VIZIENT OFFICE OF PUBLIC POLICY AND GOVERNMENT RELATIONS

CY 2027 Ambulatory Specialty Model Proposed Rule Summary

PAYMENT POLICIES UNDER THE PHYSICIAN FEE SCHEDULE AND OTHER CHANGES TO PART B PAYMENT AND COVERAGE POLICIES; MEDICARE SHARED SAVINGS PROGRAM REQUIREMENTS; AND MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM

August 17, 2026

BACKGROUND & SUMMARY

On July 16, 2026, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule, which includes proposed modifications to the Ambulatory Specialty Model (ASM). Building on policies finalized in the CY 2026 PFS Final Rule, CMS proposes updates across several aspects of the ASM, including participant eligibility, quality measurement, payment policies, and collaborative care arrangement (CCA) requirements.

Comments are due **September 14, 2026**, and the final rule is expected to be released by early November. Most ASM provisions are expected to go into effect January 1, 2027. Vizient looks forward to working with our provider clients to inform our comments to CMS.

AMBULATORY SPECIALTY MODEL

The ASM is a mandatory, two-sided risk payment model that adjusts future Medicare Part B payments for clinicians based on their performance relative to their peers treating the same targeted chronic condition. Performance is evaluated at the individual Taxpayer Identification Number/National Provider Identifier (TIN/NPI) level across four categories: quality, cost, improvement activities (IA), and Promoting Interoperability (PI). The model includes five performance years that begin January 1, 2027, and end December 31, 2031, with performance-based payment adjustments occurring two calendar years (CYs) following the end of each ASM performance year.

PARTICIPATION

CMS proposes several changes to ASM participation policies to clarify participant responsibilities and provide greater flexibility in limited circumstances:

- **Mandatory Participation**: CMS is revising the regulatory text to clarify how mandatory ASM participation requirements apply when a participant no longer meets eligibility criteria, receives an approved exception, or is terminated from the model.
- **Exceptions to Specified ASM Requirements**: CMS proposes replacing the term “exclusions” with “exceptions” to clarify that affected clinicians remain ASM participants but are excused from specified model requirements.
  - **Exceptions Due to TIN Changes**: CMS proposes expanding the TIN exception policy to address additional changes in a participant’s TIN affiliation, including changes occurring before or during an ASM performance year. Participants would be required to notify CMS in writing within 60 days after the start of the performance year to potentially qualify for an exception. For changes occurring during a performance year, CMS proposes removing the requirement that a participant reassign billing rights to a new TIN to qualify for an exception, which would accommodate circumstances like retirement. Participants would instead be required to notify CMS in writing within 30 days after stopping reassignment of billing rights to the TIN under which they were selected for an ASM.[1]
  - **Exceptions Due to Heart Failure - Related Specialty Type Redesignations:** established a new exception for eligible heart failure participants who redesignate their Medicare enrollment specialty to certain cardiac subspecialties, if CMS notification and documentation requirements are met.

[1] *See* Proposed Rule (pg. 43967–43968) for additional details on the proposed TIN change exception and notification requirements.

  - **Effect and Duration of Exceptions to Specific ASM Performance Requirements**: clarified the impact of approved exceptions on performance assessment, payment adjustments, waivers, and safe harbor protections, and proposed different durations for TIN-related and specialty redesignation exceptions.[2] CMS seeks comments on whether TIN-related exceptions should apply for the proposed duration or for the remainder of the ASM test period, and whether specialty redesignation exceptions should apply for the remainder of the ASM test period or only for the performance year in which the exception is approved.
- **ASM Participant Terminations**: proposes establishing participant termination as an additional remedial action under ASM. CMS could terminate ASM participants under specified circumstances, including program integrity concerns, noncompliance with model requirements, or when continued participation is inconsistent with the model or applicable law.
  - Under the proposal, participants would not have the right to withdraw from the model.[3]

CMS requests comments for all new proposals outlined above.

DATA SUBMISSION

CMS proposes updates to ASM data submission policies to provide greater reporting flexibility and clarify existing requirements.

- **Quality ASM Performance Category Data Submission for ASM Participants in Small Practices**: CMS clarifies that ASM participants in small practices may submit quality performance category data at either the group (TIN) or individual (TIN/NPI) level. This proposal does not substantively change existing policy.
- **Improvement Activities ASM Performance Category Data Submission**: CMS proposes to allow ASM participants to submit data for the IA ASM performance category at either the group level (TIN) or the individual level (TIN/NPI level).
- **Treatment of Multiple Data Submissions for the Quality, Improvement Activities, and Promoting Interoperability ASM Performance Categories**: CMS proposes technical revisions to the treatment of multiple data submissions across ASM performance categories.
  - **Multiple Data Submissions for the Quality ASM Performance Category for ASM Participants in Small Practices**: CMS proposes that if a small practice submits any quality ASM performance data at the group (TIN) level, the group-level submission would be scored and applied to all ASM participants in the practice. Individual level (TIN/NPI) submissions would not be scored if any group-level quality data submission is received.[4]

CMS seeks feedback on the proposed revisions to quality data submission for small practices and the proposed flexibility for the improvement activities data submission.

QUALITY ASM PERFORMANCE CATEGORY

Low Back Pain Quality Measure Set

In the CY 2026 PFS Final Rule, CMS established cohort-specific quality measure sets for heart failure and low back pain ASM cohorts to promote high quality, evidence-based care while reducing unnecessary and low-value services. CMS now proposes updates to the ASM low back pain quality measure set, as outlined below.

- **Low Back Pain Imaging Measure for the ASM Low Back Pain Cohort**: CMS proposes adding the MRI Lumbar Spine for Low Back Pain measure to the ASM low back pain quality measure set. The administrative claims-based quality measure is intended to effectively evaluate overuse and incentivize reductions in inappropriate MRI imaging for low back pain.
- **MRI Measure Specifications**: CMS proposes several methodological revisions to the MRI Lumbar Spine for Low Back Pain measure, including updates to denominator exclusions, the performance period, provider attribution, minimum case count, and the lookback period.[5] **CMS seeks comments on the proposed multi-participant provider attribution methodology and the alternative single-participant attribution approach, the proposed**

[2] *See* Proposed Rule (pg. 43969 – 43971) for additional details on the proposed effect and duration of exceptions from specified ASM requirements.
[3] For the complete list of remedial actions and the applicable grounds for remedial action, *see* Proposed Rule (pg. 43971) and 42 CFR § 512.160(b)
[4] *See* Table B-D1 of the Proposed Rule (pg. 43974) for a summary of the proposed treatment of multiple data submissions for the ASM quality category.
[5] *See* Proposed Rule (pg. 43975-43977) for details on the proposed MRI measure specifications and alternative methodologies under consideration.

minimum case count of 20 cases and the alternative 10 case threshold, and the proposed 365-day lookback period and the alternative of a 120-day lookback period.

- **Functional Outcome Assessment**: CMS proposes removing the Functional Status Change for Patients with Low Back Impairments measure (MIPS Q220) and replacing it with Functional Outcome Assessment measure (MIPS Q182), which CMS believes supports and aligns with the Quality Payment Program's Rehabilitative Support for Musculoskeletal Care MIPS Value Pathway (MVP). **CMS seeks comments on the proposed replacement of Functional Status Change for Patients with Low Back Impairments measure with Functional Outcome Assessment measure.**

Scoring and Benchmarks for Quality Measures

In the CY 2026 PFS Final Rule, CMS finalized policies to benchmark and score ASM quality measures using measure-specific benchmarks derived from ASM participant performance. Separate benchmarks are calculated for each quality measure and collection type (e.g. MIPS CQM and eCQM), and participants receive one to 10 achievement points for each measure based on the decile in which their performance falls. CMS proposes updates to the scoring and benchmark policies for quality measures under ASM to clarify existing requirements and improve quality performance assessment.

- **Administrative Claims-Based Quality Measures**: CMS proposes scoring all administrative claims-based quality measures at the individual (TIN/NPI) level to better reflect ASM participant performance.
- **Benchmark and Scoring Policies**: CMS proposes several technical revisions to the quality measure scoring framework, including updates to scoring requirements, benchmark determination policies, and the treatment of quality measures without established benchmarks.[6]

CMS seeks feedback on the proposed individual level (TIN/NPI) scoring methodology for administrative claims-based quality measures; the proposed reorganization of regulatory text[7] to separately describe the scoring requirements for non-administrative claims-based quality measures and administrative claims-based quality measures; the proposed revisions to clarify provisions related to the determination of quality measure benchmarks; and the proposed treatment of quality measures without established benchmarks in calculating ASM participant's quality ASM performance category score.

Voluntary Data Submission for the Development of Patient-Reported Outcome-Based Performance Measures (PRO-PMs)

In the CY 2026 PFS Final Rule, CMS considered the adoption of one or more patient-reported outcome-based performance measures (PRO-PMs) in the ASM. CMS now proposes establishing a voluntary data submission program to support the development, testing, and potential future implementation of PRO-PMs. CMS identified the Patient-Reported Outcomes Measurement Information System (PROMIS) as the preferred standardized instrument for future PRO-PM development, while also expressing interest in collecting data in other patient-reported outcome instruments.

- **Quality ASM Performance Category Scoring Incentive for Voluntary Patient-Reported Outcome (PRO) Data**: CMS proposes awarding five additional points to an ASM participant's quality ASM performance category score for voluntarily submitting CMS-specified patient-reported outcome (PRO) data that meets CMS requirements. The additional points would not allow participants to exceed the maximum quality ASM performance category score.
  - **CMS seeks comments on the proposed five-point scoring incentive, the alternative incentive approaches considered by CMS, and whether the proposal would support voluntary data submission to achieve the goal of developing PRO-PMs applicable to the ASM.**
- **Voluntary PRO Data Submission Requirements**: CMS proposes establishing minimum requirements for successful voluntary PRO data submission, including submission of baseline data and follow-up assessments, required beneficiary and assessment-level data, risk variables, submission deadlines, and procedures for correcting submitted data and requesting review through ASM's timely error notice process.[8]
  - **CMS seeks comments on the proposed voluntary PRO data submission requirements and alternatives considered, including the appropriate timing of data submissions, required data elements and risk**

[6] *See* Proposed Rule (pg. 43978 – 43978) for additional details on the proposed revisions to the quality measure scoring requirements, benchmark determination, and quality measure score calculations.
[7] 42 CFR 512.725(h)(1)(i)
[8] *See* Proposed Rule (pg. 43981-43983) for a list of the proposed voluntary PRO data submission requirements and alternative potential approaches.

variables, operational challenges for ASM participants, technical assistance needs, and data submission mechanisms to support future PRO-PM development.[9]

PROMOTING INTEROPERABILITY ASM PERFORMANCE CATEGORY

In the CY 2026 PFS Final Rule, CMS established the Promoting Interoperability ASM performance category measures to promote patient engagement and care coordination through objectives and measures aligned with the Merit-based Incentive Payment System (MIPS). CMS now proposes several updates to the Promoting Interoperability ASM performance category to align with recently proposed and finalized MIPS Promoting Interoperability policies, while reducing administrative burden and supporting interoperability measures.[10]

Policies Maintained Under the Proposal

- **Proposed Update to Certified Electronic Health Record Technology (CEHRT) Definition**: CMS proposes to maintain the current ASM definition of the CEHRT, which incorporates the MIPS definition by reference. Any updates finalized to the MIPS definition of CEHRT would automatically apply to the ASM.

Proposed Addition and Updates

- **Electronic Prior Authorization Measures in the Health Information Exchange Objective (HIE)**: CMS proposes incorporating Electronic Prior Authorization measures into the HIE objective. Beginning with the 2027 ASM performance year, CMS proposes adding the Electronic Prior Authorization measure (Measure ID # PI_HIE_7) as an optional, unscored ASM Promoting Interoperability measure. Beginning with the 2028 ASM performance year, CMS proposes requiring both the Electronic Prior Authorization measure (PI_HIE_7) and the Electronic Prior Authorization for Prescription Drugs measure (PI_HIE_8).
    - **CMS seeks feedback on the proposal to include the Electronic Prior Authorization as an optional, unscored measure for the 2027 ASM performance year, the alternative of awarding bonus points for voluntary reporting, the proposal to require the Electronic Prior Authorization measure and the Electronic Prior Authorization for Prescription Drugs measure beginning with the 2028 ASM performance year, and all aspects of the proposed prior authorization measures.**[11]
- **Exclusions to the Public Health and Clinical Data Exchange Objective**: CMS proposes adopting a measure exclusion policy for the Immunization Reporting Registry and Electronic Case Reporting measures, aligning with existing MIPS exclusion policies
    - **CMS seeks feedback on the proposed measure exclusion policy and the use of MIPS exclusion criteria for the Immunization Reporting Registry and Electronic Case Reporting measures.**
- **Measure Suppression Policy**: Beginning with the 2027 ASM performance year, CMS proposes adopting a Promoting Interoperability measure suppression policy, consistent with MIPS. Under the proposal, CMS could suppress a Promoting Interoperability measure when circumstances beyond participants' control affect meaningful measurement, preventing the measure from affecting objective scoring or meaningful EHS user determinations.
    - **CMS seeks feedback on the proposed Promoting Interoperability measure suppression policy.**

Proposed Removal of Reporting Requirements

- **Security Risk Analysis Measure**: Beginning with the 2027 ASM performance year, CMS proposes removing the Security Risk Analysis measure and attestation requirement from the PI ASM performance category to reduce reporting burden while maintaining compliance with the HIPAA Security Rule.
    - **CMS seeks feedback on the proposal to remove the Security Risk Analysis measure and attestation requirement.**
- **Supporting Providers with the Performance of CEHRT**: Beginning with the 2027 ASM performance year, CMS proposes removing the Office of the National Coordinator for Health Information Technology (ONC) direct review and ONC-Authorized Certification Body (ONC-ACB) Surveillance attestations to reduce administrative burden while aligning ASM with MIPS.

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[9] *See* Proposed Rule (pg. 43983) for the complete list of proposed voluntary PRO data submission requirements and PRO-PM development.
[10] Table B–D2 on Proposed Rule (pg. 43984) summarizes existing finalized requirements and new proposals in this proposed rule for the objectives and measures in the Promoting Interoperability ASM performance category for the 2027 ASM performance year.
[11] *See* Proposed Rule (pg. 43975-439774) complete list of proposals on the proposed Electronic Prior Authorization measures.

- **CMS seeks feedback on the proposal to remove the ONC Direct Review and ONC-ACB Surveillance attestations.**

FINAL SCORE

In the CY 2026 PFS Final Rule, CMS adopted a final scoring methodology that evaluates each ASM participant's performance on a scale of zero to 100 points based on applicable performance standards for measures and activities in each ASM performance category. The final score is used to determine the ASM payment adjustment factor applied to an ASM participant's Medicare Part B claims during the corresponding payment year. CMS now proposes updates to the final score methodology, including a new rural scoring adjustment and revisions to the annual ASM performance report.

- **Rural Scoring Adjustment**: CMS proposes adding a five-point rural scoring adjustment to the final score of the ASM participants who are in the rural area, as defined under MIPS[12], and meet the requirements to receive a final score greater than zero.[13] CMS states that the proposal is intended to account for the challenges faced by rural providers, including limited interoperability infrastructure and resource constraints. Rural ASM participants would remain eligible for existing small practice or solo practitioner scoring adjustments[14] and the complex patient scoring adjustment[15] if they meet such scoring adjustment's eligibility criteria.
  - **CMS seeks feedback on the MIPS-based definition of rural area, the proposed five-point rural scoring adjustment, the alternative of limiting the adjustment to rural ASM participants who do not qualify for the small practice scoring adjustment, the alternative of waiving Improvement Activity 2, Establishing Communication and Collaboration Expectations with Primary Care using CCAs, for rural ASM participants, and the proposed revisions to the final score formula.**
- **ASM Performance Report**: CMS proposes revising the structure of the annual ASM performance report to reflect the new scoring incentives and scoring adjustments, providing patients with information regarding the voluntary PRO data scoring incentive and the rural scoring adjustment, if applicable.
  - **CMS seeks feedback on the proposed revisions to the annual ASM performance report and on proposals to include information on the voluntary PRO data scoring incentive and rural scoring adjustment.**

APPLICABILITY OF CMS-SPONSORED MODEL SAFE HARBOR

In the CY 2026 PFS Final Rule, CMS made the CMS-sponsored model arrangements and patient incentives safe harbor available to eligible ASM participants for beneficiary incentives and remuneration exchanged under the Care Collaboration Arrangements (CCAs). In the CY 2027 PFS Proposed Rule, CMS proposed revising the applicability of the safe harbor.

- **CMS-Sponsored Model Safe Harbor:** CMS proposes that the safe harbor would apply only to remuneration attributable to periods during which an ASM participant is actively performing under the model. The safe harbor would not apply during periods when an ASM participant does not meet ASM participant eligibility requirements or has been granted an exception from specified ASM requirements.
  - **CMS seeks feedback on the proposal to limit the availability of the CMS-sponsored model safe harbor.**

COLLABORATIVE CARE ARRANGEMENTS (CCAs)

In the CY 2026 PFS Final Rule, CMS finalized IA-2, which requires ASM participants to establish a CCA with a primary care practice.[16] CMS proposes updates to the CCA requirements to improve implementation.

- **Parties to a CCA**: CMS proposes permitting multiple ASM participants who reassign billing rights through the same TIN to participate in a single CCA with the same primary care practice, provided that each ASM participant is explicitly named as a party to the agreement. CMS states that the proposal is intended to reduce administrative burden while maintaining individual accountability.
  - **CMS seeks feedback on permitting multiple ASM participants within the same TIN to participate in a single CCA, whether the proposal would reduce administrative burden, and whether it could disadvantage solo practitioners or group practices with only one ASM participant.**

[12] 42 CFR 512.705
[13] 42 CFR 512.745(a)(2)(i)
[14] Small practice or solo practitioner scoring adjustment eligibility criteria at 42 CFR 512.745(a)(4)
[15] Complex patient scoring adjustment eligibility criteria described at 42 CFR 512.745(a)(3)
[16] *See* Proposed Rule (pg. 49648-49655).

- **Shared ASM Beneficiary Requirement**: CMS proposes clarifying that a CCA must include at least one shared ASM beneficiary, regardless of the number of ASM participants who are parties to the agreement. CMS also proposes removing the term "established" from the shared ASM beneficiary requirement to align with IA-2 specifications.
  - **CMS seeks feedback on whether requiring one shared ASM beneficiary is sufficient to support the coordination goals of a CCA.**
- **Exchange of Remuneration Under CCAs**: CMS proposes several updates to the provisions governing remuneration exchanged under the CCAs, including:
  - Clarifying that CCA requirements apply to both monetary payment and in-kind exchanges.
  - Reorganizing remuneration-related requirements into a dedicated subsection.
  - Requiring remuneration to be reasonably related to the purpose of the CCA.
  - Revising the methodology for calculating the limitation on remuneration by using the ASM performance year rather than the corresponding payment year.
  - Updating documentation and reconciliation requirements to improve implementation and transparency.

WHAT'S NEXT?

Final ASM policies will be included in the PFS Final Rule, expected in early November, and largely effective on January 1, 2027. The comment period closes on September 14, 2026. Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this proposed rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to Jenna Stern, Vice President, Regulatory Affairs and Public Policy, in Vizient's Washington, D.C. office.

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