STATEMENT

of the

American Medical Association

to the

U.S. Senate Committee on Health, Education, Labor and Pensions
Subcommittee on Primary Health & Retirement Security

Re: Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine?

May 21, 2024

Division of Legislative Counsel
202-789-7426

Statement

of the

American Medical Association

to the

U.S. Senate Committee on Health, Education, Labor and Pensions
Subcommittee on Primary Health & Retirement Security

Re: Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine?

May 21, 2024

On behalf of the physician and medical student members of the American Medical Association (AMA), we appreciate the opportunity to submit the following statement to the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Health & Retirement Security, following your recent hearing entitled, Feeding a Healthier America: Current Efforts and Potential Opportunities for Food is Medicine. Access to nutritious food is critical to health and resilience and Food is Medicine is a concept that reaffirms this connection, recognizing that access to high-quality nourishment is essential for well-being.[1] As such, the AMA commends the Committee for focusing on this critically important issue, which if addressed, could help to significantly improve our nation's health.

The AMA is committed to preventing and reducing the burden of chronic diseases and recognizes the critical link between diet and chronic disease in America.[2] Moreover, we recognize that access to nutritious food is not equal, and that this inequity increases incidents of chronic diseases, such as diabetes and cardiovascular disease (CVD) in historically marginalized communities, making Food is Medicine a critical component of efforts to address health care inequities in this country. The AMA also recognizes the critical role that structural and societal barriers continue to play in inequitable access to healthy foods, and diet- and chronic disease-related medical treatments, and the importance of solutions aimed at addressing social determinants of health and other access-related issues.

The AMA commends the Committee for focusing attention on, and exploring policy solutions to, address this multi-faceted issue, which we believe warrants a multi-faceted

[1] https://health.gov/our-work/nutrition-physical-activity/food-medicine.

[2] Cardiovascular deaths include deaths from coronary heart disease (40.3%), stroke (17.5%), other minor CVD causes combined (17.1%), high blood pressure (13.4%), heart failure (9.1%) and diseases of the arteries (2.6%). https://newsroom.heart.org/news/more-than-half-of-u-s-adults-dont-know-heart-disease-is-leading-cause-of-death-despite-100-year-reign#:~:text=%E2%80%9CHeart%20disease%20has%20now%20been,Wu%2C%20M.D.%2C%20Ph.

policy solution. We are pleased to share our policy and recommendations regarding food is medicine, which cover the following topics: patient education and research, food labeling, food substitutes, reducing processed meats, added sugars and sodium, medical nutrition therapy services, medical foods, food assistance programs, and blood pressure monitors. In this statement we have provided links to our comprehensive correspondence with the federal government over the last two years, which includes detailed recommendations for improving federal nutrition policy as well as legislative changes that can be made to positively impact health outcomes.

Patient Education and Research

The AMA is committed working with Congress, the Administration, and industry partners to raise public awareness, fund educational programs for health care professionals, and fund research on diet's impact on health including: the risks of processed meat consumption, added sugars, sodium, and the benefits of healthy alternatives.[3,4,5] The AMA MAP™ Hypertension clinical quality improvement program was designed to improve hypertension management and control. The "P" component of the AMA MAP framework is to "Partner with Patients" and includes action steps to help guide health care organizations (HCOs) to provide patients with effective interventions to support healthy behaviors, including nutrition-related resources. The program has been provided to HCOs across 30 states since 2019. Among those HCOs, 38 percent were in systems that provide free or low-cost care to historically marginalized populations. Thanks to our success in this space, the AMA MAP Hypertension set of solutions is expanding to include management for other CVD risk factors, including cholesterol, prediabetes, and post-partum hypertension.

Furthermore, the AMA is partnering with other medical societies, voluntary health and community-based organizations, the Association of Black Cardiologists (ABC), the Minority Health Institute (MHI), the National Medical Association (NMA), the American Heart Association (AHA), and the American Medical Association Foundation (AMAF) to highlight the Release the Pressure (RTP) campaign. RTP serves as a multifaceted foundational campaign aimed at partnering with Black women to improve heart health and advance health equity by: increasing awareness and education around self-measured blood pressure (SMBP) monitoring, increasing awareness of the connection between hypertension and maternal health, strengthening relationships between Black patients and their physicians and other health professionals, and empowering Black communities by providing access to the resources and support needed to adopt heart-healthy lifestyles.[6]

The AMA Prevent Diabetes website houses a suite of tools and resources designed to help organizations build and integrate diabetes prevention strategies.[7] In line with this, the AMA has worked with more than 80 HCOs across the country to increase the identification and

[3] https://policysearch.ama-assn.org/policyfinder/detail/H-150.922%20?uri=%2FAMADoc%2FHOD.xml-H-150.922.xml.
[4] https://policysearch.ama-assn.org/policyfinder/detail/H-150.919%20?uri=%2FAMADoc%2FHOD.xml-H-150.919.xml.
[5] https://map.ama-assn.org/.
[6] https://releasethepressure.org/.
[7] https://amapreventdiabetes.org/.

management of patients with prediabetes. This suite of tools and resources, and the AMA's related expertise, served as the basis for the Bright Spot Model, which provided structure for local initiatives in Philadelphia and North Carolina to advance diabetes prevention. The AMA has since transitioned the Bright Spot model to the Centers for Disease Control and Prevention (CDC), which is now expanding the reach of the model by funding four organizations with $10 million for implementation. As part of this implementation, the CDC is funding several organizations to work with HCOs to implement the AMA Prediabetes Quality Measures. The AMA will continue to make its suite of tools and resources available to support this effort and would be happy to talk with the Committee about our efforts in this space and how these resources might be expanded upon.

Food labeling

The AMA supports national nutritional guidelines and educating patients about how nutrition labels and other resources can support families in selecting foods that are healthier for them.[8,9] The AMA specifically supports the Food and Drug Agency (FDA) development of front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value. The AMA also supports limiting the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims[10] and supports accurately portraying fat content in foods, particularly trans fats and saturated fats.[11] The AMA also recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat, trans fat, and sodium labeling on menus so consumers can be empowered to make better food choices.[12] The AMA also encourages food manufacturers to pursue more obvious packaging distinctions indicating when foods contain (or do not contain) common food allergens.[13]

The AMA recently submitted comments to the FDA regarding new draft guidance for food labeling and continues to engage regularly with the agency on this topic.[14] In our comments, the AMA expressed support for a uniform, nutritional food rating system in the U.S. that is evidence-based, has been developed without conflict of interest or food industry influence, has the primary goal of advancing public health, is broadly applicable and comprehensive in scope, and deploys a rating scale that is simple, visible, and easy-to-understand at point of

---

[8] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfclhss.zip%2F2024-4-11-Letter-to-Becerra-re-Maternal-Health-Final.pdf.

[9] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flffda.zip%2F2023-9-19-Letter-to-Califf-re-FDA-Food-Labeling-Draft-Guidance-v2.pdf.

[10] https://policysearch.ama-assn.org/policyfinder/detail/food%20labeling?uri=%2FAMADoc%2Fdirectives.xml-0-256.xml.

[11] https://policysearch.ama-assn.org/policyfinder/detail/food%20labeling?uri=%2FAMADoc%2FHOD.xml-0-617.xml.

[12] https://policysearch.ama-assn.org/policyfinder/detail/sodium?uri=%2FAMADoc%2FHOD.xml-0-623.xml.

[13] https://policysearch.ama-assn.org/policyfinder/detail/food%20labeling?uri=%2FAMADoc%2FHOD.xml-H-150.924.xml.

[14] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flffda.zip%2F2023-9-19-Letter-to-Califf-re-FDA-Food-Labeling-Draft-Guidance-v2.pdf.

purchase. Final guidance is expected later this year.

Food substitutes

The AMA understands that food alternatives are important to individuals who may have allergies or cultural considerations. Therefore, we support federal legislation that would modify the National School Lunch Act, 42 U.S.C. § 1758, to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cow's milk.[15,16]

Additionally, it is important to consider cultural and socioeconomic needs in all nutrition and dietary guidelines. We urge Congress to examine expanding dietary guidance statements to include more non-dairy, plant-based milk or yogurt and refined grains alternatives to accommodate a range of cultural and dietary needs, including allergies to common dairy-alternative products containing soy.[17]

Reducing processed meats, added sugars, and sodium in American diets

In concert with the Dietary Guidelines for Americans (DGA), the AMA strongly recommends that consumers limit the amount of added sugars, sodium, and processed meats in their diet. The AMA urges restaurants, public schools, hospitals, and other settings to improve the nutritional quality of their menu offerings by reducing caloric content, offering smaller portions, offering more fruits, vegetables, and whole-grain items, using less sodium**,** using cooking fats lower in saturated and trans fats, and reducing processed meats.[18,19,20] The AMA has called on the FDA, as well as individual food manufacturers and restaurants, to consider all options to reduce sodium levels to the greatest extent possible, recognizing that a gradual but steady reduction over several years may be the most effective way to minimize sodium levels. We are in regular communication with the FDA and other federal agencies about efforts to reduce sodium and understand that an updated voluntary sodium reduction target is expected out imminently.

In 2006, AMA's Council on Science and Public Health (CSAPH) issued a report summarizing the existing evidence available at the time on sodium intake and blood pressure, concluding that across populations, increases in blood pressure and the prevalence

---

[15] The AMA recognizes that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in white Americans, often manifesting in childhood.

[16] https://policysearch.ama-assn.org/policyfinder/detail/%22Culturally%20Responsive%20Dietary%20and%20Nutritional%20Guidelines%20D-440.978%22?uri=%2FAMADoc%2Fdirectives.xml-0-1522.xml.

[17] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flffda.zip%2F2023-9-19-Letter-to-Califf-re-FDA-Food-Labeling-Draft-Guidance-v2.pdf.

[18] https://policysearch.ama-assn.org/policyfinder/detail/sodium?uri=%2FAMADoc%2FHOD.xml-0-623.xml.

[19] https://policysearch.ama-assn.org/policyfinder/detail/H-150.922%20?uri=%2FAMADoc%2FHOD.xml-H-150.922.xml.

[20] https://www.fda.gov/media/84261/download#:~:text=Diets%20higher%20in%20sodium%20are,food%20when%20cooking%20or%20eating.

of hypertension are related to salt intake, with modest but consistent findings showing the effect of salt consumption on blood pressure. That report made the recommendation, which was adopted by the AMA, for a stepwise minimum 50 percent reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. AMA staff are currently working on an updated sodium report that will examine the following: the prevalence of excess sodium intake in the population as well as the health impacts, including differential prevalence and impacts among various sociodemographic groups; strategies implemented to reduce sodium consumption since CSAPH's last report as well as the evidence-base in support of interventions; and opportunities to expand and strengthen current AMA policy, which addresses reduction of sodium in processed foods, fast-food products, and restaurant meals; physician and public education, school-based education, and nutrition labeling. The updated report will be presented at the AMA's Interim meeting in November 2024 for review and approval and we would be pleased to share a copy of the report with the Committee once it is final.

Medical Nutrition Therapy Services

The AMA supports coverage and access to a range of evidence-based anti-obesity and diet-related disease treatments including intensive behavioral and nutritional interventions such as medical nutrition therapy (MNT) services, a specialized type of nutrition counseling provided by a registered dietitian which have been proven to improve quality of life, health outcomes, and reduce health-related costs.[21,22] Currently, Medicare Part B offers three hours of MNT services in the first year of diagnoses for certain beneficiaries with Diabetes or renal disease, and two hours of MNT every year thereafter.[23] MNT services are currently underutilized, and access to them is critically important, particularly for minoritized groups and other underserved communities who have historically faced disparities in chronic disease rates due to socioeconomic inequalities and reduced access to health care, healthy foods, and safe places to be active.[24] The AMA encourages Congress to work with the Secretary to find ways to expand and address inequitable access to MNT and other evidence-based supports for diet-related conditions, including permanently allowing MNT services to be delivered remotely, allowing MNT and Diabetes Self-Management Training services to be delivered on the same day, reducing or eliminating patient cost-sharing, and reimbursing for MNT services for individuals with prediabetes.[25] Congress should expand Medicare coverage for MNT to include additional diet-related health conditions.

[21] https://policysearch.ama-assn.org/policyfinder/detail/obesity?uri=%2FAMADoc%2Fdirectives.xml-0-1498.xml.
[22] https://www.jandonline.org/article/S2212-2672(21)00146-5/abstract.
[23] https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=252.
[24] https://www.jandonline.org/article/S2212-2672(21)00146-5/abstract.
[25] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfctl.zip%2F2023-9-11-Letter-to-Brooks-Lasure-re-2024-PFS-Proposed-Rule-Comments-v3.pdf.

Medical Foods

Metabolic disorders can be treated through specialized diets of medically necessary foods and supplements, yet these can be expensive and coverage is often limited.[26] The AMA supports legislation to establish a uniform requirement that health plans offer coverage of medical foods and foods as medical benefits, not pharmacy benefits, as well as pharmacological doses of vitamins and amino acids used for the treatment of metabolism conditions in newborns.[27]

Food Assistance Programs

The AMA has long-standing policy supporting improvements to Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and other supplemental nutrition programs that are designed to promote adequate nutrient intake, reduce food insecurity and obesity, and ensure that federal subsidies incentivize healthful foods. The AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.[28,29]

SNAP, WIC, and CHIP

WIC serves 6.7 million participants each month. Additionally, WIC serves approximately 40 percent of all infants in the United States.[30] The AMA applauds the WIC program's demonstrated success in improving the health of individual participants by increasing consumption of nutritious foods and decreasing food insecurity. The AMA provided comments and recommendations to the federal government in response to proposed revisions to the WIC Food Packages.[31] Overall, the AMA supported the primary goal of revising the program to align with the current Dietary Guidelines for Americans while providing flexibility in the variety and choice of foods and beverages. This flexibility will better reflect cultural and medical needs and personal preferences while adhering to the science associated with nutritional necessities that promote growth and health in pregnant, breastfeeding, and non-breastfeeding postpartum individuals and children. The federal

---

[26] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4541808/.

[27] https://policysearch.ama-assn.org/policyfinder/detail/food?uri=%2FAMADoc%2FHOD.xml-0-1123.xml.

[28] The AMA will continue to recommend that the federal government clearly indicate in the Dietary Guidelines for Americans (DGA) and other federal nutrition guidelines that meat and dairy products are optional, based on an individual's dietary needs.

[29] https://policysearch.ama-assn.org/policyfinder/detail/H-150.944%20?uri=%2FAMADoc%2FHOD.xml-0-622.xml.

[30] https://www.fns.usda.gov/wic/building-healthy-foundation.

[31] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2023-2-21-Letter-to-Vilsack-re-Special-Supplemental-Nutrition-Program-for-Women-Infants-and-Children-v3.zip%2F2023-2-21-Letter-to-Vilsack-re-Special-Supplemental-Nutrition-Program-for-Women-Infants-and-Children-v3.pdf

government recently released their final updates, many of which aligned with AMA recommendations.[32] Additionally, the AMA submitted formal comments supporting proposed changes to permanently allow online ordering and transactions and food delivery for WIC recipients to expand access to nutritious foods, particularly in rural and underserved communities.[33]

SNAP is considered the country's most effective anti-hunger program and is essential to the nation's nutrition safety net. It helps one in eight Americans afford a basic diet, with most SNAP participants being children, seniors, or people with disabilities. Protecting the integrity and assuring the quality of SNAP guarantees that it will continue to serve as the nation's defense against hunger. In January 2023, the AMA responded to a CMS Request for Information regarding essential health benefits outlining the importance of access to adequate nutrition, including participation in SNAP.[34] Due to the vital role that these programs play in fighting hunger, the AMA urges Congress to reauthorize and fund SNAP at full levels and ensure both SNAP and WIC receive adequate funds to provide infant formula and healthy foods for eligible families to thrive.[35]

According to the Kaiser Family Foundation, one in five (18 percent) lawfully present immigrants report that they are uninsured and nearly one in ten (eight percent) lawfully present immigrants report avoiding applying for "food, housing, or health care assistance in the past year due to immigration-related fears."[36] As such, the AMA believes that all Deferred Action for Childhood Arrival (DACA) recipients should have access to public health insurance such as Medicaid and CHIP as well as public food programs such as SNAP. The AMA submitted a letter urging the federal government to increase access to SNAP for DACA recipients.[37]

School Lunch Program

According to the CDC, 14.7 million children and adolescents, or 19.7 percent of the population, have obesity, with higher prevalence among Black and Hispanic children.[38] However, the nutrition that children receive from school meals can have a large and positive impact on their overall health since most U.S. children "consume as much as half of their

---

[32] https://www.fns.usda.gov/wic/fr-041824.
[33] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcmn.zip%2F2023-5-16-Letter-to-Vilsack-re-WIC-Online-Ordering-Rule-v2.pdf
[34] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flf.zip%2F2023-1-31-Letter-to-Brooks-Lasure-re-EHB-RFI-v6.pdf.
[35] https://policysearch.ama-assn.org/policyfinder/detail/H-245.989?uri=%2FAMADoc%2FHOD.xml-0-1731.xml.
[36] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/.
[37] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfscl.zip%2F2023-6-23-Letter-to-Becerra-and-Brooks-LaSure-re-NPRM-to-Expand-Healthcare-to-DACA-Recipients-v2.pdf.
[38] https://www.cdc.gov/obesity/php/data-research/childhood-obesity-facts.html?CDC_AAref_Val=https://www.cdc.gov/obesity/data/childhood.html.

daily calories at school."[39] It has been shown that updating nutrition standards for school "meals significantly improve[s] the nutritional quality of the meals and their consistency with the Dietary Guidelines for Americans."[40]

Health care for obesity is expensive for patients and the American health care system. In 2019, the estimated annual medical cost of obesity among U.S. children was $1.3 billion. Medical costs for children with obesity were $116 higher per person per year than for children with healthy weight. Medical costs for children with severe obesity were $310 higher per person per year than for children with healthy weight.[41] The AMA submitted comprehensive comments to the federal government regarding the proposed revisions to the Child Nutrition Programs: Revisions to Meal Patterns Consistent with the 2020 Dietary Guidelines for Americans.[42] Overall, the AMA applauded the Child Nutrition Program's primary goal of revising the program to align with the current DGA while providing flexibility in the variety and choices offered in school meals. However, the AMA provided more detailed comments and suggestions on improving the nutritional density and limiting the fat, added sugar, and sodium content in school-based food programs, accommodating food substitutions based on cultural and medical needs and preferences, and supporting initiatives to improve access to healthy, affordable foods and promoting lifelong healthy diet and lifestyle choices.[43]

Home blood pressure monitors

The AMA believes it is essential that federal programs address the issue of home blood pressure monitors being designated as Medicare durable medical equipment (DME). Access to a home blood pressure monitor can help patients better track their health, and in turn can motivate these patients to make lifestyle changes, such as eating more nutritious foods. Research indicates that reducing sodium is one of the actions that patients can take based on elevated home blood pressure readings to improve their health. This intentional patient action, in collaboration with their physician's guidance, is one step the AMA highlighted in our request to the federal government to designate home blood pressure devices as durable

[39] https://www.cdc.gov/healthyschools/nutrition/schoolnutrition.htm.
[40] https://www.jandonline.org/article/S2212-2672(19)31557-6/fulltext.
[41] Ward ZJ, Bleich S, Long MW, Gortmaker SL. Association of body mass index with health care expenditures in the United States by age and sex. *PLoS One*. 2021;16(3):e0247307.
[42] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fflr.zip%2F2023-4-10-Letter-to-Vilsack-re-Proposed-Rule-for-School-Meal-Standards-v2.pdf.
[43] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flf.zip%2F2023-1-31-Letter-to-Brooks-Lasure-re-EHB-RFI-v6.pdf.

medical equipment and a strong rationale for Medicare to cover home blood pressure devices.[44,45,46]

Research also indicates that Hypertensive Disorders of Pregnancy (HDP) are one of the leading causes of pregnancy-related deaths that occur in the first six weeks postpartum. The rate of patients entering pregnancy with chronic hypertension and the overall rate of HDP have risen considerably in recent years. The use of SMBP has been shown to increase compliance with the American College of Obstetricians and Gynecologists recommendations for blood pressure (BP) monitoring, increase patient satisfaction, and decrease readmissions for HDP. SMBP has also shown promise in reducing inequities in the monitoring and treatment of BP in postpartum patients. However, multiple barriers prevent the widespread adoption and use of SMBP for which there are potential solutions. Specifically, limited coverage and access are of concern. Medicaid covers about 42 percent of all births in the U.S.[47] However, coverage varies by states including access to an extra appropriately sized cuff, which is often needed to ensure clinical accuracy.[48] This variation, and others, are barriers to scaling SMBP.

Even when coverage exists there are still access issues. Some states prohibit shipping a covered device directly to the patients or require patients to go to a specific DME supplier rather than a more convenient location. For SMBP coverage to be clinically impactful, it necessitates that patients have coverage and access to devices that are appropriately sized and clinically validated. Therefore, we recommend the development of policies that support increased coverage and access to SMBP devices that are clinically validated for pregnancy and include appropriate cuff sizing options.[49]

---

[44] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fltfr.zip%2F2022-10-3-Joint-CMS-Letter-re-SMBP-Benefit-Category-v4.pdf.

[45] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfctl.zip%2F2023-9-11-Letter-to-Brooks-Lasure-re-2024-PFS-Proposed-Rule-Comments-v3.pdf.

[46] All patients with hypertension use their device in accordance with a treatment plan that has been created by the clinician and patient for self-management. Self-management, according to the World Health Organization, includes patients managing their own health conditions – and includes those who self-manage without or with support of healthcare providers. Treatment plans for hypertension include what patients should immediately do if their SMBP readings are low, in the expected range, or high. The treatment plan may include changes to non-pharmacological treatment (e.g. lowering dietary sodium and/or increasing dietary potassium, decreasing alcohol or tobacco, increasing physical activity or hydration) and/or pharmacologic treatment (taking skipped or forgotten doses of medication, increasing or decreasing existing medication). The patient makes these changes immediately.

[47] https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/maternal-infant-health-care-quality/index.html.

[48] https://www.ama-assn.org/system/files/smbp-coverage-medicaid.pdf.

[49] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfclhss.zip%2F2024-4-11-Letter-to-Becerra-re-Maternal-Health-Final.pdf.

Conclusion

The AMA appreciates the Committee's interest in continuing this important work on nutrition and food, which is critically linked to health and chronic disease in this country. We know that investing in expanded access to healthy foods and other nutritional supports now, particularly for disproportionately impacted populations, will improve the overall health of and reduce health care costs for all Americans, particularly millions who suffer from diet-related chronic disease.

The AMA thanks the Committee for this hearing and for its careful consideration of expanding Food is Medicine. We look forward to working with the Committee and Congress to help ensure that every American has access to high-quality, nutritious food.