# HHS launches a host of transformative payment models **(Oh my!)**

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In the annals of healthcare policy, historians will celebrate December 2025 as the month when HHS revolutionized federal payment for care delivery and drugs. In quick succession, the agency introduced 10 new, transformative and entirely practical models designed by and largely run through the Center for Medicare and Medicaid Innovation (CMMI).

Beyond creative acronyms, these programs share several attributes: They are big, voluntary, emphasize prevention over treatment and pay for health outcomes, not treatment activities. Collectively, they represent game-changing payment reform.

Warren Buffett's long-time investment partner Charlie Munger astutely observed, "Show me an incentive, and I'll show you an outcome."[a]

He further and wryly noted, "If you have a dumb incentive system, you get dumb outcomes"[b]

Endemic to U.S. healthcare are dumb payment incentives that reward high-cost, centralized delivery of acute care services and penalize preventive care services.

Applying Munger's wisdom, the way to transform the way U.S. healthcare delivers care is to change the way the system pays for care. These 10 programs do exactly that.

The "Oh my!" in my commentary's title expresses my surprise at the leadership of CMS Administrator Mehmet Oz, MD, MBA. He has doggedly pursued payment reforms that *actually improve* health outcomes as well as control costs. Let's give credit where it is due. Together, the 10 new pilots exemplify my own mantra: "outcomes matter," "customers count" and "value rules."

## FROM SPAGHETTI TO FILET MIGNON

CMMI came into existence with the passage of the Affordable Care Act in 2010. Its organizing concept is laudable: Create a vehicle with sufficient funding and flexibility to test the effectiveness of novel Medicare and Medicaid payment models.

Unfortunately, CMMI's execution to date has not achieved meaningful results.

CMMI's underperformance hasn't been due to a lack of ideas or willingness to experiment. Just the opposite: In its early years, the center seemed to hatch new payment ideas almost every week. It applied a spaghetti approach to development: Throw a bunch of models into the marketplace and see which ones would stick.

Unfortunately, almost none of them did. As he was leaving office in January 2021, CMMI Director Brad Smith published a 10-year retrospective in *The New England Journal of Medicine*.[c] He noted that only five of 54 models had generated economic savings.

Smith summarized CMMI's dismal performance by saying, "... the vast majority of the Center's models have not saved money, with several on pace to lose billions of dollars. Similarly, the majority of models do not show significant improvements in quality."

**a.** McLachlan, D., "Leadership quote – Charlie Munger on incentives and outcomes," Project Success, Nov. 24, 2020.

**b.** Warren Buffet Archive, "Munger: 'If you have a dumb incentive system, you get dumb outcomes,'" *CNBC*, April 30, 2016.

**c.** Smith. B., "CMS Innovation Center at 10 years — progress and lessons learned," *The New England Journal of Medicine*, Jan. 13, 2021.

As in the iconic 1984 Wendy's commercial, Smith is asking, "Where's the beef?" In aggregate, the new models were too numerous, too small, too complicated, too short in duration and too modest in ambition to drive meaningful reform.

Trump's CMMI has absorbed the past lesson of limited successes and frequent failure. In May 2025, current CMMI Director Abe Sutton issued a policy brief stating that the Center's vision is to "build a health system that empowers people to drive and achieve their own health goals …" [d]

Toward that vision, Sutton identified the following three "pillars" that would drive the design of new payment models within the framework of managing taxpayer funds responsibly:

- Promote evidence-based prevention
- Empower people to achieve their health goals
- Drive choice and competition for people

To a remarkable extent, the new payment models announced in December 2025 reflect CMMI's vision and priorities. They have both sizzle and steak.

Channeling Munger's wisdom, CMMI is launching pilot programs with smart incentives, aligned features and enough scale to improve the healthcare industry's supply-demand dynamics over time. They fall into two broad categories:

- New care delivery and payment models
- New drug pricing models.

Let's review the impressive list.

**NEW CARE DELIVERY AND PAYMENT MODELS**

CMMI has advanced the following models aimed at promoting new care delivery and payment models.[e]

By aligning incentives, inviting widespread participation, measuring performance and adapting design, HHS promises to engage the nation's innovation engine to solve its seemingly intractable healthcare challenges.

**ACCESS (Advancing Chronic Care with Effective, Scalable Solutions).** This 10-year voluntary model launching July 1, 2026, uses an "outcome-aligned payment" approach, rewarding providers for measurable clinical improvements (e.g., blood pressure reduction) rather than service volume. It focuses on four clinical tracks:

- Cardiometabolic
- Kidney
- Musculoskeletal
- Behavioral health (depression/anxiety)

**TEMPO (Technology-Enabled Meaningful Patient Outcomes).** This model is a first-of-its-kind regulatory initiative, announced by the Food and Drug Administration on Dec. 8, 2025, with the pilot having begun Jan. 2, to operate in direct conjunction with CMMI's new ACCESS model. TEMPO serves as the FDA's "companion" mechanism to bridge the gap between innovative technology and Medicare coverage.

**MAHA ELEVATE (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence) Model .** Launching in September 2026, this model will test whole-person, functional and lifestyle medicine interventions (nutrition, physical

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**d.** Sutton, A., "CMS Innovation Center strategy to Make America Healthy again," CMS.gov, page last modified, May 13, 2025.

**e.** Note that the acronyms' capped letters do not always line up with the first letters of each word.

activity) that are not typically covered under traditional Medicare.

**LEAD (Long-term Enhanced ACO Design).** Set to launch Jan. 1, 2027, following the conclusion of the currently underway ACO REACH model (Accountable Care Organization Realizing Equity, Access, and Community Health), LEAD is a 10-year voluntary model designed to help smaller, independent and rural practices participate in ACOs with predictable, sustainable benchmarks.

**WISeR (Wasteful and Inappropriate Service Reduction).** Launched Jan. 1, 2026, this model uses advanced technology to expedite prior authorization and reduce clinically unsupported care vulnerable to fraud and waste.

**TEAM (Transforming Episode Accountability Model).** A mandatory model that began Jan. 1, 2026, TEAM focuses on improving care coordination for patients undergoing major surgeries through five-year performance periods.

**NEW DRUG PRICING MODELS**

CMMI's proposed models aimed at improving pharmaceutical pricing include the following.

**GLOBE (Global Benchmark for Efficient Drug Pricing).** A mandatory model scheduled to launch Oct. 1, 2026, GLOBE ties Medicare Part B rebates to international pricing benchmarks.

**GUARD (Global United Action for Rebates on Drugs).** Proposed to launch Jan. 1, 2027, this model would apply international benchmarks to certain high-cost, sole-source drugs in Medicare Part D.

**BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth).** Launching in 2027, this model targets GLP-1 medications for weight management and metabolic health, negotiating lower net prices directly with manufacturers. A "bridge" GLP-1 payment demonstration is set to begin in July 2026.

**GENEROUS (GENErating cost Reductions fOr U.S. Medicaid Model).** Launching in January 2026, this voluntary model allows participating states to pay prices for certain drugs based on international benchmarks.

**THE FUTURE FOR THE MODELS**

All 10 new delivery and drug models are now soliciting proposals from companies and states (for Medicaid-related pilots). In this way, the models will employ a bottom-up development process to measure performance and incrementally improve program effectiveness.

In addition, these models will provide a trove of health data to assess their individual and collective success in managing the health of individuals and populations in real-life settings. Together with advances in health data interoperability and digital intelligence platforms, these models establish a framework for building a new American healthcare system that delivers better health outcomes at lower cost with easier access and higher quality.

**MARKET AND MEDICINE**

U.S. healthcare is the largest industry ever created by human beings. It is remarkably complex, riddled with perverse economic incentives, fraught with parochial behaviors, captured by special interests and challenged by independent actors exercising monopoly and monopsony pricing power.

The healthcare industry's scale, idiosyncrasies and inertia have frustrated top-down approaches to reform for decades. Lacking meaningful reform, the industry has become more bloated and imbalanced — spending far too much to treat diverse populations that are both aging and getting sicker. Perpetuating this approach will lead to more of the same dismal human and financial outcomes.

It's time for a new approach that prioritizes prevention and health, so the nation can spend

less on acute treatments. The 10 HHS pilots represent a prevention-first orientation to managing America's health focused on outcomes, not on process measures. This new approach will be a boon for companies delivering value-based care services. Expect more to enter the marketplace.

I use the acronym CB2E2 to evaluate the market fitness of healthcare policies and companies. It stands for **C**heaper, **B**etter, more **B**alanced (between prevention and treatment), **E**asier and **E**mpowering (for caregivers and consumers). In concept, all these new payment models pass the CB2E2 test with flying colors. Executing them well, measuring performance and adjusting as necessary will determine their ultimate effectiveness.

Moreover, HHS's organic, bottom-up, evolutionary approach for developing these 10 models is ideally suited to the U.S. healthcare ecosystem. By aligning incentives, inviting widespread participation, measuring performance and adapting design over time, HHS promises to engage the nation's innovation engine to solve its seemingly intractable healthcare challenges.

As an industry, healthcare has suffered from a lethal combination of bad medicine (e.g., over-treatment, under-treatment, under-investment in preventive care, high tolerance for medical errors) and bad market behaviors (e.g., overpricing, facility/practitioner maldistribution, poor consumerism, transaction friction). The models HHS set forth in December apply a market-driven approach to improve healthcare delivery.

Good medicine combined with good market behaviors constitute the righteous path to industry disruption, transformation and rebirth. ▮

About the author

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# The new CMMI models: Timing at a glance

**ACCESS** Applications must be submitted via the Participant Portal by **April 1, 2026.**

**TEMPO** On publishing its notice in the Dec. 18, 2025, issue of the *Federal Register*, the FDA said it was seeking statements of interest for participation in the TEMPO pilot beginning **Jan. 2, 2026.**

**MAHA ELEVATE** CMS says this model will provide about $100 million to fund three-year cooperative agreements for up to 30 proposals that promote health and prevention for "Original Medicare beneficiaries." CMS will release a Notice of Funding Opportunity in early 2026 for the first cohort, and the voluntary model will launch **Sept. 1, 2026.**

**LEAD** This 10-year voluntary model will run from **Jan. 1, 2027, through Dec. 31, 2036.** ACOs can apply to participate in the model by responding to a Request for Applications beginning in March 2026.

**WISeR** CMS says that WISeR will run for six performance years from **Jan. 1, 2026, to Dec. 31, 2031,** in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona and Washington. The application period opened on June 27, 2025.

**TEAM** CMS describes TEAM in the Aug. 4, 2025, *Federal Register* as a mandatory model that will run for five performance years from **Jan. 1, 2026, to Dec. 31, 2030,** in selected "core-based statistical areas" nationwide.

**GLOBE** According to CMS, GLOBE would be a five-year model, launching **Oct. 1, 2026,** and running through 2031, with rebate invoicing and reconciliation continuing into 2033.

**GUARD** CMS says GUARD would be tested over a five-year performance period, launching **Jan. 1, 2027,** and running through **Dec. 31, 2031**, with rebate invoicing and reconciliation continuing into 2033.

**BALANCE** CMS says State Medicaid agencies can join the model beginning in **May 2026,** and Part D plans in **January 2027**. Model testing will conclude in December 2031.

**GENEROUS** Beginning in **January of this year,** this model, voluntary for manufacturers and states, will run for five years.

Source: Information on each of these models, including what is provided here, is available at CMS.gov, or in the case of TEMPO, at fda.gov.