CMS is Demanding Change in Specialty Care: 5 Things to Know about ASM

written by Theresa Hush | July 24, 2025

Heads up! CMS's Proposed 2026 PFS Rule introduces a new payment model for tackling specialty care and costs in traditional Medicare. Clearly not a snap decision, Ambulatory Specialty

Model (ASM) has been cooked until well-seasoned and served up in 210 pages of the proposed Rule. Unlike a typical Notice from the CMS Innovation Center that initiates many Value-Based Care payment models, this detailed presentation signifies its importance.

Specialty care accounts for 40 to 60 percent of total health care costs, with a broad range of services included, such as consultations, imaging, tests, procedures, admissions, and various therapies. Until recently, costs were broken out into categories without attributing those costs to a single physician who managed the patient's condition and ordered or referred these other services. That attribution of patient to physician is now proposed in ASM. Starting with heart failure and low back pain, this new model calculates costs and quality performance for specialists treating patients with those conditions and pays them based on a formula which favors better quality and cost performance.

ASM is a significant new path for how to pay specialists for management of chronic conditions such as the two initiating the program. It goes further than any other value-based payment model in performance requirements, scope, physician-level responsibility for cost and outcomes, and engagement of physicians in Value-Based Care accountability. It's worth a deeper dive to examine the impact. Here are five things you need to understand about ASM:

1. ASM is a mandatory payment model for specialists treating heart failure and low back pain in many sites throughout the country, beginning January 2027.

CMS will identify approximately 600 randomly selected CBSAs, stratified by six patient-volume and spending categories in heart failure and low back pain. Rural Health Clinics and FQHC clinicians are excluded. A specialist providing care to patients with the diagnoses will be selected to participate, if the specialist has 20 or more episodes. This will make it one of the largest and most wide-spread of the Value-Based Payment Models, with 25 percent of all communities in the model.

2. A downside risk of 9 percent for assigned participating specialists grows to 12 percent over the five-year period and applies to individual specialist participants (TIN/NPI). But participants will get claims data to identify issues in patterns and cost of care.

Payment levels are based on meeting quality and cost measure performance levels. A significant deviation from all current payment models is scoring for individual specialists' performance. Whereas a group of practitioners can even out the cost or quality performance of a single provider, this model puts pressure on individual specialists to conform. The results will become public and thus affect patient referrals.

This is a significant distinction from TEAM (Transforming Episode Accountability Model), also specialty-oriented and for five categories of procedures. In TEAM, hospitals are the

conveners of the procedural episodes and bear the risk, which can flow to physicians depending on their arrangements with the convening hospitals. By contrast, in ASM, specialists are responsible and their fees are at risk if they pursue treatments that are higher cost than the benchmark, or if quality performance is not met. Also in TEAM, there is a year grace period prior to financial risk, whereas ASM kicks off with risk for the first performance year.

ASM participants, like those in ACOs, will receive claims data for their patients. This enables specialty practices to use specialized analytics, like Value-Based Care Episodes, to prepare for ASM with cost analytics that investigate cost drivers, identify issues with condition or treatment episodes, and deploy interventions to improve.

3. ASM participation is non-exclusive with other CMS payment models, such as ACOs. In fact, participants are required to have data-sharing agreements with primary physicians or their groups (ACOs or practices) to coordinate care.

This provides the pathway for ACOs to negotiate with specialists based on ASM Scores and communication commitments regarding processes such as handing off patient care between primary and specialty providers. Proof of such communication is required in the model.

Specialists within ACOs are not excluded from the mandatory model, either, if they fall within the ASM criteria and geographic area of ACO services. This is likely to encourage

specialists to terminate ACO participation, opting for specialty arrangements that are advantageous to both parties with less financial risk.

ASM will impact referral arrangements throughout the health care system. At greatest risk are academic health systems and specialty centers with large numbers of specialists and many primary care referral sources. The practice of specialists using historical advancement and reputations to make referral arrangements is likely to change significantly based on ASM Scoring. The model is big enough to make a difference, especially as it expands to other types of specialty care (as it is likely to do).

4. The model includes multiple specialties for low back pain management, creating a financial disincentive for higher cost surgical episodes.

Inclusion of specialties in the model is based on TIN/NPI and specialty designations in MIPS quality reporting. ASM also has volume and other criteria for participant inclusion. For the heart failure cohort, specialists are restricted to cardiologists. For the low back pain cohort in ASM, however, specialties include orthopedic surgery, neurosurgery, interventional pain management, pain management, anesthesiology, and physical medical and rehabilitation. How different root causes of low back pain will be evaluated under the program was not directly addressed by the Proposed Rule, but there is little doubt that specialists will propose exclusions to the low back pain cohort for clinical reasons or investigatory reasons.

5. ASM Scoring covers the traditional four MIPS categories: Cost, Quality, Improvement Activities, and Interoperability—but each category demands much more.

There are many similarities between the MIPS and ASM components. However, their application in ASM goes beyond the intensity and application of MIPS. ASM requires MIPS Value Pathways (MVPs) and MIPS episode-based cost measures (EBCMs) for both conditions, and then scores each specialist individually. ASM participants are waived from participating in MIPS directly.

Heart failure quality measures include elements of the well-established standard of care using pharmacological therapies such as beta-blockers, ACE, ARB and ARNI therapies, blood pressure control, and heart failure assessments. Low back pain quality measures are more diffuse and include prohibitive as well as preventive measures. They reflect the primary CMS goal of minimizing interventions without clinical indicators or without proven value. Patient-reported measures are included in quality measures for both heart failure and low back pain.

Both conditions use MIPS EBCM (cost measures) for the cost scoring of the program. Given the categories of selected geographic areas and their designated variations as high/low cost and high/low volume, the scoring will clearly—like all aspects of ASM—call out practitioners who meet or don’t meet performance. This is likely to raise resistance among specialty groups.

Improvement Activities and Promoting Interoperability

categories are both required and scored in ASM. Again, these go well beyond current MIPS requirements and together lay a foundation comprised of coordination of patient care, patient clinical data held in common, and interoperability. The Rule proposes that specialists have documented workflows, processes, and technology to support primary care for their patients. Collaboration and communication on patient care are required.

ASM also requires specialists to ensure that their patients have a primary care provider. To satisfy Improvements Activities, each participant must have at least one agreement in place with a primary care physician. Promoting Interoperability requires Certified EHRs and data-sharing agreements with primary care practices. Together, these requirements are a major transformation for physician care in medicine. In large, multi-specialty groups, some of these requirements are facilitated by common technology. But for an independent specialty practice that receives referrals from multiple primary care practices, ASM is a sea change.

Whether ASM can succeed in a Final Rule is an open question, but CMS has fired a strong opening volley. With its aggressive timetable and fundamental changes to the way specialty and primary care practices now operate, not many can take legitimate issue with the underlying goal.

What Specialty and Primary Care Practices Need to Implement ASM

Health systems and practices must move quickly to implement this model. The technology needs, alone, are beyond the capacity of many practices. And because of ASM's coordination requirements between targeted specialists and primary care physicians, this model will touch a majority of physicians. Implementation by 2027, the first performance year, requires a big push and a lot of tools.

Yet audacity may have its reward.

Most importantly, specialists need to recalculate the value of their current technology and analytics to focus on cost and quality. Up until now they have been doing MIPS group reporting and possibly not even using measures within their specialty. That must change, given the needed analytics to calculate results for MVPs addressed by ASM. Even if the practices don't intend to report MVP measures in 2025, they must begin to model their results against MVP measures.

Second, specialty practices must reevaluate EHR systems, cost tools, and current processes for primary care coordination. Creating specialized cost analytics is necessary both to calculate historic costs of episodes and to identify quality or outcomes issues.

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