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June 10, 2025

Dr. Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1829-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2026 and Updates to the IRF Quality Reporting Program (CMS-1829-P)

Dear Administrator Oz:

The American Geriatrics Society (AGS) appreciates the opportunity to submit comments on the fiscal year (FY) 2026 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) proposed rule.<sup>1</sup> We applaud the Centers for Medicare & Medicaid Services (CMS) for striving to advance the IRF Quality Reporting Program (QRP), including its recent adoption of four new standardized patient assessment data elements – Living Situation (R0310), Food (R0320A and R0320B), and Utilities (R0330) – in the FY 2025 final rule for the IRF 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 IRFs.

As discussed in greater detail below, we urge CMS to reconsider its proposals and to retain these 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 emerge

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<sup>1</sup> 90 Fed. Reg. 18534 (April 30, 2025).

from multiple adverse social drivers of health exposures, leading to morbidity, functional decline, and eventually cascading into the need for institutionalization.<sup>2,3</sup>

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

In the FY 2025 IRF PPS final rule, CMS adopted four new items as standardized patient assessment data elements for reporting using the IRF-PAI (Patient Assessment Instrument) beginning with patients discharged on or after October 1, 2026, through December 31, 2026 for purposes of the FY 2028 IRF QRP and each program year thereafter:

1. Living Situation (R0310)
2. Food (R0320A and R0320B) – 2 items
3. Utilities (R0330).<sup>4</sup>

CMS selected these items from the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool developed for the AHC Model.<sup>5</sup> 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 IRFs to address social needs with the patient, their caregivers, and community partners during discharge planning process, if indicated, and (3) support ongoing IRF QRP initiatives by providing data with which to stratify IRFs' performance on measures and in future quality measures.<sup>6</sup> CMS also noted that the four items would permit the agency to continue developing the statistical tools necessary to maximize the value of Medicare data and improve the quality of care for all beneficiaries.<sup>7</sup>

CMS also provided significant underlying support for the collection of the HRSNs relating to Living Situation, Food and Utilities items,<sup>8</sup> recognizing that they can negatively impact a person's health and are associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs.<sup>9</sup> Moreover, CMS noted that these HRSNs can lead to unmet social needs that directly influence an individual's physical, psychological, and functional status.<sup>10</sup> The agency further explained that IRFs 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.<sup>11</sup> CMS also reasoned that IRFs 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

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<sup>2</sup> Hajek A, Lupp A, Brettschneider 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.

<sup>3</sup> 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.

<sup>4</sup> See 89 Fed. Reg. 64276, 64310-64326 (Aug. 6, 2027).

<sup>5</sup> *Id.* at 64312.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> See *id.* at 64311-64312 (also citing various reports, including two (2016 and 2020) National Academies of Sciences, Engineering, and Medicine reports regarding the patient assessment items).

<sup>9</sup> *Id.*

<sup>10</sup> *Id.* at 64312

<sup>11</sup> *Id.* at 64311.

home energy).<sup>12</sup> 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 IRFs and other providers to facilitate coordinated care, continuity of care planning, and the discharge planning process.<sup>13</sup>

Notably, CMS received extensive input from interested parties that informed its decision to adopt these four new items, citing feedback considered in response to the FYs 2020, 2024 and 2025 IRF PPS rulemakings.<sup>14</sup> 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 reporting the four items at this time and that it would like to "work towards the workflow for these data elements being part of a low burden interoperable electronic system."<sup>15</sup> 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 IRF-PAI, but that it carefully weighed the burden of collecting the data against the benefits of adopting the four new elements.<sup>16</sup> The agency further noted that its policy goals outweighed such burdens and that the new assessment items will inform care planning and coordination and quality improvement across settings.<sup>17</sup> CMS also noted, in response to concerns about that this assessment would take away time from patient care, that the four data elements are all important pieces of information to developing and administering a comprehensive plan of care in accordance with the IRF regulations and that includes the initiation of a discharge plan, which, in the IRF setting is a relatively short length of stay, and begins at the time of admission – thus, the data items would inform the comprehensive plan of care.<sup>18</sup> AGS agrees with this assessment and believes that the modest burden of 10 hours (or \$748.25) per year per IRF is far outweighed by the potential for improved care coordination.<sup>19</sup>

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.

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 IRF setting. Housing instability, food insecurity, and inadequate household energy needs can have negative impacts on Medicare beneficiaries. It is essential for IRFs 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 an IRF 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

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<sup>12</sup> *Id.* at 64312-64314.

<sup>13</sup> *Id.* at 64315.

<sup>14</sup> *Id.* at 64315. CMS finalized the creation of social drivers of health standardized patient assessment data elements in the FY 2020 IRF PPS final rule.

<sup>15</sup> 90 Fed. Reg. at 18550.

<sup>16</sup> 89 Fed. Reg. at 64316.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> 90 Fed. Reg. at 18551.

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 items are the next important step.<sup>20</sup> It is precisely the geriatric population whose health is most vulnerable to effects of these issues, and we encourage you to keep these data elements 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.

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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](mailto:agoldstein@americangeriatrics.org).

Sincerely,



Paul Mulhausen, MD  
President



Nancy E. Lundebjerg, MPA  
Chief Executive Officer

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<sup>20</sup> 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