CLIENT ALERTS & INSIGHTS

CMS Finalizes Mandatory Ambulatory Specialty Model for Heart Failure and Low Back Pain Specialists

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Key Takeaways

- CMS has finalized the mandatory Ambulatory Specialty Model (ASM), requiring select heart failure and low back pain specialists in certain regions to participate in a two-sided risk payment model for Medicare patients starting January 1, 2027. Participation is automatic for eligible clinicians, with no opt-out option.
- This model introduces significant financial and operational risk for affected specialists and practices, as payment adjustments (positive or negative) will apply to all Medicare Part B services based on performance in cost, quality and care coordination. Non-compliance or poor performance could result in substantial revenue loss.
- Specialty practices can assess their eligibility, review care pathways and begin preparing for collaborative care requirements, data sharing and risk management. Early planning, contracting updates and alignment with primary care partners are essential to succeed under ASM's new value-based payment structure.

On October 31, 2025, the Centers for Medicare & Medicaid Services (CMS) finalized the Ambulatory Specialty Model (ASM) in the CY 2026 Medicare Physician Fee Schedule (PFS) final rule. ASM is a mandatory, two-sided risk alternative payment model that will apply to select specialists treating Medicare fee-for-service (FFS) beneficiaries with heart failure and low back pain in outpatient settings. The model launches January 1, 2027, and will run for five performance years (2027-2031) with corresponding payment years 2029-2033. Participation is mandatory-clinicians meeting ASM criteria within selected geographic markets will be automatically included, with no opt-out or hardship exemption pathway. CMS also confirmed that ASM is not designated as an Advanced APM under MACRA and therefore does not qualify participants for the 5% APM incentive bonus.

CMS positions ASM as a cornerstone of its strategy to shift more specialty care into value-based payment, building on the Merit-based Incentive Payment System (MIPS) and its Value Pathways (MVP) framework while expanding the use of mandatory two-sided risk outside of hospital-based episode models.

Model Overview and Policy Rationale

According to CMS, ASM is designed to "improve prevention and upstream management of chronic disease," focusing initially on heart failure and low back pain because those conditions are among

the costliest for Original Medicare, with estimated annual spending of roughly $10-13 billion and $6-8 billion respectively under Parts A and B. The American College of Cardiology has noted that heart failure was selected due to persistent variation in guideline-directed medical therapy (GDMT) adherence, high hospitalization rates, and inconsistent care-transition patterns across markets.

CMS cites several core problems the model is intended to address: (i) delayed detection and inadequate management of chronic conditions; (ii) financial incentives that favor procedures and high-intensity interventions over prevention; and (iii) fragmented, poorly coordinated care between specialists and primary care providers (PCPs), which contributes to "low-value" care and avoidable hospitalizations.

To address these issues, ASM will: (i) hold targeted specialists financially accountable for the cost and quality of care for designated heart failure and low back pain episodes; (ii) require structured collaborative care arrangements with PCPs; and (iii) leverage MIPS MVPs and episode-based cost measures (EBCMs) to standardize performance measurement across similarly situated clinicians within selected geographic areas. CMS has indicated that these collaborative care arrangements are intended to formalize co-management responsibilities that historically have been informal or optional.

Timeline and Scale

Under the final rule and accompanying CMS materials:

- **Performance Period**: ASM performance years run from January 1, 2027 through December 31, 2031, with corresponding payment adjustments applied in 2029-2033.
- **Model Size**: CMS projects that approximately 8,600 physicians in selected geographies (roughly one-quarter of core-based statistical areas (CBSAs) and metropolitan divisions) will be required to participate, collectively managing roughly 600,000 heart failure and low back pain episodes per year for about 550,000 beneficiaries and approximately $2.8 billion in episode spending annually.
- **Rulemaking Context**: ASM was proposed in the CY 2026 PFS proposed rule (July 14, 2025) and finalized in the CY 2026 PFS final rule (published October 31, 2025).

CMS expects to publish a preliminary list of 2027 ASM participants in early 2026 (based on 2024 data) and a final list in July 2026 (based on 2025 data). CMS will then reassess eligibility annually for each performance year. CMS has stated that geographic selection will consider not only spending levels but also specialty penetration, episode volume, outcome variability and model "testability," meaning inclusion will not be limited to historically high-cost markets. CMS also expects to release additional operational and reporting guidance in late 2026.

Who Will Be Required to Participate?

ASM participation is mandatory for physicians who meet all of the following criteria within selected regions:

- **Billing And Enrollment Status**

: The physician (i) bills under the Medicare Physician Fee Schedule and (ii) is identified by TIN/NPI within an eligible specialty based on the plurality of Medicare Part B claims, consistent with current MIPS specialty attribution practices using PECOS data.

- **Geographic Selection**: The physician practices in a selected CBSA or metropolitan division. CMS will stratify and select regions based on chronic condition spending and episode volumes. Once a CBSA/metropolitan division is selected, all eligible clinicians within that region who meet ASM thresholds are included.
- **Episode Volume Threshold**. The physician meets an episode-based cost measure (EBCM) threshold, defined as at least 20 attributed heart failure episodes or 20 attributed low back pain episodes for Original Medicare FFS beneficiaries in a 12-month period, as measured using the relevant MIPS EBCMs.

Eligible specialties are narrowly defined around the two target clinical conditions, with (i) heart failure attributed exclusively to general cardiology, and (ii) low back pain limited to specialists in anesthesiology, pain management and interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation.

Once a physician qualifies for ASM in any performance year, the physician is treated as an ASM participant for the duration of the model for purposes of cohort benchmarking, even if they fall below the episode volume threshold in a later year; however, they may not receive a payment adjustment if they fail to meet data submission requirements for a particular year.

Beneficiary attribution will be prospective and based on the plurality of evaluation and management (E/M) visits during the attribution window, providing predictability for care-planning and workflow design. Participation is determined at the individual TIN/NPI level, meaning hospital-employed clinicians and members of large health systems may be included even if their organization is not otherwise participating in the model.

Interaction with MIPS and the MVP Framework

ASM is explicitly built on the MIPS Value Pathways (MVP) architecture. CMS will use MVP-aligned episode-based cost measures for heart failure and low back pain, incorporating related quality measures and improvement activities while promoting interoperability requirements.

Key points for clinicians:

- ASM participants who satisfy the ASM eligibility and data submission requirements for a given performance year will be exempt from MIPS for that year.
- Performance will be measured against peer benchmarks limited to other ASM participants in the same condition-specific cohort and geographic region, rather than the broader MIPS clinician universe.

This design reinforces CMS's goal of using MVPs as a "launching pad" for more condition-specific and specialty-specific alternative payment models, with ASM as an early example. However,

because ASM is not treated as an Advanced APM, specialists may still be subject to MIPS reporting or penalties in years where ASM reporting obligations are not met.

Performance Measurement and Scoring

Each ASM participant receives a final score from 0-100 that drives the two-sided payment adjustment. The scoring structure closely parallels MIPS but with more targeted measure sets and different weighting:

- **Quality (50% weight)**: Focused on measures directly tied to heart failure and low back pain, such as (i) risk-standardized acute unplanned cardiovascular admissions for heart failure, (ii) controlling high blood pressure and guideline-directed medical therapy, (iii) functional status assessments for heart failure, and (iv) functional status change and imaging appropriateness for low back pain. Cardiology professional organizations anticipate that GDMT adherence and timely post-discharge follow-up will be highly determinative of scoring for heart-failure specialists.
- **Cost (50% weight)**: Based on condition-specific EBCMs for heart failure and low back pain, using Parts A, B, and D data to attribute episode spending and benchmark each participant against peers.
- **Improvement activities (downside-only adjustment 0% to -20%)**: Includes requirements that ASM participants (i) enter into collaborative care arrangements with PCPs, (ii) participate in preventive care screenings and lifestyle interventions in partnership with PCPs, and (iii) screen for health-related social needs.
- **Promoting interoperability (downside-only adjustment 0% to -10%)**: Requires meaningful use of certified electronic health record technology (CEHRT) and specified interoperability objectives (e.g., e-prescribing, patient access, information exchange).

CMS will then apply positive scoring adjustments to level the playing field for (i) complex patient populations (up to +10 points based on HCC risk and dual-eligible share) and (ii) small practices (up to +10 points for practices with 15 or fewer clinicians) and solo practitioners, subject to a cap of 100 total points.

Collaborative Care Requirements and Data Sharing

A central feature of ASM is the requirement for documented collaborative care arrangements between participating specialists and PCPs (including PCPs aligned with ACOs). CMS expects these arrangements to include at least three of five core elements, namely: (i) bi-directional data sharing; (ii) shared co-management processes; (iii) transitions-of-care planning; (iv) “closed-loop” referral communication; and (v) integrated workflows for care coordination and outcomes measurement.

CMS also indicates it will provide enhanced performance data to participants, including episode-level cost and utilization reports, to support analytics, care redesign and collaboration with PCPs and ACOs. Practices participating in MSSP ACOs or other CMMI models should expect to reconcile attribution, data-exchange responsibilities and care-management accountability across overlapping programs.

Two-Sided Risk Structure and Payment Adjustments

ASM uses a two-sided risk arrangement under which specialists may receive positive, neutral or negative payment adjustments to future Medicare Part B payments, based on their final score relative to peers.

ASM Risk Levels and Timing

The ASM risk corridor begins at ±9% of Medicare Part B payments in Performance Years (PY) 2027 and 2028, and increases to ±10%, ±11%, and ±12% in PY 2029-2031, respectively. As shown below, payment adjustments are applied two years after the performance year.

Performance Year (PY)	Corresponding Payment Year (PY+2)	Risk Corridor Applied to Part B Payments
2027	2029	± 9%
2028	2030	± 9%
2029	2031	± 10%
2030	2032	± 11%
2031	2033	± 12%

For example, PY 2027 performance will determine PY 2029 payment adjustments.

Incentive Pool Mechanics

CMS will create a cohort-specific “ASM incentive pool” by aggregating all Medicare Part B payments to ASM participants in that cohort during the performance year, multiplying that amount by the applicable risk level and then applying an 85% redistribution percentage, with 15% retained by Medicare to guarantee net savings. Negative payment adjustments in the payment year effectively fund positive adjustments; CMS does not prospectively withhold payments during the performance year.

CMS then uses a logistic exchange function to translate each participant’s final score into a payment adjustment factor, which is applied across the participant’s total Part B payments for covered services in the payment year.

Importantly, the ASM payment adjustment applies to all Medicare Part B allowed charges, not only those associated with heart-failure or low-back-pain services-significantly expanding financial exposure for high-volume Medicare specialty practices.

Fraud and Abuse Considerations: Safe Harbors and Stark Value-Based Exceptions

Because ASM is an Innovation Center model under Section 1115A of the Social Security Act, CMS indicates that arrangements meeting the model requirements may be eligible for protection under the Anti-Kickback Statute (AKS) safe harbor for CMS-sponsored models, including certain patient incentives and collaborative care arrangements that are integral to ASM.

However, ASM does not override the physician self-referral law (Stark Law). To the extent ASM participants share upside or otherwise structure compensation arrangements that vary with referrals

for designated health services between specialists and PCPs (for example, pooling upward adjustments and distributing a share to collaborating PCPs based on attributed ASM episodes), the parties will likely need to:

- Establish a value-based enterprise (VBE) and one or more value-based arrangements (VBAs) that satisfy a Stark value-based exception, rather than relying on traditional personal services or fair market value exceptions; and
- Confirm alignment with available AKS value-based safe harbors or the CMS-sponsored model safe harbor, as applicable.

ASM participants should expect significant contracting work around value-based arrangements, data-sharing agreements, and patient incentive frameworks, especially in markets where ASM overlaps with ACO participation, MSSP arrangements, or other CMMI models.

Key Operational Considerations for Specialists

Cardiology, spine and pain practices likely to be swept into ASM should begin planning now around several fronts:

- **Readiness Assessment:** Practices should evaluate whether (i) they have meaningful volumes of Medicare FFS heart failure or low back pain episodes, (ii) they operate in CBSAs likely to be selected based on spending/volume, and (iii) they have the data infrastructure and governance to handle two-sided risk at the clinician level. Health systems employing affected specialists should also evaluate physician-compensation methodologies to ensure ASM downside risk is allocated intentionally and compliantly.
- **Care Model Redesign:** Practices should map current care pathways for heart failure and low back pain and identify gaps in (i) preventive interventions, (ii) lifestyle counseling and social-needs screening, (iii) post-procedure and post-hospital follow-up, and (iv) patient-reported outcomes collection. Professional cardiology organizations suggest early attention to GDMT workflows, EHR-triggered care-pathway adherence and standardized hospital-to-clinic transitions.
- **Primary Care Alignment:** ASM effectively pushes specialists to formalize relationships with PCPs and ACOs. Practices should identify a manageable set of collaborative PCP partners and begin designing collaborative care arrangements that meet CMS's minimum element requirements while fitting local practice patterns.
- **Contracting and Compliance:** Legal and compliance teams will need to (i) inventory existing co-management, gainsharing and value-based arrangements, (ii) determine where Stark value-based exceptions and AKS safe harbors are needed to support ASM-related payments, and (iii) refresh policies on data sharing, patient incentives and telehealth in light of ASM-specific waivers and protections.
- **Risk Analytics:** Practices should plan for robust analytics support to interpret CMS's episode-level data feeds, monitor real-time performance against ASM benchmarks, and identify sites of care, service lines and referrals that drive performance risk. Dashboards capable of

modeling attribution, cost, quality scoring and projected Part B exposure will likely become operational necessities.

Organizations participating in MSSP ACOs, bundled payments, Medicare Advantage value-based arrangements or other CMMI models should conduct an overlap analysis now to understand attribution, reporting and risk-pool interactions.

Key CMS Resources

For clients who want to go directly to CMS sources, the most useful publicly available documents are:

- CMS Innovation Center - ASM Model Page
- ASM Model Fact Sheet (PDF)
- ASM Frequently Asked Questions
- CY 2026 Medicare Physician Fee Schedule Final Rule Fact Sheet
- CY 2026 PFS Final Rule - Federal Register Publication
- CMS Press Release Announcing Final Rule

The Benesch Healthcare team is closely monitoring ASM implementation, including forthcoming CMS technical guidance, geographic selection announcements, attribution methodologies, and evolving payer and provider responses. We are currently assisting physician practices, health systems, ACOs and other stakeholders in evaluating potential exposure, operational preparedness, contracting implications and care-model considerations as the model moves toward launch.

If you have questions regarding ASM readiness, organizational impact, contracting strategy, compliance considerations or broader value-based care planning, please contact the authors of this alert or any member of the Benesch Healthcare team.