



THE MEDICARE CCM PROGRAM IS SMART, SAFE & VITAL

- **CREATES CHECKLISTS AND PROTOCOLS TO MANAGE CHRONIC DISEASES FOR ELIGIBLE MEDICARE PATIENTS VIA MID-LEVEL NURSE TELEHEALTH VISITS.**
- **MID-LEVELS ASSIGN THEIR BILLING RIGHTS TO THE ORGANIZATION AND WORK UNDER THEIR NPI & INSURANCE.**
- **MID-LEVELS WORK UNDER THE DIRECTION OF A PHYSICIAN AND CONDUCT PROACTIVE MONTHLY TELEHEALTH OUTREACH.**
- **SPECIFIC CARE PLANS FOR EACH PATIENT ARE AGREED UPON BETWEEN THE CARE MANAGER (NP) AND PHYSICIAN.**
- **INCLUDES FIVE SETS OF REIMBURSEMENT CODES WHICH ARE REPORTED MONTHLY ON A TIMED BASIS, EACH SET WITH A BASE CODE OF 20-TO-60-MINUTES AND AN ADD-ON CODE FOR EACH ADDITIONAL 20 MINUTES.**
- **TAKES CARE MANAGEMENT AND MAKES IT PROACTIVE AND RELATIONAL, RATHER THAN REACTIVE AND TRANSACTIONAL.**

The Medicare CCM Program (MCCM) A Timely Solution

We subscribe to the motto — In an environment of government incentivized regulations — superior business intelligence is the ONLY way to triumph.

The MFS increase was not enough

Healthcare organizations and their providers appreciate the sentiment behind the 2026 CMS increase in the physician fee schedule (especially as it relates to supporting primary care physicians). The reality is that the adjustment still falls short. When measured against inflation and the rising costs, the increase does not represent a true raise. Had CMS and Congress addressed the flaws in the sustainable growth rate formula over 20 years ago, ensuring physician payments kept pace with hospital reimbursements and inflation, this increase would be far more meaningful today.

The ongoing threats of reimbursement cuts and the political instability surrounding federal healthcare funding have reached an inflection point. Without a more meaningful increase in CMS reimbursement, it will remain difficult to recruit, retain and sustain physicians as Medicare providers.

Reimbursement is also the primary reason why private practice physicians are dropping out of Medicare. Hospital-owned physicians can get around this with facility fees as well as having the primary care doctor refer everyone to have tests and see a hospital owned specialist. Private investment firms try to increase procedures in physician practices since this increases revenue.

A persistent gap remains between delivering high-value care and receiving fair compensation. In reality, these two things should not be mutually exclusive. Physicians need to continue advocating for both exceptional patient care and equitable reimburse

MCCM has not worked since 2015

In 2015, CMS began paying for CCM under a separate code (99490) in the Medicare Physician Fee Schedule. Reimbursement covers non-face-to-face structured recording of patient health information, maintaining comprehensive electronic care plans, managing care transitions, and other care management services, as well as coordinating and promptly sharing patient health information within, and outside the organization.

However, creating a separately billable code, led to new cost-sharing obligations for Medicare beneficiaries, and low utilization. Cost-sharing was a financial burden and the primary source of confusion, because patients would receive a monthly bill (on average only \$12) without having office visits.

Many healthcare organization's have participated in MCCM at some point since 2015, but fell off. As a result only about 882,000 Medicare beneficiaries eligible for CCM, receive program services (4% of the total eligible beneficiaries). The elimination of the cost-sharing requirement, will





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ensure this population receives care in the best setting for the patient.

Everything is about to change

There is now bipartisan legislation to waive beneficiary cost-sharing requirements for Chronic Care Management services to improve care coordination for the more than 22.5 million Medicare beneficiaries with chronic disease.

The “Chronic Care Management Improvement Act of 2026” (H.R. 8261), was introduced on April 16th, 2026, by Representatives Suzan DelBene (D-WA) and Mike Kelly (R-PA). If passed, would solve this problem by eliminating patient cost-sharing requirements for CCM services under Medicare. Removing this beneficiary cost-sharing requirement, will improve care coordination, and consequently result in better health outcomes for millions of senior citizens.



Many associations and foundations (including the AMA, AHA, ADA, NKF, AMGA, and the AARP) and healthcare provider organizations of all sizes, are supporting the bill. So, the chances are better than average that it will pass both houses and go to President Trump before the end of the summer. If passed, it will go into effect on January 1, 2027.

All health systems, medical groups, hospitals, clinics, and their providers need to add their names to the list of supporters of the bill. In addition, all healthcare executives, physicians, workers, and their Medicare beneficiary patients (along with their families) should contact their congressional representatives and senators, and the House of Representatives switchboard in Washington D.C., and tell them to vote in favor of H.R. 8261.

The contact information for congressional district representatives, senators representing each state, and the House of Representatives switchboard, can easily be found on search engines or you can track the bill and find your representatives contact information on govtrack.us website.

H.R.8261 and new developments now warrant a re-examination

The program is now-more-than-ever, a timely solution that will help your operation and providers improve care coordination and care management, capture additional reimbursement, and maximize financial performance.

All qualified operations and their providers need to get on the uptake as soon as possible.

One thing that should always be kept in mind, on making the decision to participate in the program: Happy patients, could stay enrolled for life, which means providers can bill Medicare, long-term.

There are two factors of a highly qualified professional vendor

We conduct a preliminary Medicare CCM Feasibility Analysis, which is required to address key issues, and complete the preliminary work





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necessary. This includes an in-depth data analysis, developing the clinical policy & culture to follow, provide physician education, conduct patient identification, develop the patient engagement & onboarding strategy, and more.

In addition, we utilize proprietary automation technology, which ensures clean documentation, denial control, and program management.

Without an initial deep analysis, program success is nearly impossible. And with our technology, and a better guidance, and support system; **your** operations and providers can achieve double or even triple average eligible patient enrollment results.

These two factors are the primary reasons why most vendors have failed to generate adequate program adoption, and patient enrollments

[Request your MCCM Info Email](#)

We will send an information email that will show your organization's additional annual reimbursement potential (MCCM Quickview and Detailed spreadsheet). In just a few minutes, your decision makers will know if they want to learn more. There will be a link to watch the Medicare CCM Program Overview video that provides the full detailed information. We have made the process very easy and break everything down in quite simple language. And the Overview video means no initial Zoom meeting to attend.

See the link on our website (URL below) to request your MCCM Info Email.

