An Incremental Process to Prepare for Value-Based Contracting: Implementing Medicare Annual Wellness Visits to Improve Quality & Practice Income

FOCUS PAPER

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Introduction

The objective of this paper is to educate managers operating in the current dynamic healthcare environment on the Medicare Annual Wellness Visit (AWV) and the positive impact it can have on practice income, quality and patient satisfaction. Medical practice managers are encouraged to analyze the existing utilization rate of these visits and evaluate options for revisiting office structure and process to incorporate the AWV into the schedule of their own practices. Implementing the AWV can be the first step in an incremental process to redesign the medical practice to prepare for value-based contracting.

The AWV, a Medicare Part B Fee-For-Service (FFS) appointment, was established in 2011 as part of The Patient Protection and Affordable Care Act (ACA) of 2010 in an effort to focus on providing preventative services at no-cost to beneficiaries. As of June 2016, there were over 56 million Americans enrolled in Medicare Part A & Part B (Centers for Medicare and Medicaid Services, 2016e). Beneficiaries do not have a co-payment associated with AWVs and healthcare professionals are offered enhanced reimbursement opportunities for providing them, making it mutually advantageous for both patients and providers. The AWV is also of benefit to the health of the population, providing access to visits that focus on wellness. According to Centers for Medicare & Medicaid Services (CMS) (2013), “prevention and early detection are vital to ensuring that Americans are healthy and Medicare is healthy”. AWVs can assist medical practices with the transition to rapidly approaching value-based contracting and coordinated care models while offering an opportunity to generate steady income, improve quality metrics and engage patients in managing their chronic conditions.

The AWV includes a comprehensive screening and involvement of the patient in the development of a personalized plan of care, which identifies any existing chronic conditions, potential for development of new chronic conditions and focuses on ideas for health promotion and disease prevention. In addition to providing comprehensive baseline data on various measurements, including cognition, functional level and health risk factors, these visits provide
practices with necessary information to risk stratify their patient populations in an effort to better manage costs while increasing quality and patient satisfaction.

By establishing a process that encourages patients to take advantage of their AWV, practice managers will be able to collect information to gain a better understanding of the needs of their patient population and the most effective ways to serve them, leading to the development of new business models and services provided by the medical practice as well as the expansion of existing service lines to capture additional market shares. This critical information gathering process is currently supported under the familiar FFS reimbursement system, permitting medical practices to generate steady income while making preparations for a successful transition to value-based contracting (Pizzo, 2016).

**Transitioning from Fee-for-Service to Value-Based Reimbursement**

The United States (US) healthcare system has historically been focused on treatment of disease and costly procedures rather than disease prevention and measurement of improved health outcomes. The US leads the world in expenditures for healthcare but ranks last in overall healthcare, 7th in coordinated care and 6th in patient-centered care when compared to other wealthy countries (Davis, Stremikis, Squires, & Schoen, 2014). Under the current FFS reimbursement system physicians are paid for each service they provide, thus incentivizing quantity over quality. According to CMS (2011b), approximately 69% of Medicare beneficiaries have 2 or more chronic conditions and 37% have 4 or more chronic conditions. Those with 2 or more chronic conditions accounted for 93% of Medicare spending in 2010. To address some of the increasing costs of care, the ACA called for a focus on improving the health of the population and encouraged the use of multidisciplinary teams to drive care coordination, engage patients and provide better quality of care, a national initiative better known as “population health”. The ultimate goal of the population health initiative is to improve access and quality of health care while reducing expenditures.
Healthcare has rapidly transformed with the introduction of the ACA and the emphasis is shifting to preventative, value-based care and reimbursement, which is at the forefront of improving our delivery system. CMS played a role in this transformation by introducing reimbursement for services such as the AWV, designed to prevent disease or slow the progression of chronic conditions, thus providing incentives for chronic care management (Snyder, 2012). Prior to this, patients were responsible for part of the cost for many preventative health services, making it difficult for some to access the care they needed.

In an attempt to reward providers for improving the quality of healthcare while reducing costs, CMS introduced the concept of value-based contracting also known as Alternative Payment Models (APMs). Most value-based reimbursement contracts are structured according to a shared savings model. The Medicare Shared Savings Program was introduced in 2011 by CMS. According to CMS (2016g), “Congress created the Medicare Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for FFS beneficiaries and reduce unnecessary costs”. Organizations can participate in the Shared Savings Program by creating an Accountable Care Organization (ACO). CMS defines an ACO as a group of doctors, hospitals and other health care providers who come together voluntarily to give coordinated high quality of care to Medicare beneficiaries. An ACO is considered successful when it is able to increase the quality of care provided to its patients while demonstrating a reduction in health care services utilization rates and corresponding costs. Annual performance is measured against benchmarks developed by CMS for cost and quality of care. For the 2016 reporting period, CMS established 34 quality measures that must be met to achieve shared savings. The cost savings generated is distributed among members of the ACO, hence the term “shared savings”. The importance of the AWV should be realized by practice managers as it presents a value-added opportunity for practices because it can easily satisfy 11 of the required quality measures established by CMS. In addition, it achieves 25 Healthcare Effectiveness Data
and Information Set (HEDIS) clinical quality and medication adherence measures identified by The National Committee for Quality Assurance (NCQA) (Snyder, 2013).

Although value-based contracting may be developing slowly in some markets, in other markets it is moving rapidly as organizations assume responsibility for managing the health of defined populations (Pizzo, 2016). As more payers follow the lead of CMS and transition to value-based contracting, they will want to know that practices can effectively manage healthcare costs, quality and outcomes for patient populations before negotiating such agreements. Many practices will find it necessary to align themselves with other practices and payers in an ACO model to build collaborative relationships and survive the changing healthcare landscape.

Implementing the AWV will allow practices to establish baseline patient data, achieve quality metrics and demonstrate the ability to successfully manage complex populations. This will be attractive to ACOs and other potential healthcare partners who are looking for ways to increase quality and lower costs as they broaden their geographic coverage, form new relationships and negotiate better contracts with value-based payers.

According to CMS (2016f), “Before the Affordable Care Act, Medicare paid essentially $0 through alternative payment models. By 2014, approximately 20% of payments were made through alternative payment models, and today more than 30% of payments are made through alternate payment models”. This rapid move toward value-based care delivery and corresponding value-based contract reimbursement will force practices to find ways to appropriately manage complex patients. Otherwise, they will face financial penalties and ultimately the question of practice sustainability in the current environment. The AWV can be used as a tool to begin the incremental process of transforming the medical practice, leading to improved quality and better patient management while adding to financial sustainability in an ever-changing environment where incentives are being realigned to promote value-based contracting.
Medicare Annual Wellness Visit Program Overview

The Medicare AWV presents an opportunity for patients and doctors to focus on health risks that impact short and long-term health (Clark, 2015). CMS introduced these covered services to contribute to promoting healthy lifestyles and improving the care of our population while addressing the financial burden these patients place on the Medicare program. These services also provide an incentive for providers to prevent, identify and treat problems earlier. According to CMS (2011), “Preventing chronic disease not only improves health and quality of life – it’s also a significant step in reducing the $2 trillion the United States spends treating preventable long-term illness today.”

The Initial Preventative Physical Exam (IPPE), also called the “Welcome to Medicare Visit”, is offered within the first 12 months of enrollment in Medicare. Practices may have missed the opportunity to provide the IPPE to some of their patients to date if the majority of the population has been Medicare beneficiaries longer than 12 months. However, opportunities exist to capture these IPPE visits by identifying patients who will turn 65 and become Medicare beneficiaries.

Medicare also offers The Initial Annual Wellness Visit (IAWV) 11 months after an IPPE visit or 12 months after being enrolled in Medicare. The Subsequent Annual Wellness Visit (SAWV) is offered every 12 months after the initial AWV.

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Welcome to Medicare (IPPE)</th>
<th>Initial AWV (IAWV)</th>
<th>Subsequent AWV (SAWV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>Within the first 12 months of Medicare eligibility.</td>
<td>After the first 12 months of Medicare eligibility or 11 months after IPPE.</td>
<td>Greater than or equal to 12 months from the Initial AWV and every 12 months thereafter.</td>
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Both the Initial and Subsequent AWVs are focused on prevention and are not considered physical exams. Patients complete a self-reported health-risk assessment, where they report on how they feel their health is overall. Providers must review chronic medical conditions, medications and specialist providers. During AWVs, depression screening, cognitive assessment and functional assessment must be completed. Advance care planning and appropriate
preventative services are also reviewed. Finally, as part of the AWV, providers give patients a written personalized plan of care with appropriate screening schedules and health advice. As part of the personalized plan of care, they also engage patients in identifying what things are most important to them and what patients would like to focus on for their health goals.

The AWV has significant value for both patients and providers. Espiridion’s (2016) patient satisfaction study found the majority of patients reported that AWVs met their expectations (88%), they would recommend this visit to friends and family (86%), and they would make the visit again next year (88%). This research supports the idea that patients are satisfied with the AWV and would continue to schedule these visits in the future, generating steady income for medical practices.

**Reimbursement Opportunities for Annual Wellness Visits**

Practices should be aware of the numerous revenue opportunities that exist with the AWV Program. The Initial AWV, which is payable only once per lifetime (Current Procedural Terminology (CPT) code G0438), and the Subsequent AWV (CPT code G0439), payable once every 12 months, are the encounters that have the greatest likelihood of impacting patient revenue and care since they are more likely to be captured by the medical practice. As mentioned earlier, the IPPE may not be as easily captured if patients have already been enrolled in Medicare for more than 12 months. Based on the Medicare Physician Fee Schedule for 2016, the national average reimbursement for the Initial AWV is approximately $173 while the Subsequent AWV is around $117. In a practice with a Medicare population of approximately 750 patients per provider, the Initial AWV could result in $129,750 of additional revenue for the first year and $87,750 each additional year per provider, demonstrating the opportunity to generate steady income.

AWVs also generate opportunities to identify the need for other preventative services, which can be addressed at the same visit, thus not incurring a co-payment, but permitting additional reimbursement. According to Cuenca (2012), “with an efficient workflow, providing covered
screening services at the same time as the Medicare wellness visit can maximize reimbursements”. According to Snyder (2012), “what many physicians fail to realize is that reimbursement for the AWV is just one component of potential downstream revenue for the practice. Medicare covers, and strongly encourages, approximately 15 other preventive services for seniors that are dramatically under-utilized. Additional preventive services, screenings, tests or treatments for chronic conditions diagnosed during the AWV represent additional, ongoing revenue for a sophisticated primary care practice or multidisciplinary practice. Results from one primary care practice that offers the AWV, for example, show the average reimbursement for all services that arise from the AWV is in excess of $375” per visit.

Data shown in the table below, which was obtained from the 2016 Medicare Physician Fee Schedule National Payment Amount, outlines some of the more frequently used codes that are associated with AWVs (Cuenca, 2012). As an example, a female smoker who is being seen for a Welcome to Medicare visit can also have tobacco-use counseling, depression screening, and a well-woman exam, maximizing the value of the appointment to the patient and increasing reimbursement to the practice from $167.56 to $239.17 (Cuenca, 2012).

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0402</td>
<td>Welcome to Medicare Visit (IPPE)</td>
<td>$167.56</td>
</tr>
<tr>
<td>G0438</td>
<td>Initial Annual Wellness Visit</td>
<td>$172.58</td>
</tr>
<tr>
<td>G0439</td>
<td>Subsequent Annual Wellness Visit</td>
<td>$117.08</td>
</tr>
<tr>
<td>G0101</td>
<td>Screening breast and pelvic exam</td>
<td>$38.67</td>
</tr>
<tr>
<td>G0102</td>
<td>Prostate cancer screening (digital rectal exam)</td>
<td>$19.69</td>
</tr>
<tr>
<td>G0436</td>
<td>Tobacco-use counseling</td>
<td>$14.68</td>
</tr>
<tr>
<td>G0444</td>
<td>Depression screening</td>
<td>$18.26</td>
</tr>
</tbody>
</table>

As the utilization rates of AWVs begin to increase, practice managers can use the data collected at these visits to develop specialized programs in dementia, falls prevention or chronic care management. In January 2015, CMS introduced the Chronic Care Management (CCM) CPT
code to reimburse medical practices for 20 minutes of non-face-to-face management and care coordination provided by a non-physician clinical staff member for Medicare beneficiaries having two or more chronic conditions. CCM services require a patient agreement and minimal co-pay. Based on the CMS Physician Fee Schedule for 2016, the national payment amount for CCM to be performed in an outpatient setting is $40.82 per member per month. Patients who may be eligible for CCM services can be identified during AWVs. Practice managers can piggyback on AWVs to introduce CCM services in their practice, leading to additional revenues and improved care coordination for patients.

Although AWVs offer opportunities for enhanced reimbursement and delivery of other preventative and chronic care services, they remain underutilized. According to CMS, (2013), “3.5 million Medicare beneficiaries were seen for an AWV in 2013, up from 2.8 million in 2012”, showing that despite a modest increase, only a fraction of the eligible beneficiaries took advantage of the AWV. The reduced uptake of implementing the AWV presents an opportunity for practices to increase revenue and collect valuable patient health data from a service not otherwise being offered to or requested by patients.

**Challenges & Barriers to offering Annual Wellness Visits**

Despite the many advantages to implementing AWVs in the medical practice, physicians and managers are sometimes reluctant to incorporate these visits due to the perceived challenges and barriers they may present (Beran, 2015). Some of the more common reasons why there is apprehension in delivering the AWV in practice include:

- *Many providers and/or patients lack of knowledge of AWV.* Providers are unsure of who is eligible for these visits and many patients are unaware that they are entitled to this service, evidenced by the small number of Medicare beneficiaries actually taking advantage of this service. Many providers also report not being familiar with the purpose and requirements of the AWVs and do not understand the important contribution these visits can make to their practice. Educating providers, staff and patients on the AWV is
instrumental to success of the program. Physician champions can guide other providers in the importance and impact the AWV can have in the practice.

- *These visits are considered complex and time-consuming for physicians to perform due to the necessary documentation and personalized plan of care that is required for billing. Practices may consider this a waste of physician time, which is costly to the practice.*

Each AWV consumes between 40 to 60 minutes of the physician’s schedule for what some consider nominal reimbursement. Also, many of the Electronic Medical Records (EMR) systems do not currently provide support for documenting the AWV, making it very time consuming for the physician to record all of the required information into the general patient record. AWVs can be conducted by non-physician providers as long as a physician is on-site at the time of the AWV. In order to bill for AWV, all of the requirements for documenting the AWV must be met. Developing the personalized plan of care is a necessary component that is not always completed accurately. If this is not in place at the time of an audit, the practice risks CMS denying the service and the need to return any associated revenue. Multidisciplinary practice teams can be created to develop AWV forms that ensure proper documentation justifying the service was appropriately provided. There are also many healthcare consultants and EMR teams that are currently marketing their services in developing these forms on behalf of the practice. Some of these companies will even manage the AWV process for your practice in exchange for a nominal fee.

- *There is a theory that wellness visits take time and practice space away from sick patients. In addition, providers and patients do not like the idea of not being able to discuss illness related problems at these visits. AWVs provide an opportunity to meet with patients once per year to discuss overall health and wellness. It is important that medical practices make it a priority to shift the focus of care away from disease treatment to disease prevention. As we continue to move toward value-based contracting, we have*
to recognize that well visits are just as important as sick visits and should be given adequate amount of schedule time and practice space. CMS and other payers continue to recognize the importance of preventative services in increasing the overall health of our population. Utilizing a room in the practice for a non-physician provider to see the patients for AWV may end up paying for itself.

- **Physicians and staff must be able to distinguish between Initial Preventative Physical Exam, Initial Annual Wellness Visit and Subsequent Annual Wellness Visit in order to schedule the appropriate appointment and assign the proper CPT code for billing.** There is sometimes confusion over the 3 different types of preventative visits offered by Medicare and the appropriate CPT codes to use for each. Practice managers, coding, billing and other front office staff must familiarize themselves with the differences in these visits and put a process in place to track which visit the patient is entitled to at the corresponding time period.

**Deciding to Implement AWV in Practice**

Practice managers should not be deterred by the misconceptions about AWVs and should thoroughly investigate all available options before deciding whether or not to implement these visits in their own medical practice. As mentioned previously, there are many solutions to the challenges of providing the AWV that can be easily integrated into current office structure and process. These include dedicating time to educating providers, staff and patients about AWVs, using non-physician providers such as nurse-practitioners to the full scope of their license to conduct these visits, developing or purchasing programs to document these visits in the EMR and ensuring proper protocols are in place for billing the correct CPT codes (Snyder, 2013).

Although developing a process to overcome these challenges and implement the AWV may initially seem time-consuming, the benefits outweigh the costs for most practices. Practice managers are encouraged to perform a cost-benefit analysis on implementing the AWV since the size of the practice and the amount of available resources dedicated to this effort will determine
whether it is feasible or not for the practice. Implementation of the AWV will be a profitable endeavor for the majority of medical practices. Practice managers who identify the possibility of an initial financial loss should still consider incorporating AWVs as an investment in familiarizing the practice with improved quality of care and patient satisfaction to prepare for value-based contracting (Holm & Zucker, 2016).

When a practice manager chooses not to implement a process for incorporating AWVs into their schedule, they forgo an opportunity to redesign their medical practice in preparation for value-based contracting and significantly decrease the prospect of expanding services, providing new services and establishing new partnerships in the rapidly changing healthcare market. Practice managers should make the decision to implement the AWV into their current schedule for the benefit of their organization. The result of this decision will be informative patient baseline data, increased practice revenue, and improved quality metrics and patient satisfaction. Most importantly, it will strategically position medical practices for value-based contracting which is the future of medicine.

**Successful Implementation of AWV in Practice**

Implementation of the AWV is an incremental process. An example from a geriatric medical practice that collected data on 1466 unique Medicare beneficiaries that presented to their ambulatory office during the period of January 1, 2015 through December 31, 2015, found only 65(4.4%) were seen for an AWV encounter. It was apparent from this data that there was not an adequate structure and process in place to optimize the identification and scheduling of the AWVs. In January 2016, the medical practice initiated a rapid cycle Quality Improvement (QI) process using the Plan/Do/Study Act (PDSA) model to increase the scheduling of AWVs. The PDSA model enabled an ongoing formative evaluation process and allowed for mid-course corrections to structure and process, by which the practice was able to optimize its workflow and redefine staff functions.
During the initial PDSA cycle, the QI team instructed the front desk to identify Medicare patients who were scheduled to come to the office but who had not been seen for an AWV. The team suggested that the front desk offer and schedule the AWV along with their next follow up appointment. The response was very encouraging. The majority of patients scheduled an AWV and only a few refused. As the PDSA project continued, it was clear to the practice manager and QI team that many of the barriers and challenges identified in research about the AWV were also present in the geriatric practice. Providers, patients and staff needed to be educated on AWV, its requirements, the billing parameters and different types of AWVs. It was also discovered that the Electronic Medical Record (EMR) did not have a template to facilitate required documentation, including personalized plan of care; and on a few occasions, the billing office realized that the incorrect CPT code had been used for the AWV. In response to these challenges, providers and staff received education and training on the requirements and importance of the AWV so they could communicate effectively to the patients and a physician champion created user friendly forms in the EMR. A template was developed for integration into the EMR which facilitated the AWV process and ensured that AWV billing requirements were met.

Evaluation of a 6-month period of the QI project showed that 886 Medicare patients had appointments at the geriatric practice. Of the 886 patients, 285 (32%) scheduled the AWV after being encouraged by the front desk staff to do so. Only 10 (1%) patients refused to schedule an AWV. Although this is still a new and evolving endeavor for the geriatric practice, AWVs continue to be popular among both patients and providers. The geriatric practice continues to incorporate and refine the delivery of the AWV and plans to hire a nurse practitioner to perform AWVs and enroll patients for CCM services. On January 1, 2017 the geriatric practice will integrate into a Next Generation ACO. The ACO has been promoting the use of these preventive services as a standard for all of their partner practices.
By implementing the AWV and CCM services for their complex patient population, the geriatric practice has created a solid foundation for successful ACO integration and generation of alternative sources of practice revenue.

**Surviving Value-Based Delivery of Care and Reimbursement**

CMS continues to move forward with value-based contracting, restructuring the reimbursement models for the practice of medicine. They recently announced the Merit-Based Incentive Payment System (MIPS) and Advanced Payment Models (APM) under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program. In order to stay abreast of rapid changes taking place in the delivery of care and the reimbursement models that support it, medical practice managers will need to develop a strategy for redesigning the way their practice operates. More importantly, they will need to form partnerships with other practices and payers, identify the most costly patients through risk assessment, and manage those risks appropriately to improve quality of care while maintaining an adequate amount of practice income to survive.

Medical practice managers should act upon the changing healthcare landscape by taking advantage of the opportunity to promote new preventative services provided by Medicare which will bring added value, expanded services and increased revenue to their practice. The successful implementation of a comprehensive program to integrate these revenue generating services into daily operations will position practices as attractive partners in a value-based healthcare delivery system that are capable of managing complex patients by providing high-quality care at a low cost. The Medicare AWV is an important tool that can serve as the first step in an incremental process of restructuring the medical practice to adopt this new model of care and ultimately contribute to survival in the rapidly changing health care environment.
References


