Trends in Traditional Medicare Spending and Outcomes in Urban and Rural Areas

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Context for This Analysis

- The September 2023 PTAC public meeting focused on “Encouraging Rural Participation in Population-Based Total Cost of Care (TCOC) Models ”
  - Topics that were discussed included challenges facing patients and providers in rural communities, approaches for incorporating rural providers in PB-TCOC model design, provider perspectives on payment issues related to rural providers in PB-TCOC models, incentives for increasing rural providers’ participation in PB-TCOC models, and successful interventions and models for encouraging value-based transformation in rural areas.

- This analysis examines the penetration of Alternative Payment Models across urban and rural areas and their impact on Medicare spending and claims-based quality measures.

Objectives of This Analysis

- Analyze trends in Traditional Medicare spending, utilization, and quality measures across metropolitan, micropolitan, and rural (non-CBSA) areas.
- Analyze the impact on spending and selected outcomes if Innovation Center (CMMI) Models or the Medicare Shared Savings Program (MSSP) were absent in both urban and rural settings, using a counterfactual approach where these programs' penetration rates are set to zero.
- Analyze the impact on spending and other outcomes if rural areas in the state had the same Innovation Center Models or MSSP penetration rates as urban areas

Methodology: County-level Analysis (2007 -2022)

- Beneficiaries continuously enrolled in Traditional Medicare with Part A and B and no Part C (Medicare Advantage), allowing death in each study year.
- Sample Medicare TM (AB) – 100% Medicare Enrollment and Claims data
- County-level data on Medicare Spending, Mortality, Utilization, and Quality Measures
- County-level penetration rates for Innovation Center Models and Medicare Shared Savings Program (MSSP)
- County-level demographic characteristics, CCW Chronic conditions, Dual eligibility

Background

How Do We Define Geographic Areas?

- Metropolitan Statistical Areas (Metropolitan)

  An area that contains at least one urbanized area with a population of 50,000 or more.

- Micropolitan Statistical Areas (Micropolitan)

  An area that contains at least one urban cluster with a population between 10,000 and 49,999.

- Rural Areas (Non-CBSA)

  Any area outside of Metropolitan and Micropolitan Statistical Areas.

Enrollment in Traditional Medicare (Parts A & B) Declined Across All Geographic Areas During the Study Period

Total Number of Traditional Medicare beneficiaries enrolled in Parts A and B

Year	Metropolitan	Micropolitan	Rural Areas (Non-CBSA)	Total
2007	23,878,323	3,872,265	2,989,409	30,739,997
2008	23,613,707	3,813,042	2,947,752	30,374,501
2009	23,604,994	3,799,596	2,927,161	30,331,751
2010	23,971,767	3,836,459	2,946,830	30,755,056
2011	24,259,597	3,867,691	2,955,402	31,082,690
2012	24,471,594	3,879,597	2,955,729	31,306,920
2013	24,719,448	3,885,574	2,950,625	31,555,647
2014	24,627,627	3,875,185	2,932,728	31,435,540
2015	24,764,594	3,887,212	2,932,606	31,584,412
2016	25,166,381	3,930,481	2,949,057	32,045,919
2017	25,046,055	3,924,157	2,942,971	31,913,183
2018	24,832,988	3,874,205	2,914,623	31,621,816
2019	24,672,589	3,824,480	2,881,274	31,378,343
2020	24,208,726	3,705,831	2,787,478	30,702,035
2021	23,193,277	3,492,134	2,619,222	29,304,633
2022	22,365,115	3,296,661	2,471,535	28,133,311

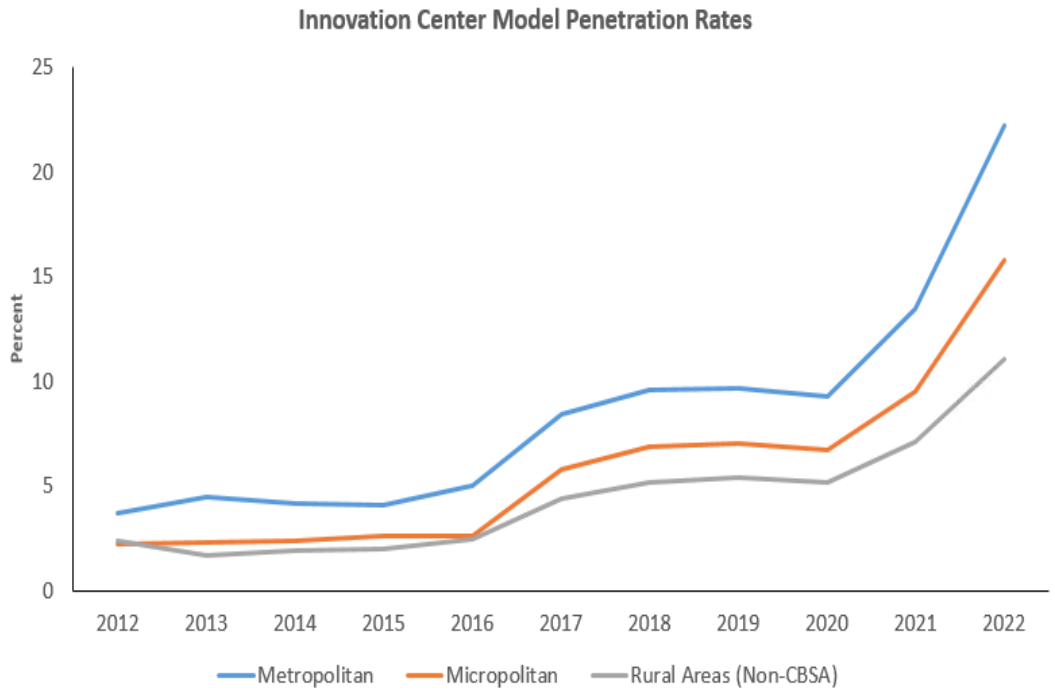
The Analysis Includes Data on Traditional Medicare Beneficiaries Attributed to 21 Alternative Payment Models (APMs)

APM Categories	List of APMs Included in the Analysis*
MSSP ACO (2 models)	MSSP Only, MSSP with Comprehensive Primary Care Plus (CPC+)
CMMI ACO (3 models)	Pioneer, NGACO, GPDC/ACO-REACH
Advanced Primary Care (6 models)	Physician Group Practice Transition Demonstration, Multi-payer Advanced Primary Care Demonstrations, Medicare Health Care Quality Demonstration – 646 Demonstration for North Carolina, Comprehensive Primary Care Initiative (CPCI), Comprehensive Primary Care Plus (CPC+, non-MSSP participants), Primary Care First
Maryland Global Payment	Maryland Total Cost of Care (MDTCOC): Primary Care Program
Vermont Global Payment	Vermont All-Payer Model
Chronic Conditions (4 models)	Comprehensive ESRD Care, Kidney Care Choices, Value in Opioid Use Disorder Treatment Demo, ESRD Treatment Choices Model
Other CMMI (4 models)	Medicare-Medicaid Coordination Office Financial Alignment Demonstration (Duals), Community Based Care Transition, Medicare Health Quality Demo (646 Demonstration for Indiana), Independence at Home Practice Demonstration

Significant Differences in Innovation Center Model Penetration Rates Exist Across Geographic Areas, with the Highest Penetration in Metropolitan Areas

County-level Innovation Center model penetration rates

Year	Metropolitan	Micropolitan	Rural Areas (Non-CBSA)
2012	3.7	2.2	2.4
2013	4.5	2.3	1.7
2014	4.2	2.4	1.9
2015	4.1	2.6	2.0
2016	5.0	2.6	2.5
2017	8.4	5.8	4.4
2018	9.6	6.9	5.2
2019	9.7	7.0	5.4
2020	9.3	6.7	5.2
2021	13.5	9.5	7.1
2022	22.2	15.8	11.1

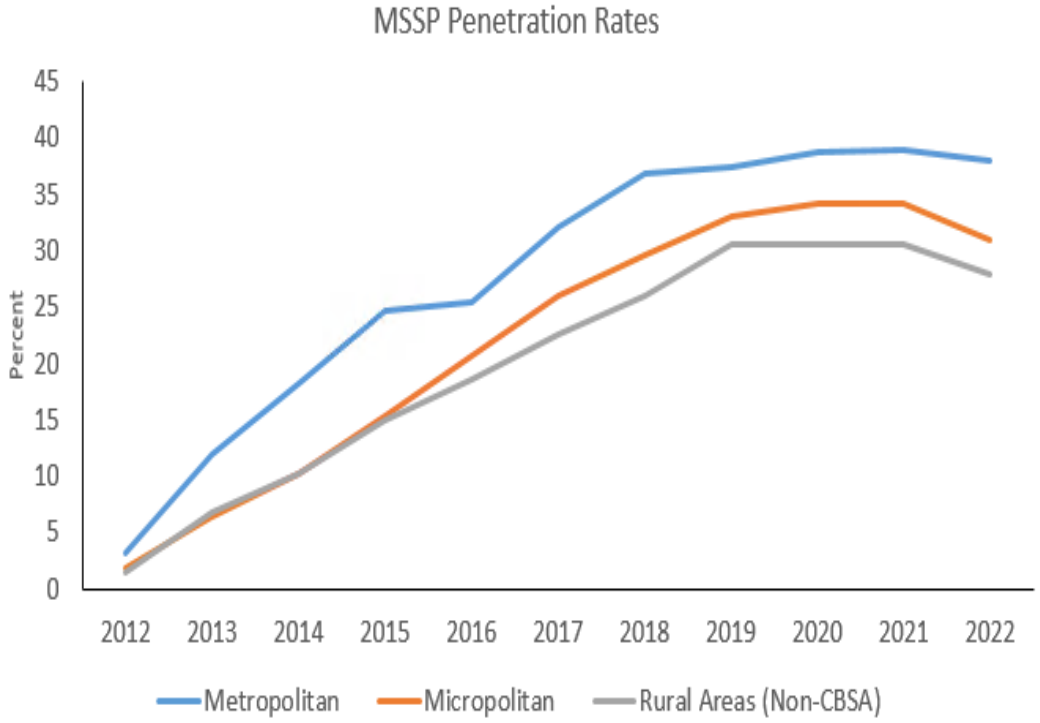


Notes: Analysis includes data on Traditional Medicare (Parts A and B enrolled) beneficiaries attributed to 19 Innovation Center Models.
Penetration rate = (Total number of beneficiary-months in Innovation Center Models) / Total number of beneficiary-months in FFS(AB)

Significant Differences in Medicare Shared Savings Program (MSSP) Penetration Rates Exist Across Geographic Areas, with MSSP Growth Slowing After 2018 Across All Areas

County-level MSSP penetration rate

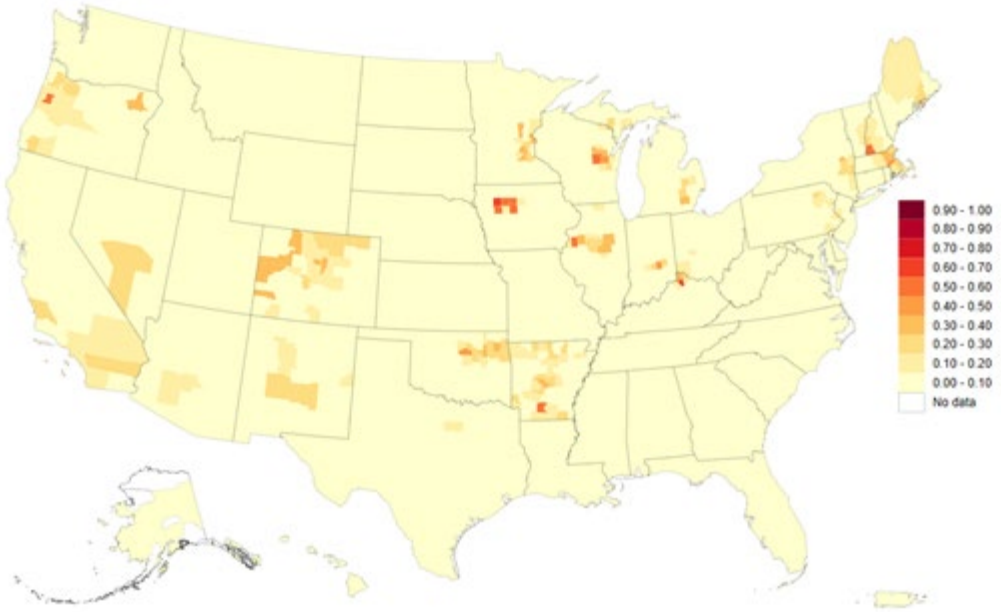
Year	Metropolitan	Micropolitan	Rural Areas (Non-CBSA)
2012	3.2	1.8	1.4
2013	12.0	6.5	6.8
2014	18.3	10.3	10.2
2015	24.7	15.3	14.9
2016	25.5	20.7	18.6
2017	32.1	26.0	22.6
2018	36.8	29.6	26.1
2019	37.4	33.1	30.5
2020	38.8	34.2	30.6
2021	39.0	34.2	30.5
2022	38.0	31.0	27.9



Notes: Analysis includes data on Traditional Medicare (Parts A and B enrolled) beneficiaries attributed to 2 MSSP models. Penetration Rate = (Total number of beneficiary-months in MSSP) / Total number of beneficiary-months in FFS(AB)

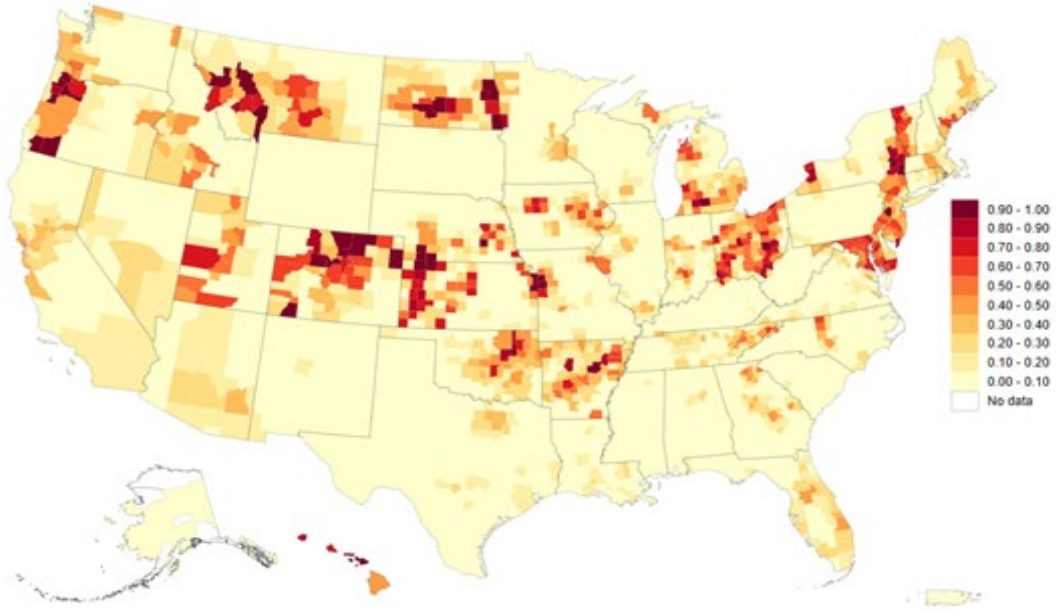
There is Significant Variation in Innovation Center Model Penetration Rates Among Medicare FFS Beneficiaries Across the United States

2013



Average Innovation Center Model penetration rate in 2013 was 3.9%.
Significant variation across counties (p10=0.1%, p50=0.5%, p90=14.8%).

2022

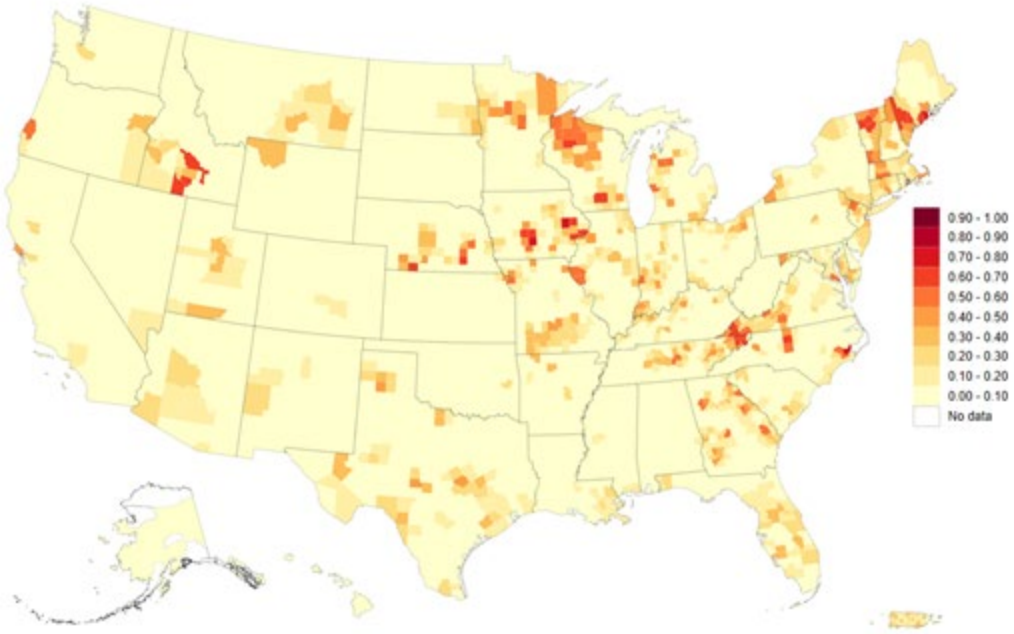


Average Innovation Center Model penetration rate in 2022 was 20%.
Significant variation across counties (p10=1.6%, p50=11.8%, p90=56.6%).

Notes: The Analysis includes data on Traditional Medicare (Parts A and B enrolled) beneficiaries attributed to 19 Innovation Center Models.
Penetration Rate = (Total number of beneficiary-months in Innovation Center Models) / Total number of beneficiary-months in FFS(AB) .
p10 = 10th percentile. p50= Median, p90= 90th percentile

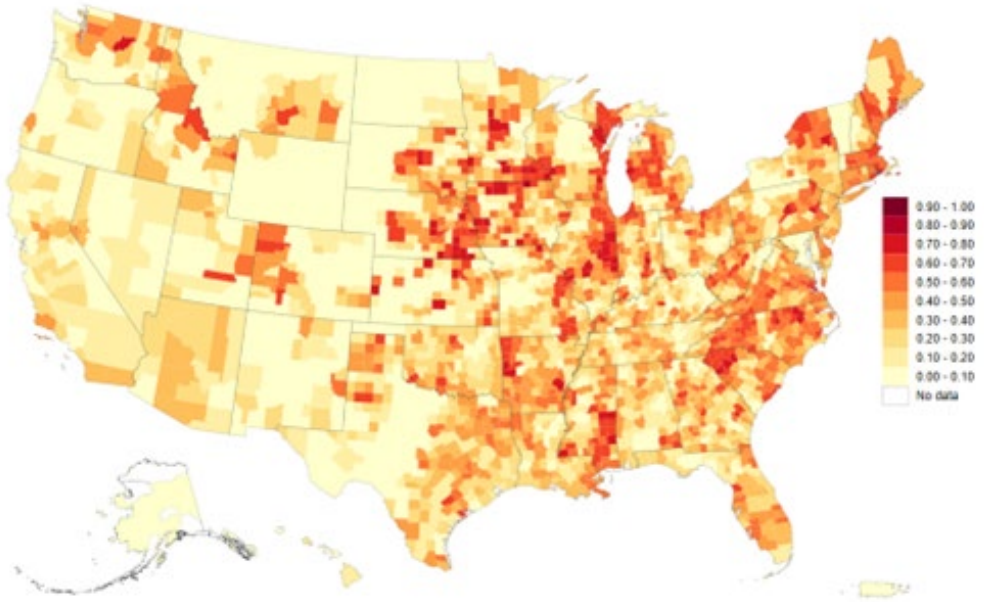
There is significant variation in Medicare Shared Savings Program (MSSP) Penetration Rates Among Medicare FFS Beneficiaries Across the United States

2013



Average MSSP penetration rate in 2013 was 10.8%. Significant variation across counties (p10=0.2%, p50=5.7%, p90=26.7%).

2022



Average MSSP penetration rate in 2022 was 36.2%. Significant variation across counties (p10=7.6%, p50=34.4%, p90=63.2%).

Notes: Analysis includes data on Traditional Medicare (Parts A and B enrolled) beneficiaries attributed to MSSP, MSSP with Comprehensive Primary Care Plus (CPC+).
Penetration Rate = (Total number of beneficiary-months in MSSP) / Total number of beneficiary-months in FFS(AB)
p10 = 10th percentile. p50= Median, p90= 90th percentile

Section 1

What are the adjusted trends in spending, utilization, and quality measures among Traditional Medicare beneficiaries across metropolitan, micropolitan, and rural (non-CBSA) areas?

Outcome variables

1. Medicare program Spending
2. Mortality
3. ER visits
4. Inpatient Stays
5. Office visits
6. HOPD visits
8. Transitional Care Management (TCM)
9. Chronic Care Management (CCM)
10. Advanced Care Planning (ACP)

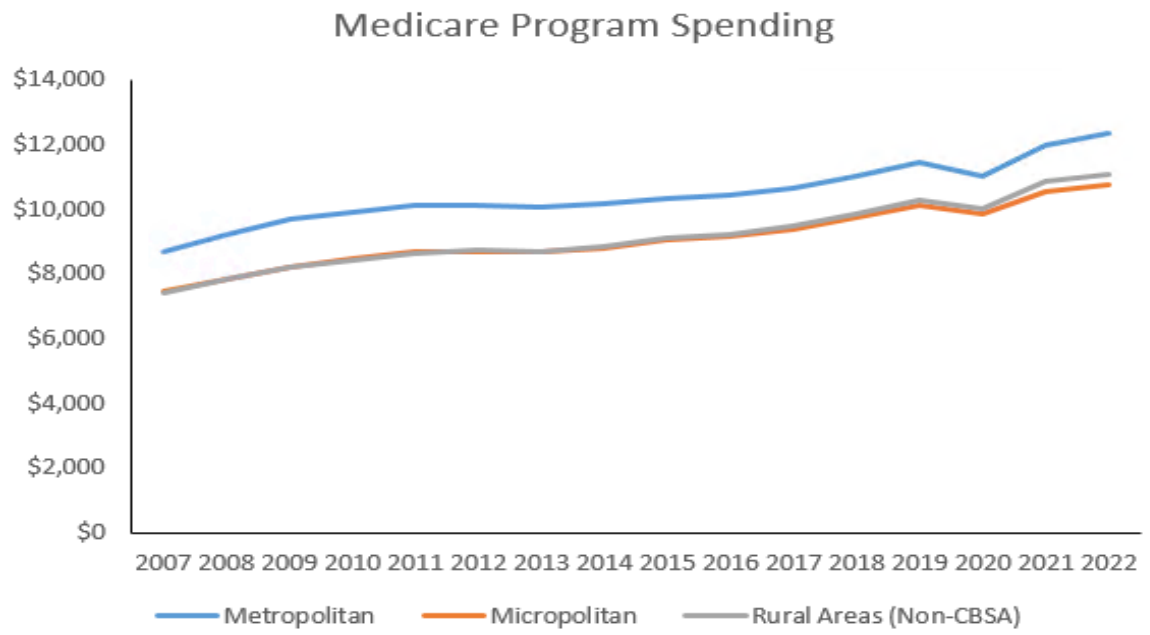
Stratified County-level Trends in Outcome Variables by Region (2007 -2022)

- **Region Definitions**: Metropolitan, Micropolitan, Rural (defined by CBSA type)
- **Outcomes:** *Medicare program spending, Mortality, ER visits, Inpatient Stays, Office visits, HOPD visits, Healthy Days at Home, Transitional Care Management (TCM), Chronic Care Management (CCM), Advanced Care Planning (ACP)*
- **Control variables*:** *Race/ethnicity, CMMI penetration, MSSP penetration, MA penetration, CCW Chronic conditions, Dual eligible, year fixed effects, baseline characteristics + interactions within all these covariates, Number of PCP & Non-PCP, County-fixed effects*
- ***Adjusted Outcomes**: Predicted outcomes controlling for covariates**

While There are Significant Differences in Medicare Program Spending Levels, the Overall Trends Remain Similar. Post-2012, the Annual Spending Growth Rate is Slightly Higher in Rural Areas

	Per Capita Medicare Spending (Parts A & B)		
Year	Metropolitan	Micropolitan	Rural Areas (Non-CBSA)
2007	$8,683	$7,441	$7,439
2008	$9,197	$7,833	$7,846
2009	$9,692	$8,227	$8,201
2010	$9,926	$8,481	$8,437
2011	$10,135	$8,660	$8,629
2012	$10,130	$8,707	$8,722
2013	$10,061	$8,678	$8,683
2014	$10,158	$8,799	$8,826
2015	$10,332	$9,057	$9,116
2016	$10,442	$9,165	$9,217
2017	$10,650	$9,380	$9,468
2018	$11,017	$9,739	$9,853
2019	$11,442	$10,110	$10,267
2020	$11,027	$9,828	$10,037
2021	$11,983	$10,564	$10,867
2022	$12,341	$10,764	$11,051

Notes: The Medicare payments are unstandardized. Medicare Spending presented here is in nominal dollars. Total payments in Medicare in the calendar year. Calculated as total payment by Medicare for Parts A and B services including Inpatient, SNF, Home Health, Hospice, Outpatient, Physician, and DME. Predicted outcome controlling for covariates.

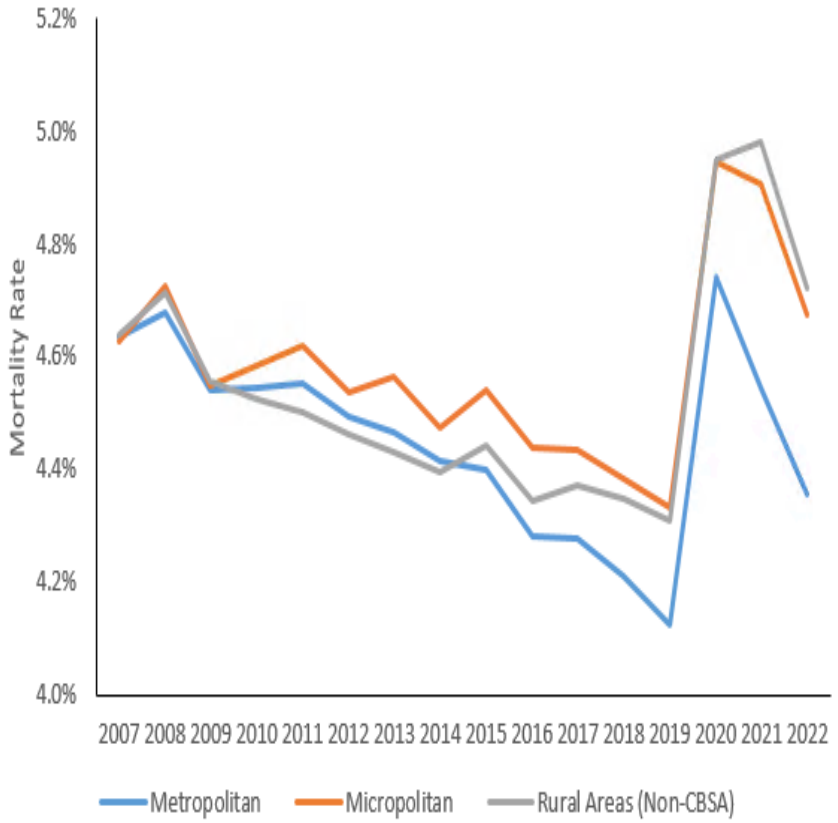


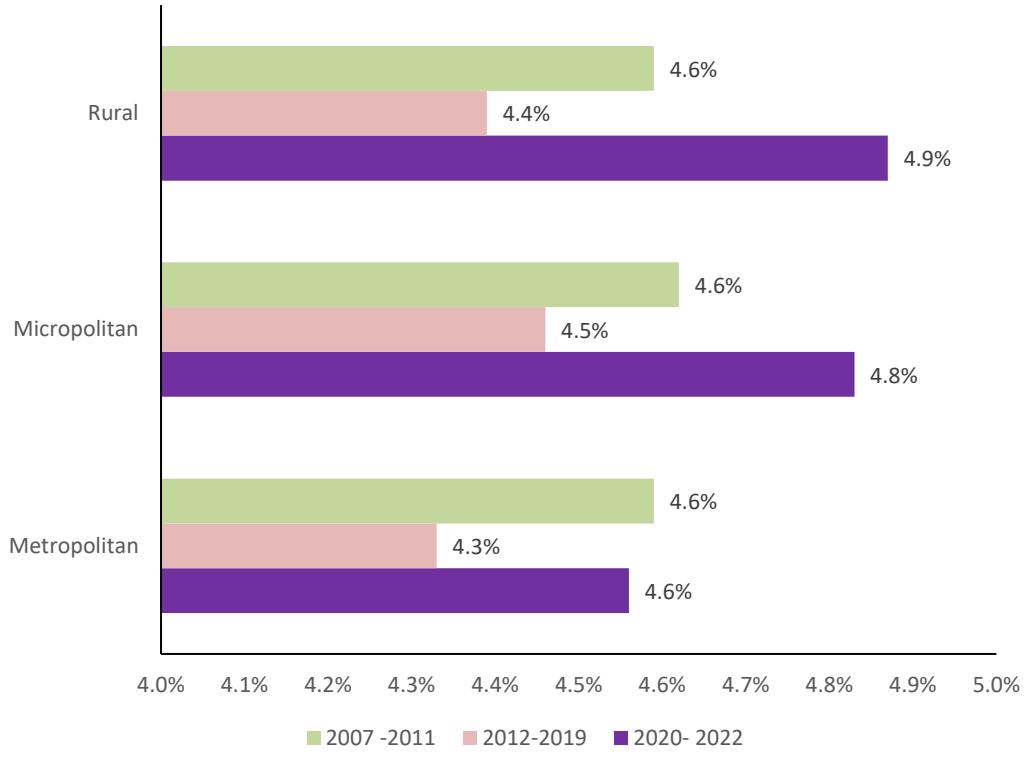
Annual per capita spending growth

Year	Metropolitan	Micropolitan	Rural
2007 -2011	3.8%	3.8%	3.7%
2012 -2022	2.0%	2.2%	2.5%

Mortality Rates are Higher in Micropolitan and Rural Areas, while Metropolitan Areas Are Experiencing a More Rapid Decline in Mortality Rates

Mortality rate in TM beneficiaries enrolled in Parts A and B

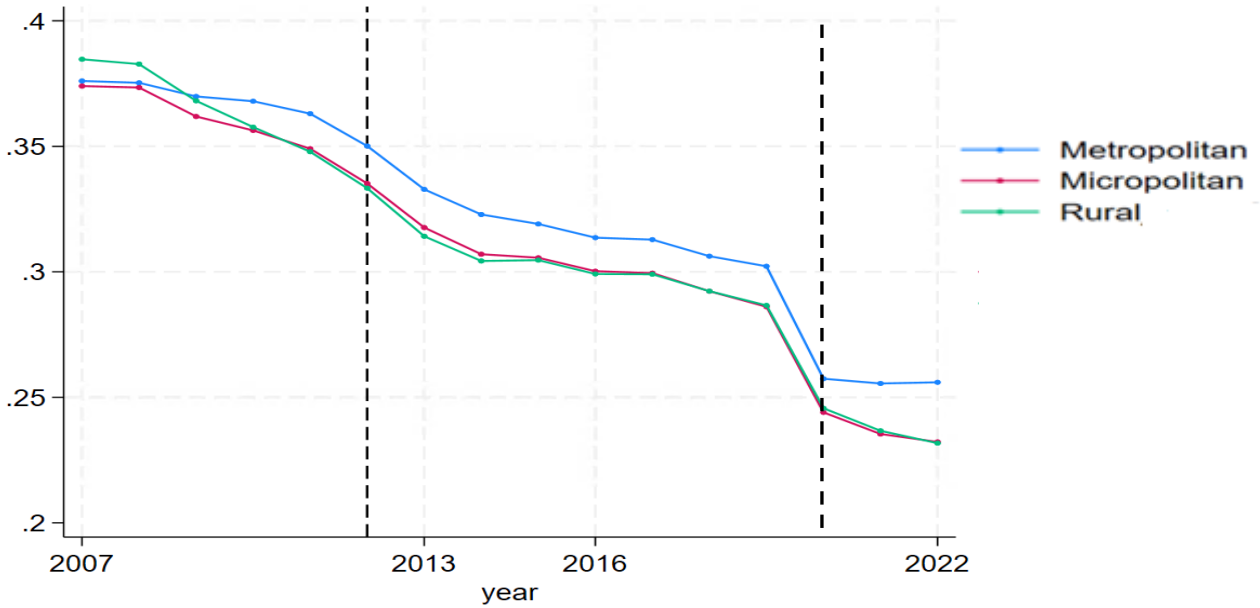




Notes: Mortality = Indicator of whether a beneficiary died in the calendar year. Rural = Rural Areas (Non_CBSA). Predicted outcome controlling for covariates.

Between 2007 and 2022, inpatient stays declined across all areas at an annual rate of 3%. Between 2020 and 2022, inpatient stays were 20% lower across all geographic areas compared to 2012-2019

Average Annual Inpatient Stays per beneficiary

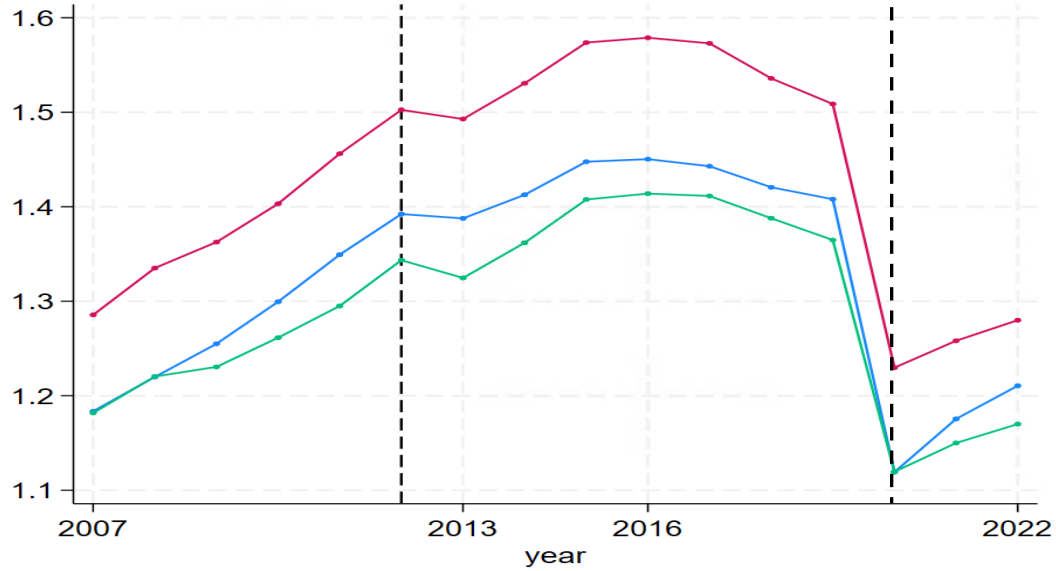


	Metropolitan	Micropolitan	Rural
2007 - 2011	0.37	0.36	0.37
2012 - 2019	0.32	0.31	0.30
2020 - 2022	0.26	0.24	0.24
	-19%	**-21%**	**-21%**

Notes: Inpatient stays=Total number of unique inpatient claims for the beneficiary in the calendar year. Rural = Rural Areas (Non_CBSA). Predicted outcome controlling for covariates.

Emergency room visits decreased by 16-18% across all geographic regions between 2020 and 2022 compared to 2012-2019

Average Annual ER visits per beneficiary

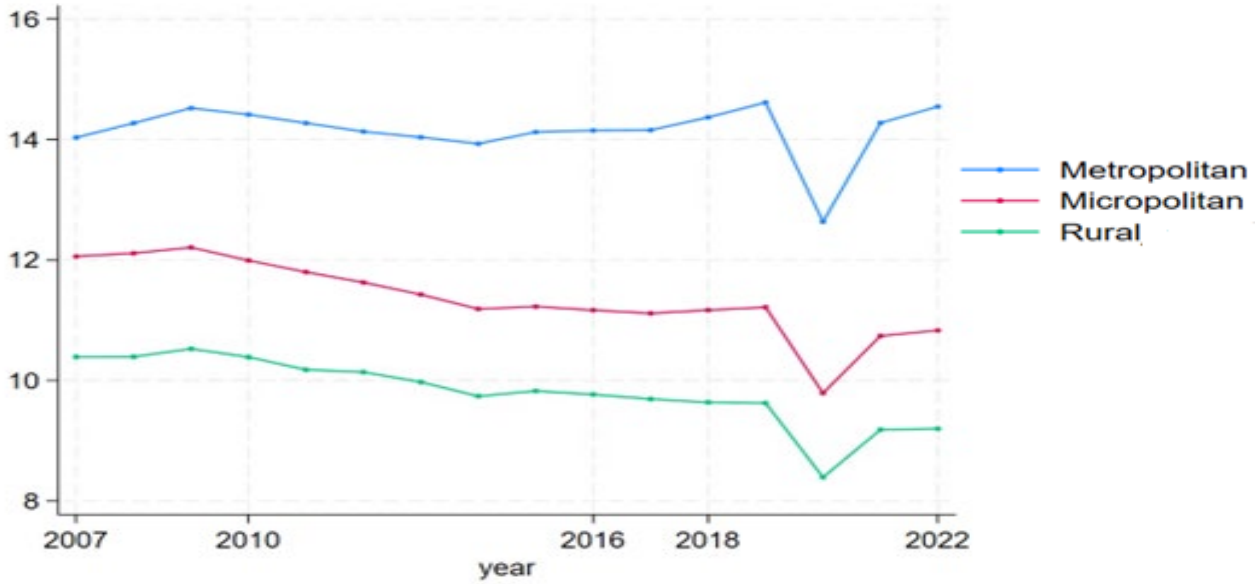


	Metropolitan	Micropolitan	Rural
2007 - 2011	1.26	1.37	1.23
2012 - 2019	1.42	1.54	1.38
2020 - 2022	1.17	1.26	1.16
	-18%	-18%	-16%

Note: ER visits=Total number of unique ER visit claims for the beneficiary in the calendar year. The sum of observational and non-observational visits for the beneficiary in the calendar year. Rural = Rural Areas (Non_CBSA). *Predicted outcome controlling for covariates.*

Office visit claims declined by 13% in rural and micropolitan areas between 2007-2011 and 2020-2022. Smaller decline of 3% in metropolitan areas

Average Doctor's office visit claims per beneficiary

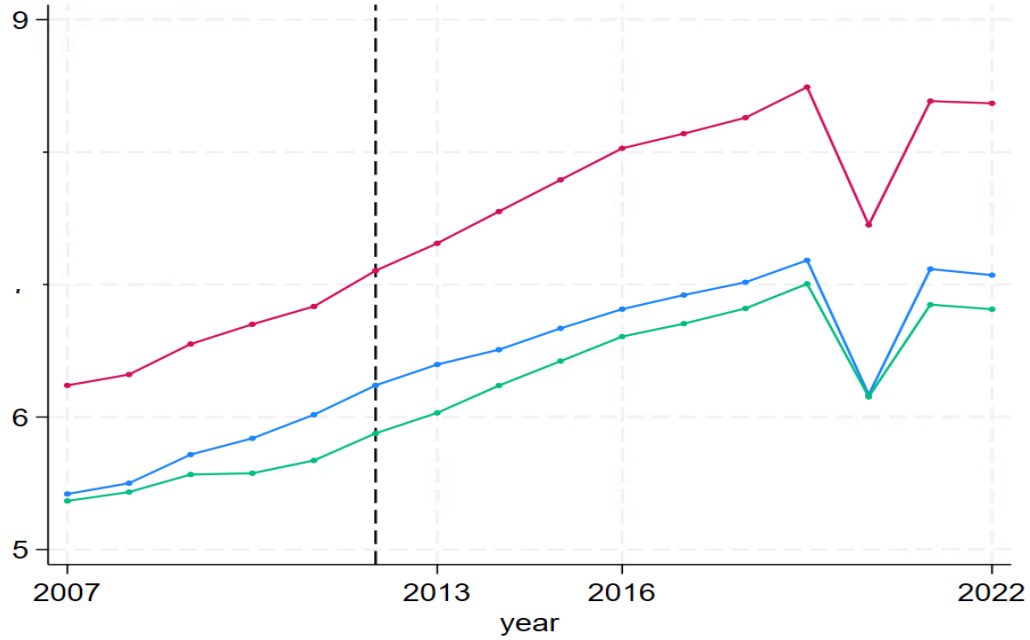


Period	Metropolitan	Micropolitan	Rural
2007-2011	14.3	12.0	10.4
2012-2019	14.2	11.3	9.8
2020-2022	13.8	10.5	8.9
2007 -2022	**-3%**	**-13%**	**-14%**

Notes: Office visits=Total number of unique office visit claims for the beneficiary in the calendar year. In Physician setting, office claim lines are identified using Line Place of Service Code (PLCSRVC)="11" (Office.) Rural = Rural Areas (Non_CBSA). Predicted outcome controlling for covariates.

Hospital Outpatient Department (HOPD) claims increased by 20% between 2007 -2011 and 2020-2022 across all regions

Average HOPD visit claims per beneficiary

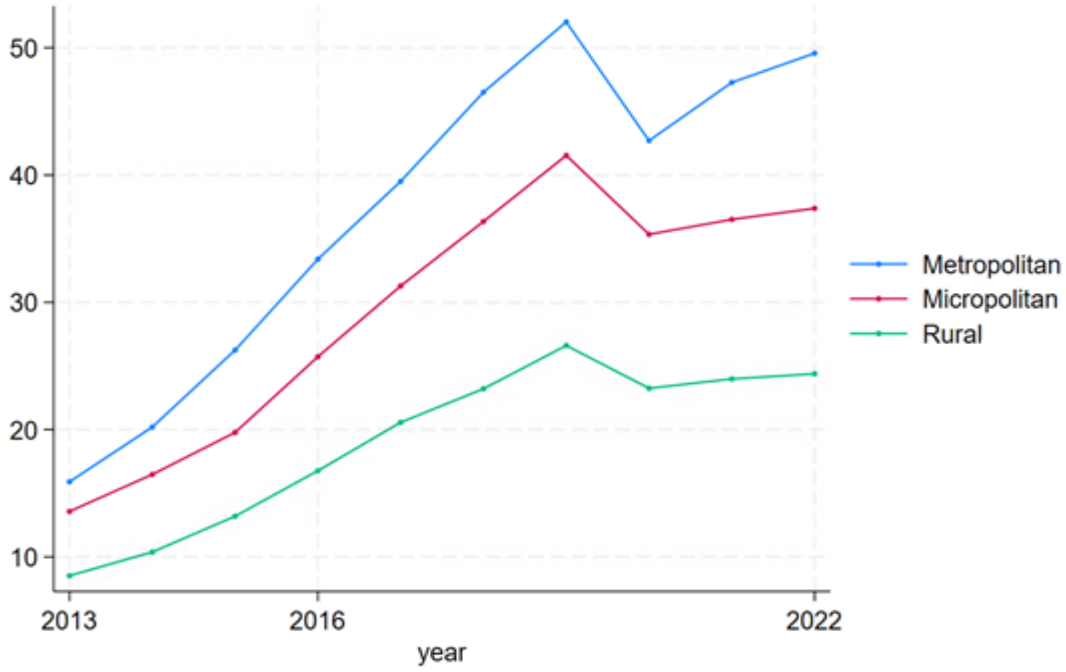


	Metropolitan	Micropolitan	Rural
2007 - 2011	5.7	6.5	5.5
2012 - 2019	6.7	7.9	6.5
2020 - 2022	6.8	8.0	6.6
2007 -2022	**21%**	**23%**	**20%**

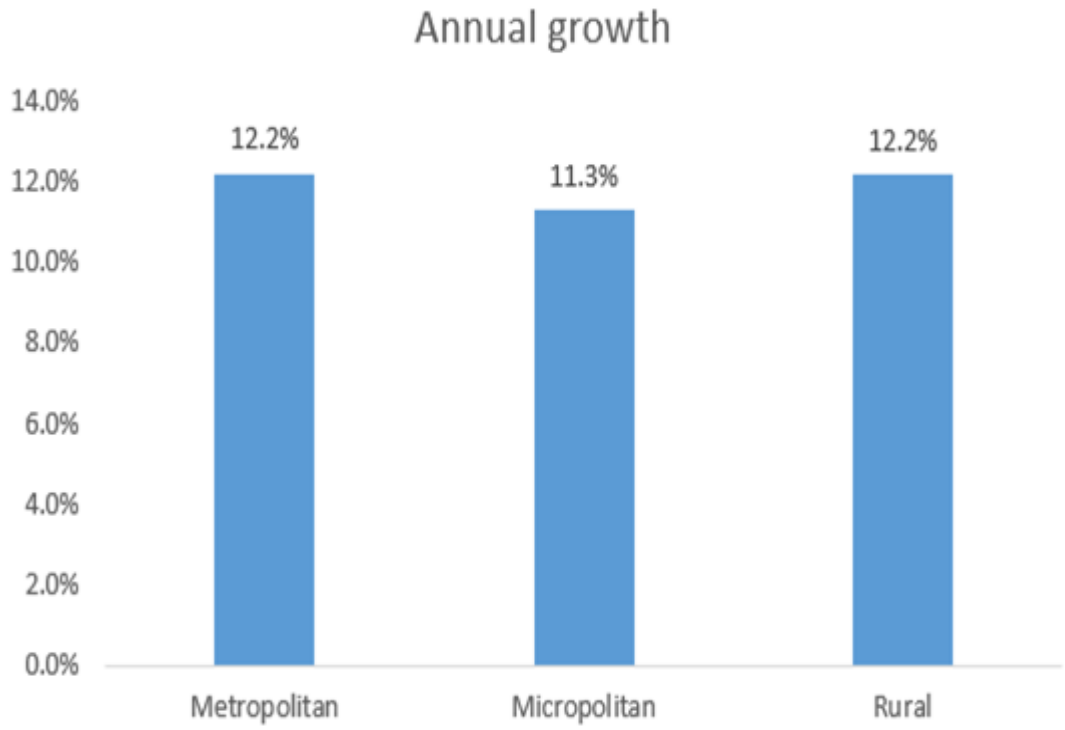
Notes: HOPD visits=Total number of unique HOPD claims for the beneficiary in the calendar year. In Hospital outpatient setting , HOPD revenue center lines identified where FAC_TYPE="1". In Physician setting, HOPD claim lines identified were PLCSRVC="19" & PLCSRVC="22". Rural = Rural Areas (Non_CBSA). Predicted outcome controlling for covariates.

There is a Significant Difference in TCM rates Across Regions; However, Overall Trends Remain Similar. Micropolitan Regions Show Slightly Lower Growth in TCM per 1,000 Beneficiaries

Number of Transitional Care Management (TCM) claim lines per 1,000 beneficiaries



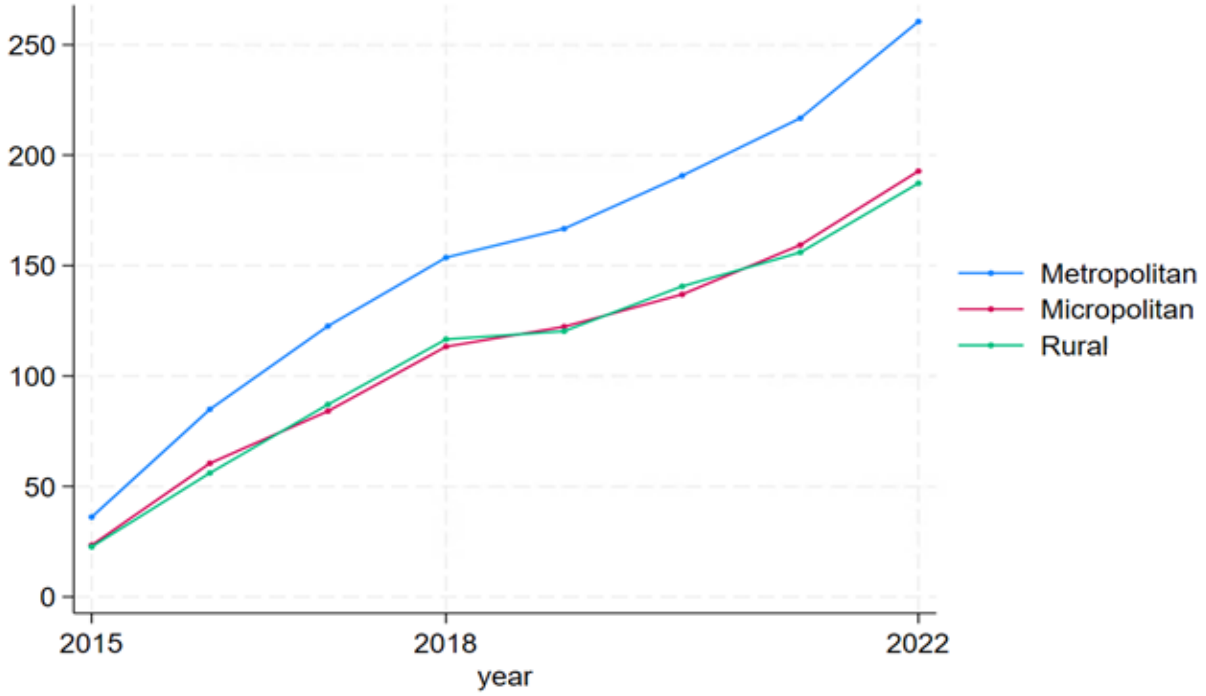
Notes: Total number of claim lines with transitional care management (TCM) for beneficiaries in Traditional Medicare with Parts A and B. TCM claims identified using HCPCS code in "99495" and "99496". Rural = Rural (Non_CBSA). Predicted outcome controlling for covariates.



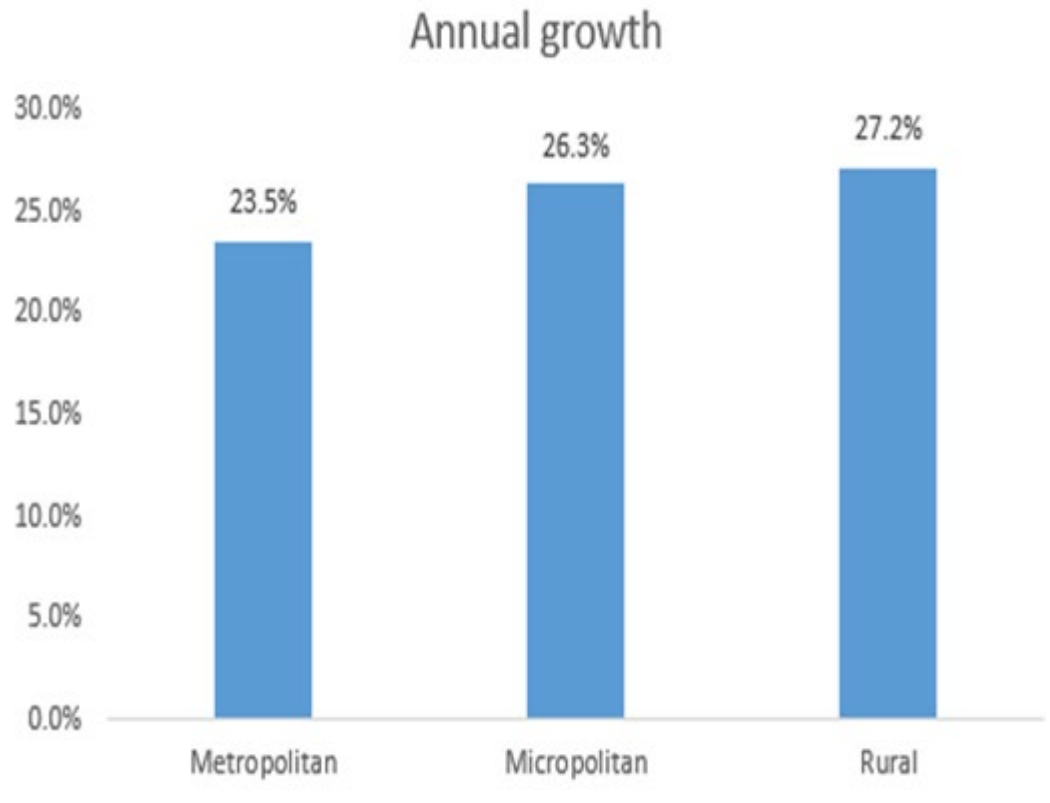
Notes: Annual growth between 2013 and 2022. Rural = Rural (Non_CBSA)

There is a Significant Difference in Levels, Yet the Overall Trends Remain Similar, with Rural and Micropolitan Areas Exhibiting Comparable Rates

Number of CCM claim lines per 1,000 beneficiaries



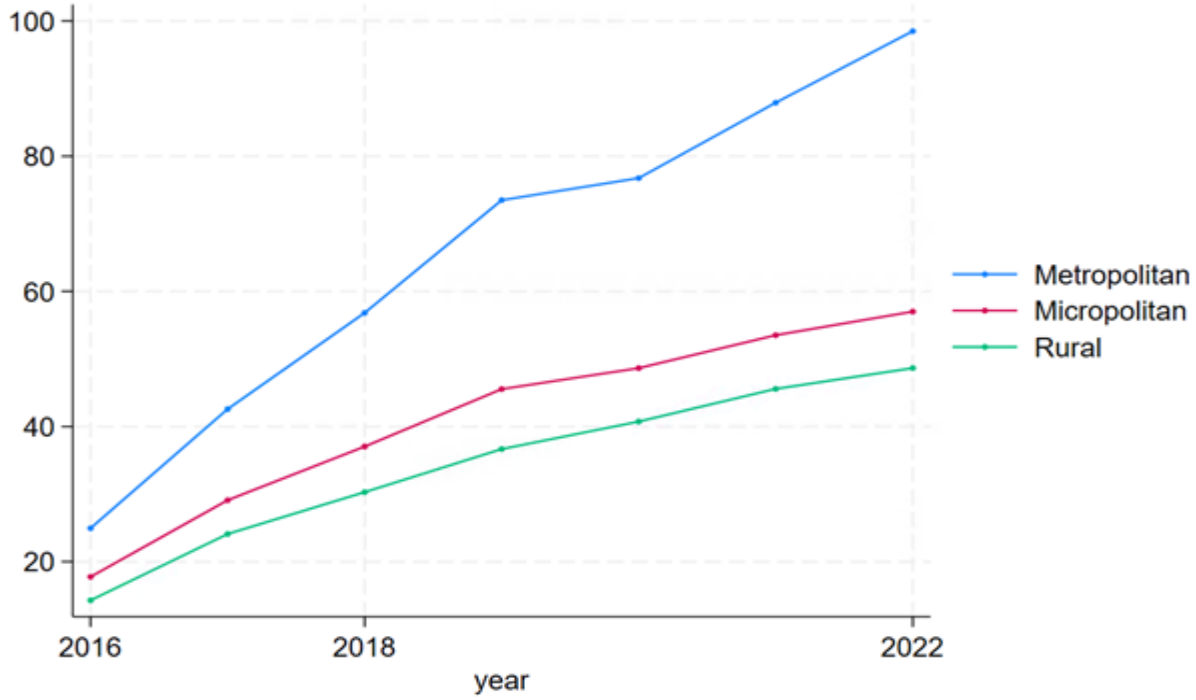
Notes: Total number of claim lines with chronic care management (CCM) for beneficiaries in Traditional Medicare with Parts A and B. CCM claims identified using HCPCS code in "99424", "99425", "99426", "99427", "99437", "99439", "99487", "99489", "99490" and "99491". Rural = Rural (Non_CBSA). Predicted outcome controlling for covariates.



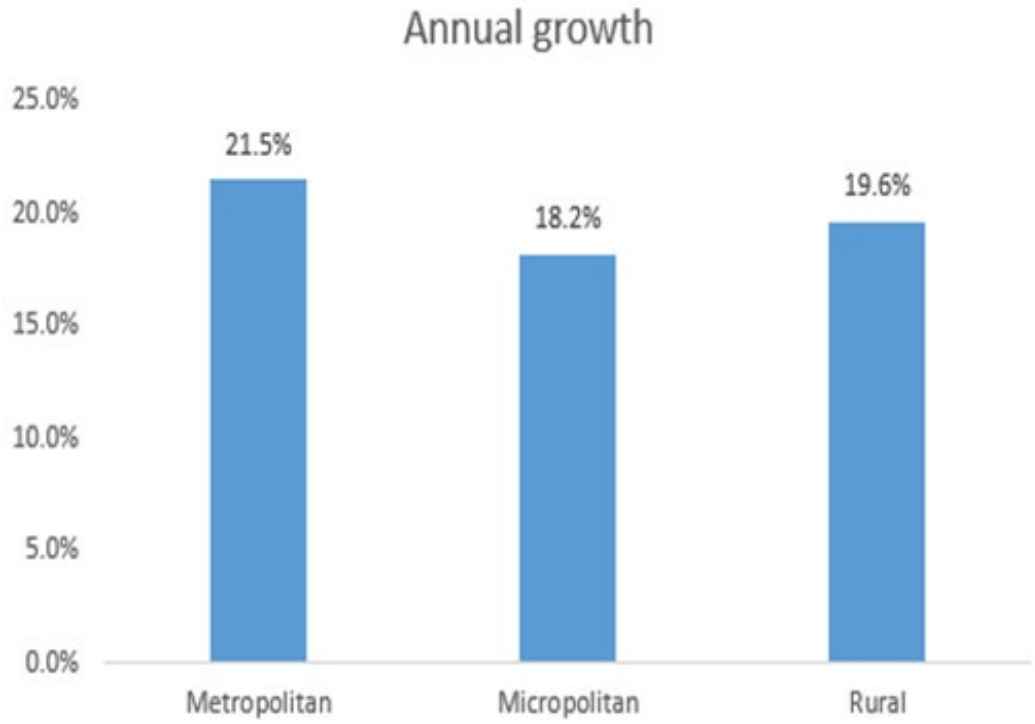
Notes: Annual growth between 2015 and 2022. Rural = Rural (Non_CBSA)

There is a Significant Difference in Levels. Advanced Care Planning (ACP) Growing at Lower Rates in Micropolitan and Rural Areas

Number of ACP claim lines per 1,000 beneficiaries



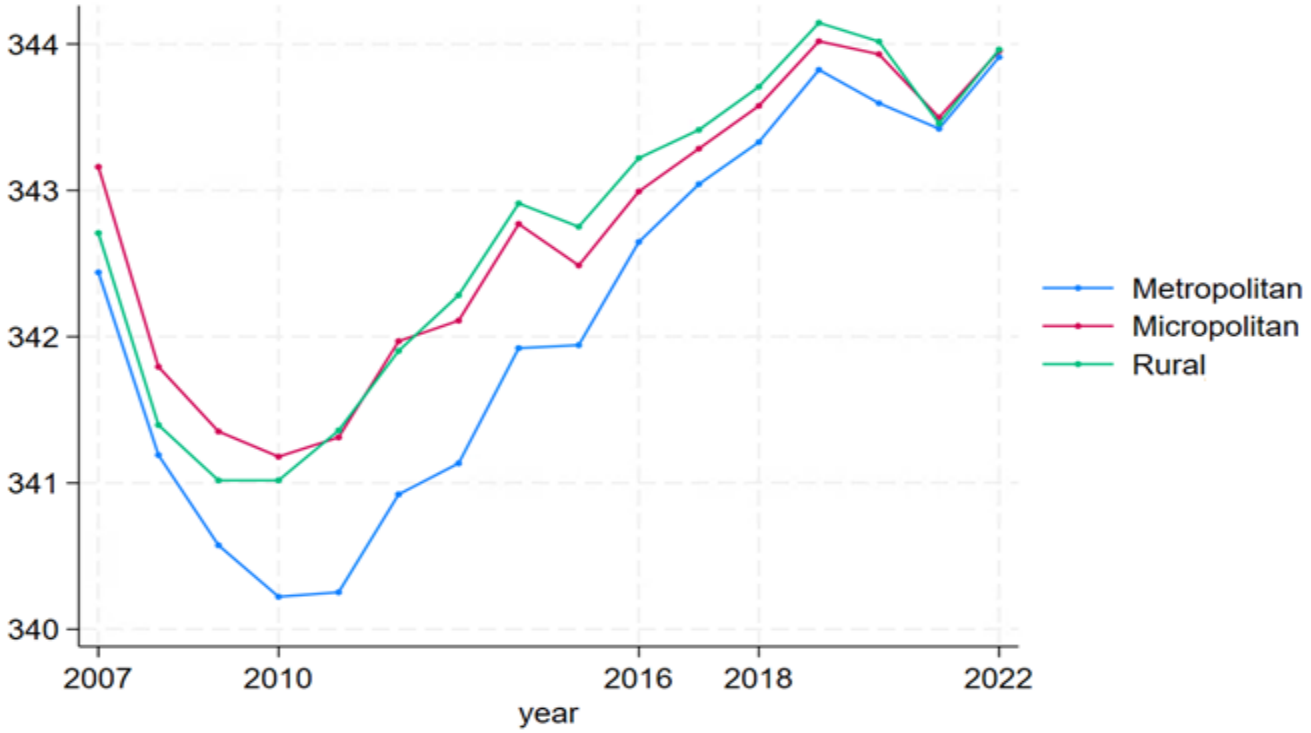
Notes: Total number of claim lines with Advanced Care Planning for beneficiaries with Parts A and B. CCM claims identified using HCPCS code in "99497", "99498". Rural = Rural (Non_CBSA). Predicted outcome controlling for covariates.



Notes: Annual growth between 2016 and 2022. Rural = Rural (Non_CBSA)

Healthy Days at Home Are Increasing Over Time Across All Regions

Average number of healthy days at home



Period	Metropolitan	Micropolitan	Rural
2007-2011	341	342	341
2012-2019	342	343	343
2020-2022	344	344	344

Notes: Health days at home (HDAH) = Number of Days Alive - (Number of Days in Inpatient + Inpatient Rehabilitation Facility (IRF) + Skilled Nursing Facility (SNF) + Long Term Care Hospital (LTCH) +Hospice + Home Health). Predicted outcome controlling for covariates.

Takeaways: Spending and Other Outcomes

- Levels continue to differ significantly across rurality
- After adjusting for important characteristics, no clear difference in trends across rurality over time
- Slightly higher Medicare spending growth in Rural (non-CBSA) areas since 2012
- Significantly higher levels of TCM, CCM and ACP rates in Metropolitan areas, however, the overall trends remain similar.

Section 2

What would be the impact on Medicare spending and other outcomes if the 19 Innovation Center Models or MSSP programs were absent in both urban and rural settings?

Regression Framework – Dose Response

Outcomes: *Medicare Program spending (2012 -2021), Other Outcomes*

Control variables*: *Race/ethnicity, any CMMI penetration (continuous) , MSSP penetration (continuous) , MA penetration (continuous) , CCW Chronic conditions, Dual eligible, year fixed effects, baseline characteristics + interactions within all these covariates, Number of PCP & Non-PCP + county fixed effects*

What happens to county-level spending?

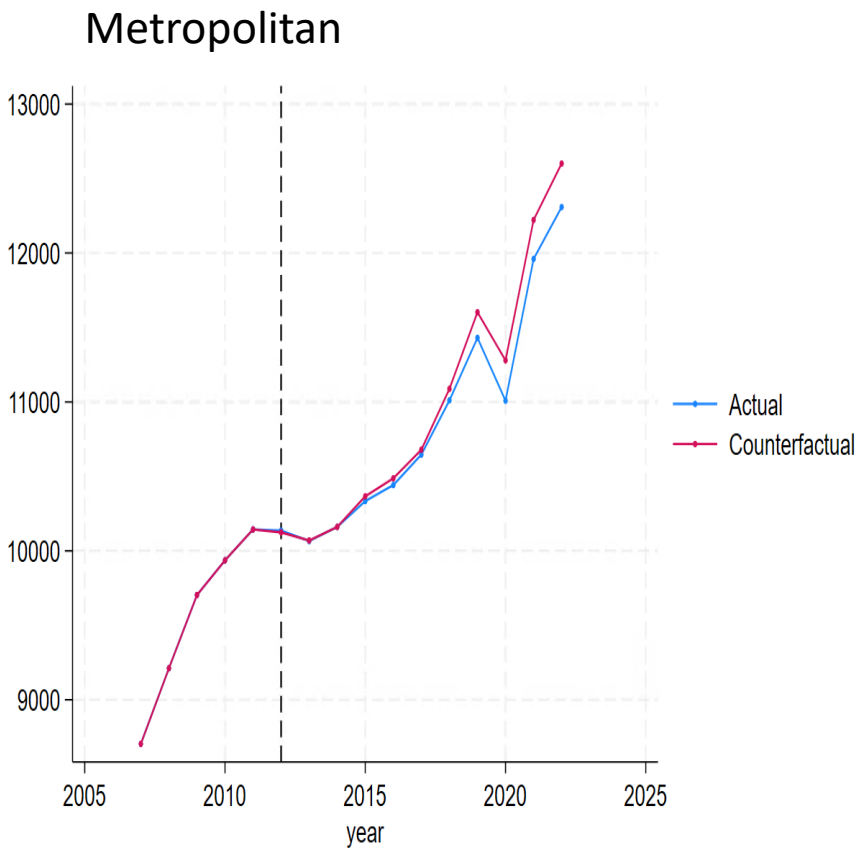
(1) Setting CMMI to 0 as Counterfactual

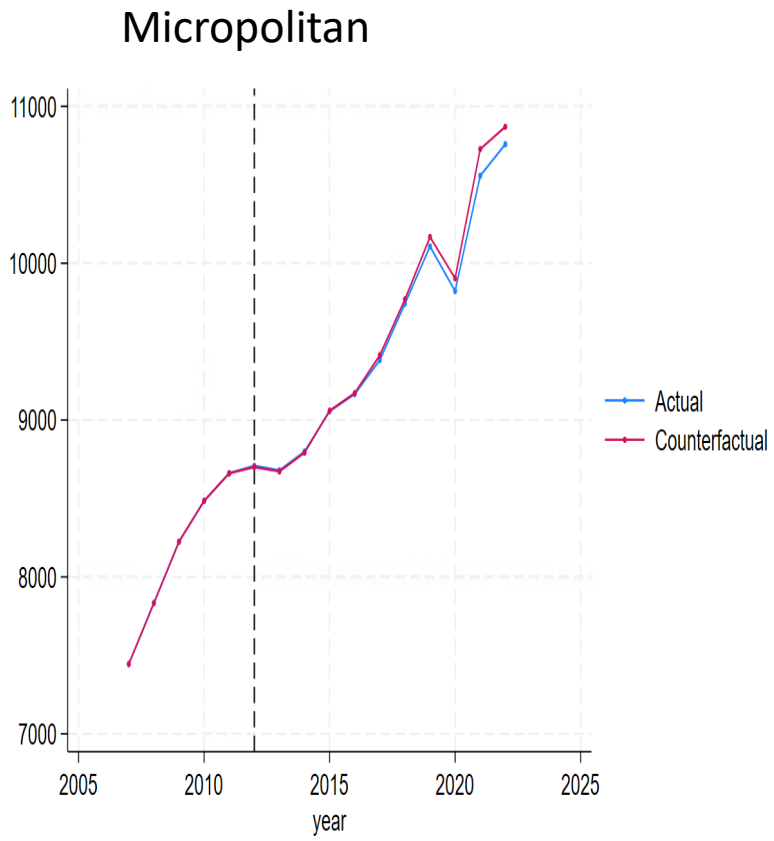
(2) Setting MSSP to 0 as Counterfactual

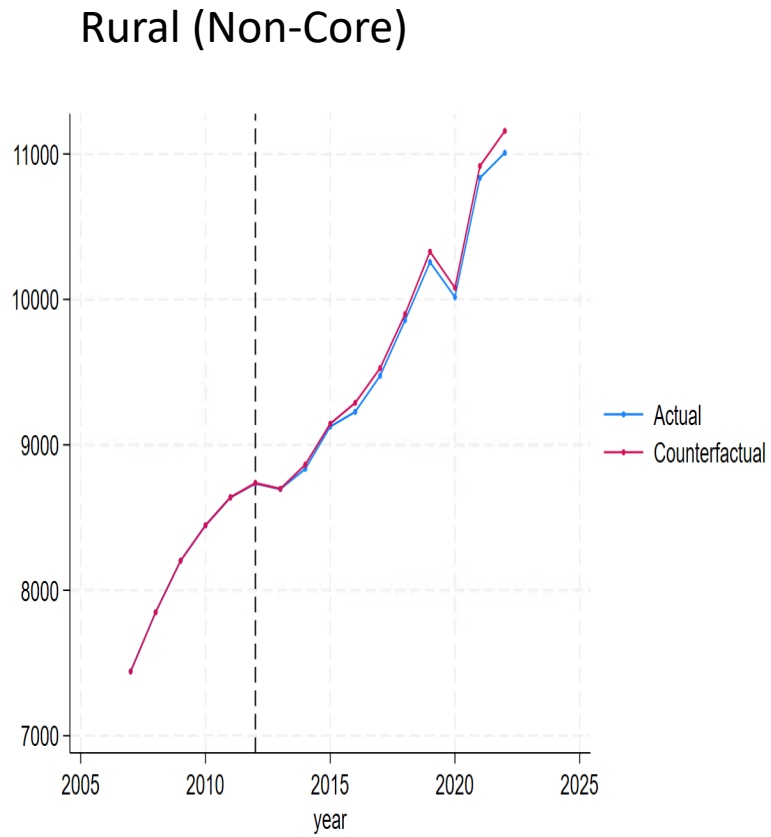
The analysis includes data on Traditional Medicare beneficiaries attributed to 21 Alternative Payment Models (APMs)

Stratified Regression:
Region Definitions: Metropolitan, Micropolitan, Rural (defined by CBSA type)

Spending Would be Higher Without Innovation Center Model & MSSP Jointly Across All Geographic Areas





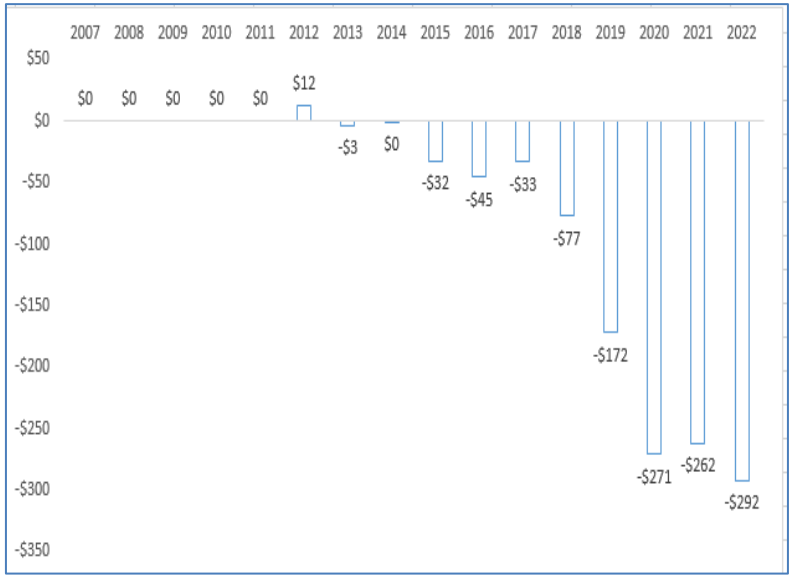


Notes: Figure illustrates the difference between predicted spending under actual Alternative payment models (Innovation Center models + MSSP) penetration rates (blue line) and counterfactual spending with zero APM models (Innovation Center models + MSSP) penetration (red line), while holding all other variables unchanged. The gap between the blue and red lines represents the estimated gross savings per Traditional Medicare beneficiary (AB enrolled) attributable to APM models, encompassing both direct and indirect effects. While the two lines follow closely, the gap between them still represents appreciable savings, especially in later years. The analysis includes data on Traditional Medicare beneficiaries attributed to 21 Alternative Payment Models (APMs).

Spending Would be Higher Without Innovation Center Model & MSSP Jointly Across All Geographic Areas. Savings from Alternative Payment Models Increase Over Time

Metropolitan

Setting CMMI/MSSP to 0 as Counterfactual

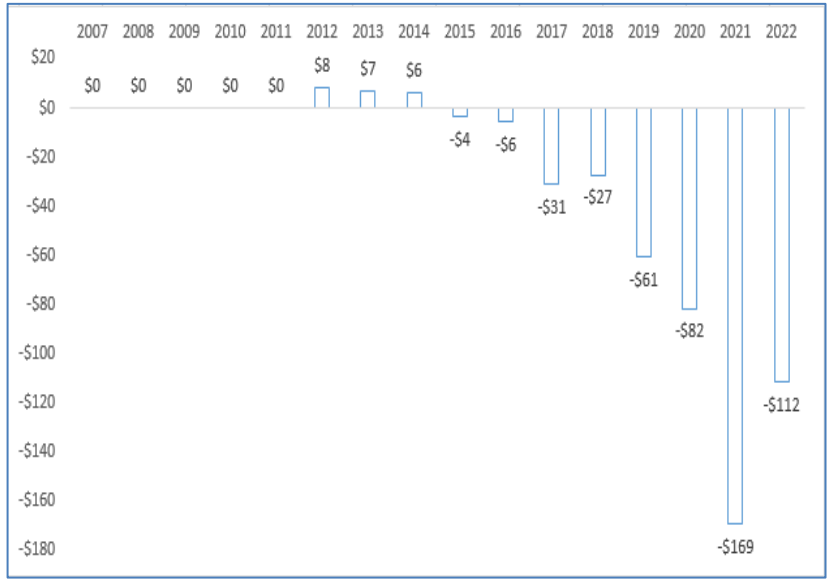


2012- 2022: $104 per person ($2.5B Annually)
2022: $292 per person ($6.5B) ~ 2.4% of total

Savings of $104 per person annually between 2012- 2022
Higher savings of $292 (2.4% of total) per person in 2022

Micropolitan

Setting CMMI/MSSP to 0 as Counterfactual

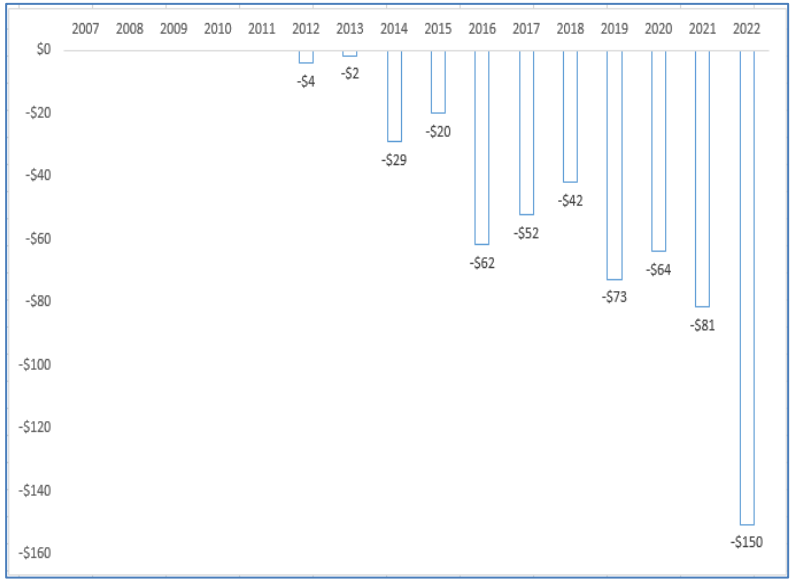


2012- 2022: $40 per person ($0.15 B Annually)
2022: $112 per person ($0.36B) ~ 1.0% of total

Savings of $40 per person annually between 2012- 2022
Higher savings of $112 (1.0% of total) per person in 2022

Rural (Non-Core)

Setting CMMI/MSSP to 0 as Counterfactual



2012- 2022: $51 per person ($0.14 B Annually)
2022: $150 per person ($0.37B) ~ 1.4% of total

Savings of $51 per person annually between 2012- 2022
Higher savings of $150 (1.4% of total) per person in 2022

Notes: The bars represent the estimated gross savings per Traditional Medicare beneficiary (AB enrolled), encompassing both direct and indirect effects. While the bars are small, the bars still represents appreciable savings, especially in later years. The analysis includes data on Traditional Medicare beneficiaries attributed to 21 Alternative Payment Models (APMs)

Takeaways: Spending

Spending Would Be Higher Without CMMI & MSSP Jointly

❑ **Metropolitan areas**:

- Savings of $104 per person annually between 2012- 2022
- Higher savings of $292 (2.4% of total) per person in 2022

❑ **Micropolitan areas**:

- Savings of $40 per person annually between 2012- 2022
- Higher savings of $112 (1.0% of total) per person in 2022

❑ **Rural areas**:

- Savings of $51 per person annually between 2012- 2022
- Higher savings of $150 (1.4% of total) per person in 2022

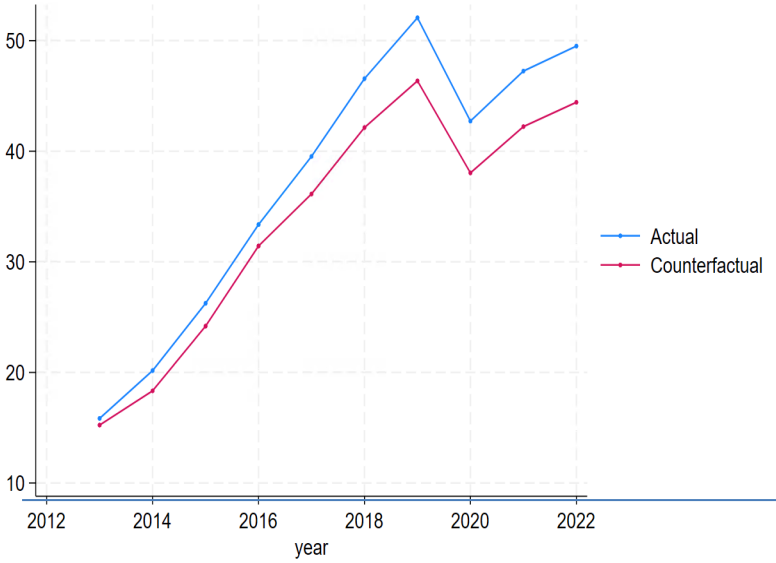
Note : The analysis includes data on Traditional Medicare beneficiaries attributed to 21 Alternative Payment Models (APMs)

Impact of Alternative Payment Models on Other Outcomes

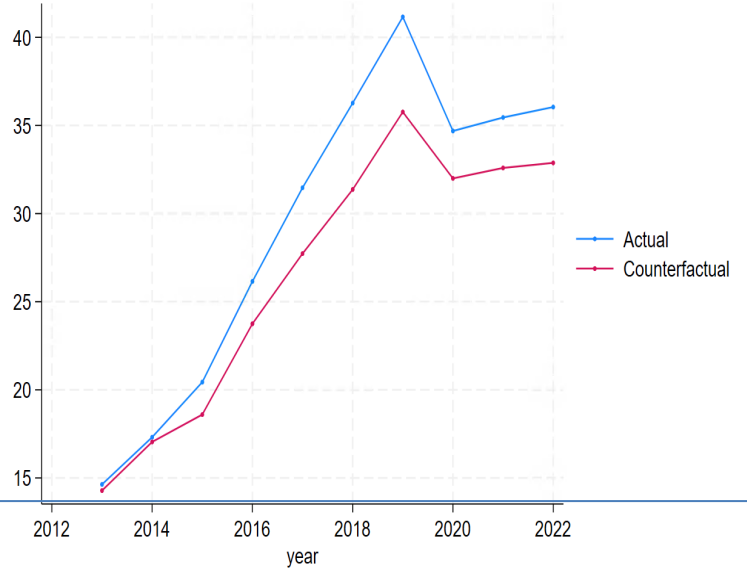
- What would be the impact on TCM and ACP if the Innovation Center and MSSP programs were absent in both urban and rural settings ?

Transitional Care Management (TCM) Claim Lines per 1,000 Beneficiaries Would Be 9% Lower Without CMMI & MSSP

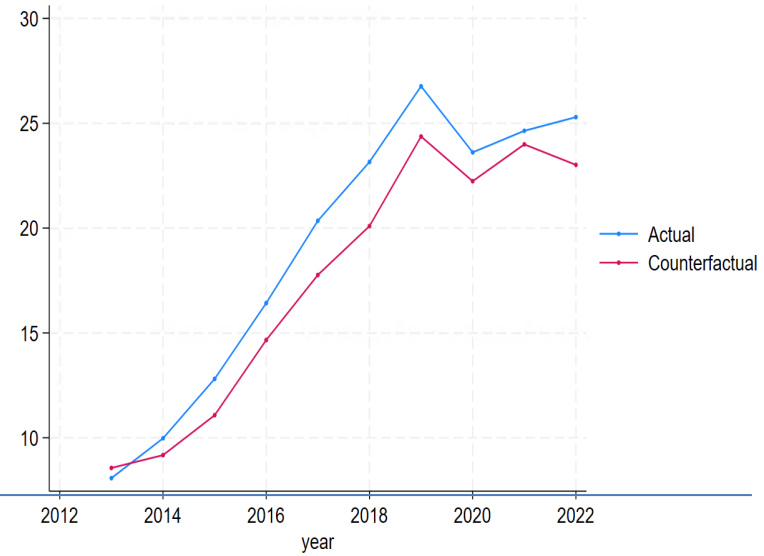
Metropolitan



Micropolitan



Rural



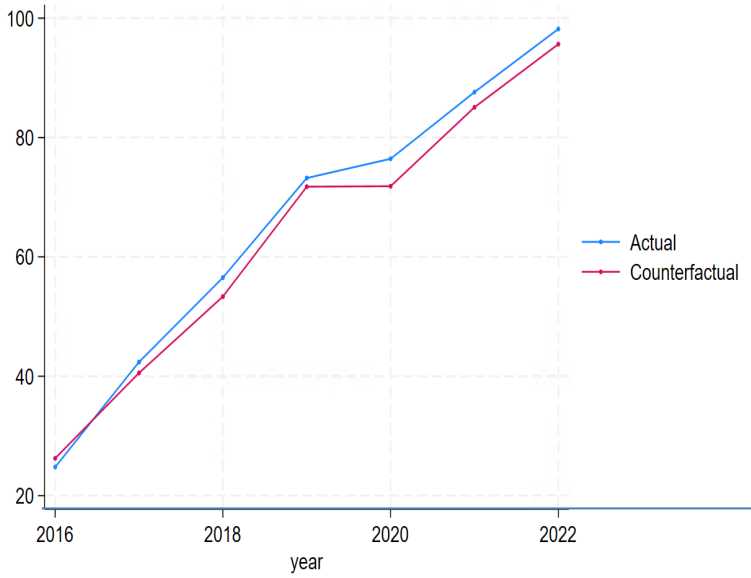
Notes: Figure illustrates the difference between predicted TCM under actual Alternative payment models (Innovation Center models + MSSP) penetration rates (blue line) and counterfactual TCM with zero APM models (Innovation Center models + MSSP) penetration (red line), while holding all other variables unchanged. The gap between the blue and red lines represents the estimated TCM per Traditional Medicare beneficiary (AB enrolled) attributable to APM models, encompassing both direct and indirect effects. While the two lines follow closely, the gap between them still represents significant difference, especially in later years. The analysis includes data on Traditional Medicare beneficiaries attributed to 21 Alternative Payment Models (APMs)

2013 -2022

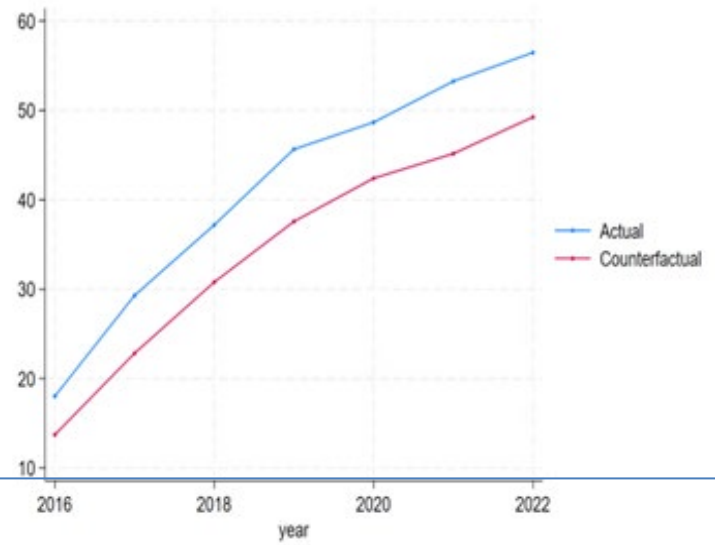
	Metropolitan	Micropolitan	Rural
Actual	37.3	29.4	19.1
Counterfactual	33.9	26.6	17.5
	-9.3%	-9.4%	-8.5%

ACP Claim Lines per 1,000 Beneficiaries Would be Significantly Lower in Micropolitan and Rural Areas Without CMMI & MSSP

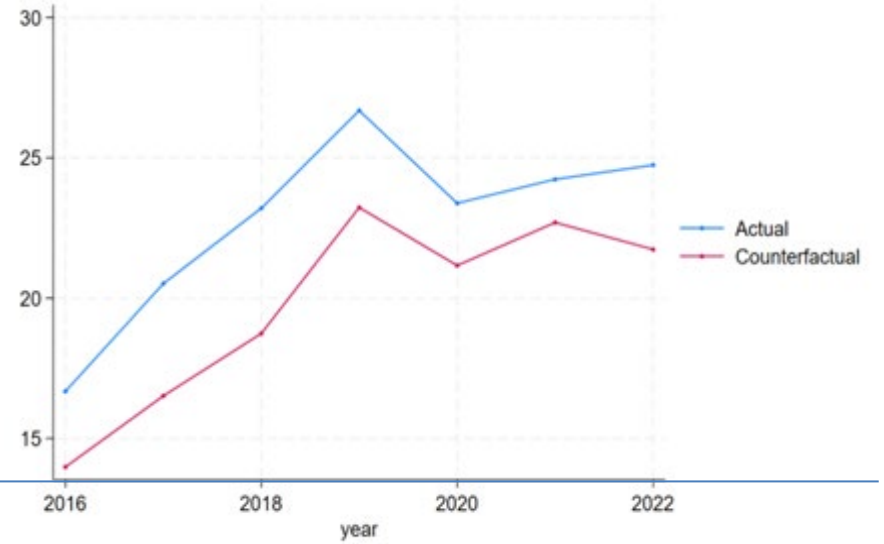
Metropolitan



Micropolitan



Rural



Notes: Figure illustrates the difference between predicted ACP under actual Alternative payment models (Innovation Center models + MSSP) penetration rates (blue line) and counterfactual ACP with zero APM models (Innovation Center models + MSSP) penetration (red line), while holding all other variables unchanged. The gap between the blue and red lines represents the estimated ACP per Traditional Medicare beneficiary (AB enrolled) attributable to APM models, encompassing both direct and indirect effects. While the two lines follow closely, the gap between them still represents appreciable difference, especially in later years. The analysis includes data on Traditional Medicare beneficiaries attributed to 21 Alternative Payment Models (APMs)

	2016 -2022		
	Metropolitan	**Micropolitan**	**Rural**
Actual	65.6	42.1	22.8
Counterfactual	63.5	33.9	19.7
	-3.2%	-19.5%	-13.4%

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Smaller Impact on Other Outcomes Without CMMI & MSSP

Metropolitan

	2012 - 2022			
	ER visits	IP stays	Mortality	HDAH
Actual	1.35	0.30	4.40%	342.70
Counterfactual	1.36	0.31	4.41%	342.33
	0.7%	1.7%	0.4%	-0.1%

Micropolitan

	2012 - 2022			
	ER visits	IP stays	Mortality	HDAH
Actual	1.32	0.29	4.52%	343.25
Counterfactual	1.32	0.29	4.51%	343.22
	0.4%	0.3%	-0.2%	-0.01%

Rural

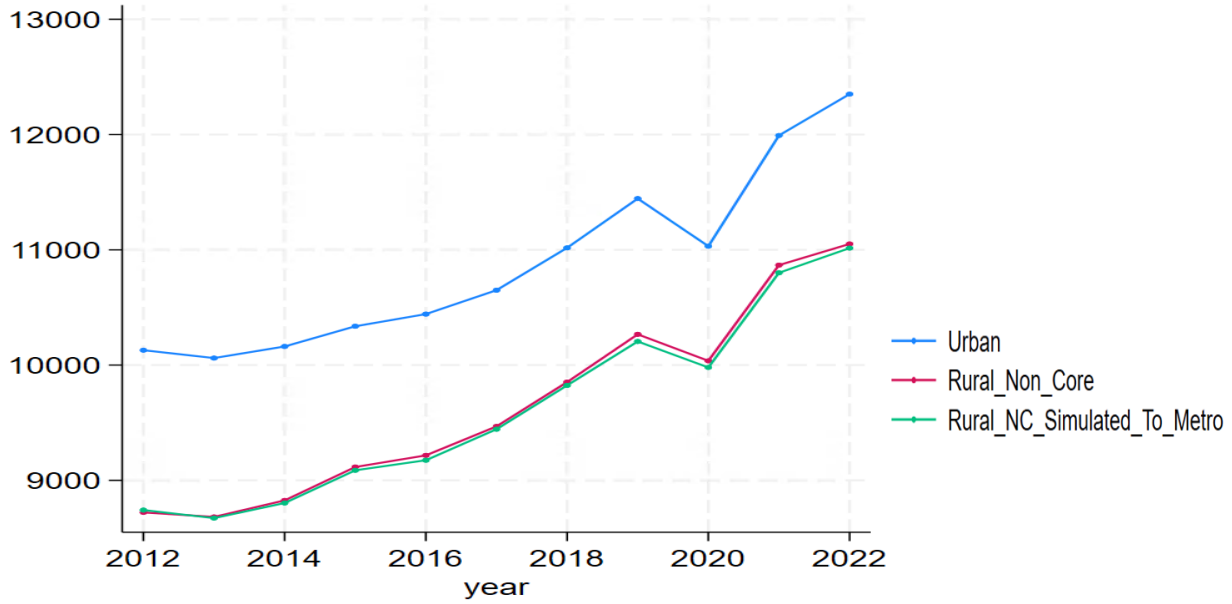
	2012 - 2022			
	ER visits	IP stays	Mortality	HDAH
Actual	1.46	0.29	4.57%	343.14
Counterfactual	1.46	0.29	4.57%	342.99
	0.1%	0.6%	0.1%	-0.05%

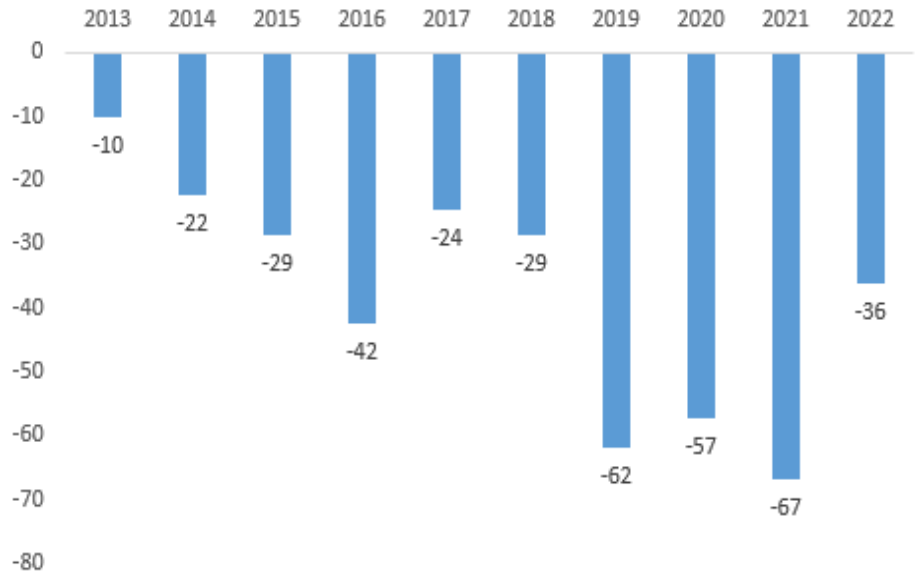
Notes: Table illustrates the difference between predicted outcomes (Inpatient Stays, ER visits, Mortality and Healthy Days at Home) under actual Alternative payment models (Innovation Center models + MSSP) penetration rates (blue line) and counterfactual outcomes (Inpatient Stays, ER visits, Mortality and Healthy Days at Home) with zero APM models (Innovation Center models + MSSP) penetration (red line), while holding all other variables unchanged. Smaller impact of these outcomes.

Section 3

What would happen to Medicare spending if Rural(Non-Core) areas in the state experienced Metropolitan Innovation Center Model and MSSP penetration rates?

Rural Areas Would Have a $37 Per Person Reduction in Annual Spending (~$0.11 B Annually)

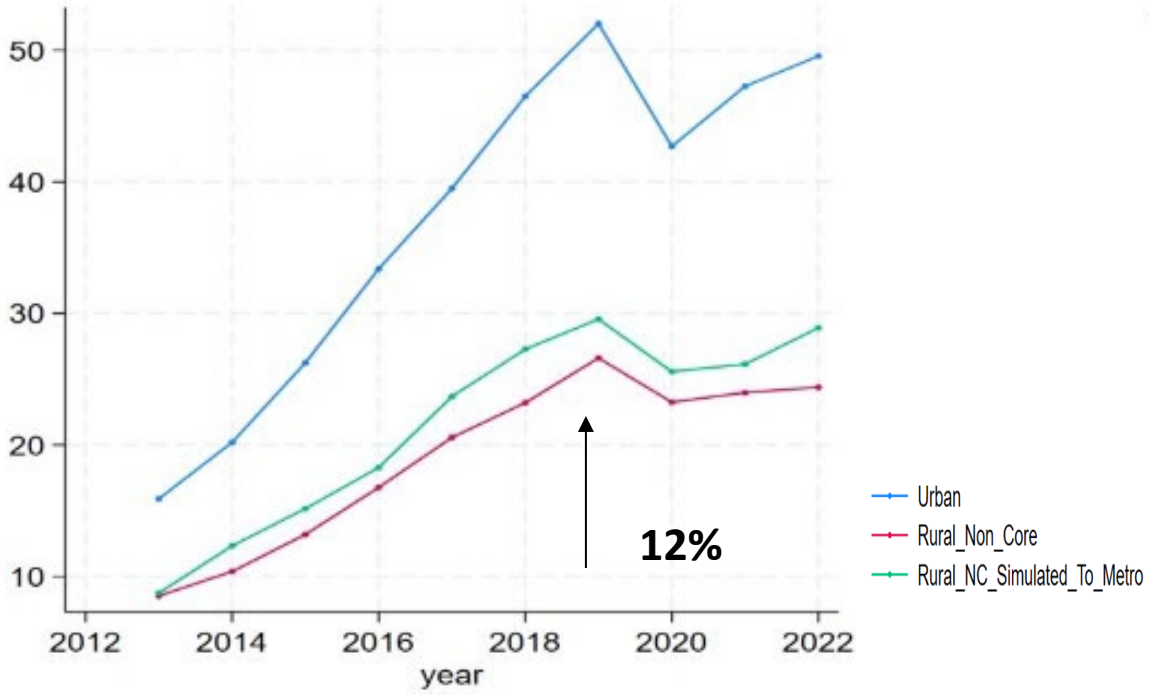




- **Red Line:** Shows the predicted spending under actual Alternative Payment Models (Innovation Center models + MSSP) based on current penetration rates in rural (non-CBSA) areas.
- **Green Line**: This would set the CMMI and MSSP penetration rates for rural (non-CBSA) areas to match the metropolitan (CBSA) penetration rates within the same state.
- **Gap Between Red and Green Lines**: This represents the potential savings per Traditional Medicare beneficiary (AB enrolled) if the rural areas in the sate (non-CBSA) had the same penetration rate as the metropolitan areas.

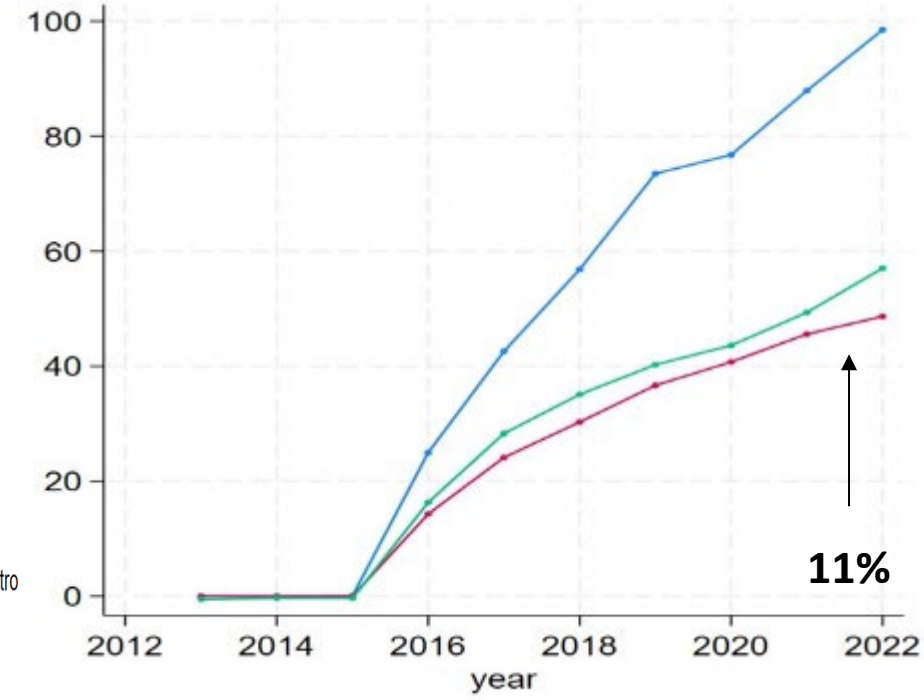
TCM Rates Would be Higher by 12%
ACP Rates Would be Higher by 11%

TCM per 1,000



Rural areas would have 12% higher TCM

ACP per 1,000



Rural areas would have 11% higher ACP

- **Red Line:** Shows the predicted spending under actual Alternative Payment Models (Innovation Center models + MSSP) based on current penetration rates in rural (non-CBSA) areas.
- **Green Line**: This would set the Innovation Center models and MSSP penetration rates for rural (non-CBSA) areas to match the metropolitan (CBSA) penetration rates within the same state.
- **Gap Between Red and Green Lines**: This represents the potential difference per Traditional Medicare beneficiary (AB enrolled) if the rural areas in the sate (non-CBSA) had the same penetration rate as the metropolitan areas.

Takeaway:

- **If Rural areas in the state experienced urban CMMI/MSSP penetration rates,**
- Rural areas would have $37 per person reduction in annual spending. ~$0.11 B annually in total
- TCM rates would be higher by 12%
- ACP rates would be higher by 11%