CMS Finalizes Ambulatory Specialty Model Allowing $1,000 For Remote Monitoring, Tech Incentives

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CMS' recently finalized Ambulatory Specialty Model (ASM), targeting specialists treating costly chronic conditions like heart failure and low back pain, will test the administration's hypothesis that linking reimbursement to cost and quality outcomes can improve care and reduce spending.

Under the model finalized in the 2026 Physician Fee Schedule last Friday (Oct. 31), cardiologists, orthopedic surgeons, pain specialists, anesthesiologists and neurosurgeons in selected regions will continue billing fee-for-service but, starting in 2029, will be subject to performance-based payment adjustments ranging from a 9% penalty to a 9% bonus, increasing to 12% by the final performance year in 2031.

CMS said the model is intended to test whether tying specialist payment to quality, cost and care coordination can both lower spending and improve outcomes for patients with chronic conditions, with participating clinicians benchmarked against peers and scored on a composite of quality, cost and interoperability metrics.

"The model aims to enhance the quality of care and reduce low-value care by improving beneficiary and provider engagement, incentivizing preventive care, and increasing financial accountability for specialists," the agency said in its press release last Friday (Oct. 31). "This model rewards specialists who detect signs of worsening chronic conditions early, enhance patients' function, reduce avoidable hospitalizations, and use technology that allows them to communicate and share data electronically with patients and their primary care providers."

The final rule also authorizes up to $1,000 per beneficiary per year in in-kind patient supports, including technology, to promote self-management and preventive care. CMS cited examples such as remote monitoring devices, nutrition supports and fitness memberships, which aligns with advocacy asks from the Consumer Technology Association (CTA) and Connected Health Initiative (CHI) to use CMS Innovation Center models to advance wearable adoption and patient-generated health data. Still, CMS is requiring additional documentation safeguards for items valued over $75, like earlier proposed.

The agency also finalized new requirements to strengthen coordination between specialists and primary care providers. Participating specialists must ensure each patient has a designated primary care provider, share clinical information after each visit, and establish at least one formal collaborative care agreement with a primary care practice. These agreements must address at least three of five core areas: data sharing, co-management, care transitions, closed-loop communication and integrated care coordination.

According to a September analysis by Forvis Mazars, the ASM's structure guarantees CMS measurable savings from the start. Unlike the budget-neutral MIPS program, the ASM allows CMS to retain a share of Part B payments -- beginning at 1.35% of episode-based reimbursements in year one and increasing to 1.8% by

year five -- which is excluded from the performance incentive pool, ensuring a steady stream of savings for the Medicare Trust Fund.

Forvis Mazars said the model's design also promotes care transformation by incentivizing improved chronic disease management, stronger care coordination and wider adoption of interoperable health records. CMS expects these changes will reduce unnecessary imaging and surgeries for low back pain, as well as help prevent avoidable hospitalizations and emergency department visits for heart failure.

Forvis Mazars advised specialists to start preparing now, given the model's complexity and mandatory participation. As a first step, practices should review the eligibility criteria and episode attribution rules to determine whether their patients and services will be included, they said.

They also encouraged physicians to evaluate their current performance on quality and cost measures, strengthen data collection and interoperability processes, and prepare to meet the Improvement Activities (IA) and Promoting Interoperability (PI) requirements that factor into ASM scoring.

"Finally, it is important to model the financial impact of ASM payment adjustments for both possible upside and downside so your organization can plan for revenue changes and identify opportunities to improve performance bonuses," the advisors write in the brief. "Early preparation and proactive engagement can help physicians reduce uncertainty and create a road map for success."

CMS will publish the initial list of mandatory regions and eligible participants in mid-2026, with the first performance year beginning January 2027 and payment adjustments starting in 2029. -- *Jalen Brown* (jbrown@iwpnews.com