Federation of American Hospitals

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STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives
Committee on Ways and Means
Re: "Medicare Advantage: Past Lessons, Present Insights, Future Opportunities"
July 22, 2025

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the joint hearing of the House Ways and Means Health and Oversight Subcommittees entitled, "Medicare Advantage: Past Lessons, Present Insights, Future Opportunities."

The FAH is the national representative of over 1,000 leading tax-paying hospitals and health systems throughout the United States, which make up 20 percent of community hospitals nationally. Many FAH member hospitals care for more seniors enrolled in Medicare Advantage than those in Traditional Fee-for-Service Medicare (Traditional Medicare). Although FAH members support private sector innovation in the Medicare program, taxpaying hospitals are increasingly concerned that MA plans are making it harder and more costly for patients to access the care they need—and that MA enrollees are not receiving the same covered benefits as beneficiaries in Traditional Medicare. We appreciate the Committee's interest in MA and urge Members to focus on ensuring timely access to comprehensive health services for all Medicare beneficiaries.

MA Delays and Denials

Abusive practices by MA plans include systematic efforts to inappropriately deny, limit, and delay the delivery and payment of health services and care. These practices force facilities and caregivers to spend valuable time and resources fighting care denials and delays, while diverting resources from patient care.

MA delays and denials through prior authorization and inconsistent administrative processes add tremendous costs to the health care system. To manage the prior authorization and payment barriers set up by MA plans, hospitals and physicians must hire extra staff and invest in expensive systems—diverting resources away from patient care.

We urge Congress to improve MA by taking steps that would simplify these administrative barriers by requiring MA plans to ensure that patients receive the same levels of coverage as patients in Traditional Medicare. Congress can protect MA enrollees by passing the *Improving Seniors' Timely Access to Care Act* (S. 1816 / H.R. 3514), which would reform prior authorization and strengthen reporting requirements. Advancing this bipartisan legislation would reduce the burden and complexity of the prior authorization requirements imposed by MA.

While this bill is an important step toward reducing delays in patient care, more must be done to stop all harmful practices by MA plans. Another effective way to reduce unnecessary paperwork, processes, and costs is to ensure that MA plans follow the Medicare Two-Midnight Rule and Inpatient Only List, which would provide assurance to beneficiaries on MA that they will receive the same level of coverage as those enrolled in Traditional Medicare.

Prompt Payment

Providers regularly report service and payment delays, inconsistent policies, and inappropriate denials by MA organizations implementing utilization management and payment delay practices. Currently, there are no clear standards defining a clean claim or timelines for MA plans to reimburse in-network providers—unlike out-of-network services, which follow Traditional Medicare rules.[1] MA plans lack consistency, frequently updating their claim submission requirements and requiring providers to follow them precisely to avoid delays in payment.

In addition, our member hospitals report that MA plans often initially deny claims with requests for additional line-item billing details or medical record information prior to paying a technically "clean" claim. These ongoing and unnecessary information requests, changes, and policy variations across plans create administrative burdens, unnecessary costs, and payment delays.

Congress should consider legislation that creates sensible guidelines for the prompt payment of clean, in-network claims by MA plans. Such legislation should hold MA plans accountable and rein in the arbitrary delay and denial of payment for clean, in-network claims.

MA Discharge Delays for Post-Acute Care and Network Adequacy

While it is increasingly difficult to get inpatient care approved and covered, once MA enrollees are admitted as an inpatient, they also routinely experience inappropriate delays in discharge from the hospital to post-acute care, such as at an inpatient rehabilitation

[1] Federal Register: Medicare Program; Establishment of the Medicare Advantage Program

facility (IRF) or long-term care hospital (LTCH). On average, MA patients that need post-acute care experience a 40% longer hospital length of stay in comparison to patients on Traditional Medicare.[2] This is due to a lack of adequate post-acute care networks and the limited number of providers within those networks willing to accept MA enrollee discharges.

Delays caused by prior authorization and other review activities further hinder timely transitions to post-acute settings. When a patient is ready for transfer from an acute-care setting to a post-acute environment, the most appropriate course of action is the prompt and safe transfer of the patient to begin receiving post-acute care (e.g., inpatient rehabilitation) in the most suitable environment. However, plans can reduce their post-acute costs by delaying discharge from the hospital. This happens because most plans pay hospitals using a per case rate (such as Medicare-Severity Diagnosis Related Groups (MS-DRGs), rather than paying based on the amount of time the patient stays in the hospital. This leaves MA plans with perverse incentives to keep enrollees hospitalized longer than medically necessary, rather than covering the additional costs of essential post-acute care services that support patient recovery. In addition to creating unnecessary risks for the patient, this "windfall" creates a disincentive to establish a more robust network of post-acute care providers.

MA post-acute networks often do not include an adequate number of post-acute facilities and post-acute providers to ensure that the appropriate facility is available, and that post-acute care is not delayed or disrupted. In fact, a recent study by NORC at the University of Chicago found that MA patients were discharged to advanced post-acute care settings (inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and skilled nursing facilities (SNFs) less often than those in Traditional Medicare even when accounting for patient acuity.[3] We urge Congress to work with CMS to ensure that MA plans are audited to determine whether they are approving timely discharges to an appropriate post-acute setting.

MA plans should also be required to demonstrate meaningful network access, including by raising the minimum number of in-network post-acute facilities, establishing a minimum facility-to-beneficiary ratio for in-network IRFs and LTCHs, and monitoring delays in inpatient hospital discharges due to the lack of capacity among in-network post-acute facilities in MA.

Current network adequacy standards fail to capture the realities of post-acute care access as they do not ensure that each MA organization offers a sufficient number of in-network post-acute beds. Members of the Ways and Means Committee have urged CMS to require

[2] NORC Analysis of Hospital Discharges for PAC Settings Among Medicare Beneficiaries
[3] NORC Analysis of Hospital Discharges for PAC Settings Among Medicare Beneficiaries

MA plans to meet distinct minimum network adequacy standards for LTCHs, IRFs, and SNFs, and to adopt policies that promote timely discharge to appropriate post-acute care settings. These steps are essential to addressing the current gap between theoretical network adequacy and actual access to timely, accessible, high-quality post-acute care, and our members urge Congress to make these network adequacy changes a requirement.

Finally, the FAH continues to urge Congress to consider incorporating network adequacy and stability into the Star Ratings Program. A metric reflecting an MA plan's historical performance on network adequacy and stability would provide valuable transparency for enrollees seeking to make informed plan choices and use quality-based competition to incentivize the MA market to meet enrollees' demands for robust and reliable networks.

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While FAH members continue to support the MA program for its private coverage options and added flexibility, we are increasingly concerned that current plan practices are creating unnecessary barriers and higher costs for patients and Medicare. As more seniors turn to MA, it is critical to ensure the program delivers on the promise of accessible, high-quality care.

We would welcome the opportunity to work with you on these important matters. If you have any questions or wish to speak further, please do not hesitate to reach out to me at CMacDonald@fah.org.

Sincerely,