The REACH Act
(Rural Emergency Acute Care Hospital)

Background: The pace of rural hospital closures has increased over the last five years totaling 55 closures since January 2010. Many of these hospitals close because they can't generate enough inpatient volume. When this occurs, communities lose their access to emergency services.

Time is the most critical factor for achieving successful outcomes in emergency medicine. Emergency medical practitioners refer to this time-sensitive period as the "golden hour." The National Conference of State Legislatures states that 60 percent of trauma deaths in the United States occur in rural areas, where only 15 percent of the population is represented. The disproportionate percentage of trauma deaths in rural areas is likely attributed to the inequity of timely access to emergency services between rural and urban areas. The percentage of rural trauma deaths could continue to increase as more rural hospitals close, further limiting access to emergency services and requiring patients to travel longer distances to receive emergency medical care.

A 2014 evaluation by iVantage Analytics for the National Rural Health Association (NHRA) identified 283 additional hospitals at risk of closure based upon performance indicators that matched those facilities already forced to close in this decade.

According to the National Center for Rural Health Works, the typical rural hospital creates over 140 jobs and generates $6.8 million in compensation while serving an average population of 14,600.

iVantage also stated that the cumulative impact of future rural hospital closures could result in the loss of 36,000 health care jobs, 50,000 community jobs, and $10,600,000,000 in gross domestic product.

The REACH Act will establish a new Medicare payment designation, the Rural Emergency Hospital (REH) to sustain emergency services in rural communities.

- Critical Access Hospitals (CAH) and rural hospitals with 50 beds or less as of December 31, 2014 are eligible to become Rural Emergency Hospitals (this includes facilities as described that have closed within 5 years prior to enactment).
- The Emergency Hospital will not operate any inpatient acute care beds.
- The Emergency Hospital must:
    - Provide emergency medical care and observation care (not to exceed an annual average of 24 hours or greater than 1 midnight), 24 hours a day, 7 days a week by on-site staff.
    - Have protocols in place for the timely transfer of patients who require a higher level of care or inpatient admission.
- The Medicare payment rate for services furnished at a Rural Emergency Hospital (both emergency care and outpatient services) will be 110% of reasonable cost.
- In addition to emergency care, Rural Emergency Hospitals could provide other medical services including, but not limited to: observation care, skilled nursing facility (SNF) care, infusion services, hemodialysis, home health, hospice, nursing home care, population health and telemedicine services.
- For every CAH that coverts to an Emergency Hospital, another hospital currently not designated as a CAH and located in the same state, would be eligible to become a CAH so long as all criteria other than the distance criteria are met.
- CAHs that convert to Rural Emergency Hospitals may revert back to the Critical Access designation at any time and under the same conditions they were originally designated.