ACAP
Association for Community Affiliated Plans
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Safety Net Health Plan Approaches to Addressing Chronic Conditions

December 2025

About the Association for Community Affiliated Plans

The Association for Community Affiliated Plans (ACAP) is a national trade association which represents not-for-profit Safety Net Health Plans. Collectively, ACAP plans serve more than thirty million enrollees. For more information, visit www.communityplans.net.

ACAP gratefully acknowledges Caroline Davis of Davis Health Strategies
and the work of ACAP's staff and interns for their efforts in developing this report.

We also thank all who were interviewed at the plans profiled in this report for their generosity in sharing their time, knowledge and experience.

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Introduction

Chronic conditions such as diabetes, cardiovascular disease, and obesity are leading drivers of poor health outcomes and healthcare-related financial strain, accounting for roughly 90 percent of the nation's $4.9 trillion in annual health care expenditures.[1] According to the U.S. Centers for Disease Control and Prevention (CDC), 6 in 10 Americans live with at least one chronic conditions; and 4 in 10 live with two or more.[2] In addition, at least 40 percent of children have one chronic disease, with an increasing prevalence over the last 20 years.[3,4] Within the Medicaid program, 75 percent of non-elderly adults report one or more chronic conditions, which is greater than for adults with commercial insurance.[5] And in 2017, two-thirds of non-dual-eligible Medicare beneficiaries reported having two or more chronic conditions.[6]

ACAP's Safety Net Health Plans (SNHP), which provide coverage to more than 30 million people through Medicaid, Medicare, the Health Insurance Marketplace, and other public programs, serve populations that are especially vulnerable to chronic disease. Their members generally have a variety of health-related social needs, which increases the likelihood of developing chronic conditions and makes disease management more difficult.

This issue brief highlights the ways in which ACAP-member plans are already addressing chronic conditions through innovative strategies that integrate medical care with upstream disease prevention and social support. It features initiatives from member plans which serve as examples of ongoing interventions that improve health outcomes for communities disproportionately impacted by chronic disease.

Plan Strategies for Tackling Chronic Conditions

Prevalence and Impact

Chronic conditions such as hypertension, diabetes, asthma, chronic obstructive pulmonary disease, and congestive heart failure are among the leading drivers of avoidable emergency department use, preventable hospitalizations, and long-term morbidity among Medicaid members. Nearly 75 percent of Medicaid enrollees aged 16–64 are reported to have at least one chronic condition, and one-third report three or more,[7] illustrating the complexity and intensity of care needed for this population. Dual-eligible individuals are more likely to have two or more chronic conditions, placing them at higher risk for poor health outcomes and leading to higher healthcare spending.

Chronic disease prevalence is closely tied to health-related social needs (HRSN), including low socioeconomic status, housing instability, food insecurity, limited access to safe exercise spaces, and low health literacy. These upstream factors shape daily living conditions and influence disease onset, management, and progression. Effectively addressing chronic conditions requires strategies that go beyond clinical care, such as integrating social supports and community-based resources. Plans consistently identify chronic disease management as a primary opportunity for quality improvement and reducing costs.

High-Level Strategies for Tackling Chronic Conditions

Health plans are increasingly adopting comprehensive, multi-sector strategies to improve chronic disease outcomes.[8] By engaging in whole-person care approaches that consider a member's physical health, behavioral health, and social needs, SNHPs are improving member outcomes and driving reductions in the total costs of health care. These strategies include:

1. Integrated Care Coordination

- Strengthening provider networks to facilitate improved coordination across primary care, specialty care, behavioral health, and social services;
- Deploying care managers and care coordinators to conduct comprehensive assessments, developing individual care plans for high-risk patients, and supporting members in navigating complex medical and social needs; and
- Improving continuity of care and reducing gaps in care via interdisciplinary teams that include physicians as well as other provider types, including community health workers, behavioral health providers, and pharmacists.

2. Disease Management Programs

- Implementing structured disease management programs for chronic conditions with high prevalence rates in the population;
- Prioritizing preventive care, early identification of potential risks that could worsen a condition, and proactive outreach to increase patient engagement in follow-up care; and
- Supporting self-management of chronic conditions via education, remote monitoring, and culturally tailored interventions.

3. Data-Driven Quality Improvement

- Leveraging analytics to identify disparities, monitor performance, and target interventions to support high-risk populations;
- Using predictive modeling to anticipate "rising risk" members and intervene before conditions worsen; and
- Aligning quality measures with state and federal priorities, as well as National Committee for Quality Assurance (NCQA) guidelines, to monitor and improve care quality over time.

4. Addressing HRSN

- Integrating HRSN screening, referral pathways, and follow-up into routine care;
- Investing in upstream interventions, such as housing support, food security programs, transportation assistance, and digital literacy initiatives; and
- Partnering with community-based organizations to provide wraparound services that address root causes of chronic disease.

5. Strengthening Cross-Partner Collaboration and Innovation

- Improving cross-sector collaboration and data exchange between health plans, providers, public health agencies, and community organizations;
- Spreading and scaling best practices, including successful member incentive programs and clinical interventions; and
- Encouraging care innovation via pilots, value-based payment models, and member-centered initiatives that test new approaches to complex care.

SNHPs have emerged as leaders in advancing comprehensive, chronic condition management strategies, and have been particularly effective in developing innovative interventions that address chronic conditions and the factors that worsen them. As highlighted below, ACAP plans have developed initiatives that focus on a wide range of conditions and HSRN to address the complex care needs of their members including type 2 diabetes, hypertension, substance use disorders and behavioral health conditions, childhood health conditions (e.g., childhood obesity, lead poisoning), and food insecurity.

Diabetes

Type 2 diabetes is a chronic metabolic condition characterized by insufficient insulin production or reduced cellular responsiveness to insulin, resulting in elevated blood glucose levels.[9] In 2021, diabetes was the eighth-leading cause of death in the United States.[10] Prevalence is higher among individuals with lower socioeconomic status, where factors such as limited income, educational attainment, and occupational strain contribute to increased risk and reduced access to preventive care.[11]

Individuals with Type 2 diabetes frequently experience multiple co-occurring chronic conditions.[12] When diabetes is left unmanaged, the risk of serious and costly complications increases significantly, including vision loss, kidney failure, heart attack, stroke, and lower-limb amputation.[13] These clinical consequences are compounded by substantial costs: in 2023, the American Diabetes Association estimated that diabetes-related direct and indirect costs totaled $412.9 billion annually, accounting for roughly one in every four healthcare dollars spent.[14]

Effective prevention and management are essential to improving member outcomes. Regular physical activity, evidence-based nutrition guidance, and early detection are central to preventing the onset of Type 2 diabetes and its associated comorbidities. For diagnosed individuals, comprehensive and coordinated management can mitigate complications and improve long-term quality of life. This includes medication adherence, self-management support, and routine monitoring. Given the significant health and financial implications of Type 2 diabetes, sustained investment in both prevention and high-quality chronic disease management remains critical for health plans, providers, and policymakers.

Spotlight: Community First Health Plans

How Community First Health Plans Introduced a New Way to Manage Diabetic Foot Complications

Setting the Scene: Located in San Antonio, Texas, Community First Health Plans (Community First) serves approximately 175,000 members, a majority of whom are enrolled in its Medicaid line of business.[15] When conducting an internal cost analysis of chronic conditions within their overall member population, Community First found that diabetes was one of the top two cost drivers for the plan's members. As a result, Community First launched a new initiative aimed at helping their members living with diabetes who are at high risk of developing diabetic foot ulcers (DFU). The condition, if left untreated, can lead to amputation.

Partnership with Podimetrics: As part of this new initiative, Community First partnered with Podimetrics, a technology and virtual care management services company, to help diabetic members manage their condition and avoid foot-related complications. Community First identifies eligible members by providing Podimetrics with claim-level member data. Podimetrics then uses an algorithm to find patients identify patients who have had DFUs within the past two years or are at high risk for developing them. Eligible members are sent welcome letters introducing Podimetrics and inviting them to participate in the initiative. Once enrolled in the program, members receive a non-invasive, easy-to-use mat from Podimetrics designed to detect early signs of inflammation by monitoring the temperature of their feet. The smart mat requires no training and no setup. By standing on the mat for just 20 seconds a day, members can proactively protect themselves from DFU and other podiatric complications. When indicated, Podimetrics case managers communicate with the member about any next steps or follow-up care. Case managers also can escalate a case to the health plan or member's clinician as needed.

Pilot & Beyond: As of July 2025, Community First had enrolled 25 members into a pilot within one of their plans' commercial lines of business. A fully-fledged version of the initiative for Community First's adult Medicaid members launched in October 2025. Early qualitative feedback from participating members noted the mat's convenience and ease-of-use. Increased member satisfaction, reduced inpatient hospitalizations and decreased Emergency Department utilization are all expected outcomes of this intervention.

Hypertension

Hypertension is a chronic condition characterized by sustained blood pressure readings of 130/80 mm Hg or higher, which places significant strain on the heart, blood vessels, and other organ systems. In 2023, hypertension was identified as the primary or contributing cause of more than 650,000 deaths, underscoring its role as a major driver of preventable morbidity and mortality in the United States.[16] Nearly half of U.S. adults have hypertension, yet only one in four individuals with the condition have their blood pressure adequately controlled.[17]

If left undetected or inadequately managed, hypertension increases the risk of serious complications, including heart attack, heart failure, cardiovascular disease, stroke, and vision

loss.[18] In 2019, individuals with hypertension incurred an estimated $2,759 more in annual healthcare costs than those without hypertension, contributing to a national expenditure of approximately $219 billion.[19] Since hypertension is a major risk factor for cardiovascular disease, and accounts for one in every eight healthcare dollars spent, evidence-based prevention and early management strategies have the potential to meaningfully reduce long-term healthcare costs and improve population health outcomes.[20]

Spotlight: Health Plan of San Joaquin/Mountain Valley Health Plan

How Health Plan of San Joaquin/Mountain Valley Health Plan Improved Hypertension Education Efforts

Setting The Scene: Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") provides a full range of medical and behavioral health benefits and services for more than 390,000 Medicaid beneficiaries in Alpine, El Dorado, San Joaquin, and Stanislaus counties in California.[21] In 2023, the plan partnered with the American Heart Association to host a series of virtual heart health classes focused on hypertension and blood pressure monitoring. Despite strong content, engagement was low — with no more than five participants per session. This highlighted the need to revisit the plan's health education strategy and create more accessible, community-based approaches.

Working with Trusted Community Partners: In 2024, the plan shifted focus to in-person health education, collaborating with the Amelia Ann Adams Whole Life Center (AAAWLC), a trusted local community-based organization. By integrating classes into AAAWLC's monthly food distribution events, the plan leveraged existing community trust and participation. AAAWLC was an ideal partner for several reasons:

- **Community Health Workers**: They employ community health workers—a covered benefit—who provide culturally-responsive education, connect members to resources, and can bill for these services.
- **Support Beyond the Classroom**: Through their broader community supports, participants were not only engaged in learning about hypertension management but also connected to other services addressing their social needs such as food security, housing, and transportation.
- **Family-Centered Approach**: The classes were made available not only to members but also to their families, extending the reach of health education and supporting healthier households.
- **Cultural and Geographic Alignment**: Hypertension disproportionately affects the plan's Hispanic and Black members. AAAWLC has deep roots in serving these communities and is centrally located in an area where many plan members reside, making it accessible and trusted.

The Health Education team delivered a hypertension management series that emphasizes lifestyle changes, behavior modification, and self-management skills, supported by an active care team. Participants learned how to take blood pressure readings at home, received tracking logs to monitor their progress, and were guided to supportive services that could further improve their overall well-being.

Outcomes and Lessons: The revamped series was a set of six monthly classes on hypertension. Participants provided positive feedback: 90 percent reported an improved understanding of hypertension, while 73 percent reported an intent to change their behavior to better their own health. In fact, participant feedback included requests for more classes on diabetes and exercise, text reminders for sessions, and access to blood pressure cuffs at events.

For next steps, the plan will continue this model of community-embedded education and evaluate participants at the end of 2025 against the HEDIS CBP (Controlling High Blood Pressure) measure to determine the impact on achieving blood pressure control—defined as being below 140/90. By moving beyond virtual education and embedding health education into trusted community settings, the plan is building stronger connections with members, reducing barriers to access, and driving better chronic condition outcomes with the support of its dedicated team and community health workers.

Substance Use Disorder and Behavioral Health

Substance use disorders (SUDs) are characterized by the inability to control the use of substances such as alcohol, nicotine, and opioids, despite harmful consequences. According to the U.S. Substance Abuse and Mental Health Services Administration, 16.8 percent of individuals in the United States aged 12 and older met the diagnostic criteria for an SUD within the past year.[22]

The economic impact of SUDs is substantial: hospital-based costs associated with SUDs exceeded $13.2 billion in 2017,[23] and when accounting for healthcare expenditures, productivity losses, and criminal justice system involvement, the societal costs of opioid use disorder alone were estimated at $787 billion in 2018.[24] These trends underscore the critical need for comprehensive, evidence-based prevention, treatment, and recovery strategies across the health system.

Behavioral health (BH) conditions, more broadly, represent a significant and growing challenge for the healthcare sector. In 2021, 22 percent of U.S. adults received a behavioral health diagnosis, accounting for 41 percent of total healthcare spending.[25] This disproportionate cost burden highlights the importance of improving access to timely, high-quality, and coordinated behavioral health services.

Co-morbidity between mental health conditions and SUDs is well documented and significantly amplifies their associated clinical and economic burden. Individuals with mental health disorders are two to three times more likely to develop an SUD, and nearly half of people with an SUD also meet criteria for a co-occurring mental illness.[26] Shared neurobiological pathways, trauma exposure, adverse childhood experiences, and HSRN (*e.g.,* housing instability and chronic stress), further exacerbate risk and complicate treatment.[27] Co-occurring conditions are associated with higher rates of chronic diseases, unmet treatment needs, emergency department utilization, hospitalization, and premature mortality[28] highlighting the need for innovative and comprehensive care options. These include integrated care models such as Certified Community Behavioral Health Clinics, collaborative care, and whole-person care approaches that simultaneously address mental health, SUD needs, and physical health.

Spotlight: Gold Coast Health Plan

How Gold Coast Health Plan Improved Follow-Up for Members with Behavioral Health Emergencies

Setting the Scene: Located in Ventura County just north of Los Angeles, Gold Coast Health Plan (GCHP) serves almost 250,000 Medicaid (Medi-Cal) members.[29] GCHP partnered with the Ventura County Medical Center (VCMC) when both organizations realized GCHP's members were experiencing challenges with accessing treatment services after an emergency department visit. Measuring the Follow-up after an Emergency Department Visit for Substance Use (FUA) and Follow-up after an ED Visit for Mental Illness (FUM) rates led GCHP and VCMC to work together to provide onsite navigation and linkage to treatment services.

FUA – Follow-up after an Emergency Department Visit for Substance Use: The percentage of emergency department (ED) visits among persons age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Both 7-day and 30-day rates are reported.[30,31]

FUM - Follow-Up After Emergency Department Visit for Mental Illness: The percentage of emergency department (ED) visits for persons 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Both 7-day and 30-day rates are reported.

Engaging Conejo Health: Conejo Health, a community-based organization, had been providing navigation and linkage services under a state program that had shuttered the year before.[32] Learning of their SUD expertise, VCMC engaged them for this purpose, and GCHP initiated a contract for community health worker services and then Enhanced Care Management services to ensure Conejo Health could be reimbursed in a sustainable way for the important services they provide. Conejo Health's onsite services launched in March 2024, and the GCHP team used the Model for Improvement (Plan-Do-Study-Act) as a framework for implementation and improvement in the VCMC ED to improve FUA and FUM rates through improved care coordination. In 2024, the health plan set a goal of increasing the rate of follow-up behavioral health services by 5 percent for their members with behavioral health-related ED visits by June 2025.

At VCMC, the hospital informatics team created a work queue based on the eligible populations for FUA and FUM. The queue generates automatic referrals that the Conejo Health navigators access while onsite and afterward for phone call follow-ups. They have found that face-to-face interactions and telephone follow-ups are equally successful; however, the team learned there are two components to successfully engaging the member by phone:

1) ensure the ED team informs the member to expect the call and creates a tone of trust and helpfulness; and
2) calls within 24 hours are the most likely to be answered; after about 5 days, it is much harder to engage members.

Timely data exchange is key to effective care coordination. For phone follow-ups, Conejo Health and other providers need accurate contact information, which has proven challenging and is the subject of upcoming PDSA tests of change.

Conejo Health screens for mental health and substance use needs and level of acuity to determine the most appropriate provider and level of care. The team tested changes to improve the screening, handoffs during

referrals, scripting, and workflow to schedule appointments and studied the results. GCHP provides the navigators with care team information to better identify members already in treatment and who are already enrolled in intensive care coordination programs. This allows more efficient and effective coordination of care and linkage to treatment, avoiding unnecessary and duplicative screenings, referrals, and outreach attempts.

Raising the Bar: The ability to share data between the health plan and the entire care team is critical to the success of this initiative. The health plan established mechanisms to exchange discharge information among care team providers. To achieve this, GCHP used a combination of custom hospital reports and a Health Information Exchange. Because not all hospitals participate in an HIE (or do not participate in the same one), GCHP and hospitals had to find other ways to capture and exchange relevant data, including custom reports and even purchasing access to another HIE.

GCHP also implemented a quality incentive program for FUA and FUM performance with its providers and hospitals.

Conejo Health provided more than 1,700 navigation services in 2024. Through its close collaboration with VCMC and Conejo Health, and the improved care coordination that resulted, GCHP was exceeded its goal of a 5 percent increase in FUM and FUA follow-up.

The health plan's 30-day FUA rate improved from 28.3 percent in measurement year 2023 to 45.8 percent in MY 2024, putting their 30-day follow-up rate above the 50th percentile of all Medicaid plans; the 30-day FUM rate increased from 23.6 percent in MY 2023 to 61.0 percent in MY 2024, a rate that exceeded the 75th percentile nationwide.

These improvements benefit the member through better care coordination and follow-up, leading to less use of the ED as a regular source of care. The work at VCMC became the template for expansion of the program into the other hospitals in Ventura County. As of November 2025, all hospitals have engaged Conejo Health for onsite ED navigation services, greatly increasing impact for GCHP members.

Childhood Chronic Conditions

The prevalence of chronic conditions among children and adolescents is increasing, representing a significant and growing public health concern. An estimated 40% of school-aged children currently live with at least one chronic condition, a reality that can significantly affect their ability to perform everyday tasks, participate fully in school and social activities, and achieve developmental milestones.[33]

Over the past two decades, the proportion of children with chronic health conditions has increased by approximately 30 percent.[34] Although many pediatric chronic conditions are treatable or manageable, persistent disparities in access to high-quality, coordinated care can lead to worsening health outcomes. Children from households with lower socioeconomic status are more likely to experience delayed diagnoses, poorer disease management, and long-term complications.

Among pediatric chronic conditions, childhood obesity is one of the most prevalent and consequential. Approximately 1 in 5 children in the U.S. meet the clinical criteria for obesity.[35] In

households below 100 percent of the Federal Poverty Level, the childhood obesity rate is even higher—24.1 percent.[36] The annual estimated medical cost of childhood obesity was $1.3 billion in 2019.[37] Additionally, nearly 85 percent of children experiencing obesity have at least one co-occurring chronic condition,[38] and they are twice as likely to experience symptoms of anxiety and depression.[39] These overlapping physical and behavioral health challenges diminish quality of life and increase the probability that chronic diseases will persist into adulthood.

Lead exposure is another critical childhood condition with lifelong health implications. An estimated 170 million Americans have been exposed to elevated lead levels during childhood.[40] Lead exposure in children contributes to learning difficulties, impaired cognitive development, behavioral challenges, and increased risk of developmental disabilities.[41] Over time, childhood exposure can elevate the risk of adult-onset chronic conditions such as hypertension and kidney disease.[42]

Spotlight: Banner Health Plans

How Banner Health Works with Members to Address Childhood Obesity

Setting the Scene: Banner - University Family Care AHCCCS Complete Care (B - UFC/ACC) is for participants in the Arizona Health Care Cost Containment System (AHCCCS), which is Arizona's Medicaid program. B-UFC/ACC is an integrated health care system that combines both physical and behavioral health services to improve coordination of care between providers and improve health care outcomes for more than 270,000 members.[43,44]

Arizona identified addressing childhood obesity as a priority for the state's Medicaid health plans. The health plan's data indicated a higher rate of heart disease and elevated cholesterol levels in children, as well as increasing numbers of children with high Body Mass Index (BMI) readings.

In 2024, Banner Heath implemented a program to support health plan members and their families with one or more children identified as overweight on the EPSDT form completed by their health care provider at each well-child visit. Childhood obesity can lead to higher rates of diabetes and heart disease, which is the leading cause of death in the U.S.

Providing Education to Families to Reduce Childhood Obesity Rates: To identify members eligible for the *Wellness Together* program, Banner analyzes data from the EPSDT forms submitted by providers to target children with BMI readings in the 85th percentile or higher. The program also takes referrals from Banner's Maternal and Child Health team. The health plan developed a flyer about the program which is mailed to members and included a QR code to make it easy to register for the virtual series. In total, Banner mailed flyers to approximately 400 families.

The program was initially designed as a series of four virtual classes (covering topics including meal planning on a budget and how to incorporate more play and exercise into daily life through simple, actionable steps). The virtual classes were led by a dietician and exercise physiologist and offered in English and Spanish.

Based on low registration rates through the QR code, however, Banner changed strategies in mid-2025 to using an automated call campaign and offering one-on-one support. Once a family is identified as eligible for the program, the health plan calls the member to offer basic information

about the importance of addressing their child's weight (e.g., by talking to their child's doctor) as well as information about the resources and support available through Banner. During the call, the member can request to be transferred to a live person who can help them access one-on-one support from a dietician. This has been more successful in reaching members, although the program remains under-utilized: of the 400 families initially identified, they have completed about 20 sessions through October 2025. In addition to offering one-on-one sessions with health plan dieticians, Banner also partners with food banks and as well as Foodsmart, a teledietitian and nutrition vendor, to help members address food insecurity, which has been a concern for *Wellness Together* participants.

Impact: While take-up rates have been low, the health plan continues to refine the program and would like to enhance it to include group meetings for families to encourage peer support as well as reach more members. Banner Health uses a pre- and post-survey tool to evaluate whether members are implementing the healthy behaviors and lifestyle changes that are emphasized in the individual sessions.

Spotlight: CountyCare

How CountyCare Improved Drinking Water for Medicaid Members by Removing Lead

Setting the Scene: CountyCare is the only government-owned, provider-led health plan in Illinois, and it currently serves more than 400,000 Medicaid beneficiaries in the Chicagoland area. Cook County Health is one of the largest safety net hospitals in the nation, caring for 500,000 people annually and providing charity care for more than 16,000 uninsured individuals.[45]

In March 2024, Illinois U.S. Senators Tammy Duckworth and Dick Durbin sent letters to all five Illinois Medicaid Managed Care Organizations challenging them to do more to prevent lead poisoning in children.[46] CountyCare accepted this challenge, creating a program to send educational materials on lead poisoning and coupons for a Brita ELITE water pitcher and filter to all families with young children on the health plan.

CountyCare's goals for the program were to increase awareness of lead exposure in children, and to improve drinking water for Medicaid families in Illinois.

Engaging Families to Learn About Lead Exposure and Prevention: CountyCare developed a mailer to send to all eligible families enrolled with the health plan, which contained a flyer and the Brita coupon.

The flyer included information about lead exposure, the importance of safe drinking water in preventing lead exposure, and resources to keep children safe from lead exposure. It also included a QR code to apply for a local program that inspects homes for lead paint and makes repairs at no cost to the homeowner or renter. In addition, the flyer offered details on how to request that the City of Chicago test the member's drinking water for lead.

Further, CountyCare worked with its storefront vendor to offer a free Brita water pitcher and filter. The storefront vendor already stocked this item, and CountyCare reimbursed the vendor for all coupons that were redeemed. The educational flyer and coupon were mailed to all CountyCare members with a child aged 12 or younger in the household. In total, the health plan sent

nearly 90,000 flyers and Brita coupons to their members. The redemption rate was 9.4 percent with a total of 8,430 coupons redeemed. CountyCare spent about $350,000 on this lead poisoning prevention program. CountyCare also provided lead poisoning prevention education to their network of providers by sending out a notice to all providers in the health plan's network encouraging them to screen children for lead poisoning.

Outcomes and Impact: As a result of the health plan's lead education program, CountyCare achieved a 7-percentage point increase in the HEDIS measure "Lead screening in children before their second birthday" (71.5% in 2023 compared with 78.6% in 2024). CountyCare also exceeded the 75th percentile for health plan lead screening in 2024. In 2025, CountyCare was awarded an Achievement Award by the National Association of Counties for their lead poisoning prevention program.

Areas for Improvement and Next Steps: While this program was successful in reaching families, CountyCare believes a virtual coupon might be more effective than sending coupons in the mail to members. The coupon could only be redeemed at one grocery store chain, which may have limited the number of Brita pitchers and filters that were claimed. CountyCare may offer this program again in the future with a virtual coupon vendor.

Food Insecurity and Nutrition Access

In 2023, an estimated 47.4 million people in the U.S. lived in food-insecure households, primarily families with lower incomes.[47] Issues of access exacerbate this risk: an estimated 23.5 million people reside in low-income areas located more than a mile from a large grocery store, where unreliable transportation, limited vehicle access, and inadequate public transit impede access to nutritious foods.[48]

Food insecurity has direct consequences for physical and cognitive functioning. Adults experiencing limited access to food report reduced ability to perform daily tasks and maintain productivity, while children experience impaired cognitive, emotional, and physical development.[49] Evidence consistently links food insecurity with elevated risk for developing multiple chronic conditions, including hypertension, cardiovascular disease, Type 2 diabetes, and obesity. And food insecurity often exacerbates challenges in managing these conditions effectively.[50]

Many communities lack full-service grocery stores that offer fresh, nutrient-dense foods. To address these inequities, health systems and community organizations are increasingly implementing nutrition-support interventions such as medically tailored meals to improve disease management and support people with complex health needs.

Spotlight: Neighborhood Health Plan of Rhode Island

How Neighborhood Health Plan Provides Nutrition Services to Postpartum Adults

Setting the Scene: Since 1993, Neighborhood Health Plan of Rhode Island (Neighborhood) has provided high-quality, accessible, affordable health care coverage. Today, more than 220,000 Rhode Islanders turn to Neighborhood for coverage, including Marketplace plans through HealthSource RI -- with federal subsidies for most enrollees.[51]

The state of Rhode Island's current Medicaid Section 1115 waiver, which expires at the end of 2025, includes nutrition services on the list of "in lieu of services."[52] Taking advantage of the waiver and driven by Neighborhood's maternal health equity strategic plan, the plan developed a maternal meal delivery benefit. This benefit provides members with a recent inpatient discharge after childbirth up to 28 home-delivered meals and is available to Medicaid and commercial health plan members.

Partnering with Meals on Wheels Rhode Island to Address Food Insecurity: Neighborhood implemented the maternal meal delivery benefit for Medicaid in November 2023. As of January 1, 2025, Neighborhood transitioned the partnership to a local organization, Meals on Wheels of Rhode Island (MOWRI), to provide this benefit. Neighborhood identifies eligible members via authorization data and sends MOWRI a daily file. MOWRI outreaches to the eligible members within two business days to educate them on the benefit, select their meals, and schedule delivery. Menu options include Asian, Latin, Kosher, "heart healthy," and diabetic-friendly meals. Members receive 28 meals in two deliveries spaced two weeks apart. The meal delivery box includes a sticker with a QR code to Neighborhood's Women's Health page which has information on women's health benefits, recommended immunizations and screening, and maternal health programs. The box also includes information on Rhode Island's SNAP and WIC programs.

Neighborhood has found partnering with a local community-based organization to be key to the initiative's success. For example, during the initial member outreach, MOWRI conducts a two-question nutrition security screening that assesses understanding of health foods and food security.[53] Neighborhood and MOWRI review the results monthly to identify opportunities for members such as additional education needs, connection to community resources, and coordination of care with Neighborhood's care management team. The plan's members "inherently trust" MOWRI: benefit acceptance rates rose from 71 percent in 2024 to 83 percent through October 2025.

Community Impact: Through October 2025, MOWRII has provided almost 40,000 meals to 1,550 Neighborhood members. In October 2024, Neighborhood launched a "New Mom's Survey," which includes questions on member awareness of the benefit and if they utilize the benefit, their level of satisfaction. As of November 2025, 75 percent of survey respondents reported utilizing the maternal meal delivery benefit, of those 77 percent reported their overall experience with the benefit as 'Excellent' or 'Very Good.'

In March 2025, two additional questions were added: "*Did the postpartum meal benefit ensure you had proper nutritional support after childbirth?*" and "*Did the postpartum meal benefit support your recovery after childbirth?*" More than 95 percent responded "Yes."

Looking Toward the Future: Neighborhood's maternal health equity workgroup continues to evaluate the maternal meal delivery benefit and explore

potential expansion of the meal delivery benefit such as offering meals to members during the second and third trimesters, or to other subpopulations that could benefit from medically-tailored meals, such as members with diabetes. CMS, however, has asked Rhode Island to remove nutrition services from their waiver renewal application, leaving the future of Neighborhood's postpartum nutrition program, and any expansions, in question as current Medicaid rates may not allow the plan to continue this work.

Spotlight: Chorus Community Health Plans

How Chorus Community Health Plans Addressed Food Insecurity and Diabetes in the Milwaukee Metro Area

Setting the Scene: Chorus Community Health Plans (CCHP) serves BadgerCare Plus (Medicaid) and Individual and Family Plan (Federal Health Insurance Exchange) enrollees throughout Wisconsin. CCHP plans cover about 120,000 adults and children in the state.[54] In Milwaukee County, home to roughly 70 percent of CCHP's member population, nearly 3 in 10 families with children live below the poverty line, and more than 1 in 4 residents rely on SNAP benefits. Both rates are more than twice the state and national averages. Moreover, the 2022 Food Insecurity Index flagged multiple Milwaukee County zip codes as having disproportionately high levels of food insecurity, underscoring stark disparities in access to nutritious food.[55]

Food insecurity and diabetes are closely linked, as individuals experiencing food insecurity are two to three times more likely to have Type 2 diabetes.[56] Conversely, food insecurity makes condition management extremely challenging. Among CCHP's Medicaid enrollees, diabetes, hypertension, and hyperlipidemia consistently rank among the top ten chronic conditions. Diabetes carries the highest annual per-member cost for both standard Medicaid and childless adult populations, and the costs around diabetes management have continued to grow. Between 2023 and 2024, it rose from the sixth- to the fifth-most costly diagnosis group among childless adults.

Confronted with these rising costs and the growing health impact of diabetes, CCHP saw a clear need to act quickly. The urgency to act was reinforced by CCHP's Medicaid contract with the Wisconsin Department of Health Services. The contract includes performance on quality measures around diabetes and blood pressure control as factors that figure into the plan's reimbursement from the state. Taken together, these factors underscored the importance of addressing nutrition-related drivers of chronic disease head-on.

Identifying Gaps to Combat Food Insecurity: CCHP began screening members for food insecurity during new member assessments and care management visits. Using standardized questions, staff identified gaps in access to food and connected eligible members to resources such as SNAP and WIC. Over the past year, this approach generated more than 1,100 referrals, linking members to vital supports aimed at reducing food insecurity.

Building on these efforts, in 2021, CCHP launched a partnership with Foodsmart. Foodsmart offers members access to telehealth visits with registered dietitians, nutrition education, personalized meal planning, grocery price comparison tools, and online grocery ordering. Since implementation, CCHP has refined its outreach strategy to target members with

chronic conditions, particularly diabetes. Recent campaigns have demonstrated that condition-specific messaging resonates with members, yielding higher engagement rates.

Additionally, in April 2025, CCHP broadened its nutrition initiatives, rolling out "Food is Medicine" after its approval by the Wisconsin Department of Health Services. The program featured medically-tailored meals as an in lieu of services (ILOS) benefit. "Food is Medicine" is available to qualified members, including those recently hospitalized for diabetes or cardiovascular disease as well as high-risk pregnant or postpartum members.

Continuous Growth and Optimization: Enrollment in the program is currently modest, though CCHP has found room to refine and grow its approach. Early lessons include learning how to contract with non-traditional providers, streamlining claims submissions, and integrating vendor services with care management to ensure a seamless member experience. Looking ahead, CCHP intends to evaluate the program through pre- and post-claims analysis.

Reducing high-cost utilization such as emergency department visits, hospitalizations, and readmissions remains a priority. At the same time, CCHP recognizes the importance of expanding preventive and specialty care, investments aimed at lowering costs and improving long-term health outcomes.

Five Ways Policymakers Can Strengthen Chronic Care

Safety Net Health Plans serve vulnerable populations with chronic conditions, but their effectiveness depends on supportive Federal and state policy across five domains: care continuity, financial sustainability, social needs, workforce development, and payment innovation.

Ensure Continuity of Coverage and Care.

Eligibility churn, the temporary loss of coverage due to administrative issues or minor income fluctuations, disrupts care for more than a million Medicaid and CHIP enrollees annually.[57] While Congress mandated 12-month continuous eligibility for children in 2022, extending this protection to adults and requiring year-long postpartum coverage would reduce churn by approximately 30 percent, preventing 267,000 adults from losing coverage monthly.[58] Continuous enrollment enables uninterrupted access to medications and disease management for conditions like diabetes, hypertension, and substance use disorder, while reducing administrative burden and allowing plans to build long-term member relationships. Continuous enrollment also reduces monthly costs: research shows 12-month enrollees spend two-thirds as much as six-month enrollees, and diabetes treatment costs increase $239 monthly after coverage lapses.[59]

Congress should extend twelve-month enrollment periods in Medicaid to adults and provide 12 months' coverage postpartum. This would bring the program into harmony with Medicare and commercial coverage, lower monthly costs of care, and prevent adverse health outcomes.

Promote Fiscal Sustainability.

Actuarially sound capitation rates are fundamental to effective chronic care management. Accordingly, **CMS should assure that rate-setting processes between the agency, state Medicaid programs and health plans are transparent and collaborative—and that rates**

adequately reflect enrollee acuity, service utilization, and policy priorities such as expanding behavioral health capacity.

Rates must account for post-pandemic increases in acuity, rising behavioral health needs, and increased pharmacy spending to enable plans to invest in evidence-based chronic care models, including integrated behavioral health and telehealth services.

Address Health-Related Social Needs.

Many Medicaid enrollees face housing instability and food insecurity that complicate chronic disease management. Federal authorities permit states to use Section 1115 demonstrations and ILOS to cover housing transitions, medically tailored meals, and transportation.[60] But adoption remains uneven due to complex waiver processes and unclear guidance.[61]

CMS can facilitate HRSN initiatives by streamlining approval pathways, clarifying Federal guidance, and incorporating health-related social needs services into capitation rates to foster sustainable, scalable programs. Evidence demonstrates that embedding these interventions within managed care payments reduces avoidable utilization and strengthens medication adherence.[62] Partnerships with community-based organizations further improve care coordination and outcomes for complex patients.

Address the Looming Provider Shortage.

Provider shortages threaten chronic care access, with HRSA projecting a shortfall of more than 85,000 physicians by 2037.[63]

Expanding grants, scholarships, medical school capacity, and residency positions, alongside placement incentives and training that recruits from underserved communities, is essential for addressing geographic imbalances and improving long-term health system sustainability.

Don't Just Pay For Health Care; Pay For Health.

One way that CMS can help drive innovation and advancement in chronic care is to nurture payment models that shift incentives from volume to quality—health outcomes. Medicare innovations such as Special Supplemental Benefits for the Chronically Ill demonstrate how flexible benefit designs improve chronic care management.[64]

CMS has urged states to adopt these approaches through managed care contracts and demonstrations. Multi-payer reforms tested under the State Innovation Models initiative showed that advanced primary care models reduce spending, admissions, and emergency visits. Medicare's Accountable Care Organizations generated $1.8 billion in savings while improving quality in 2022.[65] Primary care redesign models like Primary Care First and ACO REACH provide population-based payments that strengthen coordination for complex patients, while bundled payment models improve care transitions and reduce costs.[66,67]

These interconnected strategies—when implemented comprehensively—create sustainable infrastructure for SNHPs to deliver high-quality chronic care to vulnerable populations.

Conclusion

The initiatives featured in this brief demonstrate how Safety Net Health Plans are not only responding to the complex needs of members with chronic conditions but are setting the standard for what effective, whole-person, community-driven care looks like. The continued success of these kinds of initiatives and programs depends on support from federal and state policymakers to ensure they can continue to be sustained and scaled. By stabilizing coverage, ensuring sustainable funding, investing in workforce development, and supporting whole-person care, these policies empower health plans to deliver high-quality, coordinated, and equitable chronic care to the populations who need it most.

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