How the Ambulatory Specialty Model Will Harm Medicare Beneficiaries and Rural Communities

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EXECUTIVE SUMMARY

- **The Ambulatory Specialty Model (ASM) will reduce access to care for tens of thousands of Medicare beneficiaries who have heart failure or low back pain.**
- **Beneficiaries with heart failure or low back pain will have greater difficulty obtaining consultations, second opinions, and pain treatments from specialists.**
- **ASM will reduce access to care for low-income patients and patients with multiple health problems.**
- **ASM will reduce access to care for residents of rural communities.**
- **ASM will also harm beneficiaries with health problems other than heart failure and low back pain.**
- **ASM is likely to increase Medicare spending rather than produce savings.**
- **CMS should terminate ASM and create patient-centered payments for care of chronic conditions.**

Thousands of Medicare beneficiaries with heart failure and low back pain could lose access to needed specialty care services if the "Ambulatory Specialty Model" (ASM) is implemented by the Centers for Medicare and Medicaid Services (CMS). Dozens of small rural communities could lose access to specialty care if ASM goes into effect. CMS claims that ASM will encourage cardiologists to deliver higher-quality care for heart failure and that it will encourage orthopedic surgeons, neurosurgeons, pain medicine physicians, anesthesiologists, and physiatrists to deliver higher-quality care for low back pain. What ASM will actually do is discourage these specialists from treating Medicare beneficiaries who have heart failure and low back pain, particularly low-income beneficiaries and patients who have the most serious and complex conditions. It will also discourage these specialists from providing services in the rural communities where ASM will be implemented.

ASM will reduce access to care for tens of thousands of Medicare beneficiaries with heart failure and low back pain. More than 5,500 specialists will be forced to participate in ASM. CMS intentionally designed ASM so that it cuts payments to the majority of these physicians even if they are delivering high quality care. The payment cuts could be as high as 9%. The only way these specialists can avoid the payment cuts is to stop providing services to Medicare beneficiaries with heart failure or low back pain. This could reduce access to care for tens of thousands of Medicare beneficiaries. See Section 4 for details.

Beneficiaries with heart failure and low back pain will have greater difficulty obtaining consultations, second opinions, and pain treatments. Although CMS claims that ASM focuses on specialists who *manage* care for heart failure and low back pain, specialists can be forced to participate in ASM even if the only services they provide to Medicare beneficiaries are consultations, second opinions, and/or one-time treatments such as an injection for pain. As a result, Medicare beneficiaries will likely have greater difficulty finding specialists who are willing to provide these services. Seeing fewer heart failure and low back pain patients would prevent the physicians from receiving cuts in payments for services to all of their other patients. See Section 2 for details.

ASM will reduce access to care for low-income patients and patients with multiple health problems. Specialists who care for patients who have low incomes and more complex health problems will be more likely to receive larger payment cuts under ASM. As a result, specialists will be penalized if they continue to treat these patients. See Section 3 for details.

ASM will reduce access to care for residents of many rural communities. Most of the largest cities in the country are excluded from ASM, while dozens of small rural communities are included. Many of these rural communities have few, if any, cardiologists, pain medicine physicians, or surgeons. The payment cuts under ASM will penalize specialists for providing services to heart failure and low back pain patients in these communities, and it could discourage specialists from practicing in these communities. As a result, the residents of these communities will be less likely to receive the services they need, and mortality and hospitalization rates will increase as a result. Rural hospitals could close if specialists are no longer willing to work in the community. See Section 2 for details.

ASM will harm beneficiaries with many types of health problems. The payment cuts under ASM will apply to *all* services the specialists deliver to *all* Medicare beneficiaries, not just patients with heart failure or low back pain and not just services used to diagnose or treat those specific conditions. As a result, specialists who participate in ASM will have fewer resources to treat Medicare beneficiaries with other types of heart conditions, orthopedic problems, or pain. Negative impacts on these patients will be hidden because specialists in ASM will be measured only on care for heart failure and low back pain, not on the quality of care provided to patients with other conditions. CMS may expand ASM in the future to include other types of health problems, other types of specialists, and additional communities, and this would expand the negative impacts to even more patients. See Section 2 for details.

ASM is likely to increase Medicare spending rather than produce savings. CMS designed ASM to "ensure" savings for Medicare by cutting payments to the majority of the specialists who are required to participate. However, the reductions in access to specialty care caused by ASM will likely result in more hospitalizations and unnecessary services for patients with heart failure and low back pain. The net result will be an increase in Medicare spending rather than savings. See Section 5 for details.

CMS should terminate ASM and work with specialists to create patient-centered payments for care of chronic conditions. ASM fails to address the problems with current Medicare payments that prevent physicians from delivering services to patients who have chronic conditions in better ways. Instead of implementing a problematic pay-for-performance program like ASM, CMS should work with specialists to design and implement *patient-centered payments* that support effective diagnosis, treatment, and management of chronic conditions. See Section 5 for details.

1. How the Ambulatory Specialty Model is Structured

The Ambulatory Specialty Model (ASM) was announced by CMS in June 2025 as part of the 2026 Physician Fee Schedule regulation.[1] Although CMS received numerous comments from physicians and others expressing concerns about the way ASM was designed and the negative impacts it would cause, CMS adopted the program with relatively few changes. In the final Physician Fee Schedule regulation for 2027 that was issued in November 2026, CMS reaffirmed its intention to implement ASM beginning in January 2027. It made a number of changes to ASM, most of which were minor.[2]

1.1. CMS Goals for ASM

According to CMS, ASM is intended to "test whether adjusting payment for specialists based on their performance on targeted measures of quality, cost, care coordination, and meaningful use of certified electronic health record (EHR) technology (CEHRT) results in enhanced quality of care and reduced costs through more effective upstream chronic condition management."

1.2. Physicians Required to Participate

Physicians will be required to participate in ASM for up to 5 years between 2027 and 2031 if:

- they are classified in one of seven specialties by CMS:
  - anesthesiology,
  - cardiology,
  - interventional pain management,
  - pain management,
  - neurosurgery,
  - orthopedic surgery, or
  - physical medicine and rehabilitation (physiatry);
- they are attributed 20 episodes of care under the MIPS Heart Failure Episode-Based Cost Measure (HF-EBCM) or the Low Back Pain Episode-Based Cost Measure (LBP-EBCM) based on services they delivered two years earlier; and
- the majority of services the attributed patients received were delivered in one of 235 geographic areas selected by CMS.

Physicians are required to participate in ASM in 2027 based on the services they delivered in 2025. Eligibility for ASM is then redetermined every year, e.g., if a physician is included in ASM in 2027, but they did not meet the eligibility criteria in 2026, they will be exempt from ASM in 2028. However, even if they are excluded in 2028, they could be required to participate in ASM again in 2029, 2030, and/or 2031 if they again meet the eligibility criteria in 2027, 2028, and/or 2029.

If a physician is required to participate in ASM, they are no longer required or permitted to participate in the Merit-Based Incentive Payment System (MIPS). However, if a physician is exempt from ASM in a particular year because they did not meet the eligibility requirements two years earlier, they are required to participate in MIPS during that year.

Over 5,500 specialists will be required to participate in ASM in 2027, including 2,200 cardiologists, 826 physiatrists, 760 orthopedic surgeons, 626 pain management physicians, 395 interventional pain management physicians, 487 anesthesiologists, and 246 neurosurgeons.

1.3. Evaluation of Physician Performance

Physicians who are required to participate in ASM will be assigned a performance score based on:

- whether the average Medicare spending attributed to them under the HF-EBCM or LBP-EBCM measure is higher or lower than the spending in the same year for other specialists assigned to ASM for the same condition (heart failure or low back pain);
- whether their performance on each of five quality measures is better or worse than the performance on the same measure in the same year by the other specialists assigned to ASM. (Unlike the MIPS program, ASM will use contemporaneous benchmarks rather than historical benchmarks to determine whether performance on physician-reported quality measures is high or low.);
- whether they had a formal relationship with at least one primary care practice and whether they had processes for helping patients find a PCP if they didn't have one;
- whether they met "promoting interoperability" requirements established by CMS; and
- whether they qualify for a Complex Patient Scoring Adjustment and/or a Small Practice Adjustment and whether they are located in a rural area.

For heart failure, the following quality measures will be used:

- whether the physician's patients with left ventricular systolic dysfunction (LVSD) are receiving beta-blocker therapy (MIPS

measure Q008);

- whether the physician's patients with LVSD are receiving an ACE inhibitor or ARB or ARNI therapy (MIPS measure Q005);
- whether the physician's patients (regardless of whether they have heart failure) have their blood pressure controlled (MIPS measure Q236);
- whether the physician conducted functional status assessments for their heart failure patients (MIPS measure Q377); and
- the rate of acute unplanned cardiovascular-related hospital admissions for the physician's patients with heart failure (a modified version of MIPS measure Q492);

For low back pain, the following quality measures will be used:

- whether the physician ordered high-risk medications for their patients (regardless of whether the patients have low back pain) (MIPS measure Q238);
- whether the physician's patients (regardless of whether they have low back pain) have been screened for depression and have a follow-up plan to address depression (MIPS measure Q134);
- whether the physician's patients (regardless of whether they have low back pain) have been screened for obesity and have a follow-up plan to address obesity (MIPS measure Q128);
- whether the physician has conducted functional outcome assessments on all of their patients (MIPS Q182); and
- the proportion of patients who receive a lumbar spine MRI (this is a newly created measure for which CMS has not yet released detailed specifications).

Each physician will be evaluated based on their individual performance on the applicable cost and quality measures, regardless of whether they are part of a group practice. The one exception is that for the physician-reported quality measures, physicians in small practices (those with fewer than 15 physicians) can choose to be evaluated based on the average performance for the entire practice rather than their individual performance. However, even in small practices, physicians will be evaluated as individuals on the cost measures and the measures of hospital admissions and MRI use.

Half of a physician's performance score will be based on the cost measure, and half will be based on the quality measures. The score would be reduced if the physician fails to meet the requirements related to interoperability and relationships with primary care practices.

1.4. Changes to Specialist Payments

Medicare Part B payments to the specialists who are assigned to ASM will be increased or decreased in 2029-2033 based on the specialists' ASM performance scores in 2027-2031:

- A physician's payments will be changed two years after the year for which they received a performance score, e.g., payments will be changed in 2029 based on the physician's performance in 2027;
- Payments will be changed for all of the services the physician delivers to all beneficiaries, not just services to patients with heart failure or low back pain;
- Payments could be reduced or increased up to 9% in 2029 and 2030, 10% in 2031, 11% in 2032, and 12% in 2033.
- The payment change for an individual specialist will depend on how their overall performance score compared to the scores for all of the other specialists who are assigned to ASM for the same condition (heart failure or low back pain).
- A "redistribution percentage" limits the aggregate amount of payment increases to 85% of the aggregate amount of payment reductions. This is designed to guarantee a reduction in Medicare spending, but it also guarantees that the majority of specialists in ASM will see a reduction in their payments.
- If a physician does not have enough heart failure or low back pain patients to receive a cost measure score, a quality measure score, or both, they will not receive a performance score and will not have their payments adjusted.

1.5. Expansion to Additional Specialists, Health Conditions, and Geographic Areas

ASM is being implemented under the authority Congress granted to the Center for Medicare and Medicaid Innovation (CMMI) to test new approaches to care delivery and payment. CMMI will evaluate whether ASM has reduced spending and whether it has maintained or improved quality by comparing patients in the geographic areas included in ASM to patients in the geographic areas that are excluded. If the evaluation shows that ASM reduces Medicare spending without reducing the quality of care for patients, CMMI could expand the program to a larger geographic area, including nationwide.

It is possible that CMMI will expand the program to include additional types of patients and additional types of specialists before the evaluation of the current version of the program has been completed. In the proposed 2027 regulations, CMS stated that it was continuing "to explore whether including additional conditions and specialists would be appropriate."

2. Problems Caused by the Way Specialists Are Selected for ASM

- **Patients with heart failure or low back pain could have greater difficulty obtaining specialty care.**
- **Patients with other cardiovascular and musculoskeletal conditions could receive lower quality care.**
- **Patients would be unable to compare specialists in ASM to other clinicians who treat heart failure and low back pain.**
- **Small, rural communities could lose access to specialty care.**

The problems with ASM begin with the methodology used to determine which physicians will be required to participate and which will be excluded. There are three primary problems:

- Inclusion of specialists who do *not* manage heart failure or low back pain;
- Exclusion of most of the clinicians who *do* manage heart failure and low back pain; and
- Creation of geographic disparities in care.

2.1. Inclusion of Specialists Who Do Not Manage Heart Failure or Low Back Pain Care

The Different Roles That Specialists Play

It is widely recognized that a specialist can play many different roles in the care of patients with conditions such as heart failure and low back pain. For example,

- the specialist could take responsibility for managing the care for all of the patient's health conditions, including conditions other than heart failure or low back pain;
- the specialist could take responsibility for managing care of heart failure or low back pain, while the patient's primary care physician and/or other specialists manage care of other conditions;
- the specialist could co-manage the treatment of heart failure or low back pain together with a primary care physician or another specialist, i.e., the specialist and the other physician would share the responsibility for monitoring and treatment related to that condition;
- the specialist could take primary responsibility for all or part of the care of the patient's condition during a limited period of time (e.g., during a hospitalization), but would not manage the ongoing care of the condition;
- the specialist could determine a diagnosis for the patient's condition, but not provide treatment or ongoing management of the condition;
- the specialist could provide specific services (e.g., an examination or laboratory test) in response to a request by a primary care physician or other specialist;
- the specialist could provide consulting assistance to a primary care physician or other clinician who is managing care of a patient's heart failure or low back pain, but the specialist would not directly provide treatment or manage the patient's care for that condition.

Obviously, the aspects of a patient's care that a specialist can be held accountable for depends on the specific role they are playing. For example, if a specialist is merely advising a primary care physician regarding appropriate treatment or if the specialist is determining a diagnosis but not providing treatment, the specialist has no direct control over the treatment and management services the patient receives and thereby also has no control over the costs of those services or the outcomes they produce for the patient. In contrast, if the specialist has taken responsibility for managing care of a patient's heart failure or low back pain, then they can control or influence outcomes and costs related to that condition.

In many small rural communities, specialists do not live in the community, so patients either have to travel to see a specialist or obtain a consultation with the specialist through telehealth. Although these services are important parts of the patients' care, in most cases, the patient's overall care is managed by a physician, clinic, or hospital located in the patient's own community, not by the distant specialist. Some specialists may come to the community periodically to provide a specific type of service or treatment so that patients do not have to travel to receive it, but a local physician or other clinician will provide ongoing management of the patient's condition(s), not the visiting specialist.

ASM Penalizes Specialists for Services They Didn't Order and Can't Control

CMS has stated that it "designed ASM with a focus on clinicians who … develop longitudinal relationships with patients, and co-manage beneficiaries with primary care providers (PCP)." However, ASM does nothing to determine whether a specialist has a longitudinal relationship with a patient.

A specialist is required to participate in ASM if they have as few as 20 Medicare beneficiaries who are "attributed" to them under either the Heart Failure Episode-Based Cost Measure (HF-EBCM) or the Low Back Pain Episode-Based Cost Measure (LBP-EBCM). The cost measures first attribute a patient to the specialist's practice if the practice billed Medicare for two services

to the patient and a diagnosis of heart failure or low back pain was included on the claim forms for those services. The two services could be on the same day, or they could be on different days. In a multi-physician practice, a patient who is attributed to the practice is then assigned to any individual specialist who provided at least 30% of the practice's services to the patient during the episode. In a solo specialist practice, the patient is assigned to that specialist.

This means that **a specialist can be forced to participate in ASM if they:**

- **provide one-time consultations regarding heart failure or low back pain.** For example, a primary care physician might ask a cardiologist to see a patient to confirm the PCP's diagnosis of heart failure and to rule out other heart problems. If the cardiologist has a single visit with the patient and performs an electrocardiogram as part of the visit, that cardiologist has performed two services for a patient with heart failure and the patient would be attributed to that cardiologist's practice by the HF-EBCM. If the cardiologist performs 20 such consultations during the year, the cardiologist could be required to participate in ASM. Because of the penalties physicians would be subject to under ASM (which are explained in detail in Section 3 and Section 4), this could discourage cardiologists from consulting with primary care physicians to help them care for heart failure patients.
- **provide a specific treatment or other service as part of the patient's overall care for heart failure or low back pain.** For example, patients who are receiving physical therapy to address problems with their lower back may have difficulty controlling pain during the initial phase of therapy. They may be referred to a pain medicine physician, anesthesiologist, or surgeon who can provide a steroid injection to relieve the pain. The physician who performs the injection may never see the patient again, since they were only providing a one-time service, not managing the patient's overall care. But providing injections for 20 Medicare beneficiaries with low back pain could cause the physician to be assigned to ASM, even though they played no other role in managing or delivering care for the patient's low back pain. This could discourage these specialists from providing pain relief services to low back pain patients.
- **treat patients who have heart failure or low back pain for completely different problems.** The attribution rules in the heart failure and low back pain cost measures require only that a diagnosis code for heart failure or low back pain is present on the claim; the condition does not need to be the reason for the service. For example, if a cardiologist treats patients for atrial fibrillation, but some of the patients also have heart failure and the cardiologist records the heart failure diagnosis code on the claim forms as a comorbidity, those patients could result in the specialist being required to participate in ASM. This could discourage specialists from providing treatment for other conditions to patients who also have heart failure or low back pain.
- **provide temporary coverage for physicians who are ill or on vacation.** For example, a patient could be attributed to a multi-specialty practice based on services delivered by primary care physicians who are part of the practice. If the patient was typically seen 3 times during the year, and if one of those visits was covered by a cardiologist in the group practice because the primary care physician was not available, the patient would be attributed to the cardiologist because the cardiologist delivered more than 30% of the services for the patient. (The patient would also be attributed to the primary care physician.) If the cardiologist saw 20 patients in this way (something that could easily occur in a single day), the cardiologist would be forced to participate in ASM. This could discourage cardiologists from providing coverage for other clinicians in the group.

Not only could these specialists be inappropriately required to participate in ASM because of a single patient encounter, they would then be inappropriately held accountable under ASM for all of the services related to heart failure or back pain the patients receive during a multi-month "episode of care." This would include services delivered or ordered by other physicians or hospitals that the specialist was not aware of and could not have influenced:

Specialists can be assigned to ASM if they only provide one-time consultations or treatments for patients with heart failure or low back pain.

- In the case of a patient with heart failure, ASM would hold the cardiologist accountable for the cost of all of the patient's heart-related care for the next 12 months, even though the cardiologist may have only seen the patient on a single occasion and had no other involvement in the patient's heart-related care.
- In the case of low back pain, ASM would hold an anesthesiologist, neurosurgeon, orthopedic surgeon, pain management physician, or physiatrist accountable for all of the patient's low back pain-related care over the next 4 months, even if they saw the patient once and had no control or influence over their subsequent care. For example, a pain management physician could be held accountable for the cost of a patient's spinal surgery, even though the pain management physician had no role in determining whether the patient was appropriate for surgery or in performing the surgery.

Even if the patient moves to a different state or town after the specialist provides a service, ASM holds the specialist accountable for all of the services the patient receives in their new community during the multi-month episode period that follows.

In addition, a specialist can be held accountable for an even longer period of time if they have one additional visit or deliver one additional service to the patient during the initial episode. For example, if a cardiologist provides the initial care to a patient for heart failure, and then the patient's primary care physician takes over ongoing management of the patient's care, a single telehealth consultation with the cardiologist during the next 12 months could result in the cardiologist being held accountable for what the PCP does for an additional year.

ASM Does Nothing to Determine The Role a Specialist Plays in Patients' Care

It would be easy for CMS to modify the EBCMs or ASM to include only those specialists who are managing or co-managing the care of heart failure or low back pain. In 2015, as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress required CMS to "develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service." In response, CMS created five Patient Relationship Codes that enable specialists to indicate whether they are managing a patient's care during the episode or merely providing specific services.[3] However, *CMS has never used these codes.*

The Measure Information Forms for the EBCMs acknowledge the possibility of using these codes to improve the way patients are attributed to physicians, saying *"Future attribution rules may benefit from the implementation of patient relationship categories and codes. As required by section 101(f) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Centers for Medicare & Medicaid Services (CMS) will consider how to incorporate the patient relationship categories into episode-based cost measurement methodology as clinicians and billing experts gain experience with them."* [4] However, this has not been done.

ASM Removes Accountability for Conditions Other Than Heart Failure and Low Back Pain

The specialists who are targeted for participation in ASM typically provide care for a wide range of health problems, not just heart failure and low back pain. For example:

- cardiologists diagnose and treat patients with atrial fibrillation, coronary artery disease, and hypertension as well as heart failure;
- neurosurgeons diagnose and treat patients with conditions such as brain tumors, head trauma, and neck pain as well as lower back pain;
- orthopedic surgeons diagnose and treat many different types of musculoskeletal conditions as well as lower back pain;
- anesthesiologists provide sedation for many types of procedures and address pain for a wide range of conditions, not just lower back pain;
- pain management physicians diagnose and treat patients with all types of pain, not just lower back pain; and
- physiatrists treat patients with conditions such as stroke and limb amputations as well as lower back pain.

Yet if any of these specialists delivers services to 20 or more Medicare beneficiaries with heart failure or lower back pain, they would be assigned to ASM, and as a result, they would only be evaluated with respect to the cost and quality measures related to heart failure and lower back pain. Even if the majority of a specialist's patients are treated for cardiovascular or musculoskeletal conditions other than heart failure or lower back pain, assigning the specialist to ASM means that information about the quality of care the specialist delivers to those other patients would no longer be collected and it would no longer have any effect on the Medicare payments they receive.

Specialists who are forced to participate in ASM would no longer be accountable for the care they provide to patients with conditions other than heart failure and low back pain.

For example, Medicare data show that the majority of patients treated by the cardiologists assigned to ASM do not have heart failure.[5] For most of these cardiologists, fewer than one-third of their patients have heart failure. Their other patients have atrial fibrillation, ischemic heart disease, or other problems. Some of the cardiologists assigned to ASM primarily treat heart failure patients, but they represent less than 1% of the total.

Patients Who Do Not Have Heart Failure and Low Back Pain Could Receive Lower-Quality Care

If a specialist is forced to participate in ASM, the amount they will be paid for *any* service they deliver to *any* of their Medicare patients, including patients who do not have heart failure or low back pain, would depend solely on their performance on the ASM measures for heart failure or low back pain. As a result, the specialist would have to focus their time and attention on what is required under those measures, not on aspects of care that are more important for patients with other types of cardiovascular or musculoskeletal problems or other types of pain. This could result in lower quality care for patients who do not have heart failure or low back pain.

Patients Who Do Have Heart Failure and Low Back Pain Could Have Greater Difficulty Obtaining Specialty Care

As explained in more detail in Section 4, the payment methodology in ASM is designed in such a way that the majority of the specialists in ASM would receive a reduction in their payments, even if they deliver high-quality care to patients with heart failure and low back pain.

If delivering one-time visits or services to a small number of patients who have heart failure or low back pain could result in a specialist having their payments cut for everything else they do, specialists may be less willing to provide consultations and other services for Medicare beneficiaries with heart failure and low back pain.

CMS has indicated that almost half (43%) of the cardiologists assigned to ASM treat only 20-29 Medicare beneficiaries with heart failure, and more than one-third (35%) of the specialists assigned to the low back pain component treat only 20-29 Medicare beneficiaries with low back pain.[6] If a specialist who currently sees 25 Medicare beneficiaries for heart failure or low back pain reduces that number to 19 by seeing 6 fewer patients, they would be exempt from ASM and they could avoid a cut in payment for all of their other patients. Although seeing fewer heart failure or low back pain patients would reduce these physicians' revenue by a small amount, doing so would protect them from the much greater loss of revenue they would experience if all of their other Medicare payments were cut by ASM.

CMS states that it believes the payment adjustments in ASM "will incentivize performance improvements that will lead to more effective upstream chronic condition management." However, it seems more likely that ASM would incentivize specialists to see fewer Medicare beneficiaries who have heart failure or low back pain, and this could result in poorer outcomes for these patients. For example, studies have shown that patients with heart failure whose care is being managed by primary care practices receive more appropriate care and have better outcomes if they see a cardiologist periodically, but this could be less likely when ASM is implemented.[7] This would be particularly problematic for the subset of Medicare beneficiaries who have serious or complex conditions, such as advanced heart failure or multiple types of heart disease, and who need access to the specialized expertise that can only be provided by a cardiologist.

2.2. Exclusion of Clinicians Who Do Manage Care of Heart Failure and Low Back Pain

Most Clinicians Who Provide Care for Heart Failure and Low Back Pain Are Excluded

While ASM includes specialists who have little or no control over a patient's care for heart failure or low back pain, **ASM *excludes* most of the physicians and other clinicians who *do* manage the care of patients with heart failure and low back pain:**

- **Primary Care Practices.** Most Medicare beneficiaries who have heart failure receive ongoing care for that condition from a primary care practice, not a general cardiologist. In fact, when the heart failure episode cost measure was being tested prior to implementation, only 26% of the heart failure episodes were attributed to cardiologists, and many of these same episodes were also likely attributed to a primary care physician or other clinician.[8] Some patients may see a cardiologist to help determine an appropriate treatment plan when they are first diagnosed, or they may need a visit with a cardiologist if the treatment plan is not working effectively, but their primary care clinician takes primary responsibility for implementing the treatment plan and monitoring their condition. This approach enables the primary care practice to coordinate care of the patient's heart failure with services for the patient's other health problems that are being provided by the PCP or other specialists. Under ASM, a cardiologist who sees the patient only once might have the patient attributed to them by the HF-EBCM and thereby be held accountable for all of the patient's care through ASM. The primary care practice that is actually managing the patient's care would also have the patient attributed to them by the cost measure, but they would not be included in ASM.
- **Heart Failure Clinics.** In larger communities, many health systems and physician practices have established heart failure clinics with multi-disciplinary teams that focus solely on the care of patients with heart failure. In these clinics, a cardiologist will be involved in the diagnosis and initial treatment of a new patient, but after an effective treatment plan has been found, the patient's care will often be managed completely by nurse practitioners, nurses, nutritionists, pharmacists, and/or social workers. Since none of these clinicians would be included in ASM, most patients receiving care from a heart failure clinic would not be included in ASM.
- **Chiropractors and Physical Therapists.** Medicare beneficiaries with low back pain are far more likely to receive care from chiropractors and physical therapists than from anesthesiologists, neurosurgeons, orthopedic surgeons, or pain management physicians. When the low back pain episode cost measure was being tested prior to implementation, chiropractors were the most likely clinicians to have episodes attributed to them (with 23% of all low back pain episodes), followed by physical therapists (with 6.3% of all low back pain episodes).[9] However, chiropractors and physical therapists are not eligible to participate in ASM. Many patients with low back pain are also likely attributed to primary care clinicians, but PCPs are not included in ASM.

Patients Would Be Unable to Compare Clinicians Who Treat Heart Failure and Low Back Pain

ASM would make it difficult for patients with heart failure or low back pain to compare the quality of care delivered by different types of physicians and clinicians because:

- specialists who are assigned to ASM will only be compared to other specialists assigned to ASM, not to the many other types of physicians and clinicians who provide care for the same conditions but are not assigned to ASM.
- different types of quality measures will be used to evaluate the specialists assigned to ASM than the physicians in the Merit-Based Incentive Payment Program (MIPS). For example:
  - CMS is encouraging primary care clinicians to report quality measures under the Value in Primary Care MVP component of MIPS, but this MVP does not include any quality measures related to heart failure.
  - There is no MVP (MIPS Value Pathway) related to low back pain, and there is only one quality measure in MIPS that is directly related to low back pain.

The inability to compare performance is a problem because physicians included in ASM would face very different financial incentives than other physicians and clinicians providing care for patients with heart failure and low back pain. As explained in more detail in Section 4, physicians in ASM are much more likely to be penalized for higher-than-average spending under ASM than under MIPS, so ASM creates a problematic incentive to avoid or delay ordering expensive tests or treatments even if the patient would benefit from them. There would be no way for Medicare beneficiaries or CMS to identify whether such problems are happening because the physicians in ASM would not be measured in a comparable way.

Patients Would Be Unable to Compare Clinicians Who Treat Other Types of Cardiovascular and Musculoskeletal Conditions

Patients with other types of health problems would find it impossible to evaluate the quality of care delivered by the specialists in ASM because those specialists would only be able to report quality measures for heart failure and low back pain.

For example, as noted earlier, most cardiologists treat cardiovascular conditions such as atrial fibrillation and ischemic heart disease, not just heart failure. In the MIPS program, cardiologists can report quality measures for these conditions as well as for heart failure, but in ASM, they can only use measures related to heart failure.[10] Moreover, as noted earlier, because cardiologists in ASM would only be evaluated based on measures related to heart failure, they would have a strong incentive to focus on achieving good performance on those measures, not on other aspects of care that would have been measured under MIPS.

2.3. Creation of Geographic Disparities in Patient Care

Medicare Beneficiaries Could Receive Different Care Depending on Where They Live

The problems described above will only exist for patients who receive their care in 235 core-based statistical areas (CBSAs) and metropolitan divisions across the country that were selected by CMS as the areas where ASM will be implemented. If a specialist sees heart failure or low back pain patients primarily in one of the selected areas, that physician could be forced to participate in ASM, but if they see patients primarily in other geographic areas, they would be excluded from ASM.

It does not matter where the patient lives; what matters is where the specialist delivers most of their services for the majority of the heart failure or low back pain patients who are attributed to them by the episode-based cost measures used in ASM. CBSAs and metropolitan divisions are defined using counties, so physicians could be included or excluded from ASM based solely on which side of a county boundary they see patients or deliver treatments.

This means that physicians who deliver services to heart failure and back pain patients would be evaluated and paid differently based solely on where patients receive those services. As explained in more detail in Section 3 and Section 4:

- the majority of specialists practicing in the ASM communities would receive cuts in their payments if they treat heart failure and low back pain patients. Specialists in other communities would not be subject to these cuts.
- specialists practicing in the ASM communities would be subject to greater penalties if their patients need expensive tests or treatments. Specialists who treat high-need patients in other communities would not be subject to these penalties.
- specialists in ASM communities could receive payment cuts if they serve large numbers of low-income beneficiaries who are less likely to receive primary care and who face greater difficulty utilizing standard treatments.

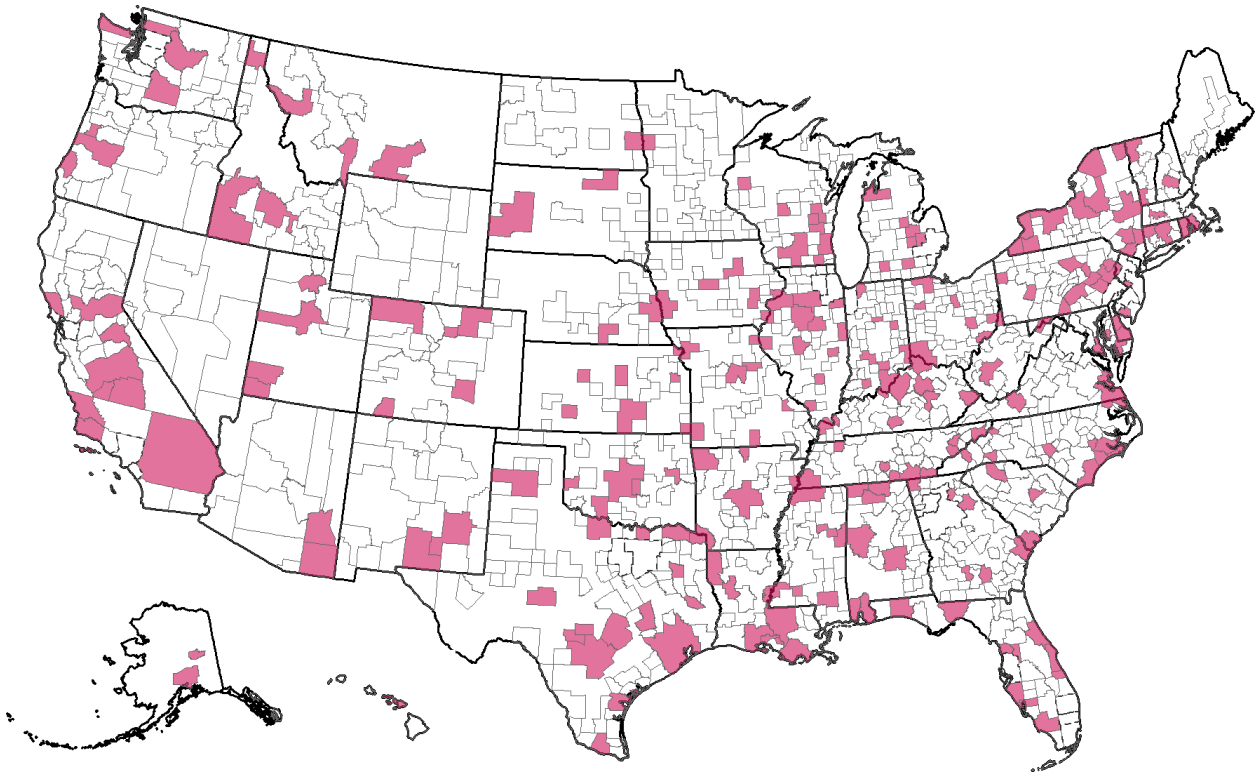
As a result of the problematic penalties under ASM, Medicare beneficiaries with heart failure and low back pain who obtain their care in the communities selected for ASM could have greater difficulty finding specialists willing to treat them. Those with low incomes and more complex conditions could experience the greatest impacts on their ability to access care.

Most of the Largest Cities in the U.S. Are Excluded from ASM

The CBSAs selected by CMS are listed in the Appendix and shown in Figure 2.1. Most of the largest cities and regions in the country are *excluded* from ASM, including New York City, Los Angeles, Chicago, Philadelphia, Albuquerque, Baltimore, Boston, Charlotte, Cleveland, Columbus, Denver, Detroit, Honolulu, Indianapolis, Kansas City, Las Vegas, Miami, Minneapolis, Nashville, Phoenix, Pittsburgh, Portland, Seattle, St. Louis and their surrounding areas. One exception is Texas, where all of the largest cities – Austin, Dallas, Houston, and San Antonio – are included in ASM.

ASM is being implemented in some areas and not others so that CMS can compare the two sets of areas in order to determine the impacts ASM has had. But it will be impossible to accurately assess the impact of ASM in large cities and metropolitan areas because most of them are excluded.

Figure 2.1
ASM Regions



Medicare Beneficiaries in Many Small Rural Areas Would Be Impacted

Although most large urban areas are excluded from ASM, many small rural communities are included. In fact, as shown in Figure 2.2, the CBSAs that were selected for ASM are disproportionately small and rural. One-third are entirely rural (i.e., every county in the CBSA is a rural county), and almost half are either mostly rural or entirely rural.[11]

Figure 2.2
Rural and Non-Rural CBSAs Selected for ASM

Rurality of CBSA	Percent of ASM CBSAs
Rural	33%
Mostly Rural	13%
Partially Rural	14%
Non-Rural	40%

Small, Rural Communities Could Lose Access to Specialty Care and Have Greater Difficulty Attracting Specialists

It is difficult for small rural communities to attract and retain specialists. These communities are fortunate if they have a single cardiologist, pain medicine physician, or orthopedic surgeon, and many of them have none of these specialists. Yet CMS is forcing a large number of these communities to be part of ASM. In fact, as shown in Figure 2.3:

- in 6% of the areas chosen for ASM, no cardiologists are assigned to the heart failure component, and in 5% of the areas, no specialists are assigned to the low back pain component. In many cases, this is because there are no specialists of the types targeted by ASM who are practicing in those areas.
- in 19% of of the areas, only 1 cardiologist is assigned to ASM and in 15% of the areas, only 1 specialist is assigned to the low

back back pain component. Here again, in many cases, this is because there is only one specialist who practices in that area.

Figure 2.3
Percentage of CBSAs
With Small Numbers of Assigned Physicians

Cohort	Percentage of CBSAs and Number of Assigned Specialists					
	0 Specialists	1 Specialist	2 Specialists	3-4 Specialists	5-10 Specialists	>10 Specialists
Heart Failure	6%	19%	16%	20%	17%	22%
Low Back Pain	5%	15%	9%	17%	25%	30%

In areas where there is only one specialist, the potential for payment cuts under ASM could discourage that physician from seeing Medicare beneficiaries with heart failure or low back pain, and ASM might cause the physician to stop practicing in the community at all. In areas where there are no specialists, the prospect of penalties under ASM could make it more difficult for the community to attract specialists to locate there. A recent study found that cardiologists, orthopedic surgeons, and anesthesiologists were some of the specialties that rural communities have the greatest difficulty attracting and retaining, and ASM would likely make this problem even worse.[12]

In a physician group practice that has multiple specialists, it might be possible for the group to designate a single physician to see all of the heart failure or low back pain patients. That would mean that only that physician's payments would be cut under ASM, rather than the practice taking the risk that payments would be cut for all of the physicians in the practice. However, in a rural area or small community, there may be only one cardiologist or one anesthesiologist, so the negative impact of ASM there would be greater.

ASM would make it more difficult for many rural communities to attract and retain specialists.

In some communities, specialists who are based in other cities travel to the rural community to see patients or perform procedures on specific days. ASM could discourage specialists from doing this because seeing a small number of Medicare beneficiaries with heart failure or low back pain in an ASM community could force the specialist into ASM, and that could cause the specialist's Medicare payments to be cut for all of the services they deliver in every other community. The specialist could avoid being assigned to ASM by not coming to the ASM community at all.

Many Patients Could Be Forced to Travel Long Distances for Specialty Care

If the only cardiologist, spinal specialist, or pain management physician who is located or practices in a rural community stops seeing Medicare beneficiaries with heart failure or low back pain because of ASM, those patients could have to travel a long distance to see a new specialist. If the specialist decides to leave the community entirely because of the problems created by ASM, patients with all types of cardiovascular, musculoskeletal, and pain problems would also have to travel further to receive their care, including individuals who are not on Medicare.

Examples of this are shown on the following pages.

Example: Rice Lake, Wisconsin CBSA

For example, as shown in Figure 2.4, CMS selected the Rice Lake, Wisconsin CBSA as one of the ASM areas. The Rice Lake CBSA consists of a single county (Barron County). No other community for many miles around was selected. None of the communities in Minnesota were selected except for Clay County, a small county that is part of the Fargo, North Dakota CBSA. Although many parts of southeastern Wisconsin were selected for ASM, the closest to Rice Lake is the Wisconsin Rapids-Marshfield CBSA, which is over two hours away.

Singling out Rice Lake/Barron County for ASM in this way could have a serious negative impact on the residents of the community:

- as shown in Figure 2.5, there is only one cardiologist who is based in Rice Lake, and that cardiologist will be forced to participate in ASM. There are no cardiologists at all in most of the surrounding counties, with the exception of one who practices in Polk County (St. Croix Falls). If the cardiologist in Rice Lake stopped seeing heart failure patients or left the community entirely because of the problems created by ASM, patients would need to travel an hour or more to see a cardiologist.
- the only specialist who will be included in the low back pain component of ASM is an anesthesiologist who practices interventional pain medicine in Rice Lake on a part-time basis as well as in Altoona, WI (Eau Claire County) and Hudson, WI (St. Croix County). As shown in Figure 2.6, there are no other anesthesiologists practicing nearby. If ASM discourages the physician who does come to Rice Lake from seeing low back pain patients there, the patients would have to travel 60-90 minutes to see him in one of his other practice sites or to see a different pain specialist in an even more distant location.

Figure 2.4
ASM Areas in the Upper Midwest

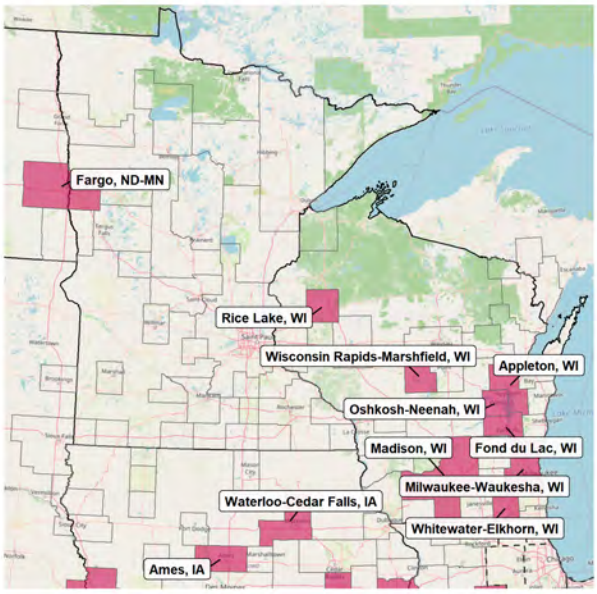


Figure 2.5
Cardiologists Located In and Near the Rice Lake, Wisconsin CBSA

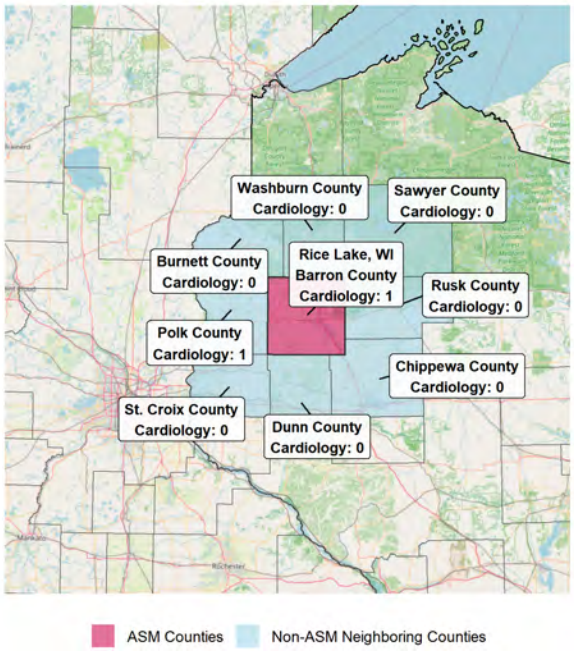
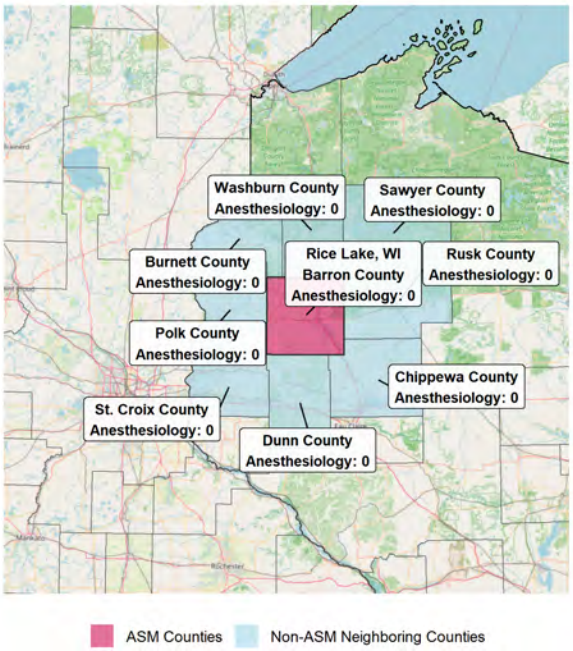


Figure 2.6
Anesthesiologists Located In and Near the Rice Lake, Wisconsin CBSA



Example: Dodge City, Kansas CBSA

Figure 2.7 shows that in Kansas, some small communities are included in ASM but others are not. Dodge City is included, but none of the communities in the surrounding areas in Kansas or in Oklahoma, Colorado, Texas, or New Mexico are.

Figure 2.7
ASM Areas in Kansas and Surrounding States

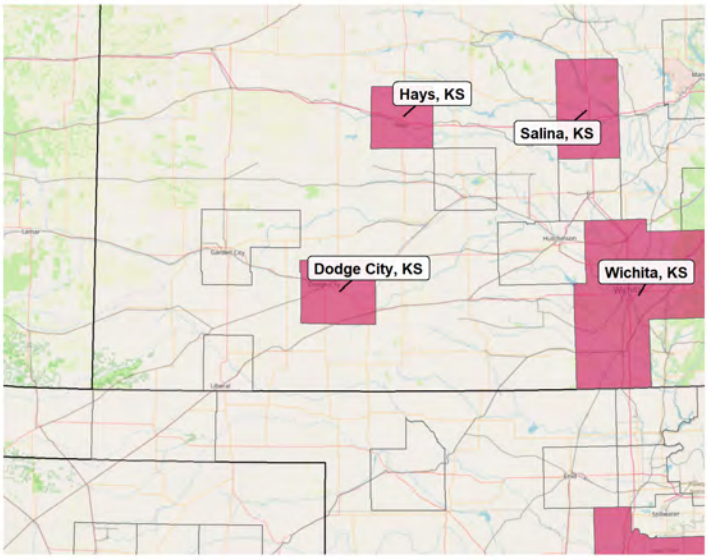


Figure 2.8 shows that there are only 2 orthopedic surgeons who practice in Dodge City, and one has been assigned to participate in ASM. There are no orthopedic surgeons in the surrounding counties. If the orthopedic surgeon in Dodge City stops seeing Medicare beneficiaries with low back pain or leaves the community entirely because of the problems created by ASM, patients would likely need to travel an hour or more to see an orthopedic surgeon. Similarly, residents of the area have access to only one cardiologist, and that cardiologist could be penalized under ASM for treating Medicare beneficiaries with heart failure.

Figure 2.8
Orthopedic Surgeons Located In and Near the Dodge City, KS CBSA

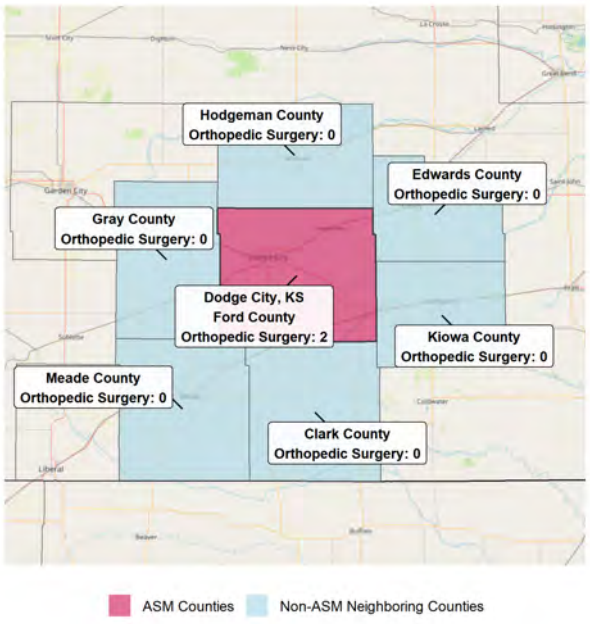
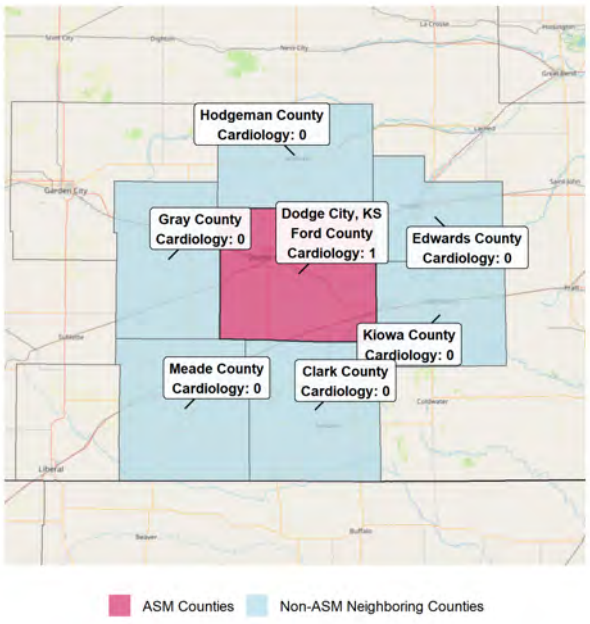


Figure 2.9
Cardiologists Located In and Near the Dodge City, KS CBSA



Rural Hospitals Would Be More Likely to Close

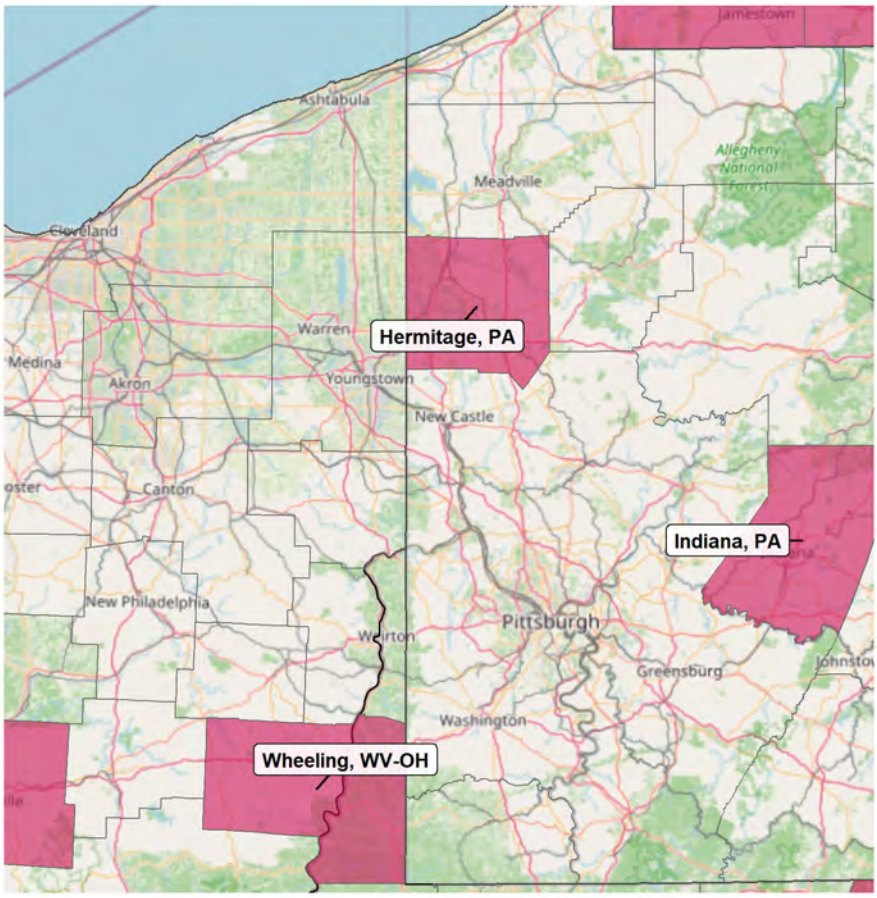
Loss of specialists in a rural community could also result in the loss of the hospital-based services that depend on those specialists.

Hundreds of small rural communities across the country are at risk of losing their local hospital because the hospitals are being paid less than it costs to deliver healthcare services in those ares.[13] If the hospital is no longer able to provide key services because they lose some or all of the specialists who deliver those services, or if they have to pay specialists more to offset cuts in Medicare payments, the hospital's losses will increase and it may be forced to close.

Example: Western Pennsylvania, Eastern Ohio, and the Hermitage, PA CBSA

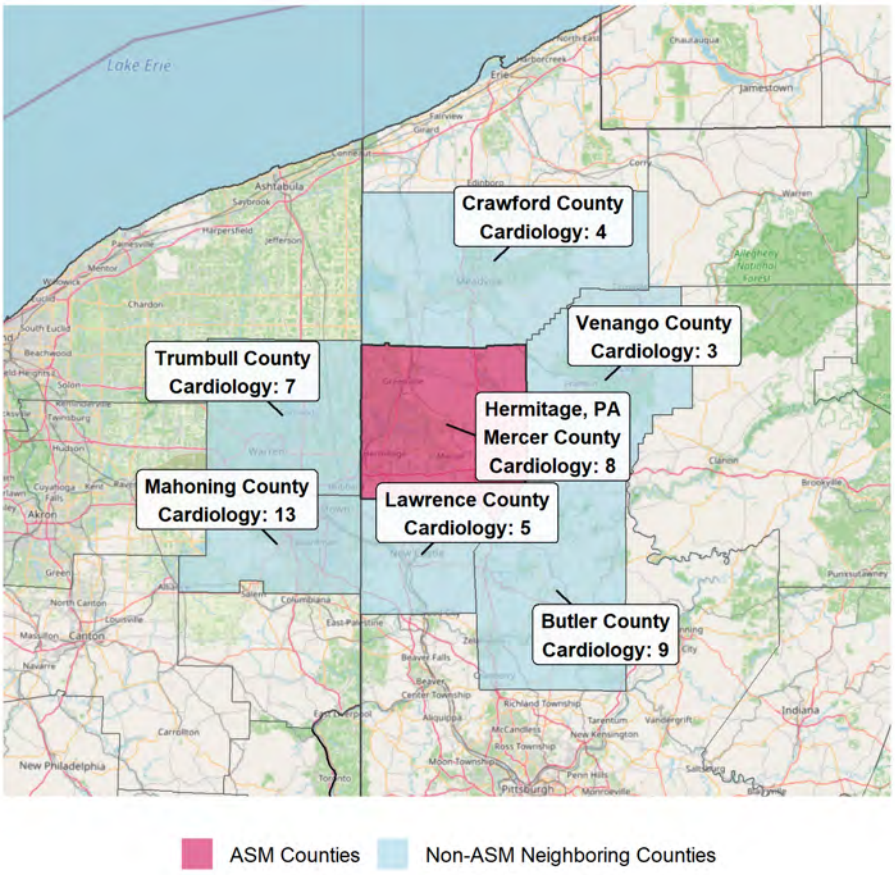
Figure 2.10 shows the ASM CBSAs located in Western Pennsylvania, Eastern Ohio, and Northern West Virginia. The large number of physicians practicing in Pittsburgh, Allegheny County, and the immediately adjacent counties would not be required to participate in ASM because the Pittsburgh CBSA was not selected for ASM. Similarly, the many specialists practicing in the Cleveland CBSA would be excluded. But specialists treating heart failure and low back pain in Mercer County (the Hermitage CBSA), in Indiana County, and in Wheeling, West Virginia would be forced to participate in ASM.

Figure 2.10
ASM CBSAs in Western Pennsylvania and Eastern Ohio



In contrast to more rural areas such as Rice Lake, Wisconsin and Dodge City, Kansas, there are specialists practicing in all of the counties adjacent to the Hermitage, PA CBSA, but none of them will be subject to the financial penalties in ASM because only the Hermitage CBSA was selected for ASM. For example, as shown in Figure 2.11, there are multiple cardiologists practicing in all of the adjacent counties who could continue to see heart failure patients without being subject to payment cuts under ASM, but the cardiologists in the Hermitage CBSA would be penalized if they treat Medicare beneficiaries with heart failure.

Figure 2.11
Cardiologists In and Near Hermitage PA CBSA



The Hermitage CBSA includes Sharon Hospital, which recently reopened after having been forced to close. The hospital was the only accredited cardiac and stroke center in the county, and closure of the hospital caused the community to lose that service.[14]

The hospital has now reopened and is providing cardiovascular care again.[15] ASM could make it more difficult to maintain that service line, which in turn might jeopardize the ability of the hospital to remain open.

3. Problems Caused by the Way Specialists Are Evaluated in ASM

- **Specialists would be discouraged from providing consultations for patients with heart failure and low back pain.**
- **Low-income patients, patients with complex problems, and patients in rural areas could have more difficulty obtaining specialty care.**
- **Patients with heart failure and low back pain could receive less treatment than they need.**
- **Performance scores would not reflect the true quality of care.**
- **Collaboration and team-based care will be less likely.**

It is widely recognized that there are many problems with the way that CMS evaluates physician performance in the Merit-Based Incentive Payment System (MIPS).[16] Unfortunately, rather than correcting these problems, CMS has created an even more problematic approach to performance evaluation in ASM.

Superficially, it may appear that the way ASM evaluates physician performance is very similar to MIPS:

- Both ASM and MIPS use a combination of quality measures and cost measures to evaluate physicians.
- Both ASM and MIPS require physicians to perform improvement activities and meet requirements for interoperability of electronic medical records systems.
- Both ASM and MIPS increase a physician's total performance score if a large proportion of their patients are on Medicaid or if their patients have multiple comorbidities.
- Both ASM and MIPS increase performance scores for physicians who are part of a small practice.

However, the details for each of these elements differ significantly in ASM from MIPS, and most of the differences are very problematic.

3.1. Problems with the ASM Cost Measures

Cost measures play a far more significant role in ASM than in MIPS. As discussed in Section 2, a cost measure is used to determine whether a specialist is required to participate in ASM in addition to being used as one of the factors in determining how much the physician's Medicare payments will be changed. ASM will assign a lower score to the same level of spending on a cost measure than the physician would receive in MIPS, and in ASM, the cost measure score will represent 50% of the physician's overall performance score compared to only 30% in MIPS.

In MIPS, most of the cost measures compare physicians on spending during an "episode of care" that is related to a specific procedure, such as spinal fusion surgery or a cardiac catheterization. The episode starts when the procedure is performed, and it ends after a short period of time in which most services are typically delivered and most complications are expected occur. Most of the services patients receive during the short episode are ordered or delivered by the physician who performed the procedure, and so for most patients, it is reasonable to hold that physician accountable for the spending associated with the services.

Specialists in ASM would be held accountable for spending on services that they did not deliver or order.

The cost measures used in ASM, however, attempt to compare spending associated with a *condition* – heart failure or low back pain – rather than spending related to a specific *procedure*. Inherently arbitrary rules are used to define an "episode" of care for these conditions and to attribute the episode to one or more physicians:

- Even though heart failure is a chronic condition that patients will have for the rest of their lives, the heart failure cost measure arbitrarily defines an episode as the 12-month period after a clinician delivers a service to the patient. Any physician or clinician who delivers two heart-related services to the patient could be held responsible for the spending on all other services the patient receives during the next 12 months, regardless of whether the physician delivered the other services or was even aware of the other services. Even if the only interaction a cardiologist has with a heart failure patient is a short office visit during which an electrocardiogram was performed, that one visit and test will cause all of the patients' heart failure-related services for the next year to be assigned to the cardiologist. If a patient receives services from multiple physicians, no attempt is made to determine what roles these different physicians play; all of the physicians are assigned responsibility for all of the heart-related services the patient receives.
- For low back pain, the "episode" is a 120-day period after a physician or other clinician delivers a service to the patient. If a physician or other clinician delivers two services to a patient that are related to low back pain, that physician or clinician could be held responsible for the spending on all other services related to low back pain the patient receives during that 4-month period. The "episode" ends in 4 months even if the patient was receiving services from other physicians for a longer period of time, and the episode lasts 4 months even if the patient's problem was resolved within a few days or weeks. If a patient receives services from multiple physicians, no attempt is made to determine what roles these different physicians play; all of the physicians are assigned responsibility for all of the services the patient receives.

If a physician delivers two services related to heart failure or low back pain to 20 or more Medicare beneficiaries, that clinician will be held responsible for all of the spending related to heart failure or low back pain for those patients during the remainder of the associated "episode of care," even though the physician may have had no further involvement in the patient's care after delivering those two services.

In ASM, hundreds of clinicians will be held accountable for these two measures even though they only provide the services to a few dozen Medicare beneficiaries. If a clinician only has 20 or 30 attributed patients, the average spending that is calculated under the measure will be highly sensitive to random variation in the needs of the patients that clinician has seen. In fact, testing of the cost measures has shown that they have low statistical reliability:

- The Measure Justification Form for the Heart Failure Episode Cost Measure[17] indicates that when the measure was tested for clinicians with 20 or more attributed patients, the reliability of the measure was below 0.7 for 70% of the clinicians, and the reliability was below 0.4 for 13% of them. This is unacceptably low reliability for a measure that is being used for payment penalties.
- The Measure Justification Form for the Low Back Pain Episode Cost Measure[18] indicates that when the measure was tested for clinicians with 20 or more attributed patients, the reliability of the measure was below 0.7 for 37% of the clinicians, and the reliability was below 0.4 for over 4% of them. This is unacceptably low reliability for a measure that is being used for payment penalties.

CMS has acknowledged the problems that can be caused by small sample sizes with respect to quality measures, but not for the cost measures.[19]

ASM Cost Measures Discourage Specialists From Providing Consultations

The cost measures in ASM will force specialists to participate in the ASM program and hold them accountable for all of the spending associated with a patient's condition even if the specialist only saw the patient on a single occasion. For example:

- if a patient with shortness of breath visits a cardiologist and the cardiologist diagnoses the patient with heart failure, the cardiologist will be responsible for all of the Medicare spending on that patient for the next year, even if the patient refuses to accept any treatment for their condition or chooses to receive care from their PCP or a different specialist.
- if a primary care clinician who is managing a patient's heart failure care asks a cardiologist to see the patient in order to advise the PCP on the most appropriate medication regimen, the cardiologist will be held accountable for all of the spending associated with the patient's heart conditions over the next 12 months, even if the cardiologist never sees the patient again and even if the PCP did not follow the cardiologist's recommendations.
- if a patient with low back pain is scheduled to receive spinal surgery from a neurosurgeon, and the patient visits a different neurosurgeon or a physiatrist to obtain a second opinion about whether surgery is appropriate, the neurosurgeon or physiatrist who provides the second opinion will be held accountable for all of the spending associated with the patient's surgery even though they did not perform the surgery and may have advised against it.

This clearly creates a disincentive for specialists to provide these types of consultations and second opinions, even though those services could help many patients achieve better outcomes and could also help reduce spending for Medicare. As explained in Section 2, this problem could be solved by simply asking the specialists whether they are managing the ongoing care of the patient or providing a one-time service, but CMS has refused to do this.

ASM Cost Measures Discourage Specialists From Treating Higher-Need Patients

If a specialist is managing the care of patients who have heart failure or low back pain, the ASM cost measure will calculate the average Medicare spending on those patients during each episode and compare it to the average spending calculated for all other specialists in ASM. The stated rationale for calculating spending during episodes is to identify which patients are experiencing complications and receiving unnecessary procedures. However, the ASM cost measures do not distinguish between spending on unnecessary and avoidable services and spending on necessary services, so a patient can have higher spending simply because the specific nature of their health problems requires that they receive more services or more expensive services. Although the cost measures are nominally "risk adjusted," the risk adjustment formulas fail to adjust for many things that result in higher spending but are beyond the control of physicians, such as the severity of the patient's heart failure or back pain. As a result, specialists who treat patients with multiple cardiac or musculoskeletal conditions and specialists who treat higher-need patients will be more likely to receive lower scores on the cost measure, and that will make it more likely they will receive cuts in their payments. For example, **ASM would discourage specialists from treating:**

- **Patients with multiple heart conditions.** Most of the variation in Medicare spending on patients with heart failure is due to some patients requiring hospital treatment for a heart condition other than heart failure, such as a malfunctioning heart valve, atrial fibrillation, or coronary artery blockage. Spending on a patient who receives a valve replacement, a pacemaker, an angioplasty, or cardiac bypass will be $20,000 - $40,000 or more higher than a patient who does not require one of these procedures. If a cardiologist is treating 20 patients with heart failure, and one of those patients needs an expensive procedure, that one patient will significantly increase the overall average spending on the physician's patients and cause the

physician to receive a worse score on the cost measure.[20]

- **Patients with advanced heart failure.** Patients with more advanced heart failure are more likely to experience complications and they may need more expensive types of treatment. The heart failure cost measure does not adjust for the stage of heart failure, so specialists who treat patients with more advanced conditions will be more likely to receive a poor score on the cost measure even if they are following evidence-based guidelines for treatment.
- **Patients who need spinal surgery.** One of the biggest reasons for differences in Medicare spending among patients with low back pain is that some patients will need spinal surgery and others will not. The physiatrists and pain management physicians who are being forced to participate in ASM do not perform spinal surgery, but the cost of spinal surgery is attributed to them if it occurs within 4 months after they see the patient. Spending on a patient who receives lumbar surgery will be significantly higher than a patient who does not receive surgery, so if more of the patients that a physiatrist sees decide to receive surgery, the physiatrist could be penalized for the higher spending.
- **Patients who need inpatient rehabilitation.** If a patient with low back pain receives spinal surgery, the overall spending on the patient's care will depend heavily on whether the patient needs to have inpatient rehabilitation in either a rehabilitation hospital or a skilled nursing facility. Medicare beneficiaries who live alone or do not have anyone to support them during recovery from surgery may need inpatient rehabilitation care, and that will increase the amount of spending significantly. The type and amount of post-acute care a patient needs will be affected by factors such as their mobility and home environment far more than the number and types of chronic conditions they have, but the cost measure does not assess or adjust for these differences. As a result, a surgeon who operates on patients that are more likely to need inpatient rehabilitation will receive a worse cost score than other surgeons.

The financial penalty under the cost measure is a particularly serious problem for Medicare beneficiaries who see specialists that only treat a small number of Medicare beneficiaries for heart failure or low back pain. As discussed in Section 2, over one-third of the specialists who are being assigned to ASM have fewer than 30 heart failure or low back patients attributed to them under the cost measures. For these physicians, treating one or two patients with significant needs could dramatically increase the average spending under the applicable cost measure and that could cause them to receive a cut in the payments they receive for all of their patients.

ASM Cost Measures Penalize Specialists Who Treat Patients from Rural Areas

Many patients who live in rural areas receive their primary care and some of their specialty care at a Rural Health Clinic (RHC) rather than a physician practice. The amount Medicare pays for an RHC visit can be several hundred dollars higher than the payment for a similar visit in a physician practice, but the cost measures do not adjust for this difference, so average spending will be higher for a specialist who treats patients who receive other services in an RHC.

Specialists could be less willing to treat patients who require more expensive treatments and those who live in small, rural communities.

In addition, if a rural patient needs post-surgical rehabilitation, the best place to receive that may be in the swing bed unit of their local Critical Access Hospital, rather than a distant skilled nursing facility. However, because Medicare pays more for rehabilitation in a Critical Access Hospital, the patient's surgeon and other specialists associated with the case would receive a worse cost score. The failure to adjust for this means that physicians in ASM may be less willing to treat patients who live in a small rural community.

ASM Cost Measures Penalize Timely, Appropriate Treatment

The average spending calculated by the episode-based cost measures will be lower if the patients receive fewer services or less expensive services during the time period included in the measure. As noted above, the cost measures do not distinguish between spending on necessary services and avoidable services. As a result, a physician who orders or delivers more services or more expensive services will receive a worse score on the cost measure, even if the patients needed the additional or higher-cost services. Since a worse score on the cost measure could increase the size of the physician's pay cut under ASM, the measures create a problematic incentive for physicians to delay or withhold services during the episode time period. For example,

- If a neurosurgeon sees a patient with low back pain who needs spinal surgery and the surgery is performed soon after the initial visit, the initial visit and the surgery will be included in a single episode of care. If the surgery is delayed by several months, the initial visit and the surgery would be included in separate episodes of care, and the average spending will be cut in half because the spending is spread across two episodes rather than one. As a result, the surgeon who delivers timely care could be penalized for having "higher episode spending."
- If a cardiologist is managing care of a heart failure patient who should receive an additional or more expensive medication under guideline-directed medical therapy (GDMT), the cardiologist will receive a worse score on the cost measure if the patient receives that medication than if the patient continued being treated with fewer, lower-cost drugs.

This penalty for delivering appropriate, timely care and the financial incentive it creates to undertreat patients is particularly strong for physicians who treat a small number of Medicare beneficiaries. Higher spending for a single patient has a much bigger impact on average spending for a physician who has 20 attributed patients than a physician with 200 patients.

3.2. Problems with the ASM Quality Measures

In theory, the quality measures in ASM could encourage appropriate treatment and to counteract any incentives to undertreat patients created by the cost measures. However, the quality measures used in ASM do not ensure that patients receive appropriate or timely care, and some of the measures also penalize appropriate treatment.

ASM Quality Measures Do Not Assure Timely, Appropriate Treatment

Heart Failure

The quality measures for heart failure do not ensure that Medicare beneficiaries will receive appropriate treatment or protect them against undertreatment for multiple reasons:

- **failure to determine whether all aspects of Guideline-Directed Medical Therapy are being delivered to patients with more severe heart failure.** ASM measures whether patients who have heart failure with reduced ejection fraction are receiving a beta-blocker and whether they are receiving an ACE inhibitor or ARB or ARNI therapy. But even if every patient is receiving those two classes of drugs, that does not mean they are receiving Guideline-Directed Medical Therapy (GDMT). GDMT involves four different medication classes, not just two; the ASM quality measures do not assess whether patients with more severe conditions or more severe symptoms are also receiving mineralocorticoid receptor antagonists (MRAs) or sodium-glucose cotransporter 2 (SGLT2) inhibitors if they are recommended for GDMT. As a result, a physician who has 100% performance on the two ASM measures may not be providing the most appropriate and effective care for patients who have more severe heart failure.
- **failure to distinguish necessary and avoidable services.** CMS has stated that the Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure measure would prevent withholding of care in order to improve performance on the heart failure cost measure.[21] However, this measure includes both hospital admissions for necessary procedures (such as a pacemaker) as well as hospital admissions for potentially avoidable complications. As a result, physicians whose patients require additional hospital procedures will appear to have worse performance on the measure than those who are treating less complex patients.
- **failure to examine all types of complications.** In addition, the Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure measure only includes patients who are admitted to a hospital for a complication, not patients who are treated in an emergency department. Since some hospitals are more likely to admit ED patients than others, the measure will not accurately identify which physicians' patients are experiencing more complications.
- **failure to include patients with preserved ejection fraction.** Although the cost measure for heart failure assesses spending on patients with all types of heart failure, two of the ASM quality measures (Beta Blocker Therapy for LVSD and ACE/ARB/ARNI for LVSD) apply only to the subset of heart failure patients with reduced ejection fraction (left ventricular systolic dysfunction). As a result, there is no way to know whether patients with preserved ejection fraction (diastolic heart failure) are receiving appropriate care.
- **failure to focus on heart failure patients.** The measure of blood pressure control used in ASM includes all types of patients with hypertension, not just heart failure patients, so a physician could achieve a good score on this measure even if the subset of patients with heart failure did not have good blood pressure control. At the same time, the measure excludes patients who are over age 85, so it does not provide any information about the quality of care for heart failure patients who are older than 85.
- **failure to focus on Medicare beneficiaries.** All but one of the quality measures for heart failure include patients of all ages, not just Medicare beneficiaries. As a result, poor quality of care for Medicare beneficiaries may not be apparent if a physician has good performance on the measures for younger patients. CMS has stated that including patients other than Medicare beneficiaries in the ASM heart failure quality measures "addresses the sample size and representativeness issues that could arise from limiting measurements to only attributed patients, which could result in unreliable or skewed performance data." However, this means that the cost measures would have the same problems of unreliability and skewness because they are limited to attributed patients.

Low Back Pain

The quality measures for low back pain also do not ensure that Medicare beneficiaries are receiving appropriate treatment for multiple reasons:

- **failure to focus on low back pain treatment.** Three of the five quality measures that would be used for the low back pain component of ASM (Use of High-Risk Medications, Screening for Depression, and BMI Screening) do nothing to assess whether patients are receiving the services needed to successfully treat their low back pain or whether outcomes such as pain and ability to function are improving. As a result, a physician could have good scores on these measures even though they are providing poor-quality care for low back pain.
- **failure to focus on patients with low back pain.** Moreover, these same three measures (Use of High-Risk Medications, Screening for Depression, and BMI Screening) are based on services to patients who have a wide range of diagnoses, not just low back pain. In 2025, CMS stated that the Low Back Pain Functional Status Change for Patients with Low Back Impairments quality measure would protect patients against undertreatment, but in 2026, CMS announced that this measure would

be removed and replaced with the Functional Outcome Assessment measure (MIPS Q182), which is neither an outcome measure nor is it specifically focused on patients with low back pain.

- **failure to focus on Medicare beneficiaries.** Two of the measures (Screening for Depression, and BMI Screening) include patients of all ages, not just Medicare beneficiaries. As a result, a physician could have good scores on these measures even though they are providing Medicare beneficiaries with low-quality care.
- **failure to distinguish necessary and avoidable treatment.** The Use of High-Risk Medications for the Elderly measure is intended to identify overtreatment rather than undertreatment. The measure is not supported by the American College of Physicians because of concerns about its validity as a measure of quality.[22] Since pain medications are included among the "high-risk medications" penalized by the measure, use of this measure in ASM could make it more difficult for patients with low back pain to receive help from the types of specialists who have the greatest expertise.
- **failure to distinguish necessary and avoidable testing.** CMS is proposing to add a measure of how often patients receive Magnetic Resonance Imaging (MRI) of the Lumbar Spine for low back pain, but this is also a measure intended to identify overtreatment, not undertreatment. Use of this measure will magnify the incentive to undertreat patients created by the cost measure, rather than mitigate it. In fact, the proposed measure is based on a measure that was removed from the Hospital Outpatient Quality Reporting Program (HOQPR) partly because of evidence that it had not improved outcomes and because of concerns that it could delay diagnosis of patients' problems. Because CMS is planning to use the measure for physicians with a small number of low back pain patients, a physician could easily be penalized for ordering an MRI for a single patient who did not meet one of the specific exclusions in the measure definition even though the MRI was necessary and appropriate. [23]
- **failure to measure the same set of patients.** CMS proposes to calculate the MRI measure over a two-year performance period. As a result, the measure would assess a different set of patients than the cost measure or any other quality measure used in ASM. In addition, use of a two-year performance period would mean that in the initial year of ASM, physicians would be held accountable for MRIs performed before the ASM program even began. Moreover, because it is a rolling two-year period, physicians would be penalized twice for what the measure classifies as poor performance in any given year – once in the current ASM performance year and again in the next ASM performance year. Since CMS is only planning to provide performance feedback to physicians after the end of each year, if a physician makes changes in response to the feedback, it would not affect the majority of patients in the measure until two years later. It appears that the primary reason for using a two-year performance period is that it would increase the number of physicians measured, not that it would provide a more accurate assessment of their performance.

ASM Quality Measures Discourage Treating Patients With Complex Problems

Most of the quality measures used in ASM are not adjusted to account for differences in the complexity of the patients being treated. As a result, specialists who see patients with more complex problems will tend to receive lower scores on those measures. For example:

- the Controlling High Blood Pressure measure assumes that reducing blood pressure below 140/90 is appropriate for every patient. The American College of Physicians does not support this as a valid measure of quality partly because it does not adjust for differences in patient characteristics.[24]
- the Use of High-Risk Medications in the Elderly measure assumes that the specified medications are equally problematic for anyone over 65, even though some patients may need them for effective treatment and be able to tolerate them. The American College of Physicians does not support this as a valid measure of quality because of this problem.[25]

The measures that do include a risk adjustment mechanism only utilize diagnosis information derived from claims forms, and exclude other important clinical and social factors that could have a significant effect on the measure scores. For example:

- CMS is proposing to use claims-based diagnosis information to determine which low back pain patients should and should not receive an MRI, even though determining whether an MRI is appropriate requires consideration of a wide range of factors that may not be captured in the diagnosis codes on claims forms. Consequently, the MRI utilization measure could penalize specialists who treat more complex patients. Moreover, CMS has not clearly defined which diagnosis codes will be included or excluded from the measure, so some patients who have conditions that require an MRI could be inappropriately counted as having received an unnecessary test.
- The measure of hospital admissions for patients with heart failure includes a risk adjustment formula that considers a wide range of comorbidities, but it does not include any adjustment for the stage of heart failure, even though patients with more advanced heart disease are more likely to experience exacerbations and hospital admissions. As a result, specialists who treat patients with more advanced heart failure will likely receive worse scores on this measure.

Because of the inadequate risk adjustment in the quality measures, specialists who see patients with more complex problems will be more likely to receive a low score in the quality ASM performance category, which will reduce their overall Performance Score and cause them to receive a larger cut in their Medicare payments. As discussed in Section 3.6, the Complex Patient Adjustment in ASM will not adequately offset this.

ASM Quality Measures Discourage One-Time Consultations and Services

As discussed in Section 3.1, the cost measures in ASM inappropriately hold physicians responsible for all of the services a patient received even if the physician only saw the patient once for a consultation or second opinion. Some of the quality measures do the same thing. This will further deter specialists from providing services to Medicare beneficiaries with heart failure and low back pain. Specifically:

- CMS originally proposed that the the measure of MRI utilization for patients with low back pain would attribute an MRI to "all physicians who provided qualifying services to the patient," but in the final physician fee schedule rule issued in November 2026, CMS announced that it would attribute an MRI to "the ASM participant with the highest number of qualifying encounters during the applicable lookback period." There is no requirement that the MRI was ordered by that physician, or that the physician was aware of the MRI, or even that the MRI was performed after the physician first saw the patient. In other words, a specialist in ASM can be held responsible for an MRI that is ordered by a completely different physician, and even if the MRI was performed before the ASM specialist first saw the patient. Because a patient can receive services from physicians and clinicians who are not required to participate in ASM, "the ASM participant with the highest number of qualifying encounters" might only have seen the patient a single time. The use of a 365-day "lookback period" means that if a specialist in ASM delivered a service to a patient with low back pain as much as a year before the patient received an MRI, the MRI could be attributed to that physician, even if the physician no longer had any involvement in the patient's care when the MRI was ordered or performed. CMS justifies using these inappropriately broad attribution rules because they will increase the number of MRIs attributed to ASM participants, not because the physicians attributed in these ways had any meaningful influence over whether an MRI was performed.[26]
- The measure of hospital admissions for heart failure patients is based on a measure that is used in MIPS only for physician groups, not individual clinicians. Although CMS has not released the specifications for the new measure, it appears that the ASM version of the measure will attribute a hospital admission for a heart failure patient to any cardiologist that saw the patient at least once during the same year, even if the admission occurred before the visit or long after the visit. [27]

3.3. Problems with How Measure Performance is Scored

How Benchmarks Are Defined and Used

In ASM, CMS will determine whether a specialist performed well or poorly on each of the cost and quality measures by comparing their performance to a "benchmark" for that measure. The benchmark for each performance measure includes 10 different categories, each of which has a minimum and maximum performance level. A specialist will receive between 1 and 10 points for the measure based on which of the ten categories includes their actual performance level. For example, if 80% of a specialist's patients received the service or achieved the outcome assessed by a quality measure, the specialist would receive only 1 point if 80% fell into the lowest performance category, but they would receive 10 points if 80% was in the highest performance category. "Partial points" are awarded depending on how the specialist's performance compares to the minimum and maximum levels in the category; for example, if 80% is in the eighth performance category, the specialist could receive 8.1 points or 8.9 points depending on whether 80% is closer to the minimum or maximum performance levels in that category.

For each measure, the minimum and maximum performance levels for each of the benchmark categories are defined based on how other specialists in ASM performed on the measure. Two different methods are used for defining the category endpoints:

- **Deciles Are Used for Quality Measures.** The performance levels for all specialists on the quality measure are ordered from lowest to highest, and then the minimum and maximum levels in each category are defined so that 10% of the specialists' scores fall within each category.
- **Standard Deviations Are Used for Cost Measures.** The standard deviation of all specialists' performance is calculated using the median performance as the midpoint. (The performance for each specialist is the average episode spending for that specialist's patients.) The categories are then defined using multiples of the standard deviation, e.g., category 6 will range from the median performance to the median plus one half of the standard deviation, and category 5 will range from the median minus one half of the standard deviation to the median.[28]

Under either approach, a specialist whose performance on a measure is exactly equal to the median for all other specialists in ASM would be assigned a score of 6.0, i.e., 60% of the maximum possible score of 10 for the measure.

CMS plans to use a *contemporaneous* benchmark for all measures in ASM, i.e., the benchmark performance categories for a measure will be based on how the other physicians in ASM performed on that measure during the *same* year. As a result, the benchmark categories will not be known until *after* physicians have already delivered the services for which performance is being assessed. This is different from MIPS, where benchmarks for most quality measures are *historical*, i.e., the benchmark categories are based on how other physicians performed on the measure two years earlier. Under MIPS, the benchmark categories are known *before* service delivery begins. The ASM regulations permit CMS to use a historical benchmark in ASM "to the extent feasible," but it does not appear that CMS intends to use an historical benchmark even where it could be feasible to do so.

Figures 3.1 and 3.2 show the most recent decile-based benchmarks in the MIPS program (for common methods of reporting) for the ASM quality measures.[29] CV-Related Admissions for Heart Failure Patients and Use of High-Risk Medications are "inverse"

measures, i.e., lower levels are better.

For example, if 85% of a cardiologist's patients had their blood pressure under control, the cardiologist would receive a score of 10 for the Controlling High Blood Pressure measure using the benchmark categories shown in Figure 3.1. The score would not change even if the other 15% of the patients had their blood pressure brought under control. If only 72% of the patients had their blood pressure under control, the cardiologist would receive a score of 7.0.

Figure 3.1
MIPS Benchmarks for ASM Heart Failure Quality Measures

Points	ACE/ARB for LVSD	Beta Blocker for LVSD	Controlling High Blood Pressure	Functional Status Assessment for Heart Failure	CV-Related Admissions for Heart Failure Patients
1.00 - 1.99	73.40% → 87.68%	69.05% → 95.78%	4.76% → 45.27%	0.04% → 0.16%	78.40% → 72.77%
2.00 - 2.99	87.69% → 96.61%	95.79% → 99.99%	45.28% → 55.55%	0.17% → 0.28%	72.76% → 70.85%
3.00 - 3.99	96.62% → 99.99%		55.56% → 61.53%	0.29% → 0.69%	70.84% → 69.51%
4.00 - 4.99			61.54% → 65.60%	0.70% → 0.82%	69.50% → 68.34%
5.00 - 5.99			65.61% → 68.97%	0.83% → 1.08%	68.33% → 67.44%
6.00 - 6.99			68.98% → 71.99%	1.09% → 2.70%	67.43% → 66.53%
7.00 - 7.99			72.00% → 74.99%	2.71% → 4.46%	66.52% → 65.64%
8.00 - 8.99			75.00% → 78.69%	4.47% → 6.65%	65.63% → 64.67%
9.00 - 9.99			78.70% → 84.03%	6.66% → 12.30%	64.66% → 63.02%
10.00	100.00%	100.00%	84.04% → 100.00%	12.31% → 100.00%	63.01% → 0.00%

Figure 3.2
MIPS Benchmarks for ASM Low Back Pain Quality Measures

Points	BMI Screening	Depression Screening	Functional Outcome Assessment	Functional Change for Low Back Impairment	Use of High-Risk Medications
1.00 - 1.99	4.50% → 31.25%	0.07% → 2.69%	57.69% → 99.58%	15.79% → 41.17%	30.71% → 15.86%
2.00 - 2.99	31.26% → 38.64%	2.70% → 11.41%	99.59% → 99.99%	41.18% → 59.99%	15.85% → 10.17%
3.00 - 3.99	38.65% → 61.59%	11.42% → 21.64%		60.00% → 69.56%	10.16% → 5.24%
4.00 - 4.99	61.60% → 77.90%	21.65% → 31.78%		69.57% → 78.37%	5.23% → 2.03%
5.00 - 5.99	77.91% → 85.70%	31.79% → 42.68%		78.38% → 85.10%	2.02% → 0.67%
6.00 - 6.99	85.71% → 90.16%	42.69% → 53.93%		85.11% → 93.74%	0.66% → 0.15%
7.00 - 7.99	90.17% → 91.49%	53.94% → 67.47%		93.75% → 97.89%	0.14% → 0.01%
8.00 - 8.99	91.50% → 94.75%	67.48% → 80.71%		97.90% → 99.99%	
9.00 - 9.99	94.76% → 96.68%	80.72% → 93.43%			
10.00	96.69% → 100.00%	93.44% → 100.00%	100.00%	100.00%	0.00%

Quality Scores Will Be Misleading

The decile approach can result in large differences in physicians' quality scores when there are only small differences in their performance. This is because the approach forces a subset of physicians to receive a score of 1 and another subset of physicians to receive a score of 10, even if their actual performance is almost identical. For several of the measures in ASM, the average performance in MIPS was over 97% and the majority of physicians had 100% performance. Under the decile scoring system, a physician who falls short of 100% by an extremely small amount would receive dramatically lower scores on these measures.

For example, one of the ASM heart failure quality measures is the percentage of the physician's patients with left ventricular

systolic dysfunction (LVSD) who are prescribed beta-blocker therapy. If a physician has 1,000 heart failure patients and all of them are prescribed a beta blocker, the physician's performance would be 100% and they would receive a score of 10. If a single patient out of 1,000 did not receive the beta blocker, the physician's performance would be 99.9% instead of 100%. 99.9% is in the 2nd decile of the benchmark table in Figure 3.1, so the physician would receive a score of 2.98 on the measure instead of 10.

This large jump occurs because when the benchmarks were established, 80% of the physicians had 100% performance on the measure, so the top 8 deciles were all the same. Anything lower than 100%, including 99.9%, was assigned to the 2nd decile or lower, even though the difference in performance was extremely small. This means that a physician's score on this measure could jump from 10 to 2 or from 2 to 10 from one year to the next based on what happens to a single patient. This is not an appropriate way of measuring quality.

Similarly, CMS has proposed using the Functional Outcome Assessment measure as a quality measure for low back pain. Based on the MIPS benchmark data, a specialist who scored 100% would be assigned to the 10th decile and receive the maximum points for the measure, whereas a clinician with 95% performance would be assigned to the 1st decile and receive less than 2 points on the measure. As a result, a physician's score could change dramatically from year to year based on what happens to one patient out of 20.

Improving the Quality of Care Can Result in a Lower Quality Score

In the MIPS program, the benchmarks are based on historical performance, so a physician who improves their performance on the quality measures can expect to receive a higher quality score. Moreover, in MIPS, a clinician who improves their performance on quality measures from the previous year will receive an "Improvement Score" that increases their quality score by up to 10 points beyond the amount they would have received based only on their current performance.

In contrast, in ASM, a physician who improves the quality of care could actually receive a lower quality score because ASM uses contemporaneous benchmarks to score performance. A physician who improves their performance significantly could still receive a lower score if the majority of other physicians performed slightly better.

For example, Figure 3.3 shows hypothetical performance levels in 2027 on the hypertension quality measure for 20 cardiologists assigned to ASM. The performance of all of the cardiologists in ASM in 2027 is assumed to be distributed similar to the MIPS benchmark for the measure that is shown in Figure 3.1, and the 20 cardiologists shown in the figure are representative of all of the cardiologists in ASM. For example:

- in the benchmark, the tenth decile for the measure ranges from 84% to 100%, so it is assumed that two of the hypothetical cardiologists (10% of the 20) achieve success for 84% or more of their patients.
- The maximum of the lowest decile is 45%, so two of the physicians are assumed to have performance levels at or below 45%.

Each cardiologist's score on the measure for 2027 would be based on which decile their performance level is in:

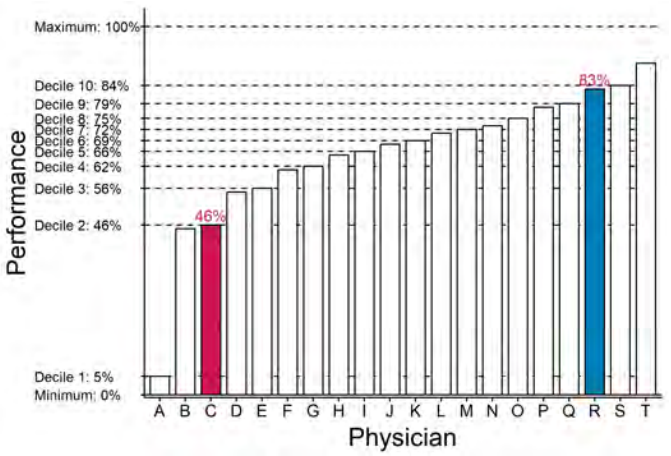
- Physician C only achieved success on the measure for 46% of their patients in 2027, and since that was in the second decile compared to all other physicians, they receive 2.0 points.
- Physician R achieved success for 83% of their patients, and since that was near the top of the 9th decile, they receive 9.8 points.

If all of the physicians in ASM improve their performance on the measure in 2028, most of their scores would not improve. The reason is that ASM uses a contemporaneous benchmark rather than a historical benchmark. For example,

- Physician C is assumed to improve their performance from 46% to 81%. As shown in Figure 3.4, if ASM had used the 2027 scores as the benchmark, their score would have increased from 2.0 to 9.4. However, as shown in Figure 3.5, because ASM uses a contemporaneous benchmark, they will only be in the 2nd decile and they will only receive a score of 2.0.
- Even though Physician R already had good performance, they improved from 83% to 92%. If a historical benchmark had been used, their score would have increased from 9.8 to 10. But under ASM, because other physicians had slightly better performance, the physician actually receives a lower score.

Figure 3.6 shows that even though all of the 20 physicians improved their performance on the quality measure, only 3 of them would receive a higher quality score, and 7 would receive a lower

Figure 3.3
Hypothetical Performance in 2027 on Quality Measure



score. Almost all of the physicians would receive a significantly lower quality score under the contemporaneous benchmark than they would have received if 2027 had been used as the benchmark.

As a result, ASM does not actually provide an "incentive" for specialists to improve on quality measures. In fact, if most physicians simply maintain the same performance from one year to the next, the performance deciles will remained largely unchanged, and the physicians will receive the same score as they did the previous year. For most physicians, their scores would be as good or better if they do nothing than if they improve performance on a measure.

Figure 3.4
Quality Performance in 2028 Compared to 2027 Benchmark

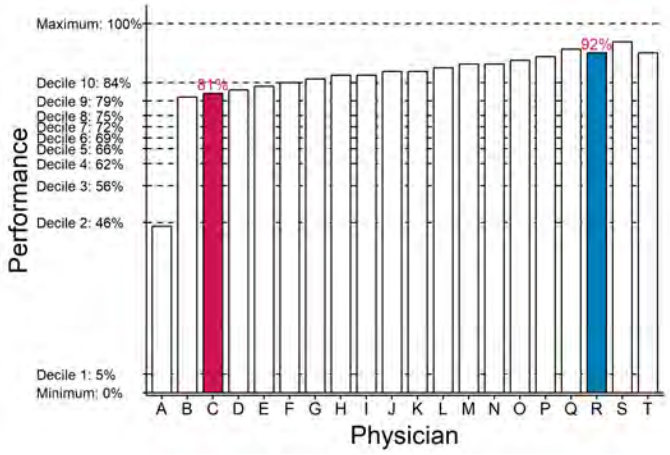


Figure 3.5
Quality Performance in 2028 Compared to 2028 Benchmark

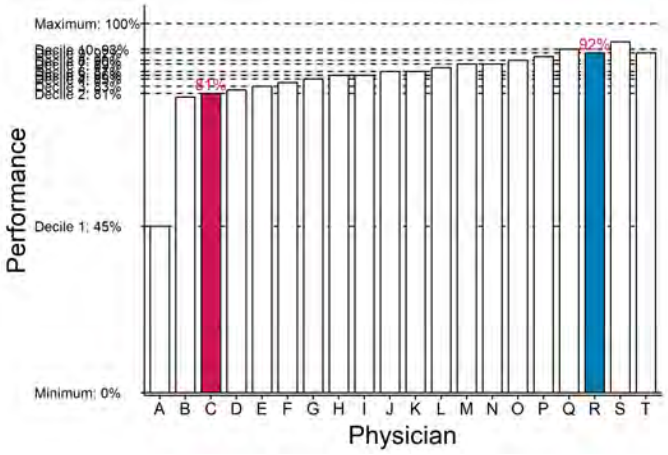


Figure 3.6
Rewards for Improvement Under Different Benchmark Periods

Physician	Patients Meeting Quality Standard in 2027	Patients Meeting Quality Standard in 2028	Change in Quality of Care	2027 Quality Score	2028 Quality Score	Change in Score	Score Using 2027 as Benchmark	Score Using 2028 as Benchmark	Difference in Scores
A	5%	45%	40%	1.0	1.0	0.0	1.9	1.0	−0.9
B	45%	80%	35%	1.9	1.9	0.0	9.2	1.9	−7.3
C	46%	81%	35%	2.0	2.0	0.0	9.4	2.0	−7.4
D	55%	82%	27%	2.9	2.5	−0.4	9.6	2.5	−7.1
E	56%	83%	27%	3.0	3.0	0.0	9.8	3.0	−6.8
F	61%	84%	23%	3.8	3.5	−0.3	10.0	3.5	−6.5
G	62%	85%	23%	4.0	4.0	0.0	10.0	4.0	−6.0
H	65%	86%	21%	4.8	5.0	0.2	10.0	5.0	−5.0
I	66%	86%	20%	5.0	5.0	0.0	10.0	5.0	−5.0
J	68%	87%	19%	5.7	6.0	0.3	10.0	6.0	−4.0
K	69%	87%	18%	6.0	6.0	0.0	10.0	6.0	−4.0
L	71%	88%	17%	6.7	6.5	−0.2	10.0	6.5	−3.5
M	72%	89%	17%	7.0	7.0	0.0	10.0	7.0	−3.0
N	73%	89%	16%	7.3	7.0	−0.3	10.0	7.0	−3.0
O	75%	90%	15%	8.0	8.0	0.0	10.0	8.0	−2.0
P	78%	91%	13%	8.8	8.5	−0.3	10.0	8.5	−1.5
Q	79%	93%	14%	9.0	10.0	1.0	10.0	10.0	0.0
R	83%	92%	9%	9.8	9.0	−0.8	10.0	9.0	−1.0
S	84%	95%	11%	10.0	10.0	0.0	10.0	10.0	0.0
T	90%	92%	2%	10.0	9.0	−1.0	10.0	9.0	−1.0

The problems with using contemporaneous benchmarks have been recognized for many years. When CMS first established the MIPS program, it stated that "benchmarks should be made public and should be known in advance when possible so that MIPS eligible clinicians can understand how they will be measured," [30] and as recently as 2025, CMS stated that "Benchmarks established based on historical data provide MIPS eligible clinicians with helpful performance targets in advance of or during the performance period." [31]

Differences in Cost Scores Will Be Misleading

Although the cost measures in ASM will be scored using standard deviations instead of deciles, specialists will still receive different scores when their performance is similar. The scoring methodology that will be used by CMS will increase or decrease a physician's score by 1 point if their performance differs from the median by one-half of a standard deviation, and the score will change by 2 points if performance differs from the median by one standard deviation, even though it is generally accepted that a difference in performance is not "statistically significant" unless the difference is at least two standard deviations. Moreover, fractional points will be added or deducted for differences that are less than one-half of a standard deviation, even though most such differences would likely be due to random variation in patient characteristics, not differences in the way physicians are delivering care.

Specialists with similar levels of spending can receive very different scores in ASM..

For example, Figure 3.7 shows what the benchmarks for the Heart Failure and Low Back Pain cost measures in ASM would be if the episode spending amounts for ASM specialists were similar to the spending amounts in 2024 for physicians in MIPS. The median cost for Low Back Pain was $1,866.68 and the standard deviation was $570.57. Under the ASM benchmarking methodology, a physician whose patients have average spending of $1,867 would receive a score of 6.0 whereas a physician with average spending of $1,582 will receive a score of 7.0, even though the spending amounts differ by less than $300. The difference is only one half of a standard deviation, which means that it is more likely to be due to random variation among their patients than to a difference in the way the physicians practice.

In addition, because of the way the cost measures are scored, specialists in ASM will likely appear to be "less efficient" in treating heart failure and low back pain than physicians who are not in ASM. MIPS awards 7.5 points to a physician with average spending at the median level instead of the 6.0 points awarded in ASM, so clinicians will receive higher scores in MIPS than in ASM even if they have the same average spending per patient.

Figure 3.7
MIPS Benchmarks for ASM Cost Measures

Points	Heart Failure	Low Back Pain
1.00 - 1.99	$23,031.03 → $21,152.40	$3,293.10 → $3,007.82
2.00 - 2.99	$21,152.38 → $19,273.75	$3,007.82 → $2,722.54
3.00 - 3.99	$19,273.74 → $17,395.10	$2,722.53 → $2,437.26
4.00 - 4.99	$17,395.10 → $15,516.46	$2,437.24 → $2,151.97
5.00 - 5.99	$15,516.45 → $13,637.82	$2,151.96 → $1,866.68
6.00 - 6.99	$13,637.80 → $11,759.17	$1,866.68 → $1,581.40
7.00 - 7.99	$11,759.16 → $9,880.52	$1,581.39 → $1,296.12
8.00 - 8.99	$9,880.51 → $8,941.20	$1,296.11 → $1,153.47
9.00 - 9.99	$8,941.19 → $8,001.88	$1,153.46 → $1,010.83
10.00	$8,001.87 → $0.00	$1,010.82 → $0.00

ASM Will Reward Cherry-Picking Patients

Because contemporaneous benchmarking will be used to score performance on the cost measures, there is no guarantee that physicians who find ways to reduce spending on their patients will receive a better cost score. Similar to the example shown in Figure 3.6 for quality measures, if most physicians reduce spending (or control the growth in spending), some of them will receive worse cost scores even though average spending on their patients has improved (i.e., decreased).

As explained in Section 3.1, because of the inadequate risk adjustment in the cost measures, physicians who treat less complex

patients will have lower average spending and thereby receive better scores on the cost measures. This means that instead of rewarding physicians for reducing spending, ASM will reward them for treating only low-complexity patients.

ASM Will Discourage Collaboration and Team-Based Care

The scoring approach used in ASM could have a chilling effect on collaboration among specialists who treat heart failure and low back pain. An ASM participant who improves their performance on the quality or cost measures will not receive a better score unless other physicians fail to improve. If a specialist develops a better way of delivering care, sharing that knowledge with other ASM participants so they can also improve could reduce or eliminate any reward for the innovative specialist.

ASM participants who are part of a group practice will be evaluated individually based on the specific patients they treat, rather than how the group as whole performs. Because of the inadequate risk adjustment in the cost and quality measures, a member of the practice who focuses their services on more complex patients will be more likely to see their payments cut.

3.4. Inappropriate and Burdensome Requirements for Improvement Activities

In MIPS, physicians have the flexibility to choose from over 90 different types of Improvement Activities based on which activities they believe will be both feasible for their practice and beneficial for their patients, and they receive a higher overall MIPS score if they engage in such activities.

In contrast, in ASM, specialists are not permitted to determine what improvement activities would be most useful. Specialists in ASM are required to perform the specific set of tasks that CMS has defined as "improvement activities," and CMS will reduce the specialist's overall performance score by as much as 20 points if they fail to perform these tasks. CMS requires that:

- specialists in ASM must "confirm" that each of their patients has "access to primary care services" and if not, to "assist the ASM beneficiary in finding a clinician who provides primary care services."
- specialists in ASM must communicate "relevant" information back to the beneficiary's primary care provider following the beneficiary's visit with the specialist.
- specialists in ASM must determine whether their patients have been screened for health-related social needs (HRSN) by their PCP, and if not, to "encourage the primary care services provider to conduct the screening or allow the ASM participant to conduct the health-related social needs screening."
- specialists in ASM must have at least one "executed collaborative care arrangement (CCA)" with "a primary care practice with which the ASM participant shares ASM beneficiaries." The CCA must include elements such as data sharing, protocols for co-management of patients and transitions of care, processes for referral, and documentation of care coordination activities.

These requirements are both burdensome and inappropriate:

- It is widely recognized that there is a significant shortage of primary care physicians in the country. It is impossible for a specialist to communicate with a beneficiary's PCP if the beneficiary does not have a PCP. It is unrealistic to expect that the specialists in ASM will be able to help beneficiaries find a PCP if there are no PCPs available in their community.
- If the patient does have a PCP, the ASM requirements imply that an ASM specialist is required to communicate information to that PCP even if the patient does not want them to do so. Similarly, the ASM requirements imply that every patient should receive a health-related social needs screening whether they want one or not.
- For the subset of the specialist's patients who do have a PCP, those PCPs will likely work for many different practices. It will be extremely burdensome for a specialist to develop formal agreements with all or most of these primary practices, particularly since the specialist may only be seeing one or a few patients from each individual primary care practice. Although ASM only requires one such "collaborative care arrangement," there is limited value in having one agreement with one primary care practice that shares only a few patients with the specialist.
- There is no requirement that any primary care practice execute a "Collaborative Care Arrangement" with any of the specialists in ASM, and there is no compensation for the time that would be required for them to do so, so it could be very difficult for specialists to convince busy primary care practices to engage in these agreements and for specialists to meet this requirement. If only a small number of the primary care practice's patients receive services from the specialist, there would be limited benefit for the primary care practice to have a collaborative care arrangement with that specialist.
- Specialists who work in specialty-specific practices will have greater difficulty meeting the requirement for a "collaborative care arrangement" than specialists who are part of a multi-specialty practice that includes primary care physicians.
- There is no additional payment under ASM to help specialists cover the time and administrative costs associated with carrying out the activities CMS requires, so the required "improvement activities" represent a new, unfunded mandate on specialists who care for patients with heart failure and low back pain. As explained in Section 4, most physicians will have their total payments reduced under ASM, and these unreimbursed costs would increase financial losses for physician practices.

3.5. Burdensome and Unnecessary Requirements for Promoting Interoperability

Beginning in 2028, ASM will also penalize specialists unless they meet a large number of requirements for "Promoting Interoperability." In order to avoid a penalty, a specialist must:

- possess and use certified electronic health record technology (CEHRT);
- conduct a security risk assessment;
- conduct a SAFER (Safety Assurance Factors for EHR Resilience) self-assessment;
- use e-prescribing for all prescriptions;
- query a Prescription Drug Monitoring Program (PDMP) for at least one opioid if opioids are prescribed;
- send and receive patient health information electronically;
- provide patients with electronic access to their health information;
- submit immunization data to a public health immunization registry/immunization information system (IIS) and obtain immunization forecasts and histories from that system; and
- make arrangements to electronically submit information on patients with reportable conditions to a public health agency.

In 2027, specialists are only required to use certified electronic health record technology.

CMS claims that these requirements will "enhance the quality of care, reduce costs by encouraging upstream chronic condition management, empower patients to engage in their care, or promote collaboration between specialists and primary care,"[32] but no evidence is provided to show that any of these requirements will do that.

ASM participants will inherently have an incentive to utilize EHRs, HIEs, e-Prescribing, patient portals, and other electronic systems if that will help them improve outcomes and control costs for their patients. If a specialist is already using these systems, forcing them to submit documentation to CMS will create an unnecessary burden. If they are unable to do all of these things due to resource limitations or other barriers, ASM will penalize them financially rather than provide additional resources to help them do so.

In contrast to MIPS, there is no increase the ASM performance score for meeting any of these requirements. Instead, a physician can *lose* up to 10 points on their final score in ASM based on how many of the requirements they *fail* to meet.

It will likely be more difficult for solo practitioners and physicians in small practices to comply with all of these requirements. Although the Small Practice Adjustment in ASM (which is discussed in more detail in Section 3.7) would offset a negative score on the Promoting Interoperability component, it is unlikely that the Small Practice Adjustment would be able to offset lower scores on the other components of ASM in addition to a penalty on the Promoting Interoperability requirement.

Although the Promoting Interoperability requirements in ASM are essentially identical to those in MIPS, CMS explicitly indicated that the requirements in ASM could differ from MIPS in the future. As explained in Section 1, a specialist could be forced to switch from ASM to MIPS or from MIPS to ASM in every year. Requiring physicians to comply with different requirements from one year to the next could be burdensome and costly for them, and ASM provides no additional payments to participating specialists to cover these costs.

3.6. Inadequate Adjustments for Low Income Patients

The Importance of Adjusting Scores for Physicians Serving Low-Income Patients

It is also widely recognized that lower-income patients have greater difficulty obtaining all of the healthcare services they need because the services are not available in the area where they live, because there is inadequate capacity to serve all patients, or because the patients cannot afford the services. Because of this, specialists who treat lower income patients will be more likely to receive lower scores on the quality measures, cost measures, and improvement activities that ASM uses to evaluate their performance. For example:

- the blood pressure control measure used in ASM does not include any adjustment for patients who do not have access to healthy foods or who cannot afford blood pressure medications. As a result, physicians who treat more of these patients will likely have lower scores on the measure.
- the low back pain cost measure used in ASM does not include any adjustment for patients who cannot afford or do not have access to physical therapy, other non-surgical treatments, and home-based rehabilitation. These patients will be more likely to need inpatient care, and ASM specialists who treat these types of patients will likely have higher average spending than specialists who do not.
- the requirement in ASM that the specialist assist patients in finding a PCP does not exempt physicians whose patients who live in areas where there is little or no access to PCPs. As a result, specialists who treat these types of patients will be more likely to receive penalties for failing to comply with this requirement.

The Complex Patient Scoring Adjustment

CMS has acknowledged that these issues exist. When ASM was announced, CMS stated:

Social and medical risk factors, such as income and co-occurring chronic conditions, play a major role in health status and, accordingly, the types of services and procedures furnished to a beneficiary. Physicians may face unique challenges delivering care to those with more "patient complexity" …[33]

However, CMS did not modify the individual measures to address these issues. CMS said that "adjustments made at the quality measure or ASM quality performance category level would undermine our core aim to promote direct accountability and high-quality outcomes for all beneficiaries." Instead, CMS included a "Complex Patient Scoring Adjustment" in the formula used to determine a physician's overall Performance Score.

The process for determining the Complex Patient Scoring Adjustment for an individual specialist is itself extremely complex. CMS will perform the following steps in order to determine the size of the Adjustment:

1. **determine the HCC Risk Scores for all specialists.** The average hierarchical condition category (HCC) risk score for each specialist's patients in the current year and the prior year are calculated.
2. **determine the Dual Eligible Proportions for all specialists.** The "dual eligible proportion" (i.e., the percentage of Medicare patients who are also on Medicaid) is calculated for each specialist's patients in the current year and the prior year.
3. **calculate the mean, median, and standard deviations for the HCC Risk Scores and the Dual Eligible Proportions in the previous year for specialists in the same ASM cohort.** The means, medians, and standard deviations of the HCC Scores and Dual Eligible Proportions for all of the specialists in each ASM cohort are calculated (i.e., separate values are calculated for the specialists who treat patients with heart failure and for the specialists who treat patients with low back pain).
4. **calculate the "Standardized HCC Score" for each specialist.** Each physician's HCC Score in the current year is "standardized" by calculating the difference between the physician's current score and the mean of the scores for the prior year, and then dividing by the standard deviation of the prior year scores.
5. **calculate the "Standardized Dual Proportion" for each specialist.** The Dual Eligible Proportion for each specialist in the current year is "standardized" by calculating the difference between the physician's current score and the mean of the scores for the prior year, and then dividing by the standard deviation of the prior year scores.
6. **calculate the Medical Complex Patient Scoring Adjustment Component.** The Standardized HCC Risk Score for each specialist is multiplied by 4 and the result is increased by 1.5 to determine this component.
7. **calculate the Social Complex Patient Scoring Adjustment Component.** The Standardized Dual Proportion for each specialist is multiplied by 4 and the result is increased by 1.5 to determine this component.
8. **calculate the Complex Patient Scoring Adjustment for the specialist.** The Medical Complex Patient Scoring Adjustment Component and the Social Complex Patient Scoring Adjustment Component are added together to determine the Complex Patient Scoring Adjustment. However, if the sum is greater than 10, the Complex Patient Scoring Adjustment is capped at 10 points. In addition, if the specialist's non-standardized HCC Risk Score and Dual Eligible Proportion are both less than the respective median scores from the prior year for the specialists in the same ASM cohort, then the specialist's Complex Patient Scoring Adjustment is set to zero.

A One-Size-Fits-All Approach for Different Health Problems

This is the same complicated formula that has been used for the Complex Patient Adjustment in the MIPS program since 2022. CMS provided no information showing that the same formula was appropriate for use in ASM. In fact, it is difficult to believe that the exact same formula is appropriate for both patients with heart failure and patients with low back pain, particularly since different quality and cost measures are used for patients with each of those conditions.

CMS said that it is using the same formula as in the MIPS program because it wanted to "reduce confusion for participants who have previously participated in MIPS."[34] (CMS apparently does not believe the many other differences between ASM and MIPS would cause similar "confusion.")

Risk Indicators are Not Specific to the ASM Patients

It appears that CMS plans to calculate both of the "risk indicators" (the HCC Risk Score and the Dual Eligible Proportion) based on *all* of the Medicare beneficiaries treated by the ASM specialists, not just those who have heart failure or low back pain, even though the cost measures and many of the quality measures used in ASM are specific to patients with heart failure and low back pain.

As a result, a specialist who treats a large number of low-income patients with heart failure or low back pain might not qualify for a Complex Patient Adjustment if most of the other patients they treat are not on Medicaid. Conversely, a specialist might receive a large adjustment even if the heart failure and low back pain patients they treat do not have low incomes.

HCC Risk Scores Do Not Adequately Assess Medical Complexity

The HCC Risk Score was developed to risk adjust total spending for Medicare Advantage plans. It was not designed to adjust for differences in patient outcomes or for spending on specific types of patients or health conditions. There is no difference in the HCC Risk Score for heart failure patients in more advanced stages of the disease, even though they will need more services and experience more complications than those in earlier stages.

Also, the HCC Risk Score is a *prospective* risk adjustor, not a *concurrrent* adjustor, which means that if a patient is experiencing an acute health problem during the current year that affects the way the specialist treats them, that will not be reflected in the HCC Risk Score, and if the patient is diagnosed with a new chronic condition, that will not affect the HCC Risk Score until a future year.

As a result, two physicians could have the same average HCC Risk Score even though one is treating much sicker patients.

Physicians Who Treat Rural Patients Could Be Penalized

Studies have shown that patients who live in rural communities are likely to have lower HCC Risk Scores than patients in urban areas even if they have the exact same health problems, because urban providers are more likely to code patients with additional diagnoses.

As a result, a physician treating patients from rural areas could receive a smaller Complex Patient Scoring Adjustment even if their patients were sicker than those treated by other physicians.

The Dual Eligible Proportion Does Not Adequately Assess Income-Related Barriers to Health Care

The Dual Eligible Proportion is used because it is easy for CMS to calculate, not because it accurately assesses how many of a physicians' patients are likely to experience barriers in accessing care. Many patients face barriers in obtaining healthy food, accessing medical services, etc. regardless of whether they are on Medicaid. Moreover, because of differences in the Medicaid payment rates in different states, patients who have Medicaid will have a harder time obtaining the same service in some states than others.

In addition, because different states have different Medicaid eligibility standards, physicians in some states will have lower Dual Eligible Ratios and receive smaller Complex Patient Scoring Adjustments even though a similar proportion of their patients are poor.

Specialists Who Treat the Poorest and Sickest Patients Will Be Penalized Under ASM

As shown in Figures 3.8 and 3.9, for most ASM participants, less than 20% of their patients are on Medicaid. However, some have much higher proportions, including some for whom the majority of their patients are on Medicaid. These physicians are likely to have lower scores on the cost and quality measures because of the greater challenges their patients face in managing their conditions.

Figure 3.11 shows that most of the specialists who are being required to participate in the Low Back Pain cohort of ASM have average HCC scores under 1.6, but Figure 3.10 shows that most of the specialists in the Heart Failure cohort have average HCC scores higher than that. Physicians whose patients have significant numbers of comorbidities are likely to have lower scores on the cost and quality measures because of the additional services and different treatments that the patients need.

In the formula for the Complex Patient Scoring Adjustment, the Medical component is higher if the HCC Risk Score is higher and the Social Component is higher if the Dual Eligible Proportion is higher. However, when the two are added together to create the Complex Patient Scoring Adjustment, the total is capped at 10.

This means that the physicians who have the most complex patients – particularly those with both high HCC Risk Scores and high Dual Eligible Proportions – will receive the same Complex Patient Scoring Adjustment as physicians with far less complex patients. Figures 3.12 and 3.12 show that for 12% of the specialists currently assigned to participate in ASM, the sum of the Medical and Social components would be greater than 10, but their Adjustment would be capped at 10. For some, the uncapped total would be as high as 50, so capping their score at 10 would be a significant disadvantage.

For example, as shown in Figures 3.15 and 3.17 for the Low Back Pain cohort:

- two physicians whose patients have an average HCC Risk Score of 1.45 would each receive the same 10 point adjustment even if 94% of the Medicare beneficiaries are on Medicaid for one physician but only 40% are on Medicaid for the other. Without the cap, the adjustment would have 20 points higher for the physician with 94% of their patients on Medicaid.
- two physicians who have 40% of their Medicare beneficiaries on Medicaid would receive the same 10 point adjustment even if one physician's patients had an average HCC score of 3.78 and the other had an average score of only 1.27, whereas in the absence of the cap, the first physician would have received 35 additional points.

The disparities would be even greater for the Heart Failure cohort because of the larger variation in the risk measures. As shown in Figures 3.14 and 3.16:

Figure 3.8
Percentage of Patients on Medicaid for ASM Heart Failure Specialists

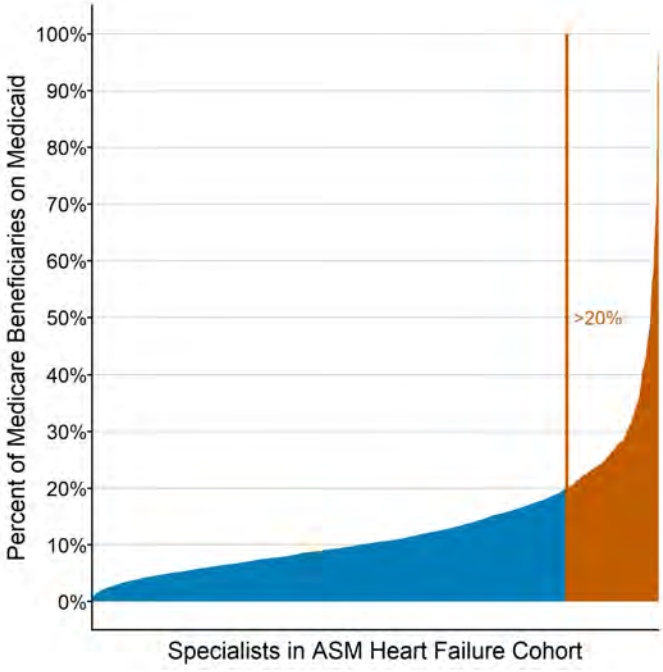


Figure 3.9
Percentage of Patients on Medicaid for ASM Low Back Pain Specialists

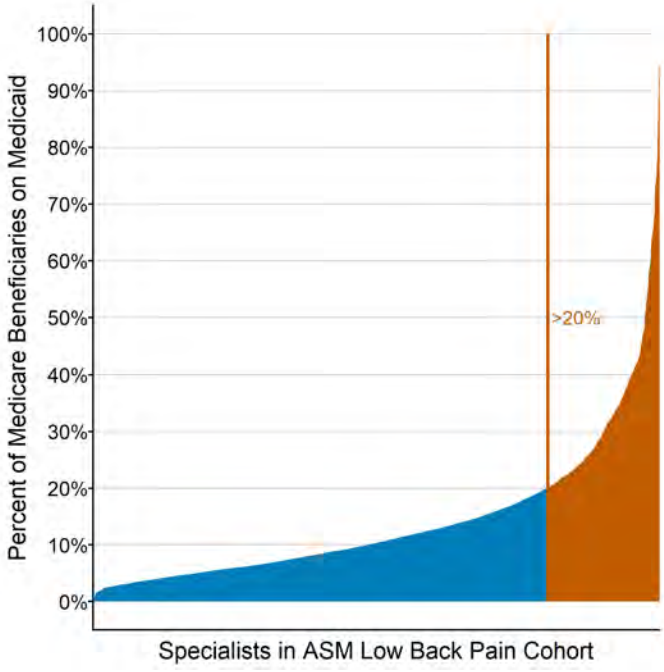


Figure 3.10
Average HCC Scores for ASM Heart Failure Specialists

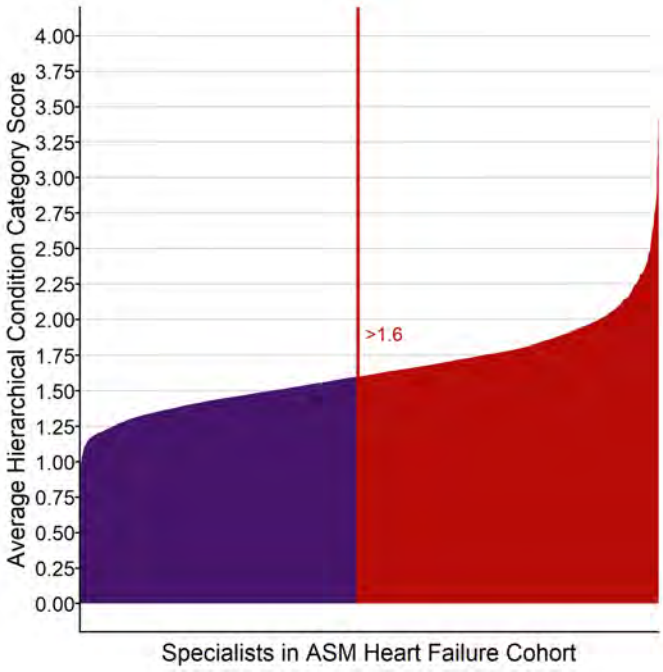


Figure 3.11
Average HCC Scores for ASM Low Back Pain Specialists

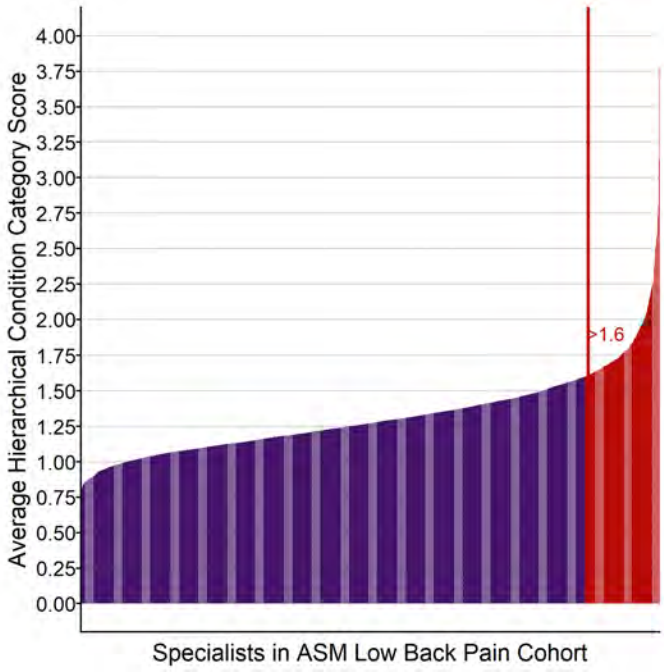


Figure 3.12
Combined Complexity Score and Complex Patient Adjustment for ASM Heart Failure Specialists

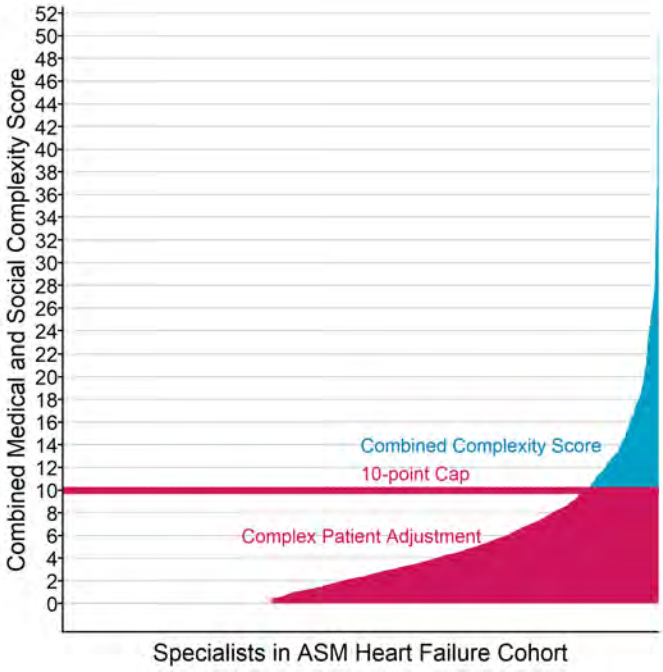


Figure 3.13
Combined Complexity Score and Complex Patient Adjustment for ASM Low Back Pain Specialists

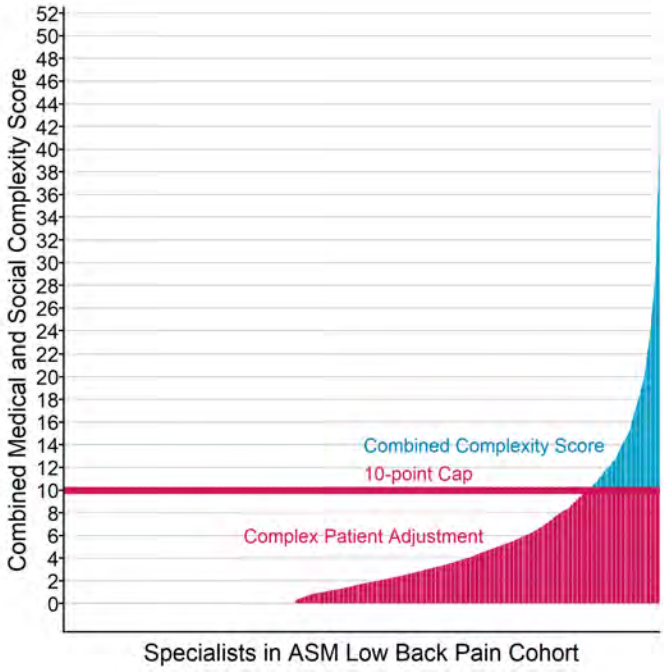


Figure 3.14
Uncapped Complex Patient Scoring Adjustment for Heart Failure Specialists

Average HCC Score	Percentage on Medicaid							
	0%	7%	10%	16%	24%	31%	57%	97%
0.96	0.0	0.0	0.4	2.7	5.8	8.4	18.3	33.5
1.45	0.0	0.0	0.4	2.7	5.8	8.4	18.3	33.5
1.61	1.1	1.1	1.5	3.8	6.9	9.5	19.4	34.6
1.79	3.5	3.5	3.9	6.2	9.3	11.9	21.8	37.0
2.01	6.4	6.4	6.8	9.1	12.2	14.8	24.7	39.9
2.17	8.6	8.6	9.0	11.3	14.4	17.0	26.9	42.1
2.62	14.7	14.7	15.2	17.4	20.5	23.2	33.0	48.2
3.41	25.4	25.4	25.8	28.1	31.2	33.8	43.6	58.9

Figure 3.15
Uncapped Complex Patient Scoring Adjustment for Low Back Pain Specialists

Average HCC Score	Percentage on Medicaid							
	0%	6%	10%	18%	30%	40%	67%	94%
0.77	0.0	0.0	0.3	2.5	6.3	9.5	17.9	26.6
1.13	0.0	0.0	0.3	2.5	6.3	9.5	17.9	26.6
1.27	0.8	0.8	1.1	3.4	7.2	10.4	18.8	27.5
1.45	3.3	3.3	3.6	5.9	9.7	12.8	21.3	30.0
1.66	6.2	6.2	6.5	8.8	12.6	15.8	24.2	32.9
1.82	8.5	8.5	8.8	11.0	14.8	18.0	26.4	35.1
2.31	15.3	15.3	15.6	17.8	21.6	24.8	33.2	41.9
3.78	35.8	35.8	36.1	38.3	42.1	45.3	53.7	62.4

Figure 3.16
Capped
Complex Patient Scoring Adjustment
for Heart Failure Specialists

Average HCC Score	Percentage on Medicaid							
	0%	7%	10%	16%	24%	31%	57%	97%
0.96	0.0	0.0	0.4	2.7	5.8	8.4	10.0	10.0
1.45	0.0	0.0	0.4	2.7	5.8	8.4	10.0	10.0
1.61	1.1	1.1	1.5	3.8	6.9	9.5	10.0	10.0
1.79	3.5	3.5	3.9	6.2	9.3	10.0	10.0	10.0
2.01	6.4	6.4	6.8	9.1	10.0	10.0	10.0	10.0
2.17	8.6	8.6	9.0	10.0	10.0	10.0	10.0	10.0
2.62	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0
3.41	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0

Figure 3.17
Capped
Complex Patient Scoring Adjustment
for Low Back Pain Specialists

Average HCC Score	Percentage on Medicaid							
	0%	6%	10%	18%	30%	40%	67%	94%
0.77	0.0	0.0	0.3	2.5	6.3	9.5	10.0	10.0
1.13	0.0	0.0	0.3	2.5	6.3	9.5	10.0	10.0
1.27	0.8	0.8	1.1	3.4	7.2	10.0	10.0	10.0
1.45	3.3	3.3	3.6	5.9	9.7	10.0	10.0	10.0
1.66	6.2	6.2	6.5	8.8	10.0	10.0	10.0	10.0
1.82	8.5	8.5	8.8	10.0	10.0	10.0	10.0	10.0
2.31	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0
3.78	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0

- two physicians with an average HCC Risk Score of 2.01 would each receive the same 10 point adjustment even if one has 24% of their patients on Medicaid and the other has 97%. In the absence of the cap, the latter physician would have received a 39.9 point adjustment.

Section 3.8 provides an example of how the cap can penalize physicians who treat a high percentage of low-income patients.

No Additional Resources to Address Greater Patient Needs

CMS justifies using a Complex Patient Scoring Adjustment based on a 2020 HHS report titled *Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.*[35] That report recommended that instead of adjusting quality measures for social risk factors, CMS should provide higher payments to physicians and other health care providers so that they have adequate resources to achieve similar levels of quality. It also recommended that CMS should provide supplemental benefits to help physicians address beneficiaries' social needs.

The Complex Patient Scoring Adjustment does neither of these things. Since the adjustment is intended to offset the lower scores on quality measures that a physician would be expected to receive for treating a more complex patient population, it would at best prevent a physician from receiving a larger penalty than other physicians, it would not result in *higher* payments to the physician or give them the ability to deliver additional services to their patients.

Nothing else in ASM would provide additional resources to help specialists who treat disadvantaged patients. For example, ASM would not provide any payments for home blood pressure monitoring equipment even though cardiologists would be accountable for improving blood pressure, and ASM would not provide any payments for home therapy equipment even though the physicians in ASM would be accountable for the cost of treatment for low back pain patients. As will be discussed in Section 4, the majority of physicians in ASM will receive a cut in their payments, so in most cases, physicians who are caring for low-income patients would experience a cut in pay if they are forced to participate in ASM, rather than receiving increased resources so they can adequately address their patients' needs.

3.7. Arbitrary Adjustments for Practice Size

Some physicians in ASM will receive a "Small Practice Scoring Adjustment" because CMS believes "it is necessary to support ASM participants against the potential challenges that they face in participation in Innovation Center models and other CMS value-based payment programs."[^SmallPractice] [^SmallPractice]: 90 FR 49674

Specialists in a practice that has 15 or fewer physicians will receive 10 points in addition to the points they receive for performance on quality and cost measures and the Complex Patient Scoring Adjustment. Physicians who are solo practitioners (i.e., there are no other physicians or other clinicians in their practice) will receive 15 points.

CMS said that it determined the magnitude of the Small Practice Scoring Adjustment based on an analysis of differences in MIPS scores for small and solo practices vs. larger practices. Figure 3.18 confirms that, for the ASM participants who participated in MIPS in 2024, the average MIPS score for small practices was about 10 points lower than the average for large practices and the average for solo practices was 16 points lower than the average for large practices. However, since the MIPS scores were calculated using different measures and a different formula, it is not clear whether the differences in performance scores in ASM will be larger or smaller than the differences in MIPS.

Figure 3.18
Average MIPS Scores in 2024
for ASM Participants

Type of Practice	Average Score
Large Practice	84.6
21-25 Member Practice	78.1
16-20 Member Practice	75.9
Small Practice	74.2
11-15 Member Practice	79.4
6-10 Member Practice	78.1
3-5 Member Practice	72.1
2 Member Practice	76.0
Solo Practice	69.6
All Practices	80.8

Some small practices and solo practitioners will likely face more challenges in meeting the ASM requirements than others, but CMS is not making adjustments for those who are having problems, it is awarding 10 points to all physicians in small practices and 15 points to all solo practitioners. For some physicians, this will be less than what is needed to prevent them from being unfairly penalized by the burdensome requirements in ASM and the problematic scoring formula.

The large differences in the point levels creates a problematic incentive for physicians to change the legal structure of their practices. For example, the physicians in a two-person practice would be better off reorganizing as two solo practices, since they would each receive 15 points rather than 10. The physicians in a 20-physician practice would be better off reorganizing into two 10-physician practices, since each physician could thereby receive an additional 10 points rather than no points at all.

3.8. Arbitrary Adjustments for Physicians in Rural Areas

CMS will also increase the ASM Performance Score by 5 points for a physician who is "in a rural area."[36] A "rural area" is defined as a zip code that is classified as rural by the Federal Office of Rural Health Policy (FORHP).[37] Although CMS does not define exactly what it means for a specialist to be "in" a rural area, it presumably means that the zip code for the physician's practice address is rural. As discussed in Section 2.3, some specialists are based in urban areas but travel to rural communities to see patients; these specialists would not benefit from the Rural Scoring Adjustment.

Figure 3.19
Differences in 2024 MIPS Scores
For Rural ASM Participants

Type of Practice	Average Score
Large Rural Practice	83.9
Large Non-Rural Practice	84.6
Small Rural Practice	73.1
Small Non-Rural Practice	74.3
Solo Rural Practice	72.1
Solo Non-Rural Practice	69.4
All Practices	80.8

In 2025, in the regulation that created ASM, CMS said that it had considered establishing a rural scoring adjustment but had decided not to because it "found in our analysis of historical MIPS performance data among likely ASM participants there was not a systematic difference in the performance data between likely ASM participants in rural and non-rural participants."[38] Figure 3.19 confirms there was almost no difference in the MIPS scores for ASM physicians in rural areas after controlling for practice size.

However, in the 2027 Physician Fee Schedule regulation, CMS reversed itself and will now use a rural scoring adjustment. Providing an additional 5 points to physicians in rural areas will cause them to receive smaller payment cuts or larger payment bonuses than other physicians even if their performance on quality and cost measures is identical. In addition, however, Section 4.5 shows that the rural scoring adjustment would cause physicians who are not in rural areas to receive larger payment cuts or smaller payment bonuses than they otherwise would receive, including physicians in small practices.

As explained in Section 2, ASM will harm rural communities, but it will do so by forcing specialists in small rural communities into ASM while exempting specialists in most large urban regions. This problem is not solved by adding an additional 5 points to the scores of physicians in all rural areas.

3.9. Problems Caused by the Way Overall Performance is Scored

A Complex Formula for Calculating the Performance Score

After the end of each year, CMS will calculate an overall Performance Score for each specialist who was required to participate in ASM during that year. The Performance Score will be used to determine the amount by which the specialist's Medicare payments will be increased or decreased the year after the score is calculated.

The Performance Score will be calculated using the seven different components described in the previous sections:

1. the scores the specialist receives for each of the applicable quality measures;
2. the score the specialist receive for the applicable cost measure;
3. whether the specialist carried out the required Improvement Activities;
4. whether the specialist met the Promoting Interoperability requirements imposed by CMS;
5. the Complex Patient Scoring Adjustment that is calculated for the specialist based on the medical and social characteristics of their patients;
6. the Small Practice Scoring Adjustment, if any, that is awarded based on the size of the specialist's practice; and
7. the Rural Scoring Adjustment for physicians located in rural areas.

A complex process will be used to combine these seven components into the Performance Score:

1. the scores the specialist receives on each of the applicable quality measures will be averaged and converted to a Quality Performance Category Score that ranges from 0 to 100 points;
2. the score the specialist receives on the applicable cost measure will be rescaled to create a Cost Performance Category Score that ranges from 0 to 100 points;
3. the Quality and Cost Performance Category Scores will be averaged (each is weighted by 50% and then the weighted amounts are summed) to create a combined score ranging from 0 to 100 points;
4. the combined score may be reduced by 10 or 20 points based on the score the specialist receives for Improvement Activities;
5. the resulting amount may be reduced by up to 10 points based on the score the specialist receives for the Promoting Interoperability requirements;
6. the resulting amount may also be increased by up to 10 points based on the Complex Patient Scoring Adjustment;
7. the resulting amount will be increased by up to 15 points based on the Small Practice Scoring Adjustment (15 points if the specialist is a solo practitioner and 10 points if the specialist is not a solo practitioner but is part of a small practice); and
8. the final amount will be increased by 5 points if the specialist is located in a rural area.

An example of this complex calculation is shown in Figure 3.20 for a cardiologist.

High Quality Care May Not Result in a High Performance Score

One might expect that the specialists who provide the highest-quality care would receive Performance Scores close to 100. However, under the ASM scoring methodology, it is unlikely that many specialists would receive a score that high even if they deliver very high quality care. There are multiple reasons for this:

- First, less than half of the overall Performance Score will based on how the specialist performs on quality measures. An equal amount will be based on the specialist's cost score, which will depend on the difference between the average spending on the specialist's patients and the median amount for other ASM participants. Since a physician at the median spending level will receive 6.0 points and the scoring categories are based on standard deviations, a specialist's average spending would have to be 1.5 standard deviations or more below the median in order to receive a cost score of 10. Statistically, fewer than 10% of physicians would be likely to have average spending that low, and most physicians will have a score between 4.0 and 8.0 points. As a result, even if a physician receives the maximum score of 10 on every quality measure, the Performance Score based on the combined cost and quality scores would likely be less than 90 (100 quality points x 0.5 + 80 cost points x 0.5), and it is more likely that it would be 80 or less.
- In addition, failure to comply with one or more of the required "improvement activities" or to meet all of the requirements for "promoting interoperability" could reduce a specialist's Performance Score by as much as 30 points. As a result, even if a specialist had a combined cost and quality score of 90 or 100, their final Performance Score might be only 60 or 70 as a result of the negative adjustments.

This is illustrated in the example in Figure 3.20. Although performance on all of the quality measures is above the median for the cardiologists in ASM and the quality score is over 80, the total Performance Score is less than 70 due to the effects of the other factors in the formula.

Figure 3.20
Example of How the ASM Performance Score is Determined

Measure	Performance	Score	Pct of Max	Points
Quality				
ACE/ARB for LVSD	100%	10.0		
Beta Blocker for LVSD	100%	10.0		
Controlling High Blood Pressure	73%	7.3		
Functional Status Assessment for Heart Failure	3%	7.2		
CV-Related Admissions for Heart Failure Patients	66%	7.6		
Quality Subtotal		42.1	84%	42.1
Cost				
Heart Failure Cost	$12,500	6.6		
Cost Subtotal		6.6	66%	33.0
Improvement				
Access to Primary Care	Yes	10.0		
Collaborative Care Arrangements	No	0.0		
Improvement Adjustment		10.0	50%	−10.0
Interoperability				
Use of EHR	Yes			
Security Risk Analysis	Yes			
EHR Safety	Yes			
E-Prescribing	90%	9.0		
Prescription Drug Monitoring	Yes	10.0		
Health Information Exchange	80%	24.0		
Patient Access to Health Info	80%	20.0		
Public Health Data Exchange	Yes	25.0		
Interoperability Adjustment		88.0	88%	−1.2
Complexity				
HCC Score	1.50	−0.5		
Dual Eligible Proportion	50%	15.6		
Complexity Adjustment		15.2		10.0
Practice				
Practice Size	Large	0.0		
Practice Adjustment		0.0		0.0
Rural				
Rural	Urban	0.0		
Rural Adjustment		0.0		0.0
All				
Total				73.9

A specialist in a small practice or a solo practitioner could receive a score of 100 if their quality and cost scores were close to 90, because they would receive an additional 10-15 points based on their practice size. However, since the rationale for providing the practice adjustments is that small practices and solo practitioners will likely have lower scores on cost and quality measures and/or have a harder time meeting the ASM requirements, the positive practice size adjustment may at best offset a portion of the negative adjustments for improvement activities or promoting interoperability, rather than make the total score higher than the combined quality and cost scores. When CMS announced the ASM program, the scoring calculation example it used included a 10 point increase from a small practice adjustment but it also included a 10 point reduction for failure to perform one of the required improvement activities, so the net result of those two adjustments was 0.[39]

If a large percentage of a specialists' patients have multiple or serious comorbidities and/or are on Medicaid, the specialist will qualify for a Complex Patient Scoring Adjustment. However, since the stated rationale for including the Complex Patient Scoring Adjustment is that physicians who treat patients with higher medical and/or social complexity tend to have worse scores on quality and/or cost measures, the Complex Patient Scoring Adjustment may simply offset lower quality and cost scores rather than result in higher Performance Scores than other ASM participants.

Lower Performance Scores May Not Reflect Lower Quality Care

Under ASM, a lower Performance Score will not necessarily mean the specialist is providing poor quality care. This is a result of both the complex and arbitrary formula used to calculate the Performance Score and the problematic benchmarking methodologies used for the quality and cost scores.

For example, Figure 3.21 shows two hypothetical physicians who each have 100 heart failure patients:

- Specialist A has performance levels on all quality measures that result in the highest possible quality scores and they have average spending equal to the median among all ASM heart failure participants. This specialist is able to implement all of the required Improvement Activities and meet all of the Promoting Interoperability requirements.
- Specialist B fails to achieve the quality standards for one of the 100 patients, so their quality performance levels are one percentage point worse than the patients seen by Specialist A. The average spending for their patients is the same as the average spending for Specialist A. Specialist B is also able to implement all of the required Improvement Activities and meet all of the Promoting Interoperability requirements.

Figure 3.21
Hypothetical Specialists With Similar Performance

Measure	Specialist A	Specialist B	Difference
Quality			
ACE/ARB for LVSD	100%	99%	-1%
Beta Blocker for LVSD	100%	99%	-1%
Controlling High Blood Pressure	84%	83%	-1%
Functional Status Assessment for Heart Failure	15%	14%	-1%
CV-Related Admissions for Heart Failure Patients	64%	65%	+1%
Cost			
Heart Failure Cost	$11,500	$11,500	0%

Neither specialist is in a small practice, neither is in a rural area, and neither qualifies for a Complex Patient Scoring Adjustment. Figure 3.22 shows that even though their performance on the quality measures is almost identical, their Performance Scores differ by 14 points – a 17% difference. This is due to the problems with the decile benchmarking system discussed in more detail in Section 3.3.

Figure 3.22
Difference in Performance Scores for Hypothetical Specialists With Similar Performance

Measure	Specialist A				Specialist B				Score Difference
	Performance	Score	Pct of Max	Points	Performance	Score	Pct of Max	Points	
Quality									
ACE/ARB for LVSD	100%	10.0			99%	3.7			
Beta Blocker for LVSD	100%	10.0			99%	2.8			
Controlling High Blood Pressure	84%	9.9			83%	9.8			
Functional Status Assessment for Heart Failure	15%	10.0			14%	10.0			
CV-Related Admissions for Heart Failure Patients	64%	9.4			65%	8.7			
Quality Subtotal		49.3	99%	49.3		35.0	70%	35.0	-14.3
Cost									
Heart Failure Cost	$11,500	7.1			$11,500	7.1			
Cost Subtotal		7.1	71%	35.5		7.1	71%	35.5	0.0
Adjustments									
Improvement Adjustment			100%	0.0			100%	0.0	0.0
Interoperability Adjustment			100%	0.0			100%	0.0	0.0
Complexity Adjustment				0.0				0.0	0.0
Practice Adjustment				0.0				0.0	0.0
Rural Adjustment				0.0				0.0	0.0
All									
Total				84.8				70.5	-14.3

Higher Performance Scores May Not Reflect Higher Quality Care

Under ASM, a higher Performance Score will not necessarily indicate that a specialist is delivering higher-quality care. Figure 3.23 shows two hypothetical physicians who have very different performance. Specialist D has much worse performance than Specialist C on every quality measure.

Figure 3.23
Hypothetical Specialists With Different Performance

Measure	Specialist C	Specialist D	Difference
Quality			
ACE/ARB for LVSD	100%	75%	-25%
Beta Blocker for LVSD	100%	75%	-25%
Controlling High Blood Pressure	95%	60%	-35%
Functional Status Assessment for Heart Failure	95%	5%	-90%
CV-Related Admissions for Heart Failure Patients	10%	67%	+57%
Cost			
Heart Failure Cost	$11,500	$8,500	-26.1%

However, Specialist D also has lower average spending because they treat lower-complexity patients and avoid using expensive treatments even if the patient would benefit. In addition, Specialist D is able to meet all of the requirements for Improvement Activities and Promoting Interoperability, while Specialist C is unable to do so.

Neither specialist is in a small practice, neither is in a rural area, and neither qualifies for a Complex Patient Scoring Adjustment. Figure 3.24 shows that even though Specialist D's performance on the quality measures is dramatically lower, their Performance Score is more than 12 points higher than Physician C, a 23% difference.

Figure 3.24
Difference in Performance Scores for Hypothetical Specialists With Different Performance

Measure	Specialist C				Specialist D				Score Difference
	Performance	Score	Pct of Max	Points	Performance	Score	Pct of Max	Points	
Quality									
ACE/ARB for LVSD	100%	10.0			75%	1.1			
Beta Blocker for LVSD	100%	10.0			75%	1.2			
Controlling High Blood Pressure	95%	10.0			60%	3.7			
Functional Status Assessment for Heart Failure	95%	10.0			5%	8.2			
CV-Related Admissions for Heart Failure Patients	10%	10.0			67%	6.5			
Quality Subtotal		50.0	100%	50.0		20.7	41%	20.7	−29.3
Cost									
Heart Failure Cost	$11,500	7.1			$8,500	9.5			
Cost Subtotal		7.1	71%	35.5		9.5	95%	47.5	+12.0
Adjustments									
Improvement Adjustment			0%	−20.0			100%	0.0	+20.0
Interoperability Adjustment			0%	−10.0			100%	0.0	+10.0
Complexity Adjustment				0.0				0.0	0.0
Practice Adjustment				0.0				0.0	0.0
Rural Adjustment				0.0				0.0	0.0
All									
Total				55.5				68.2	+12.7

Specialists Can Be Penalized for Treating Lower-Income Patients

Figure 3.25 shows a hypothetical example of how physicians who treat large numbers of poor patients would be harmed by the ASM scoring. The example assumes that on average, quality measures are lower and average spending is higher for patients on Medicaid than for patients who are not, regardless of which physician is treating them, because of the greater challenges faced by the low-income patients. As a result, a specialist's score on the quality and cost measures will depend on the proportion of patients they have on Medicaid.

Figure 3.25
Hypothetical Differences in Average Performance on Quality and Cost Measures for Patients on Medicaid

Measure	Average Performance for Patients Not on Medicaid	Average Performance for Medicaid Patients	Expected Performance with 20% Medicaid Patients	Expected Score	Expected Performance with 60% Medicaid Patients	Expected Score
Quality						
BMI Screening	97%	92%	96.0%	9.6	94.0%	8.8
Depression Screening	95%	85%	93.0%	9.9	89.0%	9.7
Functional Outcome Assessment	100%	95%	99.0%	1.9	97.0%	1.9
Use of High-Risk Medications	0%	1%	0.2%	6.9	0.6%	6.1
Cost						
Low Back Pain Cost	$1,600	$2,500	$1,780	6.30	$2,140	5.0
Complexity						
HCC Score	1.50	2.00	1.60	5.41	1.80	8.19

Figure 3.26 shows that a specialist with 10% of their patients on Medicaid would have a combined cost and quality score of 69, but a specialist with 40% of their patients on Medicaid would receive a score of only 63, a specialist with 60% of their patients on Medicaid would receive a score of only 58 and a specialist with 90% of their patients on Medicaid would only receive a score

of 52. The Patient Complexity Adjustment would roughly equalize the scores for the specialists with 10-40% of their patients on Medicaid, but because of the 10-point cap, the physicians with more than 40% of their patients on Medicaid would receive scores that are 6-12 points lower than the other physicians. Physicians with high proportions of lower-income patients who do not qualify for Medicaid could receive even lower scores because the Complex Patient Scoring Adjustment does not recognize differences in income, it only adjusts for patients who are on Medicaid.

Figure 3.26
Differences in Performance Scores for Specialists With More Low-Income Patients Based on Hypothetical Differences in Measure Performance

Measure	10% Medicaid	20% Medicaid	40% Medicaid	60% Medicaid	90% Medicaid
Quality					
BMI Screening	9.9	9.6	9.1	8.8	8.3
Depression Screening	10.0	9.9	9.8	9.7	9.4
Functional Outcome Assessment	1.9	1.9	1.9	1.9	1.9
Use of High-Risk Medications	7.3	6.9	6.5	6.1	5.8
Quality Subtotal	29.1	28.3	27.3	26.5	25.4
Cost					
Low Back Pain Cost	6.6	6.3	5.7	5.0	4.1
Cost Subtotal	6.6	6.3	5.7	5.0	4.1
Adjustments					
Improvement	0.0	0.0	0.0	0.0	0.0
Interoperability	0.0	0.0	0.0	0.0	0.0
Practice Size	0.0	0.0	0.0	0.0	0.0
Rural Location	0.0	0.0	0.0	0.0	0.0
Total Adjustments	0.0	0.0	0.0	0.0	0.0
Total Without Complexity Adjustment					
Points from Cost and Quality	69.4	66.9	62.6	58.1	52.2
Complexity					
HCC Score	4.7	5.4	6.8	8.2	10.3
Dual Eligible Proportion	0.2	3.3	9.6	15.8	25.2
Uncapped Complexity Adjustment	4.9	8.7	16.4	24.0	35.5
Capped Complexity Adjustment	4.9	8.7	10.0	10.0	10.0
Total With Complexity Adjustment					
Total Performance Score	74.3	75.6	72.6	68.1	62.2

As a result, physicians with high proportions of low-income patients will be more likely to receive large payment reductions under ASM. The only way for them to avoid payment cuts could be to reduce the number of low-income patients they treat.

Performance Scores Cannot Be Used to Compare Specialist Performance

Because of the serious problems with the methodology used to determine Performance Scores, any patient or primary care physician who attempts to use the scores to determine which specialists are "best" could be making a bad decision. In addition, since specialists' payments will be adjusted up or down based on their Performance Scores, the problems with the scores will cause some physicians who deliver high-quality care to receive a cut in their payments, while some physicians who deliver low-quality care could receive a payment increase.

Moreover, the Performance Score assigned to physicians in ASM will be lower than the MIPS Score assigned to similar physicians who are not in ASM, so patients who see the scores may believe that the ASM physicians deliver lower-quality care. A physician in MIPS who reported the same measures and achieved the same performance as a physician in ASM would receive a much higher score in MIPS because:

- the cost score assigned to the median spending level in MIPS is 7.5 rather than 6.0, so a physician in MIPS will receive a much better cost score than a physician in ASM even with the same average spending level.
- MIPS uses historical benchmarks for quality measures, so a physician in MIPS will likely receive higher quality scores than a physician in ASM even with the same performance on the quality measures.
- the cost and quality scores only represent 60% of the total performance score in MIPS, and because most physicians receive a high score on both the Improvement Activities and Promoting Interoperability components of MIPS, the overall performance score for a physician in MIPS will generally be higher than the average of their cost and quality scores.

Because the scores for the individual components will not accurately reflect differences in the care the physicians provide, the overall Performance Score will be misleading for patients as well as unfair to the physicians.

4. Problems Caused by the Way Payments to Specialists Are Adjusted

- **Most specialists in ASM would have their payments cut regardless of whether they deliver high quality care for heart failure or low back pain.**
- **Specialists' payments could be cut even if they improve the quality of care.**

4.1. How ASM Differs from MIPS

Physicians who are forced to participate in ASM will have their Medicare payments increased or decreased by as much as 9% based on the overall performance score they receive. Although the maximum payment changes in ASM are the same as those in the MIPS program, reductions in payments are more likely in ASM than in MIPS and the magnitude of reductions will also be larger in ASM because the methodology for calculating payment adjustments in ASM differs from MIPS in four important ways:

- in MIPS, if all physicians score at or above a predetermined performance threshold, none of them will receive a payment reduction. In ASM, however, physicians who score at the median or even somewhat above the median will receive a cut in their payments, i.e., the majority of the physicians will receive a reduction. This is because CMS will use a a "redistribution percentage" of 85 percent in ASM that does not exist in MIPS.
- In MIPS, a physician knows in advance how they need to perform in order to avoid a payment reduction, because the performance threshold is established prior to the beginning of the year. In ASM, however, a physician cannot know what level of performance will avoid a penalty because no performance threshold is defined in advance. A physician's payment adjustment is based on how their performance compares to other ASM physicians during the same year.
- in MIPS, a physician who falls short of the performance threshold by a small amount will only receive a small reduction in payment. In ASM, however, a small difference from the median can result in a large reduction in payment because CMS is using a "logistic exchange function" to translate the scores into payment adjustments rather than the "linear exchange function" used in MIPS.
- As discussed earlier, because of the differences in the scoring methods, physicians will receive higher scores in MIPS than in ASM even if they have the same levels of performance on the same measures.

4.2. Most Specialists in ASM Would Receive a Cut in Their Payments

Under ASM, most of the specialists will receive a cut in their payments, no matter how well they perform on the quality or cost measures. This is an intentional element of the ASM design. CMS included the "redistribution percentage" in ASM explicitly to guarantee savings to Medicare by forcing a net reduction in Part B payments to the participating physicians.[40]

When CMS announced the ASM program, it used an example of a hypothetical physician who received a performance score of 80 when the median performance score is 50. Based on the other assumptions in the example, CMS calculated that the hypothetical physician would receive a 3.85% increase in their payments.

CMS did not, however, reveal that in order for a physician with a score of 80 to receive a payment increase that large, most other physicians would need to receive a large reduction in their payments.

To illustrate this in a simple way, Figure 4.1 assumes that ASM physicians fall into three categories of performance – 1/3 receive a score of 80, 1/3 receive a score of 50, and 1/3 receive a score of 39. The median score is 50, the same as in the CMS example, and using assumptions about spending similar to those in the CMS example, the physicians who receive a score of 80 would receive an payment increase of 3.86%, the same as in the CMS example.

The physicians who score 50 (the median), however, would receive a 2.25% reduction in payments, and the physicians who score 39 would receive a 5.65% reduction. On average, physicians in the program would receive a 1.35% reduction in their payments.

Figure 4.1
Simulation of Payment Changes in ASM
Based on Example Used by CMS

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Performance Score	Payment Adjustment	Change in Payment
A	733	33%	$454,500	80	3.86%	$17,534
B	733	33%	$454,500	50	−2.25%	($10,222)
C	734	33%	$454,500	39	−5.65%	($25,694)
Total	2,200	100%		50	−1.35%	

This result is not dependent on the specific assumptions used in Figure 4.1. For example, Figure 4.2 shows the same three categories of performance, but with different proportions of physicians in each category and different amounts of revenue per physician. Although the sizes of the payment increases and decreases differ, the majority of physicians still receive a cut in their payments.

Figure 4.2
Simulation of Payment Changes in ASM
Different Amounts of Medicare Part B Revenue

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Performance Score	Payment Adjustment	Change in Payment
A	660	30%	$600,000	80	2.56%	$15,336
B	880	40%	$450,000	50	−2.93%	($13,205)
C	660	30%	$300,000	39	−5.99%	($17,979)
Total	2,200	100%		50	−1.35%	

In the example CMS used to illustrate the payment changes, CMS did not explain that it was unlikely for the median score to be 50. It is more likely that the median score would be 60 since 6 point are awarded for median performance on all of the cost and quality measures. Most physicians would have had to receive penalties for the Improvement Activities and Promoting Interoperability components in order for the median to be as low as 50. If the median is higher than 50, then the payment increase for a physician with a score of 80 would be lower, as shown in Figure 4.3.

Figure 4.3
Simulation of Payment Changes in ASM
Higher Median Performance Score

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Performance Score	Payment Adjustment	Change in Payment
A	733	33%	$454,500	80	3.25%	$14,785
B	733	33%	$454,500	60	−2.04%	($9,292)
C	733	33%	$454,500	50	−5.26%	($23,901)
Total	2,200	100%		60	−1.35%	

Figure 4.5 shows a final example with 20 different levels of performance rather than 3, different proportions of physicians in each category, and a different level of Part B revenue per physician. Once again, the majority of physicians would receive a payment reduction, because the “redistribution percentage” forces this.

Figure 4.4
Simulation of Payment Changes in ASM
20 Different Levels of Performance Scores

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Performance Score	Payment Adjustment	Change in Payment
A	33	1%	$250,000	84	4.70%	$11,756
B	33	1%	$250,000	82	4.45%	$11,120
C	66	2%	$250,000	80	4.15%	$10,376
D	66	2%	$250,000	68	1.25%	$3,115
E	264	8%	$250,000	66	0.58%	$1,440
F	330	10%	$250,000	62	−0.87%	($2,168)
G	495	15%	$250,000	61	−1.24%	($3,100)
H	1,155	35%	$250,000	60	−1.61%	($4,036)
I	330	10%	$250,000	59	−1.99%	($4,971)
J	132	4%	$250,000	58	−2.36%	($5,900)
K	66	2%	$250,000	57	−2.73%	($6,818)
L	33	1%	$250,000	56	−3.09%	($7,722)
M	33	1%	$250,000	55	−3.44%	($8,606)
N	33	1%	$250,000	54	−3.79%	($9,468)
O	33	1%	$250,000	53	−4.12%	($10,305)
P	33	1%	$250,000	52	−4.44%	($11,112)
Q	33	1%	$250,000	51	−4.76%	($11,889)
R	33	1%	$250,000	50	−5.05%	($12,633)
S	33	1%	$250,000	49	−5.34%	($13,342)
T	33	1%	$250,000	48	−5.61%	($14,016)
Total	3,267	99%		60	−1.35%	

There is no “redistribution percentage” at all in MIPS, nor is one used in the Hospital Value- Based Purchasing (VBP) program. In those programs, any payment reductions for lower-performing physicians and hospitals are used to fund payment increases for high performers. In ASM, however, most physicians would receive payment reductions because CMS wants to guarantee a reduction in Medicare spending.

4.3. All Specialists in ASM Could Receive a Cut in Their Payments

It is entirely possible that all physicians in ASM could receive a payment cut and none would receive an increase. The examples shown above assume that some specialists receive much higher scores than others. However, if most of the physicians have similar scores on quality and cost measures, and if the physicians who receive lower scores on the quality and cost measures receive higher complex patient scoring adjustments, practice size adjustments, and/or rural score adjustments that offset the differences in their quality and cost scores, the total performance scores for most physicians could be very smilar. Figure 4.5 shows an example where performance scores for all ASM participants differ by only small amounts. In this example, every participant would receive a payment reduction, because the redistribution percentage requires a net reduction in Medicare payments to the physicians, and the lowest scores are not low enough to allow payment increases for those with the highest scores.

Figure 4.5
Simulation of Payment Changes in ASM
Similar Performance Scores

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Performance Score	Payment Adjustment	Change in Payment
A	733	33%	$454,500	62	−0.59%	($2,670)
B	733	33%	$454,500	60	−1.35%	($6,136)
C	733	33%	$454,500	58	−2.11%	($9,601)
Total	2,200	100%		60	−1.35%	

4.4. Specialists May Receive Larger Payment Cuts Even If They Improve the Quality of Care

Not only would the majority of physicians receive payment cuts under ASM, a physician in ASM could receive a reduction in payment even if they significantly improve on all performance measures compared to the prior year.

Figure 4.6 shows a hypothetical example where all physicians in the example shown in Figure 4.1 improve their performance in the next year. The physicians who had the highest scores in the previous year would receive a smaller payment adjustment than they did before, even though their performance had improved. The physicians who had scored at the median before would receive a larger payment reduction, even though their performance had improved. The physicians who had the lowest scores in the previous year would still receive a payment cut, but it would be smaller than it was in the previous year.

Figure 4.6
Impact of Improving Performance

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Year 1 Performance Score	Payment Adjustment	Year 2 Performance Score	Change in Score	Payment Adjustment	Change in Payment Adjustment
A	733	33%	$454,500	80	3.86%	85	+5	2.94%	−0.92%
B	733	33%	$454,500	50	−2.25%	60	+10	−2.54%	−0.29%
C	734	33%	$454,500	39	−5.65%	54	+15	−4.45%	+1.20%
Total	2,200	100%		50	−1.35%	60		−1.35%	−0.00%

4.5. Rural Scoring Adjustments Do Not Protect Rural Physicians From Cuts and Will Penalize Physicians in Other Areas

As discussed in Section 3.8, CMS will increase the ASM Performance Score by 5 points for a physician practicing in a rural area.

Providing an additional 5 points to physicians located in rural areas will cause them to receive smaller payment cuts or larger payment bonuses than physicians in other areas even though their performance on quality and cost measures is identical. More importantly, though, it would cause physicians who are not in rural areas to receive larger payment cuts or smaller payment bonuses than they otherwise would receive, including physicians in small practices.

Figure 4.7 shows a simple illustration of this. The scenario is similar to the scenario previously shown in Figure 4.1, but it assumes that about 1/4 of the physicians in each category are in rural areas. The 5-point scoring adjustment for the ASM

participants in rural areas results in a smaller payment cut for those participants, but it results in larger payment cuts for most other participants.

Figure 4.7
Impact of Rural Scoring Adjustment

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Performance Score	Payment Adjustment	Rural Adjustment	Bonus Points	Adjusted Performance Score	Payment Adjustment	Change in Payment Adjustment
Non-Rural	550	25%	$500,000	80.0	3.92%	No	0.0	80.0	3.99%	0.07%
Rural	176	8%	$250,000	80.0	3.92%	Yes	5.0	85.0	4.27%	0.34%
Non-Rural	550	25%	$500,000	50.0	−2.22%	No	0.0	50.0	−2.51%	−0.29%
Rural	176	8%	$250,000	50.0	−2.22%	Yes	5.0	55.0	−0.81%	1.40%
Non-Rural	572	26%	$500,000	39.0	−5.61%	No	0.0	39.0	−5.84%	−0.23%
Rural	176	8%	$250,000	39.0	−5.61%	Yes	5.0	44.0	−4.47%	1.14%
Total	2,200	100%		50.0	−1.35%			51.1	−1.35%	0.00%

4.6. Incentives to Perform Additional Activities Would Increase Payment Cuts

In the proposed physician fee schedule regulation issued in July 2026, CMS proposed modifying the ASM Performance Score in order to create an "incentive" for ASM participants to collect and submit Patient Reported Outcome (PRO) data. Under the proposal, an ASM participant's score in the quality performance category would have been increased by 5 points if they submitted PRO data to CMS based on CMS-defined specifications.[41] In the final physician fee schedule regulation issued in November 2026, CMS withdrew the proposed change.

Although collecting or submitting PRO data would have technically remained voluntary, the proposed change would have had the same effect as a mandate because ASM participants would receive a payment penalty if they do not submit PRO data. Under the ASM payment methodology, higher scores for some ASM participants results in reductions in payments for all other participants.

This is illustrated in the hypothetical scenario below. The starting point is the scenario shown in Figure 4.1, but the scenario then assumes that the ASM participants in the two groups with the highest scores all submit PRO information and receive the proposed 5 point increase in their quality performance score. The increase in their quality performance score would increase their total ASM score by 2.5 points because the quality category receives a 50% weight.

As shown in Figure 4.8, the result is:

- only the ASM participants in the highest scoring group would receive an increase in their payment adjustment factor due to the PRO reporting "incentive." They would receive an increase of $489 in their total Part B payments two years later (assuming that their total Part B payments then are approximately same as in the performance year).
- the ASM participants in the second-highest scoring group would still receive a payment reduction, although it would be slightly smaller than it would have been without the additional points.
- all of the ASM participants who did not submit PRO information would receive larger reductions in their Part B payments than they would have if the PRO scoring incentive did not exist.

For example, if larger practices are able to submit PRO data and smaller practices cannot afford to do so, the proposed change would result in reductions in the payments for physicians in small practices.

Figure 4.8
Impact of Bonus Points for PRO Submission

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Performance Score	Payment Adjustment	PRO Submission	Bonus Points	Adjusted Performance Score	Payment Adjustment	Change in Payment Adjustment
A	733	33%	$454,500	80.0	3.86%	Yes	2.5	82.5	4.20%	0.34%
B	733	33%	$454,500	50.0	−2.25%	Yes	2.5	52.5	−2.07%	0.18%
C	734	33%	$454,500	38.9	−5.65%	No	0.0	38.9	−6.17%	−0.52%
Total	2,200	100%		50.0	−1.35%			52.5	−1.35%	−0.00%

Figure 4.9 shows that if all practices submit PRO data, all of their scores would be higher by the same amount, and they would receive essentially the same payment adjustments as they would have otherwise.

CMS said that the additional points were intended to serve as an "incentive" for ASM participants to collect and submit PRO data, but CMS did not provide any estimate of the cost to collect and submit the data nor was there any analysis of whether the

change in payments resulting from the additional 5 points would offset the additional costs of providing the data. In many cases, the additional points would have merely resulted in smaller cuts in the ASM participants' payments, not an actual increase in their payments. Because of the logistic exchange function that CMS has decided to use in ASM, the "incentive" would be larger for participants with scores closer to the median.

Figure 4.9
Impact of Bonus Points for PRO Submission

Group	Number of Physicians	Percent of Total	Part B Revenue Per Physician	Performance Score	Payment Adjustment	PRO Submission	Bonus Points	Adjusted Performance Score	Payment Adjustment	Change in Payment Adjustment
A	733	33%	$454,500	80.00	3.86%	Yes	2.50	82.50	3.86%	0.00%
B	733	33%	$454,500	50.00	−2.25%	Yes	2.50	52.50	−2.25%	0.00%
C	734	33%	$454,500	38.90	−5.65%	Yes	2.50	41.40	−5.65%	0.00%
Total	2,200	100%		49.99	−1.35%			52.49	−1.35%	0.00%

As noted earlier, CMS withdrew the proposed change in the final physician fee schedule regulation issued in November 2026.

5. Terminating ASM and Replacing It With Patient-Centered Payments

- ASM will reduce access to care for tens of thousands of Medicare beneficiaries with heart failure and low back pain.
- ASM will reduce access to specialty care in rural communities.
- ASM is likely to increase Medicare spending rather than produce savings.
- CMS should terminate ASM and create patient-centered payments for care of chronic conditions.
- CMS should involve physicians in the design of new models instead of its current top-down approach.

5.1. ASM Will Harm Medicare Beneficiaries and Increase Medicare Spending

ASM Will Reduce Access to Care for Tens of Thousands of Medicare Beneficiaries With Heart Failure and Low Back Pain

ASM is unlikely to improve care for Medicare beneficiaries with heart failure or low back pain. CMS designed ASM to reduce Medicare payments to specialists, not to help specialists deliver better care for their patients. As shown in Section 4, the majority of specialists in ASM will have all of their Medicare payments cut even if they are delivering high quality care to patients with heart failure and low back pain. Improving the quality of care to these patients will not prevent a physician from receiving cuts in their payments. The quality of care the specialists deliver to patients with other cardiovascular or musculoskeletal problems will not matter, because the payment changes in ASM will be based solely on measures related to heart failure and low back pain.

Because it is unlikely that any physician would willingly enroll in a program designed this way, CMS made ASM "mandatory" for the designated specialists. But it is only mandatory if the specialists see at least 20 Medicare beneficiaries with heart failure or low back pain. None of these specialists is *required* to see Medicare beneficiaries with heart failure or low back pain, and ASM creates a strong disincentive for them to do so.

A large proportion of the specialists who have been assigned to ASM see only a few dozen Medicare beneficiaries with heart failure or low back pain during the course of a year; most of the physicians' patients have different medical conditions or are not on Medicare. These specialists can avoid the ASM mandate and the associated payment cuts simply by seeing fewer Medicare beneficiaries with heart failure and low back pain. The specialists can continue to see younger patients and seniors with Medicare Advantage plans who have heart failure or low back pain, and they can continue to see Medicare beneficiaries who have other types of cardiovascular, musculoskeletal, or pain problems, with no risk of having their payments cut, because participation in ASM is only triggered by seeing Medicare beneficiaries with heart failure and low back pain.

Moreover, specialists who avoid being assigned to ASM will have more resources to treat Medicare beneficiaries with other health problems because ASM would cut payments for *all* of their services to *all* of the Medicare beneficiaries they treat, not just services they provide for heart failure or low back pain.

In addition, as shown in Section 3, physicians who treat patients who have more severe conditions and/or more complex needs will be likely to receive lower scores in ASM and larger payment cuts. Consequently, those specialists who continue to see Medicare beneficiaries with heart failure or low back pain will face a strong financial incentive under ASM to treat fewer of the beneficiaries who have more severe or complex conditions.

Tens of thousands of Medicare beneficiaries will lose access to their current specialty care if the specialists who are treating them decide it is necessary to reduce the number of beneficiaries they treat in order to avoid the cuts in payment they are likely to receive under ASM.[42]

There is a national shortage of physicians in the specialties targeted by ASM.[43] If a subset of these specialists stop seeing Medicare beneficiaries with heart failure and low back pain, or if they stop seeing the patients who have the most complex conditions, it will be difficult for those beneficiaries to find an alternative source of care. Primary care will not be able to fill the gap because the shortage of primary care physicians is even more severe. Moreover, research has shown that people with chronic conditions such as heart failure have better outcomes when they receive care from specialists, and those with the most complex conditions receive the greatest benefit from specialty care.[44]

As a result, the most likely impact of ASM will be to reduce access to specialty care for tens of thousands of Medicare beneficiaries with heart failure or low back pain, particularly beneficiaries who have a serious or complex condition. This will result in worse outcomes for these patients.

ASM Will Harm Rural Communities

The access problems caused by ASM will be particularly severe in rural areas. As shown in Section 2, many of the communities where ASM will be implemented are rural areas that have few, if any, cardiologists, pain medicine physicians, or surgeons. Specialists who treat Medicare beneficiaries with heart failure or low back pain in these communities will be forced to participate in ASM, while specialists in other communities will not. In effect, ASM will penalize specialists for practicing in these communities. The Rural Scoring Adjustment in ASM does not prevent that.

In many rural areas, there is no cardiologist, pain medicine physician, or other specialist who works in the community full time. Instead, specialists based in other areas travel to the rural community periodically to see or treat patients. These physicians can also be forced to participate in ASM if the majority of their heart failure or low back pain patients are located in an ASM community.

Some specialists who are currently practicing in or traveling to the ASM communities may be able to reduce the number of Medicare beneficiaries with heart failure or low back pain that they see in order to avoid being forced into ASM. This will be particularly problematic for Medicare beneficiaries in rural communities, because they will likely have to travel a long distance in order to see a different specialist in another community, and as a result, many of these patients may not receive specialty care at all.

However, some specialists in rural ASM communities may simply decide to stop practicing there at all. This will affect Medicare beneficiaries with other types of health problems, not just those with heart failure or low back pain, and it will affect all other types of patients who need services from those types of specialists. All of these patients would then have to travel farther in order to see a specialist in a different community, and many may not receive the specialty care they need. Communities that are trying to recruit a cardiologist, anesthesiologist, orthopedic surgeon, or other specialist may have a harder time doing so because of the potential for that physician to be forced into ASM.

People living in rural areas already have worse outcomes than those in urban areas. One study found that lack of access to specialists was the primary driver of higher mortality and more preventable hospitalizations among rural Medicare beneficiaries with chronic conditions – more important than the patients' comorbidities, functional status, or social risk factors.[45] Consequently, if ASM reduces access to specialty care in the rural areas that are included, it could result in more hospitalizations and more deaths in those communities.

Loss of the types of specialists targeted by ASM could also increase the risk that a rural hospital in the community would close. If the hospital no longer has the specialists needed to deliver cardiovascular procedures, orthopedic surgery, and other types of surgery, its revenue will decrease and its financial losses will worsen.

ASM is Likely to Increase Medicare Spending Rather Than Produce Savings

Although all payment models developed by the Center for Medicare and Medicaid Innovation (CMMI) are supposed to produce savings for the Medicare program, most of the models implemented to date have resulted in higher Medicare spending.[46] In an effort to prevent this from happening with ASM, CMMI designed the program in a way that it believed would "ensure" savings.[47]. The "redistribution percentage" of 85% was included in the program specifically to force a reduction in the total Medicare payments to the ASM participants regardless of how they perform on the quality and cost measures.

However, the reductions in access to specialty care due to ASM could easily result in more beneficiaries experiencing complications that require hospitalizations and more beneficiaries receiving unnecessary or unnecessarily expensive tests, medications, and treatments. Medicare pays large amounts for hospital stays and for many kinds of drugs and tests – far more than the fees it pays physicians for office visits and procedures that would be cut by ASM. Moreover, if the number of specialists in ASM decreases because these physicians stop seeing heart failure and low back pain patients, the aggregate savings from the cuts in physician payments will be smaller. The increased Medicare spending that would result from even a small increase in complications and unnecessary services would easily dwarf the savings CMMI would achieve from the cuts it makes in physician payments.

5.2. ASM Should Be Abandoned and Replaced By Patient-Centered Payments

CMS Should Halt Implementation of ASM

According to CMS, ASM is designed to test whether "adjusting payment for specialists based on their performance on targeted measures of quality, cost, care coordination, and meaningful use of certified electronic health record (EHR) technology (CEHRT) results in enhanced quality of care and reduced costs through more effective upstream chronic condition management."

This "test" is both unnecessary and inappropriate. As the preceding analysis makes clear, the most likely result of ASM will be a reduction in access to care and an increase in Medicare spending. No one would "test" a drug that is likely to harm most patients, and CMS should not "test" a program that is likely to harm Medicare beneficiaries, physicians, and rural communities. Thousands of beneficiaries could be harmed before the first formal evaluation is released documenting the problems caused by ASM.

ASM Should Be Abandoned Rather Than Changed

The biggest negative impacts of ASM could be reduced by eliminating the most problematic aspects of the program. For example:

- changing the redistribution percentage from 85% to 100% would prevent the majority of physicians from receiving payment cuts;
- using historical benchmarking rather than concurrent benchmarking would enable physicians to avoid payment cuts by

maintaining or improving the quality of care, and it would remove the penalty for collaboration created by the current "tournament" approach to scoring;

- improving the attribution rules and risk adjustments in the cost measures could prevent specialists from being penalized for providing consultations and reduce the chance that they will be penalized for treating patients with higher needs;
- permitting physicians to be evaluated as a group rather than as individuals would support collaboration among physicians in the care of patients;
- allowing physicians to opt out of the program would ensure that physicians only participate if they believe it will benefit their patients.

However, even if the worst aspects of ASM were removed, it would be unlikely to improve quality or reduce costs for patients because it would not remove the barriers to higher-quality care that currently exist in Medicare.

Current Medicare payment systems make it difficult for specialists as well as primary care practices to provide high quality care for patients with chronic conditions such as heart failure and low back pain. The problems with current payments would not be addressed by ASM even if its worst aspects were eliminated, because it is a "pay for performance" program rather than a change in what Medicare pays for:

- **Inadequate payment for accurate diagnosis and successful treatment planning.** The amounts Medicare pays for office visits are often not large enough to allow either a primary care physician or a specialist to spend the time necessary to accurately diagnose complex symptoms and to work with the patient to develop a treatment plan that is appropriate and feasible for that patient. As a result, patients can be misdiagnosed or fail to receive an accurate diagnosis in a timely fashion, and patients can receive unnecessarily expensive treatments or a treatment plan they are unable to follow. Any increases in payments that physicians receive under ASM would still fall short of what is needed to support effective diagnosis and treatment planning, and physicians whose payments would be cut would be even less able to spend adequate time with patients.
- **Lack of payment or inadequate payment for proactive care management services.** There is no payment at all for many aspects of the proactive care management services that physician practices should deliver to help patients effectively manage their chronic conditions, such as phone calls to monitor the patient's condition in order to respond quickly when problems arise, education from nurses or other practice staff about how to successfully manage pain or side effects of treatment, and palliative care services for a patient with more severe or advanced conditions. Even when fees for these services are available, not all patients who need them are eligible, and/or the fee amounts are lower than the cost of delivering the services appropriately. As a result, patients with severe and complex conditions may have emergency department visits, hospitalizations, and hospital readmissions that could have been avoided if a specialty practice or a primary care practice had been able to deliver more proactive care. ASM does not provide any new or different payments for services that are not adequately supported by existing fees. Most physicians in ASM would receive payment cuts rather than new or higher payments. Although a small proportion of specialists in ASM would receive higher payments, they would not receive those payments until two years after the program begins. As a result, ASM would not enable specialists to deliver care in different ways that would result in better outcomes or lower costs.
- **Financial penalties for successful treatment.** Both primary care physicians and specialists who treat patients with chronic conditions are primarily paid based on the number of times the patient comes to the physician's office and the number of treatments the physician practice provides. As a result, the physician practice is penalized financially if it helps the patient avoid exacerbations or slow the progression of their condition. ASM would not solve this problem.

CMS Should Create a Patient-Centered Payment System Instead of Another Pay for Performance Program

Instead of creating yet another pay for performance program, CMS should create new payments for chronic disease care that will solve the problems of current payment systems without reducing access to services for the patients who have greater needs. What is needed is a *patient-centered* payment system for care of chronic conditions in which:

- **A patient with a chronic condition should be able to receive the services that will best address their specific needs.** In order for patients to receive the highest-value care, the many gaps in payment under current payment systems have to be filled.
- **The payment amounts should be adequate to cover the cost of delivering services in a high-quality manner to patients with chronic conditions.** The payment amounts should be based on what it costs to deliver high-quality care, not based on the fees paid in the past or the amount of savings that has been produced.

Section 5.3 describes in more detail how CMS could create a patient-centered payment system.

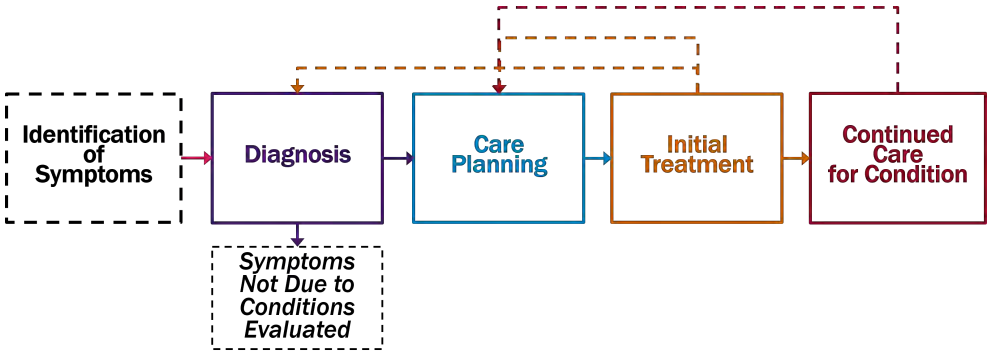
5.3. Creating Patient-Centered Payments for Care of Chronic Conditions

The Phases of Chronic Condition Care

The care patients need for chronic conditions such as heart failure and low back pain can be divided into four distinct phases, each of which has a significant impact on the outcomes the patients experience and the cost of the care they receive:

1. **Diagnosis.** The first phase is determining whether the patient has a chronic condition and which specific condition they have. Different health problems have similar symptoms, and there is not always a diagnostic test that can definitively determine whether a patient has a specific chronic condition. In some cases, initial treatment may need to begin before a diagnosis is finalized because a definitive diagnosis can only be determined based on the effectiveness of treatment. Adequate time and sufficient expertise are required to collect the information about the patient that is needed for accurate diagnosis, while avoiding unnecessary testing and misdiagnosis.
2. **Care Planning.** If a patient is diagnosed with a particular condition, there are typically multiple approaches to treating and managing the condition. The effectiveness and side effects of treatments can differ for different patients, and patients differ both in their preferences about the trade-off between effectiveness and side effects and in their ability to afford and utilize specific approaches to treatment. Patients with more advanced conditions will need palliative care services in addition to or instead of treatment. The choices and the tradeoffs will evolve continuously as new therapies are created and as new evidence emerges about the relative effects of treatments. The physician and other staff on the patient's care team need adequate time to identify the best alternatives based on the most current evidence, and they need adequate time to educate the patient about the choices and assist them in deciding which to pursue. Adequate time and expertise in this phase are needed to avoid ineffective, harmful, and unnecessarily expensive services for the patient.
3. **Initial Treatment.** When treatment first begins, patients will need adequate education and support to enable them to understand and follow the care plan correctly. Some patients may experience unexpected side effects or challenges in using the treatments, or the treatments may not work as well as expected, and adjustments or changes to treatment will be needed to address these problems. Failure to proactively address these issues can cause avoidable complications for the patient or prompt an unnecessary change to a more expensive form of treatment or a treatment with a higher risk of side effects or complications.
4. **Continued Care for the Condition.** Once the most effective treatment approach is determined, the patient's condition needs to be proactively monitored so that additional assistance can be provided or adjustments to treatment can be made when needed. In some cases, the most effective treatment available will only be partially effective in controlling the patient's symptoms, and these patients will need more intensive monitoring and additional assistance in preventing and managing exacerbations of their condition. Failure to do this can result in avoidable complications and worse outcomes for the patient.

Figure 5.1
Phase of Chronic Condition Care



Patient-Centered Payments for Chronic Condition Care

In a *patient-centered* approach to payment, a specialist should receive payments specifically designed to support each of these four phases:

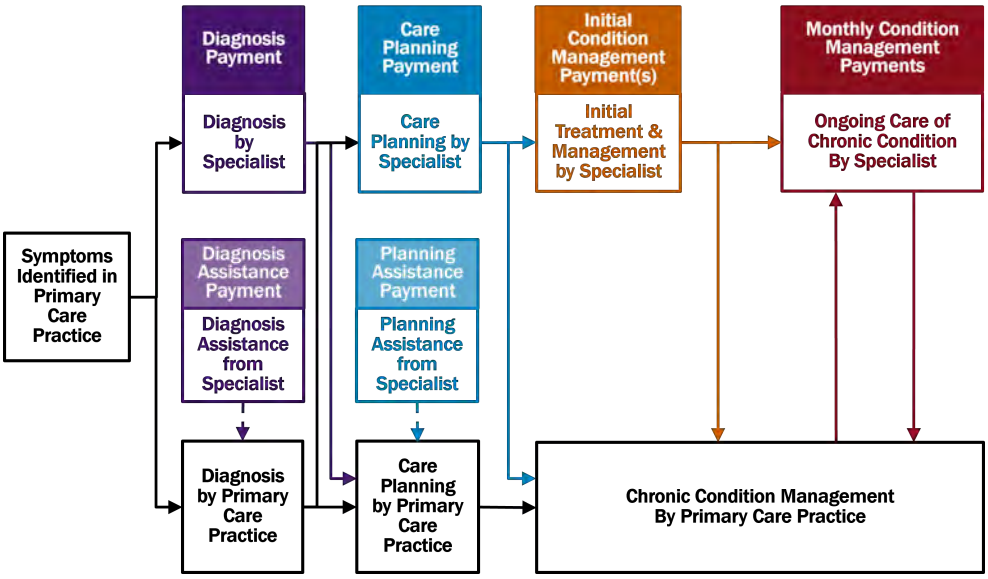
- a **Diagnosis Payment** that is specifically designed to support an accurate evaluation of the patient's symptoms, regardless of how many visits the patient made with the physician. Adequate time and sufficient expertise are required to collect the information about the patient needed for accurate diagnosis, while avoiding unnecessary testing and misdiagnosis.
- a **Care Planning Payment** specifically designed to support development of an appropriate care plan for the patient. The physician and other staff on the patient's care team need adequate time to identify the best alternatives based on the most current evidence, and they need adequate time to educate the patient about the choices and assist them in deciding which to pursue. Adequate time and expertise in this phase are needed to avoid ineffective, harmful, and unnecessarily expensive services for the patient.

- a **Diagnostic Assistance Payment** and a **Care Planning Assistance Payment** that enable a specialist to provide support to primary care physicians in making diagnoses and developing a care plan for the patient.
- a monthly **Condition Management Payment** for each patient that gives the physician practice flexibility to assist each patient in the way that will be most effective and efficient for that patient, rather than relying solely on traditional office visits. This includes providing patients with education and support to enable them to understand and follow the care plan correctly, and helping patients who experience unexpected side effects or challenges in using the treatments, thereby reducing avoidable complications.
- A higher **Initial Condition Management Payment** will be needed during at least the first month of care in order to support this additional time. For some chronic conditions, and for patients with complex needs, the Initial Condition Management Payment may need to continue for several months to allow adequate time for the care plan to be fully implemented (e.g., if dosages need to be phased in), to assess the efficacy of the treatment(s), to identify any adverse side effects, and, if necessary, to make modifications to the care plan and test their feasibility and effectiveness. When a care plan has been established that is expected to continue for an extended period of time and there is no longer a need for transitional assistance to the patient in implementing it, Initial Condition Management Payments can end and the practice can then begin receiving the standard monthly Condition Management Payments appropriate for the patient.

In return for receiving these payments, a physician should be expected to deliver services consistent with an evidence-based Clinical Practice Guideline (CPG) or a Clinical Pathway. This is a far more efficient and effective way to ensure that patients receive appropriate services than current quality measurement systems that only assess narrow aspects of care quality for specific subsets of patients.

Some patients will be able to receive adequate services from their primary care practice. Other patients will need services from a specialist in one, some, or all of the phases.[48] The only way to ensure that each patient can get appropriate specialty services for their specific needs, and the only way to ensure that each specialist is paid appropriately for the services they provide, is to create separate payments specifically designed to support each phase of care.

Figure 5.2
Supporting Coordinated Care With Patient-Centered Payments



More details on how this approach would work and how it can be implemented by CMS are available in *Patient-Centered Payment for Care of Chronic Conditions* and at the Patient-Centered Payment website.

Comprehensive Care Payments for Chronic Condition Care

Many patients with a chronic condition such as heart failure also have other chronic diseases and acute health issues. Some aspects of their care should be provided by a specialist, while others should be provided by a primary care physician. However, all of these services should be managed in a coordinated way in order for the patients to receive truly patient-centered care.

The necessary coordination will not be achieved simply by mandating the creation of a "Collaborative Care Arrangement" between a specialty practice and a primary care practice as ASM proposes to do, because the practices would not be paid in ways that support effective collaboration. Instead, CMS should created *Comprehensive Care Payments* that support coordinated care by teams of PCPs and specialists.

An example of how this could be done for patients with heart failure was developed over a decade ago by the Oregon Chapter of

the American College of Cardiology. Under that model:

- a Comprehensive Care Payment for Heart Failure would be paid to a team of primary care physicians and cardiologists who agree to jointly accept accountability for management of a patient's heart failure and chronic comorbidities.
- the Comprehensive Care Payment would be received by the team as a whole, and the members of the team would determine how to allocate that payment among themselves.
- the team would no longer receive traditional fees for office visits or other services to these patients. The Comprehensive Care Payment would serve as a budget to cover the costs of the services provided by the physicians as well as the costs of common laboratory tests, imaging studies, procedures, and heart failure-related hospitalizations.
- the amount of the Comprehensive Care Payment would be higher for patients with higher-severity heart failure and/or more serious comorbidities, because of the larger number of services these patients would need and their greater risk of experiencing complications.
- the team would be responsible for following the most current clinical practice guidelines and for monitoring outcomes for their patients.

More details on how this approach would work are available in *Alternative Payment Model for Care of Heart Failure*.

5.4. Designing Changes from the Bottom Up Instead of the Top Down

When Congress created the Center for Medicare and Medicaid Innovation (CMMI), it required CMMI to "focus on models expected to reduce program costs … while preserving or enhancing the quality of care."

ASM violates this requirement. It attempts to reduce Medicare spending by cutting payments to specialists without regard for the serious negative impacts on beneficiaries that will be caused by those cuts. ASM will likely result in higher Medicare spending rather than savings, and it will likely result in worse outcomes for patients with heart failure and low back pain.

It is possible to reduce Medicare spending while also improving outcomes for patients with chronic conditions, but achieving this requires a four-step process:[49]

1. Identify *potentially avoidable spending*, i.e., specific types of healthcare services or spending that could be reduced without harming patients;
2. Design an approach to delivering services that is expected to reduce the avoidable spending;
3. Create payments that give physicians and other healthcare providers the ability to implement and sustain the improved approach to service delivery; and
4. Hold physicians accountable for delivering appropriate, evidence-based services in return for the improved payments.

The best and perhaps only way to identify potentially avoidable spending, to develop a new approach to service delivery that will reduce avoidable spending, and to determine what types of payments are needed to support that approach is to involve the physicians and other clinicians who currently care for patients with chronic conditions. For example, the plan for Comprehensive Care Payments for Heart Failure described in the previous section was developed through a collaborative effort involving cardiologists, primary care physicians, hospitalists, nurse practitioners, health insurance plan executives, physician practice administrators, and community representatives.

None of this was done in the design of ASM. ASM was developed through the "top-down" approach that has, unfortunately, been typical of payment models developed by CMMI – CMMI designs payment models itself with little or no involvement of the physicians and other providers who would ultimately need to participate in those models and make them successful. Moreover, ASM utilizes the same simplistic approach to payment – rewarding or penalizing physicians using poorly-designed cost and quality measures – that has been used in most other CMMI models and that has failed to either produce savings or improve outcomes. Rather than creating models that physicians will voluntarily participate in because they will support better care for patients, CMMI is forced to mandate physician participation because the models are designed in such problematic ways.

CMMI not only needs to create better types of payments – patient-centered payments instead of P4P – it needs to use a better approach to designing those payments – a "bottom-up" approach that directly involves the physicians and other healthcare providers who will be responsible for delivering services in new and better ways. Congress should amend the authorizing statute to ensure that this happens.

Appendix: Geographic Areas Included in ASM

Areas Selected for ASM and Number of Specialists Assigned (Part 1)

State	CBSA	Total	Anesthesiology	Cardiology	Interventional Pain Mgt	Neurosurgery	Orthopedic Surgery	Pain Management	Physiatry
AK	Anchorage	32	8	11	1	0	5	4	3
AK	Fairbanks-College	4	0	2	1	0	1	0	0
AL	Daphne-Fairhope-Foley	16	2	5	0	0	5	0	4
AL	Decatur	4	1	1	0	0	0	0	2
AL	Florence-Muscle Shoals	9	1	6	1	0	0	0	1
AL	Huntsville	51	2	19	2	5	7	7	9
AL	Mobile	27	3	6	0	2	11	1	4
AL	Montgomery	9	2	2	1	1	1	1	1
AL	Tuscaloosa	9	0	4	2	0	0	1	2
AR	Fayetteville-Springdale-Rogers	27	1	12	5	2	1	2	4
AR	Little Rock-North Little Rock-Conway	82	14	28	4	12	11	10	3
AR	Mountain Home	8	2	3	0	2	0	0	1
AZ	Safford	1	0	0	0	0	0	1	0
AZ	Sierra Vista-Douglas	6	0	3	0	0	1	2	0
CA	Anaheim-Santa Ana-Irvine	159	16	55	14	5	24	21	24
CA	Fresno	42	2	20	1	2	3	3	11
CA	Hanford-Corcoran	3	0	2	0	0	1	0	0
CA	Riverside-San Bernardino-Ontario	100	11	43	10	3	11	15	7
CA	Sacramento-Roseville-Folsom	89	6	45	2	1	10	12	13
CA	San Francisco-San Mateo-Redwood City	74	3	25	6	3	16	3	18
CA	San Luis Obispo-Paso Robles	17	2	6	1	1	2	0	5
CA	San Rafael	14	1	7	0	0	2	0	4
CA	Santa Maria-Santa Barbara	28	1	13	1	1	9	1	2
CA	Santa Rosa-Petaluma	31	2	15	2	0	5	6	1
CA	Sonora	5	0	1	0	0	2	0	2
CA	Visalia	24	1	14	0	0	3	3	3
CO	Boulder	13	1	2	1	0	3	0	6
CO	Durango	6	0	1	0	0	2	0	3
CO	Greeley	4	0	1	1	0	2	0	0
CO	Pueblo	8	0	3	0	0	2	3	0
CO	Steamboat Springs	4	0	2	0	0	1	0	1
CT	Hartford-West Hartford-East Hartford	63	5	33	4	1	11	1	8
CT	Torrington	4	0	1	0	0	2	0	1
DE	Dover	14	0	10	1	0	1	1	1
DE	Seaford	28	2	15	1	0	3	3	4

Areas Selected for ASM and Number of Specialists Assigned (Part 2)

State	CBSA	Total	Anesthesiology	Cardiology	Interventional Pain Mgt	Neurosurgery	Orthopedic Surgery	Pain Management	Physiatry
DE-MD-NJ	Wilmington	60	3	20	3	8	7	7	12
FL	Crestview-Fort Walton Beach-Destin	9	1	4	0	1	1	2	0
FL	Deltona-Daytona Beach-Ormond Beach	48	2	23	8	0	5	7	3
FL	Fort Lauderdale-Pompano Beach-Sunrise	65	8	13	6	1	12	14	11
FL	Homosassa Springs	13	0	6	0	0	3	2	2
FL	Naples-Marco Island	34	3	17	2	4	3	4	1
FL	North Port-Bradenton-Sarasota	73	1	31	8	5	10	8	10
FL	Palm Bay-Melbourne-Titusville	58	3	23	6	0	8	8	10
FL	Punta Gorda	17	0	10	2	0	3	1	1
FL	Sebastian-Vero Beach-West Vero Corridor	30	0	14	1	0	6	4	5
FL	Tallahassee	8	0	2	2	1	1	2	0
FL	Tampa	117	14	41	19	10	12	7	14
FL	Wildwood-The Villages	9	0	6	2	0	0	1	0
GA	Athens-Clarke County	18	2	6	2	0	2	4	2
GA	Atlanta-Sandy Springs-Roswell	208	21	76	8	7	32	21	43
GA	Douglas	2	0	1	0	0	0	0	1
GA	Gainesville	27	2	11	4	3	2	1	4
GA	Savannah	42	1	19	2	8	5	4	3
GA	Tifton	6	2	2	0	0	1	0	1
HI	Kahului-Wailuku	4	0	2	1	1	0	0	0
IA	Ames	5	0	3	0	0	0	1	1
IA	Iowa City	9	3	0	1	0	3	0	2
IA	Waterloo-Cedar Falls	7	0	2	1	0	0	3	1
IA-IL	Burlington	2	0	1	0	0	1	0	0
IA-IL	Davenport-Moline-Rock Island	15	1	6	1	0	4	3	0
ID	Boise City	23	0	1	2	3	1	7	9
ID	Hailey	2	0	1	0	0	1	0	0
ID	Sandpoint	0	0	0	0	0	0	0	0
IL	Bloomington	9	1	3	2	0	0	2	1
IL	Carbondale	5	0	2	0	0	0	3	0
IL	Centralia	1	0	1	0	0	0	0	0
IL	Charleston-Mattoon	5	0	3	1	0	1	0	0
IL	Danville	4	0	3	0	0	0	0	1
IL	Elgin	12	1	2	2	0	1	1	5
IL	Kankakee	10	0	7	2	0	0	0	1
IL	Ottawa	4	0	4	0	0	0	0	0
IL	Peoria	24	4	15	0	1	3	0	1
IL	Springfield	10	0	4	0	0	2	2	2
IL-MO	Quincy	5	1	3	0	0	0	0	1
IN	Bloomington	7	2	4	1	0	0	0	0

Areas Selected for ASM and Number of Specialists Assigned (Part 3)

State	CBSA	Total	Anesthesiology	Cardiology	Interventional Pain Mgt	Neurosurgery	Orthopedic Surgery	Pain Management	Physiatry
IN	Jasper	5	0	3	0	0	1	1	0
IN	Kokomo	8	1	3	1	0	1	2	0
IN	Lake County-Porter County-Jasper County	0	0	0	0	0	0	0	0
IN	Michigan City-La Porte	3	0	2	0	0	0	1	0
IN	Muncie	11	3	4	1	0	1	0	2
IN	Seymour	2	0	1	0	0	0	0	1
KS	Dodge City	2	0	1	0	0	1	0	0
KS	Hays	4	1	2	0	0	1	0	0
KS	Lawrence	7	1	4	0	0	1	0	1
KS	Salina	3	0	2	0	0	0	1	0
KS	Wichita	34	2	23	0	2	4	2	1
KY	Glasgow	3	0	2	1	0	0	0	0
KY	Lexington-Fayette	35	5	8	4	1	5	9	3
KY	Pikeville	3	0	2	0	0	0	1	0
KY	Richmond-Berea	3	0	1	0	0	0	2	0
KY-IL	Paducah	13	1	4	3	1	1	1	2
KY-IN	Louisville/Jefferson County	59	10	15	5	5	7	13	4
LA	Baton Rouge	52	1	19	9	5	5	5	8
LA	Houma-Bayou Cane-Thibodaux	12	2	4	2	1	2	1	0
LA	Lafayette	28	4	12	1	2	3	2	4
LA	Natchitoches	3	0	1	0	0	0	1	1
LA	New Iberia	3	0	1	1	0	1	0	0
LA	Shreveport-Bossier City	47	3	20	4	4	12	2	2
MA	Amherst Town-Northampton	7	0	4	0	0	0	0	3
MD	Easton	8	2	2	0	1	1	0	2
MD	Lexington Park	0	0	0	0	0	0	0	0
MD	Salisbury	16	1	9	1	0	3	1	1
MD-WV	Cumberland	6	1	2	2	0	0	0	1
MI	Flint	12	2	4	1	1	0	1	3
MI	Jackson	4	0	3	0	0	0	0	1
MI	Kalamazoo-Portage	12	2	5	0	0	2	2	1
MI	Midland	3	0	1	0	0	0	0	2
MI	Owosso	2	0	1	0	0	0	1	0
MI	Saginaw	9	3	3	1	2	0	0	0
MI	Traverse City	11	3	4	0	0	0	0	4
MI	Warren-Troy-Farmington Hills	177	17	69	8	6	14	16	47
MO	Columbia	21	0	7	2	0	9	3	0
MO	Farmington	3	0	1	0	0	0	1	1
MO	Mexico	1	0	1	0	0	0	0	0
MO	West Plains	6	1	2	2	0	1	0	0
MO-KS	Joplin	13	0	6	1	0	3	2	1
MO-KS	St. Joseph	9	0	6	0	0	0	2	1
MS	Brookhaven	2	0	1	0	0	0	1	0
MS	Columbus	7	1	4	0	0	2	0	0
MS	Hattiesburg	12	1	1	1	1	3	2	3

Areas Selected for ASM and Number of Specialists Assigned (Part 4)

State	CBSA	Total	Anesthesiology	Cardiology	Interventional Pain Mgt	Neurosurgery	Orthopedic Surgery	Pain Management	Physiatry
MS	Starkville	1	0	0	0	0	1	0	0
MS-LA	Natchez	2	0	1	0	0	0	1	0
MT	Billings	9	0	5	0	0	1	0	3
MT	Bozeman	6	1	2	0	0	0	0	3
MT	Missoula	10	1	2	1	1	2	1	2
NC	Boone	3	0	3	0	0	0	0	0
NC	Forest City	2	0	1	0	0	1	0	0
NC	Jacksonville	9	1	4	1	1	0	2	0
NC	Kinston	5	0	4	0	0	0	1	0
NC	Morehead City	4	0	2	1	0	1	0	0
NC	New Bern	13	1	4	4	1	1	2	0
NC	Pinehurst-Southern Pines	14	1	8	2	1	2	0	0
NC	Waynesville	5	0	2	0	0	2	1	0
NC	Wilmington	27	1	11	3	1	3	3	5
ND-MN	Fargo	12	2	4	1	1	1	3	0
NE	Hastings	3	0	1	1	0	1	0	0
NE-IA	Omaha	54	4	21	0	2	8	11	8
NH	Concord	8	1	1	1	0	3	0	2
NJ	Lakewood-New Brunswick	241	8	121	11	2	32	23	44
NJ	Trenton-Princeton	16	1	6	1	1	3	0	4
NJ	Vineland	2	0	1	0	0	0	1	0
NM	Alamogordo	2	0	1	0	0	0	1	0
NM	Roswell	3	0	2	0	0	1	0	0
NY	Albany-Schenectady-Troy	60	2	37	5	1	5	4	6
NY	Buffalo-Cheektowaga	26	0	16	0	0	1	3	6
NY	Jamestown-Dunkirk	2	0	2	0	0	0	0	0
NY	Kingston	7	0	3	0	0	3	0	1
NY	Kiryas Joel-Poughkeepsie-Newburgh	51	2	27	0	1	4	4	13
NY	Massena-Ogdensburg	5	1	1	0	0	0	1	2
NY	Olean	2	0	1	0	0	0	1	0
NY	Plattsburgh	5	0	4	0	0	0	1	0
NY	Rochester	21	5	5	1	0	0	2	8
NY	Syracuse	29	1	10	0	0	7	6	5
NY	Utica-Rome	14	0	7	0	1	0	2	4
OH	Lima	16	0	10	0	0	2	2	2
OH	Mansfield	7	2	2	1	0	1	0	1
OH	Marietta	6	0	2	0	0	0	1	3
OH	Toledo	40	4	19	1	0	6	6	4
OH	Zanesville	7	0	4	0	0	0	1	2
OH-KY-IN	Cincinnati	105	8	42	5	9	12	11	18

Areas Selected for ASM and Number of Specialists Assigned (Part 5)

State	CBSA	Total	Anesthesiology	Cardiology	Interventional Pain Mgt	Neurosurgery	Orthopedic Surgery	Pain Management	Physiatry
OK	Elk City	4	1	0	0	0	1	2	0
OK	Lawton	12	1	7	0	1	1	1	1
OK	Muskogee	6	0	4	1	1	0	0	0
OK	Oklahoma City	84	12	26	8	10	12	7	9
OK	Shawnee	2	0	1	0	0	0	1	0
OR	Coos Bay-North Bend	3	0	2	1	0	0	0	0
OR	Corvallis	6	0	2	0	0	1	1	2
OR	Eugene-Springfield	12	0	3	2	2	0	2	3
PA	Bloomsburg-Berwick	2	0	0	1	0	0	1	0
PA	Chambersburg	2	1	0	0	0	0	1	0
PA	East Stroudsburg	15	1	7	0	0	4	1	2
PA	Harrisburg-Carlisle	32	3	8	4	1	12	0	4
PA	Hermitage	6	3	2	0	0	1	0	0
PA	Indiana	1	1	0	0	0	0	0	0
PA	Pottsville	9	2	4	0	0	2	1	0
PA	Reading	20	1	9	2	0	5	3	0
PA	Williamsport	6	1	0	0	0	1	3	1
PA-NJ	Allentown-Bethlehem-Easton	68	3	33	3	1	5	10	13
RI-MA	Providence-Warwick	88	13	44	2	5	11	6	7
SC	Hilton Head Island-Bluffton-Port Royal	17	3	3	2	0	6	2	1
SC	Spartanburg	10	0	2	0	2	2	1	3
SC	Sumter	2	0	1	1	0	0	0	0
SD	Aberdeen	4	1	1	0	0	1	1	0
SD	Rapid City	12	0	4	0	0	3	2	3
TN	Cleveland	4	0	1	1	0	0	2	0
TN	Johnson City	7	0	3	0	0	2	1	1
TN	Morristown	3	0	2	0	0	1	0	0
TN	Paris	2	0	2	0	0	0	0	0
TN	Sevierville	2	0	1	0	0	1	0	0
TN	Shelbyville	3	0	2	0	0	1	0	0
TN	Winchester	3	0	2	0	0	0	0	1
TN-GA	Chattanooga	22	3	7	2	0	4	2	4
TN-MS-AR	Memphis	71	4	22	4	5	22	3	11
TX	Amarillo	20	2	8	1	1	1	5	2
TX	Austin-Round Rock-San Marcos	120	13	39	16	5	13	14	20
TX	College Station-Bryan	16	2	8	0	0	1	4	1
TX	Corpus Christi	16	1	7	1	0	3	4	0
TX	Dallas-Plano-Irving	271	30	78	22	20	41	33	47
TX	Fredericksburg	4	0	1	2	0	1	0	0
TX	Houston-Pasadena-The Woodlands	306	44	131	20	15	32	38	26

Areas Selected for ASM and Number of Specialists Assigned (Part 6)

State	CBSA	Total	Anesthesiology	Cardiology	Interventional Pain Mgt	Neurosurgery	Orthopedic Surgery	Pain Management	Physiatry
TX	Kerrville	5	0	1	1	0	1	1	1
TX	Lufkin	5	0	4	0	0	0	0	1
TX	McAllen-Edinburg-Mission	6	2	1	0	1	0	0	2
TX	Paris	4	1	1	0	0	0	0	2
TX	San Angelo	10	0	6	0	2	0	2	0
TX	San Antonio-New Braunfels	116	15	39	20	5	17	15	5
TX	Sherman-Denison	9	2	2	0	1	1	1	2
TX	Tyler	30	3	10	2	0	3	5	7
TX	Wichita Falls	17	0	10	1	4	0	2	0
TX-AR	Texarkana	4	0	0	0	0	0	3	1
UT	Cedar City	3	0	1	0	0	0	1	1
UT	Ogden	21	2	7	1	0	2	1	8
UT	Provo-Orem-Lehi	14	5	1	1	1	2	3	1
UT	St. George	18	1	4	1	0	4	4	4
VA	Blacksburg-Christiansburg-Radford	6	1	3	0	0	1	0	1
VA-NC	Virginia Beach-Chesapeake-Norfolk	94	2	30	3	8	16	9	26
VA-WV	Arlington-Alexandria-Reston	149	7	74	20	4	25	5	14
VT	Bennington	2	0	1	0	0	0	0	1
VT	Burlington-South Burlington	13	4	4	0	1	2	2	0
WA	Everett	24	1	11	0	0	1	3	8
WA	Mount Vernon-Anacortes	14	0	7	0	0	3	1	3
WA	Port Angeles	2	0	2	0	0	0	0	0
WA	Tacoma-Lakewood	20	1	6	1	0	5	5	2
WA	Wenatchee-East Wenatchee	11	1	5	0	0	1	0	4
WA	Yakima	8	0	3	2	0	1	1	1
WI	Appleton	8	2	2	0	0	0	0	4
WI	Fond du Lac	3	0	1	0	0	0	1	1
WI	Madison	14	0	3	0	0	1	2	8
WI	Milwaukee-Waukesha	53	8	14	3	1	7	8	12
WI	Oshkosh-Neenah	5	1	0	0	0	0	2	2
WI	Rice Lake	2	1	1	0	0	0	0	0
WI	Whitewater-Elkhorn	1	0	0	1	0	0	0	0
WI	Wisconsin Rapids-Marshfield	1	0	1	0	0	0	0	0
WV	Charleston	7	1	3	0	0	0	3	0
WV-OH	Wheeling	6	0	3	0	0	0	3	0

Notes

1. Centers for Medicare and Medicaid Services. *CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies*. 90 Federal Register 49562.
2. Centers for Medicare and Medicaid Services. *CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies*.
3. Centers for Medicare and Medicaid Services. *CMS Patient Relationship Categories and Codes*.
4. Centers for Medicare and Medicaid Services. *Measure Information Form, Heart Failure Measure* and *Measure Information Form, Low Back Pain Measure*.
5. Medicare Fee-For-Service Provider Utilization & Payment Data Physician and Other Supplier Public Use File.
6. In the regulations establishing ASM, CMS said: "We also considered using an EBCM episode threshold greater than 20 episodes. For example, we considered the effects of using a 30-episode or 50-episode threshold. In our analysis of calendar year 2023 data, we found that a 30-episode threshold would decrease the number of potentially eligible ASM participants by 43 percent for heart failure and 35 percent for low back pain relative to the 20-episode threshold. We found that a 50-episode threshold would decrease the number of potentially eligible ASM participants by 76 percent for heart failure and by 65 percent for low back pain relative to the 20-episode threshold. We believe that the smaller number of potentially eligible ASM participants under a higher EBCM episode threshold would make for a less reliable model test." 90 FR 49586.
7. Edep ME et al. "Differences Between Primary Care Physicians and Cardiologists in Management of Congestive Heart Failure: Relation to Practice Guidelines." *Journal of the American College of Cardiology* 30:518-26.
8. Centers for Medicare and Medicaid Services. *National Summary Data Report on 5 Episode-Based Cost Measures, Winter 2022 Field Testing*.
9. Centers for Medicare and Medicaid Services. *National Summary Data Report on 5 Episode-Based Cost Measures, Winter 2022 Field Testing*.
10. In MIPS, cardiologists who select the Advancing Care for Heart Disease MVP can report not only the measures on heart failure that are included in ASM, but also measures related to care for coronary artery disease, ischemic vascular disease, and atrial fibrillation.
11. The rural status of counties in each CBSA was determined using the Federal Office of Rural Health Policy (FORHP) Data Files.
12. Jackson Physician Search, LocumTenens.com, and MGMA. *Rural Healthcare Specialty Priorities*. September 2026.
13. Center for Healthcare Quality and Payment Reform. Rural Hospitals at Risk of Closing.
14. Sharon Regional Medical Center Doctors Express Concerns for Closure.
15. Sharon Regional Expands Cardiovascular Care After Reopening.
16. Medicare Payment Advisory Commission *Moving beyond the Merit-based Incentive Payment System*.
17. Center for Medicare and Medicaid Services. *Heart Failure Measure: Measure Justification Form September 2022*.
18. Center for Medicare and Medicaid Services. *Low Back Pain Measure Justification Form September 2022*.
19. In justifying the use of quality measures in ASM that were not limited to Medicare beneficiaries, CMS said "…in the ASM heart failure quality measure set … the medication measures are all-payer measures…We believe this approach is important because it … provides more stable denominators for meaningful measurement…this approach addresses the sample size and representativeness issues that could arise from limiting measurements to only attributed patients, which could result in unreliable or skewed performance data." 90 FR 49615.
20. If average spending is $13,000 for patients who do not receive a cardiovascular procedure and $40,000 for those who do, then if one patient out of 20 receives a procedure, it will increase the average spending for a physician from $13,000 to over $14,000, which could reduce their cost score by more than 10%.
21. In the regulations establishing ASM, CMS said: "We believe that the Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with heart Failure (MIPS Q492) quality measure as discussed in section III.C.d.2.(b).(i) of this final rule would account for the inappropriate withholding of care in an effort for a participant to improve their cost ASM performance category score." 90 FR 59640.
22. American College of Physicians. "Use of High-Risk Medications in the Elderly".
23. If a physician only has 20 low back pain patients, the MRI rate will differ by 5% depending on whether one individual patient receives an MRI or not. The 2024 Annual Reevaluation Report for the OP-8 measure showed that even with minimum case counts much higher than 20 patients, a 5 percentage point increase in the rate would have moved a hospital in the 10th percentile to the 25th percentile, it would have moved a hospital in the 25th percentile to the 50th percentile, it would have moved a hospital in the 50th percentile to the 75th percentile, and a hospital in the 75th percentile would have moved to the 90th percentile.

24. American College of Physicians. Controlling High Blood Pressure.
25. American College of Physicians. Use of High-Risk Medications in the Elderly.
26. Centers for Medicare and Medicaid Services. *CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies*.
27. 90 FR 49608.
28. In MIPS, CMS is using the standard deviation approach for the measure that assesses hospital admissions for heart failure patients, but it appears that it will use the decile approach for the measure in ASM.
29. Centers for Medicare and Medicaid Services. Quality Payment Program Benchmarks.
30. CY 2017 Physician Fee Schedule Rule (81 FR 77278).
31. CY 2026 Physician Fee Schedule Rule (90 FR 49910).
32. 91 FR 43983.
33. 90 FR 49671.
34. 90 FR 49673.
35. Office of the Assistant Secretary for Planning and Evaluation. *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*. March 2020.
36. Centers for Medicare and Medicaid Services. *CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies*.
37. Federal Office of Rural Health Policy (FORHP) Data Files
38. 90 FR 49675.
39. 90 FR 49677.
40. In the regulations establishing ASM, CMS said "To ensure savings in the financial impacts for the model, ASM will also retain a percentage of the payments rather than distributing all funds as clinicians' payment adjustments." 90 FR 49564.
41. 91 FR 43980.
42. In the regulation that created ASM, CMS stated that if it were to increase the 20-episode threshold for requiring participation in ASM, "a 30-episode threshold would decrease the number of potential eligible ASM participants by 43 percent for heart failure and 35 percent for low back pain relative to the 20-episode threshold" and that "a 5-episode threshold would decrease the number of potentially eligible ASM participants by 76 percent for heart failure and by 65 percent for low back pain relative to the 20-episode threshold." (90 FR 49586) This means that more than 2,000 physicians are being assigned to ASM because they have 20-29 episodes, and they could become exempt by seeing an average of 5 fewer patients who have heart failure or low back pain. This would affect more than 10,000 beneficiaries. More than 1,700 additional physicians are being assigned because they have 30-49 episodes, and they could become exempt from ASM by seeing an average of 20 fewer patients. This would affect more than 30,000 additional beneficiaries. If the approximately 1,700 physicians who have more than 50 episodes reduce the number of low-income or complex beneficiaries they see by 5-10 patients, this would affect an additional 8,500 - 17,000 patients. Even if less than half the physicians assigned to ASM respond in this way, more than 20,000 beneficiaries would lose access to their care.
43. Health Resources and Services Administration. *Physician Workforce: Projections, 2023-2038*. December 2025.
44. Ezekowitz JA, et al. "Impact of specialist follow-up in outpatients with congestive heart failure." *CMAJ* 172(2):189–94.
45. Johnston KJ, Wen H, Maddox KEJ. "Lack of Access to Specialists Associated With Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries." *Health Affairs* 38(12):1993-2002.
46. Congressional Budget Office. *Federal Budgetary Effects of the Activities of the Center for Medicare and Medicaid Innovation*. September 2023.
47. In the regulations creating ASM, CMS said: "To ensure savings in the financial impacts for the model, ASM will also retain a percentage of the payments rather than distributing all funds as clinicians' payment adjustments." 90 FR 49564.
48. In addition, services from different specialists might be needed in different phases, e.g., if the specialist who initially diagnoses the patient determines that the patient should be treated by a different physician who subspecializes in treating the specific condition subtype for that patient.
49. Center for Healthcare Quality and Payment Reform. *4 Steps to Successful Value-Based Payment*.

About the Author

Harold D. Miller is the President and CEO of the Center for Healthcare Quality and Payment Reform (CHQPR), a national policy center focused on improving healthcare payment and delivery systems.

Miller is an internationally-recognized expert on healthcare payment and delivery. He has worked to help physicians, hospitals, employers, health plans, and government agencies across the U.S. and in other countries design and implement payment and delivery system reforms. He has twice given invited testimony to Congress on how to reform healthcare payment, and he served for four years as one of the initial members of the federal Physician-Focused Payment Model Technical Advisory Committee (PTAC) that was created by Congress to advise the Secretary of Health and Human Services on the creation of alternative payment models.

Miller's work has appeared in multiple peer-reviewed journals, including "From Volume to Value: Better Ways to Pay for Healthcare" in *Health Affairs*, "Making Value-Based Payment Work for Academic Health Centers" in *Academic Medicine*, "Win-Win-Win Approaches to Healthcare Cost Control Through Physician-Led Payment Reform," in *Clinical Gastroenterology and Hepatology*, "A Better Path to Value in Cancer Care" in the *Journal of Clinical Oncology*, "New Approaches to Both Health Care Delivery and Payment Systems Are Needed in Rural Areas" in the *Journal of Ambulatory Care Management*, "How to Create Successful Alternative Payment Models in Oncology" in the *American Journal of Managed Care*, "Aligning Payments, Services, and Quality in Primary Care" (with John Wasson and Harold Sox) in *JAMA*, and "Patient-Centered Payment for Care of Chronic Conditions" in the *Journal of Ambulatory Care Management*. He has written a number of widely-used papers and reports on health care payment and delivery reform, including the Center for Healthcare Quality and Payment Reform's reports *How to Create an Alternative Payment Model*, *Why Value-Based Payment Isn't Working and How to Fix It*, *Saving Rural Hospitals and Strengthening Rural Healthcare*, *Stopping the Loss of Rural Maternity Care*, and *Patient-Centered Payment for Primary Care*. He co-authored *A Guide to Physician-Focused Alternative Payment Models* that was jointly published by the American Medical Association and the Center for Healthcare Quality and Payment Reform.

Miller assisted the American Academy of Hospice and Palliative Medicine, the American Academy of Neurology, the American College of Allergy, Asthma, and Immunology, the American College of Cardiology, the American College of Emergency Physicians, the American College of Rheumatology, the American Society of Addiction Medicine, the American Society of Cataract and Refractive Surgery, the American Society of Clinical Oncology, and the American Medical Association in developing alternative payment models designed to support better care for patients at lower cost. He assisted the Centers for Medicare and Medicaid Services with the implementation of its Comprehensive Primary Care Initiative in 2012, and he assisted the Washington State Hospital Association and the State of Washington to develop an improved payment system for small, rural hospitals.

From 2008 to 2013, in addition to leading CHQPR, Miller served as the President and CEO of the Network for Regional Healthcare Improvement (NRHI), the national association of Regional Health Improvement Collaboratives. He served as a member of the Board of Directors of the National Quality Forum from 2009 to 2015. Prior to founding CHQPR, Miller served as the Strategic Initiatives Consultant to the Pittsburgh Regional Health Initiative (PRHI); his work there demonstrating the significant financial penalties that hospitals can face if they reduce hospital-acquired infections was featured in *Modern Healthcare* magazine in December 2007. In 2007, Miller served as the Facilitator for the Minnesota Health Care Transformation Task Force, which prepared the recommendations that led to passage of Minnesota's path-breaking healthcare reform legislation in May 2008.