INNOVATION. QUALITY. EQUITY.

SCAN DESIGN MEMO

National Scan of Publicly Owned Hospital Systems

Field	Detail
Document	Scan Design Memo, Workstream 3
Document number	LHA-MN-HHS-2026-WS3-01
Version	1.0
Status	For Subcabinet approval
Prepared for	Minnesota Health Subcabinet, through Management Analysis and Development at Minnesota Management and Budget
Prepared by	Laurel Health Advisors, LLC
Delivered	Thursday, August 27, 2026
Approval requested by	Wednesday, September 2, 2026
Scan delivered	Friday, September 11, 2026
Where it lands	Report increment v0.2 and the Meeting 2 pre read package, Monday, September 21, 2026
Statutory authority	Minnesota Session Law 2026, Chapter 127, Article 3, Section 18

1 Purpose and What Approval Releases

Section 18 directs the Task Force to evaluate the governance and financing of Hennepin Healthcare System, Inc., and of comparable systems nationwide. The national scan is how the Task Force discharges the second half of that instruction. This memo is the design of that scan, delivered before any case analysis is written so that the method is fixed in public before the findings exist rather than assembled around them afterward.

That sequence is deliberate. The most common failure in a comparative study of this kind is that the case set drifts toward famous systems, or toward systems whose experience supports a conclusion someone already holds. Fixing the template, the selection rationale, and the source standard in an approved document before the research begins is the control against that drift. It also means that if the Task Force later disagrees with a finding, the argument is about evidence rather than about whether the study was built to produce that finding.

1.1 What approval does

Approval of this memo confirms three things and nothing more: that the Governance Genome field set in Section 4 captures what the Task Force needs to know about each system, that the case selection rationale in Section 5 and the resulting candidate set in Section 6 are sound, and that the source standard in Section 8 is the standard the Task Force expects.

1.2 What approval does not do

Approval commits the Subcabinet to no finding, no option, and no recommendation. This memo contains no results. It contains no assessment of Hennepin Healthcare and no view about what should happen to it. A reader looking for LHA's opinion will not find one here, because at this point in the engagement LHA does not have one and would not be entitled to it.

1.3 The window this memo controls

The scan delivers on Friday, September 11, 2026, six business days before Meeting 2 on Monday, September 21. Counting forward from an approval on Wednesday, September 2, the research window is Thursday, September 3, Friday, September 4, and then Tuesday, September 8 through Friday, September 11, because Monday, September 7 is Labor Day, a Minnesota state holiday under Minn. Stat. 645.44, subd. 5. That is six business days.

LHA has been building the Governance Genome template and collecting public source material since August 27 at its own risk, so that approval releases analysis rather than starting collection. A late approval does not move the delivery date. It compresses the analysis, which is a quality risk rather than a scheduling one, and LHA will say so in writing on the day it happens rather than at the end.

2 The Question the Scan Must Answer

A scan that asks what other public hospitals look like will produce a catalogue. A catalogue is not decision relevant. The scan is therefore built around a single operative question, and every field in the template earns its place by contributing to it.

Across publicly owned hospital systems in the United States, what governance and financing arrangements have been used, what did each arrangement change about who controls the institution and who pays for

it, and what is the observable record of how each performed against access, financial durability, workforce stability, and public accountability?

Three properties of that question shape everything downstream.

- **Arrangements, not institutions.** The unit of analysis is the arrangement, not the institution. Two systems with identical bed counts and opposite governance are two different observations. Two systems with different bed counts and the same governance are one observation seen twice.
- **Change events carry the evidence.** A description of what a system looks like today is worth much less than a description of what changed, why, and what happened next. Systems that have never changed hands are included precisely so that the changes have a baseline to be measured against.
- **The answer has to be drafted eventually.** The Task Force must recommend future structures of ownership, governance, and funding, with draft legislative language. A scan finding that cannot be traced into an option or a recommendation is interesting rather than useful, and the template is built so that every field maps to something a drafter would need to know.

3 Scope Boundary

In scope	Out of scope
General acute care hospital systems in the United States that are, or within living institutional memory were, owned by a unit of state, county, or municipal government	Federal direct service systems, including the Veterans Health Administration and the Indian Health Service, whose constraint set does not transfer
Systems carrying a safety net function: a disproportionate share of Medicaid, uninsured, and charity care relative to their market	State psychiatric, correctional, long term care, and single specialty public facilities
The full arrangement: who owns the assets, who holds the license, who appoints the board, who bears the deficit, who employs the staff	Public health departments and clinic systems without an inpatient acute care hospital
Governance and financing change events of any direction, including changes that were proposed and rejected	Small rural and critical access public hospitals, whose scale and payer mix do not support inference to a large urban academic safety net system
The observable record after a change, to the extent primary sources establish it	International comparators operating under a different payment system

The last exclusion deserves a word, because it will be raised. Public hospital governance abroad is genuinely instructive, and LHA is not claiming otherwise. It is excluded because the recommendations this Task Force must draft are Minnesota bill language operating inside Medicaid, Medicare, and the commercial payment system, and a governance form that depends on a global budget cannot be drafted into that environment. If the Task Force wants an international appendix, LHA will design one through change control and say plainly what it can and cannot support.

3.1 The line between the scan and the options work

The scan establishes what exists and what happened. It does not evaluate what Minnesota should do. The options analysis, which follows in October, is where arrangements observed in the scan are tested against Hennepin Healthcare's actual statutory, financial, and labor conditions. Keeping that line clean is what allows

the scan to be published as a factual record that a reader who disagrees with the eventual recommendations can still use.

4 The Governance Genome

4.1 Why a fixed field set

Every case is coded against the same fields, in the same order, whether or not the field is interesting for that case. This is the difference between a comparative study and a set of profiles. A fixed field set makes absence visible: when a system has no reserved powers held by its government owner, that empty cell is a finding, and it is only a finding because every other case was asked the same question.

The field set is fixed at approval. Fields are not added mid scan to accommodate an interesting case, because a field added after nine cases are coded produces a column that is empty for the first nine for reasons that have nothing to do with the systems. If the scan reveals a genuinely necessary field, LHA will say so, recode every prior case, and record the change in the source register.

4.2 The eight domains

Domain	What it establishes	Why the Task Force needs it
D1 Identity and role	What the institution is and what function it performs in its market	Comparability. A system is a comparator because of what it does, not because of what it is called
D2 Ownership and legal form	Who holds title, who holds the license, and under what instrument	This is the layer Chapter 127 can actually change
D3 Governance and control	Who appoints, who removes, and which powers the government owner kept	Where the real answer to the ownership question lives. Ownership without reserved powers is a label
D4 Accountability and transparency	Open meetings, public records, audit, and reporting	Minnesota has no deliberative process exemption. Any option that moves the system out of ch. 13 and 13D is a public accountability decision, not a technical one
D5 Financing and public support	Levy, subsidy, debt, Medicaid supplemental structures, and margin	The financing consequence of every governance choice must be explicit rather than assumed
D6 Workforce and labor	Employer of record, civil service, bargaining, and pension	The transition costs that sink conversions are usually here, and they are usually discovered late
D7 Academic and clinical affiliation	The medical school relationship and who employs the physicians	Hennepin Healthcare's teaching role is a constraint on every option, not a detail
D8 Change events and outcomes	What changed, under what vehicle, and what happened next	The only domain that carries evidence rather than description

4.3 The field specification

Fifty two fields across the eight domains: seven, six, ten, five, seven, five, five, and seven. The source tier column states the minimum evidence quality that field will be coded from; Section 8 defines the tiers.

Field	What is recorded	Min. tier
D1.1 Legal name	The name as it appears in the enabling statute or articles, not the marketing name	1
D1.2 Jurisdiction	State, and the county or municipality that owns or owned it	1
D1.3 Year established in current form	The year the present arrangement took effect	1

Field	What is recorded	Min. tier
D1.4 Scale	Licensed and staffed beds, admissions, emergency visits, with year	1
D1.5 Designated roles	Trauma level, burn, regional referral, and any statutory designation	1
D1.6 Safety net indicator	Payer mix and uncompensated care as a share of the market, with year	1
D1.7 Teaching role	Residency programs and approved positions, with year	1
D2.1 Working archetype	One of the seven archetypes in Section 5.3	2
D2.2 Asset holder	The legal person holding title to land, buildings, and equipment	1
D2.3 License holder	The entity on the hospital license	1
D2.4 Enabling instrument	Statute, charter, ordinance, or articles, cited to section	1
D2.5 Disposition authority	Who may sell, lease, merge, or dissolve, and what approvals are required	1
D2.6 Reversion and clawback	Whether assets revert to the public owner on failure or termination	1
D3.1 Board size	Authorized and seated, with year	1
D3.2 Appointing authority	Who appoints each class of seat	1
D3.3 Confirmation	Whether appointment requires confirmation, and by whom	1
D3.4 Terms	Length, staggering, and any limit	1
D3.5 Removal standard	For cause, at will, or not removable, and by whom	1
D3.6 Composition mandates	Required qualifications, constituency seats, ex officio seats	1
D3.7 Reserved powers	Powers the government owner retained over the operating entity	1
D3.8 Budget approval	Who approves the operating budget	1
D3.9 Chief executive	Who appoints and who may remove the CEO	1
D3.10 Capital and debt	Who approves capital plans and who must consent to borrowing	1
D4.1 Open meetings	Whether the governing body is subject to the state open meetings law, cited	1
D4.2 Public records	Whether the entity is subject to the state public records law, cited	1
D4.3 Audit regime	Who audits, under what authority, and where the audit is published	1
D4.4 Reporting obligations	What must be reported to the legislature or county board, and how often	1
D4.5 Procurement and civil service	Whether public procurement and civil service rules apply	1
D5.1 Levy authority	Whether the entity may levy, the rate cap, and the yield, with year	1
D5.2 Appropriation or subsidy	Amount, mechanism, and whether it is discretionary, with year	1
D5.3 Debt	Issuer, whose credit stands behind it, amount outstanding, with year	1
D5.4 Medicaid supplemental structures	Directed payments, DSH, UPL, provider assessments, with year	1
D5.5 340B	Participation, covered entity type, and documented dependency	1
D5.6 Financial position	Operating margin and days cash on hand, with year and source	1
D5.7 Reserves and stabilization	Any reserve, stabilization fund, or standing state support	1
D6.1 Employer of record	Which entity employs the workforce	1
D6.2 Civil service status	Whether staff hold civil service or classified status	1
D6.3 Bargaining	Units, framework, and the statute governing bargaining	1
D6.4 Pension	System, and any treatment applied at a change of control	1

Field	What is recorded	Min. tier
D6.5 Change of control protections	Successorship, no layoff, or wage and benefit guarantees, cited	1
D7.1 Affiliated school	The medical school and any other health professions schools	1
D7.2 Affiliation instrument	Affiliation agreement, statute, or management agreement, with term	1
D7.3 Physician employment	Who employs the attending physicians and the residents	1
D7.4 GME flow	How graduate medical education funding reaches the parties	2
D7.5 Termination	How the affiliation ends and what happens to the clinical program	1
D8.1 Change events	Each event, its type, and its year	1
D8.2 Legal vehicle	The statute, ordinance, lease, or agreement that effected each change	1
D8.3 Stated objective	What the change was said at the time to be for, quoted	1
D8.4 Observable outcome	Access, finances, workforce, and public control after the change, with the measurement window stated	1
D8.5 Community benefit instrument	Any foundation, endowment, or binding commitment created, with amount and year	1
D8.6 Contested aspects	Litigation, referendum, labor dispute, or formal objection	2
D8.7 Subsequent review	What any auditor, legislative body, or peer reviewed study concluded	2

4.4 Coding rules

- **Unknown is not the same as none.** A field with no reliable source is coded Not established, never left blank and never filled with a plausible value. Not established is a finding about the transparency of that system and is reported as one.
- **Everything carries an as of date.** Every field carrying a number or a legal status records the date it was true. A margin without a year is not evidence.
- **Contested classifications are recorded as contested.** Where the legal form is genuinely disputed, the case records both readings and the source for each rather than picking one. Governance disputes are frequently the most informative part of a case.
- **Anomalies go in notes, not in new fields.** Where a system does something no other case does, it is recorded in a free text note attached to the domain, not by inventing a field. Notes are reviewed at the end of the scan and may generate a field for the final report.

4.5 The model card

Each case is delivered as a model card of not more than four pages: a one paragraph orientation, the coded field set in a fixed table, a change event timeline, and a short section headed What this case shows and what it does not. That last section is bounded on purpose. It is where the analyst says what the evidence supports, and, in the same place, what a reader should not conclude from it. A blank model card is at the Appendix.

5 Case Selection

5.1 The comparability principle

Hennepin Healthcare is not comparable to another system because the two are similar in size. It is comparable because the two face the same structural problem: a government owner, a safety net obligation that is not fully funded by the payer mix it attracts, a teaching mission that raises fixed cost, and a governance

arrangement that has to reconcile public accountability with the operating speed of a hospital. Comparability in this scan is defined by function and constraint. Size, geography, and name recognition are not selection criteria and were not used as ones.

5.2 Five selection criteria

#	Criterion	Why
1	Public ownership at some point, by a state, county, or municipal government	The scan is about publicly owned systems. A system that was never public cannot show what public ownership does
2	A safety net function that is material to its market	Without it, the financing problem is a different problem
3	A documented governance or financing arrangement traceable to a primary source	A case LHA cannot source is a case the Task Force cannot rely on
4	Either a change event, or a deliberate and documented decision not to change	Both are evidence. Only one is usually collected
5	Contribution to archetype coverage	The set has to populate the grid in Section 5.3, not cluster in its most familiar cells

5.3 The archetype grid

Seven archetypes describe the range of arrangements available to a publicly owned hospital system in the United States. They are ordered by distance from direct government operation. The scan must populate every cell, because the Task Force's option set will be drawn from this range and an archetype with no case in the scan is an option the Task Force would have to consider without evidence.

ID	Archetype	Defining characteristic
A	Direct government department	The hospital is an operating department of the city or county. No separate legal person
B	Independent hospital district	A special purpose unit of local government, usually with independent taxing authority and an elected or appointed board
C	Public corporation or authority	Government owned but a separate legal person, with its own board and its own balance sheet
D	Public ownership, external management	The government retains the assets; a university or health system manages operations under an agreement
E	Nonprofit operator of public assets	A private nonprofit operates the facility under lease while the public owner holds title
F	Converted to private nonprofit	Ownership transferred to a nonprofit corporation, usually with public obligations attached by the transfer instrument
G	Sold or merged into a private system	The system is acquired, typically with a community foundation created from the proceeds

On LHA's working reading of Minn. Stat. 383B.901 to 383B.928, Hennepin Healthcare sits in archetype C. That reading is stated as LHA's, is verified in Workstream 2 against the Revisor's published text, and is not a legal conclusion the Task Force is asked to accept from its consultant. It matters here only because it tells the scan where to be deepest: archetype C itself, and the archetypes immediately adjacent to it, which are the ones a Minnesota bill could plausibly move the system into.

5.4 Coverage requirement

Minimum two cases per archetype, with additional depth in C, D, and F. Fifteen core cases meet that requirement with margin. If verification during the scan disqualifies a case, it is replaced from the reserve list in Section 6.2 rather than leaving the archetype thin, and the substitution is recorded.

6 The Candidate Set

6.1 Working classification, and what that means

The archetype assignments below are LHA's working classification, made for the purpose of building a balanced case set. They are not findings and are not asserted as verified fact in this memo. Each is verified against primary sources during the scan under the standard in Section 8. Where verification does not support the working classification, the case is reclassified or replaced from the reserve list, and the change is recorded in the source register and reported to the Subcabinet rather than corrected silently. LHA states this plainly because a scan design memo that presented unverified classifications as established would be doing the exact thing this memo exists to prevent.

6.2 The fifteen core cases

#	System	State	Arch.	What this case is expected to illuminate
1	Harborview Medical Center	WA	D	County ownership with academic health system management under a long standing agreement. The closest structural analogue to a county owned teaching safety net hospital, and the primary test of whether operating management can be separated from public ownership without surrendering public control
2	Denver Health	CO	C	A municipal department that became an independent public authority. The archetype C reference case, and the one most often cited as a successful transition
3	Regions Hospital, formerly St. Paul Ramsey	MN	F	The Minnesota precedent. A county system converted under Minn. Stat. 383A.90 and 383A.91, Laws 1994 ch. 549, with the successor becoming Regions Hospital in 1997. The only case where Minnesota law, Minnesota labor, and a Minnesota county board are the actual variables
4	NYC Health and Hospitals	NY	C	Archetype C at maximum scale, with a long record of budget dependence on its municipal owner
5	Cook County Health	IL	C	A county system that moved to an independent governing board while remaining county owned. Governance reform without ownership change
6	Parkland Health	TX	B	A hospital district with independent taxing authority. The clearest example of what a dedicated revenue source does to governance
7	Harris Health System	TX	B	A second district case, allowing district outcomes to be distinguished from Parkland specific ones
8	Valleywise Health	AZ	B	A county system reorganized into a special health care district. The transition path into archetype B rather than the steady state
9	Grady Health System	GA	E	Public authority ownership with nonprofit corporate management. A structural sibling to archetype D reached by a different route, and a case with a documented financial crisis preceding the change
10	The MetroHealth System	OH	C	A county hospital system with recent, public, and contested governance events. Included because governance failure is evidence and is usually omitted

#	System	State	Arch.	What this case is expected to illuminate
11	Eskenazi Health	IN	C	A public corporation that also carries the county public health function, testing whether integration of public health and acute care changes the governance calculus
12	Alameda Health System	CA	C	A county system converted to a public hospital authority that subsequently experienced significant financial distress. The counterweight to Denver
13	Boston Medical Center	MA	F	A full conversion out of municipal ownership, far enough in the past that outcomes can be observed over decades rather than years
14	Erlanger Health System	TN	F	A recent conversion from a public authority to a nonprofit corporation. The contemporary end of the archetype F record
15	New Hanover Regional Medical Center	NC	G	A county owned system sold into a private health system with a large community foundation created from the proceeds. The archetype G case, and the one that tests what a community benefit instrument actually secures

6.3 Reserve list

Drawn on if a core case fails verification, if a core case proves undocumentable within the window, or if the Task Force directs a substitution. Reserves are pre screened against the five criteria but not coded unless activated.

System	State	Arch.	Why held in reserve
Jackson Health System	FL	C	Public trust governance with a dedicated local tax. Strong case, held back only because archetype C is already the deepest cell
Kern County Hospital Authority	CA	C	A recent and well documented authority conversion. Substitutes cleanly for Alameda if that case cannot be sourced
University Medical Center New Orleans	LA	E	State ownership with nonprofit operation under a public private partnership. Substitutes for Grady
Zuckerberg San Francisco General	CA	A	Direct municipal department. Substitutes for either archetype A case
Santa Clara Valley Medical Center	CA	A	County operated health system. The second archetype A case
Regional One Health	TN	F	Converted from county ownership. Substitutes for Erlanger
Nassau University Medical Center	NY	C	Public benefit corporation in sustained financial distress. Held because the Alameda case already carries the distress evidence

Archetype A is populated from the reserve list rather than the core set by design. Direct government department operation is the one archetype Hennepin Healthcare is not going to move toward, and depth there would spend research days that archetypes C, D, and F need. Two archetype A cases are coded so the grid is complete and the comparison has a floor. If the Task Force wants archetype A treated at core depth, LHA will move two cases up and say which two it is displacing.

7 Exclusion Logic

A case set is defined as much by what it leaves out as by what it includes, and a scan that never explains its exclusions invites the reasonable suspicion that the set was assembled to reach a destination. The categories below were considered and excluded, with the reason in each case.

Excluded	Reason	What would change this
Federal direct service systems, including VHA and IHS	Their financing, workforce, and accountability regimes are federal and do not transfer to a county owned Minnesota corporation. Nothing learned there could be drafted into a Minnesota bill	A Task Force decision that federal integration models are within the charge
State psychiatric, correctional, and single specialty public facilities	Not general acute care. The payer mix, the referral relationships, and the capital profile are different problems	A finding that the Hennepin behavioral health service line requires its own comparator set, which LHA would treat as a separate scan
Critical access and small rural public hospitals	Scale and payer mix do not support inference to a large urban academic safety net system. Including them would inflate the case count without adding evidence	Nothing within this charge. Greater Minnesota delivery is addressed through the consultation program instead
Public hospitals without a material safety net role	The governance question is real but the financing question, which is the harder half of the charge, is absent	A Task Force decision to weight governance evidence over financing evidence
International comparators	They operate inside a different payment system. A governance form that depends on a global budget cannot be drafted into Minnesota law	Change control, with a clear statement of what the appendix can and cannot support
Systems whose governance record is not available from primary sources	The source standard in Section 8 is not waivable. A case LHA cannot verify is a case that weakens the report	Access to primary material LHA has not been able to obtain, which the Subcabinet may be able to broker

7.1 Near misses worth naming

Three systems met the criteria and were still left out of the core set, and the Task Force should know it was a choice rather than an oversight. Jackson Health System and Kern County Hospital Authority are both strong archetype C cases displaced only because that cell is already the deepest. Prisma Health in South Carolina is a substantial conversion case, held out because Erlanger and Boston Medical Center already bracket the archetype F record at the recent and the historical ends, and a third conversion case would add volume rather than range.

8 Source Standard

8.1 The three tiers

Tier	What qualifies	How it may be used
1 Primary	Statute and session law as published by the state's revisor or equivalent, charters and ordinances, articles and bylaws, audited financial statements, filed Medicare cost reports, board minutes, official statements for public debt, and court opinions	Any assertion, including every legal status, every dollar figure, and every date
2 Secondary	State auditor and legislative research reports, agency summaries, peer reviewed literature, and bond rating agency reports	Context, characterization, and assessment. May support an outcome claim only where the underlying measure is identified
3 Reported	Contemporaneous news reporting from an identified outlet, trade press, and institutional communications	Establishing that an event occurred and when, and sourcing a contemporaneous quotation. Never the sole basis for a legal status, a dollar figure, or an outcome claim

8.2 Minimum sourcing by field

The Min. tier column in Section 4.3 is binding. Where a field requires Tier 1 and only Tier 2 or Tier 3 material is available, the field is coded Not established and the best available material is recorded in the note, labelled by tier. It is not promoted. A Tier 3 figure recorded as though it were audited is the single most damaging thing this scan could do to the credibility of the report it feeds.

8.3 Zero error categories

Three categories are verified against primary sources at every quality gate, on every increment, even when nothing about them has changed: statutory dates, statutory citations checked chapter, article, section and subdivision against the Revisor's published text, and dollar figures checked against the audited or filed document. This carries into the scan without modification.

8.4 The source register

Every coded field carries a register entry naming the source, its tier, the date accessed, and the specific page, section, or line relied on. The register is delivered with the scan and becomes part of Appendix D of each report. A reader who wants to check any single cell in any model card can do so without asking LHA for anything.

8.5 What LHA will not do

- Paraphrase a statute LHA has not read in the enacting jurisdiction's published text.
- Report a financial figure without the year it describes and the document it came from.
- Characterize a change event as successful or unsuccessful in LHA's own voice. Assessments are attributed to the body that made them, or the case reports that no assessment exists.
- Assert a credit rating action anywhere in this engagement without a rating agency document in hand.

9 Deliverables and Schedule

Date	Day	Deliverable or milestone	Owner
Aug 27, 2026	Thu	This memo and the Governance Genome template delivered. Public source collection begins at LHA risk	Dr. Patton
Sep 2, 2026	Wed	Subcabinet approval requested. Approval releases analysis	Client contact
Sep 3, 2026	Thu	Research window opens. Case coding begins	Dr. Patton, Ms. Sacks
Sep 4, 2026	Fri	Tier 1 source availability confirmed for all fifteen cases. Any case at risk is flagged and a reserve activated	Dr. Patton
Sep 7, 2026	Mon	Labor Day. Minnesota state holiday. No work days consumed	
Sep 8 to Sep 10, 2026	Tue to Thu	Coding completed. Model cards drafted. Cross case comparison assembled	Dr. Patton, Ms. Sacks
Sep 10, 2026	Thu	Independent review, and the four quality gates	Dr. Rosenbach
Sep 11, 2026	Fri	National scan delivered: fifteen model cards, the cross case comparison, the archetype findings, and the source register	Dr. Patton
Sep 21, 2026	Mon	Scan findings presented at Meeting 2 and carried into report increment v0.2	Dr. Harris

The scan is delivered as three artifacts: fifteen model cards of not more than four pages each, a cross case comparison keyed to the archetype grid, and the source register. The cross case comparison is the piece that

reaches Task Force members in the Meeting 2 pre read. The model cards go to the technical appendix, where anyone checking the work can find them.

10 Risks to the Scan

Risk	Trigger	Response, decided now rather than later
Approval arrives after September 2	No written approval by close of business Wednesday, September 2	Escalation notice the same business day under the plan's escalation protocol. LHA proceeds on this memo as written and records that the analysis window was compressed. The delivery date does not move
A core case cannot be sourced at Tier 1 within the window	Tier 1 material not located by Friday, September 4	Activate the matching reserve case. Record the substitution and the reason in the source register and report it in the scan
Case selection is challenged after findings appear	A member or the Subcabinet objects to the set once results are visible	This memo, approved on a date before any finding existed, is the answer. LHA will add a case on direction and will say what the addition displaced
The archetype classification of Hennepin Healthcare is disputed	Disagreement over whether 383B.901 to .928 places the system in archetype C	The classification is LHA's working reading, stated as such. The scan does not depend on it being right; it determines where the scan is deepest, not what it finds
Findings are read as recommendations	Scan material is quoted as though it were the Task Force's position	The scan contains no recommendations, and every model card says in its own text what it does not establish. LHA will restate the boundary in the Meeting 2 materials

11 What LHA Asks the Subcabinet to Approve

Six items. A single written approval covering all six is sufficient, and LHA does not need a formal instrument. An email from the client contact stating approval of items A1 through A6 releases the work.

ID	Approval item	Section
A1	The operative question in Section 2 is the question the scan should answer	2
A2	The scope boundary in Section 3, including the exclusion of international comparators	3
A3	The Governance Genome field set in Section 4.3, fixed at fifty two fields across eight domains	4.3
A4	The five selection criteria, the seven archetype grid, and the fifteen core cases	5, 6
A5	The exclusion logic in Section 7	7
A6	The three tier source standard and the minimum sourcing rule in Section 8	8

If the Subcabinet approves with modifications, LHA asks that the modifications be stated against these numbered items so the change is traceable. If approval cannot be given by September 2, LHA asks to be told that on September 2 rather than to wait, so the compression can be recorded and managed rather than discovered.

Appendix. Blank Governance Genome Model Card

The format each of the fifteen cases is delivered in. Four pages maximum.

Card header

Field	Entry
System	
Jurisdiction	
Working archetype	
Verified archetype	
Coded by	
Independent review	
Coding date	
Fields coded Not established	

Section 1. Orientation

One paragraph. What this institution is, what it does in its market, and why it is in the case set. No assessment.

Section 2. Coded field set

All fifty two fields in the fixed order of Section 4.3, each with its value, its source, and its source tier. Fields with no reliable source are coded Not established.

Section 3. Change event timeline

Year	Event	Type	Legal vehicle	Tier

Section 4. What this case shows

Bounded to what the coded fields and the sourced record support. Every claim traceable to a field.

Section 5. What this case does not show

Written with the same care as Section 4. The limits of the case, the conditions that do not transfer to Minnesota, and any conclusion a reader might reasonably but wrongly draw from it.

Section 6. Open questions carried forward

Anything this case raises that the options analysis or the consultation program should pick up, numbered so it can be tracked.