Minnesota Hospital Association

2025 Minnesota Rural Health Forum

Joe Schindler
Vice President, Finance Policy
MHA
May 22, 2025

Hospitals in Minnesota

139 hospitals

105 are part of a health system

34 are independent

- 28 CAH
- 6 PPS

15 Private, not-for-profit

19 District, county or city owned

- Plus 8 state-operated Direct Care & Treatment hospitals

109 (78%) hospitals are classified as rural

MN Hospital financials

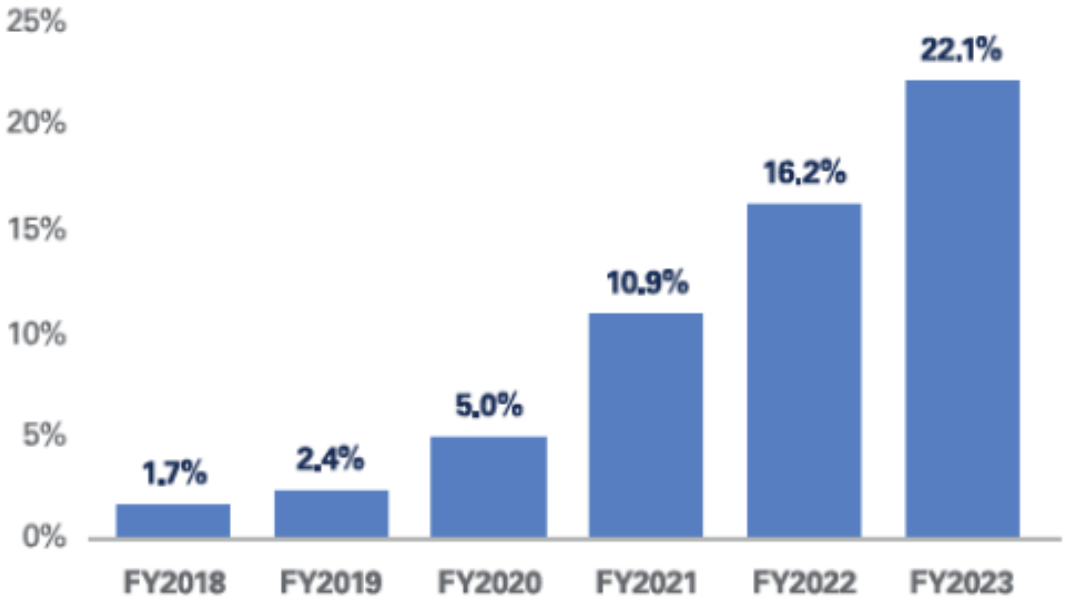
In 2023
52 hospitals had negative operating margins.
40, 77% were rural hospitals.

Statewide MN hospitals	2022	2023
Median Operating Margin	**1.6%**	**1.7%**
# hospitals negative	46	52
% hospitals negative	37%	42%
Median Total Margin	**0.3%**	**3.5%**
# hospitals negative	60	36
% hospitals negative	48.0%	28.8%

Inflection Point: MA's Growing Dominance in Rural Hospitals

Figure 1. Percentage of Rural Hospitals With More MA Inpatient Days vs. Traditional Medicare Has Seen Tenfold Growth

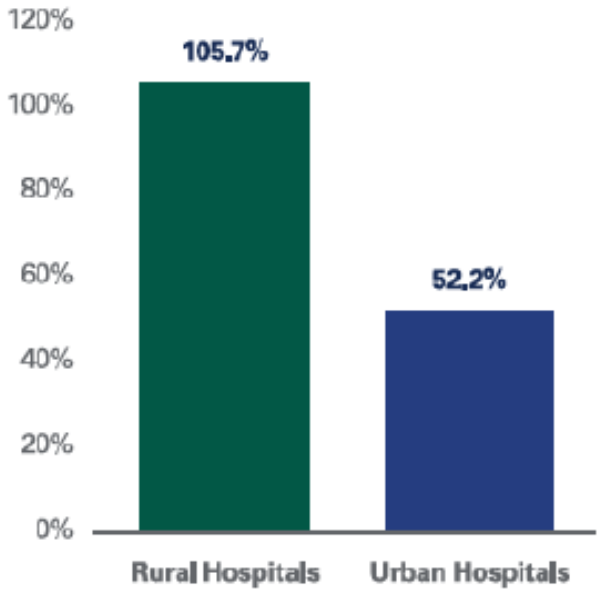
Percentage of Rural Hospitals with More MA Inpatient Days than Traditional Medicare, 2018 to 2023



Source: AHA Analysis of Medicare Cost Report data between FY 2018 and FY 2023

Figure 2. Rural Hospitals See Over 100% Growth in MA Inpatient Days Between 2018 and 2023

Growth in MA Inpatient Days as Share of Total Medicare Days



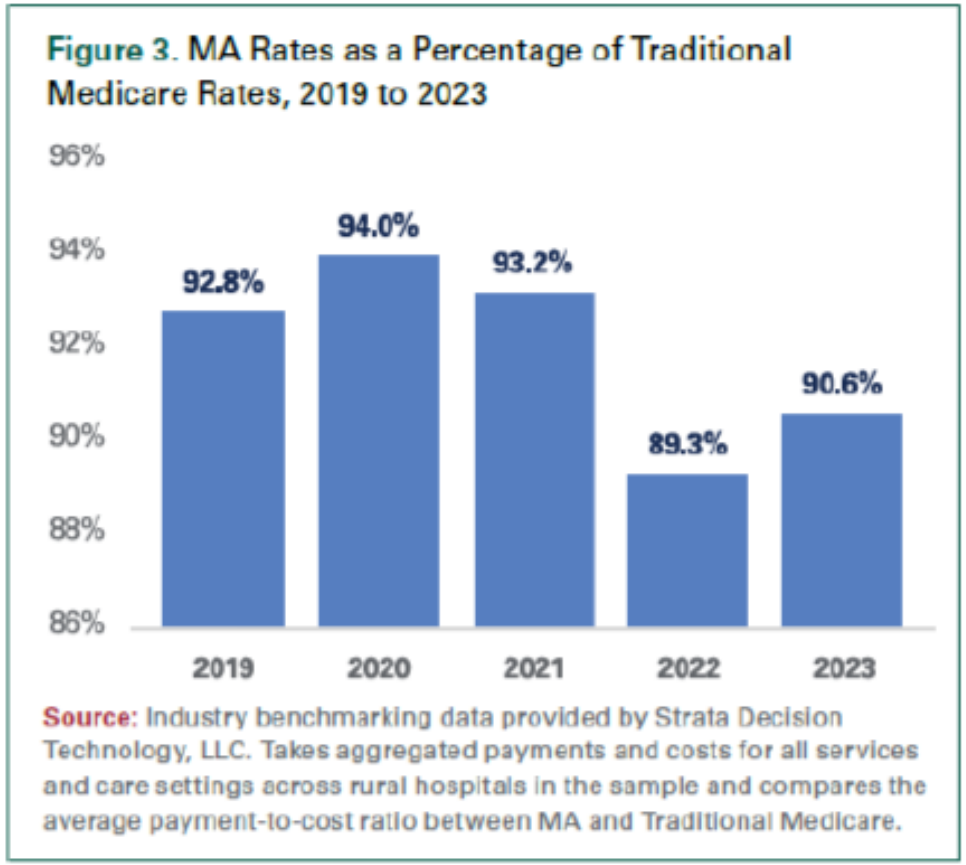
Source: AHA Analysis of Medicare Cost Report data between FY 2018 and FY 2023.

American Hospital Association™

Advancing Health in America

MA Reimbursement Falls Short for Rural Hospitals

- MA reimbursement is just **91%** of traditional Medicare rates on a cost basis.
  - MDH and LVH hospitals received average MA rates that were **85%** of traditional Medicare rates.
  - CAHs received just **95%** of traditional Medicare rates.



American Hospital Association™
Advancing Health in America

Current MN HMO market issues

UCare 'doing everything possible' to avoid layoffs after $504M operating loss

Minneapolis-based health insurer says it's implementing a multi-year strategic plan to turn around financial results.

By Christopher Snowbeck

Minnesota Blue Cross parent company's operating profit fell 73% last year

Eagan-based health insurer says the decline in earnings stemmed from "historically high" use of medical services.

By Christopher Snowbeck
The Minnesota Star Tribune

APRIL 7, 2025 AT 2:35PM

HealthPartners trims Medicaid enrollment after losing $197.9 million on operations in 2024

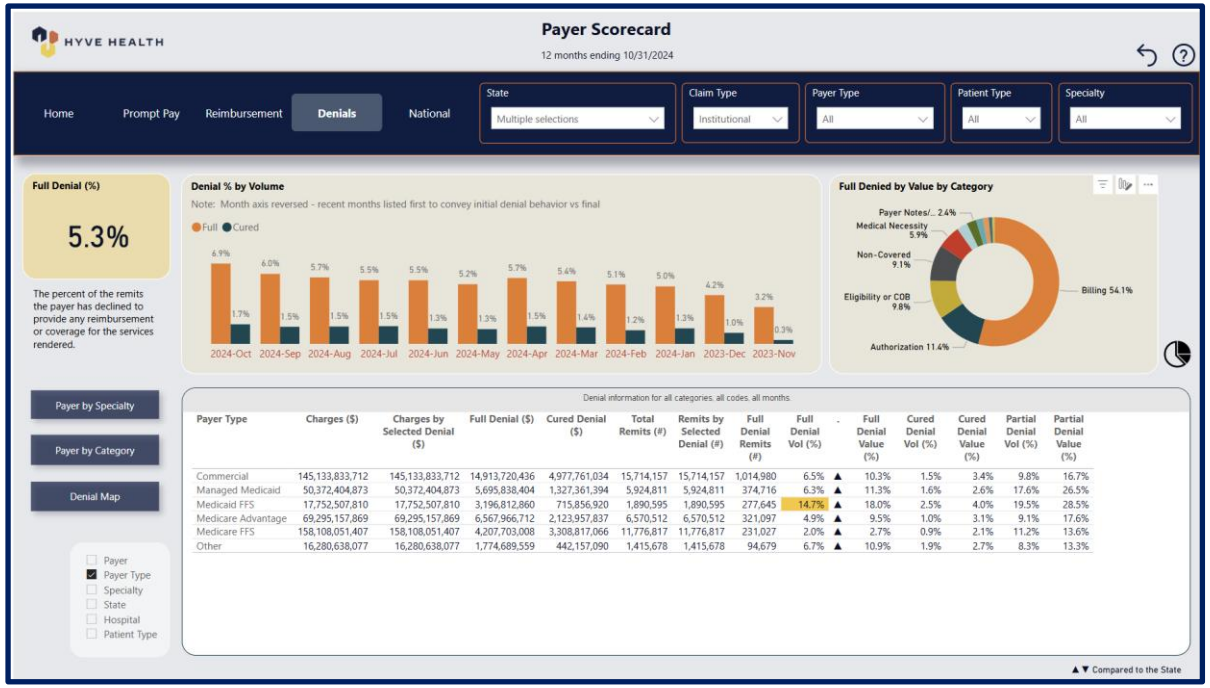
Bloomington-based nonprofit closed health plan for 6,200 people with disabilities even as investment income surged last year.

By Christopher Snowbeck
The Minnesota Star Tribune

APRIL 30, 2025 AT 11:49AM

Vitality Payer Scorecard Project

- MHA is pursuing Hyve Healthcare partnership similar to other states and AHA
- Automated payer scorecard using deidentified raw 837s/835s
- Create the most CREDIBLE data set
- Creates TIMELY data set
- Very cost effective: $3,000/year



Community Benefit - Top Line Numbers

$6,208,669,213
Community Contributions

$1,021,009,159
Uncompensated Care*

$1,438,324,359
Medicaid Underfunding

$1,666,807,323
Medicare Underfunding

*Uncompensated care is the combination of charity care and bad debt.

OLA report on CB

- Using a moderate definition of community benefit expenditures, total reported community benefits exceeded estimated total tax benefits from 2019 through 2023.
- Hospitals are going to need **ongoing vigilance** to community benefits reporting

Exhibit 3.1

Spending Categories for Limited, Moderate, and Expansive Community Benefit Definitions

Definition	Category	Description
Limited	Charity care	Free or discounted medical care for patients who are unable to pay
	Subsidized services	Health care services that are operated at a significant financial loss and that are otherwise unavailable in the area (e.g., neonatal intensive care)
	Community health services	Community health education, community-based clinic services, and other health care support services that improve community health
	Contributions	Cash and in-kind contributions to health care organizations and community groups to improve the health of a community
	Community building activities	Programs and activities that are not directly related to providing health care but may have indirect effects on community health (e.g., affordable housing)
	Overhead	Administrative overhead costs associated with operating community benefit programs
Moderate	Underpayments for state health care programs	Difference between the cost of providing services to patients enrolled in Medical Assistance and MinnesotaCare and the payments received for those services
	Education	Professional education, training programs, and financial assistance for medical students, nursing students, and other health professionals
	Research	Research that benefits the public
Expansive	Underpayments for Medicare	Difference between the cost of providing services to patients enrolled in Medicare and the payments received for those services
	Bad debt	Unpaid patient debts for which there was an expectation of payment at the time of service

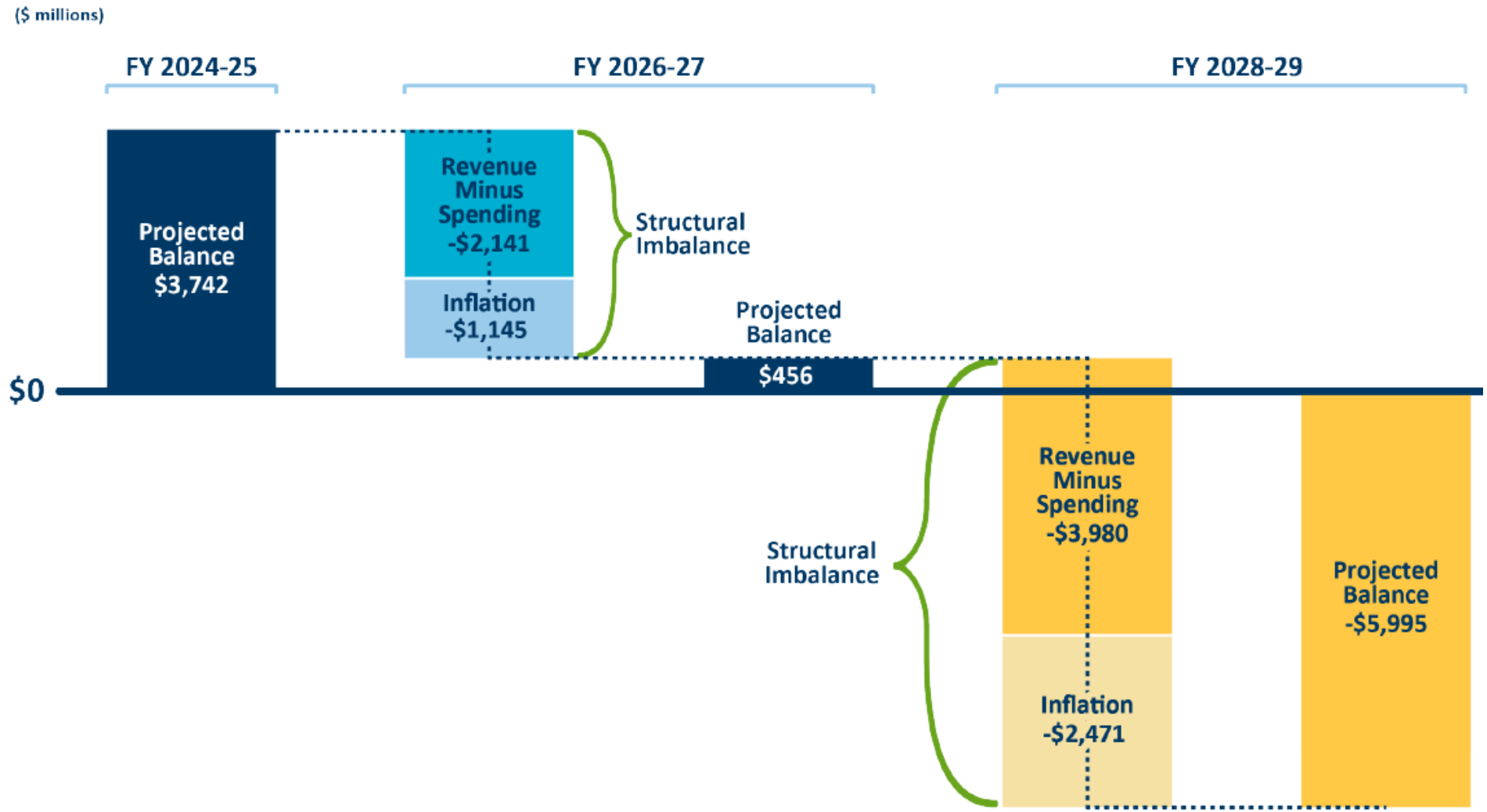
Source: Office of the Legislative Auditor.

Community Benefit Expenditures at Nonprofit Hospitals

www.auditor.leg.state.mn.us/ped/2025/comm-benefits.htm

MHA State Advocacy

MN State budget forecast - good to bad



State budget challenges

- Legislature has to put together the 2026--2027 budget. (Starts July 1, 2025.)
- Usually try to address the “tails”: 2028--2029 budget.
  - *November budget forecast* showed a $616 million surplus for the 2026-27 budget and a $5.1 billion shortfall for 2028-29.
  - *February budget forecast* showed less revenue and expenses up – the 2026-27 surplus dropped to $456 million, and now a projected $6 billion shortfall in the tails.

House and Senate budget plans

House plan:

- 2026-27: "Cut" $1.159 billion
- **$50 million Health target**
- $300 million Human Services target

- 2028-29: "Cut" $2.608 billion
- $175 million Health target
- $1 billion Human Services target

Senate plan:

- 2026-27: "Cut $754 million
- **$261 million Health target**
- $272 million Human Services target

- 2028-29: "Cut $1.738 billion
- $336.8 million Health target
- $430 million Human Services target

The WORST of many bad bills: Ban on Facility Fees

SF 1503/HF 1312; Now Senate Omnibus 2669: Prohibits hospitals from charging facility fees at hospital-based clinics.

- **$1.29 billion in lost hospital revenue** IF Emergency Room E&M codes are excluded from the prohibition on billing.
- Annual reporting of Facility Fee details to MDH
- Greater transparency / public awareness of Facility Fees

SF1503 Facility Fees Prohibitions

Subd. 2.**Provider-based clinic prohibition.**

Health care providers are prohibited from charging, billing, or collecting a facility fee for nonemergency services provided at a provider-based clinic, including services provided by telehealth as defined in section 62A.673, subdivision 2, paragraph (h).

Subd. 3.**Service-specific prohibition.** Regardless of where the services are provided, health care providers are prohibited from charging, billing, or collecting a facility fee for:

(1) outpatient evaluation and management services; and

(2) ~~any other services identified by the commissioner of health~~ pursuant to subdivision 5, paragraph (a).

Detailed facility fee reporting to MDH

Subd. 4.**Reporting.**

(a) By January 15, 2027, and each year thereafter, hospitals licensed under chapter 144 and health systems operating one or more hospitals licensed under chapter 144 must submit a report to the commissioner of health identifying facility fees charged, billed, and collected during the preceding calendar year. The commissioner must publish the information reported on a publicly accessible website. The report shall be in the format prescribed by the commissioner of health.

(1) the total amount charged and billed for facility fees;

(2) the total amount collected from facility fees;

(3) the top ten procedures or services provided by the hospital or health system that generated the greatest amount of facility fee gross revenue, the volume each of these ten procedures or services and gross and net revenue totals, for each such procedure or service, and the total net amount of revenue received by the hospital or health system derived from facility fees;

(4) the top ten procedures or services, based on patient volume, provided by the hospital or health system for which facility fees are charged, billed, or collected, based on patient volume, including the gross and net revenue totals received for each such procedure or service; and

(5) any other information related to facility fees that the commissioner of health may require.

AG enforcement + MDH penalties & audit

Subd. 6. **Enforcement.**

(a) A violation of this section is an unlawful business practice. All remedies, penalties, and authority granted to the attorney general under section 8.31 are available to the attorney general to enforce this section.

(b) The commissioner of health and health-related licensing boards may impose penalties for noncompliance consistent with their authority to regulate health care providers.

(c) In addition to penalties provided in paragraphs (a) and (b), the commissioner of health may impose an administrative penalty on a health care provider that violates this section. The penalty must not exceed $1,000 per occurrence.

(d) The commissioner of health or its designee may audit any health care provider for compliance with the requirements of this section. A health care provider must make available, upon written request of the commissioner or its designee, copies of any books, documents, records, or data that are necessary for the purposes of completing the audit for four years after the furnishing of any services for which a facility fee was charged, billed, or collected.

Current Status & Implications

- The bill has been modified to include prohibition of facility fees only on telehealth & preventative E&M
- Reporting requirements and patient notifications
- Excludes non health system CAHs

- Loss of funding for off-campus specialty care and infrastructure
- Likely service line closures, increased ER reliance
- Disproportionate impacts in rural and underserved communities

The WORST of many bad bills:

- ~~**SF 2775/HF 2289:** The most restrictive mandated nurse staffing ratio bill ever. *(Emergency Department "war zone" bill.)*~~ *Defeated by MHA*

MHA's Directed Payment Program

- **Great bill!**
  - Included in BOTH Senate & House HHS Omnibus bills
  - Hospital assessment (state portion) leverages federal matching dollars. Under a DPP, hospital Medicaid rate allowed to go up to the average commercial payment rate.
  - Potentially $1.0 billion in new federal money into quarterly payments to hospitals.
  - Sustains access to care to avoid service closures, by closing the gap of payments below cost.

Statewide Model Overview

	Estimated Net Impact
Total New Payments	$1.8 billion
Offsets: (Assessment dollars in, Admin Fee, Loss of DSH)	$0.8 billion
Estimated Net Benefit	$1.0 billion

FAFA: Finance & Reimbursement

Still in play:

- Extend the Premium Security Plan/reinsurance funding for 2026 and 2027
- Repeals the state authority to submit a Public Option waiver
- Additional EMS funding

FAFA: Health Care Workforce

Still in play:

- Delays implementation of MN's Paid Family & Medical by one year to 1/1/27 and provide some policy fixes
- Modify the Earned Sick & Safe Time law

FAFA: Mental Health

Still in play

- Funding for audio only telehealth in Medical Assistance for 2026 and 2027.
- Up to 10 placements per year for civilly committed hospital patients to be admitted into Direct Care & Treatment (Anoka Regional Treatment Center) from a community hospital for 2026 and 2027.
- Increase MA rates for physician services and outpatient mental health care in line with the DHS rate study. Senate bill establishes a new covered lives assessment on the MCOs as the payment source.
- Policy provisions to address Children's mental health and ED boarding and expand children's mental health grant programs, other policies.

FAFA: Protecting 340B Drug Pricing Program

Still in play

- SF 1574/HF 2242: Creates a single PBM for the outpatient drug program. Keeps this within managed care and protects 340 program. (MHA generally supports)

- ~~SF 1738/HF 1093: DHS instructed to create a state operated outpatient prescription drug purchasing program. This is a carve out from managed care, moving this service to FFS, triggering a loss of 340B payments to covered entities.~~ (MHA defeated)

Other issues still in play:

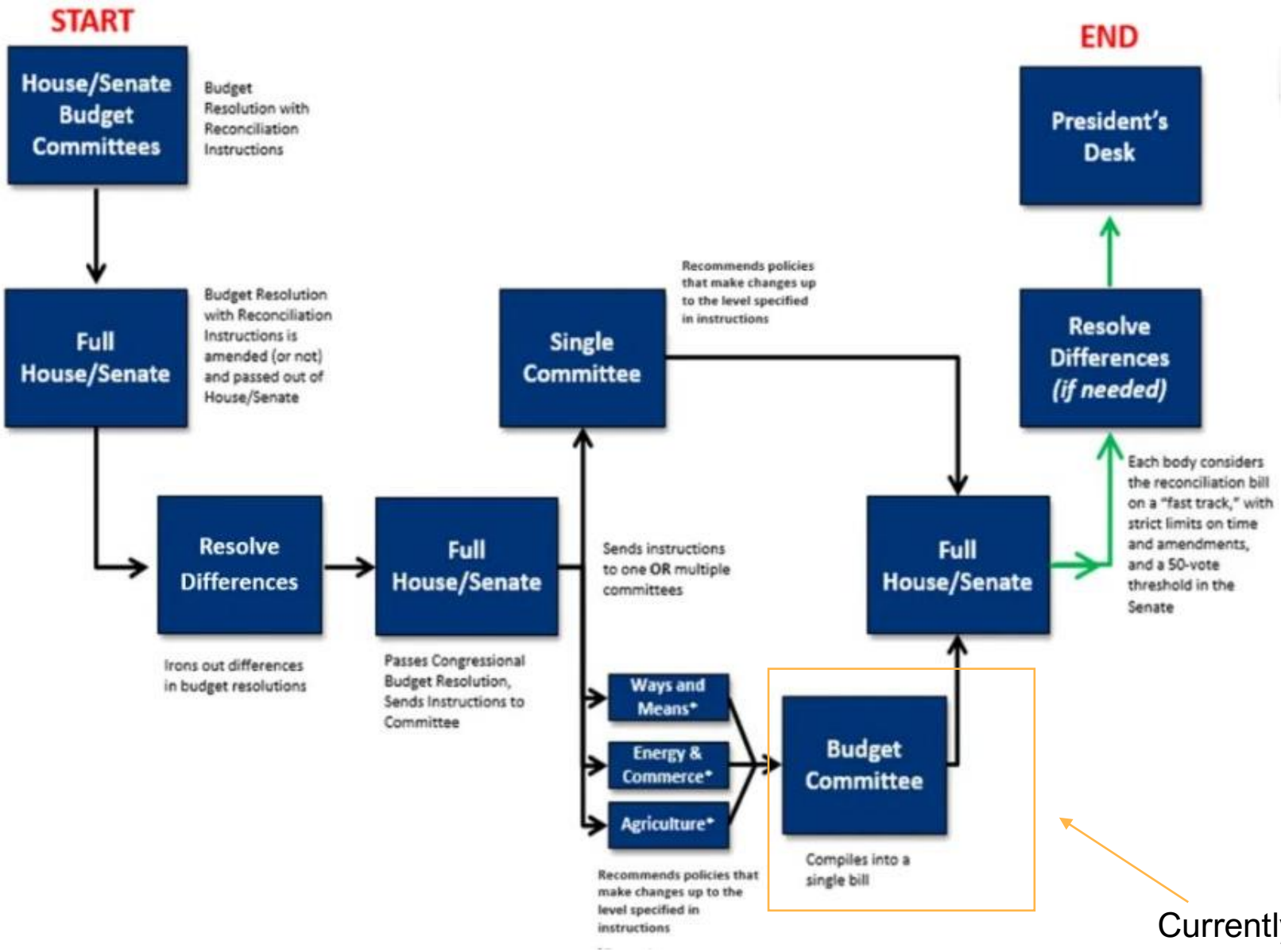
- **Eliminate eligibility coverage for non-citizens in MnCare. (Leadership's compromise is to cover children)**
- Allocate $5 million in grant monies to Undue Medical Debt, to forgive $500 million in medical debt.
  - (AG initiative, MHA Board discussed and was not opposed.)
- Require hospitals to hire "trained"/certified central service technicians, staff who decontaminate, inspect, assemble and sterilize reusable medical instruments or devices.
- PERA changes impacting Government owned hospitals desiring to privatize.

2025 MN Legislature

- Was scheduled to end by Monday, May 19
  - Currently about a month behind ‘typical’ schedule; some bills have not been heard in committee.
- Moving into Special Session

MHA Federal Advocacy

Reconciliation Process



Currently Here

Reconciliation Process Broken Down

Step	Details	Estimated Timing
House Budget Committee Markup	Individual reconciliation bills have been combined into an omnibus bill	**Completed (4/18)**
House Rules Committee Markup **(Currently Here)**	House Rules Committee to consider and set terms for floor debate	Scheduled for May 21, 2025 (1:00 a.m. ET
House Floor Consideration	Full House to debate and vote on the reconciliation package	Likely before Memorial Day
Senate Consideration	Senate to take up House-passed bill; possible amendments and negotiations	Likely in June
Conference/Final Passage	If House and Senate bills differ, conference committee resolves differences; final votes	Likely before August Recess
Presidential Signature	Final bill sent to President for signature	By August (before the debt ceiling limit is reached)

Energy and Commerce Portion

Highlight	Details
Committee Action	Passed Energy & Commerce (5/14), Budget (5/18)
Key Components	• Freezing existing provider taxes and banning new ones—undermining a core funding mechanism in many states • Capping state-directed payments under managed care at Medicare rates—risking lower provider compensation and reduced access • Cutting FMAP by 10% for states covering undocumented immigrants—creating pressure to limit coverage for vulnerable populations • Work requirement (80 hours/month) for expansion adults • Codifies ACA Marketplace rule changes, including shorter open enrollment and stricter eligibility/income verification • Cost-Sharing of up to $35 per service for expansion adults (100-138% FPL), with certain service exemptions
Impact	• 10.3 million would lose Medicaid coverage within 10 years • 7.6 million more people would be uninsured by 2034 • Uncompensated care would increase significantly

Ways and Means Portion

Highlight	Details
Committee Action	Passed Ways & Means (5/14), Budget (5/18)
Estimated Cost	$3.8T (10 years); $5.3T if temp cuts made permanent
Debt limit	$4.5T increase proposed
Key Components	• Requires annual verification of income and enrollment information for individuals claiming premium tax credits • Barrs most lawfully present immigrants from accessing the premium tax credits -- including DACA recipients, those seeking asylum and many others, effective for plan year 2027 • Does not extend the ACA premium tax subsidies that are set to expire at the end of 2025
Impact	• 4.2 million people would lose marketplace coverage, increasing the uninsured and uncompensated care

MHA has and will continue to advocate

CRA: A Powerful Tool to Overturn Biden Rules

The Congressional Review Act (CRA) allows Congress to quickly overturn recently finalized regulations. It eliminates the Senate filibuster, making it easier for Republicans to repeal Biden-era rules.

Rules in the crosshairs include:

Nursing Home Staffing Rule: Requires facilities to maintain minimum staffing levels. CRA resolutions have already been introduced to block it.

Preventive Services Under the ACA: Mandates ACA plans to cover certain preventive services without cost-sharing. Republican promises to overhaul the ACA could render these protections void.

Organ Transplant Model: A Medicare pilot program designed to improve kidney transplant access has been delayed due to concerns over access inequities and “sub-par” organ matches.

Mental Health Parity ensures insurers cover mental health care on the same terms as other care. Republicans and insurers oppose this measure due to clinician shortages and administrative burdens.

Danger Ahead? Unknown Tariff Policies

President Trump delayed **25% tariffs on Mexico and Canada, implemented 10% tariffs on China, expected to start March 12**

Pharmaceutical dependence

- Mexico, Canada, and China are top sources of U.S. pharmaceutical imports.
- **80% of generic drugs' active pharmaceutical ingredients (APIs)** are manufactured outside the US.

Medical device manufacturing under threat

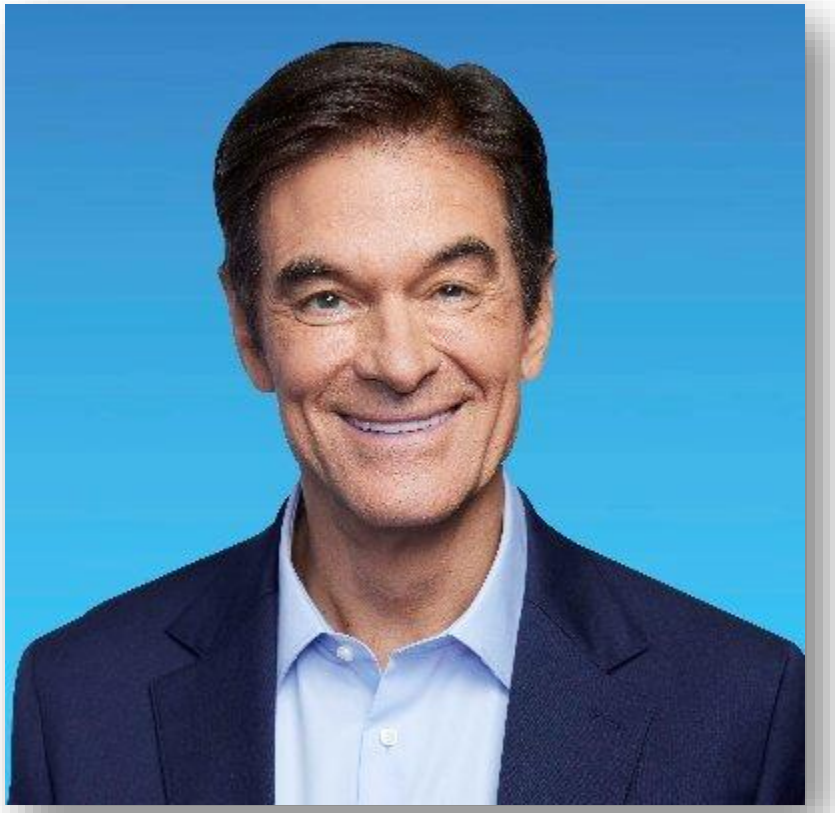
- Mexico is the **largest exporter of medical devices** to the U.S.
- Includes surgical gloves, masks, pacemakers, dialysis machines, and more.
- Tariffs will also spike costs for **materials like plastics** used in U.S. manufacturing.

Massive price surges

- **~75% of all medical devices** in the U.S. will see a price increase.

New HHS Secretary, CMS

HHS Secretary: Robert F. Kennedy, Jr.



CMS Administrator: Dr. Mehmet Oz

2025 Regulatory Outlook

- Rollback/delayed implementation of Biden regulations
  - Nursing home minimum staffing rule
- Less regulatory focus on Medicare Advantage
  - Project 2025 plan includes details on making MA the default enrollment option
- ACA reform – likely not repeal
  - Less funding for navigators, outreach efforts
  - More short-term “skinny” insurance plans
  - Enhanced premium subsides set to expire in 2025 – over 80,000 Minnesotans will see their insurance costs go up

Hospitals need help, not more cost pressures

Tariffs force Minnesota hospitals to brace for high cost of medical equipment, supply challenges

Trade groups have urged President Donald Trump to exempt medical supplies and devices, to no avail. A look inside one Minneapolis hospital shows the complexity of this supply chain.

By Victor Stefanescu
The Minnesota Star Tribune

MAY 20, 2025 AT 3:00PM

In an email, the Minnesota Hospital Association said it is working to assess the effect of tariffs on supply costs.

"As elected officials, industry experts and, most importantly, hospital leaders have been making abundantly clear: many hospitals and health systems are struggling financially," the email said. "Even so, they are facing an array of new financial challenges, and anything that further stresses non-profit hospitals and providers will only further threaten the access to care Minnesotans depend on."

Thank you!

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