

Bridging the Gap: Private Industry Opportunities in the Wake of CMS Innovation Center Program Discontinuations

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Introduction

On March 12, 2025, the Centers for Medicare and Medicaid Services (CMS) Innovation Center announced significant changes to its model portfolio. In a move described as aligning with "statutory obligation and strategic goals," the Innovation Center declared the early termination of several healthcare payment and delivery models by December 31, 2025. This decision, estimated to save American taxpayers approximately \$750 million, represents a substantial shift in the federal government's approach to healthcare innovation. The announcement signals not only fiscal reprioritization but also creates a considerable vacuum in critical healthcare delivery experiments that were designed to improve care quality while reducing costs.

The discontinued models—Maryland Total Cost of Care, Primary Care First, ES Treatment Choices, and Making Care Primary—along with the scaling back of Integrated Care for Kids and the abandonment of previously announced Medicare Drug List and Accelerating Clinical Evidence initiatives, leave significant gaps in the healthcare innovation landscape. These programs were established to test novel approaches to healthcare delivery and payment, with the ultimate goal of identifying sustainable solutions that could be implemented nationwide. Their premature conclusion raises important questions about the future of healthcare innovation in the United States.

However, where the federal government steps back, private industry has a unique opportunity to step forward. The discontinuation of these CMS Innovation Center programs creates an opening for private enterprises to continue, adapt, and enhance the experimental work begun under these initiatives. This essay explores the landscape of opportunities for private industry to assume the mantle of healthcare innovation leadership, examining which companies are best positioned to partner with the federal government in creating the empirical foundation necessary for future healthcare policy decisions.

The void left by the CMS Innovation Center's portfolio restructuring presents a unique opportunity for private companies to demonstrate their capability to drive healthcare transformation while generating the critical data needed to support actuarially sound business cases for cost reduction. This essay will analyze the specific opportunities corresponding to each discontinued model, identify the private entities best equipped to seize these opportunities, and outline potential partnership frameworks between private industry and the federal government that could foster continued innovation in healthcare delivery and payment systems.

In the following sections, we will delve deeply into the characteristics and objectives of each discontinued program, assess the capabilities and positioning of various private sector players, and propose potential collaborative structures that could ensure the valuable work initiated by the CMS Innovation Center continues to advance, ultimately benefiting patients, providers, payers, and the healthcare system as a whole.

Understanding the Discontinued CMS Innovation Models

The CMS Innovation Center: Purpose and Statutory Mandate

Before examining the specific models being discontinued, it is essential to understand the purpose and statutory mandate of the CMS Innovation Center. Established under

the Affordable Care Act in 2010, the Center for Medicare and Medicaid Innovation (CMMI) was created with the explicit purpose of testing innovative payment and service delivery models that could potentially reduce program expenditures while maintaining or improving the quality of care for beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

The Innovation Center operates under a clear statutory mandate: to identify, test, and eventually scale successful models that demonstrate the ability to reduce healthcare costs without sacrificing quality. This dual focus on cost reduction and quality maintenance has shaped the Center's portfolio of experimental models. The recent announcement of model discontinuations indicates a reassessment of which experiments align with this core mandate, particularly with respect to demonstrating cost savings.

In its March 12, 2025 announcement, CMS emphasized its commitment to a "comprehensive and data-driven review" based on "the clear statutory mandate given to the Center by Congress." This language suggests a renewed focus on measuring cost reduction as a primary criterion for model continuation, with the stated goal of saving American taxpayers nearly \$750 million through the early termination of selected models.

Maryland Total Cost of Care (2019-2026)

The Maryland Total Cost of Care (TCOC) Model represented one of the most ambitious state-level payment transformation initiatives in the country. Building on the success of Maryland's All-Payer Model, which focused primarily on hospital services, the TCOC Model expanded cost containment efforts to encompass virtually all healthcare services provided to Maryland residents. The core aim of this model was to test whether state-level accountability for the total cost of care could successfully limit healthcare spending growth while improving quality and population health outcomes.

Key features of the Maryland TCOC Model included:

1. **Global Hospital Budgets:** Continuing the approach from the All-Payer Model, Maryland hospitals operated under global budgets that established fixed amounts for hospital services, creating strong incentives to reduce unnecessary utilization and complications.
2. **Care Redesign Programs:** The model incorporated initiatives that allowed hospitals to partner with non-hospital healthcare providers to improve care coordination, with opportunities to share in savings generated through improved efficiency.
3. **Primary Care Program:** The model included a specialized primary care component that provided resources and incentives for primary care providers to offer advanced care management services, particularly for high-need, high-cost patients.
4. **Population Health Improvement:** The model established specific goals for population health enhancement, including reductions in diabetes, opioid use, and other public health priorities.

The Maryland TCOC Model was distinctive for its comprehensive approach to healthcare transformation at the state level, creating a laboratory for testing whether coordinated, multi-level interventions could produce meaningful cost containment while advancing quality and population health goals. The model's early termination raises questions about the continuation of this unique state-wide experiment and the potential loss of valuable longitudinal data on the effects of global budgeting approaches.

Primary Care First (2021-2026)

The Primary Care First (PCF) model was designed to test whether restructuring primary care payment and delivery could reduce overall healthcare costs by preventing avoidable hospitalizations and improving care coordination. The model provided participating primary care practices with simplified payment options that rewarded value and quality, with an emphasis on caring for patients with complex chronic conditions and high needs.

Key elements of the Primary Care First model included:

1. Risk-Adjusted Monthly Population-Based Payments: Practices received per-patient monthly payments adjusted for patient complexity, reducing reliance on fee-for-service billing and providing more predictable revenue streams.
2. Performance-Based Adjustments: Practices could earn performance-based adjustments of up to 50% of their primary care revenue based on quality measures and acute hospital utilization outcomes.
3. Seriously Ill Population Option: A specialized component of the model focused on providing improved care for high-need patients without established primary care relationships.
4. Reduced Administrative Burden: The model aimed to simplify documentation requirements and reporting, allowing clinicians to focus more attention on patient care.

The PCF model represented a significant step toward transforming primary care from a transaction-based service to a relationship-based care model supported by value-aligned payment structures. Its early termination creates uncertainty for participating practices and interrupts the collection of critical data about the long-term impact of primary care payment reform on overall healthcare spending and outcomes.

ESRD Treatment Choices (2021-2027)

The End-Stage Renal Disease (ESRD) Treatment Choices model was established to increase home dialysis and kidney transplantation rates for Medicare beneficiaries with end-stage renal disease. The model aimed to reduce the substantial costs associated with in-center dialysis while improving quality of life for patients with kidney failure by promoting treatment options that offer greater autonomy and potentially better outcomes.

Key components of the ESRD Treatment Choices model included:

1. Home Dialysis Payment Adjustment: The model provided an incremental payment adjustment to ESRD facilities and managing clinicians based on the

home dialysis rates, creating financial incentives to increase home-based treatments.

2. **Transplant Rate Payment Adjustment:** Participants received payment adjustment based on their rates of kidney and kidney-pancreas transplantation, incentivizing increased efforts to facilitate transplantation for appropriate candidates.
3. **Required Participation:** Unlike many Innovation Center models that relied on voluntary participation, the ESRD Treatment Choices model required participation from ESRD facilities and managing clinicians in selected geographic areas, creating a robust experimental design.
4. **Beneficiary Education Requirements:** The model included specific requirements for participant education of beneficiaries about treatment options, acknowledging the importance of informed patient choice in treatment decisions.

This model addressed care for one of the most costly patient populations covered by Medicare, with ESRD beneficiaries representing approximately 1% of the Medicare population but accounting for over 7% of Medicare spending. The early termination of this model—particularly given that CMS noted it would require rulemaking to implement the termination—raises significant questions about continued efforts to transform care for this high-cost, high-need population.

Making Care Primary (2024-2034)

The Making Care Primary (MCP) model, only recently launched in 2024, represents the newest generation of primary care transformation initiatives. Building on lessons learned from earlier models such as Comprehensive Primary Care Plus and Primary Care First, MCP aimed to create sustainable payment structures that would support comprehensive, relationship-based primary care while generating substantial savings through reduced hospitalizations and unnecessary specialty care.

Key features of the Making Care Primary model include:

1. **Multi-Payer Alignment:** The model sought to align payment approaches across Medicare, Medicaid, and commercial payers, reducing administrative complexity.

for participating practices and creating consistent incentives across a practice's entire patient population.

2. Hybrid Payment Model^{**}: Practices received a combination of risk-adjusted population-based payments and reduced fee-for-service payments, creating a blend of predictable revenue and activity-based compensation.
3. Enhanced Care Management Infrastructure: The model provided resources for practices to build robust care management capabilities, including care coordination staff, data analytics capabilities, and patient engagement tools.
4. Health Equity Focus: MCP incorporated specific requirements and incentives related to reducing healthcare disparities, acknowledging the role of primary care in addressing equity issues.

With its planned ten-year performance period, MCP was designed to provide the long-term stability necessary for fundamental practice transformation and collection of meaningful longitudinal data. Its early termination after just over a year of implementation represents perhaps the most significant gap in the Innovation Center portfolio, as it was poised to build on years of primary care innovation experience and test sustainable approaches to primary care payment reform.

Integrated Care for Kids (2020-2026)

While not slated for complete termination, the Integrated Care for Kids (InCK) model is being considered for reduced scope or other modifications. This model was developed to address the complex needs of children, particularly those with behavioral health conditions, physical health challenges, or involvement in the child welfare system. InCK aimed to test whether integrated care coordination across multiple systems—healthcare, behavioral health, schools, housing, food, and child welfare—could improve outcomes for children while reducing costs.

Key elements of the Integrated Care for Kids model included:

1. State-Based Partnership Building: The model provided funding and support for states to build partnerships across healthcare and social service sectors, creating

integrated systems of care for children.

2. **Alternative Payment Models:** InCK encouraged the development of pediatric-specific alternative payment models that aligned financial incentives with comprehensive care coordination and preventive services.
3. **Core Child Services:** The model defined a set of core child services spanning physical and behavioral healthcare, as well as health-related social needs, or a framework for holistic child well-being.
4. **Child-Centered Data Integration:** InCK provided resources for building data systems that could integrate information across typically siloed systems (healthcare, schools, child welfare), supporting comprehensive care planning.

The potential reduction in scope for this model raises concerns about continued innovation in pediatric care delivery, particularly for vulnerable children with complex needs who often experience fragmented care across multiple systems.

Abandoned Models: Medicare \$2 Drug List and Accelerating Clinical Evidence

In addition to the models being terminated early, CMS announced it would "not pursue two previously announced but not yet implemented models" following President Trump's rescission of Executive Order 14087 on January 20, 2025:

1. **Medicare \$2 Drug List:** This initiative would have tested a new approach to prescription drug coverage, aiming to make certain commonly used medications available to Medicare beneficiaries at significantly reduced costs.
2. **Accelerating Clinical Evidence:** This model would have focused on accelerating the generation of evidence about the effectiveness of medical treatments and interventions, potentially speeding the adoption of proven approaches while discontinuing ineffective practices.

While these models had not yet been implemented, their abandonment represents missed opportunities to address key challenges in the healthcare system—prescription c

affordability and the efficient generation of clinical evidence to guide treatment decisions.

The Opportunity Landscape for Private Industry

The discontinuation of these CMS Innovation Center models creates significant gaps in the healthcare innovation ecosystem. However, these gaps also represent substantial opportunities for private industry to step in, continue valuable experimentation, potentially develop commercially viable approaches that could later inform federal policy. The following sections explore the specific opportunity areas corresponding to each discontinued model.

Opportunity Area 1: State-Level Payment Reform (Maryland TCOC Model)

The early termination of the Maryland Total Cost of Care Model opens an opportunity for private entities to partner with states interested in continuing or initiating comprehensive payment reform efforts. The Maryland experiment demonstrated that state-level interventions coordinating hospital global budgets with broader care transformation initiatives could produce meaningful results. Private industry could capitalize on this opportunity in several ways:

1. **Multi-Payer Alignment Platforms:** Companies that can facilitate data sharing, payment alignment, and coordinated quality measurement across multiple payers (including commercial insurers, Medicare Advantage plans, and state Medicaid programs) could offer valuable infrastructure for states seeking to continue cost of care experiments.
2. **Global Budget Implementation Support:** Organizations with expertise in financial modeling, risk adjustment, and budget setting could provide technical assistance to states and hospital systems interested in maintaining or implementing global budget approaches.

3. **Population Health Analytics:** Data analytics firms could develop comprehensive solutions for monitoring population health outcomes at the state or regional level, connecting these outcomes to payment reform initiatives and identifying opportunities for targeted interventions.
4. **Care Redesign Facilitation:** Companies specializing in care delivery transformation could offer consulting and implementation support for hospitals and health systems participating in state-level payment reform initiatives, helping them adapt their operations to succeed under global budget or other alternative payment models.

This opportunity area would be particularly attractive to companies with experience in large-scale healthcare transformation initiatives, sophisticated data analytics capabilities, and existing relationships with state health departments, hospital associations, and diverse payer organizations.

Opportunity Area 2: Primary Care Transformation (Primary Care First and Making Care Primary Models)

The discontinuation of both Primary Care First and Making Care Primary creates perhaps the most significant opportunity space for private industry intervention. These models were testing crucial approaches to sustainable primary care payment and delivery transformation, and their early termination leaves numerous primary care practices seeking alternative paths to value-based care. Private industry could address this gap through several approaches:

1. **Primary Care Payment Platforms:** Technology companies could develop platforms that enable commercial payers, employers, and provider organizations to implement hybrid payment models similar to those tested in PCF and MCP, including risk-adjusted population-based payments and performance-based adjustments.
2. **Practice Transformation Services:** Organizations with expertise in practice redesign could offer comprehensive support services to primary care practices.

transitioning to value-based care models, including workflow optimization, team reconfiguration, and change management support.

3. Virtual Care Integration Solutions: As primary care increasingly incorporates virtual care components, companies offering seamless integration of in-person and virtual care delivery could help practices extend their reach and efficiency while maintaining continuity relationships.
4. Risk Stratification and Care Management Tools: Technology firms could develop sophisticated tools for identifying high-risk patients and implementing proactive care management strategies, enabling practices to focus resources on patients most likely to benefit from enhanced services.
5. Multi-Payer Integration Services: Companies that can simplify administrative processes across multiple payers could help primary care practices navigate the complexity of participating in various value-based payment programs simultaneously.

This opportunity space would be particularly relevant for technology companies focused on healthcare, practice management organizations, primary care-focused medical groups, and companies specializing in population health management.

Opportunity Area 3: End-Stage Renal Disease Care Innovation (ESRD Treatment Choices Model)

The early termination of the ESRD Treatment Choices model creates opportunities for private industry to advance innovation in kidney care, particularly related to increasing home dialysis and transplantation rates. This area represents a substantial market opportunity given the high costs associated with ESRD care. Private industry could engage in this space through:

1. Home Dialysis Technology and Support: Companies developing improved home dialysis equipment, remote monitoring capabilities, and support services could help increase the adoption and success of home-based treatments.
2. Transplant Facilitation Services: Organizations could develop comprehensive services aimed at increasing transplantation rates, including donor identification

pretransplant workup coordination, and post-transplant care management.

3. **Value-Based Kidney Care Platforms:** Companies could create integrated platforms that enable nephrologists, dialysis providers, and transplant centers collaborate under value-based payment arrangements that reward improved outcomes and reduced total cost of care.
4. **Predictive Analytics for ESRD Prevention:** Technology firms could develop sophisticated analytics tools to identify patients at risk of progressing to ESKD and implement targeted interventions to slow disease progression.
5. **Patient Education and Engagement Solutions:** Organizations could develop enhanced educational tools and engagement strategies to help patients make informed decisions about treatment options and actively participate in their care.

This opportunity area would be particularly appealing to existing kidney care companies, health technology firms focusing on chronic disease management, and organizations specializing in complex care coordination.

Opportunity Area 4: Integrated Pediatric Care (Integrated Care for Kids Model)

The potential reduction in scope of the Integrated Care for Kids model creates opportunities for private industry to address the challenges of coordinating care for children with complex needs across multiple systems. This area represents a chance to develop innovative approaches to a traditionally underserved market segment. Private industry could pursue this opportunity through:

1. **Cross-Sector Data Integration Platforms:** Technology companies could develop solutions that enable secure sharing of relevant information across healthcare, education, child welfare, and other systems involved in children's well-being.
2. **Pediatric Care Coordination Services:** Organizations could offer specialized coordination services for children with complex needs, helping families navigate multiple systems and ensuring comprehensive care planning.
3. **Pediatric Behavioral Health Integration: Solutions:** Companies could develop models for integrating behavioral health services into primary care and schools.

settings, addressing a critical gap in children's healthcare.

4. **Value-Based Pediatric Care Models:** Organizations could design and implement alternative payment models specific to pediatric populations, addressing the unique challenges of financing care for children with complex needs.
5. **Social Determinants of Health Interventions:** Companies could develop scalable interventions addressing social determinants of health for children, potentially reducing healthcare utilization through upstream preventive approaches.

This opportunity area would be particularly relevant for technology companies focused on data integration, behavioral health organizations, managed care organizations with pediatric expertise, and companies specializing in social determinants of health interventions.

Opportunity Area 5: Prescription Drug Affordability (Medicare \$2 Drug List)

The abandonment of the Medicare \$2 Drug List initiative creates opportunities for private industry to develop alternative approaches to increasing prescription drug affordability. With rising drug costs remaining a significant concern for patients and payers, innovative solutions in this space could find substantial market interest. Private industry could engage with this opportunity through:

1. **Drug Affordability Programs:** Pharmacy benefit managers, insurers, or health systems could develop programs offering commonly used medications at substantially reduced costs, potentially using a combination of manufacturer negotiations, formulary management, and selective subsidization.
2. **Subscription-Based Medication Models:** Companies could implement subscription-based approaches to medication access, where patients pay a fixed monthly fee for access to a defined list of medications, creating predictable costs for patients and payers.
3. **Comparative Effectiveness Platforms:** Organizations could develop platforms that help prescribers and patients identify the most cost-effective treatment options for specific conditions, potentially reducing overall prescription drug spend.

4. **Medication Adherence Solutions:** Technology firms could create solutions to increase medication adherence through a combination of affordability initiatives, reminder systems, and engagement strategies, potentially reducing downstream healthcare costs through improved disease management.

This opportunity area would be particularly attractive to pharmacy benefit managers, health insurers, retail pharmacy chains, and health technology companies focused on medication management.

Opportunity Area 6: Evidence Acceleration (Accelerating Clinical Evidence)

The decision not to pursue the Accelerating Clinical Evidence model creates opportunities for private industry to develop alternative approaches to generating and implementing clinical evidence more efficiently. With the growing volume of healthcare data and the increasing complexity of treatment options, solutions that speed the development and application of evidence could have substantial market value. Private industry could address this gap through:

1. **Real-World Evidence Platforms:** Technology companies could develop platforms that enable the systematic collection and analysis of real-world data to generate insights about treatment effectiveness and safety.
2. **Pragmatic Clinical Trial Networks:** Organizations could establish networks to facilitate the rapid implementation of pragmatic clinical trials embedded in routine care delivery, potentially reducing the cost and time required to generate meaningful evidence.
3. **Evidence Implementation Solutions:** Companies could develop tools and services that help healthcare organizations rapidly translate emerging evidence into clinical practice, accelerating the adoption of proven interventions.
4. **Patient-Centered Outcomes Research Platforms:** Organizations could create platforms that incorporate patient perspectives and priorities into research design and outcomes measurement, ensuring that evidence generation focuses on outcomes that matter to patients.

This opportunity area would be particularly relevant for health data analytics companies, clinical research organizations, academic medical centers, and technology firms specializing in healthcare information exchange.

Companies Positioned to Lead in the Post-CMMI Landscape

Having identified the key opportunity areas created by the discontinuation of CMMI Innovation Center models, we now turn to analyzing which private companies are positioned to fill these gaps. The following sections examine specific companies across various healthcare sectors that have the capabilities, experience, and market positioning to potentially take over aspects of these experimental healthcare models.

Health Information Technology Companies

Several health information technology companies possess the technical capabilities, data infrastructure, and healthcare expertise necessary to support continued innovation in areas previously addressed by CMS models.

Epic Systems Corporation stands as one of the dominant electronic health record (EHR) vendors, with its systems used by more than 250 healthcare organizations covering over 225 million patients. Epic's comprehensive data infrastructure positions it well to support several opportunity areas:

1. In the state-level payment reform space, Epic's population health management tools and health information exchange capabilities could provide the data backbone needed for monitoring total cost of care across care settings.
2. For primary care transformation, Epic's Healthy Planet module offers sophisticated risk stratification, care management, and performance tracking capabilities that could support practices transitioning to value-based care models.
3. In the ESRD care innovation area, Epic's chronic disease management tools could be adapted to support improved coordination of kidney care across provider settings.

Epic's significant market penetration and interoperability capabilities give it un
advantages in supporting multi-stakeholder healthcare transformation initiative

Cerner Corp (now part of Oracle) represents another major EHR vendor with
capabilities relevant to several opportunity areas:

1. Cerner's HealtheIntent platform provides population health management capabilities that could support state-level payment reform efforts and primary care transformation initiatives.
2. The company's experience with value-based care implementation could be leveraged to help healthcare organizations succeed under alternative payment models.
3. Cerner's data analytics capabilities could support evidence acceleration efforts enabling more efficient analysis of real-world data.

Oracle's acquisition of Cerner potentially brings additional technological capabilities and financial resources that could enhance the company's ability to invest in healthcare innovation initiatives.

Innovaccer has positioned itself as a leader in healthcare data integration and analytics, with a particular focus on supporting value-based care initiatives. Innovaccer's capabilities align well with several opportunity areas:

1. The company's data activation platform could support state-level payment reform by enabling data integration across disparate healthcare organizations and payers.
2. For primary care transformation, Innovaccer's population health management and risk stratification tools could help practices identify and manage high-risk patients more effectively.
3. In the integrated pediatric care space, Innovaccer's data integration capabilities could potentially be extended to incorporate non-healthcare data sources relevant to children's well-being.

Innovaccer's focus on supporting accountable care organizations (ACOs) and other value-based care entities gives it particularly relevant experience for continuing

work of CMS Innovation Center models.

[Arcadia.io](#) specializes in population health management and value-based care enablement, with strengths in data aggregation, analytics, and workflow optimization. Arcadia's capabilities align especially well with primary care transformation opportunities:

1. The company's experience supporting primary care practices in value-based arrangements provides directly relevant expertise for continuing the work of MCP and MCP models.
2. Arcadia's risk adjustment optimization capabilities could help primary care practices accurately capture patient complexity and receive appropriate payment under risk-adjusted payment models.
3. The company's performance analytics tools could support ongoing quality improvement efforts within primary care organizations transitioning to value-based care.

Arcadia's focus on supporting independent physician organizations may be particularly relevant as these entities seek alternative paths to value-based care following the discontinuation of CMS models.

Health Insurance and Service Organizations

Several health insurance and service organizations have developed capabilities and business models that position them well to continue aspects of the Innovation Center's experimental work.

UnitedHealth Group and its Optum division represent one of the most diversified healthcare organizations in the country, with capabilities spanning insurance, care delivery, pharmacy benefits, and data analytics. UnitedHealth Group's position is relevant across multiple opportunity areas:

1. For state-level payment reform, UnitedHealthcare's experience with value-based contracting and Optum's data analytics capabilities could support comprehensive

payment transformation efforts.

2. In primary care transformation, Optum's growing network of owned and affiliated primary care practices provides a platform for implementing and testing alternative payment and care delivery models.
3. For ESRD care innovation, OptumRx's specialty pharmacy capabilities and UnitedHealthcare's experience with complex care management could support improved kidney care coordination.
4. In prescription drug affordability, OptumRx's pharmacy benefit management capabilities could enable experimentation with alternative approaches to drug pricing and access.

UnitedHealth Group's diversified capabilities and substantial financial resources are its unique advantages in potentially assuming aspects of the Innovation Center's experimental portfolio.

Aetna (a CVS Health company) combines insurance capabilities with retail pharmacy and care delivery through MinuteClinic, creating unique opportunities to address several gaps left by discontinued CMS models:

1. In primary care transformation, Aetna's experience with value-based contracts and CVS Health's expanding primary care footprint could support continued experimentation with alternative primary care models.
2. For prescription drug affordability, CVS Health's integrated pharmacy and distribution capabilities could enable testing of novel approaches to improving medication access and affordability.
3. In evidence acceleration, Aetna's data assets and CVS Health's retail footprint could potentially support pragmatic clinical trials and real-world evidence generation.

The integration of insurance, pharmacy, and care delivery under CVS Health creates distinctive capabilities for addressing complex healthcare challenges across traditional sector boundaries.

Humana has established itself as a leader in value-based care, particularly with Medicare Advantage, and has made substantial investments in primary care and health capabilities. Humana's positioning is especially relevant to several opportunity areas:

1. For primary care transformation, Humana's CenterWell Senior Primary Care clinics (formerly Conviva) provide a platform for implementing and testing primary care payment and delivery innovations focused on seniors.
2. In home-based care, Humana's Kindred at Home business (now CenterWell Health) offers capabilities that could support increased home dialysis adoption in the ESRD space.
3. For integrated care models, Humana's experience with coordinating complex care for Medicare Advantage members could inform approaches to comprehensive care coordination.

Humana's focus on senior care creates particular relevance for continuing experiments related to Medicare beneficiaries, including those previously addressed by the Primary Care First and ESRD Treatment Choices models.

Elevance Health (formerly Anthem) has developed sophisticated value-based care capabilities and has made strategic investments in data analytics and care delivery. Elevance's positioning is relevant to several opportunity areas:

1. For state-level payment reform, Elevance's presence in multiple state Medicaid programs and commercial insurance markets provides a platform for multi-aligner initiatives.
2. In primary care transformation, Elevance's primary care enablement capabilities and value-based contracting experience could support continued experimentation with alternative primary care models.
3. For integrated pediatric care, Elevance's experience with Medicaid managed care for children with complex needs provides relevant expertise for addressing pediatric care coordination challenges.

Elevance's multi-state presence and experience across commercial, Medicare, and Medicaid markets creates opportunities for testing models that span multiple patient types and patient populations.

Primary Care Organizations

Several organizations focused specifically on primary care have developed innovative approaches to payment and delivery that position them well to continue aspects discontinued Primary Care First and Making Care Primary models.

Oak Street Health has pioneered a value-based primary care model focused specifically on Medicare beneficiaries, including those dually eligible for Medicare and Medicaid. Oak Street's model includes several elements relevant to continuing primary care transformation efforts:

1. The company operates under full-risk arrangements, accepting capitated payments for managing the total cost of care for assigned patients.
2. Oak Street's care model emphasizes extended visit times, comprehensive care teams, and proactive outreach to high-risk patients.
3. The company has developed sophisticated risk stratification capabilities and targeted care management programs for patients with complex needs.

Oak Street's experience with value-based primary care for Medicare beneficiaries makes it particularly well-positioned to continue aspects of the Primary Care First model, potentially in partnership with Medicare Advantage plans or directly with CMS through existing risk arrangements.

VillageMD (majority-owned by Walgreens Boots Alliance) combines primary care expertise with retail pharmacy integration, creating unique capabilities for continuing aspects of primary care transformation models:

1. VillageMD's partnership with Walgreens has created co-located primary care clinics within retail pharmacy settings, potentially increasing access and facilitating care coordination.

2. The company's docOS technology platform provides data analytics, risk stratification, and care management capabilities supporting value-based care delivery.
3. VillageMD's experience with both commercial and Medicare value-based arrangements creates relevance across multiple patient populations.

The integration of primary care with retail pharmacy through the Walgreens partnership creates distinctive opportunities for addressing medication management and adherence challenges within a value-based primary care framework.

Aledade has developed a network of independent primary care practices participating in accountable care organizations (ACOs) and other value-based arrangements. Aledade's approach offers several advantages for continuing primary care transformation efforts:

1. The company provides technology, data analytics, and practice transformation support to help independent primary care practices succeed in value-based care.
2. Aledade's ACO network spans multiple states and payer types, creating opportunities for testing approaches across diverse practice and patient populations.
3. The company's focus on keeping independent primary care practices economically viable aligns with broader goals of strengthening primary care infrastructure.

Aledade's experience supporting independent practices in value-based care makes it particularly relevant for continuing aspects of the Primary Care First and Making Care Primary models, potentially in partnership with commercial payers or through existing Medicare ACO programs.

One Medical (now part of Amazon) combines membership-based primary care with digital health capabilities, creating opportunities to continue aspects of primary care transformation models:

1. The company's hybrid care model, combining in-person care with virtual care, aligns with evolving approaches to comprehensive primary care delivery.
2. One Medical's technology platform supports proactive population health management and care coordination.
3. The acquisition by Amazon potentially brings additional technological capabilities and financial resources to support healthcare innovation.

One Medical's consumer-focused approach and technology integration create distinctive opportunities for testing patient engagement strategies within value-based primary care models, particularly for commercially insured populations.

Kidney Care Organizations

Several organizations focused specifically on kidney care have developed innovative approaches to ESRD management that position them well to continue aspects of the discontinued ESRD Treatment Choices model.

Fresenius Medical Care is the largest provider of dialysis services in the United States, with capabilities spanning in-center dialysis, home dialysis, and kidney transplant support. Fresenius's positioning is highly relevant to continuing aspects of the ESRD Treatment Choices model:

1. The company's substantial home dialysis infrastructure provides a foundation for continued efforts to increase home dialysis adoption.
2. Fresenius's integrated kidney care programs, including its participation in the Comprehensive Kidney Care Contracting Model, offer experience with value-based approaches to ESRD management.
3. The company's size and geographic reach create opportunities for large-scale testing of interventions to improve ESRD care.

Fresenius's dominant market position in dialysis services gives it particular influence over the evolution of kidney care delivery models, potentially enabling significant impact in continuing aspects of the ESRD Treatment Choices model.

DaVita Inc. is the second-largest dialysis provider in the United States, with substantial experience in both in-center and home dialysis services. DaVita's capabilities are highly relevant to the ESRD care innovation opportunity area:

1. The company's IKC (Integrated Kidney Care) division specifically focuses on value-based kidney care models, including participation in CMS Innovation Center programs.
2. DaVita's WellBound centers focus specifically on home dialysis training and support, addressing a key aspect of the ESRD Treatment Choices model.
3. The company's size and geographic reach enable testing of interventions across diverse patient populations and practice settings.

DaVita's experience with value-based kidney care models and home dialysis promotion creates direct relevance for continuing aspects of the ESRD Treatment Choices model.

Strive Health has emerged as a specialized kidney care management company focused exclusively on value-based kidney care models. Strive's capabilities align particularly well with continuing aspects of the ESRD Treatment Choices model:

1. The company partners with nephrologists, health systems, and payers to implement value-based care arrangements for patients with chronic kidney disease (CKD) and ESRD.
2. Strive's technology platform supports risk stratification, care coordination, outcomes tracking for kidney patients.
3. The company's focus on early intervention in CKD aligns with goals of reducing progression to ESRD and preparing patients for optimal renal replacement therapy when needed.

Strive's specialized focus on value-based kidney care management creates distinctive capabilities for addressing the challenges targeted by the ESRD Treatment Choices model.

Somatus represents another specialized kidney care management organization focused on value-based approaches to CKD and ESRD care. Somatus's capabilities relevant to the ESRD care innovation opportunity area:

1. The company partners with health plans, health systems, and nephrology practices to implement value-based kidney care programs.
2. Somatus's technology platform supports identification of at-risk patients, care coordination, and outcomes tracking.
3. The company's focus on increasing home dialysis and transplantation aligns directly with key goals of the ESRD Treatment Choices model.

Somatus's specialized expertise in value-based kidney care creates particular relevance for continuing aspects of the ESRD Treatment Choices model, potentially in partnership with commercial payers or through existing Medicare value-based care programs.

Pediatric Care Organizations

Several organizations focused on pediatric care have developed specialized capabilities relevant to continuing aspects of the Integrated Care for Kids model.

Nemours Children's Health has emerged as a leader in value-based pediatric care with particular emphasis on addressing social determinants of health for children. Nemours's capabilities align well with the integrated pediatric care opportunity.

1. The organization has developed innovative approaches to value-based pediatric care, including participation in alternative payment models and development of pediatric-specific quality measures.
2. Nemours's focus on addressing social determinants of health for children includes partnerships with community organizations, schools, and social service agencies.
3. The organization's digital health capabilities, including telehealth and remote monitoring, support innovative approaches to pediatric care delivery.

Nemours's experience with integrated pediatric care models and focus on social determinants of health positions it well to continue aspects of the Integrated Care for Kids model, potentially in partnership with state Medicaid programs or commercial payers.

Children's Hospital of Philadelphia (CHOP) has established itself as a leader in pediatric population health management and care coordination for children with complex needs. CHOP's capabilities are highly relevant to the integrated pediatric care opportunity area:

1. The organization has developed sophisticated care coordination programs for children with medical complexity, including those with multiple chronic conditions and technology dependencies.
2. CHOP's Center for Health Care Quality and Analytics provides data infrastructure and analytics capabilities to support population health management for pediatric populations.
3. The institution's community partnerships and school-based health program demonstrate experience with cross-sector collaboration for children's well-being.

CHOP's clinical expertise and experience with complex care coordination create particular relevance for addressing aspects of the Integrated Care for Kids model focused on children with medical complexity.

Boston Children's Hospital has developed innovative approaches to coordinating care for children with complex needs across medical and non-medical domains. Boston Children's capabilities align well with continuing aspects of the Integrated Care for Kids model:

1. The hospital's Integrated Care Program specifically focuses on care coordination for children with medical complexity, including those with multiple special medical and social service needs.
2. Boston Children's expertise in pediatric behavioral health integration offers relevant experience for addressing a key component of the InCK model.

3. The institution's digital health innovation initiatives, including its Innovative Digital Health Accelerator, provide technological capabilities relevant to cross-sector care coordination.

Boston Children's clinical expertise and innovation capabilities position it well to address aspects of the Integrated Care for Kids model focused on medical-behavioral and social integration.

Centene Corporation, as one of the largest Medicaid managed care organizations in the country, has developed specialized capabilities for managing care for children enrolled in Medicaid and CHIP. Centene's positioning is relevant to continuing aspects of the Integrated Care for Kids model:

1. The company's experience managing care for children with special healthcare needs across multiple states provides relevant expertise for cross-system care coordination.
2. Centene's focus on addressing social determinants of health includes programs specifically designed for children and families.
3. The company's behavioral health subsidiary, Centene Behavioral Health, offers capabilities for integrated behavioral health services for children.

Centene's scale and experience with Medicaid managed care for children creates opportunities for testing pediatric-focused care models across multiple states and populations.

Pharmaceutical and Pharmacy Benefit Management Organizations

Several organizations in the pharmaceutical and pharmacy benefit management sectors have developed capabilities relevant to continuing aspects of the abandoned Medicare \$2 Drug List model.

CVS Health/Caremark combines pharmacy benefit management with retail pharmacy operations, creating unique opportunities to address prescription drug affordability.

challenges:

1. As one of the largest pharmacy benefit managers, CVS Caremark has substantial negotiating power with pharmaceutical manufacturers and experience designing formularies that balance cost and access.
2. The company's retail pharmacy network provides infrastructure for implementing and monitoring medication affordability initiatives.
3. CVS Health's MinuteClinic and expanding primary care footprint create opportunities for integrating medication affordability programs with care delivery.

CVS Health's integrated pharmacy and healthcare capabilities position it well to explore alternative approaches to prescription drug affordability, potentially in collaboration with Medicare Advantage plans or commercial payers.

Express Scripts (part of Cigna) offers sophisticated pharmacy benefit management capabilities relevant to addressing prescription drug affordability challenges:

1. The company's scale provides substantial negotiating leverage with pharmaceutical manufacturers and ability to implement innovative contract approaches.
2. Express Scripts' specialized programs for managing high-cost medications demonstrate experience with targeted approaches to drug affordability.
3. The integration with Cigna creates opportunities for aligning medication management with broader care delivery and payment models.

Express Scripts' experience with value-based pharmacy arrangements and specialized medication management creates particular relevance for addressing aspects of the abandoned Medicare \$2 Drug List initiative.

GoodRx has pioneered consumer-focused approaches to prescription drug affordability, with technology that allows patients to compare prices and access discount programs. GoodRx's capabilities are relevant to the prescription drug affordability opportunity area:

1. The company's price comparison platform creates transparency in prescript drug pricing and helps patients identify lower-cost options.
2. GoodRx's discount programs demonstrate the potential for reducing out-of-pocket costs for medications without requiring changes to insurance benefit
3. The company's data on prescription drug pricing and utilization could support analysis of the impact of affordability initiatives on medication adherence and outcomes.

GoodRx's consumer-focused approach and technology platform create distinctive capabilities for addressing medication affordability challenges, potentially complementing more traditional payer-focused approaches.

Amazon Pharmacy (including PillPack) represents a newer entrant in the pharmacy space with innovative approaches to medication delivery and potentially pricing. Amazon's capabilities could be relevant to the prescription drug affordability opportunity area:

1. The company's logistics expertise and direct-to-consumer model could potentially enable more efficient medication distribution and lower costs.
2. Amazon's technology platform could support implementation and monitoring of medication affordability programs.
3. The acquisition of One Medical creates opportunities for integrating medication affordability initiatives with primary care delivery.

Amazon's technological capabilities and disruptive approach to healthcare services create potential for innovative solutions to prescription drug affordability challenges.

Evidence Generation and Implementation Organizations

Several organizations have developed specialized capabilities in evidence generation and implementation that position them well to address the gap left by the abandoned Accelerating Clinical Evidence model.

Flatiron Health (a Roche company) has pioneered approaches to generating real world evidence from clinical data, with a particular focus on oncology. Flatiron's capabilities are relevant to the evidence acceleration opportunity area:

1. The company's technology platform extracts and standardizes clinical data from electronic health records, enabling efficient generation of real-world evidence.
2. Flatiron's research network includes academic and community oncology practices, providing diverse settings for pragmatic clinical research.
3. The company's experience collaborating with regulatory agencies on real-world evidence initiatives demonstrates understanding of evidence standards for decision-making.

Flatiron's specialized expertise in real-world evidence generation creates particular relevance for continuing aspects of the abandoned Accelerating Clinical Evidence model, potentially in collaboration with pharmaceutical companies, academic medical centers, or healthcare systems.

Aetion has developed a platform specifically designed for analyzing real-world data to generate regulatory-grade evidence about treatment effectiveness and safety. Aetion's capabilities align well with the evidence acceleration opportunity area:

1. The company's Aetion Evidence Platform enables standardized, transparent analysis of real-world data from diverse sources, supporting efficient evidence generation.
2. Aetion's experience working with regulatory agencies, payers, and pharmaceutical companies on real-world evidence initiatives demonstrates understanding of diverse evidence needs.
3. The company's focus on methodological rigor addresses key concerns about validity and reliability of real-world evidence.

Aetion's specialized focus on real-world evidence analytics creates relevant capabilities for addressing the evidence acceleration gap, potentially in partnership with data owners, life sciences companies, or healthcare systems.

PCORI (Patient-Centered Outcomes Research Institute), while a non-profit organization, has developed substantial infrastructure and expertise in patient-centered comparative effectiveness research. PCORI's capabilities could be leveraged through public-private partnerships to address the evidence acceleration gap:

1. The organization's PCORnet research network includes clinical data from diverse healthcare organizations, creating infrastructure for pragmatic clinical trial and observational studies.
2. PCORI's focus on stakeholder engagement ensures that evidence generation addresses questions relevant to patients, clinicians, and payers.
3. The organization's methodological expertise in comparative effectiveness research provides a foundation for rigorous evidence generation.

PCORI's existing research infrastructure and focus on practical, patient-centered evidence create opportunities for public-private partnerships to continue aspects of the abandoned Accelerating Clinical Evidence model.

TriNetX has developed a global health research network that connects healthcare organizations, biopharmaceutical companies, and contract research organizations. TriNetX's capabilities are relevant to the evidence acceleration opportunity area.

1. The company's platform provides access to real-world data from millions of patients across multiple healthcare organizations, enabling efficient identification of study cohorts and analysis of treatment patterns and outcomes.
2. TriNetX's network supports both observational studies and identification of potential participants for interventional trials, bridging traditional divides in clinical research.
3. The company's experience working with diverse stakeholders in the research ecosystem demonstrates ability to facilitate collaboration across sectors.

TriNetX's research network and data analytics capabilities create relevant infrastructure for addressing the evidence acceleration gap, potentially in partnership with healthcare organizations, life sciences companies, or academic researchers.

Public-Private Partnership Models for Continued Innovation

Having identified the opportunity areas created by discontinued CMS Innovation Center models and the companies best positioned to address these opportunities, we now turn to examining potential partnership models that could enable continued healthcare innovation. The following sections explore various approaches to public-private collaboration that could facilitate the continuation of valuable experimentation in healthcare payment and delivery.

Model 1: Federal Data Access Partnerships

One of the most significant assets developed through CMS Innovation Center models is the comprehensive data collected on healthcare utilization, costs, and outcomes across different payment and delivery approaches. This data could be leveraged through partnerships that provide private entities with access to federal healthcare data while maintaining appropriate privacy protections and oversight.

Key features of such partnerships could include:

1. **Secure Data Access Infrastructure:** Development of secure environments where private entities could access de-identified Medicare and Medicaid data relevant to discontinued Innovation Center models, potentially building on existing frameworks like the CMS Virtual Research Data Center.
2. **Research Proposal Review Process:** Establishment of a streamlined review process for private entities to propose research questions and analysis approaches using federal healthcare data, ensuring that data access supports high-quality evidence generation.
3. **Public Reporting Requirements:** Requirements for entities accessing federal data to publicly report key findings, ensuring that insights generated benefit the broader healthcare system while still allowing companies to develop proprietary solutions based on these insights.

4. **Matched Funding Mechanisms:** Creation of arrangements where private investment in analyzing federal healthcare data is matched with federal funds, incentivizing private sector commitment while leveraging public resources.

This partnership model would be particularly relevant for evidence acceleration efforts and for understanding the longer-term impacts of interventions tested in discontinued Innovation Center models. Companies with sophisticated data analytics capabilities, such as Flatiron Health, Aetion, and TriNetX, would be especially well positioned to participate in such partnerships.

Model 2: State Innovation Collaboratives

With the early termination of the Maryland Total Cost of Care Model and reduction in the Integrated Care for Kids Model, states face uncertainty about continuing payment and delivery innovation efforts. Public-private partnerships at the state level could provide a framework for continued experimentation and learning.

Key elements of state innovation collaboratives could include:

1. **Multi-Payer Alignment Structures:** Development of state-level governance structures that bring together Medicaid agencies, commercial insurers, and Medicare Advantage plans to align payment approaches and quality measures, potentially building on frameworks established through State Innovation Model grants.
2. **Technical Assistance Contracts:** Engagement of private sector partners to provide technical assistance to states implementing payment and delivery reforms, leveraging expertise from companies with relevant experience in healthcare transformation.
3. **Shared Data Infrastructure:** Creation of state-level data utilities that aggregate claims and clinical data across payers and providers, enabling comprehensive monitoring of cost, quality, and utilization trends.
4. **Regulatory Flexibility Mechanisms:** Development of processes for states to request Medicare and Medicaid waivers or exemptions to support continued

innovation, with private partners providing implementation support.

This partnership model would be particularly relevant for continuing aspects of level payment reform efforts and integrated care models. Companies with experience in multi-payer alignment and state-level healthcare transformation, such as UnitedHealth Group/Optum, Elevance Health, and data integration companies like Innovaccer, would be well-positioned to participate in such collaboratives.

Model 3: Value-Based Care Accelerators

The discontinuation of Primary Care First and Making Care Primary creates significant uncertainty for primary care practices that had invested in transforming their care delivery and business models. Public-private partnerships focused on accelerating the transition to value-based care could help these practices continue their transformation journey.

Key components of value-based care accelerators could include:

1. **Practice Transformation Grants:** Federal funding for private organizations to provide technical assistance to primary care practices transitioning to value-based care models, potentially building on the framework of the Transforming Clinical Practice Initiative.
2. **Alternative Payment Model Incubators:** Creation of structured environment where private payers, provider organizations, and technology companies can collaborate to design, test, and refine alternative payment models, with federal agencies providing regulatory guidance and evaluation support.
3. **Learning Collaborative Infrastructure:** Development of learning networks to connect practices participating in value-based care initiatives, facilitating peer learning and rapid dissemination of best practices.
4. **Value-Based Payment Enablement Tools:** Federal support for the development and implementation of tools that help practices succeed under value-based payment arrangements, potentially through Small Business Innovation Research (SBIR) grants or other innovation funding mechanisms.

This partnership model would be particularly relevant for continuing aspects of primary care transformation initiatives and could also support innovation in specialized areas like kidney care. Companies with experience supporting value-care implementation, such as Aledade, Oak Street Health, and Arcadia.io, would be well-positioned to participate in such accelerators.

Model 4: Targeted Innovation Challenges

For specific high-priority healthcare challenges, such as increasing home dialysis adoption or improving prescription drug affordability, targeted innovation challenges could incentivize private sector solutions while advancing public policy goals.

Key features of targeted innovation challenges could include:

1. **Milestone-Based Prize Competitions:** Federal agencies could establish competitions with significant financial prizes for private entities that achieve specific healthcare improvement milestones, such as demonstrable increases in home dialysis rates or reductions in medication costs while maintaining quality.
2. **Advance Market Commitments:** Government agencies could make commitments to purchase or reimburse for solutions that meet specified performance criteria, creating market incentives for private investment in addressing targeted healthcare challenges.
3. **Regulatory Sandbox Programs:** Creation of defined programs that allow private entities to test innovative healthcare approaches with temporary exemptions from certain regulatory requirements, subject to appropriate oversight and patient protections.
4. **Co-Development Partnerships:** Structured collaborations where federal agencies and private entities jointly develop and test solutions to specific healthcare challenges, sharing both risks and potential benefits.

This partnership model would be particularly relevant for continuing aspects of the ESRD Treatment Choices model and the abandoned Medicare \$2 Drug List initiative. Companies with specialized expertise in these areas, such as Fresenius Medical Care,

DaVita, CVS Health/Caremark, and GoodRx, would be especially well-positioned to participate in such challenges.

Model 5: Long-Term Outcomes Contracts

Many healthcare innovations require sustained implementation over multiple years to demonstrate their full impact on costs and outcomes. Public-private partnership based on long-term outcomes contracts could provide the stability needed for meaningful healthcare transformation.

Key elements of long-term outcomes contracts could include:

1. **Extended Performance Periods:** Development of contractual arrangements between federal agencies and private entities that span 5-10 years, providing stability needed for substantial care delivery transformation and collection of longitudinal outcomes data.
2. **Outcomes-Based Payment Structures:** Establishment of payment arrangements where private entities receive base funding to implement healthcare innovations with additional payments contingent on achieving specified cost and quality outcomes.
3. **Risk-Sharing Mechanisms:** Creation of financial structures that share both the potential and downside risk between public and private partners, aligning incentives for success while providing appropriate protections for both parties.
4. **Sustainability Planning Requirements:** Inclusion of explicit requirements for private partners to develop plans for sustaining successful innovations beyond the contract period, potentially through commercial adoption or integration into existing federal programs.

This partnership model would be particularly relevant for complex, multi-component healthcare transformation initiatives like primary care redesign or integrated care models. Companies with substantial financial resources and long-term strategic orientation, such as UnitedHealth Group/Optum, CVS Health/Aetna, and Amazon, would be well-positioned to engage in such contracts.

Implementation Challenges and Solutions

While the opportunities for private industry to continue the work of discontinued CMS Innovation Center models are substantial, significant challenges must be addressed to realize these opportunities. The following sections examine key implementation challenges and potential solutions.

Challenge 1: Data Access and Interoperability

Access to comprehensive healthcare data is essential for continued innovation, but significant barriers remain to effective data sharing and utilization.

Key Barriers:

1. Privacy concerns and regulatory requirements limit sharing of patient-level data across organizations.
2. Technical challenges in integrating data from disparate electronic health record systems and claims processing platforms.
3. Competitive concerns that may discourage data sharing among healthcare organizations.
4. Lack of standardized approaches to data quality assessment and validation.

Potential Solutions:

1. Development of secure data environments that enable analysis of sensitive healthcare data while maintaining appropriate privacy protections.
2. Advancement of data standardization efforts, potentially building on existing initiatives like the USCDI (United States Core Data for Interoperability).
3. Creation of neutral, multi-stakeholder data utilities that aggregate and standardize data from multiple sources.
4. Implementation of privacy-preserving analytics techniques that enable insight generation without sharing raw patient data.

Companies with specialized expertise in healthcare data integration and analytics such as Innovaccer, Arcadia.io, and TriNetX, could play valuable roles in addressing these data access and interoperability challenges.

Challenge 2: Sustainable Business Models

Developing financially sustainable business models for healthcare innovation remains challenging, particularly given the complex incentive structures in the U.S. healthcare system.

Key Barriers:

1. Misaligned incentives across different healthcare stakeholders, with some benefiting from increased utilization while others benefit from reduced utilization.
2. Difficulties in capturing value created through preventive interventions or care coordination, which may generate savings across multiple entities.
3. Challenges in securing adequate upfront investment for innovations that may take years to demonstrate financial returns.
4. Market fragmentation that necessitates customizing approaches for different payers and provider systems.

Potential Solutions:

1. Development of shared savings arrangements that distribute financial benefits from healthcare improvement across relevant stakeholders.
2. Creation of multi-payer alignment initiatives that create consistent incentives across a provider's patient population.
3. Implementation of blended funding models that combine upfront investment with performance-based payments.
4. Establishment of "health improvement trusts" that pool resources from multiple stakeholders to fund interventions with broad system benefits.

Organizations with experience in value-based contracting and healthcare financial management, such as UnitedHealth Group/Optum, Elevance Health, and special value-based care entities like Aledade and Oak Street Health, could contribute valuable expertise to addressing these business model challenges.

Challenge 3: Regulatory Complexity

The complex regulatory environment governing healthcare payment and delivery creates significant barriers to innovation, particularly for private entities seeking to implement novel approaches.

Key Barriers:

1. Medicare and Medicaid regulations that may restrict alternative payment approaches or care delivery models.
2. Stark Law and Anti-Kickback Statute provisions that limit certain types of provider collaboration and financial arrangements.
3. State insurance regulations that may constrain innovative benefit designs or payment models.
4. Privacy and security requirements that may impede data sharing necessary for care coordination.

Potential Solutions:

1. Development of streamlined waiver processes for private entities implementing innovations similar to those tested in CMS Innovation Center models.
2. Creation of regulatory "sandbox" programs that provide time-limited exceptions to certain requirements for approved innovation projects.
3. Establishment of clear regulatory guidance on permissible innovation activities, reducing uncertainty for private entities.
4. Implementation of "deemed status" arrangements where meeting certain private sector standards is considered equivalent to meeting federal regulatory requirements.

Organizations with regulatory expertise and government relations capabilities, such as large health insurers, hospital systems, and specialized consulting firms, could play important roles in navigating and potentially reshaping the regulatory environment to support continued healthcare innovation.

Challenge 4: Evaluation and Evidence Generation

Rigorous evaluation of healthcare innovations remains challenging but essential for identifying truly effective approaches and building support for their broader adoption.

Key Barriers:

1. Methodological challenges in evaluating complex, multi-component healthcare interventions.
2. Difficulties in establishing appropriate comparison groups for innovations implemented in real-world settings.
3. Time lags in observing meaningful outcomes, particularly for interventions focused on preventive care or chronic disease management.
4. Tensions between rigorous evaluation and rapid innovation cycles.

Potential Solutions:

1. Development of standardized evaluation frameworks that balance methodological rigor with practical feasibility.
2. Implementation of rapid-cycle evaluation approaches that provide timely feedback to inform ongoing innovation.
3. Creation of learning networks that enable comparative analysis across multiple implementation sites.
4. Advancement of predictive modeling techniques that can project longer-term outcomes based on early indicators.

Organizations with specialized expertise in healthcare evaluation and evidence generation, such as Flatiron Health, Aetion, and academic research institutions,

contribute valuable capabilities to addressing these evaluation challenges.

Challenge 5: Scale and Spread

Even when healthcare innovations demonstrate success in controlled settings, achieving broad adoption and scale remains a significant challenge.

Key Barriers:

1. Variability in organizational readiness and capabilities across potential adoption sites.
2. Lack of standardized implementation guidance and support resources.
3. Difficulties in adapting interventions to diverse contexts while maintaining fidelity to core components.
4. Resource constraints that limit ability of many organizations to invest in implementation.

Potential Solutions:

1. Development of staged implementation approaches that match intervention complexity to organizational readiness.
2. Creation of learning collaboratives that connect early adopters with organizations beginning implementation.
3. Advancement of implementation science methodologies that identify core intervention components and adaptable elements.
4. Establishment of technical assistance networks that provide targeted support to organizations implementing proven innovations.

Organizations with experience in healthcare transformation and implementation at scale, such as large health systems, national payer organizations, and specialized implementation support entities, could play valuable roles in addressing these scale and spread challenges.

Policy Recommendations for Enabling Private Sector Innovation

While private industry has substantial capabilities to continue aspects of discontinued CMS Innovation Center models, supportive policy changes could significantly enhance the impact of these efforts. The following sections outline key policy recommendations that would enable more effective private sector engagement in healthcare innovation.

Recommendation 1: Create Flexible Medicare and Medicaid Waiver Pathways

The current processes for obtaining Medicare and Medicaid waivers to test innovative payment and delivery approaches are often lengthy and cumbersome, particularly for private entities. Creating more flexible, streamlined waiver pathways could accelerate private sector innovation while maintaining appropriate oversight.

Key Components:

1. Development of a "fast-track" waiver application process for private entities proposing innovations similar to previously tested CMS Innovation Center models.
2. Establishment of clear criteria for waiver approval, focusing on potential for savings, quality improvement, and protection of beneficiary rights.
3. Creation of multi-year waiver options that provide the stability needed for meaningful healthcare transformation.
4. Implementation of streamlined evaluation requirements that balance rigor with administrative burden.

Such flexible waiver pathways would be particularly valuable for enabling private sector continuation of state-level payment reform initiatives and primary care transformation efforts.

Recommendation 2: Enhance Data Access and Integration

Access to comprehensive healthcare data is essential for effective innovation, but significant barriers limit private sector access to federal healthcare data and integration across data sources.

Key Components:

1. Expansion of the CMS Virtual Research Data Center to support more diverse private sector use cases, including product development and service innovation.
2. Development of standardized data sharing agreements that protect privacy while enabling appropriate private sector access to Medicare and Medicaid data.
3. Federal investment in neutral, multi-stakeholder data utilities that aggregate and standardize data from multiple sources.
4. Advancement of privacy-preserving analytics techniques that enable insight generation without sharing raw patient data.

Enhanced data access and integration would support private sector innovation across multiple opportunity areas, particularly evidence acceleration and continuation of population-focused models like the Maryland Total Cost of Care Model.

Recommendation 3: Create Innovation Investment Incentives

Developing and implementing healthcare innovations requires substantial investment, often with uncertain returns. Creating targeted incentives for private investment in healthcare innovation could accelerate progress in priority areas.

Key Components:

1. Establishment of tax incentives for investments in qualified healthcare innovation activities, potentially modeled on the research and development tax credit.
2. Creation of a healthcare innovation investment fund that provides matching funds for private investments in priority innovation areas.
3. Development of outcomes-based payment programs that reward private entities for achieving specified healthcare improvement targets.

4. Implementation of advance market commitments for solutions addressing high priority healthcare challenges.

Such innovation investment incentives would be particularly valuable for supporting private sector efforts in areas requiring substantial upfront investment, such as comprehensive primary care transformation and home-based care models.

Recommendation 4: Reform Fraud and Abuse Regulations

Stark Law and Anti-Kickback Statute regulations, while essential for preventing improper financial relationships in healthcare, can unintentionally impede value-based care innovations that involve collaboration across providers.

Key Components:

1. Expansion of existing value-based care exceptions and safe harbors to include a broader range of innovation activities.
2. Creation of an "innovation pathway" for requesting expedited advisory opinion on proposed arrangements that support healthcare transformation.
3. Development of clear guidance on permissible approaches to provider collaboration and financial alignment in value-based arrangements.
4. Establishment of "deemed status" provisions where certain private certification programs are recognized as meeting federal compliance requirements.

Fraud and abuse regulatory reforms would be particularly important for enabling private sector continuation of care coordination models and integrated care approaches that involve collaboration across multiple provider types.

Recommendation 5: Support Implementation Science and Technical Assistance

Even when healthcare innovations demonstrate success in controlled settings, achieving broad adoption requires substantial implementation support.

Key Components:

1. Federal funding for implementation science research focused on identifying effective approaches to scaling healthcare innovations.
2. Development of public-private partnerships focused on providing technical assistance to organizations implementing proven innovations.
3. Creation of learning networks that connect organizations at different stages implementing similar innovations.
4. Establishment of a national clearinghouse of implementation resources and practices for priority healthcare innovations.

Support for implementation science and technical assistance would be particularly valuable for enabling private sector efforts to scale successful innovations across diverse healthcare settings and populations.

Conclusion: A New Paradigm for Public Private Partnership in Healthcare Innovation

The March 12, 2025 announcement of significant changes to the CMS Innovation Center's model portfolio represents both a challenge and an opportunity for the future of healthcare innovation in the United States. The early termination of several models—Maryland Total Cost of Care, Primary Care First, ESRD Treatment Choices, and Making Care Primary—along with the abandonment of previously announced initiatives creates potential gaps in the healthcare innovation landscape. However, these gaps also present a compelling opportunity for private industry to step forward and continue the valuable experimental work begun under these initiatives.

As outlined in this essay, several opportunity areas emerge from the discontinued CMS models:

1. State-level payment reform, building on the Maryland Total Cost of Care Model
2. Primary care transformation, continuing the work of Primary Care First and Making Care Primary

3. ESRD care innovation, extending the objectives of the ESRD Treatment Choice Model
4. Integrated pediatric care, addressing aspects of the reduced Integrated Care Kids Model
5. Prescription drug affordability, pursuing alternatives to the abandoned Medicare \$2 Drug List
6. Evidence acceleration, finding new approaches following the abandonment of Accelerating Clinical Evidence

Numerous private organizations across various healthcare sectors possess the capabilities, experience, and market positioning to potentially fill these gaps. Health information technology companies like Epic, Cerner/Oracle, Innovaccer, and Arcadia.io offer sophisticated data infrastructure and analytics capabilities. Health insurance and service organizations like UnitedHealth Group/Optum, Aetna/CV Health, Humana, and Elevance Health bring extensive experience with value-based contracting and care delivery innovation. Specialized organizations in primary care (Oak Street Health, VillageMD, Aledade, One Medical/Amazon), kidney care (Fresenius, DaVita, Strive Health, Somatus), pediatric care (Nemours, CHOP, Boston Children's, Centene), pharmaceuticals and pharmacy benefits (CVS Health/Carelon Express Scripts/Cigna, GoodRx, Amazon Pharmacy), and evidence generation (Flatiron Health, Action, PCORI, TriNetX) offer domain-specific expertise highly relevant to the continuing aspects of the discontinued CMS models.

For these private sector actors to effectively fill the gaps left by the CMS Innovation Center's portfolio restructuring, new models of public-private partnership will be essential. Potential partnership frameworks include federal data access partnerships, state innovation collaboratives, value-based care accelerators, targeted innovation challenges, and long-term outcomes contracts. Each approach offers distinct advantages for specific innovation contexts and would require thoughtful design to balance public and private interests.

Realizing the full potential of private sector engagement in healthcare innovation will require addressing key implementation challenges related to data access and

interoperability, sustainable business models, regulatory complexity, evaluation evidence generation, and scale and spread. Policy changes that create flexible Medicare and Medicaid waiver pathways, enhance data access and integration, c innovation investment incentives, reform fraud and abuse regulations, and supp implementation science and technical assistance could significantly enhance the environment for private sector innovation.

The discontinuation of CMS Innovation Center models need not represent an en the valuable experimentation begun under these initiatives. Rather, it could mar beginning of a new paradigm for healthcare innovation—one that leverages the complementary strengths of public and private sectors to drive meaningful health transformation. By creating the right structures, incentives, and policies to supp private sector engagement, the federal government could catalyze continued pro toward a healthcare system that delivers higher quality, greater accessibility, and improved affordability.

In this new paradigm, private organizations would have increased opportunities develop and test innovative approaches to healthcare payment and delivery, potentially creating commercially viable models that could later inform federal 1 The federal government would shift from primarily implementing and operating experimental models to creating the conditions that enable private sector innova while ensuring appropriate oversight and evaluation. This division of responsibi could potentially accelerate the pace of healthcare innovation while making mor efficient use of federal resources.

The ultimate measure of success for this new paradigm will be whether it produ the evidence needed to support federal investment in healthcare transformation actuarially sound business case of cost reduction. By enabling rigorous testing o diverse approaches to healthcare payment and delivery, well-designed public-pri partnerships could generate the empirical foundation necessary for future policy decisions, potentially identifying approaches that simultaneously improve qualit enhance experience, and reduce costs.

As the healthcare system continues to evolve, the ability to effectively harness both public and private capabilities will be increasingly important. The current moment of transition in the CMS Innovation Center's portfolio offers a unique opportunity to reimagine the relationship between public and private sectors in healthcare innovation—an opportunity that, if seized effectively, could significantly accelerate progress toward a higher-performing healthcare system for all Americans.

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