PRE READ

How the Report Gets Written, and What It Will Rest On

Areas 1 and 2: The Report and the Evidence Base

Prepared for Members of the Task Force

Advisory Task Force on Governance and Financing of Hennepin Healthcare System, Inc
September 4, 2026

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Laurel Health Advisors, LLC

About this document

This pre-read describes how the Task Force will produce its report and what evidence will support it. It is provided so members can see the method behind the materials they will receive in each meeting cycle, and so they can raise questions about that method now rather than in January.

Two areas of the work are covered. Area 1 is the report itself: how it is drafted in increments the Task Force can read and correct as it goes, the standard every recommendation must meet before it reaches a vote, and how the document is built to be accessible and readable by legislators, county officials, and the public alike. Area 2 is the evidence: the national scan of publicly owned hospital systems, the ownership and governance options that will be built from it, the stress test each option must survive, and the funding analysis that sits underneath every structural choice. A third area, covering meeting design, support to the chair, and the public consultation program, is not described here.

This material was prepared before the Task Force convened on August 26, 2026. Where it refers to meetings and their sequence, the Task Force's adopted meeting calendar now governs.

Area 1: The Report as the Organizing Artifact

A legislative report is too often treated as the thing written after the meetings end. That is precisely how task force reports are assembled in a January panic, published with accessibility defects, and shelved by the legislature that commissioned them. Area 1 begins from the opposite premise, already built into the design of the meetings themselves: the report is the operating system of the entire engagement. Area 1 is where that premise becomes editorial discipline, applied by a single accountable voice from the first week to the statutory deadline.

Element 1: The Living Draft. The annotated skeleton delivered before Meeting 1 is version 0.1 of the preliminary report. From that point forward, the report is a living, version-controlled document: every meeting cycle produces a numbered increment in which newly closed decisions become drafted text, and members deliberate on real language rather than reacting to a surprise in January. By early December, the Task Force has a complete draft and conducts a structured read-through, with a full month for adjudication, accessibility verification, and adoption. The draft increments are also what make the process public in substance, not just in form: at any point, anyone can see what the Task Force has decided and what remains open.

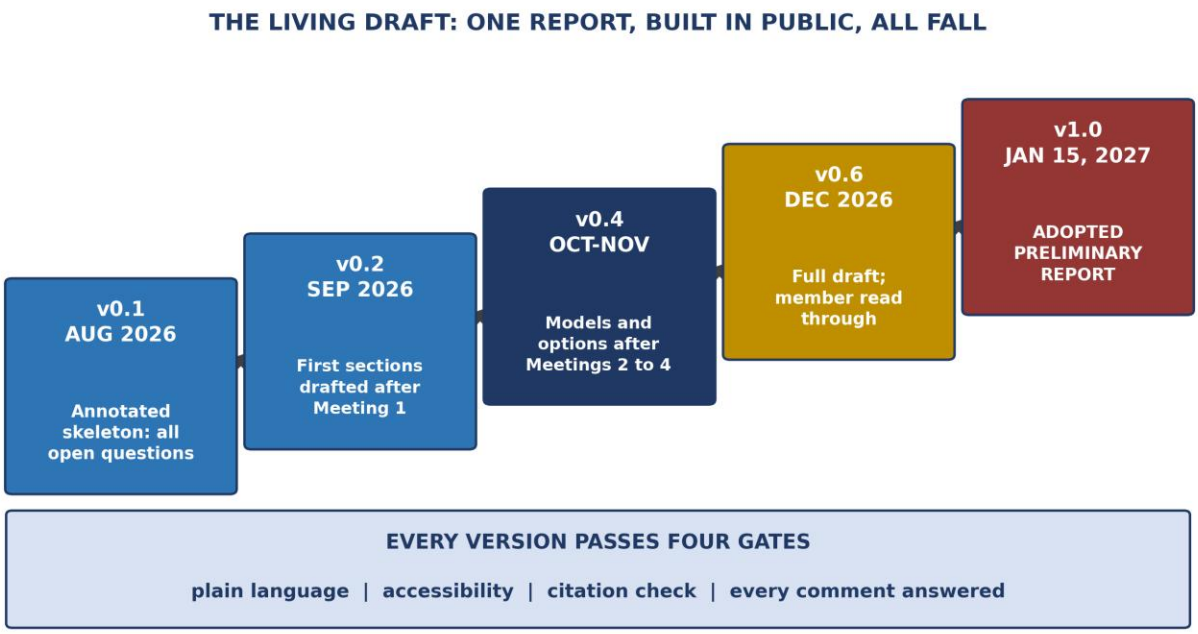

Figure 1. The Living Draft. Version numbers are illustrative; the discipline of one increment per meeting cycle is not.

Element 2: Written for every reader, it must survive. This report will be read by state legislators deciding whether to act on it, by the county board and the newly seated Hennepin Healthcare board, by organized labor and community advocates, by the press, and eventually by the agencies tasked with implementing it. Each audience needs a different level of depth, and a report that serves only one fails. We therefore build the document in three layers: a one-page plain language answer, a disciplined core report, and technical appendices that carry the evidence, the full Consultation Ledger, and the financial detail. Nothing important lives only in the appendices, and nothing in the one-pager is unsupported by what follows.

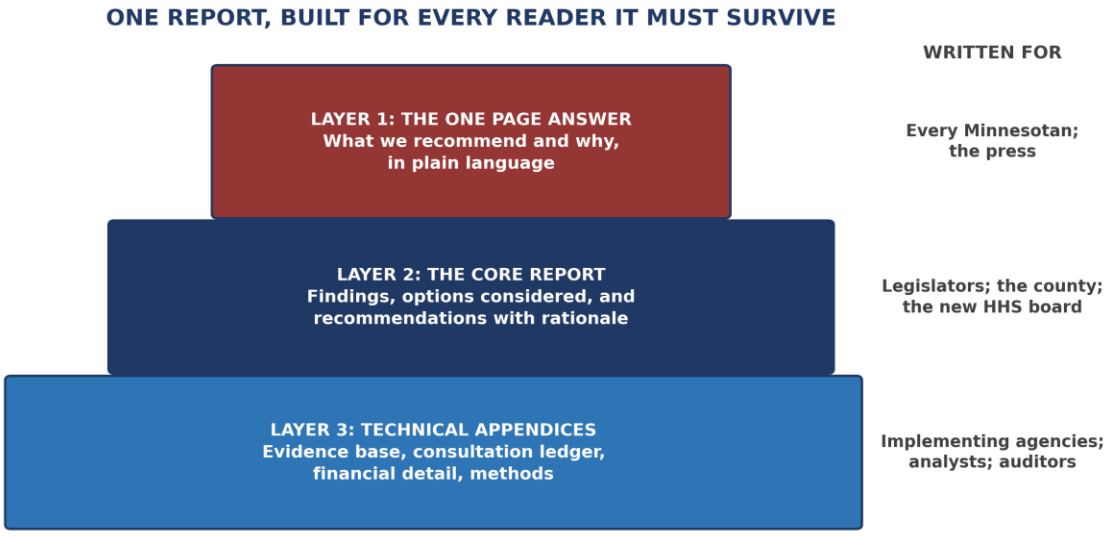

Figure 2. The layered reading architecture. One document, three depths, no orphaned claims.

Element 3: The Five-Part Recommendation Standard. The difference between a recommendation that changes Minnesota law and one that decorates a shelf is specificity. Every recommendation in the report must satisfy five tests before it reaches the Task Force for adoption:

Test	The Question It Answers
Actor	Who, by name of institution, takes this action: the Legislature, Hennepin County, the HHS board, a state agency?
Action	What exactly must they do, in language precise enough to be drafted into a bill or a board resolution?
Authority	Under what existing or needed statutory authority, with citations, does the actor act?
Timeline and cost	By when, and with what fiscal implication, so the recommendation can be scored and scheduled?
Accountability	What observable result tells Minnesotans whether it worked, and who reports on it?

Recommendations agencies can implement rather than admire.

This standard is the single strongest predictor we know of whether a task force report produces action. It is also demanding as it forces ambiguity out of the room while the Task Force is still convened and able to resolve it, rather than leaving it for legislative staff to discover in February. The decision briefs prepared for each meeting follow the same five tests, so by the time language reaches the draft, the hard questions have already been asked.

Element 4: Born accessible, not remediated. State law requires the Task Force's report to be accessible. In our experience, the difference between compliance and failure comes down to when accessibility happens. Remediation after drafting is slow, error-prone, and always the first casualty of a deadline. We therefore build accessibility into the production system from version 0.1: accessible templates and styles, correct heading and reading order structure, alt text authored with the exhibit rather than after it, data tables built to specification, color contrast verified in our standard palette, and plain language review as a scheduled gate on every increment. Before delivery, we test the report with assistive technology and deliver an accessibility conformance memo documenting the standards applied and the testing performed.[1]

Element 5: Every comment gets an answer. Nine members, a chair, and a Subcabinet will all have views on the draft. Unmanaged, reports die by a thousand edits. Every comment on every increment is entered in an adjudication log and receives a written disposition: adopted, adopted with modification, or declined with a rationale. The log is available to the chair and the Subcabinet at all times. This is the same discipline our Consultation Ledger applies to external input, applied to the room itself, and it is how a nine-member body converges on one voice without anyone's concern disappearing silently.

Where this discipline comes from. The Living Draft and adjudication disciplines come from statutory and governor commissioned reports delivered on immovable deadlines, including the report work now underway in the Mississippi Maternal and Child Health workforce engagement, and from federal policy deliverables produced at HRSA and HHS, where accessibility conformance is not

[1] Minn. Stat. sec. 16E.03 and the State of Minnesota Accessibility Standard administered by Minnesota IT Services, which incorporates WCAG and Section 508 requirements for state documents.

optional, and every stakeholder comment requires a documented disposition.[2] The writers are health policy analysts, not pass-through editors: the same people who build the Area 2 evidence write the sections that rest on it, which is what keeps the report internally consistent under deadline pressure.

Area 1 deliverables. The table below summarizes the documents this area produces and when they arrive.

Deliverable	Contents	Timing
Report skeleton, v0.1	All identified sections with open questions; shared foundation with the meeting design	Before Meeting 1
Draft increments (v0.2 through v0.6)	Newly closed decisions rendered as drafted, accessible text after each meeting cycle	Each cycle, per cadence
Comment adjudication log	Every member and Subcabinet comment with written disposition	Updated each cycle
Preliminary report, v1.0	Three layer, fully accessible legislative report with one page plain language summary	January 15, 2027
Accessibility conformance memo	Standards applied, testing performed, results	With each report
Final report	Updated findings and recommendations reflecting Phase 2 deliberation	January 15, 2028, with refinement support through June 2028 (Phase 2)

Area 2: Evidence the Task Force Can Stand On

Area 2 covers four things, settled with the Health Subcabinet: a report on publicly owned hospitals across the country and their governance models, analysis of potential ownership changes, assistance developing specific recommendations on ownership, governance and oversight, and sustainable long-term funding. Each arrives with the analytic machinery the Task Force needs to act on it. The temptation in work like this is the anecdote tour: a parade of interesting hospital stories that inform no decision. Area 2 is built to resist that temptation with three disciplines: a standardized comparative framework, a stress test of every option, and a hard rule that no analysis enters the room unless it feeds a named decision gate.

Element 1: The Governance Genome. Every publicly owned hospital system in the national scan is decoded using the same template, which we call the Governance Genome: ownership form, board composition and appointment authority, statutory relationship to its government sponsor, funding stack, statutory safety-net obligations, workforce and personnel status, capital access, and academic mission. Decoding every system the same way turns a pile of case studies into a comparison the Task Force can actually use, because it forces the same questions onto every model, including the models Minnesota already knows. The scan will include 12 to 15 systems selected for decision relevance rather than fame: authority conversions such as Denver Health, corporate public benefit structures such as NYC Health + Hospitals, county-governed systems such as Cook County Health and Harris Health, hospital authority and lease models such as Grady, and, deliberately, Minnesota's

[2] Laurel Health Advisors, engagement with the State of Mississippi supporting the Maternal and Child Health workforce initiative, commissioned by the Governor, 2025 to present.

own experience, including the conversion of Ramsey County's public hospital into what is now Regions Hospital and the 2005 statutory creation of Hennepin Healthcare System itself.[3]

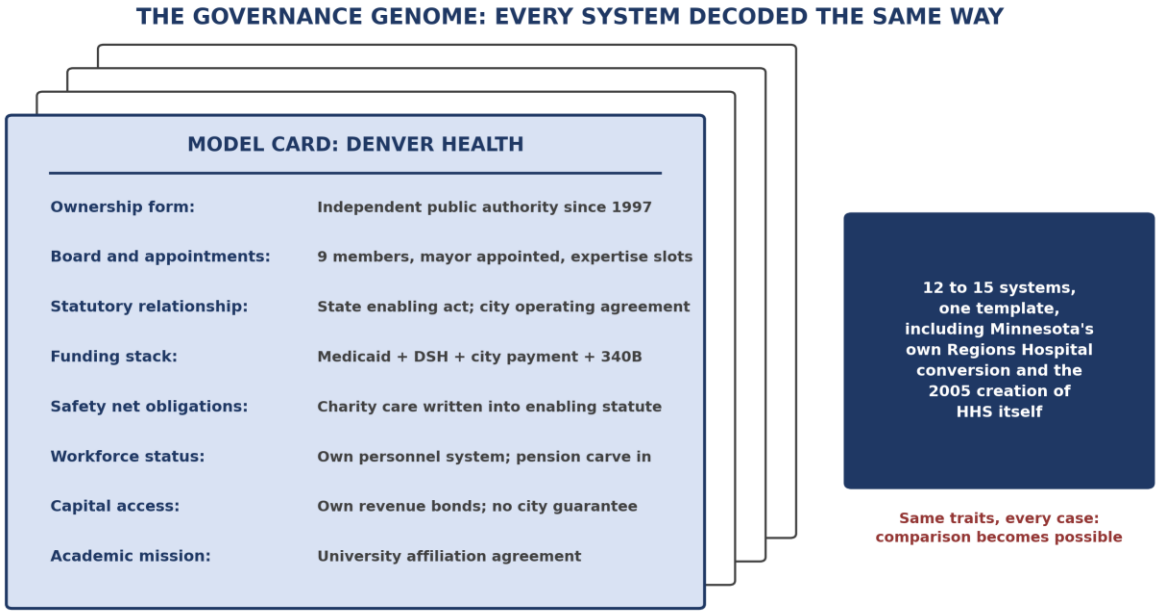

Figure 3. The Governance Genome model card. Every system in the scan is decoded with the same traits, and every card is verified against enabling statutes and public financial reports.

Element 2: Options built for Hennepin, stress-tested against bad futures. The scan is the input, not the product. From it, we will construct three to four concrete ownership and governance options for Hennepin Healthcare, each specified at the level the Five Part Recommendation Standard demands: what changes in statute, who appoints whom, what happens to the workforce and pensions, how each Medicaid and supplemental payment stream is affected, and what the transition path costs. Then we do something task force analyses rarely do: we stress test every option against five adverse futures, including deep federal Medicaid reductions, a major capital requirement, a sustained workforce shortage, a recession-driven surge in uncompensated care, and the exit of a key partner. The question we put to the Task Force is not which model is best on average, but which model fails least badly when Minnesota needs it most. That framing is deliberate for safety net institutions, and it changes conclusions: models that look elegant in steady state often concentrate risk exactly where a safety net system cannot afford it.

[3] Ramsey Health Care, Inc., the public corporation that operated St. Paul-Ramsey Medical Center, was established by Minnesota Statutes 1986, section 246A.02. Its conversion to private nonprofit ownership was authorized by Minn. Stat. secs. 383A.90 and 383A.91 (Laws 1994, ch. 549), effective on approval by the Ramsey County Board. The hospital affiliated with HealthPartners and was renamed Regions Hospital in 1997. Hennepin Healthcare System, Inc. was created as a public subsidiary corporation of Hennepin County in 2005 under Minn. Stat. secs. 383B.901 to 383B.928.

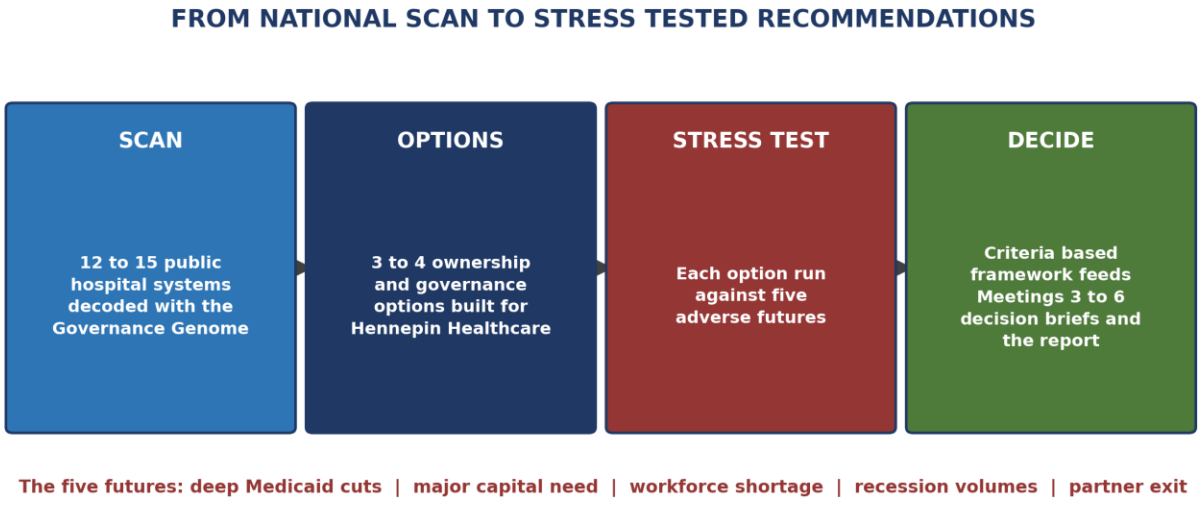

Figure 4. From scan to stress-tested recommendations. Every stage feeds a named decision gate in the meeting arc.

Minnesota has seen this before, and the precedent is part of the evidence base.

Twin Cities history contains its own natural experiment: Ramsey County's public hospital was converted out of county ownership and ultimately became Regions Hospital within HealthPartners, while Hennepin County created a public subsidiary corporation in 2005 that is now the subject of this Task Force. Those two diverging paths, their statutory mechanics, and their consequences for safety net obligations and public accountability will be documented in the scan as first-class cases.

Element 3: The funding question answered as a system, not a slogan. Sustainable long-term funding is where task force reports most often go soft, recommending, in effect, that someone should pay more. The funding analysis treats Hennepin Healthcare's revenue as a stack of interacting layers: Medicaid base rates, directed and supplemental payments, disproportionate share funding, the new uncompensated care reserve created by Chapter 127, county contributions, 340B, and commercial payer dynamics. For each ownership option, we will map which layers are preserved, enhanced, or placed at risk, because eligibility for several of the largest streams depends directly on ownership form and governmental status. The output is a funding framework in which every ownership choice is visibly also a financing choice, giving the Task Force an honest picture of the money before it votes on the structure.

Element 4: Analysis of the meeting clock. Area 2 runs on the same published cadence as everything else. The scan lands before Meeting 2, the options analysis before Meeting 3, governance and oversight design detail before Meeting 4, and the funding framework before Meeting 5, each delivered twice: as a full technical product for the record and the appendices, and as a four-page decision brief built for a volunteer member to absorb in one sitting. Between meetings, the subject matter team staffs the consultation program in the three statutory expertise fields closest to this work, so that what safety-net CFOs, labor, and public health leaders say is integrated into the analysis rather than filed alongside it.

Who does this work. Dr. Harris brings 25 years in safety net hospitals and rural health policy, including national program leadership at HRSA. Dr. Rosenbach is a national authority on Medicaid financing and coverage, the load-bearing wall of any Hennepin Healthcare funding analysis. Dr. Patton brings three decades of health policy and financing experience both within and alongside HHS, including behavioral health systems that depend on safety-net hospitals. Mr. Goldwater has spent two decades in the operational realities of safety-net hospitals, from revenue cycle to quality reporting to data infrastructure, which keeps our governance analysis tethered to how these

institutions actually operate. And Ms. Powell's work implementing value-based care in underserved communities grounds the recommendations in what change requires on the ground. The comparative method used here is the same one applied to multi-state policy scans and program evaluations for federal and state clients over the past two decades.[4]

Area 2 deliverables. The table below summarizes what this area produces and when it arrives.

Deliverable	Contents	Timing
Scan design memo	Genome template, case selection rationale, source standards; agreed with the Subcabinet before work begins	Delivered August 2026
National scan of publicly owned hospitals	12 to 15 model cards with cross cutting findings, including the Minnesota cases	Before Meeting 2
Ownership options analysis	3 to 4 fully specified options for Hennepin Healthcare with transition mechanics	Before Meeting 3
Governance and oversight design brief	Board structure, appointment, accountability, and public transparency architecture per option	Before Meeting 4
Funding framework and stress test results	Layer by layer funding analysis per option; five scenario stress test	Before Meeting 5
Recommendation support	Decision briefs and drafting support through adoption; Phase 2 deep dives as directed	Through Meeting 6; continuing in Phase 2

[4] Engagement descriptions and references are available from Laurel Health Advisors on request.