June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: CMS-2025-0031-0002, Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2026 Proposed Rule

Dear Administrator Oz,

On behalf of the National Alliance to Impact Social Determinants of Health (NASDOH), we appreciate the opportunity to provide comments on the fiscal year (FY) 2026 Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities and Updates to the Quality Reporting Program proposed rule.

Founded in 2018 by Governor Mike Leavitt and Dr. Karen DeSalvo, NASDOH is a multi-sector coalition of stakeholders seeking to make a material improvement in the health of individuals and communities by advancing the adoption of effective policies and programs to address health-related social needs (HRSNs) – such as food insecurity, housing instability, and transportation insecurity – as well as the underlying social and economic conditions in which people live that are often the root causes of poor health outcomes (non-medical drivers). NASDOH brings together stakeholders from different geographic regions with expertise in health care, public health, social services, patient and consumer perspectives, information technology, and business to share learnings, develop policy recommendations, and build consensus on solutions to support health. Our website lists all the NASDOH members.

Proposal To Remove Four Standardized Patient Assessment Data Elements Beginning with the FY 2027 SNF QRP

CMS proposes to remove four standardized patient assessment data elements under the social determinants of health (SDOH) category: one item for Living Situation, two items for Food, and one item for Utilities, beginning with the FY 2027 SNF QRP.

NASDOH supported the inclusion of the four SDOH items to be collected as standardized patient assessment data under the SNF QRP within the SNF rule for FY2025. Social determinants of health account for more health outcomes, including cost, than medical care alone. For this reason, it is critical that continued movement towards value-driven care recognizes the importance of addressing SDOH. Identification, within the clinical environment, of social factors that relate to health risk is an essential first step toward fulfilling unmet social needs and improving health by linking people with social care and health systems.

The SDOH data elements consider patient needs for housing, food security and nutrition, and utilities. Particularly, the data elements provide a clearer picture of the individual's needs and highlight the scope

of services that are needed to improve care and health outcomes. NASDOH has and continues to support the inclusion of these SDOH data elements in the SNF QRP.

In addition, NASDOH has consistently encouraged CMS to consider how to address identified needs. Responding to identified needs requires a process for assessing internal capacity of a health care provider to address certain needs, understanding the resources available in a given community, and determining the appropriate path forward whether that involves augmenting internal capacity, referring patients outside of the health care system, or a combination of the two.[1] Particularly, meaningful partnerships with community-based organizations are needed to improve outcomes for patients.

SNF QRP Measure Concepts Under Consideration for Future Years—Request for Information (RFI): Interoperability, Well-Being, Nutrition & Delirium

NASDOH appreciates that CMS is considering measures on well-being and nutrition for the SNF QRP. NASDOH agrees with CMS that a comprehensive approach is needed to address chronic disease and other potential health issues and encourages CMS to consider the root causes of poor health within potential quality measures on wellbeing and nutrition. NASDOH believes addressing the existing five four SDOH data elements support a comprehensive approach to addressing the underlying causes of chronic disease and poor health outcomes and support Secretary Kennedy's vision to Make America Healthy Again.

Well-being and nutrition specifically play a key role in promoting health and healthy outcomes. Likewise, food and nutrition insecurity are associated with increased risk for multiple chronic health conditions, including obesity, heart disease, mental health disorders, and other chronic diseases.[2]

In December 2023, NASDOH convened multiple stakeholders representing payers, providers, community-based organizations, social service providers, public health, and technology resources across the country. At this convening, stakeholders discussed the various social needs-related screening measures and how quality measures and quality programs can best meet patient needs and policymakers' objectives. Participants also discussed the goals and outcomes of screening, variability of tools and processes for screening, incorporating data from social needs screening into clinical care and decision making, funding needs for screening and addressing HRSNs, including building community capacity, and supporting multi-sector involvement. The result of the convening was ten principles for adoption, updating, and implementing quality measures related to social needs. We encourage CMS to consider these principles in furthering policies related to well-being and nutrition, two significant HRSNs, within quality reporting and payment programs.

1) Improving Outcomes—Quality measures are an important tool for advancing the use of culturally sensitive social needs screenings, connecting people to services that improve outcomes, and advancing health equity.
2) Meeting Patient's Needs—SDOH-related quality measures should be designed and implemented primarily to advance the health and well-being of individuals, including through the delivery of social services and supports. SDOH-related measures should prioritize holistic improvement in the patient's health and well-being rather than focusing on reducing the number of social needs.

[1] Freeman GA. "Health Plan Addresses Social Issues With Data." HealthLeaders, May 30, 2018.
[2] Food insecurity is associated with multiple chronic conditions and physical health status among older US adults - PMC

3) Screening Intervals and Duplication—Implementation of quality measures should consider how patients engage with the health care system and avoid unnecessary duplication of screenings. While repetition of screenings at appropriate intervals can support the identification of emerging or changing needs, duplication of screenings may lead to mistrust.
4) Strengths-Based Approach—SDOH-related quality measures should be designed to highlight assets and support strengths-based solutions rather than focusing on deficits and imposing specific interventions to address individual HRSNs.
5) Incorporate Feedback—Feedback from patients on their experiences of SDOH-related screenings should be used to inform updates to quality measures.
6) Harmonized Measures—A core set of measures harmonized across quality and payment programs would support adoption and reduce the administrative burden for patients, providers, payers, social workers, community health workers, and others involved. Determinants of health that impact health equity should be a part of measures used, including integrated healthcare, community resiliency, physical environment, socioeconomics, and community trauma.
7) Using Existing Data—Collection of data to inform SDOH measures should, whenever possible, draw from existing data sources to minimize additional data collection burden on all involved.
8) Screening Tools and Administration—Quality measures should allow for the use of a variety of validated screening tools and entities that are screening should have flexibility to determine how screenings are conducted.
9) Shared Responsibility and Commitment—Identifying and addressing HRSNs is a shared responsibility. Therefore, quality measures should be driven and informed by engagement with patients and impacted communities and should encourage meaningful collaboration between health care, public health, and social service, and other sectors to screen and connect patients to the resources they need. Additionally, each sector must be committed, supported, and empowered to address patient needs, improve outcomes of individuals and communities they serve and hold each sector accountable for performance.
10) Data Justice—Screening data should be shared with the communities it originates from to advance community-level efforts to address SDOH. The data should be useful and updated regularly, consistently, and accurately.

NASDOH appreciates the opportunity to comment on these important proposals. For more information on NASDOH and our members, please visit our website at www.nasdoh.org. Should you have any questions or wish to discuss our comments further, please contact Laura Pence at Laura.Pence@LeavittPartners.com.

Sincerely,

Laura Pence

Laura Pence
Advisor to NASDOH