

BOARD MEETING

Wednesday, October 14, 2026 | 9:00 AM

4800 Fournace Place, Bellaire, TX 77401 | 1st Floor Board Room

Notice: The meeting may be viewed online: <https://harrishealthtx.new.swagit.com/views/432/live>, and some members of the Board may participate by videoconference.

Mission

Harris Health is a public, integrated health system dedicated to improving the health of our communities by delivering high-quality, person-centered care in collaboration with community and academic partners.

AGENDA

I. Call to Order and Record of Attendance	Ms. Carol Paret	2 min
II. Approval of the Minutes of Previous Meeting	Ms. Carol Paret	2 min
Board Meeting – September 9, 2026		
III. Announcements / Special Presentations	Ms. Carol Paret	15 min
A. CEO Report Including Special Announcements – <i>Dr. Esmaeil Porsa</i>		(10 min)
- Update Regarding the Health and Wellness Fair at Gulfgate Health Center on Saturday, September 19, 2026 - Notice of Contract Termination from Molina Healthcare of Texas, Inc. Related to Medicare Advantage Plan, Effective December 31, 2026 - Pink Out Event at the Bayou City Event Center on Thursday, October 15, 2026, in Celebration of Harris Health’s Breast Cancer Survivors - Release of the University of Houston’s History Magazine which Includes Harris Health’s 60-year Celebration - Houston Named as One of Only Eight Cities in the U.S. to Receive the STREETS (Safety Through Recovery, Engagement, and Evidence-based Treatment and Support) Grant from the U.S. Health and Human Services - Launch of the Harris Collaborative to Improve Health Outcomes		
B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements		(5 min)
IV. Public Comment	Ms. Carol Paret	3 min
V. Executive Session	Ms. Carol Paret	30 min

A. [Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007 and Tex. Health & Safety Code Ann. §161.032 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, the Harris Health Quality and Safety Performance Measures, Good Catch Recipients, Centers for Medicare and Medicaid Services Quality Reporting, and Possible Action Regarding this Matter Upon Return to Open Session – Dr. Thomas Cummins and Ms. Tiffani Dusan](#) (15 min)

B. [Medical Executive Board Report and Credentialing Discussion, Pursuant to Tex. Occ. Code Ann. §§151.002, 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 Medical Staff Upon Return to Open Session – Dr. Kunal Sharma and Dr. Asim Shah](#) (5 min)

C. [Report Regarding Harris Health Correctional Health Quality of Medical and Healthcare, with Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §§151.002, 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, Including Consideration of Approval of Credentialing Changes for Members of the Correctional Health Medical Staff Upon Return to Open Session – Dr. O. Reggie Ekins](#) (10 min)

VI. Reconvene to Open Meeting Ms. Carol Paret 3 min

VII. General Action Item(s) Ms. Carol Paret 8 min

A. General Action Item(s) Related to Quality: Medical Staff

1. [Consideration of Approval of Credentialing Changes for Members of Harris Health Medical Staff – Dr. Kunal Sharma and Dr. Asim Shah](#) (2 min)

2. [Consideration of Approval of Changes to the Cardiothoracic Surgery Clinical Privileges – Dr. Kunal Sharma and Dr. Asim Shah](#) (2 min)

B. General Action Item(s) Related to Quality: Correctional Health Medical Staff

1. [Consideration of Approval of Credentialing Changes for Members of Harris Health Correctional Health Medical Staff – Dr. O. Reggie Ekins](#) (2 min)

2. [Consideration of Approval of the 2026 Correctional Health Medical Staff Bylaws – Dr. O. Reggie Ekins](#) (2 min)

VIII. Strategic Discussion Ms. Carol Paret 33 min

A. [Harris Health Strategic Plan Initiatives](#)

1. [Presentation Regarding the 90th Texas Legislature and Consideration of Approval of a Resolution Adopting Harris Health's Legislative Platform – Mr. R. King Hillier, Mr. Micah Rodriguez and Ms. Elisa Santana \[Strategic Pillar 3: Resiliency\]](#) (10 min)

2. [Presentation Regarding Harris Health's Artificial Intelligence Strategy Update – Ms.Carolynn Jones and Mr. Ron Fuschillo \[Strategic Pillar 5: System Optimization\]](#) (10 min)

3. [Presentation Regarding the Oncology Scope of Services at LBJ Hospital, Including Consideration of Approval to Proceed with the Design of a Cancer Center at the LBJ Campus Reflecting a Revised Project Scope and a Total Project Cost Authorization not to Exceed \\$150 Million – Mr. Louis Smith \[Strategic Pillar 6: Access\]](#)

(10 min)

B. [Committee Reports](#)

(3 min)

- September 22, 2026 – Quality Committee – **Ms. Libby Viera-Bland**

IX. Consent Agenda Items

Ms. Carol Paret

5 min

A. Consent Purchasing Recommendations

1. [Consideration of Approval of Purchasing Recommendations \(Items A1 through A8 of the Purchasing Matrix\) – Ms. Kimberly Williams and Mr. Jack Adger, Harris County Purchasing Office \[See Attached Purchasing Expenditure Summary: October 14, 2026\]](#)
2. [Harris Health Second Quarter of Fiscal Year 2026 Premier Spend Report for Informational Purposes \[No Action Required\] – Ms. Kimberly Williams and Mr. Jack Adger, Harris County Purchasing Office](#)

B. Consent Contract Recommendations

1. [Consideration of Approval of Contract Recommendations \(Items B1 through B4 of the Contract Matrix\) – Mr. Timothy Brown \(B1\), Dr. Amy Smith \(B2\), Mr. Patrick Casey \(B3\) and Ms. Sara Thomas \(B4\) \[See Attached Contract Matrix: October 14, 2026\]](#)

C. New Consent Items for Board Approval

1. [Consideration of Approval to Acquire Real Property for a New Health Center in Northwest Harris County – Mr. Patrick Casey](#)
2. [Consideration of Approval to Utilize the Construction Manager at Risk \(CMAR\) Delivery Method for the Acres Home Facility Replacement and Expansion – Mr. Patrick Casey](#)
3. [Consideration of Approval to Utilize the Construction Manager at Risk \(CMAR\) Delivery Method for the Cypress Health Center Construction – Mr. Patrick Casey](#)
4. [Consideration of Approval to Utilize the Construction Manager at Risk \(CMAR\) Delivery Method for the Replacement of the Vallbona Health Center – Mr. Patrick Casey](#)
5. [Consideration of Approval of a Resolution Authorizing Harris County Hospital District Attestation Response to New Requirements Related to Harris County Hospital District's Participation in a Health Care Provider Participation Program – Ms. Victoria Nikitin](#)

D. Consent Reports and Updates to the Board

1. [Bi-monthly Updates Regarding Pending State and Federal Legislative and Policy Issues Impacting Harris Health – Mr. R. King Hillier](#)

[End of Consent Agenda]

X. Item(s) Related to the Health Care for the Homeless Program	Ms. Carol Paret	15 min
A. <u>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 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</u> HCHP October 2026 Operational Update		(11 min)
B. <u>Consideration of Approval of the HCHP Consumer Advisory Report – Dr. Jennifer Small and Ms. Tracey Burdine</u>		(1 min)
C. Consideration of Approval of the HCHP Patient Satisfaction Report – Dr. Jennifer Small and Ms. Tracey Burdine		(1 min)
D. <u>Consideration of Approval of the HRSA 2027 Non-Competing Continuation Budget Report for the HCHP – Dr. Jennifer Small and Ms. Tracey Burdine</u>		(1 min)
E. HCHP Reports and Updates to the Board for Informational Purposes [No Action Required] – Dr. Jennifer Small and Ms. Tracey Burdine - Update Regarding the HRSA Community Health Quality Recognition - Update Regarding the HRSA Operational Site Visit for the HCHP		(1 min)
XI. Executive Session	Ms. Carol Paret	40 min
D. <u>Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Unaudited Financial Performance for the Eight Months Ending August 31, 2026, Pursuant to Tex. Gov’t Code Ann. §551.085 – Ms. Lisa Wright, CEO, and Ms. Anna Mateja, CFO, Community Health Choice</u>		(10 min)
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 Tex. Gov’t Code Ann. §551.071, and Possible Action Regarding this Matter Upon Return to Open Session – Ms.Carolynn Jones		(10 min)
F. Discussion Regarding the Chief Executive Officer (CEO) Evaluation, Pursuant to Tex. Gov’t Code Ann. §551.074, and Possible Action Upon Return to Open Session – Board of Trustees		(20 min)
XII. Reconvene	Ms. Carol Paret	13 min
XIII. Board Education	Ms. Carol Paret	60 min
A. <u>Presentation Regarding Harris Health’s Annual Compliance Education – Ms. Carolyn Jones [Strategic Pillar 3: Resiliency]</u>		(60 min)
XIV. Adjournment	Ms. Carol Paret	1 min

MINUTES OF THE HARRIS HEALTH BOARD OF TRUSTEES

Board Meeting

Wednesday, September 9, 2026

9:00 A.M.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
I. Call to Order and Record of Attendance	The meeting was called to order at 9:08 AM by Dr. Andrea Caracostis, Presiding Officer. A quorum was present. She noted that while some board members were present in the boardroom, others were participating remotely by video conference in accordance with the Harris Health Video Conferencing Policy and applicable state law. All others wishing to view the meeting were advised to access the meeting online through the Harris Health website: http://harrishealthtx.swagit.com/live . Attendance was recorded and is appended to the archived minutes.	A copy of the attendance is appended to the archived minutes.
II. Approval of the Minutes of Previous Meeting Board Meeting – August 12, 2026	Dr. Caracostis presented the minutes of the Board meeting held on August 12, 2026 for approval. A copy of the minutes is available in the permanent record.	Motion No. 26.09-113 Moved by Ms. Sima Ladjevardian, seconded by Ms. Libby Viera Bland, and unanimously passed that the Board approve the minutes of August 12, 2026, Board meeting. Motion carried.
III. Announcements/ Special Presentations		
	A. CEO Report Including Special Announcements - Health and Wellness Fair at Gulfgate Health Center on Saturday, September 19, 2026, from 9:00 AM – 12:00 PM - METRO Pop-ups at Ben Taub and LBJ Hospitals - Harris Health has been Re-designated as a Comprehensive Stroke Center by DNV - Ben Taub Hospital has been Re-designated as Baby-Friendly® - Meeting with Chairman James Frank and the Office of House Speaker Dustin Burrows Regarding Healthcare Affordability Dr. Esmaeil Porsa, President and Chief Executive Officer (CEO), provided the CEO report and highlighted several organizational and community developments. Dr. Porsa reported that Harris Health’s proposed tax rate had received favorable consideration by Harris County Commissioners Court and was proceeding toward adoption. He encouraged Trustees to participate in the upcoming Health and Wellness Fair scheduled for September 19, 2026, at Gulfgate Health Center, emphasizing the importance of the events as opportunities for community engagement, health screenings, access to resources, and collaboration with community partners.	As Presented.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
	Dr. Porsa also reported on METRO pop-up events conducted at LBJ and Ben Taub Hospitals, during which transportation resources and services were shared with employees, patients, families, social workers, and community health workers. Dr. Porsa announced that Harris Health had received re-designation as a Comprehensive Stroke Center by Det Norske Veritas (DNV) and that Ben Taub Hospital (BTH) had been re-designated as Baby-Friendly®. He also reported on his recent meeting in Austin with Chairman James Frank and representatives from the Office of the Speaker of the Texas House concerning the healthcare affordability report. Dr. Porsa stated that the discussions were productive and that Harris Health's role as an essential health system and its importance to the healthcare infrastructure of Texas were emphasized.	
	B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements Board members did not provide any announcements or advocacy updates.	
IV. Public Comment	There were no members of the public present to address the Board.	As Presented.
V. Executive Session	At 9:14 AM, Dr. Caracostis stated that the Board would enter Executive Session for Items V. 'A through D' as permitted by law under Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code. Ann. §§ 151.002, 160.007, and Tex. Gov't Code Ann. §551.071.	
	A. Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007 and Tex. Health & Safety Code Ann. §161.032 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, the Harris Health Quality and Safety Performance Measures, Good Catch Recipients, Centers for Medicare and Medicaid Services Quality Reporting, and Possible Action Regarding this Matter Upon Return to Open Session <i>Dr. Hooli was recused from discussion on this item related to Baylor College of Medicine.</i>	No Action Taken.
	B. Medical Executive Board Report and Credentialing Discussion, Pursuant to Tex. Occ. Code Ann. §§151.002, 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 Medical Staff Upon Return to Open Session <i>Dr. Hooli was recused from discussion on this item related to Baylor College of Medicine.</i>	No Action Taken.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
	C. Report Regarding Harris Health Correctional Health Quality of Medical and Healthcare, with Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §§151.002, 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, Including Consideration of Approval of Credentialing Changes for Members of the Correctional Health Medical Staff Upon Return to Open Session	No Action Taken.
	D. Consultation with Attorney Regarding Interlocal Agreement between Harris County and Harris Health, Pursuant to Tex. Gov’t Code Ann. §551.071, and Possible Action Upon Return to Open Session	No Action Taken.
VI. Reconvene to Open Meeting	At 9:29 AM, Dr. Caracostis reconvened the meeting in open session, noting that a quorum was present and no action was taken during 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 Medical Staff Dr. Kunal Sharma, Chair of the Medical Executive Board, presented the Medical Staff credentialing report. Dr. Sharma reported 50 initial appointments, no reappointments, 20 changes in clinical privileges, and 30 resignations, with one file discussed during Executive Session. Copies of the credentialing report were available in the permanent record. <i>Dr. Hooli was recused from discussion on this item related to Baylor College of Medicine.</i>	<u>Motion No. 26.09-114</u> Moved by Ms. Libby Viera – Bland, seconded by Mr. Paul Puente, and unanimously passed that the Board approve agenda item VII.A.1. Motion carried.
	2. Approval of Changes to the Pediatric Clinical Privileges Dr. Sharma presented proposed changes to Pediatric Clinical Privileges to formally recognize specific training and competencies related to lactation advisement. Dr. Sharma explained that several pediatric providers have specific training in lactation advisement and that the proposed change would formally delineate the privilege necessary for qualified pediatric providers to advise patients. A copy of the Pediatric Clinical Privileges is available in the permanent record.	<u>Motion No. 26.09-115</u> Moved by Ms. Sima Ladjevardian, seconded by Mr. Libby Viera – Bland, and unanimously passed that the Board approve agenda item VII.A.2. Motion carried.

	3. Approval of the Revised 2026 Harris Health Medical Staff Bylaws Dr. Asim Shah, Vice Chair of the MEB, presented proposed revisions to the 2026 Harris Health Medical Staff Bylaws. Dr. Shah summarized revisions addressing definitions of “health matter” and “inappropriate conduct,” exemptions from DEA licensing requirements for practitioners who do not require such licenses, limitations on prescribing controlled substances through Epic for exempt practitioners, self-disclosure requirements, reporting timeframes for professional license actions and criminal matters, and a change in the Utilization Review Committee meeting frequency to quarterly. A copy of the 2026 Harris Health Medical Staff Bylaws is available in the permanent record.	<u>Motion No. 26.09-116</u> Moved by Mr. Paul Puente, seconded by Ms. Sima Ladjevardian, 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 Correctional Health Medical Staff Dr. Otis Ekins, Chief Medical Officer of Harris Health Correctional Health, presented Correctional Health Medical Staff credentialing report. Dr. Ekins reported 10 initial appointments, no reappointments, no changes in clinical privileges, and no resignations. Copies of the credentialing report were available in the permanent record.	<u>Motion No. 26.09-117</u> Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda item VII.B.1. Motion carried.
VIII. New Items for Board Consideration	A. Approval of the Proposed Harris Health Fiscal Year 2027 Operating and Capital Budget Ms. Victoria Nikitin, Executive Vice President and Chief Financial Officer, presented the proposed Harris Health Fiscal Year 2027 Operating and Capital Budget. Ms. Nikitin reported that the proposed budget had been the subject of extensive discussions with Harris County Commissioners’ Court and its staff and reflected a projected 3.3% margin and net bottom line of approximately \$98.5 million. She described Fiscal Year 2027 as a transitional year as Harris Health prepares for significant facility openings and related operating expenses anticipated in Fiscal Year 2028. Ms. Nikitin reviewed the proposed tax rates, including a Management and Operations rate of 0.18086, a debt service rate of 0.01442, and a combined total rate of 0.19528. Dr. Porsa thanked Harris County Commissioners, Harris County residents, and the Harris Health team for their support of Harris Health’s financial and infrastructure needs. A copy of the presentation was available in the permanent record. Motion: <i>Approval of Harris Health Fiscal Year 2027 Operating and Capital Budget to be presented to the Harris County Commissioners Court for final approval in conjunction with its adoption of a 2026 Tax Rate that will result in a net ad valorem tax revenue not to exceed the amount shown in the proposed budget.</i>	<u>Motion No. 26.09-118</u> Moved by Ms. Libby Viera – Bland, seconded by Mr. Paul Puente, and unanimously passed that the Board approve agenda item VIII.A. Motion carried with Mr. Philip Sun abstaining from the vote.

IX. Strategic Discussion		
	A. Harris Health Strategic Plan Initiatives	
	1. Presentation Regarding the Harris Health Third Quarter Capital Projects Update Mr. Louis Smith, Senior Executive Vice President, presented the third-quarter Capital Projects Update under Strategic Pillar 5: System Optimization. Mr. Smith reviewed the status of the strategic facility plan, including project schedules, projected budgets, funding sources, bond expenditures, skilled trades participation, prevailing wage coordination, and construction safety. Ms. Nikitin reported that Harris Health voters had approved \$2.5 billion in bond funding in November 2023 and that more than \$1 billion had been expended, with approximately \$1.5 billion remaining. She further reported that the first bond issuance had been fully expended and that an additional approximately \$830 million had been issued, with more than \$200 million spent on construction. The overall project portfolio remained on schedule and within Board-approved budgets. Mr. Patrick Casey, Senior Vice President, Facilities, Construction and Systems Engineering, provided an update on construction safety, including the LBJ expansion project, which had approximately 1,700 trade workers and more than 3.5 million work hours reported. The Board discussed construction safety and the importance of protecting workers. The Board also discussed prevailing wage requirements and Harris Health’s continued coordination with Harris County. Administration reported that an updated interlocal agreement remained under discussion and would return to the Board for action when finalized. A copy of the presentation is included in the permanent record.	As Presented.
	2. Presentation Regarding Harris Health’s Pharmacy Update Dr. Michael Nnadi, Senior Vice President, Pharmacy and Lab Officer, presented an update regarding Harris Health’s pharmacy operations, including the Pharmacy Operations Center at Holly Hall and developments related to the federal 340B program. Dr. Nnadi described the pharmacy automation project as a significant strategic initiative designed to increase Harris Health’s capacity to process and distribute medications. The anticipated operational date for the new facility is May 17, 2027. The Board discussed future opportunities for Trustees to tour the facility, staff training, and anticipated increases in prescription-processing and mail-order capacity.	As Presented.

	Dr. Nnadi also provided an overview of changes to the 340B program and the revised rebate-model pilot announced by the Health Resources and Services Administration. He discussed the potential requirement for eligible entities to purchase medications at full price and subsequently submit claims-level information for manufacturer adjudication and rebate reimbursement. Administration identified potential working-capital exposure and additional administrative and technology requirements associated with the revised model. Trustees questioned Harris Health’s participation in the pilot, the anticipated financial and administrative impact, and the mechanisms that would be used to monitor the program. Dr. Nnadi reported that Harris Health was developing an impact dashboard, rapid-response work group, governance process, and technology enhancements to monitor claims, denials, delays, disputes, and financial exposure. Administration emphasized the importance of data integrity, compliance, financial discipline, and verification of eligibility requirements. The Board requested continued monitoring and reporting as additional information becomes available. A copy of the presentation is available in the permanent record.	
	B. Committee Reports • August 25, 2026 – Governance Committee • August 25, 2026 – Quality Committee • August 27, 2026 – Joint Conference Committee • August 27, 2026 – Compliance & Audit Committee Ms. Sima Ladjevardian presented the Governance Committee report from the August 25, 2026 meeting. She reported that the Committee reviewed proposed revisions to Policy 2.02 regarding participation in Board and committee meetings by videoconference and received education concerning Board Artificial Intelligence (AI) governance and emerging legal and regulatory considerations. The Committee identified key governance questions and areas for further inquiry in advance of the planned AI overview at the October Board meeting. The Committee agreed that AI oversight, governance, and risk management should remain ongoing Board responsibilities. Ms. Ladjevardian also reported that the Governance Committee reviewed proposed revisions to Harris Health Standard Operating Procedures concerning Board fiduciary responsibilities, governance versus management roles, attendance expectations, documentation of participation and voting, and governance education. Additional review was scheduled for a future Governance Committee meeting. The Committee also discussed the Texas Healthcare Trustees certification program and opportunities for Trustees to continue working toward certification.	As Reported.

	Dr. Caracostis reported on the August 25, 2026 Quality Committee meeting, including evidence-based patient safety education regarding catheter-associated urinary tract infections and reports concerning outpatient clinical services and patient-related quality matters. A more detailed presentation was scheduled for a subsequent Board meeting. Additionally, Dr. Caracostis noted that the Joint Conference Committee report from August 27, 2026 included updates concerning medical staff leadership, learner onboarding, high-reliability practices, patient safety and quality performance, hospital operations, the LBJ Level III Trauma Center survey, interventional radiology renovations and training support, throughput and length-of-stay initiatives, Ben Taub stroke designation activities, maternal levels of care, future planning, and ambulatory quality and patient experience initiatives. Dr. Caracostis reported on behalf of Ms. Paret, Committee Chair, and stated that the Compliance and Audit Committee report from August 27, 2026 included updates regarding the Fiscal Year 2026 internal audit plan, audit engagement status, outstanding procurement recommendations, management action plans, annual risk assessment activities, remaining Fiscal Year 2026 audit engagements, and preparation for the year-end report.	
X. Consent Agenda Items		
	A. Consent Purchasing Recommendations	
	1. Approval of Purchasing Recommendations (Items A1 through A9 of the Purchasing Matrix) Mr. Jack Adger, Assistant Purchasing Agent, Harris County Purchasing Department, presented the purchasing recommendations, Items A1 through A9, for Board consideration. Administration reported that Items A1 through A9 had no changes or additions and were recommended for approval. Item B1 of the purchasing matrix (related to law enforcement) was withdrawn for submission at a later time. A copy of the purchasing agenda is available in the permanent record.	Motion No. 26.09-119 Moved by Dr. Shubhada Hooli, seconded by Ms. Libby Viera – Bland, and unanimously passed that the Board approve the purchasing recommendations (Items A1 through A9 of the Purchasing Matrix). Motion carried.
	The Board continued to consider the consent agenda items. Item B1 of the purchasing matrix was clarified as distinct from the applicable consent agenda item B1 related to grant recommendations and did not require removal from the consent agenda. An intellectual property license agreement was pulled for discussion at the request of a Trustee. Clarification was requested on consent agenda item E5, concerning an intellectual property license agreement, including the negotiated license fee of \$605,242. The Board also discussed Harris Health's policy governing the naming of buildings and facilities. Administration explained the statutory and policy requirements for Board approval of gifts, donations, and naming opportunities and clarified that the current policy revision consisted primarily of administrative cleanup without material changes. A Trustee requested that the applicable naming recommendation matrix and policy information be recirculated to the Board.	

	B. Consent Grant Recommendations	
	1. Approval of Grant Recommendations (Item B1 of the Grant Matrix)	Motion No. 26.09-120 Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items X.B through E. Motion carried.
	C. Consent Contract Recommendations	
	1. Approval of Contract Recommendations (Item C1 of the Contract Matrix)	Motion No. 26.09-120 Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items X.B through E. Motion carried.
	D. Consent Committee Recommendations	
	1. Approval of Revisions to Policy 2.02, Participation in Board Meetings and Board Committee Meetings via Videoconference Call	Motion No. 26.09-120 Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items X.B through E. Motion carried.
	E. New Consent Items for Board Approval	
	1. Acceptance of the Harris Health July 2026 Financial Report Subject to Audit	Motion No. 26.09-120 Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items X.B through E. Motion carried.
	2. Acceptance of the Harris Health Third Quarter Fiscal Year 2026 Investment Report	Motion No. 26.09-120 Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items X.B through E. Motion carried.

	3. Acceptance of the Harris Health Second Quarter Calendar Year 2026 Pension Plan Report	<u>Motion No. 26.09-120</u> Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items X.B through E. Motion carried.
	4. Approval of the Harris Health Policy 2.01 - Naming of Harris Health Buildings, Facilities, and Entities	<u>Motion No. 26.09-120</u> Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items X.B through E. Motion carried.
	5. Approval of Intellectual Property License Agreement between Harris Health and Hermann Park Conservancy	<u>Motion No. 26.09-120</u> Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items X.B through E. Motion carried.
XI. Item(s) Related to the Health Care for 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 to Provide Health Services to Persons Experiencing Homelessness under Section 330(h) of the Public Health Service Act HCHP September 2026 Operational Update Ms. Binta Baudy, Vice President, Operations, Ambulatory Care Services (ACS) and Dr. Nelson Gonzalez, Grants Project Manager, HCHP, presented the Healthcare for the Homeless Program operational update. Dr. Nelson reported year-to-date service activity of approximately 4,280 patients, against a goal of 7,250 and approximately 15,884 completed visits, against a target of 30,496 through July. He also reviewed operational plans associated with additional clinic capacity and staffing.	<u>Motion No. 26.09-121</u> Moved by Mr. Paul Puente, seconded by Ms. Libby Viera – Bland, and unanimously passed that the Board approve agenda items XI.A. Motion carried.

	The Board considered a requested change to the Healthcare for the Homeless Program site information for Harmony House. Administration explained that the change was an administrative address update following reconstruction and did not represent a change in services or hours of operation. Administration presented revisions to Policy 5.12, Healthcare for the Homeless Program Credentialing and Privileging. The revisions align the program’s credentialing and recredentialing cycle with Harris Health Medical Staff Services’ three-year cycle and standardize credentialing, privileging, competency verification, review, and oversight responsibilities. The patient satisfaction report was not presented because the available data reflected first-quarter information rather than the expected second-quarter data. Administration indicated that the appropriate report would be presented at the following month’s meeting. Copies of the presentations and supporting documentation were included in the permanent record. Note: Items X. A through D were presented together and considered separately for Board action.	
	B. Approval of a Change in Scope to Revise the HRSA Form 5B: Site Details by Updating the Harmony House Address from 602 Girard Street to 702 Girard Street, Houston, Texas 77007	<u>Motion No. 26.09-122</u> Moved by Ms. Libby Viera – Bland, seconded by Dr. Shubhada Hooli, and unanimously passed that the Board approve agenda items XI.B. Motion carried.
	C. Approval of the Revised Policy 5.12 – Credentialing and Privileging for the Health Care for the Homeless Program	<u>Motion No. 26.09-123</u> Moved by Ms. Libby Viera – Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda items XI.C. Motion carried.
	D. Approval of the HCHP Patient Satisfaction Report	Agenda Item Pulled
XII. Executive Session	At 10:38 AM, Dr. Caracostis stated that the Board would enter Executive Session for Items XII. ‘E through L’ as permitted by law under Tex. Health & Safety Code Ann. §161.032 and Tex. Gov’t Code Ann. §§551.071, 551.072 and 551.085.	

	E. Review of the Health Care for the Homeless Program Director’s Performance Evaluation, Pursuant to Tex. Gov’t Code Ann. §551.074, Including Consideration of Approval of the Performance Evaluation Upon Return to Open Session Motion: <i>Approval of Homeless Program Director’s Performance Evaluation as presented in Executive Session.</i>	Motion No. 26.09-124 Moved by Mr. Paul Puente, seconded by Ms. Sima Lajevardian, and unanimously passed that the Board approve agenda items XII.E. Motion carried.
	F. Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Unaudited Financial Performance for the Seven Months Ending July 31, 2026, Pursuant to Tex. Gov’t Code Ann. §551.085	No Action Taken.
	G. Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Investment Report for the Seven Months Ending July 31, 2026, Pursuant to Tex. Gov’t Code Ann. §551.085	No Action Taken.
	H. Consultation with Attorney Regarding Settlement of Claims, Pursuant to Tex. Gov. Code §551.071, and Possible Action Upon Return to Open Session Motion: <i>Approval of the Settlement of EEOC Charge Number 460-2025-10723 in the amount of \$35,000. President/CEO of Harris Health or his designee is authorized to execute any agreement, release, or any other necessary documents to effectuate this settlement.</i>	Motion No. 26.09-125 Moved by Mr. Philip Sun, seconded by Mr. Paul Puente, and unanimously passed that the Board approve agenda items XII.H. Motion carried.
	I. Consultation with Attorney Regarding Harris Health Policy, Pursuant to Tex. Gov. Code §551.071, and Possible Action Upon Return to Open Session	No Action Taken.
	J. Deliberation Regarding the Purchase, Exchange, Lease or Value of Real Property, Pursuant to Tex. Gov’t Code §§551.071, 551.072, and Possible Action Regarding this Matter Upon Return to Open Session	No Action Taken.
	K. 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 Tex. Gov’t Code Ann. §551.071, and Possible Action Regarding this Matter Upon Return to Open Session	No Action Taken.
	L. Presentation Regarding Harris Health’s Enterprise Risk Management, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Gov’t Code Ann. §551.071, and Possible Action Regarding this Matter Upon Return to Open Session	No Action Taken.

XII. Reconvene	At 11:55 A.M., Dr. Caracostis reconvened the meeting in open session and confirmed that a quorum remained present. She noted that no action was taken in Executive Session. The Board took action on items XII. 'E and H' of the Executive Session Agenda.	
XIV. Adjournment	There being no further business to come before the Board; without objection, the meeting was adjourned at 11:56 A.M.	

I certify that the foregoing are the Minutes of the Harris Health Board of Trustees Meeting held on September 9, 2026.

Respectfully Submitted,

Andrea Caracostis, MD, MPH, Chair

Libby Viera – Bland, AICP, Secretary

Minutes transcribed by Cherry A. Joseph, MBA

Board of Trustees
Board Meeting I Wednesday, September 9, 2026
ATTENDANCE RECORD

PRESENT BOARD MEMBERS: IN PERSON	PRESENT BOARD MEMBERS: VIRTUAL	ABSENT BOARD MEMBERS
Andrea Caracostis, MD, MPH (<i>Chair</i>)	Carol Paret, BS (<i>Vice Chair</i>)	
Libby Viera-Bland, AICP (<i>Secretary</i>)	Ingrid Robinson, MBA	
Marlen Trujillo, PhD, MBA, CHW		
Paul Puente		
Philip Sun, AIA, ACHA, NCARB		
Shubhada Hooli, MD, MPH		
Sima Ladjevardian, JD		

PRESENT EXECUTIVE LEADERSHIP, STAFF & GUESTS	
Alexander Barrie	Jerry Summers
Alison Perez	Jessey Thomas
Anna Mateja (<i>Chief Financial Officer, Community Health Choice</i>)	John Matcek
Anthony Williams	Kiki Teal
Dr. Asim Shah	Dr. Kunal Sharma
Binta Baudy	Lindsey Katie Rutherford
Carolynn Jones	Lisa Wright (<i>Chief Executive Officer, Community Health Choice</i>)
Cherry Joseph	Louis Smith
Daniel Smith	Maria Cowles
DeWight Dopslauf	Mary Buzak (<i>Bracewell</i>)
Ebon Swofford (<i>Harris County Attorney's Office</i>)	Dr. Matasha Russell
Elisa Santana	Micah Rodriguez
Elizabeth Hanshaw Winn	Michael Fritz (<i>Harris County Attorney's Office</i>)
Dr. Esmaeil Porsa (<i>President & Chief Executive Officer, Harris Health</i>)	Dr. Michael Nnadi
Dr. Glorimar Medina	Nathan Bac (<i>Harris County Attorney's Office</i>)
Holly Gummert	Nelson Gonzalez
Ja' Porsha Comeaux	Dr. O. Reggie Ekins
Jack Adger (<i>Harris County Purchasing Office</i>)	Olga Rodriguez
Dr. Jackie Brock	Omar Reid
Jennifer Zarate	Patrick Casey

Virtual Attendee Notice: If you joined as a group and would like your attendance to be added to the official record, please submit an email to: BoardofTrustees@harrishealth.org before the close of business on the day of the meeting.

PRESENT EXECUTIVE LEADERSHIP, STAFF & GUESTS	
R. King Hillier	Shawn DeCosta
Randy Manarang	Dr. Thomas Cummins
Sam Karim	Dr. Tien Ko
Dr. Sandeep Markan	Victoria Nikitin
Sara Thomas <i>(Harris County Attorney's Office)</i>	Vivian Ho-Nguyen

Virtual Attendee Notice: *If you joined as a group and would like your attendance to be added to the official record, please submit an email to: BoardofTrustees@harrishealth.org before the close of business on the day of the meeting.*

Public Comment Registration Process

Pursuant to Texas Government Code Ann. §551.007, members of the public are invited to attend the regular meetings of the Harris Health Board of Trustees and may address the Board during the public comment segment regarding an official agenda item that the Board will discuss, review, take action upon, or regarding a subject related to healthcare or patient care rendered at Harris Health. Public comment will occur prior to the consideration of all agenda items.

If you have signed up to attend as a virtual Public Speaker, a meeting link will be provided within 24-48 hours of the scheduled meeting. Notice: Virtual public speakers will be removed from the meeting after speaking and have the option to join the meeting live via <https://harrishealthtx.new.swagit.com/views/432/live>. You must click the "Watch Live" hyperlink in the blue bar, located on the top left of the screen.

How to Request to Address the Board of Trustees

Members of the public must register in advance to speak at the Harris Health Board of Trustees Board meetings. To register, members of the public may contact the Board of Trustees Office during core business hours, Monday through Friday between 8:00 a.m. to 4:00 p.m. Members of the public must submit registration no later than 4:00 p.m. on the day before the scheduled meeting using 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/Documents/Public%20Comment%20Registration%20Form.pdf>
 - 2a. A hard copy may be emailed to BoardofTrustees@harrishealth.org
 - 2b. A hard copy may be mailed to 4800 Fournace Pl., Ste. E618, Bellaire, TX 77401
3. Contact a Board of Trustees staff member at (346) 426-1524 to register verbally or by leaving a voicemail with the required information denoted on the registration form

Prior to submitting a request to address the Harris Health Board of Trustees, please take a moment to review the guidelines to be observed during the Public Comment portion of the meeting.

Rules During Public Comment Period

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

Time Limits

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 with 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 be provided with one (1) minute 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.

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Executive Session

Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007 and Tex. Health & Safety Code Ann. §161.032 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, the Harris Health Quality and Safety Performance Measures, Good Catch Recipients, Centers for Medicare and Medicaid Services Quality Reporting, and Possible Action Regarding this Matter Upon Return to Open Session.



Yashwant Chathampally, MD, MSc
Associate CMO, Senior Vice President –
Quality & Patient Safety

- Pages 21 – 36 Were Intentionally Left Blank -

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Executive Session

Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007 and Tex. Health & Safety Code Ann. §161.032 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, the Harris Health Quality and Safety Performance Measures, Good Catch Recipients, Centers for Medicare and Medicaid Services Quality Reporting, and Possible Action Regarding this Matter Upon Return to Open Session.



Jessey Thomas, MBA, MSN, RN, CSMP
Senior Vice President, Medical Affairs

- Pages 38 – 49 Were Intentionally Left Blank -

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Executive Session

Report Regarding Harris Health Correctional Health Quality of Medical and Healthcare, with Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §§151.002, 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, Including Consideration of Approval of Credentialing Changes for Members of the Correctional Health Medical Staff Upon Return to Open Session.



O. Reggie Ekins, MD, CCHP-CP
Chief Medical Officer - Correctional Health

- Pages 51 – 55 Were Intentionally Left Blank -

Meeting of the Board of Trustees

Wednesday, October 14, 2026

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

The Harris Health Medical Executive Board approved the attached credentialing changes for the members of the Harris Health Medical Staff on September 15, 2026.

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

Thank you.



Jessey Thomas, MBA, MSN, RN, CSMP
Senior Vice President, Medical Affairs

Board of Trustees



October 2026 Medical Staff Credentials Report

Medical Staff Initial Appointments: 25

BCM Medical Staff Initial Appointments - 12

UT Medical Staff Initial Appointments - 12

HCHD Medical Staff Initial Appointments - 1

Medical Staff Reappointments: 0

BCM Medical Staff Reappointments

UT Medical Staff Reappointments

HCHD Medical Staff Reappointments

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Changes in Clinical Privileges: 5

BCM/UT/HCHD Medical Staff Resignations: 16

Other Business:

Leave of Absence - 3

For Information:

Temporary Privileges Awaiting Board Approval - 19

Urgent Patient Care Need Privileges Awaiting Board Approval - 2

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Files for Discussion: 0

Medical Staff Initial Appointment Files for Discussion

Medical Staff Reappointment Files for Discussion

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Consideration of Approval of Changes to the Cardiothoracic Surgery Clinical Privileges

A request was made to add the following privilege to the Cardiothoracic Surgery Privileges.

- Robotic Assisted Laparoscopic Surgery

The Chiefs of Service at BT and LBJ have reviewed and agreed with the addition of the Special Noncore Privileges.

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



Jessey Thomas, MBA, MSN, RN, CSMP
Senior Vice President, Medical Affairs

Record of Clinical Privileges Requested and Granted
Cardiothoracic Surgery Clinical Privileges
 Page 8 of 13

Applicant Name: _____

Please Choose Pavilion for Requested Privileges:

☐ Ben Taub; ☐ LBJ; ☐ ACS: _____

Print ACS Clinic Name

☐ **QUALIFICATIONS FOR TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR) REQUESTED**

Acknowledgement of Surgeon:

☐ I have reviewed and meet the minimum criteria for *transcatheter aortic valve replacement (TAVR) and request clinical privileges at Ben Taub Hospital.

Signature: _____

Printed Name: _____

Date: _____

Recommendation of Ben Taub Chief of Section:

***For Ben Taub Hospital Only:**

I/We have reviewed the requested clinical privileges and supporting documentation for the above applicant and recommend privileges for transcatheter aortic valve replacement (TAVR).

☐ YES

☐ NO

Ben Taub Chief of Section: _____

Date: _____

QUALIFICATIONS FOR ROBOTIC ASSISTED LAPAROSCOPIC SURGERY (*Lyndon B. Johnson Hospital)

Minimum qualifications for requesting *robotic-assisted laparoscopic surgery privileges include:

Criteria:

1. MD, DO, or equivalent degree
2. Successful completion of a post graduate residency program in General Surgery or a surgical sub-specialty accredited by the ACGME, AOA, or equivalent organization
3. Board eligible and/or board certified in General Surgery or a surgical sub-specialty
4. Must be applying to become a member of the medical staff in Harris Health
5. Must be applying for full privileges for the open and/or laparoscopic equivalent of the procedure(s) for which the surgeon is requesting robotic privileges
6. Certification by Intuitive Surgical ® and/or equivalent robotic platform

Record of Clinical Privileges Requested and Granted
Cardiothoracic Surgery Clinical Privileges
 Page 9 of 13

Applicant Name: _____

Please Choose Pavilion for Requested Privileges:

☐ Ben Taub; ☐ LBJ; ☐ ACS: _____

Print ACS Clinic Name

Minimal qualifications for approval as a robotic-assisted laparoscopic surgery proctor include:

Criteria:

1. MD, DO, or equivalent degree
2. Successful completion of a post graduate residency program in surgery or a surgical sub-specialty accredited by the ACGME, AOA, or equivalent organization
3. Board eligible and/or board certified in General Surgery or a surgical sub-specialty
4. Must have privileges at a Joint Commission and/or Det Norske Veritas (DNV) accredited hospital for the open and/or laparoscopic equivalent of the procedure(s) for which the surgeon is proctoring
5. At least 50 successfully completed robotic assisted laparoscopic cases (at any Joint Commission and/or DNV accredited hospital) and/or certification by Intuitive Surgical® and/or equivalent robotic platform as a certified proctor

***Required previous experience:**

***Initial Appointment: (please check appropriate category)**

For surgeons who were not trained in robotics in their residency and/or fellowship, the following is required:

☐ **If the surgeon does not have robotic privileges at an accredited hospital, the surgeon must:**

- 1) Provide documentation of robotic training (Intuitive Surgical® da Vinci TM Surgical Platform certification course or equivalent)
- 2) Must complete the following simulator training modules with a score of 90% or higher: Endowrist manipulation 1 and 2, Camera and Clutching, Energy and Dissection, Needle Control and Needle Driving
- 3) The first 5 cases must be proctored by a surgeon who meets the qualifications as a robotic surgery proctor, as noted previously

☐ **If the surgeon has robotic privileges at another accredited hospital, the surgeon must:**

- 1) Provide documentation of robotic training (Intuitive Surgical® da Vinci TM Surgical Platform certification or equivalent)
- 2) Proof of a minimum of 25 successful robotic cases performed (as primary surgeon) at any Joint Commission and/or DNV accredited hospital
- 3) If less than 25 robotic cases have been performed (as primary surgeon):
 - a. The first 5 cases must be proctored by a surgeon acceptable to the Chief of Section and meets the criteria as noted previously for an approved proctor
 - b. Must complete the following simulator training modules with a score of 90% or higher: Endowrist manipulation 1 and 2, Camera and Clutching, Energy and Dissection, Needle Control and Needle Driving

Record of Clinical Privileges Requested and Granted
Cardiothoracic Surgery Clinical Privileges
 Page 10 of 13

Applicant Name: _____

Please Choose Pavilion for Requested Privileges:

☐ Ben Taub; ☐ LBJ; ☐ ACS: _____

Print ACS Clinic Name

☐ **For surgeons trained in robotics in their residency and/or fellowship, the following is required:**

- 1) Provide documentation of robotic training (Intuitive Surgical ® da Vinci TM Surgical Platform certification or equivalent) OR verification/evaluation letter describing the surgeon's robotic training and experience from the residency and/or fellowship program director and recommendations for privileges
- 2) Proof of a minimum of 25 successful robotic cases (as console surgeon) at any Joint Commission and/or DNV accredited hospital
- 3) If less than 25 robotic cases (as console surgeon) have been performed
 - a. The first 5 cases must be proctored by a surgeon acceptable to the Chief of Section and meets the criteria as noted below for an approved proctor
 - b. Must complete the following simulator training modules with a score of 90% or higher:
 - i. Anterior Needle Driving Vertical
 - ii. ATW Needle Driving
 - iii. Camera 0
 - iv. Energy Pedals 2

***Re-appointment:**

☐ **For surgeons requesting re-appointment of robotic assisted laparoscopic surgery privileges, the surgeon must:**

- 1) Proof of a minimum of 24 successful robotic cases performed over the past 2 years at any Joint Commission and/or DNV accredited hospital
- 2) If less than 24 robotic cases have been performed over the past 2 years,
 - a. Must complete the following simulator training modules with a score of 90% or higher: Endowrist manipulation 1 and 2, Camera and Clutching, Energy and Dissection, Needle Control and Needle Driving
- 3) All cases during the re-appointment period are subject to peer review

Record of Clinical Privileges Requested and Granted
Cardiothoracic Surgery Clinical Privileges
 Page 11 of 13

Applicant Name: _____

Please Choose Pavilion for Requested Privileges:

☐ Ben Taub; ☐ LBJ; ☐ ACS: _____

Print ACS Clinic Name

Acknowledgement of Surgeon:

☐ I have reviewed and meet the minimum criteria for  robotic assisted laparoscopic surgery and request clinical privileges at Lyndon B. Johnson Hospital.

Signature: _____

Printed Name: _____

Date: _____

***For Lyndon B. Johnson Hospital Only:**

Recommendation of LBJ Chief of Section:

We have reviewed the requested clinical privileges and supporting documentation for the above applicant and recommend privileges for robotic assisted laparoscopic surgery.

☐ YES

☐ NO

LBJ Chief of Section: _____

Date: _____

QUALIFICATIONS FOR ADULT MODERATE AND DEEP SEDATION

Requires successful completion of the [ADULT MODERATE AND DEEP SEDATION EXAM](#) ([=>Click link to access exam](#)) with a **passing score of 85% or above** and a **current** ACLS or ATLS. See hospital policy, 7.03. for sedation and analgesia by non-anesthesiologists.

☐ **ADULT MODERATE AND DEEP SEDATION PRIVILEGES REQUESTED**

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Harris County Hospital District, and I understand that:

- a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies, Rules & Regulations applicable generally and any applicable to the particular situation.

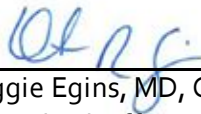
Meeting of the Board of Trustees

Wednesday, October 14, 2026

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

The Harris Health Correctional Health Medical Executive Committee approved the attached credentialing changes for the members of the Harris Health Medical Staff on September 14, 2026.

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



O. Reggie Ekins, MD, CCHP-CP
Chief Medical Officer - Correctional Health

October 2026 Correctional Health Credentials Report

Medical Staff Initial Appointments: 4

Medical Staff Reappointments: 3

Medical Staff Resignations: 11

Medical Staff Files for Discussion: 1

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Consideration of Approval of the 2026 Correctional Health Medical Staff Bylaws

The Harris Health Correctional Health Medical Executive Committee and Medical Staff have approved the attached Correctional Health Medical Staff Bylaws. The Correctional Health MEC and Dr. Otis Ekins, Correctional Health MEC Chair, requests the approval of the Board of Trustees.

A summary of changes is below:

- Definitions
 - Added definition of "Health Matter"
 - Added definition of "Inappropriate Conduct"
- Article III, Section 7 –Duty to Self-Disclose (Page 9)
 - Added new section outlining required self-disclosure events and associated reporting timeframes for medical staff members
- Article VI, Section 9 –Temporary Privileges (Page 18)
 - Language was revised to clarify criteria for temporary privileges
 - Language was added to further clarify examples of temporary privileges for important patient care need



O. Reggie Ekins, MD, CCHP-CP
Chief Medical Officer - Correctional Health

HARRISHEALTH

**CORRECTIONAL HEALTH
MEDICAL STAFF
BYLAWS**

September, 202~~5~~6

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**BYLAWS OF THE
HARRIS HEALTH
CORRECTIONAL HEALTH MEDICAL STAFF**

PREAMBLE

WHEREAS, Harris County (“County”) owns detention facilities (“Detention Facilities”) which are under the supervision and control of the Sheriff of Harris County (“Sheriff”); and

WHEREAS, the Sheriff is charged by law with the responsibility for obtaining and providing adequate medical care for detainees of the County’s Detention Facilities (each such facility generally referred to as the “Jail”); and

WHEREAS, the Sheriff desires to outsource the provision and supervision of medical and mental health care (generically, “health care”) to a qualified care provider; and

WHEREAS, the Harris County Hospital District d//b/a Harris Health is a hospital district established pursuant to Article IX, Section 4 of the Texas Constitution and Tex. Health & Safety Code §§281.001 et seq., as amended with responsibility for furnishing medical and hospital care for indigent and needy persons residing in Harris County; and

WHEREAS, in compliance with the Interlocal Cooperation Act, the County and Harris Health have entered into an Interlocal Cooperation Agreement (“the Agreement”) for Harris Health to provide certain medical care to Jail detainees; and

WHEREAS, subject to oversight by the Harris Health Board of Trustees (“Governing Body”), the Harris Health Correctional Health Medical Executive Committee (“Medical Executive Committee”) is responsible for determining, implementing, and monitoring policies governing the medical care to Jail detainees, including the quality and safety of the medical care in the Jail, and holding the medical staff accountable to fulfill Harris Health’s obligations to the Jail detainees; and

WHEREAS, the Medical Executive Committee has approved these Harris Health Correctional Health Medical Staff Bylaws (“Bylaws”).

THEREFORE, the Practitioners and Advanced Practice Professionals practicing in the Jail shall carry out the functions delegated to the Medical Staff by the Governing Body in compliance with these Bylaws.

DEFINITIONS

Whenever the context requires, words of masculine gender used herein shall include the feminine and the neuter, and words used in the singular shall include the plural.

1. The term “**ADVANCED PRACTICE PROFESSIONAL**” (**APP**) shall be defined as an individual who holds a state license in their profession as well as other educational credentials attesting to training and qualifications to provide services in one or more of the following categories: Physician Assistant (PA), Optometrist (OD), or Nurse Practitioner (NP).
2. The term “**CHIEF MEDICAL OFFICER**” shall mean the Chief Medical Officer for Correctional Health.
3. The term “**CLEAN APPLICATION**” shall mean a completed application in which all aspects of the application are complete; all references have been returned with all questions fully answered as either superior or good; the applicant has not been a party to any malpractice cases, adverse actions involving medical staff membership, clinical privileges or licensure/certification requiring further investigation; and all training, licensure, National Practitioner Data Bank, and OIG database information has been verified, with the results of such verification found to be acceptable. The term “Clean Application” may also be applied to an application from a Medical Staff member requesting new clinical privileges.
4. The term “**CLINICAL PRIVILEGES**” or “**PRIVILEGES**” means the permission granted by the Governing Body to a Practitioner to provide those diagnostic, therapeutic, or medical services which the Practitioner has been approved to render.
5. The term “**COMPLETED APPLICATION**” shall mean a signed Texas State Standardized Application in which all questions have been answered, current copy of licensure (State, DEA), peer reference letters, delineation of clinical privileges or job description, current appropriate professional liability insurance if applicable, National Practitioner Data Bank, OIG, Board Status, hospital affiliations, and verification of any other relevant information from other professional organizations according to the Bylaws and Credentialing Procedures Manual. Additionally, all information and documentation has been provided, and all verifications solicited by the Medical Executive Committee have been received and require no further investigation. A completed application may be determined to be incomplete, based upon the review of Harris Health’s Medical Staff Services, the Chief Medical Officer, or the Medical Executive Committee.
6. The term “**CREDENTIALING PROCEDURES MANUAL**” shall mean the policy containing additional details related to the credentialing process of Correctional Health, as further detailed in these Bylaws.
7. The term “**DAYS**” shall mean calendar days, including Saturdays, Sundays, and holidays unless otherwise specified herein. Days are counted beginning on the day following the transmittal or receipt of a notice or other required correspondence.
8. The term “**DENTIST**” means an individual with a D.D.S. or equivalent degree licensed or authorized to practice dentistry by the State of Texas.
9. The term “**EXECUTIVE SESSION**” means any meeting or portion of any meeting, of any section, department, or committee of the Medical Staff at which privileged and/or confidential information regarding quality assessment and improvement and/or peer review information is presented or discussed.
10. The term “**EX-OFFICIO**” shall mean service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, refers to a position without voting

rights.

11. The term **“FEDERAL HEALTH CARE PROGRAM”** shall mean any plan or program that provides health benefits whether through insurance or otherwise, which is funded directly in whole or in part by the United States government or a state health program (with the exception of the Federal Employees Health Benefits program). The most significant federal health care programs are Medicare, Medicaid, Blue Cross Federal Employees Program (FEP)/Tricare/CHAMPUS and the veterans' programs.
12. The term **“GOOD STANDING”** means that, at the time of his or her most recent appointment, this individual was deemed to have met the following requirements: satisfactory clinical competence, satisfactory technical skill/judgment, satisfactory results of Quality Assurance activity, satisfactory adherence to these Bylaws, satisfactory medical records completion, satisfactory physical mental health completion, satisfactory relationships to peers and status.
13. The term **“GOVERNING BODY”** means the Harris Health Board of Trustees.
14. The term **“HEALTH MATTER”** means any physical, mental, or emotional condition that could adversely affect a Practitioner's or APP's ability to practice safely and competently.
- ~~13.~~15. The term **“INAPPROPRIATE CONDUCT”** means behavior that adversely affects the healthcare team's ability to work effectively and/or has a negative effect on the communication and collaboration necessary for quality and safe patient care.
- ~~14.~~16. The term **“INELIGIBLE PERSON”** means any individual or entity that: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in any federal and/or state health care programs or in federal and/or state procurement or non-procurement programs (this includes persons who are on the List of Excluded Individuals or Entities of the Inspector General, List of Parties Excluded from Federal Programs by the General Services Administration or the Medicaid Sanction List); or (ii) has been convicted of a criminal offense related to the provision of a health care program that falls within the ambit of 42 U.S.C. §1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.
- ~~15.~~17. The term **“MEDICAL EXECUTIVE COMMITTEE”** means the committee with authority to exercise Correctional Health-wide functions on behalf of the Medical Staff.
- ~~16.~~18. The term **“MEDICAL STAFF”** means all physicians and dentists who are appointed to the Medical Staff to provide healthcare services at Harris Health Correctional Health and who are employed by or have a contractual relationship with Harris Health.
- ~~17.~~19. The term **“PEER”** shall mean an individual who practices in the same profession as the Practitioner under review. The level of subject-matter expertise required to provide meaningful evaluation of a Practitioner's performance will determine what “practicing in the same profession” means on a case-by-case basis. The Medical Executive Committee shall determine the degree of subject matter expertise required on a case-by-case basis.
- ~~18.~~20. The term **“PEER REVIEW”** shall mean the evaluation of medical and healthcare services, including evaluation of the qualifications and professional conduct of professional healthcare practitioners and of patient care provided by those Practitioners. The Practitioner is evaluated based on generally recognized standards of care. The Medical Executive Committee conducts a peer review with input from one or more Practitioner colleagues (peers).
- ~~19.~~21. The term **“PHYSICIAN”** means an individual with an M.D., D.O. or equivalent degree currently licensed to practice medicine in the State of Texas.
- ~~20.~~22. The term **“PRACTITIONER”** means, unless otherwise expressly limited, any Physician or Dentist holding a current license to practice in the State of Texas.

- ~~21~~23. The term “**SPECIAL NOTICE**” shall mean written notification sent by certified or registered mail, return receipt requested, or by personal or e-mail delivery with a receipt of delivery or attempted delivery obtained.
- ~~22~~24. The term “**STATE**” shall mean the State of Texas.
- ~~23~~25. The term “**STATE BOARD**” shall mean, as applicable, the Texas Medical Board, the State Board of Dental Examiners, or such other licensing board that may license individuals who have clinical privileges at Correctional Health.

ARTICLE I — NAME

The name of this organization governed by these Bylaws shall be the Medical Staff of Harris Health Correctional Health (hereinafter referred to as “Correctional Health”).

ARTICLE II — PURPOSE

The purposes of this organization are:

1. To provide the best possible care for all Jail detainees;
2. To ensure a high level of professional performance of all Medical Staff members authorized to practice in Correctional Health through appropriate delineation of the clinical privileges that each Medical Staff member may exercise and through an ongoing review and evaluation of each Medical Staff member's performance;
3. To provide an appropriate educational setting for Medical Staff members that will maintain medical and scientific standards that will lead to continuous advancement in professional knowledge and skill;
4. To initiate and maintain these Bylaws for self-governance of the Medical Staff;
5. To provide a means for communication and conflict resolution regarding issues that are of concern to the Medical Staff.

ARTICLE III — MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of Correctional Health is a privilege which shall be extended, without discrimination as to race, color, sex, religion, disability, national origin, or age only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws, and does not in any way imply or preclude employment status by Harris Health. Membership on the Medical Staff shall confer only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws.

Section 2. Qualifications for Membership

- a. Only individuals who have no health problems that could affect his or her ability to perform the privileges requested and can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others so as to assure the Medical Staff and Governing Body that patients treated by them will be given a high quality of medical care, shall be qualified for membership on the Medical Staff.
- b. Only individuals who have and continue to maintain current unrestricted privileges, in Good Standing, at Harris Health Correctional Health.
- c. Only individuals who have current licenses and certificates. Medical Staff members must have unrestricted licenses and certificates, with no past adverse licensure actions(s) (e.g., probation, suspension, revocation). Past adverse licensure action(s) do not include action(s) taken for administrative reasons, such as failure to timely pay licensure fees. Required licenses and certificates include:
 - State of Texas license to practice medicine, osteopathy, or dentistry;

- United States Controlled Substances Registration Certificate (DEA) as applicable, with exceptions approved by the Medical Executive Committee;
 - National Provider Identifier (NPI); and
 - Professional liability insurance covering the exercise of all requested privileges, except for Practitioners or APPs employed by Harris Health.
- d. Only Practitioners who have no record of denial, revocation, relinquishment or termination of appointment or clinical privileges at any other healthcare facility for reasons related to professional competence or conduct.
 - e. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in Correctional Health merely by virtue of the fact that he or she is duly licensed to practice medicine, osteopathy, or dentistry in this State or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past, or presently has, such privileges at another healthcare facility.
 - f. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he or she will strictly abide with all provisions of these Bylaws.
 - g. The Practitioner will remain in Good Standing so long as he or she is a member of the Medical Staff.
 - h. The Practitioner is required to be eligible to participate in federal and/or State healthcare programs. The Practitioner may not currently be an Ineligible Person and shall not become an Ineligible Person during any term of membership. The Practitioner must also have no record of conviction of Medicare, Medicaid or insurance fraud and abuse.
 - (1) A Practitioner is required to disclose immediately any debarment, exclusion, or other event that makes the person an Ineligible Person.
 - (2) An Ineligible Person is immediately disqualified for membership to the Medical Staff or the granting of clinical privileges or practice prerogatives.
 - i. A Practitioner or APP who does not meet one or more of the qualifications for membership described above may request special consideration by the Medical Executive Committee to waive one or more of the qualifications for membership if the Practitioner is determined unusually qualified as set forth in this subsection.

In order to be deemed "unusually qualified," Practitioners applying under this exception must (i) receive written recommendations by the Chief Medical Officer, (ii) document sufficient post-training experience in the applicant's primary field at the time of application, and (iii) be a recognized leader or innovator in his or her field, as evidenced by documented research, publications, and/or unique procedural ability not otherwise available or for which there is an unexpected and non-preventable shortage on the current Medical Staff. It is anticipated that approvals of applications under this exception will be rare and are subject to approval by the Medical Executive Committee, and the Governing Body.

At the application for reappointment, the Practitioner granted privileges under this section must submit a progress report. The Practitioner's progress report shall be confirmed by the Chief Medical Officer, demonstrating the exception continues to be warranted by the ongoing exercise of the privileges for which the exception was granted.

The Medical Executive Committee's determination not to waive one or more of the qualifications for membership is not a denial of the Practitioner or APP's application for Medical Staff membership, is not reportable to the National Practitioner Databank, and does

not entitle the Applicant to the fair hearing rights as described in these Bylaws.

Section 3. Basic Responsibilities of Medical Staff Membership

The following responsibilities shall govern the professional conduct of Medical Staff members and failure to meet these responsibilities shall be cause for suspension of privileges or dismissal from the Medical Staff:

- a. The principal objective of the Medical Staff is to render service to humanity with full respect for the dignity of each person. Medical Staff members should merit the confidence of patients entrusted to their care, rendering to each a full measure of service, devotion and continuity of care. Medical Staff members are responsible for the quality of the medical care provided to patients.
- b. Medical Staff members should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional qualifications.
- c. Medical Staff members should observe all laws, uphold the dignity and honor of their profession and accept self-imposed disciplines. They should report without hesitation, illegal or unethical conduct by other Medical Staff members and self-report their own illegal or unethical conduct. Reports should be made to the Chief Medical Officer, who will report the information to Medical Staff Services.
- d. Medical Staff members should self-report any physical, behavioral or mental impairment that could affect his or her ability to perform his or her clinical privileges, or treatment for the impairment that occurs at any point during his or her Medical Staff membership. Reports should be made to the Chief Medical Officer, who will report the information to Medical Staff Services.
- e. In an emergency, Medical Staff members should render services to the best of their abilities. Having undertaken the care of a patient, a Medical Staff member may not neglect him or her.
- f. Medical Staff members should not solicit patients.
- g. Medical Staff members should not dispense of their services under terms or conditions that tend to interfere with or impair the free and complete exercise of their professional judgment and skill or tend to cause a deterioration of the quality of their care.
- h. Medical Staff members should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of service may be enhanced thereby.
- i. Medical Staff members may not reveal the confidences entrusted to them in the course of professional attendance unless they are required to do so by law or unless it becomes necessary in order to protect the welfare of an individual or of the community.
- j. Medical Staff members must abide by these Bylaws and applicable policies and procedures.
- k. Medical Staff members must participate cooperatively in quality review and peer evaluation activities, both as a committee member and in conjunction with evaluation of his or her own performance or professional qualifications.
- l. Medical Staff members must prepare and complete medical records in a timely fashion for all patients to whom the member provides care in Correctional Health.
- m. Medical Staff members are accountable to the Governing Body.

Section 4. Conditions and Duration of Appointment

- a. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments after there has been a recommendation from the Medical Executive Committee.
- b. Initial appointments shall be acted upon following submittal of a Completed Application.
- c. All appointments to the Medical Staff shall be for a period of not more than three (3) years.
- d. Appointment or reappointment to the Medical Staff confers on the appointee only such clinical privileges as have been approved by the Governing Body.
- e. Each application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgement of a Medical Staff member's obligations to provide continuous care and supervision of their patients, to abide by these Bylaws, to accept committee assignments and to accept staff assignments in Correctional Health. All Medical Staff members shall carry an appropriate level of professional liability insurance as determined by the Governing Body.
- f. Appointments and reappointments to the Medical Staff shall always conform to applicable State and Federal laws.

Section 5. Leave of Absence

- a. Requesting a Leave of Absence. A Practitioner may submit a written request to Medical Staff Services for a leave of absence 30 days prior to the requested leave, unless related to a Medical Leave of Absence. Upon favorable recommendation by the Chief Medical Officer, the Medical Executive Committee may consider a voluntary leave of absence for up to one (1) year. An additional one (1) year may be granted for good cause in accordance with policy. During the period of the leave, the Practitioner shall not exercise clinical privileges at Correctional Health, and the Practitioner's rights and responsibilities shall be inactive. All medical records must be completed prior to granting a leave of absence unless circumstances would not make this feasible.
- b. Termination of Leave. At least 45 days prior to the termination of the leave of absence, or at any earlier time, the Practitioner may request reinstatement of privileges by submitting a written notice to Medical Staff Services along with a summary of relevant activities during the leave. The Practitioner's request, activity summary and verification, if applicable, shall be presented to the Chief Medical Officer. The Chief Medical Officer will review the documentation and provide a recommendation to the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be subject to quality review as determined by the Medical Executive Committee following recommendation by the Chief Medical Officer. If the Practitioner is scheduled for reappointment during the approved leave, the Practitioner's application for reappointment must be finalized in accordance with these Bylaws prior to the practitioner's return.
- c. Failure to Request Reinstatement. Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall not give rise to the right to a fair hearing. A request for Medical Staff membership received from a Practitioner subsequent to termination shall be submitted and processed in the manner specified for applications for initial appointments.
- d. Medical Leave of Absence. Following recommendation by the Chief Medical Officer, the Medical Executive Committee shall determine the circumstances under which a particular practitioner shall be granted a leave of absence for the purpose of obtaining treatment for a

medical condition or disability. Unless accompanied by a reportable restriction of privileges, the leave shall be deemed a voluntary medical leave of absence and will not be reported to the National Practitioner Data Bank.

- e. Military Leave of Absence. Requests for leave of absence to fulfill military service obligations shall be granted upon appropriate notice to Medical Staff Services and will be provided to the Medical Executive Committee for information only.

Section 6. Duty to Self-Disclose

Medical Staff members have an affirmative, continuing duty to self-disclose, upon becoming aware, the following items to Medical Staff Services promptly, and in no event later than the time frames stated in each subsection below. Notification may occur in writing, including via email, or via oral communication to the Director of Medical Staff Services and Harris Health Credentialing Office at medicalstaffservices2@harrishealth.org provided that any oral notification is confirmed in writing via email.

- a. **State Licensing Board Actions** – Medical Staff members must self-disclose any suspension, limitation or placement of a condition on the member's professional license by the Texas licensing board within **twenty-four (24) hours** of becoming aware of the licensure action. *This does not include investigations by the state licensing board unless the investigations involve issues that require self-disclosure pursuant to the Bylaws.*
- b. **Other Licensing or Certification Actions** – Medical Staff members must self-disclose any suspension, limitation or placement of a condition on the member's other required licenses or certifications, including but not limited to medical license, DEA license, Board certification depending on specialty, ACLS certification or other such licensure or certification related to the practice of medicine within **twenty-four (24) hours** of becoming aware of the licensing or certification action. *This does not include investigations by the state licensing board unless the investigations involve issues that require self-disclosure pursuant to the Bylaws.*
- c. **Criminal Charges, Indictment, Conviction, or Plea** – Medical Staff members must self-disclose any felony criminal charge, indictment, conviction, or guilty or nolo contendere plea, or a lesser criminal charge, indictment, conviction, or guilty or nolo contendere plea for allegations involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services no more than **twenty-four (24) hours** after becoming aware of the action.
- d. **Lawsuits and Settlements** - Medical Staff members must self-disclose within **thirty (30)** days after having actual knowledge of:
- (1) The filing or service of a lawsuit based on a health care liability claim wherein the Medical Staff member is named as a defendant or the Medical Staff member's behavior, actions, inactions and/or performance that is in any way the basis of any of the allegations; or
 - (2) A settlement of a health care liability claim or lawsuit; or
 - (3) A dismissal of a lawsuit or judgment rendered in a lawsuit based on a health care liability claim.

- e. **Health Matter** – Health Matter as defined by these Bylaws is any physical, mental, or other condition that could adversely affect a Practitioner's or APP's ability to practice safely and competently. This applies to potential Health Matters impacting the reporting Medical Staff member or potential Health Matter impacting other Medical Staff members.
- (1) Medical Staff members must self-disclose any potential Health Matter no more than **seventy-two (72) hours** of becoming aware of the potential Health Matter and in accordance with the Medical Staff Health policy. See the Medical Staff Health Policy 7.43, Section II A. and B.
 - (2) If the Health Matter involves a Practitioner or APP who is currently providing patient care or is expected to imminently provide patient care self-disclosure must occur **immediately**. *Examples include alcohol or substance use or treatment for substance use disorder, stroke.*
- f. **Inappropriate Conduct** - Inappropriate Conduct as defined by these Bylaws is behavior that adversely affects the healthcare team's ability to work effectively and/or has a negative effect on the communication and collaboration necessary for quality and safe patient care. *Examples include abusive language, demeaning comments or physical or aggressive behavior.*
- (1) Medical Staff members must self-disclose any Inappropriate Conduct no more than **seventy-two (72) hours** of becoming aware of the Inappropriate Conduct, and in accordance with the Medical Staff Professionalism policy.
 - (2) If the Inappropriate Conduct has the potential to result in harm to others, self-disclosure must occur **immediately**. This applies to Inappropriate Conduct impacting the reporting Medical Staff member or Inappropriate Conduct impacting other Medical Staff members.
- g. **Cessation of Employment** – Medical Staff members must self-disclose their own cessation of employment with Baylor College of Medicine, The University of Texas Health Science Center at Houston, Harris Health, or any other entity contracted to provide clinical care at Harris Health, within **seventy-two (72) hours** of the date of the cessation.
- h. **Leave of Absence** – Medical Staff members must self-disclose their own leave of absence with Baylor College of Medicine, The University of Texas Health Science Center at Houston, Harris Health, or any other entity contracted to provide clinical care at Harris Health, **30 days** or as soon as reasonably possible prior to the requested leave of absence, unless related to Medical Leave of Absence. See the Medical Staff Bylaws Article III, Section 6.
- i. **Ineligible Person** – Medical Staff members must self-disclose if they become an Ineligible Person, as that term is defined in these Bylaws, within **seventy-two (72) hours** of receiving notice.

ARTICLE IV — CATEGORIES OF THE MEDICAL STAFF

Section 1. Medical Staff

The Medical Staff shall be divided into the following categories: Active Staff and Moonlighters.

Section 2. Active Staff

- a. Service. All Active Staff shall be appointed to a specific service.
- b. Qualifications. The Active Staff shall consist of members who:
 - (1) Meet the general qualifications for membership set forth in Article III, Section 2;
 - (2) Are employed by or have a contractual relationship with Harris Health; and
 - (3) If the member is a physician, has successfully completed an ACGME- or AOA- accredited residency-training program in their specialty. If the member is a dentist, has successfully completed an American Dental Association-approved school of dentistry accredited by the Commission of Dental Accreditation.
- c. Prerogatives. Except as otherwise provided, the prerogatives of an Active Staff member shall be:
 - (1) Exercise of Clinical Privileges granted to the member pursuant to Article VI;
 - (2) Attend and vote on matters which are presented at general and special meetings of the Medical Staff or any meeting of any service or committee of which such person is a member;
 - (3) Hold any staff or service office for which the member is qualified; and
 - (4) Serve as a voting member on any committee to which such person is duly appointed or elected.

Section 3. Moonlighters

- a. Service. All Moonlighters shall be appointed to either the Emergency Medicine, Family Medicine, Internal Medicine, or Psychiatry service.
- b. Qualifications. Moonlighters shall consist of members who:
 - (1) Meet the general qualifications for membership set forth in Article III, Section 2;
 - (2) Be employed by or have a contractual relationship with Harris Health; and
 - (3) Has successfully completed at least one (1) year of an ACGME- or AOA- accredited residency-training program with continued enrollment in the program.
- c. Prerogatives. Except as otherwise provided, the prerogatives of a Moonlighter shall be:
 - (1) Exercise of Clinical Privileges granted to the member pursuant to Article VI;
 - (2) Attend and vote on matters which are presented at general and special meetings of the Medical Staff or any meeting of any service or committee of which such person is a member;

ARTICLE V — ADVANCED PRACTICE PROFESSIONALS

Section 1. Membership

Advanced Practice Professionals are not members of the Medical Staff, but are granted clinical privileges to provide clinical services to Jail detainees.

Section 2. Qualifications

APPs include those non-Medical Staff members whose license or certificate permits, and these Bylaws authorize, to permit the individual provision of patient care services without direction or supervision within the scope of the APP's individually delineated clinical privileges. APPs must:

- (1) Meet all applicable standards related to licensure, training and education, clinical competence and health status as described in these Bylaws and applicable policies and procedures;
- (2) Be assessed, credentialed, and monitored through existing Correctional Health credentialing, quality assessment, and performance improvement functions;
- (3) Maintain an active and current credential file and hold delineated clinical privileges approved by the Medical Executive Committee and Governing Body;
- (4) Complete all proctoring requirements as may be established by the Medical Executive Committee; and
- (5) Not assume primary patient care responsibilities.

APPs include those categories of individuals identified in the Definitions Section of these Bylaws.

Section 3. Prerogatives

- (1) By virtue of their training, experience and professional licensure, APPs are allowed to function within the scope of their licensure and delineated clinical privileges but may not assume primary patient care responsibilities. All APPs shall be under the supervision of a sponsoring physician, who is member of the Medical Staff, who is responsible for delineating the applicant's clinical privileges. If the sponsoring physician's Medical Staff membership is terminated, then the APP's ability to perform clinical services shall be suspended for a period of up to ninety (90) days or until an alternative supervising physician can be secured. If the suspension lasts longer than ninety (90) days or if there is any change in the APP's privileges, then the APP shall complete the initial application procedure. Each APP must notify Medical Staff Services immediately upon loss of required sponsorship or supervision.
- (2) APPs holding clinical privileges shall have their privileges or practice prerogatives reviewed and approved through the same mechanism described in these Bylaws unless otherwise determined by the Medical Executive Committee.
- (3) The clinical privileges and/or practice prerogatives which may be granted to specific APPs shall be defined by the Medical Staff. Such prerogatives may include:
 - (a) The provision of specific patient care services pursuant to established protocols, either independently or under the supervision or direction of a physician or other member of the Medical Staff. The provision of such patient care services must be consistent with the APP's licensure or certification and delineated clinical privileges or job description;
 - (b) Participation by request on Medical Staff and/or administrative committees or teams; and
 - (c) Attendance by request at Medical Staff and/or administrative meetings.
- (4) Participating in quality assessment and performance improvement activities as requested by

the Medical Executive Committee, or any other committee of the Medical Staff or Governing Body. Failure of an APP to participate in quality assessment or performance improvement activities when requested by the Medical Staff or Governing Body shall result in responsive action, including the possible revocation or suspension of all privileges or practice prerogatives.

Section 4. Review

Nothing in these Bylaws shall be interpreted to entitle APPs to the fair hearing rights as described in these Bylaws. An APP shall, however, have the right to challenge any action that would adversely affect the APP's ability to provide patient care services in Correctional Health. Under such circumstances, the following procedures shall apply:

- (1) Notice. Special Notice of the adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has thirty (30) days in which to request a hearing. If the APP does not request a hearing within thirty (30) days, the APP shall have waived the right to a hearing.
- (2) Hearing Panel. The Chief Medical Officer shall appoint a hearing panel that will include at least three members. The panel members shall include the Chief Medical Officer, another member of the Medical Staff, and if possible, a peer of the APP, except that any peer review of a nurse shall meet the panel requirements of the Texas Nursing Practice Act. None of the panel members shall have had a role in the adverse recommendation or action.
- (3) Rights. The APP subject to the adverse recommendation or action shall have the right to present information but cannot have legal representation or call witnesses.
- (4) Hearing Panel Determination. Following presentation of information and panel deliberation, the panel shall make a determination:
 - i. A determination favorable to the APP shall be reported in writing to the body making the adverse recommendation or action.
 - ii. A determination adverse to the APP shall result in notice to the APP of a right to appeal the decision to the Chairperson of the Governing Body.
- (5) Final Decision. The decision of the Chairperson of the Governing Body shall be the final appeal and represent the final action in the matter.

ARTICLE VI – PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Burden of Producing Information

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing sufficient information of clinical and professional performance to permit an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, to resolve any reasonable doubts about these matters, and to satisfy any request for such information. Failure of a Practitioner to produce required information related to an authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activity in a timely manner shall result in automatic suspension of all clinical privileges until such time as the required information has been provided. Initial applicants who fail to produce all appropriate information and/or documents as requested may withdraw their application prior to review by the Medical Executive Committee.

Section 2. Application for Appointment

- a. All applications for appointment to the Medical Staff shall be signed by the applicant, and shall be submitted on a form prescribed by the State of Texas. The application shall include the following detailed information:
- evidence of current licensure;
 - evidence of current United States Controlled Substances Registration Certificate (DEA) as applicable;
 - evidence of current National Provider Identifier (NPI);
 - evidence of appropriate professional liability insurance, as determined by the Governing Body;
 - privileges requested;
 - Evidence of appropriate Basic Life Support (BLS) Certificate.
 - relevant training and/or experience;
 - current competence;
 - physical and mental health status attestation;
 - previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration);
 - voluntary or involuntary relinquishment of any licensure or registration (state or district, Drug Enforcement Administration);
 - voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary decrease of privileges at any other hospital or institution;
 - suspension or revocation of membership in any local, state or national medical society;
 - suspension or revocation of license to practice any profession in any jurisdiction
 - any claims, lawsuits, settlements, or judgments against the applicant in a professional liability action, including consent to the release of information from the present and past malpractice insurance carrier(s);
 - loss of clinical privileges;
 - a clear, legible copy of a government-issued photo identification, e.g., valid driver's license or passport;
 - three professional peer references; and
 - evidence of continuing medical education satisfactory to the Medical Executive Committee.
- b. The applicant shall have the burden of producing adequate information for a proper evaluation of their competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.
- c. Upon the receipt of a Completed Application, Medical Staff Services shall verify the applicant's information on behalf of the Medical Executive Committee, including consulting with primary sources of information about the applicant's credentials. It is the applicant's responsibility to resolve any problems Harris Health may have in obtaining information from primary sources. Verifications of licensure, controlled substances registrations, and professional liability claims history, as well as queries of the National Practitioner Data Bank and queries to ensure the applicant is not an Ineligible Person shall be completed. Verification may be made by a letter or computer printout obtained from the primary

source, verbally, if documented, or electronically if transmitted directly from the primary source to Harris Health. For new applicants, information about the applicant's membership status and/or work history shall be obtained from all organizations where the applicant currently has membership or privileges and/or is employed, and where the applicant has held membership or has been granted clinical privileges and/or has been employed during the previous five (5) years. Associated details on the credentialing process are set forth in Harris Health's Credentialing Procedures Manual.

- d. The application and verifications shall be forwarded to Medical Staff Services for review. After review by Medical Staff Services for completeness, the application and all supporting materials shall be transmitted to the Medical Executive Committee for evaluation.
- e. By applying for appointment to the Medical Staff, applicants thereby signify their willingness to appear for interviews in regard to the application; authorize Harris Health and/or the Medical Executive Committee, to consult with members of Medical Staffs of other health care organizations with which the applicant has been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on the applicant's competence, character and ethical qualification; consent to the inspection of all records and documents that, in the opinion of the Medical Executive Committee, may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, as well as moral and ethical qualifications for staff membership; releases from any liability all representatives of Harris Health and the Medical Executive Committee for their acts performed in good faith and without malice in connection with evaluation of the applicant and his or her credentials; and releases from any liability all individuals and organizations who provide information to Harris Health and/or the Medical Executive Committee in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.
- f. Each applicant shall sign and return a statement that he or she has received and read these Medical Staff Bylaws and that he or she agrees to be bound by the terms thereof relating to consideration of the application and, if the applicant is appointed, to all terms thereof.

Section 3. Appointment Process

- a. Medical Staff Services shall transmit Completed Applications to the Medical Executive Committee at its next regularly scheduled meeting following completion of verifications tasks and receipt of all relevant materials.
- b. Within one hundred and twenty days (120) days after receipt of the Completed Application, the Medical Executive Committee shall report its review and recommendation to the Governing Body. Prior to making this report, the Medical Executive Committee shall examine the evidence of the character, professional competence, physical and mental health status, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant, and from any other sources available to the committee, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested.
- c. Within sixty (60) days of receipt of the recommendation from the Medical Executive Committee, the Governing Body shall determine whether to accept or reject the recommendation. The Governing Body may only make a decision contrary to the recommendation of the Medical Executive Committee if the applicant meets all of the requirements for Medical Staff membership and the Medical Executive Committee's recommendation is unreasonable or not based on sound judgment. If the Governing Body

makes a decision contrary to the recommendation of the Medical Executive Committee, the Governing Body must document its rationale for doing so.

- d. A decision by the Governing Body to accept a recommendation resulting in an applicant's appointment to the Medical Staff shall be considered a final action. Within twenty (20) days of the Governing Body's final action, the Medical Executive Committee shall provide notice of all appointments approved by the Governing Body by Special Notice to each new Medical Staff member. All such notices shall include a delineation of approved privileges and appointment dates.
- e. The time periods specified in Section 3(b) and (c) above are for guidance only and do not create any right for the applicant to have his or her application processed within those time periods.
- f. When the recommendation of the Governing Body is adverse to the applicant, either in respect to appointment or clinical privileges, the Chief Medical Officer shall notify the applicant by Special Notice within fifteen (15) days, as described in these Bylaws. No such adverse recommendation shall be forwarded to the Governing Body until after the applicant has exercised his or her right to a hearing as provided in these Bylaws. If the applicant fails to act within thirty (30) days of receipt of the Special Notice, the applicant will have waived his or her right to a hearing as provided in these Bylaws.
- g. If, after the Medical Executive Committee has considered the report and recommendations of the hearing committee and the hearing record, the Medical Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with subparagraph "b" of this section. If such recommendation continues to be adverse, the Chief Medical Officer shall promptly so notify the applicant by Special Notice. The Chief Medical Officer shall so forward such recommendation and documentation to the Governing Body.
- h. The Governing Body shall send notice of its final decision regarding any such review under these Bylaws through the Chief Medical Officer to the applicant.

Section 4. Reappointment Process

- a. It is the responsibility of Active and Affiliate members and Advanced Practice Professionals to request reappointment to the Medical Staff in accordance with the "Reappointment and Renewal of Clinical Privileges Procedure" in the Credentialing Procedures Manual. Reappointment to the Medical Staff shall be based on the applicant's maintaining qualifications for Medical Staff membership, as described in Section 2 of this Article, current competence, and consideration of the results of quality assessment activities as determined by the Medical Executive Committee. Failure to submit a completed reappointment application form with required supporting documentation no less than sixty (60) days prior to the expiration of the Practitioner's then current appointment shall constitute a resignation from the Medical Staff and all privileges will terminate upon expiration of said appointment. Such termination shall not give rise to the right to a hearing pursuant to these Bylaws. Reappointment shall occur every three (3) years. Medical Staff Services will transmit the necessary reapplication materials to the Practitioner not less than 120 days prior to the expiration date of their then current appointment.

All claims, lawsuits, settlements, or judgments against the applicant in a professional liability action, either final or pending, since the last appointment or reappointment must be reported.
- b. Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall take into consideration the following characteristics:

- the practitioner's specific case record, including measures employed in quality assurance/performance improvement program
 - professional competence and clinical judgment in the treatment of patients;
 - ethics and conduct;
 - relations with other Medical Staff members;
 - general attitude toward patients, Correctional Health, and the public;
 - documented physical and mental health status;
 - evidence of continuing medical education that is related, at least in part, to the Practitioner or APP's clinical privileges;
 - previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration);
 - voluntary or involuntary relinquishment of such licensure or registration;
 - voluntary or involuntary termination of Medical Staff membership; and
 - voluntary or involuntary decrease of privileges at any other hospital.
- c. Thereafter, the procedure provided in Sections 2 and 3 of this Article relating to recommendations on applications for initial appointment shall be followed.
- d. Members of the Medical Staff shall maintain current licensure and certifications, as described in these Bylaws. Members of the Medical Staff must notify the Chief Medical Officer and Medical Staff Services whenever their license to practice in any jurisdiction has been voluntarily/involuntarily limited, suspended, revoked, denied, or subjected to probationary conditions, or when proceedings toward any of those ends have been instituted. Those without current licensure and certifications will be subject to loss of privileges as described in these Bylaws.
- e. The appointment of any Practitioner who fails to submit an application for reappointment or ceases to be employed by have a contractual relationship with Harris Health shall automatically expire at the end of his or her employment or contractual relationship. A Practitioner whose appointment has expired must submit a new application, which shall be processed without preference as an application for initial appointment.
- f. When the final action has been taken, the Chief Medical Officer shall give written notice of the reappointment decision to the Practitioner.

Section 5. Performance Data

- a. Practitioner or APP specific performance data will be evaluated, analyzed, and appropriate action taken as necessary when variation is present and/or standard of care has not been met as determined by the Medical Staff.
- b. Performance data will be routinely collected within the reappointment period or as required as a part of the peer review process and will include specific data elements approved by the Medical Executive Committee.
- c. If the Practitioner or APP does not have sufficient performance data from his or her practice at Harris Health Correctional Health, the Practitioner or APP must submit performance data from other clinical locations where he or she practices.
- d. The Medical Executive Committee will review summarized performance data as part of the reappointment process for each Practitioner or APP and make appropriate

recommendations for any remedial or corrective action or refer the Practitioner or APP to peer review.

Section 6. Application for Clinical Privileges

Every initial application for staff appointment to the Medical Staff and each reappointment application must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, clinical training, experience, current competence, references, judgment, and other relevant information. The applicant shall have the burden of establishing his or her qualifications and competency to be granted the clinical privileges requested.

Section 7. Clinical Privileges

- a. Every Medical Staff member practicing within Correctional Health by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, exercise only those clinical privileges specifically approved, ratified, and affirmed to him or her by the Governing Body.
- b. Clinical privileges will be limited to those activities deemed the responsibility of the specialty area to which the applicant is appointed.

Section 8. Privileges in More Than One Specialty

Practitioners or APPs may be awarded clinical privileges in one or more specialty in accordance with their education, training, experience, and demonstrated competence.

Section 9. Temporary Privileges

There are only two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges.

In all cases, temporary privileges shall only persist until the meeting of the Governing Body at which the application for Medical Staff membership is to be considered (not to exceed 120 days from the date temporary privileges are granted by the Medical Executive Committee).

~~Upon the basis of information then available, including information from staffing agencies providing applicants to Harris Health, which may reasonably be relied upon as to the competence and ethical standing of the applicant, the Medical Executive Committee may grant temporary clinical privileges to the new applicant.~~

- a. **New Applicants:** Following receipt of a Clean Application from a new applicant, the Medical Executive Committee may, upon the basis of information then available, including information from staffing agencies providing applicants to Harris Health, which may reasonably be relied upon as to the competence and ethical standing of the applicant, grant temporary Clinical Privileges to the applicant; but in exercising such privileges, the applicant shall act under the supervision of the Chief Medical Officer. ~~Temporary privileges of the applicant shall persist until the next meeting of the Governing Body (not to exceed 120 days) and shall cease at the time of official action upon his or her application for Medical Staff membership.~~

Note: New Applicants include individuals applying for clinical privileges for the first time, an individual currently holding clinical privileges who is requesting one or more additional privileges, and an individual who is in the reappointment process and is requesting one or more additional privileges.

- b. **Important Patient Care Need:** The Medical Executive Committee shall also have the authority to grant temporary Clinical Privileges to an applicant upon documentation of an

important patient care need. In this case, Medical Staff Services shall verify the applicant's education, licensure, current competence, two (2) peer references (including current competence), NPDB, and OIG Exclusion Lists. An applicant is not required to have a Clean Application in order for the Medical Executive Committee to grant temporary Clinical Privileges based on an important patient care need, so long as the Medical Executive Committee considers the information available about the applicant prior to approval.

Examples of important patient care need may include, but are not limited to: (a) the patient care volume exceeds the level that can be handled by currently privileged Practitioners and APPs; or (b) a currently privileged Practitioner or APP has an unexpected absence.

~~b.c.~~ Termination. Temporary clinical privileges may be terminated at any time by the Chief Medical Officer.

~~e.d.~~ Neither termination of temporary clinical privileges nor failure to grant them shall constitute a Final Hearing Review Action and neither is an Adverse Recommendation or Action.

Section 10 Emergency Clinical Privileges

In the case of an emergency, any current Medical Staff member, to the degree permitted by his or her license and regardless of service or staff status, shall be permitted and assisted to do everything possible to save the life of a patient using the appropriate resources available, including the calling for any consultation necessary or desirable. For the purpose of this section, an "emergency" is defined as a condition in which a patient is in immediate danger of serious permanent harm or loss of life, and any delay in administering treatment could add to that danger.

Section 11 Confidentiality of the Credentials File

A Medical Staff member or other individual exercising clinical privileges shall be granted access to his or her own credentials file, subject to the following provisions:

- a. A request for access must be submitted in writing to the Chairperson of the Medical Executive Committee.
- b. The individual may review, and receive a copy of, only those documents provided by or addressed personally to the individual. All other information, including peer review committee findings, letters of reference, proctoring reports, complaints, and other documents shall not be disclosed.
- c. The review by the individual shall take place in Medical Staff Services during normal work hours with an officer or designee of the Medical Staff present.

ARTICLE VII - CORRECTIVE ACTION

Section 1. Procedure

- a. Whenever the activities, professional conduct or health status of any Medical Staff member are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of Correctional Health, corrective action against such Medical Staff member may be requested by the Chief Medical Officer or by the Governing Body. All such requests shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. The Chief Medical Officer or designee must meet with the member to discuss the issues that are the basis for the request either prior to submission or no later than 72 hours after receipt of a copy of the request. In the event that the member who is the subject of the

- request for corrective action is the Chief Medical Officer, another voting member of the Medical Executive Committee must conduct the meeting. The party conducting the meeting shall send a letter to the staff member immediately following the meeting confirming that the meeting was held and the matters discussed. The letter must be sent to the staff member via Special Notice procedures with a copy to Medical Staff Services.
- b. Whenever the corrective action could be a reduction or suspension of clinical privileges, the Chairperson of the Medical Executive Committee shall immediately appoint an ad hoc committee to investigate the matter.
 - c. Within thirty (30) days after the ad hoc committee's receipt of the request for corrective action, it shall make a report of its investigation to the Medical Executive Committee. If in the reasonable view of the Medical Executive Committee more than thirty (30) days is needed to complete the investigation, the Medical Executive Committee shall grant an extension to the ad hoc committee. Prior to the making of a report, the Medical Staff member against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, the Medical Staff member shall be informed that the meeting shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto. A record of such interview shall be made by the ad hoc committee and included with its report to the Chairperson of the Medical Executive Committee.
 - d. Within thirty (30) days following the receipt of the report of the ad hoc investigating committee, the Medical Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected Medical Staff member shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Medical Executive Committee.
 - e. The Medical Executive Committee shall take such action as deemed justified as a result of these investigations.
 - f. Any recommendations by the Medical Executive Committee to the Governing Body for reduction or revocation of clinical privileges, or expulsion from the Medical Staff shall entitle the affected Medical Staff member to the procedural rights provided in these Bylaws.
 - g. Any final adverse action taken after the procedural rights provided in Article VIII have been exhausted (1) that adversely affects the Clinical Privileges of a Physician for a period longer than 14 days must be reported in writing to the Texas Medical Board; and (2) that adversely affects the Clinical Privileges of a Practitioner for a period lasting longer than 30 days must be reported to the National Practitioner Data Bank.
 - h. All decisions resulting from investigations of a Medical Staff member in a medical administrative position shall be reviewed by the Governing Body following the process as outlined in these Bylaws.
 - i. When the Medical Executive Committee or Governing Body has reason to question the physical and/or mental status of a Medical Staff member, the latter shall be required to submit an evaluation of their physical and/or mental health status by a physician or physicians acceptable to the Medical Executive Committee and the affected physician as a prerequisite to further consideration of: (1) their application for appointment or reappointment, (2) their exercise of previously granted privileges, or (3) their maintenance of a Medical Staff appointment.

Section 2. Summary Suspension

Whenever there is a reasonable belief that a Member's conduct or condition requires that immediate action be taken to protect life or to reduce the likelihood of injury or damage to the health or safety of patients, workforce members, or others, summary action must be taken as to all or any portion of the Member's clinical privileges, and such action shall become effective immediately upon imposition.

The Chairperson of the Medical Executive Committee, the Medical Executive Committee itself, the Chief Medical Officer, Harris Health's Chief Medical Executive, or the Governing Body shall have the authority, whenever action must be taken immediately in the best interest of patient care, to suspend summarily all or any portion of the clinical privileges of a Medical Staff member, and such summary suspension shall become effective immediately upon imposition.

The Medical Staff member must be immediately notified by Special Notice from the Chief Medical Officer. A suspended member's patients must be assigned to another member by the applicable specialty, considering the wishes of the patient, where feasible, in choosing a substitute practitioner.

As soon as possible, but within ten (10) working days after a summary suspension is imposed, the Medical Executive Committee shall convene to review and consider the action taken. In its sole discretion, the Medical Executive Committee may provide the member the opportunity to meet with the Medical Executive Committee, which may recommend modification, continuation or termination of the terms of the suspension. A Medical Executive Committee recommendation to continue the extension or to take any other adverse action as defined in Article VII entitles the Medical Staff member, upon timely and proper request, to the procedural rights contained in Article VIII.

Section 3. Automatic Suspension

Occurrence of any of the following shall result in an automatic suspension as detailed. An automatic suspension is not considered a final action or an adverse recommendation or action but may be considered in any investigation or proceeding pursuant to Article VIII of these Bylaws.

- (1) Suspension, limitation or placement of a condition on a member's professional license by the state licensing board shall result in automatic suspension of the member's privileges until the Medical Executive Committee can assess whether the suspension, limitation, or condition will be adopted by the medical staff. As soon as possible, but no later than the tenth (10th) working day after the automatic suspension, the Medical Executive Committee shall convene to review and consider appropriate action.
- (2) Indictment of a member for a felony or indictment of any other criminal charges involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services shall result in automatic suspension of the member's privileges. As soon as possible, but no later than the tenth (10th) working day after the automatic suspension, the Medical Executive Committee shall convene to review and consider appropriate action.
- (3) Failure of the member to maintain current required licensure and certifications, as described in Article III, Section 2, shall result in automatic suspension of the member's privileges for up to thirty (30) days. The member's privileges will be reinstated once Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such actions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the actions as

appropriate. Failure to satisfy this requirement in thirty (30) days will result in a voluntary resignation of the member's privileges and require the submission of an initial credentialing application, which will be processed without preference. In certain circumstances, the Medical Executive Committee may approve an exception to this requirement.

Section 4. Administrative Suspension

- (1) Occurrence of any of the following shall result in an administrative suspension as detailed below. An administrative suspension is not considered a final action or an adverse recommendation or action and therefore, is not reportable or required to be disclosed in subsequent credentialing applications, but an administrative suspension may be considered in any investigation or proceeding pursuant to these Bylaws. Failure to satisfy requirements listed below in thirty (30) days after the administrative suspension will result in a voluntary resignation of the member's privileges and require the submission of an initial credentialing application, which will be processed without preference. In certain circumstances, the Chief Medical Officer, or designee, based on a recommendation from the Medical Executive Committee, may approve an exception to this requirement.
- (2) A member's delinquency in completion of medical records shall result in administrative suspension of the member's privileges and medical staff membership until Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such resolutions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the resolution as appropriate.

Section 5. Automatic Termination

Occurrence of any of the following shall result in an automatic termination as detailed. An Automatic termination is not considered an adverse recommendation or action but may be considered in any investigation or proceeding pursuant to these Bylaws.

- (1) Revocation of a physician's professional license by the Texas Medical Board shall cause all the member's clinical privileges and the medical staff membership to automatically terminate.
- (2) Conviction of or a guilty or nolo contendere plea to (including deferred adjudication) for a felony or conviction of or a guilty or nolo contendere plea to any other criminal charges involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services by a member shall result in automatic termination of the member's privileges and medical staff membership.
- (3) A member's privileges and staff membership shall automatically terminate if the member becomes an Ineligible Person as that term is defined in these Bylaws.
- (4) Loss of employment or contractual relationship with Harris Health, to provide clinical care in Correctional Health shall result in automatic termination of the Practitioner or APP's privileges and staff membership. However, if the loss of employment is related to the member's professional competence or conduct, such action is considered an adverse action pursuant to these Bylaws.
- (5) Failure to notify Medical Staff Services of the occurrence of any of the events listed in Article VII, Section 3 shall result in automatic termination of a member's privileges and medical staff membership.

- a. Notice

The member must be immediately notified by Special Notice from the Chief Medical Officer.

Section 6. Medical Administrative Positions

A Medical Staff member shall not lose staff privileges if his or her medical administrative position is terminated without following the hearing and appellate procedures as outlined in Article VIII.

ARTICLE VIII — PROCEDURAL RIGHTS OF REVIEW

Section 1. Events Giving Rise to Hearing Rights

a. Actions or Recommended Actions

Subject to the exceptions set forth in Section 1.c of this Article, the following actions or recommended actions, if deemed adverse under Section 1.b below, entitle the member (for purposes of this Article, the term “member” shall include an applicant to the Medical Staff whose application for Medical Staff appointment and clinical privileges has been denied) to a hearing upon timely and proper request as provided in Section 4:

- (1) Denial of initial Medical Staff appointment;
- (2) Denial of reappointment;
- (3) Suspension of appointment, provided that summary suspension entitles the member to request a hearing only as specified in this section;
- (4) Revocation of appointment;
- (5) Denial or restriction of requested clinical privileges;
- (6) Reduction in clinical privileges;
- (7) Suspension of clinical privileges, provided that summary suspension entitles the member to request a hearing only as specified in this section,
- (8) Revocation of clinical privileges;
- (9) Individual application of, or individual changes in, mandatory consultation or supervision requirement; or
- (10) Summary suspension of appointment or clinical privileges, if the recommendation of the Medical Executive Committee or action by the Governing Body is to continue the suspension or to take other action which would entitle the member to request a hearing under Section 4, provided that if the Medical Executive Committee initiates an investigation of the member in accordance with these Bylaws, no hearing rights shall accrue until the Medical Executive Committee had acted upon the report of the ad hoc committee.

b. When Deemed Adverse

Except as provided below, any action or recommended action listed in Section 1.a above is deemed adverse to the member only when it has been:

- (1) recommended by the Medical Executive Committee; or
- (2) taken by the Governing Body under circumstances where no prior right to request a hearing exists.

c. Exceptions to Hearing Rights

- (1) Certain Actions or Recommended Actions: Notwithstanding any provision in these

Bylaws, or in the Credentialing Procedures Manual to the contrary, the following actions or recommended actions do not entitle the member to a hearing:

- (a) the issuance of a verbal warning or formal letter of reprimand; the imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;
 - (b) the imposition of a probationary period involving review of cases;
 - (c) the imposition of a requirement for a proctor to be present at procedures performed by the member, provided that there is no requirement for the proctor to grant approval prior to provision of care;
 - (d) the removal of a Practitioner from a medical administrative office within the hospital unless a contract or employment arrangement provides otherwise; and
 - (e) any other action or recommended action not listed in Section 1.a above.
- (2) Other Situations: An action or recommended action listed in Section 1.a above does not entitle the applicant or member to a hearing when it is:
- (a) voluntarily imposed or accepted by the Practitioner;
 - (b) automatic pursuant to any provision of these Bylaws and related manuals;
 - (c) taken or recommended with respect to temporary privileges, unless the action must be reported to the National Practitioner Data Bank.

Section 2. Notice of Adverse Action

- a. Correctional Health shall, within fifteen (15) days of receiving written notice of an adverse action or recommended action under Section 1.a, give the Practitioner Special Notice thereof. The notice shall:
- (1) advise the Practitioner of the nature of and reasons for the proposed action and of his or her right to mediation or a hearing upon timely and proper request pursuant to Section 3 and/or Section 4 of this Article VIII;
 - (2) specify that the Practitioner has thirty (30) days after receiving the notice within which to submit a request for mediation or a hearing and that the request must satisfy the conditions of Section 3 and/or Section 4;
 - (3) state that failure to request mediation or a hearing within that time period and in the proper manner constitutes a waiver of rights to mediation or a hearing and to an appellate review on the matter that is the subject of the notice;
 - (4) state that any higher authority required or permitted under this Article to act on the matter following a waiver is not bound by the adverse action or recommended action that the Practitioner has accepted by virtue of the waiver but may take whatever action, whether more or less severe, it deems warranted by the circumstances;
 - (5) state that upon receipt of his mediation or hearing request, the Practitioner will be notified of the date, time, and place of the hearing, and the grounds upon which the adverse recommendation or action is based; and
 - (6) provide a brief summary of the rights the Practitioner would have at a hearing, as set forth in Sections 12-14 of this Article.

Section 3. Request for Mediation

- a. Within ten (10) days of receipt of the notice of adverse recommendations giving rise to hearing rights, an affected member may file a written request for mediation. The request must be delivered by Special Notice to the Chief Medical Officer and state the reason the member believes mediation is desirable. If a hearing has already been scheduled, mediation must be completed prior to the date of the hearing. If no hearing has been scheduled, the mediation must take place within 45 days of receipt of the request. Under no circumstances will a hearing be delayed beyond the originally scheduled date unless both parties agree to a continuance to a date certain.
- b. The mediator shall be selected by the Chairperson of the Medical Executive Committee and must have the qualifications required by state law and experience in medical staff privileging and disputes.
- c. The fee of the mediator shall be shared equally among the parties.
- d. An individual shall be appointed by the Chairperson of the Medical Executive Committee to participate in the mediation and represent the Medical Executive Committee. The affected member and the representative of the Medical Executive Committee may each be accompanied in the mediation by counsel of their choice.
- e. Under no circumstances may the mediation delay the filing of any report required by law, or result in an agreement to take any action not permitted by law. No agreement arising out of the mediation may permit or require the Medical Executive Committee, the Governing Body, or Harris Health to violate any legal requirement, accreditation requirement or any requirement of these Bylaws.
- f. If no resolution is reached through the mediation, a hearing must be scheduled no later than forty-five (45) days following the mediation, unless otherwise agreed by the parties.

Section 4. Request for Hearing

The Practitioner shall have thirty (30) days after receiving the above notice to file a written request for a hearing. The request must be delivered to the Chief Medical Officer by Special Notice.

Section 5. Waiver by Failure to Request a Hearing

A member who fails to request a hearing within the time and in the manner specified in Section 4 above waives his or her right to any hearing and appellate review to which he or she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse action or recommended action triggering the Section 2 notice. The Chief Medical Officer shall as soon as reasonably and practicably send the member Special Notice of each action taken under any of the following Sections and shall notify the Chairperson of the Medical Executive Committee of each such action. The effect of a waiver is as follows:

- a. Adverse Action by the Governing Body

A waiver constitutes acceptance of the adverse action, which immediately becomes the final decision of the Governing Body.
- b. Adverse Recommendation by the Medical Executive Committee

A waiver constitutes acceptance of the adverse recommendation, which becomes effective immediately and remains so pending the decision of the Governing Body. The Governing Body shall consider the adverse recommendation as soon as practicable following the waiver but at least at its next regularly scheduled meeting. Its action has the following effect:

 - (1) If the Governing Body's action accords in all respects with the Medical Executive Committee recommendation, the Governing Body decision becomes effective

immediately.

- (2) If, on the basis of the same information and material considered by the Medical Executive Committee in formulating its recommendation, the Governing Body proposes a more severe adverse action, the member shall be entitled to a hearing.

Section 6. Additional Information Obtained Following Waiver

When, in considering an adverse Medical Executive Committee recommendation transmitted to it under Section 5.b of this Article VIII, the Governing Body acquires or is informed of additional relevant information not available to or considered by the Medical Executive Committee, the Governing Body shall refer the matter back to the Medical Executive Committee for reconsideration within a set time limit. If the source of the additional information referred to in this Section is the member or an individual or group functioning, directly or indirectly, on his or her behalf, the provisions of this Section shall not apply unless the member demonstrates to the satisfaction of the Medical Executive Committee that the information was not reasonably discoverable in time for presentation to and consideration by the party taking the initial adverse action.

- a. If the Medical Executive Committee's recommendation following reconsideration is unchanged, the Governing Body shall act on the matter as provided in Section 5.b. of this Article.
- b. If the Medical Executive Committee's recommendation following reconsideration is still adverse but is more severe than the action originally recommended, it is deemed a new adverse recommendation pursuant to these Bylaws and the matter proceeds as such.
- c. A favorable Medical Executive Committee recommendation following reconsideration shall be forwarded as soon as reasonably practicable to the Governing Body by the Chief Medical Officer. The effect of the Governing Body action is as follows:
 - (1) Favorable: Favorable Governing Body action on a favorable Medical Executive Committee recommendation becomes effective immediately.
 - (2) Adverse: If the Governing Body's action is adverse, the member shall be entitled to a hearing.

Section 7. Notice of Time and Place for Hearing

The Chief Medical Officer shall deliver a timely and proper request for a hearing to the Chair of the Medical Executive Committee or Chairperson of the Governing Body, depending on whose recommendation or action prompted the hearing request. The Chairperson of the Medical Executive Committee or the Chairperson of the Governing Body, as appropriate, shall then schedule a hearing. Hearings held by the Governing Body or any committee of the Governing Body under this Article of these Bylaws will be closed meetings pursuant to Chapter 151 of the Texas Occupations Code and Section 161.032 of the Texas Health & Safety Code. The hearing date shall be set for as soon as practicable after the Chief Medical Officer received the request but, in any event, no more than forty-five (45) days thereafter. The Chief Medical Officer shall send the member Special Notice of the time, place, and date of the hearing, and the identity of the hearing committee members or hearing officer not less than thirty (30) days from the date of the hearing. The notice provided to the member shall contain a list of the witnesses, if any, expected to testify at the hearing on behalf of the Medical Executive Committee or Governing Body, whichever is appropriate. The member must provide a list of the witnesses expected to testify on his behalf within ten (10) days of this notice. If the member is under suspension, he or she may request that the hearing be held not later than twenty (20) days after the Chief Medical Officer has received the hearing request. The Chief Medical Officer may grant the member's request after

consultation with the Chairperson of the Medical Executive Committee or Chairperson of the Governing Body. If the member does not in good faith cooperate in scheduling a hearing date, and as a result, a hearing has not been scheduled within ninety (90) days from the date of the first proposal for a hearing date by the Medical Executive Committee or Chairperson of the Governing Body, the member shall be deemed to have waived the member's right to a hearing in accordance with this Article, Section 5, unless both parties agree to a delayed hearing date.

The notice of hearing shall contain a concise statement of the member's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.

Section 8. Appointment of Hearing Committee or Hearing Officer

a. By Medical Staff

A hearing occasioned by an adverse Medical Executive Committee recommendation shall be conducted by a hearing committee appointed by the Chairperson of the Medical Executive Committee and composed of at least three (3) members of the Medical Staff. The Chairperson of the Medical Executive Committee shall designate one of the appointees as Chairperson of the committee.

b. By the Governing Body

A hearing occasioned by an adverse action of the Governing Body shall be conducted by a hearing committee appointed by the Chairperson of the Governing Body and composed of at least three (3) persons, including at least two (2) medical staff members when feasible. The Chairperson of the Governing Body shall designate one appointee as Chairperson of the committee.

c. Service on Hearing Committee

An individual shall not be disqualified from serving on a hearing committee merely because he or she has heard the case or has knowledge of the facts involved or what he or she supposes the facts to be. Any member of the Hearing Committee shall not be in direct economic competition with the member involved. Direct economic competition may not be shown based solely on the member's medical school affiliation. Within ten (10) days of receipt of the Notice of Hearing, the member under review may submit a written challenge to a member of the hearing panel, specifying the manner in which the hearing committee member is deemed to be disqualified along with supporting facts and circumstances. The Medical Executive Committee or Governing Body, as appropriate, shall consider and rule on the challenge.

d. Hearing Officer in Lieu of Hearing Committee

Subject to the approval of the Governing Body, the Medical Executive Committee may determine that the hearing will be conducted in front of a hearing officer to be appointed by the Medical Executive Committee. This officer shall not be in direct economic competition with the member involved. The term "hearing officer" as used in this Section VIII.d shall be used to refer to a hearing officer who is appointed in lieu of a Hearing Committee and shall not refer to an appointed presiding officer of a Hearing Committee, provided, however, that a presiding officer still may be appointed. The decision of a Hearing Officer appointed in lieu of a Hearing Committee shall have the same force and effect as a decision by the Hearing Committee.

Section 9. Final List of Witnesses

The witness lists required in Section 7 of this Article shall be amended as soon as possible by the appropriate party when additional witnesses are identified. The final list of witnesses must be submitted to the Presiding Officer and exchanged by the member and the Medical Executive Committee or the Governing Body, as appropriate, no later than seven (7) days prior to the hearing. Failure of a party to comply with this requirement shall constitute good cause for the Presiding Officer to grant a continuance or otherwise limit the testimony of witnesses not disclosed within the required timeframe.

Section 10 Documents

All documents the parties plan to introduce into evidence at the hearing must be submitted to the Presiding Officer and exchanged by the member and the Medical Executive Committee or the Governing Body, as appropriate, no later than seven (7) days prior to the hearing. Failure of a party to comply with this requirement shall constitute good cause for the Presiding Officer to grant a continuance or otherwise limit the introduction into evidence of documents not produced within the required timeframe.

Section 11 Personal Presence

The personal presence of the member is required throughout the hearing, unless the member's presence is excused for any specified time by the hearing committee. The presence of the member's representative does not substitute for the personal presence of the member. A member who fails, without good cause, to be present throughout the hearing unless excused or who fails to proceed at the hearing in accordance with this Article of these Bylaws shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Sections 4 and 5 of this Article, if applicable.

Section 12 Presiding Officer

The hearing officer, if appointed pursuant to this Article of these Bylaws, or if not appointed, the hearing committee Chairperson, shall be the Presiding Officer. The Presiding Officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant evidence. He or she shall determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence. The presiding officer shall not act as a prosecuting officer or as an advocate to any party to the hearing. If a hearing officer is appointed, he or she shall not be entitled to vote. If the Chairperson of the hearing committee serves as the presiding officer, he or she shall be entitled to vote.

Section 13 Representation

The member may be represented at the hearing by a member of the Medical Staff in good standing, a member of his or her local professional society, or an attorney of his or her choice. The Medical Executive Committee or Governing Body, depending on whose recommendation or action prompted the hearing, shall designate a medical staff member to support its recommendation or action and, in addition, may appoint an attorney to represent it.

Section 14 Rights of Parties

During the hearing, each party shall have the following rights, which shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

- (1) provide an opening statement no longer than 5 minutes each;

- (2) call and examine witnesses;
- (3) introduce exhibits;
- (4) cross-examine any witness on any matter relevant to the issues;
- (5) impeach any witness; and
- (6) rebut any evidence.

If the member does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

Section 15 Procedure and Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. In the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to, during, or at the close of the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. Written memoranda, if any, must be presented to the presiding officer, and a copy must be provided to the other party. The hearing committee may ask questions of the witnesses, call additional witnesses, or request documentary evidence if it deems it is appropriate.

Section 16 Official Notice

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Texas. Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Either party shall have the opportunity to request that a matter be officially noticed and to refute the officially noticed matters by written or oral presentation of authority, in a manner to be determined by the hearing committee. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

Section 17 Burden of Proof

The body whose adverse action or recommended action occasioned the hearing shall have the burden of coming forward with evidence in support thereof. Thereafter, the member shall have the burden of coming forward with evidence and proving by clear and convincing evidence that the adverse action or recommended action lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

Section 18 Hearing Record

A court reporter shall be used to record the hearing, although those giving testimony need not be sworn by said reporter. The court reporter shall transcribe the hearing and submit a written copy to the presiding officer within 10 business days after adjournment of the hearing for his/her review. The presiding officer shall return any noted corrections to the court reporter within 7 days. The member may within ten days after the hearing's adjournment also request a copy of the hearing report upon payment of any reasonable costs associated with the preparation of said report and in such event may review the hearing report and return any noted corrections to the court reporter within 7 days. If the member fails to request a copy of the hearing report or if the hearing report is not returned in 7 days, the right to make any changes is waived.

Section 19 Postponement

Requests for postponement or continuance of a hearing may be granted by the presiding officer or hearing committee only upon a timely showing of good cause.

Section 20 Presence of Hearing Committee Members and Vote

A majority of the hearing committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing or deliberations, the presiding officer, in his or her discretion, may rule that such member may not participate further in the hearing or deliberations or in the decision of the hearing committee.

Section 21 Recesses and Adjournment

The hearing committee may recess and reconvene the hearing without Special Notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

Section 22 Hearing Committee Report

Within twenty (20) days after adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations with such reference to the hearing record and other considered documentation as it deems appropriate. The hearing committee shall forward the report to the body whose adverse action or recommended action occasioned the hearing. The member shall also be given a copy of the report by Special Notice. The hearing record and other documentation shall be transmitted to the Medical Staff Office for safekeeping as official records and minutes of the Medical Staff and shall be made available for review by any party between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday, excluding holidays.

Section 23 Action on Hearing Committee Report

Within thirty (30) days after receiving the hearing committee report, the body whose adverse action or recommended action occasioned the hearing shall consider said report and affirm, modify, or reverse its action or recommended action. It shall transmit the result to the Chief Medical Officer.

Section 24 Notice and Effect of Result

a. Notice

As soon as is reasonably practicable, the Chief Medical Officer shall send a copy of the result to the member by Special Notice and to the Chairperson of the Medical Executive Committee.

b. Effect of Favorable Result

- (1) Adopted by the Governing Body: If the Governing Body's determination is favorable to the member, it shall become effective immediately.
- (2) Adopted by the Medical Executive Committee: If the Medical Executive Committee result is favorable to the member, the Chief Medical Officer shall, as soon as is reasonably practicable, forward it to the Governing Body which may adopt or reject the result in whole or in part, or refer the matter back to the Medical Executive Committee for further reconsideration. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made,

and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Governing Body shall take action. Favorable action to the member by the Governing Body shall become effective immediately.

c. **Effect of Adverse Result**

If the hearing results in an adverse recommendation, the member shall receive Special Notice of his or her right to request appellate review.

Section 25 Request for Appellate Review

A member shall have thirty (30) days after receiving Special Notice of an adverse result to file a written request for an appellate review. The request must be delivered to the Chief Medical Officer by Special Notice.

Section 26 Waiver by Failure to Request Appellate Review

A member who fails to request an appellate review within the time and in the manner specified in Section 25 of this Article shall have waived any right to a review. The waiver has the same force and effect as provided in Sections 5 and 6 of this Article, if applicable.

Section 27 Notice of Time and Place for Appellate Review

The Chief Medical Officer shall deliver a timely and proper request for appellate review to the Chairperson of the Governing Body. As soon as practicable, said Chairperson shall schedule an appellate review to commence not less than thirty (30) days nor more than sixty (60) days after the Chief Medical Officer received the request. If the member is under suspension, he or she may request that the appellate review be held not later than twenty (20) days after the Chief Medical Officer has received the appellate review request. The Chief Medical Officer may grant the member's request after consultation with the Chairperson of the Medical Executive Committee or Governing Body. At least thirty (30) days prior to the appellate review, the Chief Medical Officer shall send the member Special Notice of the time, place, and date of the review. The time for appellate review may be extended by the Chairperson of the Governing Body for good cause.

Section 28 Appellate Review Body

The appellate review may be conducted by the Governing Body. The Chairperson of the Governing Body will appoint a committee consisting of three (3) to nine (9) members of the Governing Body to hear the appeal, including at least one (1) physician. The Chairperson shall designate one of the members as Chairperson.

Section 29 Nature of Proceedings

The proceedings by the review body are a review based upon the hearing record, the hearing committee's report, all subsequent results and actions, the written statements, if any, provided below, and any other material that may be presented and accepted. The presiding officer shall direct the Medical Staff Office to make the hearing record and hearing committee report available at the appellate review for use by any party. The review body shall determine whether the foregoing evidence demonstrates that the member has met the applicable burden of proof as required under Section 17 of this Article.

Section 30 Written Statements

The member may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he or she disagrees and his or her reasons. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review body and to the group whose adverse action or recommended action occasioned the review through the Chief Medical Officer at least five (5) days prior to the scheduled date of the review, except if the time limit is waived by the review body or its presiding officer. A similar statement may be submitted by the body whose adverse action or recommended action occasioned the review, and if submitted, the Chief Medical Officer shall provide a copy to the member and to the appellate review body at least ten (10) days prior to the scheduled date of the appellate review.

Section 31 Presiding Officer

The Chairperson of the appellate review body is the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

Section 32 Oral Statement

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative appearing shall be required to answer questions put by any member of the review body.

Section 33 Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only at the discretion of the review body and only if the party requesting consideration of the matter or evidence demonstrates to the satisfaction of the review body that it could not have been discovered in time for the initial hearing. The requesting party shall provide, through the Chief Medical Officer, a written, substantive description of the matter or evidence to the appellate review body and the other party prior to its being introduced at the review. Any such new or additional matters or evidence shall be subject to the same rights of cross-examination, impeachment, and rebuttal provided at the hearing pursuant to Section 14 of this Article.

Section 34 Powers

The appellate review body has all the powers granted to the hearing committee, and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibilities.

Section 35 Presence of Members and Vote

A majority of the members of the review body must be present throughout the appellate review and deliberations. If a member is absent from any part of the proceedings, the presiding officer of the appellate review may, in his discretion, rule that said member shall not be permitted to participate further in the review or deliberations or in the decision of the review body.

Section 36 Recesses and Adjournments

The review body may recess and reconvene the proceedings without Special Notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if allowed, the appellate review shall be adjourned. The review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

Section 37 Action Taken

Within thirty (30) days after adjournment pursuant to this Article, the review body shall prepare its report and conclusion with the result as provided below. The Chief Medical Officer shall send notice of each action taken under Section 22 of this Article below to the Chairperson of the Medical Executive Committee for transmittal to the appropriate Staff authorities and to the member by Special Notice.

a. **Governing Body Decision**

- (1) Within fifteen (15) days after adjournment, appellate review body shall make its decision, including a statement of the basis of the decision. The appellate review body may decide:
 - (a) that the adverse recommendation be affirmed;
 - (b) that the adverse recommendation be denied;
 - (c) that the matter be the subject of further hearing or other appropriate procedures within a specified time period; or
 - (d) that modification of the adverse recommendation be made so that it is no longer unreasonable, arbitrary, capricious, or discriminatory.

If the appellate review body finds that the procedures were substantially complied with and that the adverse recommendation which is the subject of the appeal was not unreasonable, arbitrary, capricious, discriminatory, or lacking in basis, it shall affirm the adverse recommendation in its decision.

- (2) A majority vote of the members of the appellate review body authorized to vote is required for an adverse decision.
- (3) The decision of the appellate review body on behalf of the Governing Body shall be effective upon the date of such decision, unless reversed or modified by the Governing Body within thirty (30) days.
- (4) A copy of the appellate review body's decision shall be sent to the member by Special Notice within five (5) days following its decision.

Section 38 Hearing Officer Appointment and Duties

The use of a hearing officer to preside at the evidentiary hearing is optional and is to be determined by, and the actual officer if any to be used is to be selected by the Chairperson of the Medical Executive Committee in conjunction with the Chief Medical Officer. A hearing officer may or may not be an attorney at law, but must be experienced in and recognized for conducting Medical Staff hearings in an orderly, efficient, and non-partisan manner.

Section 39 Number of Hearings and Reviews

Notwithstanding any other provision of these Bylaws, no member shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse action or recommended action giving use to the right.

Section 40 Release

By requesting a hearing or appellate review under this Article, a member agrees to be bound by the provisions of Article VII of these Bylaws.

ARTICLE IX – CHIEF MEDICAL OFFICER

Section 1. Appointment

The Chief Medical Officer shall be an employee of Harris Health.

Section 2. Responsibilities

The Chief Medical Officer is invested with the following duties and prerogatives, which he may perform personally or delegate to appropriate members of his or her leadership team:

1. Call and preside over Quality Improvement (QI) meetings.
2. Facilitate adherence of the Medical Staff of these Bylaws.
3. Be chief spokesperson and enunciator of policy for the Medical Staff.
4. Monitor adherence to policies with respect to patient rights.
5. Assist in arranging for an appropriately trained, professional staff capable of providing safe, efficient, quality patient care.
6. Assist in developing a structure that clearly delineates the authority and responsibility of the Medical Staff within the organization.
7. Take the initiative in developing, on behalf of the Medical Staff, appropriate policies and procedures for the safe, effective conduct of business and provision of patient care; and review all clinical policies and procedures.
8. Take the initiative in developing, on behalf of the Medical Staff, and overseeing Quality Improvement, Risk Management, and Peer Review programs in accordance with applicable standards.
9. Assist in arranging for ancillary services including laboratory, radiology, and pathology services.
10. Carry out all other duties specifically entrusted to him/her by the Medical Executive Committee, Governing Body, or any other provision of these Bylaws.

ARTICLE X — COMMITTEES

The Governing Body or Chief Medical Officer, may establish such committees as are necessary to fulfill the functions of Correctional Health.

Unless otherwise specified in these Bylaws or at the time of selection or appointment of a Committee, non-medical staff members of a committee shall serve in an ex-officio capacity without a vote.

Committees of the Medical Staff described in these Bylaws all function as “medical committees” and/or “medical peer review committees” pursuant to state law. Each committee’s records and proceedings are, therefore, confidential, legally privileged, and protected from discovery under certain circumstances.

The function that the committee performs determines the protected status of its activities. Information is protected by the privilege if it is sought out or brought to the attention of the medical committee and/or medical peer review committee for purposes of an investigation, review, or other deliberative proceeding. Medical peer review activities include the evaluation of medical and health care services, including the evaluation of the qualifications of professional health care practitioners and of patient care provided by those practitioners. These review activities include evaluating the merits of complaints involving health-care practitioners, and determinations or recommendations regarding those complaints. The medical peer review privilege applies to records and proceedings of the committee, and oral and written communications made to a medical peer review committee when engaged in medical peer review activities. Medical committee activities also include the evaluation of medical and health care services. The medical committee privilege protection extends to the minutes of meetings, correspondence between committee members relating to the deliberative process, and any final committee product, such as any

recommendation or determination.

In order to protect the confidential nature of the quality and peer review activities conducted by the committee, the committee's records and proceedings must be used only in the exercise of proper medical committee and/or medical peer review functions to be protected as described herein. Therefore, committee meetings must be limited to only the committee members and invited guests who need to attend the meetings. The committee must meet in executive session when discussing and evaluating the qualifications and professional conduct of professional health care practitioners and patient care provided by those practitioners. At the beginning of each meeting, the committee members and invited guests must be advised that the records and proceedings must be held in strict confidence and not used or disclosed other than in committee meetings, without prior approval from the Chair of the committee. Documents prepared by or considered by committee in the committee meetings must clearly indicate that they are not to be copied, are solely for use by the committee, and are privileged and confidential.

The records and proceedings of the Correctional Health and/or Harris Health departments **that support** the quality and peer review functions of a committee, such as the Patient Safety/Risk Management and Quality Program departments are also confidential, legally privileged, and protected from discovery, if the records are prepared by or at the direction of the committee, and are not kept in the ordinary course of business. Routine administrative records prepared by Correctional Health in the ordinary course of business are not legally privileged or protected from discovery. Documents that are gratuitously submitted to the committee, or which have been created without committee impetus and purpose, are also not protected.

Section 1. The Medical Executive Committee

a. Membership

All Medical Staff members are eligible for membership on the Medical Executive Committee. The Chief Medical Officer shall serve as the Chair of the Medical Executive Committee.

b. Voting Members

The Medical Executive Committee shall consist of five (5) members of the Medical Staff, including the Chief Medical Officer.

c. Election of Voting Members

Voting members of the Medical Executive Committee will be elected every two (2) years. Nominations and voting will occur at the beginning of the first Medical Executive Committee meeting of the new term. In the event a voting member is unable to complete his or her term, a special election will occur at the next Medical Executive Committee to fill the position.

d. Ex-officio Non-Voting Members:

- (1) Harris Health President & Chief Executive Officer;
- (2) Harris Health Chief Strategy Officer; and
- (3) Harris Health Chief Medical Executive.

e. Invited Guests

At the request of a committee member, non-voting guests may attend meetings of the Medical Executive Committee.

f. Duties

- (1) Report to the Governing Body on all evaluation, monitoring and recommendations

regarding the appropriateness and quality of health care services rendered to the patients;

- (2) Review, investigate, and make recommendations on matters relating to the professional competence and conduct of Practitioners and APPs, including the merits of complaints and appropriate corrective action;
- (3) Represent and act on behalf of the Medical Staff and APPs between meetings, subject to such limitations imposed by these Bylaws;
- (4) Coordinate the activities of and initiate and implement general policies applicable to the Medical Staff;
- (5) Receive and act upon committee reports;
- (6) Act as the liaison between the Medical Staff and the Governing Body;
- (7) Periodically review all information available concerning the performance and clinical competence of Practitioners and APPs with clinical privileges and make recommendations for reappointment or changes in clinical privileges;
- (8) Take all reasonable steps to ensure professional, ethical conduct and competent clinical performance on the part of the Practitioners and APPs with clinical privileges;
- (9) Review credentials of all applicants to the Medical Staff, as well as APPs, make recommendations on initial appointment and reappointment to the medical staff, and delineate clinical privileges;
- (10) Perform appropriate functions related to quality assessment and improvement, medical records, infection control, medical staff utilization, pharmacy and therapeutics, and other such functions; and
- (11) Perform other duties as requested by the Governing Body.
- (12) Monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;
- (13) Work with Service Chiefs to disseminate educational lessons learned from the review of cases pursuant to the Professional Practice Evaluation (PPE) Policy, either through peer learning sessions in the Service or through some other mechanism
- (14) Educating the Correctional Health Medical Staff and other Correctional Health staff regarding illness and impairment recognition issues specific to Practitioners and APPs;
- (15) Encourage self-reporting by Practitioners and APPs and referral by other members of the Correctional Health Medical Staff
- (16) Determining the best avenue of referral to care for a Practitioner or APP;
- (17) Monitoring the progress of an affected Practitioner or APP until the rehabilitation process is complete
- (18) Reporting to the Correctional Health Medical Director or their designee, instances when there is evidence that a Practitioner or APP represents a clear and imminent danger to self, others, or patients.

ARTICLE XI— IMMUNITY FROM LIABILITY

The following shall be express conditions to any Medical Staff member's application for clinical privileges within Correctional Health:

Condition 1.

Any act, communication, report, recommendation, or disclosure, with respect to any such Medical Staff member performed, or made in good faith and without malice, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged and immune from liability to the fullest extent permitted by law.

Condition 2.

All such privileges and immunities shall extend to members of Correctional Health Medical Staff and of its Governing Body, its other Practitioners, its Chief Medical Officer and his or her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term “third parties” means both individuals and organizations who provide information to an authorized representative of the Governing Body or of the Medical Staff.

Condition 3.

There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Condition 4.

All such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities, including, but not limited to:

- a. Applications for appointment or clinical privileges;
- b. Periodic reappraisals for reappointment or clinical privileges;
- c. Corrective action, including summary suspension;
- d. Hearings and appellate reviews;
- e. Medical care evaluations;
- f. Utilization reviews; and
- g. Other activities related to quality patient care and inter-professional conduct.

Condition 5.

The acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a Medical Staff member's professional qualifications, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Condition 6.

Each Medical Staff member shall, upon request, execute a release in favor of the entities identified in the Second paragraph of this Section and consistent with the provisions of this Article.

ARTICLE XII — CONFLICTS OF INTEREST

Section 1. Definitions

Conflicts of Interest – A conflict of interest potentially exists when a Medical Staff member, or a relative, has direct or indirect interests, including financial and personal interests, or business transactions or professional activities, that may compromise or appear to compromise: (1) the Medical Staff member's clinical judgment; (2) the delivery of patient care; or (3) the Medical Staff member's ability to fulfill his or her Medical Staff obligations.

Section 2. Compliance

Medical Staff members must comply with the Conflict of Interest policies of their affiliated organization (e.g., Harris Health).

Section 3. Disclosure of Potential Conflict of Interest

- a. Medical Staff member shall have a duty to disclose any conflict of interest when such interest is relevant to a matter of action (including a recommendation to Harris Health Administration or the Governing Body) being considered by a committee, department or other body of the Medical Staff. In a Medical Staff member's dealings with and on behalf of Correctional Health, the Medical Staff member shall be held to a strict rule of honest and fair dealing with Correctional Health. The Medical Staff member shall not use his or her position, or knowledge gained there from, so that a conflict might arise between the interests of Correctional Health and those of the Medical Staff member.
- b. As a matter of procedure, the Chairperson of the Medical Staff committee or other body designated to consider a matter that may lead to the provision of items, services or facilities to Correctional Health by a third party or the establishment of a business relationship between a third party and Correctional Health shall inquire, prior to any discussion of the matter, whether any Medical Staff member has a conflict of interest. The existence of a potential conflict of interest on the part of any committee member may be called to the attention of the committee Chairperson by any Medical Staff member with knowledge of the matter.
- c. Any Medical Staff member with a conflict of interest on any matter should not vote or use his or her personal influence regarding the matter, and he or she should not be counted in determining the quorum for the body taking action or making a recommendation to the Governing Body. The minutes of that meeting should reflect that a disclosure was made, the abstention from voting, and the quorum situation.
- d. The foregoing requirements should not be construed as preventing the Medical Staff member from briefly stating his or her position in the matter, nor from answering pertinent questions by the Governing Body or other Medical Staff members since his or her knowledge may be of great assistance.

ARTICLE XIII — CREDENTIALING POLICIES AND PROCEDURES

The Medical Staff shall adopt a Medical Staff Credentialing Procedures Manual as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner and APP in Correctional Health. Such Medical Staff Credentialing Procedures Manual shall be a part of these Bylaws, except that the Manual may be amended or repealed without previous notice at any general meeting of Medical Staff, or by the Medical Executive Committee or at any special Medical Staff meeting on notice, provided a quorum is present. A majority vote of those present shall be required for amendment or repeal.

ARTICLE XIV — AMENDMENTS

Section 1. Amendment Process

- a. Amendment(s) to the Bylaws may be proposed at any meeting of the Medical Executive Committee.

- b. All proposed amendments to the Bylaws approved by the Medical Executive Committee shall be submitted to the members of the Active Medical Staff for approval. The proposed amendment(s) to be adopted shall require a majority vote of the Active Medical Staff voting on the proposed amendment. Proposed Bylaws may be voted on at any regular or special meeting of the Medical Staff or submitted to the members of the Active Medical Staff for vote by written or electronic ballot, as approved by the Medical Executive Committee. Notice of such regular or special meeting shall be made at least fifteen (15) days in advance and shall include the Bylaws amendment(s) to be voted upon.
- c. Bylaws Amendment(s) approved by the Medical Executive Committee and the Medical Staff shall be forwarded to the Governing Body, which shall approve, disapprove or approve with modifications. If the Governing Body modifies any Bylaw amendments approved by the Medical Executive Committee and the Medical Staff, such amendments, as modified, shall be returned to the Medical Executive Committee, which may accept or reject the modifications. If the Medical Executive Committee accepts the modifications, the amendment shall be submitted to the members of the Active Medical Staff for approval or disapproval as described in Section (b) above. If the Medical Executive Committee rejects the modification, the amendment shall be submitted again to the Governing Body, which may either approve or disapprove the amendment. Any disputes regarding proposed bylaws amendments shall be referred to the Joint Conference Committee for discussion and further recommendation to the Medical Executive Committee and the Governing Body.
- d. Bylaws Amendments may also be proposed to the Governing Body by the Medical Staff by majority vote of the members of the Active Medical Staff voting on the proposed amendment. Proposed Bylaws shall be brought before the Active Medical Staff by petition signed by 20% of the members of the Active Staff. Any such proposed Bylaw amendment shall be submitted to the Medical Executive Committee for review and comment before it is submitted to the voting members of the Active Medical Staff. Any Bylaw amendment approved by a majority of the Active Medical Staff shall be presented to the Governing Body for final action along with any comments from the Medical Executive Committee.
- e. These Bylaws, and all amendments thereto, shall be effective when approved by the Governing Body, unless otherwise stated in the Bylaw provision or amendment approved by the Governing Body, and shall apply to all pending matters to the extent practical, unless the Governing Body directs otherwise.
- f. These Bylaws shall not be unilaterally amended by the Governing Body or the Medical Staff.

Section 2. Editorial Amendments

Notwithstanding Section 1 of this Article, Medical Staff Services shall have the authority to make non-substantive editorial changes to the Bylaws and to correct any typographical, formatting, and inadvertent errors.

Section 3. Review Process

These Bylaws shall be reviewed at least annually and amendments made according to the described amendment procedure.

ARTICLE XV — PARLIAMENTARY PROCEDURES

Where these Bylaws do not conflict, *Robert's Rules of Order* shall be used in the conduct of Medical Staff meetings.

ARTICLE XVI — CONFLICT MANAGEMENT

A conflict management process shall be developed and implemented when a conflict arises between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt provisions of, or amendments to, the Rules and Regulations or these Bylaws. The conflict management process shall include a meeting between the involved parties as early as possible to identify the conflict, gathering information about the conflict, working with all parties to manage and, to the extent possible, resolve the conflict, and ultimately protect patient safety and quality of care. As necessary, the Chief Medical Officer shall appoint an individual to act as mediator between the groups in an effort to resolve the conflict. The Governing Body shall have the ultimate discretion to determine an effective resolution to any conflict between the Medical Staff and the Medical Executive Committee, should the parties not be able to come to a resolution. The Governing Body shall regularly review whether the process is effective at managing conflict and shall revise the process as necessary.

ARTICLE XVII - ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Medical Executive Committee, shall replace any previous Bylaws, and shall become effective when approved by the Governing Body, unless a specific effective date is listed below.

APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE OF CORRECTIONAL HEALTH:

Otis Ekins, MD
Chief Medical Officer
Chair, Medical Executive Committee

APPROVED BY THE GOVERNING BODY OF HARRIS COUNTY HOSPITAL DISTRICT D/B/A HARRIS HEALTH:

Andrea Caracostis, MD
Chair, Governing Body

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Harris Health Strategic Plan Initiatives

A recent version of the 2026 Strategic Plan Initiatives calendar is attached for your review.



Maria M. Cowles
EVP, Chief Strategy Officer and Chief of Staff

Harris Health Strategic Plan Initiatives

2026 Board Meeting Strategic Discussion Timeline*												
Strategic Pillar	JAN 2026	FEB 2026	MAR 2026	APR 2026	MAY 2026	JUN 2026	JUL 2026	AUG 2026	SEP 2026	OCT 2026	NOV 2026	DEC 2026
Pillar 1: Quality & Patient Safety												
<i>Quality & Leapfrog Update</i>						✓						
Pillar 2: People												
<i>Retention, Workplace Safety, and/or Comm. Partnerships</i>					✓							
Pillar 3: Resiliency												
<i>Compliance Education</i>										X		
<i>Legislative Agenda</i>										X		
Pillar 4: Health Promotion & Disease Prevention												
<i>Disease Prevention</i>								✓				
Pillar 5: System Optimization												
<i>Strategic Capital and Financial Plan</i>		✓			✓				✓			X
<i>Holly Hall Project and LBJ Buildout Facilities Update</i>								✓				
<i>Big Rocks</i>						✓						
<i>Enterprise Risk Management</i>									✓			
<i>AI Update</i>										X		
<i>Pharmacy Update</i>									✓			
<i>Sustainability</i>												X
Pillar 6: Access												
<i>Harris Collaborative</i>					✓							
<i>ACS Facilities Strategic Plan</i>	✓					✓						
<i>Financial Assistance and Eligibility Programs Overview</i>		✓										
<i>ACS Community Partnerships</i>							✓					
<i>LBJ Oncology Scope of Service</i>										X		

*Subject to Change

*Denotes topic was presented ✓

Revised: 9.28.26
*Denotes upcoming topic X

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Discussion Regarding the 90th Texas Legislature and Consideration of Approval of a
Resolution Adopting Harris Health's Legislative Platform



R. King Hillier
SVP, Public Policy & Government Relations

STATE OF TEXAS
COUNTY OF HARRIS

MOTION NO. _____

On October 14, 2026, the Harris County Hospital District d/b/a 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	☐	☐
Carol Paret, BS	Vice Chair	☐	☐
Libby Viera-Bland, AICP	Secretary	☐	☐
Ingrid Robinson, MBA	Board Member	☐	☐
Marlen Trujillo, PhD, MBA, CHW	Board Member	☐	☐
Paul Puente	Board Member	☐	☐
Philip Sun, AIA, ACHA, NCARB	Board Member	☐	☐
Shubhada Hooli, MD, MPH	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:

Discussion Regarding the 90th Texas Legislature and Consideration of Approval of a Resolution Adopting Harris Health's Legislative Platform

_____ 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	☐	☐	☐	☐
Carol Paret, BS	☐	☐	☐	☐
Libby Viera-Bland, AICP	☐	☐	☐	☐
Ingrid Robinson, MBA	☐	☐	☐	☐
Marlen Trujillo, PhD, MBA, CHW	☐	☐	☐	☐
Paul Puente	☐	☐	☐	☐
Philip Sun, AIA, ACHA, NCARB	☐	☐	☐	☐
Shubhada Hooli, MD, MPH	☐	☐	☐	☐
Sima Ladjevardian, JD	☐	☐	☐	☐

The adopted resolution reads as follows:

Harris Health, by and through its Board of Trustees, hereby authorizes the adoption of Harris Health's Legislative Platform for the 90th Session of Texas Legislature as presented.

PASSED AND APPROVED this 14th of October, 2026.

Attest:

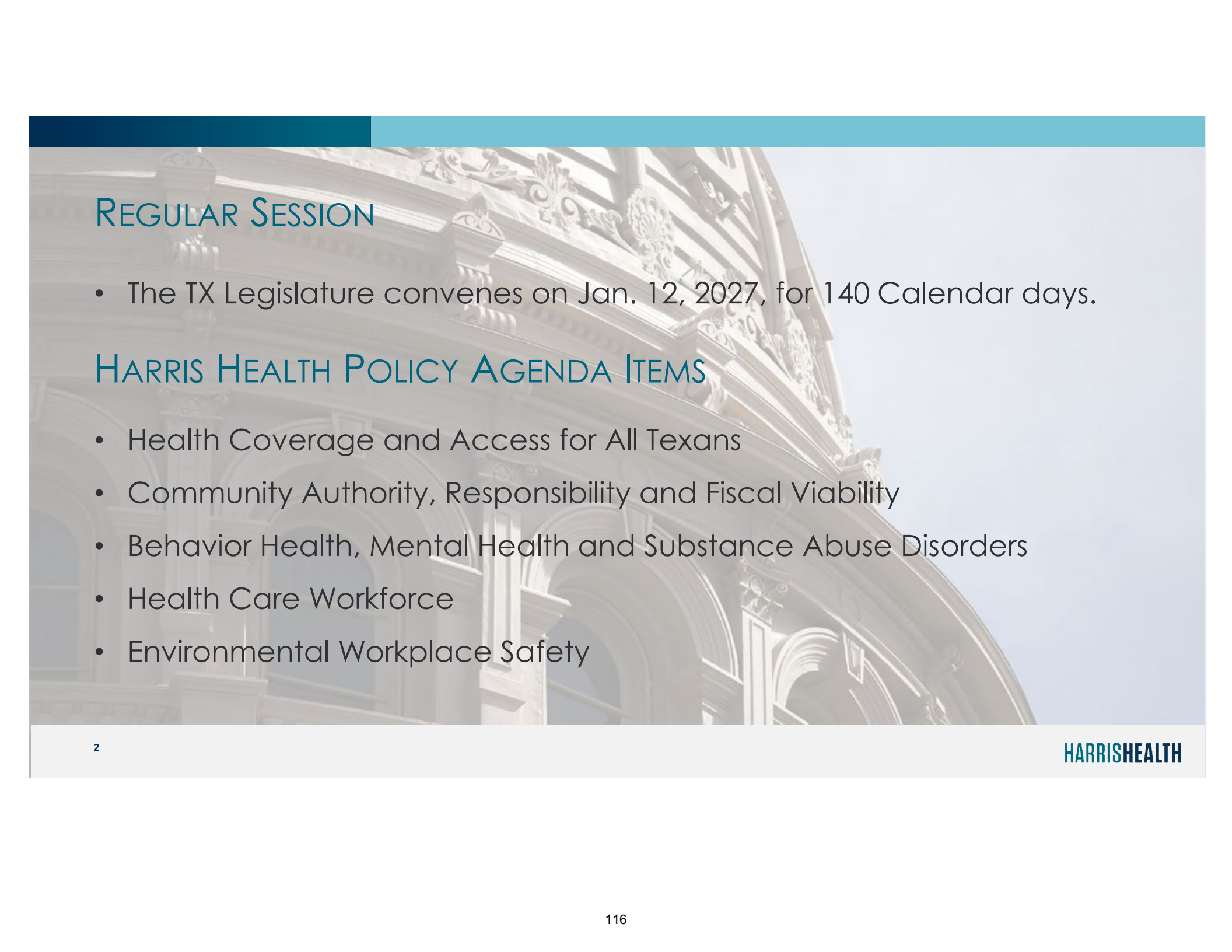
Andrea Caracostis, MD, MPH, Chair
Harris Health Board of Trustees

Libby Viera-Bland, AICP, Secretary
Harris Health Board of Trustees



90th Texas Legislative Session Policy Platform

HARRISHEALTH



REGULAR SESSION

- The TX Legislature convenes on Jan. 12, 2027, for 140 Calendar days.

HARRIS HEALTH POLICY AGENDA ITEMS

- Health Coverage and Access for All Texans
- Community Authority, Responsibility and Fiscal Viability
- Behavior Health, Mental Health and Substance Abuse Disorders
- Health Care Workforce
- Environmental Workplace Safety

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Presentation Regarding Harris Health's AI Update
[Strategic Pillar 5: System Optimization]



Ron Fuschillo
SVP & Chief Information Officer

AI STRATEGY UPDATE

From Guardrails to Enterprise Strategy

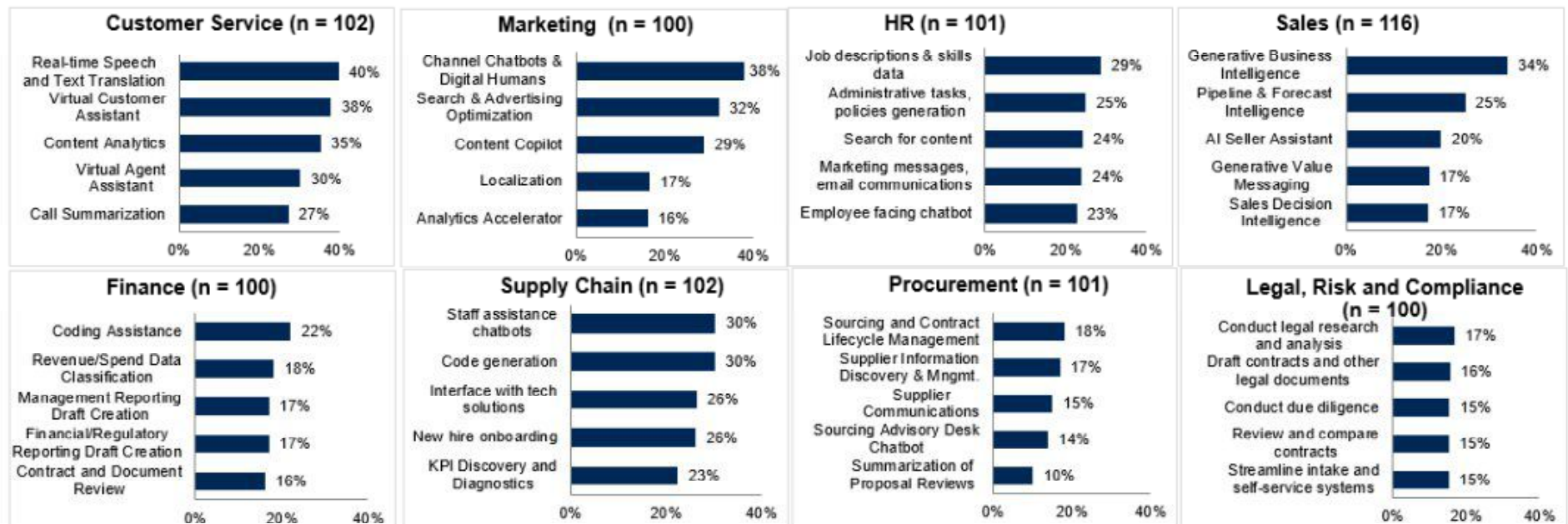
October 2026 Board Update

Understanding how Harris Health governs, evaluates, prioritizes and scales artificial intelligence within the enterprise technology roadmap.

Carolynn Jones | Ron Fuschillo

Generative AI use cases currently being implemented (i.e., in production, rolling out formally or piloting for rollout)

Currently implementing or implemented
Percentage of Respondents — Top 5



n varies, all respondents

Q: What are the potential use cases for generative AI that you foresee utilizing for your organization and in what time frame?

Source: 2024 Gartner Generative AI Planning Survey

[Back to index](#)

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Gartner

Our AI Strategy

We are not pursuing AI as a collection of tools. We are building a governed enterprise capability.

01

ENABLE

Use AI to enable our workforce through innovation to improve quality, access, workforce experience and operational effectiveness.

02

GOVERN

Apply formal decision rights, cross-functional evaluation and risk-based controls before deployment.

03

CONSOLIDATE

Favor enterprise platforms and trusted strategic partners (**Buy not Build**) over duplicative one-off tools.

04

MEASURE

Track inventory, adoption, performance, incidents, control effectiveness and value over time.

Responsible AI means scaling what creates value, declining what duplicates our strategy, and maintaining the ability to explain every decision.

AI Governance Model

Decision rights are separated from implementation so risk acceptance does not automatically commit resources or authorize deployment.



Key Point All employees within the organization receive Responsible AI Use education annually to ensure the enterprise remains competent and prepared for adopting AI.

Risk-Based Evaluation: AI Operating Model

The model evaluates **both the AI product** and the **specific use case** because risk changes with context, data and workflow.



RISK AND COMPLIANCE IS MANAGED THROUGH CYBERSECURITY, COMPLIANCE, AND OTHERS

KEY PRINCIPLE

Approval is scoped. A trusted platform may still require separate evaluation for materially different clinical or operational use cases.

What the Evaluation Model Tests

A common framework creates traceability from risk identification to controls, ownership and Board-level accountability.

VALUE & STRATEGIC FIT

Clear outcome • alternatives considered • alignment to roadmap

DATA & PRIVACY

PHI/PII • data flows • retention • model use • transparency

SECURITY & RESILIENCE

Access • vendor controls • vulnerabilities • incident response • containment

CLINICAL & HUMAN IMPACT

Patient safety • human-in-the-loop • bias • alert fatigue • workflow change

LEGAL & COMPLIANCE

Policy • regulatory obligations • contracting • auditability • notices

OPERATIONS & LIFECYCLE

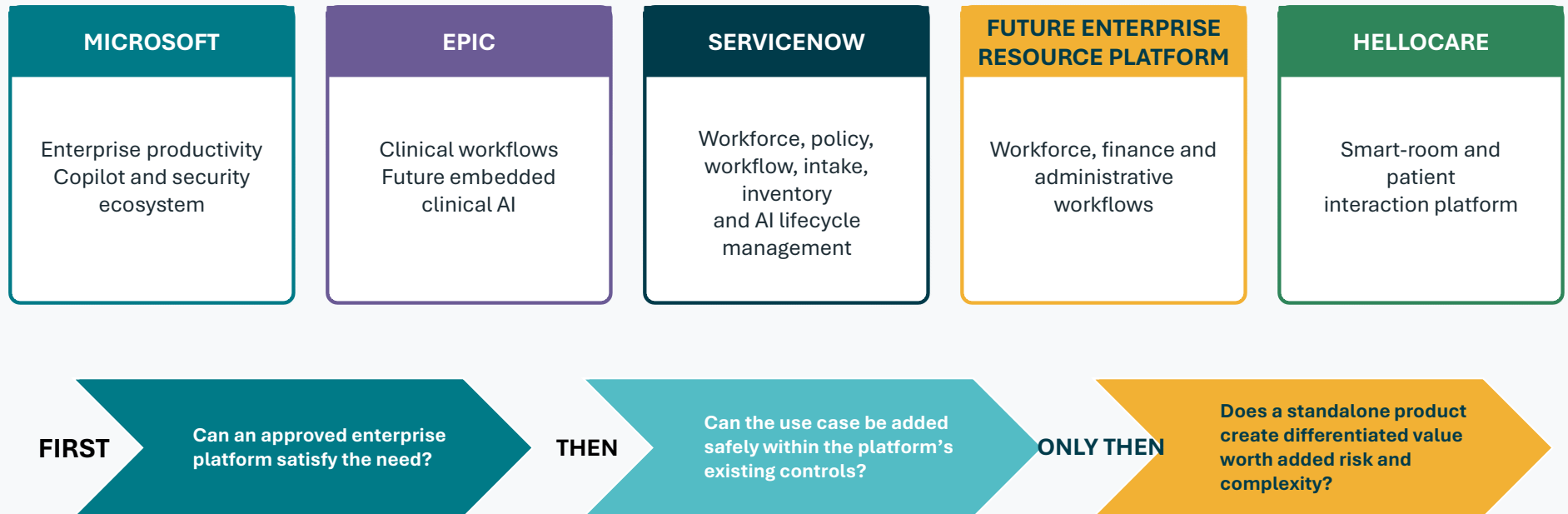
Owner • training • monitoring • drift • re-review • retirement

OUTPUT

A documented recommendation that links the identified risk, required controls, accountable owner, decision authority and monitoring expectation.

Platform Strategy: Concentrate Investment, Control and Adoption

Most AI demand should be satisfied through a small set of enterprise platforms before introducing additional standalone tools.



What to Take Away

Harris Health is creating the conditions to adopt AI responsibly, deliberately and at enterprise scale.

1

Guardrails exist

AI is governed through defined policy, decision rights, evaluation standards and approval pathways.

2

Strategy guides choice

The organization is concentrating AI on enterprise platforms and use cases tied to strategic outcomes.

3

Risk is actively managed

Risk is assessed by product and use case, translated into controls, and monitored throughout the lifecycle.

4

AI is part of the roadmap

AI depends on the same cyber, data, cloud, workflow and platform investments already underway.

NEXT STEPS

**ADMINISTRATION WILL CONTINUE TO PROVIDE UPDATES AND
RECOMMENDATIONS TO THE GOVERNING BOARD**

THANK YOU

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Presentation Regarding the Oncology Scope of Services at LBJ Hospital,
Including Consideration of Approval to Proceed with the Design of a Cancer Center
at the LBJ Campus Reflecting a Revised Project Scope and a Total Project Cost
Authorization not to Exceed \$150 Million [Strategic Pillar 6: Access]

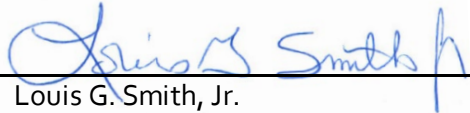
The proposed Cancer Center project on the LBJ campus is planned to provide critical cancer services for patients in the North Houston region. The services include:

- 2 new Linear Accelerators and expansion of a 3rd vault
- Brachytherapy suite and CT Simulator
- Infusion Center with up to 50 infusion patient stations
- Dedicated lobby, covered entrance, physician offices, exam rooms, and support spaces
- Nuclear Medicine Suite with PET CT
- 2 floors of outpatient clinics
- Located adjacent to existing Radiology for integrated support

Administration requests Board of Trustees approval to proceed with the design of a standalone Cancer Center at the LBJ Campus planned for approximately 125,000 square feet, reflecting a revised project scope and an increase in the total project cost to an amount not to exceed \$150 million.



Amineh Kostov
SVP, System Service Lines



Louis G. Smith, Jr.
Sr. EVP/Chief Operating Officer

Outpatient Cancer Care: Cancer Center on the LBJ Campus

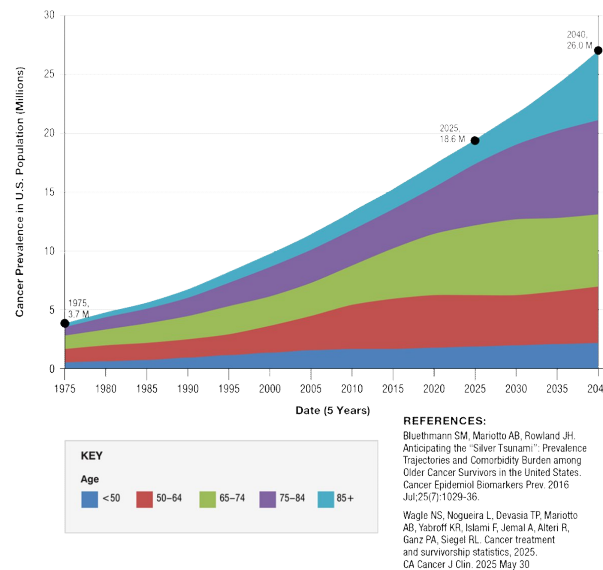
October 14, 2026

HARRISHEALTH

Cancer incidence is expected to increase significantly in the coming decade

- Cancer incidence is projected to grow due to an aging population and rising cancer risk factors across all populations, particularly younger patients.
- More cancer patients with comorbidities increases utilization across all settings.
- The growth for outpatient cancer services is expected to grow ~20% over the next 10 years
- This growth will place increasing demand on infusion, radiation therapy, and other outpatient cancer services.

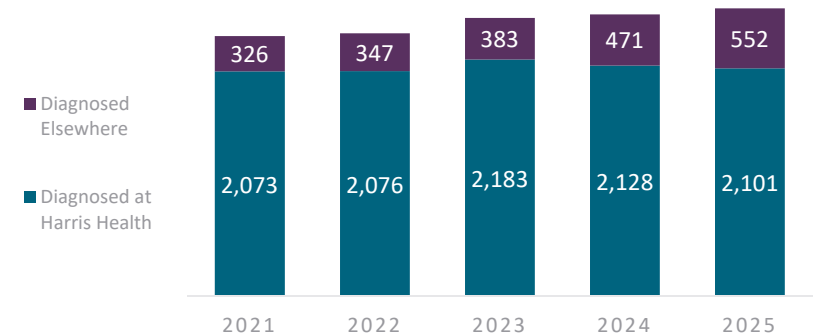
Cancer Prevalance and Projections in U.S. Population from 1975–2040, by Age



Harris Health is already experiencing sustained growth in cancer care demand.

- Cancer case volume at Harris Health has increased 10.6% over the past four years, representing an average annual growth rate of approximately 2.5%.
- More patients are entering Harris Health after diagnosis, driving a nearly 70% increase in non-analytic cases and increasing demand for ongoing treatment and support services.

NEW CANCER CASES



Improving the Cancer Care Journey

Uninsured and underinsured patients who often have no alternative source of care. Many face late-stage diagnoses, treatment delays, and social barriers that interrupt care.

These barriers are more than inconveniences. They delay treatment, disrupt continuity of care, and worsen outcomes.

For many Harris Health patients, clinical complexity is compounded by financial, transportation and daily life barriers.



Financial pressure

Medical bills, lost earnings and transportation costs compete with basic needs.



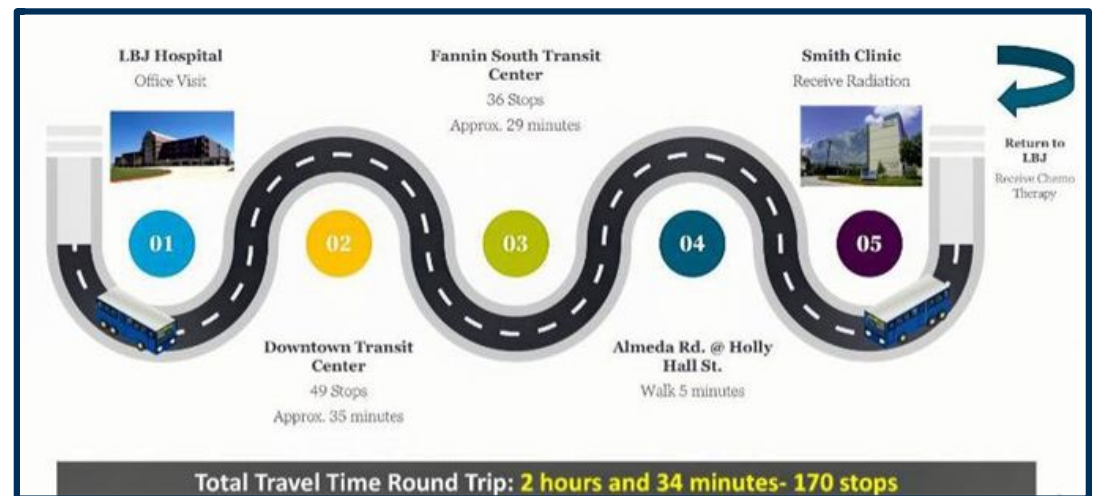
Time burden

Treatment can require long visits and multiple appointments each week.



Access gaps

Transportation, mobility and limited social support can delay or interrupt care.



2h 34m

round-trip travel

70

bus stops

5-8 hours

Per treatment

3

Visits per week

Whole Person Care: Putting Patients at the Center of Cancer Treatment



*Removing
barriers to care.*

*Supporting the
whole person.*

- A dedicated Cancer Center represents a transformational investment in our patients by providing the **organizational** and **physical infrastructure** necessary to deliver high-value, patient centered cancer care at Harris Health.
- Bringing services, specialists, and support together will help reduce disparities, improves outcomes, and create a seamless journey from prevention through survivorship.

Improving access

Improving access for Harris Health patients to quality cancer care

Integrated expertise

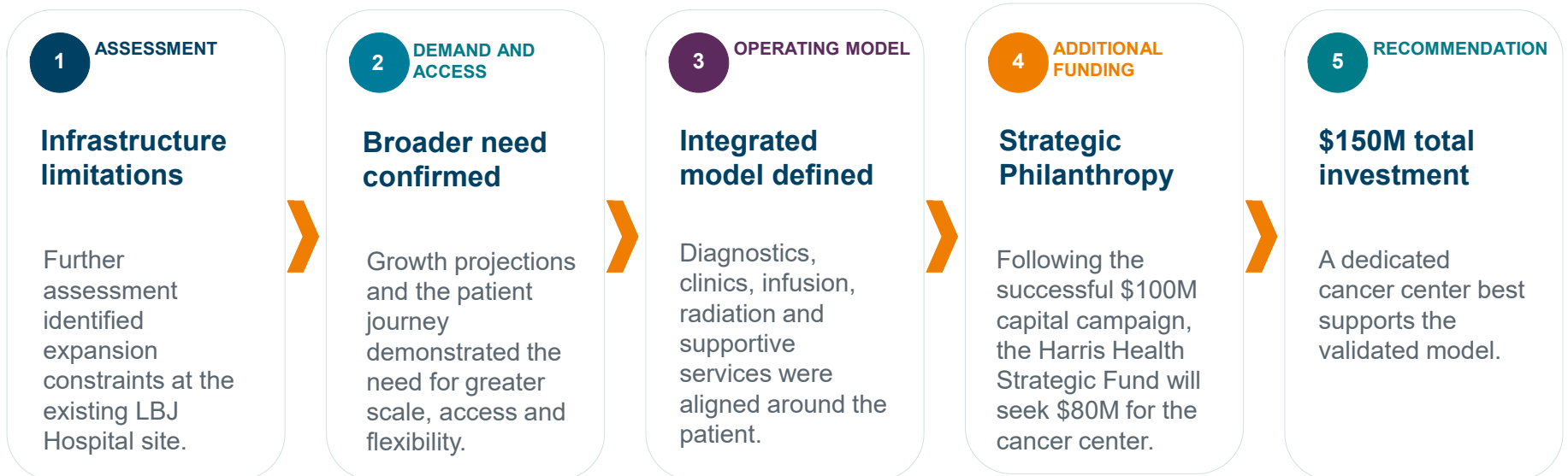
Coordinate diagnostic, medical, surgical, radiation and supportive services around each patient's needs.

Navigation & support

Address transportation, food, financial, emotional and survivorship needs that influence continuity of care.

The Recommendation Evolved as the Analysis Became More Complete

A phased process shifted the strategy from a \$70 million plan for immediate radiation oncology and infusion capacity to a long-term model for cancer care.



Planning discipline The immediate priority was established first; subsequent data defined the full model and the investment required to deliver it.

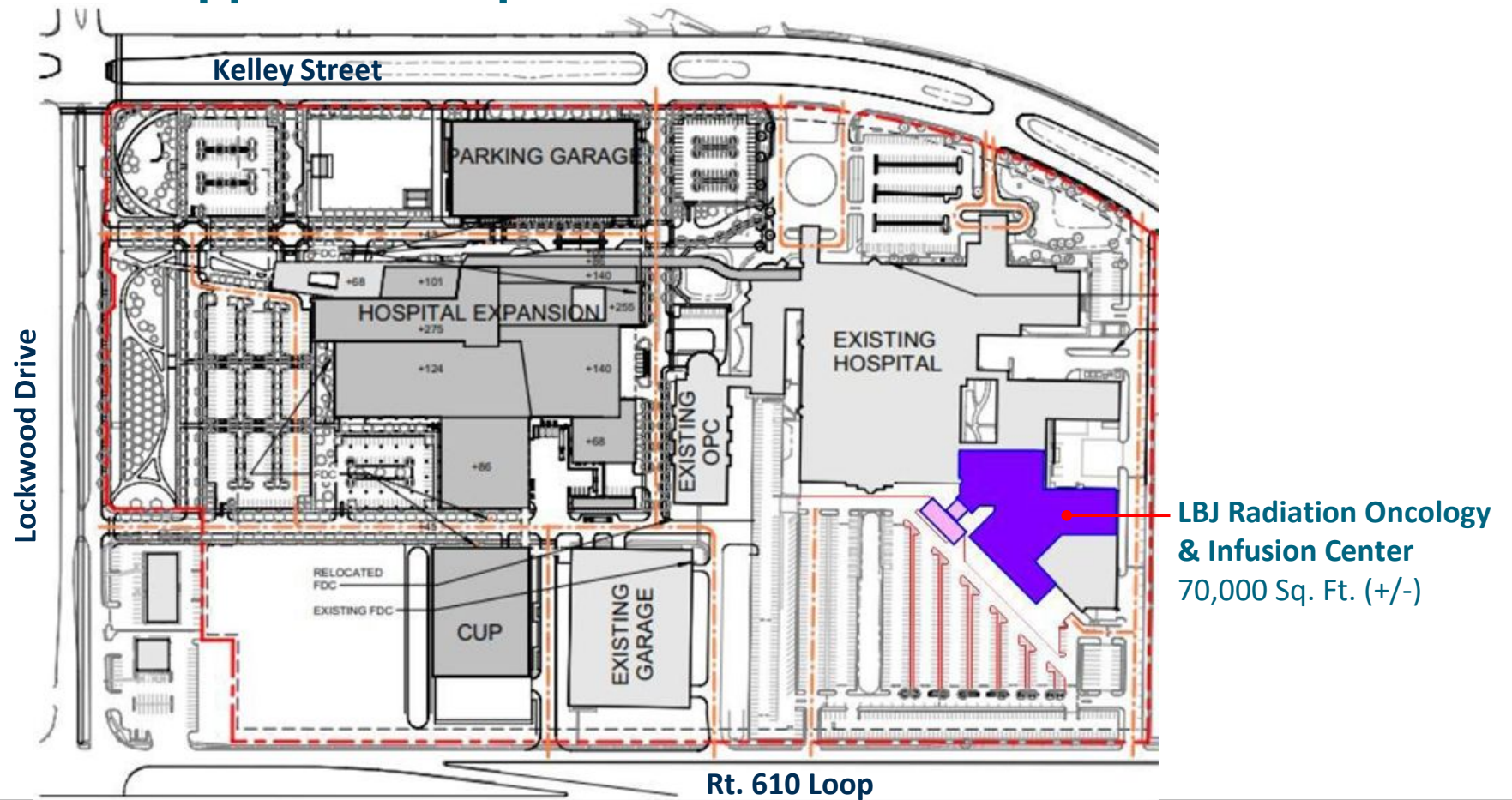
Cancer Center on the LBJ Campus:

Summary of Proposed Project:

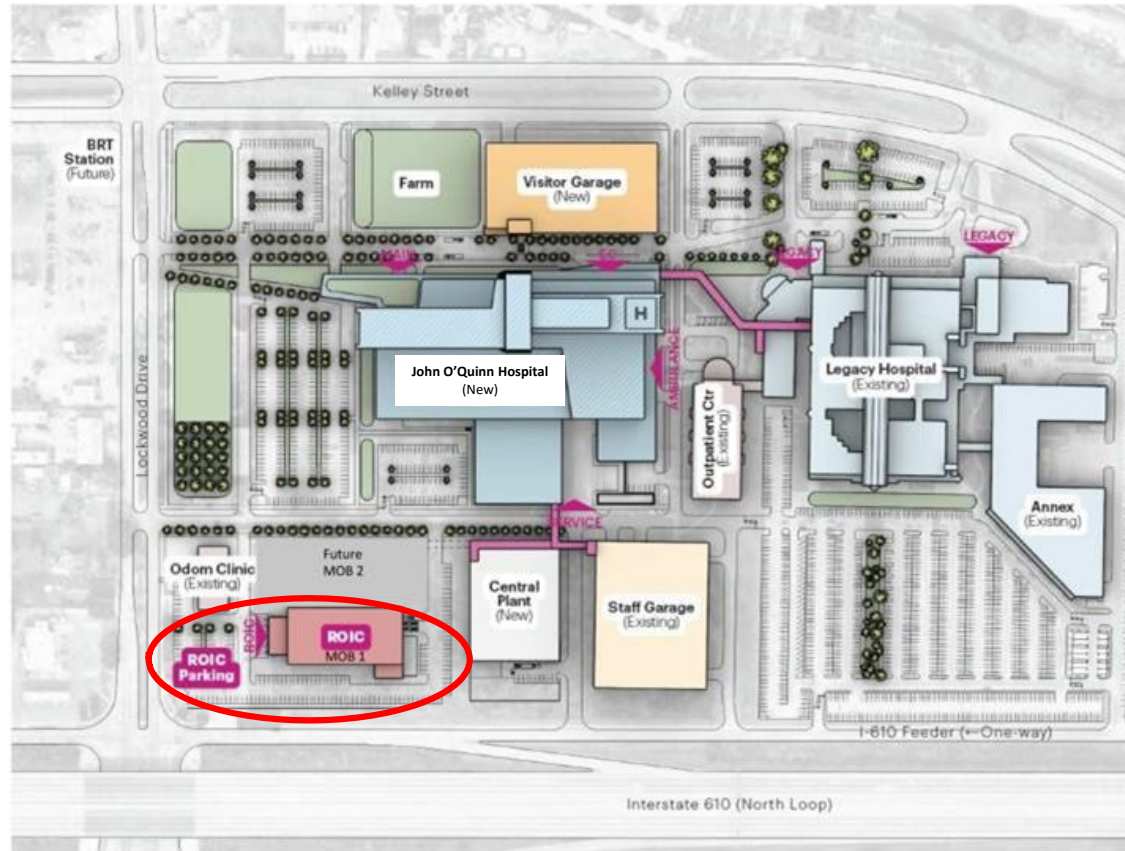
- Planned to address growing cancer care needs in Harris County
- Features:
 - 2 new Linear Accelerators and expansion of a 3rd vault
 - Brachytherapy suite and CT Simulator
 - Infusion Center with up to 50 stations
 - Dedicated lobby, covered patient entrance, physician offices, and support spaces
 - Nuclear Medicine Suite with PET/CT
 - 2 floors of outpatient clinics
- Located adjacent to existing Radiology for integrated support



Prior Board Approval Campus Plan



Revised Campus Plan



PROS

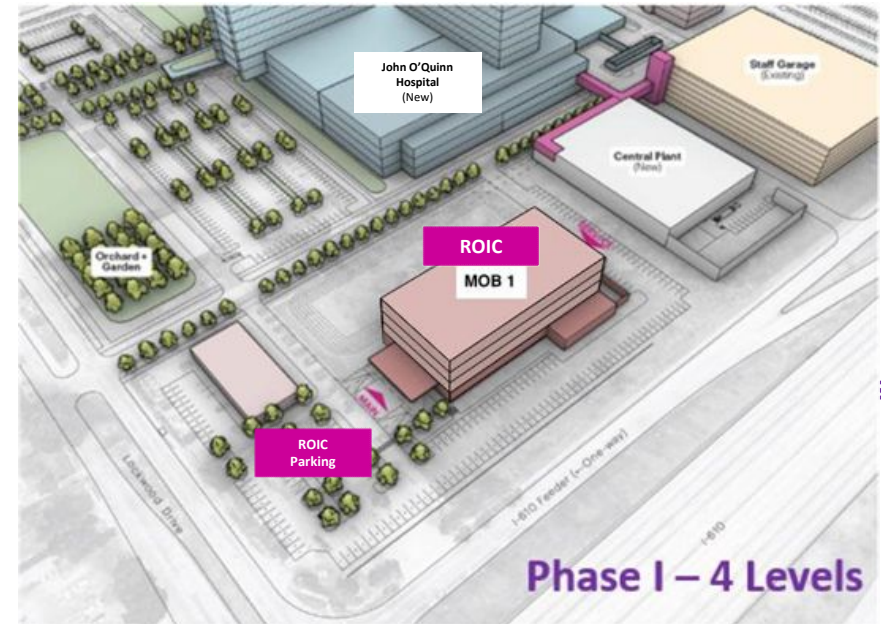
- Compact and integrated cancer program
- Maintains site organization
- Convenient parking access at front door
- Building can be designed for future expansion

OBSERVATIONS

- All-new construction is more cost-effective and reduces the risk of unforeseen site conditions.
- Future skybridge connections to staff parking and O'Quinn Hospital can be evaluated as campus needs evolve.
- Convenient patient parking adjacent to the facility entrance

Phase I: Full Buildout of MOB 1 – 4 Levels

	MOB
<i>Scope of Work</i>	
Site Improvements	Included
Level 1	35k Rad Onc
Level 2	30k Clinic
Level 3	30k Clinic
Level 4	30k Infusion
Gross Building Area	125k sf
Total Project Cost (TPC)	
Construction Cost:	\$106.0 M
Major Medical Equipment:	\$16.0 M
IT Budget:	\$6.0 M
FF&E Budget:	\$5.0 M
A/E & Other Prof Fees:	\$9.0 M
Owner Contingency:	\$8.0 M
TPC:	\$150.0 M
PET CT Suite Included in TPC	4 Levels



Milestone	Target Date
Design Completion	Q3 2027
Construction Start	Q4 2027
Construction Completion	Q3 2029

Cancer Center on the LBJ Campus: Revised Project Scope

Prior Board Action:

The Board of Trustees previously approved Administration to proceed with the design of the LBJ Radiation Oncology & Infusion Center. Original project scope is to repurpose existing space within the LBJ Legacy Hospital Annex and construct new radiation oncology vaults at a total project cost not to exceed \$70 million.

Revised Project Scope:

Following further planning and evaluation, Administration is recommending a broader project approach to construct a Cancer Center on the LBJ Campus on a separate campus site. This will increase the project cost authorization by \$80 million (philanthropic support expected), resulting in a revised total project cost not to exceed \$150 million.



Cancer Center on the LBJ Campus: Authorization

Recommendation and Board Action:

“Administration requests Board of Trustees approval to proceed with the design of a Cancer Center at the LBJ Campus, reflecting a revised project scope and a total project cost authorization not to exceed \$150 million.”

Meeting of the Board of Trustees

[Wednesday, October 14, 2026](#)

[Committee Reports](#)

Committee Meetings:

- Quality Committee – September 22, 2026 (Open Session)
 - HRO Safety Message Video Regarding Central Line Associated Bloodstream Infection (CLABSI)



Kimberly J. Williams, JD
Harris County Purchasing Agent

October 1, 2026

Board of Trustees Office
Harris Health

RE: Board of Trustees Meeting – October 14, 2026
Budget and Finance Agenda Items

The Office of the Harris County Purchasing Agent recommends review of the attached procurement actions:

- A. Approvals
- B. Harris Health Premier Spend Report for Q2 FY2026 (01/01/2026-03/31/2026) information only, no action requested.

All recommendations are within the guidelines established by Harris County and Harris Health.

Sincerely,

Kimberly J. Williams

Kimberly J. Williams, JD
Purchasing Agent

JA/ea
Attachments

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

Expenditure Summary: October 14, 2026 (Approvals)

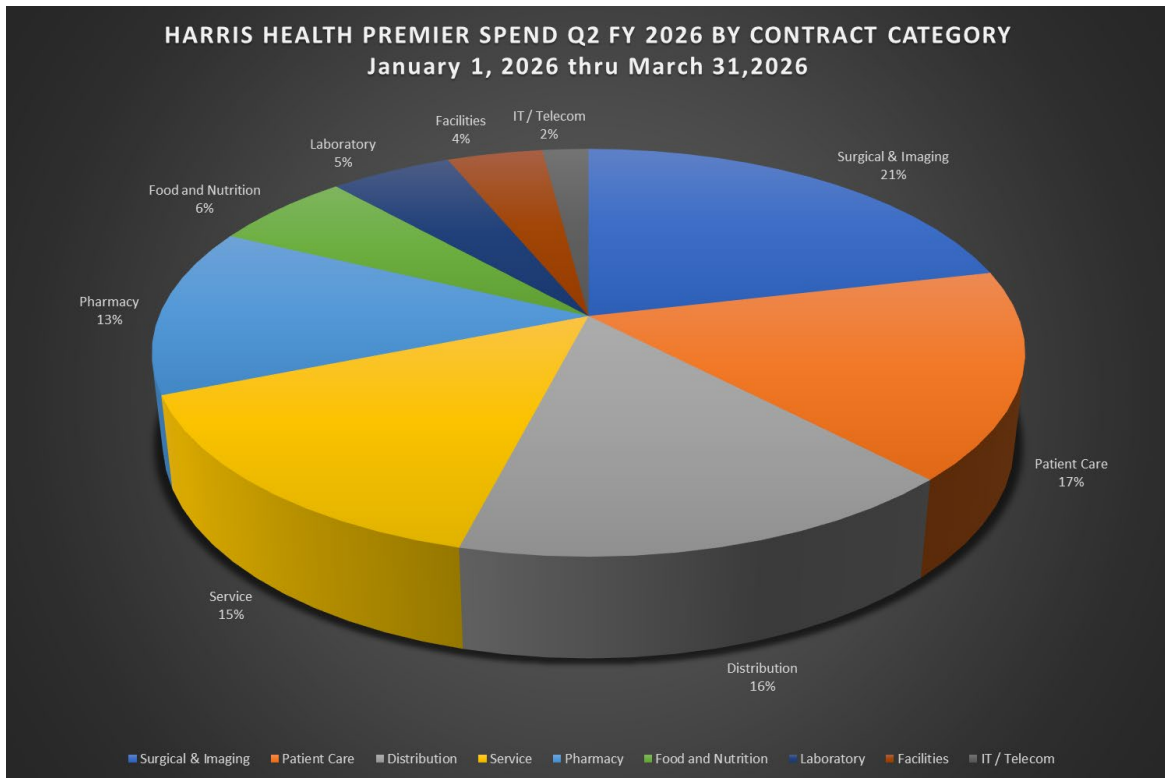
No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
A1	HDR Architecture Inc. MWBE Goal: 27%	Professional Architectural and Engineering Services for Ben Taub Hospital Expansion Project - To provide planning & programming, cost estimating, architecture & engineering design, and construction administration activities necessary for the Ben Taub Hospital Expansion Project. <i>Job No. 260226</i>	Award Highest overall evaluation Four-year initial term with two (2) one-year renewal options	Patrick Casey		*
A2	Philips Healthcare (HCHD-1968) MWBE Goal: Exempt Sole Source	Hellocare.ai for Harris Health - To provide user training, and ongoing support and maintenance services for the new Healthcare AI-driven solution and virtual care platform to include remote patient monitoring, virtual nursing support, telehealth capabilities, and installed and configured hardware and software components. <i>Sole Source Exemption</i>	Purchase Sole Source Exemption Five-year initial term	Russ Burlew		\$ 9,995,940
A3	Metropolitan Life Insurance Company (HCHD-927) MWBE Goal: 5%	Basic and Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance for Harris Health - To continue providing basic and voluntary life and accidental death & dismemberment (AD&D) insurance for Harris Health. <i>Job No. 220341</i>	Renewal October 01, 2026 through September 30, 2027	Amanda Jones-Duncan	\$ 6,800,636	\$ 7,278,858
A4	O'Donnell Snider Construction, LLC MWBE Goal: 25.92%	Nuclear Medicine Renovation & Systems Upgrade at Ben Taub Hospital for Harris Health - To provide all labor, materials, equipment and incidental for the Nuclear Medicine Renovation & Systems Upgrade at Ben Taub Hospital. The owner contingency provides for coverage on unanticipated costs throughout the construction project. <i>Job No. 260138</i>	Award Best proposal meeting requirements	Babak Zare		\$ 3,377,182
A5	Southland Industries MWBE Goal: 18%	Chilled Water Heat Exchanger Plate Refurbishment and System Upgrades at Ben Taub Hospital for Harris Health - To provide all labor, materials, equipment and incidental for the Chilled Water Heat Exchanger Plate Refurbishment and System Upgrades at Ben Taub Hospital. The owner contingency provides for coverage on unanticipated costs throughout the construction project. <i>Job No. 260196</i>	Award Best proposal meeting requirements	Babak Zare		\$ 1,573,402
A6	Stryker Corporation (HCHD-1267) MWBE Goal: Exempt Sole Source	Repair Services for Stryker Brand Equipment for Harris Health - To provide repairs, replacement parts, and loaner equipment as needed for Stryker brand endoscopic cameras and related equipment. <i>Sole Source Exemption</i>	Additional Funds Extension Sole Source Exemption July 26, 2027 through July 25, 2030	James Young	\$ 480,318	\$ 1,421,682
A7	Guidehouse Inc. MWBE Goal: 0% Specialized, Technical, or Unique in Nature	Managed Care Benchmarking, Strategy, and Negotiation Support Services for Harris Health - To provide consulting services to assess of current payer contracts, benchmark current reimbursement structure, strategy building to optimize reimbursement, and support Harris Health in negotiations to execute new contracts. <i>Job No. 260160</i>	Award Best proposal meeting requirements One (1) year initial term with six (6) one-year renewal options	Polle Martinez		*

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
A8	Mopec MWBE Goal: Exempt Sole Source	Pathology Workstations for Harris Health - To provide Harris Health with a replacement of Maestro Encore Grossing stations units for Ben Taub and Lyndon B. Johnson laboratories. <i>Sole Source Exemption</i>	Award Sole Source Exemption	Arun Mathew		\$ 282,267
					Total Expenditures	\$ 44,789,331
					Total Revenue	\$ (0)

- Pages 143-144 Were Intentionally Left Blank -

Wednesday, October 14, 2026

Harris Health Second Quarter of Fiscal Year 2026 Premier Spend Report
for Informational Purposes [No Action Required]



HARRIS HEALTH PREMIER Q2 SPEND FY2026	
01/01/2026 - 03/31/2026	
Premier Contract Category	Q2 Spend FY2026
Surgical & Imaging	\$15,153,486
Patient Care	\$11,718,548
Distribution	\$11,470,827
Service	\$10,573,976
Pharmacy	\$9,446,544
Food and Nutrition	\$4,390,274
Laboratory	\$3,818,532
Facilities	\$2,992,750
IT / Telecom	\$1,442,324
Grand Total	\$71,007,262

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
MEDLINE INDUSTRIES, LP	\$12,782,599
AMN HEALTHCARE, INC.	\$6,970,984
MORRIS & DICKSON CO., L.L.C.	\$3,378,735
US FOODS, INC.	\$3,187,747
GE PRECISION HEALTHCARE LLC	\$2,784,222
GLOBO LANGUAGE SOLUTIONS, LLC	\$2,174,966
PHILIPS HEALTHCARE	\$2,023,896
CARDINAL HEALTH 200, LLC	\$1,740,112
OLYMPUS AMERICA INC.	\$1,604,018
STRYKER SALES, LLC DBA STRYKER MEDICAL	\$1,568,496
BOSTON SCIENTIFIC CORPORATION	\$1,538,039
BECTON, DICKINSON AND COMPANY	\$1,425,598
PFIZER (BRAND)	\$1,230,005
JOHNSON & JOHNSON HEALTH CARE SYSTEMS INC.	\$1,120,774
COVIDIEN SALES LLC	\$1,119,698
CLEAN HARBORS ENVIRONMENTAL SERVICES, INC.	\$984,279
LABORATORY CORPORATION OF AMERICA HOLDINGS	\$871,615
BAXTER HEALTHCARE CORPORATION MEDICAL PRODUCTS - INFUSION PUMPS	\$761,228
CSL BEHRING L.L.C.	\$717,960
INSIGHT DIRECT USA, INC.	\$717,745
ABBOTT LABORATORIES INC.	\$705,852
BECKMAN COULTER, INC.	\$684,915
FFF ENTERPRISES, INC.	\$675,131
MASIMO AMERICAS, INC.	\$609,538
PFIZER (GENERIC)	\$564,891
PARTSSOURCE, INC.	\$525,400
HOWMEDICA OSTEONICS CORP. DBA STRYKER ORTHOPAEDICS	\$509,812
KCI USA, INC. DBA 3M MEDICAL SOLUTIONS	\$490,583
VERITIV OPERATING COMPANY	\$458,566
STERIS CORPORATION	\$395,175
GE HEALTHCARE INC.	\$392,373
PC CONNECTION, INC.	\$380,732
ABBVIE INC. DBA ABBVIE US LLC	\$362,887
HILL-ROM COMPANY, INC.	\$349,683
STANDARD TEXTILE CO., INC.	\$339,974
GETINGE USA SALES, LLC	\$321,838
SMITH & NEPHEW INC - ORTHOPAEDIC DIVISION	\$321,042
ODP BUSINESS SOLUTIONS, LLC	\$311,004
W.W. GRAINGER, INC.	\$302,007
ICU MEDICAL SALES, INC.	\$290,317
SYSMEX AMERICA, INC.	\$260,933
COOK MEDICAL LLC	\$252,611
FRESENIUS KABI USA, LLC	\$238,084
ZIMMER US, INC. DBA ZIMMER BIOMET	\$229,634
STRYKER SALES, LLC DBA STRYKER INSTRUMENTS	\$225,875

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
LANTHEUS MEDICAL IMAGING, INC.	\$222,720
BARD MEDICAL DIVISION	\$220,393
STRYKER SALES, LLC DBA STRYKER ENDOSCOPY	\$219,710
SOLVENTUM US LLC	\$216,148
TELEFLEX LLC	\$200,889
JUBILANT DRAXIMAGE INC.	\$200,147
MEDTRONIC, INC.	\$192,972
CHIESI USA, INC	\$170,272
BIOMERIEUX, INC.	\$163,643
MOLNLYCKE HEALTH CARE US, LLC	\$161,025
NESTLE HEALTHCARE NUTRITION, INC. DBA NESTLE HEALTH SCIENCE	\$155,096
SHARED IMAGING, LLC	\$152,762
BARD PERIPHERAL VASCULAR, INC.	\$141,982
GEORGIA-PACIFIC CONSUMER PRODUCTS LP	\$133,833
SHOCKWAVE MEDICAL, INC.	\$132,790
STRYKER SALES, LLC DBA STRYKER CRANIOMAXILLOFACIAL	\$132,289
EDWARDS LIFESCIENCES LLC	\$129,510
BAXTER HEALTHCARE CORPORATION BIOPHARMA SOLUTIONS	\$129,243
PENUMBRA INC	\$127,375
LINDE GAS & EQUIPMENT INC.	\$124,221
VERATHON INC.	\$123,641
PROFESSIONAL DISPOSABLES INTERNATIONAL, INC.	\$122,960
MERCK SHARP & DOHME LLC	\$118,872
LYFT	\$113,967
CDW CORPORATION	\$112,724
AVKARE, LLC	\$112,533
BAUSCH HEALTH US, LLC	\$112,459
PRESTIGE AMERITECH, LTD. DBA S2S GLOBAL	\$111,999
AMERISOURCE HEALTH SERVICES, LLC DBA AMERICAN HEALTH PACKAGING	\$110,593
QUVA PHARMA, INC.	\$108,654
STEELCASE INC.	\$107,735
LEICA BIOSYSTEMS A DIVISION OF LEICA MICROSYSTEMS INC.	\$101,931
FISHER SCIENTIFIC HEALTHCARE	\$100,146
WELCH ALLYN, INC.	\$99,798
MUSCULOSKELETAL TRANSPLANT FOUNDATION	\$99,781
SWISSLOG HEALTHCARE	\$99,460
PRECISION DYNAMICS CORPORATION	\$98,447
CAREFUSION SOLUTIONS, LLC	\$97,669
GLAXOSMITHKLINE INC.	\$97,270
AGILITI HEALTH, INC.	\$97,080
I.B.S. SOLUTIONS CORPORATION	\$93,832
B. BRAUN MEDICAL INC.	\$91,700
SOFIE CO.	\$90,758
US MED-EQUIP, LLC	\$90,500
AESULAP, INC.	\$88,937

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
ECOLAB USA INC.	\$86,442
PERFORMANCE HEALTH SUPPLY, LLC	\$86,095
EHOB, LLC	\$85,282
SUN PHARMACEUTICAL INDUSTRIES, INC.	\$84,848
SMITH & NEPHEW INC - WOUND MANAGEMENT DIVISION	\$84,612
MERIT MEDICAL SYSTEMS, INC.	\$84,164
OURPHARMA, LLC	\$82,801
APPLIED MEDICAL DISTRIBUTION CORPORATION	\$80,911
INARI MEDICAL, INC.	\$79,500
BIO-RAD LABORATORIES, INC.	\$77,343
SUNMED GROUP HOLDINGS, LLC DBA AIRLIFE	\$75,882
DAVOL INC.	\$74,948
RAULAND-BORG CORPORATION	\$72,824
DIAGNOSTICA STAGO INC.	\$70,674
DIVERSEY, INC.	\$69,763
HOLOGIC SALES AND SERVICE, LLC	\$67,174
AMERICAN REGENT, INC.	\$66,969
PACTIV LLC	\$66,734
FISHER & PAYKEL HEALTHCARE, INC.	\$65,926
ADVANCED STERILIZATION PRODUCTS SERVICES INC.	\$65,318
THE CLOROX SALES COMPANY	\$64,979
TYSON FOODS, INC.	\$63,696
HIKMA PHARMACEUTICALS USA INC.	\$63,463
ASTELLAS PHARMA US, INC.	\$63,238
FAGRON COMPOUNDING SERVICES, LLC DBA FAGRON STERILE SERVICES	\$61,955
DRAEGER, INC.	\$61,931
TRILLIANT SURGICAL, LLC	\$60,527
TIDI PRODUCTS, LLC	\$60,136
SANOFI-AVENTIS U.S. LLC	\$59,580
SABERT CORPORATION	\$58,679
POLYNOVO NORTH AMERICA LLC	\$58,321
AT&T MOBILITY NATIONAL ACCOUNTS LLC	\$57,782
DEROYAL INDUSTRIES, INC.	\$57,694
MEDELA LLC	\$57,576
TEVA PHARMACEUTICALS USA (BRAND)	\$56,474
CARCO GROUP, INC. DBA PRECHECK	\$55,697
INTEGRA LIFESCIENCES CORPORATION	\$54,862
GLOBAL HEALTHCARE EXCHANGE, LLC	\$52,500
CONVATEC INC.	\$50,960
SOLAIRE MEDICAL STORAGE, LLC DBA INNERSPACE H.C.	\$50,608
DOLE PACKAGED FOODS COMPANY	\$50,068
MICHAEL FOODS, INC.	\$49,784
THE COCA-COLA COMPANY	\$49,598
RICHARD-ALLAN SCIENTIFIC LLC	\$49,569
MYLAN INSTITUTIONAL INC.	\$48,701

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
ACUMED LLC	\$48,676
HOWMEDICA OSTEONICS CORP. DBA STRYKER SPINE	\$47,900
ARUP LABORATORIES, INC.	\$47,478
REMEL INC.	\$47,464
BAUSCH & LOMB AMERICAS INC.	\$47,103
ERBE USA, INC.	\$44,175
NALCO COMPANY LLC	\$43,655
KIMBERLY-CLARK GLOBAL SALES, LLC	\$42,911
FRITO-LAY NORTH AMERICA, INC.	\$41,835
HEALTHMARK INDUSTRIES CO., INC.	\$41,400
QUIDELORTHO SALES COMPANY, LLC	\$40,065
DART CONTAINER CORPORATION	\$38,580
MOZARC MEDICAL US LLC	\$37,566
BELMONT INSTRUMENT, LLC DBA BELMONT MEDICAL TECHNOLOGIES	\$37,137
MAJOR PHARMACEUTICALS	\$36,532
ENCOMPASS GROUP, LLC	\$35,874
ASTRAZENECA PHARMACEUTICALS LP	\$35,538
HELMER SCIENTIFIC, LLC	\$35,192
XODUS MEDICAL, INC.	\$35,088
PEPSICO SALES, INC.	\$34,003
HORMEL FOODS CORPORATION	\$33,302
ANGIODYNAMICS, INC.	\$32,404
URGO MEDICAL NORTH AMERICA	\$31,911
THE J. M. SMUCKER COMPANY	\$31,440
KRAFT HEINZ FOODS COMPANY	\$31,264
BAVARIAN NORDIC INC.	\$30,955
MEDICAL POSITIONING, INC.	\$30,920
BAYER HEALTHCARE LLC	\$30,741
AZURITY PHARMACEUTICALS, INC.	\$30,100
TRI-ANIM HEALTH SERVICES, INC.	\$28,702
SIEMENS MEDICAL SOLUTIONS USA, INC.	\$28,667
3M COMPANY	\$28,483
O&M HALYARD, INC.	\$28,220
HEALTH CARE LOGISTICS, INC.	\$28,166
KURIN, INC.	\$28,000
SMITH & NEPHEW, INC.	\$27,548
ASAHI INTECC USA, INC.	\$27,365
HAMILTON MEDICAL, INC.	\$25,620
AMPHASTAR PHARMACEUTICALS, INC.	\$25,588
KARL STORZ ENDOSCOPY-AMERICA, INC.	\$25,441
KATENA PRODUCTS, INC. DBA CORZA OPHTHALMOLOGY	\$25,077
ANCHOR PACKAGING	\$24,007
MCKESSON MEDICAL-SURGICAL INC.	\$23,846
ADVANCE MEDICAL DESIGNS, INC.	\$23,531
PEPSICO INC.	\$23,061

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
KIMBALL INTERNATIONAL BRANDS, INC.	\$22,966
BONESUPPORT INC.	\$22,311
RADIOMETER AMERICA INC.	\$22,212
AMBU INC.	\$22,171
SAGENT PHARMACEUTICALS, INC.	\$21,635
ANDWELL LLC	\$21,530
VAPOTHERM, INC.	\$21,214
CIPLA USA INC.	\$20,991
MEDEGEN MEDICAL PRODUCTS, LLC	\$20,436
DR. REDDY'S LABORATORIES, INC.	\$20,387
IMAGES OF AMERICA, INC.	\$20,336
BAXTER HEALTHCARE CORPORATION MEDICAL PRODUCTS - SPECIALTY PHARMA	\$20,318
NEOGENOMICS LABORATORIES, INC.	\$20,279
TAYLOR HEALTHCARE (FORMERLY STANDARD REGISTER)	\$20,252
CAMPBELL FOODSERVICE COMPANY	\$20,235
WG CRITICAL CARE, LLC	\$20,232
US FOODS CULINARY EQUIPMENT & SUPPLIES	\$19,840
LIFENET HEALTH	\$19,706
CORDIS US CORP.	\$19,687
EXELA PHARMA SCIENCES, LLC	\$19,527
BIOTISSUE HOLDINGS INC.	\$19,174
ORASURE TECHNOLOGIES, INC.	\$18,600
SLMP, LLC DBA STATLAB MEDICAL PRODUCTS	\$18,573
APOTEX CORP.	\$18,072
ASPEN MEDICAL PRODUCTS, LLC	\$17,992
ORTHOFIX US LLC	\$17,925
MEDTRITION, INC.	\$17,159
HOSHIZAKI AMERICA, INC.	\$16,880
COLOPLAST CORP.	\$16,468
OWENS & MINOR DISTRIBUTION, INC.	\$16,322
LABORIE MEDICAL TECHNOLOGIES CORP.	\$16,160
CONMED CORPORATION	\$16,153
W. L. GORE & ASSOCIATES, INC.	\$16,065
SCIENTIA VASCULAR, INC.	\$15,930
PAR HEALTH USA, LLC	\$15,713
LSL INDUSTRIES, LLC DBA LSL HEALTHCARE	\$15,670
NESTLE PROFESSIONAL NORTH AMERICA	\$15,478
KLS MARTIN LP	\$15,419
STEELCOBELIMED INC.	\$15,251
PROGRESSIVE MEDICAL, INC.	\$15,126
UCB PHARMA, INC.	\$14,770
GLOBUS MEDICAL NORTH AMERICA, LLC	\$14,707
MELINTA THERAPEUTICS, LLC	\$14,637
PACIRA PHARMACEUTICALS, INC.	\$14,353
CONAGRA FOODS INC	\$14,037

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
KERECIS LLC	\$13,772
BSN MEDICAL, INC.	\$13,649
MONDELEZ INTERNATIONAL, INC.	\$13,399
MICROGENICS CORPORATION	\$13,385
AVANOS MEDICAL, INC.	\$13,251
EUGIA US LLC	\$12,725
ABBOTT NUTRITION	\$12,498
STERICYCLE, INC.	\$12,241
HARTMANN USA, INC.	\$12,151
TZ MEDICAL, INC.	\$12,000
GOJO INDUSTRIES, INC.	\$11,873
PILGRIM'S PRIDE CORPORATION	\$11,588
CARLISLE FOODSERVICE PRODUCTS	\$11,257
PAI HOLDINGS, LLC DBA PAI PHARMA	\$10,930
KOCH FILTER CORPORATION	\$10,607
HUB PHARMACEUTICALS, LLC	\$10,385
ASPEN SURGICAL PRODUCTS, INC.	\$10,287
BASIC AMERICAN FOODS	\$9,981
TENNANT SALES AND SERVICE COMPANY	\$9,812
NISSHA MEDICAL TECHNOLOGIES	\$9,770
GENERAL MILLS INC.	\$9,766
BRISTOL MYERS SQUIBB US PHARM	\$9,750
MICROTEK MEDICAL LLC	\$9,695
BOEHRINGER INGELHEIM PHARMACEUTICALS, INC.	\$9,632
INTEGRA LIFESCIENCES SALES LLC	\$9,629
WADDINGTON NORTH AMERICA, INC.	\$9,570
KOCH FOODS	\$9,560
WELLS DAIRY, INC.	\$9,399
LANDAUER, INC.	\$9,259
SOMERSET PHARMA LLC	\$9,159
NOVARTIS PHARMACEUTICALS CORPORATION	\$9,140
SANDOZ INC.	\$9,092
RETRACTABLE TECHNOLOGIES, INC.	\$8,927
CASE MEDICAL, INC.	\$8,900
BRACCO DIAGNOSTICS INC.	\$8,887
D. T. DAVIS ENTERPRISES, LTD. DBA HOVERTECH INTERNATIONAL	\$8,531
TARRY MEDICAL PRODUCTS DBA DANDLELION MEDICAL	\$8,486
WERFEN USA LLC	\$8,295
PHARMA LOGISTICS	\$8,284
FLEXICARE INCORPORATED	\$8,156
AERO US INC. DBA AEROGEN	\$8,126
MXR IMAGING, INC.	\$8,080
NOVA BIOMEDICAL CORPORATION	\$7,981
HORIZON ORGANIC DAIRY, LLC	\$7,721
COUNTRY PURE FOODS, INC.	\$7,679

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
QUEST DIAGNOSTICS INCORPORATED	\$7,486
STRATUS PHARMACEUTICALS, INC.	\$7,321
TEVA PHARMACEUTICALS USA (GENERIC)	\$7,293
SARA LEE FROZEN BAKERY, LLC	\$7,067
NOVOLEX HERITAGE BAG, LLC	\$7,015
LITTLE RAPIDS HOLDING CORPORATION DBA GRAHAM MEDICAL	\$6,850
FORTEC MEDICAL, INC.	\$6,840
ANSELL HEALTHCARE PRODUCTS LLC	\$6,670
B&G FOODS, INC.	\$6,663
BEUTLICH PHARMACEUTICALS, LLC	\$6,496
STERIS INSTRUMENT MANAGEMENT SERVICES, INC.	\$6,488
JOHNSONVILLE, LLC	\$6,278
KNOUSE FOODS CO-OP INC	\$6,269
KEDRION BIOPHARMA INC.	\$6,225
MEDICAL COMPONENTS, INC.	\$6,210
BURLINGTON MEDICAL, LLC	\$5,978
LOGIQUIP L.L.C.	\$5,889
ARMSTRONG WORLD INDUSTRIES, INC.	\$5,879
INTERSURGICAL INCORPORATED	\$5,868
BAXTER HEALTHCARE CORPORATION	\$5,709
CIVCO MEDICAL SOLUTIONS	\$5,648
CARRIER CORPORATION	\$5,563
PHILIPS DS NORTH AMERICA LLC	\$5,481
STELLEX/CF BUYER (US) LLC	\$5,303
ZYDUS PHARMACEUTICALS (USA) INC.	\$5,194
CHOBANI LLC	\$5,173
HOFFMASTER GROUP, INC.	\$5,094
GREINER BIO-ONE NORTH AMERICA, INC.	\$4,971
KELLANOVA	\$4,968
DJO, LLC DBA ENOVIS BRACING & SUPPORTS	\$4,926
PEDIGO PRODUCTS INC	\$4,844
NOVO NORDISK INC.	\$4,819
WK KELLOGG SALES LLC	\$4,812
BEAVER-VISITEC INTERNATIONAL, INC.	\$4,805
LONG GROVE PHARMACEUTICALS, LLC	\$4,792
SHASTA FOODSERVICE DIVISION OF SHASTA BEVERAGES, INC	\$4,784
PETERSON FARMS FRESH, LLC	\$4,717
RESER'S FINE FOODS, INC.	\$4,558
AMD MEDICOM INC.	\$4,527
ENERGIZER BATTERY COMPANY	\$4,502
SPECGX LLC	\$4,443
SUGAR FOODS LLC	\$4,386
MICRO-TECH ENDOSCOPY USA, INC.	\$4,352
ASP GLOBAL, LLC	\$4,297
FEDERAL EXPRESS CORPORATION	\$4,269

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
ACCUVEIN INC.	\$4,202
INTERNATIONAL BIOMEDICAL, LTD.	\$4,188
CARL ZEISS MEDITEC USA, INC.	\$4,044
ALCON VISION, LLC	\$3,846
J & J SNACK FOODS CORP	\$3,732
CONTEC, INC.	\$3,697
CONMED LINVATEC	\$3,669
BLUETRITON BRANDS, INC.	\$3,663
HOLLISTER INCORPORATED	\$3,432
NEPHRON PHARMACEUTICALS CORPORATION	\$3,398
MEDTRONIC USA, INC.	\$3,393
CUSTOM CULINARY, INC.	\$3,382
ACUTE CARE PHARMACEUTICALS	\$3,252
BE PHARMACEUTICALS, INC.	\$3,248
ALBA BIOSCIENCE, INC.	\$3,242
ULTRAVIOLET DEVICES, INC.	\$3,235
OLE MEXICAN FOODS, INC.	\$3,162
AMNEAL PHARMACEUTICALS LLC	\$2,991
GENDOSE PHARMACEUTICALS	\$2,869
MEAD JOHNSON & COMPANY, LLC	\$2,619
SWEET STREET DESSERTS, INC.	\$2,483
BOEHRINGER LABORATORIES, LLC	\$2,442
PRECISION DOSE, INC.	\$2,341
SMITH & NEPHEW INC - ENDOSCOPY DIVISION	\$2,324
ACIST MEDICAL SYSTEMS, INC.	\$2,266
MARS FOOD US, LLC	\$2,217
RICH PRODUCTS CORPORATION	\$2,201
CAMBRO MANUFACTURING COMPANY	\$2,155
TRI-UNION SEAFOODS, LLC DBA CHICKEN OF THE SEA INTERNATIONAL	\$2,126
RICHARD WOLF MEDICAL INSTRUMENTS CORP.	\$2,102
MYCO MEDICAL SUPPLIES INC.	\$2,100
TOLMAR, INC.	\$2,080
ROBERT BUSSE & CO., INC. DBA BUSSE HOSPITAL DISPOSABLES	\$2,016
LAND O'LAKES, INC.	\$1,993
J.R. SIMPLOT COMPANY	\$1,986
SMITHFIELD FOODS, INC.	\$1,970
THE PROCTER & GAMBLE DISTRIBUTING LLC	\$1,880
ASPIRE BAKERIES LLC	\$1,826
RON'S HOME STYLE FOODS, INC.	\$1,785
HETTICH INSTRUMENTS, LP	\$1,784
MEITHEAL PHARMACEUTICALS, INC.	\$1,779
CANVIY, LLC.	\$1,778
KETTLE CUISINE	\$1,732
BROOKWOOD FARMS, INC.	\$1,648
MEGAMEX FOODS, LLC	\$1,648

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
XGEN PHARMACEUTICALS DJB, INC.	\$1,581
ACCORD HEALTHCARE, INC.	\$1,516
LYONS MAGNUS	\$1,495
MGC DIAGNOSTICS CORPORATION	\$1,473
CMP PHARMA, INC.	\$1,465
CONTINENTAL MILLS, INC. DBA THE KRUSTEAZ COMPANY	\$1,448
MCCORMICK & COMPANY, INC.	\$1,393
MIZUHO ORTHOPEDIC SYSTEMS, INC. DBA MIZUHO OSI	\$1,371
IMPOSSIBLE FOODS INC.	\$1,363
DEL MONTE FOODS CORPORATION II INC.	\$1,338
BRAINTREE LABORATORIES, INC.	\$1,250
BPI LABS, LLC	\$1,236
PADAGIS US LLC	\$1,203
CARDIOVASCULAR SYSTEMS, INC.	\$1,200
MYLAN PHARMACEUTICALS INC.	\$1,189
OHIO MEDICAL, LLC	\$1,114
SURGICAL SPECIALTIES CORPORATION DBA CORZA MEDICAL	\$1,097
KIKKOMAN SALES USA, INC	\$1,095
DARLINGTON COOKIE COMPANY DBA DARLINGTON SNACKS	\$1,065
DANONE NORTH AMERICA	\$1,064
KING'S HAWAIIAN BAKERY WEST, INC.	\$1,053
THE ORIGINAL CAKERIE LTD	\$1,049
SHEATHING TECHNOLOGIES, INC.	\$1,036
PULMODYNE	\$984
ANI PHARMACEUTICALS	\$968
LACTALIS AMERICAN GROUP, INC.	\$922
MED ALLIANCE GROUP, INC. DBA MED ALLIANCE SOLUTIONS, LLC	\$922
MILLERKNOLL, INC. DBA HERMAN MILLER, INC.	\$912
SKLAR CORPORATION	\$905
RISE PHARMA HOLDINGS, INC. DBA RISING PHARMACEUTICALS	\$880
ECO-PRODUCTS, PBC	\$867
BIONIX, LLC	\$852
HENRY SCHEIN, INC.	\$826
CINTAS CORPORATION NO. 2	\$822
MERCURY ENTERPRISES, INC. DBA MERCURY MEDICAL	\$812
SENSOSCIENTIFIC, LLC	\$798
M.C.I. FOODS, INC.	\$761
HANDGARDS, INC.	\$755
VESTIS SERVICES, LLC	\$745
SCHWAN'S SALES CO., INC.	\$744
MERISANT US, INC.	\$735
OCEAN SPRAY	\$726
ALVOGEN, INC.	\$675
GRACE MEDICAL, INC.	\$659
GRIFOLS USA, LLC	\$657

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
SANOFI PASTEUR (FLU)	\$654
GVS TM, INC.	\$606
FERNDAL LABORATORIES, INC.	\$605
NOVADOZ PHARMACEUTICALS, LLC	\$545
POSITIVE PROMOTIONS, INC.	\$539
CONOPCO, INC DBA UNILEVER NA FOODSOLUTIONS	\$532
SUNOPTIC TECHNOLOGIES LLC	\$509
CARRIER ENTERPRISE, LLC	\$504
EDENBRIDGE PHARMACEUTICALS, LLC DBA DEXCEL PHARMA USA	\$496
ADVANTICE HEALTH, LLC	\$494
CONCORDANCE HEALTHCARE SOLUTIONS LLC	\$478
BARILLA AMERICA INC.	\$469
LEADIANT BIOSCIENCES, INC. FKA SIGMA-TAU PHARMACEUTICALS, INC.	\$448
ADVAGEN PHARMA LTD.	\$443
LIPTON TEAS AND INFUSIONS MSO USA LLC	\$404
GREENFIELD GLOBAL USA INC.	\$403
VIATRIS SPECIALTY LLC	\$400
BRIDGFORD FOODS CORPORATION	\$382
MCCAIN FOODS USA, INC.	\$347
CARDINAL HEALTH 414, LLC	\$317
GERI-CARE PHARMACEUTICALS CORP.	\$314
KING CHEESECAKE COMPANY, INC.	\$310
DAISY BRAND, LLC	\$309
ROYAL CUP, INC.	\$308
METREX RESEARCH, LLC	\$301
ZOLL MEDICAL CORPORATION	\$279
T MARZETTI COMPANY	\$276
NESTLE USA, INC.	\$275
HIGH LINER FOODS	\$268
KENTEC MEDICAL, INC.	\$263
KERMA MEDICAL PRODUCTS, INC.	\$262
DYMA BRANDS, INC.	\$257
BREG, INC.	\$257
PERDUE FOODS LLC	\$256
MONAGHAN MEDICAL CORPORATION	\$251
BEYOND MEAT, INC.	\$226
THE STERNO GROUP COMPANIES, LLC DBA STERNO PRODUCTS	\$221
GLOBAL INDUSTRIES, INC. DBA GLOBAL FURNITURE GROUP	\$220
ELI LILLY AND COMPANY	\$182
ACADEMY OF NUTRITION AND DIETETICS	\$180
GEHLS FOODS	\$179
AJANTA PHARMA USA INC.	\$172
KEN'S FOODS, INC.	\$171
PATRIN PHARMA, INC.	\$165
DIVERSIFIED FOODS, INC.	\$161

HARRIS HEALTH PREMIER SPEND Q2 FY2026 (01/01/2026 thru 03/31/2026)	
SUPPLIER	SPEND
MEDTECH PRODUCTS INC	\$150
HERSHEY	\$143
AMNEAL BIOSCIENCES, LLC	\$142
THEA PHARMA INC	\$141
SIEMENS HEALTHCARE DIAGNOSTICS INC.	\$136
ORGANON USA, INC.	\$131
INTERMETRO INDUSTRIES CORPORATION	\$116
SPECTRUM VASCULAR	\$105
ACTION HEALTH	\$95
FERRERO U.S.A., INC.	\$86
SLATE RUN PHARMACEUTICALS	\$82
BRANDING IRON HOLDINGS, INC.	\$78
RUIZ FOOD PRODUCTS, INC.	\$73
HALEON US INC.	\$70
C.H. GUENTHER & SON, INC.	\$65
MEDEFIL, INC.	\$61
GLENMARK PHARMACEUTICALS INC., USA	\$54
PRAIRIE MILLS BAKING COMPANY, LLC DBA BAKE CRAFTERS FOOD COMPANY	\$50
KING & PRINCE SEAFOOD CORPORATION	\$48
SOL-MILLENNIUM MEDICAL INC	\$45
FURMANO FOODS, INC.	\$44
ALORA PHARMACEUTICALS, LLC	\$44
OHM LABORATORIES INC.	\$44
HURON BIDCO, INC. DBA SECOND NATURE BRANDS	\$41
POST CONSUMER BRANDS	\$39
THE SHERWIN-WILLIAMS COMPANY	\$39
RC BIGELOW, INC.	\$37
NORDIC PHARMA, INC.	\$21
HR PHARMACEUTICALS, INC. DBA HR HEALTHCARE	\$17
AUROBINDO PHARMA USA, INC.	\$16
BIRCHWOOD LABORATORIES INC	\$16
RED GOLD, LLC	\$15
STRIDES PHARMA, INC.	\$14
LIFESTAR PHARMA LLC	\$14
SOLCO HEALTHCARE US, LLC	\$5
GRAND TOTAL	\$71,007,262

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Consideration of Approval of Contract Recommendations
(Items B1 through B4 of the Contract Matrix)

Contract Recommendations:

B1. Memorandum of Understanding

- Contractor: Harris County Universal Services
- Project Owner: DeWight Dopslauf
- Term: One Year from Execution Date
- Amount: \$ 720,000.00

B2. New Membership Agreement

- Contractor: Harris County Public Health "HCPH", the Houston Health Department "HHD" and the Harris Center for Mental Health and IDD "Harris Center"
- Project Owner: Dr. Amy Smith
- Term: One Program Year
- Amount: N/A

B3. New Agreement

- Contractor: City of Houston
- Project Owner: Patrick Casey
- Term: 30 Years from Execution Date
- Amount: N/A

B4. New AdHoc Agreement

- Contractor: Bracewell, LLP
- Project Owner: Sara Thomas
- Term: January 23, 2027 – January 22, 2028
- Amount: \$ 500,000.00

Contract Agenda Item(s) for the Harris County Hospital District d/b/a Harris Health, Board of Trustees Report
Contract Matrix: October 14, 2026

No.	Contractor	Description/Justification	Action, Basis of Recommendation	Term	Project Owner	Amount
B1	Harris County Universal Services	Consideration of Approval of Memorandum of Understanding (MOU) between Harris Health and Harris County Universal Services for the use of fuel services via Fuelman and Harris County owned and operated fueling and EV stations. <i>*Harris Health will pay HCUS Fleet up to \$720,000 annually for its services.</i>	Memorandum of Understanding	One Year from Executive Date	DeWight Dopslauf	\$ 720,000.00
B2	Harris County Public Health "HCPH", the Houston Health Department "HHD" and the Harris Center for Mental Health and IDD "Harris Center"	Consideration of approval of a membership agreement between Harris Health, Harris County Public Health "HCPH", the Houston Health Department "HHD" and the Harris Center for Mental Health and IDD "Harris Center" to Establish and Join a Collaborative Group to Perform Care Coordination for providing health services to uninsured persons residing in Harris County, Texas, and Houston. <i>*The term of this contract is for one program year of October 1st through September 30th of the immediately following calendar year which shall be determined upon the execution of this agreement.</i>	New Membership Agreement	One Program Year	Dr. Amy Smith	\$ -
B3	City of Houston	Consideration of approval of an agreement between the City of Houston and Harris Health to permit use and occupancy of a public street right-of-way for the Casa de Amigos Urgent Care Expansion Project at 1615 N Main Street, Houston, Texas 77009. <i>*The expansion includes a canopy which encroaches on the public rights-of-way on Harrington Street. Under the agreement terms, Harris Health (Permittee), and its successors, shall be permitted to construct, use, occupy, operate, maintain and repair the property which encroaches within, under, over, across and/or along the Harrington Street right-of-way for a 30-year term which shall begin on the effective date of this agreement.</i>	New Agreement	30 Years from Execution Date	Patrick Casey	\$ -
B4	Bracewell, LLP	Consideration of approval of an agreement between Bracewell, LLP and Harris Health to serve as counsel for Harris Health in matters related to real property and public law matters. <i>*Upon expiration of the initial term, the Agreement shall automatically renew for an additional two (1) year term.</i>	New AdHoc Agreement	January 23, 2027 through January 22, 2028	Sara Thomas	\$ 500,000.00
TOTAL AMOUNT:						\$ 1,220,000.00

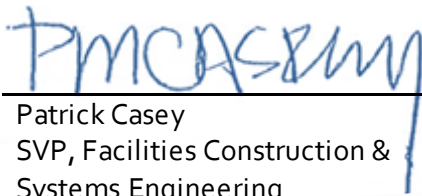
Meeting of the Board of Trustees

Wednesday, October 14, 2026

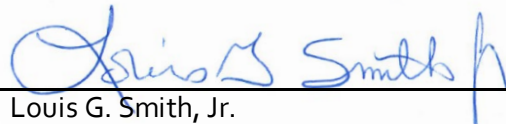
Consideration of Approval to Acquire Real Property for a New Health Center in
Northwest Harris County

Administration recommends that the Board of Trustees approve the acquisition of real property, as detailed on the attached Fact Sheet, for a new Northwest Health Center at 1006 W 34th Street, Houston, Texas 77018.

Thank you.



Patrick Casey
SVP, Facilities Construction &
Systems Engineering



Louis G. Smith, Jr.
Sr. EVP/Chief Operating Officer



Valbridge
PROPERTY ADVISORS

Appraisal Report

W. 34th Street Tract
1006 W. 34th Street
Houston, Harris County, Texas 77018

Report Date: March 30, 2026



FOR:

Harris Health System
Mr. Brian Pitre
4800 Fournace Place
Bellaire, Texas 77401

Valbridge Property Advisors | Houston

974 Campbell Road, Suite 204
Houston, Texas 77024
(713) 467-5858 phone
(713) 467-0704 fax

valbridge.com

Valbridge File Number:
TX02-26-0364-000

The findings and conclusions are further contingent upon the following extraordinary assumptions and/or hypothetical conditions, the use of which might have affected the assignment results:

Extraordinary Assumptions:

- None

Hypothetical Conditions:

- None

Based on the analysis contained in the following report, our value conclusions are summarized as follows:

Value Conclusion

Component	As Is
Value Type	Market Value
Real Property Interest	Fee Simple
Effective Date of Value	March 20, 2026
Value Conclusion	\$4,145,000
	\$39.00 PSF

Respectfully submitted,
Valbridge Property Advisors | Houston



Jason Mushinski, MAI
Senior Managing Director
Texas License #1335986-CG
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Erin Pechal, MAI
Senior Appraiser
Texas License #1338809-CG
epechal@valbridge.com

Summary of Salient Facts

Property Identification

Property Address	1006 W. 34th Street Houston, Harris County, Texas 77018
Tax Parcel Number	1167850000003
Property Owner	Richards Property Management, LLC

Site

Zoning	Not Zoned
FEMA Flood Map No.	48201C0660M
Flood Zone	Zone X (unshaded)
Gross Land Area	2.440 acres

Existing Improvements

Property Use	Office Warehouse
Gross Building Area (GBA)	11,952 sf
Net Rentable Area (NRA)	11,952 sf
Number of Buildings	2
Number of Stories	2
Year Built	1986
Condition	Average
Construction Class	C - Masonry
Construction Quality	Average
Percent Office	48.5%
Clear Height	18.0'

Valuation Opinions

Highest & Best Use - As Vacant	Multi-family development
Highest & Best Use - As Improved	Redevelopment
Reasonable Exposure Time	12 months
Reasonable Marketing Time	12 months

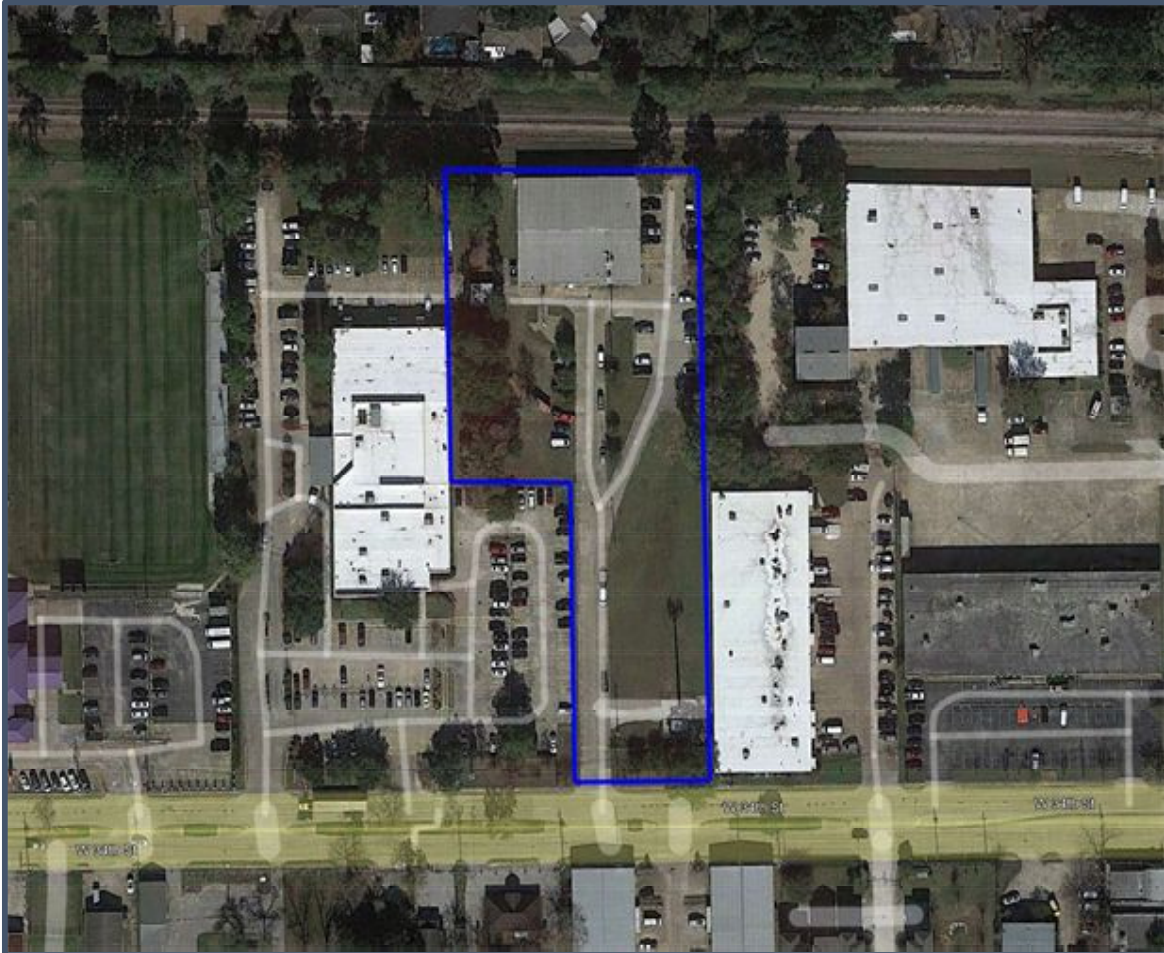
Value Indications

Approach to Value		As Is
Sales Comparison		\$4,145,000
Cost		Not Developed
Income Capitalization		Not Developed

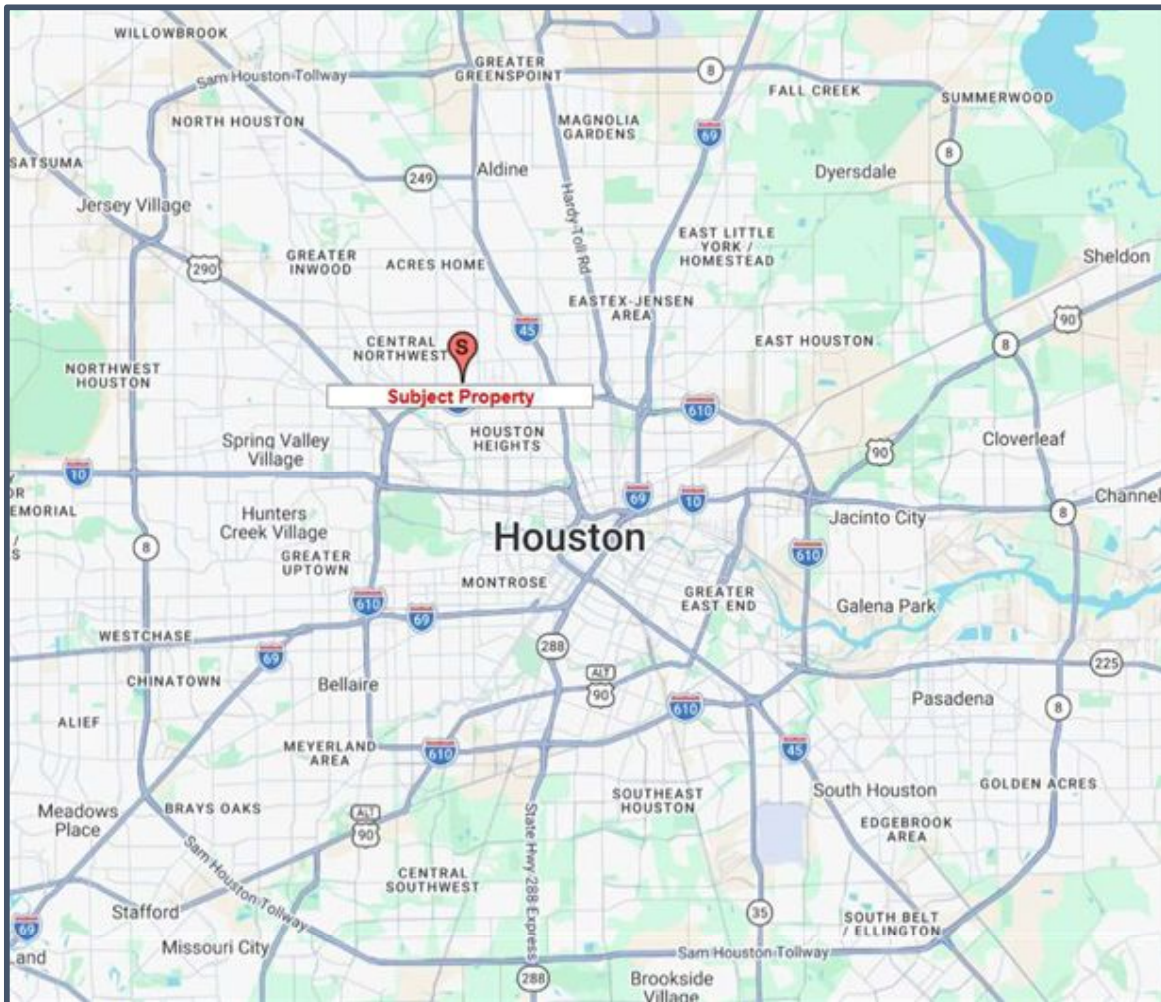
Value Conclusion

Component		As Is
Value Type		Market Value
Real Property Interest		Fee Simple
Effective Date of Value		March 20, 2026
Value Conclusion		\$4,145,000
		\$39.00 PSF

Aerial View



Location Map





COMMERCIAL CONTRACT - IMPROVED PROPERTY

USE OF THIS FORM BY PERSONS WHO ARE NOT MEMBERS OF THE TEXAS ASSOCIATION OF REALTORS®, INC. IS NOT AUTHORIZED.
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- 1. PARTIES:** Seller agrees to sell and convey to Buyer the Property described in Paragraph 2. Buyer agrees to buy the Property from Seller for the sales price stated in Paragraph 3. The parties to this contract are:

Seller: Richards Property Management LLC

Attn: Barry Richards

Address: 8453 County Road 410 Navasota TX 77868

Phone: _____ E-mail: brichardstx@gmail.com

Mobile: (713) 254-8621 Fax or Other: _____

Buyer: Harris County Hospital District d/b/a Harris Health

Attn: Brian Pitre

Address: 4800 Fournace Place Bellaire TX 77401

Phone: _____ E-mail: Brian.Pitre@harrishealth.org

Mobile: (346) 426-0733 Fax or Other: _____

2. PROPERTY:

- A. "Property" means that real property situated in Harris County, Texas at 1006 W 34th St, Houston, TX 77018 (address) and that is legally described on the attached Exhibit A or as follows:

- B. Seller will sell and convey the Property together with:

- (1) all buildings, improvements, and fixtures;
- (2) all rights, privileges, and appurtenances pertaining to the Property, including Seller's right, title, and interest in any minerals, utilities, adjacent streets, alleys, strips, gores, and rights-of-way;
- (3) Seller's interest in all leases, rents, and security deposits for all or part of the Property;
- (4) Seller's interest in all licenses and permits related to the Property;
- (5) Seller's interest in all third party warranties or guaranties, if transferable, relating to the Property or any fixtures;
- (6) Seller's interest in any trade names, if transferable, used in connection with the Property; and
- (7) all Seller's tangible personal property located on the Property that is used in connection with the Property's operations except: _____.

Any personal property not included in the sale must be removed by Seller prior to closing.

(Describe any exceptions, reservations, or restrictions in Paragraph 12 or an addendum.)

(If mineral rights are to be reserved an appropriate addendum should be attached.)

(If the Property is a condominium, attach Commercial Contract Condominium Addendum (TXR-1930) or (TXR-1946).)

- 3. SALES PRICE:** At or before closing, Buyer will pay the following sales price for the Property:

A. Cash portion payable by Buyer at closing\$ 4,250,000.00

B. Sum of all financing described in Paragraph 4\$ _____

C. Sales price (sum of 3A and 3B)\$ 4,250,000.00

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Initialed for Identification by Seller: BR, _____, and Buyer: _____, _____

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Commercial Contract - Improved Property concerning 1006 W 34th St, Houston, TX 77018

4. FINANCING: Buyer will finance the portion of the sales price under Paragraph 3B as follows:

- ☐ A. Third Party Financing: One or more third party loans in the total amount of \$_____. This contract:
- ☐ (1) is not contingent upon Buyer obtaining third party financing.
- ☐ (2) is contingent upon Buyer obtaining third party financing in accordance with the attached Commercial Contract Financing Addendum (TXR-1931).
- ☐ B. Assumption: In accordance with the attached Commercial Contract Financing Addendum (TXR-1931), Buyer will assume the existing promissory note secured by the Property, which balance at closing will be \$_____.
- ☐ C. Seller Financing: Buyer will deliver a promissory note and deed of trust to Seller under the terms of the attached Commercial Contract Financing Addendum (TXR-1931) in the amount of \$_____.

5. EARNEST MONEY:

- A. Not later than 7 business days after the effective date, Buyer must deposit \$ 50,000.00 as earnest money with Charter Title (title company) at 1717 W Loop S 12th Floor, Houston, TX 77027 (address) Susan Simmons (closer). If Buyer fails to timely deposit the earnest money, Seller may terminate this contract or exercise any of Seller's other remedies under Paragraph 15 by providing written notice to Buyer before Buyer deposits the earnest money.
- B. Buyer will deposit an additional amount of \$_____ with the title company to be made part of the earnest money on or before:
- ☐ (i) _____ days after Buyer's right to terminate under Paragraph 7B expires; or
- ☐ (ii) _____.
- Buyer will be in default if Buyer fails to deposit the additional amount required by this Paragraph 5B within 3 days after Seller notifies Buyer that Buyer has not timely deposited the additional amount.
- C. Buyer may instruct the title company to deposit the earnest money in an interest-bearing account at a federally insured financial institution and to credit any interest to Buyer.

6. TITLE POLICY, SURVEY, AND UCC SEARCH:

- A. Title Policy:
- (1) Seller, at Seller's expense, will furnish Buyer an Owner's Policy of Title Insurance (the title policy) issued by any underwriter of the title company in the amount of the sales price, dated at or after closing, insuring Buyer against loss under the title policy, subject only to:
- (a) those title exceptions permitted by this contract or as may be approved by Buyer in writing; and
- (b) the standard printed exceptions contained in the promulgated form of title policy unless this contract provides otherwise.
- (2) The standard printed exception as to discrepancies, conflicts, or shortages in area and boundary lines, or any encroachments or protrusions, or any overlapping improvements:
- ☐ (a) will not be amended or deleted from the title policy.
- ☒ (b) ~~will~~ may be amended to read "shortages in areas" at the expense of ☒ Buyer ☐ Seller.
- (3) Within 10 days after the effective date, Seller will furnish Buyer a commitment for title insurance (the commitment) including legible copies of recorded documents evidencing title exceptions. Seller authorizes the title company to deliver the commitment and related documents to Buyer at Buyer's address.

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B. Survey: Within 10 days after the effective date:

- ☐ (1) Buyer will obtain a survey of the Property at Buyer's expense and deliver a copy of the survey to Seller. The survey must be made in accordance with the: (i) ALTA/NSPS Land Title Survey standards, or (ii) Texas Society of Professional Surveyors' standards for a Category 1A survey under the appropriate condition. Seller will reimburse Buyer _____ (insert amount) of the cost of the survey at closing, if closing occurs.
- ☐ (2) Seller, at Seller's expense, will furnish Buyer a survey of the Property dated after the effective date. The survey must be made in accordance with the: (i) ALTA/NSPS Land Title Survey standards, or (ii) Texas Society of Professional Surveyors' standards for a Category 1A survey under the appropriate condition.
- ☒ (3) Seller will deliver to Buyer and the title company a true and correct copy of Seller's most recent survey of the Property along with an affidavit required by the title company for approval of the existing survey. If the existing survey is not acceptable to the title company, ☐ Seller ☒ Buyer (updating party), will, at the updating party's expense, obtain a new or updated survey acceptable to the title company and deliver the acceptable survey to the other party and the title company within 30 days after the title company notifies the parties that the existing survey is not acceptable to the title company. The closing date will be extended daily up to 30 days if necessary for the updating party to deliver an acceptable survey within the time required. The other party will reimburse the updating party not to exceed \$2,500 (insert amount or percentage) of the cost of the new or updated survey at closing, if closing occurs.

C. UCC Search:

- ☐ (1) Within _____ days after the effective date, Seller, at Seller's expense, will furnish Buyer a Uniform Commercial Code (UCC) search prepared by a reporting service and dated after the effective date. The search must identify documents that are on file with the Texas Secretary of State and the county where the Property is located that relate to all personal property on the Property and show, as debtor, Seller and all other owners of the personal property in the last 5 years.
- ☒ (2) Buyer does not require Seller to furnish a UCC search.

D. Buyer's Objections to the Commitment, Survey, and UCC Search:

- (1) Within 10 days after Buyer receives the last of the commitment, copies of the documents evidencing the title exceptions, any required survey, and any required UCC search, Buyer may object to matters disclosed in the items if: (a) the matters disclosed are a restriction upon the Property or constitute a defect or encumbrance to title to the real or personal property described in Paragraph 2 other than those permitted by this contract or liens that Seller will satisfy at closing or Buyer will assume at closing; or (b) the items show that any part of the Property lies in a special flood hazard area (an "A" or "V" zone as defined by FEMA). If the commitment or survey is revised or any new document evidencing a title exception is delivered, Buyer may object to any new matter revealed in such revision or new document. Buyer's objection must be made within the same number of days stated in this paragraph, beginning when the revision or new document is delivered to Buyer. If Paragraph 6B(1) applies, Buyer is deemed to receive the survey on the earlier of: (i) the date Buyer actually receives the survey; or (ii) the deadline specified in Paragraph 6B.
- (2) Seller may, but is not obligated to, cure Buyer's timely objections within 15 days after Seller receives the objections. The closing date will be extended as necessary to provide such time to cure the objections. If Seller fails to cure the objections by the time required, Buyer may terminate this contract by providing written notice to Seller within 5 days after the time by which Seller must cure the

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objections. If Buyer terminates, the earnest money, less any independent consideration under Paragraph 7B(1), will be refunded to Buyer.

- (3) Buyer's failure to timely object or terminate under this Paragraph 6D is a waiver of Buyer's right to object except that Buyer will not waive the requirements in Schedule C of the commitment.

7. PROPERTY CONDITION:

- A. Present Condition: Buyer accepts the Property in its present condition except that Seller, at Seller's expense, will complete the following before closing: None

- B. Feasibility Period: Buyer may terminate this contract for any reason within 90 days after the effective date (feasibility period) by providing Seller written notice of termination.

- (1) Independent Consideration. (Check only one box and insert amounts.)

- ☒ (a) If Buyer terminates under this Paragraph 7B, the earnest money will be refunded to Buyer less \$ 1,000.00 that Seller will retain as independent consideration for Buyer's unrestricted right to terminate. Buyer has tendered the independent consideration to Seller upon payment of the amount specified in Paragraph 5A to the title company. The independent consideration is to be credited to the sales price only upon closing of the sale. If no dollar amount is stated in this Paragraph 7B(1) or if Buyer fails to deposit the earnest money, Buyer will not have the right to terminate under this Paragraph 7B.

- ☐ (b) Not later than 3 days after the effective date, Buyer must pay \$ _____ as independent consideration for Buyer's right to terminate by tendering such amount to the title company. Buyer authorizes escrow agent to release and deliver the independent consideration to Seller at any time upon Seller's request without further notice to or consent from Buyer. If Buyer terminates under this Paragraph 7B, the earnest money will be refunded to Buyer and Seller will retain the independent consideration. The independent consideration will be credited to the sales price only upon closing of the sale. If no dollar amount is stated in this Paragraph 7B(1)(b) or if Buyer fails to pay the independent consideration, Buyer will not have the right to terminate under this Paragraph 7B.

- ☒ (2) Feasibility Period Extension: Prior to the expiration of the initial feasibility period, Buyer may extend the feasibility period for a single additional period of 30 days by delivering \$ 15,000.00 to the title company as additional earnest money.

- (a) \$ 15,000.00 of the additional earnest money will be retained by Seller as additional independent consideration for Buyer's unrestricted right to terminate, but will be credited to the sales price only upon closing of the sale. If Buyer terminates under this Paragraph 7B, the additional earnest money will be refunded to Buyer and Seller will retain the additional independent consideration.

- (b) Buyer authorizes escrow agent to release and deliver to Seller the following at any time upon Seller's request without further notice to or consent from Buyer:

(i) The additional independent consideration.

(ii) (Check no boxes or only one box.)

☐ all or ☐ \$ _____ of the remaining portion of the additional earnest money, which will be refunded to Buyer if Buyer terminates under this Paragraph 7B or if Seller defaults under this contract.

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If no dollar amount is stated in this Paragraph 7B(2) as additional earnest money or as additional independent consideration, or if Buyer fails to timely deliver the additional earnest money, the extension of the feasibility period will not be effective.

C. Inspections, Studies, or Assessments:

- (1) During the feasibility period, Buyer, at Buyer's expense, may complete or cause to be completed any and all inspections, studies, or assessments of the Property (including all improvements and fixtures) desired by Buyer.
- (2) Seller, at Seller's expense, will turn on all utilities necessary for Buyer to make inspections, studies, or assessments.
- (3) Buyer must:
 - (a) employ only trained and qualified inspectors and assessors;
 - (b) notify Seller, in advance, of when the inspectors or assessors will be on the Property;
 - (c) abide by any reasonable entry rules or requirements of Seller;
 - (d) not interfere with existing operations or occupants of the Property; and
 - (e) restore the Property to its original condition if altered due to inspections, studies, or assessments that Buyer completes or causes to be completed.
- (4) Except for those matters that arise from the negligence of Seller or Seller's agents, Buyer is responsible for any claim, liability, encumbrance, cause of action, and expense resulting from Buyer's inspections, studies, or assessments, including any property damage or personal injury. Buyer will indemnify, hold harmless, and defend Seller and Seller's agents against any claim involving a matter for which Buyer is responsible under this paragraph. This paragraph survives termination of this contract.

D. Property Information:

- (1) Delivery of Property Information: Within 10 days after the effective date, Seller will deliver to Buyer the following to the extent in Seller's possession: *(Check all that apply.)*
 - ☐ (a) a current rent roll of all leases affecting the Property certified by Seller as true and correct;
 - ☒ (b) copies of all current leases, including any mineral leases, pertaining to the Property, including any modifications, supplements, or amendments to the leases;
 - ☐ (c) a current inventory of all personal property to be conveyed under this contract and copies of any leases for such personal property;
 - ☐ (d) copies of all notes and deeds of trust against the Property that Buyer will assume or that Seller will not pay in full on or before closing;
 - ☒ (e) copies of all current service, utility, maintenance, and management agreements relating to the ownership and operation of the Property;
 - ☐ (f) copies of current utility capacity letters from the Property's water and sewer service provider;
 - ☐ (g) copies of all current warranties and guaranties relating to all or part of the Property;
 - ☐ (h) copies of fire, hazard, liability, and other insurance policies that currently relate to the Property;
 - ☐ (i) copies of all leasing or commission agreements that currently relate to the tenants of all or part of the Property;
 - ☐ (j) a copy of the "as-built" plans and specifications and plat of the Property;
 - ☒ (k) copies of all invoices for utilities and repairs incurred by Seller for the Property in the 24 months immediately preceding the effective date;
 - ☐ (l) a copy of Seller's income and expense statement for the Property from _____ to _____;
 - ☒ (m) copies of all previous environmental assessments, geotechnical reports, studies, or analyses made on or relating to the Property;

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- ☒ (n) real and personal property tax statements for the Property for the previous 2 calendar years;
- ☐ (o) Tenant reconciliation statements including, operating expenses, insurance and taxes for the Property from _____ to _____; and
- ☐ (p) _____

(2) Return of Property Information: If this contract terminates for any reason, Buyer will, not later than 10 days after the termination date: *(Check all that apply.)*

- ☒ (a) return to Seller all those items described in Paragraph 7D(1) that Seller delivered to Buyer in other than an electronic format and all copies that Buyer made of those items;
- ☒ (b) delete or destroy all electronic versions of those items described in Paragraph 7D(1) that Seller delivered to Buyer or Buyer copied in any format; and
- ☒ (c) deliver to Seller copies of all inspection and assessment reports related to the Property that Buyer completed or caused to be completed.

This Paragraph 7D(2) survives termination of this contract.

E. Contracts Affecting Operations: Until closing, Seller: (1) will operate the Property in the same manner as on the effective date under reasonably prudent business standards; and (2) will not transfer or dispose of any part of the Property, any interest or right in the Property, or any of the personal property or other items described in Paragraph 2B or sold under this contract. After the feasibility period ends, Seller may not enter into, amend, or terminate any other contract that affects the operations of the Property without Buyer's written approval.

8. LEASES:

A. Each written lease Seller is to assign to Buyer under this contract must be in full force and effect according to its terms. Seller may not enter into any new lease, fail to comply with any existing lease, or make any amendment or modification to any existing lease without Buyer's written consent. Seller must disclose, in writing, if any of the following exist at the time Seller provides the leases to the Buyer or subsequently occur before closing:

- (1) any failure by Seller to comply with Seller's obligations under the leases;
- (2) any circumstances under any lease that entitle the tenant to terminate the lease or seek any offsets or damages;
- (3) any non-occupancy of the leased premises by a tenant;
- (4) any advance sums paid by a tenant under any lease;
- (5) any concessions, bonuses, free rents, rebates, brokerage commissions, or other matters that affect any lease; and
- (6) any amounts payable under the leases that have been assigned or encumbered, except as security for loan(s) assumed or taken subject to under this contract.

B. Estoppel Certificates: Within _____ days after the effective date, Seller will deliver to Buyer estoppel certificates signed not earlier than _____ by each tenant that leases space in the Property. The estoppel certificates must include the certifications contained in the current version of TXR Form 1938 – Commercial Tenant Estoppel Certificate and any additional information requested by a third party lender providing financing under Paragraph 4 if the third party lender requests such additional information at least 10 days prior to the earliest date that Seller may deliver the signed estoppel certificates.

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9. BROKERS:

A. The brokers to this sale are:

Principal Broker: Boyd Commercial LLC

Cooperating Broker: Brian Pitre

Agent: Greg Barra

Agent: Brian Pitre

Address: 2200 W Loop S, Ste 525
Houston, TX 77027

Address: 4800 Fournace Place
Bellaire, TX 77401

Phone & Fax: 713-877-8400

Phone & Fax: 346-426-0733

E-mail: gbarra@boydcommercial.net

E-mail: Brian.Pitre@harrishealth.org

License No.: 511967

License No.: 413866

Principal Broker: (Check only one box)

☒ represents Seller only.

☐ represents Buyer only.

☐ is an intermediary between Seller and Buyer.

Cooperating Broker represents Buyer.

B. Fees: (Check only (1) or (2) below.)

(Complete the Agreement Between Brokers on page 15 only if (1) is selected.)

☐ (1) Seller will pay Principal Broker the fee specified by separate written commission agreement between Principal Broker and Seller. Principal Broker will pay Cooperating Broker the fee specified in the Agreement Between Brokers found below the parties' signatures to this contract.

☒ (2) At the closing of this sale, Seller will pay:

Principal Broker a total cash fee of:

☒ 3.5 % of the sales price.

☐ _____.

Cooperating Broker a total cash fee of:

☒ 2.5 % of the sales price.

☐ _____.

The cash fees will be paid in Harris County, Texas. Seller authorizes the title company to pay the brokers from the Seller's proceeds at closing.

NOTICE: Chapter 62, Texas Property Code, authorizes a broker to secure an earned commission with a lien against the Property.

C. The parties may not amend this Paragraph 9 without the written consent of the brokers affected by the amendment.

10. CLOSING:

A. The date of the closing of the sale (closing date) will be on or before the later of:

(1) ☒ 30 days after the expiration of the feasibility period.

☐ _____ (specific date).

☐ _____.

(2) 7 days after objections made under Paragraph 6D have been cured or waived.

B. If either party fails to close by the closing date, the non-defaulting party may exercise the remedies in Paragraph 15.

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Initialed for Identification by Seller: BR, _____, and Buyer: _____, _____

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Commercial Contract - Improved Property concerning 1006 W 34th St, Houston, TX 77018

- C. At closing, Seller will execute and deliver to Buyer, at Seller's expense, a ☐ general ☒ special warranty deed. The deed must include a vendor's lien if any part of the sales price is financed. The deed must convey good and indefeasible title to the Property and show no exceptions other than those permitted under Paragraph 6 or other provisions of this contract. Seller must convey the Property:
- (1) with no liens, assessments, or Uniform Commercial Code or other security interests against the Property which will not be satisfied out of the sales price, unless securing loans Buyer assumes;
 - (2) without any assumed loans in default; and
 - (3) with no persons in possession of any part of the Property as lessees, tenants at sufferance, or trespassers except tenants under the written leases assigned to Buyer under this contract.

- D. At closing, Seller, at Seller's expense, will also deliver to Buyer:
- (1) tax statements showing no delinquent taxes on the Property;
 - (2) a bill of sale with warranties to title conveying title, free and clear of all liens, to any personal property defined as part of the Property in Paragraph 2 or sold under this contract;
 - (3) an assignment of all leases to or on the Property;
 - (4) to the extent that the following items are assignable, an assignment to Buyer of the following items as they relate to the Property or its operations:
 - (a) licenses and permits;
 - (b) service, utility, maintenance, management, and other contracts; and
 - (c) warranties and guaranties;
 - (5) a rent roll current on the day of the closing certified by Seller as true and correct;
 - (6) evidence that the person executing this contract is legally capable and authorized to bind Seller;
 - (7) an affidavit acceptable to the title company stating that Seller is not a foreign person or, if Seller is a foreign person, a written authorization for the title company to: (i) withhold from Seller's proceeds an amount sufficient to comply with applicable tax law; and (ii) deliver the amount to the Internal Revenue Service together with appropriate tax forms; and
 - (8) any notices, statements, certificates, affidavits, releases, and other documents required by this contract, the commitment, or law necessary for the closing of the sale and the issuance of the title policy, all of which must be completed and executed by Seller as necessary.

- E. At closing, Buyer will:
- (1) pay the sales price in good funds acceptable to the title company;
 - (2) deliver evidence that the person executing this contract is legally capable and authorized to bind Buyer;
 - (3) sign and send to each tenant in the Property a written statement that:
 - (a) acknowledges Buyer has received and is responsible for the tenant's security deposit; and
 - (b) specifies the exact dollar amount of the security deposit;
 - (4) sign an assumption of all leases then in effect; and
 - (5) execute and deliver any notices, statements, certificates, or other documents required by this contract or law necessary to close the sale.

- F. Unless the parties agree otherwise, the closing documents will be as found in the basic forms in the current edition of the State Bar of Texas Real Estate Forms Manual without any additional clauses.

11. POSSESSION: Seller will deliver possession of the Property to Buyer upon closing and funding of this sale in its present condition with any repairs Seller is obligated to complete under this contract, ordinary wear and tear excepted. Any possession by Buyer before closing or by Seller after closing that is not authorized by a separate written lease agreement is a landlord-tenant at sufferance relationship between the parties.

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Initialed for Identification by Seller:  _____, _____, and Buyer: _____, _____

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Commercial Contract - Improved Property concerning 1006 W 34th St, Houston, TX 77018

12. SPECIAL PROVISIONS: The following special provisions apply and will control in the event of a conflict with other provisions of this contract. *(If special provisions are contained in an Addendum, identify the Addendum here and reference the Addendum in Paragraph 22D.)*

See Addendum (Exhibit B)

13. SALES EXPENSES:

A. Seller's Expenses: Seller will pay for the following at or before closing:

- (1) releases of existing liens, other than those liens assumed by Buyer, including prepayment penalties and recording fees;
- (2) release of Seller's loan liability, if applicable;
- (3) tax statements or certificates;
- (4) preparation of the deed and any bill of sale;
- (5) one-half of any escrow fee;
- (6) costs to record any documents to cure title objections that Seller must cure; and
- (7) other expenses that Seller will pay under other provisions of this contract.

B. Buyer's Expenses: Buyer will pay for the following at or before closing:

- (1) all loan expenses and fees;
- (2) preparation fees of any deed of trust;
- (3) recording fees for the deed and any deed of trust;
- (4) premiums for flood and hazard insurance as may be required by Buyer's lender;
- (5) one-half of any escrow fee; and
- (6) other expenses that Buyer will pay under other provisions of this contract.

14. PRORATIONS:

A. Prorations:

- (1) Interest on any assumed loan, taxes, rents, and any expense reimbursements from tenants will be prorated through the closing date.
- (2) If the amount of ad valorem taxes for the year in which the sale closes is not available on the closing date, taxes will be prorated on the basis of taxes assessed in the previous year. If the taxes for the year in which the sale closes vary from the amount prorated at closing, the parties will adjust the prorations when the tax statements for the year in which the sale closes become available. This Paragraph 14A(2) survives closing.
- (3) If Buyer assumes a loan or is taking the Property subject to an existing lien, Seller will transfer all reserve deposits held by the lender for the payment of taxes, insurance premiums, and other charges to Buyer at closing and Buyer will reimburse such amounts to Seller by an appropriate adjustment at closing.

B. Rollback Taxes: If Seller's use or change in use of the Property before closing results in the assessment of additional taxes, penalties, or interest (assessments) for periods before closing, the assessments will be the obligation of Seller. If this sale or Buyer's use of the Property after closing results in additional assessments for periods before closing, the assessments will be the obligation of Buyer. This Paragraph 14B survives closing.

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Initialed for Identification by Seller: DS BR, _____, and Buyer: _____, _____

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Commercial Contract - Improved Property concerning 1006 W 34th St, Houston, TX 77018

- C. Rent and Security Deposits: At closing, Seller will tender to Buyer all security deposits and the following advance payments received by Seller for periods after closing: prepaid expenses, advance rental payments, and other advance payments paid by tenants. Rents prorated to one party but received by the other party will be remitted by the recipient to the party to whom it was prorated within 5 days after the rent is received. This Paragraph 14C survives closing.

15. DEFAULT:

- A. If Buyer fails to comply with this contract, Buyer is in default and Seller, as Seller's sole remedy(ies), may terminate this contract and receive the earnest money, as liquidated damages for Buyer's failure except for any damages resulting from Buyer's inspections, studies or assessments in accordance with Paragraph 7C(4) which Seller may pursue, or
(Check if applicable)
~~☐ enforce specific performance, or seek such other relief as may be provided by law.~~
- B. If, without fault, Seller is unable within the time allowed to deliver the estoppel certificates, survey or the commitment, Buyer may:
- (1) terminate this contract and receive the earnest money, less any independent consideration under Paragraph 7B(1), as liquidated damages and as Buyer's sole remedy; or
 - (2) extend the time for performance up to 15 days and the closing will be extended as necessary.
- C. Except as provided in Paragraph 15B, if Seller fails to comply with this contract, Seller is in default and Buyer may:
- (1) terminate this contract and receive the earnest money, less any independent consideration under Paragraph 7B(1), as liquidated damages and as Buyer's sole remedy; or
 - (2) enforce specific performance, ~~or seek such other relief as may be provided by law, or both.~~

16. CASUALTY LOSS AND CONDEMNATION:

- A. If any part of the Property is damaged or destroyed by fire or other casualty after the effective date, Seller must restore the Property to its previous condition as soon as reasonably possible and not later than the closing date. If, without fault, Seller is unable to do so, Buyer may:
- (1) terminate this contract and the earnest money, less any independent consideration under Paragraph 7B(1), will be refunded to Buyer;
 - (2) extend the time for performance up to 15 days and closing will be extended as necessary; or
 - (3) accept at closing: (i) the Property in its damaged condition; (ii) an assignment of any insurance proceeds Seller is entitled to receive along with the insurer's consent to the assignment; and (iii) a credit to the sales price in the amount of any unpaid deductible under the policy for the loss.
- B. If before closing, condemnation proceedings are commenced against any part of the Property, Buyer may:
- (1) terminate this contract by providing written notice to Seller within 15 days after Buyer is advised of the condemnation proceedings and the earnest money, less any independent consideration under Paragraph 7B(1), will be refunded to Buyer; or
 - (2) appear and defend the condemnation proceedings and any award will, at Buyer's election, belong to:
 - (a) Seller and the sales price will be reduced by the same amount; or
 - (b) Buyer and the sales price will not be reduced.

- 17. ATTORNEY'S FEES:** If Buyer, Seller, any broker, or the title company is a prevailing party in any legal proceeding brought under or with relation to this contract or this transaction, such party is entitled to recover from the non-prevailing parties all costs of such proceeding and reasonable attorney's fees. This Paragraph 17 survives termination of this contract.

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18. ESCROW:

- A. At closing, the earnest money will be applied first to any cash down payment, then to Buyer's closing costs, and any excess will be refunded to Buyer. If no closing occurs, the title company may require payment of unpaid expenses incurred on behalf of the parties and a written release of liability of the title company from all parties.
- B. If one party makes written demand for the earnest money, the title company will give notice of the demand by providing to the other party a copy of the demand. If the title company does not receive written objection to the demand from the other party within 15 days after the date the title company sent the demand to the other party, the title company may disburse the earnest money to the party making demand, reduced by the amount of unpaid expenses incurred on behalf of the party receiving the earnest money and the title company may pay the same to the creditors.
- C. The title company will deduct any independent consideration under Paragraph 7B(1) before disbursing any earnest money to Buyer and will pay the independent consideration to Seller.
- D. If the title company complies with this Paragraph 18, each party hereby releases the title company from all claims related to the disbursement of the earnest money.
- E. Notices under this Paragraph 18 must be sent by certified mail, return receipt requested. Notices to the title company are effective upon receipt by the title company.
- F. Any party who wrongfully fails or refuses to sign a release acceptable to the title company within 7 days after receipt of the request will be liable to the other party for: (i) damages; (ii) the earnest money; (iii) reasonable attorney's fees; and (iv) all costs of suit.
- G. ☐ Seller ☐ Buyer intend(s) to complete this transaction as a part of an exchange of like-kind properties in accordance with Section 1031 of the Internal Revenue Code, as amended. All expenses in connection with the contemplated exchange will be paid by the exchanging party. The other party will not incur any expense or liability with respect to the exchange. The parties agree to cooperate fully and in good faith to arrange and consummate the exchange so as to comply to the maximum extent feasible with the provisions of Section 1031 of the Internal Revenue Code. The other provisions of this contract will not be affected in the event the contemplated exchange fails to occur.

19. MATERIAL FACTS: To the best of Seller's knowledge and belief: *(Check only one box.)*

- ☐ A. Seller is not aware of any material defects to the Property except as stated in the attached Commercial Property Condition Statement (TXR-1408).
- ☒ B. Except as otherwise provided in this contract, Seller is not aware of:
 - (1) any subsurface: structures, pits, waste, springs, or improvements;
 - (2) any pending or threatened litigation, condemnation, or assessment affecting the Property;
 - (3) any environmental hazards or conditions that materially affect the Property;
 - (4) whether the Property is or has been used for the storage or disposal of hazardous materials or toxic waste, a dump site or landfill, or any underground tanks or containers;
 - (5) whether radon, asbestos containing materials, urea-formaldehyde foam insulation, lead-based paint, toxic mold (to the extent that it adversely affects the health of ordinary occupants), or other pollutants or contaminants of any nature now exist or ever existed on the Property;
 - (6) any wetlands, as defined by federal or state law or regulation, on the Property;
 - (7) any threatened or endangered species or their habitat on the Property;
 - (8) any present or past infestation of wood-destroying insects in the Property's improvements;
 - (9) any contemplated material changes to the Property or surrounding area that would materially and detrimentally affect the ordinary use of the Property;

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Initialed for Identification by Seller: DS
BR, _____, and Buyer: _____, _____

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- (10) any material physical defects in the improvements on the Property; or
- (11) any condition on the Property that violates any law or ordinance.

(Describe any exceptions to (1)-(11) in Paragraph 12 or an addendum.)

20. NOTICES: All notices between the parties under this contract must be in writing and are effective when hand-delivered, mailed by certified mail return receipt requested, sent by a national or regional overnight delivery service that provides a delivery receipt, or sent by confirmed facsimile transmission to the parties addresses or facsimile numbers stated in Paragraph 1. The parties will send copies of any notices to the broker representing the party to whom the notices are sent.

- ☒ A. Seller also consents to receive any notices by e-mail at Seller's e-mail address stated in Paragraph 1.
- ☒ B. Buyer also consents to receive any notices by e-mail at Buyer's e-mail address stated in Paragraph 1.

21. DISPUTE RESOLUTION: The parties agree to negotiate in good faith in an effort to resolve any dispute related to this contract that may arise. If the dispute cannot be resolved by negotiation, the parties will submit the dispute to mediation before resorting to arbitration or litigation and will equally share the costs of a mutually acceptable mediator. This paragraph survives termination of this contract. This paragraph does not preclude a party from seeking equitable relief from a court of competent jurisdiction.

22. AGREEMENT OF THE PARTIES:

- A. This contract is binding on the parties, their heirs, executors, representatives, successors, and permitted assigns. This contract is to be construed in accordance with the laws of the State of Texas. If any term or condition of this contract shall be held to be invalid or unenforceable, the remainder of this contract shall not be affected thereby. All individuals signing represent that they have the authority to sign on behalf of and bind the party for whom they are signing.
- B. This contract contains the entire agreement of the parties and may not be changed except in writing.
- C. If this contract is executed in a number of identical counterparts, each counterpart is an original and all counterparts, collectively, constitute one agreement.
- D. Addenda which are part of this contract are: *(Check all that apply.)*
 - ☒ (1) Property Description Exhibit identified in Paragraph 2;
 - ☐ (2) Commercial Contract Condominium Addendum (TXR-1930) or (TXR-1946);
 - ☐ (3) Commercial Contract Financing Addendum (TXR-1931);
 - ☐ (4) Commercial Property Condition Statement (TXR-1408);
 - ☐ (5) Commercial Contract Addendum for Special Provisions (TXR-1940);
 - ☐ (6) Addendum for Seller's Disclosure of Information on Lead-Based Paint and Lead-Based Paint Hazards (TXR-1906);
 - ☐ (7) Notice to Purchaser of Real Property in a Water District (MUD);
 - ☐ (8) Addendum for Coastal Area Property (TXR-1915);
 - ☐ (9) Addendum for Property Located Seaward of the Gulf Intracoastal Waterway (TXR-1916);
 - ☒ (10) Information About Brokerage Services (TXR-2501);
 - ☐ (11) Information About Mineral Clauses in Contract Forms (TXR-2509);
 - ☐ (12) Notice of Obligation to Pay Improvement District Assessment (TXR-1955, PID);
 - ☒ (13) Addendum (Exhibit B)

(Note: Counsel for Texas REALTORS® has determined that any of the foregoing addenda which are promulgated by the Texas Real Estate Commission (TREC) or published by Texas REALTORS® are appropriate for use with this form.)

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E. Buyer ☒ may ☐ may not assign this contract. If Buyer assigns this contract, Buyer will be relieved of any future liability under this contract only if the assignee assumes, in writing, all of Buyer's obligations under this contract.

23. TIME: Time is of the essence in this contract. The parties require strict compliance with the times for performance. If the last day to perform under a provision of this contract falls on a Saturday, Sunday, or Federal Reserve Bank holiday, the time for performance is extended until the end of the next day which is not a Saturday, Sunday, or Federal Reserve Bank holiday.

24. EFFECTIVE DATE: The effective date of this contract for the purpose of performance of all obligations is the date the title company receives this contract after all parties execute this contract.

25. ADDITIONAL NOTICES:

- A. Buyer should have an abstract covering the Property examined by an attorney of Buyer's selection, or Buyer should be furnished with or obtain a title policy.
- B. If the Property is situated in a utility or other statutorily created district providing water, sewer, drainage, or flood control facilities and services, Chapter 49, Texas Water Code, requires Seller to deliver and Buyer to sign the statutory notice relating to the tax rate, bonded indebtedness, or standby fees of the district before final execution of this contract.
- C. Notice Required by §13.257, Water Code: "The real property, described below, that you are about to purchase may be located in a certificated water or sewer service area, which is authorized by law to provide water or sewer service to the properties in the certificated area. If your property is located in a certificated area there may be special costs or charges that you will be required to pay before you can receive water or sewer service. There may be a period required to construct lines or other facilities necessary to provide water or sewer service to your property. You are advised to determine if the property is in a certificated area and contact the utility service provider to determine the cost that you will be required to pay and the period, if any, that is required to provide water or sewer service to your property. The undersigned purchaser hereby acknowledges receipt of the foregoing notice at or before the execution of a binding contract for the purchase of the real property described in the notice or at closing of purchase of the real property." The real property is described in Paragraph 2 of this contract.
- D. If the Property adjoins or shares a common boundary with the tidally influenced submerged lands of the state, §33.135, Texas Natural Resources Code, requires a notice regarding coastal area property to be included as part of this contract (*the Addendum for Coastal Area Property (TXR-1915) may be used*).
- E. If the Property is located seaward of the Gulf Intracoastal Waterway, §61.025, Texas Natural Resources Code, requires a notice regarding the seaward location of the Property to be included as part of this contract (*the Addendum for Property Located Seaward of the Gulf Intracoastal Waterway (TXR-1916) may be used*).
- F. If the Property is located outside the limits of a municipality, the Property may now or later be included in the extra-territorial jurisdiction (ETJ) of a municipality and may now or later be subject to annexation by the municipality. Each municipality maintains a map that depicts its boundaries and ETJ. To determine if the Property is located within a municipality's ETJ, Buyer should contact all municipalities located in the general proximity of the Property for further information.
- G. If apartments or other residential units are on the Property and the units were built before 1978, federal law requires a lead-based paint and hazard disclosure statement to be made part of this contract (*the Addendum for Seller's Disclosure of Information on Lead-Based Paint and Lead-Based Paint Hazards (TXR-1906) may be used*).

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- H. Section 1958.154, Occupations Code requires Seller to provide Buyer a copy of any mold remediation certificate issued for the Property during the 5 years preceding the date the Seller sells the Property.
- I. Brokers are not qualified to perform property inspections, surveys, engineering studies, environmental assessments, or inspections to determine compliance with zoning, governmental regulations, or laws. Buyer should seek experts to perform such services. Buyer should review local building codes, ordinances and other applicable laws to determine their effect on the Property. Selection of experts, inspectors, and repairmen is the responsibility of Buyer and not the brokers. Brokers are not qualified to determine the credit worthiness of the parties. NOTICE OF WATER LEVEL FLUCTUATIONS: If the Property adjoins an impoundment of water, including a reservoir or lake, constructed and maintained under Chapter 11, Water Code, that has a storage capacity of at least 5,000 acre-feet at the impoundment's normal operating level, Seller hereby notifies Buyer: "The water level of the impoundment of water adjoining the Property fluctuates for various reasons, including as a result of: (1) an entity lawfully exercising its right to use the water stored in the impoundment; or (2) drought or flood conditions."
- J. PUBLIC IMPROVEMENT DISTRICTS: If the Property is in a public improvement district, Seller is required by §5.014, Property Code to give Buyer a written notice concerning the obligation to pay assessments. The form of the required notice is available as a part of the Notice of Obligation to Pay Improvement District Assessment (TXR-1955).
- K. LICENSE HOLDER DISCLOSURE: Texas law requires a real estate license holder who is a party to a transaction or acting on behalf of a spouse, parent, child, business entity in which the license holder owns more than 10%, or a trust for which the license holder acts as a trustee or of which the license holder or the license holder's spouse, parent or child is a beneficiary, to notify the other party in writing before entering into a contract of sale. Disclose if applicable: _____

26. CONTRACT AS OFFER: The execution of this contract by the first party constitutes an offer to buy or sell the Property. Unless the other party accepts the offer by 5:00 p.m., in the time zone in which the Property is located, on _____, the offer will lapse and become null and void.

READ THIS CONTRACT CAREFULLY. The brokers and agents make no representation or recommendation as to the legal sufficiency, legal effect, or tax consequences of this document or transaction. CONSULT your attorney BEFORE signing.

Seller: Richards Property Management LLC

Harris County Hospital District
Buyer: d/b/a Harris Health

By: Richards Property Management LLC

By: Harris County Hospital District d/b/a Harris Health

By (signature): Barry Richards

By (signature): _____

Printed Name: Barry Richards

Printed Name: Louis G. Smith, Jr.

Title: Director

Title: Senior EVP/Chief Operating Officer

By: 9/18/2026

By: _____

By (signature): _____

By (signature): _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Commercial Contract - Improved Property concerning 1006 W 34th St, Houston, TX 77018

AGREEMENT BETWEEN BROKERS

(use only if Paragraph 9B(1) is effective)

Principal Broker agrees to pay _____
(Cooperating Broker) a fee when the Principal Broker's fee is received. The fee to be paid to Cooperating Broker will be:

- ☐ \$ _____, or
☐ _____% of the sales price, or
☐ _____% of the Principal Broker's fee.

The title company is authorized and directed to pay Cooperating Broker from Principal Broker's fee at closing. This Agreement Between Brokers supersedes any prior offers and agreements for compensation between brokers.

Principal Broker: _____ Cooperating Broker: _____

By: _____ By: _____

ATTORNEYS

Nathan Bac
 Office of the Harris County Attorney
 Counsel for Harris Health System

Seller's attorney: _____

Buyer's attorney: _____

Address: _____

Address: 4800 Fournace Place, 6th Floor East
Houston, Texas 77401

Phone & Fax: _____

Phone & Fax: _____

Email: _____

Email: nathan.bac@harrishealth.org

Seller's attorney requests copies of documents, notices, and other information:

- ☐ the title company sends to Seller.
☐ Buyer sends to Seller

Buyer's attorney requests copies of documents, notices, and other information:

- ☒ the title company sends to Buyer.
☒ Seller sends to Buyer

ESCROW RECEIPT

The title company acknowledges receipt of:

- ☐ A. the contract on this day _____ (effective date);
☐ B. earnest money in the amount of \$ _____ in the form of _____ on _____.

Title company: _____ Address: _____

By: _____ Phone & Fax: _____

Assigned file number (GF#): _____ E-mail: _____

Exhibit A – Property Description

Address: 1006 W 34 Th St, Houston, TX, 77018

Legal: Res A2 & A3 Three Bills Acres. HCAD #: 116-785-000-0003





Information About Brokerage Services

Texas law requires all real estate license holders to give the following information about brokerage services to prospective buyers, tenants, sellers and landlords.



TYPES OF REAL ESTATE LICENSE HOLDERS:

- **A BROKER** is responsible for all brokerage activities, including acts performed by sales agents sponsored by the broker.
- **A SALES AGENT** must be sponsored by a broker and works with clients on behalf of the broker.

A BROKER'S MINIMUM DUTIES REQUIRED BY LAW (A client is the person or party that the broker represents):

- Put the interests of the client above all others, including the broker's own interests;
- Inform the client of any material information about the property or transaction received by the broker;
- Answer the client's questions and present any offer to or counter-offer from the client; and
- Treat all parties to a real estate transaction honestly and fairly.

WRITTEN AGREEMENTS ARE REQUIRED IN CERTAIN SITUATIONS: A license holder who performs brokerage activity for a prospective buyer of residential property must enter into a written agreement with the buyer before showing any residential property to the buyer or if no residential property will be shown, before presenting an offer on behalf of the buyer. This written agreement must contain specific information required by Texas law. For more information on these requirements, see section 1101.563 of the Texas Occupations Code. **Even if a written agreement is not required, to avoid disputes, all agreements between you and a broker should be in writing and clearly establish: (i) the broker's duties and responsibilities to you and your obligations under the agreement; and (ii) the amount or rate of compensation the broker will receive and how this amount is determined.**

A LICENSE HOLDER CAN REPRESENT A PARTY IN A REAL ESTATE TRANSACTION:

AS AGENT FOR OWNER (SELLER/LANDLORD): The broker becomes the property owner's agent through an agreement with the owner, usually in a written listing to sell or property management agreement. An owner's agent must perform the broker's minimum duties above and must inform the owner of any material information about the property or transaction known by the agent, including information disclosed to the agent by the buyer or buyer's agent. **An owner's agent fees are not set by law and are fully negotiable.**

AS AGENT FOR BUYER/TENANT: The broker becomes the buyer/tenant's agent by agreeing to represent the buyer, usually through a written representation agreement. A buyer's agent must perform the broker's minimum duties above and must inform the buyer of any material information about the property or transaction known by the agent, including information disclosed to the agent by the seller or seller's agent. **A buyer/tenant's agent fees are not set by law and are fully negotiable.**

AS AGENT FOR BOTH - INTERMEDIARY: To act as an intermediary between the parties the broker must first obtain the written agreement of *each party* to the transaction. The written agreement must state who will pay the broker and, in conspicuous bold or underlined print, set forth the broker's obligations as an intermediary. A broker who acts as an intermediary:

- Must treat all parties to the transaction impartially and fairly;
- May, with the parties' written consent, appoint a different license holder associated with the broker to each party (owner and buyer) to communicate with, provide opinions and advice to, and carry out the instructions of each party to the transaction.
- Must not, unless specifically authorized in writing to do so by the party, disclose:
 - that the owner will accept a price less than the written asking price;
 - that the buyer/tenant will pay a price greater than the price submitted in a written offer; and
 - any confidential information or any other information that a party specifically instructs the broker in writing not to disclose, unless required to do so by law.

A LICENSE HOLDER CAN SHOW PROPERTY TO A BUYER/TENANT WITHOUT REPRESENTING THE BUYER/TENANT IF:

- The broker has not agreed with the buyer/tenant, either orally or in writing, to represent the buyer/tenant;
- The broker is not otherwise acting as the buyer/tenant's agent at the time of showing the property;
- The broker does not provide the buyer/tenant opinions or advice regarding the property or real estate transactions generally; and
- The broker does not perform any other act of real estate brokerage for the buyer/tenant.

Before showing a residential property to an unrepresented prospective buyer, a license holder must enter into a written agreement that contains the information required by section 1101.563 of the Texas Occupations Code. The agreement may not be exclusive and must be limited to no more than 14 days.

LICENSE HOLDER CONTACT INFORMATION: This notice is being provided for information purposes. It does not create an obligation for you to use the broker's services. Please acknowledge receipt of this notice below and retain a copy for your records.

<u>Boyd Commercial LLC</u>	<u>511967</u>		<u>(713) 877-8400</u>
Name of Sponsoring Broker (Licensed Individual or Business Entity)	License No.	Email	Phone
<u>Greg Barra</u>	<u>571663</u>	<u>gbarra@boydcommercial.net</u>	<u>(713) 877-8400</u>
Name of Designated Broker of Licensed Business Entity, if applicable	License No.	Email	Phone
<u>Name of Licensed Supervisor of Sales Agent/Associate, if applicable</u>	<u>License No.</u>	<u>Email</u>	<u>Phone</u>
<u>Cory Grant</u>	<u>511967</u>	<u>cgrant@boydcommercial.net</u>	<u>(713) 877-8400</u>
Name of Sales Agent/Associate	License No.	Email	Phone

Buyer/Tenant/Seller/Landlord Initials

Date

IABS 1-2

Exhibit B

Addendum to Commercial Contract – Improved Property

This Addendum to Commercial Contract – Improved Property (this “Addendum”) is attached to and incorporated herein by reference to that certain Commercial Contract – Improved Property (the “Base Contract”) by and between Richards Property Management LLC (“Seller”), and the Harris County Hospital District d/b/a Harris Health (“Buyer”), relating to certain real property located at 1006 W. 34th Street, Houston, Texas 77018. Seller and Buyer may each be referred to herein individually as a “Party” and collectively as the “Parties.” Seller and Buyer hereby agree as follows:

1. Base Contract. Seller and Buyer have entered into the Base Contract. The Base Contract and this Addendum are hereinafter collectively called the “Contract.” If any provision of this Addendum conflicts with any provision of the Base Contract, then the provision of this Addendum shall govern and control. Defined terms used in this Addendum shall have the same meaning given such terms in the Base Contract, unless otherwise indicated in this Addendum.

2. State Law Representations. Seller is a limited liability company with less than ten full-time employees. Chapters 2271, 2274 and 2276, Texas Government Code, do not apply to Seller with respect to this Contract. To the extent that this Contract constitutes a “governmental contract” as defined in Section 2252.001, Texas Government Code, Seller represents that neither it nor any of its parent company, wholly- or majority-owned subsidiaries, and other affiliates is a company identified on a list prepared and maintained by the Texas Comptroller of Public Accounts under Section 2252.153 or Section 2270.0201, Texas Government Code. The foregoing representation excludes Seller and each of its parent company, wholly- or majority-owned subsidiaries, and other affiliates, if any, that the United States government has affirmatively declared to be excluded from its federal sanctions regime relating to Sudan or Iran or any federal sanctions regime relating to a foreign terrorist organization. As used in the foregoing representation, “affiliate” means an entity that controls, is controlled by, or is under common control with Seller within the meaning of Securities and Exchange Commission Rule 405, 17 C.F.R. § 230.405, and exists to make a profit.

3. Governmental Approvals. The execution and delivery of this Contract by Buyer is subject to the approval of the Harris Health Board of Trustees and the Harris County Commissioners Court.

4. Brokers. Notwithstanding any provision of the Base Contract to the contrary, including but not limited to Paragraph 9 thereof, the Parties agree that the Cooperating Broker’s fee will be applied as a credit against the sales price paid by Buyer at closing. For purposes of Subsection C of Paragraph 9, the Principal Broker and the Cooperating Broker have executed this Addendum to evidence their consent to the foregoing provision.

5. Entire Agreement; Counterparts; Execution. The Contract contains the entire agreement between the Parties relating to the Property, and neither party shall be bound by any verbal statement or agreement made heretofore. Except as otherwise expressly set forth in this Section, the Contract may only be amended, modified, or changed by a traditional written document properly executed by Seller and Buyer. Such amendment may be transmitted by e-mail,

Error! Unknown document property name.

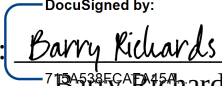
facsimile, or other method permitted by the provisions for giving notice in the Contract. The Base Contract and/or this Addendum may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Additionally, (i) the signature pages taken from separate individually executed counterparts of the Base Contract and/or this Addendum may be combined to form multiple fully-executed counterparts; and (ii) a facsimile signature or an electronically-scanned signature shall be deemed to be an original signature for all purposes.

[execution pages follow]

IN WITNESS WHEREOF, Seller and Buyer have executed this Addendum to be effective as of the Effective Date.

SELLER:

Richards Property Management LLC

By:  _____ 9/18/2026
Barry Richards
Director

BUYER:

Harris County Hospital District d/b/a Harris Health

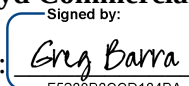
By: _____
Louis G. Smith, Jr.
Senior EVP/Chief Operating Officer

BROKERS' CONSENT:

The Principal Broker and the Cooperating Broker have executed this Addendum to evidence their consent to the provisions set forth in Section 4 hereof.

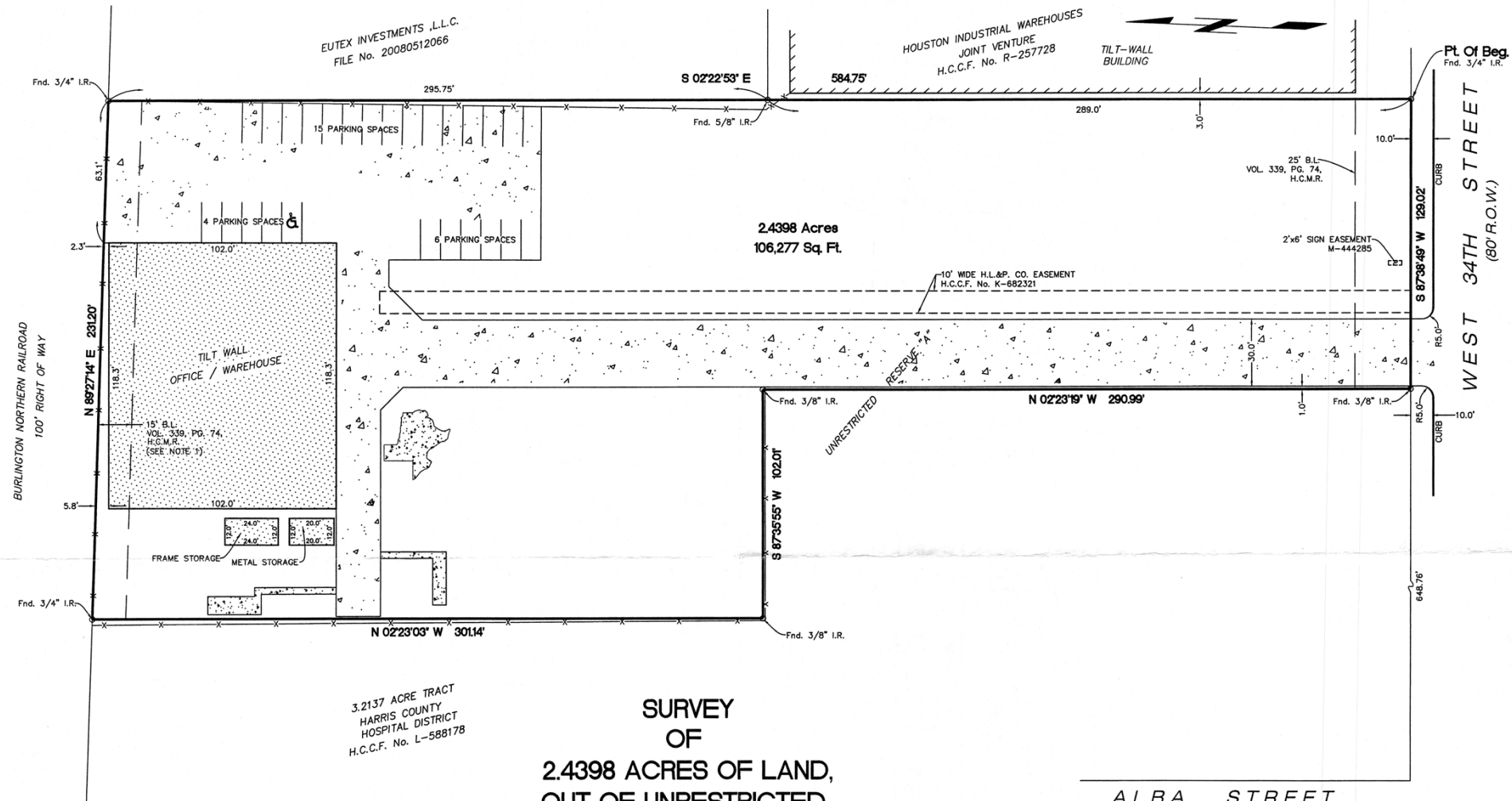
Principal Broker:

Boyd Commercial LLC

Signed by: 9/18/2026
By: 
F5208B0CCE104BA...
Greg Barra

Cooperating Broker:

Brian Pitre



**SURVEY
OF
2.4398 ACRES OF LAND,
OUT OF UNRESTRICTED
RESERVE "A" OF
THREE BILL'S ACRES,
RECORDED IN VOL. 339, PG. 74,
HARRIS COUNTY MAP RECORDS,
HARRIS COUNTY, TEXAS**

ALBA STREET
(60' R.O.W.)

I, F.G. HUFFMAN, a registered Professional Surveyor in the State of Texas; hereby certify to: BARRY RICHARDS AND TIM RICHARDS, AND/OR ASSIGNS, AND ALAMO TITLE COMPANY, exclusively, that this plat was made from an actual survey on the ground by me or under my direction, that no encroachments exist at the time of this survey unless reflected hereon; and that said survey conforms to the current Texas Society of Professional Surveyors Standards and Specifications for a Category 1A, Condition 2 Survey. except as shown, there are no visible encroachments or protrusions, no improvements, no visible easements or rights-of-way, and no discrepancies, conflicts, shortages in area or boundary line conflicts affecting the Property; the Survey was performed in connection with the Title Commitment, GF # 09-40105140, as revised and updated; all recorded easements and other exceptions, in reference to the Title Commitment, have been shown; boundaries, dimensions and other details are true and correct; and the Property has access to and from a public roadway."

F.G. Huffman
F.G. Huffman
Reg. Professional Surveyor No. 1682



NOTES:
1) VARIANCE GRANTED FOR BUILDING ENCRANCHING INTO BUILDING, VOL. 339, PG. 74, H.C.M.R.

LEGEND			
UE	Utility Easement	IR	Iron Rod
AE	Aerial Easement	IP	Iron Pipe
WE	Water Line Easement	B	Handicap Parking
BL	Building Line	—/—	Board Fence
CP	Covered Porch	-X-	Chain Link Fence
ROW	Right of Way	-W-	Wrought Iron Fence

This Property Lies Within Zone X, As Per The Flood Insurance Rate Map, HARRIS County, Community No. 480296
Panel No. 0660 Suffix L Date 06-18-2007

Note: Zone X Indicates Outside 100 Year Flood Plain
Zone AE Indicates Inside 100 Year Flood Plain

Purchaser: BARRY & TIM RICHARDS OR ASSIGNS
Address: 1006 WEST 34TH STREET, HOUSTON, TEXAS
Title Co. ALAMO TITLE COMPANY, GF# 09-40105140

Scale: 1"=30'
Date: 03/01/09
Job # 902004
Key Map: 452-Q
Drawn: DTR
Checked By: FGH

Revisions
04/02/09
Adjoining Building
Bearing Reference
Vol. 339, Pg. 74
H.C.M.R.

F.G. HUFFMAN
12819 Eldridge Place Drive
Houston, Texas 77041
281 447 7802 Fax 713 896 1301
E-Mail FGHUFFMAN@SBCGLOBAL.NET

AGH

F. G. Huffman

2430 Lexford Lane
Houston, Texas 77080

Registered Professional Land Surveyor

(281) 447-7802
Fax (713) 467-9370

Job No. 902004

Exhibit "A" Metes and Bounds

DESCRIPTION of a 106,277 Square Foot (2.4398 Acres) tract of land out of Unrestricted Reserve "A" of the Three Bill's Acres Subdivision as recorded in Vol. 339, Page 74 of the Harris County Map Records, Harris County, Texas and being more particularly described by metes and bounds as follows,

BEGINNING at a found 3/4" iron rod in the North Right of Way of West 34th Street and being the Southeast corner of said Unrestricted Reserve "A" of Three Bill's Acres,

THENCE, S 87° 38' 49" W, along the North Right of Way of West 34th Street, a distance of 129.02 feet to a found 5/8" iron rod and the most Southerly Southwest corner of the tract herein described,

THENCE, N 02° 23' 19" W, a distance of 290.99 feet to a found 3/8" iron rod and a point for an interior corner,

THENCE, S 87° 35' 55" W, a distance of 102.01 feet to a found 3/8" iron rod in the West line of Three Bill's Acres and the most Westerly Southwest corner of the tract herein described,

THENCE, N 02° 23' 03" W, along the common line of Three Bill's Acres and the Harris County Hospital District 3.2137 Acre tract as described in Clerk's File No. L-588178, a distance of 301.14 feet to a found 3/4" iron rod and the Northwest corner of the tract herein described,

THENCE, N 89° 27' 14" E, along the common line of Three Bill's Acres and the South Right of Way of the Burlington Northern Railroad (100' R/W), a distance of 231.20 feet to a found 3/4" iron rod and the Northeast corner of the tract herein described,

THENCE, S 02° 22' 53" E, along the common line of Three Bill's Acres and the West line of Dead Oak as recorded in Vol. 188, Page 8 of the Harris County Map Records, a distance of 584.75 feet to the POINT OF BEGINNING and containing 2.4398 Acres.


F. G. Huffman
RPLS No. 1682



fg Huffman@sbcglobal.net

Meeting of the Board of Trustees

Wednesday, October 14, 2026

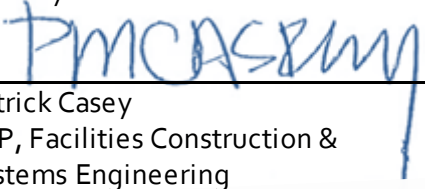
Consideration of Approval to Utilize the Construction Manager at Risk (CMAR) Delivery Method for the Acres Home Facility Replacement and Expansion

Administration requests Board of Trustees approval to utilize the Construction Manager at Risk (CMAR) delivery method for Acres Home Facility Replacement and Expansion and that the Purchasing Agent be authorized to issue a Request for Qualification (RFQ) for the selection of the Construction Manager. This is required by the Texas Government Code, Title 10, General Government, Subtitle F, State and Local contracts and Fund Management, Chapter 2269, Contracting Delivery Procedures for Construction Projects, Subchapter B, General Powers and Duties, Section 2269.056 (a). The governing body of a governmental entity (Harris Health) that considers a construction contract using a method authorized by this chapter other than competitive bidding must, before advertising, determine which method provides the best value for the governmental entity.

The CMAR project delivery method is recommended because of the complexity, duration of the project, and the best value method of selection may be utilized. Best value considers many factors including:

- The ability of the General Contractor (GC) to be engaged early in the design, ensuring constructability concerns are addressed during design.
- Cost evaluation and materials trade-offs are determined during design, reducing cost overruns and unnecessary delays/change orders throughout the project.
- A guaranteed maximum price can be established prior to the start of the project, reducing owner's risk.
- An experienced CMAR contractor can help position the project, so it meets or exceeds diversity goals established by Harris Health prior to the bidding of the project work by the CMAR.

Thank you.


Patrick Casey
SVP, Facilities Construction &
Systems Engineering


Louis G. Smith, Jr.
Sr. EVP/Chief Operating Officer

Meeting of the Board of Trustees

Wednesday, October 14, 2026

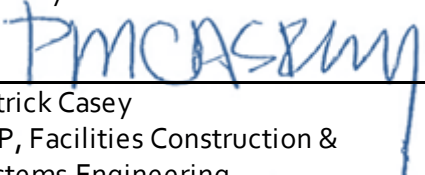
Consideration of Approval to Utilize the Construction Manager at Risk (CMAR) Delivery Method for the Cypress Health Center Construction

Administration requests Board of Trustees approval to utilize the Construction Manager at Risk (CMAR) delivery method for the Cypress Health Center Construction and that the Purchasing Agent be authorized to issue a Request for Qualification (RFQ) for the selection of the Construction Manager. This is required by the Texas Government Code, Title 10, General Government, Subtitle F, State and Local contracts and Fund Management, Chapter 2269, Contracting Delivery Procedures for Construction Projects, Subchapter B, General Powers and Duties, Section 2269.056 (a). The governing body of a governmental entity (Harris Health) that considers a construction contract using a method authorized by this chapter other than competitive bidding must, before advertising, determine which method provides the best value for the governmental entity.

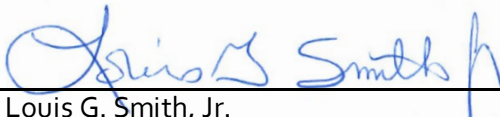
The CMAR project delivery method is recommended because of the complexity, duration of the project, and the best value method of selection may be utilized. Best value considers many factors including:

- The ability of the General Contractor (GC) to be engaged early in the design, ensuring constructability concerns are addressed during design.
- Cost evaluation and materials trade-offs are determined during design, reducing cost overruns and unnecessary delays/change orders throughout the project.
- A guaranteed maximum price can be established prior to the start of the project, reducing owner's risk.
- An experienced CMAR contractor can help position the project, so it meets or exceeds diversity goals established by Harris Health prior to the bidding of the project work by the CMAR.

Thank you.



Patrick Casey
SVP, Facilities Construction &
Systems Engineering



Louis G. Smith, Jr.
Sr. EVP/Chief Operating Officer

Meeting of the Board of Trustees

Wednesday, October 14, 2026

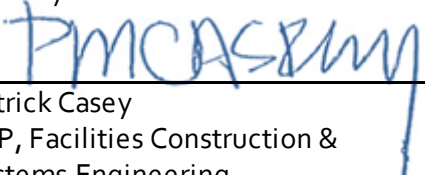
Consideration of Approval to Utilize the Construction Manager at Risk (CMAR) Delivery
Method for the Replacement of the Vallbona Health Center

Administration requests Board of Trustees approval to utilize the Construction Manager at Risk (CMAR) delivery method for the Vallbona Health Center Replacement and that the Purchasing Agent be authorized to issue a Request for Qualification (RFQ) for the selection of the Construction Manager. This is required by the Texas Government Code, Title 10, General Government, Subtitle F, State and Local contracts and Fund Management, Chapter 2269, Contracting Delivery Procedures for Construction Projects, Subchapter B, General Powers and Duties, Section 2269.056 (a). The governing body of a governmental entity (Harris Health) that considers a construction contract using a method authorized by this chapter other than competitive bidding must, before advertising, determine which method provides the best value for the governmental entity.

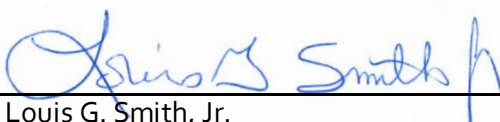
The CMAR project delivery method is recommended because of the complexity, duration of the project, and the best value method of selection may be utilized. Best value considers many factors including:

- The ability of the General Contractor (GC) to be engaged early in the design, ensuring constructability concerns are addressed during design.
- Cost evaluation and materials trade-offs are determined during design, reducing cost overruns and unnecessary delays/change orders throughout the project.
- A guaranteed maximum price can be established prior to the start of the project, reducing owner's risk.
- An experienced CMAR contractor can help position the project, so it meets or exceeds diversity goals established by Harris Health prior to the bidding of the project work by the CMAR.

Thank you.



Patrick Casey
SVP, Facilities Construction &
Systems Engineering



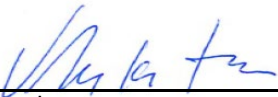
Louis G. Smith, Jr.
Sr. EVP/Chief Operating Officer

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Consideration of Approval of a Resolution Authorizing Harris County Hospital District
Attestation Response to New Requirements Related to Harris County Hospital District's
Participation in a Health Care Provider Participation Program

Attached for your review and consideration is a resolution related to Harris County Hospital District's participation in a Health Care Provider Participation Program.



Victoria Nikitin

EVP – Chief Financial Officer

Resolution Authorizing Harris County Hospital District Attestation Response to New Requirements Related to Harris County Hospital District's Participation in a Health Care Provider Participation Program

WHEREAS, pursuant to Chapter 299 of the Texas Health and Safety Code, the Board of Trustees (the "Board") of the Harris County Hospital District (the "District") on June 27, 2019 authorized the District to participate in a Local Provider Participation Fund (the "Harris LPPF");

WHEREAS, the purpose of participation in a Harris County health care provider participation program is to generate revenue from a mandatory payment that may be required by the Harris County Hospital District from an institutional health care provider to fund certain intergovernmental transfers for a supplemental Medicaid payment program or Medicaid managed care rate enhancements;

WHEREAS, Section 299.151 of the Texas Health and Safety Code provides that the Board calculate mandatory payments from institutional health care providers using net patient revenue without bifurcating inpatient and outpatient services or the exclusion of revenues from non-hospital services;

WHEREAS, pursuant to Board approval, the District issued a Harris LPPF mandatory payment assessment invoice on July 1, 2026 imposed on institutional healthcare providers' aggregate net patient revenue;

WHEREAS, on September 17, 2026, the Texas Health and Human Services Commission ("HHSC") issued the "Notice Regarding New Policy for Acceptance of Intergovernmental Transfer (IGT) Funding for the Texas Medicaid Program Effective October 1, 2026" describing requirements for intergovernmental transfers derived from mandatory payments to remain eligible for federal matching funds for assessment periods starting on or after October 1, 2026, including calculating mandatory payments by bifurcating inpatient and outpatient services and excluding non-hospital service revenues;

WHEREAS, on October 6, 2026, HHSC held a public meeting promulgating additional guidance for intergovernmental transfers derived from mandatory payments to remain eligible for federal matching funds entitled "New Policy for Acceptance of Intergovernmental Transfer (IGT) Funding for the Texas Medicaid Program Effective October 1, 2026" (the "New Policy") describing detailed documentation requirements due to HHSC by November 6, 2026;

WHEREAS, the Board intends to comply with the New Policy for all Harris LPPF mandatory payment assessment invoices issued for assessment periods beginning on or after October 1, 2026 but is unable to complete all documentation outlined in HHSC's New Policy prior to November 6, 2026; and

WHEREAS, the Board desires to authorize the District to provide a preliminary response to HHSC regarding HHSC's November 6, 2026 deadline and request appropriate time to comply with the New Policy requirements before the District issues any new Harris LPPF mandatory payment assessment invoices attributable to assessment periods on or after October 1, 2026.

Be it hereby resolved by the Board of Trustees of the Harris County Hospital District that:

1. The Board hereby authorizes the District to execute the attestation attached to this Resolution and identified as Exhibit A: Attestation Response to New Requirements Related to Harris LPPF Operations.
2. The Board hereby authorizes the District to take all reasonable actions to request HHSC accept the Attestation Response to New Requirements Related to Harris LPPF Operations as support for continuing Harris LPPF operations without interruption and respond to HHSC inquiries related to the attestation.
3. This Resolution shall be in full force and effect from and after the date of its adoption.

PASSED AND APPROVED this 14th day of October, 2026.

Exhibit A: Attestation Response to New Requirements Related to Harris LPPF Operations

I attest that Harris County Hospital District (the “District”) operates a Local Provider Participation Fund (the “Harris LPPF”) pursuant to Chapter 299 of the Texas Health and Safety Code on a fiscal year beginning July 1 and ending June 30, and issued a mandatory payment assessment invoice on July 1, 2026 imposed on institutional healthcare providers’ aggregate net patient revenue.

I further attest that the District will not issue or collect revenues from a mandatory payment assessment attributable to Harris LPPF fiscal years beginning on or after October 1, 2026 until such time that the Board of Trustees of the District and the District have completed all documentation requirements outlined in the Texas Health and Human Services Commission October 6, 2026 guidance entitled “New Policy for Acceptance of Intergovernmental Transfer (IGT) Funding for the Texas Medicaid Program Effective October 1, 2026.”

To the best of my knowledge and belief, the information is true, correct, and prepared from the records of the government entity.

Meeting of the Board of Trustees

Wednesday, October 14, 2026

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



R. King Hillier
SVP, Public Policy & Government Relations

October 2026**Board of Trustees Bi-monthly Legislative Report****FEDERAL UPDATE**

House Federal Budget: The President signed a Continuing Resolution (CR) into law on September 2, 2026, funding the federal government through December 11, 2026. House and Senate lawmakers left Washington and will return on November 9 for approximately 22 legislative days to pass an omnibus appropriations bill or a longer-term CR.

The outcome of congressional elections will factor significantly in future funding decisions and the “lame duck” session. As a reminder, Republicans in the House hold a narrow majority over the Democrats. With one independent aligning with Republicans, the current majority is 219 to 214 for voting control. The current Senate breakdown is 53 Republicans, 45 Democrats, and 2 Independents who vote with the Democrats. The November elections will shape the lame duck session from a policy perspective as well as the FY27 appropriations process. More clarity will come when the House and Senate reconvene in mid-November.

Front Line Hospital Alliance (FLHA) Update: Following the July fly-in, FLHA followed up with House Energy and Commerce’s Health Subcommittee staff and Member offices on CMS’s proposed 340B rule and federal designation.

Government relations personnel also worked with FLHA to submit formal comments (attached) to:

- CMS on the proposed rule that would reduce Medicare Part B reimbursement for 340B-acquired drugs from ASP +6% to ASP -33.4%
- CMS on the proposed rule regarding the Home Health Prospective Payment System
- Chairman Bill Cassidy on his draft 340B legislation.

Looking ahead, Dr. Porsa will participate in a CEO fly-in with other FLHA CEOs in November.

On September 22, 2026 the U.S. Patent and Trademark Office issued the Certificate of Registration issued to Front Line Hospital Alliance the service mark **FRONT LINE** for “association services in the nature of a coalition of health services providers promoting the interests of underserved patients and the hospitals dedicated to serving them” (Class 35).

Federal Register: In addition to the FLHA submissions to the federal register, Harris Health also submitted a letter to CMS asking the agency to work with stakeholders on a balanced approach regarding proposed remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) policies. The letter (attached) highlighted Harris Health initiatives like HealthyConnect, a remote blood pressure monitoring program that uses patient reported data submitted via third-party platform to monitor and capture important medical information.

The comment letters and trademark certificate are attached.

STATE UPDATE

90th Legislative Session Policy Platform: The Legislature convenes on January 12, 2027, for 141 consecutive days. The proposed platform is attached for your review and approval. The following five policy areas are covered:

- Health Coverage and Access for All Texans
- Community Authority, Responsibility and Fiscal Viability
- Behavior Health, Mental Health and Substance Abuse Disorders
- Health Care Workforce
- Environmental Workplace Safety

Rep. Lauren Ashley Simmons Meeting: Ahead of a House Public Health Committee meeting, Harris Health government relations staff and Harris Health Chief Medical Executive, Dr. Thomas Cummins, met with State Rep. Lauren Ashley Simmons in Houston regarding ambient AI scribes for patient encounters.

Rep. Simmons has many Harris Health facilities in her district and sits on the House Public Health Committee in addition to the House Select Committee on Healthcare Affordability and House Appropriations Committee. She is a critical voice on policy matters relevant to Harris Health.

These AI scribes listen to the patient encounter and assist providers in accurately capturing the conversation for continuity of care and billing purposes. It also frees the provider from the added administrative burden and allows for greater focus on care delivery.

Certain interests at the Texas Capitol are seeking to equate the use of AI scribes with fraudulent upcoding—which is already illegal. Harris Health, working with our industry partners, continues to educate policymakers about the actual benefits and limitations of AI scribes and other novel tools deployed in healthcare delivery.

Chairman James Frank Meeting: Ahead of a House Select Committee on Healthcare Affordability, representatives from Harris Health and Parkland Health met with committee Chairman James Frank in Austin to discuss the work of his committee and the importance of super safety net health systems like Harris Health and Parkland to the state of Texas. In attendance were government relations members from Harris Health and Parkland in addition to the CEOs of both institutions.

We discussed the central role our mission of serving the underserved plays in our daily work, in addition to how critical revenue streams like property taxes and 340B support that mission and our patients. We also discussed the importance of preserving the local capacity for funding the nonfederal share of Medicaid supplemental payments.

In addition to chairing the House Select Committee on Healthcare Affordability, Rep. Frank also chairs the House Subcommittee on Disease Prevention & Women's and Children's Health. He is heavily involved in matters essential to Harris Health and our patients.

Chairwoman Lois Kolkhorst Meeting: Harris Health government relations personnel, Harris Health CEO, Dr. Porsa, and Community Health Choice CEO, Lisa Wright, traveled to Brenham for a meeting with Sen. Lois Kolkhorst. In addition to representing portions of Harris County, Sen. Kolkhorst is the longtime chair of the Senate Committee on Health & Human Services and the Senate Finance Subcommittee that writes the state's biennial healthcare budget.

We discussed healthcare affordability in Texas from the perspective of both provider and payor, including common reasons why healthcare costs have increased and potential solutions. We also discussed the importance of our mission and operations in keeping costs as low as possible and stressed how vital revenue streams—ad valorem taxes, facility fees, 340B—allow us to accomplish this goal. There was interest in special designation for super safety net hospitals and financially endangered rural hospitals.

Sen. Kolkhorst was particularly interested in Harris Health's Food Farmacy and Food as Medicine program.

Speaker of the House, Senior Healthcare Staff Meeting: Pursuant to efforts from the Texas hospital and healthcare industry and the governor's office, Harris Health government relations staff and Harris Health CEO met with the senior healthcare staff person for the Speaker of the Texas House.

We discussed the vital role local funding, including property tax revenue, plays in providing the nonfederal share of state Medicaid supplemental funding and uncompensated care funding. We outlined the dire consequences to the safety net and the broader healthcare system in the absences of that funding and the strain this would place on the state budget moving into next session.

Texas Conservative Coalition Research Institute Health Policy Summit: Harris Health government relations personnel attended the TCCRI Health Policy Summit to hear state lawmakers discuss the growing affordability challenges in healthcare and how health insurance and health care delivery may evolve in response to these challenges. They also addressed innovation in designing health insurance coverage by examining certain health plan models seeking to disrupt the legacy market.

Featured lawmakers were:

- Rep. James Frank – Chair of the House Select Committee on Healthcare Affordability and the House Subcommittee on Disease Prevention & Women's and Children's Health
- Rep. Trey Wharton – Wharton sits on both the House Committee on Insurance and the House Select Committee on Healthcare Affordability

Chair Frank spoke about the impacts of market and regulatory incentives on participants in the healthcare sector and the downstream effects on patient care and cost. Rep. Wharton spoke about his personal experience as an insurance agent and owner of Wharton Insurance Network in Huntsville, TX.

Other speakers addressed novel approaches to health coverage, such as those offered by relatively new entrants into health insurance market, like Sidecar Health and Curative, Inc.

Texas Tribune's 2026 TribFest: Every year the Texas Tribune hosts a gathering of who's who in state and national politics in a series of live panel discussions and one-on-one interviews on a wide range of topics from healthcare to education and immigration to the cost of living.

Some prominent speakers were:

- US Senate candidate and current state representative, James Talarico
- Texas gubernatorial candidate and current state representative, Gina Hinojosa
- Congresswoman Lizzie Fletcher
- Congressman Christian Menefee
- Karl Rove
- Congressman Michael McCaul
- Former White House Chief of Staff, Rahm Emanuel
- Former Congresswoman Marjorie Taylor Greene
- State Representative Ann Johnson
- State Representative Jeff Leach
- State Representative Cody Vasut

In keeping with broader discussions in government, the affordability of both health coverage and health care delivery was a key issue with lawmakers promising to address the issue this coming regular session in the Texas Legislature. Panelists also discussed the impact of AI in healthcare, both the potential benefits and pitfalls, as well as the need to always have a qualified human in the loop.

Health & Human Services Commission and Department of State Health Services Legislative Appropriations Request (LAR): Ahead of every legislative session, state agencies submit funding requests, or LARs, to lawmakers outlining their requests for biennial appropriations. The governor, Lt. governor, and speaker have instructed agencies to submit initial requests with 3% spending cuts as a starting point for budget deliberations—although certain items as follows have been exempted:

- K–12 public education funding
- Debt service requirements and bond authorizations
- State pensions and employee group benefits
- Benefits and eligibility for Medicaid and CHIP as required by state law
- Texas Education Savings Account Program

We are working with our trade associations on a comment letter, which will likely contain recommendations on restoring funding to several key budget items:

- Healthy Texas Women and Breast and Cervical Cancer Screening program (\$79 million)
- Supporting HHSC restoration of 3% percent reductions
 - Community Mental Health Services (\$24.9 million)
 - Substance Use Prevention and Treatment (\$16.6 million)
 - Community Mental Health Grants (\$10.3 million)
 - Community Mental Health Hospitals (\$341.0 million)
- Seeking a waiver of the Medicaid Institution for Mental Disease (IMD) exclusion to allow for Medicaid funding of inpatient behavioral health care for adults
- Funding long-term cost-effective strategies for developing step-down behavioral health care program options including Intensive Outpatient Therapy (IOT) and Partial Hospitalization (PHP)

Harris Health 4800 Fournace Place, Bellaire, Texas 77401 | harrishealth.org

- Restoring funding for the Texas Nurse Family Partnership Program (\$6.5 million)
- Restoring cuts to critical Kidney Health Care (\$2.8 million)
- Restoring reductions to the Primary and Specialty Care Administration Strategy (\$14.4 million)

HARRIS HEALTH 90TH TEXAS LEGISLATURE POLICY PLATFORM

Health Coverage and Access for All Texans

Living in a state and county with both the largest number and highest percentage of uninsured persons, Texans and Harris County residents have long faced challenges in accessing healthcare.

To preserve access, Harris Health supports:

1. Ensuring Medicaid beneficiaries are free to choose community provider-based, not-for-profit health plans.
2. Efficiency in Medicaid supplemental payment methodologies and models of finance supporting essential hospitals.
3. Access to community-based primary, specialty and women's healthcare.
4. Addressing non-medical drivers of health, such as housing, transportation, and food insecurity.
5. Ensuring all residents with chronic kidney disease requiring dialysis can access quality and appropriate healthcare.
6. Ensuring those with chronic kidney disease requiring dialysis can maintain care in the most appropriate setting, even during natural and manmade disasters.
7. Maintaining 340b upfront drug discounts for providers serving vulnerable populations.
8. Funding and policy support for innovative, value-based care, including telemedicine, telehealth, and hospital at home programs.
9. Seeking a Medicaid waiver to expand mental and behavioral health coverage for adults.
10. Funding for the Texas HIV Medication Program and statewide expansion of HIV testing, early diagnosis, and treatment. Support ensuring Texans with HIV are able to access life-saving therapies, including single-dose medications.

Community Authority, Responsibility, and Fiscal Viability

With an area of over 268,596 square miles, Texas is bigger than the UK, France, and Germany. With a population of approximately 31.7 million, Texas has more people than Australia, and if it were its own country, it would be the eighth largest economy in the world with a 2025 GDP of \$2.9 trillion.

Texas is a big state with many different communities that have different needs. Communities must have the ability to address healthcare needs in a way that works best for them.

To preserve healthy, responsible, productive, and fiscally viable Texas communities, Harris Health supports:

11. Maintaining the ability to seek the current hospital district voter-approved ad valorem tax rate.
12. Maintaining the ability to deliver high-quality care that meets the needs of the patient, while maximizing operational efficiencies of our hospitals and clinics.
13. Maintaining the ability to annually fund \$6 billion in IGT for Texas Medicaid supplemental payments.
14. Maintaining communities' freedom and decision-making around taxes and bond authority.
15. Preserving the ability to exercise the First Amendment right to petition the state and federal government.
16. Preserving the Texas Tort Claims Act in its current form to ensure critical Texas healthcare providers are not subjected to an increased risk of frivolous litigation
17. Protecting and preserving longstanding Texas financing mechanisms for Medicaid, Medicaid supplemental, and health care safety-net funding; including the ability of public entities to continue sending intergovernmental transfers to CMS and the ability of private entities to continue contributing to and utilizing local provider participation funds.
18. Legislation allowing all Hospital Districts to protect, license, and use innovations and intellectual property acquired or developed by the Hospital District, ensuring the benefit of which flows back to patients and taxpayers.
19. Ensuring recognition and protection of health systems and market participants who serve a critical role in caring for the state's most vulnerable residents, all while serving as the training grounds for the next generation of Texas physicians, nurses, and allied health workers.

Behavioral Health, Mental Health, and Substance Abuse Disorders

Despite historic investments in mental health services for essential systems in Texas, gaps still exist. When patients fall through these gaps, it places additional, unnecessary, and costly burdens on non-healthcare institutions, such as schools and the justice system.

To secure the mental health resources patients and essential systems need, Harris Health supports:

20. Streamlining and modernizing emergency detention orders for patients who, due to a mental illness, are a danger to themselves or others.
21. Integrating the delivery of behavioral and primary health services, both in person and via telehealth.
22. Providing the same level of insurance coverage for mental illness and substance abuse disorders as for medical and surgical care.
23. Leveraging federal and state funding for resources to increase access to substance use disorder treatment for uninsured residents and Medicaid beneficiaries.
24. Increasing the number of forensic and civil beds available.

Healthcare Workforce

Texas' explosive growth brings blessings but also strains the state's healthcare infrastructure. With 224 of Texas' 254 counties designated as health professional shortage areas (HPSAs), and over 6 million Texans calling those HPSAs home, the shortage of health professionals presents both a challenge and an opportunity to improve access to quality healthcare for Texans across the state.

To secure Texas' critical healthcare infrastructure, Harris Health supports:

25. Expanding the state's healthcare workforce, including physicians, nurses, and allied health professionals.
26. Investing further in the state's mental health workforce.
27. Increased funding for access to healthcare clinical training and preceptorship programs.
28. Protecting our healthcare workforce from workplace violence incidents.

29. Preserving facilities' freedoms to make staffing and employment decisions to meet the needs of the community.

Environmental Workplace Safety

Patients and providers should have the freedom to receive and deliver care in a safe and healthy environment.

To ensure the health and safety of Texas patients and healthcare providers, Harris Health supports:

30. Prohibiting concrete crushing facilities from operating near healthcare facilities, as they are currently prohibited from operating near schools, places of worship, and residential buildings.
31. Protecting the freedom of patients and health care personnel to seek and deliver care in a safe workplace where infectious disease control meets the highest safety standards, including standards for a workforce fully protected against vaccine preventable diseases.



August 31, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Re: Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies (CMS-1844-P)

Dear Administrator Oz:

The Front Line Hospital Alliance welcomes the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS's) Calendar Year (CY) 2027 Home Health Prospective Payment System (HH PPS) proposed rule (CMS-1844-P), which was published in the *Federal Register* on July 8, 2026.

Front Line multi-mission hospitals are characterized by high disproportionate share and tertiary services provided to the sickest, most impoverished and costliest of patients in our communities. We are "super" safety-net hospitals, caring for a substantially higher volume of low-income patients than most hospitals. We also provide the full continuum of primary through tertiary services, including complex critical and trauma care, and specialized services to patient populations with multiple comorbidities and other medical and social determinants of health challenges. In addition, we train the next generation of physicians to care for these vulnerable patients. ***While there are many worthy safety-net hospitals, what distinguishes the 135 qualifying "Front Line" hospitals is the triple mission of caring for an exceptionally high number of low-income patients; providing high-cost, specialized treatment to medically complex and socially at-risk patients; and training the next generation of clinicians to serve those most in need, resulting in serious stresses on our financial viability.***

We commend CMS for its continuing efforts to strengthen program integrity through the provider enrollment reforms proposed in this rule, including the proposed revisions to the temporary moratorium policy. **We write to express our strong support for these anti-fraud and oversaturation measures and to urge CMS to use this rulemaking as an opportunity to extend the temporary moratorium framework under § 424.570 to encompass trauma centers.** In certain metropolitan areas, trauma center proliferation has outpaced any demonstrable patient need, mirroring the very oversaturation patterns that prompted CMS to impose national moratoria on home health agencies (HHAs), hospices, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers.

The regulatory infrastructure that CMS is strengthening in this proposed rule, including clarified effective dates, an expanded definition of "new" enrollments, and updated ownership-change exceptions, provides the foundation for a targeted moratorium on new trauma center enrollments in oversaturated geographic areas. We respectfully request that CMS either include such a moratorium in the final rule or initiate a



separate Federal Register notice imposing a temporary moratorium on new trauma center enrollments pursuant to section 1866(j)(7) of the Act.

I. Background

A. History of CMS's Moratorium Authority

This proposed rule arrives at a critical juncture for the temporary moratorium program. CMS first exercised its moratorium authority on July 30, 2013, imposing temporary moratoria on the enrollment of new HHAs in Miami-Dade County, Florida and Cook County, Illinois (and surrounding counties) and Part B ambulance suppliers in Harris County, Texas (and surrounding counties). CMS's rationale was grounded in both quantitative data, Miami-Dade County had 37.6 HHAs per 10,000 Medicare FFS beneficiaries compared to a national average of 1.8, and qualitative law enforcement intelligence developed through the Health Care Fraud Prevention and Enforcement Action Team (HEAT). Those initial moratoria were repeatedly extended and expanded, ultimately covering HHAs statewide in Florida, Illinois, Michigan, and Texas, and Part B non-emergency ambulance suppliers in New Jersey, Pennsylvania, and Texas. The original moratoria expired on January 30, 2019.

More than six years later, CMS restarted the moratorium process with a new, broader approach. On February 27, 2026, CMS imposed a six-month nationwide [moratorium](#) on the enrollment of certain DMEPOS medical supply companies. CMS determined, in consultation with the Office of Inspector General (OIG) and Department of Justice (DOJ), that medical supply companies present heightened program integrity risks based on patterns of elevated revocations, payment suspensions, investigations, and improper billing among new entrants. Then, on May 13, 2026, CMS imposed six-month nationwide moratoria on the enrollment of new [HHAs](#) and [hospices](#). The shift from regional to nationwide moratoria reflects CMS's recognition that "some fraud schemes are viral, meaning they replicate rapidly within communities, and that health care fraud also migrates" as law enforcement cracks down in one area.

B. CMS's Rationale for Establishing Temporary Moratoria

In the HHA moratorium notice, CMS stated that "HHA fraud, waste, and abuse has been a severe problem for over two decades" and that HHAs "have long been among the highest-risk Medicare provider/supplier types in terms of program integrity." In this proposed rule, CMS documented an alarming increase in situations where numerous providers of the same type simultaneously operate within very small geographic areas. Specific examples include several dozen hospices within a four-block area of Los Angeles County; 18 HHAs within the same building in Columbus, Ohio; at least nine cases in Ohio where at least five HHAs share the same practice location; and similar clusters in Michigan, Nevada, North Carolina, and Texas. Los Angeles County has been a particularly serious concern. Per CMS data, the number of HHAs in the county rose over 45 percent between 2019 and 2023, with at least 1,400 new HHAs enrolling since 2019 — an increase CMS found was "entirely out of proportion with any increase in the county's beneficiary population and can be a strong indicator of widespread fraud."

Separately, in the hospice moratorium notice, CMS stated that the hospice fraud risk "has dramatically increased in the past 7 years to the point where hospices present no less of a payment safeguard threat



than HHAs and DMEPOS suppliers.” The HHS OIG has identified hospice care among the services posing a high risk of fraud, noting significant problems with the program including “poor—sometimes harmful—quality of care, fraud schemes that involve enrolling beneficiaries without their consent, inappropriate billing practices, limited transparency for patients and their families, a payment system that creates incentives to minimize services, and a rapid growth in the number of new hospices, often to take advantage of these conditions.” CMS has also identified cases involving false physician certifications of terminal status, kickbacks to certifying physicians, criminal cases involving administrators, and individuals serving as medical director or administrator of numerous hospices simultaneously, sometimes from opposite sides of the country.

Critically, CMS explained in the hospice moratorium notice that the earlier regional moratoria on HHAs and ambulance suppliers were successful precisely because they operated as preventive, enrollment-side controls. “Since there were no new enrollments of these provider/supplier types in the impacted high-fraud regions, new providers/suppliers that would or might otherwise have engaged in fraud, waste, and abuse in these areas were blocked from doing so.” With no new entrants, CMS was able to focus its program integrity resources on enrolled providers, and “the overall number of enrolled HHAs and ground ambulance suppliers in said localities fell to a level more commensurate with the number of beneficiaries therein.”

These patterns share a common thread with trauma center oversaturation. When providers proliferate in excess of patient need, competitive pressures create incentives for billing non-compliance, quality of care suffers from diluted volumes, and the Trust Funds bear the cost. The moratoria on HHAs, hospices, and DMEPOS suppliers represent CMS’s recognition that enrollment-side controls, which can prevent further market entry before waste takes root, are a necessary complement to after-the-fact revocation. The same preventive logic applies to trauma centers in oversaturated markets.

C. Proposed Regulatory Changes in This Rule

Having restarted the moratorium process after this extended hiatus, CMS has identified several operational issues that this rulemaking seeks to address. These proposed regulatory changes are directly linked to the national moratoria because they codify the procedural infrastructure needed to make moratoria effective: clarifying when they take effect, what applications they cover, and which ownership transactions fall within their scope.

First, CMS proposes that the moratorium’s effective date is the date on which the moratorium notice is filed for public inspection at the Office of the Federal Register (OFR). Gaps between the OFR filing date and the *Federal Register* publication date can allow affected providers to rush enrollment applications to “beat the deadline,” partially obstructing the moratorium’s goal of halting all new enrollments and potentially leading to a rush of new applicants during this gap. Using the OFR filing date eliminates this vulnerability and ensures the moratorium’s imposition is immediate.

Second, CMS proposes to define the application types that constitute new enrollments subject to a moratorium, including initial enrollment applications, changes of ownership requiring initial enrollment, enrollment applications from revoked providers whose reenrollment bars have expired, reactivation



applications, and enrollment applications from voluntarily terminated providers seeking to reenroll. CMS's rationale for including reactivation applications is that deactivated providers are blocked from Medicare billing in a manner functionally akin to revocation, and the bases for deactivation typically involve concerning provider behavior. The same rationale applies to voluntary terminations, where the provider has consciously severed its Medicare relationship. This broader definition closes loopholes that could otherwise allow potentially problematic entities to circumvent the moratorium by structuring reentry as a reactivation rather than a new enrollment.

Third, CMS proposes clarifying that changes in ownership requiring an initial enrollment, including hospice and DMEPOS supplier changes in majority ownership, are subject to the moratorium. This conforms the moratorium regulation to other provisions addressing the "36-month rule" and codifies existing CMS policy.

We support these proposed changes. Together, they transform CMS' temporary moratorium regulations into a robust, enforceable enrollment barrier, and they establish the regulatory architecture upon which future moratoria, including for trauma centers, could be built.

II. Recommendation to Extend Moratorium Authority to Trauma Centers

We urge CMS to exercise its authority under section 1866(j)(7) of the Act and § 424.570 to impose a temporary moratorium on the enrollment of new trauma centers in geographic areas experiencing demonstrable oversaturation. The same program integrity rationale that CMS has articulated for HHAs, hospices, and DMEPOS suppliers — that an excessive concentration of providers in a limited geographic area "raise[s] questions as to whether there is a patient need for all these providers or whether other considerations, such as fraud, are involved" — applies with equal force to trauma centers. Importantly, the program integrity risks associated with trauma centers are not theoretical.

The HHS Office of Inspector General's 2025 report, *Hospitals Charged CMS for Trauma Team Activations That Did Not Comply With Federal Requirements*, estimated that hospitals billed approximately \$2.4 billion in unallowable charges for trauma team activation fees that did not meet applicable Medicare requirements between January 1, 2020, and June 30, 2022.¹ This report demonstrates that billing non-compliance in the trauma center context is a documented, systemic concern and it underscores the need for stronger enrollment-side controls to prevent further proliferation of trauma centers in markets where competitive pressures may incentivize improper billing practices.

These findings are consistent with the clinical literature demonstrating that trauma center proliferation directly undermines patient outcomes. Multiple studies have found an inverse relationship between trauma center proliferation and patient outcomes because it will dilute the trauma volume at each center, leading to degradation in experience and worsening of mortality. One such study used national data and found significantly improved survival at high-volume centers with greater than 650 cases per

¹ HHS Office of Inspector General. *Hospitals Charged CMS for Trauma Team Activations That Did Not Comply With Federal Requirements*. 2025. Available at <https://oig.hhs.gov/reports/all/2025/hospitals-charged-cms-for-trauma-team-activations-that-did-not-comply-with-federal-requirements/>.



year for the highest-acuity patients.² Another study showed a seven percent decrease in odds of mortality for every 500 patient increase in volume for those with shock or traumatic brain injury.³ Similarly, researchers found that increasing trauma volume was associated with improved outcomes, while each one percent decline in volume over time was associated with a two-fold increase in the odds that a trauma center's death rates would be worse than expected given the severity of the injuries treated.⁴

In certain metropolitan regions, the concentration of trauma centers exceeds the volume of trauma patients needed to sustain clinical competency, dilutes case volumes across existing facilities, and creates conditions in which facilities may engage in aggressive patient-steering practices or submit claims that do not reflect the complexity of care actually provided. The OIG's findings reinforce this concern. When trauma centers compete for a limited pool of trauma patients, the financial incentive to activate trauma teams and bill the associated activation fees in cases that do not warrant such activation increases. A moratorium on new trauma center enrollments in oversaturated areas would address this problem at the front end by limiting further market entry where the existing provider base already exceeds patient need.

III. Proposed Trauma Center Moratorium Approach and Legal Authority

Under 42 CFR 424.570(a)(1)(i), ***"CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area"*** [emphasis added]. Nothing in this authority limits moratoria to the provider types currently subject to national moratoria. CMS's proposed § 424.535(a)(24) — permitting revocation when a provider's enrollment presents a high risk of fraud, waste, or abuse due to location within an area with an excessive number of providers — further confirms the Agency's recognition that geographic oversaturation itself warrants enrollment action. The moratorium framework should be extended accordingly. In short, CMS has authority to impose a moratorium on the establishment of new trauma centers in high trauma-center density geographic areas.

We suggest that a "high trauma-center density" geographic area is defined as follows:

- Metropolitan statistical areas (MSAs) or State Designated Trauma Service Regions with a population less than 1 million that have one Level I trauma center, and
- MSAs or State Designated Trauma Service Regions with a population over 1 million that have either (i) two Level I trauma centers or (ii) a combination of one Level I and two Level II trauma centers per each million people.

² Nathens AB, Jurkovich GJ, Maier RV, Grossman DC, MacKenzie EJ, Moore M, Rivara FP. Relationship between trauma center volume and outcomes. JAMA. 2001 Mar 7;285(9):1164-71.

³ Minei JP, Fabian TC, Guffey DM, et al. Increased trauma center volume is associated with improved survival after severe injury: results of a resuscitation outcomes consortium study. Ann Surg 2014; 260:456–65.

⁴ Brown JB, Rosengart MR, Kahn JM, Mohan D, Zuckerbraun BS, Billiar TR, Peitzman AB, Angus DC, Sperry JL. Impact of volume change over time on trauma mortality in the United States. Ann Surg. 2017 Jul;266(1):173-178.



For illustrative purposes, consider the following MSAs:

- The San Antonio MSA has 1.5 million people and two existing Level I trauma centers, so it would be considered a high trauma-center density geographic area. Therefore, the temporary moratoria would pause enrollment for new Level I and Level II trauma centers.
- The Indianapolis MSA has a population of 1.6 million people and three Level I trauma centers. It would be a designated high trauma-center density geographic area and subject to the moratorium on new Level I and Level II trauma centers.
- The Houston MSA has a population of 4.1 million people and only two Level I trauma centers. Because it is under the threshold for a high trauma-center density geographic area, it would not be subject to the moratorium on new Level I and Level II trauma centers.

We urge CMS to extend this targeted moratorium to state Medicaid and CHIP programs. Under 42 C.F.R. § 455.470(a)(1) through (3) and 42 C.F.R. § 457.990, the Secretary may impose a temporary moratorium, in accordance with § 424.570, on the enrollment of new providers or provider types after consulting with any affected State Medicaid agencies. The State Medicaid agency must impose a temporary moratorium on the enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid and CHIP programs unless the state determines that the imposition of a moratorium would adversely affect Medicaid and CHIP beneficiaries' access to medical assistance and notifies the Secretary in writing.

A temporary, targeted moratorium would not adversely affect Medicaid or CHIP beneficiaries' access to medical assistance in high trauma-center-density geographic areas where data shows that existing enrolled trauma centers provide sufficient geographic access and capacity. On the contrary, a targeted moratorium would further the statutory and regulatory purposes of preventing unnecessary or inappropriate utilization, avoiding excess payments, and preserving trauma-system resources for clinically necessary, properly documented trauma care. Furthermore, the moratorium would prevent the dilution in quality of care in communities oversaturated with trauma centers.

IV. Complementary Program Integrity Measures

During a six-month moratorium on new trauma centers in oversaturated areas, CMS would have the opportunity to develop proposals that address underlying program integrity concerns raised by the HHS OIG. We recommend the following complementary program integrity measures:

- Issue sub-regulatory guidance clarifying appropriate billing requirements for G0390, including activation criteria and documentation expectations;
- Conduct targeted program integrity reviews focused on outlier billing patterns, rather than applying broad-based restrictions that may affect compliant providers;
- Increase transparency regarding how CMS identifies and monitors high-risk utilization patterns.

Additionally, the moratorium period would allow CMS to consider a revised reimbursement model for trauma services aligned with developing a national military and civilian system. Congress is investing in military-civilian partnerships through the National Defense Authorization Act (NDAA) and the Mission



Zero program to improve battlefield injury readiness. Ensuring the viability of high-volume trauma centers is essential to this effort.

V. Conclusion

CMS' proposed clarifications to the temporary moratorium program would establish a more robust and enforceable moratorium framework by addressing effective dates, the definition of "new" enrollments, and ownership-change exceptions. We urge CMS to build on this strengthened framework by extending moratorium authority to trauma centers in geographic areas where oversaturation threatens both quality of care and program integrity. The statutory authority under section 1866(j)(7) of the Act is clear, the policy rationale that CMS has articulated in this very rule is compelling, and the need is urgent.

We appreciate the opportunity to comment on this important proposed rule and welcome the chance to discuss these recommendations further.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Esmaeil Porsa".

Esmaeil Porsa, MD, MPH, MBA, MPH, CCHP-A
President and Chief Executive Officer
Harris Health



August 31, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1850-P – Calendar Year 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Proposed Rule

Dear Administrator Oz:

On behalf of the Front Line Hospital Alliance, we appreciate the opportunity to provide comments on the Calendar Year (CY) 2027 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. Front Line Hospitals provide the highest-level care to the sickest and most vulnerable Medicare patients throughout the country and will face severe financial hardship due to the proposed 340B drug payment reduction.

We strongly believe CMS has the legal authority to exempt Front Line Hospitals from the proposed 340B drug payment cuts and doing so would fit squarely with the agency's request for comments about exempting other hospital designations similar to the rural sole community hospitals. At a minimum, CMS should hold these hospitals harmless from the cuts by redistributing any savings in a targeted manner. Furthermore, we respectfully request that CMS establish a targeted moratorium on new trauma centers in oversaturated markets to preserve high-quality patient care as a logical outgrowth of its proposals to control unnecessary increases in the volume of outpatient services.

I. Background on Front Line Hospitals

A. Front Line Hospitals Are “Super” Safety-Net Hospitals

Front Line multi-mission hospitals are characterized by high disproportionate share and tertiary services provided to the sickest, most impoverished and costliest of patients in our communities. We are “super” safety-net hospitals, caring for a substantially higher volume of low-income patients than most hospitals. We also provide the full continuum of primary through tertiary services, including complex critical and trauma care, and specialized services to patient populations with multiple comorbidities and other medical challenges. In addition, we are major teaching hospitals, training the next generation of physicians to care for these vulnerable patients. ***While there are many worthy safety-net hospitals, what distinguishes the 135 qualifying “Front Line” hospitals is the triple mission of caring for an exceptionally high number of low-income patients; providing high-cost, specialized treatment to medically complex and socially at-risk patients, and training the next generation of clinicians to serve those most in need, resulting in serious stresses on our financial viability.***



Front Line multi-mission hospitals' commitment to providing complex care to those most in need with humanity and dignity results in *a perpetual financial struggle to make ends meet and deliver necessary services to these populations* that typically have relatively poor health status, multiple comorbidities and challenges related to social risk factors. Our patients commonly suffer from multiple conditions, mental health and substance abuse challenges. Many lack stable housing, employment and proper nutrition – all of which contribute to poorer health. Most are insured by public programs such as Medicaid, Medicare, and CHIP, or have no insurance at all. And commercial populations are small, often well below 20 percent. Many have high populations of dually eligible Medicare and Medicaid beneficiaries.

B. Front Line Hospitals Are Leading Value-Based Care to Lower Costs and Improve Outcomes.

According to the National Academy of Medicine (NAM), “the exceptionally high expenditures associated with providing care for a relatively small but growing number of individuals with significant medical needs drive the escalating cost of medical care in the United States.” Currently the top 5% of health care consumers in the US are responsible for nearly 50% of all health care expenditures in our country. This phenomenon is created by the traditional approach to health care in the U.S. of pouring resources into downstream care which is not only much more expensive than upstream preventive care but also much less effective.

Front Line Hospitals have proven that you can control costs *and* improve outcomes by shifting from reactive, high-cost sick care to **proactive, value-based health promotion and disease prevention practices**. They do this through integrated care models, innovation, and community-level prevention strategies that reduce avoidable utilization. For Front Line Hospitals, value-based care is not simply a policy trend; it is a financial and operational necessity. Front Line Hospitals serve a population with high rates of chronic disease, limited access to private insurance, significant social needs, and lifestyle challenges. Traditional fee-for-service models incentivize reactive, episodic care, which while profitable, is both costly and ineffective. By contrast, value-based models reward improved outcomes, reduced hospital utilization, and coordinated care across settings. That’s exactly why value-based care works for Front Line Hospitals: it rewards **better outcomes**, not more procedures.

We offer this to emphasize that our hospitals are worthy of the 340B drug pricing and utilize our precious resources, including savings from the 340B program, for the direct benefit of our patients.

II. Proposed Payment of ASP-33.4% Will Harm High Need Urban and Rural 340B Hospitals

A. Not all 340B Hospitals are Alike

1. Congressional Intent.

When the 340B Drug Discount Program was created in 1992, the Congress anticipated that there were approximately 90 public or publicly equivalent hospitals that would qualify for 340B.¹ According to a recent study on the legislative history of 340B, “[a]lthough the program was designed to help core safety-net providers, it, like other programs made to support the safety-net, now primarily benefits non-safety-

¹ See the House Energy & Commerce Committee Report accompanying the Medicaid Drug Rebate Amendments of 1992, 102 H. Rept. 384



net providers.”² Interestingly, this study indicates Congressional intent to include approximately 200 public hospitals which belonged to the National Association of Public Hospitals, though the final statutory language was loosened to some degree to include hospitals in certain legislative districts.³

We believe that it is our public and public-equivalent hospitals on the front lines of caring for the most medically and socially vulnerable and low-income individuals that are exactly those intended by the original authors of the 340B Program to benefit from the drug discount.

The 340B Program is fundamental for our “super” safety-net hospitals to keep our doors open and fulfill our multiple missions for our distinct and challenging patient population. Caring for this population isn’t part of our mission, it is our mission. Accordingly, we support modernization of the 340B Program to ensure it is working as intended by the Congress, that patients are benefiting from it, and that it enables the “super” or “core” safety-net hospitals to continue serving our distressed communities.

2. Front Line Hospitals Have Much Higher Disproportionate Patient Percentage (DPP) and Allowable/Adjusted Disproportionate Share Hospital (DSH) Percentages

There are 206 340B hospitals in metropolitan statistical areas that qualify for 340B as “rural referral centers” which only requires an adjusted DSH percentage of 8%. By contrast, the approximate adjusted DSH percentage range for qualifying Front Line Hospitals under our definition is 20-70% adjusted DSH. When looking at raw DPP, you see a similar differential. The lowest DPP among qualifying Front Line hospitals is 35% and the highest is 97%.

3. Profitable Hospitals Benefit More from 340B than Front Line Hospitals

A 2025 USC Schaffer Institute study⁴ of the 340B Program compared a hypothetical payer mix and 340B net revenue, demonstrating that Hospital A with 50% commercial, 27% Medicare, 18% Medicaid, and 5% uninsured would generate 12.9 million in 340B revenues as opposed to Hospital B with 18% commercial, 22% Medicare, 40% Medicaid, and 20% uninsured, with \$4.9 million in 340B revenues. According to the study, “Hospital A can leverage its relatively high percentage of commercial insurance patients to generate significantly more revenue from the 340B program than the truly needy Hospital B.”⁵ The comparatively little that Hospital B derives from 340B is a lifeline that could be the difference between its closure and still being able to serve patients.

This is illustrated further by two real life comparisons.

- In 2024, M Health Fairview-University of Minnesota Medical Center had the highest net 340B revenue in Minnesota of \$334,683,472 million (26.1% of Statewide Net 340B Revenue), whereas

² *Stretching Scarce Authorizing Legislation as Far as Possible: A Legislative History of the 340B Drug Pricing Program*, Sayeh Nikpay et al, The Milbank Quarterly, Vol. 00, No. 0, 2026.

³ *Id.* at 24-25.

⁴ *Cui Bono? Misaligned Incentives in the 340B Program*, SC Schaeffer, Ryan Long, Je et al, September 2025, p. 5.

⁵ *Ibid* p. 6.



Hennepin (a qualifying Front Line hospital) had \$99,659,845 in Net 340B Revenue (7.8% of Statewide Net 340B Revenue).⁶

- Both MetroHealth and Cleveland Clinic qualify for 340B as DSH hospitals in the Cleveland–Elyria MSA, drawing on the same wage index, the same labor market, and overlapping catchment areas. MetroHealth is a county-owned public hospital operating under Ohio law — precisely the category of hospital the 1992 legislative history contemplated — with a disproportionate patient percentage of 51.7 percent, ranking in the 97th percentile statewide and first among every Ohio hospital over 200 beds, with Medicaid alone accounting for 35 percent of its net patient service revenue. Cleveland Clinic's main campus reports a disproportionate patient percentage of 24.9 percent, with Medicaid at 10 percent of net patient service revenue and managed care and commercial at 52 percent. On a per-claim basis, MetroHealth absorbs approximately 4.6 times the uncompensated care cost of Cleveland Clinic. Yet Cleveland Clinic's substantially larger commercially insured infusion and oncology volume generates materially greater 340B margin per patient served. Within a single market, the program delivers the most to the hospital with the least low-income exposure — and the proposed reduction would take proportionally more from the hospital with the least capacity to replace it.

4. The Medicare Payment Advisory Commission (MedPAC) Has Recognized the Need for Higher Outpatient Payments for Safety-Net Hospitals

Since its initial recommendation to the Congress in 2023,⁷ MedPAC has repeatedly recommended revamping the Medicare DSH program to focus the payments on hospitals most in need, and to recognize that there is no Medicare DSH for outpatient services, only inpatient services. In the March 2026 Report to Congress, MedPAC again reiterated its recommendation for moving to its proposed Medicare Safety-Net Index (MSNI) model, providing:

[t]here continued to be substantial variation within the aggregates in each of our payment-adequacy indicators; in particular, hospitals that treat larger shares of low-income Medicare patients continue to face larger financial challenges. Therefore, for 2027, the Commission reiterates our recommendation from March 2023 that the Congress implement the MSNI, which would better target limited Medicare resources toward those hospitals that are key sources of care for low-income Medicare beneficiaries and are facing financial challenges. (MedPAC, 2026, p. 86).⁸

MedPAC further recommended that Congress add \$1 billion to the MSNI pool to help maintain the financial viability of Medicare safety net hospitals.⁹

⁶ Minnesota Department of Health 340B Covered Entity Report, Report to the Legislature, February 27, 2026.

⁷ Medicare Payment Advisory Commission. *March 2023 Report to the Congress: Medicare Payment Policy*.

⁸ Medicare Payment Advisory Commission. *March 2026 Report to the Congress: Medicare Payment Policy*.

⁹ *Id.*



B. Cost Acquisition Survey Data

1. FLHA Members Submitted Data.

The Front Line Alliance member hospitals all submitted the OPPS Drug Acquisition survey data as requested by CMS. Our hospitals are proud to be transparent about the critical benefit of 340B to our hospitals and the most vulnerable patients it is our mission to serve.

2. Model Rebate Pilot Program Implementation Impact

The survey reflects a historical period—July 1, 2024, through June 30, 2025—during which hospitals reported total net acquisition costs, inclusive of discounts and rebates. Since that period, the federal drug-pricing environment has continued to evolve, including implementation of negotiated Maximum Fair Prices (MFPs) for selected drugs and ongoing consideration of alternative mechanisms for effectuating 340B ceiling prices. These developments warrant caution in assuming that historical acquisition-cost relationships will necessarily remain representative of hospitals' experience in CY 2027.

For drugs potentially subject to both Medicare drug-price negotiation and 340B, the interaction is particularly complex. CMS's MFP guidance recognizes the need to prevent duplicative discounts between the MFP and 340B ceiling price and contemplates access to the lower applicable price rather than cumulative discounts. Accordingly, CMS should evaluate whether acquisition-cost data collected during the historical survey period appropriately reflect the net prices hospitals will experience for affected drugs in CY 2027.

Moreover, even where a covered entity's ultimate net drug price remains unchanged, a retrospective rebate structure can impose financial and operational burdens that are not captured by a historical acquisition-cost survey. Requiring a hospital to fund a higher upfront purchase price pending reconciliation or rebate can increase working-capital requirements and create liquidity pressures, particularly for safety-net hospitals operating on narrow margins. Claims-level reporting, reconciliation, dispute resolution, and other administrative requirements may likewise impose additional operating costs that are distinct from the net acquisition price reported in the survey.

These costs may not constitute “acquisition cost” for purposes of CMS's statutory survey methodology, but they are relevant to CMS's assessment of the real-world financial effects of its proposed payment policy on safety-net hospitals. For Front Line Hospitals, which serve a disproportionately high share of Medicare, Medicaid, and dually eligible beneficiaries, even temporary increases in working-capital requirements can affect resources otherwise available to support patient care.

For these reasons, CMS should not assume that historical acquisition-cost data alone provide a complete picture of the financial environment hospitals will face in CY 2027. At a minimum, CMS should evaluate whether subsequent changes in federal drug-pricing policy materially affect the representativeness of the survey data before relying on those data to establish a substantial prospective payment reduction.



Furthermore, the rebate model creates a very serious concern for hospitals like ours with more limited cash flow that must front the cash to purchase drugs at high amounts in the hopes we will secure a rebate. It further complicates our hospitals' efforts to provide financial assistance to our low-income patients at the time they are being dispensed 340B drugs, again in the hopes that we get a rebate.

3. Survey Data is Extremely Limited for Major Teaching Hospitals.

Our definition of Front Line hospitals includes 135 major urban teaching hospitals with high disproportionate share and case-mix index. Only 134 of 400 Major Teaching Hospitals responded to the survey, comprising only 10.3% of the 1304 total responding hospitals. On the other hand, 265 major teaching hospitals did not respond. As high-volume providers, we are concerned that the data is insufficient to justify such a major cut for Front Line hospitals.

C. CMS' Proposal Redistributes Cuts from Front Line Hospitals to Profitable and Non-Safety-Net Hospitals

CMS' proposal would redistribute \$4.85 billion from 340B hospitals to all hospitals providing outpatient services. The adverse impact for our hospitals ranges from \$1-16 million per year. One hospital estimates a \$7 million dollar cut to their cancer service line alone. For our hospitals, this is a meaningful cut.

Worse, our hospitals will not be made whole. Despite implementing the 340B cuts in a budget neutral manner, CMS itself acknowledges that "for most 340B providers, the decreased 340B drug payments will outweigh the increased payments for non-drug services." In other words, the 340B cut is expected to be a net negative specifically for the population of hospitals most likely to be high-Medicaid-volume, high-DSH, and heavily 340B-dependent.

The negative impact is compounded by another CMS proposal to raise the 340B remedy offset from 0.5 to 3.0 percent to recoup \$7.8 billion in prior non-drug overpayments. This offset is projected to reduce overall OPPS payments by \$2.3 billion in CY 2027. This proposal further erodes the non-drug service revenue that is supposed to cushion the drug-rate cut under budget neutrality.

The first Trump Administration protected Front Line and other high need rural and urban hospitals during COVID, enabling us to keep our doors open for medically and socially vulnerable patients. We ask that the second Trump Administration similarly recognize that, not all hospitals – even 340B Hospitals – are the same, and that true safety-net hospitals should be treated differently so as not to impact our patient care services and our continued drive to improve health and outcomes through early interventions.

Front Line hospitals are the exact hospitals most adversely affected under the proposed rule, as evidenced by CMS' impact table, due to our multiple missions of major teaching, high DSH, and high tertiary care. As stated previously, it is this confluence of multiple missions that renders Front Line hospitals financially strained.

Of the 135 Front Line qualifying hospitals under our proposed definition, 76 are public and 57 are public equivalent. All are urban hospitals over 100 beds, major teaching hospitals (as evidenced by an intern-and-resident-to-bed (IRB) ratio of at least 0.17 (or ≥ 100 residents)), high case mix (as evidenced by a case



mix index (CMI) of at least 1.3) and have at least a 35% DPP (our definition requires 45% DPP for nonprofits between 100-1000 beds, and 55% over 1000 beds).

The rule's own impact table (Table 88) shows the following negative payment adjustments:

- Major teaching hospitals: -3.1 percent
- $\geq 35\%$ DPP: -4.5 percent
- Urban teaching and DSH: -0.3 percent
- Government-owned: -1.3 percent

Conversely, hospitals with no teaching and no DSH would receive a 9.0% increase in their funding for non-drug services. Proprietary hospitals would receive a 10.3% increase.

In short, CMS' proposed rule would give an overall increase to non-safety-net hospitals while substantially cutting the most financially vulnerable urban hospitals with long-standing commitments to the highest levels of service to medically and socially vulnerable patients, providing them the full spectrum of care from primary through life-saving tertiary care, and training the next generation of physicians to serve exactly this patient population. CMS' proposal is Robin Hood in reverse – taking from the most financially precarious hospitals and giving to the richest hospitals with the least commitment to low-income patients.

CMS can and should change course in the final rule to protect Front Line hospitals, and either exempt them, or in the alternative, redistribute the \$4.85 billion in savings to those hospitals most in need.

D. CMS Has Authority to Establish Classes of Hospitals.

Under Section 1833(t)(2)(E) of the Social Security Act, the Congress statutorily directed that the Secretary shall, under the payment system, establish in a budget neutral manner certain adjustments including "other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals."

Indeed, the Secretary has done just that in establishing three classes of hospitals which cannot in the aggregate for each class exceed the Medicaid upper payment limit.¹⁰ Those classes, established by the Secretary and absent a statutory definition, include state owned government hospitals, non-state owned government hospitals, and private hospitals. In so doing, the Secretary recognized the inherent differences between each class of hospitals, including the inherent differences even between public hospitals that are owned by the state, and those owned by local governments (such as county hospitals, hospital districts, hospital authorities).

¹⁰ 42 C.F.R. § 447.272



E. Using that Authority, CMS should Exempt Front Line Hospitals.

We urge the Secretary to establish a class of Front Line Hospitals in the final rule and exempt them from the cut to ASP minus 33.4%.

To qualify as a Front Line hospital, we urge the following definition: public teaching hospitals over 100 beds with a CMI equal to or greater than 1.3, an IRB ratio equal to or greater than 0.17 (or ≥ 100 residents), and Medicare DPP of $\geq 35\%$ (all averaged over 3 years), or a nonprofit hospital that otherwise meets the same criteria, if between 100-1000 beds, has a DPP $\geq 45\%$, or if over 1000 beds, has a DPP $\geq 55\%$.

These criteria reflects our multiple missions of high DSH, teaching and tertiary care, all of which in combination results in financial instability. Under this definition, only 135 hospitals would currently qualify, which we believe is consistent with the original intent of Congress in including certain financially distressed public hospitals, and their equivalent nonprofits, in the 340B Program.

F. CMS' Rationale for Exempting Rural Sole Community Hospitals (SCHs) Extends to Front Line Hospitals

We appreciate that CMS proposes to exempt rural SCHs from the 340B drug payment reduction and invites comments about whether other hospital designations should also be exempted. CMS's rationale for exempting rural SCHs is two-fold: (1) Medicare has long recognized the unique needs of rural communities and the financial challenges rural hospital providers face and (2) there are a number of special payment provisions to maintain access to care in rural areas. We strongly believe that Front Line Hospitals are directly analogous to rural SCHs as both have higher-than-typical expenses, care for Medicare beneficiaries who often have nowhere else to turn, and receive special payments to maintain access.

1. Akin to Rural SCHs, Front Line Hospitals Have Higher-than-Typical Costs

Front Line Hospitals face high costs driven by a myriad of factors, including:

- Patient complexity, as safety net populations present with higher rates of uncontrolled chronic disease, behavioral health comorbidities, and upstream drivers of health that increase the resources required per encounter;
- Uncompensated care costs, including the direct cost of treating uninsured and underinsured patients whose care is never fully reimbursed;
- The provision of interpreter services, patient navigation, transportation assistance, and other wraparound services that are clinically necessary for effective care delivery to limited-English-proficiency and socially complex populations;
- Staffing requirements, including behavioral health integration and care coordination staff; and



- Urban facility and labor costs, including security infrastructure and wage pressures, that are not fully reflected in the OPPS wage index.

In light of these demonstrable costs facing Front Line Hospitals, we urge CMS to consider them analogous to rural SCHs as far as they have additional resource costs that far exceed other hospitals.

2. Similar to Rural SCHs, Front Line Hospitals Serve Patients with Nowhere Else to Go

Front Line Hospital patients face unique barriers to accessing care outside of our hospitals, including:

- Limited provider networks as many specialists do not accept Medicaid;
- Transportation challenges;
- Language and cultural competency needs, and
- Lack of integrated delivery systems that Front Line Hospitals provide to patients with complex medical and social needs.

Furthermore, Front Line Hospitals are often the only tertiary or quaternary provider in a large service area. For example, one of our members in Lubbock, Texas is the only Verified Level I Burn Center serving burn patients between Dallas and Las Vegas.

3. Medicare Also Makes Special Payments to “Super” Safety Net Hospitals

Like rural SCHs, Front Line Hospitals receive special treatment in Medicare. As high DSH hospitals, our hospitals receive special inpatient payment adjustments in the Medicare Program, as well as uncompensated care payments. As Front Line Hospitals are also major teaching hospitals, we also receive Indirect Medical Education payments, as well as Direct Graduate Medical Education payments.

Because Front Line Hospitals are the most negatively impacted by the proposed 340B payment reduction and, like their rural SCH counterparts, face unique challenges in providing care to the most vulnerable members of their communities, CMS should expand the exempted hospital designations to include Front Line Hospitals.

G. Alternatively, CMS should Redistribute \$4.85B to Front Line and High Need Hospitals.

1. The Statute Requires CMS to Redistribute Funding Within Part B

The budget neutrality adjustment provision in Section 1833(t)(9)(B) requires that if the Secretary makes adjustments pursuant to periodic review, then the adjustments must not cause expenditures under Part B to increase or decrease.

The proposed rule would redistribute approximately \$4.85 billion in 340B drug payment reductions to hospitals through a flat increase of 8.44% to nondrug OPPS payment rates.



2. CMS Should Redistribute \$4.85B Prioritizing Hospitals Most in Need

While an overhaul of Medicare disproportionate share payments must be enacted by the Congress, in redistributing \$4.85 billion in a manner consistent with MedPAC's continued recommendation would be far more targeted toward the safety-net hospitals that would shoulder the burden of the cut from ASP plus 6% to ASP minus 33.4% and that MedPAC has repeatedly expressed concern about their viability.

While the current Medicare DSH methodology is based on inpatient services, it does form a Congressional recognition of differential need for DSH based on levels of DSH. Under current law, urban and rural hospitals receive differential DSH payments based on the adjustment formula, distinguishing between bedside, and a DSH threshold at $\geq 15\%$, and $\geq 20.2\%$ DPP.

We recommend the agency apply Medicare metrics for high DSH, teaching and tertiary care prioritizing funding for Medicare outpatient services for Front Line hospitals that need it the most in the top category, major teaching and DSH in the second category, and then all other Medicare DSH hospitals according to the following ordering:

- a) Front Line Hospitals with 35% DPP for public hospitals (45% DPP for nonprofit under 1000 beds, and 55% DPP for over 1000 beds), 1.3 CMI, and 0.17 IRB (or ≥ 100 residents).
- b) Major teaching hospitals with a DPP of at least 20.2%, 1.3 CMI, and 0.17 IRB (or ≥ 100 residents).
- c) All other disproportionate share hospitals with a DPP of greater than or equal to 15%.

III. Volume Control Moratorium on New Trauma Centers in Oversaturated Markets

This proposed rule provides a regulatory framework for a market-based moratorium on new trauma center entry under CMS's existing authority at Section 1833(t)(2)(F) to develop a method for controlling unnecessary increases in the volume of covered outpatient department services. Volume growth in markets where existing trauma centers fulfill the community's needs constitutes "unnecessary" utilization in trauma fee activations. Medicare should direct new trauma entrants to underserved geographic areas rather than disrupt the well-functioning trauma systems in place.

A. Concerns with Excessive Trauma Center Saturation

The HHS Office of Inspector General's 2025 report, *Hospitals Charged CMS for Trauma Team Activations That Did Not Comply With Federal Requirements*, estimated that hospitals billed approximately \$2.4 billion in unallowable charges for trauma team activation fees that did not meet applicable Medicare requirements between January 1, 2020, and June 30, 2022.¹¹ This report demonstrates that billing non-compliance in the trauma center context is a documented, systemic concern and it underscores the need

¹¹ HHS Office of Inspector General. *Hospitals Charged CMS for Trauma Team Activations That Did Not Comply With Federal Requirements*. 2025. Available at <https://oig.hhs.gov/reports/all/2025/hospitals-charged-cms-for-trauma-team-activations-that-did-not-comply-with-federal-requirements/>.



for stronger enrollment-side controls to prevent further proliferation of trauma centers in markets where competitive pressures may incentivize improper billing practices.

These findings are consistent with the clinical literature demonstrating that trauma center proliferation directly undermines patient outcomes. Multiple studies have found an inverse relationship between trauma center proliferation and patient outcomes because it will dilute the trauma volume at each center, leading to degradation in experience and worsening of mortality. One such study used national data and found significantly improved survival at high-volume centers with greater than 650 cases per year for the highest-acuity patients.¹² Another study showed a seven percent decrease in odds of mortality for every 500 patient increase in volume for those with shock or traumatic brain injury.¹³ Similarly, researchers found that increasing trauma volume was associated with improved outcomes, while each one percent decline in volume over time was associated with a two-fold increase in the odds that a trauma center's death rates would be worse than expected given the severity of the injuries treated.¹⁴

In certain metropolitan regions, the concentration of trauma centers exceeds the volume of trauma patients needed to sustain clinical competency, dilutes case volumes across existing facilities, and creates conditions in which facilities may engage in aggressive patient-steering practices or submit claims that do not reflect the complexity of care actually provided. The OIG's findings reinforce this concern. When trauma centers compete for a limited pool of trauma patients, the financial incentive to activate trauma teams and bill the associated activation fees in cases that do not warrant such activation increases. A moratorium on new trauma center enrollments in oversaturated areas would address this problem at the front end by limiting further market entry where the existing provider base already exceeds patient need.

B. Statutory Authority to Establish a Moratorium

In this proposed rule, CMS leverages its authority under Section 1833(t)(2)(F) to “develop a method for controlling unnecessary increases in the volume of covered OPD services” to propose expanding the site-neutral policies to imaging without contrast services provided at excepted off-campus provider-based departments. In establishing and expanding the site neutral policy, CMS has reasoned that the higher OPPS rates (relative to the Physician Fee Schedule (PFS) rates) were incentivizing migration of routine evaluation and management encounters to hospital outpatient departments and increasing costs for the Medicare program and beneficiaries.

The trauma activation fee presents a similar volume control issue. Although there is no analogous site-of-service differential for trauma care, separate payment for the trauma activation fee can create an economic incentive for hospitals to seek trauma designation or verification in markets that already have adequate trauma capacity. In high-density markets, the proliferation of trauma centers may result in an

¹² Nathens AB, Jurkovich GJ, Maier RV, Grossman DC, MacKenzie EJ, Moore M, Rivara FP. Relationship between trauma center volume and outcomes. *JAMA*. 2001 Mar 7;285(9):1164-71.

¹³ Minei JP, Fabian TC, Guffey DM, et al. Increased trauma center volume is associated with improved survival after severe injury: results of a resuscitation outcomes consortium study. *Ann Surg* 2014; 260:456–65.

¹⁴ Brown JB, Rosengart MR, Kahn JM, Mohan D, Zuckerbraun BS, Billiar TR, Peitzman AB, Angus DC, Sperry JL. Impact of volume change over time on trauma mortality in the United States. *Ann Surg*. 2017 Jul;266(1):173-178.



increase in the number of separately billable trauma encounters without improving patient access to care. To control unnecessary increases in trauma activation fees, we urge CMS to establish a moratorium on new trauma centers in areas where existing capacity meets or exceeds the community's trauma needs.

Furthermore, under 42 CFR 424.570(a)(1)(i), “***CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area***” [emphasis added]. Accordingly, CMS has authority to impose a moratorium on the establishment of new trauma centers in high trauma-center density geographic areas.

We urge CMS to extend this targeted moratorium to state Medicaid and CHIP programs. Under 42 C.F.R. § 455.470(a)(1) through (3) and 42 C.F.R. § 457.990, the Secretary may impose a temporary moratorium, in accordance with § 424.570, on the enrollment of new providers or provider types after consulting with any affected State Medicaid agencies. The State Medicaid agency must impose a temporary moratorium on the enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid and CHIP programs unless the state determines that the imposition of a moratorium would adversely affect Medicaid and CHIP beneficiaries' access to medical assistance and notifies the Secretary in writing.

A temporary, targeted moratorium would not adversely affect Medicaid or CHIP beneficiaries' access to medical assistance in high trauma-center-density geographic areas where data shows that existing enrolled trauma centers provide sufficient geographic access and capacity. On the contrary, a targeted moratorium would further the statutory and regulatory purposes of preventing unnecessary or inappropriate utilization, avoiding excess payments, and preserving trauma-system resources for clinically necessary, properly documented trauma care.

C. Supporting Rationale

1. Trauma Activation Fee Spurred Growth Not Where Needed

Between 2002 and 2023, the total number of Level I-IV trauma centers increased from 1,154 to 2,076, including an additional 30 Level I and 63 Level II trauma centers.¹⁵ For example, data from Pennsylvania suggest an increase in trauma center designations in already well-served regions, growing from 23 Level I-III trauma centers in 2004 to 38 today. While this example may not be nationally representative, it illustrates how payment structures can interact with local market dynamics in ways that may not always align with broader system needs.

Available analyses indicate that a significant share of trauma center growth has occurred in areas already served by existing centers. For instance, between 2014 and 2019, approximately 91% of new Level I and Level II trauma centers were established in areas with existing access, with similar trends observed among

¹⁵ Dehghan, N, et al, on behalf of the Orthopedic Trauma Association Health Policy Committee; *Trauma center proliferation in the United States: concerns and potential solutions*. March 2025 – Volume 8 – Issue 1



Level III–V centers. The Orthopedic Trauma Association (OTA) Health Policy Committee noted in March 2025 that growth has occurred primarily in urban areas where access was already adequate, while gaps persist in rural regions. Looking nationwide, the distribution of trauma centers varies significantly across states, with substantial variation in trauma centers per capita.

2. *New Trauma Centers Threaten Financial Viability of Some Front Line Hospitals*

The proliferation of new trauma centers has been at hospitals with better payer mix, lower trauma acuity, less penetrating trauma, often sponsored by for-profit or very profitable hospitals systems.¹⁶ Also of serious concern is the “trend of increasing trauma centers in wealthy areas of the nation combined with persistent scarcity or loss in less advantaged areas [which] threatens the goal of zero preventable deaths in trauma care.”¹⁷ A Pennsylvania-specific study also found that new trauma centers cared for a growing share of total trauma patients, but a disproportionately low share of Medicaid and uninsured patients, while new centers designated after 2004 served only 12.7% Medicaid and uninsured patients in 2018, hospitals designated prior to 2004 served 21.3% of these vulnerable patients. The study’s authors wrote:

“New trauma centers saw patients with higher rates of Medicare and private insurance versus Medicaid when compared with patients at established trauma centers over time. This discrepancy may indicate that the more socially and medically complicated patients – those with Medicaid, the highest injury severity and older age with comorbidities – were least likely to be cared for at new trauma centers. While overall increasing access to trauma care, our data suggest that the arrival of new trauma centers has the potential to adversely affect financial stability of established centers that continue to care for the patients least able to pay.”¹⁸

Trauma center over-proliferation threatens the financial stability of many super safety-net hospitals with higher Medicaid and uninsured patients which have long-standing commitments to Level I trauma care for the underserved well before it became financially advantageous. If already financially vulnerable hospitals are unable to maintain their Level I trauma center verification under the American College of Surgeons (ACS) volume threshold, as well as Accreditation Council for Graduate Medical Education (ACGME) accreditation for insufficient number of patients seen by residents, it is the most medically underserved in the poorest urban neighborhoods who will suffer from lack of timely access to life-saving trauma care.

3. *Dilution of Volume Threatens Clinical Proficiency*

We agree with the ACS Revised Statement on Trauma Designation in 2021,¹⁹ which observed:

“As there is no national trauma systems legislation or infrastructure, state and local governments have established these systems of care with significant variability in structure, process, resources,

¹⁶ Haddad at 5.

¹⁷ Ferre.

¹⁸ Haddad at 5.

¹⁹ Trauma Center Designation Based Upon the System Need and the Economic Drivers Impacting Trauma Systems, American College of Surgeons, October 1, 2021



and authority. As a result, in most states the number and distribution of trauma centers is not matched to the needs of the population, with ongoing inadequate access to care in rural areas, while some urban and suburban areas have a plethora of trauma centers that raises costs and dilutes the patient volumes, particularly at Level I trauma centers. Adequate trauma center volume is important for clinical proficiency, innovation and research, leadership development, education and expertise.... The problem arises when a lead [state] agency passively allows health care organizations and hospital groups to establish new trauma centers in areas that yield an economic advantage, while ignoring areas of true need. Such uncontrolled growth of trauma centers – some of which may lack long-term commitment – has the potential to undermine the quality of trauma care within a region, creating areas of oversupply and adverse competition while ignoring underserved areas entirely.²⁰

More recently, in 2024, the American College of Surgeons issued a Statement on Trauma Activation Fees, in which ACS said the following²¹:

There is wide variation in the amounts charged for activation fees, as well as how they are reimbursed across payers. There is also a lack of transparency in what is charged by hospitals and how fees are used for readiness. Trauma activation fees may not be managed optimally in all circumstances: (1) revenue from trauma activation fees might exceed readiness costs without attribution to the trauma center; (2) fees might place an undue burden on under- and uninsured patients with high out-of-pocket costs; and (3) trust in trauma centers may be compromised by the perception of high fees for trauma team activation.

The ACS asserts that trauma activation fees are necessary for the viability of trauma centers to ensure optimal care for patients. *Absent reimbursement for such fees, alternate funding would be needed to sustain trauma centers and their missions.* [emphasis added]

The ACS affirms the following considerations for accountable and transparent trauma activation fees:

1. Trauma activation fees should be considered “trauma patient readiness fees” that reflect the contingent costs of immediate resource availability at all times for all trauma patients.
2. Trauma activation fees must only apply to designated/verified trauma centers.
3. Trauma activation fees must be used to defray the costs of trauma center readiness for injured patient care.
4. Trauma activation fees should be public and transparent.
5. Trauma team activation must be based on evidence-based activation guidelines, which are reevaluated regularly for effectiveness.
6. Trauma medical directors and program managers should be included in developing activation fees, determining their allocation, and reassessing their appropriateness.

²⁰ Ibid, p. 3-4.

²¹ <https://www.facs.org/about-ac/s/statements/statement-on-trauma-activation-fees/>



7. Public and private payers should be responsible for reimbursement of trauma activation fees appropriate for trauma patient readiness costs and without patient charge.

Further, the ACS advocates for a system of public and private sector financial support for trauma centers and systems.

Similarly, the Orthopaedic Trauma Association Committee concluded that “[u]ndisciplined distribution of trauma centers increases costs and negatively affects patient outcomes. It also lowers the efficiency and competency of each trauma center and surgeons from the dilution effect and negatively affects research, education and experience for surgeons, trainees, and other allied health professionals.”²² A Pennsylvania study stated that “the redundancy of trauma centers does not improve injury-related mortality and may even lead to an increase in injury-related mortality, as additional trauma center designation dilutes the trauma volume seen and the expertise developed at each center.”²³

We applaud the leadership of these esteemed physicians and medical societies in addressing the challenging issues of ensuring access to the highest quality life-saving trauma care, and ensuring that our trauma system is patient centered and clinically driven.

D. Determining Moratorium Locations

For purposes of identifying geographic areas already well served and thus subject to the moratorium, we suggest that a “high trauma-center density” geographic area is defined as follows:

- Metropolitan statistical areas (MSAs) or State Designated Trauma Service Regions with a population less than 1 million that have one Level I trauma center, and
- MSAs or State Designated Trauma Service Regions with a population over 1 million that have either (i) two Level I trauma centers or (ii) a combination of one Level I and two Level II trauma centers per each million people.

For illustrative purposes, consider the following MSAs:

- The San Antonio MSA has 1.5 million people and two existing Level I trauma centers, so it would be considered a high trauma-center density geographic area. Therefore, the temporary moratoria would pause enrollment for new Level I and Level II trauma centers.
- The Indianapolis MSA has a population of 1.6 million people and three Level I trauma centers. It would be a designated high trauma-center density geographic area and subject to the moratorium on new Level I and Level II trauma centers.
- The Houston MSA has a population of 4.1 million people and only two Level I trauma centers. Because it is under the threshold for a high trauma-center density geographic area, it would not be subject to the moratorium on new Level I and Level II trauma centers.

²² Dehghan OTA Committee – 6. Conclusions.

²³ Haddad at 1.



This approach would exempt trauma-underserved markets from the moratorium, incentivizing market entrants in areas that need additional trauma capacity.

E. Complementary Program Integrity and Payment Reforms

During a moratorium on new trauma centers in oversaturated areas, CMS would have the opportunity to develop proposals that address underlying program integrity concerns raised by the HHS OIG. We recommend the following complementary program integrity measures:

- Issue sub-regulatory guidance clarifying appropriate billing requirements for G0390, including activation criteria and documentation expectations;
- Conduct targeted program integrity reviews focused on outlier billing patterns, rather than applying broad-based restrictions that may affect compliant providers;
- Increase transparency regarding how CMS identifies and monitors high-risk utilization patterns.

Additionally, the moratorium period would allow CMS to consider a revised reimbursement model for trauma services aligned with developing a national military and civilian system. Congress is investing in military-civilian partnerships through the National Defense Authorization Act (NDAA) and the Mission Zero program to improve battlefield injury readiness. Ensuring the viability of high-volume trauma centers are essential to this effort.

IV. Conclusion

We greatly appreciate CMS's consideration of our recommendation to exempt Front Line Hospitals from the 340B drug payment reductions to preserve Medicare patient access to these "super" safety net providers that meet the original intent of the 340B Program, face similar challenges to rural SCHs, and use the savings to directly benefit their low income, uninsured, and underinsured patient population. Additionally, CMS' proposed expansion of its volume control methodology to additional outpatient services is a regulatory and statutory framework for establishing a moratorium on new trauma centers in geographic areas where oversaturation threatens both quality of care and program integrity.

We appreciate the opportunity to comment on this proposed rule and welcome the chance to discuss these recommendations further.

Respectfully submitted,

Esmaeil Porsa, MD, MPH, MBA, MPH, CCHP-A
President and Chief Executive Officer
Harris Health



August 28, 2026

The Honorable Bill Cassidy, MD
Chairman
Health, Education, Labor, and Pensions Committee
United States Senate
455 Dirksen Senate Office Building
Washington, DC 20510

Re: 340B Drug Pricing Integrity and Affordability for Patients Act (340B for Patients Act) discussion draft

Dear Chairman Cassidy:

On behalf of the Front Line Hospital Alliance, thank you for the opportunity to respond to your 340B for Patients Act discussion draft. We appreciate your long-standing and continued commitment to improving the 340B Program and focusing its benefit on those covered entities and patients that need it the most, including Front Line Hospitals dedicated to caring for our nation's most medically and socially vulnerable.

At this pivotal moment, the Front Line Hospital Alliance urges Congress to modernize 340B in a way that preserves the program for the safety-net hospitals and patients it was originally designed to serve, while avoiding new operational burdens that would undermine access to care.

Front Line Hospitals are "super" safety-net hospitals distinguished by three responsibilities: caring for exceptionally high volumes of low-income patients, including those on Medicaid and the uninsured; providing the full continuum of primary through tertiary services, including complex critical, trauma, burn, and other specialized services to patient populations with comorbidities; training the next generation of physicians and the broader healthcare workforce to care for medically and socially vulnerable patients. While many hospitals play important safety-net roles, the 135 Front Line Hospitals combine unusually high low-income patient volume, high-cost specialized treatment for medically complex patients, and workforce training obligations that place serious stress on their financial viability.

When the 340B Drug Discount Program was created in 1992, the Congress anticipated that there were approximately 90 public or publicly equivalent hospitals that would qualify for 340B.¹ According to a recent study on the legislative history of 340B, "[a]lthough the program was designed to help core safety-net providers, it, like other programs made to support the safety-

¹ See the House Energy & Commerce Committee Report accompanying the Medicaid Drug Rebate Amendments of 1992, 102 H. Rept. 384



net, now primarily benefits non-safety-net providers.”² Front Line Hospitals are among those hospitals intended by the original authors of the 340B Program to benefit from the drug discount.

We have previously provided detailed comments on the Bipartisan 340B Senate Working Group discussion draft legislation and the Supporting Underserved and Strengthening Transparency, Accountability, and Integrity Now and for the Future of 340B Act of 2024 (SUSTAIN 340B Act of 2024), including a redline provided at the request of your Committee staff several years ago. We attached those responses for your benefit.

Implementation of the Health Resources and Services Administration (HRSA) 340B Rebate Model Pilot Program, effective January 1, 2027, and the Centers for Medicare & Medicaid Services’s (CMS’s) Medicare Outpatient Prospective Payment System (OPPS) proposal to reduce 340B hospitals’ payment for Part B physician-administered drugs purchased through 340B, which would reduce payment to ASP minus 33.4% effective January 1, 2027 if finalized, create both urgency and opportunity for bipartisan 340B reform this year. For that reason, we focus our comments on areas of potential agreement for disproportionate share hospitals and offer suggestions to simplify the discussion draft so it can attract bipartisan support.

As we have discussed with you and your staff over many years, we believe there are several critical areas of change that are paramount to modernizing 340B, and which we believe can be achieved through clear and streamlined legislative language, including:

1. **Transparency Is Achievable by Defining Child Sites by Physical Locations.** Transparency in 340B is essential to preserving the program’s purpose: ensuring access to lower-cost drugs for true safety-net hospitals and directly benefiting the patients they serve. That transparency is not achievable under the child site definition in current law and the 340B for Patients Act, but it can be achieved by redefining child sites to align with the physical locations of hospital clinics already reported to CMS on Form 855 and reflected in existing hospital accounting systems. To further streamline the discussion draft, the 340B for Patients Act should reference the existing provider-based regulations at section 413.65 of title 42, Code of Federal Regulations, or any successor regulation, as Congress did in Section 6225 of the Consolidated Appropriations Act, 2026. These changes would reduce unnecessary complexity while maintaining clear, auditable program integrity standards.
2. **Data Disaggregation is Necessary to Inform Policy Makers.** Data should be disaggregated by meaningful hospital characteristics (e.g., disproportionate patient percentage (DPP), ownership type, teaching status, and measures of financial strength such as operating margin and days cash on hand) rather than in a single undifferentiated pool. Because the

² *Stretching Scare Authorizing Legislation as Far as Possible: A Legislative History of the 340B Drug Pricing Program*, Sayeh Nikpay et al, The Milbank Quarterly, Vol. 00, No.), 2026.



draft already collects DPP and the underlying cost-report data, this requires no new data collection, only that the data be organized so its meaning is visible. Bundling all hospitals together creates a false impression that all are equally needy, when there is a decisive difference between a hospital with a DPP of 60% and one at 15% in commitment to low-income and medically complex patients and in profitability. Presented properly, disaggregated data would make plain that large, highly profitable systems qualifying through pathways such as the rural referral center designation, despite single-digit adjusted DPPs, do not resemble the safety-net hospitals 340B was enacted to serve.

3. Payment Data for Clinic-Administered Drugs Cannot Be Reported on a Per-Drug Basis.

The discussion draft's margin reporting requires covered entities to report aggregate payments received for covered outpatient drugs, including drugs administered in a clinical setting and billed on a medical claim. Payment for drugs furnished under the medical benefit payment is in substantial part determined through grouper and bundled methodologies (e.g., ambulatory payment classifications (APCs), enhanced ambulatory patient groups (EAPGs)) under which the payment attributable to an individual drug is packaged into the payment for the encounter and is not separately adjudicated or reported on the remittance advice. Because a material portion of medical-benefit drug payments is embedded in these grouped payments, covered entities cannot produce a complete or accurate aggregate payment, and therefore cannot compute a reliable payment-based margin, for clinic-administered 340B drugs. Payment is adjudicated and identifiable at the drug level only for drugs dispensed through the pharmacy benefit, where claims are priced per National Drug Code. We therefore recommend that any payment-based margin reporting be limited to drugs dispensed through the pharmacy benefit, and that reporting for clinic-administered drugs be confined to data covered entities can actually produce (e.g., units and acquisition cost) or to a methodology the Secretary defines to account for grouper-based reimbursement. This change would make the requirement administrable and its output meaningful, consistent with our shared goal of simplifying the legislation.

4. Patient Benefit Requires a Neutral Clearinghouse. Low-income patients should directly benefit from the 340B discount provided to safety-net hospitals. We support hospitals applying their Financial Assistance Policy to 340B drugs dispensed to their patients, but a rebate model makes pharmacy-counter application difficult because the hospital's actual acquisition cost is not known until after the transaction. A robust neutral clearinghouse could provide real-time information to prevent duplicate discounts involving states, Medicare Part D, manufacturers, and other stakeholders. Congress can accomplish this without overly complex legislative language by directing the Secretary to establish a neutral clearinghouse with clear objectives and guardrails that ensure fairness and transparency for all stakeholders and policymakers.



5. **A Clearinghouse Requires a Clear Patient Definition Grounded in Actual, Modern Healthcare Delivery Models.** A workable patient definition should require an actual medical service, supporting medical records, responsibility for care, and a timestamp of either 18 months or two years from the last date of service for the patient to be considered 340B eligible. That timestamp would allow a clearinghouse to determine quickly whether the patient was seen within the relevant period. By contrast, requiring a prescription to be tied in real time to the patient’s clinical condition is not grounded in the practical reality of healthcare delivery, particularly for medically complex patients with comorbid conditions served by Front Line Hospitals. Physicians and other prescribing professionals are responsible for seeing patients, using clinical judgment and expertise to make diagnosis and treatment decisions, and prescribing appropriate medications. Existing oversight bodies, including state medical boards, already hold physicians accountable for maintaining a high standard of care. A requirement that the patient be seen within the previous 18 months or two years aligns with medical practice, avoids duplicating current processes for enforcing medical professional conduct, and provides a simple bright-line test for identifying an active provider-patient relationship. Manufacturers and hospitals responsible for avoiding duplicate discounts need a simple, meaningful, and auditable patient definition that is not so complex that it renders the clearinghouse ineffective.
6. **Contract Pharmacy Arrangements Should Be Designed to Serve Patient Need, Access, and Adherence.** The purpose of contract pharmacies is to enable patients to access prescribed drugs closer to home. We strongly support the draft’s requirement that manufacturers ship or facilitate shipment of 340B discounted drugs to contract pharmacy location, however including a requirement to provide the appropriate 340B discounts, which restores access that manufacturer-imposed restrictions have eroded since 2020. We recommend four changes to the draft’s limits on these arrangements. First, we urge the Chairman to strike from the discussion draft the following passage in Section 5(E)(i): “Except with respect to covered outpatient drugs shipped to and dispensed by a contract pharmacy as provided in this subparagraph, and notwithstanding any other provision in this section, a manufacturer of covered outpatient drugs shall have no obligation to pay a discount or rebate under this section with respect to covered outpatient drugs delivered or otherwise transferred to any location other than a registered address of the covered entity (including an entity pharmacy or child site (as described in subparagraph (I)(i)), as applicable) listed in the identification system described in subsection (d)(2)(B)(iv).” The language may inject confusion and result in warranted discounts going unrealized because the manufacturer may lack clarity as to whether certain contract pharmacy arrangements have satisfied all criteria in this section. Second, the fixed cap of five contract pharmacies for disproportionate share and other hospital covered entities should be struck; a rigid numeric cap bears no relationship to patient need and would cut



off access for patients of high-volume safety-net systems. Third, the draft’s definition of “service area” — the entity’s Public Use Microdata Area (PUMA) and contiguous PUMAs — is too rigid to reflect how patients actually receive specialty and tertiary care, and should be replaced with a primary-service-area standard that scales with the acuity of services provided. A hospital delivering specialty, tertiary, and quaternary care serves a correspondingly larger, sometimes multi-state region, while a hospital in a dense urban area may have a compact one. For example, one of our members in Lubbock, Texas is the only Verified Level I Burn Center serving patients between Dallas and Las Vegas; those patients, discharged home across state lines, must still be able to obtain discounted medications for intensive follow-up care. For the same reason, hospitals providing specialty and tertiary care must retain the ability to dispense through mail-order pharmacies to patients who reside outside the immediate service area following such care. The draft’s apparent foreclosure of mail order for these hospitals would sever access for precisely the patients who most need continuity of specialty medications. The service-area standard should also include a buffer of at least ten miles beyond its outer boundary, so that a qualifying pharmacy located just outside the line is not arbitrarily excluded. Fourth, specialty pharmacies must be exempt from both the numeric cap and the service-area restriction. Covered entities often have no choice but to contract with distant pharmacies because many specialty and limited-distribution therapies can be obtained only through a small number of manufacturer-designated, insurer-designated, or pharmacy benefit manager-designated specialty pharmacies nationwide. For these drugs there is often no in-service-area dispensing option and imposing one would deny our patients access to the therapy altogether. Although the draft acknowledges restricted-distribution drugs within the manufacturer’s shipment obligation, it does not correspondingly permit the covered entity to designate the necessary specialty pharmacy as a contract pharmacy without exhausting its cap or breaching the geographic limit. Specialty pharmacies dispensing drugs subject to a limited or restricted distribution network should therefore neither count against any contract pharmacy limit nor be subject to the service-area requirement. HRSA can require hospitals to report on their primary service areas by level of care and require contract pharmacy arrangements to align with those areas. This approach is grounded in patient access, not revenue generation, and achieves the draft’s integrity goals without the collateral damage of an arbitrary cap or the loss of access to life-sustaining specialty medications.

7. **Correctional Care Facilities Operated by Government Hospitals Should Be Exempt from Child Site Restrictions.** Government hospitals often operate correctional care facilities through provider-based arrangements and complex intergovernmental agreements, including state and county funding contracts. To ensure these hospitals can continue caring for incarcerated patients without disruption, 340B reform legislation should



exempt correctional care sites operated by 340B-eligible government hospitals from child-site restrictions, including the provider-based status requirement.

We also offer the following input related to additional topics in the 340B For Patients discussion draft and seismic policy shifts occurring in the 340B Program that will impact congressional reform efforts.

1. Exempt Front Line Hospitals from CMS's Proposed OPPS 340B Drug Payment Reduction.

Any legislative reform to the 340B Program must be considered in the context of CMS's proposed CY 2027 OPPS rule, which would substantially reduce Medicare Part B reimbursement for 340B-acquired drugs from ASP plus 6% to ASP minus 33.4%. CMS estimates this would cut 340B drug payments by approximately \$4.85 billion in CY 2027, an amount it would redistribute to all OPPS hospitals through an 8.44 percent increase to the non-drug conversion factor. CMS also proposes raising the 340B remedy offset from 0.5 to 3.0 percent to recoup \$7.8 billion in prior non-drug overpayments, an offset projected to reduce overall OPPS payments by \$2.3 billion in CY 2027. If finalized, these payment adjustments would take effect on January 1, 2027, the same date the HRSA 340B Rebate Model Pilot Program becomes effective. The combined impact on Front Line Hospitals would be severe.

The proposed 340B cuts disproportionately harm hospitals serving the largest share of low-income patients. The rule's own impact table shows hospitals with a disproportionate patient percentage of 0.35 or greater are projected to see a 340B-related adjustment of -5.8 percent and an overall CY 2027 payment impact of -4.5 percent.

Front Line Hospitals will not be made whole. Despite implementing the 340B cuts in a budget neutral manner, CMS itself acknowledges that "for most 340B providers, the decreased 340B drug payments will outweigh the increased payments for non-drug services." In other words, the 340B cut is expected to be a net negative specifically for the population of hospitals most likely to be high-Medicaid-volume, high-DPP, and heavily 340B-dependent.

The Front Line Hospital Alliance respectfully asks the Chairman to (1) urge CMS to exempt High Needs Hospitals from the proposed 340B payment cuts and (2) pursue a legislative exemption for High Needs Hospitals if CMS does not act. Our financially distressed hospitals care for the sickest, poorest, and costliest patients throughout the country and cannot absorb these cuts while upholding our mission.



2. Remove Manufacturer Choice of Rebate Model.

The bill would allow manufacturers to choose an upfront discount, clearinghouse-based approach, or retrospective rebate. The Front Line Hospital Alliance does not support allowing manufacturers to implement a rebate-based model under the 340B Program because such a model shifts financial, operational, and compliance risk from manufacturers to covered entities, contrary to the statutory purpose of 340B.

For super safety-net hospitals like the Front Line Hospital Alliance members, whose ability to serve vulnerable populations depends on predictable 340B savings, a rebate model would destabilize operations, strain liquidity, compromise confidential, financial, and patient data, divert resources from patient care, compliance, and program integrity, and reduce patient access to medications and other essential services. We have serious concerns about the HRSA 340B Rebate Model Pilot Program and caution against any legislative initiative that could result in its expansion at the option of the manufacturer. At a minimum, consideration should be given to unique circumstances of Front Line Hospitals.

As always, we would welcome the opportunity to meet with you and your staff to provide detailed information and legislative language that can support meaningful, bipartisan 340B reform this year.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Esmaeil Porsa".

Esmaeil Porsa, MD, MPH, MBA, MPH, CCHP-A
President and Chief Executive Officer
Harris Health

1776-2026

United States of America

United States Patent and Trademark Office

FRONT LINE

Reg. No. 8,450,299

Registered Sep. 22, 2026

Int. Cl.: 35

Service Mark

Principal Register

Front Line Hospital Alliance (District of Columbia UNINCORPORATED ASSOCIATION)

2525 Holly Hall
Houston, TEXAS 77054

CLASS 35: association services in the nature of a coalition of health services providers promoting the interests of underserved patients and the hospitals dedicated to serving them

FIRST USE 00-00-2019; IN COMMERCE 00-00-2019

THE MARK CONSISTS OF STANDARD CHARACTERS WITHOUT CLAIM TO ANY PARTICULAR FONT STYLE, SIZE OR COLOR

SER. NO. 99-709,713, FILED 03-18-2026



DIRECTOR OF THE UNITED STATES
PATENT AND TRADEMARK OFFICE



Harris Health P.O. Box 66769, Houston, Texas 77266-6769 | harrishealth.org

August 19, 2026
The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Proposed Remote Monitoring Policy

Dear Administrator Oz:

We respectfully urge the Centers for Medicare and Medicaid Services not to finalize its proposed policies for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM).

If finalized, these proposals would cause immediate and significant disruption to “super” safety net hospitals that care for Medicare beneficiaries. For Harris Health, RPM and RTM is not a convenience—it is essential infrastructure for delivering value-based care to medically and socially complex populations.

The following letter will address why Harris Health and other “super” safety net hospitals utilize RPM and RTM and how the proposed remote monitoring policy would impact our patients and programs.

High Expenditures

Currently the top 5% of health care consumers in the United States are responsible for nearly 50% of all health care expenditures in our country. This phenomenon is created by the traditional approach to health care in the US of pouring resources into downstream care. Harris Health serves more than 247,000 unique patients annually and has more than 162,000 emergency visits annually.

Out of necessity, Harris Health and other “super” safety net hospitals control costs and improve outcomes by shifting from reactive, high-cost sick care to proactive, value-based health promotion and disease prevention practices. RPM and RTM are integral to this approach. Instead of reaching the point where an established patient may have to visit an emergency center for a high-cost visit, RPM and RTM allow Harris Health staff to engage the patient to a lower cost site of care, including their primary care provider.

RPM and RTM

Harris Health serves Harris County, which has a population of more than 5 million residents, including Medicare recipients that the proposed rule will impact. Harris Health extends health care delivery through its RPM and RTM programs.

Specifically, Harris Health has more than 4,000 established patients in its Care Companions program, which utilizes a third-party platform to monitor pregnancy, post-partum, prescription anti-depressant utilization, type 2 diabetes, and bowel prep.

In addition, HealthyConnect is a remote blood pressure monitoring program that uses patient reported data submitted via third-party platform to monitor and capture important medical information. HealthyConnect is the clearest example of why remote patient monitoring must be protected: patients enrolling in HealthyConnect at Harris Health demonstrate blood pressure control within six months, with systolic and diastolic results improving from pre-enrollment baseline to graduation and aligning with clinical control goals of less than 140/90.

HealthyConnect gives Harris Health the ability to monitor patients between visits, identify risk earlier, and intervene before uncontrolled hypertension becomes an emergency, hospitalization, maternal complication, or avoidable high-cost encounter. HealthyConnect receives an average of 237 referrals per month and shows that RPM is not a small pilot but scalable infrastructure for population health management. Finally, patient-reported results are equally strong, with a Net Promoter Score of 87.3 and a Health Literacy Score of 8.1, demonstrating that patients not only accept the model but gain confidence in understanding and managing their health.

At Harris Health, staff go above and beyond with patients enrolled in RPM or RTM, they explain to patients what numbers indicate and if a number will trigger an alert to staff. And clinical staff do the onboarding and monitoring of patients and their data. The proposed policy would impact RPM and RTM programs at Harris Health like HealthyConnect where the third-party platform send notifications, including text messages and calls to patients to remind them to submit their blood pressure readings.

Finally, Harris Health also utilizes Outpatient Parenteral Antimicrobial Therapy (OPAT). OPAT is an RTM that enables patients requiring prolonged intravenous antimicrobial therapy to safely complete treatment outside the hospital while maintaining physician, nursing, pharmacy, and care coordination oversight. At Harris Health, the program averages approximately 54 new patient initiations per month and 32 patients receiving infusion at home per month, reducing avoidable inpatient utilization and supporting hospital throughput. In June 2026, OPAT supported treatment for serious infections including bacteremia, osteomyelitis, abscesses, endocarditis, and pyelonephritis, demonstrating how complex therapies can be safely managed beyond facility walls. OPAT has saved the system nearly 10,000 bed days.

Impact

The ability to provide healthcare services beyond brick-and-mortar facilities is no longer optional for “super” safety-net health systems; it is essential to Harris Health, to patients with complex needs, and to the nation's broader health care infrastructure. Home-based care models and remote monitoring

programs allow Harris Health to extend clinical expertise into homes and communities, reduce avoidable emergency department visits and hospitalizations, improve access for vulnerable populations, and maximize limited healthcare resources.

Harris Health is concerned about the impact the proposed remote monitoring policy would have on our ability to utilize third-party companies for RPM and RTM, which would directly impact our patients. Additionally, we are concerned that the proposal will result in increased health care costs. Finally, there is concern that this policy sets a precedent of how Medicare approaches the technology, partnerships, and clinical infrastructure for home division programs.

As policymakers evaluate the future of remote monitoring, programs such as HealthyConnect should be understood as core healthcare infrastructure that enables scalable, efficient, patient-centered care well beyond the walls of the hospital.

Conclusion

Traditional health care models rely on episodic encounters that occur only when patients are able to physically access care. “Super” safety net hospital system’s like Harris Health serve patients who frequently face transportation barriers, unstable housing, food insecurity, limited financial resources, and competing life priorities that make traditional care models insufficient.

RPM and RTM enable continuous patient engagement between visits, extending care into homes, shelters, workplaces, and communities. RPM and RTM allows “super” safety net hospitals to proactively identify risks, intervene earlier, improve medication adherence, and reduce avoidable emergency department visits, hospitalizations, and readmissions.

Again, we respectfully urge the Administration not to finalize its proposed policies for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM).

Sincerely,

A handwritten signature in black ink, appearing to read 'Esmaeil Porsa', with a stylized, flowing script.

Esmaeil Porsa, MD, MPH, MBA, MPH, CCHP-A
President and Chief Executive Officer
Harris Health

Meeting of the Board of Trustees

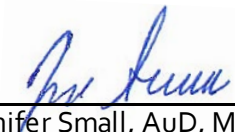
Wednesday, October 14, 2026

Review and Acceptance of the Following Report for the Health Care 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

Attached for review and approval:

- **HCHP October Operational Updates**

Administration recommends that the Board accept the Health Care 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 to provide health services to persons experiencing homelessness under Section 330 (h) of the Public Health Service Act.



Jennifer Small, AuD, MBA, CCC-A
Chief Executive Officer – Ambulatory Care Services

Health Care for the Homeless Monthly Update Report – October 2026

Jennifer Small AuD, MBA, CCC-A, Chief Executive Officer, Ambulatory Care Services

Tracey Burdine, Director, Health Care for the Homeless Program

HARRISHEALTH



Agenda

- Operational Update
 - Productivity Report
 - Consumer Advisory Council Report
 - Patient Satisfaction Report
 - 2027 HRSA Non-Competing Continuation Budget
 - HRSA Community Health Quality Recognition
 - HRSA Operational Site Visit – Final Report

HARRISHEALTH

Patients Served – Operational Productivity Update (August 2026)

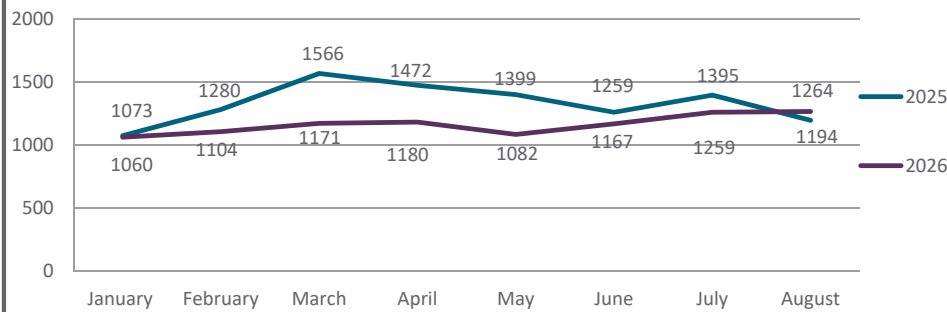
HRSA Unduplicated Patients Target: 7,250

YTD Unduplicated Patients: 4,743

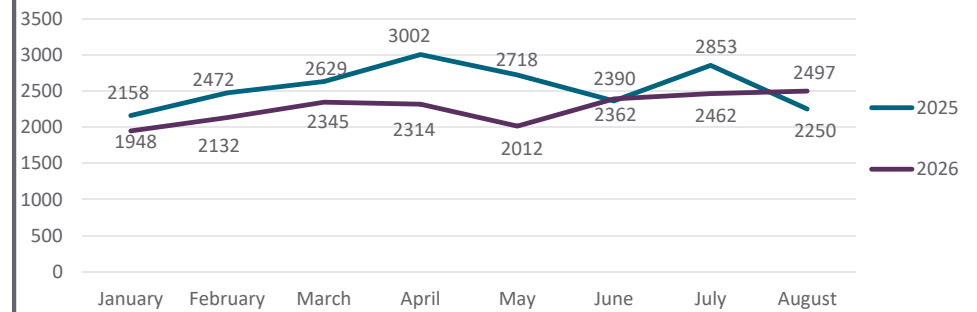
HRSA Completed Visit Patients: 30,496

YTD Completed Visits: 18,399

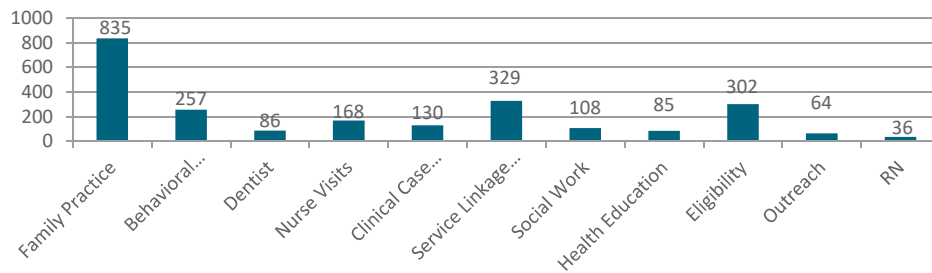
Monthly Unduplicated Patients (January – August)



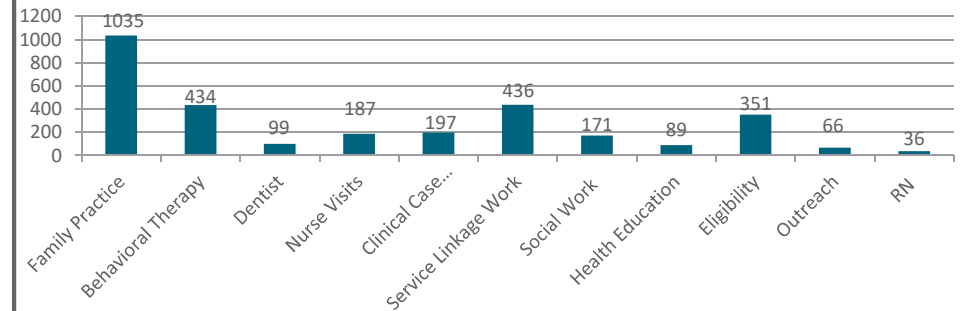
Completed Visits (January – August)



Monthly Unduplicated Patients by Department (August 2026)



Completed Visits by Department (August 2026)



HARRISHEALTH

Consumer Advisory Council – Key Updates

Highlights of Council Activities from May 2026 – July 2026:

Program Operations



- Members received updates on ongoing Harris Health and HCHP operational changes
- Council received updates on staff vacancies and changes
- Members were introduced to the new HCHP Medical Director

Service Delivery Changes



- Harris Center selected by the City of Houston to operate the Emancipation Hub
- HCHP is currently supporting the location through a mobile unit
- A contract is being developed to establish an HCHP clinic at the site

Strategic Initiatives



- Council supported the HRSA Nutrition Services Expansion grant application
- Continued focus on expanding HCHP services and improving access for the population served

Quality & Compliance

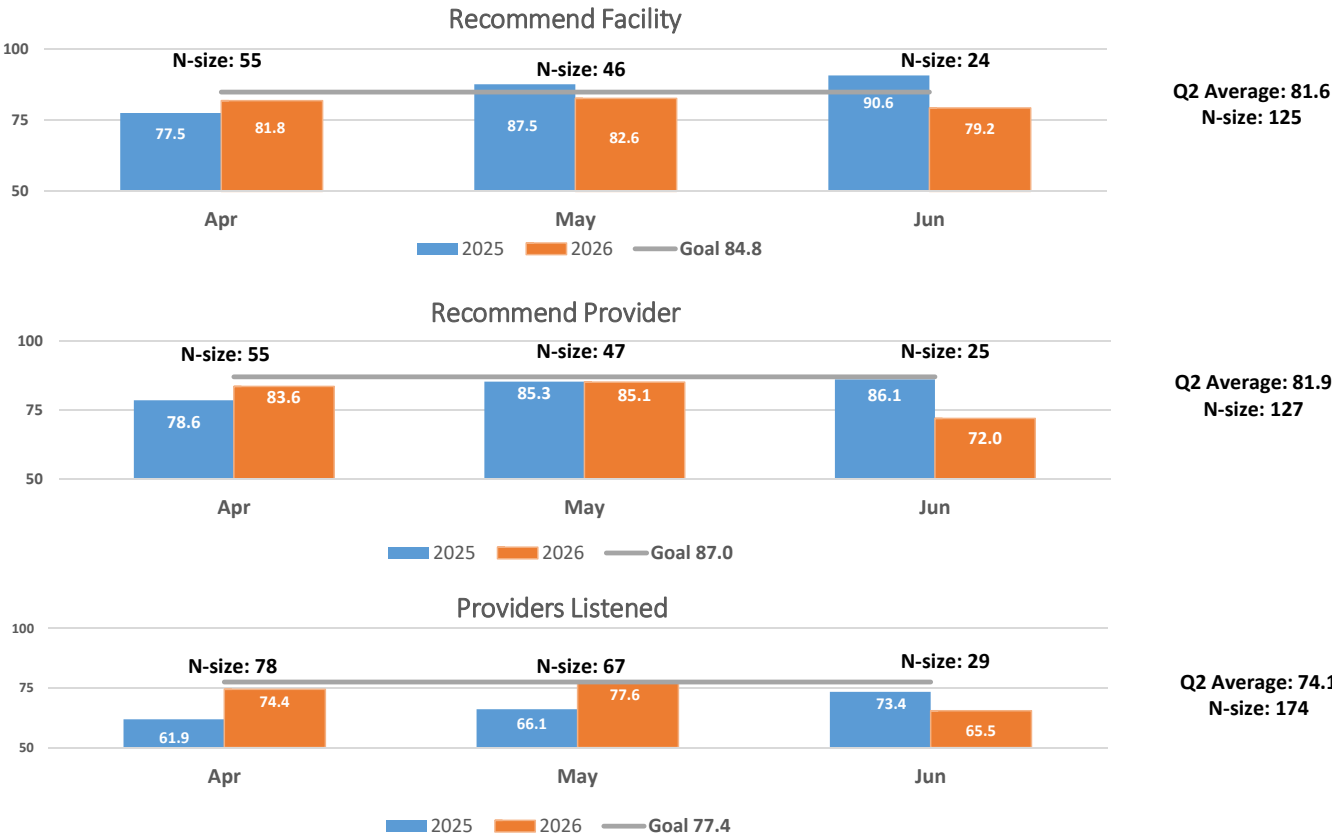


- Council reviewed performance improvement, productivity, and patient satisfaction reports and related corrective action plans
- Members received updates on the HRSA Operational Site Visit preliminary findings and corrective actions
- DNV site visit completed with no findings at assessed HCHP sites

Council discussions focused on program operations, service access, and upcoming community partnerships.

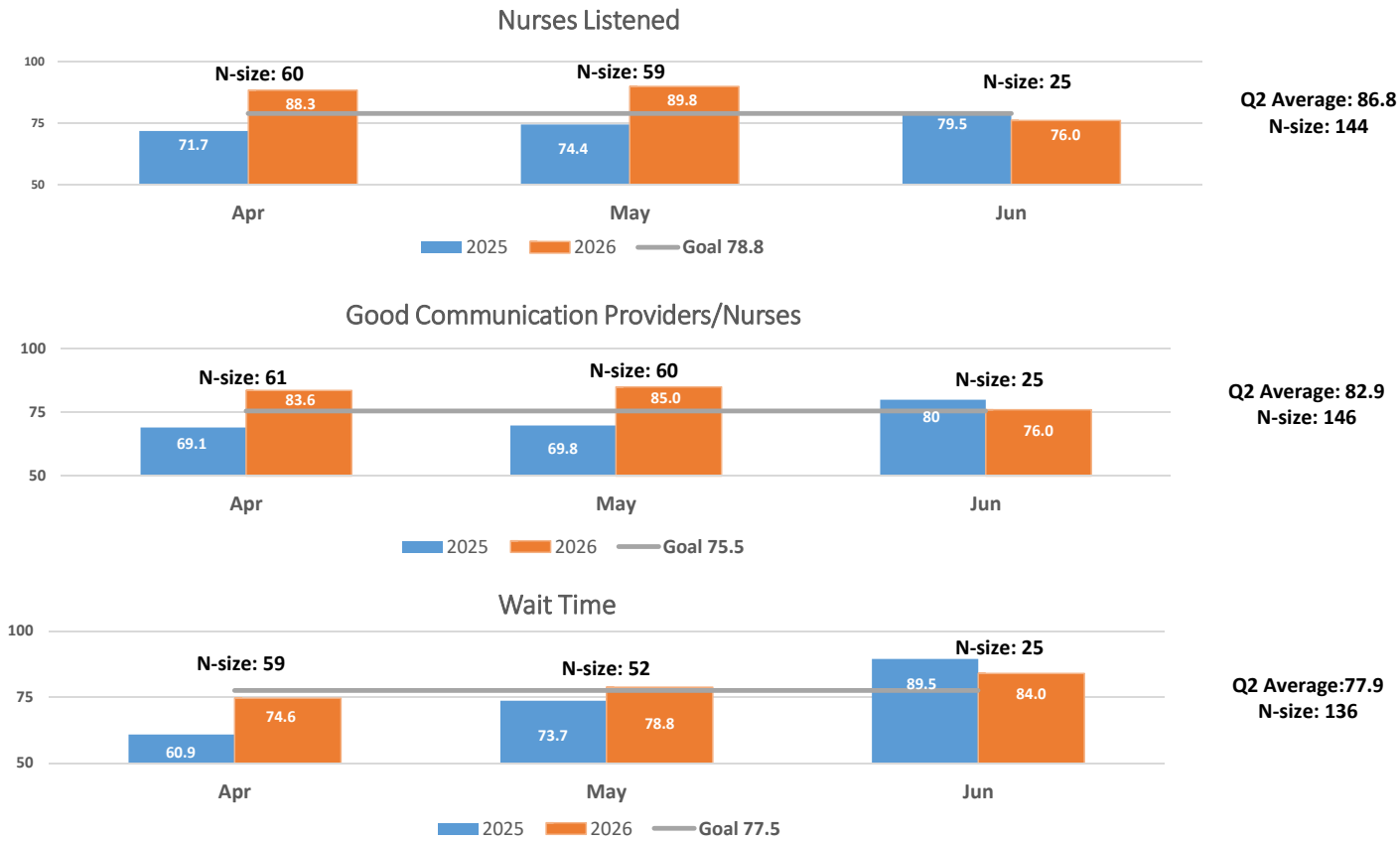
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HCHP Patient Satisfaction Trending Data Q2



Note: June results reflect a lower N-size. Further analysis of the decline in survey response volume is underway.

HCHP Patient Satisfaction Trending Data Q2



Note: June results reflect a lower N-size. Further analysis of the decline in survey response volume is underway.

2027 HRSA Non-Competing Continuation Budget

Harris County Hospital District
Budget Narrative
January 1, 2027 – December 31, 2027

	FEDERAL	NON-FEDERAL	TOTAL
PERSONNEL	\$3,282,529	\$2,797,574	\$6,080,103
FRINGE	\$886,282	\$671,418	\$1,557,700
TRAVEL	\$7,278	\$19,886	\$27,164
SUPPLIES	\$71,740	\$212,804	\$284,544
CONTRACTUAL	\$221,845	\$18,350	\$240,195
OTHER	\$0	\$47,903	\$47,903
TOTAL CHARGES	\$4,469,674	\$3,767,935	\$8,237,609

HRSA Community Health Quality Recognition

Based on 2025 UDS performance data submitted to HRSA, HCHP earned four Community Health Quality Recognition badges and recognition as a Patient-Centered Medical Home. Recognition reflects HCHP's performance in clinical quality, access to care, health information technology, and patient-centered care.



HCHP earned 4 quality badges, exceeding the badge count of 6 of 7 Houston-area community health centers reviewed.

HRSA Operational Site Visit – Final Report

Health Care for the Homeless Program (HCHP)

Site Visit: July 7–9, 2026
HRSA Health Center Program

Final Outcome

0 DEFICIENCIES

19 Program Requirements Reviewed | 93 Compliance Elements Assessed

Second Consecutive Triennial Site Visit with Zero Deficiencies

Final HRSA report received September 23, 2026



Site Visit Overview

- Reviewed clinical, financial, administrative, and governance operations
- Evaluated policies, documentation, and operational practices
- Verified compliance with HRSA Health Center Program requirements

Meeting of the Board of Trustees

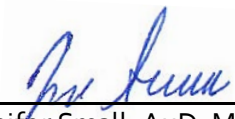
Wednesday, October 14, 2026

Consideration of Approval of the HCHP Consumer Advisory Report

Attached for review and approval:

- **HCHP Consumer Advisory Report**

Administration recommends that the Board approve the Health Care 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 to provide health services to persons experiencing homelessness under Section 330 (h) of the Public Health Service Act.



Jennifer Small, AuD, MBA, CCC-A
Chief Executive Officer – Ambulatory Care Services

Health Care for the Homeless Program Consumer Advisory Council Report

Highlights of Council Activities from May 2026 – July 2026:

- Members received updates on ongoing operational changes at Harris Health and the Health Care for the Homeless Program (HCHP).
- Members reviewed reports related to performance improvement, productivity, and patient satisfaction, with corresponding corrective action plans.
- The council was updated on staff vacancies and changes.
- Members were informed of the DNV site visit and of no findings at the HCHP sites that were assessed.
- The council was informed that the Harris Center has been selected by the City of Houston to operate the Emancipation Hub, and that a contract is being developed to establish a clinic at this location, and that HCHP is serving the site through a mobile unit.
- The council supported the grant application for the HRSA funding opportunity – Nutrition Services Expansion.
- Members were updated on the preliminary findings of the HRSA operational site visit and of corrective actions.
- Members were introduced to the new HCHP medical director.

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Consideration of Approval of the HRSA 2027 Non-Competing Continuation Budget Report
for the HCHP

Attached for review and approval:

- **HRSA 2027 Non-Competing Continuation Budget Report for the HCHP**

Administration recommends that the Board approve the Health Care 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 to provide health services to persons experiencing homelessness under Section 330 (h) of the Public Health Service Act.



Jennifer Small, AuD, MBA, CCC-A
Chief Executive Officer – Ambulatory Care Services

HARRIS COUNTY HOSPITAL DISTRICT
BUDGET NARRATIVE
JANUARY 1, 2027 TO DECEMBER 31, 2027

REVENUE:

REVENUE	Federal Resources	Non-Federal Resources	Total
BPR Funding Request	\$4,469,674		\$4,469,674
Applicant Organization		\$3,587,235	\$3,587,235
Local Funds			
Other Support			
Program Income		\$180,700	\$180,700
TOTAL REVENUE	\$4,469,674	\$3,767,935	\$8,237,609

EXPENSES:

PERSONNEL	Federal Request	Non-Federal Resources	Total
ADMINISTRATION	\$549,107	\$533,573	\$1,082,680
MEDICAL STAFF	\$1,473,355	\$1,376,014	\$2,849,369
DENTAL STAFF	\$108,754	\$13,778	\$122,532
MENTAL HEALTH STAFF	\$269,361	\$14,177	\$283,538
SUBSTANCE USE DISORDER STAFF	\$66,262	\$3,487	\$69,749
ENABLING STAFF	\$815,690	\$42,931	\$858,621
FACILITY PERSONNEL		\$132,534	\$132,534
PATIENT SERVICES SUPPORT PERSONNEL		\$391,551	\$391,551
SALARY INCREASES 2027		\$289,529	\$289,529
TOTAL PERSONNEL	\$3,282,529	\$2,797,574	\$6,080,103

FRINGE	Federal Request	Non-Federal Resources	Total
FICA @ 7.65%	\$251,113	\$214,014	\$465,127
Retirement/401K match @ 5%	\$164,126	\$139,879	\$304,005
Insurance @ 14.35%	\$471,043	\$317,525	\$788,568
TOTAL FRINGE @ 27%	\$886,282	\$671,418	\$1,557,700

TRAVEL	Federal Request	Non-Federal Resources	Total
Local - all staff: 0.76/mile X 9,576 miles = \$7,278	\$7,278		\$7,278
Airfare to National Health Care for the Homeless Council Conference for 2 staff members. \$900 per individual X 2 individuals = \$1,800		\$1,800	\$1,800

Hotel for National Healthcare for the Homeless Council Conference for 2 staff members. \$500 per night X 4 nights X 2 individuals = \$4,000		\$4,000	\$4,000
Travel related meals for National Healthcare for the Homeless Council Conference for 2 staff members. \$60 per day X 5 days X 2 individuals = \$600		\$600	\$600
Mileage to airport for travel to National Health Care for the Homeless Council Conference for 2 staff members. 40 miles x 2 ways X 0.76 cents per mile x 2 staff = \$122		\$122	\$122
Airfare to Mobile Health Care Association Conference for 3 staff members. \$700 per individual X 3 individuals = \$2,100		\$2,100	\$2,100
Hotel for Mobile Health Care Association Conference for 3 staff members. \$400 per night X 4 nights X 3 individuals = \$4,800		\$4,800	\$4,800
Travel related meals for Mobile Health Care Association Conference for 3 staff members. \$60 per day X 4 days X 3 individuals = \$720		\$720	\$720
Mileage to airport for travel to Mobile Health Care Association Conference for 3 staff members. 40 miles x 2 ways X 0.76 cents per mile x 3 staff = \$182		\$182	\$182
Airport transfers for travel in conference city for Mobile Health Care Association Conference for 3 staff members. \$40 per trip X 2 trips X 3 individuals = \$240		\$240	\$240
Airport transfers for travel in conference city for National Health Care for the Homeless Council Conference for 2 staff members. \$40 per trip X 2 trips X 2 individuals = \$160.		\$160	\$160
Airfare to TACHC Annual Conference for 2 staff members. \$600 per individual X 2 individuals = \$1,200		\$1,200	\$1,200
Travel related meals for TACHC Annual Conference for 2 staff members. \$60 per day X 4 days X 2 individuals = \$480		\$480	\$480

Hotel for TACHC Annual Conference for 2 staff members. \$400 per night X 4 nights X 2 individuals = \$3,200		\$3,200	\$3,200
Mileage to airport for travel to TACHC Annual Conference for 2 staff members. 40 miles x 2 ways X 0.76 cents per mile x 2 staff = \$122		\$122	\$122
Airport transfers for TACHC Annual Conference for 2 staff members. \$40 per trip X 2 trips X 2 individuals = \$160		\$160	\$160
TOTAL TRAVEL:	\$7,278	\$19,886	\$27,164

SUPPLIES	Federal Request	Non-Federal Resources	Total
Office Supplies: \$3,046 per month X 12 months=\$36,552	\$10,740	\$25,812	\$36,552
Medical & Dental Supplies: \$13,166 per month X 12 months=\$157,992	\$61,000	\$96,992	\$157,992
Pharmaceuticals: \$7,500 per month X 12 months = \$ 90,000		\$90,000	\$90,000
TOTAL SUPPLIES	\$71,740	\$212,804	\$284,544

CONTRACTUAL	Federal Request	Non-Federal Resources	Total
Residential substance abuse services provided by Cenikor Foundation. Salary \$13,000 + Benefits \$3,120 + Residential costs \$28,880 = Total of \$45,000. This is a fixed agreement to be paid at \$3,750 per month to include reimbursement for residential services, counseling, and other services and supplies related to substance abuse treatment. \$3,750 per month X 12 months = \$45,000	\$45,000		\$45,000
Dental services provided by Maceo Carter Investments, LLC dba Sterling Staffing Solutions to homeless individuals on the mobile dental unit. Reimbursement at \$183.45 per hour of service. The position is a 0.80 FTE and the federal request is \$176,845. Harris Health will provide \$18,350. Total = \$195,195.	\$176,845	\$18,350	\$195,195

TOTAL CONTRACTUAL	\$221,845	\$18,350	\$240,195
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OTHER	Federal Request	Non-Federal Resources	Total
Cab vouchers/Lyft for patients: \$1200 per month X 12 months = 14,400		\$14,400	\$14,400
Bus tokens for patients: \$150 per month X 12 months = \$1,800		\$1,800	\$1,800
Copier Lease: \$150 X 12 months = \$1,800		\$1,800	\$1,800
Registration fee for 3 staff members to attend the Mobile Health Care Association Conference. \$968 per individual X 3 individuals = \$2,904		\$2,904	\$2,904
Registration fee for 2 staff members to attend the National Healthcare for the Homeless Council conference. \$900 per individual X 2 individuals = \$1,800		\$1,800	\$1,800
Internet connectivity fees for access to Harris Health server from homeless sites. \$300 per month X 12 months = \$3,600		\$3,600	\$3,600
Membership - Mobile Health Care Association Conference: Annual fee = \$299		\$299	\$299
Membership - National Health Care for the Homeless Council: Annual fee: \$4,200		\$4,200	\$4,200
Meeting Meals & Incentives for Staff		\$7,500	\$7,500
Portable pump out services for mobile unit: \$200 per month X 4 Units X 12 months = \$9,600		\$9,600	\$9,600
TOTAL OTHER:	\$0	\$47,903	\$47,903
TOTAL DIRECT CHARGES	\$4,469,674	\$3,767,935	\$8,237,609

BOARD OF TRUSTEES

HARRISHEALTH

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Executive Session

Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Unaudited Financial Performance for the Eight Months Ending August 31, 2026, 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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BOARD OF TRUSTEES

HARRISHEALTH

Meeting of the Board of Trustees

Wednesday, October 14, 2026

Presentation Regarding Harris Health's Annual Compliance Education
[Strategic Pillar 3: Resiliency]



Carolynn Jones, JD, CHC
EVP, Chief Compliance and Risk Officer

From Oversight to Insight: Strengthening Board Compliance Governance

Carolynn Jones, Chief Compliance and Risk Officer

Anthony Williams, Deputy Chief Compliance and Risk Officer

Yvonne K. Puig, Norton Rose Fulbright US LLP

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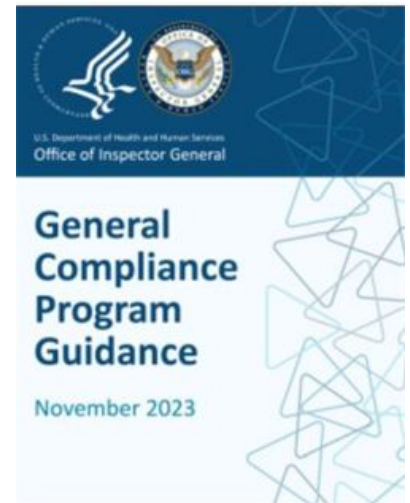
Agenda

- Introduction
- Board Member Fiduciary Duties Related to Compliance
- The Purpose of a Compliance Program/Why Compliance Matters
- Compliance Program Infrastructure: DOJ Evaluation vs. OIG Seven Elements
- Healthcare Fraud Enforcement: Overview of Certain Federal Laws
- Key Compliance and Enforcement Takeaway
- Discussion/Questions

Introduction

All board members, officers, employees, contractors, and medical staff (if applicable) of the entity should receive training at least annually on the entity's compliance program and potential compliance risks.

The training should describe the entity's commitment to complying with Federal and State standards and review the applicable fraud and abuse laws (e.g., the Federal False Claims Act, the Federal anti-kickback statute, PSL, and any applicable State fraud and abuse laws). This training also should explain the elements of the entity's compliance program.



[Source: HHS-OIG General Compliance Program Guidance | November 2023](#)

Board Fiduciary Duties Related to Compliance



Duty of Care

The Board must exercise reasonable diligence in overseeing the organization's compliance program



Duty of Loyalty

The Board must act in the best interests of Harris Health and its mission, not personal interests

The Board must support ethical conduct and accountability and ensure decisions are not driven solely by financial incentives at the expense of legal or regulatory compliance



Duty of Oversight

The Board must ensure an effective compliance program exists; and

The Board must act when significant compliance concerns are identified.

The Purpose of a Compliance Program

PREVENT

Prevent violations of law, regulation, and organizational policy

DETECT

Detect violations through monitoring, auditing, and reporting mechanisms

CORRECT

Correct violations promptly through remediation, reporting, and systemic improvements

*"The effectiveness of a compliance program requires a high-level commitment by the organization's leadership to create a culture that **promotes prevention, detection, and resolution of noncompliant conduct.**"*

HHS-OIG, Spring 2025 Semiannual Report to Congress (June 2025), at ii

Why Compliance Matters More than Ever

- The federal government is investing unprecedented resources in healthcare fraud detection and enforcement
- Executive Orders signed in 2025-2026 direct agencies to eliminate information silos, share data across programs, and intensify fraud prosecutions
 - EO 14243 (Mar. 2025): Stopping Waste, Fraud, and Abuse by Eliminating Information Silos
 - EO 14249 (Mar. 2025): Protecting America's Bank Account Against Fraud, Waste, and Abuse
 - EO 14395 (Mar. 2026): Establishing the Task Force to Eliminate Fraud
- The 2026 National Health Care Fraud Takedown charged 455 defendants with over \$6.5 billion in alleged fraud, making it one of the largest coordinated federal enforcement actions in U.S. history

OIG Enforcement by the Numbers

At a Glance:

OIG Accomplishments

October 1, 2025–March 31, 2026



MONETARY IMPACT^{*†}

 **OIG's work returns \$12.70 in expected recoveries and receivables for every \$1 invested.**



OVERSIGHT ACTIVITIES



*Totals in appendices may differ and numbers in figures may not sum due to rounding.

†See Appendix E for an explanation of terms.

ENFORCEMENT ACTIONS



Compliance Program Infrastructure: DOJ Evaluation vs. OIG Seven Elements

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How the DOJ Evaluates Compliance Programs

1

Is the compliance program well designed?

- Risk assessment process
- Policies and procedures
- Training and communications
- Confidential reporting structure and investigation process
- Third party management

2

Is the program being applied earnestly and in good faith? Is it adequately resourced and empowered?

- Commitment by senior and middle management
- Autonomy and resources for the compliance function
- Incentives and disciplinary measures

3

Does the compliance program work in practice?

- Continuous improvement, periodic testing and review
- Investigation of misconduct
- Analysis and remediation of underlying misconduct

Source: DOJ Criminal Division, Evaluation of Corporate Compliance Programs (first issued 2017; periodically updated)

OIG: The Seven Elements of an Effective Compliance Program

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1. Written Policies and Procedures

- Through written policies and procedures, entities can provide a **roadmap** to its workforce:
 - Outlining their duties within the organization;
 - Developing workflow management;
 - Imposing documentation requirements;
 - Defining individual and organizational oversight roles;
 - Implementing controls entity-wide to mitigate compliance risks specific to the entity; and
 - Demonstrating to the stakeholders and other interested parties, including government regulators, how the entity strives to comply with applicable laws, regulations, and requirements.

1. Written Policies and Procedures

- Code of Conduct
 - www.harrishealthcoc.org
- Compliance Policies
 - Implementation and operation of the entity's Compliance Program (including the 7 elements)
 - Processes to reduce risks caused by noncompliance with federal and state laws
- Policies and procedures must be easily accessible, searchable, and kept up-to-date.



2. Compliance Leadership and Oversight

- Boards and senior leadership are vital to effective compliance programs.
- An effective compliance program reduces and mitigates risk, provides patients safe and high-quality care, and saves costs.
- To be effective, a compliance program should have a board and senior leadership that understand its value and are committed to its success.
- One of these senior leaders should be the **Compliance Officer**.

2. Compliance Leadership and Oversight

- The Compliance Officer's Primary Responsibilities:
 - Overseeing and monitoring implementation and operation of the Compliance Program;
 - Advising CEO, Board, and other senior leaders on compliance risks and operation of the Compliance Program;
 - Chairs Compliance Committee and reports to Board;
 - Coordinates with Human Resources to ensure all appropriate parties are screened for possible exclusion;
 - Coordinates with others (Internal Audit, Risk, Quality, IT) to develop work plans for reviewing, monitoring, and auditing compliance risks;
 - Independently investigates matters related to compliance; and

2. Compliance Leadership and Oversight

- The Compliance Officer's Primary Responsibilities, cont.:
 - Develops policies and programs that encourage personnel to report suspected fraud and other improprieties without fear of retaliation.
- To be effective, the Compliance Officer should maintain a degree of separation from the entity's delivery of healthcare items and services and related operations.
- The Compliance Officer should have the authority to review all documents, data and other information relevant to the organization's compliance activities and to interview anyone within or connected to the organization in connection with a compliance investigation.

3. Training and education

- All board members, officers, employees, contractors, and medical staff should receive training at least annually on the entity's compliance program and potential compliance risks.
- The training should:
 - Describe the entity's commitment to complying with federal and state standards;
 - Review the applicable fraud and abuse laws; and
 - Explain the elements of the entity's compliance program.

4. Effective Lines of Communication/Disclosure Program

- An open line of communication between the compliance officer and the entity's workforce is critical to the successful implementation of a compliance program and reduction of any potential for fraud, waste, and abuse.
- Workforce members should be informed about the ways they can reach the compliance officer directly; this information should also be posted in commonly frequented physical and virtual spaces.
- Workforce members should be encouraged to bring compliance questions to the compliance officer.

5. Enforcing Standards: Consequences and Incentives

- For a compliance program to be effective, the organization should establish appropriate consequences for instances of noncompliance, as well as incentives for compliance.
- Consequences may involve remediation, sanctions, or both, depending on the facts. These should be consistently applied and enforced at all levels of the organization.
- Incentives may be used to encourage compliance performance and innovation.
- Both incentives and consequences are important to enforcing compliance.

6. Risk Assessment, Auditing, and Monitoring

- Risk assessment is a process for identifying, analyzing, and responding to risk.
- A compliance risk assessment is a process that looks at risk to the organization stemming from violations of law, regulations, or other legal requirements.
- Periodic compliance risk assessments should be conducted at least annually.

6. Risk Assessment, Auditing, and Monitoring

- Entities should consider using data analytics (i.e., analyzing its data) to identify compliance risk areas.
- All entities should be able to compare standard metrics of their healthcare operations internally to determine whether there are any outliers in a particular area of focus.
- The Compliance Committee should include in the compliance work plan a schedule of audits to be conducted based on risks identified by the annual risk assessment.

6. Risk Assessment, Auditing, and Monitoring

- The Compliance Committee should ensure that the Compliance Officer has the capacity to perform or oversee additional audits based on risks identified throughout the year.
- The compliance work plan should also contain routine monitoring of ongoing risks, plus the capacity to monitor the effectiveness of controls and risk mitigation.
- Entities should also periodically assess the Compliance Program's effectiveness.

7. Responding to Detected Offenses and Developing Corrective Action Initiatives

- Compliance programs should include processes and resources to:
 - Thoroughly investigate compliance concerns;
 - Take the steps necessary to remediate any legal or policy violations that are found, including reporting; and
 - Analyze the root cause(s) of any identified impropriety to prevent a recurrence.
- How an entity responds when it finds a violation resulting in a substantial overpayment or serious misconduct sets apart those that have a strong compliance program from those with a compliance program that is more form than substance.

Other – Quality and Patient Safety

- Entities should incorporate quality and patient safety oversight into their compliance programs.
- Besides patient harm, quality and patient safety concerns, such as excessive services and medically unnecessary services, can lead to overpayments and may cause False Claims Act liability.

Healthcare Fraud Enforcement: Overview of Certain Federal Laws

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Overview / Objective

➤ **Know the framework**

- Understand the principal federal laws that create criminal, civil, administrative, repayment, and exclusion exposure

➤ **Connect law to operations**

- Focus oversight on arrangements, claims, overpayments, patient access, workforce screening, privacy, cybersecurity, and emergency care.

➤ **Ask the right questions**

- Confirm that management identifies changing risk, tests controls, escalates significant issues, and documents corrective action

Federal laws covered today

Financial relationships

Anti-Kickback Statute

Physician Self-Referral Law (Stark)

Claims and repayments

Civil False Claims Act

Criminal false claims and healthcare fraud

Medicare overpayment rule

Administrative remedies

Civil monetary penalties

Exclusion authorities

Patient and information protections

Emergency Medical Treatment and Labor Act (EMTALA)

HIPAA Privacy, Security, and Breach Notification Rules

AI in Healthcare

Federal Anti-Kickback Statute (AKS)

- **The prohibition**

- Prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by federal healthcare programs.
- Covers both payers and recipients of kickbacks.

- **“Remuneration”**

- Includes anything of value, regardless of its form, including cash, credit arrangements, gifts, supplies, equipment, excessive rent payment, or tangible items.
- The AKS has been interpreted to cover any arrangement where *one purpose* of the remuneration was to induce referrals or order items or services.

Federal Anti-Kickback Statute (AKS)

- **Penalties**

- Felony criminal offense
- Fine up to \$100,000 per violation
- Imprisonment up to 10 years
- Exclusion from federal healthcare programs
- Civil False Claims Act (FCA) liability

- **Safe harbors**

- The AKS provides several safe harbors that protect certain payment and business practices that would otherwise implicate AKS violations.

- **AKS based FCA claims**

- One of DOJ's most common pathways to FCA liability.
- AKS and medical necessity theories remain foundational healthcare FCA enforcement tools.

AKS Safe Harbors

AKS Safe Harbors and Enforcement Risk

- The statute provides several safe harbors that protect certain payment and business practices that would otherwise implicate AKS violations.
- Affordable Care Act Amendment
 - “[A] claim that includes items or services resulting from a violation of [the AKS] constitutes a false or fraudulent claim for purposes of” the FCA
- April 2026 HHS OIG FAQ update
 - Compliance with a Stark Law exception or payment of fair market value compensation does not, by itself, preclude AKS liability.
 - See HHS OIG, General Questions Regarding Certain Fraud and Abuse Authorities, FAQs #4 and #17 (updated Apr. 23, 2026).

Physician Self-Referral Law (Stark Law)

The Prohibition

- Prohibits physicians from referring patients to receive “designated health services” payable by Medicare or Medicaid from entities with which the physician or immediate family member has a financial relationship, unless an exception applies.
- Strict liability statute – proof of specific intent to violate the law is not required.
- Financial relationships
 - Direct and indirect ownership/investment interests
 - Direct and indirect compensation arrangements

Designated Health Services

- ✓ Clinical lab services
- ✓ PT, OT, outpatient speech-language pathology services
- ✓ Radiology and certain other imaging services
- ✓ Radiation therapy services and supplies
- ✓ DME equipment and supplies
- ✓ Prosthetics, orthotics, and prosthetic devices and supplies
- ✓ Parenteral and enteral nutrients, equipment and supplies
- ✓ Home health services
- ✓ Outpatient prescription drugs
- ✓ Inpatient and outpatient hospital services

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AI in Healthcare

Civil False Claims Act (FCA)

Government's primary fraud enforcement tool

- Imposes liability against persons who:
 - Submit false or fraudulent claims to the government
 - Cause false or fraudulent claims to be submitted
 - Conspire to submit false or fraudulent claims
 - A person or entity may also be liable for “knowingly” and improperly avoiding paying the government or knowingly and improperly retaining an overpayment by the government, also known as a “reverse false claim.”
- “Knowing” or “Knowingly”
 - Actual knowledge
 - Deliberate ignorance
 - Reckless disregard
 - No specific intent to defraud required

Civil False Claims Act (FCA)

Government's primary fraud enforcement tool, cont.

- “Qui tam” (whistleblower) action
 - A lawsuit brought by a private whistleblower (relator) under the federal or a state FCA alleging fraud against public programs or funds.
 - The relator may receive a percentage of any recovery.
- Potentially huge damages models
 - 2026 updated penalty range for FCA violations (\$14,308 to \$28,619 per claim)
 - Treble damages
 - Attorney's fees
- Whistleblowers are protected from retaliation under the FCA.

Civil FCA Fiscal Year Statistics (2023-2025)

	<u>2025</u>	<u>2024</u>	<u>2023</u>
New FCA matters opened	1,698 (record)	1,402	1,212
Qui tam actions filed	1,297 (record)	979 (record then)	712
Total recovery	\$6.8B (record)	\$2.9B	\$2.68B
Healthcare recovery	>\$5.7B (≈84% of total)	≈\$1.67B (≈58% of total)	>\$1.8B (≈67% of total)
Qui tam recovery	>\$5.3B (≈78% of total)	>\$2.4B (≈83% of total)	>\$2.3B (≈86% of total)

“Health care fraud remained a leading source of False Claims Act settlements and judgments. Of the more than \$6.8 billion in FCA settlements and judgments ... over \$5.7 billion related to matters that involved the health care industry.”

DOJ Press Release (Jan. 16, 2026)

Amounts rounded; percentages are calculated from rounded DOJ-reported figures. “New FCA matters opened” combines qui tam filings and government-initiated matters/investigations.

Claims Integrity and Overpayment Risk

Criminal false claims and healthcare fraud

- Knowingly submitting, or causing the submission of, false information to obtain payment from a federal healthcare program may result in criminal liability.
- Penalties may include criminal fines, imprisonment, exclusion from federal healthcare programs, and reputational harm.
- Common risk areas include billing for services not provided, falsified documentation, upcoding, and misrepresentations regarding medical necessity.

Medicare overpayment rule

- Medicare and Medicaid overpayments must be reported and returned *within 60 days of identification*.
- Overpayments may arise from billing errors, coding issues, documentation deficiencies, or underlying compliance violations.
- Failure to timely report and refund overpayments may create FCA exposure.

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AI in Healthcare

Civil Monetary Penalty (CMP) Authorities

Civil monetary penalties

- The OIG may impose civil monetary penalties, assessments, and exclusion for fraud, abuse, and other program integrity violations.
 - Common risk areas include beneficiary inducements, improper claims, EMTALA violations, and relationships with excluded individuals.
 - Penalties can be significant and may apply even without criminal prosecution.
- 2026 update
 - The OIG has requested public input on potential modifications to Beneficiary Inducements CMP exceptions related to compensation and support provided to clinical-trial participants, signaling continued agency review of beneficiary remuneration policies.
 - *See HHS Office of Inspector General, Medicare and State Health Care Programs: Fraud and Abuse; Request for Information Regarding the Federal Anti-Kickback Statute and Beneficiary Inducements CMP, 91 Fed. Reg. 37902 (June 24, 2026).*

Exclusion Authorities

OIG exclusion authority

- Exclusion
 - Bars an individual or entity from receiving federal healthcare program payment for items or services furnished, ordered, or prescribed.
- Mandatory exclusion
 - Applies to specified convictions, including Medicare or Medicaid fraud, patient abuse or neglect, felony healthcare fraud, and felony controlled-substance offenses.
- Permissive exclusion
 - May apply to other misconduct, including false claims, kickbacks, license actions, unnecessary or substandard services, and certain fraud-related offenses.
- List of Excluded Individuals/Entities (LEIE) [maintained by the OIG]
 - Organizations may face CMPs for employing or contracting with excluded parties.

Exclusion Authorities

2026 Delegation of exclusion authority to CMS

- During a July 21, 2026, press conference (broadcast on C-SPAN), the HHS Secretary announced the delegation of exclusion authority to CMS “effective immediately,” allowing exclusion action to be initiated *through either CMS or OIG*.
- The addition of CMS brings exclusion authority into the agency that processes claims, manages enrollment, and conducts program-integrity reviews, creating a potential pathway to faster exclusion action tied directly to billing and enrollment data.
- As of the date this presentation was drafted:
 - No formal delegation instrument, *Federal Register* notice, or implementing guidance had been published.
 - The division of responsibility, procedures, notices, appeals, reinstatement, and coordination between CMS and OIG had not been formally addressed.

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AI in Healthcare

Emergency Medical Treatment and Labor Act (EMTALA): Core Obligations

Medical screening examination

A Medicare-participating hospital with emergency services must provide an appropriate medical screening examination when an individual comes to the emergency department and requests examination or treatment.

Stabilizing treatment

If an emergency medical condition exists, the hospital *must provide stabilizing treatment* within its capability or arrange an appropriate transfer.

No payment delay

A hospital must provide an appropriate medical screening examination and any necessary stabilizing treatment regardless of a person's citizenship, immigration status, legal status, insurance status, or ability to pay.

Beyond the emergency department

EMTALA obligations are not limited to the emergency department. The law may apply when an individual seeks care for a potential emergency medical condition elsewhere on hospital property, including certain hospital-owned ambulances.

EMTALA: Enforcement and Compliance

Enforcement and compliance risk

- CMPs and other sanctions may be imposed for EMTALA violations.
- Fines may exceed \$136,886 per violation for larger hospitals.
- Hospitals may face termination of their Medicare provider agreement.
- Patients may pursue private lawsuits for certain EMTALA violations.

Current areas of enforcement focus

- Psychiatric emergency boarding and delays in screening, stabilization, placement, or transfer.
- Transfer practices involving hospitals facing capacity constraints or specialty-service limitations.
- Closures of hospitals, labor-and-delivery units, and specialty services that affect access to emergency care.
- Emergency pregnancy-related care following Dobbs and the evolving interaction between EMTALA and state law.

HIPAA: the baseline and the current pressure points

Privacy Rule

Governs permitted uses and disclosures of protected health information (PHI) and gives individuals rights concerning their records.

Security Rule

Requires administrative, physical, and technical safeguards for electronic PHI.

The current rule remains in effect while HHS considers proposed changes (expected in 2027).

Breach Notification Rule

Requires notification after a breach of unsecured PHI, subject to the rule's standards and deadlines.

2026 oversight focus

OCR's public breach portal continues to show hacking and information-technology incidents involving providers and business associates.

Existing Privacy and Security Rule obligations apply by default to PHI processed by AI systems.

Cybersecurity: Recent Lessons for Healthcare

- **Ransomware remains an active enforcement priority**
 - OCR reports hacking and ransomware are the most frequently reported type of large breach incidents.
 - OCR continues to settle HIPAA Security Rule enforcement actions arising from ransomware incidents, with corrective action plans monitored by OCR.
- **Risk analysis is the recurring compliance issue**
 - OCR continues to emphasize risk analysis, risk management, and security governance as foundational HIPAA Security Rule requirements.
 - Recent enforcement actions focus on whether organizations identified and addressed vulnerabilities before an attack occurred.
 - Cybersecurity is increasingly viewed as a patient-safety and operational-resilience issue, not solely a privacy issue.

AI in Healthcare: Federal Landscape

1 Federal posture favors adoption

- Executive policy promotes AI innovation, agency adoption, and procurement reform.
- The Administration relies largely on existing legal authorities rather than a single comprehensive federal AI law.

2 Healthcare remains sector-specific

- HHS, CMS, FDA, OCR, FTC, ASTP/ONC, and NIST each contribute through distinct rules, guidance, standards, and enforcement.
- The result is overlapping oversight rather than a single healthcare AI regulator.

3 Regulation is layered, not centralized

- Existing frameworks continue to apply, including FDA device requirements, CMS coverage rules, HIPAA, Section 1557, the FTC Act, and NIST standards.
- AI governance must account for the use case, affected data, decision-maker, and agency jurisdiction.

Healthcare oversight remains sector-specific and layered

AI in Healthcare: From Policy to Operations

1 CMS: guidance becomes operational

- Medicare Advantage coverage requirements and the WISeR Model bring algorithmic review into medical-necessity, prior-authorization, and program-integrity operations.
- WISeR uses enhanced technologies, including AI and machine learning, with human clinical review for selected Medicare services.

2 Congress remains active but fragmented

- Federal proposals address targeted issues such as deepfakes, AI safety, healthcare oversight, and possible preemption of state AI requirements.
- The proposals do not yet amount to a single comprehensive federal framework.

3 States drive compliance pressure

- State AI laws increasingly shape transparency, notice, discrimination, and automated-decision requirements.
- Federal policy increasingly responds through preemption proposals, funding leverage, and agency guidance.

Federal initiatives increasingly translate AI policy into coverage, payment, program-integrity, and compliance expectations

Key Compliance and Enforcement Takeaway

BIG TAKEAWAY

Compliance risk is no longer confined to a few discrete fraud-and-abuse laws – it increasingly arises across routine operational, clinical, financial, and technology activities throughout the organization

The compliance landscape now reflects the overlap between healthcare-specific requirements and broader enterprise risks

Fraud and abuse • Patient care • Privacy and cybersecurity • Emerging technology

Discussion/Questions

Thank You