ASPN REIMBURSEMENT & REGULATORY AFFAIRS

The CMS Ambulatory Specialty Model (ASM): What Every ASPN Member Must Know Before January 1, 2027

A mandatory, two-sided risk Medicare payment model is coming to interventional pain and pain management. Here is what it is, who it affects, and how to prepare.

Prepared by: ASPN Office of Reimbursement & Regulatory Affairs **Published:** May 2026 **Audience:** All ASPN Members

Status: Mandatory — Action Required

BOTTOM LINE UP FRONT

CMS has **finalized** a mandatory, two-sided risk payment model — the Ambulatory Specialty Model (ASM) — that will directly affect thousands of interventional pain, anesthesiology, and pain management physicians beginning **January 1, 2027**. Payment adjustments range from **−9% to +9%** in Year 1, escalating to **−12% to +12%** by 2031, applied to **all Medicare Part B services**. Members in selected regions must begin preparing now.

2027	5 yrs	±9→12%	6,637
Performance Year 1 begins Jan 1	Model duration through 2031	Payment swing on all Part B	Clinicians on preliminary list

1 What Is the ASM?

The Ambulatory Specialty Model is a mandatory payment and performance model from the **CMS Innovation Center (CMMI)**, authorized under Section 1115A of the Social Security Act. It is the **first mandatory CMMI model targeting outpatient specialists** who treat chronic conditions — specifically **low back pain** and **heart failure** (CMS).

First proposed on July 14, 2025 in the CY 2026 Physician Fee Schedule proposed rule and finalized October 31, 2025, the model shifts specialty care away from volume-based fee-for-service toward accountability for clinical outcomes and total episode cost of care (CMS; SavyaCRISP). CMS estimates low back pain and congestive heart failure together cost Medicare an estimated **$16–21 billion annually**, with low-value care and delayed disease management cited as primary drivers (CMS).

Figure 1. ASM timeline. Payment adjustments are applied two years after each performance year (PY 2027 → 2029; PY 2031 → 2033).

2 Are You in the Crosshairs? Mandatory Participation

Participation is **mandatory — there is no opt-out** — for physicians who meet **all three** criteria below (SavyaCRISP; CMS):

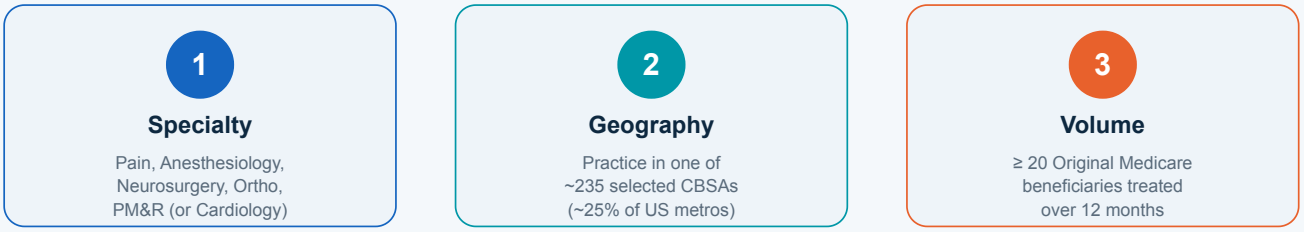

Figure 2. All three criteria must be met for mandatory inclusion.

⚠️ The "Lock-In" Trap

Once you meet the 20-episode threshold in **any** performance year, you are permanently treated as a participant for the remainder of the model — even if your volume later drops (SavyaCRISP).

The preliminary list identifies **6,637 clinicians**: ~4,027 in the Low Back Pain cohort and ~2,610 in the Heart Failure cohort. Specialties in the **Low Back Pain cohort** include Anesthesiology, Pain Management, Interventional Pain Management, Neurosurgery, Orthopedic Surgery, and PM&R.

TX · 1,121 **CA · 644** **FL · 643** **NJ · 298** **MI · 281** **VA · 270** **NY · 251**

✅ ASPN Action Item

Verify your status now using the **CMS ASM Participant Lookup Tool** (searchable by NPI, name, or organization) and complete the ASM Participant Contact Information Form (CMS Data).

3 How You Are Scored: The 0–100 Composite

The ASM uses a MIPS Value Pathway (MVP)–based framework adapted into a mandatory Alternative Payment Model. Clinicians earn a composite score of **0–100** across four categories (SavyaCRISP):

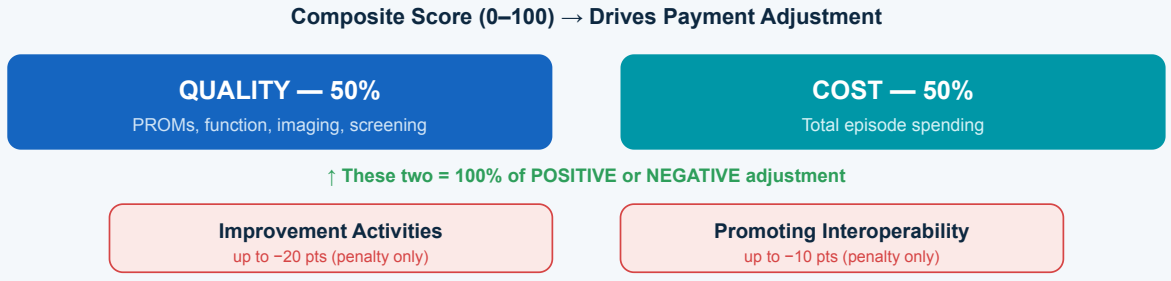

*Figure 3. Quality + Cost drive the adjustment. Improvement Activities and Promoting Interoperability can **only subtract** points — they never raise your score.*

Five Mandated Quality Measures (Low Back Pain)

Physicians cannot self-select measures as under traditional MIPS. CMS specifies the following required measures and collection types (CMS ASM Overview Webcast):

Cost, Care Coordination & Tech

- **Cost:** A single claims-based episode cost measure on **total Medicare spending** — not just your fees.
- **Improvement Activities:** Mandatory **Collaborative Care Arrangement (CCA)** with a primary care practice

Required Measure	Collection Type(s)
Use of High-Risk Medications in Older Adults **(MIPS Q238)**	eCQM / MIPS CQM
Preventive Care & Screening: Screening for Depression & Follow-Up Plan **(MIPS Q134)**	eCQM / MIPS CQM
Preventive Care & Screening: BMI Screening & Follow-Up Plan **(MIPS Q128)**	eCQM / MIPS CQM
Functional Status Change for Patients with Low Back Impairments **(MIPS Q220)**	MIPS CQM
Excess Utilization Measure — *to be proposed in CY 2027 rulemaking*	Administrative Claims

+ HRSN screening.

- **Interoperability:** CEHRT + FHIR-based health information exchange. Failure triggers an automatic penalty (SavyaCRISP).

4 The Money: Payment Adjustment Mechanics

Clinicians are ranked **relative to peers within their cohort** using decile-based scoring — meaning a bottom tier of performers always exists, even if overall quality improves. The composite score is translated into an adjustment applied to **all Medicare Part B services**, escalating each year (SavyaCRISP):

Performance Year	Payment Year	Minimum	Maximum
2027	2029	−9%	+9%
2028	2030	−10%	+10%
2029	2031	−11%	+11%
2030	2032	−11%	+12%
2031	2033	−12%	+12%

💵 Real-World Exposure

For a physician billing **$500,000/year** in Medicare Part B:

−9% (Yr 1) = **$45,000** reduction · −12% (Yr 5) = **$60,000** reduction.

⚠️ Not Budget-Neutral

Unlike MIPS, CMS retains **~15%** of redistributed funds (85% redistribution in 2027), so winners' gains **do not fully offset** losers' penalties. The system is structurally tilted to generate Medicare savings (SavyaCRISP).

Portability: Adjustments follow the clinician's NPI/TIN — if you change employers, your accountability travels with you. **MIPS exemption** applies for qualifying ASM episodes, but MSSP ACO participation does **not** exempt you from ASM.

5 What This Means for Interventional Pain

The ASM explicitly targets specialists with historically high utilization of procedures and imaging. It does **not** prohibit interventional procedures, but it creates powerful incentives to prioritize conservative care earlier, embed **patient-reported outcomes** into routine practice, reduce early imaging, and treat **functional improvement** — not pain relief alone — as the primary metric.

ASPN's position is that evidence-based interventional therapies — **spinal cord stimulation (SCS), radiofrequency ablation (RFA), and targeted nerve blocks** — are opioid-sparing, function-improving, and hospitalization-preventing. Under the ASM, members must be positioned to **document and demonstrate these outcomes** through the mandated PRO framework to justify interventional approaches within the cost-measure structure.

Model Flexibilities to Leverage

🎁 Beneficiary Incentive Waiver

Up to **$1,000 per beneficiary** in in-kind engagement incentives (RPM devices, healthy-food vouchers, health coaching) via an Anti-Kickback safe harbor. **Caution:** the rule is ambiguous on whether the cap is annual or lifetime — seek legal counsel.

📱 Telehealth Waivers

Geographic and originating-site requirements are waived, letting beneficiaries receive follow-up care from home — valuable for chronic low back pain monitoring (SavyaCRISP).

6 Your Readiness Roadmap

Immediate (before Summer 2026)

- ✓ Verify status in the CMS ASM Participant Lookup Tool
- ✓ Complete the ASM Participant Contact Information Form
- ✓ Confirm inclusion when the final list releases (Summer 2026)
- ✓ Baseline your MIPS quality & cost performance

Short-Term (Q3–Q4 2026)

- ✓ Implement PROMIS/PRO collection in clinical workflow
- ✓ Execute a Collaborative Care Arrangement (CCA)
- ✓ Audit EHR for FHIR / CEHRT compliance
- ✓ Engage counsel on CCA & the $1,000 incentive program

Operational (before January 1, 2027)

- ✓ Document functional status at every encounter via validated PRO tools
- ✓ Adopt a depression screening protocol
- ✓ Build lifestyle-counseling & referral pathways
- ✓ Set up episode-attribution tracking with your billing team

ASPN'S COMMITMENT

ASPN will monitor the CY 2027 rulemaking cycle (including the anticipated MRI utilization measure), advocate for quality measures that reflect the full clinical value of SCS, RFA, and nerve-block therapies, engage CMS on attribution methodology, and provide members with PRO templates, CCA templates, and episode cost-benchmarking support. Members with questions should contact the ASPN Office of Reimbursement & Regulatory Affairs.

References & Resources

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