DEPARTMENT OF HEALTH

# Rural Health Care in Minnesota: Data Highlights

Division of Health Policy

November 2024

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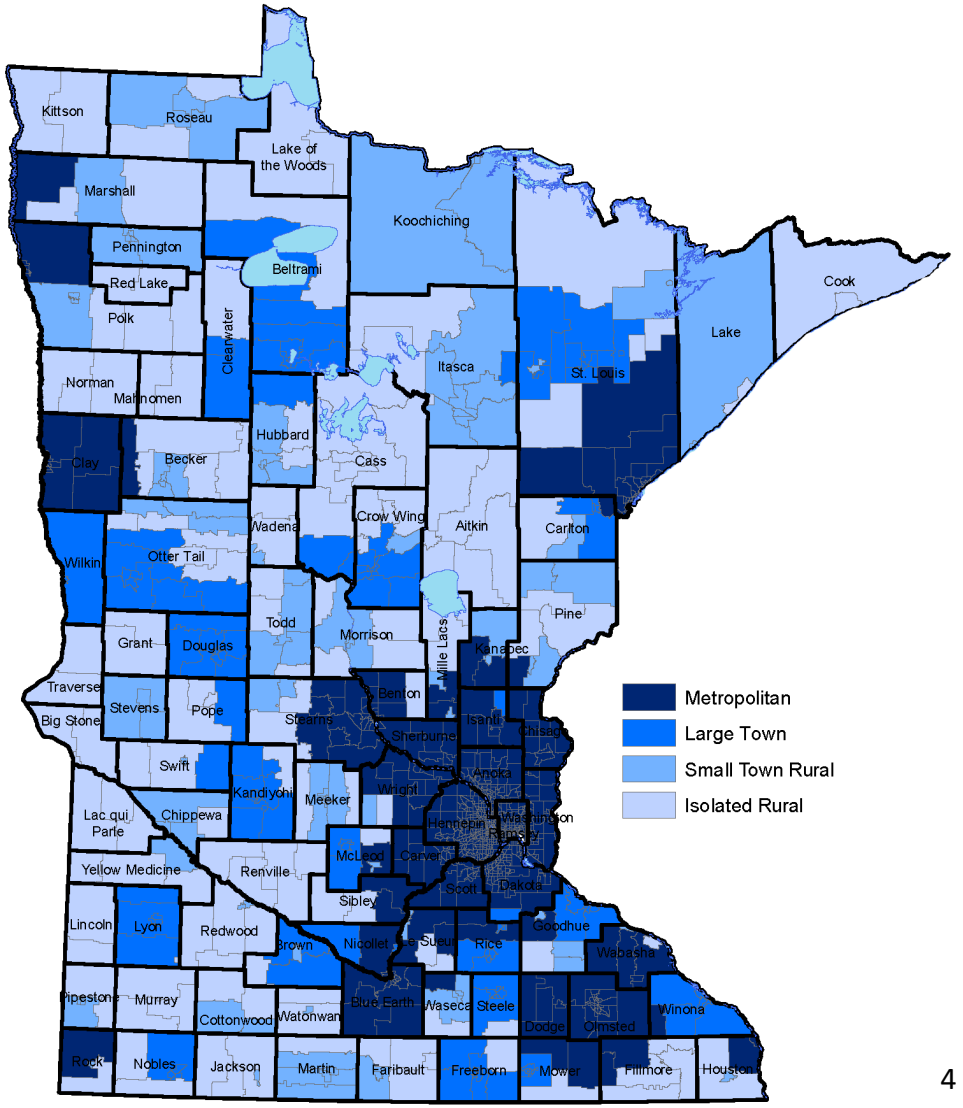
# Technical notes

- A summary of all data sources and notes are available here: https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmnsum.pdf
- There are a number of ways to report on rurality and geography. This chartbook uses the following constructs (defined in subsequent slides). The use of a particular construct is informed by the availability of the data.
  - Rural-Urban Commuting Area codes (RUCA codes)
    - Based on zip code, census tract, or county, as noted in each slide
  - State Community Health Services Advisory Committee (SCHSAC) regions
- When possible, the most up-to-date data are used. Therefore, the data year(s) presented may vary across the chart book.
- To access this chart book in an alternate format, a summary of the charts, graphs and maps is available here: https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmndata.pdf
- Direct links are listed on each slide.

# Defining rural: Rural-Urban Commuting Area (RUCA) Codes

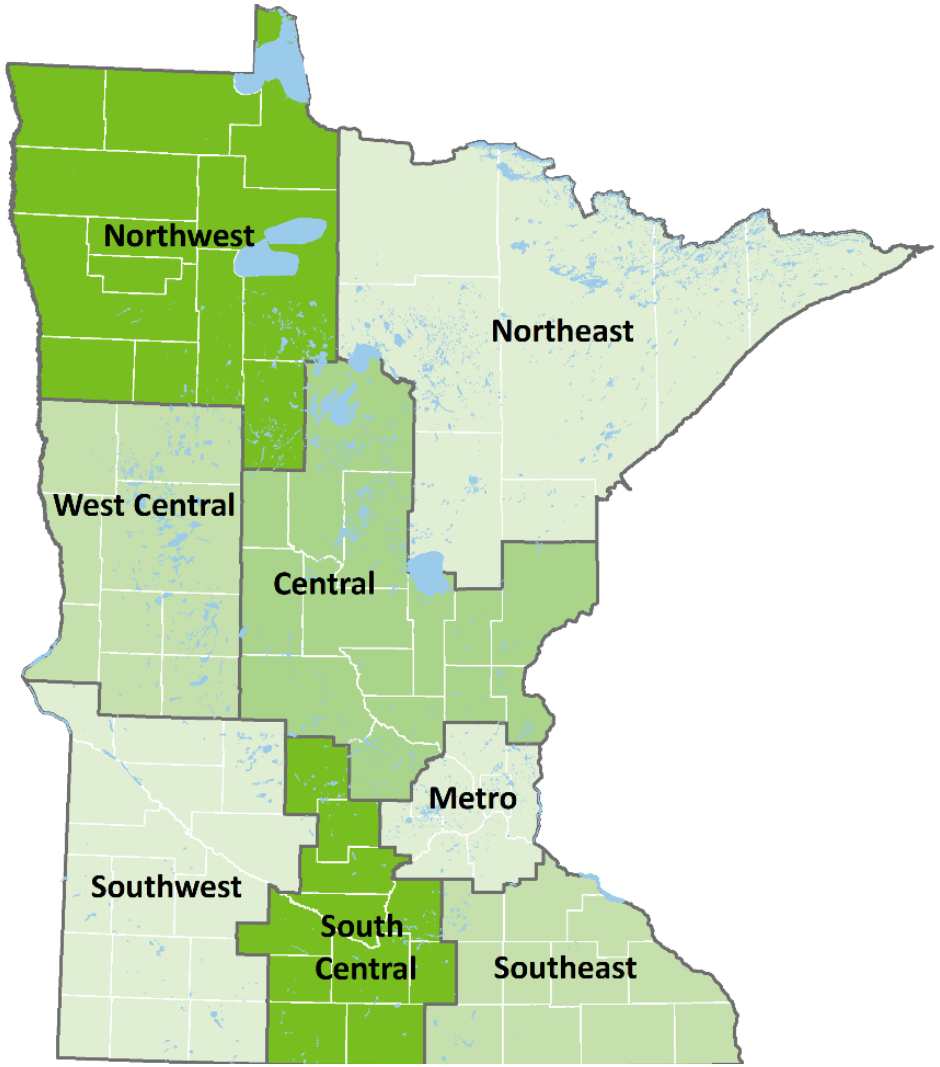
- Rural-Urban Commuting Areas or RUCAs are one of many ways to measure rurality.
- RUCAs take into account population density, urbanization and daily commuting patterns to identify urban and rural regions of the state.
- Current definitions are based on 2010 census data. More areas of the state became urban between the 2000 and 2010 census.
- For slides with two categories, unless otherwise noted:
  - urban = metropolitan
  - rural = large town + small town rural + isolated rural
- RUCA codes are based on zip code unless otherwise noted each slide.




Source: MDH. RUCAs were developed by the U.S. Department of Agriculture, Economic Research Service, and the University of Washington's WWAMI Rural Health Research Center. This map is based on census tract.

Summary of Slide

# Defining rural: Regions




## State Community Health Service Advisory Committee (SCHSAC) Regions

- 8 regions based on groups of counties.
- Focused on developing, maintaining and financing community health services.

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# State of Rural Minnesota

What are the demographic characteristics of rural Minnesota?

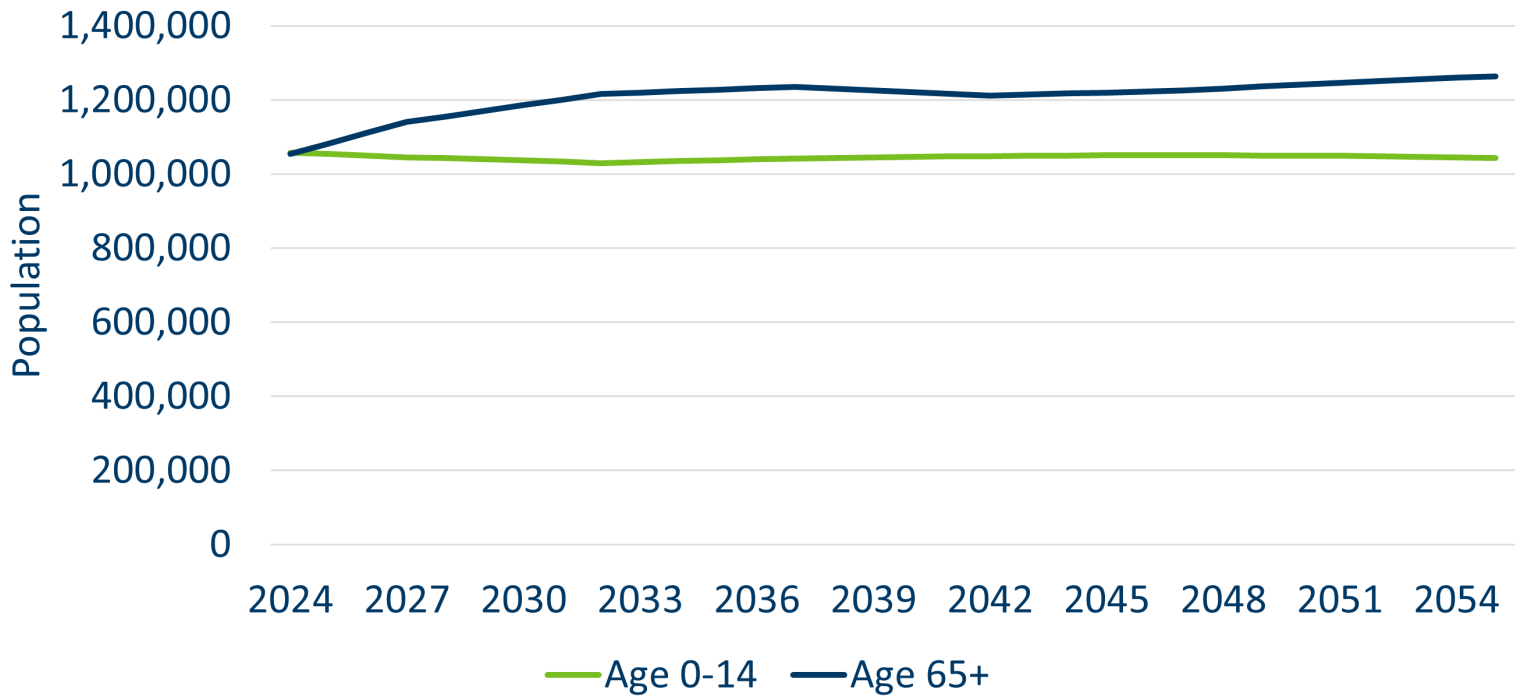
# Key points – Minnesota rural demographics

- Minnesota is projected to gain nearly 335,000 residents between 2024 and 2075.
- Minnesota's population in the 65+ age group will more than double from 2024 to 2075.
- Top five rural counties with the largest projected increase in population by 2055 will be Crow Wing (18,300), Douglas (10,600), Cass (9,600), Otter Tail (9,300), and Todd (4,100).
- Population growth in the state overall will be driven by communities of color.

Source: Minnesota Demographer's Office, https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/

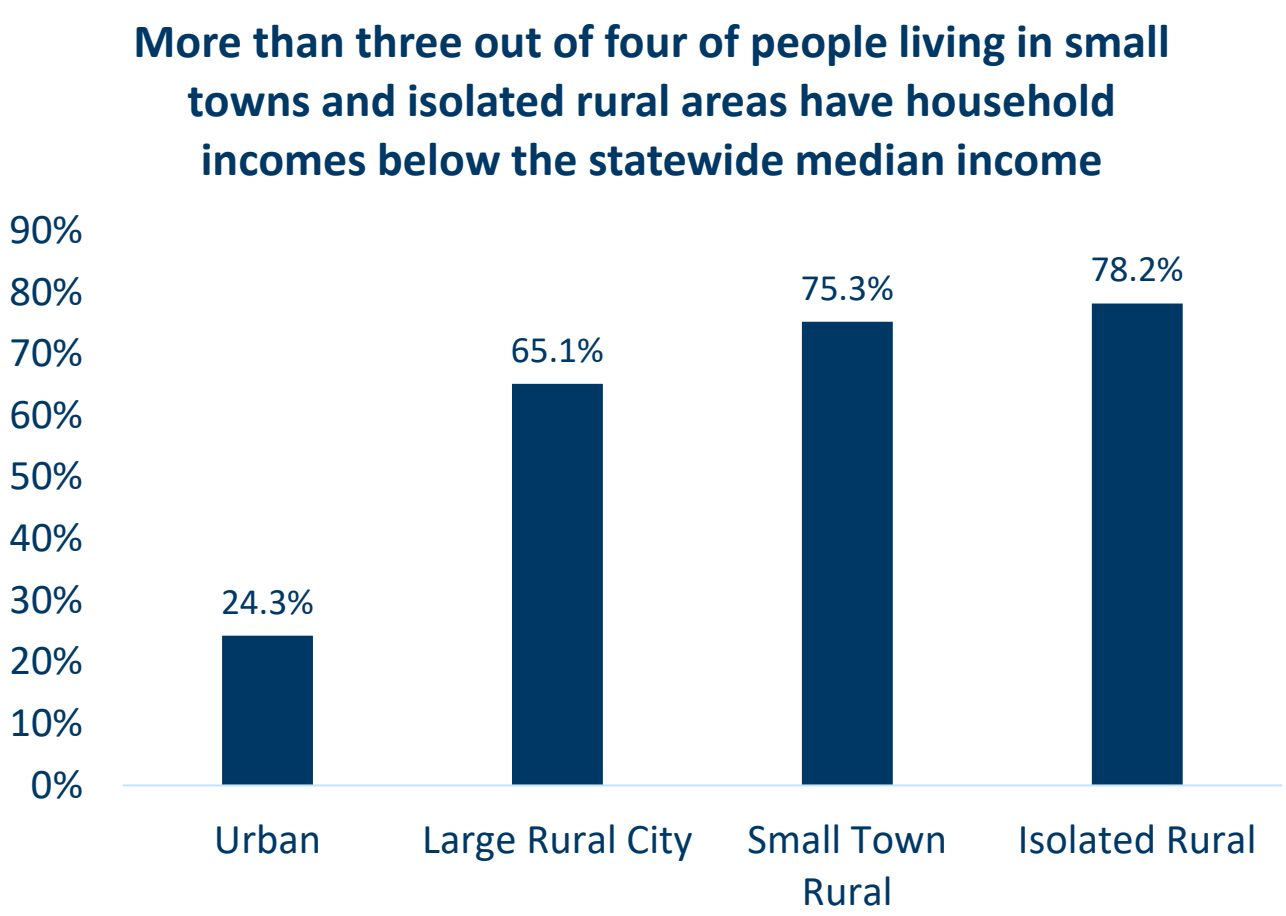
# The population of Minnesota is aging

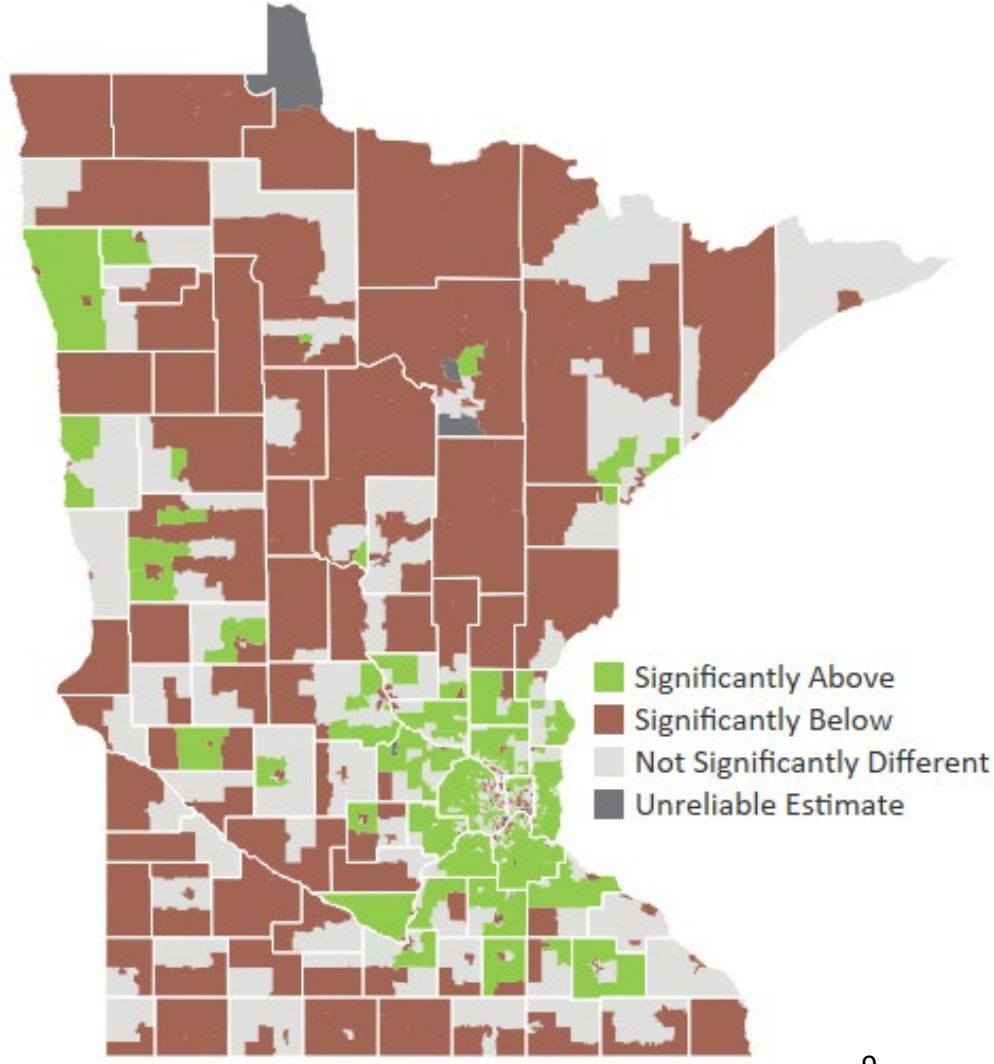
- In 2025, the total number of older adults (65+) is projected to outnumber children in Minnesota age 0 to 14.
- In 2030, one quarter (25.4%) of residents of rural Minnesota counties are projected to be 65 years of age or older vs. 19% for urban counties.




Source: Minnesota State Demographic Center data obtained on October 8, 2024, from https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/ (vintage May 2024).
Summary of Slide

# People living in rural Minnesota are more likely to have household incomes below the statewide median income




Source: MDH/Health Economics Program analysis of the 2022 American Community Survey Five-Year Estimate. RUCA based on census tract.

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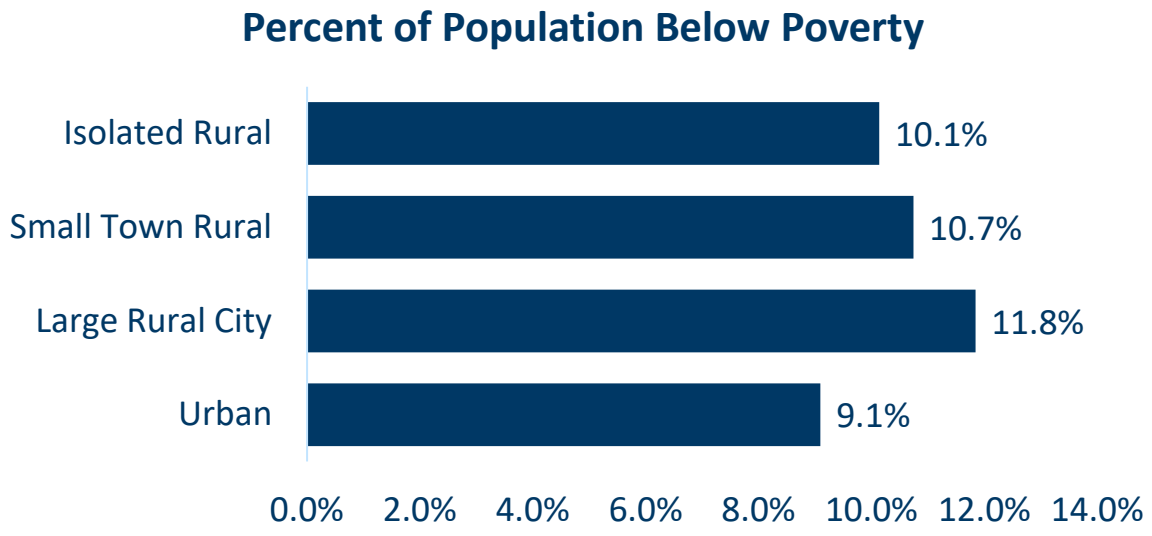
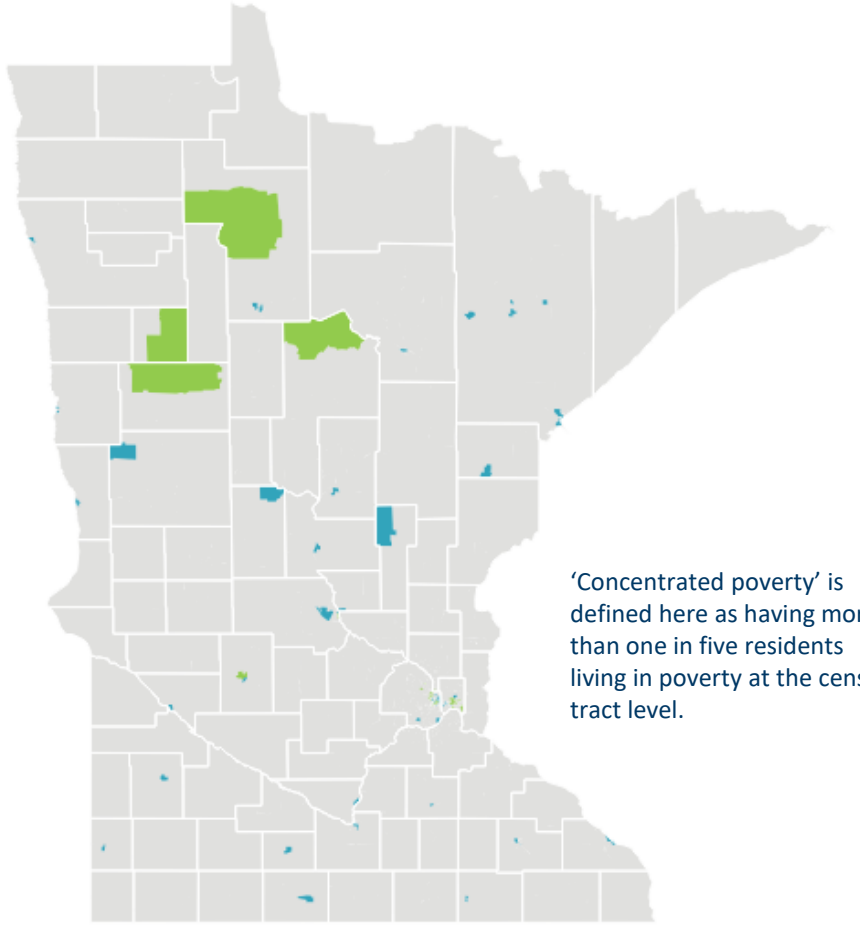
# Areas of concentrated poverty occur in both rural and urban areas of the state

There are an estimated 105,000 people living in concentrated poverty areas in rural Minnesota.



'Concentrated poverty' is defined here as having more than one in five residents living in poverty at the census tract level.

Majority Non-White or Hispanic Concentrated Poverty Area
Majority White, Non-Hispanic Concentrated Poverty Area
Not a Concentrated Poverty Area

Note: The percentages are not statistically different by geographic category.
Source: MDH/Health Economics Program analysis of the 2022 American Community Survey Five-Year Estimate. RUCA based on census tract.

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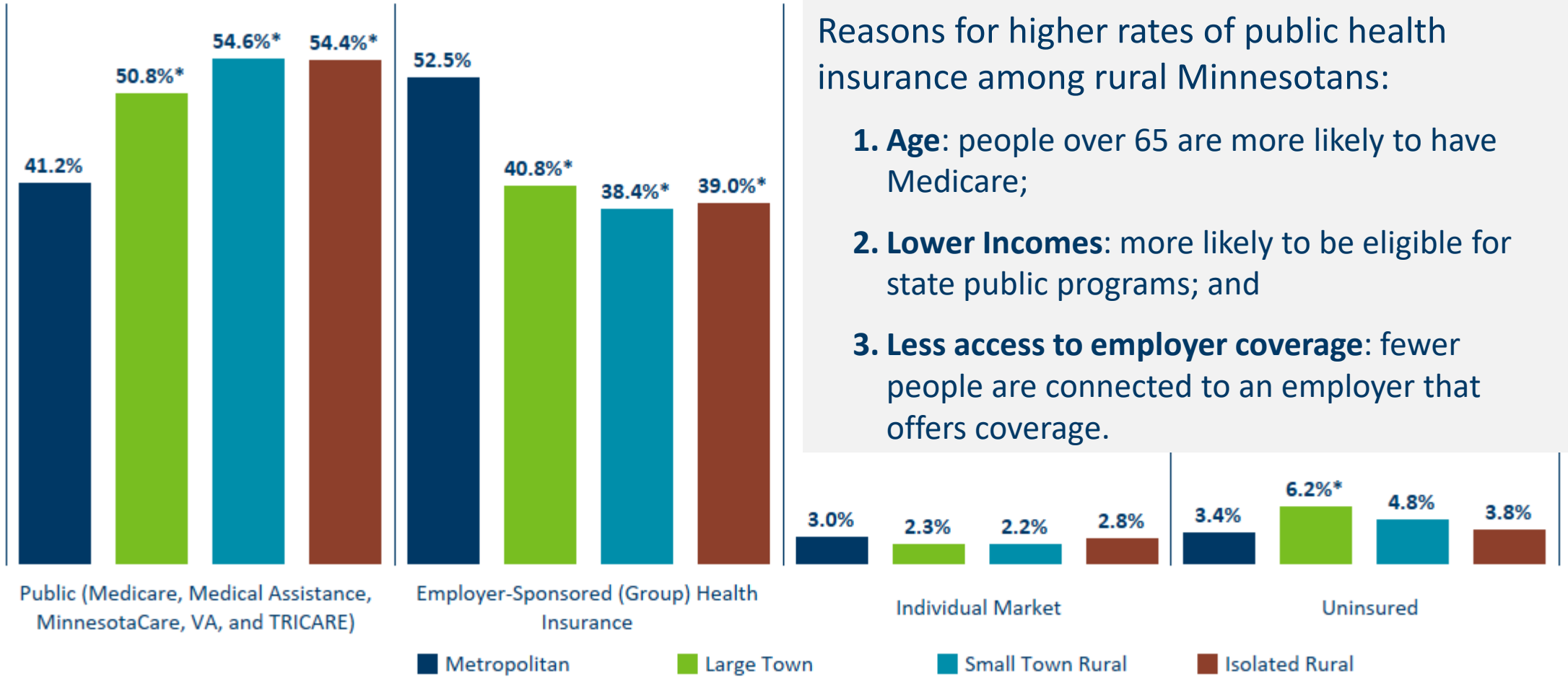
# Structure of Rural Health System: An Overview

How do people in rural areas access health care? Where are health care facilities in the state?

# Key points – Access to health care

- Rural residents are more likely to get health care through public sources, such as Medicare, Medicaid and MinnesotaCare.
- While health care facilities are distributed throughout the state, they are more spread out in rural areas.

# Rural Minnesotans are more likely to have public health insurance coverage, such as Medicare, Medicaid or MinnesotaCare




Reasons for higher rates of public health insurance among rural Minnesotans:

1. **Age**: people over 65 are more likely to have Medicare;
2. **Lower Incomes**: more likely to be eligible for state public programs; and
3. **Less access to employer coverage**: fewer people are connected to an employer that offers coverage.

Source: Minnesota Health Access Survey, 2023; Geographies based on RUCA zip-code approximations.
*Indicates significant difference from Metropolitan at the 95% level.
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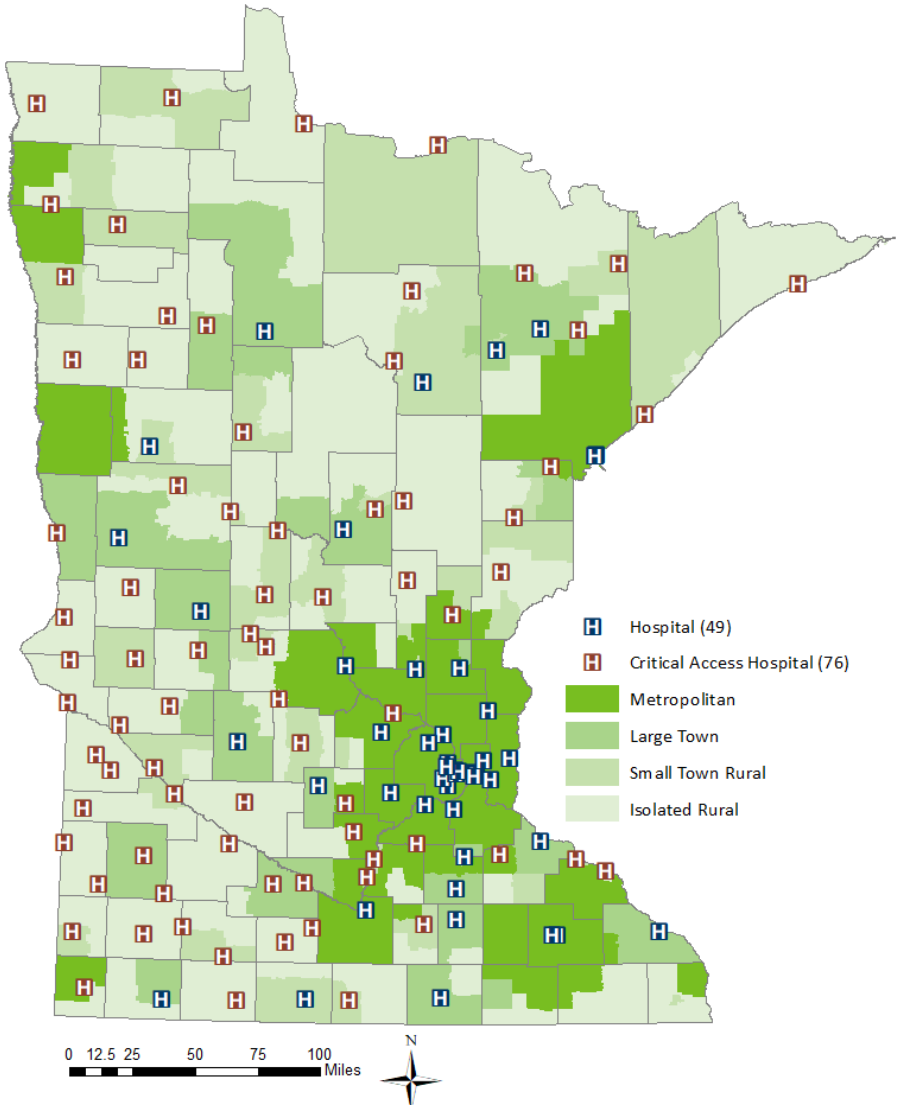
# Hospital and nursing home services are available throughout the state




- Of the 125 acute care hospitals in Minnesota, 76 are designated Critical Access Hospitals.[1,2]
- In total, 90 hospitals are located in rural areas.[1]
- Around one-third of all hospital outpatient clinics in the state, 138 of 408 total clinics, are in rural areas.[1,3]
- All but one county, Red Lake, has at least one nursing home as of 2024.[4]

[1] Source: MDH Health Economics Program analysis of 2023 hospital annual reports, October 2024.
[2] There are 77 Critical Access Hospitals in Minnesota; however, one is an Indian Health Services Hospital. This is not included in the count of community hospitals, which are limited to non-federal short-term general and other special hospitals and are accessible by the general public. https://www.health.state.mn.us/facilities/ruralhealth/flex/cah/index.html
[3] Outpatient clinics are designated by the hospital and may not be co-located with the hospital but are billed to Medicare under the hospital's provider identification number. Clinic location data is from fiscal year 2022.
[4] Source: Minnesota Department of Health, Health Economics Program analysis of 2024 Directory of Registered, Licensed and/or Certified Health Care Facilities and Service.

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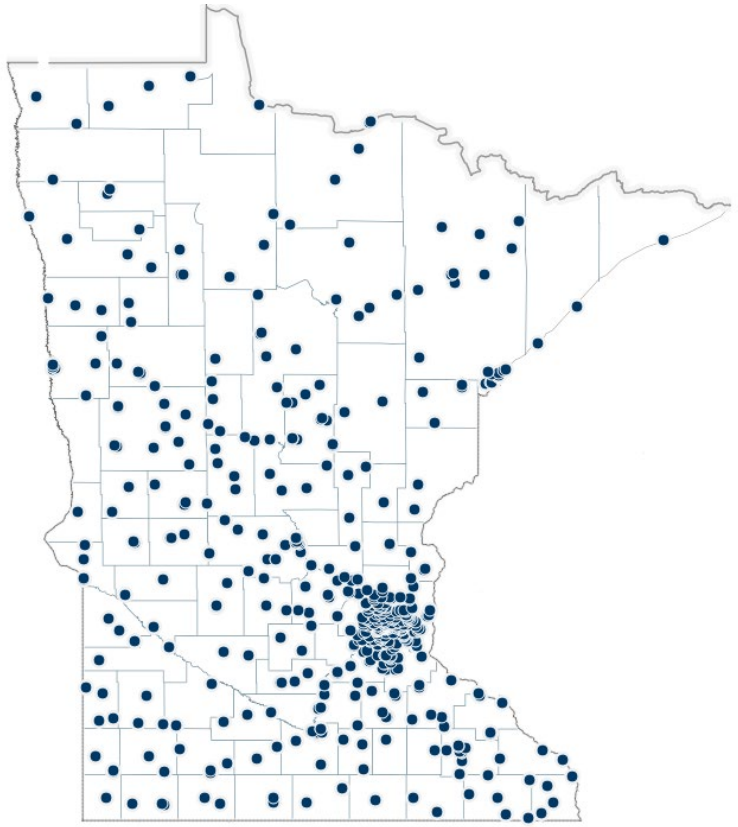
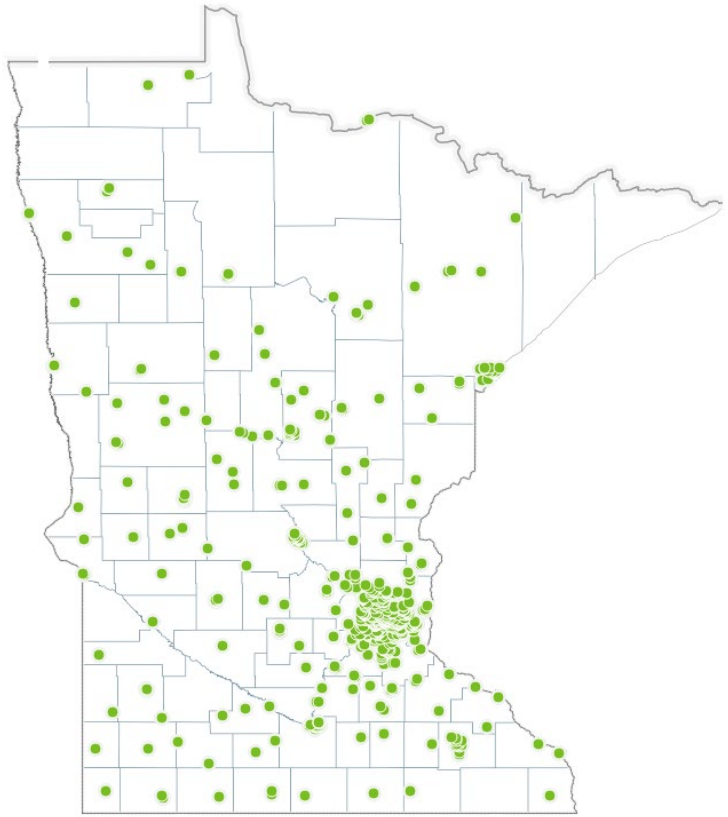
# Primary and specialty clinics are available throughout Minnesota

Primary Care Clinics, 2023



Specialty Care Clinics, 2023



- 40% (241) of all primary care clinics (599) are located in rural areas.[1]
- 22% (196) of all specialty care clinics (907) are located in rural areas. [1]
- Minnesota's 17 Community Health Centers care for nearly 200,000 low-income people.[2]

Map notes: Each dot represents one clinic. This does not account for patient population or number of practicing physicians. Primary care clinics include clinics that provide family medicine, internal medicine, and/or pediatrics. Specialty care clinics include clinics that provide one or more non-primary care specialty. Clinics that provide both a primary care specialty and a non-primary care specialty are included in both groups of clinics.

[1] Source: MDH Health Economics Program analysis of the Minnesota Statewide Quality Reporting and Measurement System 2023 Physician Clinic Registry; also source for maps.

[2] Source: https://www.mnachc.org/what-is-a-community-health-center

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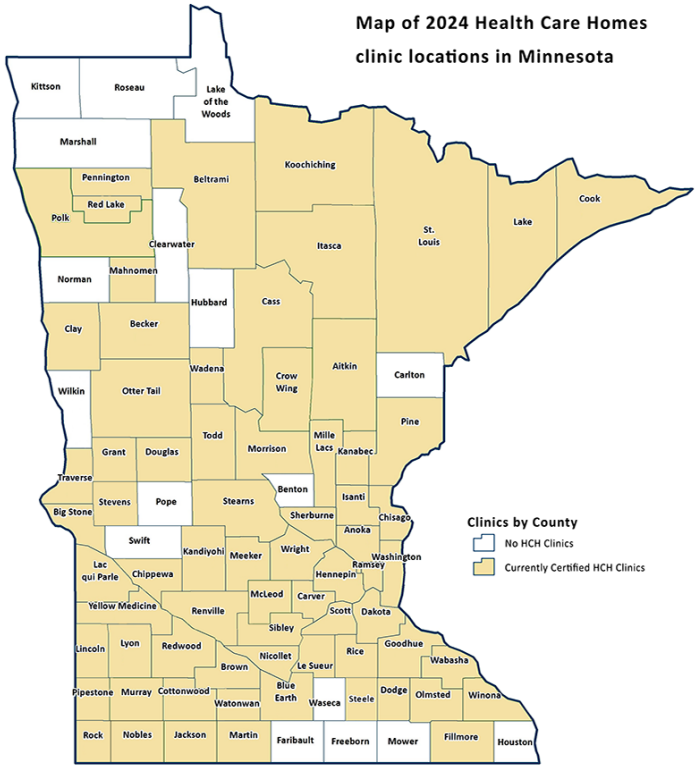
# Person-centered, coordinated primary care available to most Minnesotans




- MDH certifies primary care clinics and clinicians as health care homes, known nationally as a patient centered medical home.
- The health care home clinic team coordinates care with the patient and their family to ensure whole person care and to improve health and well-being.
- 80% of MN counties have at least one health care home clinic.
- The health care homes framework certifies clinics at the following levels of progression: Foundational Level (324 clinics), Level 2 (13 clinics), and Level 3 (90 clinics). Organizations may choose to certify at the level appropriate for each clinic.

Source: HCH Certified Clinic List data obtained on October 24, 2024, from https://www.health.state.mn.us/facilities/hchomes/hchmap/index.html

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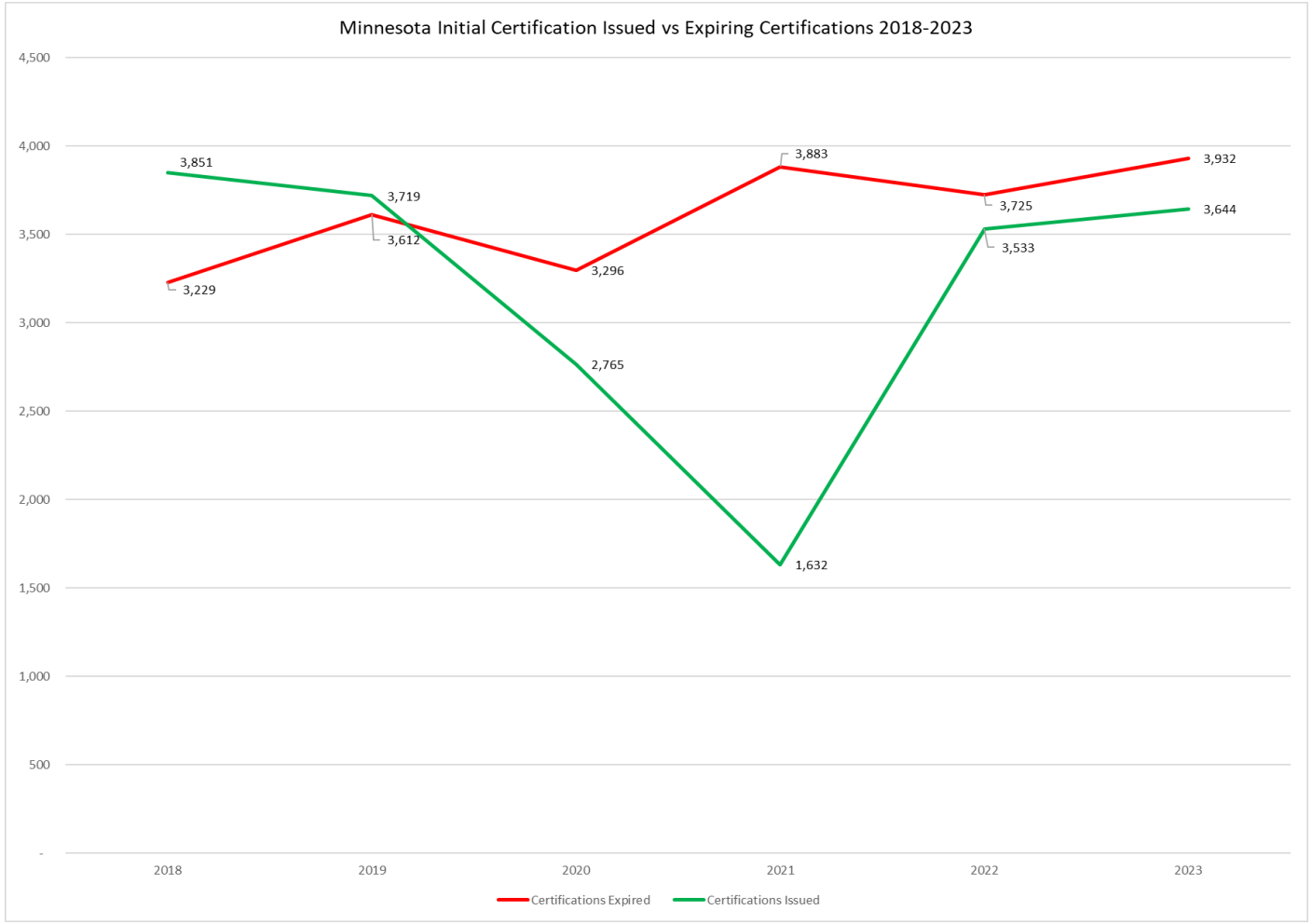
# Rural Emergency Medical Services (EMS) workforce is in crisis!




Source: Minnesota EMS Certification/ Licensure System

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- Minnesota mirrors the nation's declining EMS workforce.
- There is a gap between the numbers of EMS certifications issued vs. those expiring.
- In 2023, the state lost 288 certified EMS providers.

# Access to critical trauma and stroke care is available throughout the state

- Minnesota has 126 designated trauma hospitals across four adult and two pediatric designation levels.
- 99% of Minnesotans live within 60 minutes of a trauma hospital.
- 84% of Minnesotans live within 60 minutes of a Level 1 or 2 trauma hospital.
- 77% of Minnesota children live within 60 minutes of a pediatric trauma hospital.
- Minnesota has 120 designated stroke system hospitals.
- 94% of Minnesotans live within a 30-minute drive of a designated stroke system hospital.
    - The proportion of rural Minnesotans living within a 30-minute drive of stroke designated hospital increased from 2% to 84% from 2013-2023

Source: MDH Trauma System October 2024; MDH Stroke System July 2024
Note: The methodology used for capturing trauma data changed over the past year, which resulted in more accurate data as well as changes in year over year results of this slide.
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# Rural Health Care Workforce

What is the composition, demographics and geographic distribution of the state's licensed health care workforce?

# Key points – Health care workforce

- Nurses make up the largest share of the state's licensed providers and are the foundation of the health care system.
- There is a maldistribution of providers in the state—the majority work in the urban areas. Consequently, the more rural parts of the state face a severe shortage of all provider types, especially in primary care and mental health.
- 80% of Minnesota counties qualify as mental health professional shortage areas.
- Rural providers are older and closer to retirement.

# Registered nurses and licensed practical nurses make up the majority of the health care workforce in Minnesota

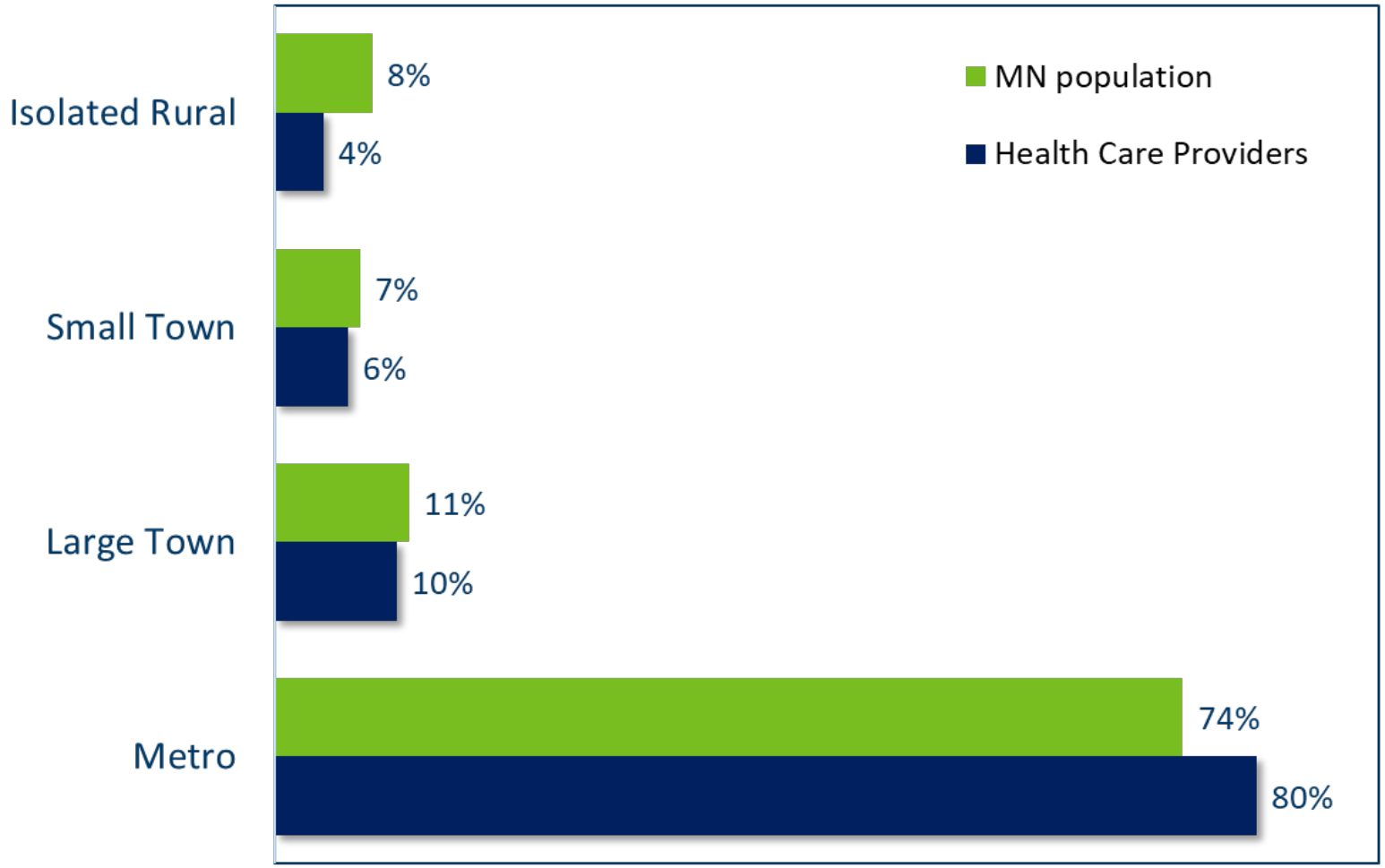
| Provider Group | Number of Providers in Minnesota (2024) |
|---|---|
| Alcohol and Drug Counselors | 4,156 |
| Dental Professionals | 13,444 |
| Dentists | 3,979 |
| Mental Health Providers | 28,197 |
| Pharmacists | 9,912 |
| Pharmacy Technicians | 14,023 |
| Physical Therapy Professionals | 8,147 |
| Physicians | 28,373 |
| Physician Assistants | 4,461 |
| Registered Nurses and Licensed Practical Nurses | 152,110 |

Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, 2024. This table excludes Respiratory Therapists and some other smaller licensed occupations, including: Chiropractic, Sports Medicine, and Occupational Therapy.

Summary of Slide

# The majority of licensed health care providers work in metropolitan areas

Very few licensed health care providers work in rural areas.




Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, 2024. Data includes: physicians, physician assistants, respiratory therapists, oral health professions, pharmacy professions, physical therapy professions, and mental health professions.

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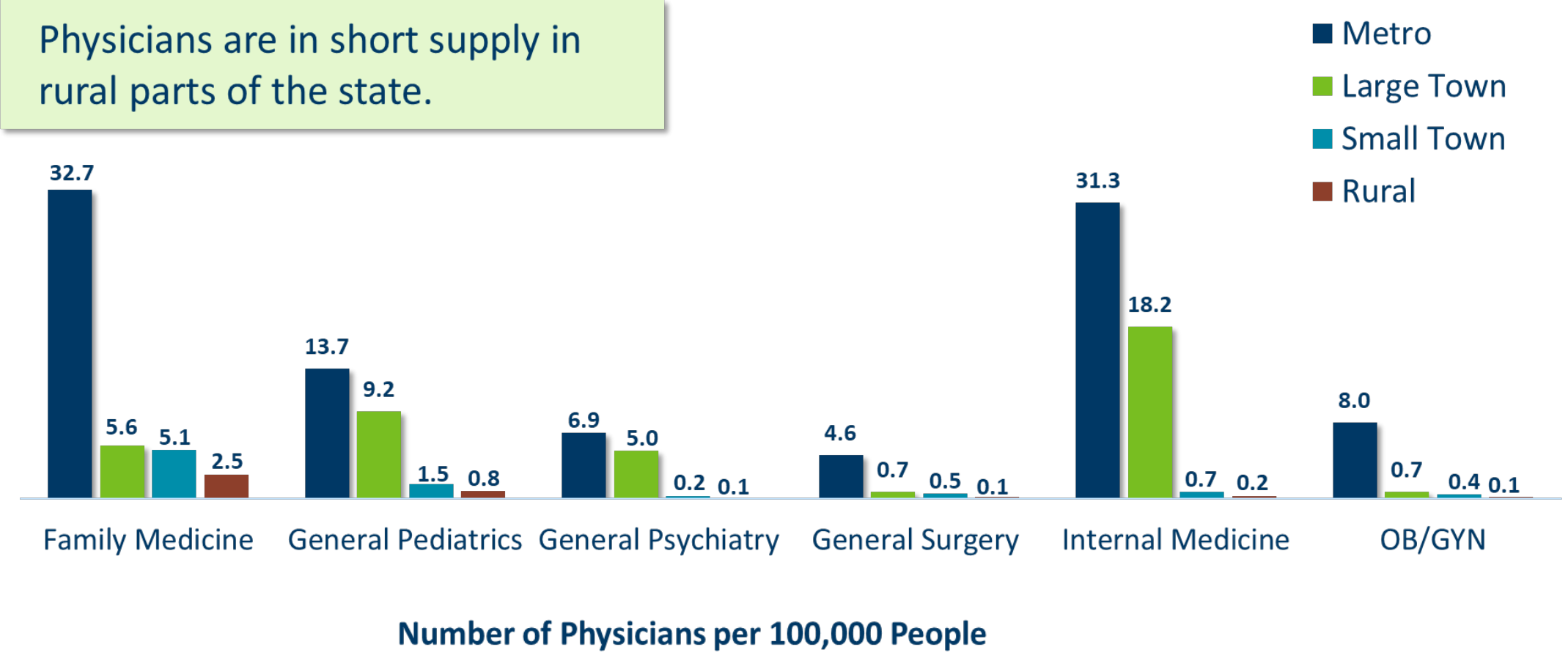
# Rural areas face severe shortages of primary care physicians

Physicians are in short supply in rural parts of the state.




Source: MDH Office of Rural Health and Primary Care analysis. Data provided by the American Board of Medical Specialties and American Osteopathic Association. Counts by region are based on primary practice address that physicians report to the Board of Medical Practice. September 2024.

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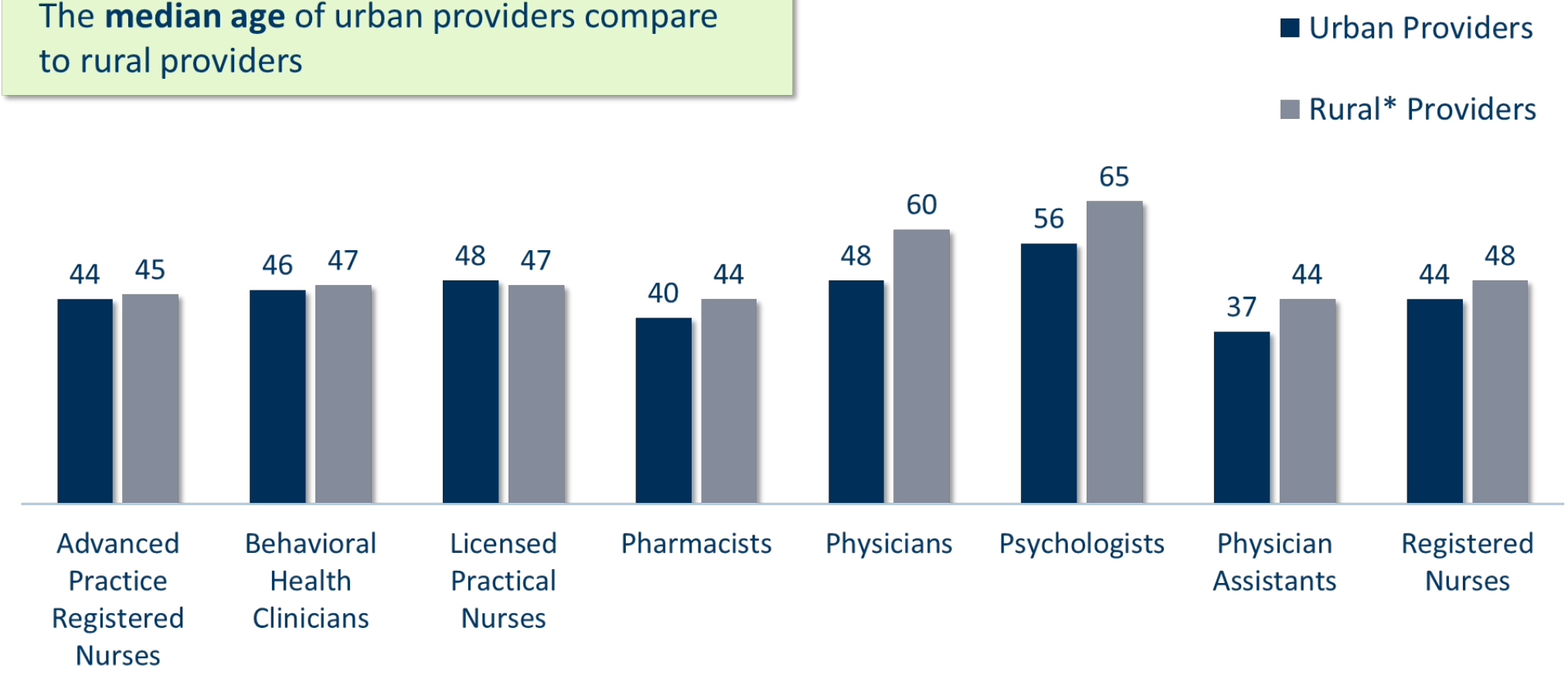
# Rural providers are older than their urban counterparts

The **median age** of urban providers compare to rural providers




Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, 2024.
*Rural = isolated rural from Rural-Urban Commuting Area codes.

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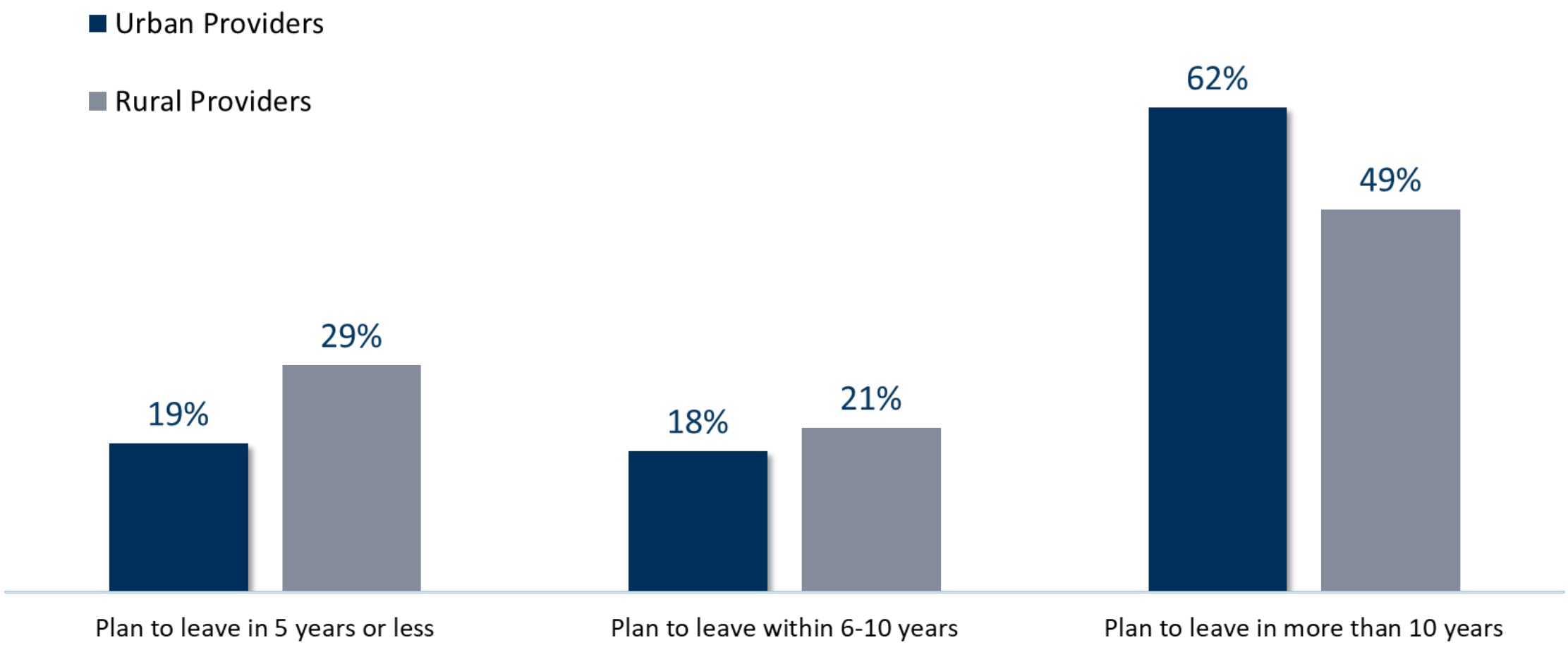
# Almost one in three rural physicians plan to leave the workforce within the next five years




Source: MDH Office of Rural Health and Primary Care, Physician Workforce Survey, 2024.
Rural = isolated rural from Rural-Urban Commuting Area codes.
Summary of Slide

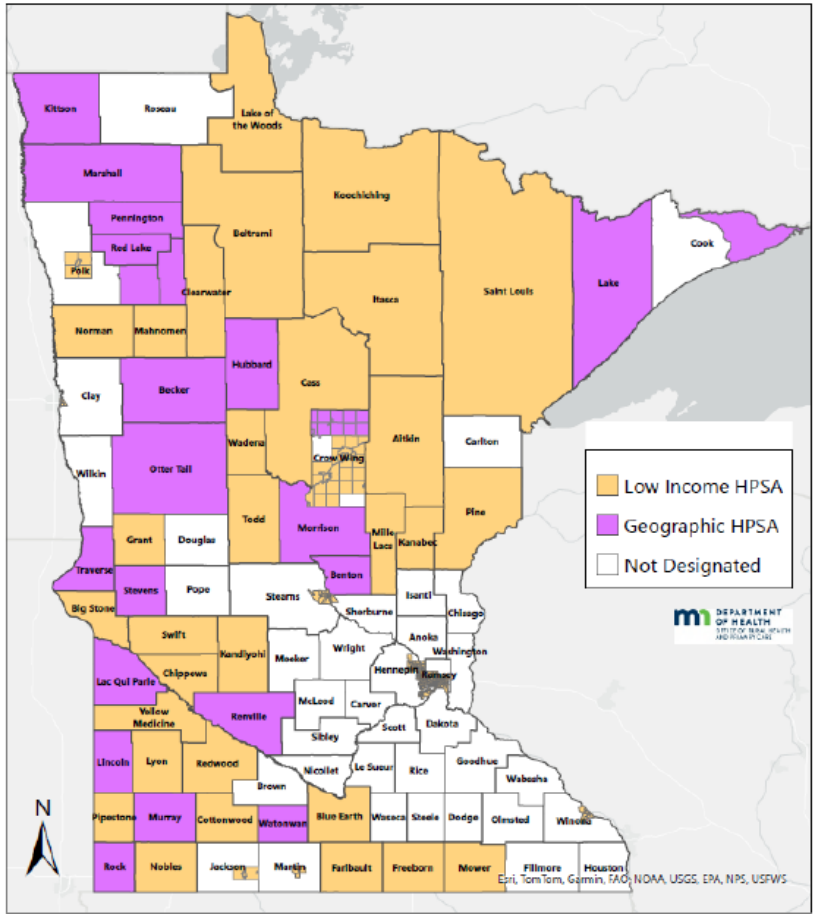
# Building the rural provider pipeline

Providers practice where they train. MDH supports efforts to grow the next generation of rural providers by locating clinical training opportunities in rural area.

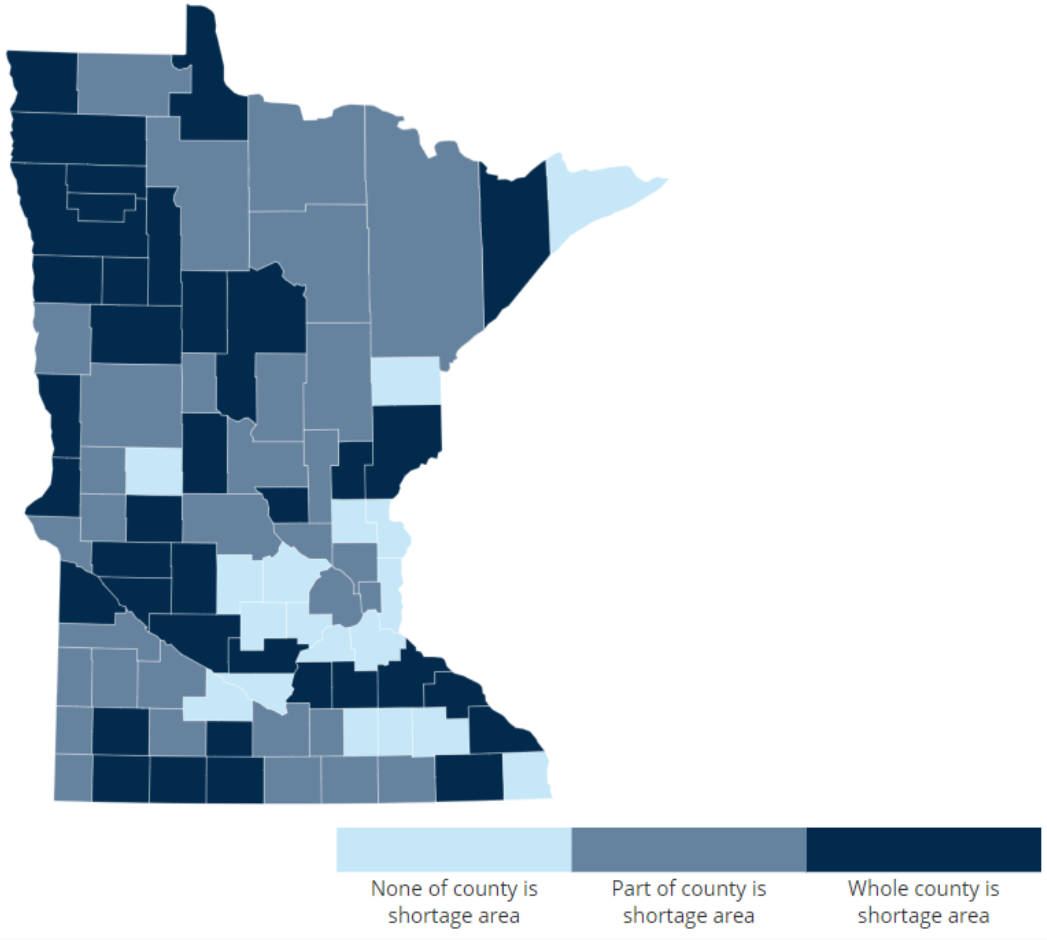
| Expected Matriculation date | Urban partner | Rural partner | Slots/seats | Field |
|---|---|---|---|---|
| 2025 | CentraCare System, St. Cloud | CentraCare, Wilmar | 3 | Family medicine |
| 2026 | Fairview Health System, Minneapolis | Grand Itasca Clinic and Hospital, Grand Rapids | 3 | Family medicine |
| 2027 | North Memorial, Minneapolis | Lakewood Health System, Staples | 3 | Family medicine |
| 2025 | ... | Sanford Health System, Thief River Falls | 1 | Post-doctoral psychology residency |

# Minnesota has 519 designated Health Professional Shortage Areas

## Health Professional Shortage Areas Dental




## Health Professional Shortage Areas Primary Care




Source: HRSA Fact Sheet – FY 2023 – Minnesota. Downloaded from data.hrsa.gov.

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# Availability of Health Care Services in Rural Minnesota

What health care services are available to people living in rural Minnesota, and has it changed over time?

# Key points – Health care availability

- The availability of services, especially in hospitals, has been changing over the past 10 years:
  - Fewer services are available at rural hospitals, or the hospitals have closed.
  - Non-metro counties have seen a loss of service availability in obstetrics services, inpatient mental health (psychiatric), and increases in outpatient psychiatric services.
  - More than half of the nursing home closures between 2013 and 2023 were in rural counties.

# Rural hospitals saw declines in surgical services due to hospital closures, consolidation, or service loss over the past decade

| | Hospitals with service available in 2013 | Change in Service due to: Closure or Consolidation | Lost Service | Added Service | Hospitals with service available in 2023 | Percent Change 2013 to 2023 |
|---|---|---|---|---|---|---|
| **Surgery** | | | | | | |
| Inpatient Surgery | 84 | 1 | 5 | 1 | 79 | -6.0% |
| Outpatient Surgery | 91 | 2 | 2 | 1 | 88 | -3.3% |
| **Mental Health/Chemical Dependency Services** | | | | | | |
| Outpatient Psychiatric | 40 | 1 | 6 | 11 | 44 | 10.0% |
| Detoxification Services | 9 | 1 | 4 | 4 | 8 | -11.1% |
| **Diagnostic Radiology Services** | | | | | | |
| Computer Tomography (CT) Scanning | 92 | 2 | 0 | 0 | 90 | -2.2% |
| Magnetic Resonance Imaging (MRI) | 90 | 2 | 1 | 1 | 88 | -2.2% |
| Positron Emission Tomography (PET) | 4 | 0 | 3 | 1 | 2 | -50.0% |
| Single Photon Emission Computerized Tomography (SPECT) | 19 | 0 | 2 | 14 | 31 | 63.2% |
| **Other Services** | | | | | | |
| Cardiac Catheterization Services | 2 | 0 | 0 | 1 | 3 | 50.0% |
| Organ Transplant Services | 1 | 0 | 1 | 0 | 0 | -100.0% |
| Renal Dialysis Services | 14 | 0 | 4 | 2 | 12 | -14.3% |

Over the same time period, rural hospitals added cardiac catheterization services, outpatient psychiatric services, and advanced diagnostic imaging services.

Source: MDH Health Economics Program analysis of hospital annual reports, September 2024; 2023 data is considered preliminary. Services are considered "available" when they are provided on site by hospital staff, on site through contracted services, or off site through shared services agreement. No rural hospitals had open heart surgery from 2013 to 2023.

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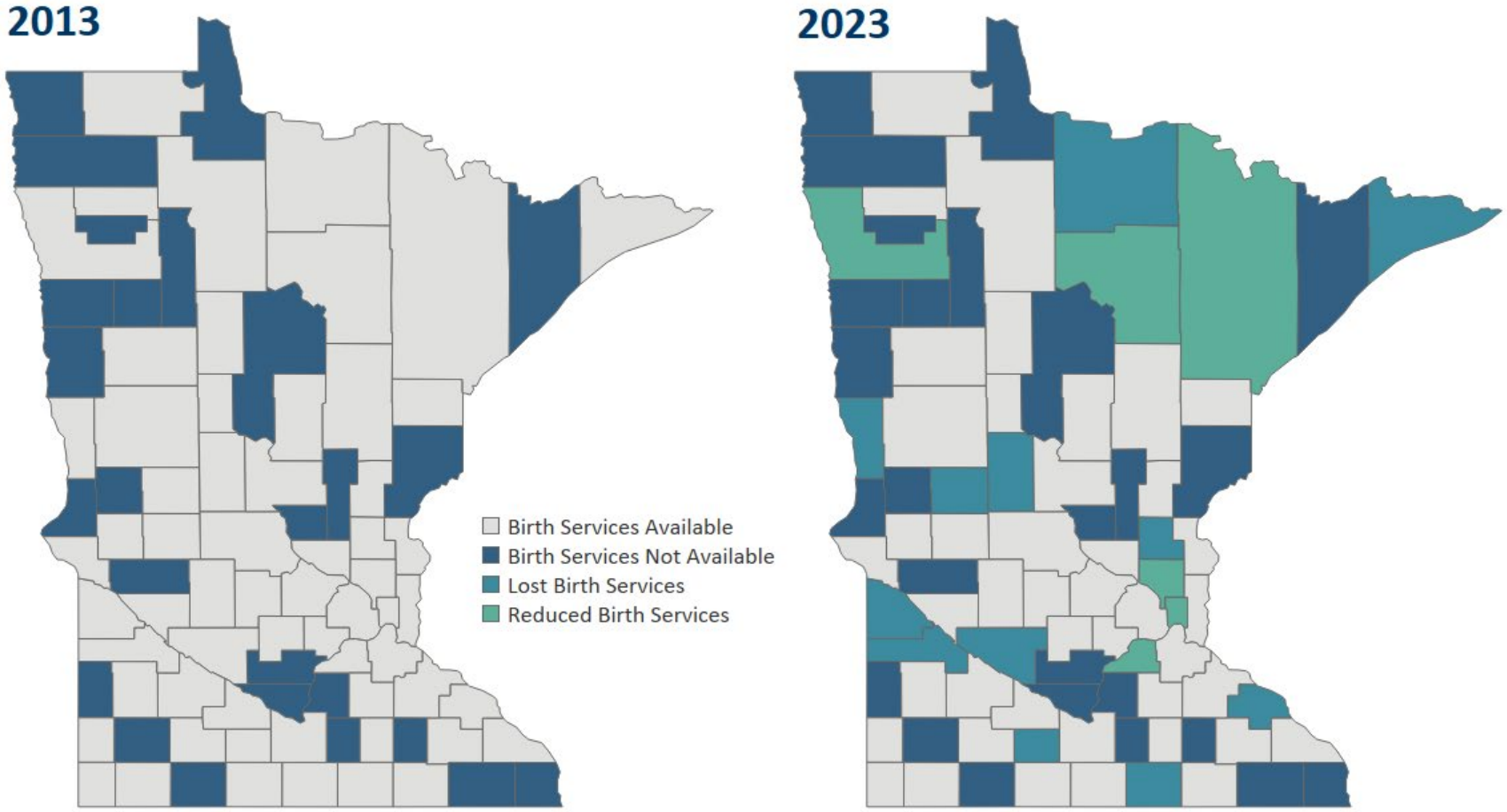
# 18 Minnesota counties have lost or reduced hospital birth services between 2013 and 2023




Increases in preterm births have been associated with the loss of hospital birth services in rural areas.

Note: MDH Health Economics Program analysis of hospital annual reports, September 2024; Due to a merger, the hospital in Mower County was no longer an independent licensed entity; however, birth services were offered at that site under the license of the remaining corporate entity.
Source: MDH Health Economics Program analysis of hospital annual Reports; 2023 data is considered preliminary and includes planned birth service reductions in 2024 for Polk County and Scott County.
Definition: Community hospitals were categorized as not offering birth services if they did not have at least one routine birth, had no licensed bassinets, or stated that services were not available.

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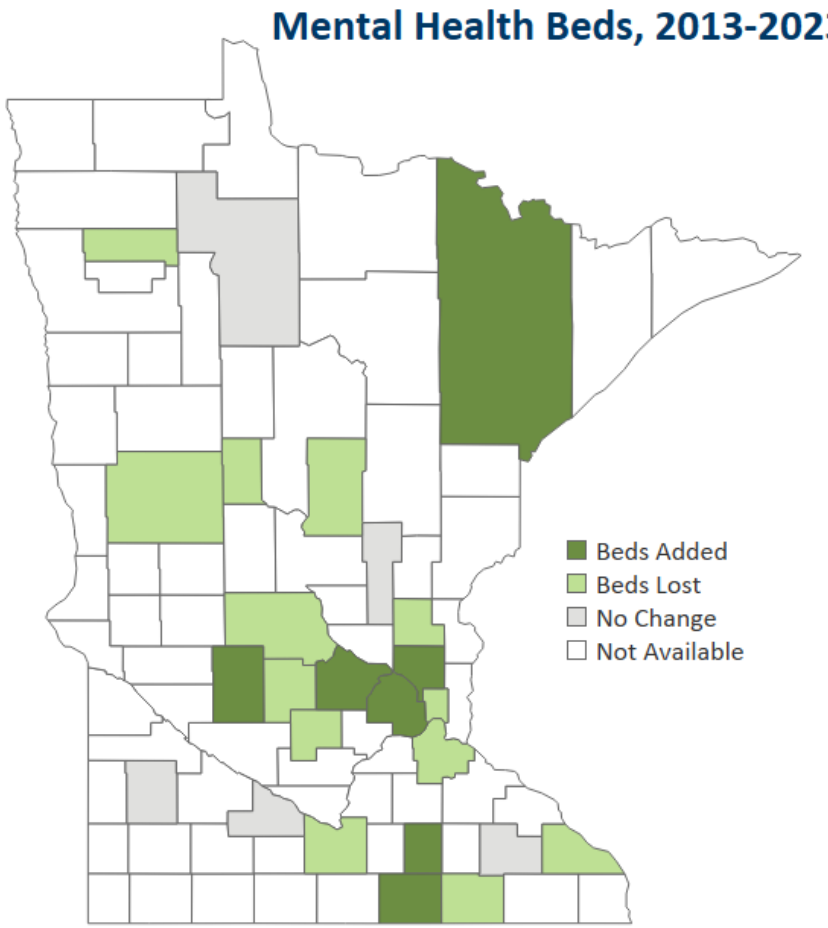
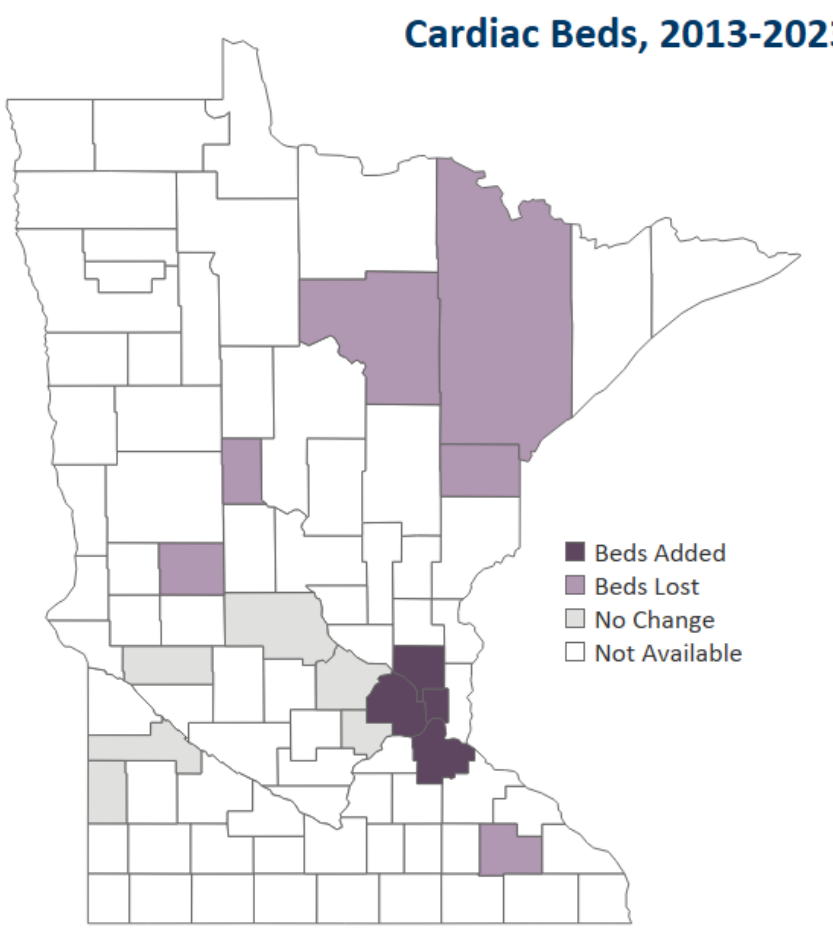
# Other counties had changes in cardiac and mental health beds from 2013 to 2023




Statewide between 2013 and 2023*:

- 80 mental health beds were *lost.*
- 51 cardiac beds were *added.*

Source: MDH Health Economics Program analysis of hospital annual reports, September 2024; 2023 data is considered preliminary and includes planned mental health bed closures for Otter Tail County and Todd County in 2024. In addition, there was a closure of a 17-bed inpatient rehabilitation unit in Beltrami County in 2024. For more information on hospital closures, please visit the following MDH website: Health Regulation Division: Public Hearings - MN Dept. of Health (state.mn.us)

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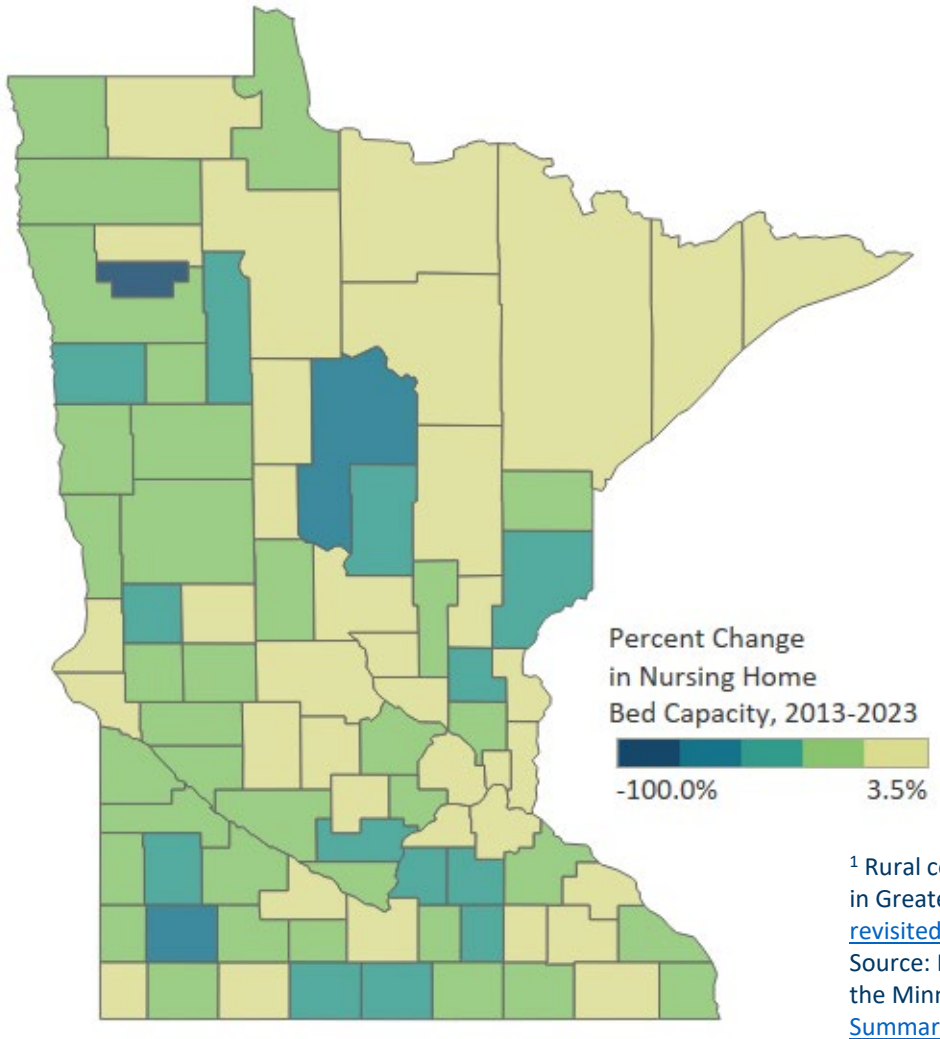
# The relative decline in nursing homes and nursing home beds was greater in rural Minnesota between 2013 and 2023




- Rural counties[1] have about one third (32.7%) of all nursing homes but accounted for most closed nursing homes in the state (55.9%) between 2013 and 2023.
- In total, rural counties[1] lost 19 nursing homes, and had 23.6% decline in nursing home beds.
- There was an overall reduction of 7,600 nursing home beds in 2023 compared to 2010, with alternative options for long-term care, including home care and assisted living becoming more common.

[1] Rural counties are those that are either entirely rural, or a rural/town mix (49 counties), as defined by the Minnesota Population Center in Greater Minnesota: Refined and Revisited (https://mn.gov/admin/demography/reports-resources/greater-mn-refined-and-revisited.jsp), page 33.

Source: Minnesota Department of Health, Health Economics Program analysis of 2013 and 2023 nursing facility counts and capacity from the Minnesota Department of Health, Health Regulation Division.

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# Health Care Use in Rural Minnesota

What is the health status of people in rural Minnesota?
What are the barriers they face to receiving health services, and what are their health outcomes?

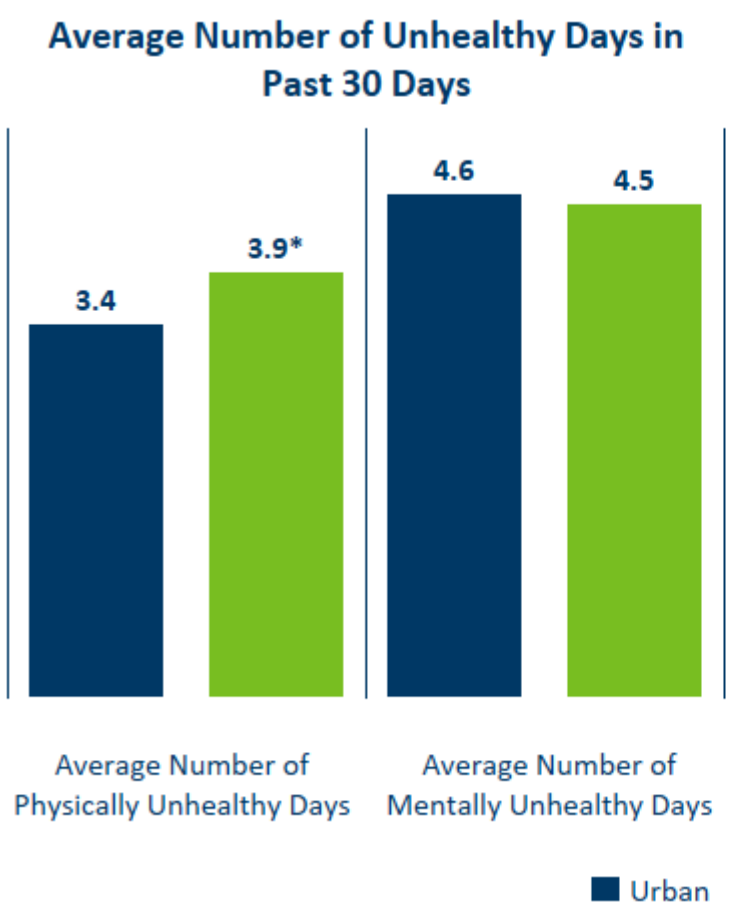
# Key points – Health care access and use

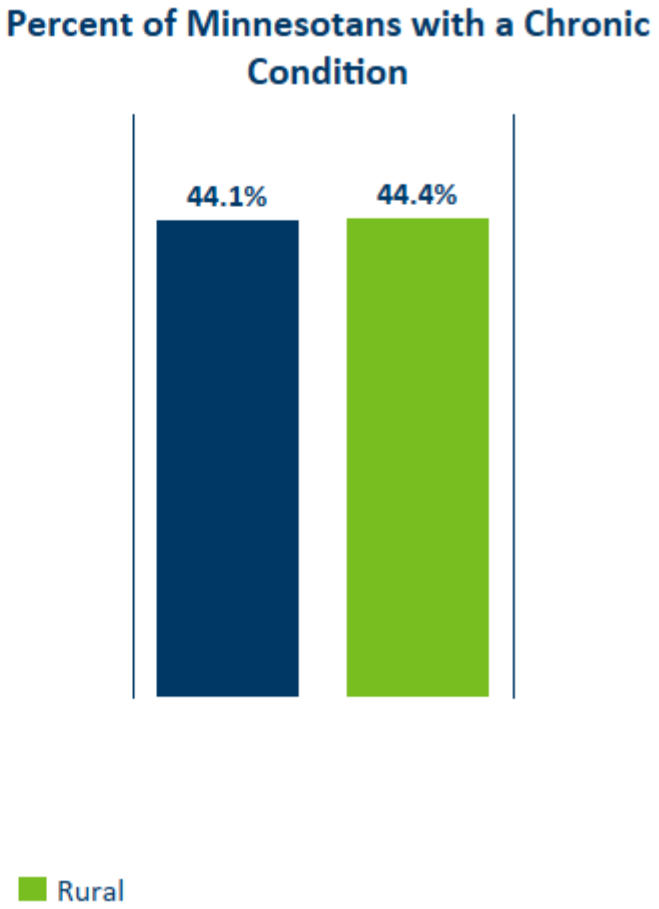
- Rural and urban Minnesotans report similar health status, but rural Minnesotans experience higher rates of suicide.
- Rural Minnesotans have to travel farther to receive inpatient health care services – especially mental health and obstetrics services.
- Rural Minnesotans are more likely to have problems getting appointments with primary care providers when needed and finding dentists accepting new patients.
- Primary care providers work to fill “gaps” in care, especially in mental health, obstetrics, and pediatric care.
- Rates of adolescent mental health screening are lower in rural areas.

# How Minnesotans access health care services

- Most Minnesotans – 96.0% – use health insurance to help pay for health care services.
- Even with health insurance to help cover costs, many Minnesotans still face substantial health care costs – 16.6% of Minnesotans struggle with medical bills, and 20.2% forgo needed health care due to cost.
- Minnesotans in rural areas were less likely to have telephone or video visits with providers in 2023.

# Rural and urban residents report about the same number of unhealthy days



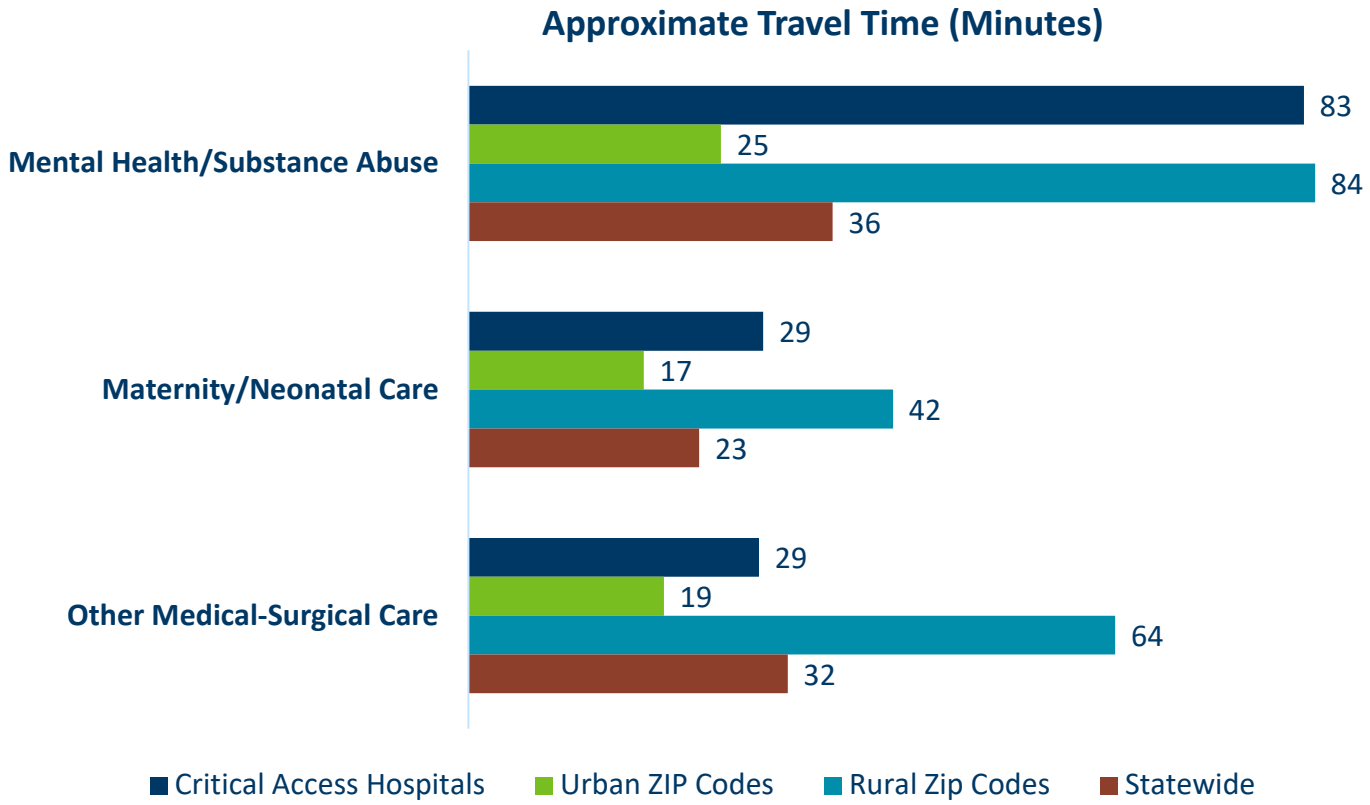




- Minnesotans living in rural areas reported frequent mental distress at about the same rate (13.6%) as those living in urban areas (13.7%).[1]
- Age-adjusted suicide rate in rural counties of Minnesota have been higher in 2023 with over 16 per 100,000 vs. a rate of 13.1 in urban non-metro and 11.8 Twin Cities Metro counties, respectively.[2]

[1] Source: Minnesota Health Access Survey, 2023. Urban and Rural defined based on RUCA zip-code approximations. Difference was not statistically significant at the 95% level. Differences in unhealthy days and chronic conditions were not statistically significant at the 95% level.
[2] Source: Minnesota Department of Health Injury and Violence Prevention Section. July 2024. Data Brief: Suicide Up in 2022, Down in 2023. Accessed on October 21, 2024 from https://www.health.state.mn.us/communities/suicide/documents/2023suicidedatabrief.pdf.
Summary of Slide

# Minnesotans in Rural Areas have to travel longer to get inpatient services – especially mental health services

- Rural patients seeking inpatient mental health and chemical dependency treatment travel more than three times longer than urban patients.
- Patients receiving medical/ surgical care at Critical Access Hospitals experience shorter travel times than those traveling to other types of hospitals.

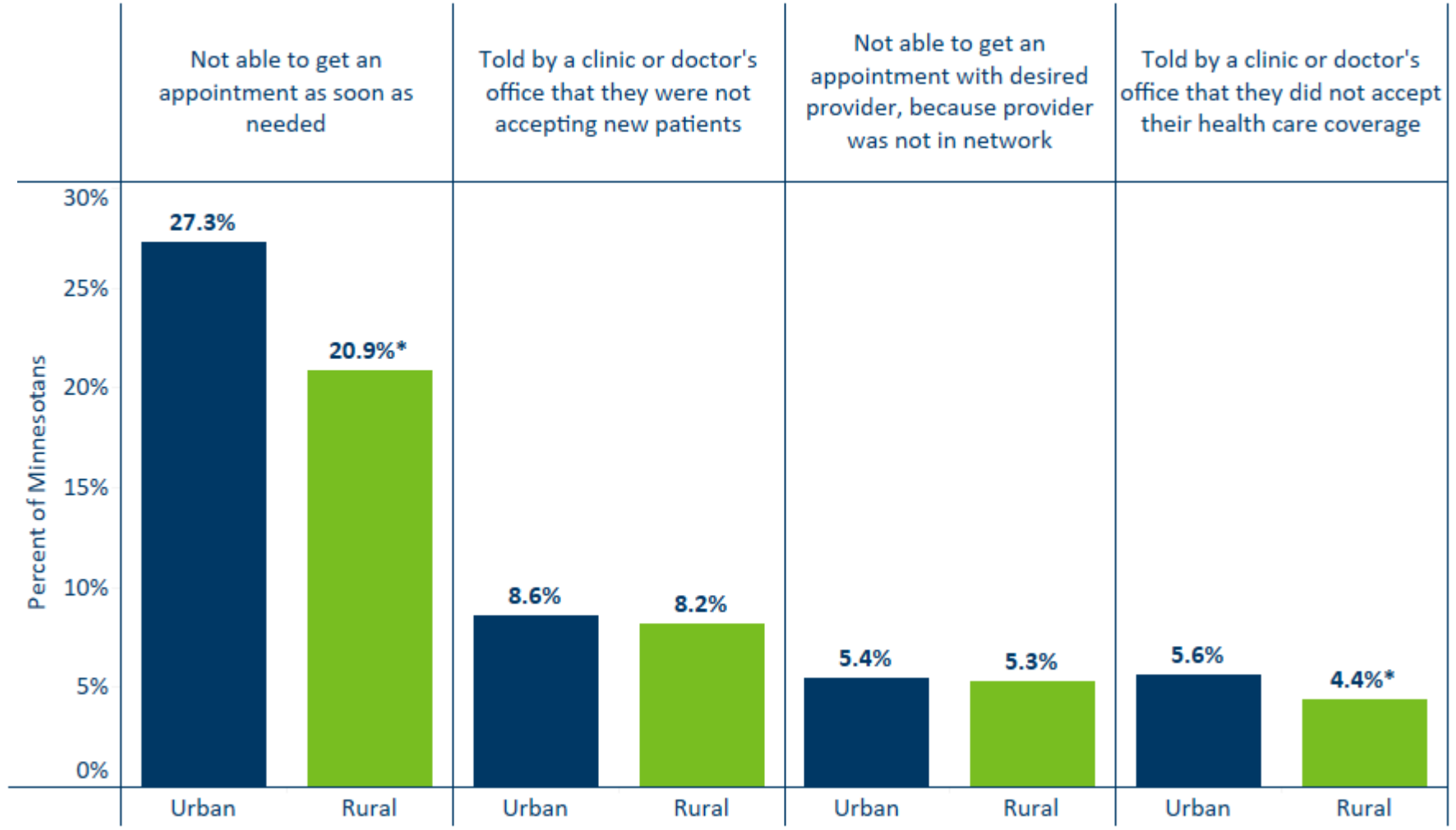



Source: MDH analysis of Minnesota hospital discharge inpatient records for medical-surgical care, obstetrics care, and mental health or chemical dependency care occurring in calendar years 2020-2022. The analysis calculated the distance between the geographic centroid of each ZIP code to respective hospitals and excluded hospital stays that were transferred to another hospital to avoid duplication. Patients with planned services, such as surgeries, may intentionally travel longer distances. Non-metropolitan ZIP codes are classified as 'rural' using RUCA.

Summary of Slide

# Rural Minnesotans have similar or better access to clinical providers than those living in urban areas

- 21% of rural Minnesotans could not see a provider as soon as needed.
- Issues with providers not being in network and being told that doctor/clinic were not accepting new patients were similar for urban and rural Minnesotans.

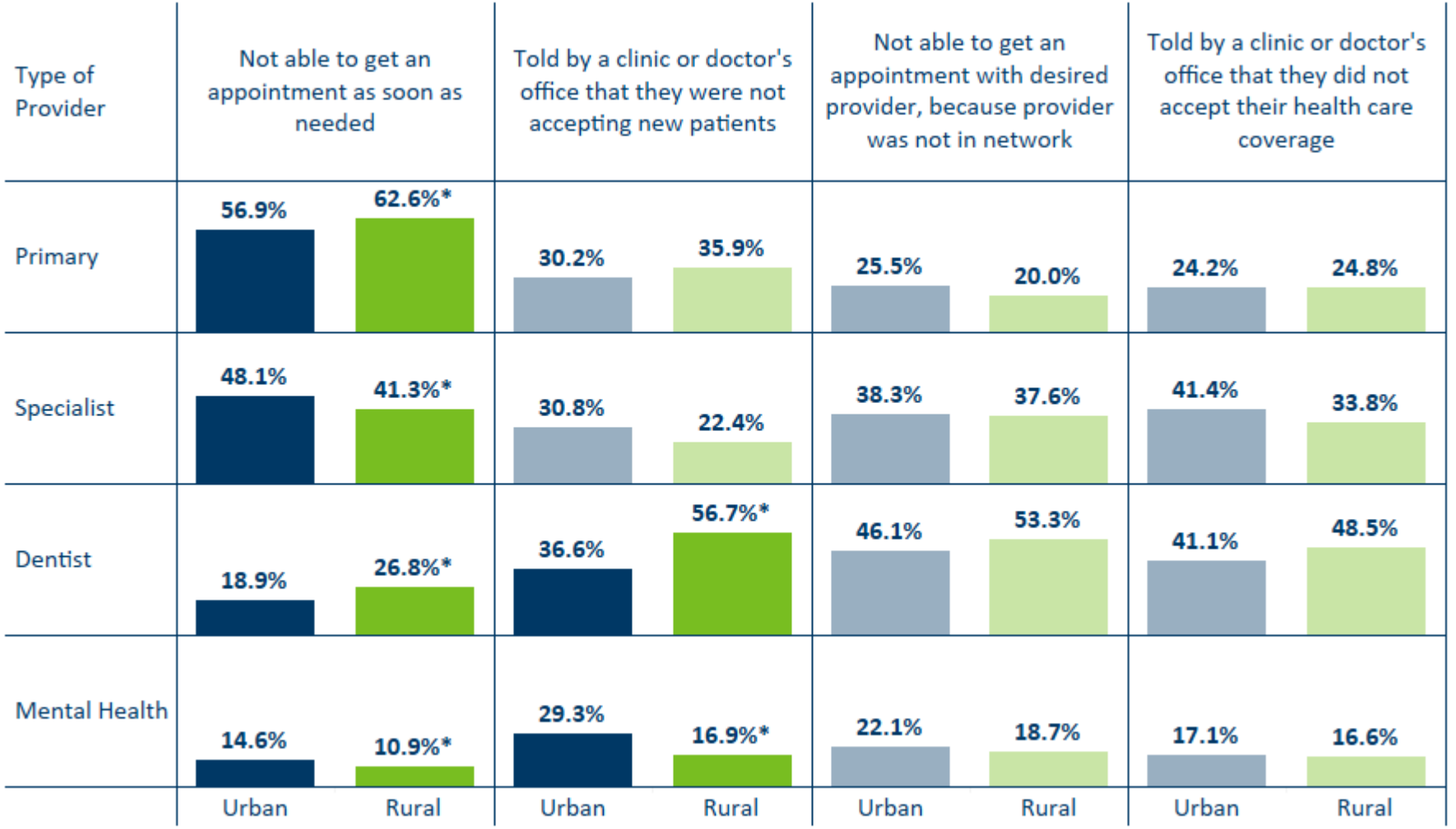



Source: Minnesota Health Access Survey, 2023.
*Indicates significant difference from Urban at the 95% level.
Urban and Rural defined based on RUCA zip-code approximations.
Summary of Slide

# People in rural Minnesota had the most trouble getting primary care appointments as soon as they were needed

Among those who weren't able to get an appointment as soon as needed: Rural Minnesotans were more likely to say they couldn't get an appointment with a primary care provider or a dentist.

Rural Minnesotans also had more problems finding dentists that were accepting new patients.

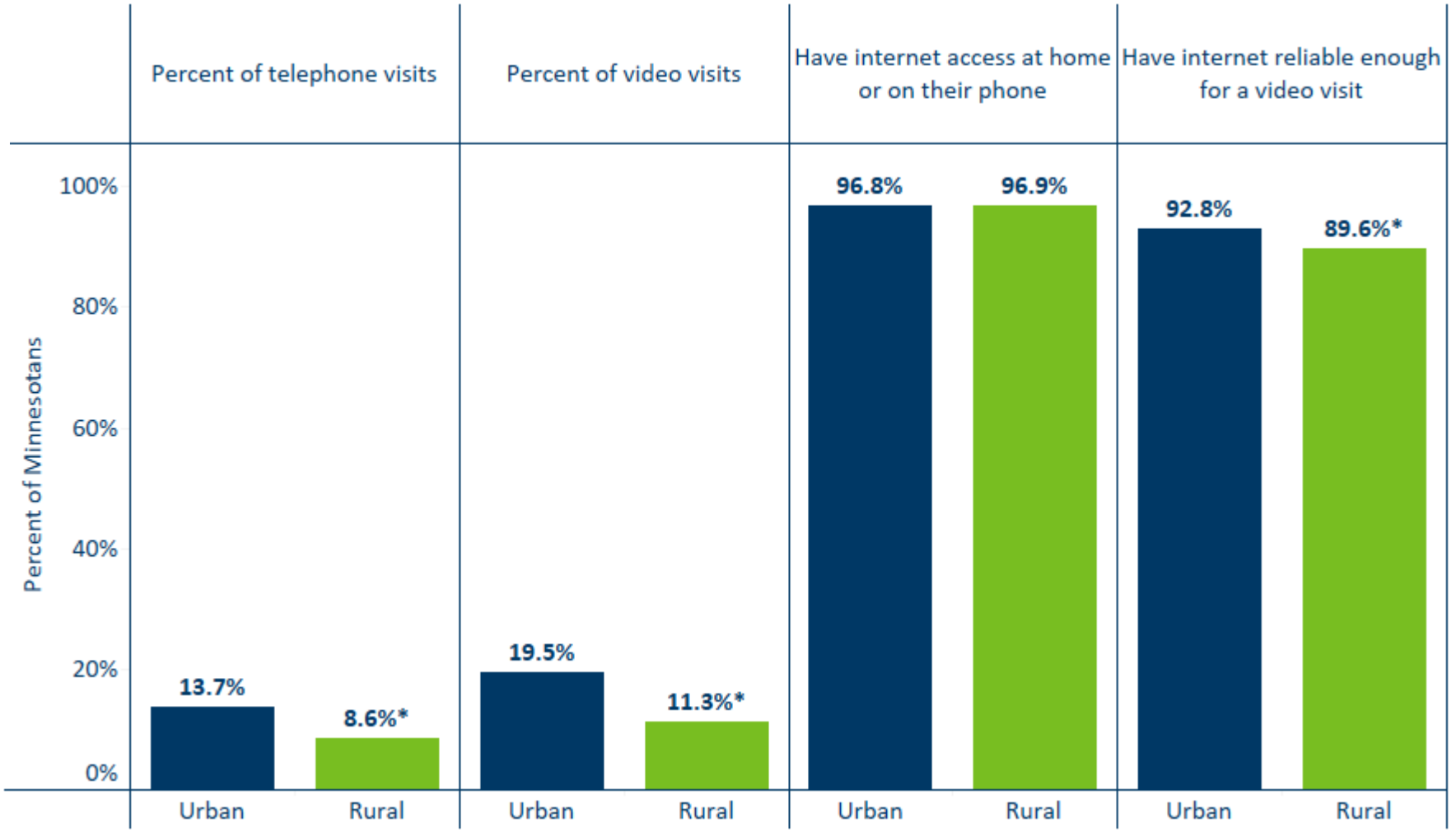



Source: Minnesota Health Access Survey, 2023.
*Indicates significant difference from Urban at the 95% level.
Percentages for Type of Provider do not sum to 100 because respondents were able to select more than one type of provider. Urban and Rural defined based on RUCA zip-code approximations.

Summary of Slide

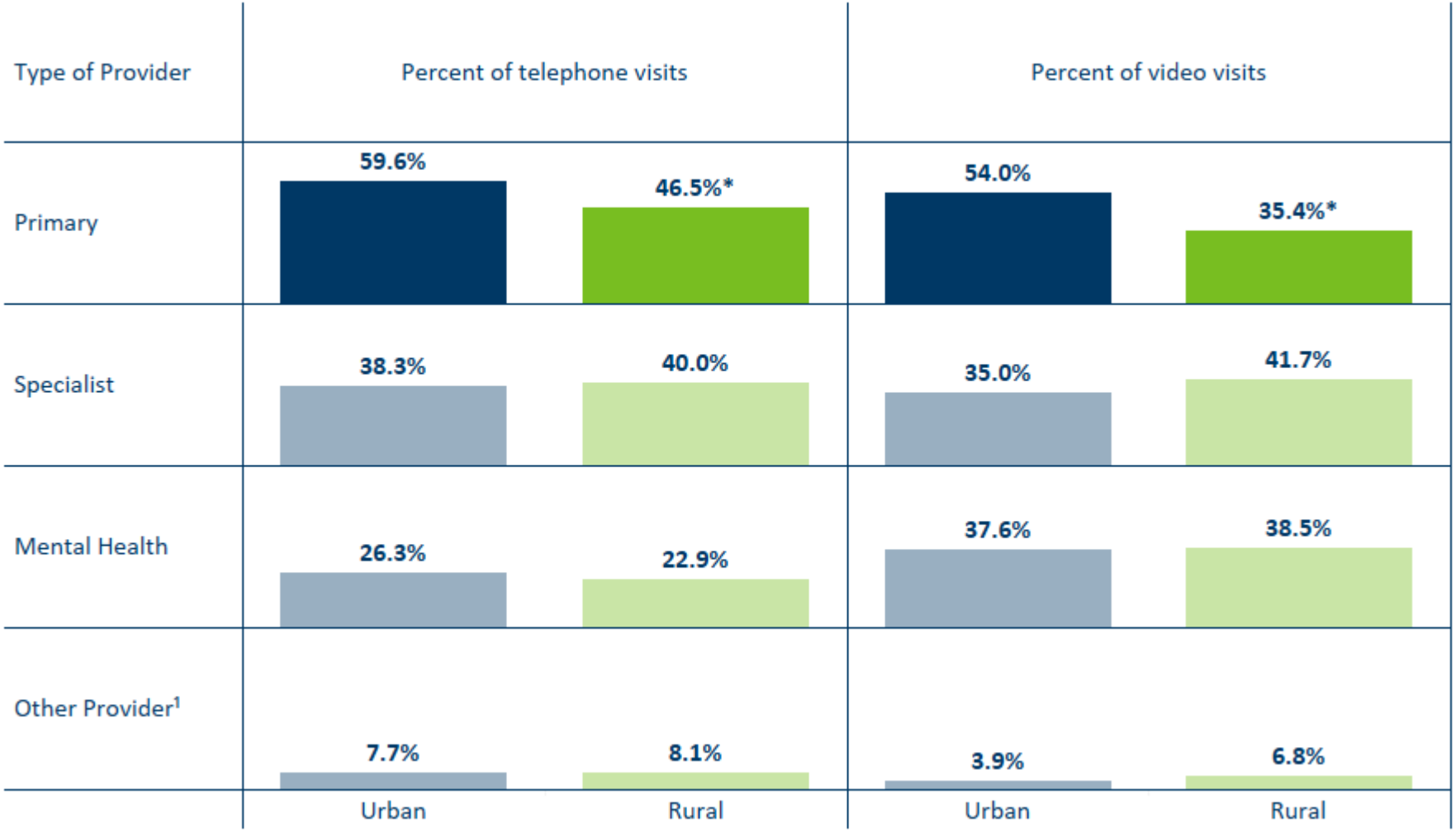
# Rural Minnesotans had lower telehealth use

- Rural Minnesotans had lower utilization of both phone and video visits.
- One in ten rural Minnesotans lack internet reliable enough to use for a video visit.




Source: Minnesota Health Access Survey, 2023.
*Indicates significant difference from Urban at the 95% level.
Urban and Rural defined based on RUCA zip-code approximations.
Summary of Slide

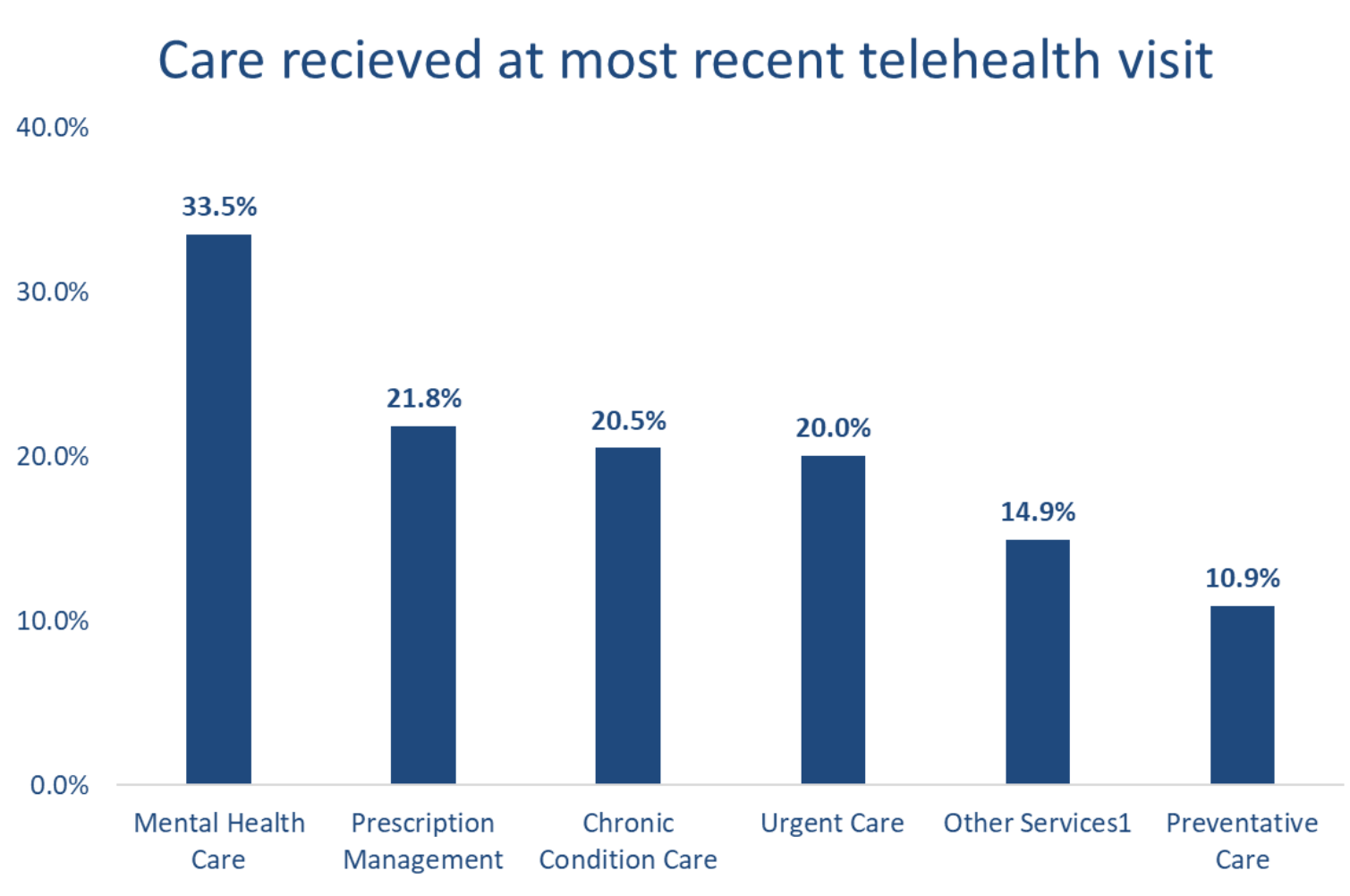
# Most telehealth visits in the state were to primary care providers




- Mental health visits made up a higher percentage of video visits than phone visits.
- Most people would do a telehealth visit again.
  - 81.4% for phone visits
  - 85.0% for video visits
  - This was similar for urban and rural respondents.

Source: Minnesota Health Access Survey, 2023.
*Indicates significant difference from Urban at the 95% level.
1 Other providers include dentists, alternative medicine providers, emergency rooms/urgent cares or COVID testing sites.
Percentages for Type of Provider do not sum to 100 because respondents were able to select more than one type of provider.
Urban and Rural defined based on RUCA zip-code approximations.
Summary of Slide

# Most recent telehealth visits in the state were for mental health care in 2023

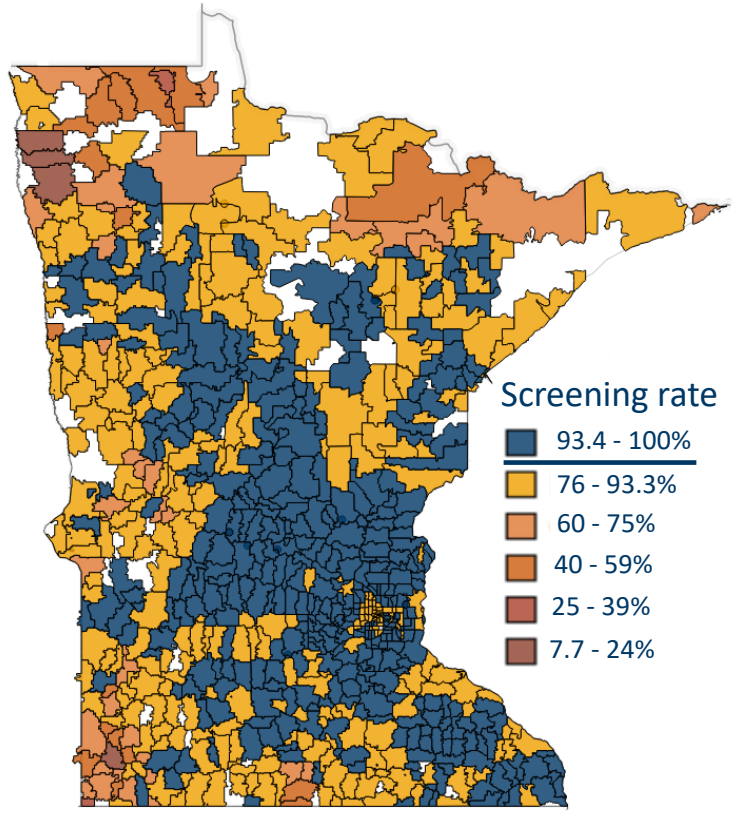



- Tele-mental health visits were a lower proportion of telehealth use in Greater Minnesota than the Twin Cities Metro (24.4%).
- Most people would do a telehealth visit again.
  - 81.4% for phone visits
  - 85.0% for video visits
  - This was similar for urban and rural respondents.

Source: Minnesota Telehealth Access Survey, 2023.
1 Other services include behavioral health care, prenatal care, in-hospital care, and emergency care.
Percentages for care received do not sum to 100 because respondents were able to select more than one type of care.
Summary of Slide

# Fewer adolescent patients in rural areas are screened for mental health or depression problems, with rates improving slightly

## Adolescent Mental Health Screening Rate by Patient Zip Code, 2023




| Geography | 2022 Screening Rate | 2023 Screening Rate |
|---|---|---|
| Urban | 93.3% | 94.1% |
| Rural | 89.6% | 90.8% |
| **Statewide** | **92.5%** | **93.4%** |

- Screening has *increased* over time in both urban and rural areas
- Rural adolescents are still less likely to be screened
- Half of all mental health conditions begin by age 14.[1]
- Early treatment may lead to better outcomes in the long term.

[1] Kessler, et al. "Lifetime Prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication." Arch Gen Psychiatry, 2005 Jun; 62(6): 593-602.

Source: MDH Health Economics Program analysis of Adolescent Mental Health and/or Depression Screening data from the Minnesota Statewide Quality Reporting and Measurement System. Based on adolescent patients aged 12-17 who had at least one telehealth or face-to-face well-child visit in a Minnesota clinic. White areas on the map had fewer than five patients for this measure.

US Preventive Services Task Force recommends mental health screening for all adolescents (see: Final Recommendation Statement: Depression in Children and Adolescents: Screening (2016), U.S. Preventive Services Task Force).

Summary of Slide

DEPARTMENT OF HEALTH

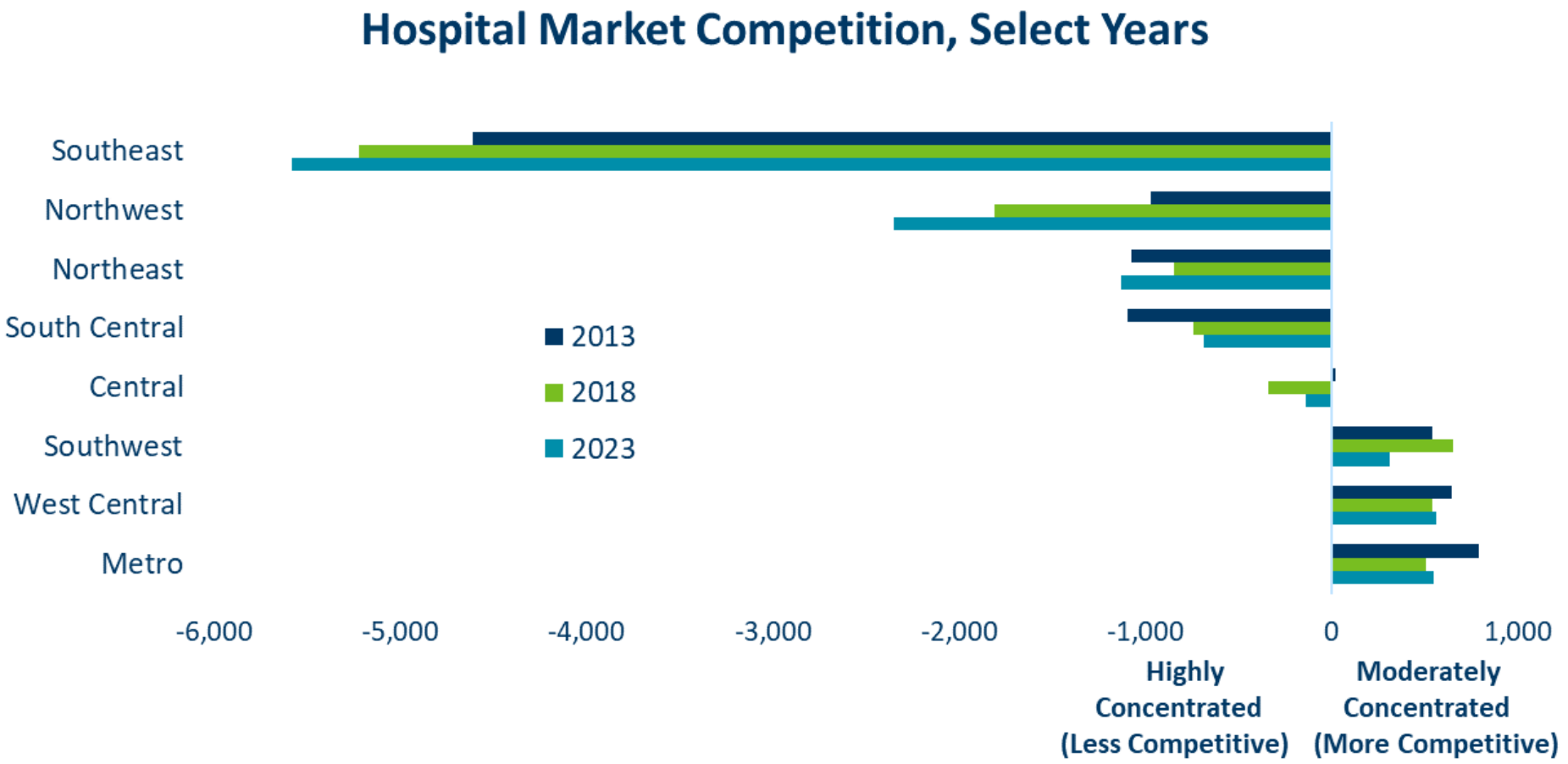
# Financing

What level of competition do we see among rural health care providers?
Do we pay more for health care different in rural areas? How are providers doing financially?

# Key points – Health care financing

- More and more rural hospitals are affiliated with larger hospital and provider systems.
- CAH status has been associated with higher net incomes for hospitals.
- Rural residents experience higher monthly cost sharing as compared to their urban counterparts for commercial insurance and Medicare.
- Isolated rural hospitals provider higher levels of community benefit relative to operating expenses.
- Community benefit in rural hospitals is more focused on keeping services available than providing charity care.

# Many hospital markets in Minnesota are not competitive

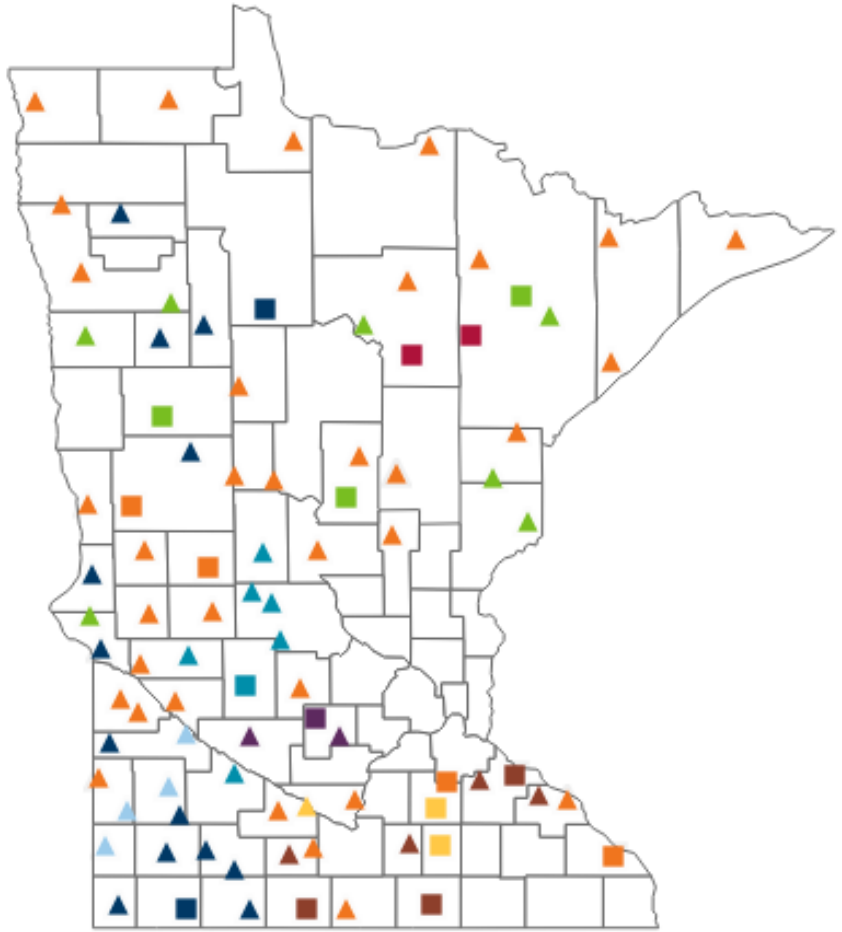



- Market concentration can lead to higher prices.
- Three out of eight regions had moderately concentrated markets in 2023.

Source: MDH/Health Economics Program calculation of Herfindahl-Hirschman competition (HHI) index based on net patient revenue from Hospital Annual Report Data, October 2024. Data from 2023 is considered preliminary. Values in chart are subtracted from 2,500, or a highly concentrated market; positive values indicate a competitive market, negative values indicate a concentrated market. For more information on this index, visit the US Department of Justice website at www.justice.gov/atr/herfindahl-hirschman-index. SCHSAC Regions are defined on slide 5.

Summary of Slide

# Over half of Minnesota's rural hospitals were affiliated with a larger provider group in 2023



| | Hospitals | Available Beds |
|---|---|---|
| Sanford Health | 15 | 389 |
| Essentia Health | 10 | 336 |
| Mayo Clinic | 7 | 229 |
| CentraCare Health System | 7 | 189 |
| Avera Health | 4 | 105 |
| Catholic Health Initiatives | 4 | 90 |
| Allina Health System | 3 | 109 |
| HealthPartners, Inc./Park Nicollet Health Services | 3 | 77 |
| M Health Fairview | 2 | 114 |
| Unaffiliated or Single Rural Hospital in Hospital System | 35 | 843 |
| **Total** | **90** | **2,481** |

▲ **Critical Access Hospital** ■ **Non-Critical Access Hospital**

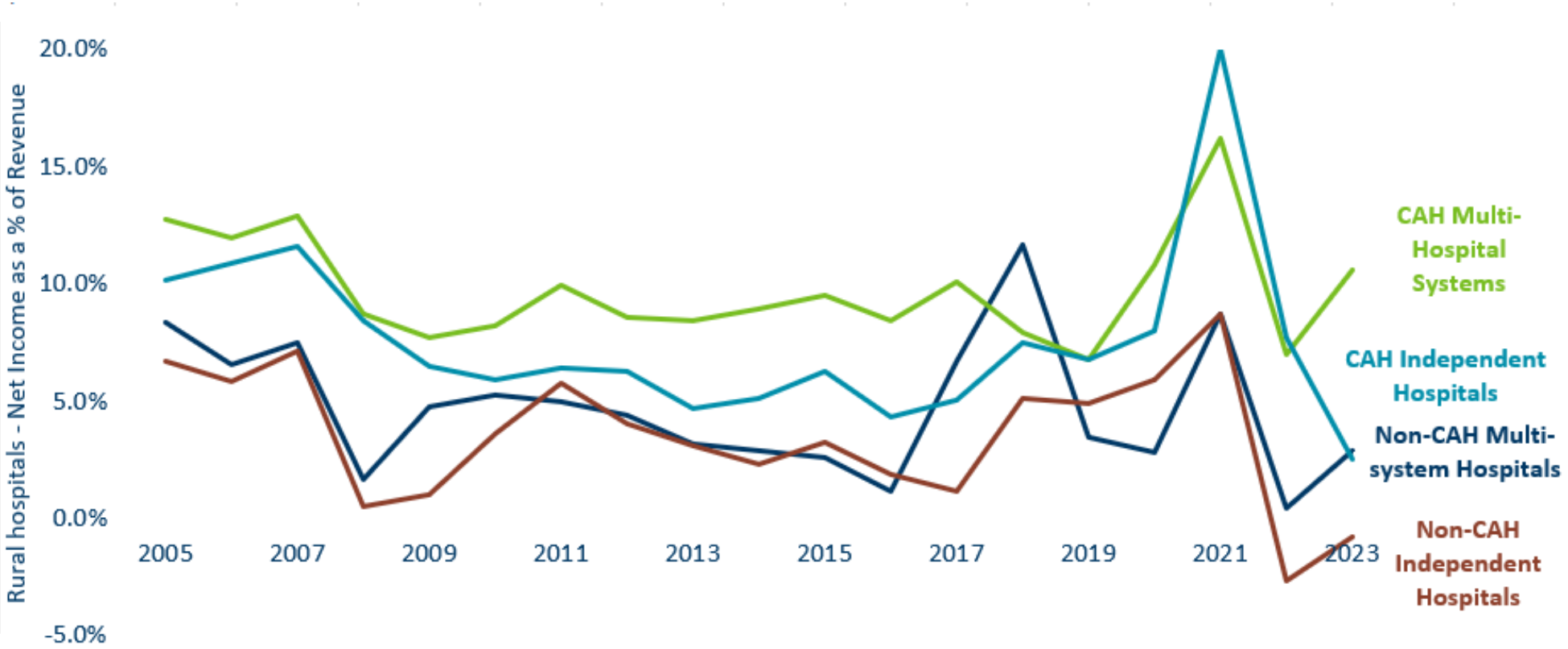
Hospitals that are part of larger systems:

- May offer increased access to specialty services only available in urban areas.
- May increase financial viability.
- Lead to consolidation of services to fewer hospitals, meaning some services may be less available in rural areas.

Hospitals are classified based on RUCA zip code. Health care systems are ordered by total number of hospitals in descending order. Data does not include urban hospitals. Locations are plotted by zip code and may not be exact.
Source: MDH Health Economics Program analysis of hospital annual reports, October 2024. Data from 2023 is preliminary.
Summary of Slide

# Of rural hospitals, Critical Access Hospitals have higher net income as a percent of revenue

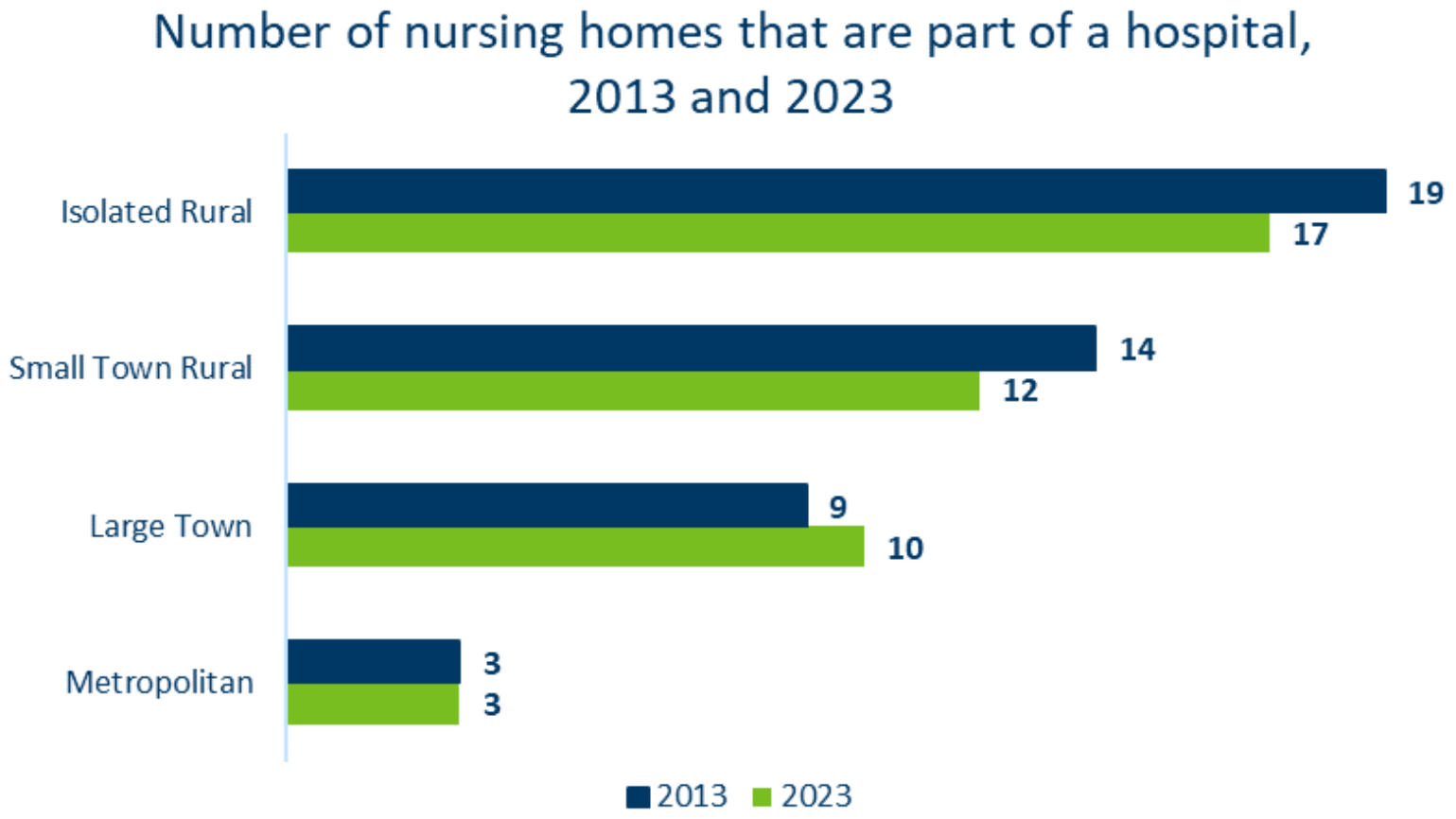
- All rural hospitals saw an increase in net income as percent of revenue in 2021, likely due to COVID-19 funding.
- CAHs had higher percentages of net income than non-CAHs for most years since 2005.




Note: Does not include urban hospitals. Data from 2023 is preliminary.
Source: MDH Health Economics Program analysis of hospital annual reports, October 2024.
Summary of Slide

# Certain rural areas have seen small declines in nursing homes attached to hospitals in the past 10 years

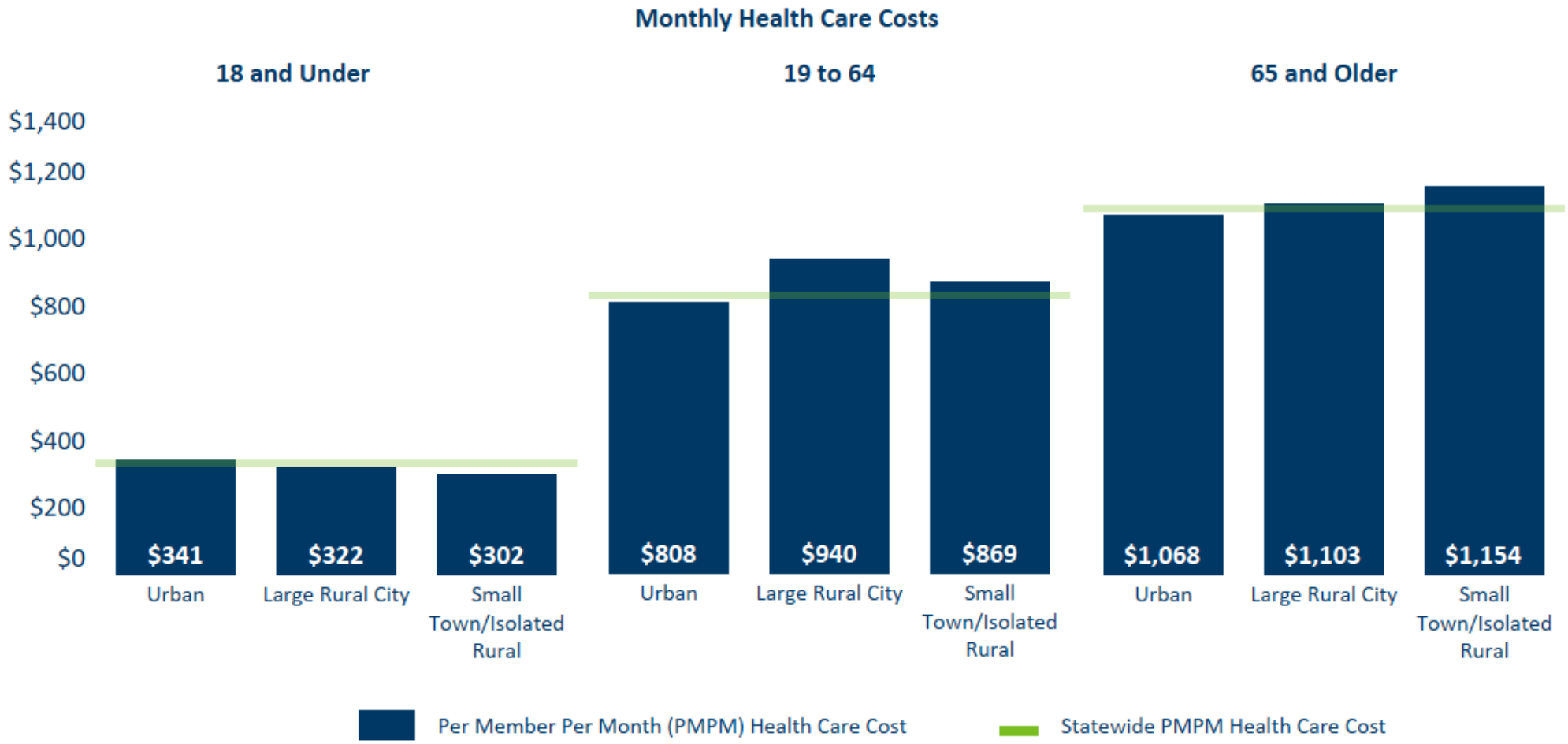
- Fewer urban hospitals have attached nursing homes.
- Having nursing home services attached to hospitals may lead to more days at home for patients.
- However, it may cause financial strain for hospitals if nursing homes are operating at low capacity.




Note: Data from 2023 is preliminary, numbers are based on charges for nursing homes reported by hospitals. Urban and Rural defined based on RUCA zip code designation.
Source: MDH Health Economics Program analysis of hospital annual reports, October 2024.

Summary of Slide

# Monthly health care costs are higher in rural areas for adults, lower for children



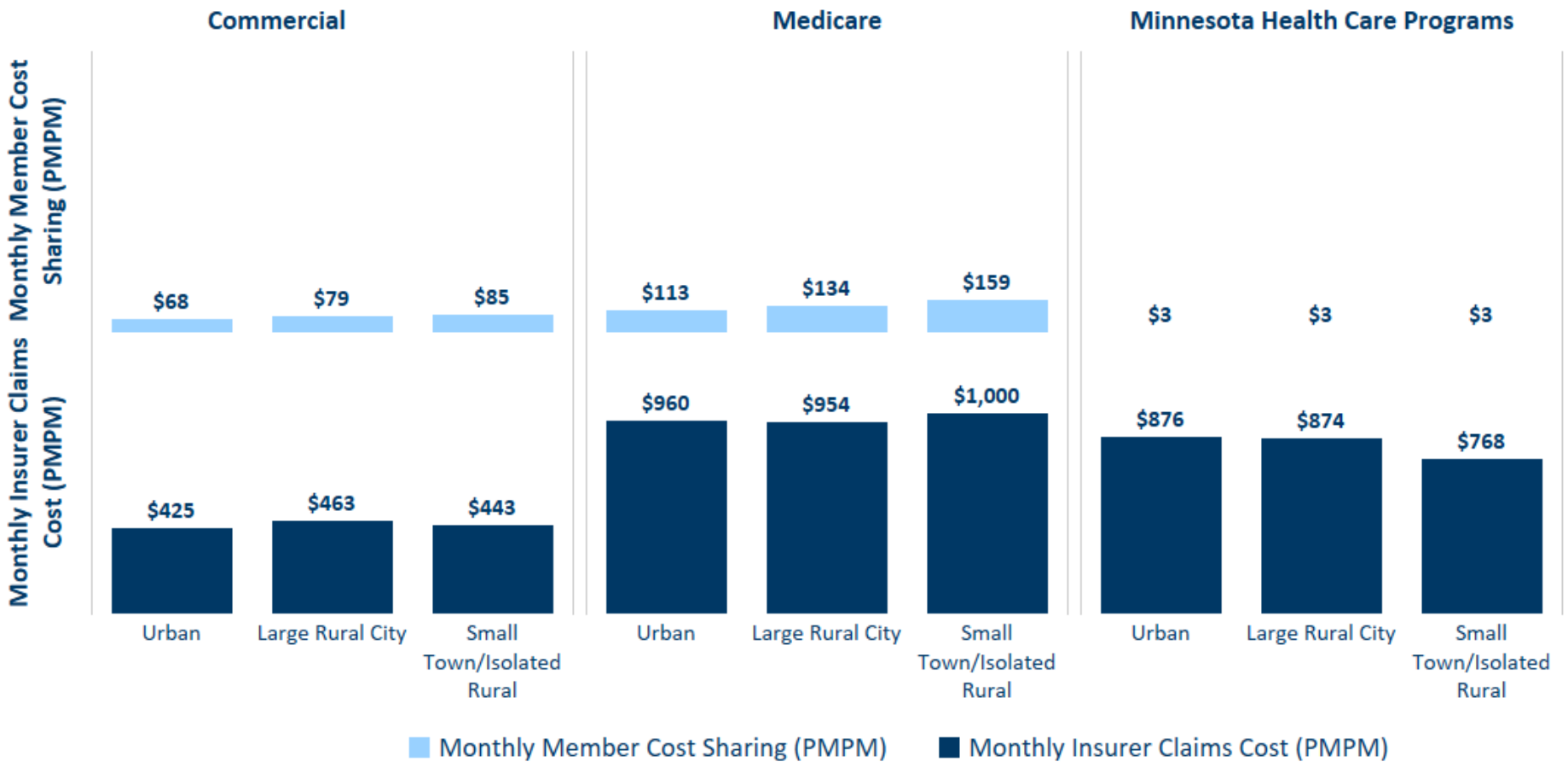

Source: MDH Health Economics Program analysis of All Payer Claims Database Public Use Files - Member (2020). Small town rural and isolated rural are combined. Monthly health care costs are based on total dollars spent divided by number of months with enrollment across all types of coverage. For more information on the MNAPCD, or to get data: https://www.health.state.mn.us/data/apcd.

Summary of Slide

# Minnesotans in rural areas experience higher monthly cost sharing for commercial insurance

Higher member cost sharing in rural areas could be related to:

- Provider network differences.
- Health status differences.
- Different available health plan options.

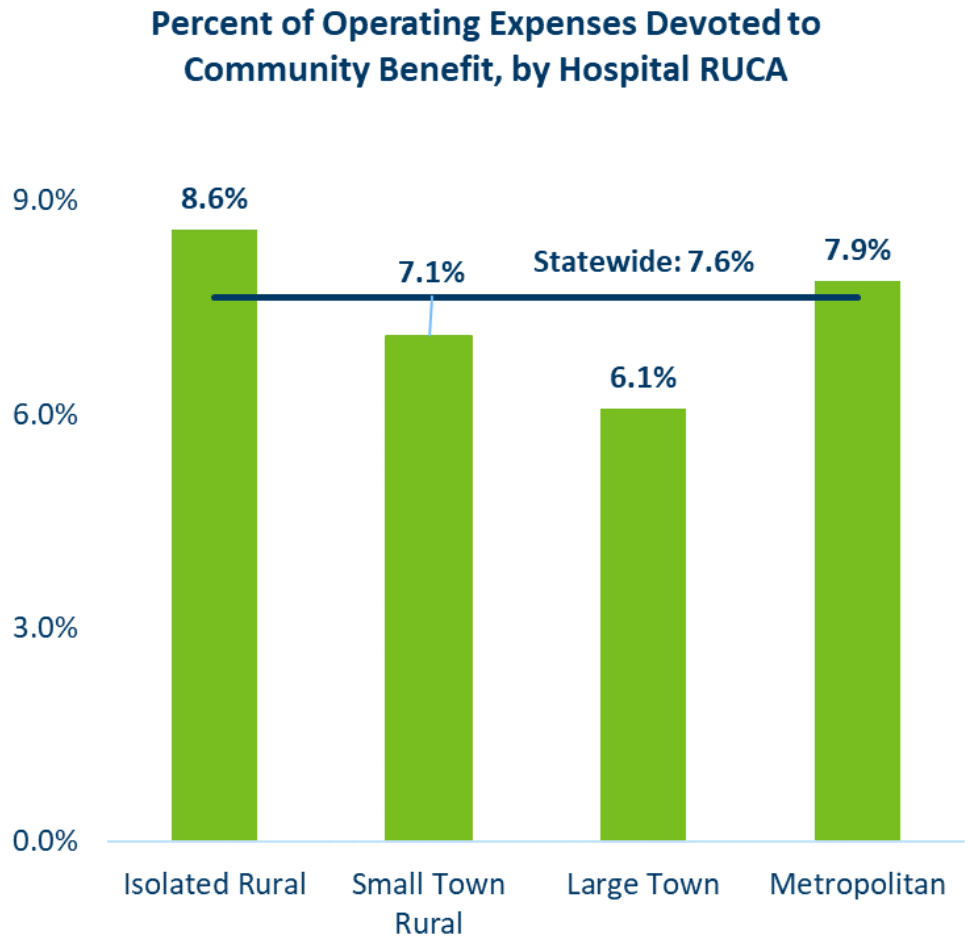



Source: MDH Health Economics Program analysis of All Payer Claims Database Public Use Files - Member (2020). Small town rural and isolated rural are combined. Monthly claims costs are based on payments made by insurers for health care services received by members divided by number of months with enrollment in that type of coverage; monthly member cost sharing is based on cost sharing (deductible, copayment or coinsurance) that was expected to be paid by member for health care services received divided by number of months with enrollment. For more information on the MNAPCD, or to get data: https://www.health.state.mn.us/data/apcd.

Summary of Slide

# Isolated rural hospitals devote a larger percentage of operating expenses to community benefit

- Non-profit hospitals provide community benefit as part of their tax-exempt status.
- Community benefit spending can be categorized into four broad categories:
  - Direct patient care or unreimbursed services
  - Research and education
  - Financial and in-kind contributions
  - Community activities
- Most community benefit is in the “direct patient care” category.



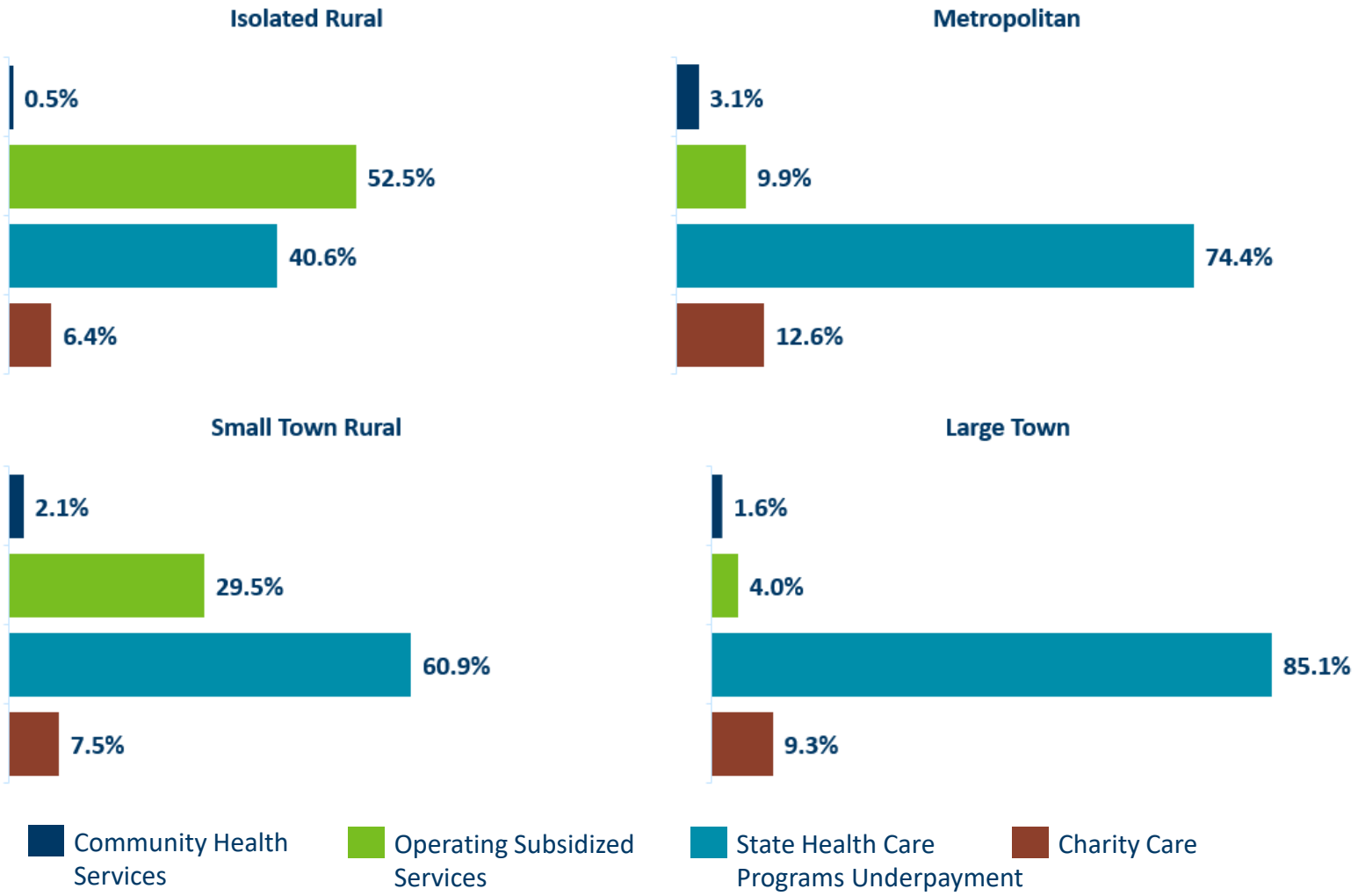

Source: MDH, Health Economics Program analysis of preliminary 2023 Hospital Annual Reports, October 2024.
Summary of Slide

# Rural hospitals rely more on Medicare revenue than their urban counterparts

| | Critical Access Hospitals | | Rural, Non-Critical Access Hospitals | | Statewide Community Hospitals | |
|---|---|---|---|---|---|---|
| | 2013 | 2023[1] | 2013 | 2023[1] | 2013 | 2023[1] |
| **Medicare** | 42.2% | 47.0% | 36.2% | 36.4% | 31.0% | 34.2% |
| **State Public Programs[2]** | 9.7% | 11.7% | 10.7% | 12.0% | 12.1% | 14.3% |
| **Private Insurance** | 42.3% | 36.3% | 48.0% | 45.6% | 51.7% | 47.3% |
| **Self-Pay** | 3.8% | 2.2% | 3.5% | 2.9% | 3.3% | 2.5% |
| **Other Payers** | 2.0% | 2.7% | 1.6% | 3.1% | 2.0% | 1.7% |
| **Hospital Patient Revenue, All Payers** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

[1]2023 data is preliminary.
[2]Includes Medical Assistance and MinnesotaCare.
Percent shown is a percent of Hospital Patient revenue. Totals may not sum to 100% due to rounding.
Source: MDH Health Economics Program analysis of hospital annual reports, October 2024.
Summary of Slide

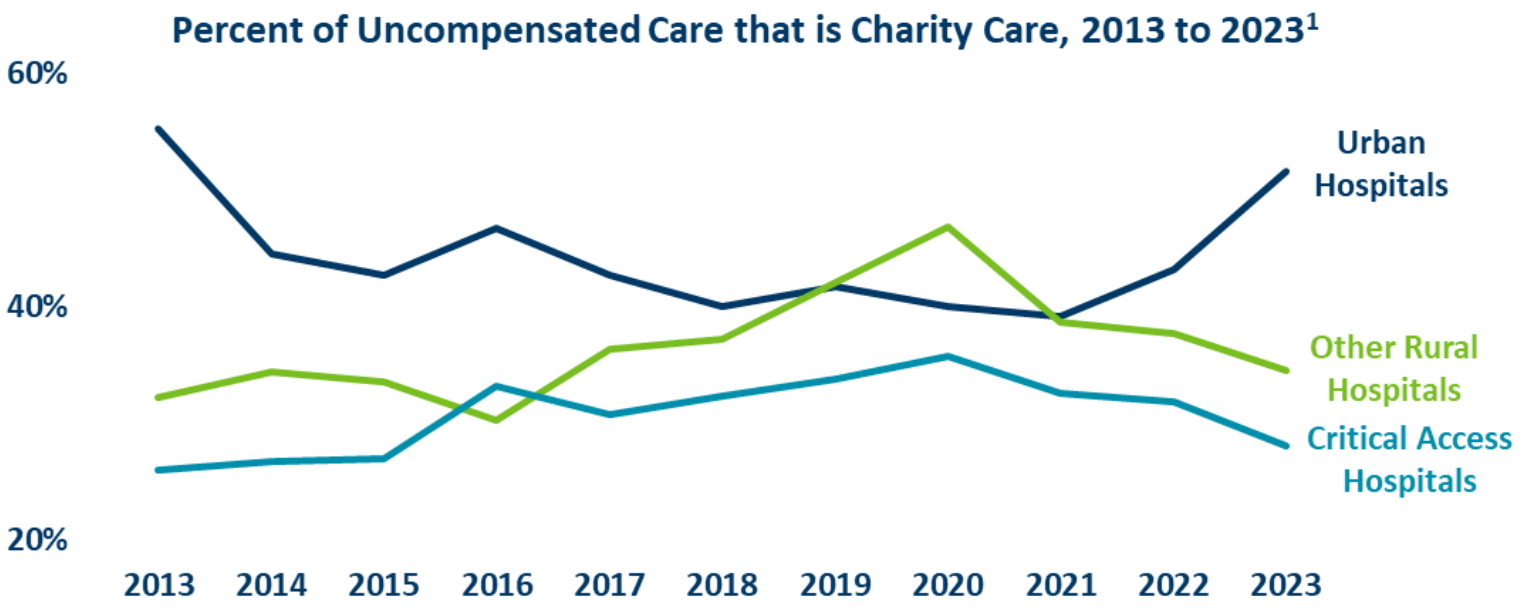
# Community benefit for direct patient care is different across the state




- Isolated rural areas focus on operating subsidized services – such as keeping emergency rooms open and staffed.
- State health care programs underpayment – the difference between the cost of care provided to state program patients and the actual payment received – are greater in hospitals located in metropolitan areas, large towns, and small rural towns.

Source: MDH, Health Economics Program analysis of preliminary 2023 Hospital Annual Reports, October 2024.
Summary of Slide

# Most uncompensated care in rural hospitals is bad debt


- The divide between rural and urban hospitals has increased in the past two years, due to a higher percentage of charity care at urban hospitals.
- In 2023, the percentage of uncompensated care that was charity care was higher for rural hospitals than a decade earlier.
- Bad debt is not considered community benefit.

[1]2023 data is preliminary.
Source: MDH, Health Economics Program analysis of Hospital Annual Reports, October 2024.
Summary of Slide

DEPARTMENT OF HEALTH

# Appendix of Data Sources Available Here:
https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmnsum.pdf

## Health Economics Program

www.health.mn.state.us/healtheconomics

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Phone: 651-201-4520

Publications: heppublications.web.health.state.mn.us/

Health Care Markets Chartbook:
www.health.state.mn.us/data/economics/chartbook/

## Office of Rural Health and Primary Care

www.health.state.mn.us/facilities/ruralhealth/

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Phone: 651-201-3838

Publications:
www.health.state.mn.us/data/workforce/reports.html

A summary of the charts and graphs contained within is provided at
https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmndata.pdf
Direct links are listed on each page. If you need the information in a different format, please use the contact links above.