Comprehensive Evaluation of Current and Future Statewide Health Care Needs

Summary of Results and Recommendations from a Request for Information for a Potential Health Care Needs and Capacity Study

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Executive summary

As required in Laws of Minnesota 2024, Chapter 127, Article 66, Section 23, the Minnesota Department of Health (MDH) issued a Request for Information (RFI) to gather public comments around a potential comprehensive evaluation of current and future health care needs and provider capacity in the state (see Appendix).

In all, 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. The feedback received from these respondents is detailed in this report and will help the Minnesota Legislature to define the scope of the study and answer methodological questions in support of conducting the study, including development of any potential requests for proposals (RFP). Note that the recommendations presented in this report are not comprehensive of all affected groups and viewpoints.

Study focus. MDH should consider both short-term and long-term trends in its potential evaluation and include the entire continuum of care, with a particular emphasis on mental health care along with chronic diseases and substance use disorder treatment. The study should examine health care workforce and facility capacity, taking into account persisting workforce shortages as well as underserved populations. The role of technology should also be a component of the study, including telehealth, electronic health records, medical technologies, and artificial intelligence. Additionally, MDH should include a variety of population demographics in the analysis (especially socioeconomic status, geography/ location, age, and social determinants of health).

Study approach. The potential study should use a mixed methods approach. This approach should combine transparent analysis of quantitative data (e.g., all payer claims data) with analysis of qualitative data collected through focus groups, listening sessions, and/or town hall meetings that include a range of perspectives from individuals across the state. Online surveys could have wide reach and should be considered, especially because they can be easily tailored for specific audiences.

Outreach and engagement. The study should be designed in collaboration with interested groups, and MDH should consider establishing a stakeholder group to ensure transparency over the course of the study. MDH should gather study input from a diverse and comprehensive set of interest holders including community leaders, health care providers, health system leaders, and patients in communities throughout the state.

Engagement in underrepresented communities should be facilitated by trusted local organizations.

Access to care and community need. Access to care measures for the study should incorporate geographic distance, appointment wait times, and insurance networks. MDH should also consider a range of surveillance indicators and health care service measures that can be used to understand community need. These include, for example, chronic disease type prevalence, hospital admission types by disease, and mental health diagnoses.

Workforce supply and capacity. MDH should consider all provider types when evaluating workforce supply issues, including physicians, nurses, physician assistants, dentists, pharmacists, mental health providers, nursing home providers, and long-term care providers, among others. Potential evaluation approaches include comparing entrances and potential exits from the workforce, examining provider panel sizes and roster sizes compared to claims, and comparing the number of licensed professionals to the number of working professionals in different provider categories.

Health care financing. MDH should focus on both administrative costs and broader health care system costs for the potential study. The study should look at topics such as the difference between charges submitted and charges reimbursed, telehealth costs, payment arrangements, reimbursement rates for low-value procedures compared to rates for evidence-based high-value care, patient outcomes, and patient satisfaction. Challenges around financing for health care facilities are a particular area of concern, and MDH should consider issues such as insufficient reimbursement rates from public payers, facility consolidation into larger systems that require more administration, private equity acquisition of providers, rising labor costs, and uncompensated care costs.

Data sources. To explore the above topics, MDH should consider both federal data sources and Minnesota's own data sources around workforce, claims and costs, health system capacity, and demographics and geography. Suggested sources include, for example, professional licensure data, population survey data, data from the Minnesota All Payer Claims Database (MN APCD), and data from the Minnesota Health Care Cost Information System (HCCIS).

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RFI recommendations and feedback

Data and research to consider

Respondents discussed types of data, data sources, and research and information that MDH should consider as part of the potential evaluation.

Types or categories of data recommended by respondents include data around workforce, claims and costs, health system capacity, and demographics and geography. A summary of how respondents framed data types follows, along with a list of recommended data sources and suggestions around the collection and breakdown of data.

Respondents recommended a consideration of data around general health care workforce supply and capacity, dental workforce supply and capacity, health professional licensure, provider practice setting, health care professionals in complementary and integrative health disciplines, and health care facility hiring patterns, as well as demographic data on areas affected by workforce shortages. Respondents recommended a number of data sources that could be used to analyze questions around workforce:

- American Dental Association, Health Policy Institute: National and state-level dental workforce data
- Health Professional Shortage Areas, Health Resources and Services Administration (HRSA)[1]
- Medically Underserved Areas/Populations (MUA/P), HRSA*
- Minnesota Medical Professional Licensure data
- American Community Survey, U.S. Census Bureau

Respondents made several suggestions around these data and data sources. One respondent noted that data are not currently collected and provided to MDH on complementary and integrative health (CIH) professionals and encouraged MDH to "assist licensing boards in the collection of CIH provider workforce information, including geographic distribution, career plans, and practice characteristics." Another respondent recommended that labor market information from the Department of Employment and Economic Development

[1] The respondent who suggested HRSA and Census Bureau datasets cautioned that "Federal datasets must be used carefully, as federal directives will likely impact them. If MDH uses federal data as benchmarking, it must be able to reasonably reproduce the federal findings on a state level. Moreover, the study must examine (as much as possible) how decreased or eliminated federal support will impact conclusions, and how the state will make up the difference."

(DEED) better delineate between worker categories as the data currently do not distinguish between management and frontline workers. In another case, a respondent recommended that the state explore the number of applications compared to hires at health care facilities.

Respondents identified several data sources for assessing health system capacity around workforce. One noted the particular value of available quality evaluations from health insurers, highlighting the utility of evaluation findings related to network access. In particular, information on geographic access, appointment availability, and provider data accuracy are potentially important inputs into an assessment of Minnesota's health system capacity. Another respondent highlighted the DHS Legislative Dental Report Dashboard, which contains Minnesota Health Care Program (MHCP) data on dental utilization by county.

Respondents recommended that a potential health system planning effort take into consideration both claims and cost data to inform a number of analyses. All Payer Claims Database (APCD) and Uniform Billing (UB) data should be used to examine patterns of care, such as differences between rural and urban residents in the state, by focusing on services that are absent or limited by type of service and geography. These data should also be used to assess hospital usage across the state, and they should be reviewed by epidemiologists for disease surveillance. Cost data like those in Minnesota's Health Care Cost Information System (HCCIS) can be used to assess hospital financial health and inform year-over-year benchmarking of offered services. Assessments of hospital health should also use Medicare cost reports from CMS's Healthcare Cost Report Information System (HCRIS). Specific data sources suggested by respondents include:

- Minnesota All Payer Claims Database (MN APCD): State repository of health care claims data from insurance companies, plan administrators, and public payers across Minnesota
- Minnesota Health Care Cost Information System (HCCIS): Financial and utilization data for hospitals collected by the Minnesota Hospital Association (MHA) under agreement with MDH
- Healthcare Cost Report Information System (HCRIS): Medicare cost report data from providers, collected by CMS
- Uniform Billing (UB) claims data: Hospital discharge records collected by the Minnesota Hospital Association

Respondents noted that demographic data such as socioeconomic status, race/ethnicity, and household structure, will help researchers estimate and evaluate which populations are impacted by health system planning. The American Community Survey (ACS) and other U.S. Census data can be used to determine sub-state demographic characteristics.

One potential use of these data would be to characterize areas of the state impacted by workforce shortages and to determine those areas' ability to attract health care workers.

For geographic analyses, data around travel time (assessed via Travel Time Calculators such as those available through Google) can be used to assess patients' distance from health care more accurately than other calculations. This information will be important when considering the challenges of transporting patients to care locations. Pending infrastructure changes from local municipal projects should also be considered, as planners must consider the impact of these changes on the availability/accessibility of health care to nearby residents. Finally, data from the National Oceanic and Atmospheric Administration (NOAA) should be leveraged to evaluate the accelerating effects of climate change (e.g., extreme weather events, changing disease patterns, and infrastructure challenges) on emergency services and health care needs so the system is ready to face these challenges.

RFI respondents pointed to research and information that planners should consider when building out an evaluation of Minnesota's health system. In particular, planners should review:

- Evidence from clinical trials around therapies used by chiropractic doctors, licensed acupuncturists, and massage professionals that supports the clinical practice guidelines from the American College of Physicians, the CDC, and others
- Why We Left: Nursing Workforce Report from the Minnesota Nurses Association
- Concern for Safe Staffing Reports from the Minnesota Nurses Association
- Queue Simulation: Why Does the COVID-19 Pandemic Overwhelm Hospital Intensive Care Unit Bed Capacity? from the Public Service Management Laboratory (micro- and macro-capacity tools)
- The Importance of Vaccination in the Mitigation of Coronavirus Epidemic: Computer Simulations from the Public Service Management Laboratory (micro- and macro-capacity tools)
- Strengthening the Oral Health System in Rural Minnesota from the Minnesota Department of Health, Office of Rural Health and Primary Care

Similar studies and evaluations to consider

The RFI asked respondents to identify similar studies in other states or countries that MDH should use, whether in whole or in part, as examples when designing a health system planning effort for Minnesota. Respondents offered examples from the academic and gray literature that could guide MDH's initiative. This literature, from academics at the University of Minnesota and elsewhere, addresses topics such as the loss of hospital-based obstetric services in rural areas, health care utilization in rural areas with limited

maternity care, the cost efficiency and effectiveness of including chiropractic care under Medicaid, workforce planning models for oral health care, the impacts and costs associated with inadequate oral health system capacity, and capacity inventory tools for assessing systems-level capacity factors. Study citations are listed in the appendix.

In addition to these resources, one respondent highlighted the Rural Health Research Centers and Rural Health Policy Initiatives that are located across the country and funded by the Federal Office of Rural Health Policy (FORHP). These centers, including the University of Minnesota Rural Health Research Center, produce timely data and information on health care access and capacity, rural/urban comparisons, and state and national trends that could inform Minnesota's evaluation.

Method and design choices

The RFI asked respondents to identify specific methodological frameworks or design choices that MDH should consider when planning for data selection/collection and analysis, as well as whether a mixed methods approach should be used.

Respondents consistently supported a mixed methods approach that incorporates a variety of perspectives including those of patients, caregivers, individuals from both rural and urban areas, and a wide spectrum of providers from a range of service settings. Suggested strategies to support a mixed methods approach include, for example, using MN APCD data for service and outcomes analysis followed by focus groups to explore barriers identified by the data. In addition to focus groups, respondents suggested listening sessions with interest holders to gather patient perspectives.

Regarding study design, one respondent specified that MDH should emphasize "transparent and 'open-sourced'" access and capacity modeling to ensure that interested groups (e.g., hospitals and health systems) can clearly see inputs, processes, and outputs to benchmark performance and better understand the analysis. The respondent noted that proprietary and nontransparent models make it difficult for interest holders to participate in a meaningful way.

Another respondent cautioned MDH about the reliability of provider data when evaluating provider access. Providers may practice at multiple locations within care systems, and it is not always clear when practitioners are only at a given location occasionally. Because of this reliability issue, MDH should focus on practitioners' primary locations when assessing provider access.

Gathering input from individuals and communities

The RFI asked respondents how to gather input from both individuals and specific communities across Minnesota in a way that reflects a wide spectrum of perspectives and experience.

Focus groups and listening sessions were commonly identified as methods for gathering input. Focus groups could be used to collect input from targeted communities by engaging community leaders, Tribal leadership, organized labor, community-based organizations, local government officials, local public health organizations, county social services, public school educators, and patient groups. MDH should reach out to interested groups to assist with outreach to their audiences when planning focus groups or listening sessions.

Respondents suggested leveraging online surveys to reach more people for both individual and community perspectives. Surveys could be distributed by local government or other trusted agencies to leverage trust and ensure responses from across the state. More targeted surveys could gather input from patients obtaining care for which there are service gaps in certain geographies (e.g., obstetric care in rural areas or the outer metro area). The state could also administer surveys to current and prospective health care professionals.

Additional techniques for identifying community perspectives include town hall meetings where community members can pose questions and share feedback and one-on-one interviews with community and Tribal leaders to better understand local barriers to care. Nominal Group Technique (NGT) was also suggested as a data collection method. In this systematic and collaborative group decision-making process, participants first work independently to generate ideas and then come together to discuss and prioritize the ideas.

Respondents stressed that input must be gathered from a diverse and comprehensive set of interest holders. The following groups should be included: trusted community leaders (including Tribal leaders), current and prospective health care providers (including dental professionals), patients, health care unions, and workers in helping professions (e.g., workers in victim/survivor advocacy programs, addiction medicine clinics, school-based counselors).

Respondents also emphasized the importance of gathering community perspectives from "those who are the least listened to," noting that this will be challenging and that researchers must make it clear to potential participants that data will be destroyed after the evaluation. To gain a comprehensive understanding of community viewpoints, one respondent suggested establishing multiple channels for feedback across the state, and conducting meetings in diverse communities. Engagement in underrepresented communities should be facilitated by trusted local organizations.

Finally, respondents recommend that MDH gather information and scope a health system evaluation collaboratively through ongoing engagement of interested groups, including industry trade associations and unions. To support this engagement, MDH should consider establishing an interest holder group with whom to share regular updates and have discussions in order to ensure transparency throughout the process.

Areas of expertise and experience

The RFI asked respondents to identify areas of expertise and experience that MDH should have available in order to conduct the health care needs and capacity evaluation. Respondents provided suggestions for expertise and in some cases identified roles/positions that could provide this expertise.

Recommended areas of expertise were extensive and are listed here:

Heath care delivery

Social determinants of health

Cultural competence

Local health care needs (from both the patient and provider perspective)

Telehealth

Emergency medical services (EMS)

In-migration to Minnesota for care and access

Health system/marketplace considerations

Unique challenges and needs of Minnesota's health care providers, hospitals, clinics, and health systems

Mergers and acquisitions and how they impact infrastructure, services, and capacity in Minnesota's health care system

Acute care workforce education and training

Electronic health records (EHR) and cybersecurity

Geographic information systems (GIS)

Transportation

Supply chains

Health policy

Current public health challenges and their impact on future health care needs and provider capacity

How to create effective policy solutions

Demographics

Civil engineering

Broadband and internet access

Changing legislative and regulatory frameworks

Research design and methods

Service management principles

Operations analysis

Statistical analysis

Community needs assessments

Financial structures and reimbursement modeling

Positions/roles that could provide some of the expertise listed above include frontline providers, patient advocates, other state agencies, academic research and policy teams, clinical directors, school principals, program coordinators, and MDH employees or outside management consultants (for research design and methods).

Scope and parameters for evaluation and planning

The RFI asked respondents to recommend parameters for scoping a potential evaluation as well as topics or areas of the health care system that should be considered as part of the evaluation.

Respondents suggested that MDH consider both short-term and long-term trends in its evaluation. One respondent suggested a retrospective evaluation of the MN APCD over the last five years to understand trends and disease/condition prevalence by condition and population cohort, with a particular emphasis on rural communities.

Respondents identified a number of demographic characteristics that should be explored in the evaluation of health system capacity including socioeconomic status, geography/ location, and age, along with social determinants of health. Age was an important characteristic when examining patterns in access to care. Respondents highlighted the access challenges faced by older populations, especially in rural areas, as this group is "much more likely to be hospitalized more frequently" than others. One respondent highlighted access to childcare, especially in rural Minnesota, noting the important perspective child care providers can bring to the study.

Respondents highlighted several health care services that should be included in the state's evaluation, with chronic diseases, mental health care, and substance use disorder (SUD) treatment commonly mentioned. While the importance of including the entire continuum of care was stressed, challenges related to mental health care were firmly highlighted, particularly related to Minnesota's county-based mental health authority structure.

One respondent highlighted the consolidation of health care services in Minnesota, highlighting the University of Minnesota's proposed plan to consolidate East Bank and West Bank medical services and facilities. The respondent noted that the impacts of any consolidation decisions, including any decisions made by the University, need to be considered in a capacity assessment.

Respondents stressed the importance of certain workforce and access considerations for a health system evaluation. One pointed to the imbalance between the number of nurses registered with the Minnesota Board of Nursing and the number of open nursing positions

in the state, noting that the number of nurses exceeds the number of positions and calling for an examination of working conditions. Another suggested that MDH's analysis of access and capacity should assess the available health care workforce in all provider settings rather than just hospitals.

RFI respondents suggested several additional topics for consideration in a larger study. These topics include disease incidence and prevalence, health disparities and inequities, health care quality, needs and challenges around addressing chronic diseases, total cost of care for episodes of pain management, sexual violence, gun violence, and the impact of insurance status and payer type on care delivery.

Defining health care provider capacity

The RFI asked respondents to indicate how the health planning evaluation should define health care provider capacity and how capacity expectations should take into consideration variables such as geography/distance, service/provider/facility type, and so on.

One respondent suggested: "Health care provider capacity should be defined as the ability of a healthcare system/hospital/clinic or other facility to provide care to patients when and where it is needed." Other respondents recommended that this definition also take into account persisting workforce shortages and underserved populations.

Respondents identified factors that should be considered when making a capacity calculation, such as the fit of provider specialty to patient needs, the personal capacity of individual providers (dependent upon skill set, experience, patient acuity, etc.), geographic factors (e.g., average travel time), and the extent to which practitioners are delivering care and services at the top of their license.

Respondents also provided cautionary insight around some specific measures of capacity. One respondent warned against using bed counts as a measure of capacity, describing them as a "reductive" way of quantifying hospital access and capacity since they do not account for the full set of inputs needed to staff a single bed. Another warned against using the number of dental providers accepting MHCP as a measure of dental care capacity, making the case that dental provider capacity should also take into consideration whether a provider is accepting new patients as well as the number of MHCP patients, visits, or services provided.

Defining minimum level of access to care

The RFI asked respondents to provide their definition of minimum level of access to care by service type and to consider whether access should be measured by geographic distance, wait times for appointments, and/or insurance network.

Respondents did not offer a specific definition of minimum level of access to care. However, one suggested that MDH should set access levels by referencing network adequacy standards as an existing model through which several variables interact. This respondent also stated that "a useful evaluation would segment access by insurance network and payer type for all levels of care across the full continuum." Another respondent emphasized that access should be conceptualized in as broad a manner as possible, and that efforts to measure access should take into consideration five dimensions of access: "affordability, availability, accessibility, accommodation, and acceptability."

While not defining level of access, respondents identified indicators to use when measuring access and were generally in agreement that geographic distance, appointment wait times, and insurance network should be part of any access calculation. Some respondents prioritized one of these three indicators over the others, but there was broad consensus on the indicators themselves. Others pointed out the nuances of wait times versus travel times, where services may be close by but involve significant appointment wait time, or services may be far away with short wait times.

One respondent recommended considering where indicators and metrics are generated, suggesting that access and need should not be measured by insurance metrics. Rather, these concepts should be measured more subjectively by collecting survey data on satisfaction from key "essential worker" demographics at emergency departments, school administrations, and mental health and SUD support programs.

Conceptualizing community need

The RFI asked respondents how the evaluation should conceptualize community need or demand and how community need should be framed when taking into consideration geography, service/provider/facility type, population characteristics, insurance network, and/or insurance acceptance by providers (vs. private pay). Respondents were asked to specify any target diagnoses or utilization patterns that should be considered.

Respondents recommended a range of surveillance indicators, health care service measures, and other resources to consider when conceptualizing community need. Respondents suggested that an understanding of community needs take into consideration chronic

disease type prevalence, hospital admission types by disease, use of emergency departments for non-traumatic dental conditions, availability of pregnancy-related services, and availability of pediatric services, for example. The proposed evaluation could also leverage the framework of community health needs assessments, by which hospitals conceptualize community needs, to construct their own understanding of community needs.

Conditions or utilization patterns that should be considered when conceptualizing community need included mental health diagnoses, with a particular focus on needs related to mental health prevention, and seeking emergency department care for non-traumatic dental conditions like tooth decay.

Respondents emphasized that community needs or demands should be identified in consultation with local providers, local health system leaders, and community members who interact with the health care system. Additionally, the evaluation should highlight unique needs in both urban and rural communities to generalize key geographic differences, available service/provider/facility types, population characteristics, and available insurance networks (or acceptance by providers).

Hospital-based services

The RFP asked respondents to consider – if inpatient care continues to become less central to health care delivery – how hospital-based services should be considered as companions to services that are not hospital-based. Additionally, respondents were asked to consider how this shift affects analyses of health care capacity, as the number of inpatient beds available may no longer be the most appropriate default capacity measure. Relatedly, respondents were asked how the number of inpatient beds should be incorporated into the evaluation of health care needs and capacity in Minnesota.

RFI respondents were insistent that inpatient care and hospital-based services remain a central component of health care delivery, with one citing the state's hospital case mix index, which indicates that the overall inpatient acuity and complexity of patient care needs continue to increase. Given this ongoing centrality of inpatient care, respondents consistently stated that the number of inpatient beds is a critical measure of capacity: "…When it comes to capacity, beds matter," noted one respondent. However, respondents also put caveats around the use of bed counts. For example, according to one respondent, "the number of inpatient beds should not serve as the default capacity measure for Minnesota's care delivery totality" and should instead be considered when an evaluation contemplates the need and capacity for acute care services in particular.

Respondents observed that while hospital-based services are still central to health care delivery in Minnesota, capacity around these services should be considered together with capacity of outpatient services that help reduce hospitalizations.

The role of technology

The RFI asked respondents how the evaluation of health system capacity in Minnesota should consider the role of technology in service delivery, asking 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.

Respondents acknowledged the increased role of technology in health care and noted that technology "must be a core component of the evaluation." One said that it will be important to assess the role of technologies like AI in advancing health care to understand how these technologies will need to be supported to supplement local patient care. Another respondent called for an assessment of how AI is being used by hospitals beyond charting, whether the deployment of AI has impacted the health care workforce, and whether these impacts have negatively affected health care services. Another suggested that the evaluation should investigate whether there are additional costs to patients to use telehealth and the extent to which electronic health records are available to providers across systems. It will also be important to consider whether and how medical technologies impact disparities.

Respondents stressed that both patients and caregivers should be asked about their experiences with telehealth—when it works and when it does not. One respondent pointed to the relevance of MDH's recent study and ongoing work on telehealth, the recent telehealth study from DHS, and the work of the MDH e-Health Initiative Advisory Committee, when considering how medical technology directly impacts the delivery of care.

Workforce supply issues

The RFI asked respondents how the evaluation should consider health care workforce supply issues, which provider types should be considered, how to define or measure adequate workforce supply, and what existing benchmarks for adequate supply should be considered.

Respondents thought all provider types should be considered when evaluating workforce supply including physicians (primary care and specialized), nurses (all types), physician assistants, vision care specialists (ophthalmologist/optometrist), dentists, dental therapists, dental hygienists and assistants, pharmacists, mental health providers, therapists (physical

therapy, occupational therapy, etc.), nursing home providers, and long-term care providers. Respondents also highlighted the importance of considering capacity of county social service administrators, social workers, and health care support staff ("non-direct patient care jobs that are no less mission-critical to delivering care"). Several respondents emphasized the importance of monitoring the supply of mental health practitioners (prescribing and non-prescribing) in particular.

To address workforce movement into and out of Minnesota, MDH's evaluation should "attempt to account for" the potential positive and negative impacts of anticipated uptake of Earned Sick and Safe Time (ESST) and Paid Leave benefits within the state's health care workforce and its direct correlation to the likelihood of hospitals seeking providers from out of state or from other hospitals to provide needed care.

Respondents suggested several approaches for the evaluation of workforce supply. Workforce should be measured, according to one respondent, by examining "how many people intend to leave the workforce and how many are entering the workforce" and evaluators should assess how many people are experiencing burnout or work stress as a way to gauge potential exits from the workforce. Another respondent suggested considering a provider's panel size and roster size along with their number of E&M ("evaluation and management") claims, while another suggested that evaluators consider the number of licensed professionals versus the number of working professionals in each health care provider category (e.g., physicians, nurses, mental health professionals and support staff). The evaluation should also: look at current job vacancies and openings; account for trends in Minnesota higher education, including enrollment and graduation rates in health care-specific degrees; and access licensing board data to quantify the trend(s) and number of licensed providers delivering care in Minnesota but residing in another state (as an indicator of the impact of licensure compacts on adequate supply).

Measuring postsecondary education

The RFI asked respondents to comment on how MDH should measure postsecondary education—specifically for primary care, mental health care, oral health, and nursing—relative to the population's health care needs. Additionally, the RFI asked what factors, trends, technologies, etc. will impact these specialties and how MDH should factor in workforce supply from or exit to other states.

A suggested method for measuring postsecondary education relative to population needs is to "access available data on post-secondary graduation rates in primary care, mental health care, oral health, and nursing compared to the number of vacancies and open jobs in each field."

Respondents observed challenges around workforce supply for the specified provider specialties and in some cases suggested ways to address these challenges. One respondent observed that the University of Minnesota, School of Dentistry, acts as an "exporter" of dentists. A potential solution is the provision of advanced education programs that may function to "import" dentists who then remain in Minnesota. Another challenge is that while bringing in temporary workers or workers from other states can help in times of supply crisis, evidence shows that this strategy does not improve workforce issues in the long run. A potential solution to help create and foster a workforce that can manage current and future health care needs is for the state to provide education and training opportunities in rural and underserved areas.

Health care facility financing

The RFI asked respondents to identify the types of challenges (e.g., payer mix and reimbursement, regulations, decreased inpatient admissions, uncompensated care) that health care facilities are facing that impact their financing. Additionally, the RFI asks which are the biggest of these challenges and how these challenges vary by facility type and geography.

Respondents noted that financial challenges are occurring across the board, although they vary in rural versus urban settings and by facility types and size. The most commonly cited challenge was insufficient reimbursement rates. Government payers like Medicaid or Medicare—which cover nearly 64% of patients in Minnesota hospitals—reimburse "well below the actual cost of care." One respondent noted the potential for cuts in federal support for Medicaid/MHCP threatens to be a major challenge, especially for private dental providers for whom inadequate MHCP reimbursement rates already make it difficult to accept significant numbers of patients with public insurance. Respondents also commonly reported excessive administrative burdens (e.g., prior authorizations) that lead to "bloated" administrative costs. These costs are driven up, respondents say, by the consolidation of health care facilities into larger and larger systems that require more administration. Additional financial challenges include staffing shortages/turnover, aging health care workers approaching retirement age, rising labor costs, prior authorization and claim denials, regulatory compliance, increasing patient avoidable days, uncompensated care, increasing medical supply and drug costs, and liability insurance. "These challenges, mostly if not entirely outside of the control of hospitals, have reached a critical point, straining hospital capacity and operations across the state," noted one respondent.

One respondent, in the context of discussing low reimbursement rates from public payers, suggested that MDH should reference the recently published DHS Outpatient Services

Rates study to better understand how low government payments impact not just hospitals but the entire care continuum. Another identified a need to examine trends in private equity companies acquiring health care providers and "squeezing out margins" in Minnesota—particularly in the ambulatory care setting.

Systemic health care financing issues

The RFI asked respondents how the potential evaluation should examine broader systemic health care financing issues. The RFI asked if, for example, the evaluation should consider both administrative (e.g., non-benefit health care spending) and health care costs. Additionally, the RFI asked what particular issues the evaluation should focus on (contracting and payment arrangements, payer mix, resource allocation, etc.) and what data could be used to examine these issues.

Respondents most often recommended that the evaluation focus on administrative costs. One emphasized the administrative costs from using an insurance-based system rather than a single payer system, noting in particular the burden that dealing with insurance puts on providers, patients, and support staff.

Another respondent reported that hospitals across the country spend nearly $39 billion per year on administrative activities related to regulatory compliance, but that some providers, like hospitals, have a greater administrative responsibility to state and federal government than others, so a comparison across facilities would be challenging.

Respondents recommended that analyses of health care costs consider a number of issues, including: the cost to provide care by patient type, setting, and service; the difference between charges submitted and charges reimbursed; and "hidden costs" such as travel to care and time off work or school that could be offset using telehealth or community-based care.

Respondents also recommended focusing on contracting (including public program contracting for both health services and insurance administration) along with payment arrangements, executive compensation, reimbursement rates for low-value procedures vs. evidence-based high-value care, patient outcomes, and patient satisfaction.

Factors and trends to consider when projecting needs and capacity

The RFI asked respondents to recommend factors and trends to include in a projection of future health care needs and capacity. Additionally, the RFI asked what types of scenarios should be considered, what forecasting models should be considered, and what forecast horizon should be used.

The following factors and trends were identified by respondents for inclusion in analyses projecting health care needs and capacity:

- Workforce shortages across health care professions
- Minnesota's aging population and its health care needs
- The increasing prevalence of chronic diseases
- Mental health needs and increases in mental health and substance use disorders
- Changes and advancements in medical technology, including the role of telehealth
- The role of AI in health care
- Disparities in health care outcomes among marginalized communities
- Pregnancy-related care and services
- Pediatric care
- Chronic disease management
- Disability services
- The impacts of health system consolidation on case costs, quality, and access
- The health concerns of BIPOC populations, LGBTQIA+ populations, women, and people with disabilities
- Public payer reimbursement rates
- Social determinants of health
- Provider location
- Coordination of services that impact health such as transportation, housing, access to health food, etc.

One respondent touched on forecasting itself, suggesting that MDH develop both high-cost and low-cost scenarios based on economic trends and federal Medicaid funding.

Additional perspectives for planning an evaluation of health care needs and capacity

The RFI asked respondents to share additional perspectives that MDH should consider in the planning and design of an evaluation of current and future health care needs and capacity.

Respondents recommended that MDH focus especially on a number of key areas: socioeconomic status and health; rural health; decreasing dental provider supply, especially in greater Minnesota and especially for Medicaid; mental health parity (i.e., considering mental health and physical health needs at the same level); use of a central infrastructure (e.g., health information exchange) to assist in the management of a growing population; structural changes in reimbursement; workforce investment; and federal-state financial alignment.

To examine these suggested topic areas, MDH is urged to seek input from health care providers, health care system leaders, the education systems that train health care providers, and community members.

Conclusion

Recommendations from RFI respondents address a range of considerations that should inform a potential evaluation of health care needs and capacity in Minnesota. Respondents represented a range of perspectives that informed their feedback, but there were no major points of disagreement across their responses beyond emphases on particular topics of interest. They noted that the study should look at both short-term and long-term trends and should examine health care workforce and facility capacity as well the role of technology while incorporating population demographics. The study should be mixed methods, should incorporate both federal and Minnesota-specific data sources, and should be designed in collaboration with a diverse and comprehensive set of interested groups. The study should examine access to care by looking at geographic distance, appointment wait times, and insurance networks, as well as surveillance indictors and health care service measures. Workforce supply and capacity should be analyzed for all provider types, and an analysis of health care financing should consider both administrative costs and broader health care system costs.

Respondent recommendations and insights will be considered and leveraged by MDH as researchers work to define the scope of a potential study about health care needs and capacity and to answer methodological questions in support of conducting the study.

Appendix: Similar studies and evaluations to consider

Kozhimannil, K. B., Hung, P., Henning-Smith, C., Casey, M. M., & Prasad, S. (2018). Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. *JAMA*, *319*(12), 1239-1247.

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McGowan, J.R., & Suiter, L. (2019). Cost-efficiency and effectiveness of including doctors of chiropractic to offer treatment under Medicaid: A critical appraisal of Missouri inclusion of chiropractic under Missouri Medicaid. *Journal of Chiropractic Humanities*, *26,* 31-52.

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CareQuest Institute for Oral Health. (2025). *Adult dental benefit.* https://www.carequest.org/topics/adult-dental-benefit

National Maternal and Child Oral Health Resource Center. (2024). *Capacity inventory for integrating oral health care into primary care for pregnant women: Tool.* https://www.mchoralhealth.org/PDFs/capacity-inventory-tool.pdf

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