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Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201
PTAC@hhs.gov

Re: "Annual Wellness Visit Billing at Rural Health Clinics"

Dear Committee Members:

Mercy Accountable Care Organization submits for your review, "Annual Wellness Visit Billing at Rural Health Clinics." As described in the proposal, we believe this model will increase utilization of the Annual Wellness Visit service at rural health clinics.

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We appreciate your consideration of this model. We believe it will provide a direct benefit to healthcare providers and patients in rural health clinics.

Sincerely,

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President, Mercy Accountable Care Organization

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Annual Wellness Visit Billing at Rural Health Clinics

Submitted by:
Mercy Accountable Care Organization

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Table of Contents

Abstract:
Annual Wellness Visit Billing at Rural Health Clinics

Mercy Accountable Care Organization and our member rural health clinics have identified issues in rural health clinic reimbursement structure which make it difficult to make the significant progress in preventative care seen in other clinics. This proposal addresses two changes to Medicare Annual Wellness Visit reimbursement policies which we believe could significantly increase preventative care utilization by rural beneficiaries.

Challenges: Rural health clinics (RHCs) are not able to receive reimbursement for the Annual Wellness Visit (AWV) in conjunction with another service provided on the same day. The visit falls under the all-inclusive rate regardless of the number of services performed. This makes completing an AWV challenging. Clinics are left with the option to provide a service that will not be reimbursed or to ask patients to return on another day to complete the AWV.

The second challenge RHCs experience when implementing AWVs is the requirement that a patient be seen by an RHC practitioner, which includes physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or certified social worker. Rural health clinics are not allowed to have registered nurses (or other licensed staff who are not practitioners) provide the AWV without a face-to-face practitioner visit, even under direct supervision of a physician. When properly supervised by a physician, and within state licensure, registered nurses are allowed to provide this care in other primary care settings.

Payment Model Solution: Mercy Accountable Care Organization's payment model proposes a two pronged solution to improve preventative care through increased Annual Wellness Visit utilization in rural health clinics. First, we propose that RHCs be reimbursed the all-inclusive rate (AIR) for an AWV when performed in conjunction with a secondary medical visit. Thus, receiving two AIR payments for the services completed the same day. This is the case for Initial Preventive Physical Examinations in RHCs and for AWVs in provider-based clinics. Second, we propose that licensed professionals, under the direct supervision of a physician, be allowed to complete the AWV. This will make the important preventative services included in an AWV more feasible, without reducing the time physicians and mid-level providers have available to work with patients whose appointments require their skill and knowledge. Together these changes will facilitate an important culture shift toward making preventative services readily available in rural communities.

Annual Wellness Visit Billing at Rural Health Clinics

1. Background and Model Overview

1.1 Background

Mercy Accountable Care Organization (ACO) was one of the first ACOs to include rural hospitals and clinics as participants. This experience with our 37 rural health clinics (RHCs) and the 152 primary care physicians, nurse practitioners, and physician assistants they employ, has brought to our attention aspects of the Medicare Shared Savings Plan model that do not work well with reimbursement structures at critical access hospitals and rural health clinics. These differences in reimbursement structure make it difficult to make the significant progress in preventative care we have seen in other clinics. This proposal addresses two changes to Medicare Annual Wellness Visit (AWV) reimbursement policies which we believe could significantly increase preventative care available to rural residents.

AWVs benefit individual patients and advance larger population health efforts in our clinics. These visits include[1]:

- A health risk assessment;
- Establishment of a current list of providers and suppliers;
- Review of medical and family history;
- Measurement of height, weight, BMI, and blood pressure;
- Review of potential risk factors for depression and other mood disorders;
- Review of functional ability and level of safety;
- Detection of any cognitive impairment the patient may have;
- Establishment of a written screening schedule (such as a checklist);
- Establishment of a list of risk factors; and
- Provision of personalized health advice and referral to appropriate health education or other preventative services.

Our participating clinics have reported many instances when screenings scheduled as a result of an AWV identified a serious condition. As a result of the screening the patient received proper treatment, and the AWV was described as life-saving. As an example, one of the preventative services reviewed during an AWV is the Colorectal Cancer Screening to ensure that patients between the ages of 50 and 75 receive a colonoscopy at intervals appropriate to their cancer risk. Studies suggest that colonoscopy reduces deaths from colorectal cancer by about 60 to 70%.[2]

Annual Wellness Visits are also a potential step in attribution of patients to ACOs with Heathcare Common Procedure Coding System (HCPCS) code G0438 or G0439. Knowing which patients' care we are responsible for managing allows us to offer appropriate care coordination services to those patients. This leads to improved health care quality for our patient populations. The process of completing AWVs ensures that important quality measures – including assessment of chronic conditions – are addressed with patients each year.

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[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. MLN Matters. Number SE1338 Re-issued. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1338.pdf

[2] National Cancer Institute. Tests to Detect Colorectal Cancer and Polyps. https://www.cancer.gov/types/colorectal/screening-fact-sheet

1.2 Model Overview

Challenges: Rural health clinics (RHCs) are not able to receive reimbursement for the Annual Wellness Visit (AWV) in conjunction with another service provided on the same day. The visit falls under the all-inclusive rate regardless of the number of services performed. This makes completing an AWV challenging for clinics and patients. Our rural health clinics are located in small communities where public transportation is often not available, requiring patients to travel up to 30 miles and depend on transportation provided by a friend or family member for a primary care visit. This burden makes it prohibitive for many patients to leave and return for a follow-up annual wellness visit. This is challenging to RHCs, which are left with two options under the current reimbursement structure:

- Encourage patients to return for a subsequent visit. We have found this leads to the majority of patients declining the service, which they view as unessential.

or

- Provide the AWV service with a qualifying medical visit and not receive an additional encounter payment at the All-Inclusive Rate. Unfortunately, many of our RHCs are located in the poorest counties in Iowa and it is not financially feasible for them to use their limited resources to provide a free service. Further, time spent providing a service without revenue results in time not available for billable services. This is likely a common issue in rural health centers in other states.

The second challenge RHCs experience when implementing AWVs is the requirement that a patient be seen by an RHC practitioner, which includes Physician, Nurse Practitioner, Physician Assistant, Certified Nurse Midwife, Clinical Psychologist, or Certified Social Worker. Rural health clinics are not allowed to have registered nurses (or other licensed staff who are not practitioners) provide the AWV without a face-to-face practitioner visit, even under direct supervision of a physician. When properly supervised by a physician, and within state licensure, registered nurses are allowed to provide this care in other primary care settings.

The difficulty presented by requiring practitioners to complete the AWV is magnified by the large-scale challenges rural communities face with physician recruiting. To achieve rural health clinic designation, these clinics must be located in areas that are federally designated health professional shortage areas. Thus, access to a physician is problematic, especially for a visit which in other clinic settings could be completed by a registered nurse or other licensed medical professional. Mercy Accountable Care Organization (ACO) has developed processes which promote team based care and alleviate the burden of care required by physicians. Providers are encouraged to work at the top of their license, which ideally would result in registered nurses providing AWVs under the supervision of a physician. The requirement of a practitioner completing a face-to-face visit for an AWV results in practitioner and clinic administrator resistance to offering AWVs to patients. Practitioner time needs to be prioritized, and, when forced to choose between offering treatment to an ill patient and a preventative service to a well patient, they choose treating the sick patient.

Payment Model Solution: Mercy ACO's payment model proposes a two pronged solution to improve preventative care through increased Annual Wellness Visit compliance in Rural Health Clinics(RHCs). First, we propose that RHCs be reimbursed the all-inclusive rate (AIR) for an AWV when performed in conjunction with a secondary medical visit. Thus, receiving two AIR

payments for both services completed the same day. This is the case for Initial Preventative Physical Examinations in RHCs and for AWVs in provider-based clinics which are reimbursed via the Physician Fee Schedule for all services performed in a day. Second, we propose that licensed professionals, under the supervision of a physician, be allowed to complete the AWV. This will make the important preventative services included in an AWV more feasible, without reducing the time physicians and mid-level providers have available to work with patients whose appointments require their skill and knowledge. Together these changes will facilitate an important culture shift toward making preventative services readily available in rural communities.

Our data show compliance for completing AWVs is much greater in the provider based clinics in our network. For example, we can compare two participating clinics, both located in northern Iowa towns with populations between 5,000 and 6,000.[3] These clinics are located one county away from each other, and their physicians are employed by the same larger network. Medicare claims through April, 2017 show the provider based clinic (Hansen Family Hospital) has Annual Wellness Visit completion rates of 405.02 per 1000 patients attributed through our Medicare Shared Savings Program. In comparison, the rural health clinic (Kossuth Regional Health Center) had a rate of 116.42 per 1000 attributed patients who had completed an AWV. The variance between the clinics is the result of the payment incentives which are hindering compliance with Annual Wellness Visits at rural health clinics.

2. Scope of Proposed Physician Focused Payment Model (PFPM)

2.1 Related to Physician Practices:

Numbers affected: The changes proposed in this model will affect federally designated RHCs. If fully implemented, the proposed changes could affect all practices designated as RHCs and the health care providers that work in those clinics. Mercy ACO has 37 participating RHCs which are staffed by 152 primary care physicians, nurse practitioners, and physician assistants. Additionally, our RHCs employ over 500 RNs and over 100 LPNs. All of the providers are employees of these clinics and would participate in a pilot test of this payment model. A full implementation would reach 4177 RHCs nationwide, per a CMS report dated May 24, 2017.[4]

Financial Impact: The providers who are part of our network are employed, either by the RHC or by the regional health system. While billing for the AWV services would be through their employer, providers would indirectly benefit because additional revenue to the clinic would allow the organization to invest in additional staff and resources which would benefit the providers in efficiency. Additionally, providers are incentivized through the Medicare Access and CHIP Reauthorization Act (MACRA) to offer high quality services to patients. A higher completion rate of AWVs will increase the quality scoring for the providers, which represents fifty percent of their score. The providers in our network will be in the Merit-Based Incentive Payment System Advanced Payment Model track of MACRA and their combined score will result in an adjustment to the clinic's Part B billing. Additional revenue streams to the providers' employers would strengthen their practices financially, and allow them to provide their patients with preventative care.

[3] United States Census Bureau. American FactFinder. https://factfinder.census.gov

[4] Centers for Medicare & Medicaid Services. CASPER Report 0006D Name and Address Listing For Rural Health Clinic Based on Current Survey. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/rhclistbyprovidername.pdf

Providers in our network would directly benefit from the billable service as their compensation models include Relative Value Units as an incentive component to their base pay. AWVs have Relative Value Units tied to the service, increasing compensation to the providers.

Experience with Other Payers: Annual Wellness Visits are a benefit unique to Medicare. Therefore, we do not have previous experience with other payers to report. The cost to implementing the practice would be related to administrative overhead for billing for the service, but the proposed reimbursement would be sufficient to offset that administrative expense. We do not foresee any financial risks for practices.

2.2 Related to Patient Populations:
In our network alone, these changes could make AWVs more easily available to 16,000 Medicare beneficiaries. Patient access to these preventative visits is an important part of providing better care at lower costs. Patients would have easier access to and shorter wait times for Annual Wellness Visits and the preventative services they include if they are available on the same day as another appointment. Also, if practitioners are not required to have a face-to-face visit as a part of the AWV, appointment access will be less of an issue when patients schedule their AWVs. The AWV is an opportunity for patients and their medical professionals to assess the patient's health risk, identify routine screenings that are needed, monitor chronic conditions, check functional ability, etc. These practices are all important in improving or maintaining patients' health status. An annual check-in allows medical professionals to identify changes in health that need attention, avoiding costly emergency department visits and hospital stays.

Initially, Medicare spending may increase as more patients in Rural Health Clinics have access to AWVs. CMS introduced these services as preventative measures which will save money over time, however. By finding and treating disease early, identifying health risks that can be mitigated, and discussing advance care planning with patients, medical professionals can use Annual Wellness Visits as a cost savings measure.

Cost savings could also be seen by other payers, especially for patients who are dually-eligible. Upon demonstrating success of AWVs for Medicare patients, other insurance plans may also consider paying for this service. Our ACO has used results from our value based care initiatives to share with large employers in our community and have successfully developed partnerships to manage employees in their employer-sponsored health plans. We anticipate increased success in value based care in our rural communities would allow us to develop similar partnerships with employers in those rural communities.

3. Quality and Cost

Quality and cost are tightly intertwined in the care patients receive. AWVs allow time for a detailed assessment of overall patient health, improving the quality of care patients receive from their care team. In turn, better coordinated, preventative care can decrease the cost of the patient's care.

The diagnostic and preventative services assessed during the annual wellness visit include:

- BMI Screening and follow-up

- Colorectal Screening
- Breast Cancer Screening
- Depression Screening
    - Remission
- Fall Risk
- Tobacco use screening and follow-up
- Pneumonia vaccination
- Flu vaccination

Addressing all of these areas of a patient's health, educating patients on the importance of getting the preventative screenings completed, and filling gaps in care all align with the concept of providing value based care. Annual Wellness Visits (AWVs) provide guidance for ensuring that patients receive routine wellness services which have been demonstrated to reduce downstream costs.

The measures noted in Table 1 below are included in our quality measures reported through the CMS Group Practice Reporting Option web interface. We will use our previous years' results as a baseline and anticipate improved results upon implementing the proposed changes to billing for AWVs at RHCs.

Measure	2016 Results
Prev-6: Colorectal Cancer Screening	64.76%
Prev-10: Tobacco Screening & Cessation	96.83%
Prev-12: Depression Screening & Follow-up	43.90%
Care-2: Screening for Fall Risk	74.12%
Prev-5: Breast Cancer Screening	77.35%

Table 1. Mercy Accountable Care Organization Quality Measures

3.1 Improvement in Health Care Delivery

Quality: Annual Wellness Visits offer health care providers a unique opportunity to improve the quality of care their patients receive. During the AWV, providers and patients address eleven of the quality measures that are reported through the Physician Quality Reporting System. Rural providers who are eligible for the Merit-Based Incentive System (including the 152 providers participating in this proposal) have their payment tied directly to quality. Additionally, quality scoring impacts practitioners' ability to achieve savings in a Medicare Shared Savings Program. Eliminating the reimbursement barriers noted in this proposal would encourage high performance and accountability in both programs.

Annual Wellness Visits align with other population health quality initiatives, such as Patient Centered Medical Home (PCMH) designation, which are integral to ACO success. The standards outlined in the designation promote care coordination, quality improvement, and access to primary care services. For example, depression screening is part of the AWV, and is also a standard for PCMH, which requires a depression screening using a standardized tool if the practice has access to services for positive results.

Cost: In recent years CMS has identified a need to reimburse for services which promote population health management. CMS understands that paying for preventative services has an upfront cost, but these services prevent more costly, reactive treatments over time. Intervention with patients who have chronic conditions can help them better manage their conditions and avoid costly heathcare utilization. Annual Wellness Visits fall into this category; while the cost of increasing the number of Annual Wellness Visits completed in RHCs will initially increase costs to Medicare, the expected outcome is lower costs through prevention and proper management of serious and chronic health conditions.

Other examples of up-front Medicare spending with the intention of lowering long-term costs are billing for Transitions of Care Management (TCM) and Chronic Care Management. CMS developed TCM reimbursement for services done in follow-up to the patient being discharged from the hospital. Patients often fall through the cracks when they move from a care facility to home, as the result of not fully understanding their discharge instructions or their medications. TCM services facilitate a safe transition between hospital and home.

CMS also developed Chronic Care Management (CCM) reimbursement, which acknowledges that patients with multiple chronic conditions require more resources to manage. AWVs often identify patient's chronic conditions during the assessment, which moves the patient into eligibility for CCM billing. Identifying the patients eligible for CCM allows our care management staff to intervene and help the patient maintain or improve their status, which improves patient outcomes and also leads to appropriate utilization of health care services which results in overall reduced cost. "Medicare requires initiation of CCM services during a face-to-face visit with the billing practitioner (an Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE], or other face-to-face visit with the billing practitioner). This initiating visit is not part of the CCM service and is separately billed."[5]

The 2018 proposed rule for the Physician Fee Schedule are of interest to us and connect with this program in that there are proposed changes for CCM at RHCs. RHCs currently cannot bill for complex CCM or general behavior health integration (BHI). CMS has proposed adding a new G code for care management (GCCC1). The new code would be paid at the average of the national non-facility Physician Fee Schedule payment rates for codes 99490 (CCM), 99487 (Complex CCM), and G0507 (BHI).[6] Using calendar year 2017 rates, the payment for the new G code would have been approximately $61.37. This would be an improvement from the current CCM payment rate of $42.71 that our RHCs currently receive.

Additionally, completing an AWV broaches the topic of advance care planning with patients. If a patient expresses a desire to further discuss their wishes and document preferences they can schedule an Advance Care Planning (ACP) visit with the provider. ACPs are also a reimbursable service and empowers patients to understand the trajectory of their conditions and the impact that treatment options have on their quality of life. ACPs are another great initiative to incentivize quality and the service is introduced through the completion of the AWV.

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[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Chronic Care Management Services. ICN 909188 December 2016. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

[6] Centers for Medicare & Medicaid Services. Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2018. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-2.html

In order for patients to be properly managed across the continuum of care, providers need to be incentivized accordingly.

3.2 Barriers and Risks

Table 2 below illustrates the impact Annual Wellness Visits have on total cost of care. We measure cost using per member per month for Medicare Shared Savings Plan patients attributed to our rural sites (based on April 2017 Medicare Claims data) and make a comparison between cost for sites which have a high completion rate of AWVs compared to those with a low completion rate. All of the sites noted below are in our network of rural affiliate hospitals and participate in our Track 1 Medicare Shared Savings Program (MSSP).

Facility	County	Annual Wellness Visit Completion Rate (per 1000 attributed patients)	Per Member Per Month Expense
Palo Alto County Hospital	Palo Alto Co, Iowa	357.38	$589.10
Mercy – New Hampton	Chickasaw Co, Iowa	344.64	$593.02
Wayne County Hospital	Wayne Co, Iowa	57.14	$795.24
Audubon County Hospital	Audubon Co, Iowa	33.13	$831.50
Adair County Hospital	Adair Co, Iowa	23.77	$783.46

Table 2. Annual Wellness Visit Impact on Total Cost of Care

3.3 Assessing Performance

Measures currently reported through the CMS Group Reporting Option web interface will indicate progress if Annual Wellness Visits become more accessible to patients at Rural Health Centers. Being able to track progress with existing measures will reduce the data collection burden on participating sites, while maintaining a means of evaluation.

Several patient-reported measures, such as depression screening and falls risk assessment, are included in the AWV. Screening is the first step in being able to connect patients with resources for treatment options. By completing the AWV we will better identify patients in need of support and offer an intervention.

Our data systems are set up to link patient information from multiple sources in order to have a more complete picture of the patient's history. We are building a data warehouse which pulls claims data from both Medicare and private pay insurers. Our system also pulls in EHR data from all of our network organizations. We use this platform to create a disease registry which helps us to monitor clinical quality metrics and resource utilization. Our network participates in a MSSP and we receive Per Member Per Month (PMPM) expenditures to monitor total cost of care. We receive quarterly updates on expenditures on a rolling 12 month period and share with our care management leaders.

No monitoring or auditing would be required for this proposal beyond what is typically required for processing Annual Wellness Visit Claims. Monitoring will continue through the results of our clinical quality performance and cost savings tracked through our MSSP.

4. Payment Methodology

4.1 Payment Methodology

Our proposal to address the challenges we face related to Annual Wellness Visit reimbursement at Rural Health Clinics is two-fold:

1. We propose that Annual Wellness Visits be eligible for an additional encounter payment at the All-Inclusive Rate, similar to the Initial Preventative Physical Examination (IPPE) for patients who are new to Medicare. Per MLN Matters Number MM6445: "Effective for dates of service (DOS) on or after January 1, 2009, RHCs and FQHCs may bill for the professional portion of an IPPE in addition to a daily encounter by using Type of Bill 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series, and must include HCPCS G0402. For RHCs, the Part B deductible for the IPPE is waived." We propose that the AWV with HCPCS G0438 and G0439 fall within the same guidelines.[7]
2. We propose Annual Wellness Visits be categorized as an Incident To carve-out so that RNs are able to provide the AWV under direct supervision of a physician at the clinic, without the need for a face to face visit with the practitioner.

With these changes, we feel strongly that Rural Health Clinics (RHCs) would be in a better position to increase AWV completion rates. Spending is needed in the short run to achieve savings in the future. Because our providers are in an ACO their performance is tied to value. However, value based incentives alone are not sufficient to complete an AWV in conjunction with another visit and forgo the revenue from the AWV. Clinic budgets are tight and operational leaders are not often willing to provide a service that isn't tied to revenue. Patient compliance with attending a secondary visit for the AWV is low and unreliable.

Physician compensation models vary at our participating RHCs, as there are nuances to each of their contracts depending on the market and their individual organization. The providers are employed by the organization but a component of the physician's compensation is tied to productivity. If AWVs were to be an Incident To service billable by the registered nurse or other licensed medical professional, the number of billable services would increase for the entity for the year. The physicians and other eligible clinicians would be incentivized to increase the number of billable services each year because the additional revenue into their clinic allows the organization to reinvest in their resources and staff.

Because AWVs are a benefit unique to Medicare, the proposed model will not include other payers. If successful we would certainly be willing to share success with other payers and incorporate into other value based contracts.

[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. MLN Matters. Number MM6445 Revised. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6445.pdf

4.2 Sustainability

The model improves rural health clinics' (RHCs') opportunities for reimbursement of Annual Wellness Visits (AWVs), which in turn contributes to sustainability of the changes. Likewise, expanding the level of medical professional able to provide the AWV service make the changes more sustainable. Spreading the AWV caseload across additional professionals keeps the burden manageable for the entire clinic.

The incentive change proposed would be beneficial in supporting the transition from volume to value for our rural sites. Making the service profitable in a volume-driven system helps to drive the initiative while using the outcomes to support the results which could be obtained in a value-driven system.

We have set a goal for all of our sites to complete AWVs on 50% of their Medicare attributed patients. For our RHCs this is unattainable due to limited provider access and patients' unwillingness to come in for a separate visit. In not achieving this goal, all members of the Medicare Shared Savings Program (MSSP) are penalized by their potential to demonstrate high quality care while managing utilization and costs as a system. The long-term risk for RHCs who are participating in an MSSP is that they would be asked to leave the MSSP by the other members who are incentivized to complete AWVs.

The proposed payment methodology is consistent with precedents established with Medicare payment methodologies and could be replicated at RHCs nationally. We propose that Annual Wellness Visits be eligible for an additional encounter at the All-Inclusive Rate, linking AWVs to the precedent established through the Initial Preventative Physical Examination (IPPE) for patients who are new to Medicare. Per MLN Matters Number MM6445: "Effective for dates of service (DOS) on or after January 1, 2009, RHCs and FQHCs may bill for the professional portion of an IPPE in addition to a daily encounter by using Type of Bill 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series, and must include HCPCS G0402. For RHCs, the Part B deductible for the IPPE is waived."[8]

Additionally, we propose Annual Wellness Visits be categorized as an Incident To carve-out so that RNs are able to provide the AWV under direct supervision of a physician at the clinic, without the need for a face-to-face visit with the practitioner, which there is a precedent for at provider-based clinics.

4.3 Current Payment Methodologies and CMMI Models

This issue was identified during Mercy Medical Center's CMMI award, as we learned that Medicare Shared Savings Programs were not a good fit for the cost based reimbursement methodology at rural health clinics and the critical access hospitals with which they are affiliated. The idea for this proposal originated in discussions about how to improve critical access hospital and rural health clinic performance under the Medicare Shared Savings Program. One strategy was to increase the proportion of eligible patients that receive Annual Wellness

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. MLN Matters. Number MM6445 Revised. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6445.pdf

Visits; however these reimbursement issues were raised by several participating rural health clinics (RHCs) as barriers to the strategy. Current payment models do not provide a vehicle for addressing these issues in rural health clinic reimbursement.

In completing the Annual Wellness Visits (AWVs) we identify patients with chronic conditions. This could lead to enrolling patients in Chronic Care Management services (CCM) and/or Advance Care Planning services. Identifying patients' chronic conditions helps us to code these conditions which in turn allows Medicare to more precisely risk-adjust patients attributed to RHCs. Additionally, knowledge of the patients' conditions helps the clinical practice to establish an annual health baseline for the patient and a time to review diagnosis codes for accuracy.

4.4 Appropriateness of Payment

Please see section 4.1 for specific information about the level of payment requested. We are requesting reimbursement for AWVs at the All-Inclusive Rate even when performed with a second encounter at the All-Inclusive Rate. This is consistent with the reimbursement available to rural health clinics for the Initial Preventative Physical Examination. Because the visits are similar in scope, we feel this level of reimbursement is appropriate.

4.5 Barriers

The current payment structure contains barriers which discourage rural health clinics from implementing Annual Wellness Visits with eligible patients. The RHC all-inclusive rate does not allow these clinics to be reimbursed for AWVs that are conducted on the same day as another service, requiring additional appointments and travel for patients. While AWVs are within the scope of licensed medical professionals such as registered nurses, RHCs cannot receive reimbursement for AWVs that they conduct without a face-to-face visit with a practitioner. This barrier is unique to RHC reimbursement policy, and is not required of physician-based clinics. Eliminating this barrier and reimbursing for AWVs provided by licensed medical professionals will pave the way for conducting more AWVs in RHCs, the desired change in care delivery.

Current Medicare methodology creates the barriers we seek to remove. Rural health clinics cannot be reimbursed for an Annual Wellness Visit provided on the same day as another visit due to the all-inclusive rate, and without a face-to-face visit with a practitioner. Rural Health Clinics are treated differently than physician based offices in reimbursement for Annual Wellness Visits. Physician based offices have more flexibility in scheduling and in staffing for Annual Wellness Visit appointments, making them more available to patients in those clinics. The proposed model depends on removal of barriers in reimbursement policies. If these barriers are not addressed, the model is not viable.

5. Value over Volume

5.1 Financial Incentives

Our overarching strategy as an Accountable Care Organization is to reduce health care costs by keeping patients healthy, and we have learned that preventative and maintenance services can curb downstream utilization. Providers in our network are encouraged to deliver value as they participate in our Medicare Shared Savings Program (MSSP). Additionally, they will all be part

of the Merit-based Incentive Payment System Advanced Payment Model (MIPS APM) track of the Medicare Access and CHIP Reauthorization Act of 2015, as noted in Section 2.1. Through these programs, their organizations are at financial risk to demonstrate value.

We work to educate administrators and providers in our network on the impact of MIPS APM and emphasize that payment structures are evolving more and more to incentivize value. However, our Rural Health Clinics (RHCs) feel protected from that change because they have minimal Part B billing due to their All-Inclusive Rate reimbursement structure. Without value based care having a larger impact at the RHCs, it is even more important to financially incentivize preventative visits through volume initiatives such as what is reflected in this proposal. Through monitoring and reporting outcomes of preventative services, rural providers will be more willing to accept risk as value based incentive models become more relevant to RHCs.

The past several years we have incorporated incentives into our provider contracts to drive value-based initiatives. During our first year of implementing this program we set a goal relating to an increase in patients with an A1C test result of less than 9 and a percentage of hypertensive patients being controlled. If the target was met in both measures for patients attributed to individual providers the provider received a bonus of five percent on top of their base pay. The targets were set attainably the first year to build acceptance of incentive payment. The majority of providers achieved the bonus payment in our first year of this model.

Because we were successful in using incentive pay to drive behavior change and drive awareness and focus around initiatives that we feel are important, we were able to alter our physician compensation plans to include value based initiatives for the second year. In the current fiscal year we have included a 10% withhold in provider compensation unless the following targets are achieved:

- Providers must complete their documentation within a week.
- Providers must have 40% of their attributed Medicare patients complete an Annual Wellness Visit.
- Patient Satisfaction standards must be met.
- Providers in a Track 3 MSSP must achieve savings / Providers in a Track 1 MSSP must not incur a penalty.

There are risks in implementing changes in compensation models, such as provider resistance to change and diverting attention towards these initiatives diluting focus from others. We have made progress in trying to strike a balance between productivity incentives and value incentives but will continue to evaluate. We feel we have set a foundation for providers to accept that their compensation will evolve and performance expectations will continue to be raised and align with organizational strategies.

We have found that transparency of performance data also drives behavior change. With all of our providers being in the same Medicare Shared Savings Program, they have a heightened level of accountability to one another. As our providers practice in clinics which are dispersed around the state, they don't necessarily have personal connections to one another. We use data illustrating percent of AWVs completed per 1000 attributed patients to instill confidence in their partners' performance and to hold each other accountable.

5.2 Non-financial incentives

Flexibility of scheduling is the non-financial incentive used in the proposed model. By adding flexibility in scheduling Annual Wellness Visits (AWVs) and whether the practitioner is required to conduct a face-to-face visit, we expect that the number of these preventative visits will increase. This flexibility allows each clinic and even each practitioner to decide what is best for patients without concerns about creating charges that are not reimbursable.

We expect compliance to increase as a result of these changes. We also expect this flexibility will lead to more RHCs offering and prioritizing the preventative care of AWVs, and that practitioners will be more inclined to encourage patients to access this care if the AWV is not seen as a burden for the patient or the practitioner. The improvement in patient care because of evidence revealed by the AWV is an additional incentive.

6. Flexibility

As discussed in 5.2, flexibility is essential to the proposed model. Depending on processes at individual clinics, some providers prefer to see patients during Annual Wellness Visits. This model creates flexibility in rural health clinics that matches what other clinics are allowed, and extends the flexibility to the practitioner. The proposed model could be replicated at all rural health clinics across the country.

There could be some additional burden on clinic staff members. For example, the scheduling and billing offices may need to set up new processes related to Annual Wellness Visits. Registered nurses who conduct annual wellness visits may have to revise schedules. In addition, practitioners will be called upon to explain the importance of prevention through Annual Wellness Visits and to encourage patients who are hesitant to attend an Annual Wellness Visit.

The infrastructure is already present in our rural health clinics however. Registered nurses and other licensed medical professionals are available to conduct Annual Wellness Visits. Our ACO leadership has been educating practitioners and administrators about the importance of these preventative visits for some time, and many rural health clinics have started to offer them. The requested changes to reimbursement policy would allow the Annual Wellness Visit approach to gain traction in other rural health clinics. Mercy Accountable Care Organization has technical assistance available at many levels to support rural health clinics through this transition.

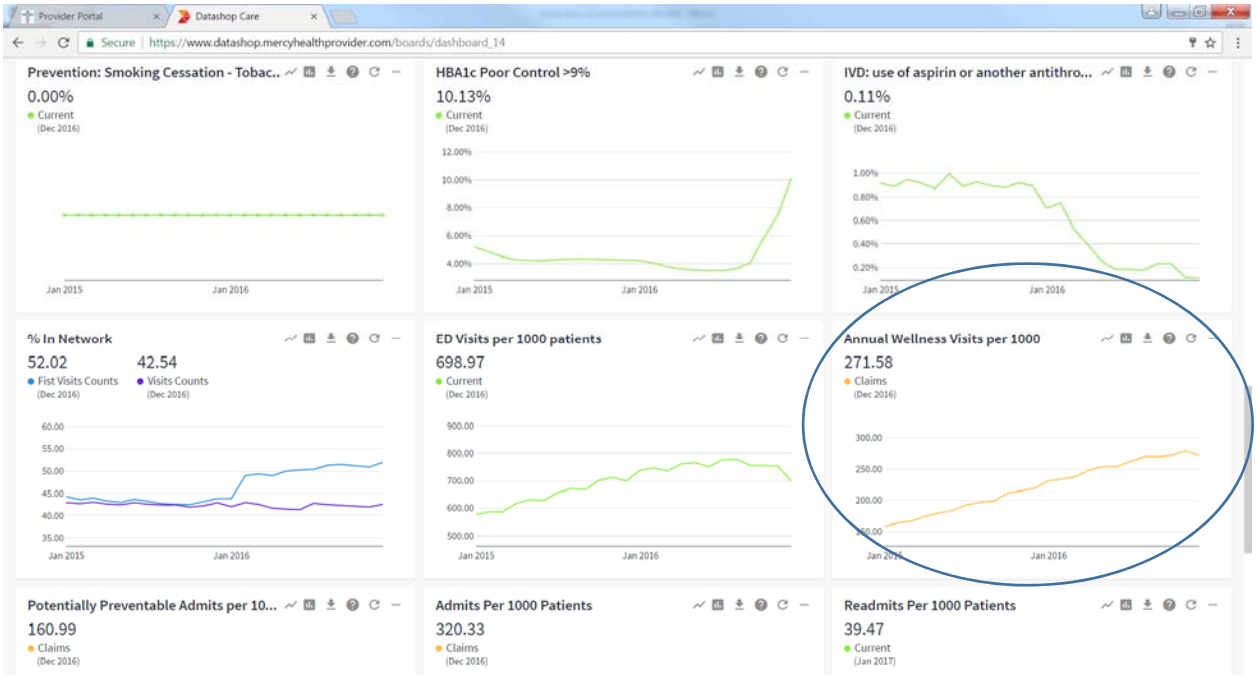
7. Ability to be Evaluated

The impact of the proposed model will first be measured by tracking AWV completion rates across our sites. Group Practice Reporting Option metrics will then indicate improvements in quality that coincide with an increase in AWV completion rates. Additionally, we measure volumes of the diagnostic and preventable services discussed during an AWV and track the activity related to the follow-up care triggered by the AWV.

Impact on Metrics and Evaluable Goals

Improving compliance with Annual Wellness Visits is one of our Accountable Care Organization's key strategic initiatives. Medicare claims data allows us to monitor the rate of

completion by site per 1000 attributed patients on a monthly basis. A depiction of our dashboard is included below:



In addition to tracking and monitoring our own network's performance in completing AWVs, Medicare also publishes this statistic. According to the report "Beneficiaries Utilizing Free Preventive Services by State, 2016", Iowa, as a whole, has a low completion rate for Annual Wellness Visits. In 2016 Iowa completed 87,222 AWVs for its 476,399 Medicare Part B Enrollees, which is a rate of 18.3%. By contrast, the rate in New York was 32.1% (646,479 / 2,015,104) and Florida was 39.1% (959,849 / 2,457,397) in 2016. Other predominately rural states also have a low rate of completion of AWVs. Kansas, for example, had a rate of 18.2% completion (75,958 / 416,775).[9] The state of Kansas has 170 RHCs.[10] Our proposal would incentivize all rural health clinics to increase the number of patients receiving annual wellness visits, and the impact of this proposal can be evaluated on a national scale.

We are not aware of a test of this model underway with Medicare or any other insurers.

Patient satisfaction has been demonstrated to improve with the addition of care coordination services. Patients feel confident that their provider team is being thorough and are better equipped for self-management of their symptoms through the assistance of preventative services being offered.

[9] Centers for Medicare & Medicaid Services. Beneficiaries Utilizing Free Preventive Services by State, 2016. https://downloads.cms.gov/files/Beneficiaries%20Utilizing%20Free%20Preventive%20Services%20by%20State%20YTD%202016.pdf

[10] Centers for Medicare & Medicaid Services. CASPER Report 0006D Name and Address Listing For Rural Health Clinic Based on Current Survey. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/rhclistbyprovidername.pdf

8. Integration and Care Coordination

8.1 Included Professionals

The proposed model will include practitioners and licensed medical professionals at rural health clinics, allowing the flexibility in scheduling to allow all to work to the top of their licenses.

8.2 Care Coordination

A review of providers involved in the patient's care is an important element of the Annual Wellness Visit. This review allows primary care providers to identify specialists with whom they need to communicate regarding the patient's care.

The AWV is also an opportunity to identify patients who could benefit from care management and/or health coach services to better manage their chronic conditions or risk for chronic conditions. This allows care management teams to offer intervention. For example, each of our network clinics employs a certified registered nurse Health Coach, to work with patients who have chronic conditions and, through the use of motivational interviewing techniques, help patients set goals for better health. This coordination of care and more intensive intervention can prevent future health problems and/or slow the progression of disease.

If the proposed model was actualized it could support the hiring of additional nurses to assist with AWVs and care coordination, and further reduce the burden on physicians.

The proposed model aligns with our initiative of having our clinics working towards implementing National Committee for Quality Assurance's Patient Centered Medical Home (PCMH) standards. If we are able to complete both an AWV and a secondary visit together we are focusing holistically on the patients' care, both chronic and preventative. AWVs give our medical homes a standard "measuring stick" to care for the patient so the clinic team can understand the patient's health status from year to year. Population health strategies, such as AWVs, add to the RNs' satisfaction because the clinician truly gets to know the patients and can better care for them having a complete understanding of their conditions and history. AWVs provide an opportunity to discuss advanced care plans and other topics that do not typically come up during a routine office visit.

9. Patient Choice

9.1 Preservation of Patient Choice

Our proposal stems from the needs of our patients. We believe Annual Wellness Visits are a valuable service which we want our patients to receive. Currently, patients are informed that AWVs are a thorough evaluation (not a physical), but they will need to come in for a separate visit. And, with provider shortages, the visit often needs to be scheduled more than a month out. While the patient is at the clinic for their AWV a nurse is able to begin the survey with the patient but, as it is currently a requirement that a physician see the patient during the visit, the visit requires coordination in scheduling. This coordination often results in longer patient wait times. If an RN or licensed professional were able to complete the entire visit it would result in more efficient use of the patient's time.

9.2 Addressing Disparities

We believe this model will help to narrow the gap between rural and urban Medicare beneficiaries and the preventative care they receive.

10. Patient Safety

This model makes preventative care more accessible to patients in rural health clinics. Therefore it is expected to improve quality and outcomes and not create any opportunities for patient harm. Annual Wellness Visits address patients' risks for falls and chronic conditions as well as assessing patients' eligibility for preventative screenings. If these weren't assessed at the Annual Wellness Visit they would likely go unaddressed until an incident occurred. Annual Wellness Visits promote prevention in an effort to avoid conditions which require treatment.

We do not see any potential for stinting of care with this proposal. Potential risk associated with this proposal is the consideration for increasing primary care visits with constrained capacity of clinical staff and physical limitations of the clinics. We feel strongly that preventative primary care services are best for our patients but this proposal runs the risk of creating demand for services that we cannot meet. This could result in patients leaving our system if it takes too long for us to create capacity to meet the demand.

11. Health Information Technology

PHI protection measures are already in place in each rural health clinic. No changes will be required with the implementation of this model

AWVs satisfy numerous quality indicators. Particularly if the clinic is participating in a Medicare Shared Savings Program the visit can address multiple quality indicators. Additionally, because the annual wellness visits focus on prevention they increase the quality of care patients receive and can lead to the potential of decreased costs by caring for patients while they are still well.

Interoperability of EHRs is crucial to success – having a functional EMR that pulls patient information in a discreet manner leads to better care for patients and better workflow for the care team. It is helpful to better coordinate patient care if all information is in one location and the care team has access.

12. Supplemental Information

Rural health clinics which are members of Mercy Accountable Care Organization(ACO) will benefit from these changes, however Mercy ACO will not receive payment under the proposed model. CMS already has AWV reporting mechanisms in place, but some changes in CMS claims processing mechanisms may be required.