

My name is Cathryn Couch. I'm the founder and CEO for Ceres Community Project, a non-profit medically tailored meal (MTM) organization providing about 200,000, 100% organic meals annually in Northern California. I'm also a board member for Partnership HealthPlan of California, an MMCO serving fourteen counties; a founding member of the California Food is Medicine Coalition; an advisory board member for the Food is Medicine Coalition; a member of The Root Cause Coalition; a leader of a cardiovascular disease collaborative for Sonoma County; as well as a member of many other local and regional health collaboratives.

All the clients we serve at Ceres Community Project are living with a serious health challenge, including cancer, congestive heart failure, Parkinson's, hypertension, and diabetes. While we serve people of all ages – including families whose children have been diagnosed with cancer – the majority of our clients are 60 years of age or older. Many are living alone with little or no support. Eighty-five percent of our clients are living on less than \$25,000 a year. Even if they had the physical ability to shop and cook, most can't afford the quality of meals that they need to prevent, manage and/or treat their health condition. And for many – such as someone living with congestive heart failure or end stage renal disease – the nutritional complexity of their illness makes it difficult for them to prepare and eat meals that are medically appropriate. And yet, there is now a preponderance of evidence to support that what and how people eat is one of the most important things they can do to prevent, manage and treat illness.

The White House Conference on Hunger, Nutrition, and Health represents a historic opportunity to decrease the burden of hunger and chronic nutrition-related diseases on individuals and families, and on our nation's healthcare spending and productivity. Based on Ceres' experience delivering more than a million meals over the past 15 years I would like to submit the following policy recommendations for consideration. These recommendations are the direct result of our experience, which includes feedback gathered from the clients we serve, participation in multiple MTM studies and pilots, and collaboration with local and state governments and coalitions to create programs in California based on what we've learned. Federal leadership in this area can make these programs available more broadly and equitably across the country.

Integrate Medically Tailored Meals into Medicaid and Medicare as Reimbursable Benefit

To tackle the growing burden of nutrition-related chronic disease, we must integrate MTM and other medical food and nutrition services (such as medically tailored grocery boxes and produce prescriptions) into our health care system as fully reimbursable benefits, especially Medicaid and Medicare. There is no other single action available at the federal level that would do more to improve nutrition security and reduce the burden of chronic disease, particularly for those who are most impacted by health disparities. This can be done administratively by reinterpreting existing statutes to include MTM as follows:

- To establish Medicare coverage, the U.S. Code could be amended at 42 U.S.C. § 1395x(s)(2) to add MTM to the list of services covered as “medical and other health services” under Medicare Part B.
- Within Medicaid, the U.S. Code could be amended at 42 U.S.C. § 1396d(a)(13) to specifically allow coverage of MTM as a Medicaid preventive or rehabilitative services.

Medically tailored meals are an innovative and low-cost intervention that addresses the high health care costs associated with those who face food insecurity and malnutrition. There is a significant – and growing -- body of evidence showing that MTM result in lower health care costs, increased patient satisfaction and better health outcomes. We know that there is a higher burden of chronic and serious

illness among those served by Medicaid and Medicare. MTM are one of the least expensive ways to improve health equity.

Despite research proving the efficacy of MTM, this benefit is not available in a consistent way—except for a limited scope in Medicare Advantage. While several states, including California, are now offering MTM in their Medicaid programs, these opportunities are primarily based on waivers with plans deciding whether or not to offer the benefit, and to whom. Federal legislators and/or agency officials could make MTM a fully reimbursable benefit, either legislatively or administratively, by clarifying or reinterpreting key sections of the Social Security Act governing Medicaid and Medicare benefits as outlined above.

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Additional Key Recommendations

There are several other key recommendations that relate to and would support the integration of MTM and other medical food and nutrition services in Medicaid and Medicare:

- Implement consistent screening for food insecurity and malnutrition across community health centers and hospitals.
- Establish appropriate diagnostic, referral, and billing codes for malnutrition and food/nutrition insecurity; and for MTM and other medical food and nutrition interventions.
- Elevate the importance of nutrition by creating a federal office of nutrition and nutrition research that would coordinate and leverage efforts across all federal agencies. This includes agencies establishing food labeling and health claims; USDA agricultural subsidies; and the dietary guidelines for Americans. We need to be speaking and acting with one voice if we are going to have an impact on the epidemic of chronic disease in the United States.

Prioritize and Fund Locally Based Non-Profits as Providers

I also want to speak to the critical role that locally based CBOs play in this area. Food is Medicine Coalition member agencies first developed the MTM model in the late 1980's during the height of the AIDS/HIV epidemic. Collectively we have more than 400 years of experience caring for clients and researching and innovating medical nutrition services. In addition, we – and other food and nutrition nonprofits – are embedded in the communities we serve. We know and work with local health care partners, low-income housing, substance abuse and mental health organizations. We understand the cultural, racial, and socio-economic context that exists in our communities. We seek feedback and input from our clients to improve our services. Our volunteers deliver meals face to face to our clients' homes, strengthening social and caring connections that help build resilient and democratic communities.

We also provide meals and services to a wide range of community members that will never be funded by Medicaid and Medicare – family members and those whose age or income mean they are ineligible for these programs. These are sometimes intangible, but vital benefits that directly result in better health outcomes. For example, at Ceres Community Project we have a robust Youth Development Program. In the past 15 years, more than 4,000 youth have worked as volunteers in our two organic gardens and three commercial kitchens, learning to grow, cook and eat healthy foods; gaining skills for success in school, life and work; and discovering their value as contributing members of the community.

We also engage more than 600 adult volunteers each year and our data shows that 78% of them make improvements in their eating habits.

As MTM and other medical nutrition services become covered health benefits, a whole host of new and existing venture-funded, for-profit organizations are competing for these dollars. These for-profit companies provide none of the broader benefits that I've outlined above. We ask that in all of this work, locally based nonprofits be supported as the "first and best choice" for delivering these services. With adequate funding, many of these organizations could significantly scale their services, including into new neighboring geographic areas. The long-term benefits of investing in these non-profit organizations is far beyond what can be achieved with an out-of-state, for-profit shipping meals only to those in a community for whom they are fully funded.

To ensure that non-profits can be competitive and sustainable as providers of Medicaid and Medicare medical food and nutrition services, reimbursement rates must fully cover the services provided. We have an underlying belief in the United States that food should be cheap. However, it is cheap food that has created the epidemic of chronic disease and that is also contributing to the climate crisis. Providing high-quality, sustainably grown fresh food; making meals from scratch that meet medical and cultural needs; ensuring the safety of clients through a medical referral from a health care partner and oversight by a registered dietitian nutritionist (RDN); and delivering directly to people's home costs more money than a poor quality mass produced meal shipped to a client – but those costs don't tell the full story of what you are buying, nor do they reflect the externalities of those systems. At Ceres Community Project, we can produce a 100% organic, medically tailored meal and deliver it in person to a client's home – often with a bouquet of flowers or a hand-written card in the bag, for \$12.50. Think about what you pay at a restaurant for a high-quality sandwich or salad. Is \$12.50 too much to pay for sustainably raised food, a personal connection that strengthens resiliency in a community, and youth and adult volunteers who also improve their eating habits? This is a far better value than the \$7.75 meal that is produced with food that is contributing to climate change; shipping across the country in packaging that ends up in the landfill; and that provides no other benefits to the community.

Thank You

The White House Conference on Nutrition, Hunger and Health is a once in a lifetime opportunity to change the trajectory of chronic disease and health disparities in the United States. I urge you to prioritize the integration of medically tailored meals and other medical nutrition services into Medicaid and Medicare as fully reimbursable benefits. This can be done administratively by reinterpreting existing statutes. I also urge the White House to prioritize and invest in locally based non-profit organizations as the "first and best choice" to deliver these services, and to support reimbursement rates that enable these nonprofits to effectively scale services and to afford organic and sustainably raised foods.