Texas Hospital Association

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September 19, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Via Email:medicarepartcdquestions@cms.hhs.gov

Re: Aetna Medicare Advantage/Special Needs Program – "Level of Severity Inpatient Payment Policy"

Dear Administrator Oz:

On behalf of our more than 460 member hospitals and health systems, the Texas Hospital Association (THA) is writing to notify you about our opposition to a new Aetna payment policy for its Medicare Advantage (MA) and Special Needs Plans.

On Aug. 1, Aetna announced a new policy to begin November 15, 2025, that reimbursement for hospital stays of one or more midnights for Aetna members urgently or emergently admitted to the hospital would be approved without a medical necessity review but paid "at a lower level of severity rate that's comparable to your [hospital's] rate for observation services." Aetna states it would only pay the claim at the hospital's contracted inpatient rate if the inpatient stay meets "MCG (Aetna Supplemental Milliman Care Guidelines for inpatient admissions)." We echo other state hospital associations' strong concerns with this intended policy and request that CMS assess and determine its compliance with federal law. For the reasons stated below, we believe this new policy is in violation of multiple federal regulations governing the Medicare Advantage program.

I. Requirement to Provide Basic Benefits Which Includes Coverage for Hospital Admissions That Cross Two Midnights

Federal law requires that a MA plan must provide enrollees with coverage of basic benefits that include "all items and services for which benefits are available under Parts A and B of Medicare…."[1] CMS regulations governing payment for Medicare Part A services, particularly for hospital admissions, have determined that "an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights."[2] The regulation goes on to state that the physician's judgment should be based on "such

[1] 42 U.S.C. §1395w-22(a)(1)(A); 42 C.F.R.§422.100(a), (c)(1).
[2] 42. C.F.R.§412.3(d)(1)(i).

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complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event" and such factors must be documented by the physician in the patient's medical record.[3]

CMS' frequently asked questions, released on Feb. 6, 2024, included a question and answer carefully explaining the nuances of the MA plan's responsibility to comply with the two-midnight benchmark versus complying with the "two-midnight presumption."[4] CMS made clear that MA plans must follow the inpatient admission criteria set forth in 42 C.F.R. §412.3 when determining coverage of an inpatient stay, noting that the criteria is based on the expectation of the admitting physician, as supported by the medical record. MA plans are allowed to evaluate the reasonableness of the physician's expectation, but that evaluation should defer to the judgment of the physician.

Aetna's proposed policy seeks to disregard this federal statutory requirement to provide basic benefits and coverage. Instead, it proposes substituting Aetna's MCG criteria for the criteria set forth in 42 C.F.R. §412.3. Thus, hospital industry opposition to this policy ought not be simply waved away as a contractual dispute between providers and Aetna. The literal and realistic implementation of this policy means that Aetna is only providing coverage, and thus a benefit, for "observation" and not hospital inpatient admission, in spite of the law passed by Congress and regulations adopted by CMS. Alternatively, to the extent Aetna's proposed policy could be considered to provide coverage for inpatient hospital admission, it still fails to do so in accordance with the criteria required by federal law.

II. MA Organizations May Not Interfere with a Health Care Professional's Advice to Enrollees

CMS' payment regulation for hospital inpatient admissions also makes clear that the determination for whether a patient requires inpatient admission rests solely with the admitting physician, not the enrollee's insurance plan, nor a physician or other health care professional employed by the MA organization, and certainly not Aetna's MCG - Supplemental Guidelines for inpatient admission.[5] By automatically and unilaterally downcoding all inpatient hospital admissions for enrollees in the applicable Aetna MA plans, Aetna is replacing the admitting physician's judgment with a set of written guidelines that do not account for the professional evaluation of the individual patient performed by the clinician. We remind CMS that MA organizations "may not prohibit or otherwise restrict a physician from advising or advocating on behalf of MA enrollees about

[3] *Id.*
[4] https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf
[5] *Id.*

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the enrollees' health status, medical care, or treatment options…".[6] By substituting Aetna's guidelines for physician judgement, Aetna is arguably interfering with the physician/patient relationship in violation of the law.

III. MA Organizations Must Provide Opportunity for Appeal

Federal law also requires that MA organizations, like Aetna, have a procedure in place for "organization determinations" regarding the benefits enrollees are entitled to receive under the MA plan, including basic benefits. CMS defines an "organization determination" as:

> "any determination made by an MA organization with respect to…(2) [p]ayment for any other health services furnished by a provider other than the MA organization that the enrollee believes-(i) are covered under Medicare…." Including "(3) [t]he MA organization's refusal, pre-or post-service or in connection with a decision made concurrently with an enrollee's receipt of services, to provide *or pay for services in whole or in part,* including the *type or level of services*, that the enrollee believes should be furnished or arranged for by the MA organization …., and (5) [f]ailure of the MA organization to approve, furnish, arrange for, or provide payment for health care services *in a timely manner….*(emphasis added).[7]

CMS regulations further specify that providers may request organization determination and adverse medical necessity decisions must be reviewed by a physician or other appropriate health care professional with medical expertise.[8]

Aetna's proposed policy appears to bypass this patient right and regulatory requirement altogether by unilaterally making a payment determination before any services are sought. In other words, Aetna seeks to make a universal "organization determination" against enrollees and providers before an enrollee ever sets foot inside a hospital. Additionally, Aetna's notice fails to specify whether providers can appeal a determination that the claim does not meet the MCG criteria justifying the payment of the fully contracted rate.

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[6] 42 C.F.R. §422.206(a).
[7] 42 C.F.R. §422.566.
[8] *Id.*

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IV. MA Organizations Agree to Abide by Certain Conditions to Contract with CMS as an MA Organization

In order for an entity to qualify as an MA organization that can enroll persons in MA plans, MA organizations must enter into a contract with CMS.[9] CMS regulations further stipulate that MA organizations must demonstrate, among other actions, that they have adopted and implemented an effective compliance program that includes written policies, procedures, and standards of conduct that "articulate the organization's commitment to comply with all applicable Federal and State standards."[10]

Additionally, federal law requires that contracts between CMS and MA organizations must contain contract provisions that require the MA organization to comply with all applicable requirements and conditions set forth in [Part C] and that the MA organization provide "*(3)* basic benefits required under §422.101…and access to benefits as required…(6) to comply with all applicable provider and supplier requirements…including…rules governing payments to providers.[11] MA organizations must also agree to comply with the federal False Claims Act.[12] Violations of the False Claims Act include "possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property.*[13]*

As mentioned, CMS requires that MA organizations provide basic benefits, which includes hospital inpatient admissions for urgent or emergent reasons, for stays that cross two midnights in accordance with the inpatient admission criteria set forth in 42 C.F.R. §412.3. Aetna's new payment policy does not comply with this rule; therefore, Aetna may be in violation of its agreement with CMS to comply with all applicable MA federal laws and regulations, consequentially impacting its eligibility to continue participating as an MA organization in the program.

Conclusion

For the reasons stated above, we urge CMS to conduct an immediate and thorough review of Aetna's new payment policy before it goes into effect on Nov. 15. Investigating and ensuring compliance with applicable rules and regulations that govern the Medicare Advantage program is not a form of interference by CMS that would violate the no-interference clause which prohibits CMS interference with contracts between MA organizations and providers.

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[9] 42 C.F.R. §422.503(a).
[10] 42 C.F.R. §422.503(b)(4)(vi)(A)(1).
[11] 42 C.F.R. §422.504(a)(3),(6).
[12] 42 C.F.R. §422.504(h)(1).
[13] 31 U.S.C. §3729(a)(1)(D).

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As we have demonstrated, this letter is not the result of a simple "contractual dispute" to be resolved between Aetna and applicable Texas hospitals. It is the result of a blatant attempt by Aetna to circumvent federal laws governing the MA program. Texas hospitals and their patients expect MA organizations to comply with federal law governing the Medicare Advantage programs in the same manner that MA organizations expect Texas hospitals to comply with regulations governing the Medicare program in general.

We have repeatedly notified CMS about the problems and concerns Texas hospitals have had with the improper behavior of MA organizations regarding payment and prior authorization, among others. These prior actions have already negatively impacted patient care and hospital sustainability. Policies such as Aetna's will only continue these negative trends. We urge you to take swift action so other MA organizations do not follow suit. THA stands ready and willing to assist CMS on this very important matter. Thank you for your consideration of our concerns, and if you have any questions, you may contact me at hdelagarza@tha.org.

Kind regards,

/s/Heather De La Garza-Barone

Heather De La Garza-Barone
Associate General Counsel
Texas Hospital Association

Cc: Shannon Hills, Regional Administrator, CMS Dallas (Region 6)
Kathryn Coleman, Director, Medicare Drug & Health Plan Contract Administration Group, CMS