DEPARTMENT OF HEALTH

Rural Health Care in Minnesota: Data Highlights

NOVEMBER 2025

Technical Notes

A chartbook presents statistical information on a broad range of topics and usually includes numerous graphs and charts. This document provides the alternative text for Rural Health Care in Minnesota: Data Highlights (PDF) (https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmn.pdf) and offers written explanations and summaries of the charts contained in the original chartbook.

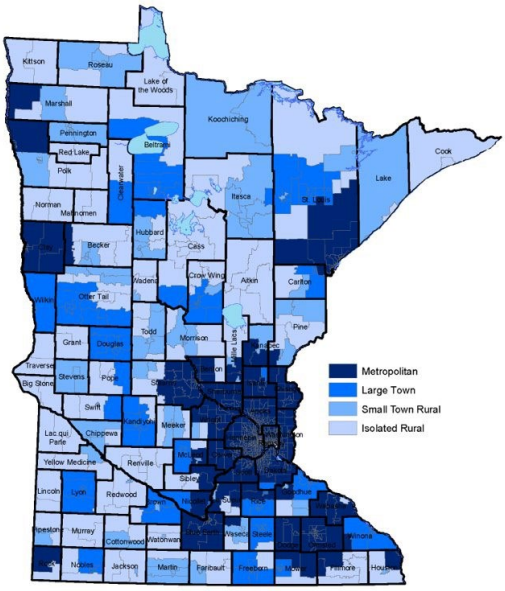
A summary of all data sources and notes are available at Data Sources Used in Rural Health Care in Minnesota: Data Highlights (PDF) (https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmnsum.pdf)

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.

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



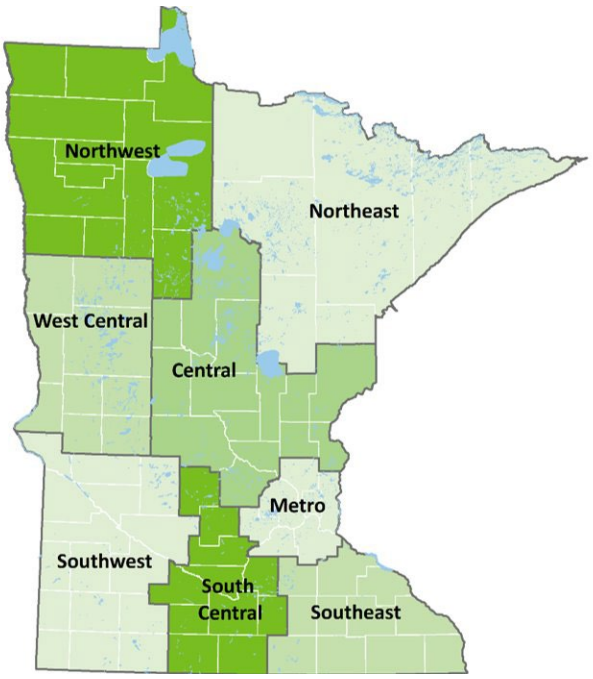
Map of the state of Minnesota divided into Rural Urban Commuting Area Codes, indicated by four different levels: Metropolitan, Large Town, Small Town Rural, and Isolated Rural.

- 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” means metropolitan; “rural” combines large town, small town rural, and isolated rural.
- RUCA codes are based on zip code unless otherwise noted each slide.

Source: Minnesota Department of Health. 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.

Defining rural: Regions

State Community Health Service Advisory Committee Regions



A map of Minnesota showing the 8 State Community Health Service Advisory Committee (SCHSAC) Regions based on groups of counties. The regions are Northwest, Northeast, West Central, Central, Metro, Southwest, South Central and Southeast.

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

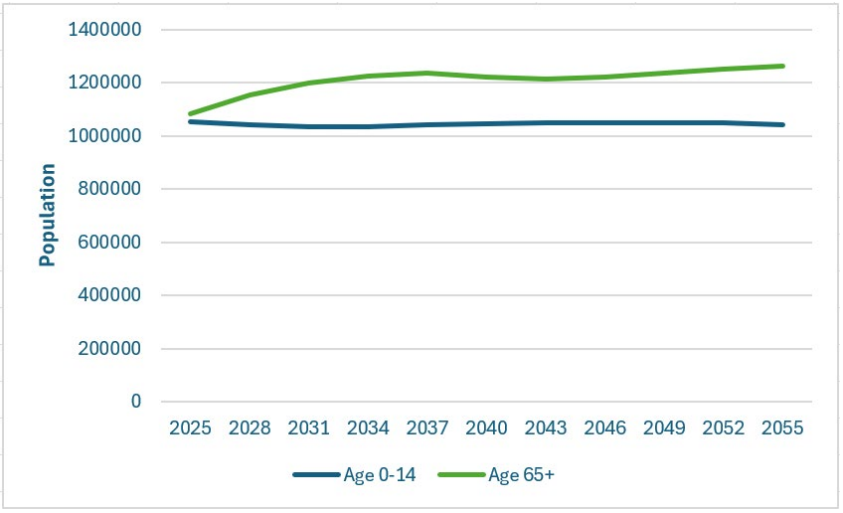
The State of Rural Health Care in Minnesota

Minnesota rural demographics

- Minnesota is projected to gain nearly 330,000 residents between 2025 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 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 will be driven by communities of color

Source: Minnesota Demographer's Office, Data by Topic: Our Projections MN State Demographic Center (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 percent) of residents of rural Minnesota counties are projected to be 65 years of age or older vs. 19% for urban counties.

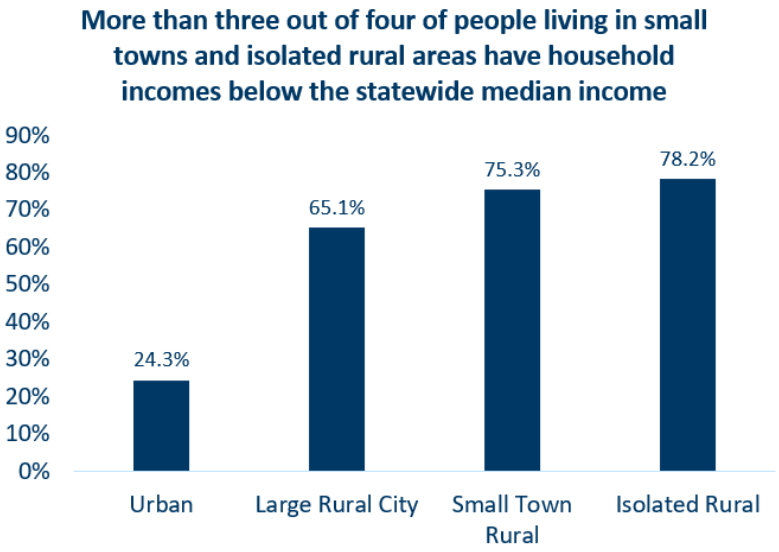
This line graph compares the growth of the population ages 0 to 14 and aged 65 or older in Minnesota between 2025, projected out to 2055; the total counts are shown with adults 65 or older projected to be 17.5% greater than children age 0-14 by 2055.

Source: Data is from Data by Topic (https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/) (vintage May 2024).

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

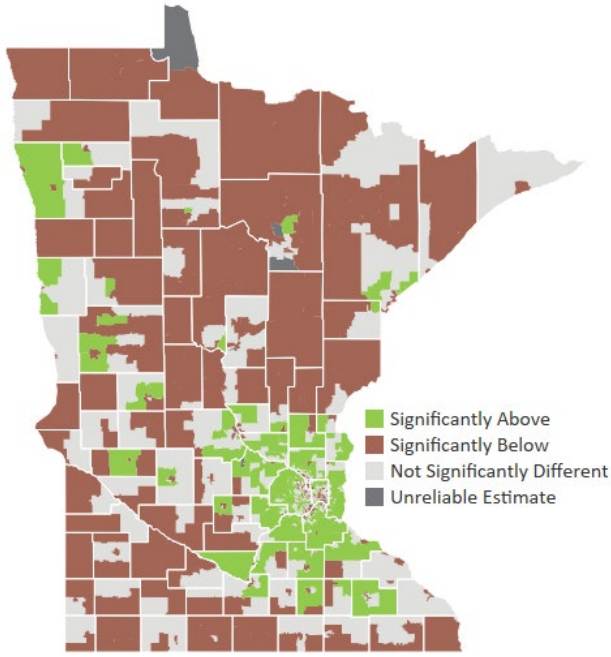
Incomes by area

More than three out of four people living in rural areas have household incomes below the statewide median income.



This bar chart shows the percent of people, by RUCA, with household incomes below the statewide median income in the 5-year period of 2018 to 2022. Urban areas have the smallest percent of people with a household income below the statewide median income (24.3%), followed by large rural city (65.1%), small town rural (75.3%) and finally isolated rural (78.2%).

Census tract



The map of Minnesota indicates, by census tract, if the median income is significantly higher, about the same, or significantly lower than the state median income.

39.1% of census tracts have median income below the statewide median – these are largely concentrated in outstate areas, or in major cities.

31.5% of census tracts have median income about the same as statewide median – these are distributed throughout the state, with no clear pattern

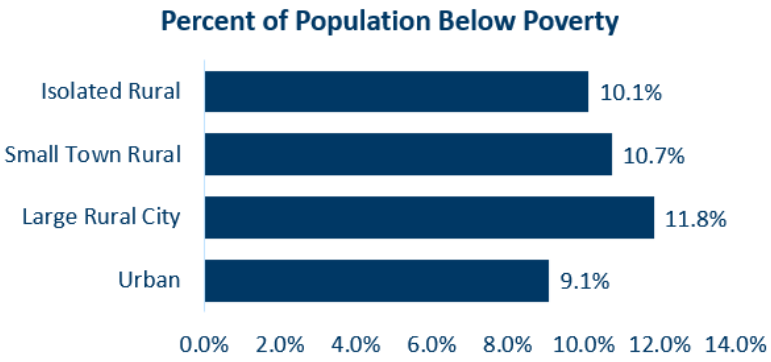
29.3% of census tracts have median income above the statewide median – these are concentrated in areas around the cities of Duluth, Minneapolis, St. Paul, Mankato, Rochester, St. Cloud, Fargo, ND, and Grand Forks, ND.

Source: MDH Health Economics Program analysis of US Census Bureau data from the American Community Survey 5-year estimate 2018 to 2022.

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

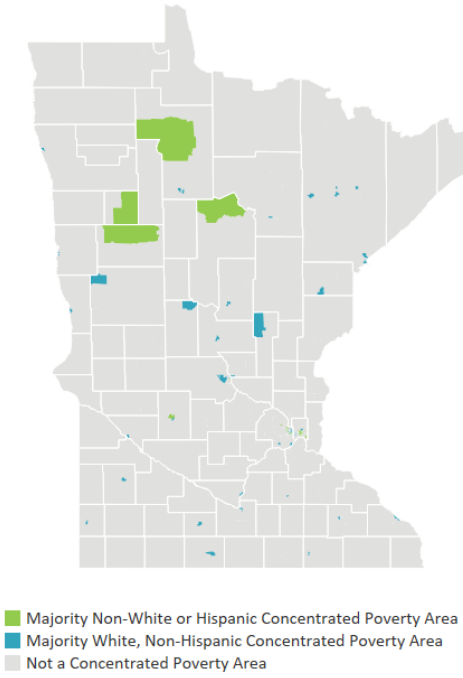
Percent of population below poverty

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



A bar chart showing the percent of the population below poverty, by RUCA. Urban areas have the smallest percent of population below poverty (9.1%), compared to isolated rural (10.1%), small town rural (10.7%) and large rural city (11.8%).

Census tract



A map of Minnesota showing census tracts in the state with concentrated poverty, and either white non-Hispanic majority population or Non-white or Hispanic majority population. 45

census tracts have concentrated poverty, with a majority non-white or Hispanic population and 79 census tracts have concentrated poverty, with a majority white non-Hispanic population

'Concentrated poverty' is defined here as having more than one in five residents living at or below federal poverty guidelines for income at the census tract level.

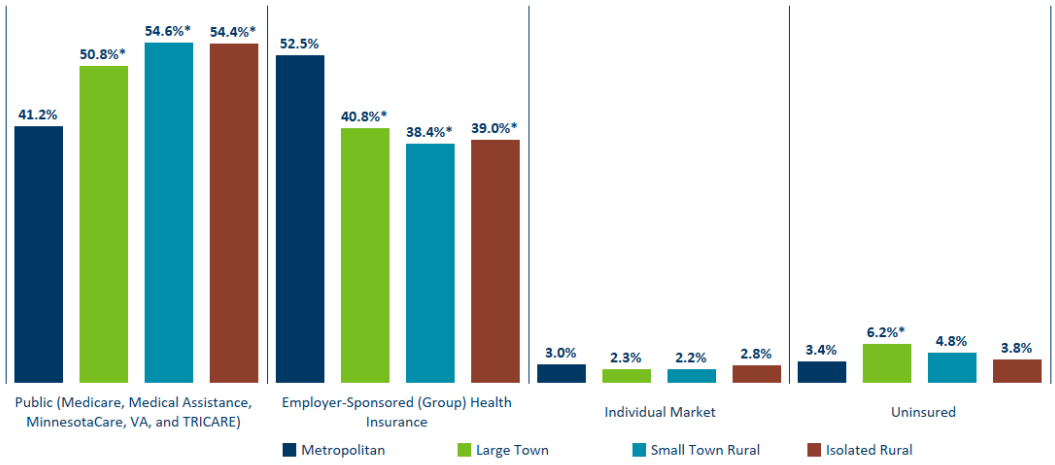
Source: MDH Health Economics Program analysis of US Census Bureau data from the American Community Survey 5-year estimate 2018 to 2022.

Structure of Rural Health System: An Overview

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



A bar chart shows the percentage of Minnesotans who have different sources of health insurance coverage in 2023 by RUCA (Metropolitan, Large Town, Small Town Rural, Isolated Rural). The four different types of health insurance are Public (Medicare, Medical Assistance, MinnesotaCare, VA and TRICARE), Employer-sponsored (Group) Health Insurance, Individual Market, and Uninsured. A higher percentage of individuals with public insurance lives in small town rural (54.6%), isolated rural (54.4%), and large town (50.8%) than metropolitan (41.2%). Metropolitan areas have more individuals with employer-sponsored (group) health insurance (52.4%) compared to large town (40.8%), isolated rural (39%) and small town rural (38.4%). Few individuals have insurance from the individual market (metropolitan has 3.0%, large town has 2.3%, small town rural has 2.2% and isolated rural have 2.8% of individuals that have insurance

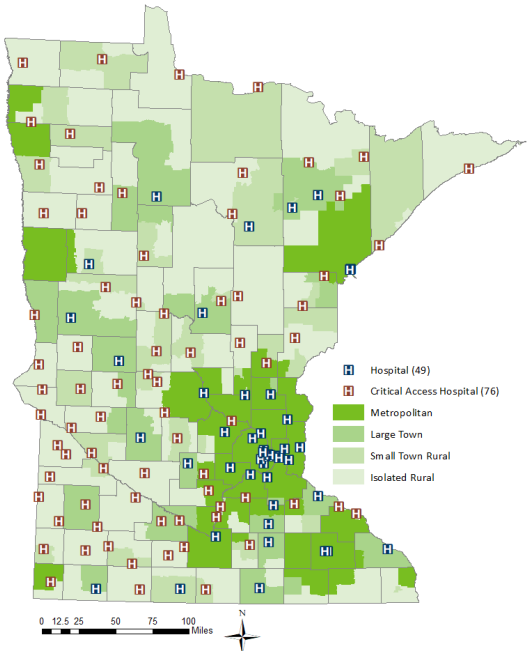
from the individual market. Rates of those that are uninsured are highest in large towns (6.2%) compared to small town rural (4.8%), isolated rural (3.8%) and metropolitan (3.4%).

- Reasons for higher rates of public health insurance among rural Minnesotans include:
  - Age: people over 65 are more likely to have Medicare;
  - Lower Incomes: more likely to be eligible for state public programs; and
  - 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.

Hospital and nursing home services are available throughout the state



Map of Minnesota divided into the four RUCA groups, with the location of all hospitals indicated. There are 125 community hospitals, 76 of which are Critical Access Hospitals (CAHs), and 49 other hospitals.

Critical Access Hospitals (CAHs) are smaller hospitals (fewer than 25 beds), mostly in rural areas, which receive higher reimbursement from Medicare, as long as they maintain certain services.

Of the 125 community hospitals in Minnesota, 76 are designated Critical Access Hospitals.

In total, 90 hospitals are located in rural areas.

Around one-third of all hospital outpatient clinics in the state, 138 of 408 total clinics, are in rural areas.

All but one county, Red Lake, has at least 1 nursing home as of 2024.

Notes and sources:

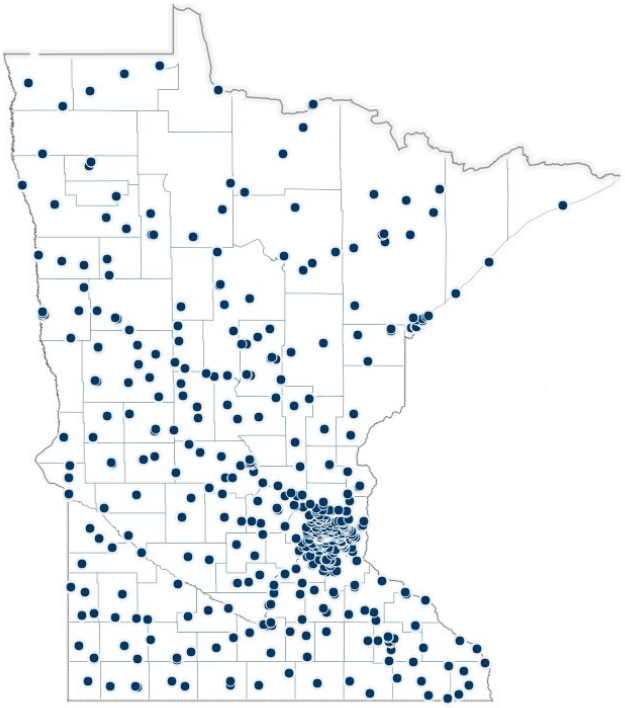
Source: MDH Health Economics Program analysis of hospital annual reports, October 2024.

There are 76 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. Critical Access Hospitals (https://www.health.state.mn.us/facilities/ruralhealth/flex/cah/index.html)

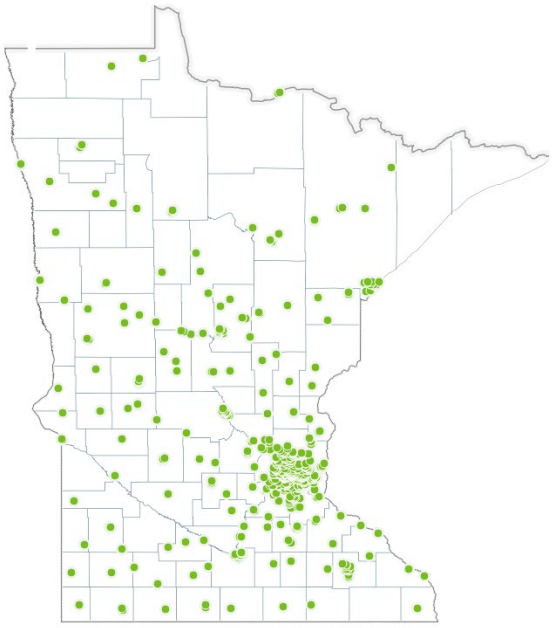
Outpatient clinics are designated by the hospital and may not be co-located with the hospital, but are billed to Medicare under the hospital's provider identification number. Clinic location data is from fiscal year 2022.

Source: Minnesota Department of Health, Health Economics Program analysis of 2024 Directory of Registered, Licensed and/or Certified Health Care Facilities and Services.

Primary and specialty clinics are available throughout Minnesota



Map of Minnesota showing the distribution of primary care clinics in 2023.



Map of Minnesota showing how specialty care clinics are distributed across the state.

Both maps show a relative concentration of clinics in the Twin Cities metro area, with dots more spread out across the rest of the state. Each clinic is represented as a dot, regardless of how many physicians practice there or the patient population.

40% (241) of all primary care clinics (599) are located in rural areas.

22% (196) of all specialty care clinics (907) are located in rural areas.

Minnesota's 17 Community Health Centers care for nearly 200,000 low-income people.

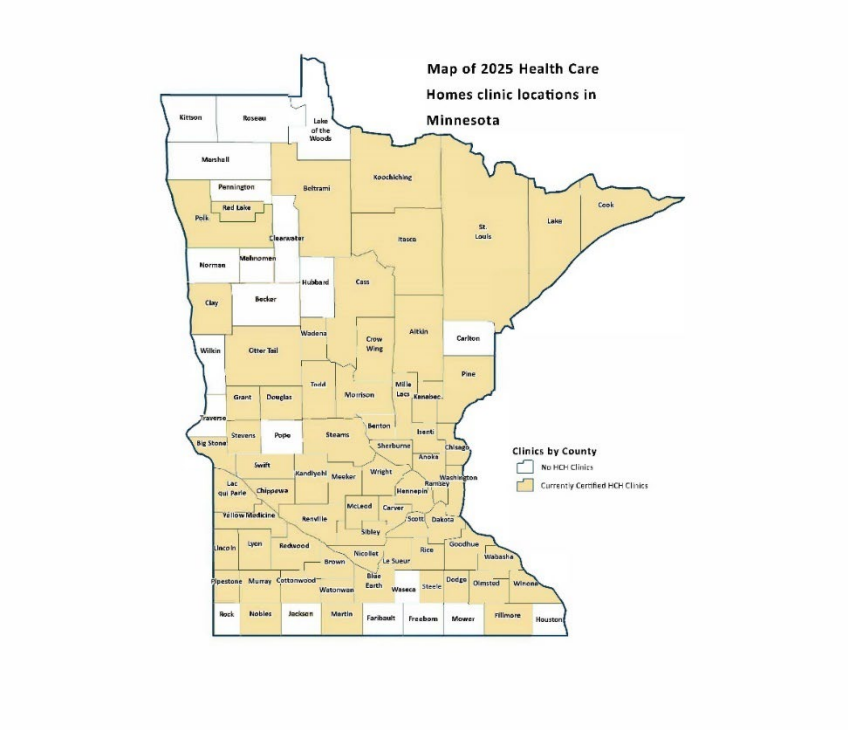
Notes and Sources:

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.

Source: MDH Health Economics Program analysis of the Minnesota Statewide Quality Reporting and Measurement System 2023 Physician Clinic Registry.

Source: What is a CHC — Minnesota Association of Community Health Centers (https://www.mnachc.org/what-is-a-community-health-center)

Person-centered, coordinated primary care available to most Minnesotans



Map of Minnesota that shows the locations of certified Health Care Homes designated clinics by county as of 2025. There are some counties, mostly in the Northwest and southern parts of the State, that do not have Health Care Home certified clinics.

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 improve health and well-being.

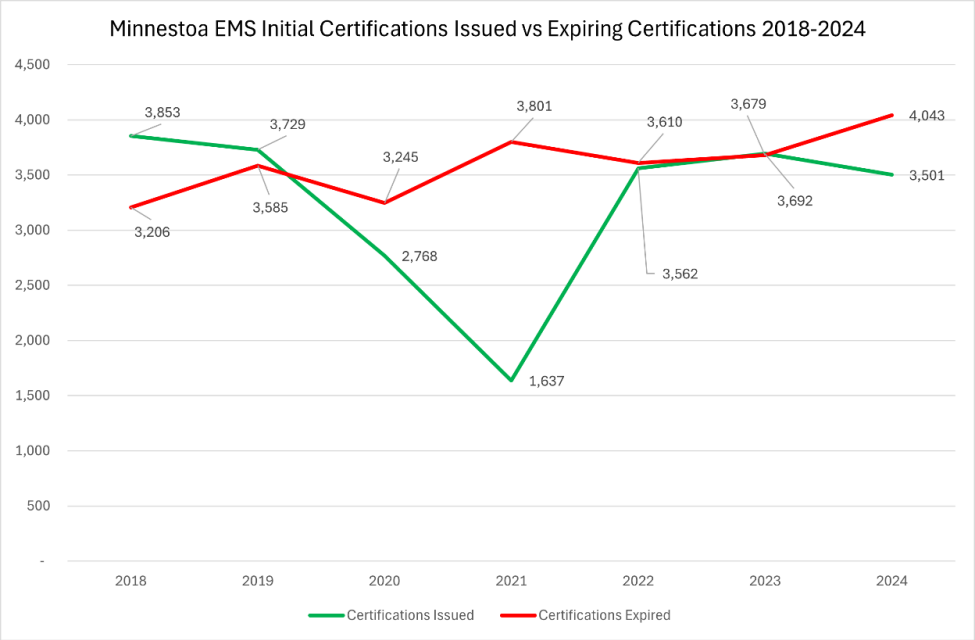
76% of MN counties have at least one health care home clinic.

The health care homes framework certifies clinics at the following levels of progression: Foundational Level (101 clinics), Level 2 (58 clinics), and Level 3 (236 clinics). Organizations may choose to certify at the level appropriate for each clinic.

Source: HCH Certified Clinic List data obtained on September 2, 2025, from Health Care Homes (https://www.health.state.mn.us/facilities/hchomes)

HCH Find Certified Health Care Homes (https://www.health.state.mn.us/facilities/hchomes/hchmap/index.html)

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



Line graph that depicts the number of initial EMS certifications issued vs. those expiring from 2018-2024. The State has seen an increase in expired certifications with decreases in 2020 and 2022. The state has seen a decrease in certifications issued with a steep decrease in 2021.

Minnesota mirrors the nation's declining EMS workforce.

There is a gap between the numbers of EMS certifications issued vs. those expiring. Although this gap is beginning to close somewhat

In 2024, the state lost 542 more certified EMS providers, than new providers coming into the system for the first time.

Source: [EMS Workforce Dashboard / Office of Emergency Medical Services (OEMS) (https://mn.gov/oems/data-center/ems-workforce-dashboard.jsp)]

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

Minnesota has 125 designated trauma hospitals across four adult and two pediatric designation levels.

99.6 percent of Minnesotans live within 60 minutes of a trauma hospital.

84 percent of Minnesotans live within 60 minutes of a Level 1 or 2 trauma hospital.

77 percent of Minnesota children live within 60 minutes of a pediatric trauma hospital

Minnesota has 121 designated stroke system hospitals.

94 percent 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

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.

Source: Minnesota Statewide Trauma System (https://www.health.state.mn.us/facilities/traumasystem) September 2025

Minnesota Stroke System (https://www.health.state.mn.us/diseases/cardiovascular/stroke/system.html) November 2024

Rural Health Care Workforce

Key Points – Health care workforce

- Nurses make up the largest share of the state's licensed providers followed by physicians.
- 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 percent of Minnesota counties qualify as mental health professional shortage areas.
- Rural providers are older and closer to retirement.

The number of actively licensed providers in Minnesota by profession type

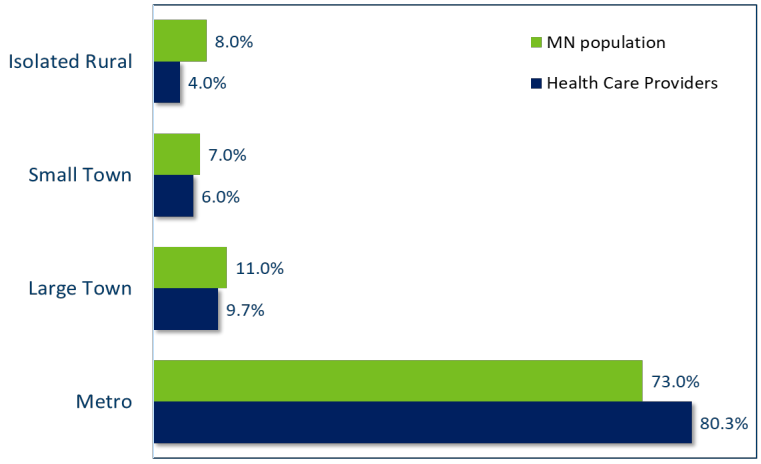
Provider Group	Number of Providers in Minnesota (2025)
Alcohol and Drug Counselors	4,316
Dental Professionals	13,630
Dentists	4,018
Mental Health Providers	33,633
Pharmacists	9,912
Pharmacy Technicians	14,023
Physical Therapy Professionals	8,258
Physicians	29,238
Physician Assistants	4,787
Registered Nurses and Licensed Practical Nurses	137,937

This shows the number of health care providers by profession in 2025 actively licensed to practice in Minnesota. This table excludes Respiratory Therapists and some other smaller licensed occupations, including Chiropractic, Sports Medicine, and Occupational Therapy. Mental health providers include marriage and family therapists, social workers, psychologists, counselors, etc. Counts by health care providers include:

- 4,316 Alcohol and Drug Counselors
- 13,630 Dental Professionals
- 4,018 Dentists
- 33,633 Mental Health Providers
- 9,912 Pharmacists
- 14,023 Pharmacy Technicians
- 8,258 Physical Therapy Professionals
- 28,238 Physicians
- 4,787 Physician Assistants
- 137,937 Registered Nurses and Licensed Practical Nurses

Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, 2025.

The majority of licensed health care providers work in metropolitan areas



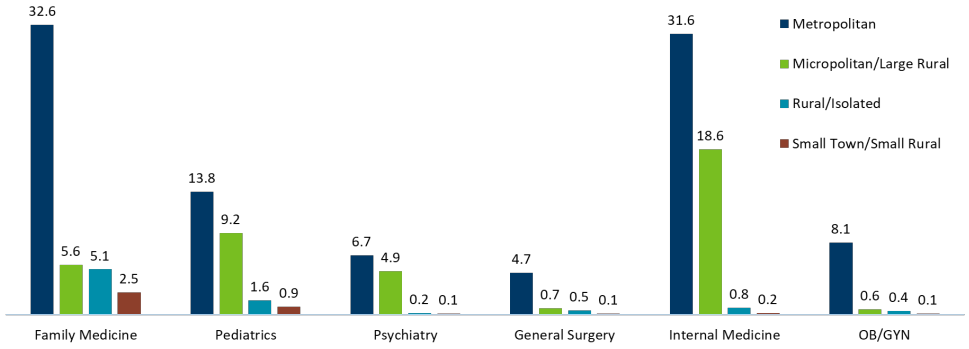
Bar chart that shows the percentage distribution of licensed health care providers by Rural-Urban Commuting Area in comparison to the percentage distribution of the population in each Rural-Urban Commuting Area. The data for licensed health care providers in this chart include: physicians, physician assistants, respiratory therapists, oral health professions, pharmacy professions, physical therapy professions, and mental health professions. 73 percent of the state's population lives in Metropolitan areas and 80.3 percent of licensed health care providers are working Metropolitan areas. 11 percent of the state's population lives in Large Town areas and 9.7 percent of licensed health care providers are working Large Town areas. 7 percent of the state's population lives in Small Town Rural areas and 6 percent of licensed health care providers are working Small Town Rural areas. 8 percent of the state's population

lives in Isolated Rural areas and 4 percent of licensed health care providers are working Isolated Rural 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, 2025.

Rural areas face severe shortages of physicians in multiple specialties

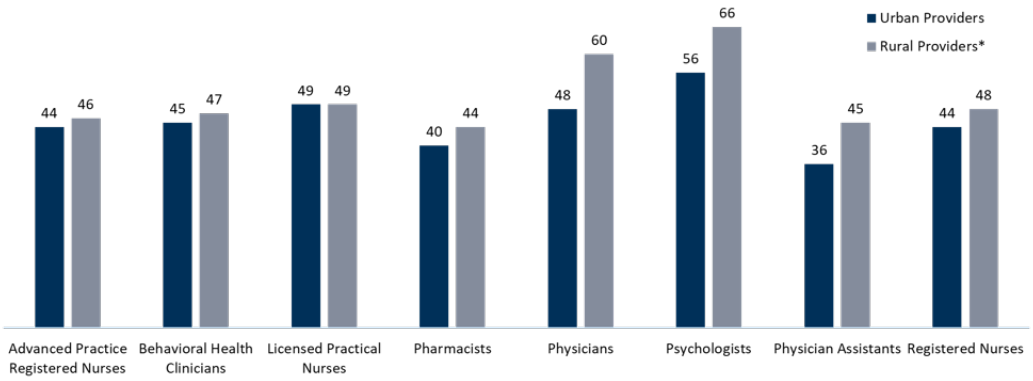


Bar chart showing the number of physicians by specialty per 100,000 people by Rural-Urban Commuting Area. The health care profession specialties included are: Family Medicine, Internal Medicine, Obstetrics/Gynecologists, General Pediatrics, General Psychiatry, and General Surgery. The counts by Rural-Urban Commuting Area are based on the primary practice address that physicians report to the Board of Medical Practice. All health care profession specialties shown have higher rates of practitioners in metropolitan areas than other areas of the State, followed by Micropolitan areas, then rural/isolated areas and finally the fewest specialty practitioners are in small town/small rural areas.

Obstetrics/Gynecologists, Pediatricians, and Psychiatrists are in short supply in rural parts of the state.

Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Board of Medical Practice, 2025.

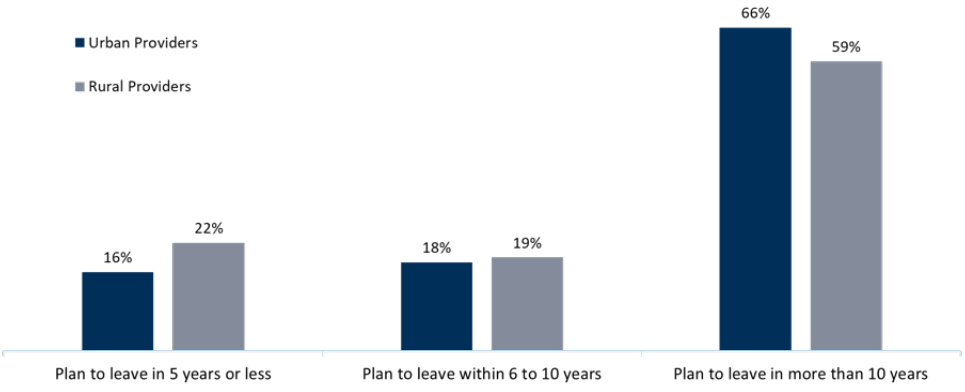
Rural providers are older than their urban counterparts



Bar chart of the median age of health care providers by urban and isolated rural Rural-Urban Commuting Area codes. The health care professions included in this data are: Advanced Practice Registered Nurses, Behavioral Health Clinicians, Licensed Practical Nurses, Pharmacists, Physicians, Physician Assistants, Psychologists, and Registered Nurses. The average age of all providers shown in the chart are higher in rural areas compared to urban areas of Minnesota.

Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, 2025.

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



Bar chart with the percentage of health care providers who plan on retiring from their profession in the next 5 to 10 years. There is a comparison between the urban and isolated rural providers defined by the Rural-Urban Commuting Area codes. The survey categories used to show these data are as follows: Plan to leave in 5 years or less, plan to leave within 6 to 10 years, and plan to leave in more than 10 years. 16% of urban physicians and 22% of isolated rural physicians plan to leave their profession in 5 years or less. 18% of urban physicians and 19% of isolated rural physicians plan to leave their profession in 6 to 10 years. 66% of urban

physicians and 59% of isolated rural physicians plan to leave their profession in more than 10 years.

Source: MDH Office of Rural Health and Primary Care, Physician Workforce Survey, 2025.

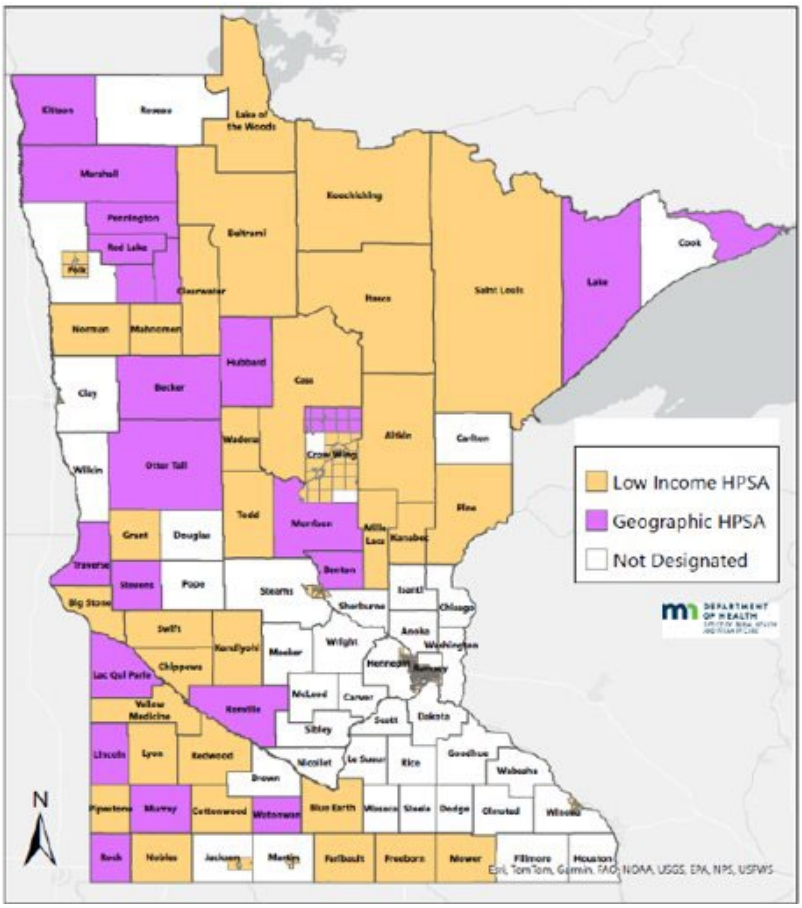
Building the rural provider pipeline

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

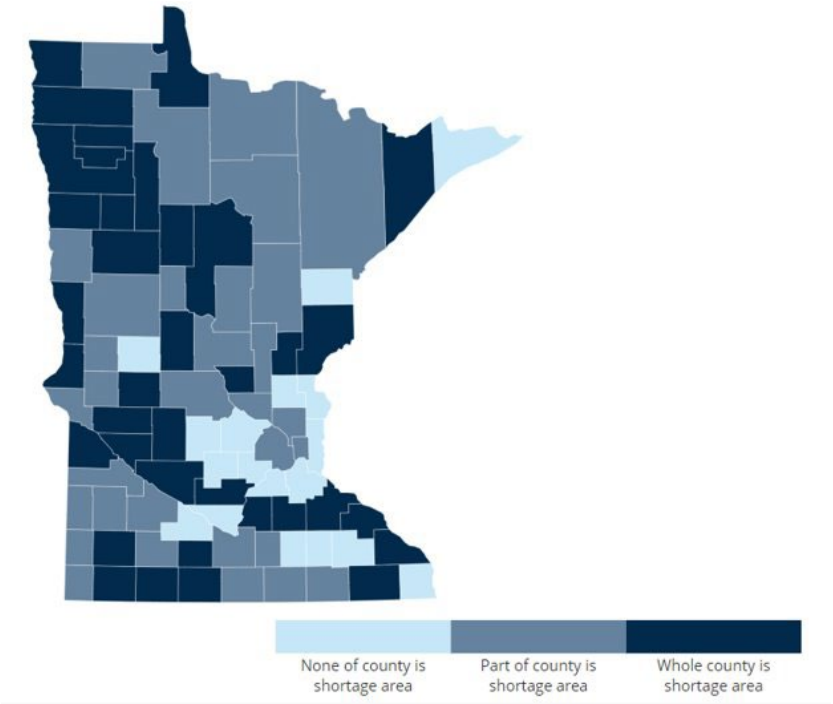
Expected Matriculation date	Urban partner	Rural partner	Slots/seats	Field
2025	CentraCare System, St. Cloud	CentraCare, Wilmar	3	Family medicine
2026	Fairview Health System, Minneapolis	Grand Itasca Clinic and Hospital, Grand Rapids	3	Family medicine
2027	North Memorial, Minneapolis	Lakewood Health System,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

The table shows rural provider pipeline programs currently in development in the field of primary care in Wilmar, Grand Rapids, Staples and Thief River Falls, Minnesota, each site's urban partners, and number of student seats/slots.

Minnesota has 557 designated health professional shortage areas



Map of counties in Minnesota that are designated as low-income and geographic Health Care Professional Shortage Areas for dental professions. Out of the 57 counties with the designation for dental Health Care Professional Shortage Area, 48 of them include full counties, 9 counties have partial designation, and 30 counties are without a designation.



Map of counties in the state of Minnesota that are designated as low-income and geographic Health Care Professional Shortage Areas for primary care physicians. Out of the 69 counties with the designation for primary care physician Health Care Professional Shortage Area, 37 of them include full counties, 32 counties have partial designation, and 18 counties are without a designation.

Data is from U.S HRSA, July 2024. Last accessed October 24, 2024.

Source: Shortage Designations (https://www.health.state.mn.us/facilities/underserved/designation.html)

Source: Map of Health Professional Shortage Areas: Primary Care, Geographic, by County (https://www.ruralhealthinfo.org/charts/5?state=MN)

Availability of Health Care Services in Rural Minnesota

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 obstetric 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

		Change in Service due to:				
	Hospitals with service available in 2013	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%

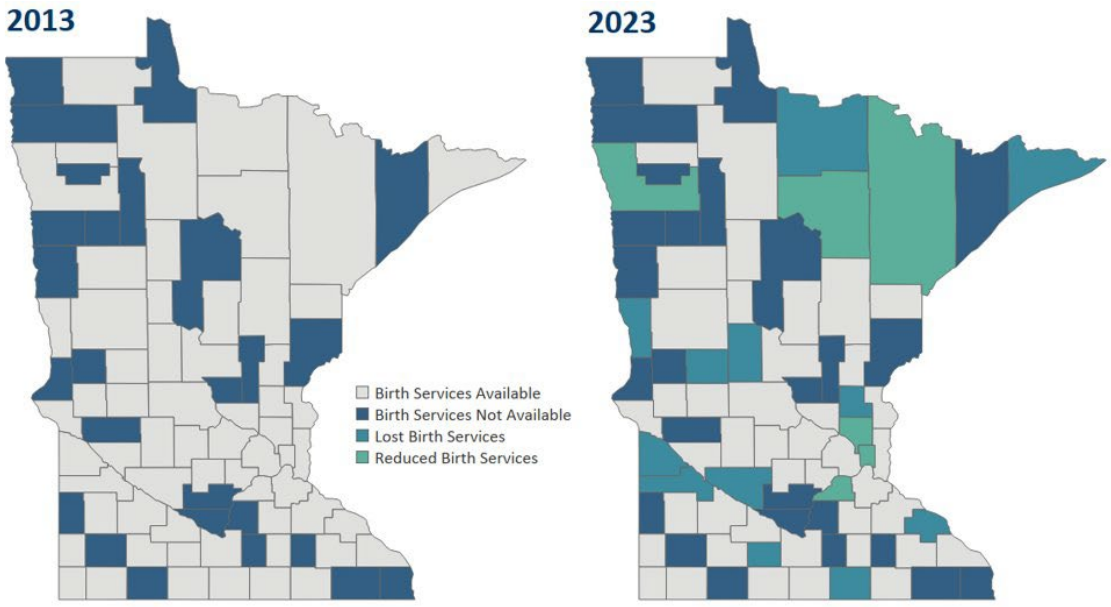
Table of the change in hospital service lines between 2013 and 2023 at rural hospitals. The table provides the number of rural hospitals with the service in 2013, the number of hospitals that closed/consolidated, lost service, or added services between 2013 and 2023, the number of hospitals with services available in 2023 and the percent change between 2013 and 2023.

Over this time period, rural hospitals lost inpatient and outpatient surgery, detoxification services, Computer Tomography (CT) services, Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) services, Organ Transplant services and renal dialysis services. Much of this loss was due to hospitals losing services, as opposed to hospital closure or consolidation.

Rural hospitals saw increases in outpatient psychiatric services, Single Photon Emission Computerized Tomography (SPECT), and cardiac catheterization services advanced diagnostic imaging services, due to hospitals adding these service lines.

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 or organ transplant services available in 2013 or 2023.

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



Two maps side-by-side that show the change in availability of obstetrics services within each Minnesota county between 2013 and 2023. The map of obstetric services in 2023 also highlights twelve counties that services were no longer available in 2023 when there was availability within the county in 2013. It also highlights six counties that reduced hospital birth services in 2023 compared to 2013.

The twelve counties that lost services are: Cook, Douglas, Freeborn Isanti, Koochiching, Lac Qui Parle, Renville, Todd, Wabasha, Watonwan, Wilkin, and Yellow Medicine.

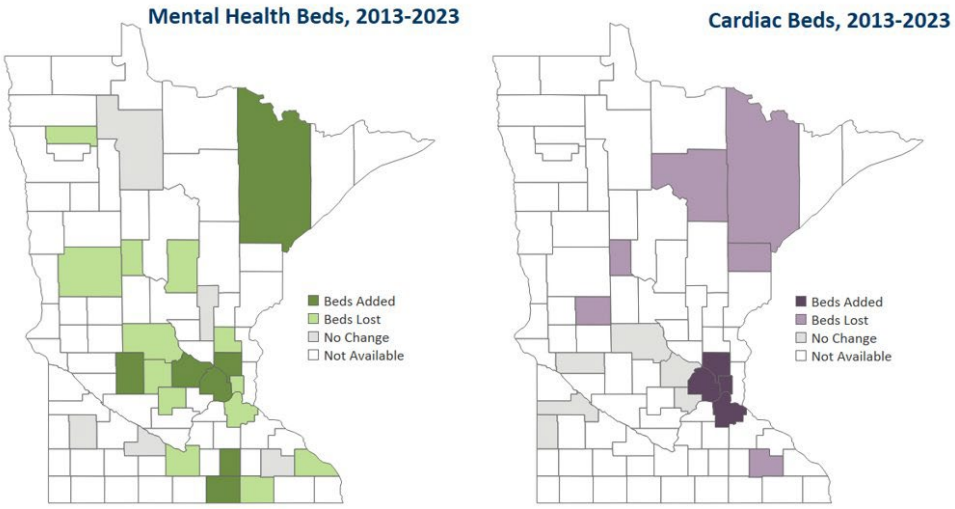
The six counties that reduced birth services in 2023 are: Anoka, Itasca, Polk, Ramsey, Scott and St. Louis.

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

Note: Due to a merger, the hospital in Mower County was no longer an independent licensed entity as of the end of 2014; however, birth services were offered at that site under the license of the remaining corporate entity.

Sources: 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.

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



Two maps of Minnesota side-by-side. The first map depicts the counties that had changes in mental health and the second map depicts counties that had changes in cardiac beds between 2013 and 2023.

Counties that added mental health beds: Anoka, Freeborn, Hennepin, Kandiyohi, Steele, St. Louis, and Wright.

Counties that lost mental health beds: Blue Earth, Crow Wing, Dakota, Isanti, McLeod, Meeker, Mower, Otter Tail, Pennington, Ramsey, Stearns, Wadena, and Winona.

Counties that kept the same number of mental health beds: Beltrami, Brown, Lyon, Mille Lacs, and Olmsted.

Counties that added cardiac beds: Anoka, Dakota, Hennepin, and Ramsey.

Counties that lost cardiac beds: Carlton, Douglas, Itasca, Olmsted, St. Louis, and Wadena.

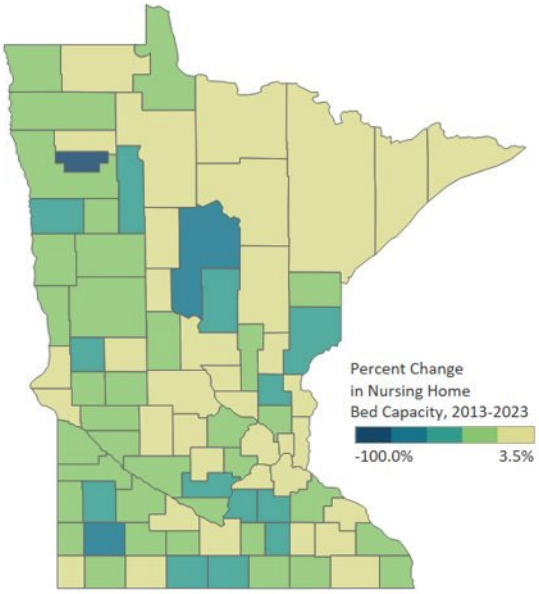
Counties that kept the same number of cardiac beds: Carver, Lincoln, Stearns, Swift, Wright, and Yellow Medicine.

Statewide, 80 mental health beds were lost, and 51 cardiac beds were lost between 2013 and 2023.

Note: Counties not listed do not have dedicated beds in that category.

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 (https://www.health.state.mn.us/about/org/hrd/hearing/index.html)

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



Map of Minnesota that shows the percent change in the number of nursing home beds by county in Minnesota between 2013 and 2023. Most counties that lost nursing home beds were in rural areas.

The percent change in nursing home beds ranged from an increase of 4% (Morrison County) to a decrease of 100% (Red Lake County).

Other counties with large decreases in nursing home beds included Cass, Murray, Faribault, Isanti, Pine, Lyon, Sibley, Clearwater, Rice, Le Sueur, Steele, Crow Wing, Grant, Martin, and Norman.

Rural counties have about 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 counties1 lost 19 nursing homes, and had a 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.

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 Greater MN: Refined & Revisited / MN State Demographic Center (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.

Health Care Use in Rural Minnesota

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.

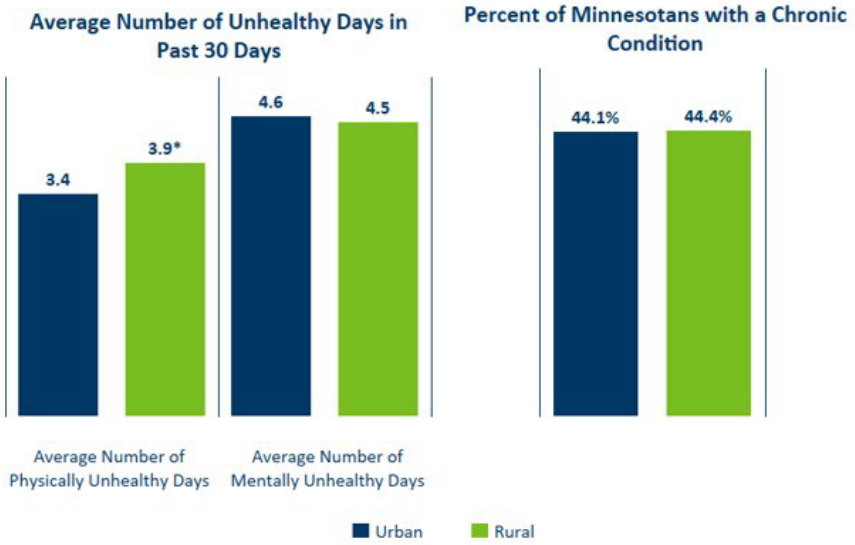
How Minnesotans access health care services

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



Two bar charts are side by side. The first chart shows the average number of unhealthy days in the past 30 days experienced by residents in urban and rural areas of Minnesota. Minnesotans in rural areas reported a statistically similar average number of physically unhealthy days in the past 30 days (3.9*) as compared to Minnesotans in urban areas (3.4). There was also no difference for mentally unhealthy days between rural (4.6) and urban (4.5).

The second chart shows the percent of Minnesotans who reported a chronic condition, by urban and rural areas. Minnesotans in rural areas were equally likely to report having a chronic condition (44.4%) as compared to Minnesotans in urban areas (44.1%).

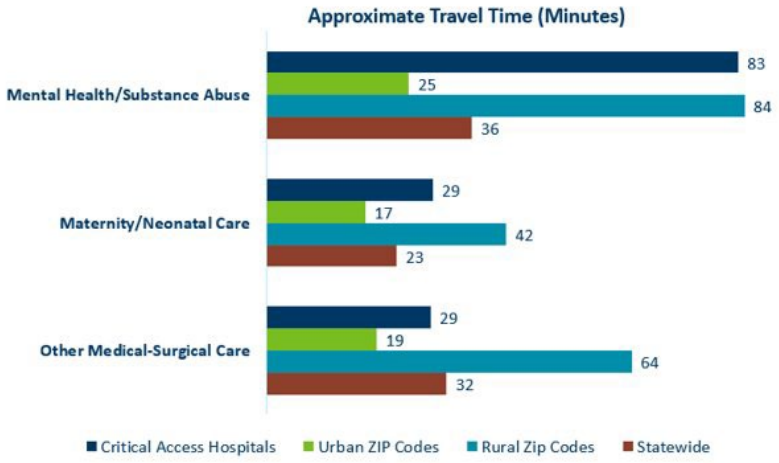
Minnesotans living in rural areas reported frequent mental distress at about the same rate (13.6%) as those living in urban areas (13.7%).

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.

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.

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 Data Brief: Suicide Up in 2022, Down in 2023 (PDF) (https://www.health.state.mn.us/communities/suicide/documents/2023suicidedatabrief.pdf).

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



Bar chart with the approximate travel time in minutes for inpatient hospital stays for patients seen in Critical Access Hospitals, urban ZIP codes, rural ZIP codes, and statewide. The major categories of hospital stays are mental health/substance abuse, maternity/neonatal care, and other medical-surgical care. Non-metropolitan ZIP codes are classified as 'rural' using RUCA.

Mental health/substance abuse services: Critical Access Hospitals=83 minutes; urban=25 minutes; rural= 84 minutes; statewide=36 minutes.

Maternity/neonatal services: Critical Access Hospitals=29 minutes; urban=17 minutes; rural=42 minutes; statewide=23 minutes.

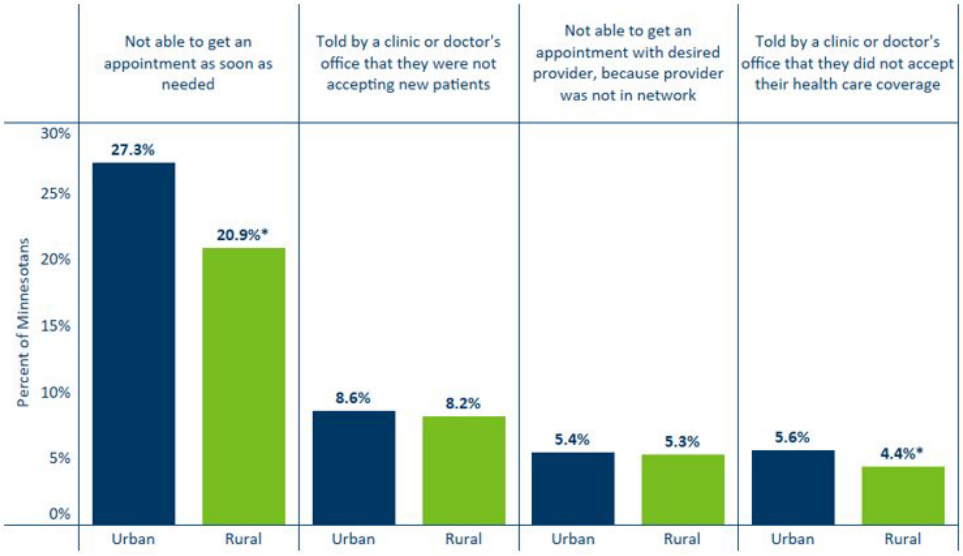
Other medical-surgical services: Critical Access Hospitals=29 minutes; urban=19 minutes; rural=64 minutes; statewide=32 minutes.

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.

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.

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



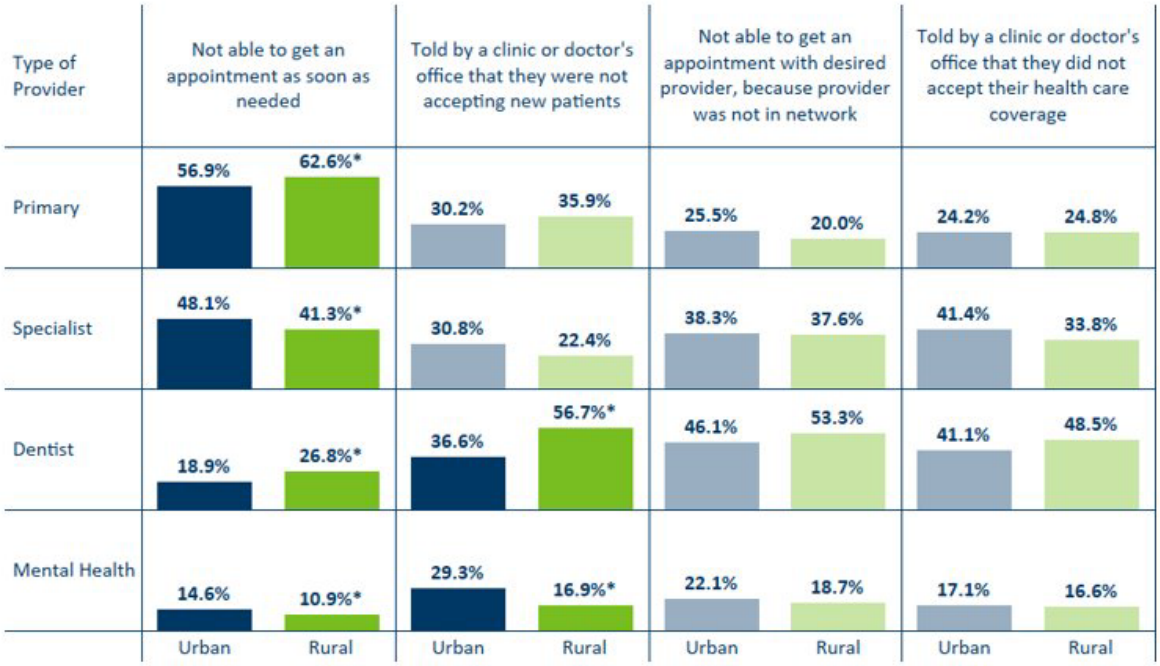
Bar chart with the percentage of Minnesotans who indicate having a problem accessing a provider for four different reasons. The four reasons are 1) not able to get an appointment as soon as needed, 2) told by a clinic or doctor's office that they were not accepting new patients, 3) not able to get an appointment with desired provider, because provider was not in network, or 4) told by a clinic or doctor's office that they did not accept their health care coverage. "Not able to get an appointment as soon as needed" is the number one reason reported by Minnesotans for not being able to access a provider in both urban and rural areas (Urban=27.3%; Rural=20.9%*.), followed by "told by a clinic or doctor's office that they are not accepting new patients" (Urban=8.6%; Rural=8.2%.), then "not able to get an appointment with desired provider, because provider was not in network (Urban=5.4%; Rural=5.3%.), and finally "told by a clinic or doctor's office that they did not accept their health care coverage (Urban=5.6%; Rural=4.4%*)."

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.

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



Multiple bar charts with the percentage of Minnesotans who had trouble accessing different types of providers in both urban and rural areas, among those who indicated they had problems accessing providers. The types of providers include primary care, specialist, dentist, or mental health. The four reasons are 1) not able to get an appointment as soon as needed, 2) told by a clinic or doctor's office that they were not accepting new patients, 3) not able to get an appointment with desired provider, because provider was not in network, or 4) told by a clinic or doctor's office that they did not accept their health care coverage.

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 (62.6%* rural; 56.9% urban) or a dentist 26.8%* rural; 18.9% urban) as soon as they needed.

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

Not able to get an appointment as soon as needed: Primary care provider – Urban=56.9%, Rural=62.6%*; Specialist – Urban=48.1%, Rural=41.3%*; Dentist – Urban=18.9%, Rural=26.8%*; Mental Health – Urban=14.6%, Rural=10.9%*

Told by a clinic or doctor's office that they were not accepting new patients: Primary care provider – Urban=30.2%, Rural=35.9%; Specialist – Urban=30.8%, Rural=22.4%; Dentist – Urban=36.6%, Rural=56.7%*; Mental Health – Urban=29.3%, Rural=16.9%

Not able to get an appointment with desired provider, because provider was not in network: Primary care provider – Urban=25.5%, Rural=20.0%; Specialist – Urban=38.3%, Rural=37.6%; Dentist – Urban=46.1%, Rural=53.3%; Mental Health – Urban=22.1%, Rural=18.7%

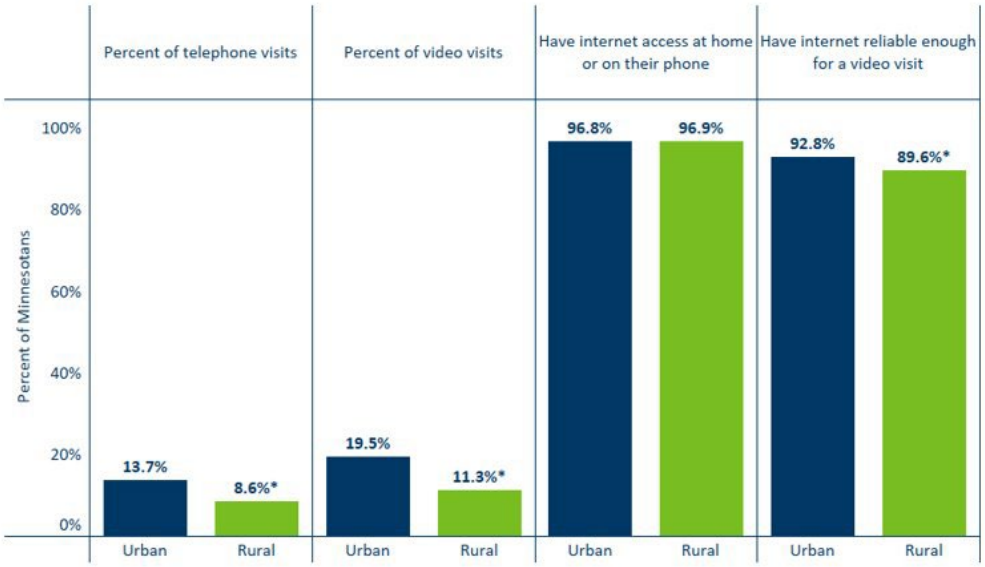
Told by a clinic or doctor's office that they did not accept their health care coverage: Primary care provider – Urban=24.2%, Rural=24.8%*; Specialist – Urban=41.4%, Rural=33.8%; Dentist – Urban=41.1%, Rural=48.5%; Mental Health – Urban=17.1%, Rural=16.6%

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.

Rural Minnesotans had lower telehealth use



Bar chart that shows the percentage of Minnesotans that had either telephone or video telehealth visits and their internet access and its reliability in urban and rural areas of the State.

Rural Minnesotans had lower utilization of both phone and video visits.

More rural Minnesotans lack internet reliable enough to use for a video visit.

Had a telephone visit: Urban=13.7%; Rural=8.6%*.

Had a video visit: Urban=19.5%; Rural=11.3%*.

Have internet access at home or on their phone: Urban=96.8%; Rural=96.9%*.

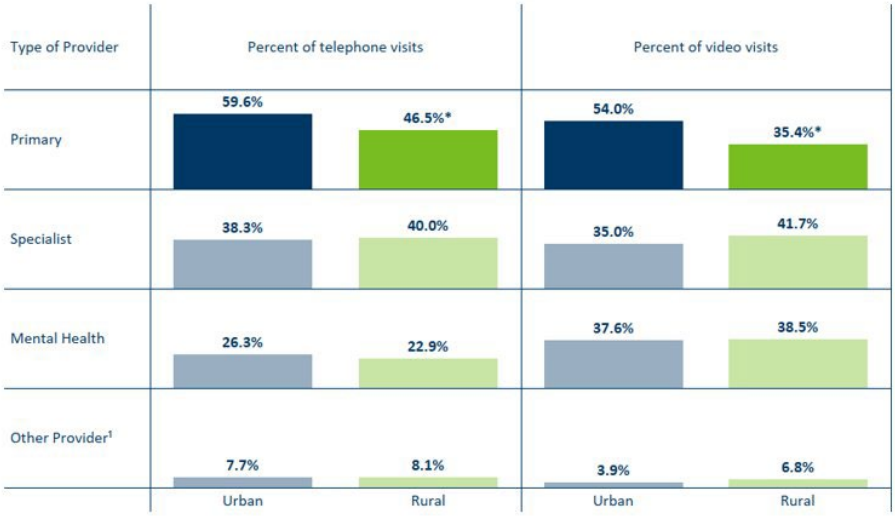
Have internet reliable enough for a video visit: Urban=92.8%; Rural=89.6%*.

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.

Most telehealth visits in the state were to primary care providers



Bar chart that shows the percentage of Minnesotans in urban and rural areas that had either telephone or video telehealth visits with different types of providers, among those who had telephone or video telehealth visits. The types of providers include primary care, specialist, mental health, or other. Other providers include dentists, alternative medicine providers, emergency rooms/urgent cares, or COVID testing sites.

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.

Of those who had a telephone visit: Primary care provider – Urban=59.6%, Rural=46.5%*; Specialist – Urban=38.3%, Rural=40.0%; Mental Health – Urban=26.3%, Rural=22.9%; Other provider – Urban=7.7%, Rural=8.1%.

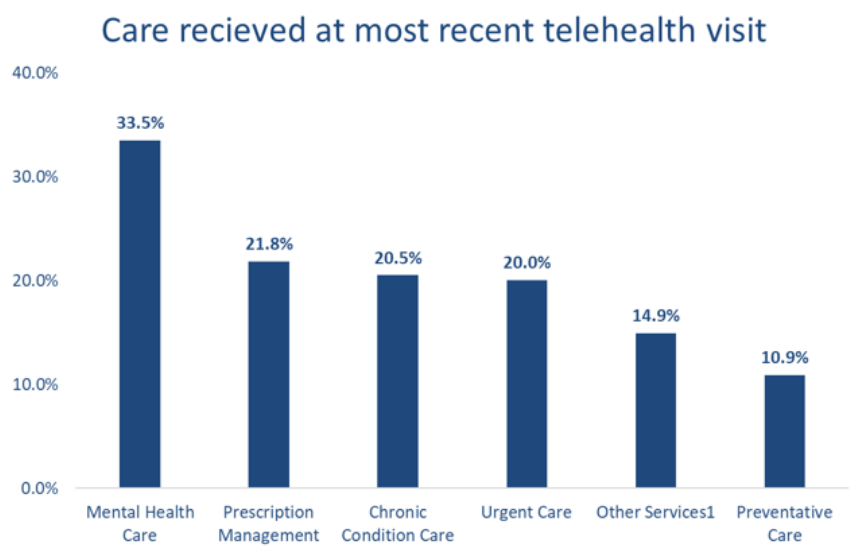
Of those who had a video visit: Primary care provider – Urban=54.0%, Rural=35.4%*; Specialist – Urban=35.0%, Rural=41.7%; Mental Health – Urban=37.6%, Rural=38.5%; Other provider – Urban=3.9%, Rural=6.8%.

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.

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



Bar chart shows the type of care Minnesotans received at their most recent telehealth visit. The percentage of Minnesotans that had either telephone or video telehealth visits with different types of providers.

Of those who had a telehealth visit, the most recent visit was a video visit with: Mental Health Care= 33.5%; Prescription Management=21.8%; Chronic Condition Care=20.5%; Urgent Care=20.0%; Other Services (behavioral health care, prenatal care, in-hospital care, emergency care) =14.9%; Preventive Care=10.9%.

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.

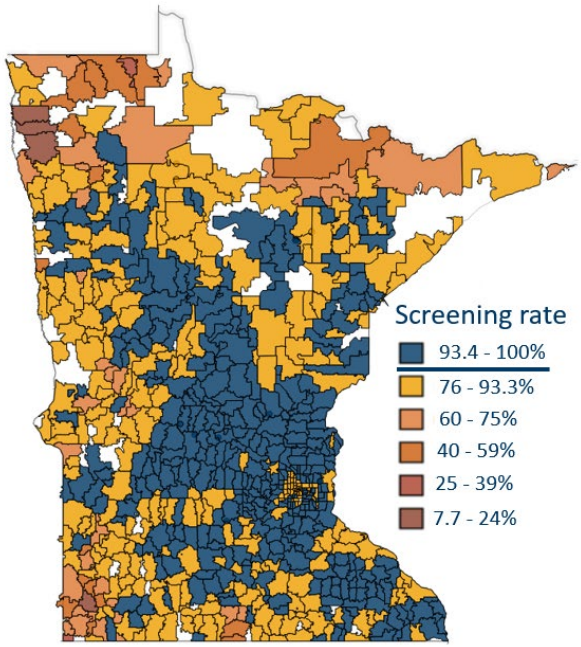
- 81.4% for phone visits
- 85.0% for video visits

This was similar for urban and rural respondents.

Source: Minnesota Telehealth and Access Survey, 2023

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.

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



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

Map of Minnesota that shows mental health and/or depression screening rates for adolescents in Minnesota in 2023 by patient ZIP code. It shows screening rates compared to the statewide average, with screening rates at or above the statewide average present around the Twin Cities area, Southeast Minnesota, East Central Minnesota, and around the Duluth and Brainerd Lakes areas. Parts of Northwest Minnesota, Southwest, and South Central Minnesota have screening rates below 50%. ZIP codes with fewer than 5 patients for this measure were excluded and are white on the map.

The table provides screening rates by geography:

- Urban: 2022 = 93.3%; 2023=94.1%
- Rural: 2022=89.6%; 2022=90.8%
- Statewide: 2022=92.5%; 2023=93.4%

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.

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

Source: 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.

Early treatment may lead to better outcomes in the long term.

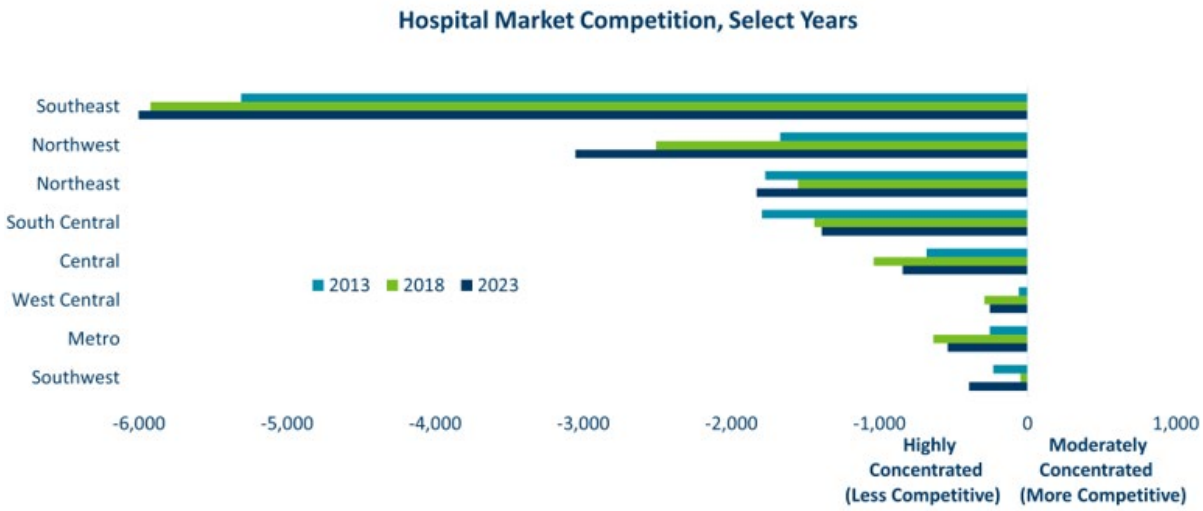
The US Preventive Services Task Force recommends that all adolescents are screened for mental health concerns or depression.

Financing

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.
  - Rural residents experience higher monthly cost sharing as compared to their urban counterparts for commercial insurance and Medicare.
  - Isolated rural hospitals provide 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.

Minnesota hospital markets are not competitive



Bar chart that shows the difference between actual competitiveness of State Community Health Services Advisory Committee (SCHSAC) hospital markets in three annual periods (2013, 2018, and 2023). The values are a calculation of Herfindahl-Hirschman competition (HHI) index based on net patient revenue from hospital annual report data. Values in chart are subtracted from 1,800, or a highly concentrated market; positive values indicate a competitive market, negative values indicate a concentrated market.

- Metro: 2013=-255; 2018=-636; 2023=-541
- West Central: 2013=-58; 2018=-297; 2023=-256
- Southwest: 2013=-231; 2018=-49; 2023=-395
- Central: 2013=-683; 2018=-1,038; 2023=-843
- South Central: 2013=-1,793; 2018=-1,440; 2023=-1,391
- Northeast: 2013=-1,773; 2018=-1,550; 2023=-1,830
- Northwest: 2013=-1,670; 2018=-2,507; 2023=-3,053
- Southeast: 2013=-5,310; 2018=-5,922; 2023=-6,283

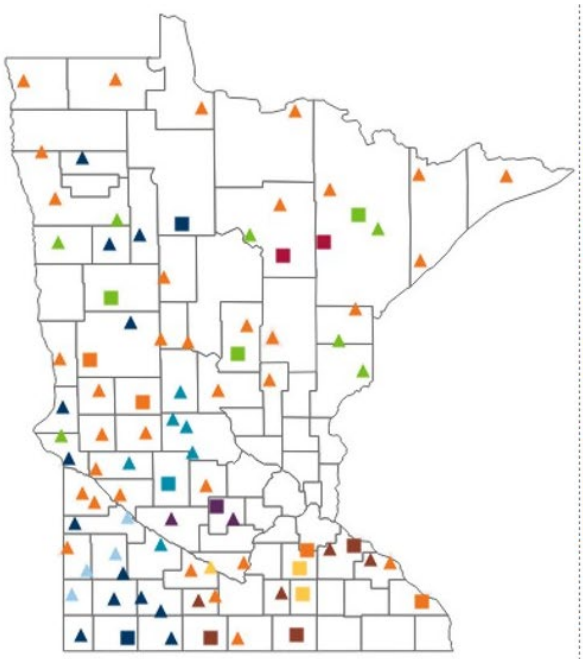
Market concentration can lead to higher prices.

All eight regions had moderately concentrated markets in 2023.

Source: Source: MDH Health Economics Program analysis of hospital annual reports, updated August 7, 2025.

For more information on this index, visit the US Department of Justice website at https://Antitrust Division Herfindahl-Hirschman Index (www.justice.gov/atr/herfindahl-hirschman-index). SCHSAC Regions are defined on slide 5.

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

Map of Minnesota and accompanying table depict rural hospitals and whether or not they are affiliated with a larger provider group. Of the 90 rural hospitals in 2023, 55 were affiliated with

a larger provider group or hospital system. Critical Access Hospitals, as well as non-Critical Access Hospitals are affiliated with larger hospital systems.

Most of the provider groups were geographically based. Sanford Health is in Western Minnesota, though mostly in the Southwest; Essentia Health is in Northern Minnesota; Mayo Clinic is in Southeast and South Central Minnesota; Catholic Health Initiatives is in Central and West Central Minnesota; CentraCare Health System is in Central Minnesota; Avera Health is in Southwest Minnesota; and Allina Health System is in South Central and Southeast Minnesota.

Hospitals that are part of larger systems: 1) May offer increased access to specialty services only available in urban areas; 2) May increase financial viability; and 3) Lead to consolidation of services to fewer hospitals, meaning some services may be less available in rural areas.

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

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.

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

Line chart that shows hospital net income as a percent of revenue for the following four groups of rural Minnesota hospitals: Medicare Critical Access Hospital designation (CAH) that are part of multi-hospital systems, CAH hospitals that are independent, non-CAH hospitals that are part of multi-hospital systems, and non-CAH hospitals that are independent.

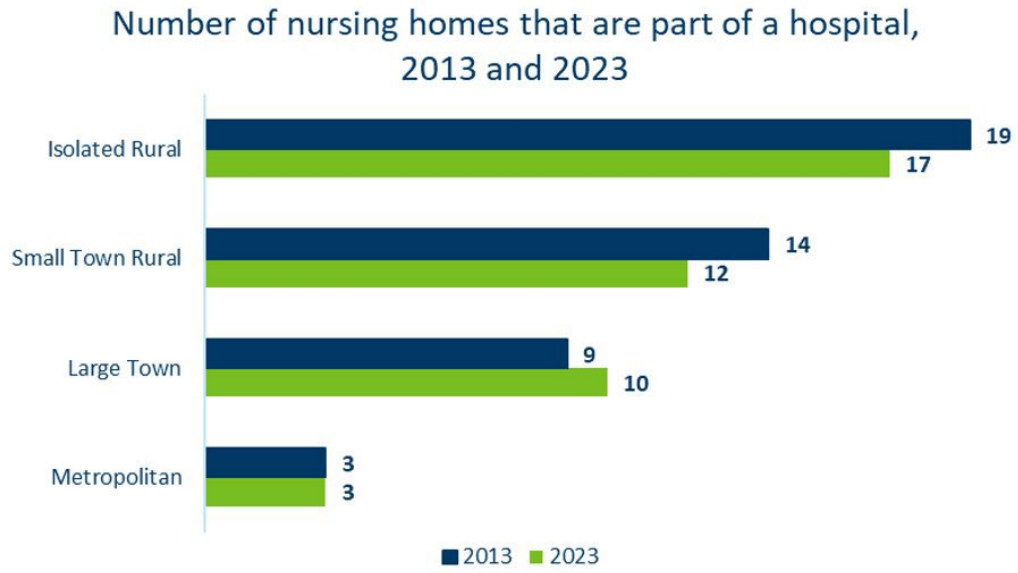
All rural hospitals saw an increase in net income as percent of revenue in 2021, likely due to COVID-19 funding.

CAHs had higher percentages of net income than non-CAHs.

Note: Does not include urban hospitals. Data from 2023 is preliminary.

Source: MDH Health Economics Program analysis of hospital annual reports, October 2024.

Rural areas have seen slight declines in nursing homes attached to hospitals in the past 10 years



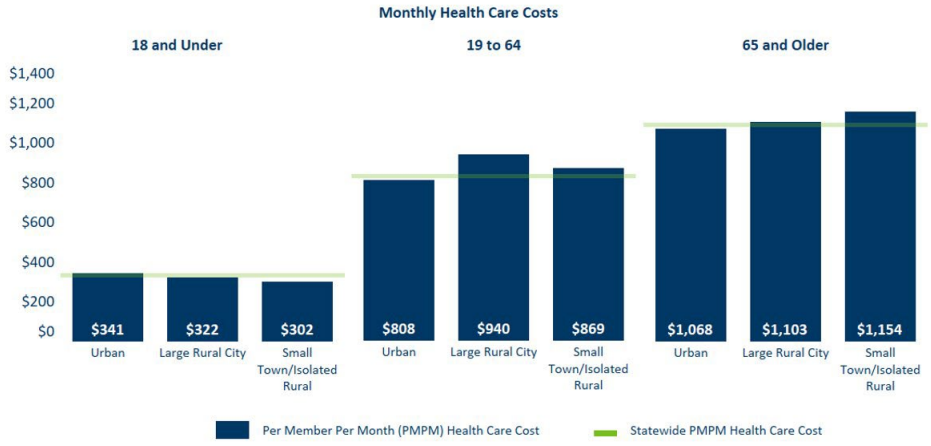
Bar chart shows the number of nursing homes attached to hospitals in 2013 and 2023 by RUCA in Minnesota. The number of hospitals stayed the same in metropolitan areas and small town rural but dropped by one each in large town and isolated rural areas.

- Metropolitan 2013=3; 2023=3;
- Large Town 2013=9; 2023=10;
- Small Town Rural 2013=14; 2023=12;
- Isolated Rural 2013=19; 2023=17

2023 data 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.

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



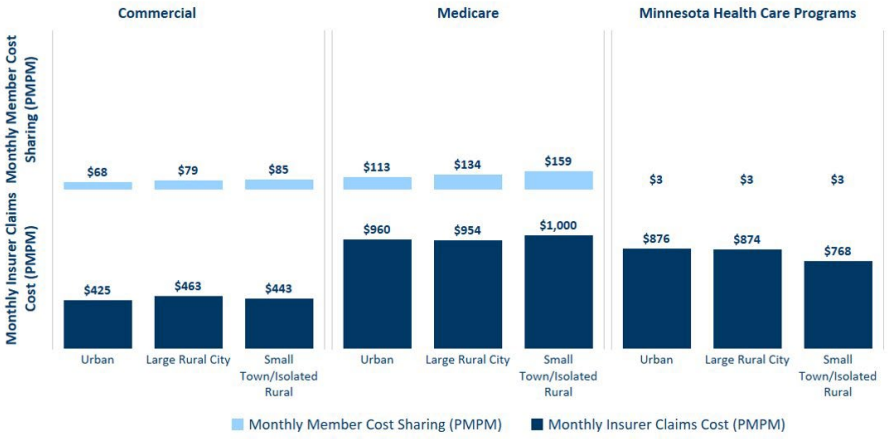
Three bar charts show monthly health care claims costs for Minnesotans living in Urban, Large Rural Cities, and Small Towns/Isolated Rural Areas (these are combined), based on patient zip code. Spending is based on claims submitted to health insurers. Chart 1 shows monthly health care costs for those aged 18 and younger, chart 2 shows monthly health care costs for those aged 19 to 64, and chart three shows monthly health care costs for those aged 65 and older.

- Chart 1: Monthly Health Care Costs, 18 and under. Urban=$341; Large rural city=$322; Small town/isolated rural= $302; statewide=$334.
- Chart 2: Monthly Health Care Costs, 19 to 64. Urban=$808; Large rural city=$940; Small town/isolated rural= $869; statewide=$830.
- Chart 3: Monthly Health Care Costs, 65 and older. Urban=$1,068; Large rural city=$1,103; Small town/isolated rural= $1,154; statewide=$1,090.

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: Minnesota All Payer Claims Database (https://www.health.state.mn.us/data/apcd) .

Minnesotans in rural areas experience higher monthly cost for commercial insurance



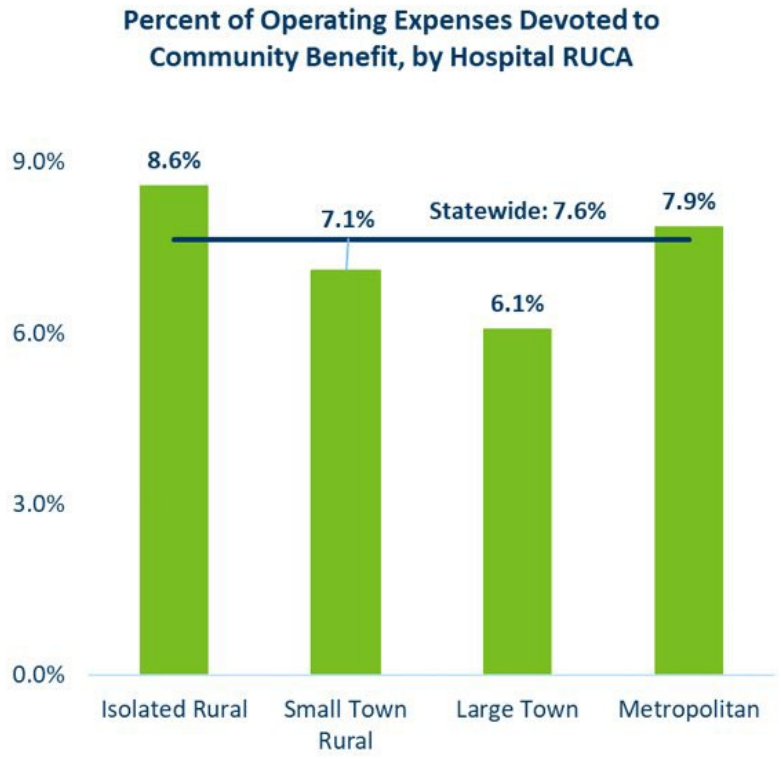
Two bar charts show the distribution in monthly health care costs by insurance coverage type for Minnesotans living in Urban, Large Rural Cities, and Small Towns/Isolated Rural Areas (these are combined), divided by the amount covered by insurers for claims costs, and by individuals as part of cost sharing (such as deductibles, copayments and coinsurance).

- Commercial insurance: Urban=$425 insurer claims cost/$68 member cost sharing; Large rural city=$463 insurer claims cost/$79 member cost sharing; Small town/isolated rural=$443 insurer claims cost/$85 member cost sharing;
- Medicare: Urban=$960 insurer claims cost/$113 member cost sharing; Large rural city=$954 insurer claims cost/$134 member cost sharing; Small town/isolated rural=$1,000 insurer claims cost/$159 member cost sharing;
- Minnesota Health Care Programs (includes Medical Assistance (Medicaid) and MinnesotaCare): Urban=$876 insurer claims cost/$3 member cost sharing; Large rural city==$874 insurer claims cost/$3 member cost sharing; Small town/isolated rural=$768 insurer claims cost/$3 member cost sharing;
- Higher cost sharing in rural areas could be related to: Provider network differences; health status differences; different health plan options available.

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: Minnesota All Payer Claims Database (https://www.health.state.mn.us/data/apcd).

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



Bar chart that depicts what percentage of hospital operating expenses are for community benefit in 2023, by RUCA category, as well as showing the overall statewide percent.

Non-profit hospitals provide community benefit as part of their tax-exempt status and are required to report community benefit spending to the Minnesota Department of Health.

Community benefit spending can be categorized into four broad categories: 1) Direct patient care or unreimbursed services; 2) Research and education; 3) Financial and in-kind contributions; and 4) Community activities.

Most community benefit is in the “direct patient care” category.

Statewide, hospitals devoted 7.6% of their operating expenses to community benefit.

Hospitals in isolated rural areas devoted 8.6% of their operating expenses to community benefit.

Hospitals in small rural towns devoted 7.1% of their operating expenses to community benefit.

Hospitals in large towns devoted 6.1% of their operating expenses to community benefit.

Hospitals in metropolitan areas devoted 7.9% of their operating expenses to community benefit.

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

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%**

Table that depicts the percent of patient revenue from different payers in 2013 and 2023 for Critical Access Hospitals (CAHs), rural hospitals that are not CAHs, and all hospitals statewide. Payers include Medicare, state public programs (Medical Assistance or Medicaid and MinnesotaCare), private insurance, self-pay (which includes uninsured), and other payers (such as workers' comp, auto insurance, VA or TRICARE, or Indian Health Services).

Across all types of hospitals, the primary payers are Medicare and private insurance.

Medicare has increased as a percent of revenues between 2013 and 2023, as the number of people with Medicare coverage has grown.

Critical Access Hospitals have a larger percentage of their revenue from Medicare than private insurance, while other rural hospitals and statewide have private insurance as the largest source of patient revenue.

2023 data is preliminary.

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 2022.

Community benefit for direct patient care is different across the state

Four bar charts that depict the differences in how direct patient care community benefit is distributed between hospitals in different RUCAs in 2023.

The four direct patient care categories are: 1) charity care (care that is provided for free); 2) state health care program underpayments (the difference between the cost of providing services to state public program enrollees and the amount reimbursed – this amount can be $0); 3) operating subsidizes services (the cost of keeping services always staffed regardless of use – such as trauma and emergency services, burn units, and neonatal intensive care units); and 4) community health services costs (costs of community education, community clinic services and free screenings, and self-help programs).

Isolated rural areas focus on operating subsidized services – such as keeping emergency rooms open and staffed;

State health care programs underpayments – 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.

Isolated rural hospitals' distribution of community benefit for direct patient care: charity care=6.4%; state health care programs underpayment=40.6%; operating subsidized services=52.5%; community health services=0.5%.

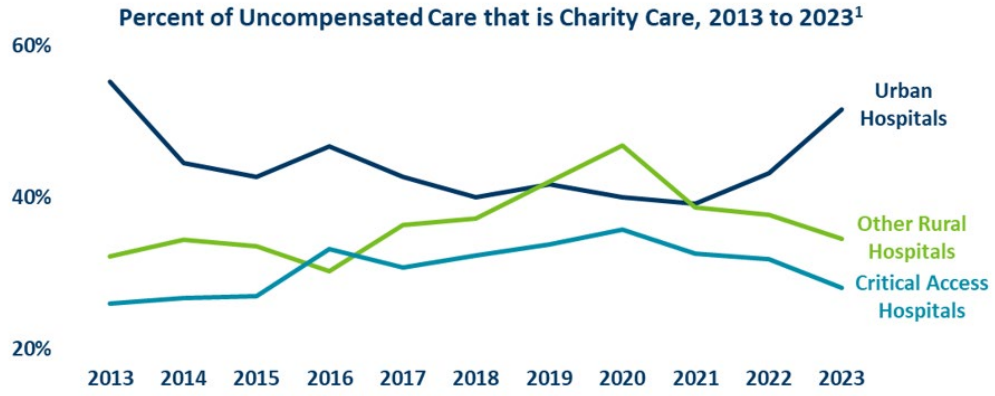
Small town rural hospitals' distribution of community benefit for direct patient care: charity care=7.5%; state health care programs underpayment=60.9%; operating subsidized services=29.5%; community health services=2.1%.

Large town hospitals' distribution of community benefit for direct patient care: charity care=9.3%; state health care programs underpayment=85.1%; operating subsidized services=4.0%; community health services=1.6%.

Metropolitan hospitals' distribution of community benefit for direct patient care: charity care=12.6%; state health care programs underpayment=74.4%; operating subsidized services=9.9%; community health services=3.1%.

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

Most uncompensated care in rural hospitals is bad debt



Line chart that depicts the percent of uncompensated care between 2013 and 2023 that is charity care.

Hospitals provide uncompensated care (health care services that are received, but not fully paid for) in two ways. The first is bad debt, health care services are provided, and payment is expected but not received. The second is charity care, health care services are provided and payment is not expected. Charity care is part of hospital community benefit, bad debt is not.

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.

The percent of uncompensated care that is charity care between 2013 and 2023 was the following:

- 2013: Urban hospitals=55.3%; critical access hospitals=25.9%; other rural hospitals=32.2%;
- 2014: Urban hospitals=44.5%; critical access hospitals=26.7%; other rural hospitals=34.4%;
- 2015: Urban hospitals=42.7%; critical access hospitals=26.9%; other rural hospitals=33.5%;
- 2016: Urban hospitals=46.7%; critical access hospitals=33.1%; other rural hospitals=30.3%;
- 2017: Urban hospitals=42.7%; critical access hospitals=30.7%; other rural hospitals=36.3%;
- 2018: Urban hospitals=40.0%; critical access hospitals=32.3%; other rural hospitals=37.2%;
- 2019: Urban hospitals=41.7%; critical access hospitals=33.8%; other rural hospitals=42.1%;
- 2020: Urban hospitals=39.9%; critical access hospitals=35.5%; other rural hospitals=46.9%;
- 2021: Urban hospitals=39.1%; critical access hospitals=32.6%; other rural hospitals=38.7%
- 2022: Urban hospitals=43.1%; critical access hospitals=31.8%; other rural hospitals=37.7%

2023: Urban hospitals=51.6%; critical access hospitals=28.0%; other rural hospitals=34.5%

2023 data is preliminary.

Source: MDH, Health Economics Program analysis of Hospital Annual Reports, October 2024.

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