Policy Spotlight

The Medicare Annual Wellness Visit and Opportunities for the Aging Network

Introduction

Developed in partnership with the National Council on Aging (NCOA), this Policy Spotlight describes Medicare's Wellness Visits, current approaches to provide this benefit to Medicare beneficiaries, challenges related to access and opportunities for the Aging Network. This brief also presents policy and programmatic recommendations to improve uptake and effectiveness of Wellness Visits and an enhanced role for the Aging Network.

Background

Medicare Wellness Visits were introduced as a part of the Patient Protection and Affordable Care Act (ACA) in early 2011 as an expansion of Part B preventive services. There are two types of Medicare Wellness Visits: a "Welcome to Medicare" visit, also known as an Initial Preventative Physical Exam (IPPE), and Annual Wellness Visits (AWV). The IPPE is only covered once within the first 12 months of Medicare Part B enrollment. The AWV provides a regular opportunity to focus on preventive health and supports healthy aging. The AWV includes a review of a patient's medical and social history, risk factors for disease, including depression. Functional ability and safety are also assessed on the AWV. Using a required Health Risk Assessment, or HRA, the AWV also enables providers to collect basic health measurements, review medications including opioid prescriptions, screen for substance use disorders, detect cognitive impairment, establish a screening schedule and help establish or update a written personalized prevention plan (PPP), jointly developed by the patient and provider. Advance care planning is an optional component of the AWV. The beneficiary pays nothing for these benefits if their provider accepts Medicare assignment.[i]

The AWV provides a regular opportunity to focus on preventive health and supports healthy aging.

By offering the AWV to Medicare beneficiaries, health care providers enhance patient activation and engagement, identify health risks such as depression and falls, and connect beneficiaries to behavioral counseling, such as nutrition counseling and smoking cessation, and preventive care services, including vaccinations and cancer screenings. These benefits are intended to prevent disease and disability through the PPP, improve quality of life and potentially reduce health care expenditures for Medicare beneficiaries.

Uptake of this Medicare benefit has been low. A 2019 study of Medicare beneficiaries showed that only 18 percent of Medicare Fee-for-Service beneficiaries and 25 percent of Medicare Advantage enrollees had received an AWV.[ii] Low uptake rates stem from barriers for both physicians and patients. For physicians, time and resource constraints, workflow obstacles and complex requirements make AWVs less likely. For patients, there is confusion around what the benefit is, and many may have more complex medical and social needs to address during limited time with physicians. Disparities also exist in the uptake of the AWV; patients who are dually enrolled in Medicare and Medicaid, non-White, or living in rural and underserved communities, were shown to be less likely to receive an AWV, potentially worsening disparities in prevention and health outcomes for underserved patients.[iii]

Data on whether the AWV improves health are mixed and some researchers suggest that those who are most in need of receiving AWVs are not receiving

them. One study showed a cost savings of $418 per beneficiary and improvement in screenings for fall prevention, tobacco, depression, colorectal cancer and breast cancer. AWVs were also shown to be associated with increased pneumococcal and influenza vaccinations[iv] and improved diabetes control. There was little evidence of benefit to doing AWVs in terms of early detection of cognitive impairment or depression when comparing those who were or were not provided an AWV.[v,vi] Further, studies have not shown a significant reduction in the total number of emergency department visits or hospitalizations for those who receive the visits.[vii]

Existing Models of AWV Delivery

Physician Model: Typically, the initial Wellness Visit or IPPE consists of the components shown in Table 1 with the HRA being the primary component. Subsequent AWVs include the same components as the IPPE, with the goal of reviewing and updating each component.

Table 1. Components of the Annual Wellness Visit

- Perform a Health Risk Assessment (HRA)[viii]
- Establish medical and family history
- Establish a list of current health care providers and suppliers
- Measure vital signs
- Screen for cognitive impairment
- Review potential risk factors for depression
- Review functional ability and level of safety
- Establish an appropriate written screening schedule for the next five to 10 years
- Furnish personalized health advice and appropriate referrals to health education or preventive counseling services or programs
- Establish a list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or underway
- Discuss optional advance care planning services

Currently Medicare reimburses for AWVs that are conducted by a physician (Doctor of Medicine or Osteopathic Medicine), physician assistant, nurse practitioner or a certified clinical nurse specialist. In addition, other medical professionals, such as a health educator, registered dietitian, nutrition professional, or other licensed practitioner or team of medical professionals working under the direct supervision of a physician, can conduct the AWV. Direct supervision is defined as being physically present in the office suite to render assistance, if necessary.

The reimbursement rate for the IPPE is $169.23, and for the AWV, the rate was $133.64 in 2021.[ix]

Use of Non-Physician Staff: Some physicians choose not to perform AWVs because they perceive it to be too onerous. However, most components of the AWV can be performed by the non-physician care team. Non-physician staff can collect and record data from the HRA, administer questionnaires (such as the PHQ9 for depression), access records of prior screening activities (such as when the patient last had colon cancer screening and what kind) and conduct a wide range of other activities. However, non-physician staff cannot interpret results, create care plans, order tests independently, make referrals or bill for the service without the participation of the physician or qualified non-physician practitioner (physician assistant, nurse practitioner or certified clinical nurse specialist). The physician's role is to synthesize the findings and make recommendations for preventive services and referrals to other providers as needed.

Use of Telehealth: During the coronavirus pandemic, the Centers for Medicare & Medicaid Services (CMS) adopted a number of changes meant to ensure older adults could continue to receive medical care. Among these changes were allowing the AWV to be completed by clinical staff under a physician's supervision using telehealth. Before these pandemic flexibilities were in place, Medicare beneficiaries could only receive services via telehealth if they lived in a rural setting and had specific conditions. Under these new telemedicine rules, patients can receive select telehealth services with only audio to fulfill the telehealth requirement; however, an AWV requires both audio and video. CMS does not allow the IPPE to be conducted via telehealth.

All the normal service and documentation requirements of the in-person AWV remain the same for a telehealth AWV. Billing and coding use the same CPT and ICD codes, but providers must add a modifier to signify it was performed via telehealth.[x] During the pandemic, Medicare is reimbursing telehealth AWVs at the same rate it would if the visit were completed

in person. Medicare waived the requirement for providers to need licensure in the state where a patient is located. Under the expansion, other practitioners, such as licensed clinical social workers, can perform telehealth services alongside doctors and nurses.

Coding for the AWV: Both In-Person and Telehealth

G0402: Initial Preventive Physical Exam (IPPE) – Not allowable under telehealth

G0438: Initial Annual Wellness Visit

G0439: Subsequent Annual Wellness Visit

Team-Based Approach: Several examples exist in which other licensed practitioners provide the AWV as part of a team-based approach, which sheds light on the potential roles of the Aging Network to conduct the HRA or other components of the AWV. For example, a small pilot project was conducted with Medicare patients using a nurse/medical assistant/physician team-based approach.[xi] Sixty-seven percent of the patients completed the AWV within one hour, and none of the visits required physician or other providers' attention during the wellness visit. More than 80 percent of patients reported satisfaction with the visits conducted by the nurse, and all staff members were satisfied with the process. The approach found a return on investment (ROI) of 37 percent in the first year, and 52 percent thereafter. ROI was calculated based on the added costs associated with the nurse conducting the AWVs (hourly wage, training, supplies, etc.) and the revenue generated from AWV reimbursement.

Another study included patients of three community-based and two retirement community outpatient clinics in western North Carolina using a team-based AWV over a 20-month program, with the goal of improving the uptake and delivery of the AWV. A clinical pharmacist saw high-complexity patients (defined as taking five or more medications), and a licensed practical nurse (LPN) saw low-complexity patients. The study examined the effectiveness of team-based AWV on patients' use of preventive services and conducted a retrospective chart review to access change over time in use of preventive services. Overall, utilization of AWV increased from 14 percent at baseline to 44 percent after the 20-month program. The percentage of patients up to date with all recommended services increased from 17.4 percent at the AWV to 42 percent within six months, with the most improvement for preventive screens and vaccines. The study concluded that team-based AWVs with a clinical pharmacist or an LPN, who were supervised by physicians, were associated with significantly improved utilization of preventive services.[xii]

Health education specialists are often employed by community-based organizations (CBOs) in the Aging Network and could potentially serve this function via a contract between the health care provider and the CBO.

Health Education Specialists: A family medicine clinic in North Carolina reported on the effective use of Health Education Specialists (HES) to promote AWVs through patient outreach and education. The HES schedules visits directly with patients, typically sees the patient for up to an hour, and performs and documents all items required by Medicare. The HES completes the note and forwards it to the patient's physician for review, which usually takes two to three minutes of the physician's time. If the patient has a medical complaint or question during the AWV, the HES will schedule an appointment for the patient to meet with their physician in a subsequent office visit unless a medical problem requires immediate attention. The clinic reported that since the HES took over organizing and performing the AWVs, visit documentation has been more complete and the percentage of eligible patients who have completed an AWV has quadrupled.[xiii] Health education specialists are often employed by community-based organizations (CBOs) in the Aging Network and could potentially serve this function via a contract between the health care provider and the CBO.

Benefits of the Aging Network's Partnership

For Health Care Providers: Despite the barriers, there are several reasons why health care providers should prioritize the AWV among their Medicare patients. No other reimbursable visit focuses on prevention to the

extent that the AWV does. The AWV provides a time to review health status, identify risk factors and take action before a concern turns into a larger problem. One study found that medical practices that conduct AWVs have shown increases in their revenue, stability of patient assignment and patient mix.[xiv] AWVs can also help a practice improve its quality measures and meet HEDIS requirements. Having Aging Network CBOs as partners for the AWV could reduce burden in providing the benefit, and serve as a resource for referrals, care coordination and follow-up.

For Older Adults: One of the primary challenges for older adults receiving the AWV is that they do not know how or whether the AWV is different than their annual physical. The Aging Network, with its strong connections to older adults and experience explaining various benefits, such as through the State Health Insurance Assistance Programs (SHIPs)[xv], could play a greater role in helping older adults understand how this visit is different and why it is important. Additionally, many older adults do not attend medical appointments due to needs such as transportation or caregiving responsibilities. Area Agencies on Aging (AAAs) and other aging service providers often assist in facilitating respite services or transportation to reduce some of the barriers that may exist to accessing services and could do so with the AWV.

AWV Opportunities for the Aging Network

A small unpublished survey conducted by NCOA in late summer/early fall 2021 found that many CBOs are eager to work with health care providers and partner on improving AWV uptake and referral. When asked what role they are best suited to provide, CBOs responded in varying ways, including the following:

- Administering the HRA at a social services appointment (such as SDOH assessment as part of the enrollment in a meal program)
- Trained, contracted and professional network of social health assessment professionals
- Contractually aligned network of CBOs to deliver care coordination and wraparound community services to support AWV and HRA
- We have staff who could help conduct the assessment and make referrals to community services and resources based on needs identified. Screening and coordinating those services.
- Transportation and staff to perform the Annual Wellness Visit
- Assessing clients and Information and Referral
- Provide computers and laptops with internet access onsite. Can offer risk assessments on-site. Provide home-delivered meals, exercise classes to increase wellness.
- Collecting and analyzing data on AWV utilization, including a focus on racial disparities

Medicare Beneficiary Awareness and Education: The survey referenced above found that CBOs use a variety of approaches to increase awareness and educate beneficiaries about the AWV, including:

- Articles with reminders about the AWV in local newspapers and on social media
- One-on-one benefits screening and counseling
- Brochures about the AWV
- Medicare Improvements for Patients and Providers Act (MIPPA) program outreach and assistance to eligible Medicare beneficiaries who apply for benefit programs
- Welcome to Medicare events and events held during the annual Medicare open enrollment period
- Educational community presentations related to health and wellness
- Community health workers, referral specialists and care coordinators who educate and remind Medicare beneficiaries about the AWV benefit

These and other educational activities are vitally important since many Medicare beneficiaries are unaware of the benefit, how it differs from other doctor's appointments, and that it is a free annual benefit. Further, CBOs may be more successful at reaching low-income and underserved Medicare beneficiaries who have been least likely to receive the benefit. Individuals who have higher health risks could especially benefit from the preventive screens and referrals to needed services identified through the AWV. Reaching this underserved population and annual communication about the benefit are important roles for the Aging Network to play to improve access.

Supportive Services: In addition to awareness and education activities, the Aging Network can provide services that support Medicare beneficiaries in accessing the AWV. Based on the NCOA survey, the following services were cited as the most common supports:

- Transportation to doctor's appointments
- Care coordination for referred services
- Assistance accessing telehealth appointments, i.e., improving technology literacy
- Provision of technology devices such as phones, laptops and tablets
- Assistance with internet connectivity (e.g., device with data plan, wireless hotspot, etc.)

Transportation is a core service provided by the Aging Network that could be leveraged and paid for by plans and providers to assist Medicare beneficiaries keep their medical appointments, including the AWV.

Care coordination is one of the most frequently cited services that are included in the aging and dissability networks' contracts with health plans and payers.[xvi] The Aging Network's experience and expertise in care coordination can be further leveraged for services that beneficiaries have been referred to as a result of the AWV, as well as any follow-up that may be needed post AWV.

As clearly shown throughout the pandemic, access to technology is a vital need among older adults. This access includes broadband/internet, technology (tablets, laptops, cell phones) and education to improve technology literacy among older adults. During the pandemic, AAAs and other aging CBOs have been a vital resource helping older adults connect to a range of programs and services via online platforms like Zoom. These CBOs can assist beneficiaries with AWV delivered via telehealth by helping with access to the internet and technology needed for the visit, as well as instructions on how to connect with their providers for the visit. The Aging Network can also assist with any AWV follow-up that might be conducted virtually.

Referrals from Local Health Care Providers: CBOs also receive referrals from local health care providers as a result of needs identified through the AWV/HRA. NCOA's survey found that the top programs and services that older adults were referred to as a result of the AWV are:

- Fall prevention programs
- Nutrition programs
- Care coordination
- Caregiver support
- Chronic Disease Self-Management Education Programs
- Transportation
- Respite services
- Alzheimer's or dementia care

Other referred services could include benefits access, housing, physical activity and other health promotion/disease prevention programs, behavioral health, homemaker/personal care services, legal and social work services. In order for these referrals to work effectively, it's important that CBOs develop relationships with local health care providers and keep them up to date on the array of services available from the Aging Network in order to obtain referrals for needed services identified through the AWV. Providing evidence on the value of these referred services and programs is key to reimbursement and long-term funding.

Policy and Programmatic Recommendations

Given the low uptake of the AWV, especially among minority and underserved Medicare beneficiaries, policy changes and programmatic improvements are needed to increase access and better leverage the Aging Network to assist with this important Medicare benefit. A core goal of any legislative proposal or regulatory change for AWV improvements should be to increase the low AWV beneficiary participation rates and increase the number and types of practices that offer the AWV.

AWV Awareness: One barrier to access is lack of knowledge regarding the benefit among Medicare beneficiaries. An important recommendation is that CMS be directed, with funds available, to conduct a national outreach campaign, in partnership with the

Aging Network, to educate Medicare beneficiaries on the value of the annual AWV and the fact that there is no out-of-pocket cost for this important benefit. For example, this campaign could be conducted as part of the annual Medicare Open Enrollment Period in which CBOs, such as SHIPs, provide other important information to beneficiaries about their Medicare options. Written and online materials from CMS could be provided to promote the AWV.

AWV Approved Providers: Another policy recommendation to address barriers is to expand the list of licensed providers who can administer the AWV and submit for reimbursement, independent from working under the direct supervision of a physician. These health care professionals—such as clinical social workers, physical therapists, occupational therapists and pharmacists—have the specialized training and expertise to administer evidence-based screening tools and are more likely to have the community linkages with the Aging Network for appropriate referrals and personalized prevention plan services. As described earlier, a model that utilized a clinical health care team of pharmacists and a licensed nurse to administer the AWV demonstrated a significant increase in Medicare patients obtaining an AWV. Improvements were also found in the percentage of Medicare patients who obtained needed preventive services following their Medicare AWV with this care team of non-physicians.

Allowing more licensed practitioners to provide the AWV without the direct supervision of a physician opens up the settings of care, such as physical therapy clinics and pharmacies, in which older adults can obtain the AWV. This expansion also creates opportunities for the Aging Network to partner with more providers and receive referrals and payments for their services. Further, some practitioners, such as licensed clinical social workers, may be employed by CBOs, could provide some or all of the HRA, as well as recommend and coordinate referrals.

Standardization: Standards and requirements for screenings and referral protocols for home and community-based services, such as nutrition, care coordination, evidence-based health promotion/disease prevention programs and transportation, should be strengthened, including recommended best processes and practices. For example, the evidence-based falls prevention risk screen, assessment and intervention, Stopping Elderly Accidents, Deaths, and Injuries (STEADI) tool, developed by the Centers for Disease Prevention and Control (CDC) should be compulsory as part of the AWV in order to establish an individually tailored and effective plan of care to prevent falls. According to the CDC, savings of $3.5 billion in direct medical costs could be achieved over a five-year period for every 5,000 health care providers that adopt STEADI.[xvii] Many CBOs serving older adults are already using STEADI resources and could provide this service in partnership with health care providers.

SDOH Assessment: Consideration should be given to incorporating screening for the social determinants of health (SDOH) in the AWV and including a modest bonus payment or increased reimbursement to providers who incorporate the SDOH screen. Aging and disability CBOs could provide this screening as this aligns with what many CBOs do as part of client needs assessments and care coordination. Examples of SDOH assessment tools include the Accountable Health Communities Health-Related Social Needs Screening Tool[xviii] developed by the CMS Center for Medicare and Medicaid Innovation and PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences).[xix]

Continuation of Telemedicine: Permissible circumstances under which visits can be conducted in a beneficiary's home and virtually under telehealth rules should be expanded. In-home visits also provide an opportunity for aging and disability CBOs to provide the AWV. Many aging and disability CBOs are already in the home delivering other services; the AWV could be added to the array of services provided. However, the rule requiring that a direct supervisor be physically present would need to be changed.

Compliance: Data should be collected and oversight conducted to track and better ensure compliance with statutory requirements that health risk assessments meet the guidelines established by the Secretary, and regarding "[t]he furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including

weight loss, physical activity, smoking cessation, fall prevention and nutrition."[xx]

Follow-Up Processes: CMS should amend CFR §410.15[xxi] to include guidance on processes and standards for the post-visit follow-up to ensure consistency and compliance with the prevention plan and referrals. Follow-up is an area where aging and disability CBOs could contract with health care providers to deliver these services.

Research and Demonstration: An evaluation supported by the CMS Center for Medicare and Medicaid Innovation or another entity of current practices and how to improve access to and the effectiveness of the AWV would be valuable. Studies might focus on:

- Whether and to what extent personalized prevention plan services and appropriate referrals are taking place for beneficiaries who are at particular risk;
- Whether and to what extent referrals are increasing beneficiary access to services provided by aging and disability CBOs and which referral models have been most effective;
- Whether and how the AWV can improve vaccine take-up rates and access to other Medicare preventive services;
- The impact of Medicare reimbursement rates on access to the AWV and whether increases or other modifications would improve take-up rates;
- Whether and to what extent models using the services from the Aging Network for the AWV can contribute to reductions in Emergency Department visits, hospital admissions, readmissions and other health care utilization.

Conclusion

Assessing for and providing preventive services to older adults is more critical now than ever, considering the impact of the pandemic on older adults and those with chronic illness and/or physical disabilities. Medicare AWVs were introduced to provide health promotion and preventive care to Medicare beneficiaries and are an important strategy in addressing a range of issues that significantly impact quality of life. However, Medicare AWV policy and inherent limitations have failed to realize its potential and address the preventive health needs of older adults. The reality of incorporating those visits into clinical practice poses challenges for health care providers, given the time constraints and other pressing health concerns for older patients. The Aging Network can address identified barriers to AWV access, especially for minority and underserved older adults. AAAs, CBOs and others in the Aging Network are well poised to deliver education and awareness, provide supportive services, conduct all or part of the HRA, and accept referrals for social services that address unmet needs. CBOs can also provide follow-up for needed services from health care providers conducting the AWV.

As policymakers consider improvements to Medicare, an expanded role for the Aging Network relative to the AWV should be part of these considerations. In addition, regulatory changes, such as allowing the AWV to be conducted without direct physician oversight and extending telehealth benefits under Medicare, will be needed to reduce barriers to access to AWVs for Medicare beneficiaries. NCOA and USAging will continue to advocate for needed changes to the AWV to reduce barriers to access and for increased opportunities for the Aging Network to partner with health care providers through contracts and reimbursement for services related to the AWV.

Appendix

Resources to Increase Uptake of the Annual Wellness Visit (AWV)		
For Providers		
Resource	**Organization**	**Description**
Medicare Wellness Visits Quick Start Guide[1]	Medicare Learning Network (MLN)	The AWV resources help health care professionals understand each type of exam, their purpose and the requirements for submitting claims for each exam.
Medicare Wellness Visits: Get Your Patients Off to a Healthy Start[2]	Centers for Medicare & Medicaid Services (CMS)	A website with information and resources for providers to encourage them to recommend the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV).
The Evolution of Annual Wellness Visits at Bellin Health Partners Next Generation ACO (2018)[3]	Center for Medicare & Medicaid Innovation (CMMI)	This case study describes the strategy Bellin Health Partners ACO developed to maximize effectiveness of AWVs, including increasing the percentage of patients who completed an AWV from baseline of 43 percent to 70 percent over three years.
Mapping Medicare Disparities Tool[4]	CMS Office of Minority Health	The Mapping Medicare Disparities Tool contains health outcome measures for disease prevalence, costs, hospitalization for 60 chronic conditions, emergency department utilization, readmission rates, mortality, preventable hospitalizations and preventive services, including the AWV. Users can compare differences by race, ethnicity, age, sex, and dual and Medicare eligibility.
A Key Challenge for Medicare's Annual Wellness Visits: Spreading The Benefits to Underserved Seniors (2018)[5]	HealthAffairs	This article discusses the challenges of providing access to the AWV to underserved older adults and offers possible solutions to eliminating this disparity. It discusses a new care model needed for this population, broadening social determinants of health screenings in AWVs, and the potential risks/benefits of AWVs.

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Appendix, *continued*

Resources to Increase Uptake of the Annual Wellness Visit (AWV)		
For Consumers – Examples of Patient Education Resources		
Resource	**Organization**	**Description**
Annual Wellness Visit[6]	MedicareInteractive.org	A website with information on the AWV for Medicare beneficiaries, including eligibility, covered services and cost.
Medicare Preventive Services: Coverage and Costs[7]	National Council on Aging	An overview of the various preventive services covered by Medicare, including the AWV.
The Benefits of an Annual Wellness Visit[8]	Mantachie Rural Health Care, Inc.	Website with information for patient on the benefits of the AWV.
What is the Medicare Annual Wellness Visit? (2021)[9]	MedicareGuide	This article provides information for Medicare enrollees on the AWV.
What is an Annual Wellness Visit and Why is it Important? (2019)[10]	Today's Caregiver	This article for caregivers provides information on the annual wellness visit, how to prepare and what to expect.

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This publication was produced for the Aging and Disability Business Institute by the National Council on Aging (NCOA). Led by USAging in partnership with the most experienced and respected organizations in the Aging and Disability Networks, the mission of the Aging and Disability Business Institute is to build and strengthen partnerships between aging and disability community-based organizations and the health care system. Funded by The John A. Hartford Foundation, The SCAN Foundation and the Administration for Community Living, the Aging and Disability Business Institute provides community-based organizations with the tools and resources to successfully adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Learn more at www.aginganddisabilitybusinessinstitute.org.

The National Council on Aging (NCOA) is the national voice for every person's right to age well. We believe that how we age should not be determined by gender, color, sexuality, income, or zip code. Working with thousands of national and local partners, we provide resources, tools, best practices, and advocacy to ensure every person can age with health and financial security. Founded in 1950, we are the oldest national organization focused on older adults. Learn more at www.ncoa.org and @NCOAging.