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Indian Health Service

MANAGED HEALTH CARE STRATEGIES WORKSHOP

Minneapolis, Minnesota
November 5-8, 1990

Sponsored by:
Office of Planning, Evaluation & Legislation
Division of Program Evaluation & Policy Analysis
Branch of Policy Analysis
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PREFACE

During the week of November 5-8, 1990, the Indian Health Service sponsored the Managed Health Care Strategies Workshop for tribal health programs and interested IHS staff. As part of the continuing effort to seek methods to improve health care delivery, this training workshop provided practical management tools to achieve cost savings while ensuring that health care procured from the private sector is appropriate in terms of cost and quality.

This workshop is the most recent meeting on this issue sponsored by the Office of Planning, Evaluation, and Legislation (OPEL) and has evolved out of a series of meetings which have continued to refine the manner in which managed care can be applied in the IHS and tribal programs.

The growing interest and enthusiastic response on the part of participating tribal programs and IHS staff is indicative of the need for more effective approaches to health care delivery in the light of increasingly constrained and finite IHS resources.

The IHS is grateful for the contribution and guidance received from the participants of this workshop and from the previous conferences which were held to define the IHS approach to this issue. Most especially, a debt is owed to the tribal and IHS programs that have been willing to test the managed care approach. This is a dynamic and continually evolving issue and will require even greater and wider participation if it is to remain a viable approach for providing health care to Indian people.

The IHS is appreciative of the willingness of TCI, Inc. to continue with the logistical support of this effort and for the development of this report. The IHS is fortunate to have had the interest and involvement of Sheila Leatherman, Vice President for Research and Development, United HealthCare Corp., from the earliest inception of this issue.
Managed Health Care Strategies Workshop: Introduction

Ramona Ornelas, R.N., M.P.H.
Chief, Policy Analysis Branch
Indian Health Service

Workshop Purpose.

This workshop was designed to assist tribes and IHS staff to maintain and/or increase managerial capacity to deliver cost effective, quality health care in a constrained economic environment.

Challenges posed by increasing health care cost inflation, a rapidly expanding Indian population, and the pressure of the Federal budget deficit to decrease Federal spending, are expected to increase. It is unlikely that the IHS Budget will be increased to allow for new or expanded programs.

Roughly 50% of the IHS Budget now supports purchase of health services from the private sector. Maintaining current levels of care becomes increasingly difficult. It behooves those responsible for providing health care to Indian people to entertain additional methods of providing or financing health care. If Indian health care is to be sustained then we must become smarter in expending scarce health care dollars.

Managed health care techniques of cost and quality control hold some promise for managing more effectively. It is no accident that managed care virtually dominates the health care market in the present and foreseeable future. These organizations have proven their viability in a very competitive market. The question is whether or not the management techniques they use can be applied to tribal programs and the IHS. We believe they can with some adaptations. However, this requires a change in focus and behavior in which IHS and tribes move from simply being the payor for health care to being a player in the market place. Hopefully, the
information provided in this workshop will facilitate a reorientation to more effective approaches to health care.

Through a series of analytical studies and policy consultation meetings, the conclusion has been reached that managed health care delivery approaches hold substantial promise for tribes and the IHS to at least maintain the level of current services, or, preferably, to realize cost savings that will allow expansion of services. Consequently, this workshop was designed to provide an overview of managed care and the management tools used by managed care organizations to control costs and maintain quality of care. Broadly state, these tools are:

- Appropriateness of Care (Utilization, Quality, and Cost Review)
- Case Management
- Benefits Determination
- Information Management Systems
- Quality Assurance
- Referral Systems and Contracting
- Reimbursement Methods (Contracting, Negotiated Discounts, Capitation)
- Specialty Service Arrangements
- Applications: Tribal and IHS Case Studies

Faculty.

The managed care experts presenting at this workshop have a practical, working knowledge of the subject matter. Each is an acknowledged expert in his/her field with several years of experience in a highly competitive segment of the health care industry. The speakers have collectively and individually contributed to the tremendous growth of the managed care portion of the health care market. Each has made a sincere effort to learn as much about IHS and tribal programs as possible. The expertise of these
people will provide useful approaches to tribal programs and the IHS as they reorient their approach to health care.

Background and Evolution of Issue.

The issue of the alternative approaches to health care delivery and financing has evolved over the last three years from an initiative to promote competition during the Reagan Administration to one of assessing alternative methods to improve the management of health care delivery. The IHS, from the time this issue surfaced, has defined its approach to alternative health care in terms of Indian Self-Determination and has proceeded with directions defined by the tribal consultation process.

The first national meeting, the Alternative Health Care Delivery and Financing Conference, on this issue was convened at Baltimore, Maryland in November of 1987. The intent of this meeting was to assess the potential impact of more interaction with the private sector as tribal corporate entities or as purchases of services from managed care organizations and to define a desirable direction for the IHS.

The consensus of this first meeting was that there appeared to be a potential for enhancing Self-Determination. However, since the IHS had only limited experience in procuring health care from managed care organizations, it was the participants' recommendation that case studies of tribal and IHS applications be conducted.

Consequently, the IHS Policy Analysis Branch developed the Tribal Case Study Project in cooperation with the Office of the Assistant Secretary of Health. Four case studies of tribal programs and IHS service units were developed to assess the potential for: (1) tribal incorporation as an HMO; (2) purchasing services from an HMO in lieu of a CHS program; (3) cost savings realized from purchasing drugs through an established Medicaid Formulary; and (4) establishing or procuring services from a rural HMO. The results of the Tribal Case Study Project are described in a report entitled "Assessment of Strategies to Promote Cost and Management Efficien-
cies in IHS Tribal and CHS Programs. The report is available upon request from OPEL.

The findings from the Tribal Case Study Project indicated that:

- Tribal incorporation as a federally qualified HMO is not generally feasible due to extensive financial and management requirements.
- Purchasing services from an HMO requires a guarantee of volume and membership for a defined period of time and resolution of the 3rd party reimbursement fluctuation problem.¹
- Use of the Medicaid formularies decreases the cost of prescription drugs by at least 25% — a significant savings to the CHS budget.
- And, there are significant opportunities for joint ventures, shared services, and negotiated discount agreements with non-Indian community providers.

Underlying all the projects was the consistent lack of precise utilization and cost data necessary for a meaningful dialogue and negotiation between a tribe and a private provider organization.

As a result of the Tribal Case Study Project, it became apparent that more information and/or training was needed on the topic of managed care and the basic management techniques utilized by managed care organizations.

In order to provide the kind of information identified in the case studies and at the recommendation of the participants at the Baltimore meeting, a second national meeting, the Invitational Colloquium on Tribal Health Delivery: What Does the Future Hold?, was held in May of 1989, at La Jolla, California. The purpose of this meeting was to present a perspective on managed care and the relationship to tribal programs. In addition to health care industry expert presentations, alternative tribal

¹The tribes studied were moving toward small 638 contracts, thereby decreasing the volume of clients.
health care delivery projects were presented as well. Featured were affiliation agreements, third party administration contracts, the ACCCHS study (capitation of Medicaid), and a multi-tribal pooled insurance program for tribal employees.

The response to this meeting was very enthusiastic and the group was overwhelmingly in favor of IHS pursuing a managed care initiative and sponsoring another more focused training workshop on managed care techniques. In addition, they recommended that OPEL sponsor more studies to assess the potential for additional forms of alternative health care delivery and financing.

The IHS Policy Analysis Branch has sponsored additional studies under the auspices of the IHS Research and Evaluation Plan administered by OPEL. These studies assess the potential for risk sharing with private corporations (including insurance companies), adopting utilization reviews as a cost saving and quality assurance measure, Registered Nurse case management in a tribal CHS program, capitation of Medicaid, and alternative payment methodologies including prepayment.

The IHS has now moved beyond studying the viability of implementing various managed care strategies and has made a decision to implement managed care in the IHS. A workgroup has been formed to develop an implementation plan.

Future Plans.

This workshop was designed as a model and has been purposefully kept small in order to allow for questions and discussion pertaining to individual program needs. Since it is a model training workshop under consideration for replication in the future, feedback was invaluable.

Evaluation forms were distributed and each participant was encouraged to record responses and comments which will be coded and analyzed. Rec-
ommendations will be carefully evaluated and utilized in planning future workshops.

In addition to training workshops sponsored by the IHS, there are other managed care workshops sponsored by various associations and other health policy nonprofit organizations. For those programs interested in developing a concept or preliminary plan for a managed care strategy, it is essential to conduct a thorough feasibility analysis. Only if it appears feasible should an implementation plan for a demonstration project be developed. The demonstration phase of development is important because it allows unforeseen problems to be resolved with minimal risk and gives a real indication of what works. Unfortunately, there is no federally sponsored demonstration grant program currently available to support these efforts. It may be worthwhile to seek support from philanthropic foundations now focusing on Indian populations.

Competitive non-recurring funding support for feasibility studies and demonstration model development is available through the annual IHS Research and Evaluation plan administered by OPEL. On an annual basis, solicitation for projects is sent out through the IHS Area Offices in late spring or early summer. Area Directors make the guidance and protocol for submissions available to each tribe and service unit. The proposed projects are reviewed, ranked and assembled into a plan for implementation in the next fiscal year.

In addition, the Tribal Management Grant Program administered by the Office of Tribal Activities, funds various kinds of management improvement projects on a competitive basis in accordance with prescribed priorities. Normally, feasibility studies or alternative demonstration model development are not a high priority.

Tribal Program Workshop Objectives.

The information provided in this workshop was designed to provide an overview of various components of managed care. By design, the work-
shop is an introductory course and, while it is comprehensive in scope, it was not intended to be an in-depth course. Each of the components presented could itself be the subject of an entire workshop.

Individual program needs should determine what information in the workshop is pertinent to each participant. As presentations are made, each participant should ask: "What are my next steps and what do I need from what source in order to meet my next objectives?"
Overview of Managed Care

Sheila Leatherman
VP, Research and Development
United HealthCare

Health Maintenance Organizations (HMOs).

HMOs are just one type of managed care. They are defined by the following criteria:

1. They must have a distinct, enrolled population eligible for services.
2. They must have a defined set of health care benefits.
3. They must have a predetermined, prepaid price.
4. Their services must be provided from a defined delivery system.

History of HMOs.

As early as the 1920s, a few progressive companies desired to create health care entitlement for their employees. They established systems for anticipating costs and set up relationships with physicians and hospitals in order to ensure employee coverage. Since then, HMOs have proliferated. Currently, enrollment in the nation’s various HMOs is estimated at 45 to 50 million.

There are two basic models of HMOs of particular interest to the IHS:

1. Staff HMOs which employ all their own health care providers and function as a clinic, generally owning their own buildings.
2. Independent Practice Associations (IPAs) which contract with physicians who maintain individual private practices in the com-
munity. Generally, the physician's contract with the IPA represents only a small part of his or her practice.

HMOs have undergone a gradual transition during recent years. Originally designed to provide health care to a specific population (company employees), HMOs have gradually shifted to providing medical insurance coverage and services to varying populations including Medicaid and Medicare beneficiaries.

Problems and Issues Relating to HMOs.

1. Many HMOs have grown too fast and are attempting to satisfy needs of too many populations. By seeking contracts with Medicare, Medicaid and individuals, many HMOs have spread themselves thin. Many have insufficient experience to meet the resultant increased demands.

2. HMOs are undercapitalized. Many have geographically expanded their operations, incurring tremendous development costs. Further, many have deliberately priced their coverage lower than that of their competitors in order to expand enrollment, thus creating severe financial difficulties.

3. HMOs often face difficulties establishing and maintaining relationships with the community and physicians. For example, many physicians in hospitals feel threatened by the amount of control HMOs have over their financial situations.

4. HMOs have been criticized for focusing on costs at the expense of providing quality health care.

The Future of HMOs.

HMOs as individual organizations may come and go, but the basic concepts on which they are built (provider reimbursement, quality manage-
ment, utilization management, and risk management) will continue to be viable alternatives to traditional health care delivery.

**Planning Managed Care Systems.**

In planning managed health care systems, exact policies and procedures must be defined for: (1) utilization management, and (2) provider contracting.

In defining policies and procedures, focus should be placed on cost-effectiveness rather than cost containment — that is, attention must be on determining where to spend money in order to improve the health status of individuals. Priority should be given to quality.

**Managed Care Concepts + Definitions.**

1. **Utilization Management** — Directly related to quality assurance, utilization management is a technique which focuses on monitoring the use and overuse of services through three primary monitoring and intervention systems: authorization (precertification or prenotification); concurrent review; and case management.

   a. Authorization may be conducted through:

      1) Precertification, whereby a physician must call the managed care organization for permission to perform a specific procedure. (Permission is granted — or rejected — according to set guidelines. Precertification is particularly effective in controlling costs.)

      2) Or, prenotification, whereby the hospital or physician must notify the managed care organization that a procedure will be performed. (While prenotification does not save as much money as other forms of authorization, it encourages physician accountability. Further, it serves as a basis for
collecting the data needed to determine where money goes and which systems need better management.)

b. Concurrent review systems monitor and influence the health care service being provided. Inpatient services are investigated in terms of length of stay, resources used and patient discharge planning.

The review method generally involves simple monitoring of patient services through telephone calls. Some plans utilize their own in-hospital nurses to conduct the reviews.

Occasionally, concurrent review is used on outpatient cases where review may be conducted by personal or telephone interviews.

c. Case management systems are those in which the provider or HMO staff monitors the care of individuals or even whole populations. For example, case management monitoring concerns itself with reasonable protocols for treating all patients with a specific illness or condition, such as diabetes.

The goal of utilization management monitoring is not simply financial. It also involves the objective that patients not be subjected to unnecessary procedures.

By the same token, utilization management also aims to assure that services are not underutilized and that patients have access to preventive care in order to help reduce sickness or death. Providing regular mammograms after the age of 50 is an example.

2. Cost — The challenge of monitoring health care delivery involves achieving a careful balance of concerns. On the one hand, emphasis should be placed less on cost than on quality. On the other, enough attention should be paid to costs that judicious use of resources is assured.

According to the *New England Journal of Medicine*, 20-30 percent of medical care in this country is unnecessary. A primary example is Cesarean sections, up from 1 out of every 18 births in 1970 to 1 out of every 4 in 1990.
3. Benefits Coverage Policy/Necessary Care — This is both a legal and an ethical concept. Through careful benefits design, managed care providers must define what kinds of coverage or service access patients should have according to the obligations and promises of their particular system. Preventive health care, catastrophic benefits, and transplants are examples of the types of care which must be considered.

4. Technology Assessment — This is the effort to determine the effectiveness and/or appropriateness of specific medical or surgical interventions, particularly controversial ones such as back surgery or liver transplants. Technology assessment seeks to translate what is technically or scientifically known into actual policy in order to determine what is worth paying for.

5. Quality — There are several first-stage ways in which quality of care can be judged. They include questioning a treatment's:
   - Adherence to predetermined standards. For example, predetermined standards require that tubes would not be inserted in a child's ear unless a certain number of ear infections have occurred and trials on antibiotics have been unsuccessful.
   - Adherence to the norm. This quality judgement is used when there are no practice guidelines or protocols. For example, if the Caesarean section rate in a community is about 20%, and 50% of any one physician's patients undergo sections, the quality of care received by these patients would logically be questioned.
   - Maximum utilization of what is available. There may be situations in which enough money is not available to cover all the care needed, so the provider must optimize resources.
   - Degree of success in increasing the probability of desired patient outcomes and reducing the probability of undesired outcomes.
   - Adherence to accepted guidelines such as those developed, or being developed, by the Joint Commission on Accreditation of
Hospitals, the American Medical Association (AMA), or individual medical societies.

There are also a number of second-stage methods for evaluating quality of care. These involve examining existing problems and attempting to correct them. They include questioning:

a. Clinical outcomes (Was there mobility after hip surgery? Blindness out of diabetes?) or tracking patient mortality rates.

b. Patient satisfaction. This can be done by examining the patient's relationship with hospital and physician.

c. Credentialing. The managed care organization must establish systems for determining provider background, capability and licensing. (The law holds that HMOs which choose to send patients out for services may be held legally liable for adverse outcomes.)

6. Risk Management — This enables health care providers to balance quality and cost issues. Risk management may be accomplished by:

a. Lessening financial risk through arrangements like capitation (paying the physician one amount to care for the patient regardless of treatment provided) or shared risk arrangements.

b. Lessening clinical risks through monitoring:

1) Costly or complex individual cases, such as those involving premature infants.

2) Problem trends in areas in which there seems to be inadequate access to care.

3) Underuse and overuse of physician appointments.
Quality Control through
Credentialing and Performance Review

Gloria Swanson
Director of Medical Services
MedCenters Health Plan
Minneapolis, MN

The information offered in this presentation is drawn in large part from MedCenters, a nonprofit HMO in Minnesota which was organized by practicing physicians. Employers pay MedCenters to provide care to employees and dependents. MedCenters is responsible for delivering health prevention, health promotion, ambulatory, and acute care services. A management company administers nonclinical programs.

Cost effectiveness is a chief concern. Administrative costs associated with managed health care are high. (MedCenters' administrative expenses, including case management and review, run from 11-16% of budget.)

Because MedCenters, like any managed care contractor, is held legally liable for the quality of the care it provides, quality control is a chief concern.

Credentialing.

MedCenters ensures the quality of its services through an expansive provider credentialing program.

Credentialing involves the careful review and verification of each individual provider's professional background.
Each MedCenters provider is sent an application; in the state of Minnesota, HMOs have a joint agreement with the local medical society to verify the provider's claimed credentials.

Additionally, MedCenters has established the following minimum acceptance criteria:

a. Graduation from an accepted school of medicine;
b. Valid current state licenses;
c. Valid current DEA registration;
d. Admitting privileges at one or more local hospitals;
e. Current professional liability insurance coverage;
f. No history or involvement in any malpractice arbitration or settlement (although exceptions may be made in the case of some nuisance malpractice suits);
g. No history of denial or cancellation of professional liability insurance;
h. No health problems, as determined by the physician’s own statements, which would interfere with his/her ability to practice medicine;
i. No history of professional disciplinary action.¹
j. No history of chemical abuse.

¹State boards of medical examiners, the National Board of Medical Examiners, and the Board of the Healing Arts, for example, may provide information about physicians who've been disciplined or sanctioned. In addition, the Federal Government has recently initiated a National Practitioner Data Bank to process information on disciplinary actions and malpractice cases nationwide. Because it is still in the early stages of collecting information, the Bank is limited in the amount of physician histories it can currently provide. It will, however, be a good future source of physician practice behaviors.
k. No history of termination of employment, criminal conviction or indictment.

l. No history of wasteful use of medical resources or failure to comply with any plan's utilization and quality assurance programs.

m. Absence of intentional falsification of the application.

Performance Review.

MedCenters has a written plan as part of its quality assurance program. If a provider is reported for substandard performance, the report is reviewed by a committee of the provider's peers in a manner that protects the rights of both the physician and the HMO. In the typical case, the committee may recommend disciplinary action or oversight of the provider for a specified period of time.

Monitoring Quality and Use of Services

Ellen Pinkowski, R.N., PHN
Manager, Concurrent Review
MedCenters Health Plan

This presentation reviews utilization management monitoring strategies which can be employed to monitor the use, and assure the quality, of managed health care services. These methods include: Precertification; Admission Notification; Referral Management; Concurrent Case Review; and Second Surgical Opinion.

2Case Management, another utilization management strategy, will be discussed in the following workshop presentation. See pages 23-27.
Like the preceding presentation, this one is based on the experience of MedCenters, a nonprofit HMO in Minnesota. MedCenters has a membership of nearly 250,000. It contracts with approximately 1200 physicians in 126 clinics and admits to 31 regional hospitals.

The described strategies are used (or have been tested) by the 30 staff of MedCenters' Department of Medical Services, which is divided into four sections:

a. Hospital Administration Review and Data Analysis Section, where hospital admissions departments phone for verification of patient eligibility and approval of services to be provided.

b. Concurrent Review Section, which administers reviews of acute care, discharge planning, and continuing care.

c. Quality Assurance Section, which monitors issues identified by case reviews, complaints, appeals, and credentialing.

d. Medical Policy Section, which clarifies coverage policies for services and evaluates the appropriateness of new technologies.

Case managers on MedCenters' Department of Medical Services staff must meet the following qualifications:

1. Bachelor's degree RN;
2. 3-5 years acute hospital (med/surg background), or HHC experience helpful;
3. Strong initiative, good sense of humor;
4. Excellent verbal and written communication skills;
5. Assertive personality to be able to work in emotionally charged situations;
6. Knowledge of community resources.
Each staff member receives training to prepare him/her. This includes education concerning the organization's mission, policies, and provider networks. A manual summarizing this information has been developed. New case managers make rounds with existing case managers.

**Utilization Management Strategies.**

**Precertification**

Precertification is the process by which a managed care organization is given advance notice of any elective admissions or surgical procedures. This gives the managed care organization the opportunity to verify coverage and to determine whether the service is appropriate.

Precertification is generally the responsibility of the patient, though contracts may be structured to require physicians to precertify admissions or procedures. In these cases, penalty systems should be built into the physician's contracts.

The precertification process generally includes:

a. Verification of member eligibility;

b. Evaluation of medical appropriateness of diagnosis, admission, care and procedure;

c. Assignment of length of stay\(^3\) and provision of procedures for obtaining extensions of initial authorization.

The following will facilitate a precertification procedure.

1. A clearly identified central phone number should be provided.

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\(^3\) There are a number of ways to determine length of stay. Intensity of services guidelines can be used and are available from various sources.
2. The member or physician must be aware of his responsibility to obtain precertification.
3. Guidelines must be available to assist in making consistent decisions.
4. A medical director should be internally available if questions arise.
5. A list of surgical procedures, appropriate for outpatient surgery should be available.
6. In cases where outpatient surgery/treatment is standard, staff — if requesting inpatient admission — need to clarify if medical complications exist or if patient is poor anesthesia risk.
7. Staff should clearly communicate who is responsible for providing updates if an extension is necessary.

Admission Notification

This is a process by which the managed care organization is notified of nonelective — or emergency — admissions. Notification may be the responsibility of the hospital or the individual provider, depending upon predetermined policy.

MedCenters has worked out an admission notification system agreement whereby:

1. Providers call a central recorder with basic information, member ID, diagnosis, admission date, and attending physician for all MedCenters' admissions.
2. That information is passed on to utilization review technician, who verifies coverage, eligibility and appropriateness of admission.
3. If the technician can approve the admission, he/she notifies the hospital of the patient's coverage.
4. If the patient has not been admitted by a contracted provider, then MedCenters must arrange with the member's primary physician for an appropriate referral.

5. When the technician cannot approve a nonelective admission, the case is turned over to a case manager, who works with the attending physician and the primary physician to evaluate the patient for continued stay, transfer to another facility, or discharge.

The earlier an admission notification is received, the better. Early notification allows the managed care organization to get the appropriate parties involved early so that internal resources can be utilized and financial liability can be protected.

Referral Management

Through referral management, referrals to specialists outside the managed health care organization are arranged where internal services do not meet the patient's needs.

In making referrals, it is important that the managed care facility have the ability to limit the number of visits, procedures, and other services provided to members. Referrals should be specific in terms of services to be provided. (Is it to be a one-time consult or full diagnostic workup, one visit or three?)

The primary care physician is responsible for determining whether a patient should be referred to an outside specialist. Guidelines for patient referrals should be developed by a committee of physicians. Trends and patterns in patient referral should be tracked.

The following are helpful in facilitating referral management.
1. A mechanism to communicate authorization for care being provided outside of the HMO system is helpful.

2. The primary care MD determines if he/she can provide the needed care or if the patient needs to be referred to another provider.

3. When the Primary MD makes a referral, he should state if a one-time evaluation or a specific number of visits is authorized.

4. A paper system should be provided to doctors for referring patients. It should include a form that notifies the referral physician of the number of approved visits, a form that explains how to get an extension, a form that clearly states what is authorized. The forms should be multi-part to provide copies. The referral form should include as much data as possible, including patient name, provider name, diagnosis codes, number of visits allowed, etc. This will enable the managed care organization to track helpful data over time. A copy of the form should be given to the patient so the patient is aware of the specific limitations of the referral.

5. A committee of MDs should be established to review — where necessary — referral authorization for appropriateness and make recommendations for available alternatives.

6. Policies should be developed for primary MD to follow in making referrals.

7. System should be easy to use and understand.

8. A mechanism should be made available for members to file appeal of denied referrals.

Concurrent Case Review

Concurrent case review is the process by which the managed care organization can get medical information about its hospitalized members during their hospitalization. This can be performed either on-site or by phone.
MedCenters review staff look for appropriateness of admission, patient, progress, length of stay, and discharge procedures in order to ensure quality of care and appropriateness of utilization. They also review cases for quality of care indicators (whether the admission was due to inappropriate outpatient management or whether the patient suffered from hospital-induced situations such as a fall or an error in medication, for example.) In conducting on-site concurrent case review, staff members have clear roles and responsibilities, taking care not to duplicate any hospital services. They are respectful of hospital policies regarding external review and patient confidentiality. Phone review is conducted only during specific hours of the day.

On-site review allows for direct access to physician orders, treatment plans, laboratory results and nursing staff... and thus greater accuracy. Anticipating on-site review staff, physicians tend to be more careful about case documentation.

For concurrent case on-site review to be cost-effective, hospital or ambulatory facilities should be geographically close, and there should be more than one or two patients to review at a time. If this is not the case, phone review may be the better option. Phone reviews may not be as accurate, so care must be taken to request specific information and to comply with the requirements of the facility.

There are a number of criteria sets available to assist the managed care organization in reviewing admission and continued stay. MedCenters uses the Appropriateness Evaluation Protocol (AEP), which looks at three categories:

a. Medical services being provided to patient, including surgical procedures and testing that can only be performed in the hospital setting.

b. Nursing life support services being provided (IV therapy, frequent nursing assessment or dressing changes).
c. Individual patient condition factors, such as the sudden inability to void or the sudden onset of acute confusion.

The InterQual Intensity of Service Severity of Illness Criteria (IS/SI Criteria) is also available to the managed care community. These criteria break down into adult and pediatric sets, evaluating the various body systems (circulatory, respiratory, etc.). They break down further to review temperature, blood pressure, or laboratory values. Discharge screens are available on these criteria to determine if a patient is appropriate for discharge.

Literature on both the AEP and the IS/SI Criteria show that they are comparable. Both should be reviewed in order to determine which best suits the individual needs of the organization. They may be obtained by contacting the following:

AEP
Joseph Restuccia
Health Care Research Unit
Boston University Medical Center, Suite 1102 Boston, MA 02118
(617) 638-8188

IS/SI Criteria
InterQual, Inc.
44 Lafayette Road
P.O. Box 988
North Hampton, MA 03862-0988

Second Surgical Opinion

Another utilization management strategy is that of the second surgical opinion, whereby a second physician is consulted. If the findings of the original and the consulting physicians conflict, a third is called in and a de-
cision is reached through the agreement of two. Second opinions are often requested for surgical procedures such as mastectomy, cesarean section, and back surgery. Depending on specific contracts and situations, second opinion physicians can be from within or outside the managed health care system.

MedCenters has not found the second surgical opinion strategy to be cost-effective, because physicians generally concur in their diagnoses.

**Savings Strategies.**

MedCenters has found that the use of continuing care resources (home health care, skilled nursing facilities, etc.) may be beneficial and may provide viable alternatives to extended hospitalizations. Such resources are particularly suited for patients involved with kidney dialysis, ongoing intravenous or physical therapy, post-stroke therapy, or treatment for low back pain.

MedCenters uses Medicare criteria to determine whether continuing care should be covered. Regional Medicare intermediaries can assist you for further information on continuing care.

Another area of savings is use of day-of-surgery admission. Many surgical cases don't require inpatient stay prior to surgery and physical work-ups, laboratory testing and paperwork can be done in the physician's office. On arriving at the hospital, patients are admitted and then sent directly to surgery. They are actually admitted to their hospital room from the recovery room.

**Data Needs.**

Regardless of the monitoring technique to be used, complete, accurate data must be gathered. Every managed health care program must develop
its own appropriate data system. The system should meet national data requirements but must also meet local needs.

MedCenters evaluates its cases according to discharges per month breaking them down by type of service — i.e., medical, surgical, obstetric, newborn, mental health. The number of hospital days utilized and the average cost per day for each admission is determined. Potential financial liability for hospitalized cases is calculated.

MedCenters recommends keeping track of the following data elements, whether using paper or computer systems:

a. Members;
b. Admitting and specialty physicians;
c. Admitting diagnoses;
d. Surgical procedures;
e. Type of admission (medical, surgical, ob);
f. Dates of admission and discharge;
g. Length of stay;
h. Other available insurance, such as motor vehicle, workman's comp, or product liability.

Computer packages have been designed to assist managed care facilities in gathering and tracking patient data.
Case management is a utilization management strategy which involves monitoring the health care of entire population with emphasis on:

1. Providing quality, medically-necessary care and ensuring that all eligible members receive appropriate services through appropriate systems. (The services an organization is able to deliver may not represent all the population needs; the organization must determine the maximum services its resources can provide and must explore community resources to meet the needs it cannot.)

2. And, containing costs.

Case management monitors the use of both outpatient and inpatient services and facilities. In high risk populations, many patients will cross over between the two, and the managed care organization needs a good system of communication in order to manage cases between the two services.

**Outpatient Case Management.**

The following types of patients/cases usually require monitoring through outpatient case management:

a. Outpatients with diagnoses related to high cost or high utilization, such as asthma, pulmonary disease, cancer, or AIDS.
b. Patients with a history of noncompliance leading to decreased health and high utilization of services for conditions such as diabetes, hypertension, or alcoholism.

c. Patients with comprehension problems, such as the elderly, children, or the developmentally disabled.

d. Patients with limited capacities for self-care, such as poor mobility or cognitive impairment, or families who cannot provide adequate care.

e. Cases with unusual providers and unusual requests such as Magnetic Resonance Imaging, CT scans, or outpatient surgery.

Initially, the managed care organization may not have the resources to target all cases. It should focus on crisis or post-crisis cases initially and, as it refines its systems, it will be able to deal with less serious cases.

The goals of outpatient case management include:

1. To facilitate access to a complete continuum of services from homecare to outpatient to hospital services and including health education and other services not necessarily provided by the managed care organization but available within the community.

2. To facilitate the choice of the most appropriate service level, whether hospitalization or a home health nurse.

3. To ensure a coordinated delivery of services to prevent duplication by other agencies in the community.

Outpatient management is the tool by which you can identify any segments of the population at risk for poor care, poor access to services, or late diagnosis. It also takes into account social and emotional environments which can restrict members' access to care. Once the at-risk populations have been identified and their needs assessed, appropriate referrals can be made and further health deterioration can hopefully be prevented.
The process of outpatient assessment includes the following activities:

1. Establish the member's eligibility;
2. Establish the member's individual needs with special attention to social support systems, environment/living situation, intellectual abilities, emotional stability/stressors, ability to perform selfcare, health history, and current physical condition and medical needs;
3. Establish a care plan according to your system's limitations and resources;
4. Assign the responsibility for the coordination of that care plan to one person who assumes responsibility for coordinating all services;
5. Implement plan of care;
6. Maintain ongoing reassessment and evaluation of outpatient needs so that services can be increased or decreased appropriately.

Inpatient Case Management.

Special attention and assessment must be provided for cases in which the inpatient:

a. Is hospitalized more than 5 days;
b. Has a special diagnosis;
c. Has an unusual length of stay;
d. Incurs high costs; or
e. Requires unusual providers/requests.

The managed care organization must determine the specific diagnoses for which it will provide care. IHS has defined five main categories of care. (See IHS Medical Priorities in APPENDIX A.)

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Each managed care organization must develop policies regarding the minimum level of care it can provide for all of its members, year-round. Depending on its resources, an organization may be able to provide only emergency treatment (Category A of IHS Medical Priorities). The organization with greater resources may, in addition, provide its members acute and chronic primary and secondary care (Category C of IHS Priorities). And, so on.

The Process of Inpatient Case Management includes the following steps:

1. Establish whether patient is an eligible member admitted to the appropriate facility.
2. Access information on the patient from hospital or ambulatory facility charts, staff, nurses, therapists, or physicians, by phone or in person. (See Medical Record Documentation Outline, APPENDIX B.)

The following information should be documented:

1. Overall presentation of patient at admission (See QA/UM Screening Abstract in APPENDIX C.). Does the patient meet admission criteria for acute hospitalization? Why is he/she here? Why didn't outpatient management work?
2. Why was this problem not solved in previous admission?
4. What is the treatment plan? Find in MD's admission notes or orders.
5. Is there other insurance including Medicare, Medicaid, Workman's Compensation, Motor Vehicles, or other group plans, which may provide primary payment for inpatient services? (The hospital social worker can verify other coverage and help maintain those certifications.)
6. Are there legal issues pertinent to the case? (These might include clarification of the organization's financial risk, clarification of its liability — especially in cases of denial of coverage — and notification steps when services are denied.)

7. Are there ethical issues, such as living wills, discharges against medical advice, child or adult protection issues, appropriate pain control, or euthanasia?

8. Are there quality issues or trends in care which are not consistent with mission of IHS?

Once this information has been documented, it should be used to:

1. Assess appropriate hospital utilization using AEP, IS/SI (see page 20) or other criteria.

2. Assess appropriate medical management. This is especially important when contract physicians are non-IHS providers. It is often difficult to get involved in the planning of care by outside physicians. Because outside physicians and managed care organizations may not agree on how the patient should be managed, the case review staff person must assume responsibility for patient advocacy.

3. Ensure that appropriate services, inside or outside, are called in. To assure earliest discharge, assist in arranging timely consults and alert discharge planners and social workers to the patient's expected needs so necessary services can be in place.

4. Investigate the cost-effectiveness of covering services that aren't normally covered (such as intravenous home therapy) in lieu of hospitalization.

5. Assess education deficits and/or needs of members and providers. Talk to families of members. Clarify misunderstandings about care limitations, as well as any other options for care.
Developing Medical Policy concerning Benefits

Kris Carlton, Director
Medical Policy, AETNA Health Plans

This presentation addresses the development of medical policy for determining benefits based on procedures used by AETNA Health Plans. The speaker, as AETNA's Director of Medical Policy, provides strategic direction to clinicians by overseeing three areas of policy development:

1. New technology assessment;
2. Assessment of established medical services, such as repeat cesarean-sections;
3. Assessment of billing appropriateness including coding accuracy.

Policy Development Process.

The process used for AETNA's Medical Policy development is as follows:

1. Identify specific issues according to populations involved.
2. Develop policy — describing what benefits will be available to the population.
3. Define benefit categories both categorically and specifically. Under the benefit category "Prescription Drugs," for example, list: drugs for which reimbursement will be provided, the quantity or length of supply to be covered, the dollar amount to be allowed per initial prescription and refill, co-payments, and any exceptions such as growth hormones, fertility drugs, etc.
4. Provide members with a written contract in order to assure reasonable expectations and avoid any misconceptions.
5. Define services to be provided for particular diagnoses. Where multiple alternative therapies exist, for maximum cost efficiency, steer population towards the most cost effective suitable service.

Issue Identification

AETNA identifies issues through a variety of channels. These include:

1. Monitoring activity and phone calls from managed health care organizations.
2. Monitoring the press and reviewing medical/scientific literature, including the *Journal of the American Medical Society* and the *New England Journal of Medicine*. (Once a new technology reaches the market, members will expect access to it.)
3. Developing relationships with manufacturers in order to (a) receive information before it is published and (b) to steer development of new technologies toward services which you believe most cost-effective and beneficial.
4. Analyzing data.
5. Tracking research. Criteria sets and other information regarding advances in research are generally available.

Supporting Policy

Once a medical policy is developed, certain techniques can be utilized to demonstrate its credibility.

1. Contact the American Medical Association or individual specialty societies for their written positions on products and procedures.
2. Contact the Food and Drug Administration or other pertinent government regulatory agencies for their decisions regarding particular devices and technologies.

3. Expert clinicians should also be consulted to support your policy position.

Status Policy

Written policy statements should be prepared. These statements should define services and describe their specific uses. They should clearly state intent of coverage or noncoverage and identify limitations or contra-indications to applying service. The statements should also identify any regulatory mandates or any other unusual circumstances which could impact the policy.

The typical AETNA Statement of Medical Policy on a given procedure or service defines the procedure, any related issues, and coverage limitations. It also enumerates criteria the patient must meet in order to qualify for coverage.

Reviewing Policy

A process should be developed by which policy drafts are reviewed. AETNA backs up its drafts with supporting bibliographies, research summaries, and expert opinions. The drafts and their accompanying backup are routed to assigned individual physicians who may request additional information or approve a draft for wider distribution. The draft is then forwarded to a committee representing administrative personnel and multiple medical specialties.
Distributing Policy

Policy statements should be distributed to all medical management personnel. The policy language should also be used to develop member contracts and member materials.

Policy Analysis

A system should be developed by which policies are analyzed once they are implemented in order to assess and report their effectiveness. AETNA currently compiles analysis information from claims data and from its multiple medical management processes. Through this system, costs and frequency of services are evaluated in aggregate as are policy positions as applied to individual cases.

Use of Information Systems in Managed Health Care

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The primary purposes for which management information systems (MIS) can be used in managed health care programs include:

1. To provide operational support, through claims and payments processing for example, for day-to-day business functions.
2. To provide management control, through accounting systems for example, for administrative monitoring and decision-making; and
3. To provide **decision support**, through utilization data reports for example, for administrative planning and evaluation.

**Functions of MIS.**

The main functions of management information systems include:

1. Actuarial analysis and underwriting for projecting utilization and cost for the purpose of budgeting and setting sound premium rates;
2. Administering group contracts and multiple plan options including billing premiums to employers;
3. Managing provider networks to maintain contractual relationships with participating providers and affiliated hospitals;
4. Processing claims and payments;
5. Planning and controlling finances;
6. Managing medical services and assuring quality, including admission precertification, second opinions, case management, etc.;
7. Providing member services including enrollment, eligibility verification, and general communications; and
8. Marketing and sales support.

**Central Components of MIS.**

To manage the above-listed functions, almost all of the management information systems used in managed health care programs consist of the following six central components:

1. Membership and eligibility data entry and tracking, which enables managed care organizations to enroll their membership, obtain and store demographic information, and verify ongoing eligibility;
2. Premium billing and accounts receivable processing;
3. Claims processing;
4. General accounting;
5. Utilization management monitoring; and
6. Analysis and reporting for decision support.

Success Factors.

The terms Key Success Factor (KSF), or Critical Success Factor (CSF), are often used to describe the specifications, or key needs, which a managed health care organization is attempting to meet.

KSFs are generally established by teams representing different areas of the managed care organization. These teams identify success factors for their particular management area. Examples of KSFs include establishment and maintenance of accurate eligibility information, actuarially sound premium rates, or accurate payment of claims.

MIS Design Concepts.

In designing an information system for a managed care organization, the following concepts should be considered.

1. Modularity. Typically, information systems are designed as sets of discrete software modules, each for a specific function within a health care plan. A complete information system will include a claims processing module, a premium billing module, etc. Any particular organization may need several modules, or only a few. The modules must be specific to the organization.
2. Flexibility. Because managed care evolves constantly, management information systems must be able to adapt to changes — in market demand, plan design, or management approaches.

3. Integration. This important design concept refers to a system's ability to link data from different modules. Not all systems are able to integrate data; some do so more readily than others.

4. New technology. Systems vary in their ability to incorporate new developments in technology. For example, as the capacity to increase data storage has increased, some systems have been more readily able to expand than have others.

5. Appropriate size and scope. The "fit" of a management information system should suit organizational needs. "One size" does not "fit all."

Guidelines for Assessing Software Systems.

In evaluating the features of various information systems, a managed health care organization should:

1. Identify the essential current and future business functions which the MIS must support;

2. Evaluate and document the immediate and long-range needs of all users;

3. Define KSFs for each function based on a needs assessment survey performed within the organization;

4. Identify the relevant capabilities of alternative systems; and

5. Determine the need for possible modifications.
Software for Tribes.

Almost all existing software systems for managed care plans are for organizations that operate a complete HMO or PPO. Also, systems for hospital case management and precertification focus on reducing excess utilization.

Managed health care generally assumes that the patient population has access to care and thus focuses on identifying and reducing inappropriate care.

However, for tribal programs, excess utilization may not be a primary concern. Many tribal populations are struggling to ensure access to the most basic levels of care.

Thus, the MIS needs of a tribal program may be significantly different from those of non-tribal managed health care programs. The majority of existing software packages may have little relevancy for tribal organizations.

In addition, for tribes to individually evaluate and purchase managed care information systems wouldn't be practical. It could be more cost-effective for a single organization representing all the tribes' interests to buy software. United HealthCare, for example, purchases software for all of its participating HMOs.
Data Analysis for Utilization and Cost Evaluation

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Primary Purposes of Data Analysis in Managed Health Care.

1. To quantify utilization and costs;
2. To manage and reduce utilization and costs;
3. To improve care management;
4. To provide medical management and provider education; and
5. To perform customer reporting.

Methods of Data Analysis.

There are two basic methods of data analysis.

1. Descriptive analysis or the "counting" of costs and services such as admissions, office visits or prescriptions.
2. Evaluation analysis, or performance assessment, through which patterns are compared to norms and standards.
   Assuming you have already tracked the numbers and dollars, evaluation analysis focuses on opportunities for improvement such as reducing the number of unnecessary procedures.
Standards or Norms.

Since there is an absence of agreement on standards in medical care, each organization must establish its own standards for what is appropriate versus inappropriate (or excessive) use. Overusage is a relative concept and often differs between organizations or even within the various departments of a single organization. Norms refer to statistical averages for various measures of use and costs.

Types of Reports.

The standard types of reports which are used by managed health care organizations include:

1. **Demographic reports** which outline the general size of a covered population plus give information on members' age, sex, family structure and average contract size.

2. **Benefit administration reports** which track the number of claims submitted and their total dollar amount and provide information on covered versus non-covered expenses, total allowed amounts and total cost-sharing amounts.

3. **Utilization reports** which consist of descriptive analysis and provide, for example, an accounting of total numbers of admissions and lengths of stay; inpatient totals and rates by age, sex, and service; and total number of physician visits per member per year by specialty.

4. **Costs reports** which (a) track total costs by age, sex, inpatient/outpatient, medical service, and hospital admission and (b) provide total costs per member per month (PMPM).
Utilization Evaluation Reports.

These reports focus on assessing utilization and cost patterns in order to identify inappropriate patterns and to determine where there is room for improvement of care management.

Some typical indicators found in utilization evaluation reports include:

1. Admissions and inpatient days/rates versus the norm; and
2. Number of "suspect" cases (i.e., those exceeding the normal length of stay) within a particular diagnosis group versus a standard or norm.

It is relatively easy to count admissions, inpatient days and numbers of cases that HMOs have in a particular diagnosis group. However, trying to apply those figures against norms and standards to determine what percentage of cases are suspect is a much more difficult task. Yet herein lies a great opportunity to improve the management of care.

The managed health care organization can help this process through the use of good utilization management strategies. (See Monitoring Quality and Use of Services chapter, page 13.) For example, in a hospital admission involving low back pain, the managed health care organization — during the precertification process — might ask the following:

1. Whether or not there has there been a previous trial of bedrest at home;
2. Whether the patient is taking any medications;
3. Whether there are any potentially complicating conditions in the management of this patient necessitating inpatient admission.
If precertification, as well as all other utilization management strategy systems, is in place in terms of low back pain cases, then the appropriateness rate for that diagnosis should be good.

**Quality Evaluation**

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**Defining and Measuring Quality.**

Defining the concept of quality in managed health care is challenging. There is no single definition. Definitions will vary depending on type of care being evaluated (preventive care, acute care, etc.).

Keeping this in mind, quality can be defined as:

1. Appropriate care;  
2. Technically effective care;  
3. Care which conforms to standards and specifications;  
4. Sound preventive care; and  
5. Care which provides customer satisfaction.
Problems with Prevailing Approaches to Measuring Quality.

Most current efforts for measuring quality of health care focus on inpatient care and specifically on negative inpatient outcomes (such as patient mortality) to the exclusion of all other indicators.

There are several reasons for this. There are fewer hospitals than physicians, and inpatient data is more accessible. Inpatient data is more easily organized, managed, and analyzed. (We have ways of categorizing inpatient cases into roughly 470 diagnosis groups, giving us logical units of analysis.) Further, technologies exist which measure the severity of inpatient's illnesses in hospital. These technologies do not give information on quality and performance.

Because negative outcome rates are influenced by many variables, including the severity and mortality rate of the diagnostic group into which a patient's illness falls — and since negative outcomes are relatively rare, these rates alone are not truly useful measures of quality. That is not to say that negative outcome analysis is unimportant, however. To be effective, though, it must be focused.

Positive Direction for Quality Measurement and Management.

If quality is to be measured and managed effectively, we must adopt a broad set of definitions. These definitions should center on appropriateness but should also consider technical effectiveness, outcome of care, preventive care, and customer satisfaction.

Just as there is no one definition of quality, there is no one right way to measure performance.

Data is not useful in itself. It is not meaningful unless analysis translates it into information that guides and evaluates action and, subsequently, improves the quality of care. Translation of data into action is the key. The
managed health care organization must pose specific questions and must articulate the information it needs to evaluate specific programs.

**Potentially Useful Data.**

The data that would be useful for analyzing any specific program depends on that specific program. Each program must determine what information it needs and which questions to ask in order to get that information.

Demographic, primary care, and hospital claims data can be extremely useful. An example of their use is shown by looking at a teen prenatal care management program.

Demographic data can determine the program's target population. It can develop information profiles on that target — Who? How many? How many teenaged girls?

Primary care data can, not only pinpoint population groups, but identify specific individuals such as teenaged girls who have been in for a single health care visit but have not returned for follow-up.

Hospital claims data can help quantify costs.

**Comparability Issues.**

Counting units of utilization and analysis is not always an easy task. Some HMOs do not, for example, begin counting days of inpatient hospitalization for a newborn who stays on after his mother is discharged until after the mother is discharged. Others start counting days of inpatient hospitalization as soon as a baby is born.
Partial hospitalizations, or day treatments, also pose counting problems. Some organizations count day treatment patients as inpatients. Others count them as outpatients. For some, day treatment is a half-day; for other a full day. Some partial hospitalization cases are actually admitted.

Defining outpatient encounters is similarly challenging. Is an outpatient counted only if he sees a physician? Is he counted the same when he sees both a physician and a nurse? What if the patient is admitted for x-ray only?

Again, there is no one right or wrong way to define an encounter, but the managed health care organization must select and standardize a set of definitions so that its statistics are consistent.

IHS Managed Health Care

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Health Care Economic Environment and IHS.

1. IHS is a large payor and must think like payor.
2. IHS is subject to the pressures of private marketplace.
3. Cost shifting is eroding IHS buying power in contract health services.
4. IHS is subject to the causes of health care cost inflation in both direct and contract facilities.
5. Managed care principles can bring some understanding and control.

IHS has formed a Managed Care Advisory Committee to define feasible managed care policies for Indian communities. Blue Cross-Blue Shield of New Mexico is working closely with that Committee.

*Education is critical.* Eduate your staff on the goals and benefits. Present managed care as a partnership to allow more access to quality care. Concepts everyone is talking is the same language.

Look at starting small. There are lots of approaches and lots of pieces in managed care. Break it into what's "do-able" for you. Expend your resources where it will make a difference. Make someone accountable for analysis of your initiatives.

**Basic Considerations for Managed Care and the IHS.**

Small, sole-provider communities represent the greatest challenge for managed health care. These communities are the least likely to participate in networks such as Medicare and Medicaid. Tribal communities fall in this challenge category and IHS must be innovative as it explores managed care possibilities for tribal people.

One possibility at which IHS is looking is the concept of "piggy-backing" on managed health care networks which are already in place. In evaluating this possibility it is important to look at a tribe's present buying power and resources, considering existing direct care, contract health services and the availability of a direct care facility.

Although New Mexico's Blue Cross/Blue Shield (NMBCBS) does not presently contract to cover tribal health services, this possibility is being explored. Whether such an arrangement is feasible depends on individual tribal program needs.
If a specific tribal program approached NMBCBS stating, "We want to do things the same way the rest of IHS is doing them," then NMBCBS may be able to accommodate the tribe at a reasonable cost.

On the other hand, if the tribe asked NMBCBS to process claims in a unique manner (that is, issue checks imprinted with the tribe's logo or interface with the tribe's finance system) then the costs could be prohibitive.

Another practical way to begin exploring managed care options for tribes is to be sure tribal systems are in place for getting data to the IHS Albuquerque data center. This centralized IHS data system can help tribes increase their data collection and reporting by taking advantage of a system which is already designed and operating.

Piggybacking on the IHS central system could enhance a tribe's ability to capture detailed data. The tribe could have that data fed into IHS centrally, and then contract with someone to take that data from the central system and run it through programs specific to the tribe's unique needs. Increasing tribal capacity to collect more UB82 (hospital billing form) information is a good way to increase a tribe's available data base. Data must be compiled not only on contracted services but also on direct care. A tribe must have the same kind of information on what's happening at its direct care facility as it has for its contracted health care. Direct care costs may not have the same visibility in a tribe's budget, but — if not properly used — they too can erode buying power and resources.

Data may also help in looking at means of reducing costs. Should specialty MDs be hired to travel thru the area? Can preventive programs be put in place? Are there alternatives to hospital care?

Managed care is typically very centralized — with decisions being made centrally and from the top down. IHS, however, is a bottom-up organization. People in service units might buy into the managed care process, but the process won't work if front liners aren't committed to the concept.
Specific Recommendations.

1. Establish a network of managed health information in order to avoid individual tribes having to "reinventing the wheel." This could help prevent redundant efforts and save vital budget resources.

2. Conduct small area analyses, focusing on step-by-step questions. It won't be possible to revamp entire programs overnight; it is best to evaluate and make recommendations for change "piece by piece."

3. Adequate contracting is key to success for the managed care organization. Providers must be prohibited from billing the patient for balances on authorized care or for care unauthorized by IHS or for care found to be inappropriate.

4. Be creative, but cautious, in setting up reimbursement methods. Assure that reimbursement agreements benefit your organization. Don't contract for a method of reimbursement that will cost more to administer than it will save in program dollars. Recognize that health care is a business, especially for hospitals. They will therefore enter negotiations well-prepared and will cut hard deals. Be aware of your options.

5. It is crucial to all managed care organizations that appropriateness of service and utilization reviews not only be performed, but that they be acted upon.

6. When entering cost negotiations, never lose sight of quality assurance obligations.

7. Use consolidated bargaining power where possible. In many cases, IHS/tribes are a larger payor. Use that clout in contracting.
The IHS Portland Area Utilization Cost Review Study was organized in 1989 by the former Contract Health Services Director in an effort to verify the accuracy of the charges IHS was incurring. The study is a contracted medical audit which looks at billing, charges and quality of care in two hospitals. It serves as a model for possible application throughout the IHS.

The Portland study, set up in two phases, is still underway. Preliminary findings suggest that it has been tremendously effective in terms of cost-control and quality assurance.

Since initiation of the utilization cost review study, the Portland Area has made a conscious move toward adopting a managed care system. Attention is now going to investigating the need for managed care before care is given, rather than after.

The initial phase of the study began in July, 1989, when a Portland firm was contracted to perform retrospective inpatient audits in two area hospitals.

The first hospital, a 340-bed facility in an urban area in Washington State, provides obstetrics, medical-surgical, and pediatric care as well as intensive care, emergency room, and emergency psychiatric services. The second hospital is a 150-bed facility in a small town in Oregon. It offers similar medical services to the urban facility, but also provides extra laboratory and chemical dependency services. Both hospitals were under contract with IHS at time of review.
The audits were performed by an R.N., who conducted on-site reviews of inpatient charges, medical records and itemized bills.

At the first hospital, 43 cases were screened and 14 were audited. Out of total charges amounting to $24,243,98, nearly 48%, or $11,000, was found to be excess charge. This is an exceptional case.

Overcharges to the IHS mainly involved cases of inappropriate lengths of stay. In addition, a good number of inpatient surgeries were identified which should have been performed on an outpatient basis. No evidence was found for excess lab work-ups, tests, or treatments.

The total cost of auditing at the first hospital was $1,908 — 15% of the total amount recovered.

At the second hospital, 91 cases were screened and 48 were reviewed (with total billing charges of $234,000). According to the auditor's findings, the hospital had overcharged IHS by $41,366, or 17.6% of the total charges.

The cost of the audit at the second hospital was $8,588. No charges have yet been recovered because the hospital is appealing the auditor's findings. By the audit firm's appeal process, if the hospital disagrees with findings, the hospital must furnish additional information justifying the charges. To avoid conflict of interest, the data will be reviewed by an outside physician, whose decision is final.

If the hospital still doesn't agree, the case is turned over to the IHS. In the case of this particular hospital, IHS is currently negotiating discrepancies.

As in the first audit, excess billing was shown to be due primarily to longer than appropriate lengths of stay and inpatient surgery where outpatient surgery would have been possible.
A contract for the second phase of the IHS Portland Area Utilization Cost Review Study will be awarded soon. This contract will pay for expanded case reviews in three states, including fifteen program sites for a total of 1,725 cases. Focus will be on auditing inpatient, facility-based outpatient, emergency, and dental services. Audits on physician's office visits have not been conducted yet because this is a relatively new field, and many physicians are still reluctant to open their records for review. Portland hopes that as a result of these second phase audits, physicians will become more accustomed to the presence of reviewers in facility-based practices, and that this will lead to more future outpatient audits.

In looking for an auditing firm, exercise caution. There are many audit firms in business; thus, you should encourage several bids.

Inquire into a contractor's experience and ask for references from previous users. References should include work histories and descriptions of reporting systems. Ask for examples of other client reports, reviewing them for both format and quality. Require the firm to submit very specific plans on how they will accomplish your job.

If the audit firm does not have sufficient staff, it would be difficult to require that they conduct multiple site reviews. Ask if the firm has adequate manpower and resources to handle the scope of your work.

Most importantly, review the auditors' credentials. Do they have other experience in managed care? What is their training? Are they physicians or registered nurses? Just because a firm employs one RN doesn't mean it is qualified to perform audits.
Yakima Case Management Study

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For the benefit of tribal patients, the Yakima Indian Nation made a decision early on to be innovators in the field of managed health care.

In 1980, the Yakima Indian Nation obtained a self-determination contract to manage its Contract Health Service Program. The Yakima Indian Nation improved the performance of this health delivery system by researching various managed care methodologies and looking at the methods of other successful organizations.

The Contract Health Service Program basically had a fixed price contract and a responsibility to provide 12 months of service with the fixed allocation. The program began operation with approximately $2.2 million in funding and this amount has remained fairly constant despite the fluctuations in medical costs.

In the first year, the Yakima Contract Health Service Program found itself over budget due to administrative problems, external problems with other systems (such as hospitals), and difficulties with patient compliance.

It became evident the Contract Health Service Program would have to concentrate on two management methods: (1) cost avoidance, and (2) sustained management.
1. Cost avoidance. The program had a financial resource problem. With limited funding, how could it meet the growing demand for medical care?

One solution was to identify and utilize other currently available medical resources. The Tribe made a decision that it was not the only medical provider treating Indian patients in the community. Through the use of alternate resources such as Medicare, Medicaid, and other insurance, the program was able to deliver the needed medical care without having to carry its entire health care operation alone.

2. Sustained management. The program has identified the need to grow incrementally within the limits of contract funding. It has mapped its long range goals and has determined which are financially feasible for implementation in the short run. The other long range goals are being put off until the future. The Program is careful not to take on any more management or service responsibilities than it can handle with current resources. The program strives to attain and sustain full performance at each incremental level with its current resources before considering attainment of other long range goals.

The Yakima Indian Nation is currently looking into expanding management of patient care to better utilize direct care services. Some of the services provided by private sector providers could be sustained by existing IHS and tribal programs (direct services). As demand for private sector care rises, the tribe must look for alternatives such as pilot grants and projects to improve their health delivery system.

The Yakima Indian Nation recognizes the need to have a presence in the medical community and to assess first-hand what health resources patients need or are utilizing.

The Yakima Indian Nation is now in the process of hiring a Registered Nurse to help them with utilization review, service coordination, and to
explore other options for improving managed care. The Registered Nurse will also be involved in coordinating private physician discharges, in-home health care service access, and other related post-medical care. By making maximum utilization of available direct care services, the Contract Health Service Program will carry less of a financial burden.

In the fiscal year just ending, the Contract Health Service Program processed over $6 million in medical claims and, through cost avoidance, expended only approximately $3 million in contract dollars. The program has not found a clear balance between patient expectations for private medical care and improving the limited contract funding. Many patients believe they should receive full medical care and make the most of current medical technologies.

The Yakima Indian Nation has found cost avoidance through the use of alternate resources to be a key tool towards improving financial resources. The savings of contract funding are then used to improve administration refining the data systems, improving case management, and finding alternatives within the community to make more care available to the patients.

Developing a Provider Network

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Managed Care: A Working Definition.

Managed care is a process through which health care is covered, delivered, and financed in a competitive market. It includes development of a provider network.
To be effective, a provider network must embody the following three elements:

1. Coverage. What services are available to what population under what conditions or environment? Answers to these questions are provided in policy contracts with enrolled populations. These contracts may be written to include various degrees of formality.

2. Delivery. Services are delivered through a provider network. There are three basic options for delivery:
   a. Traditional indemnity insurance arrangements through which the patient may see any physician he wishes.
   b. Defined provider networks where the patient may not visit outside providers.
   c. Defined provider networks which allow the patient to visit outside providers, but require patient payment of more out-of-pocket expenses.

An important component of delivery is the management of care, which involves general medical management including utilization management, quality assurance, etc.

3. Financing. The present day trend is toward shared risk arrangements, in which financial responsibility for members' care is shared by patients, providers, and buyers (both the government and private employers). Provider networks must carefully outline who is at risk and who is eligible for what services.

Provider networks are also responsible for the actual flow of financial resources — how money is transferred and how quickly. Are services paid for on a pre-pay or on a claims basis? Does the government hold the money or is it passed on to the individual entities?
**Coverage Issues.**

1. Which services are needed?
   Prior to developing a provider network, the managed health care organization should perform a needs assessment in its community. This involves: (a) determining the level of public health and acute — or emergency — care needed by the population to be served; (b) defining priorities; and (c) determining which providers should be utilized.

2. Who is eligible for services?
   The managed health care organization must study the demographics of the community. Questions must be answered concerning the population's age, sex, the number of its members who are of childbearing age, over sixty, etc. Where people live and how easily they can access needed care must also be determined.

3. What responsibilities do patients have for accessing their own health care?

4. How can the ability to collect from third parties, such as governmental resources or other insurance, be maximized? The managed health care organization must create procedures for determining if a patient's employer may have cross-coverage for the employee or whether worker's compensation or auto insurance may have primary responsibilities. (Patient co-payments are another option for reducing the health care organization's costs though the organization must be careful that these co-payments are not so high as to discourage the patient's seeking needed care.)

5. Finally, which health services are appropriate and effective for this particular community?
Delivery Issues.

1. Should the health care organization hire or contract out for needed services? There are advantages and disadvantages to both options, depending upon the patient population and on available capital. The larger the membership, the more cost-efficient it might be to have a neurosurgeon or cardiologist on staff. It may be more efficient to mix options by hiring a cardiologist but contracting out to a cardiovascular surgeon.

2. What is the availability of providers in the community, not only in terms of numbers but scope? Identify MDs, midwives, public health nurses, physician assistants, etc. Determine which services you need and match them to the appropriate providers.

3. What is the quality, accessibility, and cost of available providers?
   a. Quality. Provider quality can be assessed in terms of facilities, staffing and staff credentials. It should be measured in terms of process. What do providers do to assure quality care? How well do they chart patient encounters? What information does the provider collect? Is it up-to-date? (It is not unreasonable to ask to review medical charts.) Do providers have a process by which they review each other's quality?

   It is virtually impossible to measure providers' actual case outcomes, especially in private practice. The managed care organization should try to set up an agreement whereby the physician or practitioner is held accountable for reporting outcomes.

   b. Accessibility. Questions to be asked include: Can disabled patients physically access clinic? Are clinics, hospitals, and provider offices located near people's homes and workplaces? Often, there are tradeoffs between access and cost. If you concentrate more business into one or two clinics, you may be able to get better financial arrangements.

   c. Cost. Information on the costs of providers is readily available from a number of sources. Ask the providers themselves to
make their fee schedules available. Access public information; often, Medicare or other state offices have cost reports and other information about providers' fees. Where hospitals are public entities, they must make this information available to you under the Freedom of Information Act.

Once you have gathered quality, accessibility and cost information, you are in a position to begin negotiating with providers.

In addition to discussing cost, you should look at what a provider is willing to arrange in terms of financial reimbursement. Some physicians and hospitals are willing to discount their fees if patient volume is high enough.

Financial Issues.

The following steps will assist the health care organization in managing financial risk: develop reasonable contracts; make separate payment arrangements for in/out patient services; individually tailor payments for specific physicians/services; and require financial and provider accountability.

1. Develop reasonable contracts.
   a. Include provisions which protect against under/overutilization of services.

Straight capitation arrangements invite underutilization. In a straight capitation arrangement, a managed care organization gives a certain amount of money per person per month to a group of physicians which agrees to provide specified health services to the organization's members. The providers thus function like an insurance company in that they are responsible for all the costs associated with the patient population's use of the specified services. However, unless providers are experienced and have the financial resources to safely cover the risks,
capitation arrangements can result in patients' being denied needed services.

On the other hand, contracts should not result in overutilization where providers wind up providing more services than appropriate.

Contracts should include a structure that neutralizes. Salary payment to providers is probably one of the most neutral arrangements.

b. Include provisions which make providers accountable for the outcome and costs of their services. Require providers to report their experience with patients. There are forms available which are widely used for this. They include, for example, UB 82 forms from hospitals and 1500 forms from physicians.

c. Offer a fair, reasonable payment schedule.

Under no circumstances should you consider cutting back reimbursements to providers. A poor relationship with providers ultimately affects your member population.

d. Make sure your payment method reflects the actual resource use or the actual cost that the provider incurred in caring for the patient.

e. Keep your financial arrangement administratively simple, so that payment can be made in a timely and accurate manner.

2. Separate in/outpatient payments.

a. Make separate financial arrangements for inpatient and outpatient services.

b. Hospital costs are rising most rapidly in outpatient treatment where services are being increasingly performed. Try to establish fixed reimbursement arrangements with hospitals in order to maintain some control over outpatient costs.

c. On the inpatient side, have the hospital assume some financial risk by fixing fees on either a per diem or a per stay basis.
(Some hospitals avoid fixed-fee agreements, preferring bill charges or discounts on bill charges.)

d. Review alternate payment methods. (See "Hospital Risk Exposure by Type of Contract" in APPENDIX D.) The following are some of the more common reimbursement options available.

1) **Routine Bill Charges.** A fee-for-service arrangement in which the hospital assumes no risk whatsoever.

2) **Discounted Bill Charges.** A fee-for-service arrangement by which the hospital agrees to reduce charges by a specified percentage. Example: You agree on a 10% discount from billed charges and an 8% inflation rate for medical care. The hospital increases its bill charges by 10%. You get to add the difference between the agreed on and the actual inflation rate (2%) to your discount. This equals a 12% discount. That way, you will have countered the inflation increase in billed charges.

3) **Per Diem Payment Method.** A fee-for-service arrangement by which a flat daily rate covers routine and ancillary services. The flat rate will vary by service category (medical, surgical, psychiatric, obstetrical, neonatal). Per diem arrangements are advantageous to the managed care organization when it is able to keep the length of stay down.

4) **Per Case Payment Method.** An arrangement in which costs are set for specific diagnoses and are fixed by case.

Where the health care organization's influence is limited, it is best to go with a per case payment. For example, in cardiovascular, transplant, or other "big ticket" cases, the managed care organization generally has limited influence and it is best to arrange reimbursement on a per case basis. Per diem and per stay rates should be all-inclusive, so that there is no guessing about liability.

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5) **Capitation.** A method whereby a single rate is set per member per month and pre-paid to cover all inpatient care provided. Few hospitals agree to this method as they are not willing to assume the risk involved. Future legislation may prohibit these arrangements altogether.

Capitation arrangements, however, are still being made in some areas. In considering this method of payment, carefully define your population and define specific hospital service responsibilities.

6) **Percent of Premium.** A method in which the plan pre-pays a set percentage of premiums to the hospital for defined inpatient services. Differs from capitation in that a flat fee is paid. Again, the hospital assumes most of the financial risk.

e. Try to arrange for fixed, all-inclusive rates for each possible outpatient procedure or service, especially surgery.

Medicare divides outpatient surgical procedures into six to eight Outpatient Surgical Groupings, based on anticipated cost. Consider using these groupings as a guide when negotiating fixed outpatient rates.

Alternatively, make a list of the 25 most common outpatient surgical procedures and negotiate a cost for each. Make sure your coding system is consistent and efficient.

Outpatient services such as emergency room or physical therapy are more complex to negotiate. A sound way to arrange reimbursement of these services is through straight billing or discounted bill charges. It would be nearly impossible to establish an emergency room per case rate.

When emergency room patients are admitted to the hospital, make sure emergency room costs are not paid in addition to per diem or per case rates. Make sure emergency room costs are folded into per diem or per case rates.

f. Consider multi-year contracts which include a defined adjustor for inflation.
g. Consider sharing risk between the managed care organization and the hospital.

By definition, managed care organizations and hospitals have conflicting incentives; hospitals would like to fill all of their beds, while managed care systems would like to empty them. Risk can be shared around length of stay. If the length of stay is above the norm, the managed care organization and the hospital split the difference in charges; if it is less than the norm, they split the savings.

Another option is to negotiate for staged per diem arrangements, whereby the greatest amount per case is paid for the first day of stay. The per diem decreases for each subsequent day of hospital stay.

3. Tailor payment methods to individual services and physicians. Physicians can be encouraged to care for patients in an effective and efficient manner through contract incentives (see Kind of Delivery System in APPENDIX E for a description of payment methods and incentives by various physician/association arrangements.)

There are three general options: fee-for-service, capitation or salary. Fee-for-service and capitation can be combined especially for small clinics which can't take on straight capitation. In these cases, payment is on a capitated basis, but the clinic is guaranteed reimbursement which, at the end of the year, will not go below a certain percentage of its fee schedule.

Negotiating Fees

In negotiating fees for service, the managed care organization has the following options.
a. Discount from the physician's fee schedule. This is one of the easiest ways for your system to work.

b. Develop a usual and customary fee schedule by setting rates for each diagnosis and/or procedure based upon what is usual, customary, and reasonable. This is difficult to establish, especially when the managed care organization does not have sufficient experience.

c. Develop a fixed fee schedule. This is often the best approach, since it allows the managed care organization to control increases per year. The drawback is that such schedules may involve a great number of billing codes and thus be complex to administer.

Fixed Payment Options

Fixed payment options, besides capitation, include retainer arrangements and per unit arrangements.

a. Retainer arrangements are a contracted salary arrangement, by which you pay a certain amount per month to the provider, irrespective of the population to be served. For example, $50,000 a month will be paid to anesthesiology for whatever services they provide. You then have incentive to bring more and more service to that hospital. Retainer fees may be adjusted, and are best suited to anesthesiology or other services which are easy to predict over time.

b. Per unit arrangements, by which the managed care system pays per hour.
   a. Claims systems should accurately pay for appropriate services in an efficient, timely manner. All large bills should be reviewed for error. The managed care organization may opt to hire someone to operate the claims system in exchange for a percentage of the claims.
   b. Cash should be paid out on a timely basis (two to four weeks).
   c. Medical authorization and referral systems should be established to assure appropriateness of medical claims. Provider claims should be linked to whomever authorized the service.
   d. Provider fee schedules and code techniques should be regulated. Providers, for example, may code for higher reimbursement by changing "brief visits" to "intermediate visits" or by changing their diagnosis codes. If any significant changes in billing schedules or coding are noticed, the provider should be challenged.

5. Assure Provider Accountability.
   A managed care organization may opt to include the following in its provider contracts:
   a. Require continuous licensing and certification of providers.
   b. Prohibit any form of discrimination or access denial by providers.
   c. Require contracted providers to cooperate with organization's quality assurance and utilization management systems by allowing access to their records.
   d. Require providers to support organization's quality assurance and utilization management efforts by reporting all necessary medical and financial information.
   e. Seek legal assurances by providers (such as liability insurance) to assure that organization is not held liable for provider's negligence. Though the managed care organization may be named
in legal cases, such assurances as liability insurance will normally hold up in court.

f. Clearly define services to be provided and population to be served.

Contract Development Suggestions

1. See "Contract Evaluation Checklist," APPENDIX F, for provisions which should be included in contract.

2. Consider developing a contract abstract or review form (see APPENDIX G) for each individual contract. The abstracts can be filed and referred to as an alternative to leafing through long contracts.

3. Develop a contract manual for providers and others (such as utilization reviewers) with an interest in the contract. (See APPENDIX H for an outline of steps to be followed in developing the contract and for what to include in the manual.)

Risk-Sharing

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Risk-sharing is an issue that needs evaluation. Currently, the private sector is not asked to share any of the risks relating to Indian health. The tribes or IHS assume the full burden. Third-party reimbursement may be sought but is rarely obtained.
At present, federal dollars may not be used to purchase indemnity (insurance) plans for Indian health. This may change. A legislative proposal has been made — but has not cleared OMB yet — that would allow tribes to purchase insurance plans with federal dollars.

Medicaid/Medicare-eligible enrolled tribal members are not being reimbursed for care provided by IHS or Tribes. The State of Arizona, for example, has refused to provide reimbursement through its Medicaid/Medicare HCFA programs for Medically Needy/Medically Indigent Indians who reside on reservations.

**IHS Analysis of Arizona Medicaid Program.**

In response, IHS has contracted an Indian firm to analyze Medicaid's responsibility for services provided to American Indians who are eligible for both IHS and Medicaid/Medicare services.

The analysis focuses on ACCESS (Arizona Health Care Cost Containment System), the Arizona Medicaid program. It is following a preliminary study which showed that the Navajo Area IHS was eligible for some $19 million in Medicaid reimbursements but, because it is a federal entity, it could not obtain this reimbursement.

The Arizona study, still in its early stages, focuses on access and risk issues:

**Access Issues**

The study is analyzing:

a) Possibilities for IHS access to Medicaid resources through statutes and regulations providing for direct billing of fee-for-service costs to State Medical Assistance Plans;
b) Methods and procedures which provide access for IHS to Medicaid reimbursement;

c) Medicaid categories and eligibilities in relation to Fiscal Intermediary payments processing;

d) Statutes, regulations, and procedures pertaining to tribal contractor access to Medicaid resources via IHS;

e) Tribal coordination with State Medical Assistance Plans.

Risk Issues

The study is analyzing Capitated Risk Contracting by reviewing: (1) sources of risk, (2) cost accounting, (3) cost allocation, and (4) financial management system requirements necessary to minimize financial risk.

The study is also analyzing Anti-Deficiency Act Risk Avoidance. This includes analysis of: (1) discretionary and entitlement program anti-deficiency budget expenditure requirements and (2) procurement methods which minimize risk.

Tulalip Risk-Sharing Study

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The Tulalip Tribe is in the Portland IHS Area, located approximately thirty miles north of Seattle. It is one of twelve Puget Sound Service Unit Tribes. Currently, the Tribe has an enrollment of 2,300 people.
The Tulalip health care organization is a tribally-owned health clinic with a user population of 1,700 members. It has no hospitals or clinics and has utilized some 200 health care vendors since 1987. Tulalip has maternal child health and CHR contracts with the IHS. Its newly-installed automated billing system is still collecting preliminary data and is not yet capable of providing long-term study data.

The Tulalip Tribe is a large employer, with approximately 300 full-time employees, 200 of whom are tribal members covered under private insurance.

Tulalip offers two insurance options to its employees: 1) an HMO, which covers all health care costs, with some copayments and deductibles; and 2) a partially self-insured plan.

Like many other organizations, Tulalip has experienced difficulties in coordinating health resources particularly in the area of billing, the responsibility for which it had contracted to IHS. Patient bills were frequently not paid on time and their accounts were sent to collection. Subsequently, providers would often refuse to see these patients.

Tulalip has identified the problem as being one of coordinating resources.

If, for example, a patient has ever been Medicaid/Medicare eligible or has ever had private insurance, he is recorded in the IHS system as having other resources — even after these have expired. The bills of people who are noted as having "other resources" are referred back to the provider. This causes lengthy delays in payment and reluctance to utilize the system. As a result, some Tulalip tribal members do not tell IHS if they have private insurance. Others fully utilize private insurance and get IHS to cover the copayments. Still others don't report at all.
Risk-Sharing Study.

Two years ago, IHS approached Tulalip to propose a risk-sharing study. It targeted the Tulalip Tribe because the latter was successfully providing private insurance for its employees and because Tulalip was dissatisfied with the IHS billing system.

Tulalip agreed to participate in the study, believing it would be a good way to automate its clinic, which at the time was still compiling its data manually. Currently, Tulalip is in the data gathering stage of the study.

The data collection phase of the Tulalip study involves gathering data on population and utilization of health care from a number of sources. This is time-consuming as there are difficulties in searching out sources.

After data gathering and analysis have been completed, the Tribe hopes to be able to effectively combine resources to provide all-encompassing quality health care, including preventive care. The Tribe also hopes to see a substantial reduction in the numbers of members currently on deferred services lists. Tulalip believes these to be realistic goals.

In the State of Washington, recognized tribes have signed an agreement known as the Tribal State Accord. This recognizes the sovereign status of individual tribes and affirms that the relationship between the State and a tribe is one of government to government.

Tulalip feels the Accord strengthens the Tribe's position for obtaining increased access to needed programs.

Tulalip is hoping to create a comprehensive health plan which would be funded by a combination of IHS, tribal, and Medicare/Medicaid dollars.