Value-Based Care & the Ambulatory Specialty Model

AAPM PainConnect Member Briefing — Webinar, August 3, 2026

Effective: Jan 1, 2027
CMS 42 CFR §512
painconnect.org

MANDATORY for eligible pain specialists — Performance Year 2027 | Payment Adjustments begin 2029 | Final Rule: October 31, 2025

BY THE NUMBERS

$40B
Annual Medicare spend on chronic low back pain

25%
U.S. CBSAs included in ASM launch

±9%
Initial payment adjustment, rising to ±12%

20+
LBP EBCM episodes required for eligibility

5 / 50
5% of patients drive 50% of national health expenditure

WHAT IS ASM?

The **Ambulatory Specialty Model (ASM)** is CMS's first mandatory two-sided risk value-based payment model for specialists. Starting **January 1, 2027**, it holds pain specialists accountable for outcomes and total cost of care for patients with **chronic low back pain** — with financial bonuses or penalties tied to performance.

- **Two-sided risk:** Bonus for exceeding metrics; penalty for falling short
- **Specialists covered:** Anesthesiology, Interventional Pain, Neurosurgery, Orthopedic Surgery, PM&R
- **Builds on MACRA/MIPS** — familiar 4-domain performance structure
- **Geographic rollout:** 25% of U.S. Core-Based Statistical Areas (CBSAs)

ASM ELIGIBILITY CRITERIA

- Bills under Medicare Physician Fee Schedule (TIN/NPI)
- Specialist in a covered pain or spine specialty
- Treats **20+ chronic LBP EBCM episodes** per year
- Located in a mandatory CBSA geographic area

POLICY EVOLUTION: ROAD TO ASM

1965	Medicare & Medicaid established — President Johnson
1989	RBRVS physician payment schedule enacted (eff. 1992)
1997	Balanced Budget Act introduces Sustainable Growth Rate (SGR)
2010	Affordable Care Act — value-based purchasing programs emerge
2015	MACRA eliminates SGR; establishes MIPS & APMs
Oct 2025	ASM Final Rule published (42 CFR Part 512)
2027	ASM Performance Year 1 begins — claims paid at FFS
2029	First payment adjustments applied (±9% of all Medicare Part B)

HOW PAYMENT WORKS

Submit Claims
Performance Year (e.g. 2027)
→
Paid at FFS Rate
Standard Physician Fee Schedule
→
Risk Adjustment
Applied retroactively in 2029

The ±9% adjustment applies to *all* attributed Medicare Part B services — not only low back pain patients.

4 PERFORMANCE DOMAINS

QUALITY — 50%
5 outcome measures: medications in elderly, depression, BMI, functional status, excess utilization

COST — 50%
Episode-Based Cost Measure for ALL attributed Medicare beneficiaries — calculated by CMS from claims data

IMPROVEMENT ACTIVITIES
PCP connectivity, collaborative care arrangements, SDOH screening, care coordination workflows

INTEROPERABILITY
CEHRT/FHIR compliance; e-prescribing; PDMP query; bidirectional health information exchange

SCORING AT A GLANCE

Quality — Outcomes, medications, BMI, depression, function — 50%

Cost — Total cost of care for all attributed Medicare pts — 50%

Improvement Activities — PCP coordination, SDOH screening, care workflows — ±

Interoperability — CEHRT, HIE, e-prescribing, PDMP, patient access — ±

- 100% IA → no adjustment · 50% IA → **−10 pts** · 0% IA → **−20 pts**
- Complex patient bonus added when HCC risk ≥ cohort median and score > 0
- Data submission deadline: **March 31** following each performance year

Supporting Solo & Small Practices (<15 providers)

AAPM is developing **PainOS** to deliver an ASM-ready Pain Operating System — covering outcome collection, care coordination, and CMS data submission — purpose-built for independent and small-group pain practices.

Check the CMS ASM Participant List — Final list expected Late Summer 2026 | Confirm your participation status before year-end

5 REQUIRED QUALITY MEASURES (LOW BACK PAIN)

MIPS Code	Measure	Collection
Q238	High-Risk Medications in Older Adults	eCQM / Claims
Q134	Depression Screening & Follow-up Plan	eCQM
Q128	BMI Screening & Follow-up Plan	eCQM
Q220	Functional Status Change — Low Back Pain	eCQM
TBD	Excess Utilization Measure (CY 2027 Rulemaking)	Claims Data

Data collected for **all patients** (Medicare, Medicaid, commercial) to provide a complete quality performance picture and support multi-payer benchmarking.

RECOMMENDED OUTCOME INSTRUMENTS

Pain Control
VAS | NRS

Function
ODI | PROMIS

Mental Health
PHQ-9 | GAD-7

Collected longitudinally via an Episode-Based Dashboard within a patient registry — leveraging tablets and patient phone apps for between-visit data capture.

MANAGING COMPLEX & ELDERLY PATIENTS

- Complex pain patients = **5% of population, 50% of expenditure**
- 40% of complex patients are 65+; 35% musculoskeletal pain; 25% depression; 20% diabetes
- CMS adds a **complex patient scoring bonus** for HCC risk ≥ cohort median
- Formula: Medical = 1.5 + 4 × HCC standardized score; Social = 1.5 + 4 × dual-eligible proportion
- Reference: **42 CFR §512.745**

Evidence Base for Interdisciplinary Care
Multidisciplinary/transdisciplinary management of complex chronic pain shows significant improvement in functional capacity, pain scores, emotional wellbeing, return-to-work rates, and reduction in ED visits and hospital admissions — the foundation of ASM's value-based model.

DATA SUBMISSION QUICK REFERENCE

Domain	Submission Method	Deadline
Quality	Direct login & upload (TIN/NPI)	March 31
Improvement Activities	Attestation — direct upload (TIN)	March 31
Interoperability	Performance data + attestation (TIN)	March 31
Cost	No submission — CMS calculates from claims	—

COLLABORATIVE CARE ARRANGEMENT WITH PCP

ASM requires a formal arrangement with referring PCPs covering five elements: **bidirectional data sharing** of tests and treatment plans; **co-management** of complex patients; defined **care transition protocols** between specialist and PCP; **closed-loop communication** standards; and **structured care coordination** workflows embedded into practice operations.

PRACTICE READINESS CHECKLIST

Procedural

- [ ] Confirm your name on the CMS ASM participant list
- [ ] Complete the ASM Participant Contact Information form
- [ ] Monitor the final ASM participant list (expected late summer 2026)
- [ ] Review current MIPS quality and cost performance data

Clinical Operations

- [ ] Embed PRO collection (PROMIS, ODI, PHQ-9, GAD-7) into check-in/check-out workflow
- [ ] Add SDOH screening and documentation to every patient encounter
- [ ] Formalize referral tracking: Orthopedic/Neuro, PM&R, PT, Psychology, Psychiatry
- [ ] Integrate BMI counseling and nutritional education into visit workflow
- [ ] Establish post-visit PCP communication protocol for every Medicare patient
- [ ] Embed Health & Wellness counseling with before/after status documentation

Administrative & Technology

- [ ] Execute Collaborative Care Agreements with all referring PCPs
- [ ] Confirm EHR is FHIR/CEHRT compliant
- [ ] Enable e-prescribing and PDMP query in EHR
- [ ] Implement HIE (electronic referral loops or Trusted Exchange Framework)
- [ ] Set up episode-based cost tracking via EHR to monitor Medicare attributed costs
- [ ] Enable immunization registry reporting and electronic case reporting

HOW AAPM PAINCONNECT IS SUPPORTING MEMBERS

- **Advocacy:** Negotiated MACRA timeline with CMS; represented pain medicine at CMMI HCPLAN roundtable (2024); active engagement with CMS Division of Practitioner Services (2025/2026)
- **Education:** Value-Based Care plenary sessions at 2021 and 2026 Annual Scientific Conferences
- **Technology:** Partnering with Group Therapeutics to build **PainOS**, an ASM-ready Pain Operating System for pain practices
- **Policy:** Advocating with CMS and legislators since 2022 for a dedicated interdisciplinary pain management payment methodology

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Supplemental Resources Handout — The Big Shift: Value-Based Care & What It Means for Pain Management

About this handout: The following summarizes the key Q&A content from the AAPM PainConnect Webinar (August 3, 2026) on the Ambulatory Specialty Model (ASM). Starting **January 1, 2027**, CMS will implement ASM — the first mandatory two-sided risk value-based payment model for pain specialists. This handout provides a concise reference for each question addressed during the session.

THE ASM MODEL — CORE QUESTIONS

Q1 What is ASM?

CMS's first mandatory **two-sided risk value-based payment model** for specialists treating chronic low back pain and congestive heart failure (outpatient), starting January 1, 2027. Payment is tied to clinical outcomes, total cost of care, care coordination, and interoperability.

Q2 What is a value-based model?

Coined by Porter & Olmsted (2006), value-based care pays for **outcomes and cost-efficiency** rather than volume. ASM is the culmination of decades of CMS payment reform — MEI, SGR, MACRA/MIPS — and is CMMI's first mandatory specialty-level value-based model.

Q3 What happens to fee-for-service?

FFS continues as the base payment mechanism, layered with a **retrospective risk-based adjustment** starting at ±9%, rising to ±12%. Performance Year 1 is 2027; first payment adjustment is applied in 2029.

Q4 How will ASM affect chronic pain practice?

Practices will need **structural changes** (IT systems to capture and transmit outcomes/cost data, revised workflows) and **process changes** (outcomes documentation, PCP communication, care coordination, and CEHRT/FHIR interoperability).

Q5 What values does CMS track, and how?

Five initial quality measures collected via standardized tools across **all payers** (not just Medicare):
• High-risk medications in older adults • Depression screening
• BMI screening • Functional status change • Excess utilization
Tools: VAS/NRS, ODI/PROMIS, PHQ-9/GAD-7

Q6 What about complex elderly patients?

CMS applies a **complex patient scoring adjustment** based on HCC risk score and dual-eligible proportion. Practices should identify, stratify, document SDOH, and coordinate care — this population is ~**5% of patients but ~50% of national health expenditure**. Ref: 42 CFR §512.745.

PHYSICIAN OBLIGATIONS & AAPM SUPPORT

Q7 Does value-based care apply to all patients?

CMS's goal is to expand value-based care to **all Medicare populations by ~2030**. ASM initially targets low back pain, but participants must collect the same data across all payers per **42 CFR §512, Subsection G**.

Q8 Do physicians need to prove outcomes to be paid?

Yes. Physicians must submit data across **four domains** with specific weighting, scoring adjustments, and submission mechanisms — all under 42 CFR Part 512. Annual deadline: **March 31**.

Quality (50%) · **Cost (50%)** · Improvement Activities (scoring adj.) · Interoperability (scoring adj.)

Q9 How is AAPM preparing members?

Advocacy — since the 2015 MACRA legislation; negotiated ASM implementation timeline with CMS.
Education — plenary sessions on value-based care since 2021 Annual Scientific Conference.
Tools — AAPM is developing **PainOS**, an ASM-ready Pain Operating System for solo and small-group practices.

Q10 Next steps for physicians

Three categories of action required:

Procedural
- Confirm ASM participant status on CMS list
- Complete ASM contact information form
- Review current MIPS quality & cost data

Clinical Operations
- Embed PRO capture into workflow
- Add SDOH screening to encounters
- Formalize PCP communication protocol

Admin & Technology
- Execute PCP collaborative care agreements
- Confirm EHR is FHIR/CEHRT compliant
- Enable e-prescribing & PDMP query

Q11 Chronic LBP patient journey under ASM

No single standardized workflow exists yet. **Near-term priority:** implement structural Improvement Activities and Interoperability changes. **Medium-term:** optimize clinical workflow for quality/outcomes delivery.

Q12 What must the physician document?

Overlaps substantially with Q8. Physicians must document and submit data across all four ASM domains — Quality, Cost, Improvement Activities, and Interoperability — per the specifications in **42 CFR Part 512** by **March 31** annually.