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IN FOCUS

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Recent Developments Regarding New and Existing Payment Models at the Center for Medicare and Medicaid Innovation

Introduction

On March 12, 2025, the Center for Medicare and Medicaid Innovation (CMMI), within the Centers for Medicare & Medicaid Services (CMS), announced it would terminate several alternative payment models (APMs) and modify others. In May 2025, CMMI announced a new strategic plan to "Make America Healthy Again." These changes follow several recent reports on CMMI's operations. The Medicare Payment Advisory Commission (MedPAC) recommended in 2021 that CMMI operate fewer, more streamlined APMs with consistent methodologies for measuring quality and expenditures. The Congressional Budget Office's (CBO's) 2023 assessment of CMMI's budgetary effects found that although certain individual models have generated savings, the net impact of CMMI's activities has been to increase federal spending. In 2024, the Assistant Secretary for Policy and Evaluation (ASPE) released a report recommending that CMMI adopt more robust model evaluation frameworks. The recent changes proposed by CMMI and described in this In Focus may be a first step in implementing these recommendations to streamline and standardize CMMI's APM portfolio.

Background on CMMI

Section 3021 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) established CMMI and gave it the authority to "test innovative payment and service delivery models to reduce program expenditures" under Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP) while "preserving or enhancing the quality of care" provided to beneficiaries enrolled in those programs. There are currently over 20 active CMMI models, with additional models announced. CMS has estimated that between October 2022 and September 2024, 57 million individuals, including some enrollees with private health insurance, were affected by or received care through a CMMI model.

Under current law, the Secretary of the Department of Health and Human Services (HHS) must evaluate each model and may expand it (through duration and/or scope) only if the Secretary determines and the Chief Actuary of CMS certifies that the model does or is expected to improve quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. Models that do not meet those criteria may be terminated. Some models that require mandatory participation may be terminated for other reasons, including if CMS no longer has funds to support the model. Individual Model Participation Agreements also may include other conditions under which CMS can terminate model agreements, such as if CMS determines that continuing the model is no longer in the public interest.

Modifications to CMMI Models

CMMI announced that four models are to be terminated earlier than initially planned on December 31, 2025: the Maryland Total Cost of Care (MDTCOC) model, the Primary Care First (PCF) model, the End-Stage Renal Disease (ESRD) Treatment Choices model, and the Making Care Primary (MCP) model. In addition, CMMI is adapting its prescription drug model offerings due to policy changes under the current Administration and is considering modifications to the Integrated Care for Kids (InCK) model. CMS estimates these changes will result in $750 million in net savings, although its methodology has not been made public.

Maryland Total Cost of Care Model

The MDTCOC model is an all-payer APM begun in 2019, limited to the state of Maryland. The MDTCOC evolved from the hospital all-payer rate setting mechanisms the state of Maryland has utilized since the early 1970s. The MDTCOC consists of a hospital global budget component, in which Maryland hospitals are paid a prospective population-based payment amount to cover all annual hospital services, as well as additional incentive payments designed to motivate care coordination and enhance primary care. The most recent evaluation report of the MDTCOC found net savings to Medicare of $689 million and reduced hospital readmissions. The MDTCOC will now end on December 31, 2025, instead of on December 31, 2026, and Maryland will transition to a new, expanded multistate total cost of care model, the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model, in 2026. Maryland signed an AHEAD model state agreement with CMS in October 2024, which set January 2026 as the first performance year for Maryland under the AHEAD model. Additional states and regions will join AHEAD in 2027.

Primary Care First Model

The PCF model is a nationwide multi-payer APM for primary care practices intended to improve patient access to advanced primary care and reduce Medicare expenditures and acute hospitalizations by transitioning participating practices away from fee-for-service payments (FFS). Participating primary care practices receive population-based payments, along with flat visit fees and performance-based payment adjustments. As of December 2023, there were 2,175 practices participating in PCF. An interim evaluation report of PCF published in 2025 found it did not reduce hospitalizations and had increased Medicare expenditures by 1.3%. Twenty-seven percent of initial participants left the model by its third year. The first performance year for PCF was 2021. It will now end on December 31, 2025, one year earlier than planned.

ESRD Treatment Choices Model

The ESRD Treatment Choices (ETC) model was created by CMMI through rulemaking in response to President Trump's "Advancing American Kidney Health" executive order (EO) in 2020. The ETC model is a mandatory model for ESRD facilities and clinicians, designed to incentivize home dialysis, transplant waitlisting, and kidney transplantation. The ETC model is composed of two types of payments: a positive Home Dialysis Payment Adjustment and a Performance Payment Adjustment that can be positive or negative. In an interim evaluation report published in 2024, CMS found no difference in Medicare spending, no difference in the growth rate of home dialysis treatment, and no significant increase in transplant waitlisting or living donor transplantation associated with the model. The ETC model began in 2021 and will now end 1½ years earlier than scheduled.

Making Care Primary Model

The MCP Model was designed to enhance primary care services by offering participating clinicians a pathway toward adopting a prospective population-based payment system. The MCP began in July 2024, with 772 participating practices spread across eight states. Eligible participants could apply for three different tracks, with all tracks eligible for upside-only (i.e., gains but not losses) performance incentive payments and risk-adjusted, per beneficiary, per month Enhanced Services Payments. Participants who were newer to value-based-care could receive upfront infrastructure payments, and more advanced practices could begin to replace FFS revenue through adopting a prospective primary care payment. Although these payments were designed in the context of Medicare FFS, CMMI encouraged the participation of state Medicaid agencies and private payers. No interim evaluation reports on the MCP model are available. The MCP model will now end on December 31, 2025, nine years earlier than originally planned.

Integrated Care for Kids Model

CMMI also stated that it may modify the InCK model as part of the portfolio changes. InCK focuses on reducing out-of-home placements for children by improving early identification and treatment of children's behavioral and physical health needs (including those needs related to the opioid epidemic), improving care coordination, and creating state-specific APMs. The InCK model generally covers children aged 0-20. Some states also serve pregnant adults and CHIP enrollees. The InCK model awarded almost $126 million in funding across six states: Connecticut, Illinois, North Carolina, New Jersey, New York, and Ohio. An interim evaluation report found most participants have implemented per member, per month payments. The model had its first performance year in 2020 and is currently scheduled to run through 2026.

Developments Regarding CMMI Drug Models

CMMI also has announced it will no longer continue developing two models that had been announced but were not yet active: the Medicare $2 Drug List model and the Accelerating Clinical Evidence (ACE) model. These models were developed in response to President Biden's 2022 EO, "Lowering Prescription Drug Costs for Americans," which President Trump rescinded on January 20, 2025. The $2 Drug List model would have standardized cost sharing for certain generic drugs under Medicare Part D at $2. The ACE model would have tested making payment adjustments under Medicare Part B to providers utilizing drugs that were approved under the Food and Drug Administration's Accelerated Approval Program. A third model created under the auspices of the 2022 EO, the Cell and Gene Therapy Access model, is currently reviewing applications and has not been canceled.

On April 15, 2025, President Trump issued a new EO, "Lowering Drug Prices by Once Again Putting Americans First." Section 4 of this EO instructed the Secretary of HHS, through CMMI, to develop a new payment model for high-cost prescription drugs and biological products under Medicare within one year. Another EO issued on May 12, 2025, "Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients," directed the administrator of CMS, and other relevant executive department and agency officials, to create most-favored-nation (MFN) price targets for pharmaceutical manufacturers. During the first Trump Administration, CMS proposed a mandatory MFN model that would have based Medicare Part B payments for certain drugs on the lowest adjusted international price rather than 106% of the average sales price in the United States. CMS rescinded the MFN model interim rule in December 2021.

Considerations for Congress

Although Section 1115A(g) of the Social Security Act provides CMMI broad discretion in its development of models, Congress retains the authority to mandate specific APMs. For example, Section 6042 of the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271) required CMMI to implement the Value in Opioid Use Disorder Treatment Demonstration Program in 2021. Congress also can permanently encode in law a payment tested through a CMMI model if it otherwise may be terminated by CMMI. Section 4134 of the Consolidated Appropriations Act, 2023 (P.L. 117-328), made the services provided under the Medicare Intravenous Immune Globulin Demonstration a standard feature under Medicare Part B.

MedPAC, ASPE, and the CBO have made numerous recommendations on ways CMMI could refine the model development, testing, and evaluation processes. Congress could amend CMMI's underlying statute to incorporate recommendations. H.R. 6732 (introduced in the 118th Congress), for example, would have added limitations on the scope of certain CMMI models; required CMMI to submit proposals for testing, expanding, or modifying models to Congress as well as for public notice and comment; and required a report on model overlap. CMMI is already required under statute to submit a report on its activities to Congress at least once every other year.

Laura A. Wreschnig, Analyst in Health Care Financing

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