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Meeting Summary

Advisory Task Force Meeting 4 | Thursday, November 5, 2026

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

Meeting	Meeting 4 of the Advisory Task Force (afternoon session)
Date and format	Thursday, November 5, 2026, approximately 1:00 p.m. to 5:00 p.m. Central Virtual meeting, 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
Source	The meeting transcript, read against the presentation slides shown at the meeting

1. Purpose of This Summary

This document is the Laurel Health Advisors summary of Meeting 4 of the Advisory Task Force on Governance and Financing of Hennepin Healthcare System, Inc. It summarizes what was presented, the main themes of member discussion, where the Task Force signaled direction, and the follow up actions the meeting generated. Presentations are summarized briefly; the slides are, or will be, available on the Task Force website.

Meeting 4 was the last meeting devoted mainly to gathering information and the first devoted to active discussion of possible recommendations. Hennepin Healthcare presented on its teaching and research mission, its workforce, and a framework for describing its safety net role. Laurel Health Advisors presented the findings of the national scan and an update on the public consultations. The Chair then tested eight types of recommendations drawn from conversations with members, and members gave direction on each.

> **What this summary is not**
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> Nothing in this document is a recommendation, a finding, or a legal opinion. The Chair stated at the meeting that the recommendation discussion reflects no decisions of the Task Force, and that the degree of agreement on each idea had not yet been tested. Where this summary says members "supported" an idea, it records direction given in discussion, not a vote.
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> Figures presented by Hennepin Healthcare are recorded as presented and have not been independently verified by Laurel Health Advisors (see Section 16).

2. Meeting at a Glance

Meeting	Meeting 4 of the Advisory Task Force.
Date and time	Thursday, November 5, 2026, approximately 1:00 p.m. to 5:00 p.m. Central
Format	Virtual, open to the public.
Chair	Jan Malcolm
Attendance	The Chair confirmed at the opening that all Task Force members were present.
Presentations	• Teaching and research at Hennepin Healthcare: Dr. Meghan Walsh, Chief Academic Officer and President of the Medical Staff • The Hennepin Healthcare workforce: Rachel Dunnette, Chief Nursing Executive • Length of stay and a framework for the safety net role: Dr. Dan Hoody, Chief Medical Officer • National scan findings: Dr. Yael Harris, Laurel Health Advisors • Public consultation update: Dr. Yael Harris, Laurel Health Advisors • Toward recommendations: Jan Malcolm, Chair
Next meeting	Thursday, November 19, 2026. Scheduled as virtual; the Health Subcabinet may poll members by email on a hybrid meeting option.

3. What Meeting 4 Established

The meeting closed the information gathering phase and opened the recommendation phase. Three things stand out. First, Hennepin Healthcare offered a three part framework for describing its safety net role, and members broadly welcomed it as a way to define and measure the public mission. Second, the national scan placed Hennepin Healthcare in the middle of its peers on structure and at the edge on financing: it has no dedicated tax, no credit of its own, county support set each year, and state support that is one time only. Third, the Chair set out eight types of recommendations and members gave direction on most of them, with

the strongest agreement on Medicaid payment, on defining the public mission, and on pairing any new support with clear accountability.

Theme	Takeaway
Teaching and workforce	Hennepin Healthcare described itself as a statewide training resource. About 850 medical students and more than 800 residents and fellows train there each year, and it reported turning away hundreds of training requests. Federal medical education payments do not cover the cost of training in a high Medicaid setting.
Safety net framework	Hennepin Healthcare grouped its safety net role into three categories: established regional assets, less visible specialty access, and care for patients with complex needs across specialties. Members generally supported building on it.
National scan	Hennepin Healthcare is typical in most governance features but differs in two: the county may remove the whole board in one vote, and the 2026 budget rule. It differs most in financing. Protections elsewhere carried over only where a law or lease required them.
Public consultations	Nine of the ten statutory areas had been heard by October 28, 2026. The strongest shared messages: Hennepin Healthcare is a statewide resource, payment does not cover the cost of care, and people want clear lines of authority and a voice.
Direction on recommendations	Members supported defining the public mission, raising Medicaid payment toward cost for efficient providers, treating Hennepin Healthcare as broader than a one county responsibility, exploring partnerships, and making accountability explicit. Members were wary of narrowing services but asked that the option be analyzed.

4. Where the Task Force Landed

The Task Force made no formal decisions at Meeting 4. The table records the direction members gave so that it can be carried into the Chair's working paper and the report. Each entry is direction heard in discussion, not a vote.

Subject	Where it landed	Basis in the source
Define the public mission	Define what the Task Force means by public mission, safety net and public goods; quantify each wherever possible; build on the three category framework Hennepin Healthcare presented.	General support; the Chair stated the Task Force will keep working in this direction.
Medicaid payment	Pursue a recommendation to raise Medicaid payment to a level at which efficient providers at least cover their costs, so payment is never a barrier to serving the population.	Broad support. No member argued against it when the Chair invited objection.
A statewide asset	Hennepin Healthcare is broader than a one county responsibility; funding, governance and possibly organizational form should evolve to reflect that. Financial risk and governance should be directly aligned; a funder should have a governance role.	Directional agreement, with reservations from two members on unique state funding for Hennepin Healthcare alone.
Narrow the services or grow	Little support for narrowing services to a core. Members asked that the narrower option and its consequences still be analyzed so the report shows it was considered.	Stated by several members; not settled.
Partnerships	Explore partnerships consistent with the public mission in depth: the University of Minnesota, other trauma centers, other tertiary hospitals, and other public systems.	Broad support; no specifics yet.
Accountability and authority	Any case for added funding must come with explicit, ongoing accountability for operational, financial and quality performance, paired with the operational authority to deliver it.	Raised by one Task Force member, supported by three others; the Chair agreed it should be stated explicitly.

5. Opening

The Chair welcomed members and the public and described the meeting as the close of the data gathering phase and the start of the discussion of recommendations. The Chair recalled that the previous meeting began to articulate principles on governance: the need to align financial accountability with governance, and the need for clarity on the mission and on what a strong board needs to guide the organization with more flexibility in a fast moving health care environment.

6. Hennepin Healthcare: Teaching and Research

Dr. Meghan Walsh, Chief Academic Officer and President of the Medical Staff, presented Hennepin Healthcare's role as a teaching health system and as a statewide training resource.

- **Workforce need.** Health care professionals are unevenly spread across Minnesota, and where clinicians train influences where they practice. Alongside the dedicated rural residencies other Minnesota systems are building, Hennepin Healthcare builds month long rural rotations into its existing residencies in partnership with Sanford Bemidji.
- **Scale.** Each year about 850 medical students and more than 800 residents and fellows train at Hennepin Healthcare, along with nursing, emergency medical services and allied health learners. It reported declining hundreds of training requests in the last year because clinical education is limited by faculty, supervision and patients.
- **Retention.** In 2025, 70 percent of graduating residents and fellows stayed in Minnesota.
- **Research.** The Hennepin Healthcare Research Institute, a subsidiary, supports National Institutes of Health funded research and works with state and county partners to evaluate how public programs reach people.
- **Financing.** Hennepin Healthcare received about $55 million in 2025 in federal and state graduate medical education funding and grants, against expenses that reach nearly $90 million a year once faculty, administration and clinical infrastructure are included. Federal payments rest on Medicare patient volume, which disadvantages hospitals that serve mostly Medicaid patients.

Dr. Walsh asked the Task Force to recognize health workforce education as a public good rather than a cost borne by individual hospitals, to protect existing clinical training infrastructure because it is very hard to rebuild once lost, and to consider sustainable state investment that lets Hennepin Healthcare maintain and expand training, including rural partnerships.

7. Hennepin Healthcare: Workforce

Rachel Dunnette, Chief Nursing Executive, described the workforce and how it is managed.

- **Size and representation.** More than 7,400 employees, including about 1,700 nurses, 900 providers and 400 emergency medical services personnel. About 63 percent are represented by unions.
- **Staffing productivity.** Using the Vizient Operational Database of more than 800 hospitals with a customized comparison group, Hennepin Healthcare staffs at about the 39th percentile, where lower means more productive. Other metro hospitals commonly target the 40th percentile or below.
- **Position control.** A targeted rather than blanket approach. Five clinic specialties closed toward the end of 2025, and overtime and contract labor are being held down.
- **Turnover.** Voluntary turnover is 9.42 percent against a national benchmark of about 18.5 percent; voluntary nursing turnover is 8.07 percent against about 17.6 percent nationally.

8. Hennepin Healthcare: Length of Stay and the Safety Net Framework

Dr. Dan Hoody, Chief Medical Officer, answered questions from the prior meeting on length of stay and then presented a framework for making the safety net role visible.

Length of stay

- Using Vizient data adjusted for clinical complexity, Hennepin Healthcare's length of stay index falls within the range of large safety net peers for medical and surgical patients and has generally improved since 2022. The adjustment does not capture housing or placement barriers.
- Days beyond the geometric mean length of stay have an annualized financial impact of about $75 million. This is a measure of impact, not an amount that could be removed from the budget. Each occupied bed is also a bed unavailable to the next patient, including transfers from elsewhere in Minnesota.

Three categories of safety net responsibility

Category	What it covers	Evidence presented
Established regional assets	Trauma, burn and hyperbaric medicine: specialized capabilities referring hospitals depend on	About 44 percent of trauma, 63 percent of burn and 52 percent of hyperbaric patients came from outside Hennepin County.
Less visible specialty access	Behavioral health, addiction medicine and dentistry, where Hennepin Healthcare carries a large share of the practical access burden	About 42,000 behavioral health clinic visits a year. Medicaid covers about 40 percent of behavioral health and nearly three quarters of addiction medicine visits. Several programs have waits of months or have closed to new referrals.
Complex needs across specialties	Common services delivered to patients whose housing, behavioral health, language or transportation barriers change what care requires	Among Medicaid Integrated Health Partnership adults, about 20 percent need an interpreter (about 6 percent in the comparison group), and more than half live in deep poverty.

Dr. Hoody said these costs fall outside the traditional definition of uncompensated care: a patient can have insurance and still need resources that payment does not recognize, and current risk adjusters do not capture the social complexity. If Hennepin Healthcare stopped or limited these services, the need would remain, and patients could face longer delays and more emergency and inpatient care. The framework as presented does not yet include two further benefits that could be added: the workforce trained in these settings, including graduates who choose rural practice and reduce rural spending on temporary staff, and the downstream costs that timely access avoids. Hennepin Healthcare hopes further analysis can quantify these incurred costs to inform a long term funding mechanism.

9. Member Discussion of the Hennepin Healthcare Presentations

The Chair thanked the presenters. Members heard that the presentations inform the Task Force's public good concept and the cost of the value Hennepin Healthcare provides, and that Hennepin Healthcare is recording members' questions so that it can respond. The Chair invited members to send further questions and said the Task Force will keep a "parking lot" of questions for further data or research (see Section 14).

- **Efficiency.** Members noted that staffing below the 40th percentile, read with case mix and length of stay, points to an efficient operation, and asked for comparable measures for teaching faculty. Dr. Hoody answered that the medical group is at about the 50th percentile in aggregate on a physician group benchmark.

- **Hard to replace.** Members stressed that training capacity takes years to rebuild once lost and pointed to further functions located at Hennepin Healthcare, such as toxicology, the medical examiner and mass casualty readiness. Dr. Hoody said the framework is not all inclusive and that, if it resonates with the Task Force, Hennepin Healthcare will add specialties and begin to quantify the unreimbursed incurred cost.
- **Funding for medical education.** Asked whether the teaching funding problem is unique to Hennepin Healthcare, Dr. Walsh said every teaching hospital struggles, but safety net hospitals have less patient care revenue to subsidize education. Dr. Walsh named the state Medical Education and Research Costs program, legislative work on a Medicaid graduate medical education strategy, and state grants for specific residencies and fellowships as current funding streams.
- **Sponsoring programs.** Asked by the Chair, Dr. Walsh said sponsoring its own programs costs more because Hennepin Healthcare carries the full accreditation infrastructure, but it lets the programs reflect the mission and yields high retention. Hennepin Healthcare keeps a pediatric dentistry residency that the University of Minnesota has scaled back significantly. Without it the metro would lack capacity.
- **Further questions.** Members also asked about the cost of the dental service line for insured patients with complex needs, the budget effect of recent service reductions, and whether benchmark comparisons are made with like institutions. Hennepin Healthcare will respond to members.

No member raised questions on the workforce presentation. The Chair said the Task Force would return to the framework during the recommendation discussion.

10. National Scan Findings

Dr. Yael Harris presented the findings of the national scan. The scan compares Hennepin Healthcare with 25 public hospital systems, including Regions Hospital in Saint Paul, each owned or controlled by a government at some point since 1990, each serving a high share of uninsured and Medicaid patients, and each training many physicians. It gathers the same 52 facts for every system from primary sources such as laws, leases and audited financial reports. Dr. Harris stressed that the scan describes how systems are set up and does not evaluate performance, and that it offers options rather than recommendations. The Chair added that the scan is an input and a resource, not something that will dictate the recommendations; its greatest use will come once the Task Force settles on recommendations and looks back to see how similar choices worked elsewhere.

What the scan found

- **Structure.** The 26 systems range from a government department to a private nonprofit; none was sold to a private system. Hennepin Healthcare is a public corporation, the most common setup, but two systems with the same label can divide powers very differently.
- **Services carried over where required.** Where a hospital changed its structure, trauma, uncompensated care and training continued when a law or lease required them; at Regions after 1994, trauma, burn and teaching services were conditions of the change.
- **Transitions take time.** Changes took from about 9 months (Boston) to about 32 months (Denver) to take effect; Hennepin Healthcare's 2005 change took 19.
- **Ownership.** Hennepin County owns the land and buildings, and Hennepin Healthcare runs the hospital under a lease. In 17 of 26 systems a government still owns the land.
- **Transparency.** Hennepin Healthcare follows open meeting and public records rules in part, and its board may close a meeting when openness would harm it competitively. Elsewhere meetings close only for reasons listed in law.

- **Financing.** Hennepin Healthcare has no tax set aside, no bonds or credit rating of its own, county support set each year under a formula the county can change, and state support that is one time only. Others make support dependable through a minimum in law, a voter approved tax with an end date, a minimum in state Medicaid payments, or a multiyear contract.
- **Public status and revenue.** Hennepin Healthcare pays about $100 million a year as the nonfederal share of Medicaid supplemental payments, and the 340B program brought $99.7 million in 2024. Neither requires public ownership, but any change in legal form, owner or operator would need to specify how 340B and Medicaid public hospital status are kept.
- **Governance.** Hennepin Healthcare is typical in most respects but differs in two: the county can remove the entire board in one vote, which it did on August 12, 2025, and since 2026 only under defined conditions; and the 2026 budget rule.

Questions and discussion

- **Comparison systems.** Dr. Harris clarified that Cook County Health is a county system supported by county property tax, directed payments, disproportionate share payments and its own Medicaid health plan, and that the City and County of Denver does not approve Denver Health's budget, with public money coming from a flat city payment and a voter approved sales tax. Both systems draw patients from across their states.
- **Structural or financial outlier.** One member suggested that Hennepin Healthcare is not a structural outlier but is a financial one. Dr. Harris agreed with the description and said that which problem is primary is for the Task Force to decide, and that both need to be addressed.
- **State support elsewhere.** Members asked how other states support comparable systems, including direct state subsidies, provider fees, dedicated taxes and military funding, and the Chair asked whether other states have grappled with what the state should do when a city or county asset serves the whole state. Dr. Harris committed to follow up.

11. Public Consultation Update

Dr. Harris summarized emerging themes from the first ten consultation sessions, drawn from anonymized session summaries in which comments are attributed to groups, never to individuals. The themes are not positions of the Task Force, and further sessions will add to them. Every group was asked the same core questions about Hennepin Healthcare today and its future, plus questions written for its vantage point. Sessions were recorded only to verify notes, summaries were sent to each group to confirm accuracy, and recordings are then deleted.

Coverage

By October 28, 2026, at least one session had been held for nine of the ten statutory areas. Consumer and patient advocates with safety net experience are scheduled for Monday, November 9, 2026. State legislators met once, with a second session scheduled for Thursday, November 12, 2026, and several commissioners have been consulted. Sessions with Hennepin Healthcare staff and with former leaders and board members, which fall outside the ten areas, are also part of the program.

Themes heard most widely

- **A statewide resource no one else could absorb.** Trauma, burn, hyperbaric medicine, the poison center and disaster readiness. Other hospitals already run at or near capacity. Ambulance leaders reported patients arriving from 85 of Minnesota's 87 counties since 2024. Rural participants rely on Hennepin Healthcare for burn care and the physicians it trains.

- **Beds are full and patients have nowhere to go.** The binding constraint is beds, not trauma capability. Long stays for people in behavioral health crisis or without housing are statewide and trace to too few post acute, group home and mental health beds.
- **Payment does not cover the cost of care.** Every group agreed. Many called Hennepin Healthcare the "canary in the coal mine" for pressures reaching other hospitals. Several groups said a statewide resource is funded largely by one county. The most cited remedy was Medicaid payment that covers cost for every hospital.
- **Clear lines of authority and a voice.** Partners often cannot tell whether they are dealing with Hennepin County or Hennepin Healthcare. Hospital and physician groups said politics makes partnering hard; workers and nurses recalled a clearer chain of command under the county and warned against a board out of reach. Suggested board voices included labor, community health centers, patients, clinical leaders and financial expertise.
- **Keep it public, open and staffed.** Labor, nurses and clinics asked that Hennepin Healthcare stay public; others asked that care for the uninsured and public health stay public whatever the structure. Workers and nurses asked for open meetings and department level budget and staffing data, while hospitals and physicians said boards need some confidentiality. Turnover is driven by uncertainty, and nearly every group asked that staff and training be protected through any change.

Where groups disagree

- **Drivers of losses:** mainly reimbursement (clinics, the policy observer, one urban hospital sitting) or reimbursement plus internal costs such as staffing, space, supplies and management layers (labor, rural and urban hospitals, nurses, some legislators).
- **Scope:** keep all services (clinics, physicians, nurses) or define a core around trauma and burn and let others take lower volume programs (urban and rural hospitals).
- **Transparency:** open meetings and published data (labor, nurses) or candid closed deliberation with public accountability for results (urban hospitals, physicians).
- **Who decides:** the county with a board within reach (labor, nurses) or a state role with clinical and expert input (clinics, hospitals, physicians). Legislators differed on pace: some want decisive action in 2027, others a clearer picture first.

Dr. Harris described how findings are compiled: a summary of each session, a numbered public record, and a chapter of the report that will integrate the remaining sessions. The Chair said all session reports, once reviewed by each group, will be available to members.

Questions and discussion

- Members asked what cost savings Hennepin Healthcare has made, whether they worked, and which were temporary and which sustainable. The Chair placed the question in the parking lot to return to.
- A member asked whether the findings could be separated by which board was meant, the County Board or the Hennepin Healthcare board, since the two are currently the same people. Dr. Harris said the nurses were speaking of the hospital board and departmental clarity, and that partners' comments reflect the need to distinguish the two boards, whether anyone sits on both, and which holds which power.

12. Toward Recommendations

The Chair presented a reflection of conversations with members and discussion from earlier meetings, stressing that it does not reflect any Task Force decisions. The Chair will turn the discussion into a written

working paper for members the week of November 9, 2026. Ideas were captured on a shared virtual whiteboard during the discussion.

The policy context

The Chair framed several macro issues that shape the recommendations without being the Task Force's to fix: whether health care is treated as a market commodity, a right or a necessary public function; a financing system built piece by piece over decades, like a Jenga tower now losing pieces; risk pools that have grown more fragmented, leaving no one with an incentive to fund safety net and public goods functions; uncompensated care that will keep growing and fall unevenly; costs outside hospitals' control, including extended unreimbursed stays and input costs for equipment, information technology, drugs and labor, often from highly profitable suppliers; and a statewide system so interdependent that if Hennepin Healthcare reduces services, the choice is whether to preserve that access elsewhere or let the care go undone. The Chair expects the report to describe these forces, and members will be able to edit the draft.

The eight types of recommendations

No.	Type of recommendation as the Chair framed it
1	Define the public mission, safety net and public goods, and set an explicit strategy to support those functions, which the market is not built to deliver. Some changes will be specific to Hennepin Healthcare; others would benefit all providers.
2	Raise Medicaid payment to a level at which efficient providers at least cover their costs. This would also free hospital community benefit dollars now consumed by Medicaid underpayment.
3	Recognize Hennepin Healthcare as a critical statewide asset, with funding, ownership and governance to match: structural change to the organizational form, ongoing state support from a broader base, and governance that reflects the broader funding.
4	One path: narrow Hennepin Healthcare to an essential core that would still need public support. Downstream costs would fall on others.
5	The other path, heard more often: Hennepin Healthcare, or a network of public providers, does more, including filling gaps such as step down capacity and expanding health workforce development, since the state lacks a robust workforce plan.
6	Explore partnerships consistent with the public mission: coordination among trauma centers, the relationship with the University of Minnesota, other public systems such as the state's direct care and treatment programs and the Veterans Affairs health system, and service line coordination with other tertiary hospitals.
7	Make the financial model more sustainable: collaborations that improve cost structure, higher Medicaid rates, more medical education funding, a larger statewide uncompensated care pool.
8	Explore new revenue sources and tax policy for equity and sustainability, with the caveat that health care is already unaffordable for public and private payers, and look for offsetting savings through greater efficiency.

Member discussion by type

Defining the public mission. Members agreed this is the right place to start. Members suggested "public mission" as the umbrella term, since teaching and readiness reach beyond what "safety net" usually means and much of Hennepin Healthcare's strength is having all of these functions in one place. Views on how to define the safety net varied: as a place people can go when they have no other option; by continuity and an obligation to care for patients, as distinct from the emergency care every hospital must provide; by the population served and the goal of reducing disparities; or by a quantified measure such as payer mix, because many hospitals call themselves safety nets and Hennepin Healthcare is not the only one in the state. Members generally supported adopting and building out the three category framework Hennepin Healthcare presented, and Hennepin Healthcare offered data to help build a measure of patient complexity.

Medicaid payment. Members broadly supported this direction, and one member called payment the simplest and most equitable lever. Members asked that the report separate what requires federal action from what the Legislature can do, show that partial progress toward a target would still matter, and consider tying part of any increase to outcomes for the Medicaid population. Members also noted that a statewide payment recommendation and recommendations specific to Hennepin Healthcare are not either or, that addressing underpayment should ease cost shifting to private insurance premiums, and that investment in prevention and public health partnerships would keep costs created elsewhere from falling on the hospital alone. The Chair noted that the Task Force must plan on H.R. 1 as enacted, and that recommendations on desirable federal changes, such as outdated federal graduate medical education policy, are in bounds.

A statewide asset. Members generally agreed that responsibility for Hennepin Healthcare is broader than one county and that financial risk and governance should be directly aligned: if the state takes a continuing financial stake, it should have a governance role. One view was that the system has outgrown the county and that governance should move away from it. Two members were not ready to say that Hennepin Healthcare should receive unique state funding when other hospitals also provide trauma, burn, teaching and uncompensated care. Others responded that no single service is unique but the whole of what Hennepin Healthcare provides under one roof is, and that the population served drives its cost. The Chair clarified that the aim at this stage is directional.

Narrowing or growing. Members showed little support for narrowing Hennepin Healthcare to a core. Members noted that a Level I trauma center must offer many services and cannot easily narrow, and were wary of narrowing without a clear path for where patients would go. Several preferred partnerships to shrinking. Members nonetheless asked that every option, including downsizing and even closure, be examined so that the report shows it was considered. One suggestion was to name the gaps that drive cost, such as mental health and step down care, without assuming Hennepin Healthcare must be funded to fill them; the Chair agreed that a stronger public safety net strategy need not run through the clinical enterprise.

Partnerships. The Chair heard broad support for a deep look at relationships with the University of Minnesota, other trauma centers and tertiary hospitals, and for ways that all who benefit from these public goods share in supporting them, possibly including pay or play concepts. Asked whether the Task Force would ask other systems what they would contribute, the Chair said it is not yet at that stage, noted that a conversation between North Memorial and Hennepin Healthcare about collaboration is expected, and said capacity to fill system gaps might come through partnership with several institutions.

What is missing: accountability. Members said any case for added funding needs explicit, ongoing accountability for operational, financial and quality performance, and that accountability must come with the operational authority to act on it. Members tied this to a governance model attentive to quality as well as finance, and noted that a defined mission makes it easier to set up governance and give the board freedom to act within bounds.

13. Other Business and Closing

- **Board search.** The Task Force heard of a large number of exceptional candidates for the reconstituted Hennepin Healthcare board. The first round of vetting is nearly done and the second may begin as early as the week of November 9, 2026.
- **Governance documents.** The county and hospital staff are updating the operating and funding agreement, which expires at the end of 2026, and discussing possible bylaw changes, with the aim of being ready when the new board convenes in January 2027.
- **Term of the agreement.** The Chair reported urging the parties to the agreement to stay open to the Task Force's recommendations and not to lock in an arrangement for a long period; the three year term under discussion seemed too long.

- **Rural maternal health.** A member noted that the Attorney General recently announced a rural maternal health project, the first from a rural health stabilization fund in which Sanford made an anchor commitment under the oversight agreement for Sanford and North Memorial, as another example of a public role where the market does not provide.
- **Next meeting.** The Task Force will meet in two weeks, on Thursday, November 19, 2026, scheduled as virtual. The Health Subcabinet may poll members by email on a hybrid meeting option.

14. Parking Lot for Additional Data

Members raised a number of questions during the meeting that reach beyond what the recommendations depend on. The Task Force is building a "parking lot" of additional data that might be useful for benchmarking or for future research; the Chair and Health Subcabinet staff maintain it. Follow up that is needed now for decision making is listed in Section 15.

15. Action Register

Each action shows its basis. "Stated" means the commitment was made at the meeting. Where no date was given, none is invented.

Action	Owner	Due
Write up the recommendation discussion as a working paper for members to react to	The Chair and Health Subcabinet staff	Week of November 9, 2026
Respond to the questions members raised on the Hennepin Healthcare presentations	Hennepin Healthcare	No date stated
Add specialties to the three category framework and begin to quantify unreimbursed incurred cost	Hennepin Healthcare	No date stated
Provide the national scan follow up on how other states support comparable systems, including direct state subsidies, provider fees, dedicated taxes and military funding	Laurel Health Advisors	By email before the next meeting or at it, as the Chair directs
Integrate the remaining consultation sessions into the consultation chapter, with a summary of the full set	Laurel Health Advisors	No date stated
Make every consultation session report available to members once reviewed by the group	Health Subcabinet and Laurel Health Advisors	No date stated
Keep a "parking lot" of questions for further data or research	The Chair and Health Subcabinet staff	Ongoing
Send any further questions on the presentations to the Chair or to Hennepin Healthcare	Task Force members	Ongoing

Appendix A. How This Summary Was Produced

- **Source.** An automated transcript of the virtual meeting, read against the slides shown. Automated transcripts misspell names and garble some figures; names were checked against the Task Force roster and figures against the slides where slides were available.
- **Attribution.** Presenters and the Chair are named. Member discussion is summarized by theme and is not attributed to individual members. Consultation findings are attributed to groups only.

- **Dates.** Relative dates are converted to absolute dates: "next week" is the week of November 9, 2026; "in two weeks" is Thursday, November 19, 2026; "Monday" for the consumer and patient advocate session is November 9, 2026.
- **Accessibility.** Produced to the State of Minnesota Accessibility Standard v4.0, which adopts WCAG 2.1 Level AA: headings in order, real lists, header rows that repeat across pages, alternative text for the logo, and spacing set by paragraph formatting rather than blank lines.