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CY 2027 Physician Fee Schedule Proposed Rule: Detailed Summary of Proposed Changes to the Ambulatory Specialty Model

Pages 345-453 of the unpublished proposed rule

OVERVIEW

The Ambulatory Specialty Model (ASM) is a mandatory Innovation Center model under section 1115A of the Social Security Act, that was finalized in the CY 2026 Physician Fee Schedule final rule. The model, scheduled to launch on January 1, 2027, will test whether holding specialists accountable for the quality and cost of longitudinal management of heart failure and low back pain can reduce Medicare spending while preserving or improving quality.

In the Calendar Year (CY) 2027 Medicare Physician Fee Schedule proposed rule, CMS proposes a broad series of technical and operational refinements to the ASM. Although several changes are technical or clarifying in nature, the proposal also makes substantive changes to participant exceptions, quality measurement, Promoting Interoperability, final-score adjustments, payment-adjustment portability, the model safe harbor, and collaborative care arrangements.

The proposals retain ASM's core structure and would continue to run for five performance years, from 2027 through 2031. Performance-based adjustments would continue to apply two years after the applicable performance year to all Medicare Part B covered professional services, with potential positive or negative adjustments beginning at up to 9 percent and increasing over the model.

Comments on the proposed rule, including proposed changes to ASM, are due by **September 14, 2026.**

PROPOSED CHANGES AT A GLANCE

Area	Proposed Change
Definitions	Clarify the definitions of "ASM beneficiary" and "dual eligible proportion" and add a definition of "rural area" aligned with MIPS.
Participation	Expand and clarify exceptions for TIN changes; add a permanent exception for certain heart-failure specialists who redesignate their specialty; permit CMS termination for program-integrity or model-purpose concerns.
Payment Adjustments Following TIN Changes	Clarify that an ASM payment multiplier earned in a prior performance year follows the participant's NPI to a new TIN during the corresponding payment year.
Safe Harbor/Waivers	Limit model safe-harbor and MIPS-waiver availability to periods of active ASM performance.
Data Submission	Allow improvement-activity reporting at the individual or group level; clarify small-practice quality reporting and multiple submissions.
Low Back Pain Quality	Add a claims-based MRI overuse measure and replace the low-back-pain functional-status change measure with a functional outcome assessment process measure.
Quality Scoring	Score claims-based measures at the individual TIN/NPI level; clarify benchmark treatment; add a five-point voluntary PROM-data incentive.
Promoting Interoperability	Make electronic prior authorization optional in 2027 and mandatory for medical services and prescription drugs in 2028; remove certain attestations; create measure suppression.
Final Score	Add five points for qualifying rural participants and report new incentives/adjustments in annual performance reports.
Collaborative Care Arrangements	Allow multiple ASM participants in one arrangement, broaden permissible counterparties, revise shared-patient, referral, remuneration, valuation, reconciliation, and documentation rules.

DEFINITIONS

CMS proposes three changes or clarifications to key definitions:

- "ASM beneficiary" would mean a Medicare fee-for-service beneficiary being treated by an ASM participant for an ASM targeted chronic condition.
- "Dual eligible proportion" would be clarified as the share of an ASM participant's beneficiaries who are dually eligible for Medicare and Medicaid.

- "Rural area" would be added and aligned with the definition and determinations used under MIPS at 42 C.F.R. 414.1305.[1] This would support the proposed rural scoring adjustment, discussed further below.

PARTICIPATION AND PARTICIPANT STATUS

Mandatory Participation and CMS Termination Authority

CMS proposes to clarify that clinicians selected for at least one performance year would generally remain ASM participants for the duration of the model once selected unless CMS terminates the model or terminates that participant. CMS emphasizes that the proposal would not create a participant right to voluntarily withdraw.

In this proposed rule, CMS also proposes to establish authority to terminate participants for program-integrity, patient safety, legal, or model-compliance concerns.

Impact of Failing Eligibility Criteria

CMS proposes to reorganize the regulation to distinguish the consequences that apply during the performance year, the corresponding payment year, and the period for model flexibilities. A participant who does not meet eligibility criteria for a particular performance year would not be subject to performance assessment, data submission, or final scoring for that year and would not receive a payment adjustment attributable to that year. The participant also would be ineligible for applicable program waivers and the model safe harbor for that performance year.

Importantly, ineligibility in a later year would not erase a payment adjustment earned in an earlier performance year. For example, a participant ineligible for the 2029 performance year could still receive the 2029 payment adjustment based on 2027 performance.

Exceptions for TIN Changes

CMS proposes expanded exceptions for clinicians who change TIN affiliations before or during a performance year. A TIN-change exception would apply only for the applicable performance year and would begin on a CMS-determined date. The participant would not be subject to performance assessment, data submission, final scoring, or the corresponding payment adjustment for that year, and would not be eligible for model waivers or the safe harbor during the exception period.[2]

- **TIN Change Before the Performance Year:** A participant who stops reassigning billing rights to the selected TIN before the applicable performance year could request an

[1]42 C.F.R. 414.1305, "Rural Area means a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP), using the most recent FORHP Eligible ZIP Code file available."
[2]An exception for one TIN/NPI combination would not excuse the clinician's obligations under another TIN/NPI combination for which the same NPI was selected.

exception by providing written notice no later than 60 days after the start of that performance year. CMS would determine whether the exception applies.

- **TIN Change During the Performance Year:** A participant who stops reassigning billing rights to the selected TIN during the performance year could request an exception by notifying CMS in writing, in the form and manner CMS specifies, within 30 days. The participant would no longer need to begin reassigning billing rights to a different TIN during the same year. This expansion is intended to cover situations such as retirement or departure from practice.

Application of Prior-Year Payment Adjustments Following a TIN Change

A TIN-change exception for the current performance year would not eliminate payment adjustments based on the participant's performance in an earlier year. CMS proposes to clarify that an ASM payment multiplier earned for a prior performance year would continue to apply to the participant's Medicare Part B covered professional services during the corresponding payment year, even if the participant begins billing under a new TIN after the performance year. The multiplier would follow the participant's NPI when the reassignment occurs before the end of the corresponding payment year.

This clarification is operationally significant for acquisitions, physician employment changes, practice consolidation, and recruitment because a new employer or affiliated TIN could receive positive or negative payment adjustments based on the clinician's performance while practicing under a prior TIN.

Specialty-Redesignation Exceptions for Heart-Failure Participants

CMS also proposes a permanent exception for heart failure participants who formally redesignate their specialty to certain procedural or highly specialized cardiac subspecialties[3] and provide evidence of board certification. The participant would have to notify CMS in writing within 30 days of the effective date of the approved redesignation. Prior-year payment adjustments would continue to apply even when a participant is excepted in a later year.

CMS does not propose an equivalent exception for low-back-pain participants, reasoning that the existing low-back-pain specialty categories already capture common specialty changes and that broader exceptions could introduce selection bias.

Model Safe Harbor and MIPS Waiver During Ineligible or Excepted Years

CMS proposes to clarify that the CMS-sponsored model arrangements and patient incentives safe harbor would be available only while an ASM participant is actively subject to the model's performance requirements. A participant who does not meet eligibility criteria for a performance year or receives an approved exception would not be eligible to use the safe harbor during the applicable period.

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[3]Eligible subspecialty changes include: cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, or adult congenital heart disease.

CMS similarly proposes to clarify that the ASM waiver of MIPS reporting obligations would not apply during a performance year in which the participant fails to meet eligibility criteria or is excepted from specified ASM requirements. These proposals align the availability of model flexibilities with active participation and performance under ASM.

DATA SUBMISSION

CMS proposes several changes to ASM data-submission policies to provide greater reporting flexibility while promoting consistent scoring.

For participants in small practices—defined as TINs with 15 or fewer clinicians—CMS would clarify the existing option to submit non-claims-based quality data at either the group/TIN level or the individual TIN/NPI level. CMS also proposes to allow improvement-activity attestations at either level, rather than requiring group-level attestation that all ASM participants within the TIN completed the activity. This change would reduce the risk that an individual participant is penalized because other clinicians in the practice did not complete the required activity.

CMS would also reorganize the rules governing multiple submissions by performance category without materially changing most existing policies. Submissions from different organizations generally would each be scored and the highest score would be used, while the most recent submission would be used when multiple submissions come from the same organization; for Promoting Interoperability, CMS would continue to calculate each submission and assign the highest score. However, for small practices, if CMS receives any group-level quality submission, it would score that submission and apply the resulting score to every ASM participant in the practice, disregarding any individual-level submissions. CMS intends this policy to prevent practices from strategically mixing reporting levels to maximize scores.

QUALITY PERFORMANCE CATEGORY

Low Back Pain Quality Measures

For the low back pain cohort, CMS proposes adding a claims-based measure assessing potentially unnecessary lumbar MRI use. CMS would calculate the measure from administrative claims over the ASM performance year, with a proposed 20-case minimum, a 365-day lookback period, and attribution to multiple ASM participants whose care is sufficiently connected to the imaging event.

CMS would also replace the discontinued Functional Status Change measure with the Functional Outcome Assessment measure, which evaluates whether clinicians complete a standardized functional assessment and document an appropriate care plan. Administrative claims-based measures would be calculated and scored at the individual TIN/NPI level, and measures for which CMS cannot establish a valid benchmark would be removed from the quality-score calculation rather than assigned zero points.

Quality Scoring and Benchmarks

CMS proposes to clarify that all administrative claims-based quality measures would be calculated and scored at the individual TIN/NPI level, including for participants in small practices that report other quality measures at the group level.

CMS would also revise the regulatory text to distinguish the scoring requirements for participant-reported measures from those for administrative claims-based measures. In addition, CMS proposes to remove duplicative language governing the benchmark period for claims-based measures and instead apply the general ASM benchmark policy.

When CMS cannot establish a valid benchmark for a required quality measure, the measure's earned and available points would be removed from the quality-score numerator and denominator rather than assigning the participant zero points for that measure.

Voluntary Patient-Reported Outcome Data

CMS also proposes a voluntary patient-reported outcome data initiative to support the development of future patient-reported outcome performance measures for heart failure and low back pain. Participants that submit qualifying beneficiary-level baseline and follow-up data meeting CMS-established requirements could receive five additional points in the quality category, without exceeding the category maximum. The submitted data would be used for measure development and testing and would not constitute a new required performance measure during the applicable year.

PROMOTING INTEROPERABILITY

CMS proposes several changes to the Promoting Interoperability performance category to align ASM more closely with MIPS and reduce differences between the two programs. The most significant changes involve electronic prior authorization, which would be optional during the first ASM performance year but become a required component of the performance category beginning in 2028. CMS also proposes new measure exclusions, the removal of certain attestations, and a measure-suppression policy for circumstances outside participants' control.

Certified Electronic Health Record Technology

ASM would continue to use the MIPS definition of certified electronic health record technology (CEHRT). As a result, any changes to the MIPS CEHRT definition finalized through the CY 2027 Physician Fee Schedule rulemaking would automatically apply to ASM. Participants would therefore need to monitor broader MIPS certification and technology requirements in addition to ASM-specific guidance.

Electronic Prior Authorization for Medical Items and Services

For the 2027 performance year, CMS proposes to add the Electronic Prior Authorization measure for medical items and services as an optional measure under the Health Information Exchange objective. The measure generally would require the participant to use CEHRT and a payer's prior authorization application programming interface to submit at least one electronic

prior authorization request for a non-drug medical item or service during the performance year. Reporting the measure in 2027 would be voluntary and would not provide bonus points or otherwise increase the participant's Promoting Interoperability score.

Beginning with the 2028 performance year, CMS proposes to make the measure mandatory, subject to applicable exclusions. The measure specifications and exclusions would generally align with those used under MIPS. ASM participants would therefore need to ensure that their CEHRT, payer connections, and internal workflows can support API-enabled prior authorization and retain the information necessary to demonstrate successful electronic submission.

Electronic Prior Authorization for Prescription Drugs

CMS also proposes to require a new Electronic Prior Authorization for Prescription Drugs measure beginning with the 2028 performance year. The measure would generally require an ASM participant to use CEHRT to electronically submit at least one prior authorization request for a prescription drug during the performance year, subject to CMS-specified measure requirements and exclusions.

Together, the two required electronic prior authorization measures could create substantial implementation challenges for specialty practices. Successful reporting may depend not only on the participant's own EHR capabilities, but also on the readiness of EHR vendors, payers, pharmacy benefit managers, pharmacies, and other technology partners. Practices may need to update clinical and administrative workflows, vendor contracts, interfaces, and documentation processes before the 2028 performance year.

Public Health and Clinical Data Exchange Exclusions

CMS proposes to establish measure-level exclusions for measures within the Public Health and Clinical Data Exchange objective, consistent with the longstanding MIPS approach. When a participant qualifies for an exclusion, the points assigned to the excluded measure generally would be redistributed to another measure or objective under the applicable scoring methodology.

Removal and Revision of Attestations

CMS proposes to remove the separate Security Risk Analysis measure attestation from the ASM Promoting Interoperability reporting requirements. This change would eliminate the ASM attestation but would not relieve participants of underlying obligations to conduct security risk analyses under HIPAA, the MIPS program, or other applicable requirements.

CMS would also remove the attestations associated with ONC Direct Review. However, CMS would retain the requirement that participants not knowingly and willfully take actions that limit or restrict the interoperability of CEHRT, while reorganizing the related regulatory text.

Measure Suppression

CMS proposes a new policy allowing it to suppress a Promoting Interoperability measure for an entire ASM performance year when external circumstances materially affect participants'

ability to comply or would make the resulting scores inaccurate or misleading. CMS could consider the nature, breadth, and duration of the issue; the availability of certified health IT; outdated or conflicting technical standards; the operational or technical capacity of required partners; and other relevant factors.

If CMS suppresses a measure, it would notify participants through existing model communication channels and, when technically feasible, before the applicable data-submission period.

FINAL SCORING AND PERFORMANCE REPORTS

Rural Scoring Adjustment

CMS proposes adding five points to the final score of eligible participants practicing in rural areas. The rural adjustment could be awarded in addition to existing adjustments for complex patients, small practices, and solo practitioners when the participant separately qualifies. Annual performance reports would also be revised to identify whether the participant received the rural adjustment or the voluntary patient-reported outcome reporting incentive.

Annual Performance Reports

CMS proposes to reorganize annual performance reports so that they present performance-category scores, scoring incentives, scoring adjustments, the final score, the payment-adjustment factor, and the payment multiplier in a clearer sequence.

COLLABORATIVE CARE ARRANGEMENTS

Finally, CMS proposes significant revisions to collaborative care arrangements to make them more workable while strengthening compliance requirements. A single arrangement could include multiple ASM participants billing through the same TIN and one or more primary care partners, provided each participant is identified and the parties share at least one ASM beneficiary.

The rules would address both monetary and in-kind remuneration, prohibit remuneration conditioned on referrals, require remuneration to relate to the arrangement's care-coordination purposes, and calculate the remuneration limit using Medicare Part B payments from the applicable performance year. Arrangements would also be subject to valuation, reconciliation, repayment, traceable-payment, and concurrent documentation requirements.