

# Using Annual Wellness Visits to Support Age-Friendly Health Systems

## Background

The United States population is aging. The number of older adults, individuals ages 65 years and older, is growing rapidly. As we age, care often becomes more complex. Health systems are frequently unprepared for this complexity and older adults suffer a disproportionate amount of harm while in the care of the health system.

To address these challenges, in 2017, The John A. Hartford Foundation (JAHF) and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA), set a bold vision to build a social movement so that all care with older adults is age-friendly care.<sup>1</sup>

According to our definition, age-friendly care:

- Follows an essential set of evidence-based practices;
- Causes no harm; and
- Aligns with What Matters to the older adult and their family or other caregivers.

## Overview of the 4Ms Framework

To obtain recognition by IHI as an Age-Friendly Health System, health care organizations need to demonstrate that they are reliably providing a set of four evidence-based elements of high-quality care, known as the “4Ms,” to all older adults: What Matters, Medication, Mentation, and Mobility (see Figure 1).

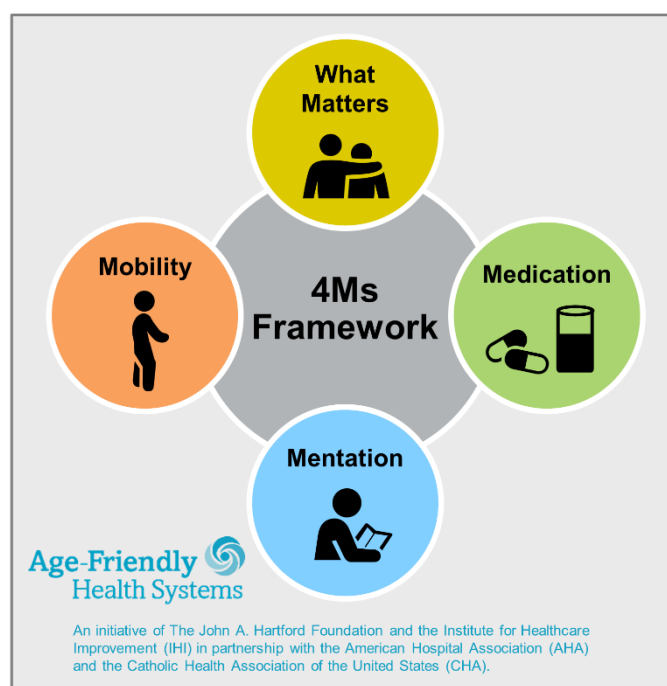
**What Matters:** Know and align care with each older adult’s specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

**Medication:** If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

**Mentation:** Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

**Mobility:** Ensure that older adults to move safely every day in order to maintain function and do What Matters.

Figure 1. 4Ms Framework of an Age-Friendly Health System



There are two levels of Age-Friendly Health Systems recognition that organizations can achieve: Level 1 (Participant), which means the organization has successfully developed plans to implement the 4Ms, and Level 2 (Committed to Care Excellence), which means that the organization has three months of verified data to demonstrate early impact of using the 4Ms.<sup>2</sup>

The Age-Friendly Health Systems movement is on track to achieve its aim of recognizing 3,600 hospitals, practices, nursing homes, and convenient care clinics as Age-Friendly Health System Participants by December 2026.

IHI and The John A. Hartford Foundation want to continue to increase the scale and spread of the 4Ms Framework of an Age-Friendly Health System to make the health care ecosystem more age-friendly. The most potentially advantageous areas on which to focus this effort are services that are well-suited for incorporating the 4Ms, and for which there are already established billing codes. A prime example is Medicare's Annual Wellness Visit.

## Scaling the 4Ms: Why the Annual Wellness Visit Is a Worthy Partner

The Medicare Annual Wellness Visit (AWV) is a preventative health benefit introduced by the Centers for Medicare & Medicaid Services (CMS) in 2011 as part of the Affordable Care Act. All Medicare beneficiaries enrolled in Medicare Part B are provided coverage for an initial AWV (Billing Code: G0438) followed by a subsequent AWV (Billing Code: G0439). To receive Medicare reimbursement, subsequent AWVs must occur 365 calendar days or more following the last visit.<sup>3</sup> The AWV is a co-pay-free visit for patients, and providers are reimbursed at a higher rate as a way for Medicare to incentivize providers to adopt wellness visits over the problem-based visit.<sup>4</sup>

In another effort to incentivize greater AWV adoption, providers can also co-bill during the visit. This may occur if a patient discusses an acute problem during the visit (Billing Codes: 99213, 9921) or for discussions about advance care planning (ACP) that last a duration of 16 minutes or more during the AWV (Billing Code: 99497).<sup>4</sup> For more information, please reference Appendix A.

The AWV is not a hands-on physical exam, but rather an opportunity for older adults and their providers to focus on health promotion and disease prevention and the early recognition of disease, rather than the management of acute and chronic medical conditions.<sup>5</sup> This reimbursable and inherently personalized benefit covered for more than 56 million individuals on Medicare is a well-targeted starting place to incorporate the 4Ms into care.<sup>6</sup> Effectively using the AWV could reduce patients' experiences with care gaps, decrease total cost of care, and help catalyze more widespread adoption of the 4Ms framework into all systems of care involving older adults.<sup>7</sup>

### Provider Billing Recommendations for Effective Scale-up of the 4Ms in the AWV

- Set up a system to ensure scheduling that meets the AWV 365 calendar days billing parameter.
- Ensure providers have documentation of the length of an acute problem conversation during the AWV to be able to bill appropriately for their time and effort related to ACP.

## Incorporating the 4Ms into the AWV

There are certain requirements that the initial and subsequent AWV must cover to receive Medicare reimbursement:<sup>8</sup>

- The initial AWV requires an assessment of height, weight, BMI, and blood pressure as well as screening for and detection of cognitive impairment, depression, functional ability and safety concerns, including fall risk and home safety, performance of activities of daily living, and hearing impairment.
- The provider must obtain a patient's medical history as well as current medications, and provide printed information with screening and preventative service schedules, an updated list of disease risk factors and treatments, and personalized care planning.
- Practitioners are required to assess an individual's health through a health risk assessment (HRA). Providers may create their own HRA form or use standard forms that are available for public use on the Internet. The HRA must include demographic data, a self-assessment, psychological risks, behavioral risks, activities of daily living (ADLs), and instrumental activities of daily living (IADLs).
- The subsequent AWV requires the completion and review of a new HRA, as well as an assessment of BMI and blood pressure, and screening for cognitive impairment.

Elements of the AWV that can be mapped directly to the 4Ms are as follows:<sup>8</sup>

4Ms Element	AWV Element
What Matters	Personalized Care Planning (for discussions 15 minutes or less related to ACP)
Mobility	Level of Safety/Falls Assessment
Medication	Medication Review
Mentation	Cognitive Assessment (mood and mentation)

A standardized framework that outlines where and how the 4Ms fit into the AWV is key to ensure ease of implementation for providers. To standardize this implementation, Ascension St. Vincent Medical Group, a pioneer health system in the Age-Friendly Health Systems initiative, created a 4Ms-focused encounter template for practitioners to follow during the AWV. The template maps indicators to each of the 4Ms and includes a recommended action based on the response to the indicator. See Appendix B for an example of a 4Ms AWV template. By embedding this process into providers' workflows, Ascension St. Vincent was able to impact the number of patients who received an AWV and, more specifically, received age-friendly care. Ascension's approach serves as an example for other practices to follow, outlining how to systemically implement the 4Ms into all AWV care encounters.<sup>9</sup>

## Advancing Health Equity

As noted, the AWV is a "talk" visit rather than a hands-on physical exam. This allows providers to develop a deeper understanding of an older adult's health care goals and values, aiding in achieving health equity by better aligning care with a patient's cultural and personal values.<sup>5</sup>

However, there are inequities that persist in the provision of the AWV across racial/ethnic subgroups, with non-Hispanic Blacks being the least likely to receive this care compared to white Medicare beneficiaries.<sup>5</sup> To ensure equitable care is being provided, there must be a concerted effort to conduct the AWV with all older adults

served by each provider and expand AWVs to providers serving communities of color.

## Return on Investment Considerations

There are certain approaches that can support a positive return on investment (ROI) when incorporating the 4Ms into the AWV. Most importantly, 4Ms-focused AWVs improve the reliability and dignity of care for older adults during the AWV. They can also create financial benefits for providers. For example, while traditional primary care clinicians such as physicians and nurse practitioners can perform the AWV, CMS regulations also allow the AWV to be completed by registered dietitians, health educators, or other licensed practitioners, or by a team of medical professionals under the supervision of a physician.

To ensure practitioners are operating at the top of their licenses, practices may choose to increase the proportion of AWVs conducted by these other licensed practitioners rather than by physicians.<sup>10</sup> In addition, to save time during the AWV, some safety/risk assessment tools can be completed by the older adult/caregiver while they are in the waiting room, as appropriate, then subsequently scanned and reviewed by the practitioner conducting the visit. This will help maximize AWV net income and ensure a better investment of providers' and the team's time.<sup>9</sup>

As noted earlier, incorporating the 4Ms into the AWV may also drive subsequent income-generating encounters including the advance care plan. The ACP requires permission of the older adult and is a voluntary face-to-face conversation between a physician and patient that concerns advance directives pertaining to future medical treatment should a patient not be able to make decisions independently at that time. Effective in 2016, CMS began paying for the ACP under standard fee-for-service Medicare reimbursable codes. Because using the 4Ms framework encourages acknowledgement of a patient's end-of-life goals, especially when What Matters is explicitly addressed, the AWV can prompt a subsequent ACP that is either co-billed with the AWV (if the discussion lasts a duration of 16 minutes or more) or scheduled as a separate visit.

It may be advantageous to discuss the ACP during an AWV, especially for older adults who are frail or for family caregivers who have health issues and/or need to take

time away from work to transport the older adult to the appointment. Benefits may include reduced time to prepare for the visit, travel time, and related expenses. However, it is also important to be mindful that longer visits can also be challenging for individuals, so the concerted decision to take additional time during the AWW or schedule a separate ACP visit should be based on What Matters to the older adult and family caregiver. Overall, after formally implementing the 4Ms framework into the AWW at Ascension, data showed the probability of a subsequent ACP was nearly doubled.<sup>9</sup>

Incorporating the 4Ms into the AWW can also lead to potentially improved quality scores in value-based reimbursement programs. There are 25 preventative screenings that can be prescribed under Medicare Part B, which for many medical groups contribute to performance on quality measures in addition to directly driving revenues. When following a prescribed 4Ms framework, the AWW provides an opportunity for practitioners to address some of the most common screenings, including falls, depression, colorectal cancer, and breast cancer, thus driving the number of these preventative screenings.<sup>9</sup> At Ascension, these changes to incorporate the 4Ms into the AWW had a projected potential to generate an added annual net income of about \$3.6 million.<sup>9</sup>

## Challenges

While the AWW is a universal benefit for all beneficiaries covered under Medicare Part B, only an estimated 24 percent of eligible beneficiaries receive an AWW each year.<sup>11</sup> In addition, Medicare data have shown that less than half of all medical practices provide an AWW.<sup>5</sup> Efforts are needed to increase the number of AWWs provided overall, as part of a more specific strategy to incorporate the 4Ms.

It is important to acknowledge that it may be challenging for some practices to immediately scale up these visits. Practices may want to start implementation with the “Welcome to Medicare” visit in year one, which includes a review of an older adult’s medical and social history related to their health, and then gradually add the AWW.<sup>12</sup> Given the current low adoption of the AWW, this is an advantageous time for the 4Ms framework to be universally adopted into the AWW as that will become the precedent among new providers learning about how to conduct the visit.

## Moving Forward

Because of its standard fee-for-service reimbursable code, the AWW is a compelling opportunity for providers to begin to systematically incorporate the 4Ms into everyday patient interactions with older adults. Practical tools and a solid business case can meaningfully reduce barriers to implementation and clear a path for more widespread integration of the 4Ms into all points of care.

Incorporating the 4Ms framework into the AWW through a 4Ms-focused encounter template for practitioners to follow during the visit will help ensure clinical best practice intersects with billing, resulting in the most effective clinical and financial outcomes. In addition to creating this template, it is necessary to support more widespread uptake of a 4Ms-focused AWW by developing more case examples, training materials (including videos), and professional development regarding how to apply billing codes effectively to provide a ROI for providers.

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### What Is an Age-Friendly Health System?

Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, known as the “4Ms,” to all older adults: What Matters, Medication, Mentation, and Mobility.

Visit: [ihi.org/AgeFriendly](https://ihi.org/AgeFriendly)

## References

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## Appendix A: Example Notable Billing Codes

Notable Billing Codes	
<b>Initial Annual Wellness Visit (IAWV)</b>	G0438
<b>Subsequent Annual Wellness Visit (SAWV)</b>	G0439
<b>Advanced Care Planning</b>	99497 for the first 30 minutes of counseling or 99498 for each additional 30 minutes of time, A provider must provide a diagnosis code with the advance care planning code, but this can be any diagnosis pertinent to the patient's medical care. To waive the patient's deductible for advance care planning, Medicare requires a modifier (-33,) noting that the counseling was completed on the same day and by the same provider who completed the AWV. It is billed in the same claim as the AWV.
<b>Problem-Based Office Visit</b>	99213, 99214; If an additional separately identifiable and medically necessary service unrelated to the AWV is provided in the visit (e.g., evaluation of a new cough). Modifier (-25) is used with the appropriate CPT code for the level of service provided.

## Appendix B: Example 4Ms Annual Wellness Template

What Matters					
How would you rate your health?	Excellent	Good	Fair	Poor	
What matters most to the patient?	Notes:				
Specific health outcome goals to achieve what matters most	Goal 1:	Goal 2:	Goal 3:		
Care preferences	Prefers home health	Prefers curative treatment options	Prefers minimally invasive treatment options	Prefers palliative care	Prefers hospice
Advance directive	Advance health directive on file		Advance health directive not on file		
Medications					
Medication List Reviewed	Medication reconciliation performed		Medication reconciliation not performed		
	Medication reviewed by:				
	Taking medications as directed		Not taking medications as directed		
High Risk Medications	Not currently taking high-risk medications		Currently taking high-risk medications		
	Sleep medications	Benzodiazepines	Highly anticholinergic medications		
	Antipsychotics	Muscle relaxants	Opioids	Tricyclic antidepressants	
Perception of Medication Barriers	None	Non-adherence	Ineffective symptom control	Medication cost	
	Interferes with sleep/activities	Lack of trust/communication with provider	Not helping illness	Personal beliefs	
	Taking pills is unpleasant	Trouble swallowing	Transportation issues	Other:	
Questions or Concerns Regarding Medications or Medication Routines	Notes:				
Problems with Home Medications	None	Non mechanism for timely refill	Difficulty obtaining medication		
	Lack of transportation	Lack of money	Uses multiple pharmacies	Other:	
Mentation					
Dementia Tool	Mini-Cog	SLUMS		MOCA	
Dementia Finding	Unremarkable	Needs further follow-up	Not completed	Not applicable	
Depression	PHQ2/PHQ9 completed and reviewed		PHQ2/PHQ9 not completed		
Mobility					
Screen for Mobility Limitations	STEADI screening completed and reviewed				
	Unremarkable		Increased risk		
	Additional fall assessment performed:				