



Ambulatory Specialty Model

Improvement Activities Toolkit

September 2026

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1. Background

This resource is intended to serve as a reference guide and starting point for the Ambulatory Specialty Model (ASM) improvement activities performance category. Please reference ASM regulations at [42 CFR § 512.735](#) and [42 CFR § 512.771](#) for a more comprehensive understanding of requirements.

1.1 Objectives of ASM Improvement Activities

ASM improvement activities are intended to strengthen coordination between specialty and primary care by promoting consistent communication, collaborative care, and integrated care delivery. The activities are designed to:

- Enhance collaboration between specialty and primary care through routine communication, shared care planning, and collaborative care arrangements (CCAs).
- Improve patient outcomes and experiences by connecting beneficiaries to a primary care provider that coordinates the specialists to support their care.
- Reduce fragmentation of care through clearer care transitions, closed-loop communication, and defined co-management approaches for shared patients.
- Promote use of appropriate health care services by strengthening referral pathways, reducing duplicative care, and improving continuity of care across settings.

1.2 Overview of ASM Improvement Activities Requirements

The table below includes the specifications for the two improvement activities in ASM and how data is collected and reported to CMS.

Improvement Activity (IA) Name	Description (42 CFR § 512.735)	Data Collection Type
IA-1: Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs (HRSN) Screening	An ASM participant must have evidence of processes, workflows, or technology that require the ASM participant to do all of the following: ▪ Confirm the ASM beneficiary has access to primary care services and, if not, assist the ASM beneficiary in finding a clinician who provides primary care services. ▪ Communicate relevant information back to the ASM beneficiary's primary care provider following the ASM beneficiary's visit with the ASM participant. ▪ Determine whether the ASM beneficiary has received an annual health-related social needs screening in the primary care setting and, if not, encourage the primary care services provider to conduct the screening or allow the ASM participant to conduct the health-related social needs screening.	Attestation

Improvement Activity (IA) Name	Description (42 CFR § 512.735)	Data Collection Type
IA-2: Establishing Communication and Collaboration Expectations with Primary Care Using Collaborative Care Arrangements (CCAs).	An ASM participant must do all of the following: (i) Have at least one executed collaborative care arrangement between a primary care practice with which the ASM participant shares ASM beneficiaries. (ii) The CCA must include collaborative efforts related to at least three of the following five elements: ▪ Data sharing, which includes setting expectations for bi-directional sharing of patient information between the parties to the CCA, including but not limited to test results, treatment plans, and follow-up recommendations. ▪ Co-management, which includes defining co-management approaches, where the parties to the CCA work together to furnish complementary care for patients with complex or chronic conditions. ▪ Transitions in care planning, which includes defining protocols for seamless transitions of care between ASM participants, the primary care practice, or different care settings. ▪ Closed-loop communication, such as clearly articulated processes enforcing parameters on how ASM beneficiaries may be referred between the parties to the CCA. ▪ Care coordination integration, which includes establishing structured processes to embed care coordination activities into the ASM participant's routine practice workflows in collaboration with the primary care practice.	Attestation

ASM participants have flexibility in how they implement the two ASM improvement activities. Except for the requirements that apply to a CCA specifically, the table captures the full specifications provided by CMS for the improvement activities.

CMS intentionally does not prescribe detailed implementation requirements for ASM's improvement activities. This allows participants to integrate the activities into existing practice operations in ways that reflect their workflows, care partners, available resources, and patient populations.

For example, IA-1 does not specify which HRSN screening tool should be used. The tool used is at the discretion of the ASM participant and should be chosen based on best fit for the patient mix, practice setting, and other relevant factors. As another example, IA-2 does not require specific standards for meeting the three collaborative elements implemented under the CCA, such as requiring that data be shared using certified electronic health records technology (CEHRT).

1.3 Data Collection and Reporting

Reporting improvement activities to CMS is done by submitting a "yes" attestation during the ASM reporting period. It does not require submission of additional documentation or data; however, ASM participants should retain documentation substantiating their performance of the activities for at least six years as specified under [42 CFR § 512.135](#).

2. IA-1: Connecting to Primary Care and Ensuring Completion of HRSN Screening

IA-1 is designed to strengthen the connection between specialty care and primary care while addressing factors that may affect a beneficiary's health beyond the immediate specialty condition. ASM participants are expected to establish repeatable processes, workflows, and/or technology that help ensure patients have access to primary care, that relevant specialty-care information reaches the patient's primary care provider, and that annual HRSN screening is addressed.

2.1 Examples of How to Complete IA-1

2.1.1 Confirm Access to Primary Care

Establish a routine process for determining whether each ASM beneficiary has access to primary care services.

Examples of what to do:

- Capture and verify the patient's primary care provider information during intake or the visit.
- Identify patients who do not have a primary care provider.
- Assist patients in finding and establishing care with a primary care provider.

GOAL: Ensure patients have a regular source of primary care that can coordinate overall health needs and support chronic disease management.

2.1.2 Communicate After the Specialty Visit

Establish a process for sharing relevant information from the ASM participant's visit with the beneficiary's provider of primary care services. Information may include:

- Test results
- Treatment plans
- Visit summaries
- Follow-up recommendations

GOAL: Keep primary and specialty care aligned so that treatment decisions, follow-up, and overall care planning are coordinated rather than occurring in isolation.

2.1.3 Verify Annual HRSN Screening

Determine whether the beneficiary has received an annual HRSN screening in the primary care setting.

If screening has not occurred:

- Encourage the primary care provider to conduct the screening and initiate appropriate follow-up; or
- Conduct the screening within the specialty practice and communicate the results and follow-up actions to the primary care provider.

ASM does not specify which screening tool should be used. This is up to the discretion of the ASM participant. HRSNs may cover housing, food insecurity, transportation, and financial constraints.

GOAL: Identify and address health-related social needs that may affect a beneficiary's health, particularly those that may influence the management and outcomes of the chronic condition of focus.

2.1.4 What Documentation Should Be Maintained?

ASM participants should retain evidence showing that these processes are operationalized, such as documented protocols, EHR templates or prompts, staff training materials, and audit trails or reports demonstrating primary care provider identification, information exchange, and HRSN screening follow-up.

3. IA-2: Establishing Communication and Collaboration Expectations With Primary Care Using CCAs

IA-2 is designed to facilitate collaboration between an ASM participant and a primary care practice through establishment of a CCA. To receive measure achievement points for IA-2, an ASM participant must enter into at least one CCA with a primary care practice.

3.1 CCA Blueprint

A CCA must meet the requirements of [42 CFR § 512.771](#). The blueprint below provides an outline of these requirements.

3.1.1 Parties to a CCA

A CCA must be exclusively between:

- An ASM participant and
- A primary care practice with which the ASM participant shares at least one patient who is an ASM beneficiary.

The primary care practice may be within the same health system or tax identification number (TIN) as the ASM participant or may be external to the TIN.

3.1.2 CCA Form and Format

The CCA must be:

- In writing;
- Signed by all parties; and
- Include an effective date.

3.1.3 Purpose of the CCA

The purpose of the CCA is to advance an ASM clinical goal:

- Promoting preventive care through improved management of ASM targeted chronic conditions.
- Empowering patients to actively participate and be accountable for quality and whole health outcomes.
- Facilitating meaningful and efficient coordination between specialists and primary care providers to increase independent physician participation in value-based payment programs.

3.2 Collaborative Elements

A CCA must include three of five collaborative elements: data sharing, co-management, transitions in care planning, closed loop communication, and care coordination integration.

One way that ASM participants and primary care partners may choose to structure a CCA is by agreeing on specific responsibilities in operationalizing the selected collaborative elements. This should be specific enough to provide clarity enabling each care partner to design workflows to fulfill responsibilities efficiently and reliably.

We provide examples below for two collaborative elements, data sharing and co-management. **These examples are illustrative only and do not establish additional CCA requirements or prescribe how responsibilities must be allocated between the parties.**

3.2.1 Data Sharing

Data Sharing
Examples of Shared Responsibilities
▪ Accurate and timely updates to the clinical record ▪ Agree to standard patient information (identification, demographic information, contact information) for inclusion in consultations requests and reports ▪ Document the plan for care approved by the patient and share with the care team ▪ Identify secure systems for sharing patient data needed for consultation and co-management (i.e., shared EHR, secure messaging tool, interfaces between EHRs or structured data documents) ▪ Identify secure systems and cadence for sharing practice performance data needed for reporting to CMS and needed to refine collaborative processes

▪ Coordinated implementation of an acquired solution if required ▪ Ensure use of mutually identified secure systems and alternate back-up processes for sharing patient privacy data and protected health information between practices ▪ Comply with applicable laws pertaining to sharing patient data including privacy information and protected health information ▪ Maintain the security of practice information systems with up-to-date measures for physical and cyber security	
Examples of Primary Care Practice Responsibilities	Examples of ASM Participant Responsibilities
▪ Provide patient information and demographics ▪ Clearly describe the reason for the consultation and provide relevant clinical information to the consultant ▪ Ensure use of identified secure systems by clinical and administrative staff for sharing patient privacy data and protected health information between practices	▪ Provide consultation report addressing the question posed plus any additional information important to the patient's care ▪ Ensure use of identified secure systems by clinical and administrative staff for sharing patient privacy data and protected health information between practices

3.2.2 Co-Management

Co-Management	
Examples of Shared Responsibilities	
▪ Collaborate to develop the recommended co-management plan for care for discussion with the patient/family for approval ▪ Document the patient-approved co-management plan and treatment goals in the clinical record and share with the care management team ▪ Identify members of the care management team in accordance with the co-management plan ▪ Timely, accurate communications and documentation in the clinical record by the care management team ▪ Timely, accurate communications and documentation in the clinical record of patient-approved adjustments to the co-management plan ▪ Clinicians available for discussion of time-sensitive issues when identified by the care management team	
Examples of Primary Care Practice Responsibilities	Examples of ASM Participant Responsibilities
▪ Provide care in accordance with the co-management plan to the extent of the clinician's scope of practice ▪ Incorporate the co-management plan into the overall care for the patient ▪ Timely discussion of questions or concerns with the ASM participant specialist as appropriate ▪ Apprise specialist of new conditions or changes to existing conditions impact the patient's health or care	▪ Provide care in accordance with the co-management plan ▪ Provide updated reports to the PCP as care progresses with diagnostic results and treatment provided ▪ Advise PCP of needed additional specialty consultation

▪ Apprise the specialist and care management team of significant changes to the patient's social circumstances	
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3.2.3 CCA Compliance Requirements

Every CCA must meet all of the following requirements.

- Comply with all applicable laws.
- Ensure the arrangement is not conditioned on the volume or value of referrals.
- Preserve each clinician under the CCA's ability to make decisions in the best interests of beneficiaries, including the selection of clinicians, devices, supplies, and treatments.
- Must not induce the ASM participant or primary care practice to reduce medically necessary care or reward medically unnecessary items or services.

Additional requirements apply to any CCA that includes the exchange of payment between the ASM participant and primary care practice. See Appendix A for more information.

3.2.4 What Documentation Should Be Maintained?

ASM participants must maintain documentation regarding all CCAs they enter, including the relevant written agreement.

3.3 CCA Checklist

☐	CCA is in writing, signed by all parties, and includes an effective date
☐	CCA is exclusively between the ASM participant and primary care practice
☐	ASM participant and primary care practice share at least one patient who is an ASM beneficiary
☐	ASM participant and primary care practice agree on the purpose of the CCA
☐	CCA outlines at least 3 of 5 collaborative elements
☐	Parties agree to comply with all applicable laws
☐	CCA is not conditioned on volume or value of referrals
☐	CCA does not incentivize reducing medically necessary care
☐	CCA does not reward medically unnecessary care
☐	Each physician under the CCA retains ability to make decisions in the best interest of ASM beneficiaries
☐	The ASM participant maintains contemporaneous documentation of all relevant CCAs

Appendix

Appendix A: Additional CCA Compliance Requirements

Remuneration under a CCA

The exchange of remuneration is optional under CCAs. An ASM participant may wish to include incentives related to the clinical goals of ASM under a CCA. CMS made the CMS-sponsored model arrangements safe harbor at [42 CFR § 1001.952\(ii\)](#) available under ASM at [42 CFR § 512.765](#) to protect remuneration exchanged between the ASM participant and primary care practice, provided that all requirements are met. In addition to the requirements that apply to all CCAs, a CCA that includes any exchange of remuneration must meet the following conditions.

- Any payment between the parties must be made by check, electronic funds transfer, or another traceable cash transaction.
- Payment must not exceed a limitation set in regulation. The limitation is the amount of an ASM participant's reimbursement for Medicare covered Part B services furnished in the ASM payment year, multiplied by the ASM participant's performance-based payment adjustment.
- The ASM participant must maintain contemporaneous documentation of any and all payments exchanged under a CCA.

Data sharing under a CCA

An ASM participant may enter into a data sharing agreement with CMS to receive beneficiary-identifiable claims data from CMS for ASM beneficiaries under their care as described in [42 CFR § 512.760](#). This data may only be disclosed to downstream entities such as the primary care practice under a CCA if the CCA binds the primary care practice to the same terms included in the ASM participant's data sharing agreement with CMS.

Appendix B: Additional Resources

Note: These resources are not specifically designed for ASM so the details provided in them should not be taken as guidance for meeting ASM requirements. They should function as additional reading for those interested in how other organizations have approaches primary-specialty care coordination.

No.	Resource	Description	Type of Resource
1	Colorado Systems of Care/Patient Centered Medical Home Initiative: Colorado Primary Care – Specialty Care Compact	Demonstrates how one practice network approaches collaborative care with specialists, and the different aspects and guidelines they lay out to guide their formal arrangements.	Guide

No.	Resource	Description	Type of Resource
2	Resource Library for Delivering Collaborative Care	Provides evidence, tools, and implementation information regarding how primary care practices can establish collaborative care and why it is beneficial for practices and patients.	Resource Library
3	Institute for Healthcare Improvement's (IHI) Model for Improvement and Plan-Do-Study-Act (PDSA) worksheet	Provides an approach for continuous improvement.	Guide
4	The University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center CCAs	Implementation guide that provides information and resources for establishing the processes of collaborative care, many of which are applicable in other specialties.	Academic Article

Appendix C: Helpful ASM Links

ASM Website: For more information on the ASM Model, please visit the ASM home page: <https://www.cms.gov/priorities/innovation/innovation-models/asm>.

Some resources on the ASM website include:

- ASM participant list
- Mandatory geographic areas
- Participant checklist
- Performance categories technical fact sheet
- Participant portal user guide

ASM Help Desk: For questions specific to your organization, please reach out to the ASM Help Desk. Email: AmbulatorySpecialtyModel@cms.hhs.gov.