Rural Hospital Transformation Program: Rural Hospital Recommendations

Background

The One Big Beautiful Bill Act (OBBBA), signed into law on July 4, 2025, created a $50 billion Rural Health Transformation Program (RHTP) fund designed **to offset revenue losses rural hospitals will experience.** States must submit a one-time application to the Centers for Medicare & Medicaid Services (CMS) that includes a Rural Health Transformation Plan, articulating how funding will be used in alignment with a set of initiatives detailed in the OBBBA. The MHA Board of Trustees empaneled a **RHTP Task Force to produce a set of recommendations on behalf of Michigan's rural hospitals.** These recommendations are to be shared with the Michigan Department of Health & Human Services (MDHHS), the entity that must submit the application to CMS. The Task Force had the following objectives:

1. Review data provided on the rurality of Michigan and select data that clearly articulates the need for RHTP funds in Michigan.
2. Incorporate feedback from peer rural hospitals on priorities to ensure recommendations represent the needs of Michigan's rural hospitals.
3. Produce a set of recommendations for the MDHHS that outlines how available funds could be used to ensure access to critical healthcare services, while maintaining the financial stability of rural hospitals in Michigan.
4. Others as identified by Task Force members.
5. Develop recommendations for the MHA Board of Trustees.

Recommended Priorities

The task force met three times between September and October. Dr. Michael Shepherd from the University of Michigan provided data on the demographics and access to care barriers in rural Michigan at each meeting. This data informed discussions from task force members on the types of programs and initiatives that could address critical gaps. The MHA convened a Rural Hospital CEO Townhall meeting via Zoom to collect additional feedback from rural hospital leaders. Based on this feedback and the Notice of Funding Opportunity (NOFO) from CMS, the task force narrowed its recommendations to three of the required strategic goals:

1. Sustainable Access
2. Workforce Development
3. Tech Innovation

The MHA RHTP Task Force recommends the MDHHS include the following initiatives in the federal application, and direct funds in the following ways:

1. Expand Access to Critical Behavioral Health Services *(Sustainable access)*

Provide Medicaid Reimbursement for Behavioral Health Transport

Behavioral Health Transport (BHT) is an innovative solution to address the increasing demand for safe, effective and cost-efficient transportation for patients with acute mental health and behavioral health (MH/BH) needs. Providing Medicaid reimbursement for this service will generate significant cost savings for Medicaid by reducing the reliance on non-emergency ambulance services, which is much more expensive. Further, it provides patient-centered care by offering a safe and secure environment for individuals in crisis.

Michigan faces growing challenges in transporting MH/BH patients to appropriate care settings. The rising demand for these transports, combined with long distances between sites of care, puts significant strain on an already overstretched emergency medical services (EMS) system, which is severely understaffed. This contributes to the need to create a safer, condition-appropriate transport solution for patients with MH/BH needs.

Paramedics and emergency medical technicians (EMT), trained to respond to physical health emergencies, are increasingly tasked with transporting MH/BH patients who often don't require medical monitoring or intervention. Michigan data shows that over 99% of MH/BH patients don't require ambulance transport; a finding emergency medicine physicians and MH/BH professionals support. This misalignment results in unnecessary costs and strains valuable EMS resources that could be better prioritized for patients with high acuity physical needs.

Ambulance transport remains the primary mechanism by which behavioral health patients are moved, as reimbursement for BHT and other alternative transport specific to MH/BH is limited. While some Community Mental Health (CMH) and commercial insurers (Priority Health) are reimbursing for BHT services, this is not universal, nor has it been adopted by Medicaid.

Because MH/BH transport is not an approved (payable) service, Medicaid and other payors are paying a higher cost to transport patients via ambulance, when use of BHT would afford a cost savings. Adding MH/BH transport to the Medicaid Transport Benefit expands the options for transporting MH/BH patients and reduces cost. Despite it being a new covered and reimbursable service, doing so would not increase Medicaid costs, as BHT would be used *in lieu of* ambulance transport, which Medicaid already covers. Covering BHT services would be a cost-saving measure for Michigan Medicaid.

For example, a 15-mile transport of an MH/BH patient via BHT results in a cost savings of approximately $95 per trip compared, to using a basic life support (BLS) non-emergency ambulance transport.

- Ambulance (Medicaid allowable BLS non-emergency transport): $393.64
- BHT Transport: $299.00
- Estimated Savings per Transport: $94.64

The MHA RHTP Task Force recommends the MDHHS leverage RHTP funding to reimburse for BHT. Doing so will support access to care for patients in rural areas who need

to be transported to an urban area for treatment. This solution will improve access in rural areas, while also creating meaningful improvements in the care delivery system statewide. Further, leveraging RHTP funds in this way will help meet the sustainability requirements outlined in the RHTP NOFO, as there is existing legislation being drafted in Michigan to create a permanent funding mechanism for BHT. **Additional details on this proposal are included in the attached.**

Provide Medicaid Reimbursement for Emergency Department Boarding for Behavioral Health Patients

The demand for behavioral health services in Michigan continues to increase, and the number of patients presenting to emergency departments in a behavioral health crisis continues to rise. The Joint Commission defines ED boarding as the process of holding admitted patients in the ED while waiting for an inpatient bed. This practice is often associated with crowding in the ED and can lead to increased patient safety events and burnout among clinicians. The Joint Commission recommends the time spent on ED boarding should not exceed four hours to ensure patient safety and quality of care[1]. Using this definition and based on data from the Michigan Inpatient Database, there were more than 6,500 behavioral health patients boarding in rural hospital EDs last year. The cost of boarding in the ED is estimated at $950 per day. When patients are boarding in the ED, hospitals are not getting paid for the care they provide or the services that patients receive. **Based on this data, rural hospitals incurred more than $6 million in uncompensated costs for ED boarding in a single year. The MHA RHTP Task Force recommends the MDHHS leverage RHTP funding to create a fund to reimburse rural hospitals for these costs.** These uncompensated care costs significantly impact rural hospital vitality and must be addressed given the forthcoming Medicaid cuts as a result of OBBBA.

2. **Leverage Innovative Financing Models to Maintain Access to Obstetric Services at Rural Hospitals** *(Sustainable access)*

Support OB Workforce in Rural Areas

The Michigan Senate Fiscal Agency reports nearly 22% of Michigan counties are considered maternity deserts.[2] **At least 11 labor and delivery units at hospitals closed in Michigan since 2010.** The maternity desert counties include Keweenaw, Ontonagon, Baraga, Iron, Alger and Luce in the Upper Peninsula; Cheboygan, Presque Isle, Antrim, Oscoda, Alcona, Missaukee, Lake, Gladwin and Arenac in the northern Lower Peninsula; and Ionia, Cass and

[1]https://www.jointcommission.org/en-us/knowledge-library/news/2023-11-ed-boarding-impact-on-patient-care-and-clinician-well-being
[2] SFA - Publications

Sanilac in the southern Lower Peninsula. When calculating the distance from the population center of each county, 20% of Michigan's counties are 30 miles or more from the nearest birthing hospital.

Rural hospitals report the primary driver of OB unit closures is the significant expense of employing the highly trained OBGYN providers necessary to operate a program. Rural hospitals must typically employ three to four OBGYNs to ensure providers are available for call 24/7, year-round. The MHA proposes establishing a fund to support rural hospitals by helping offset OB call-standby costs. Estimates indicate employing three to four OBGYNs costs a hospital $1.2 to $1.6 million annually in wages and benefits. Due to the low volume of deliveries at most rural hospitals, these physicians are unable to work and bill an adequate number of services to cover this cost, but must be available 24/7, resulting in hospitals having approximately $500,000 in unpaid, stand-by/call time costs. **The MHA RHTP Task Force proposes creating a grant fund to which rural hospitals can apply for up to $500,000 annually to cover call-stand-by cost. Hospitals would be required to attest that they intend to maintain labor and delivery services in the community for at least three years after receipt of these funds.**

Ensure Safe Deliveries in Rural Areas

CMS's new final rule on *Health and Safety Standards for Obstetrical Services* includes emergency service readiness requirements.[3] The Conditions of Participation establish new health and safety requirements for hospitals, including Critical Access Hospitals (CAH), providing obstetric services. Implementing these standards will require additional training and practice opportunities for rural hospitals. Ensuring that healthcare providers are properly trained and equipped to provide safe and quality care to birthing patients is essential. **The MHA RHTP Task Force recommends the MDHHS leverage RHTP funding to create training and technical assistance opportunities for rural hospitals.** A one-time, $500,000 investment will allow the MHA to partner with the American College of Obstetricians & Gynecologists to design trainings and technical assistance to support rural hospitals in meeting these new OB requirements.

3. Provide Direct Funding to Support Rural Providers *(Workforce Development)*

Recruit and Retrain Specific High-Need Rural Providers

Hospitals across the state are experiencing a workforce crisis and rural hospitals are particularly impacted. Statewide data estimates there are more than 19,000 hospital workforce vacancies across the state.[4] Similarly, there are numerous Health Professional

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[3] CMS Announces New Policies to Reduce Maternal Mortality, Increase Access to Care, and Advance Health Equity | CMS

[4] Michigan Hospitals Fill 61,000 Jobs in 2023

Shortage Areas (HPSA) and Medically Underserved (MUA) in Michigan's rural counties.[5] The Michigan Center for Rural Health reports there are more than 2.8 million underserved residents who need primary care in the state, meaning there is a need for an additional 546 primary care practitioners to meet the need. There are more than 4.2 million underserved residents in need of mental health services, which would require an additional 207 mental health providers to meet the need. To address this issue, the MHA recommends a portion of RHTP funds be allocated to support recruiting and retaining primary care, behavioral health and maternal health providers to rural areas. Each hospital and community have different needs and strategies in place for workforce development efforts. **The MHA RHTP Task Force recommends annual $200,000 direct grants to each rural hospital to use to support the rural hospital workforce. These should be distributed annually, for each year that Michigan receives RHTP funds.** These types of investments will ensure Michigan residents maintain access to critical care in rural areas. Hospitals awarded funds would commit to tracking a core set of recruitment and retention efforts to be reported back to CMS each year.

4. Invest to Create a Real-time Bed Census System *(Tech innovation)*

Michigan hospitals propose the development of a statewide, real-time hospital bed census system to strengthen care coordination, improve emergency response and support rural communities. It would be modeled after the Oregon Capacity System that provides an up-to-date view of bed availability across all levels and locations of care. By developing a similar system in Michigan, hospitals can improve communication and create a reliable statewide view of hospital capacity. This real-time visibility will be especially important for rural hospitals and EMS, which often face longer transport times. EMS agencies will be able to view current hospital diversion status and bed capacity, ensuring patients are transported to the most appropriate facility without delay. A real-time bed census system will also help balance patient loads between hospitals, reducing bottlenecks in emergency departments and enabling smoother transfers to higher levels of care, when needed. By connecting hospitals, EMS and other providers in near real-time, **Michigan can leverage RHTP funds to create an integrated platform within existing state HIE infrastructure that ensures rural patients receive timely, appropriate and effective care.**

This will require a $2 million dollar investment in year one to design and launch the bed board, and an annual investment of $1 million for each year thereafter. In total, this is a **$6 million investment**.

Maximize RHTP Investments to Mitigate Cuts to Care

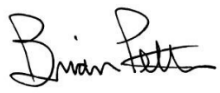
The CMS allows 10% of funds awarded to states to be invested directly in providers. The MHA RHT Task Force strongly encourages the MDHHS to direct the full 10% of allowable funds to be distributed equally among rural hospitals. These hospitals are the entities that will be the most impacted by the forthcoming Medicaid cuts. Direct payments to hospitals will support

[5] HPSAs | MCRH | Michigan State University

each rural hospital across the state in designing programs that help eligible patients retain access to healthcare. Funds can be used to support hiring community health workers, peer coaches or peer navigators to support patients in navigating the healthcare system and to maintain access to insurance. The MHA strongly recommends the MDHHS allocate the full annual 10% of funds directly to the MHA, an entity with a long history of expeditiously getting critical dollars to hospitals. Please see the previous letter sent to the MDHHS, which outlines the technical grant management and clean audit history the MHA has in support of using this type of process.

Both the MHA and the MHA RHTP Task Force thanks the MDHHS for the opportunity to inform the state's RHTP application. This is a critical, one-time opportunity to invest in rural healthcare. On behalf of the more than 70 rural Michigan hospitals, we urge the MDHHS to incorporate the recommendations outlined above and take the necessary steps to create a process to distribute the funds to rural hospitals expeditiously. The MHA and its members understand how critical it is the funds be allocated appropriately, required metrics be tracked and funds be invested to make transformation change. Thank you again for this opportunity. Questions should be directed to Lauran LaPine-Ray, vice president, policy and rural health, MHA, at llapine@mha.org.

Thank you,



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