The Technology Your ACO Needs to Thrive in the Shapeshifting Value-Based Care Future

written by Theresa Hush | May 28, 2026

We started this series with a simple observation: The Value-Based Care world—for which your ACO was built—has greatly altered. ACOs now have a much bigger charge to manage specialty care for their patients and to adopt CMS tools to negotiate rates with high performance networks. The TEAM payment model is live and ACOs have a role. ASM arrives in 2027 with more ACO investment. LEAD will reshape the ACO model for the next decade. Ahead lies a deeper role in care management, quality outcomes, and coordinated care across all types of providers, not just ACO participating providers. The same high-risk primary care patient sitting in your ACO panel is very likely the same person walking into a TEAM surgery or an ASM episode.

This new reality demands better technology. But here's the honest truth: Many ACOs have no platform now and are still working their services from claims data with no aggregated data to back it up. Further, most Value-Based Care platforms are not

yet organized to handle all the functions your ACO will need. Don’t lose time researching the ultimate system. Begin a process now that will enable your ACO to meet this central need: a unified hub for Value-Based Care that can draw from every relevant data source to give your team a single coherent view of each patient, then support the interventions for that patient in each episodic or condition-based payment model. You need to be building toward that hub and evaluating your current tools against those needs, if your ACO is to be at the center of your Value-Based Care ecosystem.

The Essential Layers of Your VBC Technology

1. Your Foundation: A Central Database to Integrate Data from EHRs, Claims, Finance, Population Health, Episode Analytics, and Risk Adjustment Algorithms

Many ACOs discovered shortfalls in their data mastery during implementation of APP Reporting; they struggled to aggregate clinical data from diverse EHR systems across a heterogeneous practice mix. Some resorted to Medicare CQMs or chose eCQMs to avoid data hassles, but in the end both strategies wasted their data resources. As CMS moves to FHIR-based digital quality measures, your platform must have a credible, specific path toward FHIR adoption and seek deep clinical data.

2. A Bifocal Lens on Total Cost of Care and Episodic Analytics

Patients most at risk in your ACO panel are likely those heading into a TEAM surgery or an ASM episode. A patient with uncontrolled hypertension, Type 2 diabetes, and coronary artery disease doesn't stop being your ACO's responsibility the moment a surgeon schedules a CABG. In fact, that's exactly when your ACO's role becomes most critical—and most financially consequential. The comorbidity burden in CABG patients is high, the complication rates are significant, and the opportunity for pre-surgical intervention to prevent complications is real.

This is precisely where ERAS (Enhanced Recovery After Surgery) protocols are so powerful and so underused. Hospital adoption has been slow because ERAS is operationally difficult without the right infrastructure. But your ACO, with visibility into a patient's longitudinal primary care record, is uniquely positioned to facilitate that process. When should an ACO begin preparation for a TEAM surgery? It must be long before the surgical date, so you can hand a better-prepared patient to the surgical team. Validating patient conditions and pre-treatment of patient risks improves outcomes and reduces episodic costs. Your technology must be able to support this kind of coordinated view, spanning primary care, specialty care, and the episode window, without losing the patient in a hand-off between disconnected systems.

3. Quality Reporting That Keeps Pace With CMS—Easily

Quality performance is not a compliance activity, but a direct multiplier on shared savings. APP Plus measures will grow, and

MIPS Value Pathways are expanding to new specialties and may become mandatory. ASM will bring its own quality requirements in 2027. Your hub must keep pace with this trajectory automatically, not as a special project every fall when CMS releases a new final rule.

4. Post-Acute Care Visibility—Close the Black Hole

Post-acute care is an expensive and often poorly managed transition point in both Total Cost of Care models and TEAM episodic payments. For lower extremity joint replacements—the highest-volume TEAM procedure—the difference between a well-managed SNF referral and a poorly chosen one can mean days of unnecessary skilled nursing care, avoidable readmissions, and thousands of dollars in episode cost overruns. Your ACO and your TEAM hospital share a vested interest in solving this together. Your technology hub must be able to show you post-acute utilization patterns by facility, by referral source, and by episode type—so that you can build a preferred network based on performance data, not habit. Right now, many ACOs are flying blind on post-acute.

5. Specialty Network Intelligence for the LEAD Era

LEAD's CMS-Administered Risk Arrangements (CARA) create a formal mechanism for ACOs to enter episode-based risk sharing with specialist groups. This is new territory, and the data requirements are genuinely different from what ACOs have managed before. To make CARA work, your ACO needs to be able to profile specialists by cost and quality performance across episode types, identify which specialty referral patterns are

driving cost variation in your attributed population, and model what a preferred specialist network would do to your performance. These are not capabilities most ACO platforms were built for. But they are capabilities your hub must develop—because specialty costs are where the next generation of ACO savings will be won or lost.

6. Patient-Centric Care Management and Interventions

The components above are focused primarily on succeeding in payment models, or the ACO and its providers. But key ACO functions for patients, like improvement plans, specialty referral management, care management, and population health are one of the top reasons that ACOs need the functionalities that key clinical and other data provide. Interventions, for example, that are identified for patients in advance of a TEAM surgery or coming out of a condition-based episode, must be undertaken on a patient level, not a disease level. The ultimate purpose of a Value-Based Care technology is to improve the patient status and his or her risks. Thus, the technology must be able to provide a window not only on all the data, payment models, and costs associated with an individual patient, but to deploy corrective actions for that patient. Especially interventions, pre-surgical programs, and chronic disease management programs must be patient- and not disease-centric, so that the intervening providers—population health team, clinicians, health coaches, registered dieticians and so on—have an organized plan for each patient.

No one expects your technology to do all this perfectly today. The payment models are new, the data standards are still

evolving, and even the most sophisticated VBC platforms are building toward this vision, but have not yet fully arrived. But the vision itself is not optional. An ACO that is still evaluating technology purely by its claims analytics capability, or its quality reporting module in isolation, is asking the wrong questions in 2026.

The right question to ask: Does this platform have the architecture and the roadmap to become the central hub your ACO needs—connecting primary care data, specialty episode data, quality reporting, post-acute performance, and financial reconciliation into a single, coherent view of every patient? If the answer is yes, you have a foundation worth building on. If the answer is uncertain or evasive, that uncertainty will compound with every new payment model CMS introduces.

Roji Health Intelligence has been building toward exactly this vision since the beginning of the Quality Payment Program. Our platform integrates Total Cost of Care analytics, episodic payment model support, and quality reporting into a unified hub designed for actions to improve patient status. If your ACO is ready to evaluate where your technology stands against the future, let’s start a conversation.

Check out the Roji Health Intelligence Platform for ACOs

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Jadon Johnson