Investing in a Healthier America: Chronic Disease Prevention and Treatment
Written Testimony Submitted to the U.S. House Committee on Ways and Means, Subcommittee on Health
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1100 Longworth House Office Building, Washington, DC

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Dear Chairman Buchanan, Ranking Member Doggett, and distinguished members of the Committee:

I am grateful for the opportunity to testify and share what I have seen and learned about food and health as a heart and lung transplant surgeon, as the former Majority Leader of the U.S. Senate, and as a Senior Fellow at the Bipartisan Policy Center, including co-chairing the BPC's Food is Medicine Working Group.

I've personally performed many hundreds of heart surgeries, and written thousands of prescriptions, for patients to treat and prevent disease. But in all my years of practice, I never wrote a prescription for food. That is about to change. Why? Because nutritious food is finally being recognized as a fundamental component of health and health care.

WHERE WE ARE TODAY

- **Key point #1:** Poor nutrition is the leading risk factor for death and disability in the United States, causing more health harms than other major risk factors such as tobacco use, alcohol, opioids, physical inactivity, or air pollution (*Figure 1*).[1]
    - Poor diets are estimated to kill 10,000 Americans each week, cause 1,500 new cases of cancer each week, and cause 16,000 new cases of diabetes each week.[2,3,4]
    - Poor diets are a key contributor to 7 in 10 adults being overweight or having obesity,[5] 1 in 2 having diabetes or prediabetes,[6] and 14 in 15 (~93%) having suboptimal cardiometabolic health (less than suboptimal levels of body fat, blood pressure, blood cholesterol, or blood sugar).[7]
    - What these numbers tell us: more American adults are sick than healthy.
    - Children and teenagers aren't spared—among 2-5 year-olds, 1 in 8 has obesity. Among teens, 1 in 4 has obesity,[8] and nearly 1 in 3 has prediabetes.[9]

- When I began my medical career, these national epidemics of obesity and type 2 diabetes did not exist. The proliferation of these diet-related chronic diseases has occurred in our adult lifetimes.

[1] U.S. Burden of Disease Collaborators, Mokdad AH, Ballestros K, et al. The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. *JAMA.* 2018;319(14):1444-1472. https://jamanetwork.com/journals/jama/fullarticle/2678018
[2] Ibid.
[3] Zhang FF, Cudhea F, Shan Z, et al. Preventable Cancer Burden Associated With Poor Diet in the United States. *JNCI Cancer Spectr.* 2019;3(2):pkz034. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6649723/
[4] O'Hearn M, Lara-Castor L, Cudhea F, et al. Incident type 2 diabetes attributable to suboptimal diet in 184 countries. *Nature medicine.* 2023;29(4):982-995. https://www.nature.com/articles/s41591-023-02278-8
[5] https://www.cdc.gov/nchs/fastats/obesity-overweight.htm Accessed September 1, 2024.
[6] CDC. National Diabetes Statistics Report 2024. https://www.cdc.gov/diabetes/php/data-research/index.html
[7] O'Hearn et al. JACC. 2022 Jul, 80 (2) 138–151. https://www.jacc.org/doi/10.1016/j.jacc.2022.04.046
[8] https://www.cdc.gov/obesity/php/data-research/childhood-obesity-facts.html Accessed September 1, 2024.
[9] Liu et al., 2022. JAMA Pediatrics. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2790364

- Despite solid evidence that a nutritious diet is fundamental to living a healthy life, most Americans fall far short of following science-based dietary guidelines. The average score on the Healthy Eating Index (HEI) — a measure of how well one's eating habits align with those recommended in the latest federal dietary guidance — is 58 out of 100.[10] This is a failing score. Even if we separate the population by age groups, the highest score is still only 61 (that's for individuals ages 60+).[11]
    - The problem is two-fold. First, Americans eat too much refined starch, sugar, and salt, often as part of foods that have been processed far beyond their natural forms.
    - Second, most Americans eat too few fruits, vegetables, beans, nuts, whole grains, seafood, and yogurt (*Figure 2*). These minimally processed foods are rich in nutrients and other compounds that nourish our bodies and our gut bacteria.
    - We must deal with both problems. Yet, traditionally, we've spent much more time and focus on driving down excess intake of harmful components in the diet than we have on rewarding, incentivizing, and valuing health-promoting foods and their economic benefits. This is where Food is Medicine comes in.

- **Key Point #2:** Poor nutrition is crushing our economy. The U.S. economy loses an estimated $1.1 trillion each year in direct medical costs and productivity losses due to poor nutrition.[12]
    - For just one condition, type 2 diabetes – a malady almost entirely preventable and treatable with good nutrition – the U.S. government spends nearly *$200 billion* each year on direct medical costs alone.[13] This is more than the entire budgets of many agencies.
    - The costs of diet-related diseases are a major burden for families. Over the last 30 years, the average family on employer-sponsored insurance has *lost $125,000 in cumulative wages* due to rising healthcare premiums.[14] Today, the leading cause of household bankruptcy is catastrophic medical expenses. And this economic pain is greatest for rural, low-income, Black, and Hispanic families.
    - The costs of diet-related diseases represent a massive burden for U.S. businesses. The average premium for employer-sponsored healthcare has risen 50% in just 10 years.[15]
    - The costs of diet-related diseases are also driving up the federal budget and national debt. In 1969, just 5% of the federal budget was spent on healthcare. Today, it's nearly 30%.[16] And over the next decade, healthcare spending is projected to account for more than a third of federal budget spending growth – more than any other budget expenditure – surpassing both Social Security and net interest on the debt.[17]
    - **If Congress wants to do the things that you believe are important for the American people, we will never have the funds you need until we reduce healthcare spending.**

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[10] Shams-White et al., 2023. https://www.jandonline.org/article/S2212-2672(23)00246-0/fulltext

[11] https://fns-prod.azureedge.us/sites/default/files/media/file/AverageHealthyEatingIndex-2020ScoresfortheUSPopulation.pdf

[12] The Rockefeller Foundation. True Cost of Food: Measuring What Maters to Transform the U.S. Food System. 2021. https://www.rockefellerfounda□on.org/report/true-cost-of-food-measuring-what-maters-to-transform-the-u-s-food-system/.

[13] Parker ED, Lin J, Mahoney T, et al. Economic Costs of Diabetes in the U.S. in 2022. *Diabetes Care.* 2024;47(1):26-43. https://pubmed.ncbi.nlm.nih.gov/37909353/

[14] Hager K, Emanuel E, Mozaffarian D. Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families. *JAMA Netw Open.* 2024;7(1):e2351644

[15] Center for American Progress. Federal Solutions To Address Rising Costs of Employer-Sponsored Insurance. 2024. https://www.americanprogress.org/ar□cle/federal-solu□ons-to-address-rising-costs-of-employer-sponsored-insurance/. Accessed April 12, 2024.

[16] Cubanski J et al., FAQs on Health Spending, the Federal Budget, and Budget Enforcement Tools, Kaiser Family Foundation, March 20, 2023. https://www.kff.org/medicare/issue-brief/faqs-on-health-spending-the-federal-budget-and-budget-enforcement-tools/

[17] "84 Percent of Spending Growth Will Come from Health, Social Security, and Interest," Committee for a Responsible Budget, Feb. 15, 2024, https://www.crfb.org/blogs/84-percent-spending-growth-will-come-health-social-security-and-interest#:~:text=Spending%20on%20Social%20Security%20will,doubled%20between%202020%20and%202023.

And healthcare spending will never be controlled until we fix food.

- **Key Point #3:** This is also an *urgent matter of national security*.[8] Mission:Readiness, a group of more than 700 retired U.S. generals and admirals, have been making this case for more than a decade.
    - In 1941, President Franklin D. Roosevelt convened the National Nutrition Conference on Defense,[18] to create urgent new policies to fix the food supply, when 1 in 3 young Americans did not qualify for the draft due to nutritional deficiencies.
    - Today, nearly *8 in 10* young Americans do not quality for military service, and the top medical disqualifier is overweight and obesity.[19]
    - For our nation's sake, our elected leaders today must have the same vision and urgency to fix our food system.

- **Key Point #4:** The burdens of our food are also *driving societal discord*. Americans of all incomes, races, and ethnicities —and all political parties, states, and cites — are experiencing high and rising levels of diet-related diseases and downstream family, community, and economic consequences. But those with lower incomes, living in rural communities and from historically marginalized racial and ethnic groups face the greatest burdens.[20] These challenges contribute to them falling behind economically, to lost wages, lost jobs, depleted communities.
    - 44 million Americans — about 1 in 8 households — experience food insecurity at some point during the year.[21] Food insecurity is associated with worse nutrition, higher rates of diet-related diseases, and greater healthcare spending.

- **As we look to comprehensively expand treatment options for diet-related diseases, including obesity, and key in on prevention, we all need to prioritize going back to the very basics: the food we put in our bodies every day.** The lack of attention to our food explains so much about the problems we face today: hundreds of millions of sick Americans, hundreds of billions of dollars in preventable healthcare costs, exhausted federal and state budgets – and exhausted policy makers.

THE POWER OF "FOOD IS MEDICINE"

"Food is Medicine" (FIM) is a promising strategy to deal with our country's nutrition crisis. This refers to a set of food-based nutrition programs and interventions, integrated into the health care system, to advance specific health needs and health equity in different populations. Recognizing the role that nutrition plays, FIM advocates for using nutritious foods to both prevent and treat illnesses. It includes improving access to nutritious foods and calls on healthcare providers—including doctors, nurses, pharmacists, and others—to recognize the role of nutrition in health and more deliberately collaborate with nutrition experts like registered dietitians to effectively engage with and educate patients on dietary needs. It empowers patients to take control of their own health.

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[18] National Nutrition Conference for Defense. National Nutrition Conference for Defense. *JAMA.* 1941;116(23):2598-2599.

[19] Mission: Readiness. 2023. https://www.strongnation.org/articles/2006-77-percent-of-american-youth-can-t-qualify-for-military-service

[20] Benavidez et al. 2024. Preventing Chronic Disease. https://www.cdc.gov/pcd/issues/2024/23_0267.htm

[21] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/key-statistics-graphics/

- This is not just about prevention, but about treating disease. Commonly targeted conditions include diabetes, pregnancy, heart failure, chronic kidney disease, and cancer.
- FIM is a medical therapy, not a social program. But it *also* helps address important social determinants of health like food insecurity and poverty.
    - This makes FIM a "double duty" intervention – an effective medical treatment that also addresses social determinants of health and advances health equity, giving all Americans a fair opportunity to achieve their top level of health.
- FIM programs[12] include several components:
    - Physician screening for appropriate medical conditions and, often, social needs like food or nutrition insecurity.
    - Treatment with specific food-based interventions like medically tailored meals, medically tailored groceries, or produce prescriptions, covered by health insurance. Coverage is critical given that access and affordability are leading barriers for many Americans to eat nutritious foods, particularly among low-income Americans who are at highest risk for diet-related chronic diseases.
    - Nutrition coaching and culinary education, often organized by Registered Dietitian Nutritionists (RDNs) via in person, telehealth, or digital interfaces.
- Other supportive aspects of FIM are important:
    - Links to electronic medical records and clinical care pathways, including reimbursement by federal and commercial payers.
    - Medical nutrition education for doctors.
    - Partnerships with community-based organizations for assessing eligibility and supporting enrollment in federal nutrition assistance programs like SNAP and WIC.
    - Rigorous research to understand what works, and for whom. Such research is critical to understand effects on food security, diet quality, physical health, mental health, and health care utilization. We must evaluate these outcomes to know which FIM interventions work best and how we might need to modify their implementation so they work better.

Whether using meals, groceries, or produce, FIM leverages healthcare to treat diet-sensitive conditions in a holistic, effective, and cost-effective fashion. These programs help cut through barriers such as cost, transportation, and inadequate knowledge around healthy food.

What evidence do we have to back it up?

Research conducted by experts around the country shows that FIM programs work to improve physical health by increasing intake of healthy foods, reducing food insecurity, and improving health outcomes.

- Observed benefits include lower hemoglobin A1c (a measure of average blood sugar levels over a 3-month period), body mass index, and blood pressure, as well as improved mental health and disease self-management.

When targeted to high-risk patients with complex medical conditions, FIM programs can also save money. Careful analyses indicate that FIM interventions will be either *highly cost-effective or even cost-saving* compared to many other common medical interventions.

- Considering that 1% of Americans produce 25% of healthcare costs; and 5% of Americans produce 50% of healthcare costs,[22] such high-risk patients are among the best targets for FIM programs.

[22] Kaiser Family Foundation. How do health expenditures vary across the population? 2024. https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/ Accessed April 14, 2024.

    - In one state-level analysis conducted by researchers at Tufts University, a medically tailored meals program resulted in net annual savings of $9,000 for each patient treated – even after accounting for the costs of the program.
    - Research estimates that about 6 million Americans qualify for medically tailored meals, and that providing this treatment to these patients will save nearly $14 billion annually – even accounting for the costs of the program (*Figure 3*).[23]
- Medical groceries and produce prescriptions are also highly cost-effective or even cost-saving.
    - North Carolina recently evaluated their Medicaid 1115 waiver experience, which included prominent FIM programming, delivered to 20,000 Medicaid beneficiaries across 33 mostly rural counties in the state. They found that, even accounting for the costs of the program, the intervention resulted in net cost savings for Medicaid.[24]
    - Additional research from Tufts University estimates that if about $45 per month of produce prescriptions were provided to Americans with diabetes and food insecurity, the program within 5 years would prevent 65,000 cardiovascular events and – due to healthcare cost savings – have no additional net cost. Over a lifetime, the program would prevent nearly 300,000 cardiovascular events and save more than $3 billion.

FIM programs can also support local food systems, farmers, and rural communities.

- Several FIM programs, such as Recipe4Health in Alameda County, California, focus on procuring food from local small and mid-sized farmers. This serves as an economic engine for farmers, their families, and their communities.

THE MOMENTUM OF FOOD IS MEDICINE

Based on these health and cost benefits, FIM is accelerating across the nation. Action is occurring at federal and state levels, and across sectors including health systems, health care insurers, nonprofits, and more.

At the federal level, for example:

- The Department of Veterans Affairs and the Indian Health Service have launched produce prescription pilot programs.
- The Department of Health and Human Services held its first-ever FIM Summit in January 2024, drawing a packed house.
- CMS and CMMI are developing toolkits and definitions for FIM programs.
- The National Institutes of Health has an approved plan to launch FIM Networks or Centers of Excellence, similar to the NIH-funded Cancer Centers of Excellence that have been so critical to advance cancer research and treatment.[25]
- Medicare Advantage programs across the country are implementing FIM based on Congress' 2018 expansion of Special Supplemental Benefits for the Chronically Ill (SSBCI). In 2020 when the program launched, 71 plans covered medically tailored meals, and 101 plans covered medical groceries and produce prescriptions. Today, 323 plans cover medically tailored meals, and 915 plans cover medical

[23] Hager K, Cudhea FP, Wong JB, et al. Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US. *JAMA Netw Open.* 2022;5(10):e2236898.
[24] Healthcare Innovation. North Carolina Plans to Expand Medicaid SDOH Pilot Statewide. 2024. https://www.hcinnovationgroup.com/population-health-management/social-determinants-of-health/news/55002542/north-carolina-plans-to-expand-medicaid-sdoh-pilot-statewide. Accessed April 12, 2024.
[25] "Concept Clearance - Food is Medicine Networks or Centers of Excellence," NIH Division of Program Coordination, Planning, and Strategic Initiatives, https://dpcpsi.nih.gov/sites/default/files/Day-1-155PM-ONR-Concept-Food-is-Medicine-Lynch-background-508.pdf, Accessed Sept. 13, 2024.

groceries and produce prescriptions.[26]

At the state level, for example:

- At least ten states now have section 1115 waivers to implement FIM in Medicaid: California, Delaware, Illinois, Massachusetts, New Jersey, New Mexico, New York, Oregon, North Carolina, and Washington. Groups in other states are pushing for similar waivers, such as in Oklahoma, Florida, and others.

For-profit and non-profit organizations are investing in FIM, for example:

Healthcare-related companies and organizations:

- Large commercial payers are implementing FIM, including Elevance, Blue Cross Blue Shield, Geisinger Health, and Promedica.
- Kaiser Permanente, the largest nonprofit integrated health system in the nation, is coordinating its five years of growing FIM programs into the nation's first healthcare FIM Center of Excellence.
- EPIC and other large commercial EMRs are integrating food insecurity screening into their applications.
- Innovative FIM start-ups, such as Season Health, Territory Foods, NourishedRx, Good Measures, and more are emerging.

Non-profit and philanthropic organizations

- Nonprofits across the nation are implementing FIM, including within coalitions like the Food is Medicine Coalition and National Produce Prescription Collaborative.
- The Rockefeller Foundation and American Heart Association have committed $250 million to FIM research.

Professional associations

- The American Academy of Pediatrics and American College of Lifestyle Medicine have committed to FIM-related training for all their members.
- The Accreditation Council for Graduate Medical Education (ACGME) has made statements about including nutrition competencies in its common program requirements for residency and fellowship programs.

Large, private sector companies are launching FIM programs, such as Instacart, Walmart, Kroger and more.

Other private sectors companies have a proven track record of providing *medically tailored*, home-delivered meals for decades. One example I've personally worked with is Mom's Meals. For 25 years, Mom's Meals has been delivering nutritious fully prepared meals to people aging in place, living with disabilities, discharging from the hospital, managing a chronic condition or experiencing a high-risk pregnancy while reaching every address in the US. And there is a strong evidence base that demonstrates the effectiveness of medically tailored meals as an intervention. Mom's Meals has been a part of five published studies quantifying impact on health status and high-cost utilization, in patients with nutrition-sensitive chronic conditions. Findings include:

- People with type 2 diabetes wearing a continuous glucose monitor (CGM) showed significant improvements in glucose control, with a 6.8% improvement in Time In Range (TIR).[27]

[26] "Chartbook: 2024 Nonmedical Supplemental Benefits in Medicare Advantage," ATI Advisory, Oct. 30, 2023, https://atiadvisory.com/resources/wp-content/uploads/2024/01/PY2024-Nonmedical-Supplemental-Benefits-Chartbook-ATI-Advisory.pdf

[27] Callahan CN, Hart BB, McNeil CK, Duerr, JM, Weller GB. Improved Time in Range During 28 Days of Meal Delivery for People With Type 2 Diabetes. Diabetes Spectrum. 2022; 35(3).

- Dialysis patients lowered their intake of sodium by more than 1600 mg per day, had lower thirst scores, decreased volume overload, and directional lowering of blood pressure – 11% in systolic and 7% in diastolic blood pressure.[28]
- Adults with chronic liver disease experienced a 30% reduced need for surgical punctures to remove fluid and a 25% improvement in quality of life.[29]
- Medicare Advantage members with heart failure or other chronic conditions had 39-50% lower rates of 30-day rehospitalization and lower mortality.[30]
- Veterans Administration patients age 65 or older hospitalized for heart failure had directionally reduced 30-day readmissions (11% versus 27%) and spent 69% fewer days re-hospitalized.[31]

Another example is a company I co-founded, Monogram Health. Monogram has made meaningful inroads in providing a new model of care to address chronic kidney disease (CKD) via Medicare Advantage capitated care. Research has highlighted that tailored diets can help prevent and treat CKD and its comorbid complications, slow CKD progression, and lower the risk of cardiovascular disease. Recognizing this, Monogram Health has fully integrated the food is medicine approach as a core component of its care model, putting nutrition on parity with medication management and high-value clinical interventions. By integrating dietary support – with diets tailored to each patient's specific diagnosis, stage, and constellation of polychronic conditions and goals of care -- and addressing food insecurity when necessary, Monogram Health has achieved measurable improved outcomes. Monogram's data shows that patients who engage with their dietitian services experience a 7% reduction in Medical Loss Ratio (MLR) savings compared to those without dietitian visits due to lower ER utilization and readmissions. This model underscores the profound impact of combining clinical care with tailored nutritional interventions.

The evidence for the cost-effective approach of FIM continues to build. With support for FIM growing federally and at the state level, across sectors including health systems, healthcare insurers, nonprofits, and private sectors – we know that it can scale.

IMPLEMENTATION QUESTIONS AND CHALLENGES

When it comes to broader policy, FIM interventions face substantial obstacles of insurance coverage, payment, and coordination among health providers and organizations that provide nutrition-based services. Indeed, the vast majority of Americans cannot access FIM therapies.

- Most states have not applied for Medicaid 1115 waivers to implement FIM.
- Traditional Medicare Fee-For-Service, which covers nearly half of all Medicare enrollees, does not cover FIM.
- Many commercial plans are awaiting greater clarity in federal healthcare regulations around FIM.
- FIM vendors and suppliers are not available in most parts of the country.
- Most doctors remain poorly educated around nutrition and FIM.
- Most Americans are unaware of these FIM treatment options, and when told about FIM, most Americans would like to try it.

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[28] Perez LM, Fang H-Y, Ashrafi S-A, et al. Pilot study to reduce interdialytic weight gain through low-sodium home-delivered meals in hemodialysis patients. Hemodialysis International. 2020.

[29] Tapper E, Baki J, Nikirk S, Hummel S, Asrani SK, Lok A. Medically tailored meals for the management of symptomatic ascites: the SALTYFOOD pilot randomized clinical trial. Gastroenterology Report. 2020; 8(6):453-456.

[30] Nguyen HQ, Duan L, Lee JS, Winn TG, Arakelian A, et al. Association of a Medicare Advantage Posthospitalization Home Meal Delivery Benefit With Rehospitalization and Death. JAMA Health Forum. 2023;4(6):e231678.

[31] Hummel S, Karmally W, Gillespie BW, Helmke S, Teruya S, et al. Home-Delivered Meals Post-discharge From Heart Failure Hospitalization. Circulation: Heart Failure. 2018; 11:1-10.

To scale access, we should look to expand reimbursement for medically tailored meals and groceries, and other proven interventions. And we should collect more comprehensive data on food is medicine interventions to further substantiate its effectiveness. This includes data that can help us answer key research questions that relate to:

- The most important eligible disease conditions and social needs criteria.
- The optimal dose ($/month) and program duration for different patients.
- The best balance of meals vs. groceries vs. produce; and the ideal route of delivery such as clinic pick-up vs. supermarket shopping vs. online ordering and home delivery.
- The types, frequency, and delivery mode of nutrition coaching and culinary education.

POLICY IMPLICATIONS AND SOLUTIONS

Thanks to Congress, innovators in healthcare and industry, and philanthropic and academic organizations, FIM is shifting from theory to reality. But more needs to be done.

To manage diet-related diseases, we must directly address the American nutrition crisis. This can be greatly accelerated by the adoption of smart, comprehensive policies that address current hurdles such as provider education in nutrition and food affordability and accessibility. With the evidence and progress to date, the nation is at a tipping point to accelerate FIM.

The Ways and Means Committee is well-suited for making a difference in the lives of millions of Americans through sensible FIM policy. This includes:

- Authorizing pilot programs to treat qualified individuals with medically tailored meals (MTMs) and produce prescriptions through Medicare. At the end of June this committee advanced H.R. 8816, the *American Medical Innovation and Investment Act*, which contains an updated version of H.R. 6780, the Medically Tailored Home-Delivered Meals Demonstration Pilot Act. This would pilot MTMs in 40 hospitals and be funded through the Medicare Trust Fund*. I urge the full House to pass H.R. 8816 during this Congress.*
- Encouraging CMMI to continue to build on FIM work by incorporating and testing FIM approaches in their existing and/or new demonstration pilots. Incorporating report language to encourage CMS to build on existing efforts that have accelerated food and nutrition security screening and clinical care and referral pathways in the EMR.
- Incorporating report language to make it clear that Health Savings Accounts can be used for accepted, structured, evidence-based FIM therapies, with clear language on what qualifies.
- Expanding nutrition counseling in healthcare. This should include passing H.R. 6407, the Medical Nutrition Therapy Act of 2023. This bill would expand Medicare Part B coverage of medical nutrition therapy (MNT) services for a variety of chronic conditions. Medical nutrition therapy includes nutritional diagnostic, therapy, and counseling services furnished by a registered dietitian for the purpose of disease prevention, management, or treatment. Currently, MNT is covered for only diabetes and kidney disease, but a much longer list of conditions (such as prediabetes, obesity, cancer, and high blood pressure) would benefit from MNT, which is evidence-based and cost-effective.

Beyond the jurisdiction of this Committee, Congress should*:*

- Continue to grow pilots and plan to scale FIM at the Department of Veterans Affairs and Indian Health Service.
- Authorize pilot programs in the Department of Defense to provide eligible active-duty personnel and

their families with FIM therapies.

- Include support for FIM programs at Community Health Centers that serve the most vulnerable Americans and are most likely to benefit from collaborations and support in this space.
- Encourage CMS to require all Medicaid Home and Community-Based Services (HCBS) waivers to include Food is Medicine programs with nutritious medically tailored home-delivered meal benefits to: (1) help older and disabled individuals remain in the community for longer periods of time, and (2) reduce burden on the strained HCBS workforce.
- Enact the nutrition-related provisions in the "Bipartisan Primary Care and Health Workforce Act" (S. 2840) to expand access to healthy food to low-income and uninsured patients with chronic disease.
- Encourage CMS to continue to release guidance and toolkits to make it easier for states to apply for Medicaid 1115 waivers that include FIM and implement FIM through CHIP Health Service Initiatives.[32]
- Appropriate meaningful funding for the NIH Office of the Director for the specific purpose of launching the FIM Networks or Centers of Excellence, a concept which has already received clearance at NIH. This initiative will combine cutting-edge research with patient care, advancing FIM just as the NIH Cancer Centers of Excellence have advanced cancer treatment and control.
- Provide a meaningful increase in support for the NIH Office of Nutrition Research, which is today woefully underfunded compared to other NIH Office of the Director offices (*see* Table 1 on following pages) despite the pressing importance of its research mission for the American people.
- Incorporate report language to encourage NIH to implement FIM research across its institutes and centers, coordinated by the Office of Nutrition Research.
- Expand support for produce prescriptions within the USDA Gus Schumacher Nutrition Incentive Program (GusNIP).
- Make diet quality a core SNAP objective, eliminate or create disincentives for the purchase of sugar-sweetened beverages with SNAP benefits, and support healthy purchases by continuing and strengthening incentives for purchasing fruits and vegetables in SNAP.[33] Policymakers could also consider modeling SNAP on WIC's approach, limiting purchases to nutritionally sound food. In 2024, USDA finalized changes to the WIC food packages, aligning them with current nutrition science.
- Increase the sustainable supply of nutrient-rich foods as part of efforts to shift our nation's reliance on ultra-processed foods which have been linked to numerous chronic conditions. Vegetable nutrients in the US, for example, have declined between 5 and 40% since the mid-1950s, largely due to changes in varieties that favor yield over quality.[34] Looking forward, expected changes in atmospheric CO2 are anticipated to reduce protein, iron and zinc concentrations in food crops by 3-17%, which could cause up to 175 million people to become nutrient deficient.[35] Land-based solutions – such as regenerative agriculture and agroforestry – can be critical to addressing nutrient density and produce quality. Nature-friendly farming systems can also lower the risk of food contamination. Many of the practices promoted through Farm Bill funding (like no till, and cover crops) have the potential to build soil organic matter. This could lead to beneficial impacts on crop nutrient density, though this has not been widely studied in the US (and should be further studied).

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[32] Daniel Tsai, "Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program," CMCS Informational Bulletin, Nov. 16, 2023, https://www.medicaid.gov/federal-policy-guidance/downloads/cib11162023.pdf

[33] "Leading with Nutrition: Leveraging Federal Programs for Better Health," Report, Bipartisan Policy Center, March 2018. https://bipartisanpolicy.org/report/leading-with-nutrition-leveraging-federal-programs-for-better-health/

[34] Davis D, Epp M, Riordan H, "Changes in USDA food composition data for 43 garden crops, 1950 to 1999," Journal of the American College of Nutrition, 2004 Dec;23(6):669-82. https://pubmed.ncbi.nlm.nih.gov/15637215/

[35] Smith R., Myers S., "Impact of anthropogenic CO_2 emissions on global human nutrition," Nature Climate Change, 834–839 (2018). https://www.nature.com/articles/s41558-018-0253-3

Recommendations specific to medical provider education:
Part of effectively ensuring nutrition is more effectively integrated into preventive healthcare, is educating our healthcare workforce on its benefits and appropriate application. In my years of medical education, I received little to no nutrition education, despite the clear link between a healthy diet and improved health outcomes. As a co-chair of the Bipartisan Policy Center's Food is Medicine Work Group, we crafted a series of recommendations that we released last November[36] to address this issue.

These recommendations focused on (1) training health care professionals and educating patients and the public about nutrition; and (2) engaging healthcare professionals in the delivery of interventions to spur the consumption of healthy food. Some of the specific recommendations include:

A) Direct the Health Resources & Services Administration (HRSA) to review its workforce programs to incorporate nutrition education as a grantee requirement;

B) Issue an executive order directing relevant federal agencies to educate their healthcare provider workforce on nutrition science, assess diet quality, and refer patients to nutrition services and FIM interventions;

C) Undergraduate and graduate medical accreditation bodies should establish nutrition-specific competencies and report compliance, while Congress should encourage these efforts by letting accreditation and licensing bodies[37] know that it's time to act (I commend Chairman Buchanan, Rep. McGovern, and other Members for writing to the ACGME in support of increasing nutrition education in all phases of medical education[38]);

D) Convene stakeholders via an independent organization to set baseline nutrition education standards for various healthcare providers; and

E) Fund efforts by the HHS and USDA to better disseminate the Dietary Guidelines for Americans through partnerships with healthcare professionals and other stakeholders.

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Today, less than 3% of U.S. health spend goes to public health, less than 5% to clinical preventive services, and less than 6-7% to primary care, and these three categories are not mutually exclusive. How we spend our resources defines our priorities, and our priorities define our values – the question for all of us is how healthy of a nation do we want to be?

The food we eat directly and powerfully impacts our health and wellness. By addressing nutritional needs for patients with specific diet-sensitive conditions within the context of healthcare, Food is Medicine interventions like medically tailored meals, medically tailored groceries, and produce prescriptions play an important role in preventing and/or managing many of the chronic conditions that drive health outcomes and drive health care costs in the United States, including obesity, diabetes, cardiovascular disease, and several cancers. Implemented at scale, these interventions can provide a powerful tool to tackle our leading health challenges and the unprecedented healthcare spending they command. **It's time for Congressional action to bring FIM to the American people.** Thank you for the opportunity to testify today.

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[36] Healthy Eating Rx: Improving Nutrition Through Health Care, Report, Bipartisan Policy Center, November 2023, https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2023/11/BPC_Food-is-Medicine_R06.pdf

[37] Licensing and accrediting bodies include the American Association of Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), Accreditation Council for Continuing Medical Education (ACCME), and American Board of Internal Medicine (ABIM).

[38] Buchanan V., McGovern J., et a., Letter to Dr. Thomas Nasca, ACMGE CEO, re: Nutrition Education in Medical Training, 4/25/24

Figure 1. Modifiable causes of death in the United States. Source: JAMA. 2018;319(14):1444-1472. doi:10.1001/jama.2018.0158/

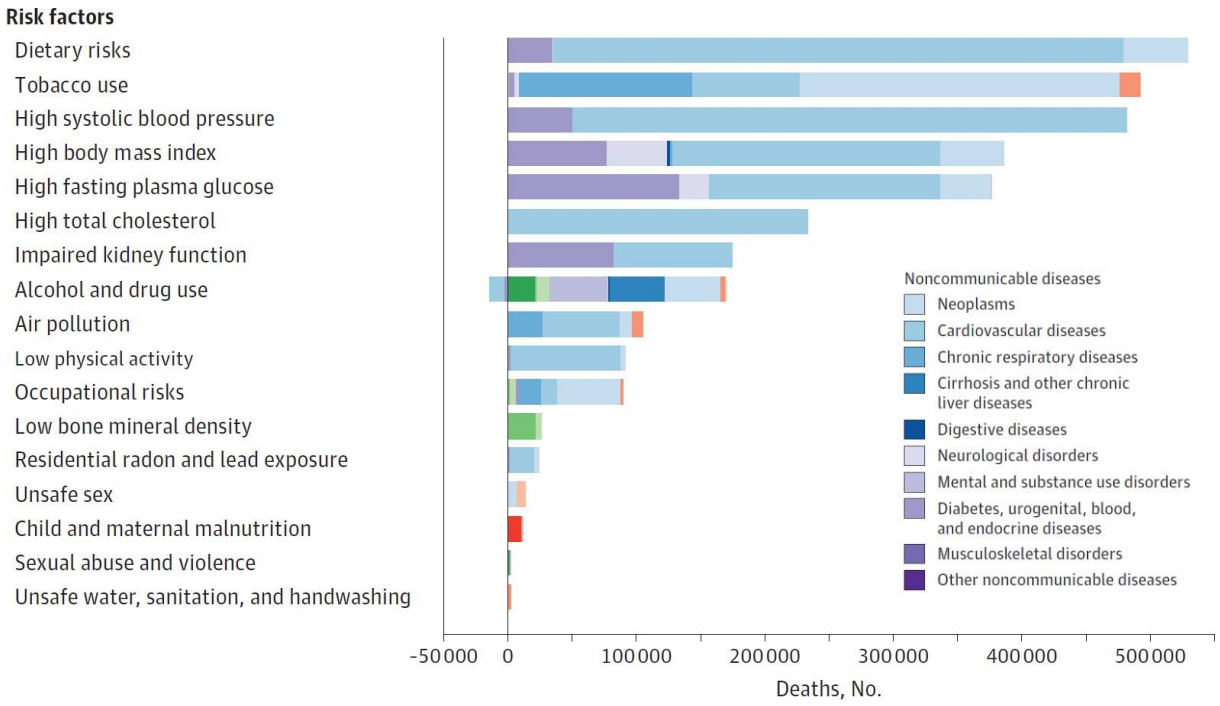

Figure 2. Dietary intakes of Americans compared to goals (Dietary Guidelines for Americans). Source: https://www.dietaryguidelines.gov/sites/default/files/2021-11/DGA_2020-2025_CurrentIntakesSnapshot.pdf

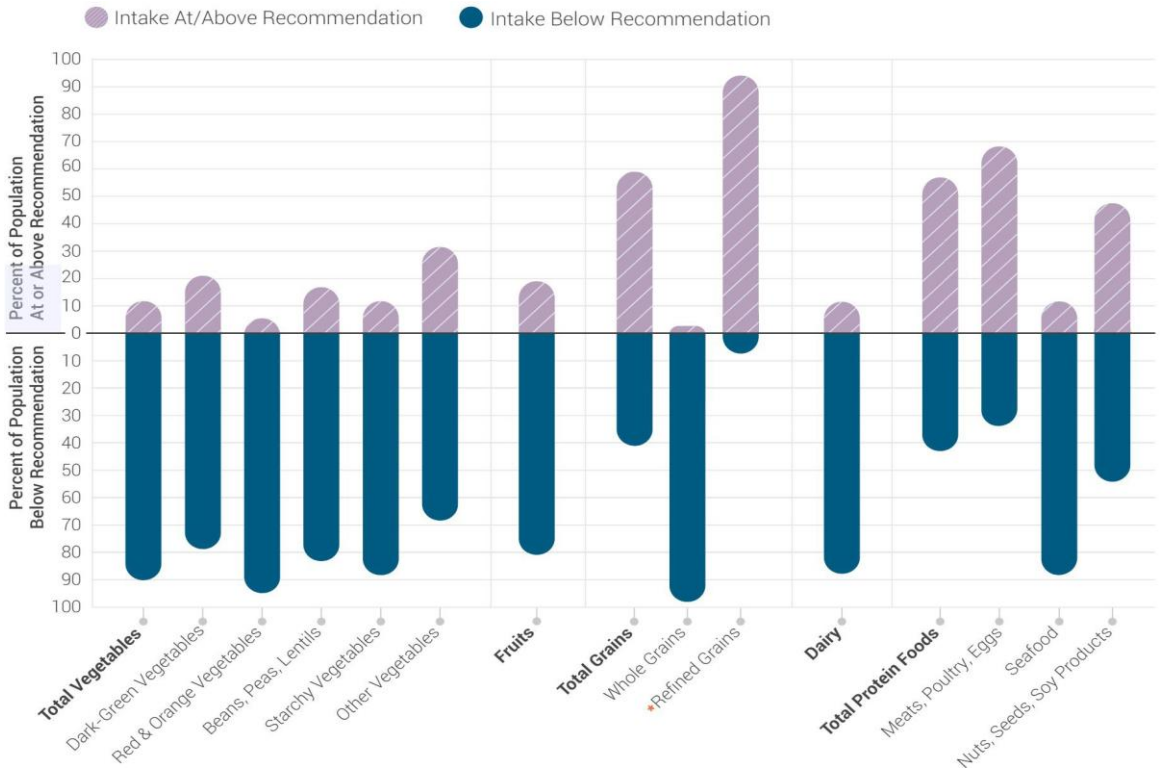

Figure 3. Estimated health effects, costs, and net savings of providing medically tailored meals to the approximately 6.3 million eligible Americans with high-risk, complex medical conditions and limited activities of daily living. Source: https://tuftsfoodismedicine.org/true-cost-fim-case-study-report/

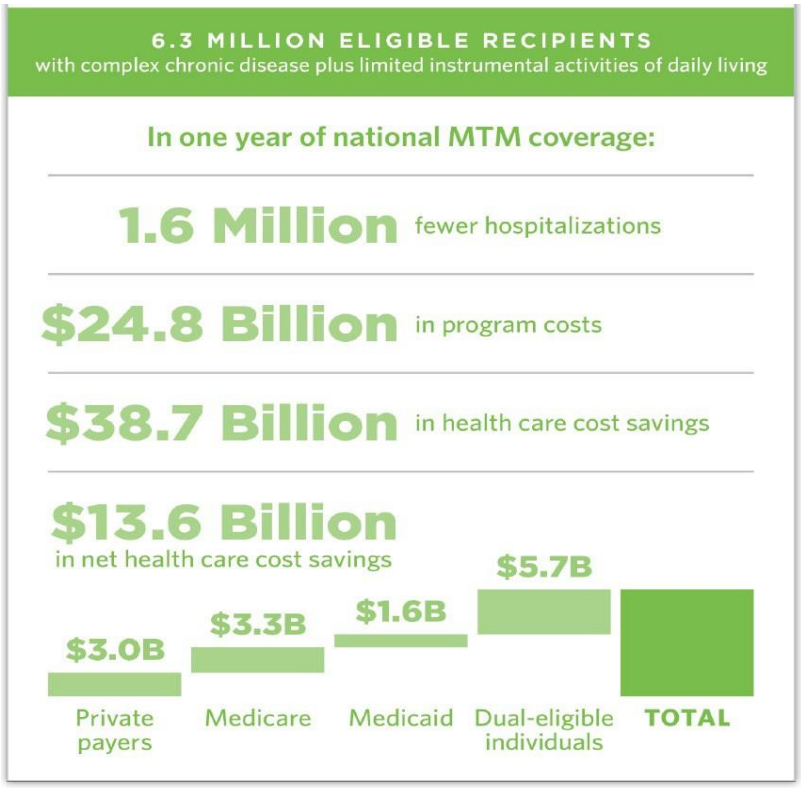

Table 1. FY 2023 and FY 2024 Funding for Offices within the NIH Office of the Director. Source:

Division of Program Coordination, Planning, and Strategic Initiatives (DPCPSI)
Budget Summary
(Dollars in Thousands)

	FY 2023 Final	FY 2024 CR	FY 2025 President's Budget	FY 2025 +/- FY 2023
Office of the DPCPSI Director	28,426	28,426	41,026	12,600
Office of Behavioral & Social Sciences Research	40,845	40,845	40,845	0
Office of AIDS Research	67,589	67,589	67,806	217
Office of Research on Women's Health	77,557	77,557	153,909	76,352
Office of Disease Prevention	17,873	17,873	17,873	0
Office of Dietary Supplements	28,500	28,500	28,500	0
Office of Data Science Strategy	85,000	85,000	85,000	0
Office of Research Infrastructure Programs	309,393	309,393	259,393	-50,000
Office of Nutrition Research	1,313	1,313	1,313	0
Common Fund	735,001	735,001	722,401	-12,600
Total	**$1,391,497**	**$1,391,497**	**$1,418,066**	**$26,569**

https://officeofbudget.od.nih.gov/pdfs/FY25/insti_center_subs/27-OD_FY25_CJ_Chapter.pdf