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

written by Theresa Hush | April 22, 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.

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: Yi Liu