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**The “Two-Midnight” Rule (CMS’ New Requirements for Part A Payment and When
it is Appropriate to Admit a Beneficiary as an Inpatient)
and the Impact on Teaching Hospitals**

AUTHOR

Allison Cohen, JD, LLM*

Association of American Medical Colleges
Washington, DC

EDITORS

Lori K. Mihalich-Levin, JD

Ivy Baer, JD, MPH

Association of American Medical Colleges
Washington, DC

In an effort to reduce Recovery Audit Contractor (RAC) denials of short inpatient stays, the Centers for Medicare & Medicaid Services (CMS) recently finalized a “Two-Midnight” regulation that attempts to establish a bright-line rule to determine which short stays are appropriate for Medicare Part A payment. Under CMS’ new standard, only hospital stays that physicians expect will last two midnights or longer will be presumed to be appropriate inpatient admissions. This article explains this legal issue and its important implications for beneficiaries and providers, particularly teaching hospitals.

Background

Because of concerns about the number of RAC rejections of short stays and increases in the length of time Medicare beneficiaries spend as hospital outpatients receiving observations services, CMS sought to establish guidelines for when a physician should

order an inpatient admission. CMS solicited broad input on potential policy changes to address these trends in the calendar year (CY) 2013 Outpatient Prospective Payment System (OPPS) Proposed Rule¹ and summarized public input in the CY 2013 OPPS Final Rule.²

In the fiscal year (FY 2014 Inpatient Prospective Payment System (IPPS) Proposed Rule, CMS proposed to change the criteria for short inpatient hospital admissions that could be billed under Part A.³ Specifically, CMS proposed presumptions to use in medical necessity reviews based on the physician's expectation of the length of the beneficiary's stay. Although many commenters objected to these policy changes, CMS finalized new "Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A" (also known as the Two-Midnight Rule) in the FY 2014 IPPS Final Rule.⁴

Explanation of the Two Midnights Benchmark and Presumption

The Two-Midnight Rule applies to surgical procedures, diagnostic tests, and other treatments (in addition to services designated as inpatient-only) provided in acute care inpatient hospital facilities, long term care hospitals (LTCHs), critical access hospitals

¹ Medicare and Medicaid Programs, Hospital Outpatient Prospective and Ambulatory Surgical Center Payments Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations, 77 Fed. Reg. 45061, 45155-45157 (proposed July 30, 2012).

² Medicare and Medicaid Programs, Hospital Outpatient Prospective and Ambulatory Surgical Center Payments Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Revision to Quality Improvement Organization Regulations, 77 Fed. Reg. 68210, 68426-68430 (Nov. 15, 2012).

³ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Proposed Rules, 78 Fed. Reg. 27486, 27644-27650 (proposed May 10, 2013).

⁴ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care; Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. 50496, 50938-50954 (Aug. 19, 2013).

(CAHs), and inpatient psychiatric facilities (IPFs), and is effective for dates of admission on or after October 1, 2013.⁵

This Rule establishes both a benchmark for physicians to determine when an inpatient admission will likely be viewed as appropriate for Part A payment, and a presumption for reviewers to guide which claims will generally be considered to be appropriate for payment under Medicare Part A.

The Two-Midnight Rule benchmark specifies that inpatient admission and Part A payment are generally appropriate if at the time of admission the physician expects the patient stay will cross two midnights or require services that are on the inpatient-only list. This benchmark applies regardless of a patient's severity of illness or the intensity of care required.

The Rule also establishes a presumption that inpatient claims for lengths of stay greater than two midnights after a formal inpatient order for admission are appropriate for Part A payment.

There are limited exceptions to the Two-Midnight Rule. Stays shorter than two midnights may still be billed as inpatient stays if there was an *expectation* that the beneficiary's stay would cross two midnights, but unforeseen circumstances resulted in a shorter length of stay. This includes unforeseen deaths, transfers, departures against medical advice, and clinical improvement.⁶

CMS also makes an exception for procedures defined as "inpatient-only," which may be appropriately provided on an inpatient basis irrespective of the length of the patient's stay. Otherwise, CMS explains that only "rare and unusual circumstances" could be considered appropriate for short inpatient stays.⁷

⁵ CMS will direct Medicare Administrative Contractors (MACs) *not* to apply these instructions to IRFs, which are specifically excluded from the two-midnight inpatient admission and medical review guidelines per CMS-1599-F.

⁶ *Inpatient Hospital Reviews*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html.

⁷ *Id.*

In sub-regulatory guidance, CMS states that beneficiaries admitted for telemetry and beneficiaries admitted to an intensive care unit (ICU) are “[e]xamples of situations that do not represent instances in which inpatient admission would be appropriate without an expectation of a 2 midnight hospital stay.”⁸ CMS explains that the agency does not view either of these situations on their own as “rare and unusual” circumstances. Further, CMS states that “[a]n ICU label is applied to a wide variety of services,⁹ therefore CMS “does not believe that a patient assignment to a specific hospital location, such as a certain unit or location, would justify an inpatient admission in the absence of a 2-midnight expectation.”¹⁰

CMS also has agreed to work with the hospital industry and Medicare administrative contractors (MACs) to determine if there are other circumstances or types of patients that should be considered appropriate for inpatient admission regardless of the two-midnight expectation. CMS is accepting suggestions for additional exceptions via email at the following address: IPPSAdmissions@cms.hhs.gov. Emails should include the subject line “Suggested Exceptions to the 2-Midnight Benchmark.”

What Counts Toward the Benchmark

The clock for the two-midnight benchmark starts when the beneficiary begins receiving hospital services. While a formal inpatient admission order is required to begin inpatient status, hospital care provided in another treatment area of the hospital such as the emergency room (ER), an operating room, or observation services provided on an outpatient basis may count toward the benchmark when the physician determines whether or not the patient will require hospital care crossing two midnights.

⁸ *Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013*, CMS (Nov. 1, 2013), www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/ReviewingHospitalClaimsforAdmissionFINAL.pdf.

⁹ *Id.*

¹⁰ *Id.*

CMS will not count the following when determining if the two-midnight benchmark was met: wait times before the initiation of care, including triaging activities, and inpatient admissions to prevent inconvenience to the patient, family, physician, or hospital.

All services counted toward the two-midnight benchmark must be medically necessary, which must be supported by documentation in the medical record. If the beneficiary's admission lasts less than two midnights due to unforeseen circumstances, clear documentation in the medical record is required for an exception to the Two-Midnight Rule to apply. For purposes of medical review, contractors will evaluate the medical record to determine whether the "expected length of stay and the determination of the need for medical or surgical care are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which review contractors will expect to be documented in the physician assessment and plan of care."¹¹

Part B Rebilling

In general, CMS requires that claims for stays of less than two midnights must be billed under Part B. Also in the FY 2014 IPPS Final Rule, CMS finalized a policy allowing hospitals to rebill an expanded list of services under Part B after a Part A claim is denied for lack of medical necessity, or to self-audit by submitting a no pay/provider liable Part A claim before submitting Part B claims.¹² In both cases, the Part B billing must occur within one year of the date of service.¹³ This means that if a hospital submits a short stay claim under Part A that is rejected, the hospital appeals the rejection, and the appeal is denied, the hospital will be unable to rebill if the appeals process lasts longer than one year from the date of service.

¹¹ 2 *Midnight Admission Guidance & Patient Status Reviews for Admissions On or After Oct. 1, 2013*, CMS FREQUENTLY ASKED QUESTIONS, www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf.

¹² Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care; Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. at 50908–50914.

¹³ *Id.*

Delay of Post-Payment Status Reviews

Soon after the FY 2014 IPPS Final Rule was released, the hospital community raised many questions about how the Two-Midnight Rule would be operationalized. On September 5, 2013, CMS issued guidance clarifying inpatient order and certification requirements. Subsequently, on September 27, CMS released a Frequently Asked Questions (FAQ) document that delayed for 90 days RAC review of stays less than two midnights. This limited delay has since been extended through September 30, 2014 by guidance issued on January 31, 2014. At the same time, CMS explained how “patient status reviews” should be conducted by MACs to evaluate hospitals’ compliance with the Two-Midnight Rule.¹⁴ CMS has directed MACs and Recovery Audit Contractors (RACs) to no longer review claims spanning more than two midnights. CMS will also delay post-payment patient status reviews for claims with dates of admission October 1, 2013 through September 30, 2014.¹⁵ RACs, MACs, and Supplemental Medical Review contractors can still conduct other types of inpatient hospital reviews including: “Coding reviews, Reviews for the medical necessity of a surgical procedure provided to a hospitalized beneficiary, Inpatient hospital patient status reviews for dates of admission prior to October 1, 2013 (based on the applicable policy at the time of admission).”¹⁶ As required by statute, RACs will limit prepayment reviews to therapy services until further notice.¹⁷

The “Probe-and-Educate” Program

CMS established a “probe and educate” period, which was initially three months (through December 31), and was subsequently extended to six months (through March

¹⁴ *Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013*, CMS (Jan. 31, 2014), http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/ReviewingHospitalClaims_forAdmission_forPosting_01312014_508Clean.pdf.

¹⁵ *Id.*

¹⁶ *Inpatient Hospital Reviews*, CMS, www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html.

¹⁷ *Id.*

2014), and then extended another six months (through September 2014)¹⁸ During this period, MACs will do a prepayment review of a sample of ten claims of less than two midnights for most hospitals (25 claims for large hospitals).¹⁹ MACs will educate providers that are having trouble complying with the Two-Midnight Rule based on the sample and hospitals will be able to rebill denied inpatient claims under Part B.

While the “probe and educate” period has been characterized as a limited delay in enforcement because of the postponement of RAC review, it is important for providers to note that claims that are not in compliance with the new policy will be denied by the MAC even during the delay period. The MAC will outline the reasons for the denial in a letter to the hospital. CMS will also instruct MACs to offer individualized phone calls to those providers with either moderate to significant or major concerns. During these calls, the MAC will explain the reasons for the denials and provide relevant education and reference materials to answer any questions.²⁰ The probe-and-educate period can lead to corrective action depending on how many errors the hospital had: zero to one claim of less than two midnights in a ten-claim sample or three to 13 in a 25-claim sample that were erroneously submitted as inpatient will not lead to additional reviews. If a provider has two to six errors in a ten-claim sample, or three to 13 in a 25-claim sample, CMS will repeat the probe and educate process for an additional ten claims for small hospitals or 25 claims for large hospitals.²¹

CMS will characterize providers as having major concerns if they have seven or more non-compliant claims in a ten-claim sample, or 14 or more in a 25-claim sample.²² For these providers, CMS will instruct MACs to repeat the probe and educate first with the same sample size (ten or 25 claims).²³ By April 1, 2014, CMS will evaluate the need to

¹⁸ *Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013*, CMS (Jan. 31, 2014), http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/ReviewingHospitalClaims_forAdmission_forPosting_01312014_508Clean.pdf.

¹⁹ *2 Midnight Admission Guidance & Patient Status Reviews for Admissions On or After Oct. 1, 2013*, CMS FREQUENTLY ASKED QUESTIONS, www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf.

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ *Id.*

extend the probe-and-educate process for some of these providers if concerns persist. Hospitals that CMS identifies as having ongoing compliance concerns will be subject to having a 100-claim sample (or 250 claims for large hospitals) selected for further review.²⁴ Additionally, throughout the probe-and-educate period, CMS will monitor provider billing trends for inconsistencies suggestive of abuse, gaming, or systematically delaying claim submission to avoid the probe-and-educate prepayment reviews.²⁵

Physician Order and Certification Requirements

Along with the medical record documentation, the physician certification provides evidence to support that the hospital services furnished were reasonable and necessary. The physician certification is comprised of the authentication of the practitioner order (certifying that the hospital inpatient services were reasonable and necessary), the reason for inpatient services, and the estimated time the beneficiary is required to spend in the hospital (if the certification is completed prior to discharge) or the actual time in the hospital (if the certification is completed after discharge).²⁶ The expected or actual length of stay may be documented in any of four ways: in the order, on a separate certification or recertification form, in the progress notes assessment, or as an aspect of routine discharge planning.²⁷

The order for inpatient admission starts the certification, which must be completed, signed, dated, and documented in the medical record before the patient is discharged. CMS clarified that discharge need not occur at the exact time that the discharge order is written. Instead, discharge may occur upon the effectuation of activities that the physician specifies have to occur before the discharge (e.g., if the physician specifies to “discharge after supper,” the patient’s discharge is effectuated at that time).

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Hospital Inpatient Admission Order and Certification*, CMS, 1 (=Jan. 30, 2014).
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf>

²⁷ *Id.*

CMS also clarified that in accordance with 42 C.F.R. §§ 424.13(c) and 424.14(e), a patient who is already appropriately an inpatient may be kept in the hospital as an inpatient to await the availability of a skilled nursing facility (SNF) bed. Therefore, a physician may certify the need for continued inpatient admission on this basis.²⁸

Only a physician who is a doctor of medicine or osteopathy, dentist (in circumstances specified in 42 C.F.R. § 424.13(d)), or a doctor of podiatric medicine (as provided by state law) is authorized to sign the certification. Additionally, CMS requires that the “certification or recertification must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital’s medical staff.”²⁹

The only physicians that Medicare considers to have sufficient knowledge of the case to serve as the certifying physician include: the attending or a physician on call for the attending physician or a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for her. A physician member of the hospital staff (e.g., a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement can serve as the certifying physician when there is a non-physician admitting practitioner who is licensed by the state and has been granted privileges by the facility.³⁰ The admitting physician of record may also be an emergency department physician or hospitalist. The certifying physician is not required by Medicare to have inpatient admission privileges at the hospital.³¹

CMS has not specified a specific procedure or form for the certification and recertification statements. As long as the method the provider adopts permits verification, certification, and recertification, statements may be entered on forms, notes, or records that an authorized individual signs, or they may be made on a special separate form.³² It is appropriate for a certifying physician to write a statement indicating

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at 2.

³¹ *Id.* at 3.

³² *Id.*

that the patient's medical record contains the information required (if all the required information is included in progress notes) and that hospital inpatient services are or continue to be medically necessary.³³ A separate signed statement is necessary for each certification or recertification except in the case of delayed certifications.³⁴

The order to admit as an inpatient ("practitioner order") is an essential component of physician certification. As a condition of Part A payment, the regulations at 42 C.F.R. § 412.2 require that the order must be properly documented in the medical record. Therefore, CMS will deny a Part A claim that does not include a formal order of admission, even if it meets the two midnight benchmark.³⁵ The order to admit can be furnished by a physician or other qualified practitioner who is "(a) licensed by the State to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission."³⁶

The ordering practitioner is not required to be the person who signs the certification. CMS has clarified that "a medical resident, a physician assistant, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner provided they are authorized under state law to admit patients" and meet certain specified requirements.³⁷ As long as a resident or non-physician practitioner is authorized to admit inpatients in the state where the hospital is located and is permitted to do so under the hospital's bylaws or policies, she may write inpatient admission orders on behalf of the ordering practitioner (e.g., the attending), if the ordering practitioner allows it and accepts responsibility for the admission decision by countersigning the order before the patient is discharged.³⁸ An order that is countersigned before discharge by an ordering practitioner who meets the requirements for a certifying physician will satisfy the order component of physician certification.³⁹ CMS indicated that this same process could be used for physicians who do not have

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.* at 4.

³⁶ *Id.*.

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.* at 5.

admitting privileges (e.g., emergency department physicians) but have been authorized by the hospital to issue temporary or “bridge” inpatient admission orders.⁴⁰

Practitioners who lack the authority to admit inpatients under state or hospital bylaws (e.g., registered nurses) may enter inpatient admission orders as a verbal order. The ordering practitioner may directly communicate the inpatient order to such staff as a verbal order without having to separately record the order to admit.⁴¹ This verbal order may not be a standing order.⁴² The staff member receiving the verbal order must document the verbal order in the medical record at the time it is received in accordance with state laws, hospital policies, and medical staff bylaws and regulations.⁴³ Additionally, the order must identify the “admitting practitioner” and has to be authenticated (countersigned) by the ordering practitioner before the patient is discharged.⁴⁴ If the physician responsible for countersigning does not believe the inpatient admission was appropriate or valid, CMS has indicated that the physician should refrain from countersigning and the hospital stay may be billed as an outpatient stay under Part B.⁴⁵

While the order may be furnished at or before the time of inpatient admission, the inpatient admission does not commence until formal admission by the hospital and documentation of the inpatient order.⁴⁶ CMS does not permit retroactive orders.⁴⁷

Other Issues of Importance to Teaching Hospitals

⁴⁰ *Id.* at 4.

⁴¹ *Id.* at 5.

⁴² *Id.* at 5.

⁴³ *Id.* at 5.

⁴⁴ *Id.* at 5.

⁴⁵ *Id.* at 5.

⁴⁶ *Id.* at 6.

⁴⁷ *Id.*

Stays Less than Two Midnights That Require an Inpatient Level of Care and Other Issues Associated with Implementing the Two-Midnight Rule

By establishing a bright-line rule for the appropriateness of an inpatient admission that is based on the duration of a patient's stay, the Two-Midnight Rule does not provide flexibility for clinical judgment. There are circumstances in which a patient requires one night of intensive services prior to release. For example, a patient who enters the hospital with congestive heart failure (CHF) symptoms requires inpatient monitoring during a rapid and potentially life-saving intervention to balance electrolyte levels. With prompt yet aggressive treatment, a CHF patient can switch quickly from an intravenous to oral regimen and go home in short order without having to stay "two midnights." These patients often are treated in teaching hospitals, which typically care for patients with more-severe conditions and who need complex surgeries.

Similarly, a patient entering the hospital with symptoms of a myocardial infarction (MI or heart attack) may require a brief yet intensive inpatient stay. Care could include close monitoring during rapid treatment with heparin, beta blockers, aspirin, statins, coronary angiography, and other immediate interventions. After a short period of acute inpatient monitoring treatment, some MI patients could return home without having to stay more than one night.

As the Medicare population ages and an increasing number of elderly patients suffer from multiple or complex conditions, situations regularly arise when a physician decides to admit a patient as an "inpatient"—even for just one night—to allow more intense monitoring and care than can be offered in an observation unit.

Given that teaching hospital ICUs treat only patients with acute conditions, there may be a need to distinguish ICUs in hospitals that train residents and to challenge CMS' characterization of the ICU label as applying broadly. Because there is no recognized definition of ICU, distinctions between ICUs should be drawn based on the patients treated, their conditions, and the services provided rather than based on whether the unit is labeled as an ICU.

If services furnished to these and other high-risk, complex patients are no longer reimbursed under Part A, hospitals will be substantially underpaid for care provided to these beneficiaries. Also, because CMS is significantly changing what can be characterized as an appropriate inpatient stay, several operational issues are emerging. Hospitals will need to retrain physicians, modify health information technology systems, and change billing practices to comply with the rule.

Beneficiary Issues

Another significant change resulting from the Two-Midnight Rule is the potential for increased beneficiary liability for copayments and coinsurance related to stays that do not cross the two-midnight benchmark. For example, given that CMS has indicated even ICU visits will not be considered appropriate inpatient admissions without meeting the two-midnight benchmark, beneficiaries could accrue substantial copayments for services that will now be billed under Part B. It likely will be difficult for beneficiaries and their families to understand why a stay in an ICU is not considered an inpatient stay.

Another source of confusion and financial burden for beneficiaries is that even though ER, observation, and other outpatient time can count toward the two-midnight benchmark, this time does not count toward the three-day inpatient stay needed to qualify for Skilled Nursing Facility benefits.

Offset to Pay for the Two-Midnight Rule

In the FY 2014 IPPS proposed rule, CMS proposed a 0.2% reduction to IPPS payments to offset expected shifts in utilization between inpatient and outpatient settings. CMS received many comments arguing that the estimated offset was unsupported and stakeholders lacked sufficient detail about the assumptions CMS relied upon to come up with the estimate to provide meaningful comment.⁴⁸ In making assumptions, CMS

⁴⁸ See U.S. Dep't of Health & Human Services, Office of Inspector General, *OIG-02-12-00040, Memorandum Report: Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare*

also appears to have considered that the new policy will have the likely result of decreasing the number of inpatient admissions, thereby reducing indirect medical education payments. Despite this feedback, CMS finalized the 0.2% offset.

Conclusion

Many questions remain about the Two-Midnight Rule, particularly with regard to how medically necessary one-night inpatient stays will be adequately reimbursed, how hospitals will fare through the probe-and-educate period, whether the enforcement delay will be extended yet again and how hospitals will retrain physicians, modify health information technology systems, and change billing practices to comply with the rule. The teaching hospital community will provide further input to CMS about the impact of the Two-Midnight Rule and the circumstances and types of patients that should be considered appropriate for inpatient admission regardless of the two-midnight expectation.

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Beneficiaries (July 29, 2013) (shows the sensitivity of the impact estimates to assumptions about the percentage of outpatient stays converting from outpatient to inpatient and vice versa).