportunities—has led to adverse health outcomes for racial and ethnic groups marginalized by systems and structures.¹⁹ Second, racism and implicit bias in medicine have resulted in lower quality health care for minoritized and marginalized individuals.²⁰

A. The Higher Rates of Adverse Health Outcomes Experienced by Minoritized and Marginalized Individuals Are Tied to Social Drivers of Health, and Are Not Primarily Accounted for by Other Observable Risk Factors

Crucially, inequities in health outcomes for minoritized and marginalized individuals “do

¹⁶ *Unequal Treatment*, *supra* note 15, at 1.

¹⁷ Dep’t of Health & Hum. Servs., *Nearly 40 Years of Advancing Health Equity*, bit.ly/4dIdbhY (visited Nov. 12, 2024); Agency for Healthcare Research and Quality, *Chartbook on Health Care for Blacks, Part 2: Trends in Priorities of the Heckler Report*, <https://bit.ly/3KinrIk> (June 2018).

¹⁸ See generally CDC, *Social Determinants of Health: Know What Affects Health*, <https://bit.ly/3IWQXd3> (Jan. 17, 2024) (defining “social determinants” of health as “nonmedical factors that influence health outcomes”).

¹⁹ See, *e.g.*, CDC, *Racism and Health*, <https://bit.ly/4f0x8St> (updated June 20, 2024); Braveman et al., *What is Health Equity?*, Robert Wood Johnson Found. (May 2017), <https://rwjf.ws/3Gkedjx>; Afifi et al., *‘Most At Risk’ for COVID19? The Imperative to Expand the Definition from Biological to Social Factors for Equity*, 139 *Preventive Med.* 106229 (2020).

²⁰ See Vela et al., *Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs*, 43 *Ann. Rev. Pub. Health* 477 (June 7, 2022), <https://bit.ly/48sGLXL>; O’Reilly, *AMA: Racism Is a Threat to Public Health*, *Am. Med. Ass’n* (Nov. 16, 2020), <https://bit.ly/35xEoGE>.

not arise from bad individual choices or biological differences between races but the social factors that shape people’s lives every day.”²¹ Numerous social drivers of health have historically prevented people of color, and Black individuals in particular, from having the same opportunities as white individuals to attain good physical health.²² Studies have linked historical slavery to current health outcomes, with counties that had slavery in 1860 experiencing higher current stroke mortality overall, among both Black and white residents, compared to counties that did not have slavery in 1860.²³ Historical higher density of enslaved populations is connected to current higher stroke mortality²⁴ and shorter life expectancy²⁵ among Black residents.

Living in a racially segregated community is a prime example of a negative social determinant of health. Greater segregation is connected to lower life expectancy for Black neighborhood residents.²⁶ Inequitable life conditions, substantially driven by residential segregation, have adverse health impacts. For example, disproportionate concentration of pollution causes more, and more severe, asthma.²⁷ Concentrated industrial exposures cause disproportionate

²¹ 2 *COVID-19 Policy Playbook* 7 (Burris et al. eds., 2021) (“*COVID-19 Policy Playbook*”); see also Paradies, *A Systematic Review of Empirical Research on Self-Reported Racism and Health*, 35 *Int’l J. Epidemiology* 888, 888 (2006) (“The manifestations of racism ... in general ensue from societal systems that produce an unequal distribution of power (and hence resources) in societies based on the notion of ‘race’, where race is a social rather than a biological construct related to the notion of essentialized innate phenotypical, ancestral, and/or cultural difference.”).

²² CDC, *Racism and Health*, *supra* note 19; Weinstein et al., eds., *Communities in Action: Pathways to Health Equity* 3 (Nat’l Acad. Press 2017), bit.ly/3AoIznY (collecting sources linking structural inequities—not biological differences—to persistent racial disparities in health such as low birthweight and higher infant mortality, IQ differences due to lead exposure, among others)

²³ Reece, *Life Expectancy for Black People Living in Former Slave Counties Is Considerably Lower Than the Life Expectancy for White People, Even after Taking a Whole Host of Factors into Account*, Pop. Res. Ctr., Univ. Texas at Austin (June 2022), <https://bit.ly/3YKKbC2>.

²⁴ Esenwa et al., *Historical Slavery and Modern-Day Stroke Mortality in the United States Stroke Belt*, 49 *Stroke* 465, 466 (2018).

²⁵ Reece, *Slave Past, Modern Lives*, 53 *J. Black Studies* 677, 693-695 (Oct. 2022), <https://bit.ly/3YfZ1yq>.

²⁶ Khan et al., *Associations Between Neighborhood-Level Racial Residential Segregation, Socioeconomic Factors, and Life Expectancy in the US*, 4 *JAMA Health Forum* e231805, at 2 (July 14, 2023).

²⁷ Martinez et al., *Structural Racism and its Pathways to Asthma and Atopic Dermatitis*, 148 *J. Allergy & Clinical Immunology* 1112, 1115 (2021).

cancer outcomes.²⁸ And unsafe water supplies cause disproportionate lead exposures and related health outcomes.²⁹ Poverty, also concentrated in racially segregated areas,³⁰ is linked to adverse health outcomes. Child poverty “has a profound effect on ... birth weight, infant mortality, language development, chronic illness, environmental exposure, nutrition, and injury[,] ... influences genomic function and brain development by exposure to toxic stress,” and increases risk “of difficulties with self-regulation and executive function, such as inattention, impulsivity, defiance, and poor peer relationships.”³¹ Housing in segregated communities is disproportionately poorer quality and more crowded.³² Racially segregated neighborhoods also have lower quality schools—another factor linked to adverse health outcomes.³³ Segregation has also been linked to later-stage diagnosis of cancers and lower cancer survival rates.³⁴

Racial and ethnic inequities in employment opportunities lead to adverse health outcomes, with minoritized and marginalized individuals disproportionately working jobs that pay less, leaving less money to spend on health care,³⁵ and provide no or lesser health insurance,³⁶ while requiring in-person work in health care, service, and retail occupations as well as longer commutes

²⁸ James et al., *Uneven Magnitude of Disparities in Cancer Risks from Air Toxics*, 9 Int’l J. Environ. Res. Public Health 4365 (2012), [bit.ly/3Adti9H](https://doi.org/10.3390/ijerph9114365).

²⁹ Mizelle, *A Slow-Moving Disaster—The Jackson Water Crisis and the Health Effects of Racism*, 388 New Eng. J. Med. 2212, 2212-2213 (2023).

³⁰ Wang et al., *The Association of Residential Racial Segregation with Health Among U.S. Children: A Nationwide Longitudinal Study*, 19 SSM Population Health 101250 (2022); Massey & Fischer, *How Segregation Concentrates Poverty*, 23 Ethnic & Racial Stud. 670, 671 (2000).

³¹ Gitterman et al., *Poverty and Child Health in the United States*, 137 Pediatrics e20160339, at 1-2 (2016).

³² *Id.*; CDC, *Racism and Health*, *supra* note 19.

³³ Braveman et al., *What is Health Equity?*, *supra* note 19, at 5.

³⁴ Zhang et al., *Association of Residential Racial and Economic Segregation With Cancer Mortality in the US*, 9 JAMA Oncol. 122 (Nov. 17, 2022), [https://bit.ly/48AQHhR](https://doi.org/10.1001/jamaoncol.2022.4884).

³⁵ U.S. Dep’t of Labor, Women’s Bureau, *Median Annual Earnings by Sex, Race and Hispanic Ethnicity*, <https://bit.ly/3rhy5PX> (visited Nov. 12, 2024); *see also* Williams et al., *Racism and Health*, 40 Ann. Rev. Pub. Health 105, 108 (2019) (“In 2016, for every dollar of income that white households received, Hispanics earned 73 cents and blacks earned 61 cents.”).

³⁶ Huberfeld & Watson, *Lessons Learned*, in 2 *COVID-19 Policy Playbook* 89, *supra* note 21, at 90.

on public transportation—factors that increased risk of exposure to COVID-19.³⁷

Across all social determinants of health, stress is a primary pathway for disparate health outcomes. Chronic stress “degrades physiological systems,” resulting in “greater susceptibility to pathogens” and decreased “effectiveness of the immune system and resistance to infections, leading to serious illnesses.”³⁸ Researchers “have documented a direct link between social stress and sickness, with stressful life events predicting illnesses as serious as heart disease.”³⁹ Racism, discrimination, and inequitable living circumstances can cause chronic stress, linked to an array of poor health outcomes through various psychophysiological pathways.⁴⁰

The daily experience of racial and ethnic discrimination is a social determinant of health, with extensive research documenting a direct negative impact on health over time through “weathering” (*i.e.*, “early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization”).⁴¹ “Discrimination is not necessarily conscious, intentional or personal; often it is built into institutional policies and practices,” but such “unconscious bias in interpersonal interactions is [nevertheless] strong, widespread, and deeply rooted.”⁴² A review of 138 studies clearly linked racism and adverse health impacts for oppressed racial groups, even after adjusting for

³⁷ Galea, *Introduction: Politics, Policies, Laws, and Health in a Time of COVID-19*, in 2 *COVID-19 Policy Playbook* 11, *supra* note 21, at 12; Gould & Shierholz, *Not Everybody Can Work from Home*, Economic Policy Inst., Working Economics Blog (Mar. 19, 2020), <https://bit.ly/3Yjkyq8> (noting that only 16.2% of Hispanic workers and 19.7% of black workers are able to telework, compared to 30.7% of white workers and 37.0% of Asian workers).

³⁸ Hill, *Inequality and African-American Health*, *supra* note 15, at 74.

³⁹ *Id.* at 16.

⁴⁰ Williams & Mohammed, *Discrimination and Racial Disparities in Health*, 32 *J. Behav. Med.* 20, 37 (2009); Harrell et al., *Multiple Pathways Linking Racism to Health Outcomes*, 8 *Du Bois Rev.* 143, 143 (2011); Hill, *Inequality and African-American Health*, *supra* note 15, at 5.

⁴¹ Geronimus et al., “Weathering” and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States, 96 *Am. J. Pub. Health* 826, 826 (2006).

⁴² Braveman et al., *supra* note 19, at 5.

confounding factors.⁴³ Studies found that more than 90% of Black individuals reported having experienced racial discrimination,⁴⁴ that exposure to discrimination and segregation during childhood predicts adult inflammation with an effect “considerably more robust than that of traditional health risk factors such as diet, exercise, smoking, and low [socioeconomic status],”⁴⁵ and that the adverse health effects of “weathering” persist even when controlling for upward mobility and wealth.⁴⁶

B. Minoritized and Marginalized Individuals Receive Lower Quality Health Care and Reduced Access to Treatments Due to Medical Racism and Bias

Racism against minoritized and marginalized individuals within the health care system also results in adverse health outcomes. In exercising independent judgment to determine the appropriate treatment for individual patients, medical professionals may sometimes need to consider race and ethnicity—as a proxy for racism—alongside other relevant factors.⁴⁷

Health care inequities are “undesirable differences in outcomes or care and are generally not driven by informed differences in expressed patient preference.”⁴⁸ Numerous studies show that minoritized and marginalized patients—and Black patients in particular—receive lower quality treatment by health care providers, “even when variations in such factors as insurance status,

⁴³ Paradies, *A Systemic Review*, *supra* note 21, at 895.

⁴⁴ Hill, *Inequality and African-American Health*, *supra* note 15, at 16.

⁴⁵ Simons et al., *Discrimination, Segregation, and Chronic Inflammation*, 54 *Developmental Psych.* 1993, 1994 (2018); *see also* Kuzawa & Sweet, *Epigenetics and the Embodiment of Race*, 21 *Am. J. Hum. Biology* 2, 2 (2009) (“[E]nvironmentally responsive phenotypic plasticity, in combination with ... acute and chronic effects of social-environmental exposures,” better explains the “persistence of [cardiovascular disease] disparities between members of socially imposed racial categories” than does genetics.).

⁴⁶ Geronimus et al., *“Weathering” and Age Patterns*, *supra* note 41, at 829-830.

⁴⁷ *See* AMA, Press Release, *supra* note 11.

⁴⁸ Bryant, *Racial and Ethnic Inequities in Obstetric and Gynecologic Care and Role of Implicit Biases*, Patient Safety Network, <https://bit.ly/4f6jUUx> (updated July 2, 2024); *see also* Harris, *Cultural Competence*, 33 *J. Health & Hum. Servs. Admin.* 2, 4 (2010) (defining health disparities as “differences in treatment experienced in the quality of health care received by racial and/or ethnic minorities even when access to care is equal.”).

income, age, co-morbid conditions, and symptom expression are taken into account.”⁴⁹ Black and other patients of color are less likely than white patients to receive preventive care and routine medical procedures,⁵⁰ and Black patients are treated less for pain than white patients.⁵¹ Race-based kidney function adjustments based on false ideas about differences in muscle mass have resulted in Black people being denied access to dialysis and transplants.⁵² Physicians refer white patients to a specialist almost twice as often as Black patients.⁵³ Although Black patients are three times as likely to develop and twice as likely to die from cardiovascular disease, they are more likely than white patients “to receive older conservative coronary treatments than newer or more expensive therapies [that are] more readily available to white [patients].”⁵⁴

Minoritized and marginalized patients are sometimes denied care due to racially biased algorithms. For example, racial biases in pulse oximeters make Black patients nearly three times as likely as white patients to have undetected low oxygen levels, which can negatively impact treatment for COVID-19.⁵⁵ Although Black individuals have more chronic illnesses than white individuals (despite similar risk scores), algorithms have referred healthier white patients to care

⁴⁹ *Unequal Treatment*, *supra* note 15, at 1, 2-3; *see also* Matthew, *Just Medicine* 35 (2015) (“*Just Medicine*”).

⁵⁰ *Unequal Treatment*, *supra* note 15, at 123; Chin, *Using Patient Race, Ethnicity, and Language Data to Achieve Health Equity*, 30 *J. Gen. Intern. Med.* 703 (2015), <https://bit.ly/3Cd59Ri>; Wynia et al., *Collecting and Using Race, Ethnicity and Language Data in Ambulatory Settings* 6, *Comm’n to End Health Care Disparities* (2011); *Just Medicine*, *supra* note 49, at 1.

⁵¹ Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 *PNAS* 4296, 4296 (2016); *Just Medicine*, *supra* note 49, at 61, 95.

⁵² Ahmed et al., *Examining the Potential Impact of Race Multiplier Utilization in Estimated Glomerular Filtration Rate Calculation on African-American Care Outcomes*, 36 *J. Gen. Intern. Med.* 464, 470 (2021); *see also* 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://bit.ly/48QyahU>.

⁵³ Hill, *Inequality and African-American Health*, *supra* note 15, at 91.

⁵⁴ *Just Medicine*, *supra* note 49, at 57-58.

⁵⁵ Winny & Jurmo, *The Problem with Pulse Oximeters: A Long History of Racial Bias* (July 8, 2024), <https://bit.ly/3NOZSBL>; Sjoding et al., *Correspondence: Racial Bias in Pulse Oximetry Measurement*, 383 *New Eng. J. Med.* 2477 (2020).

management programs more than less healthy black patients, due to racial biases in data collection.⁵⁶ There is racial bias in clinical algorithms physicians use, such as who gets heart surgery or requires kidney treatment. Consequently, Black and, in certain circumstances, Latino patients are less likely to get proper care.⁵⁷

These inequities are widespread. A report from the Commonwealth Fund found deep-seated racial health disparities in all 50 states. Such disparities are nowhere more pronounced than in Mississippi where, for example, Black individuals and American Indian/Alaskan Native individuals are more likely to die early in life from conditions that are treatable with timely access to high quality health care.⁵⁸ In Mississippi, Black women experience maternal mortality rates four times higher than white women, and one study shows that 92.3% of these pregnancy-related deaths were preventable.⁵⁹ Mississippi also has the nation's highest fetal and infant mortality and pre-term death rates.⁶⁰

The NMA has been responding to inequities in health care throughout its history. Although the reasons for disparate health outcomes are numerous and complex, research shows that health care inequities are due not only to social factors, but also to exposure to racism within the medical system.⁶¹ One study found that 73% of “white medical students and residents ... hold beliefs about biological differences between” Black and white people, “many of which are false

⁵⁶ Obermeyer et al., *Dissecting racial bias in an algorithm used to manage the health of populations*, 366 *Science* 447, 447-448 (2019) (“At a given risk score, Black patients are considerably sicker than White patients, as evidenced by signs of uncontrolled illnesses. Remedying this disparity would increase the percentage of Black patients receiving additional help from 17.7 to 46.5%.”).

⁵⁷ Vyas et al., *Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms*, 383 *New Eng. J. Med.* 874 (2020).

⁵⁸ Radley et al., *Advancing Racial Equity in U.S. Health Care: The Commonwealth Fund 2024 State Health Disparities Report* (Apr. 2024), <https://bit.ly/4eq9rSC>.

⁵⁹ Mississippi State Dep't of Health, *Mississippi Maternal Mortality Report 2016-2020*, at 7 (Dec. 2023).

⁶⁰ Ely & Driscoll, CDC, *Infant Mortality in the United States, 2022: Data from the Period Linked Birth/Infant Death File*, 73 *Nat'l Vital Statistics Rep.* 1, at 1, 5, (July 25, 2024).

⁶¹ See, e.g., AMA, Press Release, *supra* note 11; Rees, *Structural Racism In Historical And Modern US Health Care Policy*, Health Affairs (Feb. 2022), <https://bit.ly/40L3Ym6>.

and fantastical in nature, and that these false beliefs are related to racial bias in pain perception.”⁶² Another study found that among children who visited emergency departments, Black and Latino children were less likely to “have their care needs classified as immediate/emergent” and “experienced significantly longer wait times and overall visits as compared to white [children],”⁶³ and the “difference could not be fully explained by possible confounding factors available in the dataset, such as demographic, socioeconomic, or clinical variables.”⁶⁴ Additionally, Black residents have higher life expectancy and lower all-cause mortality in counties where Black physicians make up a greater proportion of the primary care workforce.⁶⁵

Since 2007, research has shown that physicians’ implicit bias contributes to racial and ethnic disparities in the use of medical procedures.⁶⁶ A study showed that higher scores on the Implicit Association Test—a test that measures implicit bias—decreased physicians’ likelihood of treating Black patients with thrombolysis.⁶⁷ A systematic review of 15 studies measuring implicit bias and health outcomes confirmed that health care professionals hold the same level of implicit bias against Black, Latino, and dark-skinned people as the general population, and that “implicit bias was significantly related to patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes.”⁶⁸ A systematic review of 37 studies confirmed the substantial evidence of “pro-[w]hite or light-skin/anti-Black, Hispanic, American

⁶² Hoffman, *supra* note 51, at 4299.

⁶³ Zhang et al., *Racial and Ethnic Disparities in Emergency Department Care and Health Outcomes Among Children in the United States*, 7 *Frontiers in Pediatrics* 1, at 1 (Dec. 19, 2019).

⁶⁴ *Id.* at 5.

⁶⁵ Snyder et al., *Black Representation in the Primary Care Physician Workforce and its Association with Population Life Expectancy and Mortality Rates in the US*, 6 *JAMA Network Open* e236687, at 8 (Apr. 14, 2023).

⁶⁶ Green et al., *Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 *Soc’y of Gen. Internal Med.* 1231, 1231 (2007).

⁶⁷ *Id.*

⁶⁸ Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes*, 105 *Am. J. Pub. Health* e60, e60 (2015).

Indian or dark-skin bias among a variety of [health care professionals] across multiple levels of training and disciplines.”⁶⁹

Studies show that implicit bias influences behavior more directly than conscious bias.⁷⁰ Most health care professionals “are low in explicit and high in implicit” bias.⁷¹ In other words, many health care professionals unconsciously hold negative biases against minoritized and marginalized groups, and these negative biases may cause them to provide—even if entirely unintentionally—a lower quality of care to their minoritized and marginalized patients. Consistent with this evidence, the CDC has identified “potential biases in prescribing practices” as one reason for the observed racial and ethnic disparity in COVID-19 treatment.⁷²

III. ANTI-RACISM INITIATIVES ARE ESSENTIAL TO IMPROVING CLINICAL PRACTICE AND HEALTH OUTCOMES FOR ALL PATIENTS

Strategies based on ignoring group differences do not eliminate bias, but making health care professionals aware of their own biases and stereotypes can mitigate bias.⁷³ High-quality care is equitable care that improves outcomes for everyone while also closing gaps for communities that are minoritized or marginalized by social systems and structures.

A. Anti-Racism Plans Are Widely Accepted Tools for Addressing Health Inequity

Despite the claims made by Plaintiffs, anti-racism plans do not constitute racism against white individuals, and *Amici* do not encourage or condone racism in any form. Nothing in the design or effect of anti-racism plans promotes racism. Rather, the goal of health equity initiatives, including anti-racism plans, is to ensure fairness in health care.

⁶⁹ Maina et al., *A Decade of Studying Implicit Racial/Ethnic Bias in Healthcare Providers Using the Implicit Association Test*, 199 Soc. Sci. & Med. 219, 219 (2018).

⁷⁰ *Just Medicine*, *supra* note 49, at 39.

⁷¹ Van Ryn et al., *The Impact of Racism on Clinician Cognition, Behavior, and Clinical Decision Making*, 8 Du Bois Rev. 199, 204 (2011).

⁷² Wiltz et al., *Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021*, 71 MMRW 96, 99 (2022).

⁷³ *Just Medicine*, *supra* note 49, at 66-67, 165, 167.

To that end, anti-racism plans involve strategies that “include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one.”⁷⁴ Anti-racism actions can come in many forms, including “individual transformation, organizational change, community change, movement-building, anti-discrimination legislation and racial equity policies in health, social, legal, economic and political institutions.”⁷⁵ In a health care setting, anti-racism plans may involve, for example, “a clinic-wide review of existing tools and policies,”⁷⁶ “increas[ing the] capture and accuracy of race/ethnicity data in patient records,”⁷⁷ or creating “easy-to-understand print ... in the languages most commonly used by ... patient populations (e.g., English, Spanish, and Mandarin).”⁷⁸ Institutional anti-racism plans can be comprehensive or specific to a service line or initiative.

Under the CMS rule at issue, providers need only adopt two to four activities, and an anti-racism plan is one of more than 100 improvement activities that providers may choose to adopt, and only one of ten possible activities designed specifically to advance health care equity.⁷⁹ Contrary to Plaintiffs’ allegations, anti-racism plans and other measures to achieve health equity

⁷⁴ 86 Fed. Reg. 64,966, 65,969 (Nov. 19, 2021).

⁷⁵ 86 Fed. Reg. at 65,969; see e.g., Assoc. Am. Med. Coll., *Diversity, Equity & Inclusion Competencies Across the Learning Continuum* (2022), <https://bit.ly/3YS19NM>.

⁷⁶ 86 Fed. Reg. at 65,969; Bryant et al., *A Health System Framework for Addressing Structural Racism: Mass General Brigham’s United Against Racism Initiative*, 7 Health Equity 533 (2023), <https://bit.ly/3CkNtmO>; Nat’l Alliance to Impact the Social Determinants of Health, *A Framework for Promoting Equity & Excellence in Healthcare, Raising the Bar* (2022), <https://bit.ly/3O81yqh>.

⁷⁷ Univ. of Rochester Med. Ctr., *Equity & Anti-Racism Action Plan: FY2021 to FY2025* (Sept. 30, 2022), <https://bit.ly/3K153bj>; see also Williams et al., *Antiracist Documentation Practices—Shaping Clinical Encounters and Decision Making*, 389 N. Engl. J. Med. 1238, 1244 (Sep. 28, 2023), <http://bit.ly/48PT0ho>.

⁷⁸ Oregon Health & Science Univ. Med. Sch., *Diversity, Equity, Inclusion and Anti-Racism Strategic Action Plan 2021 – 2025*, at 14 (2021), <https://bit.ly/3OO2G3D>; see also Seattle Children’s Health Equity and Anti-Racism Action Plan Progress, <https://bit.ly/3CqHNrp> (visited Nov. 12, 2024) (“expand[ing] families’ ability to request interpretation support as needed in real time”).

⁷⁹ As of 2024, an anti-racism plan is only one of 106 improvement activities recognized as part of the MIPS assessment, which also includes 196 quality measures, 38 measures for promoting interoperability in electronic health record systems, and 29 cost measures. See CMS, *Explore Measures & Activities*, <https://bit.ly/478AmA5> (visited Nov. 12, 2024).

do not advocate racism. Under the rule, if a provider chooses to adopt an anti-racism plan, that “should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines,” as well as steps to remedy the “issues and gaps” identified in that review, but those broad outlines permit a variety of tools and strategies to help counteract racism and implicit bias that may otherwise affect clinical practice and decision-making and lead to adverse health outcomes for minoritized and marginalized individuals.⁸⁰

Such anti-racism strategies are already widespread in health care, and many organizations have helped to elaborate frameworks relevant to the development of anti-racism plans in the clinical setting. These organizational frameworks include, among many others:

- **American Hospital Association’s Health Equity Roadmap.** A “national initiative to drive improvement in health care outcomes, health equity, diversity and inclusion,” the Equity Roadmap identifies six levers of transformation, including culturally appropriate patient care, equitable and inclusive organizational policies, collection and use of data to drive action, diverse representation in leadership and governance, community collaboration for solutions, and systemic and shared accountability.⁸¹
- **Healing ARC.** Formed by a prominent group of health care professionals, The Healing Arc (Acknowledgment, Redress, and Closure) uses race-conscious interventions to create an environment “[where hospitals and health centers] in Massachusetts treat ALL patients with dignity, respect, and fairness,” by “addressing the institutional racism that prevents some, particularly those in communities of color, from receiving equal care.”⁸²
- **Rise to Health Coalition.** The Coalition is led by the AMA and the Institute for Health

⁸⁰ 86 Fed. Reg. at 65,969.

⁸¹ Am. Hospital Ass’n Inst. for Diversity and Health Equity, *The Health Equity Roadmap*, <https://bit.ly/4541v1F> (visited Nov. 12, 2024).

⁸² *The Healing Arc*, <https://bit.ly/44UMgMf> (visited Nov. 12, 2024).

Improvement in partnership with several organizations, including the National Committee for Quality Assurance responsible for several MIPS quality measures. Focusing its work on four impact areas—access, workforce, social and structural drivers of health, and quality and safety—the Coalition outlines six steps groups can take to advance a vision of equitable health in which “all people have the power, circumstances, and resources to achieve optimal health.”⁸³

- **American Academy of Pediatrics (AAP).** In its book *Untangling the Thread of Racism*, the AAP includes a chapter on “Using Racial Equity Policy Tools to Further Anti-Racism in Pediatrics.” The chapter notes that “addressing the racist policies of the institutional environment is given little attention” and that “[s]tructural change is required to embrace anti-racism in multiple settings.” The chapter then “provides the key components of racial equity tools and, through a case study example, illustrates how to apply racial equity tools in pediatric settings.”⁸⁴
- **United Against Racism.** Led by Mass General Brigham, this initiative declares that “systemic racism is a public health issue which impacts our patients, workforce, and the communities we serve” and commits to “dismantling the barriers, systems, and actions inside and outside our walls to provide excellent medical care and equity for all.” Key actions include “increas[ing] diversity on system and institution boards,” “improv[ing] the collection of race/ethnicity and language clinical data,” “develop[ing] system-wide anti-racism education,” “creat[ing] multilingual correspondence,” and “ensur[ing] equitable

⁸³ Rise to Health Coalition, *Together, We Can Create Health Care that Cares for All of Us*, <https://bit.ly/3Koug4u> (visited Nov. 12, 2024).

⁸⁴ Heard-Garris & Heard, *Using Racial Equity Policy Tools to Further Anti-Racism in Pediatrics*, in *Untangling the Thread of Racism: A Primer for Pediatric Health Professionals* (Trent et al. eds., Am. Acad. of Pediatrics 2023), <https://bit.ly/3ACnbf6>.

access to virtual health services.”⁸⁵

Individual providers have also contributed recognized anti-racism frameworks for training in medicine,⁸⁶ as well as teaching anti-racism in the clinical setting.⁸⁷

B. Anti-Racism Plans Advance Equitable Health Care

Amici view commitment to anti-racism as a public good that improves health outcomes for *all* of society and closes gaps. The impact of anti-racism plans is demonstrably positive, with many accreditation agencies, professional societies, public health institutions, and health systems using anti-racism plans to improve clinical practice and health outcomes. For example:

- The Accountability for Cancer Care Through Undoing Racism and Equity (ACCURE) project implemented an anti-racism intervention consisting of training, data tracking, and feedback for providers at health care facilities in Greensboro, North Carolina and Pittsburgh, Pennsylvania. The intervention nearly eliminated the 7-percentage-point gap in treatment completion rates between Black and white patients, improving cancer outcomes for both Black and white patients.⁸⁸
- HealthPartners, a Minnesota-based health care and insurance provider, sent stool sample test kits to patients of color with no history of colon cancer screening, resulting in a 3.5-point increase in screening, reducing the disparity gap in colon cancer screening between patients of color and white patients.⁸⁹ HealthPartners also created an Equity, Inclusion and Anti-Racism Cabinet to increase equity, improving diversity

⁸⁵ Mass General Brigham, *United Against Racism*, <https://bit.ly/3O30xj0> (visited Nov. 12, 2024).

⁸⁶ Manchanda et al., *Training to Build Antiracist, Equitable Health Care Systems*, 25 *AMA J. Ethics* E37-47 (2023), <https://bit.ly/4hLH1VW>; Monroe et al., *Antiracism Training in Medicine*, 1 *JAMA Health Forum* e201477, at 1-2 (Dec. 3, 2020).

⁸⁷ Wang et al., *Teaching Anti-Racism in the Clinical Environment*, 136 *Am. J. Med.* 345, 348-349 (2023).

⁸⁸ The Bridgespan Group, *A Case Study in Anti-Racist Organizing* 10-12 (2022), <https://unc.live/45e9HQx>.

⁸⁹ HealthPartners, Press Release, *HealthPartners Recognized for Colorectal Cancer Screening Efforts* (Mar. 29, 2018), <https://bit.ly/3OkuECi>.

- in its workforce, eliminating gaps in COVID-19 vaccination rates, and making progress in closing gaps in breast cancer screening.⁹⁰
- The New York City Department of Health and Mental Hygiene “formed the Coalition to End Racism in Clinical Algorithms (CERCA), a health system consortium charged with eliminating clinical practices and policies that perpetuate racism.... Given the disproportionately higher rates of chronic kidney disease risk factors, estimated glomerular filtration rate (eGFR) was prioritized for change.... This collaborative process enabled [the consortium] to tackle ... concerns and successfully eliminate race as a coefficient in the eGFR algorithm.”⁹¹
 - The Ohio State University’s Wexner Medical Center and Health Science Colleges created an Anti-Racism Action Plan, which established anti-racism goals to improve health equity and created action groups to monitor their progress. In Ohio, for example, Black infants are more than 2.4 times more likely to die from prematurity-related conditions than white infants.⁹² The Plan saw a decrease in infant mortality rates in marginalized neighborhoods, an increase in flu vaccination rates in minoritized communities, and improvement in colorectal cancer screening rates in Black patients.⁹³
 - A 2020 study of hospitals in California and Florida on their culturally and linguistically appropriate services found that hospitals offering such services experienced shorter

⁹⁰ HealthPartners, *Equity, Inclusion and Anti-Racism Report to the Community 2*, 7, 11-12 (2023), <https://bit.ly/3DIozus>.

⁹¹ Boutin-Foster et al., *Promoting Anti-Racism in Clinical Practice: Lessons Learned in the Process of Removing the Race Coefficient from the Estimated Glomerular Filtration Rate Algorithm*, 7 *Health Equity* 782, 782 (2023), <https://bit.ly/4hGNO3h>.

⁹² Ohio Dep’t of Health, *2022 Infant Mortality Annual Report 5* (Jan. 2024).

⁹³ The Ohio State University Wexner Medical Center and Health Science Colleges, *Health Equity and Anti-Racism Report: HEAR 2021*, at 8, 17, 20-21 (2021).

lengths of stay than the median length of stay across all surveyed hospitals.⁹⁴

These anti-racist initiatives in health care highlight the opportunities to effectively improve clinical practice and reduce health inequities as intended by Congress and CMS.

CONCLUSION

For the reasons stated above and in Defendants' brief, *Amici* respectfully urge this Court to deny Plaintiffs' motion for summary judgment and grant Defendants' cross-motion.

⁹⁴ Schiaffino et al., *Culturally and Linguistically Appropriate Hospital Services Reduce Medicare Length of Stay*, 30 *Ethnicity & Disease* 603, 603 (2020).

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