Elevance Health | Public Policy Institute

From Policy to Plate: Surveying Food as Medicine Initiatives at Elevance Health

February 2025

Contents

Key Takeaways

- Food insecurity and diet-related illnesses are critical issues in the U.S., disproportionately affecting underserved populations.
- A "Food as Medicine" (FAM) strategy is one way to address these issues, by integrating nutritional support into healthcare systems. Examples of FAM interventions include the use of medically tailored meals or groceries, produce prescription initiatives, and nutrition security programs.
- The main goals of FAM are to improve health outcomes, decrease food/nutrition insecurity, and mitigate health disparities, all of which can also reduce healthcare costs.

Overview

The quote, "Let food be thy medicine and medicine be thy food," often attributed to Hippocrates, demonstrates that the link between nutrition and health is not new. The type and amount of food people consume contributes to the development and treatment of many chronic conditions including cardiovascular disease, hypertension, obesity, stroke, Type 2 diabetes, metabolic syndrome, some cancers, and neurological diseases.[1]

Increasing prevalence of diet-related health conditions indicates the concept of Food as Medicine (FAM) is relevant now more than ever. FAM is defined as strategies or interventions that are coordinated with the delivery of healthcare to provide access to nutritious foods focused on prevention, management, or treatment of disease.[2] Over half of American adults experience at least one chronic condition—the majority of which are diet-related (for example, cardiovascular disease, Type 2 diabetes).[3–5] In addition, these chronic conditions appear to be amplified in households that experience food insecurity.[6]

The prevalence of households experiencing food insecurity also demonstrates a need for a coordinated strategy to address food and nutrition support. One in seven households in the United States (U.S.) in 2023 experienced food insecurity at least some time during the year, meaning they had difficulty providing enough food for their household because of a lack of resources.[7] The term nutrition insecurity, a complementary concept to food insecurity, has also garnered increased attention in recent years. According to the United States Department of Agriculture (USDA), nutrition insecurity indicates that all Americans do not have consistent and equitable access to healthy, safe, and affordable foods essential to optimal health and well-being. While food security focuses on providing access to enough food, nutrition security emphasizes access to healthy, safe, and affordable foods essential for good health.

This brief describes a snapshot of Elevance Health's efforts—throughout the U.S. and across multiple lines of business (commercial, Medicaid, Medicare)—to advance members' access to food and nutritionally appropriate meals. The results illustrate the company's investments in six key FAM areas: personalized nutrition counseling and education; community-level healthy food policies and programs; government nutrition security initiatives; produce prescription initiatives (PRx); medically tailored groceries (MTG); and medically tailored meals (MTMs).

Background

Food as Medicine focuses on the prevention and treatment of health conditions and diet-related conditions using nutrition-related interventions.[8] Sociodemographic and economic factors significantly influence diet quality, which can exacerbate health disparities among underserved populations.[9]

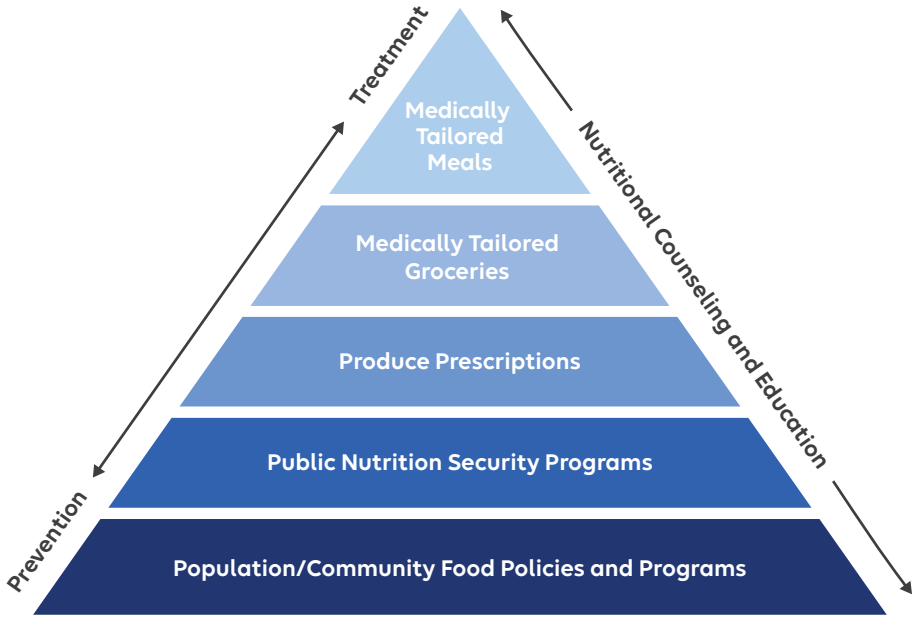
The goals of FAM include increasing consistent access to nutritious foods and addressing nutrition-related health conditions—while acknowledging the needs, preferences, and experiences of patient populations. Limited access to nutritious food exacerbates health inequities, which not only can result in undesired health outcomes but also increases healthcare spending.[10–13]

The FAM framework (Figure 1) categorizes these interventions, which range from prevention to treatment.[14] At the base of the pyramid are population- and community-based programs and policies that support or ensure equitable access to nutritious foods in communities. Examples of interventions in this category include health plan partnerships with food banks or soup kitchens. Moving up the pyramid are public nutrition security programs that reach a wide segment of the population, such as SNAP (Supplemental Nutrition Assistance Program) and WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), which can come in the form of financial subsidies for healthy foods or grocery cards to purchase food, as well as education and training to promote improved health outcomes.

The next level up in the pyramid includes PRx and MTG initiatives. These options often provide more autonomy for individuals to use their culinary skills to prepare and incorporate these foods to optimize health. PRx offers fresh, frozen, or canned fruits and vegetables to support individuals' health.

Figure 1

Food as Medicine Framework



Note. Image adapted from Center for Health Law and Policy Innovation of Harvard Law School. (2019). Massachusetts Food is Medicine State Plan. Retrieved November 15, 2024, from https://foodismedicinema.org/wp-content/uploads/2024/09/MA-FIM-State-Plan-Executive-Summary.pdf.

Examples of this type of FAM intervention include produce prescription cards or produce/farm boxes.[15] MTGs are often designed with support from dietitians and offer a combination of nutritious food items, including fruits, vegetables, whole grains, nuts, seeds, or legumes. Examples of this type of FAM intervention include restricted grocery benefit debit cards and tailored food pantries in clinical settings (often called "Food Farmacies").

At the top of the pyramid are more narrowly focused, "high touch" programs, called MTMs, which are often tailored with dietitians and chefs to treat or manage a specific health need, condition, or disease (for example, post-hospital discharge, high blood pressure, diabetes, or HIV).[16,17] Lastly, personalized nutrition counseling and education integrates seamlessly into each of the other initiatives, or serves as a standalone option for individuals and families. These options can amplify the effects of interventions through their synergistic qualities. Examples include one-on-one and group dietitian support or coaching, culinary education, online interactive platforms, and recipe tools.

Government-Funded FAM Programs

Medicare and Medicaid are demonstrating their commitment to reducing food/nutrition insecurity and addressing chronic diseases with the integration of FAM programs into healthcare delivery and financing.

For example, some Medicare Advantage plans include, as part of their supplemental benefits, home-delivered meals based on a specific event—such as after surgery or discharge from the hospital.[18] Additionally, in 2020, MA plans were permitted to begin offering food-based interventions to members with certain complex or disabling chronic conditions (that is, Special Supplemental Benefits for the Chronically Ill [SSBCI]). These FAM interventions—including MTMs, MTGs, and grocery benefit debit cards[19]—were designed to maintain or improve the function or health of members with chronic conditions.

In Medicaid, Section 1115 waivers allow states to implement pilots or demonstration programs to test innovations in Medicaid managed care plans and the fee-for-service program. As of July 2023, 19 states (15 approved and 4 pending) have used an 1115 demonstration waiver to provide nutrition-related programs to support pregnant and post-partum individuals as well as individuals with diet-sensitive conditions.[20] Medicaid also supports the provision of nutrition interventions through Home and Community-Based Service (HCBS) programs and managed care In Lieu of Services (ILOS).

Examples of nutrition interventions in these programs include: food/nutrition case management, home food preparation or storage equipment, nutrition counseling, home-delivered meals or pantry restocking, nutrition prescriptions (for example, fruits and vegetables), and groceries.[21] Federal rules also allow MCOs to offer additional "value-added services" beyond covered contract services—which are additional member benefits designed to improve health and wellbeing and may include FAM interventions. These value-added services, also known as value-added benefits (VABs), are offered voluntarily by the plan and the cost of these

services cannot be included when determining the Medicaid rates paid by a state to a plan.[22] Finally, the Children's Health Insurance Plan allows states to use a limited amount of funding for health services initiatives that can include support to address food and nutrition insecurity.[23]

Other government programs include programs like SNAP and WIC, which are funded by the USDA and provide financial assistance for the purchase of groceries by families earning low incomes.[24] The Gus Schumacher Nutrition Incentive Program (GusNIP), also administered by USDA, provides funding to communities to enable eligible people who are at high-risk of diet-related health conditions to redeem paper or electronic debit "prescriptions" for fruits and vegetables.

Private Sector Adoption of FAM

Health plans also have increasingly become involved in addressing food and nutrition insecurity by testing and scaling FAM programs such as MTMs, MTGs, or PRx, as well as helping members enroll in appropriate federal nutrition programs. Results of these programs appear promising, showing early successes at helping health plan members manage their diabetes, cardiovascular disease, and other chronic conditions.[25]

Elevance Health's FAM strategy spans commercial insurance, Federal Employee Health Benefits program (FEHB), Medicaid, and Medicare Advantage to address health across the continuum of care—from prevention to treatment. The range of programs and services available to its affiliated health plans' members varies somewhat due to differences in the population served, eligibility criteria, and federal and state policy regulations.

For example, many affiliated MA plan members have access to and use nutrition-related services through supplemental benefits.[26] Grocery allowances are available to MA members with chronic conditions via SSBCI. MA members who meet eligibility criteria have access to MTMs, but these benefits extend for a relatively brief duration due to regulatory limits.

Elevance Health's affiliated Medicaid managed care plans are partnering with state Medicaid agencies to implement benefits under 1115 waivers, HCBS programs, and ILOS. Some state Medicaid programs are piloting non-medical interventions related to food to certain Medicaid enrollees with higher needs based on their potential to improve health outcomes and reduce disparities, which can also lower costs. For example, New York was the first state to approve medically tailored meals as part of its ILOS to benefit Medicaid managed care enrollees with serious illnesses. Eligibility is dependent upon having qualifying health conditions and social risk factors (for example, restrictions in activities of daily living).[27]

Other FAM programs in Medicaid leverage partnerships with community-based organizations (CBOs) that address social drivers of health, such as a MTM program in Georgia that delivers nutritious meals to pregnant individuals with gestational diabetes or who are on bedrest, or to postpartum members with chronic conditions.

Elevance Health FAM Survey

Elevance Health conducted a survey across the company to obtain a comprehensive view of the current use of FAM strategies within its affiliated health plans. The objective of this survey was to better understand how health plans have implemented these strategies, share lessons learned, and gain insight into future directions for FAM strategies at Elevance Health.

Survey data was collected from Elevance Health leaders who were identified as having direct involvement in FAM strategies. These individuals represent health plan markets in the commercial, Medicaid, and Medicare Advantage lines of business, as well as FEHB. Most of these individuals worked in Medicaid, in part because each state's Medicaid health plan had a leader directly involved in FAM strategies, and many Elevance Health FAM programs are offered through Medicaid plans. The survey was fielded in English from May 6, 2024, through June 6, 2024, and yielded a 68 percent response rate (n=36).

The survey included 26 questions asking about the type of approach implemented (for example, MTGs, PRx), duration of the FAM program, populations served by the program, community-based partners, and program funding.

Respondents reported a total of 89 different FAM programs operating in 18 states and Washington, D.C. (including several multi-state programs) and provided detailed information for about 68 of the programs.

Results

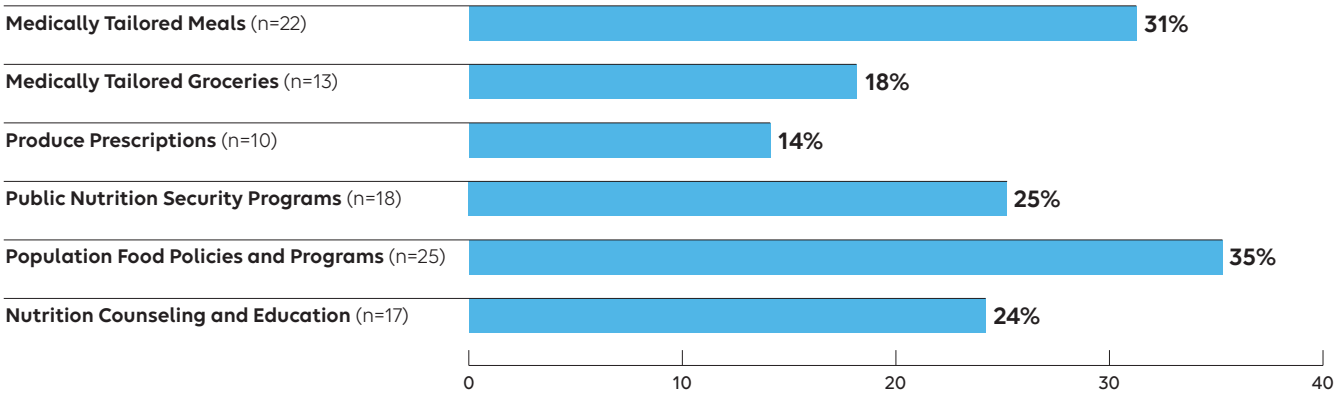
FAM Approaches

Results show that FAM programs are distributed across the spectrum of food-based interventions described in the FAM framework. Half of FAM programs were designed to deliver more intensive treatments for individuals with chronic conditions, high healthcare utilization, or diet-sensitive conditions (that is, programs categorized as MTM, MTG, or PRx). And 71 percent of FAM programs were designed as population-based initiatives, with the objective of broadly promoting access to affordable and nutritious foods within communities (that is, programs categorized as public nutrition security or population food policies/programs). (21 percent of programs had both treatment-related and population-based components.) Figure 2 shows the percentage of programs with each type of approach.

Figure 2

FAM Programs at Elevance Health

(n=68)



Note. FAM programs/policies can be included in multiple categories, so percentages can sum to more than 100%.

Populations Served

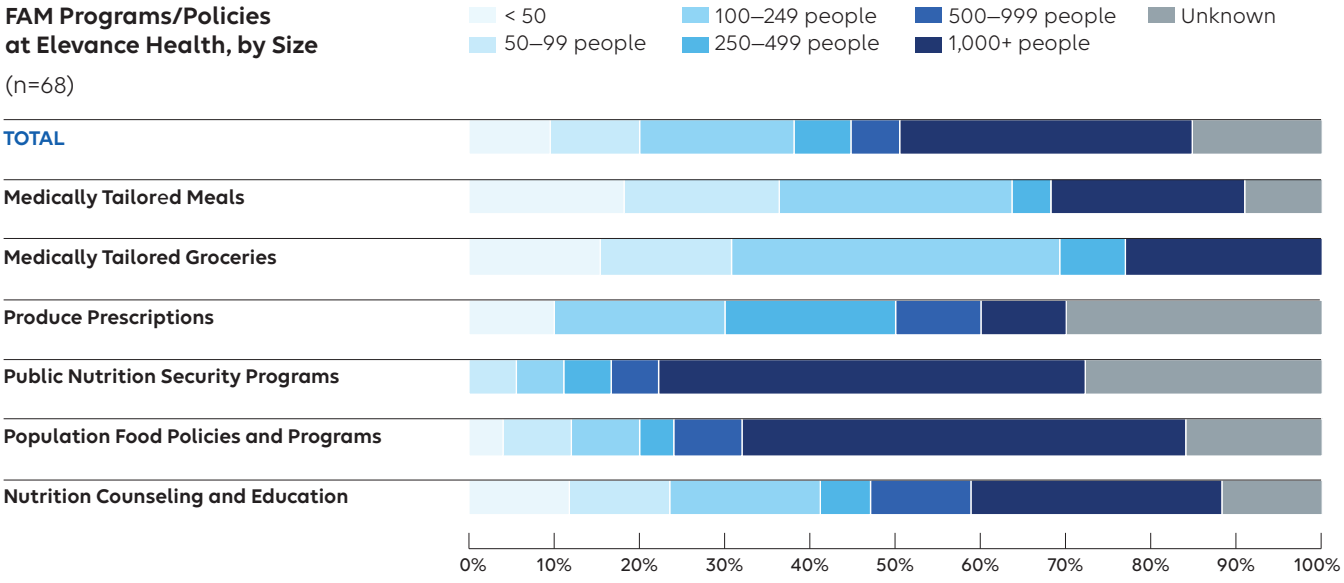
Results show that population-based FAM approaches tended to serve a relatively large population. More than half (52%) of population/community-level food programs and 50 percent of public nutrition security programs served populations of 1,000 people or more each year.

MTM and MTG programs, in contrast, served relatively smaller populations. More than half (68 percent) of MTMs and 63 percent of MTGs served fewer than 250 people. This is somewhat expected, given that individuals who qualify for these programs typically have complex conditions and/or chronic illnesses and require referral or a prescription from a medical professional.[28] Nevertheless, nearly one in four MTM programs and MTG programs served 1,000 people or more. (Figure 3)

Figure 3

Populations Served by FAM Programs/Policies at Elevance Health, by Size

(n=68)



Note. Program types are not mutually exclusive (programs can be counted in multiple categories).

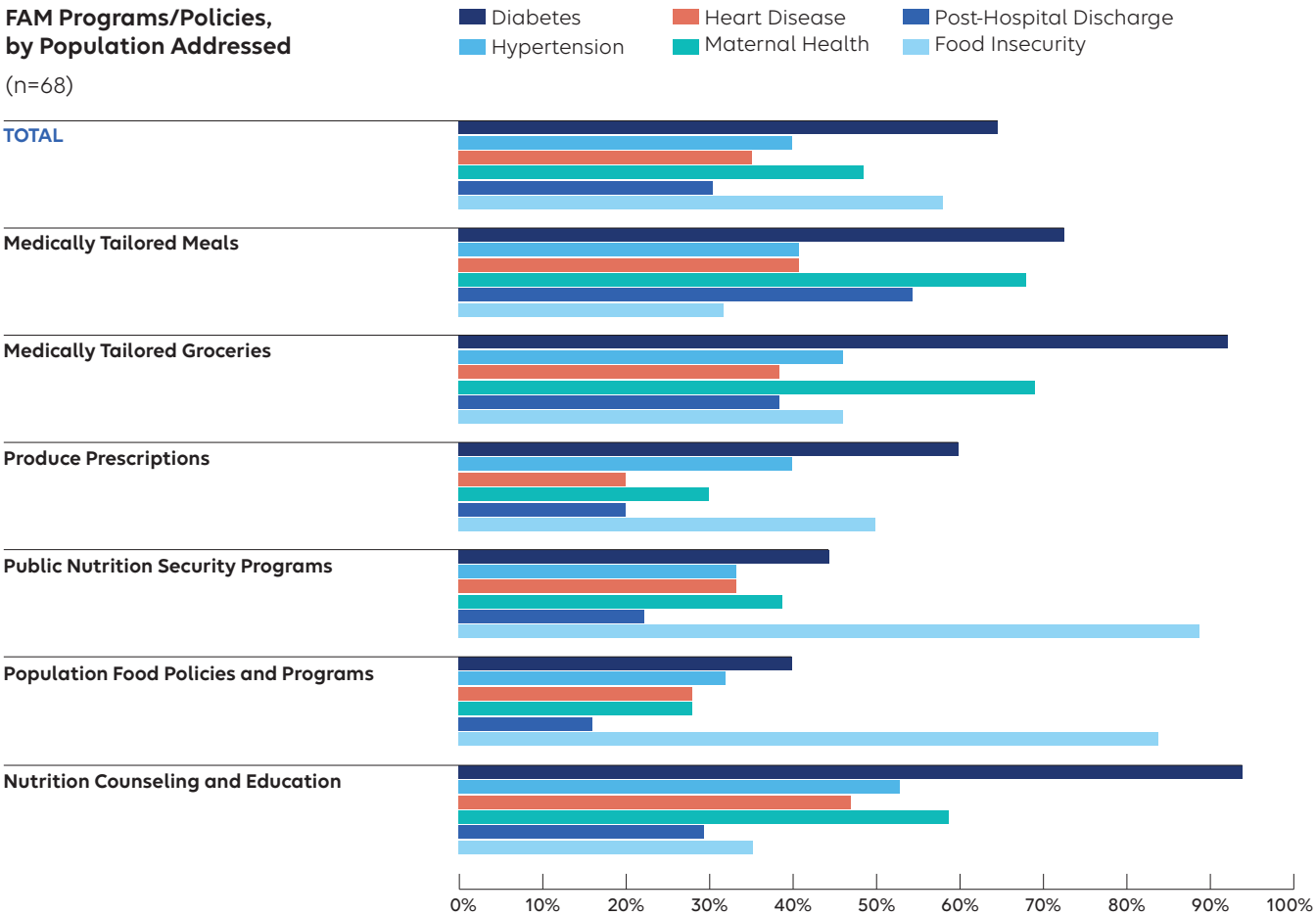
Many different populations are served by these FAM approaches, including individuals experiencing food insecurity, individuals who are pregnant, individuals recently discharged from a hospital stay, and individuals diagnosed with HIV. Although FAM programs often focus on addressing the needs of multiple different population groups, individuals with diabetes were the most frequently included across nearly all FAM approaches, with at least 70 percent of MTMs, MTGs, and nutrition counseling programs serving members with diabetes. (Figure 4)

These findings are generally consistent with other analyses of FAM approaches in the U.S., indicating people with diabetes as the first or second most common population of focus.[29,30] One possible explanation is that glycemic control is sensitive to dietary changes,[31] and uncontrolled diabetes can lead to painful and costly complications, including kidney failure, blindness, cardiovascular disease, and amputation.[32] A growing amount of research demonstrates the efficacy of FAM interventions in the treatment of people with diabetes,[33] and so a relatively large portion of the population (1 in 8 Americans has diabetes) could potentially benefit from FAM approaches addressing diabetes. Research on the efficacy of FAM interventions for other areas, such as maternal health or cardiovascular disease, appears promising but is relatively limited.[34]

Figure 4

Percent of Elevance Health FAM Programs/Policies, by Population Addressed

(n=68)



Note. FAM programs/policies can be included in multiple categories. Additionally, programs/policies can serve multiple populations, so percentages can sum to more than 100%.

Duration of FAM Interventions

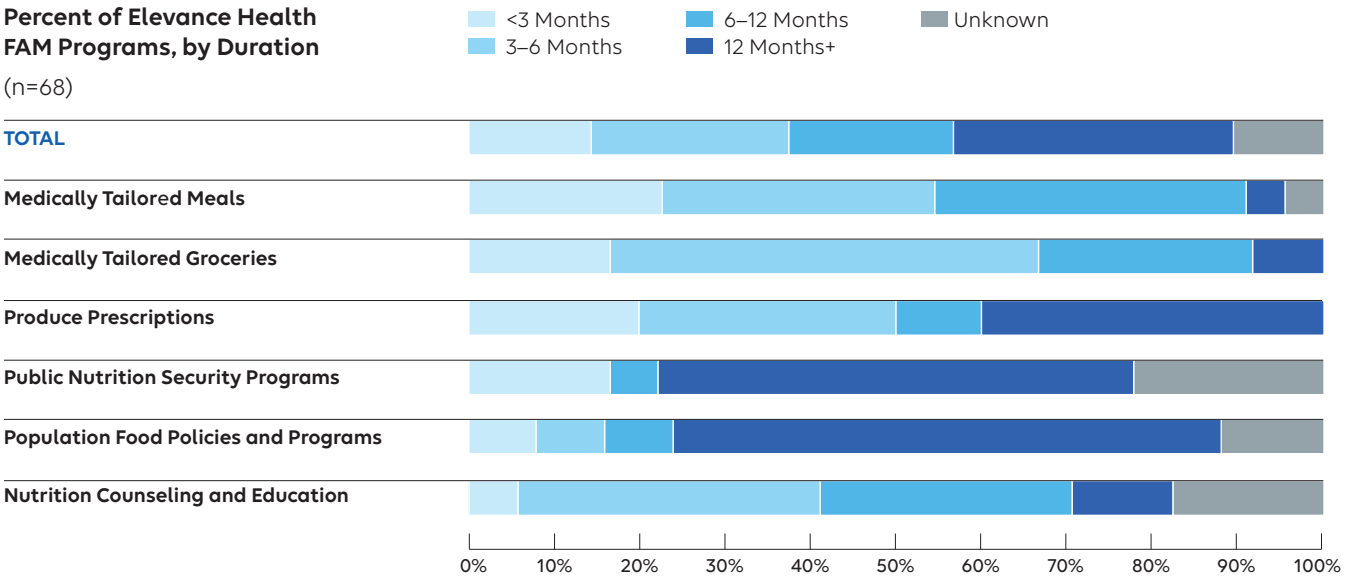
The duration of FAM programs appeared dependent upon the type of program offered. Traditional prevention-focused programming at the base of the FAM pyramid showed longer duration compared to tailored treatment-focused programming at the apex of the pyramid. For example, a majority (64%) of members were eligible to receive services from population food policies and programs for 12 months. In contrast, most (67%) members who receive MTGs had these benefits for less than 6 months. (Figure 5)

Duration of FAM programs was also dependent upon factors such as funding mechanisms and policy requirements. Section 1115 Medicaid waivers for meal support, for example, specify a maximum of 6 months' benefit.[35] Results from this survey were consistent with the average time spans reported in the literature of different FAM strategies.[36]

Figure 5

Percent of Elevance Health FAM Programs, by Duration

(n=68)



Note. Program types are not mutually exclusive (programs can be counted in multiple categories).

Community Partnerships

Community partnerships are integral in the delivery of FAM to help connect the clinical experience with the local needs and resources in communities. Collaboration between health care entities and CBOs helps ensure that FAM interventions are culturally relevant and resonate with the communities they serve.[37] In addition, it ensures that FAM helps to enhance the community infrastructure and sustainability that is critical to the success of these programs.

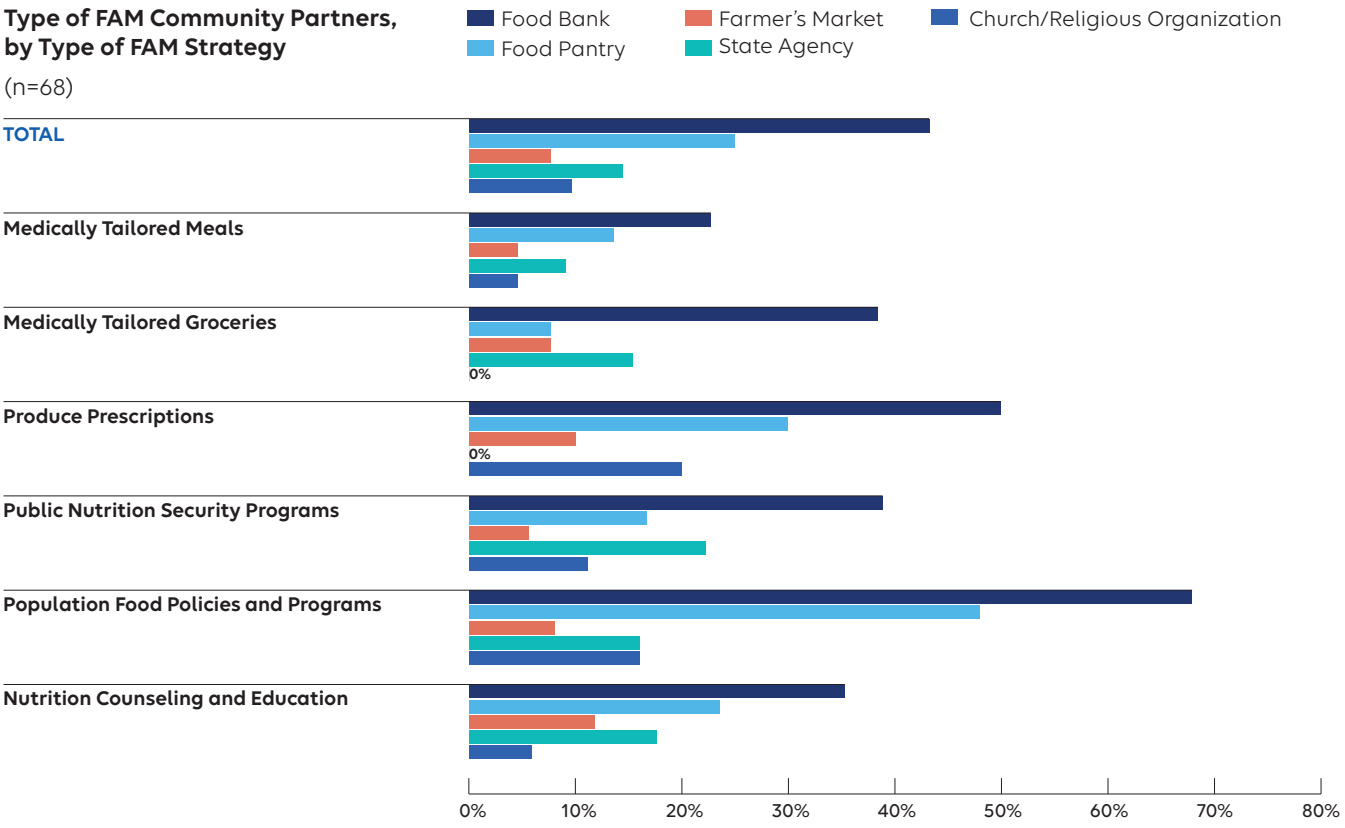
Results from this survey indicated that 33 programs (49%) have at least one community-based partner; 31 percent did not have a community-based partner, and for 21 percent of programs, the respondent did not know. Of the 33 programs with known partners, nearly half (48%) had multiple community partners. The most common type of community-based partner was a food bank or food pantry. Other community-based partnerships involved vouchers for health plan members who have a clinical need for a special diet to receive prepared meals from local MTM organizations that meet their nutritional needs. Still other partnerships involved eligible Medicaid members receiving medically supportive meals and nutritional counseling from a community-based partner.

Lastly, some community partnerships that organized farmers' markets, food pantries, and produce boxes were funded by Elevance Health Foundation grants. These partnerships benefited the entire community and were not exclusive to health plan members.

Figure 6

Type of FAM Community Partners, by Type of FAM Strategy

(n=68)



Note. FAM programs/policies can be included in multiple categories. Additionally, programs/policies may have multiple community-based partners, so percentages can sum to more than 100.

Policy Considerations

As FAM increasingly becomes part of a healthcare system-wide approach to addressing diet-related health conditions, policymakers, government agencies, health plans, and other stakeholders may want to consider the following:

Maximize appropriate use of federal programs in place to address food and nutrition insecurity. Policymakers should support continued and increased SNAP and WIC enrollment by streamlining the enrollment process.

Support stabilization and expansion of Medicaid funding for proven programs. Individuals with low incomes, who experience the highest rates of food insecurity, can particularly benefit from FAM programs tailored to their unique needs.[38] Although states leverage 1115 waivers to address health-related social needs (HRSN), CMS limits HRSN spending to three percent of the state's total annual Medicaid spending. Other avenues that states can use to expand or implement FAM initiatives include managed care contracting mechanisms (e.g., ILOS, VABs), HCBS programs, and CHIP health services initiatives.[39]

Enable stability and flexibility in MA plans' supplemental benefits offerings. MA plans play an important role in addressing the HRSNs of people with disabilities and older adults' HRSNs through supplemental benefits. CMS should ensure payments to MA plans are appropriate and stable to allow plans to continue to provide these kinds of benefits to members. Policymakers should also consider allowing plans greater latitude to offer meals more broadly as a general supplemental benefit. Additionally, because SSBCI are currently only available to people with specific chronic conditions, policymakers may consider expanding SSBCI eligibility to allow for additional qualifiers, such as HRSN and income. This would increase access to these benefits and provide essential support to a broader group of members.

Include insurer HRSN-related activities in the numerator of the Medical Loss Ratio (MLR). Federal statute requires health insurers to spend at least 80 to 85 percent of their premium revenues on clinical care and quality improvements. The MLR represents the share of total premium dollars spent on medical claims and quality improvement costs. Where not already permissible, policymakers should consider allowing plans to include HRSN-related investments, including FAM initiatives, in the numerator of the MLR calculation (that is, along with medical claims and quality improvement costs rather than as an administrative expense).

Conclusion

This analysis represents findings from an initial survey of the FAM landscape, which reveals a robust set of strategies available to a variety of populations throughout the U.S. Elevance Health is working to improve and expand FAM programming, enhance member experience, and build off the literature to implement stronger programs across communities.

FAM strategies, however, are one element of plans' increasing focus on whole health and addressing HRSNs, because food insecurity and poor diet and nutrition can further contribute to increased health disparities, adverse outcomes, and avoidable healthcare utilization. FAM should be considered complementary to other policies and programs that are important for improving population health.

The best way to understand the impact of individual FAM strategies on the populations they reach is to conduct program evaluations and analyses. Results from such studies can be used to help health plans, policymakers, and other stakeholders most effectively leverage limited resources to execute and improve FAM programs.

Endnotes

[1] Gropper, S.S. (2023). The Role of Nutrition in Chronic Disease. *Nutrients, 15*(3), 664. Retrieved October 23, 2024, from https://doi.org/10.3390/nu15030664.

[2] Downer, S., et al. (2020). Food is Medicine: Actions to Integrate Food and Nutrition into Healthcare. *BMJ, 369*, m2482. Retrieved November 15, 2024, from https://doi.org/10.1136/bmj.m2482.

[3] Gropper, S.S. (2023).

[4] World Health Organization. (2021, June 9). *Malnutrition*. Retrieved October 16, 2024, from https://www.who.int/news-room/fact-sheets/detail/malnutrition.

[5] U.S. Department of Agriculture. (2016, March 16). The Healthy Eating Index: How is America Doing? *USDA Media Blog*. Retrieved November 3, 2024, from https://www.usda.gov/media/blog/2016/03/16/healthy-eating-index-how-america-doing#:~:text=About%20half%20of%20all%20American,cancers%2C%20and%20poor%20bone%20health.

[6] U.S. Department of Agriculture, Economic Research Service. (n.d.). Chronic Disease Risk Increased with U.S. Household Food Insecurity. Retrieved November 30, 2024, from https://www.ers.usda.gov/data-products/charts-of-note/chart-detail?chartId=108913.

[7] Rabbitt, M. P., et. al. (2024). Household Food Security in the United States in 2023 (Report No. ERR-337). U.S. Department of Agriculture, Economic Research Service. Retrieved November 30, 2024, from https://doi.org/10.32747/2024.8583175.ers.

[8] Mozaffarian, D., et al. (2024). "Food is Medicine" Strategies for Nutrition Security and Cardiometabolic Health Equity: JACC State-of-the-Art Review. *JACC, 83*(8), 843-864. Retrieved November 23, 2024, from https://pubmed.ncbi.nlm.nih.gov/38383100/.

[9] Thomas, O.W., et al. (2024). Enhancing Cultural Humility in Food is Medicine Services: A Mixed-Methods Investigation of Patient Food and Dietary Preferences. *Healthcare, 12*, 100749. Retrieved December 3, 2024, from https://www.sciencedirect.com/science/article/abs/pii/S2213076424000162.

[10] Demetrio, F., et al. (2020). Food Insecurity in Pregnant Women is Associated with Social Determinants and Nutritional Outcomes: A Systematic Review and Meta-Analysis. *Ciencia & Saede Coletiva, 25*, 2663-2676. Retrieved October 15, 2024, from https://www.scielo.br/j/csc/a/G4D8fWBMWS9Qpgktrdtp8DL/?format=html&lang=en.

[11] Hawkins, M., & Panzera, A. (2021). Food Insecurity: A Key Determinant of Health. *Archives of Psychiatric Nursing, 35*(1), 113-117. Retrieved October 9, 2024, from https://www.psychiatric-nursing.org/article/S0883-9417(20)30567-7/fulltext.

[12] Banks, A.R., Bell, B.A., & Ngendahimana, D. (2021). Identification of Factors Related to Food Insecurity and the Implications for Social Determinants of Health Screenings. *BMC Public Health, 21*, 1410. Retrieved November 12, 2024, from https://doi.org/10.1186/s12889-021-11465-6.

[13] Norris, K., et al. (2023). A Systematic Literature Review of Nutrition Interventions Implemented to Address Food Insecurity as a Social Determinant of Health. *Nutrients, 015*(15), 3464. Retrieved November 12, 2024, from https://doi.org/10.3390/nu15153464.

[14] Center for Health Law and Policy Innovation of Harvard Law School & Community Servings. (2019, June). Massachusetts Food is Medicine State Plan. Retrieved December 12, 2024, from https://foodismedicinema.org/wp-content/uploads/2024/09/MAFoodisMedicineStatePlan20194.pdf.

[15] Bhat, S., et al. (2021). Healthy Food Prescription Programs and their Impact on Dietary Behavior and Cardiometabolic Risk Factors: A Systematic Review and Meta-Analysis. *Advances in Nutrition*, 12, 1944-1956. Retrieved December 6, 2024, from https://pmc.ncbi.nlm.nih.gov/articles/PMC8483962/.

[16] Mozaffarian, D., et al. (2022). A Food is Medicine Approach to Achieve Nutrition Security and Improve *Health. Nature Medicine, 28*(11), 2238-2240. Retrieved November 23, 2024, from https://doi.org/10.1038/s41591-022-02027-3.

[17] Center for Health Law and Policy Innovation of Harvard Law School & Community Servings. (2019, June).

[18] Center for Medicare & Medicaid Services. (2016, April 22). Medicare Managed Care Manual. Retrieved September 27, 2024, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf. Chapter 4 articulates limited circumstances in which meals may be offered as a supplemental benefit.

[19] Wu, C. (2021, March 30). Special Supplemental Benefits for the Chronically Ill: An Opportunity to Provide Comprehensive Supports for Medicare Beneficiaries with Complex Needs. Better Care Playbook. Retrieved November 16, 2024, from https://bettercareplaybook.org/_blog/2021/26/special-supplemental-benefits-chronically-ill-opportunity-provide-comprehensive.

[20] Hanson, E., et al. (2024). The Evolution and Scope of Medicaid Section 1115 Demonstrations to Address Nutrition: A US Survey. *Health Affairs Scholar, 2*(2), qxae013. Retrieved November 1, 2024, from https://pmc.ncbi.nlm.nih.gov/articles/PMC10986195/.

[21] Georgetown University Health Policy Institute. (2024). State Use of Section 1115 Demonstrations to Support the Health-Related Social Needs of Pregnant and Postpartum Women, Infants, and Young Children. Retrieved November 1, 2024, from https://ccf.georgetown.edu/wp-content/uploads/2024/06/Using-1115-for-HRSN-Final-PDF.pdf.

[22] Kaiser Family Foundation. (2024, January 29). Medicaid Authorities and Options to Address Social Determinants of Health. Retrieved December 17, 2024, from https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/.

[23] U.S. Department of Health and Human Services. (2024). Pathways to Enable Food is Medicine Interventions through Select Federal Health Policies. Retrieved November 17, 2024, from https://odphp.health.gov/foodismedicine/understanding-food-medicine/select-policy-pathways-fim-interventions#:~:text=Health%2DRelated%20Social%20Needs%20Services%20Coverage&text=on%20Coverage%20of%20Health%2DRelated,and%20benefit%20program%20application%20fees.

[24] U.S. Department of Agriculture. (2024). Supplemental Nutrition Assistance Program (SNAP). Retrieved November 17, 2024, from https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program.

[25] America's Health Insurance Plans. (2024). Food is Medicine Policy Recommendations to Improve Efficacy and Scalability of Programs that Increase Access to Healthy Foods. Retrieved November 23, 2024, from https://www.ahip.org/resources/food-is-medicine.

[26] Elevance Health Public Policy Institute. (May 2024). Medicare Advantage Supplemental Benefits and Improved Healthcare Use. Retrieved December 12, 2024, from https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/reports/MA-Supplemental-Benefits-and-Improved-Healthcare-Use.pdf.

[27] God's Love We Deliver. (n.d.). Retrieved December 12, 2024, from https://www.glwd.org/get-meals/faqs/.

[28] Sharma, V., & Sharma, R. (2023). Food is Medicine Initiative for Mitigating Food Insecurity in the United States. J*ournal of Preventive Medicine & Public Health, 57,* 96-107. Retrieved November 1, 2024, from https://pmc.ncbi.nlm.nih.gov/articles/PMC10999299/.

[29] Hager, K., et al. (2022). Association of National Expansion of Insurance Coverage of Medically Tailored Meals with Estimated Hospitalizations and Health Care Expenditures in the US. *JAMA Network Open, 5*(10), e2236898. Retrieved November 16, 2024, from https://doi.org/10.1001/jamanetworkopen.2022.36898.

[30] Mozaffarian, D., et al. (2024).

[31] Berkowitz, S.A., et al. (2019). Medically Tailored Meal Delivery for Diabetes Patients with Food Insecurity: A Randomized Cross-Over Trial. *Journal of General Internal Medicine, 34*(3), 396-404. Retrieved November 16, 2024, from https://doi.org/10.1007/s11606-018-4716-z.

[32] Hippisley-Cox, J., & Coupland, C. (2016). Diabetes Treatments and Risk of Amputation, Blindness, Severe Kidney Failure, Hyperglycemia, and Hypoglycaemia: Open Cohort Study in Primary Care. *BMJ, 352,* i1450. Retrieved November 17, 2024, from https://doi.org/10.1136/bmj.i1450.

[33] Levi, R., Bleich, S.N., & Seligman, H.K. (2023). Food Insecurity and Diabetes: Overview of Intersections and Potential Dual Solutions. *Diabetes Care, 46*(9), 1599-1608. Retrieved November 18, 2024, from https://doi.org/10.2337/dci23-0002.

[34] Balis, L.E., et al. (2024). Implementation and Impact of Perinatal Food is Medicine Programs: A Qualitative Research Study. *Journal of the Academy of Nutrition and Dietetics, 124*(10), 1255-1265.e21. Retrieved October 11, 2024, from https://www.sciencedirect.com/science/article/pii/S2212267224000820.

[35] Kaiser Family Foundation. (2024). Section 1115 Medicaid Waiver Watch: A Closer Look at Recent Approvals to Address Health-Related Social Needs (HRSN). Retrieved November 15, 2024, from https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-waiver-watch-a-closer-look-at-recent-approvals-to-address-health-related-social-needs-hrsn/.

[36] Mozaffarian, D., et al. (2024).

[37] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). Feeding Health: The Essential Role of Community-Based Organizations. Retrieved December 1, 2024, from https://odphp.health.gov/foodismedicine/promising-practices-and-tools/promising-practices/feeding-health-essential-role-community-based-organizations.

[38] U.S. Department of Agriculture. (2023). Food Security and Nutrition Assistance: Food Insecurity Rates are Highest and Very Low Food Security. Retrieved November 13, 2024, from https://www.ers.usda.gov/data-products/ag-and-food-statistics-charting-the-essentials/food-security-and-nutrition-assistance/#:~:text=Food%20insecurity%20rates%20are%20highest,and%20very%20low%20food%20security.

[39] Centers for Medicare & Medicaid Services. (2024, August 22). Budget Neutrality for Section 1115(a) Medicaid Demonstration Projects. Retrieved December 12, 2024, from https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf.

About Us

Elevance Health Public Policy Institute

The Public Policy Institute (PPI) was established to share data and insights that inform public policy and shape the healthcare programs of the future. PPI strives to be an objective and credible contributor to healthcare transformation through the publication of policy-relevant data analysis, timely research, and insights from Elevance Health's innovative programs. For more information:

Visit us
ElevanceHealthPPI.com
Follow us
PPI on LinkedIn

Elevance Health

Elevance Health is a lifetime, trusted health partner whose purpose is to improve the health of humanity. The company supports consumers, families, and communities across the entire healthcare journey—connecting them to the care, support, and resources they need to lead better lives. Elevance Health's companies serve approximately 112 million consumers through a diverse portfolio of industry-leading medical, pharmacy, behavioral, clinical, and complex care solutions. For more information:

Visit us
ElevanceHealth.com
Follow us
@ElevanceHealth on X
Elevance Health on LinkedIn