

Current Center for Medicare and Medicaid Innovation (CMMI/Innovation Center) Models

This past spring, CMMI [announced](#) significant changes to its model portfolio, including the early termination of several models at the end of 2025, actions projected to save \$750 million. The Innovation Center also abandoned the Medicare \$2 Drug List and Accelerating Clinical Evidence models and signaled it would potentially scale-back the Integrated Care for Kids Model. Several months later, CMMI released a new [strategic framework](#) emphasizing prevention, individual engagement, and market-based mechanisms, and subsequently announced nine new models as well as modifications to several existing models.

Ultimately, CMMI oversaw the closeout of seven models and the launch of six new models in 2025. Looking ahead, the Innovation Center plans to initiate at least nine new models and sunset two existing models in 2026, putting the agency’s portfolio at 19 active models by year’s end, assuming no further changes.

The tables below alphabetically catalogue the 16 currently active and 5 announced Innovation Center models as of January 9, 2025. Expanded models (i.e., the Home Health Value Based Purchasing Model and the Medicare Diabetes Prevention Program) and models that have been indefinitely delayed (e.g., Radiation Oncology Model) are not included.

A. Active Models

Demonstration	Summary	Key Dates
ACO PC Flex (Accountable Care Organization Primary Care Flex) Model (Impact summary)	Purpose: Strengthen primary care within Medicare by transitioning select ACOs from traditional fee-for-service (FFS) payments to more flexible, prospective payments.	The model launched in January 2025 and will run through 2030.

Demonstration	Summary	Key Dates
	<p><u>Details:</u> Participating ACOs receive a portion of their primary care payments as upfront, population-based payments rather than through claims-based billing. This approach gives ACOs greater flexibility to deliver high-quality, team-based, and patient-centered primary care, while holding them accountable for improving outcomes, enhancing care coordination, and managing total costs for their attributed Medicare population.</p>	
<p>ACO REACH (Accountable Care Organization Realizing Equity, Access, and Community Health) Model (Impact summary)</p>	<p><u>Purpose:</u> Transition health care providers from FFS models to a total cost-of-care (TCOC) approach for Medicare beneficiaries.</p> <p><u>Details:</u> Participating ACOs are responsible for managing the quality and cost of care for an aligned population over a performance year. Providers receive capitated or risk-adjusted payments and are held financially accountable for meeting quality benchmarks and reducing unnecessary spending while ensuring equitable, coordinated, and patient-centered care.</p>	<p>The first performance period began January 2023 and the model will run through 2026.</p> <p>In June 2025, CMMI published changes to the model for performance year 2026.</p>
<p>AHEAD (States Achieving Healthcare Efficiency through Accountable Design) Model (Impact summary)</p>	<p><u>Purpose:</u> Transition states from fragmented, payer-specific health care systems to a coordinated, multi-payer model that stabilizes health system financing, strengthens primary care investment, and improves population health.</p> <p><u>Details:</u> Participating states (MD, CT, HI, VT, RI, NY) receive funding and regulatory flexibility to implement TCOC and primary care investment targets across payers, supported by statewide accountability structures. States and providers are collectively responsible for better managing total health care spending while advancing prevention, competition, and patient choice.</p>	<p>The model launched in 2026 for Cohort 1 and will launch in 2028 for Cohorts 2&3. All cohorts will run through 2035.</p> <p>In September 2025, CMMI announced new policy and operational changes affecting Medicare payment design and governance that will be implemented across all cohorts beginning in January 2026.</p>

Demonstration	Summary	Key Dates
CGT (Cell and Gene Therapy) Access Model (Impact summary)	<p><u>Purpose:</u> Transition Medicaid coverage of high-cost, transformative therapies from fragmented, state-by-state arrangements to a coordinated, outcomes-based framework that improves access and affordability.</p> <p><u>Details:</u> CMS negotiates multi-state, outcomes-based agreements with manufacturers, tying payment to the effectiveness of therapies for Medicaid beneficiaries. The model initially focuses on gene therapies for sickle cell disease, aiming to enhance health equity, reduce administrative burdens, and ensure sustainable access to life-changing treatments for underserved populations.</p>	<p>In July 2025, the agency announced that 33 states, along with DC and Puerto Rico, will participate in the model. Of these, seven states and DC have applied for and been awarded cooperative agreement funding.</p> <p>States may begin participation anytime between January 2025 and January 2026.</p> <p>The performance period depends on the length of the administration period, the measurement period, and the reconciliation period as negotiated with the manufacturer(s).</p>
EOM (Enhancing Oncology Model) (Impact summary)	<p><u>Purpose:</u> Transition oncology practices from FFS reimbursement to a value-based payment approach focused on high-quality, equitable cancer care.</p> <p><u>Details:</u> Participating practices receive performance-based payments and monthly care management fees to support enhanced services such as patient navigation, care planning, and symptom management. Providers are financially accountable for the TCOC and quality outcomes over a six-month episode of chemotherapy treatment, with a focus on improving care coordination, reducing disparities, and supporting patients throughout their cancer journey.</p>	<p>The model launched in July 2023 and will run through June 2030.</p>
FCHIP (Frontier Community Health)	<p><u>Purpose:</u> Improve health outcomes and access to care in rural, frontier communities in Alaska, Wyoming, Montana, Nevada, and</p>	<p>The initial demonstration began August 1, 2016 and ran through July 31, 2019.</p>

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Integration Project Demonstration	<p>North Dakota by testing new payment and service delivery models tailored to Critical Access Hospitals (CAHs).</p> <p><u>Details:</u> Participating CAHs are given greater flexibility in how they deliver and bill for services such as skilled nursing, home health, and ambulance care. Providers are accountable for enhancing care coordination, reducing avoidable hospital transfers, and maintaining essential services locally, with the goal of strengthening rural health care infrastructure and improving the efficiency and quality of care in isolated regions.</p>	<p>Congress extended the model and the FCHIP demonstration resumed on the next cost report period beginning on or after January 1, 2022.</p>
GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model (Impact summary)	<p><u>Purpose:</u> Transition Medicaid drug payment from fragmented, state-by-state rebate arrangements to a coordinated, CMS-led, most-favored-nation (MFN) pricing approach for brand-name outpatient drugs.</p> <p><u>Details:</u> Under this voluntary model, participating manufacturers provide supplemental rebates to participating states so that Medicaid net prices for model drugs are aligned with what selected other countries pay, in exchange for standardized coverage criteria across those states. The model aims to lower federal and state Medicaid drug spending, improve access to high-cost therapies for people with Medicaid, and support the long-term sustainability of state budgets through fairer, internationally benchmarked drug prices.</p>	<p>The model launched on January 1, 2026 and will run for five years, through 2030.</p>
GUIDE (Guiding an Improved Dementia	<p><u>Purpose:</u> Transition dementia care from fragmented, reactive treatment to a comprehensive, person-centered approach that supports individuals living with dementia and their caregivers.</p>	<p>The model launched in July 2024 and will run through June 2032.</p>

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Experience) Model (Impact summary)	<p><u>Details:</u> Participating organizations receive monthly per-beneficiary payments to deliver coordinated care through interdisciplinary teams that provide care management, caregiver support, and 24/7 access to assistance. Providers are accountable for improving quality of life, reducing caregiver burden, and minimizing unnecessary hospitalizations, with the goal of enabling people with dementia to remain in their homes and communities longer while receiving high-quality, supportive care.</p>	
IBH (Innovation in Behavioral Health) Model (Impact summary)	<p><u>Purpose:</u> Transition behavioral health care from siloed and reactive services to an integrated, whole-person approach for Medicaid and Medicare beneficiaries with moderate to severe mental health conditions and substance use disorders.</p> <p><u>Details:</u> Participating community-based behavioral health organizations receive model-specific payments to deliver coordinated physical and behavioral health care, supported by care management, health-related social needs screening, and connections to community resources. Providers are accountable for improving health outcomes, reducing emergency and inpatient utilization, and addressing health disparities through more accessible, person-centered, and equitable care.</p>	The model launched in January 2025 and will run for eight years, through 2032.
InCK (Integrated Care for Kids) Model (Impact summary)	<p><u>Purpose:</u> Transition pediatric care providers from fragmented, service-based delivery to a coordinated, child- and family-centered approach for Medicaid and CHIP beneficiaries.</p>	The model launched in January 2020 and will run through 2026; however, the Trump administration is considering 'scaling back' the model.

Demonstration	Summary	Key Dates
	<p><u>Details:</u> Providers and community organizations work together to integrate physical health, behavioral health, and social services across multiple settings. Participants are accountable for improving health outcomes, reducing avoidable inpatient stays, and managing the TCOC for children through early identification, prevention, and effective care coordination.</p>	
<p>IOTA (Increasing Organ Transplant Access) Model (Impact summary)</p>	<p><u>Purpose:</u> Transition kidney transplant care from fragmented, volume-based services to a coordinated, value-based approach that enhances access, efficiency, and equity for Medicare beneficiaries with ESRD.</p> <p><u>Details:</u> In this mandatory model, participating transplant hospitals receive performance-based payments tied to metrics such as transplant volume, organ acceptance efficiency, and post-transplant outcomes. Hospitals are financially accountable for increasing transplant rates, maximizing the use of deceased donor kidneys, supporting living donor processes, and improving care coordination, with the goal of reducing disparities and improving patient outcomes nationwide.</p>	<p>The model launched in July 2025 and will run for six years, through June 30, 2031.</p> <p>In December 2025, CMMI released a proposed rule that would update and revise model provisions for performance year two through the end of the model.</p>
<p>KCC (Kidney Care Choices) Model (Impact summary)</p>	<p><u>Purpose:</u> Shift kidney disease management from reactive, late-stage treatment to proactive, coordinated care for Medicare beneficiaries with chronic kidney disease and ESRD.</p> <p><u>Details:</u> Participating providers receive capitated and performance-based payments to support early identification, care coordination, and patient education, including support for home dialysis and kidney transplantation. Providers are financially accountable for</p>	<p>The model launched in January 2022 and will run through 2027.</p> <p>In May 2025, CMMI published changes to the model for performance year 2026.</p>

Demonstration	Summary	Key Dates
	improving quality, slowing disease progression, and reducing unnecessary hospitalizations and costs, with the goal of delivering more person-centered, preventative kidney care.	
RCH (Rural Community Hospital) Demonstration (Impact summary)	<p><u>Purpose:</u> Support small rural hospitals by transitioning them from the Medicare IPPS to a cost-based reimbursement approach.</p> <p><u>Details:</u> Participating rural hospitals receive payments based on the reasonable costs of delivering inpatient care, rather than fixed rates, to help sustain essential services in underserved areas. Providers are accountable for maintaining access to inpatient care, improving financial stability, and supporting the long-term viability of rural health care infrastructure, with the goal of preserving access to high-quality hospital services in isolated communities.</p>	The demo was initiated as a 5-year program under the Medicare Modernization Act of 2003, and extended for an additional 5-year period under the Affordable Care Act. The 21st Century Cures Act provided another 5-year extension, and the Consolidated Appropriations Act of 2021 required an additional 5-year extension, through June 30, 2028.
TEAM (Transforming Episode Accountability Model) (Impact summary)	<p><u>Purpose:</u> Transition acute care hospitals from FFS payments to a mandatory, episode-based payment system for Medicare beneficiaries undergoing certain surgical procedures.</p> <p><u>Details:</u> The model applies to hospitals in selected Core-Based Statistical Areas (CBSAs), representing approximately 25 percent of eligible regions nationwide. These hospitals receive a predetermined target price covering all Medicare Part A and B services associated with the surgical episode, including the inpatient stay or outpatient procedure and the 30-day post-discharge period. Hospitals are financially accountable for the total cost and quality of care during this episode, incentivizing improved care coordination, reduced complications, and enhanced patient outcomes. The model includes procedures such as lower extremity joint replacement, surgical hip</p>	<p>The model launched in January 2026 and will run for five years, through 2030.</p> <p>The agency published updates to the model in July 2025 via the FY 2026 IPPS Final Rule.</p>

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	and femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedures.	
TMaH (Transforming Maternal Health) Model (Impact summary)	<p>Purpose: Shift maternity care from fragmented and episodic services to a coordinated, person-centered approach for pregnant and postpartum individuals enrolled in Medicaid and CHIP.</p> <p>Details: Participating state Medicaid agencies (AL, AR, CA, DC, IL, KS, LA, ME, MN, MS, NJ, OK, SC, WV, WI) and care delivery partners receive funding and technical support to implement whole-person care that integrates physical, behavioral, and social services across the pregnancy and postpartum period. Providers are accountable for improving maternal and infant health outcomes, reducing disparities, particularly among underserved populations, and enhancing continuity of care, with the goal of ensuring safer, more equitable maternity care nationwide.</p>	The model launched in January 2025 and will run for 10 years, through 2034.
WISeR (Wasteful and Inappropriate Service Reduction) Model (Impact summary)	<p>Purpose: Reduce unnecessary spending and improve program integrity.</p> <p>Details: Under the model, CMS will contract with third-party vendors, compensated based on a percentage of savings generated, to implement and manage prior authorization in FFS Medicare across select states (NJ, OH, OK, TX, AZ, WA) and services. The model does not modify Medicare coverage determinations or existing appeals processes. While voluntary for model participants (i.e., companies managing prior authorization), providers in model regions who do not submit a prior authorization request will face mandatory pre-payment medical review. The model introduces AI-enabled prior</p>	The model launched in January 2026 and will run for six years, through 2031.

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	authorization processes for services such as electrical nerve stimulators, arthroscopic knee surgery for osteoarthritis, and skin and tissue substitutes.	

B. Announced Models

Demonstration	Summary	Key Dates
ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model (Impact summary)	<p><u>Purpose:</u> Support technology-enabled, team-based care for Medicare beneficiaries with chronic conditions by layering recurring, outcomes-aligned payments (OAPs) on top of existing FFS and risk arrangements.</p> <p><u>Details:</u> Participating organizations receive OAPs that they can use flexibly to deploy remote monitoring, care coordination, and other digital and person-centered supports, while being held accountable for quality and cost outcomes. The model is designed to complement ACO and other shared-savings frameworks, encouraging providers to leverage technology-enabled care to improve chronic disease management, reduce avoidable utilization, and enhance patient experience.</p>	Model operations begin in July 2026 with OAPs excluded from ACO benchmark and performance year calculations until 2028 for MSSP and ACO REACH. The model is scheduled to end June 30, 2036.
ASM (Ambulatory Specialty Model) (Impact summary)	<p><u>Purpose:</u> Transition specialty care from fragmented FFS arrangements to a value-based, performance-based framework for Medicare beneficiaries with chronic conditions managed by specialists (e.g., cardiology, pulmonology, nephrology).</p>	Participation begins in July 2026 and runs for 5 years, through 2031.

Demonstration	Summary	Key Dates
	<p><u>Details:</u> This mandatory model adjusts Medicare Part B claims for participating specialists based on a total performance score reflecting cost and quality outcomes. ASM aims to improve care coordination, reduce unnecessary services, and enhance equity. The model includes protections for small and solo practices, supports multi-payer alignment, and emphasizes timely performance feedback to clinicians.</p>	
<p>BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model (Impact summary)</p>	<p><u>Purpose:</u> Increase access to select GLP-1 medications for weight management and accompanying healthy lifestyle interventions for people with Medicare and Medicaid by reducing costs and standardizing access.</p> <p><u>Details:</u> Under this voluntary model, CMS will negotiate drug pricing and coverage terms directly with GLP-1 manufacturers on behalf of state Medicaid agencies and Medicare Part D plan sponsors, with the goal of making GLP-1s more affordable and accessible for eligible beneficiaries. The model also pairs medication access with lifestyle support programs (e.g., reduced-calorie diet and increased physical activity supports consistent with FDA labeling) to improve metabolic health and prevent or delay chronic disease and disability.</p>	<p>CMMI released a manufacturer RFA in late 2025, with responses due January 8, 2026.</p> <p>State Medicaid agencies may begin participation in May 2026, while Medicare Part D plan participation is expected to begin in January 2027.</p> <p>A separate, time-limited Medicare GLP-1 payment demonstration will begin in July 2026 to bridge access prior to full implementation.</p> <p>The model will operate through December 31, 2031, with performance periods and reconciliation timelines varying based on manufacturer agreements and participant start dates.</p>
<p>ELEVATE (Make America Healthy</p>	<p><u>Purpose:</u> Transition Medicare’s approach to lifestyle and functional medicine from ad hoc, limited-evidence use to a structured,</p>	<p>CMMI will release a NOFO in early 2026. Roughly 30 cooperative agreements will be</p>

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<u>Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence) Model (Impact summary)</u>	<p>evidence-building framework that evaluates whole-person interventions not currently covered under Original Medicare.</p> <p><u>Details:</u> Participating organizations receive three-year cooperative agreements to deliver evidence-based lifestyle, nutritional, physical activity, and functional medicine services to Medicare beneficiaries, with a focus on preventing or slowing chronic disease progression. Awardees are responsible for implementing safe, research-supported interventions; collecting detailed clinical, utilization, and cost data; and supporting beneficiary engagement and behavior change. Findings from the model will inform future Medicare coverage decisions and potential CMMI model design aimed at improving population health and reducing long-term costs.</p>	<p>awarded (up to \$100 million) in two rounds for cohorts launching in 2026 and 2027; each award will support a three-year performance period.</p>
<u>GLOBE (Global Benchmark for Efficient Drug Pricing) Model (Impact summary)</u>	<p><u>Purpose:</u> Test whether an alternative method for calculating Medicare Part B drug inflation rebates based on international price benchmarks can reduce spending for the Medicare program and lower out-of-pocket costs for beneficiaries while preserving or enhancing quality of care.</p> <p><u>Details:</u> Under the proposed mandatory model, CMS would compare U.S. prices for select Part B drugs administered in clinical settings to prices in economically comparable countries and assess additional rebates when U.S. prices exceed those benchmarks. The model aims to address high and growing costs for physician-administered medications such as cancer therapies and autoimmune treatments by bringing U.S. net prices more in line with international standards.</p>	<p>Public comments on the NPRM for the model are due February 23, 2026. The model is proposed to begin October 1, 2026 and run through September 30, 2031, with rebate invoicing and reconciliation continuing into 2033.</p>

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GUARD (Guarding U.S. Medicare Against Rising Drug Costs) Model (Impact summary)	<p><u>Purpose:</u> Test whether modifying the calculation of manufacturer rebates for certain Medicare Part D prescription drugs using international price benchmarks can lower drug costs for beneficiaries and the Medicare program while preserving or enhancing quality of care.</p> <p><u>Details:</u> Under the proposed mandatory model, CMS would assess additional rebates on select Part D drugs whose U.S. prices exceed prices paid in a set of economically comparable countries, with the goal of reducing out-of-pocket costs, improving medication affordability and adherence, and supporting the sustainability of the Part D program. The model would apply to beneficiaries residing in randomly selected geographic areas and builds on international reference pricing concepts intended to align U.S. drug prices more closely with those paid in other developed nations.</p>	<p>Public comments on the NPRM for the model are due February 23, 2026. The model is proposed to begin January 1, 2027 and operate through December 31, 2031, with rebate invoicing and reconciliation continuing into 2033.</p>
LEAD (Long-term Enhanced ACO Design) Model (Impact summary)	<p><u>Purpose:</u> Transition Medicare accountable care to a long-term, prevention-oriented framework that expands participation among small, rural, independent, and underserved-provider organizations while improving care coordination for high-needs populations.</p> <p><u>Details:</u> In this voluntary ACO model, participating organizations receive flexible, prospective, population-based payments and enhanced benchmarking stability to support team-based, preventive, and whole-person care. Providers are financially accountable for the total cost and quality of care for their attributed Medicare population, with design features that promote patient engagement, evidence-based prevention, and integration of care for</p>	<p>CMMI will release a RFA in March 2026. The model will launch on January 1, 2027, following the conclusion of ACO REACH, and will run for 10 years, through December 31, 2036.</p>

Demonstration	Summary	Key Dates
	beneficiaries with complex needs, including dually eligible and homebound individuals.	