June 17, 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-2022-0074) Medicare Program: Hospital Inpatient Prospective Payment Systems; Quality Programs and Medicare Promoting Interoperability Program Requirements, etc.

On behalf of the National Produce Prescription Collaborative, we strongly recommend that Centers for Medicare and Medicaid Services (CMS) enact both the proposed measures “Screening for Social Drivers of Health” and “Screen Positive Rate for Social Drivers of Health” (p. 28,497-28,506) for the reasons cited by CMS in its proposed rule.

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 Prescription programs are designed to improve healthcare outcomes, optimize medical spending, and increase patient engagement and satisfaction.

The NPPC is composed of dozens of produce prescription 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.

PRx has consistently demonstrated to be effective at reducing HbA1c among patients with or at risk of diabetes, increasing fruit and vegetable intake, lowering blood pressure, and improving patient empowerment. The current absence of standard drivers of health (DOH) data or measures in federal healthcare programs – including Medicare or Medicaid – impedes efforts to improve health outcomes, reduce healthcare costs, and address health disparities through PRx.
Nearly 90 percent of hospitals and health systems across the country are already conducting social drivers of health (SDOH) screening to identify patients’ unmet social needs, including via a number of CMMI models, but without the benefit of any formal quality measures, guidance, or tools from CMS.

CMS’s proposing these historic measures thus represents a significant milestone for our healthcare system and an essential expression of this Administration’s commitment to making visible and acting upon health disparities. Indeed, these measures are particularly significant given that of all the potential Medicare measures under consideration by CMS this cycle, these are the only patient-level health equity or DOH measures.

In particular, these DOH measures are important for the many reasons cited by CMS in its proposed rule. If implemented together, these two measures will:

❖ **Advance health equity** by addressing the health disparities that underlie the country’s health system, a key Biden-Harris Administration priority;
❖ **Make visible** to the healthcare system the impact of food insecurity, housing instability, and other drivers of health on patients – including fueling health disparities;
❖ Support hospitals and health systems in *actualizing their commitment to address disparities* and implement associated equity measures to track progress;
❖ Encourage meaningful *collaboration between healthcare providers and community-based organizations* to connect patients to the resources they need to be healthy; and
❖ **Guide future public and private resource allocation** to promote collaboration between hospitals and health systems and invest in leveraging assets and addressing capacity and other gaps in the community resource landscape.

In addition, person-level SDOH data – which will be generated by the screen positive rate measure in the proposed rule – is essential to begin quantifying the health and economic implications of SDOH and to inform work on SDOH-related billing codes, risk-adjustment, and cost benchmarks. For example, it is well-documented that a food insecure diabetic costs, on average, $4,500 more PMPY and has a greater risk of complications compared to a diabetic that has access to healthy food. Not knowing if a diabetic is food insecure is both a safety and quality issue and a cost issue that must be understood – as well as key to addressing health disparities.

It is also imperative that CMS require screening for all five of the drivers of health domains for the reasons that CMS states in the proposed rule. We note that the SDOH screening measure numerator (p. 25502, column 3, paragraph d) and “measure calculation” (p. 25503, column 1, paragraph f) introduce confusion by stating “patients… are screened for *one or all* of the following five HRSNs.” The screening measure numerator and calculation should provide that patients are *screened for all five SDOH domains*. This is consistent with CMS’s screen positive rate “measure calculation” (p. 25,506, column 1, paragraph f) which references “the total number of patients… screened for all five HRSNs.”

We also note that CMS’s introduction of these first-ever SDOH measures is critical to avoid fragmentation and unnecessary provider and patient burden and to enable alignment across public and private quality and payment programs. In particular, these SDOH measures create the opportunity for
alignment of these proposed measures and CMS’s **CY2023 Medicare Advantage and Part D rule** (providing that SNPs must complete enrollee health risk assessments including SDOH) and its **ACO REACH Model** (requiring patient-level SDOH data collection).

The SDOH data collected via these proposed measures will also enable and align with other elements of this proposed rule, including CMS’s Hospital Commitment to Health Equity Measure and its RFIs relative to SDOH Diagnosis Codes and Inclusion of Health Equity Performance in the Hospital Admissions Reduction program.

In response to CMS’s requested information regarding SDOH Z codes, we believe that the most immediate and important action CMS could take to increase the use of Z codes is to finalize the proposed SDOH measures discussed above. These measures create an unprecedented opportunity to collect inpatient SDOH data at a scale that could radically improve Medicare Severity Diagnosis-Related Groups’ (MS-DRGs) precision and ability to recognize severity and complexity of illness and utilization of resources.

CMS has also requested comment on the inclusion of health equity performance in the Hospital Readmissions Reduction Program (HRRP). We strongly recommend that CMS apply the Social Drivers of Health measures proposed in the current rule for the Hospital Inpatient Quality Reporting Program (IQR, p. 28497) to the HRRP, enabling measure alignment.

Given all this, we urge CMS to enact both the SDOH Screening and the Screen Positive Rate measures, recognizing these measures are crucial to align policymaking with the realities of people’s lives; to lay the foundation to invest in those community resources necessary for health; and to illuminate and enable action in addressing health disparities.

Sincerely,

Brent Ling, MSPH  
Chief of External Affairs, Wholesome Wave  
on behalf of the **National Produce Prescription Collaborative**