

# Increasing Medicare Annual Wellness Visits in Accountable Care Organizations

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## ABSTRACT

Medicare's annual wellness visit (AWV) was introduced in 2011 as an opportunity for providers to focus on aspects of preventive care for eligible beneficiaries. Despite potential incentives for doing so, adoption of the AWV has been slow, which may be contributing to a relative paucity of data evaluating how conducting AWVs affects patient outcomes and health care spending. In this article, we discuss how a large Medicare accountable care organization implemented several innovations aimed at decreasing barriers to scheduling and increasing the efficiency and convenience of conducting AWVs, which led to a substantial increase in AWV rates within 12 months. This manuscript provides a conceptual analysis assessing the potential benefits and costs of implementing the AWV and subsequently details the innovations and the effects of these innovations on AWV rates among attributed patients.

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In 2011, Medicare introduced the annual wellness visit (AWV) to expand coverage of preventive health services to older adults. The visit provides an opportunity for providers to focus on aspects of preventive care (eg, evidence-based screening services, personalized health risk assessments, advance care planning) that may often be overlooked during acute problem-based visits because of time constraints or more pressing health concerns. For AWVs, patients owe no co-pay and clinicians are reimbursed at a high rate.<sup>1</sup>

CMS requires that certain elements be addressed at each AWV. Patients and providers work to create a personalized prevention plan, which includes age-appropriate preventive services, cognitive screening, personalized health advice to identify and work to mitigate risk factors, and the implementation of recommendations from the US Preventive Services Task Force and the Advisory Committee on Immunization Practices.<sup>2</sup> Ideally, the AWV affords the opportunity for early disease detection and downstream mitigation of disease effects, improving patient outcomes and lowering overall costs.

Although the overall utility of annual preventive visits in achieving these aims has been debated,<sup>3</sup> the relatively recent adoption of the AWV renders any definitive conclusions regarding its effectiveness premature. Some studies have shown associations between the AWV and increased utilization of preventive care services. One study indicated that the AWV is associated with significantly higher odds of undergoing mammography, Pap tests, bone mass measurement, and prostate and colon cancer screening, as well as obtaining the influenza vaccine.<sup>4</sup> Another study showed that patients who had an AWV had increased testing for possible causes of cognitive impairment (eg, thyrotropin, B<sub>12</sub>) relative to those without an AWV.<sup>5</sup> Additional work has demonstrated that Medicare beneficiaries who utilize AWVs have higher pneumococcal vaccination and influenza vaccination rates than those who do not,<sup>6</sup> and another study similarly

demonstrated that patients who had an AWV had a higher percentage of influenza vaccination, depression screening, and sexually transmitted infection screening than those who did not.<sup>7</sup> However, one study suggested that depression screening was low (10%) among patients who receive AWVs and was not significantly different from those with non-AWV visits.<sup>8</sup>

Although studies have shown increases in utilization of certain preventive services among AWV attendees, few studies have assessed the effects of the AWV on costs, and the existing studies show mixed results. One study demonstrated that a first-time AWV was associated with a 5.7% reduction in total health care costs in the 11 months following the AWV, estimating a per-member per-month decrease of \$81 in overall spending.<sup>9</sup> Of note, patients in the highest-risk hierarchical condition category (HCC) quartile had the greatest reduction in costs for those attending an AWV relative to those who did not. Another study showed that AWV users had a significant reduction in total health care spending (\$162) at 24 months following an AWV relative to matched beneficiaries who did not receive an AWV,<sup>10</sup> and a case report noted that increasing the percentage of its patients attending an AWV was associated with overall reductions in health care costs.<sup>11</sup> However, another large study comparing outcomes in practices that adopted the AWV vs those that did not found no consistent evidence of associations between AWV use and spending, emergency department visits, or hospitalizations.<sup>3</sup> Another study found that AWV rates were not correlated with Medicare spending.<sup>12</sup>

Nevertheless, the prospect of eventually realizing decreases in health care costs by prioritizing preventive health has led Medicare to incentivize practices to incorporate the AWV, resulting in opportunities for accountable care organizations (ACOs) to increase revenue while providing this service to patients. Medicare covers AWVs at 100%, attributing 2.43 relative value units (RVUs) for initial AWVs and 1.5 RVUs for subsequent AWVs<sup>13</sup>; additionally, providers are able to bill for diagnostic and treatment services provided at the same time as the AWV, often resulting in greater revenue for those practices utilizing the AWV (although these additional services may require a patient co-pay).<sup>14,15</sup> The mandated structure of the visit also helps physicians to close pay-for-performance quality measure gaps, and ACOs participating in the Medicare Shared Savings Program can satisfy quality measures using data collected at the AWV.<sup>16</sup> The visit also provides the opportunity to ensure the accuracy of HCC-related diagnoses, which may result in higher risk-adjusted factor scores and associated higher reimbursement rates for more complicated, at-risk patients. The AWV also provides an additional patient care visit, which may improve the stability of the beneficiary assignment to the practice conducting the visit.<sup>14</sup> As may be expected given these possible benefits, patients who are attributed to an ACO have

been shown to be more likely to receive an AWV than those who are not.<sup>12</sup>

Despite the possible benefits to both providers and patients, adoption of the AWV has been modest, with an estimated 24% of eligible beneficiaries receiving an AWV in 2017,<sup>10</sup> up from 7.5% in 2011.<sup>12</sup> The large proportion of eligible beneficiaries not receiving an AWV presents an opportunity to increase the evidence-based preventive care services provided to patients and realize additional revenue. Not many studies exist exploring the effects of interventions aimed at increasing the proportion of beneficiaries receiving an AWV. A case study of Bellin Health Partners described a 4-pronged approach utilizing a structured care team (registered nurse–led AWVs), health information technology applications (including work lists, compliance reports, and care gap reports), provider incentives, and staff communication (contacting beneficiaries to schedule visits), which ultimately led to an increase in the rate of AWVs among eligible beneficiaries.<sup>11</sup> Aledade similarly implemented training sessions and automated work lists to help small practices engage AWV-eligible beneficiaries.<sup>17</sup> A small university-affiliated practice utilized a nursing care manager, in concert with specific physician recommendations, to increase the rate of AWVs among eligible patients.<sup>18</sup> A 2008 systematic review examined the effects of various clinician interventions (computer-generated prompts and paper-based prompts) and patient interventions (including mailed reminder letters, telephone notifications, flyers and posters directed toward patients, home visitations encouraging vaccinations, and education to encourage return visits) on increasing use of preventive care services. Although it was conducted prior to the implementation of AWVs, the study demonstrated overall modest effects of utilizing prompts on increased utilization of preventive services, showing average differences of 10% to 14%, depending on the prompting method.<sup>19</sup>

## METHODS

BJC is an integrated health system that operates a Medicare Shared Savings Program ACO, with roughly 150 primary care providers caring for 34,728 beneficiaries in Illinois and Missouri. BJC identified the AWV as a key opportunity to improve care delivery and sought to increase the rates at which its attributed eligible beneficiaries received AWVs. BJC identified 2 broad areas on which to focus its attention: decreasing barriers to scheduling AWVs and increasing the efficiency and convenience of conducting AWVs. BJC identified obstacles within both categories and implemented the innovations outlined within the following sections.

### Increasing Ease of Scheduling AWVs

**C-SNAP access for offices.** C-SNAP is a service provided by CMS that allows providers and office staff to view eligibility

and claim status information for Medicare beneficiaries. Medicare covers 1 AWV within each 12-month period for eligible beneficiaries. Given that other providers (including, at times, wellness vans<sup>20</sup>) may have already conducted an AWV within the prior 12-month period, BJC providers may not know whether the AWV that they provide would be covered. BJC identified this uncertainty regarding whether beneficiaries had already obtained an AWV as a possible barrier to providing AWVs. C-SNAP allows users to review whether beneficiaries have had an AWV conducted with a provider outside the BJC system. BJC provided C-SNAP access for every office to facilitate reviews of claims for beneficiaries and ensure that the AWV is not duplicated.

**Electronic health record tracking.** BJC utilizes the Epic electronic health record (EHR), which allows for identification and tracking of pertinent health maintenance data. BJC ACO and information technology staff worked together to add a feature to each patient's chart listing the date of the patient's last AWV and the date that the patient would be eligible for their next AWV. This was viewable by providers and office staff to assist in scheduling patients for AWVs and identifying patients who presented to clinic for an acute visit who were also eligible for a concurrent AWV.

**Eligible patient lists.** ACO staff created a claims database of all ACO members indicating the date of the members' most recent AWV (if any) and the date they were eligible for their next AWV. Individual patient lists were sent to each primary care clinic, and each clinic proactively contacted patients who were not yet scheduled for an AWV in the upcoming year. If patients were already scheduled (for a diabetes follow-up visit, for example), clinic staff would reach out to the patient regarding the possibility of adding an AWV at the same visit. Although significant manual efforts were still required, this intervention provided clarity regarding which patients were eligible for AWVs and ensured that they were scheduled at appropriate times to limit claim denials.

**AWV tracking dashboard.** BJC developed dashboards allowing for the visualization of AWV rates by provider, practice, and region. These dashboards allowed ACO leadership to analyze trends and allocate resources as needed (eg, more attention might be given to regions with low AWV rates, and providers with higher AWV rates might be able to offer additional feedback on effective methods).

**Compensation bonus.** To incentivize providers to address remaining barriers to scheduling and conducting AWVs, BJC approved a 1% compensation bonus for any primary care provider who achieved an AWV rate of 50% or greater among eligible ACO beneficiaries within the provider's patient panel. To help providers monitor their progress, they were given updated AWV rates each month.

## Increasing Efficiency and Convenience of Conducting AWVs

BJC incorporated the requirements of the AWV into a standardized note template in the Epic EHR to facilitate efficient entry of pertinent patient health information and reduce burden on clinicians. As has been demonstrated in other patient populations, patients who receive care at BJC often had a lack of clarity and understanding regarding the purpose and contents of the AWV. BJC therefore created a written communication ([eAppendix](#) [available at [ajmc.com](#)]) to explain the purpose and contents of an AWV to patients and answer frequently asked questions.

BJC also sought to further streamline visits by beginning data acquisition prior to the visit. A portion of the AWV involves the completion of the health risk assessment (HRA) questionnaire. To facilitate the efficient collection of this information, BJC staff can send the HRA questionnaire to the patient before the visit through a patient portal; if the patient completes this before the visit, their responses will automatically populate the provider note.

To lay a consistent organizational groundwork, BJC additionally invested in webinar training sessions to further educate staff and providers on the purpose, content, and best practices of an AWV. BJC further developed and disseminated a best-practice workflow among providers to standardize elements of the AWV and give providers a consistent framework for conducting the visit. BJC also held in-person meetings with all member practices to communicate pertinent background information regarding the AWV, explain the interventions addressed herein, and provide the opportunity for providers to ask questions and offer feedback.

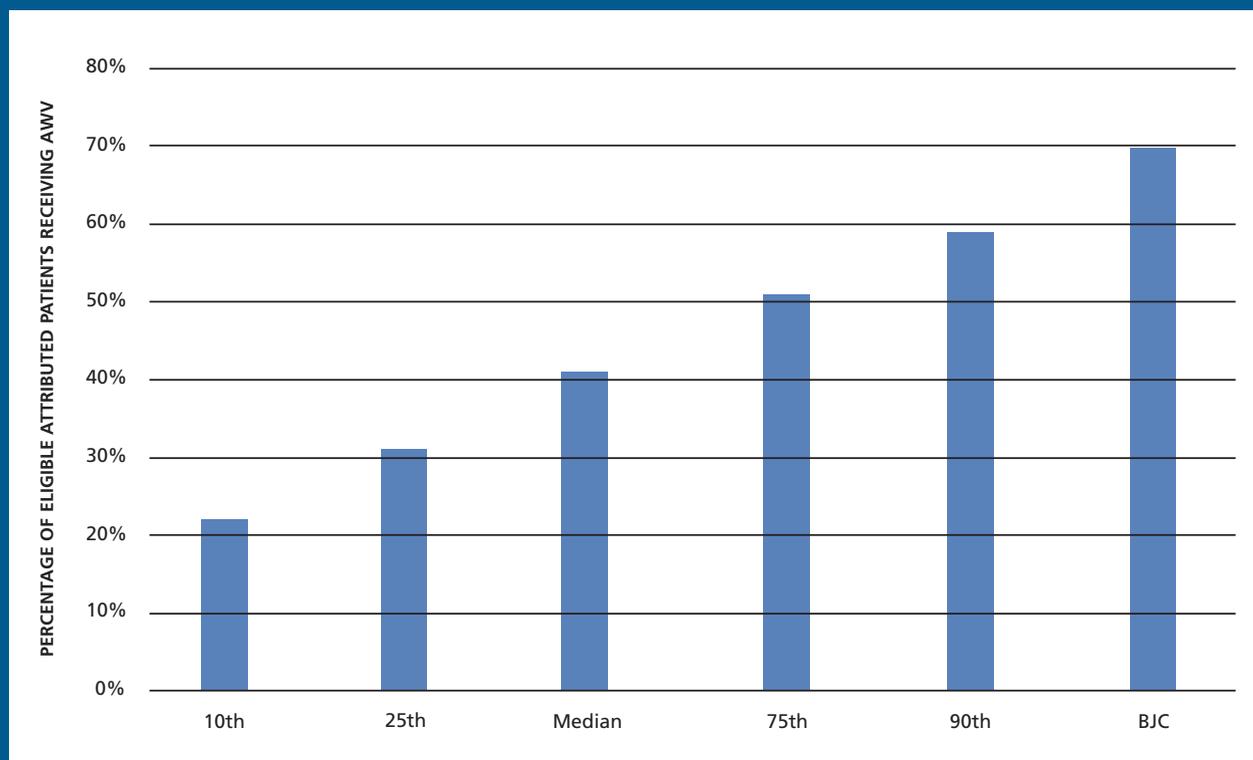
## RESULTS

In 2018, BJC conducted AWVs for 44.3% of eligible attributed patients. BJC set a goal of conducting an AWV for 50% of eligible attributed beneficiaries in 2019 following the implementation of these interventions. BJC was able to exceed its goal, conducting AWVs for 69.7% of eligible patients in 2019. This places BJC above the 90th percentile among ACOs participating in the Medicare Shared Savings Program ([Figure](#)) (Institute for Accountable Care, email communication, analysis of 2019 Medicare claims data for 517 MSSP ACOs, March 19, 2021).

In total, of the 129 primary care providers who have at least 50 eligible beneficiaries within the BJC ACO network, 112 met the individual goal of providing AWVs to at least 50% of eligible patients within the provider's patient panel. This equates to a total of 86.7% of providers meeting the established target.

## DISCUSSION

Because the overall rate of AWVs has been increasing at the national level from the inception of the AWV through 2017, it is difficult to ascertain the portion of the year-over-year increase in AWVs across BJC that is attributable to the

**Figure.** Distribution of 2019 AWW Rates for MSSP ACOs

ACO, accountable care organization; AWW, annual wellness visit; BJC, BJC Healthcare Accountable Care Organization; MSSP, Medicare Shared Savings Program.

Source: Institute for Accountable Care, email communication, analysis of 2019 Medicare claims data for 517 MSSP ACOs, March 19, 2021.

interventions discussed in this article. However, the magnitude of the increase (an absolute increase of 27% in AWW rates, or a relative year-over-year increase of 63%) suggests that the innovations were associated with benefits. Similar efforts to increase AWW rates at Bellin Health Partners yielded an increase from 43% of ACO-aligned beneficiaries having an AWW to 58% in the first year following the implementation of its innovations, and a further increase to 68% in the second year.<sup>11</sup>

BJC did not specify which provider needed to conduct the AWW; thus, AWWs may have been carried out by physicians, nurse practitioners, or physician assistants. Furthermore, different portions of the AWWs may have been conducted by different members of the team.

Although AWWs are designed to address preventive health and in theory should yield benefits in the setting of adequate time horizons, the overall utility of well-visit checkups in reducing mortality and improving outcomes has not been definitively demonstrated<sup>21</sup> and has long been a subject of debate. Another study examining the association of the AWW with health care quality, costs, and utilization demonstrated cost reductions associated with the AWW

and suggested that the greatest reductions in costs were achieved in the highest-risk segment of the population (using patient HCC calculations for risk stratification).<sup>9</sup> This may suggest that the allocation of resources toward higher-risk patients may yield proportionally greater returns on investment. Unfortunately, practices caring for higher-risk patients offer fewer AWWs, possibly as a consequence of resource limitations.<sup>14</sup> Utilization of the AWW has also been shown to vary by ethnoracial group (which the pertinent study defined as the social identification of a beneficiary based on their ethnicity, social background, and culture), with disparities largely explained by differences in income and education.<sup>22,23</sup>

### Limitations

To date, there have been few peer-reviewed studies that have explored the associations of the AWW with cost savings. Existing studies have analyzed cost impacts over a time horizon of no more than 24 months. Given the nature of the preventive measures included in the AWW, longer time frames may be necessary to more adequately evaluate the impact of the AWW on cost reductions and improvements in outcomes.

Additionally, as AWW rates are slowly increasing nationwide, a portion of the increases in AWWs may be attributable to external factors favoring the adoption of AWWs independent of the interventions adopted.

The identification and implementation of the AWW initiative required time and resources; although BJC did achieve its AWW goal, it is difficult to assess whether the associated focus on preventive health and increased revenue has, to date, ultimately provided value in keeping with the magnitude of the investment. This question may be better assessed as subsequent years demonstrate the durability of the improvements seen in AWW rates. If patients and providers perceive the AWW to be valuable and the efforts of BJC to decrease barriers to conducting the AWW are well received, AWW rates will remain high and the increases in revenue will continue to yield returns on the up-front investments.

Finally, BJC did not conduct formal data collection to directly assess patient or provider satisfaction with AWWs and the changes discussed herein. Accordingly, although the innovations were associated with a short-term increase in the rate of AWWs among eligible patients, impacts on patient perspectives and patient-provider relationships cannot be assessed presently.

### Future Directions

Given the demonstration of the potential for the AWW to reduce health care spending for higher-risk patients, both patients and practices may benefit from the application of resources toward addressing barriers that may prevent patients (especially those who are older and frailer) from attending their AWW, including transportation and technological solutions. Previous association between HCC score and the magnitude of cost benefit from AWWs highlights the importance of continuing to monitor costs and quality measures for patients in the coming years. Future data may suggest that AWWs may be particularly important for a certain subset of patients, and greater resources and incentives may be dedicated to delivering AWWs to those patients who stand to derive the greatest benefit.

Given that a physical exam is not required for completion of an AWW, a telehealth visit may be an effective way of administering the visit. Patients could be provided blood pressure cuffs and scales, as necessary, to facilitate the body mass index calculation and blood pressure measurement required by an AWW. Some providers are already conducting AWWs via telehealth; additional consideration may be given to this possibility pending further guidance from CMS, especially as telehealth solutions continue to gain traction among patients and providers.

Assessing patient perspectives and satisfaction may also provide valuable insight. Patient satisfaction scores could be compared to assess whether certain aspects of the AWW are associated with greater satisfaction; for example, whether mode

of delivery (in person or telehealth), the provider conducting the visit (eg, nurse, pharmacist, physician), length of visit, or whether the patient is co-billed for acute problems may affect the patient's perspective and perceived utility of the AWW.

### CONCLUSIONS

ACOs strive to provide patients with the proper care at the right time while reducing unnecessary costs and services. AWWs represent tremendous opportunities for ACOs to move toward meeting these objectives for patients. Efforts by BJC to increase the uptake of AWWs focused broadly on increasing the ease of scheduling AWWs and improving the efficiency and convenience of conducting an AWW. These efforts included increased communication, organizational support, and technological innovations, and they were associated with significant increases in AWWs in the first year following implementation. In the coming years, BJC will continue to monitor AWW rates to evaluate the durability of the improvements from the implemented changes and seek to assess effects on costs and the quality of care associated with the provision of the AWW.

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**BJC** Medical Group

## Medicare Annual Wellness Visits

Taking Charge of Your Health Has Never Been Simpler

### What is an Annual Wellness Visit?

An annual wellness visit is a preventative check-up that is a dedicated time for physicians and patients to discuss procedures, immunizations, and health screenings that you need to remain healthy. This visit is highly recommended by the American Medical Association, and preventative care screenings are covered by most insurances. There is an exception however of any older, existing plans grandfathered in that do not have to cover in full for these services.

### What is usually included in a Medicare Annual Wellness Visit?

- A conversation about your medical and family history
- Measurement of height, weight, body mass index, blood pressure and other measurements as deemed appropriate by the medical/family history
- Establishment of a list of current providers who are involved in your medical care
- Review of potential risk factors for depression
- Establishment of a written screening schedule, such as a checklist for the next five to 10 years

### What is not included in a Medicare Annual Wellness Visit?

A Medicare Annual Wellness Visit is not necessarily a complete physical\*, and it does typically not include:

- Medication refills
- Problem visits
- Testing
- Medical treatment

If you require medication refills or have other health issues that need to be addressed, we may suggest that you make an appointment for these conditions and schedule your Annual Wellness Visit at another time. Or if we schedule both for the same day, then you will be charged for the problem visit or other office visit service. This is a different service and is billed to your health plan in addition to the preventative services on that day. If you have a co-payment for office visits, coinsurance or deductible amounts that you must pay before your health plan pays for these services, these would apply.

*\*Medicare patients who are new to the insurance (6 months or less) are allowed a one-time Welcome to Medicare (IPPE) exam. This exam is more comprehensive and includes several types of tests.*

### When should I schedule a Medicare Annual Wellness Visit?

We recommend that you contact your physician early in the year to schedule this visit. It's important to start out the year on the right foot with healthy habits, and your physician can help you live your best possible life.

If you have any additional questions about preventative care or annual wellness visits, please talk to your physician or physician's office.