ASM Unpacked:

What You Need to Know About CMS's New Mandatory Payment Model

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Presenters

Erin Heilman

SVP, Regulatory Affairs, CPHQ

Erin Heilman is a distinguished leader in the healthcare quality regulatory space, known for her innovative approach to simplifying complex regulations. For over a decade, Erin has developed award-winning content, including articles, guides, and tools that empower quality leaders to excel in their reporting obligations.

CMS Has A Cost & Quality Problem

Specialty care today is optimized for moments - not outcomes over time

- Care is episodic and reactive
- Payment rewards volume of services, not prevention
- Quality measures focus on point-in-time performance
- Limited accountability for:
  - downstream utilization
  - total cost of care
  - long-term patient outcomes

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Before ASM

Clinician Approach

- Engages when patient is referred
- Focus on treating the visit or procedure
- Variable use of conservative therapy (e.g., PT)
- Early imaging and escalation more common
- Limited follow-up on patient progress
- Minimal accountability for downstream cost

Patient Experience

- Care feels reactive and fragmented
- Unclear plan or expectations
- Higher likelihood of:
  - unnecessary imaging
  - procedures or surgery
- Symptoms may worsen before action is taken

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After ASM

Clinician Approach

- Accountable for total episode cost and outcomes over time
- Emphasis on early, conservative management
- Avoidance of low-value care (e.g., unnecessary imaging)
- More active monitoring of patient progress
- Increased coordination with PCPs and care teams
- Decisions influenced by downstream impact

Patient Experience

- Care feels more proactive and guided
- Earlier intervention and clearer care plan
- Greater focus on:
  - function
  - symptom improvement
- Lower likelihood of unnecessary escalation
- More continuity across the care journey

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Ambulatory Specialty Model (ASM)

ASM shifts accountability from "what happened at the visit" → to "what happened to the patient over time"

- Financial accountability to incentivize care coordination
- Reduction of unnecessary or duplicate services
- Enhancing overall care experience for beneficiaries

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Agenda

01. An overview of the model including participation and selected cohorts

02. A review of the requirements by category: Quality, Cost, Improvement Activities, Promoting Interoperability

03. Calculating your final score

04. Demo of Medisolv's ENCOR for Electronic Clinician Measures

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ASM Performance Period

- ASM is a 5-year program that starts January 1, 2027, and ends on December 31, 2031. Final data submission of clinical data elements and quality measures in CY 2032.

5 Performance Years (Calendar Years) PY 1-PY 5

Performance Year 1 (PY 1)	January 1, 2027 – December 31, 2027
Performance Year 2 (PY 2)	January 1, 2028 – December 31, 2028
Performance Year 3 (PY 3)	January 1, 2029 – December 31, 2029
Performance Year 4 (PY 4)	January 1, 2030 – December 31, 2030
Performance Year 5 (PY 5)	January 1, 2031 – December 31, 2031

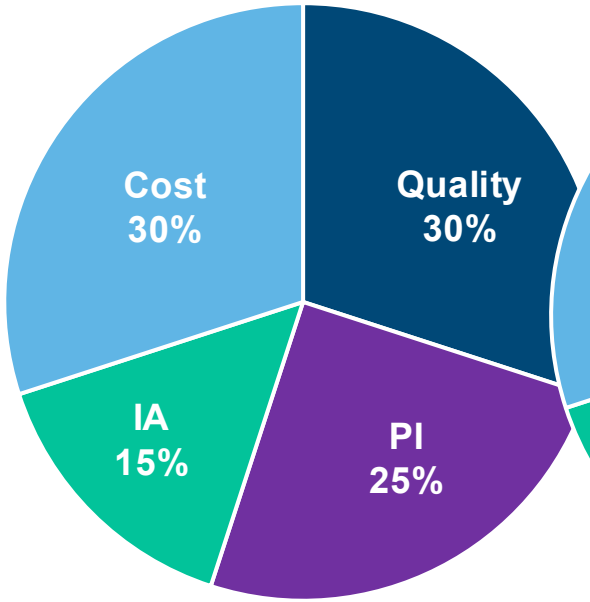
You can think of it like MIPS

- “ASM Participants” (those clinicians selected for the model) are required to participate.
- They carry out services on behalf of Medicare beneficiaries and bill CMS.
- During the performance year they track measure performance
- In the following year, they submit or are scored on four categories: Quality, Cost, Improvement Activities, and Promoting Interoperability.
- Depending on their score they get a penalty or bonus to their claims submitted in the applicable fiscal year (two years after the performance year).

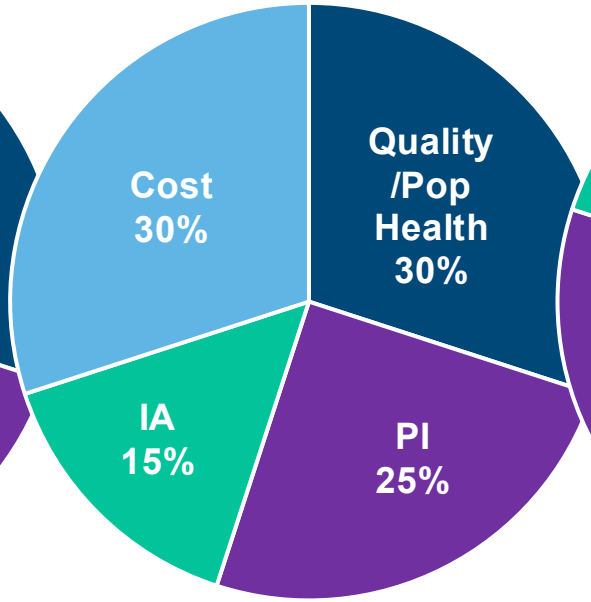
Category Weights

Quality Payment Program

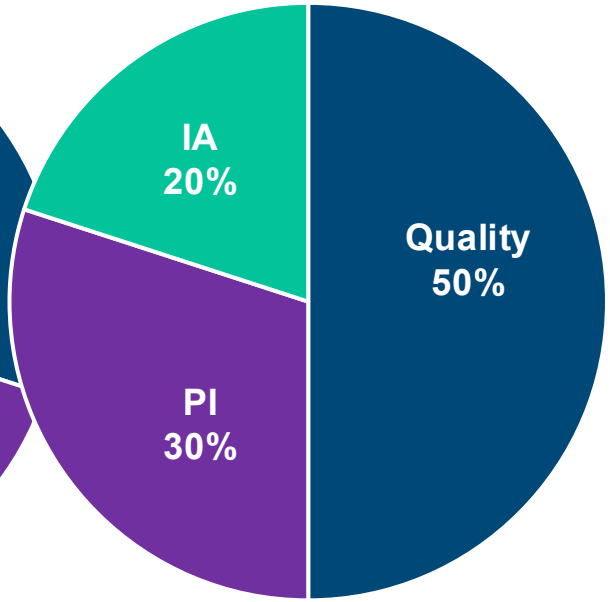
MIPS



MVP



APP



Ambulatory Specialty Model

ASM

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Ambulatory Specialty Model

Like MIPS & MVP

- ❑ Two-sided risk adjustment (-9% - 9%)
- ❑ Like MVP: Specialty Focused: Outpatient specialty care of chronic conditions
- ❑ Mandatory for selected participants who are excused from MIPS reporting.

Unlike MIPS

- ❑ Direct competition between specialists – no predetermined thresholds
- ❑ Reporting at clinician level (quality & cost)
- ❑ Requires connection with a beneficiary's PCP
- ❑ Can share money between specialists and PCPs
- ❑ Participants can receive ongoing beneficiary-level information to evaluate their beneficiaries' costs and healthcare interactions

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ASM Participant

ASM Participant

- Individual clinician who, for at least one ASM performance year, satisfies the ASM eligibility criteria and has been selected for participation.
- Bills under Medicare Physician Fee Schedule

Episode-Based Cost Measures

- Minimum 20 episodes annually (Episode-Based Cost Measures)
- Instead of counting individual office visits, they consider complete episodes of care from start to finish.
- Office visits, diagnostic tests, medications, hospitalizations, and follow-up care.

Located in selected geographic area (25% of CBSAs randomly selected)

- To figure out a clinician's zip code, CMS will:
- Look at all the clinician's Medicare claims from 2 years before the performance year
- Find the zip code that appears most often on those claims
- That zip code determines the clinician's location for program purposes

Visit the ASM Participants dataset to check if a provider is listed as an ASM participant.

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ASM Initial Cohorts

Cardiology Cohort

- Eligible clinicians who have been assigned a specialty code of cardiology on the plurality of their Medicare Part B claims.
- Example
  - 45% cardiology claims
  - 30% internal medicine claims
  - 25% other specialty claims

Low Back Pain Cohort

- Eligible clinicians with a specialty code of anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, or physical medicine and rehabilitation on the plurality of their Medicare Part B claims.

Visit the ASM Participants dataset to check if a provider is listed as an ASM participant.

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Quality Category

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Quality Category

Category Weight

50% of total score

Performance Period

365 days

Requirements

1. Submit all required measures specified by cohort
2. Meet data completeness threshold
3. Meet case minimum criteria

Quality performance must be submitted at the individual level unless the ASM participant is in a small practice (consisting of 15 or fewer clinicians).

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Quality Measures – Heart Failure

Measure ID	Measure Name	Collection Type
Q492	Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF	Claims
Q008	HF: Beta-Blocker Therapy for LVSD	eCQM, MIPS CQM
Q005	HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD	eCQM, MIPS CQM
Q236	Controlling High Blood Pressure	eCQM, MIPS CQM
Q377	Functional Status Assessments for Heart Failure	eCQM

Quality Measures – Low Back Pain

Measure ID	Measure Name	Collection Type
TBD in CY 2027 Rulemaking	(Excess Utilization Measure) MRI Lumbar Spine for Low Back Pain	Claims
Q238	Use of High-Risk Medications in Older Adults	eCQM, MIPS CQM
Q134	Preventative Care and Screening: Screening for Depression and Follow-up Plan	eCQM, MIPS CQM
Q128	Preventative Care and Screening: BMI Screening and Follow-Up Plan	eCQM, MIPS CQM
Q220	Functional Status Change for Patients with Low Back Impairments	MIPS CQM

Data Completeness

Data completeness to remain at 75% through performance year 2028.

- CQMs - “is calculated by considering both the total number of patients seen who are eligible for a measure, and the total number of patients for which you report.”
- eCQMs – if you report through a certified health record, include all data, you will achieve 100% data completeness.
- If you do not submit at least one eCQM or CQM and meet the data completeness threshold **you fail ASM altogether and get a -9%** on your Medicare Part B claims.

CQM Data Completeness Requirement:

Numerator: The number of patients for which you report performance data *(performance met, not met, denominator exceptions)*

Denominator: The total number of patients eligible for the measure

≥ 75%

Case Minimum

- 20 denominator eligible instances

- If a measure does not meet case minimum requirements, the measure will earn 0 decile points

Cost

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Cost

Category Weight

50% of total score

Performance Period

365 days

Requirements

CMS will evaluate your performance using the Episode-Based Cost Measures

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Cost Category Details

Cost Category (50% Weight)

- Uses Episode-Based Cost Measures (EBCMs)
- Compares total Medicare spending per episode vs other specialists
- Scoring based on standard deviations from cohort median
- Lower costs = higher scores (generally)
- Adjusts for patient complexity and other factors
- Must have ≥20 episodes for scoring

Benchmark Range	Points	Illustrative Methodology for the Bottom of the Benchmark Range ($)
Benchmark Range 1	1 – 1.9	Median cost + (2.5 × standard deviation)
Benchmark Range 2	2 – 2.9	Median cost + (2 × standard deviation)
Benchmark Range 3	3 – 3.9	Median cost + (1.5 × standard deviation)
Benchmark Range 4	4 – 4.9	Median cost + (1 × standard deviation)
Benchmark Range 5	5 – 5.9	Median cost + (0.5 × standard deviation)
Benchmark Range 6	6 – 6.9	Median cost + (0 × standard deviation)
Benchmark Range 7	7 – 7.9	Median cost - (0.5 × standard deviation)
Benchmark Range 8	8 – 8.9	Median cost - (1 × standard deviation)
Benchmark Range 9	9 – 9.9	Median cost - (1.25 × standard deviation)
Benchmark Range 10	10	Median cost - (1.5 × standard deviation)

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Improvement Activities

Improvement Activities

Category Weight

No weight. Negative Impact Only

Performance Period

90 days

Requirements

- Complete two activities. The same activities for each cohort.
- Complete only one, and you lose 10 points from your final score.
- Complete neither and you lose 20 points.
- Failure to attest Yes or No to both, **you fail ASM altogether and get a -9%** on your Medicare Part B claims.

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Improvement Activities (Penalty Only)

Two Required Improvement Activities

IA-1: Primary Care Connection & HRSN Screening

- Help patients find PCPs if needed
- Communicate with PCPs after every visit
- Ensure patients get health-related social needs screening
  - Yes, the SDOH screening measure questions!

IA-2: Collaborative Care Arrangements

- Execute formal agreement with primary care practice
- Must include 3 of 5 elements: data sharing, co-management, care transitions, closed-loop communication, care coordination integration

Collaborative Care Arrangements (CCA)

Specialists must enter into a CCA with a PCP for ASM

- Specialists can pay primary care practices for coordination services
- Primary care can pay specialists for consultation/training
- Legal protection from anti-kickback violations

Requirements:

- Written agreements
- Fair market value only
- No conditioning on referrals
- Must advance ASM clinical goals

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Promoting Interoperability

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Promoting Interoperability

Category Weight

No weight. Negative Impact Only

Performance Period

180 days

Requirements

- Submit the required measures (next slide)
- Attest to this measure: ONC Direct Review
  - You do not need to attest to the Actions to Limit or Restrict Compatibility or Interoperability of CEHRT attestation.
- Have CEHRT functionality that meets ONC's certification criteria in 45 CFR 170.315 in place **by the first day** of your MIPS Promoting Interoperability performance period
- Have your EHR certified by ONC to the certification criteria in 45 CFR 170.315 **by the last day** of your performance period
- Provide your EHR's CMS Identification code from the Certified Health IT Product List (CHPL)
- Conduct or review a Security Risk Analysis on your CEHRT functionality on an annual basis
- Attest to conducting an annual assessment of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)

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Promoting Interoperability

Objective	Measure	Maximum Pts	Required
Electronic Prescribing	E-Prescribing	10	Required
	Query PDMP	10	Required
Health Information Exchange	Option 1: Sending Health Information AND Receiving and Reconciling Health Information	15 15	Required to choose 1 of 3 options
	Option 2: HIE Bi-Directional Exchange	30	
	Option 3: Enable Exchange Under TEFCA	30	
Provider to Patient Exchange	Provide Patients Electronic Access to Health Information	25	Required
Public Health and Clinical Data Exchange	Electronic Case Reporting	25	Electronic Case Reporting and Immunization Registry Required
	Immunization Registry		

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Promoting Interoperability (Penalty Only)

Promoting Interoperability Requirements

- Must report at the group level (TIN level)
- No bonus points available for optional measures
- **Penalty calculation:** [(Score × 100) - 100] ÷ 10
- **Example:** 73% score = -2.7 points penalty
- **Perfect score (100%) = 0 penalty**

Step by Step Calculation

Example: 73% Performance Score (you earned 73 points)

Step 1: Multiply the score by 100

- 73% × 100 = 73

Step 2: Subtract that result from 100

- 100 - 73 = 27

Step 3: Divide by the maximum negative adjustment (10 points)

- 27 ÷ 10 = 2.7

Step 4: Apply as negative adjustment

Final scoring adjustment = **-2.7 points**

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Performance Threshold

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Performance Threshold

Unlike MIPS, there is no performance threshold to achieve. Your score is completely dependent upon how you score in comparison to everyone else.

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Bonus Point Opportunities

Special Scoring Adjustments

Small Practice Bonus:

- 2-15 clinicians: +10 points
- Solo practitioners: +15 points

Complex Patient Bonus:

- Up to +10 points for treating sicker/more disadvantaged patients
- Based on HCC risk scores and dual-eligible percentages
- Must be above cohort median on ≥1 indicator to qualify

Final Score Calculation

Putting It All Together

Formula: Final Score = [(Quality × 50%) + (Cost × 50%)] × 100 + IA Adjustment + PI Adjustment + Complex Patient Bonus + Small Practice Bonus

Example: Dr. Flowor

- Quality: 80%, Cost: 75% = Base 77.5 points
- IA: -10, PI: -2.7, Complex: +5.5, Small practice: +10

Final Score: 80.3 points

There is no minimum score required to "pass." Your performance is evaluated relative to other clinicians in your cohort, and payment adjustments (positive or negative) are based on how you rank compared to your peers.

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Final Considerations

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Data Sharing Opportunities

Clinicians will get regular aggregate and patient-level beneficiary files

- De-identified performance trends
- Cost, utilization, quality data
- Regular intervals during performance year

Patient-Level Data (By Request):

- Detailed Medicare Parts A, B, D claims
- For participants' ASM patients only
- Requires signed data sharing agreement
- Can be used for care coordination and quality improvement

ASM Model Overlap Considerations

ASM + Other CMS Programs

Designed to overlap with:

- ACOs and other Innovation Center models
- Advanced APMs

Potential benefits:

- Specialists can get ACO shared savings AND ASM bonuses
- Different payment types avoid legal conflicts

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The Bigger Picture

Who Will Succeed in ASM

Winners will be specialists who:

- Embrace systematic quality improvement
- Build strong primary care partnerships
- Invest in care coordination capabilities
- Focus on evidence-based, cost-effective care
- Adapt to data-driven practice management

What ASM Means for the Future

- If ASM is successful, expect:
  - Expansion to other chronic conditions and specialties
  - Template for specialty payment reform across Medicare
  - End of volume-based, independent specialist practice
- CMS's message:
  - They want specialty data!
  - Future belongs to collaborative, accountable specialists
  - Patient outcomes and care coordination drive financial rewards

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Turning ASM Requirements into Action

- Measure performance accurately across programs
- Track outcomes over time - not just at submission
- Ensure complete and compliant reporting
- Gain visibility into performance drivers

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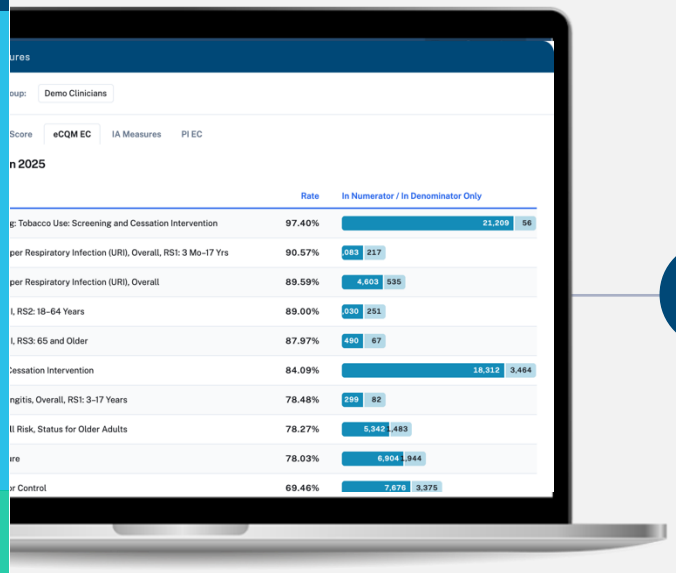
The Solution

QualityIQ & ENCOR

Purpose-built for ambulatory practices; helping you stay ahead of CMS requirements while driving meaningful clinical impact.



Complete Measure Coverage

- Support for eCQMs and CQMs in one platform
- Access to all required ASM measures
- Continuous tracking—not just at submission

Actionable Insights

- Drill into why patients fall out of measures
- Identify gaps in care and missed opportunities
- Prioritize interventions at the patient level

Unified Data Across Clinicians & Systems

- Aggregate data across multiple EHRs and data sources
- Create a single, trusted view of performance
- Normalize data for consistent measurement

Performance Visibility in Real Time

- Track performance throughout the year
- Identify trends before they impact final scores
- Benchmark against internal and external targets

Scalable System-Wide Quality Management

- View performance across:
  - clinicians
  - specialties
  - locations
- Support enterprise-wide quality strategy

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ENCOR for Electronic Clinician Measures (eCQMs)

DEMO

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Questions?

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