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June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1833-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 rates; Requirements for Quality Programs and Other Policy Changes (CMS-1833-P)

Dear Administrator Oz:

The American Geriatrics Society (AGS) appreciates the opportunity to submit comments on the fiscal year (FY) 2026 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS proposed rule.¹ We applaud the Centers for Medicare & Medicaid Services (CMS) for striving to advance the Hospital Inpatient Quality Reporting (IQR) program and LTCH Quality Reporting Program (QRP), including its recent adoption of two Social Drivers of Health Measures in the FY 2023 final rule for the Hospital IQR and four new standardized patient assessment data elements² – Living Situation (R0310), Food (R0320A and R0320B), and Utilities (R0330) – in the FY 2025 final rule for the LTCH QRP. We are concerned, however, at CMS' proposal to remove these elements. These new quality measures and standardized patient assessment data elements are critical to retain. For our patients in geriatric medicine with complex issues and advancing age, the items in these measures are a critical part of the work that geriatricians do to add value to a health system.

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (NPPs) who are devoted to improving the health, independence and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals that furnish services across all settings, including inpatient hospital and LTCH.

As discussed in greater detail below, we urge CMS to reconsider its proposals and to retain measures and data elements about social drivers of health measures because this data is essential to help older adult patients with complex and multiple chronic conditions. Multiple chronic conditions often

¹ 90 Fed. Reg. 18002 (April 30, 2025)

² Section 1886(m)(5)(F)(ii) of the Social Security Act requires LTCHs to submit standardized patient assessment data required under section 1899B(b)(1), which further requires post-acute care providers that are LTCHs to submit such assessment data under the LTCH QRP with regard to admission and discharge of an individual.

emerge from multiple adverse social drivers of health exposures, leading to morbidity, functional decline, and eventually cascading into the need for institutionalization.^{3,4}

I. CMS Should Not Finalize Removal of Two Social Drivers of Health Measures and Instead Should Allow Reporting To Continue Under the Hospital IQR

In the FY 2023 IPPS/LTCH final rule, CMS adopted two Social Drivers of Health Measures: (SDOH-1: Screening for Social Drivers of Health measure; SDOH-2: Screen Positive Rate for Social Drivers) under the Hospital IQR, to apply beginning with the FY 2026 payment determination and subsequent years.⁵ In adopting the measures, CMS acknowledged that Health Related Social Needs (HSRN) are important to the overall well-being of beneficiaries. HSRN is comprised of five specific health-related social needs and include food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. As a result, hospitals were required to begin reporting these two measures during calendar year 2024. SDOH-1 requires hospitals to report how many patients were screened and SDOH-2 requires hospitals to report the number of patients that screened positive.

In adopting these evidence-based measures, CMS stated it believed collecting patient-level health-related social needs (HRSNs) data through screening was essential in encouraging meaningful collaboration between healthcare providers and community-based organizations, and that the two measures could support ongoing hospital quality improvement initiatives by providing data with which to stratify patient risk and organizational performance.⁶ The agency cited substantial evidence in support of the two measures, noting that both were derived from the Accountable Health Communities (AHC) Model and emerging evidence of correlations between the designed drivers of health and higher healthcare utilization in emergency departments and hospitals, worse health outcomes and/or drivers of health for which interventions have shown marked improvement in health outcomes and healthcare utilization.⁷

CMS took an incremental approach to implementation by providing an initial voluntary reporting period in 2023 and then mandatory reporting periods starting in 2024. It also afforded hospitals flexibility in data collection (*e.g.*, use of self-selected screening tool and collection of data in multiple ways), so that providers could vary to accommodate the population they serve and their individual needs, such as use of administrative claims data, electronic clinical data, standardized patient assessments, or patient-reported data and surveys. This approach was intended to address concerns about burden and the development of new workflows. According to CMS, its final policy struck the appropriate balance between such burden concerns and the need to adopt the measures.⁸ Significantly, CMS noted that 92 percent of hospitals already screen for one or more HRSNs (food insecurity, housing instability, transportation needs, utility safety and interpersonal safety) and that it was a strong indication that hospitals have processes in place to conduct the screening required.⁹ Even if health systems cannot intervene directly on social drivers of health, they can use this screening tool to risk stratify, screen early for correlated diseases, and treat aggressively for medical risk factors such as hypertension, diabetes, and mental health needs.¹⁰ The proactive application of social drivers of health via risk stratification can help identify the highest risk

³ Hajek A, Lupp A, Bretschneider C, van der Leeden C, van den Bussche H, Oey A, Wiese B, Weyerer S, Werle J, Fuchs A, Pentzek M, Löbner M, Stein J, Weeg D, Bickel H, Hesel K, Wagner M, Scherer M, Maier W, Riedel-Heller SG, König HH. Correlates of institutionalization among the oldest old-Evidence from the multicenter AgeCoDe-AgeQualiDe study. *Int J Geriatr Psychiatry*. 2021 Jul;36(7):1095-1102. doi: 10.1002/gps.5548. Epub 2021 Apr 2. PMID: 33772875.

⁴ Geyskens L, Jeuris A, Deschodt M, Van Grootven B, Gielen E, Flamaing J. Patient-related risk factors for in-hospital functional decline in older adults: A systematic review and meta-analysis. *Age Ageing*. 2022 Feb 2;51(2):afac007. doi: 10.1093/ageing/afac007. PMID: 35165688.

⁵ 87 Fed. Reg. 48780, 49201-48215 and 49215-49220 (Aug. 10, 2022).

⁶ 87 Fed. Reg. at 49201.

⁷ 87 Fed. Reg. at 49214.

⁸ 87 Fed. Reg. at 49219.

⁹ *Id.*

¹⁰ Chang E, Ali R, Seibert J, Berkman ND. Interventions to Improve Outcomes for High-Need, High-Cost Patients: A Systematic Review and Meta-Analysis. *J Gen Intern Med*. 2023 Jan;38(1):185-194. doi: 10.1007/s11606-022-07809-6. Epub 2022 Oct 11. PMID: 36220944; PMCID: PMC9849489.

groups of Medicaid and Medicare patients for future institutionalization and to prevent the decline associated with under-recognized burden of illness at younger ages tied to social drivers of health.

Despite the well-reasoned basis for adopting the measures and efforts to facilitate hospital reporting of the two measures, CMS is now reversing course in the midst of reporting, and proposing to eliminate both measures from the program. The primary rationale cited is hospital burden. CMS acknowledges that some hospitals may have expended resources to implement screenings in connection with the measure, which would support retaining the measures under the IQR and proceeding with reporting.

In describing its proposal, CMS noted that some hospitals already implemented such screenings prior to the adoption of the measures and would not have expended additional resources – a factor that would *support* retention of the measures. It is unclear what has transpired that would change the agency’s view that the importance of the measures no longer outweighs burden concerns.

CMS also identifies as a potential concern patient burden associated with repeated screenings across multiple healthcare facilities. As CMS is aware, however, patients can decline such screenings. Moreover, given that patients provide the same information to different providers across various clinical settings, it makes this particular concern questionable. Indeed, CMS has attempted to create consistency across its quality programs and capture similar data across settings.

The AGS urges CMS not to finalize its proposal. We continue to agree with the strong rationale CMS set forth when adopting these measures under the Hospital IQR program. AGS believes it is important to beneficiary well-being that hospitals continue to screen for and identify HRSNs and reporting of the two measures appropriately incentivizes this activity. CMS’ proposal also seems less compelling given that hospital reporting is already underway. CMS makes clear that if its proposal is not finalized, hospitals that do not report their CY 2024 reporting data for both measures to CMS would be considered noncompliant with the measures for the FY 2026 payment determination and would result in payment adjustments. We believe hospitals now have experience with these measures and have invested resources (or are using existing resources), such that this reversal is unnecessary. Accordingly, CMS should allow reporting to continue as previously finalized.

II. CMS Should Not Finalize Its Proposal to Remove Four Standardized Patient Assessment Data Elements (Living Situation, Food, and Utilities)

In the FY 2025 IPPS/LTCH final rule, CMS adopted four new items as standardized patient assessment data elements for reporting through the Long-term Care Data Set (LCDS) from October 1, 2026, through December 31, 2026 for purposes of the FY 2028 LTCH QRP (and for reporting full calendar years beginning in 2027, for FY 2029 LTCH QRP and beyond):

1. Living Situation (R0310)
2. Food (R0320A and R0320B) – 2 items
3. Utilities (R0330)

In the FY 2025 rulemaking, CMS provided extensive support and rationale for adopting these four data elements, noting that these items would collect information not already captured. CMS expected that screening for concerns related to these items would provide three significant benefits: (1) promote evidence-based building blocks to support healthcare providers in actualizing their commitment to addressing health disparities, (2) allow LTCHs to address social needs with the resident, caregiver and community partners during discharge planning process, if indicated, and (3) support ongoing LTCH QRP initiatives by providing data with which to stratify LTCHs’ performance on measures and in future quality measures.¹¹ CMS also noted that the four items would permit the agency to continue developing the

¹¹ 89 Fed. Reg. 69583-69548 (Aug. 28, 2024).

statistical tools necessary to maximize the value of Medicare data and improve the quality of care for all beneficiaries.¹²

CMS also provided significant underlying support for the collection of the Living Situation, Food and Utilities items (HRSNs),¹³ recognizing that they are associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs.¹⁴ The agency further explained that LTCHs can use information obtained to offer assistance by connecting patients and their caregivers with these associated needs to social support programs, as well as inform understanding of patient complexity.¹⁵ CMS also reasoned that LTCHs can use information obtained from the Living Situation item during the patient's discharge planning, data about the patient's food security at home to gain insight on health complexity and help facilitate coordination during transitions of care, and information about utility security to identify patients that may benefit from engagement efforts (*e.g.*, support programs related to home energy).¹⁶ With regard to collection of similar elements under other quality programs, the agency indicated that partial alignment in screening of these elements would facilitate the longitudinal data collection on the same topics across healthcare settings and that using common standards and definitions for new assessment items would help to promote interoperable exchange of longitudinal information between LTCHs and other providers to facilitate coordinated care, continuity of care planning, and the discharge planning process.¹⁷

Notably, CMS received extensive input from interested parties that informed its decision to adopt these four new items, citing feedback considered in response to its RFI on "Closing the Health Equity Gap in CMS Hospital Quality Programs" in the FY 2022 IPPS/LTCH PPS final rule, as well as public comments on its FYs 2020 and 2025 IPPS/LTCH PPS rulemakings.¹⁸ The adoption of its current policy was well-vetted and examined in detail.

And yet, the agency's rationale for the proposed removal of these data elements is the burden associated with such reporting, and a change in focus of data collection with a desire to "work towards the workflow for these data elements being part of a low burden interoperable electronic system."¹⁹ However, CMS addressed that concern in the FY 2025 rulemaking. CMS acknowledged the additional four assessment items would increase the burden associated with completing the LCDS, but that it carefully weighed the burden of collecting the data against the benefits of adopting the four new elements.²⁰ The agency further noted that the new assessment items could inform the discharge planning process for LTCHs, reducing discharge planning burden overall, rather than negatively impacting the time LTCHs spend on discharge planning.²¹ AGS agrees with this assessment and believes that the modest burden of 7.88 hours per year per LTCH is far outweighed by the potential for improved care coordination.²²

CMS has not set forth any reasoning why these four assessment items are no longer important and offers no explanation of any changed facts or circumstances that would necessitate the proposed removal of these elements.

¹² *Id.* at 69589.

¹³ *See id.* at 69583 (also citing various reports, including two (2016 and 2020) National Academies of Sciences, Engineering, and Medicine reports regarding the patient assessment items).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.* at 69584-69586.

¹⁷ *Id.* at 69590.

¹⁸ *Id.* at 69587-69587.

¹⁹ 90 Fed. Reg. at 18350.

²⁰ *Id.* at 69587.

²¹ *Id.* at 69588.

²² *Id.* at 18414.

The AGS strongly opposes this proposal and urges the agency to retain these data elements as previously planned. As CMS has acknowledged (with ample supporting evidence), an individual's living situation, food, and utilities are areas that bear on their health and wellbeing and are worthy of assessing, particularly before discharge from the LTCH setting. Housing instability, food insecurity, and inadequate household energy needs can have negative impacts on Medicare beneficiaries. It is essential for LTCHs to collect information on these elements in order to accurately identify patient needs and potential avenues of assistance. Without this information, facilities cannot fully support patients transitioning to home which increases the likelihood of poor health outcomes that may be associated with future Medicare expenditures. Acquiring and being able to utilize information about the patient's living situation and access to food and utilities during a facility stay will help ensure that the post-facility care is most appropriate for the individual patient's needs. Such improved coordination between the facility and community care providers will help ensure that Medicare dollars are spent efficiently and better facilitates high quality care across settings. Medicare policy changes have already helped reduce the impact of socioeconomic status on healthcare utilization, and these new measures are the next important step.²³ It is precisely the geriatric population whose health is most vulnerable to effects of these issues, and we encourage you to keep these measures to help health systems better identify ways to care for the health of our oldest citizens.

Accordingly, AGS continues to support the inclusion of these data elements in a standardized patient assessment. We urge CMS to maintain its existing policy and not finalize its proposal.

III. CMS Should Continue to Support and Utilize the Age Friendly Hospital Measure

In the FY 2025 IPPS final rule, CMS approved a new quality measure based on the principles of age-friendly care in an effort to help ensure hospitals better align care with older patients' goals and preferences. The Age Friendly Hospital Measure domains reflect the [Age-Friendly Health Systems 4Ms Framework](#),²⁴ an approach to care that focuses on addressing the key drivers of good health outcomes for older adults: asking and acting on What Matters to the older patient and assessing and intervening on issues related to their Medications, Mentation, and Mobility. Beginning in 2025, hospitals that participate in Medicare's Hospital IQR Program are required to report on the extent to which they meet all elements within five domains of the new Age Friendly Hospital Measure. The domains represent whether hospitals have protocols in place to: 1) elicit patient health care goals, 2) responsibly manage medications, 3) implement frailty screening and intervention (including for cognition and mobility), 4) assess social vulnerability (e.g. social isolation, caregiver stress, elder abuse) and 5) designate leaders to ensure the equitable delivery of age-friendly care.

The Age Friendly Hospital Measure closely aligns with Make America Healthy Again by pushing for transparency and accountability. The measure is publicly reported, helping to build a better, safer hospital environment that will help older patients and caregivers know where to get the best care. The measure also aligns in other key areas of the Make America Healthy Again agenda, such as emphasizing the importance of appropriate medication prescribing—both the right medications and the right doses. In addition, the Measure advances two other key priorities of Make America Healthy Again by promoting physical activity and supporting healthy lifestyles. The measure also identifies opportunities to reduce social vulnerability among older adults. The Age Friendly Hospital Measure is in direct alignment with the Administration's efforts to reduce waste and lower costs. The 4Ms age-friendly framework reduces

²³ Escarce JJ, Kapur K. Racial and ethnic differences in public and private medical care expenditures among aged Medicare beneficiaries. *Milbank Q.* 2003;81(2):249-75, 172. doi: 10.1111/1468-0009.t01-1-00053. PMID: 12841050; PMCID: PMC2690217

²⁴ <https://www.ihl.org/networks/initiatives/age-friendly-health-systems>.

unnecessary tests, treatments, and hospitalizations, leading to shorter stays, fewer readmissions, and less medication-related harm.

Accordingly, AGS strongly supports the Age Friendly Hospital Measure and CMS' continuation of its use.

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The AGS appreciates the opportunity to provide the above comments and recommendations. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,

A handwritten signature in black ink that reads "Paul Mulhausen, MD." The signature is written in a cursive, slightly slanted style.

Paul Mulhausen, MD
President

A handwritten signature in black ink that reads "Nancy E. Lundebjerg". The signature is written in a cursive, slightly slanted style.

Nancy E. Lundebjerg, MPA
Chief Executive Officer