Do No Harm

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September 8, 2025

VIA ELECTRONIC SUBMISSION

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

Re: Medicare and Medicaid Programs; CY 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, 90 Fed. Reg. 32,352 (July 16, 2025)

Do No Harm, Inc., is a nonprofit organization with over 30,000 members, including physicians, nurses, medical students, patients, and policymakers. Do No Harm is committed to ensuring that the practice of medicine is driven by scientific evidence rather than ideology and that professional opportunities are allocated based on merit rather than race, gender, or some other immutable characteristic. *See About Us*, Do No Harm, bit.ly/4imToqX. To that end, Do No Harm opposes the spread of so-called "DEI" policies and transgender ideology in the medical profession. The association engages policymakers to encourage legislation and regulations that limit such practices and, when necessary, files lawsuits against universities, employers, and others whose DEI practices violate antidiscrimination laws. *See, e.g.*, *Federal Policy*, Do No Harm, bit.ly/4i16XwF; *Do No Harm Supports the EDUCATE Act*, Do No Harm (Mar. 19, 2024), bit.ly/43iASfa; *Rep. Crenshaw Introduces Bill Banning Medicaid Funding for Child Sex Change Interventions*, Do No Harm (Jan. 24, 2025), bit.ly/43eNpQS; *Litigation*, Do No Harm, bit.ly/3XpN3D6.

Part of Do No Harm's mission is to ensure that the public, courts, and federal agencies have a proper understanding of these issues. Do No Harm submits this comment to highlight the importance of ensuring that federal healthcare programs like the Merit-Based Incentive Payment System ("MIPS") do not push physicians to insert race into the intimate relationship between a patient and a doctor. Incentivizing discriminatory treatment practices is both repugnant to our constitutional order and flatly inconsistent with Congress's focus on improving patient care. Do No Harm supports the Center for Medicare Services'

plan to repeal the Anti-Racism Rule embodied in the Achieving Health Equity subcategory of the MIPS clinical practice improvement activity inventory.

One of Do No Harm's members, Dr. Amber Colville, filed a federal lawsuit challenging the Anti-Racism Rule. *See Colville v. Becerra*, 2023 WL 2668513, at *20 (S.D. Miss. Mar. 28). By rewarding physicians who inject race into their medical practice, the Anti-Racism Rule punishes doctors like Dr. Colville who believe that a patient's skin color should not affect the care that they receive. Dr. Colville joins this comment.

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The Anti-Racism Rule should be repealed. Injecting race was not what Congress had in mind when it created MIPS. And more fundamentally, incentivizing healthcare professionals to prioritize one racial group over another is repugnant to the Constitution and federal civil-rights laws.

In 2015, Congress authorized MIPS to incentivize clinicians to improve their efficiency and effectiveness. MIPS performs this important function by giving clinicians a "composite performance score" between 0 and 100 that affects how much CMS pays clinicians. *See* 42 U.S.C. §1395w-4(q)(5)(A). Up to fifteen percent of a clinician's score is determined by their participation in "clinical practice improvement activities." §1395w-4(q)(5)(E)(i)(III). In turn, clinical practice improvement activities are defined to include activities that "relevant eligible professional organizations and other stakeholders identify as improving clinical practice or care delivery" and that the Secretary of HHS determines are "likely to result in improved outcomes." §1395w-4(q)(2)(C)(v)(III).

Congress made a list of the kinds of activities it understood to meet this definition. Among them are "expanded practice access," "care coordination," "beneficiary engagement, such as the establishment of care plans for individuals with complex care needs," and "patient safety and practice assessment." §1395w-4(q)(2)(B)(iii). Nowhere did Congress mention "equity" or "race."

The Anti-Racism Rule, however, required participating clinicians to "include a clinic-wide review of existing tools and policies … to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct." 86 Fed. Reg. at 65,970. The rule further required clinicians to create "and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools." *Id.* CMS's 2021 Disparities Impact Statement instructed clinicians to "[s]tratif[y] measures and health outcomes by race and ethnicity" and to identify the "population(s)" they will "prioritize." CMS, *Disparities Impact Statement* (Mar. 2021), perma.cc/NYL7-9AQ2.

The Anti-Racism Rule is illegal at worst, and bad policy at best. Either way, it should be repealed on both grounds.

First, anti-racism plans aren't analogous to any of the examples of clinical practice improvement activities listed in the statute. Those examples—same-day appointments, "monitoring health conditions," "timely communication of test results," and the like—have one thing in common: improving care for all patients, not a racial subset. 42 U.S.C. §1395w-4(q)(2)(B)(iii). The fact that the specific examples enumerated don't look anything like prioritizing patients of one race over patients of another shows that anti-racism plans aren't the kinds of activities that relevant organizations can identify as improving "clinical practice or care delivery" within the meaning of the statute. 86 Fed. Reg. at 65,970; *cf. Biden v. Missouri*, 595 U.S. 87, 90 (2022) (per curiam) (explaining that the Department's "core mission" is "patients' health and safety"); Medicine, *Black's Law Dictionary* (11th ed. 2019) ("The scientific study and practice of preserving health and treating disease or injury.").

Second, the relevant medical organizations did not identify these anti-racism plans and race prioritization as clinical practice improvement activities before CMS issued the Anti-Racism Rule. Such professional determinations must occur before CMS's designation. This is clear from the statute, which defines these activities as those already identified by professional organizations. If it were otherwise, HHS could designate non-compliant activities in the hope that a professional organization will eventually ratify that decision, a theory that makes a mockery of statutory compliance. This is why the statute requires that in initially applying the statute, "the Secretary shall use a request for information to solicit recommendations from stakeholders." §1395w-4(q)(2)(C)(v)(I). No relevant medical organization had identified the creation of anti-racism plans as improving clinical practice or care at the time of the rule's promulgation. Indeed, the only sources the Rule cites are a CDC webpage decrying systemic racism and an article by a single physician. 86 Fed. Reg. at 65,969, 65,977. Neither source constitutes a "relevant professional organization."

The Anti-Racism Rule failed to meet the statutory requirements for promulgation. And a federal district court in Mississippi agreed that the points Do No Harm is raising in this comment are valid legal defects. *See Colville*, 2023 WL 2668513, at *20. As such, it should be repealed as ultra vires.

Moreover, the Anti-Racism Rule was repugnant to the Constitution and federal civil-rights law. The Constitution is "color-blind, and neither knows nor tolerates classes among citizens." *Plessy v. Ferguson*, 163 U.S. 537, 559 (Harlan, J., dissenting). Congress has codified this principle in federal statutory law. And every time the government places citizens on "'racial registers and makes race relevant to the provisions of burdens or benefits, it demeans us all.'" *SFFA v. Harvard*, 600 U.S. 181, 262 (2023) (Thomas, J., concurring). Clinicians

receiving federal funds (through Medicare or Medicaid, for instance) are barred from discriminating "on the grounds of race, color or national origin." 42 U.S.C. § 2000d; *see also* 42 U.S.C. §18116 ("an individual shall not … 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.").

The Anti-Racism Rule was itself—and further promoted—unlawful racial discrimination. Race-based classifications are unconstitutional, even if they aim to reduce disparities. *Harvard*, 600 U.S. at 205-08, 223-25. The Anti-Racism Rule endorsed the ideology of antiracism, which insists that "[t]he only remedy to past discrimination is present discrimination." Ibram X. Kendi, *How to Be an Antiracist* 19 (2019). The 2021 Disparities Impact Statement makes this clear, by instructing clinicians to "prioritize" populations. Telling clinicians to prefer some populations over others because of race is an invitation to engage in unlawful discrimination. Although HHS changed the Disparities Impact Statement after litigation in *Colville*, the Rule itself allowed the use of "other anti-racism tools." 86 Fed. Reg. at 65,970. That HHS sought to implement its Anti-Racism Rule by telling clinicians to prioritize some races over others is telling both of the scope of the Rule and the dereliction of constitutional duty.

The Anti-Racism Rule should thus be rescinded. It teaches that "doctors should engage in Antiracist discrimination to prioritize group disparities over individuals' needs while providing care." GianCarlo Canaparo, *Permissions to Hate: Antiracism and* Plessy, 27 Tex. Rev. L. & Pol. 97, 152 (2022). Such an ideology is incompatible not only with the congressional intent behind MIPS but also with the promise of racial equality embedded in the Constitution and federal civil-rights law.

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For these reasons, Do No Harm supports the proposed repeal of the Anti-Racism Rule. If you have any questions or require further information, please feel free to contact me at kristina@donoharmmedicine.org. Thank you for your attention to this important matter.

Sincerely,

Kristina Rasmussen
Executive Director
Do No Harm

/s/ Amber Colville
Dr. Amber Colville
New Wave Internal Medicine