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Rural-based Accountable Care Organizations Agreement Renewal

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Background and Purpose

Accountable Care Organizations (ACOs) are entities composed of combinations of physician practices, hospitals, and other health care providers, formed with the goal of delivering high-quality coordinated care to patients.[1] When an ACO achieves a pre-determined high level of quality care in a value-based model, it will share in the savings it generates for the payer. The Centers for Medicare & Medicaid Services' (CMS) Medicare Shared Savings Program (MSSP) is the largest ACO program in the country, with over 11 million beneficiaries enrolled as of 1/1/2025.[2]

ACO's in the MSSP can participate in various levels of risk that determine their performance-based awards or penalties. Those participating in upside-only models can earn rewards when their performance (financial and quality) exceeds pre-established benchmarks – they are not subject to penalties when their performance fails to meet those benchmarks. ACOs participating in two-sided models (i.e., both up- and downside risk) earn higher rewards when they exceed their benchmarks but may be required to pay a penalty when they fall short of meeting their expenditure benchmarks. The MSSP was significantly changed under Pathways to Success in rulemaking in 2019, which created multiple risk model tracks (both up- and downside) and encouraged participants to accept financial accountability more quickly.

Rural providers have participated in MSSP ACOs at lower rates than urban providers and often face distinct structural and financial constraints when transitioning to value-based payment models. Smaller organizational size, limited access to capital, workforce shortages, and greater financial volatility may influence decisions about entering or renewing participation in models that require downside financial risk. Understanding how rural ACOs engage with risk-bearing arrangements and the factors associated with renewal or exit is important for informing policies intended to expand value-based care in rural communities. This policy brief describes characteristics of ACOs participating in MSSP (referred to hereafter simply as "ACOs") and compares trends in exits and entries into MSSP between nonmetropolitan (rural) and metropolitan (urban) geographies from 2013 through 2022.

Key Findings

- In 2013, only 10.9 percent of new ACOs were rural. The rate of growth has been somewhat uneven over the years, but in 2022, 34.8 percent of new ACOs were rural – down from a peak of 48.0 percent in 2016.

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- Between 2013 and 2016, the average program tenure (years an ACO remains in the MSSP) was slightly longer in urban ACOs. From 2017 to 2022, the tenure in rural ACOs was slightly longer compared to urban ACOs.
- Two-sided risk adoption was almost nonexistent through 2016. Starting in 2017, the proportion of ACOs assuming two-sided risk has grown unevenly but substantially as a result of CMS's modifications to the MSSP in 2016 that encouraged ACOs to choose two-sided performance-based risk arrangements. Agreement renewals among ACOs with two-sided risk have been high, with up to 94.1 percent of urban ACOs (2019) and up to 100 percent of rural ACOs (2017-2019) with two-sided risk renewing their agreements. A relatively small proportion of rural ACOs initiate with two-sided risk.
- The CMS Innovation Center ACO Investment Model (AIM) was designed to encourage new rural ACOs, as well as existing ACOs, to transition to arrangements with more financial risk when renewing participation in MSSP. Starting in 2016, more than half (60.4 percent) of rural ACOs participated in AIM, but only 17.2 percent of them renewed their MSSP agreement after the initial three-year term.

Data and Methods

We used CMS MSSP Provider-Level Research Identifiable File (RIF) data from 2013 to 2022 to identify provider types participating in MSSP ACOs. The RIF data identified participants using CMS Certification Numbers (CCN) and National Provider Identifiers (NPI). Provider records containing CCNs were linked with the CMS Provider of Services (POS) data to obtain facility characteristics and county locations.[3] Provider records containing NPIs were linked to year-specific NPI data to identify provider specialty and address information to geocode to primary practice county locations. Those county locations were then classified into two groups using 2013 Urban Influence Codes (most current available at the time of analysis): metropolitan (1,2), and nonmetropolitan (3-12).[4]

There is no set rule for determining whether an ACO is urban or rural. Earlier RUPRI work defined rural ACOs based on the proportion of nonmetropolitan counties where any ACO participating provider practiced. But this relatively loose definition was open to overclassification bias as the presence of a single primary care provider would include a nonmetropolitan county in an ACO's service area. To develop a tighter urban/rural classification we examined the provider-level RIF data for rural and urban participant institutional composition (Federally Qualified Health Centers [FQHCs], Rural Health Clinics [RHCs], Critical Access Hospitals [CAHs], non-CAH hospitals, and primary care providers [PCPs]) of ACOs in their first year of operation. Those findings are summarized in Appendix Table A1. Based on those findings, we defined a rural ACO as one with any two or more of the following characteristics:

- One or more nonmetropolitan prospective-payment system (PPS) hospital or rural CAH
- One or more nonmetropolitan FQHC
- One or more nonmetropolitan RHC
- 15 percent or more of participating PCPs in a nonmetropolitan location

Data on ACO characteristics were obtained from the CMS website on MSSP "Performance Year Financial and Quality Results."[5] The data included start date, participation track, and total earned shared savings/losses for the performance year.

Results and Findings

The annual number of new ACOs (overall) has largely declined since the program's introduction. There were no new ACOs in 2021 due to CMS temporarily pausing new MSSP entrants during the coronavirus pandemic.[6] Rural ACOs were relatively uncommon in the early years of the program. Table 1 shows that the proportion of new rural ACOs hovered around 10-13 percent in 2013 and 2014. It spiked at 48 percent in 2016 (the first year of AIM). In general, rural ACO participation has remained relatively steady since then, varying between 23 percent and 38 percent of new ACOs.

Table 1. Rural and Urban MSSP ACO starting 2013-2022, Years in Program and Agreement Renewal

Start Year	New ACO Count		Average Years in Program[a]			Renewed Agreement[b]		
	Total	Rural	Overall	Rural ACOs	Urban ACOs	Overall	Rural ACOs	Urban ACOs
2013[c]	220	24 (10.9%)	5.89	5.63	5.93	147 (66.8%)	14 (58.3%)	133 (67.9%)
2014	116	15 (12.9%)	5.87	5.80	6.03	73 (61.3%)	10 (66.7%)	63 (62.4%)
2015	89	27 (30.3%)	5.97	5.78	6.04	63 (70.8%)	19 (70.4%)	44 (71.0%)
2016	100	48 (48.0%)	4.73	4.33	5.10	49 (49.0%)	17 (35.4%)	32 (61.5%)
2017	96	22 (22.9%)	4.51	4.82	4.42	58 (60.4%)	15 (68.2%	43 (58.1%)
2018	123	45 (36.6%)	4.20	4.31	4.14	99 (80.5%)	38 (84.4%)	61 (78.2%)
2019	65	25 (38.5%)	3.68	3.92	3.60	58 (87.9)	25 (100%)	33 (82.5%)
2020	53	12 (22.6%)	2.81	2.83	2.80	NA	NA	NA
2021[d]	---	---	---	---	---	NA	NA	NA
2022	66	23 (34.8%)	1.0	1.0	1.0	NA	NA	NA

a. Years in program were measured from year of program start until program withdrawal with maximum follow-up data through 2022. Therefore, the maximum possible value is 10 years and programs that started after 2013 had smaller maximum years.
b. Includes ACOs that – after their initial 3-year agreement period ended – either extended or renewed their agreement. Note that ACOs beginning in 2019 or later agreed to participate for a five-year period.
c. 2013 performance data includes the first year's performance for ACOs starting in 4/1/2012, 7/1/2012, and 1/1/2013.
d. There were no new MSSP ACOs in 2021 due to the coronavirus pandemic.
NA (Not Applicable): The agreement renewal data for ACOs starting in 2019-2022 was not available at the time of this analysis.
Data source: CMS MSSP Provider-Level RIF data, 2013-2022, CMS POS data, 2013-2022, CMS Performance Year Financial and Quality Results 2013-2022.

Table 1 also shows ACO tenure, and the number and proportion of ACOs (overall and by rural/urban designation) that either renewed or extended their agreement following the completion of the initial 3-year agreement period*. For ACOs starting between 2013 and 2016, average program tenure was slightly longer in urban ACOs compared to rural. Rural ACO tenure was slightly longer than urban starting in 2017. Rates of ACO agreement renewal have fluctuated inconsistently over time. Only 35.4 percent of the rural ACOs starting in 2016 renewed their agreement, but 84.4 percent of those starting in 2018 (the last year for which 3-year agreements were applicable) renewed. Those fluctuations are not as dramatic in the urban ACOs, where the low point was 58.1 percent for ACOs starting in 2017 and the zenith was 78.2 percent in 2018.

*At the start of the MSSP, ACOs agreed to participate in the program for a period of three years period (the agreement period). For agreements beginning on or after July 1, 2019, agreement periods are for five years.

Tables 2a-2c show characteristics of rural and urban ACOs at their time of program initiation, broken down by their decision to renew participation in the program after their initial three-year agreement[*]. Table 2a shows that two-sided risk assumption was nearly nonexistent through 2016. Starting in 2017, the proportion of ACOs assuming two-sided risk in their initial agreement was uneven but grew considerably in 2022. Agreement renewals among ACOs with two-sided risk has been high, with up to 94.1 percent of urban ACOs and up to 100 percent of rural ACOs renewing their agreements. However, it should be noted that a smaller proportion of rural ACOs initiate with two-sided risk compared to urban ACOs, likely due to concerns about structural and financial constraints that might increase their exposure to downside loss.

Table 2a. Rural and Urban MSSP ACO starting 2013-2022, Two-sided Risk and Agreement Renewal[a]

	Rural				Urban			
Start Year	ACOs	2-sided Risk at Start (% yes)	2-sided ACOs: Renewed	1-sided ACOs: Renewed	ACOs	2-sided Risk at Start (% yes)	2-sided ACOs: Renewed	1-sided ACOs: Renewed
2013[b]	24	0.0%	---	58.3%	196	2.5%	60.0%	68.1%
2014	15	0.0%	---	66.7%	101	0.0%	---	62.4%
2015	27	0.0%	---	70.4%	62	0.0%	---	71.0%
2016	48	2.1%	0.0%	36.2%	52	1.9%	0.0%	62.7%
2017	22	22.7%	100%	58.8%	74	18.9%	57.1%	58.3%
2018	45	11.1%	100%	82.5%	78	19.2%	66.7%	80.9%
2019	25	20.0%	100%	100%	40	42.5%	94.1%	73.9%
2020	12	25.0%	NA	NA	41	29.3%	NA	NA
2021[c]	---	---	NA	NA	---	---	NA	NA
2022	23	52.2%	NA	NA	43	62.8%	NA	NA

a. Includes ACOs that – after their initial 3-year agreement period ended (ACO agreements beginning on or after 7/1/2029 are for five years) – either extended or renewed their agreement. One-sided (upside-only) risk models include Track 1, and Basic Tracks A and B. Two-sided risk models include Tracks 1+, 2 and 3, and Basic Tracks C, D, E, and Enhanced.
b. 2013 performance data includes the first year's performance for ACOs starting in 4/1/2012, 7/1/2012, and 1/1/2013.
c. There were no new MSSP ACOs in 2021 due to the coronavirus pandemic.
NA (Not Applicable): The agreement renewal data for ACOs starting in 2019-2022 was not available at the time of this analysis.
Data source: CMS MSSP Provider-Level RIF data, 2013-2022, CMS POS data, 2013-2022, CMS Performance Year Financial and Quality Results 2013-2022.

CMS introduced two models through its Innovation Center that tested early funding to promote the formation of MSSP ACOs (especially in rural[†] and underserved areas). The Advance Payment Model (APM) was made available for MSSP participants with a start date of January 1, 2013, and allowed selected participants to receive "upfront and monthly payments, which they could use to make important investments in their care coordination infrastructure."[7] AIM, the second model, used pre-paid shared savings to "encourage new

[†] The APM did not set criteria for "rural" areas. It restricted applications to ACOs with no inpatient facilities or those where the only inpatient facilities were critical access hospitals or low-volume rural hospitals. The AIM request for applications specified scoring criteria that included the proportion of ACO providers located in nonmetropolitan counties or rural areas (based on Rural Urban Commuting Area codes) of metropolitan counties.

ACOs to form in rural and underserved areas and to encourage current MSSP ACOs to transition to arrangements with greater financial risk."[8] AIM was launched in 2015 and was made available to ACOs already in existence as well as new ACOs. A total of 45 ACOs participated in AIM (two began in MSSP in 2013, two began participating in 2014, five began in 2015, and 36 began participating in 2016).[8] Both APM and AIM were three-year agreements where ACOs initiated in one-sided risk models.

The APM was not widely adopted (20.8 percent of rural ACOs and 15.8 percent of urban ACOs, as shown in Table 2b). Only one of the rural ACOs in the APM renewed its agreement, and only slightly more than half (54.8 percent) of the urban ACOs renewed their agreement. AIM had a larger uptake, with more than half (60.4 percent) of the rural ACOs starting in 2016 participating in the model. Its uptake in urban ACOs was much smaller (13.5 percent of ACOs starting in 2016). But it appears that AIM participation had little impact on agreement renewals in rural ACOs (only 17.2 percent of rural ACOs starting in 2016 with AIM funding renewed) and a marginal impact on agreement renewals in urban ACOs (71.4 percent of urban ACOs starting in 2016 with AIM funding renewed, compared to 60.0 percent without AIM funding renewing). Program evaluation and outside research point to the model's insistence of ACOs shifting to two-sided risk as a major factor in ACO decisions to leave the program.[9,10]

Table 2b. Rural and Urban MSSP ACO Demonstration Participation and Agreement Renewal[a]

Advance Payment Model (APM)

	Rural				Urban			
Start Year	Rural ACOs	APM Partic.	APM Partic.: Renewed	Not APM Partic.: Renewed	Urban ACOs	APM Partic.	APM Partic.: Renewed	Not APM Partic.: Renewed
2013[b]	24	5 (20.8%)	1 (20.0%)	13 (68.4%)	196	31 (15.8%)	17 (54.8%)	116 (70.3%)

ACO Investment Model (AIM)

	Rural				Urban			
Start Year	Rural ACOs	AIM Partic.	AIM Partic.: Renewed	Not AIM Partic.: Renewed	Urban ACOs	AIM Partic.	AIM Partic.: Renewed	Not AIM Partic.: Renewed
2013[b]	24	0 (0.0%)	---	58.3%	196	2 (1.0%)	2 (100%)	131 (67.5%)
2014	15	0 (0.0%)	---	66.7%	101	2 (2.0%)	2 (100%)	61 (61.6%)
2015	27	4 (14.8%)	4 (100%)	65.2%	62	1 (1.6%)	1 (100%)	43 (70.5%)
2016	48	29 (60.4%)	5 (17.2%)	63.2%	52	7 (13.5%)	5 (71.4%)	27 (60.0%)

a. Includes ACOs that – after their initial 3-year agreement period ended – either extended or renewed their agreement.
b. 2013 performance data includes the first year's performance for ACOs starting in 4/1/2012, 7/1/2012, and 1/1/2013.
Data source: CMS MSSP Provider-Level RIF data, 2013-2022, CMS POS data, 2013-2022, CMS Performance Year Financial and Quality Results 2013-2022.

Table 2c shows rural and urban ACO aggregated shared savings in the first three years and agreement renewal. Across all start years, the proportion of ACOs (combined rural and urban) earning shared savings ranged from 37.1 percent to 83.0 percent (data not shown). With the exception of two years (2016-2017), urban ACOs have continuously been more likely than rural ACOs to earn shared savings. Regardless of urban/rural status, ACOs earning

shared savings (with the exception of a couple of years) were more likely to renew their agreement.

Table 2c. Rural and Urban MSSP ACO starting 2013-2020, Agreement Renewal[a] and ACO Earned Savings in First Year

	Rural				Urban			
		% Earning Shared Savings[b]				% Earning Shared Savings[b]		
Start Year	ACOs	Overall	Shared Savings: Renewed	No Shared Savings: Renewed	ACOs	Overall	Shared Savings: Renewed	No Shared Savings: Renewed
2013[c]	24	16.7%	100.0%	50.0%	196	49.0%	77.1%	59.0%
2014	15	13.3%	100.0%	61.5%	101	41.6%	73.8%	54.2%
2015	27	18.5%	100.0%	63.6%	62	45.2%	67.9%	73.5%
2016	48	52.1%	32.0%	39.1%	52	50.0%	76.9%	46.1%
2017	22	72.7%	81.3%	33.3%	74	51.3%	76.3%	38.9%
2018	45	55.6%	96.0%	70.0%	78	62.8%	83.7%	69.0%
2019	25	72.0%	NA	NA	40	77.5%	NA	NA
2020	12	75.0%	NA	NA	41	85.4%	NA	NA
2021[d]	---	---	NA	NA	---	---	NA	NA
2022	23	---	NA	NA	43	---	NA	NA

a. Includes ACOs that – after their initial 3-year agreement period ended – either extended or renewed their agreement.
b. Shared savings aggregated over the first three years of the agreement period.
c. 2013 performance data includes the first year's performance for ACOs starting in 4/1/2012, 7/1/2012, and 1/1/2013.
d. There were no new MSSP ACOs in 2021 due to the coronavirus pandemic.
NA (Not Applicable): The agreement renewal data for ACOs starting in 2019-2022 is not yet available
Data source: CMS MSSP Provider-Level RIF data, 2013-2022, CMS POS data, 2013-2022, CMS Performance Year Financial and Quality Results 2013-2022.

Discussion

In 2013, only 10.9 percent of new ACOs were in rural areas, but by 2022, this figure had increased to 34.8 percent (Table 1). Rural ACOs have shown greater program tenure than urban ACOs since 2017, with two-sided risk models gradually becoming more prevalent among both urban and rural ACOs after 2016. While rural ACOs initially hesitated to adopt two-sided risk, agreement renewal rates among those who did have been high, with up to 100% (n=5) of rural ACOs renewing their agreements, compared to 94.1% (n=16) of urban ACOs. This may indicate a history of implementing care management and other strategies to manage risk among ACOs accepting financial risk upon entering the program, consistent with research conducted by the RUPRI Center[11]. Without prior experience, rural healthcare organizations may need longer lead time to develop the skills and protocols needed to succeed in a model requiring downside financial risk.

Several structural factors may help explain the slower uptake of downside risk and lower renewal rates among some rural ACOs. Rural health systems often operate with thinner financial margins, smaller patient volumes, and more limited access to capital and analytic infrastructure than their urban counterparts. These constraints can make the transition to two-sided financial risk more challenging, particularly when benchmark rebasing, longer agreement periods, and earlier risk assumption are required. Prior research has also shown that smaller and rural ACOs frequently cite workforce shortages, limited care management capacity, and concerns about financial volatility as reasons for delaying or avoiding

participation in higher-risk MSSP tracks.[9–11] Together, these factors suggest that differences in renewal and risk adoption may reflect structural readiness rather than lack of interest in value-based care.

The CMS Innovation Center introduced the ACO Investment Model (AIM) to encourage the formation of ACOs in rural and underserved areas and to facilitate transition to greater financial risk by providing upfront and ongoing payments to support care coordination infrastructure. Although AIM attracted substantial rural participation (60.4% (n=29) of new rural ACOs in 2016), only 17.2% (n=5) of participating rural ACOs renewed their MSSP agreements after the initial term (Table 2b). This low renewal rate likely reflects structural challenges faced by rural organizations, including limited readiness for downside financial risk and the model's requirement to assume two-sided risk in the fourth year of participation, consistent with prior evaluations and research.[9,10]

Changes in the MSSP included in the 2023 Medicare Physician Fee Schedule (PFS) final rule (published November 2022) introduced a number of significant changes for MSSP participants. Built on lessons from the AIM, the rule gives new inexperienced ACOs more time to advance to higher risk levels, provides advance shared savings payments, adjusts quality benchmarks, and makes a number of other changes important to new ACOs.[13] These enhancements may attract smaller ACOs that serve more disadvantaged markets yet lack the resources needed to build capacity compared to larger ACOs that can take on additional risk.[14] Consequently, new ACOs may develop in rural areas.

Moving forward, the CMS Innovation Center will test a new model within the MSSP that will begin in 2026. The ACO Primary Care Flex Model focuses on increasing the number of low-revenue ACOs, which include providers that serve rural areas.[12] The model proposes a shift away from fee-for-service payments into a new prospective primary care payment based on a county's average primary care spending and payment enhancements that provide additional resources to ACOs without added risks.[12] The goal of this new payment model is to improve predictability of revenue streams and stability of primary care resources for low-revenue ACOs.[1]

These findings suggest that policymakers, including CMS, might consider weighing the benefits and costs of transitioning small, rural ACOs to two-sided financial risk tracks. Rural ACOs may take longer than a few years before they are willing to take on further risk. Assessing recently implemented policies in the MSSP for new and experienced ACOs (with rural providers intentionally targeted) that delay the time to transition to two-sided risk, offer a different payment model, revise benchmarks, and increase shared savings rates may assist in increasing savings for the Medicare program while continuing to deliver high quality-care for rural beneficiaries.

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Appendix

Table A1 shows the participant institutional composition (hospitals, CAHs, FQHCs, and RHCs) of ACOs in their first year of operation. The ACO participation of rural institutions was very low in the early years of the program. That level of participation – as measured by the proportion of ACOs with at least one of each rural provider type – grew from 2013 with a peak in 2016 (the first year of AIM). In general, rural institutional participation remained steady until the most recent year (2020), which saw a substantial retrenchment of rural representation.

Table A1. Counts of Participant Institution Types, MSSP ACOs starting 2013-2022

Start Year	ACOs	ACOs with Hospitals				ACOs with CAHs			
		1 or more		Avg. # Hosps		1 or more		Avg. # CAHs	
		Total	Rural	Total	Rural	Total	Rural	Total	Rural
2013[a]	220	31 (14.1%)	8 (3.6%)	0.50	0.06	10 (4.6%)	8 (3.6%)	0.11	0.08
2014	116	43 (37.1%)	7 (6.0%)	0.80	0.09	9 (7.8%)	6 (5.2%)	0.16	0.10
2015	89	62 (69.7%)	16 (18.0%)	1.94	0.29	23 (25.8%)	18 (20.2%)	0.94	0.67
2016	100	54 (54.0%)	32 (32.0%)	1.62	0.68	37 (37.0%)	35 (35.0%)	1.35	1.10
2017	96	47 (49.0%)	15 (15.6%)	1.38	0.23	10 (10.4%)	8 (8.3%)	0.68	0.57
2018	123	82 (66.7%)	35 (28.5%)	2.59	0.71	26 (21.1%)	20 (16.3%)	0.64	0.51
2019	65	30 (46.2%)	15 (23.1%)	1.69	0.60	17 (26.2%)	15 (23.1%)	1.08	0.82
2020	53	10 (18.9%)	4 (7.6%)	0.51	0.09	8 (15.1%)	5 (9.4%)	0.25	0.17
2021[b]	0	---	---	---	---	---	---	---	---
2022	66	27 (40.9%)	14 (21.2%)	1.9	0.95	14 (21.2%)	12 (18.2%)	1.83	1.44

Start Year	ACOs	ACOs with FQHCs				ACOs with RHCs			
		1 or more		Avg. # FQHC		1 or more		Avg. # RHCs	
		Total	Rural	Total	Rural	Total	Rural	Total	Rural
2013[a]	220	27 (12.3%)	13 (5.9%)	1.49	0.60	26 (11.8%)	19 (8.6%)	0.53	0.37
2014	116	21 (18.1%)	11 (9.5%)	3.76	0.84	18 (15.5%)	10 (8.6%)	0.40	0.24
2015	89	16 (18.0%)	7 (7.9%)	2.03	1.00	24 (27.0%)	22 (24.7%)	2.33	1.74
2016	100	23 (23.0%)	15 (15.0%)	2.90	1.55	53 (53.0%)	51 (51.0%)	3.44	2.65
2017	96	11 (11.5%)	8 (8.3%)	4.40	1.20	22 (22.9%)	18 (18.8%)	1.71	1.34
2018	123	21 (17.1%)	10 (8.1%)	2.60	0.88	46 (37.4%)	38 (30.9%)	2.13	1.72
2019	65	17 (26.2%)	10 (15.4%)	2.77	1.17	26 (40.0%)	23 (35.4%)	3.31	2.58
2020	53	11 (20.8%)	4 (7.6%)	6.91	3.28	17 (32.1%)	9 (17.0%)	0.85	0.45
2021[b]	0	---	---	---	---	---	---	---	---
2022	66	16 (24.2%)	11 (16.7%)	10.91	5.09	22 (33.3%)	18 (27.3%)	6.86	5.47

a. 2013 performance data includes the first year's performance for ACOs starting in 4/1/2012, 7/1/2012, and 1/1/2013.
b. There were no new MSSP ACOs in 2021 due to the coronavirus pandemic.
Data source: CMS MSSP Provider-Level RIF data, 2013-2022, CMS POS data, 2013-2022, CMS Performance Year Financial and Quality Results 2013-2022.

Table A2 shows the primary care provider (PCP) composition (combining individual PCPs and PCP groups) of ACOs in their first year of operation. The average number of participating PCPs – both overall and rural only – has grown over the years until 2020. The general trend of ACOs with 15 percent or more of their PCPs in a rural location has followed a similar pattern except for a peak in 2016 (the first year of AIM).

Table A2. Counts of Participant Primary Care Providers, MSSP ACOs starting 2013-2022

Start Year	ACOs	Primary Care Providers[a]			
		Avg. Number		Proportion Rural	
		Total	Rural	Any	15%+[c]
2013[b]	220	116.6	11.1	147 (66.8%)	41 (18.6%)
2014	116	104.7	6.7	67 (57.8%)	15 (12.9%)
2015	89	163.7	15.9	73 (82.0%)	25 (28.1%)
2016	100	87.7	19.2	81 (81.0%)	51 (51.0%)
2017	96	199.1	23.4	75 (78.1%)	27 (28.1%)
2018	123	201.9	24.8	106 (86.2%)	38 (30.9%)
2019	65	294.9	47.2	56 (86.2%)	26 (40.0%)
2020	53	162.3	14.2	38 (71.7%)	13 (24.5%)
2021 [d]	---	---	---	---	---
2022	66	316.1	62.7	58 (87.9%)	26 (39.4%)

a. Includes individual primary care providers and primary care provider groups.
b.2013 performance data includes the first year's performance for ACOs starting in 4/1/2012, 7/1/2012, and 1/1/2013.
c.15 percent was selected as a threshold because it is a rough approximation of the proportion of the population in rural counties.
c. There were no new MSSP ACOs in 2021 due to the coronavirus pandemic.
Data source: CMS MSSP Provider-Level RIF data, 2013-2022, CMS POS data, 2013-2022, CMS Performance Year Financial and Quality Results 2013-2022.

Table A3 displays, by start year, ACOs with one or more of each of the provider types used to assign rural/urban status.

Table A3. Counts of Participant Types, MSSP ACOs starting 2013-2022

Start Year	ACOs	Hospital	CAH	FQHC	RHC	Prim. Care Phys.[a]	Rural "Presence"	Rural "Presence"
		Ct/% with 1+ rural	Ct/% with 1+ rural	Ct/% with 1+ rural	Ct/% with 1+	Ct/% with >15% rural	Ct/% with 2+ criteria (w/o PCP)	Ct/% with 2+ criteria (inc. PCP)
2013[b]	220	8 (3.6%)	8 (3.6%)	13 (5.9%)	19 (8.6%)	40 (18.2%)	11 (5.0%)	24 (10.9%)
2014	116	7 (6.0%)	6 (5.2%)	11 (9.5%)	10 (8.6%)	15 (12.9%)	9 (7.8%)	15 (12.9%)
2015	89	16 (18.0%)	18 (20.2%)	7 (7.9%)	22 (24.7%)	25 (28.1%)	20 (22.5%)	27 (30.3%)
2016	100	32 (32.0%)	35 (35.0%)	15 (15.0%)	51 (51.0%)	51 (51.0%)	41 (41.0%)	48 (48.0%)
2017	96	15 (15.6%)	8 (8.3%)	8 (8.3%)	18 (18.8%)	27 (28.1%)	14 (14.6%)	22 (22.9%)
2018	123	35 (28.5%)	20 (16.3%)	10 (8.1%)	38 (30.9%)	38 (30.9%)	39 (31.7%)	45 (36.6%)
2019	65	15 (23.1%)	15 (23.1%)	10 (15.4%)	23 (35.4%)	26 (40.0%)	18 (27.7%)	25 (38.5%)
2020	53	4 (7.6%)	5 (9.4%)	4 (7.6%)	9 (17.0%)	13 (24.5%)	5 (9.4%)	12 (22.6%)
2021[c]	---	---	---	---	---	---	---	---
2022	66	14 (21.2%)	12 (18.2%)	11 (16.7%)	18 (27.3%)	25 (39.4%)	18 (27.3%)	23 (34.9%)

a. Includes individual primary care providers and primary care provider groups.
b. 2013 performance data includes the first year's performance for ACOs starting in 4/1/2012, 7/1/2012, and 1/1/2013.
c. There were no new MSSP ACOs in 2021 due to the coronavirus pandemic.
Data source: CMS MSSP Provider-Level RIF data, 2013-2022, CMS POS data, 2013-2022, CMS Performance Year Financial and Quality Results 2013-2022.