REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-16

Subject: Providers and the Annual Wellness Visit (Resolution 824-I-15)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee J (Candace E. Keller, MD, Chair)

At the American Medical Association's (AMA) 2015 Interim Meeting, the House of Delegates referred Resolution 824, "Defining the Annual Wellness Visit as Provided by Community-Based Primary Care Physicians." The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2016 Interim Meeting. Introduced by the Pennsylvania Delegation, Resolution 824-I-15 asked:

> That our AMA advocate for clear definition of the Centers for Medicare & Medicaid Services' Medicare Annual Wellness Visit as one that is provided only by physicians or members of a community-based, physician-led team that will provide continuity of care to those patients.

This report discusses the history and components of Medicare's Annual Wellness Visit (AWV), including its purpose; explains the role of continuity of care in the AWV; outlines the role of commercial entities; and recommends policy recognizing the importance of the physician-led health care team and the promotion of continuity of care.

BACKGROUND

The Affordable Care Act expanded Medicare preventive services coverage and in particular created the AWV as a new Medicare benefit. The AWV benefit is available to beneficiaries who have had Medicare Part B for longer than 12 months and have not had an AWV in the last 12 months.[1]

The purpose of the AWV is to develop or update a personalized prevention plan based on current health and risk factors. It aims to keep Medicare beneficiaries healthy by promoting positive health habits.[2] The AWV may include the following elements: review of medical and family history; a list of current providers and prescriptions; height, weight, blood pressure, and other routine measurements; a screening schedule for appropriate services; and a list of risk factors and treatment options. It is important to note that the AWV was meant to provide more comprehensive preventive services to Medicare beneficiaries but does not replace the annual physical, which is a more extensive examination.[3] Further, if a patient is experiencing physical symptoms or complaints, it is suggested that a patient schedule a problem-oriented visit separate from the AWV. In addition, during both the initial AWV and any subsequent visits, the health professional performing the visit is statutorily required to establish and update a list of current providers and suppliers that are regularly involved in providing medical care to the beneficiary.[4, 5]

There is no deductible or copayment for the AWV.[6] However, if during the AWV it is discovered that a patient has a particular medical condition that requires further evaluation or treatment, pursuant to Medicare rules, the additional time or treatment would be billed separately with Medicare paying 80 percent of the allowed charges and the patient paying the remaining 20 percent.

The relevant legislation and Centers for Medicare & Medicaid Services (CMS) regulations list who is eligible to provide the AWV. The list of eligible providers includes: a physician; physician assistant, nurse practitioner, or clinical nurse specialist; or a medical professional or a team of medical professionals working under the supervision of a physician.[7, 8] Neither the legislation nor the regulations expressly define a "medical professional" eligible for providing the AWV working under the supervision of a physician or otherwise address the issue of physician-led team-based care.

CMS does not assign particular AWV tasks or restrictions for particular members of the team because the concept of team-based care should enable the supervising physician to assign the professionals best suited to provide a portion of the AWV based on individual patient needs.[9] Physicians leading these teams are empowered to determine the coordination of various team members during the AWV.

CONTINUITY OF CARE

Although the AWV is not a thorough preventive visit or examination, the AWV encourages Medicare beneficiaries to engage with their primary care physician or usual source of care on an annual basis for prevention and early detection of illness, the treatment of which that usual source of care could provide or manage. The AWV facilitates an ongoing relationship between the provider of the AWV and the beneficiary. Consistent with the tenets of continuity of care, the patient and physician are cooperatively involved in ongoing health care management toward the goal of high quality and cost effective care. Continuity of care is rooted in a long-term patient-provider partnership in which the provider knows the patient's history and can integrate new information, such as that obtained during the AWV, and share in medical decision-making from a whole-patient perspective.

NON-PHYSICIAN COMMERCIAL ENTITIES PROVIDING THE ANNUAL WELLNESS VISIT

Non-physician commercial entities such as retail and mobile health clinics have entered the marketplace to provide the AWV and bill the code to CMS, which potentially precludes the patient from the benefits of the AWV with a regular source of care.[10] These commercial entities often have no prior relationship with the patient and have no intention of caring for the patient after the AWV.[11] Commercial encounters can therefore lead to fragmented and duplicative care if the information gathered at the AWV is never communicated to the patient's physician. Because of potentially disjointed care, there is concern that these commercial entities are subverting the intended benefit of the AWV and may be misleading patients. The presence of commercial entities may interfere with both the provider-patient relationship and appropriate continuity of care.

RELEVANT AMA POLICY

Policy H-425.994 supports the premise of the AWV stating that the evaluation of healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. Policy H-425.994 also states that the testing of individuals should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors identified.

Policy H-425.997 addresses preventive services and encourages the development of policies and mechanisms to assure the continuity, coordination, and continuous availability of patient care,

including preventive care and early-detection screening services. Policy H-425.997 states further that preventive care should ideally be coordinated by a patient's physician. To promote continuity of care, Policy H-160.921 states that store-based health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community and should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care. Further, Policy H-160.921 states that store-based health clinics should encourage patients to establish care with a primary care physician to ensure continuity of care.

Policy D-35.985 recognizes non-physician providers as valuable components of the physician-led health care team. With respect to the health care team, Policy H-275.976 states that the health professional who coordinates an individual's health care has an ethical responsibility to ensure that the services rendered are provided by those whose competence and performance are suited to render those services safely and effectively.

AMA ACTIVITY

Consistent with Resolution 824-I-15, the AMA and several medical specialty societies, whose members often provide the AWV, sent a joint letter to Acting Administrator of CMS expressing concern about potential misuse of the AWV by commercial entities on April 30, 2015. The letter noted that provision of the AWV from a source other than the patient's primary care physician or other usual source of care inhibits the provision of preventive services through the patient's usual source of care and disrupts the continuity of care important for both the physician-patient relationship and the patient's health. The AMA also met with senior CMS officials following the agency's receipt of the letter, and CMS staff expressed appreciation to the physician community for bringing this issue to their attention. CMS indicated that it shares these concerns, particularly for Medicare patients who have regular sources of care that also provide their annual visits.

DISCUSSION

Continuity of care is a bedrock principle of the physician-patient relationship and is a fundamental feature of high-quality health care.[12, 13] It is the process by which the patient and the physician-led health care team are cooperatively involved in ongoing health care management with the shared goal of high quality, cost-effective care. The Council recognizes continuity of care as a hallmark and primary objective of medicine and believes it is consistent with quality patient care provided though a patient-centered medical home. Continuity of care is rooted in the long-term physician-patient relationship in which the physician knows the patient's information from experience and can integrate new information and decisions from a holistic standpoint.

A physician-led, team-based approach to health care facilitates continuity of care which in turn, reduces fragmentation and thus improves patient safety and quality of care. It ensures salient issues and markers are tracked consistently to further the goal of high quality care.[14] To that end, the Council recommends reaffirming Policy H-425.997 encouraging continuity of care and supporting the principle that preventive care should be coordinated by the patient's physician.

Retail clinics and other non-physician facilities may provide a limited scope of services to patients that may seem to be timely and convenient. However, these clinics can ultimately lead to fragmentation if not properly coordinated with the patient's primary physician's office or usual source of care. This fragmentation compromises patient care and health care quality and cost. Using a retail health clinic for the AWV may result in a missed opportunity to address more complex patient needs. Care delivered in retail clinics and other non-physician facilities must work in coordination with the patient's current and regular sources of care to mitigate the effects of fragmentation. Fragmentation

and unaccountable silos of care are in direct opposition to achieving continuous whole-person care with improved health outcomes.[15] Accordingly, while there is no statutory authority to require that one must be physician or member of a physician-led health care team to provide the AWV, it is crucial to note that the AWV is most appropriately provided by a physician or member of a physician-led health care team to promote efficient, quality care that either establishes or continues to provide ongoing continuity of care. Further, the Council recommends reaffirming Policy H-160.921 on protocols for store-based health clinics to ensure and promote continuity of care. Notably, the Council will be preparing an updated report on retail health clinics for the 2017 Annual meeting. Additionally, the Council recommends that any clinic performing the AWV enumerate all relevant findings and make provisions for all appropriate follow-up care. The Council believes this recommendation will more explicitly hold other clinicians to a reasonable reporting and follow-up standard.

Physicians often do not know whether a patient has received the AWV in the past 12 months until after the physician's claim is denied. Therefore, the Council recommends that CMS promote a mechanism to ensure that physicians have a way to determine whether Medicare has already paid for an AWV for a patient in the past 12 months, thereby ensuring that physicians are paid appropriately for the health care services they provide. Additionally, the Council notes the importance of educating patients on the AWV and continuity of care and believes CMS should have the responsibility for educating beneficiaries. Accordingly, the Council recommends that CMS communicate to Medicare enrollees that, in choosing their primary care physician, they are encouraged to make their AWV appointments with this physician in order to facilitate continuity and coordination of care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 824-I-15 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-425.997 encouraging continuity of care and supporting the principles that preventive care should be coordinated by the patient's physician. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-160.921 on protocols for store-based health clinics to ensure continuity of care. (Reaffirm HOD Policy)

3. That our AMA support that the Medicare Annual Wellness Visit (AWV) is a benefit most appropriately provided by a physician or a member of a physician-led health care team that establishes or continues to provide ongoing continuity of care. (New HOD Policy)

4. That our AMA support that, at a minimum, any clinician performing the AWV must enumerate all relevant findings from the visit and make provisions for all appropriate follow-up care. (New HOD Policy)

5. That our AMA support that the Centers for Medicare & Medicaid Services (CMS) provide a means for physicians to determine whether or not Medicare has already paid for an AWV for a patient in the past 12 months. (New HOD Policy)

6. That our AMA encourage CMS to educate Medicare enrollees, that, in choosing their primary care physician, they are encouraged to make their AWVs with their primary care physician in order to facilitate continuity and coordination of their care. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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[2] Available at http://prevent.org/data/files/news/hraawvguidancereportfinal.pdf.
[3] *Supra* note 1.
[4] Medicare Preventive Services National Provider Call: The Initial Preventive Physical Exam and the Annual Wellness Visit. Centers for Medicare & Medicaid Services. Available at https://www.cms.gov/outreach-and-education/outreach/npc/downloads/ippe-awv-faqs.pdf.
[5] 42 CFR 410.15. Available at https://www.law.cornell.edu/cfr/text/42/410.15
[6] *Id.*
[7] *Supra* note 5.
[8] 42 U.S.C. § 1861. Available at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.
[9] *Supra* note 4.
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[12] *Supra* note 9.
[13] Definition of Continuity of Care. American Academy of Family Physicians. Available at http://www.aafp.org/about/policies/all/definition-care.html.
[14] Artemis March. Perspective: Consistency, Continuity, and Coordination-The 3Cs of Seamless Patient Care. Commonwealth Fund. Available at http://www.commonwealthfund.org/publications/newsletters/quality-matters/2006/june/perspective-consistency-continuity-and-coordination-the-3cs-of-seamless-patient-care.
[15] *Id.*