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Health Policy 2016 – Implications for Geriatric Urology

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Abstract

Purpose of Review—The U.S. healthcare system is undergoing fundamental changes in an effort to improve access to care, curtail healthcare spending, and improve quality of care. These efforts largely focused on Medicare, and therefore will have a fundamental impact on the care of geriatric patients. This article reviews contemporary health policy issues, with a focus on how these issues may impact the care of geriatric urology patients.

Recent Findings—The Affordable Care Act (ACA) has broadened the scope of Medicare coverage. Future Medicare reimbursement will be increasingly tied to care coordination, quality reporting, and demonstration of appropriate outcomes. Additional research is needed to better define the comparative effectiveness of urologic therapies in geriatric patients. Workforce projections indicate that there is a shortage of urologists in many areas of the country, and that this shortage will worsen over time unless a new funding model is instituted for graduate medical education.

Summary—Medicare spending drives many health policy decisions. Therefore, few health policy topics are unique to geriatrics or geriatric urology. However, certain health policy topics (e.g., care coordination, risk-stratification) are particularly germane to the elderly patients. Urologists with a particular interest in geriatric urology should be familiar with these issues.

Keywords

quality of care; Medicare; healthcare reform

Introduction

The healthcare landscape for older Americans is overwhelmingly dominated by Medicare. The vast majority of healthcare reform activities is also focused on Medicare. Therefore, geriatric care is directly affected by health policy decisions. Clinicians with an interest in geriatric urology should be familiar with future changes that have been legislated for Medicare. This article reviews the current structure of the U.S. healthcare system for older

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adults, and discusses health policy topics which have particular relevance for geriatric urology.

Current structure and contemporary considerations of the healthcare system for older adults

As a federal insurance program run by the Centers for Medicare and Medicaid Services (CMS), Medicare is the nation's largest fee-for-service health insurance program and began in 1965 when the U.S. government passed legislation to improve access to acute health care for old, disabled, and poor people.¹ Today, fifty years later, over 100 million Americans are covered under these services,² a number that is expected to grow and exceed 20% of the United States Population by the year 2030.³

The structure of the Medicare system is outlined in Table 1 and consists of two separate fee-for-services plans referred to as Medicare Parts A and B. Older Americans and their spouses are entitled to Part A if they have had Medicare taxes deducted from their paychecks for at least 10 years, or if they opt to pay a premium for these services. Part A covers care rendered in hospitals, skilled nursing homes, home-health, and hospice services. Older Americans who are entitled to Part A are also eligible for Part B, which includes payments to physicians, nurse practitioners, social workers, psychologists, therapists, laboratory tests, and durable medical equipment. Medicare Part B is paid for by premiums that vary based on the income of the individual in relation to their monthly Social Security checks.

Older Americans can choose to opt out of Medicare Parts A and B, in which case they can elect to enroll in Medicare Part C, otherwise known as Medicare Advantage Plans (MA)⁴. These plans are operated by private insurers that hold contracts with CMS and work on a risk-adjusted basis. MAs include Medicare Health Maintenance Organizations (HMOs), preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, special needs plans, and medical savings accounts.

Medicare Part D was introduced by President George W. Bush in 2003 so that older Americans would have an option to purchase insurance coverage for outpatient prescription medications. Many plans have a relatively small deductible (\$325 in 2012), after which typically 75% of drug costs are covered up to a predetermined amount (\$2,970 in 2012). Once this amount is reached, Part D coverage resumes. This amount between the deductible and the resumption of Part D coverage is often referred to as the "doughnut hole", which has been revised in recent years with the passage of the Affordable Care Act so that drug companies now split payment in this gap with the beneficiary 50:50.

The Affordable Care Act (ACA), often referred to as "Obamacare", represents the largest regulatory overhaul in United States healthcare since the introduction of Medicare in 1965 and was signed into law by President Barack Obama on March 23, 2010. The ACA initially underwent many obstacles but was ultimately upheld by the United States Supreme Court in two separate rulings; the 2012 case of *National Federation of Independent Business v. Sebelius* to allow its mandate to exercise Congress's taxing power and the 2015 case of *King*

v. *Burwell* to affirm the law and its federal subsidies to help individuals to pay for health insurance in all states.

The key elements of the ACA for older individuals center around (1) increasing access to healthcare and (2) changing the current fee-for-service reimbursement system⁵. In terms of access, the ACA eliminates out-of-pocket expenses for many preventative screening measures, reduces the Medicare Part D coverage gap (“doughnut hole”), and expands Medicaid coverage which increases the number of dual eligible (for both Medicare and Medicaid) older individuals. The ACA also changes reimbursement from a fee-for-service system to one based on improved outcomes via coordinated care, bundled reimbursements, and pay-for-performance measures.¹

As urologists, it is important to consider the policy implications of taking care of large numbers of older individuals. Almost half (46.2%) of all urology visits are for patients ages 65 and older and 62% of all urologic procedures are performed in this population⁶. With the rapid expansion of the older population in the coming years, these numbers are only expected to grow and will challenge our healthcare system in many ways. As reimbursements will become progressively linked to quality-related outcomes, it is important for us as a field to understand how to best deliver care to this population with its special needs and considerations. The presence of multiple medical comorbidities (more than 20% of older adults have at least 5 chronic medical conditions³) and the added complexity of geriatric syndromes (i.e. difficulty swallowing, malnutrition, bladder control problems, sleep problems, delirium, dementia, vision problems, hearing problems, dizziness, fainting, difficulty walking, falls, osteoporosis, and pressure ulcers⁷) make this population unique and different than caring for other groups.

Workforce issues

It has been well publicized that there is a shortage of primary care physicians in the United States^{8,9}, but in fact there is a physician workforce shortage across all of medicine. Recent estimates from the Association of American Medical Colleges (AAMC) indicate that the overall shortage will be approximately 130,600 physicians by 2025, half of which will be specialty physicians¹⁰. AUA Census results indicate that urology has the second-oldest surgical subspecialty workforce with an average age of 52.5 years¹¹. Forty four percent of the urology workforce is over the age of 55, with 18% age 65 or older, and 7.4% over the age of 70. Per population, there is a much higher density of urologists practicing in urban areas as compared with rural areas, leaving many rural counties in the United States without a practicing urologist. Furthermore, rural urologists are on average 2.2 years older than their urban counterparts. The urology workforce shortage is compounded by the aging US population, and the fact that many urologic conditions occur more commonly in older adults. Therefore, a urology physician shortage is likely to have a disproportionate impact on geriatric patients.

Medicare funds are provided to hospitals to support graduate medication education training, but the Balanced Budget Act of 1997 froze this support at 1996 levels. Since then, additional training positions have been funded by philanthropy, hospitals, and physician practice

revenue. It is increasingly recognized that this funding model will not be able to meet future demand for physician trainees. As health policy solutions are pursued, it is important to recognize potential threats to urology (and urologic patient access). For instance, policies which preferentially fund primary care training positions over specialty care positions will exacerbate the shortage of specialists and will provide barriers outpatient access. It is likely that innovative ideas will be required in order to expand the number of training positions. Examples of such ideas include the use of physician extenders to provide medical care, reducing residency training requirements, or involving the private sector in the funding of GME positions.

Care coordination

Coordination of care is a major tenant of the ACA and is of great importance in the management of older individuals. As previously discussed, many older patients have multiple medical comorbidities in conjunction with the presence of various geriatric syndromes. These medical factors, in addition to potential ethical and legal issues surrounding competency and decision-making in older adults,¹² make medical management and coordination of this population extremely complex and time consuming.

Adding to the unique complexities of care coordination among older individuals is the task of managing care transitions across healthcare settings, which can include nursing homes, hospitals, rehabilitation centers, home healthcare and other sites. Unfortunately, these additional provider-level efforts are not routinely reimbursed and up to 80% of Medicare beneficiaries do not have access to care coordination services under current Medicare policies¹³, placing these patients at particular risk of “falling through the cracks”.

Urologists have an important role to play in the coordination of care among older individuals. While it is typically primary health care providers that are at the center of care coordination for these patients, urologists need to take an active role to help facilitate these transitions and to ensure adequate communication between providers.

Quality of Care

Most clinicians are convinced that they provide good quality care to their patients. Unfortunately, most clinicians lack objective data to prove it. Furthermore, population-based studies suggest that the overall quality of healthcare in the United States is below expectations¹⁴, and policymakers have fully embraced the concept that improvements in quality will result in reductions in healthcare costs. Therefore, clinicians are under increasing pressure from patients, hospitals, insurers, and legislators to provide data related to the quality of care that they provide.

Quality of care is typically assessed using measures, which are evidence-based calculations that quantify the quality of a selected aspect of care by comparing it to a criterion. Measures are categorized as ‘Structure’ measures, ‘Process’ measures, or ‘Outcome’ measures¹⁵. Examples are provided in Table 2. Each measure has a numerator (the number of items/patients which meet the measure specifications) and a denominator (the number of eligible items/patients). Therefore, each measure is a ratio with a value ranging from 0 (complete

noncompliance) to 1 (complete compliance). For example, if 8/10 eligible patients receive appropriate preoperative antimicrobial prophylaxis, the score (ratio) for that measure would be 0.8. A large number of clinical quality measures exist for hospitals, physicians, and other healthcare entities.

Quality measures are currently utilized in a variety of ways to affect reimbursement. For example, the Physician Quality Reporting System¹⁶ requires physicians to report on a number of measures in order to avoid a payment penalty on all Medicare patients in their practice. Some payments models combine quality reporting with cost data, such as Accountable Care Organizations (ACOs), which provide rewards to groups which meet quality standards (assessed by measures) AND keep costs below a specified amount.

One frustration with quality reporting is that there may be numerous requirements both locally and nationally, creating a duplication of efforts on the part of physicians. The Medicare Access and CHIP Reauthorization Act (MACRA), which was signed into law in April 2015, proposes to merge established physician pay-for-performance programs into a single Merit-Based Incentive Payment System (MIPS)¹⁷. With this system, physicians can continue to participate in the traditional fee-for-service model, with payments adjusted annually on the basis of performance in 4 categories: clinical quality, meaningful use of information technology, resource use, and practice improvement. As an alternative to MIPS, physicians will be able to participate in alternate payment models (such as ACOs or patient-centered medical homes) in which they accept responsibility for the quality and cost of care of a group of patients.

Regardless of the specific payment models that are eventually instituted, it is quite clear that physicians will need to take some responsibility to track their clinical outcomes. With this in mind, the AUA has developed the AQUA registry, which is a national quality improvement registry focusing on urologic diseases¹⁸. Urologists who participate in AQUA will receive data about their practice patterns and their performance on quality measures. These data can be provided to patients and to external bodies such as Medicare, in order to meet requirements for MIPS and other future federal programs.

Research

Research both on urologic issues related to older patients and on the delivery of care within this population is of the utmost importance in advancing both public policy and the manner by which we care for older patients. Not only is there an underrepresentation of research on disorders that primarily affect older individuals, but there is also an underrepresentation of older adults in clinical trials, including those for urinary incontinence, urinary tract infection, genitourinary cancer, prostate disease, sexual dysfunction, stone disease and renal transplantation⁵. As previously discussed, older individuals often have distinct healthcare needs and may respond differently to medical and surgical treatments in comparison to younger individuals, furthermore, studies performed on younger cohorts may not be generalizable to the older population.

The American Geriatric Society and the John A Hartford Foundation put together the Research Agenda-Setting Project (RASP) to help develop the field of science for patients

undergoing surgical care. They included priorities for 10 surgical specialties including urology. The latest revision of this project has outlined three Key Questions in the field of urology that they deemed warranted future research: (1) to better define the pathophysiology and natural history of the most common genitourinary disorders affecting older adults (urinary incontinence, urinary tract infection, prostate disease, urologic malignancies, sexual dysfunction, stone disease, and renal failure and transplantation), (2) To develop and validate predictive models to identify appropriate candidates for early surgical or other active therapies versus more conservative treatment options in older adults, and (3) to analyze the longitudinal outcomes of various urologic therapies, including potential risks, benefits, and costs.¹⁹

The American College of Surgeons recently initiated a geriatric pilot project with the National Surgical Quality improvement Program (NSQIP) that began January 1, 2014. This pilot captures additional variables on patients ages 65 and older including the following: origin from home with support, use of mobility aid, history of falls, history of dementia, competency status on admission, palliative care on admission, postoperative delirium, postoperative pressure ulcer, do not resuscitate order during hospitalization, palliative care consults, discharge functional status, fall risk on discharge, need of mobility aid on discharge, discharge with/without services²⁰. As urologists, we should be equally invested in assessing these types of variables among our patients and should follow the lead of the American College of Surgeons to make this a priority among research initiatives.

There are currently several funding opportunities through the National Institutes of Health that urologists can apply for. The National Institute on Aging's (NIA) mission is to improve the health and well-being of older Americans. They also have a specific funding opportunity for young investigators transitioning into aging research called the Grants for Early Medical/Surgical Specialists' Transition to Aging Research (GEMSSTAR), formerly referred to as the Jahnigen Fellowship Program. Additional funding opportunities are also available through the Veterans Affairs Office of Research and Development (VA ORD) among other funding mechanisms.

Conclusion

Workforce projections and U.S. demographics suggest that urologists will encounter an ever expanding number of geriatric patients. Geriatric patients often present with numerous medical comorbidities which raise the risks for adverse outcomes from urologic therapies. In the near future, reporting of quality measures and outcomes will be expected for all clinicians. Care coordination will be increasingly important to optimize outcomes of geriatric patients. Comparative effectiveness research focused on the geriatric patient will have direct policy relevance as clinical outcomes are more strongly tied to reimbursement.

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Key Bullet Points

- Workforce projections indicate a shortage of urologists and an increasing number of geriatric patients.
- Urologists should participate in the coordination of care for their geriatric patients.
- In the near future, urologists will be required to report on their clinical outcomes, including the outcomes for their geriatric patients.
- Comparative effectiveness research is needed to better define the outcomes for urologic therapies in geriatric patients.

Table 1Structure of Medicare system^{1,2}

Medicare benefit types	Coverage
Medicare Part A	Hospital, skilled nursing home, home-health, and hospice services
Medicare Part B	Physicians, nurse practitioners, social workers, psychologists, therapists, laboratory tests, and durable medical equipment
Medicare Part C	Provides benefits offered under Parts A and B through Medicare Advantage (MA) plans, or managed care plans. Most MAs also offer Medicare Part D benefits.
Medicare Part D	Some of the cost of prescription medications

Table 2Quality Measures¹³

Type	Definition	Examples
Structure Measures	The settings in which medical care takes place	Procedure volume Clinician training Board certification Nurse-to-patient ratio
Process Measures	A set of activities that go on between practitioners and patients.	% of patients who receive appropriate preoperative antibiotics % of patients who receive venous thromboembolism prophylaxis prior to surgery % of patients who receive intraoperative cystoscopy during pubovaginal sling placement % of patients with low risk prostate cancer who undergo a staging bone scan
Outcome Measures	The consequences of structure and processes of care to health and welfare of individuals and society.	Mortality rate Complication rate Patient satisfaction score