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Ambulatory Specialty Model (ASM) Summary: Final CY 2026 Updates to Medicare Physician Fee Schedule Payment Policies, Quality Programs, and Other Part B Provisions

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Background & Summary

On October 31, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Final Rule, which also finalized the creation of the Ambulatory Specialty Model (ASM) - a new mandatory and risk-bearing payment model. Those required to participate in the ASM will no longer be required to participate in the Merit-based Incentive Payment System (MIPS). The ASM aims to test if payment adjustments based on performance can enhance care quality and reduce costs for heart failure and low back pain, which account for a combined 6.2% of Medicare Parts A and B spending.

As finalized, ASM will begin on January 1, 2027 and run for five performance years through December 31, 2031. CMS plans to provide educational resources for ASM participants in CY 2026 to help participants prepare for meeting model requirements before ASM begins in CY 2027.[1] Final data submission of measures and activities will be in CY 2032, with final model payment adjustments in CY 2033.

Ambulatory Specialty Model (ASM)

Under the Final Rule, a participant's future Medicare Part B payments would be adjusted based on a composite performance score derived from four categories: quality, cost, improvement activities and promoting interoperability. The model includes five performance years (2027-2031), with payment adjustments applied during five corresponding payment years (2029-2033), creating a two-year lag between performance and financial impact. All performance scoring and payment adjustments are applied at the individual clinician (Tax Identification Number (TIN)/National Provider identifier (NPI)) level.

Terms and Definitions[2]

CMS finalized as proposed terms and definitions to implement the ASM, several of which are provided in Table 1.

Term	Definition
ASM participant	"means an individual clinician who, for at least one ASM performance year, satisfies the ASM participant eligibility criteria and has been selected for participation in the model as described at § 512.710(g).[3]
ASM cohort	"means a group of ASM participants who treat the same targeted chronic condition, specifically the ASM heart failure cohort and the ASM back pain cohort."

[1] CMS ASM https://www.cms.gov/priorities/innovation/asm-ambulatory-specialty-model-frequently-asked-questions
[2] CMS will codify the definitions and policies of ASM at 42 CFR part 512 subpart G (finalized § 512.705 through § 512.780)
[3] See Final Rule § 512.710 Participant eligibility and selection, pgs. 1884-1891

ASM targeted chronic condition	"means a medical condition that is a core focus of the ASM; that is, heart failure or low back pain."
ASM payment multiplier	"means the numerical value equal to 1 plus the ASM payment adjustment factor determined for an ASM participant for an applicable ASM payment year as described at § 512.750(c)."[4]
ASM performance year	"means a 12-month period beginning on January 1 and ending on December 31 of each year during the first 5 calendar years of ASM test period."
ASM payment year	"means a calendar year in which CMS applies the ASM payment multiplier to Medicare Part B payments based on the final score achieved by that ASM participant for the ASM performance year 2 years prior."
Small Practice	"means a practice consisting of 15 or fewer clinicians at the time we [identify ASM participants for an ASM performance year as described at § 512.710(g)."[5]

Table. 1. Finalized terms and definitions applicable to the proposed ASM model.

Participation Requirements and Exclusions

CMS finalized policy as proposed that all eligible clinicians must participate in the ASM, with eligibility reassessed each year based on four core criteria that clinicians must meet:

- Qualifying Specialty: A clinician must belong to a specific specialty:
  - For the heart failure cohort, CMS finalized that participation is limited to Cardiology. The Final Rule, consistent with the Proposed Rule, excludes subspecialties such as interventional and transplant cardiology, among others.
  - For the low back pain cohort, CMS finalized that participation will include clinicians in orthopedic surgery, neurosurgery, pain management, physical medicine and rehabilitation and other related specialties.
- Volume Threshold: A clinician must have at least 20 attributed episodes for the relevant condition during the prior calendar year, based on MIPS Episode-Based Cost Measure (EBCM) logic.
- Geographic Location: A clinician must practice in a specific geographic area, which is a Core-Based Statistical Area (CBSA) or metropolitan division randomly selected by CMS for participation. A clinician's location is determined by the ZIP code most frequently found on their attributed Medicare claims.
- Billing Type: A clinician must bill for services under the Medicare PFS.

Exclusions and Exceptions from Mandatory Participation

CMS finalized as proposed the following exclusions and exceptions to the mandatory participation component of the ASM:

- Clinician Type: Non-physician practitioners (NPPs) are excluded because they are not assigned the specialty codes required for eligibility. To ensure appropriate comparison among peers, the agency is limiting ASM to specific physicians.
- Geographic Areas: Entire regions are removed from the selection pool before participation is determined, including all U.S. territories and any CBSA that lacks a minimum volume of eligible clinicians.

[4] See Final Rule § 512.750 Payment adjustment, pgs. 1908-1910
[5] See Final Rule § 512.710 Participant eligibility and selection, pgs. 1884-1891

- Practice Setting: Clinicians who bill exclusively through payment methods for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) or certain Critical Access Hospitals (CAHs) are not included as they do not bill under the Medicare Physician Fee Schedule.
- Change in Practice During a Performance Year: A participant who changes their billing TIN and notifies CMS within 30 days can be excused from ASM requirements for that year and would instead be subject to MIPS reporting, if applicable. CMS noted it will monitor TIN changes and may revisit the policy in future rulemaking if needed.

Geographic Selection

CMS finalized the proposal that participation in the ASM is mandatory and limited to clinicians in randomly selected geographic areas. The model does not have an option for voluntary participation for those outside of these areas. CMS will select areas using a stratified, random sampling of CBSAs and metropolitan divisions.[6] Clinicians will be assigned to one CBSA or metropolitan division based on the ZIP Code of their service location. Before this selection, entire regions will be excluded from the pool (e.g., all U.S. territories and CBSAs that lack a minimum volume of eligible clinicians). In the Final Rule, CMS indicated it will not exclude areas in states participating in the Advancing All-Payer Health Equity Approaches and Development (AHEAD) model.[7]

CMS finalized selection criteria through approximately 40 percent of CBSAs or divisions within each stratum. CMS also noted that the selection will occur closer to the model's launch[8]. Geographic selection will follow a six-stratum stratified random sampling process, incorporating:

- Total Parts A and B episode spending (low vs. high)
- Episode volume (low, high, very high)
- Metropolitan division status (assigned its own stratum)

Stratum #	Average Total Parts A & B Spending	Volume of Eligible Episodes	CBSA or Metropolitan Division?	Selection Probability	Estimated # of CBSAs or Metropolitan Divisions in Stratum
1	Low	Low	CBSA	40%	156
2	Low	High	CBSA	40%	117
3	High	Low	CBSA	40%	123
4	High	High	CBSA	40%	135
5	—	Very High	CBSA	40%	28
6	—	—	Metropolitan Division	40%	37

Table 2. Number of Eligible CBSAs and Metropolitan Divisions by Stratum[9]

Annual Participant Selection and Notification

CMS finalized that beginning with the 2028 performance year, ASM participant eligibility will be reassessed annually based on data from two years prior:

[6] For large urban areas, metropolitan divisions will be used, consistent with definitions in OMB Bulletin 23-01 (July 2023). This structure supports statistical rigor and aligns with the geographic units used in other CMS Innovation Center models such as TEAM and ACO REACH.
[7] The AHEAD model is a state-wide initiative to increase primary care investment and hospital stability.
[8] In the Final Rule, CMS justified its sampling with power analyses. Selecting 240 CBSAs allows detection of a 3.5 percent spending change per condition, or 1.7 percent if heart failure and low back pain are pooled and a 0.25 Type I error rate is used.
[9] Table is adapted from Table B-D3 in the Final Rule pg. 762

- Entering the Model: Each year, new clinicians who meet the volume, specialty and location criteria will be added to the model.
- Exiting the Model: Existing participants who no longer meet the eligibility criteria (e.g., they fall below the 20-episode threshold) will be removed from the ASM for that performance year and must resume MIPS participation, if applicable.

In the Final Rule, CMS states the agency will notify ASM participants through multiple channels, including posting lists on the ASM website, emailing clinicians and working with specialty societies. In addition, resources and webinars for preliminary ASM participants will begin in CY 2026. For the 2027 performance year, a preliminary list based on 2024 data will be released in early 2026, with the final list, based on 2025 data, to be published around July 2026. Only clinicians on the preliminary list will be eligible for the final list. In later years, CMS will post and email participant lists about six months before each performance year, using data from two years prior.

TIN Change Policy[10]

CMS finalized two policies for clinicians who change their Taxpayer Identification Number (TIN), depending on when the change occurs. If the change happens during a performance year, a participant who notifies CMS within 30 days is excused from ASM requirements for that year and reverts to MIPS. If they fail to notify CMS, they remain responsible for reporting under their original TIN. However, if a TIN change occurs after a performance year, the participant's earned payment adjustment follows their National Provider Identifier (NPI) and will be applied to claims billed under the new TIN during the corresponding payment year.

Model Overlap and MIPS Status

In the Final Rule, CMS finalized the proposal to permit ASM participation to overlap with other CMS programs, such as the Medicare Shared Savings Program. Under this policy, CMS clarifies that participation in the ASM is mandatory for any eligible clinician, regardless of their involvement or status in another model like an Advanced Alternative Payment Model (APM). For specialists who are also part of an Accountable Care Organization (ACO), the ASM requirements apply to their entire fee-for-service panel for the relevant condition, not just those beneficiaries formally assigned to the ACO. Moreover, all ASM participants, including clinicians who have achieved Qualifying APM participant (QP) status through another model, are exempt from MIPS reporting and payment adjustments.

Performance Assessment Framework

The ASM uses a performance framework based on MIPS Value Pathways (MVPs), but with significant modifications to support direct peer comparison.[11] The scoring structure is different from MIPS: the Quality and Cost categories are each weighted at 50% to determine the final score, while the Improvement Activities (IA) and Promoting Interoperability (PI) categories function only as potential negative scoring adjustments.

CMS originally proposed that ASM participants would report on a fixed, mandatory set of measures at the individual clinician (TIN/NPI) level only, with no group reporting permitted, for cost, quality, IA and PI. In the Final Rule, CMS agreed with stakeholder concerns that the proposal to require submission of the IA and PI performance categories data at the TIN/NPI level could increase administrative

[10] See pgs 731-737 in the Final Rule
[11] A MIPS Value Pathway (MVP) is a MIPS reporting option offering a focused set of clinically relevant measures for a specific condition or specialty. In ASM, the negative scoring adjustments for the non-weighted categories are as follows: failing to complete required IAs results in a -10 or -20 point adjustment, and failure to meet PI requirements can result in an adjustment of up to -10 points. Pg. 683-686

burden for ASM participants regardless of practice size. Therefore, the agency finalized that reporting the IA and PI categories as the requirements of these ASM performance categories will typically reflect work done at a practice level. CMS also notes in the Final Rule the agency did not consider subgroup reporting for ASM performance categories for CY 2026 but may consider this in future notice-and-comment rulemaking

Further, CMS finalized as proposed a small practice scoring adjustment to add 10 points to the final score of an ASM participant who is in a small practice to support ASM participants against any potential challenges that they may face in ASM participation (e.g., costs to implement and maintain Certified Electronic Health Record Technology (CEHRT) and staff and training costs).[12]

Design Choices and Considerations

Instead of using the reweighting policies found in MIPS, the ASM applies direct scoring adjustments. The model's focus on heart failure and low back pain is based on its established Episode-Based Cost Measures (EBCMs). These EBCMs were developed with specialists and stakeholders to target high-spending conditions with opportunities for care improvement.[13,14] For quality measures where performance is uniformly high (topped-out measures), CMS will monitor performance during initial ASM performance years before designating an ASM measure with topped out status.

Quality Performance Category[15]

In the Final Rule, CMS finalized policy that the quality performance category accounts for 50% of each ASM participant's final score. The agency finalized as proposed two distinct measure sets, one for each clinical cohort with one minor modification (see Table 3: Heart Failure and Table 4: Low Back Pain below). CMS notes that each measure set is designed to assess and incentivize improvement in three domains: reducing excess utilization, promoting evidence-based care and capturing patient-reported outcomes.[16]

In the Final Rule, the agency specified that each ASM participant must report the finalized measures specified in Tables 3 and 4 for their applicable chronic condition, except for the administrative claims-based measures, which would be calculated by CMS based on their submitted claims.

Measure ID	Measure Description	Type
Q492	Risk-standardized cardiovascular-related admission rate	Claims
Q008	Beta-blocker prescribed for LVSD	CQM / eCQM
Q005	ACEi/ARB/ARNI therapy for LVSD	CQM / eCQM
Q236	Controlling high blood pressure	CQM / eCQM
Q377	Functional status assessment for HF[17]	eCQM only

Table 3. Heart Failure (HF) Cohort – Final Quality Measure Set

[12] See pg. 1907 of Final Rule
[13] See page 682 of Final Rule
[14] In the Final Rule, while CMS notes that the EBCMs were developed in consultation with specialists and stakeholders, the specific provider or stakeholder groups involved in that process are not named.
[15] HF and LBP Measure Set Tables adapted from Table 39; 90 Fed. Reg. 32577
[16] A Patient-Reported Outcome Measure (PROM) is a required component of each measure set. The proposal also signals a future direction of evolving the heart failure PROM from a simple assessment into a performance-based measure (a PRO-PM) that would hold clinicians accountable for improvements in patient functional status.
[17] Commenters opposed developing the proposed Q377 into a PRO-PM, citing concerns about factors outside clinician control, added burden, workflow changes, vendor contracts, and costs. As a result, CMS finalized only the process version of the measure, not the PRO-PM, but will continue evaluating a PRO-PM for the future. Any future implementation of this measure as a PRO-PM would be clearly indicated through future notice-and-comment rulemaking, to provide time for adoption by ASM participants. CMS would also consider opportunities to support participants and phased implementation.

Measure ID	Measure Description	Type
Q238	High-risk medication use in older adults	CQM / eCQM
Q134	Depression screening and follow-up	CQM / eCQM
Q128	BMI screening and follow-up	CQM / eCQM
Q220	Functional status change for LBP (PROM)	CQM only

Table 4. Low Back Pain (LBP) Cohort – Final Quality Measure Set[18]

Patient Activation Measure

In the Proposed Rule, CMS asked for feedback on whether the Patient Activation Measure (PAM, MIPS Q503) should be added to the heart failure and low back pain quality measure sets in ASM.[19] In the Final Rule, CMS acknowledged PAM's potential benefits but agreed with stakeholder concerns and decided not to finalize adding PAM to the heart failure or low back pain quality measure sets.

Reporting and Scoring

CMS finalized as proposed that starting in the 2027 ASM performance year, participants must meet a 75 percent data completeness requirement and must report quality measure data for at least 75 percent of eligible patients. CMS also finalized as proposed that if an ASM participant fails to meet the 75 percent data completeness requirement for any required quality measure, they would receive zero "measure achievement points" for that measure. CMS noted concerns that participants may face documentation challenges, but the agency asserts the 75 percent data completeness threshold is necessary to keep quality measurement accurate, matches other CMS programs (e.g., MIPS) and is the minimum needed for meaningful scores. CMS also finalized that a minimum of 20 cases is needed for a measure to be scored and failing to report a required measure or submitting it with incomplete data results in zero points for that measure.[20] Each scored measure receives 1-10 points based on decile benchmarks derived exclusively from the performance of other participants within the same ASM cohort.

Cost Performance Category

The Cost performance category accounts for 50% of a participant's final score. Performance is based on MIPS Episode-Based Cost Measures and is calculated by CMS using administrative claims data, requiring no data submission from clinicians. The measures assess the total risk-adjusted Medicare Parts A and B spending during a beneficiary's care episode, holding the attributed clinician accountable for all related costs, not just their own services. Beginning in ASM payment year 2029, cost measures will be assessed using the full calendar year that is two years before the payment year (e.g., for payment year 2029, cost measures will use CY 2027 data).

CMS finalized the use of two EBCMs, one for each cohort:

- Heart Failure EBCM: Attributed to cardiologists based on two related services and the prescribing of relevant medications.

[18] CMS had originally proposed a new measure of Inappropriate MRI use for low back pain under the heart failure cohort but did not finalize this measure in the Final Rule. Stakeholders opposed adding this measure citing that it is still under development, lacks detailed specifications, and was previously removed from the Hospital Outpatient Quality Reporting program due to low volume, stable performance, and misalignment with guidelines. CMS stated that the agency will continue to explore this measure and/or other measures focused on low back pain low-value care that are claims-based for inclusion by the January 1, 2027 ASM start date and will propose any additional measures through future notice-and-comment rulemaking.

[19] PAM assesses a patient's knowledge, skills, and confidence in managing their health.

[20] CMS finalized if an ASM participant reports a measure with fewer than 20 cases but meets the data completeness requirement, CMS will acknowledge the submission but not count it toward the quality performance score. This standard matches the case minimum used in MIPS.

- Low Back Pain EBCM: Attributed to the relevant specialists based on two related services.

CMS also finalized the requirement that to receive a score, a participant must have a minimum of 20 attributed episodes during the performance year; otherwise, they receive no cost score and a neutral payment adjustment. Performance is scored from 1-10 points based on 10 benchmark ranges.

In addition, CMS finalized that if CMS determines that a cost measure's data is unreliable due to "significant changes or errors" (e.g., major coding changes), the measure will be excluded from scoring for that year, and the affected participant will receive a neutral payment adjustment. The model will also incorporate any future updates made to these EBCMs within the MIPS program.

Improvement Activities (IA) Performance Category

The Improvement Activities (IA) category requires participants to perform two specific activities focused on care coordination, rather than choosing from a menu of activities as in MIPS.[21] CMS finalized these activities, which include:

- Ensuring patients are connected to primary care and ensuring Health-Related Social Needs (HRSN) screening is completed.
- Establishing communication and collaboration expectations with primary care using Collaborative Care Arrangements (CCA).

Additionally, CMS finalized that starting in ASM payment year 2029, the performance year for improvement activities will be any continuous 90-day period (or up to the full year) from the calendar year two years before the payment year.

Promoting Interoperability (PI) Performance Category

The PI performance category functions as a potential negative scoring adjustment of up to 10 points; it is not positively weighted in the final score. CMS finalized that to avoid a penalty, participants must use Certified Electronic Health Record Technology (CEHRT) for a continuous 180-day period and report on the required MIPS PI measures, which cover objectives for e-Prescribing, Health Information Exchange, Provider to Patient Exchange and Public Health Reporting. The methodology allows for point redistribution if a measure is excluded but does not offer bonus points for optional reporting. Failure to meet these requirements results in a PI score of zero and the maximum 10-point negative adjustment. In the Final Rule, CMS finalized that there will be no alternative policies allowing ASM participants to avoid using CEHRT.

CMS also finalized that beginning with ASM payment year 2029, PI measures must be reported for at least 180 continuous days (or up to the full year) from the calendar year two years before the payment year. Further, the Final Rule does not include the MIPS exceptions or reweighting policies for practice size or type.

Final Score and Payment Methodology

As described above, a participant's final score is based on their performance in the Quality and Cost categories (each weighted at 50%), with several potential adjustments because ASM participants would be likely to achieve higher ASM performance category scores in these two performance categories.

[21] The required activities are IA 1, which requires processes to identify patients without a primary care provider (PCP) and help them establish care, share visit information with the PCP, and confirm or coordinate completion of an annual Health-Related Social Needs (HRSN) screening; and IA 2, which requires a formal written Collaborative Care Arrangement (CCA) with a primary care practice that includes at least three of the following five elements: Data Sharing, Co-Management, Transitions in Care, Closed Loop Communication, or Care Coordination Integration.

Also, the final score may be adjusted based on scores in the IA (scoring adjustment can range from zero, -10 or -20 points) and PI (scoring adjustment can range zero to -10 points) categories. Conversely, the score is increased for treating complex patients (up to +10 points) and for being in a small or solo practice (+10 or +15 points, respectively).

CMS finalized requirements to receive a final score, (e.g., a participant must submit required quality data and be scored in both the Quality and Cost categories) and the proposal that an ASM participant who does not meet these requirements would receive a final score of zero for the applicable ASM performance year.

This final score determines a payment adjustment applied to Medicare Part B payments two years later. The adjustment is not budget-neutral and is calculated based on an increasing risk level (starting at 9%), with 85% of a virtual incentive pool redistributed among participants. A logistic exchange function then compares a participant's score to their direct peers to determine the final payment multiplier. The resulting payment adjustment is tied to the individual clinician's NPI and follows them to a new practice.

Final Score Policies and Payment Adjustments

ASM Participant Meets Quality ASM Performance Category Data Submission Requirement?	ASM Participant Receives a Quality ASM Performance Category Score?	ASM Participant Receives a Cost ASM Performance Category Score?	Final Score	Payment Adjustment
Yes	Yes	Yes	Greater than 0 and not exceeding 100	Positive, neutral, or negative adjustment depending on final score
Yes	No	Yes	None	None (that is, neutral)
Yes	Yes	No	None	None (that is, neutral)
Yes	No	No	None	None (that is, neutral)
No	No	Yes	0	Negative adjustment equal to the applicable ASM risk level
No	No	No	0	Negative adjustment equal to the applicable ASM risk level

CMS finalized an appeals process where participants can dispute their annual performance reports through a specific "Timely Error Notice Process" if they believe there is a calculation error due to data quality issues or a misapplication of the model's methodology. This notice must be submitted within 30 days of the report's issuance.

CMS also finalized key waivers that provide flexibility to clinicians participating in the ASM. Most notably, CMS finalized as proposed a policy giving ASM participants a waiver from MIPS during any year they qualify for the ASM. Participants would only report ASM measures and avoid duplicate reporting and double payment adjustments. The waiver applies for any year a clinician qualifies for the ASM, but the participant must return to MIPS reporting if they do not qualify. CMS also finalized as proposed a waiver to remove the standard geographic and originating site restrictions for telehealth,

allowing ASM participants to furnish telehealth services to beneficiaries in any location, including in their homes.

Extreme and Uncontrollable Circumstances (EUC) Policy

CMS finalized an Extreme and Uncontrollable Circumstances (EUC) Policy for the ASM. Under this policy, if an ASM participant is in an area affected by a federal disaster or public health emergency, they may automatically be exempt from submitting performance data. Participants who qualify and do not submit data would receive a neutral payment adjustment instead of a final score, but those participants who qualify and still submit valid data would be scored normally. CMS plans to apply the same geographic methodology used for ASM eligibility to ensure consistency. In addition, CMS could grant exemptions for other uncontrollable events, such as large-scale cyberattacks, if data are found to be inaccurate or unusable. CMS would notify participants of such determinations and has discretion over how notices will be issued.

Participant and Beneficiary Engagement

CMS finalized several provisions in the model to encourage care coordination and patient engagement for patients with heart failure or low back pain:

- Beneficiary Incentives: Participants may provide in-kind incentives to beneficiaries (up to a $1,000 annual cap), provided the item is reasonably connected to their medical care. Items of technology valued over $75 must be documented and retrieved when the care relationship ends. This policy was finalized as proposed.
- Claims Data Sharing: CMS finalized a policy where ASM participants can receive beneficiary-identifiable claims data (Parts A, B and D) by submitting a formal request, signing a data sharing agreement and attesting that the data is the minimum necessary for their health care operations. Beneficiaries will be notified of their right under HIPAA to request restrictions on this data sharing. CMS proposed, but did not finalize, a policy to allow ASM beneficiaries to request restrictions on data sharing under HIPAA.
- Collaborative Care Arrangements (CCAs): CMS finalized an IA requirement that participants must enter into a voluntary, formal, written CCA with a primary care practice. CMS also responded to stakeholder feedback regarding the proposal to make the CMS-sponsored model arrangement's safe harbor available to ASM participants when establishing CCAs as long as they comply with the requirements of that safe harbor.[22] Based on stakeholder feedback that this proposal could create conflicting incentives between PCPs and specialists, potentially leading to greater fee-for-service billing, CMS finalized the proposal with two modifications. The first modification was that CMS clarified that payments within CCAs cannot exceed the payment adjustments an ASM participant earns or loses in a given year. The agency said that strong incentives are needed so both specialists and primary care providers in a CCA share equal responsibility for their patients' health outcomes. The second modification is that CMS added a new requirement for ASM participants to screen collaborators against the Office of Inspector General (OIG) Exclusion List to maintain program integrity.

ASM Evaluation

CMS finalized methods to evaluate ASM to ensure it improves quality of care and reduces costs. The methods include a randomized "gold standard" design and will combine statistical and qualitative methods to measure outcomes such as quality, access, costs and patient experience. Analyses will be done at geographic, provider and patient levels, with adjustments to prevent large practices from

[22] See Final Rule § 512.771 Collaborative care arrangements, pgs. 1918-1920

skewing results. The analyses will also consider programs, such as the Medicare Shared Savings Program, and additional outside factors to ensure ASM's impact is measured accurately.

CMS plans to evaluate the ASM using a wide range of data sources to capture both quantitative and qualitative impacts. Much of the analysis will rely on Medicare fee-for-service claims, which provide detailed information on utilization and spending by provider and service type. CMS plans to administer surveys to both patients, particularly those who experienced heart failure or low back pain episodes during the test period, and to providers. The findings of these surveys will be used to assess ASM's impact on care delivery and patient experience.

What's Next?

The ASM Model[23] will start January 1, 2027 and run for five performance years. CMS intends to release an initial list of ASM participants in early CY 2026 and plans to finalize that list during CY 2026 to give specialists time to prepare for ASM requirements that will go into effect in CY 2027.[24] Also, CMS plans to release educational materials beginning in CY 2026 to help participants prepare for meeting model requirements beginning in CY 2027. CMS indicated it will respond to email or phone inquiries related to ASM: AmbulatorySpecialtyModel@cms.hhs.gov, or 1-844-711-2664 (Option 4).

If you have questions, please reach out to Jenna Stern, Vice President, Regulatory Affairs and Public Policy, at Vizient's Washington, D.C. office.

[23] ASM Model Fact Sheet, https://www.cms.gov/files/document/asm-model-fact-sheet.pdf
[24] CMS ASM FAQ, https://www.cms.gov/priorities/innovation/asm-ambulatory-specialty-model-frequently-asked-questions