ENSEMBLE

Payer Trendscape

From Two-Midnight Rule compliance to requests for information, here are 3 payer trends worth tracking.

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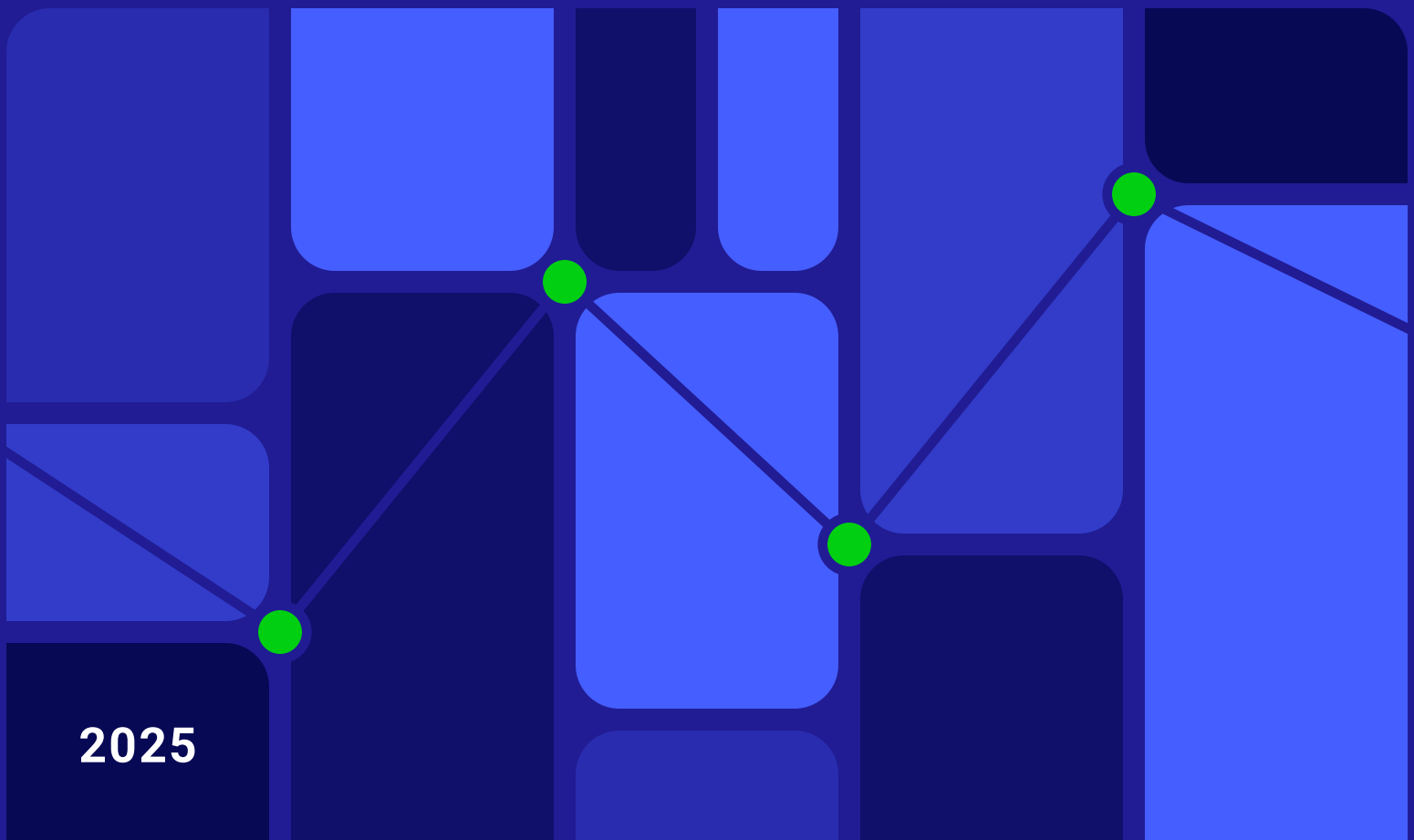


2025

01

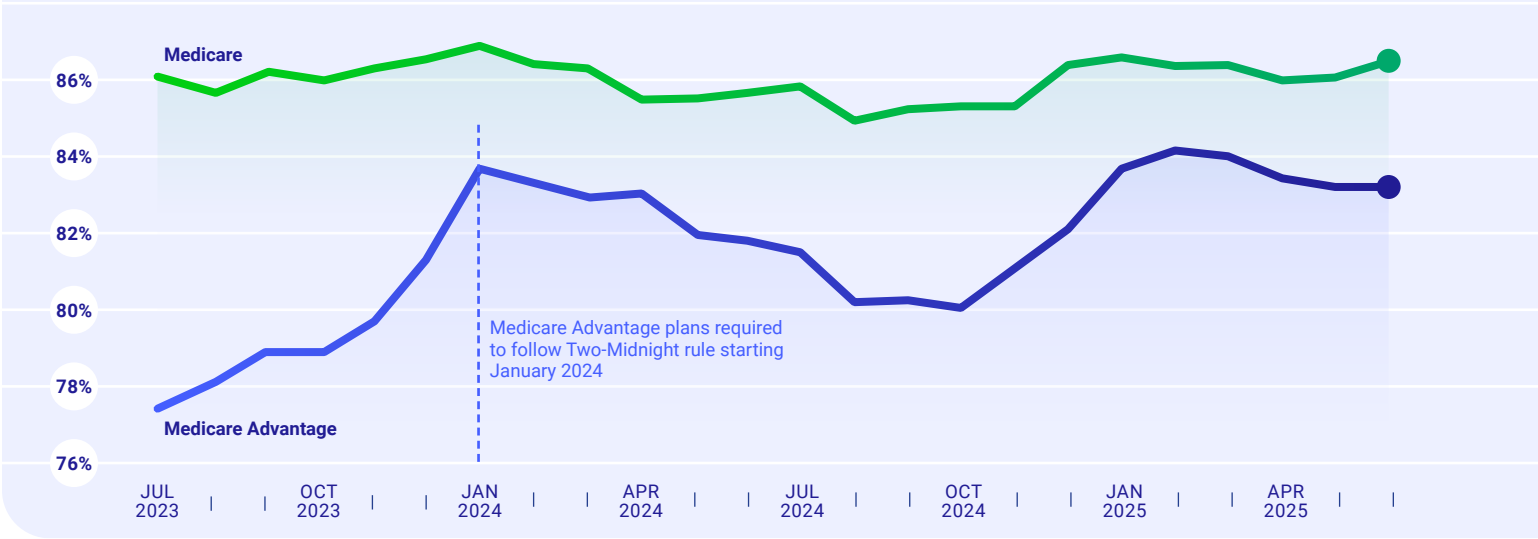
Medicare Advantage payer resistance to the Two-Midnight Rule persists.

The CMS Two-Midnight Rule, clarified Jan. 1, 2024, mandates hospital stays expected to span at least two midnights should be classified as inpatient. This rule now applies to Medicare Advantage (MA) plans, aligning them with traditional Medicare standards. Each time the payer denies inpatient status for a patient, they avoid paying around $9,000.[1]

Medicare Advantage inpatient admission ratios are improving but still fall short of traditional Medicare.

Since the Two-Midnight Rule clarification, Medicare's average inpatient admission rate has been 85.9% across our clients[1]. Since the Medicare patient population is nearly identical to the Medicare Advantage patient population, we expect the MA inpatient admission rate to be nearly identical to Medicare's. Instead, MA plans are admitting 4% fewer patients, with an inpatient admission rate of 81.6%, despite our relentless efforts to enforce MA plan compliance. Without adequate resources to monitor, flag and challenge MA decisions that don't comply with the Two-Midnight Rule, many hospitals face a much more significant variance.

Medicare Advantage vs. traditional Medicare inpatient admission ratios



[1] Ensemble's data represents national payer trends from nearly 300 facilities across more than 30 health systems.

Tips for monitoring + improving performance

It's not enough to improve accuracy of admission rates for patients that span two midnights. The goal is to do it in a way that results in accurate, timely payment for the inpatient care provided. Monitoring initial denial rate and average days to pay in conjunction with admission ratios will help ensure your utilization management program is effective in holding payers accountable for compliance.

KPI	DEFINITION	WHAT TO EXPECT	TIPS FOR IMPROVEMENT
First-pass denial rate	MA initial denials as percent of gross revenue by remit month	Increase in initial denials as payers challenge inpatient status	If initial denials increase, so will average days to pay. If you see a negative trend, consider: > Educating providers to improve the quality of documentation > Implementing a thorough physician advisory program to conduct concurrent peer-to-peer reviews > Leveraging EHR functionality to standardize documentation protocols and workflows
Average days to pay	Average days for a payer to issue remit after a claim is billed	Increase in average days to pay resulting from increasing initial denials	
Peer-to-peer reviews	Volume of phone or virtual conversations where a hospital's physician advisor speaks directly with a payer's medical director to explain why a patient's admission or treatment is medically necessary	Increase in peer-to-peer reviews as more inpatient admissions are challenged	Staff enough physician advisors to manage increase in peer-to-peer volume
Revenue impact	Average revenue per case (inpatient + observation)	Increase in total revenue across aggregate population	This is a lagging indicator metric. Evaluate in conjunction with the others to ensure program efficacy or to identify interventions.

02

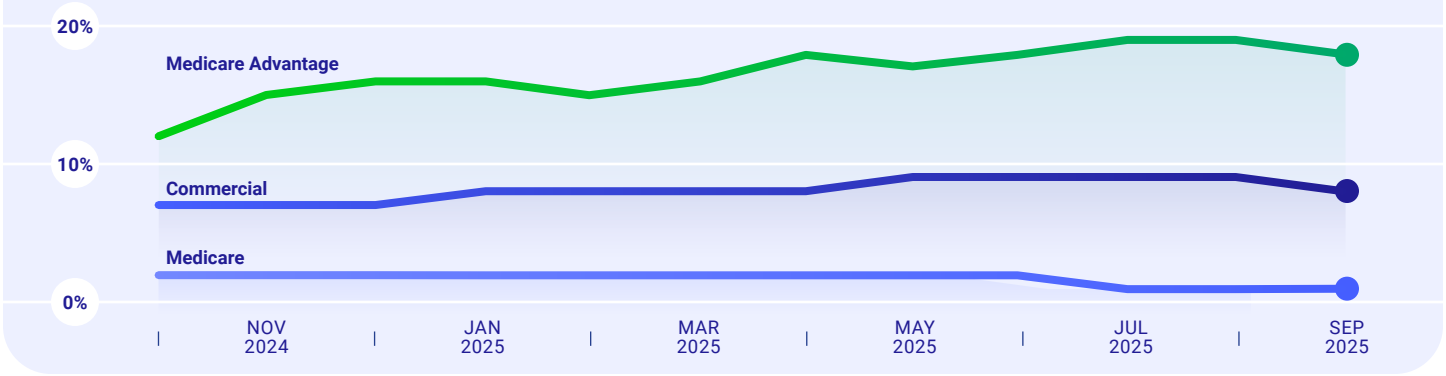
Medicare Advantage plans often challenge clinical decisions.

Medicare Advantage plans are denying inpatient claims at significantly higher rates than both traditional Medicare and commercial insurers — a trend that's accelerating and impacting hospital revenue. This growing gap is driven by stricter prior authorization requirements, increased use of AI in claim reviews and more aggressive utilization management strategies.

MA plans are increasingly denying more inpatient claims than other plans.

Over the past 12 months, Medicare Advantage plans have increased inpatient denials by 42% while commercial plans and Medicare denial rates remained relatively flat. These reflect "authorization," "medical necessity" and "reduced level of care" denials.

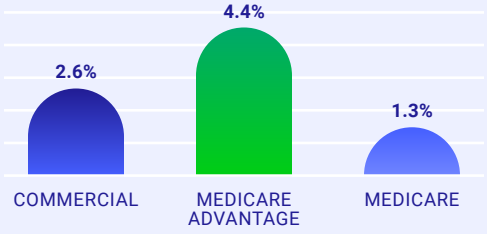
Inpatient denial rates across all lengths of stay



Final denials from MA plans are nearly double commercial plans.

Medicare Advantage plans are issuing 1.7 times more final denials than commercial insurers, meaning providers are writing off a larger share of revenue when appeals are exhausted. These upheld denials — often tied to inpatient stays and high-dollar services — represent a growing financial risk as MA enrollment climbs.

12-month final denial rates[1]



[1] Based on denial write-off adjustments and payments posted between Oct. '24 and Sep. '25

Tips for monitoring + improving performance

Increasing Medicare Advantage denials underscore the need for stronger denial tracking, payer-specific appeal strategies and proactive documentation practices to protect hospital revenue.

Strengthen coding methodology + validation

- Ensure your ED coding system is uniformly applied across all patients and aligns with CMS guidelines.
- Conduct internal audits to validate consistency and defensibility.
- Deploy AI-driven tools to flag vulnerable codes and validate DRG assignments before claim submission.
- Use predictive analytics to identify patterns in payer downgrades and preemptively adjust coding strategies.

Engage in transparent dialogue with payers

- Request detailed criteria and analysis used to justify pre-payment review.
- Ask for the metrics that will determine continuation or termination of review status.
- Hold monthly payer meetings to escalate accounts, clarify audit behaviors and align on adjudication standards.
- Share data on overturned audits and payer inconsistencies to build leverage in negotiations.

Appeal unjust downgrades + denials

- Establish a dedicated denials management team to track, appeal and overturn unjust downgrades.
- Prepare comprehensive appeals with supporting documentation; if denied, pursue reconsideration through independent review boards.
- Maintain a repository of overturned cases to support future appeals and payer negotiations.

Negotiate stronger contracts

- Negotiate contract language that limits payer discretion in DRG reclassification and enforces prompt pay provisions.
- Include clauses that prohibit unilateral downgrades and require transparency.
- Demand a structured appeal process and dispute resolution mechanisms.

Safeguard against legal + compliance issues

- Consult legal counsel to ensure payer policies do not violate CMS standards.
- Consider mediation or litigation if contractual obligations are breached.
- Utilize binding arbitration under AHLA rules when disputes escalate.

Enhance documentation practices

- Maintain thorough, accurate and timely medical records, ensuring physician documentation clearly supports the assigned DRG, especially for high-risk diagnoses like sepsis.
- Use clinical indicators and evidence-based protocols in documentation to justify E/M levels and resource utilization.

03

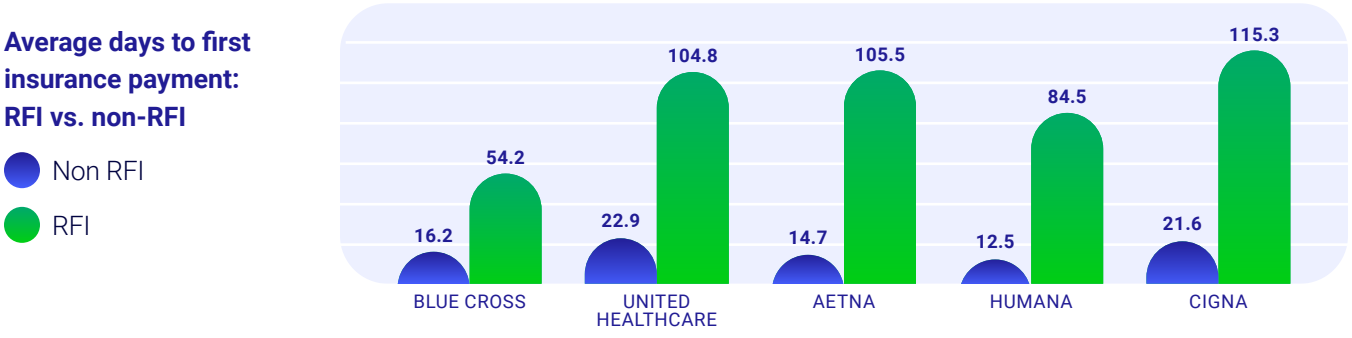
Requests for information don't change the outcome, they just delay payment.

Payers are asking providers for more data than ever, largely to fuel their own AI models — even though many already have access to this information through solutions like Epic's Payer Platform. These requests don't change whether a claim gets paid. What they do is create extra work for providers and delay reimbursement, essentially giving payers an interest-free loan.

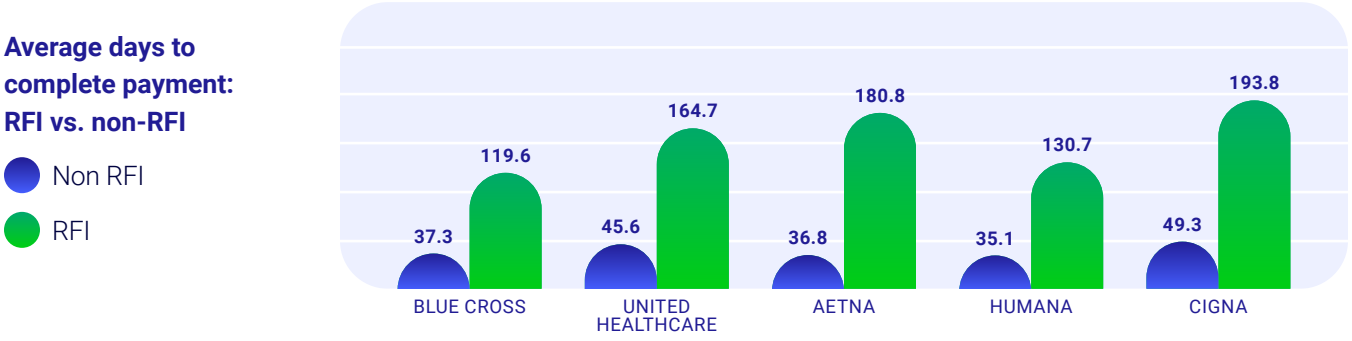
90% of RFI denials are paid as billed, but delay payment by 100+ days.

Requests for information act as a delay tactic for payers, given that they add a substantial administrative burden for providers, but the majority are still paid in full. The delay itself poses a major problem: Most hospitals don't have cash on hand to go without payment for more than 100 days. In an industry where operating margins and cash resources are historically low, increasing payment delays have direct repercussions on the ability of a hospital or health system to provide patient care.

Average days to first insurance payment: RFI vs. non-RFI



Average days to complete payment: RFI vs. non-RFI



Tips for monitoring + improving performance

With payers slowing down reimbursement through unnecessary RFIs, providers can't afford to wait. Tightening internal processes is critical to keep claims moving, reduce administrative waste and shorten payment cycles. By monitoring performance and making targeted improvements, providers can offset delays and protect revenue — even when payers add friction.

Enforce Epic Payer Platform (EPP) use for claims

Many payers underutilize EPP for claims processing, despite having access. Engage payer strategy teams to enforce EPP usage for claims, not just audits.

Strengthen contract language

Contracts often lack provisions requiring payers to use EMR access tools. Include clauses that deactivate RFI-related CAS codes and enforce prompt pay timelines once records are accessed.

Track denial patterns

Use trackers, PowerBI dashboards, and custom denial breakdowns to reveal which plans are most prone to RFI denials. Optimize workflows, prioritize payer engagement and tailor contract negotiations using denial data.

"Without a doubt, I wouldn't be emboldened to bring litigation against commercial payers or do the things we are doing if I didn't have the experts at Ensemble behind us."

HEALTH SYSTEM CFO

SEPTEMBER 2023

KLAS SURVEY RESPONSE

Don’t let payers dictate your bottom line.

Ensemble holds payers accountable, so your claims get paid, your teams stay focused and your patients get the care they deserve.

By monitoring national payer performance across hundreds of healthcare facilities, we’re able to surface patterns and insights to support issue resolution with payers, strengthen contract negotiations for providers and inform policy changes across the industry.

Learn more about our approach to payer strategy

ENSEMBLE™