April 05, 2024

Elizabeth Hertel, Director of the Michigan Department of Health and Human Services (MDHHS)
Michigan Department of Health and Human Services
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CC: Meghan Hodge-Groen, Senior Deputy Director, Behavioral and Physical Health and Aging Services Administration; Brad Barron, Director, Managed Care Plan Division; and Penny Rutledge, Director, Bureau of Medicaid Care Management and Customer Service

Attn: Response to Proposed Food and Nutrition ILOS

Dear Director Hertel,

The Michigan Farmers Market Association (MIFMA) is a statewide, member-based non-profit organization that places equity at the forefront of supporting the viability of community-driven marketplaces to connect ALL consumers to local farms and businesses. MIFMA places a strong emphasis on increasing food access to create meaningful impacts on Michigan's health, community, and economy. Annually, we work with our members and our Advocacy Committee to set advocacy priorities. Our current advocacy priorities and past policy accomplishments reflect our broad scope of work which includes our role and partnership within the Produce Prescription (PPR) field in Michigan and nationally.

Since 2014, MIFMA has served as a centralized support for Michigan PPR programming with the establishment of the PPR Statewide Learning Network (SLN)-- a quarterly meeting convening current and interested PPR implementers alike to collaboratively help programs start, grow, and mature. Since the SLN began, MIFMA has observed extensive growth in the number, size, and scope of programs in Michigan which has expanded to approximately 20 individual programs currently operating across the state. Currently, the SLN brings together a diverse group of individuals including PPR implementers, healthcare organizations, food retail partners, local and state health departments, funders, and supporters reaching over 200 individuals and around 35 organizations actively attending quarterly meetings. Michigan's PPR landscape will be further depicted under our response to the Statewide Service Availability question.

PPR falls under the umbrella (and movement) of "Food is Medicine" interventions pushing to integrate food and nutrition treatments into healthcare nationwide. Understanding Michigan's elevated prevalence of food insecurity, nutrition insecurity, diet-related health conditions, and associated healthcare costs, the growth of PPR programming, in particular, directly and equitably responds to these health and nutrition needs across Michigan's underserved communities. Food is Medicine and Produce Prescription's national recognition has warranted federal funding opportunities for PPRs under the Farm Bill through the Gus Schumacher Nutrition Incentive Program and the Indian Health Services 2.5 million dollar PPR service pilot. Additionally, PPRs have been highlighted in a number of guidance documents from The Center for Medicare and Medicaid Services (CMS). Notably, 1115 waivers and In Lieu of Services are highlighted as

feasible coverage pathways for PPRs in CMS' recently published Health-Related Social Needs Coverage Table. This top-down guidance has coincided with numerous federal and state-based advocacy and implementation efforts, leading states to incorporate Produce Prescriptions and other Food is Medicine programs into their State Medicaid plans:

- **Section 1115 demonstrations waivers:** 7 of 10 states with approved or proposed Food is Medicine-focused waiver include PPR programs including California, Massachusetts, North Carolina, Oregon, and Washington
    - The evolution and scope of Medicaid Section 1115 demonstrations to address nutrition: a US survey
- **In Lieu of Services:** New York and California
    - Pending Michigan's ILOS approval, MIFMA looks forward to Michigan being the first state in the US to adapt ILOS to include food and nutrition supports outside of a waiver's authority.

In Michigan, MIFMA is currently focused on building a capacity for change, including the creation of coalitions needed to shift PPR programs from temporarily funded programs into operationalized healthcare interventions. Informed by our SLN, MIFMA has formed a PPR Participant Advisory Council to ensure our focus remains on the participants of these programs throughout our advocacy efforts and has convened a PPR Steering Committee that is strategically guiding and leading decision-making to sustain and grow Michigan PPR programs. MIFMA is also a member of the National Produce Prescription Collaborative, a national coalition bringing together states advocating for PPR's integration into healthcare. Understanding MIFMA's role and connections in the Produce Prescription field in Michigan and nationally, we leveraged our internal knowledge, connections, MI PPR SLN, and published resources* to draft an RFI response on behalf of MI PPR programming from a *statewide* perspective. This response was reviewed and finalized through a participatory process incorporating feedback from the MI PPR SLN and Steering Committee to ensure its comprehensive MI PPR representation through the following:

- On 3/29, MIFMA hosted an ad-hoc ILOS RFI listening session for PPR SLN and Steering Committee members to attend and give verbal feedback on MIFMA's proposed RFI response for PPR.
- A survey was provided to PPR SLN and Steering Committee members with a window for written feedback on MIFMA proposed RFI response for PPR.

MIFMA extends a thank you to the Michigan Department of Health and Human Services (MDHHS) in leveraging In Lieu of Services (ILOS) to expand access to food and nutrition services for Michigan Medicaid recipients. We are gratefully encouraged to see the MIHealthyLife Initiative's continued support of Michigan's community-based organizations and service providers by offering this Request for Information opportunity.

* A MIFMA published report entitled *The Landscape of Produce Prescription Programs in Michigan* showcases the diverse set of programs known to MIFMA who operated throughout the state in 2017 - 2021 highlighting size, scope, and key partnerships among programs. This report is of the utmost relevance in understanding MI PPR programming. We recommend readers start with the summary chart on pages 8-10.

Answers to Questions:

A. Enrollee Needs:

1. **Will the proposed service meet enrollee clinical and nutrition needs?**

Yes. PPR programs respond to the critical intersection between food security, nutrition, and diet-related chronic disease by targeting at-risk populations and providing increased access to and resources for appropriate fruit and vegetable consumption. Research shows that fruit and vegetable intake is a proactive approach to chronic disease prevention, positively impacting various chronic conditions. Understanding this linkage, there is an evolving evidence base for PPR nationwide highlighting its tangible health, social and economic impacts.

Similar findings can be found in our state, as highlighted in MIFMA's *Case for Produce Prescription Programs in Michigan*, showcasing PPR impacts on positive health outcomes, dietary change, self-reported quality of life, and food security for adults and children.

2. **Would enrollees likely use the services if offered by their MHP?**

Yes. While there is no formal figure detailing how many current PPR participants are Medicaid enrollees and their direct retention rates, there are PPR programs in each of Michigan's 10 Prosperity regions, as further detailed in the Statewide Service Availability section. Based on surveys and conversations of the Michigan PPR SLN, network attendees have reported increased PPR participation in recent years–likely due to the resource disparities in food security and access to healthcare highlighted by the COVID-19 pandemic. Of the attending network programs collecting participant retention data, many reported a 60-80% retention rate in early 2022, with a few programs tracking above 80%. Gathered data showcasing recent participant retention statistics from a few MI PPR programs include:

- Washtenaw County Prescription for Health, led by the Washtenaw County Health Department, *Washtenaw County*
    - In 2023, 459 patients from 14 different health clinics and agencies serving low income individuals participated.
- The U.P. Food as Medicine Program led by Upper Peninsula Commission for Area Progress (UPCPAP); *U.P. wide*
    - In 2023, 63% of vouchers were redeemed with an 80% satisfaction rate from their farmers market food retail sites.
- Prescription for a Healthy Oakland, led by the Oakland County Health Department and Oakland University, *Oakland County*
    - In 2022, had 300+ enrollees and has a running waitlist for the program.
- Fresh Prescription Network, led by Eastern Market Partnership, *Wayne County*
    - In 2022, had 180 enrollees + 334 household members = 514 total individuals impacted

Additionally, MI PPR programs have tracked program satisfaction through the collection of participant testimonials. As seen through MIFMA's Participant Voices from Michigan's Produce Prescription

Programs, participants' feedback underscores the profound impact PPR programs have on their personal and family's lives, behavior changes, health outcomes and ability to experience a shared sense of community. The interest of incorporating participant voices into MI's PPR development, from both the service implementers' and enrollees' points of view, is emphasized through the MI PPR Participant Advisory Council. As of March 2024, this council is composed of 13 PPR participants representing 6 programs across Michigan. Often considered 'program champions,' these Council members are actively engaging in PPR advocacy as a result of their PPR program participation.

3. **Definition recommendations to ensure the service meets enrollee needs and mitigates any challenges enrollees may face in accessing services:**

Each PPR program is 'community-driven' in Michigan, meaning programs are individually composed of local or regional healthcare providers, food retailers, and community-based organizations (or a combination of the sort) to provide the PPR service to a specific population subset within their collective community. Mission aligned and often working within grant-bound budget processes, these providers work together to decide what program operations work best for them, their population, and their community. This PPR trait must be considered when creating a streamlined definition of a Produce Prescription program as the resources and needs for different service areas, populations, retail types, and implementation models can vary. For example, the resources and needs of a PPR service in an urban setting like Detroit contrast those of a PPR service in a rural setting like Marquette. Intersecting factors of Michigan, each PPR provider, and each target population's capacities–such as transportation and accessibility barriers, funding availability and requirements, produce availability, local food and economy impact, culturally relevant resources, reporting and evaluation capacities, etc–can all distinguish a program.

Question for Consideration: Per the State's PPR service limitation of enrollee's not receiving duplicative supports through other federal, state, or locally-funded programs, which entity would be charged with verifying the non-duplication requirement? It is MIFMA's recommendation that this function not be carried out by PPR providers due to capacity limitations.

With this notion, MIFMA and partners feel as if the following definition would best serve the current and future field of Produce Prescriptions in Michigan:

A Produce Prescription is prescribed for enrollees experiencing and/or at risk for food insecurity and a diet-related chronic health condition. The prescription provides an electronic benefit card, physical voucher, or aggregated box for the enrollee to purchase and/or obtain eligible foods from participating food retail site(s). Eligible food items can include fruits, vegetables, and food producing plants and seeds with recommendation to align with at least one of the following guidelines:

- *Gus Schumacher Nutrition Incentive Program (GusNIP) Nutrition Incentive and Produce Prescription eligible foods*
    - *Nutrition Incentive allows for fresh, canned, dried, or frozen whole or cut fruits and vegetables without added sugars, fats or oils, and salt; Dried herbs, as long as they are*

not part of a blend that contains added sugars, fats or oils, and salt; Dried fruit without added sugars, fats or oils, and salt; and Dry beans and dried corn
        - *Please see link above for further GusNIP Nutrition Incentive eligibility details*
    - *Produce Prescription allows for fresh whole or cut fruits or vegetables*
    - *Note that USDA NIFA has an approval process for appropriate exceptions for their current eligible foods guidelines including situations of supply chain disruptions and culturally-relevant foodways.*
- *Double Up Food Bucks Michigan eligible foods*
    - *Allows for fresh whole or cut fruits or vegetables and food producing plants and seeds*
    - *Note that Double Up Food Bucks Michigan is a GusNIP funded Nutrition Incentive project.*
- *WIC eligible fruits and vegetables*
    - *Any variety of fresh, frozen, canned, or dried fruits and vegetables without added sugars, fat, oils, or salt*
    - *WIC eligibility includes any type of immature beans, peas, or lentils, fresh or in canned forms and any type of frozen beans (immature or mature) without added sugars, fats, oils, or meat as purchased.*
    - *Please see link above for further WIC eligibility details*

Transactions may be facilitated depending on the most appropriate method for a given program, including home-delivery of a box with eligible foods, but it is encouraged that products and retail settings within Michigan's local and regional food system are incorporated as a food retail site or source. Prescriptions may also be provided alongside behavioral, cooking, and/or nutrition education materials and services. This is an optional addition to the medical treatment benefit.

The definition changes above are set up for a broad PPR definition to encompass current and potential future PPR program needs and the respective needs of their enrollees. Per MIFMA's altered eligible food guidelines, it is our recommendation that PPR encompass only fruits, vegetables, and food producing plants and seeds. As the second most agriculturally diverse state in the US, Michigan has a robust local and regional food system that should continue to be leveraged in Michigan's food and nutrition support services. As of 2024, over 15 of the 20 currently operating PPR programs partner with a local food provider such as a farmers market, farm stand, Community-Supported Agriculture (CSA) program, mobile market, and/or local-sourcing grocery store. It is MIFMA's recommendation that the State should prioritize local food procurement with this ILOS opportunity to support purchase of locally grown foods, strengthening Michigan's intrinsic food system and economy.

B. Potential Eligible Populations:

1. **Do you support the inclusion of these potential populations? If so, please share any evidence that indicates it is appropriate to provide the proposed ILOS to any of these potential eligible populations.**

Yes. For MIFMA, current eligibility for Produce Prescription aligns well with the MDHHS guidelines provided within the RFI in that eligibility is primarily determined based on an individual's health status

and social factors. Evidence supporting the listed population's eligibility for the proposed ILOS can be found here**.**

Select additional evidence supporting some the State's potential eligible populations list:

Potential Eligible Populations Included:	**Title**	**Author(s) and DOI**
• Individuals with nutrition-sensitive conditions	*Fruits and vegetables consumption and risk of stroke: a meta-analysis of prospective cohort studies*	Dan Hu, et al. DOI:https://doi.org/10.1161/strokeaha.114.004836
• Individuals with nutrition-sensitive conditions	*CLINICAL TRIALS IN CARDIAC REHABILITATION AND PREVENTION–Abstract 14690: ProduceRX Clinical Trial*	Claudia Nau, et al. DOI:https://doi.org/10.1161/circ.148.suppl_1.14690
• Individuals with nutrition-sensitive conditions	*Impact of Produce Prescriptions on Diet, Food Security, and Cardiometabolic Health Outcomes: A Multisite Evaluation of 9 Produce Prescription Programs in the United States*	Kurt Hager et al DOI:https://doi.org/10.1161/CIRCOUTCOMES.122.009520
• Individuals with nutrition-sensitive conditions	*A Rural Delivery-Based Produce Prescription Intervention Improves Glycemic Control and Stress*	Brandon Stroud, et al. DOI:https://doi.org/10.1016/j.jneb.2023.08.006
• Individuals with nutrition-sensitive conditions	*Current State of Food Prescriptions Used to Treat Cardiometabolic Risk Factors in the US Adult Population*	Karim Bourenane, Nora Emon DOI:https://doi.org/10.7759/cureus.53629
• Children with elevated blood levels, experiencing adverse childhood experiences (ACEs) or at risk of developing chronic or acute conditions due to food insecurity	*Influence of a Pediatric Fruit and Vegetable Prescription Program on Child Dietary Patterns and Food Security*	Amy Saxe-Custck et al. DOI:https://doi.org/10.3390/nu13082619
• Children with elevated blood levels, experiencing adverse childhood experiences (ACEs) or at risk of developing chronic or acute conditions due to food insecurity • Former foster care youth • Children eligible for the Children's Special Health Care Services (CSHCS) program	*Pediatric produce prescription initiatives in the U.S.: a scoping review*	Hemen Muleta et al. DOI:https://doi.org/10.1038/s41390-023-02920-8
• Individuals who are eligible for Medicaid based on an eligibility designation of disability	*Disparities in Obesity and Related Conditions Among Americans with Disabilities*	Katherine Froehlich-Grobe, PhD; Jaehoon Lee, PhD; Richard A. Washburn, PhD

• Individuals eligible for the Persons with Special Health Care Needs (PSHCN) program		DOI:https://doi.org/10.1016/j.amepre.2013.02.021
• Individuals who are eligible for Medicaid based on an eligibility designation of disability • Individuals eligible for the Persons with Special Health Care Needs (PSHCN) program	*Promoting nutrition equity for individuals with physical challenges: A systematic review of barriers and facilitators to healthy eating*	Marianna S. Wetherill et al. DOI:https://doi.org/10.1016/j.ypmed.2021.106723

2. **What changes, if any, to the potential eligible populations would you propose?**

a. Would you remove any populations from the potential list? If so, why?

No. We make no recommendation to remove any of the listed populations.

b. Would you add any additional populations to the potential list? What evidence can you share indicating that it would be medically appropriate and cost-effective to provide these individuals the proposed nutrition-focused ILOS?

Yes. Given the potential eligible populations list provided by the State, a majority of MI PPR program's current eligibility is incorporated. However, MIFMA would like to see broadened language for:

1. "At-risk pregnant individuals…" be extended beyond at-risk pregnancies and encompass current and recently pregnant and maternal individuals. The Special Supplemental Nutrition Services Program for Women, Infants, and Children (WIC) is considered the first, large scale Food is Medicine program in the US with targeted eligibility to pregnant mothers and their young children to improve health outcomes. The WIC program has had documented success with these eligible populations and in the select studies where WIC patients additionally qualified for Produce Prescriptions, case studies showcased examples of increased food insecurity and average FV intake frequency in comparison to a control group as well as a 37% lower odds of preterm delivery in intervention group compared to births in a historical control group (Ridberg 2021 pg 72). By aligning PPR's eligibility in this category with WIC's it can supplement, but not supplant, food and nutrition services for these eligible enrollees.
2. A social and clinical risk factor MIFMA recommends to account for is age eligibility. While all ages are inferred to be included in the proposed eligible populations, allowing for selected age ranges would additionally meet target enrollees needs. This inclusion is specifically relevant for PPR's supporting pediatric and senior populations. This aligns with Oregon's eligibility list, a state working within an 1115 demonstration waiver to provide HRSNs.
3. While many diet-related chronic conditions are included on the State's potential eligible populations list, note that PPR is also a *preventative* medical service. Understanding this, MIFMA recommends enrollees experiencing pre-existing symptoms and conditions of chronic disease, such as pre-diabetes, also be considered as eligible. By allowing a medical-professional to

proactively prescribe a food and nutrition support, like PPR, before a diet-related chronic condition is onset, emerging FIM trends suggest reduction and/or prevention of future healthcare services and costs, and strengthened patient-provider relationships.

3.1. Please note that there is an evidence-based sentiment amongst many MI PPR providers that food insecurity can be clinically linked to the onset of a diet-related chronic condition. Therefore, many MI PPR's have centralized food insecurity to their PPR's eligibility as a clinical risk factor. MIFMA understands that the Centers for Medicare and Medicaid Services and the State's proposed PPR service definition segregate clinical and social risk factors (with food insecurity belonging under the latter) when discussing food and nutrition supports eligibility and require an enrollee align with at least one in each category. In an effort to bridge these viewpoints, MIFMA would like to make a callout for MHP's to integrate equitable and representative food insecurity screening into their healthcare services. This robust screening could accurately identify enrollees in need of this service in a way that would allow for them to qualify for both clinical and social risk factors.

Question for Consideration: Under the State's social risk factor eligibility provision, how is the State defining food insecurity?

C. Statewide Service Availability:

1. **As defined, is the service likely to be available across the state?**

Yes, it is possible for PPR to be available across the state if the definition is broadened to best serve programs who've already operated in Michigan. As documented in the report *Produce Prescription Programs: 2017 - 2021 Descriptive Assessment and Cost Analysis of Michigan's PPR programs*, MIFMA collected data from 25 PPR programs who operated or were planning operations during that time. As shown in Exhibit 1 on p. 4, programs serviced approximately 70% of counties in Michigan between 2017 - 2021. While the landscape since 2021 has shifted due to the addition of new programs, existing programs expanding, and programs who've ceased operation due to lack of funding, partnerships have been formed between community-based organizations and healthcare **in each of Michigan's 10 prosperity regions** in order to operate a Produce Prescription program.

Medicaid Health Plans should be encouraged to partner with community-based organizations and healthcare providers in each of their approved service regions in order to work towards statewide service availability. With opportunities for greater partnership and the incentive of available funding, we expect an eventual growth in greater programming. MIFMA, as a statewide convener, is well suited to help facilitate connections between Medicaid Health Plans and organizations who have experience operating a Produce Prescription program and/or organizations who are interested in getting involved in this space. As existing programs have already developed models successful in serving their communities, existing programs should be prioritized over those starting from scratch.

2. **Which, if any, specific prosperity regions or counties might have limited service availability?**

Due to the readiness of past and current programs and their ability to build capacity, MIFMA does expect that some prosperity regions will be slower to adopt service under Medicaid ILOS authority. Additionally, some service regions have fewer existing partnerships known to MIFMA which may limit service availability. These service regions may include, but are not limited to, Region 7, southern counties in Region 8, eastern-rural counties in Region 4, and Region 6 outside of Genesee County.

3. **What changes, if any, to the service description would ensure community-based service providers could meet the requirements to provide these services? What changes might increase enrollee access to these services in these regions?**

   As challenges to implementation and barriers to participation can differ between geographic regions, it is recommended to keep the service definitions broad (see Enrollee Needs section above) in order to allow existing programs to provide PPR under ILOS authority. Setting a broad definition, such as allowing for home-delivery, will also provide greater flexibility to programs when adapting to challenges identified by the community they are serving, such as transportation barriers, to better serve and retain enrollees and improve enrollee access to the services. For example, just as Non-Emergency Medical Transportation (NEMT) serves as a critical bridge to care for many, it could also help overcome transportation barriers individuals face in redeeming their prescriptions. It would be helpful to have clear guidance from MDHHS that the existing NEMT benefit can be used to access allowable ILOS services. Additionally, providing funding to support community-based service providers in building capacity to address challenges identified by the community they are serving and challenges hindering program expansion will have a lasting impact on reach and enrollee access. In addition to transportation, capacity challenges that may limit expansion include staffing support and the development of point-of-sale technology that aligns with retailer requirements.

   Adequate reimbursement rates and technical assistance will need to be set up and provided to support community-based organizations in engaging in this work. See Section E. Technical Assistance for further information on ILOS pricing. If careful consideration is not applied to ILOS pricing, it could hinder program expansion and service availability.

D. Community-based Provider Capacity, Interest and Experience:

1. **Which community-based providers currently provide the service as defined (or a similar service)? How many people do they provide the service to on average currently? How many people could they provide the service to if they were reimbursed by MHPs?**

   The Overview Chart of Programs found in *The MI PPR Landscape Report* on p. 8-10 details the project lead and the number of participants served by 22 different identified programs during the years of 2017 - 2021. Public Sector Consultants' analysis on a similar set of programs [*Produce Prescription Programs: 2017 - 2021 Descriptive Assessment and Cost Analysis of Michigan's PPR programs*], found that the number of participants served per program on an annual basis ranged from ten to 1,837, with an average of 245 and a median of 100. In 2021, programs reached more than 3,000 participants across the state.

As previously suggested, it is important to note that the landscape has changed since the release of the above reports. While some programs have ended or paused due to lack of funding availability, others have launched. MIFMA is currently aware of 20 programs currently operating and would expect that a new funding pathway through Medicaid Health Plans may allow some programs on pause to return to operation. The following is a list of Produce Prescription programs or similar services known to MIFMA that are not included in the above Overview Chart of Programs showing continued momentum of PPR:

- The U.P. Food as Medicine Program led by the Upper Peninsula Commission for Area Progress (UPCAP); *UP wide*
- Prescribe Life led by Corewell Health East; *Wayne, Oakland, and Macomb Counties*
- The Farm Share Assistance Program led by Trinity Health; *Washtenaw & Oakland County*
- Tribal Food Farmacy Program led by Inter-Tribal Council of Michigan; *Hannahville Indian Community, Little Traverse Bay Bands of Odawa Indians, Pokagon Band of Potawatomi Indians*
- Grace Health's Fresh Food Pharmacy led by the Food Bank Council of Michigan; *Calhoun County*
- Produce Prescription Program led by the Street Medicine Program at the WMU Homer Stryker M.D. School of Medicine; *Kalamazoo County*

Within the current landscape, access does not meet the need and funding has been identified as a critical limiting factor to increasing that access. Increasing capacity, including the opportunity for new funding to support these programs, will positively impact expansion and program sustainability. This has been seen through past investments in PPR. Between the years of 2017 and 2021, the Michigan Health Endowment Fund made significant monetary investments in Produce Prescription implementation through their grantmaking services. During this time period, MHEF provided support to eleven different programs significantly contributing to the growth and support of PPR throughout the state. For example, with funding received through MHEF, Prescription for a Healthy Oakland was able to grow their program from 100 enrollees in their 2018 pilot program to over 400 enrollees in 2021.

2. **Which community-based providers would be interested in contracting with MHPs and delivering the service to enrollees?**

At the beginning of 2024, the PPR Steering Committee, on behalf of the PPR Statewide Learning Network, submitted a letter to MDHHS to request that PPR become one of the community-based resources the Department will approve as an ILOS option. The letter had sign-on support from 72 organizations and individuals from the Steering Committee and Statewide Learning Network – showing the momentum behind this work and interest organizations have in contracting with Medicaid Health plans. Organizations with an affiliated Produce Prescription program are noted in the letter.

3. **Would these existing community-based providers meet the allowable provider criteria defined in the Draft ILOS Definition (attached)?**

Partnership types and the roles performed will differ depending on the program model, the resources available in the community, and the capacities of program partners. Programs typically have an organization who serves as the project lead or "service provider" and oversees program administration and brings together partnering organizations. The project lead partners with other organizations in the

community, each fulfilling roles based on their capacities and strengths, to build a sustainable program. Additional roles fulfilled by the project lead or its partners include patient identification and referral, patient enrollment, marketing and advertising, nutrition education delivery, sourcing produce and/or working with retailers, and data collection and evaluation support.

In summary, the types of organizations currently leading Produce Prescription programs includes, but is not limited to:

- Health care providers (hospital systems, community health centers, medical centers, etc.)
- Tribes and tribal providers*
- Local health departments and other city, state, and local government agencies*
- Non-profit and community-based organizations focused on services such as health, food access, education, or other publicly beneficial actions*
- Social-service agencies or community-based organizations serving seniors, families, or underserved populations*
- Business leagues, local Chamber of Commerce, etc.*
- College and Universities*

*Note: Organizations with an asterisk are not already on the allowable provider criteria defined in the Draft ILOS Definition.

In order to ensure organizations already operating Produce Prescription programs to Michigan communities have the option to contract with Medicaid Health Plans, it is recommended that the above types of organizations be added to the allowable providers list in the ILOS definition for Produce Prescription programs. It is expected that these community-based providers would then further partner with additional community organizations, healthcare, and local businesses and food retailers to operate all facets of the program. It is important that either the **Community-based providers and/or its partners have experience working with the target population and understand the needs of the community. Providers with previous experience implementing PPR and those who incorporate products and retail settings within Michigan's local and regional food system should be considered and prioritized.**

4. **Which existing community-based providers have experience contracting with MHPs? If so, what types of activities or services did they provide under contract with MHPs previously?**

Since the first Produce Prescription program started in Michigan back in 2008, programs have evolved through iterative program design developing successful models and partnerships to best serve their communities. Current capacities include the ability to design and tailor programs to meet the needs of specific populations and geographies, the development of strong relationships with local and regional food systems which have magnified the impact on health and economic development, and the formation of a Statewide Learning network connecting program implementers and elevating best practices to advance the field as a whole. While community-based providers have many strengths, capacities will need to be built to further integrate these programs into healthcare including the establishment of systems and processes needed to contract with MHPs.

Despite the fact that current systems haven't previously created opportunities for community-based providers to contract with MHPs to provide PPR, many programs have still begun relationship building with MHPs in their region and have formed partnerships to support their work. MHPs' involvement to date has been mostly in the philanthropic space providing funding to support program operations and incentives as a whole. One example of this is Meridian Health Plan who sits on the Steering Committee for the FreshRx Network in Detroit and provides grant funding to support the program as needed. While many programs have not yet had experience contracting with Medicaid Health Plans, the UP Food as Medicine Program is one example of a program who has. The UP Food as Medicine program has contracted with the Care Management team at the Upper Peninsula Health Plan (UPHP) as a referral partner and the two organizations have agreements in place to share protected health information. While the UP Food as Medicine program works with over 15 healthcare providers to provide referrals, UPHP is their largest source for referrals. Technical Assistance and funding support will be needed to further build the capacities and infrastructure for ILOS implementation, particularly in the areas of contracting and sharing data with MHPs.

E. Technical Assistance Needs:

1. **What would make it more feasible for community-based providers to enter into contracts with MHPs and deliver the proposed services?**

The feasibility for community-based providers to enter into contracts with MHPs and deliver the proposed service will depend on the technical assistance available and funding to support infrastructure (technology, process and system development, evaluation), capacity (staffing to support infrastructure buildout and implementation, workforce development), and the costs of future identified needs. One advantage a Section 1115 Demonstration Waiver would bring is access to infrastructure funding to support implementation of health-related social needs initiatives, an important need for community-based providers to build the necessary capacity to enter into contracts with MHPSs. Without an 1115 waiver in place, alternative funding will need to be identified, either philanthropically or through the State, to support community-based providers in the development and implementation of Produce Prescription programs under ILOS authority. It is recommended that pathways for funding support similar efforts states with an 1115 waiver have developed. Two examples include:

- The SSO FS Preparation Fund in Massachusetts supports qualified Social Service Organizations (SSOs) with infrastructure costs necessary to participate in the program, with particular focus on technology, data exchange, business practice elements, and other areas where close collaborative communication with ACO partners is needed.
- Oregon's proposed uses of HRSN Infrastructure funding include activities surrounding technology, development of business and operational practices, workforce development, and outreach, education, and stakeholder convening.

In addition to funding, programs will need technical assistance and support to become equipped with the necessary skills, knowledge, and resources to successfully contract with MHPs and deliver services. MIFMA has already built the infrastructure to support a strong network of implementers and partners through the PPR Statewide Learning Network and would look towards experts within the State, healthcare, and health law policy to provide the expertise including, but not limited to, contracting and

pricing negotiation, referral and authorization, billing and reimbursement, and understanding legal requirements associated with data sharing and evaluation. An example of this in the State of Michigan includes the technical assistance the MDHHS Diabetes and Kidney Unit is providing to Michigan Diabetes Prevention Program providers to assist with the contracting process. In Massachusetts, with infrastructure funding received through their 1115 waiver, the state was able to provide funding to community-based providers to consult with experts in the field and additionally, any organization that received funding through the above-mentioned SSO prep fund participated in a shared learning network where technical assistance was provided.

Additionally, if community-based providers will be required to register as a non-traditional "provider" within CHAMPS, technical assistance would be needed to assist organizations in this process. It is recommended for technical assistance to start in advance of the "go-live" timeline to prepare community-based providers for the contracting conversations that will start shortly afterwards.

2. **To what extent do community-based providers have experience documenting and invoicing for services? Billing and coding?**

   At large, current Produce Prescription programs led by a non healthcare entity such as a community-based organization have little to no experience working through invoicing and the medical billing process. Programs led by a healthcare entity and local health departments will have a different set of experiences given the nature of their work. Given the different levels of familiarity and capacities, it is recommended that Michigan follows California (DHCS Guidance) in providing easier, streamlined methods for invoicing such as simple spreadsheet invoice templates with the minimum necessary data element defined while the infrastructure and support for automated billing is developed.

   Currently, there are no specific medical codes for Produce Prescription programs. The Coding4Food initiative is working on creating new HCPCS Level II codes, but the approval of those codes is still about one to two years out. In the interim, Michigan would have to create a modifier, similar to California's ECM and Community Supports HCPCS Coding Guidance. However, we would recommend modifiers be made to allow distinctions between different ILOS offered to address enrollees' health-related nutrition needs.

3. **Should MDHHS develop standard terms and conditions (e.g., a "model contract") that all MHPs and community-based providers would use to contract for ILOS?**

   Standard guidance for contracting and considerations for both MHPs and Community-based providers would be recommended to support those who are new to this process and/or programs looking to contract with multiple MHPs. However, given the unique nature of programs and that there will be learnings as organizations begin navigating the process, it is recommended that **guidance be provided but not required**. This guidance should further support community-based providers in tandem with their need for ongoing technical assistance support and guidance in navigating the contracting process.

   MDHHS should further investigate hub and spoke models to improve coordination, data-sharing capabilities, and the ability for community based-organizations to become a PPR provider under this

ILOS opportunity. MIFMA is interested in having further conversations with the department around who may be best suited to serve this role and the resources needed.

4. **Should MDHHS release suggested ILOS pricing or would MHPs and community based providers prefer to negotiate directly on payments for ILOS?**

   MDHHS should release a suggested framework or guidance providing a range for ILOS pricing, which MHPs need to reimburse at or above to ensure pricing considers adequate rates for MHPs and establishes a minimum payment level that community-based providers find equitable and sustainable. As program models and needs differ regionally and across programs, this range should take into account costs associated with operating different PPR models and regional and community factors that may come into play. MDHHS should carefully consider the ILOS pricing range suggested, especially the lower bound, to ensure it is high enough to adequately meet the needs of community-based providers and allows for providers to continue to meet the needs of enrollees. To create a sustainable service, ILOS pricing range should include more than just food costs, but all costs to provide the service to enrollees. Examples include costs to support administration and personnel, evaluation, services to further meet enrollee needs and/or increase access such as delivery and technology costs, supplies, and more.

   Further, it is suggested that MDHHS provides guidance on a tiered level approach for ILOS pricing and considerations for what type of community-based providers and services should receive higher level pricing. Considerations for receiving reimbursements in higher tiers should be based on values and higher costs associated with the level of service provided:

   - Program models who have higher associated costs to better serve the needs of their community (Ex. programs that aggregate and box food or provide home delivery will have higher costs)
   - Community-based providers who prioritize working with local and regional food systems
   - Community-based providers that serve rural or underserved communities
   - Community-based providers consisting of community-based organizations who work locally in the community and are operating programs that meet enrollee needs

   If pricing is not guided appropriately, the risk will be that community-based organizations will not be able to sustainably participate disrupting service coverage. Additionally, without clear guidance MHPs may seek out the lowest cost interventions, namely national organizations, instead of community-based organizations who are familiar with the needs of their community. It is suggested that MDHHS conduct future feedback sessions with community based providers already doing this work, to further understand services, needs, and costs to inform suggested ILOS pricing range and guidance. MIFMA would be happy to work with our PPR Statewide Learning Network and Steering Committee to serve as an audience for MDHHS to conduct these sessions.

   Based on the suggested ILOS pricing range, MHPs and community based providers should be allowed to further negotiate directly on payments for ILOS to determine a rate that fits the unique needs of the model utilized, the cost of food in their region, and the **administrative costs to support that model**. Risks with only allowing set ILOS pricing include that set prices may not fully support administrative costs leading to an unsustainable system and lower rates may incentivize food retailers to source from cheaper, national wholesalers instead of prioritizing local food systems. It is recommended that guidance should be created

and technical assistance provided to help community based providers talk through negotiations and set fair pricing with MHPs including rate considerations and allowable billable services.

In order to support adequate pricing rates, the state also needs to consider start-up costs MHPs will incur to implement and deliver services. While ILOS are required to be cost-effective substitutes, PPR programs can be preventative in nature and may not produce immediate return on investment for MHPs. This is not to imply that PPR doesn't produce returns on investment or show cost-effectiveness (See Evidence provided in Section A. and B. above). Capitation rates should be adjusted to take into account that return on investment may not be immediate and ensure that MHPs receive adequate compensation for the projected costs of providing ILOS, particularly in the first year of implementation. Without adequate compensation, MHPs may choose not to provide ILOS causing a risk to equitable service availability.

Additional Recommendations:

- **Referral System**: In addition to the technical assistance needs and guidance outlined in Section E above, a robust and effective referral technology system that can be integrated and bidirectional is needed to support Community-based providers and MHPs. A robust referral system will not only increase referral partner awareness of the ILOS program and further streamline the referral process into healthcare workflows, but will more easily connect patients to community-based providers for services they are eligible for.
- **Nutrition Education**: Nutrition Education should be an optional service in addition to the fruit and vegetable incentives to further support healthy behavior change. As an optional service, nutrition education should have its own reimbursement and pricing process. Further discussions and clarification are needed to establish a process for the inclusion of this optional service. Under California's Community Supports, behavioral, cooking, and nutrition can be offered as long as it is paired with any of the six other approved Medically Supportive Food interventions.
- **Incentives for MHPs**: As an optional service, it is important that MHPs are incentivized to leverage ILOS. Service availability and enrollee access will be limited without adequate adoption from MHPs hindering the State's goal to support individuals made vulnerable through food insecurity, ultimately providing a healthier future. The line item under the Governor's Budget to create a new pool for MHPs to access based on their deployment of ILOS programming is a good example of funding for MHPs to further incentive their participation in ILOS.
- **Service Considerations for Households**: While we are strongly supportive of targeting individual needs, the realities of food and nutrition supports is that food resources provided to one target enrollee will likely be shared with the entire household, who are also likely to be enrollees. Additionally, as identified by the State in the RFI, experiences of food insecurity often extend across entire households; therefore, knowing that food access can positively impact health in various ways, we would like to inquire on the provision of nutrition services, like PPR, to be allowed at the household-level. We understand that expanding may undermine the effectiveness of PPR services for the target enrollee and skew direct long-term results. However, given its importance to the health of Michigan Medicaid enrollees at large and to the successes demonstrated of MI PPRs servicing households in practice, we urge the State to consider a flexibility through the ILOS process and call for its examination in the ILOS evaluation framework.

MIFMA applauds the commitment from MDHHS to address social determinants of health and expand access to food and nutrition services for Michigan Medicaid recipients through investment in and engagement with community-based organizations. We are grateful for the opportunity to offer feedback through this Request for Information opportunity on behalf of MI PPR programming from a *statewide* perspective.

MIFMA has worked to build the infrastructure to support a strong network of implementers and partners through the PPR Statewide Learning Network and recently formed governing body, the PPR Steering Committee. MIFMA, along with our coalitions, are prepared to serve as resources, be an audience for key stakeholder feedback, and engage in conversation with MDHHS throughout the development and early implementation of ILOS. We'd be happy to work with MDHHS to further address any comments above and hope to create a pathway for open dialogue and collaboration to successfully develop and launch PPR as an ILOS option between MHPs and community-based providers in Michigan.

Questions can be directed to Bella Pagogna, Produce Prescription Manager at the Michigan Farmers Market Association, at bella@mifma.org.

Sincerely,

The Michigan Farmers Market Association (MIFMA) with additional support from the following MI PPR Steering Committee Organizations:

[Organization Name, Affiliated Produce Prescription Program (if applicable)]

- Food Bank Council of Michigan
- Michigan Health & Hospital Association
- MyMichigan Health, Prescription for Health-Midland
- Upper Peninsula Commission for Area Progress/UPCAP, UP Food As Medicine
- Washtenaw County Health Department, Prescription for Health