

February 17, 2026

Submitted Electronically

Chair Backer, Chair Bierman, and members of the House Health Finance and Policy Committee,

The Minnesota Hospital Association (MHA) represents 139 hospitals and health systems serving communities of all sizes across the state, and we appreciate the opportunity to comment on the federal Rural Health Transformation Program (RHTP). Our members employ 151,000 Minnesotans, and annually invest more than \$6.2 billion in local communities, deliver 9.8 million outpatient visits and 2.6 million inpatient days, welcome more than 62,000 births, and provide over \$1 billion in uncompensated care. Charity care increased 40 percent in 2024, and hospitals continue to provide community benefits far exceeding the value of their tax-exempt status. Hospitals and health systems remain fully committed to caring for every patient, regardless of ability to pay or circumstance.

Hospitals and health systems continue to face historic financial pressures. Medicare and Medicaid reimbursements remain below the cost of care, and federal changes under H.R. 1 intensify these longstanding challenges:

- The Directed Payment Program (DPP), designed with bipartisan support to mitigate a \$2 billion Medical Assistance underfunding, is now uncertain and may not provide the expected relief.
- Instability in the 340B Drug Pricing Program threatens a critical financial mechanism relied upon by safety-net providers statewide.
- More frequent Medicaid redeterminations, new work reporting requirements, and administrative barriers could result in significant coverage losses, shifting additional costs to hospitals.
- Rising premiums and deductibles in the private market health coverage may increase the number of uninsured and underinsured Minnesotans.

While all hospitals are impacted, these pressures fall most heavily on rural hospitals. More than 30 percent of hospitals—primarily rural—are operating with negative margins, and some have fewer than 10 days of cash on hand. Service reductions have already occurred in many communities as mounting pressure pushes hospitals to the limit of available capacity to deliver 24/7/365 care. Over the next decade, federal changes are projected to reduce rural Medicaid spending by billions and cut rural hospital funding by millions, further straining already underfunded facilities and putting patient care at risk across the state.

The federal Rural Health Transformation Program (RHTP) offers meaningful opportunities over the next five years, but it will not stabilize hospital patient care or finances. Minnesota's initial \$193 million award through RHTP, jointly administered by the Minnesota Department of Health (MDH) and the Centers for Medicare and Medicaid Services (CMS), focuses on chronic care management, workforce development, partnerships, and technology-enabled improvements like

telehealth—not uncompensated care or service shortfalls. Through our work with MDH to implement RHTP, it is our understanding that the majority of the funding in the first year will go to rural hospitals per federal intent and in direct support of their role as critical community safety net providers. We are cautiously optimistic about the opportunity RHTP provides to rural hospitals and the patients they serve over the next five years.

We will work to optimize all available opportunities within RHTP but unknowns in the implementation plan present challenges:

- CMS requires resubmission of plans to match the awarded amount.
- Detailed provider approvals could delay rollout.
- MDH's grant model requires hospitals to incur costs upfront before reimbursement, which will complicate hospital cashflow and project management.
- Current year grants will be reviewed by CMS and are not guaranteed at the same level as the program continues.

RHTP will help hospitals innovate, but it cannot resolve the underlying financial instability that threatens access to care across Minnesota. We appreciate the opportunity to provide testimony and remain committed to working with you to ensure stable, equitable, and statewide access to hospital services.

Thank you for your continued leadership and dedication to the health of Minnesota.

Sincerely,



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February 17, 2026

Representative Jeff Backer
Chair, Health Finance and Policy Committee
Minnesota House of Representatives
2nd Floor, Centennial Office Building
St. Paul, MN 55155

Re: Rural Health Transformation Program – Minnesota Application

Dear Representative Backer and members of the House Health Finance and Policy Committee,

Created in 1994, the MRHA has grown to be a recognized advocate for rural health in Minnesota. Our mission is to strengthen health care for rural Minnesotans. On behalf of our nearly 200 members, thank you for the opportunity to submit written testimony on Minnesota’s application to the **Rural Health Transformation Program (RHTP)**. Minnesota’s plan reflects national best practices to expand rural access, strengthen workforce and technology, and stabilize the financial health of rural providers.

In this letter, MRHA focuses on **concrete benefits to rural patients and providers** that flow from Minnesota’s initiatives.

Benefits to Patients in Rural Minnesota

- 1) **More preventive and chronic care close to home**
Minnesota’s initiatives prioritize community-based screenings, chronic disease management (especially cardiometabolic conditions), and mobile care—bringing services to trusted local settings. Patients benefit from earlier detection, fewer avoidable hospitalizations, and lower travel and out-of-pocket burden, a critical need in communities where average travel times for inpatient care dramatically exceed those in metro areas.
- 2) **Sustained access to essential services**
Targeted RHTP investments help rural communities maintain core services such as emergency, maternity, and behavioral health care. For patients, this means continuity of care with local clinicians, fewer deferred visits, and better adherence to treatment plans—key drivers of improved outcomes in areas with long-standing service gaps.
- 3) **Integrated, whole-person care through regional models**
Minnesota’s plan advances regional partnerships that connect primary care, specialty services, and behavioral health. Patients will see clearer handoffs, less fragmentation, and access to specialty expertise that is rightsized to rural volumes yet delivered locally or via shared regional capacity.
- 4) **Faster, equitable specialty access via telehealth**
Investments in telehealth and interoperable data systems expand rural access services, reducing wait times and long-distance travel while enabling more frequent remote follow-up—each associated with better chronic disease control.

Benefits to Rural Health Providers

- 1) **Financial stabilization through modernization and shared services**
The Minnesota application highlights technology upgrades, data infrastructure, and collaborative

models designed to reduce administrative overhead, support participation in value-based arrangements, and enable shared clinical/operational resources (e.g., regionalized specialty coverage and common platforms). These steps improve margins and reduce duplication—vital for small-volume rural facilities.

2) **Rural workforce pipelines that retain talent locally**

Minnesota's initiatives strengthen education pathways, training rotations, and rural-based upskilling to address shortages across primary, specialty, and behavioral health professions. Rural providers benefit from improved recruitment and retention, reduced reliance on costly short-term staffing, and succession capacity as experienced clinicians retire.

3) **Expanded capacity through regional collaboration**

By supporting regional care models, rural hospitals and clinics can share specialists and care teams, align protocols, and coordinate care transitions—expanding service scope without each provider bearing full fixed costs. This is especially important for services with low rural volumes that nonetheless must remain accessible.

4) **Digital tools that level the playing field**

Investments in **interoperability, telehealth platforms, and analytics** enhance quality reporting, care coordination, and population health management. Rural providers gain the tools to **compete for outcomes-based payments**, meet reporting requirements, and **track results** comparable to larger systems.

Why Legislative Support Matters

Minnesota's approach—prevention and chronic disease management, workforce development, technology modernization, and regional collaboration—aligns with the strongest rural transformation strategies seen across states. It presents a cohesive plan to improve outcomes and sustain rural access in the years ahead. While Minnesota requested multi-year funding at a scale consistent with statewide needs, continued state-level engagement and oversight will maximize impact, ensure equitable participation by Tribal and frontier communities, and maintain momentum as initiatives scale.

Conclusion

For patients, Minnesota's RHTP strategy means more care close to home, earlier intervention, integrated services, and timely access to specialists. For providers, it means stable operations, a reliable workforce pipeline, and modern digital infrastructure that supports high-quality, collaborative care. MRHA urges the Committee to support the implementation of Minnesota's RHTP initiatives and to ensure they are carried out equitably, sustainably, and with transparent reporting so that every rural Minnesotan—and every rural providers—realizes the full promise of this transformation.

Thank you for your leadership and for the opportunity to provide this testimony. I would be pleased to answer any questions or provide additional detail. Feel free to contact me at mark@mnruralhealth.org or 218-201-0098.

Sincerely,



Mark Jones
Executive Director



DEDICATED TO A STRONG GREATER MINNESOTA

February 17, 2026

Dear Co-Chair Backer, Co-Chair Bierman, and members of the House Health Finance and Policy Committee,

On behalf of the Coalition of Greater Minnesota Cities (CGMC), thank you for the opportunity to comment on the Minnesota Department of Health's (MDH) federal Rural Health Transformation Program application and the initiatives they propose to pursue with those funds. The CGMC represents more than 110 cities across Greater Minnesota, many of which either directly operate or financially support local ambulance services. Statewide, more than half of ambulance licenses are held by local units of government, and the long-term sustainability of rural emergency medical services (EMS) remains one of the most urgent issues facing our communities.

Rural EMS challenges are not new, and while we thank the legislature for the one-time relief provided over the last two sessions, these temporary investments have not been sufficient to stabilize EMS operations in Greater Minnesota. Providers continue to struggle with persistent deficits caused by structural problems: chronically low federal reimbursement rates, an aging workforce, increased reliance on volunteers, rising operational and equipment costs, and large geographic service areas that demand significant resources to cover. These pressures have only grown, according to the most recent Office of Emergency Medical Services (OEMS) reports that were released this past weekend, eligible grantees of the 2025 Ambulance Operating Deficit Grant Program reported more than \$39 million in losses, while available funding totaled just \$8.209 million for SFY26.

We appreciate that MDH recognized these challenges in its application to CMS and echoed the concerns of the CGMC and EMS providers. We are supportive of pilot programs like the one MDH proposed, which would compensate EMS agencies for 911 responses that result in patient contact but do not require transport. Non-transport calls make up a substantial portion of service volume for many Greater Minnesota EMS providers and contribute significantly to their financial strain. The pilot program is a step in the right direction, but it addresses only one element of a much larger, system-wide financial crisis that providers continue to face.

We urge the legislature and MDH to pair the federal dollars for pilot programs with **ongoing, stable funding to rural EMS providers**. The Ambulance Operating Deficit Grant Program has been essential, but its funding ends in 2027, leaving no long-term solution to the chronic deficits providers face.

While long-term system changes and workforce strategies are important, maintaining basic EMS operations must remain the top priority to prevent service reductions or closures. We are committed to participating in broader discussions on service delivery pilots, workforce development, and governance structures, but these conversations will only be meaningful if EMS providers remain open.

Sustained financial support is essential to protecting the health and safety of residents and visitors throughout Greater Minnesota. We encourage the legislature to recognize the gravity of this situation and ensure that federal and state funding solutions move forward.

Thank you for your attention to this critical issue and for your ongoing efforts to protect the health and safety of our communities. If you would like to discuss this issue further, please reach out to Lily Hijazi-Sacay at lsacay@flaherty-hood.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Bradley Peterson". The signature is fluid and cursive, with the first name "Bradley" being more prominent.

Bradley Peterson, Executive Director
Coalition of Greater Minnesota Cities

A handwritten signature in black ink, appearing to read "Lily Hijazi-Sacay". The signature is cursive and elegant, with a long, sweeping tail on the last name.

Lily Hijazi-Sacay, Lobbyist
Coalition of Greater Minnesota Cities



Chairs Backer and Bierman,

On behalf of Caring Hands Dental Clinic, thank you for your leadership on health policy and for your continued oversight of the Department of Health's implementation of the federal Rural Health Transformation Program (RHTP). We appreciate the Committee's attention to this important initiative and the opportunity to share a perspective from the front lines of rural oral health care.

Caring Hands Dental Clinic was founded to ensure that vulnerable Minnesotans are not left behind in accessing oral health care. As private dental practices increasingly closed their doors to patients enrolled in Medicaid and MinnesotaCare due to inadequate reimbursement, Caring Hands stepped in to fill that gap. By doing so, we have reduced preventable oral disease, limited unnecessary emergency room utilization, and helped contain long-term health costs for the state.

Dental health is not simply about teeth. It is foundational to overall wellness, school attendance, employability, and personal dignity. Untreated oral disease affects nutrition, chronic disease management, mental health, and educational outcomes for children. Caring Hands exists to make these vital services accessible and equitable—especially for patients who otherwise have nowhere to turn.

This mission is particularly critical in rural Minnesota. Our patients often travel significant distances to reach care, and for many, we are the only viable option within a reasonable radius. In rural communities, the loss of even one access point can mean the difference between receiving preventive care and going without treatment altogether. Our hope is that the Rural Health Transformation Program will be administered in a way that not only strengthens existing providers like Caring Hands, but also creates additional access points so rural residents are not forced to delay or forgo care.

Without Caring Hands Dental Clinic, many Minnesotans enrolled in Medicaid or MinnesotaCare would face severe and immediate access challenges. Families would be required to travel hours for basic dental services due to the scarcity of providers willing to accept state programs. Preventive care for children in schools and for seniors in long-term care or assisted living settings would be significantly diminished. Oral health inequities would deepen, resulting in more pain, untreated decay, and costly emergency department visits for issues that could have been addressed earlier in a dental setting.

Prior to Caring Hands' existence, many patients cycled through emergency rooms—receiving pain medication but no definitive treatment—only to return again when the problem inevitably worsened. Put simply, the safety net our organization provides would be absent, leaving thousands of rural Minnesotans without reliable dental care options.



What sets Caring Hands apart is our culture of compassionate, high-quality care delivered at scale. We have built operational efficiencies that allow us to serve large numbers of Medicaid and MinnesotaCare patients without sacrificing clinical excellence. Our services span all life stages, from pediatric preventive care to comprehensive and sedation dentistry for anxious or medically complex adults. We extend care beyond our clinic walls through outreach in schools and senior facilities, meeting patients where they are and removing barriers to access. By investing in patient comfort and trust, we strengthen long-term adherence to preventive care—producing better outcomes, not just more appointments.

As the Department of Health continues to roll out the RHTP, we respectfully urge MDH to ensure that critical-access dental providers in rural areas are explicitly included in future RFPs and funding opportunities. Oral health providers play an essential role in rural health infrastructure, and excluding them—intentionally or unintentionally—would undermine the program’s core goals of improving access, outcomes, and cost efficiency. Dental care should not be viewed as ancillary to rural health transformation, but as a necessary component of it.

We support the intent of the Rural Health Transformation Program and believe it presents a meaningful opportunity to strengthen Minnesota’s rural health system. We simply ask that, as implementation moves forward, dental providers serving as safety-net access points in rural communities are recognized, included, and empowered to continue this work.

Thank you for your consideration and for your commitment to improving health outcomes for all Minnesotans. We would welcome the opportunity to serve as a resource to the Committee or the Department of Health as this important work continues.

Sincerely,

John Kunelius, CEO

Dr. Emma Zimmerman, DMD

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RURAL MINNESOTA NEEDS SUSTAINABLE ACCESS TO ESSENTIAL HEALTHCARE SERVICES

Albert Lea in Freeborn County has become ground zero for the rural health crisis, where patients wait in fear because of delayed ambulances, medical service gaps threaten lives, and residents pay more for care if they can even get an appointment. This is where Mayo Clinic transfers seniors hours away to a critical access hospital like Cannon Falls, so Mayo collects higher Medicare reimbursements.

Mayo dismantled the full-service hospital that served over 35,000 people. They shuttered the birthing center, devastating the local economy, and stripped the outpatient clinic to the bone. As troubling, for eight years, the Governor and the Minnesota Department of Health (MDH) looked the other way, jeopardizing people's health.

Despite repeated requests, MDH has held no patient meetings, formed no partnerships, and proposed no changes to critical access criteria or emergency designations. Legislators should ask: What has MDH done with taxpayer dollars over the past eight years? Has its rural health division stabilized care? No.

MDH acknowledged that county public health budgets—largely state-funded—operate with limited oversight to achieve improved health. In Freeborn, taxpayers didn't fund access, yet paid for a treadmill at a private bank and funded a \$200,000 "awareness" campaign consisting of a few Facebook posts and a school visit.

Compounding the problem, the Provider Service Area (PSA) law strips local government of any control, insight, or data needed to address ambulance delays. Mayo holds exclusive control. PSA reform is necessary.

Who is overseeing this taxpayer money to ensure it's helping people? What is concerning is the distribution of the \$193 million rural health transformation grant. MDH has indicated that funds will go to the \$18 billion system that caused the decimation. This grant must sustain clinics and serve rural Minnesotans. And telehealth is not the panacea MDH claims—ask your parents or a pregnant woman who needs in-person care.

Years of inaction have shattered confidence in MDH. We are calling on our legislators to step in, as help has long been absent, and Minnesotans need the support.

PROPOSED LEGISLATIVE SOLUTIONS

1. Establish and realign MDH funding to strengthen and stabilize rural health infrastructure, in-person clinics, ambulance service, and other transport options.
2. Require state-funded programs to address citizen-identified health priorities and link funding to measurable improvements; set clear criteria and metrics and require public reporting of outcomes and expenses; establish measured oversight of funding to prevent waste, fraud, and duplication of MDH funds in Minnesota counties.
3. Direct at least 90% of Rural Health Transformation Program funds to independent rural clinics or locally governed health systems. Protect taxpayer dollars from subsidizing service reductions that weaken local, in-person care. Directly address grants for community-identified medical services, such as primary care, urgent care, maternity, behavioral health, and specialties, rather than discretionary wellness programs.
4. Authorize local control and collaboration of emergency medical transportation using non-HIPAA data to improve response times and service, and fund local non-emergency medical transportation to reduce avoidable ambulance use, so patients can access care before conditions become emergencies.

Submitted by Martha J. Sichko, a volunteer advocate for rural healthcare in Freeborn County.