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Practicing Geriatrics: Mission Impossible?

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Practicing Geriatrics: Mission Impossible?

This editorial comments on the article by Johnston et al. in this issue.

Geriatricians are in a peculiar quandary. They care for frail older people who take a lot of clinical time and cost Medicare a lot of money in hospitals and nursing homes. However, geriatricians generate less revenue than generalists who care for patients with better payer mixes and can see younger patients in less time. In this issue of the *Journal of the American Geriatrics Society*, Johnston et al examine the case mix of geriatricians and excess costs of caring for older persons who are frail or have the common geriatrics condition of Alzheimer disease or depression.[1] They interpret these analyses in the context of Medicare's Merit-Based Incentive Payment System (MIPS) value-based program, which in 2020 will include performance on costs, which will contribute 20% to the formula that determines whether a physician receives a bonus or financial penalty.

The authors used Medicare Current Beneficiary Survey data linked to fee-for-service (FFS) Medicare claims to calculate total costs and preventable hospitalization rates for geriatricians and nongeriatricians. They also compared geriatricians and nongeriatricians on the proportion of three conditions: frailty, Alzheimer disease, and depression. The findings are not surprising. Geriatricians take care of older, sicker patients, and their practices include higher percentages of patients with these conditions. In addition, more of that care is provided in long-term care institutions. Geriatricians' patients cost more and had more preventable hospitalizations. The authors conclude that without adjustments for these conditions, geriatricians will be inappropriately penalized in the MIPS revision.

Considering these grim prospects, geriatricians might ask, why bother? They have devoted their careers to the care of older persons only to be disrespected by some physicians and underpaid. Yet, the perspective of Medicare as a payer also must be considered. The Centers for Medicare and Medicaid Services (CMS) is charged with paying for healthcare that taxpayers have purchased through their taxes and older persons have paid for through their premiums. Medicare should expect and pay for high quality, good outcomes, and lower costs (the Triple Aim).[2] Reimbursement policies for evaluation and management services generally have not been tied to a specific specialty; and because geriatricians provide a small percentage of the total care of older persons, it is unlikely that changes or adjustments will be made for geriatricians, even though their knowledge, skills, and attitudes fit the population that Medicare insures. Medicare's payment regulations are considerably broader, and geriatricians must play by the general rules. That said, it is unfortunate when a well-intentioned policy undermines the work that geriatricians do. Research, such as that published by Johnston et al,[1] is valuable in helping identify unintended consequences of new policies that should be rectified.

Nevertheless, the payment landscape is changing, with Medicare Advantage (managed care) enrollment rising, covering one-third of beneficiaries in 2019.[3] Although FFS Medicare will remain for some time, many of the emerging payment systems (eg, accountable care organizations [ACOs], alternative payment models [APMs], and bundled payments) are more like managed care as they shift responsibility for controlling utilization on the provider rather than the payer. This means that the discussions about compensation for geriatricians will increasingly move from CMS headquarters to local decision-making rooms. Yet, the conversations will not be any easier. The local leaders and administrators will focus on return on investment with immediate rather than downstream savings. Few will have insight into what is different about care provided by a geriatrician (unless, of course, their parents have been treated by a geriatrician).

So, what does this all mean for clinical geriatrics, a discipline that still struggles to recruit trainees? First, geriatrics must accept that the geriatrics model of care that is taught in fellowship training is not scalable. The older population is growing too rapidly and too few physicians are becoming geriatricians. Therefore, clinical geriatrics will need to be limited. But how? The discipline would benefit by agreeing on what is the core clinical work of geriatricians. How much should be focused on providing primary care and for whom? Should the focus of geriatrics practice shift toward consultative care or comanagement? Second, at local institutions, what metrics should be used to judge the clinical performance of geriatricians and how should these metrics be considered in compensation, if at all? Third, how can the knowledge of the small number of geriatricians be leveraged within health systems that are responsible for populations of older persons with diverse needs who receive care in many settings? Can geriatricians take leadership roles in shaping the delivery of care for older people?

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Going forward, paying for the work of geriatricians must follow two pathways. One path is to work through FFS Medicare to appropriately compensate for services that geriatricians provide. Some examples include using the recent Current Procedural Terminology (CPT) 99483 code for cognitive assessment and care planning services, CPT codes 99497 and 99498 for advance care planning, and CPT codes 99358 and 99359 for prolonged services without face-to-face contact. Geriatricians can also identify additional services and seek new codes. The other path is to work through local health systems that are paid differently (eg, Medicare Advantage, ACOs, and APMs) to make the case for the value of geriatricians and identify what are the best roles for them to serve the health system. These efforts are often led by experienced geriatricians who can transform insights learned from the care of older persons into innovations at a systems level. Some successes include those under the aegis of Age-Friendly Health Systems[4] and individual institutions that have begun extending geriatrics principles throughout their healthcare systems.[5]

Historically, geriatricians have been extremely satisfied with their work,[6] perhaps because of the diversity of patients and problems, the complexity of creating and implementing care that is personalized and patient centered, and the relationships with patients and families that are formed as care is provided. Geriatricians thrive on these challenges and rewards. However, if geriatrics practice is to be sustainable, geriatricians need to work with national and local payers to ensure that their value is appropriately recognized and compensated.

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REFERENCES

1. Johnston KJ, Wen H, Joynt Maddox KE. Inadequate risk adjustment impacts geriatricians' performance on Medicare cost and quality measures. J Am Geriatr Soc. 2020;68(2):297-304.https://doi.org/10.1111/jgs.16297.
2. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. Health Aff. 2008;27(3):759-769.
3. Jacobson G, Freed M, Damico A, Neuman T. A dozen facts about Medicare Advantage in 2019. https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/. Accessed November 17, 2019.
4. http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx. Accessed November 16, 2019.
5. Booth KA, Simmons EE, Viles AF, et al. Improving geriatric care processes on two medical-surgical acute care units: a pilot study. J Healthc Qual. 2019;41(1):23-31. https://doi.org/10.1097/JHQ.0000000000000140.
6. Leigh JP, Tancredi DJ, Kravitz RL. Physician career satisfaction within specialties. BMC Health Serv Res. 2009;9:166. https://doi.org/10.1186/1472-6963-9-166 PubMed PMID: 19758454; PubMed Central PMCID: PMC2754441.