



CorroHealth



# The CMS Innovative Focus for 2026



# A *WAVE* of CMS Innovation

## Today's Discussion

- History of the CMS Center for Medicare and Medicaid Innovation (CMMI)
- Let's Review – CMS Focus and Goals
- The CMMI Models and Current Initiatives
- Overview of The Top Models



# CMS CMMI

## Brief History

- CMMI is part of CMS, focused specifically on driving innovation in healthcare payment and delivery models, while CMS provides the broader administrative and regulatory oversight for Federal healthcare programs.
- Created by the Affordable Care Act in 2010 with the intent to improve care quality and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) through innovation.
- CMMI can test and expand many models without direct Congressional approval provided the Secretary of Health and Human Services determines the model improves quality without increasing spending OR reduces spending without reducing quality. However, Congress can *mandate* specific models or enact models through *legislation* **and** it has the power to prevent a model's expansion.



### Models Requiring Congressional Approval :

1. Mandatory Demonstrations: Congress can pass a law requiring CMI to implement a specific program as it did with the *value in opioid use disorder treatment demonstration* program in the SUPPORT Act;
2. Legislation Impacting Federal Law: if a CMI model would change federal statutes Congress would need to pass legislation to enact it such as enacting A Modell's payment structure permanently into law.



# Recent CMMI Models

## Value in Treatment Demonstration – 4 years

- Opioid Use Disorder Treatment

## GLOBE – 5 years

- Medicare Part B
- MFN Negotiated Prescription Drug Pricing

## GUARD – 5 years

- Medicare Part D
- MFN Negotiated Prescription Drug Pricing

## BALANCE – 5 years

- Medicare Part D and Medicaid
- Increases Access to Select GLP-1 Meds





# December 2025 Activity

## GLOBE – GUARD - BALANCE

### Newsroom Homepage

Press Releases Dec 21, 2025

#### CMS Proposes New Mandatory GUARD Model

CMS Proposes New Mandatory Drug Payment Model to Deliver Lower Drug Prices for Beneficiaries in Medicare Part D The Centers for Medicare & Medicaid Services...

[Read more](#)

Press Releases Dec 21, 2025

#### CMS Proposes New Mandatory GLOBE Model

CMS Proposes New Mandatory Drug Payment Model to Deliver Lower Drug Prices for Beneficiaries in Medicare Part B The Centers for Medicare & Medicaid Services...

[Read more](#)

Press Releases Dec 23, 2025

#### CMS Launches Voluntary Model to Expand Access to Life-Changing Medicines, Promote Healthier Living

CMS Launches Voluntary Model to Expand Access to Life-Changing Medicines, Promote Healthier Living Model test enables state Medicaid agencies, Medicare Part D sponso...

[Read more](#)

GUARD: <https://www.cms.gov/newsroom/press-releases/cms-proposes-new-mandatory-guard-model>

GLOBE: <https://www.cms.gov/newsroom/press-releases/cms-proposes-new-mandatory-globe-model>

BALANCE: <https://www.cms.gov/newsroom/press-releases/cms-launches-voluntary-model-expand-access-life-changing-medicines-promote-healthier-living>



# CMS Innovation Center

<https://www.cms.gov/priorities/innovation/overview>

## Putting all patients at the center of care

The CMS Innovation Center works toward a vision of a health system that achieves optimal outcomes through high quality, affordable, person-centered care.



### Innovation Models

Models test ways to achieve better care for patients, smarter spending, and healthier communities. Learn how to participate.

[Find models](#)



### Where Innovation is Happening

Innovation Center models are implemented across the United States. Locate a participant.

[Access map](#)



### Strategic Direction

Strategies guide the Innovation Center's efforts to drive our health care delivery system toward meaningful transformation.

[Learn more](#)



## CMS Innovation Center

About the Center Value-Based Care

### What Does the Center Do?

The CMS Innovation Center develops and tests health care payment and service delivery models to improve patient care, lower costs, and align payment systems to promote patient-centered practices.

[Learn more](#)



- Functions as CMS's innovation arm, with a specific mandate to test new payment and service delivery models to improve care and reduce costs;
- Operates under CMS's authority and structure, but has its own budget and flexibility to pilot innovative programs;
- If/when a CMMI model is successful (ie. proven to improve care **and/or** reduce cost), CMS can scale it nationally without further Congressional approval;



# “M.A.H.A.”

## Strategic Direction

### CMS Innovation Center 2025 Strategy to Make America Healthy Again



The CMS Innovation Center’s strategic direction focuses on empowering Americans to achieve their health goals and live healthier lives. Building on 15 years of Innovation Center experience and lessons learned, the updated 2025 Innovation Center strategy takes a comprehensive approach to preventive care anchored in our statutory mandate to protect taxpayers.

**Vision:** To build healthier lives through evidence-based prevention, patient empowerment, and greater choice and competition.

**Foundational principle:** Protect federal taxpayers in all CMS Innovation Center models and other activities.



# A Few CMMI Models

**AHEAD** – Achieving Healthcare Efficiency through Accountable Design Model

- Began January 1, 2026 – runs 10 years
- Recent operational adjustment added 1 year

**ASM** – Ambulatory Specialty Model

- Begins January 1, 2027 – runs 5 years

**TEAM** – Transforming Episode Accountability Model

- Began January 1, 2026 – runs 5 years

**WISeR** – Wasteful and Inappropriate Service Reduction Model

- Began January 1, 2026 – runs 6 years



# Achieving Healthcare Efficiency through Accountable Design

## States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model Overview Factsheet



### MODEL PURPOSE

The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model is a state total cost of care (TCOC) model designed to **curb growth in health care cost spending, improve population health, and advance health equity by reducing disparities in health outcomes**. The CMS Innovation Center has identified State TCOC models as one approach to **drive accountable care, advance health equity, and achieve health system transformation**.

### AHEAD MODEL FLEXIBLE STATE FRAMEWORK

The AHEAD Model is a flexible framework designed to improve health care outcomes for people residing in participating states. AHEAD will use hospital global budgets and a primary care program (Primary Care AHEAD) to assist states in achieving higher quality care delivery, increasing investment in primary care, and supporting the delivery of advanced primary care - all while controlling overall growth in health care costs.

#### Statewide Accountability Targets<sup>1</sup>

Medicare and All-Payer Cost Growth, Medicare and All-Payer Primary Care Investment, and Equity and Population Health Outcomes through State Agreements with CMS



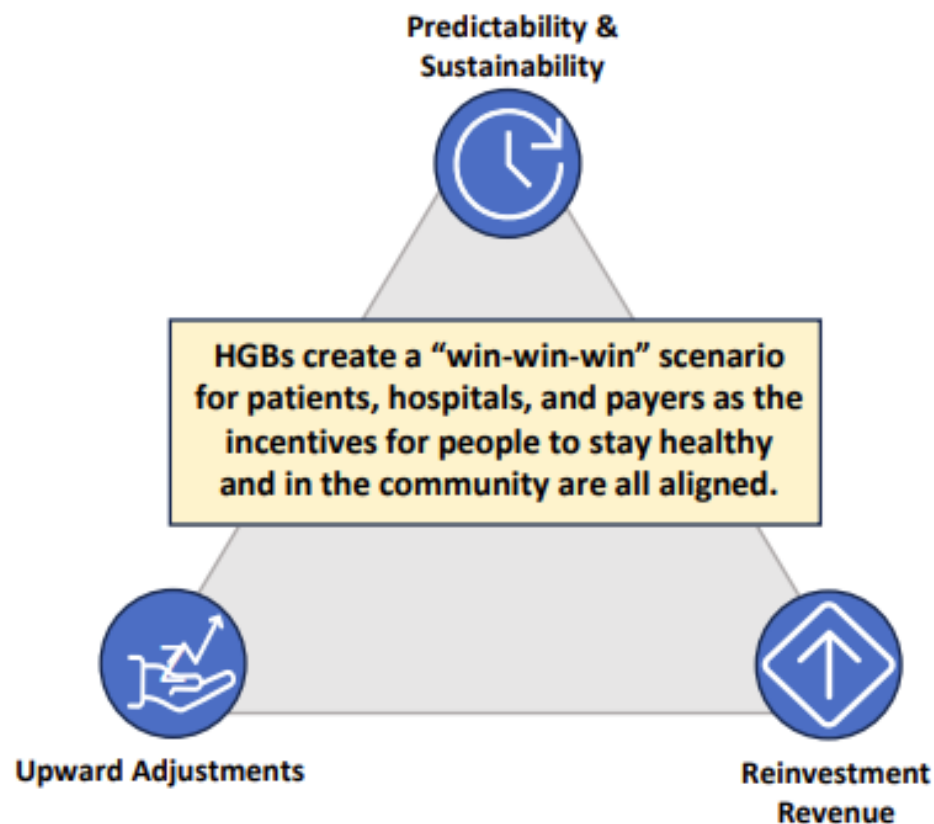
# AHEAD cont.

## Hospital Global Budgets

### Benefits of Hospital Global Budgets

By participating in HGBs and shifting away from FFS, hospitals benefit financially from:

- Stable, predictable funding,
- Payment levels comparable to FFS, plus the opportunity to earn upward annual adjustments to their HGB revenue,
- The potential to reinvest revenue from reduced Potentially Avoidable Utilization (PAU) and shifts to non-hospital settings.
- Ability to shift focus to population health management, and
- Opportunity to implement innovative strategies to enhance patient care quality and boost clinician engagement.





# AHEAD cont.

## PHASED Cohort Model Approach

The policy and operational changes to the AHEAD Model, as well as the updated model timeline announced in 2025 will help states achieve their total cost of care (TCOC) targets, while advancing the Center’s commitment to promote choice and competition, increase prevention, empower patients, and protect taxpayer dollars.

		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	
NOFO	Model Year (MY)		MY1	MY2	MY3	MY4	MY5	MY6	MY7	MY8	MY9	MY10	MY11	MY12	
November 2023	1st Period	Cohort 1		NOFO	Pre-Implementation (18 months)	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	PY9	PY10
		Cohort 2			Pre-Implementation (42 months)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	
	2nd Period	Cohort 3		NOFO	Pre-Implementation (36 months)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	
Late 2025	3rd Period	Additional States Cohort Options			NOFO	Pre-Implementation (18 months)	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	
						Pre-Implementation (30 months)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	



# ASM

# Ambulatory Specialty Model

## Ambulatory Specialty Model

**Mandatory Model: 2027-2031**

The Ambulatory Specialty Model (ASM) will promote prevention, upstream management, and timely, targeted care of **low back pain** and **heart failure** to help patients stay in better health and lower their cost of care.



### Model Goals

- Prevent worsening of chronic conditions
- Detect risks and signs of chronic conditions early
- Enhance patient experience
- Reduce unnecessary procedures and surgeries



### Care Approaches

ASM will require specialists to implement:



**Collaborative Care Arrangements with primary care**



**Support for lifestyle changes and health-related social needs screening**



**Preventive care screening**



**Health information exchange data sharing**



# ASM cont.

## Model Participation

ASM will include specialists who frequently treat low back pain or heart failure, practice within selected core-based statistical area (CBSA)s or metropolitan divisions, and have historically treated at least 20 Original Medicare patients with heart failure or 20 Original Medicare patients with low back pain over a 12-month period. Physicians will be assessed individually for quality and cost performance and assessed at the group level on care improvement activities and Promoting Interoperability performance.



**Low Back Pain Specialists:** anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation



**Heart Failure Specialists:** cardiology



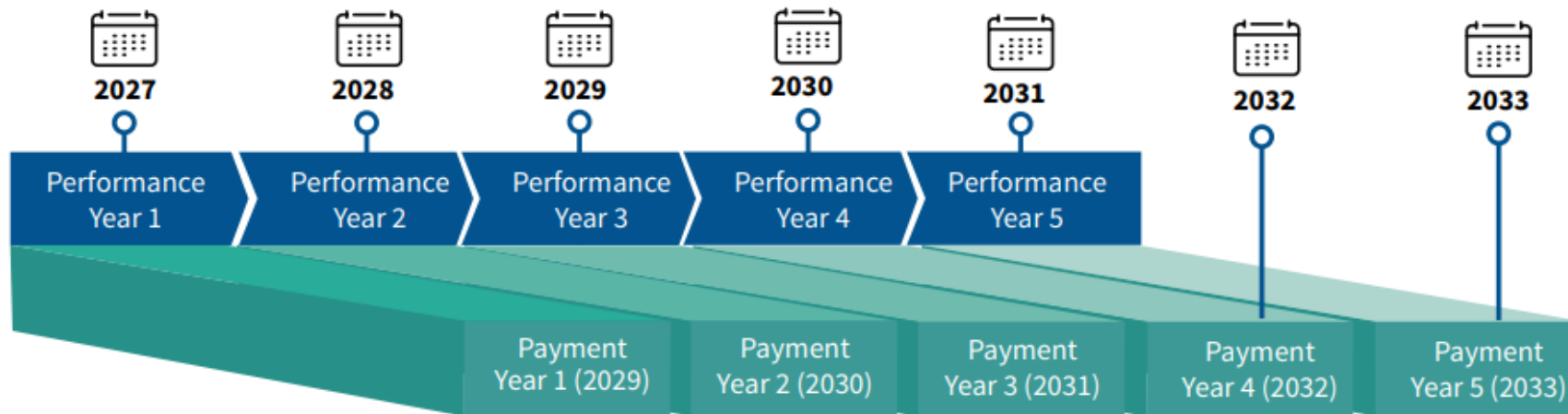
# ASM cont.

## Model Goals

ASM will reward clinicians who:

- **Prevent worsening or recurrence of chronic conditions** by encouraging lifestyle changes
- **Improve chronic disease management** by encouraging collaboration between specialists and primary care providers
- **Detect** risks and signs of chronic conditions early
- **Enhance patient experience** by prioritizing patient-reported outcomes on function
- **Reduce avoidable hospitalizations** and care lacking clear evidence of benefit

## Model Timeline





## TEAM

# Transforming Episode Accountability Model

## Transforming Episode Accountability Model

Mandatory Model: 2026-2030

The Transforming Episode Accountability Model (TEAM) will support people with Medicare undergoing certain surgical procedures by promoting better care coordination, seamless transitions between providers, and successful recovery.

**Included procedures:** lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure.



### Episode Components

Participating acute care hospitals will be responsible for overseeing a patient's care from hospital admission or outpatient procedure through 30 days after the individual leaves the hospital, including **coordination and communication** between providers across all care settings and with the patient and family. An episode includes:

- ▶ Inpatient hospital services
- ▶ Physician services: specialists and primary care
- ▶ Outpatient therapy services
- ▶ Skilled nursing facilities
- ▶ Home health services
- ▶ Clinical laboratory services
- ▶ Durable medical equipment
- ▶ Medications (Part B drugs and biologicals)
- ▶ Hospice

Participants will connect the patient to a **primary care provider** after they leave the hospital to support continued recovery and positive long-term health outcomes.



### Model Goals

- ▶ Quicker recovery after surgery
- ▶ Fewer avoidable hospital and emergency department visits
- ▶ Shorter hospital/post-acute care stays
- ▶ Smoother transitions to primary care
- ▶ Lower costs



## TEAM cont.



Some beneficiaries who undergo a surgical procedure in a hospital may experience **fragmented care** that can lead to **complications, avoidable hospitalizations, and increased spending.**



TEAM aims to solve this issue by **holding acute care hospitals accountable for quality and spending performance** during a patient's hospital inpatient stay/hospital outpatient procedure and the 30-day period following hospital discharge.



TEAM encourages hospitals to provide Medicare beneficiaries with **coordinated, high-quality care during and after certain surgical procedures.**



# TEAM cont.

## Model Snapshot

**Model Type:** Mandatory Episode-Based Payment Model

**Model Performance Period:** Five-year model; five 12-month performance years (PY)

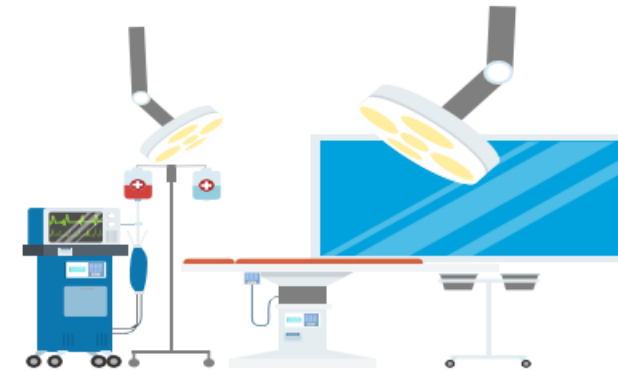


**Participants:** Acute Care Hospitals in Core-Based Statistical Areas required to participate and eligible Acute Care Hospitals that voluntarily elect to participate in TEAM and are accepted by CMS

**Beneficiaries:** Original Medicare (fee-for-service) beneficiaries with an included episode

### Required Episodes:

- Coronary Artery Bypass Graft (CABG)
- Major Bowel Procedure
- Lower Extremity Joint Replacement (LEJR)
- Surgical Hip and Femur Fracture Treatment (SHFFT)
- Spinal Fusion





# TEAM cont.

## Episode Initiation and Length

An **episode is initiated** by a beneficiary's:

- Admission to a TEAM participant hospital for an **anchor hospitalization** (as defined at § 512.505) paid under a Medicare Severity Diagnosis Related Group (MS-DRG) listed below, *or*
- Receipt of an **anchor procedure** (as defined at § 512.505) at a TEAM participant hospital billed under a Healthcare Common Procedure Coding System (HCPCS) code listed below

**Episode Length:** An episode **ends on the 30<sup>th</sup> day** following the date of the **anchor procedure** or on the **30<sup>th</sup> day following** the date of discharge from the **anchor hospitalization**

Episode Category	MS-DRG and/or HCPCS codes
CABG (inpatient)	MS-DRG: 231, 232, 233, 234, 235, 236
Major Bowel Procedure (inpatient)	MS-DRG: 329, 330, 331
LEJR (inpatient/outpatient)	MS-DRG: 469, 470, 521, 522 HCPCS: 27447, 27130, 27702
SHFFT (inpatient)	MS-DRG: 480, 481, 482
Spinal Fusion (inpatient/outpatient)	MS-DRG: 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473 HCPCS: 22551, 22554, 22612, 22630, 22633





WiSER

# Wasteful and Inappropriate Service Reduction

## Wasteful and Inappropriate Service Reduction Model

Voluntary Model: 2026 - 2031

The Wasteful and Inappropriate Service Reduction Model (WiSeR) will harness enhanced technologies like Artificial Intelligence (AI) and Machine Learning (ML) to streamline the review process for certain services that are vulnerable to fraud, waste and abuse, helping people with Medicare receive safe and appropriate care and protecting federal taxpayers.



### Model Goals

- Focus health care spending on services that will improve patient well-being
- Increase transparency of existing Medicare coverage policy
- Apply commercial payer processes that may be faster, easier, and more accurate
- De-incentivize and reduce use of medically unnecessary care



### Performance Measures

Model participants will be assessed on performance across quality measures such as:



**Volume** of prior authorization requests processed




**Timeliness** of response



**Clarity** of explanation of request determination



### Examples of Included Services

 Skin and tissue substitutes

 Electrical nerve stimulators

 Knee arthroscopy for knee osteoarthritis



# WISeR cont.

The following participants are companies with expertise providing recommendations on medical necessity of coverage for payers using enhanced technology like AI. They are required to have clinicians with the expertise to conduct medical reviews to validate determinations.

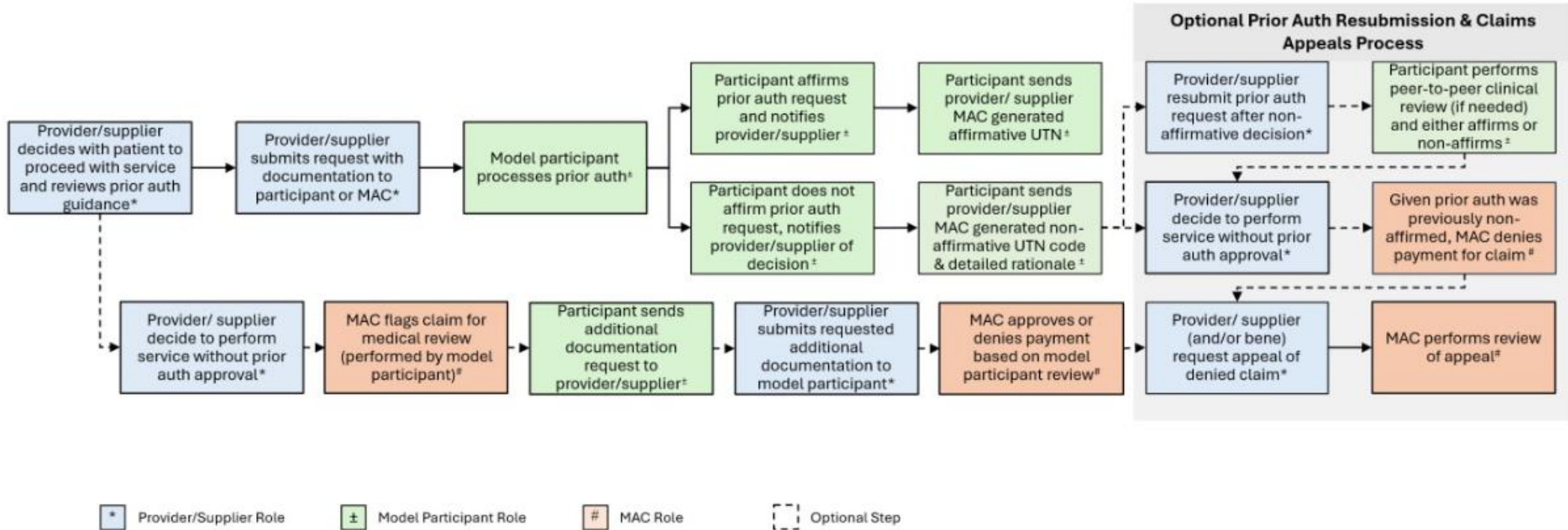
## WISeR Model Participants

Participant Name	MAC Jurisdiction	State
<a href="#"><u>Cohere Health, Inc.</u></a>	JH Novitas	Texas
<a href="#"><u>Genzeon Corporation</u></a>	JL Novitas	New Jersey
<a href="#"><u>Humata Health, Inc.</u></a>	JH Novitas	Oklahoma
<a href="#"><u>Innovaccer Inc.</u></a>	J15 CGS	Ohio
<a href="#"><u>Virtix Health LLC</u></a>	JF Noridian	Washington
<a href="#"><u>Zyter Inc.</u></a>	JF Noridian	Arizona

Model participants receive a percentage of the expenditures associated with averted wasteful, inappropriate care as a result of their reviews. That percentage is adjusted based on the participant's performance on measures related to the process, including provider experience.



# WISeR cont.





# WISeR cont.

## Appendix A. WISeR Select Items and Services as of December 23, 2025<sup>23</sup>

The following Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes<sup>24</sup>, organized by service category, are subject to prior authorization or pre-payment medical review under the WISeR Model.

**Table A1. Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9)**

Code	Code Description
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

**Table A2. Induced Lesions of Nerve Tracts (NCD 160.1)**

Code	Code Description
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring

**Table A3. Vagus Nerve Stimulation (NCD 160.18)<sup>25</sup>**

Code	Code Description
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator.

**Table A4. Phrenic Nerve Stimulator (NCD 160.19)**

Code	Code Description
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed.
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)



# WISeR cont.

## The “Gold Card” Exemption



WISeR is launching a ‘gold carding’ or exemption program in July 2026. Under the WISeR gold carding or exemption program, providers and suppliers who consistently meet coverage criteria by achieving a certain affirmation threshold associated with their prior authorization requests will generally be exempt from any additional prior authorization and pre-payment review processes for the selected items and services in WISeR. Providers and suppliers who achieve gold card or exemption status will be able to maintain it for a defined period of time before undergoing re-evaluation to ensure they continue to meet Medicare coverage criteria for those selected WISeR services.



# QUESTIONS???



# Appendix



# CMMI Initiatives Referenced Resources

CMMI Innovation Center: <https://www.cms.gov/priorities/innovation/overview>

GUARD: <https://www.cms.gov/newsroom/press-releases/cms-proposes-new-mandatory-guard-model>

GLOBE: <https://www.cms.gov/newsroom/press-releases/cms-proposes-new-mandatory-globe-model>

BALANCE: <https://www.cms.gov/newsroom/press-releases/cms-launches-voluntary-model-expand-access-life-changing-medicines-promote-healthier-living>

AHEAD: <https://www.cms.gov/priorities/innovation/innovation-models/ahead>

ASM: <https://www.cms.gov/priorities/innovation/innovation-models/asm>

TEAM: <https://www.cms.gov/priorities/innovation/innovation-models/team-model>

WISeR: <https://www.cms.gov/priorities/innovation/innovation-models/wiser>

WISeR Provider & Supplier Operational Guide (v. 3.0)

<https://www.cms.gov/priorities/innovation/files/wiser-provider-supplier-guide.pdf>



# Clinically Led Healthcare Analytics

Intelligent Technology to Improve your Financial Health



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