



AMERICAN
COLLEGE of
CARDIOLOGY®

FALL 2026

Navigating the Ambulatory Specialty Model For HF: A Practical Guide



Background

The Centers for Medicare and Medicaid Services (CMS) has the stated goal of placing all beneficiaries into some form of value-based care (VBC) reimbursement arrangement by 2030. The aim of VBC is to improve patient survival, reduce burden of symptoms, and elevate the experience of care while doing so sustainably relative to resource utilization. For chronic disease conditions, VBC models have principally involved primary care clinicians. With the launch of the Ambulatory Specialty Model (ASM) in 2027, CMS now seeks to involve specialists in its chronic condition VBC efforts. The first two ASMs center on (1) Low Back Pain and (2) Heart Failure (HF-ASM). The intent of this document is to provide specific recommendations to physicians (and their health care organizations) selected to be mandatory participants in the HF-ASM.

HF-ASM Overview

A physician's performance in the HF-ASM will be assessed based on CMS-defined Quality and Cost measures compared with the results of other participating clinicians for the five-year demonstration project. The outcome of this comparative assessment will result in an adjustment applied to that physician's entire Medicare Part B professional reimbursement in the Calendar Year (CY) two years after the Performance Year (PY). Note that this adjustment is not restricted to charges related to the care of patients in the HF-ASM; this adjustment applies to every Medicare Part B charge that the physician submits in the CY. The payment adjustment may be positive, neutral or negative. In CY 2029, which represents PY 2027, the maximum adjustment is $\pm 9\%$. This range increases annually, reaching $\pm 12\%$ in CY 2033. Because CMS retains a 15% discount factor before redistributing dollars, the upside pool will be smaller than the downside pool. Thus, an at-median performer should expect a slightly negative adjustment.

While HF-ASM attaches significant financial accountability to the delivery of chronic HF care, clinical quality and cost are influenced by many factors beyond the control of the individual clinician, including patient complexity (both disease severity and variables related to social determinants of health [SDOH]), practice referral patterns, geographic barriers to care, and available practice resources. Success in the HF-ASM will hinge on delivering and coordinating effective HF care across the inpatient and outpatient continuum.

The key to performing well in the HF-ASM lies in having command of the technical details of the model. Participants must know (1) whether and why they are in the model; (2) which patients are attributed to them; (3) how the clinical and cost performance is measured; and (4) which patient factors and local operational processes most influence these clinical and cost outcomes. Drawing from ACC's clinical practice guidelines and other resources - including statements of best practice related to population management, transitions of care, clinical documentation, quality reporting and performance monitoring - this practical guide provides recommendations to best assess and address these issues.

Key Considerations

- ✓ Participation is determined by PECOS specialty designation, geography and historical episode volume - verify all three now.
- ✓ Attribution follows E/M billing, not acuity. The clinician who anchors the longitudinal HF relationship owns the episode.
- ✓ Hospitalizations drive cost. Proactive outpatient management and effective care transitions can improve outcomes.
- ✓ Medication optimization (GDMT) is foundational.
- ✓ Quality measures are calculated on every eligible patient the clinician sees - not only HF-ASM-attributed beneficiaries.
- ✓ Readmissions are multifactorial and may reflect disease progression, patient factors, social determinants of health and care coordination opportunities.
- ✓ Data visibility drives performance improvement. Team-based care reduces clinician burden and improves outcomes.

I. Confirming Participation: The PECOS Assessment

Participation in HF-ASM is mandatory and automatic. There is no application, opt-in, opt-out or hardship exemption. A physician is a participant for a given performance year if all three of the following are true, as determined by CMS from claims and enrollment data two calendar years prior (e.g., 2025 data determine PY 2027; 2026 data determine PY 2028, and so on):

- 1. Geography:** The physician's practice location is in a CMS-selected Core-Based Statistical Area (CBSA) or metropolitan division (roughly 25% of CBSAs, spanning 47 states). Location is taken from the practice address associated with the physician's billing, so a group with sites on both sides of a CBSA boundary may have some cardiologists in the model and others not.
- 2. Specialty:** The physician's Medicare enrollment specialty in the Provider Enrollment, Chain and Ownership System (PECOS) is **Cardiovascular Disease / Cardiology (Medicare specialty code 06)**. Physicians enrolled as Interventional Cardiology (C3), Cardiac Electrophysiology (EP) (21), or Advanced HF and Transplant Cardiology (C7) are not in the HF cohort. Non-physician practitioners (NPs, PAs, CNSs) are not ASM participants.
- 3. Volume:** The physician was attributed ≥ 20 HF episodes under the MIPS HF Episode-Based Cost Measure (EBCM) in the determination year. (See Section II for how episodes are attributed.)

Why PECOS Deserves a Dedicated Review

CMS does not identify the HF-ASM physician cohort from review of board certification, clinical practice pattern or how the physician self-identifies. Instead, CMS identifies the HF-ASM cohort from the specialty designation code on file in PECOS – the national Medicare enrollment database in which every physician's billing information is recorded, including the primary specialty designation that CMS uses to classify claims. The physician's specialty within PECOS is whatever the physician's administrative team entered either at the time of initial Medicare enrollment or at last manual update. Note that PECOS designation remains static unless purposefully updated; designation does not change automatically upon completion of fellowship training, achievement of subspecialty board certification or evolution in clinical practice.

Ensuring correct PECOS classification is important. An ACC analysis of the preliminary HF-ASM participant list found that ~20% were enrolled because they were considered to be practicing General Cardiology (PECOS Code 06), despite these cardiologists practicing Interventional Cardiology, EP or Advanced HF. By design, the HF-ASM intends to involve only General Cardiology. All other ABIM-recognized cardiology subspecialists are expected to be excluded from the model.

The financial stakes of misclassification are asymmetric and predictable. **The costs associated with HF care delivered by interventional, EP and advanced HF cardiologists are substantially higher than the costs associated with general cardiologists.** These subspecialists provide more advanced, resource-intensive care to the HF patients they care for relative to the HF population served by the general cardiologist. Each ICD, CRT implantation, generator change, or catheter ablation; each coronary or structural intervention; each episode of mechanical circulatory support, inotrope management, or transplant evaluation all contribute to the costs assigned to the HF episode. A misclassified subspecialist – who is appropriately providing advanced care – will be benchmarked against general cardiologists whose HF patients are on average less sick and far less costly to manage.

Cost Performance constitutes 50% of the total HF-ASM score. A misclassified subspecialist will likely receive a -9 to -12% adjustment applied to all of that physician's Medicare Part B revenue, including all procedural revenue derived from caring for patients that do not have HF.

Recommended PECOS Assessment: Verify Every Cardiologist in the TIN, Not Only Those on the CMS List

- 1. Pull the current PECOS enrollment record for each physician** (via the PECOS portal or the Medicare Administrative Contractor). Confirm the primary specialty code, any secondary specialty codes, all practice locations and their CBSAs; ensure the physician's National Provider Identifier (NPI) is active and not in a deactivated or revalidation-pending state; assess whether there have been reassignments of physicians within the practice, as defined by the practice's TIN.
- 2. Compare PECOS specialty to actual practice.** Flag any physician whose primary specialty is "06" but whose practice is predominantly interventional, EP or advanced HF/transplant (board certification, procedural volume and clinic mix are supporting evidence).
- 3. Correct the record.** Specialty changes are made electronically through PECOS or manually through submission of Form CMS-855I. Retain documentation supporting the change. Because eligibility for each PY is determined from data two years earlier, a correction made in 2026 does not remove a physician from PY 2027; it governs PY 2028 and later. For PY 2027, CMS has proposed an exception process for HF subspecialty redesignations and for physicians who change TINs. Monitor the CY 2027 Medicare Physician Fee Schedule (PFS) final rule (to be released in the fourth quarter of 2026) and CMS ASM guidance for the mechanism and deadlines, and be prepared to submit promptly.
- 4. Reconcile against the CMS lists.** The preliminary PY 2027 participant list (2024 data) was published in February 2026 and the final list (2025 data) was published in September 2026 on the ASM Participants dataset webpage. Physicians may be added to the final list even if absent from the preliminary list. CMS will notify physicians who dropped from the initial list due to a change in location, subspecialty designation or attributed patient volumes. Any physician initially assigned to HF-ASM who no longer meets criteria will revert to MIPS for that year.
- 5. Re-check annually and at every roster change.** The TIN roster is redetermined each year. Newly recruited cardiologists, those achieving subspecialty board certification, physicians relocating between sites, retirements and mid-year TIN changes all alter who is in HF-ASM. Build the PECOS review into onboarding, credentialing and annual revalidation workflows, and assign ownership (typically the physician enterprise or credentialing office, with the ASM program lead as reviewer).
- 6. Inform the affected physicians in writing,** including who is in, who is out, why, and what it means financially - before the PY begins.

PECOS AND PARTICIPATION TIMELINE

Performance Year (Calendar Year Adjustment)	Determination Data Year (Patient Attribution From Claims)	Participant List / Actions
PY 2027 CY 2029: $\pm 9\%$	CY 2025	Preliminary list: February 2026 (based on 2024 claims and PECOS data) Final list: September 2026 (based on 2025 claims and PECOS data) Exception requests: per the 2027 final rule (Q4 2026)
PY 2028 CY 2030: $\pm 9\%$	CY 2026	PECOS corrections made in 2026 take effect here List published 2027
PY 2029 CY 2031: $\pm 10\%$	CY 2027	Annual re-determination
PY 2030 CY 2032: $\pm 11\%$	CY 2028	Annual re-determination
PY 2031 CY 2033: $\pm 12\%$	CY 2029	Final model year

II. Patient Attribution: How Episodes Are Built and Assigned

A general cardiologist must have been involved in the care of >20 HF patients in the CY two years before the PY to be selected for HF-ASM participation. The methodology for determining this “involvement” is complicated and is termed “attribution.”

Attribution not only determines whether the participant reaches the 20-episode threshold, it also determines which of those patients’ total health care costs will count against a participant and which patients populate the other clinical outcome measures. From a technical standpoint, HF-ASM uses the attribution logic of the MIPS HF EBCM without modification. Specifics are outlined below, drawn from the CMS Measure Information Form for the measure (see Resources). Participants should read the full specification and the accompanying code list. In brief:

Episode Trigger

- **Trigger claim:** A Part B claim billed by the HF-ASM participant (submitted under the physician’s own NPI, under the practice TIN) that carries an ICD-10 HF diagnosis together with an outpatient E/M, advance care planning, home health care oversight, transitional care management (TCM), or chronic care management (CCM) code. The trigger is the physician’s own HF-coded visit – not an HF diagnosis appearing elsewhere on the group’s claims. This is termed a “qualifying claim.”
- **Confirming claim:** A second qualifying claim with a HF diagnosis within 180 days of the trigger claim (another trigger code, or a code from the measure’s additional list of HF treatment services). CMS constructs the episode at the group (TIN) level, so the confirming claim may come from the same physician or from another clinician in the TIN. For the episode to be attributed to a given ASM participant, that physician must personally have billed at least 30% of the trigger and confirming codes during the episode and at least one trigger or confirming code in the year before the episode began (see next section). In practice, the participant’s own HF-coded E/M billing is what will result in attributing the episode to that physician.
- **Attribution window:** Opens on the date of the trigger claim and runs for one year. Any further confirming claim during an open window (a “reaffirming claim”) extends the window to one year from that claim. Episodes therefore run 365-729 days and are split into CY segments for scoring.
- **Practical implication:** An inpatient stay or ED visit does not by itself create or attribute an episode and neither does another clinician in the group billing for HF. Attribution to a physician is created by that physician’s own outpatient HF-coded E/M and care management billing. A patient seen once, with no second qualifying claim from anyone in the TIN within 180 days, never becomes an episode. A patient with two qualifying HF-coded claims within 180 days always does, and the episode is then attributed to every physician who billed at least 30% of those claims, so a physician who bills the trigger visit and a partner who bills the confirming claim are each attributed at 50%.

Attribution to the Group (TIN) and to the Physician (TIN/NPI)

- **TIN level:** The episode belongs to the clinician group that billed the trigger and confirming claims, provided at least one clinician in the group prescribed greater than or equal to two HF-related medications on different days to two different patients during the measurement period plus a one-year lookback.
- **TIN/NPI level (the ASM participant):** Within the attributed TIN, the episode is attributed to **every physician who billed at least 30% of the trigger or confirming codes during the episode**, and who also (a) billed at least one trigger/confirming code within the year before or on the episode start date, and (b) met the same prescribing check. Because the threshold is 30% rather than a plurality, a single HF episode can be attributed to two or three cardiologists in the same group who share the patient.
- **Cross-coverage and NPPs:** Visits billed under an NP/PA's own NPI count toward the TIN trigger but not toward any physician's 30% share. However, visits billed under the physician's NPI (e.g., incident-to) will count toward the physician's 30% share. Practices should understand how their billing conventions distribute attribution before changing them.
- **Case minimum:** To be an ASM participant, a physician must have 20 attributed episodes in the determination year. CMS applies the same minimum for scoring the cost measure.

What is Excluded

The following patients or episodes are removed before scoring. Accurate diagnosis coding is therefore consequential. These conditions must appear on claims to be recognized:

- **Clinical exclusions:** Cardiac amyloidosis, congenital heart disease, high-output HF, hypertrophic cardiomyopathy, peripartum cardiomyopathy, other infiltrative disease, and prior or recent left ventricular assist device (LVAD) or heart transplant. An LVAD or transplant during an episode terminates it; the episode is retained only if greater than or equal to one year of pre-event data exists.
- **Coverage exclusions:** Any Medicare Advantage (Part C) enrollment, primary payer other than Medicare, or lack of continuous Parts A and B enrollment during the episode plus a 120-day lookback; patients not found in enrollment data; residence outside the U.S.
- **Other:** Death before the episode end date; episodes shorter than one year; episodes with extremely low treatment costs.

What Counts Toward Episode Cost

- **Parts A, B and D services clinically related to HF management during the episode window:** Outpatient clinician and facility services, ED visits, inpatient medical and surgical stays, SNF (capped at 30 days per stay), IRF/LTCH (if within 7 days of an inpatient stay; capped at the 90th percentile), home health, durable medical equipment (DME), and Part D drugs. Cost related to cardiac procedures, imaging, laboratory, infusions and hospitalizations (including readmissions) are included.
- **Costs are attributed regardless of who generated them.** Catheterization, device and advanced imaging costs ordered by interventional, EP or Advanced HF colleagues - who bear no HF-ASM risk - accrue to the attributed general cardiologist's episode.

Risk Adjustment

- Comorbidity burden is captured through CMS-HCC categories grouped by count (0, 1, 2-3, 4-6, 7+), plus age, disability status, ESRD, dual eligibility, recent institutional long-term care, and the number and types of clinician specialties from which the patient received care.
- HF-specific adjusters: Cardiomyopathy, coronary artery disease, idiopathic HF, right HF, rheumatic/other valve disease, all-cause recent inpatient admission, substance-related cardiomyopathy and obstructive sleep apnea.
- Separate models are run by Part D enrollment status. Comorbidities and HF-specific conditions are recognized only if coded on claims during the lookback and episode; under-coding lowers the expected cost against which the participant is judged.
- **Apart from dual Medicare-Medicaid eligibility, SDOH are not directly factored into the risk-adjustment algorithm.**

Attribution Management: Recommended Actions

- Using the practice's own claims data, build an internal replica of the trigger that incorporates exclusion logic, so the attributed panel is known months before CMS feedback arrives. Reconcile this against CMS reports when released.
- Identify those HF-ASM attributed patients whose care provision is shared amongst cardiologists within the TIN and those patients whose HF is managed by an NPP under the NPP's NPI. Develop a strategy for how longitudinal HF follow up will be managed (i.e., physician-driven or NPP-driven).
- Ensure HF (ICD-10 I50.x and related) is coded on every visit at which HF is managed and that excluding diagnoses (amyloid, HCM, congenital, LVAD/transplant) and risk-adjusting comorbidities are coded to specificity at least once annually.
- Map referral and co-management relationships with interventional, EP, and advanced HF colleagues and with hospital-based teams. Their utilization lands on the general cardiologist's episode.
- Identify attributed patients at high risk (recent admissions, rising NT-proBNP, multiple HCCs, dual eligibility). These patients drive episode cost the most.

The specific Cost Measure within HF-ASM is "Cost_HF_01." Enhance familiarity with the [heart failure cost measure](#) documents - Measure Information Form, measure codes list (trigger, confirming, exclusion and service-assignment codes), and risk-adjustor specifications.

III. Quality Measures

HF-ASM quality performance is based on CMS-calculated results related to five Quality measures (see table). The Quality Score contributes 50% of the HF-ASM score. Cost performance accounts for the remaining 50%.

Measure Denominators: All Patients, Not Only Attributed Beneficiaries

The most common misunderstanding about HF-ASM quality reporting is that the measures apply to the attributed HF-ASM population. They do not. **The four eCQM/MIPS CQM measures (MIPS #5, #8, #377, #236) are all-payer and all-patient. Every patient who meets the measure's denominator criteria and is seen by the participant during the PY is counted, regardless of payer (Medicare fee-for-service, Medicare Advantage, commercial, Medicaid, self-pay) and regardless of whether the patient is attributed to the participant under the HF cost measure.** Practically:

- MIPS #5 and #8 include every HF with reduced ejection fraction (EF $\leq$ 40%) patient seen, including patients whose HF is managed by another cardiologist, who are enrolled in Medicare Advantage or under 65.
- MIPS #377 includes every patient with a HF diagnosis seen across all EF phenotypes.
- MIPS #236 includes every patient aged 18-85 with a hypertension diagnosis seen by the participant – most of a general cardiology panel, most of whom do not have HF at all.
- In contrast to the other reported Quality measures, MIPS #492 is a claims-based outcome measure calculated by CMS on Medicare fee-for-service HF patients using the measure's own attribution. CMS has proposed scoring it at the individual TIN/NPI level beginning in PY 2027.

The consequences for workflow are significant. **Measure workflows (contraindication documentation, functional status assessment, blood pressure [BP] re-measurement) must be applied universally in the clinic**, not triggered by an "ASM patient" flag. **CMS data completeness requires that at least 75% of denominator-eligible patients across all payers be reported for each eCQM/MIPS CQM measure; a measure reported on a curated subset will fail data completeness and score zero.** Quality measures are reported at the TIN/NPI level (small practices may report at the TIN level), so every participating physician needs his or her own denominator captured.

Ensuring Access to a Validated Functional Status Instrument (e.g., KCCQ)

MIPS #377 requires a standardized, validated patient-reported functional status instrument; free text or NYHA class alone does not satisfy the measure. Accepted instruments are the **Kansas City Cardiomyopathy Questionnaire (KCCQ, including KCCQ-12)**, Minnesota Living with Heart Failure Questionnaire (MLHFQ), PROMIS-10 Global Health, PROMIS-29, VR-12 and VR-36. The KCCQ is the instrument most aligned with ACC/AHA guidance, has an established minimal clinically important difference, and is the natural candidate for the voluntary patient-reported outcome submission (with a proposed scoring incentive) in the CY 2027 proposed rule. Practices should confirm the following before Jan. 1, 2027:

- **Licensing:** The KCCQ and MLHFQ are copyrighted; confirm the practice or health care system holds a current license for the intended use and volume (many EHR vendors distribute the KCCQ under a vendor license – verify in your organization). PROMIS and VR-12/VR-36 are available without fee.

- **EHR integration:** The instrument must be captured in discrete fields (not scanned or free text) with an automatically calculated score, a date stamp, and mapping to the eCQM/MIPS CQM value set used by the reporting vendor or QCDR. Test end-to-end extraction on sample patients.
- **Administration workflow:** Pre-visit delivery through the patient portal or text link, tablet completion at check-in, or MA/RN-administered completion in the room; having non-English language versions and a designated staff role responsible for completion at each HF visit is recommended. MIPS #377 requires an initial assessment and a follow-up assessment for each patient during the performance period (verify the current specification for the required interval), so the instrument must be administered more than once per year, not annually.
- **Clinical use:** Trend the score in the HF registry/dashboard; a decline of ≥ 5 points on the KCCQ should trigger reassessment of GDMT, volume status and advanced HF referral criteria.
- **Reporting readiness for PRO submission:** If the voluntary PRO option is finalized, having KCCQ collected at scale in PY 2027 banks the incentive and positions the practice for the PRO-based measures CMS has signaled will follow.

What 2024 QPP Data Show About Cost and Quality Measures

Analysis of preliminary 2024 QPP data (10,367 HF cost measure submissions; 9,567 unique NPIs) indicates where differentiation is likely:

- HF cost measure scores are tightly clustered (mean 7.06, median 7.30 on a 10-point scale) with no consistent advantage by subspecialty, practice size or reporting option, and essentially no correlation with quality or final MIPS scores. Cost alone will not separate participants – quality will.
- MIPS #492 (unplanned CV admissions) is by far the most widely reported HF measure (8,351 reporters) and has the lowest average score (5.26 of 10). It is the measure with the most opportunity and the one most aligned with overall MIPS performance.
- MIPS #377 (functional status) was reported by only 43 clinicians, with a high average score (9.26) among those who did. Most cardiology practices have no production-grade PRO collection today; those that build it early will hold an advantage. Clinicians reporting #377 trended toward worse cost scores, consistent with sicker panels – a reminder that risk-adjusting comorbidity capture matters.
- MIPS #5 (8.15), #8 (8.49) and #236 (8.13) are high-performing process measures where the remaining gap is largely structured documentation of exclusions.

The Quality measures included in HF-ASM reflect CMS-selected measures and do not capture every aspect of high-quality HF care. In addition to the measures below, practices should routinely monitor optimization of all four GDMT pillars, including MRAs and SGLT2 inhibitors, when clinically appropriate. Measure specifications are available via the [CMS Measures Inventory Tool](#).

QUALITY MEASURES

Measure	Collection Type(s)	Focus Area	How To Improve
MIPS #492: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates For Patients With HF (Outcome measure)	Administrative claims (CMS-calculated; proposed TIN/NPI scoring from PY 2027)	- Risk-standardized acute cardiovascular-related hospital admission rates among Medicare beneficiaries with HF - Track all CV admissions (AMI, stroke, arrhythmia, not just HF) and identify preventable patterns - Lowest-scoring HF measure nationally (2024 avg 5.26)	- Ensure follow-up within 7 days of discharge - Optimize GDMT before discharge (don't defer to outpatient) - Use remote monitoring for high-risk patients - Analyze root causes within 72 hours of any readmission - Use same-day urgent visits and outpatient IV diuresis to avoid ED
MIPS #8: HF: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (Process measure)	eCQM / MIPS CQM (all-payer, all patients)	% of HFrEF patients (EF $\leq$40%) prescribed evidence-based beta-blocker (carvedilol, metoprolol succinate or bisoprolol) - Target 100% of eligible patients on beta-blocker or documented contraindication/intolerance	- Add EHR alert when HFrEF patient not on beta-blocker - Use standardized contraindication checkboxes (not free text) - Default to prescribing during every HF visit until at target dose
MIPS #5: HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD (Process measure)	eCQM / MIPS CQM (all-payer, all patients)	% of HF patients (all EF phenotypes) with initial and follow-up patient-reported functional status assessment using a validated tool - Validated tools: KCCQ, MLHFQ, PROMIS-10, PROMIS-29, VR-12, VR-36 - Reported by only 43 clinicians in 2024 - an infrastructure gap and an opportunity	- Prioritize ARNI (sacubitril/valsartan) over ACEi/ARB for all HFrEF patients - Check RAAS inhibitor status at every HF visit - Address cost barriers: use patient assistance programs for ARNI - Build EHR template prompts to flag patients not on ACEi/ARB/ARNI - Use structured documentation for contraindications - Decide in advance what potassium or creatinine level suggests pausing therapy vs. closer monitoring
MIPS #377: Functional Status Assessment For HF (Process measure)	eCQM / MIPS CQM (all-payer, all patients)	% of HF patients (all EF phenotypes) with initial and follow-up patient-reported functional status assessment using a validated tool - Validated tools: KCCQ, MLHFQ, PROMIS-10, PROMIS-29, VR-12, VR-36 - Reported by only 43 clinicians in 2024 - an infrastructure gap and an opportunity	- Secure KCCQ license and build instrument into EHR as a discrete, scored, required field - Assign MA/RN ownership; deliver via portal pre-visit or tablet at check-in - Set reminders for the required follow-up assessment interval - Use results clinically (declining score = intensify management)
MIPS #236: Controlling High Blood Pressure (Intermediate outcome measure)	eCQM (all-payer, all patients with hypertension)	% of patients aged 18-85 with hypertension whose most recent BP is $<$140/90 mmHg - Applies to the entire hypertensive panel, not only HF patients; most HF patients have comorbid hypertension, and BP control reduces HF events	- Recheck BP if initially elevated (don't accept a single high reading) - Optimize antihypertensive regimen (many GDMT drugs lower BP) - Address white-coat hypertension (use home BP monitoring) - Document exclusions when applicable (e.g., hypotension, palliative care, advanced dementia, ESRD)

Tips For Improving Your Quality Score

- ✓ Report measures at the TIN/NPI level; small practices may report at the TIN level.
- ✓ Apply measure workflows to every eligible patient, every payer - the denominator is the whole panel, not the attributed list - and confirm $\geq 75\%$ data completeness per measure.
- ✓ Quality measures potentially score better when medications are e-prescribed, data are exchanged with the PCP, BP is shared electronically, and care plans are accessible via the portal.
- ✓ Use structured EHR fields (not free text) to ensure data extraction from discrete fields only.
- ✓ Document contraindications explicitly with checkboxes/dropdowns, not buried in notes.
- ✓ Assign measure responsibility (e.g., MA administers the KCCQ, pharmacist checks GDMT, MD documents contraindications).
- ✓ Test file submission early. Validate data 60-90 days before the March 31 deadline.

IV. Improvement Activities and Promoting Interoperability

Improvement Activities (IA) and Promoting Interoperability (PI) are mandatory reporting requirements. Failing to attest to completion of or compliance with IA or PI will result in reduction of final HF-ASM score.

Improvement Activities

CMS assigns adjustments based on participants' completion and documentation of required IA components, which can be 0, -10 or -20 points.

IA 1: CONNECTING TO PRIMARY CARE AND HEALTH-RELATED SOCIAL NEEDS SCREENING

Component	Operational Expectation	Examples of Evidence
PCP Identification and Communication	Defined workflow for identifying PCP and sharing information	Written protocol; referral workflow diagram
HRSN Screening	Process for screening and tracking completion	EHR template; screening tool integration
Documentation	Evidence coordination is occurring	Audit reports; follow-up verification logs
Staff Preparedness	Training on PCP coordination and HRSN processes	Training materials; attendance logs

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

The ASM participant must enter at least one CCA with a primary care practice, including at least three of the five elements below. The CY 2027 proposed rule would allow multiple participants under one TIN to use a single CCA, require only one shared ASM beneficiary between the PCP and any participant named in the CCA, and broaden "payment" to "remuneration" (monetary or in-kind).

Required Element	Operational Expectation	Documentation Examples
Data Sharing	Bi-directional clinical data exchange	Data-sharing agreement; EHR screenshots
Co-Management	Defined care model (Consultative / Shared / Principal)	Written CCA outlining roles
Transitions in Care	Standardized discharge-to-outpatient protocols	Transition checklist; reconciliation workflow
Closed-Loop Referrals	Confirm referrals completed and acknowledged	Referral tracking logs
Care Coordination Integration	Clear responsibility for follow-up communication	Care team role descriptions

Tips For Completing Improvement Activities

- ✓ Report these at the TIN level.
- ✓ The ASM participant does not need to directly connect the patient to a PCP. It can be a separate activity not tied to the HIE system and/or an initiative/process within the practice or health system to ensure this coordination is happening effectively.
- ✓ Prioritize PCP practices with whom you share the largest number of Medicare patients.

Promoting Interoperability

HF-ASM participants **MUST** use certified EHR technology (CEHRT). No CEHRT = 0% PI score = downside penalty of up to -10% on the final ASM score.

- Minimum continuous 180-day period during the CY (or up to full CY).
- Use CEHRT that meets ONC certification criteria.

Provide your EHR's CMS Certification ID from the [Certified Health IT Product List](#).

Required Attestations

- ONC Direct Review Attestation and annual Security Risk Analysis attestation (the CY 2027 proposed rule would remove both; verify against the final rule).
- SAFER Guides, High-Priority Practices: Complete annual self-assessment (required but unscored).
- Actions to Limit or Restrict Compatibility or Interoperability of CEHRT: Attest "yes" that you acted in good faith and did not knowingly limit interoperability.

Required PI Objectives and Measures

- You must report on all of the measures and objectives. The proposed rule adds a voluntary electronic prior authorization measure for 2027 (required in 2028).
- PI requirements must be reported at the TIN level (not TIN/NPI).

Scoring and Exceptions

- PI score is used as a scoring adjustment (downside-only, 0% to -10%) to the final ASM score.
- Unlike MIPS, ASM does not include PI-specific hardship exceptions. The extreme and uncontrollable circumstances policy applies. A small practice scoring adjustment is available.

V. Optimizing Clinical Outcomes and Acute Care Utilization

Evidence-based treatment, GDMT optimization and proactive outpatient management can improve outcomes (see [GDMT and expert consensus](#) for HF care).

7-Day Transition Pathway

Before Discharge

- Discharge summaries should include: GDMT changes/targets, titration plans, follow-up, diuretic adjustment and patient education completed.
- Develop timely discharge information to reduce care gaps and readmissions.
- Establish processes that support patient education and confirmation of understanding (e.g., teach-back methods).

After Discharge

- Establish reliable processes to identify recently discharged HF patients.
- Schedule follow-up within 7 days using appropriate modalities (in-person, virtual or team-based).
- Determine accountability for scheduling and outreach.
- Monitor follow-up completion rates and address gaps.

GDMT Optimization

- Implement standardized workflows to support initiation and optimization of all four GDMT classes, symptom monitoring, and patient access and tolerance to therapies.
- Adjust medications as needed with appropriate laboratory monitoring.
- Incorporate biomarker monitoring (e.g., NT-proBNP) and clinical trends to guide therapy and identify patients at higher risk.
- Ensure documentation of contraindications, including intolerance and patient refusal, in structured fields; these move patients out of the quality measure denominators.

Patient Management and Acute Care Avoidance

- Establish risk-based monitoring to detect and respond to early signs of worsening symptoms, determine follow-up frequency, and ensure same-day or next-day appointments are available.
- Set clear plans for who responds when symptoms worsen and who handles alerts or urgent issues.
- Set up standardized treatment protocols for managing HF in the outpatient setting, including offering IV diuretics in the office for suitable patients.

- Ensure timely laboratory and clinical follow-up after acute outpatient interventions.
- Ensure accurate documentation of comorbidity burden, which drives risk adjustment on cost and the complex-patient bonus.

SDOH Screening and Support

- Significant racial and ethnic disparities exist in HF hospitalization and mortality. Incorporate structured screening for social risk factors that may impact treatment adherence or clinical stability.
- Establish referral pathways to address common barriers such as medication access, transportation, food insecurity and home safety.
- Monitor high-risk patients for unresolved social needs and coordinate with community partners when appropriate.

Medication Access and Adherence

Care processes should support medication initiation, adherence and affordability through:

- Timely resolution of access barriers (e.g., prior authorizations, cost concerns).
- Simplified medication treatment plans when clinically appropriate.
- Routine assessment of adherence and patient understanding.
- Engagement of caregivers or support systems when needed.

Patient Education and Self-Management

Provide standardized, accessible education that supports patient self-management, including:

- Clear action plans for symptom recognition and escalation.
- Education on weight monitoring, diet, fluid management and when to seek care.
- Materials tailored to health literacy level and preferred language.

Documentation Priorities

Successful participation in the ASM depends on consistent use of structured documentation and workflows. Practices should ensure documentation supports:

- ✓ HF diagnosis, phenotype (EF), stage, severity and risk factors coded on claims, not only in the note.
- ✓ GDMT prescribing, titration, contraindications, intolerance and adherence in structured fields.
- ✓ Care transitions, follow-up and care coordination activities.
- ✓ Quality, Improvement Activities and Promoting Interoperability reporting requirements.
- ✓ Submit all required data and attestations for each ASM performance category by March 31 following the close of the PY (March 31, 2028, for PY 2027), or a later date if specified by CMS.

VI. Data, Reporting and Performance Monitoring

Drawing from the background information previously cited, here are specifically recommended activities a practice or health care organization should complete to be successful in HF-ASM:

Program Governance

- Designate an ASM program lead (clinical or operational) with authority across cardiology, care management, pharmacy, IT/data, finance/quality, and primary care.
- Confirm sufficient IT, staffing and workflow support for the model and establish a standing meeting cadence (monthly during PY 2027).
- Identify primary contacts for cardiology, nursing/care management, pharmacy, IT/data, finance/quality, primary care, and credentialing/PECOS.
- Establish a process to regularly reconcile CMS attribution and feedback information with internal HF patient lists, and to identify patients entering or leaving attribution.

Reporting Infrastructure

- Assign an organizational champion to ensure accuracy of PECOS designation. PECOS verification should be performed at least annually.
- Confirm that the EHR, QCDR or reporting vendor can generate and submit required data files for each collection type, and that the vendor's value sets include the functional status instrument codes. Ensure that Quality measure reporting can be performed at the Provider (TIN/NPI) level.
- Allow sufficient time to program, test and validate patient data and submission workflows.
- Ensure capacity to meet Promoting Interoperability and Improvement Activities reporting requirements at the TIN level, and Quality and Cost requirements at the TIN/NPI level. In addition, ensure a CCA is in place with at least one primary care group.

Performance Monitoring and Attribution Oversight

- Maintain the internal attribution replica (Section II) and reconcile against CMS feedback as it is released. Investigate discrepancies in trigger coding, TIN/NPI billing and exclusions.
- Monitor HF episode performance, including cost patterns by service category (inpatient, post-acute, professional, diagnostic, Part D) and acute care utilization.
- Track ED and observation use and evaluate the impact of monitoring and outpatient management strategies.
- Use problem lists, registries or dashboards to make patient status visible to the entire care team, including HF stage (A-D), EF phenotype, NYHA class, KCCQ trend and attribution status.
- Review CMS feedback reports promptly and initiate corrective action when needed.

Periodic Performance Reviews

Review at least quarterly at the individual physician level:

- Readmissions (30-day all-cause, HF-specific) and all CV-related unplanned admissions (#492 definition).
- ED visits and observation stays.
- Seven-day follow-up completion rate.
- GDMT optimization rates (all four pillars) and documented exclusions.
- Functional status assessment completion and KCCQ trends.
- NT-proBNP trends; BP control rate across the hypertensive panel.

Financial and Cost Oversight

- Analyze patterns in acute, post-acute, professional and diagnostic spending. Route echocardiography and advanced imaging to lower-cost sites when clinically appropriate.
- Identify high-cost patients and evaluate root causes of utilization.
- Monitor cost trends over time and assess projected performance against model benchmarks.
- Implement targeted strategies to reduce avoidable utilization while maintaining quality, including optimal post-acute care pathways and timely referrals.

Advanced HF Care

Define triggers for advanced HF consultation and establish a timely referral pathway (direct line to the advanced HF team). Note that an LVAD or transplant terminates the cost episode; the advanced HF specialist is not a HF-ASM participant, but the referring general cardiologist remains accountable for the episode up until that point. Examples include:

- Persistent NYHA IV despite optimal GDMT.
- Recurrent hospitalizations (greater or equal to two in six months).
- Rising NT-proBNP or declining KCCQ despite therapy.
- Need for inotropic support.
- LVAD or transplant evaluation.

HF-ASM Practical Checklist

Complete before Jan. 1, 2027. Re-verify items annually (U). Assign an owner and date to every line.

Readiness Item	Owner	Target Date	Done
I. Participation and PECOS			
PECOS record pulled for every cardiologist in the TIN: primary/secondary specialty, practice locations and CBSA, NPI status, TIN reassignments U			☐
Physicians whose PECOS specialty (06 vs C3/21/C7) does not match actual practice identified; corrections filed via PECOS/CMS-855I; PY 2027 exception request submitted per CY 2027 final rule			☐
Roster reconciled against the final CMS participant list; affected physicians notified in writing; PECOS check embedded in onboarding/credentialing/revalidation with a named owner U			☐
II. Attribution			
Internal attribution replica built from practice claims (trigger/confirming/30% rule/exclusions); attributed panel known before CMS feedback U			☐
Confirming-code list verified against the CMS HF Measure Codes List (Trigger Confirming tab), including status of diagnostic services			☐
Shared-patient and NPP-billed HF follow-up patterns mapped; longitudinal HF follow-up strategy (physician- vs. NPP-driven) decided			☐
HF (I50.x), excluding diagnoses and risk-adjusting comorbidities coded to specificity annually; referral/co-management map with interventional, EP, advanced HF and hospital teams completed U			☐
III. Quality Measures			
KCCQ (or other accepted instrument) licensed for the organization and volume			☐
Instrument built into EHR as discrete, scored date-stamped field mapped to the reporting value set; end-to-end extraction tested			☐
Administration workflow (portal/tablet/MA-RN) live for every HF patient, all payers; follow-up assessment interval reminders set			☐
Measure workflows (#5, #8, #236, #377) applied to the entire eligible panel, not an ASM flag; structured contraindication fields in use; ≥75% data completeness confirmed per measure U			☐
IV. Improvement Activities and Promoting Interoperability			
At least one CCA executed with a primary care practice (≥3 of 5 elements); shared-beneficiary requirement met			☐
PCP identification and HRSN screening workflows documented with evidence (protocols, EHR templates, audit logs, training records)			☐
CEHRT in use for ≥180 continuous days; CMS Certification ID recorded from CHPL			☐
All required PI objectives/measures and attestations (SAFER Guides, interoperability) prepared at TIN level			☐
V. Clinical Operations			
7-day post-discharge follow-up process live with named accountability and completion rate tracking; SDOH/HRSN screening and referral pathways operational U			☐
GDMT titration workflow (all 4 pillars) with lab monitoring and pharmacist/APP support; same-day access and outpatient IV diuresis protocol in place			☐
VI. Data, Reporting and Governance			
ASM program lead designated; standing monthly meeting with cardiology, care management, pharmacy, IT/data, finance/quality, primary care, credentialing			☐
EHR/QCQR/vendor confirmed for each collection type at TIN/NPI level; test submission validated 60-90 days before March 31			☐
Physician-level dashboard live (readmissions/#492, ED/observation use, 7-day follow-up, GDMT, KCCQ, attribution); quarterly performance/cost review scheduled; CMS feedback reviewed on receipt; advanced HF referral triggers defined U			☐

Resources

1. [ACC/AHA HF Guidelines and Expert Consensus Decision Pathways](#)
2. [ACC ASM For HF Resource Hub](#)
3. [CMS ASM Model Page](#)
4. [CMS ASM Frequently Asked Questions](#)
5. [CMS ASM Participant Readiness Roadmap](#)
6. [ASM Participants Dataset \(preliminary and final lists\)](#)
7. [HF Cost Measure - Measure Information Form \(PY 2025\)](#)
8. [CMS Cost Measures Overview, Information Forms and Codes Lists](#)
9. [Measure Specifications \(CMS Measures Inventory Tool\)](#)
10. [PECOS \(Medicare Provider Enrollment\)](#)
11. [Certified Health IT Product List](#)
12. [Strategies For Success in Bundled Payments \(CMS\)](#)
13. [CMS ASM Improvement Activities Toolkit](#)

Questions? Stay Connected

- For additional information and updates specifically about the ASM Model, subscribe to the [CMS ASM Model listserv](#).
- Contact the CMS ASM team at AmbulatorySpecialtyModel@cms.hhs.gov.
- [Submit ASM questions](#) to ACC staff.



**AMERICAN
COLLEGE of
CARDIOLOGY®**