Medicare Annual Wellness Visit including Health Risk Assessments

**Summary:** Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. Such services would include a comprehensive health risk assessment. The personalized prevention plan would take into account the findings of the health risk assessment.

**Status Updates:**
- On June 20, 2011, the Centers for Medicare and Medicaid Services (CMS) released a new report showing that more than 5 million Americans with traditional Medicare – or nearly one in six people with Medicare – took advantage of one or more of the recommended preventive benefits now available for free. Over 780,000 beneficiaries received an Annual Wellness Visit between January 1 and June 10. Additionally, more seniors have used the Welcome to Medicare Exam this year. 66,302 beneficiaries had taken advantage of the benefit by the end of May 2011, compared to 52,654 beneficiaries at the same point in 2010 – a 26 percent increase.
- On July 1, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates for physicians and nonphysician practitioners (NPPs) for services paid under the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2012. As part of that proposed rule, CMS outlined criteria for a health risk assessment to be used in conjunction with Annual Wellness Visits, for which coverage began January 1, 2011 under the Affordable Care Act.

**Next steps:**
- January 1, 2011 – Effective date of this new provision (and included in the 2011 Medicare Physician Fee Schedule).
- March 16, 2011 – HHS released a report stating that 150,000 seniors have received an annual wellness visit.
- March 23, 2011 -- Secretary must establish standards for inter-active telephonic or web-based programs used to furnish health risk assessments.
- June 20, 2011 – CMS issued a report stating that over 780,000 seniors received an annual wellness visit between January 1 and June 10.
- July 1, 2011 – CMS issued proposed rule.
- August 30, 2011 – Comments due on proposed rule.
- November 1, 2011 – CMS final rule.
- September 23, 2011 -- Secretary must develop and make publicly available a health risk assessment model.
- January 1, 2012 – Changes for calendar year 2012 go into effect.
Additional information:
- Center for Medicare Advocacy article on the annual wellness visit -- http://www.medicareadvocacy.org/InfoByTopic/PartB/10_09.09.WellnessVisit.htm
- American College of Physicians article regarding the annual wellness visit -- http://www.acponline.org/running_practice/practice_management/payment_coding/wellness.htm
- National Council on Aging article on the annual wellness visit -- http://www.mymedicarecommunity.org/showthread.php?t=4544

Long summary:
Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan (as modified by sec. 10402).
Effective January 1, 2011, Medicare may provide coverage of personalized prevention plan services, including a health risk assessment and the furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services.

Clinicians covered. The services may be furnished by: (1) a physician, (2) a nurse practitioner, clinical nurse specialist or physician assistant, or (3) a medical professional (including a health educator, registered dietician, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

Interaction with “Welcome to Medicare” physical. A Medicare beneficiary is eligible to receive personalized prevention plan services each year provided the beneficiary has not received such services or a “Welcome to Medicare” physical within the preceding 12-months.

No deductible, no coinsurance. Medicare payment to the provider will be at 100 percent of the physician fee schedule amount (that is, no deductible, no coinsurance) even when the services are provided in a hospital outpatient setting.

Legislative text:
SEC. 4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.
(a) COVERAGE OF PERSONALIZED PREVENTION PLAN SERVICES.—
(1) The term ‘personalized prevention plan services’ means the creation of a plan for an individual—

(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

(B) that—

(i) takes into account the results of the health risk assessment; and

(ii) may contain the elements described in paragraph (2).

(2) Subject to paragraph (4)(H), the elements described in this paragraph are the following: “

(A) The establishment of, or an update to, the individual’s medical and family history.

(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

(C) A measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

(D) Detection of any cognitive impairment. “

(E) The establishment of, or an update to, the following:

(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual’s health status, screening history, and age-appropriate preventive services covered under this title.

(ii) A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits. “

(F) The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

(G) Any other element determined appropriate by the Secretary.

(3) A health professional described in this paragraph is—

(A) a physician;

(B) a practitioner described in clause (i) of section 1842(b)(19)(C); or

(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

(4) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after the date of enactment of this subsection, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

(ii) may be furnished—

(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B);

(II) during an encounter with a health care professional;

(III) through community-based prevention programs; or

(iv) through any other means the Secretary determine use by beneficiaries, while ensuring the privacy of such beneficiaries.

(B) Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I). The Secretary may utilize any health risk assessment developed under section 4004(f) of the Patient Protection and Affordable Care Act as part of the requirement to develop a personalized prevention plan to comply with this subparagraph.

(C) Not later than 18 months after the date of enactment of this subsection, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

(D) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

(I) ensure that health risk assessments are accessible to beneficiaries; and

(ii) provide appropriate support for the completion of health risk assessments by beneficiaries. ’

(E) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of adherence to provider recommendations in order to improve the health status of beneficiaries.

(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (ww)(1))
during the 12-month period after the date that the beneficiary’s coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.

“(H) The Secretary shall issue guidance that—

“(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

“(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.”.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(a) by inserting “other than personalized prevention plan services (as defined in section 1861(hhh)(1))” after “(as defined in section 1848)(i)(3))’’;

(b) by striking “and” before “(W)”;

(c) by inserting before the semicolon at the end the following: “, and (X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848’. 

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting “(2)(FF) (including administration of the health risk assessment) ,” after “(2)(EE),”.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking “and diagnostic mammography” and inserting “, diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1))”.

(b) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking “and” at the end;

(ii) in subparagraph (G)(i), by striking the comma at the end and inserting “, and”; and

(iii) by inserting after subparagraph (G)(i) the following new subparagraph:

“(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),”.

(4) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(a) by striking “and” before “(9)”;

(b) by inserting before the period the following: “, and (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1))”.

(d) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking “and” at the end;

(B) in subparagraph (O), by striking the semicolon at the end and inserting “, and”; and

(C) by adding at the end the following new subparagraph:

“(P) in the case of personalized prevention plan services (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;”;

(2) in paragraph (7), by striking “or (K)” and inserting “(K), or (P)”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.