

Ambulatory Specialty Model (ASM)

Overview Webcast



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Welcome and Introductions

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Model Overview

Ambulatory Specialty Model



PROBLEM: Seeing more specialists can lead to fragmented care, leading to poor coordination, delayed treatments, unnecessary procedures, and worse health outcomes for Medicare beneficiaries with chronic conditions.



SOLUTION: ASM will test whether performance-based payment adjustments for specialists can improve care and lower costs by encouraging better chronic condition management and coordination.

— Model Goals



Increase active collaboration between specialists and primary care providers (PCPs)



Improve management of chronic disease and slow disease progression through more effective risk assessment



Empower participants by measuring them on factors within their control and **providing transparent feedback** on how their performance compares to their peers



Reduce avoidable hospitalizations and unnecessary procedures that provide little benefit or could cause harm

Model Snapshot

ASM is a **mandatory model** with five performance years (2027–2031).

ASM Participants: Individual heart failure and low back pain specialists that meet specific eligibility criteria

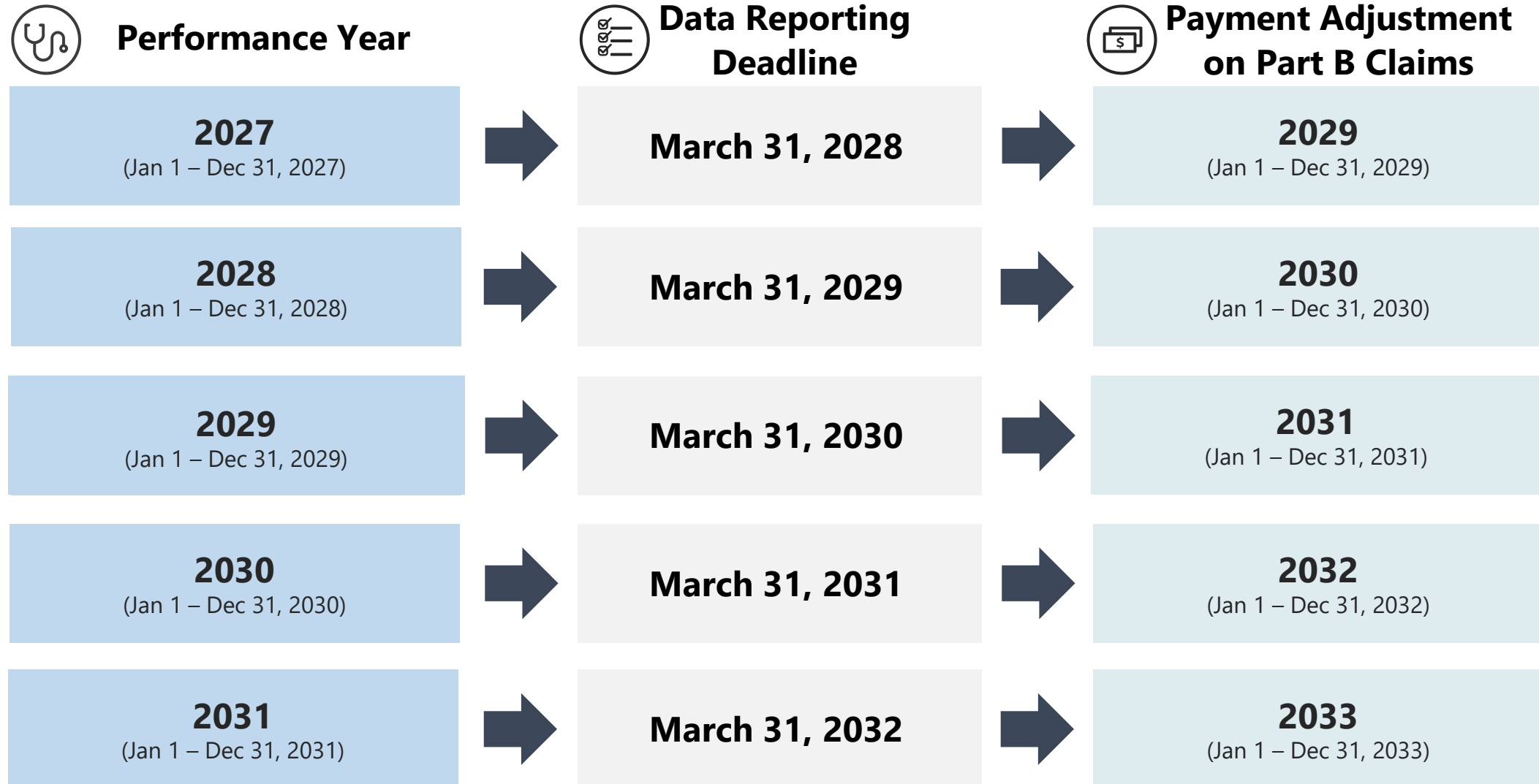
Heart Failure Cohort Specialists: Cardiology

Low Back Pain Cohort Specialists: Anesthesiology, Interventional Pain Management, Neurosurgery, Orthopedic Surgery, Pain Management, and Physical Medicine and Rehabilitation

ASM Beneficiaries: Original Medicare (fee-for-service) patients receiving treatment from an ASM participant for heart failure or low back pain

Performance, Reporting, and Payment Timeline

ASM participants must report required data three months after a performance year ends. CMS then evaluates performance and applies payment adjustments to Medicare Part B claims for covered services in the subsequent calendar year (CY).



Model Participants

Participant Eligibility

Participation is mandatory for selected specialists. Those selected must meet all model requirements for any performance year for which they meet eligibility criteria.

ASM Participant Eligibility Criteria¹

Physicians (identified by a TIN and NPI combination) that

- ✓ Bill claims under the Medicare Physician Fee Schedule
- ✓ Have a selected specialty type
 - Heart Failure Cohort:** Cardiology
 - Low Back Pain Cohort:** Anesthesiology, Interventional Pain Management, Neurosurgery, Orthopedic Surgery, Pain Management, Physical Medicine and Rehabilitation
- ✓ Are attributed 20 or more episode-based cost measure (EBCM) episodes for the relevant condition
- ✓ Practice in one of the selected [mandatory geographic areas](#)

¹Participant eligibility is evaluated using data from the calendar year two years prior to each performance year. For example, final participants for the 2027 performance year will be selected using CY 2025 data. Refer to Calendar Year (CY) 2026 Physician Fee Schedule (PFS) Final Rule [Section III.C.2.c.\(3\)](#) and regulations ([42 CFR part 512, § 512.710](#)) for more information.

Participant Notification

- ✓ CMS released a preliminary list of physicians in February 2026 based on CY 2024 data. View the ASM Participants dataset [here](#).
- ✓ CMS will check the eligibility of all ASM participants again using CY 2025 data. The final list of 2027 ASM participants will be released in late summer 2026.
- ✓ CMS will reassess ASM participant eligibility annually. New ASM participants may be added in future years.

Model and Program Overlap

Concurrent Participation in Accountable Care Organizations (ACOs)

ASM participants can remain in ACOs (e.g., Medicare Share Savings Program) and receive financial incentives from them.

Concurrent Participation in Other Models

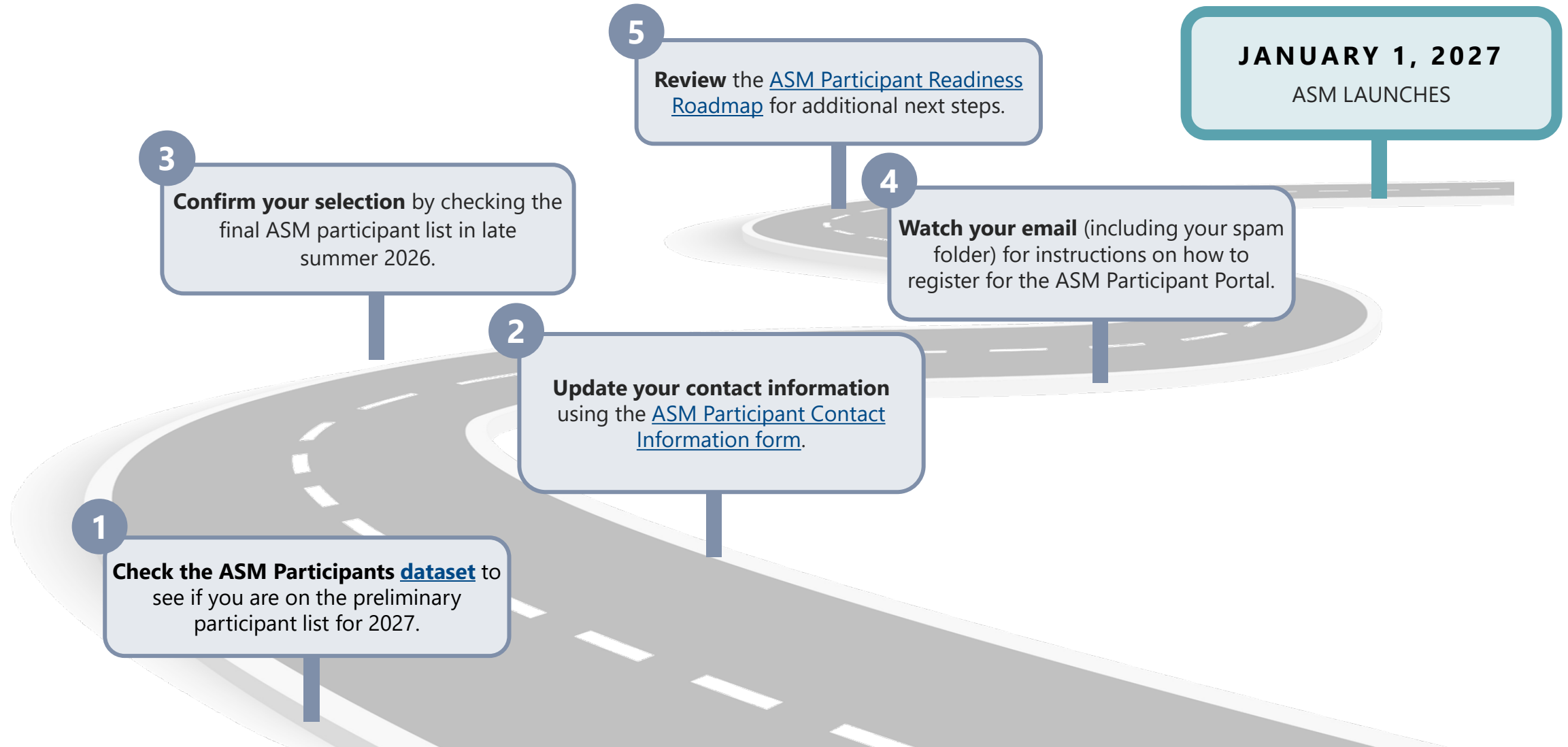
ASM participants can participate and receive financial incentives through other Innovation Center models, including Advanced Alternative Payment Models (AAPMs).

Exemption from MIPS Reporting

ASM participants are not required to complete Merit-based Incentive Payment System (MIPS) reporting for any ASM performance year they meet ASM participant eligibility criteria.

ASM Participant Next Steps

ASM participants should follow these steps to confirm their 2027 participation, receive key updates, and prepare for model launch on January 1, 2027.



Performance Categories

Performance Categories

ASM uses four performance categories to assess an ASM participant's performance.

Quality



CMS will assess ASM participants' quality of care using a focused set clinical measures relevant to each specific ASM chronic condition and specialty type.

Cost



CMS will assess the efficiency and cost-effectiveness of the care ASM participants provide for each of ASM's chronic conditions.

Improvement Activities



CMS will assess ASM participants' efforts to improve care coordination, strengthen collaboration between primary and specialty care, and address the upstream drivers that affect their patients' health.

Promoting Interoperability



CMS will assess ASM participants' use of certified EHR technology (CEHRT) to engage patients, improve care, reduce costs, and better manage chronic conditions through more integrated care.


Heart Failure Quality Measures

Required Measure	Collection Type(s)
Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF (MIPS Q492) (modified specifications)	Administrative Claims
HF: Beta-Blocker Therapy for LVSD (MIPS Q008)	Electronic Clinical Quality Measures (eCQM) MIPS CQM
HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD (MIPS Q005)	eCQM MIPS CQM
Controlling High Blood Pressure (MIPS Q236)	eCQM MIPS CQM
Functional Status Assessments for Heart Failure (MIPS Q377)	eCQM

Low Back Pain Quality Measures

Required Measure	Collection Type(s)
Use of High-Risk Medications in Older Adults (MIPS Q238)	eCQM MIPS CQM
Preventive Care and Screening: Screening for Depression and Follow-Up Plan (MIPS Q134)	eCQM MIPS CQM
Preventive Care and Screening: BMI Screening and Follow-Up Plan (MIPS Q128)	eCQM MIPS CQM
Functional Status Change for Patients with Low Back Impairments (MIPS Q220)	MIPS CQM
Excess Utilization Measure - To Be Proposed in CY 27 Rulemaking	Administrative Claims

Quality Performance Category Overview

	 Quality
Measures & Reporting Requirements	<ul style="list-style-type: none">• ASM participants must report data on at least 75% of eligible cases for each required measure that is not claims-based• Small practices¹ can report measures at TIN or TIN/NPI level• Non-small practices must report measures at TIN/NPI level
Measure Scoring	<ul style="list-style-type: none">• Measures are scored using performance year or historical benchmarks based on each cohort's performance• Measures that meet the data completeness requirement (at least 75% of eligible cases) but do not have at least 20 cases are not scored• Unreported or incomplete measures receive zero points
Final Score Weight	50%

¹In ASM, a small practice consists of 15 or fewer NPIs. Please refer to ASM regulations ([42 CFR, part 512, § 512.725](#)) for additional information about the quality performance category.

Quality Performance Category Scoring

ASM participants must report complete quality measure data, but only measures that meet the case minimum are included in the quality performance category score.

Data Completeness Requirement Report on at least 75% of cases eligible for a quality measure's denominator		Meets Data Completeness (≥75% eligible cases)	Does Not Meet Data Completeness (<75% eligible cases)
Case Minimum Have at least 20 eligible cases in the quality measure's denominator	Meets Case Minimum (≥20 cases)	✓ Measure scored 1-10 points	✗ Measure receives zero points
	Does Not Meet Case Minimum (<20 cases)	— Measure not scored and excluded	✗ Measure receives zero points

Quality Performance Category Scoring Example


Heart Failure Cohort Quality Measure	Data Completeness	Cases	Score
Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF (MIPS Q492)	100%	65	9.5
HF: Beta-Blocker Therapy for LVSD (MIPS Q008)	70%	60	0
HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD (MIPS Q005)	92%	85	8.5
Controlling High Blood Pressure (MIPS Q236)	95%	85	7
Functional Status Assessments for Heart Failure (MIPS Q377)	100%	18	Excluded

Illustrative Quality Performance Category Score¹

$$\frac{9.5 + 0 + 8.5 + 7.0}{40} = 62.5\%$$


¹Note: The data and calculations are for illustrative purposes only and does not reflect actual data.

Cost Performance Category Overview

	 Cost¹
Measures & Reporting Requirements	<ul style="list-style-type: none">• CMS directly calculates cost measures, ASM participants do not need to report this data<ul style="list-style-type: none">• Heart Failure Cohort Cost Measure: Heart Failure EBCM• Low Back Pain Cohort Cost Measure: Low Back Pain EBCM
Measure & Performance Category Scoring	<ul style="list-style-type: none">• Benchmarks are calculated for each performance year based on cohort performance• ASM participants that do not have at least 20 EBCM episodes will not receive an EBCM score or a cost performance category score
Final Score Weight	50%

¹Please refer to ASM regulations ([42 CFR, part 512, § 512.730](#)) and the [EBCM cost information forms](#) for additional information on the cost performance category.

Improvement Activities Performance Category Overview

	 Improvement Activities¹
Reporting Requirements	<ul style="list-style-type: none">• ASM participants must attest to completing two ASM-specific improvement activities• Attestation at the TIN level is required to confirm the improvement activity was completed by all ASM participants
Performance Category Score & Final Score Adjustment	<ul style="list-style-type: none">• Complete both improvement activities = No adjustment• Complete one improvement activity = -10 points• Do not complete either improvement activity = -20 points

¹Please refer to ASM regulations ([42 CFR, part 512, § 512.735](#)) for additional information on the improvement activities performance category.

ASM Improvement Activities

IA-1 Primary Care Connections and Health-Related Social Needs (HRSN) Screening

Must have workflows in place to

1. Ensure every ASM beneficiary has a PCP or help them find one
2. Update the PCP with important information after an ASM beneficiary's appointment
3. Confirm ASM beneficiaries have received HRSN screening

IA-2 Establishing Communication and Collaboration Expectations Using Collaborative Care Arrangements (CCAs)

Establish at least one CCA with a primary care practice that meets minimum requirements

Each improvement activity must be active for a **90-day continuous period** within a performance year.

Collaborative Care Arrangements

Collaborative Care Arrangement Use and Key Requirements¹

- Broadly, CCA requirements include:
 - ✓ **Formal agreement.** Maintain a written, signed, and dated ASM Participation Agreement with a PCP that shares at least one established patient with the ASM participant and is not excluded from Federal health programs.
 - ✓ **Purpose.** Must be to advance clinical goals of ASM or further improvement activity performance.
 - ✓ **Relationship between parties.** PCP participation must be voluntary without penalty for nonparticipation. Must preserve clinical independence of each party.
 - ✓ **Safeguards.** Agreement must not limit medically necessary services or reward unnecessary utilization.
 - ✓ **Financial incentives, if offered under CCA, comply with additional requirements.** May opt to offer financial incentives to CCA partners under CMS-sponsored model safe harbor if additional requirements are met, including complying with payment cap and not linking payment to volume / value of referrals.

¹This slide is a high-level summary of the ASM requirements for CCAs. Please refer to a list of the full requirements, ([42 CFR, part 512, § 512.771](#)) when developing CCAs.

Promoting Interoperability Performance Category Overview



Promoting Interoperability¹

Measures & Reporting Requirements

- ASM participants must submit a CEHRT ID, complete required attestations, and report interoperability measures at the TIN level
- This reported data may include individuals who are not ASM participants

Measure & Performance Category Scoring

- Measures are scored and weighted using the MIPS methodology to produce a performance category score between 0% and 100%
- A score of zero is given for incomplete reporting of attestations and measures

Final Score Adjustment

0 to -10 point adjustment based on performance category score

¹Please refer to ASM regulations ([42 CFR, part 512, § 512.740](#)) for more information on Promoting Interoperability performance category requirements.

Promoting Interoperability Attestations and Measures

Attestations

The Office of the National Coordinator Health Information Technology (ONC) direct review

Actions to Limit or Restrict Compatibility or Interoperability of CEHRT

The Security Risk Analysis Measure

The High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure

Measures

e-Prescribing

Health Information Exchanges (HIEs)

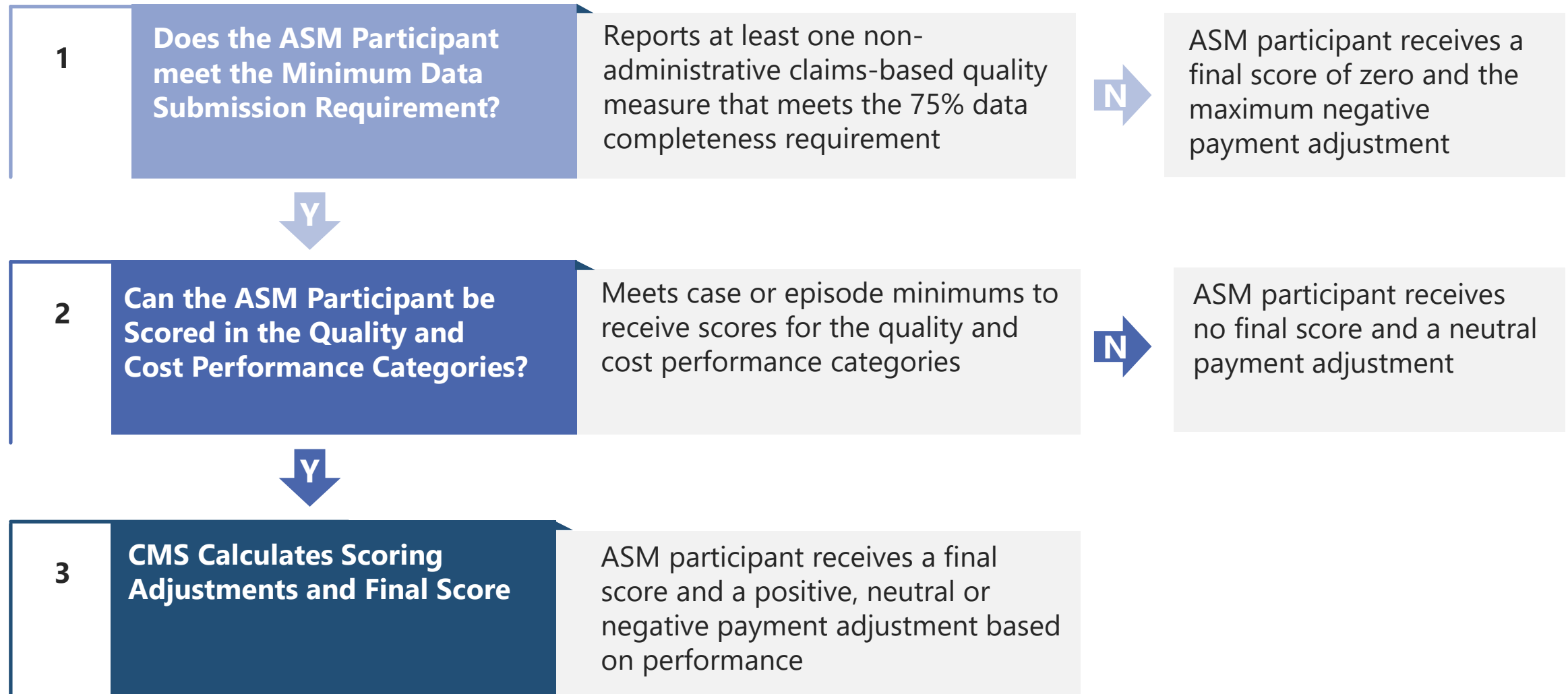
Provider to Patient Exchange

Public Health and Clinical Data Exchange

Final Score and Payment Methodology

Final Score Methodology

Final Score Calculation Process



Final Score Adjustments and Calculation

Complex Patient Scoring Adjustment

ASM participants may earn up to 10 bonus points on their final score based on their patients' Hierarchical Condition Category (HCC) risk scores and the proportion of dual eligible patients they serve.

Small and Solo Practice Scoring Adjustments

ASM participants may receive a final score bonus of 10 points if they are in a small practice of 2-15 clinicians, or a bonus of 15 points if they are a solo practice.

$$\text{Final Score}^1 = \left[\left(\text{Quality ASM Performance Score} \times \text{Quality ASM Performance Weight} \right) + \left(\text{Cost ASM Performance Score} \times \text{Cost ASM Performance Weight} \right) \right] \times 100 + \text{Improvement Activities ASM Performance Scoring Adjustment} + \text{Promoting Interoperability ASM Performance Scoring Adjustment} + \text{Complex Patient Scoring Adjustment} + \text{Small Practice Scoring Adjustment}$$

Note: An ASM participant who does not meet minimum data submission requirement will receive a final score of zero for the applicable ASM performance year regardless of eligibility for the complex patient scoring adjustment or the small practice scoring adjustment. The final score cannot be below zero or exceed 100 points.

Payment Adjustments and Risk Levels



Payment Adjustments

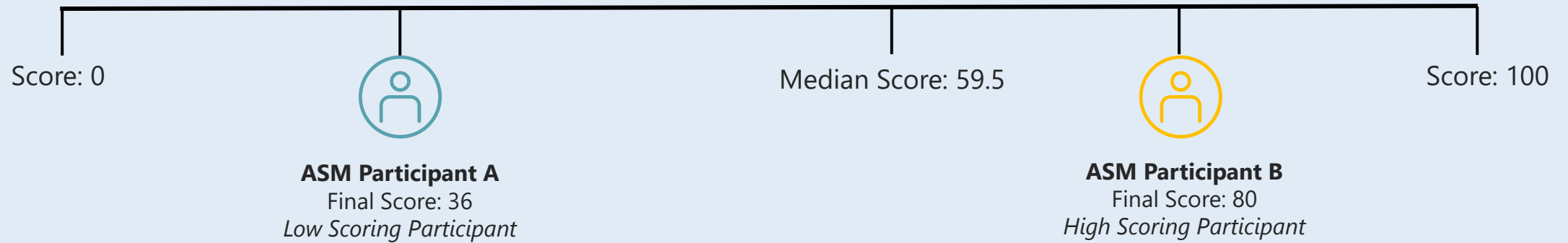
Final scores determine if ASM participants receive positive, neutral, or negative payment adjustments to their Medicare Part B claims for covered services during an ASM payment year.

Performance Year	Payment Year	Two-Sided Risk Level
2027	2029	9% Upside or Downside
2028	2030	9% Upside or Downside
2029	2031	10% Upside or Downside
2030	2032	11% Upside or Downside
2031	2033	12% Upside or Downside

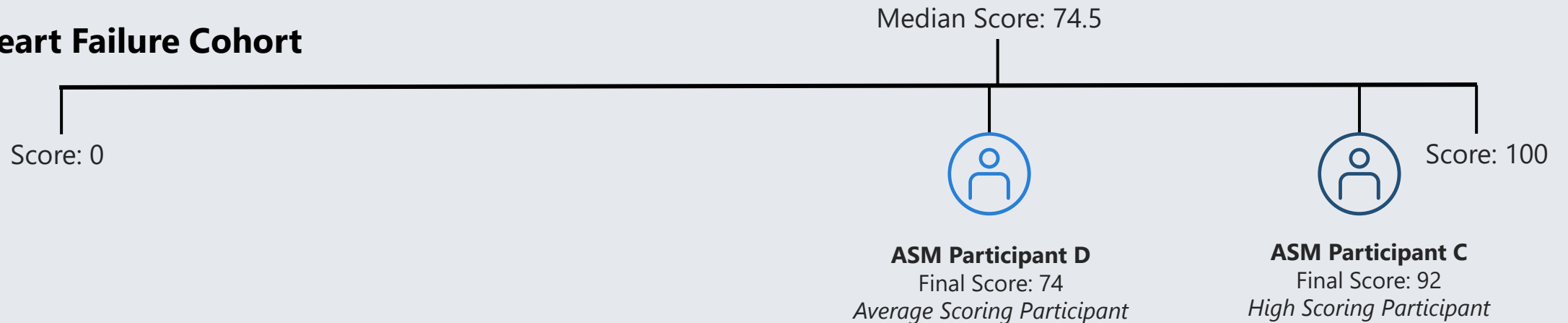
Performance Comparison

CMS determines payment adjustments by comparing an ASM participant's final score against their cohort's performance.

Low Back Pain Cohort

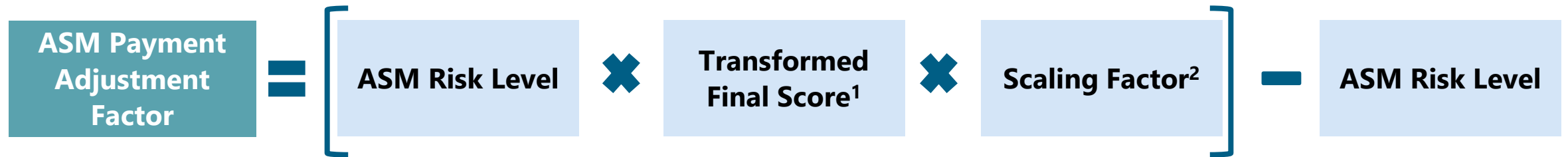


Heart Failure Cohort



Payment Adjustment Calculation

CMS will calculate each ASM participant's *payment adjustment factor*, which is the percentage adjustment ASM participants will receive on all Medicare Part B covered service payments during an ASM payment year.



Payment Adjustment Factor Illustrative Example³



ASM Participant B
Final Score 80
Transformed Final Score: 0.95



¹The transformed final score is calculated using a logistic exchange function specified for each cohort.

²The scaling factor ensures that the estimated total payment adjustments equal a cohort's incentive.

Note: All data and calculations are illustrative and do not reflect actual data.

Performance Report

ASM participants will receive annual performance reports detailing their scores and payment adjustments.

Annual Performance Report Components



Performance Scoring

- Individual measure-level scores for required measures within each performance category
- Performance category-level scores
- Complex patient scoring adjustment (as applicable)
- Small practice / solo practitioner scoring adjustment (as applicable)
- Final score



Payment Impact

- ASM payment adjustment factor
- ASM payment multiplier

ASM Participant Vignette



Dr. Brown is an ASM participant in the heart failure cohort. During a performance year, she treated 200 heart failure patients. Dr. Brown's performance being above several benchmarks, yielded a positive payment adjustment.

Improving Care Management

Dr. Brown made quality improvements to improve heart failure management.

- Hypertension Control (Q236): 90%
- Beta-Blocker Therapy for LVSD (Q008): 85%
- ACE Inhibitor or ARB or ARNI Therapy for LVSD (Q005): 92%
- Functional Status Assessments (Q377): 90%

Strengthening Care Coordination

Dr. Brown established a **CCA** and **used patient-facing health technology and health information exchange** to put critical information in the hands of patients and other clinicians.



Reducing Hospitalizations

Proactive heart failure management limited unplanned hospitalizations.

- Low Unplanned Cardiovascular Admission (MIPS Q492): 6%

Managing Costs

Better care management and fewer unplanned hospitalizations resulted in **lower spending in many heart failure episodes.**



Final Score



Quality



Cost



Improvement Activities



Promoting Interoperability

Hypothetical ASM Payment Adjustment Factor: +6%

Hypothetical +6% impact on annual Medicare Part B payments totaling \$250,000: +\$15,000

Waivers and Beneficiary Incentives

Model Waivers



MIPS Waiver

MIPS requirements will be waived for ASM participants for performance years they meet the model's eligibility criteria.



Telehealth Waiver

ASM participants and their patients will be **waived from geographic and originating site restrictions.**

Beneficiary Incentives

ASM participants may offer in-kind engagement incentives to beneficiaries if they meet compliance requirements.



Eligibility and Provision

- ASM participants may provide optional in-kind items or services to their patients to incentivize their engagement, subject to compliance with model requirements and applicable federal and state laws and regulations.
- Incentives must be provided directly by ASM participants or their staff and only given to established ASM patients.



Financial Responsibility and Limits

- No costs associated with incentives may be shifted to any federal health care program.
- Totality of engagement incentives must not exceed \$1,000 for any one patient.
- Technology valued over \$75 must remain the property of ASM participants and be retrieved upon the end of the care relationship.



Appropriate Use and Restrictions

- **The item or service must**
 - Connect to care for an ASM-targeted chronic condition and support prevention, patient engagement, accountability, or clinical goals.
 - Empower patients to take an active and responsible role in managing their own health.
 - Support better care coordination between ASM participants (specialists) and primary care physicians.
 - Only be promoted or advertised if it provides a genuine benefit to the patient.
- **Items or service must not**
 - Be tied to the patient receiving items or services from an outside provider or supplier.

Data Sharing, Monitoring, and Compliance

Data Sharing

ASM participants will receive additional data from CMS to guide efforts in improving patient care.



Aggregate Data Sharing

- CMS will provide aggregate and de-identified data (e.g., claims-based cost, utilization, and quality data).
- This data will help ASM participants track their progress towards meeting model objectives, and identify areas of improvement for care delivery, and cost reduction.



Patient Identifiable Data

- To help assess and improve care plans and treatment patterns, ASM participants will be able to request certain Medicare patient-identifiable claims data.¹

ASM participants will need to sign a Data Request and Attestation (DRA) to access ASM patient data.

¹Please refer to ASM regulations ([42 CFR, part 512, § 512.760](#)) for additional information.

Monitoring and Compliance

ASM participants **must comply** with CMS evaluation and monitoring activities and applicable laws and regulations.¹



Monitoring and Compliance Activities

- Documentation requests including surveys and questionnaires
- Audits of claims data, quality measures, and patient medical records
- Interviews with clinical staff and leadership, patients, and caregivers
- Site visits
- Ongoing monitoring of your quality outcomes and clinical data and any complaints or appeals filed by patients



Remedial Actions

- CMS may take remedial actions in cases of noncompliance, falsification, threats to patient health, or risks to program integrity

¹Please refer to ASM regulations (42 CFR, part 512, [§ 512.150](#) and [§ 512.160](#)) for additional information.

Closing



We appreciate your time and interest!

Contact the ASM model team via email at

AmbulatorySpecialtyModel@cms.hhs.gov

Additional Resources

- [ASM Webpage](#)
- [ASM Participants Dataset](#)
- [Participant Roadmap](#)
- [Overview Factsheet](#)
- [Frequently Asked Questions](#)
- [ASM Regulations](#)