AHCA
AMERICAN HEALTH CARE ASSOCIATION

NCAL
NATIONAL CENTER FOR ASSISTED LIVING

WHITEPAPER

Advancing Accountable Care for Long Term Care Residents:

Recommendations from AHCA/NCAL's ACO Workgroup

February 2026

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) is committed to developing innovative solutions that advance the care and well-being of older adults and individuals with complex needs. In August 2025, AHCA/NCAL re-convened its Accountable Care Organization (ACO) Workgroup to refine and deepen its recommendations to the Centers for Medicare and Medicaid Services (CMS) on accountable care models best suited for long term care (LTC) residents. This effort built on earlier phases of work, including the development of a whitepaper[1] with the National Association of ACOs (NAACOs) and an internal deep dive into value-based care model alignment policies.

To better understand the foundation for these recommendations, the following section provides background on long term care (LTC) ACO concepts and the role of nursing facilities (NFs) and assisted living (AL) communities within these models. This paper reflects AHCA/NCAL's continued work in this area and includes further recommendations to guide CMS policy development. This whitepaper specifically aims to inform CMS as the agency finalizes the Long-Term Enhanced ACO Design (LEAD) Model by highlighting critical considerations for the integration of the LTC population into the model. CMS has stated that LEAD is designed to serve high-needs, complex patients – including homebound beneficiaries such as LTC residents. LEAD presents CMS with a unique opportunity to ensure the model fully addresses the realities of LTC settings and advances coordinated, person-centered care for residents.

1 AHCA/NCAL and NAACOS, "Considerations for Long Term Care Providers Participating in Value-Based Care Models," 2025.

Background on Long Term Care Facilities and Their Role in ACOs

Skilled nursing facilities and nursing facilities (SNF/NFs)—commonly referred to as nursing homes or nursing facilities—and assisted living (AL) communities are two examples of long term care (LTC) providers. In this whitepaper, the term LTC encompasses both nursing homes and AL communities.

Nursing facilities care for a medically complex population. The HCC risk score for long-stay nursing facility residents is two times higher than other Medicare beneficiaries.

Nursing Facilities

Nursing facilities (NFs) care for two distinct populations: short-term patients who require post-acute rehabilitation and/or skilled care following a hospital stay, and long-term (long-stay) residents who need custodial or residential care. Nursing home care is the only LTC benefit that federal law mandates state Medicaid programs to provide. Additionally, nursing homes are the only care setting where Medicaid funds both health care services and housing.

Long-stay NF residents represent a high-need, high-cost population with complex medical needs. Most have multiple chronic conditions, require assistance with three or more activities of daily living, and experience higher rates of dementia. According to MedPAC's October 2024 report, the median age of these residents is 81, with 24 percent aged 90 or older; 82 percent are eligible for Medicaid; 25 percent die within one year; and their average Hierarchical Condition Category (HCC) risk score is 2.12—more than two times the 1.01 average for other Medicare beneficiaries. These characteristics underscore that NFs provide care for a medically complex population within a licensed residential medical setting.

Within an ACO, NFs can play a critical role in managing high-need, high-cost populations through a unique model of care that differs significantly from models of care designed for community-dwelling individuals. NFs integrate 24-hour clinical oversight, NF staff, interdisciplinary care teams, and the resident's primary care provider to coordinate care transitions, reduce avoidable hospitalizations, and leverage data sharing for improved outcomes.

Assisted Living

Assisted living (AL) has evolved into a variety of models based on consumer preferences and regional differences. As a result, states take a variety of approaches in overseeing the profession and establishing standards. While assisted living is the most common term used in the nation both by the profession and state regulatory agencies, AL communities may be known by different names, including, but not limited to, residential care, personal care, and adult shared housing. AL communities typically:

- Are residential settings that provide or coordinate personal services, 24-hour supervision, assistance, and access to staff (scheduled and unscheduled), activities and health-related services;
- Promote aging in place;
- Provide person-centered care to accommodate residents' evolving health care needs and preferences;
- Maximize and foster residents' quality of life, dignity, autonomy, privacy, socialization, independence, choice, and safety based on their preferences;
- Encourage community involvement and interaction; and
- Support coordination of care with other providers.

Within an ACO, AL communities can be an important partner in population health management—helping identify early changes in residents' health status, supporting chronic disease management, and facilitating coordination with primary care and specialty providers to prevent unnecessary hospital or emergency department use.

Understanding these care models is essential to identifying the populations that could benefit most from alignment with ACOs serving LTC residents.

Current ACO models were designed primarily for community-dwelling Medicare beneficiaries and rely on clinician-centric attribution methodologies that do not reflect the realities of LTC populations.

Current ACO Models do not Fully Support LTC Residents

Current ACO models were designed primarily for community-dwelling Medicare beneficiaries and rely on clinician-centric attribution methodologies that do not reflect the realities of LTC populations. These models typically assign beneficiaries based on historical patterns of primary care utilization, which often misalign residents who have transitioned into NFs or AL communities. As a result, many LTC residents remain attributed to community-based providers who do not predominantly manage their care, creating accountability gaps and undermining care coordination. This structural misalignment is compounded by program design elements—such as benchmarking, risk adjustment, and quality metrics—that were built for ambulatory populations rather than

LTC settings, leaving LTC providers without a clear pathway to meaningful participation in ACOs and value-based care.

The consequences of these design flaws are significant. LTC residents represent one of Medicare's most medically complex and highest-cost populations, yet fewer than 10 percent of skilled nursing facilities participate in ACOs, and participation is concentrated among a small subset of organizations. Those that do participate often do so through limited affiliate arrangements that exclude them from beneficiary alignment, quality scoring, and shared savings opportunities. This disconnect means that facilities bearing primary responsibility for residents' day-to-day care lack both the visibility and financial incentives to invest in care coordination, data infrastructure, and preventive interventions. At the same time, ACOs struggle to manage these patients effectively because attribution methodologies fail to capture the providers most accountable for their outcomes.

AHCA/NCAL is raising this issue because it represents a critical barrier to achieving CMS' strategic goals of aligning financial incentives with improved health outcomes for all Medicare beneficiaries and embedding preventative care in all CMS Innovation Center models.[2] Without a model that explicitly addresses the unique needs of LTC populations, CMS risks leaving behind a segment of beneficiaries who drive disproportionate costs and require intensive, coordinated care. Expanding alignment through (for example) facility-level attribution, while simultaneously tailoring financial and quality methodologies to LTC settings, would unlock substantial opportunities for improved outcomes and cost savings for the Medicare program. Evidence from LTC participation in models such as ACO REACH and Institutional Special Needs Plans (I-SNPs) demonstrates that when financing is aligned with care delivery, avoidable hospitalizations decline and resident experience improves.[3] AHCA/NCAL believes that a defined pathway for LTC attribution and participation - or a dedicated LTC ACO track - within the LEAD model. within the LEAD model is essential to close these gaps, strengthen accountability, and ensure that value-based care fulfills its promise for one of Medicare's most vulnerable populations.

The Two Biggest Elements to Include in LEAD:

1. CMS should include Facility TIN attribution in LEAD so NFs and AL communities can manage their beneficiaries' care more efficiently and avoid fragmentation across multiple ACOs.

2. CMS should use the LTI Flag to determine eligibility for high needs LTC populations so that approximately one-third of beneficiaries currently excluded due to technical ineligibility-rather than actual need-are eligible.

2 Abe Sutton, Director of the Center for Medicare and Medicaid Innovation and Deputy Administrator for the Centers for Medicare & Medicaid Services, "CMS Innovation Center Strategy to Make America Healthy Again," May 2025.

3 ATI Advisory, "Institutional Special Needs Plan (I-SNP) Enrollment and Outcomes in Long Term Care Settings," February 2025.

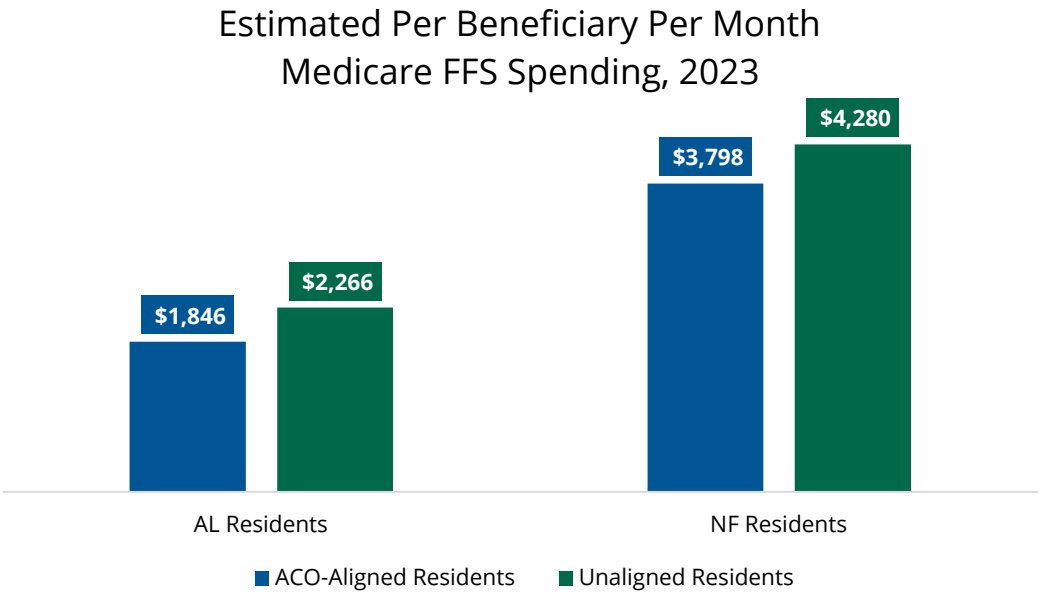
LTC Residents are a Key Population for ACO Attribution and Participation in LEAD

Recent analysis by ATI Advisory found that Medicare fee-for-service (FFS) spending for long term care residents who are aligned to an ACO is significantly lower than for those who remain unaligned (not part of an ACO), reflecting the impact of coordinated, accountable care (Figure 1).

While the differences are striking at the per-beneficiary level, they are also substantial in aggregate.

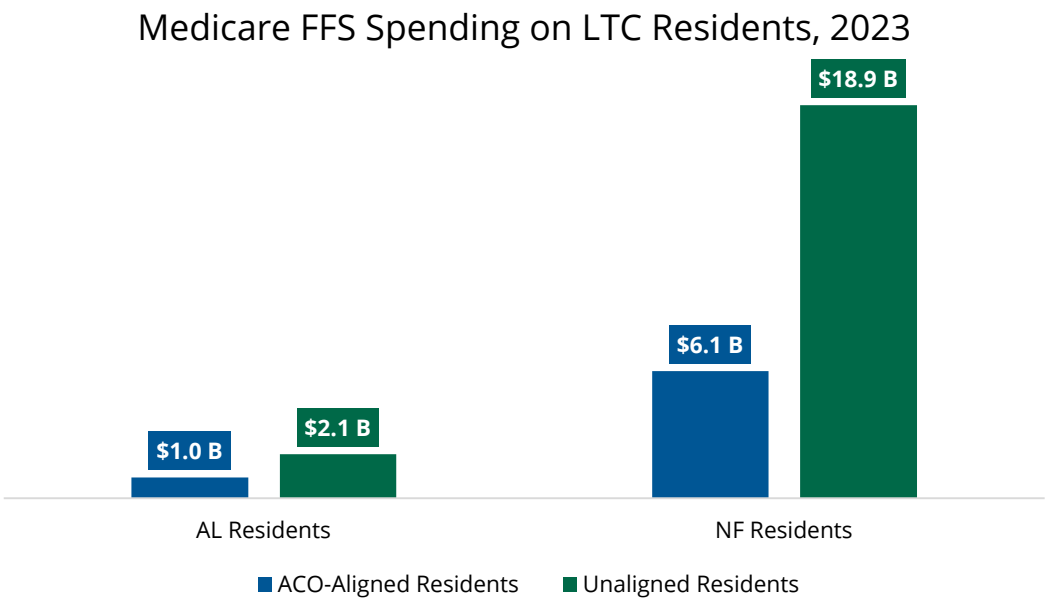
While the differences are striking at the per-beneficiary level, they are also substantial in aggregate (Figure 2). In 2023, unaligned FFS beneficiaries living in NFs incurred approximately $18.9 billion in Medicare FFS spending, compared to roughly $6.1 billion in spending on ACO-aligned FFS beneficiaries. In AL communities, unaligned FFS beneficiaries accounted for about $2.1 billion in spending, while ACO-aligned FFS beneficiaries accounted for $1.0 billion. These differences underscore the inefficiencies in current attribution models.

Figure 1



Source: ATI Advisory analysis of Medicare Minimum Data Set (MDS) data, Medicare FFS claims, the Master Beneficiary Summary File (MBSF), the OneFact Assisted Living file, and the Medicare Enrollment Database (EDB) 9-digit ZIP code file. 2023 is the most recent MDS data publicly available; ATI uses the MDS to accurately include both short-stay and long-stay patients in nursing facilities. Analysis excludes individuals who are not enrolled in both Medicare FFS Part A and Part B. Per beneficiary per month (PBPM) spending is calculated as average spending per MDS stay day (or AL community residence day) multiplied by 30 days.

Figure 2



In 2023, unaligned fee-for-service (FFS) beneficiaries living in NFs incurred approximately $18.9 billion in Medicare FFS spending, compared to roughly $6.1 billion in spending on ACO-aligned FFS beneficiaries.

Source: ATI Advisory analysis of Medicare Minimum Data Set (MDS) data, Medicare FFS claims, the Master Beneficiary Summary File (MBSF), the OneFact Assisted Living file, and the Medicare Enrollment Database (EDB) 9-digit ZIP code file. 2023 is the most recent MDS data publicly available; ATI uses the MDS to accurately include both short-stay and long-stay patients in nursing facilities. Analysis excludes individuals who are not enrolled in both Medicare FFS Part A and Part B.

These high levels of spending on unaligned beneficiaries across both AL and NF settings underscore a significant and largely untapped opportunity to better align LTC beneficiaries to ACOs and potentially drive substantial savings for the Medicare program.

Expanding ACO alignment among LTC beneficiaries directly supports CMS' stated goal in the LEAD model of building more inclusive accountable care frameworks that reach smaller, rural, and independent providers as well as organizations serving high-needs populations. LTC residents who are aligned to an ACO are disproportionately located in NFs that are rural, that serve a higher share of dual-eligible individuals, or that care for residents with greater medical and functional complexity (Table 1). Bringing these facilities into a consistent accountable care structure helps ensure that communities historically underserved by earlier ACO models—particularly those with fewer primary care clinicians, limited access to community-based services, or higher concentrations of medically complex residents—benefit from coordinated, person-centered care. LEAD's emphasis on lowering participation thresholds, broadening provider pathways, and strengthening accountability for special populations directly complements strategies to increase alignment for LTC beneficiaries, ensuring that the model reaches the very settings where the need for integrated, high-touch care is most pressing.

In addition to improving care delivery, expanding the model's reach also carries important financial implications for the Medicare program. Unaligned long term care residents living in rural, independent NFs account for $2.2 billion, or 11.5%, of the $18.9 billion in total Medicare FFS spending on unaligned NF residents (Table 3; Table 4), and 71.9% of the total Medicare spending on Medicare FFS beneficiaries in rural, independent NFs (Table 3; Table 5).[4] This concentration of high-cost, high-need individuals in settings historically outside ACO participation highlights a significant opportunity: by extending opportunities for ACO alignment to these facilities, CMS could meaningfully reduce spending while improving care continuity for some of the program's most vulnerable beneficiaries.

The same dynamic is true for AL communities, where ACO-aligned beneficiaries are more likely to reside in settings with high shares of dual-eligible or high-needs individuals and in rural communities (Table 2). Expanding ACO alignment in these settings is essential because AL residents frequently present with evolving care needs and a high risk of avoidable deterioration if coordination across providers is weak. Ensuring that these individuals have the opportunity to be brought into accountable care relationships strengthens care continuity, enhances monitoring and early identification of health changes, and creates shared incentives across LTC providers and ACOs to prevent unnecessary transitions and avoidable utilization. As CMS finalizes LEAD, expanding alignment among LTC beneficiaries will reinforce the model's broader aim of bringing the benefits of value-based care to complex, high-need populations and to the full mix of provider organizations that serve them.

4 Unaligned nursing facility residents at rural, independent nursing facilities incurred $2.2 billion in Medicare FFS spending, compared to $0.8 billion in spending at rural, independent nursing facilities for ACO-aligned beneficiaries.

Table 1

ACO-Aligned FFS Beneficiaries Are More Likely To Be in NFs That Are …	MSSP-Aligned Beneficiaries	REACH-Aligned Beneficiaries
Rural	✓	
Above the median resident length of stay	✓	
In a preferred ACO relationship		✓
In a county with high ACO penetration among all Medicare FFS beneficiaries	✓	✓
Above the median share of dual-eligible individuals		✓
Above the median share of high-needs eligible individuals	✓	✓

Table 2

ACO-Aligned FFS Beneficiaries Are More Likely To Be in AL Communities That Are …	MSSP-Aligned Beneficiaries	REACH-Aligned Beneficiaries
Rural	✓	
Above the median resident length of stay	✓	
In a county with high ACO penetration among all Medicare FFS beneficiaries	✓	✓
Above the median share of dual-eligible individuals		✓
Above the median share of high-needs eligible individuals		✓

Source: ATI Advisory analysis of Medicare Minimum Data Set (MDS) data, Medicare FFS claims, the Master Beneficiary Summary File (MBSF), the OneFact Assisted Living file, and the Medicare Enrollment Database (EDB) 9-digit ZIP code file. 2023 is the most recent MDS data available; ATI uses the MDS to accurately include both short-stay and long-stay patients in nursing facilities. Analysis excludes individuals who are not enrolled in both Medicare FFS Part A and Part B.

Table 3

Medicare FFS Spending on LTC Residents, 2023			
Nursing Facility Setting	**Unaligned NF Residents**	**ACO-Aligned NF Residents**	**Total Spending in This Setting**
Rural, Independent	$2.2 B	$0.8 B	$3.0 B
Rural, Chain-Affiliated	$1.2 B	$0.5 B	$1.7 B
Urban, Independent	$10.3 B	$3.0 B	$13.4 B
Urban, Chain-Affiliated	$5.1 B	$1.6 B	$6.7 B
Total	$18.9 B	$6.1 B	$24.8 B

Table 4

Medicare FFS Spending on LTC Residents, 2023 Spending by Setting as a % of Total Unaligned or ACO-Aligned Spending		
Nursing Facility Setting	**Unaligned NF Residents**	**ACO-Aligned NF Residents**
Rural, Independent	11.5%	14.0%
Rural, Chain-Affiliated	6.3%	8.7%
Urban, Independent	54.9%	50.7%
Urban, Chain-Affiliated	27.3%	26.6%
Total	100.0%	100.0%

Table 5

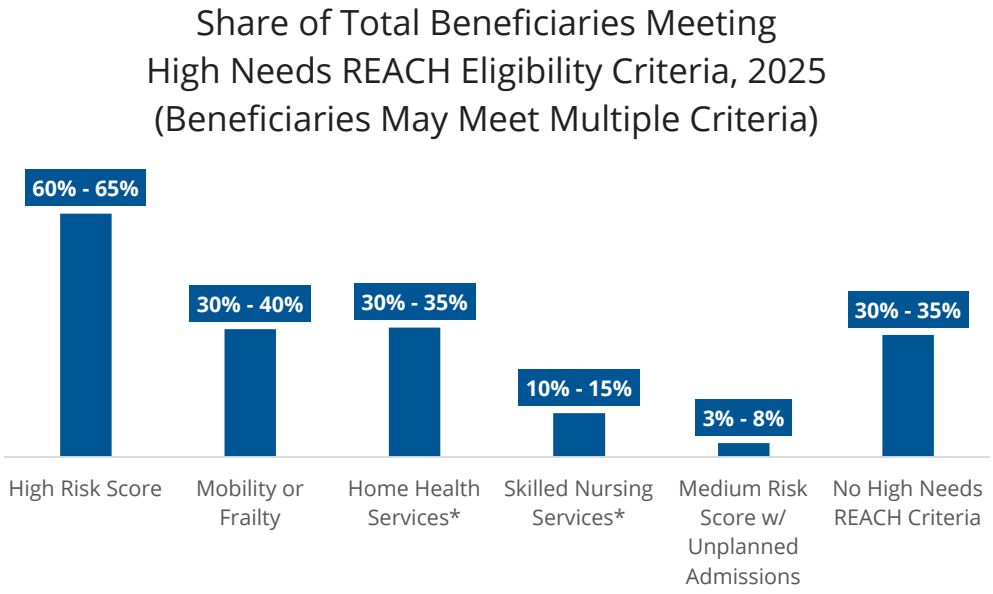
Medicare FFS Spending on LTC Residents, 2023 Unaligned and ACO-Aligned Spending as a % of Total Spending in This Setting			
Nursing Facility Setting	**Unaligned NF Residents**	**ACO-Aligned NF Residents**	**Total**
Rural, Independent	71.9%	28.1%	100.00%
Rural, Chain-Affiliated	69.2%	30.8%	100.00%
Urban, Independent	77.2%	22.8%	100.00%
Urban, Chain-Affiliated	76.2%	23.8%	100.00%

Source: ATI Advisory analysis of Medicare Minimum Data Set (MDS) data, Medicare FFS claims, the Master Beneficiary Summary File (MBSF), the OneFact Assisted Living file, and the Medicare Enrollment Database (EDB) 9-digit ZIP code file. 2023 is the most recent MDS data available; ATI uses the MDS to accurately include both short-stay and long-stay patients in nursing facilities. Analysis excludes individuals who are not enrolled in both Medicare FFS Part A and Part B. Rows and columns may not sum to row and column totals exactly due to rounding.

The High Needs track within ACO REACH was designed to capture beneficiaries with significant clinical complexity and acuity, including those with high Hierarchical Condition Category (HCC) risk scores, mobility or frailty challenges, recent use of skilled nursing services, or patterns of unplanned hospital readmissions. In theory, these criteria should encompass most LTC residents, who typically present with multiple chronic conditions, functional limitations stemming from mobility and/or frailty challenges, and elevated risk profiles. By targeting these characteristics, the High Needs track sought to align financing with care delivery for patients requiring intensive, coordinated management – precisely the population served in LTC settings.

In practice, however, the eligibility framework falls short, and a substantial share of LTC residents are not eligible for the High Needs track. Within NFs, more than 30 percent of residents fail to meet the High Needs criteria (Figure 3), largely due to systemic issues such as incomplete or low-quality coding prior to a resident's transition into an LTC setting and the inherent lag in quarterly or annual alignment processes – even for voluntary alignment. These delays create challenges, especially for Medicare beneficiaries whose health status deteriorates rapidly, leaving them unaligned during critical periods of care. Concurrent risk adjustment addresses this challenge, and CMS has indicated that LEAD will apply concurrent risk adjustment at the beneficiary level for individuals designated as High Needs. However, residents who do not satisfy these defined eligibility parameters may be omitted from concurrent risk adjustment even when their care needs are comparable. In LTC settings, this outcome is often driven by the structure and timing of eligibility requirements—rather than differences in underlying acuity—potentially creating misalignment for ACOs responsible for managing clinically complex LTC populations.

This challenge is also pronounced in AL communities, where, as the population is healthier overall, the proportion of residents excluded from High Needs eligibility is higher still. These gaps underscore the need for a dedicated LTC-focused track within future models like LEAD to ensure timely and accurate alignment for one of Medicare's most vulnerable populations.



*Source: ATI Advisory analysis of internal High Needs REACH ACO data. *CMS added the skilled nursing and home health utilization eligibility criteria to ACO REACH in PY2024, so these criteria are not reflected in analyses in this whitepaper that use 2023 data.*

Within nursing facilities, more than 30 percent of residents fail to meet the High Needs criteria, largely due to systemic issues such as incomplete or low-quality coding prior to a resident's transition into an LTC setting and the inherent lag in quarterly or annual alignment processes – even for voluntary alignment.

Increasing ACO Alignment Among LTC Residents Could Drive Substantial Savings to the Medicare Program

Even modest improvements in ACO alignment among long-stay residents could generate meaningful savings for the Medicare program. Today, ACO alignment varies widely across LTC settings, with many facilities falling far below even minimal thresholds. For example, the 25th percentile of ACO alignment within NFs is just 4.4 percent – meaning that 25 percent of NFs have fewer than 4.4 percent of their long-stay residents aligned to a Medicare Shared Savings Program or REACH ACO. If every NF achieved this modest level of ACO alignment in its LTC population, Medicare could save approximately $19 million annually, driven by the lower per-beneficiary-per-month (PBPM) spending observed among ACO-aligned residents compared to those who remain unaligned (Table 6). Similarly, if every AL community achieved 18.7% ACO alignment among their residents—the 50th percentile of ACO alignment within AL communities nationally—Medicare could save approximately $32 million annually (Table 7). These incremental gains underscore the opportunity to capture tens of millions of dollars in savings without achieving more significant ACO alignment gains.

Table 6

Nursing Facilities				
All NFs achieve at least…	4.4% of LTC residents aligned to an ACO [25th percentile]	16.4% of LTC residents aligned to an ACO [50th percentile]	47.8% of LTC residents aligned to an ACO [75th percentile]	100% of LTC residents aligned to an ACO
Savings to Medicare Program from Increasing ACO Alignment	$19.0 M	$162.5 M	$773.7 M	$2,130.5 B

Table 7

Assisted Living Communities				
All ALCs achieve at least…	0.0% of LTC residents aligned to an ACO [25th percentile]	18.7% of LTC residents aligned to an ACO [50th percentile]	66.7% of LTC residents aligned to an ACO [75th percentile]	100% of LTC residents aligned to an ACO
Savings to Medicare Program from Increasing ACO Alignment	$0.0 M	$32.0M	$205.8 M	$389.7 M

Source: ATI Advisory analysis of Medicare Minimum Data Set (MDS) data, Medicare FFS claims, and the Master Beneficiary Summary File (MBSF). 2023 is the most recent MDS data publicly available; ATI uses the MDS to accurately include both short-stay and long-stay patients in nursing facilities. Analysis excludes individuals who are not enrolled in both Medicare FFS Part A and Part B. Per beneficiary per month (PBPM) spending is calculated as average spending per MDS stay day (or AL community residence day) multiplied by 30 days.

Guiding Principles

In building tracks within the newly-announced LEAD model or creating a new model designed to address the promise of value-based care in the LTC population, AHCA/NCAL is guided by the following principles:

1. **Center a Model or a LEAD track on the LTC Population:** ACO models serving LTC residents must reflect their distinct clinical, functional, nutritional, and social needs, including those with chronic conditions, cognitive impairment, and limited mobility. These populations require care models that prioritize stability, continuity, and person-centered care.
2. **Address Systemic Gaps in Long Term and Post-Acute Care:** Focus on long-standing challenges such as fragmented care transitions, inadequate discharge planning, and poor coordination for high-need residents. Align payment incentives to support integrated, team-based care across settings.
3. **Advance Quality and Cost Efficiency:** Ensure the model improves outcomes and access while reducing avoidable hospitalizations and unnecessary spending. Prioritize underserved LTC populations and facilities with limited resources or infrastructure.
4. **Design for Diverse Provider Participation:** Recognize the wide variation in experience, capacity, and readiness among LTC providers. Include flexible entry points, phased implementation, and technical assistance to support participation by small, rural, and independent organizations.
5. **Balance Risk and Reward Thoughtfully:** Offer meaningful financial incentives while accounting for the operational realities of LTC providers. Include appropriate risk adjustment, protections for outliers, and a glide path to risk-bearing participation.
6. **Ensure Data Access and Interoperability:** Provide timely, actionable data to LTC providers and ACOs. Support technology adoption and interoperability to enable effective care coordination and performance tracking.
7. **Create a Stable and Predictable Model Environment:** Establish clear, consistent rules and financial benchmarks to build provider confidence. Allow flexibility to adapt to policy changes while maintaining core model integrity.

Guiding Principles Summary

AHCA/NCAL's framework prioritizes care models designed for the long term care population, emphasizing coordinated, person-centered care that improves quality and cost efficiency, reduces avoidable utilization, and supports diverse providers through flexible participation, balanced risk-sharing, and a stable, predictable model environment.

AHCA/NCAL'S RECOMMENDATIONS

The AHCA/NCAL ACO Workgroup proposes a number of recommendations covering a range of different value-based care topics such as alignment, financial considerations, quality, data and technology and prevention.

Attribution. The workgroup recommends that CMS implement ACO alignment via Tax Identification Number (TIN) and/or CMS Certification Number (CCN) – paired with a facility-based attribution model using the Long Term Institutional Flag and monthly roster updates – to create predictable market opportunities for nursing facilities and assisted living communities. LEAD can offer this attribution methodology as an alternative or a complementary methodology to the provider-level TIN or TIN/NPI attribution methodology currently in use in MSSP and ACO REACH, respectively. CMS already offers somewhat similar attribution methodology for Federally Qualified Health Centers (FQHCs), an important precedent.

Financial Methodology. CMS should offer flexible risk-sharing options, maintain fee-for-service (FFS) claims flow with end-of-year reconciliation, provide up-front capital, adopt ACO REACH-style benchmarking and concurrent risk adjustment, and set realistic caps to protect providers serving high-needs populations. CMS intends to offer flexible, capitated population-based payments in LEAD, which could create a pathway for this financial methodology that directly supports LTC providers and facilities.

Quality. CMS should streamline quality measurement for participating LTC settings to a core set of cross-cutting metrics, apply a predictable quality withhold with risk-adjusted measures, and ensure timely, transparent performance data across Medicare and Medicaid.

Technology and Data. CMS should incentivize interoperable technology adoption, promote resident-centered data sharing, provide technical and financial support for smaller LTC settings, and encourage technology-neutral standards to advance interoperability and reduce administrative burden.

Prevention and Chronic Disease Management. Finally, assisted living communities offer a natural setting for prevention and early intervention opportunities for lower-acuity residents, while nursing facilities focus on managing complex conditions and supporting stability, comfort, and quality of life. CMS can strengthen this continuum by expanding payment and quality incentives for AL-based prevention and wellness and by advancing coordinated chronic disease management models that link hospitals, primary care, and LTC

providers, aligning perfectly with CMS' stated goal of improving the integration of care for special populations, including patients with complex needs and dually eligible beneficiaries.

The workgroup's full recommendations are as follows:

ATTRIBUTION

Medicare beneficiaries residing in LTC settings, both NF and AL, have unique care patterns that are not well-aligned to value-based care model attribution approaches based on historic utilization of care. Their reliance on facility-based providers, episodic specialty care, and limited access to community-based primary care services means that traditional attribution methodologies may not accurately reflect the clinicians most responsible for their overall care. In addition, LTC settings often lack visibility into which residents are attributed to an ACO and how to coordinate with multiple accountable entities, limiting effective care management and creating accountability challenges. ATI Advisory's analysis indicated that 75.4% of NFs had two or more MSSP or REACH ACOs managing Medicare FFS spending for their LTC residents (Figure 4). The presence of multiple ACOs across their population within the same facility detracts from the facility's ability to effectively manage care and contributes to administrative burden. Within the LEAD model framework, CMS has several opportunities to update the ACO attribution methodology to fully support LTC Medicare beneficiaries and LTC organizations. As CMS finalizes the LEAD model and other Innovation Center initiatives, incorporating these recommendations will be critical to closing persistent gaps in accountability and ensuring that LTC residents—one of Medicare's most medically complex and highest-cost populations—are fully integrated into value-based care.

- A distinct model or different tracks within LEAD and other value-based care models would be appropriate to accurately align LTC populations. Tailored tracks could account for their higher acuity, specialized care needs, and reliance on long-term services and supports, ensuring that attribution reflects the providers truly responsible for their care. This approach would also allow quality measures and financial benchmarks to be better calibrated to the realities of LTC populations.
- CMS should attribute LTC residents based on the facility's TIN and/or CCN. To avoid mis-attributing short-stay residents, eligibility for LTC attribution would be limited to those the Long Term Institutional (LTI) Flag, which used by CMS to identify all nursing home residents residing or expected to reside for 90 days or more. In addition, for participating facilities, CMS can refresh the LTI Flag patients each month—as is done with I-SNPs—producing an iterative roster of participating beneficiaries. Beneficiaries would either be added or removed (death or facility change) on a monthly basis, creating the most accurate possible eligibility list. Primary care practitioners who continue to care for LTC residents would be encouraged to maintain their designation as a preferred provider.

- This would create clearer accountability for both the facility and the primary care clinician, while reducing the misattribution in claims-based alignment that stems from fragmented or infrequent community-based care. This attribution approach would also create clear financial incentives for facilities to invest in care coordination and managing the health of their residents. By consolidating attribution under a single accountable entity, facilities could invest in care coordination, technology, and preventive interventions that improve quality (such as reducing avoidable hospitalizations).
- This updated alignment methodology would also address NFs' concerns with voluntary alignment. Although voluntary alignment is popular within the ACO REACH model, the majority of LTC residents experience physical or cognitive impairments, which makes voluntary alignment an imperfect substitute for claims-based alignment.

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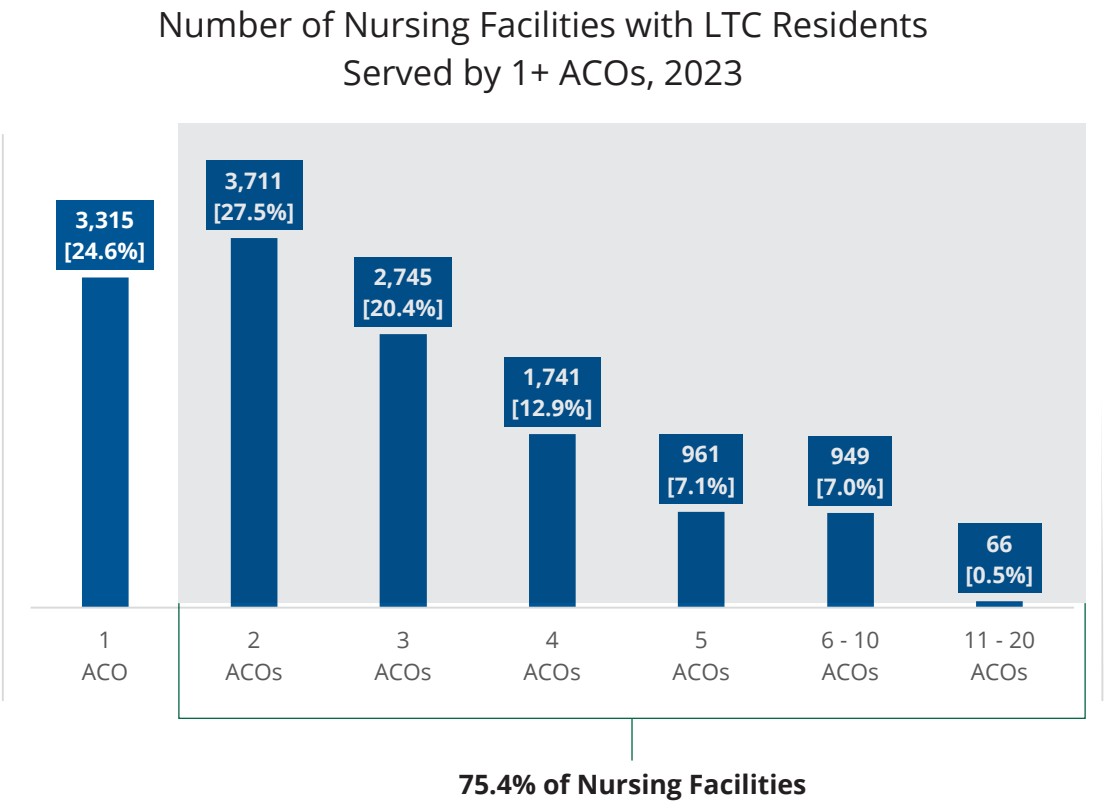
Figure 4



Source: ATI Advisory analysis of Medicare Minimum Data Set (MDS) data, Medicare FFS claims, and the Master Beneficiary Summary File (MBSF). 2023 is the most recent MDS data available; ATI uses the MDS to accurately include both short-stay and long-stay patients in nursing facilities. Analysis excludes individuals who are not enrolled in both Medicare FFS Part A and Part B.

- Facility-level attribution, coupled with use of the LTI flag, would also address concerns that NF residents who are appropriately aligned to an ACO—but who do not meet the prescriptive High Needs eligibility criteria—may not receive concurrent risk adjustment under LEAD. CMS has indicated that LEAD will include concurrent risk adjustment at the beneficiary level for beneficiaries classified as High Needs; however, in LTC settings, failure to meet these criteria often reflects technical eligibility limitations, coding lags, or timing of assessment rather than a lack of clinical complexity. Without a facility-based attribution approach, ACOs focused on caring for high-needs LTC populations could be negatively impacted when residents with comparable acuity fall outside the High Needs definition and are excluded from concurrent risk adjustment. Anchoring attribution to the facility and the LTI flag would help ensure that all long-stay residents for whom the ACO is accountable are included within an appropriately risk-adjusted financial framework, preserving model integrity and avoiding disincentives to serve medically complex LTC populations.

By reducing the threshold from the traditional 5,000-beneficiary minimum, CMS will remove a major barrier for smaller providers and rural facilities that serve dispersed populations, enabling them to participate in accountable care arrangements without needing to aggregate large panels across multiple geographies.

CMS could combine this updated attribution methodology with the lower minimum attribution requirements in the LEAD model. These lower requirements, coupled with other LTC-focused methodological changes, will strengthen access to comprehensive primary care among the LTC population in rural and underserved areas. By reducing the threshold from the traditional 5,000-beneficiary minimum, CMS will remove a major barrier for smaller providers and facilities that serve dispersed populations, enabling them to participate in accountable care arrangements without needing to aggregate large panels across multiple geographies. Second, by making participation feasible for these organizations, CMS would create incentives for ACOs and risk-bearing entities to focus on rural and underserved markets rather than concentrating exclusively in dense urban areas where critical mass is easier to achieve. This shift would expand the reach of value-based care and ensure that LTC residents in historically overlooked communities benefit from coordinated, high-quality accountable care. CMS may need to implement policies related to attribution in the event of a change in facility ownership or other TIN-related changes. These policies could help maintain stability in beneficiary assignments and prevent inappropriate shifts in accountability during organizational transitions, while simultaneously minimizing incentives for operators to restructure entities to avoid participation.

FINANCIAL METHODOLOGY

Risk-sharing arrangements must account for the diverse capacities of both NF and AL providers to assume financial accountability for their patient populations. Models such as ACO REACH expose participants to full global risk for the total cost of care (TCOC), while others, such as the MSSP, offer partial or phased pathways into two-sided risk. Providing multiple entry points, including no risk, partial risk, and full risk options, would create a more inclusive framework that allows providers to select arrangements consistent with their risk tolerance and experience while still advancing the transition to value-based care. The upcoming LEAD Model retains similar global and professional

risk-sharing options as ACO REACH, reinforcing the importance of offering multiple risk pathways rather than a single mandatory approach for providers with varying levels of financial readiness. A structured glide path into higher levels of risk may also help to engage a greater number of providers and prevent "ACO squatting" in other models.

- Payment mechanisms must balance administrative feasibility with incentives that promote provider participation and patient care. Models including ACO REACH maintain traditional fee-for-service (FFS) claims flow but include optional partial capitation and advance payment elements for certain primary care services. These payment structures can add administrative complexity and require infrastructure that may not be effectively translated into facility-based settings, where care is delivered by multidisciplinary teams rather than by individual PCPs. A payment approach that maintains FFS claims flow with end-of-year reconciliation, similar to the MSSP model, would better align incentives with facility-based care delivery, preserve accountability, and minimize administrative burden. CMS could incorporate this payment approach into the flexible, capitated population-based payments it will offer in LEAD.
- Any payment model should also address up-front and advanced capital in a way that supports infrastructure investment without creating insurmountable barriers for providers. Offering the option of up-front capital can help organizations build the systems necessary to manage risk, but should not be mandatory. At the same time, establishing minimum capital requirements, scaled to provider size and type, would demonstrate program credibility and ensure participants can absorb losses. Separating eligibility standards from payment mechanisms will help maintain flexibility while protecting the integrity of the Medicare program.
- Benchmarking should be modeled closely on the current High Needs ACO REACH risk adjustment approach, which works effectively because it couples historical lookback with concurrent risk adjustment. Preserving concurrent risk adjustment and avoiding overly restrictive caps is essential, as any change to this element would significantly distort benchmarks and disadvantage providers serving high-needs patients. To improve accuracy, benchmarks should use a shorter one- or two-year lookback period, incorporate both regional and national adjustments, and utilize population adjustments to enhance the accuracy of risk adjustment and reimbursement processes. This approach would ensure fairness for beneficiaries who may have been low-cost in the community but later experienced a debilitating event that led to high-cost facility-based care. As CMS further develops benchmarking and risk adjustment approaches under LEAD and other Innovation Center models, coordination across models will be important to ensure that facility-based accountable care models can align with, but are not constrained by, methodologies designed for different provider types and care settings.
- Risk adjustment should remain closely aligned with the concurrent model used in ACO REACH, which better reflects changes in patient acuity over time. While both MSSP and ACO REACH currently cap how much a beneficiary's risk score can rise or

Benchmarking should be modeled closely on the current High Needs ACO REACH risk adjustment approach, which works effectively because it couples historical lookback with concurrent risk adjustment.

fall, preserving flexibility in this methodology is essential to avoid disadvantaging providers serving high-needs populations. In ACO REACH, voluntarily aligned beneficiaries are uncapped for their first 12 months before a cap is applied, whereas Medicare Advantage does not utilize caps whatsoever. To balance program integrity with fairness, caps should remain in place but be set at levels that realistically account for acuity changes.

Core measures for LTC-focused ACOs should include inpatient hospitalizations, hospital readmissions, emergency department visits, discharge to community, successful return to home, pressure ulcers, falls with major injury, and functional status, metrics that capture both cost and resident experience impacts.

QUALITY

The recommendations below refer to quality measurement for an LTC-focused ACO serving Medicare beneficiaries living in AL and NF settings—not to the AL or NF settings themselves, nor to the creation of new federal quality measures for AL providers or communities.

- For an LTC-focused ACO caring for Medicare beneficiaries residing in AL and NF, quality measurement should prioritize a concise, meaningful set of population and setting relevant, cross-cutting metrics already used across CMS programs such as ACO REACH, MSSP, I-SNP, and other reporting metrics. Core measures should include inpatient hospitalizations, hospital readmissions, emergency department visits, discharge to community, successful return to home, pressure ulcers, falls with major injury, and functional status, metrics that capture both cost and resident experience impacts. Prioritizing these shared outcomes would promote consistent care coordination through stronger discharge planning (as appropriate), medication reconciliation, and communication between acute care, post-acute care, and LTC settings. Aligning reporting around this common measure set, while leveraging digital quality and interoperability initiatives, would streamline data collection, reduce duplicative reporting, and ensure that quality measurement supports the CMS' broader goals. Ultimately, providers that demonstrate strong performance on these core process and outcomes measures will be well positioned to succeed in value-based care models, as these metrics reflect both the quality-of-care delivery and the overall health outcomes of residents.
- AL communities do not have federally standardized quality measures given their state-based regulatory structure and social model orientation. These recommendations do not propose federal quality measures for AL communities. Instead, they highlight the need for a future ACO-level framework that respects the variety in AL, avoids federal standardization, and focuses on process measures appropriate for an ACO managing Medicare beneficiaries living in AL—not quality requirements for AL providers as facilities.
- A future LTC ACO model, such as a specialized High Needs track within LEAD, should incorporate a predictable quality withhold—similar to the ACO REACH withhold—to create a transparent and consistent incentive structure. Unlike MSSP's variable shared savings adjustments, a fixed withhold paired with a high-performer pool

would directly reward measurable quality without adding uncertainty to payment streams. This approach recognizes the resource limitations in post-acute care settings, ensuring accountability without penalizing providers who serve high-acuity, low-income populations. Quality measures within the model should include risk adjustment for social need and geographic factors to ensure fair comparisons and reflect the realities of diverse resident populations.

- To strengthen accountability, CMS should ensure that LTC and AL participants in LEAD or ACOs receive timely, transparent data on resident attribution, quality performance, CMS Administered Risk Arrangements (CARA) or shadow bundles, and readmission patterns. The recommended ACO design would overlay Medicaid services on top of LEAD's structure, creating a unified framework for managing both programs' populations. This approach would streamline reporting across Medicare and Medicaid components, align performance feedback with actual care responsibility, and improve coordination between facility-based and community-based providers, including specialist providers partnering with ACOs under CARAs.

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TECHNOLOGY AND DATA

- The Centers for Medicare and Medicaid Innovation (CMS Innovation Center) should promote technology standards that enable participation across all facility types while focusing on incentives rather than mandates. LTC providers lag in data maturity due to their exclusion from past Electronic Health Record (EHR) incentive programs, limiting their ability to exchange data and coordinate care. CMS Innovation Center can encourage the adoption of appropriate, scalable technology solutions such as FHIR®-based systems for nursing homes and simplified or modular reporting tools for AL communities to ensure LTC providers can participate in data-driven models. The recently announced Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model highlights a potential opportunity to apply condition-focused, technology-enabled, outcomes-based approaches that could be adapted to LTC populations. The ACCESS Model prioritizes alignment and usability rather than prescriptive technology requirements, creating incentives that improve interoperability, reduce administrative burden, and expand real-time data exchange across care settings.
- CMS Innovation Center should ensure that future models use resident-centered data to improve care coordination, quality measurement, and transparency. Many long term and post-acute care providers lack timely access to CMS data on attribution, outcomes, and follow-up care, hindering coordination and extending patient stays. Future models should emphasize meaningful data sharing that links skilled nursing facilities (SNFs), NFs, and ACOs in real time and incorporate resident-centered measures such as functional status, satisfaction, and self-management outcomes. Integrating wearable and remote monitoring data into these systems would align with CMS Innovation Center's Pillar 2 goals of empowering patients, promoting

prevention, and enabling continuous improvement through timely feedback and transparent performance monitoring.

- CMS should provide targeted technical assistance and financial supports to help smaller and non-medical facilities participate in health information exchange. Many LTC providers face cost and capacity barriers to adopting certified EHR systems or joining Health Information Exchanges (HIEs). CMS should offer technical and financial support to help these providers connect through existing exchange networks or certified interfaces, ensuring they can share data securely and efficiently.
- CMS should promote technology-neutral standards and flexibility to encourage participation and reduce administrative burden across settings. Existing frameworks such as the Trusted Exchange Framework and Common Agreement (TEFCA) create opportunities for smaller and non-medical facilities to share health data securely without requiring full EHR certification. CMS should encourage technology-neutral standards that allow AL and community-based providers to adopt right-sized digital tools rather than hospital-grade systems, maintaining accountability for outcomes while preserving innovation. Promoting flexibility in how facilities connect and report would foster interoperability across diverse care environments and advance CMS' goals of operational efficiency and data-driven care coordination.

CMS should provide targeted technical assistance and financial supports to help smaller and non-medical facilities participate in health information exchange.

PREVENTION

AL communities can serve as a critical site for prevention within long term care. AL residents typically have lower clinical acuity and greater functional independence, making these settings well-suited for identifying and addressing health issues before they progress to conditions requiring skilled nursing care or hospitalization. Preventive efforts delivered in AL communities—such as proactive care coordination, medication management, fall prevention, chronic disease monitoring, and early intervention for behavioral or cognitive changes—can help residents maintain their health and independence longer. Integrating AL communities into an LTC ACO model strengthens the continuum of care by emphasizing prevention and wellness upstream, thereby reducing downstream utilization of higher-cost services.

In contrast, NFs generally focus on managing residents with more complex medical and functional needs, often after a significant health event or hospital stay. For a long-stay resident, the average length of stay (LOS) in a NF is approximately two years. Given the prevalence of chronic conditions and significant comorbidities, care priorities center on maintaining function and enhancing quality of life. Improvement potential is constrained as disease progresses, making restorative gains modest at best. Care delivery in these settings emphasizes stability, comfort, and dignity rather than recovery.

- CMS should expand quality and payment incentives that reward prevention, lifestyle interventions, and sustained wellness across LTC settings. The agency has already begun moving in this direction through the administration's Make America Healthy Again (MAHA) efforts and recent Benefit Enhancements (BE) within LEAD. These

incentives should reward care teams that integrate nutrition counseling, exercise programs, and digital wellness tools into care planning, while avoiding prescriptive participation requirements that could disadvantage smaller facilities. Allowing flexibility in how providers incorporate these interventions would encourage broader adoption and ensure that both AL and NFs can tailor prevention strategies to their populations. As CMS advances prevention and wellness-focused approaches through technology-enabled models such as the ACCESS Model—and signals further alignment through additions like the Medical Nutrition Therapy BE and the Chronic Disease Prevention Reward and Substance Access Beneficiary Engagement Incentives (BEIs)—coordination across models will be essential to ensure that lessons on condition management, digital tools, and outcomes-based incentives inform LTC settings without imposing one-size-fits-all participation or reporting requirements.

Given the prevalence of chronic conditions and significant comorbidities, care priorities center on maintaining function and enhancing quality of life.

- CMS should design coordinated chronic disease management incentives that link hospitals, primary care, and LTC settings around prevention and continuity of care, building on steps the agency has already taken through MAHA and the new preventive-focused BE and BEI additions in LEAD. LTC providers often operate in silos despite being central to managing high-need, high-cost populations. CMS should align incentives that connect hospitals, primary care, and LTC settings through shared accountability for chronic disease management, including use of care coordination payments or per-member-per-month (PMPM) models that support wellness and early intervention. These recent signals from CMS demonstrate growing openness to models that encourage timely data sharing, smoother transitions, and stronger partnerships across settings—advancing an infrastructure that supports sustained health and prevents avoidable deterioration.

Conclusion

LTC populations present a meaningful opportunity for attribution within value-based care models due to the unique circumstances of the facility setting. Traditional attribution and alignment methods often misalign accountability, creating barriers to care coordination and increasing administrative burden. A facility-based alignment approach anchored to the Long Term Institutional Flag would better reflect care responsibility and reduce misattribution.

These recommendations offer a strategic pathway to advance value-based care in long term settings, directly aligning with the administration's goals of expanding accountable care to broader populations, fostering market competition, and driving innovation in care delivery. These proposals strengthen the integration of quality and data, promote prevention strategies for high-need, high-cost beneficiaries, and generate Medicare savings. It is critical that CMS ensure payment models reflect the complexity of specialized populations rather than defaulting to frameworks designed for community-dwelling individuals. Ultimately, CMS has the opportunity to create a distinct LTC-focused

track in LEAD that aligns financial, clinical, and quality goals with the realities of long term care, advancing the shift towards accountable care relationships for all Medicare FFS beneficiaries.