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Meeting Record

Advisory Task Force Meeting 2 | Tuesday, September 22, 2026

Advisory Task Force on Governance and Financing of Hennepin Healthcare System, Inc.

Meeting	Meeting 2 of the Advisory Task Force, (2 out of 6)
Date and format	Tuesday, September 22, 2026, 9:00 a.m. to 12:30 p.m. In person, Room 1200, Minnesota Senate Building, Saint Paul Online viewing through Teams. Open to the public.
Statutory basis	Minnesota Session Law 2026, Chapter 127, Article 3, Section 18 (S.F. 4612).
Prepared for	Minnesota Health Subcabinet, through Management Analysis and Development Minnesota Management and Budget
Prepared by	Laurel Health Advisors, LLC.

1. Purpose of This Record

This document is the Laurel Health Advisors record of Meeting 2 of the Advisory Task Force on Governance and Financing of Hennepin Healthcare System, Inc. It is produced under the Statement of Work and delivered to the Minnesota Health Subcabinet within three business days of the meeting, as the Project Management Plan requires.

Meeting 2 was the first working session of the Task Force. It carried four substantive presentations, a chair led discussion of the charge, and the first procedural choices about how recommendations will be reached and how public input will be recorded. This record carries forward, in numbered form, every decision, information request and action the meeting generated, and it flags each place where a figure stated in the room needs to be reconciled before it travels into the legislative report.

What this record is not

Nothing in this document is a recommendation, a finding, or a legal opinion. Laurel Health Advisors provides research, analysis, and facilitation. Recommendations belong to the Task Force. Legal conclusions, including the application of the Open Meeting Law and the Data Practices Act, belong to State counsel.

Attribution is deliberately limited. Statements are recorded by substance rather than by speaker, except where a presentation, a role assignment, or a commitment requires a name.

2. Meeting at a Glance

Meeting	Meeting 2, first working session
Date and time	Tuesday, September 22, 2026, 9:00 a.m. to 12:30 p.m.
Location	Room 1200, Minnesota Senate Building 95 University Avenue West, Saint Paul Online viewing through Teams
Chair	Jan Malcolm
Attendance	All Task Force members were present.
Presentations	Report structure and national scan, and consultation and public engagement: Dr. Yael Harris, Laurel Health Advisors. Role of Hennepin Healthcare in Minnesota's health system: Stefan Gildemeister, Minnesota Department of Health Hennepin Health System status: Hennepin Healthcare staff.
Materials	Draft report skeleton v0.1 Presentation on the report and the national scan Presentation on consultation and public engagement Minnesota Department of Health presentation on uncompensated care; Hennepin Healthcare financial update.
Next meeting	Wednesday, October 14, 2026, 9:00 a.m. to 12:30 p.m. In person preferred with a virtual option.

3. What Meeting 2 Established

While the first meeting focused on introductions and a common understanding of the Task Force, Meeting 2 presented an in-depth review of how the work will be operationalized to align with the legislative directive. It also provided background on Hennepin Healthcare’s current financial status complemented by a presentation from the Department of Health on uncompensated care in the state. By the close of the

meeting, the Task Force had a working report architecture, a confirmed meeting schedule, and a first view of the supporting activities, information and approvals needed to deliver its report in January 2027. Specific agenda items included: an agreed upon meeting schedule and confirmation of a date for the October meeting, discussion of activities and an associated timeline, which will be revised, review of the draft outline (skeleton) for the report, a preliminary comparison of 25 health systems included in a national scan, two independent accounts of the financial pressure on Hennepin Healthcare, and a decision on how spoken public comment will be recorded. The meeting did not include a written statement of the Task Force's charge which will be the first product generated for the Task Force.

Theme	Takeaway
Report and schedule	The report architecture was adopted as working guidance. Chapters will be drafted in sequence. The drafting and review schedule presented at the meeting will be revised and brought back to the Task Force.
How recommendations are reached	The Task Force will document degrees of consensus rather than require unanimity, so a recommendation may be carried as unanimous or as divided. The Task Force will make recommendations to the Legislature and Administration. The Legislature makes the final policy decisions.
National scan	The scan informs rather than determines the recommendations. It is a purposive selection, not a random sample, and it describes system design rather than evaluating performance.
Financial position	State funding has improved liquidity and stabilized the workforce but has not closed the structural gap. Presenters from both the Department of Health and Hennepin Healthcare pointed to payer mix, patient complexity and federal policy change as the drivers, and to H.R. 1 as a further pressure on public program reimbursement including directed payments.
What success means	Members distinguished between a system that survives and one that thrives, and discussed measuring success across clinical quality, population health, workforce stability and financial health, with public accountability attached to any future ownership option. No success measures were adopted; any measures will be discussed at a future meeting on the basis of a proposed draft.
Public input	Spoken public comment made at Task Force meetings will be entered in the Consultation Ledger with a written disposition. Statutory consultations with subject matter experts will be distinguished from general public comment.

4. What the Meeting Settled

The Task Force formally adopted its meeting calendar. The table below lists the specific source records and their status as adopted, agreed or supported. The last column documents decisions; but general support is not to be read as a formal decision.

ID	Subject	Where it landed	Basis in the source
D-M2-01	Report architecture	Adopted as working guidance. Reimbursement adequacy is addressed within the funding discussion rather than as a separate part.	Recorded as adopted.
D-M2-02	How recommendations are reached	Degrees of consensus are documented rather than unanimity required. A recommendation may be unanimous or divided. Recusals on specific topics were discussed and not settled.	Recommended by Jan Malcolm; carried in the source's summary.
D-M2-03	December milestones	Members discussed the December review and adoption steps. The drafting and review schedule will be revised and brought back to the Task Force, so no dates are recorded here.	Recorded as discussed; schedule to be revised.

ID	Subject	Where it landed	Basis in the source
D-M2-04	Scope of the financing analysis	The Task Force will consider the broader health care financing challenges for health systems and safety net institutions across Minnesota, and may discuss general principles for broader financing reform, but will not make specific recommendations on specific mechanisms or funding sources for such broader reforms.	Recorded as supported by participants.
D-M2-05	Scan selection criteria	The broad selection criteria, including the safety net thresholds for comparable systems, were generally supported.	Recorded as generally supported.
D-M2-06	Spoken public comment	Option C: comments made during Task Force meetings are entered in the Consultation Ledger with a written disposition. Comments sent by email remain written comments.	Recorded as agreed. The presentation asked for a decision before Meeting 3.
D-M2-07	Meeting calendar	The Task Force adopted its meeting schedule and confirmed an October date and time for the next meeting.	Adopted by the Task Force under Agenda Item I.

5. Agenda Item I. Opening, Charge and Legislative Purpose

The Task Force adopted its meeting schedule (D-M2-07). The opening then framed the need to clarify the Task Force's charge, its scope boundaries, and the contribution it intends to make to the 2027 legislative and administrative deliberations. The discussion established the initial framework for deciding what the Task Force should address.

6. Agenda Item II. Report Architecture and Process

Dr. Yael Harris, Laurel Health Advisors, the state’s contracted entity to support the Task Force, described the company’s role and the planned process for developing the report: the statutory duties, the separation between factual findings and recommendations, and the crosswalk that demonstrates compliance with the session law. The first page of the report will be organized as a public summary. The full report will include a main body and appendices. Content will include information describing Hennepin Healthcare's current status, comparison with other health care systems that have faced similar challenges. The comparison will include an investigation of different approaches for ownership, governance, financing, and staffing. The report will conclude with recommendations, draft legislative language, and strategies for implementation. Minimum requirements for any recommendation, and a hierarchy for sourcing and validating information, were set out.

Two reports, one document. The 2027 and 2028 reports were described as successive stages of a single document, with the later report resolving outstanding questions and documenting what changed. The discussion also recognized that the 2027 Legislature might request additional work or might conclude the Task Force after the session.

Consensus. The Task Force considered how to reach internal consensus while recognizing that the Legislature makes the final decisions. Chair Malcolm recommended documenting degrees of consensus rather than requiring unanimity, and participants discussed the possibility of recusals on specific topics. See D-M2-02 and open item 2.

7. Agenda Item II. The National Scan

Purpose. The national scan will provide comparative evidence on publicly owned and publicly controlled hospital systems. The information will inform the Task Force's recommendations but is not intended to

determine them. It covers 25 systems across the United States. The selection criteria was described including a focus on post-1990 events, when Regions Hospital was approved by the state, public ownership or governance, volume of safety net service, and medical school teaching. Therefore, the selected health systems do not represent a random sample.

What it covers. The scan codes 52 questions across ownership, governance, accountability, financing, workforce, medical education and ownership change. It identifies seven ways a public hospital system can be organized and examines differences in board appointment, budget control, executive selection, borrowing authority, public funding, operations and transparency.

What it will and will not establish. The scan establishes a shared vocabulary, gives concrete examples of operating models, documents policy consequences and implementation challenges, and identifies relevant statutory language. Its stated limitations are that it carries no comparable case of private ownership, and that it examines system design rather than evaluating performance.

Task Force Engagement. Task Force members requested information on why a private system in Detroit, Charity Hospital in New Orleans, federally owned facilities, and Maryland Shock Trauma were excluded or treated differently in the comparison. Dr. Harris clarified that Detroit was excluded because it is privately owned and, therefore, did not meet the selection criteria. Charity Hospital was considered but there is limited information on the complete set of factors and preceding deliberations that resulted in its ultimate closure. Federally owned facilities operate very differently than those included in the national scan and, therefore, would compromise the ability to compare across systems. The selected criteria for hospitals caring for underserved patients (30% or more on Medicaid or at least 10% on charity care) was discussed. Task Force members generally supported the selection criteria (D-M2-05).

Synthesis. Members asked how the detail on each system would be brought together. Dr. Harris said a summary report comparing system characteristics, policy levers and outcomes would be prepared in October.

8. Agenda Item II. The Charge, the Safety Net, and What Success Means

The chair led discussion addressed the two questions the report is built backward from: what the Task Force understands its charge to include and exclude, and what legislative decisions the preliminary report has to enable. Dr. Harris framed the substantive questions for the charge statement as system function, problem diagnosis, financing dependencies, public roles, necessary conditions, performance assessment and accountability, and noted that the Task Force still has to settle its scope boundaries, which recommendations will require draft bill language, the baseline for assessment, the report outline and the meeting calendar.

Hennepin specific charge, statewide consequences

Members weighed the statutory, Hennepin specific charge against the interconnected needs of health systems and safety net institutions across Minnesota, and supported considering the broader financing implications while agreeing that detailed recommendations on the mechanics and funding sources for health care financing generally are beyond the Task Force's current scope (D-M2-04). Participants asked which functions would have to be replaced if Hennepin Healthcare stopped providing them, and how the appropriate level of state support should be defined. The discussion named uncompensated care, medical education, regional capacity, capital needs and workforce effects, and drew a line between the hospital's operating needs and its broader system responsibilities.

Members also asked that the operational and external factors driving financial performance be understood before any funding relief is recommended, and emphasized maximizing safety net coverage, preventing gaps when systems change, and balancing affordability with access.

Preventing failure and defining a sustainable future

Dr. Harris asked the group to help formulate the charge statement's questions on how system failure is identified and prevented. Participants discussed economic distress metrics, the timing of intervention, desired outcomes, and the need to measure whether the system is thriving rather than merely surviving. Members supported a public investment sufficient to produce a sustainable outcome, and discussed operating margin and cash on hand. Those measures were proposed as indicators of financial distress for access to the reserve account and are not necessarily measures of sustainable success.

Success was then widened beyond financial measures: the ability to meet changing population needs, support medical education, connect with rural health systems, serve patients effectively, and strengthen the regional health care system as a whole. Participants argued that community health and access to care should guide decisions, framing health care as a right, and cautioned that a focus on organizational finances alone could overlook the obligation to care for people regardless of ability to pay.

Metrics, Medicaid pressure and the workforce

The group discussed a balanced framework covering clinical quality, population health, workforce stability, engagement, turnover and financial health. One Task Force member described the effect of federal coverage changes and low Medicaid reimbursement and also pointed to strong physician retention and to Hennepin Healthcare's reputation as a place to build a career. Participants expressed confidence that the 2026 legislative investment had resolved the immediate question of whether Hennepin Healthcare would continue operating, moving attention to its future path, and emphasized that workforce stability should remain a central goal.

Public control, governance and accountability

The Task Force began examining which public powers should remain under any future ownership structure, including authority over appointments and removals. Participants emphasized transparency and accountability for every source of investment, and the group discussed governance, financing, and the way each depends on the other.

Consultation

Consultation is part of the charge. Dr. Harris described required meetings with experts with identified expertise across ten domains, as designated in the legislation. The Laurel Health team will produce an interview guide that is both standardized and tailored, noting that consultation meetings are not public and will not be reproduced verbatim. Consultants will be identified by the state based on recommendations from Task Force members, legislators and the Administration. Discussions will be scheduled beginning in October.

9. Agenda Item III. Role of Hennepin Healthcare in Minnesota's Health System

Stefan Gildemeister, State Health Economist and director of the Health Economics Program at the Minnesota Department of Health, described the program's objective as data driven analysis of health care markets, coverage, cost and quality, and presented Minnesota's hospital market, the position of Hennepin County Medical Center against statewide averages, and trends in uncompensated care. The figures below are recorded as presented.

Topic	As presented
The market	125 acute care hospitals, from rural critical access facilities to urban teaching and trauma hospitals, accounting for approximately one third of statewide health care spending.
Data	Organizational, utilization, financial, clinical, federal and claims data, with a typical reporting lag of about eight months. Admissions have recently increased; outpatient activity has been generally stable outside the COVID period.

Topic	As presented
Financial performance	Statewide acute care hospital net income above $2 billion, with modest median operating margins, somewhat higher total margins after investment income, and wide variation between stronger and weaker hospitals.
Payer mix	Declining private insurance admissions and a rising Medicare share statewide. Hennepin County Medical Center relies far more heavily on Medicaid and MinnesotaCare than other hospitals.
Statewide role	Hennepin County Medical Center carries a substantial share of statewide admissions, outpatient visits and emergency department visits. Other providers, including other safety net hospitals, would have to absorb substantial volume if it were not available.
Length of stay	Substantially longer than at other Minnesota hospitals, linked to patient complexity, discharge barriers, payment limitations and wider legal and system challenges, alongside unfavorable operating margins.
Uncompensated care	Defined as charity care plus bad debt, measured at cost by applying cost to charge ratios to charges. Statewide, approximately $490 million in 2025, with charity care and bad debt now nearly equal, and still relatively favorable against national levels as a share of operating expenses. Hennepin County Medical Center remained the largest single contributor, at approximately $67 million in 2025.
Policy effects	The decline from the prior year was attributed to temporary MinnesotaCare eligibility for immigrant patients, with an increase expected now that the policy has been reversed. Uncompensated care affects insured patients too, particularly those unable to meet deductibles and other cost sharing.

Reporting obligations and data requests. The presentation turned to the Department of Health's reporting obligations under the 2026 hospital stabilization legislation, and the discussion focused on which quarterly data would help Minnesota Management and Budget evaluate the legislative reserve account. The source records this body as the Commission of Management and Budget. Members asked whether Mayo Clinic distorts statewide comparisons, and requested case mix index data and adjustments for unusually complex patients and for uncompensated care. Participants noted that uncompensated care raises hospital rates and reaches every Minnesotan through insurance premiums, and the Health Economics Program described its forecasting of federal policy changes, uninsured rates and their likely effect on hospital uncompensated care. The resulting requests are DR-M2-01 to DR-M2-05 and DR-M2-10.

> **Verification note V-M2-01: two uncompensated care figures for 2025. Open.**
>
> Two figures for Hennepin's 2025 uncompensated care were presented at this meeting. The Department of Health presented approximately $67 million for Hennepin County Medical Center, measured at cost as charity care plus bad debt. Hennepin Healthcare presented $84 million for 2025, down from $104 million in 2024. The two 2025 figures will be reconciled before either enters the report.

10. Agenda Item V. Current Financial Status of Hennepin Healthcare

Hennepin Healthcare staff presented the system's financial position and its developments since the 2026 session, characterizing the challenges as structural: safety net obligations, inadequate funding, exposure to public programs, and infrastructure needs. The presenters said that operational efficiencies alone cannot close the underlying funding gap. The figures below are recorded as presented.

Topic	As presented
Cash and operating margin	Reviewed on rolling twelve month measures. Temporary cost controls, partial payments from UCare, and state funding have improved cash, but expected equipment purchases, wage increases, debt payments and seasonal effects are projected to draw the balance down.

Topic	As presented
Payor mix	Heavy reliance on public programs, growth in uncompensated care, and a decline in directed payments since 2022, which together make the system financially vulnerable.
Directed payments	Directed payments supplement Medicaid managed care reimbursement and approximate Hennepin Healthcare's average commercial rate. Hennepin Healthcare pays an intergovernmental transfer of about $100 million to the Department of Human Services to receive them. The State draws the federal match and pays the health plans through capitation payments, and the plans pay Hennepin Healthcare claim by claim. Other supplemental payments, together more than $100 million a year, were reviewed along with their limits in addressing the structural gap.
H.R. 1	A projected 10 percent annual reduction in directed payments, because H.R. 1 caps reimbursement under directed payment arrangements at the Medicare rate rather than the average commercial rate used previously, along with missed inflation adjustments, and the resulting funding gap. H.R. 1 is already affecting the hospital: a decline of about $20 million in 2026 follows the determination by the Centers for Medicare and Medicaid Services to cap directed payments at their value before July 2025. Medicaid eligibility changes and administrative burden could raise uncompensated care while directed payment revenue falls; the update estimates about $60 million in payments and about 6,000 people a year at risk of losing coverage.
Charity care	Charity care thresholds (household income below 300 percent of the federal poverty level, about $99,000 for a family of four in 2026), county uncompensated care funding, and differences among financial reporting definitions were explained. Uncompensated care is rising statewide, Hennepin Healthcare has historically borne a disproportionate share, and residents of counties other than Hennepin accounted for approximately $24 million of Hennepin's 2025 uncompensated care.
Statewide clinical role	A statewide referral center and safety net provider, with a high volume and wide geographic reach of transfers, and trauma, burn, behavioral health and specialized services accepted on clinical need, with the financial consequences that follow.
Bridge funding	State funding appropriated in the 2026 legislative session is a temporary bridge from financial instability to a sustainable long term model. Three connected priorities: workforce stability, operational excellence and financial responsibility. Planned uses of $205 million in one time support include workforce, infrastructure, campus preservation and cash adequacy.
Stewardship	Preserving specialized clinical expertise and reversing the effects of compensation uncertainty; prioritized equipment and infrastructure investment; improvements in length of stay, surgical efficiency and capacity use. Funding has supported staff stabilization, urgent equipment and IT needs and emergency cash reserves, but has not resolved the long term funding gap.

Questions and requests. Members asked for clarification of the intergovernmental transfer and asked why other hospitals do not pay the nonfederal share for a directed payment. The response was that no other hospital currently has a directed payment arrangement; one was sought in the 2025 legislative session and has not yet been approved by the Centers for Medicare and Medicaid Services because of changes made in H.R. 1. One Task Force member requested modeling of dependence on federal funding, of H.R. 1 effects on operating margins, and of the potential effect of medical education funding, and Hennepin Healthcare agreed to address these in future forecasting. Members also asked about the geographic distribution of uncompensated services and about the operational barriers that lengthen stays and delay transfers to other care settings. The resulting requests are DR-M2-06 to DR-M2-09.

> **Verification note V-M2-02: presenter figures. Open.**
>
> The statewide market figures in Section 9 and the Hennepin Healthcare figures in this section are recorded as presented. The $205 million in one-time support comprises $100 million toward the nonfederal share of the directed payment arrangement and approximately $105 million in direct payments to Hennepin Healthcare, as appropriated in Minnesota Session Laws 2026, Chapter 127, which is publicly available. The Hennepin Healthcare

update presents the direct support as received in two payments, $50 million in June and $55 million in July 2026. Chapter 127 is the primary source for every state appropriation cited in the report.

11. Agenda Item VI. Consultation and Public Engagement

Dr. Harris introduced the consultation process that will govern the Task Force's continuing work, and kept two sources of input distinct: consultation required by the statute, and public participation at open meetings. Consultations with experts are confidential in the sense that they are not reproduced verbatim; public participation is recorded.

Element	As presented
Schedule	Thirteen initial consultation meetings, four follow up meetings, and six group meetings held before Task Force meetings. All virtual, so that participation does not depend on geography.
Areas of expertise	The ten areas at Minnesota Laws 2026, Chapter 127, Article 3, Section 18, Subdivision 4, paragraph (7). At a minimum, the Task Force must consult with these groups. Task Force members and legislators were asked for their thoughts on whom to consult within each area.
Public channels	Attendance at open meetings, online viewing, a continuous written comment period, and accommodation requests. Because chapters are drafted in sequence, delayed timing of a submission affects ability to meet timeline.
The Consultation Ledger	Every consultation is numbered, documented, given a written disposition and used to evaluate recommendations, the group deliberates before each meeting, and the complete ledger is an appendix to both reports.
Ready now	The ledger and the public posting route. The standardized question set is still being developed.
Still to finalize	Scheduling of consultations with the participants identified by the Health Subcabinet, and, in consultation with Hennepin County, a process for soliciting input from state and county commissioners that complies with open meeting requirements.

Spoken public comment. Dr. Harris presented three approaches: minutes only; logging spoken comments by topic with the written comments; and full entry in the Consultation Ledger with a written disposition. The group clarified that the choice applies to comments made during Task Force meetings, while email submissions remain written comments, and agreed to the full ledger approach, option C (D-M2-06). The discussion then turned to future public comment opportunities, consultation categories, stakeholder recruitment, group meetings and broader outreach.

Ten categories, not ten individuals. Consultation covers ten categories of expertise, each of which may include several people.

12. Other Business and Closing

County governance update. Hennepin County reported progress toward reconstituting the Hennepin Healthcare corporate board by January 15, 2027. KP Companies is assisting with recruitment, interviews are expected to begin in October 2026, and the related bylaws and the operating and funding agreements are being updated. No votes are expected before November 2026.

Sanford, North Memorial and Hennepin Healthcare. Participants reviewed the agreement requiring Sanford to continue operating North Memorial for at least ten years, to make an initial $100 million investment, and to maintain the Level I trauma center. Sanford and North Memorial also indicated openness to exploring cooperation with Hennepin Healthcare while remaining independent competitors. The agreement terms are recorded as presented. At Meeting 1, John Cumming had raised uncertainty about North Memorial's future services when members asked whether other metro trauma centers could absorb Hennepin's volume.

System collaboration and public engagement. The discussion broadened to statewide concerns about health care financing, rural access, public goods, and the balance between competition and collaboration. Participants emphasized the importance of showing continued commitment to the Task Force's work and of communicating its seriousness to the wider hospital community.

Closing. The meeting closed with appreciation for staff and public participants and with the expectation that the next meetings will turn on data requests, decision points and structured options. The next meeting is set for Wednesday, October 14, 2026, from 9:00 a.m. to 12:30 p.m., in person preferred with a virtual option.

13. Information Requests

Each request is numbered so it can be traced from this meeting to the report section where it lands. Two refine requests carried from Meeting 1 and say so.

ID	Information requested	Source named	Status or link
DR-M2-01	Trauma care analysis	Minnesota Department of Health; the analysis is in progress	Refines DR-M1-02. Open.
DR-M2-02	Study of length of stay, discharge, payment and legal system challenges at Hennepin Healthcare	Hennepin Healthcare	Open.
DR-M2-03	Case mix index data, derived from encounter data, to adjust statewide hospital comparisons (including whether Mayo Clinic distorts them) for unusually complex patients and for uncompensated care	Stefan Gildemeister, Minnesota Department of Health	Open.
DR-M2-04	How prolonged ventilator stays, psychiatric placement barriers and other complex patient factors at Hennepin Healthcare are represented in the analysis	Hennepin Healthcare	Open.
DR-M2-05	Data on care forgone because of cost	Stefan Gildemeister, Minnesota Department of Health	Open.
DR-M2-06	Multi year forecast covering operational, legislative, equipment and campus infrastructure challenges	Hennepin Healthcare	Due at Meeting 3.
DR-M2-07	Baseline operating margins, H.R. 1 effects, and the resulting post H.R. 1 financial outlook	Hennepin Healthcare	Open.
DR-M2-08	Effect of medical education funding on resident education, in future forecasting	Hennepin Healthcare	Open.
DR-M2-09	Map or geographic analysis of where recipients of uncompensated services from outside Hennepin County come from	Not identified in the source	Refines DR-M1-01. Open.
DR-M2-10	Forecasts of how federal policy changes, including H.R. 1, are expected to affect uninsured rates and uncompensated care, statewide and at individual hospitals including Hennepin Healthcare	Health Economics Program, Minnesota Department of Health	Continuing.
DR-M2-11	Summary report comparing the 25 scan systems, their policy levers and their outcomes	Yael Harris and the Laurel Health Advisors team	October 2026.

ID	Information requested	Source named	Status or link
DR-M2-12	How the 2026 legislative financial relief has affected workforce stability at Hennepin Healthcare	Hennepin Healthcare	Open.

14. Action Register

The actions below remain open after the meeting. Information requests are tracked in Section 13 and are not repeated here. Owners are as confirmed with the Health Subcabinet.

ID	Action	Owner	Due	Basis
A-M2-01	Draft the written charge statement, covering the Task Force's scope boundaries, legislative objectives, which recommendations need draft bill language, and the assessment baseline, and invite Task Force members to edit it	Laurel Health Advisors and the Health Subcabinet; Task Force members invited to edit	Before Meeting 3 on Wed, Oct 14, 2026, for confirmation at that meeting	Stated; confirmed by the Health Subcabinet
A-M2-02	Revise the drafting and review schedule presented at Meeting 2 and bring it back to the Task Force	Laurel Health Advisors and the Health Subcabinet	No date set	Added on Health Subcabinet review
A-M2-03	Report the remaining national scan questions and findings	Laurel Health Advisors	Meeting 3, Wed, Oct 14, 2026	Stated
A-M2-04	Develop the consultation interview guide and send the draft questions to the Health Subcabinet, which will share them with the Task Force for feedback	Laurel Health Advisors	No date stated	Stated; process confirmed by the Health Subcabinet
A-M2-05	Continue developing recommendations for communicating Hennepin's long term institutional stability to current and future staff	Task Force	No date stated	Stated
A-M2-06	Share the quarterly reporting metrics with the Task Force once they have been identified, and update the Task Force when the data are received	Minnesota Department of Health and Hennepin Healthcare	No date stated	Stated; owners confirmed by the Health Subcabinet

15. Open Items

No.	Item	Where it stands
1	Drafting and review schedule	The schedule presented at Meeting 2 will be revised and brought back to the Task Force (A-M2-02).
2	Recusals	The possibility of recusals on specific topics was discussed. No process was settled.

No.	Item	Where it stands
3	The written charge statement	Scope boundaries, which recommendations need draft bill language, and the assessment baseline were discussed and not settled. Laurel Health Advisors and the Health Subcabinet will draft charge language, and Task Force members will be invited to edit it (A-M2-01).

Appendix A. How This Record Was Produced

- Source. A meeting recap export titled for the in person meeting, carrying a summary, action items and key discussion points. It is not a transcript and does not record attendance; attendance was confirmed by the Health Subcabinet. The source does not separately record the member round robin, item VII.
- Checking. The source was read against the published agenda and the materials presented at the meeting. Where the source and the materials differ on a figure, the difference is recorded in a verification note.
- Attribution. Statements are recorded by substance rather than by speaker.
- Dates. Every relative date is converted to an absolute date.
- Numbering. Decisions (D), information requests (DR) and actions (A) carry the meeting code M2 and a sequence number so that each can be traced into the report.
- Review. This record incorporates the Health Subcabinet review of September 30, 2026.
- Accessibility. Produced to the State of Minnesota Accessibility Standard v4.0, which adopts WCAG 2.1 Level AA. Headings begin at Heading 1 and are applied in order, lists are real lists, every table is marked with a header row or a header column and header rows repeat across page breaks, the logo carries alternative text, spacing is set by paragraph formatting rather than blank lines, and no meaning is conveyed by color alone.