National Rural Health Association

The National Rural Health Association (NRHA) is pleased to offer comments for the White House Conference on Hunger, Nutrition, and Health. We appreciate the White House's continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Food insecurity, which is the lack of consistent access to food for each individual in a household to live a healthy life, is a key barrier to nutrition and has been exacerbated by COVID-19.[1] Rural counties account for 87% of the counties with the highest rates of overall food insecurity.[2] In total, about 12.5% of rural residents, or 5.4 million individuals, are food insecure. Food insecurity is magnified by poverty, especially in rural communities. In 2019, 13.3% of all people in rural areas lived below the poverty line.[3] Even though there are programs in place, rural areas and their public schools often receive less federal funding for programs that have been shown to alleviate factors contributing to high obesity rates.[4] Methods of increasing access to healthy food often do not accept Supplemental Nutrition Assistance Program (SNAP) or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits, making nutritious choices inaccessible to rural beneficiaries.

NRHA recognizes the key role that adequate nutritious food plays in health outcomes. Individuals that are food insecure face a higher risk of obesity, developing chronic diseases, overall worse health outcomes, and greater health disparities.[5] Further, poor diets are associated with higher health care costs.[6] Unfortunately, characteristics of rural areas contribute to food insecurity. Longer distances and travel times between homes and stores, compounded by fewer supermarkets, make food insecurity in rural areas more likely.[7] Because of this, **NRHA urges the White House to take all action within its power to move the needle on food insecurity and improve the health of rural Americans.** The Administration should work with Congress, relevant federal agencies, and states to reduce hunger and food insecurity.

Free Meals for Students

The White House must urge Congress to continue supporting K-12 students. The Keep Kids Fed Act, signed by the President on June 25, 2022, was a great first step towards extending and making permanent child nutrition waivers put in place because of the COVID-19 Public Health Emergency.

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[1] https://www.feedingamerica.org/hunger-in-america/food-insecurity#:~:text=Food%20insecurity%20is%20defined%20as,many%20people%20cannot%20afford%20food.
[2] https://www.feedingamerica.org/hunger-in-america/rural-hunger-facts
[3] https://www.feedingamerica.org/hunger-in-america/rural-hunger-facts
[4] https://iop.harvard.edu/get-involved/harvard-political-review/little-school-prairie-overlooked-plight-rural-education#:~:text=Funding%20Disparities&text=In%20states%20like%20Connecticut%2C%20Michigan,funding%20than%20their%20rural%20counterparts
[5] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity ; https://www.americanactionforum.org/research/the-economic-costs-of-poor-nutrition/
[6] https://www.nhlbi.nih.gov/news/2019/americans-poor-diet-drives-50-billion-year-health-care-costs
[7] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity

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However, increased federal reimbursement and free meals for students, ending September 2022, are not enough. Free school lunches, as provided under the Families First Coronavirus Response Act, should be made permanent to ensure all children, including those residing in rural areas, have adequate food needed to focus, learn, and grow.

The free summer meal program flexibilities should be extended past 2022 and made permanent. Communities saw great success in summer meal programs during the COVID-19 pandemic because of the waivers granted by the Department of Agriculture (USDA).[8] Without these flexibilities, children face burdensome rules that impede their access to free meals during the summer, especially in rural areas. Historically, summer meal programs have had to operate under the "congregate model," meaning all children had to gather at a certain time to eat the free meal. This marginalizes rural children with working parents that lack transportation to the meal site at the given time. These sites are only available in areas where 50% of students qualify for free or reduced-price meals. This disadvantages the poorest children in certain communities as they are restricted from participating in free summer meal programs, particularly in rural areas.

GusNIP and Produce Prescription Programs

The Gus Schumacher Nutrition Incentive Program (GusNIP) is currently authorized through fiscal year (FY) 2023. GusNIP includes competitive grant programs, meaning that awardees are chosen through a rigorous selection process. These programs include the Nutrition Incentive Program to encourage the purchase of fresh produce and the Produce Prescription Program. The White House should urge Congress in the 2023 Farm Bill to make GusNIP Produce Prescription Program noncompetitive, or give priority to rural underserved areas within the selection process, and thus open the door to more rural recipients.

The Centers for Medicare and Medicaid Services (CMS) covers 83 million beneficiaries that would benefit from participating in a produce prescription program. Produce prescription programs are a medical treatment or preventative service for patients who are eligible due to diet-related health risk or condition, food insecurity or other documented challenges in access to nutritious foods and are referred by a provider or health insurance plan. CMS should cover and provide reimbursement for such programs, including food insecurity screenings that could determine eligibility for a produce prescription. GusNIP Produce Prescription Program awardees serve as an excellent model of this kind of program. Relatedly, CMS should offer support for providers to update their health coding infrastructure in order to integrate produce prescriptions into clinical care. CMS should provide resources and technical assistance to address current barriers to participation, including technology.

Food Insecurity

Food insecurity is a social determinant of health, increasing the risk of poorer health outcomes. The Department of Health and Human Services (HHS) and Department of Agriculture (USDA) should create and promote a standardized food insecurity screening program that is part of general patient intake procedures.

Additionally, CMS should reimburse providers for screenings and appointments related to food insecurity in the Medicare and Medicaid programs. Solving food insecurity and poor diets can reduce overall health care costs in the long term. This particularly important as Medicaid

[8] https://www.nokidhungry.org/sites/default/files/2022-05/Summer_Meals_Waivers_Micro_Report_.pdf (305% increase in the number of children participating in free summer meals in 2020 compared to 2019).

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beneficiaries are more likely to experience food insecurity. For example, during the early stages of the COVID-19 pandemic, 65% of surveyed Medicaid beneficiaries reported "food insufficiency."[9]

Supplemental Nutrition Assistance Program (SNAP)

SNAP is an essential safety net program for rural residents, with SNAP participation highest in rural areas compared to metro areas.[10] It is a stimulus to local economies, providing about $1.79 in local economic activity for each SNAP dollar spent.[11] Between 2013 and 2017, SNAP kept nearly 8 million individuals above the poverty line.[12] Specifically for rural communities, SNAP reduced the poverty rate by 1.4% in 2020.

Throughout the COVID-19 pandemic, the country saw how flexible SNAP can be during an emergency and how it was able to help keep food on more families' tables during an uncertain time. An extra $387 million in SNAP dollars went to rural counties as Congress increased benefits during the COVID-19 pandemic.[13] A few critical changes in the 2023 Farm Bill could make SNAP even more successful and accessible.

First, Congress must eliminate the restriction on using SNAP dollars on hot and prepared foods. This is an undue burden on recipients. SNAP recipients deserve the same access to convenient, ready-made foods as non-recipients. H.R. 6338, the SNAP PLUS Act of 2021, would remove this requirement. NRHA encourages the White House to support for this bill.

Second, Congress must broaden eligibility for SNAP. Unfortunately, there are situations in which families increase their gross income and consequently become ineligible for SNAP if they earn more than 130 percent of the federal poverty level (FPL). However, when lost SNAP benefits are considered, a family may cancel out the higher earnings because of the new out-of-pocket grocery expenditures. Essentially, once food is accounted for, the remaining household budget would be at the SNAP eligibility line. These families and individuals may not be in a better position to pay for food yet could not receive SNAP benefits. Therefore, the White House and Congress must work together in developing the 2023 Farm Bill to expand eligibility and make more homes food secure.

Third, Congress and USDA must increase education and outreach on SNAP eligibility. Many individuals qualify for SNAP but are unaware. In some rural areas, the stigma associated with public assistance prevents people from accepting SNAP benefits. Areas of the 2023 Farm Bill could work to address both issues related to eligibility and participation. Grants for non-profits and other groups could be used to amplify education about eligibility to rural residents. Trusted community voices, such as faith-based organizations, could participate and help eliminate the stigma of SNAP. Older adults should specifically be targeted as less than half of adults over sixty that are eligible for SNAP are enrolled.[14] Further, CMS must coordinate with USDA to raise awareness among beneficiaries of SNAP eligibility. There is overlap between Medicaid and SNAP eligibility requirements; however,

[9] https://www.kff.org/medicaid/issue-brief/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts/#:~:text=Recent%20data%20indicates%20that%20access,week%20ending%20July%2021%2C%202020.
[10] https://frac.org/wp-content/uploads/rural-hunger-in-america-snap-get-the-facts.pdf
[11] https://frac.org/wp-content/uploads/rural-hunger-in-america-snap-get-the-facts.pdf
[12] https://www.cbpp.org/research/poverty-and-inequality/economic-security-programs-significantly-reduce-poverty-in-every
[13] https://www.aei.org/wp-content/uploads/2022/03/SNAP-Supports-Rural-Families.pdf?x91208
[14] https://frac.org/wp-content/uploads/rural-hunger-in-america-snap-get-the-facts.pdf

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less than half of Medicaid beneficiaries receive SNAP benefits.[15] CMS can connect its beneficiaries with crucial nutrition assistance and reduce food insecurity.

Last, Congress and the Administration should think about methods to promote consumption of healthy foods in SNAP recipients. The GusNIP competitive grants allow awardees to develop projects that increase produce purchases by providing incentives to SNAP recipients. Again, these grant programs should be made noncompetitive to encourage broader participation. Individuals that receive rebates, refunds, or extra money for produce will be more likely to buy and consume it. Increased intake of fresh produce has been shown, time and time again, to improve long-term health outcomes and therefore decrease health care expenditures.

Obesity and Treatment

Today, many insurers (including Medicare) approach obesity as a lifestyle issue rather than a serious chronic disease. As a result, too many Americans do not have insurance coverage for obesity treatment. The disease of obesity is highly prevalent but underdiagnosed and undertreated. Nutrition and health must be integrated, ensuring that people have access to healthy food choices and the medical care they need. For example, obesity is treated through a combination of lifestyle intervention, medications, and surgery. Ideally, access to good nutrition and coverage for treatment work together to address this disease.

Medicare currently only covers behavioral therapy and bariatric surgery, and Medicare Part D continues to exclude coverage for anti-obesity medications even though they are recommended in clinical guidelines. The Administration must work to ensure that everyone living with obesity has access to the full continuum of obesity care. Rural areas, seniors, and communities of color are disproportionately impacted by obesity. In fact, these groups live with obesity at higher rates, 41% percent of those aged 65-74 live with obesity, obesity is approximately 6.2 times higher in rural areas, and American Indian/Alaska Native had the highest prevalence of obesity at 48.1%, followed by and Hispanics at 44.8%, compared to their non-Hispanic white counterparts at 42.2%. And in 75% of the country obesity prevalence among non-Hispanic blacks exceeds 40%.

Changing Medicare Part D's policy on coverage of anti-obesity medications would ensure seniors have access to the full continuum of obesity treatments and send a strong signal to states and other payers to also cover these medicines, thus improving access for rural areas, and communities of color.

[15] https://www.kff.org/medicaid/issue-brief/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts/#:~:text=Recent%20data%20indicates%20that%20access,week%20ending%20July%2021%2C%202020.

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