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Native American Tribes in Wisconsin Improve Health Care Delivery

Wisconsin Inter-Tribal managed care demonstration project

SUMMARY

From 1996 to 2000, staff the Great Lakes Inter-Tribal Council developed and implemented a more coordinated, cost-effective approach to health care among Native American tribes in Wisconsin, based upon assessment and planning activities conducted by the University of Wisconsin-Madison Medical School.

The council, based in Lac du Flambeau, Wis., supports member tribes in expanding sovereignty and self-determination.

Key Results

The project resulted in the following improvements among the tribal health operations:

- Increased access to third-party revenues, with tribal benefits counselors helping to promote a 41 percent increase in Medicaid and Healthy Start applications over 18 months and gaining client eligibility in 82 percent of cases.
- Improved drug pricing.
- Greater leverage with laboratories.
- Closer communications among pharmacists.
- Better data.
- Improved clinical management.
- Stronger university-tribe ties.

Funding

The Robert Wood Johnson Foundation (RWJF) supported this project through two grants totaling $689,948.

- $195,976 to the University of Wisconsin-Madison Medical School for planning activities.

- $493,972 to the Great Lakes Inter-Tribal Council for implementation.

THE PROBLEM

By treaty and statute, the health care of Native Americans is an obligation of the federal government. The Indian Health Service (IHS), an agency in the US Department of Health and Human Services, operates health facilities of its own and also funds health systems run by tribes under a law permitting Native Americans to control federal programs on their reservations.

Each of the 11 Native American tribes in Wisconsin operates its own community-based health care centers, which together serve about 40,000 people.

In the 1990s, these centers—like other tribal health facilities across the nation—were experiencing financial difficulties. In particular, IHS funding was failing to keep pace with tribal needs, most noticeably in allocations for contract health services (CHS)—services unavailable at reservation clinics and thus purchased for tribal members from nontribal providers.

The Wisconsin tribes estimated that collectively their CHS shortfall ranged between $4.2 million and $7.9 million per year. As a result, services were restricted.

Factors contributing to the financial pressure included:

- The return of increasing numbers of Native Americans to the Wisconsin reservations.
- Lack of an in-state IHS hospital to help control costs.
- Greater dependence on CHS due to the relatively small sizes of the Wisconsin tribes and their limited on-reservation services.

However, some inside and outside the tribes also recognized that the tribal clinics themselves needed to become more efficient and better able to cope in the increasingly competitive medical marketplace.

Prizing their sovereignty, the 11 tribes were operating their health systems separately with no mechanism for pooling procurement and obtaining economies of scale. Also, the clinics were not fully utilizing Medicaid and other revenue sources that could supplement CHS funding.

In addition, Wisconsin was implementing mandatory enrollment of Medicaid recipients in managed care, raising concern that the tribes' Medicaid-eligible members would be forced to seek care at nontribal facilities.

THE PROJECT

These grants from RWJF provided funds to develop a more coordinated, cost-effective approach to health care among the nine Wisconsin Indian tribes belonging to GLITC, a nonprofit organization that aids tribes in delivery of health and other tribal services. (Two other Wisconsin tribes were not GLITC members at the start of the project but participated in project activities; for a list of GLITC member tribes, see Appendix 1.)

In addition to maximizing the limited IHS resources of these tribes, the new structure was to serve as a model for struggling Native American-operated health systems across the nation.

The project, known as WIM Care (for Wisconsin Intertribal Managed Care), was a joint initiative of GLITC and researchers at UWMS. The first grant (ID# 028719) was formally awarded to UWMS. RWJF awarded the second grant (ID# 033190) to GLITC in order to give the tribes a greater sense of project control. Both grants, however, funded project staff at both institutions.

Consultants to the project included Milliman & Robertson, Inc. (Brookfield, Wis.), a national actuarial firm; ABC for Health (Madison, Wis.), a nonprofit public interest law firm; and Resolve Consulting (Scottsdale, Ariz.), a firm familiar with pharmaceutical issues. An advisory committee (see Appendix 2) met semiannually to guide the project.

The Wisconsin Tribal Health Directors Association also provided direction. In-kind support for WIM Care came from the Marshfield Medical Research Foundation of Wisconsin, the Wisconsin Primary Health Care Association, and the IHS-funded Epidemiology Center at GLITC.

The first grant (ID# 028719) supported assessment and planning activities. The initial goal was to create an intertribal managed care system that would be operated by a consortium of the nine tribal governments and provide a single insurance product for tribe members. During the planning process, however, that goal was abandoned in favor of efforts to promote improvements within the individual tribal systems and collaboration among them.

The change in direction came, in part, in response to requests from tribal health directors that any reforms respect individual tribal sovereignty. Also, project personnel concluded that the tribal clinics needed more effective management tools before attempting an extensive redesign.

In addition, enactment of a 1997 federal law exempting Native Americans from mandatory enrollment in state Medicaid managed care programs reduced the need for a managed care strategy.

Under the first grant, WIM Care personnel and consultants:

- **Assessed the performance of each of the nine tribal health operations, including on-site interviews with clinic staff, tribal leaders, and members.**
- **Analyzed the tribal clinics' use and expenditure patterns based on data from the Resource and Patient Management System (RPMS), the IHS online clinical information system.**
- **Analyzed various self-insurance and managed care options for tribal consideration.**
- **Identified all potential public and private revenue sources available to the clinics.**

These activities extended into the second grant period. The second grant (ID# 033190) focused on implementation. WIM Care personnel and consultants:

- **Used collected data to track clinic operations and design optimal use of third-party revenues.** They:
  - Drafted internal tribal-specific reports analyzing clinic operations and recommending improvements.
  - Trained clinic personnel in RPMS applications.
  - Reviewed the RPMS analysis and made recommendations to tribal health directors.
  - Provided technical assistance to the clinics in patient registration and electronic billing.
  - Trained tribal benefits counselors in eligibility determination for third-party payments.
- **Designed and implemented a range of managed care strategies.** They:
  - Established intertribal purchasing arrangements for laboratory services and pharmaceuticals.
  - Organized a workshop on obtaining discounts from referral care providers and vendors.
  - Implemented a diabetes management program.
  - Held a series of conference calls with tribal clinicians to promote clinical networking and cost-reduction/care-improvement strategies.

— Analyzed clinical patterns associated with six high-cost/high-frequency conditions (asthma, back problems, vision services, heart disease, otitis media, and tonsilar disease).

- **Assisted tribal efforts to quantify their IHS funding shortfalls and participated in discussions between the tribes and federal and state health-financing agencies on issues, including Medicaid managed care and HMO enrollment.**

RESULTS

The project resulted in the following improvements among the tribal health operations:

- **Increased access to third-party revenues.** Tribal benefits counselors helped promote a 41 percent increase in Medicaid and Healthy Start applications over 18 months and gained client eligibility in 82 percent of cases. (Medicaid is a federal program providing health care to low-income individuals; Healthy Start is a state program covering children and pregnant women not covered by Medicaid aimed at reducing low-birthweight babies and infant mortality.)
- **Improved drug pricing.** Intertribal contracting with two principal pharmaceutical vendors produced savings of 2 to 3 percent in drug distribution costs—an average of $12,000 to $18,000 per tribe per year.
- **Greater leverage with laboratories.** A joint contract for laboratory services produced discounts of 2 to 6 percent, and provided leverage for price negotiations with other labs.
- **Closer communications among pharmacists.** Tribal pharmacists developed a communication network that has the potential to improve pharmaceutical management of patients and reduce the clinics' drug costs.
- **Better data.** All clinics received detailed information on patient registration and demographics, utilization, insurance status, billing and collections, direct and CHS costs, and patterns of clinic care, plus recommendations for improved revenue flow and collections.
- **Improved clinical management.** The clinics received analyses and guidance on the six high-cost/high-frequency conditions analyzed under the second grant, and began working to implement clinical guidelines to reduce costs and improve care associated with these conditions.
- **Stronger university-tribe ties.** WIM Care brought the Wisconsin tribes and UWMS into a new working relationship that can continue to benefit the clinics.

Communications

WIM Care produced a report, *Wisconsin Intertribal Managed Care Demonstration Project—Data Collection & Analysis Component: Aggregate Report,* analyzing data on

all nine tribes; it has been made available to researchers and other members of the public on request. Milliman & Robertson produced a report on self-insurance issues. Project staff produced two briefing papers and a fact sheet on funding and payment issues, which were disseminated to national advisory committee members, tribal health directors, and regional IHS personnel.

After close of the implementation grant, RWJF gave UWMS $18,600 in supplemental communications funding to disseminate project information by:

- Producing a four-page report for distribution to 560 tribes across the country.
- Preparing articles for submission to professional journals.
- Making presentations at four conferences.

As of late 2000, work on the report and articles remained in progress. WIM Care personnel had made one of the four presentations in addition to five earlier presentations at state-level and national meetings. (See the Bibliography for details.)

LESSONS LEARNED

1. **When working with Native Americans or other racial or ethnic groups, one must be responsive to cultural differences and gear project expectations to the needs and preferences of the groups.** Cultural differences result in different preferences for the pacing of work, one project director said. WIM Care also demonstrated the importance of tribal sovereignty and the need for project personnel to recognize and respect tribal differences, she said.

2. **Tribally operated clinics face unique challenges in their efforts to succeed in today's volatile health care industry.** WIM Care showed that tribal clinics are accountable to a range of interests, i.e., those of patients; tribal governments; the federal Indian Health Service; other federal and state health agencies; and, increasingly, the private insurance market, one project director said. The clinics must balance the demands of these different sectors and cultures while trying to reengineer financial, administrative, and clinical systems.

AFTERWARD

After WIM Care ended, UWMS and GLITC continued to work together to assist tribal clinics in management of high-cost/high-frequency conditions; research into health policy and financing issues; and data collection and analysis. They also planned to form a Native American research center to support clinical research and the training of Native American students and faculty. UWMS provided one-year funding for this ongoing effort, and is seeking sustaining support from foundations and agencies.

Additionally, ABC for Health continued to train tribal benefits counselors as part of its work under a grant from RWJF's national program *Covering Kids®*, which seeks to increase the number of low-income, uninsured children who benefit from health insurance coverage programs.

In an interview in November 2006, Glen Safford, GLITC deputy director, reported that the Native American Research Center for Health, formed in the early 2000s, had recently received a second multi-year grant from the National Institutes of Health via tha Bureau of Indian Health Services. The first grant was for approximately $600,000 and the second, $500,000.

Tribal health centers recommend priority topics for the research (as of November 2006 research topics included childhood obesity and family environmental factors, health effects of mercury in lake fish and how to improve reproductive health outcomes). Researchers at the University of Wisconsin medical schools in Madison and Milwaukee were conducting the research.

Safford noted also that the student development program is providing educational and mentoring opportunities for the Great Lakes tribes' youth. The program has several components:

- A college preparatory program for 14- to 17-year olds that graduates ten to 15 youth per year;
- A week-long science immersion program for high school juniors, seniors and college freshmen at the University of Wisconsin-Milwaukee (15 participants in 2006);
- A research internship with mentoring (six undergraduates and three graduate students in 2006 with at total of 40 participants as of 2006); and
- A program to help Native American youth make the transition to graduate education in the health sciences, in partnership with the University of Minnesota, University of Wisconsin and Michigan State University.

Prepared by: Michael H. Brown
Reviewed by: Richard Camer and Robert Narus
Program Officers: Terri Gibbs and Pamela S. Dickson
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APPENDIX 1

Wisconsin Tribes Belonging to Great Lakes Inter-Tribal Council in 1996

(Current as of the end date of the program; provided by the program's management; not verified by RWJF.)

- Bad River Band of Lake Superior Chippewa
- Forest County Potawatomi Community
- Lac Courte Oreilles Band of Lake Superior Chippewa
- Lac du Flambeau Band of Lake Superior Chippewa
- Menominee Tribe of Wisconsin
- Red Cliff Band of Lake Superior Chippewa
- Sokaogon Chippewa Tribe (Mole Lake)
- St. Croix Chippewa Tribe
- Stockbridge-Munsee Indians of Wisconsin

Wisconsin has two additional tribes, the Oneida and Ho-Chunk nations. The Oneida Nation has since joined GLITC. GLITC also includes one Michigan tribe, the Lac Vieux Desert Tribe.

APPENDIX 2

WIM Care Advisory Committee Members

(Current as of the end date of the program; provided by the program's management; not verified by RWJF.)

Jerry Waukau, Chair
President
Wisconsin Tribal Health Directors Association
Keshena, Wis.

Kathleen R. Annette, MD
Director, Bemidji Area
Indian Health Service
Bemidji, Minn.

William Freeman, MD, MPH
Director, Research Program
Indian Health Service
Albuquerque, N.M.

Bruce Goldberg, MD
Associate Professor, Department of Family Medicine
Oregon Health Sciences University
Portland, Ore.

Merwyn (Mitch) Greenlick, PhD
Chair, Department of Public Health and Preventive Medicine
Oregon Health Sciences University
Portland, Ore.

Pamela Hanes, PhD
Associate Professor, Department of Public Health and Preventive Medicine
Oregon Health Sciences University
Portland, Ore.

Marc Hansen, MD
Professor Emeritus, Department of Family Medicine
University of Wisconsin
Madison, Wis.

Emery Johnson, MD, MPH
Consultant
Rockville, Md.

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