Provider Groups Urge CMMI To Delay ASM; CHQPR Calls For Scrapping Model

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Major hospital and physician groups are urging CMS' innovation center to delay the Jan. 1 launch of its mandatory Ambulatory Specialty Model (ASM), warning that unresolved technical problems and limited guidance from the agency have left practices with insufficient time to prepare -- as another organization separately calls on the agency to abandon the model altogether.

In an Oct. 27 letter to CMS Innovation Center Director Abe Sutton, seven organizations -- the American Hospital Association, American Medical Association, AMGA, Health Care Transformation Task Force, Medical Group Management Association, National Association of ACOs and Premier -- call on the agency to postpone implementation until the model's operational and technical infrastructure is actually ready.

If CMMI proceeds with the scheduled launch, the groups want participants protected from downside financial risk for the first performance period.

"Delays in participant identification, online portal access, operational guidance, and technical support have materially constrained participants' ability to prepare," the groups wrote in the letter. "Given the model's significant financial risk and its imminent January 1, 2027 start date, if these issues are not resolved, participants' focus and resources will be diverted to resolving avoidable operational and technical challenges and could undermine both participant performance and the validity of the model's early results."

ASM will test whether performance-based payment adjustments improve care and reduce spending for traditional Medicare beneficiaries with heart failure or low back pain. Selected specialists will be evaluated on quality, cost, improvement activities and interoperability, with their performance affecting future Medicare Part B payments for covered professional services. The first performance year begins in 2027, with the payment adjustments taking effect in 2029.

As far as the problems with the model are concerned, the coalition says CMS published the final participant list Sept. 15, approximately two months later than indicated in the 2026 Physician Fee

Schedule final rule. The groups also noted that proposed changes in the forthcoming 2027 fee schedule could further affect participation because it would allow certain cardiac subspecialists to be excluded.

“The net effect of these actions is that 2027 ASM participants have three-months’ notice prior to model launch to prepare for implementation,” the groups wrote. “Perhaps if pre-implementation information resources, like the ASM online portal, were readily available, three months would be an inconvenience rather than a detriment. Unfortunately, participants continue to encounter delays.”

According to the letter, practices have also encountered problems logging into the model’s portal, accessing information, and delegating authority to staff. The groups said participants and administrative staff also have struggled to obtain timely answers from the agency.

The coalition wants CMMI to establish a single help desk with published response-time targets, maintain a searchable resource for frequently asked questions, and resolve outstanding portal problems.

The coalition also urges CMS to provide prospective cost and quality performance thresholds before each performance year so participants can assess their standing and make improvements.

“Such information would allow participants to understand their current performance level and take quality improvement or corrective actions to improve their overall performance,” the groups wrote. “CMMI could use historical cost and quality data to project the prospective thresholds, with the caveat that final performance thresholds can and will vary with actual performance results.”

The organizations also want practice-level reporting. They argue that individual submissions impose unnecessary burdens on specialists who rely on a centralized reporting infrastructure.

“Addressing these implementation issues before the performance period begins will strengthen participant readiness, protect the integrity of the model’s evaluation, and help ensure that the model’s results reflect the care participants deliver to Medicare beneficiaries living with chronic conditions,” the groups wrote. “Accordingly, we urge you to delay the model’s launch until these issues are resolved.”

At the same time, Harold Miller, president and CEO of the Center for Healthcare Quality and Payment Reform, is calling for CMS to abandon ASM altogether.

In a statement sent to *Inside Health Policy* this week, Miller argues the model’s payment structure could undermine access to specialty care, as physicians could face payment cuts even if they deliver high-quality care or improve their performance.

“Unlike the MIPS program, more physicians in ASM will receive payment reductions than increases. This was done solely so that CMMI could ‘ensure’ that the program reduces Medicare spending,” Miller wrote. “Moreover, unlike MIPS and other CMMI programs, ASM has no predefined performance standard or target that physicians are expected to meet -- they will get a pay cut if they get a slightly lower score than the majority of the other physicians in ASM, even if they are delivering high quality care and even if they improved their performance compared to the prior year.”

“The net result of this is that the majority of physicians in the program will see their payments cut, and there is no way for any physician to know what they could do to avoid a cut,” Miller added. “This is hardly an ‘incentive’ to improve care.”

Miller also warned that specialists could treat fewer traditional Medicare beneficiaries with heart failure or low back pain to fall below the model’s participation threshold.

“For example, many cardiologists are being required to participate in ASM because they saw 20 or 30 Medicare beneficiaries with heart failure during the year,” Miller wrote. “If they receive a payment cut under the program, the cut will apply to ALL of their Medicare payments, not just the payments for services to heart failure and low back pain patients. If they see fewer Medicare beneficiaries with heart failure, they will be exempt from the model.”

Miller also raised concerns about the rural communities selected for the model, where access to specialists is already limited.

“The rural communities selected for ASM will likely have much greater difficulty attracting and retaining specialists because of the penalties the specialists will face by practicing there. If the rural hospital in the community can no longer attract specialists, it may have to eliminate services or it may be forced to close completely,” Miller wrote. “All of this could happen while CMS is ‘testing’ the model, and the negative impacts will be difficult to reverse.” -- *Jalen Brown* (jbrown@iwpnews.com)