Annual Wellness Visit (AWV) Delivery – Business Case

The implications of the adopting and/or actively promoting AWV services for the practice's bottom line are dependent on a number of factors, including:

- The practice's payer and patient mix
- Current delivery of AWV and related services
- Current capacity and demand for services
- Capacity of the care team to deliver wellness care
- Approach to operationalizing AWV delivery – especially the roles and functions assigned to (where applicable):
    - Physicians
    - Physician Assistants
    - Nurse Practitioners
    - Certified Clinical Nurse Specialists
    - Registered Nurses, Licensed Practical Nurses and other Medical Professionals
- Other services the practice may be providing that depend on the same team resources
- Current consistency in capturing and coding patient problem for accurate risk adjustment.
- Participation in shared savings programs, performance incentives or penalties

Approximate[1] Medicare payment, in 2016 for some services that can be considered in business case development (actual payment includes a geographic adjustment) is:

HCPCS Code	Short Description	Approximate Fee
99495	Transitional Care Management (14 day disch)	$160
99496	Transitional Care Management (7 day disch)	$225
G0402	Initial Preventive Exam	$165
G0438	Initial Annual Wellness Visit	$170
G0439	Subsequent Annual Wellness Visit	$115
99213	Office visit - established patient	$70
99214	Office visit - established patient (moderate decision-making)	$105
99497	Advance Care Planning (30 min)	$85
99498	Advance Care Planning (addl 30 min)	$75

[1] Since Medicare payment rates different by geographic region we have used approximate averages rates.

HCPCS Code	Short Description	Approximate Fee
	Beginning January, 2017 Medicare benefits include the following Chronic Care Management services	
99487	Complex chronic care management (60 minutes of clinical staff time – per calendar month)	$90
99489	Complex chronic care management (each additional 30 minutes of clinical staff time – per calendar month)	$47
99490	Complex chronic care management (20 minutes of clinical staff time – per calendar month)	$42

For scenario planning, we will use the following parameters:

- Each physician or qualified non-physician provider in the practice has a panel of 200 Medicare fee-for-service patients.
- 10 percent of Medicare fee-for-service patients in the practice currently receive an AWV.

The business case can be adjusted based on the actual circumstances of the practice.

For scenario development, we'll use a practice with four (4) physicians or qualified non-physician providers. This translates to a total panel of 800 Medicare patients. At 10% coverage, this practice is currently delivering about 80 AWVs per year.

Medicare Part B covers AWV if performed by a:

- Physician (a doctor of medicine or osteopathy);
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist); or
- Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician (doctor of medicine or osteopathy).

Scenario #1: Leverage provider/clinical staff capacity – adding only Annual Wellness Visits

Action – through scheduling return visits, add one (1) additional AWV per provider per week (4 new visits per week, 200 new visits per year). Note that in the first year, most of these new AWVs will be the initial visit. As time goes on, more of these will become subsequent AWVs, which pay less. Subsequent AWVs may require less time to complete than initial visits.

Assuming they number of Medicare fee-for-service patients remains the same, this scenario increases AWV coverage from 10 percent to 35 percent. The limit to the acceptability of this service in the Medicare fee-for-service population with a well-executed communications plan is not known at this time. We expect that 70 percent or more Medicare fee-for-service patients would accept the service, if it were recommended by their primary care provider. That is, patient demand for these services may be double that outlined in this scenario.

Worksheet – Monthly revenue from adding four new AWVs per week

Services	Fee per visit (approximate)	Revenue
4 AVW (Initial)	$ 170	$ 680
12 AWV (Subsequent)	$ 115	$1,380
Total		**$2,060**

Note that no new expenses are modeled in this scenario, it anticipates that the additional four visits per week can be provided using current practice staffing and resources. Practices might adopt a "ramp up" approach – seeking to build up to 4 (or more) new visits per week over time. Or, practices may determine that new revenue potential justifies expanding clinical staffing (e.g., adding part time staff); in this case, new expenses would be deducted to determine net gain (see scenario #2, below).

While increasing AWV coverage may improve the practice performance under new Medicare payment models, no incentive payment effects were incorporated in these calculations.

Scenario #2: Expanding Services - Annual Wellness Visits and Chronic Care Management

Practices may find that they don't have staff capacity to add visits to their schedule, but would like to offer wellness care to their patients. Using the logic from scenario #1, practices can explore the feasibility of incrementally expanding staffing.

In this scenario, we review the feasibility of expanding clinical staff to provide not only AWV, but also Complex Chronic Care Management (CCM) services. In 2017, payment for CCM has been substantially increased to better recognize actual costs of providing this care. Note that CCM services require patient consent (and co-pay) and include electronic medical record requirements. Clinical staff time under the general supervision of a physician (or other appropriate practitioner) counts toward CCM time billing – but non-clinical staff time does not.

This scenario uses the same parameters for the practice as #1 – four practitioners, a panel of 800 fee-for-service Medicare patients.

For the added clinical staff, we will use the salary range for an early career registered nurse working in primary care.

Actions

- Through scheduling return visits, add two (2) additional AWV per provider per week (8 new visits per week, 400 new visits per year). Note that in the first year, most of these new AWVs will be initial. As time goes on, more of these will become subsequent AWVs, which pay less. Subsequent AWVs may require less time to complete than initial visit. This scenario increases AWV coverage from 10 percent to 60 percent.
- Through AWV and other patient encounters, the practice identifies 200[2] patients eligible for CCM services. For scenario planning, we assume that, in any given month, 40 (20%) of those patients require clinical staff time of at least 20 minutes (the minimum billable threshold); half of these require 60 minutes or more clinical staff time.

Worksheet – Monthly revenue: increasing AWVs and CCM

Services	Fee per visit (approximate)	Revenue
8 AVW (Initial)	$ 170	$ 1,360
24 AWV (Subsequent)	$ 115	$ 2,760
	Fee for CCM	
20 (CPT 99490) 20 minutes	$ 42	$ 840
20 (CPT 99487) 60 minutes	$ 90	$ 1,800
5 (CPT 99489) 30 minutes	$ 47	$ 235
Total		**$ 6,995**

We estimate annual salary for a full-time mid-career registered nurse[3] working in primary care at no more than $80,000[4]. Adding 25 percent for leave and fringe benefits, brings the cost to $100,000 annually or $8,333 per month.

[2] This is conservative. It is estimated that more than 50% of Medicare beneficiaries may eligible for CCM services.
[3] Practices may determine clinical staff other than registered nurses can serve in the functions outlined.
[4] This figure is on the high end of the geography served by HealthInsight. Practices should assess their local labor market.

If we assume that clinical staff effort at an average of one hour per AWV, this scenario requires (approximately):

- 32 hours clinical staff effort per month for AWV
- 30 hours clinical staff effort per month for CCM

That is, these new or expanded services would require a little less than half-time for the new clinical staff.

Practices may find that the investment in additional clinical staff (at least part-time) can be justified based only upon expanded AWV and CCM services alone. Scenario planning can be expanded to include other mechanisms by which additional clinical staff might contribute to the financial bottom line – for example:

- Additional billable services not considered under this scenario. This might include:
  - AVW and CCM for Medicare Advantage patients, similar services for other payers
  - Preventive care and screenings
  - Supporting transitional care management
- Improving the practice's quality performance, improving positioning under value-based payment models, earning performance incentive payments
- Improving efficiency and throughput for the practice's providers – that is, increasing provider productivity

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