Public Interest Review

EVALUATION OF A PROPOSED EXPANSION of INPATIENT BEDs AT REGIONS HOSPITAL IN SAINT PAUL, MINNESOTA

03/13/2026

Public Interest Review: Evaluation for a Proposed Expansion of Inpatient Bed Capacity at Regions Hospital in Saint Paul, Minnesota

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Minnesota Senate

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The Honorable Paul Utke, Ranking Member, 2403 Minnesota Senate Building

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The Honorable Tim O'Driscoll, Co-Chair, 2nd Floor, Centennial Office Building

March 13, 2026

To the Honorable Chairs and Ranking Members:

Minnesota Statutes, section 144.552 (https://www.revisor.mn.gov/statutes/cite/144.552), requires that any hospital seeking to increase its number of licensed beds, or an organization seeking to obtain a hospital license, submit a plan to the Minnesota Department of Health (MDH) for review and assessment as to whether the plan is in the public interest.

On August 1, 2025, Regions Hospital submitted a plan to the Minnesota Department of Health (MDH) to expand bed capacity at its existing inpatient hospital in Saint Paul, Minnesota. Under the proposal, Regions would add 85 inpatient beds for general medicine, surgery, cardiology, orthopedics, trauma, neurology, and intensive care services, as well as other acute care services, incrementally between 2026 and 2033.

The findings are based on quantitative analyses of actual and expected capacity and demand for inpatient medical/surgical services in the hospital service area, the anticipated impact on other hospitals in the region, the provision of care to low-income and patients with an inability to pay for services, and public comments received on the proposal.

Although MDH has concerns with the extent to which projections supporting the Regions Hospital proposal account for potential contractions of inpatient care demand associated with payment policy changes by the Centers for Medicaid & Medicare Services (CMS), increased availability of medical technology, shifts in care practices, and potential congressional changes to the financing, eligibility, and administration of health care programs, **MDH finds the proposed expansion of 85 licensed beds is in the public interest**.

Three primary factors from the forthcoming analysis informed MDH's findings:

1. **Needed capacity:** With the recent loss of inpatient bed capacity in the East Metro and throughput challenges due to a range of factors, area hospitals—including Regions Hospital—experience capacity challenges visible through high occupancy and emergency department boarding. While other East Metro hospitals are planning their own expansion of inpatient bed capacity, these (not yet fully specified) changes are unlikely to fully address the current and future East Metro gap for patient care. Moreover, initiatives aimed at shoring up capacity in lower-cost, downstream services are not expected in the near term.
2. **Impact:** Evidence suggests that portions of Regions' service profile differ from other East Metro hospitals. As a result, it is unlikely that those hospitals will experience significant impacts on patient volume, revenue, or staffing because of the proposed expansion.
3. **Flexibility**: While the projections used by Regions Hospital may be higher than actual future demand, the addition of licensed beds, combined with the proposed iterative implementation, may give Regions the flexibility other East Metro hospitals enjoy by being able to draw on unused licensed beds that originated from past facility contractions.

If you have questions or concerns regarding this study, please contact Stefan Gildemeister, Minnesota's state health economist, at 651-201-3554 or stefan.gildemeister@state.mn.us.

Sincerely,

/s/

Brooke Cunningham, MD, PhD
Commissioner
P.O. Box 64975
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Introduction

Minnesota regulates hospital construction and expansion to limit unnecessary duplication of services, reduce upward pressure on health care costs, and protect access at hospitals that serve emergency and low-income patients. As shown in the literature, large capital investments at health care facilities can increase market concentration, drive inefficient duplication of services, sometimes termed the "medical arms race," resulting in higher health care spending without improving access or quality.[1]

According to the National Conference of State Legislatures, Minnesota is one of 35 states (and Washington D.C.) that employs a mechanism for regulating major health care capital expenditures such as building or expanding hospitals.[2]

Overview of the hospital Public Interest Review process

Minnesota first enacted a state law in 1971 to regulate hospital construction and expansion projects with a certificate of need (CON) program.[3] The stated purpose of this original CON law was as follows:

- Promote comprehensive health planning
- Provide high-quality health care at the lowest possible costs
- Avoid unnecessary duplication in the development of health care facilities and services
- Provide for an orderly method for resolving questions about the need to construct or modify health care facilities[4]

The CON program was repealed in the early 1980s. In 1984, the Legislature adopted a hospital construction moratorium that continues to regulate expansion of hospital capacity today. Under the moratorium, hospitals may expand capacity only if the Legislature grants a statutory exception or waiver.[5] Under this law, the expansion or establishment of a new hospital required either a statutory exception or an emergency waiver. The law originally included specific exceptions to the moratorium, and more exceptions were added over time. The statute currently includes 34 exceptions that have been enacted by the Legislature.[6]

In 2004, the Legislature created a public interest review process to inform decisions on proposed exceptions to the hospital construction moratorium. Under this procedure, hospitals

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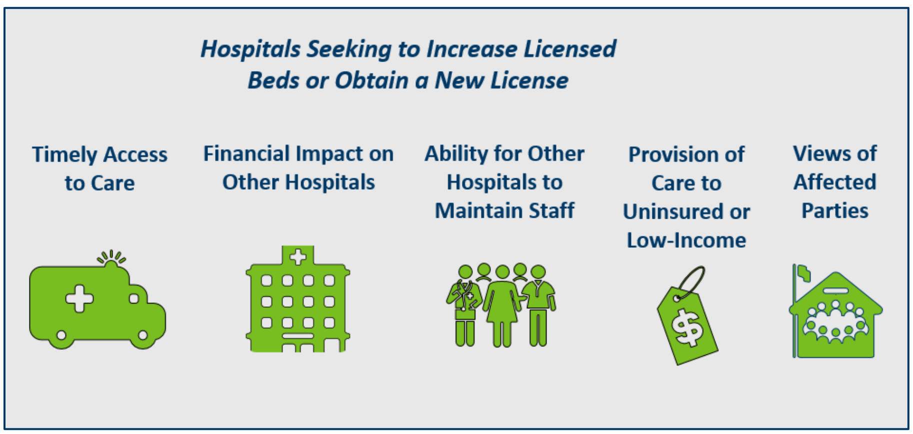
[1] Beaulieu, N. D., Hicks, A. L., & Chernew, M. E. (2025). Hospital Capital Expenditures Associated with Prices and Hospital Expansion or Withering, *Health Affairs*, *44*(5), 546-553.
[2] National Conference of State Legislatures. Updated April 2025. "Certificate of Need State Laws." https://www.ncsl.org/health/certificate-of-need-state-laws.
[3] Klarqvist, E. (January 2023). "Minnesota's Hospital Construction Moratorium." Minnesota House Research. https://www.house.mn.gov/hrd/pubs/hospmorat.pdf
[4] Ibid.
[5] Minnesota Statues, section 144.551.
[6] In 2022, the Legislature enacted a temporary five-year exception for any expansion of mental health bed capacity or establishment of a new psychiatric hospital under certain monitoring conditions from August 1, 2022, to July 31, 2027. Minnesota Statutes, section 144.551, subd. 1a.

seeking an exception to the moratorium must submit a plan to MDH for a "public interest review."[7]

The public interest review is required to address, at minimum, the following criteria (also shown in Figure 1):

- Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services given the number of available beds
- The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments
- How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain staff
- The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region
- The views of affected parties

Figure 1: Public interest review general considerations



To reiterate, state policy in Minnesota regulating hospital construction and expansion is responsive to two fundamental issues:

1. The concern that costly new construction or expansion addresses service gaps and is not motivated by inefficiently duplicating services, driving unneeded services use, and consolidating markets to increase prices.[8]
2. The concern that new construction or expansion may harm existing hospitals that must accept patients on an emergency basis regardless of their ability to pay and public insurance status.

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[7] Minnesota Statutes, section 144.552.
[8] Beaulieu, N. D. et al. (2025)

The purpose of the public interest review is to provide the Legislature with an independent, evidence-based assessment of whether the proposed expansion is in the public interest by investigating all relevant criteria related to those concerns. **Authority to approve exceptions to the hospital moratorium ultimately rests with the Legislature.**

This document and additional information about the proposal under review for an exception to the hospital construction moratorium—as well as documents related to previous reviews by MDH on the Hospital Bed Moratorium[9] webpage.

Regions Hospital project background and description

Regions Hospital ("Regions") is a nonprofit acute-care hospital in Saint Paul that provides a broad range of inpatient and outpatient services. Regions provides several highly specialized services, including Level 1 adult and pediatric trauma care and one of the state's two hospital-based burn programs. Regions also operates the second-largest mental health program in Minnesota and serves as a major safety-net hospital for low-income and uninsured patients.[10] Regions also has a long history of medical education going back to a time when it was owned and operated by Ramsey County and is currently one of the largest teaching hospitals for University of Minnesota residents and students.[11] In exchange for providing charity care, education, and other community benefits, the hospital is granted exemption from taxation by local, state, and the federal government[12,13] as well as benefitting from other direct and indirect subsidies[14] and private donations.

Regions is part of the vertically integrated health care system HealthPartners Inc. This organization owns and operates 55 primary care clinics and about the same number of medical and surgical specialty clinics across Minnesota and Western Wisconsin that include HealthPartners Central Minnesota Clinics, Park Nicollet Clinics, Physicians Neck and Back Clinics, and TRIA Orthopedics, 22 urgent care centers, 24 dental clinics, a short-term rehabilitation center, an online care system called Virtuwell, and the Melrose Center, a residential treatment facility for eating disorders. In addition to Regions Hospital, HealthPartners Inc. also owns and operates the following eight other acute care hospitals:

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[9] Hospital Bed Moratorium (http://www.health.state.mn.us/data/economics/moratorium/)

[10] Minnesota Department of Health, Health Economics Program. Chartbook Section 6 – Uninsurance, forgone care, and the safety net. Page 45. https://www.health.state.mn.us/data/economics/chartbook/docs/section6.pdf

[11] In 2024, Regions reported the fourth highest number of full-time resident physicians in the state. The other three in order of residents were: Mayo Clinic - Rochester, M Health Fairview University of Minnesota Medical Center, and Hennepin Healthcare.

[12] Nonprofit hospitals such as Regions benefit from six general tax exemptions including property taxes, sales taxes, state and federal income taxes, the ability to borrow at lower rates for bond interest, and the ability of donors to the institution to deduct contributions from their state and federal taxes.

[13] Most of the Regions' main campus is owned by Ramsey County and leased to through 2066. This agreement requires Regions to provide care to the indigent of Ramsey County, consult with representatives from the county before discontinuing its major or unique services (e.g., trauma center, burn unit, graduate medical education), and stipulates that Regions cannot assign the lease to a for-profit corporation. There is also a requirement that Regions provide a minimum dollar amount of charity care to Ramsey County residents that can be offset by capital improvements to the property.

[14] Examples include the Medicaid Disproportionate Share Hospital program (see https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/types/payment-methodology-for-inpatient-hospitals.jsp) and the federal 340B Drug Pricing Program (see https://www.health.state.mn.us/data/340b/index.html.

- Amery Hospital & Clinic in Amery, WI
- Hudson Hospital in Hudson, WI
- Hutchinson Health Hospital in Hutchinson, MN
- Lakeview Hospital in Stillwater, MN
- Methodist Hospital in St. Louis Park, MN
- Olivia Hospital & Clinic in Olivia, MN
- St. Francis Regional Medical Center in Shakopee, MN (partial ownership)
- Westfields Hospital in New Richmond, WI

HealthPartners also provides coverage for health care services through a nonprofit health maintenance organization (HMO), a third-party administrator, and a for-profit commercial health insurance company.[15]

Regions is currently the fourth-largest hospital in Minnesota with 554 licensed beds, a figure that has grown by 100 beds since 2017 under two previous exceptions to the hospital bed moratorium granted by the Minnesota Legislature in 2018 and 2021 (see more below).

Table 1 summarizes key operational metrics for Regions in 2014, 2019, and 2024. Over this period the hospital experienced growth in admissions, average length of stay, emergency department visits, and inpatient occupancy. Other notable changes in 2024 included growth in the workforce, an increase in resident physicians, and a shift in payer mix toward a higher share of Medicare admissions and a lower share of commercial admissions.

Table 1: Regions Hospital summary information

	2014	2019	2024*
Licensed beds	454	509	554
Available (staffed) beds	424	474	516
Admissions	25,069	26,616	28,783
Average length of stay (days)	4.92	5.24	5.76
Maximum daily census	435	474	544
Medical/surgical* average occupancy rate	83.6%	85.9%	95.8%
Emergency department visits	76,154	85,265	97,052
Newborn deliveries (births)	2,510	2,257	2,968
Outpatient surgical registrations	11,108	11,660	13,014
Inpatient surgical admissions	6,995	5,736	7,836
Full-time equivalents (FTEs)**	3,669	4,224	4,554
Staff vacancies (FTEs)	50.25	20	46.5
Resident physicians	142	143	153
Inpatient admission percentages by payer type			
Medicare	38.8%	43.4%	45.9%
Minnesota public program coverage***	25.8%	24.0%	24.2%

[15] For an overview of the HealthPartners Inc. corporate structure, see p.62 of MDH's preliminary report to the Legislature on HMO conversions (2024): https://www.health.state.mn.us/facilities/insurance/managedcare/docs/hmostudyprelimreport.pdf

	2014	2019	2024*
Commercial health insurance	25.2%	23.9%	22.3%
Self-pay (potentially uninsured)	2.7%	3.2%	2.6%
Other payers (Auto, Workers' Comp, etc.)	7.4%	5.6%	5.0%
Charity care as % of operating expenses	2.5%	2.2%	2.3%

* Data is preliminary.
**Excludes maternal/obstetrics, chemical dependency/mental health, and rehabilitation units.
*** Includes Medical Assistance (Medicaid) and MinnesotaCare.
**** Includes contracted FTE.
Source: MDH Health Economics Program analysis of Hospital Annual Reports.

Hospital expansion 2018 to 2024

Public Interest Review, 2018: On November 20, 2017, Regions applied for a public interest review on a proposal to add 100 licensed beds to its licensed capacity of 454 beds at the time. That proposal sought to add 60 medical/surgical beds, 20 mental health beds, and 20 obstetrics beds that were deemed by Regions as necessary to address gridlock at the emergency department for mental health patients and high occupancy at the facility. This estimated bed need was based on a 30-year projection window (through 2050).

While numerous public comments were in support of the 100-bed expansion at the time, there were also many that voiced opposition. Two of the competing health systems (Allina Health and Fairview Health Services) were critical of the long projection window that was not typically employed for health planning purposes given the uncertainty in the emergence of new technology and continued movement of care from inpatient to outpatient settings.

In addition, Fairview, and a large group of supporters for M Health Fairview St. Joseph's Hospital, which was less than one mile away, saw the expansion as directly jeopardizing the financial viability of that hospital. At the time, St. Joseph's Hospital was still operating 239 beds that included 105 beds dedicated to inpatient mental health and chemical dependency treatment.

The MDH review concluded that the full proposed 100-bed expansion was not in the public interest for three reasons:

1. The projections submitted to MDH seemed to overstate actual bed need by not robustly accounting for factors that could affect future rates of hospitalizations such as continuing shifts of care to outpatient or other settings, and the impact of technology and economic conditions.
2. The addition of 100 beds would negatively impact the financial status of other East Metro Area hospitals, including potentially contributing to closure of important services such as inpatient mental health and chemical dependency services at St. Joseph's Hospital.
3. There was a surplus of existing licensed capacity at other East Metro hospitals that was available to meet the needs of patients in the area.

While MDH indicated the full proposal was not in the public interest, the review nonetheless found compelling evidence that Regions was facing capacity pressure that required a more limited expansion in medical/surgical care and mental health services. MDH did not issue a recommendation on the number of additional beds to be granted.

In May of 2018, the Legislature approved a 55-bed expansion in licensed capacity at Regions. The exception required that 15 of the additional bed licenses be used for mental health services and allowed 40 to be used for other purposes.[16]

While it is uncertain to what extent the expansion of Regions Hospital may have contributed to Fairview Health Services' decision to close St. Joseph's Hospital in the fall of 2020, the system gradually phased out services at the facility by early 2022 while still providing care for patients resulting from the COVID-19 pandemic.

Public Interest Review, 2021: On July 30, 2021, Regions submitted a request to MDH to conduct a review on a proposal to add 45 licensed beds, or the remaining beds initially sought in 2017. This proposal had already been granted an exception one month earlier by the Minnesota Legislature,[17] yet was contingent upon submitting a plan to MDH for a review. The legislative preapproval allowed the hospital to add licensed beds before the completion of the review. MDH issued a finding that the expansion was in the public interest on January 28, 2022, based on the following observations:

- St. Joseph Hospital was in the process of closing during the review period; the facility had operated 239 licensed beds, including 37 high-demand mental health beds. While other nearby hospitals would likely accommodate many patients that would have sought care at St. Joseph's Hospital, not all patients could be absorbed.
- There was evidence of capacity constraints at the time at Regions for inpatient medical/surgical and mental health services.
- The financial impact on other hospitals would be limited given the closure of St. Joseph's.
- There were no vocal opponents to the expansion and general support from other hospitals.

Between August of 2018 and May of 2025, a total of 89 licensed beds have been activated at Regions as shown in Figure 2 below.

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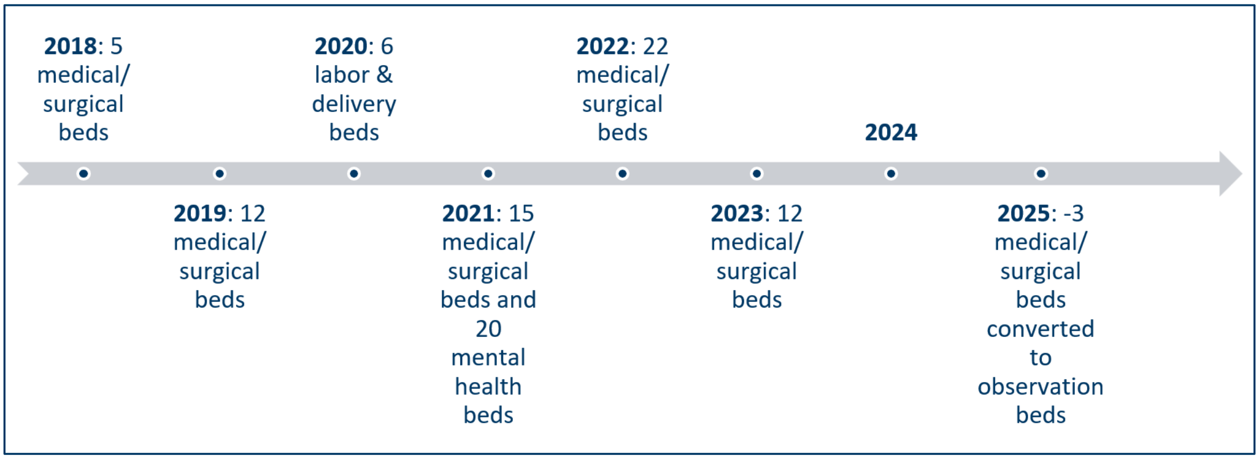
[16] Minnesota Statues, section 144.551 subd. 1, subpart b, item 28.
[17] Minnesota Session Laws, 2021, 1st Special Session, Chapter 7—H.F. 33.

Figure 2: Regions Hospital licensed inpatient bed deployment



Application for Public Interest Review in 2025

On August 1, 2025, Regions submitted a proposal to MDH to conduct a public interest review to add up to 85 additional beds at the existing facility in Saint Paul. According to the proposal, the requested beds would be used for a variety of services already in place at the hospital; they are not intended to introduce new services. For example, beds in new units would include general medicine, surgery, cardiology, orthopedics, trauma, neurology, intensive care unit (ICU) services, and other acute care. These new units would also be integrated with existing hospital infrastructure and staff with proximity to diagnostics, operating rooms, the emergency department, and ICU.

Regions indicated the following deployment schedule:

- Regions would use one additional licensed bed along with 11 previously unused licensed beds to open a medical/surgical unit within the hospital's existing space by mid-2026.
- Regions would also assign 21 licensed beds to an existing boarding unit that currently holds patients awaiting an available inpatient bed.
- Following an initial expansion that would start in 2026, Regions would then incrementally add beds in 12-bed units as needed by renovating existing space at the hospital, which would involve relocating other services, so the majority of the additional 85 licensed beds would be in operation by 2030-2031.

This second phase (2027 forward) would include major capital construction projects, including building out new inpatient units or vertical expansion of the hospital unit-by-unit. The Regions proposal describes this incremental approach as a strategy to confront challenges in staffing and operational resources in coming years.

Financing for this incremental expansion would be accomplished through a combination of internal capital investment and debt financing. In total, the cost for the entire project of seven 12-bed inpatient units was estimated to range from $49-$63 million (excluding incidental expenses for relocating existing services). This would likely include tax-exempt hospital revenue bonds; it would not involve direct state funding or bonding. The new hospital units would be part of the existing hospital-wide accreditation by the Joint Commission.

Evaluation according to statutory criteria

This section assesses whether the project to add 85 beds at Regions meets public interest criteria for each of the five factors specified by Minnesota Statutes, section 144.552, and other relevant considerations. Considerations according to these factors are based on the following sources of information:

- Materials supplied, and requested by MDH, from Regions.
- Feedback from interested parties through written comments, informal interviews, or other conversations.
- Public reporting by Regions, and other hospitals, on financial, utilization, and services data.
- De-identified hospital discharge data on diagnoses, utilization, and patient demographics.
- Academic literature and governmental reports.

As much as was possible, the following information was generated from empirical evidence. Any conclusions or observations are based on objective analysis of available information and data. MDH's methodological approach is documented or available upon request.

Factor 1: Need for hospital beds to provide timely access to care

The current Regions proposal emerged in response to what was described as the convergence of multiple factors that required an expansion in medical-surgical inpatient capacity at the facility in Saint Paul. The factors identified in the proposal included:

- Reductions in nearby inpatient beds.
- Anticipated population growth.
- A rapidly aging patient population.
- Observed and anticipated increases in patient acuity levels leading to longer stays in the hospital.
- Growing patient volumes, as well as persistent high occupancy levels that were having an adverse impact on patients and staff.

These converging and interrelated factors distill to three major themes that MDH sought to assess: lost inpatient bed capacity in the hospital service area, existing capacity constraints at Regions and nearby hospitals, an increasing bed need in the community due to shifting demographics and patient acuity.

Lost inpatient bed capacity in the hospital service area

The application tied the need for additional inpatient capacity to changes in the fabric of care in the East Metro resulting from the closure of St. Joseph's Hospital and M Health Fairview Bethesda Hospital. Bethesda Hospital dramatically reduced its supply of beds from 114 in 2018 to just 15 beds in 2021 and most recently 24 beds in 2024 in relocated space on the former St. Joseph's Hospital campus. Bethesda was a long-term acute care (LTAC) hospital that provided specialized inpatient care for patients recovering from critical illnesses. Such hospitals serve the needs of patients no longer in need of intensive care unit-level care such as those recovering from cardiac failure, post-traumatic neurological damage, pulmonary and ventilator weaning, or medically complex infectious disease or wound care.

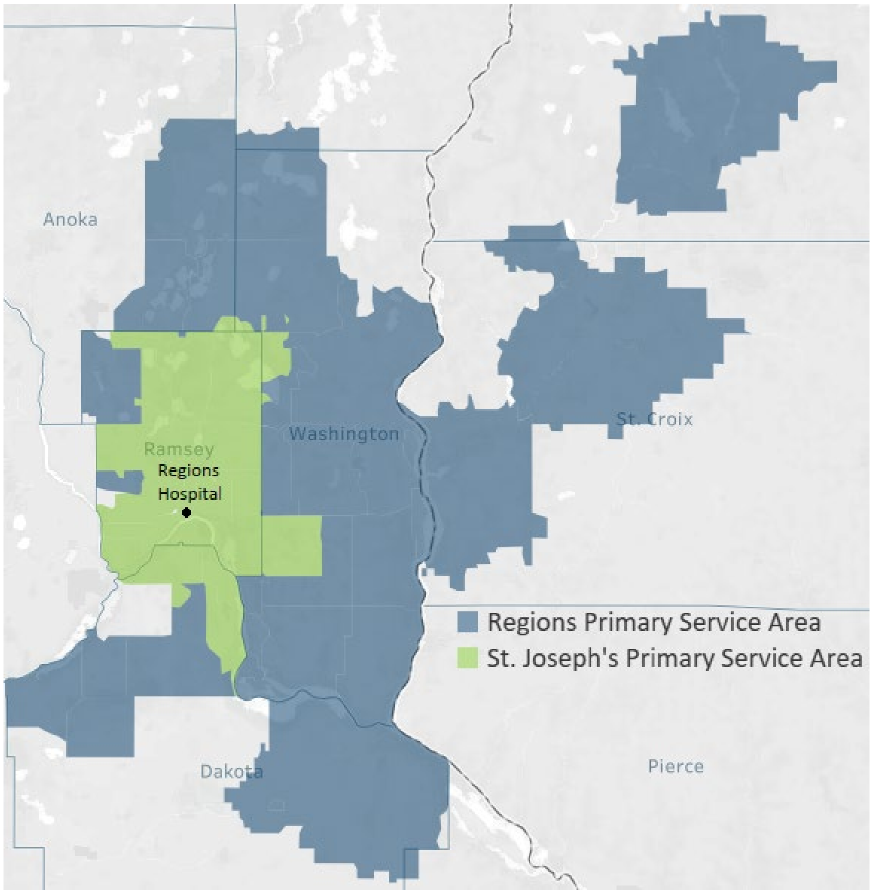
Although Regions is not proposing to replace the 90 LTAC beds closed at Bethesda, in 2024 Regions partnered with Regency Hospital of Minneapolis to relocate 26 long-term acute care beds to the Regions hospital campus after gaining approval from the Minnesota Legislature for that net-zero shift in beds.[18] Still, the contraction in bed capacity at Bethesda was described by Regions as resulting in patient flow challenges for recovering patients and worsening high occupancy rates. For example, application materials note that the loss of local LTAC beds has contributed to longer lengths of stay for certain complex patients at Regions as patients can no longer be discharged in a timely way to an LTAC bed.

In addition, the closure of St. Joseph's Hospital reduced available inpatient bed capacity in the East Metro area for mental health services and acute inpatient care, including to accommodate over 9,100 medical-surgical admissions.

As Figure 3 displays, by analyzing the residential ZIP codes from which most of the hospitalizations (the top 75% of discharges) originated for both Regions and St. Joseph's Hospital between 2016 and 2020, patients seeking care at St. Joseph's Hospital came from entirely within Regions' primary service area.

[18] For more information on this project please visit the Public Interest Review website for Regency Hospital at https://www.health.state.mn.us/data/economics/moratorium/regency/index.html.

Figure 3. Primary service areas for Regions Hospital and St. Joseph's Hospital



Source: MDH analysis of discharge data for St. Joseph's Hospital 2016-2020 and from Regions Hospital from 2021-2023. The shaded areas for each hospital represent ZIP codes where most patients originate (75th percentile) for hospitalizations excluding normal newborns.

Although Regions' service area also overlaps with several other area hospitals such as M Health Fairview St. John's Hospital, United Hospital, and M Health Fairview Woodwinds Hospital, as well as the M Health Fairview University of Minnesota Medical Center, it is likely that patients who would have sought care at St. Joseph's Hospital concentrated at Regions after the closure of St. Joseph's Hospital. An examination of discharges based on the patients' home ZIP codes for the St. Joseph's Hospital service area shown above is shown in Table 2 for an average of the years 2016 to 2019, and then the subsequent three years.

These data indicate that Regions was, and continues to be, the dominant hospital service provider in the East Metro and gained the highest percentage of medical-surgical hospitalizations (a 4.0% increase) compared with other Metro Area hospitals between the pre-COVID pandemic years and 2023. This is unsurprising given the expanded licensed capacity of up to 80 beds (20 beds were dedicated to inpatient mental health) between 2018 and 2022. The actual deployment of just over 60 beds for medical-surgical purposes as some bed licenses were used to expand labor and delivery services.

The nearest hospital to St. Joseph's, Allina Health's United Hospital, meanwhile gained nearly 2% of the medical-surgical hospitalizations from this service area. Other hospitals that gained in these types of hospitalizations included several of the M Health Fairview hospitals, including Woodwinds Hospital (3.3%), St. John's Hospital (2.8%), and, to a lesser extent, the University of Minnesota Medical Center (0.3%). However, these and other Fairview hospitals had a net loss in market share of about 7.1% going from 42.2% of this market from 2016-2019 to 35.1% in 2023. Most of the remaining hospitalizations from the service area were at other Twin Cities Metro Area hospitals with each comprising about 1% or less than 1% of the total from the area.

Table 2. Percent of medical-surgical discharges for selected hospitals from the St. Joseph's Hospital primary service area, 2016-2019 average, 2020-2023

Hospital	2016-19 Average	2020	2021	2022	2023	Change 2023 vs. 2016-20 Average
Regions Hospital	21.8%	24.4%	26.2%	25.9%	25.8%	4.0%
United Hospital	20.7%	20.9%	22.8%	22.6%	22.5%	1.9%
M Health Fairview St. John's Hospital	12.8%	12.6%	14.6%	14.8%,	15.7%	2.8%
M Health Fairview Woodwinds Hospital	6.0%	7.0%	9.1%	9.9%	9.3%	3.3%
M Health Fairview Univ. of MN Medical Center	8.1%	7.0%	7.5%	7.9%	8.4%	0.3%
Children's Minnesota	5.0%	3.5%	4.3%	5.5%	4.9%	0.0%
Abbott Northwestern Hospital	2.6%	2.6%,	3.4%	2.9%,	2.9%	0.3%
Mayo Clinic - Rochester	1.5%	1.7%	1.7%	1.8%	1.6%	0.1%
Hennepin Healthcare	1.4%	1.6%	1.6%	1.4%	1.4%	0.0%
M Health Fairview St. Joseph's Hospital	13.8%	11.9%	0.5%	0.1%	0.0%	-13.8%
Other Hospitals	6.3%	6.8%	8.3%	7.3%,	7.4%	1.2%

Source: MDH analysis of discharge data from 2016 through 2020. The primary service areas are identified as the ZIP codes where most discharges originate (75th percentile) inpatient hospital stays excluding the following major diagnostic categories and groups defined by the Centers for Medicare & Medicaid Services (CMS): Newborns & Other Neonates with Conditions Originating in Perinatal Period, Pregnancy, Childbirth & the Puerperium, Mental Diseases & Disorders and Rehabilitation.

Existing capacity constraints

The closure of St. Joseph's Hospital had a substantial lasting impact on inpatient volumes at Regions despite licensed bed expansions at the hospital from 2021-2023 as patients migrated to Regions and other hospitals. In 2024, two years following the closure of St. Joseph's, Regions reported having about 9,100 more emergency department registrations compared to five years earlier in 2019 (see Table 1 above). MDH analysis of Regions' discharge data for 2023 indicates that most of the medical-surgical hospital stays (75.7%) came in through an emergency department. Therefore, an increase in emergency department volume would likely also lead to increased inpatient admissions. Materials submitted to MDH indicated that Regions medical/surgical occupancy averaged 92% to 93% since 2023 and that there were some days when all staffed beds were in use. [19] Additional responses from Regions indicated that the current occupancy level was at a 96% sustained occupancy rate.[20]

Operating at such high occupancy levels can impose barriers on timely access to care—particularly for a tertiary referral center that must be able to serve a wide variety of specialized patient populations. Hospitals such as Regions must also have a level of surge capacity to accommodate seasonal flu or other infectious disease and accommodate mass casualty events.[21] In practical terms, high occupancy levels impact patient flow as the emergency department gets backed up when patients are unable to move into appropriate inpatient beds due to a shortage of available beds or hospital crowding (hospital access block).[22,23,24,25,26] Meanwhile, a hospital faces limited ability to take urgent transfers for critical conditions like stroke or severe heart attacks.[27,28] Studies have found that high levels of hospital occupancy strain have been associated with increased patient mortality,[29] and being above 85% occupancy specifically poses the highest risks for mortality.[30]

Regions reported that high occupancy has contributed to persistent access challenges, with total emergency department boarding hours—measured as the combined time patients wait on average for an inpatient bed— nearly doubling from about 34 hours on a given day in 2021 to nearly 70 hours by mid-2025. While not all of this is due solely to lack of bed capacity—MDH has previously published analysis of transfer and discharge challenges and highlighted a range of reasons—the application also described how inpatient bed turnover suffered from bottlenecks due to the lack of capacity for pre-op and step-down care resulting in longer hospital stays and inefficient use of resources. The hospital's post-anesthesia care unit had 1,600 to 1,700 surgical patients per year awaiting beds and limited elective surgeries. It also

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[19] Regions Hospital 2026 Public Interest Review Application – Proposed 85-Bed License Expansion. August 1, 2025. Page 3.

[20] Responses to PIR Request for Additional Information. September 19, 2025. Page 3.

[21] Minnesota Department of Health. March 1, 2020. Minnesota Crisis Standards of Care Framework

[22] Morley, C., Unwin, M., Peterson, G. M., Stankovich, J., & Kinsman, L. (2018). Emergency department crowding: a systematic review of causes, consequences and solutions. *PloS One*, *13*(8), e0203316.

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[25] Forster, A. J., Stiell, I., Wells, G., Lee, A. J., & Van Walraven, C. (2003). The effect of hospital occupancy on emergency department length of stay and patient disposition. *Academic Emergency Medicine*, *10*(2), 127-133.

[26] Schull, M. J., Szalai, J. P., Schwartz, B., & Redelmeier, D. A. (2001). Emergency department overcrowding following systematic hospital restructuring trends at twenty hospitals over ten years. *Academic Emergency Medicine*, *8*(11), 1037-1043.

[27] Ofoma, U. R., Montoya, J., Saha, D., Berger, A., Kirchner, H. L., McIlwaine, J. K., & Kethireddy, S. (2020). Associations between hospital occupancy, intensive care unit transfer delay and hospital mortality. *Journal of Critical Care*, 58, 48-55.

[28] Greenwood-Ericksen, M., Kamdar, N., Swenson, K., Pruitt, P., McCrum, M. L., Paul, G., ... & Zachrison, K. S. (2025). Emergency department boarding, inpatient census, and interhospital transfer acceptances. *JAMA Network Open*, *8*(5), e2512299-e2512299.

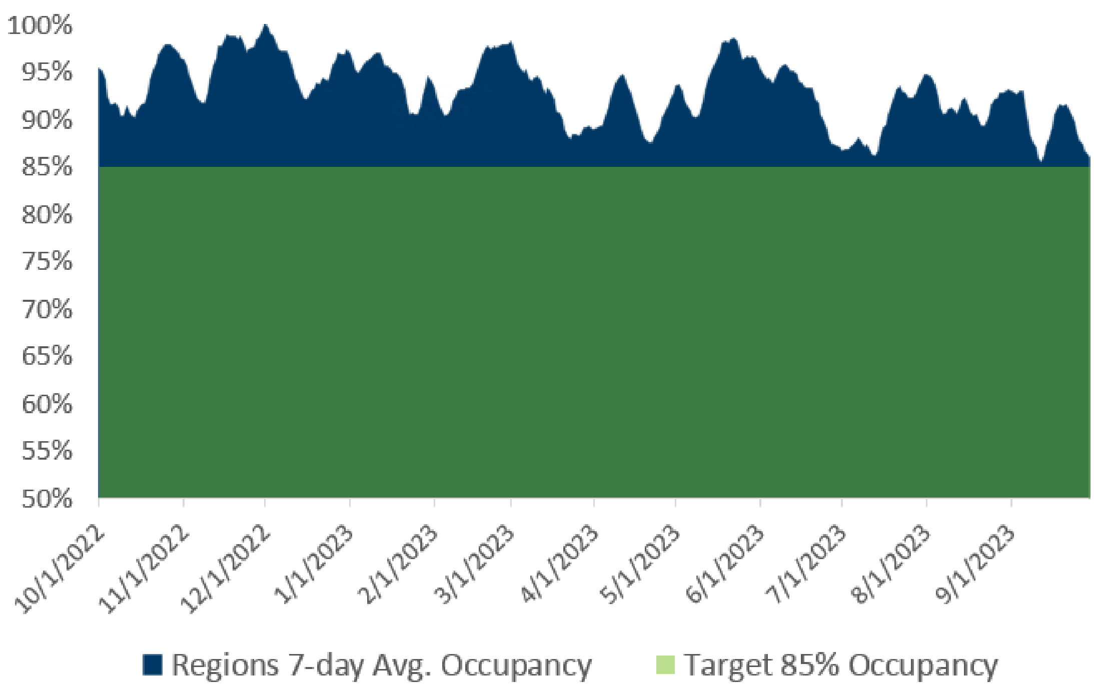
[29] Eriksson, C. O., Stoner, R. C., Eden, K. B., Newgard, C. D., & Guise, J. M. (2017). The association between hospital capacity strain and inpatient outcomes in highly developed countries: a systematic review. *Journal of General Internal Medicine*, *32*(6), 686-696.

[30] Sharma, N., Moffa, G., Schwendimann, R., Endrich, O., Ausserhofer, D., & Simon, M. (2022). The effect of time-varying capacity utilization on 14-day in-hospital mortality: a retrospective longitudinal study in Swiss general hospitals. *BMC Health Services Research*, *22*(1), 1551.

noted that certain patients have isolation requirements prolonging stays until they can be moved into a different room.

MDH analysis of medical-surgical discharges confirmed high occupancy levels during the most recent year available (2023) and Regions experienced several peaks of occupancy approaching 100%. Figure 4 below illustrates that medical-surgical units had an average occupancy rate of 90.9% from January 1 to December 15 of 2023. The green shaded area in Figure 4 is an occupancy rate of 85% viewed by some as optimal and identified in the application as a target rate or upper limit of best practice for Level 1 trauma centers for surge capacity, as well as necessary to avoid overuse of staff and resources in the application. Regions was over this limit for almost the entire year.[31] The MDH analysis of discharge data from 2023 also found that Regions would still have likely been short the number of necessary licensed beds to meet the target 85% occupancy threshold even if it was able to activate a second 12-bed medical surgical unit (application materials noted that only 11 licensed beds remained available for use after this activation).

Figure 4. Regions medical-surgical seven-day average occupancy, Oct. 1, 2022– Sept. 30, 2023



Source: MDH, Health Economics Program analysis of hospital discharge data. Medical-surgical discharges are defined above in Table 2 of this report.

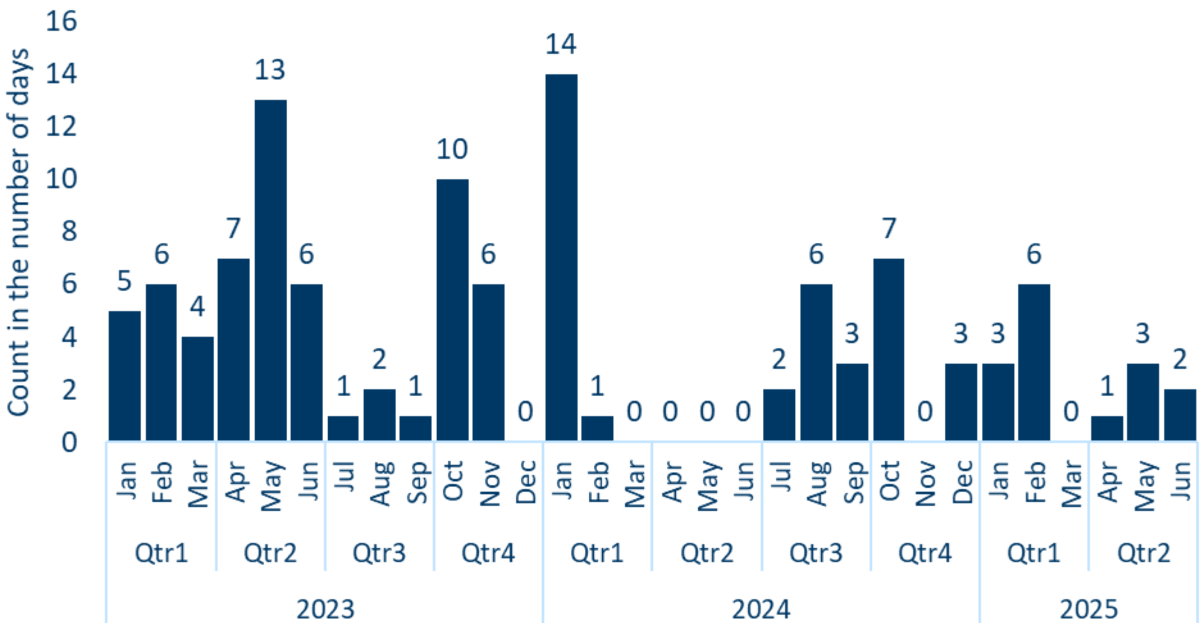
Regions provided additional detail highlighting how high occupancy levels led to hospital access challenges from January 2023 through June of 2025 as 69% of direct admission requests routed through the HealthPartners Direct 24/7 acute care access center were not immediately placed in a bed despite a clinical determination of need. Of these potential patients, nearly 2,200 were

[31] Hospital discharge data is typically incomplete at the end of the year due to the nature of the data being pre-adjudicated claims and lagged reporting systems. This suggests that the rates are much higher during this period than shown.

denied admissions at Regions due to lack of bed capacity (2.4 patients per day or about 17 patients per week). There were also about 6.5 patients during this period who went on a waitlist and were unable to be admitted to an inpatient bed at Regions despite meeting clinical criteria for admission.[32]

MDH also analyzed daily hospital capacity data reported by East Metro area hospitals of M Health Fairview St. John's, M Health Woodwinds, and United Hospital during the January 2023 - June 2025 period that is used for incident planning and hospital diversions. Figure 5 shows that when there were, on average, a little more than two patients unable to gain access to an inpatient bed at Regions, at least a portion of these patients were also unable to gain access to a bed at other nearby hospitals in the immediate area.[33] The Figure shows an improved trend after 2023; nonetheless, there were still occurrences of this dynamic during the second half of 2024 and into 2025.

Figure 5. Number of days with two or fewer available adult medical-surgical beds available at East Metro hospitals, Jan. 1, 2023 – June 30, 2025



Source: MDH analysis of data from MNTrac (Minnesota system for Tracking Resources, Alerts, and Communication) for M Health Fairview St. John's, M Health Woodwinds, and United Hospital.

It is worth noting that, based on MDH analysis, these other East Metro hospitals (like Regions) admit most medical-surgical patients through their emergency departments ranging from just over 70% to 79.5% instead of direct admissions from other points of origin based MDH analysis of discharge data.

[32] MDH analysis of the Regions Hospital 2026 Public Interest Review Application information found on page 4.
[33] This analysis was limited to adult beds since there was a very small percentage of medical-surgical patient discharges 0.7% came from pediatric patients (under age 18) in 2023.

Anticipated future bed need due to changing demographics and patient acuity

Regions used a proprietary forecasting model to project future inpatient demand based on demographic trends, service-line utilization, and referral patterns considering, among other things, length of stay and targeted occupancy.

The key assumptions in the model included the following:

- Baseline data from internal electronic medical records systems only included patients ages 18 and older from the identified primary service area that excluded neonatology, newborns, obstetrics, mental health, and rehabilitation.
- Inpatient market demand factors were applied to diagnosis related group use and service lines from the proprietary Impact of Change®; Claritas Pop-Facts® Sg2 Market Demand Forecast Version: 2023. Factors included population growth and distribution on service use; price sensitivity and economic trends; expected change in disease incidence and prevalence; new technology; impacts of federal policy;[34] and changes in use due to improved systems of care.
- Regions reported that several adjustments were incorporated in their bed need model, including shifting of services to Lakeview Hospital in Stillwater (reducing bed need by about 290 inpatient surgical admissions); adding approximately 690 inpatient admissions per year that were turned away from HealthPartners (HP) Direct, a specialized, single call transfer service, during 2023 due to capacity constraints; an increase in market share due to expanded oncology services in Woodbury; an increase in gynecology oncology based on the assumption that estimates from the baseline period appeared artificially low; removal of projected pulmonology case reduction; and the addition of three beds in the expanded extracorporeal membrane oxygenation (ECMO) program, commonly known as life support.

The data from the model presented to MDH estimated there was a shortage of 27 medical-surgical and two intensive care unit licensed beds in September of 2025 compared to baseline use to meet 85% for medical-surgical beds and 75% intensive care unit occupancy targets respectively. That deficit was anticipated to grow to 86 licensed beds by 2033 as inpatient volume would increase by 9.2% (0.9% per year) and average length of stay would increase by 4.4% (0.4% per year). According to Regions, increases in discharges and length of stay were projected based on demographic changes (an aging population and growth in the overall population), as well as clinical factors (more complex, higher acuity patients), and persistent downstream capacity challenges affecting the timely discharge of patients to clinically appropriate setting.

Demographic pressure

Regions emphasized that the hospital was experiencing rising utilization across service lines, but that there were demographic pressure points that would exacerbate an inadequate bed supply.

[34] Regions did not explicitly model the impacts of more recent policy changes passed in July of 2025 that may result in shifts in coverage for patients currently eligible for Medical Assistance (Medicaid).

Most pressing was a concern about the growing needs of the last cohort of the Baby Boom generation who would become 65 by the end of the decade and many more entering the 75-to-85-year age range. This senior population would have a growing need for services to treat chronic illnesses and age-related issues—including cardiac conditions, stroke, orthopedic concerns, and cancer. Hospital expansion was also seen as necessary to treat a wider age range of patients expected to reside in the service area in coming years, pointing to data from the Metropolitan Council's latest population forecast for 2050.

MDH projections

MDH was not granted direct access to the model used by Regions to validate assumptions for shifts in demand related to demographics, technology, or service model changes. Instead, MDH separately analyzed data from the Minnesota State Demographic Center for a more immediate timeframe to assess population growth, focusing on the three counties primarily served by Regions, namely: Dakota, Ramsey, and Washington counties. Those counties are expected to have modest population growth of 0.6% between 2024 and 2033 for adults 18 years of age and older, an increase of nearly 55,000 additional adult residents in this area by 2033.[35]

To assess expected demand for inpatient beds, MDH used hospital discharge data, focusing on of medical-surgical beds required between 2024 and 2033, an occupancy targets of 85% for general medical-surgical beds, and 75% for intensive care unit beds. This projection incorporated:

Estimated demographic shifts within the service area.[36]

Expected referral pattern changes submitted by Regions, including:

- Accepting a higher proportion of unrealized HP Direct referrals, noted above, that would annually increase hospitalizations by 690 per year.
- Shifting approximately 300 hospitalizations annually to Lakeview Hospital in Stillwater (and away from Regions) due to expanded capacity at the replacement hospital facility.
- Anticipated growth in medical-surgical cases for general oncology conditions that would add about 55 hospitalizations per year, on average between 2026 and 2033.

Crucially, the MDH analysis assumed a constant age group-specific length of stay into the immediate future, rather than the persistent annual increases assumed in the Regions model.

Figure 6 below illustrates that based on demographic factors, and changes in referral patterns, MDH projects that Regions could face a shortfall of up to 53 beds by 2026.

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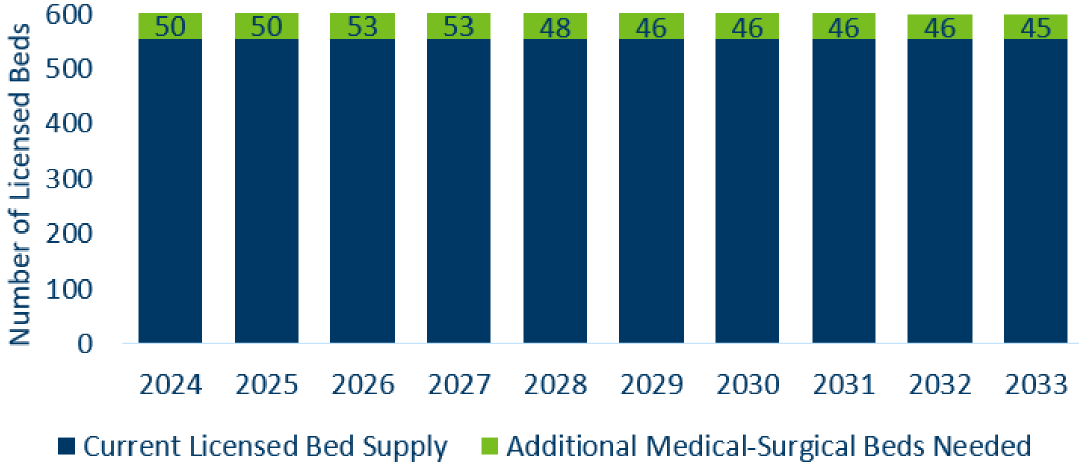
[35] MDH analysis of Minnesota State Demographic Center population projections for Minnesota counties, May 2024 dataset. Accessed on November 3, 2025 from https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/.

[36] The MDH estimate employs the medical-surgical hospital use and observed growth rate for the age cohorts of 18-44, 45-64, 65-74, and 75 and older from a hospital service area of the top 85% of ZIP codes. It also accounts for ICU bed use along these same age cohorts and assumes a target occupancy rate of 85% for general medical-surgical beds and 75% for intensive care unit beds. About 18 beds (net increases and decreases) were attributed to changing referral patterns.

Figure 6. Estimated number of necessary additional medical-surgical beds at Regions Hospital to meet occupancy targets, 2024-2033



Source: MDH analysis of hospital discharge data with a discharge date from October 2022 through September 2023 and demographic projections from the Minnesota State Demographer and Wisconsin Demographic Services Center. Medical-surgical discharges are defined in Table 2 of this report.

In considering inpatient bed demand, MDH assess the potential for change in bed capacity outside the East Metro Area, and noted that, in addition to the closure of M Health Fairview St. Joseph's Hospital (189 medical-surgical beds), M Health Fairview Southdale Hospital reported a reduction of 80 beds. Meanwhile, in addition to the previous expansion of beds at Regions described earlier, other hospitals reported expanding their bed capacity:

- Nearby United Hospital made available an additional 68 beds from their pool of licensed beds.
- Abbott Northwestern Hospital added 62 staffed beds to their pool of available beds.
- M Health Fairview University of Minnesota Medical Center expanded their available beds by 42 medical-surgical beds, again from their pool of banked licensed beds.

Regions' projection suggests a larger long-term increase in bed demand than MDH's analysis indicated. Moreover, MDH is concerned that projections of future demand for inpatient services do not seem to consider anticipated disruptions by federal policy changes made by HR-1, the 2025 reconciliation bill (more detail below) and proposed rule changes expected to increasingly move surgical services into outpatient settings.[37] It is also not clear how changes in technology and practice patterns were incorporated into Regions projections. While uncertain in magnitude, these factors may moderate future demand at Regions and across the East Metro.

[37] Centers for Medicare & Medicaid Services, : Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2026 Rates; Changes to the FY 2025 IPPS Rates Due to Court Decision; Requirements for Quality Programs; and Other Policy Changes; Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization, August 4, 2025. 2025-14681.pdf,

Conclusion—Factor 1

Evidence of sustained high occupancy and regional capacity constraints supports the need for additional beds. However, MDH projections suggest a somewhat lower long-term demand than Regions' model and the projected magnitude of demand may be affected by anticipated changes in federal policy and rule.

Factor 2: Financial impact on other hospitals

Considering the proposal's financial impact on existing Minnesota hospitals, particularly those with emergency departments in the geographic region, requires assessing the likelihood of changes in net income at other institutions. These can derive from a loss of inpatient volume, perhaps affecting the extent to which fixed cost can be covered by service revenue, unfavorable changes in patient-mix resulting from a shift to patients requiring higher resources, or a shift in payer-mix with a loss in higher reimbursed patients for medical-surgical inpatient care.

The plan materials submitted by Regions stated the planned expansion of beds is expected to have a neutral to positive financial impact on other hospitals in the region. This rationale was based on the following conclusions:

- The documented unmet demand in the service area. The expansion was aimed at primarily addressing the significant loss of medical-surgical capacity nearby in St. Paul that has not been fully replaced and need is expected to grow over time in the next decade.
- The observation that other East Metro hospitals had been at or near capacity.
- The focus of Regions on providing care to a distinct patient population is characterized by needing specialized services and trauma care consistent with the facility's designation as a Trauma 1 facility.
- The indirect benefit to other facilities from Regions financial health supporting its safety-net role in the East Metro, relieving others from contributing at higher levels.

Potential adverse impact on patient volume at other hospitals

The previous section of this report and the finding of lost capacity and demographic change in the East Metro makes it plausible that an incremental expansion at Regions may not interfere significantly with hospitals maintaining patient volumes.

There are a number of factors that may have a difficult-to-predict relative impact across East Metro facilities that are largely unrelated to the Regions proposal; however, they might affect the overall assumption about future demand. They concern previously mentioned factors related to changes in disease burden (e.g., will the broader use of GLP-1 drugs affect the need for chronic disease treatment of an aging population), the role of technology affecting inpatient demand (e.g., what role will telehealth and artificial intelligence play in reducing inpatient demand), the extent to which policymakers focus on strengthening downstream care capacity may free up inpatient care capacity to meet future demand, and the potential shifts in care practice (e.g., hospital-at-home or specialized care model for higher-acuity patients reduce anticipated demand).

As noted, two separate factors may reduce demand in the East Metro in a more predictable fashion:

- **Federal changes from the reconciliation act of 2025:** Federal policy changes affecting Medicaid and the individual insurance market are expected to increase the number of uninsured individuals between 2026 and 2033.[38] Evidence from prior health coverage expansions indicates insurance status influences hospital utilization; coverage losses may therefore reduce inpatient demand while increasing uncompensated care.[39] Reduced demand could affect hospitals across the market, while increased uncompensated care may disproportionately affect safety-net providers such as Regions.
- **Medicare regulatory changes:** A 2025 CMS proposal to phase out the Medicare "inpatient only list" of services may continue the ongoing trend of shifting procedures from inpatient to outpatient settings with the goal of reducing spending in high-cost inpatient settings and maximizing the opportunity for shorter recovery times demonstrated in outpatient settings. In the proposal, CMS would phase out 285 mostly musculoskeletal procedures from the inpatient-only list.[40] This would reduce revenue from profitable inpatient services, potentially financially weakening hospitals that would not retain those services in affiliated off-campus provider-based departments through which they might charge facility fees. This provision would be felt across the market.

One factor at Regions hospital may, however, affect volume and revenue in the East Metro: the expected shift in oncology patients to the HealthPartners system was included in Regions' modeling assumptions. The plan materials described the expansion as increasing oncology inpatient hospitalizations by about 55 additional hospitalizations per year. This number of cases would likely directly impact nearby M Health Woodwinds Hospital, potentially reducing the oncology discharges at Woodwinds. However, even a reduction of one-third of oncology cases, would only amount to about 2.8% of the total medical-surgical discharges in a fiscal year and represent a comparatively small change. Figures at M Health Fairview St. John's Hospital would be modestly higher.

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[38] Randy Haught, Akeiisa Coleman, Allen Dobson, Carson Richards, Collin McGuire, "The Impact of Proposed Medicaid Work Requirements on Hospital Revenue and Financial Margins", Commonwealth Fund Issue Brief, September 2025; Leighton Ku, Taylor Gorak, Kendal Orgera, Kristine Namhee Kwon, Maddie Krips, Joseph J. Cordes, Randy Haught, Allen Dobson, Collin McGuire, Akeiisa Coleman, "Without Renewal of Enhanced Premium Tax Credits, Rural Hospital Revenues Will Drop by $1.6 Billion", Commonwealth Fund Blog, November 2025.

[39] Pickens, G., Karaca, Z., Cutler, E., Dworsky, M., Eibner, C., Moore, B., ... & Wong, H. S. (2018). Changes in hospital inpatient utilization following health care reform. *Health Services Research, 53*(4), 2446-2469.

[40] Centers for Medicare & Medicaid Services. July 15, 2025. Fact Sheet: Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Proposed Rule (CMS-1834-P). Accessed on November 7, 2025 from: https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-and-ambulatory-surgical.

Potential changes in patient mix at other hospitals

There is evidence supporting the Regions' proposal that the hospital's patient population represents a higher-acuity mix with longer lengths of stay. MDH calculated the CMS case-mix index for medical-surgical cases (relative sickness of and resource intensity need for the inpatient population) for discharges at the five East Metro hospitals. Table 3 shows that Regions, consistent with its Trauma designation, exhibits higher case-mix, as well as longer lengths of stay. Regions was ranked seventh highest in the state and third highest in the Twin Cities Metro Area hospital in terms of average case mix index for medical-surgical discharges federal fiscal year 2023. The nearest hospital in terms of these rankings was M Health Fairview St. John's Hospital with a rank of 10 statewide and sixth highest in the Twin Cities (not shown).

Table 3. Analysis of medical-surgical case-mix index and length of stay for federal FY, 2023

Hospital	Trauma Level Designation	Case Mix Index	% Discharges with length of stay above geometric mean	% Discharges with length of stay above arithmetic mean
M Health Fairview St. John's Hospital	Level 4	1.96	43.6%	30.9%
M Health Fairview Woodwinds Hospital	Level 4	1.74	36.8%	24.3%
Regions Hospital	Level 1	2.02	44.4%	32.1%
United Hospital	Level 3	1.91	43.4%	31.1%

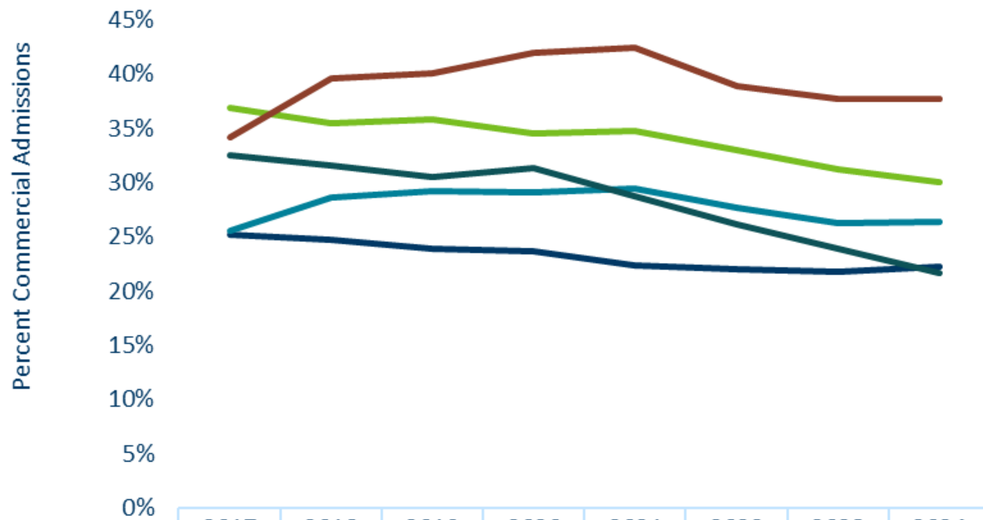
Source: MDH analysis of discharge data for medical-surgical cases and information from CMS FY 2023 Final Rule and Correcting Amendment Tables, Table 5: Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay. Medical-surgical discharges are defined in Table 2 of this report.
The geometric mean removes outlier cases to allow for better comparisons between diagnosis related groups

Regions' trauma level designation means that it is expected to deliver the highest level of comprehensive care and makes available, on a 24/7 basis, surgeons and specialists, operating rooms, and intensive care services. Given this information on patient acuity and trauma designation, MDH expects the proposal to not meaningfully shift case-mix in the East Metro.

Potential shift in payer mix at other hospitals

Regions, as described, has historically had the role of a safety-net hospital providing care to low-income and publicly covered community members. The full analysis of how the proposal is expected to provide care to low-income and nonpaying patients is found below in Factor 4, but—in brief, MDH anticipates Regions will continue to have high levels of uncompensated care (ranked second in the state behind Hennepin Healthcare in 2024), and the expansion is not anticipated to cause meaningful shifts in higher reimbursing commercial patients. MDH reaches this conclusion based on finding that since Regions started its rounds of medical-surgical bed expansion in 2018, the percentage of commercial patients admitted to the hospital has not risen as shown in Figure 8; in fact, the share of commercial patients has declined modestly over this period. This describes a similar trend, albeit at higher levels, for most other East Metro hospitals, with M Health Fairview Woodwinds Hospital being the exception.

Figure 8. Percent of commercial admissions (of all admissions) at select hospitals, 2017-2024



	2017	2018	2019	2020	2021	2022	2023	2024
Regions Hospital	25.2%	24.8%	23.9%	23.7%	22.4%	22.1%	21.8%	22.3%
M Health Fairview Ridges Hospital	36.9%	35.5%	35.9%	34.6%	34.7%	33.0%	31.3%	30.1%
M Health Fairview St. John's Hospital	25.5%	28.7%	29.3%	29.2%	29.5%	27.7%	26.3%	26.4%
M Health Fairview Woodwinds Hospital	34.2%	39.6%	40.1%	42.0%	42.4%	38.9%	37.7%	37.7%
United Hospital	32.6%	31.6%	30.5%	31.3%	28.7%	26.1%	23.9%	21.7%

In summary, while an 85-bed expansion has the potential to have a financial impact on existing hospitals in the region with emergency departments—particularly in terms of reduced patient volumes at other hospitals—indications are any impact will be modest, given the existing demand and the proposed iterative approach intended to respond to emerging market demand.

Conclusion—Factor 2

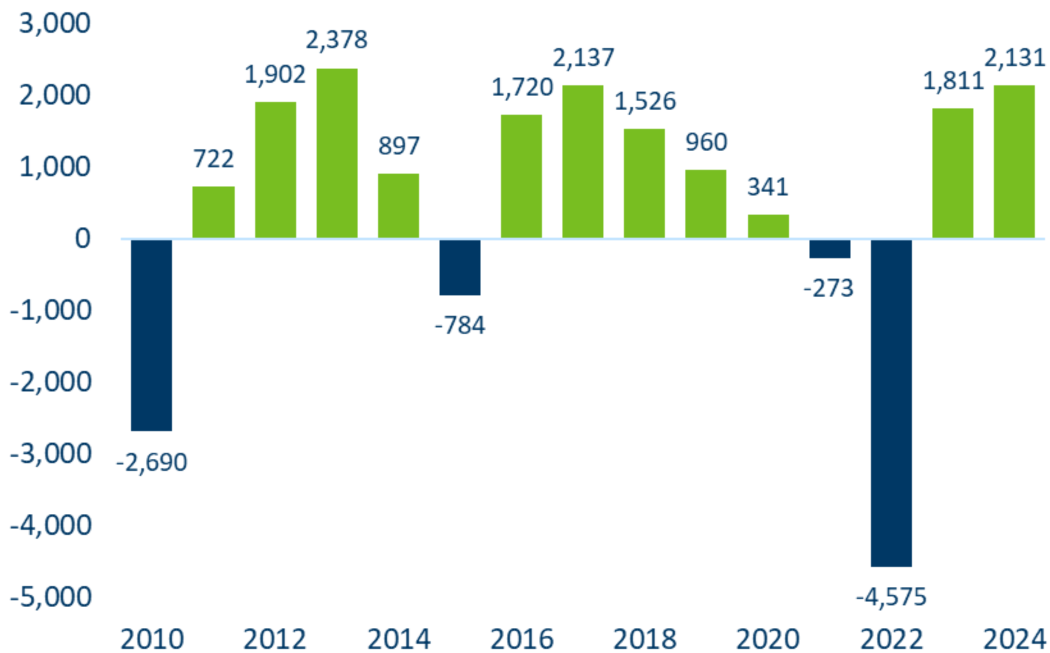
Available evidence suggests the proposal is unlikely to have a direct and substantial impact on patient volumes or financial stability at nearby hospitals.

Factor 3: Staffing impact on other hospitals

The Regions plan submitted to MDH acknowledged the broader health care workforce shortage has been challenging for hospitals. As is common in proposals for exception to the Hospital Bed Moratorium, Regions describes efforts to grow the pool of health care labor within the geographic region by investing in nursing residency programs, partnering with educational institutions that have nursing training, and engaging other targeted training programs. Regions also expresses the expectation that decompression of the high-occupancy emergency department (ED) and medical surgical units with the help of this proposal may act as a workforce retention mechanism and might reduce employee churn in the labor pool.

Employment at hospitals in Minnesota has been very volatile in the past several years—particularly following the COVID-19 pandemic, which has made staffing hospitals difficult in the Twin Cities and around the state. Figure 9 shows that since 2020, hospitals have had a net loss in employment of over 900 jobs.

Figure 9. Annual change in gross employment at general medical surgical hospitals in the Twin Cities Metro Area from 2010-2024



Source: MDH analysis of Minnesota Department of Employment and Economic Development Quarterly Census of Employment and Wages. The annual change is the difference between employment from one year to the next.

In this context, the staffing plan submitted by Regions emphasized the hospital is intending to reduce "extreme workload" experienced by staff and would like to bring back nurses who left working at the hospital due to high stress. It is possible a combination of training and recruitment of former staff may lessen competitive pressure on other hospitals' ability to maintain existing staff. It is equally possible HealthPartners' proposal, by requiring staffing of 85 beds over time, will result in competitive labor pressure for other East Metro hospitals.

Conclusion—Factor 3

Direct staffing effects are uncertain, but MDH does not find evidence that the proposal would materially undermine workforce stability at nearby hospitals.

Factor 4: Provision of care to nonpaying and low-income patients

As noted earlier, Regions has long had a role of a safety-net hospital providing care to low-income, underserved, and uninsured patients. Table 4 shows Regions was the second highest ranking hospital based on the ratio of its uncompensated care (allowances for charity care and bad debt—bills not expected to be paid) and operating expenses. Similarly, Regions is also the second highest provider of uncompensated care in Minnesota, again following Hennepin Healthcare.

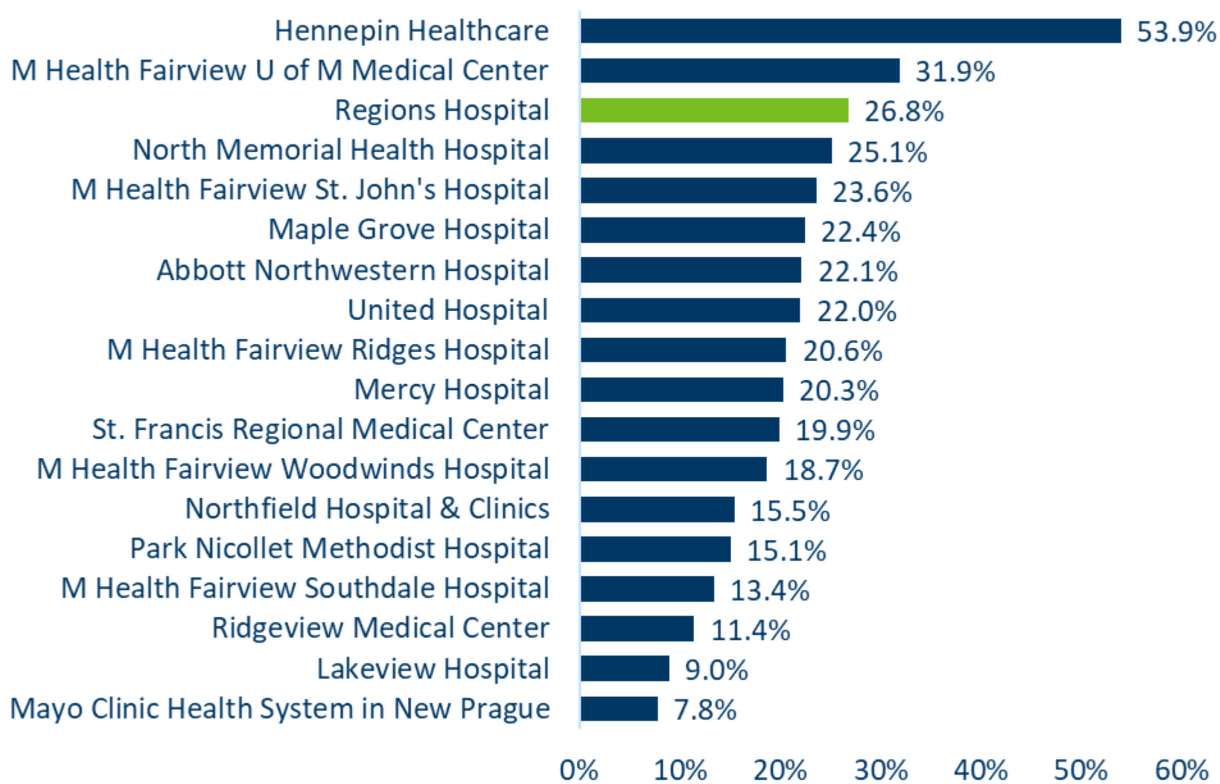
Table 4: Top 10 Minnesota hospitals' uncompensated care as a percent of operating expenses, 2024

Hospital Name	Hospital City	Available Beds	Uncompensated Care as a % Operating Expenses	Uncompensated Care as a % of All Hospitals
Hennepin Healthcare	Minneapolis	461	6.7%	20.4%
Regions Hospital	St. Paul	516	5.1%	12.4%
Mayo Clinic Health System in Waseca	Waseca	15	5.0%	0.3%
Mayo Clinic Health System in St. James	St. James	25	4.9%	0.3%
Madelia Health	Madelia	25	4.8%	0.2%
CHI St. Francis Health	Breckenridge	25	4.7%	0.2%
Sanford Worthington Medical Center	Worthington	48	4.1%	0.6%
Essentia Health - Sandstone	Sandstone	9	4.1%	0.2%
Mahnomen Health Center	Mahnomen	-	4.0%	0.1%
Avera Granite Falls	Granite Falls	25	3.7%	0.2%

Source: MDH analysis of hospital annual reports. The components of uncompensated care are adjusted to reflect costs of providing services.

Likewise, Regions is also servicing a high share of patients with state public program coverage. Figure 10 illustrates that Regions was ranked third highest among Twin Cities general acute care hospitals for the percent of admissions from state public programs—including Medical Assistance (otherwise known as Medicaid) and MinnesotaCare (a coverage program for low-income and middle-income Minnesotans, as well as those who are admitted and are paying fully out-of-pocket [presumed to be uninsured]).

Figure 10: Percent of state public program and self-pay hospital admissions for general acute care hospitals in the Twin Cities Metro Area, 2024



Source: MDH analysis of hospital annual reports.

Nonprofit hospitals such as Regions benefit from several revenue streams to support the provision of care to low-income and nonpaying patients. Among other sources, these include:

- An estimated $29.8 million (in 2023) tax expenditures from state, local, and federal governments.[41]
- About $4.4 million in Minnesota’s disproportionate share payments in 2024.[42]
- Approximately $47.9 million in revenue from participating in the federal 340B Drug Pricing Program[43]
- About $1.7 million reported as public grants for charity care.

[41] Office of the Legislative Auditor. February 2025. Community Benefit Expenditures at Nonprofit Hospitals. Accessed on November 12, 2025, from https://www.auditor.leg.state.mn.us/ped/pedrep/2025-comm-benefits.pdf. Appendix A: Tax Benefit Estimates of $57,000 per bed for 522 available beds.

[42] Minnesota Department of Human Services. Current DSH standings among Minnesota Hospitals. Accessed on November 12, 2025, from https://mn.gov/dhs/assets/dsh-hospitals-2025_tcm1053-613421.pdf.

[43] Minnesota Department of Health. 340B Covered Entity Report to the Minnesota Legislature, 2025. February 2025. Accessed on March 1, 2026, from https://www.health.state.mn.us/data/340b/docs/2025report.pdf.

Given these trends and financial supports, there is no indication that an 85-bed expansion would negatively affect Regions mission and role to provide care to low-income and nonpaying patients.

Conclusion—Factor 4

Regions has historically served a large share of publicly insured and uninsured patients. The proposed expansion is unlikely to change this role.

Factor 5: Views of affected parties

As required under statute, MDH sought public feedback on the proposal by issuing a notice in the State Register. MDH also disseminated invitations to comment through a GovDelivery notice and reached out informally to stakeholders in the East Metro. MDH received written feedback from five parties, all of which is reproduced in Appendix B.

Generally, feedback appeared supportive of a bed expansion at Regions, recognizing the need for decompression in the Emergency Departments and inpatient units across the East Metro systems and in anticipation of an aging population with greater need for inpatient care. One comment recognized there were a range of questions MDH should consider as part of the review. Another commenter acknowledged and the uncertainty about what the "right" number of needed beds is. Finally, two patients reflected their experiences at HealthPartners, with one praising the system, the other reflecting dissatisfaction with access to certain care and challenges experienced as an employee of HealthPartners with disabilities.

Conclusion—Factor 5

Public feedback was generally supportive and did not identify significant organized opposition.

Additional factors impacting the review

None considered

Concluding comment

The public interest review process of the Minnesota Hospital Bed Moratorium law continues to serve the important role of providing policymakers critical evidence and context for assessing proposals to expand the costliest care capacity— inpatient services. This is more important as Minnesotans increasingly struggle with affording health care, whether they hold insurance coverage or are uninsured.[44] Ultimately, the evidence is clear, any capital investment will be

[44] Minnesota Department of Health, Health Economics Program, Trends in Uninsurance in Minnesota: Findings from the 2025 Minnesota Health Access Survey (MNHA), March 2026.

financed through health care prices patients pay directly at the point of care or, indirectly, through health insurance premiums or taxes.

Considering the existing affordability challenges and the headwinds anticipated by Minnesota health systems associated with congressional changes in eligibility, financing, and administration of health care, the Legislature may wish to further inform the one-off public interest review analyses of projects at a given location in the state, with a more comprehensive assessment of system capacity needs, financing, and the distribution of inpatient hospital care services capacity across the state. As directed by the Legislature, MDH submitted recommendations for the design of such a study in late 2025, which it developed based on discussions with experts, public feedback from a range of stakeholders, and ongoing analyses of Minnesota's health care market.[45]

Findings

Although MDH has concerns with the extent to which the Regions projections account for potential contractions of inpatient care demand associated with payment policy changes by the Centers for Medicaid & Medicare Services (CMS), increased availability of medical technology, shifts in care practices, and congressional changes to financing, eligibility, and administration of health care programs, **MDH finds the proposed expansion of 85 licensed beds is in the public interest**.

Three primary factors from the analysis informed MDH's findings:

1. **Needed capacity:** With the recent loss of inpatient bed capacity in the East Metro and throughput challenges due to a range of factors, area hospitals, including Regions, experience capacity challenges visible through high occupancy and emergency department boarding. While other East Metro hospitals are planning their own expansion of inpatient bed capacity, these (hitherto unspecified) changes are unlikely to fully address the current and future East Metro gap for patient care. Moreover, initiatives aimed at shoring up capacity in lower-cost, downstream services, are not expected to be imminent.
2. **Impact:** Evidence suggests that parts of Regions' service profile differs from other East Metro hospitals. As a result, it is unlikely that those hospitals will notice a significant effect on volume, revenue or staffing because of the proposed expansion.
3. **Flexibility**: While the projections by Regions may be higher than actual future demand, the added beds, combined with the proposed iterative implementation, may give Regions the flexibility other East Metro hospitals enjoy by being able to draw on "banked" unused licensed beds that originated from past facility contractions.

[45] Minnesota Department of Health, Health Economics Program, Studying the Current and Future Needs of a Statewide Health Care System, November 2022; available online: https://www.health.state.mn.us/data/economics/statecapacity/docs/2025report.pdf

Appendix A: Data sources used in the review

The Minnesota Department of Health used data from the following sources in completing this public interest review:

Minnesota Hospital Annual Report: All hospitals in Minnesota file annual reports with the Minnesota Department of Health. Data used in this report includes the following items:

Available beds: for the number and type of available beds (acute care beds that are immediately available for use or could be brought online within a short period of time) in the most recent fiscal year.

Charity care, bad debt, and other hospital financial information: Acute care hospitals in Minnesota file annual financial reports to MDH on overall revenue and expenses, uncollectible bills, and other adjustments.

Following are the sections of the annual report considered most directly for this public interest review:

- Section 1: Revenue and Expense Summary
- Section 2: Non-Operating Revenue and Expense
- Section 3: Patient Revenue
- Section 4: Other Operating Revenue
- Section 13: Primary Payer Charges Summary
- Section 14: Primary Payer Adjustments & Un-collectibles

Section 21: Community Benefit Summary[46]

Hospital Discharge Data: The Minnesota Hospital Association (MHA) collects administrative billing data from hospitals in Minnesota and for Minnesota residents who were patients in Iowa, North Dakota, and South Dakota hospitals (Wisconsin hospitals do not provide data). The unit of analysis is the hospital stay, or emergency department discharges, at short-term, non-Federal, non-State, and non-specialty, general acute care hospitals. MDH acquires these data annually from the MHA.

Inpatient hospital stays and emergency department visits were identified and analyzed using the following sources:

- 3M All-Payer Refined Diagnosis Related Groups (APR-DRG)
- Hospital billing codes developed by the National Uniform Billing Committee
- Clinical Classifications Software Refined (CCSR) defined by the U.S. Agency for Healthcare Research and Quality

[46] Additional information and data are available online: https://www.health.state.mn.us/data/economics/hccis/index.html

- Medicare Severity Diagnosis Related Groups (MS-DRGs) developed by the Centers for Medicare and Medicaid Services

Population Projections: Population estimates and projections were used from the Minnesota State Demographic Center for the 15-county service area: 'Long-term Population Projections for Minnesota' (May 2024 release).[47]

Literature Review: In this review MDH considered evidence from the peer review literature on evidence about hospital financing, labor market dynamics, hospital operations, and inpatient capacity constraints.

[47] Available online: https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/

Appendix B: Public comments

For this public interest review, MDH received five comments on the record from the public and affected stakeholders; as is practice, all comments are reproduced and available at the links below.

- Jim Ostrem, Allina Health—Public Comment (https://www.health.state.mn.us/data/economics/moratorium/regions2025/docs/ostrem.pdf)
- Paul Allegra, American College of Emergency Physicians—Public Comment (https://www.health.state.mn.us/data/economics/moratorium/regions2025/docs/allegra.pdf)
- Regions 2025 Public Comment 3 (https://www.health.state.mn.us/data/economics/moratorium/regions2025/docs/comment3.pdf)
- Regions 2025 Public Comment 4 (https://www.health.state.mn.us/data/economics/moratorium/regions2025/docs/comment4.pdf)
- Regions 2025 Public Comment 5 (https://www.health.state.mn.us/data/economics/moratorium/regions2025/docs/comment5.pdf)

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