The Hospital + Healthsystem Association of Pennsylvania

August 26, 2025

Honorable Mehmet Oz, MD, MBA
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Aetna Medicare Advantage/Special Needs Program "Level of Severity Inpatient Payment Policy" Effective November 15, 2025

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), and our more than 235 hospitals and health system members statewide, we are writing to strongly oppose an **Aetna policy change** announced earlier this month that effectively violates CMS' "two-midnight rule." The policy unilaterally alters how urgent and emergent hospital admissions are reviewed and reimbursed. Not only does the policy remove the initial medical necessity reviews for stays exceeding one night, it also eliminates the collaborative processes that ensure appropriate patient care and fair reimbursement. We strongly urge you to instruct Aetna to rescind this policy.

Issue: Effective November 15, the new Aetna policy for urgent and emergent inpatient hospital admissions of one or more midnights will automatically approve payment for an inpatient hospital claim; however, that payment will be at a "lower level of severity rate that's comparable to the hospital's rate for observation services."

Further, the new policy states that "if the inpatient stay meets Milliman Care Guidelines (MCG) criteria, the payer will pay the remainder of the claim up to the hospital's inpatient rate." Aetna will not assess for medical necessity using the MCG criteria, but rather for "severity" of the inpatient admission to determine if the severity justifies the inpatient contracted rate.

Impact: Aetna's new policy threatens patient access to appropriate, quality care by eliminating opportunities for peer-to-peer clinical reviews and skirting appeal opportunities. This approach undermines physician judgment, bypasses established medical review safeguards, and shifts financial risk to hospitals that are already struggling. Collectively, these changes will significantly reduce provider reimbursement and add additional administrative burden for providers to be paid appropriately for the care rendered.

This new policy is the most recent attempt to circumvent CMS' "two-midnight benchmark." CMS clarified under Final Rule **CMS-4201-F** that Medicare Advantage (MA) plans must comply with coverage and benefit conditions under Traditional Medicare, such as payment criteria for inpatient admissions under 42 C.F.R. § 412.3. Additionally, during February 2024, CMS issued a series of **Frequently Asked Questions** that included the following:

"8. Question: Does the CY 2024 final rule mean that MA organizations must follow the Medicare "two-midnight rule"?

Answer: *The term 'two-midnight rule' is sometimes used to describe different things: either the "two-midnight presumption" or the "two-midnight benchmark" admission criteria. As explained further below, MA plans do not have to follow the "two-midnight presumption," which relates to medical review instructions for contractors in Traditional Medicare. However, another colloquial use of the term "two-midnight rule" is to describe the inpatient admission criteria in 42 C.F.R. § 412.3, which include a "two midnight benchmark;"* ***MA plans are required to follow these inpatient admission criteria."***

Aetna's policy directly conflicts with payment criteria for inpatient admissions at **42 CFR §412.3(d)(1)**, which states the MA plan must provide coverage for an inpatient admission when:

- The admitting physician expects the patient to require hospital care that crosses two midnights (§ 412.3(d)(1);
- The admitting physician does not expect the patient to require care that crosses two midnights, but determines, based on complex medical factors documented in the medical record that inpatient hospital care is nonetheless necessary (§ 412.3(d)(3)); or
- Inpatient admission is for a surgical procedure specified by Medicare as inpatient only (§ 412.3(d)(2)).

Aetna proposes to replace this criteria with MCG criteria. Federal regulation, however, asserts that the admitting physician makes the determination for inpatient status. The admitting physician—not an administrator, algorithm, or AI tool—determines when a patient is expected to require hospital care that crosses two-midnights. CMS has already made clear its concerns with supplanting the § 412.3 payment criteria for inpatient admissions with MCG criteria, when CMS stated in Final Rule CMS-4201-F that MA plans may not use MCG criteria "to change coverage or payment criteria already established under Traditional Medicare laws."

CMS Action: In closing, we request that CMS instruct Aetna to immediately withdraw their "level of severity inpatient payment policy." Please don't hesitate to reach out to **me** at 717-561-5308 with any questions or if you need additional information.

Respectfully,

Jolene H. Calla, Esq.
Vice President, Finance and Legal Affairs