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Aetna New Medicare Advantage Inpatient Policy: A Threat to Hospitals and Patients

Hospitals are experiencing a growing number of payor denials, but how do hospitals respond when a payor disguises a denial as a contractual payment adjustment? Can payors decide to unilaterally change their contracted reimbursement agreements? Is this compliant with Medicare regulations? Will the hospital be allowed due process to challenge these decisions? How will the patient be impacted?

Aetna recently announced that beginning November 15, 2025, they will implement the "level of severity inpatient payment policy." This policy discusses how Aetna will apply different medical necessity review standards to Medicare Advantage (MA) beneficiaries with urgent or emergent inpatient admission depending on how many midnights are crossed.

The announcement raises more questions than it answers, leading to industry speculation. Through our commitment to supporting our hospital partners, Brundage Group shares this call to action as we read between the lines in anticipation of how this policy change will impact hospitals. We look forward to additional details on how the new "level of severity inpatient payment policy" will be implemented. Per Aetna's announcement, that information will not be available until October. In the meantime, here is what we know.

Claims with an inpatient order and Length of Stay (LOS) of

- Less than one midnight are subject to medical necessity reviews using Centers for Medicare and Medicaid Services (CMS) guidelines i.e., presumably the Medicare Two-Midnight Rule
- One or more midnight will automatically be approved as an inpatient (so a medical necessity denial will not be issued)
    - If the claim does not meet MCG (i.e., Aetna Supplemental Guidelines for inpatient admissions) it will be paid at a "lower level of severity rate" comparable to the hospital's observation rate.
    - If the claim meets MCG (i.e., Aetna Supplemental Guidelines for inpatient admissions) it will be paid at the hospital inpatient rate in "accordance with the hospital agreement."

Key Issues Emerge upon Closer Examination

Payor contracts outline the agreed-upon payment mechanism for each type of hospital service. Like Medicare, commercial payors often use a different payment structure for hospital inpatient and outpatient services. MCG is a screening tool that uses severity of illness, among other concepts, to identify cases that may need further review by a physician

to determine patient status. Use of MCG should not circumvent physician medical judgment. It is not a replacement for medical judgement. Under CMS rules, the decision to admit as an inpatient may be appropriate when supported by the physician's clinical judgment, even if MCG criteria are not satisfied.

It is irresponsible for Aetna to assert that short-stay inpatient stays failing to meet MCG criteria only require hospital resources consistent with an observation level of care and should therefore be paid at that lower rate. This policy is a calculated decision designed to sidestep the issuance of medical necessity denials that CMS regulates. While Aetna presents this as a benefit to hospitals, its true intent is to reduce their cost, shifting the financial burden onto hospitals and creating additional operational and financial strain.

Because these will not be denials, there is industry speculation about how Aetna will adjudicate these claims. The most reasonable conclusion is that these claims will be processed as "paid in full," from Aetna's perspective, yet at a significantly reduced rate inconsistent with the contracted inpatient amount. Hospitals will discover these payment downgrades through their electronic remittance advice (ERA), which will indicate:

1) if the claim was paid or denied
2) if payor adjustments are made and
3) the patient's responsibility

What about the Patient?

With this policy, Aetna effectively denies full inpatient benefits in violation of Medicare regulations. Federal law 42 CFR §422.568 requires beneficiary and provider written notice when an MA plan denies a service or payment in whole or in part. This written notification informs the MA plan beneficiary of their appeal rights. This policy appears designed to reframe coverage decisions as payment adjustments—potentially to circumvent regulatory oversight and appeal requirements.

This policy may also have a financial impact on their beneficiaries. Aetna MA plans include copays that range from $250 to almost $400 per day, compared to observation services copays that are at a per-visit rate.

Aetna Removes Physician Judgment

It is unclear how Aetna can implement this policy across the board with all hospitals without renegotiating contracts. Unfortunately, many contracts refer to MA plan policies, so it is likely this is how these types of changes can be implemented without allowing hospitals to opt out. Although Aetna says hospitals will maintain their right to dispute the inpatient reimbursement rate, they have yet to explain this process or to state what rights will be afforded to their beneficiaries within this new process. When payor contracts become too restrictive or place

hospitals at a disadvantage, the only choice for hospitals is to terminate these contracts so they can be paid as an out-of-network provider.

If Aetna can successfully portray this as a contractual or payment dispute, hospitals will likely be unable to use the peer-to-peer review process, a common mechanism for overturing inpatient denials. This tactic effectively blocks hospitals from challenging disease severity concerns that aren't reflected within MCG. In doing so, Aetna removes physician judgment from the decision-making process, despite Medicare 42 CFR 422.566(d) requirements that organizational determinations include such clinical input.

"If the MA organization expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision."

Additionally, 42 CFR 422.566(d) demonstrates "medical necessity" is not limited to this exact phrase. CMS had the foresight to include "(or any substantively equivalent term used to describe the concept of medical necessity" so MA plans could not avoid the physician-review requirement by using different wording within their policies.

Severity is being used as a proxy to determine:

- whether a service is clinically appropriate,
- whether it's needed for the patient's condition, and
- whether it meets Medicare coverage criteria

Therefore, "severity" is functionally and legally a substantially equivalent term to "medical necessity" for purposes of this regulation. If "severity" or any other terminology results in a decision to deny, partially deny, or limit coverage, it must be reviewed by a qualified physician before the denial is issued – exactly as if the policy had used the words "medical necessity."

If Aetna is applying "severity" in a way that bypasses regulatory requirements, CMS could view it as a compliance violation, because the regulation is designed to stop semantic loopholes. If implemented as proposed, this policy undermines Medicare protections, including the right to independent review of adverse determinations. It risks setting a precedent where MA plans can reduce payment unilaterally without accountability or transparency—posing significant long-term risks to hospital sustainability and patient rights.

Is This Compliant?

The Medicare Two-Midnight Rule

As outlined in the notice, this policy conflicts with Medicare's Two-Midnight Rule that was expanded to MA plans in 2024. Aetna appears to be aware of their gamesmanship by stating, "We won't use MCG to determine whether an inpatient stay is medically necessary. Instead, we'll use it to determine the severity of an inpatient admission and whether that severity justifies the inpatient contracted rate."

The Two-Midnight Rule and Short-Stay Reviews

CMS contends that inpatient admissions are generally appropriate when the patient is expected to stay at least two-midnights based on the admitting physician's judgment at the time of the inpatient order. For inpatient admissions that don't cross the two-midnight threshold 42 CFR 412.3(d)(3), states,

"Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination.

Severity is just one of the components upon which inpatient determinations should be made under the Medicare Two-Midnight Rule. As Medicare clearly states, it is a complex decision, one for which it would be impossible for a screening tool to correctly apply. Specifically, both 42 CFR 412.3(d)(1)(i) and (d)(3) include the statement,

"The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration."

This quote reinforces that severity (like what MCG evaluates) is only one part of the full clinical picture and that Medicare requires a physician's documented expectation to guide status decisions—even when the stay is under two midnights.

The Two-Midnight Rule and Use of Proprietary Screening Criteria

As announced in this notice, Aetna ignores the Two-Midnight Rule by applying MCG-based severity methodology to make payment determinations. This will be a retrospective decision by Aetna, which may further corrupt the validity of their determination. As they say, hindsight is twenty-twenty.

Medicare does not endorse the use of commercial screening criteria like MCG to determine medical necessity under the Two-Midnight Rule. However, healthcare organizations may use commercial screening tools to help their Utilization Review nursing staff identify which cases need escalation to a Physician Advisor. Medical necessity determinations must be based upon physician judgement. The findings of a screening tool are not binding.

CMS Medicare Advantage and Part D Final Rule 4201-F requires MA plans to follow traditional Medicare coverage criteria (i.e., the Medicare Two-Midnight Rule). An updated FAQ related to Medicare short-stay reviews specifically states,

"As indicated in the Hospital OPPS Final Rule 1633-F, CMS does not mandate the use of such tools [proprietary commercial screening tools], nor is it necessary for a beneficiary to meet an inpatient 'level of care,' as may be defined by a commercial screening tool, for Part A payment to be appropriate." MACs will not be using screening tools as part of their review."

Final Rule 4201-F also prevents MA plans from denying coverage based on internal, proprietary guidelines if they result in less coverage than under original Medicare. Again, Aetna is trying to bypass this regulation by downgrading the payment without changing the patient status. Lastly, this rule instructs MA plans to make coverage decisions based upon the beneficiary's particular circumstances and not blanket rules or internal guidelines.

What Can Hospitals Do Today?

- Conduct a legal review of Aetna Contracts.
  - Review contractual rates as well as when/how Aetna is able to make payment adjustments.
  - Review contractual rights for arbitration or mediation.
  - Determine if this policy could be in breach of contract for deviation from agreed terms.
- Amend Aetna Contracts.
  - Add language that forces Aetna to issue a medical necessity denial for inpatient care rather than accepting payment at a reduced rate for inpatient stays that don't meet MCG criteria.
  - Update contracts to define which types of denials and payment adjustments can be made by Aetna.
  - Remove ambiguity that may allow medical necessity determinations or payments to be adjusted through methods other than what is outlined within CMS regulations and the spirit of those regulations.
- If a mutually beneficial agreement cannot be reached, consider terminating Aetna Managed Care Plan contracts.
- Inform Aetna beneficiaries that their co-pay may be affected, and this policy may compromise their right to appeal Aetna's decision.

- Advocate
    - All communications equate the Aetna policy to a "substantively equivalent term" used to describe the concept of medical necessity, so it falls within Medicare regulations.
    - Work with your state American Hospital Association and other advocacy groups.
    - Request CMS unequivocally equate "severity" to "medical necessity"
    - File a complaint with CMS, if necessary.
- Escalate to the State Department of Insurance, who has the authority to investigate Unfair Claim Practices.

Conclusion

Aetna's new policy represents a significant shift in how Medicare Advantage payors may attempt to reframe coverage decisions such as payment classifications, sidestepping federal regulatory protections for hospitals and patients. If not challenged, this policy may set a precedent that erodes clinical judgment, reduces appropriate and earned reimbursement, and undermines patient appeal rights across the industry.

Hospitals must proactively assess and respond through legal, contractual, advocacy, and regulatory channels to safeguard operational integrity, ensure fair compensation for care delivered, and protect patient access to medically necessary services.