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Chapter 2. Hennepin Healthcare Today

What Hennepin Healthcare does today in each of the five areas the report uses, with most attention to how it is governed and how it is paid for

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

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In Brief

- **A statewide resource.** Minnesota's largest Medicaid provider and first Level I trauma center, training about a third of the state's physicians in training. Nearly 30 percent of its patients live outside Hennepin County.
- **Governed by one county.** A public corporation owned by Hennepin County, which appoints and can remove its board. The Hennepin County Board of commissioners have functioned as the Hennepin Healthcare System board since August 2025; a new independent board is due by January 15, 2027.
- **Paid for year to year.** No tax set aside for it, no credit of its own, county support decided each year, one-time state money in 2026, and less than 2 days cash on hand at the end of 2025, its last audited year.
- **Supported by the State, governed by the county.** The State provided $105 million to HHS in 2026 and will provide $100 million to fund directed payments in 2027 Additionally, the state established a contingency reserve but has no current role in governing it.

This chapter follows the five areas used throughout the report. Role, ownership and accountability are covered briefly; governance and financing, the center of the Task Force's charge, are covered in more depth.

2.1 Role: What Hennepin Healthcare Does

Hennepin Healthcare runs Hennepin County Medical Center in downtown Minneapolis with specialty and primary care clinics, an ambulance service covering 14 cities, the Regional Poison Center and a research institute. In 2025 it staffed about 470 beds and cared for 165,631 people on annual operations of about $1.5 billion. Its patients are among the most complex in the state: about four in five are covered by Medicaid or Medicare or are uninsured (Figure 2.2), and one in five had unstable housing, a sign of the social needs many bring. Consultation participants described patients who stay weeks or months after they no longer need a hospital bed because no post acute, group home or mental health bed is available. It provides $80 million to $100 million a year of uncompensated care, about one fifth of all uncompensated care in Minnesota hospitals (as presented).

Service	Why the state relies on it
Trauma and burn	Minnesota's first and largest Level I trauma center for adults and children and a verified burn center; 40 percent of trauma and burn patients come from other counties.
Transfers	More than 2,100 patients in 2025 from 130 facilities, 109 of them outside Hennepin County.
Training	24 programs of its own and 277 residents and fellows, about 31 percent of Minnesota's physicians in training.
Behavioral health	About 10 percent of discharges but about 24 percent of hospital bed days.

Insight from the consultations

Every group consulted so far described a resource no one else could fully replace if Hennepin Healthcare were to close or significantly reduce capacity. Ambulance leaders said patients from 85 of 87 counties arrive by ambulance; other Twin Cities systems said they already run at capacity; clinic leaders said uninsured patients would go without specialty care. Leaders of other systems suggested some low volume services could move to systems with room.

2.2 Ownership: Who Owns It

Hennepin County owns the land and buildings and leases them to Hennepin Healthcare System, Inc., the public corporation that runs the hospital, under a lease renewed in late 2025. It holds the bonds for the system's major buildings and receives its assets if the corporation ends. The county may dissolve or reorganize the corporation, but since 2026 only after sustained financial distress, mediation and failure to agree.

2.3 Governance: Who Decides



Figure 2.1. Authority over Hennepin Healthcare since 2005. The corporation was not dissolved in 2025; the commissioners became its board (Minn. Stat. 383B.908, subd. 7).

The county is the corporation's only member and holds 22 powers covering almost every major decision. Five of these powers decide who controls the hospital, and Table 2.1 shows where each sits today. The board, not the county, hires and removes the chief executive. Partners in the consultations said it is often unclear whether they are dealing with the county or the system; these five powers are the answer. Chapter 3 compares how other public owners hold them.

Table 2.1. Five powers that decide control, and who holds them today

Power	Who holds it today
Appoint the board	The county: two commissioners directly, the rest by approving a slate nominated by a board committee. At least 75 percent of the other seats need relevant expertise.
Remove directors	The county, for cause; and the whole board by a two thirds vote, since 2026 only after sustained distress, mediation and failure to agree. It used this power on August 12, 2025.

Power	Who holds it today
Approve the budget	The county, which since 2026 must approve it as presented unless the system is in sustained financial distress.
Approve the chief executive	No one outside the board.
Approve borrowing	The county, for borrowing on county credit. The law does not bar the corporation from borrowing, but it has no credit, major assets or dedicated revenue of its own.

The county's proposal for 2027 to 2029

Hennepin County is developing a proposal for its support of, and relationship with, Hennepin Healthcare in 2027 to 2029; the County Board is expected to act on it in December 2026. Because the proposal is not final, its terms are not described here.

Insight from the consultations

Union representatives in the organized labor session recalled a clear chain of command under the county and an independent board that felt out of reach, and asked for a labor seat on the new board. Clinic leaders asked that patients and community providers have a voice. Ambulance leaders asked for financial expertise and a board that answers to both the Legislature and the County Board. Leaders of other hospital systems said no nonprofit would partner with the hospital while a second layer of governance can override the hospital board's decisions.

2.4 Accountability: What the Public Can See

Minnesota's open meeting and public data laws apply, but the board may close a meeting on its own judgment that openness would cause competitive harm, and decides which business data stays private. An independent firm audits the system; the State Auditor has no role. The quarterly reports to the Legislature added in 2026 end after fiscal year 2027, and the health services plan the county approves was last approved in 2016.

2.5 Financing: How It Is Paid For

In 2025, its most recent audited year, Hennepin Healthcare lost approximately $40 million before pension actuarial impacts on operating revenue of $1,536 million, a margin of minus 2.6 percent, and held less than 2 days of cash, with a $185 million pension liability and $188 million of debt, most of it owed to the county for county bonds. It has lost money in 74 percent of years since 2007. Most of its business is government paid, and its largest supplemental payment is already falling (Figure 2.2).

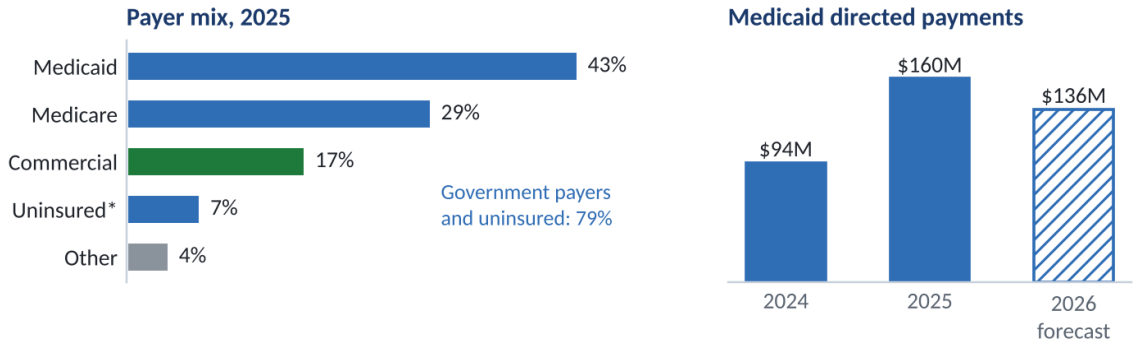

*Figure 2.2. Payer mix and Medicaid directed payments. *Uninsured is derived from the system's figure of 79 percent for Medicaid, Medicare and uninsured together. As presented.*

Source of public money	Amount	Can it be counted on?
County subsidy	$71.1 million (2024, audited): $38.0 million unpaid care, $33.1 million buildings	Set each year under a county formula the county can change
State support	About $105 million (2026), $100 million (2027)	One time
State support	$500 million available in a reserve account that Hennepin Healthcare can draw on if in financial distress begining in July 2027, through June 2031	Only in distress, after State certification and legislative review (see 2.6)
Medicaid directed payments	$160 million (2025); the system pays the State about $100 million a year to draw them	Falling under the federal cap set by H.R. 1 (2025); see the box below
340B drug discount	$99.7 million net (2024)	Depends on federal rules and on how it qualifies; see the box below
A tax set aside for it	None; 2026 county sales tax proposals were not enacted	Not applicable

Three features set Hennepin Healthcare apart from most public hospitals in the national scan: it has no tax set aside for it; no bonds, credit rating, major assets or dedicated revenue of its own; and almost no cash cushion. Its cash on hand fell to about one day at the end of 2025 and below zero in early 2026 before the State's payments lifted it to about 33 days (unaudited). The five year forecast presented at Meeting 3 assumes $38 million a year from the county and no further state money, and still shows the margin below 2 percent from 2028, as H.R. 1, the 2025 federal budget law, removes an expected $450 million through 2030 and directed payments fall about 10 percent a year (as presented).

Maintaining eligibility for federal programs

Directed payments ($160 million in 2025) and 340B savings ($99.7 million in 2024) together exceed $250 million a year. Neither requires public ownership: private nonprofit hospitals can qualify for 340B, as many in Minnesota do, and can receive directed payments. But public status is Hennepin Healthcare's present route to both: it qualifies for 340B as a government owned hospital, and it pays the nonfederal share of its directed payments through an intergovernmental transfer, which only a government entity can make. State law protects that status (Minn. Stat. 383B.927); an option that changed it would need another route to both, or would need to replace the money.

Insight from the consultations

Most participants placed the main causes of Hennepin Healthcare's financial challenges outside the system: public programs that pay below cost, rising levels of uncompensated care and no payment for round the clock readiness. Union representatives also pointed to unused space and management layers, and leaders of other systems asked why directed payments are not sufficient to close the Medicaid gap. Across groups, participants called the 2026 money a stopgap and said a statewide resource needs ongoing statewide funding.