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What's Next for CMMI?

Promise and Peril in the Latest Strategic Direction

Introduction

In May 2025, the Centers for Medicare & Medicaid Services (CMS) released its updated strategic direction for the Center for Medicare & Medicaid Innovation (CMMI), which promotes new approaches to lowering costs and improving health that had not previously been taken up by CMMI under prior administrations. Each approach has its own set of new opportunities and potential pitfalls.

Since its establishment 15 years ago, CMMI has worked to transform U.S. health care payment and delivery by shifting away from paying for inefficient volume-based care toward an approach to Medicare and Medicaid payments that holds providers accountable for health care costs and health outcomes. While each new federal administration sets its own strategic goals and direction for CMMI, the mission and mandate of the agency — to change and improve the way the U.S. pays for and delivers health care by lowering costs and improving care quality and health outcomes — has historically been an area of bipartisan agreement and partnership.

This bipartisan partnership has been grounded in the near-universal acknowledgement that U.S. health care spending is unsustainable, particularly when considering the poor health care quality and outcomes experienced by patients across the country.[1] It has also been based in the long-standing evidence that fee-for-service (FFS), the predominant U.S. health care payment model which reimburses providers based on the volume of services delivered, drives inefficient health care spending and fragmented care delivery with no link to quality of care.[2] FFS is not designed to reward successes in promoting the health

and well-being of our communities or to bolster the independent, rural and safety net providers working to treat illness and keep our families healthy.[3] Instead, the way the U.S. pays for health care results in more than $1.4 trillion dollars of wasteful health care spending, much of that due to price increases driven by unchecked health care consolidation and inefficient FFS payments.[4]

CMMI has been a key player in the efforts to shift how the U.S. pays for health care in order to address the outsized impact that rising health care costs have on American families, taxpayers and federal and state governments. It has carried out this critical work through the development and implementation of more than 50 health care payment and delivery models, most notably alternative payment models (APMs).[5] These models have helped pave the way for innovation across public and private payors by better aligning the economic incentives of the health care sector with the health and financial security of our nation's families.

CMMI's new strategic direction and what it could mean for consumers

CMMI's latest strategic direction offers important clarity on the Trump administration's goals and vision for the program. The updated strategy signals a strong focus on generating health care savings for the federal taxpayer — a priority made clear by the recent decision to prematurely sunset four innovation models — including Maryland Total Cost of Care, Primary Care First, ESRD Treatment Choices and Making Care Primary — due to their failure to generate sufficient savings for the Medicare program.[6] While protecting federal taxpayers through achieved savings is the foundational goal of the Trump administration's Innovation Center strategy, CMS describes the agency's ultimate vision as building healthier lives through a three-pronged approach:

Promote evidence-based prevention.

Empower people to achieve their health goals.

Drive choice and competition.

On its surface, this new strategic direction appears to build from previous CMMI strategies set by prior administrations, including President Trump's first administration, which prioritized person-centered care delivery, health care affordability and cross-sector partnerships.[7] However, the details of the latest strategic direction include new approaches to lowering costs and improving health not previously taken up by CMMI under prior administrations, including potential reforms to the Medicare Advantage (MA) program and new investments in the use of technology. Each new pillar simultaneously presents an opportunity to make meaningful improvements to the health care system and has significant risks that could undermine CMMI's progress to strengthen U.S. health care payment and delivery. Below is a breakdown of each of the key components of the updated strategy.

Pillar 1: Promoting evidence-based prevention

This pillar includes two components: embedding preventive care in all models and measuring the impact of preventive care.

1. Embedding preventive care in all models.

The first component outlined in CMMI's updated strategy is the integration of preventive care in CMMI models, including the integration of primary, secondary and tertiary prevention activities, such as nutrition counseling and tobacco cessation, early cancer screenings, and blood pressure control, respectively. Creating financial incentives and ensuring sustainable payment to health care providers to address the underlying drivers of health conditions is essential for any high-value health care system to effectively prevent diseases before they start. A growing body of evidence demonstrates that investments in clinical preventive services, such as early cancer screenings, as well as services that address the non-clinical drivers of health, including those concerned with nutrition or housing stability, reduce health care expenditures and improve the long-term health of patients.[8]

Yet, while CMMI's focus on evidence-based prevention signals a larger shift toward a more holistic approach to health, it also stands in stark contrast to recent executive orders and other administrative actions. The Trump administration drove the passage of H.R. 1 — budget reconciliation legislation that will force more than 15 million people to lose health care coverage and cut $300 billion from the Supplemental Nutrition Assistance Program (SNAP) which provides food assistance to more than 42 million people each month.[9] It also undertook record-breaking reduction in force (RIF) efforts that led to thousands of layoffs of health experts in the Department of Health and Human Services (HHS) and resulted in the dismantling of critical programs on the frontlines of national efforts to combat and prevent chronic diseases. Entire programs were eliminated, including the FDA Center for Tobacco Products, which had been tasked with educating consumers on the dangers of tobacco, as well as the CDC National Center for Chronic Disease Prevention and Health Promotion, which supported healthy behaviors and provided essential services.[10] The administration's promises to promote services like nutrition counseling and tobacco cessation programs, while simultaneously eliminating the infrastructure to do so, raises serious questions about the potential for success for these new goals.[11]

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CMMI also plans to test payment and delivery models that leverage CMS waiver authority and that provide cost-sharing relief to consumers as a way to financially incentivize access to high-value or preventive health care services. One example of the types of innovations CMMI may test would be allowing accountable care entities to use waivers to provide durable medical equipment (DME) not covered by the Medicare program. Due to restrictions on Medicare Part B DME coverage, patients have reported challenges obtaining coverage for DME they rely on outside the home, such as power wheelchairs.[12] Waivers and models designed to incentivize accountable care agencies and physicians with the flexibility to meet patient needs outside the rigidity of FFS payment rules are narrow in focus, yet they offer promise in making modest improvements to health care delivery and payment.

In addition to expanding access to key services, payment models that aim to directly lower costs for patients and consumers by offering cost-sharing relief could help strengthen patient engagement and patient attribution to accountable care and alternative payment models, ultimately helping to accelerate the adoption of APMs across payors and patients and to scale successful payment models nationally.[13]

2. Measuring the impacts of preventive care.

CMMI's new strategy also aims to make changes to its approach for evaluating new models through a greater focus on measuring preventive health outcomes that are important to patients. CMS will specifically test models with incentives designed to increase beneficiary engagement in health promotion and prevention activities. CMMI has not yet defined which activities will be considered "health promotion" or "prevention," but the strategy makes a clear statement that the agency will focus on expanding access to "evidence-based alternative medicine." The shift to incorporate alternative medicine approaches into models poses an opportunity to better integrate whole-person health care delivery needs for patients and consumers into the broader health care system.

However, given actions by HHS Secretary Kennedy and the Trump administration to roll back access to vaccines and terminate funding for hundreds of medical research grants, the emphasis on testing alternative medicines also signals significant risk that CMMI could begin to test models and use Innovation Center authority to undermine evidence-based medical interventions, medical science and health care professionals.

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Pillar 2: Empowering people to achieve their goals

Pillar 2 includes two components: expanding data and information access, including patient health data, treatment information and provider data; and aligning financial incentives with patient health outcomes.

1. Expanding data and information access.

Under this component of CMMI's new strategy, the agency plans to test new models that leverage a variety of consumer information technology tools, such as mobile device applications or health education materials, to identify what resources best support the management of chronic illness. CMMI also hopes to better inform and empower patient decision-making by strengthening the use of transparency and technology tools such as wearable health monitoring devices and those that promote data sharing. These efforts could help drive improvements in patient access to health care providers, increase patient engagement and better inform patients in choices about their health care.[14]

At the same time, medical technology that is impersonal or overly complex, such as through AI-driven or certain digital therapeutic systems, can create distance between patients and providers, unintentionally causing delays in access to needed health care.[15] Other risks include ensuring that new models that test new technologies include important consumer protections for personal and health data collection and use. It will be critical for CMMI to align these new innovations with strong accountability metrics for health care providers using these new technologies to meaningfully drive improvements in health outcomes and improve patient experiences.[16]

2. Aligning financial incentives with health outcomes.

CMMI will also focus on ensuring that provider incentives align with consumer needs through more widespread use of two-sided risk arrangements, global risk and total cost of care (TCOC) models in both traditional Medicare and Medicare Advantage. Global risk and TCOC models are examples of population-based payment models that hold providers financially accountable for delivering all of a patient population's health care needs and effectively managing their health conditions under a pre-determined, defined budget.[17] The focus on continuing to design and test two-sided risk, global risk and TCOC payment models sends a strong signal that CMMI will continue to advance efforts to better align health care costs with patient health outcomes. While participation in value-based arrangements has steadily increased over the past 10 years, in 2023 only 28% of health care payments flowed through arrangements with downside risk and less than 15% flowed through population-based payments, which means the vast majority of health care payments continue to flow through broken FFS economics, including for most providers participating in APMs.[18] CMMI's continued focus on aligning incentives and leveraging population-based payments is an encouraging signal that future models will take meaningful steps to ensure the health care system works for patients.

Pillar 3: Driving choice and competition

Pillar 3 includes three components: increasing independent provider participation in APMs, improving the administration of value-based payment programs and creating more care options for patients.

1. Increasing independent provider participation in APMs.

CMMI's updated strategy aims to create more opportunities for independent providers to participate in alternative payment models by testing new models focused on addressing the financial and infrastructure barriers that prevent many independent providers from engaging in value-based payment efforts. This may include testing models with upfront payments to providers to support the adoption of the technology infrastructure required to participate in models or collecting losses from failure to achieve adequate quality, process or outcome metrics over longer time-horizons to support the success of more financially vulnerable providers in APMs. Testing both components, among others, would be a major step in increasing the adoption of value-based payments among a greater number of providers, including independent providers who typically don't have the financial resources needed to make significant infrastructure and technology investments required to participate in APMs.[19]

2. Improving the administration of value-based payment programs.

Under this component, CMMI plans to improve the administration of value-based payment programs, including through standardizing model design, reducing model changes and generally reducing the administrative burden associated with CMMI models. CMMI has long been criticized for developing overly burdensome models that don't work together, creating challenges and confusion for providers.[20] In 2021, the Medicare Payment Advisory Commission (MedPAC) recommended CMS develop a more harmonized portfolio with fewer APMs that are better designed to work together.[21] While CMMI has been able to test a large number of models and worked to create an evidence base in support of APMs, overlapping model participation has made models difficult to evaluate and muddled the financial incentives for providers.[22] Over the past few years, CMMI has made notable progress in streamlining model testing but more work is needed to improve the compatibility of existing and future models and reduce administrative burden for providers. One caution for CMMI on this front is that models cannot be oversimplified to the point that they are no longer promoting improvements in quality, process and health outcomes. It is essential that CMMI maintain the integrity of individual models, while ensuring these models are thoughtfully designed to work well together — both aspects are critical to increasing adoption of APMs and ensuring incentives are truly aligned with the needs of patients.

While CMMI is a critical testing ground for new innovations and is effective in building a strong evidence base for novel payment models that may eventually be scaled after years of testing, it remains a slow-moving vehicle for policy change that is already widely accepted and grounded in evidence.

3. Create more care options for patients.

CMMI's new strategy includes a stronger focus on addressing real problems in Medicare payment. One example is CMMI's plan to test models in the Medicare Advantage (MA) market that reform MA payment risk score calculations, benchmarks and quality assessment. Research shows that high MA expenditures are driven by flaws in risk score and benchmarking methodologies that have enabled plans to game the system and rake in high levels of profit with little accountability.[23] CMMI also hints at plans to test site-neutral payments in traditional Medicare which address site-of-service payment differentials that pay hospital outpatient departments (HOPDs) more than doctor's offices for the same services.[24]

We are glad to see this strengthened focus from the administration, as flawed payments in the Medicare Advantage program and overpayments to hospitals in the form of site-of-service payment differentials are both major drivers of rising health care costs for taxpayers and the federal government. But ultimately these policy problems require binding legislative and regulatory policy change to meaningfully address them. CMMI's efforts to use its authority to test such policy solutions risks delaying or undermining the legislative and administrative efforts already under way that would more comprehensively and permanently rein in wasteful health care spending. While CMMI is a critical testing ground for new innovations and is effective in building a strong evidence base for novel payment models that may eventually be scaled after years of testing, it remains a slow-moving vehicle for policy change that is already widely accepted and grounded in evidence.

Conclusion

CMMI is an essential laboratory for testing non-FFS payment models, such as population-based payments, and for scaling those models nationally through the Medicare program to establish a sustainable reimbursement system that financially incentivizes whole-person care and population health improvements. As Medicaid and the commercial market often base their payment approaches on Medicare, the impacts of model testing under CMMI have ripple effects across health care payors and will shape the future of American health care payment and delivery. Because of this, it is critical that consumer advocates engage with CMMI in a regular and meaningful way to ensure that current and future models are designed in the best interest of patients and serve to address the deepest consumer needs.

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