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Medicare vs Medicare Advantage - Grid Comparison

Category	Traditional Medicare	Medicare Advantage (MA)
Program Structure	Managed by the federal government (Parts A & B). Standardized CMS fee schedule. Broad nationwide provider access. 👉 Medicare.gov Coverage Choices: https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance	Offered by private insurers (Part C). Must cover all Medicare-equivalent services. Often includes extras like dental, vision, hearing, wellness programs. 👉 KFF 2023 MA Snapshot: https://www.kff.org/medicare/fact-sheet/medicare-advantage/
Policy Oversight	Fully regulated by CMS. Claims processed by Medicare Administrative Contractors (MACs). MACs issue Local Coverage Determinations (LCDs). National Coverage Determinations (NCDs) set by CMS. 👉 AB MAC Jurisdiction Map: https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors-macs/who-are-the-macs	CMS sets overarching rules, but private insurers manage operations. No MACs—plans create their own coverage policies, approved by CMS. Subject to CMS audits, complaints, and prior authorization reviews. 👉 CMS MA Oversight: https://www.cms.gov/medicare/health-plans/medicare-advantage/medicare-advantage-regulations-and-guidance 👉 CMS Audit Program: https://www.cms.gov/medicare/audits/medicare-advantage-audits
Provider Contracting	No contracting—provider enrolled as a participating provider in Medicare is paid via fee schedule. Providers who select to not participate in Medicare do not accept fee schedule payment but may treat Medicare beneficiary under “patient contract” however the provider must be enrolled with Medicare as an ordering/referring provider if they intend to request laboratory or pathology services for Medicare beneficiary.	Providers must contract with MA plans; network participation varies. Rates and terms are negotiated. Providers must be enrolled as participating provider in Medicare to contract with MA plan(s). 👉 Medicare.gov MA Networks: https://www.medicare.gov/plan-compare/#/?year=2025 👉 AMA MA Contracting Guide: https://www.ama-assn.org/system/files/2022-05/medicare-advantage-toolkit.pdf
Prior Authorization	Rare; mainly for DMEPOS and select services.	Common; applies to imaging, surgeries, SNF stays, etc. Can add administrative burden. 👉 CMS Final Rule on Prior Auth: https://www.cms.gov/newsroom/fact-sheets/reducing-burdensome-prior-authorization-policies-and-increasing-healthcare-transparency 👉 KFF Prior Auth Analysis:

		https://www.kff.org/medicare/issue-brief/prior-authorization-in-medicare-advantage/
Claims & Denials	Lower denial rates. Appeals handled through CMS process.	Higher denial rates. Appeals managed internally by plans. 👉 OIG Report on MA Denials: https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp 👉 KFF MA Denial Comparison: https://www.kff.org/medicare/issue-brief/beneficiary-denials-and-appeals-in-medicare-advantage/
Coverage Policy Decisions	NCDs: Set by CMS, apply nationwide. LCDs: Issued by MACs, vary by region. Flexibility limited to CMS/MAC guidance. Appeals at national level are managed by CMS. Appeals at local level are managed by MACs	NCDs: Must follow CMS NCDs. LCDs: Not applicable—plans develop internal policies (subject to CMS approval). Greater flexibility (e.g., supplemental benefits, genetic test coverage). Appeals handled by individual plans. 👉 Medicare Rights Center FAQ: https://www.medicarerights.org/fliers/ma-plan-rules.pdf
Example: Genetic Testing	Generalized coverage criteria under NCD 90.2 with CPT / procedure specific coverage established by MAC's LCD within each region.	May cover additional tests if clinically justified and included in CMS-approved bid.