

CMS Innovation Center (CMMI) Models

CMMI Strategy to Make America Health Again

CMMI announced a new 2025 Strategy to focus on empowering Americans to achieve their health goals and live healthier lives. “Building on 15 years of Innovation Center experience and lessons learned, the updated 2025 Innovation Center strategy takes a comprehensive approach to preventive care anchored in our statutory mandate to protect taxpayers.” CMMI adopted three pillars: promote evidence-based prevention, empower people to achieve their health goals, and drive choice and competition. The strategy outlines how the agency plans to design future models and which ones it will continue or terminate.

Early Terminations of Models (4)

In March 2025, CMMI announced the early termination of four models to align the Center’s portfolio with statutory obligations to reduce program spending while maintaining or improving the quality of care. Specific to primary care, CMMI flagged the importance of accountable care organization (ACO) models to transform primary care delivery in Medicare, as well as the new Advanced Primary Care Management (APCM) service codes available under the Physician Fee Schedule to support primary care.

Making Care Primary (MCP) Model

[MCP](#) was a 10.5 year multi-payer model intended to build off previous primary care models in eight states but was cut short after only one year (ending June 2025).

Primary Care First (PCF) Model

The [PCF Model](#) began in 2021 and tests voluntary participation in a payment structure designed to support advanced primary care delivery through December 2026. The model ended one year early in 2025 and included practices in 26 states/regions.

ESRD Treatment Choices (ETC) Model

The [ETC Model](#) began in 2021 as a mandatory model intended to encourage greater use of home dialysis and kidney transplants for Medicare patients with ESRD. The model was terminated effective December 2025 due to multiple model evaluation reports not showing savings as initially projected.

Maryland Total Cost of Care (TCOC) Model

CMMI and Maryland partnered to test a state-based model setting a per capita limit on Medicare spending in Medicare and was the first CMMI model to hold a state fully accountable for cost for all Medicare patients within the state. The [model](#) built off the prior Maryland All-Payer Model, and will sunset early in December 2025 to transition the state to the AHEAD model in 2026.

New Models (9)

Over the course of 2025, CMMI announced nine new models, focused on several key themes: advancing the Make America Healthy Again (MAHA) agenda (MAHA ELEVATE and BALANCE), using technology & digital tools (ACCESS and WISer), reducing drug costs (GENEROUS, GLOBE, and GUARD), creating new opportunities for ACOs (LEAD), and engaging specialists in value-based care models (LEAD and ASM).

ACCESS (Advancing Chronic Care with Effective, Scalable Solutions)

The [ACCESS model](#) tests outcome-aligned payments (OAP) in lieu of visit-based traditional fee-for-service (FFS) for using digital technology to manage certain conditions (cardio-kidney-metabolic, musculoskeletal, and behavioral health conditions). Participants must be enrolled in Medicare Part B, but participating tax identification numbers (TINs) cannot bill Medicare for any services for patients aligned to them in the model. Participants are guaranteed 50% of the OAP and earn the rest of the OAP based on measured outcomes for a condition population and ensuring there is no overlapping FFS spend by other providers. The model will run from July 2026 through June 2036 and includes a complimentary FDA Pilot program to develop evidence to support bringing more digital tools to the market.

WISer (Wasteful and Inappropriate Service Reduction) Model

[WISer](#) tests the leveraging of AI and machine learning for prior authorization in traditional Medicare for specified services considered vulnerable to fraud, waste and abuse (e.g., skin & tissue substitutes, knee arthroscopy for knee osteoarthritis, etc.) in certain states (AZ, NJ, OH, OK, TX, and WA) from January 2026 through December 2031. The model does not include inpatient-only services (though the Initial Public Offering [IPO] list is sunsetting entirely by 2029), emergency services, or “services that would post a substantial risk to patients if delayed.” Clinicians in impacted states will need to submit prior authorization requests for the model’s items/services or go through post-service pre-payment review by model participants, who receive a percentage of savings associated with averted spending.

LEAD (Long-term Enhanced ACO Design) Model

[LEAD](#) is the Innovation Center’s newest voluntary ACO model that expands on ACO REACH’s professional and global risk arrangements and capitated population-based payments to test new policies for ACOs taking on the highest levels of risk in traditional Medicare. Specifically, CMMI will test Medicaid integration, new CMS-Administered Risk Arrangements (CARA) between ACOs and specialists for episode-based payments, expanding access to medical nutrition therapy services, and in later years, allowing ACOs to partially or fully offset Part D premiums for aligned patients. The model will start in 2027 and run through 2036.

Ambulatory Specialty Model (ASM)

[ASM](#) is the first mandatory physician payment model and was finalized through the CY 2026 Physician Fee Schedule. The model is based heavily off MIPS Value Pathways reporting under the Quality Payment Program and will impact a subset of physicians who treat low back pain or heart failure in selected geographic areas. Physicians will participate as individuals and will be compared to other physicians treating the same condition, starting with 9% risk and growing to 12% by the model’s fifth and final year (2031, impacting payment in 2033). The AAMC [commented](#) on the model proposals in September 2025.

MAHA ELEVATE (Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence)

Under [MAHA ELEVATE](#) CMMI will fund up to 30 proposals that promote health and prevention for traditional Medicare patients that utilize evidence-based, whole-person care approaches – including functional or lifestyle medicine interventions – currently not covered by Medicare to transform health care system to one that proactively addresses root causes of chronic disease. Proposals must incorporate nutrition or physical activity as part of the design and three awards are reserved for interventions to address dementia. Projects will begin September 2026 and run through August 2029.

BALANCE (Better Approaches to Lifestyle And Nutrition for Comprehensive hEalth)

[BALANCE](#) addresses coverage and affordability of GLP-1s for state Medicaid agencies and Medicare Part D plan sponsors. CMMI negotiated prices with Eli Lilly and Novo Nordisk, and now states and Part D plan sponsors can apply to participate in the model, as early as May 2026 for participating Medicaid states and January 2027 for Medicare Part D.

GENEROUS (GENErating cost Reductions fOr U.S. Medicaid)

As a voluntary Medicaid model, [GENEROUS](#) aims to ensure fair and reasonable drug prices for Medicaid through CMS-led negotiations with drug manufacturers. Under the GENEROUS Model, manufacturers will provide supplemental rebates to participating states for drugs included in the model to align Medicaid net prices with what certain other countries pay. The model launched in January 2026 and will run for five years.

GLOBE (Global Benchmarks for Efficient Drug Pricing)

[GLOBE](#) is a proposed mandatory model that will assess a rebate for certain drugs payable under Medicare Part B if the prices exceed those paid in economically comparable countries. Notably, the rebates under this model would be paid by manufacturers to CMS, and not directly impact reimbursement to providers. The model is proposed to run October 2026 through December 2031, with rebate invoicing and reconciliation continuing into 2033. The AAMC [commented](#) on the model in February 2026.

GUARD (Guarding U.S. Medicare Against Rising Drug Costs)

[GUARD](#) is a proposed mandatory model that will assess rebates for specified drugs payable under Medicare Part D if the prices exceed those paid in economically comparable countries. Notably, the rebates under this model would be paid by manufacturers to CMS, and not directly impact reimbursement to providers. The model is proposed to run January 2027 through December 2031, with rebate invoicing and reconciliation continuing into 2033. The AAMC [commented](#) on the model in February 2026.

Modified Models (4)

The Innovation Center retained but modified (or proposed modifications) to four existing models in 2025.

Transforming Episode Accountability Model (TEAM)

[TEAM](#) is a mandatory episodic model focusing on five surgical procedures testing 30-day episodes and better transitions of hospital-based procedures with primary care. CMS amended details of the model as part of the FY 2026 IPPS rulemaking cycle, including by adding a low-volume threshold for holding hospitals harmless for financial performance and adding new quality metrics for future performance years. The model runs through December 2030.

Increasing Organ Transplant Access (IOTA)

The [IOTA](#) model aims to increase access to kidney transplants by incentivizing transplant programs through a mandatory model that measures programs on their number of kidney transplants, organ acceptance, and post-graft survival metrics to achieve incentive payments or penalties. In December 2025, CMMI proposed modifications to the model, including risk adjustment the survival metric and increasing the low-volume threshold; the AAMC submitted [comments](#) in February 2026.

AHEAD (Achieving Healthcare Efficiency through Accountable Design)

[AHEAD](#) is a voluntary state total cost of care model aiming to drive state and sub-state regional health care transformation through multi-payer alignment to improve population health. Specifically, the model considers investments in primary care, hospital global budgets, and geographic ACO entities to share cost and quality targets across payers to stabilize funding and expand access to primary care. The model currently has three cohorts (1: MD, 2: CT, HI, and VT, and 3: RI, NY) and will run through December 2035. CMMI will now allow up to two new states to join the model in July 2026 and begin performance in 2028 or 2029.

CGT (Cell and Gene Therapy Access) Model

The [CGT Access Model](#) is a voluntary model that aims to test outcome-based agreements for cell and gene therapies for Medicaid patients, like for sickle cell disease, as a means to increasing access to potentially transformative treatments. Manufacturers (2) and state (34) participants joined the model between January 2025 and January 2026. CMMI is accepting ideas for additional conditions and treatments for the future years of the model.

Continuing Models (2)

The following models of note have continued without modifications.

GUIDE (Guiding an Improved Dementia Experience) Model

[GUIDE](#) is a voluntary, nationwide model testing impact of coordinated dementia care to support patients and their caregivers through care navigation, 24-hour support lines, caregiver training and resources, and limited annual respite services. The model began July 2024 and runs through June 2032.

IBH (Innovation in Behavioral Health) Model

The [IBH Model](#) is a voluntary state-based model that serves both Medicare and Medicaid patients through improved specialty behavioral health integration with primary care. It runs through 2032, with three active states (MI, NY, and SC).