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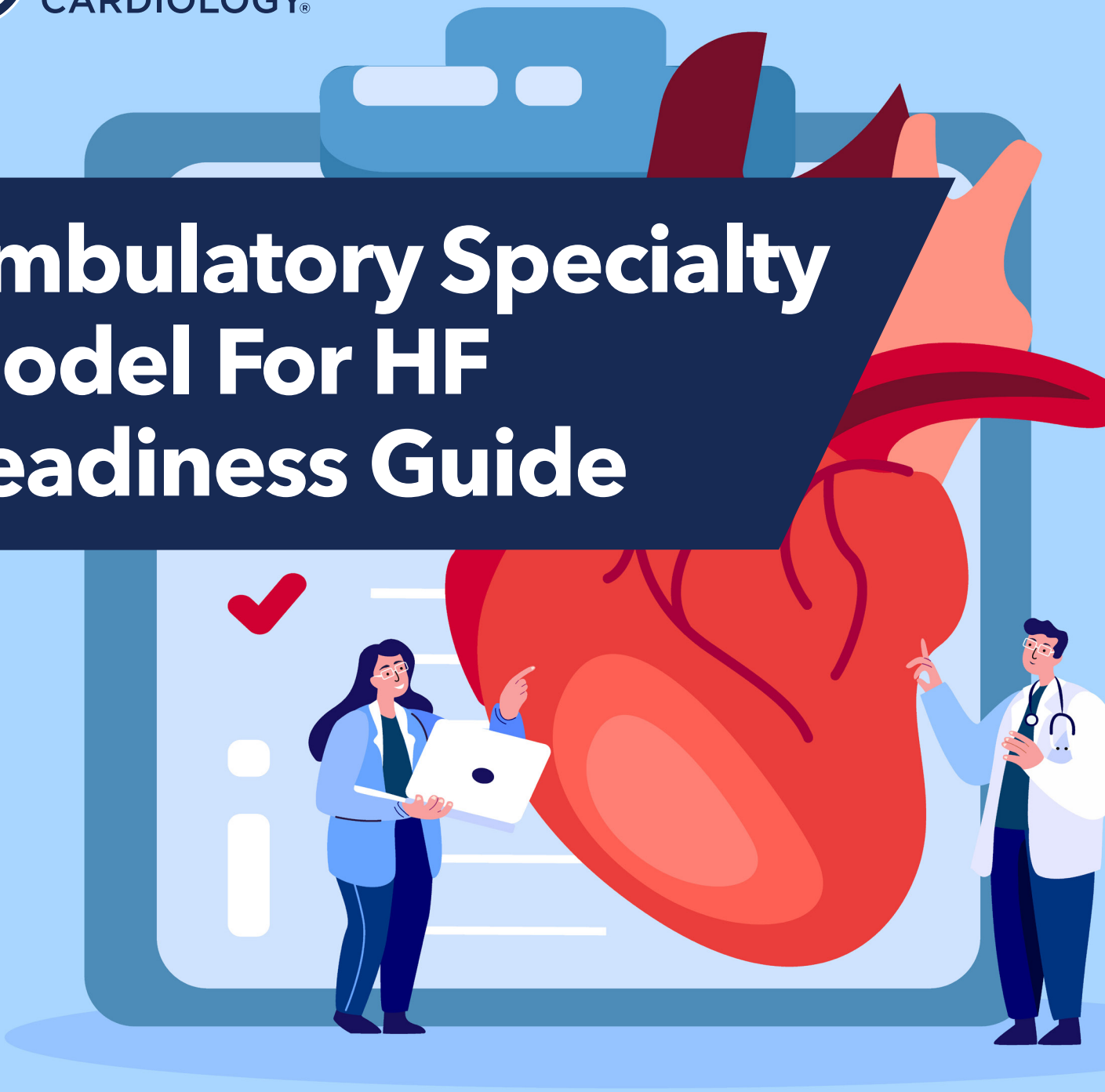
Ambulatory Specialty Model For HF Readiness Guide



Prepare Your Practice For Individual Clinician Accountability Under ASM

I. Eligibility and Accountability

Successfully preparing for the Ambulatory Specialty Model (ASM) for heart failure (HF) begins with understanding whether and why a clinician is participating in the model. Practices should review participation information, verify provider enrollment and specialty data, and understand how patient attribution and individual clinician accountability may affect reporting, performance assessment, and payment adjustments.

- Review Centers for Medicare and Medicaid Services (CMS) participation notifications and verify that your NPI, PECOS and MIPS specialty designation, taxonomy and practice information accurately reflect your clinical practice.
- Participation and accountability are determined at the clinician-level (NPI and TIN-level), and payment adjustments are applied based on individual physician performance. Note that payment adjustments will follow the physician, while performance is assessed individually.
- Confirm whether each practice location is within a mandatory ASM geographic area.
- Understand how patients become attributed and what attribution information CMS makes available to participants.
- Be prepared to identify patients at elevated risk for hospitalization, readmission or worsening HF.
- Map HF care delivery workflows and identify where advanced practice providers (APPs), pharmacists, nurses and physicians contribute to care that may affect attribution and measure performance.

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II. Financial Risk and Incentives

Success under the ASM requires understanding both the model's financial incentives and the drivers of HF-related costs. Practices should develop a baseline understanding of their utilization patterns, available performance data and the operational changes needed to reduce avoidable utilization while maintaining high-quality care.

Payment

- ASM replaces MIPS scoring for applicable performance categories. Familiarize yourself with the four performance categories: quality measures, cost, improvement activities and promoting interoperability. Review the incentive pool process.
- Understand when downside risk begins and how it escalates from model years one to five (9% to 12%). Recognize that payment is tied to HF-specific outcomes and patient-reported measures, not just process compliance.
- Identify all available sources of HF cost and utilization data, such as "shadow bundle" or accountable care organization (ACO) cost data, or CMS supplemental physician reports available for physicians who met the case minimum for MIPS episode-based cost measures.
- Engage ACOs, clinically integrated networks, health systems or analytics vendors to establish baseline performance.

Utilization and Cost Drivers

Consider these factors:

- Emergency department (ED) use and drivers
- Inpatient admissions, length of stay and readmission
- Post-acute utilization (SNF, IRF, LTCH, home health)
- Site of service (hospital outpatient vs. office)
- Specialist and primary care visit patterns
- Durable medical equipment and remote monitoring utilization
- Medication access, affordability and adherence

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III. Clinical Care and Outcomes

The ASM emphasizes outcomes that reflect effective longitudinal HF management. Practices should establish workflows that support early intervention, timely follow-up, guideline-directed medical therapy (GDMT) optimization, and collection of patient-reported outcome measures to improve both patient care and performance under the model.

Decide How to Handle Worsening Symptoms

- Define when patients should call the clinic, come in urgently or go to the ED.
- Assign responsibility for reviewing symptom calls, remote monitoring alerts, and adjusting diuretics or medications.

Manage Post-Discharge Follow Up

- Ensure ≤7-day follow up after HF discharge is reliably achievable.
- Assign clear ownership for scheduling and outreach.
- Have a plan for same-day or next-day evaluation when symptoms worsen.

Optimize GDMT Before Discharge

- Ensure GDMT is initiated or continued during hospitalization unless contraindicated.
- Establish workflows for addressing medication affordability, prior authorizations and financial assistance programs.
- Avoid deferring GDMT optimization "to outpatient follow up."
- Document contraindications clearly when GDMT is not used.
- Know who is responsible for titration in the first 30 to 60 days.

Capture What Patients Report

- Select a Patient-Reported Outcome Measure (PROM) tool (e.g., VA, PROMIS, KCCQ, MLHFQ) and determine when and where it will be administered (visit, discharge, portal, phone, etc.).
- Obtain proper licenses for functional status assessments.
- Ensure optimal workflows exist to collect, document and ensure completion of PROMs.
- Be prepared to explain PROMs to patients.

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IV. Care Transitions, Coordination and Access

Patients with HF often receive care from multiple clinicians and across multiple settings, making coordination and follow up critical components of high-quality care. Practices should establish processes that support smooth care transitions, address barriers to care, and facilitate communication and collaboration across the care team.

Address Social and Access Barriers Early

- Confirm if Health-Related Social Need (HRSN) screening is occurring in primary care.
- Implement a workflow for HRSN screening and referral documentation.
- If within scope, screen HF patients for transportation, medication access, food insecurity, etc.
- Know how referrals to social work or community resources are triggered.
- Ensure medication access issues are addressed before discharge.

Primary Care Coordination

- Identify primary care partners and key contacts for attributed HF patients.
- Define shared care roles and responsibilities.
- Establish expectations and create a protocol for information sharing.
- Ensure the ability to electronically exchange information with referring primary care providers (PCPs) and other clinicians involved in HF care.
- Document collaborative care arrangements.

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V. Data, Measurement, Reporting and Implementation

Strong data and reporting capabilities are essential for identifying performance gaps, meeting ASM requirements and tracking progress over time. Practices should confirm that the necessary systems, workflows and personnel are in place to support quality measure reporting, improvement activity documentation, physician-level performance monitoring, promoting interoperability and CMS feedback review.

Confirm Your Data Can Support the Model

- Ensure your electronic health record (EHR) can identify HF patients and left ventricular systolic dysfunction, track GDMT classes, and support required electronic clinical quality measures and quality measure file submission. Identify gaps requiring workflow changes.
- Conduct a test extraction of HF quality measure data before the first performance period.
- Know who reviews CMS feedback reports and when.
- Confirm practice-level (TIN-level) process for improvement activity attestation and documentation (ensure workflows, screenshots/templates and audit logs).
- Determine whether physician-level dashboards can be created for quality, utilization, admissions and cost performance.
- Confirm your EHR is ONC-certified (CEHRT), identify your CEHRT Certification ID and verify your ability to report required Promoting Interoperability measures at the TIN level.
- Ensure your practice can electronically exchange information with other clinicians and provide patients with electronic access to health information.
- Complete required annual CMS Promoting Interoperability measures and attestations, including Security Risk Analysis, SAFER self-assessment and interoperability compliance requirements.

Assemble an ASM Implementation Team

- Include physician(s), quality administrators, staff
- Identify someone to own coordination across inpatient, outpatient, IT and quality teams
- Identify a designee for participation and administrative reporting purposes
- Identify who adjusts diuretics
- Identify who manages GDMT titration
- Identify who reviews remote monitoring data
- Identify who calls patients after discharge

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Additional Resources

Quality Measures

For measure specifications, visit the CMS Measure Inventory Tool.

HEART FAILURE

Domain	Prevention Category	Measure	Collection Type
Excess Utilization	Adverse events and acute care utilization	Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF (MIPS Q492) with modification	Claims
Evidence-based Care and Outcomes	Reduction of disease progression	HF: Beta-Blocker Therapy for LVSD (MIPS Q008)	eCQM MIPS CQM
Evidence-based Care and Outcomes	Reduction of disease progression	HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD (MIPS Q0005)	eCQM MIPS CQM
Evidence-based Care and Outcomes	Reduction of disease progression	Controlling High Blood Pressure (MIPS Q236)	eCQM MIPS CQM
Patient Reported Outcomes and Experience	Function/health status/ wellbeing	Functional Status Assessments for Heart Failure (MIPS Q377)	eCQM

Cost Measure

Visit CMS' website for specifications on the HF cost measure.

Improvement Activities

(IA-1): CONNECTING TO PRIMARY CARE AND ENSURING COMPLETION OF HEALTH-RELATED SOCIAL NEEDS SCREENING AND IMPROVEMENT

ASM participants must have the processes, workflows and technology to be able to attest that the patient has access to primary care, communicate back to the patient's primary care provider (PCP) after each specialist visit, and determine whether an annual HRSN screening has occurred. No specific screening tool is required and manual workflows do count. These activities are reported via attestation (e.g., "yes"). Each improvement activity is worth 10 achievement points and equally weighted. Improvement activities can be reported at the TIN level.

Evidence may include:

- Intake process to identify "no PCP"
- Steps for helping a patient find a PCP
- Standard process for sending visit summaries/results to PCP after each visit
- Process to confirm HRSN screen status annually
- Process for prompting PCP to complete screen
- PCP field captured in chart
- Simple audit/report mechanism showing actions taken
- Referral template/consult template
- Care transition checklist

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Additional Resources *(continued)*

Improvement Activities

(IA-2): ESTABLISHING COMMUNICATION AND COLLABORATION EXPECTATIONS WITH PRIMARY CARE USING COLLABORATIVE CARE ARRANGEMENTS (CCAS)

The ASM participant must have at least one CCA with a primary care practice that shares at least one ASM beneficiary, and the CCA must include at least three of five collaborative elements. The five elements are:

1. Data sharing – e.g., sending consult reports, EHR to EHR exchange
2. Co-management – shared, principal or consultative
3. Transitions in care – e.g., protocols for handoffs
4. Closed-loop communication – e.g., referral templates, monitoring until follow-up is complete
5. Care coordination integration – e.g., embedded into workflows, meeting minutes, training materials

Promoting Interoperability

CMS will assess ASM participants' use of CEHRT to engage patients, improve care, reduce costs and better manage chronic conditions through more integrated care. ASM participants must submit a CEHRT ID, complete required attestations and report promoting interoperability measures at the group (TIN) level. ASM participants should review promoting interoperability measure details and ensure all other activities are occurring.

Promoting Interoperability Element Name	Collection Type
CEHRT ID	Submission
e-Prescribing	Measure
Health Information Exchanges (HIEs)	Measure
Provider to Patient Exchange	Measure
Public Health and Clinical Data Exchange	Measure
The Office of the National Coordinator for Health IT (ONC) direct review (45 C.F.R. pt. 170, subpt. E [2026])	Attestation
Actions to Limit or Restrict Compatibility of Interoperability of CEHRT	Attestation
The Security Risk Assessment	Attestation
SAFER Self-Assessment (Safety Assurance Factors for EHR Resilience)	Attestation

Clinical Practice Guidelines

- 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure
- 2023 ACC Expert Consensus Decision Pathway on Management of Heart Failure With Preserved Ejection Fraction
- 2024 ACC Expert Consensus Decision Pathway for Treatment of Heart Failure With Reduced Ejection Fraction

Stay Connected

- For additional information and updates specific to the ASM, subscribe to the ASM Model listserv.
- Contact the CMS ASM team at *AmbulatorySpecialtyModel@cms.hhs.gov*.
- Visit ***ACC.org/ASMForHF*** for more ACC resources and to submit your questions to ACC staff.

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