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CENTRAL HEALTH

Our Vision
Central Texas is a model healthy community.

Our Mission
By caring for those who need it most, Central Health improves the health of our community.

Our Values
Central Health will achieve excellence through:
Stewardship - We maintain public trust through fiscal discipline and open and transparent communication.
Innovation - We create solutions to improve healthcare access.
Respect - We honor our relationship with those we serve and those with whom we work.
Collaboration - We partner with others to improve the health of our community.

BUDGET AND FINANCE COMMITTEE

STAYS IN FILE

Wednesday, November 13, 2019, 6:30 p.m.
(or after conclusion of Strategic Planning Committee Meeting)

Central Health Administrative Offices
1111 E. Cesar Chavez St.
Austin, Texas 78702
Board Room

AGENDA*

***Agenda item numbers are assigned for ease of reference only and do not necessarily reflect the order of their consideration by the Committee.**

1. Consider and approve the minutes of the October 23, 2019 meeting of the Central Health Board of Managers Budget and Finance Committee. (*Action Item*)
2. Discuss and take appropriate action on amendments to the Central Health Reserve Policy. (*Action Item*)
3. Discuss and take appropriate action on the local provider participation fund (LPPF) administrative program rules. (*Action item*)
4. Receive and discuss a presentation from Sendero Health Plans, Inc. on enrollment in IdealCare and the proposed Fiscal Year (FY) 2020 budget.[1] (*Informational Item*)
5. Receive and discuss an update on a capital line of credit agreement with J.P. Morgan Chase. (*Informational Item*)
6. Confirm the next regular Committee meeting date, time, and location. (*Informational Item*)

Note [1], Possible closed session item.

A quorum of Central Health's Managers may convene to discuss matters on the agenda, and such quorum may take Board action on items consistent with the Board's bylaws and the limits of any posting on this agenda.

The Budget and Finance Committee may consider any matter posted on the agenda in a closed session if there are issues that require consideration in a closed session and the Committee announces that the item will be considered during a closed session.

Any individual with a disability who plans to attend this meeting and requires auxiliary aids or services should notify Central Health at least two days in advance, so that appropriate arrangements can be made. Notice should be given to the Board Governance Manager by telephone at (512) 978-8049.

Came to hand and posted on a Bulletin Board in the Courthouse,
Austin, Travis County, Texas on this the 8th day of
November 2019.
Dana DeBeauvoir
County Clerk, Travis County, Texas
By _____ Deputy
A. MACEDO

FILED AND RECORDED
OFFICIAL PUBLIC RECORDS
Dana DeBeauvoir
Dana DeBeauvoir, County Clerk
Travis County, Texas
201981602
Nov 08, 2019 02:49 PM
Fee: $0.00 MACEDOS

CENTRAL
HEALTH

BUDGET & FINANCE COMMITTEE MEETING

November 13, 2019

AGENDA ITEM 1

Consider and approve the minutes of the October 23, 2019 meeting of the Central Health Board of Managers Budget and Finance Committee.

MINUTES OF MEETING – OCTOBER 23, 2019

CENTRAL HEALTH BUDGET AND FINANCE COMMITTEE

On Wednesday, October 23, 2019, the Central Health Board of Managers Budget and Finance Committee convened at 6:51 p.m. in the Board Room, 1111 East Cesar Chavez, Austin, Texas 78702. Clerk for the meeting was Briana Yanes.

Committee Members present: Chairperson Bell, Manager Greenberg, Manager Oliver

Board Members present: Jones, Valadez

REGULAR AGENDA

1. Consider and approve the minutes of the July 24, 2019 meeting of the Central Health Board of Managers Budget and Finance Committee.

Clerk's Notes: Discussion on this item began at 6:51 p.m. Manager Valadez moved that the Committee approve the minutes of the July 24, 2019 meeting of the Central Health Board of Managers Budget and Finance Committee with the correction that Manager Valadez was absent for the vote on Item 13.

Manager Greenberg seconded the motion.

Chairperson Guadalupe Zamora	Absent
Vice Chairperson Sherri Greenberg	For
Treasurer Charles Bell	For
Secretary Abigail Aiken	Absent
Manager Shannon Jones	For
Manager Maram Museitif	Absent
Manager Julie Oliver	For
Manager Cynthia Valadez	For
Manager Julie Zuniga	Absent

2. Receive, discuss and take appropriate action on a presentation from Southwest Retirement Consultants and Branch Banking and Trust (BB&T) on the quarterly investment results of the Travis County Healthcare District Retirement Plan and 457 Deferred Compensation Plan, including recommended fund changes.

Clerk's Notes: Discussion on this item began at 6:53 p.m. BB&T presented on the Central Health Retirement Plan and 457 Deferred Compensation Plan.

Manager Greenberg moved that the Committee recommend that the full Board approve the changes suggested by Southwest Retirement Consultants and Branch Banking and Trust to the Central Health Retirement Plan and 457 Deferred Compensation Plan.

Manager Valadez seconded the motion.

Chairperson Guadalupe Zamora	Absent
Vice Chairperson Sherri Greenberg	For
Treasurer Charles Bell	For
Secretary Abigail Aiken	Absent
Manager Shannon Jones	For
Manager Maram Museitif	Absent
Manager Julie Oliver	For
Manager Cynthia Valadez	For
Manager Julie Zuniga	Absent

3. Discuss and take appropriate action on an Interlocal Agreement between Central Health, The University of Texas at Austin, and Emergency Services District 11 for the establishment of a health care clinic in southeast Travis County.

Clerk's Notes: Discussion on this item began at 7:16 p.m.

At 7:18 p.m. Chairperson Bell announced that the Board was convening in closed session to discuss agenda item 3 under Texas Government Code Section 551.071, Consultation with Attorney.

At 8:10 p.m. the Board returned to open session.

4. Discuss health care service delivery expansion in Eastern Travis County, including project budgets.

Clerk's Notes: Item 4 was not discussed.

5. Discuss Central Health owned or occupied real property, and potential property for acquisition or lease, including the Downtown Campus.

Clerk's Notes: Item 5 was not discussed.

6. Discuss and take appropriate action on the 1115 Medicaid Waiver, Delivery System Reform Incentive Payment (DSRIP) projects, the Community Care Collaborative including its health care delivery arrangements, and other community partnerships.

Clerk's Notes: Item 6 was not discussed.

7. Confirm the next regular Committee meeting date, time, and location.

Clerk's Notes: Discussion on this item began at 8:11 p.m. Chairperson Bell announced that the next Central Health Board of Managers Budget and Finance Committee meeting is scheduled for Wednesday, November 13, 2019 at 5:30 p.m., Central Health Administrative Offices, 1111 E. Cesar Chavez St., Austin, Texas 78702.

Manager Greenberg moved that the Committee adjourn. Manager Oliver seconded the motion.

Chairperson Guadalupe Zamora	Absent
Vice Chairperson Sherri Greenberg	For
Treasurer Charles Bell	For
Secretary Abigail Aiken	Absent
Manager Shannon Jones	For
Manager Maram Museitif	Absent
Manager Julie Oliver	For
Manager Cynthia Valadez	For
Manager Julie Zuniga	Absent

The meeting adjourned at 8:12 p.m.

_____

Charles Bell, Committee Chairperson
Central Health Budget and Finance Committee

CENTRAL
HEALTH

BUDGET & FINANCE COMMITTEE MEETING

November 13, 2019

AGENDA ITEM 2

Discuss and take appropriate action on amendments to the Central Health Reserve Policy.

CENTRAL HEALTH

MEMORANDUM

DATE: November 8, 2019
TO: Central Health Board of Managers
FROM: Lisa Owens, Deputy Chief Financial Officer
CC: Jeff Knodel, Chief Financial Officer
Holly Gummert, Travis County Attorney's Office
Mike Geeslin, President and CEO
RE: Agenda Item 2- Discuss and take appropriate action on amendments to the Central Health Reserve Policy. ACTION ITEM

Overview:

As discussed in previous briefings regarding the Pay for Success Permanent Supportive Housing project that is being negotiated between Central Health and PAATH, LLC, a reserve policy is drafted below. This policy allows Central Health to maintain control of funds, while reserving them on our balance sheet for future use, specifically for this project. This policy would be effective after the execution of a contract.

Synopsis:

Pay For Success Reserve Policy

Upon execution of a contract, a Pay For Success (PFS) reserve will be established to restrict available funds to pay for all possible outcomes in accordance with the terms of the fully executed contract with PAATH, LLC approved by the Central Health Board of Managers. The amount of funds placed in the PFS reserve each year will be based on the maximum at-risk contractual requirements for the current year and any other outstanding balances from prior periods. Funds will be removed from the PFS reserve during any fiscal year if, for example, it is determined that the outcomes will not be achieved and there will be no payment obligation from Central Health. In addition, at the completion of the full term, including all renewals, any remaining balance in the PFS reserves will be converted back to unrestricted funds.

Action Requested:

Staff requests the committee recommend approval of the Central Health Reserve Policy to the full board at the November 20th regular board meeting.

CENTRAL
HEALTH

BUDGET & FINANCE COMMITTEE MEETING

November 13, 2019

AGENDA ITEM 3

Discuss and take appropriate action on the local provider participation fund (LPPF) administrative program rules.

CENTRAL HEALTH

1111 E. Cesar Chavez
St. Austin, Texas
78702
Phone: 512 978-8155
Fax: 512 978-8156
www.centralheath.net

MEMORANDUM

To: Central Health Budget and Finance Committee
From: Katie Coburn
CC: Mike Geeslin, President & CEO
Date: November 20, 2019
Re: Agenda Item 3- Discuss and take appropriate action on the local provider participation fund (LPPF) administrative program rules. ACTION ITEM

Overview:
Central Health staff plans to request the Board of Managers take action at the November 20th board meeting to adopt the attached Local Provider Participation Fund (LPPF) program administrative procedures and delegate authority to the Central Health CEO to amend them as necessary to ensure compliance and optimal functioning of the LPPF program.

Background:
Based on enabling legislation in Chapter 298E of the Texas Health and Safety Code, the Central Health Board of Managers approved the creation of the Local Provider Participation Fund (LPPF) program in summer of 2019 to fund the local share of certain Medicaid supplemental program payments.

Central Health staff developed the attached administrative procedures for its role as the LPPF Administrator. The procedures define the program's scope and purpose and outline administrative processes, including the rate setting process, assessment and collection of mandatory payments, and authorized uses of funding. The administrative procedures are in compliance with statutory language from Chapter 298E, which is the LPPF's enabling legislation.

Central Health staff shared draft program rules with hospitals subject to the TCHD LPPF mandatory payment on July 26, 2019 and incorporated feedback into the final document. A copy of the draft rules was presented to the Central Health Board of Managers on July 31, 2019.

Action Requested:
Staff requests the committee recommend approval of the LPPF administrative rules to the full board at the November 20th regular board meeting.

TRAVIS COUNTY HEALTHCARE DISTRICT D/B/A CENTRAL HEALTH
HEALTH CARE PROVIDER PARTICIPATION PROGRAM
RULES AND PROCEDURES

General Provisions

Rule 1. Definitions. In these rules and procedures:

(a) "AHA Survey Data" means any financial and utilization data required by and reported to the Department of State Health Services under Texas Health & Safety Code Sections 311.032 and 311.033 and any rules adopted by the executive commissioner of the Health and Human Services Commission to implement those sections.

(b) "Board" means the board of managers of the District.

(c) "District" means the Travis County Healthcare District d/b/a Central Health.

(d) "Mandatory payment" means a mandatory payment authorized under Chapter 298E, Subtitle D, Title 4, Texas Health and Safety Code.

(e) "Institutional health care provider" means a hospital that is not owned and operated by a federal, state, or local government and provides inpatient hospital services.

(f) "Local provider participation fund" means a public fund created by the District, that is under its administrative control and consists of (1) all revenue received by the District attributable to mandatory payments; (2) money received from the Texas Health and Human Services Commission as a refund of an intergovernmental transfer under the program, provided that the intergovernmental transfer does not receive a federal matching payment; and (3) the earnings of the fund.

(g) "Paying hospital" means an institutional health care provider required to make a mandatory payment.

(h) "Program" means the health care provider participation program authorized under Chapter 298E, Subtitle D, Title 4, Texas Health and Safety Code.

(i) "Year" refers to the District's fiscal year (October through September).

Rule 2. Health Care Provider Participation Program; Participation in Program; Purpose.

(a) The Board has adopted, on the affirmative vote of at least a majority of the Board, a resolution authorizing the District to participate in the Program.

(b) The Program authorizes the District to collect mandatory payments from each institutional health care provider located in the District to be held in a local provider participation fund established by the District.

(c) The Program's purpose is to enable the District to collect mandatory payments from institutional health care providers to fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for nonpublic hospitals to support the provision of health care by institutional health care providers to residents in need of health care.

(d) To the extent any provision or procedure under Chapter 298E, Subtitle D, Title 4, Texas Health & Safety Code causes a mandatory payment to be ineligible for federal matching funds, the District may provide for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare & Medicaid Services.

Powers and Duties of Board

Rule 3. Limitation on Authority to Require Mandatory Payment. The District may require a mandatory payment from an institutional health care provider only in the manner provided in these rules and procedures.

Rule 4. Institutional Health Care Provider Reporting; Inspection of Records.

(a) From time to time as deemed necessary for administration of the program, the District will obtain a copy of a recent Medicare cost report for each institutional health care provider. Each institutional health care provider will provide the District a copy of such Medicare cost report if requested by the District.

(b) From time to time and no less frequently than annually, the District will obtain or require each institutional health care provider to submit to the District:

(1) a copy of its AHA Survey Data; and

(2) in the event that an institutional health care provider hospital does not complete a Medicare cost report or AHA Survey Data for a period when it will be assessed mandatory payments, its net patient revenue for that period on a form and in a manner prescribed by the District.

(c) The District may inspect the records of an institutional health care provider to the extent necessary to ensure that the provider has submitted all required data under these rules and procedures.

General Financing Provisions

Rule 5. Hearing.

(a) Each Year the Board will hold a public hearing on the rate of any mandatory payments that the Board intends to require for the Year and how the revenue derived from those payments is to be spent.

(b) Not later than the fifth day before the date of the hearing required under Rule 5(a), the District will publish notice of the hearing in a newspaper of general circulation in the District and provide written notice of the hearing to each institutional health care provider in the District.

(c) A representative of a paying hospital is entitled to appear at the time and place designated in the public notice and to be heard regarding any matter related to the mandatory payments.

Rule 6. Depository.

(a) The Board will designate one or more banks as a depository for the local provider participation fund and mandatory payments received by the District will be deposited in those accounts.

(b) All income received by the District under these rules and procedures, including revenue from mandatory payments remaining after fees for assessing and collecting the payments are deducted, will be deposited in the local provider participation fund and may be withdrawn only as provided by these rules and procedures.

(c) All funds under these rules and procedures will be secured in the manner provided for securing other funds of the District.

Rule 7. Local Provider Participation Fund; Authorized Uses of Money.

(a) The District will only use money deposited to the local provider participation fund to:

(1) fund intergovernmental transfers from the District to the state to provide the nonfederal share of Medicaid payments for:

(A) uncompensated care payments to nonpublic hospitals if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) and allowed by applicable laws and regulations;

(B) uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area in which the District is located;

(C) payments available under another waiver program authorizing payments that are substantially similar to Medicaid payments to nonpublic hospitals described by Rule 7(b)(1)(A) or Rule 7(b)(1)(B); or

(D) any reimbursement to nonpublic hospitals for which federal matching funds are available;

(2) pay the administrative expenses of the District in administering the Program, including collateralization of deposits;

(3) refund a mandatory payment collected in error from a paying hospital;

(4) refund to paying hospitals a proportionate share of the money the District:

(A) receives from the Health and Human Services Commission that is not used to fund the nonfederal share of Medicaid supplemental payment program payments; or

(B) determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments;

(5) transfer funds to the Health and Human Services Commission if the District is legally required to transfer the funds to address a disallowance of federal matching funds with respect to programs for which the District made intergovernmental transfers described by Rule 7(a)(1); and

(6) reimburse the District if the District is required by the rules governing the uniform rate enhancement program described by Rule 7(a)(1)(B) to incur an expense or forego Medicaid reimbursements from the state because the balance of the local provider participation fund is not sufficient to fund that rate enhancement program.

(b) The District will not commingle money in the local provider participation fund with other District funds.

(c) An intergovernmental transfer of funds described by Rule 7(a)(1) will not be used by the District to:

(1) expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152); or

(2) fund the nonfederal share of payments to nonpublic hospitals available through the Medicaid disproportionate share hospital program or the delivery system reform incentive payment program.

Mandatory Payments

Rule 8. Mandatory Payments Based on Paying Hospital Net Patient Revenue.

(a) Except as provided by Rule 10, the Board may require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the District.

(b) The District may provide for mandatory payments to be assessed on a periodic basis but no more frequently than quarterly. Mandatory payments are typically due no later than 30 days after such payment is assessed unless the District sets a different due date.

(c) Mandatory payments for the first Year of the Program will be assessed on the net patient revenue of an institutional health care provider as follows:

(d) on the institutional health care provider as determined by the provider's Medicare cost report for a fiscal year selected by the District; or

(e) if no CMS Medicare cost reports identified in subparagraph (1) of Rule 8(c) are available, on the institutional health care provider's net patient revenue as determined by AHA Survey Data for the most recent fiscal year such data is available; or

(f) on the net patient revenue for the applicable fiscal year as reported on a form and in a manner prescribed by the District, to the extent this information can be provided and is otherwise unavailable through the means described in subparagraphs (1) and (2) of Rule 8(c).

(g) Mandatory payments for following Years of the Program will be assessed on the net patient revenue of institutional health care providers for subsequent fiscal years as determined by each institutional health care provider's applicable Medicare cost report or AHA Survey Data, or, if deemed necessary, by another method selected by the District.

(h) To determine the rate of mandatory payments set by the Board, the District may require institutional health care providers to provide information and data regarding the Medicaid payments and related services described under Rule 7(a)(1).

Rule 9. Mandatory Payment Requirements

(a) All institutional health care providers will be assessed mandatory payments in accordance with the rate set by the Board.

(b) The amount of a paying hospital's mandatory payment will be uniformly proportionate with the amount of net patient revenue generated by that paying hospital in the District .

(c) The Board will set the rate of the mandatory payment no less frequently than on an annual basis.

(d) Subject to the maximum amount prescribed by Rule 10(a), the Board will set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the District for activities under these rules and procedures and to fund intergovernmental transfers in an amount deemed proper for the purposes described in Rule 7(a). The annual amount of revenue from mandatory payments that will be used to offset the District's administrative expenses is $150,000 plus the cost of collateralization of deposits, regardless of actual expenses.

(e) The District shall not condition the use of mandatory payments for the nonfederal share of any Medicaid payment described by Rule 7(a) that is made to an institutional health care provider on whether that institutional health care provider makes mandatory payments or the amount of any such mandatory payments.

Rule 10. Mandatory Payment Prohibitions.

(a) The amount of the mandatory payment required of each paying hospital will not exceed an amount that, when added to the amount of the mandatory payments required from all other paying hospitals in the District, exceeds six percent of the aggregate net patient revenue of all paying hospitals in the District.

(b) An institutional health care provider hospital may not include as a surcharge to a patient any amount of a mandatory payment required by the District.

(c) Mandatory payments will not be used for raising general revenue and will not be raised in excess of the amount deemed to be reasonably necessary to:

(1) fund the nonfederal share of Medicaid supplemental payments and Medicaid managed care rate enhancements for services by nonpublic hospitals to Medicaid and uninsured patients; and

(2) cover the administrative expenses of the District.

(d) The District will only assess and collect a mandatory payment if a waiver program, uniform rate enhancement, or reimbursement described by Rule 7(a)(1) is available to the District for nonpublic hospitals in the District.

Rule 11. Assessment and Collection of Mandatory Payments.

(a) The District may designate an official of the District or contract with another person to assess and collect the mandatory payments.

(b) The District will limit the collection fee of any person charged by the District with the assessment and collection of mandatory payments to be within the person's usual and customary charges for like services.

(c) If the person charged with the assessment and collection of mandatory payments is an official of the District, any revenue from a collection fee will be deposited in the District general fund and, if appropriate, will be reported as fees of the District.

(d) The District will establish due dates and payment options for mandatory payment amounts.

CENTRAL
HEALTH

BUDGET & FINANCE COMMITTEE MEETING

November 13, 2019

AGENDA ITEM 4

Receive and discuss a presentation from Sendero Health Plans, Inc. on enrollment in IdealCare and the proposed Fiscal Year (FY) 2020 budget.[1]

SENDERO HEALTH PLANS | CommUnityCare | CENTRAL HEALTH

CENTRAL HEALTH
BOARD OF MANAGERS
BUDGET & FINANCE

OPEN SESSION SLIDES

SENDERO HEALTH PLANS
2020 BUDGET SUMMARY

Wednesday, November 13th 2019

Sendero Board Approved 2020 Budget

SENDERO HEALTH PLANS 2019-20 PRELIM BUDGET REVIEW

	2019 BUDGET APPROVED thru DECEMBER 2019 (Dec 5, 2018)	2019 DRAFT PROJECTED for BUDGET thru DECEMBER 2019 (Oct 28, 2019)	2020 DRAFT BUDGET PROJECTED BUDGET thru OCTOBER 2019 (Oct 28, 2019)	Notes
Total Revenue After Risk Adjustment	$86,733,600	$83,074,926	$110,484,000	2019 Membership lower than expected, 2020 more competitive
Total Medical Expenses	$66,091,003	$67,495,740	$86,729,940	2019 CHAP costs higher than expected
Contribution to Overhead	$20,642,597	$15,579,186	$23,754,060	2019 Margin $5m less than expected
Total Administrative Expenses	$19,487,345	$18,245,221	$23,238,087	2019: Saved $1m on admin in 2019, 2020 targeting full staff
Net Income (loss)	$1,155,251	($2,666,035)	$515,973	Membership and CHAP driving difference versus budget
Check Total				
Average Membership	14,200	12,632	16,500	2020: Offering 4 of 5 lowest cost plans
Member Months	170,400	151,579	198,000	
Admin as % of Revenues After Risk Adj	22%	22%	21%	Admin
Premium PMPM	$509.00	$548.06	$558.00	Average premiums higher due to more CHAP
Claims PMPM	$387.86	$445.28	$438.03	Lower average claims projected for 2020 due to more Bronze
Admin PMPM	$114.36	$120.37	$117.36	Admin is roughly half fixed and half variable per member
Net Income PMPM	$6.78	-$17.59	$2.61	

- Additional detailed financial data to be provided
- 2019 Draft Projection incorporates potential loss to provide conservative forecast for budgeting
- 2020 Budget includes conservative estimate of increased membership

CENTRAL
HEALTH

BUDGET & FINANCE COMMITTEE MEETING

November 13, 2019

AGENDA ITEM 5

Receive and discuss an update on a capital line of credit agreement with J.P. Morgan Chase.

CENTRAL HEALTH

MEMORANDUM

To: Central Health Board of Managers
From: Lisa Owens, Deputy Chief Financial Officer
CC: Mike Geeslin, President and CEO
Jeff Knodel, Chief Financial Officer
Date: November 8, 2019
Re: Agenda Item 5- Receive and discuss an update on capital line of credit agreement with J.P. Morgan Chase. INFORMATIONAL ITEM

Overview:
During the Central Health budget planning and past board meetings staff presented a bank line of credit from JP Morgan as an appropriate option for smaller capital projects. These include Central Health capital projects, to be used specifically for FFE (Furniture, Fixtures, and Equipment) and Information Technology.

Synopsis:
The Board of Managers (BOM) will be asked to approve the finance contract at an upcoming meeting. In order to ensure the contract terms are finalized with the appropriate details, one of the larger technology purchases (the CommUnityCare Electronic Health Records (EHR) system) requires additional information. As soon as the contract is finalized and reviewed by counsel, a draft finance contract will be shared with the BOM. In the meantime, we wish to continue to update the BOM on the status and timing of issuing the line of credit.

Fiscal Impact:
Central Health staff proposes a standing credit line available to draw from in order to time the draws around project cash flow needs. Staff has determined the initial credit line amount to be $10 million.

Recommendation:
Staff plans to bring this item the Central Health BOM meeting as soon as terms are finalized and finance contract is ready for BOM consideration. Further, we anticipate pledging our debt service tax rate, therefore this item will then be taken to Travis County Commissioners Court after approval by the Central Health BOM.

Action Requested:
This is an informational item and action will be requested at a future board meeting.

CENTRAL
HEALTH

BUDGET & FINANCE COMMITTEE MEETING

November 13, 2019

AGENDA ITEM 6

Confirm the next regular Committee meeting date, time, and location.