DEPARTMENT OF HEALTH

Studying the Current and Future Needs of a Statewide Health Care System

SUMMARY OF RESPONSES TO A REQUEST FOR INFORMATION AND RECOMMENDATIONS FOR A FUTURE COMPREHENSIVE STUDY

November 2025

Studying the Current and Future Needs of a Statewide Health Care System

Minnesota Department of Health
Health Economics Program, Health Policy Division
PO Box 64975
St. Paul, MN 55164-0975
651-201-4520
health.hep@state.mn.us
www.health.state.mn.us

As requested by Minnesota Statute 3.197: This report cost approximately $ to prepare, including staff time, printing and mailing expenses.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Minnesota Senate

Health and Human Services Committee

The Honorable Melissa Wiklund, Chair, 2107 Minnesota Senate Building

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

Human Services Committee

The Honorable John Hoffman, Chair, 2111 Minnesota Senate Building

The Honorable Jim Abeler, Ranking Member, 2207 Minnesota Senate Building

Commerce and Consumer Protection Committee

The Honorable Matt Klein, Chair, 2105 Minnesota Senate Building

The Honorable Gary Dahms, Ranking Member, 2219 Minnesota Senate Building

Minnesota House of Representatives

Health Finance and Policy Committee

The Honorable Jeff Backer, Co-Chair, 2nd Floor, Centennial Office Building

The Honorable Robert Bierman, Co-Chair, 5th Floor, Centennial Office Building

Human Services Finance and Policy Committee

The Honorable Mohamud Noor, Co-Chair, 5th Floor, Centennial Office Building

The Honorable Joe Schomacker, Co-Chair, 2nd Floor, Centennial Office Building

Commerce Finance and Policy Committee

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

The Honorable Kaohly Vang Her, Co-Chair, 5th Floor, Centennial Office Building

November 2025,

To the Honorable Chairs and Ranking Members:

As directed in Laws of Minnesota 2024, chapter 127, article 66, section 23, the Minnesota Department of Health (MDH) is pleased to share **recommendations for a potential comprehensive evaluation of current and future health care system needs and capacity in Minnesota**.

This report includes a synthesis of responses to a Request for Information (RFI) that MDH issued in February 2025 to inform these recommendations. It also draws on the professional expertise of the Health Economics Program and informal discussions staff had with experts in the community outside of receiving formal responses to the RFI.

MDH finds that for several reasons—but especially in light of considerable federal changes in the financing and administration of health care—a comprehensive study to assess health system capacity needs is critical to assure viable, sustainable, and affordable access for Minnesota residents to needed health care therapies and services. A comprehensive study should inform the Legislature on necessary investments in the health care system in Minnesota in terms of volume, quality, financing, and equity—including but not limited to infrastructure, workforce, and emerging care delivery needs and options.

Key recommendations from the report are as follows:

- **Recommendation 1**: Take a broad perspective when defining health system or provider capacity.
- **Recommendation 2**: Ensure wide stakeholder and community engagement.
- **Recommendation 3:** Use Minnesota data to conduct a comprehensive analysis of current health system facilities and infrastructure capacity.
- **Recommendation 4:** Assess the volume of population needed to sustain certain services.
- **Recommendation 5**: Collect new data to carefully assess the role of private capital in shaping Minnesota's health care system.
- **Recommendation 6:** Identify data gaps to assess access to health care services for all Minnesotans.
- **Recommendation 7:** Assess future health system facilities and infrastructure needs.
- **Recommendation 8:** Recognize immediate opportunities for innovation.

Because a study of this complexity that requires substantial need for engagement would take about two years to complete, MDH also offered considerations for the Legislature to initially focus on certain aspects of this study to generate urgent, actionable information.

Questions or comments about the report may be directed to Stefan Gildemeister, state health economist and director of the Health Economics Program, at Stefan.gildemeister@state.mn.us or (651) 201-3550.

Sincerely,

/s/

Brooke Cunningham, MD, PhD
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975
www.health.state.mn.us

Contents

Introduction

In 2024, the Minnesota Legislature tasked the Minnesota Department of Health (MDH) with issuing a Request for Information (RFI) to assist in planning a future comprehensive evaluation of health care facilities and infrastructure in the state (Laws of Minnesota 2024, chapter 127, article 66, section 23). This request originated with a set of recommendations issued in January 2024 by the Governor's Task Force on Academic Health at the University of Minnesota,[1] which was administered by MDH.

The Task Force recommended that a future comprehensive study consider statewide health care capacity, emerging future needs, opportunities for shared services/facilities, and existing labor agreements. The Task Force felt such a study was needed to "develop a prioritized bonding list to right-size and bring the physical infrastructure of the University of Minnesota Medical Center and other public health system facilities into the 21st century, as well as to avoid waste and duplication of community assets, and to improve access and quality for Minnesotans."

MDH worked with Wilder Research to seek stakeholder input through an RFI and conduct an environmental scan of health system capacity evaluation and planning. The full report from Wilder is provided in Supplement A and B to this report. There were 15 responses to the RFI. Of these, six were individuals representing Minnesota-based professional associations of health care providers, two were consultant organizations, one was a health insurer, and one was from an academic institution. Six respondents did not identify an institutional affiliation, and five individuals submitted feedback anonymously.

In developing recommendations for this report, MDH drew on:

- Feedback received through an RFI (Supplement B).
- Findings from informal conversations with experts in the community.
- Insights from MDH's experience and expertise in analyzing health care spending and monitoring health care market dynamics.

Background

The Minnesota health care system has gone through dramatic changes over the past several decades that affect how the system is organized and financed, how it "looks and feels" to patients, and how it

[1] Governor's Task Force on Academic Health at the University of Minnesota (https://www.health.state.mn.us/facilities/academichealth/index.html)

operates. Yet, little systematic evaluation has been conducted to assess the current needs it must meet and how it stacks up in delivering on those needs currently and in the future.

Conducting a study on the current state of Minnesota's health care system and provider capacity is therefore critically important. This is even more critical in the face of 2025 federal actions that make dramatic changes to eligibility, organization and financing of health insurance for Minnesota residents enrolled in Medical Assistance, Minnesota's Medicaid program, and for people obtaining private coverage through the state's insurance exchange. These changes are expected to reduce insurance coverage in the state and raise the need for hospital uncompensated care.[2]

In addition to forthcoming federal changes, the hospital infrastructure in Minnesota has experienced significant changes over the past 20 years that have impacted both delivery and financing of health care.

- **Shift in hospital revenue**: Minnesota has seen a shift in higher profit services moving to outpatient settings. Currently, freestanding outpatient surgery centers earn more than $1 billion in revenue from delivering surgery procedures, a significant portion of which would have been historically earned by hospitals.[3]
- **Emergency department capacity**: At the same time, hospitals are accountable for continuing to serve Minnesota residents through emergency departments that account for high fixed costs.
- **Discharge challenges**: Length of stay and emergency department boarding has increased in Minnesota hospitals, partially because patients remaining in need for inpatient care are, on average, sicker.[4] As a result, length of stay is increasing because hospitals experience challenges with discharging patients who require post-hospital institutional care in a timely way to suitable settings.[5] This is driven by workforce challenges in those settings, as well as an increase in corporate ownership and consolidation in those care settings.
- **Medical arms race**: Health care consolidation and corporatization in Minnesota's hospital industry has led to a medical arms race that is fueling capital investments. Wide adoption of high-cost technologies, thereby raising input costs, are hard to sustain financially while increasing the likelihood that lower-margin services are curtailed.

---

[2] Minnesota Department of Human Services, "Summary of Medicaid provisions in the 2025 federal reconciliation bill," August 2025. https://mn.gov/dhs/assets/summary-of-medicaid-provisions-in-the-2025-federal-reconciliation-bill_tcm1053-685438.pdf

[3] MDH, Health Economics Program analysis of annual reports from freestanding outpatient surgery centers, unpublished.

[4] MDH, Health Economics Program, "Treated Chronic Disease Prevalence and Spending in Minnesota," December 2022; https://www.health.state.mn.us/data/economics/docs/chroncondsupp121322.pdf.

[5] MDH, Health Economics Program, "Transfer and Discharge Delays for Behavioral Health Patients at Minnesota Hospitals," July 2024; https://www.health.state.mn.us/data/economics/docs/dischargedelays.pdf.

- **New costs**: Changes in how services are provided and paid for create new costs, such as managing billing and payments under value-based contracts, and managing complex information technology systems, particularly information security.

While Minnesota hospitals have access to a range of financial supports through federal programs (e.g., net revenue from the 340B initiative[6]), payment rate increases (e.g., directed Medicaid payments[7]), and one-time add-on state and federal payments (e.g., COVID-19 funding[8,9] and funding for discharge delays[10]), these payments and the burden related to delivering lower-profit and safety-net services is not distributed equally—creating "haves" and "have nots" in the industry—and may not fully serve to address local needs. While fully understanding this dynamic is ultimately an empirical question and the very purpose of this study, analyses to-date demonstrate, for example, considerable geographic variability in 340B revenue and disinvestments in mental health and hospital-based obstetric services.[11]

The changes and financial pressures on portions of the industry, paired with inflationary concerns, supply chain challenges, and workforce struggles have contributed to the termination of service lines across the state in recent years—disrupting or discontinuing care for essential pediatric, maternity, mental health, rehabilitation, substance use disorder, and other inpatient services.[12,13]

While innovations such as telehealth and artificial intelligence (AI) are promising developments that have the ability to counteract *some* of the aforementioned challenges, there is significant concern

---

[6] MDH, Health Economics Program, "340B Covered Entity Report to the Minnesota Legislature," Nov. 2024; https://www.health.state.mn.us/data/340b/docs/2024report.pdf

[7] Centers for Medicare & Medicaid Services (2025, August 7) *State Directed Payments*. https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments

[8] Laws of Minnesota 2020, chapter 66, section 1 (https://www.revisor.mn.gov/laws/2020/0/Session+Law/Chapter/66/).

[9] Minnesota Management and Budget (MMB) American Rescue Plan: State Fiscal Recovery Funds. MDH Emergency Temporary Staffing Pool—Hospital Supplemental Staffing (LCRC Action Order #11) January 15, 2022. https://mn.gov/mmb/arp/state/

[10] Laws of Minnesota 2023, chapter 74, section 4 (https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/74/)

[11] MDH, Health Economics Program, "340B Covered Entity Report to the Minnesota Legislature," Nov. 2024; https://www.health.state.mn.us/data/340b/docs/2024report.pdf.

[12] Health Regulation Division: Public Hearings (https://www.health.state.mn.us/about/org/hrd/hearing/index.html)

[13] Similarly, nursing homes reduced 1,000 beds between 2022 and 2024.

about whether the current financing and organization structure of the health care system can meet the evolving needs and priorities of Minnesota residents, related to:

- Increases in chronic disease across all age groups
- Presence of persistent health inequities
- Emergence of climate-related health needs
- Increases in the infectious disease burden
- Demographic changes of an aging population
- Disparities in the distribution of providers across the state, especially in small towns and rural areas

Shifting additional financial burden to patients and their families does not appear to be a sustainable solution. Many Minnesota residents already struggle to afford rising health care costs — through premiums and cost-sharing — that compete with other household expenses such as food, childcare, and housing. The result is more people delaying or forgoing needed care.[14]

Current and future health care financing considerations

A future study will need to acknowledge, analyze, and discuss the short-term and long-term challenges and opportunities within health care financing. Currently there is a tension between patient needs and the business of health care delivery. With pressure from lower fixed cost providers, many hospitals are pushed towards higher-cost specialty care instead of primary care. At the same time, funding mechanisms are not well designed to move patient care out of hospitals and into the community, when appropriate. Understanding these dynamics, creating more transparency about the financing that flows through the system,[15] and considering the impact of consolidation and corporatization on affordability, transparency, and system accountability must be key aspect of the study.

Workforce recruitment and retention continue to be a pressing issue, particularly in rural communities, and in mental health, dental, and primary care settings, where shortages and uneven provider distribution persists across the state. The study needs to identify sustainable financing models to support a workforce that reflects the needs of the population it serves.

[14] MDH/Health Economics Program, "Addressing our Growing Health Care Costs," https://www.health.state.mn.us/data/economics/docs/chcagraphic.pdf (December 2023)

[15] See for example: Minnesota Department of Health, Health Economics Program, "340B Covered Entity Report to the Minnesota Legislature, November 2024; https://www.health.state.mn.us/data/340b/docs/2024report.pdf

The study will need to explore community expectations of hospitals and health systems. Communities expect hospitals and health systems to be flexible, responsive, and offer specialized services while meeting basic care needs. It will be important to understand the impact of those expectations on health care costs amidst increasing chronic illnesses and evolving health care needs due to demographics and a changing climate. Local public health, Tribal public health, community organizations that represent various patient needs, and MDH-facilitated work groups such as the State Community Health Services Advisory Committee[16] and the Healthy Minnesota Partnership[17] will need to be consulted to consider public health priorities and to determine what we ask of our health systems during an emergency and if they are able to meet the demand.

Recommendations for a study approach

While the health care system in Minnesota may face challenges, the questions raised are not new.[18] There are opportunities to determine how the health care system can improve and adapt to the current needs of Minnesota residents. Minnesota is not alone in looking for ways to better understand and evaluate the infrastructure and capacities of our current health care system. The environmental scan conducted by Wilder Research reviews historical and current capacity analyses from other states (Supplement A) and shows states rely on a combination of federal and state sources to complete these evaluations. Minnesota is fortunate to have robust data sources—both for determining measures and associated outcomes, but also workforce analyses, population surveys, and public interest goals.

With consideration of existing literature and approaches from other states, the recommendations for this study incorporate stakeholder input received from the RFI along with MDH's expertise in market regulation, oversight, and systems analysis.

Recommendation 1: Take a broad perspective when defining health system or provider capacity.

[16] Minnesota Department of Health, Center for Public Health Practice, State Community Health Services Advisory Committee (SCHSAC); https://www.health.state.mn.us/communities/practice/schsac/index.html

[17] Minnesota Department of Health, Center for Public Health Practice, Statewide Health Improvement Framework, February 2025; https://www.health.state.mn.us/communities/practice/healthymnpartnership/framework.html.

[18] Minnesota Department of Health (2007) Factors and Incentives Driving Investments in Medical Facilities. (https://www.health.state.mn.us/data/economics/docs/legislative/medfacrpt.pdf)

Recognizing that Minnesotans seek health care services through a broad mix of providers, ensure that the capacity study is designed to capture the availability of traditional health care providers and provider organizations, as well as a broad spectrum of long-term care and community-based health providers, including safety-net providers and local public health.

Recommendation 2: Ensure wide stakeholder and community engagement.

Receiving community and stakeholder input is crucial to fully understanding the existing infrastructure and future needs of Minnesota's health care system. The feedback received through the RFI was a valuable starting point but is not comprehensive of all the essential perspectives. MDH recommends that a future study expand upon the RFI to focused community-based listening sessions, focus groups, and/or town hall meetings. RFI responders specifically recommended engagement with community leaders, Tribal public health, health care providers, health system leaders, local public health, and patients.

Recommendation 3: Use Minnesota data to conduct a comprehensive analysis of current health system facilities and infrastructure capacity.

MDH recommends developing an inventory and assessment of current health system facilities and existing capacity through available Minnesota-specific data, including but not limited to the Minnesota All Payer Claims Database (MN APCD), Health Plan Financial and Statistical Report (HPFSR), Minnesota estimates of health care spending by service and payer, hospital and emergency department utilization data, hospital financial reports, Minnesota Health Access Survey data, Minnesota Health Care Workforce data from the Office of Rural Health and Primary Care, and other sources that shed light on the use of non-clinical providers.

The analysis would need to consider availability of facilities and services by geography, service lines, and provider type. For example, the current supply of services, at multiple levels, would be examined along the expected population dynamics of an aging, and sometimes declining, population in some geographic regions of the state. Understanding the unique role that safety-net providers play in the current health system, including the unique demands and requirements, will be necessary to frame different financing and capacity considerations. Safety-net providers fulfill different needs depending on the communities they serve, the kind of care they can provide, and where they are located in the state.

The analysis will also need to account for capacity at long-term care facilities and challenges related to acute care transitions.[19] Other considerations include travel time, ambulance services, curtailment or closure of services, hospital community benefit reports, payment arrangements, capital investments, and health system mapping.

Recommendation 4: Assess the volume of population needed to sustain certain services.

In public hearings about health care service line closures, Minnesota health care providers argue certain services can no longer be provided with existing population levels.[20] The study should carefully consider the evidentiary basis for those assertions, by conducting a literature review, interviewing clinicians and health care provider system leadership, and consulting with national experts.

For geographic areas with definitive insufficient population volumes, the study will need to consider high-quality alternatives to current health care access options. Inversely, for areas with substantial populations, consider to what extent fixed costs in the system can be reduced through the adoption of centers of excellence and effective collaboration (without consolidation).

Recommendation 5: Collect new data to carefully assess the role of private capital in shaping Minnesota's health care system.

The promise of reliable public funding in the health care system has attracted investors to seek ownership stakes in health care organizations. By and large, this has resulted nationally in higher prices, poorer access, and no improvement in care quality.[21] While Minnesota recently adopted a requirement for notification about certain health care transactions, little is known about changes in the ownership structure of many types of care providers or the impact national players have on investment decisions, debt load, prices and care structures of providers across the state. In addition, there has also been significant growth in for-profit insurer ownership of primary care physician practices nationally

[19] Minnesota Department of Human Services (2024) Acute Care Transitions Advisory Council Report and Recommendations. https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/acute-care-transitions-advisory-council/.

[20] Minnesota Department of Health, Health Regulation Division, Public Hearings: https://www.health.state.mn.us/about/org/hrd/hearing/index.html

[21] Fuse Brown, E. C., Hall, M.A. (2024). Private equity and the corporatization of health care. *Stan. L. Rev.*, *76*, 527.

and here in Minnesota.[22] New data is necessary to assess the role of private capital in Minnesota's health care system.

Recommendation 6: Identify data gaps to assess access to health care services for all Minnesotans.

An important part of this study will be identifying areas where data is thin or limited but necessary to evaluating our current health care system. For example, data on non-clinical professions that play a role in delivering and supporting care such as health educators, information technology (IT) and health information technicians, medical scribes, and quality improvement specialists. Additionally, data from other sectors such as housing, transportation, and social services that impact, will be necessary to evaluate the current system. Local public health, tribal partners, and other policy stakeholders will be key in defining "access" and identifying barriers to care.

Recommendation 7: Assess future health system facilities and infrastructure needs.

Building upon the inventory of the current health system, stakeholder discussions and engagement with Minnesotans, MDH recommends including projected population care needs, equitable financing of service delivery (particularly for lower-profitability services), perspectives on financial barriers to care, provider/population ratios (by provider specialty), inpatient facility capacity, hours of operation, wait time for appointments, patient distance traveled, and vacancy time of unfilled provider positions. This analysis will include evaluation of quality of care delivered to patients, equity considerations, geographic access, and the expectations of the patient, providers, and payers.

A key aspect of assessing health provider capacity needs in Minnesota must include placing them in the context of health care affordability. These may include identifying opportunities for reducing societally inefficient health system redundancies, considering the effect of financial incentives that are disconnected to delivering needed health care services, and weighing the impact of differential reimbursement levels on availability of services.

Recommendation 8: Recognize immediate opportunities for innovation.

[22] Adler, L., Crow, S., Fiedler, M., Frank, R., Fernandez, R., Lake, D., & Braun, R. T. (2025). The changing landscape of primary care: an analysis of payer-primary care integration. *Health Affairs Scholar*, *3*(7), qxaf120.

Given the immediate challenges in access to certain services across several geographic areas of the state, the maldistribution of provider services, and the opportunity represented by the Rural Health Transformation Program,[23] the Legislature may wish to consider focusing initially on certain aspects of health care financing (e.g., documenting the current flow of resources through the system), identifying the most concerning gaps in delivery of certain service lines (e.g., obstetric services and mental health), and assessing duplication and redundancy in the delivery of hospital-based services. This would offer more timely results, albeit at the cost of not being able to consider the "full picture" all at once.

Conclusion & next steps

The proposed study approach considers the complexity of analyzing our current health care system and the need for innovation amidst a backdrop of unprecedented changes in financing, eligibility policies and processes at the federal and state level; further changes with the potential to affect health care delivery in Minnesota in fundamental ways appear likely. At the same time, the federal government is offering resources to states to consider transforming rural health care delivery. While the need to inform health care capacity planning and investments seem to be urgent tasks, MDH anticipates that a study of this scope and scale would take approximately two years to complete.

In addition to considering the proposed elements of a future comprehensive study, the Legislature may also consider fine-tuning this approach through direct engagement with policymakers and key stakeholders. As the Legislature considers necessary next steps for a comprehensive study, MDH is available to answer technical questions or offer feedback and input on best practices.

[23] Minnesota Department of Health, Rural Health Transformation Program: https://www.health.mn.gov/facilities/ruralhealth/ruraltrans.html

Appendix A: Request for Information (RFI): Evaluation of Statewide Health Care Needs and Capacity and Projections of Future Health Care Needs

Issued by the Minnesota Department of Health on Friday, January 24, 2025.

RFI Purpose

As required in Laws of Minnesota 2024, chapter 127, article 66, section 23, the Minnesota Department of Health (MDH) is seeking public comments through this Request for Information (RFI) to assist in planning a potential comprehensive evaluation of current and future health care needs and provider capacity in the state.

The information received through this RFI will assist MDH in defining the scope of the study and answering methodological questions in support of conducting the study, including development of any potential requests for proposals (RFP). Responses from *all* interested stakeholders – not just those who can provide the services that will be required to carry out the evaluation or who deliver health care services – will be considered for this RFI.

The Commissioner of Health must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care that provides the results of the request for information along with recommendations for conducting a comprehensive evaluation of current health care needs and capacity in Minnesota and projections of future health care needs in the state.

Relevant information

This RFI originated with a set of recommendations issued in January 2024 by the Governor's Task Force on Academic Health at the University of Minnesota, which was administered by MDH. The 2024 task force report[24] provides helpful context for respondents to consider as they prepare their responses to the RFI.

[24] Governor's Task Force of Academic Health at the University of Minnesota (2024) "Recommendations to Support World-Class Academic Health Professions Education, Research, and Care Delivery." (PDF) (https://www.health.state.mn.us/facilities/academichealth/recommendations.pdf)

While this RFI and the idea for an evaluation of current health care needs and capacity originated with the Governor's Task Force, the RFI is not specific to the University of Minnesota or M Health Fairview health care systems.

Additionally, several recent reports from MDH provide data and information addressing aspects of Minnesota's health care system that are relevant to this RFI. It may be helpful for respondents to take these reports into consideration as they frame their responses to the RFI.

- Chartbook Section 8A: Health Care Providers and Service Availability – Hospitals (November 2024). This slide deck from MDH's Health Economics Program (HEP) is part of Minnesota's Health Care Markets Chartbook, which is an annual review of key metrics in health care access, coverage, market competition, and costs. Section 8A focuses on acute care hospitals in Minnesota.
- Chartbook Section 8B: Health Care Providers and Services Availability – Clinics, Diagnostic Imaging, and Other Facilities (PDF) (November 2024). This HEP slide deck is also part of Minnesota's Health Care Markets Chartbook. Section 8B focuses on clinics, imagining, and other facilities.
- Minnesota Health Care Markets Chartbooks. The HEP chartbooks provide statistics on a wide variety of topics, including health care spending and drivers of increased health care costs in Minnesota, access to insurance coverage, foregone care, and health care provider trends.
- Minnesota Health Care Spending Projections, 2022-2031 (PDF) (October 2024). MDH issues projected estimates of health care spending for Minnesota residents and summarizes key expected trends in health care spending based on its latest projections.
- Rural Health Care in Minnesota: Data Highlights (PDF) (November 2024). This chartbook, produced by the MDH Division of Health Policy, presents statistics on a wide variety of topics regarding Minnesota's rural health care system—including rural demographics, health care access and utilization in rural areas, rural health care workforce, and rural health care financing.
- Health Care Workforce Data and Analysis. The MDH Office of Rural Health and Primary Care (ORHPC) collects and analyzes Minnesota-specific data on nearly 20 different licensed health care professions. See recent publications on the health care workforce.

Who should respond to this RFI?

MDH recognizes that there are many Minnesotans who have perspectives on the needs and capacity of the existing system, and therefore welcomes responses from a wide variety of stakeholders. MDH invites input from community members, researchers, health care advocates, associations, policy makers, providers, medical practices, and health systems of all sizes, employed staff across the care continuum, insurance companies and brokers, actuarial firms, employers, and entities that provide or pay for health services for Minnesotans. MDH also invites and encourages individuals and groups

representing patients or family caregivers to share their perspectives on what MDH might consider in developing the study.

RFI questions

Please answer as many questions as you like; **there is no need to answer all the questions. Please see Question #3 to provide additional feedback beyond the questions posed below.**

1. Purpose and Focus of the RFI

a. Are there data sources or research findings that MDH should use and/or consider as part of this evaluation? Please explain why any recommended data source and/or research is important to consider or necessary to require.

b. Are there similar studies or evaluations conducted in other states or countries that MDH should use, in whole or in part, as examples or starting points for designing Minnesota's evaluation?

c. Are there specific methodological frameworks or evaluation design choices that MDH should consider when planning for data selection/collection and analysis for this evaluation? Could a mixed methods approach be used to leverage stakeholder input for any part of the analysis?

d. What methods of gathering important input, especially from individuals, should MDH consider? For example, should MDH conduct listening session or focus groups?

e. What areas of expertise and/or experience should MDH have available or contract for to conduct the health care needs and capacity evaluation?

2. Focus and Components of the Evaluation

a. What parameters (e.g., temporal, geographic, demographic, service/provider/facility type), if any, should MDH consider in defining the scope of this evaluation? How should MDH think about framing the analysis? Are there topics/issues or particular segments of the health care system that should or should not be considered as part of the evaluation (e.g., long-term care, substance use disorder, pediatric care)?

b. How should the evaluation define health care provider capacity? How should the evaluation define expectations for capacity by geography/distance, service/provider/facility type, population characteristics, and/or insurance network?

c. Please define minimum level of access to care by service type. Should access be measured in geographic distance, wait times for appointments, and should it be measured or segmented by insurance network?

d. How should the evaluation conceptualize community need or demand? As when considering system capacity, how should the evaluation frame community need or

demand when taking into consideration geography, service/provider/facility type, population characteristics, insurance network, and/or insurance acceptance by providers (vs. private pay)? If there are specific target diagnoses or utilization patterns that should be considered, please be specific.

e. If inpatient care continues to become less central to health care delivery, how should hospital-based services be considered as companions to services that are not hospital-based? How does this shift affect analyses of health care capacity as the number of inpatient beds available may no longer be the most appropriate default capacity measure? How should the number of inpatient beds be incorporated into the evaluation of health care needs and capacity in Minnesota?

f. If inpatient care continues to become less central to health care delivery, how should hospital-based services be considered as companions to services that are not hospital-based? How does this shift affect analyses of health care capacity as the number of inpatient beds available may no longer be the most appropriate default capacity measure? How should the number of inpatient beds be incorporated into the evaluation of health care needs and capacity in Minnesota?

g. How should this evaluation consider the role of technology (e.g., telehealth and remote care, health monitoring technology, electronic health records) in service delivery? What metrics could be used to account for the impact of technology on demand for care, efficiency of care delivery, and meaningful access to care?

h. How should this evaluation consider health care workforce supply issues? Which provider type(s) should be considered? How should the evaluation define or measure adequate workforce supply? What existing benchmarks/standards should be examined when determining adequate supply?

i. Specifically for primary care, mental care, oral health, and nursing, how should MDH measure provider postsecondary education relative to the population's health care needs? What factors, trends, technologies, etc. will impact these specialties and the how should MDH factor in workforce supply from or exit to other states?

j. What types of challenges (e.g., payer mix and reimbursement, regulations, decreased inpatient admissions, uncompensated care) are health care facilities facing that impact their financing? What are the biggest of these challenges? How do these challenges vary by facility type and geography?

k. How should this evaluation examine broader systemic health care financing issues? For example, should the evaluation consider both administrative (e.g., non-benefit health care spending) and health care costs? What issues should this evaluation focus on (contracting

and payment arrangements, payer mix, resource allocation, etc.)? What data could be used?

l. When projecting future health care needs and capacity, what factors and trends will be most important to include in the analysis? What types of scenarios should be considered? What forecasting models should be considered? What forecast horizon should be used?

3. **Please share additional perspective that MDH should consider in the planning and design of a potential evaluation of current and future health care needs and capacity.**

References

- Laws of Minnesota 2024, chapter 127, article 66, section 23 (https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/)
- Chartbook Section 8A: Health Care Providers and Service Availability - Hospitals (PDF) (https://www.health.state.mn.us/data/economics/chartbook/docs/section8a.pdf)
- Chartbook Section 8B: Health Care Providers and Services Availability – Clinics, Diagnostic Imaging, and Other Facilities (PDF) (https://www.health.state.mn.us/data/economics/chartbook/docs/section8b.pdf)
- Minnesota Health Care Markets Chartbook (https://www.health.state.mn.us/data/economics/chartbook/index.html)
- Minnesota Health Care Spending Projections, 2022-2031 (PDF) (https://www.health.state.mn.us/data/economics/docs/projectedkeytrends.pdf)
- Rural Health Care in Minnesota: Data Highlights (PDF) (https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/rhcmn.pdf)
- "Recommendations to Support World-Class Academic Health Professions Education, Research, and Care Delivery." (PDF) (https://www.health.state.mn.us/facilities/academichealth/recommendations.pdf)
- Health Care Workforce Data and Analysis (https://www.health.state.mn.us/data/workforce/index.html)

Appendix B: Laws of Minnesota 2024, chapter 127, article 66, section 23

REQUEST FOR INFORMATION; EVALUATION OF STATEWIDE HEALTH CARE NEEDS AND CAPACITY AND PROJECTIONS OF FUTURE HEALTH CARE NEEDS.

(a) By November 1, 2024, the commissioner of health must publish a request for information to assist the commissioner in a future comprehensive evaluation of current health care needs and capacity in the state and projections of future health care needs in the state based on population and provider characteristics. The request for information:

(1) must provide guidance on defining the scope of the study and assist in answering methodological questions that will inform the development of a request for proposals to contract for performance of the study; and

(2) may address topics that include but are not limited to how to define health care capacity, expectations for capacity by geography or service type, how to consider health centers that have areas of particular expertise or services that generally have a higher margin, how hospital-based services should be considered as compared with evolving nonhospital-based services, the role of technology in service delivery, health care workforce supply issues, and other issues related to data or methods.

(b) By February 1, 2025, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care, with the results of the request for information and recommendations regarding conducting a comprehensive evaluation of current health care needs and capacity in the state and projections of future health care needs in the state.

Minnesota Department of Health
Health Economics Program
St. Paul, MN 55164-0975
651-201-4520
www.health.state.mn.us/healtheconomics

November 2025

To obtain this information in a different format, call: 651-201-4520