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Rural Policy Brief

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RHCs and CAHs Participating in the Medicare Shared Savings Program (MSSP): Characteristics of the Providers and Communities

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Background and Purpose

The Medicare Shared Savings Program (MSSP) is the largest value-based payment health program in the U.S., linking provider payments with improved performance in high-quality care delivery and saving Medicare almost $2 billion in 2022.[1] The Centers for Medicare & Medicaid Services (CMS) utilizes the program as a foundational framework to develop and test new Accountable Care Organization (ACO) models.[2] Since MSSP's implementation, CMS has implemented changes to the program to broaden its appeal and its impact. For example, in 2024 MSSPs were able to receive Advanced Investment Payments (AIP) aimed at rewarding ACOs that deliver quality care to dually eligible and other underserved populations, including those who live in rural areas.[2,3]

The Flex Monitoring team reported that there were 1,369 CAHs in October 2024.[4] and CMS reports that there were over 5,360 RHCs in the fourth quarter of 2024[5]. RHCs and CAHs are eligible to participate in the Shared Savings Program by establishing a new, or joining an existing, ACO. Partly as a result of adding AIP, there has been a 27 percent increase since 2023 in the number of Federally Qualified Health Centers (FQHCs), RHCs, and CAHs participating in the MSSP.[3] The purpose of this brief is to describe characteristics of RHCs and CAHs currently participating in the MSSP and the communities they serve, which will help identify locations and provider characteristics for further growth of the model.

Key Findings

- In 2023, approximately one-third of RHCs (35.9 percent) and CAHs (33.4 percent) participated in MSSP.
- Provider-based RHCs had a much higher participation rate in MSSP (42.7 percent) compared to free-standing RHCs (23.3 percent).
- One quarter (25.1 percent) of CAHs participating in MSSP are located in metropolitan counties, whereas 18.5 percent of CAHs not participating in MSSP are located in metropolitan counties.
- CAHs and RHCs participating in MSSP are larger (have larger staff sizes and more patient encounters) and have better finances (larger revenue and lower expenses) than those not participating in MSSP.
- CAHs participating in MSSP are more likely to be in counties with higher household incomes and larger Medicare enrollments.

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Data and Methods

Data from the 2023 Preliminary[a] CMS MSSP Provider-Level Research Identifiable File (RIF) were used to identify RHCs and CAHs participating in MSSP. American Hospital Association (AHA) Annual Survey data from 2022[6] (the latest available at the time of analysis) and Hospital Cost Report Data[7] from 2022 and 2021 were used to characterize CAHs. CMS Provider of Services (POS) data[8] from 2023 and Rural Health Center Cost Report Data[9] from 2021 and 2022 were used to characterize RHCs. AHA, POS, and Cost Report records were linked to the RIF data using the CMS provider number. Data to describe the characteristics of counties in which RHCs and CAHs are located were obtained from the American Community Survey (ACS)[10] 2018-2022 5-year estimates and CMS Medicare beneficiaries and Medicare Advantage enrollment files for 2023.[11]

RHCs are intended to increase access to primary care in rural communities and can either be provider-based or free-standing. Provider-based RHCs are owned and operated under the licensure, governance, and professional supervision of a larger healthcare organization such as a hospital or nursing home. Most provider-based RHCs are hospital-owned[12] and report their financial data to CMS in specific parts of their parent provider cost report. Free-standing RHCs (also referred to as Independent RHCs) are owned by a provider or a provider entity, but do not qualify for, or have not sought, provider-based status.[12] Free-standing RHCs file cost reports either indivdually or as part of a consolidated report (when multiple free-standing RHCs are owned by a single entity).

Classification of county locations of RHCs and CAHs was based on 2023 Rural-Urban Continuum Codes (RUCC)[13]: metropolitan (1,2,3); nonmetropolitan (4-9). Note that there are CAHs and RHCs located in metropolitan counties. This may be because the facility is in a rural part of a large metropolitan county or because the facility is in an area that was considered nonmetropolitan at the time of establishment. The analysis includes all RHCs and CAHs in the nation; no sampling was employed. Therefore, tests of statistical significance in the findings are irrelevant and not reported.

Findings

The CMS RIF data showed a total of 2,240 free-standing and provider-based RHCs participating in ACOs at the start of 2023. But POS data could not be identified for 11 of the RHCs (3 free-standing, 8 provider- based). Further, POS data indicated that 346 of the RHCs had been terminated. This left a total of 1,883 RHCs participating in MSSP in the analysis. CMS RIF data indicated 457 CAHs participating in MSSP, but both POS and AHA data indicated that three of those had closed prior to 2023. This left a total of 454 CAHs participating in MSSP in the analysis.

In 2023, 33.4 percent of CAHs were participating in the MSSP (Table 1), which is similar to the rate of participation for RHCs (35.9 percent). Provider-based RHCs (42.7 percent) were much more likely to participate in the MSSP than were free-standing RHCs (23.3 percent).

[a] CMS prepares the MSSP Provider-Level RIF on an annual basis. Preliminary data provides ACO information that reflects membership and conditions at the beginning of the performance year and is typically available in January at the beginning of the performance year. 'Final' data is typically not available until the Fall following the completion of the performance year.

Table 1. CAH and RHC Participation in MSSP, 2023

	CAH (n=1,361)	RHC		
		Total (n=5,252)	Free-standing (n=1,864)	Provider- based (n=3,388)
In MSSP	454 (33.4%)	1,883 (35.9%)	435 (23.3%)	1,448 (42.7%)
Not in MSSP	907 (66.6%)	3,369 (64.1%)	1,429 (76.7%)	1,940 (57.3%)

Data source: CMS ACO Provider RIF 2023, CMS Provider of Services file 2023Q1.

Critical Access Hospitals

Table 2a displays the characteristics of CAHs based on their MSSP participation status. Compared to CAHs not participating in MSSP, participating CAHs are most likely to be nongovernmental not-for-profit entities, less likely to be non-Federal governmental entities, and more likely to be members of a system. They are slightly more likely to maintain a separate nursing-home unit, more likely to have an RHC, and more likely to have swing beds.

Table 2a. CAH Characteristics by MSSP Participation, 2023*

	In MSSP (n=454)	Not in MSSP (n=907)
Metropolitan/Nonmetropolitan Location**		
Metropolitan	114 (25.1%)	168 (18.5%)
Nonmetropolitan	340 (74.9%)	739 (81.5%)
Hospital Control		
Gov., Federal	0 (0.0%)	10 (1.1%)***
Gov., non-Federal	134 (29.5%)	386 (42.8%)
Investor-owned	16 (3.5%)	41 (4.5%)
Nongov. Not For Profit	304 (67.0%)	466 (51.6%)
System Member	264 (58.2%)	373 (41.2%)
Maintains separate nursing-home unit	70 (15.4%)	101 (11.2%)
Owns RHC	332 (73.1%)	609 (67.4%)
Has Swing Beds	313 (68.9%)	553 (61.2%)

* AHA data (Control, System, Nursing Home) was not available for 4 CAHs.
** Based on RUCC assigned to county of CAH location. Note that 66.0% of the 282 CAHs in a metropolitan county are in a ZIP code classified as nonmetropolitan by RUCA code (i.e., RUCA >3).
***AHA data identifies 10 CAHs under Federal Government control. All participate in Indian Health Service.
Data source: CMS ACO Provider RIF 2023, CMS Provider of Services file 2023Q1, AHA 2022 Annual Survey.

Table 2b displays additional CAH characteristics based on MSSP participation. CAHs participating in MSSP have larger employee pools (both physicians and overall), more admissions, inpatient stays, and ED and outpatient visits. Finally, they average more revenue (both in- and outpatient) and have higher operating expenses and net income. Overall, in 2023 the CAH median operating margin (the percentage of revenue the CAH keeps as operating profit) is negative (-6.92, data not shown) but CAHs participating in MSSP have a better operating margin than CAHs not participating in MSSP.

Table 2b. CAH Characteristics by MSSP Participation, 2023

	In MSSP Median / IQR* (n=454)		Not in MSSP Median / IQR* (n=907)	
Acute Care Beds	25.0	20 - 25	25.0	17 - 25
All Beds	25.0	23 - 25	25.0	21 - 25
Phys/Dent. FTE	4.0	0 - 9	2.0	0 - 7
Total FTE	158.0	109 - 255	144.5	87 - 237
Privileged Phys.	4.0	1 - 7	3.0	0 - 5
Admissions	432.5	253 - 728	367.0	181 - 696
Inpatient Days	3,092.0	1,780 - 5,914	2,583.0	1,376 - 5,252
ED Visits	5,207.5	3,221 - 9,355	4,183.0	1,907 - 8,382
Outpatient Visits	36,838.5	20,984 - 64,017	27,471.0	13,481 - 55,105
Total Inpatient Revenue *(x$1000)*	$9,225	$5,222 - $17,524	$7,500	$3,487 - $16,436
Total Outpatient Revenue *(x$1000)*	$52,903	$29,213 - $94,185	$34,220	$14,988 - $76,450
Total Operating Expenses *(x$1000)*	$32,241	$21,13 - $50,528	$25,775	$15,238 - $45,618
Net Income *(x$1000)*	$1,180	-$369 - $3,762	$532	-$866 - $2,510
Operating Margin	-4.10%	-11.96% - 2.24%	-9.46%	-22.28% - -0.53%

* IQR is the Interquartile Range – it is an indicator of the spread of responses showing the 25th and 75th percentiles of the data distribution.
Data source: CMS ACO Provider RIF 2023, CMS Provider of Services file 2023Q1, AHA 2022 Annual Survey, Hospital Cost Report Information System 2021-2022.

Data from the ACS were used to compare the characteristics of counties with CAHs participating in MSSP and other counties with at least one CAH but none participating in MSSP. In comparison to counties without an MSSP CAH, counties with CAHs participating in MSSP have a slightly larger populaton, a higher proportion of White persons, a slightly smaller proportion of population with less than a high school degree, and a slightly higher median household income. The proportion of elderly with a disability is slightly lower in counties with CAH MSSP participation compared to those without a participating CAH. These findings are detailed in appendix Table A1.

Rural Health Clinics

Slightly more than one-third (35.9 percent) of all RHCs participate in the MSSP (Table 1). Table 3a displays the characteristics of RHCs based on their MSSP participation status. Overall, RHCs participating in MSSP are most likely to be not-for-profit entities and less likely to be proprietary or government entities (Table 3a). But that difference is driven by the very high proportion of MSSP-participating provider-based RHCs that are nonprofit entities. Among free-standing RHCs participating in MSSP, the largest proportion are proprietary entities.

The largest percentage (59.4 percent) of provider-based RHCs are owned by CAHs. CAH-owned RHCs (provider based) are slightly less likely to participate in MSSP than RHCs owned by other short-term hospitals (Table 3b). POS data for 1,400 provider-based RHCs showed that 97.8 percent had a parent provider organization (e.g., hospital) participating in MSSP (note that a parent provider organization may own more than one RHC, data not shown).

Table 3a. RHC Characteristics by MSSP Participation, 2023

	Overall (n=5,252)		Free-standing (n=1,864)		Provider-based (n=3,388)	
	In MSSP (n=1,883)	Not in MSSP (n=3,369)	In MSSP (n=435)	Not in MSSP (n=1,429)	In MSSP (n=1,448)	Not in MSSP (n=1,940)
Metropolitan/Nonmetropolitan*						
Metropolitan	459 (33.5%)	911 (66.5%)	139(22.1%)	490(77.9%)	320(43.2%)	421(56.8%)
Nonmetro.	1,424(36.7%)	2,458(63.3%)	296(24.0%)	939(76.9%)	1,128(42.6%)	1,519(57.4%)
RHC Control						
Government	280 (14.9%)	618 (18.3%)	9 (2.1%)	53 (3.7%)	271 (18.7%)	565 (29.1%)
Nonprofit	1,208 (64.1%)	1,339 (39.7%)	175 (40.2%)	192 (13.4%)	1,033(71.3%)	1,147 (59.1%)
Proprietary	395 (21.0%)	1,412 (41.9%)	251 (57.7%)	1,184 (82.9%)	144 (9.9%)	228 (11.8%)

* Based on RUCC assigned to county of RHC location.
Data source: CMS ACO Provider RIF 2023, CMS Provider of Services file 2023Q1.

Table 3b. Provider-based RHC Ownership by MSSP Participation, 2023

Ownership	Overall (n=3,388)	In MSSP (n=1,448)	Not in MSSP (n=1,940)
CAH	2,014 (59.4%)	817 (56.4%)	1,197 (61.7%)
Short-term Hospital	1,230 (36.3%)	573 (39.6%)	657 (33.9%)
Other	144 (4.3%)	58 (4.0%)	86 (4.4%)

Data source: CMS ACO Provider RIF 2023, CMS Provider of Services file 2023Q1.

Table 4 displays the characteristics of free-standing and provider-based RHCs by their MSSP participation status. The characteristics displayed are from CMS Cost Report data (free-standing RHCs file independent cost reports, while provider-based RHCs identify costs in specific parts of their parent provider [usually a hospital] cost report). Note that RHCs that are part of the same organization (e.g., multiple provider-based RHCs owned by a single hospital, or multiple free-standing RHCs owned by a single entity) can elect to file consolidated reports. Therefore, the numbers in this table are smaller than seen in prior tables.

RHCs (both free-standing and provider-based) in MSSP are, with very few exceptions, larger than RHCs not in MSSP as measured by fulltime-equivalent staff positions (FTEs), visits, and expenses.

Table 4. RHC Characteristics by MSSP Participation, 2023

	Free-standing (n=1,457)		Provider-based (n=2,850)	
	In MSSP (n=348)	Not in MSSP (n=1,109)	In MSSP (n=1,149)	Not in MSSP (n=1,701)
Median Personnel FTE				
Physician	1.00	0.85	1.04	0.93
NP	1.41	1.40	1.00	1.00
PA	0.89	0.84	0.80	0.75
RN*	1.00	1.00	1.68	1.00
Clin. Psychol.	0.58	0.38	0.49	0.39
Clin. Soc. Wk.	0.56	0.35	0.50	0.39
Total FTE	2.99	2.09	2.38	2.07
Median Number of Visits				
Physician	3,865	2,834	3,896	3,105
Svcs. under agree**	456	487	439	541
NP	4,071	4,421	2,911	2,847
PA	2,779	2,705	2,204	2,002
RN*	1.00	1.00	245	866

Clin. Psychol.	535.50	292	434	516
Clin. Soc. Wk.	604	333	465	404
Total	8,715	7,072	7,377	6,469
Median Expenses				
Administrative	$583,984	$502,210	$223,896	$166,193
Facility	$130,618	$96,086	$45,461	$33,121
Non-reimbursables	$7,898	$5,087	$13,147	$10,317
Total overhead	$723,888	$608,434	$282,757	$212,954
Services	$745,670	$350,663	$1,002,318	$920,883
Staff	$826,802	$444,042	$820,287	$729,948
Total	$1,546,089	$1,044,688	$1,366,943	$1,184,107

* Hospital cost report data for provider-based RHCs provides counts of visiting nurses, not RNs.
** "Services under agreement" refer to visits furnished to facility patients by physicians under agreement who do not furnish services to patients on a regular ongoing basis in the RHC facility (e.g., physicians not on full-time staff).
Data source: CMS ACO Provider RIF 2023, CMS Hospital Cost Reports (provider based RHCs) and Rural Health Clinic Cost Reports, 2020-2021.

ACS data were used to compare the characteristics of counties with RHCs participating in MSSP and other counties with at least one RHC but none participating in MSSP. Counties with a participating RHC have a larger median population, a higher population proportion White, and a lower population proportion Hispanic (appendix Table A2). Table 5 shows the public insurance status of counties with RHCs participating in MSSP and other counties with at least one RHC but not participating in MSSP. Overall, the proportion of the population covered by Medicaid and the total Medicare enrollment is higher in counties with participating RHCs while the Medicare Advantage (MA) penetration rate is slightly lower.

Table 5. Public Insurance Status of Counties with an RHC Participating in MSSP and those with an RHC but not Participating in MSSP, 2023

	MSSP Participating RHC County (n=966)	No MSSP Participating RHC County (n=1,448)
Median % pop. with Medicaid	22.0%	20.76%
Median total Medicare enroll.	5,587	4,515
Median MA penetration	45.74%	46.59%

Data source: CMS ACO Provider RIF 2023, CMS Provider of Services file 2023Q1, American Community Survey 2018-2022, CMS Monthly Medicare Enrollment 2023.

Discussion

Overall, about a third of CAHs (33.4 percent) and RHCs (35.9 percent) participate in MSSP and they participate at similar rates. A larger proportion of provider-based RHCs (42.7 percent) participate in MSSP compared to free-standing RHCs (23.3 percent). Our findings highlight several characteristics of providers and communities with CAHs and RHCs that participate in MSSP. Compared to CAHs not participating in MSSP, CAHs in MSSP:

- are more likely to be nongovernmental not-for-profit entities
- are more likely to be members of a healthcare system
- have larger staff sizes (including physicians and total employees)
- have higher numbers of admissions, inpatient stays, and ED and outpatient visits
- have more revenue (both inpatient and outpatient)
- have higher operating expenses and greater net income
- are more likely to be located in a metropolitan county

Compared to counties with a CAH but none participating in MSSP, counties with a CAH participating in MSSP have:

- a larger total population
- a higher White population proportion
- a higher household income
- a slightly lower proportion of people with less than a high school education
- a slightly lower proportion of elderly people with disability
- a slightly larger total Medicare enrollment and a higher Medicare Advantage (MA) penetration rate

Compared to those not participating in MSSP, RHCs participating in MSSP (both free-standing and provider-based) tend to be or have:

- not-for-profit entities
- slightly larger staff sizes
- a higher total average number of visits
- a higher total average expense

Compared to counties with an RHC but none participating in MSSP, counties with an RHC participating in MSSP have:

- a larger total population
- a higher proportion of Whites in their population
- a slightly higher proportion of the population with Medicaid coverage, and a higher total Medicare enrollment

In general, we found that CAHs and RHCs participating in MSSP are larger and have better finances. They also tend to be located in counties with larger populations and smaller minority populations. CAHs participating in MSSP are more likely to be in counties with higher household incomes and larger Medicare enrollments. These findings support the notion that health care organizations in rural areas may struggle to participate in voluntary models such as the MSSP. These organizations serve smaller, more isolated populatons, frequently lack the access to capital needed to build infrastructure for population care management, and operate at smaller profit margins making them more averse to participating in programs requiring down-side risk. While shared savings and risk are the responsibility of the ACO (not the individual healthcare organization), organizations like CAHs and RHCs must consider the ultimate costs and responsibilities associated with joining an ACO.

The CY 2023 Medicare Physician Fee Schedule Final Rule eased the transition to risk-taking by allowing ACOs inexperienced with performance-based risk to extend their participation in a one-sided model for up to seven years. Further, it introduced Advance Investment Payments (AIP) providing more than $20 million in advanced payment to eligible ACOs.[3] The rule encouraged the formation of ACOs in places with historically underserved populations, including those in rural areas, to increase access to care and improve care quality. Overall, in 2024 there was a 27 percent increase in the number of participating FQHCs, RHCs, and CAHs from 2023.[3]

Two-sided risk is a major challenge for rural ACOs that choose to participate in MSSP. It underscores the need for tailored support and strategic innovation guided by policy. Recent initiatives by CMS reflect a proactive approach to addressing these challenges by increasing participation, especially among low-revenue and rural ACOs. These efforts are crucial for ensuring that historically underserved populations, particularly in rural areas, have improved access to high-quality, coordinated care. The success of these initiatives will be pivotal in transforming the landscape of rural healthcare and ensuring equitable access to care.

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Appendix

Table A1 displays the characteristics of counties with CAHs participating in MSSP and other counties with at least one CAH but not participating in MSSP. In comparison to counties without an SSP CAH, populations in counties with CAHs participating in SSP have a slightly higher proportion of White persons, high school graduates, households with incomes above 100% of poverty, and non-disabled elderly. The median household income is also slightly higher in counties with CAH SSP participation compared to those with CAHs not participating.

Table A1. Characteristics of Counties with a CAH Participating in MSSP and those with a CAH but not Participating in MSSP, 2023

	County with CAH MSSP Participant (n=418)	**County with CAH, but no MSSP Part.** (n=750)
Population		
Median total	19,684	14,541
Median % age 65 and older	20.47%	20.53%
Median age	42.30	42.00
Race		
Median % White	90.92%	87.85%
Median % Black	0.99%	1.01%
Median % Am. Ind./AK Native	0.34%	0.44%
Median % Asian	0.48%	0.50%
Median % Haw./Pacific Isl.	0.01%	0.00%
Median % Other race	1.03%	1.25%
Median % more than one race	3.86%	4.43%
Median % Hispanic	3.42%	4.69%
Education (pop. 25 years+)		
Median % less than HS grad.	8.83%	10.17%
Median % High school grad.	34.85%	34.88%
Median % some college	32.84%	32.01%
Median % bachelor's degree	14.05%	13.68%
Median % Grad./Prof. degree	6.44%	6.32%
Poverty (population for whom poverty status is determined)		
Below 100% poverty level	12.26%	13.21%
Below 150% poverty level	21.47%	22.89%
Median Household income	$62,212	$60,005
Median % civilian unemp.	4.21%	4.34%
Percent population insured	92.85%	91.41%
Elderly		
Median % in poverty	9.51%	9.68%
Median % disabled	34.33%	36.37%
Median % living alone	28.61%	28.90%
Public Insurance Status		
Median % pop. with Medicaid	20.91%	20.41%
Median total Medicare enroll.	4,433	3,489
Median MA penetration	41.79%	40.34%

Data source: CMS ACO Provider RIF 2023, CMS Provider of Services file 2023Q1, American Community Survey 2018-2022.

Table A2 displays the characteristics of counties with RHCs participating in MSSP and other counties with at least one RHC but not participating in MSSP. Counties with a participating RHC have a larger median population, a higher population proportion White, and a lower population proportion Hispanic.

Table A2. Characteristics of Counties with a RHC Participating in MSSP and those with an RHC but not Participating in MSSP, 2023

	County with RHC MSSP Participant (n=966)	**County with RHC, but no MSSP Part.** (n=1,448)
Population		
Median total	23,767	19,567
Median % age 65 and over	19.89%	19.72%
Median age	41.80	41.70
Race		
Median % White	88.97%	83.83%
Median % Black	1.79%	1.88%
Median % Am. Ind./AK Native	0.31%	0.32%
Median % Asian	0.50%	0.56%
Median % Haw./Pacific Isl.	0.00%	0.00%
Median % Other race	1.07%	1.44%
Median % more than one race	4.05%	4.57%
Median % Hispanic	3.62%	5.04%
Education (pop. 25 years+)		
Median % less than HS grad.	10.95%	11.43%
Median % High school grad.	35.82%	34.62%
Median % some college	31.55%	30.95%
Median % bachelor's degree	12.85%	13.50%
Median % Grad./Prof. degree	6.30%	6.53%
Poverty (population for whom poverty status is determined)		
Below 100% poverty level	13.93%	14.03%
Below 150% poverty level	24.22%	24.00%
Median Household income	$58,658	$58,978
Median % civilian unemployed	4.70%	4.72%
Percent population insured	91.62%	90.71%
Elderly		
Median % in poverty	10.21%	10.08%
Median % disabled	36.87%	36.94%
Median % living alone	28.67%	27.90%

Data source: CMS ACO Provider RIF 2023, CMS Provider of Services file 2023Q1, American Community Survey 2018-2022.