1988

Evaluation of the Pascua Yaqui Health Care Plan as an Analytical Model and its Merits as an Effective Alternative to the Traditional IHS Delivery Models

Americans for Indian Opportunity

ER. Kemper

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EVALUATION OF THE PASCUA YAQUI HEALTH CARE PLAN AS AN ANALYTICAL MODEL AND ITS MERITS AS AN EFFECTIVE ALTERNATIVE TO THE TRADITIONAL IHS DELIVERY MODELS

EXECUTIVE SUMMARY

Contract No. 240-87-0068

Date: 5/30/88

CONTRACTOR

Americans for Indian Opportunity
3508 Garfield Place
Washington, DC 20007
(202) 338-8809

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Indian Health Service
Department of Health and Human Resources

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FINAL REPORT

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Table of Contents

I. Preface

A. The Pascua Yaqui Health Care Plan is an alternative to traditional IHS direct care, designed to meet the needs of a newly recognized tribe.

Pascua Yaqui tribal members became eligible for Indian Health Service (IHS) funded care in 1978 when the Tribe was first recognized by the federal government.[1] The first Congressional appropriation for Pascua Yaqui (PY) health care did not include funds for facility construction or additional manpower. Contracted health care had to be identified by the IHS Office of Health Program Development (IHS OHPD) in a short period of time.[2] The many health care providers located within the Tucson community were considered and IHS OHPD designed the Pascua Yaqui Health Care Plan (PY HCP) as an experimental health care delivery system to meet the unique situation of the Pascua Yaqui tribal members.

Reservation lands were put in trust for the tribe. The tribal population began moving from various Pascua Yaqui communities to the 892 acres of reservation land located fifteen miles southwest of downtown Tucson.[3] No health facilities were available on the reservation.

Now there are 4990 enrolled members of the Pascua Yaqui Tribe. The tribal membership roll has been temporarily closed until the first constitutional tribal council is established. There are approximately 2000 individuals whose tribal status is pending until the tribal roll is reopened.[4]

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[1] The Tribe was officially recognized by the federal government on September 18, 1978, 25 USC §1300f; P.L. 95-375 §1(a) - (c). The federal recognition legislation stated, "For the purposes of section 2005a of Title 42, the Pascua Yaqui Indians are to be considered as if they were being provided hospital and medical care by or at the expense of the Public Health Service on August 16, 1957", referring to the law which authorizes funds to be expended to public nonprofit agencies for Indian health care, 25 USC §1300f(a), (9/18/78).

[2] OHPD, *Briefing Paper; Pascua Yaqui HMO [sic] Program*; March 11, 1987, pg. 5.

[3] According to the Tribal Enrollment Office, as of 4/30/88, there are 4990 enrolled members of the Pascua Yaqui Tribe. Of the 2853 enrolled members living in Pima County--1444 live at the reservation community New Pascua (or Pascua Pueblo); 196 in Barrio Libre of South Tucson; 379 in Old Pascua Village near central Tucson; 126 in Yoem Pueblo in Maraña and 708 others within the Tucson city limits. There are also sizable communities elsewhere in Arizona, 1052 enrolled members live in the town of Guadalupe outside of Phoenix, 199 in Phoenix; 135 in Penjamo in Scottsdale, and 470 others throughout Arizona. Another 281 live outside of the state.

[4] Tribal elections for the first constitutional tribal council are scheduled to be held June 4, 1988.

The PY HCP averages 3170 members per month--those tribal members and their newborns who reside on the reservation or within its surrounding county;[5] if and only if, they are not eligible for state funded health care.[6] (The children are enrolled in the PY HCP even though they cannot be enrolled in the tribe until the tribal rolls open.) Other "pending" individuals and tribally enrolled members living outside the Service Unit area are currently eligible for IHS direct care services only. Once the rolls open--as expected sometime during the summer of 1988--it is estimated that 700 of the total "new" tribal members will also be eligible for the PY HCP and other IHS Contract Health Services in the county.

The contractual agreement for the PY HCP is signed by the IHS OHPD and a private health care provider--Southwest Catholic Health Network (hereinafter also referred to as the PY HCP Contractor). The IHS compensates the PY HCP Contractor, in advance, at a predetermined monthly rate for all eligible PY tribal members residing in Pima County, Arizona. In turn, the Contractor provides a comprehensive range of services--defined in the PY HCP benefits package--to any eligible PY HCP member requesting services.

The Contractor provides medical service through subcontracts with hospitals, clinics, and specialty physicans.[7] Two clinics must be maintained as required by the PY HCP contract. One is the main outpatient clinic located near downtown Tucson which is easily accessible to the four Pascua Yaqui communities in the service area.[8] The second is a small outpatient clinic located at the Tribal Complex on the reservation.

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[5] Pima County, Arizona defines the boundary of the Yaqui Service Unit.

[6] There are actually 10 categories of eligible individuals for the health care plan listed in the contract at IHS Contract No. 249-87-0007, Part I Section C-1, pgs. 4-5; listed also in Finding One, page 27 of this report.

[7] All subcontracts must be approved in writing by the IHS OHPD Project Officer. IHS Contract No. 249-87-0007. Part I Section F-2, C, pg. 24.

[8] The main clinic is within 5 miles of two Pascua Yaqui urban communities, within 30 miles of a smaller community and within 15 miles of the large reservation population.

The PY HCP is frequently, but mistakenly, referred to as a Health Maintenance Organization (HMO) because of its similarities to an HMO system; however, the PY HCP is not considered an "HMO" by the federal regulatory definition.[9]

B. To study whether the Pascua Yaqui Health Care Plan has been an effective health care delivery system and whether it is adaptable at other Indian Health Service sites, the Indian Health Service contracted with Americans for Indian Opportunity.

It has been nearly ten years since the PY HCP was initiated and it has not been thoroughly evaluated. Other IHS officials have inquired about its success because they are interested in the possibility of administering prepaid care in their areas.[10]

This evaluation of the PY HCP experience is intended to help other IHS sites shorten the learning curve if they choose to develop a similar health care delivery system. The PY HCP experience is helpful because IHS OHPD and the PY Tribe overcame some formidable obstacles. For example, the first Contractor went bankrupt near the end of a contract year[11] and the BIA attempted to withdraw tribal authority to "638" contract federal programs.[12]

Americans for Indian Opportunity, Inc. (AIO) was chosen to conduct the evaluation because AIO has worked on various IHS projects and environmental health projects.[13] AIO is a Washington, DC based nonprofit organization founded in 1970 which recognizes that self-governance depends on a strong and healthy tribal population.

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[9]The PY HCP is not an HMO monitiored by the Office of Prepaid Health Care.

[10]A contract specialist from the Phoenix Area IHS office who works closely with the tribal health department on the Fort Mojave reservation visited on-site and many IHS Officers have attended conference talks by the OHPD staff. For example see IHS–OHPD–Tucson, *Briefing Paper, Pascua Yaqui HMO [sic] Program*, March 11, 1987.

[11]Since the bankruptcy came at the end of a contract term, it was not as devasting as it may have been. IHS was able to cooperate with the PY HCP Contractor and its creditors. Outpatient services continued at the Clinic but on a month-to-month, fee-for-service basis; inpatient services at a local hospital were negotiated directly by IHS.

[12]The Bureau of Indian Affairs attempted to strip the Tribe of its authority to contract programs (including the 638 health department contract) due to prolonged delays in establishing a tribal constitutional government. The Tribe regained its contracting authority through litigation and soon thereafter enacted a tribal constitution.

[13]*"Messing with Mother Nature"*, DHHS, (1982); *Survey of American Indian Environmental Protection Needs on Reservation Lands: 1986*; EPA; and Tribal Governance Project, DHHS, (1987).

II. Acknowledgments

A. Key AIO staff members

Americans for Indian Opportunity
3508 Garfield Place NW
Washington, DC 20007 (202) 338-8809

1. President and Executive Director, La Donna Harris
   Ms. Harris oversees the project. Her insight and suggestions have been very helpful throughout the project.

2. Finance Director, Rebecca Aronson
   Ms. Aronson is responsible for the accounting of the project.

3. Assistant for Policy, Jacqueline Wasilewski, Ph.D.
   Dr. Wasilewski contributed to the presentation of the report.

B. Consultants

1. Project Director, Ellen R. Kemper
   2930 Upton Street NW
   Washington, DC 20008 (202) 362-0425
   Ms. Kemper coordinates this project. She is responsible for selecting and supervising the others working on this project. She conducted the field work, drafted the statistical report and is the principal author of this report.

2. Field Specialist, Dr. Robert E. Howard
   558-B Arapaho Lane
   Stratford, CT 06497 (203) 378-6385
   Dr. Howard conducted the interviews and presentations in the field. He also contributed to the written report.

3. Statistician, Saha AmaraSingham
   1828 L Street NW, Suite 908
   Washington, DC 20036 (202) 887-8110
   Dr. AmaraSingham reviewed and analyzed the Statistical Report and Patient Satisfaction Survey results.

C. Evaluation Project Committee members

1. Charles J. Erickson
   Deputy Associate Director
   IHS Office of Health Program Research & Development
   7900 South J.J. Stock Road
   Tucson, AZ 85746 (602) 629-5010

2. Frank Quam
   IHS Principal Consultant, CHS
   Albuquerque Area IHS
   505 Marquette NW--Suite 1502
   Albuquerque, NM 87102-2161 (505) 766-3632

3. Edward Simermeyer, Acting Director
IHS Evaluation & Policy Analysis
Parklawn Building, Room 8A-27
5600 Fishers Lane
Rockville, MD 20857 (301) 443-4700

D. Key project assistance

1. IHS OHPD Executive Officer, Reuben T. Howard
IHS Office of Health Program Research & Development
7900 South J.J. Stock Road
Tucson, AZ 85746-9352 (602) 629-6600
Mr. Howard is the IHS designated Project Officer. He defined the work plan and then made his staff available to provide information or assist in field work.

2. Executive Director, El Rio Santa Cruz Neighborhood Health Clinic, Robert Gomez
839 W. Congress Street
Tucson, AZ 85745 (602) 792-9890
Mr. Gomez provided statistical data and he opened up the clinic to extensive interviewing of his staff.

3. Director, Pascua Yaqui Tribal Health Department, Pete Flores
7474 S. Camino de Oeste
Tucson, AZ 85746 (602) 883-2838
Mr. Flores provided assistance on-site field work and has commented throughout the project.

4. Contract Administrator, Lyska A. Lomayesva
IHS Tucson Program Office
Contracts and Grants Branch, Bldg. SX-4
7900 South J.J. Stock Road
Tucson, AZ 85746-9352 (602) 629-6999
Ms. Lomayesva provided the details necesary to understand the PY HCP contract.

5. IHS Program Officer, PY HCP Project Officer, Jim Powers
IHS Tucson Program Office
7900 South J.J. Stock Road
Tucson, AZ 85746-9352 (602) 629-6913
Mr. Powers provided great insight to the issues underlying the PY HCP contract.

III. List of Abbreviations

AHCCCS	Arizona Health Care Cost Containment System
AIO	Americans for Indian Opportunity
BIA	Bureau of Indian Affairs
CHN	Community Health Nurse
CHR	Community Health Representative
CHS	Contract Health Service
CFR	Code of Federal Regulations
DHHS	Department of Health and Human Services
El Rio	El Rio Santa Cruz Neighborhood Health Center
HMO	Health Maintenance Organization
IHS	Indian Health Service
IPA	Intergovernment Personnel Agreement
JCAH	Joint Commission on Hospital Accreditation
OHPD	Office of Health Program Development
OMB	Office of Management and Budget
PY	Pascua Yaqui
PY HD	Pascua Yaqui Health Department
PY HCP	Pascua Yaqui Health Care Plan
RFP	Request for Proposal
SCHN	Southwest Catholic Health Network
"638"	P.L. 93-638

IV. Abstract

This evaluation of the Pascua Yaqui Health Care Plan (PY HCP) was initiated by the Tucson Indian Health Service Office of Health Programs Development to inform IHS staff, tribes and potential health care providers about the prepaid health care delivery system in place for the Yaqui Service Unit. This report is intended to answer six specific questions presented in the Request for Proposal to evaluate the PY HCP.[14] It addition, it describes issues underlying this project and the dimensions of the PY HCP arrangement.

The information in this report was obtained over a seven-month period. Throughout that time, consultants from Americans for Indian Opportunity, Inc. visited the PY HCP sites. Interviews were conducted with staff from the PY HCP Contractor, PY HCP Clinics, PY Tribal Health Department, PY Tribal Administration, and IHS OHPD. Other sources of information include data collection and interviews at IHS Area Offices in Albuquerque and Oklahoma City; frequent discussions with the IHS Project Officer (for this evaluation); further discussions with other IHS OHPD staff; and the PY HCP Patient Satisfaction Survey conducted as part of the project.

Deliverables required in the work plan of the evaluation include 1) a Statistical Report; 2) two Interim Reports; 3) a Draft Outline of this report; 4) an on-site presentation on the field work; 5) a presentation on the project at IHS Headquarters; 6) a draft Report and Executive Summary; and 7) the completed Final Report and Executive Summary.

This evaluation brings to light the major strengths of the prepaid arrangement: 1) communication and cooperation is developed between IHS, the Tribe and the private Contractor; 2) it can be an effective intermediate step between direct IHS delivery and full contract administration by the Tribe; 3) much of the financial risk and managerial tasks shift from the IHS to the private sector; and 4) the patient receives continuity of care at convenient,

[14]HRSA 240-IHS 7(7) WAK; the six questions are found in the Purpose and Conclusions sections of this report.

modern facilities. The major problems are: 1) both IHS and the Contractor increase the paperwork required for referral services; 2) patients incorrectly receive bills for referral services; 3) cultural sensitivity may be lacking in the provision of care; and 4) it can be difficult to follow-up on patients treated through alternative resources or referred providers.

The PY HCP model cannot be transferred to all IHS sites indiscriminately. Each potential site must be studied for suitability to determine if the Tribe and IHS Office are willing to undertake the additional work involved in monitoring the prepaid arrangement.

It is proposed to supplement this evaluation with a detailed financial analysis of the PY HCP and with a feasibility study of an IHS site which could potentially adapt this model.

This report begins with the statement of purpose and the six questions asked in the PY HCP evaluation proposal by the IHS Project Officer. This is followed by a review of background information, a section of findings which together describe the current prepaid arrangement, and the results of the Patient Satisfaction Survey. The latter part of the report contains Conclusions and Recommendations.

V. Main Text

A. Purpose of the Project.

This evaluation is intended to answer the following six questions:

1) How well is the present arrangement with the PY HCP Contractor meeting the needs of the Pascua Yaqui tribal members in Pima County?

2) What are the strengths and problems of this prepaid arrangement as the principal source of health services for this population?

3) What are recommended approaches for resolving the problems?

4) What aspects of the PY HCP plan seem potentially transferable to other sites?

5) How does the experience of the Pascua Yaqui tribe compare with that of other populations receiving most of their care from facilities operated by the Indian Health Service?

6) What kind of comparisons can be made with other Indian communities?

This project is the first phase of a proposed two-part study of the Pascua Yaqui Health Care Plan (PY HCP)--the prepaid arrangement established in 1980 by the IHS OHPD to serve the newly recognized Pascua Yaqui tribal members.[15] This is the first in-depth evaluation of the PY HCP. The report evaluates the prepaid arrangement primarily in terms of health care management, but also in regard to its potential to build self-determination through tribal contracting of IHS programs. The information presented in this report is a culmination of numerous interviews and discussions with personnel associated with the PY HCP and also interviews with key personnel at IHS Area offices in Albuquerque and Oklahoma City.

This report describes the PY HCP design and presents findings relevant to the evaluation of operation. It documents the cooperative efforts of the PY HCP Contractor, the

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[15]The original contract began 3/1/80.

IHS Office and the Tribe that are necessary to successfully implement this alternative health care system.

This report is written for the IHS staff officers, affected tribes, and potential health care providers at any Indian Health Service site which may consider instituting a prepaid health care delivery plan. It is not a handbook for initiating an HMO or other prepaid plan at every IHS site because each reservation situation is unique and the competitive medical environment differs in each community. It identifies obstacles overcome and persistent problems with the PY HCP. The report addresses underlying issues, suggested changes, current assessment, and considerations for replicating this prepaid arrangement at other IHS sites. This report discusses which site resources, population demographics, tribal administrative authority, tribal health programs, health provider structure, and IHS local administrative capabilities are necessary to develop an effective prepaid health care plan. With this information available, the next IHS prepaid plan can avoid certain problems and can mitigate others from the outset.

A Statistical Report on the health status of the PY HCP members was submitted with this report.[16] The proposed second phase of this project will be a financial analysis of the PY HCP to calculate of the true cost of the PY HCP arrangement. It will address the costs of all supplemental services provided by the Tribe and IHS.[17] The project will include a suitability study comparing the cost of the prepaid plan with the cost of providing the same services through IHS direct care.

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[16]The draft Statistical Report was submitted in 11/23/87. The final Statistical Report will be submitted along with this Final PY HCP Evaluation Report on 5/30/88.

[17]For example: The tribe provides community outreach, transportation, clinic space and staff through a 638 contract. The IHS OHPD provides membership verification, contract interpretation and technical assistance. For more details on their roles see Finding Three.

B. Background, issues, other factors influencing the PY HCP.

1. National issues influence this study. IHS is considering methods other than direct care to meet its twin goals of elevating the health status of all American Indians and Alaska Natives to the highest level possible and improving the ability of tribes to manage their own health care systems. Recent IHS policy changes shape these considerations.

a. OMB Initiative 10-75. On 2/18/87, the Office of Management and Budget, recommended that over the following 10 years there be a transfer of management from IHS to tribal organizations in 75% at the IHS operated hospital and clinics.[18] Although the initiative is expressly intended to advance self-determination, the IHS also interpreted this announcement as a strong message to prepare for diminishing resources. In response, the IHS OHPD sought to analyze the adaptability of the PY HCP model for other Indian communities as part of its PY HCP evaluation.

b. New IHS eligibility regulations, as modified by Congress, will change the service population for IHS care. As of September 16, 1988, eligibility for IHS services will be restricted to Indian and Alaska Native persons who are members of federally recognized tribes and reside within a designated health service delivery area.[19] This tribal affiliation is not required of children 18 years and younger who have at least one natural parent who is a tribal member eligible for services. Provisions are also made for other limited exceptions, changes in service delivery boundaries, and fee-for-service care. All eligible individuals will be required to carry beneficiary identification cards.

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[18]Letter from James C. Miller III, Director Office of Management and Budget, to Secretary of Health and Human Services, Otis R. Bowen, 2/18/87.

[19]Congress extended the implementation date of the regulations by six months as part of the 1988 Continuing Appropriations Act. Note, however, on May 12 Senator Melcher introduced S. 2382, a bill to place a three-year moratorium on any changes in regulations that govern who may receive IHS-funded medical care.

2. The relationship between the IHS and Tribes is evolving.

a. From the Indian patient's point of view. In the past, Indian patients were encouraged to seek health care whenever they felt ill; however, most did not use the services until their illness reached a serious or critical condition. Now, in order to reduce the need for acute care services, IHS encourages Indian patients to take care of themselves through good health practices that emphasize health preventative measures and regular health maintenance. Indeed, Indians are more likely to die from lifestyle behavioral related health problems. In the past, infectious diseases were the leading cause of death for Indians.[20]

b. From the IHS point of view. Congress is recognizing that federal agencies need to fully consult or work with tribes in the management of Indian programs.[21] The IHS is increasingly encouraging tribes and tribal organizations to administer IHS programs.[22]

c. From the tribal government's point of view. Many tribes fear that Contract Health Services and 638 contracting indicate that the federal government is abandoning its Indian health care responsibilities. Tribes are especially reluctant to embrace any new federal program which transfers the responsibility to the private sector.[23]

On the other hand, Tribes know IHS is seeking alternatives and they want some say in the system chosen for them. Tribes approach the IHS Health Planning Offices for background

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[20] *Indian Health Care*, Office of Technology Assessment, OTA-H-290, April 1986, pg. 19, see also Sorkin, *Health and Economic Development on American Indian Reservations.*

[21] The Omnibus Drug Law, P.L. 99-570, requires the BIA, IHS and Tribes to work together in establishing regional centers for comprehensive alcohol treatment. Programs must range from Prevention (aimed at adolescents) to after care. Tribal input is required even though the IHS is responsible for managing the center.

[22] "638" is a common term in Indian Country referring to tribal contracting pursuant to the Indian Self-Determination and Education Assistance Act of 1975, P.L. 93-638. The IHS, however, retains responsibility for monitoring tribal programs. If IHS determines that the tribal program is inadequate, then IHS is required to provide care by another means. One interviewee commented on the unfairness of the present approach because IHS is quick to judge if a tribe is managing improperly when it generally takes 5 years for programs to evolve.

[23] Tribes fear that it is the first step to "terminating" their special status with the federal government. The tribal fear of termination is strong because many of the contemporary tribal leaders were young adults when the government first instituted the termination policy. Both tribal and IHS staff recognized this fear.

information to do their own tribal planning.[24] Tribes sometimes decide to contract for programs after the IHS programs are cut back, hoping to provide more health care for tribal members with less overhead cost.[25]

*3. **IHS and the states are debating the funding of Indian indigents.*** IHS is required by regulation to pursue alternative funding sources. Under this "alternative source rule" potentially eligible patients must apply for "available and accessible alternative resources" prior to encumbering IHS Contract Health Service funds.[26] States, like Arizona, that have a similar alternative source rule debate who is primarily responsible for health care to medically indigent on-reservation Indians.

The PY HCP Contractor, with assistance from the PY HD, has identified approximately 300 PY members in Pima Country as eligible for the state program--Arizona Health Care Cost Containment System (AHCCCS). Each individual tribal member must complete the application for state coverage within 24 hours of receiving care.[27] An individual can be certified eligible to receive the state coverage for up to six months, and he or she must reapply every six months.[28]

In Arizona the issue is pending in litigation. In *Coconino Country v. USA,*[29] the U.S. District Court of Arizona ruled in favor of the IHS Alternative Resource Rule. It held that the

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[24]This was true at both of the Area Offices visited as part of this evaluation.

[25]This has been done in Nevada by the Las Vegas Paiute Tribe. Some tribes are reluctant because they are not comfortable with making life and death decisions, according to the Oklahoma City Area Office.

[26]42 CFR §36.23(f), the regulation designates the IHS contract care program as the residual payer, or payer of last resort, for eligible Indians who have access to other sources of reimbursement or health care delivery. Alternative sources would include but are not limited to Medicare, Medicaid, vocational rehabilitation, Veterans Administration, crippled children private insurance and State programs. IHS *"Indian Health Manual"*, internal document, Rockville, MD 1983.

[27]The application must be accompanied by a birth certificate, driver's license and proof of residency.

[28]If a person is eligible but not enrolled in the state program, the state will refuse to pay. A patient can enroll up to 24 hours after receiving service.

[29]Civil Docket No. 87-2523, No. 87-2525; Ninth Circuit Court of Appeals.

federal regulation overrides the state rule, therefore, the state must pay for health care received by indigent Indians at non-IHS facilities. This case is now on appeal to the Ninth Circuit Court of Appeals.

However, the Ninth Circuit Court of Appeals ruled in an earlier case--*McNabb v. Bowen,*[30] that if a county refused to pay then its funds were not considered "available and accessible" for purposes of the alternative source rule.

At a recent conference on the Arizona AHCCCS Program in relation to Indians, hosted by the Tohono O'Odham Tribe, the state agreed to include a tribal representative in the decision making process of the state medically indigent program.[31] The tribal representative agreed to participate in an AHCCCS-Indian taskforce, to be established after the conferees had an opportunity to consult with their respective tribes.[32]

The objective is to supplement the IHS contract care budget with state funds since the IHS budget can meet only about 65% of the Indian need for contract care.[33] The transfer to the state or any other alternative resource payor does not relinquish the IHS responsibility to improve the health status of an Indian patient.

4. The IHS is constrained by its level of funding. Estimated costs for health care treatment of Indians is a $600-$800 average per person/per year.[34] The cost can rise to twice the average on some reservations.[35] Appropriations in recent years have merely

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[30] 9th Circuit Court of Appeals, Montana, 10/1/87

[31] Conference held 1/18 - 1/20/88, Tucson, Arizona.

[32] Conference on AHCCCS & Indians, *Summary Report,* pg. 21.

[33] Conference on AHCCCS & Indians, *Summary Report,* pg. 32.

[34] *Alternative Health Care Delivery and Financing Systems; Summary Report of IHS Conference;* Baltimore, Maryland; November 16-19, 1987 [hereinafter referred to as *AHCS,* Baltimore Conference], pg. KS-2.

[35] Health care costs on the Mescalero Apache Indian Reservation are double the IHS average according to the Albuquerque Area Office.

reauthorized budget amount of the previous year. Increases have been narrowly targeted to specific subprograms and objectives.[36] IHS is forced to reduce its level of services as funds decrease and costs rise.[37]

On the other hand, private contractors expect regular payments for services rather than sporadic disbursement of IHS funds. This may be a handicap in attracting private contractors who want to be assured of a steady cash flow in order to make long term plans.

In addition, malpractice coverage is an extra cost factor for the private sector that should be factored into the capitated rate. IHS funding does not reflect the costs of medical malpractice. It is not considered an indirect or direct cost for the IHS because the IHS staff is covered under the Federal Torts Claim Act.

*5. **Important considerations for all prepaid health care plans.*** More than two-thirds of the American public will be receiving health care services from privately managed health care plans by the mid-1990s.[38] Competition and profit motivation account for this shift in medical services.

IHS can benefit from the increase in health care competition. Health care providers are more willing to accept various external controls and audit mechanisms in order to attract more "customers". This means the IHS can impose more data requirements and approval procedures without intimidating potential contractors. The IHS will then have the additional reports and documentation it needs to receive its full share of IHS funds.

Since cost containment is the principal incentive behind the prepaid health care delivery system, any prepaid program is expected to decrease hospital admissions, decrease average

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[36] *AHCS*, Baltimore Conference, pg. WRG-12.

[37] This happened with the experimental Pawnee Benefits Package in the Oklahoma City Area. The package was supposed to include additional coverage in its later years but funding cutbacks resulted in a decrease of services provided.

[38] Schroer, Penn, and Ahern, *Hospital Strategies for Contracting with Managed Care Plans*, American Hospital Publishing, Inc. (1987), pg. 3.

lengths of stay and stabilize or reduce use of referral services. Whether this decrease in services is an appropriate response to prior "overuse" of services or is actually a reduction of services is unclear. Critics argue both sides. Some in the medical community believe that HMOs perform fewer laboratory and diagnostic tests than may be necessary, employ less qualified physicians, and do not to allow for adequate interaction between the physician and patient.[39] Others believe that under an HMO arrangement, the increased utilization of outpatient services provides early detection and treatment of medical problems.[40]

The prepaid model differs from the public health service model used by the IHS. The public health service model emphasizes health promotion and wellness with less emphasis on cost than the prepaid model. IHS must monitor the prepaid PY HCP Contractor to ensure that cost containment is due to emphasis on health promotion and good routine primary care rather than an inadequate amount of services. One safeguard provided by the PY HCP is that IHS physicians audit the Contractor to determine if patient hospital stays are being cut short to save on costs.[41] The difference may not be so great if the Contractor actively encourages health prevention as a means to minimize costs.

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[39]Demlo, Linda, Ph.D, *Quality of Care Research and Applications for HMOs*, Speech, US Government Accounting Office.

[40]Schroer, Penn and Ahern, *Hospital Strategies for Contracting with Managed Care Plans*, pg. 2. See also *AHCS*, Baltimore Conference, pg. WGR-5.

[41]Industry-wide HMOs average 400 bed utilization days per 1000. IHS averages 700 bed days per 1000 and national health care utilization is approximately 1100 bed days per 1000. *AHCS*, Baltimore Conference, pg. WGR-5.

C. Methodology designed and used, its execution, major difficulties and resolution.

1. Scope of Work. The scope of work as presented in the Request for Proposal required a narrative and statistical description of the PY HCP; field work at the PY HCP and field visits to three comparison sites; an on-site briefing; revision of the work plan; interim reports; outline of the final report; headquarters briefing; the drafting of report and executive summary; and the final versions of the report and executive summary.[42]

The IHS Project Officer and Contractor (AIO) refined the scope of work at the initial meeting of 10/20/87. This refined work plan was further revised during the course of the contract. Changes to the work plan are: 1) The statistical description was limited to information regarding the health status of the enrollees over the years of the plan. Data was provided by the IHS OHPD and by the PY HCP Contractor. 2) Interviews at the comparison sites took place at the Area Office level rather than at the Service Unit level. 3) Two (not three) comparison sites were visited. 4) Time and funds originally allocated for the third site visit were spent on a lengthened Tucson visit in January. 5) The Patient Satisfaction Surveys were conducted at the PY HCP site only. 6) The Patient Satisfaction Surveys were conducted in January 1988 instead of November 1987.

2. Statistical Report. Data related to the health care received by the PY HCP members was compared to state and national figures, consolidated and reformatted into tables and charts presented in the draft Statistical Report.[43] IHS personnel and others reviewed the draft Statistical Report. The final Statistical Report is submitted concurrently with this report. The statistical information in the report was limited to data previously collected by the IHS OHPD;[44] data supplied by the PY HCP Contractor over the past seven years;[45] and a review of

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[42]RFP HRSA 240-IHS-(7) 7-WAK, Part I, Section C, pgs. 4 - 6.

[43]Submitted 11/23/88.

[44]The PY HCP Evaluation Project Officer explained that in the time between the writing of the RFP for the evaluation and the letting of the contract, the IHS had pulled together significant information regarding the health

all Pascua Yaqui death records since 1981.[46] The Statistical Report contains tables, charts and a narrative description.

3. The Interview Process. The majority of the conclusions and recommendations in this report are based on information gathered from personal or small group interviews. A different checklist of questions was developed for each group by the Contractor with input by the Project Officer. The interviews were unstructured and the checklists were used as guidelines to elicit information. Each interview was recorded on tape cassette.[47] Interviews tended to last one hour or more. Interviews were conducted at the interviewee's work place, in an area separate from others in the work place. and usually without interruption.

In Tucson, four groups were targeted for interviewing: 1) Selected IHS OHPD staff; 2) PY HCP Contractor personnel; 3) Clinic staff; 4) PY Health Department staff; and the 5) PY Tribal Administration personnel.

a. A listing of those interviewed in Tucson follows:

IHS Office of Health Programs Office
- (1) Project Officer, Jim Powers
- (2) Alternative Project Officer, Reuben Howard
- (3) Contract Administrator, Lyska Lomayesva

PY HCP Contractor, Southwest Catholic Health Network
- (1) President and Chief Executive Officer, Kathy Byrne
- (2) Tucson Regional Medical Coordinator, Harriet Hand

Outpatient Clinics, El Rio Santa Cruz Neighborhood Medical Center,
- (1) Executive Director, Robert Gomez

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care provided by the PY HCP Contractor. IHS OHPD provided demographic data, information of utilization rates and associated costs. Death certificates for PY tribal members that had been collected by the IHS were also reviewed.

[45]The PY HCP Contractor provided additional data on the enrollees including listings of deceased PY HCP members, major diseases and number of clinic encounters.

[46]Data requested that would have required a record-by-record search included maternity statistics and the birthweights of all newborns through 4 years of age.

[47]One interview was not recorded in respect of the interviewee's wishes.

(2) Medical Director, Dr. Lionel Tapia
(3) Clinic Physician, Dr. Carlos Gonzalez
(4) Nursing Director, Dianna Gonzales
(5) Patient Advocate, Julia Soto
(6) Billing Administration, Liz Guerra
(7) Social Worker, Kit Causey
(8) Referral Administration, Liz Gallegos

Pascua Yaqui Tribal Health Department
(1) Department Director, Pete Flores
(2) Medical Social Worker Assistant, Becky Ponder
(3) IPA Physician, Dr. Lois Steele

Pascua Yaqui Tribal Administration
(1) (Acting) Chairman, Raoul Silvas
(2) (Acting) Tribal Administrator, Lindsey Rhoades

b. Documents received in Tucson.

The El Rio Clinic has provided the following documents:
Patient Handbook
Quality Assurance Procedure
List of doctors and credentials at the El Rio Clinic
Report on Pascua Yaqui Tribe Mental Health Services: Drug and Alcohol, 1987, Prepared by the Yaqui Social Worker, C. Causey

IHS Tucson Program Office has provided the following documents:
Tucson Program Office Profile, 5/87
Current PY HCP contract
Modifications to the current contract
Correspondence re modifications and contract in the past.
Current RFP--new PY HCP Contract
Memorandum regarding AHCCCS funding.

c. Interviews conducted at comparison sites.

Two other IHS Area Offices were visited to get a greater perspective of health care management within the Indian Health Services. The sites chosen are very different from each other. The Albuquerque Area IHS beneficiaries are isolated on remote pueblos. Most care is provided at IHS direct care facilities. The Albuquerque Area Office is not anxious to "638" its contracts. In the Oklahoma City Area, the beneficiaries are not as segregated from the general population. Contract Health Care is prevalent. Tribal administration of contracts is encouraged.

d. A listing of those interviewed at the comparison sites follows:

Albuquerque Area Office
(1) Area Director, Josephine Waconda
(2) Contract Health Care Officer, Frank Quam
(3) Medical Officer, Dr. Judith Kitzes
(4) Chief Medical Officer, Dr. Richard Kotomori
(5) Tribal Affairs Officer, Mike Bird

Oklahoma City Area Office
(1) Area Director, Dr. H.C. Townsley
(2) Executive Officer, Franklin Jody Dreadfulwater
(3) Chief Medical Officer, Dr. Pat Gideon
(4) Assistant Chief of Staff, Dr. Mike Fire
(5) Contract Health Care Officer, Gloria Holder
(6) Planning Assistant, Ranelle Harry

e. Documents gathered at comparison sites.

Albuquerque Area Profile, Fiscal Year 1986
Albuquerque Area IHS Booklet, 1984
Albuquerque Area IHS Objectives, FY '87
Albuquerque Area IHS Level of Services
Oklahoma City Area Profile

4. Patient Satisfaction Surveys

During the week of January 11, 1988, Patient Satisfaction Surveys were administered to 196 PY members. The purpose of the survey was to elicit the patients' perceptions of the current prepaid arrangement and to allow them to voice their unmet needs.

The questionnaire was revised substantially. It began as the highly structured Form II of Patient Satisfaction Questionnaire (PSQ) developed at Southern Illinois University School of Medicine with modifications for Indian Country.[48] Every question in the PSQ requires a response on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). The PSI has many open ended questions and different sets of response choices. Following the initial meeting with the

[48]Developed during a study funded by the National Center for Health Services Research and Development. Form II is considered the most comprehensive and reliable version of the PSQ. Ware, J.E., et al., *Defining and Measuring Patient Satisfaction with Medical Care*, Evaluation and Program Planning, Vol. 6, pgs. 247-263, 1983.

IHS Project Officer, the PSQ was merged with the Patient Satisfaction Interview (PSI) form developed and beta tested by the IHS OHPD.[49]

This resulting combination instrument was reviewed by the Project Statistician,[50] IHS Project Director, the PY Health Director and the Clinic Executive Director. Staff from both clinics reviewed the documents. Comments were solicited from the Contractor and the PY Health Director. Meetings were held to further discuss the content of the instrument until the final version was agreed upon. A written Spanish version was also approved.

The Patient Satisfaction Survey was administered by six interviewers recruited with the assistance of the PY Health Department and the Pima County Community College Job Placement Office. Three of the interviewers are Pascua Yaqui tribal members,[51] one interviewer was married to a PY member; and two interviewers were students at the Community College. All interviewers were bilingual in Spanish and English. The interviewers were selected and trained on 1/11/88. The questions were reviewed and the interviewers role-played administration of both the English and Spanish versions of the questionnaire. Surveys were conducted 1/12/88 thru 1/15/88.

Each interviewer asked questions directly of the participant and filled out a separate questionnaire for each individual interviewed. Both Spanish and English versions of the questionnaire were supplied to each interviewer. The questionnaires were designed to elicit additional information; the interviewers were instructed to take notes on any comments offered.

Interviewers were stationed at the two clinics from 10 a.m. to 4 p.m. each day. The three interviewers stationed at the Main Clinic were provided offices located near the waiting

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[49]IHS OHPD 87.2, Beta Test version

[50]Saha AmaraSingham, International Development Director of Health Management, Inc.

[51]One interviewer was previously employed at the Main Clinic.

room for interviewing. Patients were approached in the waiting area and asked if they would be willing to participate in a survey.

The three interviewers stationed at the PY Tribal Complex interviewed in the Tribal Council Chamber and the outdoor courtyard area of the Tribal Complex. One interviewer spent two mornings interviewing at the PY Tribal Elderly Center. Patients were approached when entering the Tribal Clinic and asked if they would be willing to participate while they waited or after their visit. In addition, the interviewers approached PY members who work in the Tribal Complex and other PY tribal members who visited the area during the interviewing hours. The comments from the survey are referred to throughout this report. A presentation of the survey results in located on pages 51 thru 55.

5. Health journal articles were reviewed to provide additional information.

The major literature included:

1. *Alternative Health Care Delivery and Financing Systems; Summary Report of IHS Conference;* Baltimore, Maryland; November 16-19, 1987.

2. Berwick, D.M., *Monitoring Quality in HMOs,* Business and Health, Pg. 9, Nov. 1987.

3. Birch and Davis Associates, Inc., *Guide to Health Maintenance Organization Development*, DHHS, Office of Health Maintenance Organizations, March 1982.

4. Davies, A.R., Ware, et al., *Consumer Acceptance of Prepaid and Fee-for-Service Medical Care: Results from a Randomized Controlled Trial,* Health Services Research (Chicago), Issue 3, August 1986, pg. 429-52.

5. Demlo, Linda; *Quality of Care Research and Applications for HMOs,* speech, Government Accounting Office.

6. *Employees, HMOs and Dual Choice*, Division of HMO Compliance, DHHS Publication No. (HRSA) HRS-M-HM 842.

7. *Evaluating Quality of Care,* article from American Medical Review and Research Conference for Peer Review Organizations.

8. *GHAA's 1987 Survey of HMO Industry Trends*, Group Health Association of America, Inc.

9. *Indian Health Care,* Office of Technology Assessment, OTA-H-290, April 1986.

10. *Ohio HMO Standards*, Joint Commission on Accreditation of Hospitals, Chicago, Illinois; (312) 642-6061.

11. Scheele, Carol Ann, *Physician Criteria for Evaluating Alternative Delivery Systems*, Journal of the Kentucky Medical Association, Vol. 83, Issue 5, Sept. 1985, pg. 5157.

12. Schroer, Penn and Ahern, *Hospital Strategies for Contracting with Managed Care Plans,* American Hospital Publishing, Inc., 1987.

13. Sheldon, Alan, *Getting There: A Strategic Planning Framework for Health Maintenance Organizations*, DHHS, HRSA, Bureau of Health Maintenance Organizations and Resource Development, August 1980.

14. Sizemore, J. and Bob Peterson, *Determining the True Cost of Contracting Federal Programs for Indian Tribes*, Northwest Portland Area Indian Health Board and the Affiliated Tribes of Northwest Indians, 1987.

15. Sorkin, A.L., *Health and Economic Development on American Indian Reservations.*

16. Ware, J.E., et al., *Comparison of Health Outcome at a Health Maintenance Organisation with those of Fee-For-Service Care,* The Lancet, May 3, 1986, pg. 1017-22.

17. Ware, J.E., et al., *Defining and Measuring Patient Satisfaction with Medical Care*, Evaluation and Program Planning, Vol. 6, pgs. 247-263, 1983.

6. Difficulties and resolution

a. Shortage of Statistical Available Data.

Difficulties in gathering statistical data became apparent at the onset and resulted in a modification of the work plan. Factors contributing to the inability to collect data were: 1) PY tribal members received their health care prior to 1980 in a sporadic manner from various health centers, and 2) there is and has been no routine collection of data on PY tribal members served by alternative resources.

Specific difficulties were that 1) previous data would have to be extracted by extensive search of medical records in various state and county medical agencies; 2) maternal and infant

data would have to be compiled from searching individual medical records; and 3) a number of death records are missing because the physician or mortician had not properly documented the tribal affiliation of the deceased.

b. Inability to schedule two interviews as planned.

Both the Planning Officer of the Oklahoma City Area Office and the Executive Officer from the Albuquerque Area Officer were unavailable for interviews within the site visit schedule.

D. Other aspects of the total contract effort.

Much of the information in this report is based on information gathered during interviews. Future planning for development of prepaid plans in Indian Country needs to be supported by statistics on the cost of services delivered by the prepaid plan compared to the cost of those services provided directly by the IHS.

A feasibility study has been proposed as a second phase to this project. The emphasis is two-fold: 1) a comparison of the PY HCP and tribally administrated program costs versus the actual cost of IHS direct care for PY tribal members; and 2) a comparison of the cost of implementing the prepaid arrangement at a selected IHS site versus the provision of IHS direct care at that site.

E. Results and Findings

The Results and Findings section is a descriptive analysis of the Pascua Yaqui Health Care Plan and other health care programs available to the PY Tribe. There are four findings and one compilation of results: Findings One and Two describe the current arrangement of the PY HCP. Finding Three describes supplemental and complemental health care programs. Finding Four analyzes the capitated rate projections. The Results are a summary of patient responses to the Patient Satisfaction Survey questionnaire.

- Finding One: The contract defines the basic roles of the Contractor, IHS, and Tribe --the work plan as defined by contract provisions.
- Finding Two: The PY HCP is similar to the HMO network model --analysis in terms of structure, process, and outcome dimensions.
- Finding Three: The PY HCP is a subset of the health care provided by IHS to the PY Tribe--other health care programs described.
- Finding Four: The actual capitated rate cost for providing the benefits package was higher than the estimated capitated rate--a comparison.
- Results: The PY HCP Patient Satisfaction Surveys administered Jan. 12 - 15, 1988 (with responses from the Tribal Clinic and PY HCP downtown clinic listed separately.)

Finding One:

The contract defines the basic roles of the Contractor, IHS and Tribe --the work plan as defined by contract provisions.

Finding One describes the current arrangement between the IHS and the PY HCP Contractor. It addresses the tasks as required of the Contractor in the the contractual agreement and the supplemental services provided by the IHS and the PY Tribal Health Department.

All citations to contract provisions refer to IHS Contract No. 249-87-0007, the contractual agreement in operation at the time of this evaluation. Note, the new contract is available as a Request for Proposal (RFP) from the Office of Health Program Development:

IHS San Xavier Clinic; 7900 South J.J. Stock Road; Tucson, AZ 85746; (602) 629-6999. A revised version of the contractual agreement will be available this summer for future use and as a model for prepaid health care plans in Indian Country.

The current contract is comprehensive. It not only covers the responsibilities of the parties but also expresses that the agreement is intended to benefit Pascua Yäqui tribal members. The scope of work alone is 38-pages long; it contains a government regulations section and an appendix. The basic elements contained in this contractual agreement are: 1) the parties involved; 2) the contractual period 3) compensation and 4) scope of work.

1. Parties Involved in the Contract. The PY HCP contract was awarded by the IHS to Southwest Catholic Health Network (the PY HCP Contractor). The PY HCP Contractor is to provide services to the Pascua Yaqui Tribe in exchange for monthly prepayments.[52] Although the contract is signed only by these two parties, a number of other participants are involved. Indeed, the award notification was sent to 13 different participants: six different individuals within the IHS OHPD who assist in monitoring the contract; two other IHS offices involved in the financing, to the PY Health Department, to the Tribal Chairman, to the Contractor and to both major subcontractors, the health clinic and the hospital.

The Tribe is assured of "maximum" participation. The contract clearly states that any proposed policy changes by the PY HCP Contractor must be provided to the IHS and the Tribe in writing, 10 days before implementation is scheduled.[53] In that same provision, tribal representation is guaranteed on any governing board of the PY HCP Contractor.[54]

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[52]The PY HCP contractor competed for the contract against one other bidder. Bid protests are covered in IHS Contract No. 249-87-0007, Part I Section H-9, pg. 36.

[53]"The Contractor shall be responsible for ensuring that maximum tribal participation shall occur, including tribal representation on any governing board related to these activities. Any proposed policy change that may affect the Yaqui patient shall be provided in writing to the IHS Contracting Officer and the Pascua Yaqui Tribe, ten (10) days prior to implementation." IHS Contract No. 249-87-0007, Part I Section C-1, Q, pg. 16. (There is some debate whether or not the tribal participation provisions are adequately met by the PY HCP Contractor.)

[54]In practice, the Tribal Chairman has a seat on the Board of Directors of the Clinic. Due to tribal politics, the Chairman's seat is vacant; there has been no tribal participation on the governing board for several of months.

Beneficiaries are defined in this contract.[55] The purpose statement states that the health services provided are to be "acceptable and accessible to the Tribal members".[56] The term "tribal members" is an imprecise description of the beneficiaries of this contract. Those eligible for care are narrowly defined later in the contract :[57]

1) enrolled Pascua Yaqui members resident in Pima County, Arizona;
2) newborns of eligible participants;
3) Indian female spouse of enrolled Yaqui male[58];
4) Non-Indian pregnant with child of an enrolled Yaqui male with paternity papers[59];
5) Spouses/household members to control acute infectious diseases and other public hazards;
6) An Indian child dependent of an enrolled Yaqui;
7) An Indian child dependent of an enrolled Yaqui in a foster home;
8) An eligible person traveling outside Pima County for business, pleasure or school;
9) Relocating eligibles for 180 days if they are not in a IHS service delivery area
10) Students who legally reside in Pima County unless other IHS care is available.

In addition, any individual who is eligible for state indigent health care programs must be transferred out of the PY HCP. Any individual eligible for alternative resources through employment has the option to transfer.[60]

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[55]Tribal members are clearly "third-party beneficiaries", that is: "persons who are recognized as having enforceable rights created in them by a contract to which they are not parties and for which they give no consideration." Gifis, *Law Dictionary*, pg. 209.

[56]Emphasis IHS. IHS Contract No. 249-87-0007, Part I, Section B-1, pg. 2.

[57]IHS Contract No. 249-87-0007, Part I, Section C-1, pgs. 4-5.

[58]The gender disparity is seemingly a holdover from earlier IHS policy. All references to "Indian" mean a tribal member enrolled in a federally recognized tribe.

[59]These women are will be handled on a fee-for-service basis under the new contract. An unfair financial burden may otherwise occur under capitation if a non-Yaqui were to ask for health services late in her pregnancy. In that case the Contractor would be burdened with the costs of the delivery without either receiving premiums or monitoring the mother during the months of pregnancy.

[60]"The Contractor shall make every reasonable effort to assist the patient to apply for alternate health care resources before billing the IHS." Examples listed include Medicaid, Medicare, group and private health insurance, Veterans Administration Benefits, AHCCCS, Title XIX and Third Party Liability. IHS Contract No. 249-87-0007, Part I Section G-3, pg. 27.

The majority of the PY HCP enrollees fall within the category (1) enrolled members and then (2) newborns. There are only two PY students in category (10).

The contract omits some important provisions regarding the parties such as 1) requiring that the PY HCP Contractor notify the IHS immediately of any material changes in its status in areas such as accreditation, licenses, finances, and insurance; and 2) addressing the responsibilities of the parties in the event of insolvency.[61]

2. Compensation. One incentive for IHS or an Indian tribe to choose the prepaid arrangement is because an unlimited amount of (specified) services are available at a set rate.[62]

The capitated rate and social worker salary is paid one month in advance with back adjustments;[63] the Home Health Services and Cost Reimbursement Pool is paid no later than 30 days after invoice.[64] The estimated cost of the contract for the contract year 12/1/86 to 11/30/87 was $2,831,712,000. The actual cost expended was $2,619,723.21.[65]

Payment rates are adjusted on a yearly basis according to increases in the Consumer Price Index but are limited to a 10% increase during the course of the contract .[66] New rates

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[61]Inclusion of these provisions is recommended. See further discussion in the Recommendations Section.

[62]IHS Contract No. 249-87-0007, Part I, Section C-1, B. 2., pg. 5.

[63]Note, IHS is only required to pay the capitated rate "as soon as possible" for each billing month, but in practice it pays one month in advance. IHS Contract No. 249-87-0007, Part I Section G-4, A.&B. pg. 27.

[64]IHS Contract No. 249-87-0007, Part I Section G-4, C., pg. 27.

[65]12/1.86-11/30/87

	Projected	Actual	Difference
Capitated rate	$2,768,640.00	$2,552,098.09	($216,541.91)
Social worker	$31,871.82	$31,891.97	$20.15
Home health	$7,200.00	$3,200.00	($4,000.00)
Supplies, etc.	$24,000.00	$32,533.15	$8,533.15
Totals	**$2,831,711.82**	**$2,619,723.21**	**($211,988.61)**

See IHS Contract No. 249-87-0007, Part I Section B-3, pg. 3 and Modification of Contract No. 6, dated 11/18/87.

[66]IHS Contract No. 249-87-0007, Part I Section H-11, pg. 37-8.

are developed for each contract period. Some adjustments are made each month to adjust membership totals to reflect changes in the number of members in each category.

The PY HCP Contractor cannot collect an IHS premium for anyone who is enrolled with an alternative resource. The PY HCP Contractor is also required to bill tortuous third parties.[67] The contract requires that the PY HCP Contractor provide the IHS Project Officer a list of its subcontractors. This gives the IHS a better basis to assess the subcontracted care because payment rates and discounts influence the manner in which services are delivered.

*3. **Contract Period.*** Currently the PY HCP Contractor and IHS are operating under a six-month extension of a year-long contract.[68] This short term, an exception to the prior three-year contracts, was undertaken to facilitate tribal management of the contract. Even though IHS now has authority to issue five-year contracts, it is not practical because federal regulations restrict the Contractor to a 10% increase in cost during the course of the contract.

A calendar of deliverables is included in the contract.[69] If the PY HCP Contractor does not adequately fulfill its responsibilities, then the contract may be terminated by default at that time.[70] The contract is further qualified with a disclaimer to protect the federal government against financial liability for services rendered beyond a time stated in the contract in case additional funds are not appropriated.[71]

*4. **Scope of Work required of PY HCP.*** The contract requires the Contractor to provide comprehensive inpatient care and an ambulatory 24-hour health care program.[72]

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[67]IHS Contract No. 249-87-0007, Part I Section H-6, pg. 35.

[68]Modification of contract, no. 7, dated 3/1/88; Modification of contract, no. 6, dated 11/18/87; IHS Contract No. 249-87-0007, Part I Section H-7, pg. 35.

[69]IHS Contract No. 249-87-0007, Part I Section F, pg. 25.

[70]IHS Contract No. 249-87-0007, Part II Section I, pg. 1; incorporating by reference, FAR Regulation, 48 CFR §52.249-8.

[71]IHS Contract No. 249-87-0007, Part I, Section G-8, pg. 25.

[72]IHS Contract No. 249-87-0007, Part I, Section C-1, B.1., pg.5.

Four line items are detailed: 1) benefits package provided under the capitated rate; 2) the social worker's salary; 3) home health services and 4) cost reimbursable items.[73] There are other duties and responsibilities assigned to the Contractor in the contractual agreement.

a. Line item 0001: the benefits package:[74] (1) specified Outpatient Services; (2) Family Planning;[75] (3) Oral Surgery; (4) Pharmacy;[76] (5) Inpatient (Hospital) Services;[77] (6) Discharge Planning; (7) Emergency Services;[78] (8) Out-of-Area Emergency Services; and (9) Out-of-Area Emergency Coverage for Students.[79] Administration is also a component of the capitated rate.

Outpatient services are to be available at two clinics--a centrally located clinic and a satellite clinic on the reservation.[80] Minimum hours of operation and staff requirements are specified in the contract.[81]

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[73]Items not covered in the original contract that have been added to subsequent contracts are: interaction of the PY HCP Contractor with the tribal PHN Program; and the addition of the Home Health program along with the hiring of a special Yaqui Social Worker.

[74]IHS Contract No. 249-87-0007, Part I Section C-1, C.-P. pgs. 6-16.

[75]Includes a special provision regarding sterilization and surgical abortion. IHS Contract No. 249-87-0007, Part I Section H-10, pg. 36-7.

[76]Includes over the counter medications, 24-hour availability and access in the community of Maraña.

[77]Detailed in IHS Contract No. 249-87-0007, Part I Section C-1, E. pg. 8-9.

[78]IHS Contract No. 249-87-0007, Part I Section C-1, F. pg. 10.

[79]Emergency care provided to students is 100% reimbursable by the PY HCP Contractor. IHS Contract No. 249-87-0007, Part I Section C-1, H. pg. 11. Routine care is available only at the PY HCP clinics. For some tribes this could be costly or time consuming to administer, but there are only two PY students attending school outside of Pima County.

[80]IHS Contract No. 249-87-0007, Part I Section C-1, I., pg. 11-12.

[81]IHS Contract No. 249-87-0007, Part I Section C-1, I.4, pg. 12-13.

Family Planning;[82] **Oral Surgery; Pharmacy;**[83] **and Inpatient Services**[84] are to be available at the main clinic or designated hospital.

Discharge Planning is to be coordinated with the tribal Public Health Nursing Program.[85] To fulfill this responsibility the Contractor hosts a Patient Staffing Meeting for discharge planning each week for health care and administrative personnel. Care for hospitalized patients is discussed prior to their discharge. Attendants include: Contractor participants: Tucson Regional Medical Coordinator; the Yaqui Social Worker; Clinic Director of Social Services, Tribal Clinic Physicians; and the Clinic Director of Nursing. Tribal participants: the Health Director, Clinical Director (IPA Physician), Director of Nursing, CHNs, and the Medical Social Worker Aide.

Emergency Services. An after hours "on-call" emergency phone line is provided by the Clinic. All emergency calls are returned within fifteen minutes by a physician. If a hospital emergency room is needed then the PY HCP Contractor must be notified within three days. An agreement for emergency services is to be established for the Maraña community.

Coordination of services is the responsibility of the Contractor. To meet this responsibility, it conducts a monthly meeting of top level administrative personnel from all of the involved organizations.[86] Invitees include: Contractor participants--Chief Executive Officer, Utilization Review Nurse, Finance Administrator; Tucson Regional Medical Coordinator; Clinic Executive Director, Clinic Finance Director, Clinic Yaqui Registrar, Clinic Patient Advocate, Clinic Yaqui Social Worker; Tribal Health Department--Director and Clinic

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[82]Includes a with a special provision regarding sterilization and surgical abortion. IHS Contract No. 249-87-0007. Part I Section H-10, pg. 36-7

[83]Includes over the counter medications, 24-hour availability and access in the community of Maraña.

[84]Detailed in IHS Contract No. 249-87-0007, Part I Section C-1, E. pg. 8-9.

[85]IHS Contract No. 249-87-0007, Part I Section C-1, E.8., pg. 10.

[86]The meeting is not a requirement under the current contract but is expected to be included in the revised contract.

Director; and the Indian Health Service--IHS Project Officer; IHS Alternative Project Officer; IHS Contracting Officer. Hospital administrators and the Tribal Chairman are invited to the meetings but do not attend regularly.

Administrating invoicing. The PY Contractor invoices IHS for payment according to the procedures stated in the contract.[87] The PY HCP Contractor must submit cancelled checks to verify cost reimbursement.[88] Four copies of each invoice are submitted.

Administrating billing. The PY HCP Contractor is required to pay its outside referrals and hospitals within a "prompt time period".[89] The ambiguous provision allows flexibility for the different billing situations.[90] The Contractor is also responsible for resolving problems that occur if a referral physician bills the patient directly, even if the patient does not inform the IHS or PY HCP Contractor about the billing for months.

Administering membership verification. The PY HCP Contractor, through its administrative branch, verifies the eligibility of each individual on the membership roster. This includes verification that the otherwise eligible member does not have alternative resources for payment available.

Administering reinsurance costs, that is, insurance with a third party against financial risks above $35,000.

b. Line item 0002: Yaqui Social Worker[91] The Social Worker provides mental health counseling and referral services for all Pascua Yaqui members in Pima County,

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[87]IHS Contract No. 249-87-0007, Part I Section G, pg. 26-31.

[88]IHS Contract No. 249-87-0007, Part I Section G-5, B.4, pg. 31.

[89]IHS Contract No. 249-87-0007, Part I Section C-1, L, pg. 15.

[90]Situations contemplated include the provider who is slow in billing and the patient who receives a bill who does not notify the Contractor for a long period.

[91]IHS Contract No. 249-87-0007, Part I Section C-1, Q.1, pg.16.

not strictly PY HCP members. The PY HCP Contractor is required to "coordinate the hiring with the Pascua Yaqui Tribe and IHS."[92]

The Social Worker serves as a liaison for three different relationships: 1) between the patients and the PY HCP Contractor; 2) between the tribe and the PY HCP Contractor and 3) between the PY HCP Contractor and the other subcontractors such as the hospital and referral physicians. The Social Worker authorizes the purchase of medical supplies, durable equipment, mental health counseling and other referred (cost reimbursable) items.[93] The Social Worker also prepares monthly reports for IHS, attends the patient staffing meetings and administrative advisory meetings. The contract provision requires the Social Worker to be "the only person responsible for provding Medical Social Services"; however, the tribe hired a Social Worker Aide in its Tribal Health Department to work closely with the Social Worker.[94]

c. Line item 0003: Home Health Services[95]

Home health nursing is provided on a case-by-case basis with advance approval of the Yaqui Social Worker. Types of service offered are skilled professional nursing, physical therapy, medical social services, home health aides, and nutrition consultation.

d. Line item 0004: Cost Reimbursement[96]

With the approval of the Yaqui Social Worker or Primary Project Officer, the IHS will reimburse the costs of 1) medical supplies; 2) referrals;[97] 3) prosthesis; 4) durable medical equipment; and 5) the Yaqui Social Worker travel allowance.[98]

92". . . to insure that the individual is aware of the cultural and religious beliefs of the Tribe." (emphasis added). IHS Contract No. 249-87-0007, Part III, Section J-6. See Recommendation Section.

93IHS Contract No. 249-87-0007, Part I Section C-1, Q.1.3.c pg.19.

94IHS Contract No. 249-87-0007, Part I Section C-1, Q.1.pg. 16. Also, the Yaqui Social Worker is supervised by the Clinic Director of Social Services.

95IHS Contract No. 249-87-0007, Part I Section C-1, Q.2. pg.17.

96IHS Contract No. 249-87-0007, Part I Section C-1, Q.3. pg.18.

97Includes second and third opinions.

The Yaqui Social Worker is required to exhaust alternative resources for payment of the cost reimbursable items. Some items are available only on a limited basis. For example, each referral for outpatient physical therapy is limited to 15 therapy visits and 2 evaluations visits per patient. If additional therapy is necessary, the patient must obtain another referral.[99]

e. Other requirements.

Training programs --training for high school students during summer programs has not been pursued as strongly as it might have been.[100] But training for the tribal health department was instrumental in the establishment of the tribal department and remains helpful.[101]

Handbook to be provided for PY HCP enrollees explaining the range of services available and the procedures to follow.[102] It was written in both English and Spanish.

Enrollment cards designating eligibility are to be available within 30 days.[103] The cards are used to identify enrollees, and are computer coded for individual medical records. The card is to be presented to the referral physicians and hospitals to ensure correct billing.

An Outreach program is to be developed for Social Services and Health Education within one month of operation.[104]

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[98]IHS Contract No. 249-87-0007, Part I Section C-1, Q.3.c, pg.20.

[99]IHS Contract No. 249-87-0007, Part I Section C-1, Q.3.e. pg.20.

[100]"The Pascua Yaqui Tribe has requested that the Contractor provide summer medical exposure programs . . ." IHS Contract No. 249-87-0007, Part I, Section C-1, I.4.f. pg. 14.

[101]IHS Contract No. 249-87-0007, Part I, Section C-1, I.4.f. pg. 15.

[102]IHS Contract No. 249-87-0007, Part I Section C-1, N. pg. 15.

[103]IHS Contract No. 249-87-0007, Part I Section C-1, O. pg. 16.

[104]IHS Contract No. 249-87-0007, Part I Section C-1, I.3 pg. 12.

Special Contract Requirements are also included in the contract.[105] The contract includes an agreement that the contractor will comply with applicable laws and regulations and will verify this compliance such as: 1) non-discrimination in care of patients; 2) indemnity and insurance clauses clearing the government;[106] 3) privacy act notification; 4) confidentiality of information (including a requirement for the Contracting Officer's approval in order to disseminate information); and 5) the 60-day phase out if there is a transfer to a successor.

Outside agreements are required, within 30 days, to service emergency care and pharmacy with the Maraña Community Clinic, for the Yaqui community located 30 miles northwest of the Main Clinic.[107]

Financial and Statistical Reporting Requirements.[108] The following reports must be submitted on a monthly basis: Population Distribution by Age and Sex; Prenatal report; List of Newborns; Death Notifications; Contract Health Service Referrals, List of problems encountered and actions; List of all patient grievances and actions taken; Financial Report; Health Statistical Report; Monthly Expenditure Report (of the Social Worker).[109]

The contract includes an option for submitting some information with a magnetic tape transfer.[110] This matter is being seriously considered by the IHS at this time.

Medical records are to be maintained.[111] Although this task is routine, it is complicated by a contract provision which states that ownership of the records is retained by

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[105]IHS Contract No. 249-87-0007, Part I Section H, pg. 33.

[106]IHS Contract No. 249-87-0007, Part I Section H-2, pg. 33: "The Contractor shall indemnify, save and keep harmless the Government against any or all loss, cost, damage, claim, expense or liability whatsoever as a result of performance under the terms of this contract."

[107]IHS Contract No. 249-87-0007, Part I Section C-1, E, pg. 8-9.

[108]IHS Contract No. 249-87-0007, Part I Section C-1, M., pg. 15.

[109]IHS Contract No. 249-87-0007, Part I Section F, pg. 25.

[110]IHS Contract No. 249-87-0007, Part I Section C-1, M., pg. 15.

[111]IHS Contract No. 249-87-0007, Part I Section C-1, R, pg. 20.

the IHS. In the event a subsequent Contractor is chosen, the current Contractor would be required to turn over the medical records of the PY HCP enrollees. Clinic and referral physicians; however, are required by state law to maintain records on their patients and duplication costs are not expressly covered in the contract..[112] Another complication is that IHS asserts "ownership" over records for PY tribal members who have occasionally received care outside of the IHS system. See the Recommendations section for more detail.

Quality Assurance. The Contractor must allow IHS OHPD to randomly review 10% of the patient charts seen that month.[113] In addition, the Contractor must have an internal Quality Assurance plan in effect within 30 days.[114]

Transportation is to be provided for referral services when necessary. The Main Clinic charges a 50¢ fee since this service is not included in the capitated rate.

Patient advocacy. The Main Clinic also promotes patient advocacy through one patient advocate on the staff and the Yaqui Social Worker.

Incorporate Appendices in work plan. The second part of the contract includes Standard Government Provisions for Medical Services Contracts and a third part is an appendix of the following: 1) Indian Health Service regulations for Contract Health Service, 42 CFR, Part 36; 2) DHHS Health and Medical Records System, Privacy Act of 1974; 3) Letter regarding Indian Preference Policy; 4) Indian Health Service regulations for Reimbursement Rates for Contract Services; 5) Data re PY population, previous health care plan; 6) Social Worker Job Description; 7) PY Population Distribution by Age and Sex;

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[112]"Ownership of all original patient medical records shall remain with the IHS. Upon expiration of services provided under the contract, the Contractor pursuant to the written direction of the Contracting officer, shall furnish the original patient medical record of all patients. . . ." IHS Contract No. 249-87-0007, Part I., C-1, R.1., pgs. 20-21.

[113]IHS Contract No. 249-87-0007, Part I Section C-1, K., pg. 15, Part I Section E., pg. 22-23.

[114]The Tribal Health Department is then limited to approaching the Contractor (not the IHS) when it requests review of specific cases.

8) Prenatal report, list of newborns, death notifications; 9) Requirements for Reportable Diseases; and 10) Various forms to administer the contract.

Gatekeeper role: contain and minimize costs by servicing only eligible members, negotiating subcontract arrangements and discounts, and enforcing prior authorization levels for referral and cost reimbursable services.

5. IHS OHPD Role is only partially described in the the contract.

a. IHS OHPD has been involved in the planning and administration of the PY HCP. The IHS OHPD designated a Primary Project Officer and an Alternative Project Officer to monitor the PY HCP contract. In addition the IHS OHPD Contracting Officer routinely administers the tasks and report collection of the contract.

Rate setting. The IHS OHPD negotiated the capitated rate with the potential contractors. In this role the IHS OHPD researched utilization data and determined the appropriate level of risk in relation to the market costs.[115]

Provider Selection. IHS OHPD followed the competitive negotiation procedures to select a health care provider. It sought a provider who exhibits a willingness to serve tribal members; has an existing relationship with the tribal population; can manage the projected utilization rate; and is a strong, fiscally sound organization free of financial problems with capitalization or cash flow.

b. IHS OHPD is involved in the implementation of the contract.

Membership verification. The Contract Administrator scrutinizes the membership roster weekly for duplications (due to name misspellings) and to ensure that all additions and

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[115]This is the role of an actuary, that is, "a social mathematician who deals with various contingencies which face human beings. Their services include analyzing the financial effects birth, marriage, sickness, accidents, retirement, death, and other contingencies have on various types of insurance and benefit plans." Birch and Davis Associates, Inc., *Guide to Health Maintenance Organization Development*, DHHS, Office of Health Maintenance Organizations, March 1982, pg. V-2, footnote 2.

deletions are properly accounted for by the Contractor.[116] Each time an individual is disenrolled from the PY HCP, the Project Officer sends that individual a letter acknowledging disenrollment with a signature stamp of the OHPD IHS Area Director.

Administration of Funds. The Contract Administrator verifies that all invoices submitted by the PY HCP Contractor are correctly identified, contain the appropriate information and are received in the proper quantity. The PY HCP Project Officer reviews the invoices; they are then sent to the Phoenix Area Office for payment.

Maintaining communication with the tribe. The IHS also provides an IPA physician to the tribe, who acts both as a liaison with the IHS and as the Tribal Clinic Director. The Project Officer reviews monthly reports submitted by the Tribal Health Director. In addition, the Project Officer takes an active role to ensure that there is cooperation between the Contractor and the tribe.

Gatekeeper role: Enforcement of Contract Terms. The Project Director interprets contract terms, reconciles situations not addressed in the contract, assists in the resolution of program problems encountered during the performance of the contract, and recommends any appropriate changes in contract requirements to the Contract Administrator.

6. The Tribal role goes beyond the contract requirements.

Participation in policy changes. The Tribe is given the opportunity to comment on policy changes in advance.[117] For example, the tribe was invited to comment on the RFP before it was released to the public[118]

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[116] Additions may be due to newborns or temporary eligibility of a non-Yaqui patient. Loss of enrollment status is due to transfer to an alternative funding resource, move outside of Pima County, death, incarceration or loss of temporary eligible status by a non-Yaqui.

[117] IHS Contract No. 249-87-0007, Part I Section C-1, Q. pg. 16.

[118] But the Tribe is prohibited from reviewing the proposals due to federal regulations. This limits the amount of input the Tribe can have into the selection of PY HCP Contractor, and review of the final contract.

Tribe furnishes equipment at the tribal clinic, such as two exam tables, exam lamps, blood pressure cuffs and a resuscitator.[119]

PY Tribal Health Department provides supplemental services through 638 contracts. As explained in Finding Three, the Tribe has contracted with the Indian Health Services to provide transportation, environmental health, public education, patient advocacy, eyeglasses and hearing aids, Home Health Care, and Community Health Nursing. These services complement the PY HCP and are more effectively provided by the tribe because these services are very personal and tribal members will not likely respond to outsiders.

Gatekeeper role: patient advocacy and eligibility. In addition the Tribe provides general oversight especially as a patient advocate. PY HD is notified by the PY HCP Contractor when an individual patient's care changes as it relates to follow-up care. If there are questions arising about specific care or policy issues then the Health Department Director or Clinical Director will approach the Project Officer or the HCP Contractor.[120]

Tribal employees also identify tribal members who are eligible for the PY HCP and screen them for alternative resource eligibility. The Tribe also helps locate tribal members to resolve complaints and billing problems.

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[119]For the complete list, see IHS Contract No. 249-87-0007, Part I Section C-1, I.4.e., pg. 14.

[120]IHS would like to be the contact point between the Contractor and the Tribe, but it is not always so.

Finding Two:

The PY HCP is similar to the HMO network model --analysis in terms of structure, process, and outcome dimensions..

The PY HCP organizational structure can best be compared to the HMO network model which is a contract with a network organization that subcontracts with two or more independent group practices, such as the clinic and hospital, to provide health services.[121] This section is an analysis of the Structure, Process, Outcome dimensions of the PY HCP.[122]

1. Structure. This section describes the structural, organizational components of the network organization and the roles performed by the IHS OHPD, the PY HCP Contractor, and the PY Tribe.

Health care is being contracted through a network of services. The PY HCP Contractor is an affiliation of various medical services--outpatient clinic, inpatient hospital, and local speciality physicians. The hierarchical structure provides checks and balances in the administration and implementation of the contract.

a. ***Organizations*** involved in the PY HCP are:

1. **IHS**--Indian Health Service Office of Health Programs Development (IHS OHPD)--oversees the contract performance.
2. **PY HCP Contractor**--Southwest Catholic Health Network (SCHN)-- a private not-for-profit Arizona corporation including Mercy Care Plan, its administrative branch which provides alternative resource payor verification and handles day-to-day

[121] As contrasted with the Staff Model--an HMO that delivers health services through a physician group that is controlled by the HMO unit: or the Group Model--an HMO that contracts with one independent group practice to provide all health services. HMO/CMP FACT SHEET. Office of Prepaid Health Care. 11/1/87.

[122] The structure, process, outcome model developed by Avedis Donabedian is a customary topology for describing approaches to quality assessment. See, Demlo, Linda: *Quality of Care Research and Applications for HMOs.* speech. Government Accounting Office and *Evaluating Quality of Care,* article from American Medical Review and Research Conference for Peer Review Organizations.

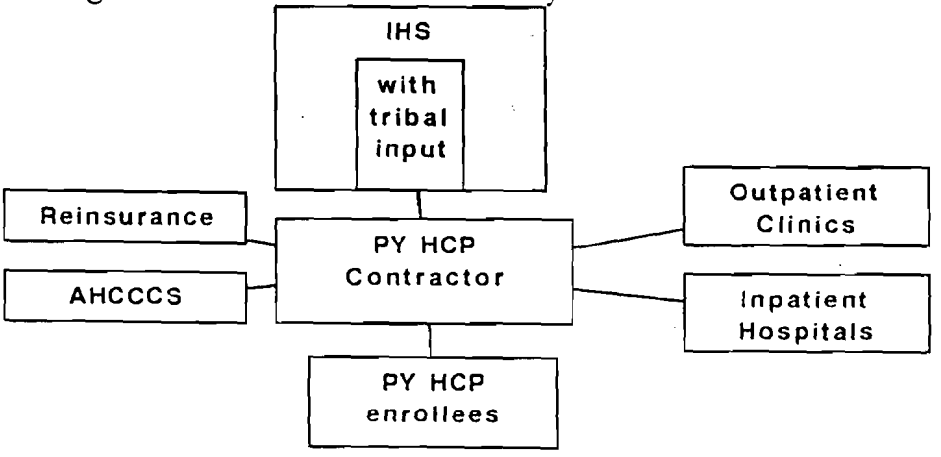
administrative problems. The Contractor monitors the care provided in the clinics, hospitals, and with the various local referral physicians.

3. **Outpatient Clinics**--El Rio Santa Cruz Neighborhood Health Center-- a public not-for-profit Arizona corporation subcontracting to provide direct (ambulatory) health services. It is a federally supported Community Health Center that provided care to the local Pascua Yaqui communities prior to federal recognition [referred to as the "Main Clinic". El Rio also staffs the Tribal Clinic.
4. **Inpatient Hospital**--St. Mary's Hospital, Tucson (St. Mary's)-- a private not-for-profit Arizona corporation subcontracting to provide inpatient services.
5. **Pascua Yaqui Health Department** (PY HD) is a department under the Pascua Yaqui Tribal Administration jurisdiction, funded by IHS through a 638 contract.
6. **AHCCCS**--Arizona Health Care Cost Containment System is a State of Arizona program for medically indigent and medical needy state citizens.

b. Administrative structure.

The organizations work together but each organization also has separate tasks and objectives. There are two regular meetings of all the organizations--the monthly administrative meetings and the weekly patient staffing meetings.

The organizations are structured in this way:



*c. **Physical Facilities.*** The physical facilities at the Main Clinic, built by federal grant, consist of one single story building which houses the administration and outpatient care functions and an adjacent two story building which provides for supplies storage, purchasing, and receiving. There is a laboratory equipped with an x-ray machine on the premises. Prescriptions and over-the-counter medications are available free of charge.

The physical facilities of the Tribal Clinic consists of about 1400 square feet in a portion of a single story building in the Pascua Yaqui Tribal Administration complex on the Pascua Pueblo reservation. The space includes office space, exam rooms, kitchen and lab facilities, and a small reception area. The IHS is working to improve the inadequate facility and meet the needs of the growing population. The PY HD facility is too small, has too little waiting area, too few examining rooms, too little administrative space, too little privacy, too few telephones, and too much noise. There are no pharmacy services available there.

*d) **Accreditation and Licensing.*** The Contractor is certified by the state AHCCCS program. The Main Clinic is licensed by the state Department of Health Services and certified by Medicare; it is currently seeking JCAH accreditation. All physicians are licensed, their credentials are verified, and they are either Board Certified or Board Eligible in their specialties. Heads of non-physician departments are similarly credentialed.

2. Process is measured in terms of accessibility, patient management, quality assurance, and data procedures of the PY HCP.

a. Accessibility. Measurements of accessibility to health care include location, transportation, parking, provisions for the handicapped, hours of operation, and patient perceptions.

The Main Clinic is conveniently located a mile west of downtown Tucson on a main thoroughfare a few blocks from the main interstate. It is fifteen miles from the New Pascua reservation and about four miles from two other Yaqui communities. The Tribe provides daily

transportation from the Pascua Yaqui communities. Public transportation is also available. The roads are never impaired by weather conditions and are easy to travel in any vehicle. There is adequate parking, with the lot being full on busy days. There is generally adequate access for the handicapped, both outside and inside the facility. Clinic hours of operation are 8:00 am to 4:30 pm Monday through Thursday, and 9:00 am to 4:30 pm Friday, excluding holidays, with no evening or weekend hours. There is a 24-hour, 7-day physician on call arrangement for telephoned emergency patient management and referrals. The Hospital is located within a mile of the Main Clinic and near the interstate highway.

The Tribal Clinic is located on a major road on the east central edge of the New Pascua Pueblo, about fifteen miles southwest of central Tucson. Transportation by tribal van is available locally, although nearly half of the patients walk from their homes to the clinic. Parking is adequate. Access for the handicapped is awkward. The Tribal Clinic hours of operation are 8:30 am to 4:30 pm Monday through Friday, excluding holidays, with no evening or weekend hours. The tribal clinic provides many services: visits by physicians, physical check-ups, eye and ear screening; maternity care, immunizations, minimal laboratory services, nutritional counseling and triage services.[123] The Tribal Clinic uses the same 24-hour, 7-day physician on call arrangement noted above for telephoned emergency patient management and referrals.

b) Patient Awareness, Orientation, and Education measures are also relevant to accessibility. Both the Main Clinic staff and the PY HD orient eligible members to the PY HCP system, supply the bilingual Patient Handbook, and actively provide patient education.

c) Patient Planning and Management. There are several indicators or measures to assess how effectively and efficiently patients are managed. These include grievance

[123]IHS Contract No. 249-87-0007, Part I Section C-I, I.4.

resolution, the scheduling and waiting for patient appointments; and data on the number of patients per years who are seen, tested, x-rayed, diagnosed, receiving therapeutic procedures, prescriptions, treatment, and discharge planning.

Follow-up and resolution of complaints is the ultimate responsibility of the IHS . The Primary Project Officer works with the PY HD and the Contractor whenever there are problems with billing of quality or care. The monthly meetings are an excellent forum for discussing and resolving these problems.

Patient appointments are made regularly at the Main Clinic and are encouraged at PY HD, but walk-in patients are also seen.[124] Appointments are usually scheduled within several days or weeks. Patient waiting times are generally reasonable for scheduled appointments, but may be excessive for nonscheduled walk-in patients.[125] Computers are used to process and document the patients through the system. Medical records are maintained under an identification number coded on the patients enrollment card.

*d. **Cultural Sensitivity*** of the PY HCP has, by all reports, progressively improved over the years. It has particularly improved due to the regular meetings, hiring of Yaqui staff at the clinics, and increased outreach. No direct measures of cultural sensitivity are available.

*e. **Evaluation.*** IHS is responsible for all aspects of evaluation of the PY HCP.

Data analysis. The IHS decides what information is necessary, and routinely analyzes both its own data and data provided by the PY HCP Contractor. The Main Clinic staff has the primary responsibility for providing service and cost data for the Contractor.

Quality Assurance. IHS conducts regular, systematic quality assurance audits of the PY HCP Contractor, based on a monthly review of randomly selected medical records.

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[124]There were 55% walk-in patients at the Primary Clinic and 56% at the Tribal Clinic reported. *PY HCP Evaluation Patient Satisfaction Survey*, conducted as part of this project, 1/12 - 1/15/88.

[125]Nine people surveyed had to wait over two hours at the Tribal Clinic. *PY HCP Patient Satisfaction Survey*, conducted as part of this project, 1/12 - 1/15/88.

This activity is independent of the Quality Assurance Program and Quality Assurance policies in place at the Main Clinic and Inpatient Hospital.

3. Outcome. The success of the PY HCP's delivery of health services can be evaluated in terms of assessments of cost, the quantity of care provided, the degree of patient compliance, and assessment of patient satisfaction.

a. Cost. The average cost of the PY HCP was $810.36 per member per year in 1987 compared with an average IHS program expenditure of $765 per capita per year and a general U.S. average of $1,500 per capita per year in 1986.[126] This comparison seems favorable given the relative newness of the PY HCP program. Further, the Health Care Finance and Administration has entered into 159 contracts with HMOs under the TEFRA legislation, and Medicare services are provided to beneficiaries at an average cost of $2556.00 per capita per year.[127] (Current general HMO industry charges are about $1,080 per member per year.) Thus, the PY HCP cost appears to be very near or at the lower end of HMO costs.

b. Levels (Quantity) of Health Care provided can be assessed by indices such as the number of clinic, physician visits, or hospital days per patient per year. At PY HCP, there are 4.16 clinic encounters per patient per year,[128] which is on par with the national average of 4.1 for HMOs.[129]

PY HCP bed utilization decreased to 459 days per 1000 in 1985-6.[130] Industry-wide HMO bed utilization is around 400 days per 1000 patients per year. Existing IHS bed utilization was 700 days per 1000 patients in 1987, while nationally the bed utilization was

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[126] *AHCS*, Baltimore Conference, pg KS-2.

[127] *AHCS*, Baltimore Conference, pg KS-5.

[128] El Rio computer data.

[129] *GHAA's 1987 Survey of HMO Industry Trends*, Group Health Association of America, Inc., pg. 43.

[130] IHS Profile of the Pascua Yaqui Prepaid Contract, notes, pg. 2.

around 1,100 days per 1000 patients.[131] Thus, PY HCP bed utilization is slightly greater than the HMO industry rate, but well below national and IHS-wide rates.

c. Patient Compliance. Patient compliance is linked to interpersonal relations and communications skills on the part of health care provider personnel, and to the degree of understanding and attitudes of the patient and family. There were no direct measures of patient compliance available.

d. Patient Satisfaction. The vast majority of patients, 84% at the downtown clinic and 92% at the Tribal Clinic, expressed comfort with the PY HCP facilities.[132] Similarly, the vast majority of patients, 83% at the downtown clinic and 90% at the tribal clinic, were satisfied with the medical care services they received. Further discussion of the Results of the PY HCP Patient Satisfaction surveys is found at pages 51 - 55.

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[131] *AHCS*, Baltimore Conference, WRG-5.

[132] *PY HCP Patient Satisfaction Survey*, conducted as part of this project, 1/12 - 1/15/88.

Finding Three:

The PY HCP is a subset of the health care provided by IHS to the PY Tribe--other sources of health care described.

The PY HCP is not designed to provide all the services needed by enrolled Pascua Yaqui residing in the Service Unit. The PY HCP relies heavily on additional funding from alternative resources, IHS fee-for service contracts, and tribally administered IHS contracts.

*1. **Additional funding from alternative resources*** eases the financial burden for the Indian Health Service. The Indian Health Service is required by regulation to pursue alternative funding.[133] This "alternative source rule" has caused much conflict between the state of Arizona and the IHS.[134]

The responsibility to screen enrolled tribal members resident in the county for eligibility in alternative resources falls on the Contractor. Approximately 50 individuals are eligible for other health insurance as employees or as relatives of employees.[135] Another 300 individuals qualify for the state funded health care programs.[136]

The IHS OHPD identified some services, such as dialysis treatment, that are covered by state or county services and which need not be included in the PY HCP benefits package.

*2. **Additional IHS fee-for service contracts.*** The IHS OHPD uses fee-for service contracts in two situations. One, for individuals eligible for alternative services--if these individuals need a service otherwise provided in the PY HCP benefits package but it not available from their alternative resource, then IHS will reimburse a private provider for the service. The most common services funded this way are podiatry; over the counter drugs; mental health; and durable medical equipment.

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[133]The "alternative source rule"--42 CFR §36.23(f).

[134]See discussion in the Background section, pages 13-14.

[135]Original research of IHS OHPD records.

[136]PY HCP Contractor's estimate.

IHS OHPD determined that it was more economical to fund some services for all Pascua Yaqui patients on a fee-for-service basis rather than factoring them into the capitated rate. Such services are dental, drug and alcohol counseling, and ambulance services.

The original benefits package included many of the services discussed here, but IHS quickly recognized the services could be acquired through alternative resources or more economically on a fee-for-service basis. IHS then employed the "for Government convenience" termination clause (in a partial termination) to eliminate these excess services from the benefit package: Skilled Nursing Home Coverage; In and Outpatient Physical Therapy; Inpatient and Outpatient Mental Health (drug and alcoholism); Oral Surgery; Transplant Services; Dialysis; Physician Home Visits; Ambulance Services and reducing out-of-area coverage from 100% to 80%.

*3. **Services provided by the Tribe.*** The PY Health Department (PY HD) has contracted with the IHS to supplement and complement the outpatient and inpatient care services provided through the PY HCP.[137] One overall goal of the PY HD is to assess the members' health needs and coordinate activities with other health resources.

The PY HD carries out its services in the tribal clinic, and the nearby "Dome" facility which has a large open area for exercise activities, several converted classrooms, and a kitchen area. The PY HD also operates out of community centers in the various PY communities. Much activity is also carried out in the patients' homes. Training is provided for the PY HD staff through this 638 contract.

Services provided by the PY HD are:

Health Administration. The Tribe has hired a Health Director and secretary to administer the 638 projects. Past projects of the PY HD include publishing a newsletter, holding quarterly community meetings, and organizing a PY Health Fair.

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[137] See IHS Contract No. 249-85-0007, Part I, Section B., the PY HD "638" contract.

Health Records (for Alcoholism Services and Health Education) are maintained by the Records Clerk.

Home Health Services are provided by the Nursing Director, one full-time nurse, two part-time nurses, a CHR Supervisor, and two CHRs. Activities conducted by the CHRs and CHNs are counseling and educations sessions, home visits, making referral appointments, patient advocacy, explain clinic procedures, and working with the providers to ensure that services are appropriate for the Pascua Yaqui patient.

Public Education and Patient Advocacy. The PY HD is a good forum for providing public education, (especially for sensitive issues such as sexual abuse) because tribal members are more likely to listen to other tribal members than to outsiders to the community. Health promotion and disease prevention are emphasized. Patient advocacy, oversight on billing problems, and AHCCCS require continuing education efforts. The PY HD also communicates information regarding disease outbreaks to the community. The Tribal Health Department takes special measures to involve and reach those eligible PY HCP members that live off the reservation by holding separate quarterly meetings at four community centers. Health prevention videos are broadcast in the waiting room of the tribal clinic.

Environmental Health services such as maintaining the reservation lands for clean water, safe roads and other environmental factors through providing trash collection, insect spraying and animal control are provided by two Environmental Health Technicians and one part-time sanitarian.

Behavioral Health Services are provided by Adolescent Health Educator; Therapeutic Recreation Specialist for Youth; Youth Peer Counselor; After-care Alcoholism Counselor; and Medical Social Worker Aide. Medical Social Services support and enhance the services currently provided by the PY HCP Contractor and work to remove or reduce barriers to access to health care created by administrative constraints inherent in the PY HCP contract.

Eyeglasses and Hearing Aid Services. Provides within budgetary restrictions eyeglasses, eyeglass repair, and hearing aids.

Transportation Services. Many tribal members do not have adequate transportation. The tribal health department hires drivers and operates two vans which are used to shuttle patients to and from the clinics on a regular schedule. The original contract required the PY HCP Contractor to provide transportation but tribal employees are better equipped to direct the transportation services because they are familiar with the Pascua Yaqui communities and the individuals requiring regular health care.

Finding Four:
The actual capitated rate cost for providing the benefits package was higher than the estimated capitated rate--a comparison.

For contract year 12/1/86 to 11/30/87, the estimated capitated rate was $65.92. The actual cost of providing medical services was $69.82, slightly higher per person per month.

Capitated Rate: Actual versus Estimated Costs

SERVICE CATEGORY	ACTUAL	ESTIMATED
Hospital In & Outpatient	14.56	30.16
Emergency Room	3.76	2.97
Physician & Non-Physcian	30.74	14.85
Radiology	3.61	2.09
Laboratory	5.79	4.82
Pharmacy	3.80	3.49
Reinsurance	2.47	2.47
SUBTOTAL	**64.73**	**60.85**
Reserve	1.33	1.33
State Tax	0.00	0.00
SUBTOTAL	**66.06**	**62.18**
Administration	3.74	3.74
TOTAL	**$69.80**	**$65.92**

Results:

Summary of the Patient Satisfaction Surveys for the Evaluation of the pascua Yaqui Health Care Plan administered Jan. 12 thru 15 (with responses from the tribal Clinic and PY HCP downtown clinic (El Rio) listed separately.

The Patient Satisfaction Surveys were administered to 196 individuals at the two PY HCP outpatient clinics. A complete description of the methodology used for the Surveys is found on pages 20 thru 22 in this report. On the following five pages is a summary of the results of the survey. In the Appendix of this report is the English Version of the Survey questionnaire used in the interviews.

According to the subjective opinion of the interviewers: At the tribal clinic the patients would like to see an expanded facility, one that would include pharmacy services. At the main downtown clinic the patients did not like to wait for doctor visits. The staff at the tribal clinic consistently received favorable ratings from the patients.

IHS--PY HCP PATIENT SATISFACTION SURVEY RESULTS

ANALYSIS OF SURVEY FINDINGS	EL RIO CENTER 98 total #	EL RIO CENTER 98 total %	TRIBAL CLINIC 98 total #	TRIBAL CLINIC 98 total %
Age-Sex Utilization:				
The highest rate of utilization is the 25-44 age group		59%		42%
The majority of the users are under 45		74%		55%
Women are the most frequent users of services, in disproportion to the numbers enrolled		80%		70%
Frequency of Utilization:				
If the responses regarding frequency are accurate, then the survey population is using the Clinic and Center at more than twice the rates reported by the Contractor	11.4 visits/ patient/year		12.9 visits/ patient/year	
Doctor visits are the most frequent		50%		78%
Pharmacy visits are an important reason for visiting the Center		17%		>2%
Waiting Time:				
All those who had to wait 30 minutes or less considered it okay	54	62%	77	75%
Several patients at the Tribal Clinic had waits of over 2 hours	0	0%	9	8%

ANALYSIS OF SURVEY FINDINGS	EL RIO CENTER #	EL RIO CENTER %	TRIBAL CLINIC #	TRIBAL CLINIC %
Transportation:				
Driving is the most common mode of transportation used to get to the Center while walking is the most common for the Clinic		70% >2%		28% 52%
A majority of patients spent less than thirty minutes getting to the sites		74%		96%
More than a third considered transportation a major problem (problems with return transportation was cited repeatedly)		41%		34%
Scheduling Appointments:				
More than half the patients were seen without previously scheduled appointments		55%		56%
Generally, it was easy to schedule appointments within a week especially at the Center. However, those using the Clinic had waits of nearly three weeks to a month.		74% 18%		43% 52%
Physicians Contacts:				
More than half the patients at the Center saw the same physician just about every time, whereas the Clinic patients who had fewer choices generally saw the same physician.		56%		82%
Patients at the Clinic saw a greater need for physician specialists than patients using the Center, with eye, dental and pediatrics being the most frequently mentioned at the Clinic.		44%		79% 72%
Access to Care:				
A majority felt that they had sufficient access to having their medical questions answered		66%		75%
Obtaining medical care without scheduled appointments was also not perceived as a major problem by over 60 percent at both sites		61%		65%

ANALYSIS OF SURVEY FINDINGS	EL RIO CENTER #	EL RIO CENTER %	TRIBAL CLINIC #	TRIBAL CLINIC %
Perceptions of Physicians Capabilities:				
High levels of satisfaction are evident in that patients feel the physician is telling them everything that is important		82%		92%
Less satisfaction was felt with the physicians inquiries about previous medical problems, especially at the Center		69%		82%
Similar disaffection was felt about questions regarding nutrition and advice given regarding nutritional habits, though the majority still responded favorably		69%		73%
Perceptions of Physicians Instructions:				
The majority of patients felt that they were sufficiently informed of effects of prescription drugs		72%		77%
and the necessity for lab tests and x-rays		87%		89%
Perceptions of Physicians Attitudes:				
Strong disaffection was expressed by a significant proportion of patients regarding the physicians condescending attitude		42%		20%
Physicians were perceived as making patients feel foolish in specific instances,		32%		19%
though generally, they were seen as showing patients lots of respect		78%		93%
Perceptions of Nursing and Other Staff:				
Nursing staff were almost universally perceived at treating the patients with respect at both sites		95%		96%
Perceptions of Clinic staff understanding the health needs of the patient were much higher than those at the Center		77%		92%

ANALYSIS OF SURVEY FINDINGS	EL RIO CENTER		TRIBAL CLINIC	
Perceptions of the Health Facility:	#	%	#	%
The vast majority expressed comfort with the facility		84%		92%
Similarly, there was satisfaction with the medical care services		83%		90%
However; less felt that the facility provided complete care		76%		70%
Suggestions for improvements included: enlarging the facility	3		20	
more physicians	8		9	
prescription drugs	5		10	
less waiting time	12		6	
improve staff	5		2	
Perceptions of Services Received:				
Patients felt good about the information provided by the medical staff during treatment and instructions regarding their treatment		81%		82%
and medications		89%		92%
Patients also seemed very satisfied with services provided via-a-vis:				
the better understanding of their health condition		81%		91%
the services making them feel better		81%		92%
understanding of instructions given by staff		88%		96%

ANALYSIS OF SURVEY FINDINGS	EL RIO CENTER #	EL RIO CENTER %	TRIBAL CLINIC #	TRIBAL CLINIC %
Records, Hours, Emergencies:				
Lower levels of satisfaction were felt about the staffs ability to keep records and health problems private and confidential		66%		69%
Office hours were considered good but not really high ratings		63%		69%
Only a simple majority felt that emergency medical care was hard to get in an emergency		52%		54%
A vast majority of patients at the sites had never attended an orientation session about the facility		84%		90%
Overall Perceptions of Services:				
Though a majority felt that the services received that day were good to excellent, these rates are not as high as some of their other positive perceptions		60%		49%
The majority felt that the services were "about right", which would suggest that their expections are lower		79%		81%
Services at the facilities were perceived as being capable of improvement through hiring more physicians, improving the pharmacy, and enlarging the facilities		40%		71%
Other facilities had also been used by patients at both sites and when this visit was to a non IHS facility, they were rated as average		23%		44%
		33%		30%
or very good in all cases		67%		70%
When asked to express likes and dislikes about the services, the responses were varied and the long waits seemed to be the only serious problem	13	40%	11	39%

a. What does the PY HCP provide all Pascua Yaqui tribal members residing in Pima County?

A comprehensive medical benefits package and reimbursable items. The PY HCP comprehensive benefits package includes general outpatient and specialty clinic services, pharmacy services, lab and x-ray services, emergency services, inpatient and outpatient hospital benefits. Included as line items of the PY HCP are social services, mental health services, home health services, and prosthetic appliances or devices.

Services that are requested on a less frequently, such as physical therapy, ambulance, dentistry, podiatry, and optometry services, are administered on a fee-for-service basis and funded through other CHS contracting mechanisms pending the availability of funds.

The 3171 enrollees in the PY HCP--2550 tribal members and over 600 newborns--are eligible for the services described above. The other 350 tribal members residing in the county who are enrolled with alternative resources can be assured their medical benefits will at least equal that provided in the PY HCP benefits package.[138] Most are enrolled in a state funded program and are treated at the same facility which treats PY HCP members.[139] The state program funds nearly all the same benefits as the PY HCP program except for podiatry; over the counter pharmacy; mental health services; and durable medical equipment. IHS will fund these services, on a fee-for-service basis, for any PY tribal member (residing in the county) not enrolled in the PY HCP benefits package. In this way all PY tribal members are eligible for the same amount of benefits, although the funding mechanism may differ.

All Pascua Yaqui tribal members are eligible for health programs administered by the PY HD, such as community health care, mental health services, and the transportation service.[140] Also, services provided alternative resources which are not part of the benefits

[138]Of the 4990 enrolled members in the PY Tribe, only 2853 reside within the Yaqui Service Unit. Another 620 are newborns enrolled in the PY HCP but not enrolled in the PY Tribe. Approximately 300 receive their health care from the state AHCCCS program; another 50 receive care from other providers. Tribal Enrollment Office figures as of 4/30/88.

[139]Each individual eligible for the state program can chose which state facility to use. The PY HCP Outpatient facility is licensed by the state and is the one most frequently chosen by PY Tribal members.

[140]See Finding Three for more detail on pages 47 thru 50.

F. Conclusions

IHS can successfully implement a prepaid health care program to meet the medical needs of a targeted population if the participating tribe, health care provider and IHS staff strongly support the project. The willingness of the three groups to sustain a cooperative working relationship is the critical factor. IHS can adapt the prepaid arrangement for use at some, but not all, IHS sites. The PY HCP evaluation specifically asked the following questions:

1. How well is the present arrangement with the PY HCP Contractor meeting the needs of the Pascua Yaqui tribal members in Pima County?
2. What are the strengths and problems of this prepaid arrangement as the principal source of health services for this population?
3. What are recommended approaches for resolving the problems?
4. What aspects of the PY HCP plan seem potentially transferable to other sites?
5. How does the experience of the Pascua Yaqui tribe compare with that of other populations receiving most of their care from facilities operated by the Indian Health Service?
6. What kind of comparisons can be made with other Indian communities?

Each question will be answered separately in the pages that follow. See Findings One and Two (pages 25 thru 46) for a thorough description of the present arrangement with the PY HCP Contractor and Finding Three (pages 47 thru 50) for a description of additional health care services provided for the PY Tribe.

1. How well is the present arrangement with the PY HCP meeting the needs of the Pascua Yaqui tribal members in Pima County?

As individuals, Pascua Yaqui tribal members resident in Pima County need a comprehensive medical benefits package that can be accessed readily at any time of the day, provides continuity of care, and insulates health care from tribal politics.

package, such as dialysis treatment provided by the county government, is available to all county residents of the PY Tribe.

Educational Outreach on how to access the PY HCP. The Tribal Health Department takes special measures to reach and involve all eligible PY HCP members. Meetings and educational classes are also held off the reservation in the other Pascua Yaqui communities in Pima County.

Service 24-hours a day, seven days a week. The PY HCP is designed to provide 24-hours a day coverage. If a patient needs services when the clinic is closed, an emergency hotline is available. A physician will return a patient's call within fifteen minutes and will advise the patient regarding their condition. Any care received at an emergency facility must be reported to the PY HCP Contractor within three days. The fee for the emergency care will be paid by the PY HCP Contractor out of the capitated rate funds.

The PY HCP facilities are modern and convenient. Most medical benefits are available at the Main Clinic, a modern facility conveniently located downtown. The tribal clinic provides physician appointments, physical check-ups, eye and ear screening, maternity care, immunizations, minimal laboratory services, nutritional counseling and triage services.[141] Referral services are coordinated from both clinics. Transportation is provided by the tribe.[142]

Continuity of care. The prepaid arrangement provides continuity both in health care services and retention of health professionals who provide those services. A Primary Care Provider (PCP) is designated for each PY HCP member.[143] The PCP must see the patient before making a referral to a specialist. This procedure provides a more holistic health care

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[141] IHS Contract No. 249-87-0007, Part I Section C-1, I.4.

[142] 65% of the patients stated that they had "no problem" with transportation to the clinic. 78% arrived at the clinic in less than 30 minutes. Over 50% of the tribal clinic patients walked to the clinic. *PY HCP Evaluation Patient Satisfaction Survey*, conducted as part of this project, 1/12 - 1/15/88.

[143] *How to Use Your Yaqui Health Care Plan*, Yaqui Member Handbook, pg. 5.

system because the PCP is aware of everything affecting the patient, instead of the patient being treated for a particular illness or injury without relating that health problem to other factors influencing the patient's health.

Health care is insulated from tribal politics. Patients receive continuous medical attention, the quality of which is not affected by tribal politics. The tribal government is consulted in the administration of the contract but it has no authority to interrupt the provision of health care.

b. What indicators are there that the needs of the PY HPC enrollees are being met?

Medical inpatient utilization has declined steadily in terms of patient days from a high of 7.2 to the present level of 3.6. The overall number of days for the entire membership has also declined to half of what it was since the PY HCP began. This adds weight to the theory when patients begin prepaid programs, they have a "stored-up" need for medical care and tend to use it frequently.[144]

The patients are generally satisfied with the care received from the PY HCP and they use the system. Results show 85% of the 196 respondents surveyed say the care is at least average or better, with 55% rating care above average.[145] In 1987, 2048 patients used the main clinic and 847 used the tribal clinic.[146]

c. What are the needs as members of the tribe?

The tribe needs to participate. The PY HCP contract requires that a seat be reserved for the Tribal Chairman on the Main Clinic's Board of Directors.[147] Tribal input is also requested regarding all policy changes.

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[144] Additional data on utilization is included in the Statistical Report.

[145] *PY HCP Evaluation Patient Satisfaction Survey*, conducted as part of this project, 1/12 - 1/15/88.

[146] These figures overlap, so it cannot necessarily be presumed that 3173 patients visit the clinics. However, it should be noted that the average monthly membership in 1987 was 3226.

[147] The Clinic Board of Director's seat is vacant now because the Tribal Chairman position is also vacant.

The tribe needs a good intermediate step for tribal contracting of services. The prepaid arrangement is well designed for a tribe that has a strong desire to implement its own health programs but weak capability to administer them. For the Pascua Yaqui Tribe, tribally administrated 638 health contracts which complement the PY HCP are preliminary steps towards tribal administration of all health care programs. As the tribe is participating in the implementation of the PY HCP contract managed by the IHS, the tribe can develop its own management expertise to at least take over administrative management, if not ownership, of the system.[148]

The tribe needs strong communications with the IHS OHPD. The nature of the prepaid arrangement necessitates a structured opportunity and process for the three groups to communicate on a regular, often daily, basis.

The tribe needs an easy way to provide health insurance for its non-Indian employees. The tribe could benefit by including its non-member employees in the same prepaid plan as its members. This would alleviate the problems associated with providing health insurance for such a small number of people.

[148]True assumption of ownership and management of any enterprise should ideally be accompanied by incentives related to risk responsibility. *Baltimore Conference, AHCS, pg. WGR-11.*

2. What are the strengths and problems of this prepaid arrangement as the principal source of health services for this population?

(The problems which have been overcome are discussed here as strengths; persistent problems will be discussed under #3)

The prepaid arrangement needs to be supplemented with tribal programs. An outside contractor is not expected to reach and enroll all its potential PY HCP membership without assistance from the Tribe. The Tribe is better suited to delivery some services that are very personal or culturally sensitive, for example, transportation and community education.

IHS must define a benefits package for its Indian beneficiaries under any prepaid arrangement. IHS is not required by law or regulation to provide a uniform package of health services. In fact, IHS facilities and local needs vary so much from one IHS Area to another that no single benefits package would be appropriate.[149] But each year IHS must consider what services it will provide to its tribal beneficiaries given its financial limitations. This is always a controversial issue and concrete limitations are seldom drawn. But under any prepaid arrangement, a benefits package is defined at the outset before a RFP is issued. IHS first researches what services will meet the medical needs of its tribal beneficiaries and investigates whether alternative resources can fulfill any of these needs. Then IHS designs a benefits package specific to a particular tribe's requirements.

The contractual agreement is flexible; it is written to accommodate different situations as they arise. The Project Officer is given authority to interpret the contract terms and make judgments about unique situations. Yet the contract is specific enough to ensure that reports are delivered on schedule and problems can be resolved in a procedural manner.

IHS reduces its level of financial risk. The prepaid arrangement appeals to the IHS because it shifts the financial risk from the IHS to the PY HCP Contractor.[150] The IHS, however, retains its trust obligation to ensure health care is provided to the tribal members.

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[149] *Indian Health Care*, Office of Technology Assessment, OTA-H-290, April 1986, pg. 174.

[150] The shift of financial risk is not to be construed as an abrogation of the federal health care obligations to the tribal beneficiaries under the law.

The Contractor has the ultimate risk because it agrees to provide unlimited services for an established rate. Non-Indians are also enrolled on prepaid plans at the same facility. Their premiums (unintentionally) offset some of the financial risk of cost for the PY HCP members. The impact of the risk is cushioned by the reinsurance coverage provided by the PY HCP Contractor to cover costs of all illnesses over $35,000. The reinsurance coverage is not directly addressed in the contract, but is included in the capitated rate.

IHS reduces its level of managerial risk. Management tasks, such as arranging for referrals and durable equipment, are handled by the PY HCP Contractor and not by IHS staff. The PY HCP Contractor also has the burden of recruitment and retention of the health care staff.[151] With the responsibility for the managerial tasks now lying with the PY HCP Contractor, the IHS saves time and financial resources.

The IHS could eliminate fee-for-service costs. Factoring cost reimbursable services and equipment into the capitated rate would simplify the administrative approval process. This would save time and money for the Contractor and IHS, and patients would likely receive services quicker.[152] Documentation would still be required of the PY HCP Contractor because the durable equipment is owned by the federal government and the equipment utilization rates are used for planning and program development.

The contract is revised only at set intervals. Unlike a 638 contract, there is no fear by IHS of a modification midstream . The capitated rate is established and remains constant throughout the contract or upon regular review.

The prepaid arrangement provides good Quality Assurance methods. Commonly there is a shortage of IHS staff members to effectively review patient care with Contract Health Services. The PY HCP arrangement establishes two levels of Quality

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[151] Although recruitment and retention is more difficult in rural Indian settings, it is a national issue for IHS.

[152] This has not been done in the PY HCP arrangement.

Assurance review--the clinic's own internal procedures[153] and the IHS medical officer's monthly review of randomly selected PY HCP medical charts. The IHS could designate any Quality Assurance procedure as a written requirement of the PY HCP contract.

The private health care provider is in a better position to negotiate for discounted services because it can negotiate with local hospitals and clinics without the encumbrance of federal government bureaucratic procedures. The PY HCP Contractor can probably negotiate a more comprehensive benefits package for a better rate than the IHS could.

Patients can easily get second and third opinions. This differs from the IHS direct care system where second opinions are not always available.

Less chance of duplication on diagnostic tests. Since the PCP oversees the medical services rendered to the patient, the PCP will know when test results acquired from one specialist may be helpful to another.

Discharged and referred patients are tracked better than in other IHS contract care situations. Discharge planning and follow-up of referred patients is greatly improved by the weekly staffing meeting at the tribal clinic where the Contractor and tribal employees identify high risk social service patients and coordinate staff intervention.

The Social Worker provides services for all the PY members resident in Pima County. The Yaqui Social Worker has direct contact with the patients, acts as their advocate when necessary and works as a liaison at the PY HCP Clinics and in the community with all referral physicians.[154] This person has direct contact with the PY HCP Contractor and is protected from tribal political decisions because the Yaqui Social Worker is employed by the PY HCP Contractor and not by the tribe.[155]

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[153]The Main (El Rio) Clinic has its own Quality Assurance Plan designating eleven separate Quality Assurance committees, updated as of 7/87.

[154]IHS Contract No. 249-87-0007, Part III, Section J-6.

[155]As a tribal employee working in the very sensitive area of mental health counseling, the Social Worker might be affected negatively by tribal politics. Job security as a tribal employee would be less secure.

3. What are recommended approaches for resolving the problems?

Provide sufficient lead time to fulfill the initial requirements of the contract. The current contract does not provide adequate time to set up the infrastructure to implement the prepaid plan. With the current it was necessary to amend the due dates for production of the handbooks and enrollment cards.

Reasonable time requirements for production and distribution of the cards elsewhere can be extrapolated from the PY HCP experience. A delay in distributing the cards was caused, in part, because of difficulty verifying mailing addresses. To solve this problem the PY HCP Contractor sent a letter to PY HCP members asking them to bring the letter into the clinic so they could pick up their new enrollment card. After four weeks, all cards not claimed were given to the tribal health department to distribute in the PY communities.

Consider phase-out costs. There is a possibility of additional costs for transferring the contract if the current Contractor is not awarded the next contract. These costs will not be incurred if the current PY HCP Contractor is selected for the new contract. Rather than factoring the costs into the capitated rate, IHS should set aside contingency funds to be used only if the transfer situation arises.

Modify funding projections on a regular basis. It is difficult to predict the amount of usage of the cost reimbursable items under the contract. At PY HCP, contract modifications to the line items (other than capitated rate) are regularly done on a as needed basis to accommodate available funding needs.

Decrease the procedural paperwork for referral services. Cost reimbursable items or other referred services require considerable paperwork and approval requirements which may delay receipt of equipment to the patient. The PY HCP Contractor has stated it

would be worth the risk to capitate these items because the current procedure uses an inordinate amount of time and personnel resources.[156]

Eliminate inappropriate direct billing to patients. A recurring problem with the current prepaid arrangement is that referral doctors bill patients directly. Patients tend to ignore the bills because they expect free health care. In extreme cases, collection agencies contact the patients. The Contractor must explain to those physicians who continually bill patients directly that they can no longer be considered for referral because they are expending too many resources of the system in administrative follow-up. In addition, the PY HCP members need to be educated to promptly direct any such bills to the staff at either clinic.

Two methods employed by the PY HCP Contractor to overcome this problem are to attach a bright red sticker to each referral slip with the correct billing address and for the Yaqui Social Worker to remind the referral physicians of the correct billing procedures.

IHS must develop methods to track people and problems not adequately recorded by the PY HCP Contractor. One problem is that the PY HCP Contractor is not required to maintain records on tribal members receiving care from alternative resources. By contrast, the commitment of the tribe and IHS extends to the health care needs of all tribal members.

Another problem is that the PY HCP Contractor does not routinely collect all the data that the IHS customarily uses for planning and program development. Data collected by the PY HCP Contractor is used primarily for billing and other administrative purposes. This is especially true of mental health, alcohol and substance abuse referrals. There is no place on the

[156]The utilization figures for the cost reimbursable items could be analyzed to calculate their cost into the capitated rate.

medical record to indicate illnesses or injuries which are related to alcoholism. (Note that the Yaqui Social Worker does track the incidences of alcohol and drug problems.[157])

To overcome these problems, the IHS OHPD is providing the PY HD with computers, computer operators and computer training. The computers will be used to establish a data base of the level of services being provided, to identify members eligible for alternative resources, and to track discharged patient care, to monitor mental health and alcoholism patients and to record demographic information of all tribal members (not just those eligible in the PY HCP.) This especially timely with the upcoming enrollment of new tribal members.

Resolve the issue of medical record ownership. One contract provision states that IHS "owns" the medical records produced as a result of the PY HCP contract.[158] The contract also requires the PY HCP Contractor to furnish "phase-in, phase out services for up to 60 days after this contract expires".[159] It obligates the IHS to reimburse "all reasonable phase-in, phase-out costs".[160] These provisions are not a valid assertion of ownership because they do not not account for information 1) documented prior to the PY HCP was established; 2) documented during periods when a PY HCP enrollee is transferred to alternative resources; and 3) required to be maintained by the medical providers according to state law. To overcome these problems the PY HCP Contractor could ask each PY HCP member on the PY HCP registration form for permission to forward copies of the medical record to a succeeding PY HCP Contractor.[161] It is further recommended that the cost of duplication be covered by IHS.

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[157]The physician may note alcohol or drug use on the record in a manner for his or her own use. In addition, the Yaqui Social Worker has been tracking alcohol and drug abuse in his work. He has completed a report on this topic, Causey, C., *Report on Pascua Yaqui Tribe Mental Health Services: Drug and Alcohol*, 4/27/87.

[158]IHS Contract No. 249-87-0007, Part I, Section C-1, R.1, pg. 21.

[159]IHS Contract No. 249-87-0007, Part I, Section H-8, B., pg. 36.

[160]IHS Contract No. 249-87-0007, Part I, Section H-8, D., pg. 36.

[161]Another means to tackle this problem is for the Tribal Government to authorize, by resolution, the duplication of the records of its tribal members. The Tribe Council of the Alabama and Coushatta Indian Reservation did just this to authorize research on the health status of its newly recognized population.

Instill cultural sensitivity in the delivery of the health care. The IHS has achieved a great deal of cultural awareness in the IHS medical community. The PY HCP Contractor, its subcontractors and referral physicians may be unfamiliar with Indian beliefs regarding family, health, medicine, or diet.

First of all, the Contractor should be educated regarding how this contract fulfills part of the federal trust relationship of the federal government to the tribal members as a tribe. It should be understood that the tribe is a sovereign nation which relates to the federal government on a government-to-government basis.

Hiring tribal members on the clinic staffs is expected to increase cultural sensitivity and facilitate use of the clinics by fellow tribal members.[162] Indian Preference regulations must be explained thoroughly to the PY HCP Contractor.[163] At PY HCP the Contractor hired 18 individuals of Yaqui descent including one clinic Physician and the Patient Advocate.[164]

At PY HCP, the Yaqui Social Worker orients the referral physicians and subcontractors to the culture and sensitivities of the Pascua Yaqui people. The subcontractor hospital has a Traditional Indian Medicine program which is highlighted by a yearly week-long conference. Many of the hospital staff members have attended these conferences. In addition the PY HD (rather than the PY HCP Contractor) conducts community outreach.

Avoid multiple collections for the same patient. Since the PY HCP Contractor is also a health provider for the state program, it may inadvertently collect two premiums for the same person from different government agencies.[165] This may occur

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[162]This feeling was expressed by the PY HCP Patient Advocate, PY (Acting) Tribal Chairman, and others.

[163]Employment positions created as a result of the PY HCP contract should be filled by Indians as much of possible.

[164]At PY HCP clinic this has taken place even though the technical aspects of Indian Preference has not been formally explained to the current PY HCP Administration.

[165]The PY HCP Contractor is liable for an overpayment to the IHS in these instances.