POM ACO Course: Session 1 - ACO Basics

September 10, 2024



POM ACO
TRANSFORMING HEALTH CARE TOGETHER

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

My Michigan
Collaborative Care Organization

Metro Health
Integrated Network

Northern Michigan
Care Partners

OSP
POWERED BY ADMINISTRATIVE NETWORK

UNIVERSITY OF MICHIGAN
HEALTH-SPARROW

Welcome to Value-Based Care Essentials: The Role of ACOs!

- Course comprised of four sessions*, covering essential topics related to ACOs, including MSSP overview, coding, documentation, care management, and quality measures.
- After the activity, participants will be able to understand the role of ACOs and their functions, as well as apply knowledge learned in the course to better serve patients and fulfill CMS requirements.

Session 1: ACO Basics
September 10, 2024
11 am – 1 pm

Session 2: ACO Quality Measures Essentials
September 25, 2024
11 am – 1 pm

Session 3: Managing the Care of ACO Beneficiaries
October 8, 2024
11 am – 1 pm

Session 4: Specialists and ACO Beneficiaries
October 23, 2024
11 am – 1 pm

**1.75 CE Credits for each session attended*

(7 CE credits for all 4 sessions)

Today's Session

Objectives

- ✓Understanding value-based care and the main goals of ACOs
- ✓Understanding risk scoring and how it impacts ACO performance
- ✓Learning documentation requirements to support appropriate coding
- ✓Learning about the importance of the Medicare Annual Wellness Visit and its components

Speakers

- David Serlin, MD, FAAFP
  Medical Director, POM ACO
- Deanna Bachman, BS, RN
  Manager, Program Development for Sparrow Health System

Introduction to MSSP and ACOs

David Serlin, MD, FAAFP

What is Value Based Care?

- Value based care is a healthcare delivery framework that reimburses health care providers for the quality and outcome of care in lieu of the volume of care provided.

The Quadruple Aim of Healthcare



Value-Based Health Care Benefits

Patients	Providers	Payers	Suppliers	Society
Lower Costs & Better Outcomes	Higher Patient Satisfaction Rates & Better Care Efficiencies	Stronger Cost Controls & Reduced Risks	Alignment of Prices with Patient Outcomes	Reduced Healthcare Spending & Better Overall Health

Historical Equation

Value = Quality / Cost

Expanded Equation

Value = (Quality + Outcomes + Patient Experience + Equity) / Cost

The Transition from Volume to Value

Anatomical markers of fee-for-service (FFS) vs. value-based care (VBC)

	Fee-For-Service Model **Paid for Volume** An economic model driven by utilization and fee-for-service reimbursement	***Value-Based Model*** **Paid for Value** An economic model driven by lives and the cost of care to provide desired outcomes
Physician Role	Referral generator focused on specialty care	Manager of comprehensive patient health
Hospital Role	Profit centers	Cost centers
Patient Acquisition	Broad referral network	Defined attributed population
Revenue Source	IP admissions, procedures, OP encounters, & above market FFS rates	Capture premium dollar, growing lives, reducing spend, & improving clinical outcomes
Margin Driver	Strategically distributed acute care platform & hospital efficiency/ clinical standardization	High-performing medical management
Core Competencies	Hospital operations, FFS rate negotiation, Mergers & Acquisitions, marketing, revenue cycle	Care Mgmt., In-Network Utilization, PAC & Transitions, Hospital Efficiency, Coding & Documentation, Data & Analytics, Disease Mgmt.

What is an Accountable Care Organization (ACO)?

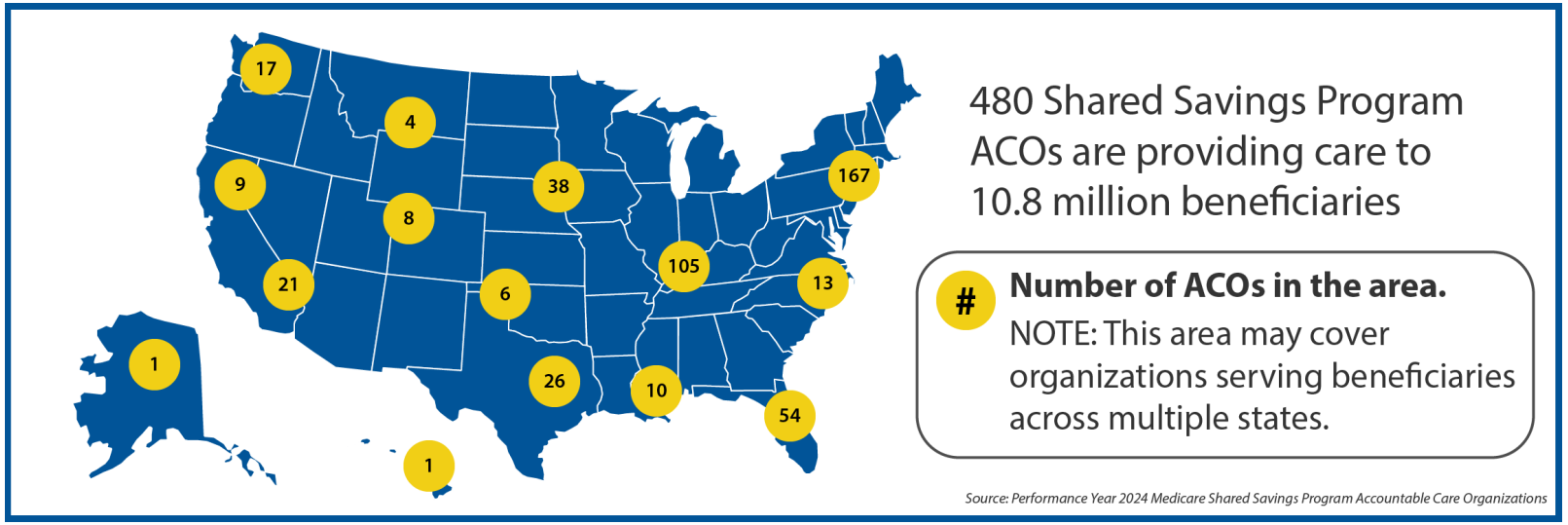
- ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to an assigned Medicare fee-for-service beneficiary population.
- Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. In certain models, ACOs may also be liable to pay back losses if their costs exceed their spending benchmarks.
- CMS makes data on Shared Savings Program ACOs publicly available through several resources, including Data.CMS.gov.

What are the goals of ACOs?

- ACOs focus on **keeping patients healthy**, rather than waiting until they get sick to get care.
- ACOs enable health care providers to work as a team to **coordinate care and better manage chronic conditions**.
- ACOs aim to **lower costs by avoiding unnecessary services or duplicate tests**, helping patients find affordable treatment options (like lower cost prescriptions, telehealth appointments, or connections to assistance programs).
- ACOs support patients and their families and caregivers by **coordinating follow-up care** and ensuring care plans meet their needs and preferences.
- **Through coordinated care, doctors are able to keep patients healthy and out of the hospital, thereby spending less money on health care.**

What is the Medicare Shared Savings Program?

- Medicare has several ACO programs that participants can choose to participate in.
- The Medicare Shared Savings Program (MSSP) is the primary Medicare ACO program. The MSSP was derived from the Physician Group Demonstration Project, which started during the George W. Bush administration, and the MSSP was permanently authorized by the Affordable Care Act.
- The Shared Savings Program has different participation tracks that allow ACOs to select an arrangement that makes the most sense for their organization.



Key Aspects of the Medicare Shared Savings Program

1. **A Population Management Incentive System**
Medicare's voluntary Shared Savings Program (SSP) enables groups of providers forming accountable care organizations (ACOs) to earn bonuses if they can keep total population health expenditures below a target benchmark.

2. **Primary Care at the Heart of the ACO**
Medicare ACOs will be structured around primary care groups but may include other providers, including hospitals and health systems, who agree to accept utilization risk for a population of patients defined by their primary care utilization.

3. **Program Options With, Without Risk**
Participating providers have two program options to choose from: a financial model with exclusively upside potential for all three years, or a model that involves downside risk in all three contract years in exchange for a more-favorable shared savings rate.

4. **Benchmarks Based on Historical Performance**
An ACOs target expenditure benchmarks will be tied to the historical service utilization of that ACO's patients. The target benchmark will be updated annually by the average national growth in per-beneficiary Medicare expenditures, enabling low-growth providers to more easily achieve shared savings payments.

5. **Preliminary Prospective Assignment Supplemented by Beneficiary-Identifiable Data**
Although an ACO's patient population will still be attributed retrospectively, CMS will make available prospective predictions of those patients. CMS will also provide ACOs regular access to continuum-spanning patient data, unless patients specifically opt to prohibit such data sharing.

6. **No Restrictions on Patient Choice or Transparency**
Although patients are attributed to ACOs for the purposes of shared savings calculations, providers may not restrict patient provider choice in any way; all patient-centered ACO marketing materials must be approved by CMS, and patients will be notified of their PCP's participation in SSP.

7. **Shared Savings Payments Adjusted for Quality Performance**
ACOs will be evaluated on ACO specific quality measures, and the shared savings earning potential will be tied to an aggregate performance standard. Performance measures will be assessed both on an absolute basis and relative to other providers.

8. **Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR)**
The Minimum Savings Rate and Minimum Loss Rates are thresholds, calculated as a percentage of the ACO's historical benchmark. The ACO must meet or exceed to share in savings or to be liable for shared losses.

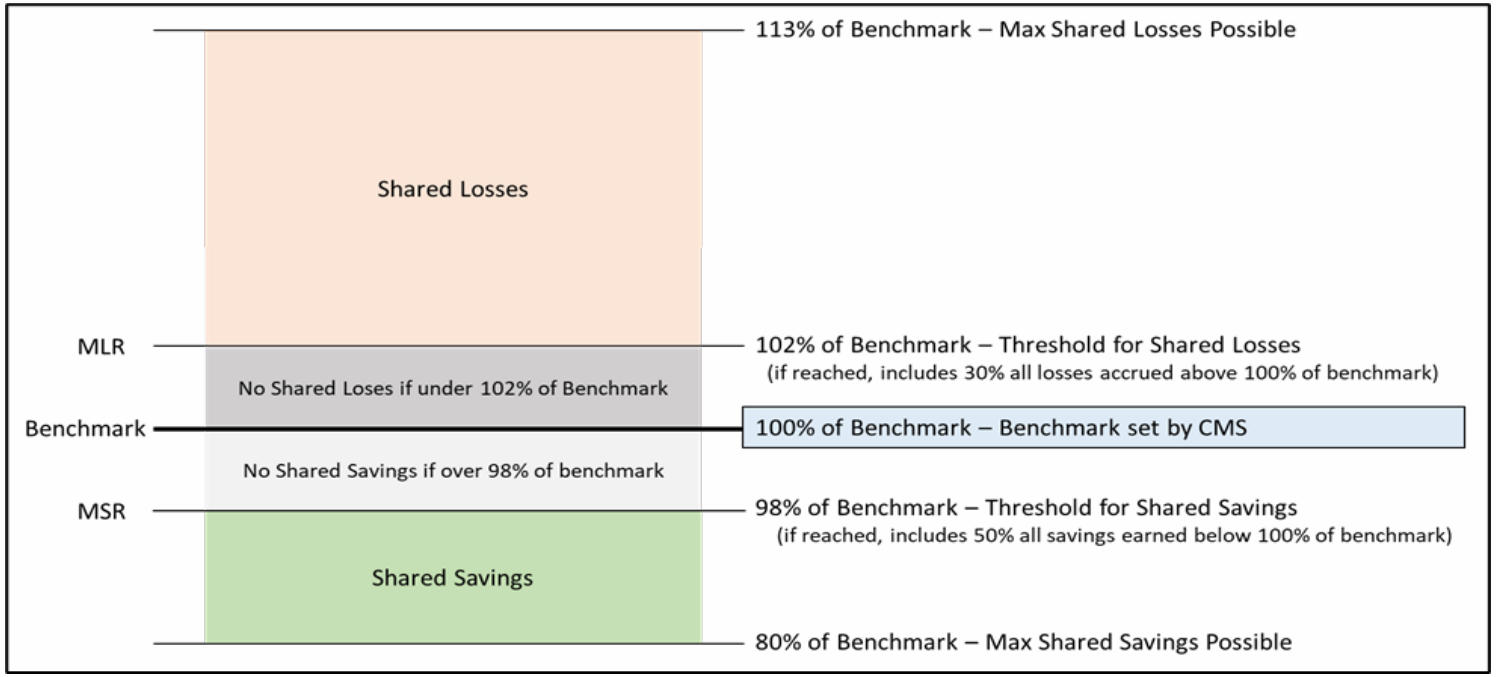
ACO Providers and Suppliers

Eligible ACO providers and suppliers that may participate in the Shared Savings Program include:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Critical Access Hospitals (CAHs) that bill under Method II
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Teaching hospitals that have elected to receive payment on a reasonable cost basis for the direct medical and surgical services of their physicians

ACO Shared Savings / Shared Losses

- CMS calculates benchmarks for each ACO. The benchmark is based on the current participating TINs in the ACO, and their historic performance in those benchmark years for their Medicare beneficiaries at that time.
- At the end of a performance year CMS compares the updated historical benchmark to an ACO's assigned beneficiaries' per capita expenditures during the year.



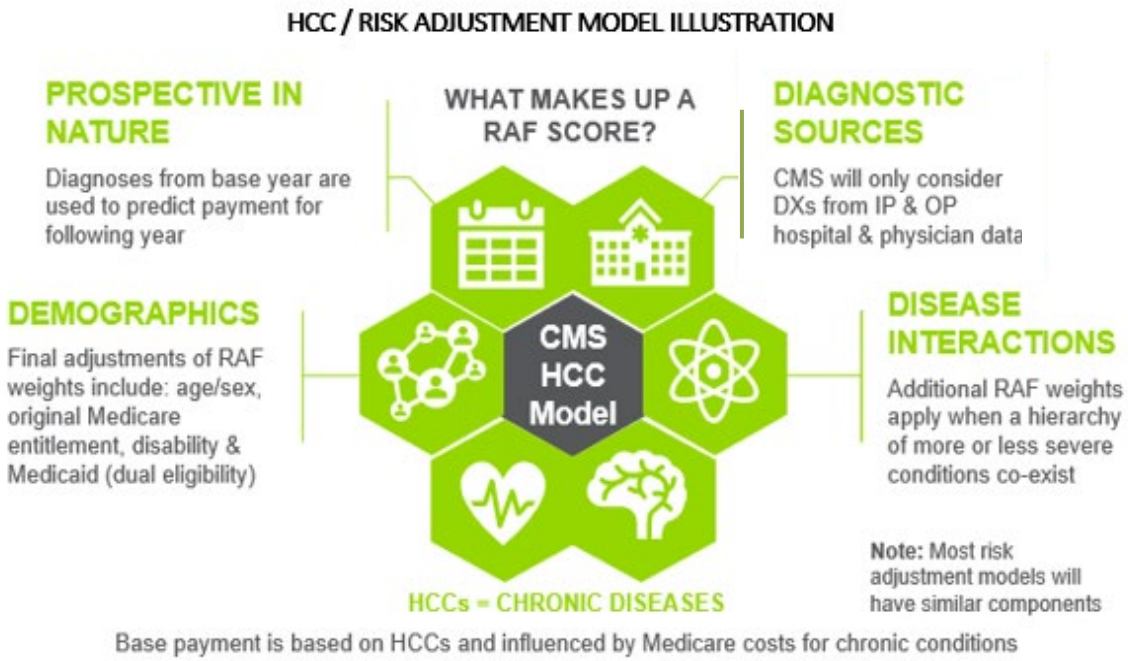
Hierarchical Condition Category (HCC) Coding

Deanna Bachman, BS, RN

What are HCCs?

- Hierarchical Condition Categories (HCCs) are a set of diagnostic based categories designed to map to coefficients developed by CMS annually. These coefficients are assigned to clinical diagnoses within the HCC category assigned. The diseases within each HCC are similar in clinical complexity and expected annual care cost.

- 'Risk score' or risk adjustment factor (RAF) is the sum of the score, or weight attributed to each of the demographic factors and HCCs within the model supporting the diagnostic acuity—which is done at individual or population levels
- CMS uses HCCs to:
  - Reimburse Medicare Advantage plans based on their current member's health and;
  - Measure acuity of populations within the Medicare ACO program to predict / project total cost of care needs and targets for ACOs



What are HCCs?

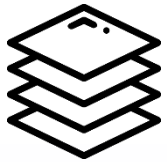
- HCCs represent costly chronic health conditions, as well as some severe acute conditions
- As of 2020, there were 86 HCCs, arranged into 19 categories-which incorporate 9,700 + ICD10 codes. In 2024 there are 115 HCCs, including 7770 individual ICD-10 codes
- Some of the top HCC categories include major depressive and bipolar disorders, asthma and pulmonary disease, diabetes, specified heart arrhythmias, congestive heart failure
- The following are NOT associated with HCCs:
  - Fee schedule within fee for service Medicare
  - CPT Codes (Procedures, evaluation, and management services)
  - ICD-10 PCS (Inpatient procedure codes)
  - Some ICD-10 diagnostic codes are not associated with HCC. Not all dx codes link to HCCs—many / most unspecified codes do NOT map to ICD-10 codes which is why level of specificity in diagnostic coding is so important
- Considerations:
  - While it is possible to capture HCCs in the IP setting, the heavy majority of HCCs are captured in the ambulatory setting
  - Primary care is uniquely positioned to capture HCCs, but there is a role for specialists to play in this effort as well specifically those where key acute and persistent conditions are treated (e.g., oncology, cardiology, endocrinology, pulmonology, etc.)

How HCCs and RAF Score works



RAF Score is made up of three main components

- Demographic information (Age, gender, disability status, etc.)
- Medicaid eligibility (dual status)
- Chronic conditions and disease interactions (HCCs)



HCCs are cumulative throughout the year

- Patients can have multiple HCCs assigned throughout the year by different providers and specialties
- HCCs can be captured during inpatient and outpatient encounters, but the heavy majority are assigned in the ambulatory environment



On January 1st, Medicare resets HCCs back to 0

- Chronic Condition HCCs need to be recaptured year-over-year to appropriately capture and identify a patient's disease burden
- The MA and ACO HCC model is prospective, meaning that it estimates costs for Medicare beneficiaries in the following year



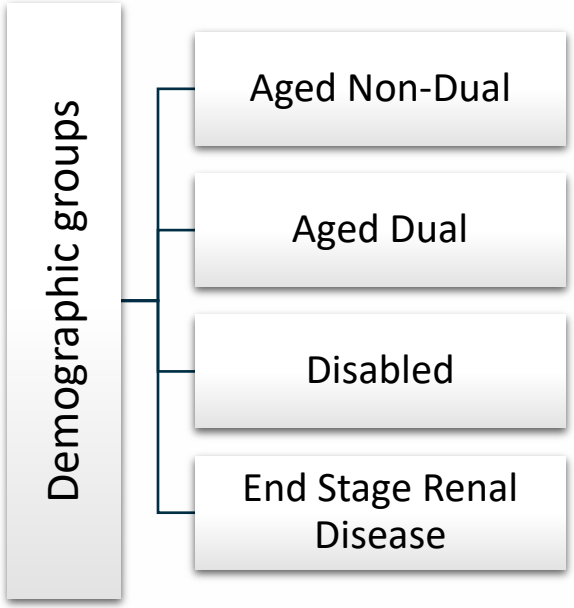
The average CMS patient has an approximate RAF score of 1.00

- Lower RAF scores tend to represent a lower chronic disease burden; & vice versa
- Disease interactions will also increase patient RAF Score
- Not every chronic condition maps to an HCC
- CMS rebases risk scores each year

MSSP Risk Adjustment Process

ACO's participating in MSSP have Financial accountability for their attributed Medicare beneficiary population's medical expenditures. Other Value Based programs have similar mathematical processes. HCC's Risk Score are calculated annually prospectively. This year's HCC scores will be used for next performance year's benchmark adjustment.

1. Assign Demographic Groups



2. Calculate Risk Ratio

1. Beneficiary Risk Score = HCC Risk scores are calculated for each attributed beneficiary
2. Demographic risk score = Average HCC risk score for each demographic group
3. Risk ratio = Beneficiary Risk Score/ Demographic Risk Score

3. Adjust Financial Benchmark

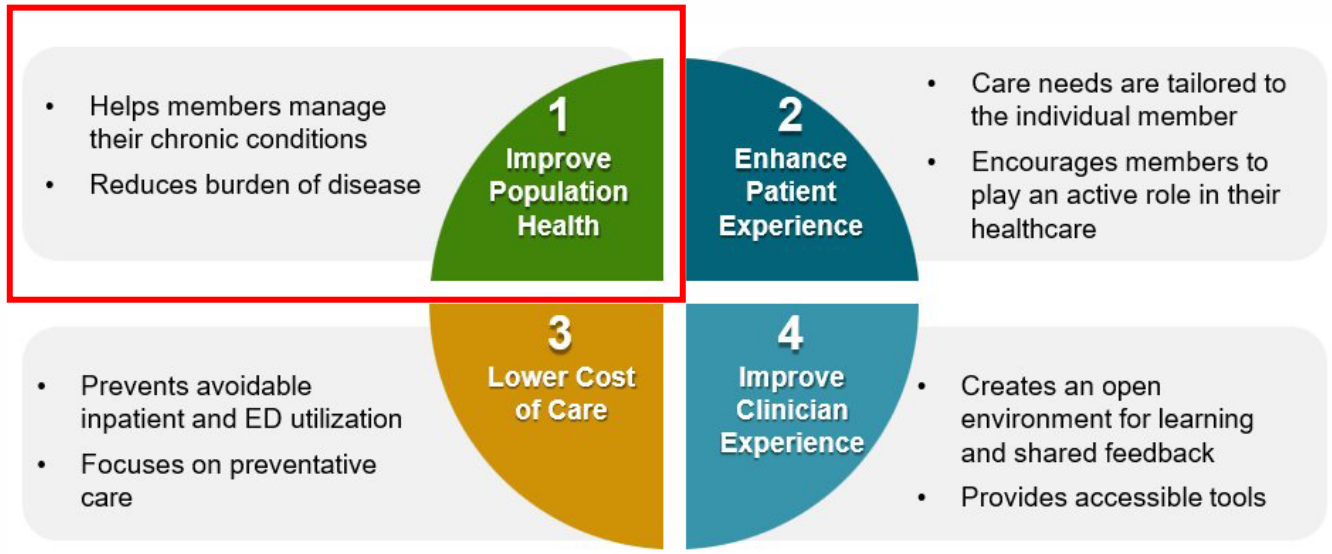
1. Benchmark is adjusted based upon each demographic groups risk ratio
    1. Risk ratio >1 financial benchmark will increase
    2. Risk ratio < 1 financial benchmark will decrease
2. MSSP only allows a total 3% positive adjustment over the contract term

HCC/ RAF Impact on ACOs

- The burden of illness as defined by a population's RAF score is a direct driver of how the total cost of care target is calculated. If full burden of illness is not represented accurately, the total cost of care target will be underestimated, making it difficult for organizations to earn shared savings
- ACO based care emphasizes high quality-lower cost and preventive patient care. Rather than be reimbursed for each test ordered, providers have incentives to collaborate and reduce redundant care.
- Hierarchical condition category coding helps communicate patient complexity and paints a picture of the whole patient's health profile. Also enables risk stratification which is used by population health programs to target care coordination and other augmented care to patients.
- In addition to helping predict health care resource utilization, RAF scores are used to risk adjust quality and cost metrics. By accounting for differences in patient complexity, quality and cost clinical performance can be more appropriately measured.

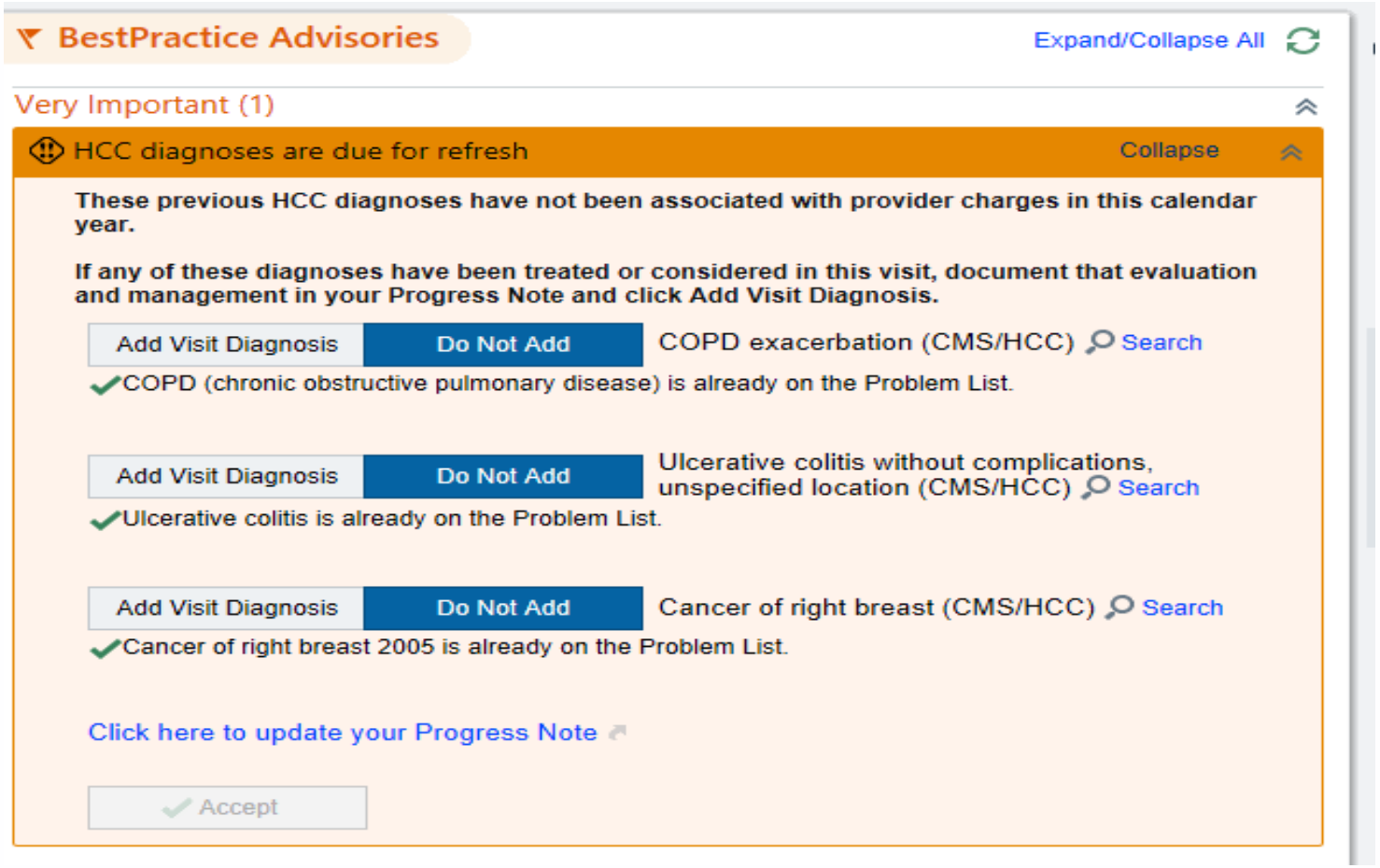
HCCs & The Quadruple Aim

- Coding patients appropriately is important to showcase patient complexity and paint a picture of the whole patient.
- Accurate coding and documentation ensures that patients are flagged for wrap around services, quality gap closure efforts, or clinical intervention when needed to provide the highest quality of care.
- If HCCs are not represented accurately, the total cost of care target will be underestimated, making it difficult for organizations to earn shared savings



Managing Risk with Decision Support

- Decision support is real time notification that reminds clinicians of best practices they should follow in clinical decision making
- Most EHRs have built in decision support, and there are many third party vendors that interact with EHRs.
- As well as suggested ICD dx that map to HCC's using discrete EHR data and/or AI/natural language processing.



Disease Interactions: Impact on HCCs

- Any HCC can only be counted once in a calendar year
- Disease interaction is a component of the CMS-HCC model that allows for higher risk scores for certain conditions in the presence of another disease or demographic status (e.g., disabled status) as an indication of higher costs
  - For example, congestive heart failure (CHF) and atrial fibrillation have a disease interaction, resulting in an additional risk factor (weight) in addition to the HCC for CHF and cardiac arrythmia
  - As a result, the patient will have a higher RAF score

Examples of Disease Interactions

- DM and CHF
- DM and CVD
- CHF and COPD
- COPD, CVD, and CAD
- Resp Failure and CHF
- Resp Failure, CHF, and DM

Disease Interactions: Example

- The CMS-HCC Model recognizes disease interactions between CHF*DM and CHF*COPD. As a result, the patient's total RAF score is greater than the sum of their individual HCCs.

Risk Score Components	ICD-10	HCC	RAF
65-Year-Old Female (Demographics)			0.323
Malignant Neoplasm of Bladder	C67.9	011	0.301
DMII with Nephropathy	E11.21	018	0.302
Angina	I20.9	088	0.135
Emphysema	J43.9	111	0.335
Congestive Heart Failure	I50.9	085	0.331
Thrombocytopenia	D69.6	048	0.192
*Disease Interaction: CHF*DM*			0.121
*Disease Interaction: CHF*COPD*			0.155
Total			**2.195**

Without disease interactions, the patient's RAF score adds up to 1.919

Note- example coefficients only for reference, relative to average Medicare beneficiary RAF=1.0

Common HCC Values- Example Weighting

- Morbid Obesity (w/ Comorbidities) 0.250
- Diabetes Type 2 w/o or w/ Complications 0.105/0.302
- Chronic Kidney Disease Stage 3B 0.070
  - Stage 4/5 0.289
- Major Depressive Disorder 0.310
- Congestive Heart Failure 0.331
- Chronic Obstructive Pulmonary Disease 0.335
- Atrial Fibrillation 0.295



Common Primary Care Encounters: HCC Example

- Patient with type 2 diabetes presents for routine follow up
- HbA1c is 8.3
- Has stable COPD on home oxygen
- Needs DME paperwork renewal for his home oxygen

ICD-10	Description	Example RAF
J44.9	COPD	.328
E11.9	DM Unspecified	.118
Total Risk =		.446

The average Medicare member is around a 1.0 risk score.

ICD-10	Description	Example RAF
J 44.9	COPD	.328
Z99.81	Oxygen Dependent	
J96.11	Chronic Respiratory Failure w/ Hypoxia	.318
E 11.65	DM with hyperglycemia	.318
Total risk=		.964

Note- example coefficients only for reference, relative to average Medicare beneficiary RAF=1.0

Common Primary Care Encounters: HCC Example

- 56-year old with hypertension and hyperlipidemia
- BMI 36.4
- OSA with CPAP, well controlled

ICD-10	Description	Example RAF
I10	Hypertension	
E78.5	Hyperlipidemia	
G47.33	Sleep Apnea	
Total Risk =		0

The average Medicare member is around a 1.0 risk score.

ICD-10	Description	Example RAF
I 10	Hypertension	
E78.5	Hyperlipidemia	
G47.33	BMI 37-37.9	
E 66.01	Morbid obesity	.273
Total risk=		.273

Note- example coefficients only for reference, relative to average Medicare beneficiary RAF=1.0

Common Primary Care Encounters: HCC Example

- 66-year old with Type 2 diabetes and polyneuropathy
- HbA1C 7.4
- Had toe amputation several years ago after infection
- Smokes ½ PPD x 30 pack years
- Needs refills of his DM meds and wants to try Chantix

ICD-10	Description	Example of
E 11.9	DM Unspecified	.118
F17.219	Nicotine Dependence/Cig	
Total Risk=		.118

The average Medicare member is around a 1.0 risk score.

ICD-10	Description	Example of
E11.41	DM w/Polyneuropathy	.318
F17.419	Nicotine Dep/cig	
Z89.412	Acquired loss L great toe	.588
Total Risk=		.906

Note- example coefficients only for reference, relative to average Medicare beneficiary RAF=1.0

Common Primary Care Encounters: HCC Example

- 67-year old with HTN and history of colon cancer for AWV
- Acute complaint of congestion and upper respiratory symptoms
- s/p colostomy and needs DME paperwork for supplies

ICD-10	Description	Example RAF
J06.9	Upper Respiratory Infection	
I10	Hypertension	
Total risk=		0

ICD-10	Description	Example RAF
J06.9	Upper Respiratory Infection	
I10	Hypertension	
Z93.3	Colostomy status	.651
Total Risk=		.651

Note- example coefficients only for reference, relative to average Medicare beneficiary RAF=1.0

More accurate RAF, more accurate cost projections



Capture basic demographics
85-year-old female
Lack of specific documentation and coding
RAF limited to demographics

Total RAF	0.641
Annual HealthPlan Payment	$6,003.29
Annual Patient Cost	$16,453.31
MLR	**274%**



Capture reason for most recent visit
85-year-old female
- ✓ Diabetes without complications
- ✓ UTI
- ✓ CKD unspecified
- ✓ Cough
- ✓ Current smoker
- ✓ PVD

Total RAF	1.034
Annual HealthPlan Payment	$9,683.93
Annual Patient Cost	$16,453.31
MLR	**170%**



Capture complete clinical information
85-year-old female
- ✓ Diabetes with CKD
- ✓ UTI
- ✓ CKD Stage 3B due to diabetes
- ✓ Diabetes with peripheral angiopathy
- ✓ Smoker's cough
- ✓ H/O toe amputation
- ✓ Dependence of nicotine

Total RAF	2.196
Annual HealthPlan Payment	$20,566.64
Annual Patient Cost	$16,453.31
MLR	**80%**

One member. Three different coding scenarios

Supporting Documentation & Specificity

- Greater documentation detail allows for greater coding specificity
  - Coders can’t assume diagnoses – they must be stated
- Specify the relationship between conditions, including underlying causes
  - Especially for diabetic complications
- Document everything addressed at visit
- If conditions impact medical decision making, document!
  - Can’t code from past problem lists; conditions involved in MDM must be documented with the visit



Documentation Examples

- No risk adjustment for overweight or obesity
- Morbid obesity does get risk adjusted
  - Coders must rely on documentation from providers; code cannot be assigned from BMI alone
  - If provider documentation says ‘obese’ or ‘morbidly obese’, that is the code that should be assigned regardless of BMI
  - Besides stating ‘morbid obesity’, BMI and comorbidities should support the dx within the documentation
  - Morbid obesity can be coded if it impacts MDM, even if not the purpose of visit
- Diabetes
  - Coders can’t make assumptions from medications, blood sugar levels, or A1C
  - Provider must say type of diabetes, uncontrolled, hyperglycemia, etc in documentation
  - Complications should be explicitly related to diabetes, if applicable
- Obesity and diabetes can be coded if they are documented as impacting MDM, even if not the purpose of visit

When to Use ‘History of’ Codes

- ‘History of’ Codes
  - Stroke: use ‘history of’ anytime after discharge from inpatient treatment for a stroke
    - Use codes under I69 – Sequelae of cerebrovascular disease for rehab or other post-acute care
  - MI: Use I21- Acute myocardial infarction within 4 weeks of event
    - Otherwise I25.2 Old myocardial infarction
    - Documentation should include timing
  - Cancer: ‘history of’ used when cancer free / no evidence of disease, even if undergoing preventative treatment (ex. Tamoxifen or aromatase inhibitors)



Active vs. History of Cancer

- If cancer is documented **as present**, coding isn't dependent on treatment status; code as **active** cancer
  - Curative or palliative treatment
  - Unresponsive to treatment
  - Observation / watchful waiting
  - Opted for no treatment
  - Ex: C50- malignant neoplasm of breast
- **In remission**: coded as active cancer as long as no contradictory documentation
- Coded as '**history of**' when documentation states
  - No evidence of disease
  - Cancer free
  - Past/prior cancer
  - Ex: Z85.3 personal history of malignant neoplasm of breast
- Routine **surveillance** post-cancer should be coded using 'history of'
- Document intent of adjuvant therapy: curative, palliative, or preventative
  - Preventative may be coded as 'history of' cancer if intent is to keep cancer from reoccurring after NED
- Coding 'history of' doesn't mean the cancer can't be coded as active again; recurrence can be coded as active

Documentation Best Practices

David Serlin, MD, FAAFP

Ensuring your Documentation has M.E.A.T.

What is M.E.A.T and what are the documentation requirements?

In addition to selecting the HCC diagnosis as an encounter diagnosis, you must document the associated "assessment & plan" to aid in clear communication of how you managed and treated the condition.

The assessment & plan can accurately be documented using the "M.E.A.T" criteria as recommended by CMS:

- **M** **Monitoring** signs, symptoms, disease progression, disease regression
- **E** **Evaluating** test results, medication effectiveness, response to treatment
- **A** **Assessing/Addressing** ordered tests, discussion, review records, counseling
- **T** **Treating** medications, therapies, other modalities

Best Practice: Prospective Clinical Review

- Clinical coding specialist reviews patient charts within EMR to identify any documentation and coding gaps and documents recommendations for clinically appropriate diagnoses to be used based upon patient medical history and data analytics
- Coding resource delivers / communicates recommendations to provider to address during encounter with the patient (i.e. EMR, HTML, secure messaging)
- Gaps and suggested diagnoses are included in problem lists / Best Practice Alerts (BPAs)
- Best Practices:
  - Focus on opportunities for few / select providers and provide intensive review and education for targeted impact
  - “Clinically intuitive” recommendations in prospective review
  - Conducting focused education / discussions with clinicians
  - Potential to conduct reconciliation between pre-service opportunities identified and codes utilized

Best Practice: Point of Service
Review and address documentation/coding gaps during the patient's encounter

- Key Activities:
  - Provider reviews identified documentation and coding gaps and suggested diagnoses from pre-service review and or EMR-based problem list / Best Practice Alert (if applicable)
  - Provider addresses gaps by appropriately coding and documenting and coding clinically appropriate / applicable diagnoses
- Best Practices:
  - Providers leverage pre-service review recommendations
  - BPAs are deployed for highest priority coding gaps
  - Provider must address whether they agree or disagree with suggested diagnosis codes, mark as persistent or resolved
  - Providers required to address all coding gaps and suggested codes based on clinical review.
  - Coding resource conducts reconciliation between coding recommendations and codes applied to record for validation / education for select providers

Annual Wellness Visits

David Serlin, MD, FAAFP
Medical Director, POM ACO

Annual Wellness Visits

- A Medicare Annual Wellness Visit (AWV) is a yearly appointment where a patient partakes in a comprehensive review with their provider, emphasizing preventative care and screenings.
- AWVs visits differ from an annual physical in that an AWV does not require a “hands on” exam and they also come at no cost to the patient
- The Annual Wellness Visit is only for preventive care and not for the diagnosis and treatment of an illness. If patients want to discuss a specific health problem with their doctor, they need to schedule a separate appointment. There could be a separate charge for managing other conditions during an AWV.
- The Medicare AWV can be scheduled once every 366 days

Who Can Provide an AWV?

- Physician
- Physician Associate
- Nurse Practitioner
- Clinical Nurse Specialist (CNS)
- Pharmacists, psychologists, social workers, nurses, or other licensed medical professionals can perform AWVs with direct provider supervision



Services covered during AWVs

- Review a patient's blood pressure, heart rate, height, weight, and body mass index (BMI)
- Conduct a health risk assessment
- Discuss preventive and screening recommendations (cancers, AAA, vaccinations)
- Review potential depression risk factors
- Provide nutrition counseling, fall prevention, smoking cessation and arrange for counseling, if necessary
- Review a patient's current health problems, as well as their medical, surgical, family, and social histories
- Review patient's current medications
- Discuss an exercise plan to fit a patient's lifestyle
- Advance Care Planning





AWV Billing Codes

- The following codes can be used to bill for an Annual Wellness Visit:
  - G0438: Annual wellness visit; includes a personalized prevention plan of service (PPS), **initial** visit
  - G0439: Annual wellness visit, includes a personalized prevention plan of service (PPS), **subsequent** visit
  - G0468: Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV
- G0438 or G0439 can only be billed once in a 12-month period. G0438 is for the first AWV, and G0439 is for subsequent AWVs. G0438 or G0439 cannot be billed within 12 months of a previous G0402 (IPPE) billing for the same patient.

Benefits AWVs have for ACO & Physician Offices

1. Capture/renew diagnosis codes (HCCs) for risk scores if completed by an eligible provider, or document patient feedback for eligible provider to document at subsequent visit
2. Facilitate beneficiary attribution to the ACO, particularly for healthy beneficiaries who do not use a lot of care or for those primarily utilizing specialty services during the year
3. Gap closure of quality metrics
4. Prevent disease progression or acute episodes of care
5. Promotion of vaccinations and cancer screenings
6. Ensure understanding of medications to increase adherence
7. Identify any barriers/issues with care (ADLs, SDOH, etc.) and connect to community resources
8. Address all preventative service recommendations

AWVs & The Quadruple Aim

- Annual Wellness Visits intersect with each of the 4 branches of the Quadruple Aim



Evolution of AWVs

- In 2011, Medicare introduced the annual wellness visit to expand coverage of preventive health services to older adults.
  - Prior to this, Medicare never covered a routine yearly physical. However, this developed into a routine health maintenance/preventive care visit as there is no requirement for an actual hands-on physical exam.
- Advance Care Planning and Social Determinates of Health assessments have recently been added as components to annual wellness visits.
- Dual AWV and E/M visits can be billed together and are beneficial to the patient and provider since they allow for the immediate intervention on medical conditions which could potentially become more serious later on.

AWV Components

1. Perform the health risk assessment (HRA)
2. Establish the patient's medical and family history
3. Establish a current providers and suppliers list
4. Measure height, weight, BMI and blood pressure
5. Detect any cognitive impairments
6. Review the patient's potential depression risk factors
7. Review the patient’s functional ability and level of safety
8. Establish an appropriate patient written screening schedule
9. Establish the patient’s list of risk factors and conditions
10. Provide personalized patient health advice and appropriate referrals to health education or preventive counseling services or programs
11. Provide advance care planning (ACP) services at the patient’s discretion
12. Review current opioid prescriptions
13. Screen for potential SUDs
14. Social Determinants of Health (SDOH) Risk Assessment



AWV Components Breakdown

Component	Details
Establish the patient's medical and family history	Document the following: • Medical events of the patient's parents, siblings, and children, including hereditary conditions that place them at increased risk • Past medical and surgical history (illnesses, hospital stays, operations, allergies, injuries, and treatments) • Use of, or exposure to, medications, supplements, and other substances the person may be using
Establish a current providers and suppliers list	Include current patient providers and suppliers that regularly provide medical care, including behavioral health care
Measurement	Measure: • Height, weight, body mass index (BMI) (or waist circumference, if appropriate), and blood pressure • Other routine measurements deemed appropriate based on medical and family history

AWV Components Breakdown

Component	Details
Detect any cognitive impairments patients may have	Assess cognitive function by direct observation or reported observations from the patient, family, friends, caregivers, and others. Consider using brief cognitive tests, health disparities, chronic conditions, and other factors that contribute to increased cognitive impairment risk.
Review the patient's potential depression risk factors	Depression risk factors include: • Current or past experiences with depression • Other mood disorders Select from various standardized screening tools designed for this purpose and recognized by national professional medical organizations. APA's Depression Assessment Instruments has more information. • Best practice is to use PHQ-9 for screening • Make sure results are documented

AWV Components Breakdown

Component	Details
Review the patient's functional ability and level of safety	Use direct patient observation, appropriate screening questions, or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the patient's: • Ability to perform ADLs • Fall risk • Hearing impairment • Home and community safety, including driving when appropriate
Establish an appropriate patient written screening schedule	Establish or update the written screening schedule for the next 5 to 10 years based on: • United States Preventive Services Task Force and Advisory Committee on Immunization Practices (ACIP) recommendations • Patient's HRA, health status and screening history, and age-appropriate preventive services we cover

AWV Components Breakdown

Component	Details
Establish the patient's list of risk factors and conditions	For risk factors and conditions include: • A recommendation for primary, secondary, or tertiary interventions or report whether they're underway • Mental health conditions, including depression, substance use disorders, suicidality, and cognitive impairments • IPPE risk factors or identified conditions • Treatment options and associated risks and benefits

Provide personalized patient health advice and appropriate referrals to health education or preventive counseling services or programs	Include referrals to educational and counseling services or programs aimed at:
	• Community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including:
	  • Fall prevention
	  • Nutrition
	  • Physical activity
	  • Tobacco-use cessation
	  • Social engagement
	  • Weight loss
	  • Cognition

AWV Components Breakdown

Component	Details
Provide advance care planning (ACP) services at the patient's discretion	ACP is a discussion between you and the patient about: • Preparing an advance directive in case an injury or illness prevents them from making their own health care decisions • Future care decisions they might need or want to make • How they can let others know about their care preferences • Caregiver identification • Advance directive elements, which may involve completing standard forms



If billed as a separate Part B service, then deductible and coinsurance charges apply

- ○99497- for the first 16 to 30 minutes
- ○99498- for each additional 30 minutes

AWV Components Breakdown

Component	Details
Review current opioid prescriptions	For a patient with a current opioid prescription: • Review any potential OUD risk factors • Evaluate their pain severity and current treatment plan • Provide information about non-opioid treatment options • Refer to a specialist, as appropriate
Screen for potential SUDs	• Review the patient's potential SUD risk factors, and as appropriate, refer them for treatment. • A screening tool can be used, but it's not required. • The National Institute on Drug Abuse has screening and assessment tools. Implementing Drug and Alcohol Screening in Primary Care is a helpful resource.
Social Determinants of Health (SDOH) Risk Assessment (optional)- Started in 2024	• This assessment must follow standardized, evidence-based practices and ensure communication aligns with the patient's educational, developmental, and health literacy level, as well as being culturally and linguistically appropriate.

Q&A