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A Urology IPA

How one group of physicians stays competitive in the 1990s and controls prostate cancer treatment costs

by Walter Alexander

About three years ago in southern California, a testing ground for new ideas about health care delivery, a group of urologists took a bold step: They formed a single specialty IPA (independent physician association) concerned solely with the delivery of health care by urologists. The impetus was a desire to find an alternative to simply watching patients flee in droves to CIGNA, Kaiser, and other managed health care plans.

"The HMOs were taking over urologic patients in record numbers," stated urologist Charles K. Metzger, M.D., in a Zeneca Pharmaceuticals-sponsored teleconference entitled *Disease Management: Prostate Cancer*, "so we saw banning together to deliver urologic care in a capitated setting as the solution. We wanted to stay competitive, control our market share, and continue practicing medicine."

Walter Alexander is a medical writer in New York City.

The urology IPA, known as the West Coast Urologic Medical Group, Inc., is composed of 12 urologists and covers some 220,000 managed care patients from a large portion of southern California. More than 60 percent of the practice includes HMO patients.

"We have taken our patients back from the HMOs, and Kaiser has a new, empty hospital," Metzger claimed definitively.

Joining together meant, of course, overcoming some resistance. The attitude, "nobody is going to tell me how to practice medicine" is common among physicians, according to Metzger. "But by forming an IPA, we gave ourselves the best chance of making our own decisions and being captains of our own ship," said Metzger. "In fact, we do not tell our urologists what to do. We simply show them the data, show them what other urologists are doing, and try to come to a consensus as to what is appropriate."

The biggest change, Metzger explained, is that patients arrive through a gatekeeper, the primary care physician. In the past, under fee for service, Metzger noted, many patients were referred to specialists unnecessarily.

"Not all hernias need to be looked at. Nor does all epididymitis or prostatitis need a specialist," said Metzger. Secondly, he continued, prior authorizations that are granted according to predetermined criteria for each diagnostic code are needed for the majority of treatments and testing. Authorization decisions, however, are not ironclad. "There is always a lot of room for give and take. You can call and make an appeal based on particular circumstances of a case," stated Metzger. "'No's' have been rare, and we have never been denied a request for surgery."

He pointed out, however, that urologists treating prostate cancer have to embrace newer cost-effective treatment alternatives to radical prostatectomy (e.g., watchful waiting, total androgen blockade) where appropriate. IPA urologists serve on the utilization review committee, sitting for an hour each week for a month, once a year. "Actually, being on the committee offers us a wonderful resource because it allows us to see what others are doing," said Metzger.

CONTAINING COSTS

The crucial negotiation process with the HMOs must clearly spell out what items are to be included in capitation rates. "A typical capitation agreement includes a fixed monthly sum of money per patient that one is responsible for in the HMO that month. The average amount we are getting from our HMOs is $ .48 per younger patient per month, and $3 for seniors," said Metzger. He emphasized the importance of negotiating out certain items from capitation rates. Excluded items may include cost of most drugs, prostate biopsies and related pathology, and chemotherapeutic drugs. Metzger noted that flat fees can be negotiated for specific procedures, for example, ultrasound-guided biopsies.

Other cost-containment measures have been essential. Minor procedures have been converted either to outpatient or to office procedures, and the IPA has successfully negotiated reduced rates for radiation treatment and for hospital care. In addition, according to Metzger, the IPA has been able to exclude some of the more costly treatments from capitation rates.

Bringing prostate cancer treatment utilization into the nineties was a primary concern. "We are at the point where all our radical prostatectomy patients are a.m. admits, all our GI preps and intravenous hydration are given on an outpatient basis, our pre-op antibiotics are given orally, and our average length of stay is four days. Approximately 60 percent of our patients never go into the ICU. For post-op care, we use the home health agency, allowing early discharge and safe hospital-type care in the home," Metzger reported.

GATHERING ESSENTIAL DATA

Providing quality care while containing costs is not enough. "We feel that one of the keys to success in the managed care environment is to develop outcome data, both quality of life and economic outcomes data. These are invaluable for our negotiations with the HMOs," Metzger continued. "When you can show better results and longer time to progression with a treatment, that will buy you almost anything." Such data had been important, Metzger said, in gaining approval from HMOs for use of anti-androgens. "Without the data, they would have given us a hard time."

Outcome data serve another function: They allow IPA physicians to measure their own utilizations and are harsh reminders when outcomes fall outside of ranges established by the IPA internal utilization committee.

"The data have an educational function," said Metzger. "You can't tell urologists what to do, but if you show them the data, they respond. Also, seeing the data gives an economic incentive for physicians to become more standard in their care and to exclude some of the more costly treatments. Usually when doctors are confronted with actual data showing that there are expensive antibiotics and then that there are hideously expensive antibiotics, they find it fairly easy to choose the cost-effective one if it accomplishes the same goal."

WORKING WITH PRIMARY CARE PHYSICIANS

Having primary care physicians do most prostate specific antigen (PSA) testing and digital rectal exams (DREs), controlling type and frequency of follow-up care, and limiting urologist referrals to problem cases help control costs. The IPA holds quarterly meetings with primary care physicians who refer HMO patients and works with them continually via telephone conversations.

According to Metzger, while the loss of control of patients is anathema to some physicians, in a capitated environment it is best for the primary care doctor to render as much care as possible. "We have to keep the patients out of our offices except when there is really a problem," he said. Regardless of potential negative financial impact, however, Metzger emphasized that urologists follow their own prostate cancer patients.

Does the IPA try to make the primary care physicians keenly aware of which patients are fee for service and which belong to an HMO, tailoring treatment and referral patterns accordingly? Are the primary care physicians constantly checking to see which costs come out of their budgets? Are all these financial concerns having a disastrous effect on urologic care? No, according to Metzger.

"While it is true that the managed care people have very effectively found ways to make sure that everybody has a vested interest in keeping costs down, it has all become enormously complex with so many different plans that you can't think things out," said Metzger in a telephone interview. Furthermore, he said, outcome data are showing equivalent treatment patterns between fee-for-service and managed care patients. California informed consent law dictates that prostate cancer patients be given detailed information on treatment options, including orchiectomy, total androgen blockade, and treatment with flutamide, Zoladex, or Lupron. "We explain the options, and they have to sign, stating that they understand them. So, we just do what is right for each patient, and the numbers work out," said Metzger.

PROSTATE CANCER UNDER MANAGED CARE

In the course of panel discussions, Metzger was asked how the changeover to a managed care setting had

affected aspects of prostate cancer management, such as screening, use of androgen blockade, surgical treatment, and neo-adjuvant and radiation therapies. PSA screening has been covered by HMOs in southern California, he stated, adding that the use of age-adjusted PSA scores has had an important effect.

"In the early days of capitated urology, the primary care physician was sending us a huge number of patients that had slightly elevated PSAs with a normal DRE," said Metzger. "It wasn't until we started using the age-adjusted PSA evaluations that we started to eliminate some of the unnecessary biopsies. HMOs in Massachusetts, however, are not paying for routine PSAs, noted faculty member William U. Shipley, M.D., of Massachusetts General Hospital, in a panel discussion.

PSA values are also used to limit bone scan utilization, according to Metzger. Health plans have reserved them for those patients with 10 or higher. For HMO patients undergoing radical retropubic prostatectomy—unless they will be getting radiation treatment—preoperative CT scans have been eliminated. Limited pelvic node dissections, however, are performed, said Metzger. "It is in our best interest to continue to practice what we think is quality care despite being in a managed care environment."

After an overview presentation on androgen blockade by moderator Paul R. Schellhammer, M.D., Eastern Virginia Medical School, Metzger was asked to comment on the place of androgen blockade and neo-adjuvant therapy under managed care in his IPA. Schellhammer had concluded that anti-androgens will be used with greater frequency in the future as components of total androgen blockade in association with medical or surgical castration. Looking farther into the future, he noted that, as a result of trials showing a strong correlation between lower PSA levels, higher anti-androgen doses, and longer durations of response, an anti-androgen (Casodex, not yet approved in the U.S.) was being investigated at escalating doses as a monotherapy for androgen blockade versus surgical castration in a European trial. Researchers are also evaluating compounds with greater affinity for the androgen receptor.

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In circumstances calling for androgen deprivation, Metzger responded, total androgen blockade is used routinely. "We have found that in our managed care environment, especially, total androgen blockade has been accepted as the proper therapy."

Neo-adjuvant therapy with LHRH analogues, Metzger continued, is being offered as standard preoperative care for radical prostatectomy patients and radiation therapy patients in the managed care arena. "Based on anecdotal information, we believe that our positive apical margin rates are much lower with this type of treatment," he said. "Cost of such treatment comes up as an issue, but we believe that we can demonstrate that it is state-of-the-art therapy and that we are getting greater disease-free time intervals. We are not having any problems getting approved. You have to remember, though, that a lot of the expense comes out of our capitated pool, so, in a sense, we are taking some of the financial risk from the HMO to deliver this therapy." HMOs have negotiated low rates from suppliers of flutamide and cost-plus rates outside of capitation for Zoladex as part of overall cost-cutting strategies, said Metzger.

LIVING WELL UNDER CAPITATION

At first, HMOs reimbursed urologists on a reduced fee-for-service basis, then moved toward capitation. The current trend is toward case rates, an even "tougher" arrangement, according to Metzger. Among the West Coast Urologic Medical Group's managed care practice there are 120,000 patients under capitation and another 100,000 under case rates, modified case rates, or some other hybrid plans.

"This IPA is totally controlled by us. The utilizations and decisions are all doctor made," Metzger affirmed. The capitation rates, he acknowledged, at first glance seemed pathetically low compared to fee for service. "But when the entire capitation is taken into account, we are actually doing better under a capitation plan than we did in the reduced fee-for-service plan."

The group's capitation check continues to increase and comes in regularly every month, distinguishing it from fee-for-service payments that can take six to eight months with some HMOs. Cash flow is better, accounts receivable are lower, and the group does not have to do billing, according to Metzger.

"We've learned to manage our HMO patients very well," he said, "and we believe we will continue to be able to effectively practice urology and treat our patients in an appropriate fashion.

"It's true that reimbursements will never again be what they once were, but in southern California, urologists without some form of managed care patients in their practice are, unfortunately, not very busy," said Metzger. "The managed care process is here to stay. We believe that our single specialty urology IPA represents one way to effectively stay competitive."

Will HMOs, seeing the IPA's success at controlling utilization, tighten capitation?

"This is one of the great fears," Metzger noted. "But while every other segment of our practice is getting ratcheted down, the capitated portion has stayed stable. The reason, I believe, is that we have made such an extensive effort to show outcome and economic data and been very aggressive about utilization issues."