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Rural Implications of Increased Medicare Beneficiary Enrollment in ACOs and MA Plans

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Purpose

This brief explores the interplay of Medicare Advantage (MA) enrollment and beneficiary attribution to Centers for Medicare & Medicaid Services (CMS) Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO). MA enrollees are not eligible for such ACO attribution, and both payment models are drawn from the same pool of Medicare beneficiaries. As the number of beneficiaries not participating in either is shrinking, it is important to understand how the growth (or shrinkage) in one model influences participation in the other.

Key Findings

- Significant growth in both MSSP ACO assignment and Medicare Advantage enrollment occurred between 2013 and 2023. ACO assignment grew from 3.2 million to 9.9 million beneficiaries, more than tripling (206 percent growth), while MA enrollment increased from 14.0 million to 30.7 million beneficiaries, more than doubling (120 percent growth).
- Between 2013 and 2023, rural (nonmetropolitan) areas experienced faster growth in both ACO assignment and MA enrollment than metropolitan areas. The percentage of Medicare beneficiaries assigned to an MSSP ACO increased from 5.1 percent to 18.6 percent in micropolitan counties and from 4.9 percent to 18.4 percent in noncore counties, compared with 7.5 percent to 16.5 percent in metropolitan counties. Similarly, the percentage of Medicare beneficiaries enrolled in MA increased from 20.9 percent to 45.8 percent in micropolitan counties and from 17.9 percent to 44.3 percent in noncore counties, compared with 32.9 percent to 54.0 percent in metropolitan counties.
- Despite faster ACO growth rates, MA plans maintained a broader reach due to a higher starting point (30.4 percent enrollment/penetration vs. 7.0 percent attribution for ACOs in 2013).

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- In 2023, 30.7 percent of eligible Medicare beneficiaries were not enrolled in an MA plan or assigned to an ACO, with noncore counties comprising the largest share.
- Counties with low uptake of both MA plans and MSSP ACOs were more rural and underserved, often with small populations and limited infrastructure, but more likely to include a Critical Access Hospital (CAH).

Background

CMS offers benefits to Medicare enrollees through several modalities. Beneficiaries in 'Original' Medicare can choose to seek their health care from any provider that accepts Medicare. Some of those Original Medicare beneficiaries may be attributed to an ACO which CMS defines as "groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs".[1] Beneficiaries are attributed to an MSSP ACO when they receive a plurality of their primary care from a provider that is a member of that ACO. CMS's concept of ACOs was formally introduced through the Patient Protection and Affordable Care Act of 2010, which authorized the implementation of the MSSP – the largest long-standing ACO program, serving up to 12.6 million assigned beneficiaries in 2026.[2] For the remainder of this document, the term 'ACO' will be used to include only MSSP ACOs.

The other primary modality that CMS uses to provide benefits to Medicare enrollees is through MA plans. Established (as "Medicare+Choice") by the Balanced Budget Act of 1997 and expanded (and renamed) under the Medicare Modernization Act of 2003, MA plans are offered by private insurers and must provide at least the same benefits as Original Medicare, with many offering additional services. Despite these additional benefits, enrolling in MA involves several tradeoffs. MA plans typically limit beneficiaries to contracted provider networks which can restrict access in areas where providers are scarce (such as rural areas). MA plans also have distinct cost-sharing structures (e.g., fixed copays, annual out-of-pocket limits, and tiered cost-sharing) and may require prior authorization for services. MA enrollment has been on a steady climb for the last 20 years, with enrollment now accounting for more than half (55.4 percent) of the eligible Medicare population in 2025.[3]

Data and Methods

Throughout this brief, beneficiaries reported in the CMS county-level data are described as "assigned" beneficiaries, consistent with CMS dataset terminology. Assignment reflects CMS attribution of beneficiaries to MSSP ACOs based on their utilization of primary care services. County-level ACO assigned beneficiary data for 2014-2023 were downloaded from a public CMS website.[4] ACO assignment data from 2023 were the latest available at the time of this report. Research Identifiable File (RIF) data purchased from CMS were used to obtain assignment data for 2013. MA and total Medicare enrollment data were obtained from the publicly available Medicare Monthly Enrollment Dashboard.[5] Enrollment data from March were used. Total beneficiary counts are based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA.

Connecticut is excluded from this analysis due to a change in FIPS codes (used to identify counties) that are in the Medicare Enrollment Dashboard data but is not yet reflected in the MA enrollment data. Urban Influence Codes (UIC) were used to classify counties as Metropolitan (UIC: 1,4), Micropolitan (UIC: 2,5,7), and Noncore (UIC: 3,6,8,9).[6] Rural counties include those identified as micropolitan or noncore. Data on county populations and healthcare facilities were obtained from HRSA's Area Health Resource File (AHRF) for 2023-2024.[7]

Findings

Table 1 and Figure 1 show beneficiary assignments to ACOs between 2013 and 2023. They show significant ACO growth in the first years of the program, with overall assignment growing approximately 200 percent between 2013 and 2018. The rate of growth during that period was even higher in nonmetropolitan counties, with 310 percent assignment growth in micropolitan counties and 289 percent assignment growth in noncore counties. Since then, ACO assignment has remained essentially flat across all geographies.

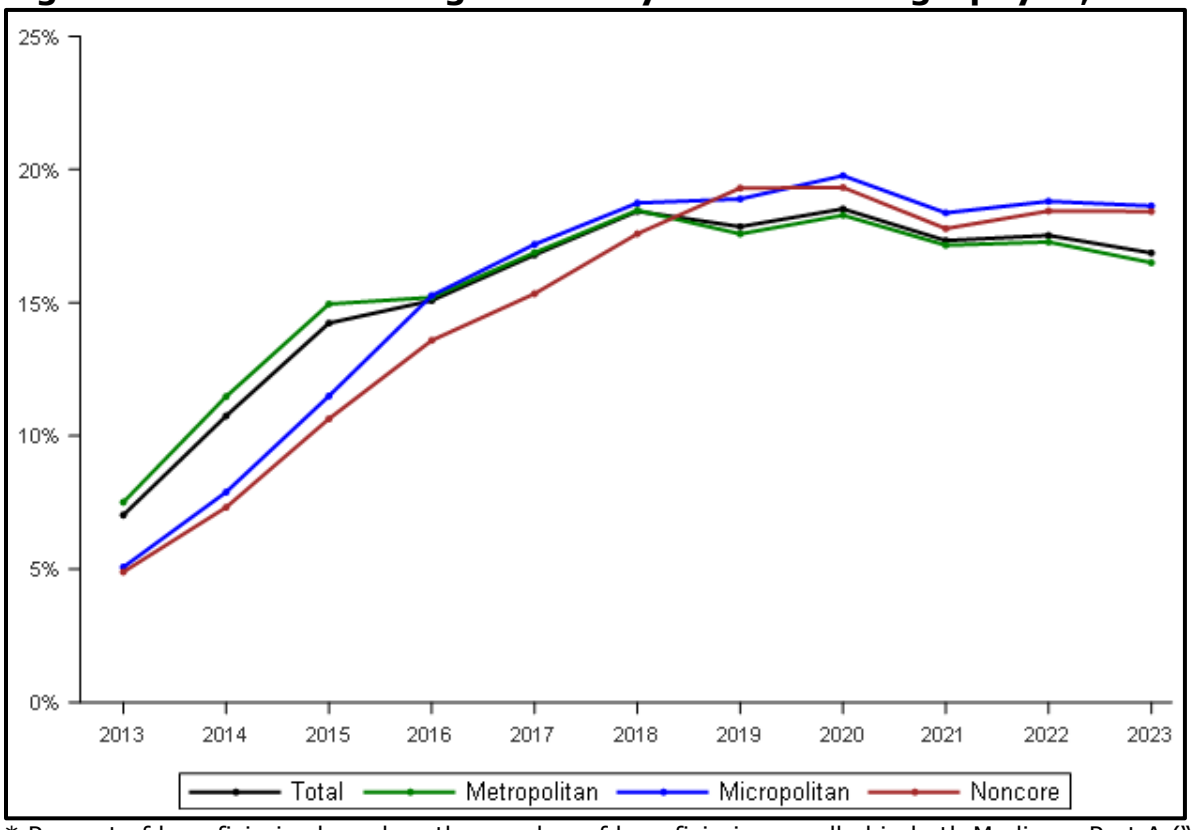
Table 1: MSSP ACO Assignment by Year and Geography*, 2013-2023

	Total		Metropolitan		Micropolitan		Noncore	
	Count	% All Ben.**	Count	% All Ben.**	Count	% All Ben.**	Count	% All Ben.**
2013	3,230,653	7.0%	2,789,750	7.5%	257,538	5.1%	183,365	4.9%
2014	5,095,025	10.7%	4,406,021	11.5%	409,891	7.9%	279,113	7.3%
2015	6,937,366	14.2%	5,915,527	14.9%	609,609	11.5%	412,230	10.6%
2016	7,547,651	15.1%	6,186,685	15.2%	826,410	15.3%	534,556	13.6%
2017	8,621,742	16.8%	7,059,388	16.9%	949,326	17.2%	613,028	15.3%
2018	9,700,340	18.4%	7,930,360	18.5%	1,056,159	18.7%	713,821	17.6%
2019	9,623,916	17.9%	7,744,227	17.6%	1,082,675	18.9%	797,014	19.3%
2020	10,231,999	18.5%	8,264,275	18.3%	1,155,684	19.8%	812,040	19.3%
2021	9,753,574	17.3%	7,909,307	17.2%	1,089,010	18.4%	755,257	17.8%
2022	10,048,553	17.5%	8,126,515	17.3%	1,130,465	18.8%	791,573	18.4%
2023	9,887,872	16.9%	7,945,813	16.5%	1,140,098	18.6%	801,961	18.4%

* Geography defined using UICs: Metropolitan (UIC: 1,4), Micropolitan (UIC: 2,5,7), Noncore (UIC: 3,6,8,9).
** Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA.
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Table 2 and Figure 2 show Medicare Advantage enrollment between 2013 and 2023. There has been significant, sustained growth in MA enrollment over the entire period. Since 2013, overall MA enrollment has grown by 120.2 percent. The rate of growth has been higher in micropolitan (164.5 percent) and noncore (186.5 percent) counties than in metropolitan (112.8 percent) counties. While these rates of growth are not as large as those seen in the ACO assignment exhibits, it is important to note that MA enrollment (30.4 percent) was substantially higher than ACO assignment (7.0 percent) in 2013, at the start of the analyzed timeframe.

Figure 1. MSSP ACO Assignment* by Year and Geography**, 2013-2023



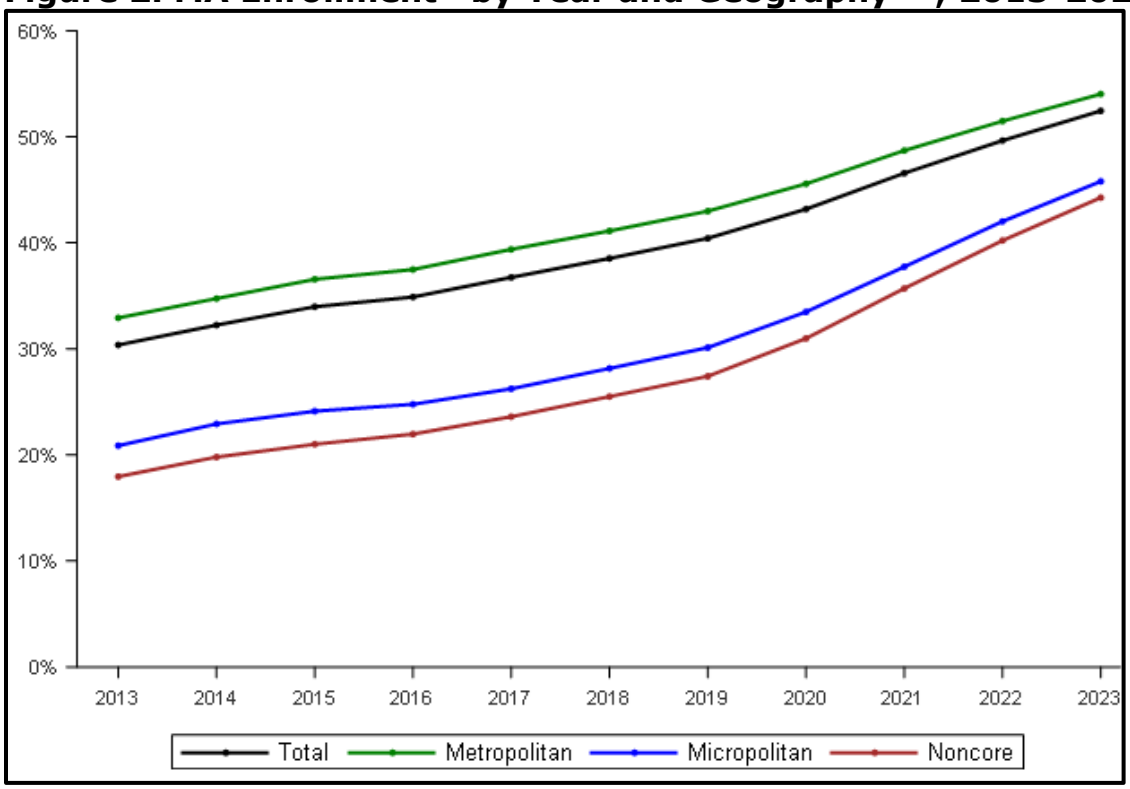
* Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA.
** Geography defined using UICs: Metropolitan (UIC: 1,4), Micropolitan (UIC: 2,5,7), Noncore (UIC: 3,6,8,9).
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Table 2: MA Enrollment by Year and Geography*, 2013-2023

	Total		Metropolitan		Micropolitan		Noncore	
	Count	% All Ben.**	Count	% All Ben.**	Count	% All Ben.**	Count	% All Ben.**
2013	13,957,959	30.4%	12,226,205	32.9%	1,059,223	20.9%	672,531	17.9%
2014	15,282,246	32.2%	13,336,539	34.7%	1,190,830	22.9%	754,877	19.8%
2015	16,559,154	34.0%	14,466,459	36.6%	1,278,968	24.1%	813,727	21.0%
2016	17,462,413	34.9%	15,257,506	37.5%	1,340,766	24.8%	864,141	22.0%
2017	18,864,849	36.7%	16,472,166	39.4%	1,449,143	26.2%	943,540	23.6%
2018	20,279,423	38.5%	17,657,626	41.1%	1,586,826	28.2%	1,034,971	25.5%
2019	21,791,759	40.4%	18,934,144	43.0%	1,725,774	30.1%	1,131,841	27.4%
2020	23,856,749	43.2%	20,597,162	45.6%	1,957,715	33.5%	1,301,872	31.0%
2021	26,206,118	46.6%	22,452,570	48.7%	2,237,373	37.7%	1,516,175	35.7%
2022	28,465,685	49.6%	24,213,386	51.5%	2,526,080	42.0%	1,726,219	40.2%
2023	30,748,021	52.4%	26,019,224	54.0%	2,802,086	45.8%	1,926,711	44.3%

* Geography defined using UICs: Metropolitan (UIC: 1,4), Micropolitan (UIC: 2,5,7), Noncore (UIC: 3,6,8,9).
** Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA.
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Figure 2. MA Enrollment* by Year and Geography, 2013-2023**



* Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA.
** Geography defined using UICs: Metropolitan (UIC: 1,4), Micropolitan (UIC: 2,5,7), Noncore (UIC: 3,6,8,9).
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Table 3 and Figure 3 overlay the ACO assignment and MA enrollment data to show the available "pool" of Original Medicare beneficiaries not assigned with either program (approximately 30.7 percent in 2023)[a]. The proportion of 'available' Original Medicare beneficiaries (i.e., those not assigned to an ACO or enrolled in an MA plan) has always been highest in noncore counties. An important distinction between the ACO and MA models is how beneficiaries come to be assigned with either. Beneficiaries "self-select" into the MA program by enrolling in an MA plan. Beneficiaries not enrolled in an MA plan may get assigned to an ACO by virtue of where they obtain their health care (CMS assigns beneficiaries to an ACO if they receive a plurality of their primary care from a provider that is a member of that ACO). In fact, many beneficiaries may be unaware of their assignment to an ACO (ACOs are required to notify beneficiaries of their participation and data sharing, but beneficiaries are not obligated to select or align with an ACO). This means that, as MA enrollment grows, the pool of beneficiaries available for ACO assignment decreases.

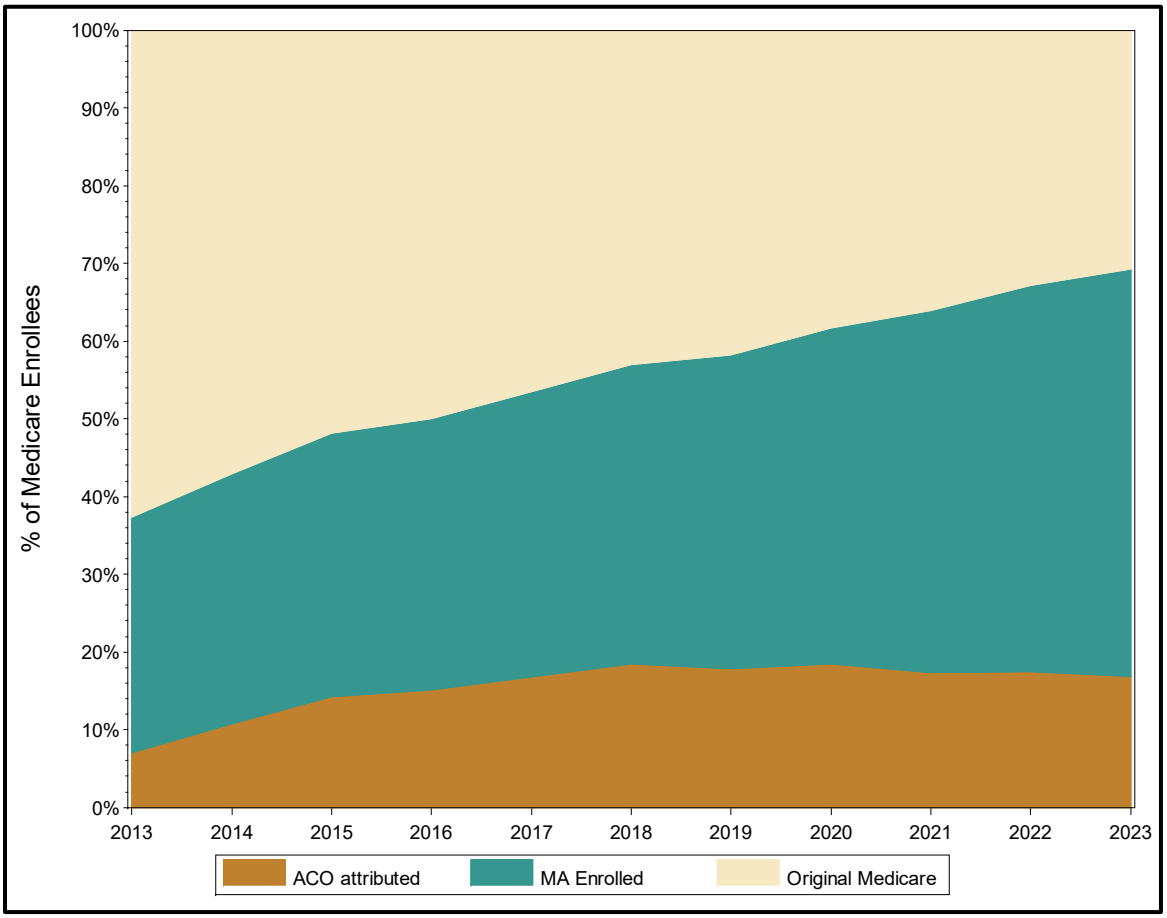
[a] Note that there are other Medicare alternative payment models available that beneficiaries not enrolled in MA nor attributed to an ACO may be aligned with. These include Cost Plans, the Program of All-Inclusive Care for the Elderly (PACE), demonstrations and pilot programs available through the CMS Innovation Center, and others.

Table 3: ACO Assignment* and MA Enrollment* by Year and Geography**, 2013-2023

	Total			Metropolitan			Micropolitan			Noncore		
	MA	MSSP	OM***	MA	MSSP	OM***	MA	MSSP	OM***	MA	MSSP	OM***
2013	30.4%	7.0%	62.6%	32.9%	7.5%	59.6%	20.9%	5.1%	74.1%	17.9%	4.9%	77.2%
2014	32.2%	10.7%	57.0%	34.7%	11.5%	53.8%	22.9%	7.9%	69.2%	19.8%	7.3%	72.9%
2015	34.0%	14.2%	51.8%	36.6%	14.9%	48.5%	24.1%	11.5%	64.4%	21.0%	10.6%	68.4%
2016	34.9%	15.1%	50.0%	37.5%	15.2%	47.3%	24.8%	15.3%	60.0%	22.0%	13.6%	64.5%
2017	36.7%	16.8%	46.5%	39.4%	16.9%	43.7%	26.2%	17.2%	56.6%	23.6%	15.3%	61.1%
2018	38.5%	18.4%	43.0%	41.1%	18.5%	40.4%	28.2%	18.7%	53.1%	25.5%	17.6%	56.9%
2019	40.4%	17.9%	41.7%	43.0%	17.6%	39.4%	30.1%	18.9%	51.0%	27.4%	19.3%	53.3%
2020	43.2%	18.5%	38.3%	45.6%	18.3%	36.2%	33.5%	19.8%	46.7%	31.0%	19.3%	49.7%
2021	46.6%	17.3%	36.1%	48.7%	17.2%	34.1%	37.7%	18.4%	43.9%	35.7%	17.8%	46.5%
2022	49.6%	17.5%	32.8%	51.5%	17.3%	31.2%	42.0%	18.8%	39.2%	40.2%	18.4%	41.3%
2023	52.4%	16.9%	30.7%	54.0%	16.5%	29.5%	45.8%	18.6%	35.6%	44.3%	18.4%	37.3%

* Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA.
** Geography defined using UICs: Metropolitan (UIC: 1,4), Micropolitan (UIC: 2,5,7), Noncore (UIC: 3,6,8,9).
***Original Medicare, not assigned to an ACO.
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Figure 3. Overall ACO Assignment* and MA Enrollment* by Year, 2013-2023



* Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA. Note: The "Original Medicare" group in the graphic refers to Medicare beneficiaries not assigned to an ACO and not enrolled in an MA plan.
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Table 4 shows annual ACO assignment penetration rates based on the available Original Medicare beneficiaries (i.e., after removing MA beneficiaries). Despite the relatively flat rate of growth seen earlier (in Table 1), this table shows that the proportion of Original Medicare beneficiaries assigned to ACOs over the years has constantly increased, with more than one-third of Original Medicare beneficiaries assigned to an ACO in 2023. Again, this is not due to the dramatic change in the numerator of the equation (i.e., beneficiaries assigned to an ACO); it is due to the dramatic change in the denominator (the number of "leftover" beneficiaries after removing the growing MA-enrolled cohort).

Table 4: MSSP ACO Original Medicare Beneficiary Penetration*, 2013-2023

	Overall	Metropolitan	Micropolitan	Noncore
2013	6.9%	9.7%	5.9%	4.9%
2014	10.8%	15.5%	9.3%	7.3%
2015	15.2%	20.9%	13.6%	10.9%
2016	18.6%	22.0%	19.1%	15.2%
2017	21.2%	25.5%	21.8%	17.1%
2018	25.2%	29.8%	24.8%	21.1%
2019	27.4%	30.5%	27.0%	24.7%
2020	29.6%	33.4%	29.5%	26.2%
2021	29.1%	33.2%	29.3%	25.2%
2022	31.7%	35.7%	32.0%	27.9%
2023	33.6%	37.5%	33.8%	29.9%

* Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA.
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Shifting our focus from national trends to county characteristics, we see that in 2023, county MA penetration rates ranged from 0 to 80.6 percent and county ACO penetration rates ranged from 0 to 76.8 percent. There were 146 counties (of 3,124) with an MA penetration rate under 10 percent and 1,014 counties with an MSSP penetration rate under 10 percent (86 counties have both ACO and MA penetration below 10 percent). For analytic purposes, we considered counties in the lowest distribution quartile as 'low penetration' counties and those in the highest distribution quartile as 'high penetration' counties. Tables 5a and 5b display population and healthcare facility characteristics of counties with low and high MA, ACO, and combined penetration rates. The tables also display characteristics of counties with high ACO/low MA penetration and low ACO/high MA penetration:

- Counties with low MA penetration rates tend to have a substantially lower overall population than counties with high MA penetration rates.
- Counties with low MA penetration rates are more likely to have a CAH or any hospital than counties with high MA penetration rates.
- Micropolitan counties with low ACO penetration rates are more likely to have a CAH or any hospital than micropolitan counties with high ACO penetration rates.

- A higher proportion of noncore counties have low MA and ACO penetration rates than micropolitan counties.
- A relatively small proportion of micropolitan counties have High ACO/Low MA penetration (10.7 percent) or High MA/Low ACO penetration (7.0 percent)
- Noncore counties were more likely than micropolitan counties to be designated as Health Professional Shortage Areas (HPSAs), regardless of their ACO or MA penetration rate. Counties with High MA/Low ACO penetration are more than twice as likely to be designated as HPSAs than counties with High ACO/Low MA penetration and, in micropolitan areas, are less likely to have Rural Health Clinics.

Table 5a. Characteristics of Micropolitan* Counties with Low/High MA/ACO Penetration, 2023 (n=656)**

		Low Penetration			High Penetration			High ACO/ Low MA	High MA/Low ACO
	Overall	MA (<33.9%)	ACO (<7.4%)	Comb. (<53.5%)	MA (>56.2%)	ACO (>26.7%)	Comb. (>76.1%)		
Median population	37,824	31,997	38,109	33,530	42,975	36,702	42,229	27,957	41,194
% of Counties	100%	24.7%	24.5%	25.3%	22.3%	27.7%	24.5%	10.7%	7.0%
HPSAs (entire county)	14.2%	11.1%	17.4%	13.3%	15.7%	12.1%	11.2%	11.4%	21.7%
Counties w/ any Hospital	87.0%	87.0%	90.1%	87.9%	82.9%	84.1%	87.6%	82.9%	78.3%
Counties w/ CAH	30.3%	40.1%	33.5%	41.0%	19.2%	28.6%	23.6%	32.9%	19.6%
Counties w/ any RHC	64.6%	64.8%	62.1%	66.3%	61.6%	65.4%	65.2%	67.1%	50.0%
Median Hosp Beds/10K	1.67	1.68	1.69	1.56	1.60	1.70	1.71	1.68	1.09
Prim. Care Phys./10K	0.48	0.56	0.49	0.52	0.44	0.55	0.49	0.58	0.35

Table 5b. Characteristics of Noncore* Counties with Low/High MA/ACO Penetration, 2023 (n=1,299)

		Low Penetration			High Penetration			High ACO/ Low MA	High MA/Low ACO
	Overall	MA (<33.9%)	ACO (<7.4%)	Comb. (<53.5%)	MA (>56.2%)	ACO (>26.7%)	Comb. (>76.1%)		
Median population	10,828	6,253	7,996	6,355	17,124	10,703	14,372	7,694	13,779
% of Counties	100%	39.2%	32.0%	39.2%	16.1%	24.4%	19.1%	13.4%	5.5%
HPSAs (entire county)	35.8%	32.6%	42.6%	39.5%	40.7%	25.9%	24.2%	24.7%	55.6%
Counties w/ any Hospital	70.2%	75.4%	70.0%	73.7%	64.1%	71.9%	71.8%	75.3%	62.5%
Counties w/ CAH	55.7%	71.3%	58.9%	65.8%	39.2%	60.9%	56.5%	70.7%	41.7%
Counties w/ any RHC	76.4%	77.2%	76.7%	76.4%	75.6%	78.6%	79.4%	77.0%	79.2%
Median Hosp Beds/10K	1.63	2.65	1.75	2.33	1.06	1.80	1.46	2.32	0.95
Prim. Care Phys./10K	0.35	0.42	0.35	0.38	0.33	0.40	0.39	0.43	0.26

* Geography defined using UICs: Metropolitan (UIC: 1,4), Micropolitan (UIC: 2,5,7), Noncore (UIC: 3,6,8,9).

** Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA.

Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment, HRSA Area Health Resources File 2024

Discussion

Between 2013 and 2023, both MSSP ACO assignment and Medicare Advantage (MA) enrollment grew significantly, particularly in rural areas. ACO assignment rose by nearly 200 percent overall between 2013 and 2018, rising 310 percent in micropolitan and 289 percent in noncore counties, before plateauing at 17–18

percent of eligible beneficiaries by 2023. During the same period, MA enrollment increased by 120 percent, with even sharper growth in micropolitan (164.5 percent) and noncore (186.5 percent) counties. Despite ACOs' faster growth, MA plans maintained a broader reach due to a higher baseline (i.e., 2013) of 30.4 percent enrollment compared to ACOs' 7.0 percent.

As MA enrollment surged, the proportion of Original Medicare beneficiaries eligible for ACO assignment declined. In 2023, about 30.7 percent of Original Medicare beneficiaries were neither enrolled in an MA plan nor assigned to an MSSP ACO, with noncore counties having the highest proportions. Since MA growth requires active enrollment, it effectively reduces the pool of beneficiaries available for ACO attribution. These trends are consistent with broader CMS efforts across multiple administrations to expand beneficiary participation in alternative payment models and other value-based care arrangements. Beneficiaries cannot actively select attribution to MSSP ACOs – they are attributed (by CMS) based on where they receive most of their primary care (beneficiaries can actively select a non-MSSP ACO in certain models through voluntary alignment).

The results show that ACOs and MA plans are less likely to operate in the smallest rural counties. Counties with low penetration in both programs were disproportionately rural and more likely to be designated as HPSAs. These areas often had smaller populations and limited infrastructure but were more likely to have a CAH.

Penetration patterns differed by county characteristics and healthcare infrastructure. Low ACO/high MA counties tended to be more populous, more likely to be designated as Health Professional Shortage Areas, and less likely to have Critical Access Hospitals or Rural Health Clinics. Conversely, low MA/high ACO counties tended to be smaller and exhibited different healthcare infrastructure characteristics. Conversely, low MA/high ACO counties were often smaller and exhibited different healthcare infrastructure characteristics than high MA/low ACO counties, including a greater presence of Critical Access Hospitals.

Several implications emerge as MA and ACO enrollment expands in rural areas. MA plans may offer supplemental benefits not available in Original Medicare, but enrollment also involves tradeoffs. MA plans typically use narrower provider networks and prior authorization requirements that are not present in FFS Medicare. These differences can influence access, continuity, and care coordination depending on program availability in each county.[8] Rural providers also may face significant barriers to ACO participation, including limited capital, health information technology (IT), infrastructure, and small patient populations that complicate risk-sharing arrangements.[9] Additionally, inadequate broadband, workforce shortages, and underdeveloped data systems hinder rural providers' ability to succeed under either model. Finally, diverging penetration patterns, such as high MA and low ACO uptake, suggest that insurer-driven MA growth may be outpacing provider-led ACO efforts.

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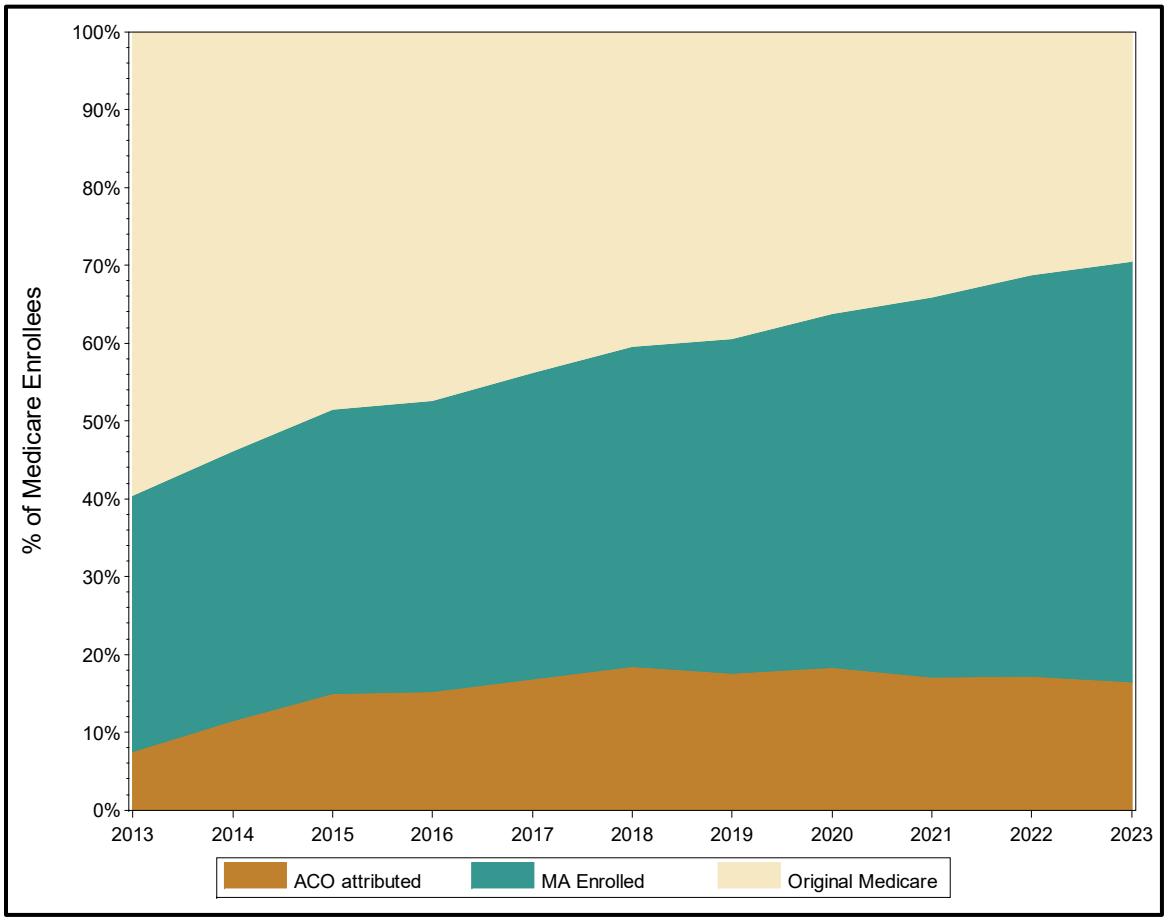
Appendix

Figure 4a. Metropolitan* ACO Assignment** and MA Enrollment** by Year, 2013-2023

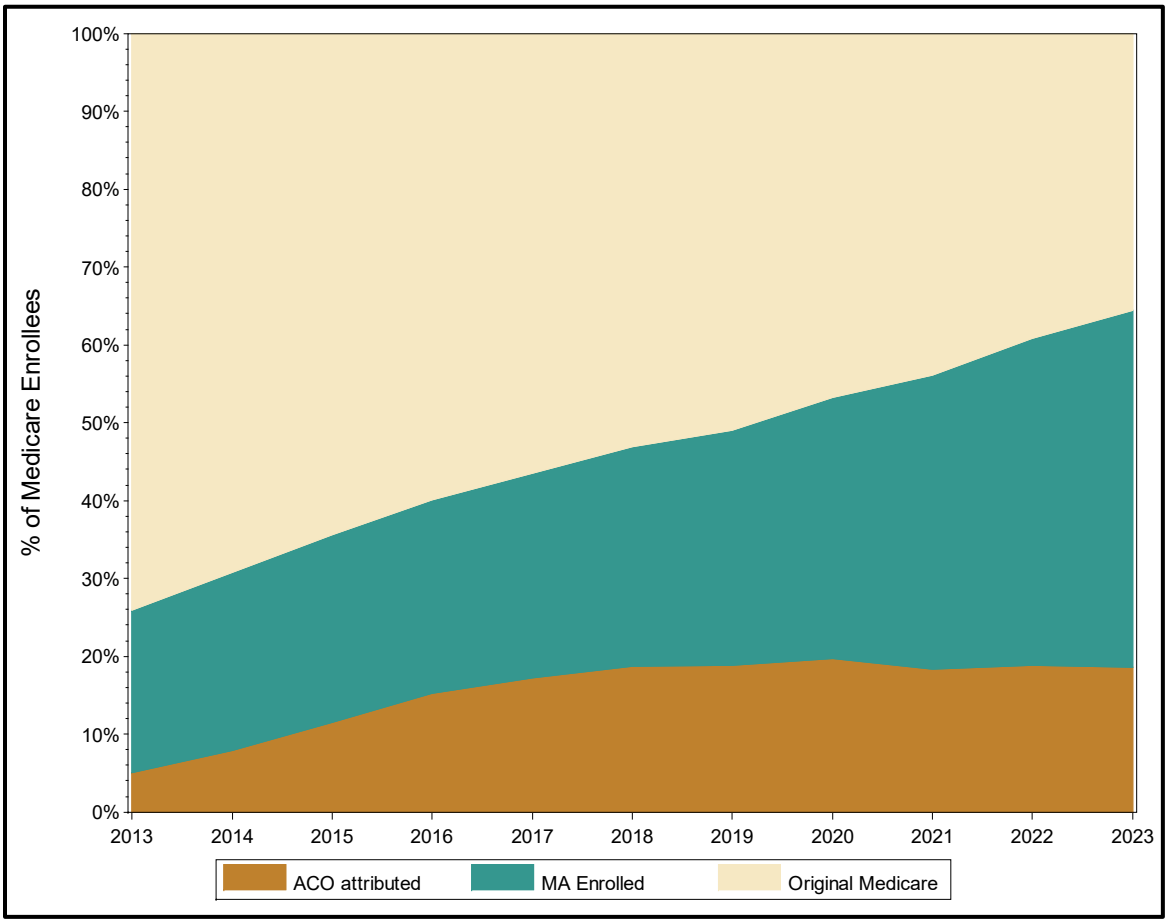


* Counties with UIC: 1,4.

** Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA. Note: The "Original Medicare" group in the graphic refers to Medicare beneficiaries not assigned to an ACO and not enrolled in an MA plan.

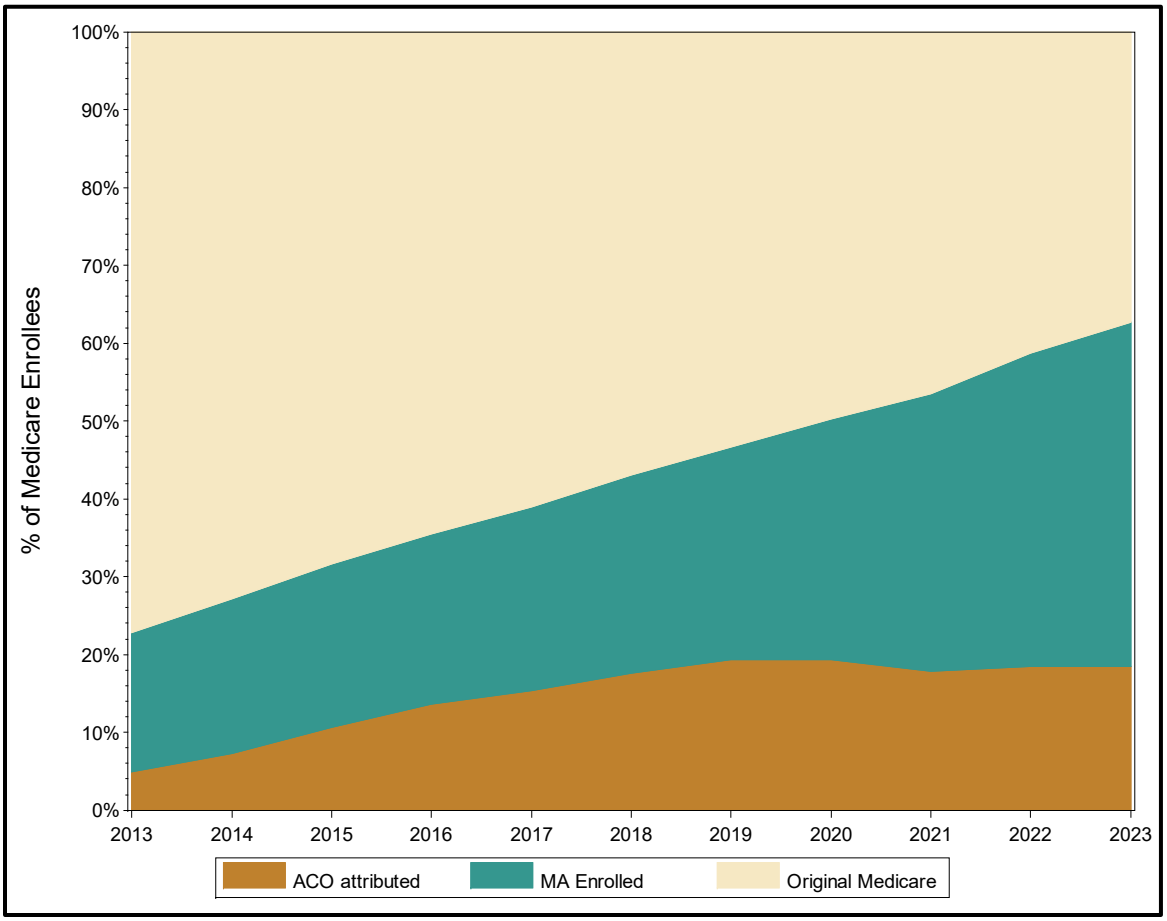
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Figure 4b. Micropolitan* ACO Assignment and MA Enrollment** by Year, 2013-2023**



* Counties with UIC: 2,5,7.
** Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA. Note: The "Original Medicare" group in the graphic refers to Medicare beneficiaries not assigned to an ACO and not enrolled in an MA plan.
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment

Figure 4c. Noncore* ACO Assignment** and MA Enrollment** by Year, 2013-2023



* Counties with UIC: 3,6,8,9.
** Percent of beneficiaries based on the number of beneficiaries enrolled in both Medicare Part A ("Hospital Insurance") and Part B ("Supplementary Medical Insurance") either as part of Original Medicare or MA. Note: The "Original Medicare" group in the graphic refers to Medicare beneficiaries not assigned to an ACO and not enrolled in an MA plan.
Data source: CMS data on Number of Accountable Care Organization Assigned Beneficiaries by County, and Medicare Monthly Enrollment