

2026 Issue Brief

Pathway to Value

Issue

Over the past several years, federal policymakers have embarked on bipartisan efforts to transition the current healthcare landscape to value-based care and reimbursement. However, providers still face significant impediments to taking on risk, which slow progress toward moving to an actual value-based healthcare system. Also, the pandemic changed the way we deliver care, and we depend on policymakers to provide clear instructions by permanently extending certain policies. Policymakers must address the significant obstacles and challenges that currently exist in the healthcare market to clear a pathway to value-based care.

Extend the Current Telehealth Waivers

This is the sixth year that the telehealth waivers passed by Congress during the COVID-19 pandemic have remained in place. The waivers, which eliminated Medicare's telehealth originating site and geographic limitations, created a dramatic shift in how care is delivered in this country. The law also extended recognition of audio-only payments in that same period. These policies should be extended permanently to ensure increased patient access to care. The waivers allow patients in rural and urban areas who lack transportation to receive care from their providers within their homes. As a result, patients have come to expect telehealth services as a standard method of care delivered by their providers. Policymakers must extend these telehealth policies permanently so providers can confidently invest in this technology and so patients, particularly those with mobility issues or reside in rural communities, can receive care. Congress should consider the inclusion of waivers in a comprehensive telehealth legislative package that includes permanent waivers for the extended provisions and the continuation of payment parity between face-to-face visits and telehealth, and audio-only services to ensure greater patient access to care.

Ensuring Access to Care for the Chronically Ill

Chronic care management (CCM) is a critical part of coordinated care. As a result, Medicare began reimbursing clinicians for CCM under a separate billing code in the 2015 Medicare Physician Fee Schedule. This code is designed to reimburse clinicians for primarily non-face-to-face care management. Clinicians and care managers report many positive outcomes for beneficiaries who receive CCM services, including greater patient satisfaction and adherence to recommended therapies, improved clinician productivity, and reduced hospitalizations and emergency department visits.ⁱ

However, instituting a separate billable code created a beneficiary cost-sharing obligation for CCM services. Under current policy, Medicare beneficiaries are required to pay a 20% coinsurance to receive care management services. This cost-sharing requirement creates a barrier to care, as beneficiaries are being billed for services that do not always include

interfacing with their clinician, thus creating confusion for patients. Consequently, only 684,000 out of 35 million eligible Medicare beneficiaries with two or more chronic conditions benefited from CCM services over the first two years of the payment policy.ⁱⁱ By reclassifying CCM as a preventive service and eliminating the coinsurance requirement, clinicians will increase the utilization of this important service, benefiting a larger proportion of eligible CCM beneficiaries.

Ensuring Provider Access to Data

AMGA members have repeatedly expressed concern that the lack of access to timely commercial payer administrative claims data is the most significant barrier to assuming risk and transitioning to high-value care. Members report that while some payers share this data with providers, the majority do not. Successfully managing a patient population requires that providers have access to data to ensure the most effective course of action to improve health outcomes. With this data, it is easier to manage the cost and care quality for a population of patients, which is a goal of moving to high-value care.

The Centers for Medicare & Medicaid Services (CMS) agrees with AMGA members on the need to share claims data. In 2024, CMS released the Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, and State Medicaid Agencies final rule. In the rule, CMS requires payers to implement and maintain a Provider Access Application Programming Interfacing (API) to facilitate this data exchange for current patients when requested by a provider or facility. The provisions became effective January 1 of this year, for Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program fee-for-service programs, Federally Facilitated Exchanges (FFE), and Medicaid managed care plans.

AMGA asks Congress to:

- **Approve S.1261/H.R. 4206, The Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act, which would permanently remove all geographic restrictions on telehealth services and expand originating sites to include the home and other sites**
- **Approve H.R. 8261, the Chronic Care Management Act of 2026, which would waive the current CCM code coinsurance requirements for Medicare beneficiaries**
- **Require federal and commercial payers to provide healthcare providers access to all administrative claims data**



ⁱ Schurrer, et. al., *Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report*, CMS, 2017, innovation.cms.gov/files/reports/chronic-care-mngmt-finalevalrpt.pdf

ⁱⁱ Colligan, et. al., *Analysis of 2019 Medicare Fee-for-Service (FFS) Claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) Services*, ASPE, 2022, aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf