Save America's Rural Hospitals Act Section-By-Section

Title I – Rural Provider Stabilization:

Subtitle A – Rural Hospitals

Sec. 101 – Eliminating Medicare Sequestration for Rural Hospitals.
60 days after the enactment of this Act, sequestration is permanently suspended for: critical access hospitals, sole-community hospitals, Medicare-dependent hospitals, small rural hospitals, or a hospital located in a rural area.

Sec. 102 – Reversing Cuts to Reimbursement of Bad Debt for Critical Access Hospitals and Rural Hospitals.
Changes the bad debt a rural hospital is liable for from 30 percent to 15 percent for cost reporting periods beginning more than 60 days following enactment.

Sec. 103 – Permanently Extending Payment Levels for Low-Volume Hospitals and Medicare-Dependent Hospitals.
Extends permanently increased payments for Medicare-Dependent Hospitals and Low-Volume Hospitals.

Sec. 104 – Extending Disproportionate Share Payments for Sole Community and Medicare-Dependent Hospitals.
Pays disproportionate share hospital payments to sole community hospitals and Medicare-dependent hospitals paid under the hospital-specific rate.

Sec. 105 – Rebasing Target Amounts for Medicare-Dependent Hospitals and Sole-Community Hospitals.
For hospitals paid under the hospital-specific rate, base years would be updated to FY 2024 for discharges occurring on or after October 1, 2025.

Sec. 106 – Implementing Area Wage Index Adjustments.
Permanently increases the area wage index for hospitals below the 25th percentile in a budget neutral manner and establishes a floor on the area wage index for hospitals not located in frontier states for both inpatient and outpatient hospital services.

Title I – Rural Provider Stabilization:

Subtitle B – Other Rural Providers

Sec. 111 – Making Permanent Increased Medicare Payments for Ground Ambulance Services in Rural Areas.
Makes permanent the two percent urban, three percent rural, and 22.6 percent super rural ground ambulance payments.

Sec. 112 – Permanently Extending Medicare Telehealth Service Enhancements for Federally Qualified Health Centers and Rural Health Clinics.
This section continues makes permanent Section 3604 from the Coronavirus Aid, Relief, and Economic Security (CARES) Act to allow for Federally Qualified Health Centers (FQHC) and Rural Health Clinics

(RHC) to serve as distant site providers. This section also updates and improves payments for services provided by FQHCs and RHCs to be equal to in-person services provided.

Sec. 113 – Restoring State Authority to Waive the 35-Mile Rule for Certain Medicare Critical Access Hospital Designations
Reopens the Critical Access Hospital necessary provider designation for rural hospitals that meet certain requirements. Proposes limitations on the number of new designations that can be established.

Title II – Rural Medicare Beneficiary Equity

Sec. 201 – Equalizing Beneficiary Copayments for Services Furnished by CAHs.
Effective the calendar year (CY) following the enactment of this legislation, this provision equalizes beneficiary copayments for services furnished by critical access hospitals (CAH) to 20 percent of the lesser of the actual charge or payment.

Title III – Regulatory Relief

Sec. 301 – Eliminating 96-hour Requirements with Respect to Inpatient CAH Services.
Effective the calendar year following enactment of this legislation, the 96-hour Physician Certification Requirement and the 96-hour average length of stay requirement for CAHs will be permanently repealed. These requirements were previously removed via the 1135 Waiver Authority granted to the Centers for Medicare and Medicaid Services (CMS) during the COVID-19 public health emergency (PHE).

Sec. 302 – Eliminating 3-Day Prior Hospitalization for Swing Bed Admission.
Effective the calendar year following enactment of this legislation, the 3-day prior hospitalization requirement will be permanently repealed for admission to swing beds in CAHs and rural hospitals. This requirement was temporarily removed via the 1135 Waiver Authority granted to the Centers for Medicare and Medicaid Services (CMS) during the COVID-19 public health emergency (PHE).

Title IV – Future of Rural Health Care

Sec. 401 – Medicare Rural Hospital Flexibility Program Grants
Reauthorizes the Medicare Rural Hospital Flexibility Program. This section authorizes grants to provide technical assistance support for CAHs and rural PPS hospitals hoping to transition to the newly created (within the CAA, 2021) rural emergency hospital (REH) designation. Additionally, this section provides a new item for rural health transformation grants to help eligible rural health providers transition to new models and evolve to meet community needs and their changing health care environment.