Innovation. Quality. Equity.

Meeting Summary

Advisory Task Force Meeting 3 | Wednesday, October 14, 2026

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

Meeting	Meeting 3 of the Advisory Task Force
Date and format	Wednesday, October 14, 2026, 9:00 a.m. to 12:30 p.m. In person, Room 1150, 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 Summary

This document summarizes Meeting 3 of the Advisory Task Force on Governance and Financing of Hennepin Healthcare System, Inc., held on Wednesday, October 14, 2026. It is written for members of the public who did not attend, as well as for Task Force members, and it is intended for posting on the Task Force website.

Meeting 3 focused on governance. The Task Force heard Hennepin County administration's proposal for the transition to a reconstituted Hennepin Healthcare board, discussed the principles that should guide its own longer term governance recommendations, and then heard Hennepin Healthcare's five-year financial forecast and the operational pressures behind it. The meeting closed with an update on the Task Force charge statement and the consultation process. No votes were taken.

> **What this summary is not**
>
> This summary is not a transcript, and nothing in it is a recommendation or a finding of the Task Force. Recommendations belong to the Task Force, and the Legislature makes the final policy decisions.
>
> Figures are recorded as presenters and participants stated them at the meeting. They have not been independently verified, and any figure used in the Task Force report will be checked against its source first.
>
> 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 3, governance and financing discussion
Date and time	Wednesday, October 14, 2026, 9:00 a.m. to 12:30 p.m.
Location	Room 1150, Minnesota Senate Building 95 University Avenue West, Saint Paul Online viewing through Teams
Chair	Jan Malcolm
Attendance	Members attended in person, and two members joined virtually.
Presentations	Hennepin County administration governance proposal: Beth Stack, Chief Compliance Officer, Hennepin County. Hennepin Healthcare financial outlook and operations: Abdirahman Abdi, Chief Financial Officer, and Dr. Dan Hoody, Chief Medical Officer, Hennepin Healthcare. National scan update, given during the governance discussion: Dr. Yael Harris, Laurel Health Advisors.
Materials	Hennepin County administration memorandum to the County Board on the governance proposal, August 2026. Written comments on the proposal from Dr. John Cumming, Chief Executive Officer of Hennepin Healthcare and a Task Force member, and from Hennepin County Commissioner Edelson. Hennepin Healthcare presentation, distributed Tuesday, October 13, 2026. Draft Task Force charge statement and draft consultation questions.
Next meeting	Thursday, November 5, 2026, 1:00 p.m. to 5:00 p.m. Task Force members meet virtually. The public may view the meeting on Teams or attend in person in the Columbine Room, Centennial Office Building, 658 Cedar Street, Saint Paul.
Report adoption	Thursday, January 7, 2027.

3. What Meeting 3 Established

Meeting 3 was the Task Force's first extended discussion of governance. Two tracks were distinguished at the outset. Hennepin County must reconstitute the Hennepin Healthcare board and transfer governance to it by Friday, January 15, 2027, and is doing so with short term documents designed for a transition period from 2027 through 2029. The Task Force's charge is the long term ownership, governance and financing of Hennepin Healthcare. The Task Force is not bound by the County's decisions, and the County cannot wait for the Task Force's report before meeting its own deadline, but each process is expected to inform the other.

The governance discussion moved quickly to the questions underneath it: what Hennepin Healthcare is expected to provide, who pays for it, and who should therefore hold authority over it. Members concluded that governance recommendations are likely to follow, rather than precede, clarity about the system's distinctive public role and its financing. Hennepin Healthcare's forecast then showed operating margins falling below 2 percent beginning in 2028, the level Hennepin Healthcare described as generally considered necessary for long term sustainability, and members tied that result directly back to the governance discussion.

Theme	Takeaway
Two tracks	The County's transition documents are intentionally short term and build in a scheduled point to revisit their terms. The Task Force's long term recommendations are informed by them but not constrained by them.
Governance principles	No principles were adopted. The ideas raised most often were a close link between financial responsibility and governance authority; enough operating authority for Hennepin Healthcare's board and leadership to act quickly; a board with balanced financial, business and clinical quality expertise; a clear line between governance and day to day operations; strong oversight of quality and patient safety; and public accountability for public funds.
Order of the work	Members agreed that a more logical order may be the system's role and services first, then financing, then governance. The chair noted two things that can be taken as given: Hennepin Healthcare's functions are critical and of statewide importance, and Hennepin County should not be expected to be the only financial backstop.
Financial outlook	Hennepin Healthcare described its financial challenge as structural rather than operational: low reimbursement, rising costs, a payer mix that is about 75 percent government, federal policy changes under H.R. 1, and essential capital needs. Without further support, operating margins are forecast to fall below 2 percent beginning in 2028. Hennepin Healthcare described 2 percent as the margin generally considered necessary for long term sustainability and as about the industry average in Minnesota.
Hennepin's distinctive role	Members asked the Task Force to identify what Hennepin Healthcare provides that other systems do not, so that the State can be clear about what any public investment buys.
Next steps	The November 5, 2026 meeting will begin to consider options. Draft recommendation language is expected at the December meeting, and the Task Force plans to adopt its report on Thursday, January 7, 2027.

4. What the Meeting Settled

No votes were taken. The table below records the procedural points the chair stated or summarized during the meeting. General support for an idea expressed in discussion is not recorded here as a decision.

ID	Subject	Where it landed	Basis
D-M3-01	Governance recommendations	No votes were taken. The discussion was held to begin articulating principles for the governance recommendations in the report.	Stated by the chair at the opening.

ID	Subject	Where it landed	Basis
D-M3-02	Order of the recommendations discussion	Governance recommendations will not be developed ahead of the other dimensions. A proposed sequence of topics will be prepared, likely beginning with the system's role and services, then financing, then governance.	The chair's summary of the discussion.
D-M3-03	Charge statement	Member feedback favored a charge statement that tracks the statutory language more precisely. No formal approval was sought at this meeting.	Stated by the chair.
D-M3-04	Structure of the consultations	In addition to the ten statutory categories, one category is divided into separate conversations with county commissioners, legislators and state agency leaders. Hennepin Healthcare staff will be consulted in Hennepin specific groups. Labor organizations and associations are consulted within the labor category.	Reported by the chair for members' awareness; the chair noted that the decision to hold Hennepin specific groups was the chair's own.
D-M3-05	Report adoption meeting	Thursday, January 7, 2027 is confirmed as the meeting at which the Task Force will adopt its report, and as its final meeting for this round of work.	Stated by the chair; members confirmed they are available.
D-M3-06	Format of the next meetings	The next two meetings are virtual for Task Force members.	Stated at the close.

5. Welcome and Overview of the Meeting

Chair Malcolm opened by recalling Meeting 2 and the Task Force's charge, which is set out in statute: specific questions the Task Force must answer, a wide range of people it must consult, and draft legislative language for any recommendation that requires legislation. Beyond the technical charge, members at Meeting 2 had described an aspiration for a Hennepin Healthcare that thrives rather than merely survives, and recognized that Minnesota's safety net is larger than any one institution.

The chair explained that while the charge is specific to Hennepin Healthcare, its issues cannot be resolved without broader discussion of health care financing and access. The Task Force does not intend to recommend specific mechanisms, such as a particular tax, but it will discuss principles for the broader policy changes that safety net functions need in order to have a stable future.

The meeting's main focus was governance, informed by the work Hennepin County has done at the Legislature's direction to put an independent board back in place by January 2027. No votes on governance recommendations were planned.

6. Hennepin County Administration Governance Proposal

Beth Stack, Chief Compliance Officer for Hennepin County, presented the County administration's proposal to the Hennepin County Board for the next phase of the County's governance and financial relationship with Hennepin Healthcare. The proposal was the subject of a public briefing of the County Board in September 2026, at which each commissioner gave individual feedback. Beth Stack emphasized that it is a staff proposal, that the County Board has not taken any formal vote on it, and that the Board is expected to consider final actions before the end of 2026. The full detail is in the County administration's memorandum, which is among the meeting materials.

Background and timeline

For many years the hospital was a County department. For about the last 20 years, Hennepin Healthcare has been a public subsidiary corporation wholly owned by the County, governed from 2007 to 2025 by a separate

board appointed by the County Board. In August 2025, the County Board exercised one of its statutory reserved powers to remove that board and resume direct management during a period of significant financial crisis. The 2026 Legislature then set a deadline of January 15, 2027 for the County Board to reconstitute the Hennepin Healthcare board and transfer governance to it.

Four factors are shaping the County's work: the January 15, 2027 deadline; the Task Force's broader review, which will inform the longer term; the existing governance documents between the County and Hennepin Healthcare, which must be reviewed, updated and reapproved; and a governance review report delivered to the County Board in June 2026, which gathered feedback from a wide range of stakeholders.

The proposal works within existing state law and covers a transition period from 2027 through 2029, intended to give Hennepin Healthcare stability while the Task Force completes its work and any resulting legislation is considered. Core features set in state law are unchanged: the parent and subsidiary relationship; the County Board's reserved powers, including approval of the Hennepin Healthcare budget, health services plan and future slates of board nominees; the County Board's ability to meet with Hennepin Healthcare in closed session; the requirement that two commissioners serve on the Hennepin Healthcare board; and the Hennepin Healthcare board's authority to hire the chief executive officer.

The County's anticipated timeline before the deadline is:

- October and November 2026: board recruitment and selection under way, and the governance documents updated in light of commissioners' feedback.
- December 2026: County Board actions expected to approve the updated documents, approve the Hennepin Healthcare 2027 budget, and appoint the reconstituted board.
- By January 15, 2027: governance transferred to the new board, with a plan for onboarding and for engagement and alignment between the two boards.

The proposal, document by document

When the County first created Hennepin Healthcare as a subsidiary corporation, it approved a lease, an operating and funding agreement, a first set of bylaws, and the first slate of board members. For the transition back to a reconstituted board, the County is reviewing each of these documents to determine whether changes are needed. The table below records what was presented for each, including where no change is proposed, and gives figures as presented.

Element	As presented
Operating and funding agreement	The current agreement expires at the end of 2026. The proposal provides $38 million in County funding in 2027 for Hennepin Healthcare to use as it determines best, the same amount the County provided in 2026 for uncompensated care. County support for 2028 and later would be considered each year through the County's regular budget process, recognizing that Hennepin Healthcare needs ongoing support and that the County cannot be its only funding source. The proposal also sets out an expedited process for Hennepin Healthcare to request a one time emergency loan of up to $35 million, sized to help meet payroll and requiring County Board approval. Any further need would require further County Board review.
Information and oversight	New provisions would require Hennepin Healthcare to provide data to the County on request and would allow the County to withhold its financial subsidy for a breach of the agreement, so that the County Board has the information it needs for its oversight role.
Lease	No changes proposed. The County owns most of the real estate the health system uses and renewed the long term lease in late 2025. Its key terms are a long term, a low rent, an obligation to use the publicly owned property as a hospital, and an obligation to maintain the facilities in good order.

Element	As presented
Bylaws: transparency and accountability	The 2026 Legislature limited two of the County Board's reserved powers: removing the corporate board and resuming management, and approving the budget. In response, the proposal adds bylaw provisions on transparency about budget changes, delegated authority and board activities, and new accountability measures for board members, including a code of conduct and a process for removal for cause by the County Board.
Bylaws: board membership	The two commissioners and the appointed public members would vote. The chief executive officer and the president of the medical staff would serve as nonvoting members by virtue of office. Other Hennepin Healthcare employees could serve on board committees.
Bylaws: commissioner participation	Keeps the two commissioners the statute requires and adds an alternate. Commissioners would serve on the governance and finance committees, which align with the County Board's reserved powers. A starting proposal of a two year term and a two year limit, on which commissioners gave feedback. A new right for commissioners to lay an item over once before final action, similar to a procedure the County Board uses for its own business.
Delegation to the chief executive officer	The Hennepin Healthcare board could continue to delegate authority to the chief executive officer, up to a maximum set by the County Board. The proposal does not specify the amount.
Board recruitment and selection	Keeps the long standing practice of unpaid board service. Minnesota residents would be considered, with a focus on, but not a limit to, Hennepin County. A consultant is helping develop a board matrix that reflects the updated statutory qualifications, under which, as the presenter summarized them, at least 75 percent of the members who are not commissioners must have experience relevant to running a health system as mandated by 2026 legislation. Two interview rounds: County and Hennepin Healthcare staff leaders in October 2026; then, in November 2026, a final panel of the two commissioners serving as chair and vice chair of the Hennepin Healthcare board, the County Administrator, the Hennepin Healthcare chief executive officer, and one more Hennepin Healthcare leader added after commissioners' feedback. The final panel recommends candidates to the County Board. This process applies only to reconstituting the whole board this year; in later years the statute provides for a board committee to recommend a slate.

Questions and discussion

Two separate tracks. The chair stressed that the County's documents are intentionally short term and that the County's process and the Task Force's work are separate tracks that can inform each other. A Hennepin County participant explained that the three year term was chosen to create a natural, scheduled point for the County and the new Hennepin Healthcare board to revisit the terms together, rather than leaving either party to ask for changes later. The County would welcome the Task Force's view on the length of that period.

Advisory boards and committees. A member asked about community advisory boards and noted the importance of on site leadership. The response was that the Hennepin Healthcare board has used community advisory boards and both standing and ad hoc committees in the past. The proposal would allow committees without specifying them, and committees cannot take over the board's powers.

Workforce confidence and board authority. A member asked how the proposal supports the confidence of the people who work at Hennepin Healthcare and its statewide role, and whether the combination of limits on County financial support and the County's strong role on the board leaves the Hennepin Healthcare board enough ability to operate. The response was that the proposal clarifies the respective roles of the two boards; that much of governance depends on relationships and alignment that legal documents cannot capture; and that the oversight provisions, including the layover right, are meant to give the County Board timely information about decisions that are rarely small, particularly now that its reserved powers have been narrowed. The presenter noted that the State's stabilization legislation includes similar information requirements.

Emergency response and the long term backstop. A participant distinguished between responding quickly to an emergency, such as the payment disruption involving UCare in the past year, and providing liquidity every day. The participant observed that Hennepin Healthcare is an operation of about $1.7 billion a year, approaching the size of the County's own budget of about $3 billion, which limits how far the County can shield it. Who serves as the long term financial backstop, and what oversight goes with that role, was identified as a central question for the Task Force.

Board practice. A member recommended reconsidering a voting role for the chief executive officer, who may best understand the clinical impact of decisions; balancing financial oversight with oversight of clinical quality and patient safety at the board level; and taking care that the layover right does not delay urgent decisions that affect patient safety.

Mission, access and community. A member asked what ensures accountability for safety, mission, access to care and the communities served. The response pointed to the County Board's reserved powers over any change in the hospital's mission and over approval of the health services plan, which remain unchanged, and to regular briefings of the County Board by Hennepin Healthcare's board chair and executive leadership, historically held quarterly.

Unpaid board service. A member asked whether unpaid service can attract and retain board members with the expertise and commitment the system needs, and whether it limits participation by people with lived experience. The response was that the question was considered; that views in the June 2026 governance review covered the full range, with some past board members strongly favoring unpaid public service; that current recruitment will show whether it is a barrier; and that state law limits the liability of uncompensated board members. The member noted that the complexity of the work and the expertise it requires also bear on the question.

Funding after 2028. A member asked what funding could be available after 2028. The presenter clarified that this part of the proposal refers only to County support: the agreement would set the amount for 2027, and in each later year Hennepin Healthcare would request County support, which the County Board would decide through its annual budget process. Other revenue sources could also be pursued.

Limit on delegation. A member asked about the proposed limit on what the Hennepin Healthcare board may delegate to its chief executive officer, noting that the County Board decides its own delegations while under this model it would set the limit for another board. The response confirmed that the County Board would set a maximum on what the hospital board may delegate. For comparison, the County Administrator's contract authority is up to $100,000.

Commissioners on the Hennepin Healthcare board. Drawing on service on the first Hennepin Healthcare board, the chair urged the County Board to recognize service on the health system board as a significant part of a commissioner's job and to support the commissioners who take it on. The chair also observed that the 2026 session established that Hennepin County will no longer be the only financial backstop, which has implications for who else contributes and how governance reflects that, and that the proposed 2027 funding introduces uncertainty for the health system during a critical period.

The County and Hennepin Healthcare relationship. Hennepin County's chief financial officer explained that although the lease requires the hospital to maintain the buildings, the County has at times provided capital support, and that Hennepin Healthcare is using part of its state funding to meet its 2027 lease obligations, which will be hard to sustain without ongoing funding. The two organizations are closely connected. Hennepin Healthcare, Hennepin Health (the County's Medicaid health plan) and NorthPoint (the County's health center in North Minneapolis) belong to an accountable care organization together; Hennepin Healthcare provides health care in the County jail under contract; and the two organizations coordinate purchasing across roughly $90 million to $100 million of contracts with similar vendors. A review of shared functions over the past year found few new savings, largely because the teams already work closely. The

chief financial officer described the need to replace aging facilities as likely beyond what the County and the hospital could take on, even together, and offered information on past County capital support.

The State's role. A member observed that the next two to three years are likely to bring federal and state policy changes, rapid change in technology, major mergers in the Minnesota health care market, and possibly new or recurring public health challenges, so Hennepin Healthcare's leadership will need agility; and that the State carries significant financial risk during this period without any role in governance.

7. Governance Discussion: Principles for the Task Force's Recommendations

The chair then opened a broader discussion. The Task Force's charge is the long term sustainability of Hennepin Healthcare and what its ownership, governance and financing should be, informed by current challenges but not constrained by them.

Financial responsibility and governance authority

The chair offered, as a starting principle, a direct relationship between financial responsibility and governance authority, noting that Hennepin County has carried the risk until recently but would retain ultimate control under the current proposal, which appears to be a mismatch. A member cautioned that many levels of government already help fund the system, including federal Medicaid funding, and that tying governance to every funder would be unworkable: governance must be accountable to someone and able to act.

A Hennepin County participant suggested that clarity is the goal. When public funding is provided for a defined purpose, such as care for people who cannot pay, accountability can follow that purpose; when funding is requested for other purposes, the oversight that goes with it should be defined. The participant noted that Hennepin County is the only county that supports its health system in this way, and asked the Task Force to be clear about what is expected of Hennepin Healthcare and why.

Authority to operate

A member said that if Hennepin Healthcare is to be accountable to the public for its financial and operational performance, it must have authority over operational matters comparable to that of other health systems. Another member agreed that decisions such as whether to repair or replace equipment must be made within Hennepin Healthcare, with flexible funding. Participants broadly supported a high level framework that leaves the hospital board and leadership accountable both for performance and for transparent use of public dollars, and asked the Task Force to set out a clear vision of the future that the County and the hospital could work toward.

Later in the discussion, a member encouraged the Task Force to consider options in which Hennepin County is neither the oversight body nor a funder, describing the existing relationship as no longer sustainable and the present moment as an opportunity to reimagine public safety net care across the state. The chair agreed that the Task Force exists to consider what the state's health care system needs from Hennepin Healthcare, and that it is free to think creatively.

The national scan

Dr. Yael Harris of Laurel Health Advisors gave a brief update. The scan compares 26 health systems, including Hennepin Healthcare; the list members reviewed earlier was expanded by one system on the advice of America's Essential Hospitals. On budget approval, for example, Hennepin's arrangement is unusual: in 10 of the systems, the owner approves the operating budget because it levies a tax or appropriates funds. Dr. Harris cautioned that the most common pattern is not always the most useful finding, since the one system that differs may offer the most relevant insight, and invited members to bring specific questions for the research team to answer from the data.

Board expertise, quality, and the line between governance and operations

Several members addressed how a future board should work:

- Accountability for quality and patient safety is a distinct and vital governance function that requires different expertise from financial oversight, and it should not be lost in the financial discussion.
- A committee structure that reinforces both clinical quality and finance, and a board with equal weight of financial, business and clinical quality expertise.
- Bylaws that set clear expectations separating governance from operations, so that the board stays at the strategic level and delegates the running of the organization to its staff.
- Board qualifications that call for experience in health care and hospital financing specifically, not only general financial administration.
- A model that balances public accountability with health care expertise and supports accreditation, patient safety, quality oversight and the recruitment of talent, and that, in one member's words, would "avoid some political micromanagement."

One member suggested that the consultants examine the Metropolitan Airports Commission, a public entity created in 1943 with a board appointed by public officials, and any other Minnesota public entity with real day to day operational responsibility, as possible models.

Hennepin Healthcare's public role

Members described the functions they see as making Hennepin Healthcare a statewide resource: capabilities that everyone relies on, such as Level I trauma care for adults and children, hyperbaric medicine, and constant readiness for disasters, from a catastrophic event to a rolling crisis such as COVID-19, in which Hennepin played a central coordinating role; the teaching of much of Minnesota's health care workforce and the research that goes with it, which are often not fully compensated; and a level of quality that draws patients from across the state, including many with good insurance. One member described Hennepin as "a safety net hospital plus." A participant noted that about 20 percent of the state's uncompensated care is concentrated in this one system, and that Hennepin Healthcare serves everyone, not only people who are uninsured or low income.

Members also observed that the market does not deliver everything people need, including care for those who cannot pay, the training of new clinicians, and readiness, and that this gap is growing.

Defining a safety net system

A member proposed that the Task Force define what makes a hospital or health system a safety net, so that federal and state dollars can follow that definition, and asked whether such a definition could belong in a governance document. Payer mix is one element. Dr. Harris noted that the national scan used thresholds based on Medicaid share and uncompensated care to select its peer systems, as presented at Meeting 2, and found wide variation among safety net systems, with no single definition even of uncompensated care.

In response to a question about how state insurance markets affect these measures, Dr. Harris said that approaches vary by state law and funding method, including local tax levies, and offered to provide examples of hospitals in other states with similarly large shares of uncompensated care. A member noted that funding models elsewhere, possibly including Parkland in Dallas, suggest the Task Force need not be confined to the current model, and that the answer could combine approaches.

What is distinctive, and what public support buys

The chair noted that the consultation process may help establish what is truly distinctive about Hennepin Healthcare, since there may not be universal agreement on the degree to which only Hennepin performs particular functions. A member with experience at another Twin Cities system observed that other systems also operate Level I trauma centers, take part in emergency preparedness, and consider themselves

underfunded for those services, so the Task Force must be clear either about Hennepin's distinctive functions or about the inadequate funding sources that affect every provider. The chair said both are true.

Another member suggested identifying the distinctive public goods and health outcomes that Hennepin Healthcare provides, working back from them to the appropriate shares for Hennepin County, the State and possibly other public entities, and from there to the makeup of the board. Members agreed that in what is expected to be a very difficult state budget environment, any request to the Legislature must state precisely what the State is buying with its support.

Order of the work

The chair summarized that the Task Force will not try to settle governance recommendations ahead of the other dimensions, and that the coming meetings may follow a more logical order: the system's role and services, then its finances, then its governance. The chair named two points that can be taken as given: the functions Hennepin Healthcare provides are critical and of statewide importance, and Hennepin County should not be expected to be the only backstop. Whether the County continues as a backstop at all is a question for further discussion. The chair raised, as possibilities, that all counties might share in paying for uncompensated care in a different way, and that Minnesota might revisit an idea used decades ago of setting expectations for providers and health plans about the share of public program patients they serve. Almost nothing is off the table.

8. Hennepin Healthcare Financial Outlook and Operations

After a break, Abdirahman Abdi, Chief Financial Officer, and Dr. Dan Hoody, Chief Medical Officer, presented Hennepin Healthcare's five-year financial outlook and responded to questions members raised at Meeting 2. The presentation was distributed to members on Tuesday, October 13, 2026. Hennepin Healthcare prepared the forecast with assistance from an independent national consulting firm. The figures below are recorded as presented.

Topic	As presented
State support	The $205 million in state support provided in 2026 has provided significant support in the near term to allow continued consideration for what a durable funding source or sources might look like Hennepin Healthcare has an experienced and competent finance team that works with Wipfli, an independent third party, to leverage their nationally recognized expertise to enhance financial forecasting.
What the forecast assumes	This is a modified forecast, not a budget. It provides a directional view of financial needs rather than predicting exact results. The forecast separates three components: base operations, potential H.R. 1 impacts, and capital needs (inclusive of capital medical equipment, IT investments and asset preservation), recognizing that future funding could address each differently. The base forecast reflects current operating assumptions and sustainable-system benchmarks, including a 2% operating margin and 7–9% capital funding. The blue boxes represent the gap between projected performance and the 2% sustainable-margin benchmark. They are not projected operating margins and are shown before H.R. 1 impacts. In other words, in 2026 HHS is forecasting operating income to exceed its 2% margin by $73 million, and in 2030 operating income is expected to be $62 million below the desired 2% margin. The forecast methodology is consistent with what was shared during the prior legislative session, with updated values and revised classifications and groupings. This forecast does not include any future draws on the $500 million Hospital Stabilization Reserve Fund which will be available in July 2027 absent legislative changes, and assumes that County support of $38 million per year continues. These are management's best estimates and depend on many factors outside of their control, particularly healthcare funding and reimbursement. This forecast reflects a commitment to capital equipment, IT and building preservation investments while also recognizing the impacts of HR1. The system's finances are interconnected. Services cannot simply be divided into those that make or lose money, and no single financial pressure tells the whole story. Additionally, there are added operating costs to make services available 24/7 365.

Topic	As presented
The trend	Together, these pressures create a widening gap against the 2% sustainable-margin benchmark after the $205 million approved by the legislature is expended, even before fully accounting for H.R. 1.
H.R. 1	Medicaid disenrollment and reduced directed payments are estimated to have a $454 million cumulative impact through 2030. For 2026 alone, directed payments are $20 million below budget based on CMS's interpretation of the legislation.
Capital needs	At the same time, Hennepin Healthcare faces non-optional capital needs, including clinical equipment replacement, IT infrastructure, and preservation of existing buildings. Aging facilities will also need replacement, and campus redevelopment is not included in this forecast. The forecast shows what it takes to operate the system, respond to a changing reimbursement environment, and maintain critical assets and technology.
Payer mix and costs	About 75 percent of the business comes from government payers. Low reimbursement combined with rising labor and other costs is what drives the operating margin.
Length of stay	Behavioral health patients account for about 10 percent of discharges and about 24 percent of bed days. Through August 2026, the average length of stay was about 5.8 days for medical and surgical patients and 17.3 days for behavioral health patients. Combining the two in one measure raises Hennepin's overall figure relative to other Minnesota hospitals, a difference not reflected in the Department of Health data presented at Meeting 2.
Discharge barriers	About 18,000 excess days for medical and surgical patients through September 2026, meaning days when patients remained in a hospital bed after hospital care was no longer needed. Waiting for a skilled nursing facility was the largest category, about 4,000 days. Others included lack of funding, bed availability, intensive monitoring needs, pending insurance, and hospice. In most cases the clinical team knows where the patient should go; the barrier is whether that setting exists and has room.
Operational improvement	Hennepin Healthcare owns the improvements within its walls. Reducing length of stay this year had a significant positive financial effect, but it has not closed the structural gap between reimbursement and the cost of care.
Summary	The takeaway is that this is not one financial problem. It is the convergence of reimbursement pressure, federal policy changes, and the ongoing capital requirements of a major safety-net academic health system. Long-term, stable funding beyond a single year's operating result would support investment in workforce, equipment, and infrastructure needed to continue serving patients and also ensure incoming employees that HHS will be here for the long-term. The numbers show the financial pressure. The drivers become clearer when we look at what is happening to patients inside the hospital.

A framework for future decisions about clinical scope

Responding to a comment at Meeting 2 about the future scope of Hennepin Healthcare's services, Dr. Hoody offered a framework for evaluating such decisions, not a decision itself. It looks at services through three lenses:

- Visible regional assets, such as Level I trauma, burn care and hyperbaric medicine, which clearly serve a regional or statewide need.
- Less visible specialty access, such as behavioral health, addiction medicine, dental care and emergency eye care, where Hennepin carries a meaningful share of the state's practical access burden.
- Specialty care for patients with complex needs. A hip or knee replacement is offered by many systems, but when the patient also faces housing instability, behavioral health needs, substance use,

transportation or insurance barriers, or difficulty finding post acute placement, the real access picture changes. These patients often come to Hennepin, whose teams have built concentrated expertise in their care.

Education runs through all three lenses: medical students, residents, nurses, pharmacists and other trainees learn at Hennepin how to care for patients with complex needs in a public mission setting, and carry that experience to communities across Minnesota. Dr. Hoody suggested that decisions about services should be based on facts and not on a narrow view of which service lines make or lose money, and proposed five questions:

- Is the service a statewide or regional access asset?
- Is Hennepin filling a market gap that others are not reliably filling?
- Is Hennepin uniquely able to care for the patients who depend on the service?
- Does the service materially support education and workforce development for the region and the state?
- Can it be sustained in a way that is operationally and financially responsible?

Questions and discussion

The forecast. Asked what drives the drop in operating income from 2027 to 2028, the presenters said it is mainly the end of the state support, which accounts for much of the positive margin in the first two years. The forecast makes no assumption about the $500 million reserve; requirements for drawing on it are an active conversation with the Minnesota Department of Health and Minnesota Management and Budget. It assumes the County's $38 million a year continues, which the County agreed is a reasonable assumption until there is a policy direction to the contrary. The chair noted that this support remains subject to the County's budget process. The forecast covers all operations, including the clinics.

Comparisons with peers. Hennepin Healthcare normally benchmarks itself against other safety net health systems. Members asked to see both pictures again, against all hospitals and against closer peers, and noted the value of comparisons with Regions Hospital and North Memorial, including the differences between Level I trauma programs, where that can be done without raising competitive concerns.

Where losses occur. A member asked whether losses can be located by service line. Hennepin Healthcare can provide service line performance, while stressing that the value of its delivery model lies in how the parts work together, and that low reimbursement and rising costs are what drive the overall margin.

Efficiency and governance. A member with long experience operating hospitals observed that a case mix index of 1.95 combined with a medical and surgical length of stay close to the Minnesota average suggests the problem is not operational inefficiency, apart from placement and behavioral health, and said that in that member's experience across several states, it is very difficult to find a positive margin once government payers exceed about 72 percent. The member drew two lessons for governance: management will need agility as H.R. 1 takes effect, and the board needs blended financial and clinical competency to ask the right questions. Another member stressed that the period covered by the County's temporary arrangement is exactly when central decisions must be made to avoid the 2028 scenario.

Lack of funding as a discharge barrier. Asked about this category, Hennepin Healthcare explained that it covers patients with no insurance or other payment source for long term, transitional or home care. Members asked for a similar chart for behavioral health patients.

Order of magnitude. A member asked how much of the financial problem is driven by hospital operations, how much by overall funding, and how much by factors within the State's control, such as the supply of mental health beds and social services. Hennepin Healthcare described the heavy effect of patients' social circumstances, such as housing and financial instability; explained that hospitals are usually paid by diagnosis rather than by day, so a patient who cannot be discharged reduces both capacity and revenue; and noted that services are interconnected, so dropping one that loses money can put Level I trauma verification or

other accreditations at risk. Asked what resolving discharge delays would mean for financial performance, the answer was that the effect would be very large.

Uncompensated care. A participant distinguished uncompensated care from low Medicaid and Medicare rates and noted that Hennepin Healthcare's uncompensated care is in the range of $80 million to $100 million a year, more than the 2 percent operating margin the system targets. The participant said County funding met this need for roughly the first 15 years after Hennepin Healthcare became a subsidiary, but rising costs since the pandemic have outstripped the County's capacity. The chair added that a growing share of uncompensated care comes from commercially insured patients facing high deductibles and copays, many of whom are functionally uninsured.

Consistent definitions. Members asked that the Task Force agree on one definition of uncompensated care for its comparisons, with clarity about the difference between charity care and bad debt, noting that reclassifying an unpaid bill as bad debt does not mean it will be collected. It was suggested that Hennepin Healthcare and the Department of Health help define it. A participant suggested that differences in charity care income thresholds between systems are not the main driver, which Hennepin Healthcare can confirm.

Care processes and hospital acquired conditions. A member described how social service and interpreter needs, and preventable complications acquired in the hospital, extend stays and reduce payment, and asked how Hennepin tracks them. Hennepin Healthcare said it tracks hospital acquired conditions very carefully, with quality and safety as its first priority, and will share both those data and its detailed document on the reasons for discharge delays.

Patients from outside Hennepin County. A member asked for uncompensated care broken down by patients' county of residence. Data discussed during the 2026 session showed about 24 percent of Hennepin's uncompensated care, roughly $24 million of about $100 million to $105 million, coming from patients who live outside Hennepin County. A member asked whether a comparable figure exists for Regions Hospital and Ramsey County residents. The chair noted a possible financing idea, a local responsibility for the uncompensated care of a county's or region's residents, not necessarily borne by county government. Another member observed that placement is likely even harder for patients from outside the county, which may lengthen their stays.

A wider system problem. The chair observed that if every provider made decisions on financial viability alone, services such as behavioral health could disappear in some places, leaving health care deserts. Federal law requiring emergency treatment for anyone who arrives functions as a national universal access policy but finances access in the most backward way, and the COVID-19 pandemic showed how hospital capacity is lost when patients can get in but cannot get out. Many of these drivers are policy questions larger than any Hennepin specific fix.

Where to start. A participant suggested starting from a governance structure in which the hospital and its leadership are empowered to focus on their mission, and then building financial support and accountability around it, noting that accountability and an enabling framework depend on each other. The chair said the sequence of the recommendations discussion is the main takeaway from the meeting and needs time with the consultants and with members. The chair will check in with each member individually over the following days to identify remaining questions and information needs.

9. Task Force Charge and Consultation

Charge statement. The chair thanked members who submitted written comments on the draft charge statement and consultation questions. The comments so far favor a charge statement that tracks the statutory language more precisely. No formal approval was sought. Further comments are still welcome.

Consultation questions. Laurel Health Advisors prepared a thorough question set. Because it is unlikely that every group will answer every question, members were asked which questions matter most and what is missing.

How consultations are organized. In addition to the ten statutory categories, one category is divided into separate conversations with county commissioners, legislators and state agency leaders. So that the Hennepin perspective does not dominate other conversations while still having a clear point of input, Hennepin Healthcare staff will be consulted in Hennepin specific groups. Labor organizations and associations are consulted in the labor category; for example, the Minnesota Nurses Association is in the labor group, while nurses generally are in the nurse group.

Progress. The first consultation, with emergency medical services providers, was held on Tuesday, October 13, 2026. Sessions will continue through the rest of October and into early November so that input is gathered and documented before the Task Force works in depth on recommendations. Laurel Health Advisors expects to share results from many of the sessions at the November 5, 2026 meeting.

Out of state referral sources. A member asked whether facilities outside Minnesota that refer patients to Hennepin Healthcare will be consulted. None are on the list explicitly, although larger systems with a presence in other states are invited under other statutory categories. The chair agreed the question should be asked explicitly.

Written input. Consultation participants may send written answers within a stated period so that they can be captured with the session notes. Members of the public may send written comments at any time, outside the formal consultation process, to the Health Subcabinet at health.subcabinet.mmb@state.mn.us, the address listed on the Task Force website. Input that reaches members through their own networks is also welcome, and all input is captured in one organized process, whatever route it arrives by.

10. Member Round Robin and Closing

One member said the meeting had clarified how the short term work and the long term work fit together. The chair said that staff and consultants will organize the discussion from the last two meetings into a proposed sequence of topics and begin to generate options. The November 5, 2026 meeting will present options on sets of issues rather than recommendations, narrowing so that the December meeting can consider specific recommendation language.

The next two meetings are virtual for Task Force members. The chair confirmed that the Task Force will meet on Thursday, January 7, 2027 to adopt its report, and that this will be its final meeting for this round of work. Members confirmed they are available on that date.

11. Information Requests

Each request is numbered so it can be traced from this meeting to the place in the report where it is used. Material provided to members is distributed through the Health Subcabinet.

ID	Information requested	Source named	Status
DR-M3-01	Examples of hospitals in other states with similarly large shares of uncompensated care, and how they are funded	Laurel Health Advisors	Open. To be addressed through the national scan rather than as a separate deliverable.

ID	Information requested	Source named	Status
DR-M3-02	Review of the Metropolitan Airports Commission and other Minnesota public entities with day to day operational responsibilities as possible governance models	Laurel Health Advisors	Open.
DR-M3-03	Comparison with safety net peer systems as well as with all hospitals, alongside related national scan information	Hennepin Healthcare; Laurel Health Advisors for the national scan	Open.
DR-M3-04	A behavioral health version of the discharge delay chart	Hennepin Healthcare	Open.
DR-M3-05	Uncompensated care broken down by patients' county of residence	Hennepin Healthcare	Open. Builds on a request made at Meeting 2.
DR-M3-06	The comparable share of uncompensated care from outside the home county at Regions Hospital	Not identified at the meeting	Open.
DR-M3-07	History of County capital support to Hennepin Healthcare	Hennepin County, with Hennepin Healthcare	Offered at the meeting.
DR-M3-08	A rough order of magnitude for the drivers of the financial gap: hospital operations, overall funding, and factors within the State's control such as placement capacity	Hennepin Healthcare	Open.
DR-M3-09	A consistent definition of uncompensated care for the Task Force's use, including the treatment of charity care and bad debt	Hennepin Healthcare and the Minnesota Department of Health, as suggested	Open.

12. Action Register

The actions below remain open after the meeting. Information requests are tracked in Section 11 and are not repeated here.

ID	Action	Owner	Due	Basis
A-M3-01	Send further comments on the charge statement and on which consultation questions matter most or are missing	Task Force members	No date stated	Requested by the chair
A-M3-02	Check in individually with each member to identify questions and information needs	Jan Malcolm, Chair	In the days following October 14, 2026	Stated by the chair
A-M3-03	Ask explicitly about out of state referral sources in the consultation process	Health Subcabinet and Laurel Health Advisors	During the consultations	Agreed at the meeting
A-M3-04	Share results from the consultation sessions held so far	Laurel Health Advisors	Thursday, November 5, 2026	Stated at the meeting
A-M3-05	Organize the discussion into a proposed sequence of topics and options for the November 5, 2026 meeting	Health Subcabinet and Laurel Health Advisors, with the chair	Before Thursday, November 5, 2026	Stated by the chair

13. Open Items

No.	Item	Where it stands
1	Where the recommendations discussion starts	The chair will work with the consultants and members on the sequence; a proposed sequence of topics is to come before November 5, 2026 (A-M3-05).
2	Definition of a safety net hospital or system	Proposed by a member. Not yet taken up.
3	Definition of uncompensated care	Requested (DR-M3-12).
4	What is distinctive about Hennepin Healthcare, and what public support should buy	To be informed by the consultations and the national scan.
5	Roles of the State and Hennepin County	Whether the State should have a role in governance if it carries financial risk, and whether Hennepin County continues as a backstop, were raised and not settled.
6	Length of the County's transition period	The County invited the Task Force's view on whether the 2027 through 2029 period is the right length.

Appendix A. How This Summary Was Produced

- Source. An automated transcript and recap of the meeting recording, read against the published agenda and the materials presented. The automated speaker labels were not reliable, so statements are recorded by substance, and names are used only for presenters and for roles and commitments.
- Figures. Figures are recorded as presenters and participants stated them and have not been independently verified. The primary source for every state appropriation is Minnesota Session Laws 2026, Chapter 127.
- Dates. Every relative date in the source is converted to an absolute date. "Yesterday" for the first consultation session and for the distribution of the Hennepin Healthcare presentation is read as Tuesday, October 13, 2026.
- Numbering. Decisions (D), information requests (DR) and actions (A) carry the meeting code M3 and a sequence number so that each can be traced into the report.
- 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, header rows repeat across page breaks, rows are banded, the logo carries alternative text, spacing is set by paragraph formatting rather than blank lines, the document language is set to English (United States), and no meaning is conveyed by color alone.