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