



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

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Via electronic submission: [<http://www.regulations.gov>.]

Re: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model (Docket No. CMS-1830-P)

Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 413 and 512
[CMS-1830-P]
RIN 0938-AV52

Dear Centers for Medicare & Medicaid Services:

The 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 1830-P regarding the End Stage Renal Disease (ESRD) Prospective Payment System for Calendar Year (CY) 2026.

The NYC Health Department opposes the proposed removal of three reporting measures from the ESRD Quality Incentive Program, beginning with Payment Year 2027:

- Facility Commitment to Health Equity reporting measure
- Screening for Social Drivers of Health reporting measure
- Screen Positive Rate for Social Drivers of Health reporting measure

Assessing the Opportunity Cost and Collateral Consequences of this Potential Rule Change Is Important to Understanding the Cost of Such Policy

The proposed rule alleges the costs of using these measures “may outweigh the benefits to providers and patients.” However, the rule fails to address the opportunity costs or collateral costs of this change. For instance, dialysis facilities across the country have already invested valuable time, effort, and funds to modify workflows and electronic health records to comply with the *Facility Commitment*

to *Health Equity* measure in anticipation of its inclusion in the Quality Incentive Program starting in Payment Year 2026. These facilities may have also begun making similar preparations regarding the two other measures. It would require additional resources to rework existing workflows and electronic health records that have already been revised to incorporate the *Facility Commitment to Health Equity* measure. Moreover, many facilities may have already taken on additional work to incorporate the *Screening for Social Drivers of Health* and *Screen Positive Rate for Social Drivers of Health* measures.

Additionally, given that CMS's own Paperwork Reduction Act analysis attributes very modest overall savings to removing these three measures from the list of 121 Quality Incentive Program reporting measures, it is possible that the savings may not outweigh the costs. This is especially the case where any expenses are miniscule when compared to their potential to greatly improve Medicare beneficiaries' care and health outcomes, which could provide cost-savings to the patient and healthcare system over time. CMS estimates the time-cost per measure per patient to be 2.5 minutes, for a total of 0.125 hours of data collection of these three measures per ESRD patient.^a At CMS's assumed average wage rate of \$48.32 per hour for a medical records specialist, the financial burden of collecting data for these three measures amounts to \$6.04 per patient. At a facility level, the average annual data collection cost of these three measures amounts to \$401.85 based on CMS' patient roster data of 66.5 patients per facility.

Assessing Social Drivers of Health Can Prevent Costly Care in the Future and Improve Chronic Disease Outcomes

Social Drivers of Health (SDOH) screenings provide considerable benefits to patients with chronic disease while reducing healthcare expenditures. These screenings are designed to identify unmet social needs that affect a patient's condition, treatment, and recovery upon discharge, and connect them to critical resources. Addressing these needs is part of a comprehensive and preventative approach to care that improves population health while reducing the long-term healthcare costs associated with treating severe chronic disease outcomes.

For example, a critical social driver of health is food insecurity or lack of access to healthy foods, which can lead to poor chronic disease outcomes. The risk of developing chronic kidney disease, specifically, can rise when a person experiences food insecurity.^b As with other SDOH, health care providers can identify food insecurity via screening and subsequently connect patients to resources in their communities. The NYC Health Department's Chronic Disease Strategy, addresses food insecurity among patients at safety net hospitals through efforts to increase SNAP participation, which is associated with improved self-reported health, reduced risk of heart disease and obesity (both risks factors for chronic kidney disease), improved adherence to medication, and lower costs of health care for hypertension and coronary heart

^a 90 Fed. Reg. 29374.

^b Ferrara F, Siligato R, Di Maria A, et al. Food insecurity and kidney disease: a systematic review. *Int Urol Nephrol*. 2024;56(3):1035-1044. doi:10.1007/s11255-023-03777-w

disease.^c The NYC Health Department also addresses food insecurity through local fruit and vegetable prescription programs that enhance access to healthy foods and support a nutritious diet for patients with poorly controlled Type 2 Diabetes while encouraging consumers to purchase food at local retail outlets and stimulating the local economy.^d However, if health care providers do not screen patients for food insecurity, this need goes unidentified, and referrals go unmade to the proper programs/resources to support communities with high rates of chronic disease. Understanding a community's material needs is essential to keeping residents healthy and preventing costly health conditions and avoidable care, and SDOH screening is a powerful tool that allows health care providers to accomplish this.

Considering Barriers to Kidney Transplant is Important to Understanding the Impact of the ESRD Treatment Choices Model

The NYC Health Department would also like to comment on the proposed termination of the ESRD Treatment Choices (ETC) Model. The ETC Model aims to encourage greater use of home dialysis and kidney transplants for Medicare beneficiaries through payment incentives to enhance accessibility to renal care, preserve quality of treatment, and reduce Medicare expenditures.

It is important to consider how evaluations of the ETC model may be impacted by existing barriers to kidney transplants, many of which are related to the social drivers of health discussed above and may negatively impact access to this life-saving treatment.^e Some kidney transplant facilities will deem patients ineligible to receive a transplant if they are experiencing unaddressed food insecurity. Other social needs, including insufficient health insurance coverage,^{5,f} lack of access to transportation,^{5,g} inability to take time off work for medical treatment,⁶ limited health literacy,^{5,6,7} and having to travel long distances to reach a transplant center (e.g., in rural areas or in parts of cities with limited public transportation),⁵ prevent patients who might otherwise be eligible for a transplant from completing the transplant evaluation process. The impact of social needs-related barriers on kidney transplant uptake will be even more difficult to recognize if the reporting measures discussed above are removed.

^c New York City Health Department, Addressing Unacceptable Inequities: A Chronic Disease Strategy for New York City (2025), <https://www.nyc.gov/assets/doh/downloads/pdf/about/chronic-disease-strategy-nyc.pdf>.

^d Yan AF, Chen Z, Wang Y, et al. Effectiveness of Social Needs Screening and Interventions in Clinical Settings on Utilization, Cost, and Clinical Outcomes: A Systematic Review. *Health Equity*. 2022;6(1):454-475. Published 2022 Jun 24. doi:10.1089/heq.2022.0010

^e Harding JL, Perez A, Snow K, et al. Non-medical barriers in access to early steps of kidney transplantation in the United States - A scoping review. *Transplant Rev (Orlando)*. 2021;35(4):100654. doi:10.1016/j.tre.2021.100654

^f Nonterah CW, Gardiner HM. Pre-transplant evaluation completion for Black/African American renal patients: Two theoretical frameworks. *Patient Educ Couns*. 2020;103(5):988-998. doi:10.1016/j.pec.2019.11.005

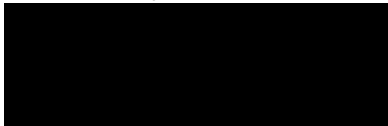
^g Boulware LE, Mohottige D, Purnell TS. Focusing on Systems and Policies to Solve the Kidney Transplant Equity Crisis. *JAMA Intern Med*. 2025;185(2):195–196. doi:10.1001/jamainternmed.2024.6654

Additionally, there is substantial evidence that kidney transplants and home dialysis are preferable to in-center dialysis in terms of health outcomes and quality of life.^{h,i,j} These treatments allow people with ESRD a degree of flexibility and independence that are not possible when relying on in-center dialysis. Kidney transplants^k and home dialysis are also associated with reduced health care expenses, with cost decreasing over time.^{10,l} The ETC model may help patients experiencing the above barriers to access home treatments which might otherwise be unavailable to them.

For these reasons, the NYC Department of Health recommends maintaining the three reporting measures discussed from the ESRD Quality Incentive Program. We strongly encourage you to continue incentivizing use of home dialysis and kidney transplant. We also strongly encourage you to keep in place reporting measures that systematically identify barriers preventing patients from receiving lifesaving and life-enhancing kidney transplants.

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

Sincerely,



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

^h Ishani A, Slinin Y, Greer N, et al. Comparative Effectiveness of Home-Based Kidney Dialysis Versus In-Center or Other Outpatient Kidney Dialysis Locations – A Systematic Review [Internet]. Washington (DC): Department of Veterans Affairs (US); 2015 Apr. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK344414/>

ⁱ Ok E, Demirci C, Asci G, et al. Patient Survival With Extended Home Hemodialysis Compared to In-Center Conventional Hemodialysis. *Kidney Int Rep.* 2023;8(12):2603-2615. Published 2023 Sep 15. doi:10.1016/j.ekir.2023.09.007

^j Walker RC, Howard K, Morton RL. Home hemodialysis: a comprehensive review of patient-centered and economic considerations. *Clinicoecon Outcomes Res.* 2017;9:149-161. Published 2017 Feb 16. doi:10.2147/CEOR.S69340

^k Yang F, Liao M, Wang P, Yang Z, Liu Y. The Cost-Effectiveness of Kidney Replacement Therapy Modalities: A Systematic Review of Full Economic Evaluations. *Appl Health Econ Health Policy.* 2021;19(2):163-180. doi:10.1007/s40258-020-00614-4

^l Bieber SD, Young BA. Home Hemodialysis: Core Curriculum 2021. *Am J Kidney Dis.* 2021;78(6):876-885. doi:10.1053/j.ajkd.2021.01.025