August 31, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator, Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
P.O. Box 8013  
Baltimore, MD 21244-1850  
(Submitted electronically to regulations.gov)

Re: Docket (CMS-4203-NC) Medicare Program; Request for Information on Medicare

On behalf of the National Produce Prescription Collaborative (NPPC), we appreciate the opportunity to respond to your public request for information about the Medicare program. Our coalition has noted and applauds the Biden administration’s efforts and commitment to equity in Medicare as well as the other health programs under your purview. We appreciate the opportunity to share some thoughts specifically on food- or nutrition-related supplemental benefits and offer recommendations for how the Administration can enhance Medicare beneficiary access to cutting edge health interventions that are showing great promise for patients with diet-related conditions.

The NPPC is composed of dozens of equity-focused produce prescription (PRx) practitioners, researchers, and advocates, who gathered in 2019 to catalyze the vital role of food and nutrition in improving health and wellness by collectively leveraging the unique opportunities for PRx to achieve wellness by embedding and institutionalizing PRx within healthcare practice. Our respective organizations are actively working to bring new and innovative PRx models to diverse communities across the country, and our collective experiences have highlighted the need for PRx to be prescribed at the point of care, and covered by the patient’s health insurer as an integral part of a clinical care treatment plan.

As the intervention at the heart of our work is food related, we will focus our response to questions 6 and 7 in section II part A of the RFI.

NPPC defines a Produce Prescription (PRx) as a medical treatment or preventative service for patients who are eligible due to a diet-related health risk or condition, food insecurity or other documented challenges in access to nutritious foods, and who are referred by a healthcare provider or health insurance plan. These prescriptions are fulfilled through food retail and enable patients to access healthy produce with no added fats, sugars, or salt, at
low or no cost to the patient. When appropriately dosed, Produce Prescriptions improve healthcare outcomes, optimize medical spending, and increase patient engagement and satisfaction.

Since 2020, Medicare Advantage (MA) plans have been able to offer PRx as a Special Supplemental Benefit for the Chronically Ill (SSBCI) as well as Value Based Insurance Design (VBID) parameters [1]. However, MA plans are not regularly reporting the extent to which they are utilizing these benefit allowances, so we appreciate that CMS is seeking to gain a better understanding through public comment submissions in response to this RFI. We know there has been steadily growing interest on the part of MA plans to offer food and produce benefits. A 2022 report by ATI [2] showed that 14% of MA plans were offering a food and produce SSBCI benefit, a significant increase from 2% in 2020 and double the 7% reported in 2021. However, beyond high level data, we know very little about how much food and produce, what type of food and produce, and for what patients these plans are offering a food and produce benefit. The NPPC recommends CMS collect detailed data about the types of food and produce benefits being offered, the associated costs, and to which patients the benefit is being offered to so that we can better understand what is working to advance equity in diet and subsequently diet-related disease. This data should be de-identified to protect MA plans’ intellectual property and published in a timely fashion by CMS.

The allowance for food and produce benefits to be tailored to the specific needs of the individual, as opposed to uniformity requirements, is essential to successful deployment and utilization of the benefits to advance health outcomes in an equitable way. Some patients have specific preferred grocery stores and a supplemental PRx benefit will not be used if it is not delivered at that particular store, while other plan members do not live near any grocery store and therefore need a home-delivery option, and finally some shoppers will not consume a plan-determined produce prescription but rather will need the opportunity to self-select which items are in their box in order for the benefit to be utilized. The flexibility CMS offers MA plans in this regard is essential for equity in uptake and we encourage the continued allowance of individualized SSBCI benefits for food and produce.

The patient experience with the PRx intervention is consistently reported as very positive [3]. MA members value the food and produce benefits they receive. Given the strong association between health equity and patient experience [4], the NPPC applauds CMS’ recent efforts to emphasize patient experience in star ratings [5] and supports the continuation of this practice going forward.

In exploring the various experiences our member community-benefit-organizations (CBOs) have had with administering SSBCI benefits under MA, the following themes arise as important to share with CMS:

Healthcare contracting requires support relating to legal compliance. CBOs have struggled, for example, to understand how MA compliance rules and regulations for first tier and downstream entities apply to their operations. For many, legal requirements for codes of conduct and fraud, waste, and abuse training are new; organizations benefit from resources that they can readily adapt and deploy. Similarly, healthcare contracting
requires investments in infrastructure to develop, for example, the requisite technological capabilities. We suggest CMS to partner with the USDA’s NIFA GusNIP NTAE and jointly publish guidelines and technical assistance for these CBO’s infrastructure development.

Regarding compensation arrangements, it is essential that CMS and MA plans/providers recognize that activities to support health-related social needs are varied and evolving. In the food and nutrition space, for example, MA plan benefits may look like standard home-delivered meals under supplemental benefits, as well as medically-tailored meals; medically-tailored groceries, fresh food and produce; and/or transportation to a grocery store or community food program via SSBCI. The cost of the benefit varies within and across each iteration, and this difference cannot be accurately captured in current billing codes. Therefore we recommend that CMS include SDOH billing code parameters as essential to its strategic advancement of equity in Medicare and Medicare Advantage.

Plans are interested in contracting with networks of PRx organizations in order to streamline administration while ensuring geographic coverage. At the same time, ensuring geographic coverage may require the inclusion of CBO partner-vendors that are newer to healthcare contracting and lesser compliance capacity in place. This reality may delay or otherwise affect the network’s ability to effectively initiate operations as a network. This is yet one more reason that financial and other resources are needed to support readiness.

**Opportunities to Expand Equitable Access**

CMS’s recent proposals to use new metrics to incentivize greater screening and referrals for food insecurity are an important major step toward equity in Medicare, but these efforts are not, on their own, sufficient to achieve equity goals. Efforts to improve screening and referrals must be paired with strategies to create clear, sustainable and timely reimbursement pathways for powerful nutrition interventions like PRx. While the recent policy changes, including the development of the SSBCI, have provided some additional opportunities, uptake has been slow and scattered. As a result, many Medicare enrollees—including many MA enrollees and all traditional Medicare enrollees—continue to face troubling inequities in access to these important treatment and prevention tools.

To address these inequities, CMS ultimately must move towards covering nutrition interventions as part of standard benefits within the Medicare program. By standardizing nutrition interventions within standard healthcare practice and cost coverage, CMS would better ensure access across all geographies, plans, and Medicare enrollment types. CMS should work to both standardize comprehensive coverage for traditional fee-for-service Medicare beneficiaries, and to expand uptake and scope of existing payment pathways. In absence of comprehensive standardization and coverage, we recommend the following considerations to expand access for patients who need food and produce benefits for their care:
• Take steps to promote and/or incentivize plan use of the supplemental benefits and SSBCI pathways to provide coverage of nutrition interventions (e.g., providing technical assistance or guidance, finalizing proposals to establish metrics related to screening and referral for food insecurity, etc.).
• Require additional plan reporting on (1) the use of supplemental benefits and SSBCI to cover nutrition interventions and (2) the impact of these efforts on patient health and patient experience. Again, CMS should de-identify this data and publish timely comprehensive reports of SSBCI utilization for food and produce.
• Provide guidance to allow coverage of produce prescriptions and medically tailored groceries within general supplemental benefits, rather than limiting coverage options to SSBCI. While all nutrition interventions help to address social needs, the primary focus of these particular Food-as-Medicine interventions is to aid in the treatment or prevention of diet-related illness. They should therefore be seen to fit within CMS’s revised definition of “primarily health related” since they seek to ameliorate the impact of health conditions and/or reduce avoidable healthcare utilization [6] by improving disease management and/or prevention. Provision of this sort of guidance would improve the overall impact of these services by allowing plans to use them to support patient health before patients become ill enough to qualify for SSBCI.
• Establish large-scale pilots (e.g., under the auspices of the Center for Medicare and Medicaid Innovation) to test the provision of nutrition interventions as a covered benefit to Medicare enrollees.

Thank you again for providing this opportunity to provide information about our experience with Medicare Advantage. For more information and any follow up requests please contact Brent Ling, Director of External Affairs at Wholesome Wave at brent@wholesomewave.org.

Sincerely,

National Produce Prescription Collaborative