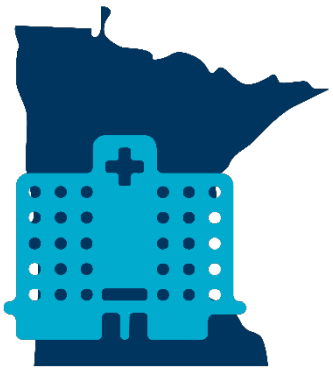
DEPARTMENT OF HEALTH

Three Key Trends for Minnesota Community Hospitals in 2020



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Key Findings:

1. Minnesota hospitals experienced large decreases in hospital use.
2. Direct public investments offset significant decreases in hospital net income; the investments varied by hospital size and location.
3. Minnesota hospitals saw a decline in the number of staff per 100,000 people in nearly all geographic regions of the state in 2020.

Health care utilization, financial stability, and care capacity have been central concerns for policymakers, the health care industry, public health, and the public since the beginning of the COVID-19 pandemic in early 2020. During this period, Minnesota hospitals faced unprecedented challenges. This brief provides insight on three key trends that emerged. A detailed overview of trends between 2017 and 2020 are available in a Data Short Take available online.[1]

1. Minnesota hospitals experienced large decreases in hospital use

Use of health care services provided by Minnesota community hospitals fell across most measures in 2020[2] (Table 1). The largest decrease in utilization occurred in outpatient surgeries (-19.5 percent), driven by limits to elective procedures and patients' caution during the spring of 2020.[3] Inpatient admissions, days in the hospital, and routine births also declined more sharply than during previous years (2018 to 2019). While hospital admissions have been on a downward trajectory for more than 10 years, there are specific factors unique to COVID-19 that contributed to the decline in 2020, including limits on elective procedures, individuals' decisions to forego health care services, the availability of capacity due to treating infectious COVID-19 patients, and challenges related to bed staffing. This analysis only looks at total number of admissions, not the reason for the decline. Only the average length of stay increased (2.2 percent), likely due to the fact that the patients hospitalized during the pandemic represented the most acute and complex cases.

Table 1: Minnesota Hospital Utilization, 2019 to 2020

Utilization Measure	2019	2020	Change from 2019 to 2020
Acute Care Admissions	509,895	457,524	-10.3%
Acute Care Patient Days	2,504,440	2,295,823	-8.3%
Routine Births	65,979	60,938	-7.6%
Average Length of Stay	4.9	5.0	2.2%
All Outpatient Visits	12,905,117	11,463,032	-11.2%
Emergency Department Visits	1,966,850	1,669,015	-15.1%
Outpatient Surgeries	432,884	348,379	-19.5%

Source: Minnesota Department of Health analysis of hospital annual reports from 2019 and 2020.

2. Direct public investments offset significant decreases in Minnesota hospital net income; these investments varied by hospital size and location.

Net income at Minnesota community hospitals fell by 25.1 percent between 2019 and 2020, from $1.96 billion to $1.47 billion, with declines in operating revenue and increases in non-operating revenue, operating expenses, and non-operating expenses. Changes in net income were not the same across hospital categories. Declines in net income were greatest for hospitals: with 50 or more beds, that did not have Critical Access Hospital[4] status, in urban areas, and were affiliated with larger health care systems.

Table 2: Minnesota Hospital Financials, 2019 to 2020

Financial Measure	2019	2020	Change from 2019 to 2020
Net Income	$1,964,439,452	$1,471,291,722	-25.1%
Operating Revenue	$21,255,177,454	$20,877,661,155	-1.8%
Operating Expenses	$19,604,662,352	$19,786,117,609	0.9%
Non-Operating Revenue	387,680,244	495,647,923	27.8%
Non-Operating Expenses	73,755,894	115,899,747	57.1%

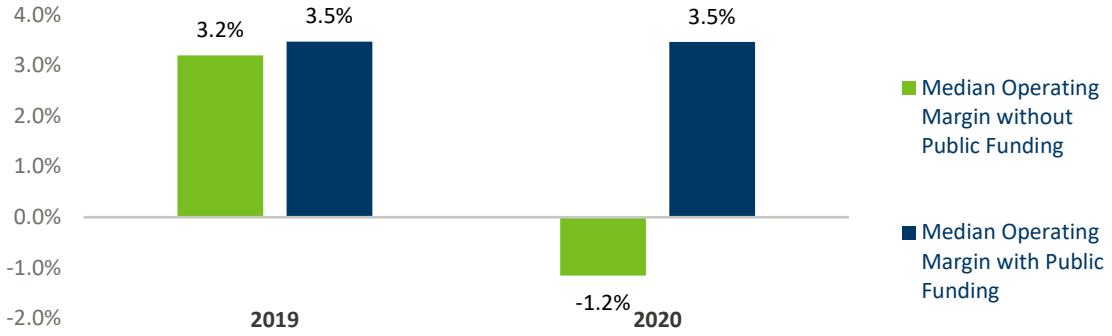
Source: Minnesota Department of Health analysis of hospital annual reports from 2019 and 2020.

Public funds, for both operating and non-operating expenses, totaled $879.25 million in 2020, an increase of over 500 percent, or $735 million, from 2019. As a proportion of all operating revenue, public funding rose from 0.7 percent to 4.1 percent in 2020. The volume of public funding varied widely across hospitals, with higher government support per bed occurring for hospitals with 25 to 49 beds, facilities located in rural areas, and hospitals not affiliated with a health care system.[5]

The median operating margin for 2020 remained the same as that for 2019 – 3.5 percent – after accounting for public funding[6] disseminated as part of COVID-19 relief funds. In previous years, public funding accounted for a diminishingly small impact on the median operating margin, 0.0

to 0.3 percentage points. However, in 2020, if those funds were removed from the calculation, the median operating margin would drop from 3.5 percent to -1.2 percent and over half of Minnesota's hospitals would be facing negative operating margins (see Figure 1).

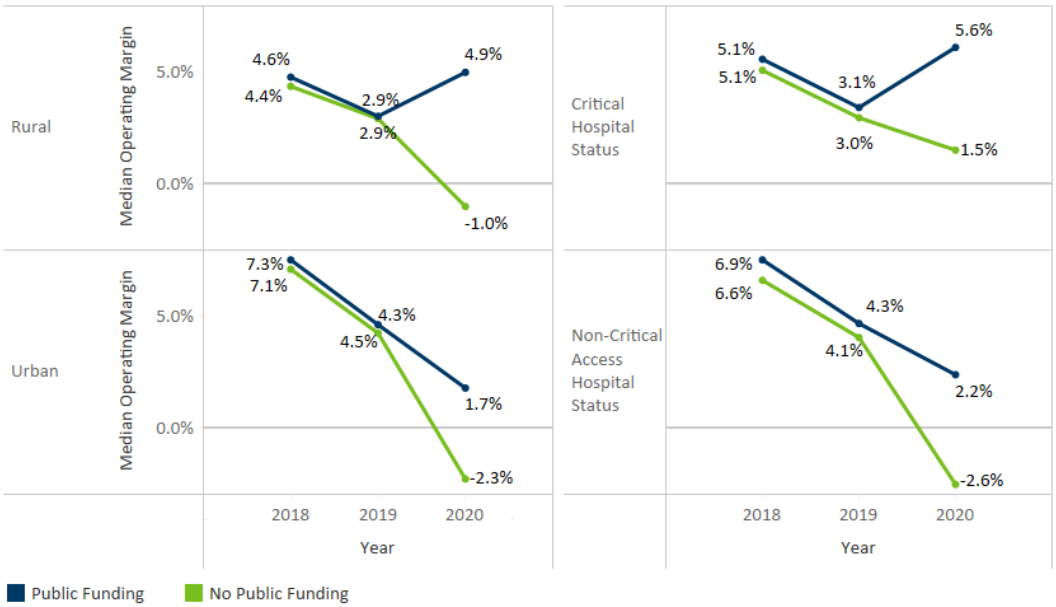
Figure 1: Minnesota Hospital Median Operating Margins, 2019 to 2020



Source: Minnesota Department of Health analysis of hospital annual reports from 2019 and 2020.

Hospital location correlated with median operating margins as well. Compared to urban hospitals, rural hospitals had a lower median operating margin in 2019, but a higher median operating margin in 2020 (Figure 2). Even when the impact of public funding is removed, the median operating margin for rural hospitals did not decline as dramatically. A similar trend was seen when comparing CAHs and non-CAH facilities (Figure 2).

Figure 2: Median Operating Margins by Rural or Urban Location and Critical Access Hospital Status, 2018 to 2020



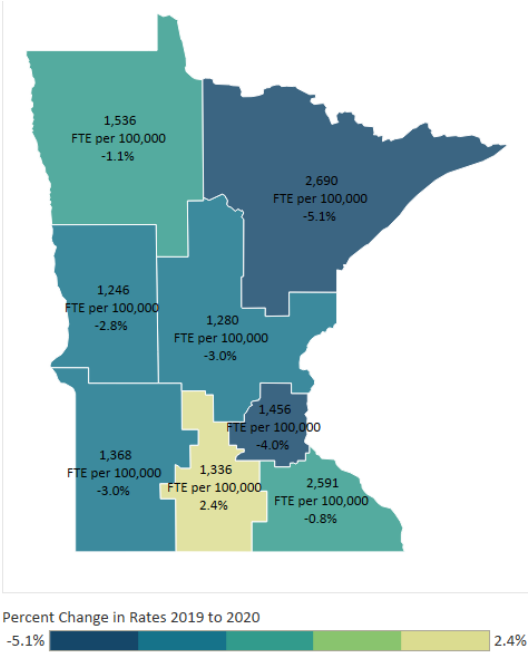
Source: Minnesota Department of Health analysis of hospital annual reports from 2016 through 2020. The terms "urban" and "rural" are defined by either being in a metropolitan commuting area for urban locations and outside of these areas for rural locations, using Rural-Urban Commuting Area (RUCA) codes. For more information on RUCA codes, see https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx

3. Minnesota community hospitals saw a decline in the number of staff per 100,000 people in nearly all geographic regions of the state

After steady increases, the number of people employed by hospitals decreased 3.1 percent between 2019 and 2020 (Figure 4). The number of full-time equivalent staff (FTEs)[7] decreased from 93,629 in 2019 to 90,723 in 2020 – closer to the level of staffing in 2016.

The only region that saw an increase in hospital employment per population was South Central Minnesota which saw an increase of 2.4 percent (30.9 FTEs). The largest declines were observed for Northeast Minnesota (-5.1 percent) and the Twin Cities Metro area (-4.0 percent).

Figure 4: Percent Change in Rates of Full-Time Equivalent Hospital Employees per 100,000 People, 2019 to 2020



Source: Minnesota Department of Health analysis of hospital annual reports from 2019 and 2020. Population data is from the 2020 Census.

Conclusion

Federal and state investments provided financial stability for Minnesota hospitals during the COVID-19 pandemic in 2020 when utilization and staffing declined substantially. Some of these supports continued into 2021 and even 2022, though at considerably lower levels. With continued stresses on hospital capacity and staffing at several points in 2021 and into early 2022, it will be important to monitor hospital financial health and staffing levels over the next few years, as the system adjusts to new health care realities. As part of MDH's follow-up work, we intend to analyze more in depth how the mix of hospitalizations changed over time, how health care spending was affected, how public supports are distributed between federal and state sources, and which provider types saw most of the staffing changes.

Endnotes

[1] Minnesota Department of Health, Health Economics Program. "Minnesota Community Hospital Trends, 2017 – 2020: A Data Short Take." February 24, 2022.

[2] Financial and statistical information is collected consistently across all community hospitals; however, the timeframe for data can vary based on the fiscal year of each facility (i.e., some hospitals may have an end date of June 30th while others December 31). In 2020, 83 percent of hospital operating revenue and 83.8 percent of admissions were for hospitals ending on 12/31/2020.

[3] Limits to elective procedures under MN Emergency Executive Orders 20-19 (https://www.leg.mn.gov/archive/execorders/20-09.pdf) and 20-51 (https://www.leg.mn.gov/archive/execorders/20-51.pdf). Patient avoidance of providers, see Czeisler MÉ, Marynak K, Clarke KE, et al. Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1250–1257. DOI: http://dx.doi.org/10.15585/mmwr.mm6936a4external icon

[4] "Critical Access Hospital" is a federal designation designed to reduce the financial vulnerability of rural hospitals and improve access to health care. For more information on Critical Access Hospitals in Minnesota, please visit: https://www.health.state.mn.us/facilities/ruralhealth/flex/mnhospitals.html.

[5] Detailed tables available at: https://www.health.state.mn.us/data/economics/docs/hosptrendshorttake2020.pdf

[6] Public funding are revenues from taxes or other municipal, county, state, or federal government sources, including grants and subsidies, that are designated for supporting the continued operation of a facility (operating revenue) or for a purpose not directly related to the normal day-to-day operations of the facility (non-operating revenue).

[7] Hospitals provide the number of FTEs for which salaries and wages are reported as well as contracted employment. These figures can reflect the percentage of time devoted to a hospital for shared staff. For example, a physical therapist that is employed by the institution as a full-time employee but devotes 50% time to the hospital and 50% time to the nursing home, would be reported as 0.5 FTE. For more information on the hospital annual report please visit: https://www.health.state.mn.us/data/economics/hccis/docs/harinst20.pdf.

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