The Hospital + Healthsystem Association of Pennsylvania

March 21, 2026

Richard Snyder, M.D.
Executive Vice President
Independence Blue Cross
1901 Market Street, 45th Floor
Philadelphia, PA 19103

**RE: Independence BlueCross MA00.59 – Reimbursement for Emergent Inpatient Admissions**

Dear Dr. Snyder:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 235 hospitals and health systems statewide, we write to express significant concerns regarding Independence BlueCross' policy: ***IBX-MA00.59 – Reimbursement for Emergent Inpatient Admissions***. While we recognize and value Independence BlueCross' intent to enhance consistency and expedite hospital reimbursement, the policy—as drafted and now implemented—presents significant operational, clinical, and financial challenges for hospitals and the Medicare Advantage beneficiaries they serve.

**1. Insufficient Time from Announcement to Effective Date.**

This policy change was announced February 3, 2026, with a March 5, 2026, effective date. This allowed only 22 business days for hospitals to: identify the change, update workflows, retrain staff, and adjust systems to ensure compliance. Moreover, introducing an additional 'intensity of services' review layer beyond medical-necessity assessment places a substantial administrative strain on hospitals that are already contending with severe workforce constraints. **CMS' utilization-management reforms** emphasize timely access to medically necessary care and require that MA plans' UM processes (including prior authorization and payment reviews) be aligned with Medicare coverage rules and be transparent, not additive barriers.

Meaningfully adapting clinical documentation processes, utilization review protocols, billing system logic, and physician education requires far more time than 22 days, assuming everything can start the day the policy comes out, which is not a realistic assumption. Rapid implementation increases the likelihood of inadvertent administrative errors and claim denials that ultimately delay or disrupt patient care.

A change of this magnitude should be coupled with a realistic implementation period, including opportunities for provider feedback, clarification, and collaborative adjustment before enforcement begins.

**2. Reliance on InterQual Criteria Before Medical Judgment is Inappropriate.**

Policy MA00.59 appears to rely heavily—if not exclusively—on InterQual criteria as the basis for determining the appropriateness of emergent inpatient admissions, while calling this a payment policy. Tools such as InterQual may assist clinicians, but they should not replace a physician's clinical assessment and should not be used independently, at any stage, to determine payment for hospital claims. **CMS's 2024 MA FAQ** further cautions against using algorithms or software tools (including proprietary criteria engines) as the basis for coverage decisions; determinations must rest on the individual patient's condition and clinician judgment.

When insurers treat InterQual as a pass/fail test, any case lacking a specific data point—even if treatment was 100% clinically appropriate—risks being denied. This approach undermines both clinical autonomy and the foundational principle that the treating provider is best positioned to determine the appropriate level of care. Further, **Medicare's Two-Midnight regulation** expressly ties inpatient appropriateness to the admitting physician's expectation based on "complex medical factors" (history/comorbidities, severity of signs/symptoms, current needs, risk of adverse events) documented in the record, not to a proprietary checklist.

Additionally, unilaterally reducing hospital reimbursements prior to review of the complete case interferes with existing payment arrangements and creates unnecessary and burdensome multi-layered revenue reconciliation activities for hospitals.

For all the reasons noted above, we respectfully urge IBX to rescind *IBX-MA00.59 – Reimbursement for Emergent Inpatient Admissions* and work collaboratively with hospitals to design a revised policy framework. That framework should consistently (1) apply Traditional Medicare coverage rules (including the Two-Midnight benchmark for inpatient status) to MA beneficiaries; (2) limit any use of internal criteria to circumstances where Medicare has not fully established coverage standards and only with publicly accessible, evidence-based criteria; and (3) ensure case-specific determinations grounded in the treating physician's documented clinical judgment. Such a framework will support sound clinical decision-making, reduce administrative burden, and ensure that claims are paid *both promptly and fairly*.

Hospitals stand ready to engage constructively in that process, and meaningful collaboration is essential to protect patient access and maintain operational stability.

Respectfully,

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