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

written by Theresa Hush | March 19, 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.

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