



Medicare Advantage: A growing rural health issue

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Introduction

Rural providers operate in an increasingly challenging financial environment. Compared to their urban counterparts, rural hospitals typically serve fewer commercially insured patients and operate with payer mixes that are heavily concentrated in Medicare and Medicaid. They also face higher levels of uncompensated care, lower patient volumes, persistent workforce shortages, rising labor and supply costs, and limited economies of scale. More than 40 percent of rural hospitals nationally operate at a loss and 417 are considered vulnerable to closure,ⁱ making them particularly susceptible to payment disruptions, reimbursement reductions, and administrative burdens. Independent or smaller facilities also often lack the market leverage and negotiating power necessary to secure favorable reimbursement arrangements with commercial insurers and Medicare Advantage (MA) plans.

MA has become a dominant source of Medicare coverage and outpaces traditional Medicare growth in many communities.ⁱⁱ In 2026, 55 percent of Medicare beneficiaries are enrolled in MA plans compared with just 19 percent in 2007.ⁱⁱⁱ The Congressional Budget Office projects that MA enrollment could reach 63 percent of eligible beneficiaries by 2034. MA enrollment in rural communities has quadrupled since 2010 and is projected to exceed half of all rural Medicare enrollment in the coming years, growing 56 percent faster in rural counties compared to urban from 2024 to 2025.^{iv, v}

Payment delays, restrictive utilization management practices, unclear reimbursement policies, and questionable claim adjudications by some MA plans place additional financial strain on hospitals and in the most severe cases force rural providers to choose between financial stability and maintaining essential community services. These challenges are not limited to hospitals. Rural physician practices and clinics, EMS agencies, home health agencies, skilled nursing facilities, behavioral health providers, and other community-based providers may face the same low-volume, workforce, and administrative constraints while relying on Medicare revenue to sustain local access to care. Rural providers are uniquely vulnerable to these practices as they are already more dependent on public reimbursement and have fewer administrative resources to contest denials, delays, downcoding, and underpayments.

For rural facilities, MA increasingly shapes how care is accessed, authorized, reimbursed, and audited. MA network participation requirements, prior authorization and medical necessity review, reimbursement policies, claim denials, and payment delays can affect operational stability and availability of essential services. The current design of the MA program influences nearly every stage of the care continuum and can simultaneously affect patient access and provider financial stability. As Medicaid financing becomes more constrained, reforms that improve payment timeliness, strengthen accountability, and curb inappropriate payer practices within MA will become critical to preserving access to health care in rural communities.

Analysis

As MA enrollment increases, a growing share of rural hospital revenue becomes subject to private plan policies rather than traditional Medicare reimbursement rules. Unlike traditional Medicare, MA plans possess broad authority to establish provider networks, impose prior authorization requirements, conduct utilization reviews, adjudicate claims, and perform retrospective payment reviews. For rural providers operating with limited

Rural hospitals have less capacity

“The whole health care system's kind of broken, but all these games and administrative burdens ... it's even harder on the rural hospitals. It's driving up the cost of health care even more, because we both have to have all kinds of denial staff and revenue cycle staff ...”
Participant 007, Northwestern Virginia (HPR 1)



financial reserves and administrative capacity, the cumulative impact of these policies can be significant. In addition to hospitals, a growing share of rural health care delivery is subject to plan-specific requirements that affect physician and clinician practices, ambulance services, home health, skilled nursing, behavioral health, and other providers across the care continuum.

When quantitative data conflicts with qualitative reports

Policymakers have sought to better understand the effects on MA growth on rural hospitals. While physicians, hospital administrators, and associations consistently report problems surrounding prior authorization, prompt payment, and network adequacy in reference to MA plans, insurers point to studies that do not necessarily support these reports.

For instance, a recent Medicare Payment Advisory Commission (MedPAC) analysis found that a 10-percentage-point increase in county-level MA penetration was associated with only a 1.3 percent reduction in hospital revenue and a 1.2 percent reduction in hospital costs, resulting in no statistically significant effect on overall hospital profit margins. MedPAC also found no statistically significant relationship between MA penetration and margins among critical access hospitals.^{vi} However, these findings should be interpreted with caution. MedPAC noted that the broader research literature remains mixed. For example, a peer-reviewed study found that increasing MA penetration reduced inpatient days at rural hospitals, suggesting that MA growth may affect utilization and reimbursement patterns in ways that are not fully captured by aggregate hospital margin analyses.^{vii}

The MedPAC analysis relied on a fixed-effects methodology that examined changes within counties over time and focused primarily on overall hospital margins rather than MA-specific reimbursement. While useful for identifying broad market trends, this approach may not fully capture how individual payer classes affect hospital finances. Hospitals typically receive revenue from multiple sources, including traditional Medicare, MA, Medicaid, commercial insurance, supplemental payments, grants, and health system support. Consequently, overall hospital margins may mask meaningful reimbursement pressures if losses associated with MA are offset by other revenue streams.

MA reimbursement lower than traditional Medicare

“Managed Medicare ... has really almost wholesale shifted [Medicare] to managed [care]... I think the numbers for us as a system is we get paid, on average, about 15 percent less than we would get paid from traditional Medicare sources.” *Participant 006, Southwest Virginia (HPR 3)*

This limitation may be particularly relevant for rural providers. For example, studies show that the percentage of Medicare days from MA grew from 11.3 percent to 28 percent from 2018 to 2023 in rural hospitals.^{viii} Rural hospitals with the highest number of MA days as a percentage of total Medicare days displayed a greater operating margin, whereas no such trend was observed in urban hospitals. However, greater MA penetration had an inverse correlation with uncompensated care, the critical access hospital designation, rural health clinics, hospitals providing long-term care, non-system-affiliated hospitals, and government-owned hospitals. Larger hospitals were also more likely to have a higher percentage of MA days.^{ix}

Large health systems often possess greater negotiating leverage, diversified revenue sources, and stronger commercial payer relationships. Independent rural hospitals frequently lack these advantages. As a result, reductions in MA reimbursement associated with denials, delayed payments, downcoding, and administrative burden may be absorbed directly by the hospital, increasing financial vulnerability in ways that may not be fully reflected in aggregate margin analyses.



Denials and cash flow

“Denials, just in general, are probably the biggest culprit ... MA is by far exponentially higher with that kind of activity. So it does delay payments, and that impacts our cash flow.” *Participant 004, Southwest Virginia (HPR 3)*

The most recent MedPAC presentation on MA aligns with hospital reports regarding denials in inpatient stays.^x Acute care hospital usage rates for beneficiaries were 14.2 percent for FFS enrollees in 2023 compared to 13.2 percent for MA enrollees. Post-acute care rates were 11.1 percent and 9.67 percent, comparatively, representing a 1.43 percentage point difference in usage rates between FFS and MA enrollees. The difference jumps to 3.8 percentage points when examining beneficiaries over the age of 85.^{xi}

Findings from rural hospital finance leaders suggest that aggregate margin analyses may not fully reflect operational realities. Participants in a Virginia Rural Health Association study consistently reported [Appendix A] collecting approximately 10 to 15 percent less revenue from MA plans than traditional Medicare after accounting for denials, delays, downcoding, and administrative practices. These findings are broadly consistent with a national analysis by the American Hospital Association, which found that MA reimburses rural hospitals at approximately 90.6 percent of traditional Medicare rates on a cost basis and at lower rates for many Medicare-dependent and low-volume hospitals.^{xii}

Accordingly, policymakers should not interpret the absence of a measurable effect on overall hospital margins as evidence that MA payment practices are financially neutral for rural hospitals. Instead, the findings highlight the need for greater transparency and more granular analysis of how MA reimbursement affects rural providers and the communities they serve.

Medicare Advantage influences the entire care continuum

Historically, policymakers have approached MA challenges as isolated issues involving prior authorization, network adequacy, claim denials, or risk-adjustment practices. For rural providers, however, these issues are interconnected. MA plans influence patient access, reimbursement, and provider operations throughout the entire continuum of care.

Enrollment and plan selection

Challenges associated with MA often begin before a patient receives care. Beneficiaries frequently select plans based on premiums and supplemental benefits without fully understanding network limitations, authorization requirements, referral restrictions, or provider availability within rural communities.

Narrow provider networks may limit access to a broad range of services including physicians, specialists, behavioral health providers, ground ambulance transportation, and post-acute care services such as home health and skilled nursing. In many rural communities where health care resources are already limited, these restrictions can significantly reduce patient choice and access to care.^{xiii} Improved beneficiary education and greater transparency regarding network composition and coverage limitations are necessary to ensure rural residents can make informed enrollment decisions.

Access to care

MA plans increasingly influence whether care is delivered, when care is delivered, and where care is delivered. Prior authorization requirements, utilization management policies, referral restrictions, and network design can delay medically necessary services and create barriers to timely treatment. Federal oversight agencies have repeatedly identified concerns regarding inappropriate delays and denials within MA plans, raising questions about beneficiary access to medically necessary care.^{xiv}



Administrative burden associated with these requirements has also increased significantly. More than 50 million prior authorization requests were submitted to MA plans in 2023, representing a 43.9 percent increase since 2020.^{xv} Concerningly, over 80 percent of prior authorization appeals were partially or completely overturned in 2024.^{xvi} Federal oversight agencies have likewise documented instances in which MA plans denied services that otherwise met Medicare coverage requirements, raising ongoing concerns regarding patient access and provider burden.

Prior authorization affecting care
“One of our biggest areas of denial would be a patient comes in, the insurance company had not authorized it yet, we proceed with the case, and then don't get paid because there was no authorization.... So now we're kind of tightening up protocols... there are times when a case is rescheduled because it hasn't been secured yet.”
Participant 002, Southwest Virginia (HPR 3)

These challenges can be particularly significant in rural communities where patients often face provider shortages, transportation barriers, and longer travel distances for specialty care. Delays that may be manageable in urban settings can have disproportionate consequences for rural patients and providers.

Rural provider financial stability

Hospitals consistently report that payment delays, denials, downcoding, medical necessity disputes, and increasingly complex reimbursement requirements reduce collections and delay revenue. Downcoding occurs when a payer reclassifies a submitted claim to a lower-paying service or level of care, thereby reducing reimbursement to the provider. While upcoding involves assigning a higher-paying code than the document service supports, downcoding can result in providers receiving less reimbursement than the documented care warrants. These concerns are consistent with broader findings that rural hospitals face lower reimbursement, more administrative complexity, and growing challenges associated with insurer utilization management practices as MA enrollment expands.^{xvii}

Unlike large integrated systems, rural hospitals often lack dedicated administrative teams to challenge denials, manage lengthy appeals processes, or negotiate favorable payment arrangements. Consequently, reimbursement practices that may be manageable for larger organizations can create substantial financial strain for rural providers. As MA enrollment continues to grow, these pressures will affect a greater share of rural hospital revenue. The same pressures extend beyond hospitals. Rural EMS agencies, physician and clinician practices, home health agencies, skilled nursing facilities, behavioral health providers, and other community-based providers frequently have limited leverage in plan contracting and limited staff capacity to manage utilization review, appeals, and plan-specific administrative requirements. For these providers, delays or denials can have a direct effect on cash flow, staffing, service availability, and patient access.

Administrative burden and post-payment recovery

Administrative burden
“Every step of the way through the revenue cycle ... Medicare Advantage payers are especially egregious when it comes to those policies and denials, just in the sheer volume of them. And that adds cost.”
Participant 004, Southwest Virginia (HPR 3)

Administrative burden does not end when a claim is submitted or paid. Rural providers increasingly report challenges related to retrospective audits, payment recoupments, claim reprocessing, and post-payment reviews. Hospitals may be required to return reimbursements months or years after services have already been delivered, creating substantial financial uncertainty and disrupting cash flow.

Provider credentialing can create an additional source of delay, particularly when hospitals must wait months for a plan to approve a qualified provider and begin reimbursing covered services. These delays can leave rural hospitals carrying the cost of care already delivered while awaiting completion of



administrative processes. Providers also report concerns regarding changing payer policies, evolving documentation requirements, and increasing reliance on automated review systems. The cumulative effect of these practices extends beyond reimbursement, contributing to workforce burnout, administrative overhead, and reduced capacity to invest in patient care. For rural hospitals already struggling to maintain essential services, prolonged reimbursement disputes can undermine long-term sustainability and community access to care.

Recent findings by the HHS Office of Inspector General (OIG) indicate that some MA plans continue to deny requests for post-acute services at unusually high rates, including requests for long-term acute care hospitals and inpatient rehabilitation facilities. These findings reinforce concerns raised by rural providers regarding retrospective reviews, authorization requirements, and payment disputes that can delay care and increase administrative costs.^{xviii}

Growing scrutiny suggests structural concerns

Concerns raised by rural providers increasingly mirror concerns raised by federal policymakers, regulators, and oversight agencies. MedPAC has documented limitations in MA prior authorization data collection and enforcement, warning that misuse of utilization management tools can delay or deny beneficiaries' access to needed care. MedPAC has also attributed higher MA payments to favorable selection and coding intensity and recommended changes to improve payment accuracy.^{xix, xx} HHS OIG found that MA organizations sometimes denied prior authorization requests and provider payments that met Medicare coverage and billing rules, creating delays for beneficiaries and administrative burdens for providers.^{xxi}

Government Accountability Office has likewise identified weaknesses in CMS oversight of risk-adjusted payments and efforts to identify and recover improper payments.^{xxii}

Congressional scrutiny has continued through hearings and investigations examining prior authorization denials, access to post-acute care, and gaps in program oversight.^{xxiii, xxiv}

While MA remains a valuable coverage option for beneficiaries, growing federal scrutiny suggests policymakers should evaluate whether current incentives appropriately balance plan flexibility, patient access, provider sustainability, and accountability for taxpayer dollars.

Marketing and beneficiary education

"The people selling those plans don't always articulate what those differences are, and they can be pretty impactful to the care and the type of care patients can get ... I think they're presented as some type of savings, but they don't really explain the benefits you're gonna have apples to apples." *Participant 007, Northwestern Virginia (HPR 1)*

Strengthening Medicare Advantage supports value-based care

Improving MA will also be important to Medicare's broader transition toward value-based care. As policymakers continue expanding accountable care arrangements through the Medicare Shared Savings Program (MSSP), concerns regarding administrative burden, payment opacity, and misaligned incentives in MA risk undermining provider participation in accountable care models. MedPAC recently highlighted the importance of evaluating MA and MSSP together when considering the future of Medicare payment policy and delivery system reform. Reforms that strengthen transparency, accountability, and payment predictability within MA can complement broader efforts to advance accountable care and value-based payment models. For rural providers participating in accountable care organizations (ACOs), reducing administrative burden and improving payment predictability can allow greater focus on care coordination, chronic disease management, and population health activities rather than claims disputes and appeal processes. CMS continues to identify ACOs and MSSP participants as central components of Medicare's long-term strategy to improve quality while reducing costs.



Policy recommendations

To ensure MA serves rural beneficiaries while supporting a sustainable rural health care system, NRHA recommends the following reforms.

- **Strengthen rural network adequacy requirements:** CMS should strengthen MA network adequacy standards for rural counties and ensure beneficiaries maintain reasonable access to primary care, specialty care, behavioral health, ground ambulance, and post-acute care providers such as home health and skilled nursing without excessive travel burdens.
- **Improve rural beneficiary education:** CMS should provide clearer beneficiary education regarding differences between traditional Medicare and MA, including network limitations, prior authorization requirements, and referral restrictions that may have unique consequences in rural communities. Education materials should be aligned to health literacy levels and available in languages other than English.
- **Enact MA prompt pay and credentialing protections:** Congress should enact prompt pay requirements for MA plans that require timely payment of clean claims, establish timely credentialing standards, and provide meaningful enforcement mechanisms for noncompliance.
- **Preserve rural reimbursement methodologies:** Congress should ensure that MA enrollment does not continue to erode rural payment protections by:
 - Including MA patient days when calculating Medicare-dependent and other rural supplemental payments;
 - Evaluating MA impacts on CAHs and other rural cost-based providers including sole community hospitals, Medicare-dependent hospitals, rural health clinics, and federally qualified health centers;
 - Exploring wraparound or reconciliation payments for rural providers where MA reimbursement diverges substantially from traditional Medicare.
- **Improve claims transparency:** Greater transparency would reduce information asymmetry between plans, regulators, providers, and beneficiaries. Congress and CMS should expand oversight by requiring MA plans to publicly report the following:
 - Claim denial rates
 - Appeal rates and outcomes
 - Payment timeliness metrics
 - Network adequacy
 - Downcoding activities
- **Enforcement and oversight:** The Administration should adopt more explicit MA framework that specifically targets false, materially misleading, or materially incomplete marketing and network information and provides clear authority for escalating penalties, marketing suspensions, corrective action plans, and public reporting of violations similar to Medicaid-like sanctions found in [42 CFR § 438.700](#).
- **Limit retrospective payment recoupments:** Establish reasonable limits on retrospective payment recoveries and audit practices. Once care has been authorized and delivered, providers should not face years of financial uncertainty due to changing payer interpretations or contract administration practices.

Recommended actions

- **The Improving Seniors' Timely Access to Care Act ([S. 1816/H.R. 3514](#)):** Congress should enact this bipartisan legislation that would modernize and streamline prior authorization requirements within MA. It would also establish electronic prior authorization standards, improve transparency,



reduce administrative burden, and help ensure beneficiaries receive medically necessary care in a timely manner.

- **The Medicare Advantage Prompt Pay Act ([S. 2879](#) / [H.R. 5454](#))**: This bill would mandate MA plans to pay clean claims within 14 days or face financial penalties.
- **The Medicare Advantage Improvement Act of 2026 ([S. 4384](#) / [H.R. 8375](#))**: This legislation proposes reforms addressing prior authorization timelines, medical necessity determinations, audit practices, compliance oversight, and payment protections. The proposal reflects growing bipartisan recognition that MA oversight must evolve alongside the program's rapid enrollment growth and increasing influence on health care delivery.^{xxv}

Conclusion

MA has evolved from an alternative Medicare coverage option into a dominant force shaping health care delivery in rural America. MA plans increasingly influence every stage of the care continuum. While the program provides valuable benefits for many beneficiaries, rural providers continue to report challenges associated with prior authorization, network adequacy, payment delays, administrative burden, and retrospective payment recovery. As MA enrollment continues to grow and rural hospitals face increasing financial pressures, policymakers must ensure that MA policies support rural patient access and provider sustainability. Further, protecting rural access requires attention to the full provider landscape, including hospitals, EMS agencies, physician practices and clinics, home health agencies, skilled nursing facilities, behavioral health providers, and other community-based services. Strengthening accountability, improving transparency, ensuring timely reimbursement, and preserving access to care will be critical to protecting the health and vitality of rural communities while supporting broader Medicare goals, including the continued success of ACOs and the Medicare Shared Savings Program.



Appendix A. Selected Perspectives from Virginia Rural Hospital Finance Leaders Study Context

The quotations in this appendix were collected through UVA IRB-SBS #8198: Exploration of Virginia Rural Health Systems Finance. The study examined how current and former finance staff and executives at Virginia hospitals and other healthcare organizations perceive and navigate the health insurance landscape, claims and remittance processes, third-party payer relationships, and billing disputes. Participants completed structured informational interviews focused on their professional experiences and perspectives regarding rural hospital finance.

The study used an applied policy orientation, allowing themes to emerge from participants' accounts of reimbursement, payer relationships, administrative requirements, and financial pressures affecting rural hospitals.

To provide geographic context while protecting participant confidentiality, participants are identified by study number and the Virginia Health Planning Region (HPR) associated with their current or former facility. Virginia has five HPRs: Northwestern Virginia (HPR 1), Northern Virginia (HPR 2), Southwest Virginia (HPR 3), Central Virginia (HPR 4), and Eastern Virginia (HPR 5). The seven study participants represented three of these regions: Northwestern Virginia, Southwest Virginia, and Eastern Virginia. The study retained Health Planning Region as the only facility-level geographic identifier.

The quotations provided throughout the document constitute a selected, noncomprehensive set intended to illustrate recurring concerns related to MA. They should not be interpreted as representing every participant response or the experiences of every rural hospital. Quotations have been lightly edited for readability through the removal of verbal fillers, false starts, and repetitive language where those changes do not alter the participant's meaning. Brackets identify clarifying language added by the researcher, and ellipses indicate omitted material.

Source: McCray, J. (2026). Medicare Advantage and rural hospital financial impacts: Findings from Virginia rural hospital finance leaders. Interview study conducted under UVA IRB-SBS #8198.



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