Revenue Rebound Strategy

How to Leverage Telemedicine for Medicare

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CareGPS Health improves patient care and generates new revenue through turnkey delivery of value-based preventive care solutions, including CMS's Annual Wellness Visit and supporting care coordination services

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The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Objectives

1. Summarize the legislative changes to telemedicine allowing remote care delivery into the home
2. Identify the goals and objectives which need to be prioritized to take advantage of the opportunity
3. Summary of specific services to generate revenue amid reduced patient volume and office closures
4. Guidance on billing for telemedicine services, delivered from your office to patients at home
5. Review of Medicare and SBA programs to address short-and-long term cash flow concerns

Medicare Telemedicine Before

Models a face-to-face visit in a professional setting

- Patient must physically be at an authorized "Originating Site"
  - Facility type of physician office, hospital, clinic, skilled nursing, etc
  - Geographically in a Health Professional Shortage Area (HPSA)
- No restriction on the "Distant Site" other than provider type
- Additional limitations on the types of service that can be delivered
  - 106 original services covered; see source reference below
- Services must be delivered via live telemedicine (real-time video chat)
  - Some exceptions for HI and AK
- "Originating Site" may generate a facility fee for hosting the patient
  - Check HCPCS code Q3014 for full details
- Distant Site practitioner bills normal rate with "GT" modifier
  - Cost sharing still applicable to all delivered services

- In 2019, expansion for Virtual Check-Ins and E-Visits, which are short patient-initiated communications with an existing healthcare provider

Source: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Medicare Telemedicine Now

Allocates for care delivery into your patient's home

- Directed by the Telehealth 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act
- Starting March 6, 2020 and for an ongoing temporary basis
- "Originating Site" requirements are suspended
  - Patient's *places of residence are allowed* without restriction
- Existing patient-provider relationship requirement suspended (HR 748)
- Allowed services expanded by 85 codes to a total of 191
  - Includes E/M visits (eg, *common office visits*) and *preventive services*
- OIG providing flexibility to reduce or waive cost-sharing for telehealth
- HIPAA guidelines are relaxed – Facetime, Skype, WhatsApp, etc
  - "OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 public health emergency."
  - Public video streams should be avoided in all cases (eg, Facebook Live)

Source: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Source: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

Your Telemedicine Strategy

Prioritize meaningful goals and objectives

- Illustrative goals:
  - Be available to patients as they need
  - Be proactive with higher risk patients
  - Provide multiple options for connecting remotely
  - Address shorter-term cash flow issues
  - Drive revenue while patients are at home
  - Identify new long-term revenue options
- Illustrative objectives:
  - Deploy and train staff on a telemedicine platform solution
  - Create a website landing page describing how to reach you
  - Configure a patient information portal for incoming messages
  - Provide patient outreach to educate them on contact options
  - Engage in providing services to individual patients
- All of these are *achievable* and can be accomplished regardless of the specific telemedicine platform, *generating revenue in just days*!

Your Telemedicine Strategy

Focus on specific activities to achieve results

- Train staff on the usage of your telemedicine platform
  - Most importantly, what steps need to occur in order to initiate a video call
  - If a telemedicine platform is still under consideration, choose one with a virtual waiting room and configurable rules for routing calls
- Educate patients on your available and how to request services
  - Update your webpage, phone messaging and answering service
  - Proactively make outbound call to higher risk patients
- Create a plan to deliver your clinical care across all 4 CMS service groups
  - Virtual Check-Ins: 5+ minutes dedicated to clinical discussion via phone
  - E-Visits: Patient-initiated via portal or other electronic means (email/text)
  - Telehealth E/M: Typical FFS efforts provided in-office
  - Telehealth Preventive: Value-based preventive services
    - ✓ Proactive delivery of annual wellness, care planning and screenings
    - ✓ Care coordination and remote monitoring drives monthly revenue
- *Important*: While our focus is Medicare patients, state Medicaid and commercial payers will generally reimburse similar services at parity; check your policies!

Medicare Virtual Check-Ins

Specific service group background

❖ Virtual Check-Ins

In all areas (not just rural), established Medicare patients in their home may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. We expect that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation. These virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to receive virtual check-in services. Coinsurance and deductible would generally apply to these services, but may be waived.

- ✓ **HCPCS code G2012 ($15.70):** Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

- ✓ **HCPCS code G2010 ($13.16):** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service.

Source: https://cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Medicare Telephone and E-Visits

Specific service group background

❖ Telephone and E-Visits

In all types of locations including the patient's home, and in all areas (not just rural), established Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using the telephone or online patient portals (E-Visit). The patient must generate the initial inquiry and communications can occur over a 7-day period. Cost sharing generally applies.

- ✓ ***Practitioners*** who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following: Evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days.
- ✓ ***Clinicians*** who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these bill the following: Qualified non-physician healthcare professional assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days.

Provider	Time	CPT Tel	Avg Reimb	CPT E-Visit	Avg Reimb
Practitioners	5 – 10 min	99441	$14.44	99421	$16.51
Practitioners	11 – 20 min	99442	$28.15	99422	$32.96
Practitioners	21 + min	99443	$41.14	99423	$53.31
Clinicians	5 – 10 min	98966	$14.44	G2061	$12.90
Clinicians	11 – 20 min	98967	$28.15	G2062	$22.67
Clinicians	21 + min	98968	$41.14	G2063	$35.66

Medicare Telehealth Services

Specific service group background

- Telehealth Visits

- ✓ Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person. The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.

- ✓ Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.

- ✓ The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs. For available services, see the attached CMS MLN TELEHEALTH publication.

CMS Information via Video: youtube.com/watch?v=bdb9NKtybzo&feature=youtu.be

Medicare Telehealth Services

Highlights of available telehealth E/M services

- Below is illustrative; a full list can be found on CMS's website, as referenced below

CPT Code	Service Description	Note
99281	Emergency dept visit	COVID-19Temporary
99291	Critical care first hour	COVID-19 Temporary
99234	Obser/hosp same date	COVID-19 Temporary
99341	Home visit new patient	COVID-19 Temporary
99213	Office/outpatient visit est	
99202	Office/outpatient visit new	
99496	Trans care mgmt 7 day disch	
97750	Physical Performance Test	COVID-19 Temporary
G0438	Annual wellness visit; initial	
G0444	Depression screen annual	
G0443	Brief alcohol misuse counsel	
99473	Self-measure BP pt edu/train	COVID-19 Temporary
99497	Advncd care plan 30 min	
G0506	Comp asses care plan ccm svc	
G0459	Telehealth inpt pharm mgmt	

Source: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

CMS Information via Video: https://youtube.com/watch?v=bdb9NKtybzo&feature=youtu.be

Value-Based Preventive Services

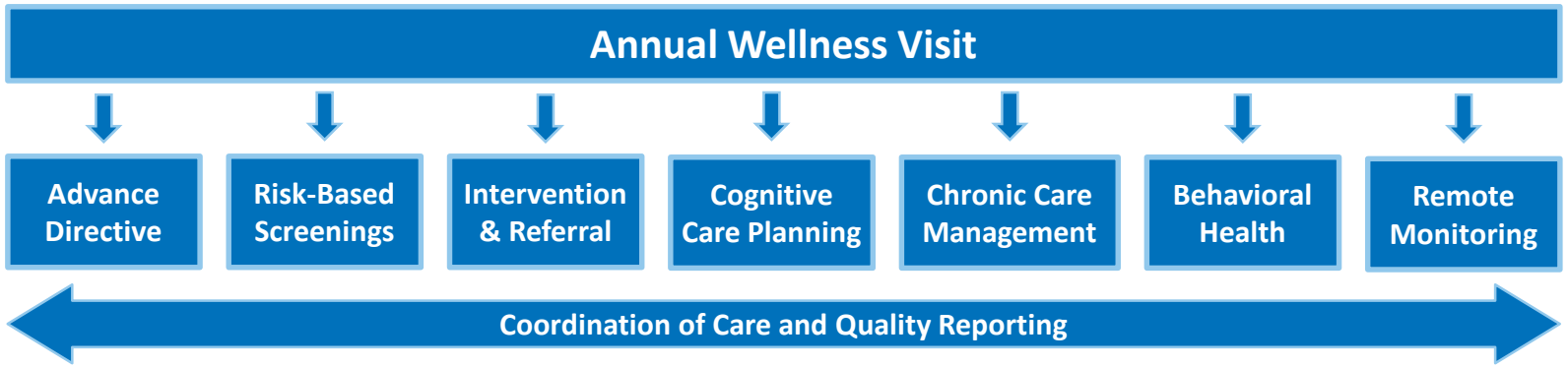
Medicare's framework for implementation

Annual Wellness Visit are considered the "initiating visit" and are the cornerstone of the roadmap to systematic implementation of CMS's value-based preventive program.

MEDICARE PREVENTIVE SERVICES

Alcohol Misuse Screening & Counseling	Annual Wellness Visit	Bone Mass Measurements	Cardiovascular Disease Screening Tests	Colorectal Cancer Screening	Counseling to Prevent Tobacco Use	Depression Screening
Diabetes Screening	Diabetes Self-Management Training	Glaucoma Screening	Hepatitis B Virus Screening	Hepatitis B Virus Vaccine & Administration	Hepatitis C Virus Screening	HIV Screening
IBT for Cardiovascular Disease	IBT for Obesity	Influenza Virus Vaccine & Administration	Initial Preventive Physical Examination	Lung Cancer Screening	Medical Nutrition Therapy	Medicare Diabetes Prevention Program Expanded Model

May be more easily understood and implemented as …



** Derivative AWV preventive services are illustrative and not intended to be a comprehensive grouping*

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AWVs + Care Coordination

Drives additional value

- "Care Coordination" activities significantly enhance the value of Medicare's preventive framework, as they are focused on the provision of personalized health advice and referral to health education or ongoing preventive counseling programs aimed at reducing risk and improving self-management.

✓ Advance Care Planning (ACP)

- ACP is the face-to-face time a physician or other qualified health care professional spends with a patient, family member, or surrogate to explain and discuss advance directives.

✓ Chronic Care Management (CCM) and Transitional Care Management (TCM)

- CCM services are generally non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient. Complex CCM requires more time and involves higher complexity decisions.

✓ Behavioral Health Integration (BHI)

- Integrating behavioral health (BHI) care with primary care is an effective strategy for improving outcomes for patients with mental or behavioral health conditions. CoCM services are administered by a care team comprised of a billing practitioner, behavioral health care manager, and a psychiatric consultant.

✓ Remote Patient Monitoring (RPM)

- RPM technology helps scale healthcare resources by using data to determine whether a physician needs to see the patient while enabling most patients to be screened and monitored at home

Source: cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

Medicare Care Coordination

Background on the family of services

<u>Important points of note about delivering CCM, BHI and RPM:</u>

- Patients must have a condition (2 for CCM) expected to last at least 12 months
- Conditions must place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline
- Physicians and non-physician practitioners (NPPs) may bill CCM services, and must spend at least 15 minutes of time which cannot be delegated
- At least 20 minutes of clinical staff time directed by a physician; may be sub-contracted to US-based qualified care professionals on an "incident to" basis
- Patient consent is required as cost sharing is applicable, and only one practitioner may be paid for CCM, BHI or RPM services for a given calendar month
- Medicare recognizes CCM, BHI and RPM as a critical component that contributes to better health and care for the senior population

Remote Patient Monitoring

Daily physiological recording by the patient

- Remote monitoring of patients' physiological vitals via FDA approved device, integrated by automatic data transmissions, with immediate threshold alarms

Important points of note about delivering remote monitoring services:

- Includes measures like weight, temperature, BP, pulse ox, glucose, spirometry, etc
- Easy-to-use wireless devices are provided to the patient as part of the program
- Patients take readings daily, which are automatically shared with the practice
- Supports chronic conditions such as diabetes, cardiovascular and respiratory diseases
- Must be an existing patient or have an initiating visit (eg, an AWV)
- Must be combined with a clinical care coordination program (20+ min/month) which includes regular outreach and follow-up with the patient on a monthly basis

Medicare Preventive Services Set

Illustrative revenue guidance

Example for a Single Medicare Patient:

CPT	Description	Reimbursement
G0438/9	Annual Wellness Visit, Initial/Subsequent visit	$126-$186
G0442	Annual Alcohol Screen (bundled G0402)	$21
G0444	Annual Depression Screen (bundled G0402/G0438)	$21
99497	Annual Advance Care Planning (16 min)	$92
99453/ G0506	Patient Education on Remote Monitoring (RPM) or Assessment and Care Planning for (CCM)	$21-$68
99490/ 99457	Monthly Care Coordination for CCM or Monthly Care Coordination for RPM	$45-$56 x 12 months
99454	Monthly RPM Monitoring, 16+ Days (Avg Net)*	$32 x 12 months
	Initiating Visit Income Per Patient	**$260-$388**
	Annual Recurring Monthly Income	**$540-$1,056**

- *Rates illustrated are average reimbursement for non-facility settings in NJ (Locality 1240299)*
- *CPT 99454 net value calculated using industry standard device cost for blood pressure, cellular service, and platform fees; 20% cost sharing applies on $70.61*

- ✓ 88% of Medicare patients are eligible for Annual Wellness; 76% eligible for care coordination
- ✓ Each patient requires an initial 90-120 min of staff time to assist in service delivery and enrollment, with 20 minutes or more time monthly to support care coordination
- ✓ Physicians benefit from happier patients, better clinical care, reduced hospitalizations, data to support decision making, and a fully managed coordination of care program
- ✓ **If delivered to only 50% of eligible patients, this generates $44,500 in new annual revenue per 100 Medicare patients, with the initiating visit set reimbursed within 15-20 days**

Preventive Service Roadblocks

Common Reasons

Some organizations have been slow to adopt CMS's preventive program, but these are able to be addressed with an organized implementation plan and the right resources!

- **General Lack of Knowledge**
  - Organizations often report not being familiar with the purpose and requirements of the each program and do not understand the important contribution these visits can make to the practice and patients; apprehension about cost vs reimbursement is common
- **Difficult to Identify, Communicate, Market and Schedule Patients**
  - Organizations often struggle to identify active and inactive patients eligible for preventative services, and conduct the necessary outreach to schedule and follow-up with patients
- **Service Delivery is Considered Complex and Costly**
  - Physicians and staff must be able to distinguish complex requirements and efficiently deliver appropriate services, correctly document, and assign the proper code for billing; high potential for non-compliance, confusion, apprehension, and high costs
- **Poor Electronic Health Records (EHR) support**
  - Most EHRs have no support for documenting the preventive services, making it very time consuming for the physician to correctly document and personalize the plan of care required for billing. Further, the capture of appropriate quality measures is often undocumented.

Medicare Telehealth Billing

Specific to current COVID-19 scenario

- ✓ Claims coding has been simplified in the current scenario
- ✓ The below example assumes a typical primary care physician delivering services from a non-facility professional office with the patient at home
- ✓ Remember to use other modifiers as normal (eg, 25, 33, 59, etc)

Service Type	Medium	Place of Service	Location	Modifier
Virtual Check-Ins	Telephone	11 (Normal POS)	Office	
Telephone and E-Visits	Telephone or Electronic	11 (Normal POS)	Office	
Telehealth Services	Synchronous Audio/Video	11 (Normal POS)	Office	95
Care Coordination	Telephone	11 (Normal POS)	Office	

- ✓ Post the current COVID-19 scenario, we would expect "Telehealth Services" to revert to a POS of 02 (telehealth) and a modifier of GT (for distant site)

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Source: cchpca.org/sites/default/files/2020-01/Billing%20Guide%20for%20Telehealth%20Encounters_FINAL.pdf

CMS Advance Payments Program

Option to address shorter-term cash flow

- CMS may provide accelerated or advance payments during the period of the public health emergency to any Medicare provider/supplier who submits a request to the appropriate Medicare Administrative Contractor (MAC) and meets the required qualifications.

- This program is only for the duration of the public health emergency. Specific details on eligibility and the request process may be found at the source below. The summary below reflects the passage of the CARES Act (P.L. 116-136):

  - ***Eligibility***: Have billed Medicare for claims within 180 days and be in good standing

  - ***Amount of Payment***: Up to 100% of the Medicare payment amount for a three-month period

  - ***Processing Time:*** Each MAC will work issue payments within 7 days of receiving the request.

  - ***Repayment:*** To start no later than 120 days after the date of issuance of the payment, with complete repayment no later than 210 days from the date of the advance payment.

Source: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

Small Business Administration Loan

Option to address longer-term cash flow

- The CARES Act was signed on March 27, 2020, which contains $376 billion in relief for American workers and small businesses, including establishment of several new temporary programs within the SBA for small businesses.

- ✓ **Paycheck Protection Program:** This loan program provides loan forgiveness for retaining employees by temporarily expanding the traditional SBA 7(a) loan program. SBA will forgive loans if all employees are kept on the payroll for eight weeks and the money is used for payroll, rent, mortgage interest, or utilities.

- ✓ **Economic Injury Disaster Loan (EIDL) Emergency Advance:** This loan advance will provide up to $10,000 of economic relief to businesses that are currently experiencing temporary difficulties. This advance will provide economic relief to businesses that are currently experiencing a temporary loss of revenue. Funds will be made available following a successful application. This loan advance will not have to be repaid.

- ✓ **SBA Express Bridge Loans:** Enables small businesses who currently have a business relationship with an SBA Express Lender to access up to $25,000 quickly. Used to help overcome the temporary loss of revenue and can be a term loans or used to bridge the gap while applying for a direct SBA Economic Injury Disaster loan.

- ✓ **SBA Debt Relief:** The SBA is providing a financial reprieve to small businesses during the COVID-19 pandemic. If your disaster loan was in "regular servicing" status on March 1, 2020, the SBA is providing automatic deferments through December 31, 2020.

Source: https://www.sba.gov/funding-programs/loans/coronavirus-relief-options

Resources

- Center for Connected Health Policy (CCHP)

A nonprofit, nonpartisan organization working to maximize teleheath's ability to improve health outcomes, care delivery and cost effectiveness. CCHP actively researches and analyzes important telehealth policy issues, engages influential public and private sectors through analyses and reports, and provides key telehealth policy resources nationwide.

Policies - https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies

Telehealth Billing - https://www.cchpca.org/sites/default/files/2020-01/Billing%20Guide%20for%20Telehealth%20Encounters_FINAL.pdf

- Small Business Administration (SBA) COVID19 Loan Resources

SBA works with a number of local partners to counsel, mentor, and train small businesses. The SBA has 68 District Offices, as well as support provided by its Resource Partners, such as SCORE offices, Women's Business Centers, Small Business Development Centers and Veterans Business Outreach Centers.

https://www.sba.gov/page/coronavirus-covid-19-small-business-guidance-loan-resources

- Interactive Guide to Medicare's Preventive Services and Preventive Checklist

This educational tool will help you properly furnish and bill Medicare preventive services with information by service.

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

https://www.medicare.gov/Pubs/pdf/11420-Preventive-Services-Card.pdf

- Framework for Patient-Centered Health Risk Assessment

Centers for Disease Control and Prevention (CDC) provides an evidence-informed framework for providers, policymakers, health plans, payers, researchers, and vendors on the implementation of patient-centered health risk assessments (HRAs), follow-up activities, and monitoring of progress toward achieving health improvement goals.

https://www.cdc.gov/policy/hst/HRA/FrameworkForHRA.pdf

- Patient-Centric NJ Advance Directive Kit

Provided by the Regents of the University of CA

https://prepareforyourcare.org/advance-directive-state/nj

Questions and Answers

- For those viewing this presentation after the live webinar, questions may be directed to: ask@caregps.health

APPENDIX

Reference on Annual Wellness Visits, the cornerstone of Medicare's Preventive Services Framework

Medicare's Annual Wellness Visit

What it is, and what it isn't

- A preventive visit covered at no cost to patients
- A way to connect with your patients, focus on issues that may be overlooked in routine physical exams and develop a long-term preventive care plan
- **IS NOT:** A typical physical exam with "touch" and lab work

Medicare AWV	VS	Physical Exam
More focused on a conversation with your patient about their current health risks and creating a comprehensive plan for necessary preventive services for the next five-10 years along with any recommendations for lifestyle intervention including: • Diet • Physical activity • Tobacco use cessation • Fall prevention		A physical exam is much more extensive. Most of the time a physical exam is a head to toe exam with lab work. • Performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury • Not covered by Medicare; prohibited by statute, patients pays 100% out of pocket

AWV Visit Comparison – 3 Types

Welcome to Medicare Visit (G0402)

Initial Preventive Physical Examination, or IPPE

- Medicare pays for one per lifetime
- Must be done in **first 12 months** of Part B coverage

Example:

According to Medicare criteria, Martha is eligible for a:

Welcome to Medicare Visit

because she enrolled in Medicare less than 12 months ago.

Initial Medicare Annual Wellness Visit (G0438)

- Applies the first time a beneficiary receives an AWV
- Patient is eligible **after the first 12 months** of Part B coverage
- Patient hasn't completed a Welcome to Medicare Visit in the past 12 months

Example:

According to Medicare criteria, Joe is eligible for an:

Initial Medicare AWV

because he's had Medicare for longer than 12 months and has never had an AWV

Subsequent Medicare Annual Wellness Visit (G0439)

- Applies to all AWVs after a beneficiary's initial AWV
- No AWV within the past year

Example:

According to Medicare criteria, Mary is eligible for a:

Subsequent Medicare AWV

because she's had Medicare longer than 12 months and it's been more than 11 months since her initial AWV.

Welcome to Medicare Visit	Initial Medicare AWV	Subsequent Medicare AWV
2.43 RVUs	2.43 RVUs	1.50 RVUs
$170 reimbursement rate*	$175 reimbursement rate*	$120 reimbursement rate*

*Approximate national average reimbursement rate in 2019. Established office visit (99214) has an RVU of 1.50 and a reimbursement rate of $110.

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

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Who Can Provide AWVs?

Any provider meeting the following criteria

- AWVs may be delivered by a physician, PA, NP, CNS, or another medical professional working in a team under the direct supervision of a physician
- Inferred responsibilities include prescription of preventive services, general coordination of care, and availability to service patients requiring clarification or guidance on care

CMS Clarification On Eligible Providers:

Frequently Asked Questions from the March 28, 2012
Medicare Preventive Services National Provider Call:
The Initial Preventive Physical Exam and the Annual Wellness Visit

Who can perform an Annual Wellness Visit?

Medicare Part B covers the Annual Wellness Visit (AWV) if it is furnished by a:

- Physician (doctor of medicine or osteopathic medicine)
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Medical professional (including a health educator, a registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals working under the direct supervision of a physician (doctor of medicine or osteopathy)

As discussed in the preamble of the calendar year 2011 Physician Fee Schedule rule, CMS is not assigning particular tasks or restrictions for specific members of the team. We believe it is better for the supervising physician to assign specific tasks to qualified team members (as long as they are licensed in the State and working within their state scope of practice). This approach gives the physician and the team the flexibility needed to address the beneficiary's particular needs on a particular day. It also

Benefits of CMS's Preventive Care

For the Patient:

- No co-pay
- Strengthened relationship with care providers
- Annual comprehensive preventive evaluation
- Early disease detection and prevention
- Prevent accidents at home
- Keep patients out of the hospital
- Delay long term care
- Potentially reduce risk of chronic disease
- Potentially add years to the patient's lifespan

Helpful Reference - "What Patients Need to Know" AAFP Handout:
https://www.aafp.org/dam/AAFP/documents/practice_management/payment/AWV-Patient-Need-to-Know.pdf

Benefits of CMS's Preventive Care

For the Practice:

- Roadmap to close gaps in care, reconcile medications, and increase care coordination
- Opportunity to build a complete medical history and care plan for complex and chronically ill patients
- Strengthens partnership between clinician and patient, and creates more patient loyalty to the practice
- Increases patient engagement, patient experience and overall level of patient satisfaction
- Opportunity to provide proactive care to patients
- Increases performance on quality metrics, including screenings and immunizations included in value-based care contracts
- Creates a new, sustainable revenue stream for practices