

September 12, 2025

SUBMITTED VIA CMS Online E-filing

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1832-P, P.O. Box 8016
Baltimore, MD 21244-8016

Re: 25-13271 – Medicare and Medicaid Programs: Calendar Year 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Secretary Kennedy,

We represent the NAACP State Conferences of Alabama, Arizona, Colorado, Montana, and Wyoming, along with the Greensboro Health Disparities Collaborative (the GHDC). The NAACP State Conferences conduct programming at the state and local level to combat discrimination in health care and reduce racial health disparities by promoting health initiatives that improve health care for all. The Collaborative is a group of community leaders, advocates, scholars, clergy, and health care professionals committed to health equity who, among other things, conduct research on racial health disparities. The Collaborative helped develop and administer the Accountability for Cancer Care through Undoing Racism and Equity study—an intervention program which eliminated disparities between Black and white patients across several metrics and improved treatment outcomes for *both* groups.

In 2021, the Centers for Medicare & Medicaid Services (“CMS”) recognized that Medicare providers could make efforts to eliminate longstanding racial health disparities without worsening treatment outcomes for any particular group. CMS promulgated and finalized a rule that allowed clinicians—as one of 106 different options for receiving increased reimbursements for certain Medicare services—to “create and implement an anti-racism plan.”¹ In promulgating this rule, CMS explained that “among Medicare beneficiaries, racial and ethnic minority individuals often receive lower quality of care, report lower experiences of care, and experience more frequent hospital readmissions and procedural complications.”² And through December 2024, CMS

¹ 86 Fed. Reg. 63854 (Nov. 16, 2021); *see also* 86 Fed. Reg. 65969-70 (Nov. 19, 2021).

² 86 Fed. Reg. 65384 (Nov. 19, 2021).

defended the rule against challenges that the rule promoting “equity” in health care would somehow lead clinicians to provide some racial groups worse care than others.³

CMS now proposes to rescind eight improvement activities, including “IA_AHE_8,” the clinical improvement activity that permits clinicians to receive MIPS credit for creating and implementing an anti-racism plan.⁴⁵ CMS contends that it is removing this rule under its regulatory authority to remove an activity that “is obsolete.”⁶ According to CMS, an improvement activity is “obsolete” if it is “out of date,” “no longer reflects current clinical best practices,” “is no longer available for implementation,” or “cannot be attested to year after year with a reasonable expectation of clinical quality improvement year after year.”⁷

CMS’ proposed rule does not identify an iota of support for its suggestion that racial health disparities either no longer exist, or cannot reliably be addressed with anti-racism planning tools. To the contrary, both ideas run counter to academic literature, history, and the lived experiences of the members of the NAACP State Conferences and the GHDC.

Barely over a year ago, the National Academy of Sciences, Engineering, & Medicine published a nearly 400-page report detailing longstanding racial health disparities that persist throughout every state in the nation.⁸ “Inequities in access to care exist across all inpatient and outpatient healthcare settings, including primary care, specialty care, emergency department (ED) and other hospital-based care, and rehabilitative, long-term, and prison care facilities.”⁹ For example, although “[p]rimary care is one of the only sectors of the health care system, shown to improve health and health care equity,” “[r]acially and ethnically minoritized individuals are significantly less likely to have a usual source of primary care.”¹⁰ Evidence similarly shows “widespread inequities in access to outpatient specialty care, with the largest differences between Black and White adults for specialties such as dermatology, otolaryngology, general surgery, orthopedics, and urology.”¹¹

³ See generally *Miss. v. Becerra*, No. 1:22-cv-00113-HSO-RPM (S.D. Miss.), ECF Nos. 28 (Am. Compl.), 92 (Defs.’ Mem. in Opp’n to Plfs.’ Mot. For Summ. J.).

⁴ 90 Fed. Reg. 32352, 33180 (July 16, 2025).

⁵ CMS perplexingly refers only to the proposed rescissions’ activity codes: IA_AHE_5, IA_AHE_8, IA_AHE_9, IA_AHE_11, IA_AHE_12, IA_PM_6, IA_PM_26, and IA_ERP_3. That is perhaps because the proposed rescissions will prevent Medicare providers from receiving MIPS credit for a range of popular initiatives, like IA_AHE_5 (“MIPS Eligible Clinician Leadership in Clinical Trials or CBPR”) and IA_AHE_9 (“Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols”). *Id.*

⁶ *Id.* at 32725 (citing 42 C.F.R. § 414.1355(d)(7)).

⁷ *Id.*

⁸ See generally Georges C. Benjamin, et al., *Ending Unequal Treatment: Strategies to Achieve Equitable Health Care & Optimal Health for All*, The Nat’l Acads. Press (2024), <https://doi.org/10.17226/27820> (hereinafter “Ending Unequal Treatment”). The National Academies are private, nongovernmental institutions established by an act of Congress to “investigate, examine, experiment, and report on any subject of science or art” upon request of the U.S. government. 35 U.S.C. § 15303. They are long recognized as a leading source of evidence-based science.

⁹ *Id.* at 79.

¹⁰ *Id.* at 80.

¹¹ *Id.* at 81.

The 2024 study on racial health disparities is not the first such study. The U.S. government’s first study of racial health disparities was published in 1985. The study, known as the “Heckler Report” (after President Reagan’s Health and Human Services Secretary Margaret Heckler), concluded among other things that racial health disparities accounted for approximately 60,000 excess deaths each year between 1979-1981.¹² Congress followed up on the Heckler Report by mandating that the National Academy of Medicine conduct its own study of racial health disparities in America.¹³ The 2003 report, *Unequal Treatment*, recognized the persistence of racial disparities in medical treatment, attributing those disparities in part to healthcare providers making decisions and offering care that was influenced by implicit bias.¹⁴

The consequences are predictable and widespread. Over half of Black adults have hypertension, which “is the highest prevalence among all racial and ethnic groups,” and “47% of Black adults have been diagnosed with cardiovascular disease, compared with 36% of white adults.”¹⁵ Black women are three to four times more likely than white women to die from pregnancy-related complications,¹⁶ with implicit bias and discriminatory attitudes in healthcare contributing to the negative high maternal health outcomes experienced by Black women.¹⁷ And even as “cancer incidence and mortality overall are declining in all population groups in the United States, some groups continue to be at increased risk of developing or dying from certain cancers.”¹⁸ Black patients, in particular, have the highest death rates and shortest survival of any racial group in the United States for most types of cancer.¹⁹ Black women are 40 % more likely to die of breast cancer than white women,²⁰ despite Black women “having slightly lower incidence rate of breast cancer.”²¹

¹² U.S. Dep’t of Health & Hum. Servs., *Rep. of the Sec’y’s Task Force on Black & Minority Health* (1985).

¹³ See Brian D. Smedly, et al., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* 1 INST. OF MED. (2003), <https://pubmed.ncbi.nlm.nih.gov/25032386/> (hereinafter “*Unequal Treatment*”).

¹⁴ *Id.* at 162-79.

¹⁵ Cleveland Clinic, *How do Race and Ethnicity Play a Role in Cardiovascular Disease?* (May 15, 2022), <https://my.clevelandclinic.org/health/articles/23051-ethnicity-and-heart-disease> (hereinafter “Cleveland Clinic”); Tsion Zewdu Minas, et al., *An Overview of Cancer Health Disparities: New Approaches & Insights & Why They Matter*, CARCINOGENESIS (Nov. 13, 2020), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7717137/>.

¹⁶ Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, CLINICAL OBSTETRICS GYNECOLOGY 387 (Jun. 2018), <https://pmc.ncbi.nlm.nih.gov/articles/PMC5915910/>.

¹⁷ Bani Saluja & Zenobia Bryant, *How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States*, 30 J. WOMEN’S HEALTH 270 (Feb. 2, 2021), <https://doi.org/10.1089/jwh.2020.8874>.

¹⁸ Nat’l Cancer Inst., *Cancer Disparities*, <https://www.cancer.gov/about-cancer/understanding/disparities> (database updated Jan. 31, 2025) (hereinafter “*Nat’l Cancer Inst.*”).

¹⁹ See American Cancer Society, *Cancer Facts & Figures for Afr. Ams. 2019-2021* 1 (2021), <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2019-2021.pdf>; *Nat’l Cancer Inst.*.

²⁰ Am. Cancer Soc., *Cancer Facts & Figures for Afr. Ams.*; Am. Assoc. for Cancer Rsch., *Cancer Health Disparities (2024)*, <https://www.aacr.org/patients-caregivers/about-cancer/cancer-health-disparities/>.

²¹ *Nat’l Cancer Inst.*

The COVID-19 pandemic also shone a light on racial health disparities. “Black and Hispanic groups had a higher risk of COVID-19 infection and hospitalization compared to their [w]hite counterparts,”²² and died from COVID-19 more than other racial groups.²³ This disparity can be attributed in part to the design of pulse oximeters. A study of over 20,000 patients hospitalized for COVID-19 from March 2020 and October 2021 showed that pulse oximeters consistently overestimated oxygen saturation for Black and Hispanic patients.²⁴ Consequently, such patients were less likely to be admitted to emergency rooms to be treated for COVID-19, which meant they were less likely to receive urgent treatment or supplemental oxygen, and if treated, often waited longer than white patients.²⁵

CMS’ justification for the proposed rescission also includes the statement that it is proposing to exclude activities “that do not have a direct and measurable impact on improving health outcomes.”²⁶ Yet its proposal cites no evidence that this rule does not have measurable impact on improving health outcomes for those that have historically and currently have worse health outcomes. Indeed, there is no evidence recited by CMS that it has made any attempt to measure the impact of a rule that was only promulgated in 2021. On the contrary, the proposed rescission will only ensure that racial health disparities continue to be unacknowledged and unremedied.

There is also no indication that using anti-racism planning tools to mitigate racial health disparities will worsen care for anyone. Nothing in the rule creating IA_AHE_8, or the administrative record supporting it, indicated that CMS intended for clinicians to abate racial health disparities by diverting resources from one group of people to another. And research by the Greensboro Health Disparities Collaborative shows that clinicians can in fact use race-neutral interventions to eliminate racial health disparities while improving care for *all* patients.²⁷

By contrast, rescinding IA_AHE_8 is likely to worsen healthcare for Medicare recipients on the basis of their race. CMS’ position that combatting racial health disparity is “obsolete” sends a clear, if badly mistaken message: health care is already equitable, and clinicians need not be

²² Khanh Duong, et al., *Disparities in COVID-19 Related Outcomes in the U.S. by Race & Ethnicity Pre-Vaccination Era: An Umbrella Rev. of Meta-Analyses*, FRONT PUB. HEALTH (Sep. 7, 2023), <https://pubmed.ncbi.nlm.nih.gov/37744476/>.

²³ Thomas J. Bollyky, et al., *Assessing COVID-19 Pandemic Pol’ies & Behavs. & Their Econ. & Educ. Trade-offs Across US States from Jan 1, 2020, to July 31, 2022: An Observational Analysis*, 401 THE LANCET 10385, 1341-60 (Apr. 22, 2023), [https://www.thelancet.com/journals/lancet/article/PIIS01406736\(23\)00461-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS01406736(23)00461-0/fulltext).

²⁴ Ashraf Fawzy, et al., *Clinical Outcomes Associated With Overestimation of Oxygen Saturation by Pulse Oximetry in Patients Hospitalized With COVID-19*, JAMA NETWORK OPEN 8 (Aug. 24, 2023), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2808735>.

²⁵ Sylvia Sudat, et al., *Racial Disparities in Pulse Oximeter Device Inaccuracy & Estimated Clinical Impact on COVID-19 Treatment Course*, 192 AM. J. EPIDEMIOLOGY 703-13 (May 5, 2023), <https://pubmed.ncbi.nlm.nih.gov/36173743/>.

²⁶ 90 Fed. Reg. 32352, 32723 (July 16, 2025).

²⁷ See Nadia Jaber, *Black Patients Are More Likely to Die of Cancer—Here’s How One Group Is Tackling That*, Nat’l Cancer Inst. (Dec. 21, 2021), <https://www.cancer.gov/news-events/cancer-currents-blog/2021/black-white-cancer-disparities-survival-accure>.

vigilant to ensure they are providing equitable health care to all their patients. Rescinding IA_AHE_8 will have the concrete effect of removing a strong financial incentive for Medicare providers' to take affirmative steps to reduce racial disparities in their practices.

Members of the NAACP State Conferences and the GHDC are well-acquainted with this country's history of racial health disparities in their states, and how a history of discrimination affects health outcomes today.²⁸ Indeed, disparities in States like Alabama, Arkansas, Mississippi, and Louisiana are some of the worst in the country.²⁹ These disparities have existed since America's founding, have been recognized by the federal government for more than forty years, and remain substantially unaddressed.³⁰ Members of the NAACP Conferences in these States, the GHDC, and others, will feel firsthand the consequences of diminished efforts to promote equitable healthcare for all.

Based on the foregoing, our clients respectfully request that CMS restore IA_AHE_8 as a clinical practice improvement activity for Calendar Year 2026.

Sincerely,



Kathryn Youker

Director, Economic Justice Project

Lawyers' Committee for Civil Rights Under Law

²⁸ See generally *Miss. v. Becerra*, No. 1:22-cv-00113-HSO-RPM (S.D. Miss.), ECF No. 177 (Br. In Supp. of Defs.' Second Mot. for Summ. J.) at 16-23.

²⁹ See generally *2025 State Scorecard on State Health Sys. Performance*, The Commonwealth Fund.

³⁰ *Id.*