Federation of American Hospitals

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STATEMENT
of the
Federation of American Hospitals
to the U.S. House Energy and Commerce
Subcommittee on Oversight and Investigations Hearing
"Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."
February 3, 2026

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Energy and Commerce Subcommittee on Oversight and Investigations hearing titled, *"Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."* FAH appreciates the opportunity to provide this statement as Congress examines the challenges posed by program integrity concerns in Medicare and Medicaid and considers solutions to strengthen these programs and safeguard patient access to care.

As the national representative of over 1,000 leading tax-paying hospitals and health systems throughout the nation, FAH shares the Subcommittee's commitment to ensuring program integrity across government programs. Our hospitals have made significant and sustained investments in developing infrastructures that detect anomalous billing patterns and prevent improper payments before they occur. These efforts reflect our understanding that program integrity is essential to protecting the American taxpayer and preserving Medicare and Medicaid for the vulnerable populations who rely on them.

Additionally, FAH believes that Congress should increase its focus on Medicare Advantage (MA) plan accountability and program integrity when looking to address unsavory behavior in government programs that impact patient care and drive up cost. Key oversight gaps enable inappropriate plan behavior such as utilization management tactics that arbitrarily delay and deny seniors the care they deserve and drive up costs. Without key program integrity and insurer transparency measures in place, beneficiaries are often left in the dark when choosing a plan that meets their needs.

Hospital Investments to Support Program Integrity

FAH hospitals are committed to being industry leaders in promoting program integrity measures and mitigating any impact of aberrant or anomalous billing across the health care industry, with the ultimate goal of keeping patients and employees safe and maintaining access to care for the patients who need it most.

Our hospitals have implemented an infrastructure of effective and transparent program integrity measures, including data-driven approaches, new training tools, and educational resources across clinical and administrative operations. These initiatives include:

- Advanced data analytics to identify potential anomalous billing patterns before claims are submitted;
- Strengthened patient identity verification processes and secure health IT systems to reduce the risk of identity-based fraud;
- Robust compliance programs, including scorecards, internal audits, and ongoing workforce training;
- Targeted prevention initiatives, such as drug-diversion prevention programs;
- Enhanced management of physician relationships, including contract management systems, fair-market-value assessment tools, and clear policies governing financial arrangements; and
- New investments in centralized payment operations, including dedicated centralized payment teams and modern payment platforms designed to improve oversight, consistency, and accountability in claims processing.

Together, these efforts demonstrate hospitals' proactive role in protecting federal health care programs and ensuring taxpayer dollars are used appropriately to support and deliver quality patient care.

Hospital Leadership in Identifying Aberrant Billing Patterns

FAH member hospitals have demonstrated strong stewardship of the Medicare program by proactively identifying and reporting aberrant billing patterns that risk significant financial harm. In 2023, hospitals observed unusual and suspicious spikes in billing for two urinary catheter codes and, in conjunction with aligned provider organizations, alerted CMS and the Office of Inspector General (OIG) to flag the issue for immediate review. This early intervention prompted CMS and OIG to investigate, ultimately stopping billions of dollars in fraudulent payments before they could further distort Medicare spending. Hospitals played a key role in drawing congressional and regulatory attention to the systemic gaps that allowed such anomalous billing patterns.

Importance of Increased Program Integrity in Medicare Advantage

FAH members increasingly care for more seniors enrolled in MA as compared to those in Traditional Medicare fee-for-service, and both FAH and our members strongly support the program's ability to offer greater flexibility beyond the structure of Traditional Medicare. However, we remain deeply concerned about the troubling and harmful practices by some MA plans that undermine patient access to medically necessary care. We encourage Congress to increase legislative and oversight efforts to ensure plans are meeting their obligations under the Medicare statute and CMS regulations. Increased transparency and accountability are essential to safeguard patient access to care, ensure seniors receive the benefits they have earned, promote appropriate plan conduct, and protect the long-term integrity of the program and the Medicare Trust Fund. We urge Congress to consider solutions across several areas where ongoing regulatory gaps allow MA plans to evade core program integrity obligations.

For more than a decade, insurers have steadily eroded the intent of Medical Loss Ratio (MLR) requirements, which were established to ensure that premium dollars are spent on medical care for beneficiaries. Through aggressive vertical integration, insurers now own or control the entities responsible for utilization management, claims processing, pharmacy benefit administration, and coding optimization. As a result, costs that are fundamentally administrative are increasingly reclassified as "quality improvement" activities, while payments to affiliated provider entities can artificially inflate reported medical spending. Although plans may technically meet MLR requirements on paper, the real-world impact has been a dramatic increase in administrative burden and a corresponding rise in care delays, claim downgrades, and denials—outcomes that directly harm beneficiary access to medically necessary care. FAH emphasizes the need for stronger oversight of vertically integrated payment arrangements that can undermine MLR accountability and weaken incentives to invest in patient care.

Utilization management tools, such as prior authorization, directly determine whether beneficiaries receive timely, medically necessary care. MA plans routinely deny or delay care that meets Medicare coverage criteria, often through prior authorization or post-service denials. Many denials are overturned on appeal—but only after costly, time-

consuming processes that delay care for patients and increase administrative costs for hospitals. Improper denials are not cost control efforts; they're cost shifting. Addressing this behavior would reduce duplicative appeals, administrative waste, and downstream care costs caused by delayed treatment.

Congress and the Administration can strengthen oversight of claim denials and care delays by requiring MA plans to publicly report behavior through the MA Star Ratings program, which plays a critical role in promoting accountability. CMS has proposed removing several administrative and operational measures in its recent proposed rule revising the MA and Part D program from the MA Star Ratings in order to streamline reporting. However, retaining a core subset of measures—such as appeals timeliness, appeals review, and complaints measures—is critical to promoting transparency and holding plans accountable for operational behaviors with direct clinical and access consequences. While FAH understands that some measures show limited variation, removing all of them would eliminate important tools that reveal how plans handle coverage decisions and respond to beneficiaries. These operational measures directly affect whether patients receive timely, medically necessary care.

To ensure that the MA Star Rating program accurately measures and reflects patient experience, we urge the incorporation of an FAH-developed Level 1 Upheld Denials measure into the Star Ratings program.[1] This measure captures plan decision-making at the initial point of denial, demonstrates meaningful variation across plans, and addresses well-documented limitations of downstream appeals measures that systematically underrepresent inappropriate denials. Adoption of this measure would meaningfully strengthen oversight of plan behavior and beneficiary protections.

FAH believes Congress should also look to strengthen network adequacy oversight and transparency, particularly in post-acute care. Chronically thin post-acute networks delay hospital discharges and disrupt medically necessary transitions of care, underscoring the need for stronger requirements.[2] FAH supports applying network adequacy standards at the sub-network level, where downstream organizations often function as enrollees' de facto provider networks. Absent transparency and oversight, sub-networks can restrict access to preferred providers and fail to meet CMS adequacy standards. Congress should promote legislation that ensures networks are evaluated at the level at which beneficiaries actually experience care and strengthen audit and enforcement tools accordingly.Without strong program integrity and oversight, seniors enrolled in MA plans ultimately receive a poorer product, with less transparency, diminished access, and weaker protections than Congress intended.

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Our hospitals stand ready to work with Congress to advance robust, modernized program integrity policies—particularly those that improve access to care and strengthen program integrity within MA and traditional Medicare.

FAH appreciates the Subcommittee's attention to fraud and abuse in government health care programs and welcomes continued collaboration with lawmakers to ensure these essential programs remain strong, sustainable, and protected for the American taxpayer and the millions of patients and seniors who rely on them.

[1] FAH Proposes New Performance Measure | FAH
[2] Analysis of Hospital Discharges to PAC Settings Among Medicare Beneficiaries | NORC