SAFETY NET HEALTH PLANS:
CRITICAL PARTNERS IN THE HEALTH CARE SAFETY NET

Safety net health plans (SNHPs) are not-for-profit health plans that serve Medicaid, SCHIP and other vulnerable populations. These plans are an integral part of the health care safety net, providing health care for low income populations and financial, operational, and leadership support to their communities. Safety net plans have three key characteristics:

Not-for-profit (or owned by a not-for-profit health care provider)	**Focused on beneficiaries in Medicaid, SCHIP, Medicare and other government health programs**	**Sponsored or affiliated with safety net providers (like community health centers or public hospitals)**

Because of these characteristics, SNHPs are committed to the safety net and well-structured to provide health coverage to Medicaid, SCHIP and other vulnerable populations. For example:

- ***Not-For-Profit Health Plans, including SNHPs, Provide Higher Quality Care Than Do Their For-Profit Counterparts***
- ***Not-For-Profit Health Plans, including SNHPs, Have Lower Administrative Costs And Spend More On Health Care Than For-Profit Health Plans***
- ***SNHPs Have A Mission Driven Commitment To Remain With The Medicaid Program Despite State And Federal Fiscal Crises***
- ***SNHPs Reinvest Their Operating Margins In The Safety Net, Providing Financial, Programmatic And Leadership Support To The Communities They Serve***
- ***SNHPs Reinvest Their Operating Margins To Support The Uninsured And Other Vulnerable Populations***

This paper further defines the characteristics of safety net health plans and the critical contributions these plans make to the safety net. Section One describes the efficiency, quality and other benefits that SNHPs' not-for-profit structure brings to the safety net. It also highlights SNHPs mission-driven commitment to provide financial, programmatic and leadership support to the safety net, as well as SNHPs commitment to the uninsured and other vulnerable populations. Section Two provides case studies from leading ACAP SNHPs that demonstrate the financial and other contributions these plans make to the safety net.

SECTION 1: AN INTRODUCTION TO SAFETY NET PLANS

Describing the Health Care Safety Net

The Institute of Medicine defines the health care safety net as "[t]hose providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid and other vulnerable populations."[1] Core safety net providers include community health centers (CHCs), public hospitals, rural health clinics, and others. The safety net also includes a core group of health plans that are committed to improving the health of these populations.

Defining Safety Net Health Plans

ACAP defines safety net health plans as not for-profit (or not-for-profit owned) Medicaid-focused health plans that are strongly affiliated with community safety net providers. This distinguishes them from two other types of plans that serve Medicaid beneficiaries: (1) for-profit plans that focus on Medicaid and, (2) commercial plans that also cover Medicaid beneficiaries. ACAP estimates that there are approximately 90 safety net plans[2]

Figure 1: Number of Medicaid Managed Care Plans in 2004

Plan Type	# of Plans
Commercial	151
For-profit Medicaid-Focused	46
Safety Net Plans	90
Total	**287**

Source: CMS and ACAP

Many safety net plans were originally started by safety net providers, such as community health centers or public hospitals. Because of their ties to the community, they are mission-driven organizations that view themselves as partners with providers, beneficiaries, and the government, focused on a common goal of improving the health of the populations they serve.

SNHPs have three key characteristics:

- plans are not-for-profit or owned by a not-for-profit safety net provider;
- plans are focused on Medicaid, SCHIP, Medicare and other government sponsored programs; and,
- plans are sponsored or strongly affiliated with community safety net providers.

Safety Net Health Plans: Their Characteristics Are Critical To Their Success

The three key characteristics described above are critical factors in SNHPs ability to serve vulnerable populations and the providers that care for them. Some may argue that for-profit Medicaid-focused plans are preferable because they have broader access to

[1] Institute of Medicine. America's Health Care Safety net: Intact but Endangered. Washington, DC: National Academy Press; 2000.

[2] According to data from the Centers for Medicare and Medicaid Services (CMS), there were a total of 287 Medicaid managed care plans in June, 2004. Of these, approximately 151 were offered by commercial plans, and 136 were Medicaid-focused plans. Although CMS does not further differentiate between for-profit and safety net plans, ACAP estimates that there are between 80-90 safety net plans in the country.

capital and achieve better economies of scale. However, research has shown that not-for-profit plans provide higher quality of care than their for-profit counterparts and are also more efficient, experiencing lower administrative ratios. SNHPs not-for-profit structure and mission-focus allow them to remain with the Medicaid program during financially challenging times. Plans reinvest their operating margins in their safety net partners, providing financial, programmatic, and leadership support. In addition, SNHPs are committed to serving the uninsured and other vulnerable populations that have difficulty accessing serves.

Not-For-Profit Health Plans Provide Higher Quality Care Than Do Their For-Profit Counterparts – In a study entitled Quality of Care in Investor-Owned vs Not-For-Profit HMOs, Dr. David Himmelstein from Harvard Medical School and his co-authors analyzed data from the National Committee for Quality Assurance's (NCQA) Quality Compass 1997. In this study, they compared a total of 329 HMOs, 248 were investor owned and 81 were not-for-profit. Collectively, these HMOs represented 56% of total HMO enrollment at the time of the study. They compared the HMOs across 14 quality of care indicators, and found that investor-owned plans had lower rates for all 14 quality of care indicators (after controlling for model type, region, and method of data collection). The largest differences were in measures focused on patients with serious medical illnesses. For example, among patients discharged from the hospital after a myocardial infarction, 70.6% of not-for-profit patients filled a prescription for beta blockers vs. only 59.2% of patients in investor-owned HMOs. Not-for-profits also had higher scores on all routine preventative services in the study. For example, the immunization completion rate for 2-year olds in not-for-profit plans averaged 72.3% vs. 63.9% for investor-owned plans.

In another study released in December 2005, Dr. Eric Schneider, M.D., M.Sc., and his Harvard colleagues published Quality of care in for-profit and not-for-profit health plans enrolling Medicare beneficiaries. This study included the 1997 HEDIS submissions for 231 health plans enrolling 283,249 Medicare beneficiaries. The authors analyzed four measures of quality of care: breast cancer screening, use of beta blockers after myocardial infarction, diabetic eye examinations, and follow-up after hospitalization for mental illness. The authors found that, on average, quality of care was lower on all four clinical measures, with for-profits scoring 7.3 percentage points lower than not-for-profits on breast cancer screenings, 14.1 percentage points lower on diabetic eye exams, 12.1 percentage points lower on beta-blockers administered after heart attack, and 18.3 percentage points on follow-up after hospitalization for mental illness. All these differences were statistically significant. The authors found that these results persisted even after adjusting for sociodemographic factors, geographic variables, and health plan differences (the differences remain significant for all measure except beta blockers).

The authors conclude that "for-profit health plans provide lower quality of care than not-for-profit health plans." They also note that their findings are "..not only consistent with

prior research but also reinforce the concern that financial incentives of for-profit plans lead to less aggressive efforts to manage the quality of care."[3]

Not-For-Profit Health Plans Have Lower Administrative Costs and Spend More on Health Care than For-Profit Health Plans – Dr. Robert Hurley, a leading expert on Medicaid managed care, recently completed an analysis of the financial performance of Medicaid managed care plans in a study titled Financial Performance Indicators for Health Plans in Medicaid Managed Care. In this study, Dr. Hurley found that not-for-profit plans spent more of each premium dollar on medical expenses than their for-profit counterparts, and spent less on administrative expenses. In this analysis, he looked at the medical benefit ratio, which measures the proportion of every premium dollar spent on medical services, and the administrative cost ratio, which measures the proportion of each premium dollar spent on Medicaid administrative costs. Finally, he looked at the operating margin, which measures the proportion of operating profits (revenues minus medical and administrative expenses) generated on each premium dollar. His study found that, in 2001, not-for-profits spent 87.92% of premium revenues on medical services, versus 84.06% for for-profits. He also found that not-for profits spent only 9.01% on administrative cost versus 11.08% for for-profits. (See figure 1)[4] In his discussion, he notes that "both for-profit and not-for-profit, Medicaid-focused plans were profitable and achieved similar profit margins..[h]owever, for-profit plans incurred significantly higher administrative costs, suggesting they are not achieving their profit through greater administrative efficiencies."[5]

Figure 2: Financial Performance of Medicaid Focused Plans by Ownership

Financial Performance	For-Profit	Not-For-Profit
Medical Benefit Ratio	84.06%	87.92%
Administrative Cost Ratio	11.08%	9.01%
Operating Margin	3.58%	3.40%

Dr. Himmelstein's et al found similar results in their study titled Quality of Care in Investor-Owned vs Not-For-Profit HMOs discussed above. In particular, they found that the medical loss ratios averaged 80.6 % in investor owned HMOs and 86.9% in not-for-profits. They also found that spending on profit and overhead was about 48% higher in investor-owned plans (19.4% vs 13.1% for not-for-profit plans).

SNHPs Have A Mission Driven Commitment To Remain With the Medicaid Program Despite State and Federal Fiscal Crises – Safety net plans do not have to answer to outside investors on a quarterly basis or make decisions based only on the bottom line.

[3] Schneider, Eric C., Alan Zaslavsky, and Arnold Epstein, Quality of care in not-for-profit health plans enrolling Medicare beneficiaries, The American Journal of Medicine, Volume 118, Issue, 12, pages 1392-1400.
[4] McCue, Michael and Robert Hurley, Financial Performance Indicators for Health Plans in Medicaid Managed Care, Managed Care Quarterly, 12(1), 2004, p. 20.
[5] McCue, p. 21.

For profits, on the other hand, require a significant ROI to participate in the program. As highlighted in an industry analysis by Lehman Brothers, there is "..widespread recognition that the successful new publicly traded Medicaid-focused firms have engaged in careful, systematic appraisal of the states into which they have chosen to enter and/or expand."[6] In short, for-profits are only willing to enter and stay in Medicaid in the most lucrative states. SNHPs, however, generally operate in only one state, [7] and as such are very focused on and committed to serving the beneficiaries, public programs, and provider communities in their state.

This distinction between mission-driven and margin-driven plans is particularly important now that most states are experiencing serious budget crises that are impacting their Medicaid programs. Lewin Group recently completed a survey of Medicaid managed care plans for ACAP and Medicaid Health Plans of America. They found that 33 percent of plans responding "..indicated that payment rates are explicitly budget-driven. Another 17 percent of the plans (in 20 percent of the states) said that budget constraints [are].. used in the rate development process."[8] This means that when these states face a budget crisis they will set Medicaid payment rates based on the availability of funds rather than the true cost of providing health care. In the past, for-profits have choosen to exit the market when payment rates decline. This was evident during the late 1990s, when many commercial health plans that offered Medicaid managed care began exiting the program due, in part, to lower than expected payment rates. As described by Michael Sparer, Lawrence Brown and others, "[o]ver time..many of the commercial plans have exited the Medicaid market, while the safety net plans have become increasingly central." [9]

SNHPs Reinvest Their Operating Margins in the Safety Net, Providing Financial, Programmatic and Leadership Support to the Communities They Serve - Not-for-profits and for-profits measure their success differently, and this dictates how they commit their resources. As described by Marcia Metcalf, in "Advancing the Role of Nonprofit Health Care":

> For-profits are legally and ethically responsible to their owners and/or stockholders, and are obligated to do well for the benefit of these owners; where markets function well, financial success will follow. Performance of for-profits can be measured most simply by profitability and return on equity for shareholders. Nonprofits, on the other hand, are directly responsible and accountable to the communities and populations they serve, and are legally and ethically bound to do "good" for the benefit of their communities. Therefore,

[6] Lehman Brothers Equity Research, Industry Update, June 9th, 2005.
[7] A few plans do operate in multiple states, but the large majority operate in only a single state.
[8] Lewin Group, rate Setting and Actuarial Soundness in Medicaid Managed Care, p. 16.
[9] Sparer, Michael, Lawrence Brown et all, Promising Practices: How Leading Safety Net Plans Are Managing the Care of Medicaid Clients, Health Affairs, September/October, 2002, p. 284.

> nonprofits must measure their performance in terms of their quantifiable contributions to the public good of the communities they serve. [10]

SNHPs reinvest their operating margins in the community, often in programs to improve health care services or expand access to health care. For example, SNHPs may invest in care management initiatives, patient satisfaction initiatives and pay-for performance programs that help providers improve their quality of care. They may invest in new technologies or provide other technical assistance to providers to improve efficiency. They may lead community-wide initiatives to address problems of access to care. They also invest their operating margins in reserves to ensure that there are resources available for the providers and beneficiaries they serve, even during financial downturns and state budget crises. Many examples of the community investments made by ACAP SNHPs are outlined in section two.

SNHPs Reinvest Their Operating Margins to Support the Uninsured and Other Vulnerable Populations – Safety net plans share similar missions to their provider partners – to improve the health of vulnerable populations. Many of these plans invest significant financial and in-kind resources to reach out to the uninsured, the homeless, and other groups that have difficulty accessing health care services. Many plans partner with CHCs and other safety net providers to establish and/or support programs that serve the uninsured. Plans provide financial support for these initiatives in a variety of ways, including through the direct commitment of plan surpluses and by securing grants from the state, foundations, and other non-profits.

SECTION TWO: ACAP PLANS' CONTRIBUTIONS TO THE SAFETY NET

As demonstrated above, safety net health plans are uniquely qualified to provide health care coverage for low-income populations. As mission driven entities, SNHPs are also deeply committed to the safety net, and share a common goal with other safety net participants – to improve the health of vulnerable populations. Their mission, combined with their not-for-profit status, enables them to contribute more to the safety net than their for-profit counterparts. Section two provides examples of some of the programs and practices that demonstrate this commitment to the safety net, accompanied by case studies from ACAP health plans. The section begins with an introduction to the ACAP membership, followed by examples focused on four areas: spending on health care services provided by safety net providers, their additional financial and in-kind investments in safety net providers, their commitment to the uninsured, and their leadership as conveners of safety net stakeholders focused on addressing the health care crises of vulnerable populations.

[10] Metcalf, Marcia. Advancing the Role of Nonprofit Health Care. Inquiry, The Journal of Health Care Organization, Provision and Financing. Vol. 39, No. 2; Summer 2002.

Facts and Figures on ACAP Plans
ACAP membership includes 26 of the leading safety net plans in 15 states. Enrollment in ACAP plans ranges from boutique plans of a few hundred members to almost 800,000. Plan revenues range from $46 million to $1 billion.

The examples included in this section are from ACAP health plans across the country. While no two plans are exactly alike, these examples present a good picture of the kinds of investments ACAP plans make in their local safety nets.

Figure 3: ACAP Members (Plan enrollment as of December 1, 2005)

Plan	State	Number of Beneficiaries
Affinity Health Plan	NY	204,540
Alameda Alliance	CA	88,062
Alohacare	HI	48,392
BMC HealthNet	MA	156,565
CareOregon	OR	101,377
CareSource	OH	493,587
Colorado Access	CO	133,566
Commonwealth Care Alliance	MA	970
Community Choice Health Plan of Westchester	NY	18,266
Community Health Plan of Washington	WA	220,241
Community Health Plan of CT	CT	84,929
Contra Costa Health Plan	CA	60,033
Health Plus	NY	268,000
Health Right, Inc.	DC	13,408
Hudson Health Plan	NY	55,153
LA Care	CA	794,449
MDWise	IN	116,389
Medically Fragile Children's Program	SC	~100
MercyCare	AZ	287,589
Monroe Plan for Medical Care, Inc.	NY	87,809
Neighborhood Health Plan of Massachusetts	MA	127,273
Neighborhood Health Plan of Rhode Island	RI	74,777
Network Health	MA	74,153
Santa Clara Health Plan	CA	95,332
Total Care	NY	22,772
Virginia Premier Health Plan, Inc.	VA	102,926
TOTAL		3,730,558

Spending on Primary Health Care Services

Safety net plans rely extensively on CHCs and other safety net providers to deliver primary health care services to their beneficiaries. In a 2004 ACAP member survey, ACAP plans reported on the percentage of their beneficiaries that use CHC-based

providers. While the figures vary on a plan by plan basis, the percentages ranged from 10% up to 75%, with a median percentage of 45%, reflecting a high dependence on CHC-based providers. These figures are even higher when they include other safety net providers such as public hospitals and community based practices with large safety net patient bases. Plan's reliance on CHCs translates into significant revenues for the health centers. Individual plans reported providing CHCs anywhere from $2 million to $73 million annually in revenues. Below are two examples of plan's spending on primary care services provided by safety net providers:

Case Study #1: Community Health Plan of Washington Spending on Primary Care Services in 2004

CHPW spent just over $31 million on the primary care services of safety net providers. This spending went to provide care for approximately 78% of CHPW's 136,000+ Medicaid and SCHIP beneficiaries, as detailed below:

Provider Type	# of enrollees	% of enrollees	Spending
CHCs	77,396	55%	
Hosp based	13,362	9%	
Non-hosp based	19,063	14%	
Total	109,821	78%	$31,028,524

Case Study #2: Hudson Health Plan Spending on Primary Care Services in 2004

Hudson Health Care spent over $6 million on the primary care services of safety net providers. This spending went to provide care for 40% of Hudson's 55,000+ Medicaid, SCHIP and Family Health Plus beneficiaries, as described below:

Provider Type	# of enrollees	% of enrollees	Spending
CHCs	14,811	27.4	
Hosp based	6,807	12.6	
Non-hosp based	N/A	0.0	
Total	21,618	40.0	$6,382,259

Other Financial and Programmatic Investments in the Safety Net

ACAP plans frequently invest in quality initiatives in partnership with safety net providers. These initiatives include care management services, patient satisfaction incentive programs, pay-for-performance, and technology investments, to name a few. In

addition, plans secure grants from the State, foundations, and other sources that support safety net providers, as well as offering technical assistance to providers that are applying for grants.

Care Management Initiatives Built On Trust - Almost all Medicaid Managed Care plans have disease management or other programs to help manage certain populations, such as those with chronic illnesses. Many of the initiatives managed by safety net plans, however, require intensive cooperation between the plans and providers, including the sharing of financial data, coordination among plan and provider staff, and the development of outcomes measures. When senior plan staff were asked what makes these programs work, they answered that the key was trust, born out of the fact that the plans, like the providers, were mission-driven not-for-profits who put beneficiary health, not profits, first.

Case Study #3: Monroe Plan for Medical Care's "Healthy Beginnings"

Monroe Plan developed a "Healthy Beginnings" prenatal care program that has reduced NICU admissions rates from a baseline of 107.6 admissions per 1000 births in 1998 to 34.9 admissions per 1000 births in 2004. The program's success is due in large part to Monroe Plan's work with CHCs and other community-based organizations. For example, Monroe Plan identified that is critically important for providers to complete a thorough risk assessment of pregnant patients and provide the results to the plan. However, these assessments are time consuming and costly. Monroe Plan therefore developed a program that reimburses providers $50 if they complete and submit a prenatal registration form in the first trimester, $30 in the second trimester, and $20 in the third trimester. In addition, if the registration form is never submitted, payment for the provider's prenatal, delivery and post natal services are not eligible for reimbursement. Monroe Plan also contracts with a local community based social outreach program, called BabyLove, that offers home visits, arranges transportation, and connects high-risk women with needed support services. Monroe Plan has invested almost $1 million in developing and implementing this program, and has realized a savings of $1.8 million, resulting in a saving-to- cost ratio of 2.03. More can be read about Healthy Beginnings in The American Journal of Managed Care[8].

Case Study #4: CareOregon's Care Support and System Innovation

Care Oregon has developed a program called the Care Support and System Innovation (CSSI) Program. This program, which is 100% funded from CareOregon capitation revenues, funds projects initiated by safety net clinics and other providers that address the Institute of Medicine aims for high-quality care: safe, effective, efficient, patient-centered, equitable, and timely. CareOregon invested almost $2.5 million in 2004-2005 for programs focused on access to care, care coordination, case management, health education and patient safety.

[8] Stankaitis, Joseph, Howard Brill and Darlene Walker, "Reductions in Neonatal Intensive Care Unit Admission Rates in a Medicaid Managed Care Program," The American Journal of Managed Care, Vol 1, No.3, 2005.

Case Study #5: Network Health's Integrated Care Management

Network health has a comprehensive array of care management programs that allow them to provide integrated care to all their beneficiaries. These programs not only provides care support for patients' medical needs, but also addresses a patients' mental health needs and the social barriers that can make it difficult for people to access needed health services. Along with a pharmacy benefit, their programs include:

- **Integrated Care Management (ICM) -** weaves in-house social, medical, and behavioral health care management services together with pharmacy **s**ervices to produce an interdisciplinary approach to care coordination for complex cases, working with the member's primary care provider.
- **Social Care Management** – aims to eliminate the social issues and stressors that can impact a member's health and/or ability to access health care, such as the lack of transportation or phone service, which limits the ability to access medical appointments and pharmacy needs.
- **Medical Care Management** – provides specialized care coordination for members with catastrophic, medically complex, potentially high-risk conditions.
- **Behavioral Health's in-house Care Management** – provides mental health care and substance abuse assistance in addition to specialized services to assist mentally ill high-risk members.

Due largely to Network Health's in-house integrated care management team and clinical affairs staff, Network Health has seen improved outcomes for members while at the same time realizing reduced medical expenses. For example, Network Health's mental health inpatient days have declined from 196.58 in FY 2000 to 91.12 in FY 2005.

Patient Satisfaction Initiatives That Help Safety Net Providers Get Results **–** Many safety net plans work closely with their provider partners to improve patient satisfaction. Plans often invest both financially to reward providers and compensate them for their time and through in-kind contributions to help providers act on the results.

Case Study #6: Neighborhood Health Plan of Rhode Island's Patient Satisfaction Incentive Campaign

During the 2003/2004 contract year, *NHPRI's* included an incentive for each community health center to document existing member satisfaction-related initiatives or planned initiatives. They also included an incentive for CHCs to collect a minimum of 45 Bureau of Primary Health Care patient satisfaction surveys which were then reviewed with each CHC. Payment was distributed as outlined below:

Measure	PMPM Payment
Documentation of existing member satisfaction initiatives or planned initiatives	$0.20
Minimum of 45 completed BPHC surveys per individual site	$0.37

Results of this incentive campaign were very successful. NHPRI's Visit-Based Member Satisfaction Survey showed that overall satisfaction levels significantly improved from 2003 for all measures. The plan's overall performance was driven by improvements made by CHCs as part of their member satisfaction initiatives. Some highlights were:

- Over nine in ten respondents would recommend their doctor to others (94.9%) and were satisfied with their visit overall (94.8%).
- NHPRI's members are most satisfied with the courtesy and professionalism of the nursing staff (97.8%) and the courtesy and respect of office staff (97.6%).

The 2004/2005 NHPRI/CHC contract includes an incentive allowing each CHC to develop and carry out a targeted satisfaction improvement project to address issues specific to their practice.

Pay for Performance Programs That Distribute Funds Back to Safety Net Providers – Some safety net plans have developed pay for performance programs that reward providers for good quality care. In Michael Sparer and Lawrence Brown's Promising Practices: How Leading Safety-Net Plans Are Managing The Care Of Medicaid Clients, the authors feature the pay-for-performance programs of two ACAP plans: Neighborhood Health Plan of Rhode Island and CareOregon. NHPRI's program allows participating health centers to earn up to $4 per member per month for practices such as completing a Joint Commission on Accreditation of Healthcare Organizations (JACHO) application, submitting encounter data electronically, offering expanded office hours, and other process improvements. CareOregon distributes part of any year-end surplus back to primary care clinics based on performance against certain quality indicators, which just a few years ago amounted to $3 million a year.[9]

[9] Sparer, p. 286.

Case Study # 7 : Hudson Health Plan's Supporting Excellence Program

Hudson Health Plans has developed a number of pay-for-performance initiatives that reward safety net providers for good outcomes, including:

- Quality Incentive Bonus Program – Provides bonus payments to providers for their scores on the New York State Quality Assurance Reporting Requirements (QARR), New York's annual Medicaid managed care quality audit that is based on HEDIS;
- Diabetes Bonus Program – Rewards providers for performance on diabetes care measures;
- Immunization Bonus Program – Rewards providers for each fully and timely immunized two year old in their panel;
- Perinatal Care Bonus – Offers incentive payments to providers for early registration of pregnant women into their prenatal care programs, and for post-partum care.

Joint Marketing Between Safety Net Health Plans and CHCs **–** Many CHCs have strained financial resources which limits their ability to communicate with their patients. Safety net plans work with CHCs and other safety net providers to determine what marketing and other communications programs CHCs believe would benefit their patients, and then the plans provide financing, technical expertise and implementation assistance with these efforts.

Case Study #8: Neighborhood Health Plan's Community Health Center Co-Branding

Over the past 4 years Neighborhood Health Plan (NHP) has launched a series of "mini-campaigns" designed to promote NHP and their partner CHCs to the diverse communities they serve. They have targeted a number of areas where they have retention specialists at their partner CHCs to further support these outreach efforts.

The goals of the campaign are to:

- Promote the benefits of the partnership between NHP and the community health centers by showcasing the doctors/providers in the network,
- Promote access to quality healthcare, and to;
- Personalize their beneficiaries healthcare through the CHC providers.

They rely on multiple media, including transit (buses, metro), outdoor (billboard, one-sheets), news print, radio, and television and various member collateral, and deliver these campaigns in multiple languages, including, English, Chinese, Haitian Creole, Spanish, Portuguese and Vietnamese.

Case Study # 9 : Hudson Health Plan PCP Recertification Post Card Project

Hudson Health Plan partnered with four Community Health Centers to help improve the renewal rate for its government program enrollees. Based on information that suggests enrollees in insurance programs pay more attention to correspondence that comes from their health care professional rather than their health insurer, HHP partnered with four Community Health Centers to coordinate a postcard renewal notification program. HHP designed and mailed post cards to the patients of the Health Centers that were due to renew their annual coverage in HHP. The postcards, which are sent on a monthly basis, were designed to look as if they are coming from the Community Health Centers and include a message about the importance of maintaining coverage.

Investments in Technology That Benefit Providers – Plan investments in technology help both plans and providers improve quality and efficiency. Plans often work with providers to determine where information technology investments will make the most difference, whether systems should be developed in house, and which vendor to work with.

Case Study #10: Colorado Access's Information Technology Systems

Colorado Access has invested in multiple systems that support safety net providers by improving efficiency, enhancing access to information, and improving quality. Some of these investments include:

Technology	
Provider Portal	• **Description**: Communication platform that enables real-time communications between the plan and safety net providers • **Benefit**: Will increase efficiency and improve care management by providing enhanced eligibility verification capabilities, claims inquiries, service authorization submissions, and other features. • **Investment:** $75,000 to install and $250,000 annually
ePocrates Pharmacy Formulary Tool	• **Description**: Clinical and formulary hosting service using handhelds or PCs to give providers access to drug information • **Benefit:** Increases efficiency by giving providers real-time access to the formulary and drugs requiring pre-authorization • **Investment**: $15,000 annually
Electronic Medical Records	• **Description:** Electronic Health Record/Enterprise Practice Management system (EHR/EPM)under development in partnership with a community-based health delivery system • **Benefit:** Will increase efficiency, quality and access to information for safety net providers. • **Investment:** TBD
Electronic Funds Transfer (EFT)	• **Description:** Electronic funds transfer and Electronic Remittance Advice for claims payments to Community Health Centers to improve practice cash flow and automate cash posting processes into the Enterprise Practice Management system. • **Benefit:** Reduces practice administration costs and increases accuracy of payments • **Investment:** TBD
Credentialing Software	• **Description:** Credentialing and recredentialing software developed at the request of providers to improve turnaround time. • **Benefit:** Reduced credentialing time by more than 50% and significantly improved satisfaction of CHCs • **Investment:** $5,000 annually

Grant Funding That Benefits Safety Net Providers – Safety net health plans also increase the financial resources of the safety net by securing grants that allow providers to, for instance, invest in process improvements, or cover services outside the normal benefit package, or study different models of care.

Case Study #11: Neighborhood Health Plan of Massachusetts' "Campaign for Excellence"

NHP has sponsored a major grant initiative for investments in CHCs over the past few years. Beginning in 2001, in collaboration with the Massachusetts League of Community Health Centers, NHP secured $21.4 million in grant funding from the state for a "Campaign for Excellence" designed to enhance the capacity of CHCs. Initiatives under this grant include access to primary care, use of preventative health care, access to urgent care, and integration of behavioral health and medical services. This program is currently in the third year of operation and includes all CHCs affiliated with NHP.

Case Study #12: Colorado Access's Research Grants

Colorado Access has been awarded a number of research grants that provide funds for the plan and its partnering CHC and other providers to study different models of care. For example, Colorado Access was awarded a three-year Robert Wood Johnson grant to study depression in primary care settings, a three-year grant with the Caring for Colorado Foundation to improve the treatment of depression in primary care settings (Pueblo, Colorado) and a grant from the Center for Health Care Strategies for an asthma care management program.

The results have been impressive. Both of the depression programs have seen a 20% reduction in emergency room visits, a 70% reduction in inpatient admissions and a 24% decrease in overall PMPM costs for those members. The programs have also demonstrated a 34% decrease in depression scores. Initial outcomes for the asthma program show a significant decrease in both emergency room and inpatient admissions as well as a decrease in overall PMPM costs for these members.

Technical Assistance To Providers Seeking Grant Funding – Many safety net plans provide significant staff time and other resources to help partners secure grant funding. Some plans provide this support on an ad hoc basis, while other plans have staff dedicated to supporting provider's grant initiatives.

Case Study #13: CareOregon's Community Relations Representative

CareOregon employs a Community Relations Representative that works closely with safety net clinics and the Oregon Primary Care Association to identify funding opportunities, areas of collaboration, and advocacy for the medically underserved. CareOregon's Provider Services Department also works with clinics to identify areas of administrative and technical efficiencies. CareOregon estimates that they devote approximately 1.25 FTE to these efforts.

Case Study #14: Neighborhood Health Plan of Massachusett's Dedicated Technical Assistance Team

In 1996, Neighborhood Health Plan established a Health Center Technical Assistance Team that currently includes two FTEs. Community health centers may request a team consult to obtain help with enhancing patient services, strengthening fiscal performance or improving the care process. Consults are confidential and free of charge. Solutions are tailored to the needs of each health center and the patients it serves. Some of the most popular requests have involved telephone call handling, patient visit flow, access to primary care appointments and patient registration.

Support for the Uninsured and Other Vulnerable Populations

Support for the Uninsured - Many ACAP plans provide support for the uninsured as part of their mission. Some do this by dedicating surplus dollars to programs for the uninsured, or by seeking out grants to cover the uninsured. Still others provide direct contributions to safety net providers

Case Study #15: Community Health Plan of Washington's Commitment of Financial Surplus and In-Kind Support for the Uninsured

CHPW has a strong commitment to supporting the uninsured. The CHCs share in CHNW's net excess funds, if any, resulting from the difference between projected and actual expenses. The CHCs in turn use those funds to, among other things, expand care and services to the uninsured. In addition, CHPW staff support grants sought by CHC or community entities that will enhance care for the under or un-insured. They provide technical expertise, information, and, when requested, leadership. For example, they recently assisted one of their CHCs with a HRSA grant to establish a program to assure access to care for the uninsured, establish a Senior Services Resource Center and a Community Mental Wellness Center.

Case Study #16: Virginia Premier Health Plan and Virginia Coordinated Care for the Uninsured

Virginia Premier provides the infrastructure for the Virginia Coordinated Care (VCC) program for the uninsured. This program had over 16,000 enrollees in 2004, and leverages state funds for indigent care as the major funding source. This program uses managed care principles to provide care for uninsured individuals served by the Virginia Commonwealth University (VCU) Health System. The Health System has placed an emphasis on shifting VCC patients to community practices, including the six community safety net providers that partner with VCU. Between the 2002 and 2004, the number of enrollees using community physicians for primary care rose from 5,500 to 8,000.[10]

Case Study # 17: The Children's Health Initiative of Greater Los Angeles

The Children's Health Initiative of Greater Los Angeles (CHI) was co-convened by L.A. Care Health Plan, the California Endowment, and the Los Angeles County Department of Health Services in mid-2003, and has grown into a coalition of more than 50 executives, including health care providers, private employers, business leaders, advocacy groups, foundations, public health officials, and educators The coalition launched a three-year program to expand the local Healthy Kids program to children age 6-18 and sought to cover 150,000 uninsured children in Los Angeles County through a combination of helping eligible children to enroll in Medi-Cal (Medicaid) or Healthy Families (SCHIP) as well as Healthy Kids (a program for children ineligible for Medi-Cal and Healthy Families with family incomes below 300 percent of the federal poverty level).

Enrollment into the Healthy Kids program has been more rapid than expected, requiring the coalition to implement an enrollment hold or "waiting list" on the Healthy Kids 6-18 program in June 2005. Enrollment in Medi-Cal, Healthy Families, and Healthy Kids 0-5 is not affected, since these programs have dedicated funding streams. To date, the coalition has raised $100 million to fund the Healthy Kids 6-18 expansion and continues to raise funds to finance coverage for Healthy Kids members already enrolled so that they will remain insured over the three-year life of the program—April 2007. In addition, the coalition is pursuing policy change to provide sustainable health care coverage for all low-income children.

Support for Other Vulnerable Populations – SNHPs have extensive experience in caring for vulnerable populations. As such, States often turn to them to create health insurance programs for populations that have never been covered and may be difficult to serve. Frequently, no other plan is willing to serve these populations, and it is SNHPs that step up and provide the coverage and care for these groups.

[10] National Association of Public Hospitals and Health Systems, "Managing Care for Uninsured Patients"

Case Study # 18: Community Health Plan of Washington's General Assistance Unemployable Program

The General Assistance Unemployable (GA-U) program is a Washington State-funded cash and fee-for-service medical assistance program for persons who are physically and/or mentally incapacitated and unemployable for more than 90 days. Clients have traditionally struggled to access needed medical services and providers, which has led to poor outcomes and high costs for the state. In 2005, CHPW entered into an agreement with the Health and Resources Services Administration (HRSA) to administer a managed care pilot for GA-U clients in two counties to reduce inappropriate use of pharmaceuticals and overutilitzation of hospital emergency rooms, and to facilitate more appropriate and timely use of specialists.

Case Study #19: Neighborhood Health Plan of Rhode Island's Program for Children with Special Health Care Needs

In 2001, NHPRI with Beacon Health Strategies, a managed care organization specializing in behavioral health, created a specialized program for children with behavioral health problems, such as alcoholism, depression, and other illnesses. NHPRI recognized that, for many of these children, psychiatric hospital and ERs were not the best option, but were the only one parents or guardians of kids in crisis felt they could turn. NHPRI and Beacon created a program to offer these families better options, including:

- **Acute Residential Treatment Service (ARTS)** –provides complete psychiatric evaluation and treatment on a 24-hour basis in a safe secure setting.
- **Community Based Partial Hospital (PHP)** – a community based treatment alternative for children who have a supportive home to return to in the evening.
- **Multiple Outpatient Alternatives** – including intensive outpatient services and services that are offered either in office based settings or in members' homes.
- **Psychiatric Response Network (PRN)** - delivers psychiatric evaluation and treatment services to children and adolescents in the custody of DCYF

To date, NHPRI has recognized quality of care improvements and estimates a savings of over $1M from these initiatives.

Leaders for Safety Net Initiatives

ACAP plans often assume leadership roles for safety net initiatives, either because they initiate a program or because they are selected to run a program by the state, grantor, etc. As explained by NHP leadership (who, as described above, was selected to run a $21.4 million "Campaign for Excellence)" safety net health plans are good leaders of collaborative efforts because they can ensure accountability for funds, measure outcomes, and coordinate and organize outreach efforts.

Case Study #20: Monroe Plan for Medical Care's Safety Net Initiative

Monroe Plan, in partnership with the Finger Lakes Health Systems Agency (FLHSA) and the office of NY State Assemblyman David Gantt, received funding from the NY State Legislature to identify and implement ways to improve the safety net system in the northeast part of Rochester, NY. This funding supports process improvements within the safety net practices including open access scheduling, planned care, and the streamlining of other practice processes. Monroe Plan was selected to lead this initiative because they had the skills to assist CHCs and others in process and clinical improvements and they had the trust of the provider community

Case Study #21: Neighborhood Health Plan of Rhode Island's Workgroup Model

NHPRI has initiated multiple working groups with other safety net providers to address quality improvement, member satisfaction, and other issues. For example, they initiated the Member Satisfaction Workgroup (MSW) with the goal of improving member satisfaction with their patient visit experiences and the Plan's administration of their health care benefits. The MSW is comprised of key NHPRI departmental staff, network provider representatives (CHC and private practice staff), and members, and allows for the identification of pervasive causes of member dissatisfaction and the assurance that appropriate interventions take place to address these problem areas.

Case Study #22: Save Health Care in Washington

Community Health Plan and Community Health Network of Washington engage state legislators through Save Health Care in Washington , a grassroots organizing program designed to protect and expand affordable health care by educating and activating state residents on health care decisions. Since 2003, the Save Health Care in Washington program has made it easy for CHC staff and patients, as well as regular citizens concerned about health care, to make contact with their legislators In 2005 Save Health Care in Washington mobilized more than 8,700 people to send 40,000 messages to their legislators and the governor, 25% of which were generated in the clinics. These messages led to the restoration of funding cuts made in 2003 that hurt children of the working poor and Washington's health care safety net. (See www.savehealthcareinwa.org)

Conclusion

As can be seen above, safety net health plans make extensive financial, programmatic and leadership contributions to the safety net. They provide higher quality care and are more efficient than their for-profit counterparts. Their not-for-profit status, programmatic focus, and deep ties to the safety net make them ideal choices to provide health care coverage and services to Medicaid, SCHIP and other vulnerable populations.