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Vizient Office of Public Policy and Government Relations

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

August 5, 2025

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) proposed rule which includes the creation of the Ambulatory Specialty Model (ASM) - a new mandatory and risk-bearing payment model. The model would replace the Merit-based Incentive Payment System (MIPS) for participating individual specialists who treat a high volume of beneficiaries with heart failure or low back pain and practice in randomly selected geographic areas. The ASM aims to test if payment adjustments based on performance can enhance care quality and reduce costs for certain conditions, which account for a combined 6.2% of Medicare Part A and B spending.

Comments are due by 5 P.M. ET on September 12, 2025. Vizient looks forward to supporting members in evaluating participation impacts and informing the development of our response to CMS.

Ambulatory Specialty Model (ASM)

Under the proposal, 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 (IA) and Promoting Interoperability (PI). 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.

A feature of the model is that clinicians are benchmarked exclusively against their direct peers treating the same condition, a design intended to create fairer, more analogous comparisons. All performance scoring and payment adjustments are applied at the individual clinician (TIN/NPI) level. CMS is seeking public comment on numerous aspects of the proposed model, several which are outlined below.

Terms and Definitions[1,2]

In the Proposed Rule, CMS proposes several definitions to implement the ASM. These proposed terms and definitions are provided in Table 1.

Term	Definition
ASM participant	An individual clinician, identified by a Tax Identification Number (TIN) and National Provider Identifier (NPI) combination, who meets the model's eligibility criteria for at least one performance year and has been selected for participation.
ASM cohort	A group of ASM participants who treat the same targeted chronic condition (i.e., the heart failure cohort or the low back pain cohort).

[1] CMS proposes to codify the definitions and policies of ASM at 42 CFR part 512 subpart G (proposed § 512.705 through § 512.780)
[2] 90 Fed. Reg. at 32563; 32605

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ASM targeted chronic condition	One of the two medical conditions that are the core focus of the model: heart failure or low back pain.
ASM payment multiplier	The numerical value applied to a participant's Medicare Part B payments, calculated as 1 plus the ASM payment adjustment factor.
ASM performance year	One of the five 12-month periods, beginning January 1, 2027, and ending December 31, 2031, during which performance is measured.
ASM payment year	A calendar year in which payment adjustments are applied, occurring two years after the corresponding performance year (e.g., the 2027 performance year corresponds to the 2029 payment year).

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

Participation Requirements and Exclusions

CMS proposes mandatory participation for any clinician who meets all eligibility criteria for a given performance year. Eligibility is reassessed annually; clinicians must meet four core criteria:

- Qualifying Specialty: A clinician must belong to a specific specialty.
    - For the heart failure cohort, participation is limited to Cardiology. The proposal explicitly excludes subspecialties such as interventional and transplant cardiology.
    - For the low back pain cohort, participation includes 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[3]: 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 Physician Fee Schedule.

Exclusions and Exceptions from Mandatory Participation

In the Proposed Rule, CMS provides 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.
- 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.
- 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.
- 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.

[3] 90 Fed. Reg. 32569 – 32572

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Geographic Selection

Participation in the ASM is mandatory and limited to clinicians in randomly selected geographic areas; the model includes no option for voluntary participation for those outside of these areas. CMS will select these areas using a stratified, random sampling of Core-Based Statistical Areas (CBSAs) and metropolitan divisions.[4] Before this selection, entire regions will be excluded from the pool, including all U.S. territories and any CBSA that lacks a minimum volume of eligible clinicians.

Notably, the Proposed Rule does not exclude areas in states participating in the Advancing All-Payer Health Equity Approaches and Development (AHEAD) model[5], meaning clinicians may be in both programs. **CMS is seeking public comment on this decision**.[6]

CMS expects to notify participants in a two-step process, beginning with the release of a preliminary list of eligible participants from the selected areas by the end of 2025. This will be followed by the release of the final list of participants for the first performance year (2027), which is expected by the end of July 2026.

CMS proposes selecting approximately 40 percent of CBSAs or divisions within each stratum[7]. 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	Spending	Volume	Entity Type	Selection Rate	Sample Size
1	Low	Low	CBSA	40%	160
2	Low	High	CBSA	40%	120
3	High	Low	CBSA	40%	124
4	High	High	CBSA	40%	136
5	—	Very High	CBSA	40%	29
6	—	—	Metropolitan Division	40%	31

Table 2. Number of Eligible CBSAs and Metropolitan Divisions by Stratum[8]

Annual Participant Selection and Notification

Beginning with the 2028 performance year, participant eligibility will be reassessed annually based on data from two years prior.

- Entering the Model: Each year, new clinicians who meet the volume, specialty and location criteria will be added to the model.

[4] 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.
[5] The AHEAD model is a state-wide initiative to increase primary care investment and hospital stability. CMS chose not to exclude states participating in AHEAD from the ASM because it determined the models' payment methodologies would not interfere, but is seeking public comment on this decision.
[6] 90 Fed. Reg. 32569
[7] CMS justifies 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,
[8] Table is adapted from 90 Fed. Reg. 32570

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- 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 ASM for that performance year and must resume MIPS participation, if applicable.

To provide notice, CMS proposes to make public the final list of ASM participants for each performance year. This list is expected to be released by the end of July of the preceding year (e.g., the 2028 participant list will be released by the end of July 2027).

TIN Change Policy[9]

In the Proposed Rule, CMS outlines two distinct 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. **Additionally, CMS is seeking public comment on how payment adjustments are handled for clinicians who change their TIN after a performance year.[10]**

Model Overlap and MIPS Status

In the Proposed Rule, CMS permits 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.[11] **CMS is seeking public comment on this approach.**

Performance Assessment Framework

The ASM uses a performance framework based on MIPS Value Pathways (MVPs), but with significant modifications to support direct peer comparison.[12] The scoring structure is fundamentally 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.

To support this focused, like-to-like comparison, ASM requires participants to report on a fixed, mandatory set of measures at the individual clinician (TIN/NPI) level only, with no group reporting permitted. Performance is then benchmarked exclusively against direct peers within the same specialty-condition cohort, not against the entire MIPS clinician pool.

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[9] 90 Fed. Reg. 32566; 32614
[10] 90 Fed. Reg. 32615
[11] 90 Fed. Reg. 32616
[12] 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. 125-26

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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). The proposal states 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 but is not proposing an initial scoring policy.[15]

Quality Performance Category[16]

In the Proposed Rule, CMS indicates the quality performance category accounts for 50% of each ASM participant's final score. The agency proposes two distinct measure sets, one for each clinical cohort (Table 3: Heart Failure and Table 4: Low Back Pain), with no allowance for clinician-selected substitutions. CMS notes that each measure set is designed to assess three domains: reducing excess utilization, promoting evidence-based care and capturing patient-reported outcomes.[17] **In addition to requesting feedback on the measure sets, CMS is seeking public comment on whether the Patient Activation Measure (PAM) (MIPS Q503), which assesses a patient's skill and confidence in managing their health, would be appropriate to include in both measure sets.**

CMS notes that all non-claims measures must be submitted via either MIPS Clinical Quality Measures (CQMs) or electronic Clinical Quality Measures (eCQMs), with no option to substitute alternate measures or collections.[18]

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 (PROM)	eCQM only

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

Measure ID	Measure Description	Type
New	Inappropriate MRI use for low back pain	Claims
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 – Quality Measure Set

[13] 90 Fed. Reg. 32559
[14] 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] 90 Fed. Reg. 32585 – 32586
[16] HF and LBP Measure Set Tables adapted from Table 39; 90 Fed. Reg. 32577
[17] 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.
[18] 90 Fed. Reg. 32576 - 32577; 32584 - 32585

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Reporting and Scoring

Participants must submit all applicable non-claims measures and meet a 75% data completeness threshold for each, beginning with the 2027 ASM performance year. A minimum of 20 cases is required for a measure to be scored. Failing to report a required measure or submitting it with incomplete data results in zero points for that measure.[19] 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 (EBCMs) and is calculated by CMS using administrative claims data, requiring no data submission from clinicians. The measures assess the total risk-adjusted Medicare Part A and B spending during a beneficiary's care episode, holding the attributed clinician accountable for all related costs, not just their own services.

Two EBCMs are used, one for each cohort:

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

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.

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 as in MIPS.[20] These activities are:

- 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).

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[19] CMS proposes that an ASM participant would not receive a quality ASM performance category score if the ASM participant meets the quality ASM performance category data submission requirements but does not meet the case minimum requirements for any of the required quality measures in their applicable quality measure set. If this occurs, the ASM participant would not receive a payment adjustment for the applicable ASM payment year.

[20] 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.

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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. Also, the proposal does not include the MIPS exceptions or reweighting policies for practice size or type.

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.

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. Also, the score may be reduced for failing to complete required IAs (-10 or -20 points) or for non-compliance with PI requirements (up to -10 points). 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).

To receive a final score, a participant must submit required quality data and be scored in both the Quality and Cost categories.

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.

Performance Review and Waivers

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. The model also includes key waivers, most notably waiving all ASM participants from MIPS reporting requirements for any year they are in the model. Moreover, additional waivers are proposed 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.[21]

Participant and Beneficiary Engagement

The model includes several provisions to encourage care coordination and patient engagement:

- 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.

[21] 90 Fed. Reg. 32615 – 32616

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Items of technology valued over $75 must be documented and retrieved when the care relationship ends.

- Claims Data Sharing: 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.
- Collaborative Care Arrangements (CCAs): As a required Improvement Activity, participants must enter into a formal, written CCA with a primary care practice. The CCA must include at least three of five core elements (e.g., Data Sharing, Co-Management), and an anti-kickback statute safe harbor is available for compliant arrangements.

What's Next?

Vizient's Office of Public Policy and Government Relations will be submitting comments to CMS regarding the ASM in the CY 2026 PFS proposed rule. If you have questions or would like to share feedback, please reach out to Jenna Stern, Vice President, Regulatory Affairs and Public Policy, at Vizient's Washington, D.C. office.