National Rural Health Association Policy Brief

Regulatory relief: Pandemic waiver lessons learned

Authors: Denaé Hebert, MBA/HCA, CHC, CRHCP; Cassie Odahowski, PhD, MPH; and Rebecca Reamey, PhD

Introduction

Critical access hospitals (CAHs) are unique health care service providers established to ensure access to hospital care in rural communities that are bound by a unique set of regulatory rules and requirements. These hospitals not only provide essential medical services for the community but are also often the largest employer and a major economic driver, making them vital to both health and economic prosperity.[i] Many rural hospitals are operating on razor-thin margins, struggling to keep their doors open while serving some of the country's most medically vulnerable communities.[ii] Easing unnecessary regulatory burdens for rural hospitals allows them to focus on patient care and reduce administrative costs.

Background

On March 30, 2020, the Centers for Medicare and Medicaid Services issued a blanket waiver[iii] of several regulatory requirements taking "aggressive actions and exercising regulatory flexibilities to help health care providers contain the spread of 2019 novel coronavirus disease (COVID-19)." This included several critical waivers that reduced rural CAH administrative burden, including (1) "that the length of stay be limited to 96 hours under the Medicare conditions of participation" and 2) "waiving the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay." These waivers remained in place through the end of the declared COVID-19 public health emergency (PHE) on May 11, 2023. Preliminary results indicate that CAHs continued to provide patient care and services effectively throughout this time, demonstrating that these requirements are unnecessary for ensuring high-quality care and represent undue administrative burden.

Three-day stay rule

In accordance with 42 U.S.C. §1395x(i) and 42 C.F.R. §409.30(a)(1), patients must have been hospitalized for no less than three consecutive days before transfer to a skilled nursing facility in order for the SNF services to be covered for Medicare beneficiaries. This is commonly referred to as the "3-Day Stay Rule." These rules allow CAHs to provide swing bed services, enabling them to provide SNF services within the hospital following a three-day stay in inpatient care.

As the health care landscape has evolved since the rule was first implemented in 1983, many rural hospitals have expressed that a three-day length of stay is no longer a valuable indicator in determining if a patient needs SNF care. CAHs are encountering patients in need of skilled nursing care who are forced to remain hospitalized longer than medically necessary due to the three-day requirement, increasing costs and delaying appropriate care transitions.

96-hour length of stay limitation

An additional regulatory requirement for CAHs is a condition of participation in the Medicare program (42 C.F.R. §485.620(b)) often called the "96-Hour Rule." Under this rule, CAHs are required to maintain an average length of stay of 96 hours or less per patient for acute inpatient care. Also a relic from the early days of the CAH program in 1999, this rule often prevents CAHs from offering critical medical services

that may require longer stays, particularly for patients with chronic conditions or post-acute needs. Further, CAHs are often unable to transfer patients who do not need a higher level of care but do need longer than 96 hours of hospitalization due to lack of available beds at nearby hospitals.

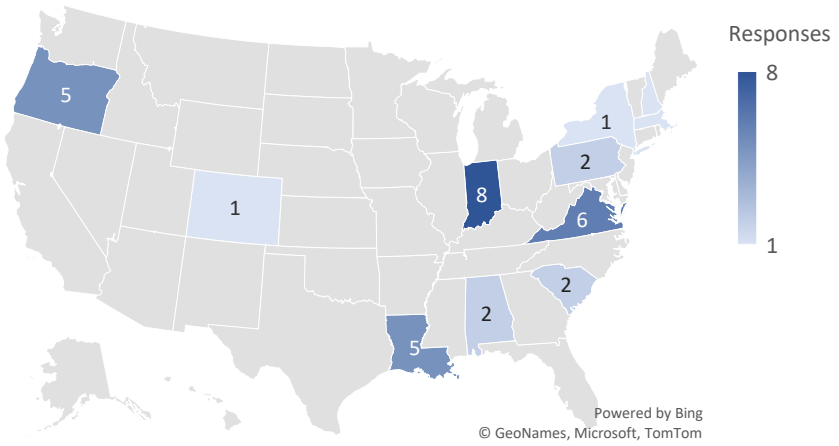
As indicated above, both the 3-Day Stay Rule and 96-Hour Rule add regulatory burden while not improving and in some cases potentially detracting from a rural hospital's ability to provide timely and high-quality patient care. Therefore, recission of these rules should be considered.

Analysis

NRHA collected data via a mixed-methods approach of quantitative survey responses and qualitative interviews. A brief online survey was distributed to CAH administrators to assess their experiences with the PHE-era waivers and reimplementation of the 3-Day Stay and 96-Hour rules following the end of the PHE. The end of each survey included an option to participate in a 20-minute qualitative interview to expand upon their experiences. Interviews were conducted using a qualitative semi-structured interview guide to allow for flexible conversation while collecting standardized data to reach saturation.

The survey was distributed through NRHA Connect and existing connections to CAH administrators and state hospital associations. The survey remained open for responses for 30 days. Geographic representation was assessed to ensure responses were received from CAHs in all four United States Census regions (Midwest, Northeast, Southeast, and West).

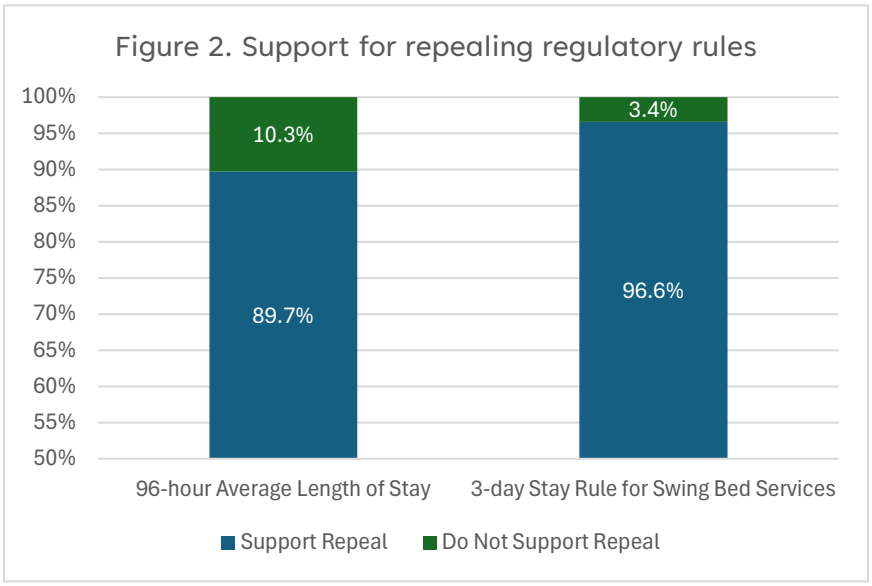
Figure 1. CAH regulatory relief survey responses by state



Survey results

Thirty-four survey responses from 11 states were received through Oct. 3, 2025. Indiana had the most responses with eight, followed by Viginia with six and Louisiana and Oregon with five (Figure 1). More than half (58.8 percent) are from CAHs that belong to a larger health system.

A majority of respondents (Figure 2) supported the repeal of both the 3-Day Stay Rule (96 percent) and the 96-Hour Rule (89.7 percent). When asked how the post-PHE reintroduction of these rules impacted their hospitals, respondents cited negative impacts on patient care and hospital finances, as well as challenges navigating patient placement.



Interview results

Four interviews were completed as of Sept. 11, 2025, from CAH administrators from Indiana (2), Louisiana (1), and Oregon (1). Three recurring themes related to the 3-Day Stay Rule were identified across all four interviews:

1) Barriers to needed care

Administrators expressed concern over patients not receiving the appropriate level of care related to 3-Day Stay Rule. Patients may be discharged after acute care instead of transferred to swing bed services or experience a delay in receiving swing bed services because a longer hospital stay is required to initiate those services. Ultimately, patients are not granted timely access to the care they need.

2) Inefficient use of resources

Administrators reported unnecessary strain on case management and administrative staff tasked with navigating three-day stay requirements. Respondents also noted that acute care costs more than swing bed services, therefore costing Medicare more when patients cannot be quickly moved from hospital services to swing bed services.

3) Interference with doctors' treatment recommendations for best patient care

Administrators felt that existing rules interfere with the health care providers' decision-making process regarding patient care. One administrator stated, "We should let doctors make decisions on what is best for the patient." Another administrator echoed this sentiment, stating, "Let doctors decide what to do." With these rules remaining in place, health care professionals must navigate around them, sometimes resulting in patients remaining in acute care longer than necessary or being discharged when they would benefit from swing bed services.

Findings/discussion

Results revealed that the current 3-Day Stay Rule and 96-Hour Rule are not reflective of the current needs of rural providers and patients. Most CAH leaders responding to the survey support repealing these policies, citing negative patient, financial, and efficiency outcomes related to the reimplementation of these rules. Medical advances since the implementation of these rules have allowed shorter hospital stays and safe provision of more procedures in the outpatient setting, eliminating the need for extended hospital stays. Hospitals also increasingly utilize "observation status" (Part B) rather than inpatient status. While this classification allows patients to receive similar care as inpatients, they are ineligible for SNF benefits. Observation status can result in unexpected bills for the patient even though they are

Medicare beneficiaries.

Data demonstrates that the temporary repeal of the 3-Day Stay Rule during COVID-19 did not alter SNF admission patterns. Swing beds, available as an alternative to free-standing skilled nursing facilities, are critical in rural areas, which are less likely to have nearby standalone SNFs. Furthermore, swing beds help stabilize health care facilities' census and may provide financial benefits. According to Nursing Homes in Rural America: A Chartbook[iv], 96 percent of micropolitan counties and 90 percent of noncore counties have access to post-acute care through a dually or Medicare-certified nursing home or hospital able to provide SNF care through swing beds. However, the Rural Policy Research Institute has highlighted rural nursing home closure trends since 2008, particularly in areas where alternative community-based nursing services are limited or nonexistent. Due to ongoing nursing home closures, rural post-acute bed availability is vital to protect as a last resource for rural communities.[v]

It is necessary to balance access to care with regulatory oversight by allowing flexibility for rural hospitals to ensure they can provide appropriate care and receive reimbursement for financial sustainability. It is also important to improve telehealth, transportation, and transfer protocols to support CAHs that exceed the 96-hour threshold due to system limitations, ensuring patients who require longer stays can be transferred when needed.

Policy recommendations

NRHA recommends the following actions to support CAH viability and rural patient access:

- Repeal the statutory **three-day inpatient hospital requirement** for SNF coverage at CAHs to ensure equitable and timely care for rural Medicare beneficiaries and that rural patients are not penalized for receiving care at a CAH. Extend the same waiver benefits to all Medicare beneficiaries that accountable care organizations and Medicare Advantage participants receive.
- Eliminate the CAH requirement that physicians certify a patient will be discharged or transferred within 96 hours. Use a rolling average over a longer period (such as 6 or 12 months). Replace or adjust the 96-hour average stay requirement to reflect regional patient acuity and access needs. Consider allowing exceptions for certain diagnosis-related groups.

Recommended actions

NRHA recommends that Congress pass Save America's Rural Hospitals Act (H.R. 3684). Among many important provisions that support the sustainability of rural hospitals, this bill eliminates the 96-hour average length of stay requirement and the requirement for a three-day stay prior to post-acute care.

Conclusion

NRHA aims to ensure all rural areas have access to essential and timely health care. CAHs save lives because they are able to respond quickly in emergency situations, stabilize urgent conditions, and discharge patients in fewer than three days. In alignment with the majority of survey responses from CAH leadership, NRHA recommends eliminating the three-day inpatient hospital requirement for SNF coverage and the 96-hour physician certification requirement to reduce operational burden on rural hospitals and ensure more equitable care for rural residents.

Appendix 1- Electronic survey questions

1. Which state is your CAH in?

2. What is your role or job title?

3. How many years have you been in your current role?

96-hour Average Length of Stay Rule

4. Before the Covid-19 Public Health Emergency (PHE), were your hospital operations affected by the 96-hour Average Length of Stay Rule?
   a. No, operations were not affected
   b. Yes, operations were easy because of this rule
   c. Yes, operations were challenging because of this rule
   d. I was not in CAH role at that time

5. During PHE when 96-hour Average Length of Stay Rule was waived, were your hospital operations affected?
   a. No, operations stayed the same
   b. Yes, operations were easier when rule was waived
   c. Yes, operations were more challenging when rule was waived
   d. I was not in CAH role at that time

6. Has the reintroduction of the 96-hour Average Length of Stay Rule affected your hospital operations?
   a. No, operations stayed the same
   b. Yes, operations are easier with reintroduction of the rule
   c. Yes, operations are more challenging with reintroduction of the rule

7. Which area of your hospital operations (if any) were impacted by the reintroduction of the 96-hour Average Length of Stay Rule? Rank by most impacted.
   a. Patient quality of care
   b. Finances
   c. Logistics of patient placement (e.g., transferring out to other hospitals or receiving patients being transferred from another hospital)
   d. Other (please specify)

8. In your hospital, does the 96-hour Average Length of Stay Rule currently impact **patient care and outcomes**?
   a. No, patient care is not impacted by this rule
   b. Yes, patient care is improved because of this rule
   c. Yes, patient care is more challenging because of this rule

3-day Stay Rule for Swing Bed Services

9. Before the Covid-19 Public Health Emergency (PHE), were your hospital operations impacted by the 3-day Stay Rule for Swing Bed Services?
   a. No, operations were not affected
   b. Yes, operations were easy because of this rule
   c. Yes, operations were challenging because of this rule
   d. I was not in CAH role at that time

10. During PHE when 3-day Stay Rule for Swing Bed Services was waived, were your hospital operations affected?
   a. No, operations stayed the same
   b. Yes, operations were easier when rule was waived
   c. Yes, operations were more challenging when rule was waived
   d. I was not in CAH role at that time

11. Has the reintroduction of the 96-hour Average Length of Stay Rule affected your hospital operations?
   a. No, operations stayed the same

b. Yes, operations are easier with reintroduction of the rule
c. Yes, operations are more challenging with reintroduction of the rule

12. Which area of your hospital operations were impacted by the reintroduction of the 3-day Stay Rule for Swing Bed Services? Rank by most impacted.
a. Patient quality of care
b. Finances
c. Logistics of patient placement (e.g., transferring out to other hospitals or receiving patients being transferred from another hospital)
d. Other (please specify)

13. In your hospital, does the 3-day Stay Rule for Swing Bed Services currently impact patient care and outcomes?
a. No, patient care is not impacted by this rule
b. Yes, patient care is improved because of this rule
c. Yes, patient care is more challenging because of this rule

14. Is there anything you would like to share about your experiences with the 96-hour or the 3-day stay rules? {Open ended response}

Interview Interest

15. Would you be interested in participating in a 20-minute phone interview to discuss your experiences with the 96-hour or the 3-day stay rules? Your identity will be confidential and not associated with your responses.

Yes. First name, email address, phone number

No.

Thank you for your participation. Your responses are valuable for understanding the impact of regulatory policies on the daily operations and patient care in Critical Access Hospitals. The final policy brief including the results of this survey will be shared with you and will be available on the National Rural Health Association website: www.ruralhealth.us

Appendix 2 - Qualitative semi-structured interview guide

Brief introduction of yourself. Highlight any shared experiences and mutual acquaintances. Thank you for agreeing to talk with me today. We are interested in learning more about how 96-hour and 3-day stay rules impact your operations and patient care for policy recommendations for federal legislators.

1. Can you remind me of the state your CAH is located in and your role/title there?

2. Which rule did you feel most impacted by

OR want to talk about first...or maybe they only want to talk about one rule

3. Can you tell me about your experiences with the impact of the reintroduction of the 96-hour rule (or 3-day stay)?

Follow Up Questions

For clarification: You said "……," can you tell me more about that?

Could you tell me what you meant when you said, "……"?

For continuation: Then what happened?

For elaboration: Can you give me an example?

Wrap Up

Thank you for sharing all of this. It is very helpful information. Would it be correct to summarize your experiences by saying….. {summarize key ideas and themes back to the interviewee to ensure you have a proper understanding of their meaning}.

Thank you again for your time. The final policy brief including the results of this survey will be shared with you and will be available on the National Rural Health Association website.

References

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