Federation of American Hospitals

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STATEMENT
of the
Federation of American Hospitals
to the United States House of Representatives
Committee on Ways and Means Hearing:
"Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud"
April 21, 2026

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Ways and Means Committee hearing entitled, "Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud." FAH appreciates the opportunity to provide this statement as Congress examines the challenges posed by program integrity concerns in Medicare and considers solutions to strengthen the program and safeguard patient access to care.

As the national representative of over 1,000 leading tax-paying hospitals and health systems throughout the United States, FAH shares the Committee's commitment to protecting the integrity of federal health care programs and ensuring that taxpayer resources are used appropriately to support patient care. Our hospitals have made significant and sustained investments in developing infrastructure that detects anomalous billing patterns and prevents improper payments before they occur. These efforts reflect our understanding that program integrity is essential to protecting the American taxpayer and preserving Medicare for the population that relies on it.

FAH believes that Congress should increase its focus on Medicare Advantage (MA) plan accountability and program integrity when looking to address practices that negatively impact patient care and drive up costs. Key oversight gaps enable plan to employ aggressive utilization management tactics that arbitrarily delay and deny seniors the care they deserve. 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 ensuring premium dollars are spent on patient care and maintaining access to care for those 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 shown 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) of the issue for immediate review. This early intervention prompted CMS and OIG to investigate, ultimately stopping billions of dollars in fraudulent payments before they further distorted Medicare spending. Hospitals played a key role in drawing congressional and regulatory attention to the systemic gaps that allowed such anomalous billing patterns.

Medical Loss Ratio (MLR) Oversight and Patient Affordability

Congress established the medical loss ratio (MLR) to ensure that most premium dollars – generally 80–85 percent – are directed toward medical services rather than administrative costs or profits. Consumers reasonably expect that the premiums they pay will translate into meaningful access to hospitals, physicians, and other essential services. However, vertical integration of insurers has created ways for plans to technically comply with MLR standards while shifting premium revenue within affiliated corporate structures. Insurers that own provider entities, pharmacy benefit managers, and other subsidiaries inflate reported medical spending by directing care to their affiliates – often paying higher rates – while retaining the funds within the same corporate family.[1] This intra-corporate spending enables plans to delay and deny care provided by unaffiliated hospitals and clinicians without risking noncompliance with MLR requirements.

Under the current regulatory framework, the opaque nature of these internal transfers makes it difficult for regulators and consumers to determine whether an insurer's reported medical spending reflects genuine investment in patient care. In fact, MedPAC has observed that traditional measures of health plan financial performance may not fully capture insurer profitability when plans are part of larger integrated organizations that include providers and other health care businesses.[2] To improve transparency and reinforce the accountability objectives of the MLR framework, CMS should consider several targeted policy improvements:

- **Require issuers to separately report payments counted as medical spending that are made to affiliated entities**, including provider organizations, pharmacy benefit managers, utilization management vendors and other subsidiaries.
- **Require issuers to disclose corporate relationships** between the insurer and entities receiving payments reported as medical claims so that regulators can evaluate the extent of vertically integrated spending.
- **Strengthen reporting requirements for quality improvement activities** to ensure that administrative functions performed by affiliated entities are not recharacterized as medical spending.
- **Expand public reporting of MLR data** to distinguish direct medical claims payments from other forms of reported medical spending, including quality improvement activities and payments to affiliated entities.

- **Incorporate review of vertically integrated payment arrangements into MLR audits and program integrity activities** to ensure that reported medical spending reflects genuine patient care rather than internal financial transfers.

Analysts and policymakers agree that gaming MLR requirements through vertical integration weakens the consumer protections Congress intended to provide, contributes to high premiums for consumers, and creates an uneven competitive landscape for providers.[3] Improving transparency and oversight of MLR reporting would help ensure that premium dollars are used to support patient care, strengthen accountability in vertically integrated insurance markets and better protect patients from rising premiums and reduced access to care.

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.

Utilization management tools, such as prior authorization, directly determine whether beneficiaries receive timely, medically necessary care. Excessive prior authorization, claim delays and denials and repeated documentation requests divert clinical resources away from direct patient care.[4] In fact, nearly 15 percent of all claims submitted to private insurers are initially denied, even when the services were preauthorized. More than half of those denials are eventually overturned, but only after multiple rounds of costly appeals.[5] Many denials involve services that fully meet Medicare coverage criteria. In 2025, hospitals spent $43 billion trying to collect payments from insurers for care already delivered.[6] 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.

FAH has long urged Congress and the Administration to 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 finalized the removal of 11 key administrative and operational Star Ratings measures in its recent CY2027 Medicare Advantage final rule with the goal of streamlining reporting. Tracking a core subset of those 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 will 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.[7] 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.[8] 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.

Conclusion

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.

A balanced approach to program integrity will crack down on fraud while supporting providers delivering services in good faith. Efforts should be carefully targeted, focusing enforcement on truly bad actors while avoiding unnecessary administrative burdens on providers operating in complex regulatory environments.

FAH appreciates the Committee'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.

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[1] Arnold, D. R. & Fulton, B. D. (November 2025). UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers. Health Affairs, 44(11). https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00155

[2] MedPAC. (March 15, 2023). March 2023 Report to the Congress: Medicare Payment Policy. https://www.medpac.gov/document/march-2023- report-to-the-congress-medicare-payment-policy/

[3] Angeles, J. & Bailit, M. (September 29, 2025). How Insurers That Own Providers Can Game The Medical Loss Ratio Rules. Health Affairs. https://www.healthaffairs.org/content/forefront/insurers-own-providers-can-game-medical-loss-ratio-rules

[4] Ibid.

[5] Premier. (March 21, 2024). Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims

[6] AHA. (March 2026). Costs of Caring. https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf

[7] Federation of American Hospitals. (Februrary 2024). Enhancing Transparency and Accountability in Medicare Advantage: FAH Proposes New Performance Measure. https://fah.org/wp-content/uploads/2024/11/FAH-Medicare-Advantage-Quality-Measure_February-2024.pdf

[8] NORC. (June 2025). Analysis of Hospital Discharges to PAC Settings Among Medicare Beneficiaries. https://strengthenhealthcare.org/wp-content/uploads/2025/06/PAC-Analysis-Findings.pdf