

Three Strategies for ACOs to Optimize Specialty Care through TEAM

written by Theresa Hush | September 2, 2025



Both the greatest strength and weakness of the ACO shared savings (MSSP) model is its focus on primary care, particularly chronic disease. ACOs have put patients with diabetes, hypertension, and other conditions usually handled through primary care physicians at the center of care coordination, population health, and care management. But as CMS Value-Based Care's central goal has shifted to cost control, ACOs will need to broaden scope to optimize specialty care. [TEAM](#) (Transforming Episode Accountability Model), a large risk-based payment model coming online in January 2026, offers the perfect opportunity to get started.

Specialty services drive about 40 to 60 percent of total health care costs. Without more involvement in specialty care, ACOs won't be able to expand savings enough to weather the future. As the ACO model incorporates an increased level of downside risk, ACOs will need to address the huge cost of specialty care by making sure they can direct care to specialists with the highest performance. But first they'll need to identify who those are.

To create incentives for better cost performance, CMS has recently created two payment models to address specialty costs directly and provide tools for ACOs to leverage specialty care. Those tools are evident in two specialty risk models: TEAM and [Ambulatory Specialty Model](#) (ASM). Let's take a closer look at TEAM, which has progressed to the announcement of participants and implementation.

TEAM Can't Work Without Primary Care Involvement

TEAM episodes start with one of five procedure types and stop at 30 days after the procedure date. All Medicare Part A and B costs are included in the episode. The five highest cost procedure types in Medicare are included in TEAM:

Coronary artery by-pass (CABG),
Lower Extremity Joint Replacements (LEJR, hips and knees),
Spinal Fusion,
Surgical Hip and Femur Fracture Repair, and
Major Bowel.

When Roji calculated the costs for TEAM episodes, we found that the largest categories, in all episodes, are inpatient and outpatient hospital costs. But the key factor for episode cost variability is surgical complications. Each major episode type has a number of major complications that involve longer hospital stays, higher level hospital services such as the Intensive Care Unit, additional hospital or physician services, and readmissions. Reducing complications will reduce average costs in TEAM and will have a greater impact on costs than any other single action.

Hidden under the medical events, however, are patient risk factors that affect the incidence of surgical complications. If the patient's risk factors are not treated or improved—or even known—prior to surgery, it is less likely that they can be

avoided. This is where ACOs and primary care can make a real difference.

Consider this example: A patient has a history of cardiac and metabolic conditions, but there was no communication from the primary or cardiologist before surgery. The patient develops Atrial Fibrillation (A-Fib) after coronary artery by-pass surgery, one of the most common complications. As a result, the patient is held in the ICU for stabilization and additional services. The use of beta blockers in the period prior to surgery, potentially with other medications, could have reduced the risk of A-Fib and associated costs, and led to a better long-term outcome for the patient.

This example is threaded throughout each of the TEAM episodes. Four sources of complication risks— patient, hospital processes (e.g., infection control and blood management), perioperative processes, and specialist decisions—weigh into the final cost of each episode. Improvement of patient outcomes and costs require an inclusive strategy that ensures information and data sharing by the whole team.

ACOs, especially those formed by medical centers and health systems, are in an ideal position to provide the organization and information to fuel TEAM success. Here's how:

Three TEAM Strategies for ACOs

1. Be the primary care referral source for patients without primary care physicians.

Patients without primary care physicians will be scheduled for TEAM procedures. The ACO can serve as the intermediary to help these patients get a primary care visit and risk assessment prior to surgery. This will allow the surgeon and anesthesiologist to have an assessment prior to surgery, and to investigate pre-treatment of conditions known to create post-surgery risks.

2. Build a primary-specialty communication platform for TEAM procedures.

Communication will be one of the most challenging elements of TEAM. There must be a common view of patient risks and events during the episode that is available to the TEAM clinical team (primary care, surgeon, anesthesiologist, respiratory specialist, other key clinical personnel, hospital). Even skilled nursing and rehab facilities must be able to engage if the patient is transferred. Hospital-based ACOs can coordinate the process to ensure that the patient risks are conveyed to the rest of the team and to enable an advance virtual visit with the anesthesiologist. ACOs can assist in defining the needs for a TEAM communication platform, either via a transportable patient record and/or an intermediary site or application.

3. Collaborate with TEAM specialty practices to create data sharing and learning.

An episode-based reimbursement model requires analytics to create episodes and evaluate cost variation and quality, which

in turn requires aggregation of data from specialty practices. As part of collaboration agreements allowed under TEAM and ASM, ACOs can facilitate data aggregation while ensuring privacy of the financial data that specialists will require. Unlike ACOs, specialty practices often do not have the infrastructure or vendors to aggregate clinical and cost data to create episodes, nor the analytics platform to enable data sharing and feedback.

TEAM gives ACOs the charge of entering a sphere of health care that has been outside their orbit. TEAM episodes in hospitals selected for TEAM's mandatory model will often involve ACO patients and thus reflect total MSSP costs as well. CMS has made a point in all its TEAM materials that it expects ACOs to be active in TEAM to create collaborations and help improve costs.

We've described strategies that extend beyond ACO patients, because they fulfill the larger mission of the ACO. With TEAM and ASM, CMS is making good on a strategy that was laid out in 2022, to create [financial incentives for ACOs to actively manage specialty care](#). CMS specifically included both referrals to high performance providers as well as episode cost and quality measures for specialty conditions. TEAM and ASM are the payment models to support it. The time is now for ACOs to extend their functions beyond primary care management and to take on the total cost of care.

Roji Health Intelligence has the [infrastructure for TEAM episodes of care](#). Contact us to help you [optimize your TEAM performance](#).

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.

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