



DEPARTMENT
OF HEALTH

Rural Health Care in Minnesota: Data Highlights

Division of Health Policy

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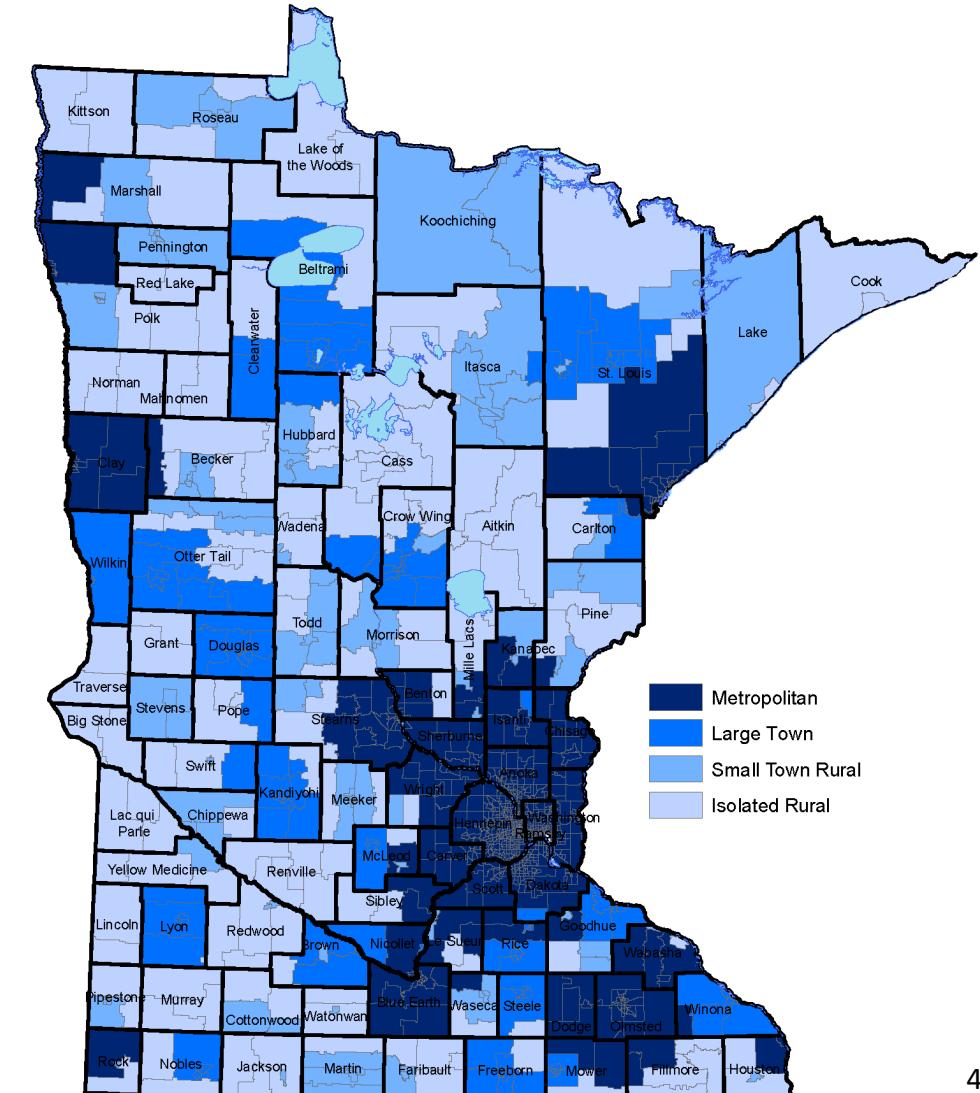
Technical notes

- A summary of all data sources and notes are available at [Data Sources Used in Rural Health Care in Minnesota: Data Highlights \(PDF\) \(<https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmnsum.pdf>\)](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 at [Rural Health Care in Minnesota: Data Highlights \(PDF\) \(<https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmndata.pdf>\)](https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmndata.pdf)
- Direct links are listed on each slide.

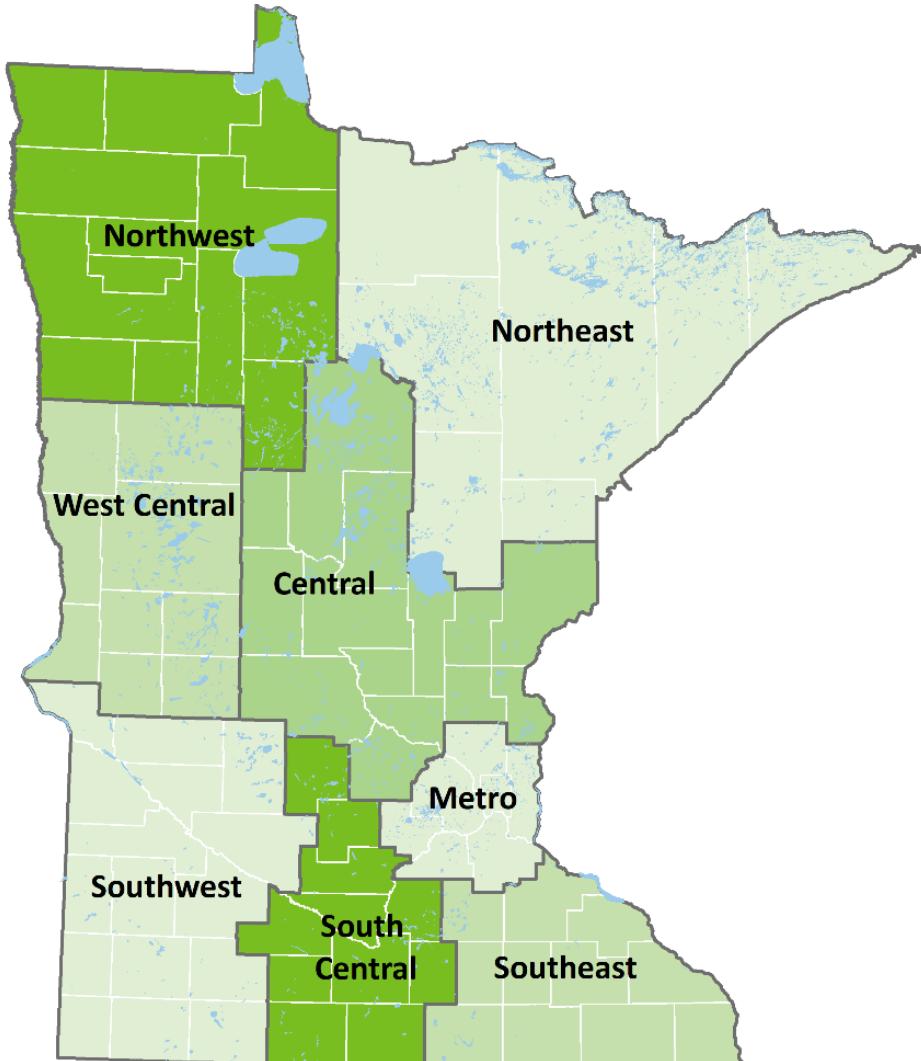
Defining rural: Rural-Urban Commuting Area (RUCA) Codes

- 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.



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.

State of Rural Minnesota

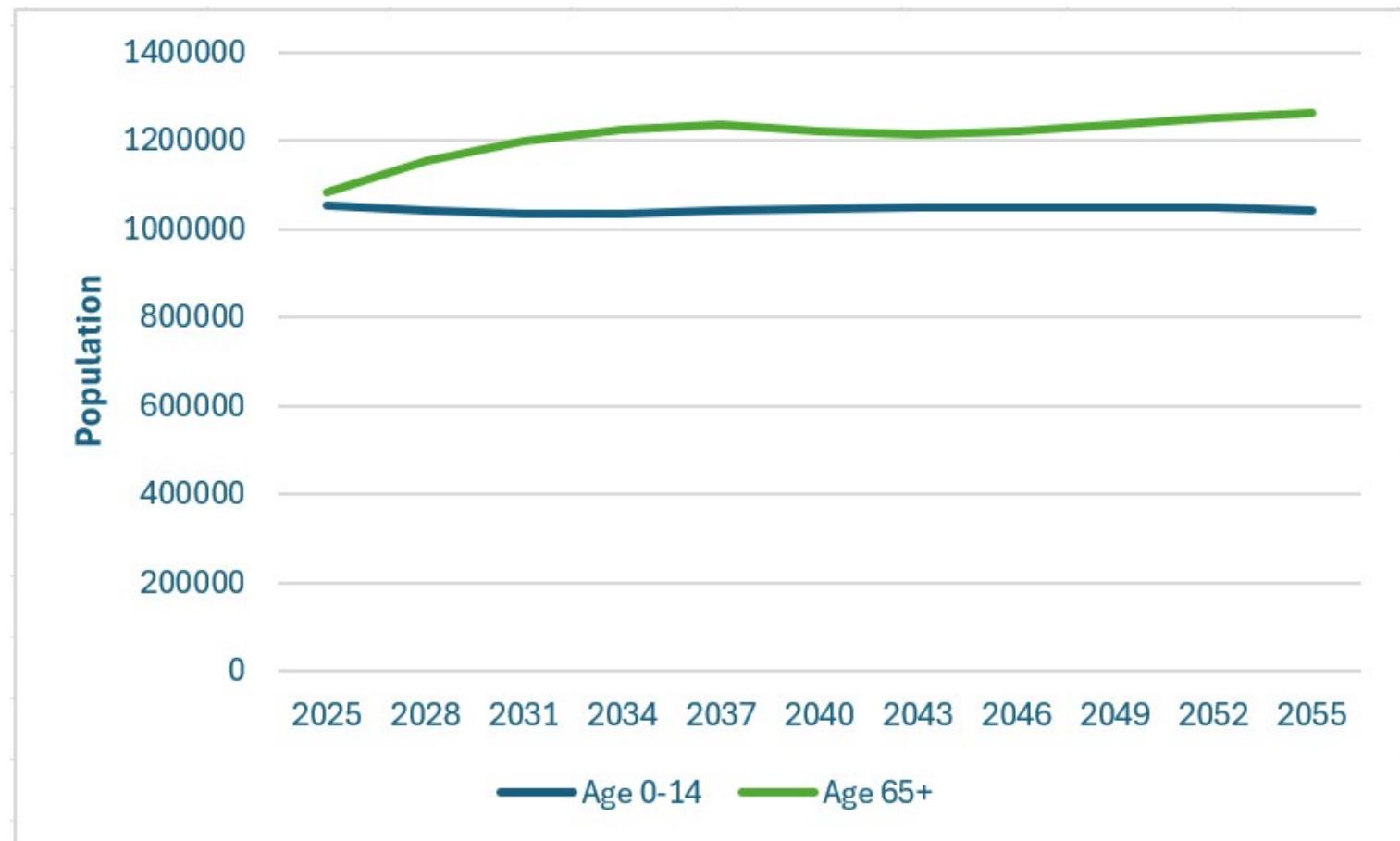
What are the demographic characteristics of rural Minnesota?

Key points – 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 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.

The population of Minnesota is aging

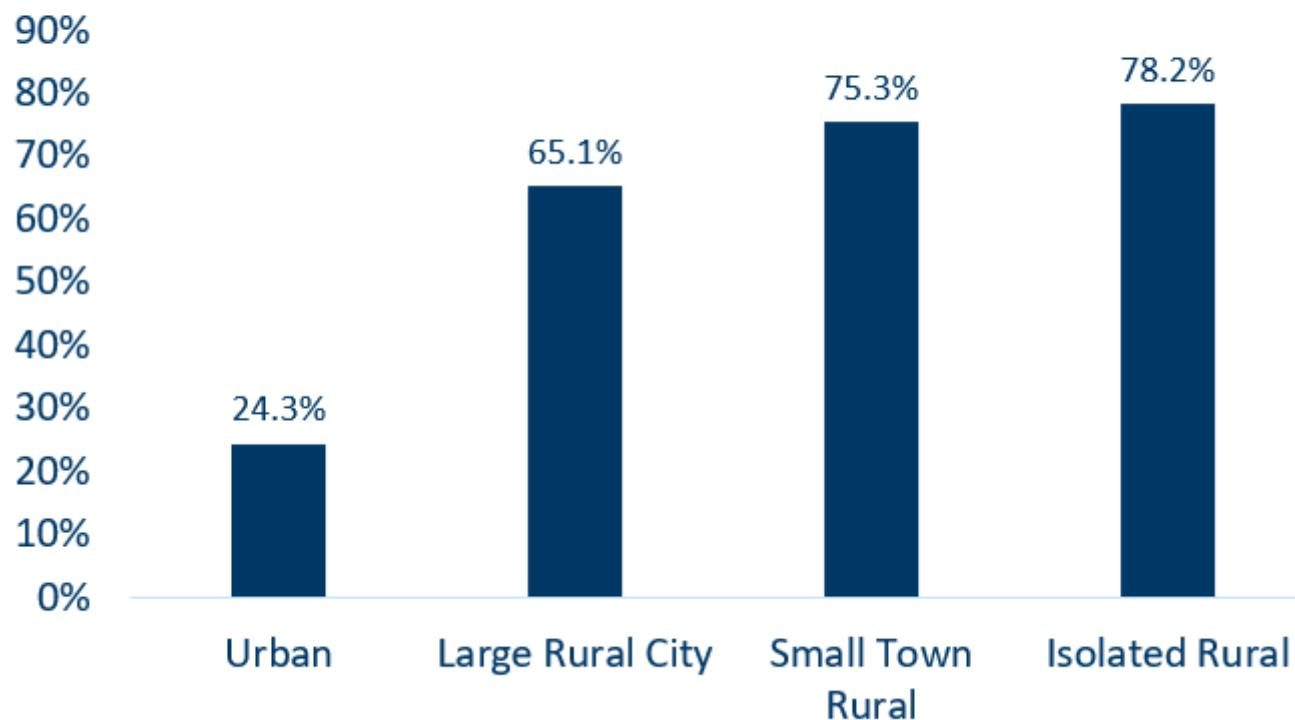
- In 2025, the total number of older adults (65+) is projected to outnumber children in Minnesota age 0 to 14.
- In 2030, one quarter (25.4%) of residents of rural Minnesota counties are projected to be 65 years of age or older vs. 19% for urban counties.



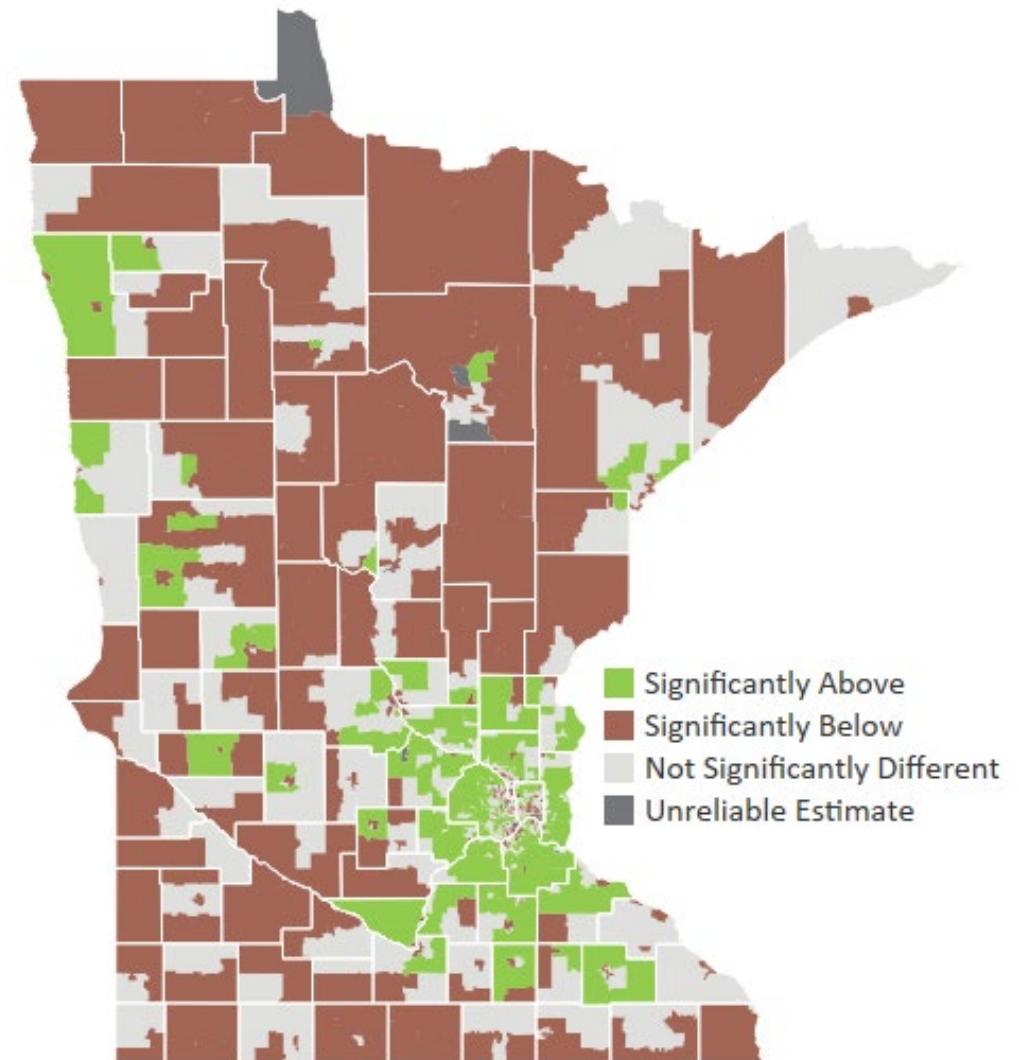
Source: Minnesota State Demographic Center data obtained on October 8, 2024, from [Data by Topic: Our Projections / MN State Demographic Center](https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/) (<https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/>) (vintage May 2024).

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

More than three out of four of people living in small towns and isolated rural areas have household incomes below the statewide median income

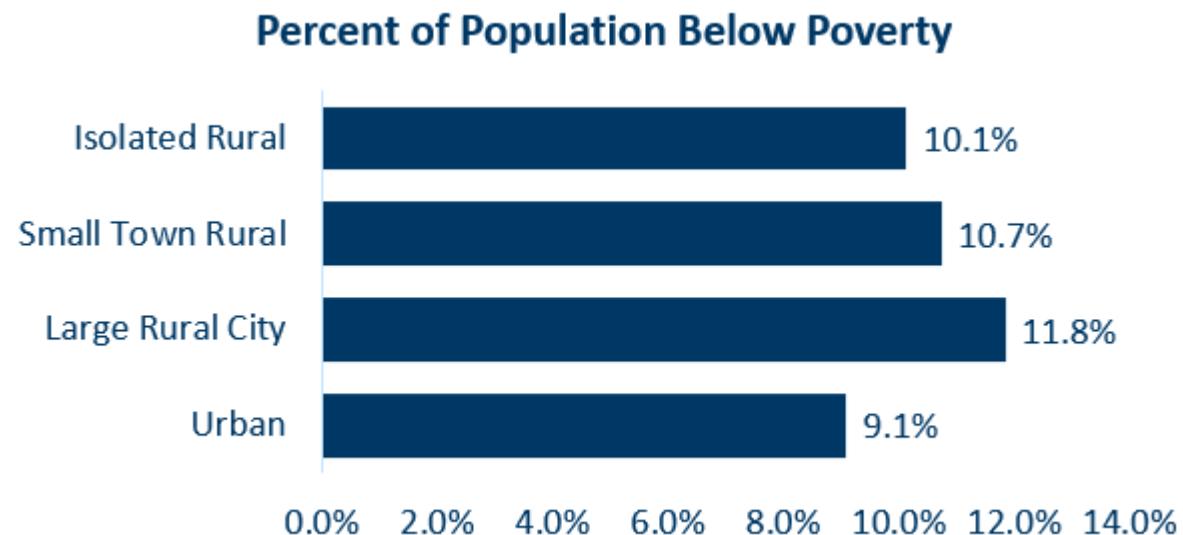


Source: MDH/Health Economics Program analysis of the 2022 American Community Survey Five-Year Estimate. RUCA based on census tract.



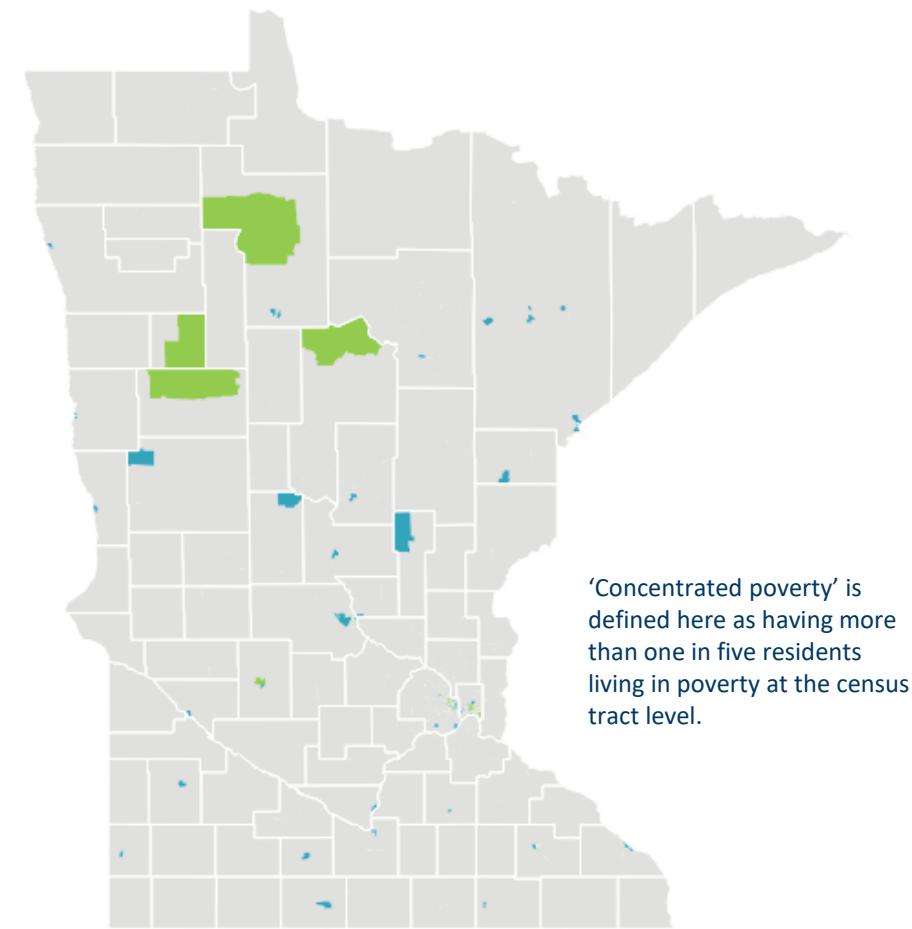
Areas of concentrated poverty occur in both rural and urban areas of the state

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



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.



'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

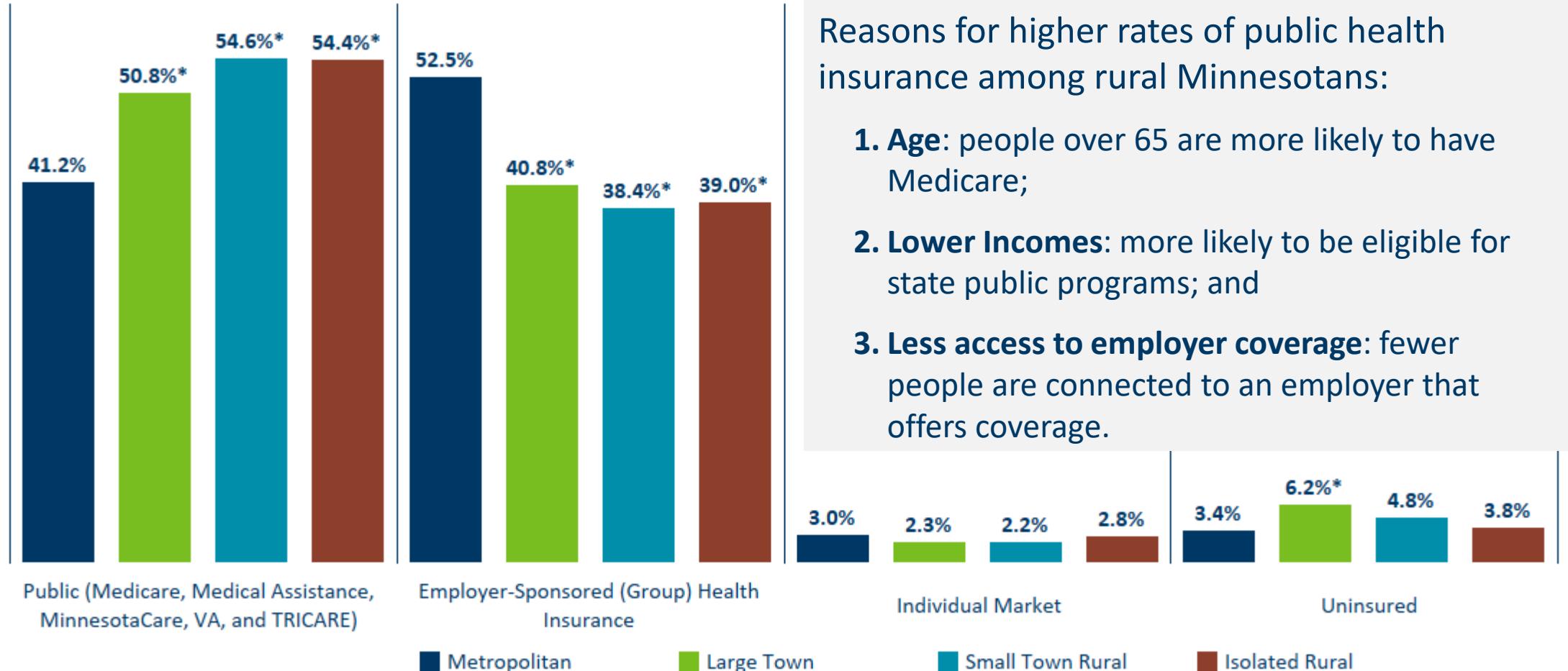
Structure of Rural Health System: An Overview

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.

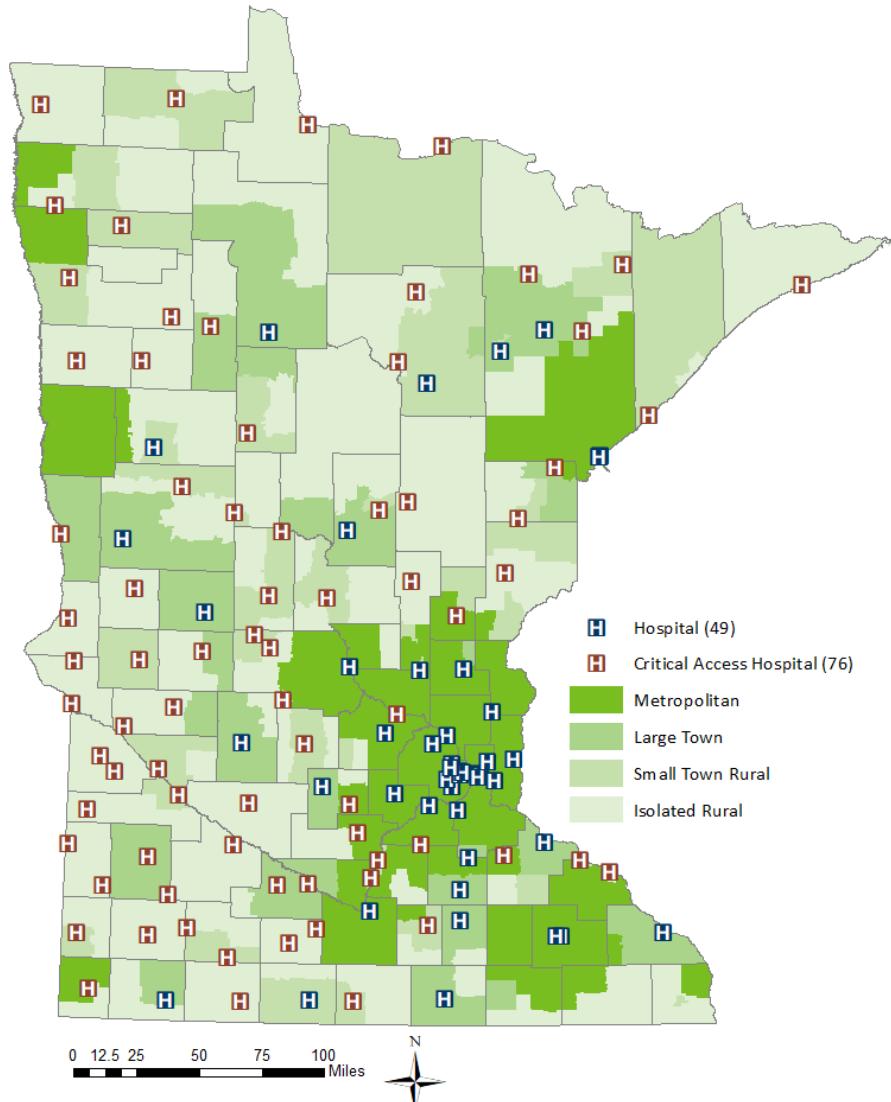
Rural Minnesotans are more likely to have public health insurance coverage, such as Medicare, Medicaid or MinnesotaCare



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



- 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.

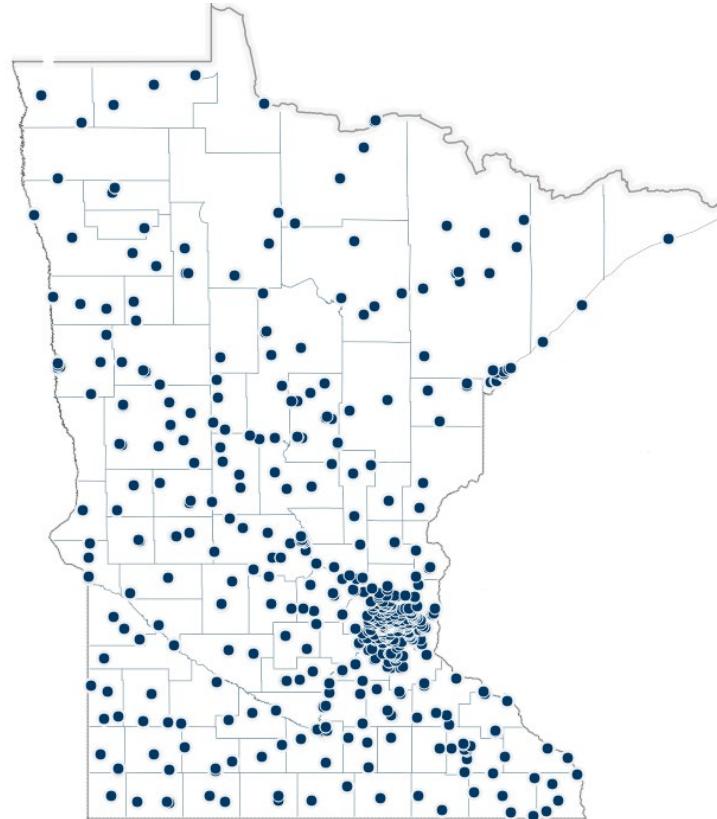
² There are 76 Critical Access Hospitals in Minnesota; however, one is an Indian Health Services Hospital. This is not included in the count of community hospitals, which are limited to non-federal short-term general and other special hospitals and are accessible by the general public. [Critical Access Hospitals \(https://www.health.state.mn.us/facilities/ruralhealth/flex/cah/index.html\)](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.

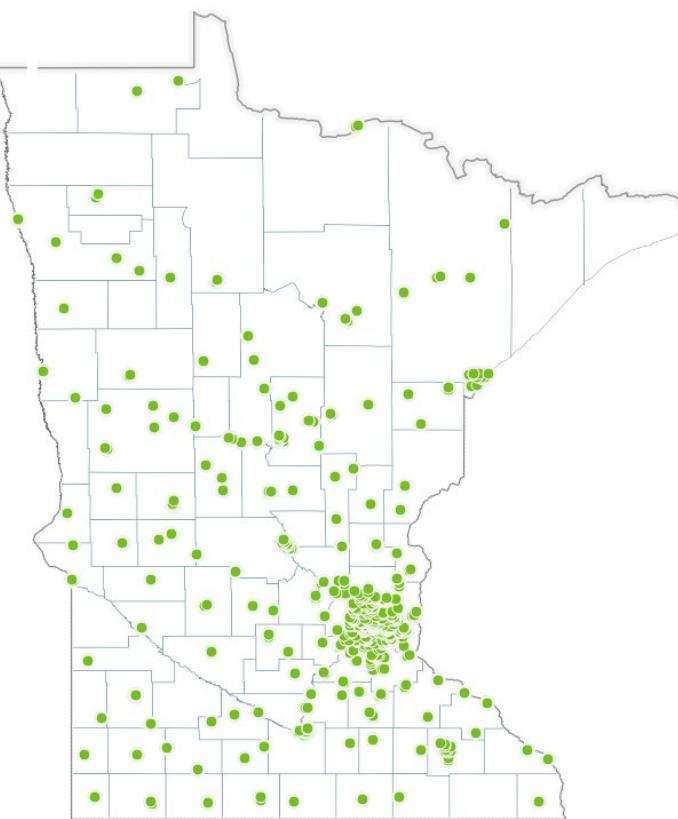
⁴ Source: Minnesota Department of Health, Health Economics Program analysis of 2024 Directory of Registered, Licensed and/or Certified Health Care Facilities and Service.

Primary and specialty clinics are available throughout Minnesota

Primary Care Clinics, 2023



Specialty Care Clinics, 2023



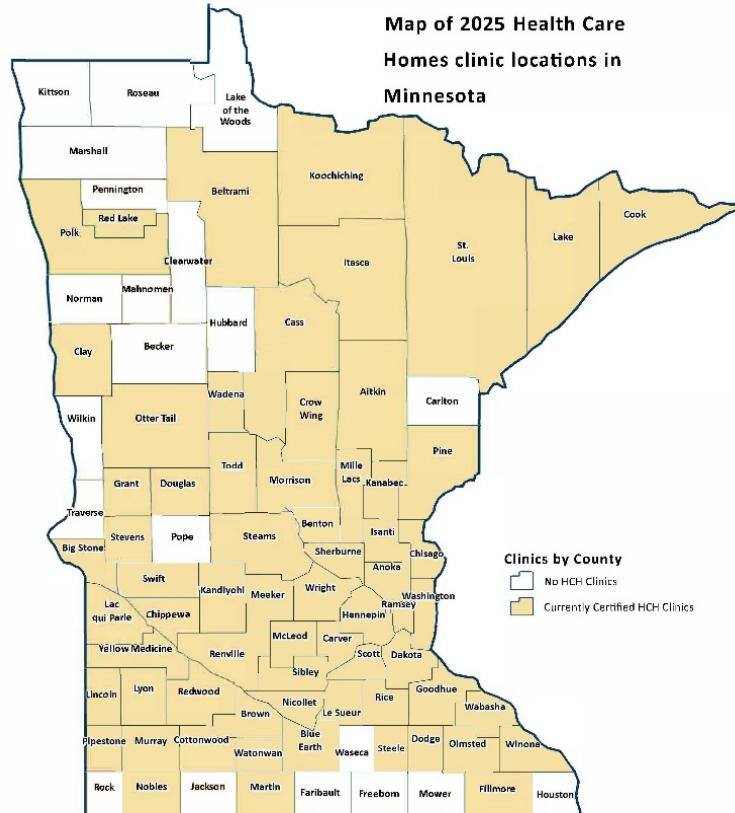
- 40% (241) of all primary care clinics (599) are located in rural areas.¹
- 22% (196) of all specialty care clinics (907) are located in rural areas.¹
- Minnesota's 17 Community Health Centers care for nearly 200,000 low-income people.²

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.

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

²Source: [What is a CHC - Minnesota Association of Community Health Centers \(https://www.mnachc.org/what-is-a-community-health-center\)](https://www.mnachc.org/what-is-a-community-health-center)

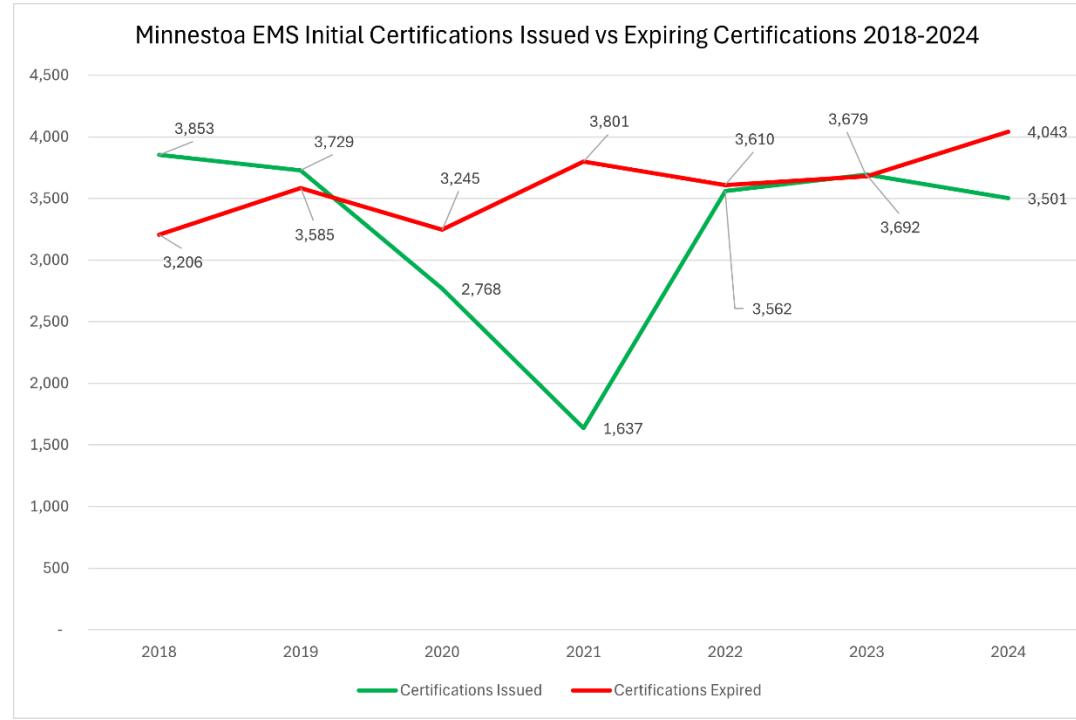
Person-centered, coordinated primary care available to most Minnesotans



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

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



- 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.

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% 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 121 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

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 actively 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 more 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.

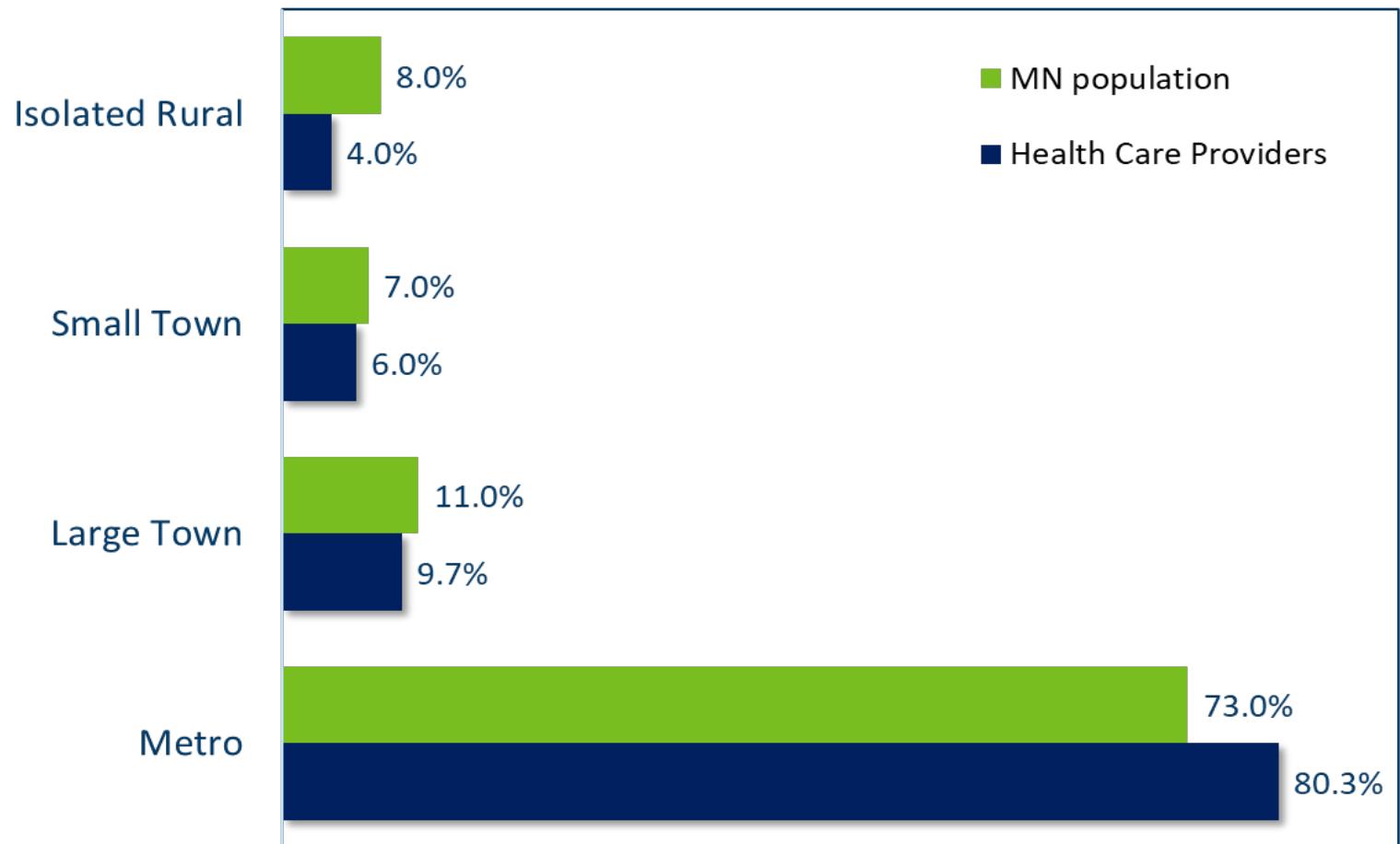
The number of actively licensed providers in Minnesota by profession type

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

Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, 2025. This table excludes Respiratory Therapists and some other smaller licensed occupations, including: Chiropractic, Sports Medicine, and Occupational Therapy.

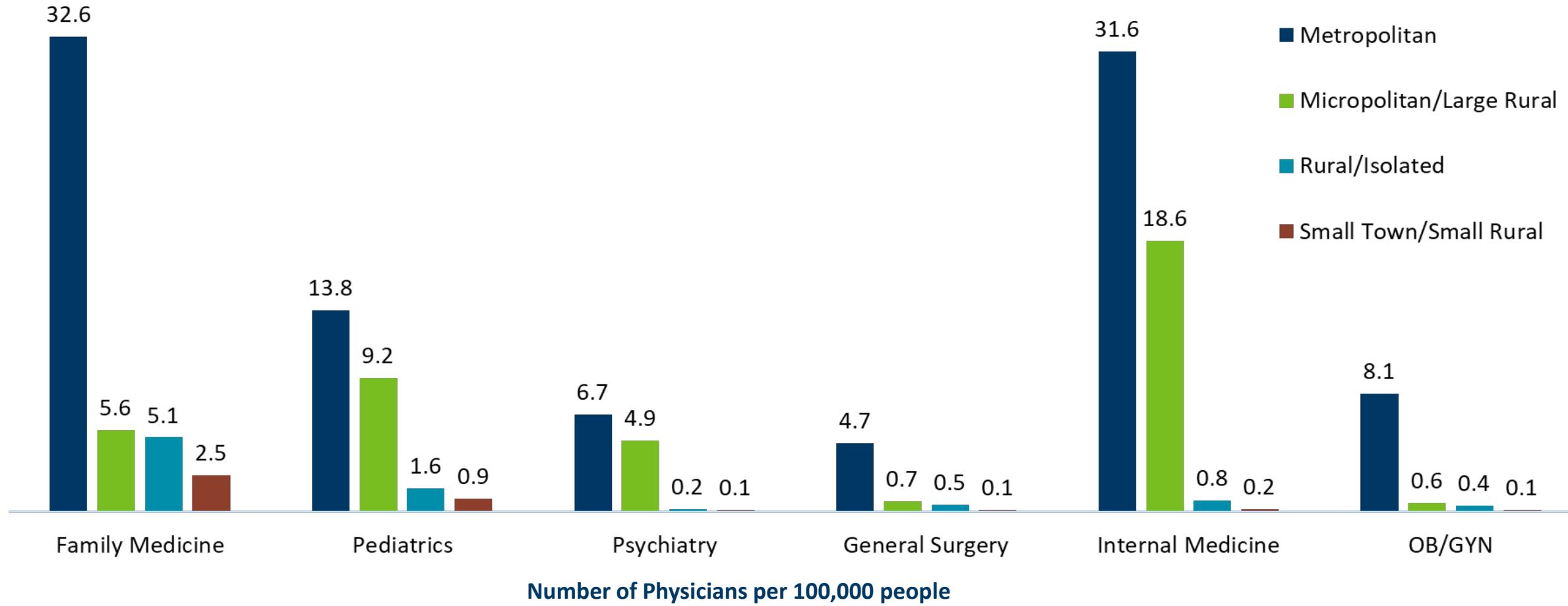
The majority of licensed health care providers work in metropolitan areas

Very few licensed health care providers work in rural areas.



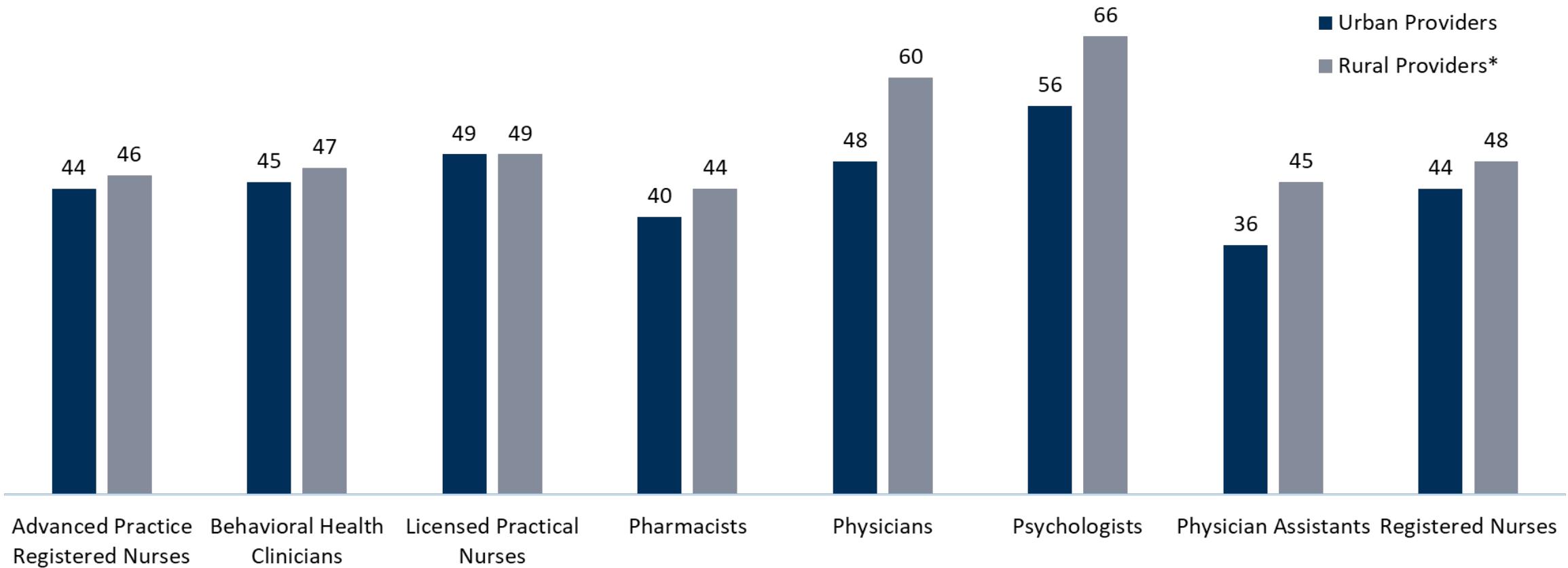
Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, 2025. Data includes: physicians, physician assistants, respiratory therapists, oral health professions, pharmacy professions, physical therapy professions, and mental health professions.

Rural areas face severe shortages of physicians in multiple specialties



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. March 2025.

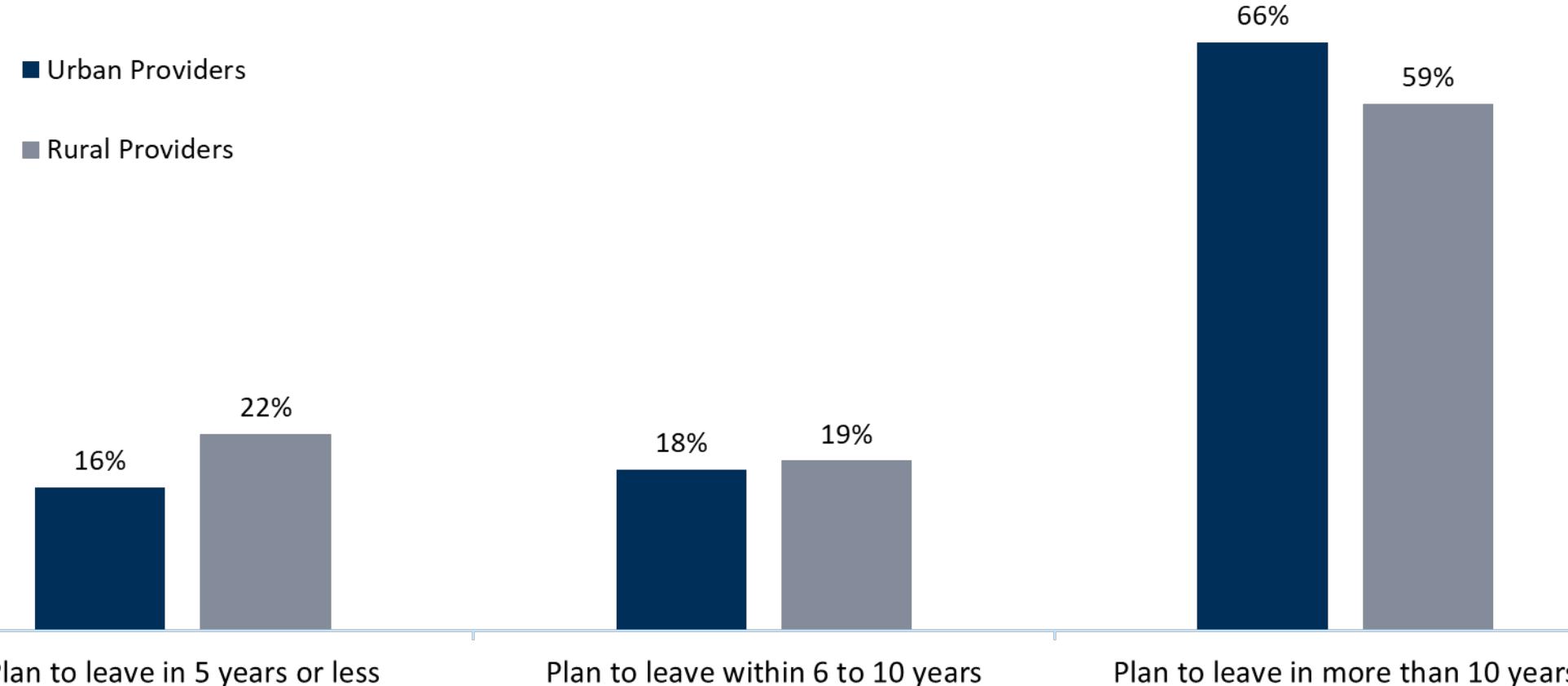
Rural providers are older than their urban counterparts



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

*Rural = isolated rural from Rural-Urban Commuting Area codes.

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



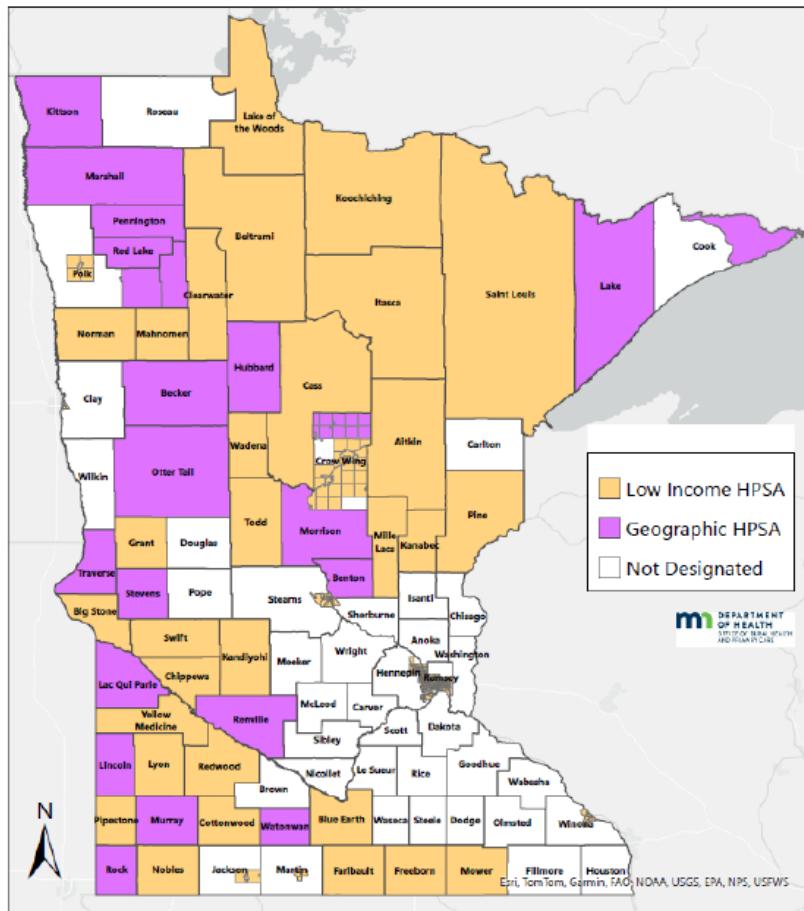
Building the rural provider pipeline

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

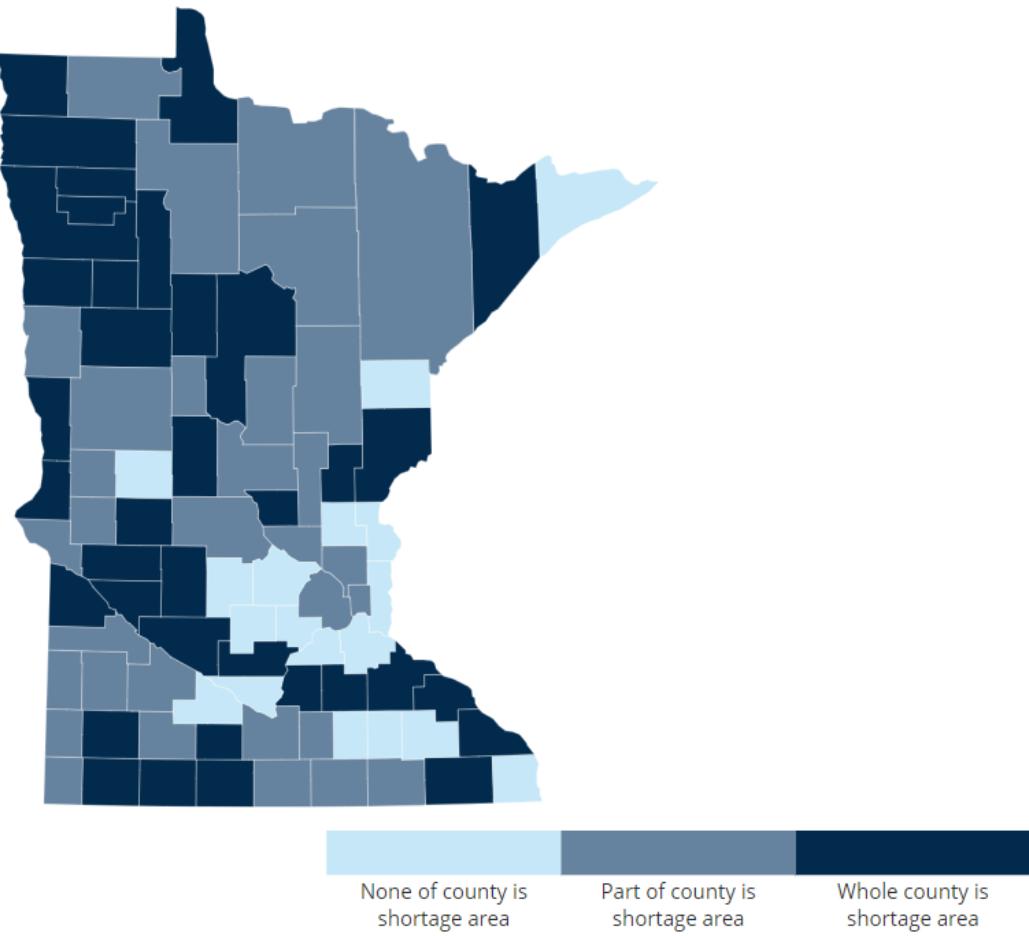
Expected Matriculation date	Urban partner	Rural partner	Slots/seats	Field
2025	CentraCare System, St. Cloud	CentraCare, Wilmar	3	Family medicine
2026	Fairview Health System, Minneapolis	Grand Itasca Clinic and Hospital, Grand Rapids	3	Family medicine
2027	North Memorial, Minneapolis	Lakewood Health System,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

Minnesota has 557 designated Health Professional Shortage Areas

Health Professional Shortage Areas Dental



Health Professional Shortage Areas Primary Care



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.

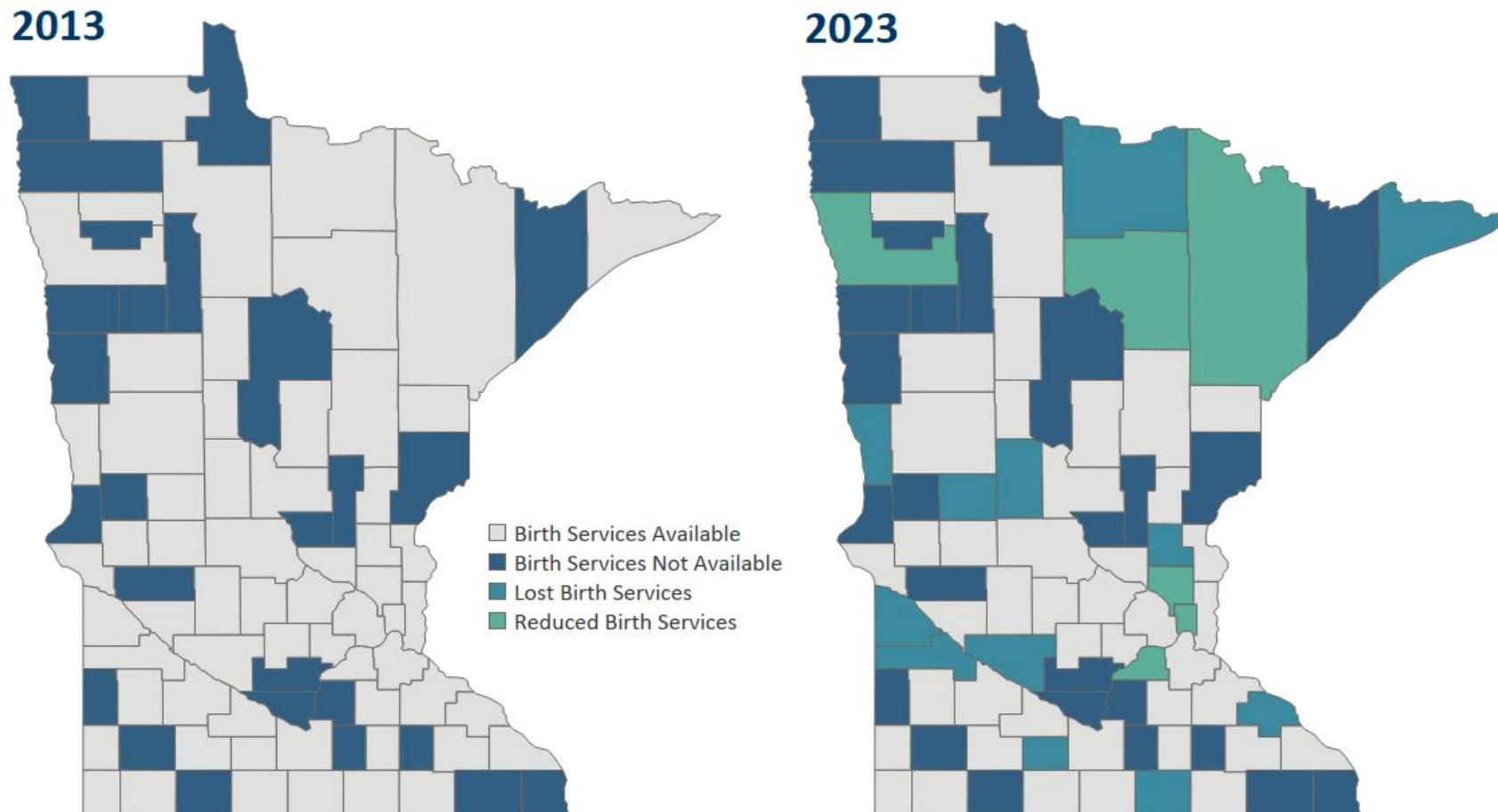
Rural hospitals saw declines in surgical services due to hospital closures, consolidation, or service loss over the past decade

	Hospitals with service available in 2013	Change in Service due to:			Hospitals with service available in 2023	Percent Change 2013 to 2023
		Closure or Consolidation	Lost Service	Added Service		
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.

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.

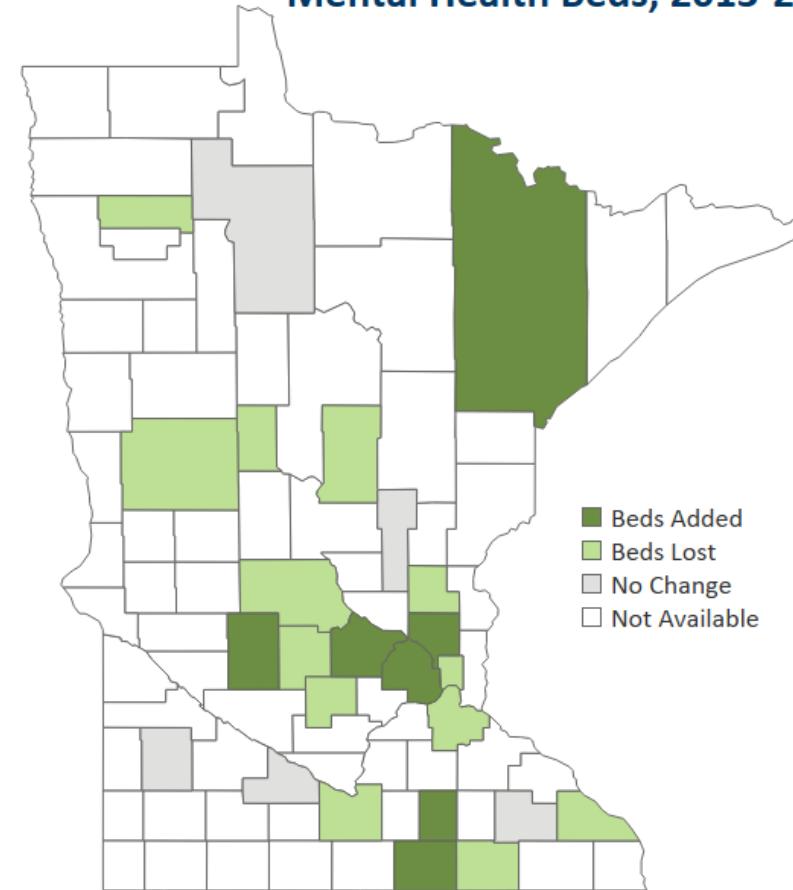
Note: MDH Health Economics Program analysis of hospital annual reports, September 2024; Due to a merger, the hospital in Mower County was no longer an independent licensed entity; however, birth services were offered at that site under the license of the remaining corporate entity.

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.

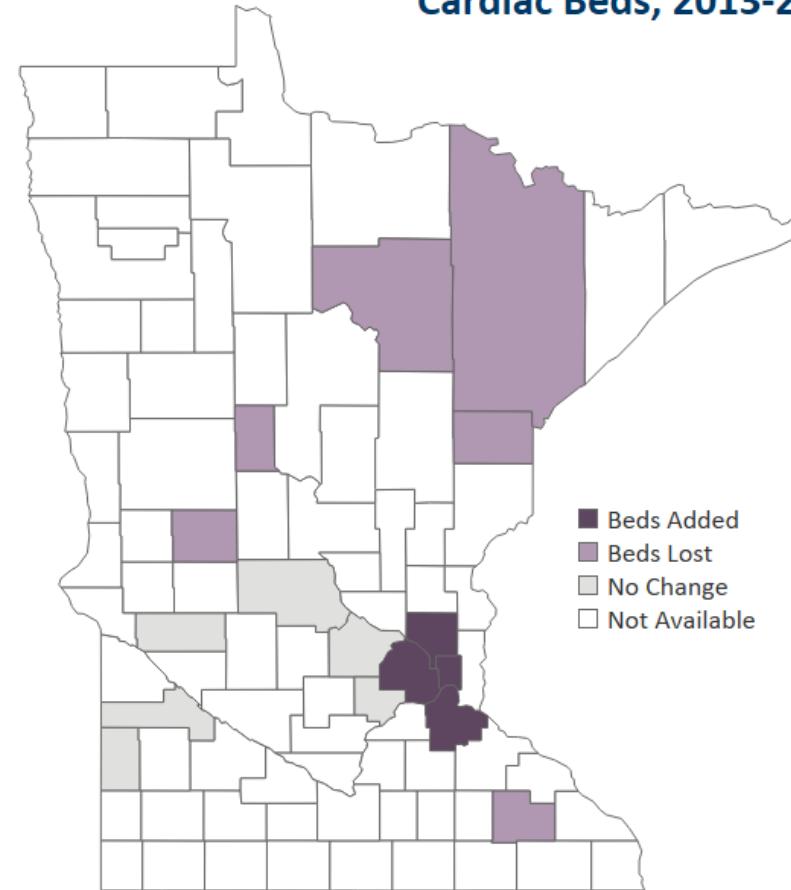
Definition: Community hospitals were categorized as not offering birth services if they did not have at least one routine birth, had no licensed bassinets, or stated that services were not available.

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

Mental Health Beds, 2013-2023



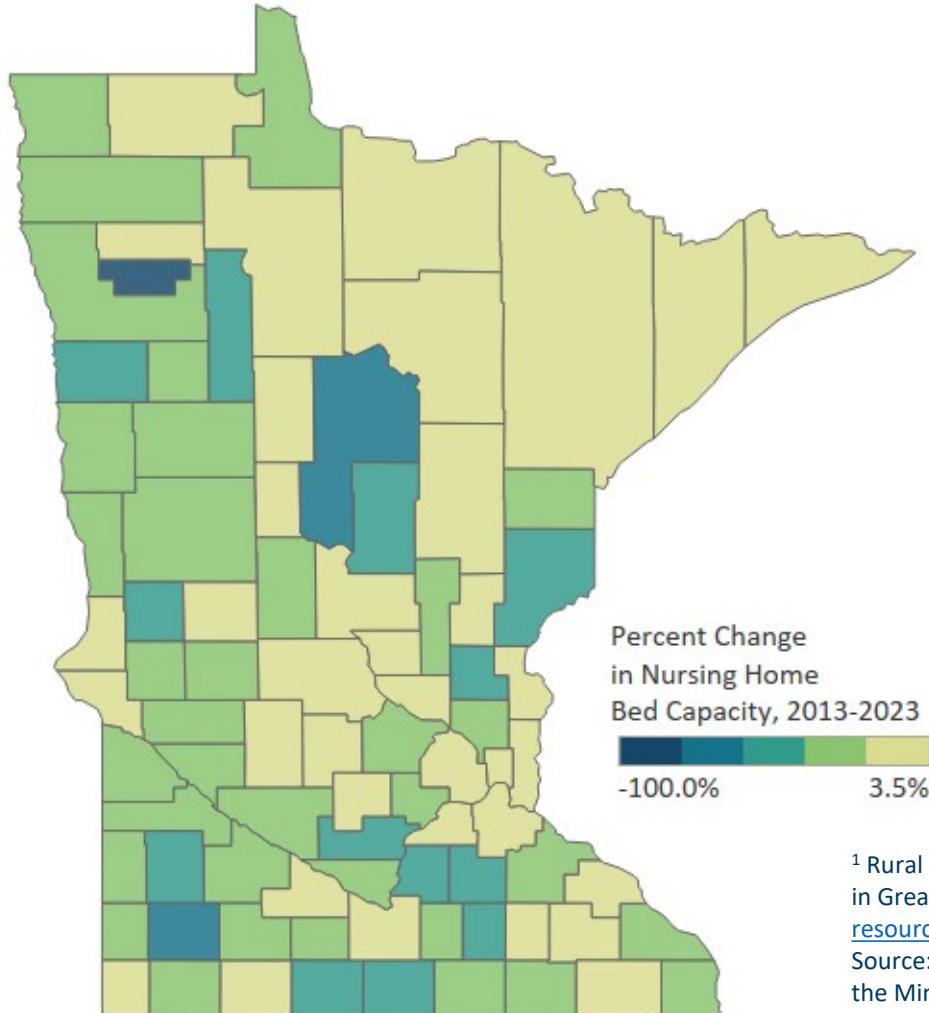
Cardiac Beds, 2013-2023



Statewide between 2013 and 2023*:

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

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



- Rural counties¹ 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 counties¹ 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 ([Greater MN: Refined & Revisited \(https://mn.gov/admin/demography/reports-resources/greater-mn-refined-and-revisited.jsp\)](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

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?

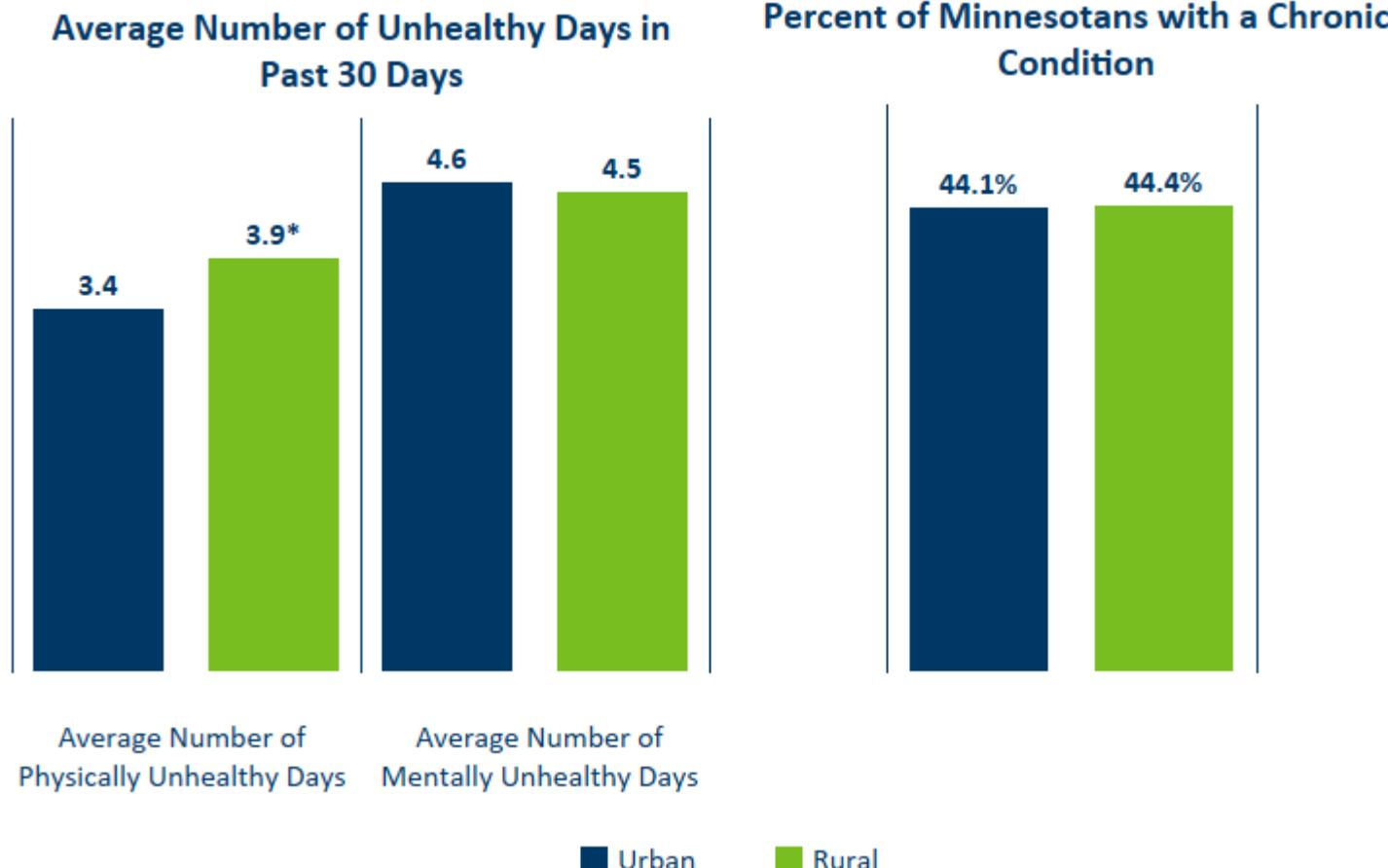
Key points – Health care access and use

- 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



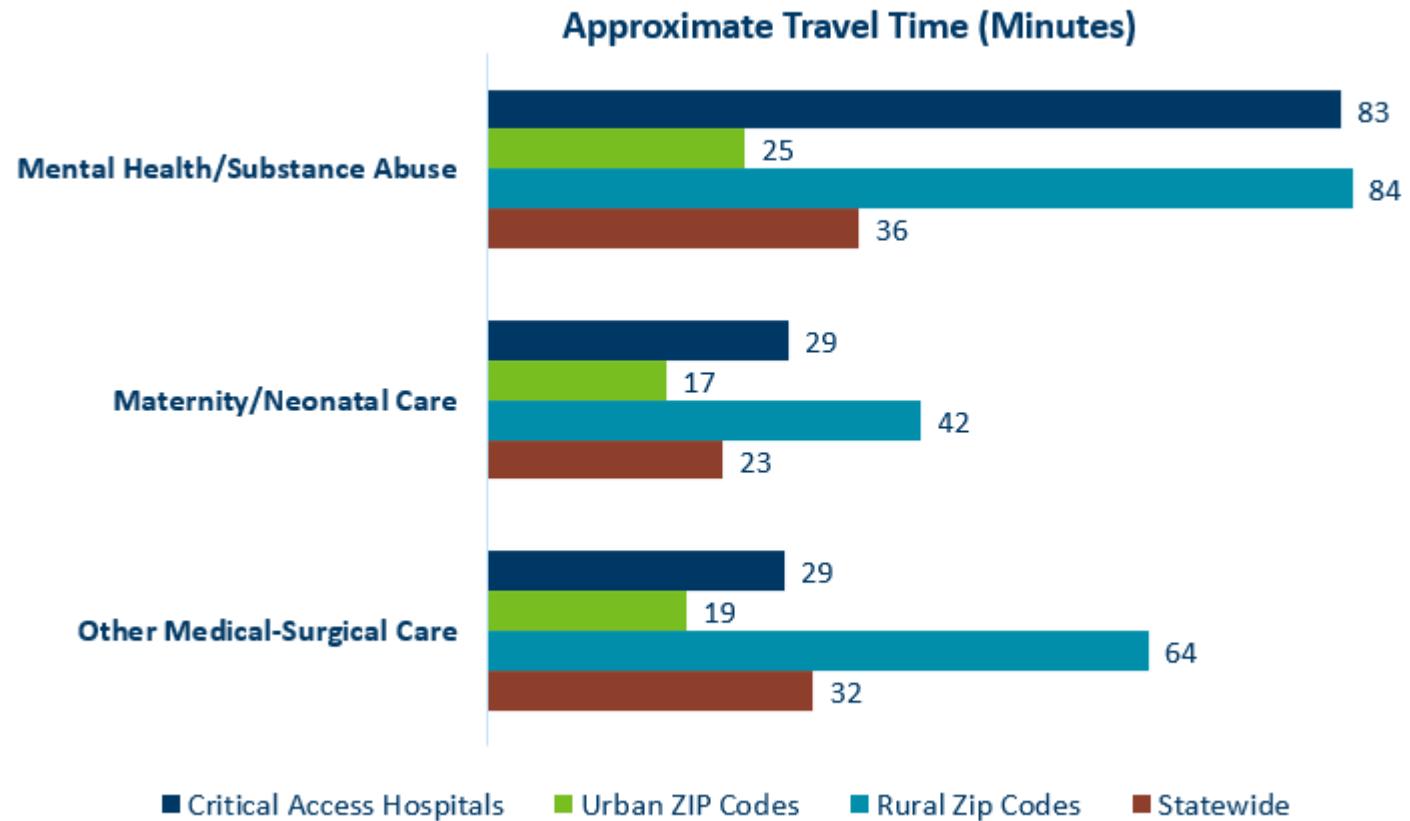
- Minnesotans living in rural areas reported frequent mental distress at about the same rate (13.6%) as those living in urban areas (13.7%).¹
- Age-adjusted suicide rate in rural counties of Minnesota have been higher in 2023 with over 16 per 100,000 vs. a rate of 13.1 in urban non-metro and 11.8 Twin 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 [Data Brief: Suicide Up in 2022, Down in 2023 \(PDF\)](https://www.health.state.mn.us/communities/suicide/documents/2023suicidedatabrief.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

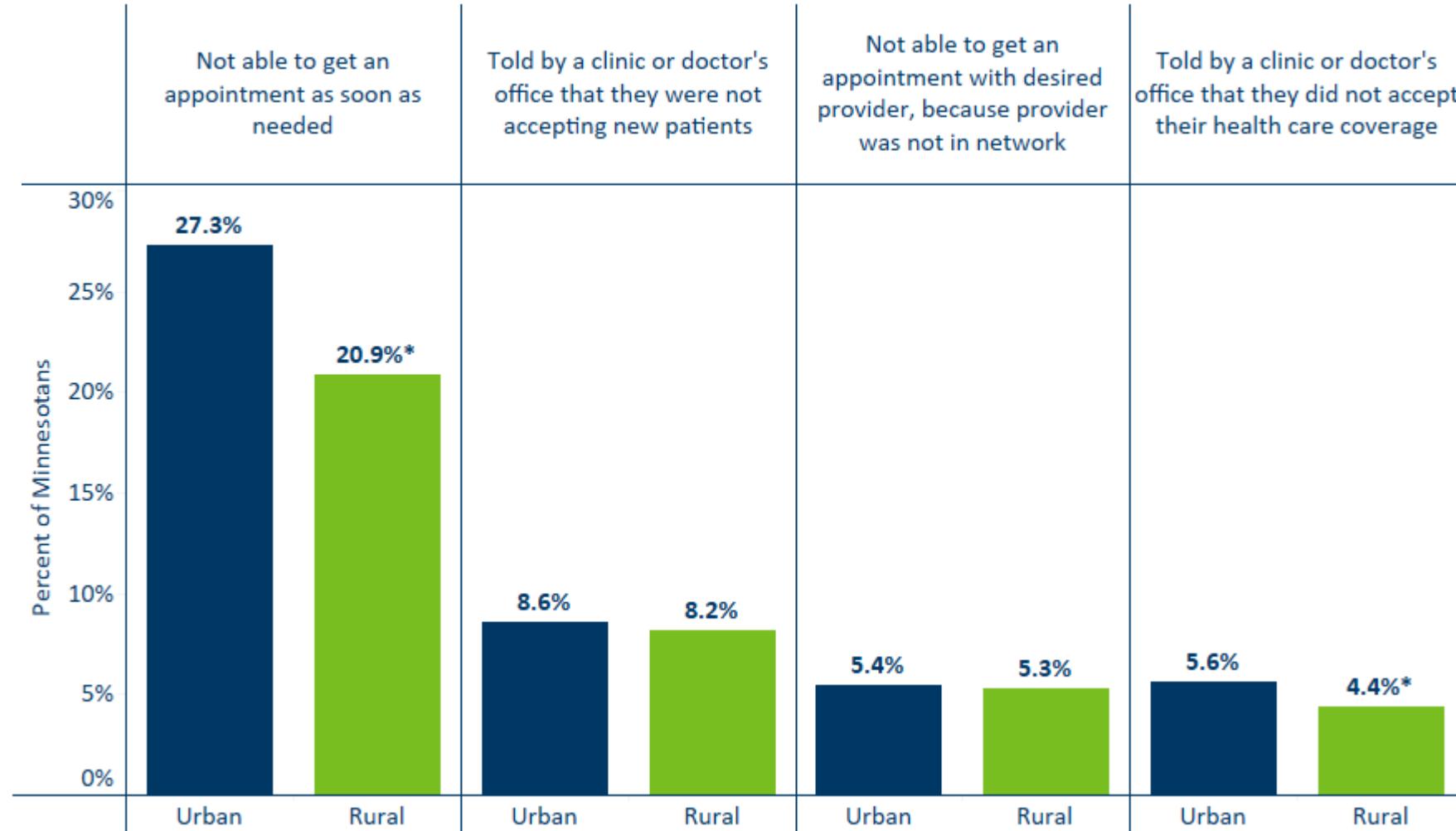
- Rural patients seeking inpatient mental health and chemical dependency treatment travel more than three times longer than urban patients.
- Patients receiving medical/surgical care at Critical Access Hospitals experience shorter travel times than those traveling to other types of hospitals.



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.

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.

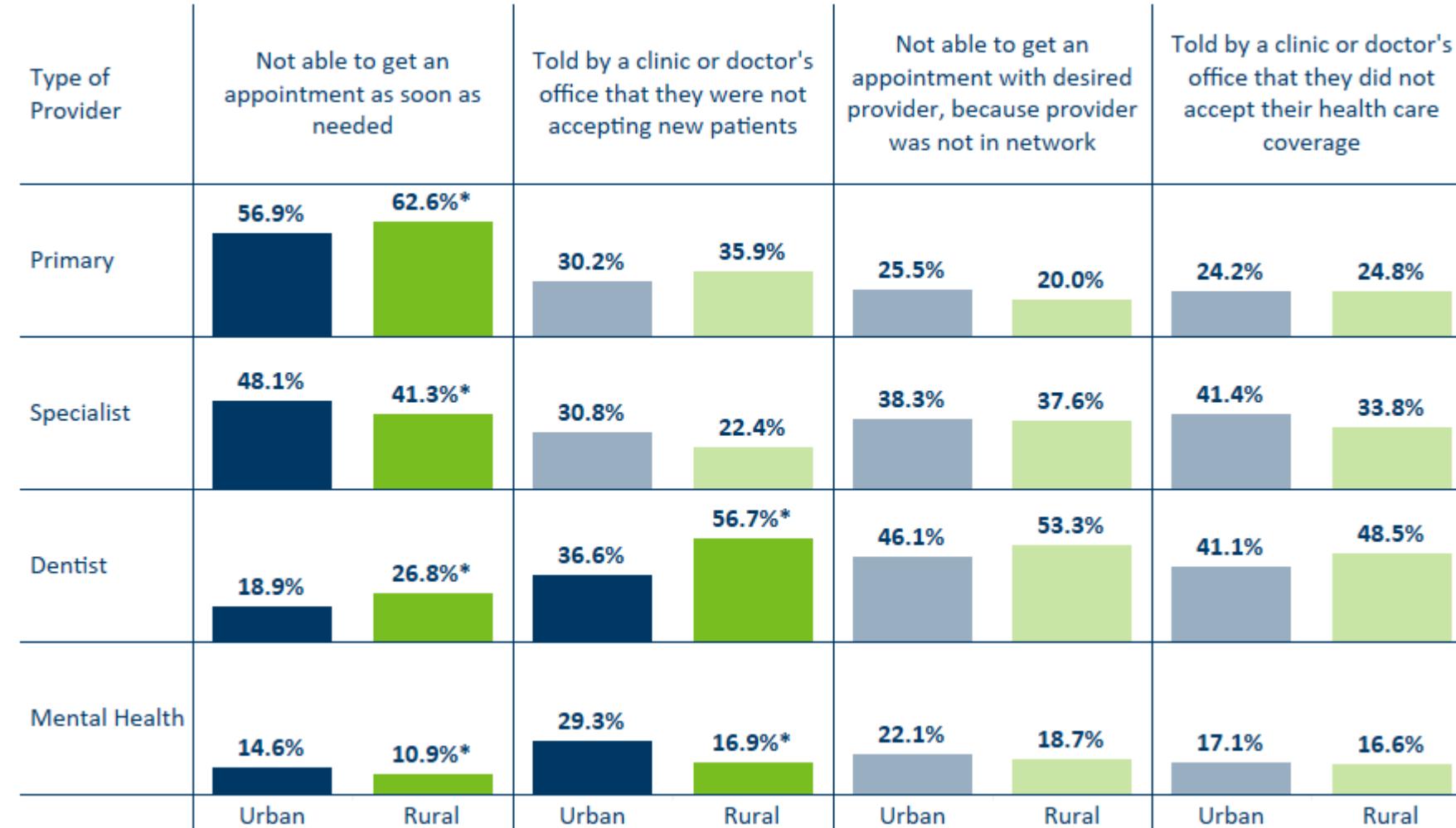
*Indicates significant difference from Urban at the 95% level.

Urban and Rural defined based on RUCA zip-code approximations.

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.



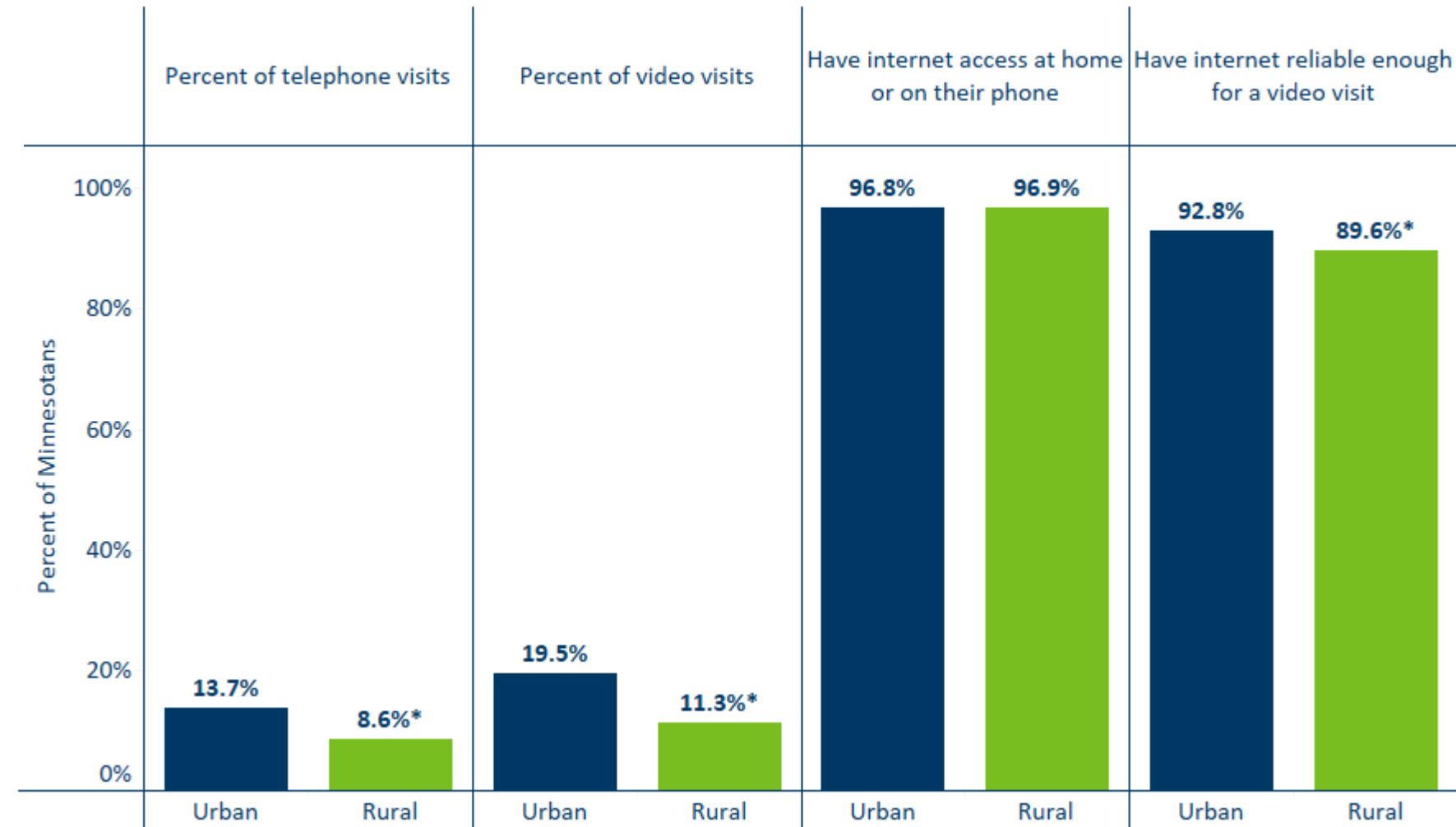
Source: Minnesota Health Access Survey, 2023.

*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.

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.

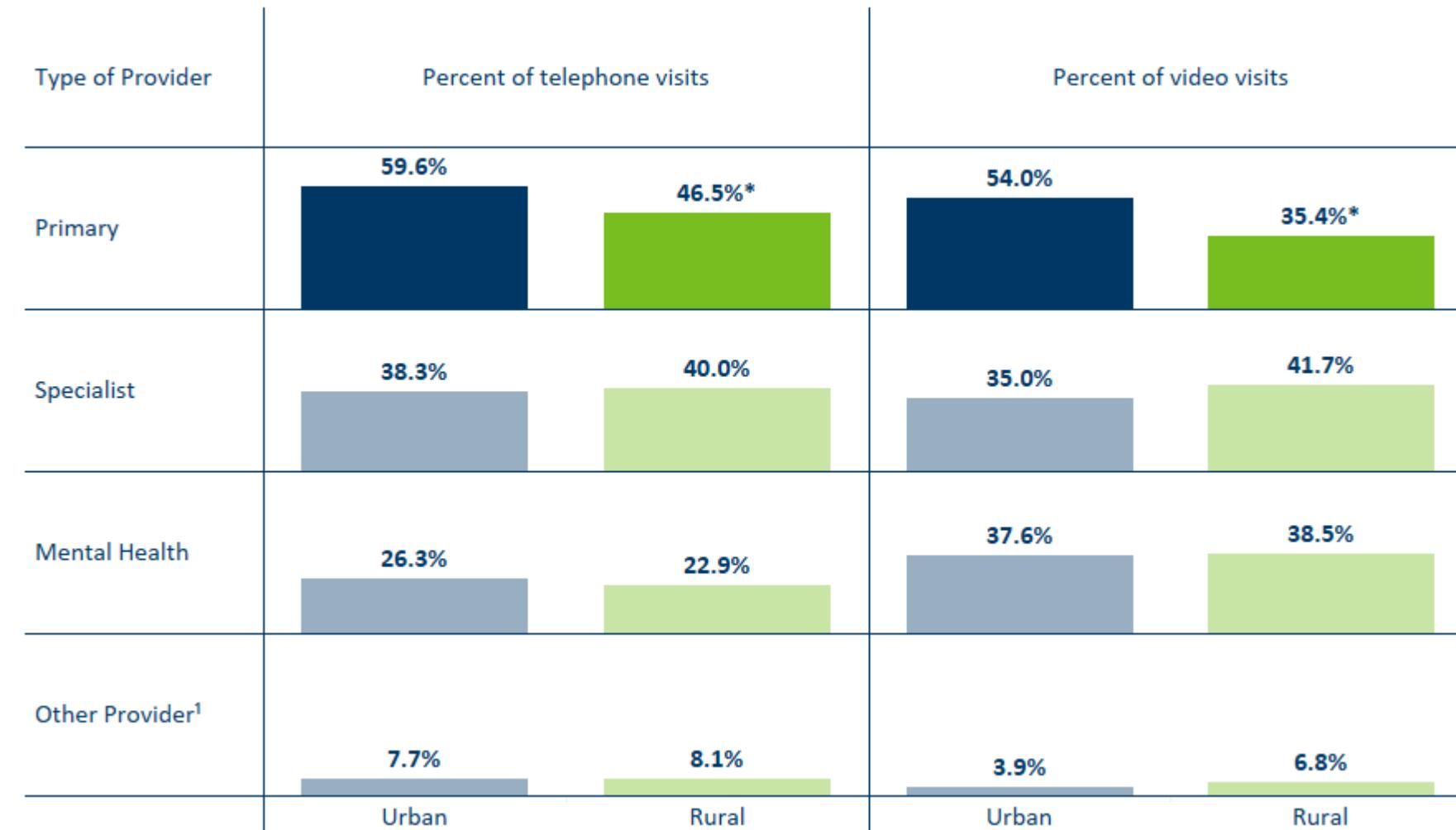


Source: Minnesota Health Access Survey, 2023.

*Indicates significant difference from Urban at the 95% level.

Urban and Rural defined based on RUCA zip-code approximations.

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.

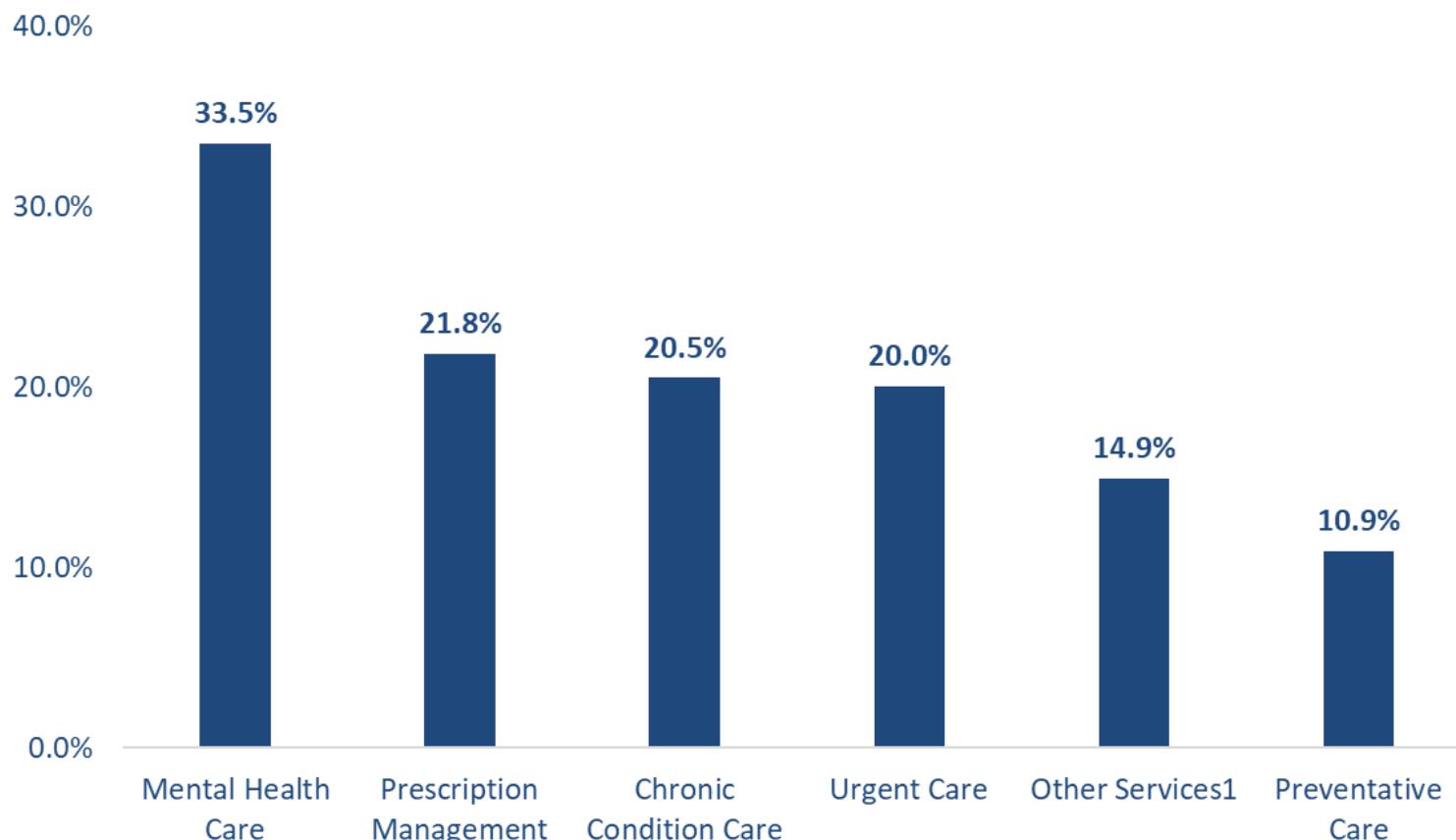
*Indicates significant difference from Urban at the 95% level.

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.

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

Care received at most recent telehealth visit



- 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.

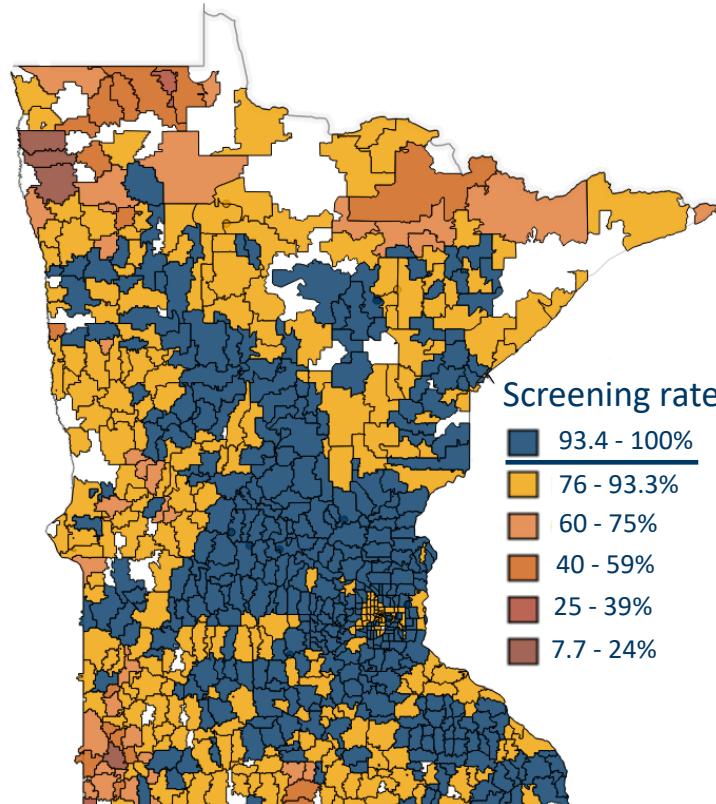
Source: Minnesota Telehealth Access Survey, 2023.

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.

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](http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-children-and-adolescents-screening1)

(<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-children-and-adolescents-screening1>)(2016), U.S. Preventive Services Task Force).

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

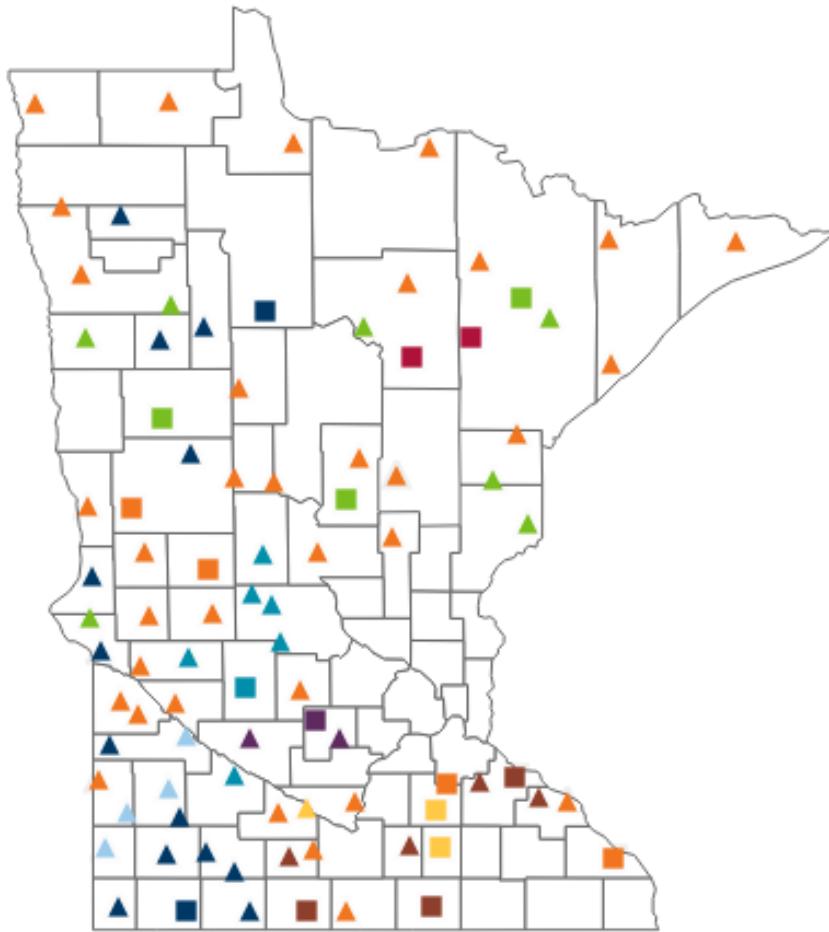
- More and more rural hospitals are affiliated with larger hospital and provider systems.
- CAH status has been associated with higher net incomes for hospitals.
- Rural residents experience higher monthly cost sharing as compared to their urban counterparts for commercial insurance and Medicare.
- Isolated 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.

Minnesota hospital markets are not competitive



Source: MDH, Health Economics Program calculation of Herfindahl-Hirschman competition (HHI) index based on net patient revenue from Hospital Annual Report Data, updated on August 7, 2025. Data from 2023. 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. For more information on this index, visit the US Department of Justice website at [Antitrust Division Herfindahl-Hirschman Index \(www.justice.gov/atr/herfindahl-hirschman-index\)](http://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

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.

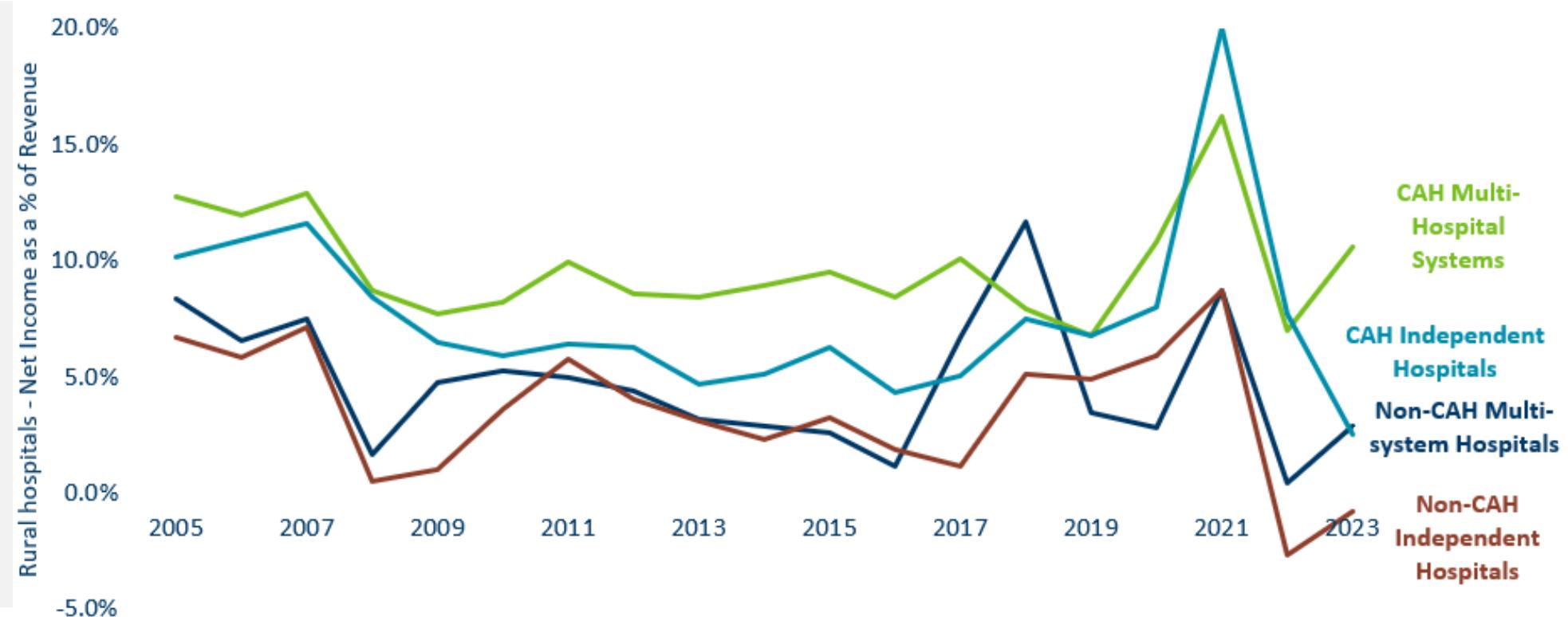
Source: MDH Health Economics Program analysis of hospital annual reports, October 2024. Data from 2023 is preliminary.

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.

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.

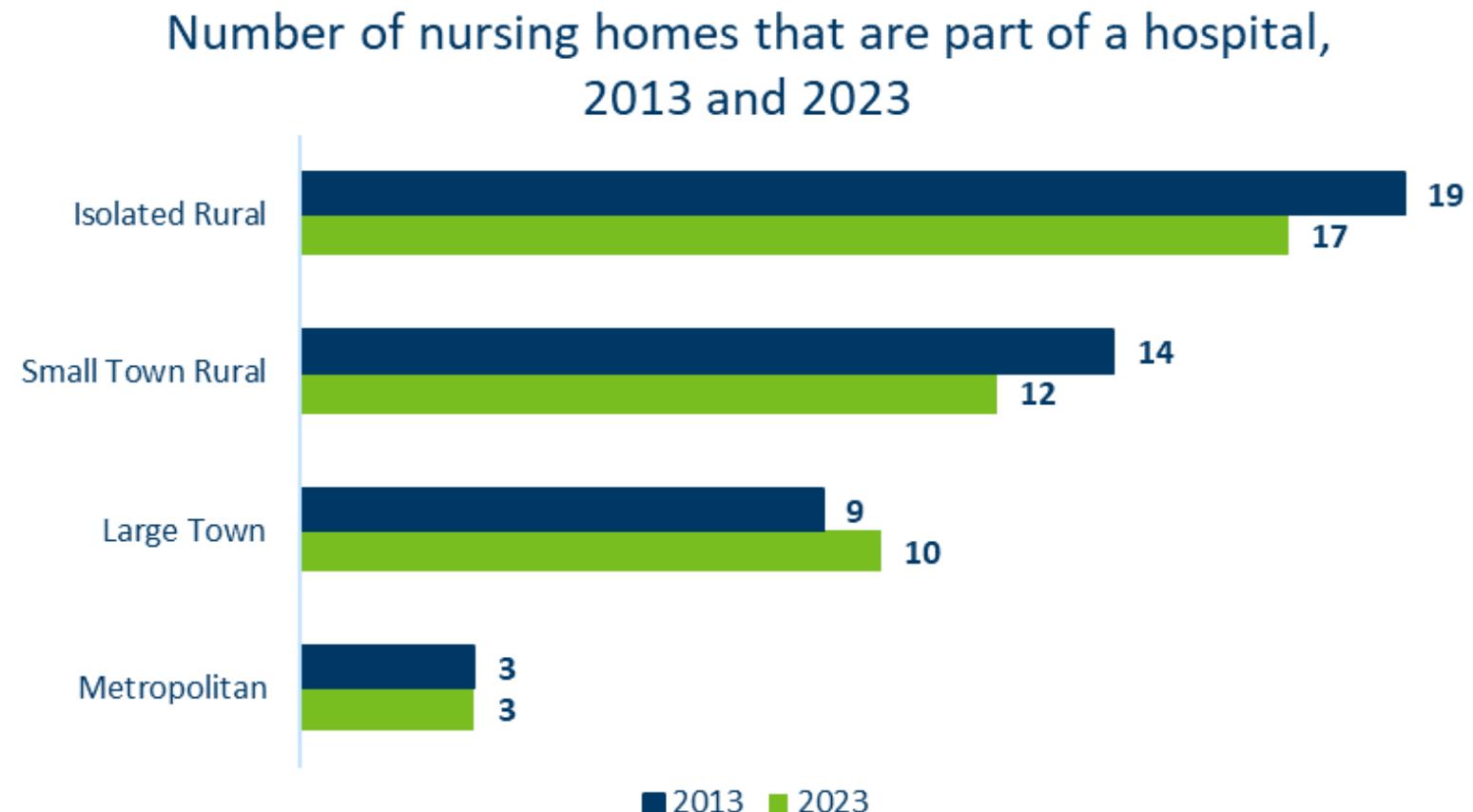


Note: Does not include urban hospitals. Data from 2023 is preliminary.

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

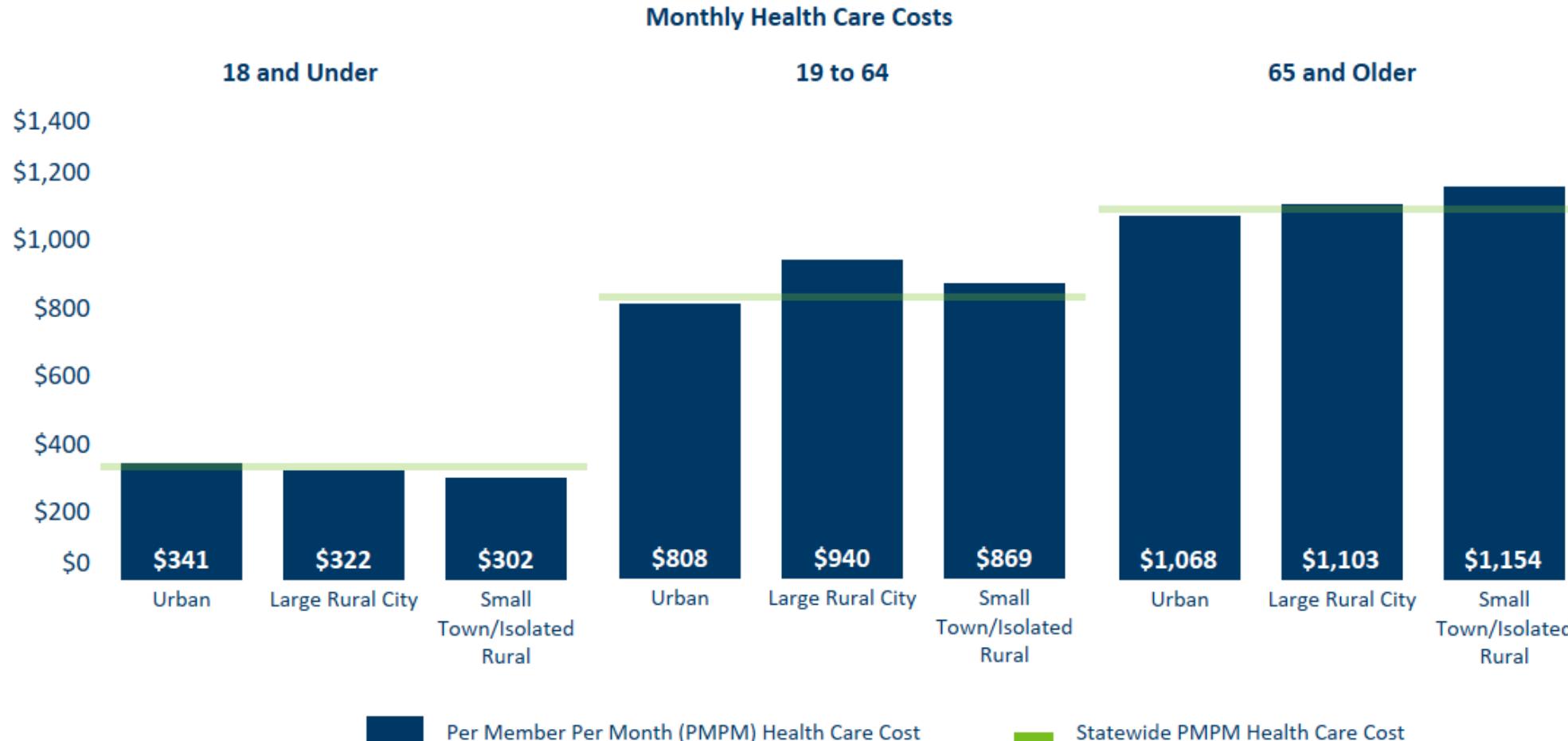
Certain rural areas have seen small declines in nursing homes attached to hospitals in the past 10 years

- 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.

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

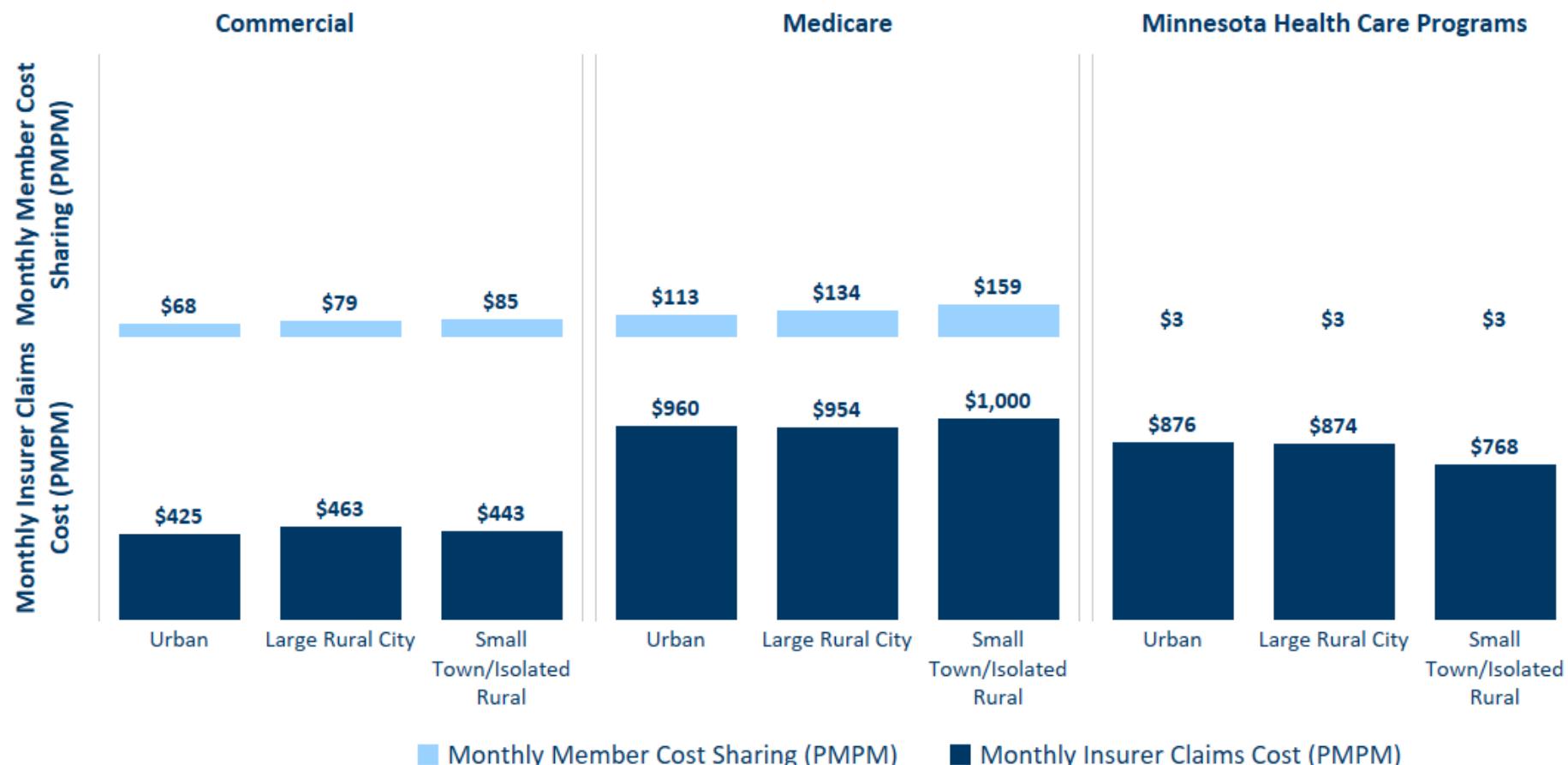


Source: MDH Health Economics Program analysis of All Payer Claims Database Public Use Files - Member (2020). Small town rural and isolated rural are combined. Monthly health care costs are based on total dollars spent divided by number of months with enrollment across all types of coverage. For more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

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.

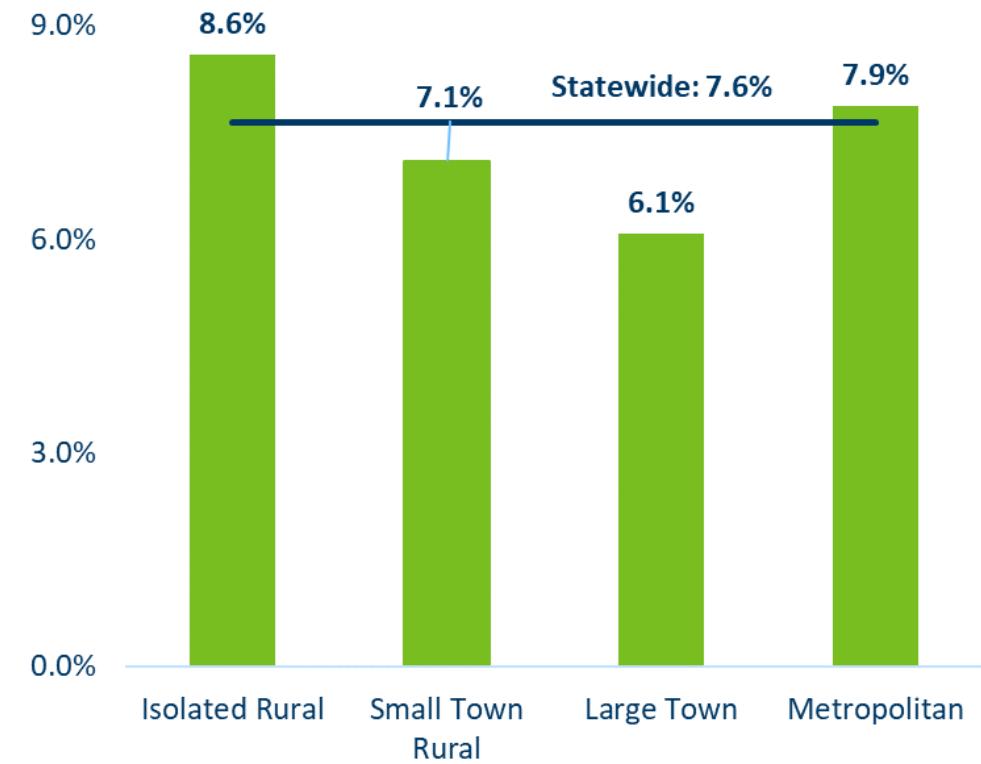


Source: MDH Health Economics Program analysis of All Payer Claims Database Public Use Files - Member (2020). Small town rural and isolated rural are combined. Monthly claims costs are based on payments made by insurers for health care services received by members divided by number of months with enrollment 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 MNPACD, 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

- 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.

Percent of Operating Expenses Devoted to Community Benefit, by Hospital RUCA



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 Programs²	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%

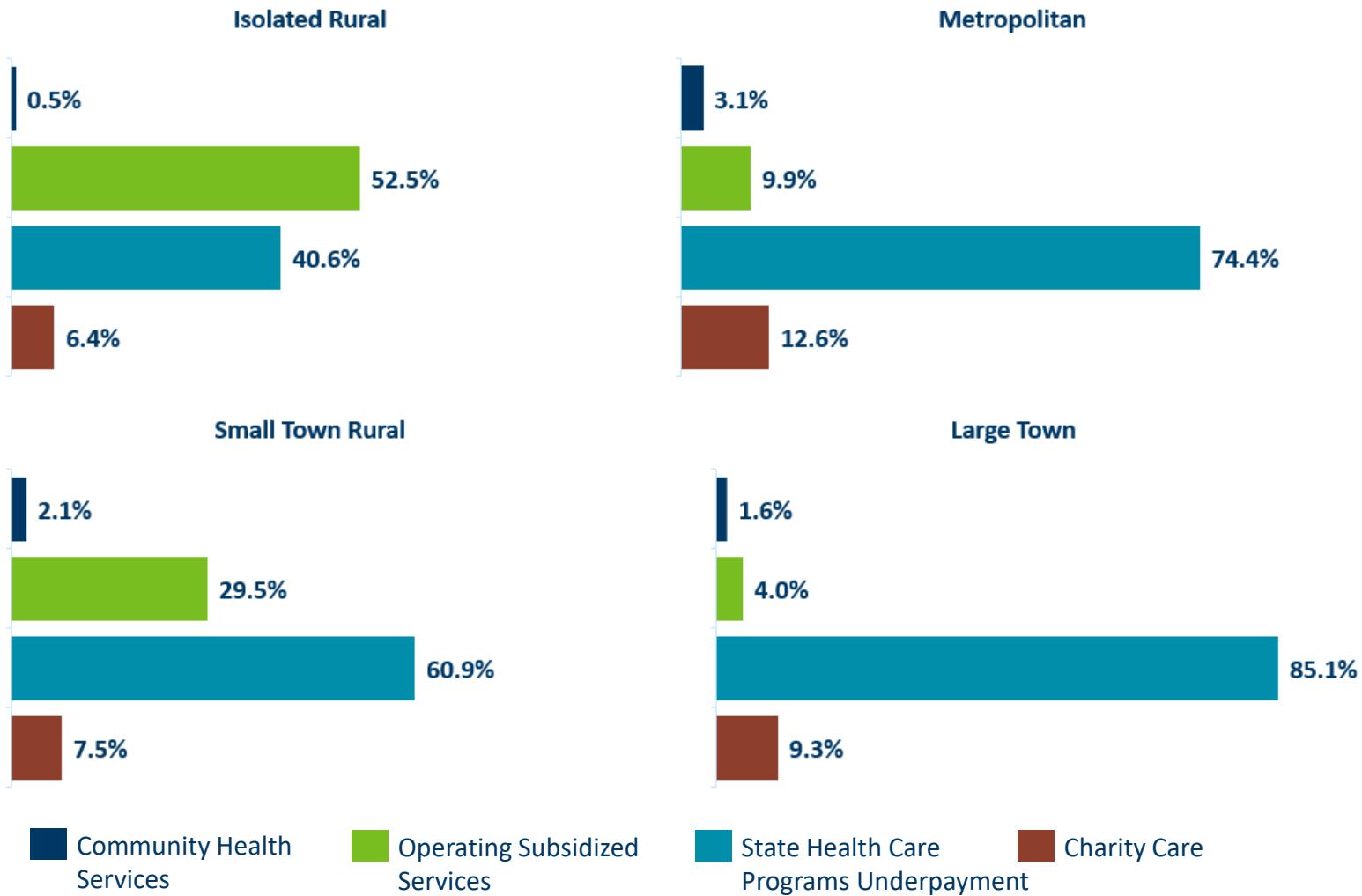
¹2023 data is preliminary.

²Includes Medical Assistance and MinnesotaCare.

Percent shown is a percent of Hospital Patient revenue. Totals may not sum to 100% due to rounding.

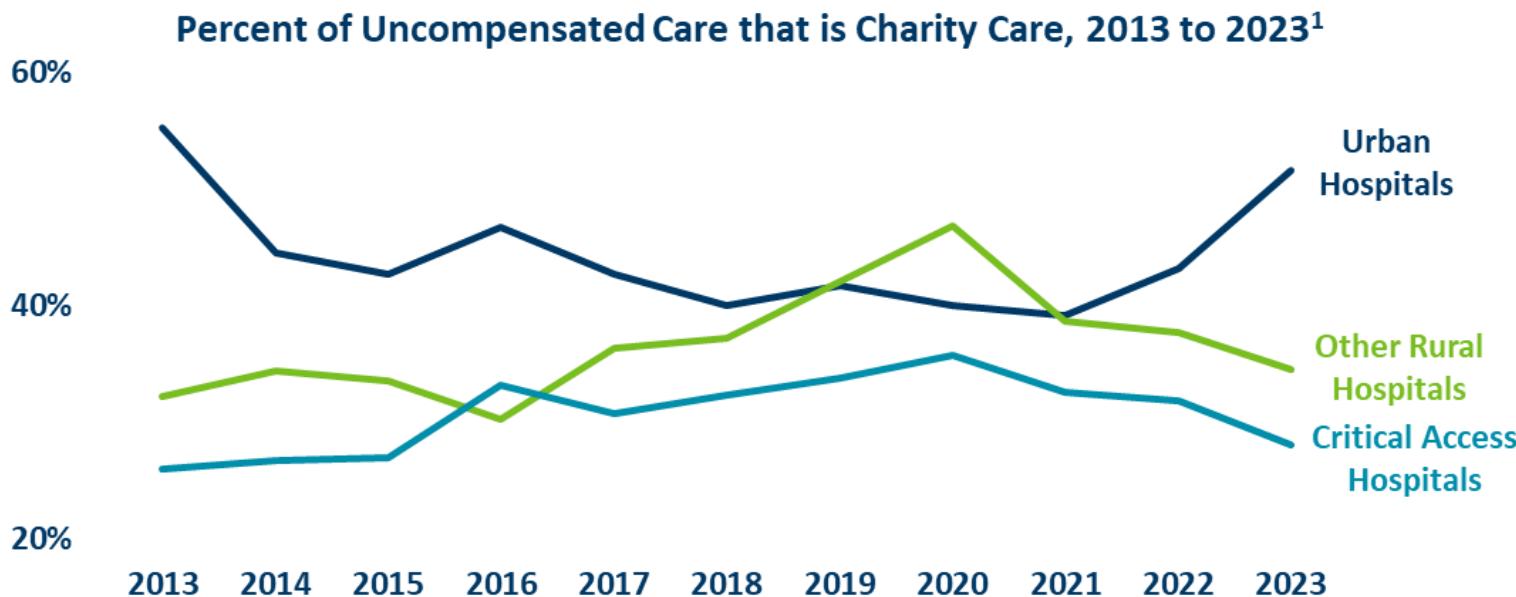
Source: MDH Health Economics Program analysis of hospital annual reports, October 2024.

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.

Most uncompensated care in rural hospitals is bad debt



¹2023 data is preliminary.

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

- 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.

Appendix of Data Sources Available Here:

Data Sources Used in Rural Health Care In Minnesota: Data Highlights (PDF)
(<https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmnsum.pdf>)

Health Economics Program

Health Economics Program
(www.health.mn.state.us/healtheconomics)

E-mail: health.hep@state.mn.us

Phone: 651-201-4520

Publications: [HEP Publications](http://heppublications.web.health.state.mn.us/)
(heppublications.web.health.state.mn.us/)

Minnesota Health Care Markets Chartbook

(www.health.state.mn.us/data/economics/chartbook/)

Office of Rural Health and Primary Care

Office of Rural Health and Primary Care
(www.health.state.mn.us/facilities/ruralhealth/)

E-mail: health.orhpc@state.mn.us

Phone: 651-201-3838

Publications: [Health Care Workforce Publications](http://www.health.state.mn.us/data/workforce/reports.html)
(www.health.state.mn.us/data/workforce/reports.html)