BOARD OF TRUSTEES

Public Meeting Agenda

HARRISHEALTH SYSTEM

Thursday, August 29, 2024
9:00 A.M.

BOARD ROOM
4800 Fournace Place, Bellaire, TX 77401
The meeting may be viewed online: http://harrishealthtx.swagit.com/live.

***Notice: Some Board Members may participate by videoconference.**

Mission

Harris Health is a community-focused academic healthcare system dedicated to improving the health of those most in need in Harris County through quality care delivery, coordination of care and education.

AGENDA

I.	**Call to Order and Record of Attendance**	**Dr. Andrea Caracostis**	**1 min**
II.	**Approval of the Minutes of Previous Meeting**	**Dr. Andrea Caracostis**	**1 min**
	• Board Meeting – July 25, 2024		
III.	**Announcements / Special Presentations**	**Dr. Andrea Caracostis**	**15 min**
	A. CEO Report Including Special Announcements **– *Dr. Esmaeil Porsa***		*(10 min)*
	• Budget & Tax Rates Update		
	B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements		*(5 min)*
IV.	**Public Comment**	**Dr. Andrea Caracostis**	**3 min**
V.	**Executive Session**	**Dr. Andrea Caracostis**	**30 min**
	A. Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code Ann. §160.007, and Tex. Occ. Code Ann. §151.002 to Receive Peer Review and/or Medical Committee Report, Including Report of the Medical Executive Board in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including the Harris Health System Quality, Safety Performance Measures, and Possible Action Regarding this Matter Upon Return to Open Session ***– Dr. Andrea Caracostis, Dr. Steven Brass and Dr. Yashwant Chathampally***		*(10 min)*
	B. Medical Executive Board Report and Credentialing Discussion, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report, Including Consideration of Approval of Credentialing Changes for Members of the Harris Health System Medical Staff ***– Dr. Martha Mims and Dr. Bradford Scott***		*(10 min)*

C.	Report Regarding Harris Health System Correctional Health Quality of Medical and Healthcare, Including Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007, Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §551.071 to Receive Peer Review and/or Medical Committee Report with Possible Action Upon Return to Open Session ***– Dr. Otis Egins***		*(10 min)*
VI.	**Reconvene to Open Meeting**	**Dr. Andrea Caracostis**	**2 min**
VII.	**General Action Item(s)**	**Dr. Andrea Caracostis**	**6 min**
A.	General Action Item(s) Related to Quality: Medical Staff		
1.	Consideration of Approval of Credentialing Changes for Members of the Harris Health System Medical Staff ***– Dr. Martha Mims***		*(2 min)*
2.	Consideration of Approval of Changes to the General Surgery and Cardiothoracic Surgery Clinical Privileges ***– Dr. Martha Mims***		*(2 min)*
B.	General Action Item(s) Related to Quality: Correctional Health Medical Staff		
1.	Consideration of Approval of Credentialing Changes for Members of the Harris Health System Correctional Health Medical Staff ***– Dr. Otis Egins***		*(2 min)*
VIII.	**New Items for Board Consideration**	**Dr. Andrea Caracostis**	**45 min**
A.	Consideration of Approval of the Appointment of Mr. Jim Robinson as Chair, and Ms. Ingrid Robinson as a Member of the Board of Trustees Budget & Finance Committee	**Dr. Andrea Caracostis**	*(5 min)*
B.	Consideration of Approval of the Appointment of Ms. Libby Viera-Bland as a Member of the Board of Trustees Governance Committee	**Dr. Andrea Caracostis**	*(5 min)*
C.	Consideration of Approval of a Board Resolution Renaming the Margo Hilliard Alford Clinic to Harris Health Urgent Care at The Outpatient Center ***– Dr. Jennifer Small***		*(5 min)*
D.	Consideration of Approval of the Proposed Harris Health Public Policy Platform for the Texas 89th Legislative Session ***– Mr. R. King Hillier***		*(10 min)*
E.	Consideration of Approval of the Proposed Harris Health Fiscal Year 2025 Operating and Capital Budget ***– Ms. Victoria Nikitin***		*(20 min)*
IX.	**Strategic Discussion**	**Dr. Andrea Caracostis**	**10 min**
A.	August Committee Reports:		
	• Quality Committee ***– Dr. Andrea Caracostis***		
	• DEI Committee ***– Dr. Cody Pyke***		
X.	**Consent Agenda Items**	**Dr. Andrea Caracostis**	**5 min**
A.	Consent Purchasing Recommendations		
1.	Consideration of Approval of Purchasing Recommendations (Items A1 through A16) ***– Mr. DeWight Dopslauf and Mr. Jack Adger, Harris County Purchasing Office***		
	(See Attached Expenditure Summary: August 29, 2024)		

B. Consent Committee Recommendations

1. Consideration of Approval to Adopt the Revised 2024 DEI Reporting Schedule to Reflect Bi-monthly Meetings with a Lengthened Meeting Time of 90-Minutes, as recommended by the Diversity Equity and Inclusion Committee **Dr. Cody Pyke**
   [DEI Committee]

C. Consent Grant Recommendations

1. Consideration of Approval of Grant Recommendations (Items C1 through C3) ***– Dr. Jennifer Small***

   (See Attached Expenditure Summary: August 29, 2024)

D. New Consent Items for Board Approval

1. Consideration of Acceptance of the Harris Health June 2024 Financial Report Subject to Audit ***– Ms. Victoria Nikitin***

2. Consideration of Acceptance of the Harris Health July 2024 Financial Report Subject to Audit ***– Ms. Victoria Nikitin***

3. Consideration of Approval to Renew and Amend the Interlocal Agreement Between Harris Health and Harris County, Texas for Legal Representation and Related Support Services Provided by the Harris County Attorney's Office ***– Ms. Sara Thomas***

4. Consideration of Approval of Payment of the Total Compensation Amount for the Fifth Contract Year of the Dental Services Agreement with The University of Texas Health Science Center at Houston ***– Dr. Jennifer Small***

5. Consideration of Approval to Enter into a First Amendment of an Interlocal Agreement between The Harris Center for Mental Health & IDD, Harris County, Texas, and Harris County Hospital District d/b/a Harris Health for Electronic Medical Record Software Subscription, Support, and Maintenance ***– Mr. Ron Fuschillo***

6. Consideration of Approval to Enter into a Second Amendment of an Interlocal Agreement between The Harris Center for Mental Health & IDD and Harris County Hospital District d/b/a Harris Health for Electronic Medical Record Software Subscription, Support, and Maintenance ***– Mr. Ron Fuschillo***

E. Consent Reports and Updates to the Board

1. Updates Regarding Pending State and Federal Legislative and Policy Issues Impacting Harris Health ***– Mr. R. King Hillier***

   {End of Consent Agenda}

XI.	**Item(s) Related to the Health Care for the Homeless Program**	**Dr. Andrea Caracostis**	**15 min**
A.	Review and Acceptance of the Following Reports for the Health Care for the Homeless Program (HCHP) as Required by the United States Department of Health and Human Services, which Provides Funding to the Harris County Hospital District d/b/a/Harris Health System to Provide Health Services to Persons Experiencing Homelessness under Section 330(h) of the Public Health Service Act ***– Dr. Jennifer Small and Ms. Tracey Burdine***		*(14 min)*
	• HCHP August 2024 Operational Update		
B.	Consideration of Approval of the HCHP Second Quarter Budget Summary Report ***– Dr. Jennifer Small and Ms. Tracey Burdine***		*(1 min)*
XII.	**Executive Session**	**Dr. Andrea Caracostis**	**50 min**
D.	Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Organizational Update and the Year-to-Date June 2024 Financial Performance, Pursuant to Tex. Gov't Code Ann. §551.085 ***– Ms. Lisa Wright, CEO and Ms. Anna Mateja, CFO, Community Health Choice***		*(10 min)*
E.	Consultation with Attorney Regarding Jail Medical Services Provided by Harris Health at the Harris County Jail, Pursuant to Tex. Gov't Code Ann. §551.071 and Possible Action Upon Return to Open Session ***– Ms. Sara Thomas***		*(10 min)*
F.	Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements, Including Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032 ***– Ms. Carolynn Jones***		*(10 min)*
G.	Discussion Regarding the Chief Executive Officer (CEO) Evaluation, Pursuant to Tex. Gov't Code Ann. §551.074 ***– Board of Trustees***		*(20 min)*
XIII.	**Reconvene**	**Dr. Andrea Caracostis**	**1 min**
XIV.	**Adjournment**	**Dr. Andrea Caracostis**	**1 min**

HARRISHEALTH SYSTEM

MINUTES OF THE HARRIS HEALTH SYSTEM BOARD OF TRUSTEES
Board Meeting
Thursday, July 25, 2024
9:00 a.m.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
I. Call to Order and Record of Attendance	The meeting was called to order at 9:05 a.m. by Dr. Caracostis, Chair. It was noted that a quorum was present and the attendance was recorded. Dr. Caracostis stated while some of Board members are in the room with us today, others will participate by videoconference as permissible by state law and the Harris Health Videoconferencing Policy. Only participants scheduled to speak have been provided dial in information for the meeting. All others who wish to view the meeting may access the meeting online through the Harris Health website: http://harrishealthtx.swagit.com/live.	**A copy of the attendance is appended to the archived minutes.**
II. Approval of the Minutes of Previous Meeting	• Board Meeting – June 27, 2024	**Motion No. 24.07-98** **Moved by Ms. Carol Paret, seconded by Dr. Cody Pyke, and unanimously passed that the Board approve the minutes of the June 27, 2024 meeting. Motion carried.**
III. Announcements/ Special Presentations	**A. CEO Report Including Special Announcements** • **Hurricane Beryl Response** Dr. Esmaeil Porsa, President and Chief Executive Officer (CEO), delivered the CEO Report. He addressed Hurricane Beryl's impact on Harris Health's facilities and expressed satisfaction with the resilience shown by Harris Health's leadership and employees. He also addressed the impact of the CrowdStrike outage and praised the leadership and staff, particularly the information technology department, for their efforts to address and resolve CrowdStrike's impact on Harris Health. Additionally, Dr. Porsa provided an overview of the notable awards received by Ben Taub and Lyndon B. Johnson Hospitals. Additionally, he highlighted that Harris Health has been included in Forbes' list of America's Best Employers for Women for 2024. Dr. Porsa first acknowledged Dr. Jennifer Small, Executive Vice President of Ambulatory Care Services, for her leadership in organizing the initiative Before highlighting that Harris Health recently held its inaugural Community Collaboration Session, which successfully convened eleven (11) Federally Qualified Health Centers (FQHCs) for a joint meeting. He announced that the Center for Accelerating Health Equity (CARE) will host its first listening session on Friday, August 2nd, from 11:00 a.m. to 2:00 p.m. Ms. Ingrid Robison, Trustee requested more information regarding Hurricane Beryl. Dr. Porsa reviewed the insights and lessons learned from the emergency preparedness process, focusing on the importance between essential versus non-essential services and needs.	**As Presented.**

	B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements Mr. Jim Robinson, Trustee, announced that the Harris County Appraisal District has released its preliminary certified estimate of the 2025 taxable property values. Ms. Tijerina, Trustee, honored the late Honorable Congresswoman Sheila Jackson Lee for her dedication and service to the community. Congresswoman Sheila Jackson Lee passed away on July 19, 2024. Dr. Cody Pyke, Trustee, announced that she will attend the 2024 Healthcare Governance Conference hosted by Texas Healthcare Trustees from July 25–27th in San Antonio, Texas. She also shared her reflections on her experience with Congresswoman Sheila Jackson Lee. Dr. Caracostis announced that The White House Initiative on Asian Americans, Native Hawaiians, and Pacific Islanders will hold a community-wide engagement event at the Hope Clinic.	**As Presented.**
IV. Public Comment	There were no public speakers registered to appear before the Board.	
V. Executive Session	At 9:27 a.m., Dr. Caracostis stated that the Board would enter into Executive Session for Items V. 'A and B' as permitted by law under Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Ann. §§151.002 and 160.007, and Tex. Gov't. Code Ann. §551.071.	
	A. Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code Ann. §160.007, and Tex. Occ. Code Ann. §151.002 to Receive Peer Review and/or Medical Committee Report, Including Report of the Medical Executive Board in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including the Harris Health System Quality, Safety Performance Measures, and Possible Action Regarding this Matter Upon Return to Open Session	**No Action Taken**
	B. Medical Executive Board Report and Credentialing Discussion, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report, Including Consideration of Approval of Credentialing Changes for Members of the Harris Health System Medical Staff	**No Action Taken**
VI. Reconvene to Open Meeting	At 9:37 a.m., Dr. Caracostis reconvened the meeting in open session; she noted that a quorum was present, and that no action was taken in Executive Session.	
VII. General Action Item(s)		
	A. General Action Item(s) Related to Quality: Medical Staff	

	1. Approval of Credentialing Changes for Members of the Harris Health System Medical Staff Dr. Martha Mims, Chair, Medical Executive Board, presented the credentialing changes for members of the Harris Health System Medical Staff. For July 2024, there were forty – nine (49) initial appointments, twenty – five (25) reappointments, two (2) change/add privileges, five resignation (5) resignations, twenty – eight (28) temporary privileges and one (1) urgent care need privileges. A copy of the credentialing report is available in the permanent record.	**Motion No. 24.07-99** **Moved by Dr. Cody Pyke, seconded by Mr. Jim Robinson, and unanimously passed that the Board approve agenda item VII.A.1. Motion carried.**
	2. Approval of Changes to the Community Dentistry Service Clinical Privileges Dr. Mims indicated that a request has been made to include Teledentistry to the Community Dentistry Service Clinical Privileges. Ms. Ingrid Robinson, Trustee, inquired about the staffing requirements for tele-dentistry, prescreening procedures, and requested information on the services being offered. This information will be provided as a Board deliverable. A copy of the Community Dentistry Service Clinical Privileges is available in the permanent record.	**Motion No. 24.07-100** **Moved by Ms. Ingrid Robinson, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Board approve agenda item VII.A.2. Motion carried.**
	3. Approval of Changes to the Advanced Practice Professional (APP) Sponsoring Physician Agreement Dr. Mims indicated that The APP Sponsoring Physician Agreement was updated with minor changes to provide clarity and simplification of the statements listed in the document per legal and compliance guidance. A copy of the Advanced Practice Professional (APP) Sponsoring Physician Agreement is available in the permanent record.	**Motion No. 24.07-101** **Moved by Ms. Carol Paret, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Board approve agenda item VII.A.3. Motion carried.**
	B. General Action Item(s) Related to Quality: Correctional Health Medical Staff	
	1. Approval of Credentialing Changes for Members of the Harris Health System Correctional Health Medical Staff Dr. Otis Egins, Chief Medical Officer, Harris Health Correctional Health, presented the credentialing changes for members of the Harris Health System Correctional Health Medical Staff. For July 2024, there were three (3) initial appointments. A copy of the credentialing report is available in the permanent record.	**Motion No. 24.07-102** **Moved by Mr. Jennifer Tijerina, seconded by Dr. Cody Pyke, and unanimously passed that the Board approve agenda item VII.B.1. Motion carried.**
VIII. New Items for Board Consideration		

	A. Approval of the Appointment of Ms. Ingrid Robinson as Chair of the Board of Trustees Diversity Equity and Inclusion Committee	**Motion No. 24.07-103** **Moved by Ms. Cody Pyke, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Board approve agenda item VIII.A. Motion carried.**
	B. Approve Extension of JPMorgan Chase Direct Pay Letter of Credit and the Amended and Restated Fee Letter and Amended and Restated Reimbursement Agreement related to the Series 2010 Bonds	**Motion No. 24.07-104** **Moved by Mr. Jim Robinson, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Board approve agenda item VIII.B. Motion carried.**
IX. Strategic Discussion		
	A. Discussion Regarding the Harris Health Tax Rate Mr. Daniel Ramos, Executive Director, Harris County Office of Management and Budget, led the discussion regarding the Harris Health Tax Rate. He provided an overview of the budget timeline, including the budget process, budget hearings, and budget adoption process. Mr. Ramos outlined the different categories of budget revenue, including the general fund ($2.4B), grant funds ($2.4B), proprietary funds ($634M), and special revenue ($351M), totaling $5.1B in the fiscal year operating budget. He explained the distinction between tax rates and tax revenue. Additionally, Mr. Ramos discussed the reduction in ARPA funding and its impact on the budget. Ms. Victoria Nikitin, Executive Vice President, Chief Financial Officer, offered further insight into the budget process, including how the rates are established and how the budgeting process works. To view Harris County's FY 2023-2024 budget and to explore data, visit www.budget.harriscountytx.gov. A copy of the presentation is available in the permanent record.	**As Presented.**
X. Consent Agenda Items		
	A. Consent Purchasing Recommendations	
	1. Approval of Purchasing Recommendations (Items A1 through A12) Ms. Jennifer Tijerina, Trustee, inquired about Item A6 concerning additional funds for law enforcement services for the Texas Medical Center Police Department. Mr. Louis Smith, Senior Executive Vice President, Chief Operating Officer, explained that temporary security officers were used to fill shifts but had other commitments that affected their ability to provide consistent	**Motion No. 24.07-105** **Moved by Dr. Cody Pyke, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item X.A.1. Motion carried.**

	coverage at Ben Taub or LBJ campuses, underscoring the need for dedicated officers at those sites. Ms. Tijerina also inquired about Items A1 and A2 concerning the Construction Manager at Risk (CMAR) at LBJ Hospital, specifically asking who is responsible for ensuring their compliance. Mr. Patrick Casey, Senior Vice President, Facilities Construction & Systems Engineering, stated that Harris Health, along with Harris County, is responsible for ensuring the CMARs are in compliance. Ms. Ingrid Robinson, Trustee, emphasized the importance of holding CMARs accountable for communicating with their subcontractors. She also stressed that Harris Health must ensure its Minority/Women-owned Business Enterprises (MWBE) goals and intentions are met to enable active community participation in the projects. A copy of the purchasing agenda is available in the permanent record.	
	B. Consent Governing Body Recommendations Ms. Jennifer Tijerina requested to have consent agenda items X.B.1. brought forward for discussion.	
	1. Approval of the Amended Governing Body Bylaws for the Ambulatory Surgical Center (ASC) at LBJ Ms. Tijerina recognized Dr. Scott Perry, Medical Director of the ASC, and Mr. Matthew Reeder, Administrator of the ASC, for their hard work and dedication to the Ambulatory Surgical Center at LBJ.	**Motion No. 24.07-107*** **Moved by Dr. Cody Pyke, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item X.B.1. Motion carried.** ***Note: this item was taken out of order after the vote on agenda item X.C**
	C. New Consent Items for Board Approval	
	1. Approval to Enter into an Agreement with CenterPoint Energy Resource Corporation to Provide Natural Gas Services for the LBJ Hospital Expansion Project	**Motion No. 24.07-106** **Moved by Ms. Ingrid Robinson, seconded by Dr. Cody Pyke, and unanimously passed that the Board approve agenda items X.C.1. through X.C.4. Motion carried.**

	2. Approval to Amend the Lease Agreement between Harris County and Harris Health Regarding the Thomas Street Health Center, Located at 2015 Thomas St., Houston, TX 77009	**Motion No. 24.07-106** **Moved by Ms. Ingrid Robinson, seconded by Dr. Cody Pyke, and unanimously passed that the Board approve agenda items X.C.1. through X.C.4. Motion carried.**
	3. Approval of an Increase to Payment for the Total Compensation Amount Not-to-Exceed $5,386,123.62 for the Fifth Contract Year of the Oral and Maxillofacial Surgery Services Agreement with The University of Texas Health Science Center at Houston	**Motion No. 24.07-106** **Moved by Ms. Ingrid Robinson, seconded by Dr. Cody Pyke, and unanimously passed that the Board approve agenda items X.C.1. through X.C.4. Motion carried.**
	4. Approval to Amend an Agreement between Harris County Hospital District d/b/a Harris Health System and The University of Texas Health Science Center at Houston Regarding Inpatient Behavioral Health Services	**Motion No. 24.07-106** **Moved by Ms. Ingrid Robinson, seconded by Dr. Cody Pyke, and unanimously passed that the Board approve agenda items X.C.1. through X.C.4. Motion carried.**
	D. Consent Reports and Updates to the Board	
	1. Updates Regarding Pending State and Federal Legislative and Policy Issues Impacting Harris Health System ***{End of Consent Agenda}***	**For Information Only**
XI. Item(s) Related to the Health Care for the Homeless Program		

	A. Review and Acceptance of the Following Reports for the Health Care for the Homeless Program (HCHP) as Required by the United States Department of Health and Human Services, which Provides Funding to the Harris County Hospital District d/b/a/Harris Health System to Provide Health Services to Persons Experiencing Homelessness under Section 330(h) of the Public Health Service Act • HCHP July 2024 Operational Update Dr. Jennifer Small, Executive Vice President, Ambulatory Care Services, delivered a presentation regarding the Health Care for the Homeless Program July 2024 Operational Update including Productivity Report, Consumer Advisory Report and Quality Improvement Award (QIA): Uniform Data System (UDS+) Award. Dr. Small reported that HCHP has provided care to 4,021 unduplicated patients and conducted a total of 13,879 visits year-to-date. In June, HCHP served 994 unduplicated patients, including 630 who received family practice services and, and completed 2,658 visits. Dr. Small shared that there are three (3) nursing vacancies, with two (2) of those positions currently filled. She highlighted the key council activities from February 2024 to April 2024, including: • The council was briefed on changes to the HCHP eligibility process. • An update was provided on the MLK parking project, particularly regarding mobile units and the need for a HRSA scope change. • The council received information on staff changes and recruitment strategies for nurse practitioners, psychiatrists, and family physicians. Additionally, Dr. Small presented on the Fiscal Year 2024 Quality Improvement Award: Uniform Data System Patient-Level Submission (QIA: UDS+), which includes funding of $33,625 for an Epic data analyst to support UDS+ implementation. A copy of the operational update is available in the permanent record.	**Motion No. 24.07-108** **Moved by Dr. Cody Pyke, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item XI.A. Motion carried.**
	B. Approval of the HCHP Consumer Advisory Report	**Motion No. 24.07-109** **Moved by Mr. Jim Robinson, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item XI.B. Motion carried.**
	C. Approval of the HCHP Budget Narrative for the Fiscal Year 2024 Quality Improvement Award (QIA): Uniform Data System (UDS+)	**Motion No. 24.07-110** **Moved by Ms. Ingrid Robinson, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Board approve agenda item XI.C. Motion carried.**

XII. Executive Session	At 10:38 a.m., Dr. Andrea Caracostis stated that the Board would enter into Executive Session for Items XII. 'C through G' as permitted by law under Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §§551.071 and 551.085.	
	C. Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. STAR+Plus, Accreditation and the Financial Performance for the Year-to-Date Ending May 31, 2024, Pursuant to Tex. Gov't Code Ann. §551.085	**No Action Taken**
	D. Discussion Regarding Community Health Choice, Inc. and Community Health Choice Texas, Inc. Financial Matters, Pursuant to Tex. Gov't Code Ann. §551.085, and Possible Action Upon Return to Open Session Related to Internal and External Lines of Credit	**Motion No. 24.07-111** **Moved by Dr. Cody Pyke, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Board approve agenda item XII.D. Motion carried.**
	E. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements, Including Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, and Possible Action Regarding this Matter Upon Return to Open Session	**No Action Taken**
	F. Consultation with Attorney Related to Human Resources Policies, Pursuant to Tex. Gov't Code Ann. §551.071	**No Action Taken**
	G. Consultation with Attorney Regarding Amended Resolution Naming Victoria Nikitin, Executive Vice President & Chief Financial Officer, the Authority to Act on Behalf of the Hospital District in all Matters Related to the Monies Distributed by the Texas Opioid Abatement Council, and Possible Action Upon Return to Open Session, Including Approval of the Amended Resolution, Pursuant to Tex. Gov't Code Ann. §551.071	**Motion No. 24.07-112** **Moved by Dr. Cody Pyke, seconded by Ms. Ingrid Robinson, and unanimously passed that the Board approve agenda item XII.G. Motion carried.**
XIII. Reconvene	At 11:58 a.m., Dr. Andrea Caracostis reconvened the meeting in open session; she noted that a quorum was present. She stated that the Board will now take action on items XII. 'D and G' of the Executive Session agenda.	
XIV. Adjournment	There being no further business to come before the Board, the meeting adjourned at 12:01 p.m.	

I certify that the foregoing are the Minutes of the Harris Health System Board of Trustees Meeting held on July 25, 2024.

Respectfully Submitted,

Andrea Caracostis, MD, MPH, Chair

Carol Paret, BS, Secretary

Minutes transcribed by Cherry A. Pierson, MBA

Thursday, July 25, 2024

Harris Health System Board of Trustees Board Meeting – Attendance

Note: For Zoom meeting attendance, if you joined as a group and would like to be counted as present, please submit an email to: BoardofTrustees@harrishealth.org before close of business the day of the meeting.

BOARD MEMBERS PRESENT	BOARD MEMBERS ABSENT
Dr. Andrea Caracostis *(Chair)*	Afsheen Davis
Carol Paret *(Secretary)*	Libby Viera-Bland
Dr. Cody M. Pyke *(Vice Chair)*	Sima Ladjevardian
Ingrid Robinson	
Jennifer Tijerina	
Jim Robinson	

EXECUTIVE LEADERSHIP/STAFF/ SPECIAL INVITED GUESTS	
Alison Perez	Kari McMichael
Dr. Amy Smith	Dr. Kunal Sharma
Anna Mateja *(Community Health Choice, CFO)*	Lindsey (Katie) Rutherford *(Harris County Attorney's Office)*
Anthony Williams	Lisa Wright *(Community Health Choice, CEO)*
Cherry Pierson	Louis Smith
Daniel Ramos *(Harris County Office of Management and Budget)*	Maria Cowles
Daniel Smith	Dr. Martha Mims
Derek Curtis	Dr. Matasha Russell
DeWight Dopslauf *(Harris County Purchasing Office)*	Matthew Reeder
Ebon Swofford *(Harris County Attorney's Office)*	Matthew Schlueter
Elizabeth Hanshaw Winn *(Harris County Attorney's Office)*	Maureen Padilla
Dr. Esmaeil Porsa *(Harris Health System, President & CEO)*	Micah Rodriguez
Franco Madrigali *(Johnson Controls)*	Michael Fritz *(Harris County Attorney's Office)*
Dr. Glorimar Medina	Michael Hill
Holly Gummert *(Harris County Attorney's Office)*	Nicholas J. Bell
Jack Adger *(Harris County Purchasing Office)*	Olga Rodriguez
Dr. Jackie Brock	Omar Reid
Jamie Lard	Dr. O. Reggie Egins
Dr. Jennifer Small	Patricia Darnauer
Jennifer Zarate	R. King Hillier
Jerry Summers	Randy Manarang
Jessey Thomas	Ray Gutierrez *(Houston Construction Services)*
John Matcek	Sam Karim

EXECUTIVE LEADERSHIP/STAFF/ SPECIAL INVITED GUESTS	
Dr. Sandeep Markan	Dr. Tien Ko
Sara Thomas *(Harris County's Attorney's Office)*	Tracey Burdine
Shawn DeCosta	Victoria Nikitin
Tai Nguyen	Dr. Yashwant Chathampally
Tekhesia Phillips	

Public Comment Request and Registration Process

Pursuant to Texas Government Code §551.007, members of the public are invited to attend the regular meetings of the Harris Health System Board of Trustees and may address the Board during the **Public Comment** segment regarding an official agenda item that the Board will discuss, review, or take action upon, or regarding a subject related to healthcare or patient care rendered at Harris Health System. Public Comment will occur prior to the consideration of all agenda items. If you have signed up to attend as a Public Speaker virtually, a meeting link will be provided. Note: Public Speakers will be removed from the meeting after speaking and have the option to join the meeting live via **http://harrishealthtx.swagit.com/live**.

How to Request to Address the Board of Trustees

Members of the public must register in advance to speak at the Harris Health System Board of Trustees meetings. To register, members of the public must contact the Board of Trustees Office during core business hours, Monday through Friday between 8:00 a.m. to 5:00 p.m. Members of the public must submit the registration no later than 4:00 p.m. on the day before the scheduled meeting and may only register in one of the following manners:

1. Providing the requested information located in the "Speak to the Board" tile found at: https://www.harrishealth.org/about-us-hh/board/Pages/public-comment-request-and-registration-process.aspx.
2. Printing and completing the downloadable registration form found at: https://www.harrishealth.org/about-us-hh/board/Pages/public-comment-request-and-registration-process.aspx.
   - 2a. A hard-copy may be scanned and emailed to BoardofTrustees@harrishealth.org.
   - 2b. Mailing the completed registration form to 4800 Fournace Pl., Ste. E618, Bellaire, TX 77401.
3. Contacting staff at (346) 426-1524.

Prior to submitting a request to address the Harris Health System Board of Trustees, please take a moment to review the rules to be observed during the Public Comment Period.

Rules During Public Comment Period

The presiding officer of the Board of Trustees or the Board Secretary shall keep the time for speakers.

Three Minutes

A speaker, whose subject matter, as submitted, relates to an identifiable item of business on the agenda, will be requested by the presiding officer to come to the podium where they will be provided three (3) minutes to speak. A speaker, whose subject matter, as submitted, does not relate to an identifiable item of business on the agenda, will also be provided three (3) minutes to speak. A member of the public who addresses the body through a translator will be given at least twice the amount of time as a member of the public who does not require the assistance of a translator.

Thursday, August 29, 2024

Executive Session

Report Regarding Quality of Medical and Health Care, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occupations Code Ann. §160.007, and Tex. Occupations Code Ann. §151.002 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including the Harris Health System Quality and Safety Performance Measures, and Possible Action Regarding this Matter Upon Return to Open Session.

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

- Pages 18-19 Were Intentionally Left Blank -

Thursday, August 29, 2024

Executive Session

Medical Executive Board Report and Credentialing Discussion, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report, Including Consideration of Approval of Credentialing Changes for Members of the Harris Health System Medical Staff.

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

- Pages 21-37 Were Intentionally Left Blank -

Thursday, August 29, 2024

Executive Session

Report Regarding Harris Health System Correctional Health Quality of Medical and Healthcare, Including Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007, Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §551.071 to Receive Peer Review and/or Medical Committee Report with Possible Action Upon Return to Open Session.

Otis R. Egins

Otis R. Egins, MD, CCHP-P
Chief Medical Officer of Correctional Health

- Pages 39-40 Were Intentionally Left Blank -

Thursday, August 29, 2024

Consideration of Approval Regarding Credentialing Changes for Members of the Harris Health System Medical Staff

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The Harris Health System Medical Executive Board approved the attached credentialing changes for the members of the Harris Health System Medical Staff on August 13, 2024.

The Harris Health System Medical Executive Board requests the approval of the Board of Trustees.

Thank you.

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

Board of Trustees

August 2024 Medical Staff Credentials Report

Medical Staff Initial Appointments: 50
BCM Medical Staff Initial Appointments - 21
UT Medical Staff Initial Appointments - 28
HCHD Medical Staff Initial Appointments - 1

Medical Staff Reappointments: 162
BCM Medical Staff Reappointments - 101
UT Medical Staff Reappointments - 56
HCHD Medical Staff Reappointments - 5

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Changes in Clinical Privileges: 10

BCM/UT/HCHD Medical Staff Resignations: 27

For Information
Temporary Privileges Awaiting Board Approval - 28
Urgent Patient Care Need Privileges Awaiting Board Approval - 5

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Files for Discussion: 2
Medical Staff Initial Appointment Files for Discussion - 1
Medical Staff Reappointment Files for Discussion - 1

Thursday, August 29, 2024

Consideration of Approval of Changes to the General Surgery and Cardiothoracic Surgery Clinical Privileges

A request was made to add Endoscopic Submucosal Dissection (ESD) and Peroral Endoscopic Myotomy (POEM) to the General Surgery Clinical Privileges and the Cardiothoracic Surgery Clinical Privileges to accommodate practitioners who qualify to request the privilege. The Chiefs of Service at BT and LBJ have reviewed and are in agreement with the additions being presented.

The Medical Executive Board has approved the revisions to the General Surgery Clinical Privileges and the Cardiothoracic Surgery Clinical Privileges and requests the approval of the Board of Trustees.

Summary Table:

Type of Change	Subject	Comments/Notes
Addition	Privilege	Added Endoscopic Submucosal Dissection (ESD) for General Surgery and Cardiothoracic Surgery non-core clinical privileges
		Added Peroral Endoscopic Myotomy (POEM) for General Surgery and Cardiothoracic Surgery non-core clinical privileges

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

Applicant Name: _____

QUALIFICATIONS FOR ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD)

Definition: A procedure to remove early tumors of the Gastrointestinal tract by creating submucosal space and dissecting the tumor under direct visualization utilizing special needles/knifes created specifically for this technique.

***Criteria*:** MD or DO fully credentialed with clinical privileges.

AND

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency training program in general surgery

OR

- Residents who completed training in their 2017-2018 academic year or thereafter must successfully complete a Flexible Endoscopy Curriculum and obtain the Fundamentals of Endoscopic Surgery ™ (FES) through a program offered by the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

OR

- Specialty Board Certification by the AOA, an ABMS affiliated specialty board or one of the affiliated Boards of the Royal College of Physicians and Surgeons of Canada

OR

- Completion of Endoscopic Submucosal Dissection course recognized by a national or international gastrointestinal society, followed by supervision by a credentialed practitioner for a minimum of five (**5**) cases is required

OR

- Completing a minimum of three (**3**) hands-on Endoscopic Submucosal Dissection courses; At least one (1) of three (**3**) courses should include live animal model training; Courses should be recognized by a national or international gastrointestinal society

Clinical Experience / Required Documentation (Initial): Demonstrate being involved in the performance of at least thirty (30) endoscopic surgical procedures, reflective of the scope of privileges requested in the past 12 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Maintenance of privilege: Demonstrated current competence and an adequate volume of thirty (30) endoscopic surgical procedures with acceptable results, reflective of the scope of privileges requested, for the past 24-months based on results of ongoing performance data review (OPDR) and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

☐ **ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) PRIVILEGES REQUESTED**

Approved by:
CCM 10/18/2017
MEB 11/14/2017
BOT 12/15/2017 motion number is **17.12-145**

Applicant Name: _____

QUALIFICATIONS FOR PERORAL ENDOSCOPIC MYOTOMY (POEM)

Description: An evolving family of procedures that utilize a natural orifice and a specialized endoscope to access a surgical site to perform a procedure that was traditionally performed using laparoscopic / thoracoscopic or open technique.

***Criteria*:** MD or DO fully credentialed with clinical privileges.

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency training program in general surgery

OR

- Specialty Board Certification by the AOA, an ABMS affiliated specialty board or one of the affiliated Boards of the Royal College of Physicians and Surgeons of Canada

OR

- Completion of Peroral Endoscopic Myotomy (POEM) course recognized by a national or international gastrointestinal society, followed by supervision by a credentialed practitioner for a minimum of five (**5**) cases

OR

- Completion of a minimum of three (**3**) hands-on Peroral Endoscopic Myotomy (POEM) or Endoscopic Submucosal Dissection courses; At least one (**1**) of the three (**3**) courses should include live animal model training on Peroral Endoscopic Myotomy (POEM; Courses should be recognized by a national or international gastrointestinal society

Clinical Experience / Required Documentation (Initial): Demonstrate being involved in the performance of at least thirty (30) endoscopic surgical procedures, reflective of the scope of privileges requested in the past 12 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months

Maintenance of privilege: Demonstrated current competence and an adequate volume of thirty (30) endoscopic surgical procedures with acceptable results, reflective of the scope of privileges requested, for the past 24-months based on results of ongoing performance data review (OPDR) and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

☐ **PERORAL ENDOSCOPIC MYOTOMY (POEM) PRIVILEGES REQUESTED**

Approved by:
CCM 10/18/2017
MEB 11/14/2017
BOT 12/15/2017 motion number is **17.12-145**

Applicant Name: _____

QUALIFICATIONS FOR ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD)

Definition: A procedure to remove early tumors of the Gastrointestinal tract by creating submucosal space and dissecting the tumor under direct visualization utilizing special needles/knifes created specifically for this technique.

***Criteria*:** MD or DO fully credentialed with clinical privileges.

-

AND

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited thoracic surgery residency training program

AND

- Advanced Endoscopy fellowship with hands on training on Endoscopic Submucosal Dissection

OR

- Completion of Endoscopic Submucosal Dissection course recognized by a national or international gastrointestinal society, followed by supervision by a credentialed practitioner for a minimum of five (**5**) cases is required

OR

- Completing a minimum of three (**3**) hands-on Endoscopic Submucosal Dissection courses; At least one (1) of three (**3**) courses should include live animal model training; Courses should be recognized by a national or international gastrointestinal society

Clinical Experience / Required Documentation (Initial): Demonstrate being involved in the performance of at least thirty (30) endoscopic surgical procedures, reflective of the scope of privileges requested in the past 12 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Maintenance of privilege: Demonstrated current competence and an adequate volume of thirty (30) endoscopic surgical procedures with acceptable results, reflective of the scope of privileges requested, for the past 24-months based on results of ongoing performance data review (OPDR) and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

☐ **ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) PRIVILEGES REQUESTED**

Applicant Name: _____

QUALIFICATIONS FOR PERORAL ENDOSCOPIC MYOTOMY (POEM)

Description: An evolving family of procedures that utilize a natural orifice and a specialized endoscope to access a surgical site to perform a procedure that was traditionally performed using laparoscopic / thoracoscopic or open technique.

***Criteria*:** MD or DO fully credentialed with clinical privileges.

- Completion of an ACGME or AOA accredited Fellowship training program in thoracic surgery

OR

- Completion of an ACGME or AOA accredited Fellowship training program in Thoracic Surgery

OR

- Completion of Peroral Endoscopic Myotomy (POEM) course recognized by a national or international gastrointestinal society, followed by supervision by a credentialed practitioner for a minimum of five (**5**) cases

OR

- Completion of a minimum of three (**3**) hands-on Peroral Endoscopic Myotomy (POEM) or Endoscopic Submucosal Dissection courses; At least one (**1**) of the three (**3**) courses should include live animal model training on Peroral Endoscopic Myotomy (POEM; Courses should be recognized by a national or international gastrointestinal society

Clinical Experience / Required Documentation (Initial): Applicant must provide documentation of provision of five (**5**) cases representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year)

AND

A letter of recommendation from the applicant's residency or fellowship Program Director that included Peroral Endoscopic Myotomy (POEM) procedure training or from the physician's proctor

Maintenance of privilege: Demonstrated current competence and evidence of the performance of at least five (**5**) successful Peroral Endoscopic Myotomy (POEM) procedures during the past 24-months based on results of ongoing performance data review (OPDR) and outcomes

☐ **PERORAL ENDOSCOPIC MYOTOMY (POEM) PRIVILEGES REQUESTED**

Thursday, August 29, 2024

Consideration of Approval of Credentialing Changes for Members of the Harris Health System Correctional Health Medical Staff

The Harris Health System Correctional Health Medical Executive Committee approved the attached credentialing changes for the members of the Harris Health System Medical Staff on July 22, 2024.

The Harris Health System Correctional Health Medical Executive Committee requests the approval of the Board of Trustees.

O. Reggie Egins

O. Reggie Egins, MD, CCHP-P
Chief Medical Officer of Correctional Health

Board of Trustees

HARRISHEALTH SYSTEM

August 2024 Correctional Health Credentials Report

Medical Staff Initial Appointments: 0

Medical Staff Reappointments: 0

Medical Staff Resignations: 1

Medical Staff Files for Discussion: 0

Thursday, August 29, 2024

Consideration of Approval of a Board Resolution Renaming the Margo Hilliard Alford Clinic to Harris Health Urgent Care at The Outpatient Center

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Jennifer Small
Executive Vice President – Ambulatory Care Services

STATE OF TEXAS
COUNTY OF HARRIS MOTION NO. _____

On August 29, 2024 , the Harris County Hospital District d/b/a Harris Health System (Harris Health) Board of Trustees convened in regular session at its regular meeting place. The following members of the Board were present:

		Present	Absent
Andrea Caracostis, MD, MPH	Chair	☐	☐
Cody M. Pyke, MD, JD, LLM, FCLM	Vice Chair	☐	☐
Carol Paret, BS	Secretary	☐	☐
Afsheen Davis, JD, MPH	Board Member	☐	☐
Ingrid Robinson, MBA	Board Member	☐	☐
Jennifer Tijerina, MS	Board Member	☐	☐
Jim Robinson, MA, CFE	Board Member	☐	☐
Libby Viera-Bland, AICP	Board Member	☐	☐
Sima Ladjevardian, JD	Board Member	☐	☐

The Board determined that a quorum was present. Among other business, a resolution on the following matter was considered:

Consideration of Approval of a Board Resolution Renaming the Margo Hilliard Alford Clinic to Harris Health Urgent Care at The Outpatient Center

_____ introduced the resolution and made a motion that it be adopted. _____ seconded the motion for adoption. The motion, carrying with it the adoption of the resolution, prevailed by the following vote:

	Yes	No	Abstain	Absent
Andrea Caracostis, MD, MPH	☐	☐	☐	☐
Cody M. Pyke, MD, JD, LLM, FCLM	☐	☐	☐	☐
Carol Paret, BS	☐	☐	☐	☐
Afsheen Davis, JD, MPH	☐	☐	☐	☐
Ingrid Robinson, MBA	☐	☐	☐	☐
Jennifer Tijerina, MS	☐	☐	☐	☐
Jim Robinson, MA, CFE	☐	☐	☐	☐
Libby Viera-Bland, AICP	☐	☐	☐	☐
Sima Ladjevardian, JD	☐	☐	☐	☐

The adopted resolution reads as follows:

> Harris Health, by and through its Board of Trustees, hereby approves a Resolution Naming the Facility Formerly Known as Margo Hilliard Alford Clinic to Harris Health Urgent Care at The Outpatient Center.

PASSED AND APPROVED this 29 of August, 2024.

Andrea Caracostis, MD, MPH, Chair

Attest:

Carol Paret, BS, Secretary

Thursday, August 29, 2024

Consideration of Approval of the Proposed Harris Health Public Policy Platform for the Texas 89th Legislative Session

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R. King Hillier
Senior Vice President, Public Policy & Government Relations

Harris Health System
4800 Fournace Place
Bellaire, Texas 77401

Harris Health System
Proposed Public Policy Platform
The Texas 89th Legislative Session

Medicaid, CHIP, and the Uninsured

- Support the statutory provision allowing Medicaid beneficiaries to choose community provider-based, not-for-profit plans.
- Support renewal, revisions, and modifications to the Harris County Local Provider Participation Fund (LPPF) as an alternative to Inter Governmental Transfers (IGTs) for methods of financing Medicaid Supplemental Payment programs, i.e., Disproportionate Share Hospital (DSH), Directed Provider Payments (DPPs), Uncompensated Care (UC) payments; private Hospital Augmented Reimbursement Program (HARP) and other rate enhancement Medicaid Supplemental Payments (MSPs) and coverage expansion initiatives.
- Support appropriate regionalization strategies through Health and Human Services Commission (HHSC) waivers that will maximize federal funds while providing commercial coverage for uninsured persons who live and work in the region.
- Support equity in Medicaid supplemental payment methodologies that better target those payments to essential hospitals.
- Support legislation to simplify and expedite seamless enrollment across Medicaid, CHIP-Perinatal, and Healthy Texas Women to meet the interconception, preconception, and postpartum needs for all Texas women.
- Support access to community-based primary care, specialty care, and women's health.
- Support legislation and appropriations to Medicaid, CHIP, and other programs for the uninsured that will address health inequities due to racial, social, and health disparities including—but not limited to—programs expanding housing and recovery options, telehealth services, medical transportation, reducing food insecurity, and a broad spectrum of prevention and early intervention services.
- Support funding for continued provider-enabled innovation and value-based adoption to improve access and outcomes, including telehealth/telemedicine, audio-only telehealth/telemedicine for non-behavioral health services, and the hospital at home program.
- Support cost effective and clinically appropriate methods to deliver Medicaid dialysis services in an outpatient setting for certain eligible populations.
- Support legislation and appropriations to help remedy Texas' worst-in-the-nation uninsured rate by enrolling over 50% of uninsured Texans eligible for existing safety net programs.
- Support legislation and appropriations for the Health and Human Services Commission to submit a Medicaid waiver to expand mental health and behavioral health coverage for adults.

- Support legislation that requires local communities to plan for and enforce continuity of care from private sector dialysis centers during natural and manmade disasters in order to maintain patient access to chronic dialysis services outside of hospital-based emergency room care.
- Oppose legislation that jeopardizes the financial stability and operational ability of Harris Health's delivery of outpatient services to the uninsured in Harris County.
- Oppose any legislative, budgetary, and/or regulatory mandates of local tax dollar IGT for the purposes of funding Medicaid Disproportionate Share, Health Care Transformation and Quality Improvement Medicaid 1115 Waiver (UC or DPPs), or Medicaid Provider Rate Enhancements.
- Oppose any legislation negatively impacting public hospitals' 340B drug discount.

Local Authority & Responsibility

- Support local freedom and decision-making for tax rates, tax use, ad valorem valuation, and bond authority for hospital districts by Commissioners Court.
- Support and recognize the financial and operational needs of hospital districts as relates to the 8% rollback rate for special districts by taking into consideration pharmaceutical inflation; health care workforce shortages; trauma and natural disaster preparedness, response, and mitigation; in addition to the over $6 billion in IGT support for Texas Medicaid supplemental payments.
- Support legislation that will grant Harris Health the statutory authority to create a police force by granting peace officer status to its security personnel.

Behavioral Health (Substance Abuse and Mental Health)

- Support legislation streamlining emergency detention orders and allowing physicians in hospitals and freestanding emergency medical facilities to initiate a temporary hold—a.k.a., an emergency detention—of a patient who, due to a mental illness, is a danger to self or others.
- Support legislation and appropriations that would direct HHSC and other relevant state agencies to increase access to appropriate Substance Use Disorder (SUD) treatments for Medicaid beneficiaries and the uninsured via state and federal funding.
- Support the maintenance of existing funding levels and increased funding allocations for all state agencies that provide behavioral health services.
- Support public and private initiatives on the local, state, and federal levels that will ensure adequate behavioral health services in the Harris County region for residents in a state of crisis management or chronic disease maintenance.
- Support the integration of behavioral and primary health delivery through co-location of services, including both in the patient-centered medical home, and using integrated health records.
- Support legislation providing the same level of insurance coverage for mental illness and substance abuse disorders as for medical and surgical care.
- Support focusing publicly funded behavioral health services on comprehensive, diagnostic therapeutic and recovery programs that are evidence-based and promote patient stability, while reducing the utilization of and cost to crisis emergency services and the criminal justice system.

- Support expanded capacity for both forensic and civil beds in the state hospital system and the Harris County Psychiatric Center.
- Support continued investments in the state's mental health workforce.
- Support continued funding of ongoing initiatives to increase psychiatric beds, including additional community, forensic, and state hospital beds.

Graduate Medical Education

- Support expansion of medical school loan repayment programs for physicians serving in a public hospital, in medical practices treating 50% or more Medicaid and uninsured patients, or in a county correctional health facility.

Nursing and Health Professional Shortage Issues

- Support legislative initiatives that address the current health care professional crisis in Texas and ensure a sufficient health care and behavioral health workforce to meet the needs of vulnerable and aging Texans.
- Support increasing funding for registered nurse and other health care professional and technical training programs by increasing access to and funding for clinical settings and preceptorships.
- Support the training of more nursing students on an annual basis and additional nursing faculty.
- Support funding for programs addressing nursing and other health care personnel workforce retention strategies, clinical training, and recruitment initiatives.
- Support grant funding for innovative partnerships between teaching hospitals and schools of nursing to increase the number of clinical sites and to create training and retention pilot programs.
- Support legislation improving workplace safety and security.
- Oppose efforts to establish and/or impose nurse-staffing ratios by non-hospital entities.

Emergency Care and Trauma

- Support maintaining at minimum Texas' Trauma care capacity at last biennium's level including the trauma, rural, and safety-net add-ons.
- Support initiatives that match "state only" appropriated funds under the Medicaid program through provider rate enhancements while maintaining funds to train trauma surgeons and nurses at academic medical centers.
- Support funding for trauma/disaster preparedness, infrastructure development, and targeting funds to maintain proficiency, quality, and system readiness.
- Support additional funding to assist trauma hospitals caring for patients injured in a mass shooting or other terrorist act similar to the Office of Attorney General's Crime Victim Compensation Program.

Public Health

- Support efforts to enhance public health infrastructure in relation to chronic diseases such as obesity, diabetes, and asthma.

HIV

- Support appropriate and equitable funding of the Texas HIV Medication Program to maintain coverage at 200% of the federal poverty level and follow current community standard treatment protocols.
- Support the statewide expansion of HIV testing, early diagnosis, and treatment.

Environmental Workplace Safety

- Support greater protection for patients and providers by ensuring concrete crushing facilities are statutorily prohibited from operating near health care facilities, as they are currently statutorily prohibited from operating near schools, places of worship, and residential buildings.

Thursday, August 29, 2024

Consideration of Approval of the Proposed Harris Health Fiscal Year 2025 Operating and Capital Budget

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Administration recommends approval of a Harris Health System Fiscal Year 2025 Operating and Capital Budget to be presented to the Harris County Commissioners Court for final approval in conjunction with its adoption of a 2024 Tax Rate that will result in net ad valorem tax revenue not to exceed the amount shown in the proposed Budget.

Victoria Nikitin

Victoria Nikitin
EVP and CFO

HARRISHEALTH SYSTEM

Fiscal Year 2025
Operating and Capital Budget

Harris Health Board of Trustees
Executive Summary and Proposed Budget

August 29, 2024

Table of Contents

APPENDIX

Fiscal Year Ending Sept. 30, 2025 - Operating and Capital Budget

Executive Summary

Harris Health is presenting for consideration its proposed FY 2025 Operating and Capital Budget for the 12-month planning period from Oct. 1, 2024, through Sept. 30, 2025.

Harris Health's administration recommends a 1% operating margin for FY 2025, predicated on the Commissioners Court final adopted tax rate for Harris Health. The proposed Operating Budget for the fiscal year currently reflects a margin of $29.1 million, and underscores the ongoing effort to manage operations and continue the implementation of the Strategic Plan 2021-2025.

The Harris Health budget excludes the operating results for Community Health Choice, Inc. (HMO), Harris County Hospital District Foundation, Harris Health Strategic Fund, and the Correctional Health program, which is supported through the Harris County Sheriff's Office Operating Budget.

Who We Are

Founded Jan. 1, 1966, Harris Health is the public safety-net healthcare provider for Harris County, Texas, and is committed to ensuring the patient care it provides meets the community's highest standards.

As the largest safety net hospital system in Texas, Harris Health continues to serve a racially and ethnically diverse population, with more than 44% uninsured and approximately 23% of patients having Medicaid and CHIP coverage. More patients (48%) speak Spanish as their primary language than any other language including English, with more than 40 other preferred languages represented among the approximately 250,000 unique patients receiving medical care in FY 2023.

Harris Health's two acute care trauma hospitals (Ben Taub and Lyndon B. Johnson) are nationally designated as Magnet® facilities, one of the industry's most prestigious recognitions for nursing excellence. Harris Health's ambulatory care health centers are recognized by the National Committee for

Quality Assurance as Patient Centered Medical Homes and have garnered multiple awards and recognitions for the high quality of care provided. In early 2024, Harris Health's Ambulatory Care Services received Pathway to Excellence® designation from the American Nurses Credentialing Center (ANCC). This recognition – previously only given to hospitals – now includes Harris Health's Ambulatory Care Services as the second ambulatory service in the U.S. awarded the designation.

Ben Taub Hospital, a Level I trauma center, and LBJ Hospital, a Level III trauma center, remain two of the busiest emergency centers in the area and annually provide more than 155,000 emergency visits. Together they also provided more than 31,000 patient discharges and close to 5,500 deliveries in FY 23.

The cost of charity care provided by Harris Health for the benefit of the Harris County community exceeded $688 million in FY 2023, but Harris Health's impact goes far beyond providing critical healthcare services. Clinical care is provided in partnership with Baylor College of Medicine, McGovern Medical School at UTHealth and The University of Texas M.D. Anderson Cancer Center. Through these and other affiliated academic partnerships, Harris Health helps train the region's future healthcare workforce, ensuring that the next generation of doctors, nurses and other healthcare professionals are prepared to provide the highest quality of care for all Harris County residents.

Also, as independent consulting firm Tripp Umbach established, Harris Health is a driving force in the Harris County economy. The study indicated that in FY 2022 (March 2021-February 2022), Harris Health operations generated more than $4.8 billion directly and indirectly in the Harris County economy. Moreover, every $1 Harris Health receives in ad valorem taxes generates $5.89 in the local economy. Harris Health supports 29,237 jobs directly and indirectly in Harris County, resulting in one in every 70 jobs in the county. Further, Harris Health's operations generated $132.9 million in state and local taxes. These impressive economic impact numbers are based on the health system's operations in the Harris County economy.

***Excludes revenue and expense associated with Correctional Health Services**

Continued Implementation of 2021-2025 Strategic Plan

Harris Health leadership, at the direction of Harris Health's Board of Trustees, continues to implement strategies and initiatives aligned with the organization's 2021-2025 Strategic Plan. The Plan is guided by six strategic pillars which serve as the system's foundation for the future.

- **Quality and patient safety:** Harris Health will become a high-reliability organization (HRO) with quality and patient safety as a core value where zero patient harm is not only a possibility but an expectation.
- **People:** Harris Health will enhance the patient, employee and medical staff experience and develop a culture of respect, recognition and trust by actively listening to feedback and developing strategies to address high-impact areas of opportunity.
- **One Harris Health:** Harris Health will act as one system in its approach to the management and delivery of healthcare.
- **Population health management:** Harris Health will lead in mitigating adverse health consequences driven by the social determinants of health through partnerships, demonstration of models, and convening the community of providers and support organizations to create a system of care that goes beyond the traditional disease management approach and toward a health promotion and diseases prevention approach to care.
- **Infrastructure optimization:** Harris Health will invest in and optimize infrastructure related to facilities, information technology (IT) and telehealth, information security, and health informatics to increase value, ensure safety and meet the current and future needs of the patients served.
- **Diversity, equity and inclusion:** Harris Health will ensure equitable access to high-quality care for patients, foster a diverse and inclusive workplace, cultivate and sustain strategic relationships with suppliers and community partners, and broaden its reach and understanding of the communities it serves.

***Excludes revenue and expense associated with Correctional Health Services**

Strategic Facilities Plan

In November 2023, Harris County voters overwhelmingly approved Harris Health's $2.5 billion bond proposal, with more than 72% of voters showing support. The bond election paves the way for Harris Health to execute the first phase of its Strategic Facilities Plan, which includes the replacement and renovation of Lyndon B. Johnson Hospital, development of an additional patient care tower and other work at Ben Taub Hospital to extend the useful life of that facility, creation of 3 new ambulatory clinics to improve primary and specialty care access in underserved areas of Harris County, and necessary infrastructure updates at many existing ambulatory care clinics.

In anticipation of a successful bond referendum, Harris Health engaged architectural and engineering firms for the LBJ project in fall of 2022. Completion of programming, schematic design and much of design development prior to the bond election allowed Harris Health to break ground on the new hospital on the LBJ campus in May 2024, only six months after the bond election. Construction on the new facility is estimated to last approximately 52 months (May 2024 – September 2028), with occupancy projected in Q1 of 2029.

Planning is also currently underway for projects that will extend the life of Ben Taub Hospital. In FY 2025, Harris Health will begin a four-phased expansion of the Intensive Care Units, expand telemetry capability to all beds, and address key mechanical, electrical, plumbing and sewer issues. Simultaneously, planning will continue for a 120-bed patient care tower.

In FY 2025, Harris Health will also continue facility work related to its Ambulatory Care Platform. Demand forecasting is currently underway that will support determination of the location of the three new clinics that will be funded with bond proceeds. The location of these clinics will be determined in Q1 of FY 2025. Further, construction will begin on a radiology and radiation therapy refresh at Smith Clinic and at the new Pasadena Health Center (Centrico) in FY 2025.

Costs associated with implementation of the Strategic Facilities Plan are projected at $18.2 million in FY 2025 for bond issuance and interest expense.

***Excludes revenue and expense associated with Correctional Health Services**

Strategic Initiatives October 2024 – September 2025

Approved Strategic Initiatives

The following strategic initiatives in support of the system's Strategic Plan are currently **in progress** and are included in the draft budget for FY 2025:

- Food Farmacy and Food Rx Expansion;
- Hospital at Home Service Expansion;
- Cardiac Catheterization Lab Expansion at Ben Taub Hospital;
- Implementation of Epic Rover and Unified Communications;
- Implementation of Epic Back to Foundation;
- Implementation of a Service Management System;
- Emergency Center Telemedicine Expansion;
- Endoscopy Center at Quentin Mease Expansion; and
- Contract with Texas Medical Center Police.

Incremental costs included in the FY 2025 projections associated with these projects totals $21.4 million.

Food Farmacy and Food Rx Expansion

Harris Health is expanding its successful Food Farmacy and Food Rx model across its primary care clinic platform to help support food insecure patients with food prescription programming. Harris Health's food Rx program currently serves adult patients expressing food insecurity (FIRST Link) while providing a more intensive intervention (Food Rx) for those with Type 2 diabetes or other identified chronic conditions. Harris Health Food Farmacies have enrolled approximately 6,000 unique patients into FIRST Link for short-term support and about 2,500 unique patients into Food Rx for ongoing programming. Food Rx diabetic graduates had an average decrease in hemoglobin A1C (HbA1c) of 1.09 percentage points with 23.2% of graduates achieving an HbA1c below 7.0%. The program will be expanded to five clinic sites (Martin Luther King, Jr., Gulfgate, El Franco Lee, Cypress and Squatty Lyons) using ARPA funds, and the remaining locations will be funded by Harris Health's operating budget, beginning with Settegast. ARPA funding will end in FY 2026, at which point Harris Health will fund the ongoing operating costs. (Pillar: Population Health Management)

Hospital at Home Service Expansion

Harris Health will expand its Hospital at Home Service, an innovative care model that provides acute care in the home setting, incrementally expanding bed-capacity and service capability for the health system. Moreover, it helps reduce Emergency Center (EC) boarding hours and overcrowding, length of stay, and observation hours, while also increasing acute care capacity, health equity and access for patients. In FY 2025 Harris Health will expand this program's staffing, infrastructure and clinical eligibility criteria in order to increase the number of patients participating in the program. (Pillars: Quality and Patient Safety, One Harris Health, Infrastructure Optimization)

Cardiac Catheterization Lab Expansion at Ben Taub Hospital

The Ben Taub Hospital Cardiac Catheterization Labs (Cath Labs) provide minimally invasive diagnostic and interventional cardiac procedures. Harris Health plans to update the Cath Lab environment at Ben Taub Hospital by November 2024 to meet current code requirements and enhance technology. Additionally, the project will increase Electrophysiology (EP) capacity by adding a dedicated EP Room. Currently, Ben Taub has two Cath Labs that are over 10 years of age, with technology that will no longer be supported within 12 months. The plan calls for building out three Cath Labs in the shelled space near the second-floor operating rooms, where a third room can be accommodated. The additional room dedicated to EP procedures will support more A-fib ablations/pulmonary vein isolations (PVI) cases, and will better support the growing interventional/EP cardiology needs across Harris Health. (Pillars: Quality and Patient Safety, One Harris Health, Infrastructure Optimization)

Implementation of Epic Rover and Unified Communications

Harris Health is in the planning phase for implementation of Epic Rover and Unified Communication. Epic Rover supports Harris Health's high standards for patient safety by supporting barcode scanning and validation of medications, specimens, blood products, and integration of infusion pumps. Epic Rover is a mobile application that allows clinicians enhanced mobility; it provides a way to manage medication administration, blood administration, documentation, and communication from a mobile device (typically at the patient's bedside), which frees up workstations and allows for more direct interaction with patients. The addition of this Epic-based tool is anticipated to increase bar code medication administration

compliance, reduce missed barcode scans, reduce bed turnaround time, improve real-time documentation, and increase clinician satisfaction and patient safety. Unified Communications allows care teams, EVS, Transportation and others to be in direct communication and allows for focused and intelligent monitoring which brings alerts directly to the closest or most relevant care providers. (Pillars: Quality and Patient Safety, People, Infrastructure Optimization)

Implementation of Epic Back to Foundation

Harris Health is in the planning stage for the implementation of Epic Back to Foundation. Epic is Harris Health's electronic medical record. Harris Health was the first hospital system in Houston to implement Epic, and over the years (particularly when Epic was in its early phases of development) has customized Epic to the extent that its current level of complexity limits needed standardization and scalability. Implementing Epic Back to Foundation will allow Harris Health to take advantage of Epic's most modern capabilities and learn from best practices from over 300 health systems. It will also allow workforce members to leverage the most robust self-service reporting and data analysis, digitize workflows and automate role recognition. (Pillars: Quality and Patient Safety, People, Infrastructure Optimization)

Implementation of a Service Management System

Harris Health is in the planning phase for a service management system to replace several key systems that are approaching their sunset period. Implementation of a service management system will create one consolidated enterprise service management platform for employee needs utilizing automation and scalability, modernize IT service delivery and technology operations, and enhance Harris Health's risk posture and audit capabilities. (Pillars: People, One Harris Health, Infrastructure Optimization)

Emergency Center Telemedicine Expansion

The Emergency Center (EC) Telemedicine Program uses Harris Health's virtual care platform to provide care to eligible patients who contact Ask My Nurse (AMN). After AMN completes its telephone triage, patients referred to the emergency department are connected with an EC provider virtually. The expansion of the EC Telemedicine Program will further reduce the utilization of emergency centers for non-emergent care, thereby alleviating long patient wait times, and ultimately decompressing our

emergency departments. With the current EC Telemedicine Program, 76% of patients connected virtually with an EC provider are able to receive needed care without having to present in-person to an emergency room. The program's current hours of operation are Monday through Friday, 8 a.m. to 5 p.m., and Harris Health plans to expand the hours of operation to 7 a.m. until 11 p.m., seven days per week. It is estimated that 3,306 additional patients could be cared for in this setting in lieu of presenting to an emergency department. (Pillars: Quality and Patient Safety, One Harris Health)

Endoscopy Center at Quentin Mease Expansion

The expanded endoscopy capabilities of the newly constructed Endoscopy Center at Quentin Mease Health Center minimize patient outsourcing and improve access to care for patients in need of colorectal cancer screening services. Harris Health currently operates two rooms three days per week, but in FY 2025, Harris Health will expand operations to two rooms five days per week in order to create additional patient access. (Pillars: Quality and Patient Safety, Infrastructure Optimization)

Contract with Texas Medical Center Police

Harris Health seeks to improve current coverage of dedicated, full time law enforcement officers at Harris Health locations that need law enforcement support by contracting with the Texas Medical Center Police Department. The contract will replace a registry program that has used off-duty police officers from assorted law enforcement agencies. The current program is unsustainable due to a growing shortage of police officers at the agencies used by Harris Health in addition to the staffing problems presented by a "second job" workforce that is often unable to work full assigned shifts, and face call-up orders for major incidents and weather disasters. (Pillars: People, One Harris Health)

***Excludes revenue and expense associated with Correctional Health Services**

Pending Strategic Initiatives

The following strategic initiatives are **not yet implemented** but are included in the draft FY 2025 budget. These initiatives, along with several other projects, total $11.3 million and will be implemented in FY 2025 assuming Harris Health's budgeted and actual revenues and expenses support the deployment of each. In the event that revenues and/or expenses do not support the implementation of all of these critical initiatives, they will be implemented in order of priority as determined by Harris Health leadership. The included strategic initiatives are:

- Addition of Phlebotomists in Emergency Centers;
- "Healthy Connect" Remote Patient Monitoring for Blood Pressure Program Expansion;
- Increase in Living Wage;
- Outpatient Parenteral Antibiotic Therapy Program Expansion; and
- Utilization Review Team Creation.

Addition of Phlebotomists in Emergency Centers

Harris Health is adding phlebotomists to the patient care teams in its emergency centers in order to support nursing staff in this extremely busy environment. Delegating the task of blood draws to the experts (phlebotomists) will reduce blood culture contamination rates, improve specimen collection and integrity, improve operational efficiency, enhance the customer experience and improve nursing satisfaction. (Pillars: Quality and Patient Safety, People, One Harris Health)

"HealthyConnect" Remote Patient Monitoring for Blood Pressure Program Expansion

Harris Health is expanding its nationally recognized "HealthyConnect" Remote Patient Monitoring program, which supports patients by monitoring home blood pressure submissions and providing self-management education, medication intervention, social determinants of health screening, and navigation. This supports Harris Health's goal of improving heart health outcomes and equity by achieving targeted improvements in hypertension, hyperlipidemia, preeclampsia, and tobacco cessation. In CY 2023 patients enrolled in the program achieved an average decrease in systolic BP of 21 mmHg and an average decrease in diastolic BP of 9 mmHg over an average seven-month program enrollment (with an average BP at graduation of 128/75). Patients also reported a medication adherence rate of 93.2%. The program

currently exists at four ambulatory care sites, and in FY 2025 Harris Health will offer this program at six additional ambulatory care sites. (Pillars: Quality and Patient Safety; Population Health Management; Infrastructure Optimization; Diversity, Equity and Inclusion)

Increase in Living Wage

Harris Health is increasing its minimum hourly wage from $15 to $16, reflecting a commitment to improving the livelihood of its workforce. This initiative positions Harris Health as a leader in fostering a fair and equitable work environment and assists in recruitment and retention efforts in certain sectors of its workforce. Harris Health also will address resulting compression in wage structures as needed to maintain a fair and differentiated compensation structure. (Pillar: People)

Outpatient Parenteral Antibiotic Therapy Program Expansion

Harris Health is expanding its Outpatient Parenteral Antibiotic Therapy (OPAT) program by creating a dedicated service team that can support both hospitals. OPAT is a program by which patients with serious infections are educated on how to receive IV antibiotics at home rather than in a hospital setting. OPAT has proven successful in reducing relevant emergency center visits and hospital admissions and improving patient experience. (Pillar: Quality and Patient Safety, Population Health Management)

Utilization Review Team Creation

Harris Health is creating a Utilization Review team and process to ensure that Harris Health hospital-based healthcare care is effective, efficient, and in line with evidence-based standards of care. Utilization Review remains a well-recognized component of a resource management approach to health care service delivery and payment. This team will consistently track patients' plans of care to ensure they are always in the appropriate status and on a trajectory to the next level of care, and support patient care teams by providing expertise to address real-time delays and management of resources. (Pillars: One Harris Health, Population Health Management)

***Excludes revenue and expense associated with Correctional Health Services**

Patient Volumes Projections

Continuing Harris Health's commitment to the community, the income eligibility criteria will be maintained at 150% of the federal poverty level. There are no plans to change the indigent care policy, Financial Assistance Program, affecting patient volumes. Overall volume for Harris Health is expected to remain stable as compared to current year levels having returned to, or exceeding, pre-COVID levels in some instances.

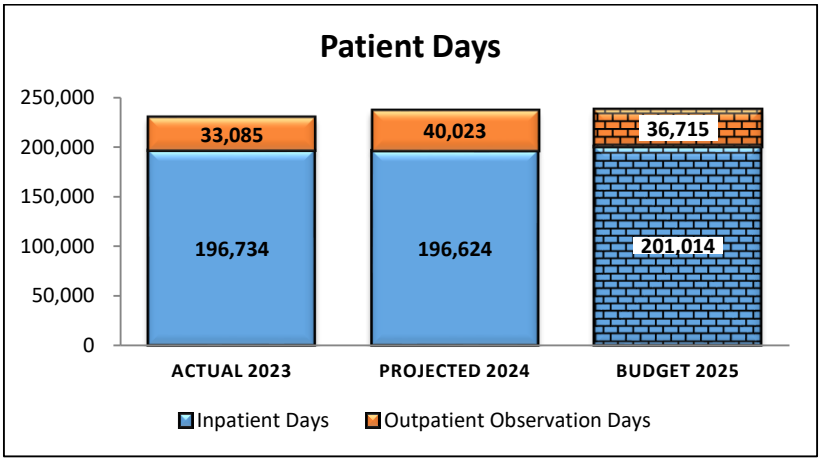
Inpatient Volumes

In the acute care pavilions capacity constraints on both the Ben Taub and LBJ campuses, with bed occupancy rates in excess of 90%, limit the ability for growth of inpatient volumes. Volume is expected to shift slightly between inpatient and observation cases related to the opening of the new observation units at both hospitals during FY 2024. A 21-bed observation unit was opened at Ben Taub Hospital in May 2024 while a 12-bed unit was opened at LBJ Hospital in March 2024. This expansion will aid in the reduction of emergency center boarding hours, observation hours, and length of time to convert patients from observation to inpatient status. Cohorting observation patients rather than placing them throughout the hospital based on bed availability allows for a more efficient management of the unique needs of these patients. In the acute care pavilions, inpatient cases are projected at 31,640 and outpatient observations cases at 11,397 for total bedded cases of 43,037 while total patient days are expected to remain consistent with current year levels at 236,806 for FY 2025.

Hospital at Home went live in February 2024 as the first program in the metro-Houston area to care for acute patients in their homes. The program is currently set up to manage an average daily census of 4 patients with plans to expand to an average daily census of 8 patients during FY2025. The program is expected to support an additional 231 inpatient cases and 923 patient days in FY2025 beyond that provided in the acute care pavilions.

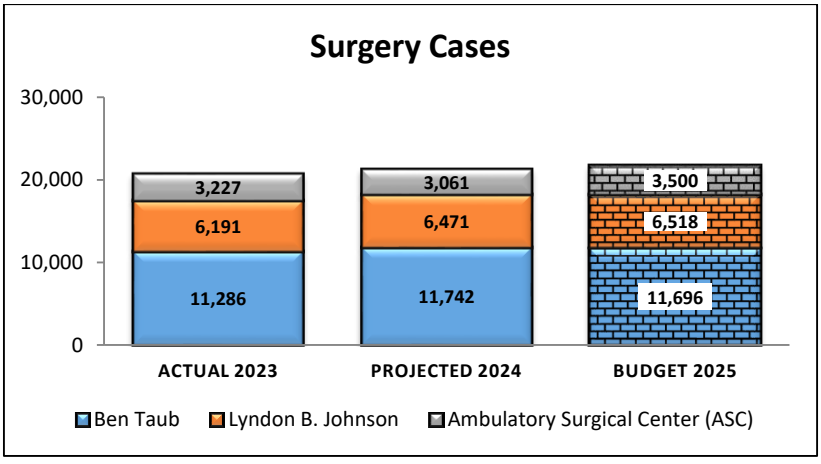
Overall, cases across the platform are projected at 43,268 and total patient days at 237,729 for FY 2025.

***Excludes revenue and expense associated with Correctional Health Services**



Surgery Cases

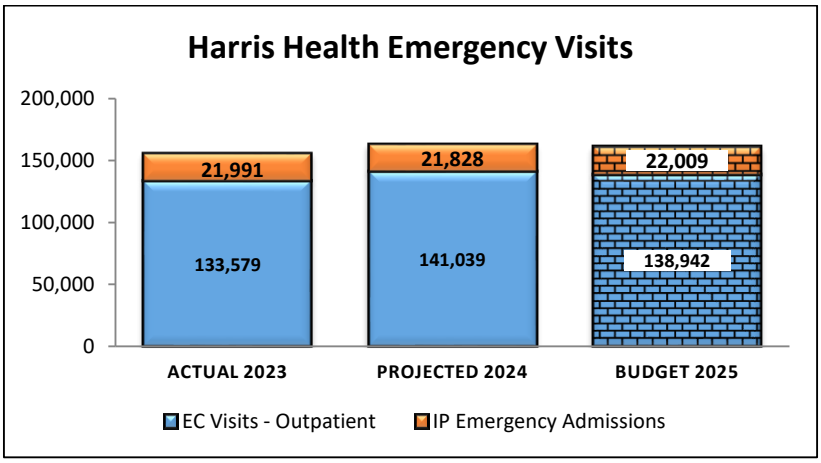
Inpatient surgery cases are expected to see a slight uptick to 10,016 cases in FY 2025 as the planned refresh project at LBJ necessitating the staged closure of operating rooms throughout FY 2024 is now complete. Outpatient surgery cases are projected to increase to 11,698 cases in FY 2025 resulting from the completion of the planned refresh project at LBJ as well as a concerted effort to reduce backlog at the Ambulatory Surgery Center. The overall impact to surgical volume in FY 2025 is an expected increase of 2.1% for a total of 21,714 cases compared to FY 2024 projected year end.



***Excludes revenue and expense associated with Correctional Health Services**

Emergency Room Visits

Emergency room visits continue to increase year over year approaching pre-COVID levels and creating throughput issues at both hospitals. As previously noted, the opening of the additional observation beds at both hospitals are expected to aid in the reduction of boarded patients in the emergency room and improve throughput. As a result of these decompression initiatives, as well as the pending Emergency Center telemedicine expansion, total combined emergency room visits are projected to remain consistent with current FY 2024 levels, which are expected to end the fiscal year almost 5% greater than prior year levels, at 160,951 visits annually.



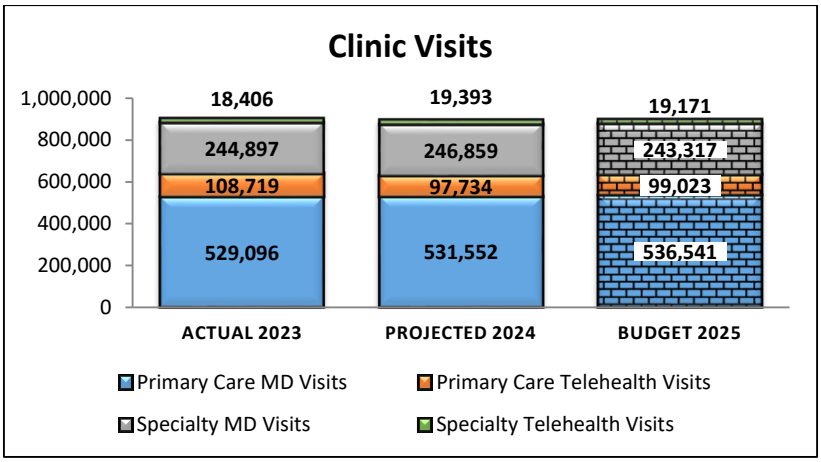
Births

Labor and delivery volumes are expected to remain steady at current year levels after having returned to pre-COVID levels with an estimated 5,340 births in FY 2024. For FY 2025, births are projected to remain at current year levels of slightly less than 5,400 annually.

Outpatient Visits

On the outpatient platform, overall outpatient visits (inclusive of primary, specialty, and telehealth visits) are expected to remain stable at 898,052 total visits for FY 2025 reflecting the multi-year trend.

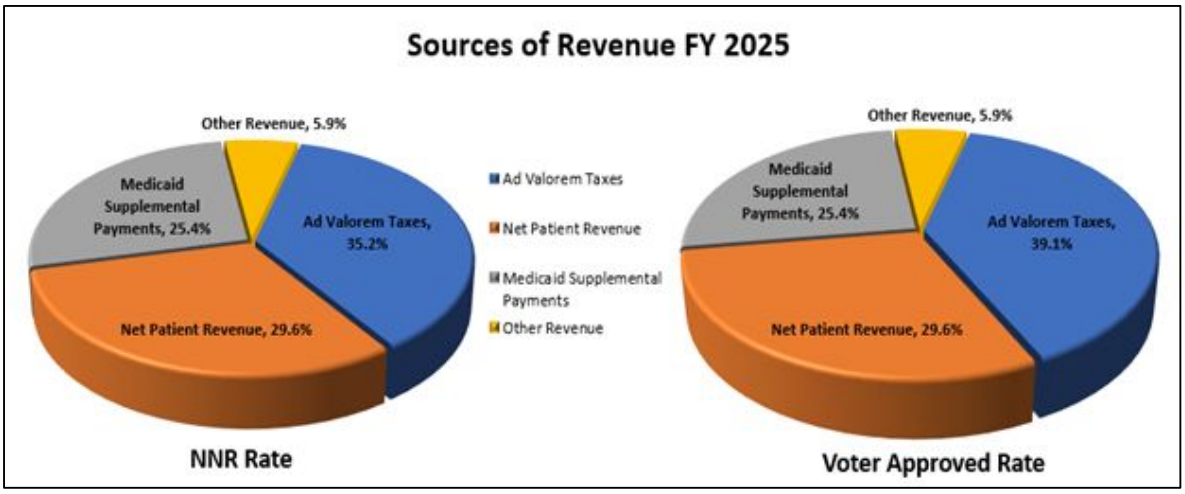
***Excludes revenue and expense associated with Correctional Health Services**



***Excludes revenue and expense associated with Correctional Health Services**

Revenue Projections

For FY 2024, Total Net Revenue is projected to end the year at $2.467 billion, which is an increase of $25.8 million or 1.1% more than FY 2023. This net increase is mostly attributed to an increase in net Ad Valorem Tax Revenue. Tax revenue projections for FY 2025, provided by the Harris County Office of Management and Budget (OMB), represent $896.3* million for the No New Revenue Rate (NNR) and $996.5* million for the Voter Approved Rate (VAR), which result in a bottom-line loss of $71.1 million and a positive net of $29.1 million, respectively. Depending on the final adopted tax rate for FY 2025, Total Net Revenue for the system is expected to be in the $2.448 to $2.549 billion range, or a corresponding decrease of $19.0 million, or an increase of $82.0 million as compared to the FY 2024 year-end projection.



Ad Valorem Tax

Net Ad Valorem Tax revenue comprises over 30% of Harris Health's total revenue. Tax projections are preliminary at this time until tax rates are set by the Harris County Commissioners Court. For FY 2025 budget cycle, Harris Health is proposing total tax revenues estimated at the VAR rate of $996.5*million. This amount is needed in order to close the expense gap and arrive at a 1% margin allowing for continued reinvestment in the system's aging infrastructure and the ongoing implementation of the current Strategic Plan.

*All estimates include $8.5 million for debt service.

***Excludes revenue and expense associated with Correctional Health Services**

Net Patient Service Revenue

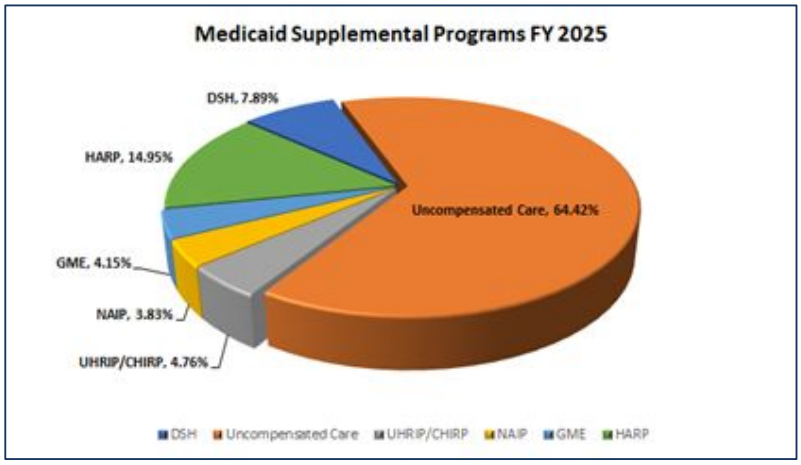
Net patient service revenue comprises approximately a third of the entire system revenue portfolio. FY 2025 projections reflect both the current trends of FY 2024 as well as overall volumes projected for next year. The ACA-mandated uncompensated care pool specific to the Medicare DSH program will result in a corresponding payment increase of $5.5 million for FFY 2025. Net Patient Service Revenue is currently estimated at $754.7 million for the year, or 1.7% higher than FY 2024.

Medicaid Supplemental Payments

Medicaid Supplemental Programs' revenues make up approximately 28% of Harris Health's total revenue and include Medicaid Disproportionate Share (Medicaid DSH), Uncompensated Care (UC) and High Impecunious Charge Hospital (HICH), Comprehensive Hospital Increase Reimbursement Program (CHIRP), Network Access Improvement Program (NAIP), Hospital Augmented Reimbursement Program (HARP) and Graduate Medical Education (GME) program funding. In FY 2025, HHSC plans to implement two new programs: APHRIQA (Alternate Participating Hospital Reimbursement for Improving Quality Award) and ATLIS (Aligning Technology by Linking Interoperable Systems).

In its FY 2025 budget estimates, Harris Health has been relying upon the modeling done by the similarly-situated peer safety net Texas hospitals while expecting the Texas Health and Human Services Commission (HHSC) to produce a final calculation file. The final analysis recently provided by the State shows a decrease of the HICH sub-pool from the anticipated $500 million to $350 million, state-wide. For Harris Health, this sizing change translates into a $37 million decrease in expected distribution for FY 2024 and FY 2025. As a result, total Medicaid Supplemental funding for the system for FY 2024 is estimated at $678.5 million, and is projected at approximately $647.2 million, or 4.6% less, in FY 2025.

***Excludes revenue and expense associated with Correctional Health Services**



Medicaid Supplemental Payments - Recap of 2023 Program Rule Update

In June 2023, the Texas Health and Human Services Commission adopted amendments concerning Disproportionate Share Hospital reimbursement methodology, Hospital-Specific Limit methodology, and Uncompensated Charity Care. The new rules require that hospitals must participate in all of the Medicaid Supplemental programs that they are eligible for, and that hospitals receive either the flat standard payment or their Medicaid shortfall limited by their State Payment Cap. The remaining DSH funds are distributed in accordance with the payment-to-cost methodology.

Medicaid Supplemental Payments - New for FY 2025

Multiple program changes result from HHSC's initial policy goal in late CY 2022 and CY 2023 of protecting the UC pool and maintaining it at $4.5 billion in FY 2028-2030; and from HHSC's subsequent decisions in May of 2024 to allow the UC pool to be reduced to a projected $3.1 billion in FY 2028-2030. While the above rebasing is not immediate, changes to programs that are new or affected for FY 2025 are detailed below.

- ***Medicaid Disproportionate Share (DSH)***

Current law calls for a reduction in federal DSH funding by $8 billion starting in FFY 2025 although Congress in March 2024 eliminated the DSH cut for FFY 2024. However, these reductions continue to remain on the

Congressional agenda for FFY 2025-2027. If not repealed again in December 2024, the available future distributions to Harris Health could drop up to 20% in FFY 2025 and beyond. At this time, Harris Health's Medicaid DSH revenue model does not include such cuts.

The annualized DSH net benefit for FY 2024 reflects a total of $82.8 million. Projected funding for FY 2025 is estimated to be $51.1 million. The reason for the decrease to Harris Health is that other supplemental funding is being considered in the payment-to-cost calculations, thus limiting the DSH funding. Harris Health will continue to provide intergovernmental transfers (IGT) for the private hospitals for Medicaid DSH, and will be credited that same IGT amount in the payment calculations.

- ***Uncompensated Care (UC) and High Impecunious Charge Hospital (HICH)***

Under the terms of the January 2021 1115 Waiver, HHSC negotiated with Centers for Medicare and Medicaid (CMS) for the continuation and resizing of the statewide UC pool. The result of that 2021 pool resizing was an increase of approximately $600 million annually, for a total UC of $4.5 billion for demonstration years DY12 through DY16. The additional UC funding was used to create a new High Impecunious Charge Hospital (HICH) sub-pool starting last year. Consequently, when HHSC updated the Uncompensated Care (UC) program rules effective FY 2023, they added the above HICH sub-pool to the overall UC pool. Eligibility to receive funds from the HICH sub-pool is restricted to rural hospitals, state-owned hospitals, and hospitals that have at least 30% of their charges from serving uninsured persons. Harris Health falls into the last category, and has received funding from the UC HICH sub-pool.

HHSC has flexibility to determine how much of the current ($4.5 billion) UC pool is in the HICH sub-pool. Based on the recently released calculations, final FY 2024 UC allocations sized the HICH sub-pool down to $350 million state-wide while FY 2025 allocations are unknown until the State publishes related data. As a result of the resizing, total FY 2024 UC funding for Harris Health was revised down by $37 million, to $429.5 million. Pending HHSC's payment projections for the next budget year, the expected UC distribution has been similarly adjusted down to $416.9 million in FY 2025 budget.

***Excludes revenue and expense associated with Correctional Health Services**

- ***Hospital Augmented Reimbursement Program (HARP)***

The Hospital Augmented Reimbursement Program (HARP) is a relatively new statewide supplemental program (as of FFY 2022) providing Medicaid payments to hospitals for inpatient and outpatient services that serve Texas Medicaid fee-for-service (FFS) patients. As of this writing, HHSC has an inquiry out to CMS related to allowing an exception for nominal charge hospitals to be paid more than their charges for the HARP program. Harris Health falls into this nominal charge category and is currently limited to $89.3 million annually, with a projected FY 2025 impact of $96.7 million.

- ***Comprehensive Hospital Increase Reimbursement Program (CHIRP)***

For the Comprehensive Hospital Increase Reimbursement Program (CHIRP), the net annual benefit to the system is estimated at $25.7 million for FY 2024 and $30.8 million in FY 2025. In FY 2025, the CHIRP umbrella will introduce two new programs, the Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA) and Aligning Technology by Linking Interoperable Systems (ATLIS). As the name implies, APHRIQA is a hospital incentive program as an additional component to the existing CHIRP hospital rate enhancement programs. The net financial impact from this component to Harris Health is about $5 million reflected in the CHIRP total above. Aligning Technology by Linking Interoperable Systems (ATLIS) is an incentive program for Medicaid MCOs that provides a different targeted percent of premium amount by service area and program type (e.g., STAR, STAR+PLUS, etc.). The overall goal of the ATLIS program is to provide an incentive to Managed Care Organizations (MCOs) to encourage their in-network hospitals to provide real time notifications on their Medicaid patients' admissions, discharges and transfers, as well as a set of clinical information. HHSC believes that MCO receipt of this data should improve MCO quality of care to patients.

- ***Network Access Improvement Program (NAIP)***

The Network Access Improvement Program (NAIP) funding is expected to be stable at around $24.8 million for FY 2024 through FY 2025. This program is slated to sunset in FY 2026.

- ***Graduate Medical Education (GME)***

The Graduate Medical Education (GME) funding program, started in October 2018, allows for recovery of some GME costs. The net benefit to Harris Health in FY 2024 is estimated at $26.3 million and is projected at the same level for FY 2025.

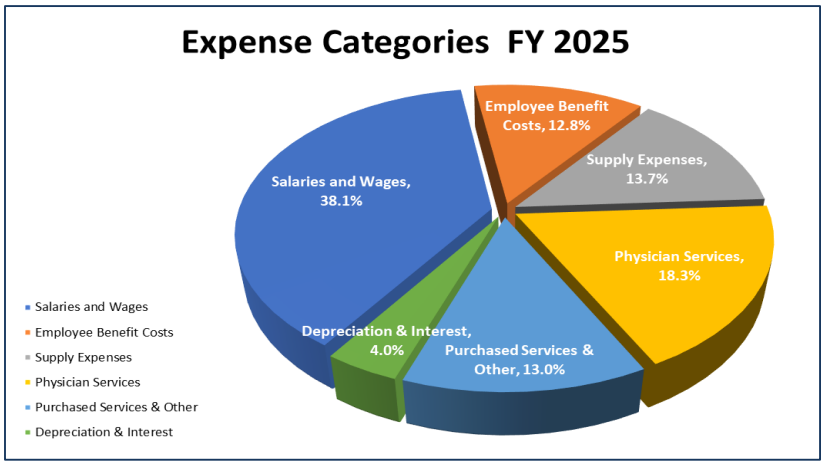
Other Revenue

Other revenues represent approximately 6% of Harris Health's total revenue and are expected to remain stable for FY 2025 at $150.2 million. Investments are expected to continue to perform favorably; thus, investment income is projected at $76.1 million for FY 2025, just under FY 2024 year-end projected values to allow for expected interest rate adjustments by Federal Reserve. The first annual philanthropic commitment of $10 million from the Strategic Fund is reflected in the capital gifts and grants section of Other Revenue. Annual tobacco settlement revenue and other operating revenue comprise the remainder of Other Revenue and are projected to remain at FY 2024 levels of $15.2 million and $48.9 million for FY 2025, respectively.

***Excludes revenue and expense associated with Correctional Health Services**

Expense Projections

During FY 2024, total Harris Health operating expense is projected to end the year at $2.379 billion, an increase of $189.5 million or 8.7% compared to FY 2023. After accounting for general inflationary increases of 3.8% or $90.0 million and an additional $50.9 million associated with the aforementioned implementation of the Strategic Plan, total operating expense for FY 2025 is expected to be $2.520 billion or 5.9% greater than FY 2024 projected year end. Inclusion of the pending strategic initiatives into the final operating budget for FY 2025 is dependent on the final adopted tax rate set by Harris County. Anything resulting in a margin of less than 1% will require reevaluation and reprioritization of the strategic projects for FY 2025.



Salaries, Wages and Benefits

Salaries and wages are expected to grow by 5.7%, or $51.7 million in FY 2025, to a total of $960.5 million. This increase includes general inflationary adjustments of 4.5% or $44 million to account for merit and market adjustments in alignment with current market trends. These adjustments are needed to remain competitive in the current healthcare market. Additional salary and wage expense anticipated in FY 2025 is attributed to volume increases and approved strategic initiatives.

Overall benefits are expected to grow by $12.1 million, or 3.9% in FY 2025 to a total of $322.4 million. This includes a 3.0% general inflationary increase for employee health insurance as well as increases

***Excludes revenue and expense associated with Correctional Health Services**

associated with the salary adjustments noted above. Pension and Post Employee Health Benefit projections are based on the most recently available actuarial assumptions.

The cost of the total compensation portfolio in FY 2025 to support ongoing operations is budgeted at $1.283 billion, or 50.9% of the total operating budget.

Supply Expense

Overall supplies, inclusive of pharmaceutical expense, is projected to increase by 4.5% or $14.9 million in FY 2025 to a total of $345.7 million. This includes inflation of 3.0% for general supplies while Premier, Harris Health's Group Purchasing Organization, is projecting a 3.9% rate of inflation in overall drug budgets for DSH-eligible hospitals and 2.5% in inpatient pharmaceutical costs for 2025. These increases are partially offset by a reduction in expense attributed to refresh projects for minor equipment and furniture which took place in FY 2024 and will not carry over into FY 2025. Additional incremental expense is attributed to approved strategic initiatives.

Physician Services

Physician Services are projected to increase by 4.8% or $21.2 million to $462.0 million in FY 2025. The projected expense assumes provider vacancies remain steady as compared to FY 2024. This increase is attributed to increases in the average contract rate for salaries as well as expected service expansions which are projected to raise the cost of provider services. Service expansions for FY 2025 include an increase in on-call coverage for the expansion of the Hospital at Home Service as well as a growth related to inpatient neonatology/pediatric providers and the Endoscopy Center at Quentin Mease. Also contributing to the additional expense for FY 2025 is an anticipated increase in psychiatry emergent on-site faculty coverage.

Purchased Services

Purchased Services are expected to grow by 14.2%, or $40.8 million in FY 2025, to a total of $328.0 million. Included in these projections are general inflationary increases of 4.0% as well as costs associated with implementation of the previously mentioned strategic initiatives, primarily the major IT initiatives which

kicked off in FY2024. Also contributing to the increase is bond issuance costs which have shifted to later in FY 2025.

Depreciation, Amortization and Interest

Overall depreciation & interest is projected to remain flat compared to FY 2024 year-end projections at $100.9 million. Interest expense is expected to increase by approximately $10.3 million attributed to the issuance of the first installment of the $2.5 billion bond expected late summer 2025. The increase in interest expense is offset by a decrease in depreciation attributed to catch-up entries recorded in FY 2024 related to the completion of major construction projects which are not expected to carry over into FY 2025.

In summary, total operating expense for Harris Health is projected to grow by $140.9 million, or 5.9%, to $2.520 billion in FY 2025, including $50.9 million earmarked for ongoing and prioritized initiatives in support of the organization's Strategic Plan discussed above. The result is a proposed operating margin of 1% or $29.1 million predicated on the approval of the Voter Approved Tax Rate by the Harris County Commissioners Court. System administration will keep the Board of Trustees updated regarding any changes in assumptions materially affecting Harris Health's FY 2025 Operating and Capital Budget resulting from ongoing discussions with the Harris County Office of Management & Budget (OMB) and Commissioners Court.

***Excludes revenue and expense associated with Correctional Health Services**

Capital Expenditures

Harris Health is continuously assessing its facilities, equipment and technology to determine the priorities for replacement, repair and any new acquisitions. The assessment and prioritization methodology addresses patient safety, building safety and code compliance requirements, planned equipment obsolescence, and new technology.

The overall capital budget for FY 2024 was $187.7 million, of which $103.8 million was for investment in facilities infrastructure. As of the 3rd Quarter of FY 2024, $179.3 million or 95.5% of the approved capital budget has been allocated, not including funds received from The Harris County Hospital District Foundation. The proposed capital budget for FY 2025 is projected at $158.7 million for routine capital only, based on commitments. Capital dollars attributed to the $2.5 billion bond issuance and associated strategic capital projects are not included.

Category Totals	Budget FY 2025
$'s in Millions	
Facility Projects	$ 53.80
Information Technology	30.49
Medical Equipment	57.59
Other	14.84
Emergency Capital	2.00
Total Capital Budget	$ 158.7

***Excludes revenue and expense associated with Correctional Health Services**

Harris Health
Statement of Revenues and Expenses
Fiscal 2025 Proposed Budget

$ In Millions	FY 2023 Audited Year End Excluding Correctional Health	FY 2024 Projected Year End Excluding Correctional Health	FY 2025 Proposed Budget Excluding Correctional Health NNR Tax Rate	FY 2025 Proposed Budget Excluding Correctional Health VAR Tax Rate
Revenue:				
Net Patient Service Revenue	$ 753.6	$ 742.2	$ 754.7	$ 754.7
Medicaid Supplemental Programs	719.3	678.5	647.2	647.2
Capital Gifts & Grants	9.5	0.0	10.0	10.0
Other Operating Revenue	44.0	46.9	48.9	48.9
Total Operating Revenue	**1,526.4**	**1,467.6**	**1,460.8**	**1,460.8**
Net Ad Valorem Tax Revenue	822.8	905.2	896.3	996.5
Net Tobacco Settlement Revenue	15.2	15.2	15.2	15.2
Interest Income & Other	76.7	78.9	76.1	76.1
Total Nonoperating Revenue	**914.7**	**999.3**	**987.6**	**1,087.9**
Total Net Revenue	**$ 2,441.1**	**$ 2,466.9**	**$ 2,448.4**	**$ 2,548.7**
Expense:				
Salaries and Wages	$ 837.3	$ 908.8	$ 960.5	$ 960.5
Employee Benefits	322.8	310.3	322.4	322.4
Total Labor Cost	**1,160.1**	**1,219.0**	**1,282.9**	**1,282.9**
Supplies	283.4	330.8	345.7	345.7
Physician Services	407.0	440.8	462.0	462.0
Purchased Services	249.3	287.2	328.0	328.0
Depreciation, Amortization & Interest	89.4	100.8	100.9	100.9
Total Operating Expense	**$ 2,189.1**	**$ 2,378.7**	**$ 2,519.5**	**$ 2,519.5**
Operating Income (Loss)	**$ 251.9**	**$ 88.3**	**$ (71.1)**	**$ 29.1**
Total Margin	**10.3%**	**3.6%**	**-2.9%**	**1.1%**

Harris Health
Statistical Highlights
Fiscal 2025 Proposed Budget

		Actual FY 2023	Projected FY 2024	Budget FY 2025
	Volumes:			
1	**Primary Care Clinic Visits**			
	MD Clinic Visits	529,096	531,552	536,541
	Telehealth Visits	108,719	97,734	99,023
2	**Specialty Clinic Visits**			
	MD Clinic Visits	244,897	246,859	243,317
	Telehealth Visits	18,406	19,393	19,171
3	**Total Clinic Visits**	**901,118**	**895,538**	**898,052**
4	**Total Emergency Room Visits**	**155,570**	**162,867**	**160,951**
5	**Total Surgery Cases**	**20,704**	**21,274**	**21,714**
6	**Total Outpatient Visits**	**1,488,890**	**1,479,563**	**1,480,381**
7	**Births**	**5,494**	**5,340**	**5,376**
8	Inpatient Cases (Discharges)	31,530	30,780	31,871
9	Outpatient Observation Cases	10,074	11,649	11,397
10	**Total Cases Occupying Patient Beds**	**41,604**	**42,429**	**43,268**
11	Inpatient Days	196,734	196,624	201,014
12	Outpatient Observation Days	33,085	40,023	36,715
13	**Total Patient Days**	**229,819**	**236,647**	**237,729**
14	**Average Daily Census**	**629.6**	**646.6**	**651.3**
15	**Payor Mix (% of Charges):**			
16	**Charity & Self Pay**	**44.26%**	**43.82%**	**43.82%**
17	**Medicaid & Medicaid Managed**	**22.65%**	**19.27%**	**19.27%**
18	**Medicare & Medicare Managed**	**11.41%**	**11.73%**	**11.73%**
19	**Other Third-Party Payers**	**21.69%**	**25.18%**	**25.18%**

Appendix A

Harris Health
Fiscal 2025 Strategic Goals and Outcomes

Harris Health's strategic priorities are set forth in the 2021-2025 strategic plan.

Strategic Focus Area	Goal Statement	Outcome Measure
Quality and Patient Safety	Harris Health will become a high reliability organization (HRO) with quality and patient safety as a core value, where zero patient harm is not only a possibility but an expectation.	Reduction in the number of safety events (high harm and never events) per 10,000 adjusted patient days
		Reduction in the number of Hospital Acquired Conditions (HACs) per 1,000 discharges
People (Patients, Employees, Medical Staff)	Harris Health will promote a culture of respect, recognition and trust with its patients, staff and providers.	Reduction in staff turnover for employees with less than two years of tenure
		Improvement in patient experience scores
One Harris Health	Harris Health will act as one system in its approach to management and delivery of healthcare and ensure that consistent structure and resources are in place across the platform.	Improvement in patient throughput and remediation of gaps to ensure one consistent framework for all support services
		Demonstrate fiscal responsibility and stewardship by controlling costs and maximizing efficiency to achieve a 2% annual margin
Population Health Management	Harris Health will measurably improve patient health outcomes by optimizing a cross- continuum approach to health that is anchored in high impact preventive, virtual and community-based services, deployed in coordination with clinical and social services partners, and underwritten by actionable population health analytics and technology.	Expansion of Food Farmacies and chronic disease management model in at least two new locations annually with the goal of reducing HbA1c levels in highest and high-risk diabetic patients enrolled
		Reduction of wait time for appointments in key specialties/procedures
		Expansion of on-site services at HCJ thus reducing the number of detainees transported to outside facilities
		Reduction in time to first provider visit after intake at HCJ
		Reduction in time to first dose medication after intake at HCJ
Infrastructure Optimization	Harris Health will invest in and optimize infrastructure related to facilities, information technology and telehealth, information security, and health informatics to	Completion of phase two facility master plans for replacement hospitals for LBJ and Ben Taub

Harris Health
Fiscal 2025 Strategic Goals and Outcomes

Strategic Focus Area	Goal Statement	Outcome Measure
	increase value, ensure safety and meet the current and future needs of the patients we serve.	Increase in the number of inpatient beds available (through internal utility failure mitigation strategies and external partnerships)
Diversity, Equity and Inclusion	Harris Health will ensure equitable access to high quality care for patients, foster a diverse and inclusive workplace, cultivate and sustain strategic relationships with suppliers and community partners, and broaden its reach and understanding of the communities it serves.	Improvement in employee engagement score for "this organization's work environment is accepting and supportive of people with diverse backgrounds
		Improvement in Race, Ethnicity, Gender, Age and preferred Language (REGAL) data capture
		Improvement in M/WBE contract review, overall spend, and community outreach efforts
		Expansion of academic and community partnerships to enhance and promote DEI workforce pipeline and talent acquisition initiatives, programs and resources

Appendix B

Harris Health
Fiscal 2025 Capital Budget

Major Capital Project Highlights		FY 2025 Budget
Infrastructure		
Lyndon B. Johnson CenterPoint (Electrical Undergroup Service and Gas)	$	18,400,000
Ben Taub Diesel Tanks Replacement		3,000,000
Ben Taub Electrical Switch Gear		2,200,000
Aldine Roof and Skylight		1,400,000
Smith Clinic Process Chillers 1, 2, and 3		700,000
	$	**25,700,000**
Renovation		
Ben Taub 4th Floor OR Refresh		4,800,000
ACS Health Information Management Renovations (Northwest, Acres Home, Aldine)		400,000
	$	**5,200,000**
Transformation		
Central Fill Pharmacy/EMS Build-Out and Expansion		8,800,000
Lyndon B. Johnson Interventional Radiology Reconfiguration		900,000
Ben Taub Tower Outpatient Vascular/Cardiology and Support Offices		850,000
Ben Taub New Echo Lab Build-Out and Relocation		750,000
	$	**11,300,000**
Medical Equipment		
System-wide Multi-device Equipment Refresh		14,243,558
System-wide Endoscope replacement (ongoing)		3,500,000
Oupatient Center/Ambulatory Surgical Center Surgical Lighting System		3,300,000
System-wide Ultrasound		3,124,785
Ben Taub Nuclear Medicine Gamma Camera & SPECT/CT		2,200,000
System-wide Patient Monitoring Update		1,500,000
	$	**27,868,343**
Other		
Leases - Facilities		6,519,845
Leases - Equipment		1,114,380
Subscription Based IT (SBIT)		1,000,000
System Vehicle Refresh (Capital Lease)		1,250,000
Ambulance Refresh		1,025,000
HH Security Equipment Refresh		983,334
HH Exterior Signage Upgrade		700,000
	$	**12,592,559**
IT		
IT Technology Governance		15,000,000
IT Data Center Core Network Hardware Refresh		3,010,500
IT Network Infrastructure Hardware Upgrade for Fournace and Forty ACS sites		3,010,500
IT Oracle Database Encryption in Exadata Environment		2,160,000
IT VMware Hosts for Harris Health projects		1,345,104
IT Workstation on Wheels tech refresh		1,070,289
IT Citrix Epic and Clinical infrastructure refresh		974,746
	$	**26,571,139**
Subtotal Major Projects	**$**	**109,232,041**

Appendix C

Harris Health

Statistical Highlights

Fiscal 2025 Proposed Budget

BT Patient Days

Actual FY2023	Projected FY2024	Budget FY2025
147,964	153,700	154,599

BT Cases Occupying Beds

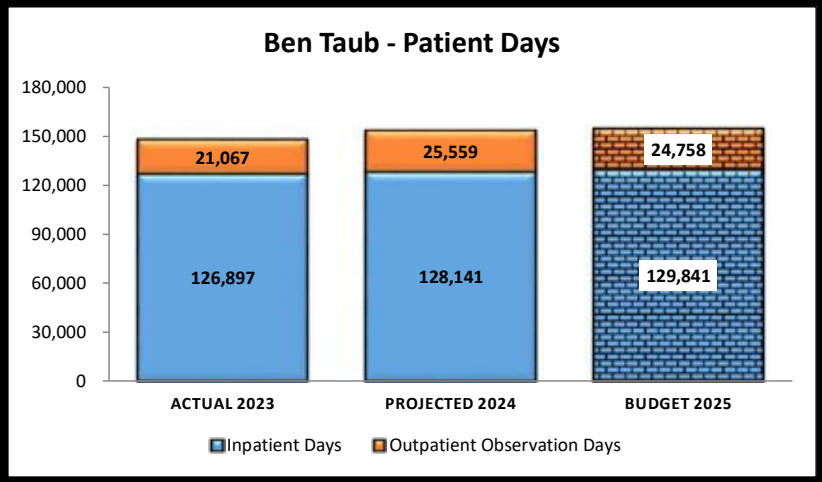
Actual FY2023	Projected FY2024	Budget FY2025
24,831	25,070	25,887

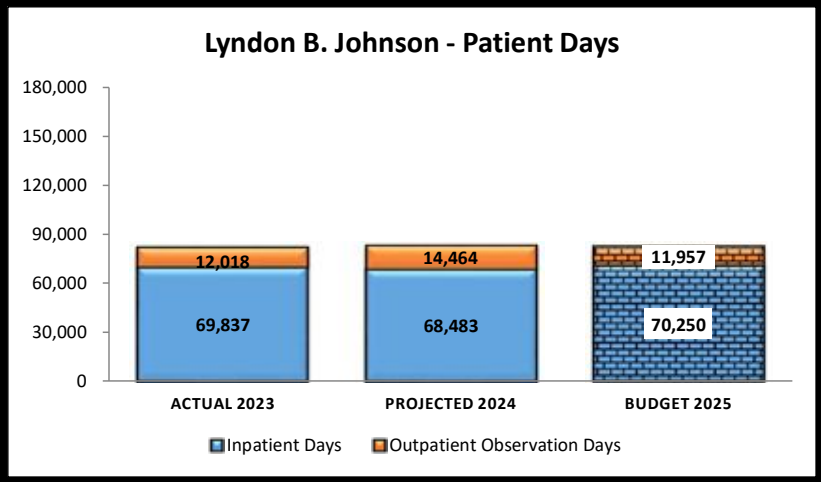
LBJ Patient Days

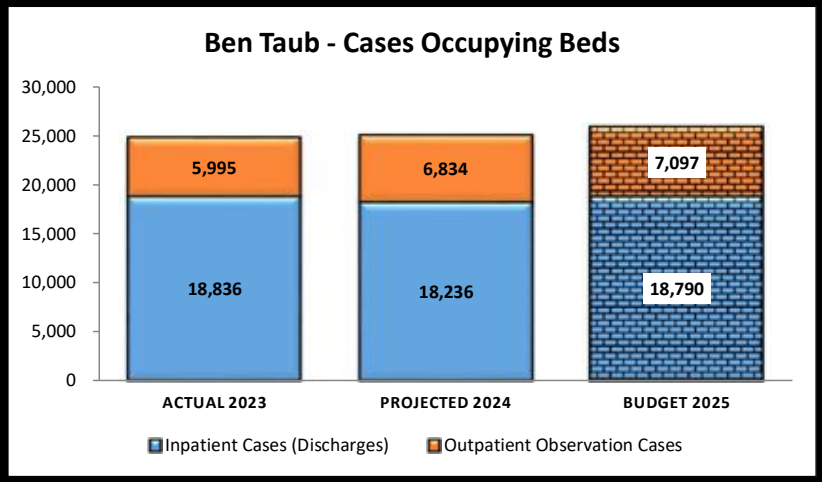
Actual FY2023	Projected FY2024	Budget FY2025
81,855	82,947	82,207

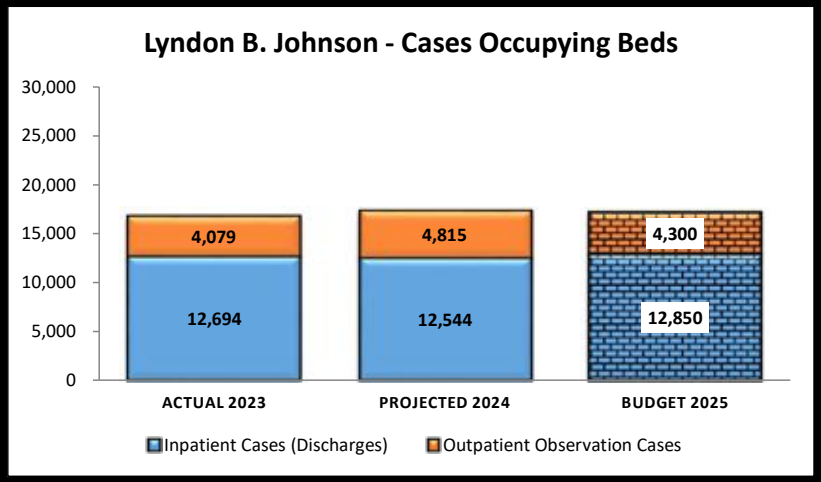
LBJ Cases Occupying Beds

Actual FY2023	Projected FY2024	Budget FY2025
16,773	17,359	17,150









Harris Health

Statistical Highlights

Fiscal 2025 Proposed Budget

BT Emergency Visits

Actual FY2023	Projected FY2024	Budget FY2025
76,693	**83,225**	**82,651**

BT Surgery Cases

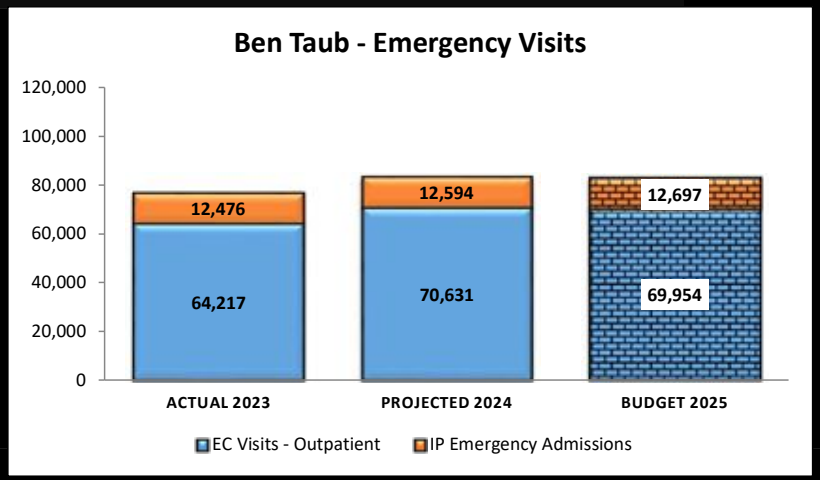
Actual FY2023	Projected FY2024	Budget FY2025
11,286	**11,742**	**11,696**

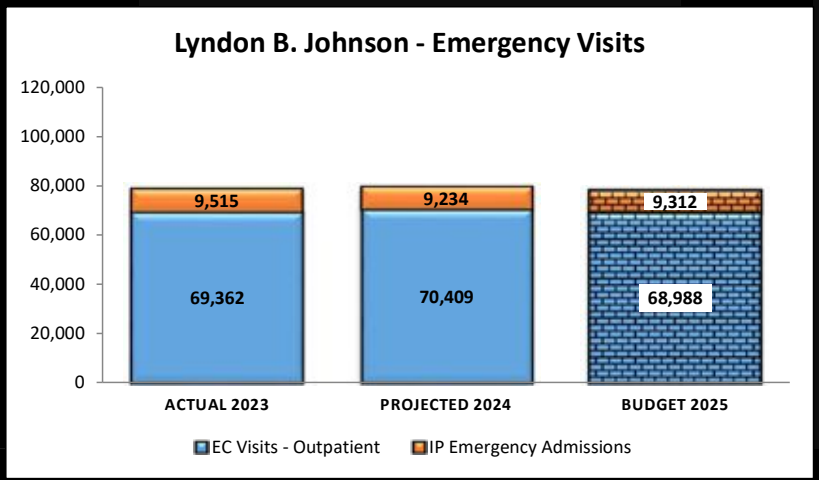
LBJ Emergency Visits

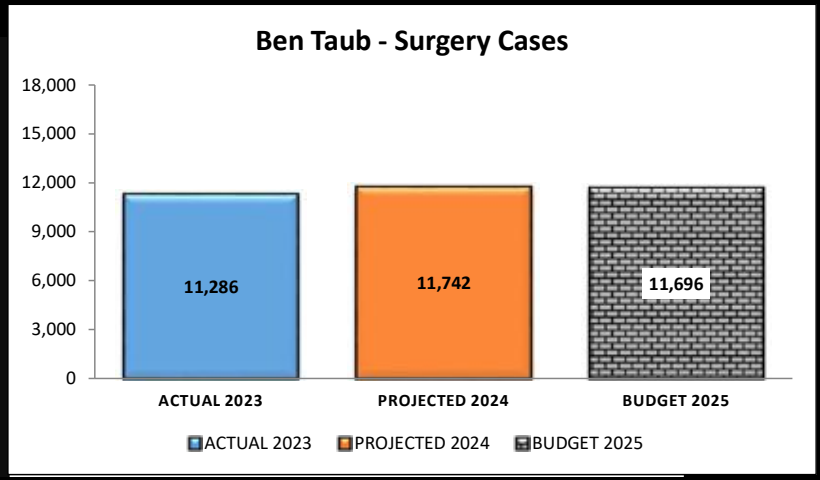
Actual FY2023	Projected FY2024	Budget FY2025
78,877	**79,643**	**78,300**

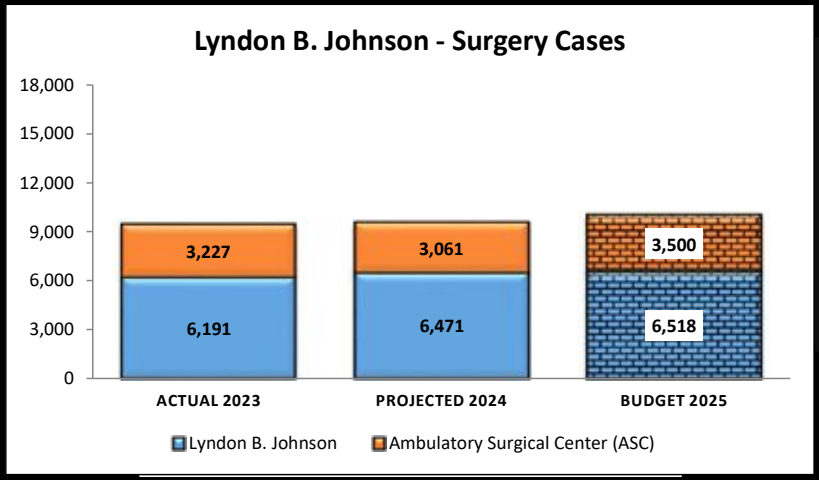
LBJ Surgery Cases

Actual FY2023	Projected FY2024	Budget FY2025
9,418	**9,532**	**10,018**









Harris Health

Statistical Highlights

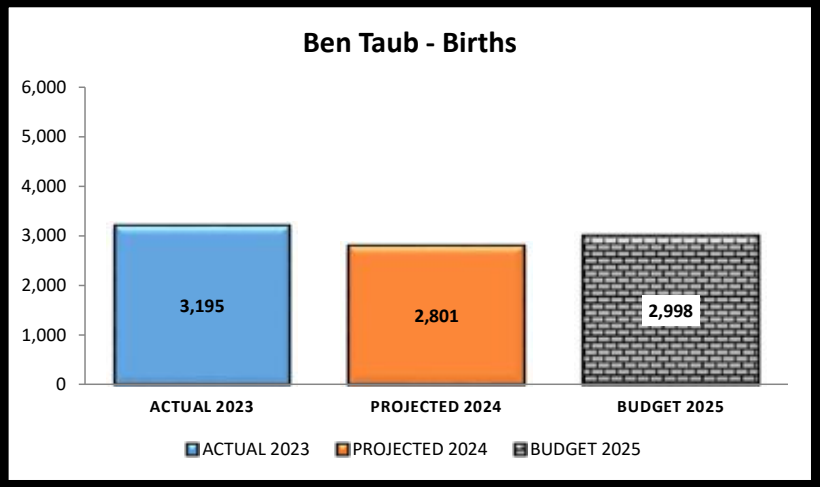
Fiscal 2025 Proposed Budget

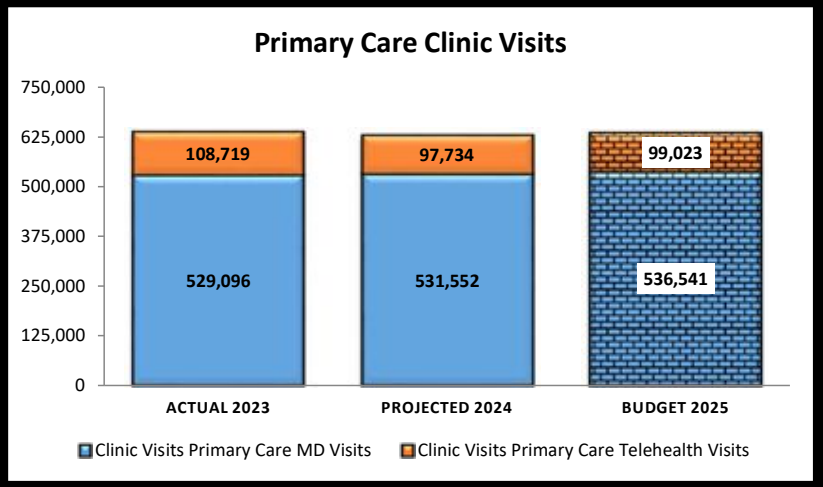
BT Births		
Actual FY2023	Projected FY2024	Budget FY2025
3,195	2,801	2,998

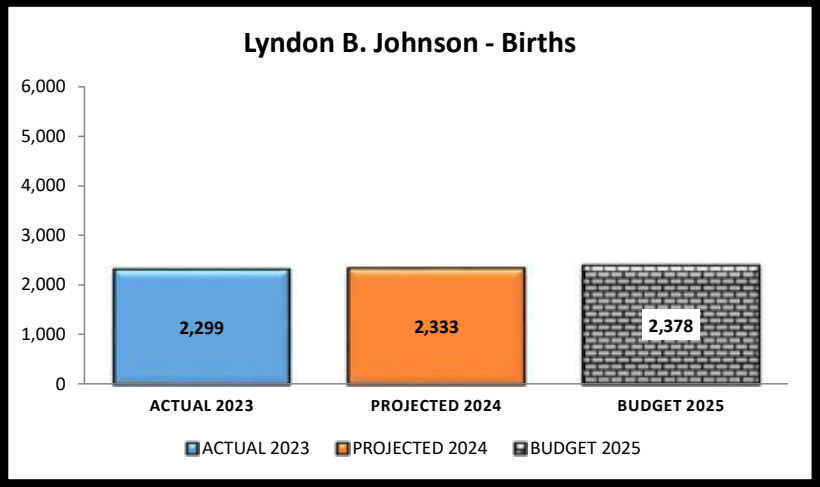
LBJ Births		
Actual FY2023	Projected FY2024	Budget FY2025
2,299	2,333	2,378

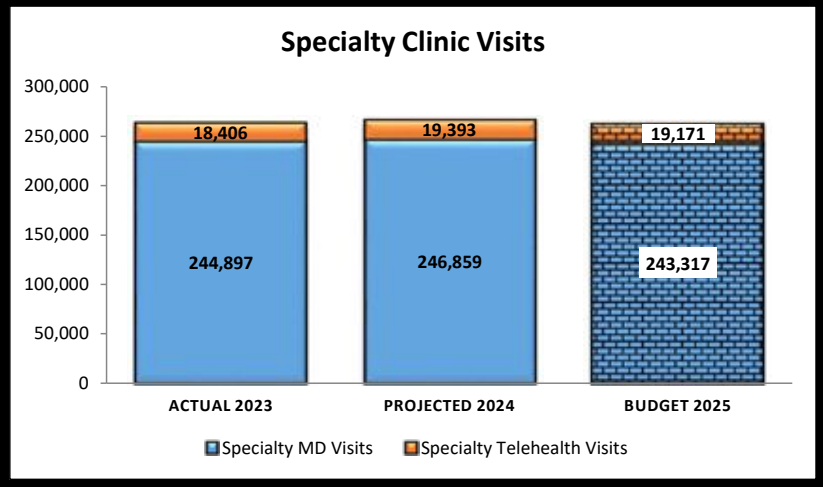
Primary Care Clinic Visits		
Actual FY2023	Projected FY2024	Budget FY2025
637,815	629,286	635,564

Specialty Clinic Visits		
Actual FY2023	Projected FY2024	Budget FY2025
263,303	266,252	262,488









2024 Strategic Discussion Reporting Schedule

Strategic Pillar	Executive Owner	JAN 2024	FEB 2024	MAR 2024	APR 2024	MAY 2024	JUN 2024	JUL 2024	AUG 2024	SEP 2024	OCT 2024	NOV 2024	DEC 2024
Pillar 1: Quality & Patient Safety	Dr. Steven Brass												
Rollout of HRO Progress (Presented in Quality Committee)	Dr. Steven Brass			X									
Physician Engagement Survey (Presented in Joint Conference Committee)	Dr. Steven Brass			X									
Pillar 2: People	Omar Reid/ Dr. Jackie Brock										X		
Employee Engagement Survey	Omar Reid/ Gary Marsh				X								
Pillar 3: One Harris Health	Louis Smith										X		
Hospital at Home - Program Operations	Dr. Amy Smith/ Dr. Shazia Sheikh					X							
Pillar 4: Population Health Management	Dr. Jennifer Small/ Dr. Chethan Bachireddy												
Systematizing Screening & Referrals for Health-Related Social Needs (HRSN) (Presented in Quality Committee)	Hope Galvan/ Denise LaRue	X											
Community Health Worker Home Visit Program (Presented in Diversity Committee)	Hope Galvan				X								
Social Determinants of Health: Medical Legal Partnership (Presented in Quality Committee)	Dr. Chethan Bachireddy/ Hope Galvan								X				
Pillar 5: Infrastructure Optimization	Louis Smith												X
New LBJ Hospital and LBJ Campus Planning	Louis Smith/ Trish Darnauer					X							
IT Technology Governance	Louis Smith/ Ron Fuschillo						X						
Pillar 6: Diversity & Inclusion	Omar Reid												
Minority Women Owned Business Enterprise (Presented in Diversity Committee)	Dr. Jobi Martinez/ Derek Holmes				X								
M/WBE Annual Report (Presented in Diversity Committee)	Dr. Jobi Martinez/ Derek Holmes								X				

*Subject to Change
Revised: 8.19.24

Thursday, August 29, 2024

August Committee Reports

August Committee Meetings:

- Quality Committee – August 13, 2024
  A summary was attached for your review.

  - HRO Safety Message – Video: Hand Hygiene
  - Social Determinants of Health: Providing Legal Services

- Diversity Equity and Inclusion (DEI) Committee – August 16, 2024

  - MWBE Annual Report
  - Revised 2024 DEI Reporting Schedule

Please refer to the reports presented at the Quality Committee Executive Session on August 13, 2024 for additional details.

HRO Safety Message – Video: Hand Hygiene

High-reliability Organizations (HROs) are those that successfully complete their missions despite massive complexity and high risk. Examples include the Federal Aviation Administration's Air Traffic Control system, aircraft carriers, and nuclear power plants. In each case, even a minor error could have catastrophic consequences. Yet, adverse outcomes in these organizations are rare. Five principles of a High Reliability Organization (HRO) are: (1) Preoccupation with failure; (2) Reluctance to simplify interpretations; (3) Sensitivity to operations; (4) Commitment to resilience; and (5) Deference to expertise.

Social Determinants of Health: Providing Legal Services

Screening patients for health-related social needs (HRSN) and connecting those who want assistance to internal and external resources is a key activity in Harris Health's health equity strategy. Harris Health's Medical Legal Partnership (MLP) with South Texas College of Law – Houston (STCL-Houston) began in October 2022 to address patients' health harming legal needs, such as housing and guardianship.

DeWight Dopslauf, C.P.M., CPPO
Harris County Purchasing Agent

August 14, 2024

Board of Trustees Office
Harris Health

RE: Board of Trustees Meeting – August 29, 2024
Budget and Finance Agenda Items

The Office of the Harris County Purchasing Agent recommends approval of the attached procurement actions. All recommendations are within the guidelines established by Harris County and Harris Health System.

Sincerely,

DeWight Dopslauf

DeWight Dopslauf
Purchasing Agent

JA/ea
Attachments

1111 Fannin, 12th Floor, Houston, TX 77002 Tel 713-274-4400 Fax 713-755-6695

Budget and Finance Agenda Items for the Harris County Hospital District dba Harris Health System - Board of Trustees Report

Expenditure Summary: August 29, 2024 (Approvals)

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
A1	**Skanska USA Building Inc.** MWBE Goal: 20%	**Construction and Build-out of New Central Fill Pharmacy and EMS at Smith Clinic for Harris Health** - To provide all labor, materials, equipment and incidentals for the construction of the Central Fill Pharmacy program and EMS relocating to a new facility at 2525 Holly Hall. The owner contingency provides for coverage on unanticipated costs throughout the construction project ***Job No. 240213***	Best proposal meeting requirements	Babak Zare		**$ 59,750,000**
A2	**The Trevino Group, Inc.** MWBE Goal: 25%	**Renovation and Buildout of the Outpatient Vascular and Cardiology Clinic at Ben Taub Hospital for Harris Health System** - To provide all labor, materials, equipment and incidentals for the renovation and buildout of the outpatient vascular and cardiology clinic at Ben Taub Hospital. The owner contingency provides for coverage on unanticipated costs throughout the construction project ***Job No. 240181***	Lowest priced proposal meeting requirements	Babak Zare		**$ 3,596,700**
A3	**Terracon Consultants, Inc. (HCHD-843)** MWBE Goal: 12%	**Professional Engineering Services for Lyndon B. Johnson Hospital Expansion Project for Harris Health** - The County Attorney's Office is preparing the First Amendment for the additional funds. ***Job No. 230018, Board Motion 23.07-114***	Additional Funds December 19, 2023 through December 18, 2024	Patrick Casey	$ 100,000	**$ 2,750,000**
A4	**The Trevino Group, Inc.** MWBE Goal: 25%	**Expansion and Buildout of MRI Suite at Ben Taub Hospital for Harris Health System** - To provide all labor, materials, equipment and incidentals for the expansion of first floor and MRI Suite at Ben Taub Hospital. The owner contingency provides for coverage on unanticipated costs throughout the construction project. ***Job No. 240187***	Lowest priced proposal meeting requirements	Babak Zare		**$ 2,107,200**
A5	**National NNL Group, Inc.** MWBE Goal: Exempt Public Health or Safety	**Generators for Harris Health** - To provide three (3) generators needed for backup power to Harris Health facilities in emergency situations. National NNL Group, Inc. was selected based on immediate availability. ***Public Health or Safety Exemption***	Ratify Purchase Public Health or Safety Exemption	Patrick Casey		**$ 1,648,550**
A6	**Baylor College of Medicine (HCHD-1346)** MWBE Goal: 0% Non-Divisible	**Medical Services to Eligible HIV-Infected Patients of Harris Health** - Physicians and healthcare practitioners will provide comprehensive outpatient primary health services for eligible HIV-infected patients at Harris Health. ***Professional Services Exemption***	Ratify Purchase Professional Services Exemption One (1) year initial term	Dawn Jenkins		**$ 1,135,739**
A7	**Highlights Electrical** MWBE Goal: 5%	**Job Order Contracting for Electrical and/or Electrical Related Projects for Harris Health** - To provide electrical repair, renovation or alteration to various hospitals and clinics for Harris Health. ***Job No. 180070, Board Motion 24.03-38***	Additional Funds	Terry Elliot	$ 925,000	**$ 925,000**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
A8	**Olympus America Inc.** MWBE Goal: Exempt Sole Source	**Repair Services for Olympus brand equipment for Harris Health** - Olympus will provide repairs, loaner equipment, and replacement parts for Olympus brand endoscopes and video equipment located throughout Harris Health. ***Sole Source Exemption***	Purchase Sole Source Exemption One (1) year initial term with two (2) one-year renewal options	James Young		**$ 863,705**
A9	**The Brandt Companies, LLC** MWBE Goal: 11%	**Replacement of RTUs and Split Systems at MLK Health Center for Harris Health** - Replacement of eleven (11) existing HVAC Rooftop Units and two (2) Split Systems that are past their useful life, and not economical to maintain and are unreliable. ***Choice Partners, a division of Harris County Department of Education Cooperative Program***	Award Low quote	Babak Zare		**$ 861,957**
A10	**Berkeley Research Group, LLC** MWBE Goal: 13%	**Strategic Planning Consulting Services for Harris Health System** - To provide consulting services to facilitate and develop a five (5) year strategic plan for Harris Health. ***Job No. 240112***	Award Best proposal meeting requirements One (1) year initial term with one (1) one-year renewal option	Maria Cowles		*
A11	**Olympus America Incorporated (GA-07591)** MWBE Goal: 0% Non-Divisible	**Repair and Maintenance Program for Endoscopy and Video Equipment** - An Amendment and additional funds are needed to extend the current Agreement 90 days and to add additional equipment to the current Agreement from the quarterly true-up process. The extension will will allow time to get a new Agreement in place. ***Sole Source Exemption, Board Motion 23.05-73***	Ratify Additional Funds Extension Sole Source Exemption June 06, 2024 through September 06, 2024	James Young	$ 901,540	**$ 538,416**
A12	**Hearst Newspaper, LLC d/b/a Houston Chronicle** MWBE Goal: 0% Specialized, Technical, or Unique in Nature	**Advertising Services and Related Items for Harris Health** - To provide advertising space in print publication as needed for Harris Health. ***Job No. 220234***	Award Best proposal meeting requirements One (1) year initial term with four (4) one-year renewal options	Amanda Callaway		**$ 500,000**
A13	**University of Texas, Health Science Center at Houston (HCHD-1345)** MWBE Goal: 0% Non-Divisible	**Medical Services to Eligible HIV-Infected Patients of the Harris Health** - Physicians and healthcare practitioners will provide comprehensive outpatient primary health services for eligible HIV-infected patients at Harris Health. ***Professional Services Exemption***	Ratify Purchase Professional Services Exemption One (1) year initial term	Dawn Jenkins		**$ 490,172**
A14	**Elekta, Inc.** MWBE Goal: Exempt Sole Source	**Maintenance and Support for the Oncology Information System (MOSAIQ) for Harris Health** - Elekta will provide maintenance and support for the Oncology Information System (MOSAIQ) for the Elekta linear accelerators at Smith Clinic. ***Sole Source Exemption***	Purchase Sole Source Exemption One (1) year initial term with two (2) one-year renewal options	David Layman		**$ 477,875**
A15	**The Trevino Group, Inc.** MWBE Goal: 27%	**Renovation of X-Ray Suite at Vallbona Health Center for Harris Health System** - To provide all labor, materials, equipment and incidentals for the renovation of x-ray suite at Vallbona Health Center. The owner contingency provides for coverage on unanticipated costs throughout the construction project ***Job No. 240192***	Best proposal meeting requirements	Babak Zare		**$ 467,500**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
A16	**The Trevino Group, Inc.** MWBE Goal: 24%	**Renovation of Mammography Suite at Vallbona Health Center for Harris Health System** - To provide all labor, materials, equipment and incidentals for the renovation of mammography suite at Vallbona Health Centerr. The owner contingency provides for coverage on unanticipated costs throughout the construction project ***Job No. 240193***	Lowest priced proposal meeting requirements	Babak Zare		**$ 411,000**
					Total Expenditures	$ 77,268,414
					Total Revenue	$ (0)

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, August 29, 2024

Consideration of Approval to Adopt the Revised 2024 DEI Reporting Schedule to Reflect Bi-monthly Meetings with a Lengthened Meeting Time of 90-Minutes, as recommended by the Diversity Equity and Inclusion Committee

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Omar C. Reid, MBA, IPMA, CP
Executive Vice President & Chief People Officer

BOARD OF TRUSTEES

Diversity Equity and Inclusion Committee

HARRISHEALTH SYSTEM

REVISED 2024 DEI REPORTING SCHEDULE

January 2024	Employee Engagement Survey Findings, Food Bank Update
February 2024	DEI Survey Analysis
March 2024	*Meeting Canceled*
April 2024	CHW Home Visits
May 2024	*Meeting Canceled*
June 2024	*Meeting Canceled*
July 2024	Break *(There are no Committee meetings scheduled for the month of July)*
August 2024	MWBE Annual Report
September 2024	*(No DEI meeting scheduled for the month due to the bi-monthly meeting change)*
October 2024 **11:30 a.m. – 1:00 p.m.*	Patient Perspectives on Access to Care F/U DEI Data Analysis
November 2024	*(No DEI meeting scheduled for the month due to the bi-monthly meeting change)*
December 2024	Break *(There are no Committee meetings scheduled for the month of December)*

Revised: 01.12.24; 04.09.24; 08.07.24

Thursday, August 29, 2024

Consideration of Approval of Grant Recommendations (Items C1 through C3)

Grant Recommendations:

C1. Ratification of a Grant Award
- Grantor: The United States Department of Health Resources and Services Administration (HRSA)
- Term: January 1, 2024 – December 31, 2024
- Award Amount: $427,612.00
- Project Owner: Dr. Jennifer Small

C2. Ratification and Amendment of an Interlocal Grant Agreement
- Grantor: Harris County Public Health, funded by Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009
- Term: March 1, 2024 – February 28, 2025
- Award Amount: $7,498,409.23
- Project Owner: Dr. Jennifer Small

C3. Ratification of a Grant Award Renewal (year 3 of a 4-year grant)
- Grantor: The United States Department of Health Resources and Services Administration (HRSA)
- Term: August 1, 2024 – July 31, 2025
- Award Amount: $464,814.00
- Project Owner: Dr. Jennifer Small

Grant Agenda Items for the Harris County Hospital District dba Harris Health System, Board of Trustees Report
Grant Agreement Summary: August 29, 2024

No.	Grantor	Description/Justification	Action, Basis of Recommendation	Term	Project Owner	Award Amount
C1	The United States Department of Health Resources and Services Administration (HRSA)	Consideration of Approval to Ratify a Grant Award allocation from the United States Department of Health Resources and Services Administration (HRSA) to the Harris County Hospital District d/b/a Harris Health System Funded by Part C of the Ryan White HIV/AIDS Treatment Extension Act of 2009 to Provide **Early Intervention Primary Medical Care to HIV Positive Patients** of Harris Health. This grant award includes an additional $212,002 + $215,610 of offset funding to the current award of $598,655 for a total of $1,026,267.	**Ratification of a Grant Award**	January 1, 2024 through December 31, 2024	Dr. Jennifer Small	$ 427,612.00
C2	Harris County Public Health *Funded by Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009*	Consideration of Approval to Ratify and Amend an Interlocal Agreement Between the Harris County Hospital District d/b/a Harris Health System and Harris County Public Health Funded by Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A to Provide **Primary Medical Care, Psychiatric Services, Obstetric and Gynecological Care, and Local Pharmacy Assistance Program to HIV Positive Patients** of Harris Health. This amendment is the 2nd allocation towards the full award for the 2024-2025 grant year and increases the current agreement by $7,498,409.23 for a total award of	**Ratification and Amendment of an Interlocal Grant Agreement**	March 1, 2024 through February 28, 2025	Dr. Jennifer Small	$ 7,498,409.23
C3	The United States Department of Health Resources and Services Administration (HRSA)	Consideration of Approval to Ratify a Grant Award Renewal from the United States Department of Health & Human Services Administration (HRSA) to the Harris County Hospital District d/b/a Harris Health System funded under Part D of the Ryan White HIV/AIDS Treatment Extension Act of 2009 to provide **Outpatient Family Centered Care for Women, Infants, Children, and Youth living with HIV/AIDS**. (year 3 of a 4-year grant)	**Ratification of a Grant Award Renewal**	August 1, 2024 through July 31, 2025	Dr. Jennifer Small	$ 464,814.00
					TOTAL AMOUNT:	**$ 8,390,835.23**

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, August 29, 2024

Consideration of Acceptance of the Harris Health June 2024 Financial Report Subject to Audit

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Attached for your review and consideration is the June 2024 Financial Report.

Administration recommends that the Board accept the financial report for the period ended June 30, 2024, subject to final audit.

Victoria Nikitin

Victoria Nikitin
Executive Vice President – Chief Financial Officer

HARRISHEALTH SYSTEM

Financial Statements

As of the Quarter Ended June 30, 2024
Subject to Audit

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HARRISHEALTH SYSTEM

Financial Highlights Review

HARRISHEALTH SYSTEM

As of the Quarter Ended June 30, 2024 and 2023

Operating income for the quarter ended June 30, 2024 was $71.3 million compared to budgeted income of $16.0 million.

Total quarterly net revenue for June of $664.8 million was $1.8 million or 0.3% less than budget. Net patient revenue and investment earnings were $15.7 million and $6.6 million more than budget, respectively. Medicaid Supplemental programs were $25.7 million less than expected primarily due to timing.

Total quarterly expenses of $593.5 million were $57.1 million or 8.8% less than budget. Total labor costs were $33.3 million less than budget due to lower benefit expense, primarily lower pension expense based on the recently issued actuarial report. Total services had a favorable variance of $9.3 million driven mostly by lower non-clinical costs and medical insurance subsidy. Interest expense was $20.2 million less than planned due to the timing of the new bond issuance shifting to FY 2025.

For the third quarter, total patient days and average daily census increased 6.8% compared to budget. Inpatient case mix index, a measure of patient acuity, was 3.0% higher than budget with length of stay 15.4% over budget. Emergency room visits were 9.7% higher than planned for the quarter. Total clinic visits, including telehealth, were 5.7% lower compared to budget. Births were 3.3% higher than budget for the quarter.

Total cash receipts for the quarter were $384.6 million. The System has $1,497.2 million in unrestricted cash, cash equivalents and investments, representing 239.1 days cash on hand. Harris Health System has $154.7 million in net accounts receivable, representing 76.0 days of outstanding patient accounts receivable at June 30, 2024. The June balance sheet reflects a combined net receivable position of $232.8 million under the various Medicaid Supplemental programs. The current portion of ad valorem taxes receivable is $18.6 million, which is offset by ad valorem tax collections as received. Deferred ad valorem tax revenue is $227.3 million, and is released as ad valorem tax revenue is recognized. As of June 30, 2024, $877.4 million in ad valorem tax collections were received and $681.8 million in current ad valorem tax revenue was recognized.

Income Statement

HARRISHEALTH SYSTEM

As of the Quarter Ended June 30, 2024 and 2023 (in $ Millions)

	QUARTER-TO-DATE			YEAR-TO-DATE			
	CURRENT YEAR	CURRENT BUDGET	PERCENT VARIANCE	CURRENT YEAR	CURRENT BUDGET	PERCENT VARIANCE	PRIOR YEAR	PERCENT VARIANCE
REVENUE								
Net Patient Revenue	$ 192.1	$ 176.4	8.9%	$ 557.9	$ 525.9	6.1%	$ 538.3	3.6%
Medicaid Supplemental Programs	178.4	204.1	-12.6%	506.4	612.4	-17.3%	513.0	-1.3%
Other Operating Revenue	30.7	30.1	2.2%	96.7	91.1	6.1%	91.2	6.0%
Total Operating Revenue	**$ 401.2**	**$ 410.6**	**-2.3%**	**$ 1,161.0**	**$ 1,229.4**	**-5.6%**	**$ 1,142.6**	**1.6%**
Net Ad Valorem Taxes	225.2	224.1	0.5%	678.2	672.4	0.9%	626.3	8.3%
Net Tobacco Settlement Revenue	15.2	15.2	0.2%	15.2	15.2	0.2%	15.2	0.2%
Capital Gifts & Grants	-	-	0.0%	-	-	0.0%	-	0.0%
Interest Income & Other	23.1	16.6	38.9%	58.9	49.9	18.1%	59.6	-1.2%
Total Nonoperating Revenue	**$ 263.5**	**$ 255.9**	**3.0%**	**$ 752.2**	**$ 737.5**	**2.0%**	**$ 701.1**	**7.3%**
Total Net Revenue	**$ 664.8**	**$ 666.5**	**-0.3%**	**$ 1,913.2**	**$ 1,966.8**	**-2.7%**	**$ 1,843.7**	**3.8%**
EXPENSE								
Salaries and Wages	$ 235.1	$ 239.1	1.7%	$ 707.8	$ 721.6	1.9%	$ 654.2	-8.2%
Employee Benefits	59.2	88.4	33.1%	224.1	265.3	15.5%	219.5	-2.1%
Total Labor Cost	**$ 294.2**	**$ 327.5**	**10.2%**	**$ 931.9**	**$ 986.9**	**5.6%**	**$ 873.7**	**-6.7%**
Supply Expenses	79.4	80.6	1.5%	223.6	239.5	6.7%	215.3	-3.8%
Physician Services	122.3	122.8	0.4%	339.3	346.3	2.0%	318.7	-6.5%
Purchased Services	72.1	80.9	10.9%	204.8	241.9	15.3%	184.4	-11.1%
Depreciation & Interest	25.4	38.8	34.4%	75.8	96.8	21.7%	62.8	-20.6%
Total Operating Expense	**$ 593.5**	**$ 650.5**	**8.8%**	**$ 1,775.4**	**$ 1,911.3**	**7.1%**	**$ 1,654.9**	**-7.3%**
Operating Income (Loss)	**$ 71.3**	**$ 16.0**		**$ 137.8**	**$ 55.5**		**$ 188.8**	
Total Margin %	**10.7%**	**2.4%**		**7.2%**	**2.8%**		**10.2%**	

Balance Sheet

HARRISHEALTH SYSTEM

As of June 30, 2024 and 2023 (in $ Millions)

	CURRENT YEAR	PRIOR YEAR
CURRENT ASSETS		
Cash, Cash Equivalents and Short Term Investments	$ 1,497.2	$ 1,486.3
Net Patient Accounts Receivable	154.7	145.2
Net Ad Valorem Taxes, Current Portion	18.6	7.4
Other Current Assets	350.2	218.0
Total Current Assets	**$ 2,020.7**	**$ 1,857.0**
CAPITAL ASSETS		
Plant, Property, & Equipment, Net of Accumulated Depreciation	$ 555.3	$ 420.8
Construction in Progress	171.0	213.9
Right of Use Assets	38.8	43.8
Total Capital Assets	**$ 765.0**	**$ 678.6**
ASSETS LIMITED AS TO USE & RESTRICTED ASSETS		
Debt Service & Capital Asset Funds	$ 37.0	$ 40.8
LPPF Restricted Cash	23.5	24.3
Capital Gift Proceeds	54.3	46.9
Other - Restricted	1.0	1.0
Total Assets Limited As to Use & Restricted Assets	**$ 115.9**	**$ 113.0**
Other Assets	48.1	43.0
Deferred Outflows of Resources	199.4	210.0
Total Assets & Deferred Outflows of Resources	**$ 3,149.2**	**$ 2,901.5**
CURRENT LIABILITIES		
Accounts Payable and Accrued Liabilities	$ 227.7	$ 210.1
Employee Compensation & Related Liabilities	150.0	133.1
Deferred Revenue - Ad Valorem	227.3	210.6
Estimated Third-Party Payor Settlements	29.1	13.1
Current Portion Long-Term Debt and Capital Leases	37.6	20.1
Total Current Liabilities	**$ 671.6**	**$ 586.8**
Long-Term Debt	280.9	316.9
Net Pension & Post Employment Benefits Liability	724.0	642.8
Other Long-Term Liabilities	6.7	7.6
Deferred Inflows of Resources	114.7	197.0
Total Liabilities	**$ 1,798.0**	**$ 1,751.2**
Total Net Assets	**$ 1,351.2**	**$ 1,150.3**
Total Liabilities & Net Assets	**$ 3,149.2**	**$ 2,901.5**

Cash Flow Summary

HARRISHEALTH SYSTEM

As of the Quarter Ended June 30, 2024 and 2023 (in $ Millions)

	QUARTER-TO-QUARTER		YEAR-TO-DATE	
	CURRENT YEAR	PRIOR YEAR	CURRENT YEAR	PRIOR YEAR
CASH RECEIPTS				
Collections on Patient Accounts	$ 225.9	$ 169.7	$ 621.7	$ 520.7
Medicaid Supplemental Programs	66.9	(0.4)	670.3	859.7
Net Ad Valorem Taxes	11.2	13.5	877.4	820.1
Tobacco Settlement	15.2	15.2	15.2	15.2
Other Revenue	65.3	73.8	192.3	181.4
Total Cash Receipts	**$ 384.6**	**$ 271.8**	**$ 2,377.0**	**$ 2,397.1**
CASH DISBURSEMENTS				
Salaries, Wages and Benefits	$ 325.7	$ 308.5	$ 995.9	$ 976.9
Supplies	81.7	78.0	239.5	229.2
Physician Services	107.8	98.3	315.8	297.5
Purchased Services	68.5	67.0	203.6	179.8
Capital Expenditures	46.7	36.9	127.3	101.1
Debt and Interest Payments	0.8	0.8	6.7	19.8
Other Uses	(4.5)	(16.3)	3.7	(70.8)
Total Cash Disbursements	**$ 626.7**	**$ 573.3**	**$ 1,892.5**	**$ 1,733.6**
Net Change	**$ (242.1)**	**$ (301.4)**	**$ 484.6**	**$ 663.5**

Unrestricted Cash, Cash Equivalents and Investments - Beginning of year	$ 1,012.6
Net Change	484.6
Unrestricted Cash, Cash Equivalents and Investments - End of period	**$ 1,497.2**

Performance Ratios

HARRISHEALTH SYSTEM

As of the Quarter Ended June 30, 2024 and 2023 (in $ Millions)

	QUARTER-TO-DATE		YEAR-TO-DATE		
	CURRENT YEAR	CURRENT BUDGET	CURRENT YEAR	CURRENT BUDGET	PRIOR YEAR
OPERATING HEALTH INDICATORS					
Operating Margin %	10.7%	2.4%	7.2%	2.8%	10.2%
Run Rate per Day (In$ Millions)	$ 6.3	$ 7.0	$ 6.2	$ 6.8	$ 5.9
Salary, Wages & Benefit per APD	$ 2,203	$ 2,615	$ 2,352	$ 2,627	$ 2,344
Supply Cost per APD	$ 594	$ 643	$ 564	$ 638	$ 578
Physician Services per APD	$ 916	$ 980	$ 856	$ 922	$ 855
Total Expense per APD	**$ 4,443**	**$ 5,195**	**$ 4,481**	**$ 5,088**	**$ 4,440**
Overtime as a % of Total Salaries	3.5%	2.9%	3.4%	2.9%	3.6%
Contract as a % of Total Salaries	3.9%	4.4%	4.3%	4.4%	5.2%
Full-time Equivalent Employees	10,420	10,192	10,362	10,189	9,920
FINANCIAL HEALTH INDICATORS					
Quick Ratio			3.0		3.1
Unrestricted Cash (In $ Millions)			$ 1,497.2	$ 1,076.4	$ 1,486.3
Days Cash on Hand			239.1	158.2	252.2
Days Revenue in Accounts Receivable			76.0	87.4	73.7
Days in Accounts Payable			46.3		48.3
Capital Expenditures/Depreciation & Amortization			195.5%		187.0%
Average Age of Plant(years)			10.3		11.8

Harris Health System Key Indicators

Statistical Highlights

HARRISHEALTH SYSTEM

As of the Quarter Ended June 30, 2024 and 2023

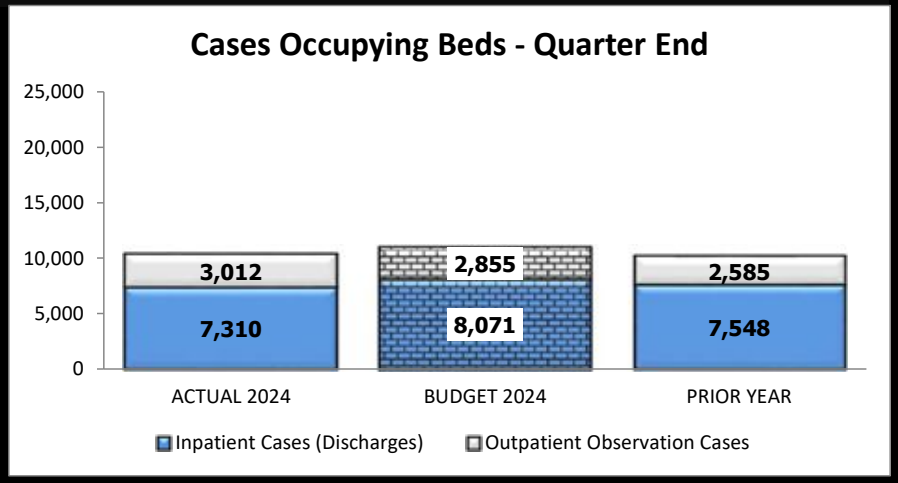
	QUARTER-TO-DATE			YEAR-TO-DATE				
	CURRENT QUARTER	CURRENT BUDGET	PERCENT CHANGE	CURRENT YEAR	CURRENT BUDGET	PERCENT CHANGE	PRIOR YEAR	PERCENT CHANGE
Adjusted Patient Days	133,587	122,194	9.3%	396,246	372,636	6.3%	373,151	6.2%
Outpatient % of Adjusted Volume	63.0%	61.3%	2.8%	62.5%	60.9%	2.6%	60.7%	3.0%
Primary Care Clinic Visits	128,862	138,482	-6.9%	393,366	407,707	-3.5%	394,671	-0.3%
Specialty Clinic Visits	63,434	62,989	0.7%	183,993	182,048	1.1%	184,215	-0.1%
Telehealth Clinic Visits	27,449	31,532	-12.9%	85,007	98,015	-13.3%	97,226	-12.6%
Total Clinic Visits	**219,745**	**233,003**	**-5.7%**	**662,366**	**687,770**	**-3.7%**	**676,112**	**-2.0%**
Emergency Room Visits - Outpatient	37,492	33,861	10.7%	106,313	98,622	7.8%	98,389	8.1%
Emergency Room Visits - Admitted	5,265	5,129	2.7%	16,154	15,000	7.7%	16,466	-1.9%
Total Emergency Room Visits	**42,757**	**38,990**	**9.7%**	**122,467**	**113,622**	**7.8%**	**114,855**	**6.6%**
Surgery Cases - Outpatient	2,941	2,910	1.1%	8,570	8,090	5.9%	8,398	2.0%
Surgery Cases - Inpatient	2,838	2,598	9.2%	7,631	7,756	-1.6%	7,153	6.7%
Total Surgery Cases	**5,779**	**5,508**	**4.9%**	**16,201**	**15,846**	**2.2%**	**15,551**	**4.2%**
Total Outpatient Visits	**377,204**	**382,405**	**-1.4%**	**1,107,118**	**1,122,365**	**-1.4%**	**1,113,723**	**-0.6%**
Inpatient Cases (Discharges)	7,310	8,071	-9.4%	22,885	23,936	-4.4%	23,493	-2.6%
Outpatient Observation Cases	3,012	2,855	5.5%	8,687	8,337	4.2%	7,398	17.4%
Total Cases Occupying Patient Beds	**10,322**	**10,926**	**-5.5%**	**31,572**	**32,273**	**-2.2%**	**30,891**	**2.2%**
Births	1,269	1,229	3.3%	3,847	3,960	-2.9%	4,001	-3.8%
Inpatient Days	49,453	47,310	4.5%	148,549	145,593	2.0%	146,641	1.3%
Outpatient Observation Days	10,364	8,688	19.3%	29,685	24,224	22.5%	23,634	25.6%
Total Patient Days	**59,817**	**55,998**	**6.8%**	**178,234**	**169,817**	**5.0%**	**170,275**	**4.7%**
Average Daily Census	657.3	615.4	6.8%	650.5	619.8	5.0%	623.7	4.3%
Average Operating Beds	710	702	1.1%	702	702	0.0%	683	2.8%
Bed Occupancy %	92.6%	87.7%	5.6%	92.7%	88.3%	5.0%	91.3%	1.5%
Inpatient Average Length of Stay	6.77	5.86	15.4%	6.49	6.08	6.7%	6.24	4.0%
Inpatient Case Mix Index (CMI)	1.744	1.694	3.0%	1.705	1.694	0.6%	1.708	-0.2%
Payor Mix (% of Charges)								
Charity & Self Pay	43.7%	44.3%	-1.4%	43.6%	44.3%	-1.4%	44.1%	-1.0%
Medicaid & Medicaid Managed	18.6%	22.7%	-17.8%	19.3%	22.7%	-14.7%	23.2%	-16.7%
Medicare & Medicare Managed	11.1%	11.4%	-2.8%	11.6%	11.4%	1.6%	11.6%	0.3%
Commercial & Other	26.6%	21.7%	22.9%	25.5%	21.7%	17.5%	21.2%	20.1%
Total Unduplicated Patients - Rolling 12				**247,386**			**248,628**	**-0.5%**
Total New Patient - Rolling 12				**89,510**			**87,459**	**2.3%**

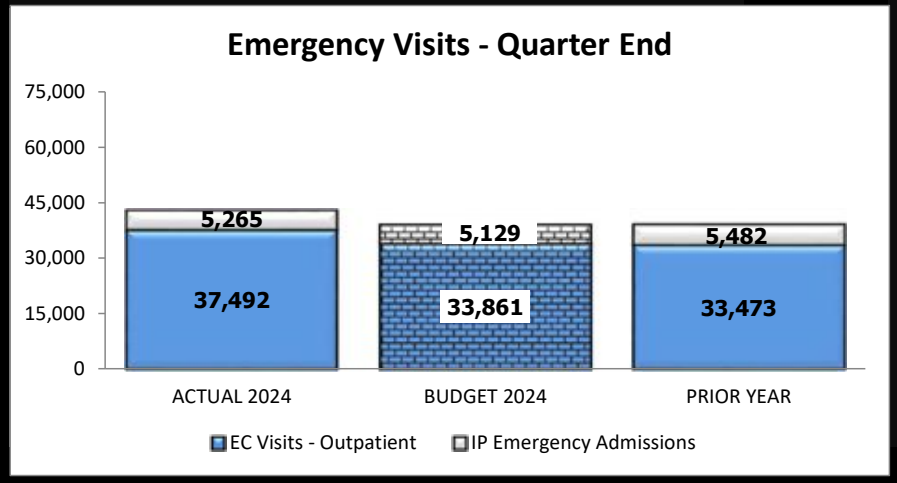
Harris Health System

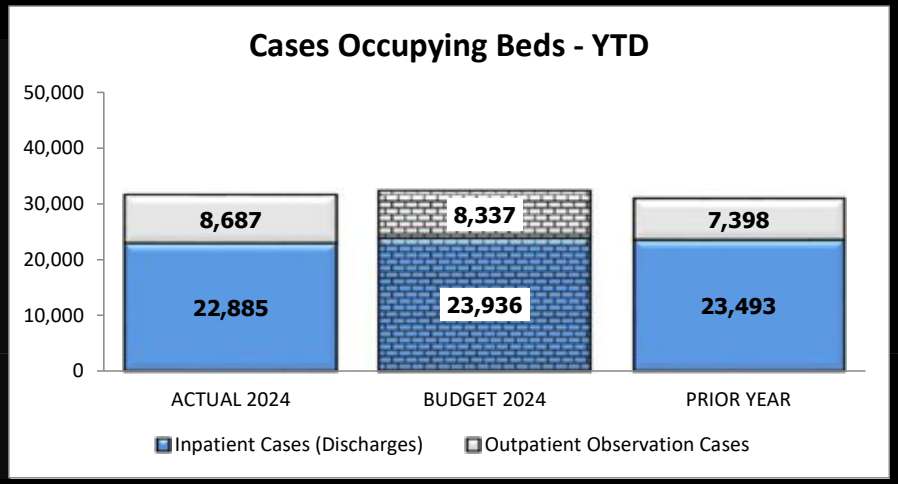
Statistical Highlights

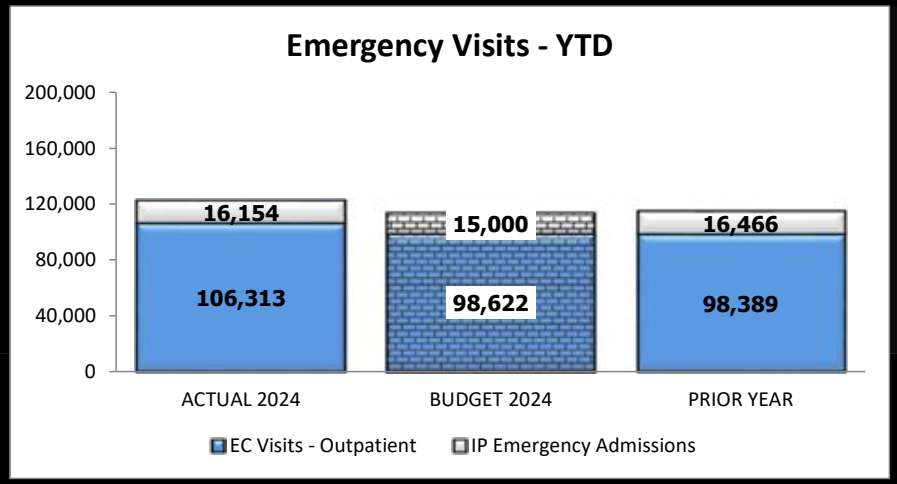
As of the Quarter Ended June 30, 2024

Cases Occupying Beds - Q3			Cases Occupying Beds - YTD			Emergency Visits - Q3			Emergency Visits - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
10,322	10,926	10,133	31,572	32,273	30,891	42,757	38,990	38,955	122,467	113,622	114,855









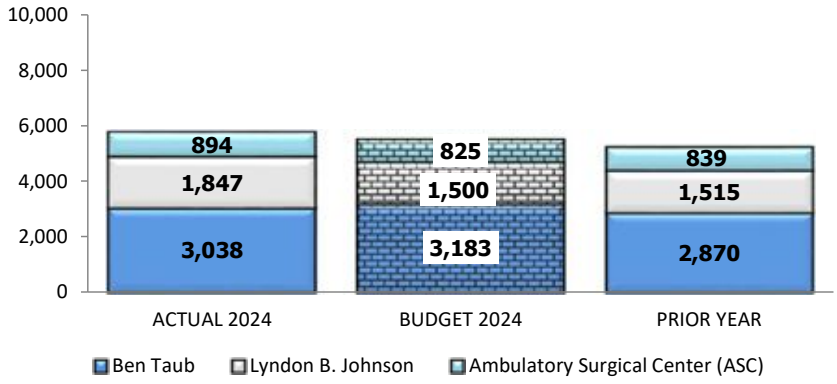
Harris Health System

Statistical Highlights

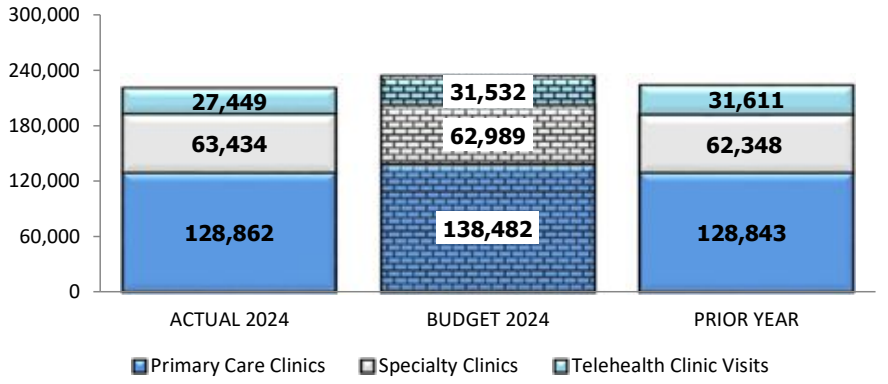
As of the Quarter Ended June 30, 2024

Surgery Cases - Q3			Surgery Cases - YTD			Clinic Visits - Q3			Clinic Visits - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
5,779	5,508	5,224	16,201	15,846	15,551	219,745	233,003	222,802	662,366	687,770	676,111

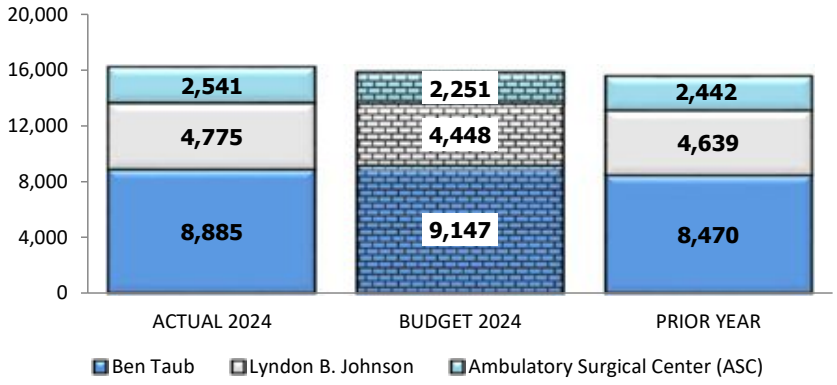
Surgery Cases - Quarter End



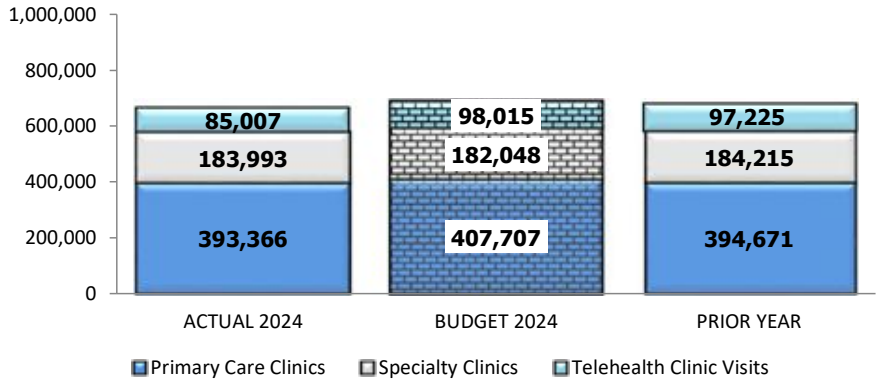
Clinic Visits - Quarter End



Surgery Cases - YTD



Clinic Visits - YTD



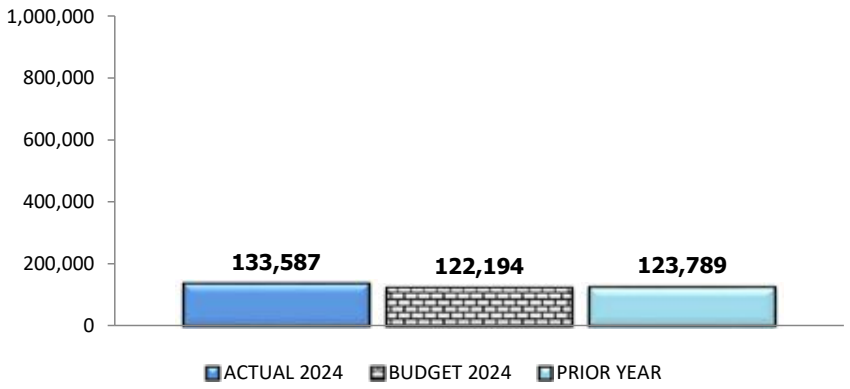
Harris Health System

Statistical Highlights

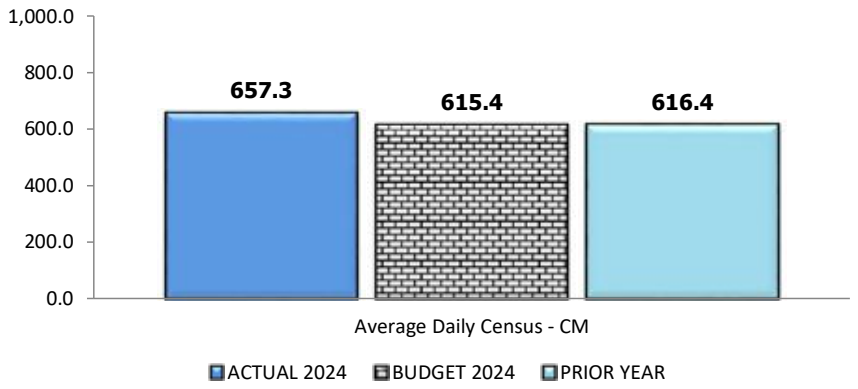
As of the Quarter Ended June 30, 2024

Adjusted Patient Days - Q3	Adjusted Patient Days - YTD	Average Daily Census - Q3	Average Daily Census - YTD
133,587	396,246	657.3	650.5

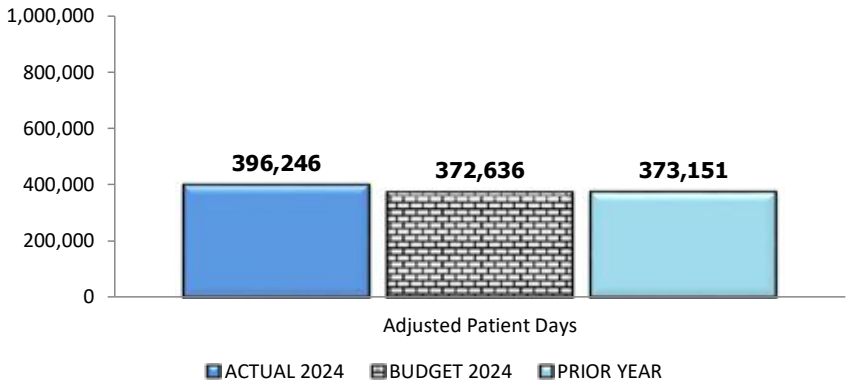
Adjusted Patient Days - Quarter End



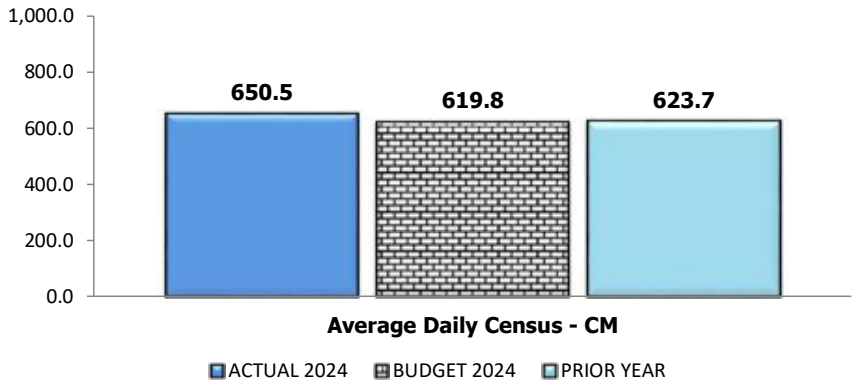
Average Daily Census - Quarter End



Adjusted Patient Days - YTD



Average Daily Census - YTD



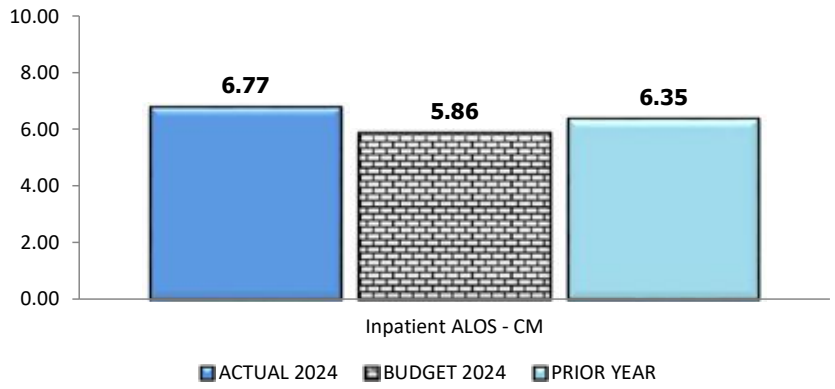
Harris Health System

Statistical Highlights

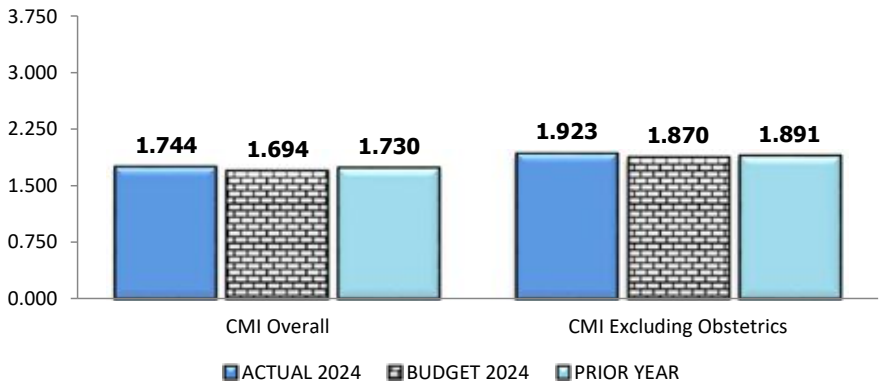
As of the Quarter Ended June 30, 2024

Inpatient ALOS - Q3	Inpatient ALOS - YTD	Case Mix Index - Q3		Case Mix Index (CMI) - YTD	
		Overall	Excl. Obstetrics	Overall	Excl. Obstetrics
6.77	6.48	1.744	1.923	1.705	1.879

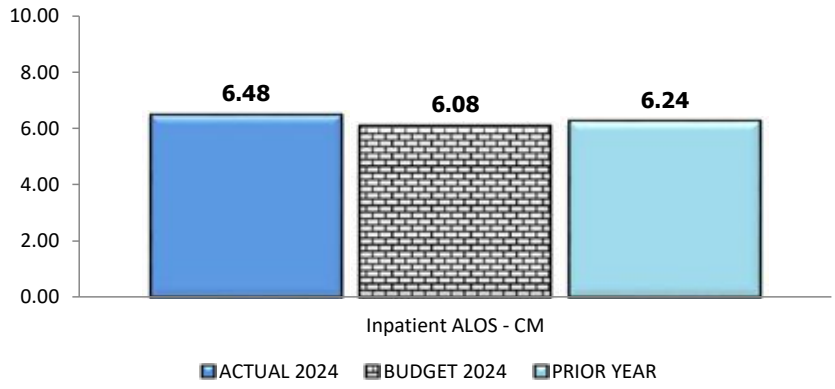
Inpatient ALOS - Quarter End



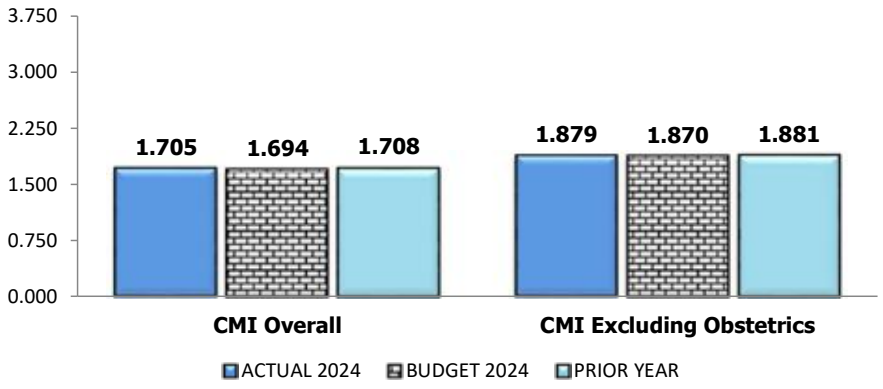
Case Mix Index - Quarter End



Inpatient ALOS - YTD



Case Mix Index - YTD



Harris Health System

Statistical Highlights - Cases Occupying Beds

As of the Quarter Ended June 30, 2024

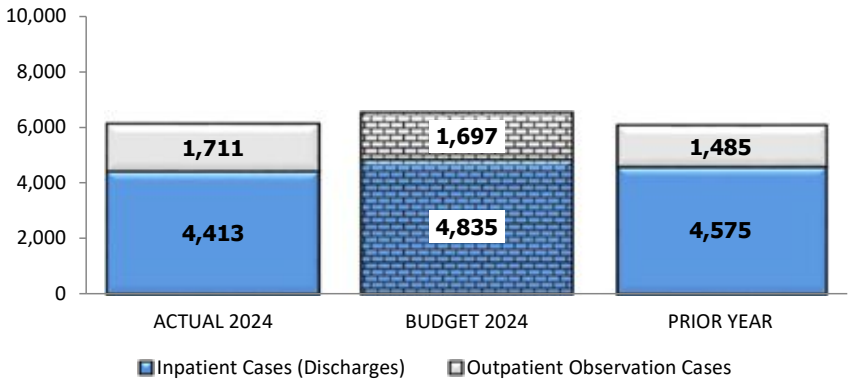
BT Cases Occupying Beds - Q3		
Actual	Budget	Prior Year
6,124	6,532	6,060

BT Cases Occupying Beds - YTD		
Actual	Budget	Prior Year
18,751	19,370	18,369

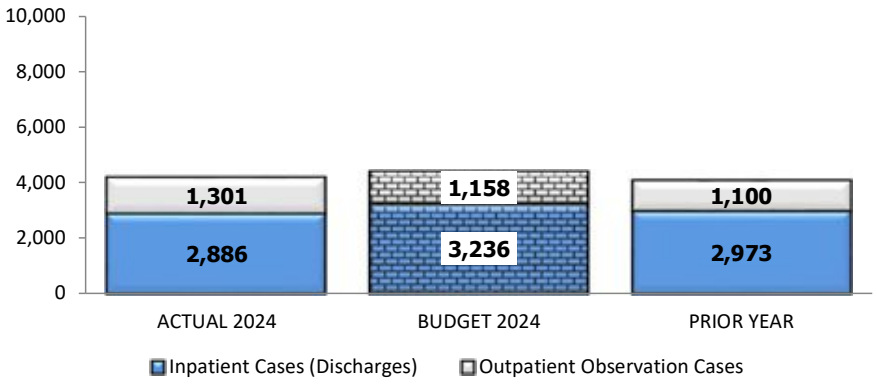
LBJ Cases Occupying Beds - Q3		
Actual	Budget	Prior Year
4,187	4,394	4,073

LBJ Cases Occupying Beds - YTD		
Actual	Budget	Prior Year
12,806	12,903	12,522

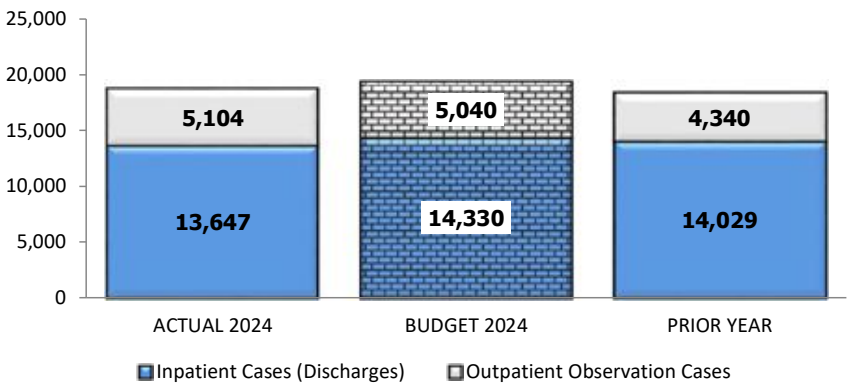
Ben Taub Cases - Quarter End



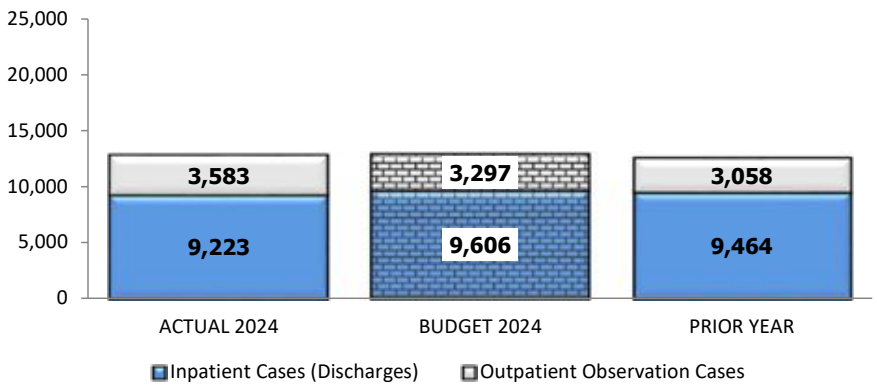
Lyndon B. Johnson Cases - Quarter End



Ben Taub Cases - YTD



Lyndon B. Johnson Cases - YTD



Harris Health System

Statistical Highlights - Surgery Cases

As of the Quarter Ended June 30, 2024

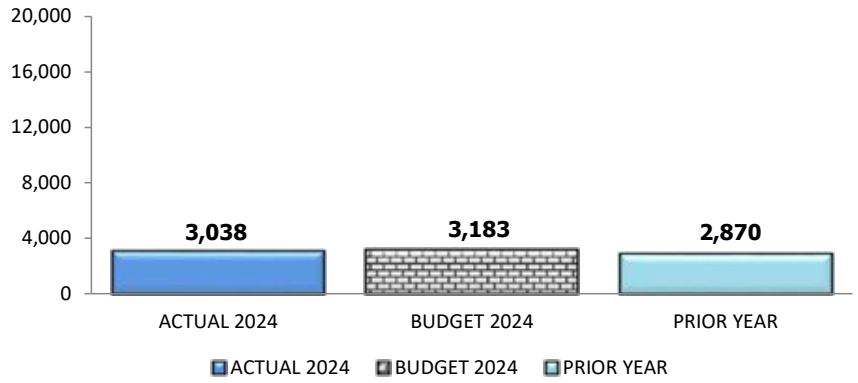
BT Surgery Cases - Q3		
Actual	Budget	Prior Year
3,038	3,183	2,870

BT Surgery Cases - YTD		
Actual	Budget	Prior Year
8,885	9,147	8,470

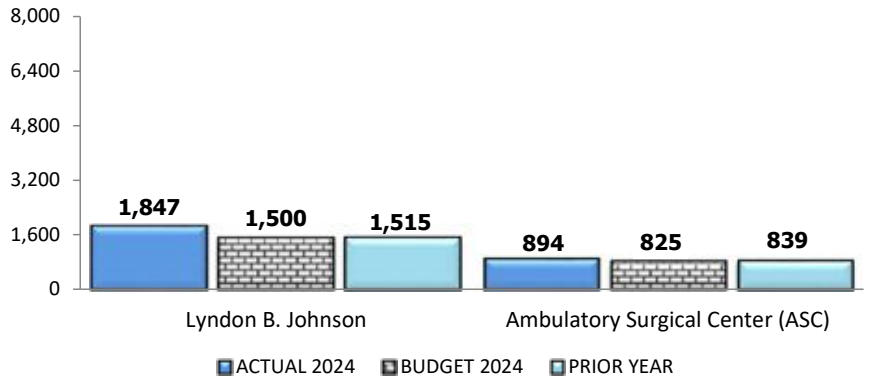
LBJ Surgery Cases - Q3		
Actual	Budget	Prior Year
2,741	2,325	2,354

LBJ Surgery Cases - YTD		
Actual	Budget	Prior Year
7,316	6,699	7,081

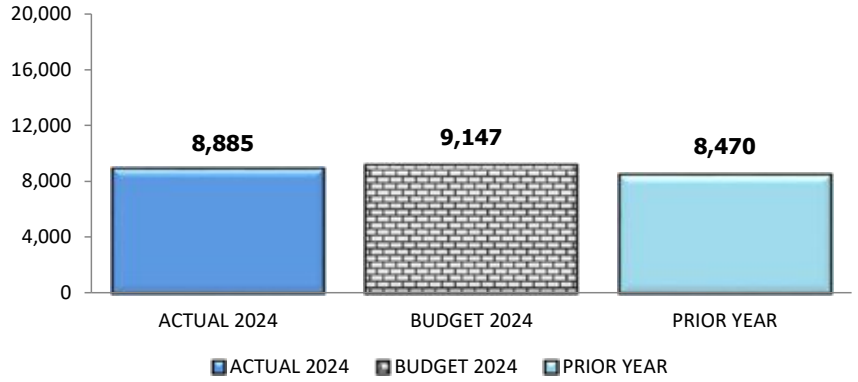
Ben Taub OR Cases - Quarter End



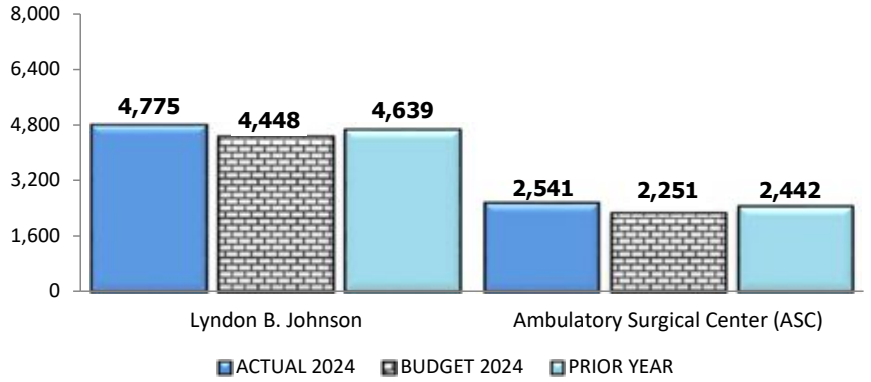
Lyndon B. Johnson OR Cases - Quarter End



Ben Taub OR Cases - YTD



Lyndon B. Johnson OR Cases - YTD



Harris Health System

Statistical Highlights - Emergency Room Visits

As of the Quarter Ended June 30, 2024

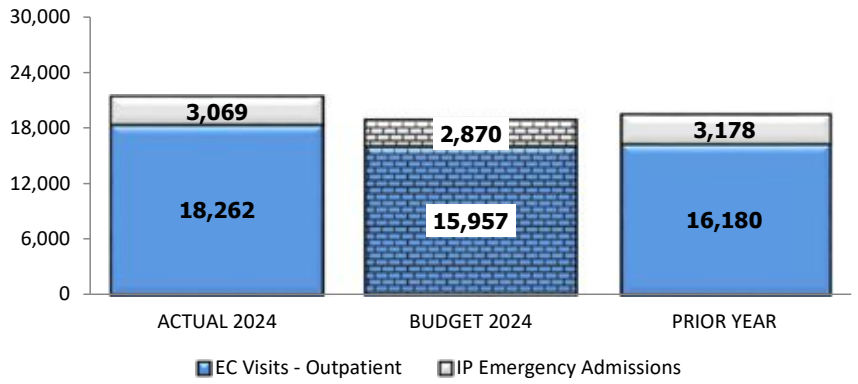
BT Emergency Visits - Q3		
Actual	Budget	Prior Year
21,331	18,827	19,358

BT Emergency Visits - YTD		
Actual	Budget	Prior Year
62,391	55,265	56,053

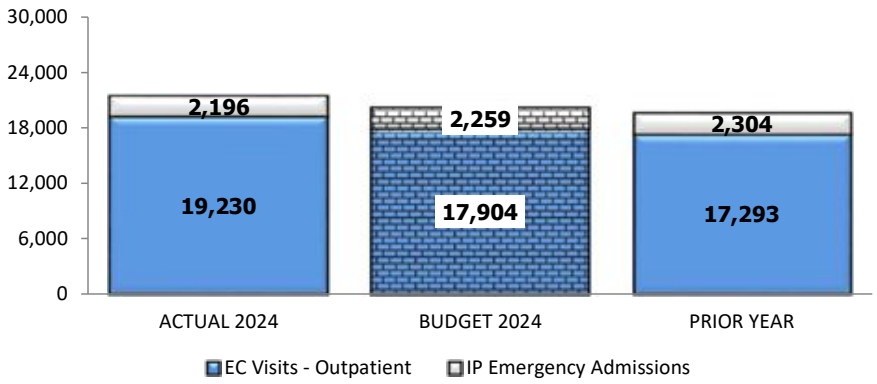
LBJ Emergency Visits - Q3		
Actual	Budget	Prior Year
21,426	20,163	19,597

LBJ Emergency Visits - YTD		
Actual	Budget	Prior Year
60,076	58,357	58,802

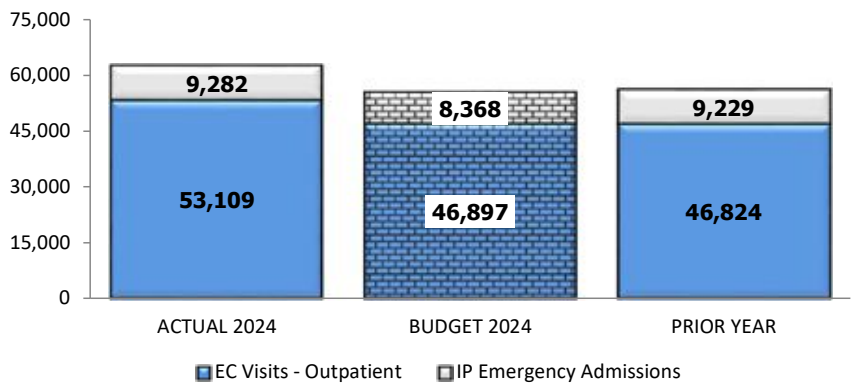
Ben Taub EC Visits - Quarter End



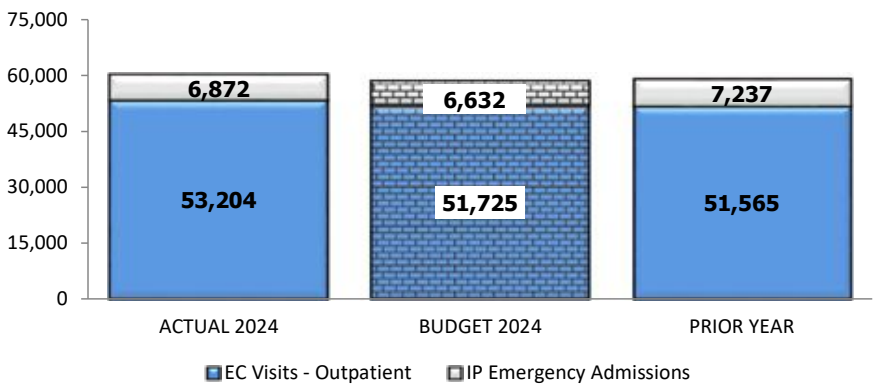
Lyndon B. Johnson EC Visits - Quarter End



Ben Taub EC Visits - YTD



Lyndon B. Johnson EC Visits - YTD

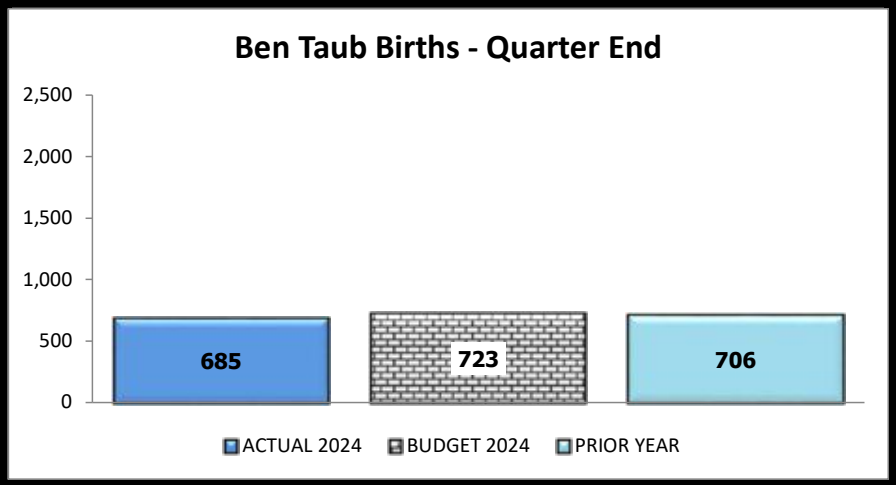


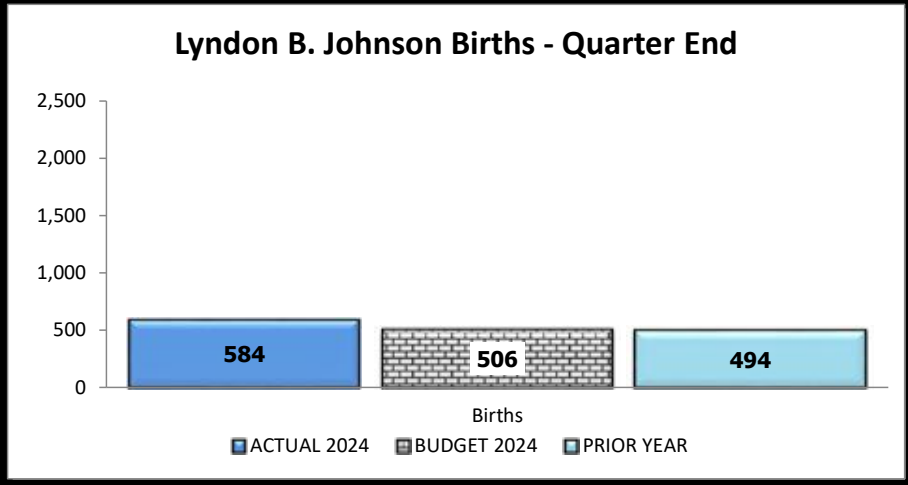
Harris Health System

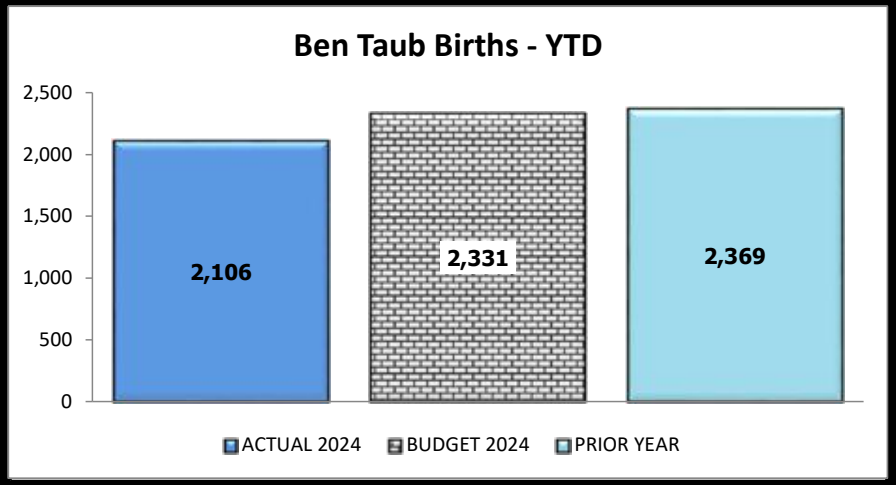
Statistical Highlights - Births

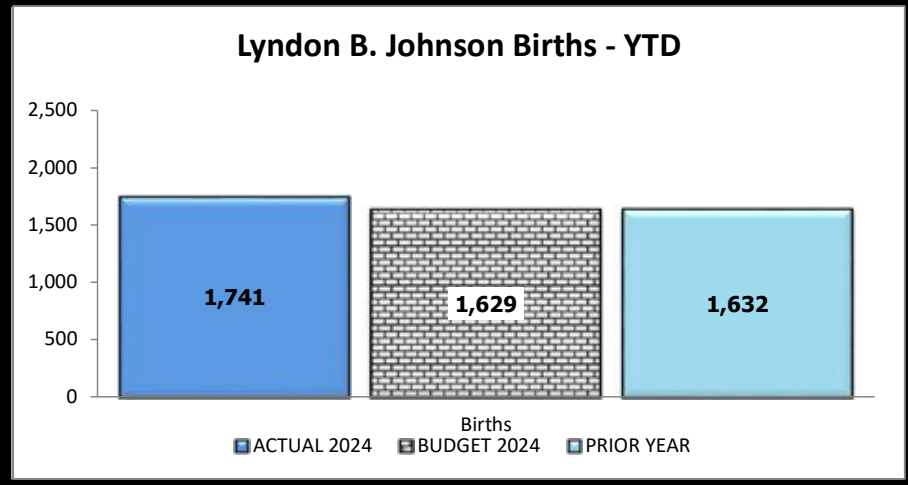
As of the Quarter Ended June 30, 2024

BT Births - Q3			BT Births - YTD			LBJ Births - Q3			LBJ Births - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
685	723	706	2,106	2,331	2,369	584	506	494	1,741	1,629	1,632









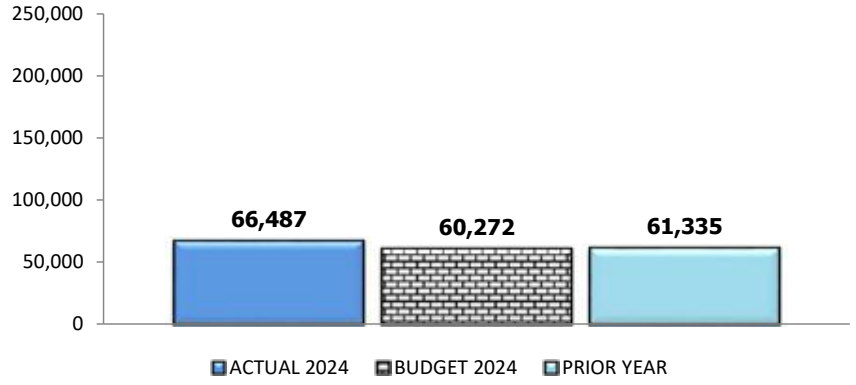
Harris Health System

Statistical Highlights - Adjusted Patient Days

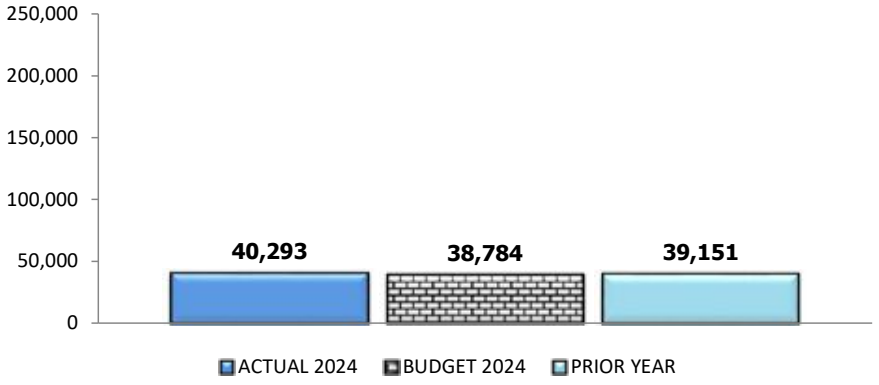
As of the Quarter Ended June 30, 2024

BT Adjusted Patient Days - Q3	BT Adjusted Patient Days - YTD	LBJ Adjusted Patient Days - Q3	LBJ Adjusted Patient Days - YTD
66,487	197,292	40,293	119,754

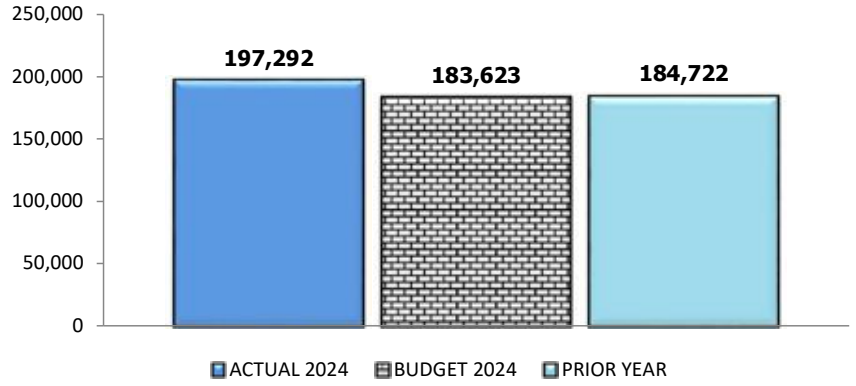
Ben Taub APD - Quarter End



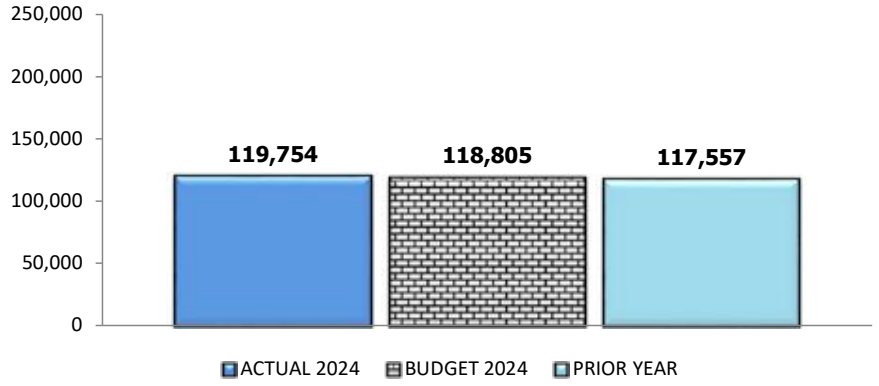
Lyndon B. Johnson APD - Quarter End



Ben Taub APD - YTD



Lyndon B. Johnson APD - YTD



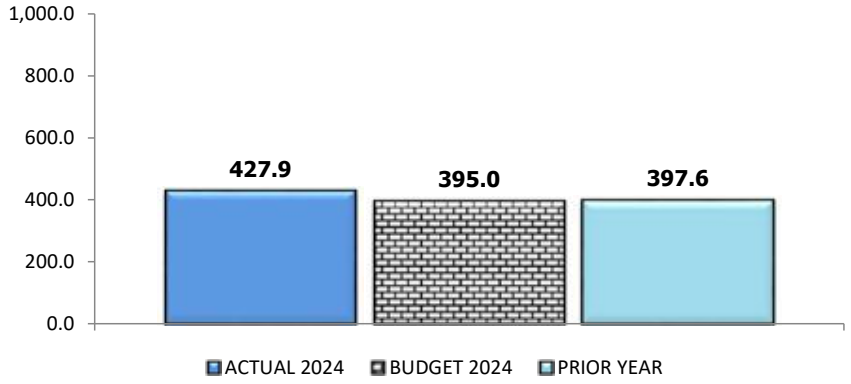
Harris Health System

Statistical Highlights - Average Daily Census (ADC)

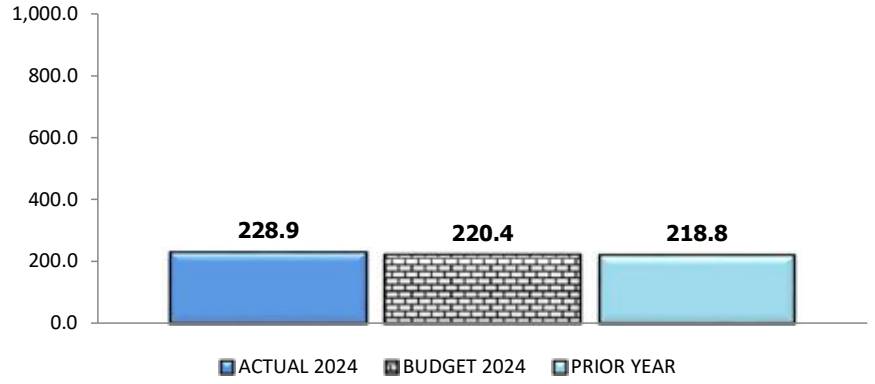
As of the Quarter Ended June 30, 2024

BT Average Daily Census - Q3	BT Average Daily Census - YTD	LBJ Average Daily Census - YTD	LBJ Average Daily Census - YTD
427.9	423.8	228.9	226.5

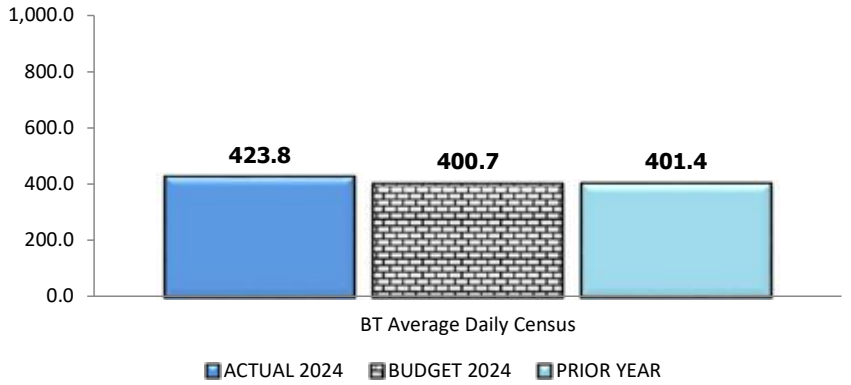
Ben Taub ADC - Quarter End



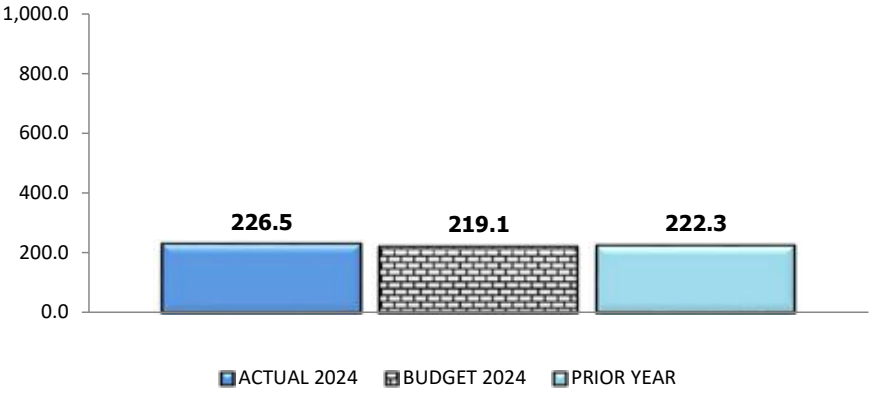
Lyndon B. Johnson ADC - Quarter End



Ben Taub ADC - YTD



Lyndon B. Johnson ADC - YTD



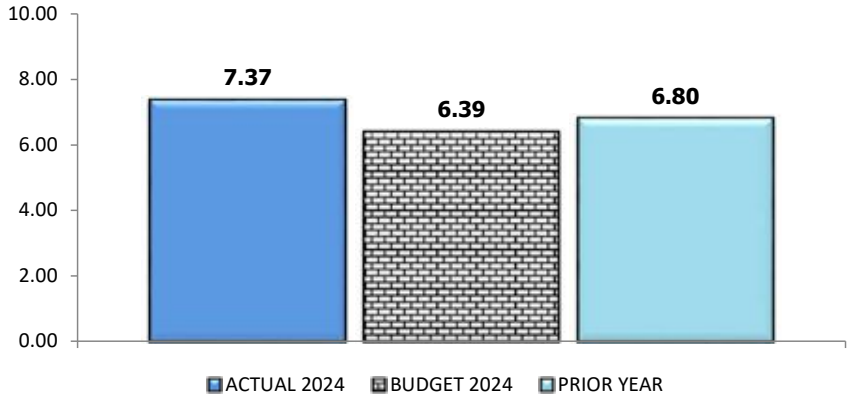
Harris Health System

Statistical Highlights - Inpatient Average Length of Stay (ALOS)

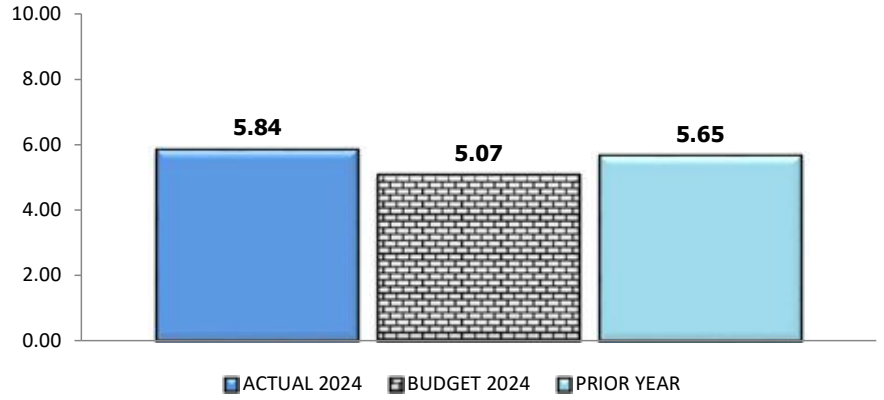
As of the Quarter Ended June 30, 2024

BT Inpatient ALOS - Q3	BT Inpatient ALOS - YTD	LBJ Inpatient ALOS - Q3	LBJ Inpatient ALOS - YTD
7.37	7.11	5.84	5.58

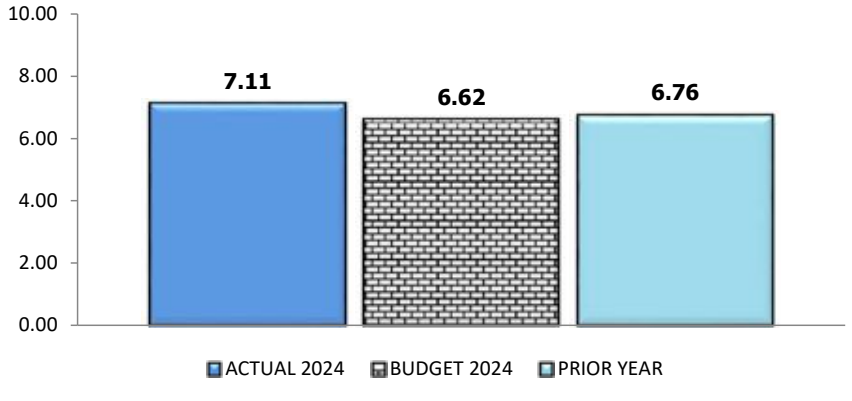
Ben Taub ALOS - Quarter End



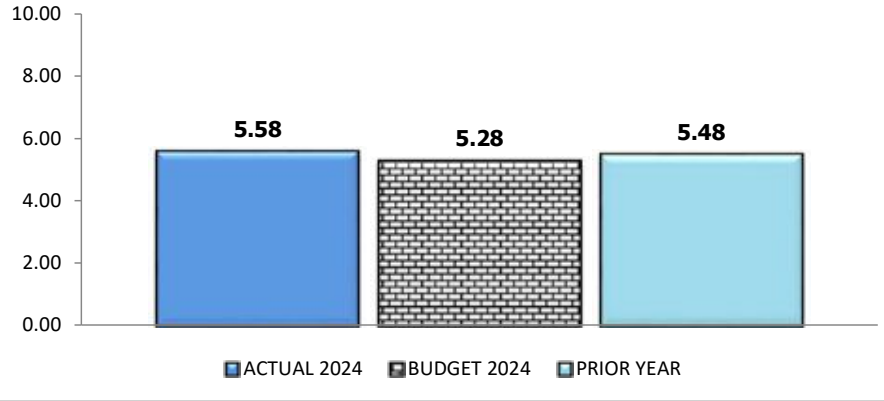
Lyndon B. Johnson ALOS - Quarter End



Ben Taub ALOS - YTD



Lyndon B. Johnson ALOS - YTD

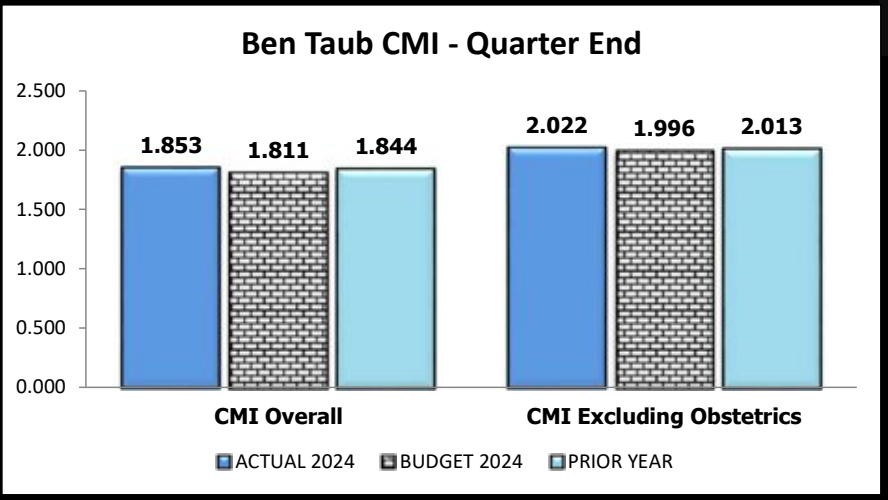


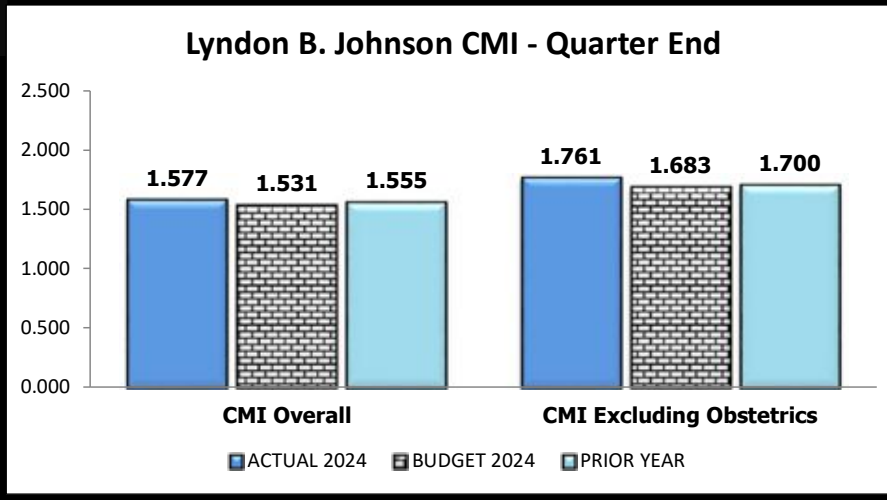
Harris Health System

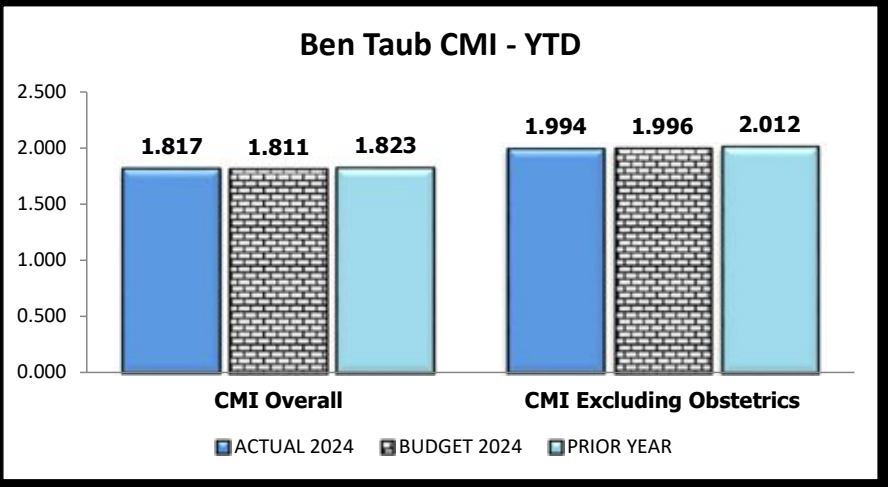
Statistical Highlights - Case Mix Index (CMI)

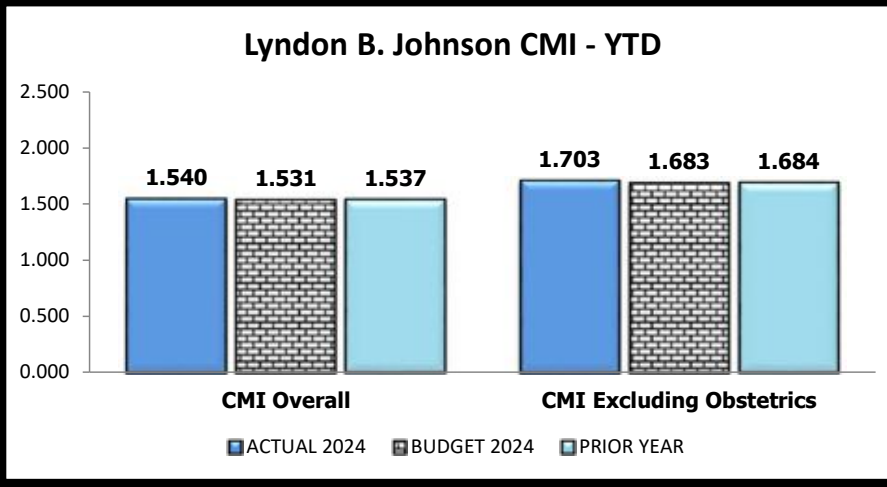
As of the Quarter Ended June 30, 2024

BT Case Mix Index (CMI) - Q3		BT Case Mix Index (CMI) - YTD		LBJ Case Mix Index (CMI) - Q3		LBJ Case Mix Index (CMI) - YTD	
Overall	Excl. Obstetrics	Overall	Excl. Obstetrics	Overall	Excl. Obstetrics	Overall	Excl. Obstetrics
1.853	2.022	1.817	1.994	1.577	1.761	1.540	1.703









BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, August 29, 2024

Consideration of Acceptance of the Harris Health July 2024 Financial Report Subject to Audit

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Attached for your review and consideration is the July 2024 Financial Report.

Administration recommends that the Board accept the financial report for the period ended July 31, 2024, subject to final audit.

Victoria Nikitin

Victoria Nikitin
Executive Vice President – Chief Financial Officer

HARRISHEALTH

Financial Statements

As of the Month Ended July 31, 2024
Subject to Audit

Table of Contents

HARRISHEALTH

Financial Highlights Review

HARRISHEALTH

As of July 31, 2024

Operating income for July was $32.1 million compared to a budgeted income of $3.8 million.

Total net revenue for July of $225.1 million was $5.7 million or 2.6% more than budget. Investment earnings were $1.2 million greater than budget due to higher interest rates. Medicaid Supplemental programs were $4.6 million more than expected primarily due to timing.

In July, total expenses of $193.0 million were $22.5 million or 10.5% less than budget. Total labor costs were $10.9 million less than budget primarily due to lower pension expense adjusted to the recently issued actuarial report. Total services had a favorable variance of $5.7 million driven mostly by lower physician costs and medical insurance subsidy. Depreciation and interest expense was $4.4 million less than planned mainly due to the timing of the new bond issuance shifting to FY 2025.

Also in July, total patient days and average daily census increased 4.7% compared to budget. Inpatient case mix index, a measure of patient acuity, was 4.7% higher than planned with length of stay 8.5% more than budget. Emergency room visits were 11.5% higher than planned for the month. Total clinic visits, including telehealth, were 23.0% lower compared to budget mostly due to the closures related to Hurricane Beryl. Births were up 0.2% for the month.

Total cash receipts for July were $138.2 million. The System has $1,419.6 million in unrestricted cash, cash equivalents and investments, representing 227.6 days cash on hand. Harris Health System has $157.8 million in net accounts receivable, representing 77.7 days of outstanding patient accounts receivable at July 31, 2024. The July balance sheet reflects a combined net receivable position of $233.4 million under the various Medicaid Supplemental programs. The current portion of ad valorem taxes receivable is $17.2 million, which is offset by ad valorem tax collections as received. Deferred ad valorem tax revenue is $151.5 million, and is released as ad valorem tax revenue is recognized. As of July 31, 2024, $877.4 million ad valorem tax collections were received and $757.5 million in current ad valorem tax revenue was recognized.

Income Statement

HARRISHEALTH

As of July 31, 2024 and 2023 (in $ Millions)

	MONTH-TO-MONTH			YEAR-TO-DATE			
	CURRENT YEAR	CURRENT BUDGET	PERCENT VARIANCE	CURRENT YEAR	CURRENT BUDGET	PERCENT VARIANCE	PRIOR YEAR	PERCENT VARIANCE
REVENUE								
Net Patient Revenue	$ 61.1	$ 60.8	0.4%	$ 619.0	$ 586.7	5.5%	$ 597.5	3.6%
Medicaid Supplemental Programs	72.6	68.0	6.7%	579.0	680.4	-14.9%	567.4	2.0%
Other Operating Revenue	10.2	10.2	-0.3%	106.9	101.3	5.5%	101.2	5.6%
Total Operating Revenue	**$ 143.8**	**$ 139.1**	**3.4%**	**$ 1,304.8**	**$ 1,368.5**	**-4.7%**	**$ 1,266.0**	**3.1%**
Net Ad Valorem Taxes	74.6	74.7	-0.1%	752.8	747.1	0.8%	695.6	8.2%
Net Tobacco Settlement Revenue	-	-	0.0%	15.2	15.2	0.2%	15.2	0.2%
Capital Gifts & Grants	-	-	0.0%	-	-	0.0%	-	0.0%
Interest Income & Other	6.6	5.5	19.7%	65.5	55.4	18.2%	65.2	0.6%
Total Nonoperating Revenue	**$ 81.2**	**$ 80.3**	**1.2%**	**$ 833.5**	**$ 817.7**	**1.9%**	**$ 775.9**	**7.4%**
Total Net Revenue	**$ 225.1**	**$ 219.3**	**2.6%**	**$ 2,138.3**	**$ 2,186.2**	**-2.2%**	**$ 2,041.9**	**4.7%**
EXPENSE								
Salaries and Wages	$ 80.3	$ 81.8	1.8%	$ 788.2	$ 803.4	1.9%	$ 727.5	-8.3%
Employee Benefits	20.1	29.5	32.0%	244.2	294.8	17.2%	253.3	3.6%
Total Labor Cost	**$ 100.4**	**$ 111.3**	**9.8%**	**$ 1,032.3**	**$ 1,098.2**	**6.0%**	**$ 980.8**	**-5.3%**
Supply Expenses	25.5	27.0	5.7%	249.0	266.5	6.6%	237.3	-4.9%
Physician Services	32.9	37.3	11.6%	372.2	383.6	3.0%	355.3	-4.8%
Purchased Services	25.6	27.0	5.1%	230.5	268.9	14.3%	204.0	-13.0%
Depreciation & Interest	8.6	12.9	33.8%	84.4	109.8	23.1%	69.9	-20.8%
Total Operating Expense	**$ 193.0**	**$ 215.5**	**10.5%**	**$ 1,968.5**	**$ 2,126.9**	**7.5%**	**$ 1,847.3**	**-6.6%**
Operating Income (Loss)	**$ 32.1**	**$ 3.8**		**$ 169.8**	**$ 59.2**		**$ 194.6**	
Total Margin %	**14.3%**	**1.7%**		**7.9%**	**2.7%**		**9.5%**	

Balance Sheet

HARRISHEALTH

July 31, 2024 and 2023 (in $ Millions)

	CURRENT YEAR	PRIOR YEAR
CURRENT ASSETS		
Cash, Cash Equivalents and Short Term Investments	$ 1,419.6	$ 1,396.3
Net Patient Accounts Receivable	157.8	155.6
Net Ad Valorem Taxes, Current Portion	17.2	4.1
Other Current Assets	382.5	233.8
Total Current Assets	**$ 1,977.0**	**$ 1,789.9**
CAPITAL ASSETS		
Plant, Property, & Equipment, Net of Accumulated Depreciation	$ 551.1	$ 421.2
Construction in Progress	193.0	221.7
Right of Use Assets	38.1	43.8
Total Capital Assets	**$ 782.2**	**$ 686.7**
ASSETS LIMITED AS TO USE & RESTRICTED ASSETS		
Debt Service & Capital Asset Funds	$ 37.2	$ 41.1
LPPF Restricted Cash	14.6	35.1
Capital Gift Proceeds	54.5	47.1
Other - Restricted	1.0	1.0
Total Assets Limited As to Use & Restricted Assets	**$ 107.3**	**$ 124.3**
Other Assets	52.9	46.2
Deferred Outflows of Resources	187.4	231.4
Total Assets & Deferred Outflows of Resources	**$ 3,106.9**	**$ 2,878.5**
CURRENT LIABILITIES		
Accounts Payable and Accrued Liabilities	$ 241.7	$ 215.1
Employee Compensation & Related Liabilities	158.1	138.9
Deferred Revenue - Ad Valorem	151.5	140.4
Estimated Third-Party Payor Settlements	28.4	16.9
Current Portion Long-Term Debt and Capital Leases	37.6	19.9
Total Current Liabilities	**$ 617.3**	**$ 531.1**
Long-Term Debt	280.2	316.6
Net Pension & Post Employment Benefits Liability	705.0	691.9
Other Long-Term Liabilities	6.6	7.6
Deferred Inflows of Resources	114.5	175.2
Total Liabilities	**$ 1,723.7**	**$ 1,722.5**
Total Net Assets	**$ 1,383.3**	**$ 1,156.1**
Total Liabilities & Net Assets	**$ 3,106.9**	**$ 2,878.5**

Cash Flow Summary

HARRISHEALTH

As of July 31, 2024 and 2023 (in $ Millions)

	MONTH-TO-MONTH		YEAR-TO-DATE	
	CURRENT YEAR	PRIOR YEAR	CURRENT YEAR	PRIOR YEAR
CASH RECEIPTS				
Collections on Patient Accounts	$ 61.0	$ 51.8	$ 682.7	$ 572.4
Medicaid Supplemental Programs	68.2	(2.0)	738.5	857.8
Net Ad Valorem Taxes	0.0	3.1	877.4	823.2
Tobacco Settlement	-	-	15.2	15.2
Other Revenue	9.0	50.5	201.4	231.8
Total Cash Receipts	**$ 138.2**	**$ 103.4**	**$ 2,515.3**	**$ 2,500.5**
CASH DISBURSEMENTS				
Salaries, Wages and Benefits	$ 104.3	$ 100.7	$ 1,100.2	$ 1,077.6
Supplies	28.0	27.3	267.5	256.4
Physician Services	35.2	45.3	350.9	342.8
Purchased Services	24.1	14.9	227.7	194.7
Capital Expenditures	28.8	10.9	156.1	112.0
Debt and Interest Payments	0.2	0.2	7.0	20.1
Other Uses	(4.7)	(5.8)	(1.0)	(76.6)
Total Cash Disbursements	**$ 215.9**	**$ 193.4**	**$ 2,108.3**	**$ 1,927.0**
Net Change	**$ (77.7)**	**$ (90.0)**	**$ 406.9**	**$ 573.5**

Unrestricted Cash, Cash Equivalents and Investments - Beginning of year	$ 1,012.6
Net Change	406.9
Unrestricted Cash, Cash Equivalents and Investments - End of period	**$ 1,419.6**

Performance Ratios

HARRISHEALTH

As of July 31, 2024 and 2023 (in $ Millions)

	MONTH-TO-MONTH		YEAR-TO-DATE		
	CURRENT YEAR	CURRENT BUDGET	CURRENT YEAR	CURRENT BUDGET	PRIOR YEAR
OPERATING HEALTH INDICATORS					
Operating Margin %	14.3%	1.7%	7.9%	2.7%	9.5%
Run Rate per Day (In$ Millions)	$ 6.0	$ 6.8	$ 6.2	$ 6.8	$ 5.9
Salary, Wages & Benefit per APD	$ 2,348	$ 2,667	$ 2,351	$ 2,631	$ 2,358
Supply Cost per APD	$ 595	$ 646	$ 567	$ 638	$ 570
Physician Services per APD	$ 770	$ 892	$ 848	$ 919	$ 854
Total Expense per APD	**$ 4,513**	**$ 5,163**	**$ 4,484**	**$ 5,095**	**$ 4,441**
Overtime as a % of Total Salaries	5.0%	2.9%	3.5%	2.9%	3.5%
Contract as a % of Total Salaries	3.6%	4.5%	4.2%	4.4%	5.2%
Full-time Equivalent Employees	10,618	10,187	10,388	10,189	9,942
FINANCIAL HEALTH INDICATORS					
Quick Ratio			3.1		3.3
Unrestricted Cash (In $ Millions)			$ 1,419.6	$ 932.1	$ 1,396.3
Days Cash on Hand			227.6	137.0	236.2
Days Revenue in Accounts Receivable			77.7	88.3	79.2
Days in Accounts Payable			45.6		48.2
Capital Expenditures/Depreciation & Amortization			214.6%		186.2%
Average Age of Plant(years)			10.4		11.8

Harris Health Key Indicators

Statistical Highlights

HARRISHEALTH

As of July 31, 2024 and 2023

	MONTH-TO-MONTH			YEAR-TO-DATE				
	CURRENT YEAR	CURRENT BUDGET	PERCENT CHANGE	CURRENT YEAR	CURRENT BUDGET	PERCENT CHANGE	PRIOR YEAR	PERCENT CHANGE
Adjusted Patient Days	42,764	42,338	1.0%	439,010	414,974	5.8%	416,436	5.4%
Outpatient % of Adjusted Volume	59.6%	60.8%	-1.9%	62.2%	60.9%	2.2%	60.7%	2.5%
Primary Care Clinic Visits	34,088	47,709	-28.6%	427,454	455,416	-6.1%	437,224	-2.2%
Specialty Clinic Visits	17,704	21,171	-16.4%	201,697	203,219	-0.7%	203,293	-0.8%
Telehealth Clinic Visits	8,407	9,275	-9.4%	93,414	107,290	-12.9%	106,549	-12.3%
Total Clinic Visits	**60,199**	**78,155**	**-23.0%**	**722,565**	**765,925**	**-5.7%**	**747,066**	**-3.3%**
Emergency Room Visits - Outpatient	13,092	11,637	12.5%	119,405	110,259	8.3%	110,112	8.4%
Emergency Room Visits - Admitted	1,766	1,689	4.6%	17,920	16,689	7.4%	18,325	-2.2%
Total Emergency Room Visits	**14,858**	**13,326**	**11.5%**	**137,325**	**126,948**	**8.2%**	**128,437**	**6.9%**
Surgery Cases - Outpatient	882	858	2.8%	9,452	8,948	5.6%	9,186	2.9%
Surgery Cases - Inpatient	886	841	5.4%	8,517	8,597	-0.9%	7,962	7.0%
Total Surgery Cases	**1,768**	**1,699**	**4.1%**	**17,969**	**17,545**	**2.4%**	**17,148**	**4.8%**
Total Outpatient Visits	**126,985**	**129,010**	**-1.6%**	**1,234,103**	**1,251,375**	**-1.4%**	**1,233,308**	**0.1%**
Inpatient Cases (Discharges)	2,629	2,744	-4.2%	25,514	26,680	-4.4%	26,187	-2.6%
Outpatient Observation Cases	925	1,088	-15.0%	9,612	9,425	2.0%	8,282	16.1%
Total Cases Occupying Patient Beds	**3,554**	**3,832**	**-7.3%**	**35,126**	**36,105**	**-2.7%**	**34,469**	**1.9%**
Births	479	478	0.2%	4,326	4,438	-2.5%	4,490	-3.7%
Inpatient Days	17,264	16,608	3.9%	165,813	162,201	2.2%	163,535	1.4%
Outpatient Observation Days	3,501	3,224	8.6%	33,186	27,448	20.9%	26,901	23.4%
Total Patient Days	**20,765**	**19,832**	**4.7%**	**198,999**	**189,649**	**4.9%**	**190,436**	**4.5%**
Average Daily Census	669.8	639.7	4.7%	652.5	621.8	4.9%	626.4	4.2%
Average Operating Beds	715	702	1.9%	703	702	0.1%	684	2.8%
Bed Occupancy %	93.7%	91.1%	2.8%	92.8%	88.6%	4.8%	91.6%	1.3%
Inpatient Average Length of Stay	6.57	6.05	8.5%	6.50	6.08	6.9%	6.24	4.1%
Inpatient Case Mix Index (CMI)	1.773	1.694	4.7%	1.712	1.694	1.1%	1.707	0.3%
Payor Mix (% of Charges)								
Charity & Self Pay	42.2%	44.3%	-4.7%	43.5%	44.3%	-1.7%	44.3%	-1.8%
Medicaid & Medicaid Managed	20.8%	22.7%	-8.1%	19.5%	22.7%	-14.1%	23.1%	-15.8%
Medicare & Medicare Managed	10.9%	11.4%	-4.4%	11.5%	11.4%	1.1%	11.4%	1.5%
Commercial & Other	26.1%	21.7%	20.5%	25.5%	21.7%	17.7%	21.3%	20.1%
Total Unduplicated Patients - Rolling 12				**246,614**			**249,349**	**-1.1%**
Total New Patient - Rolling 12				**88,974**			**87,959**	**1.2%**

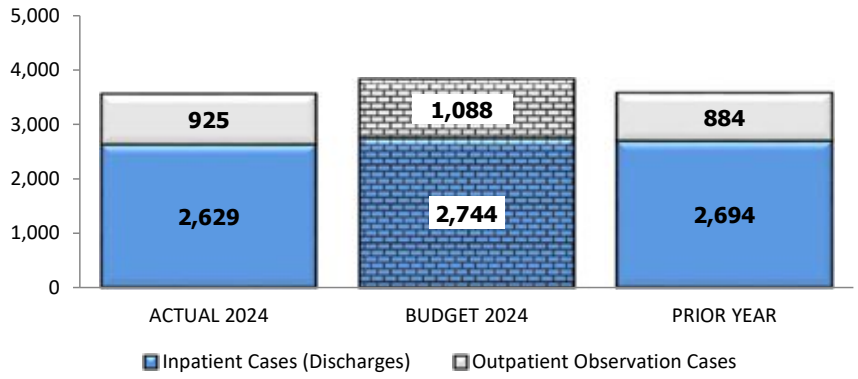
Harris Health

Statistical Highlights

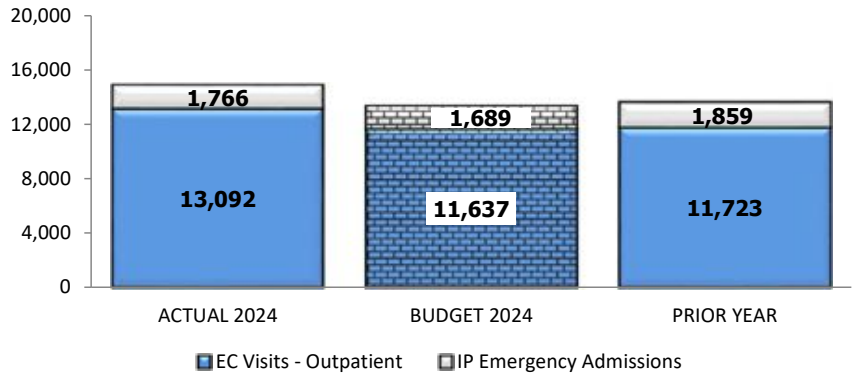
July FY 2024

Cases Occupying Beds - CM			Cases Occupying Beds - YTD			Emergency Visits - CM			Emergency Visits - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
3,554	3,832	3,578	35,126	36,105	34,469	14,858	13,326	13,582	137,325	126,948	128,437

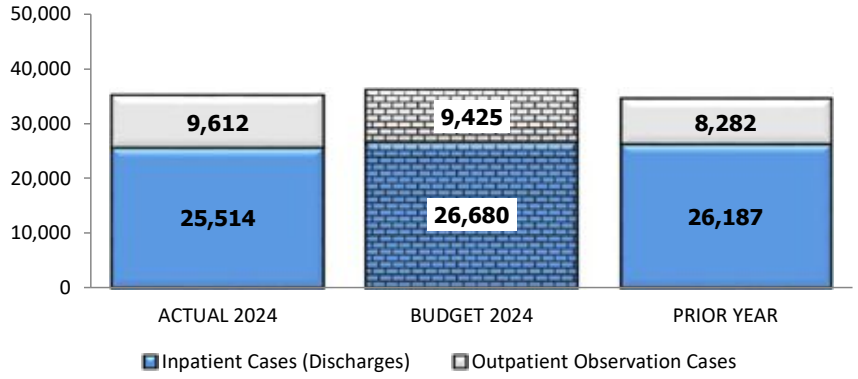
Cases Occupying Beds - Current Month



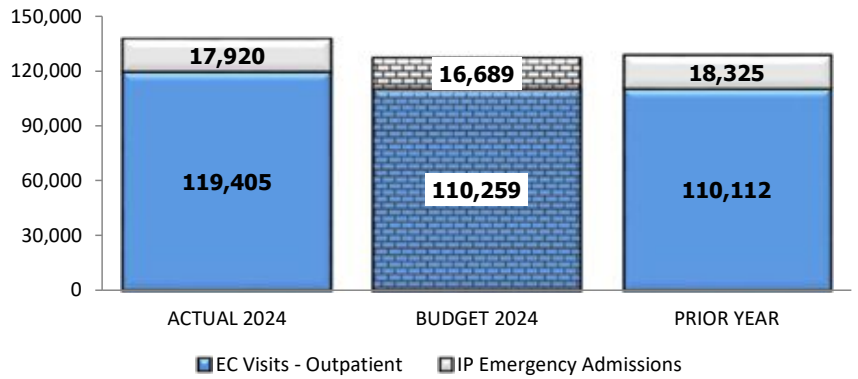
Emergency Visits - Current Month



Cases Occupying Beds - YTD



Emergency Visits - YTD



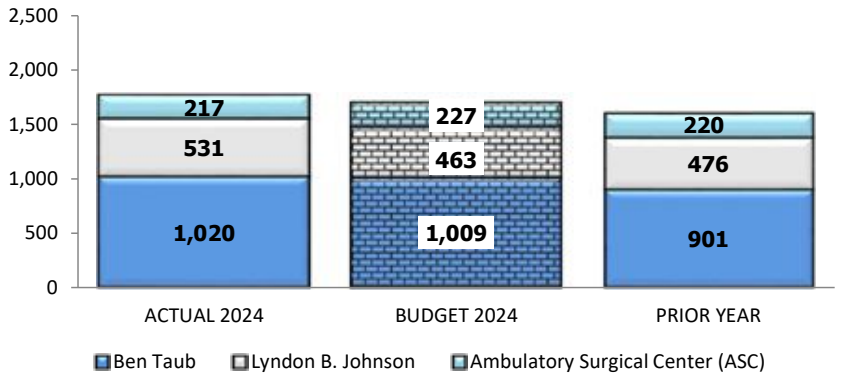
Harris Health

Statistical Highlights

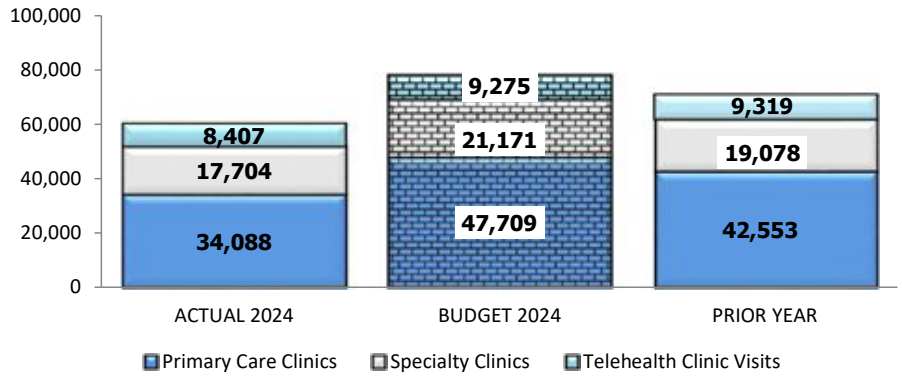
July FY 2024

Surgery Cases - CM			Surgery Cases - YTD			Clinic Visits - CM			Clinic Visits - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
1,768	1,699	1,597	17,969	17,545	17,148	60,199	78,155	70,950	722,565	765,925	747,061

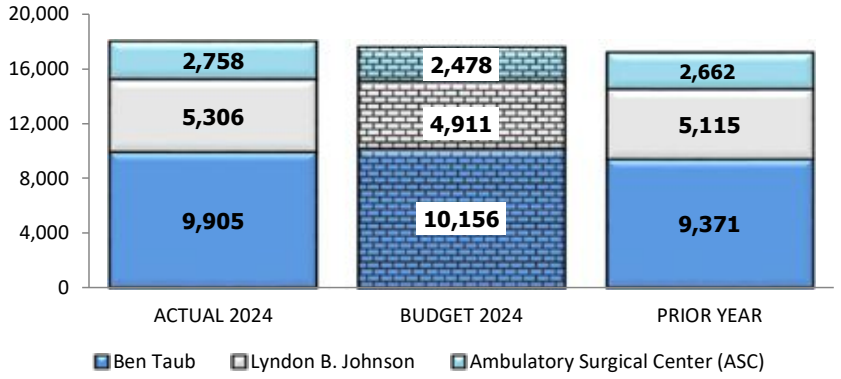
Surgery Cases - Current Month



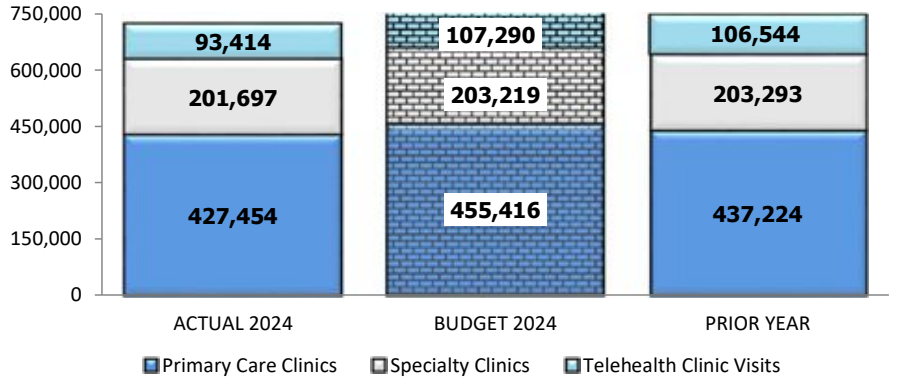
Clinic Visits - Current Month



Surgery Cases - YTD



Clinic Visits - YTD



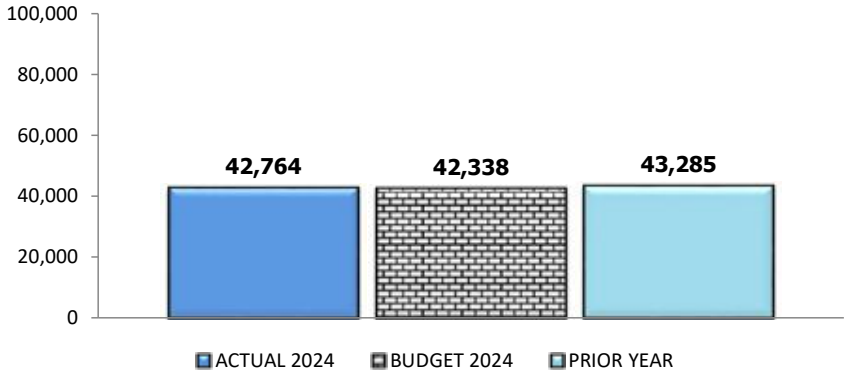
Harris Health

Statistical Highlights

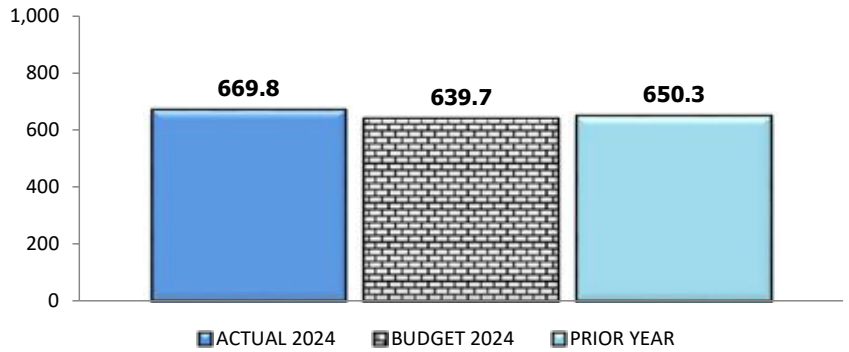
July FY 2024

Adjusted Patient Days - CM	Adjusted Patient Days - YTD	Average Daily Census - CM	Average Daily Census - YTD
42,764	439,010	669.8	652.5

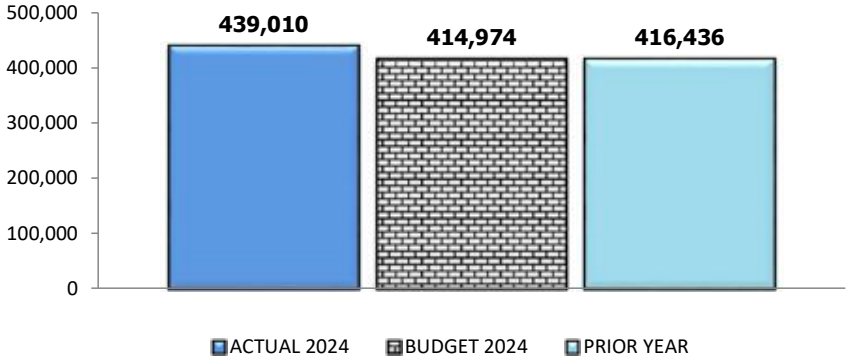
Adjusted Patient Days - Current Month



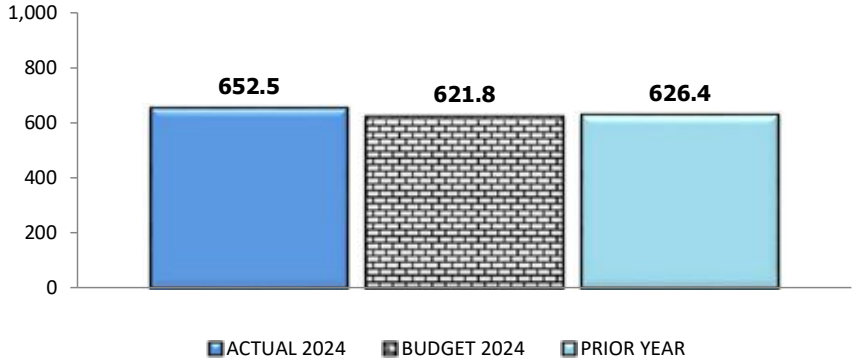
Average Daily Census - Current Month



Adjusted Patient Days - YTD



Average Daily Census - YTD



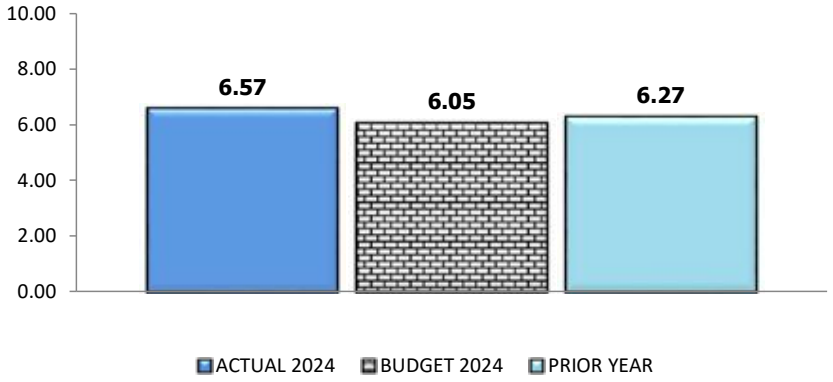
Harris Health

Statistical Highlights

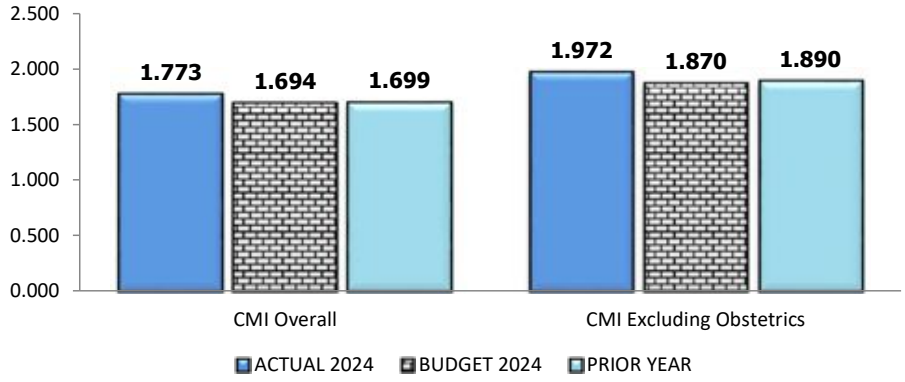
July FY 2024

Inpatient ALOS - CM	Inpatient ALOS - YTD	Case Mix Index (CMI) - CM		Case Mix Index (CMI) - YTD	
		Overall	Excl. Obstetrics	Overall	Excl. Obstetrics
6.57	6.50	1.773	1.972	1.712	1.888

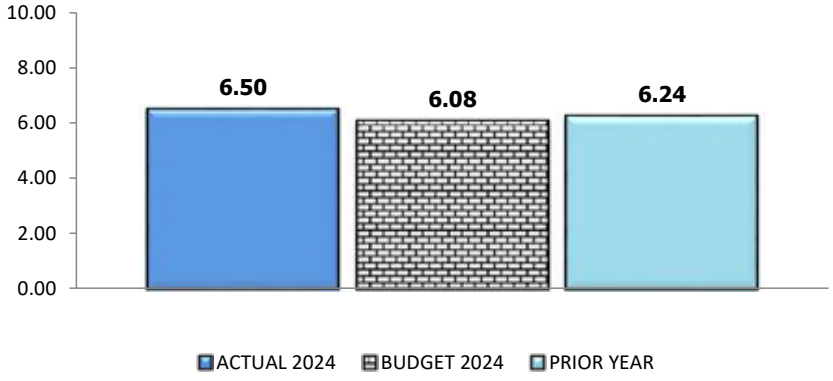
Inpatient ALOS - Current Month



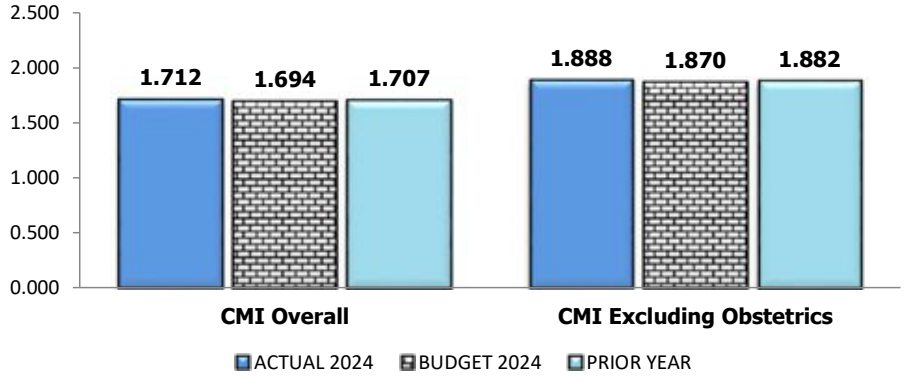
Case Mix Index - Current Month



Inpatient ALOS - YTD



Case Mix Index - YTD



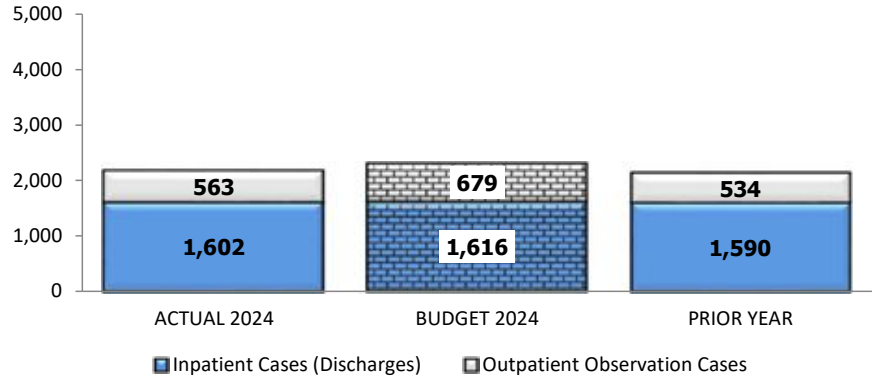
Harris Health

Statistical Highlights - Cases Occupying Beds

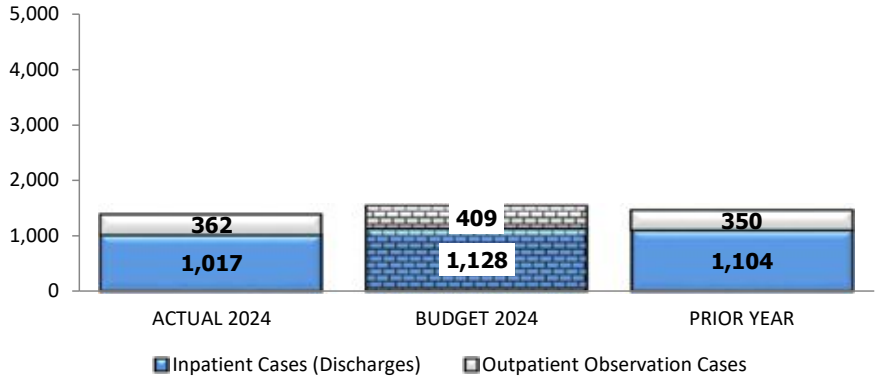
July FY 2024

BT Cases Occupying Beds - CM			BT Cases Occupying Beds - YTD			LBJ Cases Occupying Beds - CM			LBJ Cases Occupying Beds - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
2,165	2,295	2,124	20,916	21,665	20,493	1,379	1,537	1,454	14,185	14,440	13,976

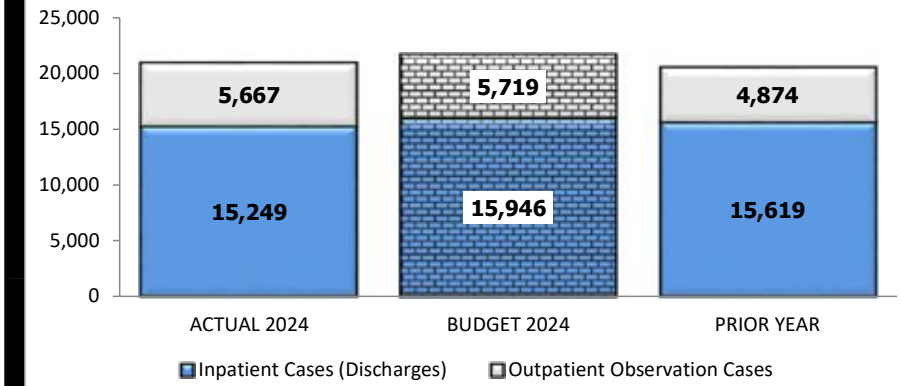
Ben Taub Cases - Current Month



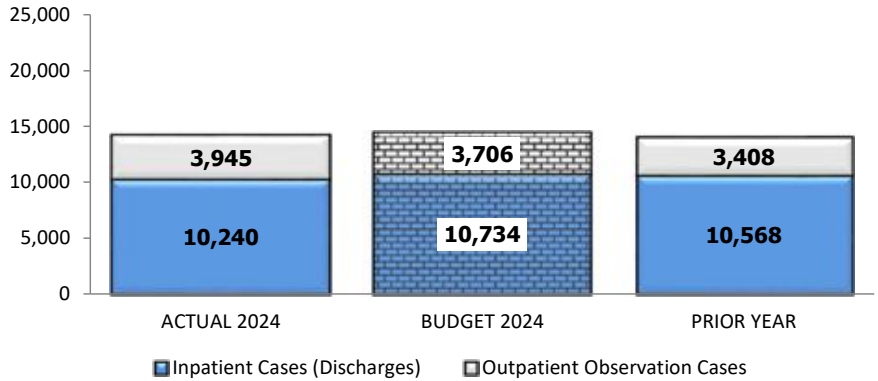
Lyndon B. Johnson Cases - Current Month



Ben Taub Cases - YTD



Lyndon B. Johnson Cases - YTD



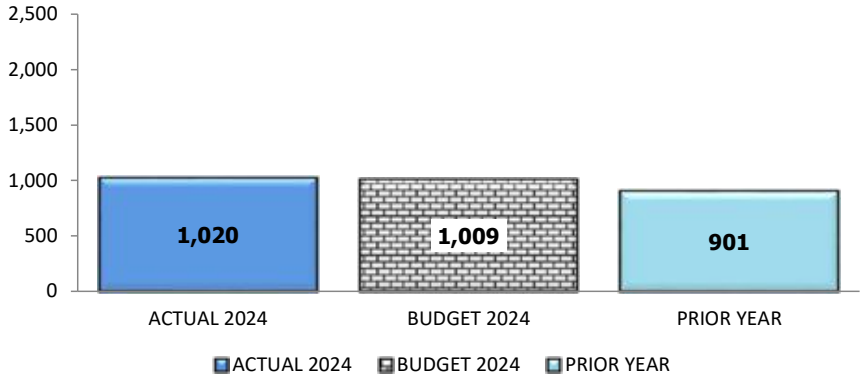
Harris Health

Statistical Highlights - Surgery Cases

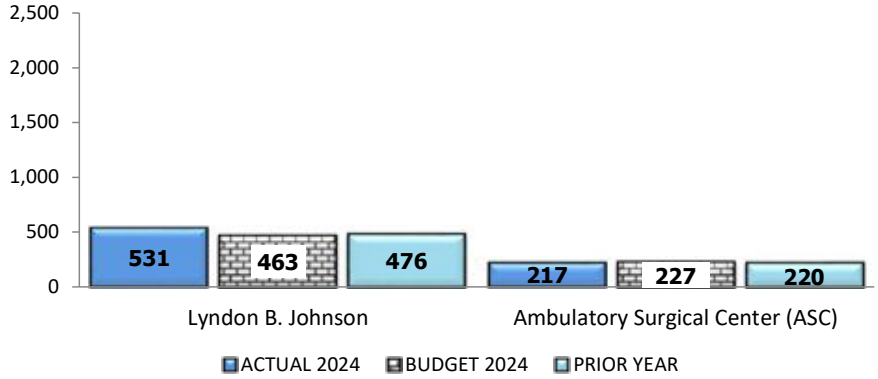
July FY 2024

BT Surgery Cases - CM			BT Surgery Cases - YTD			LBJ Surgery Cases - CM			LBJ Surgery Cases - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
1,020	1,009	901	9,905	10,156	9,371	748	690	696	8,064	7,389	7,777

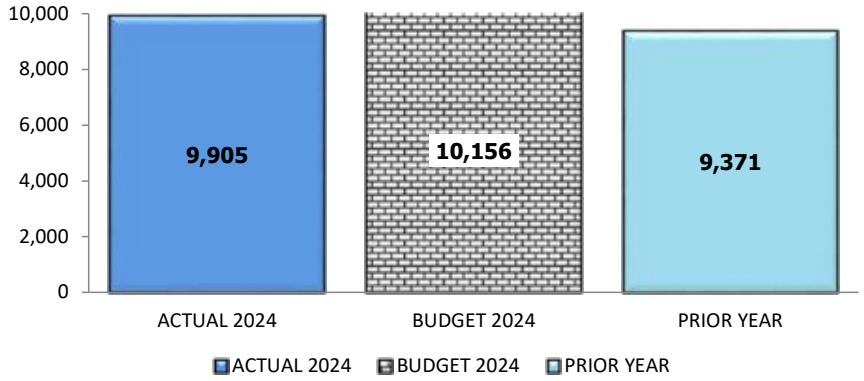
Ben Taub OR Cases - Current Month



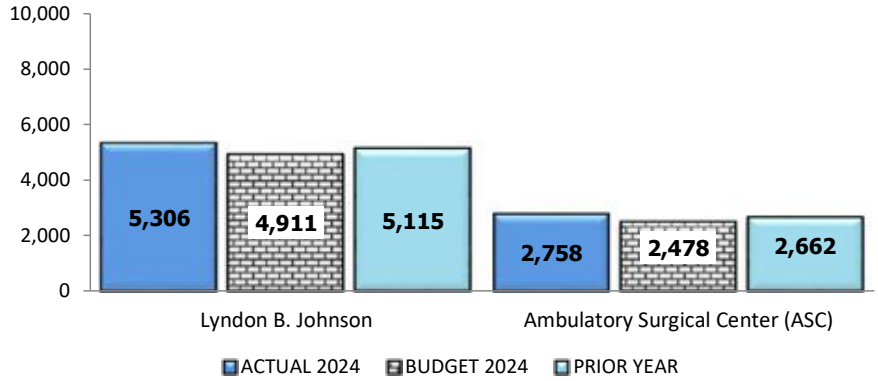
Lyndon B. Johnson OR Cases - Current Month



Ben Taub OR Cases - YTD



Lyndon B. Johnson OR Cases - YTD



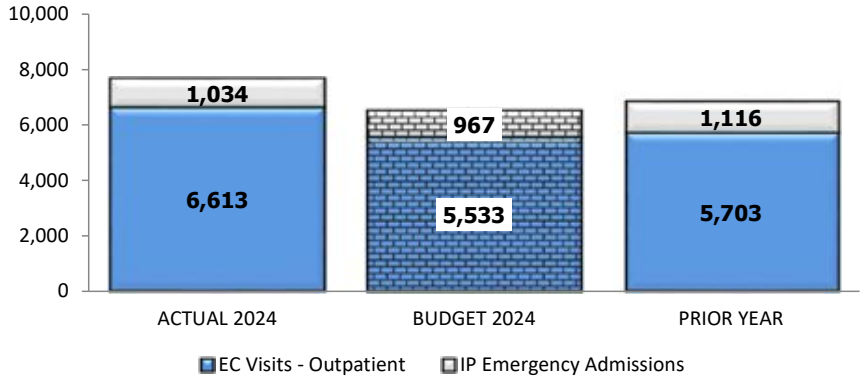
Harris Health

Statistical Highlights - Emergency Room Visits

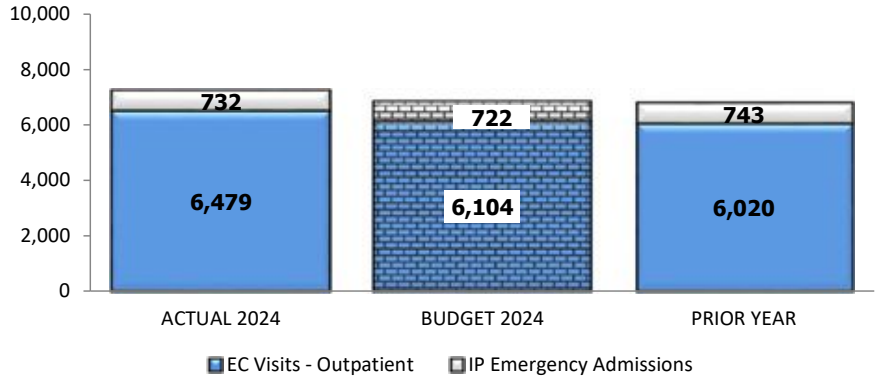
July FY 2024

BT Emergency Visits - CM			BT Emergency Visits - YTD			LBJ Emergency Visits - CM			LBJ Emergency Visits - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
7,647	6,500	6,819	70,038	61,765	62,872	7,211	6,826	6,763	67,287	65,183	65,565

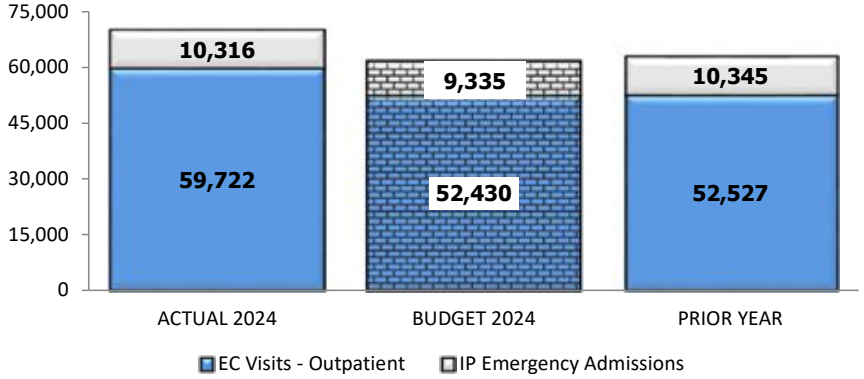
Ben Taub EC Visits - Current Month



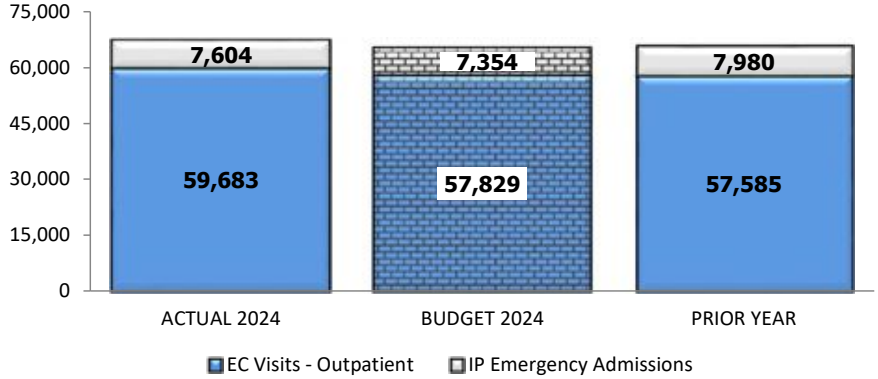
Lyndon B. Johnson EC Visits - Current Month



Ben Taub EC Visits - YTD



Lyndon B. Johnson EC Visits - YTD

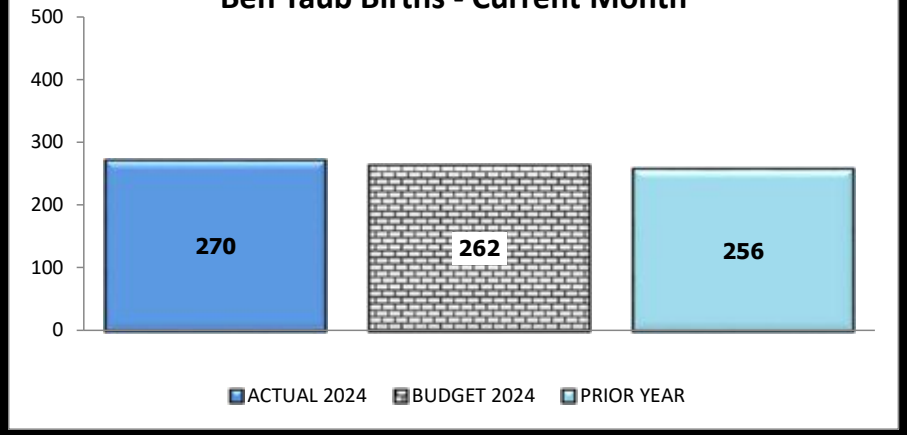


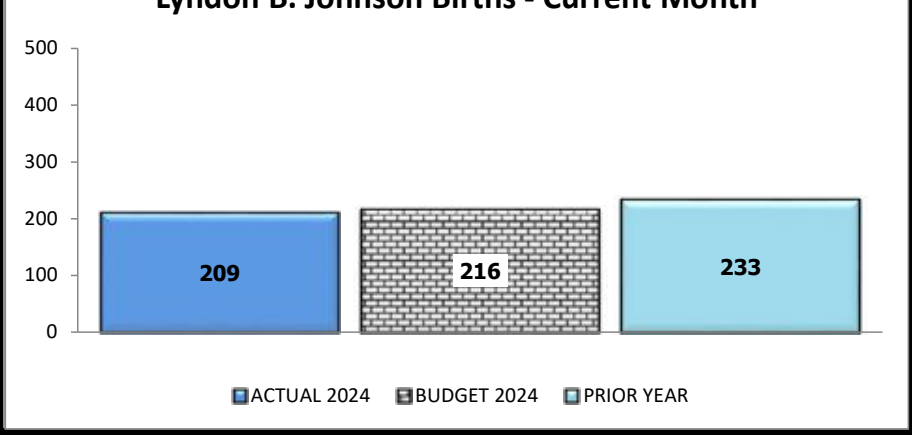
Harris Health

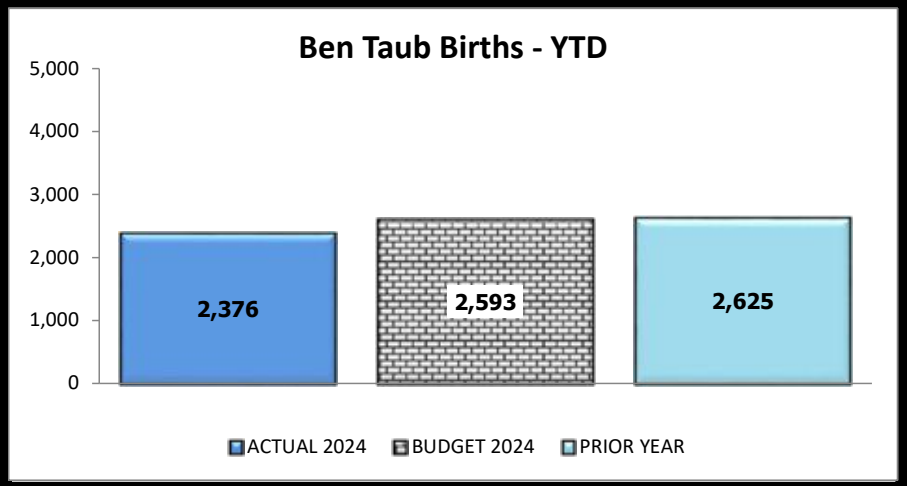
Statistical Highlights - Births

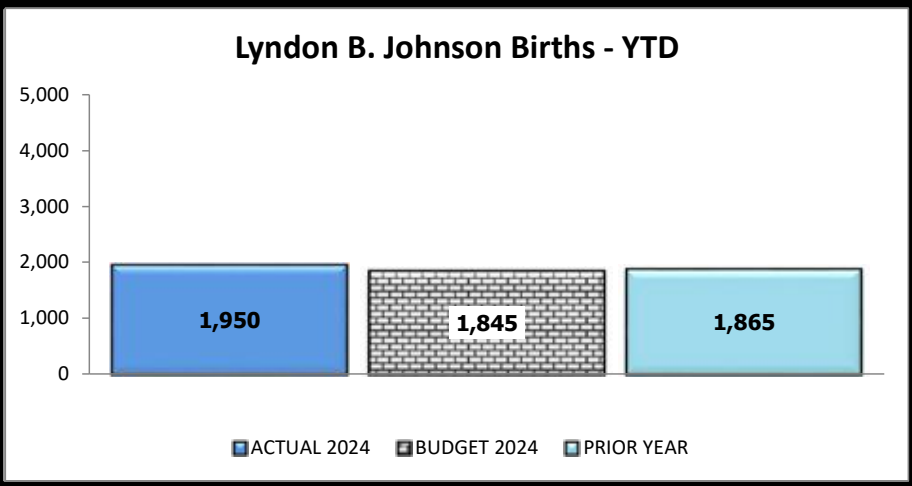
July FY 2024

BT Births - CM			BT Births - YTD			LBJ Births - CM			LBJ Births - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
270	262	256	2,376	2,593	2,625	209	216	233	1,950	1,845	1,865









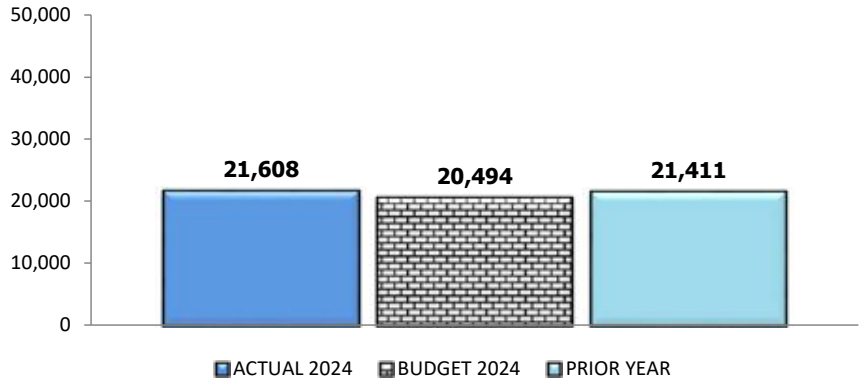
Harris Health

Statistical Highlights - Adjusted Patient Days

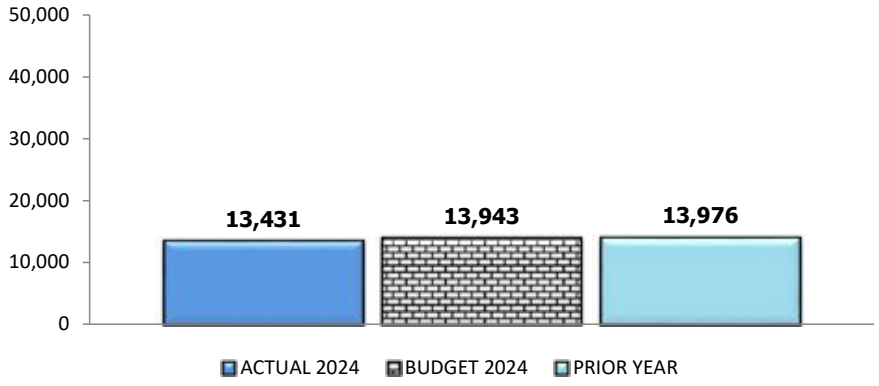
July FY 2024

BT Adjusted Patient Days - CM	BT Adjusted Patient Days - YTD	LBJ Adjusted Patient Days - CM	LBJ Adjusted Patient Days - YTD
21,608	218,900	13,431	133,185

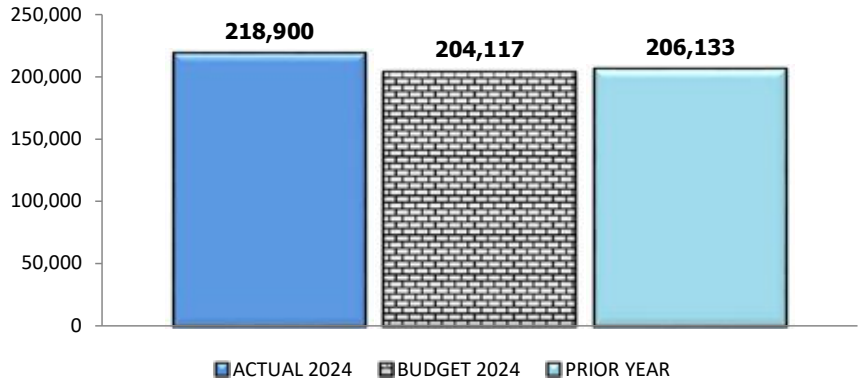
Ben Taub APD - Current Month



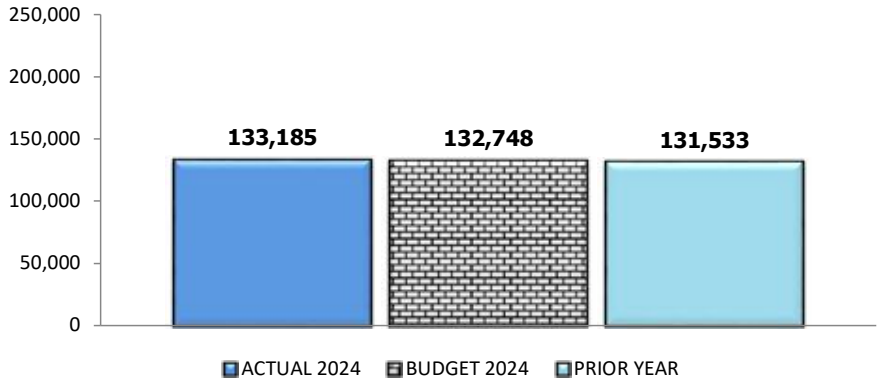
Lyndon B. Johnson APD - Current Month



Ben Taub APD - YTD



Lyndon B. Johnson APD - YTD



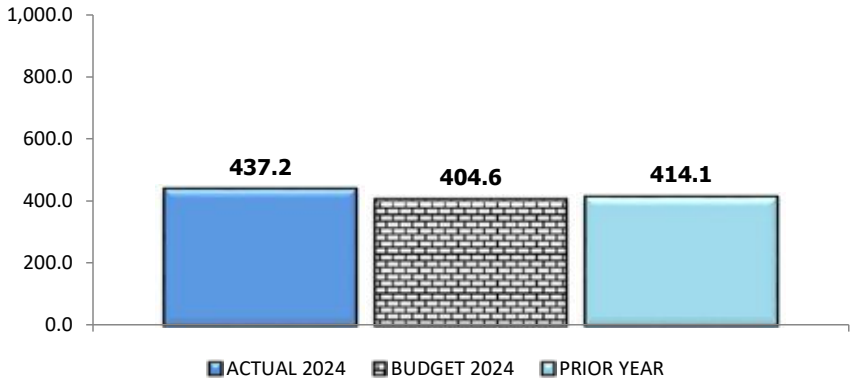
Harris Health

Statistical Highlights - Average Daily Census (ADC)

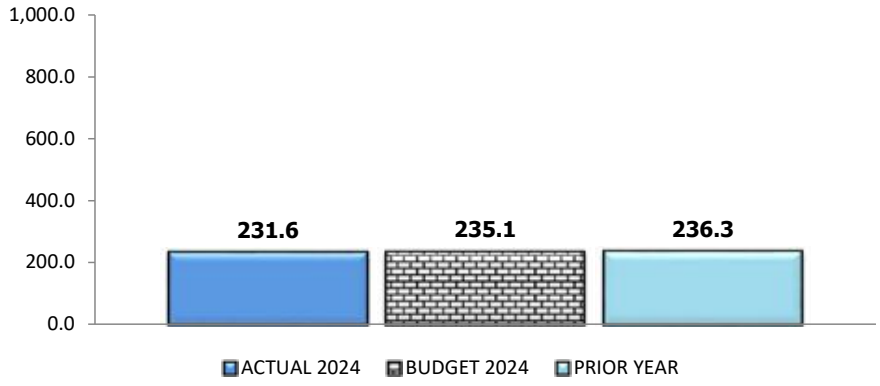
July FY 2024

BT Average Daily Census - CM	BT Average Daily Census - YTD	LBJ Average Daily Census - CM	LBJ Average Daily Census - YTD
437.2	425.2	231.6	227.0

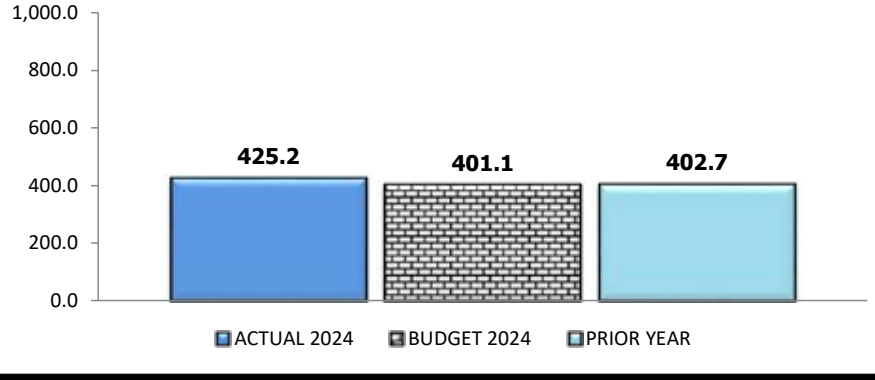
Ben Taub ADC - Current Month



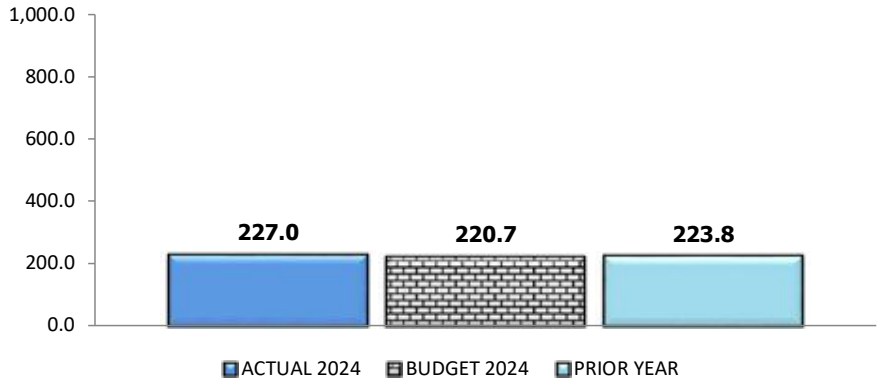
Lyndon B. Johnson ADC - Current Month



Ben Taub ADC - YTD



Lyndon B. Johnson ADC - YTD



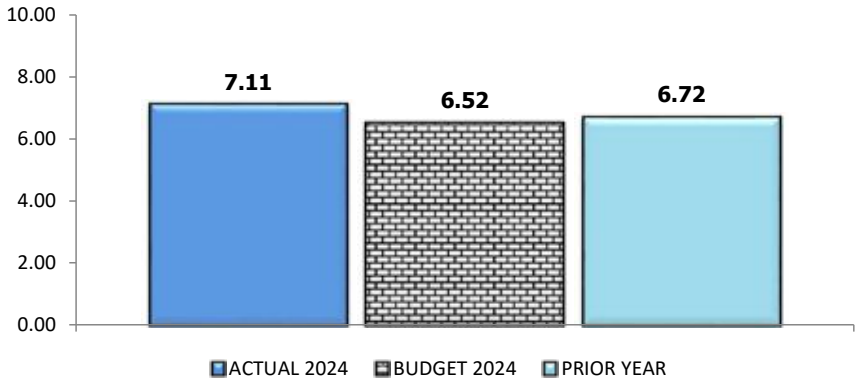
Harris Health

Statistical Highlights - Inpatient Average Length of Stay (ALOS)

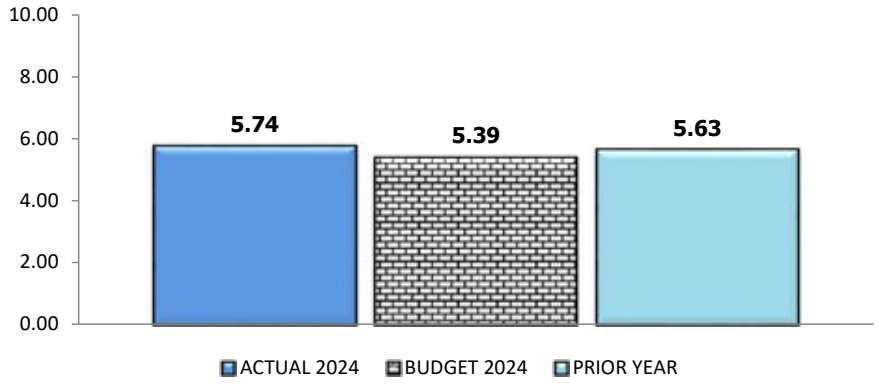
July FY 2024

BT Inpatient ALOS - CM	BT Inpatient ALOS - YTD	LBJ Inpatient ALOS - CM	LBJ Inpatient ALOS - YTD
7.11	7.11	5.74	5.59

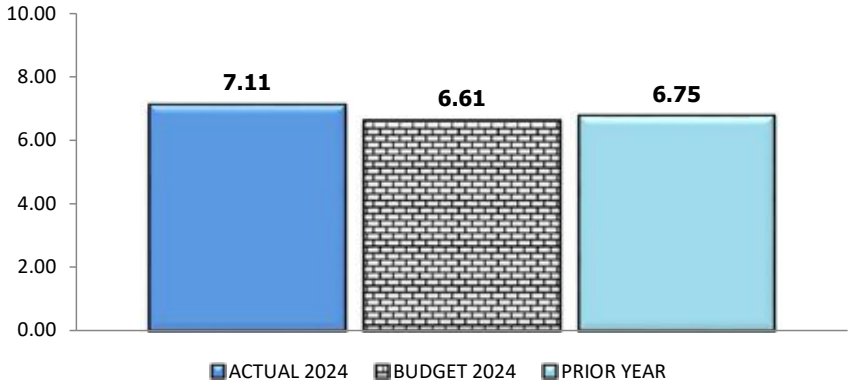
Ben Taub ALOS - Current Month



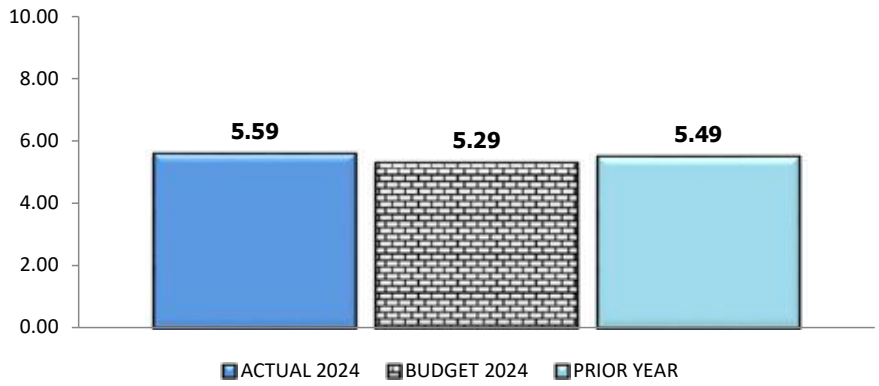
Lyndon B. Johnson ALOS - Current Month



Ben Taub ALOS - YTD



Lyndon B. Johnson ALOS - YTD



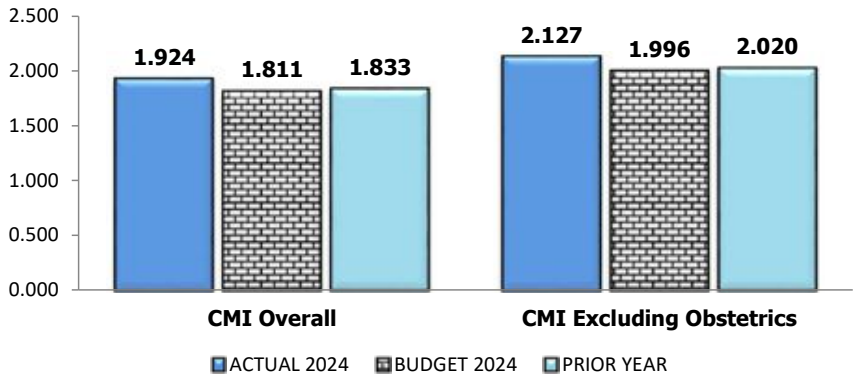
Harris Health

Statistical Highlights - Case Mix Index (CMI)

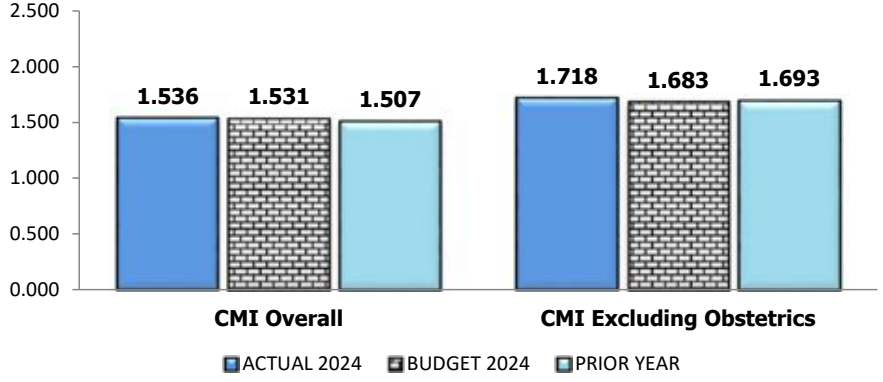
July FY 2024

BT Case Mix Index (CMI) - CM		BT Case Mix Index (CMI) - YTD		LBJ Case Mix Index (CMI) - CM		LBJ Case Mix Index (CMI) - YTD	
Overall	Excl. Obstetrics	Overall	Excl. Obstetrics	Overall	Excl. Obstetrics	Overall	Excl. Obstetrics
1.924	2.127	1.828	2.008	1.536	1.718	1.540	1.705

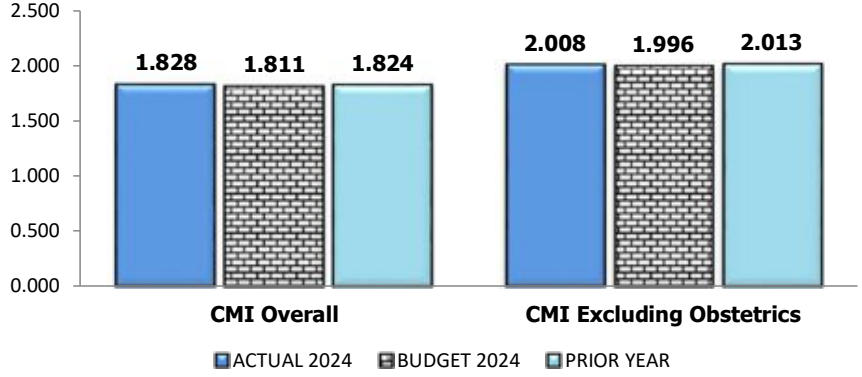
Ben Taub CMI - Current Month



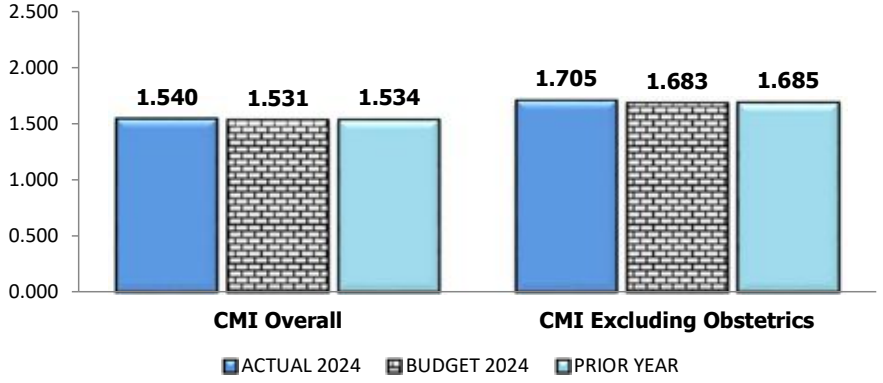
Lyndon B. Johnson CMI - Current Month



Ben Taub CMI - YTD



Lyndon B. Johnson CMI - YTD



Thursday, August 29, 2024

Consideration of Approval to Renew and Amend the Interlocal Agreement Between Harris Health and Harris County, Texas for Legal Representation and Related Support Services Provided by the Harris County Attorney's Office

For your consideration is a renewal and third amendment to the Interlocal Agreement between the Harris County Hospital District d/b/a Harris Health and Harris County, Texas, for Legal Representation and Related Support Services provided by the Harris County Attorney's Office. The underlying Interlocal Agreement was executed in 2021 and amended in 2023 with the approval of the Board of Trustees and Commissioners Court.

The Board's approval of this item will permit Harris Health to renew the Interlocal Agreement and to allocate an amount not-to-exceed $4,200,000 for services rendered during Fiscal Year 2025. This amount is used to fund the salaries and benefits for attorneys, paralegals, investigators, and administrative staff.

Sara Thomas
Chief Legal Officer/Division Director
Harris Health System
Harris County Attorney's Office

Thursday, August 29, 2024

Consideration of Approval of Payment of the Total Compensation Amount for the Fifth Contract Year of the Dental Services Agreement with The University of Texas Health Science Center at Houston

Harris Health and The University of Texas Health Science Center at Houston ("UTHealth") entered into a Dental Services Agreement effective October 1, 2020 (the "Agreement") to jointly provide Covered Dental Services ("Services") at Harris Health dental facilities to the indigent and needy residents of Harris County, Texas.

Administration requests approval of payment of the Total Compensation Amount for the fifth Contract Year (July 1, 2024 through June 30, 2025) of the Agreement for continued support of UTHealth's provision of Services for Harris Health patients. The Total Compensation Amount for UTHealth's Services for the fifth Contract Year reflects changes to Faculty and Resident Compensation, Performance Incentive Compensation, and staffing plans and shall not exceed $5,179,651.91.

Administration recommends approval of funding of the Total Compensation Amount for the fifth Contract Year of the Agreement between Harris Health and UTHealth in an amount not to exceed $5,179,651.91.

Jennifer Small
Executive Vice President – Ambulatory Care Services

Thursday, August 29, 2024

Consideration of Approval to Enter into a First Amendment of an Interlocal Agreement between The Harris Center for Mental Health & IDD, Harris County, Texas, and Harris County Hospital District d/b/a Harris Health for Electronic Medical Record Software Subscription, Support, and Maintenance

Administration requests approval of the First Amendment to an Interlocal Agreement between The Harris Center for Mental Health & IDD, Harris County, Texas, and Harris County Hospital District d/b/a Harris Health for Epic Electronic Medical Record Subscription and Support. The First Amendment includes $59,615 to reimburse Harris Health for additional Epic support services that were provided from October 1, 2022, though January 31, 2023, and also updates the Harris Health contact information and process for adding new Epic or third-party modules.

Administration recommends approval of this First Amendment.

Ron Fuschillo
SVP – Chief Information Officer

Thursday, August 29, 2024

Consideration of Approval to Enter into a Second Amendment of an Interlocal Agreement between The Harris Center for Mental Health & IDD and Harris County Hospital District d/b/a Harris Health for Electronic Medical Record Software Subscription, Support, and Maintenance

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Administration requests approval of the Second Amendment to Interlocal Agreement between The Harris Center for Mental Health & IDD and Harris Health for Epic Electronic Medical Record Software Subscription and Support. This Second Amendment increases the annual support service cost by $465,000, which will allow Harris Health to hire additional personnel to support The Harris Center. The Second Amendment also authorizes Harris Health to disclose the protected health information of Harris Center patients to Harris County Public Health for the purpose of facilitating its Accessing Coordinated Care and Self Sufficiency Program ("ACCESS").

Administration recommends approval of this Second Amendment.

Ron Fuschillo
SVP – Chief Information Officer

Thursday, August 29, 2024

Updates Regarding Pending State and Federal Legislative and Policy Issues Impacting Harris Health

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R. King Hillier
Senior Vice President, Public Policy & Government Relations

Harris Health System
4800 Fournace Place
Bellaire, Texas 77401

August 29, 2023
Board of Trustees Monthly Report

Federal Update

Congressional District 18 (CD 18) Special Election: With the passing of longtime Congresswoman and health care advocate, Sheila Jackson Lee, Governor Abbott has called a special election for Nov. 5, 2024, where voters will select a candidate to serve out the remainder of her current term—which will be around two months. On the same date, voters will select a candidate to represent CD 18 for a full two-year term beginning in 2025.

Because Jackson Lee won the Democratic primary in March, the 88 Democratic precinct chairs in CD 18 will vote on Aug. 13 to select a replacement nominee for the general election ballot. Current candidates for the full-term nomination include former Houston City Council member Amanda Edwards, state Rep. Jarvis Johnson (D-Houston), state Rep. Christina Morales (D-Houston), Houston City Council member Letitia Plummer, and former Houston Mayor Sylvester Turner. The Congresswoman's children have endorsed Sylvester Turner. Candidates for the special election must file with the Secretary of State's Office by Aug. 22 to secure their spot on the ballot.

Heritage Foundation – Project 2025 Medicaid Proposals: In anticipation of a change in Administration and the potential of a Republican majority in the upper and lower chambers of Congress, conservative organizations led by the Heritage Foundation have unveiled the Project 2025 plan to overhaul Medicaid. Below are some edited excerpts from the Georgetown University McCourt School of Public Policy analysis and links.

- **The Project 2025 plan would convert federal Medicaid funding to block grants or per capita caps.** Under the current federal-state financial partnership, the federal government pays a fixed percentage of states' Medicaid costs, whatever those costs are. In contrast, under block grants and per capita caps, federal funding would be **capped**, with states receiving only a fixed amount of federal Medicaid funding either in the aggregate or on a per-beneficiary basis, irrespective of states' actual costs. While the plan does not specify how the block grants or per capita caps would be initially set or how they would be annually adjusted, such funding caps are typically designed to fail to keep pace with expected enrollment and/or health care cost growth in order to deeply cut federal Medicaid spending over time, relative to current law. The caps would also fail to account for any unexpected cost growth such as from a recession, natural disaster, public health emergency or a new, costly drug therapy.
- **The Project 2025 plan purports to establish a "more balanced or blended" federal Medicaid matching rate (FMAP) and would replace "the enhanced match rate with a fairer and more rational match rate."** While the plan does not offer any further

explanation, this likely entails proposals similar to those included in the Republican Study Committee (RSC) budget plan. For example, the RSC budget plan would cut the FMAP to a uniform 50 percent for all states, beneficiaries, services and functions. Currently, states with lower relative average per-capita income receive higher regular FMAPs than states with the highest average per-capita income who receive the minimum FMAP of 50 percent. In fiscal year 2025, Mississippi's regular FMAP will equal 76.9 percent. This will also affect the territories; for example, in 2025, Puerto Rico's FMAP will equal 76 percent and the other territories' FMAP will equal 83 percent. The Texas FMAP rate is currently 60%. Moreover, under the Affordable Care Act (ACA), the FMAP for the Medicaid expansion is set at an enhanced rate of 90 percent on a permanent basis and certain administrative functions, such as upgrades of state Medicaid claims and eligibility computer systems are also eligible for a 90 percent FMAP. This means that the federal government will not only set caps on federal Medicaid funding through block grants and per capita caps but also require states to pay a much larger share of Medicaid costs below such caps.

- **Like the RSC budget plan, the Project 2025 plan would appear to eliminate state use of provider taxes, which nearly all states use to finance a portion of the state share of Medicaid costs.** Without provider taxes, states would likely be unable to even draw down all of their highly inadequate Medicaid block grant or per capita cap amounts because they will be unable to generate sufficient alternative revenues to finance their contribution to the cost of their Medicaid programs (up to the federal funding cap). **NOTE:** This is particularly detrimental for the Texas Medicaid program that is heavily reliant on hospital district IGTs and private hospital Local Provider Participation Funds (LPPFs) as the sole funding source for the 1115 Waiver Medicaid Supplemental Directed Provider Payments (DPPs) and the Medicaid Disproportionate Share Hospital (DSH) program. This funding accounts for almost a third of Harris Health's operating budget.
- **The Project 2025 plan would eliminate many existing federal Medicaid beneficiary protections and requirements.** For example, it would set time limits on Medicaid coverage and impose lifetime caps on benefits, which are now prohibited. It would also allow states to increase premiums and cost-sharing above current limits and to also presumably impose premiums and cost-sharing on beneficiaries like children and pregnant people who are now exempt. The plan would also eliminate mandatory benefits in Medicaid, which would allow states, for example, to drop coverage of nursing home care and the Early Periodic Diagnostic Screening and Treatment (EPSDT) benefit for children. On long-term services and supports (LTSS), the plan proposes to allow states to redesign "eligibility, financing and service delivery" though it is unclear what cuts that would entail. It also appears to permit states to eliminate coverage of nursing home care and other LTSS services for some of those who now spend down their assets to become eligible under current law. It is unclear whether the plan would also eliminate minimum income eligibility levels, such as for children, parents, seniors and people with disabilities. However, the RSC plan, for example, would eliminate minimum income eligibility for children and would appear to allow states to no longer have to cover any non-elderly non-disabled parents.
- **The Project 2025 plan would encourage the federal government and states to impose more red tape and make it harder for eligible individuals and families to apply for, enroll in, and renew their Medicaid coverage.** It would allow states to impose onerous work reporting requirements. In addition, while there is no detail, the plan would require

"more robust eligibility determinations" which would have the effect of reducing participation among people eligible for Medicaid. It also would "strengthen asset test determinations within Medicaid." It is unclear if this entails not just more burdensome paperwork and verification associated with counting assets but also reimposing asset tests for populations such as children, parents and other adults who are not currently subject to such asset eligibility requirements.

- **The Project 2025 plan would establish an option for individuals to convert their Medicaid coverage into a voucher, presumably for the purchase of coverage in the private insurance market, even though such coverage would likely be far less affordable and provide a much less generous benefits package than what Medicaid provides today.** (Moreover, private insurance does not offer comparable, comprehensive benefits that Medicaid does, including EPSDT, LTSS and a prescription drug benefit that guarantees an open formulary.) States would also be given the option to finance coverage through a high-deductible private insurance plan tied to a Health Savings Account instead of providing Medicaid benefits, under which individuals would have to pay for health care items and services themselves. There would be no guarantee that the funds deposited in their accounts would be sufficient to pay for deductibles and needed care, especially because individuals would likely have to pay for items and services at the highest self-pay prices.
- **The Project 2025 plan would appear to largely sweep away existing federal oversight of state Medicaid programs.** For example, payment reforms could be made without state plan amendments or waivers. The only standards would be some broad federal indicators like "cost effectiveness and health measures like quality, health improvement and wellness." However, in the case of reproductive health, the plan would instead impose new stringent federal requirements, including prohibiting Planned Parenthood from receiving federal Medicaid funding, prohibiting Medicaid waiver coverage of travel to obtain an abortion and cutting Medicaid funding for states that require abortion coverage in their private insurance plans (outside of Medicaid).
- **The Project 2025 plan does not include any cost estimates of the severe Medicaid cuts envisioned under the plan.** But the similar RSC budget plan can give a sense of the potential magnitude of the Project 2025 plan's draconian Medicaid cuts. According to the budget summary tables in the similar RSC budget plan, together with a related proposal that would appear to block grant the Affordable Care Act's marketplace subsidies, block granting Medicaid and instituting the other Medicaid cuts included in the RSC budget would cut federal spending by $4.5 trillion over 10 years. That constitutes a 53.7 percent cut, relative to the Congressional Budget Office's February 2024 **baseline** spending levels for Medicaid, the Children's Health Insurance Program (CHIP) and ACA marketplace subsidies for fiscal years 2025-2034. By the tenth year (2034), the cut would equal a 57 percent reduction.

With such drastic cuts in federal funding — along with restrictions on how states can finance their share of Medicaid costs — states would face a massive cost-shift in financing their Medicaid programs. They would have no choice but to institute truly draconian cuts to eligibility, benefits and provider reimbursement rates. Such cuts would be exacerbated by the dramatic rollback of existing federal beneficiary protections and requirements, including those related to benefits and cost-sharing. This, in turn, would likely drive tens of millions into the ranks of the uninsured and

underinsured and severely reduce access to health care and long-term services and supports for low-income children, families, seniors, people with disabilities and other adults.

NOTE: Recent news media reports have downplayed the 2025 plan, the lack of support from Donald Trump and his campaign team, and the dismissal of the director overseeing the blueprint, Paul Dans (Mr. Dans was a former Policy Advisor to President Trump). We are in a watershed election cycle and these proposals are very similar to the policies that the former Trump White House domestic policy team, HHS Secretary Alex Azar and CMS Director Seema Verma pursued from day one.

Two attachments are included in this submittal:

1. The 2017 report prepared by Manatt Health for the Texas Alliance for Health Care analyzing the impact of capped federal Medicaid funding in Texas; and
2. The Centers for American Progress analysis of the impact of Project 2025 on Texas.

State Update

Texas Legislature Focuses on Hurricane Preparedness & Response: In the aftermath of Hurricane Beryl and the prolonged power outages following the storm, lawmakers in both the Texas House and Senate are examining how to prevent extended outages in the future.

Lt. Governor Dan Patrick appointed 13 senators to the Senate Special Committee on Hurricane and Tropical Storm Preparedness, Recovery, and Electricity, including numerous Harris County and Gulf Coast Region lawmakers.

The Senate special committee convened its first hearing in late July where it heard testimony from state officials, electric regulators, and private sector electric companies. Soon after the Senate hearing, the House Committee on State Affairs heard similar testimony from many of the same parties discussing many of the same issues—communication breakdowns, vegetation management, staff preparedness, supply preparedness, and mobile generators. Based on testimony and deliberations, both committees will issue recommendations in the coming months.

Gov. Abbott has also been highly involved calling on certain regulated electric utilities to revamp preparedness plans and bolster response operations. Harris Health personnel continue to monitor the committees work in addition to remaining in contact with state agency personnel tasked with disaster preparedness and response.

Texas Higher Education Coordinating Board (THECB) Healthcare Workforce Task Force: The THECB's Task Force on Health Care Workforce Shortages continues its work to help address health care workforce shortages in the state of Texas.

The Task Force will convene an open meeting on Aug. 15, 2024, to review its findings thus far and prepare for upcoming hearings.

Harris Health's Chief Nurse Executive, Dr. Jaqueline Brock, was appointed to an advisory role for the Task Force and has already participated in workshop discussions with fellow appointees.

Otherwise, Harris Health personnel continue to share data and coordinate messaging with Task Force members and other stakeholders.

Harris Health to Host September 6th Teaching Hospitals of Texas (THOT) Quarterly Board Meeting: Typically held in Austin, Harris Health will host the next quarterly board meeting of the Teaching Hospitals of Texas at Fournace Place.

As part of this meeting, Harris Health will host executives and leadership from similarly situated health systems across Texas, where we will discuss policy developments at the state and federal level in addition to preparing for the upcoming 89th Texas Legislative Session in January of 2025.

Preserving Harris Health's Fiscal Autonomy: As a special taxing unit, Harris Health is subject to an 8% voter-approval rate as relates to property taxes, whereas many other local governments are subject to a 3.5% rate.

Essentially, this allows Harris Health greater autonomy and flexibilities to keep pace with the rising cost of workforce, pharmaceuticals, and other areas essential to health care operations.

Harris Health personnel are coordinating with similarly situated hospital districts to educate lawmakers on the negative health care consequences that can result from an overly restrictive voter-approval rate.

House and Senate committees will convene over the coming months to hear testimony on property taxes in general and, based on these hearings, issue recommendations for lawmakers to consider during the upcoming Legislative Session in 2025.

Upcoming Texas Legislative Interim Hearings:

TEXAS SENATE

Business and Commerce, Aug. 27, 2024 – The committee will examine the development and use of artificial intelligence (AI) and evaluate the implications of public and private sector adoption. It will make recommendations for responsible AI regulations regarding issues such as data privacy, consumer protections, risk mitigation, and compliance processes.

Finance Committee, Sept. 4, 2024 – The committee will consider cutting property taxes. Potential strategies include increasing the amount for homestead exemptions and rate compression. The committee will also seek to establish and report on the cost of eliminating all property taxes and the potential state revenue reallocations this would necessitate.

Finance Committee, Sept. 5, 2024 – The committee will monitor the implementation of Senate Bill 30, passed in 2023's 88th Regular Session. SB 30 made appropriations for

expanding mental health services and inpatient facilities in Texas. The committee will examine the pace of facility construction and the effectiveness of mental health spending.

Natural Resources & Economic Development Committee, Sept. 17, 2024 – The committee will examine the impact of cement production plants on local communities and make recommendations on properly locating these facilities. It will also consider and make recommendations on access to childcare as a way to support workforce productivity.

Health & Human Services Committee, Sept. 18, 2024 – The committee will consider available services for Texas children with high acuity mental and behavioral health needs and make recommendations for improvement. It will also consider access to primary and mental health care for all Texas patients and examine potential regulatory and licensing flexibilities that could improve access while maintaining safety.

TEXAS HOUSE

Human Services, Aug. 27, 2024 – The committee will examine implementation of House Bill 1575. Passed in 2023, HB 1575 directed the Health & Human Services Commission to create a set of screening questions for non-medical drivers of health. It also added community health workers (CHWs) and doulas as new Medicaid provider types. The aim is to improve health outcomes for pregnant Texans and their children.

manatt

FEBRUARY 2017

Capped Federal Medicaid Funding: Implications for Texas

Prepared by Manatt Health for the Texas Alliance for Health Care

Deborah Bachrach, Partner
Cindy Mann, Partner
Anne Karl, Partner

This paper was commissioned by the Texas Alliance for Health Care. The Texas Alliance for Health Care was created as a resource to lawmakers in anticipation of changes in the Affordable Care Act. The Alliance is a diversified group of stakeholders from private and public sectors representing hospitals, health plans, community clinics, other providers, business and public health. Its goal is to provide well thought out research that will inform and offer guidance as to the impact of proposed changes in the finance and delivery of healthcare in Texas. To learn more about the Alliance contact Jon Comola at jrcomola@wrgh.org or 512.695.8806.

About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice. Manatt Health's experience spans the major issues re-inventing healthcare, including payment and delivery system transformation; Medicaid coverage, redesign and innovation; health IT strategy; health reform implementation; healthcare mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law. With 90 professionals dedicated to healthcare—including attorneys, consultants, analysts and policy advisors—Manatt Health has offices on both coasts and projects in more than 30 states.

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Executive Summary

Since its inception, Medicaid has been financed jointly by the federal and state governments. There are no caps on the federal government's financial obligations; federal funding is guaranteed as a share (known as a "match") of all state expenditures that follow federal rules. Today, this open-ended funding model is being called into question. Republican congressional leadership and President Trump are seeking to replace the current matching system with a fixed allocation of federal dollars paid through block grants or per capita caps.

Drawing on proposals advanced in recent years, this paper examines the factors that go into calculating the amount of federal dollars that would be allocated to each state in a capped funding model and considers how they might play out for the State of Texas. Because capped funding proposals generally provide states with greater flexibility than the current Medicaid funding model, the paper also reviews the type of flexibilities that might be available to Texas under such proposals.

I. Medicaid Financing Models

Under the current system, the federal government matches state spending on Medicaid so long as the state follows federal Medicaid rules, including terms and conditions authorized by section 1115 waivers. Texas's federal matching rate for 2017 is 56%—meaning that the federal government generally pays 56% of all allowable Medicaid expenditures.

By contrast, under capped funding, the amount of federal dollars is set in advance and does not increase when the state's healthcare costs increase beyond the preset amount. The base funding amount is trended annually generally using a national trend rate set below the rate of medical inflation. And, at least to date, all such proposals both cap and reduce the amount of federal dollars available to states.

Two types of capped models have been advanced:

- **Block grants** impose an aggregate cap on federal funding for each state. If costs are above the federal caps—due to enrollment or rising healthcare costs—states would bear all of those costs.
- **Per capita caps** limit federal funds on a per enrollee basis. Unlike a block grant, federal payments would rise with enrollment (that is, the state is paid per enrollee up to the cap), but like a block grant, federal payments would not vary based on healthcare costs. Notably, a per capita cap could also include a state or national spending cap, placing states at risk for increasing enrollment and rising healthcare costs in much the same way as a block grant.

II. Key Features of Capped Funding Models and Considerations for Texas

To evaluate the potential impact of capped funding, Texas will want to review key elements that affect the amount of federal Medicaid dollars it will receive—the base funding, trend rate, and the treatment of supplemental payments and waivers—and consider how Texas fares relative to current law and other states. In some cases, the implications for Texas depend on whether capped funding is structured as a block grant or a per capita cap. The financial impact of capped funding will also be affected by the flexibility provided, which is considered below.

Base Funding. The proposals typically set initial state allotments based on each state's historic federal payments. Block grants are generally based on a state's total federal Medicaid payments during a base year, while per capita caps would be based on historic spending during a base year for specific populations, such as children, adults, the elderly, or people with disabilities. In doing so, capped funding models essentially lock in prior state decisions with respect to eligibility levels, covered benefits, and payment rates. Texas will likely have additional programmatic flexibility to change some or all of its earlier programmatic decisions, but the state's previous decisions, which are reflected in its base payments, will largely determine the funding available to make any future changes.

- **Eligibility.** In a block grant context, relatively low eligibility levels will translate into relatively low base payments. The eligibility issue that has garnered the most attention in connection with proposals to cap federal Medicaid funding relates to whether a state has elected to expand Medicaid under the Affordable Care Act. The 31 states plus the District of Columbia that expanded Medicaid received an additional $72.6 billion in federal funding in 2016—funding that did not flow to the 19 non-expansion states, including Texas. (Texas would have received about $10 billion in 2016 had it expanded Medicaid.) A critical question for Texas is whether in setting the caps Congress will address the disparities between expansion and non-expansion states.
- **Benefits and payment rates.** State decisions on covered benefits and plan and provider rates likewise drive its Medicaid expenditures and therefore the historical base on which the capped funding is calculated. While eligibility levels affect base funding decisions with respect to block grants, benefit and rate decisions affect the base amount with respect to both block grants and per capita caps because they drive both total state spending as well as per enrollee spending.

Texas's relatively low eligibility levels will mean that it has a smaller base upon which block grant payments will be set; those eligibility levels are less informative in the context of a per capita cap. A comparison of Medicaid spending per enrollee provides further insight into how Texas would fare under both types of capped funding models as compared to other states and whether it would have a relatively robust base payment available to underwrite future costs. The most recent data available for all states is 2011; in that year Texas spent more per enrollee than most states on children, but

considerably less on elderly and disabled beneficiaries, ranking 40th and 26th in the nation, respectively. With the elderly population (and particularly the 85 plus population) expected to grow in every state, this will disadvantage Texas under most capped funding proposals. Ironically, Texas may also be disadvantaged by having made greater strides than many other states on lowering its spending on long-term services and supports, by prioritizing less costly home and community-based services.

Trend Rate. As important as the base payment is in determining the amount of federal dollars that a state will receive, the trend rate is likewise important—particularly over time. The trend rates in recent proposals are tied to a national, not a state-specific, indicator—usually the Consumer Price Index (CPI) or Gross Domestic Product (GDP) plus one. These trend rates are projected to grow more slowly than overall healthcare costs or Medicaid spending (this is one of the ways federal savings are achieved). States might be able to lower program costs, but to the extent these trend rates do not keep up with actual costs, states will bear these added costs. From 2000 to 2011, Texas's average annual growth in spending for children was 8.4%; for elderly adults it was 5.6%; and, for disabled individuals it was 4.7%. During that same period of time, GDP grew at 2.9% and the CPI grew at 2.5%. In a block grant context, the trend rate implications for Texas are especially concerning, as Texas is projected to be one of the fastest growing states in the nation, but the trend rate is also a concern to Texas in a per capita cap context particularly when considered in combination with the low base rate for elderly enrollees and the expected rise in the elderly population.

Supplemental Payments and Waivers. Virtually every state relies on some form of supplemental payment or waiver funding, but it is not clear from most of the proposals whether these funds would be built into the base payment or continue to be available to states as a separate stream of funding. These issues are of particular importance to Texas which receives a greater percentage of total Medicaid dollars through supplemental payments and waiver funds than any other state in the nation.

State Share. While the federal government, on average, covers 62 percent of the cost of Medicaid nationally and 56 percent in Texas, state spending in the program is significant. Texas will want to look closely at a number of features relating to state share:

- **State spending requirement.** Many of the proposals are unclear as to whether states would have to spend their own funds as a condition of receiving capped federal funds. If a state-matching requirement remains and the federal funds that states can draw down are themselves reduced, Texas's state-spending requirement will also be reduced given that Texas law limits state spending for Medicaid to those expenditures that will qualify for federal matching payments. This would mean that total reductions in program spending would be much higher than the federal spending reductions—unless Texas law was changed so that it would absorb program costs above the federal caps with state-only funds.
- **Matching rate.** Assuming state spending is required, the capped funding proposals generally do not address the federal match rates that would be applied, nor whether higher matching rates currently available for certain populations and services would continue. Texas currently receives enhanced matching funds for its IT and eligibility systems and certain program integrity initiatives. Texas also was the 5th state in the nation to take advantage

of the Community First Choice federal option, which provides enhanced federal matching payments (a six percentage point increase) for the home and community-based services provided through the program.

- **Changes in how states can raise their nonfederal share.** State spending (and therefore total program spending) could also be affected if the rules relating to how states can raise their nonfederal share are changed. Some proposals are silent on this question but a few would limit state reliance on intergovernmental transfers (IGTs) or provider taxes. Texas currently relies heavily on both IGTs and provider taxes to fund the nonfederal share of Medicaid costs.

III. Flexibility

Capped funding is typically coupled with additional state flexibility. While states generally welcome more flexibility, when that flexibility is linked to a reduction of and cap on federal Medicaid funding, states will want to consider the flexibility they are looking for and the extent to which it will help them manage program costs with less federal funding. In addition, states will want to consider whether that flexibility is available today through waivers or administrative changes as well as the downstream implications for new flexibility on local governments, providers, health plans and consumers.

The three big drivers of spending in Medicaid are eligibility, benefits, and provider payment rates. With the exception of children and pregnant women, Texas's eligibility rules are set at the federal minimums today; it is unclear if Texas would have the flexibility to set lower eligibility levels or if it did, whether it would choose to take up that flexibility. Texas might gain additional flexibility to condition coverage on work or job training requirements or payment of a monthly premium, but the majority of program enrollees are children and the majority of program spending is for low-income elderly and people with disabilities. Given the population Texas Medicaid covers today, Texas will want to consider whether it would impose such requirements, how much savings it would achieve, and whether it could secure the authority to do so through a waiver today.

Similar questions arise with respect to benefits—which benefits would Texas choose to drop if it had the flexibility to do so? Notably, certain mental health services as well as substance abuse and pharmacy are optional benefits today, and Texas has determined to cover them. Finally, while Texas has considerable flexibility to set plan and provider payment rates today, it might be able to reduce rates even further and with fewer constraints in a capped funding model. Again, Texas will want to consider the impact both on access to care as well as the sustainability of its providers, most particularly rural providers.

IV. Conclusion

By design, capped funding proposals shift the risks of any Medicaid costs above the federal caps to states. States will seek to ensure that any capped funding program that is considered by Congress protects them to the greatest extent possible; that is, that decisions on base year costs, out-year trend rates, state share obligations, and the treatment of supplemental and waiver payments are fair to the state, its residents, and its healthcare providers. And each state will have different priorities; accommodating all of them would be complicated and not likely given Congress's interest in reducing federal Medicaid expenditures.

Texas comes to the capped funding discussion with a number of fiscal challenges—most notably its historically low investment in Medicaid relative to other states, its relatively low spending per enrollee for the elderly, its growing population, and its high reliance on supplemental and waiver funding. New flexibility could help Texas structure its program in less costly ways, but given its spending levels and the fact that most of the spending is driven by the needs of high cost, high-needs disabled and elderly enrollees, it is unclear how much Texas can save through any new flexibility. Texas will want to carefully consider all these factors as it evaluates the potential impact of capped funding on its budget, its residents, and its healthcare providers.

Capped Federal Medicaid Funding: Implications for Texas

Republican congressional leadership and President Donald Trump have called for a restructuring of how the federal government funds Medicaid—going well beyond repealing and replacing the Affordable Care Act. Since its inception in 1965, Medicaid has been financed jointly by the federal and state governments with the federal government providing funds to match all state expenditures made pursuant to federal Medicaid law. There are no caps or limits on the federal government's financial obligations for the program, as long as state expenditures follow federal law.[1] Replacing this matching system with a fixed allocation of federal dollars, likely coupled with fewer federal requirements, has major implications for states, healthcare providers, and consumers.

Under a capped financing system, Congress predetermines the maximum amount each state receives typically based on historic state enrollment and spending and adjusted yearly by a national trend rate. While additional adjustments could be added (for example, an adjustment for population growth), under all of the capped funding proposals federal payments to states are divorced from actual costs. At the same time, the proposals offer states new programmatic flexibility, although the proposals provide little detail on the new flexibility that would be permitted. States will want to evaluate whether the additional flexibility is a good trade-off for the risk they must assume under a capped financing system.[2]

This brief looks at capped funding proposals drawn from federal capped programs already in place as well as recent proposals relating to Medicaid. It focuses on how the caps and trend rates are designed, and the implications for Texas. Details do matter; since many important details are missing from the recently advanced proposals, this brief does not purport to calculate the impact of capped funding on Texas or anticipate with precision how new programmatic flexibility might impact the Texas Medicaid program under a capped funding structure. Instead, this brief offers a preliminary framing of the key issues related to setting funding caps and expanding state flexibility. Further discussion will be needed as new details on capped funding proposals emerge.

I. Overview of Models for Funding Medicaid

Financing Medicaid Today

States and the federal government share responsibility for funding the Medicaid program, with each covering a share of all permitted Medicaid expenditures. Federal contributions match state expenditures with no upper limit[3] on the total Medicaid expenditures.[4] As a result, as state Medicaid spending rises, so do federal expenditures. State decisions about the populations and benefits to cover and the amount they pay for services are the principal drivers of the level of federal funding a state receives.

The current model affords states significant but not unfettered flexibility to tailor their Medicaid programs to address shifting social, economic, and clinical imperatives. States can manage spending—and consequently their share of the costs—through a number of levers, most significantly through the choices they make on covering optional populations and benefits, designing their delivery system (e.g., managed care versus fee-for-service), setting plan/provider payment rates, ensuring appropriate utilization of services, as well as engaging in population health and valued-based payment arrangements. However, states operate under certain federal constraints, including minimum standards relating to benefits and requirements that payments to plans be "actuarially sound." And like all healthcare payers, states face costs that are often beyond their control. The current financing model helps states absorb these unanticipated or hard-to-control costs. States receive more federal dollars when Medicaid enrollment rises, as often occurs when the economy falters. Federal support also automatically adjusts when state costs rise due to a public health crisis such as the opioid epidemic or Zika or emerging new technologies and cures. The added federal support generally does not relieve the state of its share of rising costs,[5] but it does assure that added costs are fully shared by both levels of government (in Texas at a 56/44 split). Since federal spending rises and falls based on state spending, some proponents of capped federal funding cite the fact that the federal government lacks year-to-year certainty on Medicaid costs as an important reason for implementing caps.[6]

Texas Medicaid Today

- **4.3 M** enrollees
- **$36.1 B** total spending ($14.7 B state, $21.4 B federal)
- **56%** federal match rate

Sources: Robert Wood Johnson Foundation, "Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States"; MACStats

Capped Funding Proposals

Two different types of capped funding models are under consideration: block grants and per capita caps. The models differ in several key respects, but in both states are no longer guaranteed federal funding for the actual costs of their Medicaid programs. In addition and significantly, to date all such proposals contemplate reducing federal funding to states, through the way base payments are set or by imposing a national—rather than state-specific—year-to-year growth rate that is below the rate of medical inflation and the projected growth in Medicaid program costs.

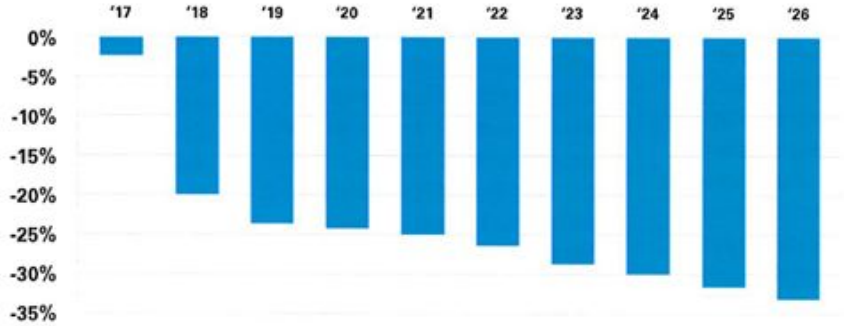
1115 Waiver Caps

States operating 1115 waivers are subject to per capita caps on federal spending to enforce the federal policy that waivers be budget neutral to the federal government. The caps in 1115 waivers differ from the proposed per capita caps in several key respects. Budget neutrality caps apply only to the population and services that are subject to the waiver, and they are negotiated based on expected growth in the state's Medicaid program to ensure that the growth under the waiver is no greater than it would have been without the waiver. In contrast, current capped funding proposals are designed to reduce federal spending, and they would be imposed by federal law program wide. Additionally, waiver caps apply over the life of the waiver, allowing savings in one year to offset overages in another. Finally, waivers are voluntary and the caps are negotiated by states.

Block grants impose an aggregate cap on federal Medicaid funding for each state. Funding under block grants is fixed and does not increase in response to a state's growth in enrollment or healthcare expenditures. Block grant proposals differ with respect to the states' obligation to match federal expenditures, and most include some additional state flexibility in designing and administering their Medicaid programs.[7] The details will matter—there might be population or other adjusters in the block grant formula —but, by design, capped federal funding shifts all costs above the caps to the states. States might have greater flexibility to reduce costs, but if capped federal funding ultimately falls short of actual costs, states must either invest additional state dollars or make further changes to eligibility, benefits, or payment rates.

Per capita caps impose a cap on federal funds on a per enrollee basis. Base payments are set for each group of enrollees (e.g., children, people with disabilities) and, like a block grant, these base payments would likely rise each year by a national trend rate. In contrast to a block grant, under a per capita cap, total federal payments would rise with enrollment (that is, the state is paid for each enrollee up to the cap), but like a block grant, federal payments would not vary based on states' decisions regarding covered

Figure A: Percent Cut in Federal Medicaid and CHIP Funds House FY 2017 Plan Relative to Current Law



benefits, provider payments, or healthcare costs. In other words, states are at cost risk, but not at enrollment risk. Because total funding fluctuates with enrollment, states operating under a per capita can be more certain that their Medicaid programs will be able to respond to financial downturns or population changes. Notably, however, some per capita cap proposals also include a national aggregate cap,[8] placing states at risk for increasing enrollment and rising healthcare costs in much the same way as a block grant. Like block grants, state matching requirements vary under different per capita cap proposals, though most proposals appear to assume states would continue to have a state match requirement.

Recent capped funding proposals split on whether they propose block grants or per capita caps (or, in some cases, give states the option). However, they all are explicitly designed to reduce federal Medicaid spending; this is largely accomplished by setting a national trend rate for the capped payments below the level of growth that is projected under current law. For example, the House Budget Committee's proposal for the FY 2017 Budget ("House Budget proposal") would reduce federal Medicaid spending by almost one trillion dollars over ten years as compared to projected spending under current law.[9] See Figure A.[10]

II. Key Features of Capped Funding Models and Considerations for Texas

Any change to federal Medicaid financing and program rules would have significant implications for Texas. Figure B shows the role that state and federal Medicaid funds play in Texas's budget.[11]

Medicaid accounts for a large share of spending of State funds—20 percent in State fiscal year 2015.[12]

But it is also the single largest source of federal funding for Texas, representing just over 50 percent of all of the federal funds available to the State. By comparison, the next largest source of federal funds—for primary and secondary education—is just under 12 percent. Proposals to cap federal Medicaid funding alter this source of federal funding for the State.

All capped funding models shift risk to the states. The magnitude of risk shifted depends on the funding levels: the lower the base funding levels and applicable trend rates, the greater the level of risk shifted to the states. We therefore begin this section of the paper by reviewing four key elements that affect the amount of the cap—the base funding, trend rate, state spending requirements, and supplemental payments and waivers—and describe how different factors work to advantage or disadvantage Texas relative to other states.[13] In some cases, the implications for Texas depend on whether the capped funding is structured as a block grant or a per capita cap. In the final section, the paper compares the flexibility that might be coupled with capped federal financing to the flexibility available under current law.

1. Base Funding

In setting initial allotments for any capped funding model, proposals typically use each state's historic Medicaid spending. Block grants are

Figure B: Medicaid's Role in Texas's Budget

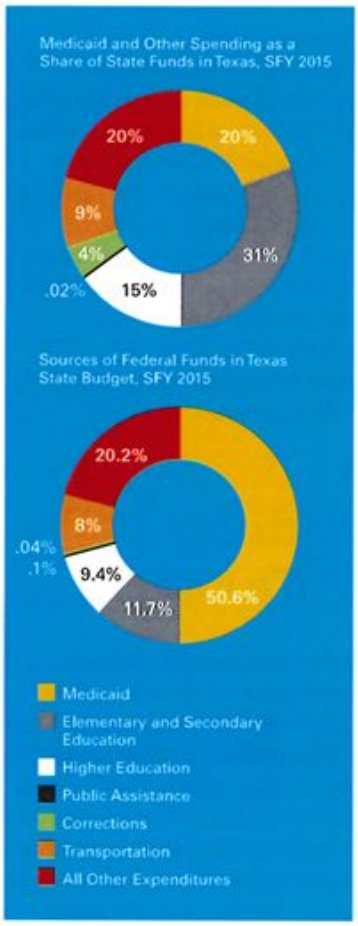
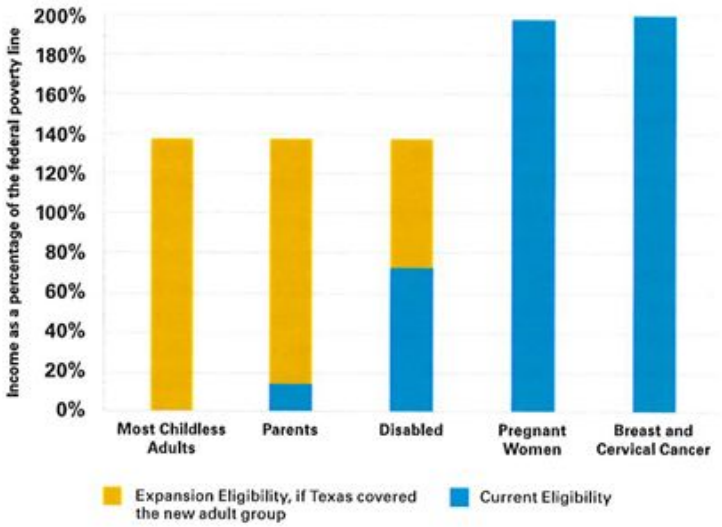


Figure C: Comparison of Current Eligibility Levels in Texas to Eligibility Levels under Expansion



generally based on a state's total federal Medicaid payments during a base year, while per capita caps would be based on historic spending during a base year for specific populations, such as children, adults, the elderly, or people with disabilities. (Note that an important question for Texas is whether the base payments incorporate spending on supplemental payments and waiver spending; that issue is discussed in section 4 below.) In doing so, all capped funding models essentially lock in prior state decisions with respect to **eligibility levels, covered benefits** and **payment rates.** In addition, the greater a state's matching rate, the greater the cap will be for a given state's spending level. At any given spending level, a state with a 70% match will have a higher federal cap than a state with a 50% match.

The base payments will likely be subject to a national trend rate, and states will likely have the programmatic flexibility to change those decisions (both issues are discussed below). But their previous decisions, which are reflected in their base payments, will largely determine the funding available to make any future changes. States with higher base payments will have more federal dollars available, affording them a relatively broader array of options for running their Medicaid programs in the future.

Eligibility Levels

The eligibility issue that has garnered the most attention in the current block grant debates relates to whether a state has elected to expand Medicaid

under the Affordable Care Act. Thirty-one states (plus Washington DC) have expanded Medicaid; nineteen states, including Texas, have not. Figure C[14] compares Texas's current eligibility levels to eligibility levels under expansion.

The 31 expansion states plus D.C. received $72.6 billion additional federal dollars in 2016.[15] (For Texas, this would represent an additional 10 billion federal dollars.) It is unclear whether these funds will survive an ACA repeal effort. Assuming they do, the expansion states will want them folded into their capped payments as these dollars are now "baked" into those states' budgets. Resolving the disparity between the expansion and non-expansion states will be one of the thornier issues Congress will navigate if it moves ahead with a block grant proposal.

Texas is further disadvantaged under a block grant structure because it has relatively low eligibility levels as compared to other non-expansion states. Today, Texas does not cover childless adults at any income level (unless disabled, pregnant or elderly) and covers parents with incomes below 15 percent of the federal poverty level. Of the 19 states that have not expanded Medicaid, most do not cover childless adults but only one state—Alabama— has lower eligibility levels for parents than Texas.[16] Figure D[17] compares parent eligibility levels in Texas relative to eligibility levels for the other non-expansion states.

States with lower eligibility levels have lower aggregate spending relative to the size of their low-income populations, resulting in a lower base payment in a block grant structure as compared to other states with higher eligibility levels. A lower base payment, in turn, will put greater fiscal pressure on Texas, making it difficult to make future changes in the program, whether those changes might involve covering more people, addressing

Figure D: Comparison of Eligibility Levels for Parents Among Non-Expansion States

Rank	State	Parent/Caretaker Eligibility Level
1	Tennessee	103%
2	Maine	100%
3	Wisconsin	95%
4	South Carolina	62%
5	Nebraska	58%
6	South Dakota	57%
7	Wyoming	55%
8	Virginia	49%
9	Utah	44%
10	North Carolina	44%
11	Oklahoma	41%
12	Georgia	34%
13	Kansas	33%
14	Florida	29%
15	Idaho	24%
16	Mississippi	23%
17	Missouri	18%
18	Texas	15%
19	Alabama	13%

Table E: State Ranking of Medicaid Spending per Full Benefit Enrollee, FY 2011

#	Aged	Adults	Children	Disabilities
U.S.	**$17,522**	**$4,141**	**$2,492**	**$18,518**
1	WY ($32,199)	NM ($6,928)	VT ($5,214)	NY ($33,808)
2	ND ($31,155)	MT ($6,539)	AK ($4,682)	CT ($31,004)
3	CT ($30,560)	AK ($6,471)	NM ($4,550)	AK ($28,790)
4	NY ($28,336)	AZ ($6,471)	RI ($4,290)	ND ($28,790)
5	DE ($27,666)	VT ($6,062)	MA ($4,173)	DC ($28,604)
6	OH ($27,494)	RI ($5,778)	MN ($3,461)	MN ($26,890)
7	DC ($27,336)	OR ($5,631)	NH ($3,241)	WY ($25,346)
8	MA ($27,205)	DE ($5,430)	PA ($3,194)	MD ($23,798)
9	NH ($26,794)	MD ($5,385)	CT ($3,158)	DE ($22,972)
10	MT ($26,704)	NY ($5,339)	AZ ($3,052)	AZ ($22,040)
11	MN ($25,030)	KY ($5,055)	**TX ($3,010)**	OH ($21,892)
12	AK ($24,288)	ID ($4,878)	MO ($2,978)	ID ($21,781)
13	OR ($24,253)	TN ($4,852)	DE ($2,942)	NH ($21,545)
14	MD ($23,491)	VA ($4,781)	MT ($2,919)	RI ($21,417)
15	WV ($23,243)	WA ($4,756)	KY ($2,911)	IA ($20,242)
16	PA ($21,372)	NJ ($4,648)	DC ($2,820)	CA ($20,080)
17	IN ($21,269)	PA ($4,631)	MD ($2,765)	NJ ($19,951)
18	IA ($21,163)	CT ($4,538)	NY ($2,707)	UT ($19,718)
19	AR ($20,484)	MA ($4,496)	VA ($2,696)	CO ($19,718)
20	ME ($19,881)	SC ($4,449)	NJ ($2,616)	IN ($19,488)
21	NJ ($19,160)	DC ($4,446)	ND ($2,531)	SD ($19,156)
22	MS ($18,592)	**TX ($4,371)**	ME ($2,528)	VA ($18,952)
23	CO ($18,478)	NC ($4,360)	WV ($2,506)	NM ($18,500)
24	AL ($18,473)	SD ($4,356)	SD ($2,503)	OR ($18,255)
25	HI ($18,328)	WV ($4,284)	CA ($2,475)	VT ($17,789)
26	KS ($18,328)	OH ($4,225)	TN ($2,470)	**TX ($17,709)**

#	Aged	Adults	Children	Disabilities
27	MI ($17,599)	GA ($4,215)	OK ($2,461)	MO ($17,481)
28	MO ($17,020)	LA ($4,168)	AR ($2,458)	NE ($17,449)
29	RI ($16,998)	MO ($4,122)	MS ($2,403)	KS ($17,153)
30	SD ($16,374)	NE ($4,015)	NC ($2,355)	HI ($17,035)
31	VA ($16,367)	WY ($3,986)	UT ($2,260)	MA ($16,927)
32	WI ($16,344)	MS ($3,983)	CO ($2,241)	ME ($16,920)
33	WA ($16,183)	MI ($3,913)	KS ($2,186)	IL ($16,689)
34	AZ ($16,145)	AL ($3,899)	AL ($2,156)	WI ($16,599)
35	KY ($15,757)	MN ($3,863)	IL ($2,123)	PA ($16,441)
36	TN ($15,745)	HI ($3,765)	IA ($2,116)	MT ($16,352)
37	ID ($15,558)	KS ($3,762)	WA ($2,111)	WA ($16,208)
38	LA ($15,491)	NH ($3,652)	OH ($2,110)	NV ($15,706)
39	NE ($14,997)	ND ($3,652)	OR ($2,085)	MI ($15,109)
40	TX ($14,739)	OK ($3,551)	LA ($2,082)	LA ($15,099)
41	VT ($14,258)	CO ($3,469)	HI ($2,062)	NC ($15,060)
42	FL ($14,253)	UT ($3,326)	NE ($2,041)	OK ($15,010)
43	GA ($14,142)	AR ($3,198)	GA ($2,023)	FL ($15,005)
44	NV ($13,226)	IN ($3,198)	ID ($2,023)	TN ($14,680)
45	OK ($12,315)	IL ($3,184)	SC ($2,008)	AR ($14,023)
46	SC ($12,256)	WI ($3,170)	WY ($1,967)	WV ($12,993)
47	CA ($12,019)	FL ($2,993)	NV ($1,940)	MS ($12,960)
48	UT ($11,763)	CA ($2,855)	MI ($1,926)	KY ($12,856)
49	IL ($11,431)	NV ($2,367)	IN ($1,858)	SC ($12,830)
50	NC ($10,518)	ME ($2,194)	FL ($1,707)	GA (10,639)
51	NM (N/A)	IA ($2,056)	WI ($1,656)	AL ($10,142)

Source: Manatt analysis of Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports.

provider payment rates, or just keeping up with costs not accommodated by the trend rate.

Benefits and Provider Rates

Eligibility levels are not the only factor that shapes capped funding calculations: state decisions on covered benefits and plan and provider rates likewise drive a state's Medicaid expenditures and therefore the historical base on which the capped funding is calculated. While eligibility levels affect base funding decisions with respect to block grants, benefit and rate decisions affect the base amount with respect to both block grants and per capita caps because they drive both total state spending as well as per enrollee spending. States with more comprehensive benefit packages or higher payment rates—or both—will tend to have higher per enrollee spending and will draw down more federal dollars on both an individual and aggregate basis.

As Table E shows, Texas's spending per enrollee group relative to other states varies based on eligibility category, with the State spending more than most states with respect to children ($3,010 compared to $2,492 for the US average). However it spends considerably less than most states or the US average on the more costly elderly beneficiaries, spending just under $15,000 a year per elderly beneficiary, with the three highest spending states (Wyoming, North Dakota and Connecticut) spending more than twice as much per elderly beneficiary. With respect to other adults and people with disabilities, Texas spending is about in the middle of states.[18] These spending figures suggest that Texas will be at a significant disadvantage in terms of federal funding levels under both a block grant and a per capita cap with respect to spending for the elderly, which along with the disabled, are the two highest cost enrollee groups covered under Medicaid. With the elderly population (and particularly the 85 plus population) expected to grow in every state, this will significantly disadvantage Texas under most capped funding formulas.

Ironically, states that have taken steps to add more cost-effective benefits to their Medicaid programs may also be at a disadvantage under capped funding formulas. In particular, given the high cost of long-term care and services to the program, states that have successfully shifted more of their long-term services and supports from higher-cost institutional settings to lower-cost community-based settings will have lower caps for elderly and disabled populations (or lower overall block grant caps) than those states that have not done so. States with limited use of community-based long-term care will have higher caps, and they may also be able to manage spending within caps more easily by shifting care from institutional to community-based settings once the caps are in effect.

Texas has made important strides with respect to providing more home and community-based services. It is ranked 13th in terms of the percentage of long-term care provided in home and community settings, placing it well ahead of most states.[19] Texas's success in implementing community-based care no doubt contributes to its lower spending on elderly and to a lesser extent disabled enrollees. While generally this would be considered a good thing, in the context of a fixed block grant or per enrollee cap, Texas may find that future options with respect to payment rates and benefits for these populations are constrained.

All of these factors—eligibility levels, payment rates, and benefits, as well as whether a state has been a good manager of limited resources—will determine a state's base payment rate under most capped funding proposals.

Alternate Approaches

Although most capped funding proposals allocate dollars based on a state's historic spending, two proposals take alternative approaches—each with implications for Texas. The Patient CARE Act, for example, proposes to allocate national federal Medicaid spending across states based on each state's number of low-income enrollees. Texas has the second largest number of low-income residents in the nation, behind California,[20] meaning that Texas would fare better under this model than if the dollars were allocated based on state-historic Medicaid spending. This ranking includes undocumented immigrants, but it is unclear whether the Patient CARE Act's proposed allocation of federal dollars would count undocumented immigrants in calculating a state's number of low-income residents since such individuals are not currently Medicaid eligible. Last year's House Budget proposal takes an entirely different approach, basing the initial cap on national average spending per Medicaid enrollee, rather than state-historic spending. Texas would have higher caps for the elderly, but lower caps for children, if national rather than state-specific average expenditures were used. Using a national average advantages states that have lower spending and disadvantages states that spend above the national average, making any movement toward a national average disruptive and difficult to achieve.

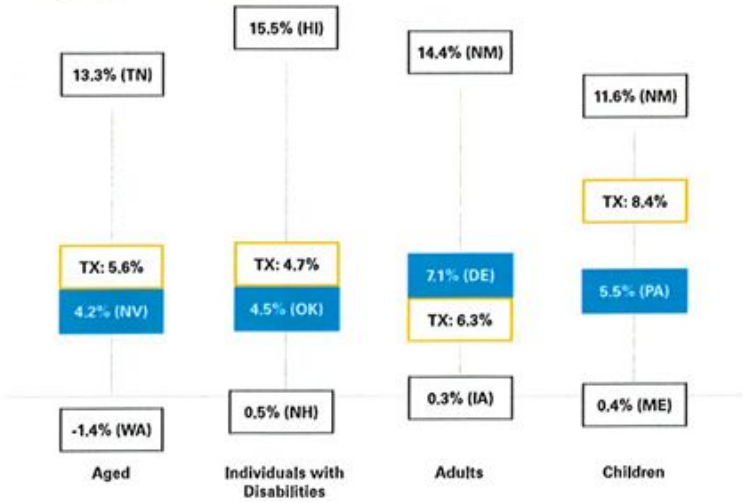
2. Trend Rate

As important as the base payment is in determining the amount of federal dollars that a state will receive, the trend rate is likewise important—particularly over time. Consider a block grant or a per capita cap that sets the base rate at the level of federal payments the State received in 2016. The trend rate will determine whether that payment is frozen over time or whether it grows year-by-year and, if so, by how much. Like other states, Texas will want to consider whether there is a prescribed trend rate and if so what that growth rate will be.

All recent proposals to cap Medicaid funding have included a trend rate that would grow the base payments year to year. This is critical; a capped proposal without a growth rate will lose value relative to the cost of healthcare. Two examples of federal block grant proposals where the base amounts do not automatically grow are the Social Services Block Grant and the Temporary Assistance for Needy Families (TANF).

While the proposals to cap federal Medicaid funding have contemplated that the base payments would be adjusted annually, the trend rates in these proposals would be tied to a national, not a state-specific indicator, and one that is projected to grow more slowly than overall healthcare

Figure F: Comparison of Growth Rates by Eligibility Category, FY 2000-2011



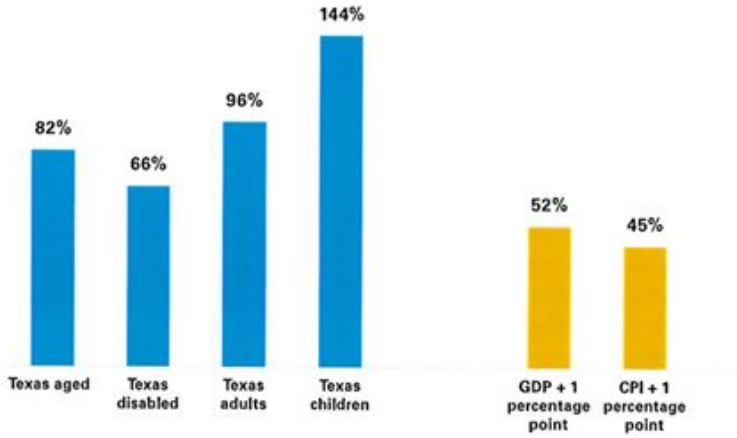
costs or Medicaid spending. For example, the Patient CARE Act uses CPI + 1 percentage point,[21] while the HAEL Act would use GDP + 1 percentage point.[22]

None of the recent Medicaid proposals to cap funding trend the initial capped payments based on state, or even the national, growth in healthcare costs. Medical inflation has outstripped general inflation factors, like changes in CPI or GDP, in recent years, with overall medical inflation averaging 3.21% over the past ten years, nearly twice as high as general inflation, which averaged 1.82% over the same period. And growth rates vary considerably across eligibility groups. Figure F[23] shows the different average trend rates across eligibility groups, underscoring that a single national trend factor might not account for variation in spending growth across different eligibility categories. Caps based on general inflation factors are therefore likely to fall short of Medicaid spending over time, at least in the absence of significant reductions in program costs. Figure G[24] illustrates the gap between the cumulative change in Texas's Medicaid spending compared to the trend factors proposed in the HAEL Act and the Patient CARE Act over the time period between 2000-2011.

The trend rates identified in the Medicaid capped funding proposals address, to a limited degree, the issue of rising healthcare costs, but they do not address enrollment growth. None of the Medicaid block grant proposals or any of the existing federal block grant programs adjusts for enrollment, or even population growth. By contrast, a per capita cap model would accommodate enrollment growth (subject of course to the limits of the base payment), so long as the model does not also include a national spending cap. Because Texas is the third fastest growing state in the nation,[25] it will be particularly disadvantaged by any capped funding approach that does not adjust for enrollment. Because of the combination of a low base rate for elderly enrollees and the expected rise in the elderly population—Texas's growth in terms of population age sixty-five or older is projected to grow 45% between 2015–2025, compared to 36% for the nation[26]—Texas is at risk under a per capita cap, too. If Texas is unable to keep costs under its per capita cap for elderly enrollees, the losses will mount with each new elderly enrollee.

One issue with applying multiple adjusters is that the more meaningful they are to a larger number of states the more they will add federal costs, unless there would also be an allowance for downward adjustment (e.g., to reflect an increase in the average health of an enrollee population in a state that scales back eligibility for long-term care or makes other changes that substantially

Figure G: Cumulative Growth in Texas Medicaid Spending per Full-Benefit Enrollee Relative to Benchmarks, 2000-2011



change its enrollee mix). In addition, while improvements are being made, the federal government currently lacks reliable, timely data for all states that can ensure an adjustment is applied appropriately and in real time. The HAEL Act would adjust per capita caps to account for "new instances of communicable diseases or other public health hazards," but the proposal calls for the adjustments to be budget neutral in the aggregate. In other words, caps could be adjusted to account for a regional health crisis, but other states' caps would need to be reduced to account for the increased federal spending. The Patient CARE Act would be adjusted to "reflect demographic and population changes," though the proposal provides few details on how those adjustments would be made.

3. State Share

While the federal government, on average, covers 62 percent of the cost of Medicaid nationally and 56 percent in Texas,[27] state spending in the program is significant. Several proposals to cap federal Medicaid funding appear to modify or eliminate the requirement that states spend their own funds as a condition of receiving capped federal payments. Speaker Ryan's Better Way proposal, for example, appears to require a state match for states operating under per capita caps but not for states opting for a block grant. (The Ryan proposal would give states a choice of a block grant or a per capita cap.) Eliminating or reducing state-match requirements could add state-spending reductions to the projected federal funding reductions, further reducing the overall funding available for the program. Or, the elimination or reduction of a federal requirement for states to spend their own funds could be illusory. Even without a federal obligation, states may determine that they have to continue to spend their own dollars—and perhaps more of their own dollars— if federal Medicaid funds were reduced and capped.

Even if a state-matching requirement remains in place, if the federal funds that Texas can draw down are themselves reduced then its state-spending requirement will also be reduced. Currently, Texas law limits state spending for Medicaid to those expenditures that will qualify for federal matching payments.[28] If that law (common to many states) remains in place and Texas was to see a 10 or 20 percent reduction in available federal payments due to federal caps, the program would experience a commensurate reduction in state payments for Medicaid coverage and services.

In addition, capped funding proposals generally do not address whether the enhanced federal match rates that are currently available for certain populations and certain services for everything ranging from health homes (for which states receive a 90 percent federal match for two years) to the cost of new IT investments (90 percent match) to the operation of eligibility systems (75 percent match) will remain in place. Texas currently receives enhanced matching funds for its IT systems (claims and eligibility systems and staffing relating to those systems) and certain program integrity initiatives.[29] Texas also was the 5th state in the nation to take advantage of the Community First Choice federal option, which provides enhanced federal matching payments (a six percentage point increase) for the home and community-based services provided through the program.

State spending could also be affected if the rules are changed with respect to how states can raise their nonfederal share. Proposals also vary on whether they would make changes to how a state is permitted to raise its nonfederal share. The HAEL Act, for example, would end state reliance on funding from intergovernmental transfers (IGTs). The House Budget Proposal, by contrast, would

reduce the effective cap on provider taxes to 5.5 percent of net patient revenues, down from the current 6 percent cap. Most other proposals do not speak to this issue.

Texas currently relies heavily on both IGTs and provider taxes to fund the nonfederal share of Medicaid costs, and thus any changes to how states may use IGTs and provider taxes would have significant implications for Texas. In total, IGTs account for roughly half of the nonfederal share for payments to hospitals. If IGTs are no longer allowed to be used to fund the nonfederal share, Texas may struggle to raise the funds required to draw down available federal dollars.[30] Texas also uses provider tax revenue to fund the nonfederal share. Texas currently has no taxes above 5.5 percent of net patient revenue, meaning that Texas's provider tax structure would not be affected by current proposals.[31]

4. Supplemental Payments and Waivers

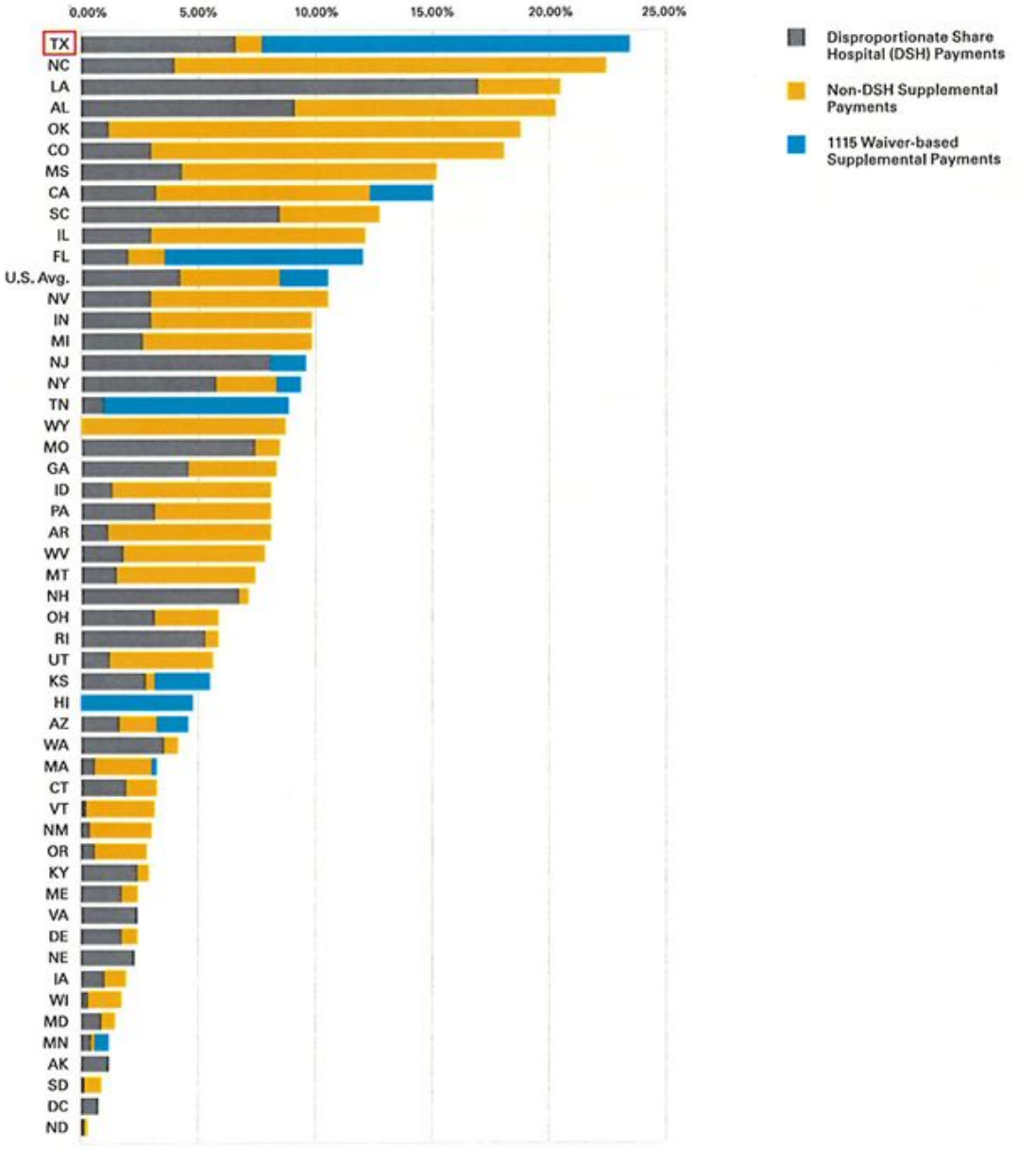
Virtually every state relies on some form of supplemental payment (Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments and Upper Payment Limit payments) or waiver funding, and many states, including Texas, rely on both. In moving to a capped funding model, several questions arise. First, how will Congress treat such spending in calculating each state's base payment? Second, will such funding be permitted outside the cap going forward? Finally, will states continue to be permitted to finance the nonfederal share of supplemental payments or waiver funds through the same mechanisms currently deployed—provider and health plan assessments, intergovernmental transfers, and with respect to waivers, "costs not otherwise matchable." Recent proposals, for the most part, do not have sufficient details to answer any of these questions. The one exception is Speaker Ryan's Better Way proposal that explicitly limits the Secretary of Health and Human Services' ability to approve certain types of new waiver funds, though it provides few details on how existing waiver funds would be handled under capped funding. It also provides that DSH and GME payments would not be included in calculating a state's funding cap; i.e., a state could maintain such funding streams outside its capped federal funding allocation. The HAEL Act, by contrast, would include DSH and GME payments under caps.

No state spends a greater percentage of total Medicaid dollars on supplemental payments and waiver funds than Texas (Figure H). Supplemental payments, most of which have been converted in Texas to waiver payments, account for nearly 1 out of 4 dollars spent in the Texas Medicaid program and for more than half (53 percent) of all Medicaid payments to hospitals participating in the DSH and waiver programs.[32] Thus, how these payments are handled under any capped funding proposal will be especially important to Texas. In addition, because Texas relies on provider and health plan assessments, as well as IGTs, to fund the nonfederal share of these payments, the State will want to track closely any proposals to eliminate or constrain these financing options.

5. The Tradeoff: Flexibility

As noted at the outset, capped funding is generally coupled with additional flexibility for states in administering their programs. More flexibility is almost always appealing to states. However, when that flexibility is linked to a reduction of and cap on federal Medicaid funding, Texas will want to evaluate carefully the added flexibility it seeks and whether that flexibility might be available today through waivers. Additionally, the State will want to consider how it might exercise that flexibility and any downstream implications for local governments, providers, health plans and consumers.

Figure H: FFY 2015 Supplemental Payments as a Share of Total Medicaid Spending



The proposals advanced to date have little detail on the scope of flexibility that would be permitted relative to current law. Whether Congress adopted a block grant or a per capita cap, billions of federal funds would not flow to states without some federal oversight and related audit and reporting requirements and perhaps new quality or outcome measures. In addition, it should be anticipated that any capped funding proposals will include some minimal requirements on eligibility levels and benefits, though current proposals have provided few details on what benefits and populations must be covered. States would have flexibility over and above those minimums. Today, Texas covers no childless adults and covers parents to 15 percent of the FPL and elderly and disabled adults to 75 percent of the FPL. These are the lowest levels permitted under current law,[33] and it may be unlikely that lower eligibility levels would be permitted for these groups. Texas covers pregnant women to 198 percent of the FPL. If Texas were to reduce eligibility, the State must consider who will bear the costs of the additional uninsured: consumers? hospitals? counties? Texas may be able to reduce the benefits it covers, but notably in three areas where benefits are optional under current law—namely, certain mental health services, substance abuse services, and pharmacy—Texas has opted to cover these benefits in part because they tend to reduce spending in other parts of the program (e.g., emergency room and inpatient hospital costs). Texas will need to consider whether there are benefits (or more to the point, costly benefits) it would like to eliminate or reduce that the state is constrained from doing under current law. Further, the State will need to evaluate the potential impact on other program costs, like emergency room and inpatient hospital care, as well as other stakeholders.

States could also gain flexibility with respect to payments to plans and providers, although this is an area where states already have significant flexibility. Federal rules require that payments to health plans be actuarially sound leaving states significant discretion to set those rates. Probably the most burdensome part of these rules for states is the process they must go through with the federal government to assure that the rates are actuarially sound. It is not clear whether even if the federal rules no longer required actuarially sound rates that Texas would change its practice in this regard; it is, however, likely that some of these process requirements would be ended or reduced under a capped funding structure.

Additionally, States could gain flexibility in administering their managed care programs. Federal rules related to network adequacy, for example, may no longer apply, enabling plans to contract with fewer hospitals with patients traveling longer distances to obtain care. Texas will want to consider the impact of such changes on hospitals, especially rural hospitals, and the communities they serve.

One of the more important set of federal rules that is less likely to be dropped in a capped funding environment has to do with how states raise their nonfederal share, assuming a nonfederal share is still required. States have discretion to use intergovernmental transfers and provider taxes to help finance their nonfederal share of costs and Texas, like most other states, rely heavily on these sources of funds. Given longstanding congressional concern about these sources of financing, it is not at all certain that new flexibility will be permitted with respect to these rules. In fact, some of the capped funding proposals would reduce state flexibility in this area.[34]

In short, Texas will want to consider whether the additional flexibility that may come with the reduction in federal funds will be sufficient to enable the state to manage coverage and care for its lowest income residents—

including children, and elderly and disabled adults—with a fixed and reduced sum of money.

Texas will also want to consider whether the additional flexibilities it seeks are available already under section 1115 of the Social Security Act. For example, several states have already secured waivers to allow them to collect premiums, apply higher co-pays, and remove non-emergency transportation and retroactive coverage from their benefit package, with respect to expansion adults. Several expansion states have likewise sought to condition coverage for the expansion adults on work or job training requirements. While such waivers have been denied in the past, these waivers and others could well be granted by the new Administration. In Texas, however, the majority of program enrollees are children and the majority of program spending is for low-income elderly and people with disabilities, likely reducing the impact of work requirements on Medicaid spending.

Thus, Texas will want to evaluate whether the flexibility the State seeks will permit it to take actions it would choose to take to manage costs and whether, at least in critical respects, such flexibility is already available under existing law and under the current open-ended financing structure.

With respect to the administrative burden imposed on states by the current Medicaid structure, it should be noted that CMS could expedite and streamline the review process for both State Plan Amendments and waivers without a change in law, or with changes in law that are not accompanied by capped funding. And, while the reporting and audit requirements might be somewhat less in connection with a capped allocation of federal Medicaid dollars, they will certainly continue given the size of even a reduced Medicaid program.

III. Conclusion

Capped Medicaid financing shifts the risk of any costs above the federal caps to the states. Particularly when capped funding is coupled with the goal of reducing federal Medicaid spending, the risk of a significant cost shift is great. If a proposal to cap funding—either through a block grant or a per capita cap—is proposed in the 115th Congress, all states will seek to ensure that any capped proposals protect their states to the greatest extent possible. But in the context of fixed and reduced federal funding, resolving issues favorably for one set of states inevitably creates issues for other states. As this paper describes, Texas comes to the capped funding discussion with a number of fiscal disadvantages—most notably its historically low investments in Medicaid relative to its low-income population, its growing population, its relatively low spending levels for the elderly and its high reliance on supplemental and waiver funding. States with higher funding caps will have the same flexibility as Texas to modify eligibility, benefits and payments, but that same flexibility will be coupled with more federal dollars to invest in their Medicaid programs. Texas will want to consider all these factors as it evaluates the potential impact of capped funding on its budget, its residents, and its healthcare providers.

Appendix A: Overview of Capped Funding Proposals

Feature	A Better Way (Ryan)	Patient CARE Act (Hatch/Upton/Burr)	FY17 House Budget Comm. Budget Resolution (Price)	HAEL Act of 2016 (Sessions/Cassidy)
Type	State option for block grant or per capita cap	Per capita cap	State option for block grant or per capita cap	Per capita cap
State Match Required	✔ (per capita cap) ✘ (block grant)	✔	✘	✔
National aggregate cap	✘	✔	✔	✘
Different caps for populations	✔	✔	?	✔
Populations covered	All	All, except acute care of elderly & disabled	All	All
Base amount	Average Medicaid spend in state during base year	Nat'l Medicaid spend allocated based on state population with income < 100% FPL	Unclear	Average Federal Medicaid spend during base year
Treatment of supplemental payments	DSH and GME payments excluded from per capita caps and paid through current match process; unclear for other waiver payments	Included in cap	DSH would be excluded from caps and transitioned to separate pool	Included in cap
Changes to financing nonfederal share	None	None	Would reduce maximum provider taxes to 5.5%	Would prohibit intergovernmental transfers and certified public expenditures
Trend rate	Unclear	CPI + 1	Unclear	GDP +1

[1] Some streams of funding in the Medicaid program (for example, disproportionate share hospital payments) are subject to caps or limitations. The basic financing of program services, however, is not subject to a cap or overall limit.

[2] In a letter to House leadership, the National Governors Association addressed the potential for capped funding to shift risk to the states. The letter urged Congress to "maintain a meaningful federal role in the [Medicaid] partnership and . . . not shift costs to the states . . . [but to] protect states from unforeseen financial risks." National Governors Association, Letter to Rep. Kevin McCarthy, January 24, 2017, available at https://www.nga.org/cms/home/federal-relations/nga-letters/health--human-services-committee/col2-content/main-content-list/health-care-reform.html.

[3] Certain types of payments, such as supplemental payments are subject to limits. See Social Security Act § 1903(i) for examples of limits on what expenditures qualify for federal match. In addition, while different from a cap on federal funding, federal law imposes certain constraints on states' use of federal funds by defining the services and populations that may be covered with federal funds. With billions of federal dollars at stake, it is likely that even under capped funding some definitional constraints would continue to operate.

[4] The federal government's share of nearly all Medicaid expenditures is determined by each state's federal medical assistance percentage (FMAP). By statute, states' FMAPs range from 50-83%, meaning that the federal government pays for between 50% and 83% of the costs of the state's Medicaid program. States with higher per capita incomes have lower federal matching rates, and states with lower per capita incomes have higher federal matching rates.

[5] At times, federal law has been changed to relieve states of some of their financing obligations; most recently during the Great Recession, states were relieved of some of their state financing responsibilities through a temporary increase in the federal matching rate for all states.

[6] See, for example, Rep. Paul Ryan's *Better Way* proposal available online at: http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.

[7] Cindy Mann, Deborah Bachrach, et al, Capping Federal Medicaid Funding: Key Financing Issues for States, Robert Wood Johnson Foundation, December 2016, available at: http://statenetwork.org/wp-content/uploads/2016/12/State-Network-Manatt-Capping-Federal-Medicaid-Funding-Key-Financing-Issues-for-States-December-2016.pdf.

[8] Both the House Budget Committee, FY 2017 Budget Proposal and the HAEL Act include a national cap.

[9] House Budget Committee, FY 2017 Budget Proposal, Appendix IV, Table S-4, Available online at: http://budget.house.gov/uploadedfiles/fy2017_a_balanced_budget_for_a_stronger_america.pdf.

[10] Source for Figure A: House Budget Committee, FY 2017 Budget Proposal, Appendix IV, Table S-4, available at: http://budget.house.gov/uploadedfiles/fy2017_a_balanced_budget_for_a_stronger_america.pdf.

[11] Source for Figure B: Manatt analysis of National Association of State Budget Officers (NASBO) State Expenditure Report, 2016.

[12] The 20% figure depicts the direct impact of Medicaid spending on the State's own revenue—it does not include the federal dollars allocated to the Medicaid program through the State budget or other federal revenues received by the state for other purposes.

[13] The Texas Hospital Association cited similar issues in its letter to Governor Greg Abbott dated Jan. 9, 2017.

[14] Centers for Medicare and Medicaid Services, Medicaid and CHIP Eligibility Levels as of June 1, 2016, available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.

[15] Manatt analysis using enrollment estimates from The Urban Institute, What if More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured and the Office of the Actuary's 2015 Actuarial Report estimate for average newly eligible adult costs of $5,910 for 2016.

[16] Centers for Medicare and Medicaid Services, Medicaid and CHIP Eligibility Levels as of June 1, 2016, available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.

[17] Centers for Medicare and Medicaid Services, Medicaid and CHIP Eligibility Levels as of June 1, 2016, available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.

[18] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000912-Block-Grants-and-Per-Capita-Caps-the-Problem-of-Funding-Disparities-among-States.pdf.

[19] Truven Health Analytics, Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014, available at https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

[20] United States Census Bureau, Small Area Income and Poverty Estimates, 2014 available at: http://www.census.gov/did/www/saipe/data/interactive/saipe.html?s_appName=saipe&menu=grid_proxy&s_inclUsTot=n&s_state=56,01,02,04,05,06,08,09,10,11,12,13,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,44,45,46,47,48,49,50,51,53,54,55&s_inclStTot=y&s_USStOnly=y&s_year=2014

[21] The Patient Choice, Affordability, Responsibility, and Empowerment Act (Senator Orrin Hatch, Senator Richard Burr, Representative Fred Upton), https://murphy.house.gov/uploads/FINAL%20Patient%20CARE%20Act%20Plan.pdf.

[22] Healthcare Accessibility, Empowerment, and Liberty Act of 2016 (Representative Pete Sessions and Senator Bill Cassidy), http://www.goodmaninstitute.org/wp-content/uploads/2016/05/SESSIO_007_xml.pdf.

[23] Rudowitz, R., Garfield, R., and Young, K., "Overview of Medicaid Per Capita Cap Proposals," Kaiser Family Foundation, June 2016. Available at: http://kff.org/report-section/overview-of-medicaid-per-capita-cap-proposals-issue-brief/.

[24] Sources for GDP per Capita, Manatt analysis of National Health Expenditure Accounts (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip), for CPI Medical, BLS CPI Medical (https://data.bls.gov/cgi-bin/surveymost?cu), and for Texas Population Groups, Kaiser Family Foundation Data, (http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/).

[25] Census Bureau, Cumulative Estimates of Resident Population Change for the United States, Regions, States, and Puerto Rico, and Region and State Rankings: April 1, 2010 to July 1, 2016.

[26] Manatt analysis of U.S.Census Bureau, Population Division, Interim State Population Projections, 2005, Table B1, https://www.census.gov/population/projections/data/state/projectionsagesex.html.

[27] MACStats December 2016, Exhibit 6.

[28] See Tex. Hum. Res. Code Ann. § 32.024.

[29] See State of Texas, Advance Planning Document Updated, March 2014, available at https://assets.documentcloud.org/documents/1357133/oig-graph-pattern-analysis-apd-uv16.pdf.

[30] Texas Health and Human Services Commission, Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and the Role of Texas's Uncompensated Care Pool, September 13, 2015, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-uncomp-care-eval-rpt-sept-2016-update.pdf.

[31] Kaiser Family Foundation, State and Medicaid Provider Taxes or Fees, 2016, available at http://kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/.

[32] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-uncomp-care-eval-rpt-sept-2016-update.pdf. The HMA analysis included the 356 hospitals that participated in the Texas Medicaid DSH/UC Pool program in FY 2015. These hospitals account for more than 98% of Medicaid payments to hospitals.

[33] Parents must be covered up to the maximum income to qualify for the state's Aid to Families with Dependent Children (AFDC) program in 1996. Alabama's income limits to qualify for AFDC at that time were lower than Texas's income limits, and thus their eligibility for parents is slightly lower in terms of a percentage of the federal poverty level.

[34] The HAEL Act would prohibit the use of intergovernmental transfers. The House Budget Committee FY 2017 proposal would reduce the implicit cap on provider taxes from 6% to 5.5%.

Project 2025's Plan To Gut Checks and Balances Harms Texas

By Colin Seeberger

The new authoritarian playbook would devastate residents of Texas in many ways.

Project 2025 is a plan to gut America's system of checks and balances in order to enact an extreme, far-right agenda that would hurt all Americans. The plan proposes taking power away from everyday people to give politicians, judges, and corporations more control over Americans' lives. Here are specific ways that Project 2025 harms residents of Texas.

This fact sheet is a part of a series.

Read more about how Project 2025 would harm states.

Taxes

- Project 2025 shifts the tax burden from the wealthy onto the middle class. Under the plan, the typical family of four in Texas would see a tax increase of $2,701 per year, while 45,000 households in America reporting more than $10 million in income would each see an average annual tax cut of $1.5 million.

Social Security

- Project 2025 cuts Social Security by raising the retirement age for roughly 79 percent of Texas residents—23,668,413 people. Project 2025 authors have endorsed and supported plans similar to the two most recent Republican Study Committee budget proposals, which propose increasing the Social Security retirement age from 67 to 69. Doing so would cut benefits by $4,100 to $8,900 after just one year, depending on when one claims Social Security. A median-wage retiree would lose $46,000 to $100,000 over 10 years.

Health care

- Project 2025 proposes imposing "limits or lifetime caps on [Medicaid] benefits." In Texas, 1,191,800 Medicaid enrollees would be at risk of losing coverage because they are low income and lack access to alternative, affordable coverage.

- The plan would raise the cost of prescription drugs for up to 1,323,430 people in Texas by eliminating out-of-pocket Medicare drug cost limits. It also blocks the government from negotiating for lower drug prices.

Abortion rights and contraception

- Project 2025 eliminates some emergency contraception medications from free preventive care requirements, meaning 4,290,000 women in Texas would lose guaranteed access to free emergency contraception.

- The plan instructs the U.S. Department of Justice to misapply the Comstock Act, a pair of laws from 1873 and 1909, to criminalize the mailing of medication abortion. Doing so would result in an effective abortion ban nationwide, even in states where abortion is legal.

- The plan instructs the Department of Justice to take legal action against local officials who refuse to briœœœng cases against women and doctors who violate state abortion bans, such as Texas' severe six-week abortion ban, which includes no exceptions for rape or incest.

Child care

- Project 2025 eliminates Head Start, which provides access to no-cost child care—among other services—for 70,727 low-income children in Texas. Eliminating Head Start would wipe out a critical supply of child care in rural and other underserved communities that already face a lack of child care slots. In Texas, for example, rural communities would lose nearly 1 in 3 child care slots.

Student loans

- Project 2025 replaces income-driven repayment (IDR) plans with a one-size-fits-all program that would increase payments for all borrowers enrolled in existing IDR plans, including the Biden-Harris administration's Saving on a Valuable Education (SAVE) Plan. Under Project 2025, 591,700 borrowers in Texas enrolled in SAVE would pay $2,700 to $4,100 more each year.

Public education

- Project 2025 eliminates the U.S. Department of Education, including Title I, which provides funds to ensure schools serving low-income students have additional resources to deliver a high-quality education beyond that which can be supported by local property tax revenue. Ending Title I would lead to the loss of 20,261 teaching positions, which serve 299,861 students, in Texas.

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, August 29, 2024

Review and Acceptance of the Following Report for the Healthcare for the Homeless Program as Required by the United States Department of Health and Human Services Which Provides Funding to the Harris County Hospital District d/b/a/Harris Health System to Provide Health Services to Persons Experiencing Homelessness under Section 330(h) of the Public Health Service Act

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Attached for review and acceptance:

- **HCHP August Operational Updates**

Administration recommends that the Board accept the Healthcare for the Homeless Program Report as required by the United States Department of Health and Human Services which provides funding to the Harris County Hospital District d/b/a/ Harris Health System to provide health services to persons experiencing homelessness under Section 330 (h) of the Public Health Service Act.

Jennifer Small
Executive Vice President – Ambulatory Care Services

HARRIS HEALTH SYSTEM

Health Care for the Homeless
Monthly Update Report – August 2024

Jennifer Small AuD, MBA, CCC-A, Executive Vice President, Ambulatory Care Services
Tracey Burdine, Director, Health Care for the Homeless Program

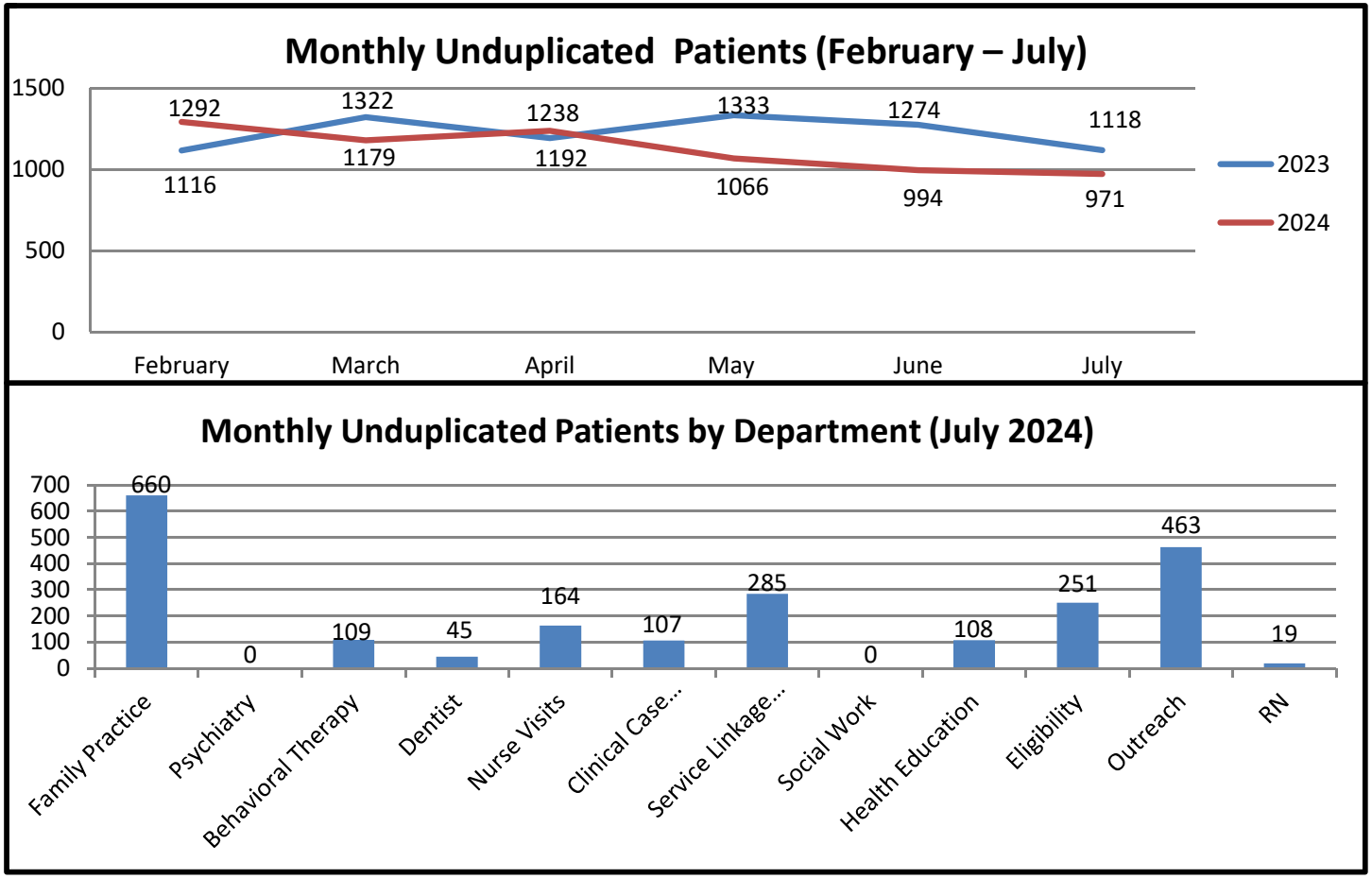
Agenda

- Operational Update
  - Productivity Report
  - Q2 Budget Summary Report

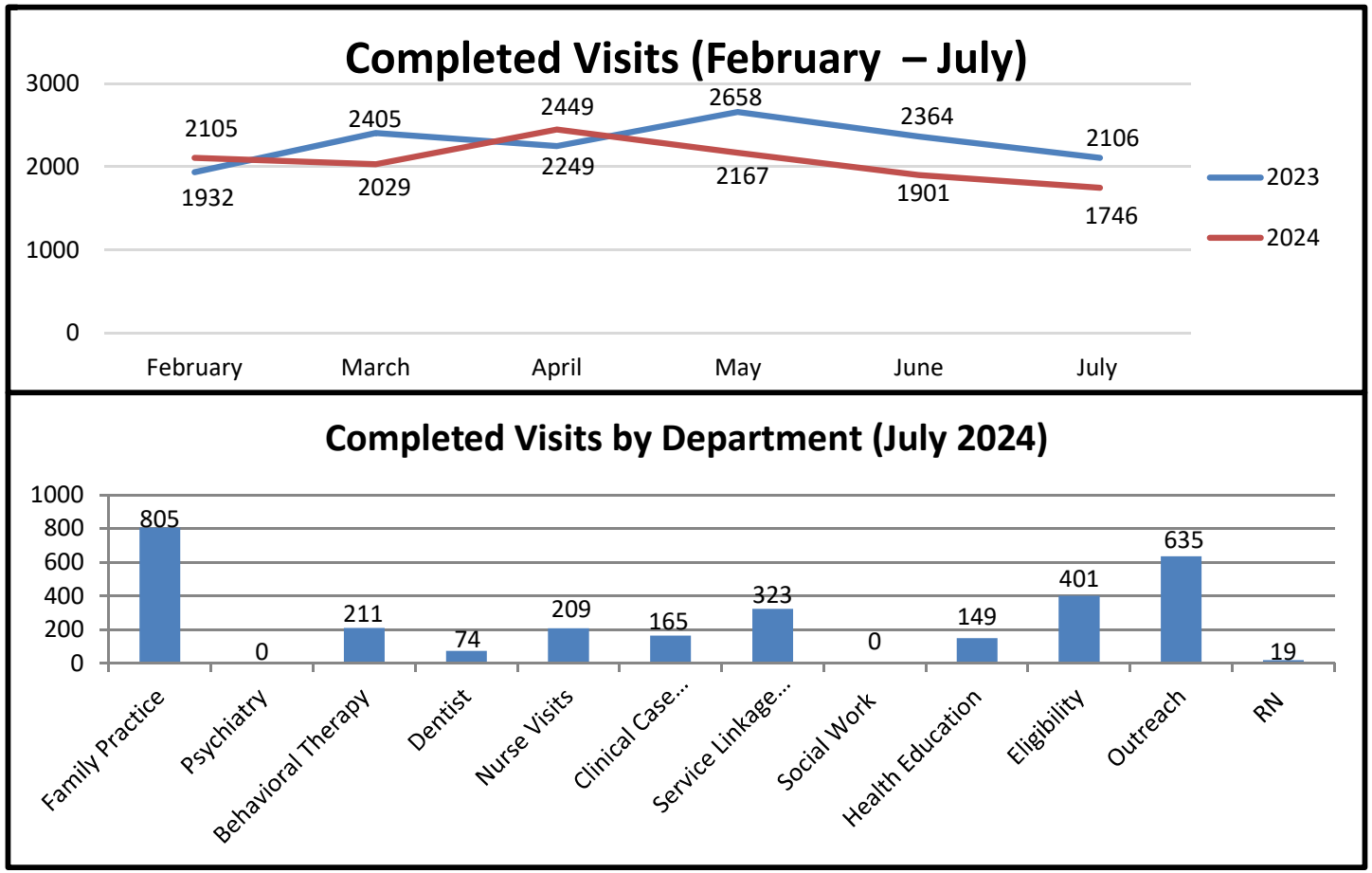
Patients Served

HRSA Unduplicated Patients Target:	HRSA Completed Visit Patients Target:
7,250	**22,500**
YTD Unduplicated Patients:	YTD Total Completed Visits:
4,400	15,623

Operational Update



Operational Update



HARRISHEALTH SYSTEM

Operational Update

Homeless -Primary Grants and Harris Health Funding					
	Period: January 1, 2024 – December 31, 2024				
	Reporting Period: January 1, 2024 – June 30, 2024				
	Line Item	Multiple Award Year Budget	YTD Total Expense	Remaining Balance (budget-projected expense)	%Used YTD
Operating	Personnel/Fringe	$6,357,306	$2,070,621	$4,286,685	32.57%
	Travel	$22,758	$2,119	$20,639	9.31%
	Supplies	$584,941	$75,197	$509,744	12.9%
	Equipment	$120,679	$0	$120,679	0%
	Contractual	$834,645	$100,587	$734,058	12.1%
	Other	$218,789	$63,383	$155,406	29.0%
	Total	**$8,139,118**	**$2,311,907**	**$5,827,211**	**28.4%**

Thursday, August 29, 2024

Consideration of Approval of the HCHP Second Quarter Budget Summary Report

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Attached for review and approval:

- **HCHP Second Quarter Budget Summary Report**

Administration recommends that the Board approve the Healthcare for the Homeless Program Report as required by the United States Department of Health and Human Services which provides funding to the Harris County Hospital District d/b/a/ Harris Health System to provide health services to persons experiencing homelessness under Section 330 (h) of the Public Health Service Act.

Jennifer Small
Executive Vice President – Ambulatory Care Services

ACS Grants - Homeless
Through June 2024

Type	Grant	Project ID	Grantor	Grant Start Date	Grant End Date	Expense Category	Award Budget	Expense through Dec 31, 2023	Budget/Balance Remaining as of Jan 1, 2024
Homeless	Homeless-Primary GYE 12/23	2936	HRSA Grant	**1/1/2024**	**12/31/2024**	Salary	3,179,078.00	-	$ 3,179,078.00
Homeless	Homeless-Primary GYE 12/23	2936	HRSA Grant			Benefits	762,978.00	-	$ 762,978.00
Homeless	Homeless-Primary GYE 12/23	2936	HRSA Grant			Travel	6,000.00	-	$ 6,000.00
Homeless	Homeless-Primary GYE 12/23	2936	HRSA Grant			Supplies	-	-	$ -
Homeless	Homeless-Primary GYE 12/23	2936	HRSA Grant			Equipment	-	-	$ -
Homeless	Homeless-Primary GYE 12/23	2936	HRSA Grant			Contractual	172,260.00	-	$ 172,260.00
Homeless	Homeless-Primary GYE 12/23	2936	HRSA Grant			Other	-	-	$ -
Homeless	Homeless-Dental GYE 12/23	2937	HRSA Grant	**1/1/2024**	**12/31/2024**	Salary	98,624.00	-	$ 98,624.00
Homeless	Homeless-Dental GYE 12/23	2937	HRSA Grant			Benefits	23,670.00	-	$ 23,670.00
Homeless	Homeless-Dental GYE 12/23	2937	HRSA Grant			Travel	270.00	-	$ 270.00
Homeless	Homeless-Dental GYE 12/23	2937	HRSA Grant			Supplies		-	$ -
Homeless	Homeless-Dental GYE 12/23	2937	HRSA Grant			Equipment		-	$ -
Homeless	Homeless-Dental GYE 12/23	2937	HRSA Grant			Contractual	169,680.00	-	$ 169,680.00
Homeless	Homeless-Dental GYE 12/23	2937	HRSA Grant			Other	-	-	$ -
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant	**1/1/2024**	**12/31/2024**	Salary	852,422.00	-	$ 852,422.00
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Benefits	204,581.00	-	$ 204,581.00
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Travel	10,063.00	-	$ 10,063.00
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Supplies	393,401.00	-	$ 393,401.00
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Equipment	-	-	$ -
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Contractual	-	-	$ -
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Other	79,213.00	-	$ 79,213.00
Homeless	ARP - Capital	1760	HRSA Grant	**9/15/2021**	**9/14/2024**	Salary	-	-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Benefits		-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Travel		-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Supplies		-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Equipment	120,679.00	-	$ 120,679.00
Homeless	ARP - Capital	1760	HRSA Grant			Contractual	471,800.00	-	$ 471,800.00
Homeless	ARP - Capital	1760	HRSA Grant			Other	21,000.00	-	$ 21,000.00
Homeless	Bridge Access Program	2689	HRSA Grant	**9/1/2023**	**12/31/2024**	Salary	31,126.00	1,917.88	$ 29,208.12
Homeless	Bridge Access Program	2689	HRSA Grant			Benefits	9,961.00	365.82	$ 9,595.18
Homeless	Bridge Access Program	2689	HRSA Grant			Travel	800.00	-	$ 800.00
Homeless	Bridge Access Program	2689	HRSA Grant			Supplies	14,361.00	-	$ 14,361.00
Homeless	Bridge Access Program	2689	HRSA Grant			Equipment	0.00	-	$ -
Homeless	Bridge Access Program	2689	HRSA Grant			Contractual	0.00	-	$ -
Homeless	Bridge Access Program	2689	HRSA Grant			Other	11,200.00	-	$ 11,200.00
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant	**9/1/2023**	**8/31/2024**	Salary	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Benefits	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Travel	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Supplies	45,000.00	-	$ 45,000.00
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Equipment	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Contractual	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Other	12,114.00	-	$ 12,114.00
Homeless	Homeless-QIA:UDS	3013	HRSA Grant	**5/30/2024**	**12/31/2024**	Salary	27,117.00		$ 27,117.00
Homeless	Homeless-QIA:UDS	3013	HRSA Grant			Benefits	6,508.00		$ 6,508.00

ACS Grants - Homeless
Through June 2024

Type	Grant	Project ID	Grantor	Grant Start Date	Grant End Date	Expense Category	Award Budget	Expense through Dec 31, 2023	Budget/Balance Remaining as of Jan 1, 2024
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation	**8/1/2017**	**7/31/2024**	Salary	-	-	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Benefits		-	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Travel		-	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Supplies	10,000.00	5,270.52	$ 4,729.48
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Equipment	164,305.00	164,305.00	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Contractual		-	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Other	25,769.09	705.12	$ 25,063.97
Homeless Support	Shelter Support Dental	2939	Harris Health	**1/1/2024**	**12/31/2024**	Salary	11,000.00	-	$ 11,000.00
Homeless Support	Shelter Support Dental	2939	Harris Health			Benefits	2,640.00	-	$ 2,640.00
Homeless Support	Shelter Support Dental	2939	Harris Health			Travel	0.00	-	$ -
Homeless Support	Shelter Support Dental	2939	Harris Health			Supplies	15,000.00	-	$ 15,000.00
Homeless Support	Shelter Support Dental	2939	Harris Health			Equipment	0.00	-	$ -
Homeless Support	Shelter Support Dental	2939	Harris Health			Contractual	7,165.00	-	$ 7,165.00
Homeless Support	Shelter Support Dental	2939	Harris Health			Other	200.00	-	$ 200.00
Homeless Support	Shelter Support Medical	2938	Harris Health	**1/1/2024**	**12/31/2024**	Salary	927,328.00	-	$ 927,328.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Benefits	222,557.00	-	$ 222,557.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Travel	5,625.00	-	$ 5,625.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Supplies	109,800.00	-	$ 109,800.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Equipment	0.00	-	$ -
Homeless Support	Shelter Support Medical	2938	Harris Health			Contractual	13,740.00	-	$ 13,740.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Other	70,000.00	-	$ 70,000.00
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation	**10/13/2023**	**10/12/2025**	Salary	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Benefits	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Travel	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Supplies	5,000.00	2,350.62	$ 2,649.38
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Equipment	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Contractual	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Other	-	2.07	$ (2.07)

Homeless Primary Grant & Non-Federal Funding Period: January 1, 2024 - December 31, 2024 Reporting Period: January 1, 2024 - June 30,2024							
	Line Item	**Annual Budget**	**YTD Total Expense**	**Annualized Expenses**	**Remaining balance(Budget-YTD Expenses)**	**% Used YTD**	**% Used Annualized**
Federal	Salary	$ 4,186,449.12	$ 1,451,633.39	$ 2,903,266.78	$ 2,734,815.73	34.7%	69.3%
	Benefits	$ 1,007,332.18	$ 386,990.07	$ 773,980.14	$ 620,342.11	38.4%	76.8%
	Travel	$ 17,133.00	$ -	$ -	$ 17,133.00	0.0%	0.0%
	Supplies	$ 452,762.00	$ 34,952.05	$ 69,904.10	$ 417,809.95	7.7%	15.4%
	Equipment	$ 120,679.00	$ -	$ -	$ 120,679.00	0.0%	0.0%
	Contractual	$ 813,740.00	$ 71,222.12	$ 142,444.24	$ 742,517.88	8.8%	17.5%
	Other	$ 123,527.00	$ 18,502.99	$ 37,005.98	$ 105,024.01	15.0%	30.0%
	Total	**$ 6,721,622.30**	**$ 1,963,300.62**	**$ 3,926,601.24**	**$ 4,758,321.68**	**29.2%**	**58.4%**
Non-Federal	Salary	$ 938,328.00	$ 190,703.93	$ 381,407.86	$ 747,624.07	20.3%	40.6%
	Benefits	$ 225,197.00	$ 41,293.87	$ 82,587.74	$ 183,903.13	18.3%	36.7%
	Travel	$ 5,625.00	$ 2,119.33	$ 4,238.66	$ 3,505.67	37.7%	75.4%
	Supplies	$ 132,178.86	$ 40,245.15	$ 80,490.30	$ 91,933.71	30.4%	60.9%
	Equipment	$ -	$ -	$ -	$ -	0.0%	0.0%
	Contractual	$ 20,905.00	$ 29,365.08	$ 58,730.16	$ (8,460.08)	0.0%	280.9%
	Other	$ 95,261.90	$ 44,879.51	$ 89,759.02	$ 50,382.39	47.1%	94.2%
	Total	**$ 1,417,495.76**	**$ 348,606.87**	**$ 697,213.74**	**$ 1,068,888.89**	**24.6%**	**49.2%**
Grand Total	Salary	$ 5,124,777.12	$ 1,642,337.32	$ 3,284,674.64	$ 3,482,439.80	32.0%	64.1%
	Benefits	$ 1,232,529.18	$ 428,283.94	$ 856,567.88	$ 804,245.24	34.7%	69.5%
	Travel	$ 22,758.00	$ 2,119.33	$ 4,238.66	$ 20,638.67	9.3%	18.6%
	Supplies	$ 584,940.86	$ 75,197.20	$ 150,394.40	$ 509,743.66	12.9%	25.7%
	Equipment	$ 120,679.00	$ -	$ -	$ 120,679.00	0.0%	0.0%
	Contractual	$ 834,645.00	$ 100,587.20	$ 201,174.40	$ 734,057.80	12.1%	24.1%
	Other	$ 218,788.90	$ 63,382.50	$ 126,765.00	$ 155,406.40	29.0%	57.9%
	Total	**$ 8,139,118.06**	**$ 2,311,907.49**	**$ 4,623,814.98**	**$ 5,827,210.57**	**28.4%**	**56.8%**

Project 2936- Homeless Medical

	Expenses through current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ 1,324,850.62	$ -	$ 1,324,850.62
Benefits	$ 357,680.07		$ 357,680.07
Travel	$ -	$ -	$ -
Supplies	$ -	$ -	$ -
Equipment	$ -	$ -	$ -
Contractual	$ 15,000.00		$ 15,000.00
Other	$ -	$ -	$ -
TOTAL	$ 1,697,530.69	$ -	$ 1,697,530.69

Project 1760 - ARP Capital

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ -	$ -	$ -
Benefits	$ -	$ -	$ -
Travel	$ -	$ -	$ -
Supplies	$ 3,839.04	$ -	$ 3,839.04
Equipment	$ -	$ -	$ -
Contractual	$ -	$ -	$ -
Other	$ 16,657.45	$ -	$ 16,657.45
TOTAL	$ 20,496.49	$ -	$ 20,496.49

Project 2937 -Homeless Dental

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ 43,767.18		$ 43,767.18
Benefits	$ 13,516.42	$ -	$ 13,516.42
Travel	$ -		$ -
Supplies	$ -		$ -
Equipment	$ -		$ -
Contractual	$ 56,222.12	$ -	$ 56,222.12
Other	$ -		$ -
TOTAL	$ 113,505.72	$ -	$ 113,505.72

Project 0002689 - Homeless FY 2023 Bridge Access Program

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ 13,708.40	$ 1,917.88	$ 11,790.52
Benefits	$ 3,604.19	$ 365.82	$ 3,238.37
Travel	$ -	$ -	$ -
Supplies	$ 56.00	$ -	$ 56.00
Equipment	$ -	$ -	$ -
Contractual	$ -	$ -	$ -
Other	$ -	$ -	$ -
TOTAL	$ 17,368.59	$ 2,283.70	$ 15,084.89

Project 0002987 -Homeless Carryover GYE 2024

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ 71,225.07		$ 71,225.07
Benefits	$ 12,555.21		$ 12,555.21
Travel	$ -		$ -
Supplies	$ 1,512.81		$ 1,512.81
Equipment	$ -		$ -
Contractual	$ -		$ -
Other	$ -		$ -
TOTAL	$ 85,293.09		$ 85,293.09

Project 0002675-Homeless Ending the HIV Epidemic

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary		$ -	$ -
Benefits		$ -	$ -
Travel	$ -	$ -	$ -
Supplies	$ 29,544.20	$ -	$ 29,544.20
Equipment		$ -	$ -
Contractual	$ -	$ -	$ -
Other	$ 1,845.54	$ -	$ 1,845.54
TOTAL	$ 31,389.74	$ -	$ 31,389.74

Project 0003013-Homeless QIA:UDS+

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ -	$ -	$ -
Benefits	$ -	$ -	$ -
Travel	$ -	$ -	$ -
Supplies	$ -	$ -	$ -
Equipment	$ -	$ -	$ -
Contractual	$ -	$ -	$ -
Other	$ -	$ -	$ -
TOTAL	$ -	$ -	$ -

Mobile Unit Purchase Support -793

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ -		$ -
Benefits	$ -		$ -
Travel	$ -		$ -
Supplies	$ 5,270.52	$ 5,270.52	$ -
Equipment	$ 164,305.00	$ 164,305.00	$ -
Contractual			$ -
Other	$ 2,124.07	$ 705.12	$ 1,418.95
TOTAL	$ 171,699.59	$ 170,280.64	$ 1,418.95

Shelter Support dental-2939

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ 3,627.11		$ 3,627.11
Benefits	$ 1,035.26		$ 1,035.26
Travel	$ -		$ -
Supplies	$ 4,090.57	$ -	$ 4,090.57
Equipment			$ -
Contractual	$ -	$ -	$ -
Other	$ 115.48	$ -	$ 115.48
TOTAL	$ 8,868.42	$ -	$ 8,868.42

Shelter Support Medical-2938

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ 187,076.82	$ -	$ 187,076.82
Benefits	$ 40,258.61		$ 40,258.61
Travel	$ 2,119.33		$ 2,119.33
Supplies	$ 36,132.28	$ -	$ 36,132.28
Equipment	$ -	$ -	$ -
Contractual	$ 29,365.08		$ 29,365.08
Other	$ 43,345.08	$ -	$ 43,345.08
TOTAL	$ 338,297.20	$ -	$ 338,297.20

Glucometers for the Homeless-2741

	Expenses through Current year June 2024	Expenses through 12/31/2023	Expenses 01/2024 to 06/2024
Salary	$ -		$ -
Benefits	$ -		$ -
Travel	$ -		$ -
Supplies	$ 2,372.92	$ 2,350.62	$ 22.30
Equipment	$ -	$ -	$ -
Contractual	$ -		$ -
Other	$ 2.07	$ 2.07	$ -
TOTAL	$ 2,374.99	$ 2,352.69	$ 22.30

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, August 29, 2024

Executive Session

Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. organizational update and the year-to-date June 2024 financial performance, pursuant to Tex. Gov't Code Ann. §551.085.

Anna Mateja
Chief Financial Officer
Community Health Choice, Inc.
Community Health Choice Texas, Inc.

Victoria Nikitin
EVP & Chief Financial Officer
Harris Health

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