



Charles N. Kahn III  
President and CEO

**STATEMENT  
of the  
Federation of American Hospitals  
to the  
U.S. Senate  
Committee on Finance**

**Re: “Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences”**

**October 19, 2023**

The Federation of American Hospitals (FAH) submits the following Statement for the Record in response to the Senate Finance Committee (Committee) hearing on *Medicare Advantage Annual Enrollment: Cracking Down on Deceptive Practices and Improving Senior Experiences*. The FAH commends the Committee’s leadership in providing oversight of the Medicare Advantage (MA) program as an increasing number of America’s seniors receive their Medicare benefits through Medicare Part C health plans instead of the traditional fee-for-service program.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across forty-six states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children’s, and cancer services.

We welcome the opportunity to work with the Senate Finance Committee on its oversight of the MA program to ensure Medicare beneficiaries enrolling and enrolled in MA plans are treated fairly, provided accurate and timely information, and have access to the same benefits and healthcare services as Medicare beneficiaries in traditional Medicare.

As an organization representing tax-paying hospitals that provide 24/7 care to patients, including MA enrollees, we understand the extensive and inappropriate practices of prior authorization abuses and patient care delay and denial. MA plans systematically limit, delay, and deny access to care for MA enrollees, and problems with deceptive marketing practices and

unclear benefit descriptions are only the tip of the iceberg. Every day our members experience patients' confusion and frustration when they realize their MA plan does not cover or will not pay for the Medicare services they expect.

Further, MA plans often offer and publicize attractive benefits to Medicare beneficiaries who struggle to afford supplemental services such as Medicare Part D, dental, club memberships, or other similar benefits. However, severely ill or injured patients who need access to specialized medical and hospital services may find these additional benefits do not outweigh limited provider networks and overly aggressive utilization control practices.

The FAH believes that greater information on an MA plan's utilization management practices should be made available to beneficiaries and potential enrollees during the enrollment process. For example, being better informed about the services that require prior authorization and the approval/denial rates for each plan could help beneficiaries with chronic illnesses or known medical conditions assess how easy it will be for them to access care in a particular plan. Additionally, all beneficiaries would benefit by being able to compare plans on the extensiveness of their utilization management practices and potential abuses. The FAH urges the Committee to pursue legislation that would accomplish this level of transparency and we believe the *Improving Seniors' Timely Access to Care Act of 2023* would provide the needed information to require this type of transparency.

Many of our concerns related to MA plan utilization management abuses were included in a 2022 HHS OIG Report.<sup>1</sup> The report showed that MA plans systemically apply problematic operating policies, procedures and protocols that limit care for MA enrollees. The OIG Report also identifies a pattern by which MA plans apply utilization controls to improperly withhold coverage or care from MA enrollees. Specifically:

- *Improper prior authorization denials.* The OIG found that 13 percent of prior authorization requests denied by MA plans would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation.* The OIG found that in many cases beneficiary medical records were sufficient to support the medical necessity of the services provided.
- *Improper payment request denials.* The OIG found that 18% of payment requests denied by MA plans actually met Medicare coverage rules and MA plan billing rules.

These OIG findings reflect a broader pattern of MA plan practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care for MA beneficiaries. CMS also recently acknowledged many of these concerns in a December 2022 proposed rule regarding improving prior authorization processes and an April 2023 final regulation with MA

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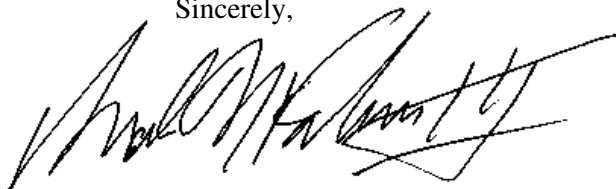
<sup>1</sup> Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General (“OIG”), OEI09-18-00260, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

policy changes<sup>2</sup> that would constrain some of the bad behaviors MA plans regularly employ related to prior authorization and non-coverage of items and services that would be covered for beneficiaries under the traditional Medicare fee-for-service program.

We commend the Committee's leadership and focus today to ensure Medicare beneficiaries have reliable access to care and meaningful information during the MA enrollment process and urge passage of the *Improving Seniors' Timely Access to Care Act of 2023* which will provide needed information and transparency on utilization management practices. Further we urge you to investigate the utilization management practices and exercise oversight authority to help protect patients against harmful MA plan behaviors through, for example, prior authorization reforms and comprehensive provider networks.

We look forward to working with you and your colleagues in Congress as you evaluate these important issues. If you have any questions or would like to discuss these comments further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,



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<sup>2</sup> <https://www.cms.gov/newsroom/press-releases/cms-proposes-rule-expand-access-health-information-and-improve-prior-authorization-process>; <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-andpart-d-final-rule-cms-4201-f>.