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Consultation Questions

What the Task Force's statutory consultations will ask

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

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Source	The questions in the Consultation Facilitator's Guide, Draft 1.1, which the Health Subcabinet is reviewing. Wording may change before the first consultation.
Prepared for	Advisory Task Force on Governance and Financing of Hennepin Healthcare System, Inc., through the Minnesota Health Subcabinet.
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How the Questions Are Used

The 2026 law that created the Task Force requires it to consult people with expertise in ten named areas. Each consultation is a 90 minute virtual conversation with the people invited in one statutory area, held as a group.

Every consultation follows the same plan. It opens with questions about Hennepin Healthcare today, which are asked in every consultation. It then turns to questions written for the area in the room, and closes with questions about the future, which are again asked in every consultation. Asking every group the same core questions lets the report show where the ten areas agree and where they differ.

Not every question will be reached in every session. Questions not reached are sent to participants in writing, and written answers carry the same weight as spoken ones. What participants say is summarized in the public Consultation Ledger, with a written answer from the Task Force on what it did with the input.

Participants receive these questions in advance, together with a one page fact sheet on the 2026 law. The questions are a draft and may change after the Health Subcabinet's review. Members' comments on them go to Ana Ashby and Jan Malcolm.

Questions Asked in Every Consultation

About Hennepin Healthcare today

1. From where you sit, what does Hennepin Healthcare do for Minnesota that no other organization does, or does at the same scale? If it could no longer do it, who would pick it up, and what would be lost?
2. How do you, your organization, or the people you represent rely on or work with Hennepin Healthcare today? Think of referrals, transfers, shared patients, training, ambulance destinations, or contracts.
3. In your view, what are the root causes of Hennepin Healthcare's financial pressure? How much of it is about how the system is governed, how much is about how it is run day to day, including its operational decisions, and how much is about how it is paid? How are these connected?
4. The 2026 law did three main things for Hennepin Healthcare. It requires Hennepin County to seat a new independent board by January 15, 2027, with at least 75 percent of the members who are not county commissioners drawn from people with expertise such as hospital administration, finance, law, business or health equity. It provided one-time funding of about $705 million: $100 million toward the nonfederal share of the Directed Payment Program, $105 million in direct payments, and a reserve account of $500 million that the hospital has access to if it continues to meet certain metrics of financial distress. It also created this Task Force to recommend a long term path. What do you think that settled, and what is still unsolved?
5. Five years from now, what would tell you Hennepin Healthcare is thriving, and not just surviving? Which two or three measures would you watch?

About the future

6. Whatever the future structure, which decisions about Hennepin Healthcare should always stay in public hands, whether with Hennepin County, the State, or another public entity? If another public entity, which one? For example: appointing and removing board members, choosing the chief executive, approving the budget, borrowing, closing a major service, or selling or leasing the hospital. Which could safely be delegated?
7. What should the public be able to see about how Hennepin Healthcare is run, and who should it answer to? What reporting would you actually read and trust?

8. Here are the seven ways public hospital systems in the national scan are organized (participants are shown a one page card describing them). Which of these would you rule out for Hennepin Healthcare, and why? Which deserve serious study? What would each mean for the people you represent?
9. If ownership or governance changed, what conditions should be written into law so that patients, workers and the public are protected? What should a change never be allowed to do?
10. What would a sustainable long term financing approach for Hennepin Healthcare need to include? Who should pay, and which of today's funding sources worry you most?
11. The Task Force will test every option against five hard futures: a deep federal Medicaid cut, a recession that sharply raises uncompensated care, the loss of a supplemental or directed payment authority, a prolonged workforce cost shock (labor costs rising faster than revenue for a sustained period, for example because staffing shortages force reliance on higher cost contract labor), and a governance transition that runs long. Which of these worries you most, and is there a risk we have missed?
12. If the Task Force recommends change, what must happen first, what must not be disrupted along the way, and who should be answerable for each step?

Closing

13. If the Task Force could make one recommendation to the 2027 Legislature, what should it be, and who should carry it out?
14. Who else should the Task Force hear from, and is there any document, data or experience we should look at?

Questions for Each Area

Each area's questions are asked in the middle part of its consultation. Areas (vii) and (viii) meet together in one session. Area (x) is split into three separate consultation workstreams, with separate questions for legislators, county commissioners and state agency commissioners.

Area (i): Rural hospitals and rural health systems

1. When your patients need care you cannot provide, how often does Hennepin Healthcare take them, and what happens when it cannot?
2. If Hennepin Healthcare narrowed or closed a service line your patients rely on, such as trauma, burn or inpatient psychiatry, what would happen to your patients and to your own finances? Which other service lines matter most to you?
3. Today Hennepin County pays for a portion of Hennepin Healthcare's uncompensated care from a county budget funded in part by Hennepin County property taxes. Should care Hennepin Healthcare provides to people from outside Hennepin County be paid for differently? If support were statewide, how should it be shared so it does not disadvantage rural hospitals?
4. When a patient treated at Hennepin Healthcare is ready to move closer to home, how well do return transfers to your hospital work? Which other partnerships work well today, or could: telehealth, specialist outreach, resident rotations?
5. Should greater Minnesota have a voice in how Hennepin Healthcare is governed? If so, through what?
6. Minnesota hospitals have affiliated, merged or converted over the years. Speaking in general terms, what conditions have protected communities, and which have not held?

Area (ii): Urban, nonprofit hospitals other than Hennepin County Medical Center

1. If Hennepin Healthcare reduced volume in a service line, how much could your system absorb, in which services, and how fast?
2. Why does uncompensated care concentrate at Hennepin Healthcare? What would share it more evenly, would that be in the public interest, and how would your system view it?
3. How do you manage patients who stay too long because there is nowhere to discharge them? What would change that?
4. What financing options should be considered to help fund Hennepin Healthcare? Under what conditions should that funding also be available to other hospitals?
5. Speaking in general terms, under what conditions could an affiliation, management agreement or merger between a nonprofit system and Hennepin Healthcare serve the public interest? What should never be part of one?
6. Where should metro hospitals collaborate rather than compete: trauma, behavioral health, workforce pipeline, data?

Area (iii): Physicians licensed and practicing in Minnesota with experience in emergency medicine, trauma care, critical care, or hospital medicine

1. Which capabilities at Hennepin Healthcare, clinical and educational, would be hardest to rebuild if lost, and how long would rebuilding take?
2. What keeps patients in the hospital longer than they need to be, and what would change it? How does this compare between Hennepin Healthcare and other hospitals where you have practiced?
3. How would a change of ownership or governance affect recruiting and keeping physicians?
4. What does the teaching mission need from any future structure?
5. How should clinical leaders take part in governance, and how are clinical priorities protected when money is short?
6. Which quality measures would show the system is thriving clinically?
7. Which services is Hennepin Healthcare uniquely positioned to provide, or does especially well, that should stay there? Which could other hospitals absorb, and what would they need to do so?

Area (iv): Registered nurses

1. For nurses at Hennepin Healthcare: what has changed since the 2026 funding arrived, and what has not? For nurses at other hospitals: what changes at Hennepin Healthcare have you seen from your side?
2. If Hennepin Healthcare's owner or governance changed, what would nurses most need protected?
3. What drives nurses to stay or leave, and what would it look like from the floor if labor costs rose faster than revenue for a sustained period (a workforce cost shock)?
4. How do boarding, acuity and discharge delays affect care and staffing?
5. What should current and future staff be told about the system's long term future, and by whom?
6. How should the nursing pipeline be protected in any future structure?

Area (v): Organized labor representing hospital workers or health care workers

1. Which protections must travel with any change of ownership or governance?
2. How did the 2007 change and the 2025 removal of the board look from the workforce side? What should the Task Force learn from them?

3. What voice should workers have in governance, and what accountability measures would workers trust?
4. How can labor costs and the system's finances be balanced without destabilizing the workforce? Where could labor and management partner?
5. Which of the seven organizing models on the reference card raise the greatest risk of outsourcing or loss of public employee status?
6. From your members' experience, how does patient care at Hennepin Healthcare compare with care at other systems? What is unique and should be preserved?

Area (vi): Ambulance service providers or emergency medical services

1. How often is Hennepin Healthcare your destination, and what happens when it is on diversion or cannot take a patient?
2. How should emergency medical services operated by Hennepin Healthcare be treated under a change of ownership or governance?
3. How does the metro trauma system depend on Hennepin Healthcare, and what would change if its capacity fell?
4. What happens today with behavioral health crises in the field, and where do those patients go?
5. How do uncompensated transports and ambulance payment rates affect the system's finances?
6. During any transition, what must not be interrupted even for a day?
7. From what your crews see at handoff and afterward, how does the care patients receive at Hennepin Healthcare compare with other destinations? What is working, what is not, and what should the Task Force recommend keep or change?

Areas (vii) and (viii): Local public health departments or community health boards, and federally qualified health centers or other community clinics serving low-income patients

1. Which services from Hennepin Healthcare matter most to your patients and community, and which public health functions depend on it?
2. When your patients need specialty or hospital care at Hennepin Healthcare, how easily can they get it, and where are the barriers?
3. If Hennepin Healthcare closed or substantially reduced its services, what would be the biggest risk to your organization and the people you serve?
4. What opportunities does Hennepin Healthcare have now to serve your patients better, including how it coordinates care with community clinics and public health?
5. How will federal coverage changes show up among your patients and in your community, and when?
6. What should the Task Force use to judge whether Hennepin Healthcare is serving the community well, and how should community voice be built into oversight?

Area (ix): Consumer or patient advocates with experience accessing services from a safety net hospital

1. What is it like to get care at Hennepin Healthcare today? What works, and what does not?
2. If ownership or governance changed, what would patients fear losing most?
3. How would you like to see Hennepin Healthcare's operations and accountability be influenced by patient and community voices?
4. What are community and patient perspectives on the availability of charity care and financial assistance at Hennepin Healthcare?

5. What do patients most want to know about how Hennepin Healthcare operates? Which public reporting measures would help patients and consumers understand its services and get the care they need?
6. Which groups of patients are most at risk of being left out of any change in ownership, governance or financing, including people from outside Hennepin County?

Area (x): State legislators, county commissioners, and state agency commissioners

Legislators

1. What does the 2027 Legislature need from the preliminary report to act, and in what form?
2. What would you expect of the health system in return for ongoing public support, and should support be one time or continuing?
3. How should Hennepin Healthcare report to the Legislature, and when should the Legislature review the arrangement again?

County commissioners

1. Which powers does the county need to keep, and which financial commitments can it sustain?
2. How will the reconstituted board relate to the Task Force's recommendations, and what should the Task Force learn from the 2025 decision?
3. How should the cost of care for residents of counties other than Hennepin be shared?

State agency commissioners

1. What services does Hennepin Healthcare provide that the State relies on? What is your agency most in need of Hennepin Healthcare for, and which functions must continue?
2. What data should the State collect to monitor Hennepin Healthcare, and what elements will be most important to inform the system's sustainability and the continuation of the services the State most needs?

Follow Up Consultations

Four follow up consultations in November 2026 will test specific draft recommendations once there is draft language to react to. These questions are a working framework and will be revised once the topics of the follow up consultations are settled.

1. Read the recommendation aloud. In your own words, what would it require, and of whom?
2. Would this language do what it says? Where could it be misread or evaded?
3. Does the named body already have the power to do this, or does the language need to create it?
4. What would this cost you or your organization, and when would you feel it?
5. How would you know in two years whether this happened?
6. What happens under each of the five adverse futures?
7. Who wins, who loses, and who is left out?
8. What one change would make you support it, or oppose it less?