ACAP
Association for Community Affiliated Plans

Safety Net Health Plans Put People First:

The Top Ten Reasons Safety Net Health Plans Support Medicaid Managed Care

1. Safety Net Health Plans are the Backbone of Medicaid Managed Care.

The not-for-profit structure of Safety Net Health Plans supports a mission to serve the vulnerable. Such plans steadfastly support the Medicaid program during good times and bad, while for-profit plans tend to enter and exit the market. Safety Net Health Plans serve nearly 10 million low-income, high-need beneficiaries in their communities—more than half of all enrollees in Medicaid-focused plans. Safety Net Health Plans sustain and secure Medicaid programs by partnering with federal and state governments, health care providers, community health centers, and other community organizations to identify and fund innovative solutions. Many Safety Net Health Plans have been serving Medicaid beneficiaries for more than 30 years.

2. Medicaid Managed Care Ensures Access Through Strong Provider Networks.

Unlike Medicaid fee-for-service, managed care ensures guaranteed access to a network of primary care, mental and behavioral health, and specialty providers. Safety Net Health Plans participating in Medicaid must meet stringent state network requirements based on geography, travel times and specialty; in fee-for-service programs, requirements are inconsistent and often unmet. Medicaid managed care plans are accountable for the access they provide through routine measurement and reporting on a variety of access measures. Similar reporting and accountability does not exist in Medicaid fee-for-service or primary care case management.

3. Safety Net Health Plans Emphasize Primary Care and Prevention.

Safety Net Health Plans promote timely primary and preventive care services. This helps to avoid inappropriate, costly visits to the emergency room. Each health plan member has access to a primary care provider responsible for coordinating care. Few, if any, fee-for-service programs provide such services. Safety Net Health Plans work with primary care providers to ensure that preventive services are available and used by members. Research has found not-for-profit plans such as Safety Net Health Plans significantly more likely to perform at a higher level than for-profit health plans on measures of preventive care.[1]

What's a "Safety Net Health Plan?"

A Safety Net Health Plan is a local, community affiliated nonprofit health plan that derives 51% or more of its gross revenues from government programs that target low-income, elderly or disabled populations. Congress has acknowledged the special nature of these plans by exempting many of them from the health plan excise tax.

4. Safety Net Health Plans Provide Continuity Between Medicaid and Health Insurance Marketplaces.

Safety Net Health Plans have developed unique expertise in delivering high-quality health care services to underserved populations, including low-income individuals and persons with disabilities. Many Marketplace enrollees share characteristics with low-income enrollees in Medicaid, and studies suggest that millions will move between Medicaid and the Marketplace owing to income volatility.[2] In other instances, families may experience "split eligibility," with children covered in Medicaid and CHIP and parents in Marketplace coverage. Safety Net Health Plans understand that serving both Medicaid and the Marketplace can enhance the cohesiveness and continuity of coverage and care for these individuals and families. As a result, 16 Safety Net Plans entered the Marketplaces in 2014 and more are expected to do so in 2015.

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[1] McCue M., Bailit M. Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide. The Commonwealth Fund, June 2011. http://tinyurl.com/79rw7ao.

[2] Sommers BD, Rosenbaum S. Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges. Health Affairs 30, no. 2 (2011): 228-236.

5. Safety Net Health Plans Promote Quality and Transparency.

Safety Net Health Plans ensure the highest-quality health care through an ongoing commitment to transparency, quality measurement, and continuous quality improvement. For the past four years, at least 4 of the top 10 Medicaid health plans as ranked by NCQA are Safety Net Health Plans. Unfortunately, no systematic quality measurement exists in Medicaid fee for service. ACAP supports requirements that would hold fee-for-service and primary care case management programs to the same high standards as Medicaid managed care plans.

6. Safety Net Health Plans Address Social Determinants of Health.

Safety Net Health Plans understand that factors beyond traditional medical conditions dramatically influence an individual's health and their ability to obtain and adhere to treatment. Safety Net Health Plans' deep connections to their communities facilitate services and supports that address these issues, improving health outcomes and reducing costs. Initiatives range from helping members secure affordable housing to employing resident community health workers. Other innovative programs include nutrition and cooking classes, supporting availability of fresh fruits and vegetables in food deserts, community resource centers, and targeted health literacy initiatives.

7. Safety Net Health Plans Provide Patient-Centered Care Management and Long-Term Supports and Services.

Safety Net Health Plans have an abiding commitment to ensuring enrollees receive the top-notch care they deserve. In partnership with safety net providers, Safety Net Health Plans manage a wide range of concerns that may not be addressed by other health care delivery systems, including providing long-term services and supports to the elderly and Medicaid enrollees with disabilities in their community. Some plans have developed intensive case management programs to help enrollees who have difficulty adhering to a treatment plan. Others have adopted health coaching programs, perinatal and pediatric well-care visits and extended hours, all to meet the needs of their members.

8. Safety Net Health Plans Support Safety Net Providers.

Safety Net Health Plans work hand-in-hand with safety net providers, including community health centers, public hospitals, children's hospitals, and primary care providers to preserve access to care for Medicaid enrollees. Many Safety Net Health Plans were created by community health centers and safety net hospitals; some plans are owned by providers. Safety Net Health Plans share responsibility with the provider community to deliver the best possible care to Medicaid enrollees and other vulnerable individuals, and in many cases work together to provide care to uninsured individuals who lack regular access to care, including supporting provider efforts to establish patient-centered medical homes and implementing electronic medical records systems.

9. Safety Net Health Plans Strive to Integrate Medicaid and Medicare.

More than 9 million people who have Medicare coverage also enroll in Medicaid to fill Medicare payment and service gaps. These "dual eligibles" are more likely to live with multiple chronic conditions and need care coordination to maintain their health and independence. More than 20 Safety Net Health Plans sponsor Medicare Special Needs Plans to serve members eligible for Medicare and Medicaid; at least a dozen Safety Net Health Plans currently or will participate in "duals demonstration" projects undertaken by states and CMS. ACAP supports these efforts and envisions the creation of a distinct, permanent program structure for integrated care for dual eligibles.

10. Medicaid Managed Care is Efficient, High-Quality Care.

Safety Net Health Plans coordinate the care and needs of their members in a way that reduces waste, improves efficiency, contains cost, and maintains quality of care. A recent analysis found Medicaid managed care to have a significantly lower payment error rate than fee-for-service Medicaid.[3] On average, not-for-profit insurers spend significantly more than for-profit insurers on health care and less on administrative overhead expenses to provide more efficient care.[4] In 2010, more than three-quarters of national Medicaid spending was not capitated, including most of the care for the costliest groups who could benefit the most from its coverage. This suggests great room for expansions of managed care, which could generate substantial savings for state and federal government programs. A significant opportunity for substantial cost savings arises from integrating care for "dual eligibles."

[3] Department of Health and Human Services."FY 2013 Agency Financial Report" p 173. http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf

[4] McCue M, Hall M, Liu X. Impact of Medical Loss Regulation on the Financial Performance of Health Insurers. Health Affairs 32, no. 9 (2013): 1546-1551.