Rural Medicare Advantage

NRHA Factsheet and Talking Points

What is Medicare Advantage?

The Medicare Advantage (MA) program, also known as Medicare Part C, is a program that contracts with private insurers to offer traditional Medicare Part A and Part B services to beneficiaries and may offer supplemental benefits, such as vision, dental, hearing, and prescription drug coverage.

Impact on Rural

Medicare Advantage enrollment has quadrupled in rural areas since 2010 and reached 48% in 2024. Medicare Advantage now accounts for 38% of all Medicare-eligible patients in rural communities. In seven states, Medicare Advantage penetration exceeds 50% (Alabama, Connecticut, Georgia, Hawaii, Kentucky, Maine and Michigan).

MA has unintended impacts on rural including:

- **Rural MA networks are limited and tend to be more restrictive:** These limited provider networks in rural communities significantly reduce the options available to beneficiaries, forcing them to travel long distances to access specialized care or leaving them with no choice but to see providers who may not be their preferred choice or within the MA plan network.
- **Erosion of Traditional Medicare reimbursement rates especially for CAHs and RHCs:** CAHs and RHCs are rural Medicare designations that are based on an alternate payment methodology. MA plans often pay rural providers less than their traditional Medicare rates eroding the importance of their rural designations. Further, CAHs rely heavily on cost-based reimbursements and are reimbursed on a per-diem rate for inpatient and swing-bed services and on a cost-to-charge ratio basis for outpatient services. Usually Medicare pays the difference between the hospital's true cost, while MA plans, unlike traditional Medicare, do not have a process for reconciling payments to the hospital's Medicare cost report. This results in reduced Medicare payments to CAHs and undermined rural supplemental payment programs, affecting the financial health of rural hospitals.
- **Increased denial rates and delays in payment:** MA plan practices routinely deny access to care through restrictive admission criteria, prior authorization denials, limitations on covered services, and denied claims.
  - Rural providers generally do not have ample cash on hand to sustain significant delays in timely payments by MA plans.
  - This leads to delays in receipt of essential medical care. MA may not cover services traditional Medicare does, including swing beds, which provide local skilled nursing care for patients and are often a source of financial stability for rural hospitals.
- **Increased administrative burden:** MA plans create administrative burdens for rural providers who struggle to keep up with prior authorization requests, denials, and appeals for necessary services. Small rural providers do not have the additional resource capacity to handle the significant burden that comes with MA prior authorizations, denials, and delays in payment. Nearly 50% of rural hospitals are operating on negative margins, meaning they don't have the capacity to handle the increased administrative burdens.
- **Lack of competition in rural communities:** There is lack of competition among MA plans in many rural communities diminishes provider leverage in negotiating Medicare-equivalent rates. This leads to providers having limited options to choose from, making it difficult to negotiate favorable reimbursement rates.
- Rural Medicare beneficiaries reported a greater financial burden of care than urban, with the most significant burden among rural MA beneficiaries, possibly due to the less generous financial structures offered by rural MA plans.

NRHA Stance

NRHA encourages that CMS should include Medicare beneficiary education regarding traditional Medicare and MA benefits in order to ensure the understanding of risks and benefits associated with MA plan participation in rural areas. We also encourage CMS to provide greater oversight in MA plans and practices through changes in plan accountability, data collection, and information sharing. Additionally, NRHA supports any legislation that allows for MA Plan processes to decrease administrative burden for physicians. Congress should allow CMS to consider the MA patient days and outpatient revenue as Medicare in each hospital's cost report when calculating payments to CAHs.