For TEAM Success, Collaboration Agreements Must Be a Win-Win for Specialists and Hospitals

written by Theresa Hush | January 8, 2026

The new Transforming Episode Accountability Model (TEAM) targets the highest cost or volume surgeries in the Medicare program. While hospitals bear the financial risk, CMS has created a vehicle to align interests with other providers through Collaboration Agreements that can include financial incentives. How those are structured will be key to the successful alignment—or fracture—of the hospital's implementation of TEAM.

In many Value-Based Care implementations, even in some ACOs, there has been a physician scoring mindset: an assumption that for physicians to change behavior, they need "feedback" on quality and costs using comparative scores with other physicians. But scoring physicians is not collaborative. It presumes fault, a mindset borrowed from payer reports that show ranking of "your cost" versus others. To succeed in TEAM, you should instead start fresh and make TEAM a win-win for both the hospital and specialists.

If physicians feel like they won't be treated well under the Collaboration Agreements allowed by TEAM, they simply won't accept them, leaving the hospital either to fully bear financial risk or potentially lose surgical patients. Scores can't—and shouldn't—shame specialists in TEAM in an attempt to lower complications, costs, and to improve patient recovery. The reality is that the root causes of costs are found everywhere, with hospitals, specialists, aftercare, and patients. In a fragmented environment with different systems and information, everyone adds to total surgical cost of care.

Here's a better, truly collaborative approach: Hospitals and physicians implement an inquiry and learning process based on trusted data and analytics, to identify the sources of cost variation and drivers. Once these factors are understood, the team should then set about constructing communication channels and processes to improve.

In our third free download of TIPS for TEAM, we present collaborative ideas that have worked in Roji's work with Clinical Integration, ACOs, and other client efforts to control costs by providing better and more coordinated care.

We welcome conversations with participants of TEAM who are eager to explore new ideas to resolve costs. 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: Angelo Casto

New TIPS for TEAM: Adopt ERAS Guidelines for Prevention of Complications and Faster Recovery

written by Theresa Hush | January 8, 2026

If TEAM has your hospital searching for an evidence-based toolkit to improve surgical outcomes and reduce recovery time, participating hospitals and their surgical teams should pay heed to ERAS (Enhanced Recovery After Surgery) protocols. The guidelines are tailored to more than twenty types of surgery as well as anesthesia and intensive care. They have been successful in reducing complications by 30 percent and lowering hospital stays.

Download your free Roji TIPS for TEAM on ERAS here.

Most of the TEAM procedures are covered within specialty guidelines addressing cardiac, colorectal, cytoreductive, orthopedic, and spinal fusion surgery types. There are significant common elements among the categories.

ERAS Guidelines are daunting in their scope and creativity, covering nutrition, infection prevention, patient comorbidities, and so much more. Trauma surgery is one of the

newest categories. Each challenges historical practices based on evidence, and all have been developed with consensus by surgeons and other experts. The American College of Surgery has endorsed ERAS.

ERAS covers pre-surgical, surgical, and post-surgical recovery. Despite the success in patient recovery results, adoption of ERAS has been slow, hovering around one third of hospitals in 2025. Academic centers generally have a higher implementation rate. But behind these numbers is another adoption dilemma—the uneven adoption related to specific categories (gastrointestinal and gynecological surgery have higher adoption rates; cardiac, lower). In addition, many organizations appear to adopt perioperative guidelines but not always pre-surgical or post-operative guidelines that tend to be more patient-centric.

TEAM is designed by CMS to rethink surgical processes, and ERAS should be top priority for adoption by participating hospitals. Download your free TIPS for TEAM on ERAS today.

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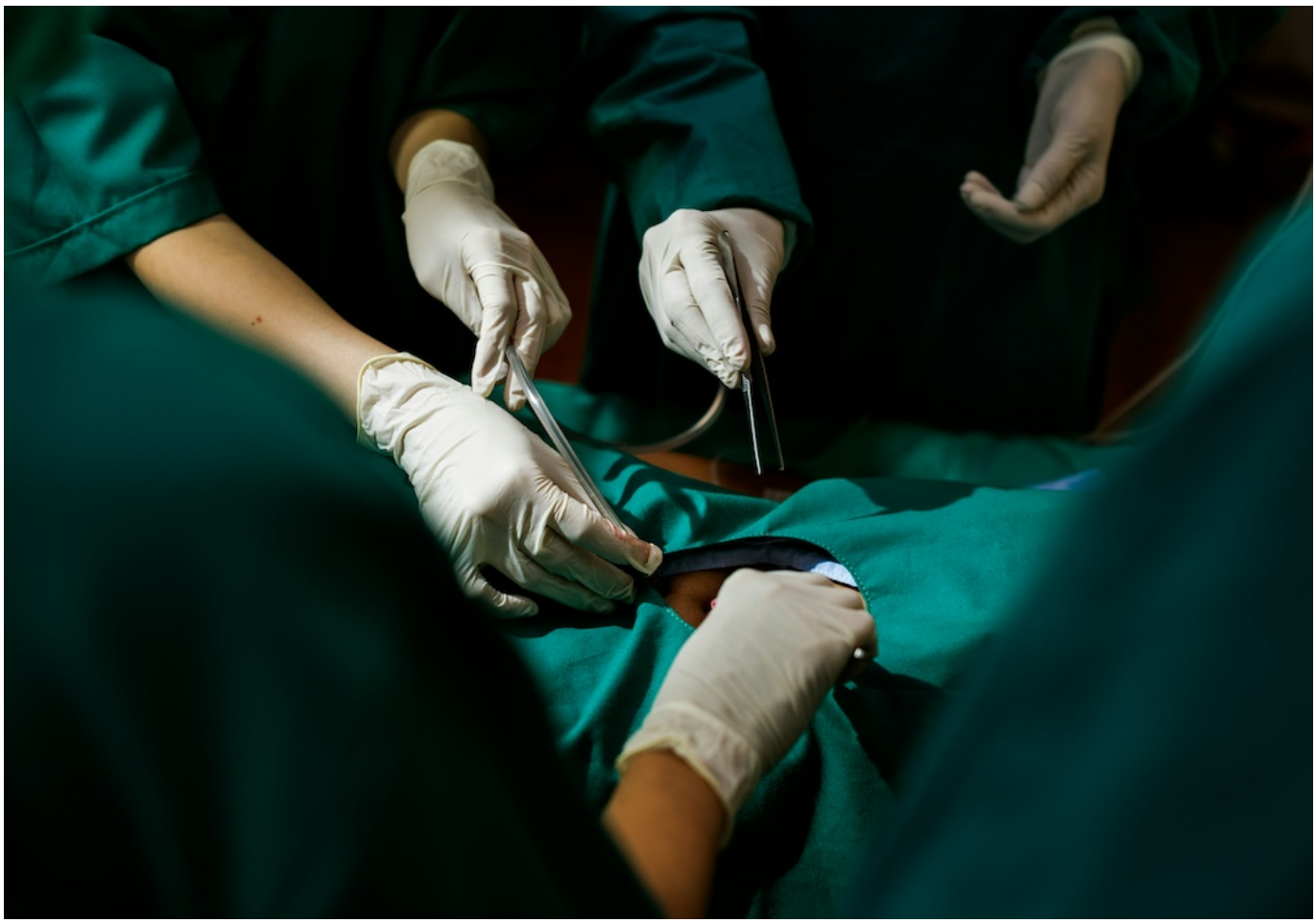
Image: Vitaly Gariev

TIPS for TEAM: How to Reduce the Top Driver of Higher Variable Costs in Surgery Episodes

written by Theresa Hush | January 8, 2026



One of the largest and most significant changes to specialty care payments in Medicare commences in January. TEAM (Transforming Episode Accountability Model) is poised to put hospitals at risk for total costs of care for the highest cost Medicare surgical episodes, including Coronary Artery Bypass Graft (CABG), Lower Extremity Joint Replacements (LEJR), major bowel procedures, surgical hip femur fracture repair (SHFFT), and spinal fusion.

Granting one year’s grace on assuming risk to meet an average cost formula, the model will force shifts in the way hospitals and physicians have typically handled surgical cases. Hospitals, which will be at risk for all episode costs for the procedure itself and the next 30 days, will need to collaborate with their surgical teams and primary care physicians on methods of lowering costs.

Failure to achieve cost levels below the targeted levels will mean that hospitals that don’t meet the cost target will have to pay back CMS. In simplistic terms, the formula targets an average cost that is patient-risk- and geography-adjusted. Over time, this calculation has the potential to lower the average cost target every year. Hospitals will compete to drive toward lower benchmarks. As their cost performance will most likely be made public, it will affect hospitals’ standing with private health plans’ high-performance networks.

Evaluating Costs of Surgical Episodes

Much recent literature regarding TEAM has focused on comparing aggregated costs of hospitals as well as categorical costs associated with type of services, such as inpatient care, SNF, and so on. However, these comparison don’t help to illuminate what is actually causing higher or lower costs, especially the variable costs of surgery: length of stay, level of services (for example, ICU), patient risk, complications, surgical returns, and do-overs.

Instead, hospitals will need to use patient episodes of care to discover the discrete reasons why episode costs are higher than others for some cases, some providers, or some patients. CMS will provide aggregated claims data, which should be integrated with clinical data from the hospital and the collaborating physicians. Only with patient-specific episodes will surgeons and other members of the clinical team be able to engage in evaluating and adjusting cost performance in each surgery, because professional reputation is at stake.

Where Is the Real Money to Be Saved in TEAM?

Roji's evaluation of actual surgical data through Roji TEAM Episodes supports the conclusion of much research into surgical costs: the top driver of variable costs comes from complications of surgery. These complications are multifactoral, caused both by breakdown in processes and communication as well as by underlying patient conditions. They include:

> Incidents related to surgery that preventive treatment may have avoided, such as development of atrial fibrillation after CABG and bleeding caused by unknown anemia for LEJR;
> Infections, including hospital MRSA related infections;
> Prolonged ventilation or other events causing extended length of stay, such as allogeneic transfusion;
> Complications caused by patient co-morbidities and frailty coming into surgery;
> Patient smoking and other lifestyle factors.

TIPS for TEAM Hospitals and Surgical Teams

Without a team approach between hospitals and their surgical teams, the TEAM payment model will impact hospitals unfairly. CMS correctly targeted hospitals as the necessary central point for collaboration. If hospitals and their surgical teams can work together on managing costs, they will be able to identify both systemic and specific processes that will achieve lower cost and better patient care.

Their first task is to begin reducing surgical complications,

regardless of cause. That leads to the next step: connecting fragmented primary-to-specialty communication and care management, addressing patient education and decisions, and addressing systemic issues in both hospital and physician care.

Roji Health Intelligence is launching its TIPS for TEAM series this week, with a focus on surgical complications. Download your free TIPS sheet to facilitate your entry into the new accountability framework for TEAM.

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Image: Curated Lifestyle

Is Your ACO at Risk of Not Meeting APP Quality Reporting Standards?

written by Theresa Hush | January 8, 2026

Do you have confidence in your ACO’s ability to meet APP Quality Reporting requirements? The 2025 Performance Year is the first year ACOs are required to report through the APM Performance Pathway (APP). Your ACO must transition to a proven technology-based solution to be successful. You need to be well along the path to successful reporting by the time you read this, or you are already in danger of failing APP Quality Reporting.

If you previously used the CMS Web Interface, it was easy to fulfill reporting through manual chart audits collection for 248 patients in the CMS sample. The APP changes that. Now your ACO must calculate measure denominators and fill responses *for at least 75 percent of eligible patients in each measure.* If you are duplicating unique patients by just adding practice

data together, you are risking your ACO Savings and potentially adding penalties.

Free Roji TIPS for APP Reporting Helps You Assess Your Reporting Status

Download our free Roji TIPS [PDF] to evaluate where your ACO should be in meeting this critical first year effort—and how to correct before it's too late.

If you haven't started your APP Reporting effort, reach out to Roji Health Intelligence today for reasonably priced APP Reporting. Roji has been collecting and aggregating data for more than 20 years and is certified with CMS to report on your behalf for APP Plus using any of the available reporting methods.

If you sign an agreement with Roji before December 15, 2025, Roji will be able to use your Quarterly Assigned List and CMS Claims files to calculate the Medicare CQM denominators for each measure in the APP Plus. From there, you will have the option to populate results in a variety of ways, including basic data file creation and transmission, pre-existing reports in your practices' EHRs, manually, through uploaded spreadsheets, or through a combination of solutions.

You will also have the option to purchase access to analytics to fuel your coordination of care activities and population health. Roji Episodes for patients with chronic conditions cover diabetes, hypertension, heart failure, hypertension, asthma, COPD, and chronic kidney disease. We provide high risk registries that are condition- and person-specific, and that identify missing key interventions in your services history.

Roji Episodes are offered at an attractive price to improve your savings.

It’s late in the game, but Roji Health Intelligence is here for you and your ACO. Meet the Quality Performance Standard with APP Plus Reporting Services and maximize your Shared Savings through delivering better patient care. Contact us to learn how Roji can help you meet the new standards on time and on budget.

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Image: Evgeniya Litovchenko

The 2026 CMS PFS Final Rule: The 5 Ways CMS Aims to Control Total Cost of Care

written by Dave Halpert | January 8, 2026

The CMS PFS Final Rule is out . . . early? If you're wondering how, in the midst of the Shutdown, a 2,375-page Rule could be released, the answer is simple: most of the proposals from this summer were finalized as is.

There are always exceptions, but the big takeaway is that this Rule solidifies CMS's proposals to control the Total Cost of Care. Through a variety of finalized proposals, we've identified five themes that illustrate how they intend to accomplish this, and what it means for you.

1. Bit by Bit, Everyone Will be Shunted into Two-Sided Risk

The key tenet in CMS's push to save money through accountable care relationships is that providers must be at financial risk. A program that will pay providers a bonus but not recoup high costs will not reduce CMS expenditures. Through a new and mandatory program, the Ambulatory Specialty Model (ASM), and a change to the Medicare Shared Savings (MSSP) ACO model, the theme of two-sided risk will have an extremely broad impact across organizations and providers.

The Ambulatory Surgical Model (ASM) was finalized as a mandatory model for providers treating patients with heart failure or low back pain. The program is set to begin in 2027 and run for seven years (including post-reporting payment years).

Not everyone will be included, but providers in certain Core Based Statistical Areas (CSBAs) and using a specific specialty code on the plurality of Part B claims will be required to participate. For heart failure, the specialty code is cardiology. Low back pain cuts across a broader set, including anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, or physical medicine and rehabilitation. For either group, there is also a requirement that at least 20 attributable episodes occurred in the calendar year two years prior.

ASM mirrors MVPs, including use of the Episode Based Cost Measures (ECBMs) in the heart failure and low back pain MVPs. However, there is a critical difference. In ASM, Quality and Cost each contribute 50 percent of the final score. A failure

to submit Improvement Activities and Promoting Interoperability categories can detract from a provider's score, but completing them will not add to it.

The other major difference between ASM and an MVP is the methodology behind the payment adjustment. MIPS is budget neutral; those who do not meet a performance threshold are penalized, and those that do will receive an incentive payment based on the size of the penalty pool. In ASM, adjustments come from an ASM incentive pool, which is a fixed rate of total Part B claims paid to ASM participants. Since there is no performance threshold, the adjustment is exclusively based on comparison against peers. The risk level starts at 9 percent in 2027, and will increase to 12 percent by the end of the program. There will definitely be winners and losers.

On the MSSP front, CMS is finalizing its proposal to limit ACOs to a 5-year period in the one-sided BASIC Track. Following that, those ACOs will need to either move to BASIC Track Level E, or to the higher-risk/higher-reward ENHANCED Track. However, this will not go into effect until 2027, as the 2026 application cycle had already started when the Proposed Rule was published in the Federal Register.

That change will be felt by a newly allowed contingent of ACOs who were formerly precluded from participation based on attributable beneficiary volume. Previously, ACOs must have had at least 5,000 attributable beneficiaries to be approved as an ACO. Now, by finalizing the proposed change that an ACO may have fewer than 5,000 attributed beneficiaries in years 1 and 2 (provided they hit 5,000 by year 3), these smaller groups can be brought into the MSSP fold. They will only be able to

participate in the BASIC Track (not ENHANCED), and will have a cap on savings/losses. Like the previously described policy, this will also not take effect until 2027

2. Consistency in MIPS is Temporary

CMS has previously expressed its intention to phase out Traditional MIPS and replace it with MIPS Value Pathways (MVPs). This Final Rule does not list an official date for sunsetting Traditional MIPS, but there is a mention that they expect to be ready by 2029. To ensure that providers have a stable ground from which to jump from Transitional MIPS to MVPs, they have finalized a multitude of proposals aimed at keeping Traditional MIPS stable while enhancing the MVP library:

- Creation of six new MVPs in underrepresented specialties;
- Updating the scoring of the Total Per Capita Cost measure and administrative claims Quality measures, adopting the more favorable scoring method using the median and standard deviation method currently employed in episode-based cost measures;
- Adding a two-year “informational-only” period for new Cost measures;
- Moving additional measures into the alternate performance calculation for topped out measures in specialties with limited choice;
- Updating the security-related requirements of Promoting Interoperability requirements, but minimizing other changes;
- Maintaining the 75-point performance threshold through 2028.

While Traditional MIPS remains stable, there are changes coming for MVP participants. The most important is that 2025 is the last year multispecialty groups can report an MVP as a single group, rather than a subgroup. This has been the deadline for years, but unlike some prior deadlines, this one was not undone by the Final Rule. Undoubtedly, although Subgroup reporting is mandatory in 2026 and beyond for multispecialty groups, the decision not to undo the deadline is partially because these multispecialty groups are only impacted if they chose to report an MVP. They still have the opportunity to report at the group level in Traditional MIPS.

An additional change to subgroup reporting was finalized. CMS has learned that they cannot use claims to determine how to accurately break a multispecialty practice into subgroups. Mid-year acquisitions, provider turnover, and NPs in specialty settings are just a few of the variables that preclude claims data from being the “source of truth” with regards to the composition of a multispecialty group. CMS has released an RFI to determine methods to determine ways to preemptively establish subgroups, but for 2026, practices must attest to their composition.

3. Accountable Care Must Enable Clinician-Level Comparisons

CMS’s stated goal is to have all Traditional Medicare beneficiaries into an accountable care relationship with a provider by 2030. Here, “provider” is the key term. Even in an ACO, patients are attributed based on encounters with a specific provider. CMS uses this Rule to advance accountable care at the clinician-level.

In the ASM, the key detail is that the accountable party is a specific provider, defined using the combination of individual NPI and practice Tax ID Number. This is in stark contrast to TEAM, which is a hospital-based program. Nevertheless, many of the strategies for success in TEAM and opportunity for collaboration agreements are applicable to ASM, and can be adopted widely. This ensures that your value-based care strategy isn't duplicating your team's efforts, and can produce maximum impact with your available resources.

ASM participant eligibility is determined yearly, and so some years, a provider will be in ASM, and others, that provider will need to fulfill QPP requirements through MIPS. CMS will notify providers annually whether they fulfill inclusion criteria, and has stated that they will provide a preliminary 2027 list based on 2024 data.

In the Quality Payment Program, CMS has finalized its proposal to make Qualified APM Participant (QP) determinations at the individual level, not just at the entity level. Previously, by looking only at the entity level, providers that may be eligible for an APM could be incorrectly seen as not having met the required patient and payment amounts, despite the fact that they would have met QP thresholds on their own (e.g. a nephrologist that would qualify for a Comprehensive Kidney Care Contracting APM, but was overlooked due to the specialty composition of the practice as a whole).

Furthermore, CMS is finalizing QP determinations using Encounter and Management services and covered professional services. Since primary care providers will have a higher proportion of E/M services compared to specialty providers,

this will advise CMS on instances in which a beneficiary had not been attributed to an Advanced APM even though they were receiving specialty care within an Advanced APM (e.g. the nephrologist in the prior example).

4. In One Form or Another, Health Equity Will Always Play a Role

For MSSPs, one of the biggest (and most unwelcome) proposals was the removal of the Health Equity Adjustment, particularly since it was proposed to take effect this year, rather than 2026. Its removal was finalized, but ACOs can breathe a temporary sigh of relief, as this policy will not begin until 2026. CMS had previously stated that this bonus was duplicative of the Complex Payment Adjustment, which rewarded practices who reported quality measures on all patients using either MIPS CQMs or Electronic Clinical Quality Measures (eCQMs).

However, those reporting using Medicare CQMs do not receive the Complex Organization Bonus, meaning that the Health Equity Adjustment was not duplicative. Nevertheless, CMS is removing it for all ACOs, stating that those reporting Medicare CQMs do not need the adjustment, as Medicare CQMs already have flat benchmarks.

The Health Equity Benchmark Adjustment (HEBA) will not be removed, but CMS will be renaming it the “Population Adjustment.” This adjustment was seen as critical to CMS’s mission of having all patients in an accountable care relationship by 2030, as it incentivized ACO creation and expansion in communities that may have been seen as too risky, based on the proportion of patients with Dual Eligible status or receiving the Part D Low Income Subsidy (LIS).

In the ASM, CMS has stated that there will be scoring adjustments for providers with greater rates of medically complex patients or “socially complex” patients. References to equity and social determinants of health (including the removal of a quality measure previously included in most MVPs) may be gone, but in theory, these factors will be considered.

In a pan-program move, CMS has finalized Advanced Primary Care Management (APCM) codes that reimburse behavioral health management in conjunction with primary care services. Their aim is to improve outcomes for patients with both behavioral health and other chronic conditions. The administration has been critical of perceived “over-medication,” and has slotted space for these codes in the hope that behavioral health is addressed through other means in the primary care setting.

5. Quality Reporting Is Here to Stay

Each year, CMS updates quality reporting requirements for existing programs and creates them for new ones. Many of these updates are intended to align program requirements, and this year is no exception. In ASM, quality measures will mirror CQMs in MIPS and the Alternative Performance Model Pathway (APP Plus), requiring that 75 percent of the eligible denominator is tagged with an applicable response. Performance for these reported cases are compared to a to benchmark, and the participant is awarded achievement points. Again, just like MIPS and in the APP, zero points are awarded if the data completion threshold is not met.

For ACOs, the Quality performance standard calculation remains steady. To meet the standard and be eligible to earn its full share of savings, an ACO must report through the APP and, at

minimum, achieve the 40th percentile for the APP Plus Measure Set. However, ACOs can still share in some savings if they meet the 10th percentile in one of the APP Plus outcome measures, provided at they perform at or above the 40th decile in another APP Plus measure. The only difference is in 2026 is that there will be an additional claims measure and additional CQM.

In MIPS and APMs (including ASM, TEAM and ACOs) CMS has defined strict rules for quality reporting. The requirements are complex, often requiring data aggregation and the ability to look at results at TIN, Practice, Site, and Provider levels. For that reason, CMS has allowed "Third Party Intermediaries" (like Clinical Data Registries) to submit data on behalf of providers and entities participating in these programs.

Roji can be your "ace in the hole." For any entity, Roji can collect claims data and provider data to integrate into the Roji Clinical Data Registry. This integration empowers you to get the most out of quality reporting, as well as to populate Roji Episodes, which enable you to link your cost and quality efforts, ensuring that your value-based care strategy is efficient and successful.

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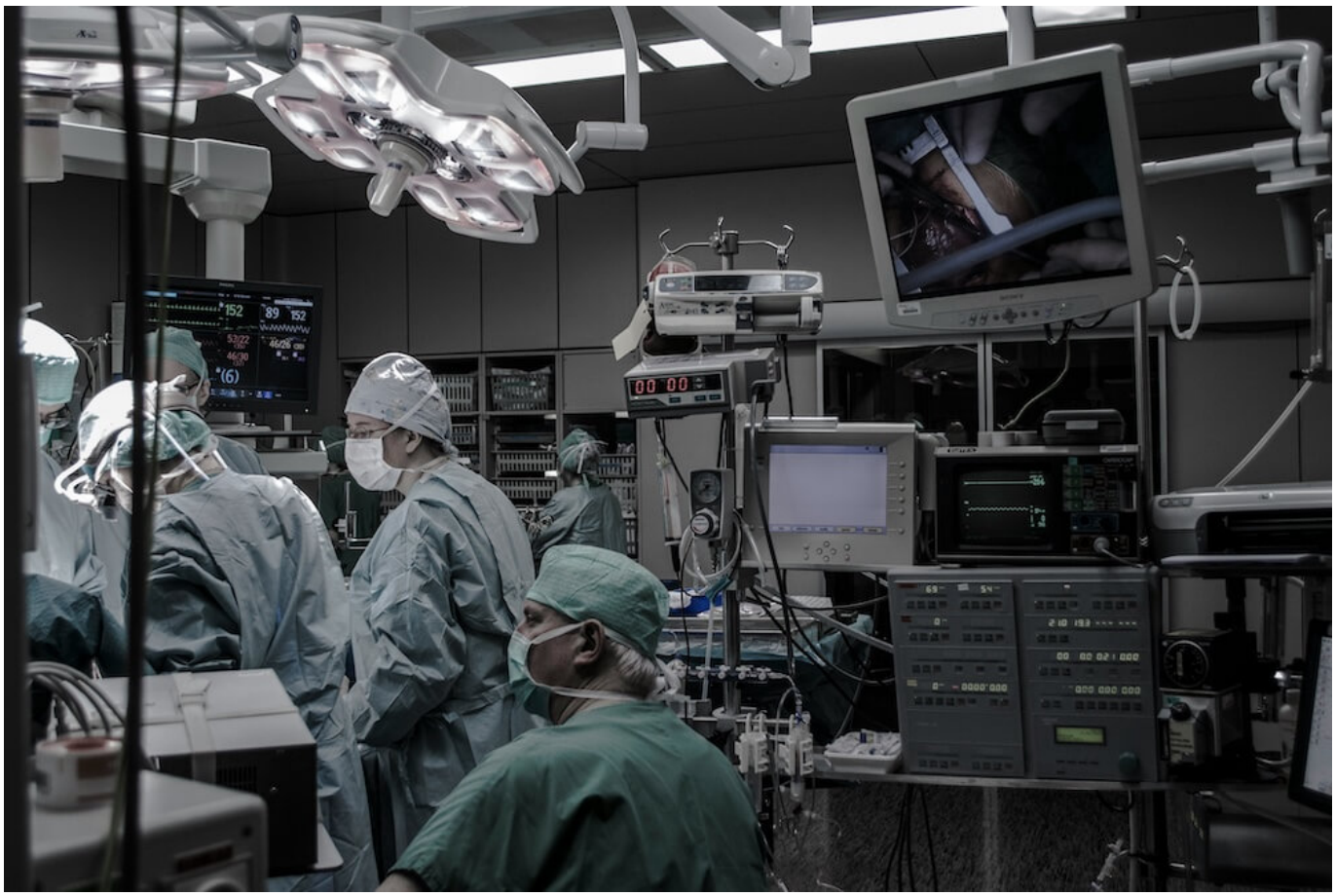
Image: John Cameron

Three Strategies for ACOs to Optimize Specialty Care through TEAM

written by Theresa Hush | January 8, 2026



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.

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Image: Piron Guillaume

Providers: Collaborate or Lose Under TEAM Risk-Based Payment for Specialty Procedures

written by Theresa Hush | January 8, 2026

Surgery will be a financial winner or loser under TEAM (Transforming Episode Accountability Model), a mandatory episodic payment model beginning in January 2026. Let's be clear: TEAM requires a tectonic plate shift in managing cost and outcomes of surgical procedures for five types of procedures. To be on the winning side of this model, your hospital and physicians must prepare now to manage patients undergoing certain high-cost surgeries, defined by *episodes starting from surgery to 30 days afterwards*. Cost management will require collaboration between the hospital, specialists, primary care physicians, and post-surgical providers.

A large model, with 743 hospitals currently involved and that covers high profile procedures (CABG, upper and lower extremity joint replacements, spinal fusion, femur fracture reduction, and major bowel surgeries), TEAM will likely thrust hospitals

and practices into the spotlight for performance, good or bad. You do not want to be on the losing end of TEAM.

TEAM Facts and Context

CMS will pay the five types of high-cost surgical procedures under a model that estimates a target cost. While all providers get payments under the normal fee-for-service system, hospitals under the target cost get a payback, while those whose costs exceed the target must pay back CMS. Since TEAM is the first episodic payment model that involves both hospitals (the key "participants") and physicians ("collaborators") who treat a Medicare patient in a TEAM episode at the participating hospital, the total costs will include everything:

- Facility costs, including the operating room and other units;
- Specialty physicians and associated costs;
- Anesthesia;
- Medications;
- Related care that occurs within the 30 days after surgery—rehabilitation or skilled nursing, equipment, home services, and costs of treating post-surgical complications.

However, hospitals are specifically targeted for risk-based reimbursement, and they must take action to hold physicians and other providers accountable for their care under collaborative arrangements, as allowed under TEAM. There are many cost-spurring variables in procedures, especially the five types in TEAM. Patients have a variety of risks going into surgery that

need special attention. Surgeons have different surgical approaches, techniques, equipment or preferred prostheses, or even volumes of surgery, all of which generate cost variations. Surgical complications—which can occur during or after surgery—raise the cost. Anesthesia varies between types and may complicate outcomes. Time itself is a factor; the hospital operating room (OR) now costs an average of $46 per minute. Each variation to the norm runs up the cost, driven by each and every participant in the process

The complexity of costs under procedures is why the optimal arrangement for TEAM providers is to create a collaboration to align incentives and economics. And it pays to create that collaboration now, because after the one-year grace period in 2026, there is a downside financial risk for costs above the CMS target.

Every TEAM Stakeholder Needs Tools for Accountability

Up to now, facility and surgical team activities have been functioning on a semi-separate basis, with hospitals more focused on physical needs and scheduling to keep patients moving through the system in order to support physicians, and physicians calling most of the shots on what happens in the OR.

TEAM makes that untenable. Hospitals will be responsible for poor outcomes generated by physicians, or incorrect anesthesia, or after-care. Outcomes and costs are interconnected, and if

there are continued barriers to communication between stakeholders, there will be no improvement in cost performance or patient outcomes.

TEAM hospitals and physicians must structure their processes and platforms for evaluation of TEAM procedural episodes and reach agreement on major points of the patient's care process. Start now to avoid losing opportunities to make gains before risk payments hit just one year later.

Your platform for evaluating costs and moderating them in the future rests on data and an open, collaborative process. How can TEAM hospitals implement such a platform and set of agreements? You can follow these six steps to create the tools needed for accountability.

1. Analyze history.

Adopt technology to replicate TEAM procedural episodes and use it to Identify historical costs, cost drivers, and quality issues in each case. All costs present in TEAM episodes should be in historical episodes. Patient EHR data and claims data should be integrated to ensure there is enough depth of clinical information for clinicians to analyze the historical events in light of new requirements. These episodes will boost your ability to avoid cost overruns.

2. Calculate cost variation for each procedure and attributable causes.

Just review of data alone can result in changes to improve clinical practice. But it is critically important for clinicians to understand what is behind variable costs. While

we expect that cases will differ, extreme cost variation might reveal lack of a good patient risk assessment, lengthy anesthesia, sub-optimal surgical approaches, or underlying complexity due to patient status and comorbidities, among other factors. You must collectively examine every part of the pre-surgical and surgical process for opportunities, with clinical teams involved in that discovery process. Clinician review and feedback of episode findings is essential.

3. Evaluate all complications and unexplained events, in particular.

With complications driving 20 percent of total episode cost increases, it is crucial to analyze what caused those issues in order to assess clinical quality and identify other factors driving costs. Episodes should report complications both during and after procedures to improve understanding of causes and how to mitigate them going forward.

4. Establish an improved pre-surgical process.

While some of the TEAM procedures will be scheduled emergently (e.g. femur fracture repair, CABG), the others potentially have wait-time to accomplish three tasks that can reduce complications and improve outcomes. These should all happen *prior to the day of surgery*:

> Improve your patient risk assessment by including anesthesia and primary care for a full assessment of existing patient risks. This should include a visit with the anesthesiologist prior to surgery and discussion between the surgeon and anesthesiologist with the patient’s primary care physician.

Begin patient strengthening therapy prior to joint replacements, if indicated, to improve patient pain and recovery after surgery.
Prepare patient for the post-surgical period, including set-up of physical therapy and rehabilitation, diet and nutrition regimen, home modification or equipment, and patient training prior to surgery.

5. Adjust or adopt clinical and patient process pathways for surgeries.

TEAM hospitals will undoubtedly want to standardize care in an effort to find economies and to reduce complications. Negotiations around the use of specific prostheses, anesthesia, medications, surgical approaches or procedures are expected. This is the time to agree on the use of robotics and AI as tools in specific surgeries or with specific proceduralists.

6. Establish interoperable communication of the episode in the hospital EHR to be shared with all providers involved, including primary care physicians, regardless of their affiliation or access to the hospital system at present.

Most likely, not all principals on the patient's team are in one organization or one system. Nevertheless, the hospital will need to ensure access to the patient's episode to everyone on the patient's team. Likewise, TEAM requires arrangements with primary care physicians, who also need to be included in this system, and later, with post-surgical providers

Now is the time to aggregate data and to look at your

experience and costs through replicated TEAM episodes. Don’t settle for just making your first year of TEAM a practice year. Take the initiative in 2026 to test and document improvement. TEAM requires a major shift in who is involved in patient surgery, and your health system must be up to the task. Your sustainability will depend on it.

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Image: Jackalope West

CMS is Demanding Change in Specialty Care: 5 Things to Know about ASM

written by Theresa Hush | January 8, 2026

Heads up! CMS's Proposed 2026 PFS Rule introduces a new payment model for tackling specialty care and costs in traditional Medicare. Clearly not a snap decision, Ambulatory Specialty

Model (ASM) has been cooked until well-seasoned and served up in 210 pages of the proposed Rule. Unlike a typical Notice from the CMS Innovation Center that initiates many Value-Based Care payment models, this detailed presentation signifies its importance.

Specialty care accounts for 40 to 60 percent of total health care costs, with a broad range of services included, such as consultations, imaging, tests, procedures, admissions, and various therapies. Until recently, costs were broken out into categories without attributing those costs to a single physician who managed the patient's condition and ordered or referred these other services. That attribution of patient to physician is now proposed in ASM. Starting with heart failure and low back pain, this new model calculates costs and quality performance for specialists treating patients with those conditions and pays them based on a formula which favors better quality and cost performance.

ASM is a significant new path for how to pay specialists for management of chronic conditions such as the two initiating the program. It goes further than any other value-based payment model in performance requirements, scope, physician-level responsibility for cost and outcomes, and engagement of physicians in Value-Based Care accountability. It's worth a deeper dive to examine the impact. Here are five things you need to understand about ASM:

1. ASM is a mandatory payment model for specialists treating heart failure and low back pain in many sites throughout the country, beginning January 2027.

CMS will identify approximately 600 randomly selected CBSAs, stratified by six patient-volume and spending categories in heart failure and low back pain. Rural Health Clinics and FQHC clinicians are excluded. A specialist providing care to patients with the diagnoses will be selected to participate, if the specialist has 20 or more episodes. This will make it one of the largest and most wide-spread of the Value-Based Payment Models, with 25 percent of all communities in the model.

2. A downside risk of 9 percent for assigned participating specialists grows to 12 percent over the five-year period and applies to individual specialist participants (TIN/NPI). But participants will get claims data to identify issues in patterns and cost of care.

Payment levels are based on meeting quality and cost measure performance levels. A significant deviation from all current payment models is scoring for individual specialists' performance. Whereas a group of practitioners can even out the cost or quality performance of a single provider, this model puts pressure on individual specialists to conform. The results will become public and thus affect patient referrals.

This is a significant distinction from TEAM (Transforming Episode Accountability Model), also specialty-oriented and for five categories of procedures. In TEAM, hospitals are the

conveners of the procedural episodes and bear the risk, which can flow to physicians depending on their arrangements with the convening hospitals. By contrast, in ASM, specialists are responsible and their fees are at risk if they pursue treatments that are higher cost than the benchmark, or if quality performance is not met. Also in TEAM, there is a year grace period prior to financial risk, whereas ASM kicks off with risk for the first performance year.

ASM participants, like those in ACOs, will receive claims data for their patients. This enables specialty practices to use specialized analytics, like Value-Based Care Episodes, to prepare for ASM with cost analytics that investigate cost drivers, identify issues with condition or treatment episodes, and deploy interventions to improve.

3. ASM participation is non-exclusive with other CMS payment models, such as ACOs. In fact, participants are required to have data-sharing agreements with primary physicians or their groups (ACOs or practices) to coordinate care.

This provides the pathway for ACOs to negotiate with specialists based on ASM Scores and communication commitments regarding processes such as handing off patient care between primary and specialty providers. Proof of such communication is required in the model.

Specialists within ACOs are not excluded from the mandatory model, either, if they fall within the ASM criteria and geographic area of ACO services. This is likely to encourage

specialists to terminate ACO participation, opting for specialty arrangements that are advantageous to both parties with less financial risk.

ASM will impact referral arrangements throughout the health care system. At greatest risk are academic health systems and specialty centers with large numbers of specialists and many primary care referral sources. The practice of specialists using historical advancement and reputations to make referral arrangements is likely to change significantly based on ASM Scoring. The model is big enough to make a difference, especially as it expands to other types of specialty care (as it is likely to do).

4. The model includes multiple specialties for low back pain management, creating a financial disincentive for higher cost surgical episodes.

Inclusion of specialties in the model is based on TIN/NPI and specialty designations in MIPS quality reporting. ASM also has volume and other criteria for participant inclusion. For the heart failure cohort, specialists are restricted to cardiologists. For the low back pain cohort in ASM, however, specialties include orthopedic surgery, neurosurgery, interventional pain management, pain management, anesthesiology, and physical medical and rehabilitation. How different root causes of low back pain will be evaluated under the program was not directly addressed by the Proposed Rule, but there is little doubt that specialists will propose exclusions to the low back pain cohort for clinical reasons or investigatory reasons.

5. ASM Scoring covers the traditional four MIPS categories: Cost, Quality, Improvement Activities, and Interoperability—but each category demands much more.

There are many similarities between the MIPS and ASM components. However, their application in ASM goes beyond the intensity and application of MIPS. ASM requires MIPS Value Pathways (MVPs) and MIPS episode-based cost measures (EBCMs) for both conditions, and then scores each specialist individually. ASM participants are waived from participating in MIPS directly.

Heart failure quality measures include elements of the well-established standard of care using pharmacological therapies such as beta-blockers, ACE, ARB and ARNI therapies, blood pressure control, and heart failure assessments. Low back pain quality measures are more diffuse and include prohibitive as well as preventive measures. They reflect the primary CMS goal of minimizing interventions without clinical indicators or without proven value. Patient-reported measures are included in quality measures for both heart failure and low back pain.

Both conditions use MIPS EBCM (cost measures) for the cost scoring of the program. Given the categories of selected geographic areas and their designated variations as high/low cost and high/low volume, the scoring will clearly—like all aspects of ASM—call out practitioners who meet or don’t meet performance. This is likely to raise resistance among specialty groups.

Improvement Activities and Promoting Interoperability

categories are both required and scored in ASM. Again, these go well beyond current MIPS requirements and together lay a foundation comprised of coordination of patient care, patient clinical data held in common, and interoperability. The Rule proposes that specialists have documented workflows, processes, and technology to support primary care for their patients. Collaboration and communication on patient care are required.

ASM also requires specialists to ensure that their patients have a primary care provider. To satisfy Improvements Activities, each participant must have at least one agreement in place with a primary care physician. Promoting Interoperability requires Certified EHRs and data-sharing agreements with primary care practices. Together, these requirements are a major transformation for physician care in medicine. In large, multi-specialty groups, some of these requirements are facilitated by common technology. But for an independent specialty practice that receives referrals from multiple primary care practices, ASM is a sea change.

Whether ASM can succeed in a Final Rule is an open question, but CMS has fired a strong opening volley. With its aggressive timetable and fundamental changes to the way specialty and primary care practices now operate, not many can take legitimate issue with the underlying goal.

What Specialty and Primary Care Practices Need to Implement ASM

Health systems and practices must move quickly to implement this model. The technology needs, alone, are beyond the capacity of many practices. And because of ASM's coordination requirements between targeted specialists and primary care physicians, this model will touch a majority of physicians. Implementation by 2027, the first performance year, requires a big push and a lot of tools.

Yet audacity may have its reward.

Most importantly, specialists need to recalculate the value of their current technology and analytics to focus on cost and quality. Up until now they have been doing MIPS group reporting and possibly not even using measures within their specialty. That must change, given the needed analytics to calculate results for MVPs addressed by ASM. Even if the practices don't intend to report MVP measures in 2025, they must begin to model their results against MVP measures.

Second, specialty practices must reevaluate EHR systems, cost tools, and current processes for primary care coordination. Creating specialized cost analytics is necessary both to calculate historic costs of episodes and to identify quality or outcomes issues.

Roji Health Intelligence is ready to help your group plan how

to navigate the road ahead. Contact us today.

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Image: Todd Turner

CMS Commits to Control Total Cost of Care: 6 Volleys in the 2026 CMS PFS Proposed Rule

written by Dave Halpert | January 8, 2026

Summer is here, and the heat is on: barbeques, beaches, and the 2026 CMS Physician Fee Schedule Proposed Rule. Throughout 1,803 pages, CMS is going after the total cost of care in the MIPS and APM tracks of the Quality Payment Program (QPP).

These proposed updates and the creation of a surprise new (and mandatory!) Alternate Payment Model (APM), share themes that you need to recognize to ensure that your Value-Based Care strategy has long-term viability.

1. Two-sided risk will come for everybody, and it will be mandatory.

The biggest news to come out of this Proposed Rule is the creation of a new and mandatory two-sided risk model named the "Ambulatory Specialty Model" or "ASM". As we've predicted, CMS has taken another step toward mandatory, two-sided risk models.

Required participation eliminates the selection bias that can corrupt the data from voluntary models and furthers CMS's goal of having all Medicare patients in accountable care relationships by 2030.

We will cover the ASM in more detail in a future blog, but in broad strokes, the goal is to reduce costs and improve care coordination in specialty care, starting with two chronic conditions: heart failure and low back pain. Aside from diabetes, these are the conditions that account for the highest Medicare Part A and Part B spending (diabetes was not included because it is frequently managed solely by primary care providers, rather than primary care providers in conjunction with specialty providers). The process will be very similar to a MIPS Value Pathway (MVP), and, in fact, it will utilize the Heart Failure and Low Back Pain Episode Based Cost Measures (ECBMs) found in MIPS.

On the ACO side, the Proposed Rule condenses the period in which ACOs that are "Inexperienced" with two-sided risk can remain in a one-sided arrangement. Rather than seven years, CMS proposes five, the length of the initial agreement period. In the ACO's second agreement period, the entire five years would need to be two-sided, in either the highest level (E) of the BASIC Track or by advancing to the ENHANCED Track.

In the ACO environment, those in two-sided models consistently outperform their non-risk counterparts, and in order for the ACO model to remain cost-effective, "Inexperienced" ACOs must be brought more rapidly into the fold. The "Experienced" ACOs have gradually moved in the same direction, with 2025 marking the first year in which participation in the ENHANCED Track has

eclipsed participation in the BASIC Track.

2. Effective care coordination can reduce costs by slowing disease progression.

Proposals related to managing chronic condition costs apply to all facets of the Quality Payment Program. In the ASM, participants are incentivized to ensure patients are aligned with PCPs who can screen and identify symptoms of chronic disease earlier for proactive intervention. Scoring on quality and cost measures reflect the progression of existing disease.

In MIPS Value Pathways (MVPs), the approach to care coordination is tailored to encourage enhanced participation. Since there is no proposed timeline to sunset Traditional MIPS, MVP participation is still optional. With mandatory subgroup reporting on the horizon, many multispecialty practices have chosen to remain in Traditional MIPS.

This has created an unintended consequence for practices that employ multiple specialty providers, but are aligned on a single, clinical focus. For example, a cancer care center may consist of radiologists, oncologists, NPs and PAs, and potentially even a primary care physician. Forcing these types of practices to report as subgroups actually detracts from their mission and will increase reporting burden while producing less meaningful results.

To alleviate this issue, these groups will be able to self-attest to being a “single specialty” group and report a single MVP, rather than breaking the larger group into subgroups. This was a concern raised when specialty composition within a practice was defined by CMS through claims.

3. Health equity by any other name will always play a role in Value-Based Care.

Although not surprising when taken in context of the current administration's priorities, there is a significant purge of Health Equity terminology and provisions within this proposal. However, the removal of the Health Equity Adjustment for ACOs this year (as opposed to 2026) was unexpected. The claim is that the Complex Organization Adjustment and the extension of the all-patient reporting incentive render the Health Equity Adjustment duplicative. Unfortunately, these incentives do not apply to those utilizing Medicare CQMs, and those ACOs stand to lose the most from the loss of the Health Equity Adjustment.

On the other hand, CMS is not removing the Health Equity Benchmark Adjustment related to Part D low-income subsidy (LIS) and Dual Eligible patients, but they are renaming it "Population Adjustment." The decision to preserve (but rename) the "Health Equity Benchmark Adjustment" and remove the "Health Equity Adjustment" comes down to CMS's goal to have all Traditional Medicare beneficiaries in an accountable care relationship by 2030. The Health Equity Benchmark Adjustment was shown to bring ACOs into communities that would have been seen as too risky.

The eradication of health equity references also applies to MIPS. On the quality side, they have proposed removing measures related to Screening for Social Drivers of Health (measure 487) and Connection to Community Service Provider (measure 498), stating that they were no longer considered "high priority" measures and were therefore "non-relevant process measures." Similarly, the "Advancing Health Equity" Improvement Activities

have also been proposed for removal, to be replaced with "Advancing Health Wellness" activities.

The rule indicates that CMS is not attempting to take focus away from access, but that they're intending to do so through nutrition, "well-being," and patient engagement. No evidence was provided to indicate that the affected quality measures and IAs were irrelevant, and time will tell what impact this will have on patient outcomes and the intermediate outcome-based quality measures. It will definitely affect MVP participation, though—the Screening for Social Drivers of Health measure was broadly included in MVPs and was prioritized by many health systems for workflow development, as it would cross all subgroups in a multi-specialty practice. Its removal will mean fewer options for participating providers.

4. CMS has its eye on specialty care, down to the clinician level.

The newly announced Ambulatory Specialty Model is mandatory, and when viewed in the context of the previously finalized (and mandatory) Transforming Episode Accountability Model (TEAM), it is clear that CMS is exploring options to control specialty-driven costs. Although ASM is an APM built on an MVP chassis, there is a significant difference: ASM will be scored at the clinician level, rather than at the group or sub-group level. This will enable an "apples to apples" comparison and may yield interesting results, especially when providers are in the same large organization, like an Academic Medical Center.

For MIPS participants, CMS uses this Proposed Rule to encourage specialists' engagement in MIPS Value Pathways (MVPs), rather than Traditional MIPS. To that end, they have released six new

MVPs, opening the MVP environment up to:

- Diagnostic Radiology
- Interventional Radiology
- Neuropsychology
- Pathology
- Podiatry
- Vascular Surgery

Although nothing was proposed, CMS does discuss considerations for ensuring that providers are reporting the most relevant MVPs, creating a true and comparable profile to other clinicians in the same field. Specifically, the Proposed Rule suggests the future use of procedures and diagnoses on claims to dictate which MVP a provider would need to report, similar to how the ASM is configured. Additionally, CMS considers making certain MVP measures (designated as Core Elements) mandatory, ensuring provider comparability and streamlining reporting options, particularly in MVPs with abundant measures.

Finally, CMS is adding a proposal to add an individual QP (Qualified Participant in an APM) determination. Currently, by looking only at the APM Entity's status, a provider could be excluded if an APM Entity did meet payment amount and patient count requirements, even if that provider would meet those criteria individually (e.g. a minority of surgeons participating in a BPCI practice). By utilizing individual and APM Entity determinations to advise QP status, specialty practitioners are more likely to remain participants in advanced APMs, furthering CMS's goals.

5. The unbreakable bond between data security and Value-Based Care is essential.

In the wake of the biggest U.S. Healthcare data breach of all time, it behooves you to ensure that your system is protected from bad actors. Although the Proposed Rule does make allotments in program participation in the form of Extreme and Uncontrollable Circumstance (EUC) exemptions for cyberattacks and ransomware, the bulk of the security proposals are added responsibilities for providers, practices, and health systems.

These proposals impact the Promoting Interoperability (PI) performance category, which is now required by ACOs, MIPS participants, and is also scored in ASM. However, as configurations vary by Certified EHR Technology (CEHRT) implementation instance, assessment by CMS is not feasible, and certain components must be handled through provider attestation.

CMS has the ability to audit any data submitted by a provider or on a provider's behalf, and this includes Promoting Interoperability. Giving the rubber stamp treatment to attestations can have severe consequences, including payment recoupments, fines, and potentially prison. Therefore, the additional attestations required for PI should not be glossed over, particularly related to the Security Analysis.

In addition to confirming whether a Security Risk Analysis was performed, a second attestation must be made to indicate whether security risk management activities have been conducted. In other words, whether the Risk Analysis was carefully reviewed, and whether steps were taken to close security gaps. It is certainly conceivable that, in the future,

the fate of a provider's cyberattack-related EUC could hinge on evidence that these tasks were performed.

Security is paramount in Value-Based Care. If your system is attacked and you are locked out, the information you need to make informed clinical decisions will suffer. The results will mean poorer outcomes and higher downstream costs.

6. Quality measurement is essential for controlling costs and swings back to per-provider.

Do not mistake the emphasis on controlling total cost of care for a withdrawal from quality measurement. Even before this proposal, CMS has solicited feedback on the Health Technology Ecosystem, including input on how quality measurement should look in the future, what should contribute to quality measure scoring, and how it can be less of a burdensome process. A notable element of quality measurement in the proposed ASM is quality and cost measurement of individual providers. Based on the language of the rule, we may see more of that in the future, especially for specialists.

The Proposed Rule continues this discussion with several Requests for Information (RFIs) intended to guide future rules and development. Of particular importance, there is an RFI on the development of Fast Healthcare Interoperability Resources (FHIR). FHIR would allow different healthcare software—and not just EHRs—to achieve a standard of interoperability that will make quality reporting more robust and more efficient in the future. Bulk data (populations of individual patients) FHIR exchanges would substantially accelerate CMS's transition to

Digital Quality Measures (dQMs), and they would like your feedback on how it should work, and your current challenges.

In the short-term, CMS has made several proposals to enhance quality measurement, including updates to scoring mechanisms that unfairly penalize providers for average—and in some cases, high—performance. The Final 2025 Rule addressed two major pain points, and this proposal follows suit.

The first issue was that MIPS Cost measures disproportionately punished those with average scores. Therefore, rather than using a bell-curve approach that gave 5 points out of 10 to average performers, CMS designed a method using the median and weighted standard deviations, meaning that providers in the middle of the pack scored in the 7-point range, rather than 5. In other words, “average” earns a “C”, rather than an “F.”

This approach was well received, and has been proposed in scoring the quality measures that CMS calculates using its claims data (e.g. readmission rates, admission rates for patients with chronic conditions). Aligning the scoring for claims-based quality measures with the existing claims-based cost measures is anticipated to produce similar results, meaning that an average score will no longer mean a failing grade.

The second concern was that many specialty providers still have limited measures to choose from, with a significant percentage hindered by “extremely topped out” status. These measures have such stringent benchmarks applied that providers who perform well in 99 percent of cases will only earn 2 out of 10 points.

Not surprisingly, this has scared many providers away from MVPs, as they can see that these limited selections put them at greater risk than reporting more peripheral measures using Traditional MIPS. That directly conflicts with CMS's goal of moving providers into MVPs and sunsetting Traditional MIPS. To alleviate this concern, additional measures have been proposed to receive the coveted "Alternative Benchmarking Methodology." While this proposal is still stringent, providers would still earn a score high enough to clear the MIPS Performance Threshold (proposed to remain at 75 points through the 2028 performance year), even if participating in an MVP.

These proposals and RFIs can bring significant changes to future care delivery and reimbursement, so we encourage you to participate in rulemaking. Before the 60-day comment period ends on September 12, go to http://www.regulations.gov/ and reference "CMS-1832-P" to make your voice heard.

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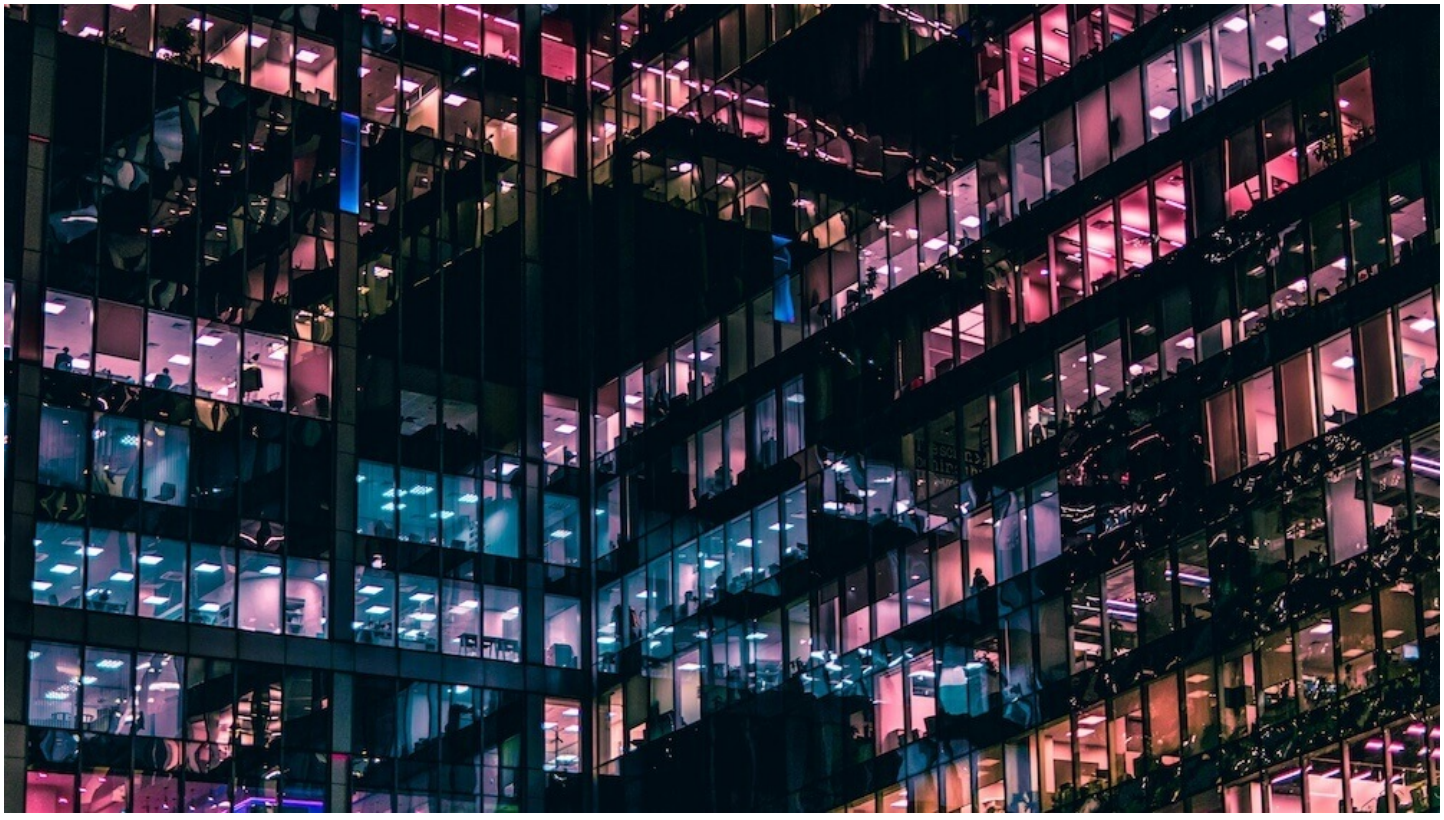
Image: iulian aghei

Roji Health Intelligence Response to CMS RFI for Health Technology Ecosystem

written by Theresa Hush | January 8, 2026



Data and technology, once simply functional assets to facilitate health care, are now a leading force for health care advancement, improvement of health care outcomes, and control of costs. Yet the panoply of technologies has not optimized information for one key actor: the patient. The Center for Medicare and Medicaid Services (CMS) is attempting to correct that problem. Its Request for Information (RFI) released on May 16, 2025 attempts to solicit a "reset" of how the informational flow between systems will work to improve the patient health status and patients' ability to make decisions. The RFI also addresses flow of data for providers to improve outcomes and delay progression of disease, and to ease the burden associated with reporting quality of care for patients.

Systems in the ecosystem include more than EHRs. Data stored in technology and analytics company applications and used by providers for clinical advancement, quality reporting, providers' business needs, and patient support are covered by the RFI.

Roji Health Intelligence has responded to the RFI in the public comment period. At the heart of our response is the goal of true and accurate information for patient and clinical decision-making, and where patients should get such information. You can read our comments here [PDF download].

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Image: Mike Kononov