COACHCARE

ASM Preparedness Report and Checklist

Who, What, When, Where, and How

For organizations in mandatory ASM geographic areas

Prepared: January 2026

Purpose: Education and operational readiness planning for Health Systems, Medical Centers, and Ambulatory Groups whose regions have been selected for mandatory participation in the CMS Ambulatory Specialty Model (ASM).
This report is educational and does not constitute legal, billing, or regulatory advice.

Sections

1 Executive Summary

ASM is a mandatory CMS Innovation Center payment model that holds selected specialists financially accountable for quality and cost performance in outpatient care for two targeted chronic conditions: heart failure and low back pain. Although accountability is scored at the individual clinician level (TIN/NPI), organizations in mandatory regions will need coordinated readiness across clinical operations, quality, finance, compliance, and IT.

Readiness lens	What to know (high level)
WHO	Individual clinicians (TIN/NPI) in selected regions who meet specialty and episode-volume criteria. Organizations support clinician-level readiness (data, workflows, governance).
WHAT	Performance is assessed across Quality and Cost (each 50% of final score), with scoring adjustments for Improvement Activities (0/–10/–20 points) and Promoting Interoperability (up to –10 points).
WHEN	Model starts Jan 1, 2027. Performance years are 2027–2031. Payment adjustments apply two years later in payment years 2029–2033.

WHERE

Mandatory participation applies in a CMS-selected set of CBSAs and metropolitan divisions (roughly one-quarter nationally).

WHY

Improve upstream management, reduce avoidable hospitalizations and unnecessary procedures, and increase transparency and comparability of specialist performance

HOW

Confirm whether your sites fall in mandatory CBSAs, identify eligible clinicians, map measure workflows (including PROMs), ensure CEHRT and interoperability readiness, stand up governance, and operationalize care coordination requirements (including Collaborative Care Arrangements).

Key regulatory anchors (selected):

- Eligibility and mandatory geographic selection: 42 CFR 512.710.
- Data submission requirements and deadlines: 42 CFR 512.720 (including March 31 submission deadline).
- Improvement Activities requirements (HRSN + CCAs): 42 CFR 512.735 and 42 CFR 512.771.
- Final scoring weights and adjustments: 42 CFR 512.745.
- Payment adjustment methodology, risk levels, and redistribution percentage: 42 CFR 512.750.
- Data sharing agreement and permitted uses: 42 CFR 512.760.
- Telehealth waivers (geographic + originating site): 42 CFR 512.775.
- CMS model overview and resources: CMS ASM webpages.

2 [WHO] Who Is Affected

ASM participation is determined at the individual clinician level (a unique TIN/NPI combination). For organizations, this means readiness must be built around provider-level attribution, measure capture, and reporting - even when clinical operations are managed centrally.

2.1 Clinician cohorts and eligibility triggers

A clinician is generally eligible when they
1 practice in a mandatory geographic area,
2 have a qualifying specialty designation, and
3 have at least 20 attributed episodes for the relevant episode-based cost measure in the lookback period (calendar year two years before the ASM performance year).

ASM cohort	Primary specialty types (examples)	Episode threshold	Lookback logic
Heart failure cohort	General cardiology (as determined by CMS specialty type rules)	≥ 20 HF EBCM episodes	Calendar year two years before the performance year (attributed per the heart failure episode-based cost measure).
Low back pain cohort	Anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, physical medicine & rehabilitation	≥ 20 LBP EBCM episodes	Calendar year two years before the performance year (attributed per the low back pain episode-based cost measure).

2.2 Organizational roles that should be involved

Even though clinicians are scored individually, successful preparation is an organizational effort. The table below highlights typical roles and the artifacts they should produce during 2026.

Role	Primary responsibilities / deliverables
Executive sponsor (system / group leadership)	Sets governance, resourcing, and accountability; approves prioritized workplan; monitors readiness milestones.
Clinical leadership (cardiology, spine/pain, PM&R, orthopedics)	Defines clinical pathways; ensures guideline-concordant care; owns adoption and escalation workflows.
Quality / performance improvement	Maps measures to workflows; builds numerator/denominator tracking; runs weekly/monthly performance huddles.
Finance / revenue cycle	Models impact of payment adjustments; validates claim flows and attribution; tracks Medicare Part B covered professional services by clinician.
Health IT / EHR / analytics	Ensures CEHRT readiness; enables structured data capture; supports PI objectives and reporting; integrates PROM tools.
Care management / population health	Implements transition-of-care workflows, patient outreach, HRSN screening coordination, and closed-loop referrals.
Compliance / privacy / security	Oversees data sharing agreement requirements; HIPAA and 42 CFR Part 2 considerations; incident response readiness.

3 [WHERE] Mandatory CBSAs and Metropolitan Divisions

ASM is mandatory only in selected geographic areas defined as Core-Based Statistical Areas (CBSAs) and, for certain large metropolitan statistical areas, metropolitan divisions. CMS selects these areas using a stratified random sampling approach and excludes areas that do not have minimum volumes of eligible clinicians/episodes and areas entirely in U.S. territories.

3.1 How to confirm whether your organization is in a mandatory area

1. Inventory all outpatient practice locations where targeted specialists bill Medicare Part B (use the NPI practice address and/or service location on claims).
2. Translate each location to its county and then to an OMB 2023 CBSA or metropolitan division code (many GIS tools and public CBSA crosswalks support this).
3. Compare the resulting codes to the CMS ASM Mandatory Geographic Areas list (Appendix A).
4. If any of your locations fall in a mandatory CBSA/metro division, proceed to clinician eligibility identification (Section 2) and operational readiness (Sections 5-7).

3.2 Common footprint pitfalls (what to watch for)

- **Multi-site groups:** participation is tied to the clinician's claims-based specialty and practice location in a mandatory area, not to the organization as a whole.
- **TIN/NPI combinations:** the same clinician may bill under multiple TINs; payment multipliers can follow the clinician and apply to different TINs depending on post-performance-year affiliation changes.
- **Metropolitan divisions vs CBSAs:** large metros may be divided into metropolitan divisions; ensure you match to the correct code type in Appendix A.

Appendix A includes the CMS-published list of mandatory geographic areas (OMB 2023 CBSA/Metropolitan Division codes).

4 [WHEN] Timeline and Key Deadlines

ASM begins January 1, 2027. The model has five performance years (2027–2031). Payment adjustments apply in the corresponding payment years two years later (2029–2033), based on the clinician's performance year final score.

4.1 A practical timeline for organizations in mandatory areas

Timeframe	What to do / what to expect
Early CY 2026	CMS intends to release an initial list of ASM participants; organizations should begin internal impact assessment and gap analysis.
CY 2026 (through year end)	Preparation year: finalize affected clinician roster; build reporting and workflow changes; execute care coordination and interoperability plans.
Jan 1, 2027	Performance Year 1 begins. Start full-year Quality and Cost performance tracking. Begin PI (>=180 days) and Improvement Activities (>=90 days) performance periods as needed.
Mar 31, 2028	Data submission deadline for 2027 performance year (quality, improvement activities, and PI submissions).
CY 2029	Payment Year 1: payment multipliers applied to Medicare Part B covered professional services based on 2027 performance.

4.2 Measurement periods and submission deadlines (operationally important)

- Quality and Cost performance are assessed over the full calendar-year performance year (Jan1–Dec 31).
- Improvement Activities performance can be a minimum continuous 90-day period in the calendar year (two years prior to the payment year).
- Promoting Interoperability performance can be a minimum continuous 180-day period in the calendar year (two years prior), up to the full year.
- Quality, Improvement Activities, and PI data are submitted after the performance year; cost and claims-based measures are calculated from claims.
- The standard data submission deadline is March 31 of the year following the applicable performance year.

5 [WHAT] What ASM Requires (Operations, Data, and Compliance)

5.1 Performance framework (how clinicians are scored)

ASM performance is organized into four categories. Quality and Cost are weighted (each 50%) to form the base final score. Improvement Activities and Promoting Interoperability are applied as scoring adjustments (penalties) based on whether required actions and attestations are completed. Additional scoring adjustments can apply for small practices/solo practitioners and for complex patient populations.

Category	How it is assessed	Impact on final score
Quality	Condition-specific and cross-cutting quality measures (mix of reported measures and claims-based measures).	50% weight.
Cost	Episode-based cost measures for heart failure or low back pain (claims-calculated).	50% weight.
Improvement Activities (IA)	Two required activities: (1) Primary care connection + HRSN screening coordination; (2) Collaborative Care Arrangement with a primary care practice including specific elements.	Scoring adjustment: 0, –10, or –20 points depending on completion.
Promoting Interoperability (PI)	Meaningful EHR user requirements using CEHRT, objective-based scoring, and required security attestations over a 180-day (minimum) period.	Scoring adjustment up to –10 points (penalty) based on PI score.

5.2 Reporting and submission requirements (what must be submitted vs calculated)

Operationally, ASM combines two data flows: (1) organization/clinician-submitted data for certain Quality measures, Improvement Activities, and Promoting Interoperability; and (2) CMS-calculated measures using administrative claims (Cost measures and certain claims-based Quality measures).

- **Quality:** submit numerator/denominator data for at least one applicable non-claims quality measure, meeting data completeness, generally at the TIN/NPI level (small practices may submit at the TIN level).
- **Improvement Activities:** attest to meeting the specifications for each required improvement activity (submitted at the TIN level).
- **Promoting Interoperability:** submit PI performance data and required attestations at the TIN level, including CEHRT certification ID and performance period dates.
- **Cost and claims-based quality measures:** no submission; CMS calculates from claims processed after the performance period.
- **Deadline:** submission is generally due March 31 of the year after the performance year.

5.3 Payment adjustments (how performance becomes dollars)

Payment adjustments are applied to Medicare Part B covered professional services in the ASM payment year, based on the clinician's final score from the corresponding performance year two years prior. CMS uses a logistic exchange function to transform final scores and applies an ASM risk level (maximum upside/downside) and a redistribution percentage to establish the incentive pool.

ASM payment year	Risk level (max upside/downside) - per regulation
2029	9%
2030	9%
2031	10%
2032	11%
2033	12%

Note: The redistribution percentage is set at 85% in the payment adjustment methodology.

5.4 Medicare payment and telehealth waivers (what changes)

- **MIPS waiver:** CMS waives the requirements of section 1848(q) (MIPS) for an ASM participant for each ASM performance year the participant meets ASM eligibility criteria.
- **Telehealth:** CMS waives the geographic site requirement and originating site requirement to permit telehealth visits to originate in the beneficiary's home or place of residence for medically appropriate services to treat an ASM targeted chronic condition (with specified exceptions, such as certain home health certification requirements).

5.5 CMS data sharing (what you can request and how to govern it)

ASM participants may request beneficiary-identifiable claims data from CMS under a data sharing agreement. Organizations should plan for a formal privacy and security governance process, including a designated data custodian, minimum necessary requests, and controls for downstream recipients (e.g., collaborative care partners and vendors).

- Permitted uses are limited to care coordination, quality/efficiency improvement, and population-based activities applied uniformly to ASM beneficiaries; data may not be used to reduce, limit, or restrict care for specific beneficiaries.
- Substance use disorder record data subject to 42 CFR Part 2 is omitted from shared beneficiary-identifiable data.
- CMS requires annual submission of a signed data sharing agreement with specified privacy/security/breach notification requirements.

5.6 Collaborative Care Arrangements (CCAs) - what 'good' looks like on paper

One required Improvement Activity involves establishing at least one executed Collaborative Care Arrangement (CCA) with a primary care practice that shares ASM beneficiaries. The CCA must be in writing, signed by both parties, and designed to further ASM goals and/or Improvement Activities performance.

- CCA must include collaborative efforts related to at least three of five elements: data sharing; co-management; transitions in care planning; closed-loop communication; care coordination integration.
- Any payments under a CCA must comply with fraud and abuse laws and cannot be conditioned on volume or value of referrals.
- Both parties must retain clinical decision-making independence and the arrangement may not induce reduction of medically necessary services.
- Maintain contemporaneous documentation (agreement, payment amounts/dates, methodology) and ensure downstream recipients comply with CMS data sharing terms.

6 [HOW] Implementation Playbook for 2026 Readiness

Use 2026 as a structured readiness year. The goal is to enter January 1, 2027 with:

1 an accurate roster of eligible clinicians in mandatory areas,
2 workflows that reliably capture required measures and PROMs,
3 executed care coordination agreements and HRSN screening pathways,
4 CEHRT-based interoperability capability, and
5 finance and compliance governance for data sharing and payment adjustments.

6.1 Workstreams to stand up (recommended)

Workstream	Primary outputs
A. Impact assessment & roster	Confirm mandatory CBSA/metro division footprint; generate preliminary list of potentially eligible clinicians; validate specialty type and episode volume; set clinician-level owners.
B. Measure-to-workflow mapping	Map each required measure to discrete EHR fields and operational touchpoints; define numerator/denominator logic; validate data completeness workflows.
C. Clinical pathway optimization	Standardize evidence-based management for HF and conservative-care-first pathways for LBP; define escalation pathways; align referral networks.
D. Care coordination & CCAs	Implement IA-1 and IA-2 requirements; design closed-loop referral and communication processes; execute and document CCAs with primary care partners.
E. PI / CEHRT & interoperability	Confirm CEHRT certification; enable e-prescribing, HIE options, patient access, public health reporting; complete Security Risk Analysis and SAFER Guide attestations.
F. Analytics, finance & forecasting	Build clinician-level dashboards for Quality, Cost, IA, and PI; model payment adjustment exposure; track Medicare Part B revenue subject to multipliers.
G. Compliance & data governance	Prepare for CMS data sharing agreement; define minimum necessary request process; vendor/downstream recipient controls; incident response procedures.

6.2 Practical clinician-level dashboards (minimum viable set)

- **Eligibility & attribution:** confirmed specialty type; episode counts; mandatory CBSA/metro division code;TIN/NPI combinations.
- **Quality performance:** measure-level denominators, numerators, completion rates, and benchmark position (where available).
- **Cost performance:** episode cost trends, high-cost service flags (e.g., admissions for HF; imaging/surgery pathways for LBP).
- **PROM completion:** baseline and follow-up completion rates; missing follow-up list with due dates.
- **IA completion:** evidence artifacts (HRSN screening coordination logs; CCA documents; referral loop compliance).
- **PI completion:** objective/measure readiness; CEHRT ID; SRA and SAFER attestation dates; 180-day performance window tracking.

6.3 Clinical workflow examples (illustrative)

Heart failure (HF) examples

- **Post-discharge touchpoint:** within 7 days of an HF-related hospitalization or ED visit, complete medication reconciliation, symptom check, and escalation plan; schedule follow-up in 7–14 days.
- **Guideline-directed medical therapy (GDMT) reliability:** structured prompts for evidence-based beta-blocker and ACEi/ARB/ARNI status with contraindication capture; lab guardrails (K+, creatinine/eGFR).
- **BP control workflow:** ensure at least one valid, recent BP measurement for eligible patients; use home BP recheck logic when clinic BP is elevated.
- **Functional status PROM cadence:** baseline and follow-up functional status assessment captured in discrete fields with timestamps.

Low back pain (LBP) examples

- **Conservative-care-first pathway:** standardized criteria for when imaging is appropriate; referral pathway to PT and non-opioid pain strategies where clinically indicated.
- **Functional status PROM capture:** baseline and follow-up functional status measure completion to support outcome reporting and care planning.
- **Medication safety for older adults:** medication review workflows to avoid high-risk medications where possible; deprescribing support.
- **Depression screening and follow-up:** screening integrated into intake or annual workflow; positive screen triggers a documented follow-up plan and referral tracking.

7 ASM Preparedness Checklist (copy/paste-ready)

Use this checklist to drive a 2026 readiness workplan. Each item should have an accountable owner and a tangible evidence artifact.

Status	Domain	Action item	Owner	Target / evidence
[ ]	Governance	Stand up an ASM readiness steering committee and monthly executive review cadence.	System/GPO leader	Q1 2026 - Charter; meeting schedule; decision log
[ ]	Footprint	Map all outpatient practice locations for targeted specialties to OMB 2023 CBSA/ metro division codes.	Analytics / Strategy	Q1 2026 - Location-to-CBSA crosswalk
[ ]	Footprint	Confirm mandatory area status using CMS Mandatory Geographic Areas list (Appendix A).	Analytics / Strategy	Q1 2026 - Impact memo + list of affected sites
[ ]	Clinician roster	Generate preliminary list of potentially eligible clinicians (TIN/NPI) in mandatory areas.	Quality / Analytics	Q1 2026 - Roster with TIN/NPI, specialty, site
[ ]	Clinician roster	Validate specialty type and episode volume eligibility criteria for each clinician.	Quality / Analytics	Q2 2026 - Validated eligibility file + assumptions
[ ]	Measure mapping	Select reporting method(s) for non-claims quality measures (EHR/eCQM, registry, etc.).	Quality / IT	Q2 2026 - Measure reporting plan
[ ]	Measure mapping	Define discrete EHR fields and workflows for all required measures (including PROMs).	IT / Clinical Ops	Q2 2026 - Data dictionary + workflow maps
[ ]	Quality ops	Build numerator/denominator and data completeness dashboards; assign measure owners.	Quality	Q2 2026 - Dashboards + owner list
[ ]	HF clinical ops	Implement HF escalation and post-discharge transition workflows (e.g., 7-day touch).	Cardiology leadership	Q3 2026 - Protocol + training completion
[ ]	HF clinical ops	Operationalize GDMT reliability workflows with contraindication capture.	Cardiology leadership	Q3 2026 - Order sets; med reconciliation steps
[ ]	HF clinical ops	Operationalize BP control workflow including home BP rechecks and device validation.	Cardiology + Nursing	Q3 2026 - BP protocol + training
[ ]	LBP clinical ops	Implement conservative-care-first pathway and imaging appropriateness governance.	Spine/pain leadership	Q3 2026 - Pathway + utilization monitoring
[ ]	PROMs	Deploy PROM collection workflow and reminders; ensure baseline + follow-up capture.	Quality / IT	Q3 2026 - PROM tool + completion dashboards
[ ]	Improvement Activities	Implement IA-1: primary care access confirmation and HRSN screening coordination.	Care management	Q3 2026 - Workflow + evidence logs
[ ]	Improvement Activities	Implement IA-2: execute at least one CCA with a primary care practice sharing ASM beneficiaries.	Network/Medical affairs	Q3 2026 - Signed CCA + required elements

Status	Domain	Action item	Owner	Target / evidence
[ ]	Closed-loop comms	Deploy closed-loop referral and communication workflow between specialists and primary care.	Clinical ops / IT	Q4 2026 - Referral loop metrics
[ ]	PI/CEHRT	Confirm CEHRT status and obtain CMS EHR Certification ID(s) from CHPL.	IT	Q2 2026 - CEHRT inventory + IDs
[ ]	PI/CEHRT	Plan PI reporting window (>=180 days) and required objective selection (HIE options).	IT / Quality	Q3 2026 - PI plan + timeline
[ ]	PI/CEHRT	Complete Security Risk Analysis and SAFER Guides annual self-assessment workflow.	Security / IT	Q4 2026 - SRA report; SAFER evidence
[ ]	Data sharing	Designate a data custodian and prepare governance for CMS data sharing agreement.	Compliance	Q3 2026 - Named custodian; SOPs
[ ]	Data sharing	Define minimum necessary request process and downstream recipient controls (vendors, CCA partners).	Compliance / Privacy	Q4 2026 - Policies; BAAs / DUA templates
[ ]	Finance	Model payment adjustment exposure and build clinician-level Part B revenue tracking.	Finance	Q2 2026 - Forecast model; revenue dashboard
[ ]	Finance	Educate clinicians and leaders on payment year lag and risk levels through 2033.	Finance / Quality	Q3 2026 - Training decks; attendance
[ ]	Submission readiness	Test end-to-end submission process for quality, IA, and PI (including March 31 deadline).	Quality / IT	Q4 2026 - Mock submission results
[ ]	Go-live readiness	Finalize 2027 performance-year operating cadence (weekly huddles + monthly review).	Quality / Clinical leadership	Q4 2026 - Cadence calendar + KPIs

Appendix A. CMS Mandatory Geographic Areas for ASM (OMB 2023 Codes)

The table below reproduces the CMS-published list of CBSAs and metropolitan divisions where ASM is mandatory. Use the OMB 2023 code to match against your practice locations. (Rows: 235.)

Code	Type	CBSA / Metropolitan Division name
10100	CBSA	Aberdeen, SD
10460	CBSA	Alamogordo, NM
10580	CBSA	Albany-Schenectady-Troy, NY
10900	CBSA	Allentown-Bethlehem-Easton, PA-NJ
11100	CBSA	Amarillo, TX
11180	CBSA	Ames, IA
11200	CBSA	Amherst Town-Northampton, MA
11244	Metropolitan Division	Anaheim-Santa Ana-Irvine, CA
11260	CBSA	Anchorage, AK

Code	Type	CBSA / Metropolitan Division name
11540	CBSA	Appleton, WI
11694	Metropolitan Division	Arlington-Alexandria-Reston, VA-WV
12020	CBSA	Athens-Clarke County, GA
12054	Metropolitan Division	Atlanta-Sandy Springs-Roswell, GA
12420	CBSA	Austin-Round Rock-San Marcos, TX
12940	CBSA	Baton Rouge, LA
13540	CBSA	Bennington, VT
13740	CBSA	Billings, MT
13980	CBSA	Blacksburg-Christiansburg-Radford, VA
10100	CBSA	Aberdeen, SD
10460	CBSA	Alamogordo, NM
10580	CBSA	Albany-Schenectady-Troy, NY
10900	CBSA	Allentown-Bethlehem-Easton, PA-NJ
11100	CBSA	Amarillo, TX
11180	CBSA	Ames, IA
11200	CBSA	Amherst Town-Northampton, MA
11244	Metropolitan Division	Anaheim-Santa Ana-Irvine, CA
11260	CBSA	Anchorage, AK
11540	CBSA	Appleton, WI
11694	Metropolitan Division	Arlington-Alexandria-Reston, VA-WV
12020	CBSA	Athens-Clarke County, GA
12054	Metropolitan Division	Atlanta-Sandy Springs-Roswell, GA
12420	CBSA	Austin-Round Rock-San Marcos, TX
12940	CBSA	Baton Rouge, LA
13540	CBSA	Bennington, VT
13740	CBSA	Billings, MT
13980	CBSA	Blacksburg-Christiansburg-Radford, VA
14010	CBSA	Bloomington, IL
14020	CBSA	Bloomington, IN
14100	CBSA	Bloomsburg-Berwick, PA
14260	CBSA	Boise City, ID
14380	CBSA	Boone, NC
14500	CBSA	Boulder, CO
14580	CBSA	Bozeman, MT
15020	CBSA	Brookhaven, MS
15380	CBSA	Buffalo-Cheektowaga, NY
15460	CBSA	Burlington, IA-IL
15540	CBSA	Burlington-South Burlington, VT
16060	CBSA	Carbondale, IL
16260	CBSA	Cedar City, UT
16460	CBSA	Centralia, IL

Code	Type	CBSA / Metropolitan Division name
16540	CBSA	Chambersburg, PA
16620	CBSA	Charleston, WV
16660	CBSA	Charleston-Mattoon, IL
16860	CBSA	Chattanooga, TN-GA
17140	CBSA	Cincinnati, OH-KY-IN
17420	CBSA	Cleveland, TN
17780	CBSA	College Station-Bryan, TX
17860	CBSA	Columbia, MO
18060	CBSA	Columbus, MS
18180	CBSA	Concord, NH
18300	CBSA	Coos Bay-North Bend, OR
18580	CBSA	Corpus Christi, TX
18700	CBSA	Corvallis, OR
18880	CBSA	Crestview-Fort Walton Beach-Destin, FL
19060	CBSA	Cumberland, MD-WV
19124	Metropolitan Division	Dallas-Plano-Irving, TX
19180	CBSA	Danville, IL
19300	CBSA	Daphne-Fairhope-Foley, AL
19340	CBSA	Davenport-Moline-Rock Island, IA-IL
19460	CBSA	Decatur, AL
19660	CBSA	Deltona-Daytona Beach-Ormond Beach, FL
19980	CBSA	Dodge City, KS
20060	CBSA	Douglas, GA
20100	CBSA	Dover, DE
20420	CBSA	Durango, CO
20660	CBSA	Easton, MD
20700	CBSA	East Stroudsburg, PA
20994	Metropolitan Division	Elgin, IL
21120	CBSA	Elk City, OK
21660	CBSA	Eugene-Springfield, OR
21794	Metropolitan Division	Everett, WA
21820	CBSA	Fairbanks-College, AK
22020	CBSA	Fargo, ND-MN
22100	CBSA	Farmington, MO
22220	CBSA	Fayetteville-Springdale-Rogers, AR
22420	CBSA	Flint, MI
22520	CBSA	Florence-Muscle Shoals, AL
22540	CBSA	Fond du Lac, WI
22580	CBSA	Forest City, NC
22744	Metropolitan Division	Fort Lauderdale-Pompano Beach-Sunrise, FL
23240	CBSA	Fredericksburg, TX

Code	Type	CBSA / Metropolitan Division name
23420	CBSA	Fresno, CA
23580	CBSA	Gainesville, GA
239801	CBSA	Glasgow, KY
24540	CBSA	Greeley, CO
25200	CBSA	Hailey, ID
25260	CBSA	Hanford-Corcoran, CA
25420	CBSA	Harrisburg-Carlisle, PA
25540	CBSA	Hartford-West Hartford-East Hartford, CT
25580	CBSA	Hastings, NE
25620	CBSA	Hattiesburg, MS
25700	CBSA	Hays, KS
25850	CBSA	Hermitage, PA
25940	CBSA	Hilton Head Island-Bluffton-Port Royal, SC
26140	CBSA	Homosassa Springs, FL
26380	CBSA	Houma-Bayou Cane-Thibodaux, LA
26420	CBSA	Houston-Pasadena-The Woodlands, TX
26620	CBSA	Huntsville, AL
26860	CBSA	Indiana, PA
26980	CBSA	Iowa City, IA
27100	CBSA	Jackson, MI
27340	CBSA	Jacksonville, NC
27460	CBSA	Jamestown-Dunkirk, NY
27540	CBSA	Jasper, IN
27740	CBSA	Johnson City, TN
27900	CBSA	Joplin, MO-KS
27980	CBSA	Kahului-Wailuku, HI
28020	CBSA	Kalamazoo-Portage, MI
28100	CBSA	Kankakee, IL
28500	CBSA	Kerrville, TX
28740	CBSA	Kingston, NY
28820	CBSA	Kinston, NC
28880	CBSA	Kiryas Joel-Poughkeepsie-Newburgh, NY
29020	CBSA	Kokomo, IN
29180	CBSA	Lafayette, LA
29414	Metropolitan Division	Lake County-Porter County-Jasper County, IN
29484	Metropolitan Division	Lakewood-New Brunswick, NJ
29940	CBSA	Lawrence, KS
30020	CBSA	Lawton, OK
30460	CBSA	Lexington-Fayette, KY
30500	CBSA	Lexington Park, MD
30620	CBSA	Lima, OH

Code	Type	CBSA / Metropolitan Division name
30780	CBSA	Little Rock-North Little Rock-Conway, AR
31140	CBSA	Louisville/Jefferson County, KY-IN
31260	CBSA	Lufkin, TX
31540	CBSA	Madison, WI
31900	CBSA	Mansfield, OH
31930	CBSA	Marietta, OH
32390	CBSA	Massena-Ogdensburg, NY
32580	CBSA	McAllen-Edinburg-Mission, TX
32820	CBSA	Memphis, TN-MS-AR
33020	CBSA	Mexico, MO
33140	CBSA	Michigan City-La Porte, IN
33220	CBSA	Midland, MI
33340	CBSA	Milwaukee-Waukesha, WI
33540	CBSA	Missoula, MT
33660	CBSA	Mobile, AL
33860	CBSA	Montgomery, AL
33980	CBSA	Morehead City, NC
34100	CBSA	Morristown, TN
34260	CBSA	Mountain Home, AR
34580	CBSA	Mount Vernon-Anacortes, WA
34620	CBSA	Muncie, IN
34780	CBSA	Muskogee, OK
34940	CBSA	Naples-Marco Island, FL
35020	CBSA	Natchez, MS-LA
35060	CBSA	Natchitoches, LA
35100	CBSA	New Bern, NC
35340	CBSA	New Iberia, LA
35840	CBSA	North Port-Bradenton-Sarasota, FL
36260	CBSA	Ogden, UT
36420	CBSA	Oklahoma City, OK
36460	CBSA	Olean, NY
36540	CBSA	Omaha, NE-IA
36780	CBSA	Oshkosh-Neenah, WI
36837	CBSA	Ottawa, IL
37020	CBSA	Owosso, MI
37140	CBSA	Paducah, KY-IL
37340	CBSA	Palm Bay-Melbourne-Titusville, FL
37540	CBSA	Paris, TN
37580	CBSA	Paris, TX
37900	CBSA	Peoria, IL
38210	CBSA	Pikeville, KY

Code	Type	CBSA / Metropolitan Division name
38240	CBSA	Pinehurst-Southern Pines, NC
38460	CBSA	Plattsburgh, NY
38820	CBSA	Port Angeles, WA
39060	CBSA	Pottsville, PA
39300	CBSA	Providence-Warwick, RI-MA
39340	CBSA	Provo-Orem-Lehi, UT
39380	CBSA	Pueblo, CO
39460	CBSA	Punta Gorda, FL
39500	CBSA	Quincy, IL-MO
39660	CBSA	Rapid City, SD
39740	CBSA	Reading, PA
39960	CBSA	Rice Lake, WI
40080	CBSA	Richmond-Berea, KY
40140	CBSA	Riverside-San Bernardino-Ontario, CA
40380	CBSA	Rochester, NY
40740	CBSA	Roswell, NM
40900	CBSA	Sacramento-Roseville-Folsom, CA
40940	CBSA	Safford, AZ
40980	CBSA	Saginaw, MI
41100	CBSA	St. George, UT
41140	CBSA	St. Joseph, MO-KS
41460	CBSA	Salina, KS
41540	CBSA	Salisbury, MD
41660	CBSA	San Angelo, TX
41700	CBSA	San Antonio-New Braunfels, TX
41760	CBSA	Sandpoint, ID
41884	Metropolitan Division	San Francisco-San Mateo-Redwood City, CA
42020	CBSA	San Luis Obispo-Paso Robles, CA
42034	Metropolitan Division	San Rafael, CA
42200	CBSA	Santa Maria-Santa Barbara, CA
42220	CBSA	Santa Rosa-Petaluma, CA
42340	CBSA	Savannah, GA
42580	CBSA	Seaford, DE
42680	CBSA	Sebastian-Vero Beach-West Vero Corridor, FL
42940	CBSA	Sevierville, TN
42980	CBSA	Seymour, IN
43060	CBSA	Shawnee, OK
43180	CBSA	Shelbyville, TN
43300	CBSA	Sherman-Denison, TX
43340	CBSA	Shreveport-Bossier City, LA
43420	CBSA	Sierra Vista-Douglas, AZ

Code	Type	CBSA / Metropolitan Division name
43760	CBSA	Sonora, CA
43900	CBSA	Spartanburg, SC
44100	CBSA	Springfield, IL
44260	CBSA	Starkville, MS
44460	CBSA	Steamboat Springs, CO
44940	CBSA	Sumter, SC
45060	CBSA	Syracuse, NY
45104	Metropolitan Division	Tacoma-Lakewood, WA
45220	CBSA	Tallahassee, FL
45294	Metropolitan Division	Tampa, FL
45500	CBSA	Texarkana, TX-AR
45700	CBSA	Tifton, GA
45780	CBSA	Toledo, OH
45860	CBSA	Torrington, CT
45900	CBSA	Traverse City, MI
45940	CBSA	Trenton-Princeton, NJ
46220	CBSA	Tuscaloosa, AL
46340	CBSA	Tyler, TX
46540	CBSA	Utica-Rome, NY
47220	CBSA	Vineland, NJ
47260	CBSA	Virginia Beach-Chesapeake-Norfolk, VA-NC
47300	CBSA	Visalia, CA
47664	Metropolitan Division	Warren-Troy-Farmington Hills, MI
47940	CBSA	Waterloo-Cedar Falls, IA
48200	CBSA	Waynesville, NC
48300	CBSA	Wenatchee-East Wenatchee, WA
48460	CBSA	West Plains, MO
48540	CBSA	Wheeling, WV-OH
48580	CBSA	Whitewater-Elkhorn, WI
48620	CBSA	Wichita, KS
48660	CBSA	Wichita Falls, TX
48680	CBSA	Wildwood-The Villages, FL
48700	CBSA	Williamsport, PA
48864	Metropolitan Division	Wilmington, DE-MD-NJ
48900	CBSA	Wilmington, NC
49010	CBSA	Winchester, TN
49220	CBSA	Wisconsin Rapids-Marshfield, WI
49420	CBSA	Yakima, WA
49780	CBSA	Zanesville, OH

Appendix B. Glossary and References

Glossary (selected)

Term	Meaning
ASM performance year	A 12-month period (Jan 1–Dec 31) during the first five calendar years of the ASM test period.
ASM payment year	A calendar year when CMS applies a payment multiplier based on the final score from the performance year two years prior.
CBSA	Core-Based Statistical Area, as defined by OMB; used by CMS to define mandatory geographic areas.
CEHRT	Certified Electronic Health Record Technology (required for Promoting Interoperability).
EBCM	Episode-based cost measure; claims-based measure used for cost accountability and eligibility thresholds.
Cohort	In ASM, clinicians are grouped into a heart failure cohort or low back pain cohort for benchmarking and scoring.
CCA	Collaborative Care Arrangement: a written agreement between an ASM participant and a primary care practice sharing ASM beneficiaries, meeting regulatory requirements.

References (selected primary sources)

· **CMS ASM overview page (model details and resources)**
- https://www.cms.gov/priorities/innovation/innovation-models/asm

· **CMS ASM FAQs**
- https://www.cms.gov/priorities/innovation/asm-ambulatory-specialty-model-frequently-asked-questions

· **CMS Mandatory Geographic Areas list (Excel)**
- https://www.cms.gov/priorities/innovation/files/asm-mandatory-geo-areas.xlsx

· **42 CFR 512.705 (Definitions)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.705

· **42 CFR 512.710 (Participant eligibility and selection; mandatory geographic areas)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.710

· **42 CFR 512.720 (Data submission requirements and March 31 deadline)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.720

· **42 CFR 512.735 (Improvement activities requirements)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.735

· **42 CFR 512.740 (Promoting Interoperability requirements)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.740

· **42 CFR 512.745 (Final scoring weights and adjustments)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.745

· **42 CFR 512.750 (Payment adjustment methodology; risk levels; redistribution percentage)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.750

· **42 CFR 512.760 (Data sharing with ASM participants)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.760

· **42 CFR 512.771 (Collaborative care arrangements)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.771

· **42 CFR 512.775 (Medicare program waivers, including telehealth)**
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-512/subpart-G/section-512.775