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Overview of Center for Medicare and Medicaid Innovation (CMMI) Models

This document provides an overview of recently released Center for Medicare and Medicaid Innovation (CMMI) models that are currently active, announced, and have applications under review, with information about their goal, stage, participation type, and eligibility criteria. The name of each model is hyperlinked to the applicable CMS page for easy access to additional information.

Model Name	Goal	Stage	Timeframe	Participation Type	Eligibility
Increasing Organ Transplant Access (IOTA) Model	Provides incentives (upside and downside risk) to transplant hospitals to increase kidney transplantation for eligible patients while lowering expenditures.	Active	July 2025 – June 2031	Mandatory	• Hospitals with an annual average of 11 or more kidney transplants in the baseline period, in half of the designated Donation Service Areas (DSAs) across the nation.
Transforming Episode Accountability Model (TEAM)	Tests the next iteration of episode-based alternative payment models. Selected hospitals coordinate care for people under traditional Medicare who undergo a qualifying surgical procedure and assume responsibility for cost and quality of care from surgery through the first 30 days after discharge who underwent one of five surgical procedures: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedures.	Active	January 2026 – December 2030	Mandatory	• All hospitals in eligible Core-Based Statistical Areas (CBSAs) and paid under the Inpatient Prospective Payment System (IPPS).

Model Name	Goal	Stage	Timeframe	Participation Type	Eligibility
Wasteful and Inappropriate Service Reduction (WISer) Model	Aims to modernize prior authorizations (PA) in Medicare Fee-for-service (FFS) Medicare by shifting initial PA responsibilities to third-party technology partners for certain services in select Medicare Administrative Contractor (MAC) jurisdictions. The model will help ensure people with Medicare receive the most appropriate care that supports the best health outcomes while decreasing costs and easing administrative burden on providers and suppliers who go through the prior authorization process.	Active	January 2026 – December 2031	Voluntary for IT participants; Mandatory for providers located in selected areas	• Experience providing recommendations on medical necessity of coverage for payers using enhanced technology like AI. • Companies with clinicians that have the expertise to conduct medical reviews to validate determinations.
Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model	Expands access to GLP-1 medications for weight management for Medicare and Medicaid beneficiaries, paired with required lifestyle interventions. CMS will negotiate drug pricing and coverage terms directly with manufacturers on behalf of participating state Medicaid agencies and Medicare Part D plan sponsors.	Announced - Applications Under Review	Medicare – begins January 1, 2027 State Medicaid agencies can join May 2026 – January 2027 Model testing to conclude December 2031	Voluntary	**Manufacturers:** • Eligible for the initial negotiations or expect to market an eligible product by January 1, 2027. • Eligible products must have an active ingredient that has been approved by the FDA for weight management; be, or act as, a gastric inhibitory polypeptide (GIP) receptor agonist, GLP-1 receptor agonist, glucagon receptor agonist, or in any combination. • Eligible product must have clinical evidence that the product reduces body weight by at least 10% on average. **States:** • Participation in the Medicaid Drug Rebate Program (MDRP).
Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model	Aims to test an alternative payment methodology, Outcome Alignment Payments (OAP), to determine whether technology-enabled chronic care reduces Medicare expenditures while preserving or enhancing quality. ACCESS will initially support Medicare beneficiaries with conditions in early cardio-kidney metabolic, cardio-kidney metabolic, musculoskeletal, and behavioral health clinical tracks.	Announced - Applications accepted on rolling basis but first cohort due April 1, 2026	July 5, 2026 – June 30, 2036 (CMS to accept applicants on a rolling basis through April 1, 2033)	Voluntary	• Part B enrolled providers or suppliers, identifiable by single organizational-level TIN • Eligible to bill under the Physician Fee Schedule
Ambulatory Specialty Model (ASM)	Aims to improve prevention and upstream management of chronic disease, which would lead to reductions in avoidable hospitalizations and unnecessary procedures. ASM focuses on care for Medicare beneficiaries with congestive heart failure and low back pain. This model will reward specialists for improving patient health outcomes and coordination with primary care providers.	Announced	January 2027 – December 2031	Mandatory	• Specialists (in cardiology, anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, or physical medicine and rehabilitation) in an outpatient setting across select regions. • Physician who has historically treated at least 20 heart failure or low back episodes per year as identified by the episode-based cost measure methodology. • ASM participant list released February 4, 2026.

Model Name	Goal	Stage	Timeframe	Participation Type	Eligibility
Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-Based Approaches Through Evidence (MAHA ELEVATE) Model	Provides approximately $100 million to fund 3-year cooperative agreements for up to 30 proposals that promote health and prevention for FFS Medicare beneficiaries. Proposals will utilize evidence-based, whole-person care approaches, including functional or lifestyle medicine interventions, currently not covered by FFS Medicare. Approaches are intended to support, not replace, the medical care received by people with Medicare.	Announced - Letter of Intent due April 10, 2026 and Applications for first cohort due May 15, 2026	First cohort 10/2026 – 10/2029 Second cohort 10/2027 –10/2030	Voluntary	• Demonstrated experience in delivering interventions and that the interventions are safe and effective for the target population • Eligible applicants may include private medical practices, health systems and accountable care organizations (ACOs), Academic organizations, Functional, lifestyle, preventive and integrative medicine centers, Federally Qualified Health Centers and Rural Health Clinics, Community-based organizations, State or local governments, Indian Health Service/Tribal Services/Urban Indian Programs, and Senior living communities. • NOFO was released March 13, 2026
Long-term Enhanced ACO Design (LEAD) Model	Enhance existing ACO framework by providing improved benchmarking for providers without rebasing. Framed as follow-on to ACO REACH, LEAD incorporates enhanced payment options and care delivery flexibility to promote stability. Intended to expand participation among small, rural, independent practices, Community Health Centers, and providers serving high-need Medicare FFS populations (including dually eligible and homebound beneficiaries).	Announced	January 2027 – December 2036 (Request for applications expected March 2026)	Voluntary	• Current ACO REACH Model participants and other ACOs • Current Medicare FFS health care providers that have historically not participated in ACOs. • Providers serving underserved populations, such as those with a high proportion of dually eligible individuals, Federally Qualified Health Centers, and Rural Health Clinics.
Accelerating State Pediatric Innovation Readiness and Effectiveness (ASPIRE) Model	Aims to support whole-person care delivery for children up to age 21 who are enrolled in Medicaid and the Children's Health Insurance Program (CHIP) and who are at risk of developing complex medical and/or behavioral needs. ASPIRE will position Medicaid providers to assume accountability for quality and cost of care of vulnerable youth populations and their families, and support long-term physical and behavioral health management for improved wellbeing, productivity, and economic stability from childhood into adulthood.	Announced	ASPIRE will run for ten years, with exact dates yet to be specified. *Notice of Funding Opportunity (NOFO) to be released in 2026.*	Voluntary	• Five state Medicaid agencies (SMAs) will be eligible to participate. They will receive funding through Cooperative Agreements to implement ASPIRE. • States will partner with organizations ("accountable entities") responsible for managing total health care costs and improving care for covered children and youth. • Entities must partner with providers who have specialized experience delivering care for high- and rising-risk children and youth.
Pharmaceutical Models					

Global Benchmark for Efficient Drug Pricing (GLOBE) Model	Tests an alternative to the Inflation Reduction Act's (IRA) Medicare Part B Inflation Rebate Program by calculating inflation rebates for certain Part B drugs using prices from a defined group of high-income OECD countries. Eligible countries must have at least 60 percent of U.S. purchasing-power-parity–adjusted per-capita GDP and a minimum of $400 billion in purchasing-power-parity–adjusted aggregate GDP. The approach aims to lower Medicare spending and taxpayer costs by benchmarking U.S. drug price growth to international prices.	Announced	October 2026 – September 2031	Mandatory	• High expenditure, sole-source Part B drugs and biological products across therapeutic classes. • Excludes generics and biosimilars, drugs below a Medicare Part B allowed charges threshold, and drugs subject to a negotiated maximum fair price under the IRA's Medicare Drug Price Negotiation Program during the applicable period. • Drugs must have annual allowed charges exceeding $100 million.
GENErating cost Reductions fOr U.S. Medicaid (GENEROUS) Model	Seeks to lower Medicaid drug prices by aligning with those paid in select ex-US countries. The goal is to reduce Medicaid drug spending for states and the federal government while improving access to medications for Medicaid beneficiaries.	Announced	January 2026 – December 2031 - Application deadline for prescription drug manufacturers extended to April 30, 2026; Deadline for manufacturer participation remains June 30, 2026	Voluntary	• Manufacturers that have an active rebate agreement with the Secretary of HHS in the Medicaid Drug Rebate Program (MDRP). • States that participate in the MDRP and secured CMS authorization to enter the necessary Supplemental Rebate Agreements (via the State Plan Amendment process) Medicaid programs and U.S. territories.
Guarding U.S. Medicare Against Rising Drug Costs (GUARD) Model	Tests an alternative to the Inflation Reduction Act's (IRA) Medicare Part D Inflation Rebate Program by calculating inflation rebates for certain Part D drugs using Most Favored Nation (MFN) pricing based on a defined group of high-income OECD countries. Eligible countries must have at least 60 percent of U.S. purchasing-power-parity–adjusted per-capita GDP and a minimum of $400 billion in purchasing-power-parity–adjusted aggregate GDP. The approach is intended to lower Medicare Part D spending and taxpayer costs.	Announced	January 2027 – December 2033 (payment period extends through December 2035)	Involuntary	• High expenditure, sole-source Part D drugs and biological products across select therapeutic classes. • Excludes generics and biosimilars, drugs below a minimum spend threshold as well as drugs subject to a negotiated maximum fair price under the Medicare Drug Price Negotiation Program during the applicable period. • Drugs must have a gross covered prescription drug costs initially exceeding $69 million, which would be indexed to inflation.