# **Safety Net Providers Have Proven their Value**

Safety Net Providers are non-profit, mission-driven organizations who specialize in serving the poorest, least healthy and most complicated-to-serve patients and communities. Most of their patients are on state programs, uninsured or on high-deductible plans and can’t afford the full cost of treatment they need. Research and pilot projects have shown that safety net providers can simultaneously reduce state costs and improve patient outcomes if paid differently. Three examples include:

1. FQHC Urban Health Network (FUHN) is an Integrated Health Partnership (IHP) pilot project that includes 10 Twin Cities FQHCs. Through investments in e-health technology, data analytics, care coordination models and primary care interventions this IHP has **reduced ED visits by 28% in 33,000 patients, improved health outcomes, and saved the state over $16 million since 2013**.
2. Guild Inc’s Hospital-to-Home initiative targets the highest need and highest cost patients with alternative interventions that also target the complex issues affecting their health. The Mobile Community Health Services Teams deliver or connect patients to person-centered, tailored care including care coordination, physical and behavioral health, housing, social and employment services to reduce costs and better serve patients. In the first 12 months, 31 participants saw a **74%** **decrease in emergency room utilization and a 32% decrease in inpatient hospitals stays.**
3. Children’s Dental Services utilizes portable dental equipment and lower cost providers, like dental therapists, to get out into underserved areas across the state to reach at-risk children, in locations such as schools and Head Start Programs, to provide preventive services and routine dental care. This **reduced future treatment costs through prevention, early treatment and making services accessible in the community so patients don’t seek treatment in emergency rooms.**

# **State Regulations and System Barriers Prevent Optimal Results**

Safety net providers offer great value to state programs by improving health and reducing costs for the poorest and neediest Minnesotans, but current state program payment, quality measurement, and state value-based purchasing arrangements do not fully recognize this value. Moreover, state measurement specifically penalizes safety net providers for using evidence-based models with proven success.

* **Provider payments do not reward value and outcomes.** Existing government program payment methods, reward providing high volumes of treatments and procedures for people with serious chronic disease. There is no incentive – payment or measurement— for working with patients to be healthier, prevent disease, and manage health conditions to reduce the need for hospital, emergency room and specialty treatments and drugs.
* **Quality measures penalize providers who serve the most difficult patients.** Under Minnesota’s standardized, statewide, publicly reported clinic quality of care measures used for state programs, providers are penalized for serving the lowest income patients with poor health and complicated economic, cultural and behavioral issues because they will be scored as poor quality providers. They score low because of who they serve, not their own clinical expertise.

# **Safety Net Reform Proposal Summary (HF 1414 Hamilton | SF 1421 Jensen)**

The Safety Net Coalition proposes establishing pilot projects that will evaluate different payment incentives and provider quality measures for providers serving complex, high-risk patients in state programs. Participaing organizations will create care models that will produce better health outcomes at a lower cost than existing approaches. The pilot projects will demonstrate successful models that can be expanded statewide in the future.

The pilot projects will authorize and evaluate state program *payment reforms* in the following areas:

1. **Provider quality measures.** 
   * **Refocus provider quality measures on value and outcomes.** Improve the relevancy of statewide provider quality of care measures by eliminating some unnecessary, duplicative, lower priority, treatment-based measures and using new measurement methods that will place a value on efforts to improve patients’ overall health and coordinate their care more cost-effectively.
   * **Add measures for improving health and reducing chronic disease.** Of 38 clinic quality measures collected by MN Community Measurement, 33 relate to *existing* diseases or chronic conditions and only 1 relates to working with patients to identify their health risks or improve their health to reduce the risk of future disease (This one is childhood obesity counseling.) The other 4 measures relate to immunizations and patient satisfaction.
2. **Provider payment methods.**
   * **Pay adequately up front for proven cost-effective services** such as patient engagement, health improvement and care coordination services for high-risk and complex populations that have been shown to reduce future health care costs and improve outcomes but are not adequately reimbursed currently.
   * **Hold pilot project providers accountable for reducing the total costs of health care** for these patients by improving health and reducing preventable utilization of hospital, emergency room and high cost specialty services and drugs.
   * **Adjust payments for the non-clinical difficulty and complexity** **of patients**. Adjustments would be based on factors such as poverty, homelessness, rural residence, transportation barriers, or language or cultural barriers.
3. **Workforce Innovations.**
   * **Grant pilot project exceptions to existing state regulations and reimbursement restrictions** that are barriers to health care workforce innovations that can improve health and reduce costs.