NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Michelle Morse, MD, MPH
Acting Health Commissioner

Re: File code CMS-1833-P

Dear Centers for Medicare & Medicaid Services,

NYC Department of Health and Mental Hygiene (NYC Health Department) appreciates the opportunity to provide comments in response to the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) proposed rule 1833-P regarding the Hospital Inpatient Prospective Payment System for FY 2026.

The NYC Health Department opposes the proposed removal of four standardized, widely used patient assessment data elements under the Social Determinant of Health (SDOH) category of the Long-Term Care Hospital Quality Reporting Program (LTCH QRP): one item for "living situation," two items for "food," and one item for "utilities." This is important information that is not collected otherwise. We also oppose the removal of the following measures from the Hospital Inpatient Quality Reporting Program:

- Hospital Commitment to Health Equity measure, beginning with the CY 2024 reporting period/FY 2026 payment determination;
- Screening for Social Drivers of Health measure, beginning with the CY 2024 reporting period/FY 2026 payment determination; and
- Screen Positive Rate for Social Drivers of Health measure, beginning with the CY 2024 reporting period/FY 2026 payment determination.

SDOH screenings are designed to identify unmet social needs that affect a patient's health, treatment, and recovery upon discharge, and connect them to resources. Social needs are dynamic, akin to a clinical condition, and it is important to identify social needs among patients, consider these conditions during treatment, and integrate social services that address needs with health care delivery. When patients screen positive for social needs, healthcare teams have many options for how to address them. Addressing these needs is part of a comprehensive and preventative approach to care that optimizes resource allocation, improves population health, and reduces long-term healthcare costs.

Furthermore, hospitals across the country have already made the investments to incorporate screening tools into electronic health records and workflows in ways allow that patients' social needs to be met. For these hospitals, removing social needs measures now does not reduce the size of the investment made in the past. It would require more resources to rework the existing workflows and electronic medical records than to continue screening patients – and hospitals would lose valuable information that supports the health of their patients.

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Assessing Social Determinants of Health Can Prevent Costly Care in the Future

Addressing social needs such as food insecurity or lack of access to healthy foods is key in improving chronic disease. Research suggests that food insecurity may worsen diet-related chronic disease outcomes.[1] Understanding a community's material needs is an essential tool to keep residents healthy and prevent costly health conditions and avoidable care, a relationship prioritized in the NYC Health Department's Chronic Disease Strategy.[2] For example, NYC is implementing efforts to increase SNAP enrollment among patients in safety net hospitals, given the association of SNAP participation with improved self-reported health, reduced risk of heart disease and obesity, improved adherence to medication, and lower costs of health care, particularly for hypertension and coronary heart disease.[3] NYC Health Department also provides local programs that enhance access to healthy foods and support a nutritious diet, including the More Veggies program, a fruit and vegetable prescription program in the Bronx, which provides patients from a federally qualified health center who are food insecure, on Medicaid and have poorly controlled type 2 diabetes, with $100 and $150 per month to purchase produce at select supermarkets, and Health Bucks, a program providing coupons redeemable for fresh fruits and vegetables at any NYC farmers markets to low-income New Yorkers. Identifying individuals at risk of food insecurity through SDOH screening can promote effective care coordination, continuous care, and discharge planning tailored to an individual's needs and with an aim to prevent future negative health outcomes and costly care.

Similarly, research demonstrates the close relationship between housing and healthcare. Identifying individuals with unstable housing through a living conditions screening question can help connect individuals with resources to support access to stable housing and enable individuals to spend resources on food, healthcare access, and promote healthy living that can reduce healthcare spending down the road.[4] For example, as explained in the NYC Blueprint for Housing and Homelessness, "housing instability and homelessness make it harder to access the

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[1] NYC Healthy Department. 2025. *Addressing Unacceptable Inequities: A Chronic Disease Strategy for New York City*. https://www.nyc.gov/assets/doh/downloads/pdf/about/chronic-disease-strategy-nyc.pdf at footnote 100-101.

[2] Chronic Disease Strategy.

[3] Chronic Disease Strategy, at footnote 89-96.

[4] Henderson, K.A., Manian, N., Rog, D.J., Robison, E., Jorge, E., Al-Abdulmunem, M. "Addressing Homelessness Among Older Adults" (Final Report). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. October 26, 2023; Lærum-Onsager E, Molin M, Olsen CF, Bye A, Debesay J, Hestevik CH, Bjerk M, Pripp AH. Effect of nutritional and physical exercise intervention on hospital readmission for patients aged 65 or older: a systematic review and meta-analysis of randomized controlled trials. Int J Behav Nutr Phys Act. 2021 May 10;18(1):62. doi: 10.1186/s12966-021-01123-w. Erratum in: Int J Behav Nutr Phys Act. 2021 Jun 25;18(1):80. doi: 10.1186/s12966-021-01152-5. PMID: 33971901; PMCID: PMC8112053.

health care system because of increased logistical burdens and competing priorities. As a result, many people experiencing homelessness lack a primary care provider, leading homeless clients to utilize the emergency department at a far higher rate than the general population."[5]

With respect to utility costs, the evidence base is well established on the relationship between health and the inability to meet basic household energy needs (known as energy insecurity).[6] The NYC Health Department conducted a representative survey of New Yorkers and found that energy insecurity was associated with higher odds of respiratory, mental health, and cardiovascular conditions and electric medical device dependence.[7] Of those cutting down on energy use because of worries about the bill, many said it affected their health conditions (18%), and decisions about medicine purchases (13%). Screening patients for trouble paying utility costs and connecting them with existing resources is particularly important for patients with chronic conditions, and doing so furthers a prevention-based health agenda.

The NYC Health Department appreciates the opportunity to submit these comments.

Respectfully,

Michelle Morse, MD, MPH
Acting Health Commissioner
New York City Department of
Health and Mental Hygiene

[5] The City of New York. 2022. *Housing Our Neighbors: A Blueprint for Housing and Homelessness*. https://www.nyc.gov/assets/home/downloads/pdf/office-of-the-mayor/2022/Housing-Blueprint.pdf.
[6] Hernández, D., 2016. Understanding 'energy insecurity' and why it matters to health. *Social science & medicine*, *167*, pp.1-10.
[7] Siegel, E.L., Lane, K., Yuan, A., Smalls-Mantey, L.A., Laird, J., Olson, C. and Hernández, D., 2024. Energy insecurity indicators associated with increased odds of respiratory, mental health, and cardiovascular conditions: study examines energy insecurity and health conditions. *Health Affairs*, *43*(2), pp.260-268.