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Uneasy Alliances: Managed Care Plans Formed By Safety-Net Providers

Will Medicaid managed care be a nail in the coffin or a healthy stimulus for safety-net providers and plans?

by Michael S. Sparer and Lawrence D. Brown

PROLOGUE: Providers have had overwhelmingly discouraging experiences when they have attempted to take control of their own destinies by assuming health plan functions. Provider-sponsored organizations (PSOs) in Medicare and commercial physician practice management firms (PPMs) represent two high-profile variations on a common theme: Restricting reimbursement and utilization of care is painful, even if you do it yourself.

Similarly, when safety-net providers band together to meet the challenges of Medicaid managed care, tensions between finance and delivery of care persist, albeit in new forms. The demanding public missions of the sponsoring organizations complicate the task in unexpected ways, as Michael Sparer and Larry Brown explain in a paper that sorts out the conflicting imperatives faced by safety-net plans in Denver, New York, Kansas City, and Boston. Unlike their commercial counterparts, though, these plans can’t walk away.

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ABSTRACT: Health care providers that have traditionally served the poor are forming their own managed care plans, often in alliance with local safety-net peers. These alliances make it easier to raise needed capital, increase the pool of likely enrollees, and enable plans to benefit from efficiencies of scale. At the same time, however, the alliances often are undermined by conflicts of interest among the different sponsors and between the sponsors and the plan. This paper suggests that these plans are most likely to do well when the state makes special efforts to help and when plans have the leadership and financial reserves to take advantage of their supportive state policies.

Now that Medicaid is wedded closely to managed care, providers must calculate carefully the impact of the new managed care “game” on their missions and budgets. Among the providers most powerfully and poignantly challenged by Medicaid managed care are those in the so-called safety net (mainly public and nonprofit hospitals, community health centers, and clinics that serve large numbers of Medicaid and uninsured patients). These providers are now compelled to pitch their wares to managed care organizations, many of them newcomers to the Medicaid program, that are determined to bargain hard and contract selectively with “efficient” providers. Some of these providers labor to make themselves attractive to the health plans now in the Medicaid market. Others launch health plans of their own, often in alliance with safety-net peers in their communities.

How safety-net health plans fare in Medicaid managed care markets is of more than academic or ideological import. Insofar as managed care fails to keep its promise to supply better access to a broader range of good providers, traditional safety-net providers will be expected to save the day. Meanwhile, the safety net delivers care of first and last resort to that 20 percent or so of the nonelderly population that has no health insurance. In this paper we try to illuminate this pressing policy issue by exploring the obstacles and opportunities that four safety-net plans have encountered as they work to win Medicaid market share.

An Unsettled Policy Context

Health care providers that serve large numbers of low-income and uninsured patients face changing times. Government policies that affect these facilities have shifted dramatically. In the late 1980s federal officials required states to increase the Medicaid reimbursement paid to most safety-net providers, to give supplemental funds to hospitals that served a disproportionate number of the poor, and to pay (federally licensed) community health centers (CHCs) the actual cost of patient care (an amount generally above previous fee schedules). These provisions gave safety-net providers extra funds...
to cope with the rising number of uninsured persons.

Within less than a decade Congress had scaled back or repealed most of these mandates. The Balanced Budget Act (BBA) of 1997 reduced the federal dollars allocated to the disproportionate-share hospital (DSH) subsidy program and began phasing out the requirement that CHCs get cost-based reimbursement. Congress also repealed the Boren Amendment, which enabled hospitals to sue challenging the adequacy of Medicaid reimbursement. These changes leave safety-net providers with less revenue per Medicaid client and with less leverage (political and legal) to challenge such cuts.

Medicare cuts in both per procedure fees and funding for graduate medical education (GME) also mean less revenue, especially for safety-net hospitals. So do reductions in local funding of public health clinics and public hospitals. Moreover, the continued rise in the number of uninsured persons (prompted in part by welfare reform) augments the cumulative impact of the revenue cuts.

Government efforts to encourage or require Medicaid beneficiaries to enroll in managed care further unsettle the policy environment. Many states encourage commercial managed care plans to compete for Medicaid business on the assumption that these plans will include in their networks many providers that were previously unwilling to accept Medicaid clients, thus providing beneficiaries with better access to the mainstream medical system. The result could be more choices for Medicaid clients and fewer paying customers for safety-net providers.

Commercial health plans, however, are ambivalent about the Medicaid market. In the early 1990s many of these insurers, assuming that Medicaid would be a profitable market, worked hard to enroll Medicaid beneficiaries. Perhaps surprisingly, the commercial insurers were anxious to have safety-net providers in their networks, mainly because these providers brought with them large numbers of Medicaid enrollees. Indeed, far from introducing large new networks of mainstream providers into Medicaid, most commercial health plans seemed instead to rely overwhelmingly on traditional Medicaid providers. Although that pattern continues, many of the commercial health plans are now disenchanted with the Medicaid market, complaining of inadequate reimbursement and excessive government regulation. Some—Oxford, Aetna U.S. Healthcare, and others—are even exiting the Medicaid market, sometimes only a year or two after they signed on.

To cope with this changing and uncertain environment, safety-net providers have adopted two main strategies. Some sign contracts with commercial health plans that remain in the Medicaid market, in hopes of retaining their current patient population. Be-
cause this approach leaves them dependent on the kindness and calculations of strangers, many have formed their own providersponsored managed care organizations, which can contract directly with state officials for the Medicaid capitation dollar. If all goes well, such plans may not only retain existing patient populations but also avoid unnecessary administrative expenses and build Medicaid market share in the process.

As commercial plans leave the Medicaid market, it becomes increasingly important to understand how safety-net plans arise and how they fare organizationally over time. The literature describing these organizations is surprisingly thin, however, and very few studies explore why some survive and thrive while others do not. This paper and an earlier paper report on the largest effort to date to study these issues. The first paper summarized the results of a written survey of ninety-nine safety-net plans across the nation. This paper reports the findings from site visits to four of these plans: Colorado Access (in Denver), Community Premier Plus (in New York City), Family Health Partners (in Kansas City), and Neighborhood Health Plan (in Boston). The goal was to visit plans sponsored by different types of providers (two were formed by hospitals, one by CHCs, and one by a combination of the two), located in different parts of the country.

**Forming The Safety-Net Plan**

Safety-net providers do not start managed care plans easily. Many lack the money to meet state capitalization and reserve requirements. This is particularly true for CHCs, but hospitals, too, sometimes struggle to generate the needed dollars. Furthermore, few safety-net providers possess a workable managed care infrastructure: Sponsors must hire new staffs, presumably with experience in the insurance arena, and charge them with creating a managed care company from scratch. Money is again an issue, because good management information systems, enrollment and marketing programs, and quality assurance initiatives are expensive. And the right staff—talented, experienced, and knowledgeable about public programs such as Medicaid, and moved by social conscience to work for lower pay than offered by the commercial sector—is hard to find.

These obstacles persuade many safety-net providers to try to align with others to form a health plan. Affiliation makes it easier to raise capital, increases the pool of likely enrollees (the plan can expect to attract enrollees from each of the provider sites), and enables the plan to benefit from efficiencies of size.

The case studies illustrate the logic of affiliation. In Boston more than a dozen CHCs banded together to form Neighborhood Health...
Plan (NHP). None of these centers had the resources to form its own health plan. Indeed, the coalition itself eventually looked for a partner with deep pockets, a search answered by the recent merger of NHP and Harvard Pilgrim Health Plan. In Kansas City the local public hospital (Truman Medical Center) aligned with Children’s Mercy Hospital to form Family Health Partners (FHP). Children’s Mercy wanted a partner that would assume the risk for care of adult enrollees; Truman wanted access to capital and an ownership share in a popular and cost-efficient Medicaid managed care plan.

State officials sometimes initiate or accelerate the affiliation process. In Colorado, for instance, the state’s Medicaid director urged three safety-net hospitals (Denver Health Medical Center, University Hospital, and Children’s Hospital) to align with a coalition of CHCs. These four parties then agreed to form Colorado Access. University Hospital and Children’s Hospital contributed capital, while Denver Health and the CHCs brought many Medicaid enrollees. In New York City, state officials encouraged two safety-net hospitals (Columbia Presbyterian and North General) to merge their applications for a managed care license. New York City officials then proposed that a public hospital also in northern Manhattan (Harlem Hospital) join the alliance. The three facilities pooled capital and formed the Community Premier Plus (CPP) plan.

These institutional marriages solve one set of problems (too little money or too few enrollees), but they generate other prickly issues, such as governance: The composition and role of the board of directors are often controversial. Sharp cultural and political differences may arise between sponsoring organizations. And perhaps most important, affiliation can create visible winners and losers among the sponsoring organizations. Maintaining and managing the affiliation’s organizational progeny are often challenging tasks indeed.

**Plan Board Members Who Wear Two Hats**

The board of directors is a critical element of the safety-net health plan. Boards select and evaluate chief executive officers (CEOs), adopt long-term strategic plans, monitor implementation of these plans, and perform various other functions. These tasks are especially critical in health plans created by multiple sponsors. The board should encourage the health plan to forge its own identity, with its own mission, independent of those of the sponsoring organizations. The board also should have sufficient independence from its sponsoring organizations to set policy in the best interest of the health plan and to protect it in cases of conflict of interest between the plan and one or more of its sponsors.

In practice, however, management theory generally yields to or-
ganizational politics. In more than 85 percent of the nation’s safety-net health plans, the board chair is an employee or board member of a sponsoring provider organization, and in each of the four plans we visited, employees or board members of the sponsoring provider organizations control the health plan board. This divergence from business-school protocol is hardly surprising. Sponsors create health plans as a long-term survival strategy, and the board is expected to protect their capital and institutional investments. Sponsors worry that without such oversight the benefits expected from their excursion into managed care could diminish or disappear.

For example, because Medicaid managed care enrollment remains voluntary in much of New York City, the sponsors of Community Premier Plus discourage the plan from marketing in sponsor hospitals’ clinics, preferring instead to generate higher fee-for-service reimbursement for as long as possible, even if that means subsidizing continuing losses in the plan’s bottom line. The health plan has little choice but to accept the results: fewer enrollees and reduced market penetration.

Conflict between sponsor and health plan is least troublesome when there is a single sponsor, which will often treat the plan as a subsidiary, not a separate entity. Plan management understands where its allegiance must lie and acts accordingly. If tensions arise between the interest of the plan and that of the sponsor, the latter usually prevails. In health plans created by multiple sponsors, however, governance issues generated by the composition of the board are often far more troublesome. In Denver’s Colorado Access, for example, all four sponsors have votes and veto power on the health plan board, and each sponsor is willing to use its leverage to protect its interests. When Columbia/HCA sought admission to the Colorado Access network, offering to deliver babies at a cost far below that of the sponsoring hospitals, health plan managers, eager to save dollars, supported the application. Board members, affiliated with one of the hospital sponsors, worried about the impact on their hospital and vetoed the proposal.

Each of the four health plans we visited had similar stories. FHP, for example, was thwarted in its effort to add the Health Midwest hospital system to its network by board members who were nervous about its impact on their own hospital systems. All four plans also reported board battles over provider reimbursement levels. Health plans succeed in part by negotiating discounts from providers, but if the negotiated rates get too low, sponsor providers—and their representatives on the board—get restive and resistant.

Plan requests for data and information are another important arena of contention. Health plans need good information systems to
track client utilization, provider practice patterns, and financial performance and to respond to government requests for data. Our four plans and nearly every plan in the survey, however, reported serious problems in getting good data from providers, especially safety-net providers. Everyone agreed in principle that these gaps limit plans’ ability to manage the care of their enrollees, and most interviewees acknowledged that too little managed care is delivered by most Medicaid managed care plans. Some plans respond by offering to pay a separate fee for every patient encounter form submitted (the carrot). Others threaten audits and sanctions (the stick). In theory, the board members who are also provider administrators have ample leverage to apply in the quest for better and more timely encounter data, but in reality, organizational inhibitions intervene. Honoring demands for data adds to the fiscal burdens of hard-pressed providers, encumbers the schedules of busy physicians and other personnel, and could make public some information that fails to flatter the institution, its providers, or both.

The first allegiance of most board members is to their sponsoring organizations, as board members with whom we spoke readily admitted. As a result, health plan managers spend much valuable time negotiating with sponsors, brokering compromises between sponsors, and complaining about inappropriate board behavior. An obvious solution, understandably popular with health plan managers, calls for fewer board members affiliated with sponsoring organizations. The sponsors, however, want to maintain the control that the health plans abhor. Beyond this change in board structure lie amendments to process: for example, a special conflict-of-interest rule under which board members recuse themselves from votes that bear directly on their sponsoring organization. After trying for months, Colorado Access officials persuaded its board to adopt such a policy. Whether and how it will work remains to be seen.

**Bottom Lines: Mission And Money**

Representational and strategic tinkering with the boards of safety-net plans can ease but not eliminate the tensions that trouble safety-net alliances. Board differences are symptomatic of deeper conflicts of mission and money, inherent in the safety-net-plan enterprise.

The “safety-net” rubric may conceal disturbing distinctions in the missions of alliance members. An obvious example is the controversy over reproductive health policy that emerges in affiliations between Catholic hospitals and their secular partners. Academic medical centers (which emphasize graduate medical education, research, and high-technology medical procedures) and CHCs (which focus on low-cost primary care) do not view the world in the same
“The most brutal conflicts flare when one sponsor believes it is unfairly obliged to subsidize costs generated by a partner.”

way. A children’s hospital and a publicly owned general care facility have different organizational pulls and drives.

Mission issues translate readily into provocative practical questions about institutional division of labor within communities—for instance, between CHCs and hospital-based clinics. Health centers now provide an increasingly broad range of services (including some previously found only in hospitals), while the hospitals’ focus on inpatient and specialty services is broadening to embrace primary care services (traditionally delivered by CHCs). The locus of care has changed, too: Both types of institutions are less wedded to central locations and are developing satellite care sites. Meanwhile, the number of Medicaid beneficiaries declines, while the number of the uninsured rises. Taken together, these trends can produce fierce competition for Medicaid (and child health) clients and dollars.

Nor is competition between safety-net providers confined to CHCs and hospitals. In every city we visited, the sponsors of the safety-net health plan were themselves competitors. In New York City, Harlem Hospital, North General, and Columbia Presbyterian vie for Medicaid clients in northern Manhattan. In Kansas City, Truman and Children’s Mercy are neighbors and competitors. In Denver, University Hospital, Children’s Hospital, and Denver Health are often sharp rivals. In Boston, the CHCs that founded NHP sometimes vie for business with the Harvard Pilgrim health centers that are now in the network.

Ironically, competition may intensify when providers jointly create a managed care plan. Sponsors now compete for plan resources as well as Medicaid patients. For example, one of the plans we visited gives grants to large network providers to improve information management and care management systems. To win a grant, providers must write an application that is more persuasive than those of their counterparts. At another plan, one sponsor agreed to invest sizable sums to upgrade the systems and services in a partner’s operation but reneged several months later. Faced with declining revenues and looking to contain costs, the erstwhile donor complained that it had not received the expected quid pro quo for the capital—namely, increased patient referrals. Tensions between the two sponsors grew, and plan management had to mediate.

As that example suggests, the most brutal conflicts flare when one sponsor believes it is unfairly obliged to subsidize costs gener-
ated by a partner. This dynamic was on display in all four sites. The most common combatants are CHCs allegedly subsidizing care delivered by hospital-based clinics. One of the health plans, for instance, pays fee-for-service for primary care. The hospital-based clinic arguably has sicker patients and practices a more costly style of medicine, so the dollars paid to the clinic far exceed those going to the CHC. Because it seems to be making money on its health center clients and losing money on its hospital-based clients, the health plan wants to adopt capitation payments. The CHC concurs, welcoming full-risk contracts; the hospital-based clinic dissents, demanding cost-based reimbursement.

**Overcoming The Obstacles**

Our site visits suggest that safety-net health plans formed by multiple sponsors can survive and even thrive, despite formidable odds. Although the costs often threaten to swamp the benefits of cooperation, several strategic factors can improve the chance of success. Among the most important are strong leadership, helpful treatment by state officials (such as increased reimbursement rates or a leg up in the enrollment process), and timely fiscal backing.

- **Leadership.** The precarious organizational nature of safety-net health plans puts a premium on skillful leadership. The CEO must be able to mediate conflicts that inevitably plague the board of trustees, understand the rules and regulations that govern the state’s Medicaid program, summon the political savvy to lobby legislators and wrangle with regulators, understand principles of insurance and managed care, grasp the subtleties of working with low-income populations, and stand ready to manage a large, complex organization in an unsettled, unpredictable environment.

Not surprisingly, the CEOs of safety-net plans have varied backgrounds. The previously reported survey of safety-net plans found that they often recruit administrators from one of the sponsoring organizations (this occurs in roughly 40 percent of the cases). In another 9 percent, plans recruit from within. About half the time, however, the CEO comes with other work history, such as state government, another plan or provider, or academe.

The four plans we visited were led by energetic men with impressive backgrounds. Two were former state Medicaid directors, one had been an administrator with a provider sponsor, and one had previously worked for a rival managed care plan. All spoke insightfully about their managerial challenges and strategies, and all had run programs for low-income populations. All had recruited solid executive staffs and stood ready and willing to mediate when sponsors had conflicts of interest.
The decision to hire former state officials, while occasionally controversial, seems to have worked well. In Boston, for instance, relations between the state and NHP, which had soured in the early 1990s, were much improved under the leadership of a former Medicaid director. The plan still struggles financially, but the state seems committed to ensuring its long-term survival. Even in Colorado, where the decision by Colorado Access to hire the former state Medicaid director moved competitors to decry an unfair inside track and the auditor general to launch an investigation, the choice now seems wise. The auditor general eventually dismissed all charges, and the CEO is credited with overseeing one of the most successful safety-net plans in the nation. Colorado Access has the highest Medicaid enrollment of any plan in the state, is expanding into new markets (from behavioral health to prisoners’ health), and generates a healthy surplus.

A former Medicaid director is not ipso facto an able health plan manager. Nonetheless, an administrator with a background in state government can supply several managerial advantages: knowledge of the intricacies of a complex program, strong ties to the state Medicaid bureaucracy, familiarity with low-income populations, contacts with key Medicaid players, and political sagacity.

**Supportive state policy.** The Medicaid program gives the states much discretion to set and implement policy. The result is enormous interstate variation in program eligibility, benefits, and reimbursement policy—and in willingness to help safety-net health plans. Some states let the market fix the fate of the safety net. Medicaid beneficiaries choose with their feet, and health plans that cannot attract enrollees or survive on standard reimbursement rates cannot seek special help from the state. States in which commercial health plans vigorously compete for the Medicaid market are more likely to adopt this laissez-faire approach.

Some states, however, make special efforts to keep safety-net plans afloat. Of the four health plans we visited, two had such help. Not coincidentally, the two that had help (Colorado Access and NHP) were more established and secure than were their counterparts in Missouri and New York.

Colorado Medicaid officials, for instance, implemented a strategy to ensure that Colorado Access began operations in early 1996 with a sizable enrollment. In late 1995 state officials declared that providers that signed on with Colorado Access could no longer participate in the state’s primary care case management (PCCM) program (a fee-for-service managed care initiative that paid extra for case management services). The goal was to deter doctors from cherry-picking—encouraging healthier patients to join the new health
“As commercial health plans continue to leave the Medicaid market, states’ interest in supporting safety-net plans increases.”

Maintenance organization (HMO) while keeping sicker clients in the fee-for-service system. More than 40,000 clients already enrolled in the PCCM program were then automatically transferred to the Colorado Access network. Clients could disenroll and choose another managed care provider, but few did. Within days of opening its doors, Colorado Access had 42,000 enrollees.

Massachusetts officials have offered safety-net plans a similar advantage in marketing and enrollment, permitting some safety-net providers to convert their fee-for-service patients to their provider-sponsored plan (unless clients affirmatively opted out), rather than asking clients to choose among several competing plans. Even more important, however, Massachusetts officials enhanced rates for NHP and other safety-net plans. This fiscal bonus let NHP show a surplus during its first several years of operation.

**Deep pockets.** In Colorado, in the early 1990s, a consortium of CHCs examined the feasibility of forming a managed care plan. The main obstacle was money: The centers ran on the fiscal edge and lacked the capital to begin their own plan. Several months later they affiliated with three large hospital-based systems to form Colorado Access. In Boston a group of CHCs began NHP but eventually, recognizing the need to align with an organization that had enough resources to keep the plan intact, merged NHP and Harvard Pilgrim Health Plan. In New York City a group of CHCs formed a health plan called CenterCare. Several years later, struggling to avoid bankruptcy, the plan affiliated with Beth Israel Hospital.

These mergers indicate that groups of CHCs may have trouble sustaining a provider-sponsored plan without a partner that has deep pockets. This pattern will probably grow more prominent as the industry consolidates. The good news, however, is that potential partners abound. One health center–based plan mentioned more than a dozen potential suitors, several offering attractive financial partnerships. Partners recognize that CHCs have many Medicaid patients who will frequently enroll in the centers’ plan and have invaluable experience in serving low-income populations.

Such partnerships carry risks, however: The mission of the CHC may clash with that of the new partner, generating organizational conflicts. One health center manager worried aloud that an accumulation of strings attached to a needed infusion of cash might gradually draw the center away from its community-based mission.
Conclusion: Better Than The Alternative?

Safety-net providers bear the costs and conflicts of forming health plans for one simple reason: Doing so looks better than the alternative, namely, suffering heavy losses in competition for the Medicaid market that used to be theirs alone. This threat also motivates external players who may supply assistance that keeps safety-net plans in business. Other health plans may not want their competitors to sew up the Medicaid population (especially if, like Harvard Pilgrim, they are determined to serve all social strata as a matter of mission). State officials may decide that leaving Medicaid beneficiaries entirely to the tender mercies of new entrants—especially those finicky commercial plans that may conclude for any number of reasons that Medicaid is not for them after all and unceremoniously end this “product line”—would be bad public policy. Alignments of threatened safety-net providers, aided by sympathetic allies, have sufficed to launch and sustain roughly 100 safety-net plans across the country.

These defensive strategies are surely better than the alternative—leaving safety-net institutions alone to meet their fates in unmanaged competitive markets—but, at least in the four sites we studied, they are not much less precarious than the safety-net plans they sustain. The policy environment that promotes multisponsor plans is unstable and unpredictable. For example, safety-net hospitals and CHCs do not live by Medicaid alone: A decent flow of revenues from Medicare, the State Children’s Health Insurance Program (SCHIP), and other miscellaneous public programs may diminish the amount of aggravation they will incur to stem losses in their Medicaid census. At the same time, external supporters can and do form their own impressions of the fiscal conditions of safety-net providers, the importance of Medicaid market share in keeping them solid and solvent, the adequacy of access for Medicaid and uninsured patients should the local safety net fray a little (or a lot) further, and—not least important—the limits of the money and the time they should invest in helping these plans. Well-heeled hospitals or commercial health plans inclined to partner with a safety-net plan may conclude that in these tough competitive times their deep pockets contain too little spare change after all.

Likewise, Medicaid providers and plans that rely heavily on public budgets may suffer heavily from political mood swings. Were Massachusetts to enact a significant rate cut, NHP could soon go bankrupt. If implementation of New York’s long-delayed mandatory Medicaid managed care program hits serious snags, CPP could be dismantled. Colorado’s wish to promote more competition in the Medicaid market would seem to be in tension with its support for
Colorado Access. The federal government could create a new initiative to subsidize the costs of public hospitals, thereby enabling Truman Medical Center to exit gracefully from the FHP consortium. Decisions of these diverse principal players emerge from an alchemy of market forecasts, financial strategizing, and managerial philosophizing that varies with time, place, and institutional circumstance.

The living has never been easy for institutions that specialize in providing medical care to high concentrations of the nation’s thirty-six million Medicaid beneficiaries and its forty-three million uninsured citizens. For safety-net providers and plans, Medicaid managed care could turn out to be a nail in the coffin, yet another burden with which to cope, or—when organizational leadership, deep pockets, and state support happily combine to help safety-net plans play in the Medicaid market—a healthy stimulus to innovation and improvement. Only time will tell. As commercial health plans continue to leave the Medicaid market, states’ interest in supporting safety-net plans increases. State officials cannot provide plans with strong leadership or deep pockets, but supportive state policies on rates, enrollment, regulation, and more can give plans a long push toward stability. Policymakers who are unwilling to wait around and watch what happens ought to commence or continue fashioning positive measures that anticipate and ease the formidable hurdles that safety-net plans now confront.

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NOTES

2. The terms of these arrangements vary greatly. The provider might deliver primary care or specialty services or both. More often than not, the provider receives a capitated payment for primary care services and fee-for-service payment for specialty and inpatient care.
4. Ninety-two percent of all safety-net health plans have their own board of directors. Moreover, every health plan with multiple sponsors has its own governing board. B.H. Gray et al., Safety-Net Health Plans: How Are They Faring? (New York: New York Academy of Medicine, May 1999), Table A-20.
7. Ibid., Table A-18.
8. CenterCare, which we did not visit in this study, should not be confused with Community Premier Plus, which we did visit.