Elevance Health | Public Policy Institute

Medicare Advantage Supplemental Benefits Are Associated with Improved Health Quality

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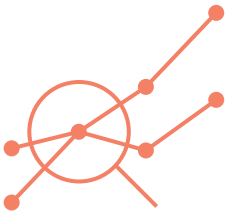
Contents

Key Takeaways

- Use of Medicare Advantage supplemental food benefits is strongly associated with improvements in quality of care, including better diabetes and cardiovascular disease management.
- Transportation benefit use is also associated with improved healthcare quality, though the associations were less pronounced than those observed for food benefits.
- These findings highlight the importance of preserving flexibility in offering non-medical supplemental benefits to support individuals with complex health and social needs.



This analysis examines the relationship between food and transportation supplemental benefit use and health quality.

Overview

Medicare Advantage (MA) plans, offered by private insurance companies, are an alternative to traditional Medicare.

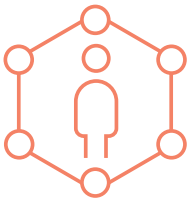
These plans are required to cover Medicare Parts A and B and typically include prescription drug coverage (Part D) along with a range of supplemental benefits. In recent years, these supplemental benefits have evolved beyond traditional services like dental, vision, and hearing benefits to encompass non-medical services that address health-related social needs.

These non-medical benefits (including food and transportation benefits) can be offered to enrollees with certain chronic conditions or through the MA Value-Based Insurance Design (VBID) model implemented by the Centers for Medicare & Medicaid Services' (CMS) Innovation Center (CMMI). The VBID model gives MA plans the option to extend these benefits to individuals who might not otherwise qualify, such as by allowing them to be offered on the basis of socioeconomic status.[1]

To date, research on the utilization of supplemental benefits remains limited. The Elevance Health Public Policy Institute has previously contributed to this area by examining the uptake of these benefits and their relationship to healthcare utilization.[2,3] Still, evidence specifically focused on VBID supplemental benefits and their impact on health outcomes is especially scarce.

The objective of this research is to address that knowledge gap by analyzing the use of VBID-specific supplemental benefits and exploring their association with health quality measures, including Healthcare Effectiveness Data and Information Set (HEDIS) measures related to diabetes and cardiovascular disease management. With the VBID model concluding at the end of 2025, this analysis offers timely insights into the role of VBID-enabled supplemental benefits and the potential impact of their discontinuation.

Background



The VBID model allows MA plans to customize supplemental benefits to enrollees' clinical and social needs.

Dual Eligible Special Needs Plans

Dual eligible individuals are eligible for both Medicare and Medicaid benefits, meaning that they are 65 or older and/or disabled, as well as low-income. Dual eligible beneficiaries typically require more comprehensive care than non-dual eligible Medicare beneficiaries due to their greater healthcare needs and higher prevalence of chronic conditions. For instance, 44 percent of dual eligible beneficiaries are in fair or poor health, compared to 17 percent of non-dual eligible beneficiaries. Similarly, 26 percent of dual eligible beneficiaries have five or more chronic conditions, compared to 15 percent of non-dual eligible beneficiaries.[4] These differences make the dual eligible population particularly well suited for the kinds of focused, flexible benefits offered under VBID.

Medicare Advantage dual eligible special needs plans (D-SNPs) are MA plans that exclusively enroll dual eligible individuals in order to better tailor benefits and plan designs to the unique needs of these beneficiaries. While plans that participate in the MA VBID model are not exclusively D-SNPs, D-SNPs represent a significant portion of VBID participants.[5]

The VBID model also allows MA plans to tailor supplemental benefits based on enrollees' specific clinical and social needs, including socioeconomic status. This flexibility aligns closely with the needs of dual eligible beneficiaries, many of whom have health-related social needs such as food insecurity and limited access to transportation. By participating in VBID, D-SNPs can more effectively address these barriers through expanded benefits to improve care coordination, health outcomes, and cost efficiency.

Medicare Advantage Supplemental Benefits

MA plans that can provide the basic Medicare Parts A and B benefits more efficiently than their applicable payment benchmark must use their share of those savings to provide supplemental benefits to enrollees. Broadly, supplemental benefits can include reducing cost sharing in Parts A and B, reducing the Part B or Part D premiums, enhancing the Part D benefit, or offering non-Medicare benefits. With some exceptions, non-Medicare benefits must be primarily health related (e.g., dental, vision, hearing, or fitness benefits).

MA plans have two primary pathways for offering non-primarily health related ("non-medical") supplemental benefits: the VBID model and Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI is specifically aimed at individuals with chronic or disabling illnesses,[6] while the VBID model requires participating MA organizations to address social determinants of health in at least two of three key areas: food and nutrition, transportation, and housing and living environments.[7,8]

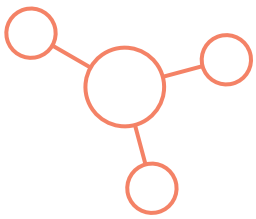
In 2024, food-related supplemental benefits were the most commonly offered type of VBID benefits, reaching over 8 million enrollees.[9] Notably, about half of the MA plans offering food and non-medical transportation supplemental benefits used the VBID model rather than SSBCI. Specifically, 47 percent of plans offering food and produce benefits, and 57 percent of plans offering non-medical transportation, did so through VBID.[10]

In recent years, MA plans have increasingly offered combined supplemental benefits that bundle multiple services (e.g., food and over-the-counter allowances) into a single package with a combined spending limit. These combined packages may include both non-medical and primarily health-related supplemental benefits. This approach offers beneficiaries greater flexibility to choose services that best meet their individual needs. D-SNPs have been at the forefront of this trend, with 87 percent of such plans offering combined benefits in 2024.[11]

Elevance Health's Supplemental Benefits

This study focuses on Elevance Health's affiliated D-SNPs that participated in the VBID model in 2023 and two categories of supplemental benefits: (1) food, and (2) non-emergency medical and non-medical transportation.

For the food benefit, plans provided members with a fixed monthly allowance that could be used for groceries, and in some cases, related expenses such as over-the-counter drugs and devices, home and bathroom safety items, and utility bills. The transportation benefit typically covered a set number of trips per year, though the number varied by plan, with some offering unlimited transportation. These trips could be used for medical appointments as well as for essential errands like grocery shopping, pharmacy visits, and other non-clinical destinations, helping members address their social needs and health needs beyond medical care.



Prior studies have found significant relationships between food, transportation, health, and healthcare use and costs.

Relationship Between Food, Transportation, and Health

Adults experiencing food insecurity are two to three times more likely to develop type 2 diabetes,[12] and have higher odds of hypertension, coronary heart disease, and cardiovascular-related mortality.[13–15] In addition to these clinical risks, individuals experiencing food insecurity are less likely to have a regular source for healthcare and more likely to forgo or delay medical visits, compounding the risk of unmanaged chronic conditions.[16,17]

Supplemental benefits that offset the cost of groceries or related items can alleviate food insecurity and support disease self-management. For example, participation in nutrition assistance programs such as the Supplemental Nutrition Assistance Program (SNAP) has been linked to improved medication adherence,[18,19] greater use of preventive healthcare,[20–22] and lower healthcare costs.[23]

Several mechanisms may explain these relationships: direct access to nutritious foods supports glycemic and blood pressure control, while financial assistance offered by food benefits may allow individuals to redirect limited income toward out-of-pocket medical costs, prescription

drugs, or transportation to care. Further, there is evidence to suggest that individuals' ability to meet basic needs (i.e., food, housing, utilities) can alleviate their stress levels and allow them to focus on their healthcare needs and long-term health behaviors.[24,25]

Reliable transportation is another critical factor in healthcare access and chronic condition management. Transportation barriers are commonly associated with missed appointments, delayed care, and gaps in prescription medication use—challenges that disproportionately affect low-income populations.[26–29] Although the literature on non-emergency medical transportation (NEMT) shows mixed findings regarding its impact on acute care utilization, some studies have identified positive associations with outpatient care engagement.[30] Greater use of outpatient services may lead to better health outcomes and lower spending in the long term.

Evidence on non-medical transportation benefits—such as trips to grocery stores or pharmacies—remains limited, but early findings suggest potential improvements in social engagement and perceived quality of life.[31] In general, transportation supports may also enable beneficiaries to attend annual wellness visits, receive laboratory tests required for chronic condition monitoring, and maintain medication adherence, all of which are directly tied to improved healthcare quality.

Methods

This analysis examined the relationship between use of two supplemental benefits—food and transportation—and whether individuals met selected quality metrics.

The HEDIS measures selected focus on diabetes and cardiovascular disease—two highly prevalent chronic conditions that are linked to food and nutrition, and have significant care management needs, some of which require in-person care. The "annual planned visit" measure was also included to capture preventive care engagement among members without diabetes and cardiovascular conditions who were able to access more extensive supplemental benefits through these VBID model plans. See Table 1 for the full list of measures evaluated.[32]

Table 1

Evaluated Quality Measures

Member Group	Measures
Measure for All Members	• Annual planned visit
HEDIS Measures for Members with Diabetes	• Hemoglobin A1c (HbA1c) control • Blood pressure control • Eye exam • Kidney health evaluation • Statin therapy initiation and adherence
HEDIS Measures for Members with Cardiovascular Conditions	• Controlled high blood pressure • Statin therapy initiation and adherence

Note. Definitions for these measures can be found in the Appendix.

The analysis used administrative claims data from Elevance Health affiliated D-SNPs for 2023, which spanned 20 states. In addition, the analysis relied on previously calculated HEDIS metrics which used both claims data and clinical data, depending on the specifications of the metric. The following criteria were required to be included in the study population:

- 12 months of continuous enrollment in a D-SNP plan participating in the MA VBID model in 2023
- Enrollment in a D-SNP plan that offered food supplemental benefits (for the food benefit analysis), and/or transportation supplemental benefits (for the transportation benefit analysis)
- Selected HEDIS measure eligibility.[33]

The relationship between supplemental benefit utilization and quality outcomes was tested separately for the use of food supplemental benefits and for the use of transportation supplemental benefits. 243,207 D-SNP members were included in the food benefit analysis; 251,666 D-SNP members were included in the transportation benefit analysis. While the analytic approach was generally the same for both, specifications varied slightly as noted below.

Summary statistics were used to describe characteristics of members who did and did not use each supplemental benefit (i.e., "users" had to have used the benefit at least once in the year). Logistic regression models were used to assess the association between individuals' supplemental benefit use and whether they met selected quality measures.

The regression models included controls for a range of demographic, socioeconomic, and health-related factors to isolate the association between the use of the food and transportation supplemental benefits and whether an individual met selected quality measures, while accounting for potential confounding factors.

These controls included age, race, gender, and rurality; Social Vulnerability Index (SVI) domains[34] for socioeconomic status and for housing type and transportation; and other supplemental benefit use—specifically, transportation benefit use (in the food benefit analysis) and food benefit use (in the transportation benefit analysis). Models also controlled for key comorbidities, including diabetes (except for diabetes HEDIS metrics), heart and lung conditions (except for cardiovascular HEDIS metrics), mental health conditions, malignant neoplasms, cognitive disorders, and substance use disorders. Additionally, the allowable monthly dollar amount for the food supplemental benefit was included as a covariate in the food benefit analysis.

Results

Food Supplemental Benefit

Individuals who used the food supplemental benefit (users) were more likely to be female, more likely to live in rural areas, more likely to identify as White, and less likely to identify as Hispanic or Latino compared to those who did not use food supplemental benefits. Food supplemental benefit users also were more likely to have diabetes and lung conditions and less likely to have mental health and cognitive conditions. (Table 2)

Table 2

Characteristics of Food Supplemental Benefit Users vs. Non-Users

Mean (standard deviation) or percentage

	Food Supplemental Benefit*	
	Users	Non-Users
Member Characteristics		
Age (in years)	66.0 (12.90)	65.4 (15.80)
Female	63.29%	52.96%
Race		
White	53.10%	46.67%
Black	23.22%	24.82%
Hispanic or Latino	16.20%	20.59%
Asian	5.19%	4.61%
American Indian/Alaska Native	0.37%	0.45%
Hawaiian/Pacific Islander	0.08%	0.11%
Two or More Races	0.08%	0.04%
Other Race	1.65%	2.52%
Unknown	0.12%	0.18%
Rural	8.72%	6.31%
SVI Socioeconomic	0.63 (0.26)	0.64 (0.27)
SVI Housing and Transportation	0.58 (0.27)	0.58 (0.28)
Member Health Conditions		
Cerebrovascular	0.59%	0.80%
Cognitive	0.79%	1.17%
Diabetes	15.54%	12.41%
Heart	11.08%	9.95%
Lung	5.29%	3.67%
Malignant Neoplasm	4.67%	3.96%
Mental Health	6.05%	7.93%
Substance Use	4.77%	3.87%

*Includes members who were offered food supplemental benefits in 2023.
Note. SVI = Social Vulnerability Index.

Transportation Supplemental Benefit

Transportation supplemental benefit users, compared to non-users, were more likely to be female, less likely to live in rural areas, less likely to identify as White or Asian, and more likely to identify as Black or Hispanic/Latino. They also had higher socioeconomic vulnerability and housing/transportation vulnerability. Users had slightly lower rates of diabetes, lung conditions, and mental health conditions, and higher rates of substance use disorders and heart disease. (Table 3)

Table 3

Characteristics of Transportation Supplemental Benefit Users vs. Non-Users

Mean (standard deviation) or percentage

	Transportation Supplemental Benefit*	
	Users	Non-Users
Member Characteristics		
Age (in years)	66.2 (12.10)	65.9 (13.60)
Female	67.66%	60.60%
Race		
White	36.82%	53.70%
Black	37.94%	21.51%
Hispanic or Latino	19.99%	16.79%
Asian	2.64%	5.47%
American Indian/Alaska Native	0.40%	0.39%
Hawaiian/Pacific Islander	0.10%	0.08%
Two or More Races	0.12%	0.06%
Other Race	1.89%	1.85%
Unknown	0.10%	0.14%
Rural	4.78%	8.50%
SVI Socioeconomic	0.69 (0.25)	0.62 (0.26)
SVI Housing and Transportation	0.61 (0.27)	0.58 (0.27)
Member Health Conditions		
Cerebrovascular	0.49%	0.65%
Cognitive	0.60%	0.90%
Diabetes	13.98%	15.13%
Heart	11.59%	10.76%
Lung	3.80%	5.12%
Malignant Neoplasm	5.18%	4.54%
Mental Health	5.69%	6.46%
Substance Use	6.76%	4.26%

*Includes members who were offered the transportation supplemental benefit in 2023.
Note. SVI = Social Vulnerability Index.

Regression Results

Use of the food supplemental benefit was consistently associated with higher odds of meeting all evaluated quality measures compared to non-use. (Table 4; Figure 1)

Food benefit users had 57 percent greater odds of completing their annual planned visit compared to non-users. The odds of meeting diabetes measures were also higher in food benefit users than non-users. Food benefit users, compared to non-users, had 45 percent greater odds of maintaining HbA1c control, 45 percent greater odds of maintaining blood pressure control, 94 percent greater odds of receiving their diabetic eye exam, 31 percent greater odds of receiving their kidney health evaluation, 25 percent greater odds of receiving statin therapy, and 39 percent greater odds of adhering to statin therapy (i.e., remained on a statin medication of any intensity for at least 80 percent of the treatment period).

Positive associations were also observed for cardiovascular-related HEDIS measures. Compared to non-users, food benefit users had 35 percent greater odds of having controlled high blood pressure, 19 percent greater odds of receiving statin therapy, and 36 percent greater odds of adhering to statin therapy.

The transportation benefit was also positively associated with higher rates of meeting all quality measures, but to a lesser extent. Odds ratios for transportation benefit users ranged from 1.06 to 1.42, with statistically significant associations for most measures. Transportation benefit users, compared to non-users, had 11 percent greater odds of completing their annual planned visit. (Table 4; Figure 2)

Among members with diabetes, transportation benefit users had 6 percent greater odds of maintaining HbA1c control, 19 percent greater odds of maintaining blood pressure control, 42 percent greater odds of receiving their diabetic eye exam, 25 percent greater odds of receiving their kidney health evaluation, and 12 percent greater odds of receiving statin therapy, compared to non-users. For members with cardiovascular conditions, transportation users had 24 percent greater odds of having controlled high blood pressure and 19 percent greater odds of receiving statin therapy.

Table 4

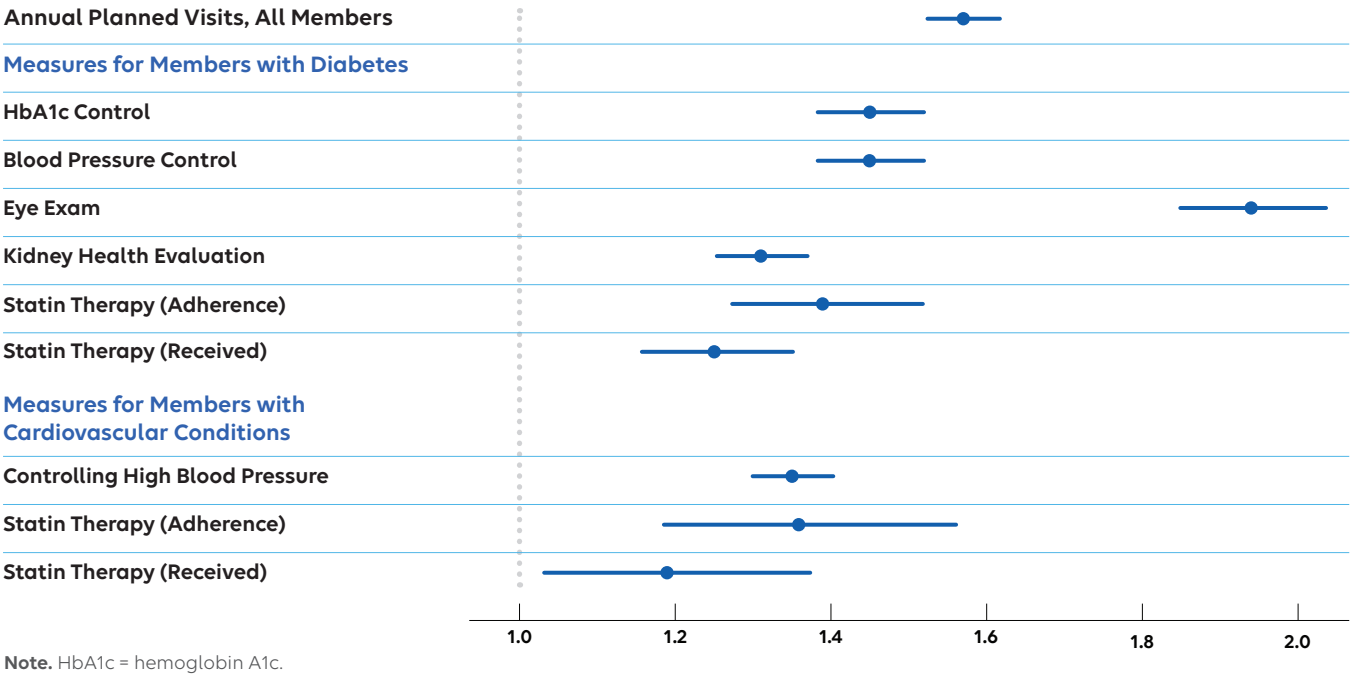
Odds Ratios of Food and Transportation Benefit Users vs. Non-Users Meeting Selected Measures

	Food Benefit	Transportation Benefit
Annual Planned Visits, All Members	1.57	1.11
Measures for Members with Diabetes		
HbA1c Control	1.45	1.06
Blood Pressure Control	1.45	1.19
Eye Exam	1.94	1.42
Kidney Health Evaluation	1.31	1.25
Statin Therapy (Adherence)	1.39	1.09 (NS)
Statin Therapy (Received)	1.25	1.12
Measures for Members with Cardiovascular Conditions		
Controlling High Blood Pressure	1.35	1.24
Statin Therapy (Adherence)	1.36	1.06 (NS)
Statin Therapy (Received)	1.19	1.19

Note. HbA1c = hemoglobin A1c. All results statistically significant at $p<0.05$ except those marked (NS). Definitions for these measures can be found in the Appendix.

Figure 1

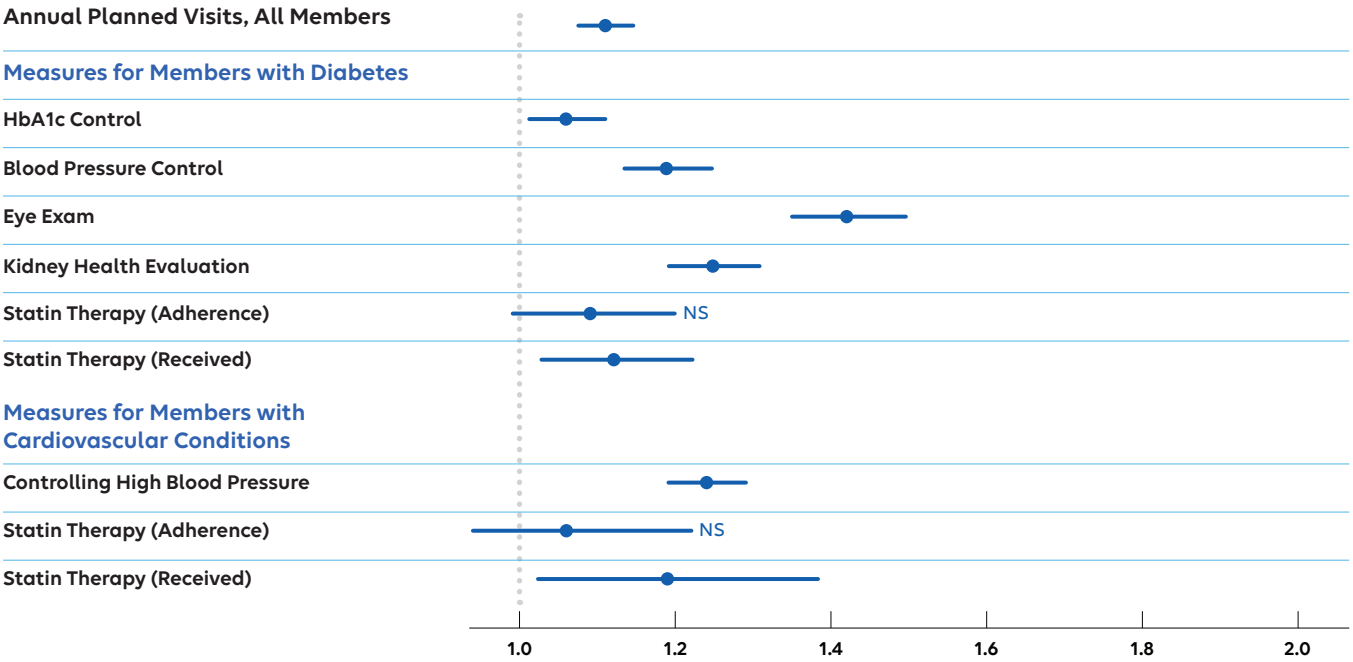
Odds Ratios of Food Benefit Users vs. Non-Users Meeting Selected Measures



Note. HbA1c = hemoglobin A1c.
The round mark denotes the odds ratio and the line spans from the lower to upper bounds of the 95% confidence interval.

Figure 2

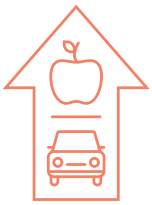
Odds Ratios of Transportation Benefit Users vs. Non-Users Meeting Selected Measures



Note. HbA1c = hemoglobin A1c; NS = not statistically significant at p<0.05.
The round mark denotes the odds ratio and the line spans from the lower to upper bounds of the95% confidence interval.

Discussion

The results of this analysis suggest that both food and transportation supplemental benefit users have greater odds of meeting a range of preventive care and chronic condition management quality measures, as compared to non-users.



Food and transportation supplemental benefit use is associated with improved health quality.

Use of the food benefit, in particular, was consistently linked to higher odds of meeting the evaluated HEDIS measures, with statistically significant associations for each measure. The strongest associations were observed for diabetes-related eye exams and annual planned visits, underscoring the potential impact of improved food access on members' opportunity for engagement with their healthcare.

These findings align with existing literature indicating that addressing food insecurity can increase utilization of preventive services, which is critical for effective chronic disease management. In addition, individuals with diabetes who used the food benefit had 45 percent greater odds of achieving HbA1c control and blood pressure control—two quality measures which are linked to diet—suggesting that assistance with purchasing groceries may help individuals maintain a healthy diet. Similarly, individuals with cardiovascular disease had greater odds of achieving blood pressure control, though the effect was smaller.

Transportation benefit use was also associated with improved HEDIS performance, though the magnitude and statistical significance of the effects were generally lower than those observed for the food benefit. The strongest associations were observed for diabetes-related eye exams and kidney health evaluations, suggesting that transportation support may be particularly important for services requiring in-person attendance.

Taken together, these findings support the hypothesis that non-medical supplemental benefits can play a meaningful role in enhancing access to and quality of care for dual eligible Medicare beneficiaries. Notably, the stronger and more consistent associations observed for food benefits may reflect the broader reach of food insecurity as a social driver of health, as well as the multifaceted ways in which nutrition support can influence chronic condition management. Transportation benefits, while impactful, may serve a more targeted role in addressing logistical barriers to specific types of care.

Supplemental benefits are made possible by the savings that result from MA providing Medicare Parts A and B benefits more efficiently than traditional Medicare. This research suggests that supplemental benefits can not only enhance the quality of life for beneficiaries but also help them reap measurable health and healthcare outcomes—such as improved preventive care and chronic disease management. Policymakers and other stakeholders should be mindful that any future changes to the MA program do not constrain plans' ability to deliver these supplemental benefits that improve quality.

Future policy should continue flexibility for MA plans to offer non-medical supplemental benefits.

These findings also have important implications for the design of MA plan benefits, particularly as the VBID model will conclude at the end of 2025. While non-medical supplemental benefits can still be offered as SSBCI, SSBCI are structurally and operationally different from VBID, and transitioning to an SSBCI-only approach could unintentionally reduce access for populations who do not meet chronic condition thresholds but still benefit from social needs-based interventions. In addition, beneficiaries with a qualifying chronic condition will need their provider to attest to their diagnosis before they are eligible to receive SSBCI in 2026, potentially delaying continued access to these benefits. The results from this analysis suggest that policymakers may wish to find alternative ways by which to extend certain non-medical benefits to dual eligible beneficiaries.

Future research could explore whether a dose-response relationship exists between the extent of supplemental benefit utilization and the likelihood of meeting quality measures. For instance, higher levels of benefit use—such as increased spending of food benefits or a greater number of trips via the transportation benefit—may be associated with varying degrees of compliance with specific quality metrics.

Limitations

The food supplemental benefit varied across plans and was often offered as part of a combined allowance that could be used not only for food and produce, but also for over-the-counter items—and, in some cases, utilities and home safety products. The benefit was structured as a combined purse and did not allow for the disaggregation of spending categories. As a result, it was not possible to determine whether members used the benefit specifically for food-related purchases.

This limits the ability to draw conclusions about the specific mechanisms that potentially influence whether individuals successfully met the selected quality measures, as the observed associations could differ depending on how the benefit was used. Nonetheless, the findings suggest that, regardless of specific use, the benefit supports members in meeting basic needs, which may in turn allow them to focus more effectively on their healthcare.

Additionally, this study could not account for differences in healthcare knowledge and health literacy within the sample. Therefore, it is possible that members who used their supplemental benefits may also be more engaged with their health plans and more proactive in managing their healthcare, which could contribute to improved quality outcomes.

Lastly, participation in value-based care arrangements by providers may influence whether members met HEDIS measures. However, it was outside the scope of this study to classify whether providers were engaged in such arrangements. This may leave unadjusted-for confounding related to providers' influence on quality measure compliance.

Conclusion

This study demonstrates that food and transportation supplemental benefits are positively associated with individuals meeting select quality measures, particularly those related to management of diabetes and cardiovascular disease.

Continued flexibility for plans to offer non-medical supplemental benefits can help promote high-quality care and improved outcomes. This is particularly critical for dual eligible beneficiaries, who face complex medical and social needs and stand to benefit most from these interventions.

The Elevance Health Public Policy Institute gratefully acknowledges the analytic contributions of Elevance Health's Health Outcomes Organization in the conduct of this study.

Appendix

Description of Evaluated Quality Measures

Measure	Description
Annual Planned Visits, All Members	Member received a comprehensive physical exam along with bloodwork and other lab tests that are based on the member's age, gender, and identified risk factors
Measures for Members with Diabetes	
Hemoglobin A1c Control	Member is 18-75 years of age, is diagnosed with diabetes, and whose HbA1c was adequately controlled (<8.0%)
Blood Pressure Control	Member is 18-75 years of age, is diagnosed with diabetes, and whose blood pressure was adequately controlled (<140/90 mm Hg)
Eye Exam	Member is 18-75 years of age, is diagnosed with diabetes, and had a retinal eye exam
Kidney Health Evaluation	Member is 18-85 years of age, is diagnosed with diabetes, and had an annual kidney health evaluation, including a blood test for kidney function and urine test for kidney damage
Statin Therapy (Adherence)	Member is 40-75 years of age, is diagnosed with diabetes, does not have atherosclerotic cardiovascular disease, and remained on a statin medication of any intensity for at least 80 percent of the treatment period
Statin Therapy (Received)	Member is 40-75 years of age, is diagnosed with diabetes, does not have atherosclerotic cardiovascular disease, and received statin medication
Measures for Members with Cardiovascular Conditions	
Controlling High Blood Pressure	Member is 18-85 years of age, has a diagnosis of hypertension, and whose blood pressure was adequately controlled (<140/90 mm Hg)
Statin Therapy (Adherence)	Member is 21-75 years of age if male and 40-75 if female, is diagnosed with clinical atherosclerotic cardiovascular disease, and remained on a statin medication of any intensity for at least 80 percent of the treatment period
Statin Therapy (Received)	Member is 21-75 years of age if male and 40-75 if female, is diagnosed with clinical atherosclerotic cardiovascular disease, and received statin medication

Endnotes

[1] Centers for Medicare & Medicaid Services. (n.d.). Medicare Advantage Value-Based Insurance Design (VBID) model. Retrieved June 23, 2025, from https://www.cms.gov/priorities/innovation/innovation-models/vbid.

[2] Elevance Health Public Policy Institute. (2023, July). Medicare Advantage Supplemental Benefits Address Health-Related Social Needs. Retrieved June 23, 2025, from https://www.elevancehealth.com/public-policy-institute/medicare-advantage-supplemental-benefits-can-address-hrsn.

[3] Elevance Health Public Policy Institute. (2024, May). Medicare Advantage Supplemental Benefits and Improved Healthcare Use. Retrieved June 23, 2025, from https://www.elevancehealth.com/public-policy-institute/medicare-advantage-supplemental-benefits-and-improved-healthcare-use.

[4] Peña, M.T., et al. (2023, January 31). A Profile of Medicare-Medicaid Enrollees (Dual Eligibles). Kaiser Family Foundation. Retrieved June 23, 2025, from https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.

[5] Centers for Medicare & Medicaid Services. (n.d.). Value-Based Insurance Design (VBID) Model: VBID General Component, 2020-2023. Retrieved June 23, 2025, from https://www.cms.gov/priorities/innovation/data-and-reports/2025/vbid-2020-2023-general-aag.

[6] Centers for Medicare & Medicaid Services. (2008, November 13). CMS Identifies 15 Chronic Conditions for Medicare. Retrieved June 23, 2025, from https://www.cms.gov/newsroom/press-releases/cms-identifies-15-chronic-conditions-medicare.
The 15 chronic or disabling illnesses include: chronic alcohol and other drug dependence, certain autoimmune disorders, cancer excluding pre-cancer conditions, certain cardiovascular disorders, chronic heart failure, dementia, diabetes mellitus, end-stage liver disease, end-stage renal disease requiring dialysis, certain severe hematologic disorders, HIV/AIDS, certain chronic lung disorders, certain chronic and disabling mental health conditions, certain neurologic disorders, and stroke.

[7] Centers for Medicare & Medicaid Services. (2023, March 23). Medicare Advantage Value-Based Insurance Design Model Extension Fact Sheet. Retrieved June 23, 2025, from https://www.cms.gov/priorities/innovation/vbid-extension-fs.

[8] Exact VBID targeting criteria can be found here: https://www.cms.gov/priorities/innovation/innovation-models/vbid.

[9] Office of Disease Prevention and Health Promotion. (2024, September 5). Medicare Advantage Value-Based Insurance Design Model. Retrieved June 23, 2025, from https://odphp.health.gov/foodismedicine/federal-resource-hub/medicare-advantage-value-based-insurance-design-model.

[10] ATI Advisory. (2025). Flash Analysis: 2025 Nonmedical Supplemental Benefits in Medicare Advantage. Retrieved June 23, 2025, from https://atiadvisory.com/resources/wp-content/uploads/2024/02/Flash-Analysis-of-2025-Nonmedical-Supplemental-Benefits-in-Medicare-Advantage.pdf.

[11] Yeh, M., & Yen, I. (2024, April 3). 2024 Combined Benefits in Medicare Advantage: Tracking Benefit Strategy and Options. Milliman. Retrieved June 23, 2025, from https://www.milliman.com/en/insight/2024-combined-benefits-medicare-advantage-tracking-benefit-strategy.

[12] Gucciardi, E., et al. (2014, October 2). The Intersection between Food Insecurity and Diabetes: A Review. *Current Nutrition Reports 3*(4), 324-332. Retrieved June 23, 2025, from https://doi.org/10.1007/s13668-014-0104-4.

[13] Liu, Y., & Eicher-Miller, H.A. (2021, March 27). Food Insecurity and Cardiovascular Disease Risk. *Current Atherosclerosis Report 23*(6). Retrieved June 23, 2025, from https://doi.org/10.1007/s11883-021-00923-6.

[14] Zierath, R., Claggett, B., & Hall, M.E. (2023, January 23). Measures of Food Inadequacy and Cardiovascular Disease Risk in Black Individuals in the US From the Jackson Heart Study. *JAMA Network Open 6*(1). Retrieved June 23, 2025, from https://doi.org/10.1001/jamanetworkopen.2022.52055.

[15] Sun, Y., et al. (2020, September 25). Food Insecurity Is Associated With Cardiovascular and All-Cause Mortality Among Adults in the United States. *Journal of the American Heart Association 9*(19). Retrieved June 23, 2025, from https://doi.org/10.1161/jaha.119.014629.

[16] Jia, J., et al. (2021, July 8). Food Insecurity, Dietary Quality, and Health Care Utilization in Lower-Income Adults: A Cross-Sectional Study. *Journal of the Academy of Nutrition and Dietetics 121*(11), 2177-2186. Retrieved June 23, 2025, from https://doi.org/10.1016/j.jand.2021.06.001.

[17] Distelhorst, K., Adams, K., & Lopez, R. (2023, April). Food Insecurity, Neighborhood, and Health Care Utilization in Health System Adults. *American Journal of Managed Care 29*(4), 188-194. Retrieved June 23, 2025, from https://doi.org/10.37765/ajmc.2023.89347.

[18] Pooler, J.A., & Srinivasan, M. (2019, January). Assistance Program Participation and Cost-Related Medication Nonadherence Among Older Adults With Diabetes. *JAMA Internal Medicine 179*(1), 63-70. Retrieved June 23, 2025, from https://doi.org/10.1001/jamainternmed.2018.5011.

[19] Islam, M., et al. (2024, February 23). Supplemental Nutrition Assistance Program and Adherence to Antihypertensive Medications. *JAMA Network Open 7*(2). Retrieved June 23, 2025, from https://doi.org/10.1001/jamanetworkopen.2023.56619.

[20] Carlson, S., & Llobrera, J. (2022, December 14). SNAP Is Linked With Improved Health Outcomes and Lower Health Care Costs. Center on Budget and Policy Priorities. Retrieved June 23, 2025, from https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-health-outcomes-and-lower-health-care-costs.

[21] Heflin, C., Arteaga, I., & Stafford, J. (2021, November 30). Consistent SNAP Participation Increases Preventative Health Care Visits for Infants. Syracuse University Lerner Center for Public Health Promotion. Retrieved June 23, 2025, from https://surface.syr.edu/cgi/viewcontent.cgi?article=1161&context=lerner.

[22] Miller, D.P., & Morrissey, T.W. (2021, September 6). SNAP Participation and the Health and Health Care Utilisation of Low-Income Adults and Children. Cambridge University Press. Retrieved June 23, 2025, from https://doi.org/10.1017/S1368980021003815.

[23] Berkowitz, S.A., et al. (2017, November). Supplemental Nutrition Assistance Program (SNAP) Participation and Health Care Expenditures Among Low-Income Adults. *JAMA Internal Medicine 177*(11). Retrieved June 23, 2025, from https://doi.org/10.1001/jamainternmed.2017.4841.

[24] Cappelletti, E.R., et al. (2015, July 15). Basic Needs, Stress and the Effects of Tailored Health Communication in Vulnerable Populations. *Health Education Research 30*(4), 591-598. Retrieved June 23, 2025, from https://doi.org/10.1093/her/cyv033.

[25] Thompson, T., Kreuter, M., & Boyum, S. (2017, April 1). Promoting Health by Addressing Basic Needs: Effect of Problem Resolution on Contacting Health Referrals. *Health Education Behavior 43*(2), 201-207. Retrieved June 23, 2025, from https://doi.org/10.1177/1090198115599396.

[26] Cochran, A.L., et al. (2022, September 20). Transportation Barriers to Care Among Frequent Health Care Users During the COVID Pandemic. *BMC Public Health 22*. Retrieved June 23, 2025, from https://doi.org/10.1186/s12889-022-14149-x.

[27] Centers for Medicare & Medicaid Services. (n.d.). Addressing Transportation Barriers: A Use Case in Leveraging the Value-Based Insurance Design (VBID) Model. Retrieved June 23, 2025, from https://www.cms.gov/priorities/innovation/media/document/vbid-cy2023-transportation-use-case.

[28] American Hospital Association. (2017, November). Social Determinants of Health Series: Transportation and the Role of Hospitals. Retrieved June 23, 2025, from https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/sdoh-transportation-role-of-hospitals.pdf.

[29] Syed, S.T., Gerber, B.S., & Sharp, L.K. (2014, December 13). Traveling Towards Disease: Transportation Barriers to Health Care Access. *Journal of Community Health 38*(5), 976-993. Retrieved June 23, 2025, from https://doi.org/10.1007/s10900-013-9681-1.

[30] Berkowitz, S.A., et al. (2022, March). Evaluating a Nonemergency Medical Transportation Benefit For Accountable Care Organization Members. *Health Affairs 41*(3). Retrieved June 23, 2025, from https://doi.org/10.1377/hlthaff.2021.00449.

[31] Saxon, L., Ebert, R., & Sobhani, M. (2019, August 13). Health Impacts of Unlimited Access to Networked Transportation in Older Adults. *Journal of mHealth*. Retrieved June 23, 2025, from https://thejournalofmhealth.com/health-impacts-of-unlimited-access-to-networked-transportation-in-older-adults/.

[32] Although "persistence of beta-blocker treatment after heart attack" and "cardiac rehabilitation" are HEDIS measures relevant to cardiovascular conditions, they were excluded from the analysis due to small sample sizes.

[33] National Committee for Quality Assurance. (n.d.). HEDIS Measures and Descriptions. Retrieved June 23, 2025, from https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2022/07/HEDIS-MY-2023-Measure-Description.pdf.

[34] Agency for Toxic Substances and Disease Registry. (2024, July 22). Social Vulnerability Index. Retrieved June 23, 2025, from https://www.atsdr.cdc.gov/place-health/php/svi/index.html.

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