Federation of American Hospitals

Charles N. Kahn III
President and CEO

September 24, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: New Inappropriate Inpatient Coverage Policy Issued by Aetna for Medicare Advantage

Dear Dr. Oz:

On behalf of the Federation of American Hospitals (FAH), we are writing to make you aware of a new and inappropriate coverage policy that Aetna has announced for its Medicare Advantage (MA) plans across the county. The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 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 commend the Centers for Medicare & Medicaid Services (CMS) for its commitment to safeguarding the care and effectiveness of the Medicare Advantage program for the millions of seniors that access their Medicare benefits through private MA plans. FAH members increasingly serve more seniors with MA coverage than through Traditional Medicare fee-for-service, and the FAH and our members support MA and the way the program can offer private options and flexibility beyond the benefit structure of the Traditional Medicare program. However, we are concerned by the alarming and abusive practices of MA plans that harm patients by eroding access to and affordability of medically necessary care. Too often, MA plans inappropriately deny, limit, and delay the delivery of services and care, requiring hospitals and caregivers to divert precious resources and time to respond to care denials and delay tactics and away from their core mission of patient care. Recently, Aetna announced a new policy for its MA plans – the "Level of Severity Inpatient Payment Policy" – that would significantly erode inpatient hospital coverage for Aetna's Medicare enrollees, deprive them and the public of essential transparency around Aetna's inpatient coverage and payment determinations, and breach Aetna's contracted rate agreements. With this policy, Aetna is running its own playbook to dodge the rules of the road. We have already expressed our concerns directly with Steve Nelson, President of Aetna, and our letter to them is enclosed as Attachment A.

Under Aetna's new "Level of Severity Inpatient Payment Policy,"[1] announced on August 1, 2025, Aetna would automatically approve certain inpatient stays that span one or more midnights, but such approval would not necessarily result in inpatient coverage of the stay. Rather, Aetna would condition actual inpatient coverage on the satisfaction of proprietary Milliman Care Guidelines (MCG) severity criteria, which conflict with Medicare inpatient admission criteria. If Aetna determines that the severity of the approved inpatient stay does not satisfy MCG criteria, Aetna will deny inpatient payment and pay the hospital at a rate that approximates the lower contracted observation rate for the hospital. Under this policy, Aetna would not make a determination regarding the medical necessity of the inpatient stay and would not apply Medicare's inpatient coverage criteria at 42 C.F.R. § 412.3 when approving the inpatient stay or when adjudicating the hospital claim.

Aetna's policy directly conflicts with CMS's coverage and benefit conditions for inpatient admissions. Under longstanding Medicare policy codified at 42 CFR § 412.3(d) (sometimes referred to as the two-midnight rule), an inpatient admission is appropriate when:

- the admitting physician reasonably expects the patient to require hospital care spanning two midnights (the two-midnight benchmark);
- complex medical factors justify admission notwithstanding the expectation of fewer than two midnights (the case-by case exception); or
- the admission involves a surgical procedure designated as inpatient only.

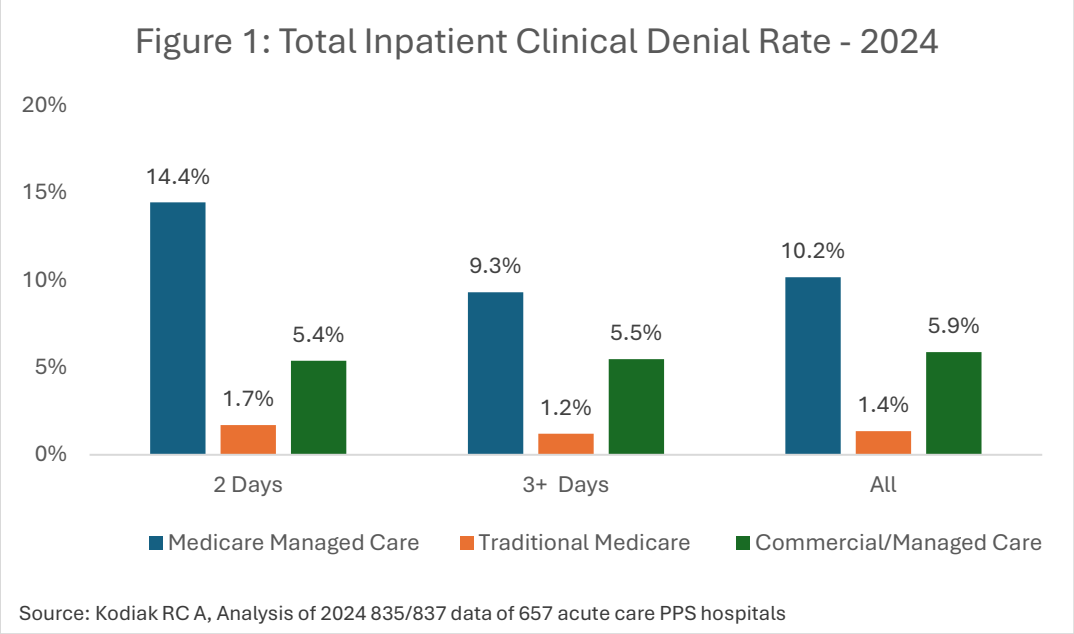
CMS expressly requires that MA plans must apply these inpatient criteria in their coverage and payment determinations (42 CFR § 422.101(b)(2)). Aetna's new approach, which conditions inpatient payment on meeting commercial criteria rather than Medicare standards, is a direct violation of federal regulations and recent CMS rulemaking. By substituting proprietary guidelines for the two-midnight rule, Aetna undermines physician judgment and CMS's own policy framework. Aetna appears to be attempting to avoid its obligation to make medical necessity determinations based on Medicare coverage and benefit criteria. The policy further indicates that Aetna will regularly reopen its approval of inpatient stays to apply its severity criteria despite having made a pre-service determination of inpatient coverage.

This policy will also deprive beneficiaries of key protections, reduce transparency, and impede effective regulatory oversight by characterizing the resulting denials of inpatient payment for approved inpatient stays as something other than an organization determination. As CMS has made clear, MA plans provide coverage by paying for care, so "the refusal to provide or pay for services, in whole or in part, including the type or level of services (e.g., inpatient services versus outpatient services) is an organization determination by the MA plan under § 422.566(b)(3)."[2] As such, Aetna's payment of inpatient claims at less than the negotiated inpatient rate under this policy plainly constitutes an adverse organization determination, and the severity and payment adjustment language used in the policy cannot obscure this fact. By mischaracterizing the partial payment of claims as anything other than an adverse organization determination, Aetna wrongly bypasses physicians' professional judgment and the medical review process diminishing the reliability of the resulting coverage and payment decisions. In doing so, Aetna will also sidestep beneficiary notice and appeals rights and the use of established denial codes. Ultimately, overburdened providers will be left to identify underpayments without the transparency of remittance advice

[1] Available at https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-august-2025-olu.pdf.
[2] CMS, Memo to MA Organizations & Medicare-Medicaid Plans, Frequently Asked Questions Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F) (Feb. 6, 2024), *available at* https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-2-february-5-9.

codes disclosing "severity" determinations and expend limited resources on confidential and costly appeals and arbitration.

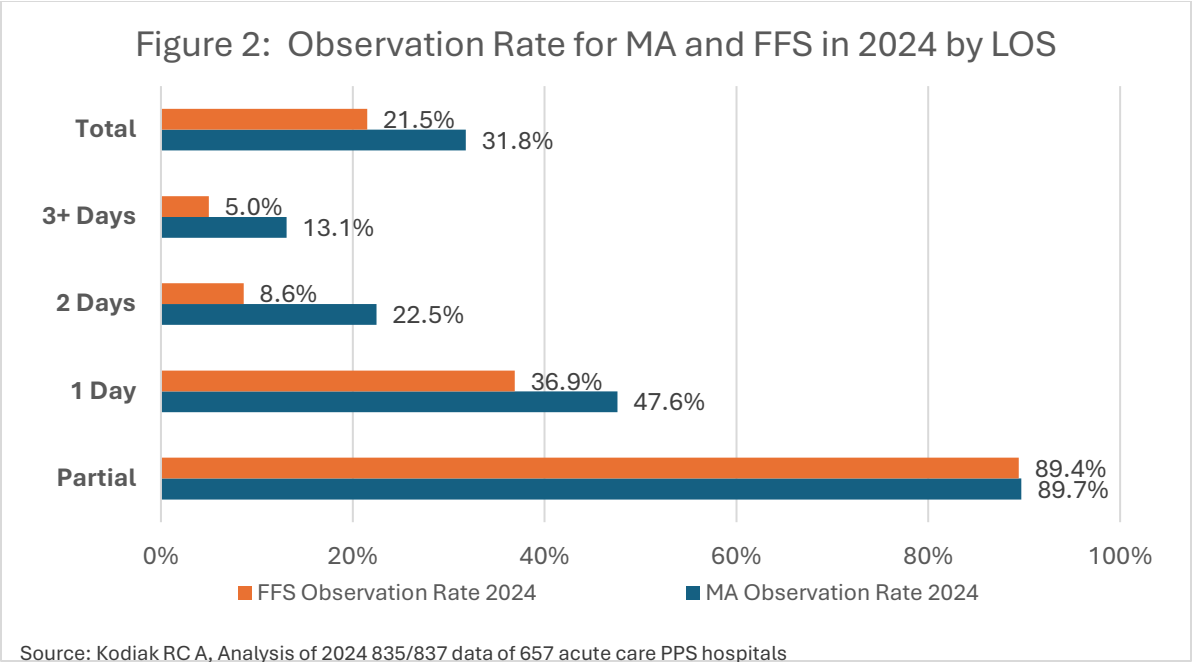
These new Aetna tactics are consistent with broader patterns of MA plans using utilization management tools to inappropriately deny or delay care, as documented by OIG reports[3]. Recent data in Figure 1 and 2 below from Kodiak Solutions of more than 650 acute care hospitals confirms these findings. In 2024, MA plans denied 10.2 percent of inpatient hospital claims for clinical reasons[4] that involved three or more days of hospital care and thus satisfied Medicare's two-midnight benchmark under 42 C.F.R. § 412.3(d)(1). That denial rate was more than 7 times higher than the 1.4% denial rate for Traditional Medicare FFS and almost double the 5.9 percent denial rate for commercial plans. This shows that MA plans are not providing the same level of inpatient coverage as FFS, and more disturbingly, that they are denying care for America's seniors at a much higher level than those same plans deny coverage for their commercially insured enrollees.



Moreover, as seen below in Figure 2, MA beneficiaries' hospital care is often inappropriately classified by MA plans as outpatient care, with MA plans treating approximately 13 percent of hospital stays of three days or more as outpatient observation in 2024 compared to 5 percent of 3+ day hospital stays being classified as observation in Medicare FFS. The inappropriate categorization of an inpatient hospital stay as an observation visit by an MA plan deprives the beneficiary of the inpatient benefits to which they are entitled and for which the MA organization has been paid out of the Medicare Trust Fund.

[3] https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf and https://oig.hhs.gov/reports/all/2018/medicare-advantage-appeal-outcomes-and-audit-findings-raise-concerns-about-service-and-payment-denials/

[4] Clinical denials include authorization, precertification, and medical necessity denials



Aetna's new policy would continue this discrepancy in coverage between Medicare beneficiaries in Traditional Medicare verses Medicare Advantage.

The FAH is also alarmed that Aetna's policy appears to be designed to evade public reporting of denial and appeal statistics that would otherwise reveal how often its members' care is denied and its determinations are overturned. The FAH has consistently urged CMS to hold MA plans accountable for inpatient coverage and denials through oversight and transparency measures, and we have welcomed CMS's efforts to improve transparency regarding MA organizations' practices and performance. Beginning in 2026, CMS requires MA organizations to report prior authorization data, including the percentage of prior authorizations that are approved and denied. By automatically approving inpatient stays but then depriving full coverage for inpatient stays through severity coverage and partial payments, it appears that Aetna intends to inflate its approval numbers and obfuscate its ultimate inpatient coverage denials, misleading regulators and the public. Likewise, by failing to provide notice of adverse organization determinations, Aetna will suppress appeals in ways that directly impact Aetna's performance on key measures in the Medicare Advantage Star Ratings Program, mislead beneficiaries that rely on accurate Star Ratings to make informed decisions about their plan selection, and ultimately divert Medicare Trust Fund and taxpayer dollars to performance bonuses premised on Aetna's Star Ratings.

If Aetna is permitted to proceed with implementation of this policy, its approach will result in reduced hospital reimbursement, greater provider administrative burden, less transparency and trackability of plan determinations, and ultimately, diminished patient access to timely inpatient care. It places hospitals—particularly those serving rural and underserved communities—in untenable positions. CMS requires that Aetna provide its MA members with coverage equivalent to fee-for-service Medicare, including by paying for medically necessary inpatient care. We urge CMS to investigate this issue and take additional steps to ensure that Aetna's MA enrollees and hospitals are treated fairly and that Aetna properly provides inpatient coverage to its MA enrollees by paying hospitals their negotiated inpatient rates for the inpatient care they furnish. We ask CMS to direct Aetna to withdraw this policy and comply with MA regulations concerning inpatient coverage criteria, prior authorizations, medical necessity determinations, organization determinations, and public reporting of denials and appeals.

****

The FAH is committed to supporting CMS's mission to safeguard Medicare, ensure Medicare funds are used to provide covered services to beneficiaries, and continue to improve the Medicare Advantage program. Aetna's new policy is an impermissible attempt to rewrite Medicare rules through unilateral policies and internal criteria. It undermines physician judgment, limits patient access, conceals plan denial practices, and violates CMS's own regulations. The FAH urges CMS to act swiftly to protect beneficiaries, safeguard hospital stability, and uphold the integrity of the Medicare program. We stand ready to work with CMS to ensure compliance with the two-midnight rule and Medicare's inpatient coverage criteria and that MA plans are held accountable for transparent and fair coverage policies.

The FAH appreciates the opportunity to share our concerns. If you have any questions, please contact me or Don May at 202-624-1500 or email at DMay@fah.org.

Sincerely,

cc: Stephanie Carlton
John Brooks
Chris Klomp

ATTACHMENT A

Federation of American Hospitals

Charles N. Kahn III
President and CEO

September 18, 2025

Mr. Steve Nelson
President
Aetna
151 Farmington Avenue
Hartford, CT 06156

Dear Mr. Nelson:

The Federation of American Hospitals (FAH) is writing to express our deep concerns with Aetna's new coverage policy proposed for its Medicare Advantage (MA) plans across the country and the adverse impact it will have on transparency, oversight, and beneficiary rights. The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 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 believe that Aetna's new "Level of Severity Inpatient Payment Policy,"[1] announced on August 1, 2025, would significantly erode inpatient hospital coverage for Aetna's Medicare enrollees, deprive them and the public of essential transparency around Aetna's inpatient coverage and payment determinations, and breach Aetna's contracted rate agreements. Under this policy, Aetna would automatically approve certain inpatient stays that span one or more midnights, but such approval would not necessarily result in inpatient coverage of the stay. Rather, if Aetna determines that the severity of the approved inpatient stay does not satisfy MCG criteria, Aetna will deny inpatient payment and pay the hospital at a rate that approximates the lower contracted observation rate for the hospital. Under this policy, Aetna would not make a determination regarding the medical necessity of the inpatient stay and would not apply Medicare's inpatient coverage criteria at 42 C.F.R. § 412.3 when approving the inpatient stay or when adjudicating the hospital claim. Instead, Aetna would assess whether the stay meets proprietary MCG criteria and would unilaterally adjust its payment of the inpatient stay based on that determination.

Aetna's policy directly conflicts with CMS's coverage and benefit conditions for inpatient admissions. Under longstanding Medicare policy codified at 42 CFR § 412.3(d) (sometimes referred to as the two-midnight rule), an inpatient admission is appropriate when:

- the admitting physician reasonably expects the patient to require hospital care spanning two midnights (the two-midnight benchmark);

[1] Available at https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-august-2025-olu.pdf.

- complex medical factors justify admission notwithstanding the expectation of fewer than two midnights (the case-by case exception); or
- the admission involves a surgical procedure designated as inpatient only.

In 2023, CMS confirmed that MA plans must apply these inpatient criteria in their coverage and payment determinations. Aetna's new approach, which conditions inpatient payment on meeting commercial criteria rather than Medicare standards, is contrary to federal regulation and recent CMS rulemaking. Aetna appears to be attempting to avoid its obligation to make medical necessity determinations based on Medicare coverage and benefit criteria. The policy further indicates that Aetna will regularly reopen its approval of inpatient stays to apply its severity criteria despite having made a pre-service determination of inpatient coverage.

This policy will also deprive beneficiaries of key protections, reduce transparency, and impede effective regulatory oversight by characterizing the resulting denials of inpatient payment for approved inpatient stays as something other than an organization determination. As CMS has made clear, MA plans provide coverage by paying for care, so "the refusal to provide or pay for services, in whole or in part, including the type or level of services (e.g., inpatient services versus outpatient services) is an organization determination by the MA plan under § 422.566(b)(3)."[2] As such, Aetna's payment of inpatient claims at less than the negotiated inpatient rate under this policy plainly constitutes an adverse organization determination, and the severity and payment adjustment language used in the policy cannot obscure this fact. By mischaracterizing the partial payment of claims as anything other than an adverse organization determination, Aetna wrongly bypasses physicians' professional judgment and the medical review process diminishing the reliability of the resulting coverage and payment decisions. In doing so, Aetna will also sidestep beneficiary notice and appeals rights and the use of established denial codes. Ultimately, overburdened providers will be left to identify underpayments without the transparency of remittance advice codes disclosing "severity" determinations and expend limited resources on confidential and costly appeals and arbitration.

The FAH is also alarmed that Aetna's policy appears to be designed to evade public reporting of denial and appeal statistics that would otherwise reveal how often its members' care is denied and its determinations are overturned. Beginning in 2026, MA organizations must report prior authorization data, including the percentage of prior authorizations that are approved and denied. By automatically approving inpatient stays but then depriving full coverage for inpatient stays through severity coverage and partial payments, it appears that Aetna intends to inflate its approval numbers and obfuscate its ultimate inpatient coverage denials, misleading regulators and the public. Likewise, by failing to provide notice of adverse organization determinations, Aetna will suppress appeals in ways that directly impact Aetna's performance on key measures in the Medicare Advantage Star Ratings Program and mislead beneficiaries that rely on accurate Star Ratings to make informed decisions about their plan selection

If Aetna proceeds with implementation of this policy, its approach will result in reduced hospital reimbursement, greater provider administrative burden, less transparency and trackability of plan determinations, and ultimately, diminished patient access to timely inpatient care. It places hospitals—particularly those serving rural and underserved communities—in untenable positions. Aetna has undertaken an obligation to provide its MA members with coverage equivalent to fee-for-service Medicare, and to fulfill this commitment, Aetna should withdraw this policy and comply with MA regulations concerning

[2] CMS, Memo to MA Organizations & Medicare-Medicaid Plans, Frequently Asked Questions Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F) (Feb. 6, 2024), *available at* https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-2-february-5-9.

inpatient coverage criteria, prior authorizations, medical necessity determinations, and organization determinations. In the end, Aetna must provide inpatient coverage by making inpatient payments pursuant to its provider contracts and cannot unilaterally select an alternative rate or provide partial payment for approved inpatient care.

****

The FAH calls on Aetna to put Medicare beneficiaries first and to fulfill its public obligations by providing full coverage of Medicare's basic benefits—including inpatient hospital care—in accordance with Federal law. Aetna's new policy is an impermissible attempt to rewrite Medicare rules through unilateral contractual adjustments, internal criteria, and opaque processes. If implemented, it would undermine physician judgment, limit patient access, conceal plan denial practices, game performance metrics, and violate critical Medicare regulations.

The FAH appreciates the opportunity to share our concerns. If you have any questions, please contact me or Don May at 202-624-1500 or email at DMay@fah.org.

Sincerely,

cc: Mehmet Oz, M.D.
Administrator, CMS