INNOVATION. QUALITY. EQUITY.

Chapter 3. What Other Public Hospital Systems Show

What Hennepin Healthcare does today in each part of the national scan, how 25 other public hospital systems compare, and what that means for governance and financing

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

Date	Tuesday, November 17, 2026
Status	Third revised draft of Chapter 3 of the report, for the Chair and the Health Subcabinet
Prepared by	Laurel Health Advisors, LLC

3.1 Why the Task Force Needed a National Scan

The 2026 law asks the Task Force to "evaluate governance and ownership models of health systems comparable to Hennepin Healthcare System, Inc.", and then to recommend an ownership structure, governance and oversight, and funding, ultimately with draft legislative language. Minnesota's own record offers little to build on. Minnesota has a number of publicly owned hospitals, including (mostly fairly small) county and city hospitals run under contract by health systems and the state operated hospitals of Direct Care and Treatment, but the Legislature has changed the legal form of a major public hospital by law only twice, for the Ramsey County hospital in 1994 and for Hennepin Healthcare in 2005. The Legislature has not received a formal evaluation of the 2005 change. The national scan widens the record by showing how other states and counties have approached the questions the Task Force is currently considering.

The scan matters for three reasons. Every arrangement it describes is already in effect somewhere, so the Task Force can weigh options that have been tested. It shows that labels mislead: two systems called "public authorities" can give their governments very different powers, so the details decide who controls a hospital and who pays for it. And it shows where change carries risk, such as the months between a new law and a new structure.

3.2 The Systems Compared, and How This Chapter Is Organized

The scan compares Hennepin Healthcare with 25 other public hospital systems, including Regions Hospital in Saint Paul. Each was chosen on three criteria: at some point since 1990 it was owned or controlled by a government; it plays a large safety net role, caring for many patients who are uninsured or covered by Medicaid; and it trains a significant number of physicians. The set includes systems that changed their legal form and systems that did not, so the two models can be compared. The same 52 facts were gathered for every system, Hennepin Healthcare included, and every legal status, dollar figure and date rests on a primary document such as a statute, a lease or an audited financial statement.

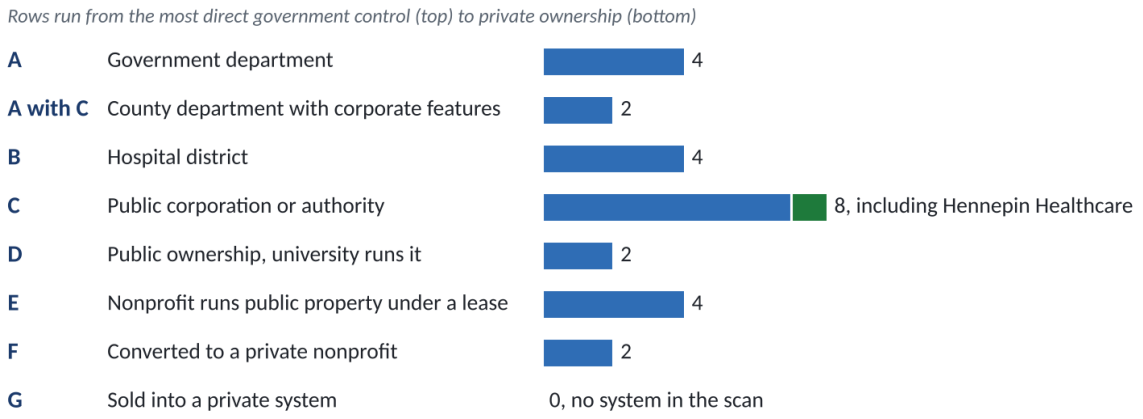

Figure 3.1. The 26 systems in the scan by organizing model. Hennepin Healthcare is shown in green under its legal form, a public corporation.

This chapter covers five of the scan's topics, called domains. Each section opens with a table that sets what Hennepin Healthcare does today beside what the scan found across all 26 systems, and then describes the findings in more detail. Identity, ownership and accountability are covered briefly; most of the chapter is given to governance and financing, the two subjects the Legislature asked the Task Force to address. Throughout, the chapter returns to a small set of systems that share Hennepin Healthcare's structure or have made a change it might consider (Table 3.1). The scan describes how systems are set up and what followed when some of them changed; it does not rank them.

Table 3.1. The systems this chapter returns to most often

System	What it shares with Hennepin Healthcare, and what it shows
Denver Health (Colorado)	The closest structural match. Like Hennepin Healthcare, a government run safety net, trauma and teaching hospital (a city department) that a state law made a public body with its own board; the change was enacted in 1994 and took effect in 1997. Since 2024 it has had a voter approved sales tax.
Erie County Medical Center (New York)	Like Hennepin Healthcare, a county hospital made a public corporation by state law (2004). The county kept the land and shares board appointments with the Governor.
Cook County Health (Illinois)	A county owned system that changed how its board is chosen, through a nominating committee named in law, without changing its owner.
Nassau Health Care (New York)	A public corporation, like Hennepin Healthcare, that fell into financial distress and is now under a state oversight board.
Harris Health and Parkland (Texas)	Large urban safety net and teaching system that has its own property tax; represents the most direct form of dedicated public money in the scan.
Regions Hospital (Minnesota)	The Ramsey County hospital in Saint Paul, converted to a private nonprofit in 1994 under six conditions written into law.

Results in the six systems

The scan also recorded what happened to access, finances and public control after each of the six systems in Table 3.1 changed its structure or faced a crisis, drawing on audits, state reviews and federal inspection findings. Two cautions apply. No public body has formally evaluated any of these changes against the goals

set when they were made. And a hospital's results depend at least as much on its patients, its public funding and federal Medicaid policy as on its structure. National quality ratings, for example, tend to be lower for safety net and teaching hospitals, which care for sicker and poorer patients, so a rating alone says little about governance.

With those cautions, the record is as follows. Colorado made Denver Health an independent authority in 1994 partly to reduce its dependence on government subsidies; three decades later it still needed public money, voters approved a dedicated sales tax in 2024, and it projected a small operating loss for 2024 (press figure). Nassau Health Care lost $78 million to $102 million a year on operations from 2021 to 2024, its hospital discharges fell by about a third from 2016 to 2024, and a 2020 consultant report to its state oversight board described its history as one of inadequate and ineffective governance; control has since moved to the State. Erie County Medical Center went from $76.3 million of county support in 2023 to none in 2024 and has budgeted an operating loss and staff reductions for 2026. Cook County Health reformed its board in 2008 and 2010 without changing its owner; under the new board it converted Oak Forest Hospital to outpatient care and enrolled 116,500 people in early Medicaid coverage, but an independent budget watchdog projects deficits for its care delivery rising to $246 million by fiscal year 2030. At Harris Health (2019) and Parkland (2011), federal inspectors found conditions that put patients in immediate danger; both corrected them through federal corrective processes rather than a change of structure, and Texas later enlarged Parkland's board to add expertise. At Regions, the conditions written into the 1994 law have held for more than 30 years: trauma, burn and teaching services continue, and licensed beds grew from 454 to 554 between 2014 and 2024.

Two patterns stand out. First, legal form alone did not decide how a system performed. The steadiest finances belong to systems with a dedicated public funding source, such as the property taxes of Harris and Parkland, rather than to any one structure. Hennepin Healthcare shows the same pattern from the other side: it has had one legal form, a public corporation, since 2007, but no dedicated source of public funding, and it has reported an operating loss in 74 percent of the years since then. Second, when finances or quality failed, the remedy came from outside the hospital's own structure: federal oversight in Texas, a state oversight board in Nassau and voters in Denver. Any change of structure the Task Force considers is therefore best weighed together with how it would be funded and how its results would be reviewed.

3.3 Domain 1: Identity and Role

The first domain asks what each system does for its region: the services it provides, the patients it serves and the physicians it trains. For the Task Force, it identifies the services that any future arrangement would need to keep, whatever form that arrangement takes. Because the systems were chosen for their safety net and training roles, they share much of Hennepin Healthcare's work; Table 3.2 shows where Hennepin Healthcare's scope is broader.

Table 3.2. Identity and role: Hennepin Healthcare and the scan

Topic	Hennepin Healthcare today	Across the 26 systems
Role	Level I adult and pediatric trauma, one of two burn centers in Minnesota, and patients from 85 of 87 counties by ambulance	25 of 26 are Level I adult trauma centers, public and private alike
Safety net	About 21 percent of Minnesota's uncompensated care	All carry a large safety net role; that was a condition of selection
Training	Sponsors its own 24 programs, about 53 residents and fellows per 100 beds	11 of 26 sponsor their own programs; elsewhere a university sponsors them

The most important lessons concern the scope of services. Hennepin Healthcare's scope is broad even among its peers: it is one of two burn centers in Minnesota, it receives ambulance patients from nearly every county, and it sponsors its own residency programs, as only 11 of the 26 systems do. In the scan, these kinds of

statewide services continued after a change in structure where the law or lease that made the change required them, not because of who owned the hospital. When Ramsey County's hospital became Regions in 1994, the Legislature made trauma, burn and teaching services conditions of the lease, and those services continue today. To be sustainable, a scope of services required by law or lease must have funding attached. A second lesson is that a new structure takes time to put in place after the law that creates it is passed (Figure 3.2). Hennepin Healthcare's own change took 19 months, and Denver Health's took about 32. During that time, everything tied to the hospital's legal entity must move without a gap: its hospital and ambulance licenses, its Medicare and Medicaid provider agreements, its trauma designation and 340B registration, and the accreditation of its residency programs.

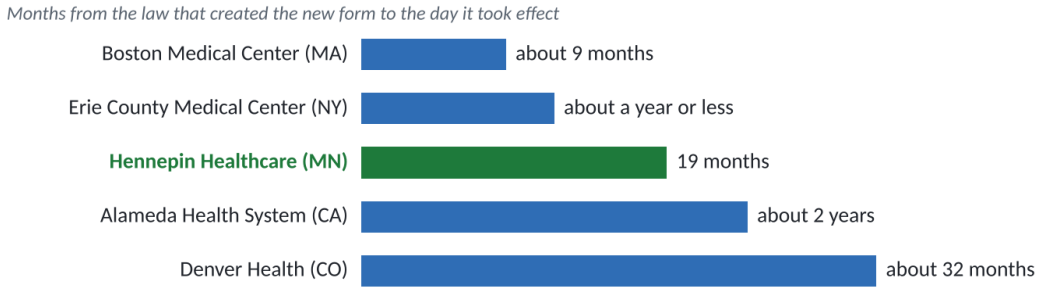

Figure 3.2. Months from the law that created a new structure to the day it took effect, selected systems.

Points for the Task Force to consider

- **Which services to preserve.** At Regions, state law made continued trauma, burn and teaching services a condition of the 1994 conversion. The same approach could protect any of Hennepin Healthcare's statewide services, whether or not its structure changes.
- **How a change would be managed while it takes effect.** Comparable changes took 9 to 32 months to take effect. The Task Force may wish to say who governs, and under what rules, until a new structure is in place.
- **What must move with the hospital without a gap.** Licenses, provider agreements, trauma designation, 340B registration and the accreditation of Hennepin Healthcare's own residency programs are tied to its legal entity.

3.4 Domain 2: Ownership and Legal Form

The second domain asks who owns the land and buildings, what law created each system, who can change or end it, and what happens to its assets if it ends.

Table 3.3. Ownership: Hennepin Healthcare and the scan

Topic	Hennepin Healthcare today	Across the 26 systems
Owner	Hennepin County owns the land and buildings; a public corporation created by state law in 2005 runs the hospital under a county lease renewed in late 2025	A government still owns the land in 17 of 26, even where a private nonprofit runs the hospital
Changing or ending it	The county may dissolve or reorganize the corporation, since 2026 only after sustained financial distress, mediation and failure to agree	No other system has comparable conditions; in Denver and Nassau, outstanding bonds block dissolution
If it ends	Land stays with the county and net assets return to the county on dissolution	Ranges from no return of assets (Boston) to a county take back of the whole operation (Alameda, from 2027)

The model's name is only the starting point. Denver Health and Erie County Medical Center share Hennepin Healthcare's model, yet Denver's city holds essentially one power, over the board, while Erie County holds a

long list of approvals and can take its land back if the hospital stops serving its mission. Hennepin County sits toward Erie's end

What happens to assets if a system ends

If the body that runs a hospital is dissolved or stops serving its mission, what happens to its land, buildings and other assets, and who receives them, varies widely (Figure 3.3). Where a government owns the land and buildings, as at Regions and Hennepin Healthcare, they never leave public ownership; the question is what happens to the operating body's own assets, such as its cash and equipment. At Boston Medical Center nothing returns to the city. At Regions the land never left Ramsey County. At Hennepin Healthcare the land stays with Hennepin County, and the corporation's net assets return to the county if it is dissolved. Denver Health's assets return to the City and County of Denver once its debts are paid; Erie County's land returns to the county if the hospital stops serving its mission; and from 2027 Alameda County may take back the whole operation. Even the strongest rules return property, usually after debts are paid; in no system do the staff move with it.

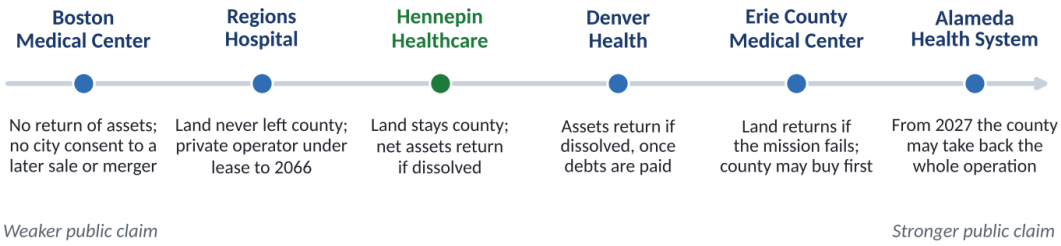

Figure 3.3. What happens to the hospital's assets, and who receives them, if the body that runs it is dissolved or stops serving its mission, selected systems.

Minnesota has written such protections before. The six conditions attached to the Regions conversion in 1994 included continued trauma, burn and teaching services, no transfer to a for profit owner without county consent, and county approval before the land is disposed of. Three of them have no direct counterpart in Hennepin Healthcare's 2005 law: continued trauma, burn, teaching and research services; county consent before any transfer to a for profit owner; and notice before a change of name.

Points for the Task Force to consider

- **How the county lease can be used as a tool of public control.** In the scan, the lease is where owners most often write service conditions, limits on sale or transfer, and what happens to assets when the lease ends or the operator is dissolved.
- **Whether to decide each of the county's powers separately.** Two systems with the same legal form can give their owners very different powers, so the form alone does not settle who controls the hospital. The Task Force could weigh each power the county holds, such as approving the budget or the sale of property, on its own merits.
- **Minnesota's example.** The six conditions attached to the Regions conversion in 1994 are a list the Task Force could adopt, adapt or set aside, one at a time.

Ownership settles who holds the hospital. The next two domains, governance and financing, settle who runs it and who pays for it, and are the center of the Task Force's charge.

3.5 Domain 3: Governance and Control

The third domain asks who sits on each board, who appoints and removes them, and which decisions the public owner keeps. These questions are urgent: a new Hennepin Healthcare board must be seated by January 15, 2027, and the Task Force must recommend a long term governance structure for the Legislature's consideration. Table 3.4 sets what Hennepin Healthcare does today beside the scan.

Table 3.4. Governance: Hennepin Healthcare and the scan

Topic	Hennepin Healthcare today	Across the 26 systems
Who appoints the board	The county appoints every director: two commissioners directly, the rest by approving a slate nominated by a board committee. No second body confirms	A government or its voters choose most of the board in 21 of 26; some add a nominating committee, split seats or confirmation
The board today	11 to 15 members by law. Since August 12, 2025, the seven commissioners have served as the board. The 2026 law requires a new board, with two commissioner seats, by January 15, 2027	Most boards have 7 to 16 voting members
Removing directors	Any director for cause; the whole board by a two thirds vote, since 2026 only after sustained distress, mediation and failure to agree. County commissioners cannot be removed by Directors.	Usually one director at a time, for a stated reason, after notice and a hearing; no other owner can remove a whole board
Approving the budget	The county approves it, but since 2026 must approve it as presented unless the system is in sustained financial distress	The owner approves it in 10, usually where it puts in money; 12 boards adopt their own budget without the owner's approval
The chief executive	Hired by the board; the county has no separate approval, although commissioners sit on the board (all seven today, two on the new board)	In 18 of 26, no one outside the board must agree
Who may serve	Two commissioners are required; as of 2026, at least 75 percent of non-commissioner seats need relevant expertise	Elected officials required in 4 systems and forbidden in 3

In most respects Hennepin Healthcare's governance is typical. It stands out in two ways: Hennepin County can remove the whole board in one vote, a power no other owner in the scan holds and one it used on August 12, 2025; and its 2026 budget rule has no counterpart anywhere in the scan.

Five powers decide who controls a hospital

Figure 3.4 shows, for each system, which of five powers its public owner (the county, city or other government) holds, rather than the hospital's own board: appointing the board, removing directors, approving the budget, approving the chief executive and approving borrowing. Appointment is nearly universal; approval of the chief executive is the rarest. Hennepin County holds three fully: it appoints the board, removes directors and controls borrowing, because Hennepin Healthcare has no credit of its own and only the county borrows for it. It holds budget approval in part, because since 2026 it must approve the budget as presented unless the system is in sustained financial distress. Hennepin County and the Board of Directors can hire and remove the CEO.

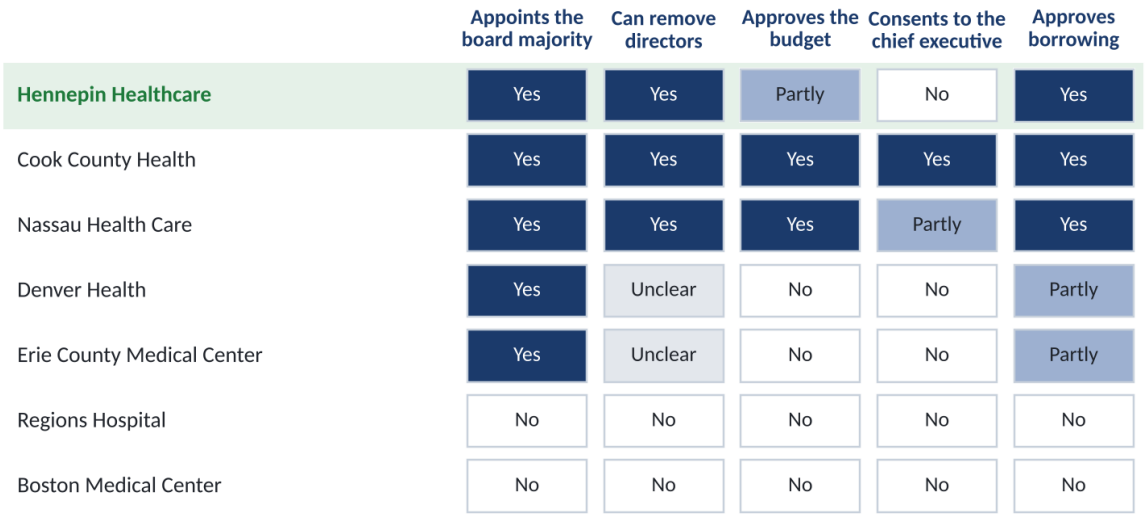

Figure 3.4. Five powers held by each system's public owner (the county, city or state that owns or created it), rather than by the hospital's own board, selected systems. Each row is a system; each column asks whether its owner holds that power. "Partly" means the power reaches only some seats, money or decisions; "unclear" means the scan could not confirm it. For Hennepin Healthcare's budget, "partly" reflects the 2026 rule that the county must approve the budget as presented unless the system is in sustained financial distress.

How the board is chosen

Hennepin County Board of Commissioners appoints Hennepin Healthcare's board (in 2026, the same individuals are acting as the County board and the hospital board), and the hospital board's committee nominates the candidates for every seat other than the two commissioner seats. Other systems give more than one body a role in choosing directors. They do it in three ways, and each could be written into law on its own: a nominating committee, seats split among several appointers, or confirmation by a second body (Table 3.5).

Table 3.5. Ways to give more than one body a role in choosing the board

Approach	Example	How it works
A nominating committee named in law	Cook County Health	The County Board President chooses each director from three nominees put forward by a 13 member committee drawn from named civic, business and health organizations.
Seats split among appointers	Erie County Medical Center; HHC Marion County	At Erie the Governor fills six of eight state seats on the county's recommendation. In Indianapolis the Mayor, the county commissioners and the council share seven seats, with a party balance rule.
Confirmation by a second body	Denver Health; Cook County Health	A council or county board confirms every appointment.

How directors are removed

As of 2026, Hennepin Healthcare's board members can be removed in four ways: the hospital board may remove a director who is not a commissioner by a two thirds vote; the county may remove a commissioner director by majority vote; the county may remove any director for cause; and the county may remove the whole board by a two thirds vote of the full county board. For other systems, the most common rule is removal for a stated reason after notice and a hearing. Some systems go further: at Harris Health only a judge can remove a member during a term, and Ohio's law for MetroHealth bars removal for political reasons. The only other time a whole sitting board was replaced was in 2025, when the New York Legislature ended every

Nassau director's term. Rules on removing board members decide how independent a board really is. Removal for cause protects directors who disagree with the appointer, while removal at any time makes the board an extension of the county rather than an independent body.

Who approves the budget, and who acts in distress

Where an owner approves the budget, it is usually because public money goes in. Hennepin County approves the budget and puts in money, but its 2026 law requires it to approve the budget as presented unless the system is in sustained financial distress. Two other systems tie control to distress differently. Nassau's law brings in a state oversight board. Since June 5, 2025, that board, the Nassau Interim Finance Authority, has approved its financial plan, contracts over $1 million, and all borrowing, during a control period triggered by events such as a missed debt payment or a deficit of one percent or more. At Grady, the hospital is owned by the Fulton-DeKalb Hospital Authority, a public body whose members are appointed by Fulton and DeKalb counties; under Georgia law, the Authority's failure to adopt a budget is grounds on which a court may remove its members. Where an owner does not approve the budget, its real influence is the money it provides: San Francisco cut its support for Zuckerberg San Francisco General by $16.3 million in an ordinary year.

Who sits on the board

The 2026 law specified that Hennepin Healthcare's new board would consist of two commissioner seats, and relevant expertise for at least 75 percent of the other seats, with up to 25 percent representing the communities and patients served. It left others open (Table 3.6).

Table 3.6. Board rules the 2026 law left open

Question	What other systems do
How long are terms, and are they limited?	From one year to six. Denver, Jackson and UNM Hospital allow two terms in a row; Alameda and Arrowhead three. Most set no limit.
Are clinicians limited or required?	Limited at Zuckerberg San Francisco General, MetroHealth and UNM Hospital; HHC Marion County requires a physician; Cambridge and Alameda reserve a medical staff seat.
Which kinds of expertise?	Cook County lists 14 areas, from finance and medicine to labor and community representation; Erie County requires the patient's view.
Is political balance required?	Only at HHC Marion County: no more than four of seven members from one party.

Where a private board governs, as at Regions and Boston Medical Center, public seats give a view of decisions rather than control over them. Commitments to the public, such as keeping certain services or limiting a sale, lasted only where they were written into the state law or the county lease that made the change.

Points for the Task Force to consider

- **Which of the five powers the owner should keep.** For each (appointing the board, removing directors, approving the budget, approving the chief executive and approving borrowing), whether the county should hold it, share it, hold it only above a set amount, or leave it to the board. The scan shows every combination in use.
- **Whether to keep the power to remove the whole board.** Hennepin County is the only owner in the scan with this power. The alternatives range from further conditions on its use to the most common rule elsewhere: removing directors one at a time, for a stated reason.
- **Whether more than one body should choose the board.** Other systems use a nominating committee named in law (Cook County), seats split among appointers (Erie County) or confirmation by a second body (Denver).
- **Who should act if the hospital is in financial distress.** The 2026 budget rule and the conditions on removing the board would need to fit together. In Nassau a state oversight board, rather than the county,

approves the financial plan, large contracts and borrowing, an approach that may be relevant if the State provides additional funding.

- **The board rules the 2026 law left open.** Terms and term limits, clinician seats, and whether workers, patients or community providers should hold seats.

3.6 Domain 4: Accountability and Transparency

The fourth domain asks what the public can see: open meetings, public records, audits and reports.

Table 3.7. Accountability: Hennepin Healthcare and the scan

Topic	Hennepin Healthcare today	Across the 26 systems
Open meetings	Applies, but the board may close a meeting on its own judgment of competitive harm; at one 2025 meeting 40 minutes were open and 140 closed	Others allow private discussion only for reasons listed in law, with a record kept and final votes in public
Records and audits	Public data law applies; the board decides which business data stays private; independent audit, no State Auditor role	Denver lists what must be public; a public auditor has a role in fewer than half
Reports	Quarterly reports to the Department of Health in fiscal year 2027, which feed a report to the Legislature due January 15, 2028; the health services plan was last approved in 2016	Erie County sends its county monthly financial reports

Public purchasing rules are the competitive bidding and contracting laws that govern how a public body buys goods and services. Civil service rules are the merit system rules for hiring, paying and disciplining public employees; they do not concern board seats. All four duties can be set one by one, and they do not travel automatically with public money (Figure 3.5). When Regions became a private nonprofit, the law repealed its open meeting and data duties; Tennessee, by contrast, extended both to Regional One, a county appointed nonprofit, through a state statute, and Shelby County's lease with the hospital also requires open board meetings. Where these duties reached a private operator, it was because a statute or the operator's lease said so.

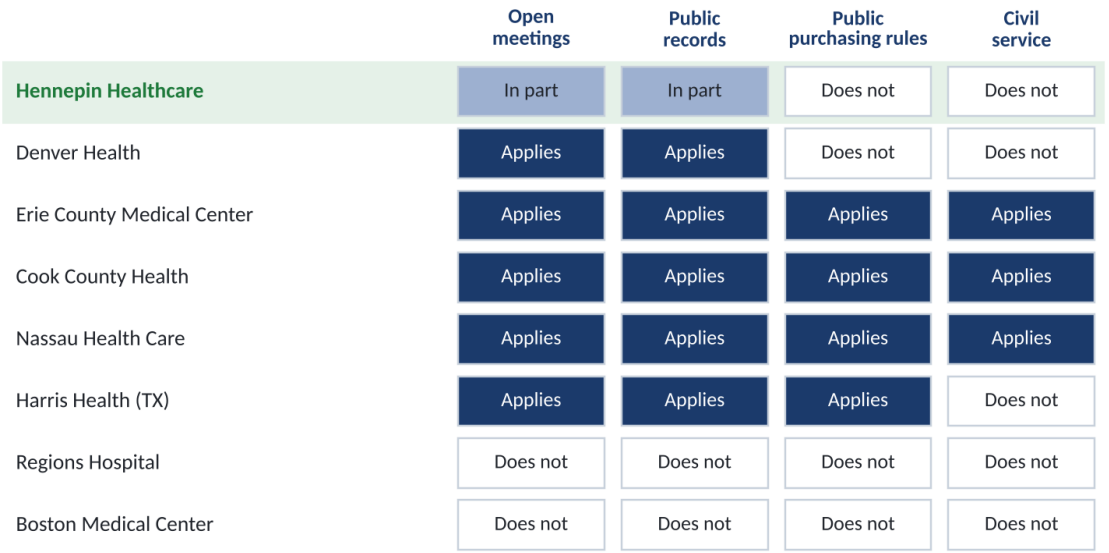

Figure 3.5. Which public accountability and transparency requirements apply to the entity that runs the hospital, selected systems.

Points for the Task Force to consider

- **When the board may meet in private.** In other systems, closed sessions are limited to reasons listed in law, with a record of each closed session and final votes in public.
- **Reporting after the 2026 law's reports.** The 2026 law requires quarterly reports to the Department of Health in fiscal year 2027 and a report to the Legislature in January 2028. The Task Force may wish to consider lasting reporting after that, and whether a public auditor should have a role.
- **Openness in any private or hybrid option.** Open meeting and public records requirements did not carry over on their own: at Regions they ended with the 1994 conversion, while Tennessee applied them to Regional One through a state statute and the county lease.

3.7 Domain 5: Financing

The fifth domain asks how each system is financed: where its public money comes from, whether that money can be counted on, who borrows for it, how much it relies on Medicaid supplemental payments and the federal 340B drug discount program. Hennepin Healthcare is financed like many public hospitals in that it depends on money from the county, and differs in that it has no tax set aside for it, and no bonds or credit rating of its own (Table 3.8).

Table 3.8. Financing: Hennepin Healthcare and the scan

Topic	Hennepin Healthcare today	Across the 26 systems
County money	No taxing power and no tax set aside for it. County support of $38.0 million for uncompensated care and $33.1 million for capital (2024), approved each year	4 have their own property tax and 7 receive a local tax set aside for them; 10 depend on a yearly decision
State money	One time only: $50 million (2026), $54.95 million (2027) and $100 million toward the nonfederal share of Medicaid directed payments (2027)	Public support is fixed only where a law, a voter approved tax or a contract sets it: own property tax (4), tax set aside (7), minimum set in law (2), minimum in state Medicaid payments (1), contract for several years (1); some systems use more than one
Borrowing	No bonds or credit rating of its own; in practice only the county borrows for it. $189.9 million of debt (2024), $154.0 million of it owed to the county for county bonds repaid through 2041	About half borrow on their own credit; in the rest the city or county borrows
Medicaid supplemental payments	Directed payments of $160 million (2025), plus more than $100 million a year in other supplemental payments; it pays the State about $100 million a year as the nonfederal share	A main source of income almost everywhere; who pays the nonfederal share varies by state
340B	Net 340B revenue of $99.7 million (2024), 2.2 times its operating loss	At least 17 of 26 take part; eligibility depends on public status or a public contract

Where the public money comes from

Every system receives public money, but by four routes (Figure 3.6). Hennepin Healthcare is in the largest group of similar systems, where support depends on a decision made each year. Hennepin County's payment for uncompensated care, $38.0 million in 2024, equaled about 2.6 percent of Hennepin Healthcare's operating revenue that year. Measured the same way, against each system's other operating revenue, regular public operating support was about 10 percent at Erie County Medical Center in 2023 (and none in 2024); about 24 percent at Parkland, 33 percent at Jackson and 62 percent at Harris Health in 2025; and roughly 8 percent at Denver Health once its new sales tax is counted (press figures). Nassau and Regions receive no regular operating support. These shares are computed from audited statements unless noted;

years differ, and systems record public money in different ways. A tax set aside for the hospital is the most common way other places have given a public hospital a predictable base. Seven systems receive one: Alameda County gives Alameda Health System 75 percent of a voter approved half cent sales tax through 2034; Denver voters approved a sales tax for Denver Health in 2024, about $70 million a year; Bernalillo County voters have renewed a property tax for UNM Hospital every eight years since 1992. Proposals in 2026 for a Hennepin County sales tax for the hospital were not enacted.

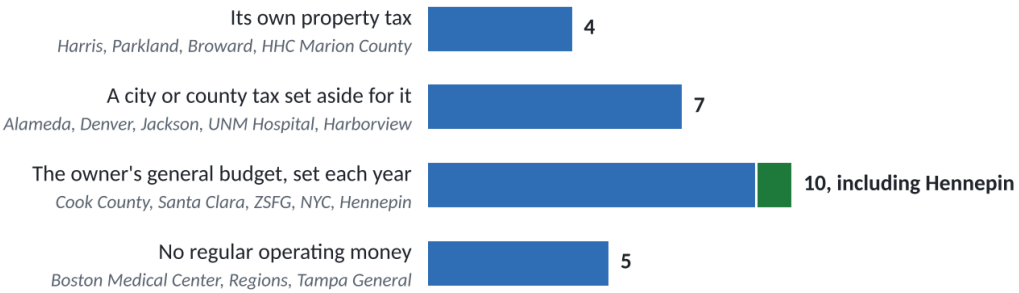

Figure 3.6. How public money reaches the 26 systems. Payments for services a government buys, such as jail health care, are not counted as support.

Whether the money can be counted on

What matters most is not the route the money takes but whether the amount is predictable. Support set by a law, a voter approved tax or a contract can be planned around; support decided each year cannot. Hennepin County has historically used a formula tied to part of the cost of uncompensated care for county residents, but approves the amount each year. The county's proposed new operating agreement would replace the formula with a dollar amount set each year in the county's annual budget, so the county's support would no longer be tied to the amount of uncompensated care the hospital provides, but to the county's budget constraints. The proposal is not final, but if adopted it would make this revenue less certain: the hospital could no longer estimate its county support from the care it gives. The scan offers tested ways to make support predictable (Table 3.9).

Table 3.9. Ways other places make public support predictable

Approach	Where it is used and how it works
A floor in law	New York requires the city to give NYC Health + Hospitals at least $175 million a year, adjusted for health care costs. Florida requires Miami-Dade County to keep its support for Jackson at no less than 80 percent of its 1991 share. Erie County must maintain its effort but with no amount: it paid $76.3 million in 2023 and nothing in 2024.
A tax with a fixed term	Alameda through 2034; University Health's levy for nine years from 2022; UNM Hospital eight years at a time. Denver's tax cannot be used to cut the city's other support.
A floor in state Medicaid payments	Massachusetts requires at least $63.6 million a year for Cambridge Health Alliance through Medicaid managed care, 2024 to 2027.
A multiyear contract	Grady's two counties pay under an agreement running from 2023 to 2029 ($69.4 million in 2025).

Who borrows, and on whose credit

Hennepin Healthcare has no bonds of its own and no credit rating, and with no major assets or dedicated revenue to pledge, it borrows in practice only through the county; its main debt is $154.0 million owed to the county for a clinic and specialty center built with county bonds (Hennepin Healthcare pays the debt service for the center, but does not own the building), and the county does not guarantee its other debt. This debt arrangement is not unusual: about half the systems borrow on their own credit, and in the rest the owner borrows for them. Among those that borrow on their own credit, Harris Health has $1.06 billion of debt,

Denver $338.9 million. Where the owner borrows, King County voters approved up to $1.74 billion of county bonds for Harborview. Some combine the two: MetroHealth borrows in the county's name but repays only from hospital revenue. Borrowing on its own credit would give Hennepin Healthcare more control of capital, but lenders look for steady public support.

Medicaid supplemental payments and who pays the State's share

Supplemental payments are paid on top of regular Medicaid rates to hospitals that serve many Medicaid and uninsured patients. The federal government pays part; the rest, the nonfederal share, must come from the state or local governments (42 C.F.R. 433.51). States raise it from their general funds, from transfers or certified spending by public bodies such as county hospitals, or from taxes on health care providers, which federal law allows within limits (42 U.S.C. 1396b(w)). Because Hennepin Healthcare is a public entity, its own transfers count toward the nonfederal share; a private hospital can contribute only through a provider tax. Hennepin Healthcare pays its own share, about $100 million a year; the State will pay it in fiscal year 2027, at a one time cost of $100 million. Other states spread the cost (Table 3.10). H.R. 1, the 2025 federal budget law, limits these payments in two ways. It caps directed payments at Medicare rates in states that expanded Medicaid, such as Minnesota, where federal rules had allowed payments up to the average commercial insurance rate, and from 2028 it reduces payments approved earlier by 10 percentage points a year until they reach that cap. It also limits the provider taxes that many states use to pay the nonfederal share. Hennepin's 2026 directed payments are forecast about $20 million lower in 2026 than budgeted, under CMS interpretation of the federal cap.

Table 3.10. Who pays the nonfederal share, and the trade offs

Who pays	Examples
The hospital itself	Hennepin Healthcare (about $100 million a year); UNM Hospital ($119.0 million in 2025); Jackson, Harris and Parkland in part **Trade off:** Needs no new public money, but the hospital pays the share from its own revenue, so the payments are worth much less than their face value.
Other area hospitals, through a local fund	Harris and Parkland run county funds that collect payments from area hospitals; Miami-Dade runs a similar fund for Jackson **Trade off:** Spreads the cost among the hospitals that benefit, but needs state authority to create the fund, and federal rules limit how payments may be returned to the hospitals that contribute to the fund.
Ownership by government entity	New York City funds nearly all of the share for NYC Health + Hospitals **Trade off:** The clearest public commitment, but it depends on the city's or county's budget each year unless an amount is fixed in law.
A statewide fee on hospitals	Ohio's franchise fee funds MetroHealth's largest payments; Minnesota authorized in 2025 a directed payment program for hospitals in Medical Assistance, funded by a new assessment on hospitals and contingent on federal approval. Because the assessment was not in effect when H.R. 1 was enacted on July 4, 2025, federal guidance indicates it may be treated as a new provider tax, which federal law and guidance no longer allows. Discussions between CMS and the state are ongoing. **Trade off:** Spreads the cost across many hospitals and draws federal matching funds, but H.R. 1 bars new or increased provider taxes from October 1, 2026, and in states that expanded Medicaid, such as Minnesota, lowers the limit on existing ones each year from October 2027 until it reaches 3.5 percent of revenue in 2032. Federal rules carrying out these limits were proposed in 2026 and are not yet final.

Who pays	Examples
Public spending certified as the nonfederal share	A public entity certifies what it spent on services and related administrative costs for Medicaid patients, and that spending counts as the nonfederal share. The entity sends no money to the state up front; instead, the federal share of the certified cost flows back to it. California public hospitals and Harborview use this method, and Minnesota law preserves Hennepin Healthcare's eligibility to use it **Trade off:** Needs no new public money and no transfer up front, but it is open only to government owned or operated providers, the provider receives only the federal share of its documented costs and never more than cost, and final payment often waits until cost reports are settled, which strains cash flow. These limits are why it is not more widely used.

The 340B drug discount and public status

For a hospital like Hennepin Healthcare, federal law ties 340B eligibility to public status: the hospital must be government owned or operated, a nonprofit given public powers, or a private nonprofit under a state or local government contract to care for low-income people, which is how many private nonprofit hospitals in Minnesota qualify. Hennepin Healthcare qualifies through its public status. Its net 340B revenue in 2024 was $99.7 million, 6.7 percent of operating revenue. Without it, Hennepin Healthcare's 2024 operating loss of $45.9 million would have been about three times larger. When Boston City Hospital became a private nonprofit in 1996, the law kept its public hospital status for all government payments. Any change of legal form, owner or operator must say how 340B eligibility and its status as a public hospital for Medicaid will be kept. That status is separate from 340B: it is what allows Hennepin Healthcare to transfer or certify its own public funds as the nonfederal share of Medicaid payments.

Points for the Task Force to consider

- **How to make public support predictable.** Options in use elsewhere include a tax set aside for the hospital, a minimum amount set in law, a tax with a fixed term and a contract for several years. A duty to support the hospital with no amount set can fall to zero, as it did at Erie County.
- **Who pays the nonfederal share of Medicaid supplemental payments.** Hennepin Healthcare pays about $100 million a year itself; the State will pay it in fiscal year 2027, and federal limits are reducing these payments, and the benefit received.
- **Keeping eligibility for 340B and status as a public hospital for Medicaid.** Together worth well over $100 million a year, both rest on Hennepin Healthcare's public status today (340B for drug discounts, Medicaid public hospital status for how it pays the nonfederal share), and any change of form, owner or operator would need to address them.
- **Who borrows for the hospital.** The hospital on its own credit, the county, or a combination, as at MetroHealth.

Taken together, the five domains show what Hennepin Healthcare does today, where it is typical and where it is unique. On governance it is typical except for the county's power to remove the whole board and its new budget rule. On financing it shares the most common arrangement, support decided each year, but it has neither a dedicated tax nor credit of its own, and its State support is one time.

Sources: national scan profiles of Hennepin Healthcare and 25 comparison systems, and their source lists; National Scan Findings, Domains 1 to 5; Minn. Stat. 383B.901 to 383B.928; Laws 2026, chapter 127; Minnesota Department of Health 340B reports. Hennepin Healthcare's directed payment figures are management figures not yet confirmed by audit.