Patient360

Finalized Policies in the CY 2026 Medicare Physician Fee Schedule Final Rule

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Meet Your Presenter!

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- 10+ years in quality reporting / analytics

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Agenda

- 2026 Finalized Policies
  - Medicare Shared Savings Program (MSSP) ACOs
  - Merit-based Incentive Payment System (MIPS)
    - MIPS Value Pathways (MVPs)
  - New! Ambulatory Specialty Model (ASM)
- 2026 Final Rule Key Takeaways
- Action Items

Polling Question 1

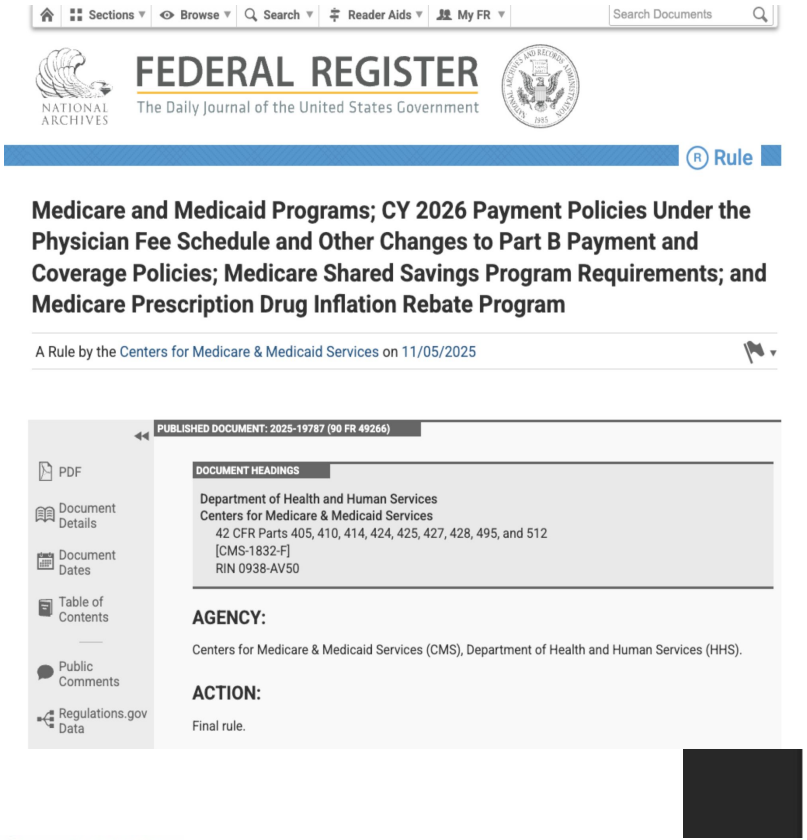
Have you been able to read the CY 2026 Physician Fee Schedule Final Rule?

A. I've read most or all of the entire document.

B. I've read some of the key highlights important to my organization.

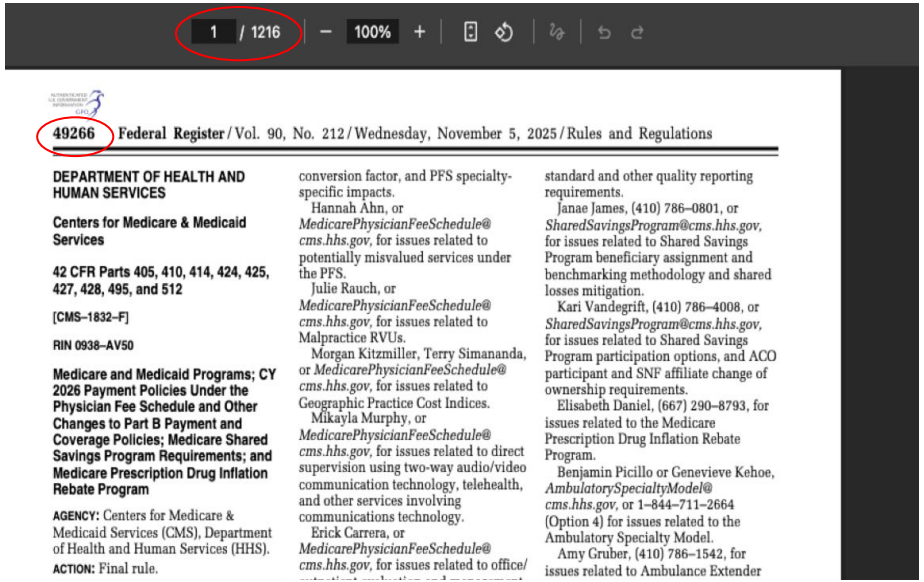
C. I've read little or none of it.

Final Rule Page Number References



Page numbers are directly from the published version of the 2026 Medicare Physician Fee Schedule Final Rule

(p.1/1,216 PDF OR 49892/50481)



Medicare Shared Savings Program (MSSP) **Participation**

One-Sided (BASIC Track) Risk Model

- CMS finalized that "inexperienced" ACOs may participate in the MSSP under a one-sided model for up to 5 performance years under the BASIC track's glide path
- Applies to agreements starting on or after January 1, 2027

p. 495 or 49760

Change of Ownership (CHOW)

- CMS finalized that ACOs must submit a change request when a participant undergoes a CHOW resulting in a change to its TIN
- Beginning Jan. 1, 2026, this ensures the new TIN is including on the participant list for the current performance year

p. 510 or 49775

Medicare Shared Savings Program (MSSP)
Eligibility for Smaller ACOs

ACOs with fewer than 5,000 beneficiaries

- CMS finalized that ACOs who have fewer than 5,000 assigned beneficiaries in Benchmark Years 1, 2, or both may participate in the BASIC track of the Shared Saving Program
- Beginning with agreements starting on or after January 1, 2027
- CMS wants to encourage program participation for smaller ACOs, rural providers, and ACOs with underserved communities

p. 516 or 49781

Medicare Shared Savings Program (MSSP)
Medicare CQMs

Beneficiaries Eligible for Medicare CQMs

- CMS finalized to revise the definition of "beneficiary eligible for Medicare CQMs" beginning with the current 2025 performance year, to clarify that the beneficiary:
  - Had at least one had at least one primary care service during the performance year from an ACO professional who is a primary care physician, or who has one of the specialty designations, or who is a PA, NP, or CNS
  - **Goal**: The MCQM roster will have greater overlap with the list of beneficiaries that are assignable to an ACO

G	H	I	J	K	L
VA_SELECTION_ONLY	PCS_ENCOUNTER	DM_AGE	DM_DX	DM_ENCOUNTE	DM_EXCLUSION
0	1	1	1	1	

p. 532 or 49797

Medicare Shared Savings Program (MSSP)
Additional Finalized Policies

Routine updates to lists of CPT and HCPCS codes used to define "Primary Care Services" for the purpose of assigning Medicare FFS beneficiaries to an ACO and

- ADDED Enhanced Care Model Management Services (HCPCS codes (G0568, G0569, and G0570)
- CMS did not finalize their proposal to remove HCPCS code G0136
    - Instead, it was finalized to change the code descriptor to describe physical activity and nutrition assessment services

p. 529 or 49794

Medicare Shared Savings Program (MSSP)
Additional Finalized Policies

Removal of Health Equity Adjustment

- Beginning with the 2026 performance year
- CMS believes the Health Equity Adjustment is duplicative to the eCQM/MIPS CQM reporting incentive and the Complex Organization Adjustment

p. 538 or 49803

Extreme and Uncontrollable Circumstances Expansion

- Beginning with the 2025 performance year
- Finalized to expand the EUC to ACOs that are impacted by cyber attacks

p. 557 or 49822

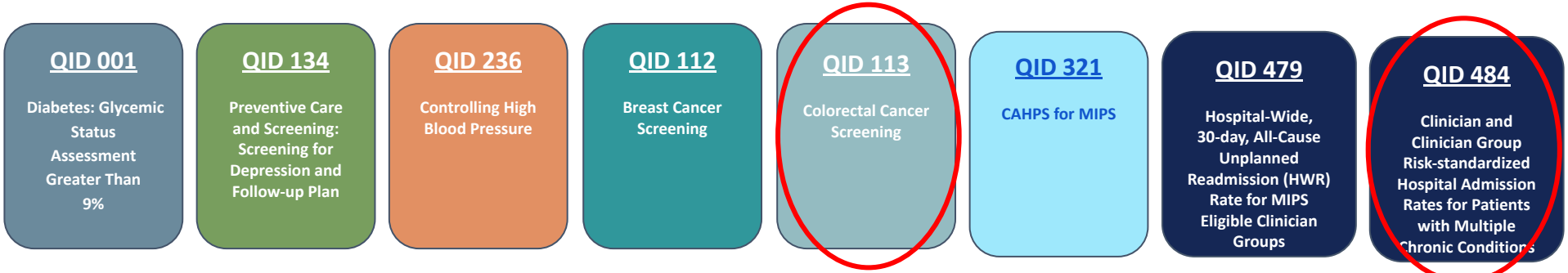
Medicare Shared Savings Program (MSSP)
P360 Public Comments

Advocating for Specialty TIN Challenges

- Misaligned specialites
- TINs lack Certified EHR Technology (CEHRT)/EHR Vendor concerns
    - https://www.healthit.gov/topic/certified-health-it-complaint-process

p. 545 or 49811

Medicare Shared Savings Program (MSSP) 2026 APP+ Quality Measure Set



Collection Type:
- eCQM
- MIPS CQM
- Medicare CQM

Collection Type:
- eCQM
- MIPS CQM
- Medicare CQM

Collection Type:
- eCQM
- MIPS CQM
- Medicare CQM

Collection Type:
- eCQM
- MIPS CQM
- Medicare CQM

Collection Type:
- eCQM
- MIPS CQM
- Medicare CQM

Collection Type:
- CAHPS for MIPS Survey

Collection Type:
- Claims

Collection Type:
- Claims

Patient360 supports full CMS requirements for APP submission of both eCQM and/or CQM and MCQM collection types.

eCQM/CQM submission under APP requires data completeness on denominator eligible patients across *all payers*, for *all patients*. MCQM submissions require data completeness on all denominator eligible medicare beneficiaries.

Medicare Shared Savings Program (MSSP)
Quality Updates

Measure #112: Breast Cancer Screening

- CMS has finalized substantive changes to the eCQM collection type beginning with the 2026 performance year:
  - Revising the description to include women 40-74 years of age
  - Added two strata:
    1. Patients aged 42-51 by the end of the measurement period
    2. Patients aged 52-74 by the end of the measurement period

- For all collection types, CMS finalized a definition for “reviewed” as follows:
  - to meet the quality action, there must be documentation in the medical record that the clinician reviewed the mammography report. The mammography report may also be provided by the patient for the clinician's review during the visit and should be documented in the medical record

Appendix 1, Table DD
p. 1,085 or 50350

Medicare Shared Savings Program (MSSP)
Quality Updates

CMS previously finalized the following **Quality measures to be added** to the APP Plus quality measure set:

- Quality #305: Initiation and Engagement of Substance Use Disorder Treatment beginning with PY 2027
- Quality #493: Adult Immunization Status beginning with PY 2028

CMS finalized the **removal** of:

- Quality #487: Screening for Social Drivers of Health

p. 552 or 49817

CAHPS for MIPS Survey

- Beginning with the 2027 performance year CAHPS for MIPS Survey vendors must administer via web in addition to mail and phone

p. 554 or 49819

Medicare Shared Saving Program (MSSP)
Promoting Interoperability (PI)

- **MSSP ACOs are REQUIRED to report the MIPS PI performance category as of PY 2025**
- PI Category Requirements:
  - Use 2015 Certified Electronic Health Record Technology (CEHRT)
  - Report on all required objectives & measures in PI, including attestation statements for continuous **180-day** reporting period

For more information on the MIPS PI category: QPP MIPS Promoting Interoperability Overview.

Check out these frequently asked questions about the MSSP PI Requirement: FAQ for Shared Savings Program PI Requirement.

Excluded Special Statuses:

- Non-MIPS Eligible Clinicians
- Not exceeding the low volume threshold
- Non-patient facing clinician
- Hospital-based clinician
- Ambulatory Surgery Center (ASC)-based clinicians
- Small practices (15 or fewer clinicians)

Medicare Shared Saving Program (MSSP)
Checking Eligibility for PI

There are two ways to check clinician eligibility status:

1. Eligibility Status can be viewed and confirmed using the CMS QPP NPI Lookup Tool: https://qpp.cms.gov/participation-lookup
2. Directly from the QPP Portal: qpp.cms.gov when logged in as a security official

For more information on eligibility: https://qpp.cms.gov/mips/how-eligibility-is-determined

Future of MSSP Reporting

Moving Towards Digital Quality Measurement

- CMS has a goal to fully transition to digital quality measurement (dQM)
- Including the eCQM collection type to the APP Plus measure set aligns with the goal to transition to dQMs
- CMS used the 2026 proposed rule to gather public input on the transition to dCQMs and on the approach to use FHIR (Fast Healthcare Interoperability Resources) standards in eCQM reporting in regards to the following:
  - FHIR-based eCQM conversion progress
  - Data standardization for quality measurement and reporting
  - The timeline under consideration for FHIR-based eCQM reporting
  - Measure development and reporting tools
  - FHIR Reporting and Data Aggregation for ACOs

p. 557 or 49822

Medicare Shared Savings Program
ACO Action Items

- Get familiar with what has been finalized and understand what that means for your ACO
- Send data monthly and validate immediately
- Upload your Medicare Beneficiary roster to Patient360 and track your Medicare CQMs
- Determine whether your member TINs will need to report on the MIPS Promoting Interoperability Category
    - Check Eligibility here: https://qpp.cms.gov/participation-lookup

MIPS: Finalized Policies

2024 Final Scores and Payment Adjustments

2024 MIPS Final Scores and Payment Adjustments are available in the CMS Quality Payment Program Portal: https://qpp.cms.gov/login

Reminder: Payment Adjustments will be applied to Medicare Part B Claims starting January 1st, 2026

For the 2026 MIPS Performance Year (PY)

- Performance threshold will remain at 75% through PY 2028
- Data completeness will remain at 75%
- Total Inventory of Clinical Quality Measures (CQMs) = 190 (3 only in MVPs)

MIPS: New Quality Measures

Finalized 5 New Quality Measures

Measure 512: Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR)

Measure 513: Patient Reported Falls and Plan of Care

Measure 514: Diagnostic Delay of Venous Thromboembolism in Primary Care

Measure 515: Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes

Measure 516: Hepatitis C Virus (HCV): Sustained Virological Response (SVR)

Appendix 1, Table Group A
p 771 or 50036

MIPS: Retired Quality Measures

Finalized Removal of 10 Quality Measures

- **Topped Out**
  - CQM 185: Colonoscopy Interval for Patients with h/o Adenomatous Polyps-Avoidance of Inappropriate Use
  - CQM 290: Assessment of Mood Disorders and Psychosis for Patients with Parkinson's Disease
  - CQM 322: Cardiac Stress Imaging
  - CQM 419 Overuse of Imaging for Headache
  - CQM 424 Perioperative Temperature Mngt
- **Not aligned with current practice guidelines:**
  - CQM 264: Sentinel Lymph Node Biopsy for Invasive Breast Cancer
- **No longer maintained by steward:**
  - CQM 443: Non-Recommended Cervical Cancer Screening in Adolescent Females
- **Process measure and no longer addresses a high-priority area**
  - CQM 487: Screening for SDoH
  - CQM 498: Connection to Community Service Provider
  - CQM 508: Adult COVID-19 Vaccination Status

Appendix 1, Table Group C
p 1,038 or 50303

MIPS: Quality Category Finalizations

Substantive Changes to Existing Quality Measures

- Tip: Be sure to notice changes (or not) specific to collection type (eCQM, CQM, claims)

Appendix 1, Table D
p. 1,052 or 50317

Modifications to Specialty Sets

- CMS modified specialty measure sets based on updates to existing measures, newly finalized measures, measures that have been removed, etc.

Appendix 1, Table B
p. 787 or 50052

Topped Out Measures Benchmarks List: 19 measures

- For specialty sets and MVPs impacted by limited measure choice
- To help providers with limited choice of measures avoid disadvantage of the 7 point cap

Table C-I1, p. 641 or 49906

MIPS: Cost Category Finalizations

- The Cost measure inventory remains at a total of 35 Cost measures
  - 33 Episode Based Cost Measures + 2 Population Based Cost Measures
- Routine coding updates
  - Revising the operational list to reflect changes to codes used to identify existing care episode and patient condition groups
- 2-year informational only feedback period for **new** cost measures starting CY 2026
  - To provide clinicians more time to gain familiarity with new cost measures and better understand their impact prior to their score being affected
- Total per Capita Cost (TPCC) measure revisions

p. 594 or 49859

MIPS: Improvement Activities Category Finalizations

Added 3 new IAs:

- PM_XX: Improving Detection of Cognitive Impairment in Primary Care
- PM_XX: Integrating Oral Health in Primary Care
- PSPA_XX: Patient Safety in Use of Artificial Intelligence (AI)

Appendix 2, Table F-B1
p. 1,089 or 50354

IA Changes:

- Significant changes to the title and description of BMH_1: Behavioral and Mental Health

- Remove Achieving Health Equity (AHE) subcategory and adding the Advancing Health and Wellness subcategory
  - Reassigned 6 IAs to other subcategories

Appendix 2, Table F-B2
p. 1,094 or 50359

Removed 8 IAs:

- AHE_5: MIPS EC Leadership in Clinical Trials or CBPR
- AHE_8: Create and Implement an Anti-Racism Plan
- AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
- AHE_11: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
- AHE_12: Practice Improvements that Engage Community Resources to Address Drivers of Health
- PM_26: Vaccine Achievement for Practice Staff
- PM_6: Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities
- ERP_3: COVID-19 Clinical Data Reporting with or w/o Clinical Trial

Appendix 2, Table F-B3
p. 1,100 or 50365

MIPS: Promoting Interoperability Category Finalizations

Finalized for the 2025 Performance Period:

- Suppress the Electronic Case Reporting measure due to the CDC pausing all new onboarding
  - Although this measure is suppressed, CMS is still requiring clinicians attest to "Yes" or claim an applicable exclusion to successfully meet PI reporting requirements

Starting with the 2026 Performance Period:

- Security Risk Analysis measure
  - Eligible clinicians must attest "Yes" to a new attestation statement indicating that the practice has implemented security measures sufficient to reduce risks and vulnerabilities
- Require the use of the **2025** High Priority Practices SAFER Guide
- Added a new optional bonus measure under the Public Health and Clinical Data Exchange Objective for using the Trusted Exchange Framework and Common Agreement (TEFCA) (up to 5 bonus points)
- Adopted a measure suppression policy

p. 603 or 49868

MIPS Value Pathways (MVPs)

MVPs are:
Streamlined subsets requiring only 4 Quality Measures, 1 IA, CMS specified Cost measures, and the same PI requirements as MIPS

- MVPs are specific to provider specialties or patient health conditions
- CMS plans to eventually replace Traditional MIPS with MVP reporting

For more on MVPs: https://qpp.cms.gov/mips/explore-mips-value-pathways

Success Tip
Consider reporting both Traditional MIPS and MIPS Value Pathways

Why?
Minimal extra effort
CMS will award the higher score
Gives you time to practice and ramp up

New MVPs

6 new MVPs Finalized:

1. Diagnostic Radiology
2. Interventional Radiology
3. Neuropsychology
4. Pathology
5. Podiatry
6. Vascular Surgery

Finalized Changes to all 21 existing MVPs

1. Adopting Best Practices & Promoting Patient Safety within Emergency Medicine
2. Advancing Cancer Care
3. Advancing Care for Heart Disease
4. Advancing Rheumatology Patient Care
5. Complete Ophthalmologic Care
6. Coordinating Stroke Care to Promote Prevention & Cultivate Positive Outcomes
7. Dermatological Care
8. Focusing on Women's Health
9. Gastroenterology Care
10. Improving Care for Lower Extremity Joint Repair
11. Optimal Care for Kidney Health
12. Optimal Care for Patients with Urologic Conditions
13. Patient Safety & Support of Positive Experiences with Anesthesia
14. Prevention & Treatment of Infectious Disorders (Hep C, HIV)
15. Pulmonology Care
16. Quality Care for Patients with Neurological Conditions
17. Quality Care for the Treatment of Ear, Nose & Throat Disorders
18. Quality Care in Mental Health & Substance Use Disorders
19. Rehabilitative Support for Musculoskeletal Care
20. Surgical Care
21. Value in Primary Care

Appendix 3, Table Group B
p. 1,141 or 50406

MVPs: Finalized Changes

Finalized MVP Registration Policies for 2026:

- **Multispeciality small practices**
  - CMS has finalized that multispecialty small are *not* required to report as subgroups
  - Large multispecialty groups will be required to report MVPs as subgroups
- **Attestation of Specialty Composition**
  - During registration, groups must attest to whether they are a single specialty or a multispecialty group

p. 576 or 49841

MVPs: Finalized Changes

Clinical Groupings for MVPs

- Added to the format of the MVP tables.
- When applicable, “Advancing Health and Wellness” and/or “Experience of Care” clinical groupings will be indicated for cross-cutting measures

Appendix 3, Table A & B
p. 1,111 or 50376

Table B.15: Pulmonology Care MVP Clinical Groupings

Pulmonology Care MVP				
Clinical Grouping	Quality			Cost
	Measure	Outcome	High Priority	
Asthma	**Q398:** Optimal Asthma Control (Collection Type: MIPS CQM)	Yes	Yes	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD)
COPD	**Q052:** Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation and Long-Acting Inhaled Bronchodilator Therapy (Collection Type: MIPS CQM)	No	No	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_COPDE_1:** Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
	ACEP25: Tobacco Use: Screening and Cessation Intervention for Patients with Asthma and COPD (Collection Type: QCDR)	No	No	
Sleep Medicine	**Q277:** Sleep Apnea: Severity Assessment at Initial Diagnosis (Collection Type: MIPS CQM)	No	No	N/A
	Q279: Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy (Collection Type: MIPS CQM)	No	No	
Advancing Health and Wellness	**(**) Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	No	No	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_COPDE_1:** Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	No	No	
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	No	Yes	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_COPDE_1:** Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
	(*) Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	Yes	Yes	

MVPs: **Action Items**

- **Determine whether there is an MVP for your speciality.** (https://qpp.cms.gov/mips/explore-mips-value-pathways)
- **Register for the MVP in the QPP Portal by Dec. 1st, 2025**: https://qpp.cms.gov/login
- **In the Patient360 portal:**
  - Designate your chosen MVP
  - You can select to report Traditional MIPS too if you'd like to monitor both
  - Continue to track all of your measure results
- **Ensure your clinicians know where to document within the EHR/PM for your chosen measures**

New! Ambulatory Specialty Model (ASM)

The Ambulatory Specialty Model (ASM) is a new mandatory program from the CMS Innovation Center

- WHO: Specialists who provide care to Medicare beneficiaries with chronic conditions of heart failure and low back pain
  - The ASM will consist of two “Cohorts”: Heart Failure and Low Back Pain
- WHY: Incentivize preventive care, improve quality of care, and keep patient costs low
- TIMEFRAME: 2027- 2031

Check out these ASM resources:

- CMS Innovation Center: ASM
- ASM Fact Sheet
- ASM FAQ

p. 297 or 49562

Ambulatory Specialty Model (ASM)
Eligibility

Eligibility

- Determined at Individual level for clinicians with the following specialities:
  - Heart Failure cohort: Cardiology
  - Low Back Pain cohort: Anesthesiology, Interventional Pain Management, Neurosurgery, Orthopedic Surgery, Pain Management, or Physical Medicine and Rehabilitation
- Clinicians who bill claims under the Medicare Physician Fee Schedule
- Clinicians who meet the Episode Based Cost Measure (EBCM) episode volume threshold of 20 attributed episodes for:
  - COST_HF_1: Heart Failure *or* COST_LBP_1: Low Back Pain
- Clinicians who are located in one of the CMS selected mandatory geographic areas
- ASM Participants would be exempt from MIPS reporting if they are required to report on the new ASM

p. 315 or 49580

Ambulatory Specialty Model (ASM)
Data Submission Requirements

Data Submission Requirements

- CMS finalized that ASM participants must submit data for:
  - Quality - at the individual clinician level*
  - Cost - at the individual clinician level
  - Improvement Activities - at TIN level
  - Promoting Interoperability - at the TIN level

***It was finalized that if an ASM participant is part of a small practice they may submit Quality data at the TIN level**

https://www.cms.gov/priorities/innovation/innovation-models/asm
AmbulatorySpecialtyModel@cms.hhs.gov

p. 336 or 49602

ASM: Heart Failure **Quality & Cost Measure Set**

ID	Measure	Collection Type
492	Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF	Claims
008	HF: Beta-Blocker Therapy for LVSD	eCQM/CQM
005	HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD	eCQM/CQM
236	Controlling High Blood Pressure	eCQM/CQM
377	Functional Status Assessments for Heart Failure	eCQM
COST_ HF_1	The Heart Failure EBCM	Claims

Reporting Period
Full calendar year

Required Measures
Must report on ALL measures

p. 341 or 49606

ASM: Low Back Pain **Quality & Cost Measure Set**

ID	Measure	Collection Type
238	Use of High Risk Medications in Older Adults	eCQM/CQM
134	Preventive Care and Screening: Screening for Depression and Follow- Up Plan	eCQM/CQM
128	Preventive Care and Screening: BMI Screening and Follow- Up Plan	eCQM
220	Functional Status Change for Patients with Low Back Impairments	CQM
TBD	To be determined in CY 2027 Rulemaking	Claims
COST_ LBP_1	Low Back Pain Episode Based Cost Measure	Claims

Reporting Period
Full calendar year

Required Measures
Must report on ALL measures

p. 351 or 49616

Ambulatory Specialty Model (ASM)
Improvement Activities and Promoting Interoperability

Improvement Activities

- Reporting period: 90 Days
- 2 Required IAs:
  - IA-1: Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs Screening
  - IA-2: Establishing Communication and Collaboration Expectations with Primary Care using Collaborative Care Arrangements
- Attestation Only

p. 381 or 49649

Promoting Interoperability (PI)

- Reporting period: 180 days
- Required use of Certified EHR Technology (CEHRT)
- All PI Objectives, Attestations, & Measures

Note: No PI Hardship Exceptions available!

p. 389 or 49654

Ambulatory Specialty Model (ASM)
Category Weights and Scoring Adjustments

ASM Performance Category	Weight or Scoring Adjustments
Quality	50%
Cost	50%
Improvement Activities	Scoring adjustment of 0, -10, or -20 points
Promoting Interoperability	Scoring adjustment of 0 to -10 points

Additional Points to Final Score for:

- Up to 10 points for complex patient care based on HCC risk scores or dual-eligible populations
- 10 points will be awarded to participants who are in a small practice (fewer than 15 clinicians)
- 15 points will be awarded for participants who are solo practitioners

p. 399 or 49664

Ambulatory Specialty Model (ASM)
Final Scores

Meets Quality Data Submission Requirements	Receives ASM Quality Score	Receives ASM Cost Score	Final Score	Payment Adjustment
Yes	Yes	Yes	Between 0 - 100	Positive, neutral, or negative adjustment
Yes	No	Yes	No Final Score	Neutral
Yes	Yes	No	No Final Score	Neutral
Yes	No	Yes	No Final Score	Neutral
No	No	Yes	0	Maximum negative adjustment based on ASM Risk Level
No	No	No	0	Maximum negative adjustment based on ASM Risk Level

p. 405 or 49670

Ambulatory Specialty Model (ASM)
Risk Level and Redistribution Percentage- Finalized

Risk Level: the magnitude of the maximum positive or negative net payment adjustment percentage that can be applied during the applicable payment year

p. 423 or 49688

ASM Performance Year	ASM Payment Year	ASM Risk Level
2027	2029	9%
2028	2030	9%
2029	2031	10%
2030	2031	11%
2031	2033	12%

ASM Redistribution Percentage: a percentage of Medicare Part B payments that CMS will distribute in the form of payment adjustments

- CMS finalized the ASM Redistribution Percentage at 85%. This means that 85% of the ASM incentive pool would be redistributed as positive or negative payment adjustments and 15% would be retained in the Medicare Trust Fund

p. 425 or 49690

Ambulatory Specialty Model (ASM)
Incentive Pool and Scoring Overview- Finalized

ASM Incentive Pool: the total amount of Medicare Part B claims paid to ASM participants that would be used to distribute the ASM scaled payment adjustments

ASM Incentive Pool = risk level × redistribution % × ∑ participant Medicare Part B payments

Example: 9% * 85% * $1 Billion = $76.5 million

p. 414 or 49679

Scoring Overview

CMS will calculate the following:

1. The ASM Incentive Pool
2. The ASM Adjustment Factor
3. The Payment Multiplier
4. The overall Payment Adjustment

p. 420 or 49685

Main Takeaways

- Different than the budget neutrality payment adjustments under MIPS, CMS proposes to calculate separate ASM incentive pools for each cohort
- ASM participants will be notified of their payment adjustment information through the ASM performance report

Ambulatory Specialty Model (ASM)
Action Items

- Understand Eligibility
  - CMS plans to release a preliminary eligibility list in early 2026
- Get familiar with the required measures for the ASM cohort that is most applicable
  - Either Heart Failure or Low Back Pain
- Ensure clinicians know where to document for the required measures in their EHR
- Fulfill the CEHRT Requirement
  - CEHRT is required for the Promoting Interoperability Category and to report on eCQM Quality measures
- Check out the CMS Innovation ASM Webpage to stay up-to-date on this new program:
  - https://www.cms.gov/priorities/innovation/innovation-models/asm

Polling Question 2

If you commented on the 2026 proposed rule, how many of your comments were directly addressed by CMS?

A. All of them

B. One or two

C. None of them

D. I did not comment

Recap of Public Comments

Comment Structure Matters!

- P360 included the section being referenced, page number, and what CMS stated that we were commenting about
- P360 Included the issues our organization foresaw as result of the proposal being finalized, who it would impact, and our organization's potential alternate solution

Sample Public Comment format from 2026 Proposed Rule:

Topic: Payment Adjustments under the ASM model: Page 479/1803
CMS States: "We seek comments on the following …"
Issues: The issue with this proposal is…
Direct Impact: This will impact the following stakeholders and here is why….
Alternate Solution: Instead, we propose to ….

2026 Final Rule Resources

Access the CMS 2026 Final Rule and Fact Sheets:

- 2026 Final Rule (published version)
- QPP Resource Library
  - 2026 Final Rule Fact Sheet
  - 2026 Finalized MVPs Guide
- 2026 Medicare Shared Savings Fact Sheet
- 2026 ASM Fact Sheet

Final Recommended Action Items

- Login to the Quality Payment Program Portal (QPP) at least once per quarter
  - Review your 2024 MIPS Feedback Report and Payment Adjustment
  - Register for a MIPS Value Pathway by Dec. 1st, 2025
  - Download final eligibility status in December
- Prepare for the ASM Model if you are a qualifying provider type for Heart Failure or Low Back Pain
  - https://www.cms.gov/priorities/innovation/innovation-models/asm
- Prepare to strategize about your ACOs composition in the summer to ensure that your Member TINs align with overall ACO reporting goals

Question & Answer

Stop by our VBCExhibitHall.com Virtual Booth

VBCExhibitHall Patient360.com

Please reach out to

john@patient360.com to learn more!

Thank you