

1989

IHS Invitational Colloquium - Tribal Health Delivery Systems: What Does the Future Hold?

Indian Health Service, Division of Program Evaluation and Policy Analysis

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INDIAN HEALTH SERVICE

Invitational Colloquium

"Tribal Health Delivery Systems:
What Does the Future Hold?"

LaJolla, California

May 16 - 18, 1989

Office of Planning, Evaluation and Legislation
Division of Program Evaluation and Policy Analysis
Branch of Policy Analysis

Preface

During the week of May 16-18, 1989, the Indian Health Service (IHS) sponsored the Invitational Colloquium on "Tribal Health Delivery Systems: What Does the Future Hold?" at La Jolla, California. The IHS sought to promote a dialogue among experts in the health care industry, tribal health delivery, and the Indian Health Service on the relevance of alternative delivery and financing systems for the IHS and tribes.

The Colloquium was planned, designed, and developed by Ramona Ornelas, Chief, Branch of Policy Analysis, and sponsored by the Office of Planning, Evaluation, and Legislation (OPEL), IHS. This report describes the proceedings of the Colloquium and provides information on the evolution and analysis of the issue. The Colloquium was constructed to feature expert presentations on specific types of alternative delivery and financing systems; the relevant trends in the health care industry; the experience of tribal programs utilizing some form of alternative delivery; and the IHS approach to assessing the feasibility of such systems. The meeting culminated in small workgroup sessions for the development of recommendations for OPEL, the IHS, and tribes.

The enthusiastic response of the participants is indicative of the importance of the issue and the timeliness of this event. The success of this meeting provides a model for future meetings recommended by those attending this Colloquium. The logistical support and conference facilitation provided by TCI, Inc., under the direction of Tom Clary, Ph.D., allowed for the meeting to proceed smoothly and without distraction. The facilitator for the Colloquium was Ralph Wetzel, Ph.D., whose capacity for distilling a wealth of information into an understandable format is reflected in this report which he constructed. Small group facilitation was ably and effectively provided by Mark Jackson, M.D., Deputy Director, California Area IHS; Bert Swift, Ph.D., Office of Prepaid Health Care, HCFA; Don Davis, Area Director, Phoenix Area IHS; and Charles Erickson, Acting Director, Office of Health Program Research and Development, IHS.

The background, interest, and expertise of the attendees fostered a dialogue grounded in the reality of current experience and the relevance to future tribal and IHS health care delivery. There is now a greater awareness of the requirements for participation with the private sector, as well as a perspective on the opportunity for improving management and cost efficiency. Participants came away from this meeting with the view that managed care and/or the techniques utilized by these organizations could enhance Indian self-determination. The recommendations contained in this report will provide a direction for continued development and future assessment of this issue.

that ADSs need exploration with or without additional resources, but funds are needed for critical demonstration projects.

Three common themes emerged:

1. **Education and Leadership.** IHS should support a broad effort to educate Indian people about ADSs and prepare people for health care leadership.
2. **Information and Information Management.** IHS should obtain and disseminate information about state of the art techniques and successful outcomes.
3. **Broad Perspective for Planning.** IHS should develop a broader view of health care possibilities and alternatives.

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Conference facilitation and logistical support were provided to the Indian Health Service by TCI, Inc. Special acknowledgement is given to Ms. Corinne L. Levy of TCI, Inc.

Office of Planning Evaluation and Legislation
Associate Director: Luana L. Reyes

Division of Program Evaluation and Policy Analysis
Branch of Policy Analysis
Chief: Ramona C. Ornelas

Tribal Health Delivery Systems: What does the Future Hold?
Summary Report of IHS Conference
La Jolla, California - May 16-18, 1989

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Foreword

The Indian Health Service (IHS) provides comprehensive health care for American Indians and Alaska Natives with the opportunity for maximum tribal involvement in developing and managing programs to meet tribal health needs. The goal of the Indian Health Service is to raise the health status of the American Indian and Alaska Native people to the highest possible level.

Major challenges to fulfillment of the IHS mission are presented by the continuing escalation of health care costs and an increasing demand for health care by a dynamic population growing both in size and age. The rapidly changing environment in which the IHS functions requires constant exploration and search for the most effective methods of health care management, delivery, and financing to assure continued access to comprehensive health care.

This report describes one such effort. The Invitational Colloquium was convened to present pertinent information on various alternative approaches to health care delivery and financing from the perspective of experts in managed care and tribal health delivery. The proceedings as described in this report should provide relevant information that can assist tribes and the IHS to provide cost-effective health care while maintaining the tenets of Indian Self Determination. The presentations made by the experts in managed care and by representatives of those tribal programs involved with alternative systems, provided a deeper understanding of the significance of this issue and a perspective on the future of Indian health care. The dialogue and participation of the attendees was of such a high caliber that it served to validate the importance of this issue and to assure that further investigation will continue.

I expect the interest in this issue to grow as tribes and the IHS seek solutions to the challenges faced in the current economic climate. The participation and enthusiasm of the attendees is deeply appreciated. The Office of Planning, Evaluation, and Legislation (OPEL) will continue to seek the collaboration of tribes, the IHS, and health care industry experts in the definition of appropriate policy alternatives that will enhance the IHS capacity to meet its mission.



Luana L. Reyes
Associate Director
Office of Planning, Evaluation, and Legislation

Background

In keeping with the President's policy on promoting competition, the Department, in 1987 and 1988, adopted an IHS policy initiative to assess the implications of using alternative delivery and financing systems to provide health care to eligible American Indians and Alaska Natives. This issue is not new to the IHS. The IHS purchases services from a health maintenance organization for one tribe, sponsors an administrative services contract with a third party administrator for another, and funds a demonstration project to support a tribal affiliation agreement with a private medical center. This limited experience was not judged sufficient to define the risks and benefits of such involvement on a larger scale.

Concurrently, tribes were beginning to request assistance in assessing the potential for alternative methods of health care delivery. The interest in this issue is driven by a number of concerns: the rising costs of health care; the rationing of health care purchased with Contract Health Services funding; the need to maintain or expand the level of services; the need for consolidation of fragmented tribal health care systems; the need for management efficiencies; and, a growing desire for effective means to fully implement Indian Self-Determination.

The public sector concern for the escalating costs of health care and the growth in the entitlement programs of Medicare, Medicaid, and Champus have prompted the formulation and implementation of cost containment policies. The private sector is equally concerned. Both are now promoting enrollments in managed care systems because of the demonstrated capacity to maintain or limit upward trends in costs through a variety of management techniques. While the IHS has no formal cost containment policy in place, it too faces challenges in maintaining access to comprehensive health care and finds that rationing of health care is necessary, particularly when demand exceeds the available CHS resources appropriated for care purchased from the private sector. Since the IHS is a discretionary program, the latter is appropriated annually.

Unlike Medicare and Medicaid, the IHS is not an entitlement program. Consequently, the IHS finite resources pose a real challenge to assuring adequate health care delivery. It must evaluate the potential for use of alternative delivery and financing mechanisms for cost saving opportunities in managing CHS funds and for supporting tribes in achieving self-determination. This potential includes the opportunities to: maintain or increase the level of services provided to tribal members; maintain or slow the growth in health care costs; increase management capacity; participate in risk pooling through joint ventures or agreements with the private sector or local communities; or, to become bona fide members of the health care industry through corporate organization.

The IHS sponsored a conference in November of 1987 for the purpose of fostering a discussion on the relative merits of further investigation, and for defining an analytical approach. Information was exchanged from the various perspectives of the IHS, the academic community, the health industry, and tribal programs. Of primary concern were the needs to preserve the principles inherent in Indian Self-Determination, and to ensure the participation of tribes in the resolution and definition of policies pertaining to alternative health care delivery and financing. As a result of this conference a feasibility analysis project was developed. A case study approach was utilized to assess various alternatives in specific tribal and CHS program settings. The results of the first phase of the analysis are described in this report. The conference participants anticipated that such an approach would elicit both the risks and benefits of tribal and Contract Health Services Program participation with the private sector. The fundamental issues to be assessed were whether or not the application of these systems or methods of financing offered an opportunity to improve the services provided at the same or lower cost, whether tribal incorporation as an alternative delivery system was feasible, and what opportunities existed for tribes to participate in joint ventures with local communities, providers, states, and various corporate forms of alternative delivery systems.

The Invitational Colloquium was designed and convened to fulfill the need for practical and applied information on managed care alternatives and to provide a forum for discussion on the future requirements of tribal health systems and the IHS in relation to alternative delivery and financing systems. The presentations were designed to provide expert information on the various types of alternative delivery and financing systems as well as an assessment of the viability and appropriateness for tribal health systems. In addition, the experiences of those tribes who are involved with some form of alternative delivery were presented. The participants at this meeting included IHS staff, tribal health directors and policy makers, and experts in the field of managed care and financing. The discussion was future oriented with a focus on the survival of Indian health care. The group considered this issue to be of considerable significance and recommended a number of steps to implement the initiative inclusive of the requirement for further meetings to expand the awareness of tribes. The proceedings and participation at this meeting surpassed expectations in defining a future course for OPEL and the IHS.

TRIBAL HEALTH DELIVERY SYSTEMS: WHAT DOES THE FUTURE HOLD?

INDIAN HEALTH SERVICE
INVITATIONAL COLLOQUIUM

La Jolla Village Inn, La Jolla, CA
May 16-18, 1989

I. Executive Summary

Executive Summary

The issue of IHS and/or tribal participation in alternative health care delivery systems remains one of the most important items on the IHS policy agenda.

In this colloquium, IHS brought together representatives from tribal organizations, IHS and other federal agencies, and private-sector health care organizations to review trends, share information on a variety of issues in managed care, and address key questions about future directions for the IHS.

Presenters addressed a range of topics including: trends in the health care industry, preferred provider organizations (PPOs) and health maintenance organizations (HMOs); affiliation agreements; indemnity insurance; rate setting; and utilization, cost, and quality reviews. In addition, individuals and panels described several specific case studies of successful approaches to managed care by tribes.

Discussions followed each presentation. The participants explored a wide range of issues and questions with the speakers.

Discussion groups addressed each of four key policy questions:

1. Should IHS and/or tribes pursue capitation of Medicaid/Medicare with HCFA . . . with states?
2. Should IHS assist tribes in pursuing relationships with alternative delivery systems (ADSs)? What should the IHS role be: technical assistance, training, development of managed care systems/strategies, etc.?
3. Is it possible to pursue ADSs without additional resources?
If additional resources were available, how would you deploy them?
4. What are the next steps for the IHS? Where do we go from here?
What is the role of the Office of Planning Evaluation and Legislation?

Discussants concurred on several major concepts:

that ADSs best express the intent of self-determination;

that tribes should have the option of dealing directly with HCFA, although several issues should be addressed first;

that IHS can help tribes pursue ADSs in several ways;

TRIBAL HEALTH DELIVERY SYSTEMS: WHAT DOES THE FUTURE HOLD?

INDIAN HEALTH SERVICE
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II. Agenda

AGENDA

INDIAN HEALTH SERVICE INVITATIONAL COLLOQUIUM

"Tribal Health Delivery Systems: What Does the Future Hold?"

La Jolla Village Inn, La Jolla, CA
May 16-18, 1989

TUESDAY, MAY 16, 1989

8:00	- 9:00 am	REGISTRATION
9:00	- 9:10	WELCOME - INTRODUCTION TO COLLOQUIUM Luana Reyes Associate Director Office of Planning, Evaluation, and Legislation Indian Health Service
9:10	- 9:30	Outline of Purpose and Structure of Colloquium Ramona C. Ornelas Chief, Policy Analysis Branch Indian Health Service
9:30	- 10:00	Introduction of Facilitator and Colloquium Participants Ralph J. Wetzel, Ph.D. Facilitator
10:00	- 11:00	Trends in the Health Industry: Dynamic Change Continues Nelson Ford, Partner Coopers & Lybrand
11:00	- 11:15	BREAK
11:15	- 12:15 pm	Preferred Provider Organization (PPO) Leesa Key, Consultant Coopers & Lybrand
12:15	- 1:30	LUNCH
1:30	- 2:30	Discussion: Participants and Presenters
2:30	- 2:45	BREAK
2:45	- 3:45	Health Insurance & Actuarial Assessment Raymond D. Goodman, M.D. Adjunct Associate Professor UCLA Medical School

- 3:45 - 4:45 pm **How to Set and Negotiate Rates**
Cost and Quality Review Applications
Tim Morton, Assistant Area Director
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Portland Area IHS
- 4:45 - 5:45 **Panel: Presenters**
Questions & Answers
Facilitator
- 6:00 - 7:00 **Reception**

WEDNESDAY, May 17, 1989

- 9:00 - 9:15 am **A Summary of First Day Proceedings**
Ralph J. Wetzel, Ph.D. - Facilitator
- 9:15 - 10:15 **Health Maintenance Organizations (HMO)**
Sheila Leatherman, Vice President
United HealthCare Corporation
- 10:15 - 10:30 **BREAK**
- 10:30 - 11:30 **Arizona AHCCCS Project/The Navajo-Arizona**
Experiment with Capitation of Medicaid
John Hubbard, Executive Officer
Navajo Indian Health Service
- 11:30 - 1:00 pm **LUNCH**
- 1:00 - 2:00 **Suquamish Administrative Services Contract**
Lisa Giles, Medical Social Worker
Suquamish Tribe
- 2:00 - 2:15 **BREAK**
- 2:15 - 3:15 **Tribal Case Study Project**
Ramona Ornelas, IHS Project Manager
Margaret Siebel, Support Services, Inc.
- 3:15 - 4:15 **Tribal Case Study Panel**
- 4:15 - 5:00 **Panel: Presenters**
Questions & Answers

THURSDAY, May 18, 1989

- 8:00 - 8:15 am Summary of Conference Activities and
Administrative Announcements
Ralph J. Wetzel, Ph.D. - Facilitator
- 8:15 - 9:15 Affiliation Agreements
Virginia Throssell, Tucson Medical Center
Ed Hansen, Health Director
Tohono O'odham Nation
- 9:15 - 10:15 Tribal Employee Insurance Mechanisms
Dean Cohan, Executive Director
United South & Eastern Tribes
- 10:15 - 10:30 BREAK
- 10:30 - 11:00 pm Panel: Presenters
Questions & Answers
- 11:00 - 12:30 Program & Policy Recommendations
Small Groups
- 12:30 - 1:00 Small Group Reports
- 1:00 - 1:15 IHS Response, Summary, and Evaluation
Ramona Ornelas

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INDIAN HEALTH SERVICE INVITATIONAL COLLOQUIUM

"Tribal Health Delivery Systems: What Does the Future Hold?"

La Jolla Village Inn, La Jolla, CA
May 16-18, 1989

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TRIBAL HEALTH DELIVERY SYSTEMS: WHAT DOES THE FUTURE HOLD?

INDIAN HEALTH SERVICE
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III. Summaries of Presentations

Trends in the Health Industry: Dynamic Change Continues

Nelson Ford, Partner
The National HealthCare Policy Group (In-Charge)
Coopers & Lybrand, Certified Public Accountants
Washington, DC

One out of every eight dollars spent in the United States is spent on health care. The atmosphere of the health care arena is filled with concerns and complaints. What are the trends?

Expenditure Slowdown. After a high growth rate history - twice the rate of inflation - the growth rate of health care expenditures is slowing down. The rate is leveling at a current 10.5% of the GNP.

Profit Margins Narrowing. Half of health care expenses go to hospital care, but hospital profit margins are narrowing. The change is largely due to cost control measures introduced by the Diagnostic Related Groups restrictions imposed by HCFA [Health Care Financing Administration]. Health spending outside the hospital is increasing.

Nursing Home Growth Falling Behind. Although spending for nursing homes is increasing rapidly, it is still unable to keep ahead of demands generated by the high growth rate of the elderly population.

FORCES AFFECTING HEALTH CARE

Various pressures in the public and private sectors are producing changes and consolidations in the health care arena.

<p>PUBLIC PRESSURE + PRIVATE PRESSURE = CHANGE & CONSOLIDATION</p>

What Are the Public Pressures?

- Trends toward increasing regulations
 - HMO Act
 - Section 89
 - Medicare Catastrophic Insurance
 - State regulations
 - JCAHO accreditation of HMOs

- Increasing financial constraints as government shifts risk to private sector
 - Medicare cuts
 - Medicaid cuts
 - DOD, VA, NIH cuts
- Political demands for:
 - Minimum benefits
 - Care of the elderly
 - Long term care

What Are the Private Pressures?

- Pressures to contain costs
 - Managed indemnity at the point of service
 - Direct contracting
 - Shifting costs to the individual
- Pressures to measure the quality of health care
 - Expert systems of utilization rate measurement and quality assurance measurement will reveal what works and what doesn't.
 - The government will probably end up doing the measurement.
 - Contracts will specify what the outcomes must be.
- Pressures to develop new technology in shorter time frames: a big cost factor
 - Diagnostic and therapeutic
 - Shorter time frames for development
 - Cost - benefit tradeoffs

HISTORICAL AND STRUCTURAL VIEWS OF HEALTH INSURANCE

Historical View

Historically, the health industry has evolved through three phases:

Phase I	Private insurance, 1940-1965
Phase II	Public sector growth, 1965-1980
Phase III	Cost containment, 1980 - present

Structural Views

From the insurer's perspective, there are public insurance programs and private insurance programs.

- Public insurance programs
 - Medicare, Medicaid
 - Veteran's Plan, DOD, IHS, PHS
- Private programs
 - National groups
 - Various large, medium, and small groups
 - Individuals

From the buyer's perspective the insurance options are:

- Direct care
 - Clinics
 - Health care systems
- Managed care
 - HMO (group, staff, or IPA)
 - PPO
 - Precert / UR
- Catastrophic
 - Major Medical
 - Self-insurance / TPA

TRENDS IN HMO DEVELOPMENT AND GROWTH

What's the big deal in managed care? It's the HMO - with a \$38 billion annual cash flow and an 18% annual growth rate - and it is characterized by boom or bust. The leading HMO in size is still Kaiser. HMO market penetration is strongest on the West Coast. Both the number and enrollment of HMOs have grown, with enrollment tripled in the last seven years.

Individual Physician Association. The most rapid growth in HMO membership has been in the Individual Physician Association (IPA) model.

Profitability Down. HMOs spend 85-90% of their revenues for medical delivery costs, and 10-15% for administrative costs. The revenue is decreasing and the expenses are increasing, over time. HMOs are experiencing shrinking profitability, and in 1987 only 32% of the HMOs showed a profit.

Variable Ownership. There are variations in HMO ownership: non-profit, for-profit, insurer-sponsored, and Blue Cross/Blue Shield.

What's Going to Happen in the Future?

The combination of trends, public pressures, and private pressures will result in a variety of changes and consolidations.

Modern health care plans are positioning themselves for the future. They are introducing cost control, managing utilization, and marketing for volume. They are seeking better decision support and engaging in joint ventures to share risks and rewards.

The Indian Health Service Should:

- Explore ways to combine resources
- Attend to employers' interests in reducing expenses
- Provide for public education about wasteful consumption patterns of health care services

Preferred Provider Organization (PPO)

**Leesa Key, Senior Consultant
Chicago Actuarial and Benefits Consulting
Coopers & Lybrand, Certified Public Accountants
Chicago, IL**

What is a PPO?

PPOs facilitate arrangements between health care providers and health care purchasers. They are a managed-care mechanism but are not prepaid like HMOs. Various types of arrangements are possible, and many hybrids can be found on the market.

PPOs came onto the market after HMOs and gave consumers more provider choices.

Who bears the risk?

PPOs tend to share risks between purchasers and providers. If one thinks of fee-for-service as putting the risk entirely with the purchaser, and HMO's as putting the risk entirely with the provider, then PPOs are somewhere in the middle. PPOs arrange to split the risk between purchasers and providers.

What are the characteristics of a good PPO?

Rates. Rates are negotiated with providers.

Utilization. Utilization is reviewed regularly.

Choice with Incentives. Choice of providers is offered, *but* incentives encourage purchasers to choose "preferred providers." Preferred providers are those with whom rates have been negotiated, and who agree to participate in utilization reviews.

MIS Data Base. Management information systems (MISs) provide cost and utilization data to employers.

What are the market share trends?

PPOs are increasing faster than HMOs and catastrophic insurance.

Traditional indemnity insurance will probably disappear.

Why consider a PPO?

PPOs maintain quality, provide convenient access for patients, provide benefits flexibility, and contain health care costs.

What are some of the factors behind the development of PPOs?

Hospitals face financial constraints as the government becomes increasingly involved in price setting. Medicaid and Medicare pay 95% of the cost. It is important to know how hospital charges are constructed, and who is picking up the remaining 5 percent.

How do PPOs manage health care costs?

PPO's manage health care costs primarily through negotiating rates and with utilization reviews.

Should we utilize a PPO?

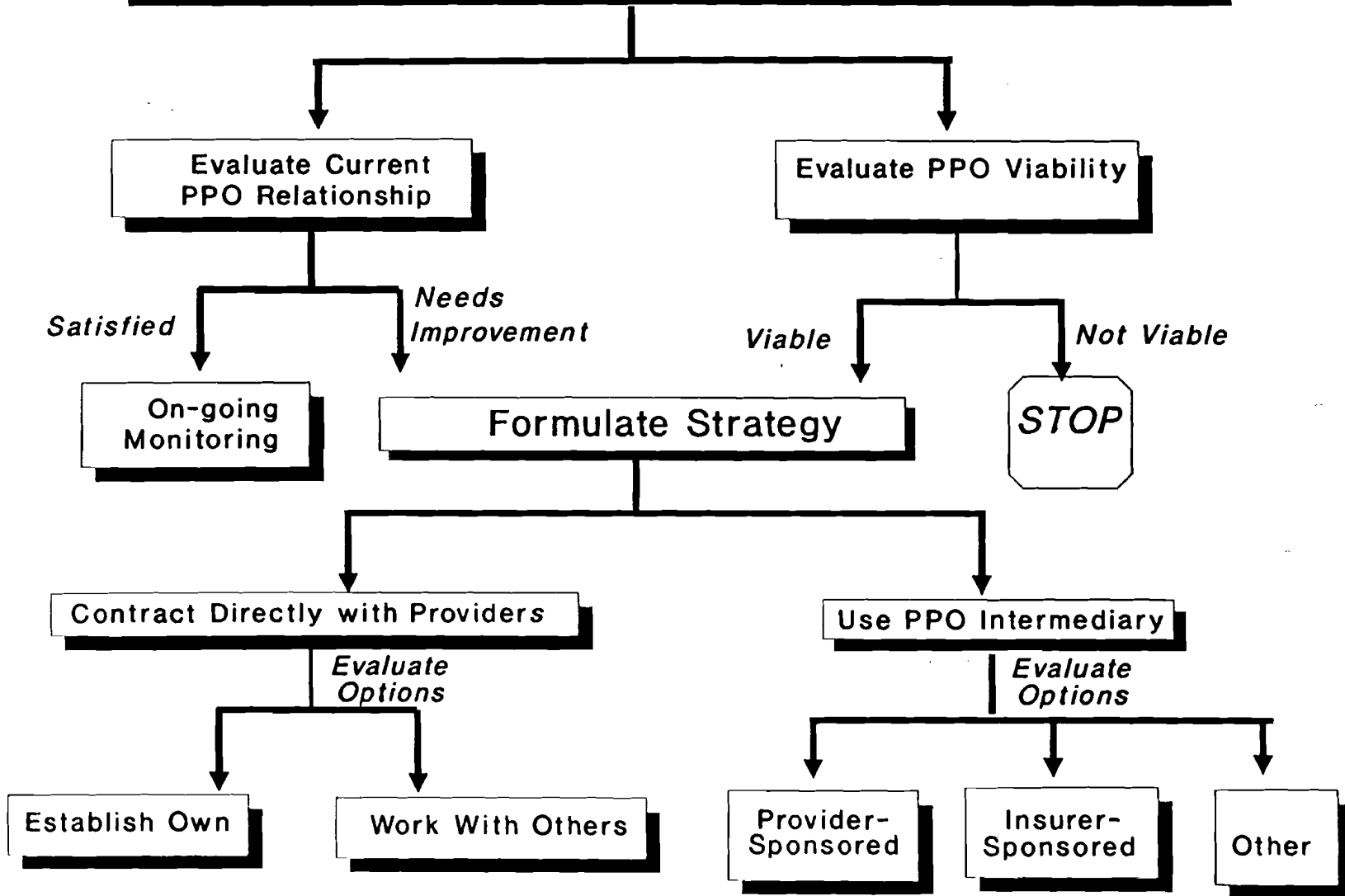
There are four issues (factors) to consider in deciding to utilize a PPO:

- Financial. Can you either buy into a network or run a preferred provider arrangement yourself?
- Political. Know what the politics are before negotiating.
- Managerial. Is the management adequate?
- Legal.

How do employers decide to go with a PPO?

(see Employer's Decision-Making Process, p. 25)

EMPLOYER'S DECISION-MAKING PROCESS



What's involved in developing win/win health care contracts?

- Knowing your objectives
- Selecting cooperative providers
- Leverage
- Understanding
- Commitment
- Communication

What are the payment options?

Listed below are provider payment options for preferred provider contracts, listed in order from no economic risk to full economic risk.

Hospital/Other Institutional Service Payment Methods

- 1) Standard charges
- 2) Discounted charges
- 3) Per diem rates
- 4) Per case / per DRG or per case / charges combination
- 5) Single rate for all cases
- 6) Per case / per diem or per DRG / charges combination with performance bonus
- 7) Capitation

Physician Payment Methods

- 1) Standard charges
- 2) Discounted charges
- 3) Reasonable & customary limits by procedure
- 4) Fixed fee schedule (relative value scale or by procedure)
- 5) Fixed fee schedule or reasonable & customary limits with performance bonus
- 6) Capitation

How relevant are PPOs for Tribes?

PPOs may have limited relevance in rural areas where there is no provider choice and therefore no room to negotiate. On the other hand, a tribe may be a provider's main source of revenue.

PPOs are applicable to tertiary care and special health categories such as *mental health* and *alcoholism*.

Health Insurance and Actuarial Assessment

Raymond Goodman, M.D.
Adjunct Associate Professor
UCLA Medical School
Los Angeles, CA

Some facts:

High Costs. Health care costs in 1988 were \$1800 per person per year for the total U.S. population.

Limited Insurance Plans. Insurance plans are becoming increasingly limited; especially in areas of mental health, alcoholism, and AIDS/ARC.

Many Left Out. Approximately 35 million people have no insurance.

What's happening with private health insurance and self-funding groups?

Cost Shifting. Insurance costs are rising as hospitals seek to shift costs to the private sector.

Premiums Up. The cost of premiums has risen 10-20 percent. A review of premium costs for self-funded groups shows that policies range between \$900/person/year to \$1600/person/year.

Comparison with HMOs. Forty to 50 percent of insurance costs go toward hospital expenses. Twenty percent goes to administrative costs, compared to 12-15 % for HMOs. On the other hand, HMOs are less viable.

Utilization Up. Increased utilization is another source of rising costs. A review of utilization suggests that people consume more services than are necessary to maintain or recover health.

Many Sources of Rise. Other sources of rising cost assessments are equipment, malpractice (1.5% total health care costs), and AIDS. Once insurance fees are established for a health care service, they are almost never reduced, even when the real cost of the service is less than the established one.

What are insurance companies doing to collect data on quality of care?

Practically nothing.

What about the level of funding available to the Indian Health Service?

Inadequate Funds. Compared to the funding level administered by most private health care organizations, the IHS is grossly underfunded.

Need for Information, Leadership. American Indians should demand public information for better understanding of the IHS situation. They should also educate Indian people for health care leadership.

What is involved in actuarial assessment of Native Americans?

Actuaries use several sources of data to project costs for any group, including:

- Geographical location
- Age and sex of people served
- Number of women of child-bearing age
- Accident data
- TB data
- Illness data

What will health care costs be in the future?

With increases of health costs, we will be at 15% of the Gross National Product by 2000 A.D. By that time, people will probably demand National Health Insurance in a form through which providers are reimbursed by a health care plan.

How to Set and Negotiate Rates Cost and Quality Review Applications

Timothy Morton, Assistant Area Director
Health Systems, Finance & Development
Portland Area IHS

Some useful clarifications:

On the difference between Indemnity Insurance and HMOs:

With Indemnity Insurance it is up to the individual to seek a provider. The individual is then reimbursed according to the policy.

With an HMO, the HMO arranges the care. HMOs are not regulated as insurance companies are.

What is the common element in HMOs, PPOs, CMPs?

They are highly motivated to be cost effective and not over-utilize services. This has not been so with Indemnity Insurance.

Their weakest point is risk management; most failures come from taking on too much risk and overly burdening the provider. On the other hand, they provide incentive to providers to manage in a cost effective manner.

SETTING RATES

If the IHS were to develop a benefit package for Native Americans, Congress would have to budget for a known level of care. What would actually be involved in setting rates?

Basically, one must project the revenue needed per member per month to cover costs. . . and then generate that revenue.

Projecting the needed revenue is the hard part; most HMOs fail because of errors in this projection.

The Process

Situation: IHS is asked by Congress to prepare a capitation rate for its operations for FY89. Capitation rate is to be calculated for IHS overall as well as for each Area.

Assumptions: Assumptions are key elements of the rate setting process. The following assumptions are made in order to predict capitation rates:

1. FY88 budget allocation as of 9/30/88 reflects actual cost experience for IHS and Tribal contractors.
2. Both IHS and Tribal contractors agree to participate in the capitation arrangement.
3. Indian user population growth rate for FY89 will be 2.75%. (Based on comparing the population as of 9/30/88 with the population as of 9/30/89). Population will be counted at the end of each month.
4. Inflation factors for each component of the IHS budget can be estimated by experience or actuarial data from the past.
5. There will be no appreciable change in utilization patterns of health care services.
6. Age and sex composition of user population will remain the same (changes would affect cost patterns).
7. Level of care to be provided will be the same as in FY88.
8. User population mix will be 40% single, 16% couples, and 44% families.
9. Average family size will be 4.2 persons.
10. Congress will want single rate for each Indian person (Composite Rate) and separate rates for singles, couples, and families (Three Tiered Rates).

Calculations of Capitation Rates:

1. Adjustment of FY88 Budget Allocation to reflect expected inflation increases:

$$\begin{aligned} & (\text{Budget Category Inflation Percentage}) \times (\text{FY88 Allocation}) \\ & = \text{Adjusted Allocation} \end{aligned}$$

Calculate for each budget category and the total budget.

$$\begin{aligned} & \text{Adjusted Allocation for the FY89 Budget (Projected Needed Revenue)} \\ & = \$992,515,000. \end{aligned}$$

2. Projected Average User Population

(Population each month) x (2.75% growth rate)
= Projected monthly population

Total monthly projected population / 12
= Projected Average User Population.

3. Projected IHS Wide Annual Per Capita Allocation

Per Capita = Projected Allocation / Average Projected User Population

The calculated Per Capita for 1989 = \$965.022. This is the "composite rate" to take to Congress. We need this much money per person this year.

4. Calculation of 3 Tiered Rates:

Single rate = Per Capita = \$965.022

Couple rate = 2 persons x Per Capita = \$1,930.045

Family Rate = Average Family Size (4.2) x Per Capita = \$4,053.092

Calculation of Area Specific Rates: The above calculations can be used for each Area to determine the Area Specific rates.

Things to Remember

Check Assumptions. Although the calculations are simple, the validity of the assumptions is critical. The most common error is utilizing data which are not accurate because of failure to adjust for known situations.

Use Accrual Systems. The failure to recognize costs associated with incurred but not yet reported claims is a major reason for the bankruptcy of managed health care delivery systems. Avoid using cash accounting systems and rely upon accrual accounting systems.

Track Users. User populations must be closely tracked. Use monthly population figures. Monitor growth trends, changes in age and sex, and variations in utilization by age and sex.

Adjust for Inflation. Be realistic with estimating the inflationary adjustments.

Do Trend Analysis. Trend analyses are needed on all utilization and expense items to make sure that future projections are not wrongly portrayed by inappropriate rates of changes.

Limit Risk. Never assume more risk than you are capable of handling.

Significant Figures. When using averages, take calculations out to three decimals.

Ongoing Data Collection. The assumptions on cost, utilization, population characteristics, etc., can be monitored on an ongoing basis. In this way they can be used as a management tool for the organization to evaluate its performance.

RATE NEGOTIATIONS

1. Both parties must be willing to accept the outcome of the negotiation process, and it is not in the long term interest of either party to take unfair advantage of the other.
2. Never accept utilization, cost, or population related assumptions that are not reasonable and justifiable.
3. Be prepared to adjust rates through application of exclusions and limitations to services to be performed.
4. Avoid committing to actions which cannot be reasonably delivered or controlled.
5. Do not assume more risk than can be managed or lived with.
6. Do not let the other party assume more risk than they can handle if a long term relationship is desired.
7. A common error in negotiating rates with new population groups is to assume their cost of care will be the same as other groups you may be more familiar with. Make sure this assumption is justifiable. For example, some industries or jobs tend to have more accidents or attract kinds of people more prone to having medical expenses.

COST AND QUALITY REVIEWS

Inaccuracy in Hospital Billings. Several AMA studies over the past 2 years have shown that hospital billings are inaccurate. One of the studies showed that out of 30,000+ hospital billings reviewed, 94% were not

correct. In the great majority of these cases the errors were over charges. In addition, a General Accounting Office review of ancillary services (lab, x-ray, pharmacy, inhalation therapy, physical therapy, etc.) provided in hospitals has found 16% of the services were either not medically necessary or lacked evidence that they had been ordered and/or provided.

Physician Billings May be Rated Too High. Physician billings, while not as bad, still tend to over charge for the actual services rendered. The most common billing error in physician billings is that the visit is rated and billed at a higher level of intensity of care than the actual situation called for (e.g., a brief office visit will be billed as an intermediate office visit).

Verify Charges. Many managed health care delivery systems have learned to either contract with providers in such a way as to eliminate the provider incentive to over-charge, or the system has instituted a methodology for reviewing provider billings for accuracy of charges and appropriateness of care.

It Pays to Verify Charges. Experience has shown that a well developed QA/Cost Containment program can return \$2.50 - \$15.00 for every dollar spent on the program. (The Portland Area has done write ups on an in-house program and a purchased program from outside firms. Copies are available.)

PAPERS AVAILABLE FROM THE PORTLAND AREA OFFICE

"Prepayment and the Community Health Center: Some Considerations to be Made Before Involvement"

This paper is addressed to providers.

"An Innovative Approach to Cost Containment Within The Portland Area Indian Health Service Contract Health Care Program"

This paper shows the relationship between quality assurance efforts and cost containment outcomes.

"Cost Containment Strategy for the Portland Area Office"

This paper describes four key elements of a cost containment system.

"Mt. Zion IPA"

An example of a provider contract.

Health Maintenance Organizations (HMO)

Sheila Leatherman, Vice President
United HealthCare Corporation
Minneapolis, MN

AN OVERVIEW OF HMOs

For purposes of a working definition, HMOs must meet four requirements.

1. Users. An enrolled population of users.
2. Benefits. A defined set of comprehensive health-care benefits.
3. Price. A predetermined price.
4. Services. Services provided from a defined delivery system.

HMOs actually have a long history. Early forms can be seen in the relationships between physician groups and companies in the 1920s.

There are three basic HMO models: group, network (contracted), and individual physician associations (IPAs). IPAs are the preponderant model. The field is diverse, and there are hybrid arrangements of all sorts.

The market is also characterized by a diversity of products such as first dollar coverage (dwindling), co-payment, PPO products, and indemnity affiliations. HMOs offering combinations of products tend to run into trouble.

The HMO market is characterized by four "real" issues:

1. Viability of organizations
2. Mechanisms of reimbursement
3. Relationships with the community
4. The rhetoric surrounding "quality" of health care

What to look for in an HMO:

Degree of regulation. HMOs are regulated either by the Office of Insurance, the Office of Commerce, or the Department of Health.

Licence or Certification

For profit or nonprofit

Management structure. A management should be dedicated to the health service, not just running the service as a sideline.

What to look for in the defined benefits:

Are there "carve outs" - exclusions that weaken the scope of the benefit package?

Is there a delivery network that can actually deliver on the benefit package?

Is there a Certificate of Coverage (COC) for the different products defined in the benefit package?

SYSTEMS OF MANAGED CARE

Quality Assurance

Some working definitions of "quality":

Working Definition #1: the optimal care achievable given the resource restraints.

Working Definition #2: the degree of conformity to a set of standards.

Sources of information about quality are: clinical studies, problem analysis, monitoring of care, and patient satisfaction measures. Measures of patient satisfaction should be more than "the twenty ways you like us." They should measure whether or not, and how, the care affected the patient's health and well being.

Utilization Management

Utilization management and quality assurance are directly related. Utilization focuses particularly on the use and overuse of services. There are three primary systems of utilization management:

- **Authorization:**
 - Notification of services in which the system shows that a patient is about to use a service.
 - Pre-approval in which the system notifies and obtains approval to use the system.
- **Concurrent Review.** During the time a patient is receiving services the services are reviewed to insure that they are needed and time limited.
- **Case Management.** Individual case management - especially for high risk cases, expensive conditions and services, and clinically complex cases.

Risk Management

Individualized Management. Individual case management of high risk cases.

Problem Trends. Systematic study of problem trends; e.g., how groups of providers compare in terms of risk problems.

Utilization: Underuse/overuse. How groups of providers compare in terms of waiting to hospitalize, referring for care, or use of laboratories.

HMO VULNERABILITIES

Fast Growth.

Diversification. Naive decisions about diversification are the "Achilles heel" of HMOs.

Financial Stability. The field is characterized by various bad decisions. One problem is "pent up demand" or the "shadow population." In this situation a new population is enrolled, the service is successful, and the population begins to use the service intensely and often at a cost higher than predicted.

Political Volatility. Providers often fear loss of control. It is important for people to try to understand where the country is going with health care.

HMO STRENGTHS

HMOs have a number of strong features or potentials:

- Working systems of health care delivery
- Potential for cost efficient management of quality care
- Measurement of quality is possible
- Assurance of quality is possible
- A version of comprehensive care is emerging

Several managed-care services are now on the market:

- Utilization management
- Case management
- Quality assurance mechanisms
- Provider relations
- Mental health delivery
- Pharmacy management
- Transplant networks
- Administrative services

The Arizona AHCCCS/Navajo Project

**John Hubbard, Executive Officer
Navajo Area Office, Indian Health Service
Window Rock, AZ**

The purpose of this study is to examine the feasibility of the Indian Health Service contracting with the Arizona Health Care Cost Containment System (AHCCCS). The service would be a prepaid capitated plan for eligible Native Americans in the State of Arizona, as opposed to participation on a fee-for-service basis. The State of Arizona has been reluctant to include Native Americans in the medically needy/medically indigent (MN/MI) portion of the AHCCCS system. This issue is currently under litigation.

In 1985, the Navajo Area Office asked if it could bid in response to an AHCCCS RFP on a pre-paid capitation basis. At that time, IHS was advised that it was unable to precisely determine its financial liability under such an arrangement, and that the Anti-deficiency Act precluded IHS from assuming risk/financial obligation in excess of, or prior to, federal IHS appropriations. Subsequently, Dr. Rhoades requested the Navajo Area IHS Director, in conjunction with the Phoenix and Tucson Area Directors, to examine the concept of "Indian Health Service as a gatekeeper under AHCCCS."

Population Characteristics

As of April 1, 1988, there were 27,732 Indians enrolled in the AHCCCS program (5.5% of the Arizona population and 12% of the AHCCCS enrollment). About one-half of the total Indian enrollment are Navajos. Also, about one-half of the total Indian enrollment are AFDCs.

Reimbursements

"Categoricals" are the traditional Medicaid-covered clients. For all AHCCCS program years (1982-1987), AHCCCS paid a total of \$29.4 million for *IHS treated* categoricals. These are 100% HCFA funds "passed through" AHCCCS to IHS.

For *IHS referred* categoricals, AHCCCS paid a total of \$18.01 million. For referrals, HCFA pays 62% and Arizona pays 38%.

Medically needy/medically indigent (MN/MIs) are state-covered clients with no federal financial participation. For all AHCCCS years, the state paid a total of \$572,374 for IHS treated MN/MIs through July 1985. The state, under protest, paid a total of \$11.9 million for IHS referred MN/MIs.

Average capitation rate based on Arizona plan

The study reviewed all state providers (counties) and determined the average "best and final offers" made by AHCCCS over a three-year period. An estimated capitation was determined for each rate code using the following formula:

$$\begin{aligned} & (\text{Average rate: \$/month}) \times (\text{number enrolled in category}) \\ & = \text{estimated capitation} \end{aligned}$$

Actual reimbursements vs estimated capitation

The study compared the *actual AHCCCS payments* (for both categoricals and MN/MIs) with *estimated capitation figures* based on the 3-year AHCCCS best and final offers. The analysis showed that AHCCCS paid \$7.3 million for categoricals compared to \$22.3 million estimated capitation; and \$4.6 million for MN/MI compared to \$10.3 estimated capitation.

Future plans and recommendations

- Develop specific capitation rates using AHCCCS procedures for all three IHS areas.
- Find ways to estimate real health care costs.
- Obtain consultation on the issue of liability.
- Recommend that IHS adapt the "gatekeeper" concept (become a provider organization).
- Study the networking of IHS service units, medical centers, and contracted providers.

Devils Lake Sioux

A medium sized tribe (4,000) now providing health care through the coordination of IHS, Tribal, and CHS services. Physician recruitment and retention is a priority issue. The purpose of the study is to make recommendations for future health care.

Puget Sound Service Unit

An IHS service unit for ten tribes in the Puget Sound area. Members are receiving care through IHS, but the providers are refusing to see patients because of delays in payment. Providers are going after the patients for payment.

The purpose of the study is to assess the feasibility of a dual-choice option plan in which members can either receive care through IHS or through an alternative provider HMO or PPO.

Taholah Service Unit

The Taholah Service Unit has developed a Formulary Project for the management of prescription medications. Bids are solicited from local providers to sell drugs at pre-existing fixed prices as determined by the Washington State Department of Social and Health Services (Medicaid/Medicare). The purpose of the study is to evaluate the effectiveness of the Formulary.

Organization of the summary reports

For the first three tribal situations, the report summarizes the study findings under the headings of:

- Key Characteristics (of the situation)
- Major Concerns (of people interviewed at the site)
- Health Care Alternatives (potential future directions for the Tribe to consider)

For the Taholah Service Unit, the report summarizes the evaluation of the Formulary Project.

Additional materials from the report concerning Alternative Delivery Systems may be found in Appendix A.

Suquamish Administrative Services Contract

**Lisa Giles, Medical Social Worker
Suquamish Tribe
Suquamish, WA**

This report describes the Suquamish Tribe's Contract Health Services (CHS) alternative delivery demonstration project. Services under this project are provided through an administrative services contract with a local third-party administrator (TPA).

The benefit package began in May, 1985, when the Tribe entered into an administrative services contract with Blue Cross of Washington and Alaska. The present contract is with Network Management, Inc.

Population served

The Tribe is located in Kitsap County, about one hour from Seattle by car and ferry. The Tribe is one of ten tribes in the Puget Sound Service Unit, which has no IHS hospital. The population of the Tribe is 665, and 400 of the total reside in Kitsap County. Three hundred and sixty-two (362) people are currently enrolled in the program.

How the program works

The patient accesses care through his or her membership card at the participating provider of their choice. A benefits booklet detailing services of the program is also provided each enrollee. Services are not preauthorized except for non-routine hospitalizations and mental health related treatments. Alcohol inpatient treatment is provided through IHS contracts and is coordinated through the Suquamish Tribe's Alcohol Director. Alcohol services are not included in the administrative services contract. The service categories available under the Suquamish plan generally parallel those available through IHS Contract Health Services.

The role of Network Management, Inc.

The Administrator pays the bills, charging the Tribe a fee for administration. The Administrator also works with the Tribe to define benefits, complete claims processing, coordinate benefits, furnish reports, contract with doctors and hospitals, and maintain consumer services. A printout of all claims to be paid is provided to the tribe bi-monthly. The Tribe also receives extensive payment and patient care reports.

capita expenditures for services are comparable or equal to those of other Tribes in the Portland Area.

Problems which have been resolved:

- Coordination with the TPA to see claims before payment
- TPA provides accurate and timely reports.
- TPA coordinates benefits for pharmacy.
- Tribe does not handle the bills for the members. Members do it with educational workshops provided by the Tribe. Tribe does help elders with bills.

Ongoing problems

- Applications for welfare are slow (up to 1 year).
- Pharmacy costs are difficult to manage. Network Management, Inc. is setting up a PPO.

Plans for the future

Use of Leftover Funds. If funds are left over this year, the program will provide eye glasses for members.

UW Hospital. Tribe will also negotiate with the University of Washington Hospital for reduced rates.

Recommendations for other tribes:

- Maintain a good relationship with the local hospital.
- Educate members about the program.
- Explore the possibility of the TPA combining the administrative contract with private insurance for Tribal employees to streamline coordination of benefits for those Tribal members who are also employees of the Tribe.

The role of the Suquamish Tribe

The tribe enrolls tribal members and spouses, updates enrollment, determines when to apply to Medicaid, negotiates the budget with IHS, and educates members about the program. The Tribe's Social Worker and Health Director review the printouts of bills to be paid (sent to the Tribe bi-monthly), verify eligibility and alternate resources, and mail the printout back to the insurer. A check is provided to Network Management monthly for all services and charges to be paid under the program.

Why the program works

The success of the program relies heavily on a good working relationship between the Tribe and the TPA. The Tribe helps members apply to alternate resources, especially welfare, and thus relieves the demand on the CHS. The Tribe also trouble-shoots with providers.

Data

Network, Inc. reported a \$62,000 savings through the coordination of benefits.

The Suquamish Tribe has considerably lower expenditures for hospital care than has the Puget Sound Service Unit or the Indian Health Service. Also, the Tribe has been able to make better use of alternative resources under its benefits package for hospital care than has the Portland Area.

The major difference between Suquamish and the Puget Sound Service Unit relates to the use of emergency rooms. Emergency room use at Suquamish was 1% of total expenditures versus 16% for the service unit.

Higher use of alternative resources by the Suquamish Tribe, combined with lower utilization rates and lengths of stay, has translated into lower overall costs for hospital care by the Tribe.

There are several conclusions to be drawn concerning the cost effectiveness of the Suquamish benefits package.

1. **Lower Hospital Costs.** The plan appears to have significantly lowered hospital costs through better coordination of alternate resources and use of outpatient surgeries.
2. **Care Provided.** Use of outpatient and inpatient services among Suquamish members is equal to that for other Indians and the general population. It appears that patients are getting the care needed.
3. **Per Capita Expenditures Acceptable.** Administrative costs of the program are higher than CHS administrative costs of IHS, but per

Tribal Case Study Project

**Ramona Ornelas, IHS Project Manager
Office of Planning, Evaluation, and Legislation
IHS/HQ**

**Margaret Siebel, Project Manager
Support Services, Inc.
Silver Spring, MD**

Tribal Case Study Panel

**Ramond F. Jarris, M.D., Clinical Director
Taholah Clinic - IHS**

**Linda Jones, Service Manager
Tulalip Board of Directors**

**Larry Jordan, Service Unit Director
Puget Sound Service Unit**

**Vern Lambert, Tribal Health Board Chairman
Devils Lake Sioux Tribe**

**William Millar, Tribal Manager
Mashantucket Pequot Tribe**

**Phyllis Monroe, Health Director
Mashantucket Pequot Tribe**

The Tribal Case Study is Phase 1 of a larger IHS feasibility study entitled "Assessment of Strategies to Promote Cost and Management Efficiencies in Tribal and CHS Programs."

The study looks at 4 different tribal situations which represent a spectrum of conditions:

Mashantucket Pequot

A small, newly recognized tribe (1983). Health care is now provided through affiliations with physicians and hospitals, although the Tribe is developing its own CMP. The purpose of the study is to make recommendations for future health care delivery.

MASHANTUCKET PEQUOT HEALTH DEPARTMENT

Key Characteristics

Service Population:	350, 850 eligible persons, primarily rural with access to multiple providers, SU uses preferred providers
Health Services:	Tribal HPDP Clinic CHS inpatient and and specialized care

Major Concerns

Range of covered services
Certainty of benefits
Access to providers
Timeliness of payment
Corporate health care

Health Care Alternatives

Tribal Initiatives:	HMO CMP Pharmacy services
Study Recommendations:	Affiliation agreements Negotiated agreements Certification as rural clinic Limited pharmacy Purchase PPO services
Benefits:	Discounted or fixed fees Responsive services Increase recovery from alternate resources

DEVILS LAKE SIOUX

Key Characteristics

Service Population:	4,500, 8,500 Active patient files, primarily rural, one hospital provider, strong market force
Health Services:	Tribal HPDP program IHS outpatient clinic CHS inpatient and specialized care Tribal CHR

Major Concerns

- Permanent clinic physicians
- Emergency room use
- Use of CHS providers
- Coordination of services
- Coordination of resources
- Need for mental health services

Health Care Alternatives

Affiliation Agreements: With hospital for mental health, and emergency room alternative

With physicians to provide treatment at clinic

Resource Coordination: Coordinate Tribal employee insurance resources with Clinic/Tribal health programs to operate call in program

Service Coordination: Establish closer link between Tribal and CHS programs

PUGET SOUND SERVICE UNIT

Key Characteristics

Nine Tribes: Muckleshoot, Nisqually, Port Gamble, Klallam, Sauk-Suiattle, Skokomish, Squaxin Island, Stillaguamish, Tulalip.

New Service Unit: Puyallup

Population: 14,000

Service Population: 11,000
Primarily rural, widely dispersed, over 1,400 providers, large Medicaid population

Health Services: Tribal outpatient primary care clinics
CHR
IHS/Tribal mental health/social services
CHS inpatient and specialized care

Major Concerns

- Access to providers
- Timeliness of provider payment
- Deferred services
- Allocation of funding
- Impact of 638
- Authorization procedures

Health Care Alternatives

PPO:	Benefits tailored to Tribal needs Large provider networks Streamlined provider payment Known health care benefits Shared risk Patient choice -- CHS or PPO
Local FI Network:	Joint Tribal and FI management Streamlined provider payment Known health care benefits

TAHOLAH SERVICE UNIT: FORMULARY PROJECT

Key Characteristics

Four Tribes:	Quinault, Chehalis, Hoh, Shoalwater Bay
Service Population:	3,700 Population primarily rural, widely dispersed
Health Services:	Tribal HPDP care clinics, CHR IHS outpatient CHS inpatient and specialized care

Study Focus

Study Focus	Cost savings under Formulary Project
Tribal Concerns:	Does Formulary preclude use of non-formulary drugs? Are patients inconvenienced by limited number of formulary pharmacists
Findings:	Possible projected savings of 25% Sixteen participating pharmacies, located convenient to patient population centers Drugs not included on Formulary are allowed (unless generic equivalent) Need to maintain communication with pharmacists

Selected comments from the panel members:

Linda Jones, Tulalip

We will probably offer an HMO and PPO option with a third party administrator.

"IHS tells us . . . this is the amount of money there is, and this is the amount you're going to get. .. you call that negotiation?"

Larry Jordan, Puget Sound Service Unit

Lack of an IHS hospital in our area puts pressure on the CHS. Only one hospital responded to our RFP.

Smaller tribes need access to a pharmacy warehouse. We could save money with a formulary.

Coordination of resources is a key issue with us.

The bottom line is: we are interested in the dual-choice option.

Raymond Jarris, Taholah Clinic

We developed the formulary on a trial basis.

Before the formulary, we were being looked at as a "deep pocket" by providers.

The incentive for providers is: less money but more volume.

Vern Lambert, Devils Lake Sioux

Our Board has decided that *tribal identity* is our most important resource. Our three identities - as Americans, as Indians, as a Tribe - can be used to improve the health care of our people. Our people need to be educated about each identity.

We need to make the transition from *politics* to *management* of health care.

Phyllis Monroe, Mashantucket Pequot

Our goal is to bring members back to the reservation with jobs and housing.

Our priorities are economic development and education.

Our preferred alternative delivery system is a Competitive Medical Plan (CMP). We would like the CMP to become a Tribal enterprise.

William Millar, Mashantucket Pequot

What we're trying to do:

- Expand our capacity for direct care services to ourselves and to our sister tribes.
 - Protect tribal resources.
 - Improve our employer benefits.
-

Affiliation Agreements

Virginia Throssell
Account Executive - Government and Tribal Sector
Tucson Medical Center

Ed Hansen, Health Director
Tohono O'odham Nation

In 1987, an Affiliation Agreement was signed by the Chairman of the Tohono O'odham Nation and the CEO of the Tucson Medical Center. The Affiliation Agreement was the outcome of a process which required more than 16 months of planning and negotiation. The basic purpose of the agreement was to make available to the T. O. Nation the professional, technical, and systems resources essential to the development of a Tribal Health Department with the capability to effectively contract, under PL 93-638, for Tribal administration, management, and operation of its health care service delivery system.

What is an affiliation?

An Association. An affiliation is simply an *association* with an organization or individual. As David O'Neill said, "We do not manage an affiliated hospital. We bring the resources to help the facility find ways to manage itself."

From Informal to Formal. Smaller and rural health care facilities have been informally affiliated with larger metropolitan facilities for years. However, because reimbursement differentials (especially from DRGs) have become so severe, rural facilities are turning more and more to metropolitan hospitals for support. Affiliations which were once informal must now be formalized and managed.

Types of affiliations

Management contracts: for example, a metropolitan hospital might contract to manage a rural hospital (at risk or at no risk).

Affiliation agreements to provide described basic services. There may or may not be a base fee for the services, and the agreement may be formal or informal.

Joint ventures: for example, a group of physicians in a rural area link up with a metropolitan hospital. Again, these agreements may be at risk or not at risk. They are usually formal agreements.

There are no limits to the types and kinds of affiliations available.

Why the T. O. Nation pursued an affiliation

The T. O. Health Board would like to 638 the services. To achieve self-management, the Tribe must fill several needs:

- Systems development
- Service enhancement
- "Mainstreaming"
- Networking
- Continuum of care development

How it looked to TMC

- New situation
- Need to learn
- T. O. Nation must be a priority client
- Must provide services at cost
- Must have a full time manager

TMC, IHS, and the T. O. Nation have managed to develop an affiliation (the Tribe is an "affiliate" of TMC). The kinks are still being worked out.

The affiliation is with the T. O. Nation, not the Board.

TMC provides technical assistance (technical advisors) to the T. O. staff to help them develop their management capacities.

If the Tribe needs a service which TMC does not provide, the Tribe goes to the IHS or to the outside.

Neither the Tribe nor TMC does anything to "rock the affiliation." For example, no "cherry picking" (trying to find the same service for less).

A real bonus of the affiliation to the Tribe is that TMC has a network of affiliates which the Tribe can access. Also, a network has more political clout than any single provider organization.

Costs of affiliation

The costs areas are the same for both the Tribe and TMC: start up, maintenance, and service and support purchase.

The general advantages of affiliation

Access to a large resource pool without paying the cost of maintaining that resource pool.

1. Purchase resources as needed.
2. Due to long-term relationship, will pay less than the cost of all resources consumed.
3. Commitment of affiliate to work as your partner to provide services and meet needs when and as requested.
4. Large facility can act as your political advocate.
5. Management support in the stormy health care environment.

"The health care management byline is:

MTBS < MTBD

The mean time between surprises must be less than the mean time between decisions" [V. Throssell].

Advantages of affiliation to Indian tribes

- Mainstream tribal health departments and facilities.
- Allow tribes to choose among providers based upon needs specific to that tribe.

Advantages of affiliation to the government

- Will generate cost savings.
- Will link public sector professionals with private sector professionals.
- Will enhance the understanding and respect for each provider's delivery system.

Disadvantages of affiliation

- **Fear of loss of autonomy:** choose affiliate carefully. Purchase an attorney's time to evaluate your contract.
- **The first time process will be full of obstacles and challenges;** this will make the process difficult.

Recommendations

Goals and Active Management. Each party, including the Tribal Board, must set goals and be active in the management of the goals.

Identify Expectations. Each party must identify expected results, outcomes, and benefits.

Negotiate Plan. Parties must mutually negotiate a strategic plan.

Affiliation Components. The affiliation should be seen as existing between the private sector provider, the tribal organization, and the IHS (the IHS should be encouraged to support the concept and participate in the dynamics of the affiliation).

Tribal Cultural Relevance. The affiliate should be fully oriented to the tribal culture.

Develop Tribal Skills. Tribal organizations must develop skills in asking the affiliate for what the Tribe needs.

Things to consider before seeking an affiliate:

1. What will be your greatest benefit from the affiliation?
2. What services do you feel you will use the most?
3. What areas of the affiliation process do you have questions about?
4. What can the proposing affiliate do to make the process easier for you?
5. Is there someone you are going to appoint to put together your entire affiliation package?
6. Describe the services you will be requesting, in as much detail as possible.
7. Design a selection process which is acceptable within tribal and IHS guidelines. Inform the proposing agencies of the process.

Tribal Employee Insurance Mechanisms

**Dean Cohan, Executive Assistant
United South and Eastern Tribes
Nashville, TN**

In 1982, the various members of the United South and Eastern Tribes, Inc. (USET), banded together to form the Indian Member Benefit Fund (IMBF). This health fund has grown to become one of the most successful of its kind in the country. There have been no increases in premiums for the last three years. Currently, 92.5% of every dollar is received back in benefits.

The IMBF Board consists of 2 members of each participating tribe.

Benefits: The fund offers a full range of benefits, including an Insured Group term, AD&D life insurance plan, and a dental plan. Claims are processed by Blue Cross/Blue Shield.

Participants: 75% of the tribal employees and employees of each tribal enterprise.

Eligibility: employees who work 30 hours or more per week.

Cost containment mechanisms

- Pre-certification
- Ambulatory surgery
- Concurrent utilization reviews
- Generic drug program
- Self auditing of hospital bills
- Wellness awards

Advantages of the fund

- Tribes can design their own plan
- Pre-existing conditions waived on initial enrollment
- Indian-owned fund

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V. Appendices

Discussion Group #1

"Should IHS and/or tribes pursue capitation of Medicaid / Medicare with HCFA? . . . with states?"

The group established a definition of *capitation*:

A funding mechanism whereby instead of paying a fee-for-service, costs are estimated and projected.

The health care organization is given money each month in advance based upon its number of enrollees.

The Problem: Indians are not being reimbursed for care provided even though they are eligible for Medicare and Medicaid.

The regulations regarding Indians are not specific. Who is responsible: states, tribes, IHS? A case in point is Arizona AHCCCS's refusal to reimburse for the IHS referred medically needy / medically indigent.

There are also problems around the issue of tribal sovereignty: Who has jurisdiction over programs, services, and facilities?

Implementing HCFA Option. The group agreed that tribes should have the option of dealing directly with HCFA. However, several problems came to the surface:

1. Problems with the states (e.g., insurance)
2. The possibility that HCFA would require matching funds from the tribes (which they don't have).
3. The issue would require new legislation in the state, tribal, and federal governments.
4. New data would be required, along with new rate-setting methodologies.
5. Many organizational adjustments would be required.

Recommendations:

- **Add Information.** Develop more information through studies like the Arizona AHCCCS/Navajo project (John Hubbard).
- **Capitation with Risk Avoidance.** If tribes do capitate, it should be on a cost basis to avoid risk.
- **Policy and Resource Controls.** Tribes or IHS should develop controls over policies and resource allocations.

Consider contracting with managed-care organizations to provide technical assistance/training. Also, consider tapping the resources of sister agencies: for example, develop compendia of state laws regarding prepayment organizations and standards.

Fundamental question: is IHS going to contract for a health care delivery system or a grab bag of unrelated services?

Consistent Standards. IHS needs to develop standards that are consistent across areas. Implementation of the standards may vary depending on local conditions.

Transmit Information. IHS needs to develop summaries of costs, utilization, and other factors to be distributed and discussed with tribes.

Note: -- boxes of APC reports are not necessary!

Broad IHS Involvement. The issue of alternative delivery systems requires a special initiative managed from the Director's office. OPEL would coordinate, but broad involvement of IHS resources is needed.

Discussion Group #2

"Should IHS assist tribes in pursuing relationships with alternative delivery systems?"

What should the IHS role be: technical assistance, training, development of managed-care systems/strategies, etc.?"

Primary recommendation: help make the managed-care scene easier for tribes to understand.

Remember: health is only one of the many issues that councils have to face. IHS is only one of the many agencies with which councils deal.

IHS as Ombudsman

IHS could take an ombudsman role; help tribes educate other agencies about their situation (e.g., sovereignty). These agencies would be federal and state ones with which tribes negotiate. IHS could help develop interagency agreements. Private sector organizations also need help understanding tribal situations and status. Further, IHS should do this with no additional, substantial resources.

Supportive Internal Environment

IHS should provide an internal environment that is positive and supportive. The educational process should be emphasized. The IHS staff needs help orienting to the "New World."

IHS needs to re-invigorate the innovative tradition it once supported.
Remember: many HMO innovations were developed by the IHS.

IHS should also preserve the strong tradition of community outreach by tribal workers.

Technical Knowledge and Assistance

IHS needs to be prepared to seek and broker technical assistance to tribes in areas of expertise that IHS does not possess. Also, IHS should be prepared to network "pockets of expertise" that are developing among the tribes.

Discussion Group #3

**"Is it possible to pursue alternative delivery systems without additional resources?
If additional resources were available, how would you deploy them?"**

How many and what kind of alternative systems?

Meaning. The group discussed the meaning of "alternative system."

For IHS and tribes, the alternatives seem to be direct care, contract health services, and community services. The market consists of HMOs, PPOs, and other systems described at this colloquium.

Self-Determination & Functions. The group agreed that alternative delivery systems (ADS's) best express the intent of self-determination. Also, ADSs seem to:

- Increase patient choice
- Maximize benefits
- Pool resources

Resources and Priorities

Without additional resources, it is difficult to explore the ADS potential:

The problems are that the IHS has no strategic plan for commitments, no special funds for demonstrations, and few ways to study the feasibility.

Also, we are a dynamic system in flux. Tribal capacity for ADS management is still low, and we're experiencing budget cuts.

Nevertheless, there may be ways to:

Adapt to circumstances: reprioritize existing dollars and reassign staff.

Justify new fund requests

Get some external high quality consultants

Re-evaluate our core values

Discussion Group #4

**"What are the next steps for the IHS?
Where do we go from here?
What is the role of the Office of Planning, Evaluation and
Legislation (OPEL)?"**

First of all, disseminate the proceedings of this colloquium.

Get information out to tribes about tribal health programs that are working, especially with fixed dollars and rising costs. Hold regional conferences.

ISSUES FOR OPEL TO EXPLORE

Eligibility issues: establishing blood quantum

To distribute IHS funds, let tribes apportion on their own, and determine who they serve (all descendents, 1/4, etc.).

Recruitment and retention of professional staff

Medicare recovery by IHS ambulatory facilities

Move away from reimbursement.

HCFA may give prospective funds.

Regional conferences

Invitational for tribes

National consultative conference every two years

Publish findings

Study laws regarding applicability

437, 638, Snyder

Recommend legislative changes: change the laws

ADSs have several advantages:

- Third party collection
- Advance contracts
- Flexibility
- Customized design for local conditions

Study and Implementation of ADSs

With new dollars (additional resources), we could develop several areas of investigation around the Native American situation:

- Assess utilization and value of services
- Explore cost sharing and risk assessment
- Establish a solid base of experience
- Disseminate information
- Develop cooperative efforts
- Explore ways to control utilization
- Develop strategies for meeting rural needs
- Provide education in Health Promotion and Disease Prevention

Gaining Cooperation. The major challenge would be getting tribal groups to cooperate.

Focus. Where would we focus the money? Demonstration projects and education about issues.

New products: how to transfer them to the Indian situation and implement them.

Financial innovations

Innovations in service delivery

Private sector advisors

Demonstrations would assess current available systems in regard to:

- Private sector linkages
- Utilization rates
- Quality assurance mechanisms
- Formularies
- Market issues
- Delivery issues
- The cost benefits of cooperation between tribes and IHS

Priorities for getting started:

1. Disseminate information
 - State of the art techniques
 - Achievements
 - Successful outcomes
2. Develop a planning process
3. Develop a Financial Innovations Committee: rural conditions should be line item.

Recommended Budget and Actions:

We need \$7 - \$12 million for demonstration projects.

We should be able to study sites without disturbing or destabilizing them (unlike the diabetes project, which was very distracting).

It is necessary to include tribal people: make issues clear and involve them in decisions.

Do not mandate people to do it! Attract people to the possibilities through information, education, and discussion.

Themes. Strong themes that emerged in the group's discussion:

Dissemination. IHS needs to disseminate information about ADSs.

Broad View. IHS needs to develop a broader view of health care possibilities and alternatives.

**"Assessment of Strategies to Promote Cost and
Management Efficiencies in Tribal and CHS
Programs" Phase I**

**MARGARET V SIEBEL
PROJECT MANAGER**

Submitted to:

**Department of Health and Human Services
Public Health Service
Indian Health Service**

Prepared by:



SUPPORT SERVICES, INC.

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Promote and encourage health care innovations

Refine the IHS approach to managed-care systems

Provide concrete guidelines before marketing the concepts.

Develop information focused on rural tribes.

What is the IHS willing to endorse?

Who makes that decision?

What are the long term objectives? Is the IHS removing itself from health care provision?

Emphasize epidemiology

Preventative: how to improve the health status of Native Americans.

As important as financing.

Quality evaluation and measurement

Provide enough support for the entire IHS program.

Include studies on education and involving patients in their own health care.

Involve CHS and IHS physicians more in case management and review.

Study issues of cost control

Fund more field and demonstration studies outside IHS

Publish findings of current successful situations.

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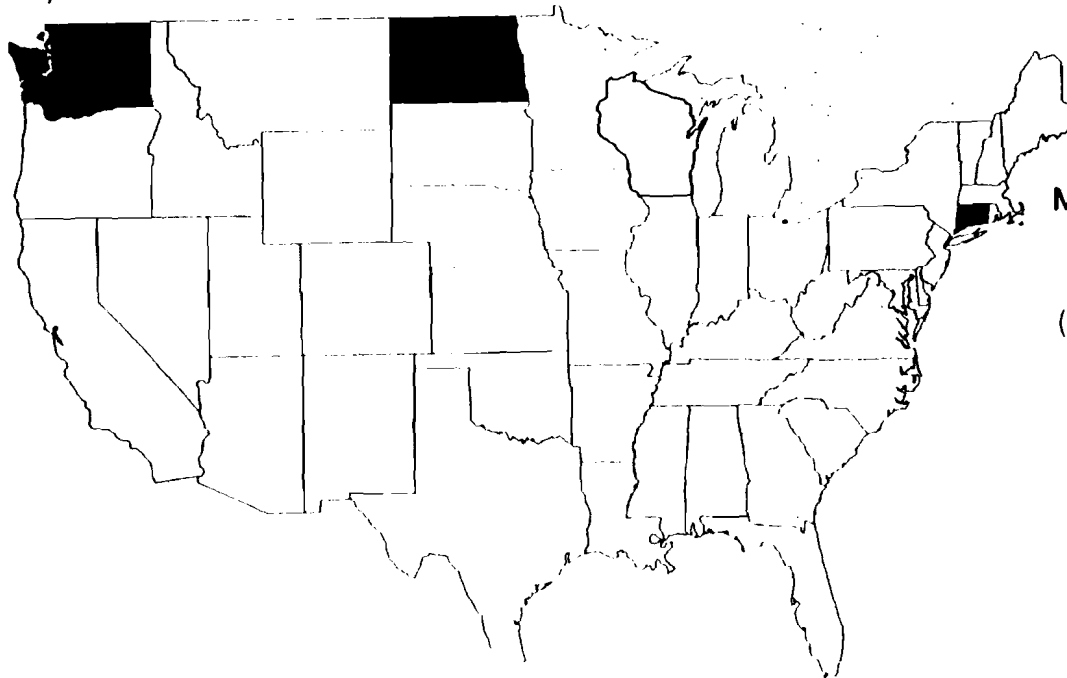
IV. Summaries of Group Discussions

Tribal Case Study Project

Additional Materials

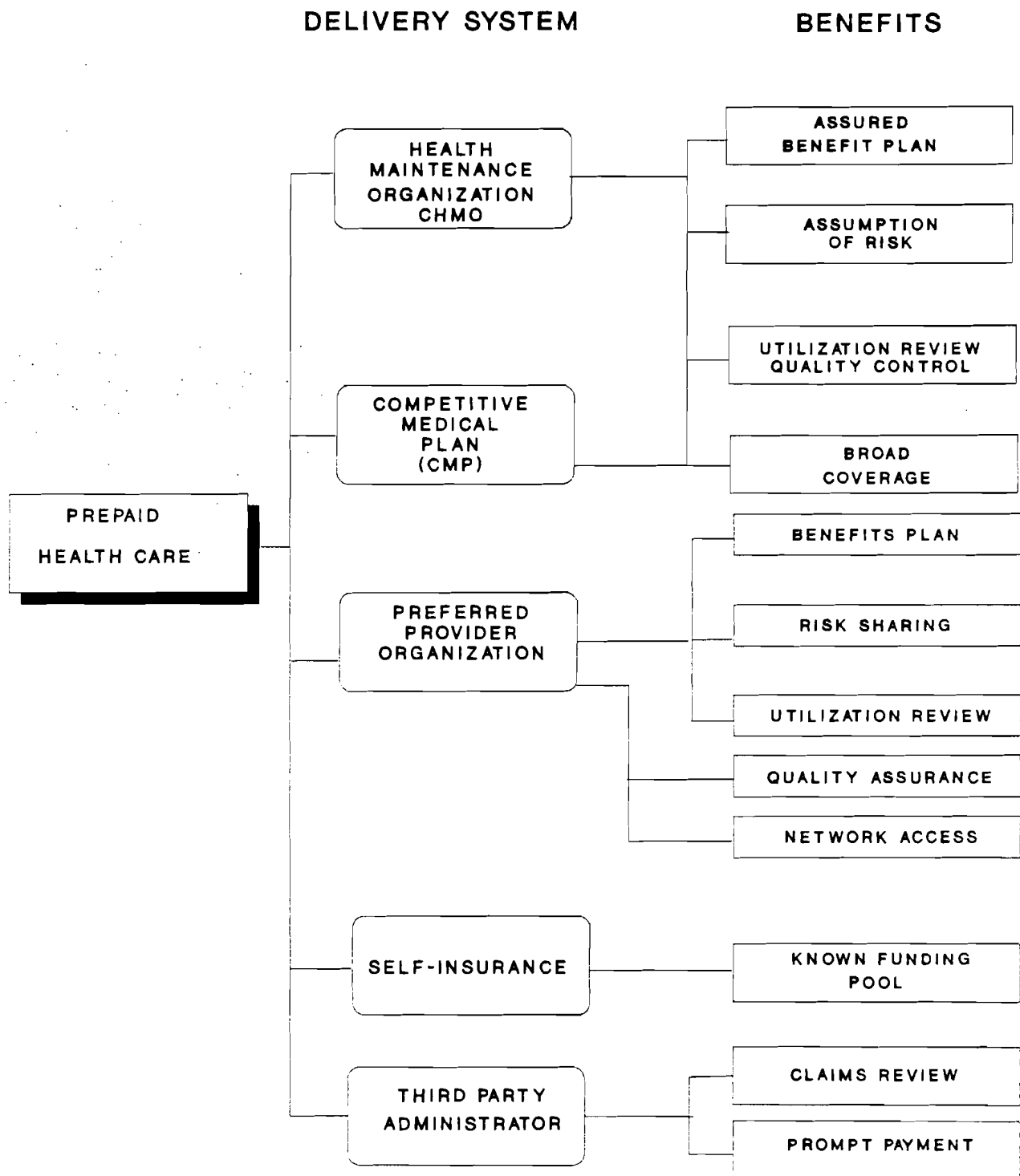
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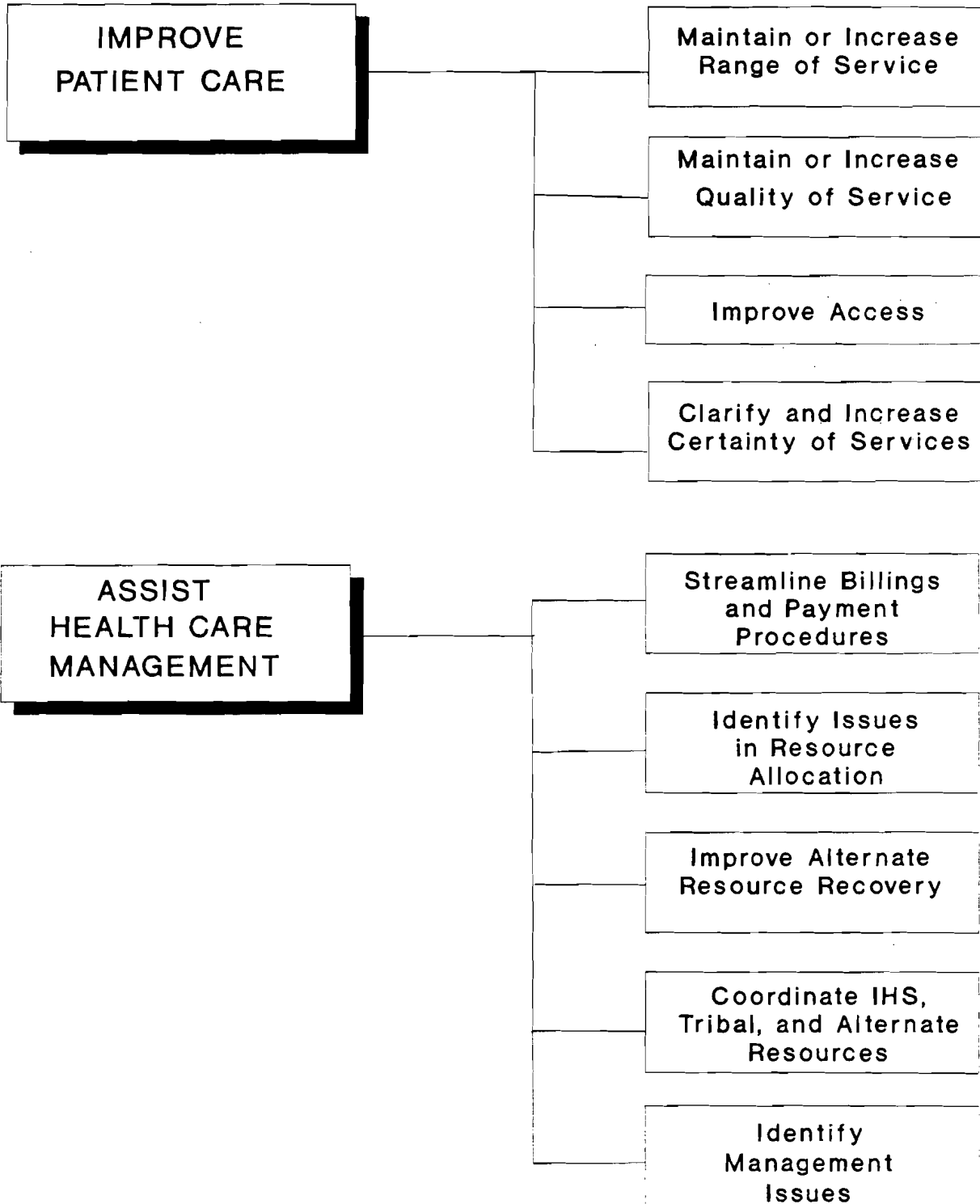
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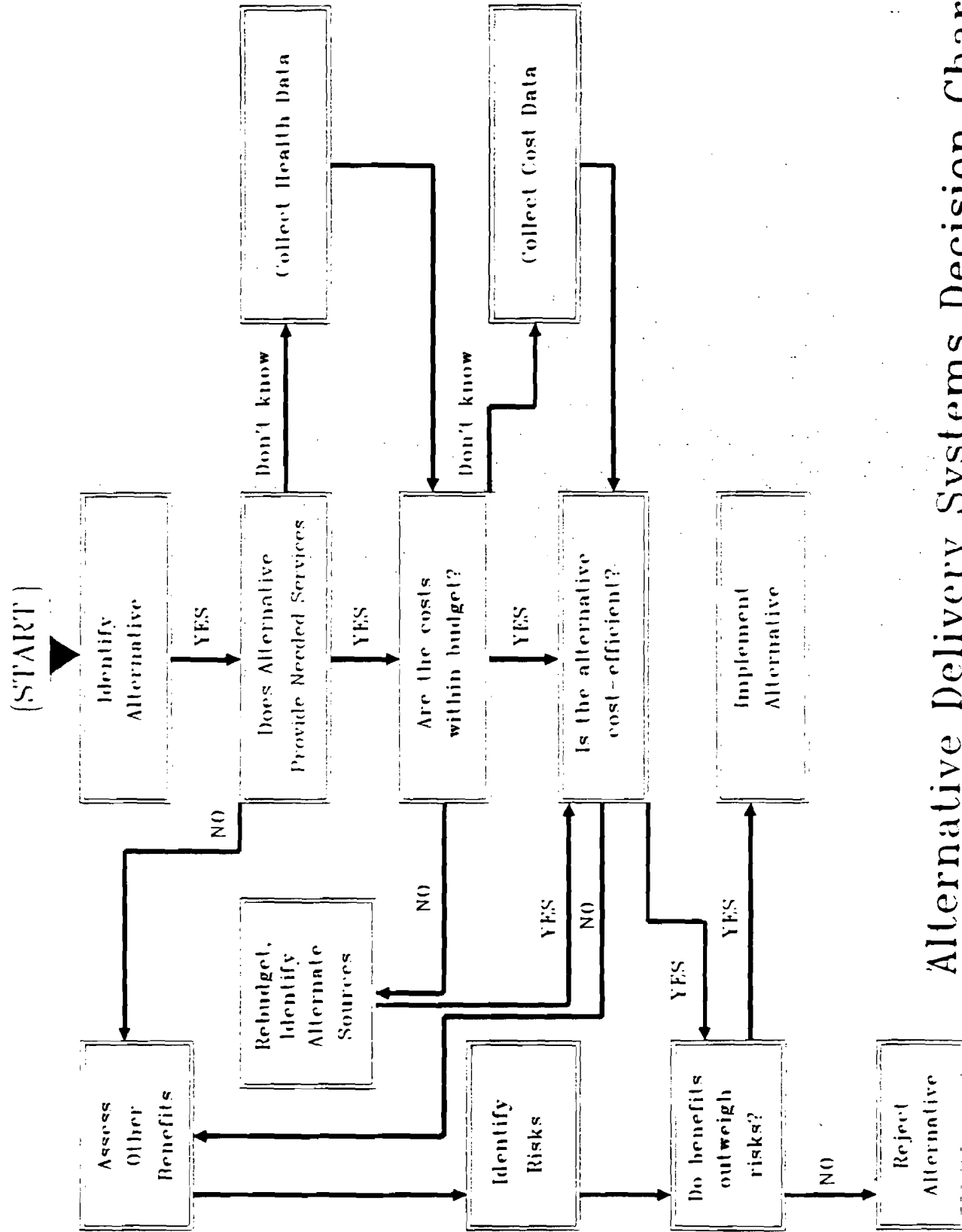
STUDY SITES



PREPAID HEALTH SYSTEMS

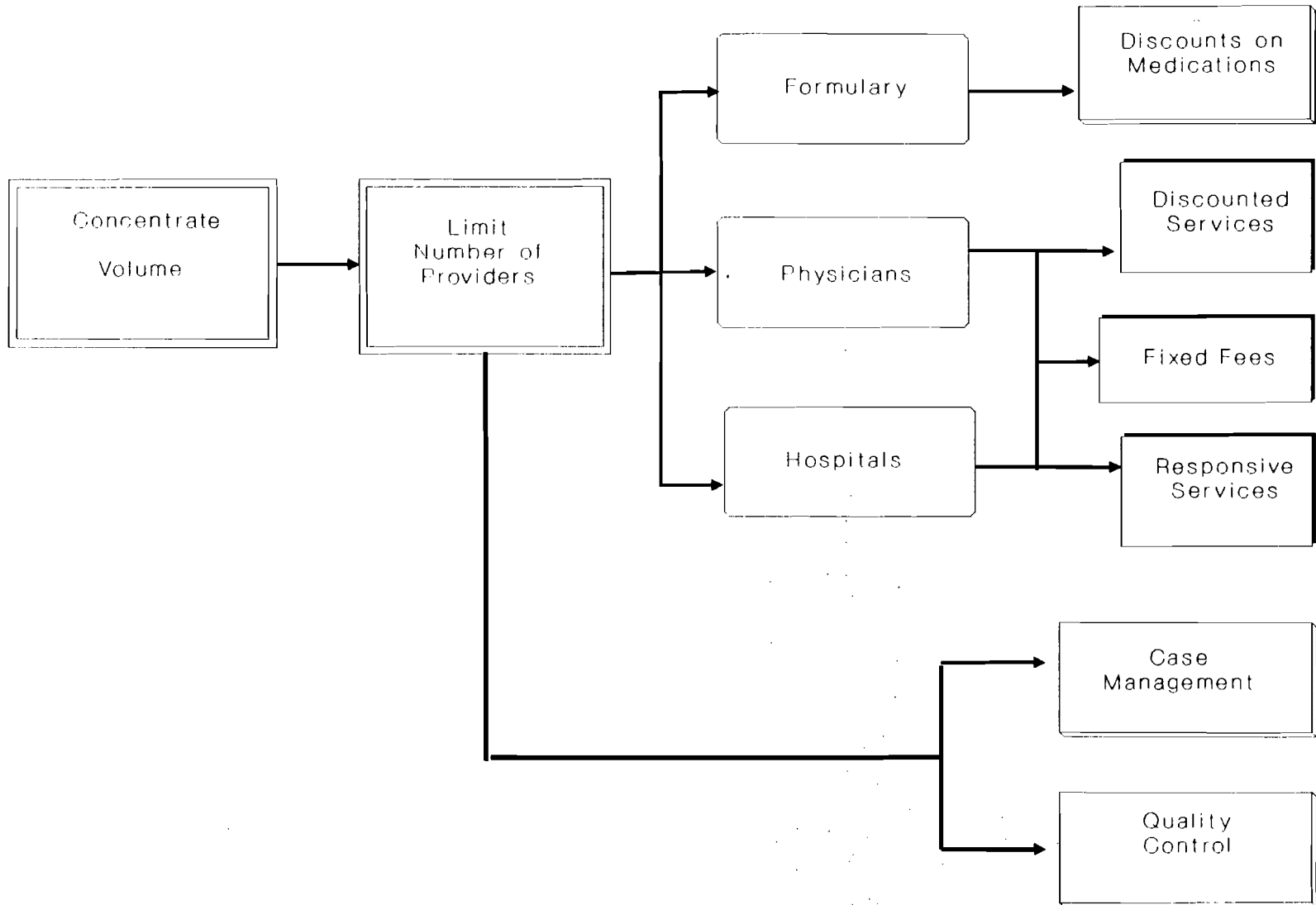
MANAGEMENT OBJECTIVES





Alternative Delivery Systems Decision Chart

Technique → Required Action → Mechanism → Result



MANAGED HEALTH CARE TECHNIQUES

GLOSSARY OF TERMS

Adjusted average per capita cost (AAPCC) - An actuarial estimate made by HCFA in advance of an HMO's or CMP's contract period. It represents what the average per capita cost to the Medicare program would be for each class of Medicare enrollees if the Medicare enrollees received their health care from other providers. A class of enrollees refers to demographics of Medicare patients according to their age, sex, entitlement of Medicare services, Medicare services, disability status, institutional status, and other relevant factors that HCFA determines have a significant effect on the use and cost of health services.

Average payment rate (APR) - The per capita weighted average of total Medicare payment rates projected by a risk HMO or CMP. It is based on rates obtained from HCFA (i.e., 95% of AAPCC) times the HMO's or CMP's enrollment distribution of its demographic classes. The amount of payment is divided to obtain a per capita monthly average payment rate.

Adjusted community rate (ACR) - The purpose of the ACR is to estimate the HMO's or CMP's revenue requirements on a per capita basis for furnishing Medicare covered services to its Medicare enrollees (less their deductible and coinsurances) during a contract period. The ACR is determined by the HMO or CMP. Determination consists of four steps:

1. constructing a base rate from the HMO's or CMP's revenue requirements that is consistent with the premiums the organization charges its non-Medicare enrollees and allocating it into approved capitation rate components;
2. constructing an initial rate by adjusting the base rate to reflect Medicare covered services;
3. factoring the initial rate for differences in utilization between non-Medicare enrollees' and Medicare enrollees' utilization, using approved and documented factors; and
4. subtracting applicable Medicare deductibles and coinsurance.

Additional benefits - Non-covered services provided to Medicare enrollees in addition to covered services, which are financed by savings between an HMO's or CMP's APR, and by premiums that may be charged by the HMO or CMP to its enrollees.

Alternative delivery system (ADS) - (working definition) The consumer transfers control or management of his or her health care in exchange for assumption of financial risk.

Breakeven - The point at which an HMO has taken in sufficient revenues to balance against the costs of development and initial operations.

Capitation - A contractual arrangement through which a health care provider agrees to provide specified health services to HMO members. In return, the provider receives a pre-determined sum (usually on a monthly basis) with which to pay for members' care.

Community rating - The method of HMO premium determination required of federally qualified HMOs. Under community rating, premiums are set without regard to the age, sex, health status, and use pattern of a particular group of HMO enrollees; instead, the rate is determined according to demographic and health status characteristics of the community at large.

Competitive medical plan (CMP) - Is an organization which: (1) is organized under State law, (2) provides a minimum range of services (physician's services, in-patient hospital services, laboratory services), (3) provides services through physicians who are employees, partners, or contractors, (4) is at financial risk for providing services, (5) has adequate protection for enrollees in the event of its insolvency, and (6) is compensated by its members on the basis of a predetermined rate.

Co-payment - A cost sharing arrangement under which an HMO enrollee pays a specified flat (and nominal) amount for a particular service.

Diagnostic Related Groups (DRGs) - The Health Care Financing Administration now defines what Medicaid will reimburse according to diagnostic condition. The reimbursements per category have generally reduced hospital profit margins.

Dual choice - A provision applied to federally qualified plans that requires employers with more than 25 employees to offer both traditional health insurance and HMO coverage (provided the latter is readily available).

Enrollment - Total enrollment equals all "individuals" receiving prepaid health services through the HMO (covered dependents are included).

Experience rating - A method of determining a particular group's HMO premium based on that group's claims experience, age, sex, and/or health status. Experience rating is prohibited for federally qualified HMOs.

Federal qualification - Following an application and review process, HMOs meeting a specified set of standards are accorded federal qualification status. This entitles them to be offered by employers in their service area having 25 or more employees.

Fee for service - The traditional method of reimbursing providers for services rendered. Payors include individual patients, insurance companies, and government programs (i.e., Medicare and Medicaid).

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IV. Summaries of Group Discussions

Staff model - An HMO that delivers health services through a physician group that is controlled by the HMO unit.

Tribe - Any Federally recognized tribe, band, nation, group, pueblo, or community, including any Alaska Native village or group which is eligible for the special services provided by the U. S. to Indians under 42 CFR 36.21(g).

Utilization review - Review of levels of use of medical services by beneficiaries and providers to assess appropriateness and/or necessity. A quantitative evaluation method which may lead to the development of quality of care issues, abuse issues or, in some cases fraudulent claims problems. It is a method to assist in to assist in controlling resource allocation.

- Lower premium costs
- Credit for deductibles and co-insurance on initial enrollment
- Actively-at-work waivers on initial enrollment (health plan)

IMBF is a key third-party resource serving as primary payer saving tribes IHS contract dollars.

Group model - An HMO that contracts primarily with one independent group practice to provide health services.

Health Care Financing Administration (HCFA) - Responsible for direct administration of Medicare program and, through the state intermediaries, the Medicaid program in the Department of Health and Human Services.

Health Maintenance Organization (HMO) - A prepaid health plan that delivers comprehensive care (both physician and hospital services) for a fixed monthly premium. Members are "locked in" for a specified period of time and must receive their health care from HMO providers (or pay for the care themselves).

Individual Practice Association (IPA) - An HMO that is organized around physicians in solo or single specialty practice. The HMO contracts directly with individual physicians and/or through one or more physicians' associations.

Mandatory supplemental benefits - Noncovered services provided to Medicare enrollees that are paid directly by Medicare enrollees. These services are imposed on all Medicare enrollees without regard to health status but may be made mandatory only if HCFA approves the benefit package and premiums in advance and determines that the package will not substantially discourage Medicare beneficiaries from enrolling in the organization.

National HMO firm - A company that manages and/or owns HMOs in more than one state.

Network model - An HMO that contracts with two or more independent group practices, possibly including a staff group, to provide health services. While a network may contain a few solo practices, it is predominantly organized around groups.

Non-metropolitan - An area with a total population of less than 50,000 having no cities of more than 25,000.

Open enrollment - The annual period during which a federally qualified HMO must make membership available (without restriction) to individuals who are not part of an employed group. The use of a health screen is not permitted during this period.

Optional supplemental benefits - Noncovered services provided to Medicare enrollees that are paid directly by the Medicare enrollees. These services and premiums apply at the option of the Medicare enrollee.

Out of area benefits - HMO members are entitled to a predetermined set of benefits when outside the service area of the HMO. Coverage is generally limited to emergency services until the member can receive care from the HMO itself.

Preferred provider organization (PPO) - Is essentially a cross between an indemnity insurance plan and an HMO, does not accept risk, is generally backed by insurance companies for employers, and does not require lock-in membership. A network of a previously identified mix of providers who contractually agree to provide services at pre-established rates. Pure PPOs do not accept risk but are often more flexible than HMOs in developing specialized managed care arrangements.

Premium - A fixed, periodic payment (usually monthly) that entitles members to all covered services regardless of the number and type of services used. (*premium* is used interchangeably with *rate*)

Primary care - The range of routine medical services that are generally provided in a physician's office. In most instances, primary care is rendered by general and family practitioners, internists, obstetricians/gynecologists, and pediatricians.

Provider - In the HMO setting, *provider* refers to individuals or organizations whose main function is to deliver health services to patients.

Quality assurance - A formally established program to measure and monitor the quality of care rendered by an HMO. Includes procedures to remedy any deficiencies or problems.

Reinsurance - The practice whereby HMOs limit their potential losses ("stop loss") by purchasing insurance from another company. This limits an HMO's liability in paying for the services used by members.

Reserves - A percentage of HMO members' premiums are set aside to cover potential future health care expenses. Federal and state regulations dictate the minimum size of the reserves.

Risk sharing - A contractual agreement between the IHS and Tribal Organization and the contracting health provider which specifically spells out the level of financial burden or risk associated with the delivery of medical services for each Party to the contract.

Rural - A more restrictive term than "non-metropolitan," rural is used in the present context to refer to open country or towns with fewer than 2500 population.

Saving - The difference between an HMO's or CMP's APR and its ACR if the APR is larger than the ACR.

Service area - The geographic area (usually delimited by counties) from which members are drawn for a particular HMO.

Service Unit - The local administrative unit of IHS.