The 2027 CMS PFS Proposed Rule: The Push for Accountability

written by Dave Halpert | July 23, 2026

This summer, cool off with a cold drink and the 1,592-page 2027 CMS Physician Fee Schedule Proposed Rule!

CMS has teased the elimination of Traditional MIPS and full

transition to MIPS Value Pathways (MVPs for several years), and we now have a proposed date. Starting in Performance Year 2029, MVPs will be the only option for MIPS participation. To prepare for this shakeup, CMS uses this Proposed Rule to create a two-pronged approach: first, to bolster the MVP library and address scoring concerns; second, to incentivize ACO participation, strengthening the program by enticing clinicians to abandon the MIPS ship altogether.

As you plot your Value-Based Care course, pay attention to these five key themes to ensure you're not beating the heat by being left out in the cold!

1. Specialty Care Is in the Spotlight

A whopping 80 percent of Part A and Part B charges come from specialty care. However, specialists in large multi-specialty groups have largely been shielded from MIPS quality reporting by the Group Practice Reporting Option. These groups have had the opportunity to report on a set of six quality measures, regardless of the volume of clinicians represented by their selection. By introducing the Ambulatory Specialty Model (ASM) and sunsetting Traditional MIPS, CMS aims to break down the barriers that have precluded meaningful quality reporting for specialty care providers.

ACOs and MIPS are the primary Quality Payment Program foci in these proposals. Remember that ASM presents a golden opportunity, but also carries significant risk. In the first year, providers can see a 9 percent incentive or penalty, which will eventually increase to 12 percent in the final ASM year. That's right—a 24-point swing. Even though the proposed ASM changes are limited (and are mainly explanations), there is too

much at stake to ignore the fine print.

The most important update is a clarification that, while CMS can terminate a clinician's participation on a year-to-year basis, that is not the expectation. If selected, a clinician should expect to remain in ASM for the duration of the program. Therefore, *organizations should begin planning for multi-year quality reporting at the individual level,* as required in ASM.

At least one quality measure from each cohort (back pain and heart failure) will need to be submitted, and CMS will further evaluate participants on additional cost and quality metrics. To address issues of care coordination and cost, now is the time to begin looking at collaboration agreements between your ASM participants and other clinicians, facilities, and organizations. A proposal allowing multiple entities to use the same agreement (provided that they are explicitly named) could make this process a little easier, but compliance and legal considerations ensure that this will not be an overnight process.

Of the two ASM cohorts, Low Back Pain is more complicated, and CMS has made several proposals to operationalize this track. The first is the introduction of a multi-attribution process. Because so many specialty types are flagged for Low Back Pain (and the fact that a patient may be seeing them concurrently), CMS has stated that the same patient may be attributed to multiple clinicians for the purposes of cost and quality measurement. This could include the addition of an administrative claims measure (a measure CMS calculates through claims analysis) related to the overuse of MRI utilization in early Low Back Pain treatment. CMS left the door open for the

incorporation of additional measures (including a patient-reported outcome measure) but did not explicitly propose adding them.

2. MIPS Value Pathways (MVPs) Development Is Accelerated (Take Note!)

To prepare for the end of Traditional MIPS, CMS has made several proposals to support MVP adoption and to address issues that have cropped up during the MVP phase-in.

Three new MVPs have been proposed for 2027:

- Diabetic Disease
- Hypertension
- Hospitalist

That brings the total MVP count to 30, and according to this Proposal, will cover nearly 100 percent of medical specialties.

To address certain scoring concerns, CMS has proposed axing the requirement that the 4+ measure submission must include an outcome measure. As many have discovered, some of the outcome measures in an MVP are topped out and capped at 7 points, which cuts quality scores 7.5 percent right out of the gate. CMS knows that, once MVPs are mandatory, those scoring glitches won't be tolerable. The update comes with a catch, though: while CMS does intend to phase out the "outcome" and "high priority" measure classifications, those will be replaced with a "Core Measure Designation." In the MVP quality reporting context, entities would need to include at least one "Core

Measure” in their quality submission.

Even though (in theory) all specialties have an available MVP, large, multi-specialty groups have been reticent to report MVPs via subgroups. The reason is simple: it is much more work. Rather than building workflows and monitoring performance on a set of 6 measures, a comprehensive practice may need to create 20+ subgroups, reporting a minimum of 4 measures apiece. The result is that groups would need to track performance on at least 80 metrics—more than 13 times what’s required today. CMS does state that they will monitor subgroup reporting burden to see if additional support is required, but do not propose any specific dispensations for those in this situation.

The other notable MIPS changes are updates to the Promoting Interoperability category (like Core Measures, these will also apply to Traditional MIPS until it sunsets). CMS proposes adding a pair of electronic prior authorization measures to facilitate quicker turnaround for certain drugs and care. Other metrics are on the chopping block, including attestations that ONC or an ONC-Authorized Certification Body can conduct a direct review to confirm CEHRT requirements, as well as the Security Risk Assessment measure.

The justification for these removals is that providers are already bound by language in HIPAA and in CEHRT, and so these attestations are extraneous. Your group may be relieved of the administrative and reporting “burden” of answering “yes” to these three questions, but know that in 2025, more than 61.5 million patients were affected by large healthcare data breaches, so do not be lulled into cybersecurity complacency. Since submission of these measures will not occur until 2027,

these removals could go live in 2026; but remember, these are only proposed actions and will not be finalized until November.

3. ACO Growth Is a Key Priority

To fulfill its goal of having all patients in an Accountable Care relationship by 2030, CMS needs to expand the ACO program. They propose several policies they hope will bring more providers into existing ACOs and encourage new ACO development.

Their most direct approach is to increase the shared savings opportunity for those at the highest level of the ACO BASIC Track (Level E). As proposed, the savings rate would increase from 50 percent to 60 percent. The rationale is that, in order for the ACO to be self-sustaining, the savings must outweigh the costs and efforts associated with its creation and maintenance. Of course, there is the potential for shared losses, and so it's critical to strike a risk/reward balance. At present, there is a substantial gap between maximum savings/losses rates in the ENHANCED Track and Level E of the BASIC Track. By increasing the stakes for the Level E ACOs, CMS hopes to lessen the divide between the two, and provide a better steppingstone from the BASIC Track to the ENHANCED Track.

To increase participation in existing ACOs, CMS is proposing a "Growth Adjustment" of up to 5 percent for ACOs who can bring in new providers. Shifting these providers from Traditional Medicare FFS arrangements into ACOs gets CMS that much closer to its 2030 enrollment goals. In addition to the carrot, they also use a stick, saying that APM incentive payments will be calculated at the TIN/NPI level, and not the NPI alone. In other words, a provider billing out of multiple practices could

only receive APM compensation when billing from the TIN in the APM's participant list.

Recognizing that Medicare patients have freedom of choice, CMS makes proposals that incentivize patients to seek care from ACOs, particularly those without Medigap, Medicaid, or employer-sponsored plans. In ACO REACH, CMS piloted a Part B cost-sharing support arrangement between ACOs and patients that limited patients' out-of-pocket costs. Given the success of ACO REACH, CMS has proposed that ACOs can enter those same types of Part B cost-sharing support arrangements with participants. These would eliminate cost-sharing for all Original Part B items except DME, Prosthetics, Orthotics and Supplies (DMEPOS) and prescription drugs. CMS uses this as a reason to cut prepaid shared savings, saying that cost-sharing eliminates the need. Nevertheless, there is fantastic potential for ACOs to more effectively care for patients in high-needs populations.

4. CMS Wants ACOs to Produce Continuous Savings

Since ACOs are judged each year against a set of benchmarks, generating savings creates an unanticipated consequence: the Ratcheting Effect. Reducing an ACO's spending also cuts its regional and historical spending trends, meaning that the ACO becomes a victim of its own success. By reducing the spending trends used to calculate benchmarks, ACOs lower the limit on what CMS believes they should spend. This limbo dance makes it more challenging for ACOs to limit spending without compromising quality and can disenfranchise ACO participants. To ensure that ACOs have predictable targets and continued incentives to generate yearly savings, CMS has proposed several changes to its benchmarking methodology.

To prevent the Ratcheting Effect, CMS aims proposals at the Prior Savings Adjustment and the Accountable Care Prospective Trend (ACPT). The Prior Savings Adjustment increases benchmarks to account for previous success (savings). To incentivize ACOs to sustain their efforts and prevent ratcheting, CMS proposes to increase its scaling factor from 50 percent to 75 percent. This would lessen the decrease in target prices that resulted in savings (as opposed to other regional trends), thus incentivizing ACOs to sustain their efforts and protect against the Ratcheting Effect. For the same reason, CMS has added a guardrail based on US Per Capita Cost (average costs for Part A and Part B per beneficiary) so that projected growth does not penalize prior savings.

CMS has also proposed limiting the weight that the Regional Adjustment has on ENHANCED Track ACO benchmarks, from 50 percent to 35 percent. ENHANCED Track ACOs have more at stake than those in the BASIC Track, but can also earn more savings. One reason is that, when spending is lower than the region average, ENHANCED Track ACOs are rewarded at a higher rate than their BASIC Track counterparts.

The issue is, according to CMS, regional adjustment dollars are on the rise, but the share of those that see the benefits have remained steady. Since only the impact (and not the breadth) of these adjustments has increased, CMS questions whether ENHANCED Track ACOs are saving more because they’re performing better or, rather, because they receive more favorable benchmarks. Reducing the impact of the Regional Adjustment would eliminate this issue and, combined with the increased savings potential for BASIC Track Level E participants, would further bridge the gap between BASIC and ENHANCED Track ACOs.

To ensure ACOs are not penalized for caring for high-risk patients, CMS has proposed modifying the 5 percent cap on increases to the Historical, Prior Savings, and Population (formerly Health Equity) adjustments. Since 5 percent may not be enough to cover the expenditures needed to manage complex populations, CMS has proposed increasing the 5 percent cap via risk adjustment.

In addition to financial benchmarks, APP reporting also impacts Shared Savings. To maximize Shared Savings, ACOs must meet the Quality Standard through APP reporting, and CMS has proposed a new method: Medicare eCQMs. These are similar to eCQMs, but rather than covering an all-patient population, this version is limited to the ACO's attributed patients, similar to the current Medicare CQM collection type. To further bolster participation options, CMS has walked back its decision to eliminate the MIPS CQM collection type, proposing it as a permanent option.

To alleviate Medicare CQM and eCQM scoring concerns, CMS has proposed that each measure receive a "flat" benchmark—e.g. 90-100 percent equals 10 points, 80-88.99 percent = 9 points, etc. This provides ACOs a more predictable and understandable scoring scale, and eliminates questions about the validity of applying historical benchmarks to recently devised measures. If finalized, since PY2026 data submission does not occur until 2027, these benchmarks would be applied retrospectively to 2026 APP scores. To reduce reporting burden (and align with priorities of the current administration), CMS will not add the planned adult immunization status and substance use disorder treatment measures to the 2027 APP measure set.

5. You Have a Voice

These proposals are far-reaching, but key details are still to be determined, and you can have a voice in the discussion. Along with your ability to comment on the rule, there are several Requests for Information that solicit suggestions for planning, implementing, and evaluating a value-based care transformation:

> How to integrate FHIR APIs into quality reporting, from a 2028 pilot stage through full implementation in 2030;
> Suggestions for improving MVP scoring, including normalization by MVP, rather than relying solely on CMS measure benchmarks. This would eliminate issues in which one MVP has more topped-out measures than others;
> Best practices for bringing specialist providers into ACOs, including MVPs, CMS data sets, and sub-capitation arrangements, similar to the risk arrangement agreements we see in TEAM and ASM.

To comment on the Proposed Rule and/or provide feedback on its included RFIs, you can do so electronically, referencing CMS-1848-P. Comments are due by September 14—make your voice heard!

Image: Getty Images for Unsplash+

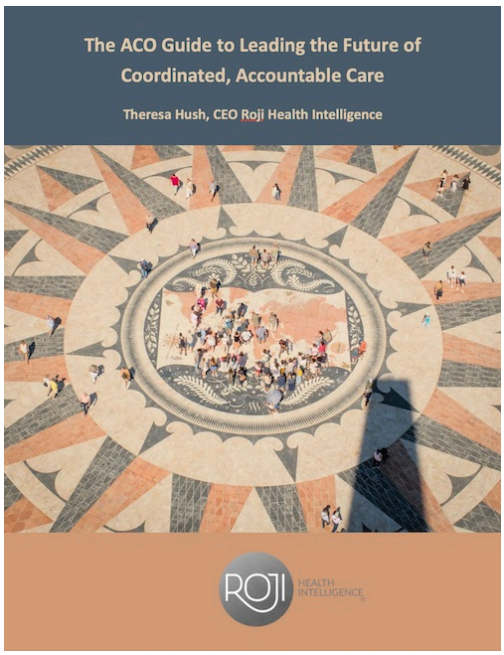
Is Your ACO Built for What Comes Next?

written by Theresa Hush | July 23, 2026

The last two years have dramatically strengthened the ACO role in providing accountable care. New CMS specialty payment models—TEAM, ASM, and the proposed CJR-X—each include specific provisions for ACO coordination and referrals, extending the ACO's reach deep into the specialty care continuum. LEAD, the

new long-term ACO model with prospective payments, has redefined the future of the ACO as the hub of accountable care, with specialty integration built into its architecture. Quality reporting requirements have tightened. Data obligations have expanded. And beneath all of it, a fundamental question persists: is your organization actually built for what comes next?

Most of the guidance available to ACO leaders focuses on compliance—how to report, how to avoid penalties, how to survive the next rule cycle. That guidance has its place. But it does not answer the harder questions: How do you build an organization that thrives in a Value-Based Care ecosystem and serves as its hub? How do you manage total cost of care and episodic risk for the same patients at the same time? How do you prepare for specialty payment models when your technology and workflows were designed for primary care population health? And how do you extend your ACO’s reach into the 359 days a year when your highest-risk patients are making decisions—about food, movement, medication, and habits—without anyone from your care team present?



We wrote The ACO Guide to Leading the Future of Coordinated, Accountable Care to address those questions directly. It collects five Roji Intel articles published over the first half of 2026, each building on the last—from the mandatory model landscape, to the analytics challenge, to the technology imperative, to the human question at the center of it all: What does the ACO owe its patients beyond claims management and quality reporting? Together they form a practical guide for ACO and health system leaders willing to step into the complexity ahead—not manage around it.

Download your free eBook:

The ACO Guide to Leading the Future of Coordinated, Accountable Care

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: Farnaz Kohankhaki

Beyond Payment Models: The ACO as a Hub for Patient Health

written by Theresa Hush | July 23, 2026

In our last four articles, we have focused on payment models and infrastructure to establish how ACOs can be central to Value-Based Care, even under specialty models. Now it’s time to shift our focus back to what the payment models set out to do: improve patient health and rationalize costs.

We cannot lift up patient health and lower costs through independent payment models, each focused separately on cohorts of practitioners or patients. They are a means to an end.

Some entity must serve as the hub to organize the pieces into an integrated care system to effect better results for patients, and to link together patients, providers, services, and the outside world. CMS envisioned the ACO fulfilling

functions in the specialty payment models and outlined its future vision for ACOs in LEAD. But what if ACOs become the hub, not only for managing patients in various payment models, but for health delivery across the spectrum?

The ACO Was Always About the Patient—Not the Payment Model

The ACO was always designed to be the hub of coordinated, accountable care for a defined population—responsible not just for what happens inside a hospital or a specialist’s office, but for the health and total cost of care for each patient. That original vision is now more achievable—and more financially urgent—than ever before. We have spent years defining their mission, working out systems of accountability and measurement of costs and quality. We have followed that with aggregation of data, initiatives, more payment models, and tweaks to those models. Peel back all the structure and here’s what we get: the patients, their health, and how we influence daily choices that quietly determine whether they thrive or deteriorate

The Gap Between Visits Is Where Health Is Won or Lost

The average high-risk Medicare patient—the one with Type 2 diabetes, hypertension, and early-stage chronic kidney disease—sees their primary care physician four to six times a year. That leaves roughly 359 days when no one from the care team is actively present in that patient's health decisions. This is where chronic disease accelerates. Not in the exam room, but in the grocery store, the drive-through, the decision to skip a walk because the day got away from them.

Consider the CABG patient—the one with uncontrolled hypertension and a hemoglobin A1C of 8.2, heading into open-heart surgery with a comorbidity burden that will drive complications, slow recovery, and inflate episode costs. The clinical team will manage the surgery brilliantly. But who managed the A1C for the two years before the surgical referral? Who had the conversation about weight, about processed food, about the metabolic cascade that connects poor glycemic control to the cardiovascular disease that led to that OR table? In our system of health care today, the honest answer is no one, or no one consistently.

The ACO that closes that gap—not just with care management check-in calls, but with structured, sustained engagement between visits—will see improvements in its outcomes and shared savings. The ACO that does not will keep managing the consequences of preventable deterioration, one expensive

episode at a time.

A New Service Architecture: What the ACO Hub Can Offer Beyond Payment Model Basics

The good news is that the tools exist. The evidence base is strong. And the ACO—with its longitudinal patient relationships, population-level data, and financial alignment with outcomes—is the right organizer for all of it. Not everything will be viable for all ACOs; physician-based ACOs or those in rural areas may focus on one or two. Here is what an expanded ACO service architecture looks like:

1. Health Literacy as a Clinical Strategy

Many patients with Type 2 diabetes do not know that poorly controlled blood sugar is simultaneously damaging their kidneys, their eyes, and their cardiovascular system. The urgency of daily behavior change remains abstract and easy to defer. We know from psychological research that patients build their behaviors not based on facts. Despite that, we also know that health literacy interventions work not by presenting facts in isolation, but by giving patients a coherent personal story that is connected with their own daily choices. It is correlated with improved patient risk and lower obesity, and with increasing positive changes in patients with metabolic disease. ACOs that invest in patient education as a clinical

strategy, delivered through education, technology and digital micro-content, and group sessions organized around shared risk profiles, will see it in their outcomes.

2. Dedicated Obesity Prevention and Management Programs.

Obesity is a clinical condition with complex origins that sits at the root of an enormous share of ACO cost. ACO dedicated programs, such as group-based weight management cohorts, help patients make behavioral changes to lower risk. Simple, practical guidance matters: how to read a food label, how to take small steps like swapping processed foods for higher-density nutrient alternatives, how to find ten minutes of movement in a day that feels already full. These are not clinical interventions in the traditional sense, but they extend the ACO reach and brands it as a health partner.

3. Patient Technology for Care

The ACO can build the organizational capability to sponsor and use digital tools as part of a structured between-visit engagement strategy. This can include fitness trackers, continuous glucose monitors, home blood pressure monitors, apps with diet or sleep tracking, and mindfulness apps—all being promoted among employers, private insurers, and practices.

ACOs can identify the right tools for specific patient populations, delegate training care managers to support digital onboarding, and integrate the data these tools generate back into the ACO’s central data hub so that the glucose trend from a patient’s CGM informs the care manager’s outreach, and the blood pressure readings from the home cuff update the care

team’s risk stratification in real time. Motivated patients respond to these powerful between-visit links. Moreover, many such technology measures have shown meaningful improvements in glucose control, weight, adherence to diets, hypertension, and other intermediate outcomes.

For ACOs, remote patient monitoring with simple technology can also reduce hospital readmissions. A prospective study of remote patient monitoring within an ACO following patients’ hospitalization for congestive heart failure and COPD demonstrated the potential to reduce post-hospitalization mortality, hospital admissions, and emergency care visits. An intervention that simultaneously improves patient outcomes and lowers total cost of care creates the defining combination in Value-Based Care performance.

4. Health Coaching for Lifestyle Changes

Health coaching is a structured, evidence-based discipline focused on the behavioral changes that clinical care alone cannot produce. For patients with prediabetes, coaching-supported programs like the CDC-recognized Diabetes Prevention Program have demonstrated that weight loss as modest as 5 to 7 percent of body weight can delay or prevent the progression to Type 2 diabetes, reduce blood pressure, and improve lipid profiles. Similarly, a randomized controlled trial demonstrated direct effects on A1C for patients with diabetes, influencing a key ACO quality measure. For patients already managing chronic metabolic disease, trained coaches using motivational interviewing techniques can transform a routine check-in call into a genuine conversation about what gets in the way of patient compliance with treatment plans, and gently guide the patient back to their goals. Health coaching can be an

independent program or combined with patient technology or specific programs.

5. Pre-Surgical Preparation: ERAS and the ACO's Unique Role

Enhanced Recovery After Surgery protocols are evidence-based clinical pathways designed to optimize patients before surgery, reduce complications, and accelerate recovery. The ACO, with visibility into a patient's longitudinal primary care record, is uniquely positioned to begin that preparation long before the surgical date. The ACO knows the A1C is elevated. It knows the patient smokes. It knows the blood pressure has been trending upward for six months. That is a pre-surgical optimization roadmap—and the ACO has both the data and the patient relationship to act on it. Doing so improves surgical outcomes, reduces complications, and directly lowers TEAM episode costs. By tying into the ACO prior to a surgical episode, the primary care physician can pre-treat conditions and prepare the patient for surgery to avoid problems after the fact.

Why the ACO Is the Right Organizer for All of This

No other entity in the healthcare ecosystem has the combination of population-level data, longitudinal patient relationships, primary care infrastructure, and financial alignment with outcomes that the ACO has. This includes ACOs in all its forms, physician-, hospital- and health system-based ACOs. Especially if the ACO also contracts value-based contracts with private

health plans, it is an essential connector between payment and value for its community. A health system without an ACO often has a vision to fulfill these patient-focused functions, but the financial alignment with Value-Based Care and risk may be lacking, and hospital ownership may change the incentives for the system. The ACO sees the whole person over time—and is the only participant whose financial incentives are aligned with keeping that person well.

This is not a new role for ACOs to invent from scratch. It is the natural extension of what many high-performing ACOs are already doing. The difference between high-performing and average ACOs in MSSP is not primarily in their claims analytics; it is in their investment in the human infrastructure of care—the care managers, the educators, the coaches, and the community health workers who extend the clinical team's reach into patients' daily lives. The payment model evolution that we've describe in this series makes that investment more financially justified with each passing year. An ACO managing TEAM episodes has a direct financial interest in whether its highest-risk surgical patients are metabolically optimized before their procedures. An ACO in LEAD has a decade-long horizon to recoup the investment in patients whose disease progression it measurably slows or reverses.

This Is What Value-Based Care Was Always Supposed to Be

Our series began with the payment model landscape, moved to the analytics challenge. We have addressed the technology imperative. And now we arrive here: the human question at the center of the whole enterprise. What does the ACO owe its patients beyond patient care coordination and quality reporting?

The answer is significant. The ACO that takes it seriously—building the between-visit engagement that genuinely changes patient trajectories along with the infrastructure to identify cost drivers and improve quality—will be the organization that justifies the original promise of Value-Based Care to the patients who most need it to work. And it will be the organization that thrives financially as CMS continues building a payment system designed to reward exactly that.

At Roji Health Intelligence, we believe that better data, better analytics, and better patient engagement infrastructure work together and that ACOs and health systems should not have to choose between them. If your organization is ready to evaluate where it stands against the future of Value-Based Care, we'd welcome that conversation.

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: Jim Gade

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

written by Theresa Hush | July 23, 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

Can Your ACO Support the Future of Value-Based Care?

written by Theresa Hush | July 23, 2026

The year 2025 wasn’t easy for most ACOs struggling with the sudden transition to data aggregation. In fact, it was a trial by fire. ACOs joined the modern era of quality reporting in 2025 with APP (APM Performance Pathway) Reporting, which spurred aggregation from multiple practice systems and patient matching across the ACO. This required a rapid learning curve to assess limitations to data aggregation from individual systems, practice or ACO processes, and system technical capabilities. Although CMS allowed ACOs to limit reporting to Medicare patients, the work was still more than many ACOs anticipated. Here’s the tough news for your ACO: The future will require even more work.

Getting your data aligned with value is key to success in a rapidly evolving Value-Based Care environment. As large health systems and equity-supported ACOs master data-driven changes, their successes will affect all ACOs’ benchmarks, quality goals, and actual savings. In the near future, your ACO must pivot to becoming a hub for a connected network with multiple payment models. Here’s what to expect:

1. The Value-Based Care future is expanding beyond the primary care focus of the original ACO model, requiring ACOs to redesign their functions.

Your ACO is no longer a stand-alone model. With the introduction of specialty payment models, CMS created a connected Value-Based Care ecosystem. In TEAM and ASM, CMS ties ACOs into referrals for primary care. In LEAD, it enables ACOs to create high-value specialty networks with CMS specialty data. To remain a relevant player in your market, your ACO must

take on the leadership necessary to facilitate patient-centric care, no matter where in the system that patient is getting care.

2. Quality Measures and Reporting are moving to a new standard and could affect ACO savings.

CMS is moving to digital quality measures based on FHIR applications to report quality. While this transition may take a few years, most ACOs have systems that run the gamut, and many are incapable of FHIR apps. Quality performance is not just a compliance activity; it will affect how much of your savings your ACO retains. CMS has standardized quality measures across all quality reporting. Its movement to MIPS Value Pathways is reflected in ACOs' APP Plus measures, built on that same pathway. It's not hard to envision that providers using digital measures backed by FHIR will improve performance and face less burden. ACOs must keep pace.

3. Mandatory payment models, especially for specialties, are growing.

With the recent announcement that all hospitals not participating in TEAM will be part of a new episodic payment model (Comprehensive Care for Joint Replacements, CJR-X) in 2027, we are witnessing the full potential for expanding risk. This will happen throughout high volume and high cost areas, first, and likely extend to most specialized areas. And have no doubt—the same will eventually be true for primary care conditions, if we cannot move the needle on chronic disease.

These certainties highlight why your ACO needs to expand data-driven activities, re-evaluate your practice EHRs if you have

diverse feeds, and establish a vision for your future platform. As part of this initiative, your ACO should evaluate your data vendors and their capabilities going forward: Are those vendors capable of working with FHIR and advanced data feeds? Do they support detailed evaluations of both Total Cost of Care and Episodic Costs? Can they provide data back to your ACO and its EHRs? These are questions you should begin asking now. In our next article, we'll dive into what you should expect from your vendor data aggregation and value-based care platforms, to ensure that you can support the future of Value-Based Care.

Roji Health Intelligence has pioneered the use of surgical, condition, and treatment episodes in Value-Based Care. We have been a CMS Qualified Registry since the beginning of the Quality Payment Program. Call us today to see how we can help your ACO support the future.

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Image: Andrej Lišakov

How ACOs Can Manage Both Total Cost of Care and Episodic Payment Models

written by Theresa Hush | July 23, 2026

It’s a new world for ACOs, especially those just immersing in aggregated patient data. Once a rarity for ACOs to look beyond claims data for population health and analytics, ACOs are now finding themselves at the center of a data need surge.

The transition from easy, manual quality reporting for a sample of ACO patients to APM Performance Pathway (APP) quality reporting thrust ACOs into data aggregation from EHRs, exponentially increasing the amount of ACO data. CMS then introduced TEAM and ASM payment models with episodic payments and required ACO coordination of primary care. Similarly, CMS has enabled ACOs to manage specialty costs through a third model, LEAD (Long-Term Advance Design), which uses CMS-administered agreements (CARA).

Now more than ever, your ACO needs to manage changes in quality reporting as well as core functions of patient care

coordination and population health. Compounded by a CMS vision that ACOs be the core entity of accountability for both primary and specialty care, ACOs will need serious data strategies and a bifocal lens to manage both Total Cost of Care (TCOC) for attributed patients, and episodic costs for patients who are covered by other CMS payment models. Here's how to think about structuring your technologies and data to support these complex models:

Accountability for Total Costs and Specialty Care? Don't Focus on Just One.

Consider this: Most specialty episodic patients are already among your ACO's high risk primary care patients. You will need to rapidly identify patients in both primary and specialty settings, then integrate their divergent patient need—while also coordinating with specialists treating those conditions. Your ACO will need technology to spot patients, identify interventions, and maintain referrals that have been effective for patients and have reduced costs of episodes.

Coronary Artery Bypass Graft (CABG), for example, is a consequence of a patient's metabolic conditions such as hypertension, diabetes, and coronary artery disease. Reviewing TEAM patient data reveals that an overwhelming majority of patients going into a CABG have comorbidities, putting them at substantially higher risk for more complications from the procedure. And, in fact, a high percentage of CABG cases do have complications. Your ACO is in a unique position to engage both before and after the surgery to minimize patient risks and to create rehabilitation options. But that means you are able to identify the patient, share information instantaneously, and

pre-establish ACO interventions.

How to make all this happen? These are our broad recommendations.

Key Insights for Your ACO’s Dual Functions

1. Two analytic frameworks are necessary for the different payment model types, each covering core analyses of the data and the intervention strategies to be deployed.

However, don’t create a separate platform for each type, at the risk of inconsistent data and blind spots at the patient level. TEAM, ASM, and other episode models focus on the costs of distinct clinical events bound by time, diagnoses, and interventions. For TEAM surgeries, cost variation and complications are key issues, along with post-acute care for joint replacement cases. ASM surgical interventions or use of expensive resources without prior treatments will be the main concern.

Total Cost of Care Models like MSSP ACOs are accountable for the total spend and quality status of their attributed patients across the whole year. For primary care, ACOs are most concerned about hospitalizations and readmissions, ER use, extended long term care, and chronic illness. Analytics will include TCOC breakdowns, patient spending in risk categories, cost drivers, and chronic disease episodes, in addition to standard reports. Even under a TCOC model, episode analytics in chronic disease are useful to highlight patients’ long-term status and costs and to produce interventions to reduce progression of disease. There is no replacement for being able

to see a patient with a high A1C for years, who receives no change in medication or referrals.

2. Total Cost of Care and Episodic models will co-exist for individual patients, so your platform needs a coordinated view for each patient for providers and ACO staff.

Imagine that you have one patient who has had both a CABG and is a primary care patient. You must be able to see the patient across all care types, whether that contributes to TCOC or to an episode.

CMS has intentionally enabled ACO involvement to forge coordination between payment models and encourage ACOs to broaden their scope (and savings). Your ACO's primary providers could prepare patients for TEAM surgeries with interventions, such as smoking cessation, pre-treatment of conditions to avoid complications, or patient "hardening" prior to joint replacements. These are strategies suggested by ERAS (Enhanced Recovery After Surgery), evidence-based guidelines to avoid complications of surgery. Unfortunately, ERAS adoption by hospitals is slow because they are operationally challenging. With your ACO's help to identify and act early, however, hospitals could potentially see an ERAS path if they could significantly reduce complications.

3. The analytics platform must be structured to key into the significant quality and cost drivers in payment models and highlight their presence for each patient.

For primary care, patients with persistent, progressing chronic disease are the main focus. For TEAM and ASM payment models, the focus is on complications of surgery and post-hospital services, many of which can be better managed by coordinating care, pre-handling of patient risk factors, and systemic changes at hospitals.

Post-acute care is a critical cost issue for both TEAM episodic payments and for ACO TCOC. But it is the biggest issue for Lower Extremity Joint Replacements. The alignment of a skilled nursing facility/rehab facility strategy through your ACO in conjunction with the hospital will be essential to take advantage of your work in this area to cut unnecessary post-acute days. More expensive and difficult are complications of surgery and anesthesia, for CABG in particular.

ACOs and health systems need to evaluate their analytics and data from the vantage point of these payment models. Do your analytics enable you to see and act on the problems both under TCOC models and episodic payments? If they don’t, or if your ACO is just coming to grips with how it will work with specialty payment models, start planning your next steps now.

Check out the Roji Health Intelligence Platform for ACOs.

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through Solutions that help providers improve their value and succeed in Risk.

Image: Yi Liu

What TEAM and ASM Tell Us About the Future of Value-Based Care

written by Theresa Hush | July 23, 2026

In the last year, CMS has made strides to revamp health care through Medicare and Medicaid, taking some controversial steps. But one of their more positive moves involves changes to their Value-Based Care strategy. So, what does that strategy—through new or restructured payment models—tell us about where the system is headed? TEAM, ASM, ACCESS and LEAD ACO payment models are not just extensions of past policies. They enter new territory. Here's how:

1. TEAM and ASM deliver a clear message about the direction of Value-Based Care: mandatory accountability.

These are not one-off experiments in accountability for costs and outcomes in surgery and treatments. They are proof of concept that the voluntary participation phase is closing in

Value-Based Care. Now CMS is taking steps to drive systemic change by ensuring that providers are invested in patient outcomes and costs.

That future will include shifting reimbursement away from Fee-for-Service and toward per-patient or per-episode payments. It will also involve a series of quality and cost measures that will hold providers responsible for meeting patient outcome goals and cost targets. There will always be some exceptions, such as the recent announcement of the ACCESS model, which tests the effects of outcome-aligned payments to providers for technology-assisted care that helps patients adhere to treatment plans.

Before TEAM, CMS experimented with voluntary participation in the Bundled Payments for Care Initiative (BPCI). The model produced a significant net loss for Medicare, mostly due to incentive payments. The Comprehensive Care for Joint Replacements (CJR), began in 2016 as a mandatory episodic model for hip and knee replacements in 751 hospitals within 67 Metropolitan Statistical Areas, equivalent to the total hospital participation in TEAM across all five categories of surgeries. During the first year, it generated significant gross savings of $40 million. Afterwards, it was reverted to a voluntary model, lost participation, and ended.

2. ACOs are here to stay, but the expectations are greater.

The TEAM-ACO relationship is intentional and repeated in the ASM model. CMS wants TEAM to tackle fragmented care. It insists that ACOs have a role in TEAM, and it requires hospitals to refer surgical patients to go back to a primary care physician

(which could be an ACO physician). Moreover, dual accountability for an individual patient among the ACO, TEAM hospital and clinical team induces collaboration between primaries and specialists and the optimization of care, surgical recovery, and post-op care.

This also brings ACOs into mandatory payment model features. While ACOs are a voluntary participation model that has succeeded by generating millions in savings, the total value of ACO savings is actually less than 2 percent of total spending. CMS has been carefully and incrementally pushing ACOs along the path to risk, in the interests of preserving the embattled and under-resourced primary care sector. But TEAM and ASM enable a coordinated path that ACOs have not envisioned.

3. Specialty costs are the next new target in Value-Based Care.

TEAM and ASM are the first major large-scale specialty payment models, and they are the only models that are mandatory for selected community providers, for now. While TEAM and ASM start with different accountable partners—hospitals and specialty physicians, respectively—they are the primary link in the chain of episode accountability and the driver of the highest costs. The Ambulatory Specialty Model (ASM) is a mandatory physician-focused model beginning in 2027, targeting heart failure and low back pain episodes. It uses MIPS Value Pathways and adjusts fee-for-service payments based on performance, with risk levels increasing over time. Together, TEAM and ASM signal that CMS is extending episode-based accountability beyond hospital walls to the entire specialty care continuum. Previous specialty payment models, like Kidney Care Choices and Enhancing Oncology Model,

are smaller scale and focused only on specialty services, without the linkage to ACOs.

4. LEAD indicates the direction of the future ACO landscape.

LEAD has multiple features that embody CMS strategies for transforming care, such as a capitated and flexible up-front payment structure, a rural health focus, and contracted specialty risk arrangements. It offers supplemental payments for infrastructure development. Of most interest, LEAD ACOs may be able to offer additional medical benefits to beneficiaries, such as medical nutrition services. CMS plans to allow existing MSSP ACOs to apply for inclusion in LEAD, demonstrating the superior status of the model in the CMS line-up. Together with the ACCESS model exploring the benefits and costs of care involving patient wearables and technology, CMS is creating a system where Value means embracing accountability, and Fee-for-Service payments connected to patient volume and services comprise a minority of health care reimbursements.

5. The strategic implication of the CMS direction: All providers will be held accountable for both quality and costs of care.

For many health systems operating in both primary and specialty care, there will be overlapping payment models that are driven by both total cost of care and episodic specialty care or treatments: ACOs, TEAM and ASM episodes, as they emerge or expand. Organizations that are behind in their development, or who have been avoiding the inevitable, will pay for it.

Roji Health Intelligence provides services to evaluate and

support Value-Based Care payment models. Now is the time to ensure that your strategies are aligned for success in this new world. Check out our customized services.

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Image: Gennady Zakharin

Why ACOs Should Create High-Performance Specialty Networks

written by Theresa Hush | July 23, 2026

Specialty costs have been a difficult problem for ACOs, driving a huge portion of total costs in specialty-driven services of all kinds: physician visits, hospital admissions, procedures, and treatments. ACOs have argued they don't have the tools needed to combat costs. But that is not quite true. We argued in a recent webinar that ACOs have the tools to go further than simply linking specialty patients to a primary care provider, and the ability to really work with specialists to help manage costs. The key method: create a High-Performance Specialty Network and help specialists participate by evaluating patient outcomes and costs.

Escalating specialty care costs have held down ACOs' savings and minimized what ACOs can accomplish. Now ACOs are being drawn into two new CMS specialty payment models: TEAM (Transforming Episode Accountability Model) and ASM (Ambulatory Specialty Model). These create an opportunity for ACOs to make

significant headway on specialty care coordination, patient outcomes, and costs. While they can't steer patients or negotiate fees with specialists, ACOs can work with specialists to help them evaluate their costs. ACOs' recent development of aggregated data makes that possibility a reality.

What is a High-Performance Specialty Network?

Industry pundits on TEAM point to High-Performance Specialty Networks as an important part of managing risk—as if these networks already exist. That is rarely the case. Most referral arrangements between primaries, in ACOs and other organizations, are still informal, based on reputation or renown, or they are "inside referrals" within a health system. A High-Performance Specialty Network is nothing short of a major change in how hospitals and physicians would market services to patients based on Value. That is a heavy lift for providers who have, until now, relied on reputation rather than actual performance for gaining patients.

Developing a High-Performance Specialty Network (HPSN) requires more than a collegial or owner relationship. To be effective in ensuring best specialty care and cost control within TEAM or other specific payment models, an HPSN must be grounded by measured performance results. This involves having four essentials enveloped in the network configuration:

> Measurement of "performance," including outcomes, cost, and patient experience, using claims and EHR data to curate analytics that are episode-based, identify patient risk factors, and separately delineate the variations in cost and various outcomes during the surgery: complications, events

during and after surgery, and the patient’s specific risk factors

Accountability boundaries for primary and specialty physicians, including patient hand-offs after initial treatment, designation of who manages ongoing or post-surgical treatments, and triggers for return to the specialist. Lack of coordination of specialty care is a huge part of the issue driving costs and results in under-informed clinicians in both primary or specialty areas. For TEAM surgeries, this lack can be dangerous and lead to patient complications during surgery.

Required communication processes so that patients are seen by primaries prior to surgery, pre-treating if necessary and conveying risk information to the specialist, preferably through EHR hooks. Likewise, specialty alerts to the primary physician is essential for hand-offs. In ASM, these hand-offs of care are essential to keep a single treatment plan and patient adherence work between primary care and specialty physicians.

Processes for improvement that are not judgmental, score-related, or solely physician focused. The point of having a High-Performance Network in TEAM is to improve recoveries and lower costs in surgeries that represent the highest cost and volume in Medicare. But achieving that requires more than specialists; it involves working on hospital processes and technology, operating room rules, and connections with primaries to lower patient risk or prevent complications.

Can ACOs Really Do This, and Why Would Specialists Participate?

A strong High-Performance Network can deliver data to specialists that they rarely receive: their surgical costs and patient outcomes, and what drives variations in those costs. Physicians often don't realize how illuminating this data is, until they see it. For specialists in competition– especially in the surgical areas covered by TEAM–this is an opportunity to prove value, if they can achieve that on their terms.

The caveat to achieving actionable data is to create a good quality performance measurement system and process. First, the supporting data and measurement system must be sophisticated and accurate enough to identify cost and outcome variations, as well as to identify the underlying drivers. Second, the results must be reviewed in a collaborative learning environment that enables specialists to provide feedback and work on improvements to surgical processes and specific issues in the hospital or organization.

The key to specialty evaluation and engagement is surgical and condition episodes at the patient level. Episodes are a tool that enables specialists to validate care and costs for a patient they can identify, giving them a 360 degree clinical view they need to trust the data and examine the episode. The patient episode, or "case," shows what went right and wrong; clinicians can then investigate the antecedent. The data are not just actuarial numbers–they are real specialty patients with events, outcomes, and costs. Cost variation of these episodes highlights the drivers that cause the problems, sometimes something as simple as a surgical complication

arising from lack of knowledge of a patient risk factor.

Specialists' willingness to examine this data with ACOs is dependent on ACOs protecting them financially and professionally by keeping competitive data private. That is an easy fix for an ACO, even one owned by a hospital or physician organization—by using a neutral third-party vendor to aggregate data and to create the episode analytics, and by ensuring that every specialist or group can see only its own data.

Can ACOs Take the Challenge and Lead Change?

A hospital or health system environment that is not open to change will have little success in its endeavors with specialists. Neither will its ACO succeed. Every accountable party must take responsibility for its own contribution to escalating costs, because there is ample fault to go around. That willingness to engage in real change is the biggest factor that will contribute to the success of these payment models.

ACOs have an opportunity to realize their role as change agents, increasing the value of health care while ramping up savings. Leadership must organize the data and the process for change. Given ACOs' primary care base and their payment model experience, their involvement expands the view of patients under TEAM and ASM, bringing primary and specialty care together for an examination of episodes that will differ slightly with each diagnosis or procedure type.

ACOs can be an important vehicle to create a common path for review of specialty care, fulfilling their mission to both coordinate and manage care and costs. Because of APP reporting, many ACOs are now aggregating clinical and cost data to

evaluate quality as well as cost. Now is the time.

Roji Health Intelligence has pioneered the use of surgical, condition, and treatment episodes in Value-Based Care. Contact us today to see how we can help your ACO or specialty group use these to create a High-Performance Specialty Network.

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Image: Nick Fewings

Discover Cost Drivers in TEAM Surgeries

written by Theresa Hush | July 23, 2026

The CMS TEAM payment model focuses on the patient surgery and recovery process, which puts hospitals at risk for both cost and quality of surgeries. The end result of TEAM, if implemented well by hospitals and clinicians, is benefits for patients, with more coordination of services and fewer complications. The American College of Surgeons supports the transition to episodic payments, a positive sign of support from physicians.

But the fact is that TEAM will require concerted effort to identify cost drivers in surgeries, and it is not a task that most hospitals and clinicians have done before. A patient recovering from a complicated surgery and a longer inpatient stay or later readmission will have a higher cost and more difficult recovery. So, too, will a patient who is admitted to a Skilled Nursing Facility. The only way for TEAM hospitals to succeed under this payment model is to ensure that patients

avoid complications and other medical events during and after surgery that are costly or that might be harmful. First, they must find where these have occurred.

Download our new TIPS for TEAM to discover how you can find actionable episode data to define your TEAM strategies.

Developing cost strategies is a complicated process for hospitals that have previously looked primarily at operating costs or aggregate data. Here's why:

> To lower surgery costs, you must reveal factors that drive cost variation in each surgical episode (and with each surgical team) and then *develop processes to prevent or reduce those problems in the future.*
> Simplistic cost strategies do not provide you with solutions for improving care and lowering cost. These formulas include: (1) comparing aggregate case costs for each TEAM surgery or different surgeons; (2) benchmarking your hospital against peers; and (3) contrasting venue or type of service costs across cases. None of these techniques illuminate a path toward reducing costs while improving patient status on a scale that matters.

Episode analytics must dig into the cost variation in each episode and examine the key contributors to the cost or quality of recovery in that episode. These typically include patient risk, complications, surgical plan and components, anesthesia, medications, and all elements of the recovery phase.

Aggregating EHR and claims data enables you to discover that patients had incoming, untreated risks that led to complications, or that site infections were specific to certain surgeries or other factors. If only CMS claims data fuels your episodes, it is virtually impossible for your hospital and clinicians to evaluate the episode clinically as well as through a cost lens.

Good episode analytics depends on having the underlying data and episode design to do the job. Let us show you how Roji Episodes track both cost and quality in single episodes, part of a transformative learning process for your hospital and clinical teams.

Download your free 3 TIPS for Discovering Cost Drivers in TEAM Surgeries today.

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Image: Yin Yin Low

Rethink the Essential Role of Primary Care Physicians in TEAM

written by Theresa Hush | July 23, 2026

With TEAM's focus on improving surgical recoveries and costs in major hospital-based surgeries, it's easy to miss the importance of primary care physicians. But their role is essential for meeting TEAM's objective to improve patient recovery and lower costs in the five major types of surgery covered by TEAM. And perhaps not in the way that is written in the TEAM Final Rule.

Learn more in the fourth of our TIPS for TEAM Series: 5 Tips for Engaging Primary Care Physicians in TEAM [PDF]

The scope of primary care physicians for TEAM requires PCP referral only after surgery and upon patient discharge. That is too late for PCPs to help prevent patient complications by

evaluating their conditions and treating them before surgery. TEAM's goal is to repair fragmented communication and services in specialty care, but it will fall short if hospitals and specialists fail to recognize that primary care physician must be involved in perioperative as well as in aftercare.

There are functions within TEAM that fall solidly within the scope of primary care practices. Notably, ERAS evidence-based guidelines for cardiac and other surgeries include preoperative tests and treatments that provide a pathway to improved patient outcomes during and after surgery. Cardiac surgery recommendations include a wide range of tests, patient engagement, and functional improvements in the patient's status prior to surgery. These include measurement of A1c and Albumin for risk stratification, as well as preoperative correction of nutritional deficiencies, patient counseling and prehabilitation, and cessation of smoking and alcohol.

Certainly, it would be difficult for most specialty practices to manage this type of patient engagement and wide array of functions. Alternatively, we can establish a coordinated approach to support the patient's recovery *before* the patient is even at the hospital. That's the kind of care patients want to expect and that TEAM can deliver.

We hope that TIPS for TEAM is opening opportunities for re-envisioning surgical processes at your hospital and practices. We would love feedback on the TIPS you are trying and your experience: Please share your thoughts: info@rojihealthintel.com.

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Image: John Cameron