

Item II

Building the report; statutory language; comparison with public hospital systems in other states

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Discussion led by Jan Malcolm, Chair

Discussion Topics

1

9:15

Building the report

Review Task Force responsibilities and process for developing the report.

2

9:30

Performing the national scan

Cross-national comparison of health systems currently or previously owned or operated by county.

3

9:45

Discussion, led by the Chair

Facilitated dialogue to decide:

- (1) Role of Task Force
- (2) Content included January report

PART ONE

Building the report

Two required reports, thirteen months apart.

Starting with a framework

The compressed timeline requires developing the report structure upfront

3

DAYS

after start of 2027 legislative session, first report is due.

11

DAYS

after office transitions following the midterm elections.

18

MONTHS

Before January 2028 due date.

Report writing must begin now.

Report will be developed in phases.

Sections written as the Task Force reaches decisions based on research findings.

Report sections clearly defined with concurrent review by members.

Role of Task Force

Five duties identified in the 2026 session law

1 Assess Hennepin Healthcare's current governance model and sources of revenue

2 Compare with similar public hospital systems

3 Examine reimbursement structure

4 Identify workforce needs

5 Recommend future ownership, governance and funding
Supply draft language

The law requires consultation with individuals representing ten areas of expertise.
Consultation process will be discussed during Item IV

Sections aligned to report requirements specified in law

Enables comparison of report to requirements

What the law asks for	Where the report answers it
1. How Hennepin Healthcare is governed and paid for	The four chapters on Hennepin Healthcare today
2. How other comparable systems are governed and paid for	The three chapters on the national picture, plus the appendix of hospital profiles
3. Reimbursement	The chapter that reviews finances
4. Workforce needs	The chapters describing Hennepin Healthcare today and again inside each option
5. Recommendations and draft bill language	The whole latter half of the report; particularly, and the draft language chapter

Crosswalk is included in the Appendix, enables comparison of statutory duties and chapters where addressed.
Ensures statutory compliance.

The report layers

Each layer is tailored to a specific reader; critical information is captured across all layers.

Layer 1. One page, in plain language

1

Audience: Legislator, reporter, or member of the public.

Content: Summary of Task Force findings
Recommendations
Strategy for measuring and tracking

Objective:

A single page summary of the Task Force's decisions and rationale.

Layer 2. Main report

2

Audience: Readers seeking full context behind decisions.

Content: 24 chapters organized into 8 parts.
Facts separated from associated recommendation.

Objective:

Content presented and discussed at Task Force meetings.

Layer 3. The appendices

3

Audience: Readers seeking more detailed information.

Content: Consultation record
Hospital profiles
Financial detail
Sources
Responses to comments
Glossary

Objective:

Additional context and resources.

The main report

Each chapter has specific purpose and a clear source of evidence

PART ONE Purpose and approach

PART TWO Hennepin Healthcare today and the current challenge

PART THREE Comparison with other public hospital systems

PART FOUR Options for ownership, governance and funding

PART FIVE Considerations and implications

PART SIX Fact-based findings

PART SEVEN Recommendations, draft bill language, implementation plan

PART EIGHT Changes after January 2027 and why (Only in the 2028 report)

Part Three includes a discussion of limitations of the available information.

Requirements in every recommendation

Every recommendation includes the following five things

- | | | |
|---|--|---|
| 1 | Who is responsible | A named individual, role, or organization |
| 2 | What action to take, written as bill language | Clear guidance on how to implement |
| 3 | What is the legal authority | Who has the power? Is it established in the recommendation? |
| 4 | What time is needed and the associated cost | Completion date and if the evidence indicates it will cost or save money. |
| 5 | How to determine its effect | Defined metrics and a timeline to assess impact |

Recommendation must be also written as draft text for a bill.

How we handle evidence

Information sources and how they are verified

Fact derived from

- **Ideally:** original documents, public laws, audited financial statements, board minutes, filings
- **Acceptable:** official summaries, legislative research, peer reviewed content
- **Last resort:** non-evidence based content, news (source must be clearly labeled if used)

Legal status, dollar figures, dates must be from original document.

Regularly re-checked

- Dates
- Legal citations checked against the revisor's published text.
- All dollar figure checked against audited or filed document

Re-checked in every draft, even if no recorded changes.

Public record

In Minnesota, government information is public, including work-in-progress.

Clear explanation required for every draft, comment, or question including how addressed or, if not, why.

Writing timeline

Written by section with five business days for the Task Force to review each

●	Sep 28, 2026	Task Force decisions; chapters on other states
●	Oct 20, 2026	Ownership and governance options
●	Nov 10, 2026	Approaches to governance and oversight
●	Nov 24, 2026	Funding mechanism(s) and process for stress testing
●	Nov 30, 2026	All chapters complete. Task Force reviews first draft of complete report
●	Dec 9, 2026	After each recommendation is testing, Task Force votes on any resulting revisions
●	Dec 17, 2026	Task Force adopts the report
●	Jan 14, 2027	Report delivered to the Legislature

*The same approach will be used in 2027 to produce a final report.
Timeline: adopted in November 2027 and delivered in January 2028.*

Two reports, thirteen months apart

Reflecting a single document drafted at different stages of maturity

January 2027

THE FIRST REPORT

Preliminary report will provide the 2027 Legislature with actionable recommendations, including:

- Existing information
- Recommendations
- Future considerations

Report must include:

- Analysis of comprehensive set of options
- Rational for recommendations
- Draft text for bill
- Description of Hennepin Healthcare's current governance model

January 2028

THE FINAL REPORT

The 2028 report will finalize the work:

- Every question answered (or determined to be unanswerable with a stated reason)
- Clear recommendation structure including actions to implement
- Draft bill language, including text not included in first report.
- Chapter summarizing all changes between 2027 and 2028 reports

Both reports assume ongoing Task Force operations through June 2028.

The report will be designed to remain relevant regardless of subsequent changes to the scope or early termination of the taskforce to remain valid even if the 2027 session changes the scope of the work or Task Force adjourns early.

PART TWO

Performing the national scan

The Task Force must look at comparable public hospital systems in other states.

Purpose of the scan

Three questions will inform Part Three and frame the options

1

How do other public hospital systems actually work?

Who owns the buildings?
Who appoints the board?

Who controls the money?
What is the public is entitled to see?

2

What happened when systems changed hands?

Which systems changed ownership?
What legal step(s) were used?

What was the objective?
Was it successful?

3

How to interpret these findings? What is supported by the evidence and what is missing?

Some arrangements depend on conditions that do not exist in Minnesota.
The analysis must define these conditions.

The scan is not intended to provide recommendations. Its purpose is to provide a description of how other systems have addressed the questions facing the Task Force.

How hospital systems were selected

Selection based on three key circumstances

1

System was public at some point since 1990

Either a government owned the buildings or a government appointed the board.

2

System carries a safety net load, as evidenced by its financial statements

At least 30% of services are delivered to Medicaid or uninsured patients or greater than 10% of operations is uncompensated care.

3

System serves as a medical school teaching site

Operates as the main teaching site for at least one medical school and trains at least 25 residents for every 100 staffed beds.

Three rules for testing

Each arrangement is tested.

If ownership and operation are different, both are tested.

Size, location, market position or reputation not included in selection process.

Membership in a hospital association is not a requirement.

Rational for selecting 1990

Why 1990

- Counting only hospitals that are currently publicly owned would exclude systems that have already changed hands.
- Two important events occurred in the 1990s:
 - Federal hospital financing changed
 - Minnesota passed law enabling Ramsey County System's conversion to Regions Hospital

Why include systems that never changed

- Serve as a baseline to measure changes caused by restructuring.
- Volume of unchanged systems was capped
- Each unchanged (control) system was matched with a similarly restructured system.

Key Considerations

- Systems were selected from over 900 publicly owned hospitals.
- The selected systems are not a random sample.
- Final systems do not reflect all publicly owned hospitals.

A standard set of questions was applied to each system

Public records reviewed to respond to 52 questions organized into 8 categories

D1 Identity and role	7 questions	D2 Ownership and legal form	6 questions
D3 Governance and control	10 questions	D4 Accountability and transparency	5 questions
D5 Financing and public support	7 questions	D6 Workforce and labor	5 questions
D7 Medical school and clinical ties	5 questions	D8 Changes of hands, and what followed	7 questions

**Focus today is on first four groups
(28 questions)**

Key information collected:
(1)Hospital role
(2)Hospital ownership

Source documentation noted for each response

Questions from first two groups: what it is and who owns it

Thirteen of the twenty eight questions.

D1 Identity and role

What is the hospital and its role in the community?

- Legal name
- State and local government authority
- Year current arrangement started and documentation
- Size: beds, admissions, emergency visits
- Formally designated roles (e.g., trauma center)
- Proportion of services billed to Medicaid or uncompensated care
- Volume of doctors trained (e.g., residency and internship)

D2 Ownership and legal form

Who owns the hospital and where is this documented?

- Ownership classification
- Name on land and building deeds
- Name on hospital license
 - If different from legal owner, why
- Law, charter, ordinance or lease establishing arrangement, cited to the section
- Authorization to sell, lease, merge or close
- Approval process
- Disposition of the buildings if arrangement is terminated

Ownership structures may not be apparent. In some systems, government retains the title while a separate organization oversees operations.

Questions in groups three and four: decision rights and access

Remaining fifteen of the twenty-eight questions

D3 Governance and control

Who is authorized to make decisions? What is still under the control of the public owner?

- Board composition and size
- Appointment authority, confirmation requirements
- Term length and limits
- Removal authority and groups for removal
- Reserved board seats, qualification requirements
- Government-retained power and authority
- Key decision rights: budget approval, executive appointment, borrowing authority

D4 Accountability and transparency

What information is publicly available and who holds ultimate responsibility?

- Public meeting requirements and disclosures
- Public access to records and exemptions
- Audit authority and oversight
- Public access to audit records
- Reporting obligations, recipients, and frequency
- Applicability of public purchasing and civil service requirements

These four questions about the money, the budget, the chief executive and the borrowing are where most of the real difference between systems turns out to sit.

Seven ways a public hospital system can be organized

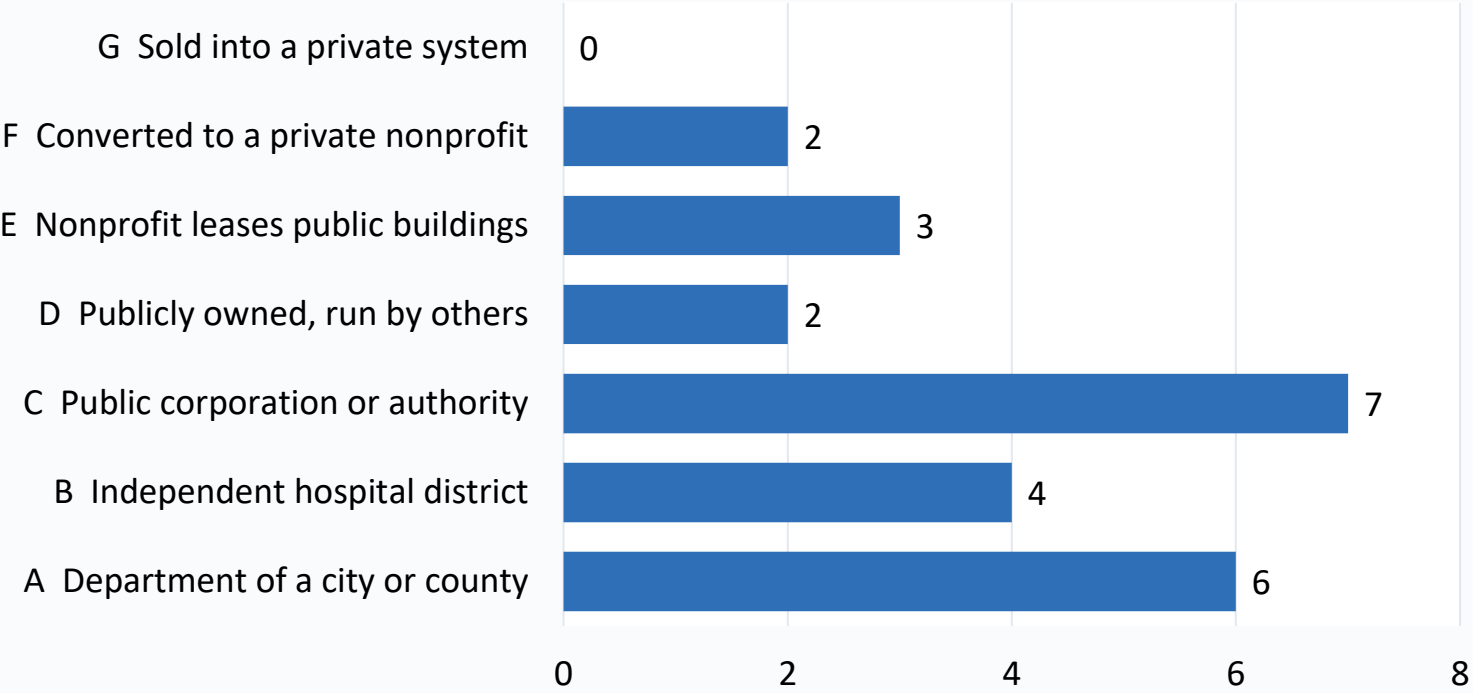
A simple classification to facilitate cross-hospital comparison

A	A department of a city or county	Hospital is part of the government.	<i>Santa Clara Valley Healthcare, California</i>
B	An independent hospital district	Hospital is operated by a unit of local government: • Differentiated territory • Potentially different taxing authority	<i>Parkland Health, Dallas</i>
C	A public corporation or authority	Government owned; operated by different organization • Separate board • Organization maintains the books	<i>NYC Health and Hospitals. Hennepin Healthcare sits here</i>
D	Publicly owned, run by somebody else	Government owned, including buildings Operated by a university or health system under n agreement	<i>University of New Mexico Hospital</i>
E	A nonprofit runs publicly owned buildings	Public holds the deed Operated by non-profit under a lease	<i>Grady Health System, Atlanta</i>
F	Converted to a private nonprofit	Ownership transferred Often public obligations attached to the transfer	<i>Regions Hospital, Saint Paul</i>
G	Sold or merged into a private system	Proceeds typically used to established community foundation	<i>No system in this scan took this route</i>

A few systems need two letters, because they are one thing today but changed from something else. This is flagged.

Organizational variation

Twenty four systems, including Hennepin Healthcare and Regions Hospital



No hospitals sold to private system

None of the selected systems was sold or merged into a private company.

Two Minnesota reference points

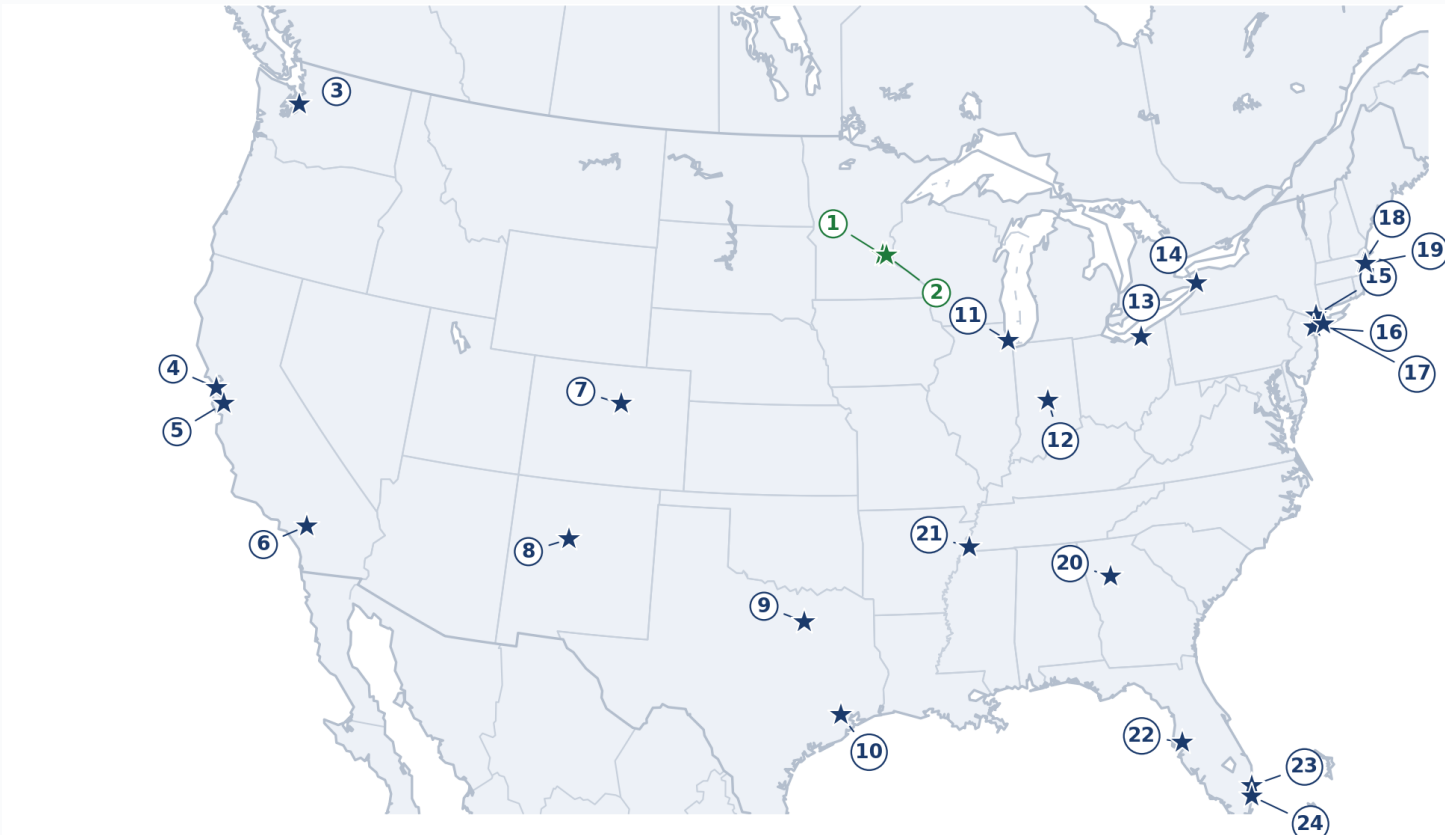
Hennepin Healthcare categorized as C: public corporation.

In 1990, Regions Hospital (Saint Paul) converted to a private nonprofit (group F) – setting the state precedent.

Classification is a starting point, not a conclusion.
Systems with same classification may have significant differences in ownership, financial control, transparency.

Where the twenty four systems are

One star for each system in the scan. The two Minnesota systems are in green



* The bed figure is provisional, carries no year, or comes from a source other than a licensing file or an audited statement. The MetroHealth System publishes no bed count on a source the field accepts, so none is stated.

System	Licensed beds / staffed
1 Hennepin Healthcare, MN	894 / 469
2 Regions Hospital, MN	554 / 516
3 Harborview Medical Center, WA	413
4 Zuckerberg San Francisco General, CA	397
5 Santa Clara Valley Healthcare, CA*	1,142
6 Arrowhead Regional Medical Center, CA*	456
7 Denver Health, CO	555 / 447
8 University of New Mexico Hospital, NM	597
9 Parkland Health, TX*	983
10 Harris Health System, TX*	617
11 Cook County Health, IL*	498
12 Marion County HHC (Eskenazi), IN	336
13 The MetroHealth System, OH	not established
14 Erie County Medical Center, NY	573 + 390 LTC
15 Westchester Medical Center, NY	652
16 NYC Health + Hospitals, NY*	4,635
17 Nassau Health Care Corporation, NY*	530
18 Cambridge Health Alliance, MA	417 / 331
19 Boston Medical Center, MA	539
20 Grady Health System, GA	953
21 Regional One Health, TN*	631 / 291
22 Tampa General Hospital, FL*	937 staffed
23 Broward Health, FL	1,579
24 Jackson Health System, FL*	2,255

The same twenty four systems, grouped two ways

Who owns the hospital, and who gets to decide

OWNERSHIP. The seven classifications, by name	GOVERNANCE. How the board is put there
A A department of a city or county Cambridge Health Alliance Cook County Health Zuckerberg San Francisco General Santa Clara Valley Healthcare Arrowhead Regional Medical Center Jackson Health System	No board of its own. The hospital is governed inside the government Zuckerberg San Francisco General (city health commission, all seven seats mayoral) Santa Clara Valley Healthcare Arrowhead Regional Medical Center
B An independent hospital district Marion County HHC (Eskenazi) Parkland Health Harris Health System Broward Health	A board appointed by one local government, with no confirmation stage Hennepin Healthcare Parkland Health Harris Health System NYC Health + Hospitals Grady Health System (each county commission appoints its own trustees)
C A public corporation or authority Hennepin Healthcare Denver Health Erie County Medical Center Nassau Health Care Corporation Westchester Medical Center NYC Health + Hospitals The MetroHealth System	Appointment, and then a second body confirms Denver Health (mayor appoints, council confirms) The MetroHealth System (a five vote authority including two judges, county council confirms) Cook County Health Marion County HHC (three appointing offices, none able to seat a majority) Jackson Health System
D Publicly owned, run by somebody else Harborview Medical Center University of New Mexico Hospital	Appointments split between the state and the local government Erie County Medical Center (governor eight, county executive seven) Westchester Medical Center (governor eight, county board seven, county executive approves) Nassau Health Care Corporation Broward Health (the governor appoints all seven)
E A nonprofit runs publicly owned buildings Grady Health System Regional One Health Tampa General Hospital	A board that no public body appoints Cambridge Health Alliance (the board nominates itself and an unelected city manager appoints it) Regions Hospital (one statutory county seat, fifteen appointed by nobody public) Boston Medical Center
F Converted to a private nonprofit Regions Hospital Boston Medical Center	
G Sold or merged into a private system No system in the scan took this route	A public board supervises, and an outside institution manages Harborview Medical Center (a county appointed board, a state university manages) University of New Mexico Hospital Regional One Health Tampa General Hospital

Two systems can carry the same ownership letter and be governed very differently, which is why the scan records ownership and appointment as separate answers.

The same twenty four systems, grouped two more ways

Where the money comes from, and who actually runs the hospital

FINANCING. How public money reaches it

It levies a tax of its own
Marion County HHC, which calculates its own property tax levy and is the only levy established in the scan so far | Parkland Health* | Harris Health System* | Broward Health*

It receives the proceeds of a dedicated tax it has no power to levy
Denver Health (a 0.34 percent city sales tax voted for its benefit in November 2024) | The MetroHealth System (county levy money, no levy of its own)

It receives a standing appropriation or subsidy from its public owner
Santa Clara Valley Healthcare (\$582.9m from the county general fund, FY2025, the largest on any card) | Zuckerberg San Francisco General (\$61.7m) | Hennepin Healthcare (\$38.0m county operating support, FY2024) | Grady Health System | Cook County Health* | NYC Health + Hospitals* | Jackson Health System* | Arrowhead Regional*

No standing appropriation. Public money arrives as payments, guarantees or a duty of effort
Nassau Health Care Corporation (Medicaid supplemental payments, state distress funding, county guarantees) | Erie County Medical Center (the statute creates a duty of effort) | Boston Medical Center (no city operating appropriation, and none was written into the 1996 act) | Tampa General Hospital | Cambridge Health Alliance | Harborview Medical Center* | University of New Mexico Hospital* | Regional One Health*

The public body has left, or is owed value rather than paying it
Westchester Medical Center (the county has paid nothing since 2005, on a route written down in 1998) | Regions Hospital (the only case in the scan where the hospital owes the public body, under the 1994 lease conditions)

OPERATIONS. Who runs it and who employs the staff

The government runs the hospital and the staff are its employees
Zuckerberg San Francisco General | Santa Clara Valley Healthcare | Arrowhead Regional Medical Center | Cook County Health | Cambridge Health Alliance

A separate public corporation runs it and employs its own staff
Hennepin Healthcare | Denver Health | Nassau Health Care Corporation | Westchester Medical Center | NYC Health + Hospitals | The MetroHealth System | Jackson Health System | Erie County Medical Center, where the workforce was kept in public employment by statute

A district runs it as its own unit of government
Marion County HHC (Eskenazi) | Parkland Health | Harris Health System | Broward Health

A nonprofit operates it under a lease and the public body keeps the buildings
Grady Health System | Regional One Health | Tampa General Hospital

A university or academic health system manages it under an agreement
Harborview Medical Center, where a state university manages the hospital and employs everyone in it | University of New Mexico Hospital

Operated privately after a completed conversion
Regions Hospital | Boston Medical Center

* Financing for these systems is coded in the second half of the card and is not complete. The grouping shown is the working classification from the enabling instrument.

Value to the Task Force

The scan is not an end in itself. It is what the options in Part Four will be built from

1

A shared vocabulary

Seven classifications enable comparisons of similar systems, providing a consistent framework beyond anecdotal examples.

2

Currently in operation

Each option reflects an operational model currently in use along with a clear example.

3

Evidence on cost and value for each decision

Understand result of different policy levers:

- Who appoints the board
- Who holds the deed
- Who controls the money
- What information is available to the public

4

Documentation of challenges

Part Five stress tests will draw on documented experiences from states.

5

Reusable language

Where another state has effectively addressed a challenge, the scan provides access to statutory provision for drafting language.

!

Record of scan limitations

Due to lack of reference, transfer to private ownership is not a considered option.
Scan characterizes system design, not performance
Comparison based on results after system change.

*Objective of the scan is to provide **information** to the Task Force, **not recommendations**:*

What are the available option? What are the implications of each choice? Which systems currently use each option?

PART THREE

The discussion

Facilitated by Jan Malcolm, Chair

Time allocated: 30 minutes

Two foundational questions to resolve early as they will shape the report and subsequent deliberations.

1

What does the Task Force consider to be within scope and what is not part of the Task Force's mandate

Why resolve this now?

An unstated charge risks renegotiation at each meeting, compromising capacity to generate report on time.

What is already defined in the law

- Five duties
- Report section addressing each question
- Consultation with 10 individuals with specific expertise
- Two reporting dates
- Report must include draft legislative language

What the Task Force decides today

- Scope boundaries beyond the explicit legal requirements
- Explicit exclusions from Task Force's charge
- Boundaries, if any, on options considered

These decisions will be documented in the opening chapter of the report, drafted at the end of September.

2 What decision should the January 2027 report enable?

The report should be structured around these decisions. Without clarity, the report risks being built upon assumptions.

Fixed date

Thursday, January 14, 2027.
(3 days after session opens; 11 days after elected officials take office)

Three elements that shape the answer

Which options require detailed analysis?
Which recommendations need draft bill language?
What should be the baseline to anchor the assessment?

Additional considerations focused on the process rather than conclusions

- Adopt the proposed outline as the work plan for both reports, providing clarity for drafting report.
- Adopt and maintain established meeting calendar as the Task Force's regular schedule. Under Minnesota law, establishing the schedule in advance eliminates the 3-day notice requirement for subsequent meetings.

*None of these decisions affect deliberations on future of Hennepin Healthcare;
Objective is to decide how to work from the start to meet the January deliverable data.*