Wisconsin Intertribal Managed Care Demonstration Project (WIM Care): A Partnership Project

Great Lakes Inter-Tribal Council
University of Wisconsin Medical School
Wisconsin Tribal Health Directors Association

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Pictured, from L-R, are the following Tribal Health Directors:
JoAnn Schedler (Stockbridge Munsee), Jerry Waukau (Menominee),
Robin Carufel (Lac du Flambeau Chippewa), and Deanna Bauman (Oneida).
The Wisconsin Inter-Tribal Managed Care Demonstration Project (WIM Care) was initiated in 1996 as a partnership between the University of Wisconsin Medical School (UWMS) and the Great Lakes Inter-Tribal Council (GLITC). WIM Care conducted extensive data analysis, and then implemented management and clinical strategies to improve quality of care, reduce costs, and increase revenues at Tribal clinics. The project was initially supported by a three-year Robert Wood Johnson Foundation demonstration grant.

Tribes in the Upper Midwest, like Tribes across the country, have experienced a decline in federal funding in relationship to population growth and the rapidly increasing local health care expenditures. The expanded influence of managed care in both the public and private sectors has intensified the financial pressures. Facing these trends, Wisconsin tribal health leaders pursued collaborative ways to enhance their strategic position in the health care marketplace and strengthen their financial and clinical management.

GLITC and individual Wisconsin Tribes have collaborated in the past on episodic health-related projects with individual University of Wisconsin faculty members. WIM Care, however, focused specifically on inter-tribal solutions and sought to institutionalize the partnership between the academic institution and the Tribes as a group. The Tribes and WIM Care, in the end, were able to establish norms and a model for institutional Tribal-academic collaboration.

WIM Care Demonstration Projects

- Benefits Counselor Training Initiative. Benefits counselors were trained to assist tribal members to gain access to public and private insurance.

- Joint Contracting and Provider Negotiations. Through an inter-tribal buying group, Tribes negotiated discounted rates with vendors for laboratory services, pharmaceutical supplies, and referral care.

- Data Collection and Analysis. WIM Care analyzed utilization, demographic, financial, and clinical data from several tribal health programs in order to identify high cost health conditions, assess data quality, and identify referral patterns across Tribes.

- Clinicians Network. Clinicians from several Tribes began teleconferencing to consider approaches to clinical quality, management, and the use of Evidence-Based Medicine.

Great Lakes Inter-Tribal Council is a consortium of eleven Wisconsin and Michigan Tribes. GLITC provides a wide range of technical assistance to the Tribes, including extensive consultation for health programs.

Tribes in the Upper Midwest, like Tribes across the country, have experienced a decline in federal funding in relationship to population growth and the rapidly increasing local health care expenditures.
The eleven Wisconsin American Indian Tribes each operate their own Tribal health centers under self-governance and the Indian Self-Determination and Education Assistance Act, Public Law 93-638. The clinics provide health care for approximately 40,000 American Indian persons in the state. The Indian Health Service (IHS) does not directly operate health programs or hospitals in Wisconsin.

Under self-governance, Wisconsin Tribal health programs have, for the most part, grown and operated independently from each other and from IHS. Inter-tribal collaboration generally focuses on matters of state and federal health policy, and is often facilitated through the Wisconsin Tribal Health Directors’ Association or through the Great Lakes Inter-Tribal Council.

With WIM Care, the Tribal leaders, health directors, and Great Lakes Inter-Tribal Council undertook collaborative strategies to keep pace with the wider health care industry trends in managed care, data collection and reporting, and clinical quality improvement. They invited the state’s largest public academic institution, the University of Wisconsin, to become a partner with the Tribes in this endeavor. Through this partnership, the Tribes gained access to the same management expertise and clinical innovations that are shared by their colleagues in academia and in the private health care industry.
The Resource and Patient Management System (RPMS) is the primary data collection and management information system used at Tribal health centers and IHS hospitals. It is a powerful tool for examining utilization trends, in-house and referral-care expenditures, and clinical care patterns. The RPMS data provide a rich source for clinical benchmarking and continuous quality improvement, as well as strengthening the financial management of the health centers. WIM Care demonstrated the benefits that may result from ongoing training in RPMS applications.

**Goals:**

- To identify potentially avoidable clinical costs through analysis of clinical care and referral-patterns for certain high frequency and/or high cost diagnoses.

- To strengthen business planning through application of RPMS data on patient demographics, utilization patterns, insurance billing and collection.

- To assess the data quality and identify methods to improve the utility of RPMS.

**Method:**

Data were examined for nine federally recognized Tribes during the three-year study period from October 1, 1994, through September 30, 1997. Each Tribe received an individual report from its own database. An aggregate report compared data, without identifiers, across Tribes. These findings provided a foundation for WIM Care’s demonstration project initiatives.

**Summary of Findings:**

- **High cost health conditions.** High cost and high incidence health conditions include diabetes, asthma, hypertension, back problems, vision services, heart disease, otitis media, and diagnoses related to tonsilar disease. The analysis suggests several areas where clinical costs may be reduced and the quality of patient care improved through the application of established protocols for medical management and preventive care.

- **Insurance coverage.** Approximately one third of all Contract and Direct Health Service patients were uninsured during the study period. A significant number of currently uninsured Tribal members may yet be eligible for public benefits, including Medicaid, SCHIP, and Medicare: 21% of children below the age of 19 and approximately 15% of seniors over 65 were listed as uninsured.

- **Billing and collections.** Clinics may substantially and immediately increase their revenue by increasing the proportion of Direct Health Service patient visits that are billed to insurance and by more vigorously pursuing collection on billed visits.

- **Contract Health Service Providers.** A few non-Tribal providers (clinics, hospitals, laboratories, pharmaceutical vendors) provide services to several Tribes through individual contracts. The group of Wisconsin Tribes may collectively spend millions of dollars at a single facility. These Tribes may substantially increase their negotiating leverage and attain better prices through joint contracting and purchasing arrangements.
Pharmacy Directors at Tribal clinics in Wisconsin undertook a coordinated effort to contain the escalating costs of pharmaceutical care. The Inter-Tribal Pharmacy Project resulted in substantial savings and opened up opportunity beyond the original business-oriented objectives. Through this forum, Pharmacists have potential to expand their role in the pharmaceutical management of patients and improve the quality of patient care.

**Methods and Activities**

Most Tribal clinics in Wisconsin operate in-house pharmacies and employ at least one pharmacist. As with the rest of the health care industry, Tribal clinics devote a large percentage of their overall budgets to stocking their pharmacies. The surveys showed that Tribal sites purchased from 80% to 90% of all pharmaceutical supplies from wholesalers – intermediaries between drug manufacturers and buyers. Each Tribal pharmacy had developed independent relationships with suppliers and drug manufacturers. A single Tribal pharmacy spent anywhere from $100,000 to approximately $1 million on pharmaceuticals per year. Yet no single pharmacy had enough volume to leverage lower prices from their vendors and suppliers. As a group, however, they purchased several million dollars worth of pharmaceuticals per year. This, they reasoned, was enough volume to gain bargaining power.

The Inter-Tribal Pharmacy Project began with an organized network of Tribal pharmacists from ten clinics. The group has undertaken several activities to reduce or contain pharmacy costs and to improve the pharmaceutical care of patients. These include forming a buying group, participating in available federal drug purchasing discount programs, considering an inter-tribal formulary, and seeking expanded participation by pharmacists in patient education and pharmaceutical management of chronic conditions.

**Benefits and Future Opportunities**

Through their network, Tribal pharmacies have increased their leverage in the regional and national purchasing pool and have built a sound infrastructure for future inter-tribal collaboration. Such a network provides an opportunity for joint negotiation and contracting, group purchasing, formulary development and management, and the broader application of pharmacy practice in improving the quality of patient care.

- **Achieve substantial savings.** The network of Tribal pharmacies negotiated joint contracts for discounted product and improved services from pharmaceutical vendors.

- **Gain leverage for future inter-tribal activities.** Tribal pharmacies are now positioned to continue to collaborate as a group in the future. Their network has already gained wide recognition, and pharmaceutical vendors are aggressively seeking their business.

- **Share expertise, resources, and workload.** Beyond business negotiations, the network also provides pharmacists a venue for communication and information sharing. Through this network, pharmacists gained new information regarding the federal discounts available to Tribes. They are also well positioned to form an inter-tribal P&T Committee and to establish and maintain an inter-tribal formulary. This particularly benefits the smaller Tribes, who otherwise lack the internal staff and resources to conduct these activities.

Overall, Tribal pharmacies are now better positioned to adopt industry practices that promise to both reduce costs and improve the quality of patient pharmaceutical care.
Tribal clinics are committed to serve all Tribal members at no cost regardless of insurance status or ability to pay. In order to fulfill this mission and maintain financial viability, Tribal clinics pursue Medicaid, Medicare, and private insurance coverage for those patients that are eligible. This allows Tribes to conserve their limited resources to care for more uninsured patients.

American Indian health centers in Wisconsin began hiring benefits counselors in 1998 to assist uninsured and uninsured patients to gain access to public and private insurance programs. The Wisconsin Tribal health benefits program has shown significant positive results in its first three years. Tribal members, who normally face a range of barriers to accessing public and private insurance programs, have been enrolled in Medicaid/Healthy Start and SCHIP/BadgerCare in much greater numbers since the beginning of the program. There was a 78% increase in Healthy Start enrollments at six Tribal sites from 1998-2000. These same Tribes showed a rate of SCHIP/BadgerCare enrollments comparable to the statewide rate of increase.

This program has shown that trained benefits counselors on-site at tribal health centers can increase substantially the number of patients with third-party coverage. Although several factors may have contributed to these impressive increases, benefits counseling appears to have a significant impact. This expands the range of health care options available to Tribal members and increases the potential for third-party revenues to Tribal clinics.

Training and Technical Assistance

WIM Care provided tribal benefits counselors with intensive training, and consultants continue to provide ongoing technical assistance and evaluation. Tribal benefits counselors themselves convene regularly (by conference call) for case-conferencing and trouble-shooting.

Training focused on two aspects of the program:

• “Outstationing” or Outstationed Medical Assistance. Specific activities related to helping pregnant women and children apply for and gain coverage by Medicaid/Healthy Start and SCHIP (called Badger Care in Wisconsin).

• Family Health Benefits Counseling. Broader advocacy to help individuals and families get access to any public or private insurance coverage.

Results

• Six Tribes showed a 78% increase in Medicaid/Healthy Start enrollments compared to a 26% increase in enrollments statewide.

• Tribes showed a rate of SCHIP/BadgerCare enrollments comparable to the statewide rate of increase.

• Tribes are saving money due to the work of the benefits counselors.

• Tribes have developed a knowledgeable network of benefits counselors and improved overall knowledge among Tribal clinic staff about alternative resources.

Factors in Success

Benefits counselors’ location in the clinics gave uninsured patients easy access to them and their services. Benefits counselors submit Medicaid/Healthy Start and SCHIP/BadgerCare applications directly to county offices on behalf of clients. This eliminates transportation and logistic barriers. Benefits counselors help patients gather all necessary documents and follow up with applicants and agencies. Most of the benefits counselors are also long-time members of the Tribal communities, and several are themselves Tribal members. This appears to bolster patients’ acceptance of benefits counselor services.
WIM Care built a foundation for a continuing institutional relationship between the UW Medical School and Wisconsin’s American Indian Tribal Clinics.

**Service:** Provide ongoing clinical consultation in care management strategies. Assist the tribes to implement quality care programs, specifically as they related to asthma, diabetes, injuries, otitis media, and use of pharmaceuticals.

**Education:** Coordinate training and continuing professional education and career development for tribal clinical and management staff. Enhance medical student knowledge of AI/AN health issues and employment opportunities, and build programs that encourage young AI/AN people to pursue health-related careers.

**Research:** Assist the Great Lakes Inter-Tribal Council to analyze data collected through the Tribes health systems databases, and create cross-walks between these clinical health service data sets and population-based epidemiologic data.

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**Tribal Health Systems**

Treaties between Tribes and the U.S. Government and subsequent legislation and court decisions hold that the U.S. Government has a “trust responsibility” for health care service provision to all federally recognized Tribes. The federal Indian Health Service (IHS) in some cases directly operates hospitals and clinics on or near reservations. In Wisconsin and several other states, Tribal governments operate their own health facilities, in accordance with self-governance and the federal Indian Self-Determination and Education Assistance Act Public Law 93-638.

Reservation-based programs consist of both direct and contract health services:

- **Direct Health Services (DHS)** are provided on-site and free of charge to eligible AI/ANs at either IHS or Tribally operated health clinics and hospitals. Health services include a range of primary care and preventive care and may include some specialty care, dental, pharmacy, vision, and hearing services. Tribes may operate their own public health programs, Women, Infants, and Children (WIC), environmental health services, mental health, and Alcohol and Other Drug Addiction (AODA) programs.

- **Contract Health Services (CHS)** are provided by non-IHS, non-Tribal health care providers. Tribally-based CHS program offices authorize payment to off reservation, non-Tribal providers for health services rendered to eligible AI/ANs. CHS-funded services include emergency, specialty, and acute health care services. Tribes not affiliated with an IHS hospital or those with limited direct health service capacity depend heavily on contracted health providers.

Tribal clinics provide care for all eligible American Indians within their service area, including uninsured and underinsured Tribal members. The IHS partially funds both DHS and CHS programs through annual allocations to Tribes. Funding is not an entitlement but rather depends on annual Congressional appropriations. American Indians and Alaska Natives, as United States citizens, may also be otherwise eligible for Medicaid, Medicare, and Veterans Administration health benefits. Many also hold private employer-sponsored insurance coverage.