Racial and Ethnic Disparities in Multisystem Inflammatory Syndrome in Children in the United States, March 2020 to February 2021

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Background: The incidence of multisystem inflammatory syndrome in children (MIS-C) varies by race and ethnicity. This study assessed whether disparities in MIS-C in the United States by race and ethnicity exceed known disparities in coronavirus disease 2019 (COVID-19) incidence.

Methods: We compared the distribution of race and ethnicity among patients with MIS-C (<21 years of age, termed children) with onset March 2020 to February 2021 to that of children with COVID-19 and in the general population. Analysis was restricted to 369 counties with high completeness of race and ethnicity reporting for MIS-C and COVID-19. For each racial and ethnic group, observed numbers of patients with MIS-C were compared with expected numbers (observed/expected ratio) in children with COVID-19 and in the general population within these counties.

Results: Compared with children in the general population, MIS-C was more frequent among Hispanic (139% of expected) and non-Hispanic Black children (183%) and less frequent among non-Hispanic White (64%) and non-Hispanic Asian children (48%). Compared with children with COVID-19, MIS-C was more frequent in non-Hispanic Black children (207% of expected) and less frequent in non-Hispanic White children (68%); however, frequency was not different among Hispanic (102%) and non-Hispanic Asian (74%) children.

Conclusions: Disparities in MIS-C by race and ethnicity exist, even after controlling for COVID-19 disparities and geographic variations. The high proportion of MIS-C among Hispanic children and low proportion among non-Hispanic Asian children align with COVID-19 rates, while the high proportion among non-Hispanic Black children and low proportion among non-Hispanic White children are not explainable by COVID-19 rates.

Key Words: multisystem inflammatory syndrome in children, COVID-19, race, ethnicity, disparities

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Multisystem inflammatory syndrome in children (MIS-C), known elsewhere as pediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2, is a severe inflammatory condition, presenting with fever, generalized inflammation and multiple organ dysfunction, that can occur following infection with SARS-CoV-2—the virus that causes coronavirus disease 2019 (COVID-19).[1–3] As of June 2021, the US Centers for Disease Control and Prevention (CDC) has reported over 4000 confirmed cases and 36 deaths from MIS-C in the United States.[4]

In the United States, non-Hispanic Black and Hispanic children (those <21 years of age are hereafter termed children) account for a higher proportion of those with MIS-C than among the general pediatric population.[1,2,5–7] COVID-19 incidence, as determined by case reporting, and estimated rates of SARS-CoV-2 infections, as determined by seroprevalence studies, also vary by race and ethnicity and are higher among Hispanic children and adults.[8–10] However, incomplete reporting and differences in rates of COVID-19 and SARS-CoV-2 infections by race and ethnicity and by location can make direct comparisons to MIS-C at the national level unreliable. Therefore, it is unclear if the racial and ethnic disparities seen in MIS-C are solely attributable to differences in rates of COVID-19, and more specifically SARS-CoV-2 infection, or if there is differential susceptibility to MIS-C by race and ethnicity among those infected with SARS-CoV-2.

While all children infected with SARS-CoV-2 (regardless of COVID-19 symptoms) are at risk of developing MIS-C, SARS-CoV-2 seroprevalence data in children by race and ethnicity are limited. However, national surveillance data on reported COVID-19 in children by race and ethnicity are available. The purpose of this study is to determine whether the known racial and ethnic disparities among children with MIS-C in the United States are independent of disparities among children with COVID-19 after accounting for confounding by county of residence.

METHODS

We compared the observed racial and ethnic distribution of patients with MIS-C in the United States to the expected distribution calculated under the assumption that the risk of MIS-C does not vary by race and ethnicity within two comparison populations residing in the same counties: children with COVID-19 and all

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children (general population). Rates and reporting of COVID-19, reporting of MIS-C, and the distribution of race and ethnicity vary by county and by state.[4,10,11] This may lead to confounding; therefore, expected distributions of race and ethnicity were calculated from the underlying county-level distribution of the two comparison populations for each included patient with MIS-C. The analysis was performed on MIS-C and COVID-19 data obtained from 369 counties from 31 states, selected for higher levels of race and ethnicity reporting completeness. This activity was reviewed by CDC and was conducted consistent with applicable federal law and CDC policy (eg, 45 C.F.R. part 46.102(l)(2), 21 C.F.R. part 56; 42 U.S.C. §241(d); 5 U.S.C. §552a; 44 U.S.C. §3501 et seq.).

MIS-C Case Surveillance Data

MIS-C data were obtained from ongoing national surveillance. State, local, and territorial health departments report patients with MIS-C to CDC using a standard case report form.[4] Briefly, the case definition for MIS-C included patients <21 years of age hospitalized with fever, involvement of at least 2 organ systems, laboratory evidence of inflammation, laboratory confirmation of SARS-CoV-2 infection or recent exposure to a suspected or confirmed COVID-19 case and no alternative plausible diagnosis.[4] Patients' sex, age, race, ethnicity, state and zip code of residence, and MIS-C onset date as recorded on the case report form, typically obtained from medical records as documented at the time of hospitalization, were used in the present analysis. Likely, county of residence was determined from zip code, where available, using HUD USPS Zip Code Crosswalk files.[12] For some patients, county or county equivalent was reported instead of zip code. To be included in analysis, MIS-C patients had to meet the CDC MIS-C case definition and have MIS-C onset (defined in the following order: symptom onset, diagnosis or CDC report date) during March 1, 2020, to February 28, 2021.[4]

COVID-19 Data

Comparison data for people <21 years of age with probable or confirmed COVID-19, as defined by the Council for State and Territorial Epidemiologists, were obtained from case-level surveillance reported to CDC by state and territorial jurisdictions, which includes demographics such as age, race, and ethnicity.[13] Because prior studies have found a 2- to 5-week lag between peaks in COVID-19 and MIS-C,[5–7] our analysis included patients with COVID-19 with a reported onset date (defined in the following order: symptom onset, diagnosis or CDC report date) during February 9, 2020, to February 7, 2021 (21 days prior to the included range of onset dates for MIS-C). An additional inclusion criterion included having a reported county or county equivalent of residence.

General Population Data

Data on the distribution of race and ethnicity of all people <20 years of age residing in the 369 counties were taken from the 2019 US Census Population and Housing Unit Estimates (as data for race and ethnicity are only publicly available in 5-year age groups, those 20 years of age could not be included).[14]

Race and Ethnicity Categorization

In the MIS-C and COVID-19 data, race was reported separately from ethnicity. For inclusion in the final analysis, patients were required to have both race and ethnicity reported. Race and ethnicity were combined and categorized as Hispanic or Latino of any race or multiple races, non-Hispanic White alone, non-Hispanic Black alone, non-Hispanic Asian alone, non-Hispanic American Indian/Alaska Native alone, non-Hispanic Native Hawaiian/Pacific Islander alone, and non-Hispanic multiple races. Categories are based on standards provided by the US Office of Management and Budget.[15,16] As with census population estimates, patients reporting "other" race in combination with a specified race were recategorized into the specified race.[14] Patients who reported "other" race alone in conjunction with non-Hispanic ethnicity and patients who were missing or refused to provide either race or ethnicity were excluded from analysis.

County Selection

Race and ethnicity reporting for patients with COVID-19 and patients with MIS-C varied by county. Similar to a method used by Moore et al to analyze disparities in the incidence of COVID-19 by race and ethnicity in hot spot counties, analysis was limited to 369 counties that had race and ethnicity data available for ≥50% of patients with MIS-C and patients with COVID-19 under 21 years of age.[17] Not all jurisdictions reported all COVID-19 cases at the case level. To account for low reporting at the case level within some counties, an additional selection criteria for counties was applied: ≥50% completeness of case-level entries of COVID-19 compared with aggregate counts as compiled by USAFacts.[11] The percentage completeness of race and ethnicity reporting for each of the 369 counties varied for patients with MIS-C (median, 100%; range, 50.0%–100.0%) and with COVID-19 (median, 70.1%; range, 50.0%–98.1%). Counties were included from each of the four US census regions.[18]

Statistical Analysis

For each race and ethnicity, the observed number of patients with MIS-C was compared with the expected number calculated separately from each of the two comparison populations: children with COVID-19 and children in the general population. To calculate the expected number for a race and ethnicity, first, the underlying proportion of children of that race and ethnicity was determined within each patient with MIS-C's county of residence. The sum of these underlying proportions across all patients with MIS-C yielded the expected number for that race and ethnicity. A relative measure of overrepresentation or underrepresentation, referred to as the observed/expected ratio (O/E), was calculated for each race and ethnicity by dividing the observed number by the expected number. Expected proportions for each race and ethnicity were calculated by dividing the expected number by the total number for all races and ethnicities combined.

Sensitivity analyses compared O/E ratios when restricting analysis by 4-month time periods, by 5-year age groups, by county-level socioeconomic status,[19] and by county urban-rural category as defined by the 2013 National Center for Health Statistics Urban-Rural Classification Scheme for Counties.[20]

The Poisson-binomial distribution—a generalization of the binomial distribution defined as the distribution of the sum of independent Bernoulli random trials with unequal probabilities of success—was used to calculate *P* values and 95% CIs for O/E ratios.[21] Statistical significance was defined using 2-sided hypothesis testing with $P < 0.05$. All analyses were completed using the R statistical software, version 3.6.0 (The R Foundation).

RESULTS

A total of 1382 patients with MIS-C and 1,090,302 patients with COVID-19 <21 years of age who met the inclusion criteria and resided in the included 369 counties from 31 states were identified (Figure, Supplemental Digital Content 1, http://links.lww.com/INF/E500). The overall population <20 years of age residing in these 369 counties was 28,743,872 (Table 1; Table, Supplemental Digital Content 2, http://links.lww.com/INF/E501). The proportions of race and ethnicity among these 1382 patients with MIS-C

TABLE 1. Demographic Characteristics of Children Included From Each Dataset Used in the Analysis*

Characteristic	n (%)		
	Children With MIS-C	Children With COVID-19† (Not Weighted)	Children in General Population‡ (Not Weighted)
Total n	1382	1,090,302	28,743,872
Sex			
Female	548 (39.8%)	552,774 (51.2%)	14,070,778 (49.0%)
Male	830 (60.2%)	527,439 (48.8%)	14,673,094 (51.0%)
Age			
0–4	342 (24.7%)	132,063 (12.1%)	6,926,727 (24.1%)
5–9	455 (32.9%)	164,795 (15.1%)	7,131,965 (24.8%)
10–14	391 (28.3%)	240,848 (22.1%)	7,315,921 (25.5%)
15–20	194 (14.0%)	552,596 (50.7%)	7,369,259 (25.6%)
Race/ethnicity			
Hispanic	546 (39.5%)	473,785 (43.5%)	8,742,127 (30.4%)
Non-Hispanic White	411 (29.7%)	447,092 (41.0%)	12,780,629 (44.5%)
Non-Hispanic Black	356 (25.8%)	107,470 (9.9%)	3,588,683 (12.5%)
Non-Hispanic Asian	36 (2.6%)	41,221 (3.8%)	1,995,251 (6.9%)
Non-Hispanic multiple races	16 (1.2%)	6265 (0.6%)	1,371,816 (4.8%)
Non-Hispanic American Indian/Alaska Native	9 (0.7%)	8881 (0.8%)	174,295 (0.6%)
Non-Hispanic Native Hawaiian/Pacific Islander	8 (0.6%)	5588 (0.5%)	91,071 (0.3%)
US census region			
Midwest	359 (26.0%)	238,454 (21.9%)	7,273,623 (25.3%)
Northeast	53 (3.8%)	62,868 (5.8%)	1,621,207 (5.6%)
South	395 (28.6%)	251,847 (23.1%)	6,585,283 (22.9%)
West	575 (41.6%)	537,133 (49.3%)	13,263,759 (46.1%)
Date			
Early (MIS-C: March 1 to June 30, 2020; COVID-19: February 9 to June 9, 2020)	167 (12.1%)	43,264 (4.0%)	-
Mid (MIS-C: July 1 to October 31, 2020; COVID-19: June 10 to October 10, 2020)	338 (24.5%)	252,952 (23.2%)	-
Late (MIS-C: November 1, 2020, to February 28, 2021; COVID-19: October 11, 2020, to February 7, 2021)	877 (63.5%)	794,086 (72.8%)	-

*Totals and percentages represent the unweighted numbers from each population contributing to the analysis. Since expected numbers of MIS-C patients by race and ethnicity are calculated from underlying populations at the county level, children from different counties in the underlying populations do not contribute equally to the analysis.

†From CDC COVID-19 case surveillance database with onset date February 9, 2020, through February 7, 2021. Numbers exclude children not meeting inclusion criteria for the analysis.

‡From the 2019 Vintage Census Population Estimates.

were Hispanic, 39.5%; non-Hispanic White, 29.7%; non-Hispanic Black, 25.8%; non-Hispanic Asian, 2.6%; non-Hispanic multiple races, 1.2%; non-Hispanic American Indian/Alaska Native, 0.7%; and non-Hispanic Native Hawaiian/Pacific Islander, 0.6% (Fig. 1). The expected racial and ethnic distribution among children with MIS-C, as calculated using the racial and ethnic distribution of persons with COVID-19 <21 years of age and the overall population age <20 years of age, is shown in Fig. 1.

Compared with the general population <20 years of age, there were more patients with MIS-C than expected among Hispanic (O/E 1.39; 95% CI 1.29–1.50), non-Hispanic Black (O/E 1.83; 95% CI 1.63–2.08), and non-Hispanic Native Hawaiian/Pacific Islander (O/E 2.37; 95% CI 1.14–infinity) children and fewer patients with MIS-C than expected among non-Hispanic White (O/E 0.64; 95% CI 0.61–0.67) and non-Hispanic Asian (O/E 0.48; 95% CI 0.40–0.62) children (Table 2). When compared with those with COVID-19 <21 years of age, observed numbers of patients with MIS-C remained higher than expected among non-Hispanic Black (O/E 2.07; 95% CI 1.84–2.37) children and lower than expected among non-Hispanic White children (O/E 0.68; 95% CI 0.65–0.72); however, there was no association among Hispanic children (O/E 1.02; 95% CI 0.97–1.08), non-Hispanic Asian children (O/E 0.74; 95% CI 0.58–1.03), and non-Hispanic Native Hawaiian/Pacific Islander children (O/E 1.44; 95% CI 0.80–8.00). Children of non-Hispanic multiple races had a lower-than-expected burden of MIS-C compared with that expected from the general population (O/E 0.27; 95% CI 0.22–0.36) but higher-than-expected burden of MIS-C compared with that expected from those with COVID-19 (O/E 1.93; 95% CI 1.14–8.00). Non-Hispanic American Indian/Alaska Native children did not have a significantly different than expected burden of MIS-C compared with the general population and those with COVID-19. Results were largely similar in sensitivity analyses when adjusting the inclusion criteria using separate 5-year age groupings and using restricted dates of MIS-C and COVID-19 onset (Fig. 2). Results were also largely similar by urban-rural category and county-level socioeconomic status (Figure, Supplemental Digital Content 3, http://links.lww.com/INF/E502; Figure, Supplemental Digital Content 4, http://links.lww.com/INF/E503).

DISCUSSION

Our study found that MIS-C disproportionately affects children of specific racial and ethnic groups even after controlling for underlying rates of COVID-19 in 369 selected counties across the United States. More non-Hispanic Black children and fewer non-Hispanic White children developed MIS-C than expected. While more Hispanic children and fewer non-Hispanic Asian children developed MIS-C than expected from the underlying general population, this is largely consistent with rates of COVID-19. The O/E ratio provides a measure of risk compared with all races and ethnicities combined; however, a comparison can also be made to non-Hispanic White children as a single reference population. Compared with non-Hispanic White children, non-Hispanic Black and Hispanic children had higher O/E ratios, suggesting that disparities in MIS-C between these individual groups remain, after accounting for disparities in COVID-19 incidence.

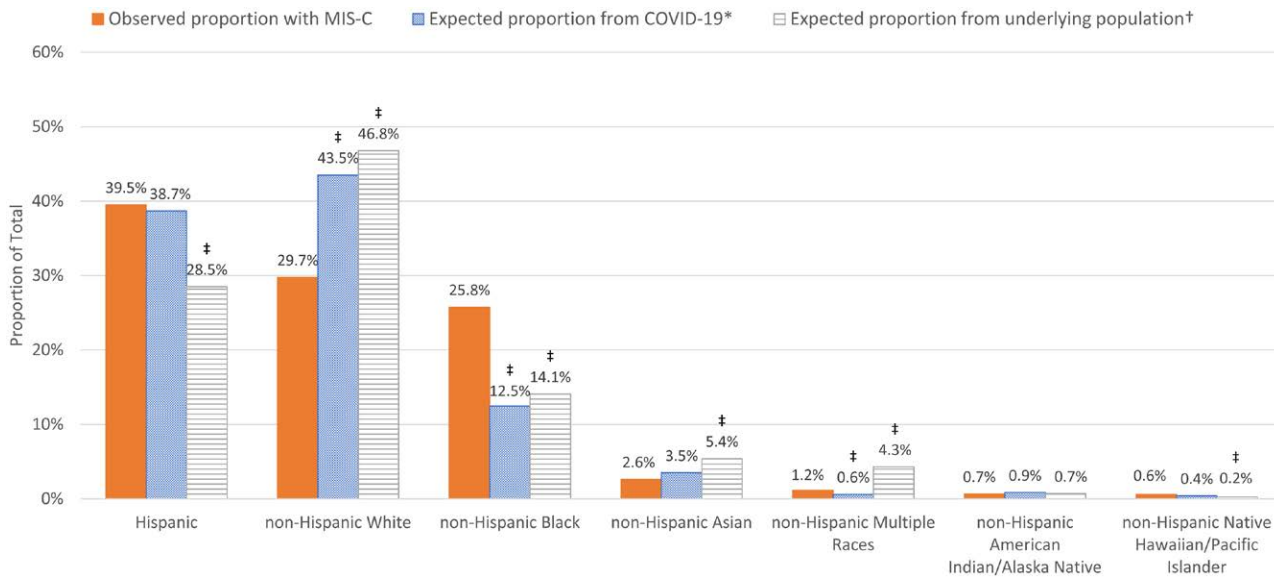

FIGURE 1. Observed distribution of race and ethnicity among patients with MIS-C in the study subset (n = 1382) compared with the expected distribution of race and ethnicity derived from those with COVID-19 under 21 years of age and the underlying population under 20 years of age within the same counties. *From CDC COVID-19 case surveillance database. †From the 2019 Vintage Census Population Estimates. ‡Significantly different from observed proportion with MIS-C of the same race/ethnicity at $P < 0.05$.

Prior studies have found a high percentage of reported MIS-C in the United States among Hispanic and Black children.[5,6] In the New York City, incidence rates of MIS-C and COVID-19 hospitalizations were higher among Black and Hispanic children than among White children.[9] In a series of US hospitalized patients <21 years of age, the risk ratio of MIS-C to severe acute COVID-19 was higher for non-Hispanic Black patients, but not Hispanic patients, compared with non-Hispanic White patients.[22] A study using enhanced surveillance and estimated SARS-CoV-2 infections from early during the COVID-19 pandemic in the United States found a higher incidence of MIS-C per SARS-CoV-2 infection among Black, Hispanic or Latino, and Asian or Pacific Islander children compared with White children.[23] In addition to MIS-C disproportionately affecting non-Hispanic Black children, severe outcomes are more likely among non-Hispanic Black children with MIS-C than non-Hispanic White children.[24]

A surveillance study in the United Kingdom and Ireland reported Black and Asian ethnicities were overrepresented among patients with pediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2 compared with the general population.[25] Although Asian children were overrepresented overall, those from places other than the Indian subcontinent appeared underrepresented among pediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2 patients.[25] However, underlying populations and associated risk factors that make up race and ethnicity groups across countries are variable and are not directly comparable with the United States.[15,16,25,26]

The reason for racial and ethnic disparities in MIS-C is uncertain. One potential explanation is disproportionate rates of SARS-CoV-2 infection. The true population at risk for MIS-C is children with prior SARS-CoV-2 infection. However, reported COVID-19 cases only make up a subset of total SARS-CoV-2 infections for multiple reasons: undiagnosed asymptomatic or mild COVID-19 may not be tested for SARS-CoV-2, testing shortages and other issues with accessing testing can be common, and SARS-CoV-2 test sensitivity is imperfect.[27] Undercounting of COVID-19 cases may

TABLE 2. Ratio of Observed Number of Children With MIS-C to Expected Number Calculated From the COVID-19 Population and to Expected Number Calculated From the Underlying General Population

Race/Ethnicity	Observed Number With MIS-C (n = 1382)	Comparison: Children With COVID-19 <21 Years of Age (n = 1,090,302)*		Comparison: General Population <20 Years of Age (n = 28,743,872)†	
		Observed/Expected	*P*	Observed/Expected	*P*
Hispanic	546	1.02 (0.97–1.08)	0.47	1.39 (1.29–1.50)	<0.001
Non-Hispanic White	411	0.68 (0.65–0.72)	<0.001	0.64 (0.61–0.67)	<0.001
Non-Hispanic Black	356	2.07 (1.84–2.37)	<0.001	1.83 (1.63–2.08)	<0.001
Non-Hispanic Asian	36	0.74 (0.58–1.03)	0.06	0.48 (0.40–0.62)	<0.001
Non-Hispanic multiple races	16	1.93 (1.14–8.00)	0.01	0.27 (0.22–0.36)	<0.001
Non-Hispanic American Indian/Alaska Native	9	0.76 (0.50–1.80)	0.43	0.93 (0.56–3.00)	>0.99
Non-Hispanic Native Hawaiian/Pacific Islander	8	1.44 (0.80–8.00)	0.28	2.37 (1.14–infinity)	0.02

*Comparison population taken from the CDC COVID-19 case surveillance database at the county level.
†Comparison population taken from the 2019 Vintage Census Population Estimates at the county level.

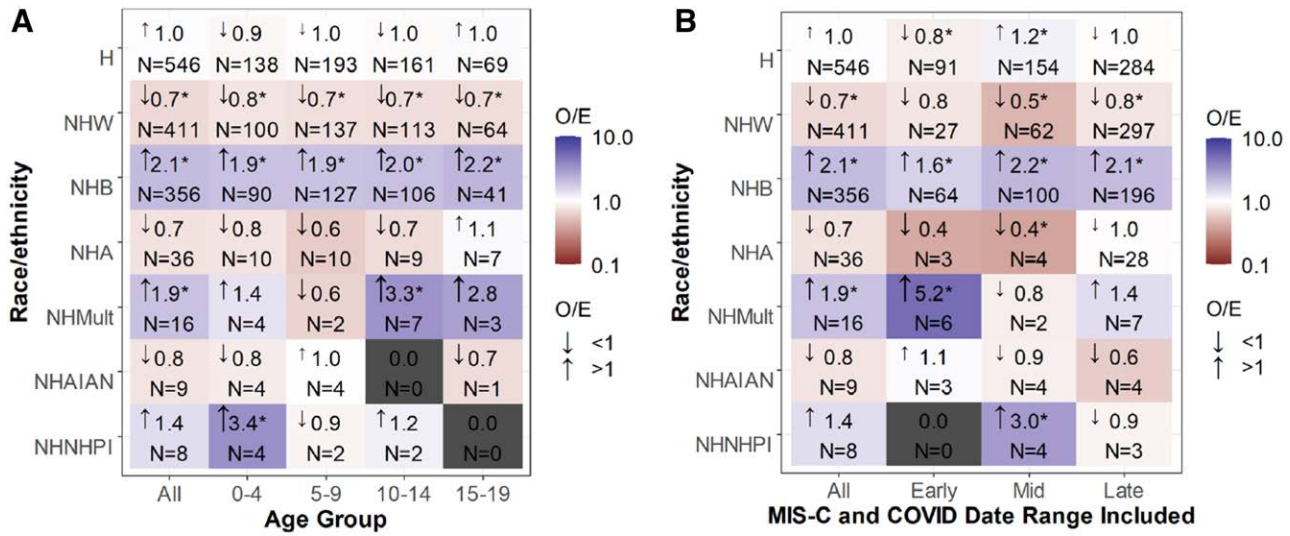

FIGURE 2. Sensitivity analyses showing the O/E of MIS-C compared with COVID-19 for each race and ethnicity by age and by onset date. Dark gray boxes denote zero observed patients with MIS-C are available for comparison at that filtering criteria. Boxes are shaded lightly when the O/E ratio is close to 1 and become darker as the O/E ratio moves further from 1. Rows with consistent intensity of coloration/shading and direction of arrows suggest minimal effect of age or of onset date. A, O/E ratios when limiting analysis to specific age groups. B, O/E ratios when limiting analysis to specific onset dates (early: March 1 to June 30, 2020; mid: July 1 to October 31, 2020; late: November 1, 2020 to February 28, 2021). H indicates Hispanic; NHA, non-Hispanic Asian; NHAIAN, non-Hispanic American Indian or Alaska Native; NHB, non-Hispanic Black; NHMult, non-Hispanic multiple races; NHNHPI, non-Hispanic Native Hawaiian or Pacific Islander; NHW, non-Hispanic White. *Statistical significance at $P < 0.05$.

differ significantly by race and ethnicity due to differences in testing rates.[28,29] Such concerns make reported COVID-19 cases an imperfect proxy for SARS-CoV-2 infections. Additionally, a higher proportion of Hispanic, Asian, and non-Hispanic Black patients with MIS-C have no preceding symptoms of a COVID-19–like illness compared with non-Hispanic White patients, potentially suggesting a higher risk of developing MIS-C among asymptomatic individuals with SARS-CoV-2 infection within these race and ethnicity groups.[7]

Another potential explanation for the disproportionate rates of MIS-C by race and ethnicity may be the role of social determinants of health. These factors, which include access to healthcare, socioeconomic status, environmental exposures, racism and discrimination, occupation, education and others, may increase the risk of COVID-19 exposure, illness, hospitalization, long-term health and social consequences and death.[30] Race and ethnicity are social constructs and serve as risk markers for other underlying conditions that impact health, including social determinants of health.[30] Racial and ethnic disparities in some social determinants of health may explain differences in mortality from COVID-19.[28] Social determinants may lead to underlying medical comorbidities that increase risk of other diseases. For example, some social determinants of health (such as socioeconomic status) may influence risk factors for inflammation that may lead to increased susceptibility for serious adverse health events from COVID-19.[31,32] Separate studies would be required to explore potential biological factors that predispose to disparities in MIS-C.

Racial and ethnic disparities in incidence of Kawasaki disease—a distinct entity with similar clinical features to MIS-C—exist.[33] In contrast to MIS-C, the incidence of Kawasaki disease is generally the highest among non-Hispanic Asian populations followed by non-Hispanic Black populations.[33]

Race and ethnicity, MIS-C incidence, and COVID-19 incidence and reporting vary greatly by geography.[11] A major strength of this analysis is the ability to control for confounding caused by these geographic differences by making comparisons between MIS-C and COVID-19 at the county level. This approach made it possible to account for differential reporting of MIS-C and COVID-19, differential positivity of SARS-CoV-2 testing, and different racial and ethnic distributions in the general population across counties.

The study is subject to several limitations. First, it is focused on selected counties with more complete race and ethnicity data and may not be generalizable to the entire US population. The sex and age distributions of the population <20 years of age residing in the 369 counties were similar to all US counties; however, there were some differences in the distributions of race and ethnicity, US census region and urbanicity. Results were largely consistent across counties by urban-rural category, and the distribution of race and ethnicity of patients with MIS-C in this analysis was generally similar to those for all patients with MIS-C with a reported race and ethnicity (n = 2969) as reported nationally on March 29, 2021 (Hispanic, 34%; non-Hispanic Black, 29%; non-Hispanic White, 27%; non-Hispanic multiple races, 3%; non-Hispanic Asian, 2%; non-Hispanic American Indian/Alaska Native, 1%; non-Hispanic Native Hawaiian/Pacific Islander, 1%).[4] Second, results may be biased if undercounting of SARS-CoV-2 infections compared with reported COVID-19 varies by race and ethnicity. Third, given limitations in available census data, the general population data only included children under 20 years of age, rather than children under 21 years of age. However, this difference is not expected to substantially affect the county-level population distributions by race and ethnicity used in analysis. Fourth, small numbers of non-Hispanic multiple races, non-Hispanic American Indian/Alaska Native, and non-Hispanic Native Hawaiian/Pacific Islander children in this analysis make it difficult to draw meaningful conclusions for

these populations. Misclassification of race is a known issue in datasets for American Indian/Alaska Native and Native Hawaiian/Pacific Islander populations.[34] There is little consistency in reporting of multiple races across race selection questions and datasets.[35] Such concerns are less likely to influence findings among Hispanic, non-Hispanic White, non-Hispanic Black and non-Hispanic Asian children.

CONCLUSION

In selected counties with higher levels of race and ethnicity reporting completeness, disparities in the burden of MIS-C by race and ethnicity exceed those seen in COVID-19, even after controlling for county-level differences in COVID-19 rates and distributions of race and ethnicity. Non-Hispanic Black children are overrepresented and non-Hispanic White children are underrepresented among children with MIS-C. The overrepresentation of Hispanic children and non-Hispanic Native Hawaiian/Pacific Islander children and the underrepresentation of non-Hispanic Asian children among patients with MIS-C is largely consistent with underlying COVID-19 rates. Such findings suggest that some social determinants of health may have an important role in the development of MIS-C beyond risk for COVID-19. It remains unclear whether there are discrepancies in SARS-CoV-2 infections by race and ethnicity beyond those seen in COVID-19 that may also explain these disparities in MIS-C. Given the overrepresentation of MIS-C among minority populations and that other studies have shown a higher risk for severe outcomes among minority populations with MIS-C, including non-Hispanic Black children, it is important that clinicians and public health professionals closely monitor minority populations for the development of MIS-C.

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