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June 12, 2024

Hon. Chiquita Brooks-LaSure

U.S. Centers for Medicare & Medicaid Services

7500 Security Blvd.

Baltimore, MD 21244

Re: Do No Harm's Comments on the Centers for Medicare & Medicaid Services, Proposed Rulemaking, "Medicare Program; Alternative Payment Model Updates and the Increasing Organ Transplant Access (IOTA) Model," 89 Fed. Reg. 43,518, Docket ID CMS-5535-P (May 17, 2024)

Do No Harm is a nationwide organization dedicated to protecting healthcare from identity politics. We accomplish our mission through education and advocacy about the divisive and discriminatory ideology increasingly embedded within medical education, training, research, practice, and policy.

Consistent with that mission, Do No Harm opposes any program or policy that encourages providers to limit access to and availability of healthcare services on the basis of race. This certainly includes organ transplants, which are often life-saving. To that end, we write to oppose CMS's proposal to mandate so-called health-equity plans.[1]

In short, the proposed rule would encourage providers to adopt plans that favor some racial groups in the kidney-transplant process over others. As a matter of policy, law, and morality, this cannot stand.

Fortunately, American jurisprudence mirrors the moral case against such policies. As CMS acknowledges, more than 800,000 Americans have end-stage renal disease (ESRD). CMS also acknowledges that "the best treatment for most patients … is kidney transplantation."[2] All these patients, regardless of race, deserve an equal opportunity to access the best treatments for their condition.

This statement and our opposition are consistent with recent rulings of the U.S. Supreme Court. "'Distinctions between citizens solely because of their ancestry are by their very nature odious to a free people whose institutions are founded upon the doctrine of equality.'"[3] "Eliminating racial discrimination means eliminating all of it," especially in medicine.[4] The Supreme Court has made clear that CMS may not enlist private actors to discriminate against patients based on race, even to reduce disparities.[5]

Our opposition, unlike the proposed rule, is also consistent with federal statutory law. Federal law safeguards equal treatment regardless of race. Pursuant to 42 U.S.C. §2000d, "[n]o person in the

United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." And this federal anti-discrimination law also explicitly applies to healthcare. Under 42 U.S.C.§18116(a), "an individual shall not, on the ground prohibited under ... 42 U.S.C. §2000d ... be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance[.]").

CMS' proposed rule will encourage providers to adopt plans that favor some racial groups in the kidney-transplant process over others. How? The proposed rule's "new mandatory Medicare payment model, the IOTA model, which stands for the "Increasing Organ Transplant Access Model," will create "performance-based incentive payments for participating kidney transplant hospitals tied to access and quality of care for ESRD patients on the hospitals' waitlists."[6] CMS will, under the proposed rule, assess kidney transplant hospitals' performance "across three performance domains: achievement, efficiency, and quality" with a final score determining incentive payments.[7]

Yet, CMS also proposes to mandate that participating kidney hospitals submit so-called health-equity plans.[8] These health-equity plans must "[i]dentify target health disparities," or those "experienced by one or more communities within the IOTA participant's population of attributed patients that the IOTA participant would aim to reduce."[9]

This vague directive does not preclude, let alone discourage, participating hospitals from prioritizing patients of certain racial communities over others. That omission is concerning and, given the race-based ideological context of "equity," quite possibly intentional. In other words, under the proposed rule, participating hospitals must develop plans which set "health equity goals," or "targeted outcomes" and it is difficult to conceive how this will not lead to some, most, or all hospitals setting or reaching goals by targeting racial groups separately to race-based ends.

As a result of the proposed rule, providers will almost certainly and intentionally select patients with ESRD for kidney transplantation based on race. Kidneys are scarce. Only about 31 percent of patients with ESRD get them.[10] Given the scarcity of kidneys, "[a] benefit provided to some ... but not others necessarily advantages the former group at the expense of the latter."[11] Some patients will be deprived of the "best treatment for" ESRD because of irrelevant factors like the color of their skin.[12] And, again, intentional race-based decisions, even to reduce racial disparities, is illegal.[13] This is especially true in "zero-sum" contexts like organ transplantation.[14]

Finally, as a matter of policy, CMS' proposed rule would incentivize doctors to prioritize or deprioritize patients for kidney transplantation depending on their racial classification. A more sensible solution—one focused on patient education—is possible and advisable. For example, the authors of one study on racial disparities in kidney transplantation wrote that:

> From the beginning of the transplant-seeking process, our study found that blacks began transplant evaluation less willing to get on the deceased donor waitlist, less willing for LDKT (living donor kidney transplantation), and less knowledgeable about the benefits of transplant compared with whites. As patients moved through the

> transplant process, those patients with less transplant knowledge and motivation to pursue LDKT at transplant onset were ultimately less likely to complete evaluation or receive LDKTs years later. When patients' initial knowledge and attitudinal differences were controlled in the multivariable modeling, the racial disparity in receipt of LDKTs disappeared.[15]

A patient's willingness to endure the rigors of transplantation should be decisive, not a patient's race. If CMS proposed to create incentives for participating hospitals to reduce these root causes, it would warrant more deference. The proposed rule, on the other hand, ignores or discards this issue in a manner which can only be described as arbitrary and capricious.

For these reasons, Do No Harm opposes CMS' proposed rule and encourages its withdrawal.

Short of withdrawal, Do No Harm encourages CMS to mitigate the proposed rule's potentially adverse effects. For example, CMS could require that "target health disparities" be defined in race-neutral terms. CMS could also prohibit participating hospitals from discriminating against ESRD patients on the basis of race and, instead, incentivize hospitals to reduce arbitrary barriers that keep patients from receiving renal care. Finally, while CMS should continue to affirm that "[d]iscrimination on the basis of race … would be prohibited," it should clarify that race-based preferences are within that prohibition.[16]

Doing so would bring the rule closer to the governing law, sound policy, and the value of equal treatment. It would ensure that participants do not favor members of one racial group over another. And the clarification would save valuable time and money, ultimately to the benefit of patients, by stopping unlawful plans before implementation. The alternative would encourage participants to waste resources creating unlawful plans, only to have CMS "rejec[t] [them], in whole or in part," on the ground that they violate federal antidiscrimination law.[17]

Respectfully submitted,

Stanley Goldfarb, MD

Do No Harm, Board Chairman

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[1] *See Medicare Program; Alternative Payment Model Updates and the Increasing Organ Transplant Access (IOTA) Model*, 89 Fed. Reg. 43,518 (May 17, 2024).
[2] *Id.* at 43,519.
[3] *Students for Fair Admissions, Inc. v. Harvard*, 600 U.S. 181, 208 (2023).
[4] *Id.* at 206.
[5] *See Harvard*, 600 U.S. at 230 (governments cannot do "indirectly" what "cannot be done directly" (cleaned up)); *Ricci v. DeStefano*, 557 U.S. 557, 594 (2009) (Scalia, J., concurring) ("if the Federal Government is prohibited from discriminating

on the basis of race, then surely it is also prohibited from enacting laws mandating that third parties … discriminate on the basis of race").

[6] 89 Fed. Reg. at 43,518-519.

[7] *Id.* at 43,519-20.

[8] *Id.* at 43,521.

[9] *Id.* at 43,582.

[10] *See* 89 Fed. Reg. at 43,519.

[11] *Harvard*, 600 U.S. at 218-19.

[12] *See id.*

[13] *See Ricci*, 557 U.S. at 561-63, 576-80.

[14] *See Harvard*, 600 U.S. at 218-19.

[15] Waterman AD, Peipert JD, Hyland SS, McCabe MS, Schenk EA, Liu J. Modifiable patient characteristics and racial disparities in evaluation completion and living donor transplant. Clin J Am Soc Nephrol. 2013 Jun;8(6):995-1002. doi: 10.2215/CJN.08880812. Epub 2013 Mar 21. PMID: 23520044; PMCID: PMC3675849.

[16] 89 Fed. Reg. at 43,582

[17] *See id.*